**Member Death**

[Member] was enrolled into the Health Home Samaritan Care Management program on November 1, 2020. [Member] was referred to care coordination for lack of social and family support, lack of attending appointments as well as taking medications as prescribed. Since working with Samaritan Care Management, [Member] was connected with providers needed such as Cardiology, Gastroenterology and Hematology. [Member] was provided with reminders of medical appointments as well as transportation and assistance at her appointments. Since care coordinator was transferred [Member]’s case in April, she has been hospitalized six times due to decline in health related to COPD, Renal Failure, Anemia and Aortic Valve Stenosis. Care Coordinator received a HIXNY alert of [Member]’s discharge from Samaritan on 09.05.21 where it was learned [Member] passed away on this date. [Member]’s family signed a DNR and DNI during Member’s latest hospitalization. [Member]’s family was called to Samaritan Hospital where they were at her bedside at time of death. Care Coordinator proceeded to leave a voicemail for [Member]’s son to give her condolences at this time. Care Coordinator also informed Twin River’s Medical where [Member] was seen by Dr. Peacock as her PCP and Abbigail from Nascentia of her passing.

**Member in Inpatient Facility**

[Member] was enrolled into the Health Home Samaritan Care Management program on November 1, 2020. [Member] was referred to care coordination for lack of social and family support, lack of attending appointments as well as taking medications as prescribed and not having adequate housing. Since working with Samaritan Care Management, [Member] was connected with providers needed such as Nephrology and had secured housing by making improvements at her current residence. [Member] was provided with reminders of medical appointments as well as transportation. Since care coordinator was transferred [Member]’s case in April, she has been in the ER multiple times as well as in Rehabilitation Facilities. In April 2021 [Member] signed herself out of rehabilitation AMA and ended back up in Greene Meadows in June 2021. [Member] was seen in the ER in late August where she was then transferred to Diamond Hill Nursing Rehabilitation center where she is currently receiving Dialysis and is bed ridden. Care Coordinator spoke with [Member] on the phone who reports she is permanently placed at a higher level of care and from Rehabilitation will transfer to an Assisted Living Facility. Care Coordinator spoke with [Member] about no longer being eligible for Health Home services due to inpatient in Rehabilitation Facility and [Member] was understanding of this. Writer also contacted [Member]’s PCP office and to inform Dr. Odin of her current inpatient at Diamond Hill and no longer receiving services from care coordination effective September 20th, 2021. CDPHP was also notified of the member's closure with Health Home services.

**Member Graduation**

[Member] is being successfully disenrolled from the Health Home program. Shew was initially enrolled on 4/2021 and identified moving to a senior housing residence, getting connected to medical providers as well as finding employment. During her time in the program [Member] has been able to manager her medical appointments well on her own. In the last few months, [Member] has become involved in online educational programs that will help her find appropriate employment. [Member] also applied to several housing residences and has been placed on multiple housing waitlist. [Member] will be working with staff at the YWCA to help with any moving needs that may arise and has information from Rensselaer County DSS in case she has additional questions. [Member]’s insurance is no longer compatible with the Health Home Program. This was discussed with [Member] and she noted that she is successfully working on her goals and feels that she will be able to manage her interests independently. [Member] met with Health Home Care Coordinator and discussed successful disenrollment; she was also able to sign the withdrawal of consent. [Member] did not have any questions or concerns with being disenrolled from the Health Home Program.

**Member moved out of State**

[Member] was enrolled into the Health Home program on 10/07/2020. At the time of enrollment, [Member] identified that he needs assistance with being more consistent when it comes scheduling and attending his medical appointments to maintain optimal health. During his time in the program, [Member] attended various medical appointments. He also started to submit applications to move out of his sister’s residence. [Member] went to visit with family in Florida on 4/2020 and had told his Care Coordinator that he would return soon. [Member] has now been in Florida for several months and states that he is planning to stay with family in Florida for an extended period of time and does not have a set return timeframe. Due to this, [Member] will be discharge from the Health Home program. [Member] was told that he can re-enroll on his return. [Member] is being disenrolled since he is not currently living in a serviceable area for Capital Region Health Connections. No mailing address was provided, and therefore discharge paperwork was unable to be mailed to the Member.

**Member Lost to Service / Disengaged from HH Services**

Member was referred to the HH in November 2019 by Eric Kingsbury, HARP Case Manager at Fidelis for risk of losing housing, assistance with transportation to appointments, lack of social and family support, food insecurities, poor connectivity with health care providers, and high-risk health issues. Member is diagnosed with Carpal Tunnel Syndrome, social phobia, depression, aggressor identification syndrome and asthma. During Member’s enrollment with HH program Member was rarely engaged with this writer. In the month of July Member was placed into Diligent Search Efforts (DSE) due to having no contact with previous CC for more than 30 days. Writer made attempts to contact Member through notifying Member’s MCO, phone calls, face to face visits as well as pop-up visits. Writer sent Member multiple notifications through mail that if Member would like to remain receiving the services from the HH program to reach out to writer. Writer never received notice from Member stating that they would like to remain in the program. Member remained in DSE for the month of July and August and these attempts were made throughout those months. Member was provided the Notification of Disenrollment on 8-17-21. Due to Member’s lack of engagement member will be disenrolled with the HH program as of 8-31-21. Member's MCO and mental health provider [Provider] were notified of the closure.