



# Outreach to High-Need, High-Cost Individuals: Best Practices for New York Health Homes

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# Introduction

## About Health Homes in New York State

The implementation of Medicaid health homes represents a major delivery system transformation effort for the New York State Department of Health (DOH), in collaboration with a number of its sister agencies, including the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS). New York's health home program seeks to provide integrated care coordination for Medicaid beneficiaries with multiple chronic physical and behavioral health needs. However, as demonstrated in previous attempts to enroll high-risk populations in similar programs, recruitment and engagement are often a challenge. Common obstacles include imperfect contact information, the transient nature of the population, and the broad array of psychosocial complexities that these individuals may face. Effective recruitment and engagement efforts require an investment in targeted strategies that acknowledge these barriers.

Based on the experience of past care coordination efforts in New York State, such as the Chronic Illness Demonstration Project (CIDP), State policymakers anticipated many of the challenges associated with engaging the high-risk health home population. CIDP, for example, did not include funding for outreach, thus provider payments did not flow until individuals were enrolled. Recognizing the extensive efforts required to locate and engage high-risk members, New York became the first Medicaid health home program in the nation to include direct payments to providers for outreach activities. As of January 2014, health home providers receive 80 percent of the per member per month care coordination payment, for up to three months prior to enrollment.

Health homes in New York are designed as integrated networks. Services are managed by lead entities, delivered in partnership with an array of "downstream" providers (community-based organizations that have subcontracted with the lead entity to provide care coordination services), and coordinated with other network partners that provide other services such as supportive housing, legal assistance, and food access to health home enrollees. To date, State officials have designated 48 health homes throughout New York State, representing 32 unique lead entities, some of which operate in multiple regions.

The program was rolled out in three distinct geographic phases between February and July of 2012, and as of February 2013, approximately 57,000 Medicaid beneficiaries in New York were receiving active care management services through health homes, with another 23,000 currently targeted for outreach and enrollment. Lessons from this implementation experience to date can support effective engagement in health home services in the months and years ahead for individuals targeted for future outreach.

## Report objectives

With support from the New York State Health Foundation, the Center for Health Care Strategies (CHCS) gleaned lessons from early-adopter health homes across the State to support effective outreach and engagement. This paper has three key objectives:

- To summarize challenges associated with outreach and engagement;
- To identify and disseminate promising practices from New York State health home providers; and
- To share additional effective strategies from other relevant programs across the country.

# Summary

## Methods

CHCS collaborated with DOH officials to identify a representative mix of health homes across the State to interview for this report. Interviews primarily focused on Phase I and II health homes, as, at the time of the interviews, they had been in operation for nearly two years. Phase III health homes, by contrast, had only been live for a little over a year, and many were still developing and refining key processes and operations. Although limited data were available to identify health homes with strong quantified track records for outreach and engagement, the team used Medicaid billing records, relevant past experience, and other anecdotal information to identify health homes that could provide insights on strategies worthy of replication. Other considerations for selection included geographical location and organizational composition of the health home network (e.g., hospital-led versus community provider-led). Exhibit 1 lists the 12 health homes that were interviewed.

EXHIBIT 1. Health Homes Interviewed for Report

Health Home Lead Entity	Region	Lead Type	Phase
Bronx Accountable Healthcare Network (Montefiore Medical Center)	Downstate	Hospital	I
Bronx Lebanon Hospital Center	Downstate	Hospital	I
Brooklyn Health Home (Maimonides Medical Center)	Downstate	Hospital	I
Coordinated Behavioral Care (CBC)	Downstate	Community	I
Community Care Management Partners (CCMP)	Downstate	Community	I
FEGS Nassau Wellness Partners Health Home	Downstate	Community	I
Health Homes of Upstate New York (HHUNY) Finger Lakes/Huther Doyle	Upstate	Community	II
HHUNY Central/Onondaga Case Management Services	Upstate	Community	II
Hudson River HealthCare	Downstate/ Upstate	Community	II, III
Institute for Family Health	Upstate	Community	II
Niagara Falls Memorial Medical Center	Upstate	Hospital	III
Visiting Nurse Service of Northeastern New York (Ellis Medicine)	Upstate	Community	I, III

Interviews were conducted telephonically. In most cases, lead health home administrators invited one or more downstream providers to participate in the discussions. Interviewers used a structured interview guide to organize the discussion (see Appendix A).

# Challenges

**T**he challenges to locating, engaging, and enrolling high-risk beneficiaries are myriad, and encompass geographical, technical, clinical, and operational issues. All operating health homes have encountered some form of the following challenges:

## CASE COMPLEXITY

The population targeted by New York's health home program has a high degree of medical and psychosocial complexity. Eligible members often have multiple chronic conditions compounded by mental health and substance use disorders, all of which often go untreated. In addition, many individuals targeted for health home enrollment have few social supports and are socially isolated, and have a broad array of unmet social service needs related to nutrition, transportation, or utilities, among others. Notably, a significant percentage is unstably housed or homeless. Outreach workers often encounter individuals who have had negative experiences with the medical and social service systems, and harbor a deep mistrust and even fear of providers. All of these factors combine to make it difficult to gain this population's trust and suggest the need for tailored engagement strategies that address each member's unique issues.

