Together4Health

A response to the State of Illinois Innovations Project
for Care Coordination Entities

Narrative

The mission of Together4Health is to be a regional community health home safety network that supports vulnerable people, including those living with chronic and multiple medical, mental health and substance use conditions, those living in poverty, those experiencing homelessness, those who are unemployed and underemployed, and those with limited access to services due to cultural or language barriers. Together4Health members are committed to going outside their own walls to find and link the people they serve to a full range of services that improve and support the health of the overall community.

Governance Structure, Scope of Collaboration, and Leadership

Together4Health (T4H) is a proposed care coordination entity comprising 37 collaborators that include hospitals, primary care providers, a pharmacy chain, mental health and substance use, social service, and housing providers. The collaboration also includes entities that will provide training and technical assistance, data analytics, clinical decision support, health information exchange, and management of the CCE's data warehouse. See Attachment E for a complete list of collaborators, their roles, and their contact information. As the lead applicant, HHO will be the entity contracting with the state and serve as the management company, if the contract is awarded.

T4H's goal is to operate as a CCE for three years, transitioning to an MCCN starting in year four. The first three years of operation will be used to build a sustainable membership base, refine care management protocols, develop the appropriate infrastructure, and accumulate financial reserves. T4H's transition to a MCCN will ultimately depend on its financial experience operating as a CCE as well as the capitation rate and risk adjustment structure offered by the state, including:

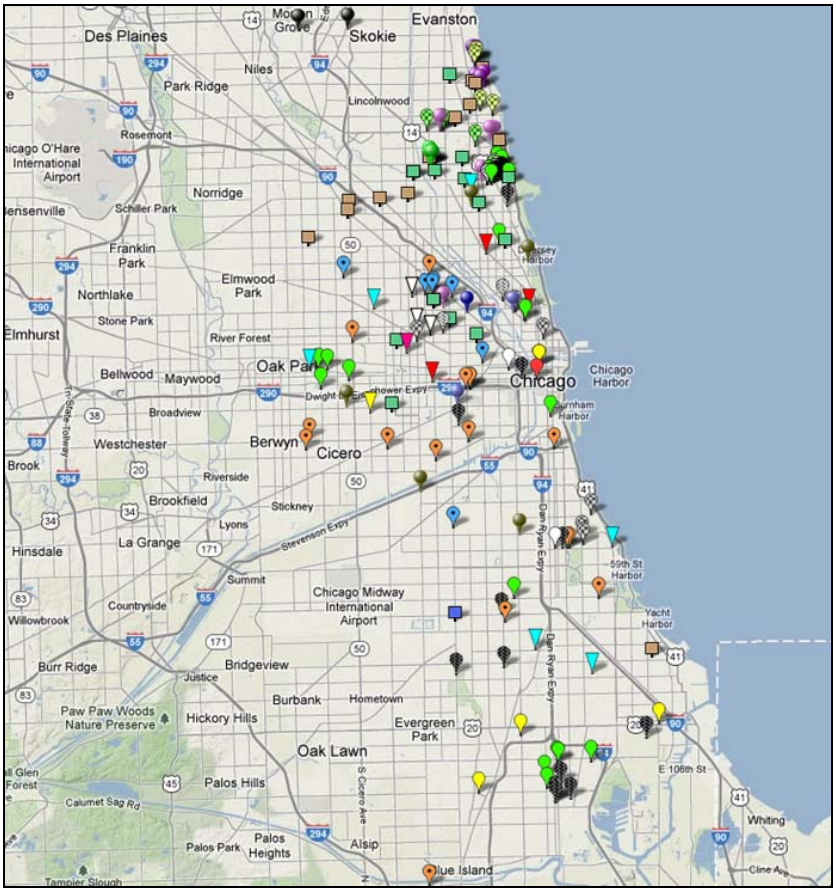
- The establishment of a sustainable rate setting methodology for MCCN rates that provides savings for the state and reasonable reimbursement for the MCCN;
- PMPM capitation rates developed for T4H's covered population;

- A reasonable administrative allowance as part of the PMPM rates; and
- Risk adjustment of the rates and appropriate quality outcome benchmarks based on diagnosis, functional status, and other social determinants of health such as access to stable housing.

Analysis of claims data

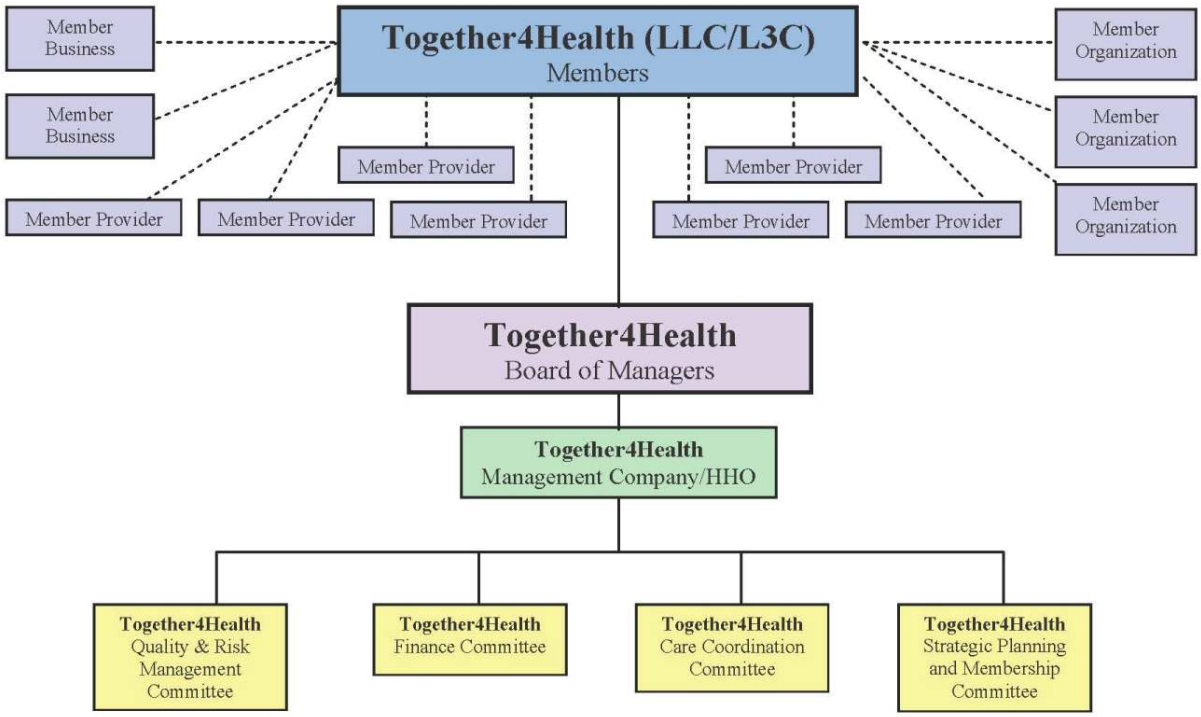
Claims data indicates that a substantial percentage of Medicaid recipients receive care through T4H's FQHCs and the primary care sites of Cook County Health and Hospital Systems. Further, T4H's hospital partners Cook County Health and Hospital Systems, Northwestern Memorial Hospital, Swedish Covenant Hospital, University of Illinois Hospital and Health Sciences System, Sinai Health System, and Vanguard Weiss Memorial Hospital accounted for over a third of all Medicaid inpatient admissions in 2010 in Cook County (excluding maternity care). Based on review of claims data made available through this RFP process, T4H has identified patterns among high users of Medicaid and matched that need with partners that have the capacity and expertise to meet the health needs of this population including mental health, substance use, cardio-vascular disease, diabetes and HIV.

Together4Health's network of providers will build on already existing partnerships and expand capacity by forging stronger links among members to a variety of services. As a result, the network will be well equipped to address the complex needs of enrollees. Enrolled participants will be assigned to one of T4H's health home hubs, based on geography and preference. Health home hub agency partners will be geographically determined, in order to maximize efficiency and accessibility, while building stronger affiliations and staff relationships. With primary care and behavioral health at the heart of participant-centered medical homes, the member FQHCs and community mental health centers represent a geographic spread throughout Chicago, as do all of the partners in T4H (illustrated below). Further, FQHC and community mental health partners have the capacity to expand services to meet enrollee growth expectations. For a more detailed map of T4H's 170 FQHC, hospital, and service agency sites: http://mapalist.com/Public/pm.aspx?mapid=266127. To locate Walgreens stores, go to: http://www.walgreens.com/storelocator/find.jsp?tab=store%20locator&requestType=locator



[Governance structure]

Together4Health will be a limited liability company comprised of member providers, member organizations, and member businesses and governed by a board of managers (BOM) that will be composed of no more than nineteen members, and an additional two to four consumers. See diagram below and the draft T4H Operating Agreement (Attachment G) for detailed explanation of BOM development (Article 4, page 6). The Operating Agreement further describes the ways in which the BOM will be accountable to members of T4H and will authorize the contract with T4H's management company, HHO, and monitor its performance. The BOM has the authority to terminate the contract with HHO and identify an alternative management company based on agreed upon terms. The management company is the entity or organization that contracts with T4H to manage the operations of T4H and is accountable to the board of managers.



The T4H operating agreement outlines the governance structure, including detailing the rights and responsibilities of members. It also establishes a management company, establishes a board of managers (BOM), and details the rights and responsibilities of the BOM and its executive committee. Members will participate in constituency groups (e.g., hospitals, primary care providers, community behavioral health providers, social service and supportive housing, consumers) for the purpose of election of board managers and developing care standards. Separate contracts will be executed between T4H and partners, detailing service, documentation and quality expectations to ensure members share information and comply with the care coordination model.

A member provider will be an owner of T4H with a member interest in T4H who provides direct services to participants (medical care, oral health care, social services, mental health services, substance use treatment, and housing). To the extent that each member provider is eligible to be a participating provider or supplier in Illinois' Medicaid program, each member provider must enroll as such in the Illinois' Medicaid program. Member providers may or may not choose to contract with T4H to provide care coordination.

A member organization will be an owner of T4H with a member interest in T4H who is exempt from federal income taxation by the Internal Revenue Code. A member organization may or may not choose to contract with T4H to provide care coordination. A member organization may offer agreed upon services to T4H. Such contribution will be valued in membership interest as outlined in operating agreement.

A member business is an owner with a member interest in T4H who is not exempt from federal income taxation by the Internal Revenue Code. The member business may or may not choose to contract with T4H for care coordination or other services.

T4H LLC (or L3C) will be formed once an award is made to HHO or services for care coordination are sought by a third party such as an insurance company or the state. The low-profit, limited liability company, or L3C, is a hybrid of a nonprofit and for-profit organization. Specifically, it is a new type of limited liability company aimed to design to attract private investments and philanthropic capital in ventures designed to provide a social benefit. Unlike a standard LLC, the L3C has an explicit primary charitable mission and a secondary profit concern. Unlike a non-profit, the L3C is free to distribute after-tax profits to owners and investors.

All partners included in this proposal have signed a memorandum of understanding (MOU) that commits them to participate in the formation of T4H. The process of creating T4H has been highly collaborative and transparent, with representatives of member organizations participating in work groups and utilizing a shared website to post and review work group and all other T4H documents, in order to ensure that T4H reflects our shared values. Partners have approval from their boards and other authorizing authorities to help develop T4H; final approval to become owners of T4H and make capital contributions will be determined, pending final contracts.

Plan for consumer input

The fragmented healthcare delivery system currently thwarts access and care coordination for consumers who often bear the brunt of well documented health disparities. T4H is committed to overcoming barriers to care by using consumers as community health workers who will help their peers navigate the systems and advocate for them with providers. Those workers will be knowledgeable about the systems and community resources that support wellness and will help to reduce health disparities. Community health workers will also be partners in informing the development of T4H as it grows and evolves.

