



GRHHN – The Provider of Choice

Supporting Your Network With the Tools and Resources to
Provide the Highest Level of Service to Your Patients





AND



Using the GRHHN referral and claims data and FLPPS DSRIP claims data, we can **expand our collective network, and data analytics capability**, to better understand and support vulnerable populations.

Optimal Care Management services for vulnerable populations will be key to the success of health care delivery system transformation, and ultimately key to a successful transition.

Care Management Agency Oversight

Tableau-based Interactive Chase List Tool

Tableau Dashboards
 QA activities
 Gap in Care Dashboards
 Re-designation
 Implementation

Dashboard Agency

Final PCP Org

Most Recent GRHH CMA

Prioritization Score (All) County MONROE

Program Type HH Patient HH Eligibility (All)

Month, Yr End Date (All)

Most Recent GRHH Activity

(All)

Assigned

Client Search

Discharge

Opt-Out/Withdraw

Count of Clients

1

CIN Search

CIN	First Name	Last Name	PCP NPI	Prioritization..	# of Notes	
			1780843649	17	8	Opt-Out/Withdraw
			1386968006	18	1	Discharge
			1225056294	NO RANK	7	Opt-Out/Withdraw
			1912943416	NO RANK	3	Discharge
			1275577488	NO RANK	1	Discharge
			1275617979	16	6	Discharge
			1265467989	NO RANK	1	Discharge
			1083970156	17	5	Opt-Out/Withdraw
			1912943416	NO RANK	9	Discharge

Notes: Outreach & Discharge
 Hover over the far right column to view [Note Text](#)
 **Unless the client is in Client Search, any notes are from their most recent episode of care that has ended.

Note Date	Contact Status	Search Type	
6/13/2016	No Contact	Telephone	Continue Search
7/12/2016	No Contact	Telephone	Continue Search
8/15/2016	No Contact	Face to Face	Continue Search
12/12/2016	No Contact	Mail (Includes Faxes)	Continue Search
1/10/2017	No Contact	Mail (Includes Faxes)	Continue Search
		Telephone	Continue Search
2/21/2017	No Contact	Face to Face	Continue Search
3/2/2017	No Contact	Note Type: "Contact" and Non-Bill..	Client Opts-out of Health Home Services

Contact Details

Phone 1	Phone 2	Email Address	
	Null	Null	



MAXIMIZING REVENUE

GRHHN can provide chase lists for Care Management agencies to make them aware of which clients are missing chronic conditions or do not have quantitative evidence of risk factors.

Chase lists are prioritized based on chronic conditions and other risk factors.

Assistance with screening tools and training to complete eligibility assessments is available.



SUPPORTING YOUR PATIENTS

Our work is part of a coordinated effort to improve care among a vulnerable population, helping individuals with appointment setting, follow-up, access, and much more.

This results in increased continuity of care, reduced system costs, improved outcomes, and reduced burdens in Emergency Departments. *

YOUR CONNECTION TO NYS DEPT OF HEALTH

GRHHN anticipates changes from the state and is proactive in leading changes that benefit patients.

GRHHN and FLPPS staff have close ties to the NYS Department of Health as a lead health home as well as FLPPS' role as an integrated healthcare delivery system to better support Medicaid and uninsured populations across the Finger Lakes region.



**Department
of Health**

A LEADER

As a lead Health Home, GRHHN is committed to ensuring quality oversight across all partnering Care Management Agencies, including universal training for non-centralized care managers supporting patients.

Search courses, content and more...

CHANGE PASSWORD MY PROFILE

100% PROGRESS

Click HERE to view your Course Catalog

35 items

As with training and resources, relevant to your job and working with GRHHN.

Writers Writing Activities **NEW** PDF

GRHHN DOH-5055 in Spanish **NEW** PDF

Job Aid - Diligent Search (DSE) **NEW** PDF

Job Aid - GRHHN Comprehensive... **NEW** PDF

Job Aid - GRHHN Health Home Plus Process **NEW** PDF

TRAINING

The GRHHN Resource Library provides a wide variety of job aids, policies, procedures and trainings.

It also contains eLearnings, classes and webinars on a wide variety of topics relating to Care Management, Professional Development and current training topics.





