UHF Medicaid Conference | DSRIP Promising Practices Highlights CBC's Innovative Community Health Hot-spotting Intervention Program™ (CHHIP)

CBC's 2 CHHIP programs were highlighted in the UHF published DSRIP Promising Practices Highlights: Strategies for Meaningful Change for New York Medicaid.

Potentially Avoidable Services

Access to Primary and Preventive Care

Clinical Improvement: Behavioral Health

Population Targeting: Identifying Individuals with Complex Behavioral and Social Needs

Using and sharing data to target individuals with complex behavioral health needs is a crucial step in the success of PPS initiatives, but creating a risk stratification method that effectively identifies individuals most appropriate for an intervention can be difficult. To overcome such challenges, **Mount Sinai PPS** has used data hot-spotting to identify patients with BH diagnoses and high ED/hospital use and to connect them to a six-month intensive care management program called CORE (Community Outreach for Recovery and Engagement). Delivered by The Bridge in partnership with Coordinated Behavioral Care Independent Practice Association, this program uses information from EMRs, the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES), and clinical referrals to target patients with a behavioral health diagnosis and either one hospital readmission or six or more ED visits.[43] As of December 31, 2018, preliminary results for a cohort of 31 program participants suggest that all individuals with a known BH admission received a follow-up appointment within seven days of discharge, and that metabolic testing was completed for 67% of patients with open diabetes monitoring or cardiovascular disease care gaps. Combined with efforts to facilitate primary care appointments, this program complements DSRIP's focus on improving adults' use of primary care while promoting better outpatient care and follow-up for behavioral health conditions.[44]

In tandem with its Mount Sinai effort, Coordinated Behavioral Care Independent Practice Association has helped arrange a partnership between **Staten Island PPS** and Project Hospitality to develop the HEALTHi (Helping, Engaging, and Linking to Health Interventions) program. The PPS uses EMR data to identify high-risk patients and works with patients' providers to enroll these individuals in the program, which provides six months of intensive care management. This includes 24-hour access to team support, weekly home visits, frequent check-in calls, accompaniment to appointments, assistance with transportation, and support for unmet social needs. The PPS reports that as of February 2019, 70 high-risk patients were enrolled in the HEALTHi program, and that many have already completed the six-month intervention. Over 95% of the participants have visited primary care physicians, and over 70% of those with substance use problems have initiated and engaged in treatment. Most participants (as applicable to their diagnoses) have adhered to their antidepressant and antipsychotic prescriptions (90%), have had a diabetes screening (70%), and have filled a prescription for asthma (64%). Over 80% of participants have not had an ED visit since enrollment.[45]

CBC's novel service offering: Community Health Hot-spotting Intervention Program (CHHIP) is an opportunity to further promote community network services serving high-acuity/high-cost populations requiring an integrated care coordination program. CHHIP targets high utilizers of medical and behavioral health services with disproportionate healthcare costs, potentially driven by avoidable emergency and acute medical and behavioral health interventions. Despite, in many instances, knowing who these individuals are, as well as having extensive data, such as demographics and health condition diagnoses, their utilization of high cost emergency and hospital-based services persists. Oftentimes, hospital discharge and aftercare plans fail to address these individual's social needs, and too often they are not connected to the appropriate community-based social services that meet their complex needs.

CBC's CHHIP is a targeted intervention tailored to the specific needs of these high-utilizers, in addition to leveraging the support of their family and care network to address each individual's distinct needs. CHHIP will be an intensive, individualized and customized program that will adopt the successful components of our innovative Pathway Home™ care transition program and use our extensive network of member and affiliate agencies to provide an intensive person-centered intervention that meets the needs of this cohort, in the context of their social network and their community.

The CHHIP service offering will be for a total of six (6) months, with the first three (3) months being the most intensive as assertive outreach and engagement occurs. Following connection with the individual, multiple weekly visits will occur which promote community stability and linkage to local health, behavioral health and social services.

CBC partnered with The Bridge and Mt. Sinai PPS in Manhattan to implement the CORE program, while simultaneously working with Project Hospitality and the Staten Island PPS to effectuate HEALTHi in Staten Island. Both programs are rooted in the traditional community hot-spotting model, servicing clients with multidisciplinary care teams. Each PPS identified a cohort of high-utilizers from their attribution lists based on designated criteria and state claims data. These individuals were assertively outreached and engaged in the community by the CHHIP teams. Comprehensive data was collected over the course of the intervention and reported back to the respective PPS'. Preliminary outcome data suggests a significant impact on reduction in ED and hospital utilization, in addition to potential cost-savings. The data also indicates a positive impact on both appointment adherence as well as diabetes screening and monitoring rates. Both programs continue to operate under their current DSRIP contracts.

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