## INADEQUATE CONTACT INFORMATION

Individuals eligible for health home services may have transient and unstable living situations, or lack sustained access to phone service. As a result, one of the most challenging aspects of outreach is obtaining accurate contact information for these members. In New York, as in many states, the Medicaid information system is limited in its ability to capture updated beneficiary contact information, and therefore much of the data that health homes receive from the DOH are months or even years out of date. Other related challenges include confusion regarding what types of data can be shared with other network partners to facilitate outreach efforts, and the technical sophistication necessary to collect and analyze data from multiple sources to support outreach efforts.

## LIMITED UPFRONT DATA ON MEMBER NEEDS

Initial data on eligible individuals provided to the health homes by the DOH often shed little light on eligible members' medical and psychosocial needs. Some outreach workers, particularly those transitioning from legacy case management programs, noted feeling unprepared and, in some cases, unsafe engaging individuals without more in-depth insight into their cases. Programs also noted that this lack of pre-enrollment knowledge can make it difficult to make informed decisions about which downstream partners to assign members to for outreach and to strategically deploy outreach workers who specialize in engaging eligible members with specific needs or backgrounds, such as non-English speakers or victims of domestic violence.

## CULTURAL AND LINGUISTIC BARRIERS

Given the diverse nature of the population, many health home-eligible members are non-native English speakers who come from a broad range of cultures. This diversity presents challenges for health homes in communicating with prospective members, and in responding to cultural differences that may

## Challenges *(continued)*

influence receptivity to health home services. For example, several interviewees mentioned that within certain cultural groups, adult children of eligible members were hesitant to relinquish their caregiver duties to an outside party. Similarly, some cultures are less amenable to behavioral health treatment or may not be inclined to seek preventive medical care in traditional Western medical settings.

### LACK OF AWARENESS OF HEALTH HOMES

Although health homes have been operating for two years, many interviewees noted that there is much confusion and limited public awareness about the program. When first approached about the program, eligible members' reactions include saying that they have never heard of the program, being suspicious as to how the outreach worker got their names and contact information, or worrying about how to pay for the service. Health care providers may be similarly unfamiliar with the program and may not understand how it would benefit them to collaborate with health home staff. Interviewees also reported that some community-based organizations that already provide social services to eligible members (e.g., supportive housing providers) may express concern about duplication of services when engaged to support outreach efforts.

### EFFICIENCY

Health homes in all regions struggle to conduct outreach efficiently. The challenges differ somewhat by region, with rural outreach workers often having to drive long distances to locate eligible members in remote areas. Public transportation options are often limited in these settings, also making it difficult to hand off engaged members to care coordination teams in a timely fashion. In urban areas, outreach staff may have to travel for hours on public transportation to locate members, or may have to work in pairs in unsafe or unknown neighborhoods. These types of issues can drain the resources and time teams have to conduct outreach.

# Promising Practices

The health homes interviewed for this report have tackled the challenges outlined in the previous section with ingenuity and persistence. The promising practices listed below are themes repeated consistently across the interviews, and reflect some of the most effective strategies identified to date to support health home engagement efforts. Promising practices from states other than New York are also highlighted throughout the paper. Appendix B includes a more detailed look at Washington State’s successful outreach campaign.

## Top 10 Must Dos for Health Homes to Improve Outreach

1. Refine job descriptions and hiring process for outreach workers to identify individuals with strong people skills, creative thinking, and a knack for sleuthing.
2. Look to hire outreach staff from within the communities targeted for enrollment.
3. Use a diverse range of data sources, including social media, to gather contact information for eligible members.
4. Add colorful stickers to outreach letters and include mail-back forms requesting updated contact information.
5. Develop a strong sales pitch: aim to sell the health home to a broad range of potential clients on the first encounter.
6. Invest in good marketing materials.
7. Know before you go: use online maps with satellite images to help sniff out bad addresses.
8. Be aggressive and persistent in outreach efforts; don’t wait weeks between contacts.
9. Identify high-volume, high-opportunity community partner sites for possible co-location of outreach staff.
10. Develop a process for receiving real-time notifications when targeted members show up to receive services from network partners.



## Promising Practices *(continued)*

### OUTREACH MUST BE STRONGLY ROOTED IN THE COMMUNITY.

All interviewees cited the importance of having outreach and engagement activities strongly grounded within the community. Outreach staff should be intimately familiar with the community's cultures, needs, geography, and resources. This has led many health homes to hire community health workers (CHWs) and peers who currently live, or have lived, within communities targeted for outreach. These staff are able to connect with eligible members based on shared experiences and mutual understanding, and are well positioned to communicate the benefits of health home enrollment. Visiting Nurse Service (VNS) of Northeastern New York, for example, evolved its outreach model over time to increasingly rely on CHWs. The health home reports that these team members bring an understanding of the community that is critical to successful engagement.

### OUTREACH WORKER SKILL SETS ARE MORE IMPORTANT THAN CREDENTIALS.

There is considerable variation across health homes regarding the type of staff hired to do outreach and engagement, with some using unlicensed staff such as peers, CHWs, or case managers, and others using social workers or nurses. Similarly, there is wide variation in how organizations conduct their outreach, with some employing a team-based approach and others relying on individual efforts. While it is not yet clear if one of these approaches is more successful than the other, all programs agree that hiring staff with the proper skill set and some key personality traits is critical to developing a successful outreach team.