Core Services Provided by Health Home Care Managers

COMPREHENSIVE CARE MANAGEMENT

Coordinate & facilitate team meetings with care manager, client and care team members to address overall needs and assist with care plan development.

HEALTH PROMOTION & CARE COORDINATION

Encourage and educate clients on healthy behaviors to promote self-management. Provide essential links to close gaps in care and address social determinants of health.

MEMBER AND FAMILY SUPPORT

Ensure the clients support system can offer the support necessary and appropriately demonstrate an understanding of the client's needs.

COMPREHENSIVE TRANSITIONAL CARE

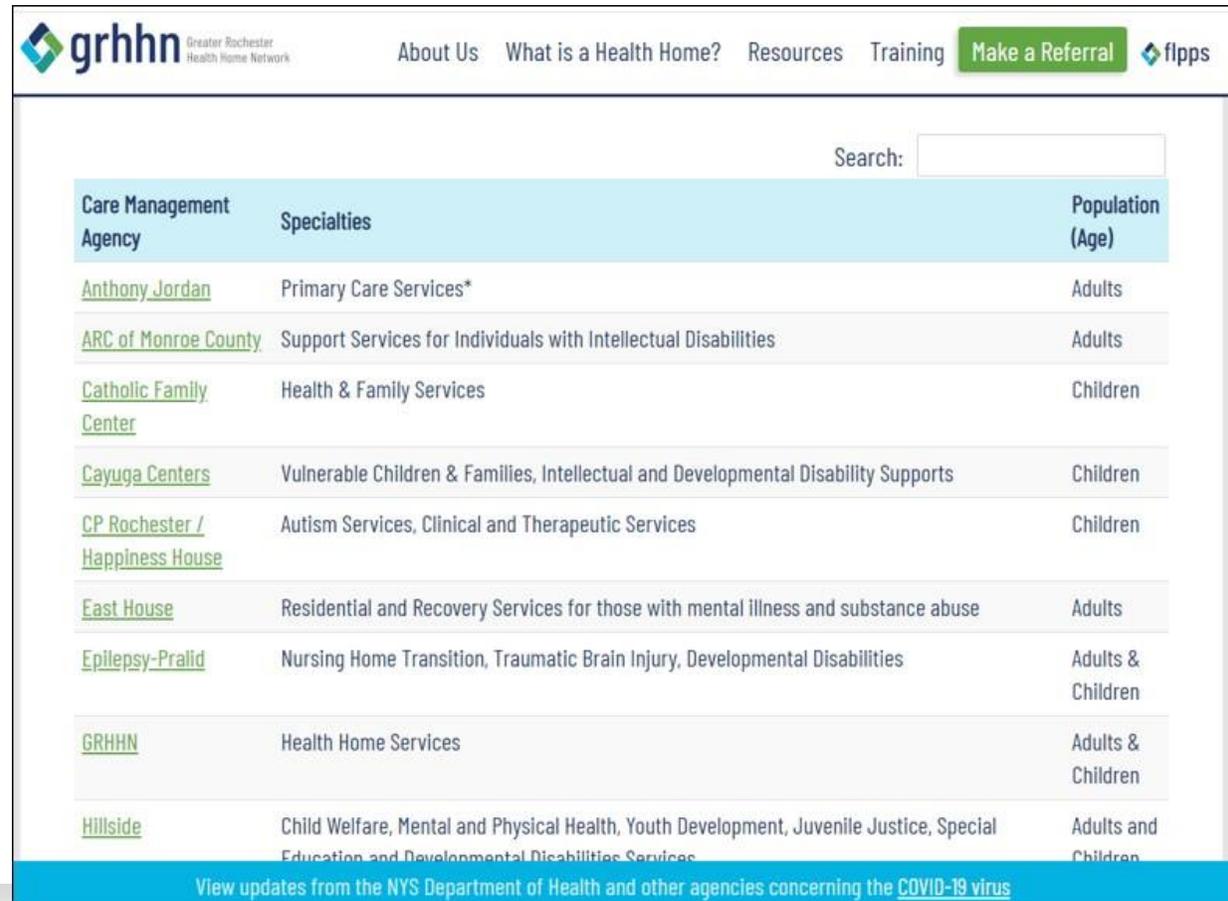
Respond to emergency department and/or inpatient hospitalizations upon notification to ensure care coordination efforts continue following discharge.

