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New York Health Homes: Member Success Stories



*A product of the New York Health Homes Learning Collaborative
Made possible by the New York State Health Foundation*

CHCS Center for
Health Care Strategies, Inc.

About the *New York Health Homes Learning Collaborative*

In partnership with the New York State Department of Health, and with the support of the New York State Health Foundation, the Center for Health Care Strategies is facilitating the *New York Health Homes Learning Collaborative* to identify and share best practices in health homes design and implementation. Through in-person meetings and online interaction, this forum helps guide representatives from New York's approved provider-lead health homes in their ongoing implementation efforts, and informs state policy decisions around this significant delivery system reform effort.

Over the past four years, it has been our great pleasure at the Center for Health Care Strategies (CHCS) to watch the *New York Health Homes* program grow and evolve — beginning as an idea about how to best serve New York’s most vulnerable individuals and ultimately becoming a robust, nationally-recognized initiative. With the generous support of the New York State Health Foundation, CHCS has hosted eleven learning collaboratives and during each of those meetings we observed how the Health Homes, downstream partners, health plans, policymakers, and other stakeholders have worked together to make this program what it is today.

During the course of this program, CHCS has asked participating Health Homes to periodically send us “success stories” to help chronicle how the program has helped members. Those stories are collected here, and serve as a testament to the incredible efforts of the people involved in the *New York Health Homes* program. Without a doubt, this initiative has made a difference in the lives of the members it has reached. We at CHCS congratulate everyone who has contributed to the *New York Health Homes* program for their extraordinary effort, and look forward to many more success stories to come.



With appreciation,

The CHCS Team

Rachel Davis, Associate Director

Allison Hamblin, Vice President

Rebecca Sax, Program Associate

Adirondack Health Institute

S., 36 years old, lives with chronic hepatitis C, hypothyroidism, asthma, gastroesophageal reflux disease, chronic pain, bipolar disorder, PTSD, ADHD, and a history of intravenous heroin use. S. was not consistently engaging in care or following treatment recommendations. Her teenage son lives with his grandmother.

S. established care management at one of Adirondack Health Institute's (AHI) Health Homes. Some of her challenges included:

- She previously had surgery to remove lower intestine polyps and has a family history of colon cancer. S. was not attending appointments to monitor her many health issues.
- Her only income is Temporary Assistance via the Department of Social Services. She had applied for Social Security Disability but was overwhelmed by the process.
- After living in an unstable environment, S. became homeless.

Her care manager was able to put the following supports in place:

- Connecting her with a substance abuse service provider;
- Assisting in scheduling transportation, and checking in with S. on any barriers;
- Assisting her in reestablishing consistent gastrointestinal care;
- Guiding her through the disability paperwork and attending interviews with the Department of Social Security; and
- Working with the Department of Social Services, Section 8, and Saratoga County Rental Assistance Program to secure a rental subsidy.

Since establishing care management, S. continues to attend weekly appointments at her outpatient substance abuse treatment program and has maintained sobriety. S. has begun hepatitis C treatment and is also attending regular appointments with her Suboxone treatment provider and following her treatment recommendations.

Finally, S. is no longer homeless — she began receiving regular rental assistance contingent on maintaining her medical and substance abuse care. S. recently signed a lease on a two-bedroom apartment and is looking forward to meeting her ultimate goal of reuniting with her son.

When asked about her AHI Health Home program and her relationship with Gayle, her care manager, S. said, "In early recovery you feel very isolated and lonely. Gayle calls and remembers me and makes me feel important. She is very kind and has an open and inviting personality. I can be completely honest with her, and this has helped me get what I needed. I am so, so grateful for this program. It opened so many doors for me. I don't know where I would be without you."

Bronx Lebanon

S. is a 39-year-old female diagnosed with major depression/bipolar disorder and a history of substance abuse. She enrolled in VIP's outpatient SUD program in November 2014 and in VIP's mental health services in January of 2014. S. moved into the shelter system in May 2014 with her daughter and husband. Her husband, unfortunately, is addicted to substances and he is not engaged in treatment at this time and also not a resident of the shelter; the daughter is with S. at the shelter.