Consumer input into the operations and management of Together4Health will be formally solicited in a number of ways. For example, up to four consumers will sit on T4H's board of managers. All FQHCs already have consumers either on their boards of directors or as members of a consumer advisory group; as the health home hubs develop and coalesce, consumer advisory board(s) will provide guidance and feedback to T4H leadership. Community health workers will be integral to care coordination, and their expertise as consumers will also provide input to T4H management. A community health worker (CHW) is a frontline public health worker who is a trusted member of and often has a close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison or link between health providers, social services, and the community to facilitate access to services and improve the quality and culture competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy (APHA CHW SPIG, 2006). Finally, annual focus groups and biannual consumer experience surveys will also be instituted across the CCE, and a grievance policy will be standardized among the members.

Experience and involvement of T4H collaborators

T4H's target population will have multiple disabling conditions that require complex services, and they are likely to be individuals who have in the past experienced significant barriers to care. As multi-system service consumers, they will benefit greatly from a care coordination network that reaches beyond primary and specialty care providers to include mental health and substance use providers, housing, and other support services. For that reason, T4H's network comprises

service providers with long histories of successfully meeting the full array of needs of the target population.

The collaborators of T4H are geographically dispersed and connected to the communities they serve; many have decades of experience providing both high intensity and culturally appropriate safety net services. Many of the collaborators have established high intensity care teams that have the expertise and capacity to successfully engage this high-need population into appropriate healthcare and keep them engaged.

Program participants who have an established health home are more likely to improve their health by managing their conditions and preventing new conditions. T4H's primary care providers exemplify the essential elements of a health home. Our FQHC partners' approach to care centers on a respectful, collaborative relationship between participant and provider through which preventive and primary care are delivered. Further, program participants are supported in making sense of their health care needs and options and empowered through coaching and linkage to services to improve their overall health. T4H's wide array of service providers will allow interventions launched in the health center to be reinforced throughout the participant's care network.

Our FQHC partners offer weekend and evening hours; dental, behavioral health, and pharmacy services; provide interpretation and linguistic services to overcome language barriers; and serve a significantly higher percentage of chronically ill, uninsured, publicly insured, and minority program participants. Some of our FQHC partners also offer open access appointments, a strategy that has proven to dramatically reduce no-show rates.

T4H providers have a history of providing cost effective services. According to the National Association of Community Health Centers, FQHC costs run almost a dollar less per patient per day compared to all physician settings ($1.67 vs. $2.64) and far below the cost of a hospital stay. A recent study of permanent supportive housing in Chicago found that individuals with chronic health conditions and histories of homelessness who were provided such housing reported significantly fewer hospitalizations and emergency department visits than those without access to supportive housing. The study also found that, after one year in permanent supportive housing, 40 percent of those with HIV had undetectable levels of the virus in their blood compared to 21 percent of those without access to supportive housing.

T4H partners also provide a range of community behavioral health services including high intensity services such as residential programs for individuals with mental health and substance use issues; assertive community treatment (ACT) teams; community support teams (CSTs), intensive outpatient mental health and substance use services; psychosocial rehabilitation programs; in-home health care and a variety of case management services. Many of the collaborators already have integrated care teams or services that meet and respond to the needs of the most complex participants. Examples include programs that specialize in serving individuals with co-occurring mental health and substance use disorders; integrated intimate partner violence (IPV) programs for individuals with HIV/AIDS or substance use issues; and systems integration teams (SIT) and supports that bring together diverse providers to coordinate the care for high acuity participants and decrease barriers to appropriate services.

T4H has specifically targeted hospitals that serve the same, or similar, individuals served by our community-based partners and have been committed to serving as a healthcare safety net for some of Chicago's most vulnerable residents. In fact, our hospital partners already engage in a variety of collaborative relationships with some of our partners. For instance, Lutheran Social Services of Illinois currently co-locates behavioral health specialists within the emergency department at Swedish Covenant who have been highly successful in managing psychiatric crises and reducing hospitalizations. Several FQHC partners are able to directly access specialty care appointments for their program participants within the Cook County Health and Hospital System through an electronic interface.

HHO, the managing partner for Together4Health, has led the formation process since its inception. Besides inviting and engaging potential partners in the development of T4H, HHO has provided staff who have overseen and been involved in the development of all components of Together4Health, including governance, operations, data systems, IT infrastructure, and financial and clinical models. HHO has educated people at the local, state, and national level about the importance, goals, objectives, and work of a CCE, as well as about Together4Health specifically. HHO has also hired consultants to assist with overall CCE formation, data analysis, and actuarial services and has raised private funds to support the development of Together4Health.

In addition to HHO, many other partners have assumed leadership roles during the formation of the CCE. Erie Family Health Center, AIDS Foundation of Chicago, Thresholds, Cook County Health and Hospital Systems, Northwestern Memorial Hospital, Lutheran Social Services, the Alliance of Chicago Community Health Services, Mercy Housing Lakefront, and Heartland Human Care Services have all assumed leadership roles within the formation of T4H.

The partners of T4H agree on a common mission and vision—that is, to be a regional community health home safety network that supports vulnerable people, including those living with chronic and multiple medical, mental health and substance use conditions, those living in poverty, those experiencing homelessness, those who are unemployed and underemployed, and those with limited access to services due to cultural or language barriers.T4H members are committed to going outside their own walls to find and link the people they serve to a full range of services that improve and support the health of the overall community.

The shared values of T4H members will guide care, ensuring that services are person and family centered and address both individual and community needs. As a health home safety network, T4H incorporates a continuum of housing and other enabling services that strengthen participants' ability to engage in, and benefit from, health care. T4H will employ evidence-based, evidence-informed, innovative, and promising practices that are regularly evaluated and vetted by consumers of care as part of its commitment to continuous quality improvement. Finally, as a network responsible for thousands of lives, T4H is dedicated to creating a sustainable and healthy business model that responds to economic realities, policy shifts, and emerging health demands, as well as to the needs of its partners and the people it will serve.

The goals of Together4Health are to:

- Ensure that participants experience and receive the highest quality care;
- Improve the health of vulnerable populations;

- Reduce the per capita cost of health care;
- Reduce health disparities;
- Share accountability for the outcomes of patient care across the partnership;
- Address social determinants (lack of housing, employment, food, and social supports) that negatively affect health;
- Continue to revise and improve its coordinated care model based on input from research partners who will evaluate and report on network services and outcomes, and on consumer and member feedback; and
- To disseminate findings on the T4H care coordination model.

Populations / Geography

T4H will serve adults and seniors with disabilities, including those with serious mental illness and people who are dually eligible. The definition of this population aligns with the criteria outlined in the Health Homes Option-Section 2703 in the Affordable Care Act—people with either two chronic conditions, one chronic condition and at-risk for another, or one serious and persistent mental health condition. Consumers covered by both Medicaid and Medicare (dually eligible) will be offered services depending on care coordination fee negotiated with the state and T4H ability to ensure savings given that Medicare spend has been eliminated.

Together4Health will enroll 500 individuals in the first quarter of the first year and will serve 5000 by the end of the third year of operation. One hundred percent of those individuals will be people with disabilities. At the beginning, the majority of participants served, approximately 80% will have co-occurring serious mental illness, targeting the highest current utilizers of Medicaid dollars. As 2014 approaches and T4H has enrolled the most medically complex people, it will expand to serve more of the health home option population without serious mental illness. Current patient stratification models target 25 percent of those served to have dual benefits.

The top 10 percent of Medicaid users who meet the criteria for the health home option definition will be the target population for T4H. Besides mental health conditions, the most frequent medical diagnoses will be asthma, chronic obstructive pulmonary disease, bronchitis, diabetes, heart disease, HIV/AIDS, substance use, and gastrointestinal diseases.

During year one, T4H will not serve non-priority populations with the exception of children of T4H enrollees. As 2014 approaches, T4H will determine whether it has the capacity to enroll non-priority populations.

T4H will serve Cook County with potential to expand beyond Cook County, as indicated by need and model effectiveness. Number of lives served is currently based on financial assessment in collaboration with actuary detailing and ramp up time to ensure quality care is provided and infrastructure is adequately in place. These numbers may shift based on member capacity and payer interest in purchasing of services.

Phasing in enrollees

T4H leadership and committees will continue to meet throughout the summer and fall of 2012 to refine the governance, finalize partner and management contracts, and create a blueprint of the health home hubs, with the goal of being ready to implement the CCE by January 1, 2013. Start date will be dependent on contract negotiations. Participants identified as high Medicaid users

who are already receiving services from one or more T4H network providers will have the opportunity to enroll in Together4Health through the state enrollment broker. T4H enrollment goals include enrolling 500 individuals within the first quarter of operations; 1,200-1,500 by the end of year one; 5,000 by the end of year three.

See Attachment H for a detailed implementation and enrollment work plan.

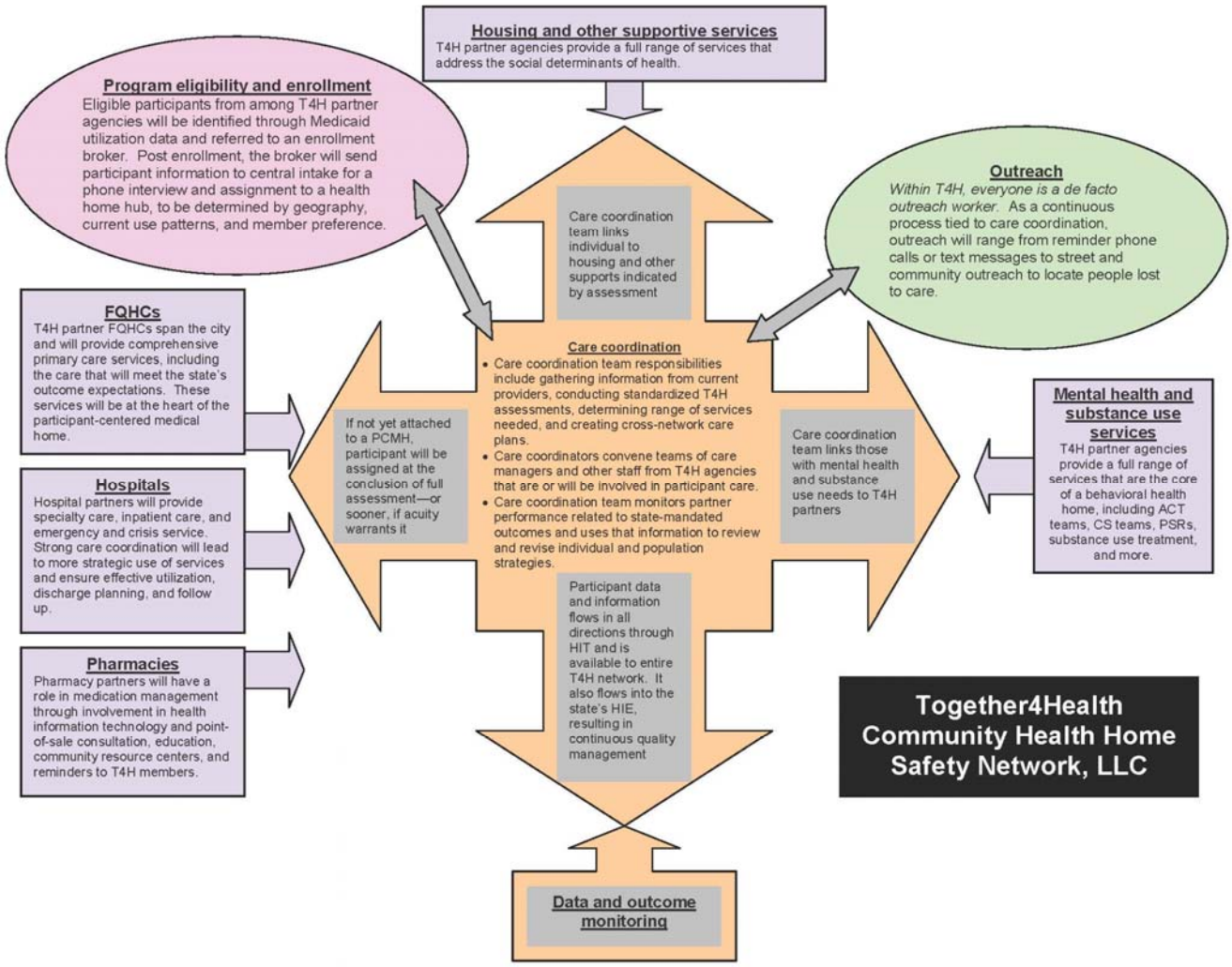
Care Coordination Model

Currently, health care is portioned out by disparate systems funded by different government agencies, with little communication and coordination among and across them. The target population for this RFP utilizes services provided by most of these systems, sometimes simultaneously and often erratically, frequently waiting until care needs have reached a crisis level. Follow up care to regular and emergency service is inhibited by homelessness, transportation problems, mental illness and substance use, limited understanding of chronic care needs, and poor communication among providers.

