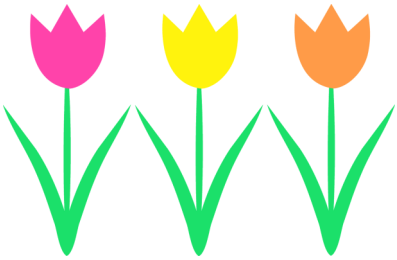
GOLISANO CHILDREN'S HOSPITAL
CHRISTINE M. BURNS CARES CENTER
CARE MANAGEMENT PROGRAM

Spring 2022

In This Edition…



OUR VISION: *The Golisano Children's Hospital Health Home Program aspires to shaping the future of care management by achieving excellence to impact health outcomes for all children.*

OUR MISSION: *The Golisano Children's Health Home Program is dedicated to connecting families to community resources and strengthening their ability to maintain a safe and healthy lifestyle.*

Happy Spring! As we moved into warmer weather and continued challenges, our team is staying positive and focusing on how to support the vulnerable children in our community. Our community has been faced with continued hardship with the pandemic, increasing struggle to meet basic needs, and navigating the challenges faced with having a child with medical, behavioral, or social complexities.

The team at CARES is dedicated to assisting our families with the support they need to be successful. This issue highlights the rewarding experiences our health home care managers and care coordinators share with their patients, introducing a new Quality Assurance and Training Coordinator role and the Pediatric Practice Diversity Committee. There is an update on the broader NYS Health Home Program and its services to the people of New York State.

The 2021 Holiday-Adopt-a-Family Program had its best year to date, providing 50 families with gifts for the holiday season, a feat that could not be achieved without the support of our local donors. The inception of the Pediatric Complex Care Program is looking toward the future, a telemedicine-based model assisting medically complex children with care management needs.

As our program grows, we will strive to be better each day and keep the patients at the center of our goals. Many thanks to the GCH Leadership team for their continued support of this program and its mission of connecting families to community resources and strengthening their ability to maintain a safe and healthy lifestyle. Together we can change lives.

Stay safe and healthy,

Cynthia Korpal

Director, Golisano Children's Hospital Care Management

Our Team

Administration
Cynthia Korpal, Director
Andrea Myer, Care Manager Supervisor
Janelle Harris, Billing Administrator
Katie Birge, Administrative Assistant
Dana Cromheecke, Quality Assurance and Training Coordinator
Michelle Tuohey, Referral Coordinator
Ayla Johnson, Intake Coordinator

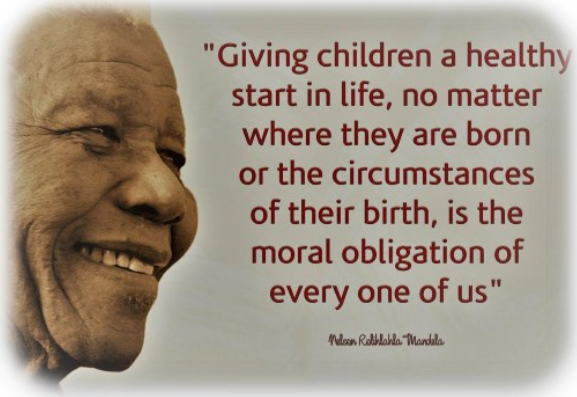
Care Managers
Elizabeth Pietrantoni, Care Manager Team Lead
Alysha Dias, Care Manager
Rebecca Gallup, Care Manager
Jessica Holly, Care Manager
Rayna Kent, Care Manager
Stephanie Lodato, Care Manager
Cratrina Meeks, Care Manager
Stephanie Neufeglise, Care Manager
Jessica Pietrzykowski, Care Manager
Claudia Santoya, Care Manager
Yahaira Vazquez-Valle, Care Manager
Dominique Wilcox, Care Manager

Care Coordination
Jackie Powell, Team Lead, Green Team
Cheryl Gordon-Barr, Yellow Team
Kate Miller, Orange Team
Melissa Horton, Blue Team

Pediatric Complex Care Program
Dr. Neil Herendeen, Medical Director
Alyssa Powell, Program Manager
Brittany Gnage, Care Coordinator
Amanda Savona, NP
Heather Shultz, RN

Health Home Update
Andrea Myer, Senior Social Worker

The Golisano Children's Health Home Program has returned to seeing our patients face to face. We had moved to a more virtual way of seeing our families during COVID. Since numbers have been declining in our area, we have moved back to completing Home Visits and seeing children and families at doctor's appointments and in the community. Our program has been enrolling more children into the Home and Community-Based Services (HCBS). This program assists certain children with getting connected to services to be meet their needs. HCBS offers respite, vehicle modifications, environmental modifications, vocational support services, youth peer support services, and many more. Another service we assist with is helping families get connected with the Office of People with Developmental Disabilities (OPWDD). This program can assist a child for