Upon initial contact with S. the care coordinator assessed patient's needs which included: housing, medical/mental health/SUD, and follow-up with a parole officer. Since engagement, the care coordinator has been able to coordinate services on behalf of S. with the housing specialist at the shelter where she currently resides. The housing specialist has since submitted an application for low-income housing through the COME NY program. The housing specialist is also in the process of submitting a 2010E supportive housing application as soon as S. completes and receives documentation of her psychosocial and psychiatric evaluations.

S. was admitted to the Beth Israel ED on March 2015 for excessive stomach pains and other gastrointestinal issues. The care coordinator traveled over to Beth Israel and had a case conference with the assigned physician. Since then S. had a colonoscopy done that was long overdue. The results were negative, and S. will continue to follow up with her gastroenterologist and primary care at VIP's primary health clinic.

Presently, the care coordinator and S.'s parole officer have been working collaboratively to stabilize S. Her toxicology reports have been positive for opioids due to her adhering to morphine for her back problems. VIP's SUD program, Health Services, and the parole officer have collaborated and closely monitored client's use of the above medication to ensure the absence of abuse. By working closely with S. and her various providers, we have been successful in stabilizing her and preparing her for permanent housing.

Catholic Charities of Broome County

At the time this member was admitted to the Health Home program, he was living in substandard housing. He was utilizing the ED for his medical treatment due to barriers such as transportation and his addiction to prescription medication. He previously had several hospitalizations, which ranged from medical to psychiatric and substance abuse, with one hospitalization lasting over two months. The member's apartment was not located on a bus route; therefore he was unable to navigate the community independently. He relied on others for assistance and did not display any self-determination or motivation.

Since his admission into the Health Homes program, the member has overcome many struggles leading to his current success. His care manager linked and connected him to various providers (medical, mental health, and substance abuse treatment) and transportation to assist him with his overall wellness. The care manager provided him with support in his decisions that he has felt were in his best interest. The member has not been hospitalized for over nine months, which demonstrates significant progress. He identifies that this is the best that he has felt in 13 years. He also identified that if he had not become involved with the Health Home program, he would not be where he is today and feels that he might have ended up dead. He expressed gratitude for his care manager supporting him in his decisions and encouraging him when he wanted to give up. He is now able to express his needs, wants, goals and hope for the future.

The member is currently living independently in his apartment. He has his benefits in place and is pleased with his housing arrangement. He enjoys skateboarding and spending time with his family and animals. He continues to pursue his personal goals. He has learned the bus system and can navigate the community independently. Throughout this whole process, he never lost his love for animals. The Care Manager recently assisted him in completing an application for volunteering at the zoo, where he would like to explore employment opportunities or somewhere else that he can work with animals.

Central New York Health Home Network

H. is a 62-year-old male living with diabetes, epilepsy, dementia, depression, mild mental retardation, and a history of difficulty managing medications and engaging with PCPs. H. was living in a shack with no running water, no electricity, and no heat.

When H. established care management at Central New York Health Home Network (CNYHHN), he faced a number of challenges:

- Non-compliance with medication and attending medical appointments.
- Defecating in his home, eating raw meat, drinking large quantities of alcohol, not bathing, and not addressing his personal hygiene.
- Limited to no transportation, preventing him from obtaining food.
- Had many seizures, was depressed, disorientated, and unwilling to leave his home.
- Has limited family supports and no friends. His mother is 85-years-old, and his sister has severe dementia, his brother is an addict.
- Had many ED visits for his safety and well-being.
- His home was later condemned, which then made H. homeless.

H.'s care manager was able to put the following supports in place:

- Transported him to doctors' appointments to stabilize his medications, which alleviated his seizures and helped to manage his diabetes.
- Coordinated temporary placement in a shelter where he was able to have cooked meals, bathe, sleep in a bed, and obtain clean clothes.
- Transported him to the grocery store and taught him basic skills on how to purchase healthy foods to reduce his high blood sugar.
- Took him for a mental health evaluation, and his PCP was able to prescribe Sertraline for his mental health needs.
- Coordinated with visiting nurses and providers to help assist his medical needs.
- Coordinated with a real-estate agency to facilitate the process of selling his property so he would qualify for an assisted living home.
- Worked with the Social Security Administration to ensure benefits were never lost.
- Coordinated with area agencies to inquire about what H. should do with his money that he would be getting once his property sold.
- Coordinated placement with an assisted living facility in his hometown.