Together4Health's care coordination model is based on the health home option and will be an integrated, holistic approach that promotes physical, mental, and social wellbeing, while improving access to care. In addition, the CCE will aim to address the social determinants of health, such as housing. The network of partner providers has been constructed to allow for several health home hubs strategically located throughout Chicago, each of which will be rooted in primary care and ensure access to mental health and substance use treatment programs, as well as referrals to services that will range from primary care and specialty care, community behavioral health services to supportive housing providers.

Care coordination will happen at several levels. First, the network itself will coordinate care by ensuring community partnerships and shared data. Second, at each primary care site within the network, care coordination will occur at the population level through registry analysis that allows us to track and improve the health outcome of a whole group of participants, such as people who have diabetes. Third, at the level of care delivery, care coordination will be provided through integrated care coordination teams that will tailor the level of care, education, and case management to the individual's need and take responsibility for ensuring connection to, and coordination among, all the services that will support health and community stability. Universal consent within T4H partners will expedite sharing of information.

T4H's philosophy is person-centered and envisions the participant as a partner in the care plan. T4H will assess individual participants' level of activation in their health care with a standardized measure. In combination with a functional assessment and understanding of the participant's goals the care plan will be developed. Based on those results, T4H will work to enhance participants' knowledge, skills and confidence to manage their own health care. Research indicates that health care consumers with a high degree of patient activation have improved outcomes and lower utilization. Care coordinators will be trained to build motivation and enhance activation. Functional status and homeless status are also indicators of increased health care expenditures. As such, specific attention to placement into stable housing will be a priority as well as improving functioning.



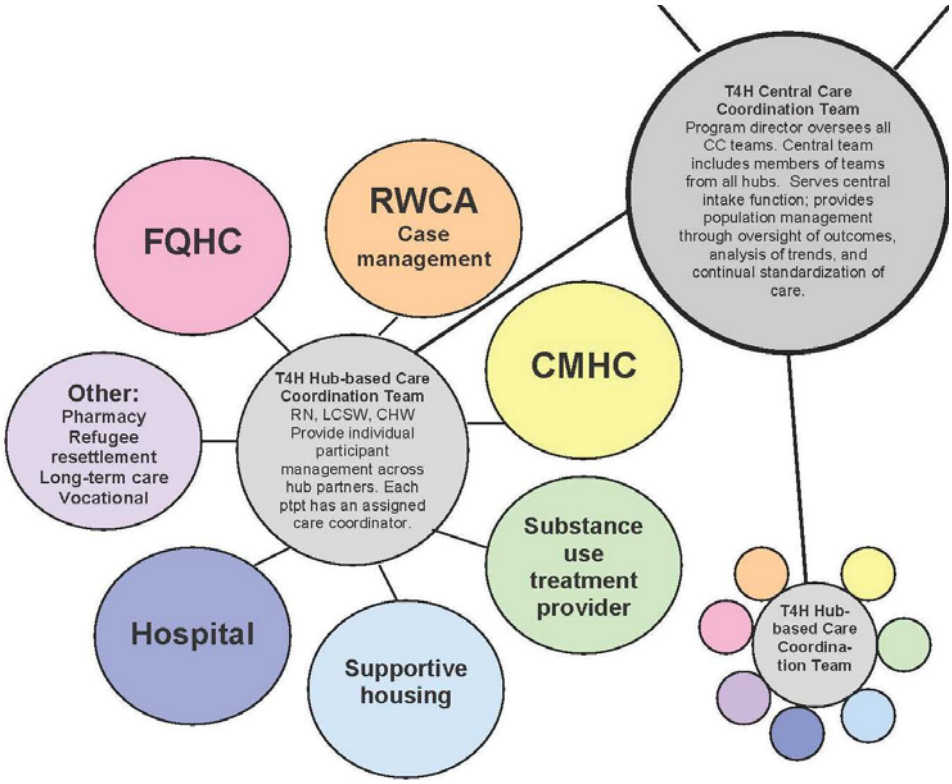
Standards of care, risk stratification, and predictive modeling regarding participant needs and how best to improve outcomes while reducing cost will be a focus of work throughout the summer and fall of 2012 as well as throughout T4H's life as a CCE.

Basic tenets of Together4 Health care coordination:

- Participants will be assigned to one of several health home hubs, based on geography, preference, and services currently being received.
- Health home hubs will be geographically determined for the most part, in order to maximize efficiency and accessibility, while building upon already existing partnerships, creating stronger and added affiliations and staff relationships.
- Care coordination (CC) will be provided by teams hired by T4H and connected to each hub.
- T4H CC teams will ideally include RNs, LCSWs, and community health workers (CHWs)—based on number of enrolled participants and level and kind of need (primary care only, or primary care and mental health). T4H care coordination teams will have direct oversight by a nurse manager.

- T4H care coordinators may be sited in different agencies w/in a hub; each hub team meets, in-person or virtually, as needed.
- Care coordinator case loads will vary from 30 to 100, depending on complexity and acuity, and current service provider support.
- Health homes will be real, existing within partners' physical sites, and virtual, the result of care-coordination-guided collaborations among partners.
- Initially, CC teams will leverage care managers at partner agencies who will act as liaisons to CC team; as enrollment goes up and revenue increases, T4H will purchase additional services from partners.
- T4H staff will be educated about population health, health disparities, and the social determinants of health.
- T4H staff will also be trained to provide trauma-informed, strengths-based care that utilizes motivational interviewing, harm reduction, and evidence-based strategies that will enhance participants' ability to manage their health.
- T4H will develop standardized clinical documents that will include an enrollment form, a release of information and consent form, an integrated assessment, and a care plan.
- T4H will also develop policies that address ethics, care philosophy, and standards of care.
- T4H will develop information sharing technology that will minimize duplicative procedures and maximize care coordination.

The diagram below illustrates care coordination within a typical T4H health home hub.



Enrollees with serious mental illness

Together4 Health anticipates that in the early stage of its development, as many as 80 percent of its participants will have a serious mental illness, so the description of the model above encompasses their needs through the development of health home hubs that include mental health service providers and a full array of mental health services, as well as care coordination staff that have expertise in mental health needs and services.

The care coordination teams will be charged with monitoring and following up with all participants as they are connected to services within and without the CCE network. Shared electronic medical records and other HIT will facilitate this process by providing a central and real-time repository for information related to each participant. This will help care coordinators track participants, identify when appointments are pending or missed, and enable information to flow in all directions within the partner network. Ideally, participants will use emergency departments and hospitals within the T4H system, so that unscheduled visits will be entered into the electronic health record, alerting the health home providers and care coordination team when they occur. Together4Health will educate area EDs and hospitals outside of the T4H network about notification practices when T4H participants use their services.

High need, unstable participants will be assigned to care coordinators with lower case loads (approximately 30:1) to ensure necessary coordination of services. Whenever possible, individuals with SMI who experience frequent psychiatric inpatient readmissions; excessive use of emergency services; and deficits in maintaining treatment continuity, self-management of medication, and independent living skills will be connected to Assertive Community Treatment (ACT) or Community Support (CS) teams based in community mental health agencies. In those instances, the care coordination team will have the advantage of a partnership that will lead to more intensive support for these participants with complex behavioral health needs.

When feasible, the care coordinator or ACT or CS team will meet with SMI participants who are hospitalized, whether in state-operated facilities or elsewhere, in order to coordinate discharge with the participant and hospital staff. Those charged with care coordination will also ensure that documentation of the hospital admission and discharge plan is entered into the electronic health record; post-discharge, they will make sure participants meet with psychiatric providers within 14 days.

As PCP's identify the need for mental health and substance use services, the care coordinators will be charged with facilitating and coordinating referrals to mental health and substance use providers, as well as between inpatient and outpatient services and subsequent transitions and follow-up care related to all aspects of behavioral health.

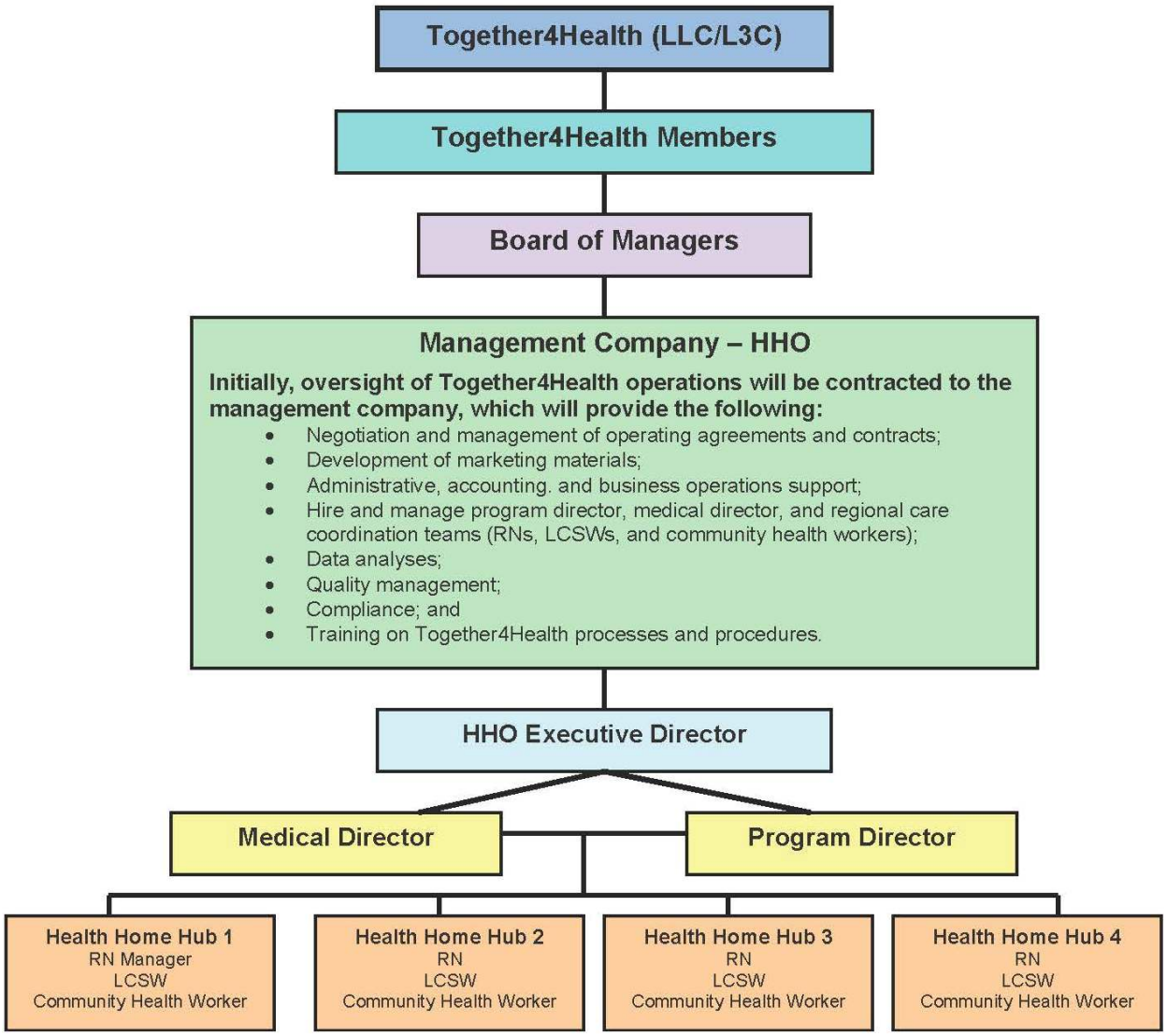
Three year staffing plan

The CCE staffing pattern illustrates the number and position type of T4H care coordination staff and business support staff that will be on board at the end of a given quarter. The CCE staffing pattern, work plan, and discrete job descriptions are included in Attachment H.

