Outreach and Engagement Strategies

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HRHCare
COMMUNITY HEALTH

Agenda

+ Background
+ Population of Focus
+ Outreach Approach
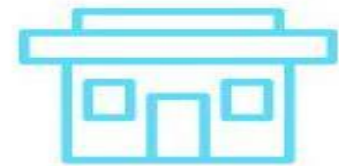+ Challenges

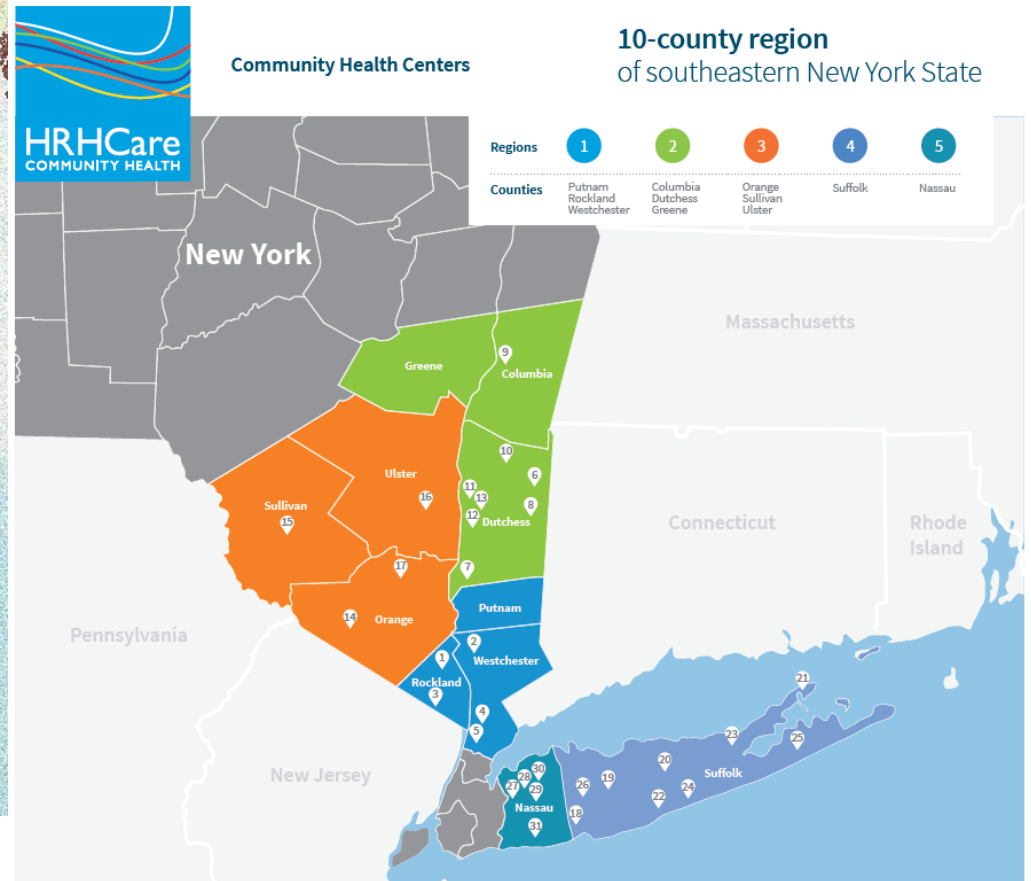# HRHCare Overview

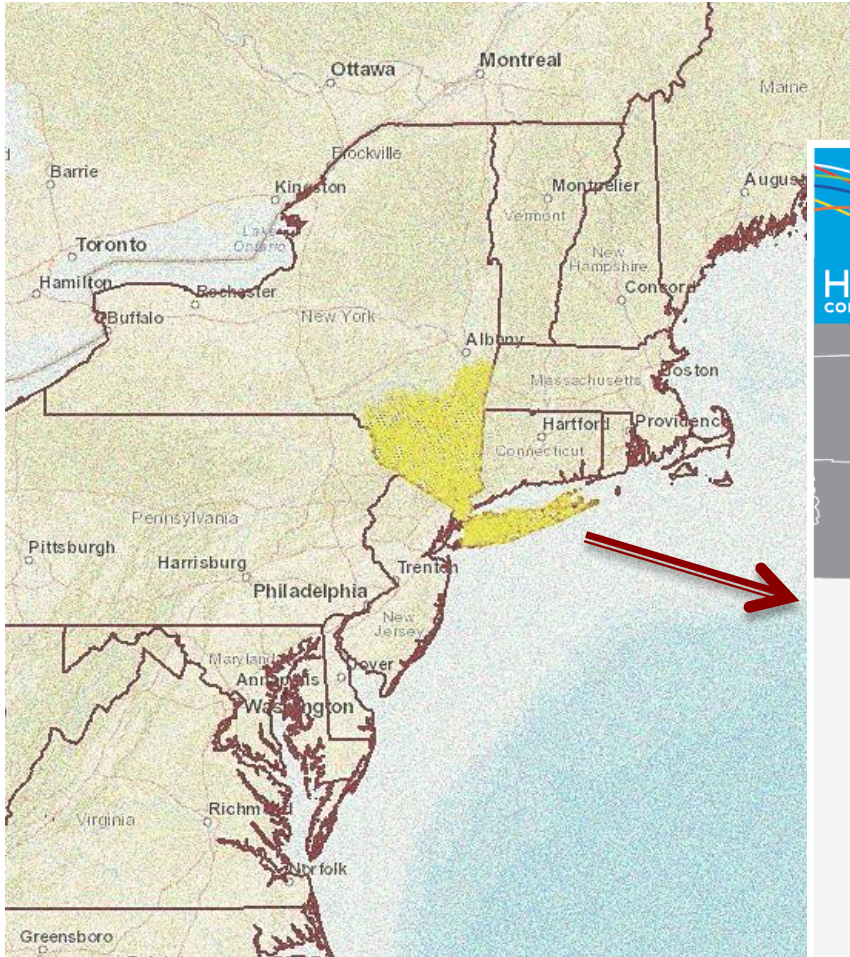## 150,000 Patients

1,200 employees

500,00 visits annually

36 locations

Payer mix – 44% Medicaid and MA HMO, 7% Medicare; 34% Uninsured; 9% Commercial; 6% other public

Service Area

Services Offered

Medicine

- Family Practice
- Pediatrics
- Internal Medicine
- Prenatal and OB
- Gynecology
- Family Planning
- HIV Primary Care
- Immunizations
- Well Child Visits
- Cancer Screening
- Lab Services

Specialty

- Podiatry
- Optometry
- Cardiology
- Telederm

Behavioral Health

- Counseling
- Substance Use Disorder Treatment
- Suboxone Treatment

Dentistry

Health Home Care Management

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# Strength through Partnership

Healthcare Landscape in New York

- Seeing a lot of consolidation among hospitals as well as among health plans
- NYS DSRIP initiative has further spurred this on
- NYS has set a goal of having 80-90% of Medicaid payments made under value-based arrangements by 2020 and has developed a Value-Based Payment Roadmap to guide this transition.
- Models for integrated primary care and behavioral health being promoted and state and national levels.

Realizing we are stronger *together.*

+ More influence.

+ Leverage and build upon existing resources.

+ Share in investment in additional capacity and infrastructure.

+ Offer a contracting alternative that is grounded in community-based primary care and behavioral health.

