

#### Adirondack Health Institute

Lead • Empower • Innovate

# Health Home Care Management Reaching the Vulnerable

#### **Panelists:**

Carol Byron, RN, Glens Falls Hospital Hayley Fye, Citizen Advocates Mary Madison, RN, Glens Falls Hospital Renee Stephenson, Alliance for Positive Health

Moderator:

Mary McLaughlin, RN, MBA, Executive Director – Glens Falls PHN, AHI

Sept. 27, 2018



## **Health Home Services**

• Health Homes provide the following services:

- ✓ Comprehensive Care Management
- ✓ Care Coordination and Health Promotion
- ✓ Patient and Family Supports
- ✓ Referral to Community and Social Support Services
- ✓ Use of Health Information Technology (HIT) to Link Providers and Services

#### **Health Home Goals**



- Lower Medicaid costs
- Reduce preventable hospitalizations and emergency room visits
- Improve patient outcomes

Think Triple Aim

#### **Target Population**

- Medicaid members with physical, behavioral and social risk factors
- Identified through community referrals and Medicaid claims

**Think High Utilizers** 





# How is Health Home Care Management Different

- Not disease-focused.
  - $\checkmark$  It is patient centered.
    - Care plan vs. treatment plan
- Not transitions-focused.
  - ✓ It is long-term.
    - Life Managers
- Not hospital-based.
  - $\checkmark$  It is home- and community-based

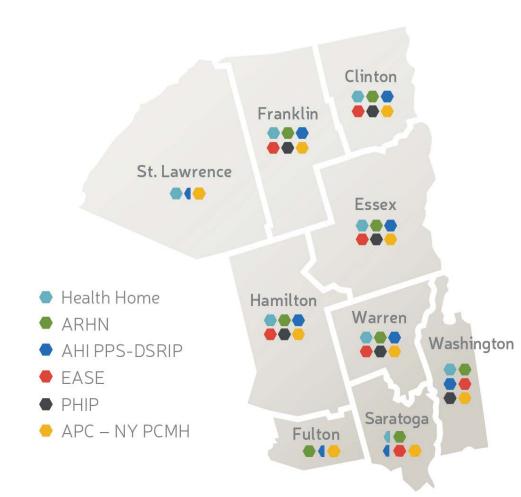
Boots on the ground











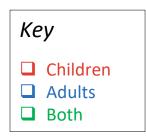
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## AHI Health Home Downstream Providers

- Alliance for Positive Health
- Behavioral Health Services North
- Capital District Psychiatric Center
- Catholic Charities
- Children's Health Network
- Children's Home of Jefferson County
- Citizen Advocates
- Community Maternity Services
- Essex County Mental Health Services
- Families First in Essex
- Fort Hudson
- Glens Falls Hospital
- Hamilton County Community Services
- HCR Care Management

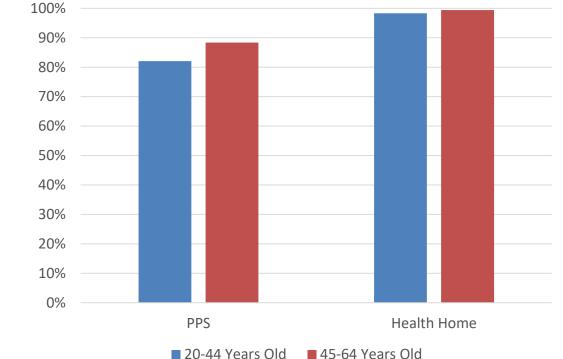
- Hudson Headwaters Health Network
- Mental Health Association in Essex County
- St. Anne Institute
- St. Lawrence Psychiatric Center
- Transitional Services Association
- United Helpers Mosaic
- University of Vermont Health Network
- Warren-Washington Association for Mental Health



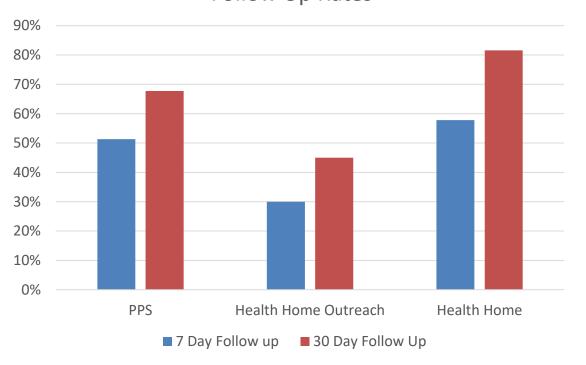


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# Evidence on Effectiveness of Health Home (May 31, 2017)



Yearly Preventative Care Visits

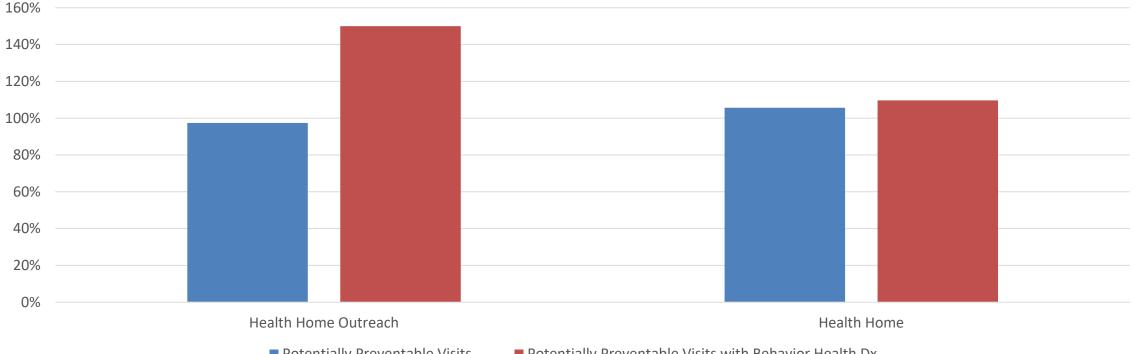


Mental Health Discharge 7 and 30 day Follow Up Rates





% of Patients with Potentially Preventable Visits



Potentially Preventable Visits

■ Potentially Preventable Visits with Behavior Health Dx





## **Health Home Panelists**

- Hayley Fye: Children's Health Home Care Coordinator
  - Citizen Advocates in Malone
- Renee Stephenson: Health Home Program Manager
  - Alliance for Positive Health
- Mary Madison, RN: Care Coordinator
  - Cambridge Family Health Center, Glens Falls Hospital
- Carol Byron, RN: Care Coordinator
  - Southern Washington County, Glens Falls Hospital

Moderator: Mary McLaughlin, RN, MBA; Executive Director, AHI