The geographic health home hub, number of FTE, and credential/discipline of care coordination staff is based on number of enrolled participants and service need (primary care only, or primary

care and behavioral health). Care coordinator case loads will vary from 30 to 100, depending on complexity, acuity, and current service provider supports. High need, unstable participants will be assigned to care coordinators with lower case loads to ensure necessary coordination of services. As provider connections are established, staff support increases, and the participant becomes more stable, care coordination responsibility will be transferred to other team members. RNs will specialize in working with those with high medical needs; LCSWs will specialize in working with those with high mental health and substance use needs; community health workers will have a variety of specialties and skill sets to enable them to work with all enrollees. Everyone will be cross-trained in the typical presenting needs of the target population.

The organizational chart below indicates that the business support staff will be overseen by the T4H management company. The director of quality management will develop the compliance plan, and oversee compliance for the first year of operation.



T4H's participant-centered medical home capacity

Each health home hub will have one or more primary care partners that will follow standard participant-centered medical home practices. This means each FQHC will have same-day urgent care appointments; health maintenance care will be scheduled within eight weeks; there will be an MD or RN providing 24-hour phone coverage at each FQHC, with chart information available through the electronic medical record to assist in emergency admission. Together4Health will recommend that each FQHC in the T4H network attain NCQA recognition.

Provider to enrollee ratios

Because the Together4Health partners are citywide and will be linked through geographic hubs, the system's capacity to meet the needs of T4H enrollees will be elastic and fluid. When any agency or provider reaches or exceeds capacity to serve T4H enrollees, that will be communicated to the hub's care coordination team in order to reallocate referrals and resources and to ensure continuity of care for participants. T4H will be responsible for monitoring capacity and resources throughout the network.

Dual eligibility

The T4H model is based on a 25% dual eligibility population. If the population changes based on payer expectations the model will need to be revisited. Dually eligible consumers will be offered services depending on a care coordination fee negotiated with the state and T4H's ability to ensure savings given that Medicare spend has been eliminated. Both HHO and T4H are in conversation with insurance companies that are applying to coordinate care for the dual population. HHO will explore opportunities to best serve T4H target populations both as a CCE and in partnership with these other networks.

Enrollee profiles

T4H staff will screen enrollees for immediate needs and complete a standardized enrollee profile that documents demographics and assignment to a health home hub. The assigned care coordination team then takes on the responsibility of completing a full assessment that will evaluate all aspects of the participant's current status, from medical and mental health and substance use concerns to problems with housing, employment, social support, community connection and functional status. Currently, HHO utilizes a tool referred to as "What I Want from Treatment" that invites participants to identify their treatment priorities as well as measures their level of commitment relative to each priority. T4H will work with its consumer advisory boards to refine such a tool to enhance the network's capacity to match service offerings with participants' level of interest. The goal of the assessment will be to establish risk and needs across all dimensions, with the goal of providing the basis for the care plan, and, ultimately, reducing costs to the healthcare system. T4H also proposes the use of a functional assessment such as that developed by the state government of Victoria, Canada: http://www.health.vic.gov.au/agedcare/downloads/pav/functional_assessment.pdf. This will determine a participant's ability to self-manage and to function in the home and the community and help direct their care coordination. In the event that an individual is not already attached to a participant-centered medical home, the care coordinator will make an assignment at the end of the assessment.

Participant profiles will be stored electronically and available to all T4H partners through the Amalga system, the HIT system that T4H will be using and that is described in some detail below on page 36.

See also: Attachment J1—Sample enrollee profile
Attachment J2—Sample integrated assessment

T4H will create health homes

Together4Health meets the definition of a health home because it is a service delivery model that facilitates access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for those with chronic conditions. It will operate with a whole-person philosophy – caring not just for an individual's medical or mental health condition, but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services will be central to the achievement of enhanced outcomes. As detailed above, T4H will serve 500 participants within the first quarter, up to 5,000 by the end of year three of operation.

As described above, all T4H enrollees will be assigned to one of several health home hubs, based on geography, preference, and services currently being received. Each health home hub will align with the diagnostic criteria outlined in the Health Homes Option-Section 2703 in the Affordable Care Act—people with either two chronic conditions, one chronic condition and at-risk for another, or one serious and persistent mental health condition—as well as meeting the service delivery criteria spelled out in the act.

Care coordination teams attached to health home hubs will ensure comprehensive care management, transitional care and appropriate follow-up, health promotion, and referral to community and social services. Care coordination will be multifaceted and involve identifying and anticipating needs through assessment, prioritizing, and monitoring. A care coordinator will communicate, network, and educate, as well as advocate for resources to meet the individual's needs, resulting in improved health and quality of life. Care coordinators will have the capacity to work with a full range of medical, behavioral and social support services offered within and outside the managed care or coordinated care organization, therefore often arranging both covered and non-covered services. Care coordinators will be prepared to work with the most disabling and complex psychosocial challenges and will be knowledgeable about case management, targeted medical case management, motivational interviewing, harm reduction, enrolling in benefits, and identifying and accessing community resources. In order to improve health outcomes, the care coordinator will be skilled at building a relationship with the individual participant, collaborating with the participant to identify and prioritize needs, determining how to get what from whom in order to meet those needs, and helping the individual navigate the health care system, as well as other unfriendly and daunting systems. Ideally, the role of those involved in care coordination will be that of a coach who focuses on "doing with" the individual, rather than "doing for." Participant activation and functional status will be continually reassessed and, as participants become increasing able to do for themselves, T4H will reduce the intensity of care coordination while continuing to monitor utilization and outcomes. These tools, along with frequent assessment will be critical to T4H's patient stratification and predictive modeling of risk, healthcare spend and outcomes.

Care coordination teams will also provide oversight and information about population outcomes to T4H partners by monitoring the health of discrete populations, identifying trends, and looking at barriers to care that individuals and populations may be experiencing. T4H and its care

coordination teams will use information sharing technology that will minimize duplicative procedures, link services, and maximize care coordination (see Health Information Technology section, page 32). Health homes will be real, existing within partners' physical sites, and virtual, the result of care-coordination-guided collaborations among partners (see health home hub diagram above, page 14).

Hospitalization and discharge planning

T4H aims to decrease hospital admission rates and shorten necessary inpatient stays by increasing access to outpatient services and intervening in health issues before people become critically ill and need to be hospitalized. Research indicates that 40 percent of readmissions are the result of failed follow-up after discharge from the hospital, inadequate home services, and housing issues. When T4H enrollees are hospitalized, care coordinators will collaborate with hospital staff to facilitate discharge planning from the beginning of the admission so as to reduce excessive days in hospital due to discharge complications, and to ensure a smooth transition back to the community. Care coordinators will check in with participants the day after discharge and do what is necessary to prevent readmission. Toward that end, care coordinators (and T4H partners) will adhere to a standard of having participants meet with their PCP within seven days of discharge (or sooner when it is clinically indicated). Access to on-call primary care providers and care coordinators will also contribute to helping participants avoid readmissions.

Finally, T4H has partners providing respite care—a vital resource in working with the target population, especially those who are homeless or at risk of homelessness. Medical respite care provides short-term residential care that allows homeless individuals to rest while receiving medical care for acute illness or injury. Medical respite programs offer hospitals an alternative to discharging patients to the streets while ensuring that the medical care received in a hospital or clinic setting is not compromised due to unstable living situations. Combined with housing placement services and effective case management, medical respite care allows individuals with complex medical and psychosocial needs to recover from an acute medical condition in a stable environment while reducing future hospital utilization. The result is improved health outcomes and housing stability.

Mental health and substance use services

Because of the high incidence of mental health and substance use concerns likely to co-occur with chronic health conditions among enrollees, T4H's initial assessment conducted by care coordinators will identify mental health and substance use concerns at the outset of enrollment, ensuring co-occurring, comprehensive care through partners in the health home. T4H will also incorporate the use of SBIRT (for substance use) and PHQ2/PHQ9 (for depression) screenings in PCMH settings, in order to continuously assess needs. All T4H partners providing mental health and substance use treatment already serve members of the target population and are trained in evidence-based practices. When necessary, however, T4H will offer technical assistance and continuing education opportunities in harm reduction, motivational interviewing, and dual disorder treatment, utilizing HHO trainers attached to the Midwest Harm Reduction Institute and the Illinois Co-occurring Center for Excellence. Other partner agencies bring expertise and experience in mental health first aid, co-location of primary care and mental health services, and in supported employment.

Some agencies already provide co-located services (e.g., HHO's Heartland Health Center Uptown and HHO's Mental Health and Addiction Services; Heartland International Health Center and Trilogy). As the health home hubs take shape and relationships among the partners within each hub solidify, opportunities for further co-location will be developed and are likely to include establishing regularly scheduled primary care clinics in supportive housing settings and integrated assertive community treatment teams that incorporate both mental health and primary care services. T4H plans to incorporate telehealth to expand access to services by decreasing barriers to care due to transportation and increasing access to specialists. T4H will also use telehealth for care coordination to improve communication and delivery of services.

Emergency department data utilization review

Data indicates that a relatively small percentage of the Medicaid population accounts for a high percentage of emergency department visits and costs. In Together4Health's service area, just 2.5 percent of all Medicaid recipients had five or more ED visits in a year, yet this group accounted for 33 percent of all ED visits in 2010. Over two-thirds (71 percent) had no ED visits in the baseline year. This highlights the importance of being able to identify high users and to develop strategies to help direct these individuals to a more appropriate and cost effective setting. According to the state's data, individuals with five or more ER visits in the baseline year were most likely to have diagnoses of serious mental illness, pulmonary, psychiatric, substance use, cardiac, and gastrointestinal diseases. Care coordination will help redirect many of these ED visits.

Initially, using the claims data on existing Medicaid users, Together4Health will identify existing high users of the emergency department and target them for enrollment through marketing and outreach. Ongoing, partner hospital emergency department utilization data will be reviewed on a quarterly basis to identify individuals who may fit the profile of high users. Together4Health will be able to review Medicaid beneficiaries, both existing enrollees and others, who are using the ED for ailments that would be better handled by their primary care physician, or who are returning to the ED for the same issue multiple times.

T4H providers will reinforce participants' use of appropriate services by reminding them that T4H offers on-call primary care and care coordination services; providing next-day phone calls from the care coordinator or primary care provider to evaluate the participant's progress; and appointments as soon as possible after the ED visit in order to provide any necessary follow up and to reinforce use of the participant's PCP for their primary health needs.

Because Together4Health's partners will include hospitals that will be part of each enrollee's health home, enrollees will be encouraged to use that hospital in case of emergency. Thus, when an enrollee uses an emergency department, systems (a T4H identification card, for example) will have been developed that will lead to the ED alerting the enrollee's care coordinator about ED use—through electronic or other means. Because a founding principle of the model is to develop a HIT solution that will allow all partners' data systems to talk to one another, T4H will strive to ensure that all information pertinent to an individual's care coordination is delivered in a seamless fashion in real time and is available at the point of care and to all ancillary providers involved in the individual's care. All PCP visits will include a query about emergency department usage in order to capture information about use that was not connected to a partner hospital.

T4H's care coordination model is rooted in a relational stance that understands the participant is a valuable partner in the effort to promote effectiveness and reduce expenses. Participant activation is imperative: we will help our participants understand our goals and support them in playing a role in our collective achievement of these goals. Through our collaborative relationship with participants, we will encourage them, when appropriate, to consult with their PCP or care coordinator prior to seeking crisis services, and to have the hospital contact their care coordinator immediately upon presentation. We intend to ask HFS to add T4H to the Medicaid card itself and may provide our participants with bracelets indicating their affiliation with T4H in order to help all providers recognize our participants. As we will do with our participants, T4H providers will develop collaborative relationships with local EDs. We will help ED staff understand the value we add to their capacity to provide effective services and reduce unnecessary costs. As mentioned before, we are working to ensure that all of our communication is facilitated electronically across our partners' EHRs. Finally, with the understanding that prevention efforts are not always effective, we will continually monitor ED and hospital usage, identify high users, and engage them in outreach based care that aims to help them improve their management of their health conditions within a community setting.

