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Precedence CCE Innovations Proposal

3.2.1 Governance Structure, Scope of Collaboration, and Leadership

3.2.1.1 Please provide the name of the Care Coordination Entity (CCE) or Managed Care Community Network *(MCCN).*

RESPONSE: Precedence Care Coordination Entity, LLC (Precedence CCE).

3.2.1.2 CCE-Only. Who are the collaborators including but not limited to PCPs, hospitals, mental health Providers, and substance abuse Providers? Please submit articles of incorporation and by-laws. Using the format found in Attachment E (Table 1), list each collaborator and its relationship with the CCE. The Department has the right to request agreements, contracts, letters of intent, etc.

RESPONSE: Precedence CCE is a collaboration of providers and community organizations located in a nine-county region in northwest and central Illinois. This newly established care coordination entity creates a governance structure to enable a range of accountable care strategies, including innovative care coordination activities envisioned by the DHFS Innovations Project 2013-24-002 and section 2703 of the federal Affordable Care Act (ACA). Precedence CCE bylaws are provided (see Attachment 1: Collaborator Governance).

Collaborators include:

- Primary Care Physicians (PCP's) – Community Health Care, Inc. (Federally Qualified Health Center), Dr. Robert Maguire, MD, KSB Medical Group and KSB Family Health Center
- Hospitals – KSB Hospital, OSF St. Elizabeth Medical Center, and Trinity Medical Center.
- Mental Health and Substance Abuse Providers – North Central Behavioral Health Systems; Robert Young Center for Community Mental Health; and Sinnissippi Centers, Inc.

Further provider details are provided (see Attachment E [Table 1]: Collaborators)

3.2.1.2.1 Who is the lead entity contracting with the State?

RESPONSE: The lead entity is Precedence CCE. Precedence CCE will be responsible for executing the CCE contract with the state and receiving and distributing care coordination fees and any shared savings payments. On June 14, 2012, Precedence CCE submitted a completed application to the Department of Human Rights for a Public Contracts Number.

3.2.1.2.2 Please explain your plans, if any, for advancing to full-risk capitation over time and applying to be a MCCN.

RESPONSE: The current fee-for-service (FFS) payment model for healthcare is volume driven and provides little incentive for coordination of care and medical testing, streamlined processes, and wellness or preventive services. The collaborative partners comprising Precedence CCE recognize the need for payment reform that encourages and maintains innovative high-value, patient-centered healthcare. Payment reform strategies include bundled payments, medical homes, accountable care organizations, and/or global payments (e.g. full-risk capitation). The DHFS Innovations Project 2013-24-002 and section 2703 of the federal Affordable Care Act (ACA) provides a platform to test payment reform strategies for Medicaid clients. As further detailed in the Financial Model (section 3.3

of this narrative), Precedence CCE is proposing a combined medical home/accountable care strategy that includes a care coordination fee and shared savings.

Aside from this Medicaid project, Trinity Medical Center (Trinity) and Robert Young Center for Community Mental Health (RYC) have a pending application with CMS to participate in the Medicare Shared Savings Program. With a proposed start date of July 1, 2012, Trinity and RYC have joined the Iowa Health Accountable Care, LC, along with various other providers in northwest and central Illinois and central and eastern Iowa. It is projected that this ACO will provide services to in excess of 70,000 Medicare beneficiaries. Iowa Health Accountable Care, LC, is also negotiating with third-party payers to establish value-based purchasing contracts for their insured populations. In addition, Precedence, Inc., of which Precedence CCE is a wholly owned subsidiary, has been providing care coordination services for more than 10 years for the behavioral health carve out for more than 30,000 covered lives of Iowa Health System employees. Like this project, these efforts will serve as platforms to further test payment reform methodology, including various capitation models.

For our targeted Health Home population, full-risk capitation and other payment reform mechanisms will be considered at the conclusion of this project. The decision to move to heightened risk model, including ACO strategies or full-risk capitation, will involve analyzing outcomes from this project, access to comprehensive personal health records (PHI) and claims information, and evaluating results from ACO projects targeting other populations. The efficacy of establishing a MCCN will also be considered as a vehicle to provide Health Home care coordination services.

3.2.1.3 MCCN-Only. Who are the MCCN founders or owners? Please submit articles of incorporation and by-laws. Attach a list of the entire network of contracted Providers in addition to the providers who are the founders or owners of the MCCN. Use the format found in Attachment E (Table 2). The Department has the right to request agreements, contracts, letters of intent, etc.

RESPONSE: Not Applicable.

3.2.1.4 Explain how your analysis of claims data leads you to believe the scope of your CCE collaboration/MCCN network (collaboration) is sufficient to effectively coordinate the care of and ensure access to care for the population you propose to serve. In discussing the scope of CCE collaborators/MCCN network of Providers (collaborators), indicate how the number of collaborators is sufficient and how the collaborators match the utilization patterns of the population you propose to serve.

RESPONSE: Using the claims data files, Precedence CCE analyzed the eligible Health Home population in the proposed service area to develop an optimum care coordination model. The data was examined to identify (1) condition(s) that provide the greatest opportunity for savings to Medicaid in the context of improved care for clients, (2) specific providers with whom to partner, and (3) the optimal care coordination services based on utilization patterns to enable accountability for cost and quality. Claims data was also used to estimate expenditures for providing Health Home services and to establish the care coordination fee.

Analysis of claims data

The claims data was analyzed using the Recipient table. The data was filtered by the ages 19 – 64 years and by the following counties: Bureau, Carroll, LaSalle, Lee, Mercer, Ogle, Putnam, Rock Island, and Whiteside. Dual and non-dual eligibles were also filtered. Populations were defined as those recipients having a mental health or substance abuse diagnosis and the co-morbidities defined

below. Cost data was analyzed based on the recipients having a mental health or substance abuse diagnoses and one or more of the co-morbidities.

Population Definitions

- Mental Health population - CDPS categories of: PSYH, PSYM, and PSYML.
- Substance Use Disorder population - CDPS categories of: SUBL, and SUBVL.
- Heart Disease population - CDPS categories of: CARM, CARL, and CAREL.
- Diabetes population - DPS categories of: DIA1H, DIA1M, DIA2M, and DIA2L.
- Obesity population - CDPS category of: METNWD.
- Pulmonary population - CDPS categories of: PULVH, PULH, PULM, and PULL.

Cost Data was grouped as follows:

- ER Costs - 348 ERCost
- IP Medical Costs - 371 IPOtherCost, 388 PhysSurgRegCos
- IIP Psych Costs - 372 IPPsychCost, 391 RehabMHCost
- IIP SA Costs - 373 IPSubAbuseCost, 393 RehabSACost
- Other Costs
- All other cost categories

How number of collaborators is sufficient and the collaborators match the utilization patterns of population to be served:

From our analysis, the number of collaborators and their services are sufficient to provide health home services to the targeted enrollees. To serve 1,500 SMI/SA enrollees in the 9-county region, proposal collaborators include three community mental health centers within this region along with four PCP sites and three hospital collaborators. An initial assessment of the claims data files was performed to confirm the number and type of collaborator required to provide sufficient access to health home services. Generally, data was used to quantify the utilization and reimbursement of healthcare services by Medicaid patients across the continuum of care. The analysis included an overview of the type, frequency and reimbursement associated with caring for targeted chronic conditions (see above definitions). The analysis aggregated total and per patient utilization and reimbursement across the continuum of care by the cost data groups above. Additionally, the analysis was broken down by county to confirm adequate services within each of the three sub-regions for mental health services.

3.2.1.5 Describe the governance structure of the CCE or MCCN, such as policies and mechanisms in place to share information and ensure compliance with the care coordination model described in your Proposal. Please attach the relevant articles of incorporation or by-laws that outline the governance structure as Attachment G.

RESPONSE: Precedence CCE is a newly created limited liability company established and in good standing in the State of Illinois. Its Board of Managers is charged with strategic direction and oversight of Precedence CCE. Officers will be elected and by-laws established at the first meeting of the Board of Managers. It is the intent of Precedence CCE that all collaborators will have a presence on the Board. Articles of Organization are provided in Attachment G and the by-laws, a list of officers and additional members will be made available to the State after the first meeting of the Board. The Precedence CCE Director will serve as an ex-officio member of the board. The board will meet

monthly with its first meeting scheduled in the first month after notification of award. (See Attachment G: Articles of Organization).

The board may establish subcommittees and advisory councils as needed. To assure that there is sufficient support to address clients' social needs, an Advisory Council will be created to review referrals to community and social service organizations and address shortages in the delivery network. Examples of social needs include access to fitness programs, nutritional food, transportation assistance, employment assistance, adult education, housing assistance and utility assistance. The Advisory Council shall meet quarterly and include at least one client representative and one representative from a state operated facility. The Precedence CCE Director shall staff the Advisory Council and serve as a liaison to the Board of Managers.

To enable the board to govern, mechanisms are in place to provide timely, complete, and accurate data to monitor progress with the proposed care coordination model. On a monthly basis, a balanced scorecard (Attachment 2: Scorecard) will be used to track outcomes such as admissions, readmissions, emergency room visits, number of PCPs, cost of medications, and quality measures identified in sections 3.2.3.26 and 3.2.3.27 of this narrative. The Precedence CCE Director is responsible for monitoring compliance with proposal milestones, providing status reports to the Board of Managers and submitting progress reports to the State.

3.2.1.6 Describe additional resources available to the CCE or MCCN to assist in implementation or operation of your care coordination model (funds committed by collaborators, Federal Innovations grants, private grants, etc.).

RESPONSE: Precedence CCE is comprised of experienced providers who will be able to leverage in-kind resources in support of this proposal. Precedence CCE and its collaborative partners will provide in-kind services including executive and administrative staff support (CEO/COO/CFO/HR), office space, and services related to governance structure/oversight,

In terms of other project resources, the Robert Young Center (RYC) through its parent organization, Trinity Medical Center (Trinity), is affiliated with the Iowa Health System (IHS), the fifth largest nondenominational health system in the United States IHS is an integrated delivery system. Among centralized services accessible to this project are (1) IT services and support with access to more than 300 IT professionals, including experts in programming, networking, interoperability, and customer service, (2) finance and corporate decision support with access to accounting, billing and auditing professionals to promote standardization and financial accountability and transparency, (3) ACO infrastructure that includes teams dedicated to population care management, health informatics and program management, and (4) clinical transformation resources targeting promotion of evidence-based standards, quality analytics and monitoring, process improvement tools and methodology, and establishment of affinity groups to disseminate best practices. It should be noted that IHS is currently participating in several value-based contracting arrangements involving more than 100,000 covered lives in total. Six IHS affiliated service areas, including Quad Cities (Trinity Medical Center and the Robert Young Center for Community Mental Health), Peoria (Methodist Medical Center of Illinois) and Quincy (Quincy Medical Group) in Illinois, have a consolidated application pending before CMS to participate in the Medicare Shared Savings Program. In addition, an IHS senior affiliate in Fort Dodge, Iowa, was the only rural health system to be awarded a CMS Pioneer Model ACO contract. Lastly, IHS has entered into a contract with Iowa's largest payer, Wellmark, to provide ACO services in four markets. With these contracts in place and the potential of serving as health homes under this proposal as well as under a similar opportunity in Iowa, IHS has developed ACO infrastructure and processes which will serve as a model for this proposal.

In addition, Precedence, Inc., of which Precedence CCE is a wholly owned subsidiary, has been providing care coordination services for more than 10 years for the behavioral health carve out for more than 30,000 covered lives of Iowa Health System employees. Precedence, Inc.'s experience with reviewing utilization patterns and working with claims data will be examined and used as a reference when appropriate.

3.2.1.7 What financial management mechanisms do you expect to have in place at the time of implementation to manage the CCE or MCCN including any subcontracting arrangement?

RESPONSE: Although Precedence CCE is a new legal entity, Trinity Medical Center (Trinity) will provide financial management services. Trinity is a senior affiliate of Iowa Health System (IHS), which has preexisting operational protocols for internal financial monitoring, compliance and auditing. In particular, IHS Policy 1.CE.07 ("Compliance Auditing and Monitoring") specifies that a monitoring program will be maintained to evaluate adherence to compliance policies and measure billing accuracy over time and that audits and other appropriate evaluation techniques will be used to monitor compliance. This policy applies to monitoring financial controls for all payers, including Medicare and Medicaid. The Board of Managers will have budgetary oversight. The budget status will be reviewed during board meetings, along with a financial and quality scorecard.

3.2.1.8 Describe your plan for consumer input into the operations and management of the program.

RESPONSE: Consumer input will be solicited through a number of avenues. In terms of management, a client representative will serve on the client social needs advisory council. The advisory council will advise management regarding access to and need for social supports for the priority and targeted populations.

In terms of operations, Precedence CCE will use assessment results continually to improve its client care and engagement efforts. Client experience will be a significant factor in determining quality of the Health Homes' delivery of care. Precedence will enlist the assistance of Iowa Health System's Center for Clinical Transformation (an internal quality improvement department) to analyze client experience instruments, including Press Ganey, HCAHPs and CAHPs surveys, for improvement opportunities. The Precedence CCE Director and Board of Managers will review client experience of care surveys with other clinic-based metrics, such as post-acute follow-up appointment with PCP after hospital discharge, chronic care office visits, engagement in case management and disease management programs and outcomes of care. Further, input from the Advisory Council will supplement survey results and gather more detailed feedback from clients and service providers. Assessments and client input will be analyzed to (1) ensure that care is client and family centered; (2) improve client safety; (3) improve collaboration between caregivers, clients, and families such that their concerns regarding quality of care are addressed promptly and effectively; (4) improve client and family satisfaction; (5) guide Health Home priorities and planning; and (6) further build a positive relationship with the community

3.2.1.9 Describe the experience of your collaborators in serving the needs and coordinating the care of the population you propose to serve.

RESPONSE: Primary collaborators and their experience are as follows:

Robert Young Center for Community Mental Health - The Robert Young Center (RYC) is an established and financially viable behavioral health care organization that is integrated within Trinity Regional Health System. This unique corporate model allows RYC to be at the national forefront of bi-

directional integration of primary and behavioral healthcare services which leads to better clinical outcomes at less expense for the patient. RYC has begun a number of projects related to integration including (1) Donated Funds Initiative Bidirectional Integration of Care, (2) Robert Young Center Co-Location Integrated Sites of Care, (3) Heart Failure Outcome Study, (4) Quad Cities Health Initiative: Bi-Directional Integration Committee, (4) Beginning the Conversation: Statewide Policy Summit on Advancing Bidirectional Behavioral Health and Primary Care Integration, (5) Illinois Department of Health and Family Services (IDHFS) Innovations Project, and 6) Quality Quest – Illinois Hospital Association.

The *Donated Funds Initiative Bidirectional Integration of Care (DFI)* project is the foundation for the Precedence CCE proposal. The DFI project was designed to improve the total health care for patients of the Robert Young Center for Community Mental Health and the local Federally Qualified Healthcare Center through the development of an integrated system of care. The target population was comprised of individuals with severe and persistent mental illness with a medical co-morbidity. Integrating the primary and behavioral health care provided a health care home for these individuals. This integration model was successful at improving the health of the whole person through coordination of care, collaboration of providers, and co-location of services. Specific outcomes included appointment attendance, rate of annual physicals completed, and identification of patients with medical co-morbidities receiving case management, improved quality of life, and implementation of depression screening (see section 3.2.3.1 and Attachment 3 for project metrics).

