New York Health Homes Learning Collaborative

CHCS Center for Health Care Strategies, Inc. | NEW YORK state department of HEALTH | NYS HEALTH FOUNDATION

Session Title: Client Assignment & Engagement

Initial Questions	• How do you assign patients to care managers? What is working well and where are the challenges? • Once a patient is assigned to a health home, how does the lead agency determine which network partner manages which clients? • What is the role of the lead agency in managing and tracking the assignment process? • How do you keep track of and share information about assignments with network partners? • How are health homes working to remain both patient-centered and equitable among partners when assigning patients for care coordination? • Beyond assignment, what strategies are being employed to effectively locate and engage clients in care?
HH to Begin Conversation	• Rosemary Cabrera, Community Healthcare Network • Colleen Florio, Adirondack Health Institute

Key Issues	• Accuracy of data from patient lists provided to health homes requires numerous rounds of "data scrubbing"
	• Some key challenges include:
	  ○ Some patients deceased
	  ○ Some come with a code 35 but it's not shown which case management provider they are linked to (SDOH says this should not happen on future lists)
	  ○ Some patients are already consented into another Health Home
	  ○ Some patients are out-of-catchment area
	• Health Homes are having to put in a lot of time up-front to scrub lists before beginning with engagement
	• PMPM rates are too low to support travel costs required for patient engagement in rural areas

Best Practices	• Develop DEAAs with all network partners to cross-reference lists against their registry of consumers • Link to DOCs and Homeless Services to locate patients • Link with Office of Vital Records to remove names of deceased patients • Using outreach teams that specialize in engaging patients and ONLY do outreach • Track return mail to record incorrect addresses • Don't need to rely solely on lists for patients- HHs can be proactive about recruiting eligible patient through bottom-up referrals

Follow-Up Opportunities or Questions with Action Items	• Training staff on PSYCKES
	• Could assignments be made at the beginning of the month to give providers more time to conduct outreach?
	• What role can support housing providers play in helping find and engage providers?
	• Develop relationships with local hospitals to receive alerts on hospitalizations
	• Continues to be confusion around TCM services versus health home services
	  ○ Many legacy patients have been assigned to multiple health homes
	  ○ Need better messaging from DOH and AIDS Institute
	• Some useful data points could include:
	  ○ Percent of assigned patients successfully located
	  ○ Percent of patients enrolled once found
	  ○ State level data on time it takes to engage
	  ○ Percent of patients found through referrals versus assignment list

Additional Comments	• Consensus that the data scrubbing is more time consuming and costly than anticipated. In fact many health homes have to conduct multiple rounds of data scrubbing to get accurate information • Need to improve linkages with other social service providers to track patients more effectively