As mentioned earlier, the role of the T4H care coordinator is that of a coach who focuses on "doing with" rather than "doing for." Thus, T4H's care coordination staff will be trained in motivational interviewing and supported in efforts to encourage participant self-management. T4H will use evidence-based, condition-specific models to help participants successfully manage their health concerns with the most minimal professional intervention possible. Care coordinators will review emergency department visits to identify trends and avoidable utilization, especially those related to diagnoses such as asthma, fever, and low back pain that can often be treated in an outpatient setting. For instance, participants will then be educated on preventing asthma attacks and on normal course of fevers and alleviation of back pain, and other providers (such as housing program staff) will be alerted to care recommendations that will help their participants avoid ED admissions. Each enrollee's care plan will indicate his or her level of activation relative to his or her health condition and will include objectives to improve that activation when necessary.

Additional strategies to reduce unwarranted emergency department visits include extending PCMH hours for increased accessibility; reminding participants that T4H offers on-call primary care and care coordination services; next-day phone call from the care coordinator and a primary care provider appointment as soon as possible after the ED visit in order to provide any necessary follow up and to reinforce use of PCMH site. Finally, T4H education and health promotion activities will improve self-management for many chronic diseases.

At the population level, T4H staff will work systemically to analyze data, identify clinical trends, develop a range of interventions, target their application, and test their effectiveness. In so doing, T4H staff will draw on the expertise of partner organizations. For example, our community mental health partners offer a wealth of information on best practices with individuals experiencing behavioral health concerns. Permanent supportive housing and other social support organizations will help us understand and address the myriad social determinants that affect the health and health system utilization of T4H members.

Utilization of preventive care

The T4H care model is designed around services that promote wellness and encourage access to and utilization of preventive care. The breadth of services within each health home hub will mean that enrollees have access to the kind of care that will support lifestyle changes in service to chronic health conditions and in concert with their treatment. This will range from nutrition counseling to asthma, diabetes, and hypertension care groups. Telehealth capacity will enlarge the scope of preventive care delivery. Further, community health workers will be members of the care coordination teams, and will bring their expertise as health care consumers to promote preventive care and help enrollees navigate various support systems, while also informing T4H leadership regarding unmet needs of individuals and populations being served.

The EMR utilized by a majority of the T4H partner FQHCs already has decision making support embedded in it that reminds providers when tests and routine preventive measures are due. That capacity will be expanded to others within the network. Through the EMR, staff will track compliance with evidenced-based preventive guidelines at both CCE and PCMH levels. Preventive care will be incorporated into individual care plans, and all partners working with participants can reinforce and encourage it. T4H will also ensure access to appropriate education materials that will spell out how participants and our non-traditional healthcare partners can manage chronic conditions and prevent crises.

Together4Health partners are attuned to the social determinants of health—housing, food security, poverty, and violence—and the health disparities that result from them. As a result, the T4H care model includes housing and service providers that will lead to community stability and improve access to and use of health care services. As such, they are a form of preventive care. Care coordination teams will leverage housing staff and case managers in other settings and educate them about prevention, so that they can help participants proactively manage their health, thereby leading to the improved outcomes that are mandated by the Accountable Care Act and the state.

Ensuring compliance with the Americans with Disabilities Act

Together4Health primary care providers will all work within partner FQHC sites, all of which are ADA accessible, or in hospitals that are JCAHO accredited. Therefore, they will be working in settings that have been found to be in compliance with the Americans with Disabilities Act, and they will be trained in working according to ADA guidelines that prohibit discrimination against individuals with disabilities and require medical care providers to make their services available in an accessible manner. This includes ensuring that staff knows how to correctly use accessible medical equipment, which examination and procedure rooms are accessible, and where portable accessible medical equipment is stored. Whenever new equipment to provide accessible care is received, staff will be immediately trained on its proper use and maintenance. New staff will receive training as soon as they come on the job and all staff will undergo periodic refresher training during each year. Finally, training staff to properly assist with transfers and lifts and to use positioning aids correctly will minimize the chance of injury for both patients and staff. Staff will be instructed to ask patients with disabilities if they need help before providing assistance and, if they do, how best they can help.

All staff working in community mental health centers, substance use settings, or any other site that has a state contract also meet ADA standards. The breadth of partners within the T4H

network guarantees that participants in need of accommodations will be able to have those needs met.

Engaging potential enrollees who are difficult to locate or engage

T4H is comprised of partners who specialize in engaging hard-to-reach populations. Proactively, from the initial intake, T4H will focus on engagement and activation. HHO currently uses teams of medical and behavioral health providers to do outreach in more than 100 shelters and other community sites throughout the city: these staff will be ambassadors for and educators about Together4Health when needed. Network agency PATH (Projects in Assistance for Transition from Homelessness) teams (sited at HHO, Thresholds, HAS, and Mt. Sinai) will also outreach, engage, and educate people who are homeless about T4H options and how to access this new system of care. HHO and PATH providers are skilled at active street-level engagement strategies that emphasize building relationships. Motivational interviewing techniques and a harm reduction approach are central to the engagement process, allowing participants to function as experts about their needs and to identify their own priorities. By offering linkage to housing and other essential community resources, T4H will be able to capitalize on meeting needs that extend way beyond furnishing basic medical care and, at the same time, make it more likely that those individuals will engage in medical care.

Cultural competency

With locations throughout the city of Chicago, T4H providers are embedded in racially and ethnically diverse communities where they have been safety net providers, often for decades. T4H partner specialty areas include refugees and immigrant communities, homelessness, HIV/AIDS, and the health care needs of diverse racial communities. The care coordination model will capitalize on these community relationships and work to expand cultural competence and capacity by training and employing community health workers who represent the target population and who will be charged with serving as cultural brokers and health promoters. HHO, in partnership with the National Healthcare for the Homeless Council as lead applicant, will receive training in implementation of the community health worker model through the Centers for Medicaid and Medicare's Health Care Innovation Challenge titled "Community Health Workers and HCH: A Partnership to Promote Primary Care." T4H's cultural competency will also be assured through the kind of consumer input described above on page 8.

According to the U.S. Department of Health and Human Services, Office of Minority Health, cultural competency is one of the main ingredients in closing the disparities in health. "Quite simply, health care services respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of customers can help bring about positive health outcomes." T4H partners' track records with the target population, our commitment to training staff in gender, age, and cultural competence, and our commitment to hiring people who are members of the community will be core values of the network. Further, T4H will strive to incorporate cultural competency assessments into the quality management process.

Linguistic competency

T4H agencies will provide language assistance to participants with limited English proficiency through bilingual staff or professional interpretation services, at no cost to participants. Language assistance also encompasses the needs of those with speech or hearing disabilities. It

will be provided at all points of contact and in a timely manner, through strategies that include the following:

- TTY line for people who are deaf or hard of hearing seeking services: the line will be answered weekdays during work hours; messages can be sent 24/7.
- Signs that are translated into 20 commonly encountered languages will be posted throughout agency sites, enabling participants to indicate the language in which they require service and informing them that it will be provided at no cost.
- Face-to-face interpretation can be arranged in advance in 40 languages (including sign language) through HHO's Cross Cultural Interpreting Services (CCIS), or provided telephonically with no notice through a contract with Pacific Interpreters.
- All interpreters for deaf services will be engaged from a reputable provider of such services.
- Partners who work with a high number of participants with language assistance needs will strive to meet those needs by creating multilingual teams, by ensuring the linguistic proficiency of bilingual staff, through using only professional interpreters or telephonic interpretation services, and through structuring resources to include funding for hiring interpreters.

T4H will require all member agencies to be linguistically competent, conveying information in a manner that is understood by program participants, including those with limited English proficiency, those who have low literacy skills or are not literate, individuals who are deaf or hard of hearing and individuals with disabilities.

T4H will require that key organizational documents, including consent forms, grievance forms, participant rights statements, and patient education, be available in commonly spoken languages.

T4H care coordination staff will be creative and versatile when it comes to communicating with enrollees, using electronic means such as email and text messaging when possible; in addition, enrollees will be educated about applying for government-funded cell phones and service, as well as about government-access voicemail for those without phones. T4H will also develop a website with a participant portal that will help enrollees navigate and connect to services.

Incentives

Incentives for patients may include CTA cards, issued according to need and frequency of appointments and services. No other incentives are envisioned at this time. In the future, as T4H resources grow incentives to increase adherence and participation may be explored. Once savings are achieved the operating agreement provides for the Board of Managers to return savings back to member owners through distribution formularies to be agreed upon by the members.

Care coordination duties and caseloads

Together4 Health care coordination teams will be at the center of each of our health home hubs across the city. Care coordination (CC) teams will include RNs, LCSWs, and community health workers (CHWs)—based on number of enrolled participants and service need (primary care only, or primary care and behavioral health). One team will be staffed with a nurse manager who will supervise the RNs. Team members may be sited in different agencies within a hub; each hub team and leveraged care managers meets weekly. RNs will specialize in working with those with

high medical needs; LCSWs will specialize in working with those with high mental health and substance use needs, but everyone will be cross-trained in the typical presenting needs of the target population. Community health workers will come from the communities they serve and may be HIV positive themselves, for example, or be in recovery from mental illness or substance use, or have experienced homelessness. Care coordinator case loads will vary from 30 to 100, depending on complexity, acuity, and current service provider supports.

T4H's partner organizations have much experience in population health, health disparities, and the social determinants of health--T4H will utilize this expertise to educate staff. They will also be trained to provide trauma-informed, strengths-based care that utilizes motivational interviewing, harm reduction, and other evidence-based strategies that will enhance participants' ability to manage their health. Their focus will be on:

- Creating a single, multidisciplinary care plan with integrated health goals;
- Enhancing communication between participant, primary care provider (PCP), and other providers;
- Improving access to support services that include substance use treatment, mental health treatment, and housing;
- Increasing patient adherence through health education, motivational interviewing strategies, and peer coaching;
- Increasing patient activation (i.e., the individual's readiness, willingness, and ability to engage in care) and, as a corollary, their self-management skills;
- Strengthening personal and community relationships, including employment and volunteer opportunities, thereby improving quality of life and addressing social determinants of health.

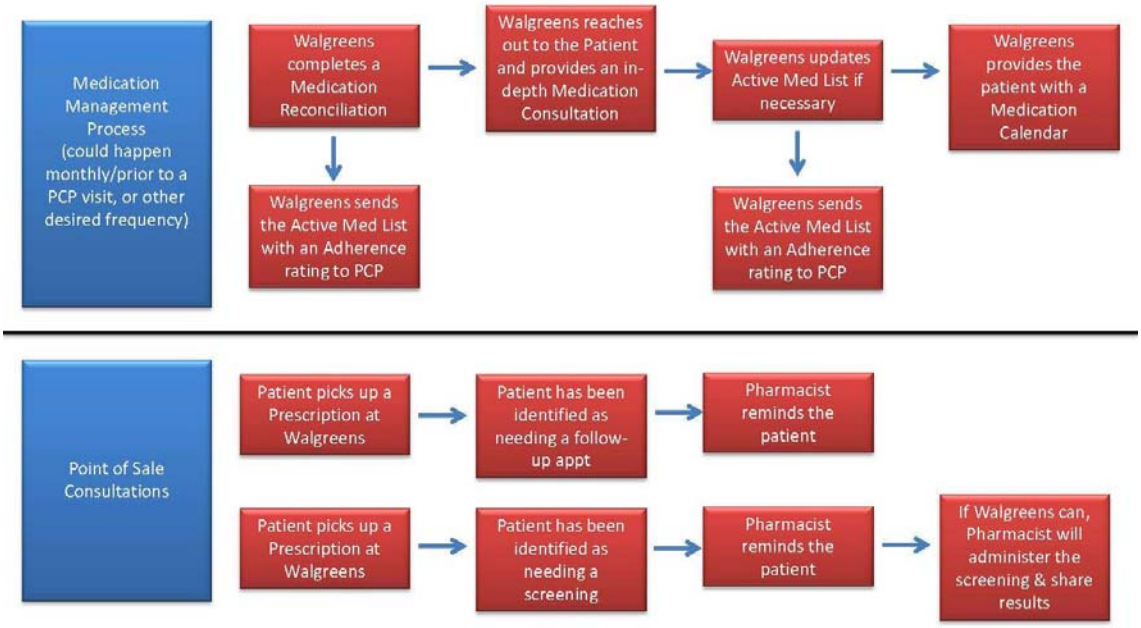
Care coordinators will focus on creating a network of services tailored to the needs of each participant, including oral health and specialty care. Some T4H providers provide oral health care, but need may well outstrip supply. Therefore, protocols may need to be developed that prioritize individuals whose clinical status will be most directly impacted by dental care. Specialty care also presents challenges for those with Medicaid, as reimbursement rates often fail to cover actual cost of care and many providers avoid serving Medicaid recipients. T4H will identify the specialties most needed by our target population, with the goal of utilizing specialists at PCMH sites. T4H will also use telehealth to expand its capacity to provide specialty care and consultation. Finally, as described in the Health Information Technology section below (page 36), Together4Health's health information technology model will develop a solution that will allow partners' current data systems to talk to one another. The model will ensure that information pertinent to an individual's care coordination is delivered in a seamless fashion and is available at the point of care.