Community Health Care, Inc. (CHC) – was founded in 1975 to offer a medical and dental home for individuals who could not access primary health care elsewhere in the community. CHC has provided a medical and dental home for over 35 years. Over 36,000 patients are provided care each year, including children, adolescents, older adults, immigrants, low-income individuals and families and the homeless. CHC is the community's primary care safety net for those most in need. Services include internal medicine, family practice, pediatrics, obstetrics and gynecology, laboratory, x-ray including mammography, pharmacy, health and nutrition education and translation services. CHC has six main clinic locations across the Quad Cities (Rock Island and Moline, IL and Davenport and Bettendorf, IA) including four medical/dental clinics, a virology clinic, and a homeless outreach clinic.

North Central Behavioral Health Systems (NCBHS) – was established January 1, 1996 and annually serves over 7,000 clients. NCBHS is a drug or alcohol rehabilitation center with a primary focus on mental health and substance abuse treatment. The treatment center provides outpatient care. There are special groups and programs for adolescents, persons with co-occurring mental and substance abuse disorders, and DUI and DWI offenders. NCBHS collaborates with Ottawa Regional Medical Center for coordination of care for residential and other high need/high risk mental health clients. They will offer telehealth services including telepsychiatry, case management, psychosocial rehabilitation, health promotion/disease management and other services to support the Precedence CCE initiatives.

Sinnissippi Centers, Inc (SCI) - was incorporated on May 31, 1966 as a private, not-for-profit, community-based behavioral healthcare agency serving a primary geographical area of Carroll, Lee, Ogle and Whiteside Counties in northwestern Illinois. The area encompasses over 2500 square miles, with a total population of nearly 165,000 people. An independent Board of Directors was established with representation from each of the four counties.

SCI provides integrated, comprehensive MH/SA services for children and adults, with designated staff on call for after hour emergencies. The agency predicates its service continuum founded on the belief that professional services should be provided appropriate to the client's level of disability, interest, and support system functioning. SCI has experience and expertise in providing Assessment and Evaluation services, Crisis Intervention, Outreach/Case Management, Individual and Family Counseling and Therapy, Intensive Day Treatment, Community Support Individual and Group services and pre-vocational skill development opportunities. SCI provides Supervised Residential services at four (4) sites in the four counties for persons with serious mental illness. A strong community prevention, education and behavioral health promotion program at SCI extends important behavioral health messages into all four counties.

Program expansion over the past decades has been the result of communication, collaboration, and cooperation between SCI and a variety of community resources. The focus of such expansion has been on making services more accessible to the people and communities SCI serves. Sinnissippi also has strong relationships of longstanding with local hospitals, with community service agencies, and with networks of providers throughout the DMH Region 2 (19 counties) area of northwestern Illinois.

3.2.1.10 Give the background of the key leaders of your collaboration, the role they will play, and the vision they bring to your Proposal.

RESPONSE: The key leaders are in charge of the day-to-day operations of the program. These individuals have been involved in the development of Precedence CCE Innovations proposal and will continue to be involved as the Health Home program evolves.

Lori Crippen will coordinate care between Trinity hospital and health home. Ms. Crippen and her team will be responsible for notifying the Care Navigator when enrollees present to the ER, are admitted or discharged. .Ms. Crippen is Director of Case Management for Trinity Medical Center. Ms. Crippen has 28 years of hospital experience and has been involved in case management for 17 years - has been promoted to Director of Case Management in 2004. Ms. Crippens focus is on care coordination in the acute care setting and striving to reduce boundaries and facilitate care coordination through all settings in order to improve patient quality of care. She is currently providing follow-up interventions after admissions to reduce readmissions (tele-health, home care visits, and follow-up phone calls).

Dennis Duke will provide support and direction related to the integration of primary and behavioral health care sites, as well as, substance abuse treatment services in Rock Island County for the Innovations proposal. He is the Director of Outpatient Behavioral Health for the Robert Young Center and Trinity Regional Health System. Mr. Duke has provided leadership for the Title XX Donated Funds Initiative Grant for the Integration of Primary and Behavioral Health and the National Council for Community Behavioral Health Primary and Behavioral Health Care Integration Learning Collaborative Grant. He also leads the Robert Young Center effort to integrate primary and behavioral health care throughout Trinity Regional Health System and Community Health Care.

Michael Freda will act in the capacity of Project Manager providing general management and oversight of the Innovations proposal. Mr. Freda is the Chief Operating Officer of Robert Young Center for Community Mental Health (Robert Young Center) and has worked in the behavioral health field since the 1970's. Mr. Freda designed the Title XX Donated Funds Initiative Grant for the

Integration of Primary and Behavioral Health and serves as its project manager. He also championed the Recovery Philosophy at Robert Young; introduced several evidence-based practices such as Individual Placement & Support (IPS), an employment-based program; and Wellness Self-Management, a curriculum for persons with serious mental illnesses. He has also been the leader for data driven decision-making.

Adam Meuser will serve as the Community Health Care (CHC) representative, the PCP for the Precedence Health Home – RYC. He currently serves as the Illinois Operations Manager for CHC overseeing the day-to-day operations for two medical clinics which serve over 13,000 patients annually. His involvement in CHC's behavioral integration program between Community Health Care, Inc. and the Robert Young Center will provide seamless integration as current enrollees enter in the Precedence Health Home program.

Rich Murphy will serve as staff to the Finance committee and provide guidance and oversight to the financial model and the care coordination fee and share savings distribution. Mr. Murphy is the Chief Financial Officer of Robert Young Center and has 37 years of health care financial management experience. His focus will be on the financial aspects of the proposal including budget preparation, monthly reporting and variance analysis, required financial reporting, review of shared savings reporting and Care Coordination fees and financial support to all collaborators.

Larry Prindaville will serve as the liaison for Precedence Health Home – SCI and provide general coordination of the Innovations Proposal for Sinnissippi Centers, Inc (SCI). Mr. Prindaville has over 40 years of experience in community behavioral health. Mr. Prindaville was instrumental in Sinnissippi's development of innovative programs and services for adults with serious mental illnesses. With the scarcity of treatment alternatives in the SCI rural area, he designed and implemented aggressive outreach and intensive case management services as well as day treatment programs. Recognizing the prevalence of co-occurring (mental illness and alcohol/drug abuse) disorders in the populations served, Sinnissippi developed concomitant "bridge treatment" options for dually-diagnosed adults. In his role as a key leader of this Innovations proposal, Mr. Prindaville will champion this initiative by facilitating communication, cooperation and collaboration between and among behavioral health and primary healthcare providers and service recipients in rural communities.

John Reinert will serve as the liaison for the Precedence Health Home –NC and provide general coordination of the Innovations proposal for North Central Behavioral Health Systems, Inc. where he is the Manager of Service Planning and Development. Following several years of direct client service as a therapist, he provided supervision and direction to 17 professional staff members, both licensed and unlicensed, as they cared for the behavioral health and substance abuse needs of a broad based population comprised of adults, adolescents and children. During his role as therapist, and subsequently clinical supervisor, Mr. Reinert was able to identify the significant impact medical conditions had on clients' behavioral health as well as the difficulty they had both securing medical services and then managing their use of those services. His current focus on an integration of medical and behavioral health care is the logical next step as he shares his belief in the efficacy of a holistic treatment approach for the target population.

Vicki Zude will serve as staff to the quality committee and be responsible for assuring that identified quality measures are being achieved and Health Homes are following procedures as

outlined in the Innovations proposal. Ms. Zude has over 33 years in the healthcare field and currently administers the Wellness Program and the Robert Young Center. Ms. Zude has worked in the behavioral health field for the past 13 years as a Nurse Manager and DFI Integration Grant Coordinator. Ms. Zude worked with the National Council on the Primary and Behavioral Integration Learning Collaborative on behalf of Robert Young Center. Through education and training has an appropriate level of sensitivity to the cultural diversity and language of the target population for the PBHCI program, additionally has over 15 years working with the demographics of the population served.

3.2.2 Populations / Geography

3.2.2.1 Which Priority Populations do you propose to serve?

RESPONSE: The Priority Population to be served is Adults with Disabilities, and includes adult clients with SMI and/or substance abuse disorders.

3.2.2.1.1 How many of each Priority Population do you propose to serve?

RESPONSE: Using claims data, there are 43,330 adults with disabilities within our service area. Of that population, we propose to provide Health Home services to 1,500 adult clients with SMI and/or substance abuse disorders.

3.2.2.1.2 Within the Priority Populations listed in this Solicitation are there particular subsets you intend to target? Please clearly define your Target Population.

RESPONSE: Within the Adults with Disabilities Priority Population, the Targeted Population subset is clients with Serious Mental Illness and/or substance abuse disorders (SMI/SA), who also meet the definition of "eligible individual with chronic conditions" in section 2703 of the ACA for Health Home services. Chronic condition is defined to include (1) mental health condition, (2) substance use disorder, (3) asthma, (4) diabetes, (5) heart disease, and (6) overweight with a BMI > 25. An eligible individual must have (a) at least two chronic conditions, (b) one chronic condition and be at risk for a second chronic condition, or (c) one serious and persistent mental health condition.

For this proposal, Precedence CCE will target individuals with serious and persistent mental health conditions and/or individuals with SMI/SA and having or being at risk for at least one additional chronic condition. In our service area, Medicaid paid for services to 21,688 duplicated individuals and 8,656 unduplicated individuals in 2010. These are individuals with at least a SMI/SA diagnosis and potentially 1 to 4 additional health home chronic conditions listed above. 2010 claims data suggests that the selected co-morbidities are present in 38% of this population, and dual eligibles are more likely to have more than one co-morbid condition. Of the co-morbidity prevalence for this population, heart disease affects 17%, while obesity affects 11%. We believe that the obesity category is under-represented in claims data and would be better represented through BMI obtained via EHR data. This is supported by the 2012 Community Health Assessment of the Quad Cities Health Initiative which cited that roughly 30% of residents in Rock Island and Scott counties are classified as obese and more than 70% are classified as overweight.

Claims data was used to provide an estimate of the unduplicated pool of potential eligible enrollees broken down by geography and Medicaid status (i.e. eligible versus dual eligible):

Table 1. Unduplicated SM/SA Medicaid Recipients Eligible for Health Home Services

	SM/SA w/o Health Home Co-Morbidity			SM/SA w/ 1-4 Health Home Co-morbidity		
County	**Medicaid – No duals**	**Dual Eligibles**	**Total Population**	**Medicaid – No Duals**	**Dual Eligibles**	**Total Population**
Bureau	297	57	354	125	83	208
Carroll	140	27	167	62	32	94
La Salle	981	195	1176	481	283	764
Lee	165	67	232	87	60	147
Mercer	144	15	159	46	19	65
Ogle	534	103	637	231	142	373
Putnam	26	1	27	10	6	16
Rock Island	1,440	392	1,832	729	396	1,125
Whiteside	618	132	750	342	188	530
Total	**4,345**	**989**	**5,334**	**2,113**	**1,209**	**3,322**

By proposing to serve 1,500 enrollees or 17% of the eligible population, we are considering the capacity of the Illinois Client Enrollment Broker as well as the intent of our model to target services to the most vulnerable population and most expensive population requiring heighten coordination services.

3.2.2.2 Do you propose to serve non-Priority Populations in your area? If so, which ones and how many do you propose to serve?

RESPONSE: Precedence CCE will provide Health Home services under section 2703 of the ACA to eligible individuals with chronic conditions within our nine-county service area. The adult Medicaid population served may be expanded beyond Adults with Disabilities to include other Illinois Health Connect (IHC) adults with SMI/SA and meeting the definition of "eligible individual with chronic conditions" in section 2703 of the ACA.

3.2.2.3 Which geographical area(s) do you propose to serve?

RESPONSE: PCCE proposes a nine-county service area comprised of Bureau, Carroll, LaSalle, Lee, Mercer, Ogle, Putnam, Rock Island and Whiteside counties (see Attachment 4: Geographic Map).

3.2.2.4 Do you plan to phase-in enrollment? Provide an estimated timetable (as part of Attachment H, below) for phasing in enrollment including when you expect to meet the minimum requirement for Priority Populations.

RESPONSE: Enrollment will be phased-in over the three-year period starting with 500 enrollees by the end of year 1; 1,000 by the end of year 2; and 1,500 by the end of year 3. Enrollment will be phased in according to the timetable in Attachment H. We expect to meet the minimum enrollment by the end of year 1.

3.2.2.5 Provide a detailed draft implementation work plan as Attachment H, with an estimated timetable to begin enrollment no later than January 1, 2013.

RESPONSE: See Attachment H: Draft Workplan

3.2.3 Care Coordination Model

3.2.3.1 Provide your definition and approach to care coordination, including your identification of any deficiencies in the health care market specific to your proposed population and geographical area and how your model will help overcome these deficiencies.

RESPONSE: The definition of care coordination is to facilitate delivery of the right health care services in the right order, at the right time, and in the right setting to clients with a chronic medical and behavioral health diagnosis. The provision of care includes primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, rehabilitation and long-term care services and assistance with community and social services support (food, shelter, transportation, etc.).

Acknowledging that improved care coordination results in improved patient-centered care, avoidable admissions/readmissions, and reduction in healthcare costs ("Triple Aim'), this model will assess clients individually and provide wrap-around services that are focused on improving health outcomes, quality of life for the clients served, and reduction of health care utilization costs.

Deficiencies - Rural Areas – Care coordination deficiencies in the rural areas of the nine-county region significantly impact persons with co-occurring physical health and behavioral health illnesses. These deficiencies are exacerbated by provider shortages throughout this rural area, minimal access to public transportation, and the lack of a structured effort to coordinate care between disparate healthcare service providers. North Center Behavioral Health Services and Sinnissippi Centers, Inc. are especially challenged in trying to provide treatment and care coordination services due the primarily rural setting of the communities they serve. Many clients are often difficult to access because of transportation and related issues. The key to successful care coordination, health promotion and a resultant cost reduction is proactive and repeated contact with clients which is difficult in rural areas. Primary care providers (PCP's) and community hospitals are available in population centers, but are frequently remote from clients with the most need. Equally, mental health/substance abuse services tend to be located in those same population centers and community hospital psychiatric beds are exceedingly limited. Access issues, provider shortages, and a lack of providers that accept Medicaid patients for both routine and specialty care are often issues that contribute to inadequate health care for these clients.

Care Coordination Model – The Precedence Health Home care coordination model uses an integrated team approach to deliver services based upon a person-centered holistic approach that "follows the patient" across the continuum including primary care, mental health, substance abuse, hospital based and social needs. This integrated service approach evolves out of the creation of a Community Mental Health Center Health Home for the SMI/SA population. Services will be delivered along a full continuum of outpatient and inpatient services including primary care, mental health, substance abuse, hospital-based and social services.