Since establishing care management, H. continues to attend medical appointments and is taking his medications. His seizures and diabetes are now under control and H. has not utilized the ED in four months. H.'s daily living skills are improving and he can address his personal hygiene. H. is no longer eating raw meat or drinking alcohol. He was able to reunite with his sister who lives in the same assisted living facility.

Community Care Management Partners

This patient resides in East Harlem near her two younger siblings. Over the course of the last several years, she has been plagued by foot and leg pain that has seriously curtailed her otherwise active lifestyle. During the initial Health Home assessment, the patient vented her frustrations about the unknown source of the pain and its effect on her everyday life. She was frustrated by having to stop at every block during her walks due to pain and numbness, and even more frustrated by the lack of answers.

In my meetings with this member, I listened to her story attentively — engaging her by asking questions about how the pain has affected her. Diligently staying positive, I encouraged her to remain hopeful and proactive despite her clear challenges.

In mid-January, she met with a Mount Sinai neurologist, who recommended that she consult with a vascular specialist. She followed this advice and met with the specialist in mid-March. She was subsequently sent for vascular tests which determined that her pains were vascular. The specialist scheduled her for two back-to-back inpatient procedures aimed at improving vascular function in her legs and feet. I visited with the patient before and after each procedure she underwent.

After both procedures had been complete, she was able to finally gain insight into why she had been in so much pain and thanks to her doctors, was able to put a name to these pains that held her back on a daily basis. This, she told me — coupled with the physical relief that came after her procedures — made her feel incredibly grateful and keenly aware of how precarious good health can be.

I continue to keep in touch with this patient as a part of the Health Home program, though not as intensively since her health is stable and her urgent care needs have been met. She came to the Health Home program at a critical time and received services to help support her health and wellbeing. I helped ensure communication and care coordination with her providers including her longtime PCP and specialists. Also, I helped coordinate home care services, provided support around transitions in and out of the hospital and stayed responsive to her care needs.

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V. is 48-year-old woman who is enrolled in the Visiting Nurse Service of New York (VNSNY) Health Home program. When V. came to the Health Home program in late 2010, she had a 10 year history of heroin and cocaine use, was diagnosed with severe depression and was homeless. V. was not adherent to her mental health or medical treatment. She also had an open child welfare case because of her inability to care for her son. V. had a lot of challenges facing her road to recovery.

“When I first met V. her care was not being coordinated correctly,” says Judy, V.’s care manager. Judy stepped in to coordinate her care, sort out her challenges, and help V. take steps to better her life. The first few times they met, V. resisted Judy just as she had past clinicians, but with persistence came success. “It was hard to earn her trust since people in the past did not follow through. But she felt a connection with me.”

V. began to take her well-being seriously with Judy’s help. She agreed to see specialists and with encouragement, she began to follow through. Judy was able to connect V. with a therapist and psychiatrist who assisted with her mental health needs and later her medical needs. In addition, Judy ensured that V. complied with her substance use treatment program. The child services case was also later closed due to the progress V. had made in treatment with the help of her care manager.

However, just as things began to turn around, V. received terrible news. Soon after she got back custody of her four-year-old son, he was diagnosed with stomach cancer, a difficult diagnosis on any person, but especially hard on someone who was working through many challenges. With no other support, Judy became V.’s rock.

Judy supported V. and her son and became an advocate for his care as well. Judy often met V. at the hospital where her son received treatment. She would call and follow up on his care, getting the answers that V. could not get on her own. During Christmas, when her son was in the hospital and had just completed surgery, the entire VNSNY team contributed and took gifts to the hospital.