Success Story
Brittany Gnage, Care Manager

The most rewarding moments as a care manager are when the family and client can see the light at the end of the tunnel. This particular phrase holds true to a family I worked with. This family actually had many supports in place, however, they were having extreme difficulty with behaviors and emotional self-regulation with their child, my client. On top of already stressful matters at home, the child's life outside the home was caving in because of a global pandemic. While we had many obstacles in our way, together, the family and I put together a team of community resources whose sole focus was this child. Little bit by little, we saw the child open up, express herself in an effective manner, and even understand the value of ownership with a brand new emotional support puppy. At discharge, I knew both the family and my client had the tools needed to support them in the future.

Quality Assurance

Dana Cromheecke, Quality Assurance

I joined the Children's Health Home Program as a Care Manager in February of 2020. In September of 2021, I accepted the new Quality Assurance Coordinator position that was created for our team. My role is to complete audits that our Lead Health Home (CHHUNY) has implemented to prepare for Department of Health Audits and be aware of the new regulations that are being required. The role also includes completion of other internal audits, from reviewing eRecord documentation completed by the Care Managers to reviewing consents, etc. From the completed audits, I meet one on one with the Care Manager and review the changes that need to be made, questions that they may have, and provide training as needed. I also provide the Care Managers with updates made by our lead Health Home (CHHUNY) to keep them aware of any new regulations and requirements. I look forward to continuing to work with my team and the development of this role.

SUCCESS STORY

STEPHANIE LODATO, CARE MANAGER

I assisted a family with requesting and attending a CSE meeting this fall. Their child was struggling with grade-level reading and math. Due to the CSE meeting, the student qualified for additional assistance/extra help from the school team. As a result, they have now been moved up a grade level in reading, and the parents report the child is enjoying school more.

OUR STATS AT A GLANCE

342 Enrolled

SUCCESS STORY

CLAUDIA SANTOYA, CARE MANAGER

One client I have been working with has faced struggles due to a language barrier causing the child's mother to have limited knowledge of his services with his IEP. The Care Manager assisted mom with requesting a meeting with teachers to learn about the services provided. Today, the child is doing very well and continues to excel in his school work. As a result, the child has been selected as Leader of the Month.

He has also been connected with Hillside for OLP services. Being connected to services has given the child the ability to interact with other students and helped his social skills.
In addition, my client loves music and enjoys playing the drum. He will usually play the drums at his local church.

Health Homes Achieve Savings and Improve Quality

NEW YORK STATE CARE MANAGEMENT COALITION
The Key to Integrated Care

NY Health Home Coalition

Over 180,000 high-risk, high-need adults and children are enrolled in Health Homes, being served by 4,000 care managers through care management agencies in their local communities. As a result:

27% reduction in inpatient PMPM costs for Health Home members post enrollment compared to the same period prior to enrolling in Health Home (most recent data 2016-17) resulting in $275m savings for inpatient costs

11.1% reduction in All-Cause Readmissions (a measure of readmission following acute inpatient stays)

After enrollment, individuals saw an **increase** in:

- Visits to primary care
- Medication compliance

According to NYS DOH, primary care costs **increased 23%**, and Rx Cost **increased 12%**, both of which indicate that individuals are going to their PCP and taking their medications – major goals of the program.

What is a Health Home?

A network of community-based Care Management Agencies that work to engage individuals with serious and complex physical health, mental health and substance use disorders in their local community to achieve better health outcomes, member satisfaction and overall cost reduction.

Health Home Priorities

- Preserve and maintain funding for Health Homes – this highly effective, cost-saving program cannot sustain additional cuts;
- Invest in a diverse workforce targeting recruitment, retention and training in the highest need communities; and
- Enact measures to lessen the administrative burden on Health Homes to ensure more resources are dedicated to patient care and to protect workforce from burn out

Member Profile

- **73%** of members have some type of behavioral health diagnosis, and **at least 10%** are diagnosed with HIV/AIDS
- Of those members with a behavioral health diagnosis, **at least 8%** had some type of hospitalization related to mental health or substance use in 2017

Health Home Fast Facts

Over the last 5-6 years individuals enrolled in a Health Home saw an:

- **11.4%** improvement in follow-up after hospitalization for mental illness within 30 days statewide for health home enrollees
- **8.4%** increase in adherence to antipsychotics for individuals with schizophrenia enrolled in HH (State established measure)
- **86%** of Health Homes improved comprehensive diabetes care rates with a corresponding statewide **4.5%** improvement rate during that time period
- **27%** improvement in follow-up after hospitalizations with mental illness within 30 days
- **29%** reduction in homelessness and a **37.5%** reduction in incarceration from 2018 to 2019 for the same cohort of individuals, based on a representative sample.
- In 2018-2019, this program achieved over $70 million in savings through the restructuring of the outreach component of the program, placing additional burden on the remaining rates to support all outreach, engagement, enrollment and ongoing care management.