The health homes interviewed consistently noted that a key set of personal qualities associated with successful outreach efforts are far more important than a background in health care or a specific set of credentials. These qualities include strong interpersonal skills, excellent listening skills, empathy, and the ability to easily relate and quickly connect with members. Effective outreach staff are also creative thinkers who can problem-solve on the fly and adapt engagement strategies to an individual member's needs. Health homes also noted the importance of having outreach staff who are multilingual.

### OUTSIDE NEW YORK: SPOTLIGHT ON ALASKA

#### Alaska's Southcentral Foundation: A Focus on Customer Service

Alaska's Southcentral Foundation has developed the Nuka System of Care to help attract members by focusing on customer service. This approach has influenced everything from the physical design of its clinics to its use of language: patients are called "customer-owners," reflecting that the system is there to serve their needs, and is ultimately beholden to them. Customer-owners are encouraged to let front-desk staff know if they have been waiting for more than 10 minutes to be seen; care team members (providers, medical assistants, case managers, and nurse care managers) share joint office space to facilitate communication and team work; and participation by customer-owners in all aspects of their treatment is consistently promoted. This customer service focus has had a tremendous impact on patient satisfaction, and is one of the key ingredients to the system's success in attracting and retaining members.

## Promising Practices *(continued)*

Several of the interviewees mentioned that staff can be trained to learn health home program details, but the qualities that give outreach workers the ability to connect and gain members' trust are innate.

A number of health homes have leveraged staff with non-traditional backgrounds that are well suited for outreach and engagement of hard-to-reach individuals. For example, the FFEGS Nassau Wellness Partners Health Home in Nassau County employs a former police detective as an outreach worker. This individual has both a natural inclination for and a wealth of training in the sleuthing that is required for locating and engaging eligible members. Other outreach staff have learned from his unique ability to "think outside the box"—for example, talking to the mailman to get more clues when there is no answer at the door.

Other health homes reported effectively using staff with sales backgrounds. For example, at the Bronx Accountable Healthcare Network (BAHN), Acacia Network, a downstream care management partner, employs outreach staff who use their retail sales experience to engage with prospective health home enrollees in compelling ways. These staff understand the importance of a good sales pitch for conveying excitement, opportunity, and services customized to meet individual needs.

### OUTSIDE NEW YORK: SPOTLIGHT ON NEW JERSEY

#### Camden Coalition of Healthcare Providers: Readiness to Change

The Camden Coalition of Healthcare Providers' (CCHP) care management model specifically identifies and targets members who are deemed "ready to change." By using a validated tool, motivational interviewing, and the stages of change theory, the team assesses high-need individuals' outlook and circumstances, and enrolls those who are identified as likely to be ready to change their behavior in a brief intervention program that provides care coordination services for only up to 90 days. Although some clients will cycle through the program repeatedly, CCHP has found that focusing outreach and recruitment efforts specifically on this population has been more cost-effective than enrolling all high-need individuals indiscriminately.

### DEDICATED OUTREACH TEAMS ARE KEY.

One of the key insights that New York's health home providers have gleaned is that it is extremely difficult for an individual to conduct outreach while also carrying an active care coordination caseload. Many health homes initially held care coordinators responsible for both directly conducting outreach and building their own caseloads. This approach minimized the number of hand-offs that members experienced when enrolling in health homes; enabled assessments and other care coordination activities to begin immediately; and, perhaps most importantly, recognized the financial constraints that health homes faced in matching staffing to initial enrollment targets. However, over time, most programs recognized that the care coordination needs of the health home population are so great that even carrying a caseload of a few individuals detracts from the time that staff can devote to outreach. Therefore, most of the health home programs interviewed are moving toward a model with staff dedicated exclusively to outreach.

## Promising Practices *(continued)*

A number of health homes in the State have carved out specialized roles within their dedicated outreach teams. For example, one of Community Care Management Partner's (CCMP) network partners divides its outreach staff into two teams—one that exclusively conducts telephonic outreach, and another to go into the community for face-to-face outreach. Other health homes, such as HHUNY Central/Onondaga Case Management Services, have separate outreach workers focused on list assignments and community referrals, respectively.

### OUTSIDE NEW YORK: SPOTLIGHT ON OREGON

#### CareOregon's CareSupport Program: Team-Based Case Management

CareOregon's CareSupport program is a team-based case management model for high-risk, high-cost individuals. Members are identified both through community referrals and predictive modeling, which looks at prior utilization patterns and predicts an individual's likelihood of being a high-utilizer of health care services in the future. The program has found great success in embedding community outreach workers in primary care clinics. These outreach workers conduct most of their work in the field, often visiting members in their homes and heavily relying on motivational interviewing. By conducting outreach and engagement in the community, these staff are the eyes and ears of the care team, and are the ones who "...can tell us what is really going on in members' lives."

