Evolution of Care Management
PANEL DISCUSSION

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• Deborah Salgueiro, Executive Director, NYCCP/HHUNY
• Christine Mack, Peer Engagement Specialists, HHUNY
• Josh Minick, Peer Engagement Specialists, HHUNY
• Christine McKinley, MC Collaborative
• Andy Carey, MC Collaborative

• Moderated by Mary Zelazny, CEO, Finger Lakes Community Health
Care Management
Health Care Transformation

Peter Bauman,
Director of Health Home Operations, GRHHN
Care Management Role in Health Care Transformation

- MRT Initiatives
- Impact on Value-Based Care
- "Care Management for all"
- Addressing Social Determinants of Health
CM Infrastructure Support

Understanding the Value of Care Management

- DSRIP Projects
- Initiatives that supported CM activities
- Community Collaboration
- Focus on VBP Readiness (Measuring Performance)
- Transformational
FLPPS System Transformation

PROJECTS BY NOCN REGION

Southeastern
Arnot Health – Hospital to Home

Monroe
Cameron Community Ministries
Center for Youth – Safe Harbor
Greater Rochester Health Home Network (GRHHN)
Health Homes of Upstate New York (HHUNY)
His Branches – Socks Room
Lifespan
RRH – Community Health Worker Conversion
Samaritan Center for Excellence
YMCA
YWCA – Health Home Case Manager
YWCA – Cultural Competency Coordinator

Finger Lakes
Ontario ARC – Managed Care Specialist
Wayne County Action Program

Southern
Ardent Solutions
Canisteo Valley Family Practice – Clinical
CareFirst NY
Catholic Charities of Stuben
Community Action for Wyoming County
Tri-County Family Medicine

Partner organizations in each NOCN
Provider Break Down

20 System Transformation projects involved Care Management activities

- **CBO Categorization** - 14 Projects
- **Health Home Categorization** - 2 Projects
- **Health System Categorization** - 2 Projects
- **Primary Care Provider Categorization** - 2 Projects

8 System Transformation projects involved Care Management activities.
Transforming Practice through Care Management

Deborah Salgueiro, MSW
Executive Director, NYCCP/HHUNY
## Care Manager Role

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assure</td>
<td>Assure members are receiving needed services</td>
</tr>
<tr>
<td>Educate</td>
<td>Educate member on key issues related to their chronic conditions and importance of regular health care</td>
</tr>
<tr>
<td>Motivate</td>
<td>Motivate clients to become active participants in their own care</td>
</tr>
<tr>
<td>Partner</td>
<td>Work in partnership with providers</td>
</tr>
<tr>
<td>Coordinate</td>
<td>Coordinate services effectively (transportation, schedule appointments)</td>
</tr>
<tr>
<td>Advocate</td>
<td>Advocate on behalf of members</td>
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</table>
Driving Transformation

Immersive Training focused on:

• Engaging clients in investing in their own health and well-being
• Understanding chronic illness (both medical and behavioral) and its impact
• Understanding Value Based Payment and Care Manager’s role in a Value Based Payment System
• Understanding Gaps in Care
• How to effectively build a ‘Care Team’
• Building relationships with medical and behavioral health providers
• Using Tableau Dashboards for data to drive practice
Driving Transformation

Organizing forums to enhance collaboration:

• Fostered opportunities for practice managers and care managers to meet and discuss opportunities for collaboration
• Promoting new approaches to assigning cases
• Forums for care managers to meet Peers and gain understanding of their role
• Meetings with discharge planners to facilitate transitions
• Incorporating Peers for support during ‘high risk’ transitions
How CMAs are working differently

- Increased understanding of chronic conditions and implications of ‘gaps in care’
- Increased strategies listed in a Member’s Plan of Care to address identified Gaps
- Increased partnership with providers
- Increased understanding of potential role and benefits of Peer engagement
- Understanding of the role of CM as ‘health coach’ and ‘motivator’
- Increased understanding of how to use data to inform practice
The Number of Gaps Closed during Grant

Gaps Closed YTD (Cumulative) for all 4 Measures

Targeted Gaps
- Diabetes monitoring
- Diabetes screening
- 7 day follow up
- 30 day follow up

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<tr>
<th>Gaps Closed YTD</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<tbody>
<tr>
<td>Gaps Closed YTD (Cumulative)</td>
<td>27</td>
<td>70</td>
<td>125</td>
<td>160</td>
<td>257</td>
<td>313</td>
<td>387</td>
<td>448</td>
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<tr>
<td>Gaps closed YTD as %</td>
<td>16%</td>
<td>30%</td>
<td>41%</td>
<td>53%</td>
<td>64%</td>
<td>70%</td>
<td>80%</td>
<td>77%</td>
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Lessons Learned

