Urban vs. Rural Care Management

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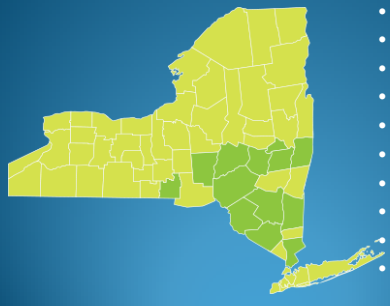
Our History & Services

- Founded in 1979
- Provide community-based mental-health and substance abuse services for children and adults
- 13 counties throughout NYS
- OMH Licensed group homes, Supportive and Transitional Apartment Programs
- PROS Services
- Clinic
- Supported Employment

Counties Where We Provide CM Services



- Albany
- Delaware
- Dutchess
- Orange
- Otsego
- Schenectady
- Schoharie
- Sullivan
- Westchester
- Tioga

Care Management Goals

- Provide cost effective services
- Support the provision of coordinated, comprehensive medical and behavioral health services
- Ensure access to appropriate services
- Improve health outcomes
- Reduce preventable hospitalizations and ER visits

Target Population

NYS Residents enrolled in Medicaid with:

One single qualifying condition: serious mental health illness or HIV/AIDs

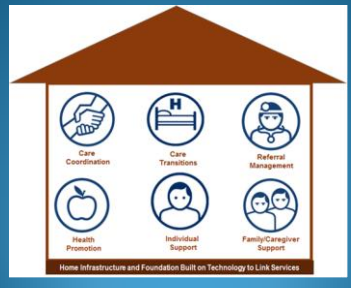
OR

Two or more chronic conditions

AND

Assessed to have significant behavioral, medical or social risk factors

Core Care Management Services



Referral Processes in Rural and Urban settings

- Self- referrals
- Community Referrals
- List assignments
- Lead HH Referral
- Direct from MCO

Otsego and Schoharie Counties

Otsego: Population: 61,683
Medicaid Population:9,578
Size: 1,003 square miles
Lead Health Home: Bassett

Schoharie: Population:31,844
Medicaid Population:4,971
Size: 626 square miles
Lead Health Home: Bassett

Otsego and Schoharie Counties

OTSEGO:
Program Coordinator: 1
Care Managers: 5
Caseload Size: 55
Enrolled: 200+
Outreach: 50+

SCHOHARIE:
Program Manager: 1
Care Managers: 1 1/2
Caseload Size: 55
Enrolled: 100+
Outreach: 20+

Rural Outreach Strategies

- Introductory letter
- Utilize EHRs for contact information
- Follow up with referral source
- Reach out to providers
- Telephonic outreach attempt
- Street Level outreach
- Conducted by direct Care Managers
- SPOA Meetings

Challenges in Rural Settings

- Marketing the program
- Lack of affordable housing
- Transition from Case Management to Care Management model
- Caseload sizes (AOT vs. non-AOT)
- Travel cost and distance
- Transportation for clients

What Resources are Available?

- Social Clubs
- Recovery Centers
- Rural Housing Coalition
- Office for the Aging
- Social Services
- Food Pantries
- DSS
- SSA
- MCAT
- Community Meals
- Shelters

Albany and Schenectady Counties

Schenectady: Population: 155,333
Medicaid Population: 31,912
Size: 210 square miles
Health Home: Care Central

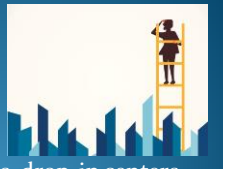
Albany: Population: 306,945
Medicaid Population: 43,786
Size: 533 square miles
Health Home: Capital Region Health Connections

Albany and Schenectady Counties

ALBANY:
Program Manager: 1
Quality Assurance: 1
Care Managers: 11
Caseload Size: 55
Enrolled: 500+
Outreach: 250

SCHENECTADY:
Program Manager: 1
Quality Assurance: 1
Care Managers: 9
Caseload Size: 55
Enrolled: 360+
Outreach: 200

Urban Outreach Strategies



- Dedicated Outreach Team
- Introductory letter
- Telephonic outreach
- Street Level Outreach
- Collaborate with local shelters, drop-in centers, social clubs
- Access the EHR, MAPP and Epaces systems
- Conduct engagements in home, coffee shop, library, McDonalds, office, etc
- SPOA meetings and coordinators

Challenges in Urban Settings

- RSS is historically a Mental Health agency
- Effectively managing program growth
- Embedding Care Managers
- Transient population
- Lack of affordable and quality housing
- Unsafe neighborhoods
- Easy access to ERs
- Connecting with individuals/maintaining relationships
- Working in silos

What Resources are Available?