### OUTREACH EFFORTS SHOULD BE STRATEGIC, AGGRESSIVE, AND QUICK.

As mentioned above, New York's payment structure allows health homes to be paid for up to three months of outreach efforts per eligible member. To qualify for the outreach payment (80 percent of the active care coordination fee), programs must conduct "progressive and meaningful" activities each month, meaning that the intensity of efforts to locate a member must escalate each month that outreach claims are submitted. For example, a program may send a letter in the first month, make phone calls in the second, and attempt to locate the member in person in the third month. Although up to three months of progressive outreach activity can be billed, the majority of interviewed health homes recommend a more aggressive strategy that seeks to locate eligible members as quickly as possible. This approach can shorten the time to successful engagement and enable the health home to draw down 100 percent of the care management payment more quickly. Many of the interviewed health homes noted that rather than limiting activities to one outreach attempt per month, they employ as many of their outreach techniques as possible as soon as outreach begins. Health homes such as CCMP and Coordinated Behavioral Care (CBC) in the downstate region pursue telephonic and community outreach concurrently, and consider using any other forms of outreach activities as needed in the first month.

## Promising Practices *(continued)*

### **STRONG RELATIONSHIPS WITH COMMUNITY PARTNERS AND PROVIDERS ARE CRITICAL.**

Under New York's health home requirements, designated programs must have a contracted network of community partners to enhance the array of available services and increase opportunities for coordination. Developing strong relationships with a broad range of providers and other community-based organizations has thus been critical to health homes' development. In turn, these relationships offer invaluable outreach support. Key partnership opportunities to maximize outreach include:

- *Educate partners about the program.*  
Interviewees reported opportunities for educating partners both within their own institutions and in the outside community. New York City's CBC, for example, has invested heavily in developing marketing materials for eligible patients and community providers. Several health homes discussed intensive efforts to educate their hospital departments about the program, and all have done health home presentations for community stakeholders. The interviewees felt strongly that these efforts led to increased community referrals and to developing relationships necessary to coordinate care for shared patients.
- *Coordinate closely with hospital-based care coordination programs.*  
In particular, interviewees noted opportunities to work with emergency and psychiatry departments, and embed outreach staff in various hospital locations. Niagara Falls Memorial Medical Center, for example, coordinates outreach efforts with the hospital's emergency department care coordination program with the goal of reducing length of stay in its inpatient psychiatric wards.
- *Establish data-sharing agreements with network partners.*  
These agreements have allowed health homes to identify which members are already known to network partners and collect additional contact information. For example, FEGS Nassau Wellness Partners Health Home sends a list of any eligible members it has not been able to locate within a month to the local Department of Social Services (DSS). DSS then sets up flags in its system to alert county mental health workers located in the DSS office when an individual shows up who is eligible for the health home program.

### **ACCESS TO TIMELY, RELIABLE DATA IS KEY TO SUCCESSFUL OUTREACH.**

All of the programs agreed that having access to timely and accurate data is absolutely necessary for effective outreach. As a long-term solution to the data accuracy challenge, the State is creating a web-based portal that will give health home providers and managed care plans access to member tracking information and real-time access to outcome and performance metrics. In the meantime, however, a number of the hospital-based programs, including Bronx Lebanon Hospital Center, Institute for Family Health (IFH), Niagara Falls Memorial Medical Center, and VNS have gained access to systems that provide real-time notification (either via e-mail or text) when an eligible member is admitted or seen on-site for a visit. Notification of an eligible member's whereabouts in real time is one of the most effective engagement tools that health homes have, particularly for those individuals who are difficult to locate through phone calls or community outreach.

# Promising Practices *(continued)*

## EXHIBIT 2. Member Contact Information Resources

### Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

[http://www.omh.ny.gov/omhweb/psyckes\\_medicaid/](http://www.omh.ny.gov/omhweb/psyckes_medicaid/)

A web-based system that provides users with access to quality indicators on individuals who have been diagnosed with or received behavioral health services and/or prescribed psychotropic medications. Contact information included.

### ePACES

[https://www.emedny.org/selfhelp/ePACES/epaces\\_generalinfo.aspx](https://www.emedny.org/selfhelp/ePACES/epaces_generalinfo.aspx)

New York's Medicaid claims data provider portal. Allows users to review claims status, Medicaid eligibility, restrictions, benefits, recertification dates, program enrollment, and contact information.

### Inmate Lookup Services

New York City Inmate Lookup Service: <http://a073-ils-web.nyc.gov/inmatelookup/ils/pages/common/find.jsf>

New York State Inmate Population Information Search: <http://nysdoccslookup.doccs.ny.gov/>

Online look-up tools that provide information on individuals currently in the corrections system.

Information includes custody status, location, date processed, reason convicted, sentence terms, release date, and parole details.

### Online search engines

Spokeo: [www.spokeo.com](http://www.spokeo.com); White Pages: [www.whitepages.com](http://www.whitepages.com)

Websites designed to provide address, phone number, and other contact information about individuals.

### Electronic health records

Systems used by hospitals and clinics to document patient encounters and services provided. Depending on information collected by users, may contain member and next of kin contact information.

### New York City Health and Human Services (HHS) Worker Connect

<http://www.nyc.gov/html/hhsconnect/html/worker-connect/worker-connect.shtml>

Web-based system that allows users to review limited data from multiple city agency databases, including New York Housing Authority (NYCHA), Human Resources Administration (HRA), Administration for Children's Services (ACS), and Department of Homeless Services (DHS), among others.

