Hudson County ACO

Problem Statement

Achievement in the chronically ill reentry and homeless population is reliant on a uniform approach to health insurance assistance, housing assistance, public assistance, health care navigation and case management. The lack of a unified approach across systems, as well as clarity of need across all domains, is the reason for a lack of success in the cited target population.

Government, non-profit, health care, and social supports are often fragmented and historically have been unable to deliver services in a coordinated effort. Reimbursement variations among systems discourage coordination as unnecessary care or duplication of services is rewarded. The components of care are not speaking to one another which impact level of care and confidence in the system.

Solution: Accountable Care Organization

A Hudson County based public private partnership shall link physical health, mental health, medication, inpatient and outpatient care with social, housing a judiciary oversight services under the model of an Accountable Care Organization (ACO). The proposed model shall operate with the acute understanding that what drives the quality of health care and positively impacts outcomes in the chronically ill is the proper utilization of the health care system.

ACOs clearly define patient goals, remove barriers to coordination among providers, and ensure all systems work in accord to raise the level of care in patients. ACOs develop performance measures which demonstrate accomplishment in a tangible way and make accountable programs patient care decisions. Success not only increases the quality of life for clients but realizes significant cost savings for healthcare and service providers alike.

Target Population

In order to ensure a streamlined approach and the greatest likelihood of success, the ACO will focus on a target population—reentry and persons experiencing homelessness.

Hudson County is the most densely populated county in New Jersey with a population of 634,000 (2010 U.S. Census). Jersey City (248,000 people), the county seat, is the second most populous city in New Jersey (2010 U.S. Census). The Hudson County Department of Corrections (HCDOC), is one of the nation's largest adult correctional centers. During calendar year 2014 (1/1/14 to 12/31/14), the HCDOC had 10,740 commitments, 9,461 (88.1%) male, 1279 (11.9%) female. 72% of the population was represented by those individuals between the ages of 24 and 50. The population is predominantly of black and Latino heritage, with 41% of commitments being African American and 42% of commitments being of Hispanic descent. The representation of minorities in the HCDOC by percentage

exceeds the 2010 minority jail populations with 20.6 national averages for those of Hispanic descent and a 39% national average for African American inmates.

Based on annual point-in-time homeless surveys (2010, 2011), there are approximately 650 "chronically homeless" individuals in Hudson County. The Jersey City Police Department are familiar with the "chronically homeless" because they are frequently arrested for disorderly persons offenses. Although the police understand that most suffer from substance abuse and/or mental health issues, mental status exams do not support hospitalization and police cannot access substance abuse programs. As a result, they are arrested and sent to HCDOC, and most (up to 80%) return to Jersey City upon release. a steadily increasing group of substance abusing and/or mentally ill and often homeless inmates have become a chronic recidivist population, dubbed "frequent flyers" by staff.

Both the male substance abuse education and psychiatric units at HCDOC are normally full and have long waiting lists. For the last five years, 17-20% of the HCDOC population (350-400 offenders) has received psychotropic medication daily, suggesting that a significant portion of the jail's population is mentally ill. In addition, HCDOC psychiatrists estimate that 40% (140-160) of the inmates receiving psychotropic medication actually suffer from co-occurring disorders and 80% of the total inmate population suffers from substance abuse disorders. This figure is relatively consistent with the Bureau of Justice Statistics Report (BJS, 2005), which indicated that on a national level, 68% of those incarcerated in local jails meet the criteria for substance abuse or dependence.

The ACO shall receive referrals from criminal justice based entities, county corrections, parole, probation and superior court. Client release stipulations shall require compliance with ACO Intensive Case Management Services (ICMS) mandates. The ACO will also receive referrals from the various county homeless outreach centers. Enrollment in the ACO shall be predicated on chronic physical health, mental health and medication needs. Hudson County recently permanently implemented its Second Chance Act demonstration project that provides pre- and post-discharge services to a minimum of 360 male and female offenders annually. In the initial pilot, the 2010 through 2011 Second Chance program provided services to 719 inmates in 24 months of operation. Eligible individuals must: 1) have a diagnosed mental health and/or substance use disorder, 2) have been arrested, incarcerated, incarcerated and sentenced to HCDOC more than once, and 3) be a Hudson County resident. Those eligible for this program will be enrolled in the ACO.