The proposed care coordination is built upon a current initiative that incorporates bi-directional integration of primary and behavioral health care. In July 2010, the Robert Young Center, Trinity

Medical Center, and Community Health Care, Inc. (CHC), a Federally Qualified Health Center, began collaborating on the "*Primary Care and Behavioral Health Integration Project",* an Illinois Title XX program that treats clients that suffer from physical and mental health problems. Outcome indicators over the last seven quarters have demonstrated the effectiveness of the integration:

- Compliance rate for Medical/Behavioral health appointment has risen from 74% to 81%
- Completion of annual health physicals has risen from 78% to 91%
- Medical case management for clients at risk or with co-morbidity has risen from 8% to 53%
- From the third quarter through the seventh quarter, the percentage of client reports of Quality of Life improvement rose from 38% to 82%.
- The percentage of clients seen in the primary care setting has risen from 0% to 100%
- 86% of clients have been given annual Health Screen Assessments, up from 60%

Please see Attachment 3: Title XX Graphs and Charts

While the results have been promising, areas of improvement have been identified. The Innovations project will allow expansion of partnerships with community agencies to support the holistic approach to patient care. As a result of the new collaborations, wrap around service that prevent patients from unnecessary emergency room visits, inpatient admissions and readmission will be implemented. Use EPIC software and Electronic Health Records (EHR's) will provide immediate knowledge when a client presents in the Emergency room or been admitted to the hospital. The Innovations Project will also provide much needed utilization management to ensure patients are getting the right care at the right time in the right setting, to analyze data and provide quick adjustments to meet our outcome measures.

Of major significance to this model is the addition of Care Navigators to serve as an extension of the primary care team and provide enhanced care coordination that follows the client across the continuum and throughout their life span in a Health Home setting. Operational changes build upon and improve current strategies of care coordination via co-morbid risk identification, service coordination, healthcare promotion and education, intensive case management and improved communications.

The goals of the care coordination model are:

1) Reduce inpatient hospitalizations, readmissions and inappropriate emergency room visits.
2) Demonstrate cost-effectiveness in order to justify and support expansion of the model.
3) Improve coordination and transitions of care to prevent duplication of services and reduce unnecessary services, therefore ensuring the appropriate level of care and reducing costs through the formal framework of Health Homes
4) Establish alliances and effectively utilize community and social service supports to help clients and family members.
5) Enhance treatment and care coordination services for clients in rural areas
6) Receive National Committee for Quality Assurance (NCQA) accreditation for Health Homes located in the nine-county region by the end of Year Three (3) or 2015.

Enrollees will be served through Health Homes comprised of primary care services, mental health and substance abuse services, and hospital(s). Health Homes will be located in three sub-regions of the nine-county area: (1) North Central Behavioral Health Systems region which covers Bureau, LaSalle, and Putnam counties; (2) Sinnissippi Centers Inc. region which covers Carroll, Lee, Ogle and Whiteside counties; and (3) Robert Young Center for Community Mental Health region

which covers Rock Island and Mercer counties. (See Attachment 4: Geographic Map). Precedence CCE will provide a comprehensive collaborative process of systematic care management to all program enrollees. Care Navigators will be located in the Precedence CCE to assist enrollees' to achieve optimal levels of care and to provide real time communication related to the enrollees healthcare utilization.

Providers in the Precedence Health Home located in the North Central Behavioral Health Systems sub-region (PHH-NC) are

- Primary Care Provider - Dr. Robert Maguire
- Substance Abuse Provider - NCBHS
- Mental Health Provider – NCBHS
- Hospital Provider – OSF St. Elizabeth Medical Center

Providers in the Precedence Health Home located in the Sinnissippi Centers, Inc. sub-region (PHH-SCI) are:

- Primary Care Provider – KSB Family Health Center and KSB Medical Group
- Substance Abuse Provider - SCI
- Mental Health Provider - SCI
- Hospital Provider - KSB Hospital

Providers in the Precedence Health Home located in the Robert Young Center sub-region (PHH-RYC) are:

- Primary Care Provider – Community Health Center, Inc.
- Substance Abuse Provider - RYC Riverside
- Mental Health Provider - RYC
- Hospital Provider - Trinity Medical Center

3.2.3.1.1 If you are targeting Clients with SMI, please expressly indicate how your model design will meet the needs of that population and how it will interface with State-operated facilities.

RESPONSE: Precedence Health Homes (PHH) will focus on clients with serious and persistent mental health conditions and/or clients with SMI/SA and having or being at risk for at least one additional chronic condition.(diabetes, asthma, obesity (BMI >25) and heart disease). Within each Health Home, a community support team, consisting of the PCP, Care Navigator(s), Care Coordinator(s), Nursing Care Coordinator(s) and a Psychiatrist, will serve as an extension of the PCP and provide enhanced care coordination and assistance with transitions of care. Other specialists and representatives of community support agencies may be included to recognize individual enrollee needs.

Primary Care Physician – Evidence Based Practice clearly demonstrates that providing on-site primary care in community mental health centers provides individuals with mental illness more comprehensive and thorough health care and helps establishes a health care home for the mentally ill. Through collaboration with the local Federal Qualified Health Center, the Robert Young Community Center for Mental Health has a primary care provider on site two full days a week. Utilizing this evidence based practice ensures that individuals are receiving quality care that will improve the overall health of the patient. In subsequent years as the population in the Health Home increases, the plan is to expand primary care services to meet patient volume and demand.

Care Navigators provide a systematic measurement and analysis of data to ensure that the various providers' interventions are effective, efficient and improve the quality of care for each enrollee in the care coordination entity. Care Navigators will conduct utilization reviews with healthcare home providers to ensure enrollee linkage with the appropriate level of care as well as community and social support organizations.

Care Coordinators work as a team and provide different levels of care to enrollees based upon their education level. Enrollees with higher needs will be assigned to Qualified Mental Health Professional (QMHP)-level Care Coordinators and enrollees with moderate to low needs will be assigned to Mental Health Professional (MPH)-level Care Coordinators.

MHP-Care Coordinators assist with the provision of supportive social services for adults with severe mental illness who need assistance to access, coordinate, and monitor resources and services. Service coordination will include developing, preparing and implementing a comprehensive targeted plan of care for each enrollee.

QMHP-Care Coordinators will work with enrollees with extensive healthcare requirements, providing them with education and assistance with navigating the healthcare system. In addition, they will provide annual health risk assessments to determine enrollees at risk for developing co-morbidities and how well enrollees are managing their comorbidities. QMPH-Care Coordinators will develop wellness and prevention initiatives, facilitate health education groups, and participate in developing care plan goals for individuals with co-occurring chronic diseases.

Psychiatrist - responsible for mental well-being of the enrollee including participating in care planning and medication management and consulting with the health home team on overall mental and physical health of the enrollee

The Health Home will interface with the State-operated facilities for all enrollees being admitted and discharged. The Care Coordinator assigned to a Health Home enrollee and individual client, in concert with crisis staff, will monitor the enrollee's mental/physical health and an appropriate level of care. Should a Mental Health or Substance-related crisis occur, assessment requiring a higher level of care will be made and hospitalization sought. In the event deflection to a lower level of care is not appropriate and a community-based psychiatric placement is not available or appropriate, the team will seek placement in a State-operated facility appropriate to the enrollee's needs. It should be noted this would be identified as a most restrictive and therefore, would be the least sought level of care unless unquestionably appropriate and necessary for enrollee safety and well-being.

The Care Navigator will serve as the single-point-of-contact for coordination of transfer plans with the State-operated facility and will manage the patient transfer. A "Ticket-to-Ride", will be reviewed and updated by the Care Navigator and accompany the enrollee. The Ticket-to-Ride (Attachment 5) will be utilized to provide continuity of care. This document will be initiated by the referring provider and provide critical information regarding the enrollee such as allergies, fall risks, sensory impairment, recent pain or sleep medications, time-sensitive treatments, special needs, current list of medications, cultural, language and communication barriers. Services will be provided to assist in an effective transition in living arrangements from a State-operated facility to a community placement consistent with the enrollees' "welfare and development" (Rule 132). The Care Navigator will work with state facility staff and the enrollee/family/caregiver to complete a return "Ticket-to-Tide" and provide the document to the Health Home.

Precedence CCE will notify State-operated facilities of the Precedence Health Home project, identify a point-of-contact and invite a representative of the State-operated facilities to serve on the Client Social Needs Advisory Board. This may prove especially helpful when the behavior of an enrollee residing in a State-operated facility deteriorates and hospitalization is required. The ability to work with the enrollees' Health Home may aid in de-escalating the situation and avoid an unnecessary trip to the emergency department and/or hospital admission.

3.2.3.2 Provide a detailed description of your care coordination model and how it meets the needs of the population you propose to serve including:

3.2.3.2.1 Services

RESPONSE: The Precedence Care Coordination Model (Model) provides a Community Mental Health Center Health Home for enrollees in which their health care needs are identified and provided for throughout the life span. Health Home team members will ensure that appropriate and unduplicated healthcare services are being provided to enrollees. This model creates and maintains an individual care plan that identifies enrollee needs, priorities and preferences and then identifies and helps to secure appropriate resources, including medical, behavioral, and community services and other social supports. Care Coordinators will collaborate with the enrollee and the Health Home team to develop the individual care plan. At minimum, this plan will be reviewed with enrollees every six months. Health Home services include*:*

Primary care services - Enrollees will receive preventive services, acute and chronic care, family practice, internal medicine, pediatrics, and obstetrics/gynecology services from participating PCP providers. Two of the sub-regions, Sinnissippi Centers, Inc. and Robert Young Center for Community Mental Health, will provide primary care services through a co-location arrangement. North Central Behavioral Health Systems will collaborate with a private PCP for these services.

Hospital services - Enrollees will receive services from participating local hospitals. The hospitals will provide emergency services, inpatient services, testing and laboratory services.

Substance abuse services - Services to enrollees will include assessment and outpatient and intensive outpatient treatment.

Community mental health center – Health Homes for enrollees will be established in each sub-region. Services will include:

1. Patient-centered holistic care
2. Care coordination-(see section 3.2.3.1.1)
3. Nurse care management-(see section 3.2.3.1.1)
4. Psychosocial Rehabilitation Services
5. Therapy/counseling
6. Psychiatric Services
7. On site Primary Care Services-Sinnissippi and RYC (offsite for North Central Behavioral Services)
8. Nurse Services
9. Residential Services
10. Community Groups
11. Health Education Groups

12. Patient, family, and staff education
13. Payee Services
14. Linkage to community agencies

3.2.3.2.2 How you will address and monitor transitions of care, including appropriate follow-up, from:

3.2.3.2.2.1 Inpatient to Outpatient (PCP, Mental Health Providers, and Substance Abuse Provider):

RESPONSE: The hospital Case Manager and the Care Navigator will coordinate transitions of care between inpatient and outpatient facilities. The Care Navigator will link the enrollee to an assigned Care Coordinator upon stabilization. The Care Navigator will monitor length of stay and facilitate discharge, and monitor post discharge follow-up and intensive care management for ninety days.

3.2.3.2.2.2 PCP to Mental Health Providers and Substance Abuse Providers, and vice versa;

RESPONSE: Bi-directional integration will be implemented to minimize barriers and improve care coordination and continuity. The Four Quadrant Clinical Integration Model will be used as the basis for developing a seamless transition between primary and behavioral healthcare providers. Each quadrant considers the behavioral health (BH) and physical health (PH) risk and complexity of the population and suggests the major system elements that would be utilized to meet enrollee needs for that population subset. The four quadrants are Quadrant I: Low BH-low PH, served in primary care; Quadrant II: High BH-low PH, served in the BH system; Quadrant III: Low BH- high PH, served in the primary care; and Quadrant IV: High MH-high SA, served by a fully integrated BH/PH program. The Four Quadrant Clinical Integration Model is not intended to be prescriptive about what happens in each quadrant, but to serve as a conceptual framework for collaborative planning within the system of care.

3.2.3.2.2.3 Outpatient (PCP and Mental Health Providers and Substance Abuse Providers) to Inpatient:

RESPONSE: Transition of care from outpatient to inpatient services will be facilitated by the Care Navigator and coordinated with the Health Home Care Coordinators. The Ticket-to-Ride (Attachment 5) will be utilized to provide continuity of care.

3.2.3.3 Provide a comprehensive statement of your proposed three-year staffing plan to demonstrate adequate support of your care coordination model.

RESPONSE: The Precedence Health Homes will expand staffing over the three years of the Innovations proposal in direct relationship to the incremental growth in enrollment. Within each Health Home, a community support team, consisting of the PCP, Care Navigator(s), Care Coordinator(s), Nursing Care Coordinator(s) and a Psychiatrist will serve as an extension of the PCP and provide enhanced care coordination and assistance.(See Attachment 6: Staffing Plan/Org. Chart & Job Description):

- 1.0 FTE MHP-Care Coordinator per 30-40 enrollees.
- 1.0 FTE QMHP-Care Coordinator per 150 enrollees**
- 1.0 FTE Care Navigator per 250 enrollees.
- 1.0 FTE Psychiatrist per 1600 enrollees.
- 1.0 FTE Primary Care Provider per 1600 enrollees.

**Providers work as a team to meet the identified needs of the patient. The team members that are assigned to a case is dependent on the assessed needs of the patients. Patients that are "low-moderate risk" are assigned to MHP. Patients that are identified to be "high risk" based on their health status will be connected with the QMHP to provide nursing intervention and monitoring. This will be in addition to the services that the MHP provides for the same patient.

3.2.3.4 Describe your expanded medical home functionality within your PCP network, including minimum hours of operation after-hours availability, minimum appointment standards, and access standards.

RESPONSE: The Precedence Health Homes (North Central, Sinnissippi, and Robert Young) will be a place where enrollees can come throughout their lifetimes to have their entire healthcare needs identified and receive the behavioral, medical, and related social services and supports they need. Holistic services will be coordinated, recognizing that wellness and prevention are as important as treatment and rehabilitation.

Precedence Health Home – RYC. The Primary Care Clinic will be open twice a week at the Robert Young Community Support Center in located in Rock Island, IL. Hours are 8:00 a.m. to 5:00 p.m. After hours availability will include the Access Center, which is open 24 hours a day, seven days a week. Clients will also be provided with a 24-hour crisis line number. A Behavioral Health Specialist (Licensed Clinical Social Worker, Licensed Clinical Professional Counselor) will work full-time at the Community Health Center located in Moline, IL. In addition to the on-site behavioral health specialist, a built-in psychiatric consultation process is in place that provides the opportunity for the primary care provider to have access to a psychiatrist for assistance with medication management issues. Minimum appointments will depend upon the severity, acuity, and condition of the enrollee, and may change as the enrollee engages in the Health Home program.

Precedence Health Home – North Central will be located in Ottawa, IL. Minimum appointments will depend upon the severity, acuity, and condition of the enrollee, and may change as the enrollee engages in the Health Home program.

Precedence Health Home - Sinnissippi. Primary care providers will have regular hour's onsite at one (or more) Sinnissippi office(s) and Sinnissippi staff will have regular hours on site at one (or more) primary healthcare delivery sites. Services will be available at least five (5) days per week, from at least 8:00am to 5:00pm, and will have evening (5:00pm – 8:00pm) services twice a week. The KSB Family Health Center will also be open five (5) days per week, with Primary Care services also available onsite at SCI and SCI Behavioral Health services available onsite at KSB, respectively (initially for 4-6 hours per week). Enrollees will be provided with a 24-hour crisis line (800) number. Face-to-face access will be provided as necessary 24 hours a day, seven (7) days a week (via SCI's EOD services system). Minimum appointments will depend upon the severity and acuity and condition of the enrollee and may change and may change as the enrollee engages in the Health Home program.