T4H will develop policies and training that address ethics, care philosophy, and standards of care. Policies and training will include cultural competency, emphasizing the need to respect and embrace differences.

Medication management

T4H will adopt a team approach to medication management including pain management, to ensure comprehensive care and attention to detail that will result in increased adherence, timely refills, and decreased negative drug interactions. At the heart of our approach to medication

management, will be a singular medication list on the enrollee care plan to which all care team members have access. Care coordinators will focus on adherence through participant activation and motivational interviewing. T4H will monitor the safety, efficacy and cost of medication. T4H will also monitor for high-risk medicines like Warfarin to ensure more intensive oversight by care team members. The EMR currently screens for drug interactions. The model below shows how T4H may be able to partner with Walgreens to streamline and improve medication management through enhanced communication between the primary care provider, the pharmacist, and the individual participant.



The care coordination team will create a medication list early in enrollment, with medication reconciliation done on ongoing basis using the electronic medical record. All providers in a participant's care network will have access to the medication list. The EMR will also enable providers to know that participants using medications are also receiving the kind of ancillary supportive care that results in therapeutic outcomes—e.g., an individual with insulin-dependent diabetes is also enrolled in nutrition classes. Currently, FQHCs utilizing Centricity have access to medication dosage guidelines for specific conditions. The example below is from the asthma management plan. T4H will focus on expanding this kind of resource across all partners.

Exam | Assessment | Education | Treatment | Action Plan | **Med Ref** | ppf2

Daily Dosages for Inhaled Corticosteroids

Adults

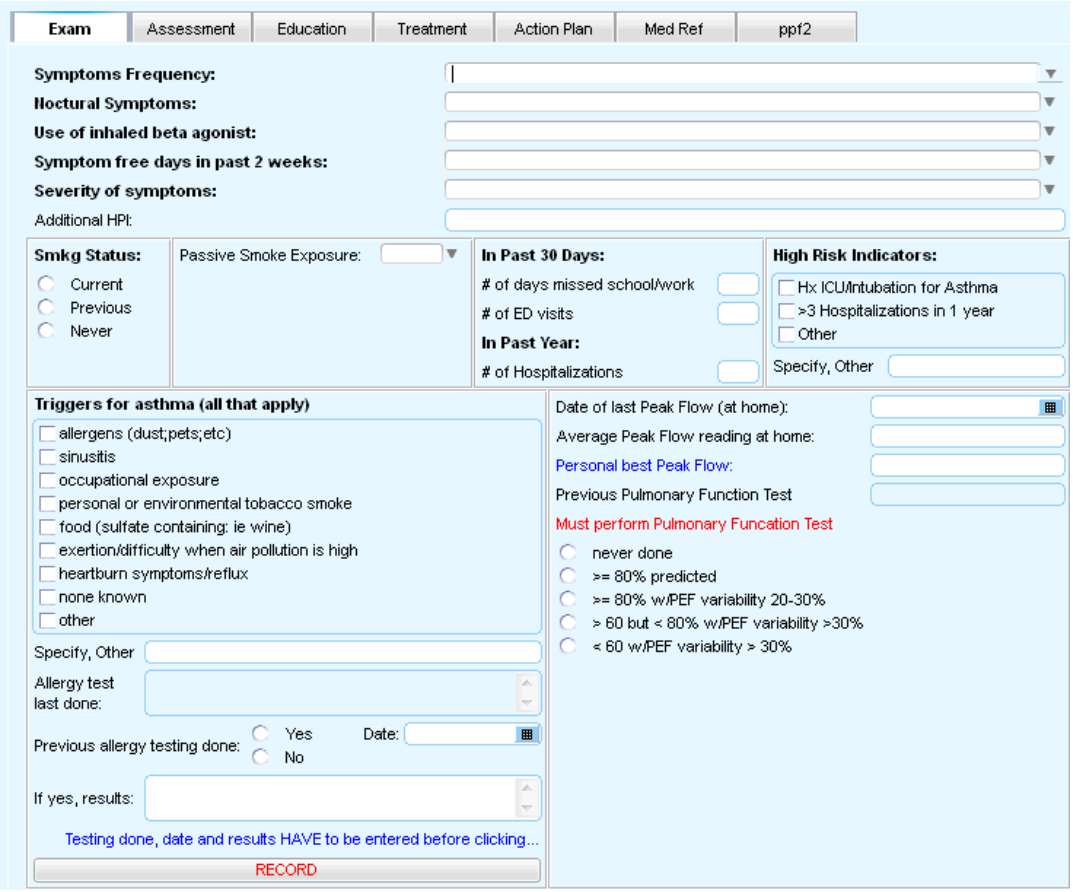
Drug	Low Dose	Medium Dose	High Dose
Beclomethasone dipropionate	168-504 mcg	504-804 mcg	>840 mcg
42 mcg/puff	(4-12 puffs - 42 mcg)	(12-20 puffs - 42 mcg)	(>20 puffs - 42 mcg)
84 mcg/puff	(2-6 puffs - 84 mcg)	(6-10 puffs - 84 mcg)	(>10 puffs - 84 mcg)
Budesonide	200-400 mcg	400-600 mcg	>600 mcg
DPI: 200mcg/dose	(1-2 inhalations)	(2-3 inhalations)	(>3 inhalations)
Flunisolide	500-1,000 mcg	1,000 - 2,000 mcg	>2,000 mcg
250 mcg/puff	(2-4 puffs)	(4-8 puffs)	(>8 puffs)
Fluticasone	88-264 mcg	264-660 mcg	>660 mcg
MDI:44,110,220 mcg/puff	(2-6 puffs - 44 mcg) OR (2 puffs - 110 mcg)	(2-6 puffs - 110mcg)	(>6 puffs - 110 mcg) OR (>3 puffs - 220 mcg)
DPI:50,100,250 mcg/dose	(2-6 inhalations - 50 mcg)	(3-6 inhalations - 100 mcg)	(>6 inhalations - 100 mcg) OR (>2 inhalations - 250 mcg)
Triamcinolone acetonide	400-1,000 mcg	1,000-2,000 mcg	>2,000 mcg
100 mcg/puff	(4-10 puffs)	(10-20 puffs)	(>20 puffs)

Care coordination staff and non-traditional healthcare partners, including community health workers, will be trained by medical providers in medication monitoring, management, and training standards. They will also be trained in risk levels associated with various drugs, and algorithms will be created to map communication and responses.

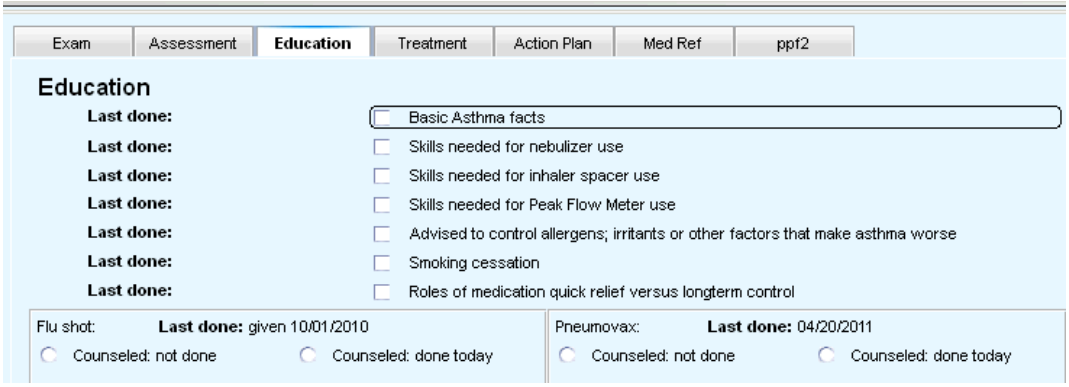
Health education

Enrollee health education plans will provide information and guidance related to medications. They will also enhance enrollee understanding of signs and symptoms and provide strategies related to disease management and therapeutic goals. Currently, FQHCs utilizing Centricity have access to management plans for diabetes, asthma, cardiovascular disease, and HIV that include a tab for education. The latter highlights skills and strategies that staff should be teaching and reinforcing with participants and allows for continuous documentation of that teaching. T4H will use HIT to expand all partners' access to this kind of standardized education information and plans. Standardized printed materials will also be created and shared among providers. As the network and technological resources come together, a participant portal will enhance consumers' ability to access health education at any time. This portal will be available across all T4H partners, who will be required to educate and support participants in its use.

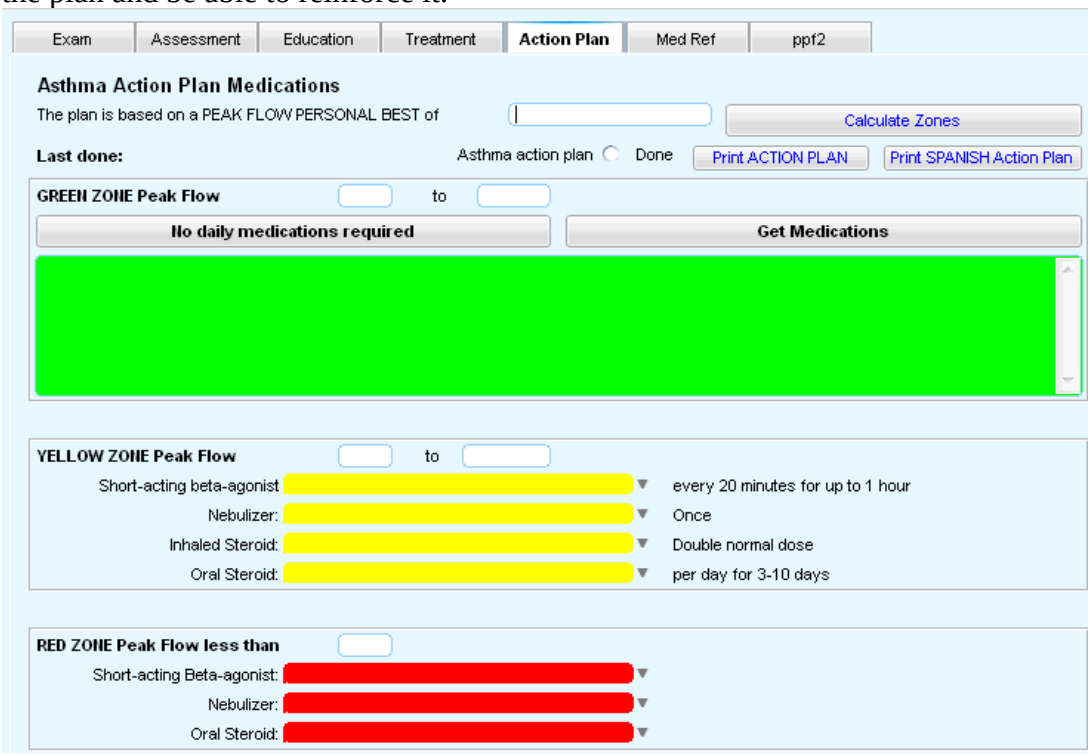
The screen shot below, from Centricity, indicates how the EMR can summarize an individual's status related to asthma.