ACO Partners and Structure

As a public private partnership, the ACO shall manage, or serve as the unifying entity, for the public and private entities currently working independently to provide services to the reentry and homeless populations. Through a formal Memorandum of Understanding (MOU) the ACO will forge partnerships with Primary care professionals, Federally Qualified Health Care Centers (FQHC), Corrections Medical Providers (CMP), community health clinics, Hospitals, IOP substance abuse treatment providers (Clinical Services which are Medicaid Billable), insurance providers and business partners.

To serve the target population, the public partner entities include:

-**County Department of Family Services**, Medicaid delivering office, public assistance and housing in the form of Emergency Assistance and Work First Training Programs, staff including Medicaid Outreach worker, public assistance outreach worker, housing or Emergency Assistance unit and community service workers who provide community case management for the reentry and homeless population.

-**County Division of Community Development,** Administrator of Federal HUD funds, Continuum of Care Funding, Homeless Alliance funding, the entity which controls affordable housing resources, provides homeless case management, coordinate the various homeless outreach centers and issue housing vouchers.

- **County Department of Corrections,** Corrections based medical provider, Bracelet Programs Reentry services, Reentry community based case management, criminal justice involved Medicaid outreach worker, health care navigator and part of the target population, therapists and a medical/mental health division who build inmate community transition plans, set in place community services, work with the aforementioned county entities to build programming.

-**Superior Court of Hudson, Probation, Parole and Diversion/Mental health courts**, Court sanctioned stipulations, Superior Court Public Defenders & Prosecutors Office).Clients will be stipulated into the program through cited judiciary based entities.

The ACO partners are then managed by a representative board.

Governance

The formal legal structure binding the partners together takes three main forms:

- A memorandum of understanding, which articulates the high-level goals of the Hudson County ACO and the nature of the partnership
- A set of business associate agreements to facilitate the sharing of data within the project
- Should the ACO becoming officially designated, the managed care contract between the New Jersey Department of Human Services and Hudson County ACO, which effectively makes all partners parties to the contract under the ACO's license with the state

ACO Board

Accountability requires integration and collaboration among providers that are currently do not have a system of open dialogue. The ACO serves as the unifying entity. As required by the MOU, the ACO will assemble a board of stakeholders and partners. The board will meet routinely to ensure services continue to be coordinated and delivered at a high level as well as establishing metrics for success. Several sub-committees shall be established.

- **Collaborative:** A leadership oversight group consisting of the Administrative team and chairs from each of the work groups

- **Operations committee:** Identified operations leads from each partner organization, focusing on practical operational issues and decision points
    - **Legal Subcommittee** examine common legal barriers and potential solutions.
- **Privacy officers work group:** Designated privacy officers of each partner organizations, who handle issues of information privacy and security
- **Analytics committee:** A group focused on data and analysis issues, including the data warehouse and electronic health record functionality
    - **Research and publication subcommittee:** A group focused on tracking and coordinating the ACO in the academic and professional literature, and seeking opportunities to answer policy-relevant research questions
- **Care model committee:** A steering group focusing on the clinical and care delivery aspects of the program, both medical and social. Includes several subcommittees:
    - Clinical and Case Management
    - Housing
    - Employment
- **Finance committee:** Chief financial officers from each partner organization and key finance staff focused on tracking finances and determining the formulas for risk-sharing and performance among the partners. Includes a budget subcommittee

Each committee shall provide reports at each board meeting.

The remainder of the work is accomplished through the time and efforts of key members of each partner organization; a series of topic-focused committees drives input, design and implementation of the Hudson County ACO.

Integrated System and Approach

As described above, the ACO is formed from many existing organizational models currently providing for a specific jurisdiction. What the models lack is a unifying entity which can motivate change resulting in better coordination and organizational expansions which allow for healthy working partnerships. The ACO shall develop a healthy blend of providers who all have the potential to have a impact of the delivery of services to the targeted population. This system starts at a coordinated entry point and connects clients to a system of community supports.