- CDSS
- Specialists
- Multiple Clinics
- Rehabs/Detox
- Food Pantries
- Community Meals
- Shelters
- Mobile Crisis
- DSS
- SSA
- Social Clubs
- Transportation

Safety Practices in Urban and Rural Settings

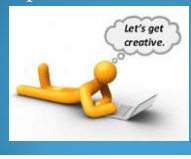
- Teams of two for outreach
- If there are concerns double up or have individuals come to the office
- Leave if you are uncomfortable
- Share your schedule and sign out
- If meeting outside of traditional hours contact supervisor after the appointment
- I-phone tracking
- Be aware of your surroundings

Innovative Solutions

- Embedded Care Managers in Clinic and ED settings
- MRT Supported Housing
- CDSS program
- Partnerships with providers
- In Home Stabilization staff
- Service Dollars and Flex Fund program
- Sense Health

Innovative Solutions

- Hixny access
- Relationships with MCOs
- Transition Support Team collaboration
- Caseloads specific to CRs and programs



Does it Work?

Data is available in MAPP system but it is lagging:

- Individuals with ER visits between 7/2014-6/2015: 37% NYS vs 42% RSS
- Individuals with an inpatient stay between 7/2014-6/2015: 46%- NYS vs 23% RSS
- Individuals who met with a PCP between 7/2014-6/2015: 64% NYS vs 76% RSS

Success Stories- Urban

Male referred at the age of 58 via assignment list

- Dx: Schizophrenia, Depression, Glaucoma, High Blood Pressure
- Hx: Alcohol and Marijuana abuse
- No Mental Health or Medical providers
- No income, desire to work
- Sanctioned by DSS and without income for 6 months- lost housing
- Registered sex offender, spent much of his life incarcerated
- Enrolled in 8/2014 and worked with CM to get linked to housing, PCP, Optometrist, Gastroenterologist, Sleep Specialist, PROS, dentist, and part-time work

Success Stories- Urban

Male referred at the age of 30 via state assignment list

- Dx: Substance Abuse and SPMI
- No clinical provider, limited family and social supports
- High ER utilizer
- Homeless
- Consented one month after assignment
- Linked him to PCP, Podiatrist, Orthopedic, housing
- Currently lives independently, maintaining sobriety, engaged in treatment
- Significant decrease in ER utilization

Success Stories- Rural

44 yr. old male referred from SPOA

- Dx: Bi-Polar D/O, diabetes, asthma, alcohol abuse
- Lived in rural area with history of being transient
- No Mental Health or Medical providers upon referral
- Untreated/uncontrolled diabetes. Wearing walking boot and using cane for 4 years from prior injury
- Unemployed
- Enrolled within 1 week of referral
- CM linked and supported in attending appointments with providers, including PCP, dentist, orthopedic and mental health
- Linked with transportation
- Referred for housing stipend and assisted in finding suitable housing

Success Stories- Rural

63 yr old Male via community referral

- Dx: Adjustment Disorder With Mixed Disturbance of Emotions and Conduct, alcohol abuse
- No benefits in place
- Homeless for 3+ yrs being housed in various locations through local DSS
- Inconsistent engagement with providers, limited social interaction and isolation based on rural location
- Recent SA relapse
- CM linked \o SH, assisted with SSI appeal, assisted in re-engagement to providers
- Approved for SSI benefits, located and maintains independent apartment with rental stipend
- Using Medicaid transportation and bus system to maintain appointments with providers

Questions or Comments?

Thank you!