This screen shot shows the asthma education tab:



This next screen shot documents an individual's asthma medication plan, and informs the printable action plan that the participant can use to monitor and manage medications. The asthma action plan will become part of the enrollee care plan so that all staff will have access to the plan and be able to reinforce it.



Monitoring the quality of care

Together4Health will create multiple internal controls to monitor the quality of care provided to our enrollees and provide ample feedback to partners on overall performance and individual providers on their specific performance. There is significant expertise within Together4Health in developing and applying strong quality monitors and in implementing changes based upon the indicators.

Together4Health will develop an integrated quality management program that incorporates participant feedback, data analysis and manual chart audits. The quality management program will use quantitative and qualitative tools to gather information and evaluate findings.

Consumer feedback is a critical component of a quality management program and Together4Health will ensure that enrollee opinions are solicited in the form of surveys and focus group/advisory group settings throughout the network. In the first year of operation, Together4Health will seek input through surveys and focus groups with greater frequency to ensure that potential problems are identified quickly and solutions found. From the outset, Together4Health will gather enrollee feedback and input at quarterly consumer advisory board meetings. These meetings will be held at each care coordination hub. In subsequent years enrollee feedback surveys frequency may be reduced, but it will remain an ongoing core activity.

Together4Health will gather feedback from staff and providers during the weekly care coordination hub staff meetings. Care coordinators will assemble relevant information discussed at these weekly meetings and provide a monthly summary report, which will be shared with all hub members and with the other care coordinators. Working together, the care coordinators will use these monthly reports to identify problem areas and evaluate trends in care across Together4Health; this information will link to the quality management program to ensure continuity and consistency across the Together4Health network. Additionally, a "drop box" for staff comments and suggestions will be developed within the data system to provide an additional mechanism for staff feedback.

On a quarterly basis, a random selection of enrollee care plans, in line with the recommendations of the Center on Accreditation, will be reviewed to evaluate the quality of care being provided to Together4Health enrollees. Additionally, incident, accident, and grievance reports will be reviewed to identify patterns and establish safeguards to prevent future events. Staff at Together4Health and its collaborators will be invited to complete surveys about the quality of care provided by Together4Health and the ways in which care coordination can be improved.

In addition to monitoring its success with the quality measures designed by the state, Together4Health will develop metrics based upon the Institute of Medicine's Six Aims to ensure that care is safe, effective, patient-centered, timely, efficient, and equitable. These domains will guide the organization of Together4Health's QM program and provide a unified framework for internal and external quality improvement discussions. Within the framework of the QM program, Together4Health will be encouraged to improve quality of care, collaborate with partner organizations and streamline workloads. Indicators that look at outcomes and collaboration will be developed.

Proposed pay-for-performance quality measures

For the pay-for-performance measure for the care coordination fee, Together4Health proposes using HIV/AIDS medical visit, which is the National Quality Foundation measure #0403. This quality measure examines the percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit in each six-month period. To successfully meet this measure, appointments must be at least 60 days apart. Regular appointments with a primary care provider are very important for this population to track viral load counts, ensure medication compliance, and monitor other medical complications. Success on this measure will be readily evaluated based on diagnostic codes and claims data that will indicate whether the identified individuals have seen their providers. While the number of Medicaid recipients living with HIV/AIDS is limited, this is a specialty population for Together4Health and its collaborators, and we believe that T4H providers see the majority of Chicagoans living with HIV/AIDS.

Further, the impact on health and cost savings could be significant including individual health, community viral load, and service utilization.

For the pay-for-performance measure for shared savings, Together4Health proposes using a diabetes medical visit measure, developed to mirror NQF measure #0403. This quality measure will examine the percentage of members between the ages of 18 and 75 with diabetes (type 1 and type 2) who have at least one medical visit in each six-month period. To successfully meet this measure, appointments must be at least 60 days apart. Diabetes is a common chronic condition for individuals connected to Together4Health collaborators and is one of the diseases identified in the ACA health home model, making it an important disease to focus on. Success on this measure will be readily evaluated based on diagnostic codes and claims codes that will indicate whether the identified individuals have seen their providers.

Because T4H's innovative care coordination model highlights the importance of integrating housing and support services into primary care models, T4H believes that the state should also use one or both of the following quality measures in conjunction with T4H's interagency payment flexibility proposal.

- Hospitalization: Together4Health enrollees who are housed in a member's housing program will see a reduction in inpatient hospitalization utilization. Medicaid claims data for the housed enrollees for the 12 month period prior to enrollment and housing through Together4Health will be used as the baseline. The frequency of inpatient stays and the total number of patient days for all housed enrollees in comparison to the baseline will be evaluated to identify savings and reductions in hospitalization. Specific targets will be developed in cooperation between the State and T4H.
- Emergency room use: Together4Health enrollees who are housed in a member's housing program will see a reduction in emergency room utilization. Medicaid claims data for the housed enrollees for the 12 month period prior to enrollment and housing through Together4Health will be used as the baseline. The number of emergency room visits per quarter for all housed enrollees in comparison to the baseline will be evaluated to identify savings and reductions in emergency room use. Specific targets will be developed in cooperation between the State and T4H.

Data tracking ability of T4H's collaborating agencies

Together4Health collaborators have extensive experience tracking data and monitoring quality outcomes for myriad funders and accrediting bodies. Combined, they have the ability to track enrollee utilization and monitor the quality measures outlined by the state. Together4Health includes hospitals, pharmacies, federally qualified health centers, behavioral health providers that specialize in both mental health and substance use disorders, and housing providers. No single collaborator has the ability to track all of the measures, nor be successful in meeting the goals, but the timely sharing of information and coordinated communication between collaborators will ensure success. Building on the knowledge of individual organizations, Together4Health will be able to monitor the quality measures outlined by the state.

Relevant information about enrollees will be collected in enrollee care plans and will be shared between collaborators using the state's secure email system during the first year. As Together4Health builds out its IT system and members develop their electronic health records, most of the information will be shared through the data warehouse, with targeted information

shared via secured email. Additionally, the health home hubs will convene weekly to discuss care plans and share relevant updates about enrollees. The regular communication between providers and the experience of members in utilizing data entry systems, electronic health records and program specific databases will allow Together4Health to monitor participant experience and ensure successful completion of the state's quality measures. With Together4Health's combined expertise we will identify underlying operational elements that impact the Quality Measures and develop tools to track those factors to ensure we meet the State's requirements.

Improving access to care.

In keeping with the community health center model, Together4Health's commitment to active care coordination and outreach will improve both access to and retention in care. The team approach to care coordination means that responsibility for individual enrollees is spread out among many, and it will be more difficult for enrollees to fall through the cracks. T4H will use proactive measures, like registries, to identify those not active in care and engage them into services with their PCP.

More concrete measures to improve access to care will include expanding primary care hours into the evenings and weekends, using an open access model of same-day-scheduling to decrease no-show rates, and phone access 24/7.

Enrollee care plans

Enrollee care coordination plans (see Attachment K) will be developed by each individual's care coordinator, in partnership with the participant and utilizing input from any other T4H partners already involved in the participant's care (whether the participant has an HCBS waiver or is enrolled in Illinois Health Connect). Insignia Health informed the creation of the care coordination plan and budget for T4H as it incorporates patient activation into care plans http://www.insigniahealth.com/solutions/patient-activation-measure. All T4H enrollees will have a care coordination plan that is based on the enrollee's care coordination assessment and on their stated preferences and diagnoses; it will be a dynamic document that changes as needs change. Outcomes will target not only physical health, mental health, and substance use, but also the social determinants of health that include housing, employment, and community stability and connection. A hard copy of the care coordination plan will be given to the enrollee upon completion; it will also be available to all of the individual's care partners, utilizing the Amalga system. Care plans will be updated regularly, according to an agreed upon schedule and incorporating information from all care providers and their plans.

Outreach

Ultimately, everyone within T4H will be a *de facto* outreach worker, focused on improving access to and retention in care. As described above, HHO currently uses teams of medical and behavioral health providers to do outreach in more than 100 shelters and other community sites throughout the city: these staff will be ambassadors for and educators about Together4Health. Network agency PATH (Projects in Assistance for Transition from Homelessness) teams (sited at HHO, Thresholds, HAS, and Mt. Sinai) will also outreach, engage, and educate people who are homeless about T4H options. As Together4Health's health home hubs coalesce, care coordination teams will maintain connections among the care managers across the different agencies that work with an enrollee. As a continuous process tied to care coordination, outreach

will range from reminder phone calls or text messages to street and community outreach to locate people lost to care or who are in crisis. The enrollee care plan and electronic health record itself will underlie outreach insofar as it will create alerts for upcoming appointments that will keep care coordinators and care managers up to date on participant care issues that may call for outreach.

High need, unstable participants will be assigned to care coordinators with lower case loads (approximately 30:1) to ensure necessary coordination of services. As provider connections are established, staff support increases, and the participant becomes more stable, care coordination responsibility will be transferred to other team members. Community health workers attached to the individual's care coordination team will also be charged with peer-to-peer outreach, engagement, and community coordination. Whenever possible, individuals with SMI who experience frequent psychiatric inpatient readmissions; excessive use of emergency services; and deficits in maintaining treatment continuity, self-management of medication, and independent living skills will be connected to more mobile Assertive Community Treatment (ACT) or Community Support (CS) teams based in community mental health agencies. In those instances, the care coordination team will have the advantage of a partnership with teams who spend the majority of their time meeting participants in the community, providing service as well as doing outreach and ensuring continuity and follow-through. T4H will work with hospitals, emergency departments, and state operated facilities to identify high users who are in need of care coordination services.

Written materials

Outreach will also include written materials that educate participants about Together4Health, its enrollment process, and its services. Those materials will be culturally and linguistically appropriate. Materials will be translated using professional medical translation service such as HHO's Cross Cultural Interpreting Services to ensure accuracy of the information. Written materials for the CCE participants will be standardized and the reading level of all written patient materials will be lower than a 6th grade reading level. The care coordinator will assess health literacy as a part of the treatment plan. Community health workers reflecting the populations served will review written materials as well.

Alternative methods of communication

Technology use will be maximized to include texting and a patient portal program. Participants can receive personalized texts to remind them about taking medication, exercise and other self-management behaviors. Participants can use internet access to communicate with the care coordinator without traveling to an FQHC or CMHC site. Participant access to and knowledge of communication methods will be assessed and the preferred methods of communication will be decided upon during the development of the care plan with the participant.

Health Information Technology

The Together4Health partnership is comprised of hospitals; federally qualified health centers (FQHCs); pharmacies; mental health, addiction, and social service providers; and supportive housing providers. Each provider group, and often each agency, has their own electronic data system. In some instances, a single agency has multiple data systems, often the result of siloed funding. While hospital, FQHC, and mental health and addition services provider partners all have some form of an electronic data system, social service and supportive housing provider

partners are less likely to have such a system currently in place. Many of T4H's partners are committed to implementing or upgrading their systems to demonstrate meaningful use of certified EHR technology. Several partners are registered for the electronic health records payment incentive program, including: Community Counseling Centers of Chicago, Lutheran Social Services of Illinois, Heartland Health Outreach, Near North Health Service Corporation, and Erie Family Health Center.