The naval building located on Hudson County Department of Corrections property shall be the point of entry for the ACO. The underpinning of the proposed model is the development of a "one-stop" agency where the client be assessed for physical health, mental health, medication, social service, public assistance and health care insurance. A holistic treatment plan shall be developed under one roof providing client's access to welfare workers, homeless outreach case management workers, Federally Qualified Health Care Center (FQHC), Intensive Outpatient substance abuse treatment (IOP) Medicaid outreach workers and health care navigators.

Plans shall be developed and clients will be linked to the network of outpatient centers in their geographical locations so that the prescribed intervention can be set in function. Each individual will be assigned a case manager to monitor compliance and make certain the interventions are delivered in a manner which ensures the greatest outcomes.

Case Management ACO Team

All ACO clients, once assessed, will be assigned a case manager, health care navigator. Navigators shall be responsible for coordinating the individuals care. The ACO team of partners shall set in place supplemental services through a combination of directly employed staff and contracted with community and government providers. Additional Services shall include,

- Social Service Case Managers (Welfare assistance)
- Medicaid Outreach Workers
- Housing Case Managers
- Hudson County Department of Corrections Community Reintegration Staff and case management
- Vocational Service Providers
- Legal Service Providers
- Probation
- Parole
- Network of Community non-profit providers

The cited added services set in place interventions which have demonstrated to be impactful in driving down the cost of delivering health care services.

Clients will be assessed for the following needs

- Transportation
- Accessibility to communication
- Nutrition,
- Physical health
- Learning Aptitude
- Housing
- Social Supports
- Depression/Mental Illness
- Alcohol/Drug Dependence
- Legal issues
- Financial issues
- Work
- Medications
- Readiness to Change

Triage, One Stop Service Destination

ACO Intensive Case Management Services (ICMS) workers will assess clients' need, refer to in-house Medicaid Outreach worker for health insurance enrollment, Public Assistance intake worker to determine eligibility for Case Management and eligibility for Emergency Assistance (housing) and schedule an immediate appointment to expedite activation of cited benefits. ACO ICMS worker will refer client to in-house FQHC so that a health care treatment plan may be developed. Work First New Jersey (WFNJ) based training and employment search programs shall also be offered in-house.

Community Based Services

After the assessment and evaluation of need is completed at the naval building ACO ICMS will link clients to specific community based social service, housing, clinical and legal services. Prior to enrollment in the ACO a clients will undergo a complete needs and health assessments, using all relevant information gathered from partners, at the one stop destination . From the assessment will emerge a community plan for each ACO enrollee.

ACO case managers shall introduce clients to the system of community care. Jail, family service and community development case management services will be used by the ACO in order to remove barriers so the potential for compliance with treatment remains high.

Case Study: Functioning ACO Hennepin County Financial System

ACOs around the country have demonstrated clear success in both raising the quality of care and producing financial savings. Programs enrolling approximately 50 to 70 thousand beneficiaries save on average over $10million annually. One such example, Hennepin Health—a county-based ACO in Minnesota—has forged such a partnership to redesign the health care workforce and improve the coordination of the physical, behavioral, social, and economic dimensions of care for an expanded community of Medicaid beneficiaries. Early outcomes suggest that the program has had an impact in shifting care from hospitals to outpatient settings. For example, emergency department visits decreased 9.1 percent between 2012 and 2013, while outpatient visits increased 3.3 percent. An increasing percentage of patients have received diabetes, vascular, and asthma care at optimal levels. At the same time, Hennepin Health has realized savings and reinvested them in future improvements. Hennepin Health offers lessons for counties, states, and public hospitals grappling with the problem of how to make the best use of public funds in serving expanded Medicaid populations and other communities with high needs.

The alignment of financial incentives across the hospital, outpatient clinics, social services and public health has been integral to Hennepin Health's success. The price of component services is no longer the focus of the entities' business relationships; moving away from fee-for-service reimbursement means, for example, that fewer hospitalizations no longer represent lost revenue to the hospital.