In addition to hospital-based notification systems, some health homes have obtained real-time alerts for members from either the State's Regional Health Information Organizations (only after a member has been engaged and enrolled) or some managed care organizations (MCOs). To effectively use this information, health homes have had to develop robust workflows to outline how exactly this information is transmitted, who receives it, and who is deployed to respond to it.

Health homes have also discovered an array of sources to mine for additional contact information on eligible members. Exhibit 2, above, summarizes the online tools mentioned during interviews.

Some of the health homes have also formed close relationships with local departments of social services to obtain additional contact information for eligible members.

## Promising Practices *(continued)*

Many of the interviewees were also working closely with one or more MCOs to leverage the information they have on eligible members. Health homes such as Bronx Lebanon, CBC, FECS Nassau Wellness Partners Health Home, HHUNY-Finger Lakes, and Brooklyn Health Home (Maimonides Medical Center) all relied on MCOs, and in some cases behavioral health organizations, to send out letters, provide available contact information, or forward real-time notifications of hospitalizations or other service utilization.

### A COMPREHENSIVE DATA SYSTEM IS CRUCIAL.

Most interviewees noted that a comprehensive and centralized IT infrastructure was necessary to monitor outreach activities effectively. Health homes are required to regularly report data about member outreach and enrollment to the State. Health home lead entities are ultimately responsible for submitting this information, but because outreach activities and associated data entry are often conducted by downstream providers, data must be combined from multiple sources into a single system.

Interviewees agreed that ideally all partners would utilize a single system for not only entering data related to outreach and enrollment, but also for tracking, billing submission, and report generation. None of the health homes had such a system in place as of yet, but a number have developed basic dashboards as an interim step. In the absence of fully integrated systems, some programs are contracting with external vendors to coordinate tracking and reporting functions. For example, Institute for Family Health, CBC, and Brooklyn Health Home have contracted with BTQ Financial, a financial management services company, to handle tracking and reporting. Similarly, Hudson River HealthCare is partnering with the Hudson Center for Health Equity and Quality, a nonprofit technology company, to develop a business portal that will help with data processing, billing, and the shared care plan component.

### OUTSIDE NEW YORK: SPOTLIGHT ON WASHINGTON

#### Tips from Washington State: Enhanced Strategies for Outreach

Washington State has been implementing and evolving complex care management programs for high-need members for more than a decade. When the state's chronic care management program adopted an enhanced outreach strategy (involving sophisticated data-gathering, redesigned client letters, and telephonic outreach), successful enrollments more than doubled and hard-to-reach members became substantially more engaged. (See Appendix B)

# Additional Strategies

## *worth further exploration*

**I**n addition to the promising practices that emerged as consistent themes across the health homes interviewed for this report, the interviews also identified less common strategies being implemented by one or more health homes. In each case, health home providers indicated that these practices helped improve (or are expected to contribute to) their overall outreach and engagement efforts.

### OUTREACH THROUGH FACEBOOK

Central Nassau Guidance, a downstream provider in the FEGS Nassau Wellness Partners Health Home in Nassau County, uses Facebook to support outreach efforts. If outreach team members are able to locate an assigned individual on Facebook and verify the individual's name, date of birth, and hometown, they send a Facebook message introducing the health home program and inviting the individual to contact them to learn more. Staff report that many newly assigned individuals are on Facebook and most are amenable to being contacted this way; however, staff also note that this approach is less successful for legacy case management clients, many of whom are lower functioning or less technically savvy.

### COLLABORATION WITH DEPARTMENT OF PROBATION

In Brooklyn, CBC has structured a unique partnership with the local Department of Probation (DOP). With a signed Business Associate's Agreement and a Data Exchange Application Agreement, the health home will share lists of assigned individuals with DOP to identify prospective enrollees. DOP is providing office space at its Brooklyn location for embedded health home staff to enable real-time introductions (commonly referred to as "warm handoffs") of health home-eligible members to the program. A number of CBC's network partners will be participating in this co-location opportunity, which is expected to yield many new enrollees and facilitate better care coordination with the corrections system. A number of health homes are similarly pursuing collaborations with other partners in the corrections system; for example, Bronx Lebanon has a demonstration project with the New York City Department of Health and Mental Hygiene Bureau of Correctional Health Services.

### INCENTIVES FOR STAFF AND PROSPECTIVE ENROLLEES

Most health homes noted the importance of monitoring outreach and engagement efforts to support quality improvement. Some health homes are considering performance targets for staff involved in outreach efforts. CCMP, which operates in the Bronx and Manhattan, is exploring incentives to encourage staff outreach (for example, awarding gift cards to staff who meet or exceed performance targets). Some CCMP partners also use member-level incentives to support engagement, including providing prospective enrollees with small tokens such as hand sanitizer when meeting to discuss health home services.