Establishment of CBHCare IPA

CBHS

HRHCare

Collaborative of 9
(grown from 7)
behavioral health
providers

CBHCare
IPA, LLC

Primary care
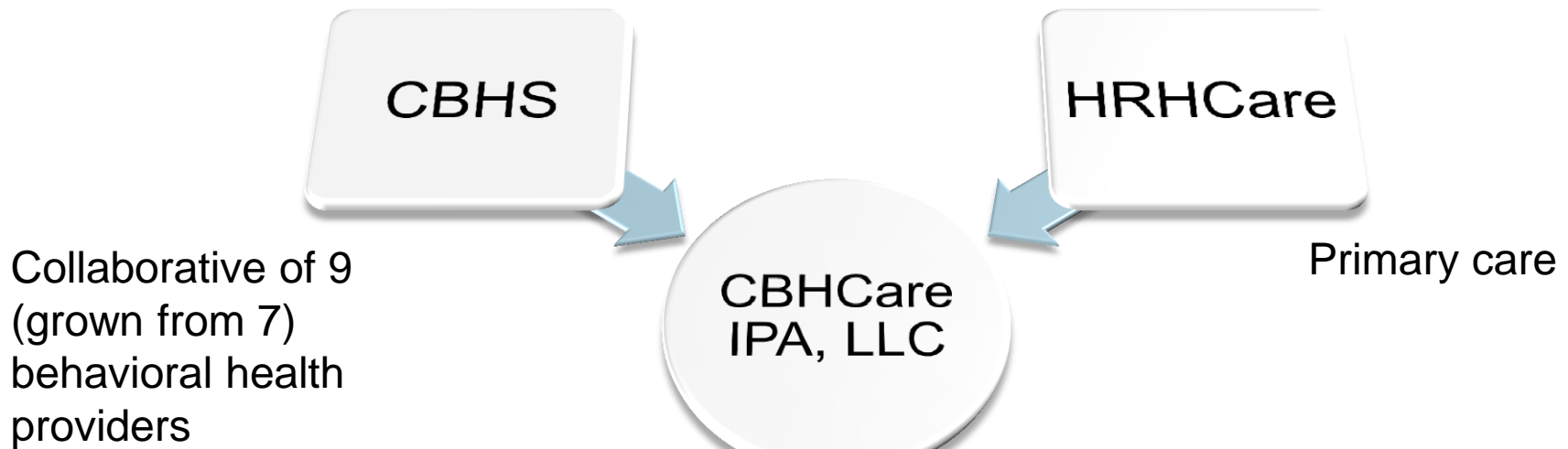