To address gaps in health information technology, the Alliance of Chicago Community Health Services, a T4H partner, was created in 1997. The Alliance has created a formal infrastructure that bridges four FQHCs — Heartland Health Outreach, Near North Health Service Corporation, Erie Family Health Center, and Howard Brown Health Center— with expertise in coordinating primary care for diverse, fragile, and disabled patients who experience chronic diseases. These FQHCs own the Alliance, which also provides EMR and the related support to 32 community health centers across the country. As a result, the Alliance has developed considerable expertise in leveraging health information. The Alliance currently hosts and operates an EHRS (a customized version of GE's Centricity). The system has been developed that documents all aspects of care provided, including not only primary medical care, but also dental, behavioral health, case management, and other services. A data warehouse and reporting infrastructure facilitates more advanced population-level analysis and reporting and allows for benchmarking of data with other community health centers for quality purposes.

The exchange of some clinical data between the Alliance and its hospital partners is not electronic at present, but is available to primary care providers (although not in a searchable format). The Alliance has approved a project with its Alliance partners to procure a secure patient portal, secure email, online appointment and registration and other care management features through Kryptiq, which is expected to be completed in 2012. Kryptiq is designed to improve the movement of health information throughout the community with automated clinical messaging (ACM). In advance of the development of a more sophisticated technical information exchange, ACM will enable seamless health information exchange transactions among T4H partners. This includes results delivery; discharge document distribution; and patient summary transfers. The results will facilitate distribution of health information throughout the community, allow for the integration of existing health information technology, and automate the exchange of health information. Full integration with hospital networks will be completed no later than 2014. The Alliance has a grant to support 50 percent of the cost of the Kryptiq/Surescripts enhancement. The Alliance has already tested a two-way transfer of an EMR successfully, and this system upgrade will contribute to the development of a successful CCE.

Additionally, several T4H partners, including HHO, are registered partners of and are participating in the interim testing of the Illinois Health Information Exchange (ILHIE), which is a secure electronic system for sharing clinical and administrative data among health care providers in Illinois. As all Medicaid providers will be mandated to participate in the ILHIE, T4H will require network partners who bill Medicaid to use the ILHIE as one of the mechanisms for exchanging health information. Based on information from the Illinois Office of Health Information Technology and the ILHIE, we anticipate the ILHIE will be operational no later than January 2013.

Since there is currently limited capacity among each partners' data systems to interface with one another directly, most T4H partners rely on phone and fax to coordinate the care of their participants. The ILHIE Direct Secure Messaging Solution will be of great use to T4H in its early stages of development while a more robust system is built. ILHIE Direct will allow all T4H partners to quickly and easily share pertinent health information via a secure and encrypted email. ILHIE Direct will allow all partners – regardless of their data system or lack thereof – to electronically share information with one another in real time.

Anticipated HIT functionality after 12 months

The founding principle of Together4Health's health information technology model is to develop a solution that will allow all partners' current data systems to talk to one another, not to have each partner adapt a new data system given the vastness of T4H's partner network. The model will ensure that all information pertinent to an individual's care coordination is delivered in a seamless fashion and is available at the point of care.

T4H's HIT model will be based on Microsoft's Amalga, which is a centralized repository with near real-time data access that acts as both a data exchange and a data warehouse. Amalga can integrate many siloed data systems and can capture clinical, financial, and performance information. The product will assist T4H in providing more coordinated care through patient-centric analysis, population views, and information sharing across the entire partner network. As an enterprise health intelligence platform, Amalga provides a flexible structure and data aggregation capabilities to support patient-centric analytics. The product allows for both patient and population perspectives and meets meaningful use requirements. The benefit of Amalga is that each partner does not need to adapt a new data system; it connects current systems to one another.

Current funding and a new national partnership will provide access to these more advanced data warehouse and analytic capabilities. These capabilities will support the integration of patient information among T4H partners, while allowing for more robust analytics and reporting capacities that will support system-level service monitoring and development, as well as financial management. As a result, data analysts will be able to identify significant trends and markers that can be used to develop predictive modeling approaches to target patients at high risk for hospital admissions, readmissions, and overuse of emergency and specialty care. Further, plans are underway for implementation of patient engagement technology that includes clinical messaging through a patient portal, as well as mobile device text messaging.

T4H members will be able to participate through Amalga via one of the following:

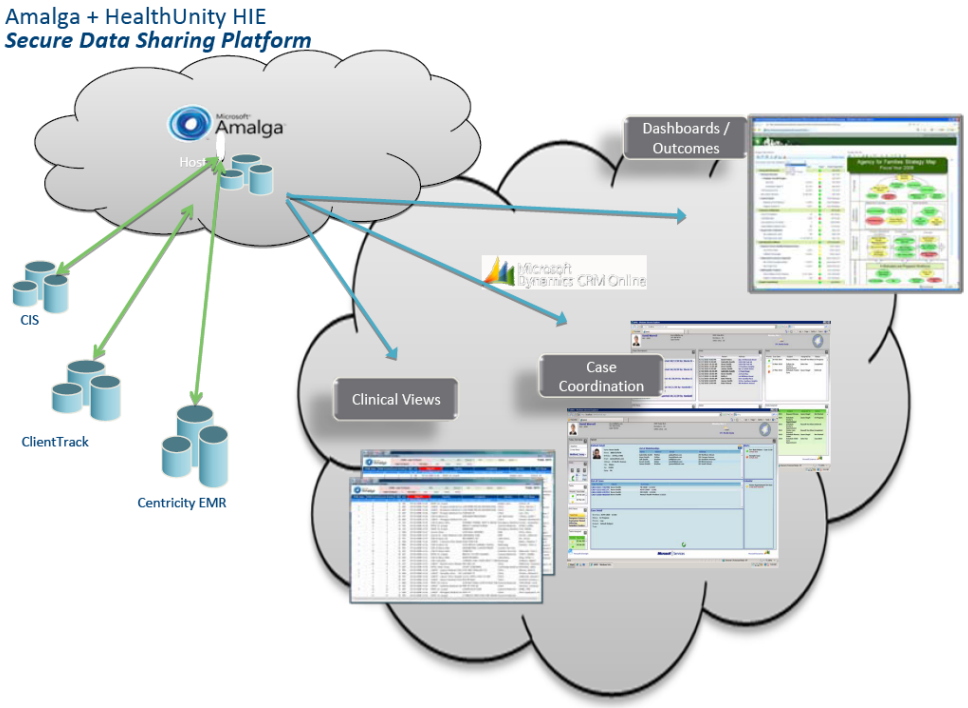
- Direct connection – members can participate via direct connection when there are existing data systems and they can interface with one another. The information from the source system will flow seamlessly into Amalga and information from Amalga will flow back out to the source system. Hospital, FQHCs, and mental health and addiction services providers will fall within this category.
- Web interface or portal – when no data system currently exists at a partner agency or the data system is unable to ingest data from Amalga; a web portal will be available. Staff will be able to log in to the portal to view a participant's information and enter pertinent

- Read only capacity – for partners that are not contributing data to the CCE, a read only capacity will be available.

In order to implement this model, a mapping process will need to be undertaken with each partner. For direct connection users, which are about 60 percent of T4H's partners, this process will include defining the data elements from the source system, mapping these elements to the Amalga data model, and creating a connection and testing the data ingestion between the two systems. A similar process for web interface users, which represent about 40 percent of T4H's partners, will also be conducted to determine what data elements they will contribute. Clinical views and dashboards will be created to assist in care coordination and outcomes tracking.

Amalga will also connect T4H to the Illinois Health Information Exchange (ILHIE). As more information about ILHIE becomes available, we will determine at what points in the HIT model T4H will connect with ILHIE – at the Amalga level or at each partner agency level, since all T4H partners will be required to participate in ILHIE.

Visual of T4H's HIT model:



Confidentiality

The health information technology solutions that were selected by T4H are all compliant with industry regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and state laws. As T4H maps out what information needs to be exchanged, by whom, for whom, and how frequently, HIPAA and state laws will dictate the parameters of the information exchange. Each T4H participant will be asked to sign a release of information, which will be

updated annually, so his/her information can be shared across T4H partners, as permissible by law. Breaches in confidentiality will be handled according to industry regulations.

HIT resources
Together4Health will leverage the work of the Alliance of Chicago Community Health Services and its partners to provide some HIT resources to T4H partners, including the initial purchase of Amalga. The Alliance will also provide in-kind services on EHRS optimization, workflow analysis to determine the best way for each T4H partner to use Amalga, and technical integration between Amalga and T4H's current data system.

Financial Model

Care coordination fee
See Attachment F for information and calculations related to fees.

Population definition number(s) and version number
Population definition numbers 14 and 25 and version number 1 were relied upon in the development of the proposal.

Additional data used
T4H gathered basic demographic and cost data from partners who completed a Memorandum of Understanding.

Methodology to Monitor Cost Neutrality and Establish Shared Savings Payments
T4H's success in demonstrating cost neutrality to the State of Illinois will be significantly affected by the cost neutrality targets that will be used to monitor the cost effectiveness of T4H and establish the shared savings payments. The State of Illinois and its contracted actuary will establish the targets. T4H will work with the State of Illinois and its contracted actuary to develop a sustainable process that includes:

- Actuarially sound PMPM medical cost targets rates that:
  - Are specific to T4H's four target populations
  - Are based on FFS data projected to the contract period
  - Reflect the acuity level of the enrolled population, including mental health needs, chronic disease burden, and functional status
  - Reflect the social determinants of health, including access to stable housing
- Risk adjustment of the PMPM medical cost targets based on diagnosis, functional status, and other social determinants of health such as access to stable housing
- A process for T4H to review the cost target calculations prior to contract finalization
- A transparent process to review shared savings calculations and settlement amounts

Impact of the Social Determinants of Health
Various studies of the homeless population clearly show that the combination of supportive housing and high-touch care management will reduce Medicaid expenditures the homeless populations that will be included in T4H's membership. A summary of these studies compiled by the Corporation for Supportive Housing is included as part of the actuary report in Attachment I. In general, the studies show that providing the homeless population with supportive housing has the following effect on Medicaid cost:

- Reduced hospital inpatient usage of 25% to 45%
- Reduced emergency room usage of 25% to 60%
- Significant net cost savings, even when factoring in the cost of supportive housing services

The financial projections in Attachment I model the Medicaid cost reductions of the homeless population as well as other covered populations. Savings due to T4H care coordination efforts are estimated based on Milliman's national experience with Medicaid managed care programs and benchmark data, supplemented with information from the studies summarized by the Corporation for Supportive Housing.

In addition to the impact on Medicaid costs, the studies summarized by the Corporation for Supportive Housing show cost reductions for other parts of State government. In particular, the following studies show significant reductions in law enforcement and incarceration costs. Cost savings to other state agencies are in addition to the cost savings demonstrated in Attachment I.

- The Colorado Coalition for the Homeless/Denver Housing First Collaborative Study showed 76% fewer days in jail for a chronically homeless adult population that entered supportive housing.
- The Maine Cost Analysis of Permanent Supportive Housing Study showed 62% fewer days in jail and 68% fewer police contacts for a chronically homeless adult population that entered supportive housing.

Distribution of payment among collaborators

It is expected that over the first few years of operation, T4H savings will be invested in the infrastructure of T4H and not redistributed to members. Savings will be determined by the ability of T4H to meet the specified quality measures both determined by the state and the ones posed by T4H, along with the full healthcare spend being reduced from previous years. Cash distribution formulas will be recommended by the Board of Managers (BOM) to the members for approval as stipulated in the operating agreement. It is expected they will be based both on member percentage interest, number of total T4H population served and quality outcomes achieved. Current financial models anticipate shared savings being returned to T4H at a 50% full allowable share with the state. Given current modeling T4H anticipates 10% of savings going toward a reserve and the remainder being distributed between T4H operations and members.

Percentage of payments in reserve pool

Current financial models anticipate shared savings being returned to T4H at a 50% full allowable share with the state. Given current modeling T4H anticipates 10% of savings going toward a reserve and the remainder being distributed between T4H operations and members.

Case management fees other than IHC fees

T4H collaborators do not receive any other case management fees.

Advance on care coordination fee

T4H's ability to attract investors, members, and other potential lenders (social impact bonds, foundations, and banks), in combination with contract specifics negotiated with the state, will determine whether T4H needs to request an advance on the care coordination fee to assist in the development of the CCE infrastructure and ensure cash flow. Leadership will also continue to explore partnership with insurance companies if awarded a CCE contract.