HEALTH PLANNING COUNCIL ADVISORY BOARD
Joint with the Tompkins Health Network Board
Rice Conference Room, TC Health Department
March 14, 2016

"Care Management: A Look into Health Homes in Tompkins County"

(excerpt from meeting notes)

***Scott McCown**, Program Director of Tompkins County Mental Health Services Care Management*, began the presentation by providing background on care coordination services in New York State. Earlier programs included intensive case management, supportive case management, and others. These programs help targeted population with by coordinating access to needed medical, social, behavioral, and other services that promote independent living in the community. Around 2012, the health home model was introduced for additional Medicaid beneficiaries to address high Medicaid utilization and expenses among populations with multiple health care needs.

Scott cleared several misconceptions he hears about health homes:

- Health homes are not a physical structure;
- Health homes are not affordable housing;
- Health homes are not home health aide programs

Health homes provide care management for a broad range of services that include traditional health care, behavioral, and substance abuse services as well as for social services like housing, educational needs, community supports. Care is person-centered and address all needs based on a mutually developed care plan that is shared with the client's providers. Each care coordinator may work with 20 to 40 clients whereas in earlier case management programs, the ratio of clients was lower.

Stephanie Flash, *Health Homes Senior Care Manager at Southern Tier Care Coordination*, outlined the process for eligible individuals to participate in homes.

1. **Outreach and engagement** – Eligible individuals include Medicaid recipients who must meet one of the following conditions: (i) two or more chronic health conditions like asthma, diabetes, heart disease; or (ii) one single qualifying condition of either a serious mental illness; or HIV/AIDs. Individuals may be dual Medicare/ Medicaid eligible, or enrolled in a managed care plans. The Department of Health and/or the managed care organization sends lists of potential health home clients. They also receive direct referrals from providers or from the community. Referral clients are contacted within 24 hours. Care managers are expected to reach out to individuals on the list by phone or visits at their home for at least 3 months. They can then take a break from outreach and try for an additional 3 months.
2. **Intake and enrolled client work flow** – Intake involves verifying diagnoses, consents, and an initial needs assessment (state mandated assessments, prioritize client goals). The NYS Health Department consent form (DOH 5055) allows them to communicate with the client's listed providers. HealtheConnections, based in Syracuse, is the regional health information organization (RHIO) that provides electronic access enabling further data sharing and hospital/ health information for the client. Both Cayuga Medical Center and Cortland Regional Memorial Hospital participate in the area health information network.
3. **Five core services** – are provided for the enrolled client:
   i) *Comprehensive care management*- Care plans involving providers and family, Crisis Plans, 6-month Care/Crisis Plan reviews, yearly assessments
   ii) *Care coordination and health promotion*- Coordinating with physical and mental health providers (PCPs, counselors, specialists, insurance, medication, transportation, etc.)
   iii) *Comprehensive transition care*- Working with hospital's staff and discharge planners to avoid re-admissions (follow up appointments with providers, medication reconciliations)
   iv) *Patient and family support*- Including family in Care Plan, consult with family on advance directives/health care, refer client/family to supports/services
   v) *Referral to community and social support services*- Anything related to housing or non-medical social supports; SNAP, TANF, SSI/DI, housing, etc.

- At least monthly contact providing one core service, often more depending on the client and their goals
- Goal is to help clients obtain self-sufficiency, if discharged can always easily re-enroll. While several clients are able to reach a level of independence, others are care managed for years.

4. **Concerns and barriers we see** – When clients were transferred from Targeted Case Management to care coordination, caseloads increased substantially to 40-50. This increased caseload requires more documentation and a greater focus on referrals and coordination as opposed to providing direct services. Other barriers include: limited affordable housing, difficulty locating clients as many do not have phone access or are homeless, gaps in mental health/ substance abuse treatment options, or limited providers, particularly when a client had "burned their bridges" with a practitioner.
5. **Positive outcomes and benefits** – Health homes do have many advantages over the former case management system including: (i) the ability to serve a larger population; (ii) the ability to meet goals of improved health outcomes and quality of life (while reducing hospital re-admissions and improper Medicaid usage); (iii) being person-centered and meeting clients were they are, at the center of 'care-planning'. Fortunately, Tompkins County is characterized by strong working relationships among providers and local organizations that are willing to work together on behalf of the client.

Stephanie and Scott fielded many questions from the audience covering:

- Number of staff - TC Mental Health has eight full time care coordinators while the Southern Tier Care Coordination has four. Southern Tier Care Coordination serves both Cortland and Tompkins.
- Community referral process – the individual who is the subject of the referral must sign the release and forms are then sent to Health Homes of Upstate New York. Contact is made within 24-48 hours.
- Age – 18+, including those 65 and over can participate in health homes; health homes for children will start in September (not at STCC).
- Ratio of clients to care coordinator and how can needs be adequately addressed – case loads are balanced for acuity levels so that several clients may have fairly low needs and others require more attention. This is definitely a balancing act for the coordinator.
- Outreach lists – are sometimes out of date with inadequate information. Letters sent by NYS Health Department are difficult to interpret by the client.
- Overlap with Adult Protective Services – often there are referrals between this department and health homes.
- Physical locations – Mental Health Department is located on Green Street, and Southern Tier Care Coordination is located in the former Planned Parenthood space.
- Qualifications to be a care coordinator – civil service, if TC Mental Health. For STCC, a four-year degree in a related field, or a two year degree with two years of experience.
- OPWDD related individuals and are they eligible? – it was thought that OPWDD has its own care management type of program

Items Distributed: Health Homes of Upstate New York brochure; Health Homes Community Referral Process; Eligibility Criteria for Health Home Services; HHUNY Information for Providers