Hennepin Health receives per-member, per-month capitation payments from the Minnesota Department of Human Services for enrolled members. The funds are managed by Metropolitan Health Plan (MHP), which operates as the program's administrator on a fixed percentage of revenue. Hennepin Health partners have agreed to a risk-sharing arrangement that shifts the remainder of the financial risk toward provider partners and dictates how gains and losses will be distributed. Provider partners continue to submit claims and are paid through contract relationships with Metropolitan Health Plan. Funds remaining are distributed back to the partners and into the system. Like other Medicaid managed care contracts in Minnesota, Hennepin Health has a percentage of its revenue withheld. Its return depends on improvement on a number of quality measures. These withhold measures are unique to Hennepin Health's population and are Healthcare Effectiveness Data and Information Set measures calculated by the Minnesota Department of Human Services.

The margin left over at the end of each contract year is used in two ways:

Direct distributions to individual partner organizations based on formulas that reflect each partner's relative size and agreed-upon performance measures.

Reinvestment initiatives to drive further system improvement. Hennepin Health staff identify and formally propose these reinvestment projects to the program's Operations and Finance committees, which determine the initiatives that will be funded. Projects are expected to have a short-term return on investment and measurable outcomes, which are used to determine whether funding will continue beyond an initial one-year period. Examples of reinvestment initiatives include:

- Leasing transitional housing units for medically complex homeless patients as an alternative to hospitalization
- Offering vocational services for high-cost behavioral health patients
- Developing a sobering center, to reduce inappropriate emergency department use by chronic inebriates

Collective reinvestment

The Hennepin Health finance model's mix of direct financial incentives for partners and shared reinvestment projects has created a space and resources for new ideas to incubate and be tested. Reinvestment initiatives also allow the partners to invest in longer-term system changes that will be important for the program's long-term success, as their financial and quality benefits may take time to accrue.

Balance of incentives

The finance model ensures that Hennepin Health is not inappropriately limiting access or adversely affecting quality of care. Externally, quality incentives come from our contract with the state Medicaid agency. Internally, incentives come through self-imposed quality goals that determine the incentive money distribution.

Financial Reporting

Within the confines of managed care, it can be difficult to know how best to capture how dollars are flowing through the system and affecting patients in the process of care delivery reform. For example, use of community health workers in the clinics could be accounted for in at least three different ways, each with very different regulatory implications. They could be

- Funded directly from capitation revenue and reported as an administrative cost

Billed through claims and reported as medical cost

Funded through reinvestment dollars and reported as margin from a prior year

Financial Incentives

The ACO, working with the health care insurance field, develops bench marks based on expected health care expenses in the targeted population. The ACO enters into an agreement which aims to slow spending growth, and raises the quality of care by incorporating holistic services which in turn drive down costs. When ACO cost savings are generated they are distributed to the stakeholders as per the MOU and placed in a reinvestment fund to provide capital for further improvements and preventative cost saving interventions.

ACOs are **accountable** to increasing the quality of life within the community and to the stakeholders. ACOs must have a sound **legal structure,** a series of binding MOUs and a governing board which measures progress and makes improvements to the delivery system as needed. **Primary Care** in an outpatient setting must be the focus; supports are set in place to deal with what have been traditionally barriers to justice compliance and/or preventative measures within the health care network. **Shared Savings** ACO partners and providers must share in the savings, opportunity for providers to share in the savings creates incentive and increases the efficacy of the multisystem approach.

GOAL

The intention of an ACO is to develop programming which provides stabilization across all domains in order to improve health outcomes and the quality of care. Through defining the target population-- persons experiencing homelessness and the criminal justice involved-- patient focused aims are defined, a higher quality of care can be provided, and baseline health care costs can be decreased.

The ACO provides the clinical providers a support system where treatment protocols can have the greatest positive impact. Adherence to educational, vocational, case management, legal stipulations and housing programs are proven to be more successful within this model. Success can be measured and provides fiscal burden relief across numerous fields (Public Assistance, Corrections, Judiciary, Law Enforcement, housing programs and health care).