### BROAD DISSEMINATION OF TRAINING MATERIALS

To promote consistent use of evidence-based or promising practices, some health homes have developed network-wide trainings for outreach staff. For example, the HHUNY consortium has leveraged its partnership with the New York Care Coordination Program (NYCCP) to hold a series of training webinars addressing outreach as well as other relevant topics. Outreach training content

## Additional Strategies *(continued)*

includes providing education on specific techniques (e.g., skills related to effectively communicating services to individuals); sharing lists of useful websites and resources; and discussing strategies for building relationships within communities (e.g., outreach to barber shops and faith-based organizations). Recorded trainings are posted to the NYCCP website (<http://www.carecoordination.org/Work-of-the-Health-Home.aspx>), providing a resource library for providers both within and outside the HHUNY network. Similarly, CBC has developed a training manual for its broad network of downstream providers and disseminated this information through webinar trainings, which have been posted on YouTube.

### SUPPLEMENTAL WORKFORCE/TRAINING RESOURCES

Given resource constraints, many health homes report “wishing they could invest more” in outreach and engagement activities. Accordingly, some health homes are bolstering their outreach efforts through collaboration with other programs or by seeking supplementary funding. For example, Bronx Lebanon Hospital Center is leveraging two groups of non-health home staff to support outreach efforts. First, the health home team collaborates with the hospital’s community physician liaisons to receive alerts when current or prospective health home enrollees receive services from within the hospital system. Second, the health home uses volunteers from STRIVE, a job readiness program, to support its outreach efforts.

Other health homes have been able to leverage additional funding to enhance training capabilities. For example, Brooklyn Health Home is developing training modules for its staff and network partners by linking these efforts to its Center for Medicare & Medicaid Innovation (CMMI) Award and to the hospital workers’ union, 1199, which has a Training and Upgrading Fund. Similarly, CCMP received funding from the Altman Foundation to develop a training curriculum. By identifying new funding sources, these health homes have been able to expand staff training resources beyond what would be available solely through health homes funding.



# Observations & Opportunities

**T**wo years into health home implementation, interviews with health home providers in New York State identified valuable lessons to guide successful outreach and engagement efforts. Following are key considerations for policymakers and providers to support the continued evolution of New York’s health home model, as well as relevant models in other states.

**Payments for outreach to high-need populations are critical, but the current method may warrant reform.** As New York officials recognized in the initial design of the State’s health home program, substantial effort is required to locate and engage many of the individuals targeted for health home services. Health homes universally report that outreach payments provide vital support, enabling the hiring of dedicated outreach teams to find and enroll individuals who are likely to benefit from the health home model, but who might otherwise remain off the radar. Most providers further agreed that the time limit of paying for outreach for up to three months is sufficient, as most of the eligible members who can be found will be located during that period.

Even so, most interviewees suggested that other aspects of the outreach payment methodology could be improved. Whereas the current methodology pays 80 percent of the acuity-adjusted health home rate for outreach, providers generally agreed that the level of outreach required is unrelated to an individual’s acuity score. While some suggested that a flat rate for engagement be considered as an alternative, others proposed that outreach payments be adjusted based on the quality of contact information available or by where an individual lives.

Washington State’s health home model provides one example of an alternative approach. Washington health homes receive an initial payment upon completion of a “health action plan,” a comprehensive care plan based on assessment of individual needs. This payment is larger than the ongoing monthly payment for intensive care management that follows, because it covers costs associated with outreach and engagement as well as the cost of developing the care plan.

**Flexibility is useful at the start of a broad-scale rollout, but standardization of practices within health home networks will likely emerge over time.** Across the landscape of health home providers, and even within individual health home networks, there is substantial variation in outreach efforts. By necessity, programs have leveraged a diverse array of legacy staff, and lead health home entities have largely allowed network partners to define their own approaches to outreach and other health home functions. These decisions have been driven by business and operational realities, as well as the need to build organizational knowledge about which approaches are worthy of replication. To date, providers have “let a thousand flowers bloom” with respect to engagement in and delivery of health home services. Arguably, a system principally focused on outcomes should be willing to tolerate variation in these processes. However, as best practices emerge and the health home model matures, health homes should encourage the replication and spread of more effective approaches, and discourage use of outreach models that do not produce desired engagement rates.

## Observations & Opportunities *(continued)*

**Assignment lists are necessary, but community referrals are the key to long-term viability.** Health homes are not shy about their many frustrations with “working the lists” of assignees; the information is poor, the resource demands are high, and the yield is low. Regardless, most health home providers agree that the lists include many individuals who would benefit from health home services, and also acknowledge that the lists provide initial enrollment volume that is necessary for financial viability.

Still, as one upstate health home put it, if health homes remain dependent on lists, they are not going to survive—particularly given the magnitude of the outreach and engagement challenge associated with list assignments. Improved outreach strategies will help, but many health homes are increasingly focused on generating referrals from network providers and other community partners. This vision is consistent with the overall policy goal for New York health homes: integrated networks of providers and social service organizations that work in coordinated fashion to ensure that individuals with complex needs do not fall through the cracks.

**“Feet on the street” may require different approaches in rural settings.** Many aspects of health home implementation vary between rural and urban environments, and outreach strategies are no exception. For example, rural health homes that were interviewed shared the challenges, both financial and logistical, associated with the “feet on the street” approach that is considered essential for effective outreach in urban or suburban settings. For example, it may be highly inefficient for outreach workers to travel long distances in rural regions to locate and engage new assignees given the risk of incorrect address information. Although bad addresses exist for urban populations as well, the opportunity costs of sending someone out to these addresses are much higher when it might take an hour or more to get from one location to the next.