REFERRAL AND COMMUNITY SUPPORT

Identify & connect the client with community supports and services by referring to appropriate agencies who can assist in meeting the client's needs.

CLOSE TIES TO COMMUNITY BASED PROVIDERS

GRHHN works closely with frontline community providers, offering support, training, workflows, data analysis and clear, open transparency.



The screenshot shows the GRHHN website interface. At the top, there is a navigation bar with the GRHHN logo (Greater Rochester Health Home Network) and links for 'About Us', 'What is a Health Home?', 'Resources', 'Training', and a green 'Make a Referral' button. A search bar is located on the right side of the page. Below the navigation bar is a table listing various community-based providers. The table has three columns: 'Care Management Agency', 'Specialties', and 'Population (Age)'. The providers listed include Anthony Jordan, ARC of Monroe County, Catholic Family Center, Cayuga Centers, CP Rochester / Happiness House, East House, Epilepsy-Pralid, GRHHN, and Hillside. A blue banner at the bottom of the screenshot contains the text: 'View updates from the NYS Department of Health and other agencies concerning the COVID-19 virus'.

Care Management Agency	Specialties	Population (Age)
Anthony Jordan	Primary Care Services*	Adults
ARC of Monroe County	Support Services for Individuals with Intellectual Disabilities	Adults
Catholic Family Center	Health & Family Services	Children
Cayuga Centers	Vulnerable Children & Families, Intellectual and Developmental Disability Supports	Children
CP Rochester / Happiness House	Autism Services, Clinical and Therapeutic Services	Children
East House	Residential and Recovery Services for those with mental illness and substance abuse	Adults
Epilepsy-Pralid	Nursing Home Transition, Traumatic Brain Injury, Developmental Disabilities	Adults & Children
GRHHN	Health Home Services	Adults & Children
Hillside	Child Welfare, Mental and Physical Health, Youth Development, Juvenile Justice, Special Education and Developmental Disabilities Services	Adults and Children

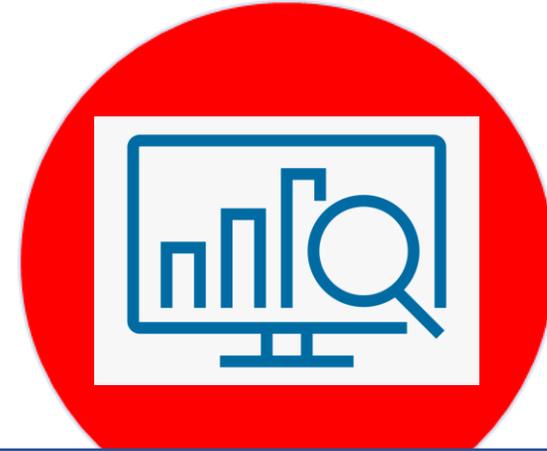
View updates from the NYS Department of Health and other agencies concerning the COVID-19 virus

High Level Steps to become a Health Home Care Management Agency

The GRHHN represents a network of 20 Care Management Agencies across Monroe County.

- ✓ Hire and train qualified care managers
- ✓ Adopt health home care management policies, procedures and workflows in your organization
- ✓ Provide care management services to newly enrolled patients
- ✓ Administrative requirements include:
 - Establish your Organization as a certified Medicaid provider
 - Implement a robust quality and compliance program
 - Adhere to data-sharing and PHI requirements, including HIPAA compliance
 - Training on and implementation of certain technology platforms including the Electronic health record (Netsmart)
 - Required training and background checks for Workforce (complete within 60 days)

ELIGIBILITY



Medicaid recipients (includes managed care and dual eligible - Medicaid and Medicare)

Those who may have:

- significant mental illness or serious emotional disturbance
 - HIV/AIDS
 - complex trauma, if under 21
 - two or more chronic health conditions (i.e. asthma, diabetes, heart disease, mental health condition, substance use disorder, etc.)
- Risk assessment - individual must be assessed for factors that influence health care: Homelessness, recent hospitalization, barriers to accessing care, food insecurity

QUESTIONS?



Make an **ONLINE CARE MANAGEMENT REFERRAL** at: <https://referral.grhhn.org> or call **585-350-1400** if you have any questions about making a referral.

- Referrals can also be submitted to GRHHN via fax 585-978-7714 or sent via secure email to grhhnintake@flpps.org