Health Home Improved Member Quality and Services

- Expanded more intensive care management for highest risk populations.
- Improved quality outcomes despite medical complexity of patients.
- Exceeded statewide results on 20 of 24 key performance measures.
- Exceeded statewide performance for all 6 behavioral health hospital follow-up measures including: alcohol/drug dependence treatment; medication management, HIV; monitoring, and screening for sexually transmitted disease.

The Role of Care Management and Health Homes

According to a NYSOMH HARP Focused Clinical Study – Performance Opportunity Program October 2021, members with a health home care manager were **5.0 times more likely** than those with an MCO-employed care manager to receive follow-up at 7 days and **14.4 times more likely** to receive follow-up within 30 days.

Health Homes improve outcomes for members by coordinating healthcare and social services which result in:

- A reduction of no-show appointments
- Increased engagement in treatment
- Support for members and their caregivers
- Member connections with culturally competent providers that understand and can meet their needs
- Address underlying social determinants of health such as housing and employment

Health Home Care Management improves outcomes across the entire healthcare system including:

- Reduction of avoidable or preventable inpatient stays
- 2019 HHSA PM Dashboard data showed a **26.2% decrease** in emergency department utilization after Health Home enrollment
- Improved health outcomes for persons with mental illness and/or substance use disorders
- Improved management of disease-related care for chronic conditions, including HIV
- 2019 HHSA PM Dashboard data showed a **10.3% increase** in connectivity to primary care after Health Home enrollment
- Focus on social determinants of health such as homelessness, housing, lack of food security, employment and benefit connectivity
- Individuals enrolled in Health Homes also saw improvements in rates of chlamydia screenings, colorectal cancer screenings, follow-up after emergency department visits, engagement in comprehensive HIV/AIDS care including viral load monitoring, medication management for people with asthma and overall prevention quality of care (HEDIS measure).

Health Homes Care Management addresses Social Determinants of Health (SDoH):

- Based on representative sample of Health Home enrolled members completing the Accountable Health Communities (AHC) health-related social needs screening tool in Foothold Care Manager (FCM) at intake and reassessment, there was a **47% reduction** in members who identified as being housing insecure after 1 year of continuous Health Home enrollment and a **52.6% reduction** in Health Home enrolled members that identified as food insecure. Additionally, transportation access for Health Home enrolled members **increased by 48%.**[1]

[1] *Coalition of NYS Health Home analysis of 5803 Health Home enrolled members, in Foothold Care Manager (FCM), that had an Initial Accountable Health Communities (AHC) health-related social needs screening tool and a reassessment using the same tool in 2020-2021. All Health Home members had at least one year of continuous Health Home enrollment.*

Care managers work with adults, children and their families who enroll in a health home to develop an individualized comprehensive plan of care, and then help them navigate the health care delivery system, schedule appointments, arrange transportation and communicate between health care providers.

Care managers also provide education about how to manage chronic conditions, taking medications properly, and understanding often complex discharge plans, next steps and follow-up after a hospitalization.

The Care Management Agencies in Health Homes networks are experts in providing care management services in communities across the state.

The care managers are located in communities where individuals live and provide culturally relevant and responsive support to their members. Care Managers meet members where they are most comfortable, providing person-centered support and coordination of services. By using individual member health data, including utilization and outcomes, care managers can connect the individual to appropriate health and social services in the least restrictive, most cost-efficient setting.

Our dedicated Care managers also help adults, children and families enrolled in Health Homes in other ways such as:

- Medicaid eligibility determination
- Enrollment and renewal of benefits
- Assessing eligibility and completing applications for other public benefits
- Securing safe and affordable housing, and
- Connecting individuals to social services.

Who We Are

The **Coalition of New York State Health Homes (CNYSHH)** represents 27 Health Homes across every region of New York State serving Health Home membership statewide working collaboratively with the New York State Care Management Coalition.

The **New York State Care Management Coalition** represents thousands of care managers from across New York State's behavioral health community and offers them the opportunity to become one voice on many issues facing the clientele and the agencies served.