Spent a little over 1 year
establishing the legal and
governance structure
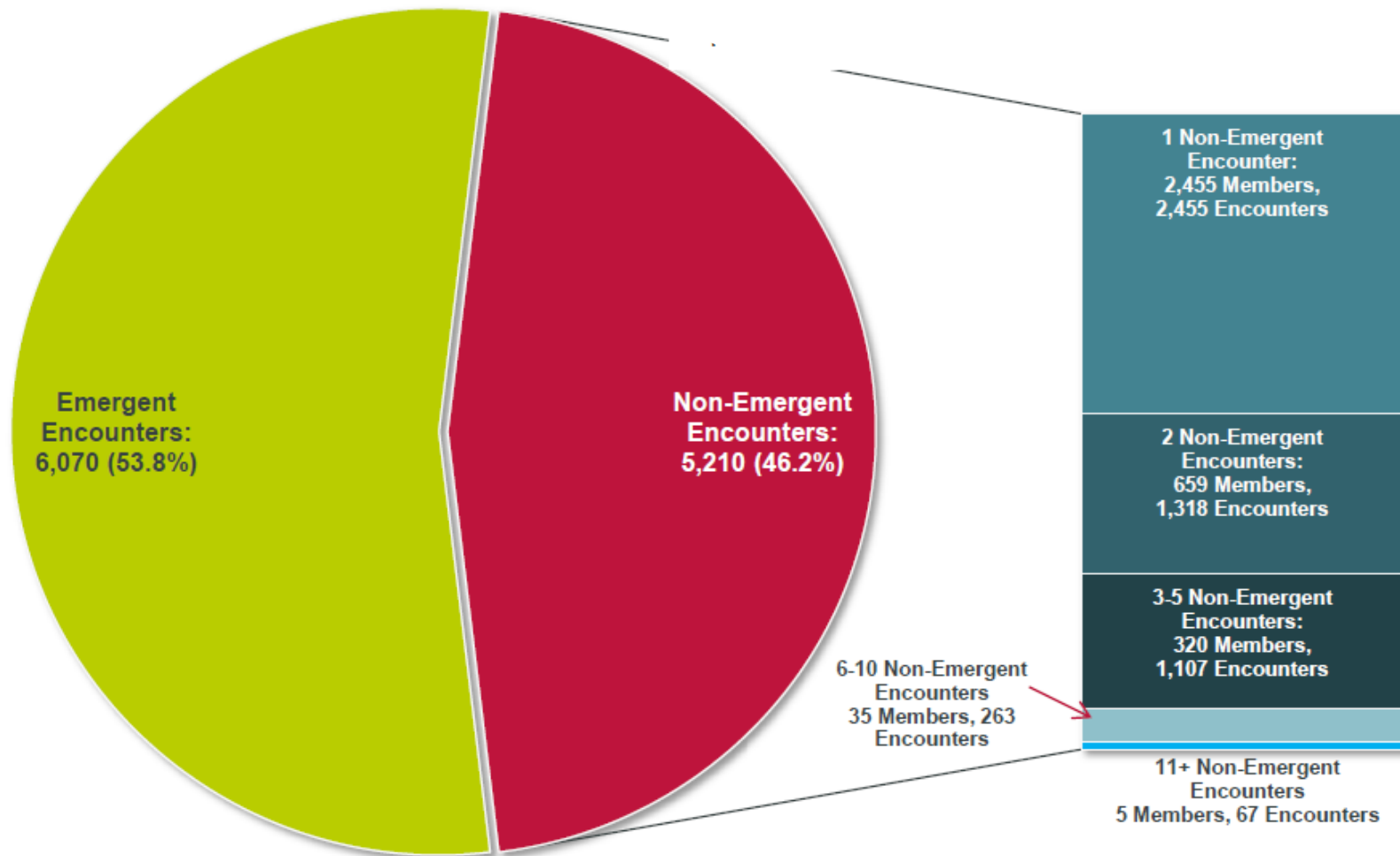
Taking First Steps toward Value-Based Contracting