3.2.3.5 Describe your proposed Provider to Enrollee ratios, including your plan to monitor and maintain ratios:

RESPONSE:

3.2.3.5.1 *PCP to Enrollees* - 1:1600

3.2.3.5.2 Mental Health Provider to Enrollees - 1:35-50

3.2.3.5.3 Substance Abuse Provider to Enrollees – 1:35-50

3.2.3.5.4 Specialist to Enrollees – 1:1600 for psychiatrists

The Precedence CCE Director will monitor provider ratios and provide monthly reports to the Board of Managers. The Board will approve the addition of positions to fulfill enrollment responsibilities. In cases where ratios become deficient in between Board of Manager's meetings, a special meeting of the Board will be called to address the situation.

3.2.3.6 Provide a detailed three-year budget as Attachment I that includes:

3.2.3.6.1 Revenue sources (projected care coordination or capitation reimbursement revenue and other revenue sources).

RESPONSE: Revenues will be derived from per member per month fees which are estimated to generate a $1,573,000 over three years. Shared savings are estimated to generate $2,473,000 over three years for a net total revenue of $899,920. Please see Attachment I: Budget detail.

3.2.3.6.2 Costs (operations, staffing, health information technology, performance incentive payments, estimates of reimbursement distribution among collaborators, and other costs).

RESPONSE: Expense include staff and fringe benefits, IT and office supplies. Total expenses over the three years are estimated at $1,573,174. Please see Attachment I: Budget detail.

An estimated reimbursement distribution among collaborators is shown below.

Summary Table of Revenue And Expenses

					Estimated Reimbursement Distribution					
					State	PCCE	NCBHS	RYC	SCI	
							85%			
	Total Expenses	Total CCE Fees	Total Shared Savings	Net Revenue (Fees - Svgs)	50%	15%	5%	90%	5%	Total Collaborator Distribution
Year 1	$ 303,253	$ 303,240	$ 247,500	$ (55,740)	0	0	$ -	$ -	$ -	$ -
Year 2	$ 514,944	$ 514,920	$ 742,000	$ 227,080	$ 113,540	$ 17,031	$ 4,825	$ 86,858	$ 4,825	$ 113,540
Year 3	$ 754,977	$ 754,920	$ 1,483,500	$ 728,580	$ 364,290	$ 54,644	$ 15,482	$ 278,682	$ 15,482	$ 728,580
	$ 1,573,174	$ 1,573,080	$ 2,473,000	$ 899,920	$ 477,830	$ 71,675	$ 20,308	$ 365,540	$ 20,308	$ 955,660

3.2.3.7 To the extent that your model includes Dual Eligibles, describe your plan to address the specific needs of dually eligible populations.

RESPONSE: Dual eligibles are eligible enrollees with the Precedence CCE health home. While dual eligibles represent only about 9% of the individuals enrolled in Medicare and Medicaid programs, they account for a disproportionate amount of program spending. Specifically, dual eligibles account for 16% of Medicare enrollees but 27% of Medicare spending. According to MEDPAC, the dual

eligible population has many different health characteristics but is firmly represented by this group's need for chronic care management, intensive case and disease management, and medical oversight that is outside the normal service set of the traditional medical community. National statistics indicate that nearly a quarter of this population residing in nursing homes (or other institutions). Most are at a significantly greater risk for health issues, including major mental health disorders, cognitive impairment issues, and highly increased rates of chronic diseases such as diabetes, pulmonary diseases, strokes, and similar health problems. Claims data attributes a significant number of ED visits and inpatient hospitalizations and re-hospitalizations to dual eligibles. Additionally, issues that compound this population's health status are poverty, poor living conditions, difficult or non-existent family situations, lack of personal integration into the community, low educational levels, and often ethnic/minority status.

Given this population description, our model is tailored to the specific needs of dual eligibles. First, our Care Navigators monitor care for complex patients – those with multiple co-morbidities, heightened and unique medical needs, greater utilization patterns and multiple payers. This care coordination will enable dual eligibles to receive the appropriate care at the appropriate level and appropriate setting. Second, our health home model utilizes a multidisciplinary team to develop an individualize care plan and address confounding and compounding health issues. Specialists are consulted when needed and actively involved in patient care. Third, our model engages the dual eligible in their care and holistically addressed both their behavioral and physical needs. Specifically, our Care Coordinators provide self-management education for comorbidities, develop wellness and prevention initiatives, and facilitate health education groups. Additionally, our model integrates the dual eligible population within our care delivery system and meets the requirements outlined in Federal CMS Managed FFS model (see following responses).

3.2.3.7.1 If your model to serve Dual Eligibles meets the requirements outlined in Federal CMS Managed FFS model, describe:

3.2.3.7.1.1 How will you promote seamless integration and access to all services in the Medicare and Medicaid programs, based on the Enrollee's needs, through coordination across both programs;

RESPONSE: At present, Medicare-Medicaid enrollees must navigate two separate programs: Medicare for coverage of basic acute care services and drugs, and Medicaid for coverage of supplemental benefits, such as long-term care supports and services. In addition, primary care and behavioral health treatment and supports are often funded and managed in different, uncoordinated systems. Precedence CCE provides care navigation across the care continuum to promote person-centered, seamless care. The Health Home team, as well as other assigned staff, provides appropriate levels of care to each enrollee based on need and medical necessity. The Care Navigators specifically monitor care to ensure seamless delivery of services regardless of payer. The decision to bill to appropriate programs is managed by the client accounts department and does not impact delivery by service providers.

3.2.3.7.1.2 How you will assure access to all necessary care:

3.2.3.7.1.2.1 Is provided in a culturally and linguistically appropriate manner;

RESPONSE: Health Home team members assigned to an individual enrollee assure enrollee needs are met. Enrollee cultural and linguistic needs, as well as functional impairments, are identified by the team to assure appropriate providers are identified and utilized. Where auxiliary supports are necessary, they are engaged. More information on cultural and linguistic sensitivity is contained in section 3.2.3.20 of this narrative.

3.2.3.7.1.2.2 Includes caregivers, when appropriate:

RESPONSE: Health Home team members engage caregivers at the direction of the enrollee after appropriate authorizations are secured. When appropriate, family/caregivers are notified of changes to enrollee status (MH/SA/Medical) and level of care. Communication is provided prior to and following changes to the treatment level and care regimen. Caregivers may be granted access to the patient portal (see section 3.2.4.1 for portal information) with the consent of the enrollee.

3.2.3.7.1.2. 3 Is provided in the appropriate care setting including home and community:

RESPONSE: Health Home team members assure enrollees are treated in the least restrictive environment, which provide for the enrollee's safety and well-being and also accounts for enrollee preferences. As needed, other community service providers will be engaged to facilitate coordinated efforts and avoid duplication. To support community placements and access to supportive services, Health Home teams may seek input from the Social Needs Advisory Council.

3.2.3.7.1.2.4 Is person-centered:

RESPONSE: Health Home team members assure care is delivered in a person-centered manner, always allowing enrollee preferences to be supported as their needs are met. The cornerstone of person-centered care is the individual care plan. The enrollee determines feasibility of, and agrees to, the plan of care, has access to the plan, and contributes goals and updates to the plan.

3.2.3.7.1.2.5 Encourages consumer-direction.

RESPONSE: Health Home team members assure the enrollee is always involved in the determination of their care and can assess the merits of various treatment options in the context of his or her values and convictions. Shared decision-making is encouraged to promote understanding, foster dialogue, and encourage questions through the use of health literacy (appropriate education materials and teach-back) as well as through activation techniques, including motivational interviews. Enrollees have the right to refuse medication and/or treatment. Levels of guardian/caregiver direction are managed by the enrollee.

3.2.3.8 Describe how you will maintain a profile for each Enrollee that includes:

RESPONSE:

3.2.3.8.1 Demographics – Each of the participants will have an intake form with information being entered on the EHR and then uploaded to a web-accessible portal provided through IHS. If demographic information is missing, an alert will be sent to the Care Navigator to obtain the information. The Care Navigator will also contact the providers to obtain missing information.

3.2.3.8.2 PCP – The PCP will be identified from information provided by the Illinois Client Enrollment Broker (ICEB).

3.2.3.8.3 Results of risk assessment - The Care Navigator will be responsible for uploading the Health Risk Assessment (HRA) onto the web-accessible portal or (future) Health Information Exchange (HIE) site. Please see section 3.2.4 of this narrative (Health Information Technology) for further information on the proposed web-based portal.

3.2.3.8.4 Care management assignment - Each Care Navigator will be responsible for 250 enrollees. The Precedence CCE Director will be responsible for monitoring the number of enrollees assigned to the Care Navigator. The Care Navigator will be included in the individual care plan which will be available on the clinical web-based portal and patient portal.

3.2.3.9 Submit a sample enrollee profile as Attachment J.

RESPONSE: Please see Attachment J: Enrollee Profile.

The profile is obtained from actual profile from information provided by information from intake form, HRA This is an example profile obtained from the Intake form, ICP and notes that are found on the (clinical) web based portal.

3.2.3.10 If you are proposing to operate as a health home and serve Clients eligible under Section 2703 of the ACA, describe:

3.2.3.10.1 How you meet the definition of a health home:

RESPONSE: This proposal is intended to establish and provide Health Home services under Section 2703 of the ACA and is roughly based on the Missouri Health Home model. Precedence CCE assists designated providers that operate with a team of health care professionals to provide Health Home services to eligible individuals with chronic conditions. In this model, the designated provider may be either a community mental health center or a PCP (physician, clinical practice or clinical group practice). Eligible enrollees are defined in section 3.2.2.1.2 of this narrative, and this definition is derived from Section 2703. The Health Home services proposed are detailed section 3.2.3.10.4 of this narrative.

3.2.3.10.2 The process for identifying Clients with chronic conditions as defined in Section 2703 of the ACA and further clarified by the State;

RESPONSE: For this Health Home proposal, Precedence CCE will target enrollees with serious and persistent mental health conditions and/or clients with SMI/SA and having or being at risk for at least one additional chronic condition as listed in section 2703. The process for identifying potential enrollees for health home services will involve a review of the EHR and claims data from the collaborators based on primary diagnosis matching those conditions/codes specified in section 3.2.1.4 of this narrative. The initial review will be conducted by the Care Navigators. The Care Navigators will consult the named PCP (physician or psychiatrist) to determine if an individual is “at risk” for an additional chronic condition. Once an enrollee has been determined to meet the eligibility requirements, their file will be flagged in the relevant EHRs. An updated list of enrollees will be maintained by the Care Navigators.

3.2.3.10.3 How many Clients you expect to serve;

RESPONSE: The Health Homes expect to serve 500 enrollees by the end of year 1; 1,000 by the end of year 2; and 1,500 by the end of year 3. For further details about the populations to be served, Please see section 3.2.2 of this narrative.

3.2.3.10.4 How you will provide the following required services in addition to those outlined in Section 3.2.3.2:

3.2.3.10.4.1 Comprehensive Care Management:

RESPONSE: The Care Navigator will provide a comprehensive collaborative process of systematic care management to the enrollees in this program. This will assist consumers, families and providers to better coordinate the medical and mental health care more effectively. The goal of this comprehensive care management is to achieve an optimal level of wellness and improve

coordination of care while providing cost effective, non-duplicative services. The care management framework will include the following:

1. Identification, Stratification and Prioritization of enrollees who are at the highest risk to offer the greatest potential for improvements in health outcomes. Precedence Care Navigators will utilize data provided by the enrollees' providers to incorporate clinical and non-clinical sources of information to coordinate care. Tools to be used will include health risk assessments (HRA's), predictive models (algorithm-driven model that uses multiple inputs to predict high-risk opportunities for care management), enrollee health questionnaire (SF12v2 and PHQ-9) results and case findings (e.g. chart reviews).

2. Interventions will be individualized to meet the needs of the enrollees. Interventions will be coordinated by the Care Navigator's and include the multidisciplinary care teams. All interventions will be designed to best serve the enrollee, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care. The tools used will include evidence-based practices, individual care plan, developed based on enrollee-set priorities, multidisciplinary care teams, emergency plan and the Precedence Health Homes.

3. Evaluations of the interventions by providers will be completed by the Care Navigators. This will include systematic measurements and data analysis to ensure that the various providers interventions are effective, efficient and improving the quality of care. Consistent evaluation of data by the Care Navigators will provide the health team the necessary information to adjust the current care provided to better meet the needs and outcomes for the enrollees. The tools to be used include access to all providers health information systems, systematic measurements, program evaluations, rapid-cycle adjustment, measures of quality and costs, review of the SF12v2 results, review of the PHQ-9 results and IL Department of Healthcare and Family Services (HFS) data.

3.2.3.10.4.2 Comprehensive Transitional Care, including appropriate follow-up, from inpatient to other settings:

RESPONSE: The Care Navigators will provide an oversight to the transitions of care for the enrollees making sure they receive the appropriate follow-up care when leaving from an inpatient setting to outpatient care. They will make sure that there is a discharge plan in place for all hospitalized enrollees and that follow-up care will be initiated within 7 days of the discharge.

The discharge plan will include the following components; 1) support system for enrollee including linkage to appropriate community resources, 2) a safety plan which includes a 24-hour, seven days a week emergency phone number for enrollees to call when in need of help or support, 3) the enrollee will have a follow-up appointment with a provider within seven days of discharge, and 4) the enrollee will receive a "personal outreach letter" post-discharge with contact information.

Transition of care from inpatient to outpatient: - the Care Coordinator will be provided at the Health Home to ensure the stabilization of the enrollee post discharge from an inpatient to outpatient. This will include providers meeting with the enrollee within the first 7 days after discharge and providing more intensive case management for 90 days to prevent unnecessary readmissions.

Transition of care from inpatient to State operated facility or long-term care: - the Care Navigator will assist with the transition from the inpatient setting to long-term care or state operated

facility as required by the hospital case manager. The Ticket-to-Ride will be completed by the hospital case manager to facilitate a safe transfer of care.

All information will be uploaded to the PHH secure web portal within 24 hours of discharge activities.

3.2.3.10.4.3 Care Coordination and health promotion:

RESPONSE: The care coordination model will include a full continuum of care. This model will provide timely access to services, continuity of care, family support, strengths-based rather than deficit-based thinking and advocacy. This care coordination model will also include identification and targeting of high-risk enrollees, monitoring health status and adherence, coordination of enrollees' caregivers and providers, and implementation of an individual care plan with the health home team while promoting enrollee self-management.

A Health Home will be established by each mental health center to provide a place where individuals can come throughout their lifetimes to have their healthcare needs met. A major focus of care provided in the Health Home will be health promotion. All new enrollees will have a health risk assessment completed (see Attachment 7) that screens individuals for existing co-morbidities and those who are at risk for developing a co-morbidity. These enrollees will be assigned to Care Coordinators who will develop an individual care plan with the enrollee that will address health status.

Care Coordinators will engage high-risk enrollees with severe and complex needs and will provide care coordination at the Health Home level for each enrollee. Care Coordinators will provide appropriate enrollee-centered and "whole person" strategies. Care Coordinators will assist in managing chronic diseases by providing the following services:

- Assist enrollees' in developing a greater understanding of their chronic diseases
- Assist enrollees to adopt healthy lifestyles
- Educate enrollees on how to manage chronic health conditions and better utilize primary care services.
- Assist with public entitlements
- Assist with housing, food, clothing
- Assist with Payee services
- Facilitate admissions and discharges from acute care facilities
- Develop individual crisis plans with enrollees to reduce hospital admissions and/or to reduce crisis utilization therefore lowering rates of Emergency room services.
- Assist enrollees in developing an individual care plan

Health promotion programs will include a Wellness program, diabetic program, cooking classes, exercise programs, women and men health issues, and smoking cessation. All enrollees who are at risk for developing a chronic co-morbidity will be assigned a QMPH-Care Coordinator to provide education and a preventative plan of care. In addition, any enrollee who is having difficulty managing a chronic health condition will be referred to a Care Coordinator to assist and advocate for the client amongst the various providers. Care Coordinator's will provide education and follow-up care in the home to ensure that recommended care is being followed and that there are no duplications.