Not only did V. get better mentally and physically through all of this, but she also learned coping skills, developed a good support network and is able to have a positive attitude despite all the challenges she has faced. She has indicated on many occasions how wonderful it has been to have the Judy in her life and she considers Judy one of her main supports in her recovery. Without Judy’s help she would have been overwhelmed when her son was diagnosed — maybe she even would have relapsed. It would have been very difficult for her to manage that kind of stress alone.

Today, V. and her son are doing so much better. Her son is now able to attend kindergarten and although he is still receiving cancer treatment, he is doing well and living a more normal life. V. currently lives in a family shelter with her boyfriend and son and Judy is working with her to apply for supportive housing and Supplemental Security Income. Judy continues to assist V. in connecting to the appropriate services to ensure she is able to manage her health, sobriety and family stability.

Community Healthcare Network

When I met AP at the 30th Street shelter in May 2014, he presented as depressed, suffering from diabetes, hypertension, cholesterol, anxiety, and arthritis. AP used to wander the city daily as he was required to leave the shelter at 9:00 AM and could not come back to his room until after 4:00 PM. AP would often forget his medical and behavioral health appointments, impacting the stability of his diabetes and hypertension.

With the assistance of the Department of Homeless Services' staff and the Community Healthcare Network's Health Home team, AP is now happily residing in a one-bedroom apartment. He adheres to his medication regimen as directed and attends all medical and behavioral health appointments. The Health Home team provides AP with monthly reminders for his appointments as needed. Due to language barriers, (his primary language is Spanish), the Health Home team also assists AP with interpreters to facilitate his understanding of the provider's directives. We make sure that we speak to AP at least two times a month to inquire about his overall health.

Currently, all of AP's medical and behavioral health needs are stable. AP has been doing so well that he recently decided to get a job at a supermarket. A lot of people would not see this as a "job," but for someone who has been through so much, being able to perform work where they know they are needed is the most satisfying feeling in the world.

As part of the Health Home team, I am very proud of the work we have done with AP and how far he has come. Even with all of the stressors that we may experience on a daily basis as care managers and patient navigators, it is all worth it when we can witness positive outcomes. We all have those clients/patients that are hard to work with, who are very demanding, and who may not seem to appreciate what we do; however, those may be the clients that need us most. We try not to feel like we have to make everything right all at once, and recognize that it takes time and effort. I am proud of being part of such a huge movement. The Health Home teams are changing lives, one person at a time!

CommunityHealth Care Collaborative

S. is a 35-year-old woman from the Hudson Valley who lives with mood and borderline personality disorders along with a history of illegal substance use. S. has been part of the system since 2008. Unfortunately, due to a long history of untreated mental illness and non-compliance with her medication, S. has difficulties engaging in active care activities and following treatment recommendations.

When S. started in the Health Home program at one of the CommunityHealth Care Collaborative's (CCC) contracted care management agencies, some of her challenges included: illegal substance consumption; stabilization of mental health disorders; loss of her job in 2008 and struggling to keep a full-time job since; multiple inpatient admissions to the ED; and unstable housing.

Her care manager was able to put a number of supports in place including: positive conversations with both her care manager and PCP about the importance of complying with her medical appointments and the impact of this in her state of mind; a rehabilitation program for the substance abuse, enforcing the importance of attending her therapy appointments and taking her medications; assistance in getting an appointment with a job seeker agent at the local New York State Department of Labor through the Westchester County Employment Center; assistance in the scheduling and compliance of group and/or individual therapy sessions; and assistance in getting her into an Apartment Treatment Program.

Since joining care coordination, S. has been able to recover from her substance use disorder. Furthermore, she has learned about coping skills, continues with group and individual therapy, and has set short- and long-term goals for her life. She is a certified peer specialist and has done volunteer work in one of the clinics where she received treatment in the past. Currently, she holds a part-time job at one of CCC's care management agencies and lives by herself.

When asked about her Health Home experience and her relationship with the care manager, S. said, "At the beginning, I was very resistant to get help — I thought I was able to manage the situation by myself — but after so many hospitalizations I understood that I needed something more besides myself. My care manager along with the medical team showed me that besides complying with my medication, I needed to learn to set realistic goals and be responsible for my recovery. I needed to understand that for me 'to have a mental health issue,' would always be an enduring process in which some days I will need help and some other days I will not". When we asked her about words to describe her care manager, S. said, "I enjoyed her approach, we set goals and expectations; she had a lot of patience and organizational skills. She knew the system, and she never gave up on me."

