



CLINIC PARTNERSHIP INTRODUCTORY PACKAGE

City Health Works equips ambulatory care practices with the **capacity, protocols** and **systems** to more effectively manage the care of **high need, high cost patients** with chronic illnesses within and beyond clinic doors.

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I. OBJECTIVE SETTING

City Health Works is collaborating with _____ (CLINIC NAME) to implement **Health Coaching + Care Management services** with the aim of demonstrating that City Health Works is able to support _____ in managing and engaging the care needs of high risk patients.

To start, City Health Works offers subsidized services to new clinic partners to demonstrate agreed upon objectives. Successful completion of a short-term demonstration pilot will facilitate a scaled-up, contractual relationship.

The following is a sample list of core metrics and KPIs set with each clinic partner for initial short-term demonstrate pilots:

<p>VOLUME</p> <ul style="list-style-type: none">• Enroll ____ patients.• Complete 3-month Health Coaching intervention with ____ patients. <p>OUTCOME MEASURES</p> <p>Primary indicators for 3-month evaluation, as appropriate:</p> <ul style="list-style-type: none">• Blood Pressure• Blood Sugar (measure by HbA1c)• Medication Adherence• Asthma Control Test• #of ED visits and IP stays related to acute cardiac, asthma or hyperglycemic episodes• _____• _____ <p>Key Performance indicators for 3-month evaluation:</p> <ul style="list-style-type: none">• Identification of ____ eligible patients• Referral of ____ patients• 3 month Health Coaching service completed for 50 patients• % of appointments kept• Net Promoter score (patient satisfaction)• _____
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II. DETAILED SCOPE OF SERVICES

The majority of activities required to manage the day-to-day reality of living with chronic illnesses take place in the home. For most clinicians, the home is a black box. City Health Works' care team amplifies the reach of overburdened clinics by serving as vital eyes and ears to clinics and providing extra support to the patients who need the most help.

WHAT WE OFFER

City Health Works excels in serving high need, high cost patients who struggle with complex medical, socio-economic and cultural barriers by developing their capacity to more proactively self-manage their care needs and making them savvy users of the tricky health care system. Our service entails the following three components.

Personalized Health Coaching

- One-on-one coaching sessions to implement realistic, culturally appropriate lifestyle & daily routine changes.
- Sessions held in home or convenient community settings
- Medication & care plan education to decrease barriers to adherence.
- Continuous evaluation of progress towards goals via phone check-ins
- Assess support system; engage household members & care givers



Clinical Integration & Coordination

- Regular communication and care planning between CHW's Clinical Care Manager and primary care clinicians
- Early identification of complications. Escalation of urgent medical, medication and psychological issues to avert emergency room & hospital visits
- Compare medication lists with actual patient usage; inform clinicians to align lists & address barriers to access (cost, etc.)

Coordination w/ Non-Clinical services

- Referrals to social service providers and Health Homes to address legal, employment, housing, and related socio-economic needs
- Depression care planning under supervision of Depression Care Specialist social worker & PCP using the Collaborative Care Model; escalation of severe mental health needs.
- Identify and engage individuals who are "lost to follow-up" or not connected to clinical care through community partners

NEIGHBORHOOD-BASED CARE TEAMS & CLINIC PARTNERS

- **Care teams:** Each team of 9 Health Coaches are supervised by 1 Health Coach Supervisor (RD or RN, CDE)
- **Clinical Supervision:** Care Teams are integrated into partnering Primary Care Clinics. The Health Coach Supervisor serves as the bridge between each clinic and our Health Coaches.
- **Neighborhood-based model:** Care teams serve patients living in upper Manhattan and select zip codes in the Bronx who are connected to clinics across the neighborhood. Care teams are integrated into local clinics.