For More Information

Laurie Lanphear, Coalition of NYS Health Homes llanphear@hhcoalition-org
Jackie Negri, NYS Care Management Coalition nyscaremanagement@gmail.com

Diversity Committee

Kate Miller, Care Coordinator

The community in Rochester, New York, comprises a diverse group of people coming from a variety of backgrounds and cultures. A multitude of ethnicities, cultures, and lived experiences contribute to a culturally vibrant community, each with their own distinct identities and needs. We at the Committee for Diversity, Equity, and Inclusion at Golisano Children's Hospital Pediatric Practice believe this is what makes our community so dynamic.

We recognize that in order to foster a vibrant and culturally diverse community, we need to create an environment that promotes inclusivity while also understanding that our individual values and common goals are valuable. The committee wants to make sure that we continue to propel these efforts forward within our own practice while also expanding services and support to the wider community.

The committee recognizes that our community is facing a period of unprecedented hardships that impact everyone, from the patients we serve to the person sitting beside you in the office. In light of the changing landscape, we are taking this time to refocus our goals and support the continued growth of camaraderie, diversification, and inclusiveness within our practice. It is important to us to celebrate monthly heritage milestones while also acknowledging the changing political, socioeconomic, and cultural landscapes and what that may look like for our practice. These goals will be accomplished through a group effort, and we recognize that diversification and inclusion do not occur overnight. Everyone has a part to play. We welcome the opportunity to speak with parents, patients, providers, and others within our community to acknowledge our successes while also identifying goals and actionable items for the upcoming year.

If you are interested in speaking with the committee, please do not hesitate to reach out to myself or any other provider or committee member. We will continue to strive to build an environment where everyone's voices are heard, and the culture is based on mutual respect and compassion.

Care Coordination for Families

Cheryl Gordon-Barr, Care Coordinator

As a patient care coordinator of a 14,000 patient General Pediatric Practice, one of the main goes is to remove barriers from the patients' lives. So that they may focus more on the family's medical needs, these barriers that families face are transportation, food insecurities, lack of housing, and no health insurance.

For instance, I was working with a family of six. The grandmother gained custody of five of her grandchildren from out of state. They came to her with the out-of-state health insurance that needed to be closed before we could obtain insurance for the children here in New York State. Some of the children needed medical care right away, which the grandmother would have had to pay out pocket. It took a couple of months to secure insurance for this family.

Holiday Adopt -A- Family

For Christmas, 2021, we had 32 donors, adopting 34 families for the Holidays. Using additional donor funds, we were able to adopt another 16 families for a total of 50 families adopted! Family sizes ranged from 2 people up to families of 8. Many of the families were overjoyed and thankful for all the items received. Our care managers enjoyed being Santa with all of the amazing donations we received. A special thank you to the generous donors who helped make the holiday season a bit brighter for our families.

CARES CENTER UPDATE– PEDIATRIC COMPLEX CARE PROGRAM

Dr. Neil Herendeen

Golisano Children's Hospital is happy to announce approval for a new pediatric care and coordination program for families caring for children with the highest level of medical complexity and technology dependence at home. We are hiring our interdisciplinary team of experienced pediatric providers initially to include a nurse, nurse practitioner, doctor, care coordinator, administrator, and social worker to support families, as well as their primary care provider, in managing their child's medical and psychosocial wellbeing at home or during transitions in and out of Golisano Children's Hospital. Modeled after a successful pilot program at Mercy Virtual in St Louis, we plan to use the electronic medical record (MyChart) to communicate directly with caregivers, coordinate with subspecialists at the hospital and conduct telemedicine visits when needed to avoid unexpected trips to the Emergency Room or readmission to the hospital. We expect to demonstrate that enhanced patient support for our highest risk children gives parents peace of mind and improves medical outcomes, and saves money by proactively avoiding the need for urgent/emergent hospital-based services. Limited enrollment will start in May, with expansion to include eligible children throughout the Finger Lakes region next fall.

Welcome to the new members of the complex care team, Brittany Gnage, Care Coordiantor, Alyssa Powell, Program Manager, and Heather Shultx, RN, and Amanda Savona, NP.

CARES WISH LIST

Bicycles/Helmets	Crafts/Coloring Books/ Crayons	Pots and Pans
Board Games	Cleaning Supplies/Equipment	Microwaves/Hot Plates
Backpacks	Fans	Sport Items
Books	Personal Hygiene Products	Diapers
Amazon Fire Tablets	Twin Size Bedding	Recreational Activities

CONTACT US!

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