• Care managers can serve a key role in closing Gaps in Care and improving the members’ engagement in care.
• Care Managers welcome Peer engagement when they have true understanding of the potential benefits and role of Peers to support members to engage in treatment and overcome personal barriers.
• Care Managers can drive the formation of the member’s ‘Team’ and facilitate coordination of care.
• Contacting Primary Care Providers and Mental Health providers directly significantly reduces the time it takes to close gaps.
Lessons Learned

• Peers can have a significant impact on client engagement

• Peers support members in overcoming personal barriers that interfere with their health and well being

• Peers serve as ‘living proof’ of recovery

• Peers working hand in hand with care managers can maximize positive outcomes
NOCN Initiative
Homeless Outreach Project
Christine McKinley
Andy Carey
12 Month Homeless Outreach Program

- Engagement Specialists – provided navigation/referral, eligibility, and linkage for homeless individuals,
- 5,000 hrs of outreach, 692 individuals served

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>#</th>
<th>PROVIDER NAMES</th>
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<tbody>
<tr>
<td>Shelters</td>
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<td>House of Mercy, Dimitri House, St. Joseph’s House of Hospitality, Open Door, RAIHN, REACH, Salvation Army Booth Haven</td>
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<td>Outreach Location (non-shelter)</td>
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<td>Asbury, St. Joseph’s Neighborhood Center, Dimitri Lunch Program, LROC, AME Zion, Cameron Ministries, Peace Village, Memorial AME Zion Church</td>
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<td>Primary Care Providers</td>
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<td>Health Reach for the Homeless, Antony Jordan, RRH, Strong</td>
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<td>Other Health providers</td>
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<td>GRHHN/HHUNY CMAs, Open Access, RRH Psychiatric Urgent Care at St. Mary’s</td>
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Dashboard Example

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<thead>
<tr>
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<th>Service Needs Name</th>
<th>HARP Status</th>
<th>HH status post referral</th>
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<td>(All)</td>
<td>(All)</td>
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<tr>
<td>MCCOVE</td>
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<td>Public Benefits</td>
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<td>Patient Navigate to PCP</td>
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<td></td>
<td>Mental Health</td>
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<td>Transportation</td>
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<td>Substance Abuse</td>
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<td>Other</td>
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<td>17</td>
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# Summary of High Utilization by Shelter stay

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<tr>
<th>Measure</th>
<th>2+ER BH Visits</th>
<th>2+ER Medical Visits</th>
<th>2+ER MH Visits</th>
<th>2+Inpatient_Medical Visits</th>
<th>2+Inpatient-BH Visits</th>
<th>2+Inpatient-MH Visits</th>
<th>4+Inpatient/ER-BH Visits</th>
<th>4+Inpatient/ER-Medical Visits</th>
<th>4+Inpatient/ER-MH Visits</th>
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<td>50</td>
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<td>House of Mercy</td>
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<td>No Response Needed!</td>
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<td>1</td>
<td>2</td>
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<td>Salvation Army - Booth Haven - Emergency</td>
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<td>1</td>
<td>4</td>
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<td>St. Joseph’s House of Hospitality</td>
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<td>VOA - The Guest House</td>
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</table>
Focusing on data – helps to inform practice
  ◦ Helped MC Collaborative get people reconnected with HHCM
  ◦ Can help inform providers where their hard to reach clients are staying (shelters) or going (outreach locations)
  ◦ Could inform where embedded CM’s are needed
  ◦ Shows the focus of needs for individuals who are homeless
Results

Of the 692 encountered

391 were eligible for HH and were not enrolled

109 individuals were enrolled in HH as a result of our intervention

28% of individuals were engaged in a HH
Primary Care Access Data

55 individuals identified linking to a primary care provider as a need

8% were linked to primary care

90% had difficulty engaging in primary care
Lessons Learned

Relationship – Consistently seeing the individual, demonstrating reliability helped to engage the most difficult to engage clients.
  ◦ Started following to sites they knew we would be at.

  - Care management isn’t perfectly designed to assist this population – with the rigid guidelines of HH CM. Need more flexibility in services to assist this population. There are more immediate needs that need to be addressed.

  - The systems – silos and variety of requirements make assisting this population very difficult.

Primary Care Access – booking months out does not work with this population
Accessing Housing – Extremely difficult due to requirements