Accordingly, rural health homes may need an even greater focus on community referrals than their urban counterparts—and many are investing their resources in this direction. Whereas urban health homes may hire cadres of community health workers to pound the pavement in local neighborhoods, rural health homes might invest similar resources in “community liaisons” who build relationships with referring service providers—potentially embedding such staff in high-volume, high-opportunity settings.

**Tailored outreach approaches are needed for discrete sub-populations.** Health homes report that certain sub-populations are more difficult to engage in health home services than others. For example, a number of interviewees cited that individuals served by legacy case management programs—such as those focused on mental health, substance use, or HIV—are accustomed to being offered these types of services and supports, and thus may be quicker to accept offers for health home enrollment. However, individuals with other chronic medical conditions such as diabetes or congestive heart failure, for example, may need more time, information, or convincing regarding how health homes could help meet their needs.

A number of health homes reported on the unique strategies required to engage individuals experiencing homelessness, including partnerships with shelter operators and a concerted focus on addressing housing needs. Others mentioned individuals with family caregivers, and the need to tailor

## Observations & Opportunities *(continued)*

the health homes pitch around how the model can support (and, importantly, not supplant) caregivers in their broader efforts to manage family members' needs. Finally, a number of health homes identified certain racial/ethnic groups as being more apprehensive about health home enrollment, highlighting the need to develop culturally sensitive and language-accessible marketing materials, as well as the opportunity to engage CHWs representing these groups to support outreach.

**Hand-offs are tricky and require further attention.** As highlighted earlier, most health homes are evolving toward the use of dedicated outreach staff who solely focus on “working the lists,” managing referrals, or some combination of the two. However, interviewed health homes also universally recognized the risk that enrollees might fall through the cracks during the hand-off from outreach staff to care coordinators and most acknowledged that they have not yet perfected their approaches to managing these transitions. All suggest that hand-offs should happen as quickly as possible; each day that passes increases the risk of losing an otherwise engaged individual. Some point to promising kernels of success, such as real-time hand-offs by phone to available care coordinators, or same-day hand-offs in certain regions/neighborhoods where the logistics make that feasible. As more accurate tracking and monitoring data become available to health home administrators, hand-offs should be a critical area of focus. Finally, if the data point to organizations with particularly strong performance in managing hand-offs, best practices should be identified and broadly replicated across health home networks.

# Conclusion

**H**ealth homes in New York State have evolved from concept to reality over the last several years, spurring the development of newly integrated networks of providers with shared accountability for delivering coordinated health care services to high-risk Medicaid beneficiaries. This substantial delivery system reform effort holds tremendous potential to improve outcomes and reduce costs for some of the State’s most vulnerable residents; however, in this case, policymakers and providers cannot rely on the adage “if you build it, they will come.” Experience both within and beyond New York suggests that a highly resourced outreach and engagement effort is necessary to bring the benefits of health homes to many of those who need these services the most.

As described throughout this report, many valuable lessons can be gleaned from the outreach efforts employed by New York’s health homes to date. To improve the delivery of care for some of New York’s most vulnerable populations, it will be important to continue to build upon and refine this list of best practices over time. Fortunately, a number of resources exist to facilitate ongoing investment in the identification and spread of effective outreach and engagement strategies. For example, DOH officials have recently provided \$15 million in implementation grants to assist health homes with implementation challenges, including outreach efforts. Moreover, the State is also working with the Centers for Medicare & Medicaid Services to provide additional resources through the State’s Medicaid Redesign Team waiver for health information technology connectivity, health home promotion and member engagement, governance, and workforce training. Collectively, these resources have the potential to considerably enhance health homes’ outreach and engagement efforts, and to strengthen their capacity overall.

# Appendix A.

## *Interview Guide*

1. **Enrollment Efforts To Date**
  - a. How many individuals have you been assigned to date?
  - b. Of these, how many are new vs. converting/legacy clients?
  - c. Of the new clients, how many are currently in outreach? In active care management?
  - d. On average, how long does it take to enroll new members?
  
2. **Organizational Structure**
  - a. Describe the overall structure of your health home network. How many downstream provider organizations are included? What types of entities do they represent?
  - b. What services are you providing directly, if any?
  
3. **Staffing/Resource Model**
  - a. How do you staff the outreach function?
    - i. Does outreach occur at the lead health home level or within the downstream provider organizations?
    - ii. Do you have dedicated outreach workers? If so, what skill set/credentials do you look for in hiring? How do you manage hand-offs to care coordinators so as not to lose people in the transition?
    - iii. Are there standard caseloads for outreach workers?
  - b. Is there a standard approach to outreach across downstream providers? Are specific protocols required? (e.g., definition of meaningful and progressive outreach)
  - c. Do you provide any specific training to support outreach efforts?
  - d. Do you partner with other organizations to support/enhance outreach efforts?
  - e. Do you use any external data sources/services to enhance outreach efforts?
  
