Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

Mental Health Association in Orange County, Inc. (MHA) has provided quality services to Orange County (OC) residents with mental illness, developmental disabilities and sexual assault victims and their family members since 1958. Some of the agencies' primary services began with the initiation of our 24-hour Helpline which provides crisis intervention, information and referrals as well as the Rape Crisis Services Program offering both hotline and in-person advocacy and support. Other recognized services and supports are Care Coordination, Medicaid Service Coordination, Vet2Vet, Family Support, Compeer Services, Supported Housing to name a few. MHA seeks to promote the positive mental health and emotional well-being, working towards reducing the stigma of mental illness, developmental disabilities and providing support to victims of sexual assault and other crimes. In partnership with service recipients, families, volunteers and the community, MHA strives to fulfill its mission through culturally competent advocacy, direct services, public education, and responsiveness in times of community emergency. The MHA family shares a system of values and behaviors that recognizes and respects the presence and contributions of all diverse groups. We believe that every person is to be treated with dignity, respect, compassion, and acceptance. MHA has been designated as a safety net provider by NYS OMH and NYS OPWDD. As a result, MHA has signed Master Services Agreements and is actively engaged with all 3 regional Performing Provider Systems (PPS) implementing DSRIP (Delivery System Reform Incentive Plan) in Orange County. MHA is regionally connected to two Health Homes. MHA attends and is an active participant of the JMHCA Supervisor/Care Manager meeting held each month to learn about Health Home updates and network with other Health Home service providers. Finally, MHA serves on multiple regional and local committees (i.e. WELCOME Orange) and is actively involved in the healthcare transformation initiatives throughout the county.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

In Orange County, NY, the Delivery System Reform Incentive Payment Program (DSRIP) along with a funding opportunity through the Montefiore Hudson Valley Collaborative (MHVC) Innovation Fund inspired six Health Home Care Management Agencies, and a local hospital to think creatively about how they might build on their existing collaboration and utilize existing resources in a new way to improve the collective health of the Orange County community.

Problem Statement:

1. Hospitals throughout New York State have limited resources to engage patients in the Emergency Room.

2. The New York State (NYS) Health Home Program in Orange County has been operational since April 2013. The state-wide enrollment rate sits at about 20%. Health Home Care Management Agencies across New York struggle with locating and engaging patients identified as potentially eligible by NYS and/or regional Managed Care Organizations. Contact information is often inaccurate and many patients deemed as eligible are disconnected from ambulatory care, leading to multiple avoidable presentations at the Emergency Room Department.

Innovation Description:
Targeting patients who are high risk, high ED utilizers, this-project aims to decrease unnecessary ED, inpatient visits and readmissions, and improve the rate of enrollment for Health Home eligible patients.
The project aims to address identified service gaps in the delivery of care management services as outlined below:

1) Access to Care Management Service -At St. Luke's Cornwall Hospital Emergency Department (ED), provide full access to care management services eight hours a day, five days a week and after-hours response follow up
   - This is being accomplished through a mutually developed rotating schedule where staff from the 6 Orange County based Care Management agencies are co-located in the ED.
   - Additionally, an Innovations Coordinator has been hired to manage the schedule and tracking of data relative to the project including distribution of after hour referrals for follow up.

2) Development and delivery of Standardized Care Management Education
   - Hospital staff have been trained on the role of Health Home Care Manager and to make referrals as appropriate.
   - Hospital staff are utilizing a standardized social determinants of health screening. Patients with identified needs are connected to a Health Home Care Manager to be further assessed and referred for services.
   - Although Health Home services are only available to the Medicaid population, many Orange County Care Management Agencies have capacity to provide care management and/or direct services to other populations using alternate funding sources.
   - Care Managers across six agencies have agreed to participate in standardized trainings.

Relevance to the Medicaid population:

This collaborative innovation helps the Medicaid population by making connections to community resources that are more appropriate and less costly than the ED, by introducing and engaging (eligible) patients in Health Home Care Management and connecting those who are already enrolled into the program, meaningfully back into care.

Feasibility:
This success of this project is contingent on buy-in from key stakeholders. In Orange County all 6 CMAs were responsive to being part of the rotating schedule at St. Luke's Hospital and to respond to referrals received after hours and on weekends. Partner organizations offered in kind support and commitment to participate in the on- site trainings at St. Luke's Hospital to discuss the role of a care manager and other resources available in the community for individuals that utilize the ED for non-medical related issues. For example, peer specialists, recovery coaches, housing case managers, etc. Additionally, key service providers trained in specialized core competencies have agreed to provide in kind support through offering their trainings for free, i.e. Mental Health First Aid, Cultural

Competency, Stages of Change, Defensive Driving, ASIST (Applied Suicide Intervention Skills Training), Engagement Strategies, Concurrent Documentation, SBIRT (Screening, Brief Intervention and Referral to Treatment), Motivational Interviewing, Brief Action Planning, Health Literacy to name a few. More importantly, each CMA understands that an essential part of the project is to ensure their care managers are scheduled for the standardized trainings and complete the core competencies within a specified time frame. Finally, each stakeholder represents a community resource that is dedicated to the individuals we serve. We have all committed to enhancing care management services in Orange County to reduce preventable ED visits and avoidable inpatient admissions.

Speed to market:
This collaborative model can be implemented relatively quickly. As described above, our model was operational within 3 months of receiving funding.

Scalability:
This model of co-location and education can easily be replicated across Orange County and other Counties in New York State. While the start-up funding provided by the MHVC Innovation Fund supported the curriculum development, the development of a CMA schedule, and the opportunity for Orange County partners to think outside of the box, (by incentivizing multi-stakeholder collaboration) this model intends to be fully sustainable utilizing existing state and local resources.

Return on Investment:
MHVC provided technical assistance to guide us in thinking about ROI for this intervention.
Below are the measures of success currently being tracked:

1) Health Home Enrollment Rate – Current enrollment rate compared to Statewide average
a. Total # referrals received, #of assessments completed, # screened eligible, # enrolled (Conversion rate = # eligible/#enrolled)

2) Connection to Care Manager for patients enrolled in the Health Home Program
a. # Individuals that are enrolled in a Health Home connected to proper CMA for reengagement and follow up.

3) Connection to SDH Services
a. # assessed, # referred for services

4) Post engagement utilization (for all cohorts)
The project intends to demonstrate a decrease in the number of ED visits for patients enrolled/meaningfully connected to a HH CMA.

Currently the six Care Management Agencies are working collaboratively to determine the # of enrollments needed to sustain the co-located staffing model with existing funding.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	Yes (please specify when and the estimated number of people impacted): The Innovation Project was funded in October of 2017 and the first three months were spent operationalizing logistics of co-location, and supporting workflow development and training. Care Managers were actively co-located in the ED by mid-December. Up to March 31, 2018, 576 referrals have been received by CMAs during their working hours at the hospital (11:00am-7:00pm Monday through Friday). A total of 458 social determinant of health assessments have been completed with appropriate referrals made and 49 resulted in participants being enrolled in a Health Home program. Additionally, 140 individuals were identified as Health Home enrolled upon presentation at the ED and referred back to their CMAs for reengagement and follow up. Furthermore, after completing the assessments, only 218 individuals were eligible for Health Home services. Ultimately, the project has resulted in a 22.48% enrollment rate. Pre and post engagement utilization for each of the cohorts described above will be completed.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Education,** **Social and Community Context ,** **Health and Health Care**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**