The Patient Portal will give enrollees the ability to track their own health goals and have an opportunity to receive health incentives as provided in section 3.2.3.21 of this narrative.

3.2.3.10.4.4 Individual family support, which includes authorized representatives

RESPONSE: During treatment planning, the enrollee can identify and invite friends, family members and authorized representatives that they would like to have included in the treatment process. Once authorizations are obtained, members of the treatment team are able to engage authorized representatives in the care of the enrollees. Enrollees can also identify specific roles for each person involved in supporting their recovery at any point during treatment. As treatment progresses, and through participation in services such as individual and family sessions, the friends, family member and authorized representatives can be identified as a natural support for the enrollee to access and as a collaborator in the overall care provision.

3.2.3.10.4.5 Referral to community and social support services (e.g. homelessness assistance and housing counseling):

RESPONSE: The Care Coordinator at the Health Home level will act as the primary counselor for community-based support services. In an effort to assist in keeping an enrollee's Social Security benefits both current and active, Care Coordinators can accompany enrollees to their appointments at the local office. Care Coordinators are also able to use the internet and phone inquiries between re-certifications for general questions. Care Coordinators can also stay apprised of an enrollee's Medicaid benefit by accompanying enrollees to their redetermination appointments at the local DHS office. Between redeterminations, enrollees can get assistance from the Care Coordinators to call or visit the local DHS office.

For services that require a referral to a community agency, Care Coordinators will utilize local resources in an effort to assist in meeting the enrollee's needs. Linkage will occur with agencies such as housing authorities, community action agencies (Project Now, Salvation Army, etc.), food pantries, homeless shelters, hot meal sites, churches, and support groups (Alcoholic Anonymous, Narcotics Anonymous).

3.2.3.10.4.6 The use of HIT to link services, as feasible and appropriate.

RESPONSE: HIT plays an integral role in the plan to deliver care based on the needs and services of the enrollees. Through the use of the EHR and HIE, information will be linked for each enrollee and made available for all providers requiring access.

A Patient Portal will be made available to each Health Home enrollee which will offer enrollees (and family/caregivers if permitted by enrollee) access to their health records, community support programs and resources, and health information. The portal can also be used as an informational tool for announcements and updates on available community resources.

Portal technology will also be used for a Clinicians portal where Health Home teams will have access to health records, care plans, health risk assessments and other relevant patient care information.

3.2.3.11 What is your approach to discharge planning and ensuring Enrollees receive appropriate follow-up services?

RESPONSE: The approach to discharge planning will begin with the Care Navigators who will provide oversight regarding admissions and discharge dates for the enrollees. This includes facilitating the link between the acute care agency and the Health Home Care Coordinators. The Care Navigator will notify the appropriate Health Home of the pending discharge to ensure that follow-up care has been initiated within seven days of discharge. They will also provide utilization management of the enrollee to ensure that appropriate levels of services have been provided. Prior to discharge, the Care Navigator will complete a "Ticket-to-Ride" ensuring that information is readily available post-discharge if problems arise. The Care Coordinator will upload the Ticket-to-Ride as

well as all other discharge information to the web-based portal for access by other Health Home team members. In addition, the Care Navigator will ensure that medication management review is completed prior to discharge.

The Care Coordinators will see the enrollee within seven days of the discharge. The Care Coordinator will assist the enrollee in attending all post-discharge appointments for follow-up care. Most importantly, the Care Coordinator will provide intensive case management for a period of ninety (90) days assessing for stabilization and education on crisis prevention, thus preventing readmissions.

A Care Navigator will be notified if an enrollee is discharged on the weekend. Hospital staff will know if enrollee is part of the Health Home from a notation of the EHR. Depending on the situation, the Navigator will contact the Care Coordinator who will then monitor and manage the enrollee as necessary. The Care Navigator will notify the Health Home team of the weekend discharge.

3.2.3.12 How will your model of care decrease hospital readmission rates?

RESPONSE: Avoidable readmissions will be reduced by 10% in year 1; 15% in year 2 and 20% in year 3 resulting in an estimated $2,473,500 in shared savings over three years. The Care Navigators will be the first line of defense to decrease hospital readmission rates. This will be accomplished by providing utilization management to ensure that the appropriate level of care is being provided to each enrollee in a timely manner. In addition, they will monitor high utilizers of services to prevent hospitalization.

The Care Navigators will consult with the Health Home providers, recommending changes to the service mix or volume. The Care Navigators and/or Health Home providers will also recommend partial hospital services as an alternative to hospitalization.

At the Health Homes level, Care Coordinators will prevent hospital readmissions by doing the following:

Pre-admission

- Providing each enrollee the appropriate level of care under the guidance of the LOCUS, DLA-20 and Qualified Mental Health Professionals.
- Providing education regarding chronic disease management, healthy lifestyle choices, signs and symptoms of relapse, medication training, and psychosocial rehabilitation.
- Monitoring that basic needs are being met (housing, food, clothing, medication).
- Monitoring medication to ensure that all providers' prescriptions are being taken as prescribed and are effective.
- Ensuring a crisis plan is in place and being followed.
- Providing continual assessment for signs and symptoms of relapse.
- Implementing early interventions at the first sign of relapse.
- Monitoring appointment attendance or isolation

Post-discharge

- Providing face-to-face contact post-discharge within seven days.
- Modifying crisis and individual care plans within seven days of discharge.
- Providing diagnostic assessment and Level of care assessment to ensure that medical necessity is being met.
- Scheduling and arranging post-discharge follow-up appointments
- Assessing the enrollee weekly for signs and symptoms of relapse.

3.2.1.13 Describe the process for identifying mental health and substance abuse issues among primary care patients and ensuring the delivery of appropriate mental health and substance abuse care.

RESPONSE: Primary care providers have become the behavioral health provider for up to 50% of all persons seeking behavioral health services. The processes for identifying these issues and ensuring service delivery are crucial to the success of the Health Home.

Enrollee Identification and Screening for Depression in Primary Care - All new enrollees presenting in primary care sites complete depression screening. Enrollees identified to be "at risk" will complete the screening every two weeks or until there is full symptom remission. The PCP and mental health center will collaborate in the implementation of the PHQ-9, a 9-item depression module derived from the Patient Health Questionnaire. The PHQ-9 screens for depression based on diagnostic criteria for making a DSM-IV depression diagnosis. The brevity and self-report of PHQ-9 lends itself well to clinical practice settings. The PHQ-9 has the potential of being a dual-purpose instrument that can establish depressive disorder and assess depressive symptom severity. The PHQ-9 can also be used in serial fashion to monitor symptoms over time.

Enrollee Identification and Screening for Substance Abuse in Primary Care - The CAGE screening tool (See Attachment 8: CAGE Assessment) will be used in addition to a PHQ-9. The CAGE is a 4-item questionnaire for detection of alcoholism. The CAGE takes less than one minute to administer and is easy to learn, remember and replicate. The CAGE will be completed at the PCP site each time the enrollee presents to assess for substance abuse. The enrollee will complete the CAGE in the waiting room, and then the assessment will be scored by the PCP.

Referral and Treatment Protocol for Patients Presenting in Primary Care - The PCP will ultimately direct referrals for behavioral health treatment for enrollees presenting to PCP sites. All enrollees identified through screening or PCP interview to have behavioral health problems will be referred first for an evaluation by an on-site Licensed Mental Health Professional. If the PCP determines that further behavioral health evaluation is needed, the on-site Licensed Mental Health Professional is available to provide a "warm handoff" to initiate this evaluation. Enrollees that are assessed to be in need of a psychiatric evaluation will be referred to a psychiatric provider.

Psychiatric Consultation, Evaluation, and Treatment - The PCP will have access to psychiatric consultation and case support provided by the psychiatrist, psychiatric nursing staff, and the on-site licensed mental health professional. The PCP may choose to prescribe psychotropic medication or refer to a psychiatrist for evaluation. If the enrollee is referred for psychiatric evaluation, the psychiatrist will provide initial evaluation and symptom stabilization. Once the enrollee is stable, the psychiatrist will refer back to the PCP for on-going management. If the enrollee decompensates at any point, the PCP can choose to refer back to the psychiatrist for stabilization.

Mental Health Consultation, Assessment, and Therapy - The Licensed Mental Health Professional (LMHP) will provide consultation, assessment, referral, and brief therapy (up to six sessions). Enrollees will be referred for additional care as needed. The LMHP will provide a full mental health assessment on all enrollees referred by the PCP. A primary role of this position will be to ensure treatment continuity, coordination, and collaboration with all involved providers. The LMHP will serve as an on-site access point for all behavioral health services offered by the Health Home.

3.2.3.13.1 Describe how you will educate PCPs in your CCE or MCCN about the importance of screening for mental health and substance abuse issues and the use of evidence-based practices in the treatment of Enrollees with SMI and substance abuse disorders.

RESPONSE: Education is a key component for the successful integration of primary care/behavioral health services. The understanding of the co-morbid illness and physical health problems, as well as what each system will contribute to provide integrated services, is essential to achieving improved treatment outcomes. This will be accomplished by setting up mutual learning collaborative educational opportunities and/or online in-services for the medical and allied health staff.

The Health Home psychiatrist will provide education to the medical and allied health staff regarding prominent mood disorders such as depression, bipolar disorders, schizophrenia, substance abuse and anxiety, including presentation, symptoms and treatment. Emphasis will be placed on the psychopharmacology of the medication used to treat this Health Home enrollee, including the psychodynamics response and adverse effects.

The PCP will provide the mental health professionals and other Health Home team members with education regarding the common co-morbidities that the severely mentally ill population is at risk for developing. There will be an emphasis on diabetes, heart disease, asthma and obesity.

3.2.3.14 Please describe your plans, if any, to co-locate physical health and mental health or substance abuse services:

RESPONSE: In the larger market areas, co-location is an integral component of our care model. In the Quad Cities area (served by the Robert Young Center for Community Mental Health and Community Health Care, Inc. (FQHC)), a bi-directional integration project will be expanded to include the Health Home population. Currently an Advanced Practice Nurse from the FQHC comes to the Robert Young Center Community Support Program facility two days per week to conduct a medical clinic. This allows over 350 patients to have a Health Home at the mental health center. In addition, RYC has a licensed therapist working full-time at the CHC located in Moline. This provides the PCP's onsite consultation with a behavioral specialist and the ability to do a "warm handoff" to initiate further assessment and treatment. The CHC providers are also given the ability to consult with psychiatrists. In the Dixon area (served by Sinnissippi Centers, Inc. and KSB Family Health Center (PCP)), a bi-directional project will start with 4-6 hours of co-located services weekly. Co-located services for enrollees will be complemented by a 24-7 access to an 800-number crisis line and face-to-face access as necessary via Sinnissippi's EOD services system.

In the North Central smaller service area of Ottawa (served by North Central Behavioral Health Systems and Dr. Robert Maguire), it is anticipated that initial enrollees will be limited in number and will reside primarily in permanent supported housing or residential programs. This initial population would not support a co-location of physical health staff; however, tele-health services are available to supplement face-to-face, off-site visits from mental health and substance abuse providers. As the Health Home expands and enrollees increase, co-location and other care coordination strategies will be revisited and used as appropriate.

3.2.3.15 Describe the process for emergency department data utilization review and identification of Enrollees with high utilization.

RESPONSE: High utilization of emergency department services has been defined by Precedence CCE as an enrollee who frequents the emergency department/or has a hospitalization at least more than once throughout their enrollment period. To prevent potential unnecessary or high

utilization of services, the Care Navigator will access and review data reports daily regarding all enrollees care utilization for emergency room services for both behavioral and medical issues. The identification of enrollees presenting to the emergency room data will be shared with the Health Home Care Coordinator to ensure appropriate linkage. The individual care plan will be reviewed to determine if any service changes or additions are required. The Care Coordinator will provide education regarding symptoms of relapse for both behavioral and physical health conditions and update the crisis plan with enrollee input. All information related to the enrollee's emergency room visit will be available on the secure clinical web portal within 24 hours of the emergency room visit.

3.2.3.16 Explain the strategies to address high emergency department utilization that you will implement.

RESPONSE: All EHR's of the Health Home enrollee will have a Precedence CCE enrollee notation. When an enrollee presents to the ER, the hospital Case Manager will send a communication to the Care Navigator. Enrollees with high utilization of emergency services that present to the ER will warrant direct contact with the Care Coordinator by the hospital Case Manager. Care Navigator's will monitor all enrollees' admissions to the emergency departments through data reports from each Health Home. This information will then be distributed to Care Coordinators assigned to the enrollees to provide follow-up care within one day of an emergency room visit. The Care Coordinators responsibility is to help provide stabilization and future deflection to emergency services. This will be accomplished by providing intensive case management (a minimum of bi-weekly visits) post-discharge for a period of 90 days. In addition, individualized crisis plans will be in place for all enrollees. The crisis plans will be developed using the Wellness Recovery Action Plan (WRAP). Components of this plan will include (1) a written plan of care for crisis situation developed by the enrollee and care coordinator, (2) a checklist of warning signs individualized per enrollee and what to do if these warning signs occur, and (3) a social support network that includes who to call on the treatment team, where to go to be safe during a crisis and who to notify (i.e. family/caregiver/significant other).

On weekends, a Care Navigator will be notified if an enrollee presents in the emergency department. ED staff will know if enrollee is part of the Health Home from a notation of the EHR. Depending on the situation, the Navigator will determine whether to contact the Care Coordinator in an effort to defuse the crisis or ensure that medically necessary and appropriate services are provided. The Care Navigator will notify the health home team of the outcome.

3.2.3.17 Describe strategies you will employ to promote wellness and encourage access to and utilization of preventive care.

RESPONSE: The Health Home team members will provide education regarding health promotion to the enrollee and their family/caregiver/significant others. Education regarding wellness and preventative care will be provided on an individual basis and in group settings.

The Care Coordinators responsibility will be to promote health and wellness and to help enrollees manage their chronic illnesses. Health risk assessments completed on all new enrollees will be used as an identification tool for enrollees at risk for or who have developed a medical co-morbidity. The Nursing Care Manager will also be responsible for co-facilitation of wellness groups, diabetic groups and a diabetic program for which the hospital's diabetic educator provides oversight. Enrollees will have access to education, nutrition and lifestyle management classes through diabetes education programs as well as specialized counseling from a Diabetes educator. Best practices and medications for optimal asthma control will be offered through the local Asthma and COPD clinic. Preventive services such as wellness checks, HeartAware health screenings for heart, stroke and vascular conditions, and blood pressure screenings will be offered. To promote wellness and

encourage access and utilization of preventative care, incentives for obtaining preventive health services will be offered (such as gift cards, blood pressure cuffs, scales, etc.). See section 3.2.3.21.