4. **Best Practices**
  - a. What aspects of your outreach model are most effective and worthy of replication?
  - b. What modifications or new elements, if any, are you considering making to your outreach efforts?
  - c. How are you monitoring the success of outreach efforts among downstream providers? Do any organizations stand-out as doing a particularly good job?
  - d. Do you have targets for moving individuals from outreach to active status? If so, who is accountable for achieving them? (e.g., lead health home, downstream partner, outreach workers, care coordinators)
  
5. **Challenges Encountered**
  - a. Are there specific subpopulations that pose particular outreach challenges for your health home? If so, are you attempting any tailored strategies to address them?
  - b. What administrative challenges affect your outreach efforts? What suggestions would you have for addressing them?
  - c. Is the fact that Medicaid pays for outreach efforts important? Is three months sufficient? Would you recommend any changes to this incentive structure?

# Appendix B.

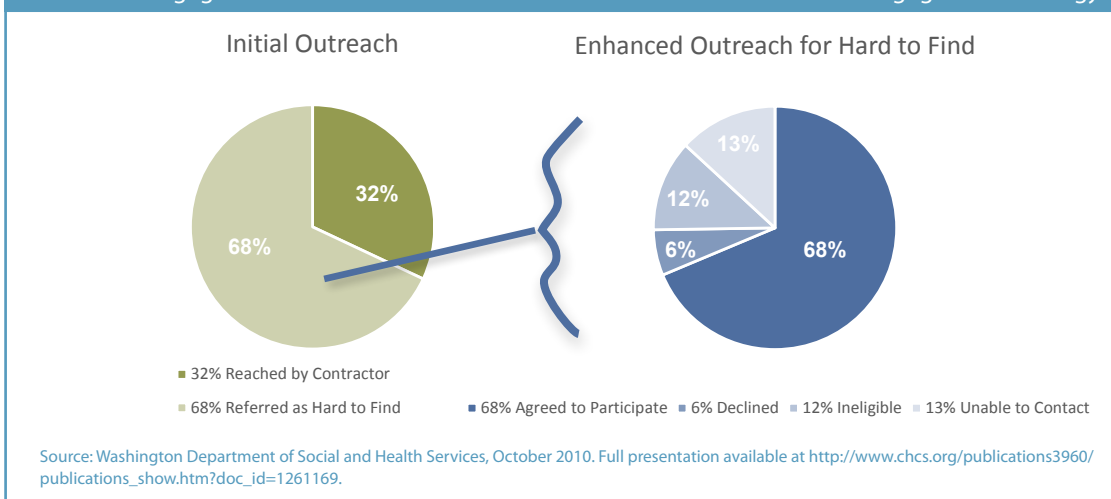
## Tips from Washington State

### “Mail on a Tuesday” and Other Tips for Effective Letter Campaigns

One important element that particularly lends itself to broad replication is an introductory letter to prospective enrollees. Washington State significantly improved their response rate by doing the following:

- Including bright stickers on envelopes to distinguish from bills or Medicaid eligibility inquiries. Follow-up calls by outreach workers can then refer to “the letter with the green sticker.” Suggested messages include:
  - “New Services for You!”
  - “Important! Please reply”
- Sticking to simple messaging. Use plain language and avoid use of complex terminology.
- White space is your friend. Minimizing the amount of text to the essential elements, leaving plenty of white space on the page.
- Signing in cursive in blue ink by medical directors. Letters signed by doctors have more credence with clients, and blue ink gives a more individualized appearance.
- Offering an incentive. The Washington program has had great success with supermarket gift cards.
- Sending follow-up letters with handwritten notes.
- Including mail-back response forms (Exhibit B2) with self-addressed, prepaid envelopes. Response forms should be simple and colorful, use visual cues, and ask for confirmation of address, language, phone numbers, and best times to call. The back page of the Washington form included a paragraph in 20 different languages explaining how to call for assistance with translation, with the TTY/TDD line.
- Mailing on a Tuesday: Survey research has documented that letters mailed on a Tuesday have the highest likelihood of being read.

Exhibit B1. Engagement of Hard-to-Find Members Before and After Enhanced Engagement Strategy



# Appendix B. (continued)

## Exhibit B2. Sample Response Form



### Tell Me About My New Services

### and the \$10 Safeway Gift Card!

#### Here's How To Reach Me:



My phone numbers are:

( ) \_\_\_\_\_ Days  
( ) \_\_\_\_\_ Evenings  
( ) \_\_\_\_\_ Cell Phone  
( ) \_\_\_\_\_ Messages



Best time to call me (mark all that are good):

- Mornings (9-noon)
- Afternoon (1-4)
- Early Evening (5-7)
- Later Evening (7-9)
- Weekends



Do we have the right language for you?

«Primary Language»

- Yes, it's right!
- No, the best language is: \_\_\_\_\_



Do we have the right address for you?

- Yes, it's right!
- No, it's not right. See corrections marked below:

Name: «NAME»  
Address: «Address Line 1»  
          «Address Line 2»  
          «City», «State» «ZIP Code»

Remember to send this form back in the enclosed envelope. You won't need a stamp. If you would rather call to tell us how to reach you, or let us know you don't want to be contacted again, **please call (206) 727-6270.**



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