UHF Medicaid Conference | DSRIP Promising Practices Highlights CBC's SI CARES

Staten Island Community At-Risk Engagement Services (SI CARES) is a short-term health focused preventive case management intervention, offered as part of Coordinated Behavioral Care (CBC) case management continuum of service offerings.

SI CARES was highlighted and served as Staten Island PPS's Case Study in the UHF published DSRIP Promising Practices Highlights: Strategies for Meaningful Change for New York Medicaid.

Potentially Avoidable Services

Access to Primary and Preventive Care

Care Coordination and Care Transitions

Health Literacy

CASE STUDY: PROVIDING COMPREHENSIVE CARE COORDINATION TO AN AT-RISK POPULATION

Staten Island PPS (SIPPS) has partnered with Staten Island's two Health Homes (Coordinated Behavioral Care and Northwell Health Solutions), as well as Community Health Center of Richmond and the Seamen's Society for Children and Families, to provide care coordination staff and services for its SI CARES program. SI CARES offers health coaching and community support to individuals "at risk" of Health Home eligibility—defined as PPS members with at least one chronic health condition and at risk of developing another condition.

The program's care coordinators help at-risk members access needed health care and social support services. The PPS trains these staff on chronic condition and care coordination fundamentals, value-based-payment and pay-for-performance measures, and health literacy and cultural competency standards. The PPS has also developed checklists, scripts, and motivational interviewing strategies for the care coordinators to identify and close specific gaps in care that could affect DSRIP performance. Examples include assisting members with accessing primary care and referring members for condition-specific screenings or follow-up visits.[39]

SI CARES also uses sophisticated tools for targeting and tracking at-risk patients, such as the PPS's data warehouse and connections to its local regional health information organization (RHIO). For instance, the PPS's data warehouse generates reports identifying ED and inpatient super-utilizers, while the RHIO provides immediate alerts on ED visits and inpatient admissions. Patients who eventually become Health Home-eligible are identified through these tools and through the front-line care coordination staff, whose connections to the Health Homes allow for seamless care management during changes in patient status.

The PPS uses key performance indicators to measure and monitor care coordination staff performance on patient engagement, clinical outcomes (ranging from primary care utilization to chronic disease management), and social determinants of health interventions. SIPPS reports that over 7,500 members received SI CARES between April 2015 and October 2018, and that these members' ED use was reduced by 22% over that period. Ultimately, the SI CARES design is consistent with DSRIP priorities in multiple areas, such as reducing avoidable ED visits and hospitalizations, improving access to primary care and care coordination, and advancing PPS members' health literacy.[40]

SI CARES is designed to assist community members to become linked and engaged with community-based providers to better manage their health care needs. As one of the DSRIP projects implemented on Staten Island, the goal is to provide a comprehensive intervention for Medicaid lives with one chronic health condition to achieve reduced hospital utilization rates and prevent/ delay the onset of other chronic health conditions.

In partnership with 4 Care Management Agencies (Staten Island Mental Health Society, The Jewish Board, Community Health Action of Staten Island, and Project Hospitality), CBC provides a centralized access point for referrals across Staten Island. Each SI CARES team is made up of four Health Coaches who engage eligible community members around their health care needs and factors that influence health care outcomes, specifically social determinants. SI CARES engagement includes a check in, follow up, and follow through of needs, and consists of handoffs to other internal or external services as necessary. The SI CARES model of preventative care management includes immediate needs assessment, health promotion, education, connections to services, and annual community needs "check-ups."

The SI CARES model has demonstrated how it is possible to serve a high volume of individuals while still positively impacting quality outcomes.

For more information on SICARES:

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