CURRENT CLINIC PARTNERS:

- Mount Sinai Health Systems' IMA Clinic
 - Mount Sinai EHHOP Clinic
 - Mount Sinai St Lukes' (1090 clinic)
- Metropolitan Hospital / NYC Health & Hospitals Corporation
 - Settlement Health
- Community Healthcare Network of NYC (HBA clinic)
 - Boriken
- Institute for Health (Harlem site, through PCORI grant)

DETAILED SCOPE OF SERVICES

City Health Works' team of clinician supervised Health Coaches provide the following services for high-risk patients with uncontrolled **Diabetes, Cardiovascular Disease, or Asthma.**

Future health areas will include: **Falls Prevention, Chronic Kidney Disease, CHF, co-morbid Depression and others.**

I. HEALTH COACHING

a) Increase percent of patients whose diabetes, blood pressure & asthma is controlled

- Provide education & coaching to motivate behavior change through **2-3 months of weekly health coaching sessions** followed by **on-going monthly maintenance sessions** to support long-term maintenance of healthy behaviors.
- Evaluate & address psychosocial barriers to behavior change
- Provide support for maintenance of healthy behaviors

b) Increase medication adherence

- Complete yearly review of all medications and supplements taken
- Evaluate & identify barriers to adherence to medications (e.g. side effects, home remedies, costs, pharmacy issues)
- Communicate with PCP to address adherence issues
- Increase number of patients taking medications as prescribed
- Reduce overall days per year of patients not taking medications
- Increase number of patients on 90-day prescription regimens
- Monitor physical activity and functional improvements in patients over time
- Complete yearly assessment of activities of daily living
- Complete yearly assessment of physical pain

c) Evaluate & improve patient's health literacy

- Increase disease-specific knowledge & self-efficacy
- Increase understanding of how and when to access care
- Increase understanding of behaviors that positively & negatively impact chronic illness

d) Monitor & Improve Depression (PHQ-9) Values

- Evaluate patients for depression
- Make appropriate referrals with positive screen
- Evaluate and address stress and other psychosocial issues
- Encourage medication adherence
- Provide supportive counseling

e) Help patients achieve clinically significant weight loss (5-10% of body weight)

- Engage in culturally-appropriate programs to teach about healthy eating, healthy cooking techniques and increased physical activity

II. CARE COORDINATION & ENHANCED PRIMARY CARE

a) Increase patient engagement with PCP

- Remind patients of appointments
- Prepare patients for appointments (assist with checklist of questions to ask, prompts to bring in medications, logs or other items PCP needs)
- Accompany patients to maintenance medical visits as needed (assist with translation and development of care plan)
- Reinforce care plan & goals for self-management
- Reduce no-shows

b) Improve patient communication with PCP

- Alert PCP with urgent medical issues
- Provide update on progress of patients on a regular basis

c) Improve adherence to specialty visits (eye doctor, dentist, foot doctor)

d) Improve patient satisfaction & engagement

- Educate & remind patients about timetable to get visits
- Make & prepare patients for appointments
- Document visits outside of HHC's health system
- Increase patient satisfaction scores
- Improve patient trust in PCP and medical facility
- Reduce no-show visits
- Increase medication management visits

III. ADULT PREVENTIVE CARE

a) Reduce preventable hospitalizations due to flu & pneumonia

b) Increase tobacco use screening & referrals to cessation programs

c) Reduce preventable hospitalizations due to falls

d) Increase breast, colorectal and cervical cancer screening rates

- Educate on ways to reduce flu & pneumonia transmission
- Encourage and monitor flu & pneumonia vaccines according to established timetables
- Evaluate for tobacco use
- Educate & help make appointments to cessation programs
- Support patient's self-management goals throughout cessation process
- Complete falls risk assessment
- Provide education and support to address and reduce risks
- Evaluate for need for screening according to guidelines
- Educate & help make appointments for screening
- Prepare patients for screening appointments
- F/U with patients regarding positive results and treatment

IV. SOCIAL / MENTAL HEALTH

a) Monitor & Improve Depression Scores

b) Improve quality of life & social support

- Screen and evaluate patients (PHQ-2 and/or PHQ-8)
- Make appropriate referrals
- Evaluate and address stress and other psychosocial issues
- Encourage medication adherence
- Provide individual support via home/community visits
- Increase engagement of family members and social champions
- Make referral to group-based services & programs

III. TARGET POPULATION

Clinic Partner will identify and refer eligible high need, high cost patients to City Health Works who require additional support to achieve better health outcomes and reduce avoidable hospital / ER visits.

