Closing Gaps in Care to Improve Health and Wellness

Those involved in health care understand that health services do not always run as smoothly as intended. For instance, an individual's care may be disrupted when they do not get connected with an outpatient provider for on-going services after an inpatient stay. Or an individual could miss necessary blood work due to a lack of transportation to a lab. When there is a discrepancy between the recommended 'best practices' and the care that is actually being provided, we call these 'gaps in care'. Making sure that 'gaps in care' are appropriately addressed is particularly important for individuals with chronic physical and behavioral health conditions. Health Homes of Upstate New York (HHUNY) was recently awarded a grant by Finger Lakes Performing Provider System (FLPPS) to help facilitate closure of those gaps for individuals receiving care management services throughout the FLPPS 13 county region. CCSI staff recently met with Christine Mangione, Director, Clinical Operations for HHUNY, to learn more about this critical new initiative.

What is HHUNY's role in this initiative?

Our role at HHUNY is to give care managers the support they need to facilitate closing gaps in care. While care managers try to maximize the health and wellbeing of members by ensuring that the multiple providers involved in a member's care are effectively coordinated, care managers face multiple challenges. They often have high caseloads and may have challenges contacting health care providers, getting transportation for clients to get to needed care, and ensuring clients follow through with appointments. This new initiative is focused on streamlining the work of the care managers by supporting them with some of these concrete tasks. We want to take as much off their plates as possible, including tasks like scheduling appointments with healthcare providers and arranging transportation for members to get to appointments.

We're thinking creatively to find solutions and are learning more about what we can do to be most helpful for care managers. For example, we are contracting with a mobile lab and will assist with making arrangements to ensure lab services are available for members to get their blood work done. We are building relationships with inpatient discharge planners to better facilitate linkages to outpatient treatment when a member completes their inpatient stay. HHUNY's health coordinators will be working as supports and liaisons to the care manager in order to assist with gap closure. HHUNY's peer engagement specialists will assist enrolled members by providing support through their shared experience, and they will educate individuals about health homes and facilitate enrollment. We will also deliver trainings to care managers, recommend workflows, and offer incentives for care management agencies and members when gaps are closed.

What types of training will HHUNY provide to care management agencies?

Care managers will be trained in Motivational Interviewing, Trauma-Informed Care, and Gaps in Care (GIC)/Chronic Conditions training. We know that engagement with members is critical to improving member follow-through. Trainings like Motivational Interviewing and Trauma Informed Care are evidenced-based and person-centered to support both member engagement and change.

How will HHUNY measure gap closure?

While we'll be monitoring multiple data metrics each month, we'll mainly be focused on four key measures:

1. *# of individuals screened for diabetes when taking an antipsychotic medication and diagnosed with schizophrenia or bipolar disorder*
2. *# of individuals monitored for diabetes who are diagnosed with diabetes and schizophrenia*
3. *# of individuals who attend a follow-up outpatient appointment after their mental health inpatient hospitalization stay:*
    - *Within 7 days of discharge*
    - *Within 30 days of discharge*

What progress has been made so far, and what are the next steps for this project?

HHUNY started work on this initiative about a month ago, and on January 23rd, we kicked things off with a webinar for the care management agencies. The webinar gave an overview of the project and explained the different roles and responsibilities of project team members. While the project officially ends in June 2019, we will continue to work through the end of the year to integrate as much of the project as we can into our daily processes. We aim to have this initiative become a daily part of what we do going forward beyond the end of this year.

For next steps, HHUNY will have in-person meetings with the 43 care management agencies. We will ask care mangers how they can best be supported by HHUNY, and we'll explain what support HHUNY can offer them. We will start conducting trainings for the care management agencies, reach out to the discharge planners from the inpatient facilities, and connect with transportation in all the regions.

Why is this initiative so important?

Most importantly, with this funding from FLPPS, we will have a positive impact on the health and well-being of our high risk/high need members across a 13-county region. By addressing care appropriately, we hope to reduce the number of avoidable emergency department visits and inpatient stays, therefore improving the quality of care and reducing costs at the same time. We know that care managers play a vital role in coordinating care for clients and are confident that this initiative will further demonstrate the value of health home care management in a value-based payment system.

If participating agencies have any questions and/or want more information, who should they contact?

They can call our toll-free number at 1-844-890-6969. This line is for participating agencies and providers to expedite any questions, such as provider requests for assistance with gap closure, requests for clarification regarding the gaps in care project, discharge planners requesting assistance, etc.