Greater Buffalo United Accountable Health Network

Since Greater Buffalo United Accountable Health Network's (GBUAHN) inception many rewards have been realized, but the most important reward is patient satisfaction. One particular case is a call received by our health home administrator praising a patient health navigator.

Prior to GBUAHN's intervention and constant support, the patient presented as angry, depressed, and ravaged by chronic pain, which resulted in a poor quality of life, loss of her support system, and a feeling of hopelessness and despair. Her primary care physician was not willing to manage her pain or connect her to a pain management program. The patient stated that she felt everyone had turned their back on her — she had lost hope.

Then, GBUAHN entered her life and helped her regain control by connecting her to appropriate care to stop the chronic pain, which enabled her to get her family back. The health navigator enrolled the patient into a pain management program and was also able to connect her to a provider who helped her manage her pain. The patient stated that her health navigator was "her angel" — she had considered ending her life prior to receiving the safety net that the health navigator provided for her.

2014 was not a banner year for D. and her 21-year-old son, J. in November 2014, a vehicle struck J. in a hit and run auto-pedestrian accident. The accident resulted in severe injuries that landed J. in the hospital for eight months.

After his hospitalization, D. was in need of physical therapy; however, he did not have health insurance. D. searched for a provider who would take her son on as a patient; however, she was turned down each time due to J.'s lack of health coverage.

One day while D. was in her doctor's office, she saw a flyer for GBUAHN. She called the number and was connected with Patient Health Navigator, Dominique Hall. Dominique went to work right away. She helped J. sign up for Medicaid. He was connected to a physical therapist and his health greatly improved. Dominique secured transportation for J. so he could make his appointments. In short order, J. went from using a wheelchair to walking with the assistance of a cane.

When D. talks about how GBUAHN helped her son, her eyes well up. She says she is amazed at Dominique's tenacity. No matter how many walls she hit, Dominique did not give up in her search for a physical therapist for J.

D. was so impressed with GBUAHN that she joined herself. With the organization's help, D. signed up for Medicaid and is also very pleased with GBUAHN services.

Health Home Partners of Western New York/ Spectrum Human Services

A. was referred to Health Home Partners of Western New York/ Spectrum Human Services in March 2012. At that time she was 18 years old and had been involved in the child care system for several years. She had been hospitalized at a psychiatric facility, had been in residential services, and had received children's care coordination services. She had a history of bipolar disorder, post-traumatic stress, and borderline personality disorder.

At the time of her enrollment in health home services, A. was homeless, minimally linked to outpatient treatment, and minimally linked to her PCP. A. suffered from a first-degree heart blockage, resulting from a medication she was given as a child. She was drinking alcohol daily, had a history of psychiatric hospitalizations, multiple ED visits, multiple suicide attempts, and several arrests, which led her to be involved in the local Mental Health Treatment Court.

A. had dropped out of school after eighth grade. She was estranged from her family. She reported a childhood of trauma and abuse. A. was trying to work part-time at a local supermarket, and she reported that her SSI benefits had been sporadic.

Upon admission to our health home, we utilized an intensive, person-centered, care transition model that focused on engagement, identifying immediate needs with A.'s active involvement, assistance in making referrals and linkages, and working to help her stabilize and be able to reside independently in the community.

Shortly after A. was enrolled with our health home, she learned she was pregnant and was determined to carry her child to term and become a good parent. This became a critical changing point for her. She contemplated going into a shelter for women and children and explored that option. A. decided, with the support of her care coordinator, to also reach out to her mother. There was a plan put in place to work on repairing and restoring her relationship with her mother. With assistance and emphasis on that, the relationship improved and her mother agreed she could live with her.

A. began following through with doctors' appointments and with all recommendations made by her providers and care coordinator. She was linked to outpatient mental health/chemical dependency treatment. Her symptoms began stabilizing and she was more focused on her health and making better choices.

She followed through with her prenatal care and delivered a healthy baby girl. A. was able to continue living with her mother.