ELIGIBILITY

- **Medical:**
 - Adults with uncontrolled chronic illnesses (uncontrolled diabetes (HbA1C \geq 8), uncontrolled blood pressure (\geq 140/90), or uncontrolled asthma).
 - All measures should have been taken within 30 days before referral.
- **Current Geography:**
 - Upper Manhattan: 10024, 10025, 10026, 10027, 10029, 10030, 10031, 10032, 10033, 10034, 10035, 10037 & 10039.
 - Additional zip codes will be added in 2016.

CHARACTERISTICS OF PATIENTS WHO WOULD BENEFIT MOST

- **Patient engagement factors:**
 - Patients who do not keep appointments, frequently run out of medications, utilize the Emergency Room for ambulatory sensitive needs, get lost to follow-up after discharge, etc.
- **Social factors:**
 - Over 65 years old, low/no literacy, limited education, hearing/vision impairments, physical disabilities, multiple morbidities, and poverty.

(CURRENT) EXCLUSION CRITERIA

- Advanced dementia, severe mental illness, gestational diabetes, cancer treatment, end-stage disease, active alcohol or substance abuse.

IV. OUTCOMES LIST: Better care, lower costs

We already have a history of success. Our high performing disease management Health Coaching model has proven in Harlem that we can enhance the quality of primary care, dramatically improve clinical outcomes, and achieve cost savings – especially among high need, high cost populations.

OVERVIEW OF UNIQUE BENEFITS

- **Better clinical outcomes** – we improve the ability of patients at varying risk to self-manage their care needs
- **Efficiency in service delivery costs**
 - Enables clinic-based staff – Primary Care Providers (PCPs), Care Coordinators, and Certified Diabetes Educators (CDEs) – to operate at the top of their license and achieve greater job satisfaction
 - Extends PCPs and CDEs via Health Coaches for targeted patients who are higher cost/risk
- **Reduced total cost of care**
 - Reduction in in ER visits and inpatient days
 - Proactive, earlier identification of and response to complications to prevent adverse events
- **Enhanced primary care and disease management**
 - Increased patient engagement in routine primary and preventive care visits
 - Increased communication between patients and providers for more responsive clinical care

OUTCOMES MENU

List of potential outcomes for evaluation of services:

Clinical Outcome Measures

- A1C
- Blood Pressure
- BMI & Weight
- Depression (PHQ-9) Values
- Kidney Function (patients with diabetes and hypertension)
- Eye Exam (patients with diabetes)
- Foot Exam (patients with diabetes)
- Taking diabetes, blood pressure, cholesterol and/or asthma medications as prescribed

Adult Preventive Care Measures

- Falls Assessment & Risk Reduction
- Annual Flu Vaccine
- Pneumococcal Vaccine
- Tobacco Use Screening & Referral for Smoking Cessation
- Colorectal Cancer Screening
- Breast Cancer Screening
- Improving or maintaining self-rated physical health
- Improving or maintaining functional impairment scale (Karnofsky Performance Scale)
- Improving or maintaining mental health
- Yearly review of all medications & supplements taken
- Yearly assessment of activities of daily living
- Yearly assessment of physical pain

Costs Averted

- Reduction in # of ED visits in 1 year

- Reduction in # of preventable IP admissions in 1 year
- Reduction in readmission to hospital within 30 days of discharge

Care Coordination & Quality of Care

- Creation & documentation of self-management goals & care plans
- Medication Adherence (Morisky Scale)
- Patient Satisfaction (Net Promoter Score)
- Asthma Control Test
- Disease-Specific Knowledge
- Disease-Specific Self-Efficacy
- Disease-Specific Self-Monitoring
- Improved patient engagement with primary care (reduction in no-shows)

V. CLINIC INTEGRATION PROCESS

INTEGRATION PROCESS

Every primary care site is unique. City Health Works starts by collaborating with each site to customize how the City Health Works team’s structure, services and workflow align with each clinic’s existing needs and assets. We produce a Project Plan that is specific to each site to ensure clinic buy-in, cost effective allocation of resources across sites, and coordination of Health Coaching with existing population health services.

