NYS Health Home 101

HEALTH HOME PARTNERS OF WESTERN NEW YORK
your partners in hope

GBUAHN
The Greater Buffalo United Accountable Healthcare Network

Niagara Falls Memorial Medical Center Health Home

HHUNY
HEALTH HOMES OF UPSTATE NEW YORK
Empowering you. Expanding possibilities.

best|self
BEHAVIORAL HEALTH

- Health Homes are not a place. They are **FREE** community care management services. Health Homes serve eligible high need/high cost Medicaid beneficiaries with multiple and chronic conditions.

Chautauqua County Department of Mental Hygiene

What is a Health Home?

- A Medicaid care management service model in which:
  - All individuals' caregivers communicate with each other
  - All individuals' needs are addressed
- Care is coordinated by a care manager who oversees and helps provide access to needed services to:
  - Ensure improved health
  - Avoid ER visits and hospital stays
- Various organizations provide services that will help that individual achieve their goal to stay healthy
- **Collectively these services are called a Health Home**

Reference: health.ny.gov

What is a Health Home? (continued)

- Participation is not mandatory but is encouraged
- The Health Home benefits the individual as a whole, not just his or her chronic conditions
- The care manager helps develop a care plan that is consistent with the goals of the individual
- It is free of charge

Eligible Population

- Medicaid eligible AND:

Either

- 2 chronic conditions (asthma, diabetes, COPD, obesity, substance abuse impacting patient's ability to function, etc.)

OR

- 1 single qualifying condition:
  - HIV/AIDS
  - Serious mental illness (bipolar disorder, schizophrenia, etc.)

Determinants of Medical, Behavioral, and/or Social Risk Can Include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission)
- Lack of or inadequate social/family/housing support
- Lack of or inadequate connectivity with healthcare system
- Non-adherence to treatments or medication(s) or difficulty managing medications
- Recent release from incarceration or psychiatric hospitalization
- Deficits in activities of daily living such as dressing or eating
- Learning or cognition issues

How Do Health Homes Work?

- **Patients can be referred by:**
  - Primary care providers
  - Managed care organizations
  - **Any provider organization**
  - NYS Department of Health
  - Emergency departments
  - Inpatient/outpatient providers
  - Self referrals
- Patients are assigned a care manager who provides person-centered navigation of both:
  - Healthcare services
  - Social determinants of health needs (assisting with linkage to housing, transportation, behavioral health, nutrition, social services, etc.)
- **PCP relationship is retained**

Why a Health Home?

- Helps patients with complex medical, behavioral, and long-term needs navigate the healthcare system more effectively
- Goal: to improve their health, stay linked with their PCP, and decrease healthcare costs
- Core services free to patients include:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Referrals to community and social supports
  - Use of health information technology (HIT)to link services

How Can a Health Home Help Your Practice?

- Today
  - Fee for service
  - Care and payment for individual patients only if/when they show up for an office appointment
- Tomorrow
  - Value-based
  - Responsibility, payment and RISK for health & wellness of ALL patients on your panel (population health) even when they don't seek care – Health Homes can "extend" your care 24/7 into the community where patients live, work and recreate

Health Home Enhance Patient Outcomes by….

- Bi-directional communication with Providers
- Reduce No Shows
- Increase Treatment Adherence
- Support Patients and their Care Givers
- Better Patient Satisfaction
- Anticipate changing payment environment(VBP)
- "Boots on the ground"
- Practices, Health Homes and Millennium are all being held to the same HEDIS performance measures by MCO and State payers. We can help each other meet them!

Health Home Providers in WNY

- Greater Buffalo United Accountable Healthcare Network: **GBUAHN** (www.gbuahn.org)
- Health Home Partners of WNY: **HHPWNY** (healthhomewny.com)
  - Catholic Health
  - Spectrum Human Services
  - Evergreen Health Services of WNY
- Health Homes of Upstate New York: **HHUNY** (carecoordination.org)
  - Western: BestSelf Behavioral Health
  - Southern: Chautauqua County Dept. of Mental Hygiene
- Niagara Falls Memorial Medical Center: **NFMMC** (nfmmc.org)-Niagara County Only

How to Make a Referral

- Use Universal Referral Form which is available - located on Millennium Collaborative Care Web Site
- http://millenniumcc.org/resources/

HEALTH HOMES

- Health Home Information Sheet-Patients
- Health Home Information Sheet-Providers
- Universal Referral Form – Adult
- Contact Health Home directly via website or phone

Together We can Make our Community Healthy!