3.2.3.18 Describe how you will educate PCPs on their responsibilities for compliance with the American Disabilities Act.

RESPONSE: All Health Home PCPs will receive education and resources regarding their responsibilities under the American Disability Act (ADA). Education shall be provided to all PCPs during the course of this project and shall specifically relate to the priority population of Adults with Disabilities. ADA resources will be provided on the web-based, Health Home Provider portal. As soon as a new provider comes on board, the Care Navigator will contact the new provider and immediately provide materials on ADA compliance.

3.2.3.19 Describe the strategies that you will utilize to address Potential Enrollees who are very mobile, difficult to locate, homeless, or difficult to engage.

RESPONSE: When Care Coordinators encounter enrollees that are mobile, homeless or otherwise difficult to engage several strategies will be employed. First, utilizing the EHR will assist Care Coordinators in finding the last known address and phone numbers of the enrollee. The EHR will also have a record of any emergency and/ or collateral contacts that Care Coordinators can use to contact the enrollee. Care Coordinators will also align their own appointments with other providers in an effort to make contact with an enrollee at the time they are scheduled to see their therapist or doctor. Community Health Care operates a dedicated homeless outreach clinic located in the Salvation Army Family Services Center that provides emergency shelter, transitional housing, food and nutrition programs, clothing and emergency assistance to homeless individuals and families in the community. The Homeless Outreach clinic is located within the center and provides preventive, acute and chronic medical care along with basic laboratory services to walk-in patients on a daily basis. Care Coordinators will reach out to the Homeless Clinic to try to locate enrollees. The Social Needs Advisory Committee will develop an alert system to notify Home Health staff when an enrollee shows up at the clinic or other homeless outreach facilities. Assertive outreach attempts will be made with the difficult to engage enrollee in order to connect at their home or in the community to provide services in the enrollee's environment. In order to have 24-hour capability to capture an enrollee's communication, the enrollee will be directed to the Care Coordinator's number and a crisis line in all correspondence.

3.2.3.20 Describe methods you will employ to ensure your care coordination model takes into account the culture of and the specific needs of the population you propose to serve.

RESPONSE: All evidence based practices employed by Precedence CCE will be done in a manner that is sensitive to the multitude of demographic characteristics. Precedence CCE will use the linguistic and cultural competency program in place at the Robert Young Center to accommodate individuals with disabilities, language barriers, and cultural differences. Cultural sensitivity and competence will be embedded into our daily practice. Interpreters and flash cards will be used to overcome language barriers and disabilities. In addition, all facilities are handicapped accessible and compliant with the American Disability Act, and staff complete an annual cultural/diversity training.

Precedence CCE will survey the enrollees quarterly to assess if they perceive their cultural needs are being met. Delivery of services will be done in a culturally appropriate and sensitive manner. This is accomplished by requiring all staff to complete cultural sensitivity and diversity

training on an annual basis through Net Learning. Some of the required courses to address cultural competence include; "The Influence of Culture on How We Communicate and Understand the Cultural Framework of Communication" Diversity classes are also offered at various times throughout the year in a "Lunch and Learn" format.

3.2.3.20.1 Describe how you will supply interpretive services for all key oral contacts and ensure that written materials can be easily understood by the various populations:

RESPONSE:

Interpretive services: Health Home use several providers for interpretation and translation services based on the individual's specific need (AT&T language line, Translation Unlimited and IA/IL Independent Living Center). Other interpretive aides include TTY devices, picture boards from the US Census Bureau and communication kits that include extra hearing aide batteries and speaking assistance devices.

Written materials: PCCE will follow the RYC Linguistic and Cultural Competency Plan (LCCP) that demonstrates strategies that are in place to assist Limited English Proficient (LEP), hard of hearing and/or deaf customers and persons with limited literacy. The plan will be distributed to all collaborators participating in the program. In addition, a Health Literacy Committee made-up of the key leaders will be formed and be responsible for evaluating the reading level of patient materials using the FRY Readability Formula or other formulas if necessary. Language services are available through written, telephonic, and in-person interpreters. Patient understanding is verified using health literacy techniques and may include teach-back techniques and Ask Me Three.

Health Homes have access to IHS assessment tools used to determine current capacity and set goals for health literacy. Tools include Nation Center for the Study of Adult Learning and Health Literacy's The Health Literacy Environment of Hospitals and Health Centers; AHRQ Health Literacy Universal Precautions Toolkit; AHRQ Pharmacy Health Literacy Assessment Tool; and America Health Insurance Plans' Health Plan Organization Assessment of Health Literacy Activities.

3.2.3.20.2 Describe alternative methods of communication and how Enrollees will access these methods:

RESPONSE: To facilitate access to information, a patient portal ("FollowMyHealth") through Jardogs will be maintained by IHS and made available to all program enrollees. The portal will enable reminders and messaging with providers, viewing of personal health information, prescription refills, appointment scheduling, bill payment, home health support, and online educational resources. Approved family members may access the portal as well. Computers will be available at the Health Homes for enrollees to use.

When available, Health Homes will also offer telehealth options to select enrollees who have limited access to specialized healthcare services, transportation and other barriers that stand in the way of effectively treating SMI clients with chronic illnesses. In particular, telehealth may be used for frequent monitoring of physical conditions such as weight, blood pressure, oxygen levels and glucose readings. Clinical monitoring and evidence-based intervention will be implemented based upon transmitted data. Duration of telehealth services will depend upon individual needs and aptitude.

3.2.3.21 Describe any incentives you will allow PCPs and other Providers to use to encourage healthy behaviors and patient engagement in preventive care.

RESPONSE: Health incentives will be provided to enrollees to promote healthy behaviors and preventive care. The Board of Managers will adopt and maintain an incentive policy that includes

eligibility, type, distribution and frequency. Eligible activities may include:

- Annual physical, labs, health screening and immunizations completed
- Completion of diabetic education classes for diabetics
- Completion of nutrition classes for diabetics and overweight or obese patients
- Keeps diary of blood sugars that reflects all appropriate blood sugars were completed
- Any marked improvement of any of the chronic health condition, diabetes, heart disease, Obesity (BMI>25)
- Participation in an exercise program as defined on their plan of care for a period of six months.

For enrollees who demonstrate improvement or progress, incentives may include gift cards or medical equipment, such as scales to monitor weight or blood pressure cuffs.

3.2.3.22 To the extent your model includes Care Coordinators, provide proposed care coordinator to Enrollee ratios:

RESPONSE: In the Precedence CCE model, a heightened level of care coordination is provided by the Care Navigators. The proposed ratio of Care Navigator to Enrollee is 1:250. The Precedence Health Home Care Coordinators will be assigned to enrollees based on medical co-morbidity risks. The MPH-Care Coordinator to enrollee ratio is 1:30-40; the QMPH-Care Coordinator to enrollee ratio is 1:150.

3.2.3.22.1 How caseloads will differ depending on the needs of the Enrollees they are assigned:

RESPONSE: Care Coordinator caseloads will depend on enrollee medical co-morbidity risks, acuity levels, and functional assessment. Enrollees with higher needs will be assigned to Qualified Mental Health Professional (QMHP)-level Care Coordinators. Enrollees with a moderate to low needs will be assigned Mental Health Professional (MPH) -level Care Coordinators. Care Coordinators will use an assessment package that includes the LOCUS, DLA-20 and an annual health risk assessment to determine individual needs.

3.2.3.22.2 The qualifications of Care Coordinators and whether they vary depending on the Enrollee assigned;

RESPONSE: The qualifications of Care Coordinators will vary depending on the acuity level of the enrollee. Enrollees with high medical acuity/risks will be assigned to Qualified Mental Health Professionals (QMHP)-level Care Coordinators. Enrollees with low to moderate acuity/risks will be assigned to Mental Health Professional (MHP)-level Care Coordinators.

QMHP qualifications

EDUCATION, TRAINING & EXPERIENCE

a. A licensed social worker (LSW) possessing at least a master's degree in social work and licensed under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] with specialized training in mental health services or with at least 2 years' experience in mental health services; or

b. A licensed professional counselor possessing at least a master's degree and licensed under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] with

specialized training in mental health services or with at least two years' experience in mental health services; or

c. A registered nurse (RN) licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65] with at least one year of clinical experience in a mental health setting or who possesses a master's degree in psychiatric nursing; or

d. An occupational therapist (OT) licensed under the Illinois Occupational Therapy Practice Act [225 ILCS 75] with at least one year of clinical experience in a mental health setting; or

e. An individual possessing at least a master's degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum or internship that included a minimum of 1,000 hours of supervised direct service, or who has one year of clinical experience under the supervision of a QMHP.

KNOWLEDGE, ABILITIES & SKILLS

a Demonstrates a knowledge of and commitment to Recovery and Resiliency as an applied practice. Possesses the ability to apply critical thinking and problem-solving abilities to a range of client situations; has the ability to accurately assess and diagnose; can develop individual care plans and interventions with clients; possesses interpersonal skills, professional attitude and understands the ethical standards of behavioral healthcare. Possesses good written and oral communication skills. Has the ability to plan and organize their work. Is able to recognize signs of suicidal behavior and assess for lethality.

Mental Health Professional (MHP) qualifications

EDUCATION, TRAINING & EXPERIENCE:

a. Requires a BA, BS, BSW in behavioral healthcare services related field, or a practical nurse (LPN) licensed under the Nursing and Advanced Practice Nursing Act (225 ILCS 65) with 2 years' supervised experience in mental health or human services, or a certificate of psychiatric rehabilitation from a DHS approved program plus a HS diploma and 2 years' experience in providing mental health or human services, a recovery support specialist certified and in good standing with the Illinois Alcohol and Other Drug Abuse Professional Certification Association, plus one year experience providing mental health services, or minimum of five (5) years supervised experience in mental health or human services and a HS diploma.

KNOWLEDGE, ABILITIES & SKILLS:

a. Demonstrates an ability to apply critical thinking and problem-solving abilities to a range of client situations; has the ability to accurately collect and assess information; can develop individual care plans and interventions with clients; possesses interpersonal skills, professional attitude and understands the ethical standards of behavioral healthcare. Is able to recognize signs of suicidal behavior and assess for lethality.

3.2.3.22.3 The duties of the Care Coordinators

RESPONSE: The Care Coordinator/QMHP provides comprehensive community-based mental health services, including the assessment of the individual care plan, psychosocial rehabilitation and community support services.

The Care Coordinator /MHP provides case management for of mental health care who are deflected from psychiatric inpatient care and are discharge from inpatient psychiatric care. Case Management is an outreach oriented set of activities requiring a high degree of involvement by the care coordinator.

3.2.3.22.4 The training programs Care Coordinators may receive regarding cultural competency.

RESPONSE: Delivery of services will be done in a culturally appropriate and sensitive manner. This will be accomplished by requiring all staff to complete cultural sensitivity and diversity training on an annual basis through Net Learning. Some of the required courses to address cultural competence include; "The Influence of Culture on How we Communicate and Understand the Cultural Framework of Communication" Diversity classes are also offered at various times throughout the year in a "Lunch and Learn" format.

3.2.3.23 To the extent your care coordination model includes any of the following services, describe how you will facilitate the delivery of appropriate health care and coordinate care between medical homes:

3.2.3.23.1 Specialist service:

RESPONSE: Care Coordinators are responsible for arranging appointments with specialists for enrollees. Once the need for a specialist has been identified, the Care Coordinator can begin the process to schedule an appointment with the new provider. A psychiatric specialist will be consulted at least every 90 days for enrollees with serious mental illness. At the time of the appointment, the Care Coordinator will assist the enrollee in getting to the appointment and assist with any paperwork that will be necessary. At this appointment, the Ticket-to-Ride can be shared with the specialist to facilitate the coordination between the Health Home and the specialist services. By updating the Ticket-to-Ride once the appointment has been completed, any new information can be updated in the enrollee's EHR. Changes to the individual care plan can be made at any time when new information becomes relevant to care provision.

3.2.3.23.2 Dental services;

RESPONSE: When provided in the individual care plan or requested by the PCP, Care Coordinators are responsible for arranging appointments with dentists for enrollees. Care Coordinators will use available clinics including the use of Community Health Care Dental Clinic (part of the Precedence Health Home – RYC) to insure that enrollees are able to receive exams and any recommended follow up care. The Care Coordinator will assist the enrollee in problem solving any barriers to attending appointments and assist with any paperwork that is required at the time of appointment. In addition, Care Coordinators will act as advocates when necessary to insure that enrollees understand the risks and benefits to services.

3.2.3.23.3 Existing HCBS Waiver case management services;

RESPONSE: When enrollees are discovered to be utilizing HCBS Waiver services, Care Coordinators will work with the enrollee to include these services in the individual care plan. Once an authorization is obtained, Care Coordinators can become engaged in the care at the HCBS Waiver agency. Representatives from the HCBS Waiver agency can also become engaged in the care provided by the Health Home to the extent that an enrollee wishes.

3.2.3.23.4 Other community agencies and services.

RESPONSE: Care Coordinators will be the central point of coordination between enrollees and community agencies and services. The Care Coordinator will work with the local housing agencies and homeless shelters for placement into safe, affordable housing opportunities. For Social Security benefits, Care Coordinators can accompany enrollees to their appointments and use the internet and phone inquiries between recertification for general questions. Care Coordinators will stay apprised of an enrollee's Medicaid benefits by accompanying enrollees to their redetermination appointments and assisting the Care Coordinators to call or visit the local DHS office. For services that require a referral to a community agency, Care Coordinators will utilize local resources in an effort to assist in meeting the enrollee's needs. Linkage will occur with agencies such as community action agencies, food pantries, hot meal sites, local churches and support groups. Care Coordinators will assist the enrollee in accessing these services by problem solving barriers to getting to the resource, accompanying the enrollee to the appointment and assisting with any paperwork or tasks that are required in order to access the services. Many of these agencies will be represented on the Social Needs Advisory Council as described in section 3.2.1.5 of this narrative.

3.2.3.24 To the extent your care coordination model includes medication management; describe your approach to monitoring prescription drug usage including selected standards, models, and algorithms.

RESPONSE: All prescriptions and drug usage is monitored through the EHR. Prescriptions are created, stored, and recorded for each enrollee in their individual EHR. Medication Reconciliation is completed each time the enrollee visits an outside provider. The Ticket-to-Ride is utilized to ensure a safe transition of care from one provider to the next and from one level of care to another.

3.2.3.25 To the extent your plan includes Enrollee health education plans, explain your plans and submit sample materials.

RESPONSE: Health education plans exist and will continue to be developed for the Health Home chronic health conditions. Group curriculum exists for (1) Diabetes Program - PSR Diabetes Group, Community Support Diabetic Peer led Group, Healthy Eating Group, Learning to plan, prepare and cook healthy diabetic meals (see Attachment 9); (2) Cardiovascular Education (see Attachment 10); (3) Cardiopulmonary Education (see Attachment 11); (4) Wellness Group Level 1 & 2 (see Attachments 12 & 13); (5) Eating Well Level 1 & 2 (see Attachments 14 &15); and (6) Healthy Lifestyle 1 & 2 (see Attachments 16 &17). The Health Home team will refer enrollees to the various groups as indicated by their chronic health conditions. For enrollees, their active engagement may enable them to earn incentives (see section 3.2.3.21 of this narrative).

3.2.3.26 Describe your plan for monitoring quality of care provided to your Enrollees and providing ongoing feedback to affiliated Providers on their performance.