MAJOR WORK STEPS	
GOAL SETTING Establish target measures	<ol style="list-style-type: none"> 1) LIASONS: Identify administrative & clinician liaisons at each site. 2) OUTCOME METRICS: Define primary & secondary clinical, quality of care and cost outcomes that the clinic aims to optimize with support from City Health Works. 3) KEY PERFORMANCE INDICATORS (KPIs): Establish priority KPIs related to referral targets and operational processes. 4) PROPOSAL: CHW submits proposal defining goals and timeline for approval by clinic partner.
PRACTICE READINESS Conduct comprehensive assessment of each clinic	<ol style="list-style-type: none"> 5) SURVEY: Clinic to complete online survey with key data points about clinic’ patient population and volume, current staffing structure, and current services. 6) CLINIC ASSESSMENT MEETING: In-person meeting (2-3 hours) to discuss strategies to establish Referrals and bi-directional Communication protocols. 7) DATA SHARING [*]: Conduct meeting with relevant IT and HIPAA representatives to develop plan for safe exchange of information and access to EMR system / data. 8) POST-ASSESSMENT MEETING: Review Referral and Communication Protocols proposal with key stakeholders.
SITE SPECIFIC PLAN	<ol style="list-style-type: none"> 9) FINALIZE SITE-SPECIFIC INTEGRATION PLAN, covering: <ul style="list-style-type: none"> • Referral Process • Staffing model - define how relevant staff relates to each other for each service area. • Communication protocols for escalating urgent / semi-urgent alerts, progress notes, medication reviews, etc. • Data sharing • Regular case reviews and review of Key Performance Indicators • Integration of services with existing primary care, behavioral health, pharmacy, health home and social work services
PREPARE TEAMS Prepare sites for launch & ensure clarity of roles	<ol style="list-style-type: none"> 10) Educate team on new roles & processes. Provide mini-trainings & protocols on new workflows.
QUALITY ASSURANCE & REPORTING	<ol style="list-style-type: none"> 11) ESTABLISH REPORTING TIMELINE: Establish schedule for routine check-ins with administrative and clinical leadership to discuss progress towards target outcome metrics & KPIs.
CONTRACTING	<ol style="list-style-type: none"> 12) Execute BAA between Clinic and City Health Works. 13) Execute site-specific Partnership Legal Agreements with each site

[*] Note on DATA SHARING:

City Health Works requires the following data about each patient:

- Complete Problem list
- Complete Medication list
- Complete Care plan + goal list
- Upcoming Appointments
 - Note: we need to be notified if any of the above items change during the intervention
- Lab values (disease-specific) + anthropometric data
 - Note: we need this info at baseline and follow-up on a quarterly basis

PRICING & CONTRACTING

To get started, City Health Works offers subsidized services to a pilot population at your clinic for a limited period with the aim of demonstrating value. Further expansion is based upon installment of a paid contract.

To be able to evaluate our success, we require that clinic partners share health data and participate in our effort to evaluate impact on reducing costs and improving outcomes.

Key Requirements from Clinic Partner to ensure success:

- Identify a dedicated administrative liaison:
 - To meet regularly with City Health Works' Director of Health Coaching & Clinic Partnerships and review referral process, volume and quality.
- Establish a high quality and realistic referral process:
 - Establish agreement on the definition of target population (eligibility and exclusion criteria)
 - Commit to target volume of referrals based on the volume of eligible high need patients
 - Commit to actions to make referrals
 - Commit to securely share agreed upon data
 - Commit to iteratively adapt referral process
- Ensure a collaborative working relationship with clinic
 - Establish on-going Clinical Champion(s) to participate in regular team-based sessions with City Health Works' Health Coach Supervisor
 - Provide access to appropriate care team members to conduct clinic assessment
- Secure IT committee and executive-level buy-in
 - Sign an agreement defining HIPAA compliant arrangement for the exchange of health information and communication.
 - On-going engagement with IT committee to inform relevant workflows for current state and planned design of care processes