+ First arrangement focused on (among other things) avoidable use of Emergency Department

+ Have stood up a care management program to address individuals with exceptional Emergency Department utilization.

Population of Focus

Population of Focus

Number of Emergent and Non-Emergent ER Encounters, Calendar Year 2015

Emergent Encounters: 6,070 (53.8%)

Non-Emergent Encounters: 5,210 (46.2%)

1 Non-Emergent Encounter: 2,455 Members, 2,455 Encounters

2 Non-Emergent Encounters: 659 Members, 1,318 Encounters

3-5 Non-Emergent Encounters: 320 Members, 1,107 Encounters

6-10 Non-Emergent Encounters 35 Members, 263 Encounters

11+ Non-Emergent Encounters 5 Members, 67 Encounters

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Population of Focus

Non-Emergent ER Encounters by Top Diagnoses
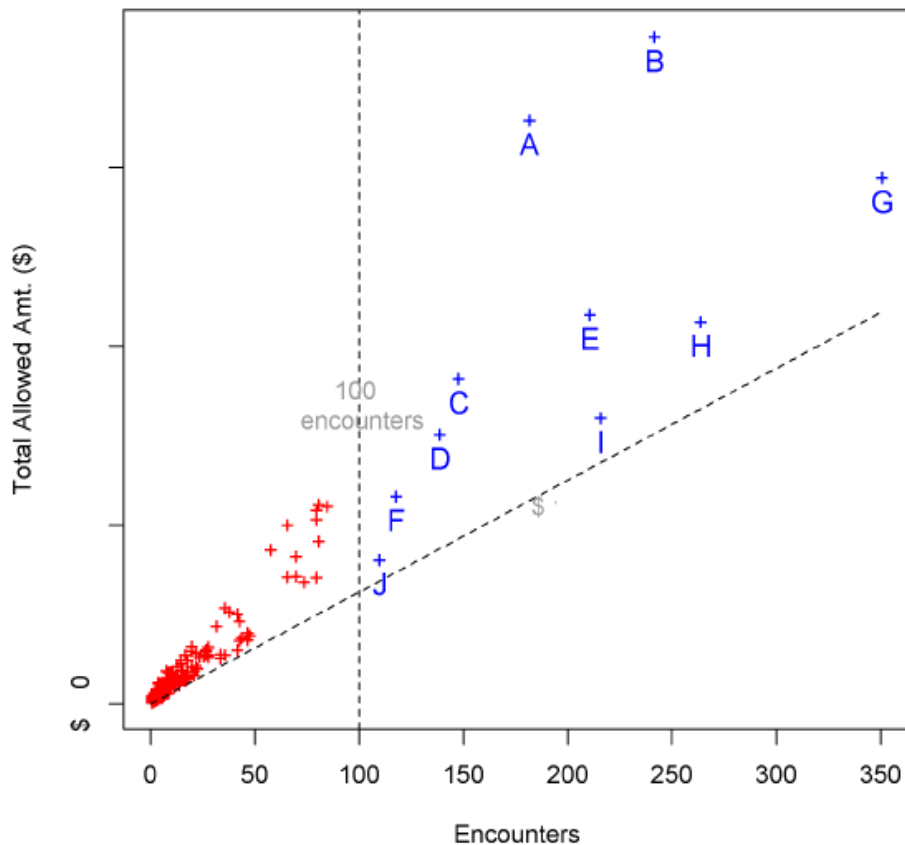
Key	Diagnosis Description
A	Headache
B	Urinary tract infection; site not specified
C	Lumbago
D	Acute bronchitis
E	Fever; unspecified
F	Streptococcal sore throat
G	Acute upper respiratory infections of unspecified site
H	Acute pharyngitis
I	Unspecified otitis media
J	Unspecified disorder of the teeth and supporting structures

Population of Focus

Non-Emergent ER High Utilizers
PCP Visit Correlation

Population (n = 359)	Members who had 3+ months of continuous enrollment AND 3+ non-emergent encounters
Total non-emergent ER encounters	1,437
Total PCP encounters	653
Ratio of non-emergent ER encounters to PCP encounters in 2015	2.2:1

Who we are reaching out to

+ Individuals who are using the Emergency Room as the source for primary care.

+ Not necessarily individuals with a behavioral health diagnosis.

+ But lots of issues related to the social determinants of health.

+ Some are using the Emergency Room due to substance abuse issues.

Outreach Approach

Choosing the Right People

➕ CBHS agencies identified their most experienced, high-performing Health Home Care Managers to work on this program.

- Knowledgeable and experienced about outreach techniques
- Willing to get out into the community to reach targeted individuals.

Strengthening their Skills

Each of our Care Managers was provided with additional training in:

+ **Motivational Interviewing**
+ **Trauma-Informed Care**

Making Them Part of the Primary Care Team

While these Care Managers and comfortable and experienced with community-facing outreach techniques….

+ Offices are based in the primary care office
+ Attend daily huddles and periodic staff meetings with the primary care team
+ Introduce themselves in a manner that leverages the patient's connection with primary care:
  - Specifically state that they are calling from Hudson River Health Care and that they work with Dr. Smith.

Making it Easy for the Individual to Connect with Care Management

+ No formal "enrollment process." No forms to fill out, no paperwork to complete.

+ Contacts between Care Manager and Individual are captured in the EHR.

+ No quotas, no minimum number of "touches" per month. Frequency and method of contact can be tailored to the individual circumstances.

Challenges

Ongoing Challenges Include

+ Contact information is not always accurate.

+ Individuals who are utilizing the emergency department due to drug-seeking are often not receptive to care management.

+ Lack of real-time data about ED use.

THANK YOU!

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