RESPONSE: The Precedence CCE Director with assistance from the IHS Health Informatics team will provide quarterly reports to the Board of Managers and its Quality and Cost Committee. Performance/quality measures will include enrollee experience, safety, care coordination, and specific disease marker metrics. Enrollee experience input will be obtained in part through bi-annual surveys regarding (1) overall organizational services (staff attitudes, problem issues resolved in timely manner, information requests met, etc.). (2) availability (provider saw client within the time standards), (3) acceptability of behavioral healthcare practitioners, programs and services (qualified providers who met the clients the service request), and (4) cultural needs. These reports will be correlated to

care coordinate efforts within the Precedence CCE service area. In addition, individual provider and collaborative partner performance will be reported to those providers and entities. Providers are also audited on confidentiality, charting and facilities, and results and feedback are provided by the Precedence CEE Director.

The Quality and Cost Committee of the Board of Managers will monitor and report provider performance and any non-compliance with program expectations. Based upon this ongoing analysis, the Quality and Cost Committee will provide recommendations for provider intervention to the Board of Managers and Precedence CCE Director. As needed, the Care Navigators and the Quality and Cost Committee will be responsible for working with the collaborators to identify key actions to improve performance. Any enrollee survey identifying a problem with a Health Home provider will result in the Care Navigator following up with the Health Home team members on the issue; and documenting the situation and outcome and making modifications to improve service to the enrollee. Complaint and appeal logs will be maintained and categorized by (1) quality of care, (2) access, (3) attitude, (4) service, and (5) Health Home team members.

3.2.3.27 Propose at least one Quality Measure to be used as a pay-for-performance measure.

RESPONSE: Using Attachment A of the Innovations Solicitation, we have selected Quality Measure #4 to use as a Pay-for-Performance measure. The category is Behavioral Health Support and the Quality Measure is "Follow-up after hospitalization for Mental Illness: 1) Follow-up in 7 days and 2) Follow-up in 30 days". The measure is appropriate to our priority and target population and our care coordination delivery model.

32.3.28 Describe the experience of the collaborators using data to track utilization and to monitor Quality Measures:

RESPONSE: All Precedence CCE collaborators actively measure financial and quality performance as part of their healthcare operations. The overall reporting capacity of collaborators' systems and registries will enable Precedence CCE to provide the State with timely, accurate reports. Specifically, several collaborators track some measures from the Medicaid's Initial Core Set of Health Care Quality Measures program as well as report outcomes to programs such as Meaningful Use, PQRS, HCAHPs, etc. Although collaborators use several systems for data capture and reporting, reports are produced and submitted to external agencies for regulatory purposes and to a variety of national registries for benchmarking purposes. Additionally, IHS is enhancing its own ability to track utilization and monitor quality measures through the implementation of a population health management system and the development of a clinical data repository.

Precedence CCE will track utilization and monitor Quality Measures with the assistance of the IHS Health Informatics team, a dedicated staff that produces internal scorecards for strategic initiatives, including ACO strategies at Trinity Medical Center. Utilization measures include inpatient utilization; average length of stay (ALOS); recidivism; follow-up visits within 7 days of discharge; partial hospital; and intensive outpatient ALOS. Within the Precedence 9-county service area, results will be broken down by mental health region to show internal performance comparisons and identify areas of success as well as continued opportunities. Along with drill down capabilities, the use of appropriate statistical techniques will be instituted to analyze the data. Some examples include control charting to look at longitudinal performance trends and predictive modeling techniques to identify potential gaps in care for individual patients.

3.2.3.29 Describe how you will improve access to care:

RESPONSE*:* Access to care will be improved by providing the enrollees' with a lifetime of medical, behavioral and related social service needs and supports provided throughout their lifetime. By building relationships with enrollees, the Health Home team will be able to understand the obstacles enrollee face with recovery. Care Navigators will assure that enrollees and their care are not falling through the cracks and will work with Care Coordinators when gaps are identified. Caseloads will be closely monitored to assure that the health home team members are not exceeding provider to enrollee ratios which can negatively impact the enrollees overall quality of care. Community Health Care recently adopted a "same day access" model that will be incorporated into the health home model.

If an enrollee presents in the ED, Care Navigators will be contacted and coordinate with the ED and Health Home team members to support the enrollee through a crisis. Through coordinated care, correct utilization as opposed to ineffective utilization will enhance the enrollee's ED experience.

HIT plays an integral role in the plan to deliver care based on the needs and services of the enrollees. Through the use of the EHR (and HIE), information will be linked for each enrollee and made available for all providers.

An Enrollee Portal will be made available to each Health Home enrollee offering enrollees (and family/caregivers if permitted by enrollee) access to their health records, community support programs and resources, and health information. The portal can also be used as an informational tool for announcements and updates on available community resources.

Portal technology will also be used for a Clinicians portal allowing Health Home teams to have timely access to health records, care plans, health risk assessments and other relevant enrollee care information.

To assure that there is sufficient support to address enrollees' social needs, a Social Needs Advisory Council will be created to review referrals to community and social service organizations, address shortages in the delivery network and provide linkages with enrollees who are difficult to locate. Examples of social needs include access to fitness programs, nutritional food, transportation assistance, employment assistance, adult education, housing assistance and utility assistance

Health Home enrollees will receive personal phone calls to remind them of important preventative services or events. Postcards and email reminders will notify them of appointments, events or screenings. A 24/7 telephone crisis is always available and the ability to provide on-line conversations will be explored.

3.2.3.30 Enrollee Care Plan. Enrollee care plans are required for Priority Populations. To the extent your care coordination model includes Enrollee care plans for non-Priority Populations, please answer the following questions for those populations.

RESPONSE: Our care coordination model may include non-priority populations in the Health Homes. The adult Medicaid population served may be expanded beyond Adults with Disabilities to include other Illinois Health Connect (IHC) adults with SMI/SA and meeting the definition of "eligible individual with chronic conditions" in section 2703 of the ACA. If non-priority populations are included, we would approach care planning in the same manner as we do the priority populations.

3.2.3.30.1 Describe your approach to Enrollee care plan development, including:

3.2.3.30.1.1 The populations for which you will develop a care plan

RESPONSE: Primary care providers have become the behavioral health provider for up to 50% of all persons seeking behavioral health services. The establishment of individual care plan for enrollees with an acute behavioral health diagnosis recognizes the inter-relationship of physical and mental health – specifically, the impact of how various behavioral disorders can exacerbate the severity of physical disorders and how physical disorders may increase the prevalence of behavioral disorders. Beneficiaries may present with physical complaints that are an underlying behavioral health condition. Primary care providers often fail to diagnose or successfully treat the behavioral health conditions. The individual care plan will assist the primary care provider to improve access to behavioral health services, identify behavioral health problems, collaborate with behavioral health providers, and improve overall enrollee health status. The bilateral provision of services has been demonstrated to improve clinical outcomes for co-morbidities, such as depression, diabetes, hypertension and heart disease. In terms of costs, it is anticipated that health care utilization will reduce for avoidable ED visits, hospital admissions and readmissions, physician office visits, and prescription costs.

3.2.3.30.1.2 How each Enrollee's needs, goals, and preferences are identified and addressed

RESPONSE: Care Coordinators will interview the Enrollee to gain information and insight into their recovery issues and health needs to help them develop short and long-term goals to improve their mental and physical health. The Care Coordinators will also monitor enrollee progress and work with them in modifying their care plan to assure achievable results that encourage continued improvement.

3.2.3.30.1.3 Who develops and completes the Enrollee care plan and the process for collaboration

RESPONSE: The development and implementation of the enrollee's care plan will be coordinated between the health home team and the Care Coordinators. Health Home team members assure care is delivered in a person-centered manner, always allowing enrollee preferences to be supported as their needs are met. The cornerstone of person-centered care is the individual care plan. The enrollee determines feasibility of, and agrees to, the plan of care, has access to the plan, and contributes goals and updates to the plan.

The Health Home team works with the PCP to create a care plan that documents the medical, functional and social issues along with the prognosis, likely course and patient preferences in response to expected events. Services and supports from key collaborations within the broader healthcare community will be incorporated into the individual care plans. Because community resources differ by region, individual care plans will be tailored to available resources within the area.*).* Care coordinators will be responsible for compiling the plan and uploading onto the clinical and patient portals developed for this program.

3.2.3.30.1.4 Your approach, if any, to risk stratification and how it relates to Enrollee care plan development

RESPONSE: Risk stratification and treatment planning are coordinated to ensure that patient care plans are individualized and reflective of the identified risk level. The framework for risk stratification and care planning is below:

1. **Identification, Stratification and Prioritization** of individuals who are at the highest risk with medical and behavioral co-morbidities. The integrated care team will assess and identify clients according to severity of health condition and/or risk factors. The tools used will be:
   a. Health risk assessments,

b. Quality of Life Assessments, SF12v2
c. PHQ-9 depression screening
d. DLA-20 functional assessment
e. Level of Care Utilization System (LOCUS)-six dimension level of care placement tool

2. **Interventions** will be individualized to meet the needs of the enrollees. Interventions will be coordinated by the health care home and include all providers inside and outside the health care home. All interventions will be designed to best serve the enrollee, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care. The interventions used will be:
   a. Direct patient care including primary care, nurse case management, mental health, and substance abuse treatment as indicated.
   b. Interactive treatment plan, developed based on consumer-set priorities
   c. Emergency plans

3.2.3.30.2 Provide a sample Enrollee care plan as Attachment K.

3.2.3.30.3 Describe how the Enrollee care plan will be made available to Providers and Enrollees.

RESPONSE: Using a secure website portal created for this project, providers will be able share information with each other, manage documents and coordinate care across settings. Lacking a better way to communicate in the first twelve months of this program, this site will be the vehicle to access individual care plans, Tickets-to-Ride, health risk assessments and other documents related to a Health Home enrollee.

For enrollees, a patient portal ("FollowMyHealth") through Jardogs will be maintained by IHS and made available to all Health Home enrollees. The portal will enable reminders and messaging with providers, viewing of personal health information, prescription refills, appointment scheduling, bill payment, home health support, and online educational resources. Approved family members may access the portal as well. Computers will be made available at provider sites for enrollee use

3.2.3.30.4 Describe your strategies to enhance Enrollee compliance with Enrollee care plans.

RESPONSE: The following are the strategies that will be implemented to ensure the enrollees' involvement and compliance with their care plans:

- Active involvement and participation by enrollees through the use of collaborative documentation for engaging, monitoring and planning care.
- Enrollees will choose their goals for their individual care plan with the assistance of the care coordinator.
- Enrollees having difficulty identifying their goals, motivational interviewing and techniques will be utilized.
- During treatment when an enrollee has more than two no-shows to multiple providers, Care Coordinators will work with the enrollee to problem solve any barriers to treatment.

3.2.3.30.5 Describe how you will coordinate Enrollee care plan development and implementation with Enrollee care plans and case coordinators serving Enrollees in HCBS (home and community-based services) Waivers.

RESPONSE: The development and implementation of the individual care plan will be coordinated between Health Home providers and the Case Coordinators serving enrollees with HCBS waivers. With current releases obtained, collaboration on the types, amounts and frequency of service provision can take place among the enrollee, the HCBS Waiver providers and the providers within the Health Home. Care Coordinators will work the enrollee to include HCBS services in the

individualize care plan. The enrollee can have HCBS Waiver providers integrated into treatment within the Health Home and vice versa.

3.2.3.30.6 Many of the Enrollees may already be enrolled in IHC and may have an Enrollee care plan with the Enrollee's PCP. Describe how you will incorporate these existing Enrollee care plans into the development of new Enrollee care plans.

RESPONSE: Applicants enrolled in the Illinois Health Connect (IHC), will be identified at the time of enrollment into the Precedence care coordination program. Consents will be obtained to access the Medical electronic data interchange system for each enrollee. The existing care plans in IHC will be incorporated into the individual care plans at the Health Home level.

3.2.3.31 Outreach

3.2.3.31.1 Describe your plan for outreach to engage the population you propose to serve. And target providers who come in contact with that populations

RESPONSE: Outreach will be led by the Precedence CCE and carried out with support from the Board of Managers and other collaborative partners.

The Director and Board members will reach out to and educate community partners by distribution of printed materials to regional healthcare providers and community organizations. Other communication will include public presentations and educational sessions, internet strategies and ongoing medial relation activities. Added emphasis will be given to rural areas through personal visits by the Precedence CCE Director to healthcare providers and resource centers.

Targeted mailings, posters and brochures at resource centers, and health and wellness fairs will be conducted thought the nine-county region to assure broad exposure to current and potential enrollees and healthcare providers.

Outreach may also include newsletters, cable and public television public service announcements. Linkages will be created from provider websites to a newly created Health Home page.

If this Precedence CCE proposal is approved, the Board will initiate outreach to potential enrollees through media relation activities. A press release will be distributed to media outlets throughout the 9-county region announcing the collaboration, the Health Home initiative and contact information on how to obtain further information.

3.2.3.31.2 Describe your staffing plan for outreach.

RESPONSE: The Precedence CCE Director is primarily responsible for overseeing the development and implementation of the outreach plan and serves as the key spokesperson for the program. Care Navigators, key leaders listed in section 3.2.1.10 of this narrative, and the Board of Managers may assist with outreach activities, including presentations to providers and potential enrollees and review of outreach materials.

3.2.3.31.3 Describe the outreach process in your PCP offices.

RESPONSE: Outreach to potential enrollees in PCP offices will include program posters and flyers. These materials will include a phone number for Precedence CCE to obtain further information. In addition, potential enrollees will be targeted by searching PCP EHRs for program eligibility. EHRs will be flagged for program referral and patients will be contacted through a mailing as well as through follow up by the PCP at their next office visit. Posters, flyers and mailings will only be disseminated after content approval from the State.

3.2.3.31.4 Describe how you will ensure that written materials can be easily understood by various populations, including ensuring the accuracy of translated materials.

RESPONSE: Precedence CCE will follow the RYC Linguistic and Cultural Competency Plan (LCCP) that demonstrates strategies that are in place to assist Limited English Proficient (LEP), hard of hearing and/or deaf customers and persons with limited literacy. The plan will be distributed to all collaborators participating in the program. In addition, a Health Literacy Committee comprised of the key leaders will be formed and be responsible for evaluating the reading level of patient materials using the FRY Readability Formula or other formulas if necessary. Language services are available through written, telephonic, and in-person interpreters. Patient understanding is verified using teach-back techniques and Ask Me Three.

Precedence CCE also has access to IHS assessment tools used to determine current capacity and set goals for health literacy. Tools include Nation Center for the Study of Adult Learning and Health Literacy's The Health Literacy Environment of Hospitals and Health Centers; AHRQ Health Literacy Universal Precautions Toolkit; AHRQ Pharmacy Health Literacy Assessment Tool; and America Health Insurance Plans' Health Plan Organization Assessment of Health Literacy Activities. In addition, IHS has interpreters on staff to assure accuracy of materials.

3.2.3.31.5 Describe alternative methods of communication you will offer and how Enrollees will access these methods.

RESPONSE: To facilitate access to information, a patient portal ("FollowMyHealth") through Jardogs will be maintained by IHS and made available to all Health Home enrollees. The portal will enable reminders and messaging with providers, viewing of personal health information, prescription refills, appointment scheduling, bill payment, home health support, and online educational resources. Approved family members may access the portal as well. Computers will be available at the Health Homes for enrollee use

Outreach may also include newsletters, cable and public television public service announcements. Linkages will be created from provider websites to a newly created Health Home page. Health Homes will offer telehealth monitors to rural enrollees who have limited access to specialized healthcare services, transportation and other barriers that stand in the way of effectively treating SMI clients with chronic illnesses. Clinical monitoring and evidence-based intervention will be implemented based upon transmitted data. Duration of the telehealth monitoring in any particular setting could last as long as six months to a year of the enrollee daily transmitting weight, blood pressure, oxygen levels and heart weight and glucose.

