CCSI
Coordinated Care Services, Inc.
Innovative Solutions in Human Service Delivery

Finger Lakes Southern Tier Behavioral Health Care Consortium

Health Engagement Project Report

Problem Statement:

Clients with chronic mental health, substance use, and medical conditions often live in poverty and are unable to obtain resources needed for everyday life, such as stable housing, transportation, food, and clothing. This lack of resources creates barriers to the medical and behavioral health treatment services they need. In many cases, clients who are not engaged in treatment experience worse long-term health outcomes compared to those who receive healthcare. The Health Engagement project was designed to provide identified clients with the support needed to obtain necessary resources and navigate the systems of care on which they depend.

Project Goals:

This project sought to identify clients in need of services based on PSYCKES data and connect them with the medical and behavioral health services designed to address those needs. PSYCKES is a secure online healthcare database that allows healthcare providers across NYS to access Medicaid-enrolled client health information. PSYCKES data identified individuals in need of medication adherence support, diabetes screening and monitoring, and outpatient medical services/Primary Care engagement, along with individuals demonstrating frequent use of acute services.

Guided by the information provided in PSYCKES, a team of outreach and engagement specialists (OES), many of whom shared lived experiences with behavioral health needs, were deployed to support clients in addressing healthcare needs, barriers to care, and helping to connect them with long-term supportive resources. Ultimately, the OES team aimed to identify the medical and/or behavioral health services needed (as indicated by PSYCKES data) and connect clients to those services. They accomplished this through the following (as indicated by individual needs):

- Support clients through enrollment in Health Homes
- Help clients address needs related to social determinants of health that created barriers to obtaining needed services
- Support the reduction of preventable hospital and ER visits by actively engaging clients in addressing healthcare needs and connecting them with long-term support and resources as required
- Educate and aid clients to feel more confident and self-determined in navigating systems of care, included attending appointments with clients and helping them follow through with activities aligned to achieving health outcomes
- Support client participation in career readiness programs to facilitate readiness for meaningful employment and volunteer experiences

Outcomes

- **542** clients received outreach specifically for identified target health care measures:
  - **225** Health Home engagement
  - **104** PCP visit
  - **81** Diabetes Screening + **78** Diabetes Monitoring
  - **78** Adherence to Antipsychotic Medication
- A total of **1,316** clients received at least one outreach attempt between March-August 2019. Outreach efforts included clients outreached specifically for identified target health care measures and additional clients as specified by agencies.
- Among the **228** clients with data permission enabled within PSYCKES to allow health outcomes to be tracked, 62 or **27% had documented treatment care gaps closed during this project period**

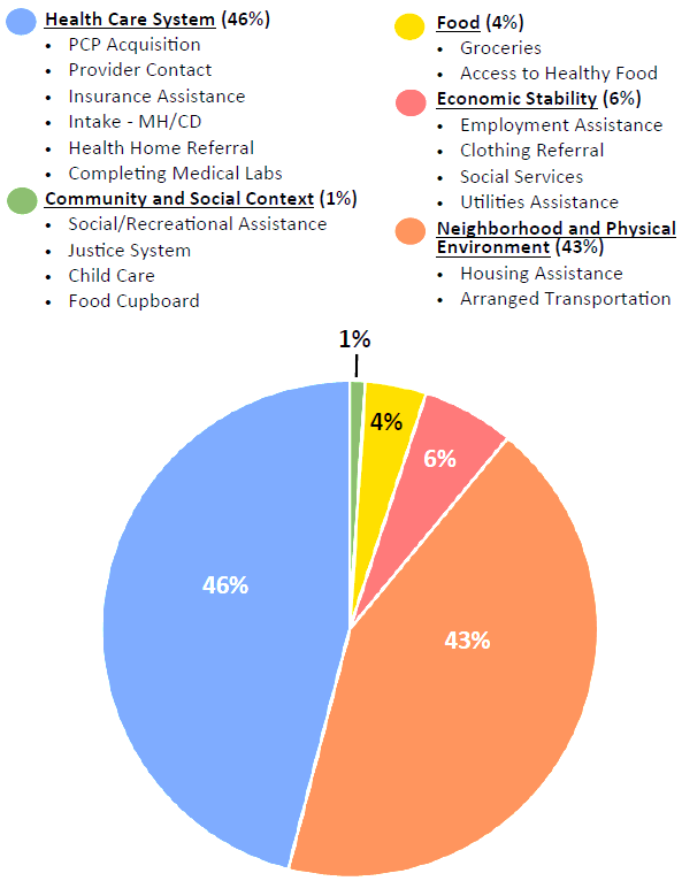
Impact of OES Outreach on Health Home Enrollment

Health Home care managers (HHCM) serve an important role in helping individuals with complex needs navigate the health care system. Through organized coordination and management of individual treatment plans, HHCMs support clients in meeting treatment goals, seeking out and receiving services as needed, and maintaining wellness within the community.

- **138** clients were referred to Health Homes
- **83** clients were actively enrolled in Health Homes

Connections Made to Address Social Determinants of Health

Of the individuals with identified health care needs, over one-half required additional support and social determinants of health assistance. These additional supports and assistance were essential in overcoming barriers to health care service delivery.



Project Activities:

An Alert Manager was hired as a centralized resource to actively track and identify clients in need of outreach using PSYCKES data, Regional Health Information Organization (RHIO) Alerts, and agency referrals. Each month, data were extracted and analyzed to identify clients for outreach. ShareFile was used to securely share sensitive data with agencies.

OES underwent training on the following topics to prepare them to effectively engage with clients.

- Background of serious mental illness and substance use disorders
- Supportive services and resources available to clients
- Health Home care management
- Person-centered, trauma-informed care
- Motivational interviewing
- Continuous quality improvement and measurement
- Documentation
- HIPAA and secure data exchange

OES met with clients in the community to develop relationships and support establishment of personalized goals and strategies. The rapport developed between the client and OES allowed for a greater understanding of client needs, barriers to receiving care, and potential opportunities for assistance. OES primarily worked with clients through face-to-face contact, phone conversations, and attended healthcare appointments with clients.

OES worked to link clients with services and, in many cases, supported them by attending initial appointments. By modeling behaviors and strategies that promote wellbeing within the context of each client's unique health and life circumstances, OES provided clients with a roadmap toward engagement in the healthcare system and long-term recovery.

Throughout the span of the project, OES provided clients with assistance in a variety of ways, including help with acquiring a primary care provider, health insurance, a place of residence, childcare, and employment. OES either provided transportation themselves or arranged transportation for hundreds of client medical and behavioral health appointments. They also completed Health Home referrals and enrolled over 80 clients in Care Management services.

Participating Agencies:

A total of 14.6 full-time equivalent (FTE) OES were deployed across 12 behavioral health agencies. OES serving clients enrolled with Rochester-based agencies worked out a central location while other agencies utilized an on-site OES.

Agency	OES FTE Resources
Baden	1
Casa Trinity	3
Delphi	1
Depaul/Winship	.5
East House	1
Family Services of Chemung	2
FLACRA	2.5
Helio	1.5
Lakeview	.6
Mid Erie - Endeavor	.5
Rochester Rehab	1

Located at CCSI
Located on-site at agency

Health Engagement Workflow:

The process for engagement began with verification that the client's identified need for outreach was not already resolved. Any clients best addressed by resources other than the OES, such as clients already enrolled in health homes, were redirected to the appropriate resource and the remaining clients were targeted for engagement by OES.