3.2.4 Health Information Technology (HIT)

3.2.4.1 Describe the technology capacity among the collaborators (CCE collaborators/MCCN network) at the time of submission, including:

RESPONSE: At the time of submission, all Precedence CCE members utilize an EHR; however, the systems are not fully interoperable, an HIE does not exist and not all EHRs support a bidirectional exchange of information through an HIE. In order for Precedence CCE to manage clinical information to serve as the basis for clinical decisions and provide feedback to providers, a combination of web-based portal technology and manual processes will temporarily support the exchange of information among the EHRs. The processes secure necessary information for the Health Home from the disparate EHRs and transmit the information through various means to the Precedence Care Navigator. In turn, Precedence standardizes and maintains the clinical information in the VisionWorks

EHR and distributes or enables access to information to the Health Home provider via web-based portal technology to their Care Coordinators or directly to the provider. Precedence CCE also receives data analytics and individual and summary reports relative to Health Home quality and outcome measures. Precedence CCE will establish a secure platform for Health Home providers to enable 24/7 access to program analytics and individual and summary reports relative to Health Home quality and outcome measures. This information will be shared through a web-based portal technology, which may include SharePoint sites or specially designed provider portals. Presently, all Precedence CCE collaborators have the technology capacity to access web-based portals for the Health Home. The current technology capacity of each Precedence CCE collaborator is detailed below.

3.2.4.1.2 Mental Health and Substance Abuse Provider communication capabilities to support their role in care coordination;

RESPONSE: The role of mental health and substance abuse providers in care coordination is to support the enrollee's mental well-being and provide mental health leadership to the Health Home team by participating in individual care planning and consultation regarding identified health conditions. The ability to push and pull real-time enrollee information is crucial to this role.

The Mental Health and Substance Abuse providers use the following EHR systems: VisionWorks (Robert Young Center for Community Mental Health); Netsmart (Sinnissippi Centers, Inc. Center); and Anasazi (North Central Behavioral Health Systems). These EHRs can "flag" Precedence enrollees and extract Health Home data elements. In conformance with federal HIPAA law and state privacy laws regarding mental health information, Mental Health and Substance Abuse providers currently provide EHR reports and export files to primary care providers and hospitals providing services to clients. Additionally, North Central Behavioral Health Systems uses a consumer support team to coordinate/consolidate the information and share it electronically with other providers. EHR reports and export files from Mental Health and Substance Abuse providers for Precedence enrollees can likewise be made available to Precedence for input into VisionWorks.

3.2.4.1.3 Hospital communication capabilities to support their role in care coordination;

RESPONSE: The role of hospitals in care coordination is to support the enrollee's acute care needs and to assist the Health Home team by actively participating in transitions of care. The ability to push and pull real-time enrollee information is crucial to this role.

Trinity Medical Center currently uses CareCast as its EHR, but will be transitioning to Epic in August 2012. Both EHRs can "flag" Precedence enrollees and produce reports to identify services provided to enrollees on a daily basis. These reports are provided to the Robert Young Center for Community Mental Health (RYC). EHR reports can likewise be made available to Precedence for input into VisionWorks for Precedence enrollees and used in care coordination efforts.

KSB Hospital uses Phillips ICIP as its EHR. Phillips ICIP can "flag" Precedence enrollees and produce reports and export files to identify services provided to enrollees on a daily basis. Presently, EHR reports and export files are provided to Sinnissippi Centers, Inc. Center, KSB Medical Group, and KSB Family Health Clinic. These EHR reports and export files can similarly be made available to Precedence for input into VisionWorks for Precedence enrollees and used in care coordination efforts.

St. Elizabeth's Hospital uses Meditech EHR in partnership with Ottawa Regional Medical Center but will be transitioning to the OSF Healthcare System EHR sometime in the future. Both EHRs can "flag" Precedence enrollees and produce reports to identify services provided to enrollees on a daily basis. These EHR reports can be made available to Precedence for input into VisionWorks for Precedence enrollees and used in care coordination efforts with North Central Behavioral Health and Dr. Robert McGuire.

3.2.4.1.4 Indicate which collaborating or network Providers have registered for Electronic Health Records Payment Incentive Program payments with either the State or federal government.

RESPONSE:

- Community Health Care is registered with Iowa Medicaid.
- North Central Behavioral Health System is registered with both the federal government and the State of Illinois.
- Trinity Medical Center is registered with Iowa Medicaid and will register with the federal government in 2012.

3.2.4.2 What is the expected HIT functionality of the collaborators 12 months after Contract Execution and how will this capacity support your care coordination model?

RESPONSE: Twelve months after contract execution, we anticipate that HIE capacity will be in place for automated sharing of the majority of clinical information required for Precedence CCE to enable Health Home providers to make timely clinical decisions and receive timely feedback. In particular, information exchanged among the members will include admissions, ER visits, medication reconciliation, and access to allergy information and will be available to all providers wherever the enrollee presents. The HIE will be provided through ILHIE Direct (the Illinois Health Information Exchange) and/or Iowa Health System's internal HIE. Iowa Health System plans to deploy its own HIE later in 2012. In addition, all Precedence CCE collaborators will have the opportunity to register with ILHIE Direct. Both HIEs will enable real-time access to updated clinical information. Precedence CCE will establish provider alerts and triggers to notify Health Home providers of status changes to the continuity of care document. In addition, Precedence CCE will continue to support a secure platform for Health Home providers to enable 24/7 access to program analytics and individual and summary reports relative to Health Home quality and outcome measures. This platform will contain automated alerts for content updates. The expected HIT functionality and its support of the care coordination model are detailed below.

3.2.4.2.1 Describe your connection to and support of: 1) PCPs, 2) Hospitals, and 3) Mental Health and Substance Abuse Providers; and

RESPONSE: Within twelve months of contract execution, Precedence CCE will further support the care coordination roles of our collaborators by facilitating data sharing through an HIE and thereby reducing the number of manual processes required to share data. Specifically, IHS will include Precedence CCE and Health Home project collaborators within the IHS HIE in order to exchange continuity of care documents. For each EHR, it will take approximately 3-6 months for go live with the HIE, assuming that the EHR supports the bi-directional exchange of continuity of care documents. Precedence CCE through its EHR VisionWorks supports the bi-directional exchange documents within the HIE and will be included within the HIE. Trinity, St. Elizabeth's and Robert

Young Center also have EHRs that support this heightened level of data exchange and will be included within the HIE. The other collaborators (PCPs, hospitals and mental health and substance abuse providers) require changes to their EHR or changes to their data governance policies/procedures to support this heightened level of exchange for purposes of this project. We anticipate that the majority of these issues will be resolved and that these collaborators will be able to replace their manual processes for HIE participation by the end of 2013. Regardless of whether entities are able to bi-directionally exchange continuity of care documents, IHS will work with all collaborators in order for them to view documents on this exchange. Aside from the IHS HIE, collaborators will be assessing the capabilities of the ILHIE Direct for purposes of this project, and the IHS HIE is hoping to be able to also share data with ILHIE Direct. In addition to HIE technology support, IHS is piloting a patient portal (Jardogs) regionally, which is expected to go live through the system by Fall 2012. This patient portal will be made available to health home enrollees for this project.

3.2.4.2.2 Describe how you will address issues of privacy and confidentiality.

RESPONSE: The Board of Managers will adopt policies and procedures related to privacy, confidentiality and HIPAA and name a compliance officer at its first meeting. Policies will require the appropriate use of consents to release information by enrollees. For those providers involved with the ILHIE Direct, a separate release from the enrollee will be obtained in order to share information with the HIE. Presently, all collaborators have written policies and procedures related to privacy, confidentiality and HIPAA. In addition, the Trinity compliance officer will serve as the compliance officer for Precedence CCE on an interim basis. Once data is obtained, Precedence CCE will ensure the use of firewalls and secure networks to protect the data (personal health information.

3.2.4.3 Describe any resources you plan to provide to collaborators in the area of HIT.

REPONSE: IHS will assist in development of portal technology for use by Home Health staff to share clinical information. This portal technology will be used primarily in year 1 in order to allow for access of enrollee information (individual care plans, health risk assessment, etc.) in order to initiate immediate care coordination. IHS will also assist collaborators in connecting to the IHS HIE network and ultimately the Illinois HIE. IHS is currently piloting its patient portal and is expecting to go-live by the end of 2012. This will also a patient access to their health information as well as wellness and community information.

Iowa Health System and Trinity Medical Center IT personnel will provide training for portal and HIE use. There is also a 24-hour technical support line that will be available to the collaborators

3.3 Financial Model -

3.3.1 CCE Reimbursement

3.3.1.1 Which of the three reimbursement options is the CCE selecting?

RESPONSE: The Precedence CCE is selecting two reimbursement options; Care Coordination Fee and Shared Savings.

3.3.1.2 If proposing a Care Coordination Fee, propose an administrative PMPM by population type for each of the first three years of the Contract, following the template provided in Attachment F.

RESPONSE: Precedence CCE proposes a PMPM Care Coordination Fee as noted on Attachment F.

3.3.1.3 If proposing another interagency payment flexibility methodology, describe the proposed payment structure I including amounts and how often the CCE would be paid.

RESPONSE: Precedence CCE is not proposing any Interagency Payment Flexibility methodology.

3.3.1.4 With respect to Department data, please indicate the population definition number(s) and version number that you relied upon for preparing this Proposal.

RESPONSE: Precedence CCE relied on the following Department data for preparing this proposal:

- Population definition number:
  - Population Description – Entire State
  - Population Number – 1.0
- Version number:
  - Data Release Number – 1.0
  - Documentation Number – 1.0

3.3.1.5 Please describe any data (other than data received from the Department) that you relied upon.

RESPONSE: Aside from internal claims data**,** Precedence CCE did not rely on any other data for preparing this proposal.

3.3.1.6 Please describe in detail how you expect your care coordination model to result in cost neutrality – to reduce costs by at least as much as the care coordination fees you expect to receive over three years

RESPONSE: The Precedence CCE care coordination model will focus on reducing costs for Emergency Room and Inpatient services (excluding substance abuse) which currently average $4,947 per Medicaid client annually. It is anticipated that we will be able to reduce these costs by 10 to 20% from their current levels per client. This will result in total savings of $2.5 million, more than sufficient to offset the cost of the $1.6 million care coordination fees we expect to receive over the three years. Please refer to Attachment I: Budget Detail.

Precedence CCE will be the first line of defense to decrease the costs and rates of hospital admissions and Emergency room visits. This will be accomplished by providing utilization management to ensure that the appropriate level of care is being provided to each enrollee in a timely manner. In addition to this they will monitor high utilizers of services, to prevent hospitalization and Emergency room visits. Precedence will consult with the healthcare home providers, recommending changes to the service mix or volume. Partial hospital services will also be recommended by Precedence and/or healthcare home providers as an alternative to hospitalization and Emergency room utilization.

3.3.1.7 How do you plan to distribute the payment(s) among collaborators?

RESPONSE: Payments will be distributed as follows:

Care Coordination Fee payments will be distributed to Precedence CCE to offset the cost of care coordination services

Shared Savings will be distributed to collaborators through two categories:

1) Regional Integrated Delivery Systems (Regional IDS): The CCE program will be in multiple regions: Rock Island, North Central, and Sinnissippi. The Regional IDS consists primarily of the collaborating hospitals, PCP/FQHCs, and mental health/substance abuse providers in a region.

2) CCE Infrastructure: The PCCE will retain a portion of shared savings to cover infrastructure costs not covered by the Care Coordination Fees such as IT expenses as well as administrative staff related to the successful execution of the shared savings.

3) Percentage of Shared Savings Distributed for Each Category -Initially, the expected initial percentage of savings distributed to each category would be 85% to the Regional IDS's and 15% for the CCE infrastructure. The specific percentages will be determined by the CCE Board upon review of the baseline claims and CCE infrastructure costs and projections.

4) Criteria for Distribution among Participants

   Regional IDS: Amounts will be distributed to the Regional IDS's based upon the proportional number of enrollee participants from each region.

   Collaborators: Each Regional IDS will distribute their shared savings to collaborators based on:
   1/3rd to collaborating hospital(s)
   1/3rd to PCPs
   1/3rd to MH/SA CMHCs

   The proposed distributions reflected above are tentative and subject to change by the CCE Board.

A diagram illustrating the distribution methodology is shown as Attachment I: Shared Savings Distribution

3.3.1.8 What percentage of payment(s), if any, do you plan to put into a reserve pool?

RESPONSE: Precedence CCE does not intend to place a percentage of payment(s) into a reserve pool.

3.3.1.9 Please list all case management fees collaborators receive other than IHC fees, such as case management fees paid in HCBS Waivers. The State will not pay twice for the same care coordination services.

RESPONSE: None of the Care Coordination costs in this proposal are paid in part or in total

from any case management fees received by collaborators.

3.3.1.10 Do you plan to request an advance on the care coordination fee to assist in the development of the CCE infrastructure prior to implementation?

RESPONSE: No

3.3.1.10.1 What percentage or amount are you requesting?

RESPONSE: Not applicable.

3.3.1.10.2 Describe the intended use of the fee advance.

RESPONSE: Not applicable.

3.3.1.10.3 Propose a repayment schedule.

RESPONSE: Not applicable.

3.3.2 MCCN Reimbursement. If applying to become a MCCN, describe in detail the package of services for which you will assume risk as well as any risk corridors or stop loss requirements.

RESPONSE: Precedence CCE is not applying to become a MCCN at this time.

3.4 Payment Terms and Conditions

3.4.1 CCE Payment Terms and Conditions

3.4.1.1 Care Coordination Fees:

RESPONSE: Reimbursement to the Precedence CCE will be an administrative Per Member Per Month (PMPM) fee.

3.4.1.1.1 Pay-for-Performance – Quality Measures

RESPONSE: Precedence CCE is proposing Quality Measure #4 as provided in the solicitation under Attachment A "Behavioral Health Support: follow-up after hospitalization for Mental Health Illness in 7 and 31 days". See Attachment 18: CCE Quality Measure Pay-for-Performance

3.4.1.2 Shared Savings Reimbursement

RESPONSE: Precedence CCE will participate in a shared savings distribution as illustrated in Attachment I.

3.4.1.2.1 Pay-for-Performance – Quality Measures

RESPONSE: Precedence CCE is proposing Quality Measure #28 as provided in the solicitation under Attachment A "Preventive Services: Adult BMI Assessment". See Attachment 18: CCE Shared Savings Quality Measure

3.5 Compliance with Federal law, regulations, and policy

All CCE and MCCN Contracts must be compliant with federal regulations found at 42 C.F.R. Part 438. See http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr438_02.html for the federal regulations.

3.6 Required Forms

Consistent with Section 2, all Proposals must include completing and submitting the following:

3.6.1 Taxpayer Identification Number.

Response: See Attachment 19: Precedence CCE LLC

3.6.2 Disclosures and Conflicts of Interest

Response: See Attachment 20: Precedence CCE, LLC, and Precedence Inc