Hudson Valley Care Coalition

We recently received a letter of gratitude from a provider's member that exemplified how quality, patient-centered care can truly improve an individual's quality of life.

The woman who wrote the letter was referred to the Health Home program by her managed care plan after a home care request was initiated by her PCP due to non-adherence to outpatient medical management. At the time of the referral, she was unemployed and living in a one bedroom, rodent-infested apartment with her ten-year-old daughter. She also had two other children removed from her care. She has a long psychiatric history that includes both inpatient and outpatient behavioral health services and frequent ED use.

Since her enrollment in the Health Home program in 2013, the member, with the assistance of her care manager and peer support specialist, has engaged in outpatient therapy and has started a new medication regimen. She regularly attends interdisciplinary network meetings with a Department of Social Services, child preventive service worker, and community-based family support services, and will be reunited with her two children that were previously removed from her care.

She and her ten-year-old daughter are enjoying their new, rodent-free apartment in a safer neighborhood, and she is scheduled to begin vocational training so that she may become gainfully employed.

Institute for Family Health

At intake, the client stated that he would like assistance in finding mental health providers to address mental health concerns. He was also complaining of chest pain, and stated that he had seen his doctor several times, but did not feel he was being taken seriously. The care manager incorporated these concerns into his care plan goals.

In one of the first monthly meetings, the care manager linked him to Hudson Valley Mental Health (HVMH), and a few weeks later the client called to inform the care manager that he went to HVMH and was assigned to a therapist. He was diagnosed with PTSD and said he would be working on some exercises with his therapist to alleviate the symptoms.

The client and care manager discussed the benefits of changing PCP, and the care manager facilitated a switch from a larger family practice to a smaller practice. His new PCP ordered an MRI and sent him to a rheumatologist to see if that would shed some light on the source of his chest pain. His referral to the rheumatologist-led to the discovery of calcium buildups in his shoulder joints, which was causing the pain in his arms and chest. He started physical therapy at Kingston Hospital and reported good progress. During this time, the client also took the initiative to arrange several other provider visits, including to a gastroenterologist, and getting tick bites examined.

Then, the care manager called the client for a semi-annual care plan revision appointment while the client was out for a walk. He stated that walking was one of his best coping skills, which is something he picked up in therapy. The care manager asked him how his therapy was going, and he stated that he really liked his therapist and felt as if he had made a lot of progress. He had been seeing his therapist regularly. He finished with his physical therapy and reported feeling less pain in his arms and chest. He was done seeing the gastroenterologist until his six-month follow-up. The client indicated that he felt like he had met all of his goals. The care manager reviewed his care plan with him over the phone, and all of the goals that they had formulated seemed to have been met, including getting a new PCP, addressing his emerging health concerns, and linking him with mental health supports. The client reported feeling very well physically and feeling mentally stable. They agreed that he would handle his care independently moving forward, and would call the care manager back if he ever wanted to enroll in services again.

Mount Sinai Health Home

There have been many success stories within the Mount Sinai Health Home program, which highlight the variety of work that we do with different populations across the care continuum.

One patient was referred due to multiple ED visits. He has a substance use history, is in a methadone maintenance program, and has a diagnosis of chronic obstructive pulmonary disease (COPD). He has very limited support and lives alone. He was non-compliant with his COPD regimen, and many providers believed that he had relapsed. The health home social worker and patient navigator worked with the patient and his PCP intensively both in the patient's home and in medical practice settings. They were able to identify that the patient did not have appropriate oxygen deliveries, didn't know how to use his continuous positive airway pressure (CPAP) machine appropriately, had no assistance at home, and was presenting as if he was intoxicated due to a lack of oxygen.

The Health Home team connected the patient to home attendant services, an oxygen company that delivers pre-filled tanks to the patient's home, mental health services in his community, and a system for reaching the patient via a neighbor when the patient's phone is not in service.

The patient still requires regular home visits and assistance, but has been out of the ED since March, has more energy, and is more committed to his care.

St. Mary's Healthcare-Amsterdam

J. is 53 years old with end-stage kidney disease, insulin-dependent diabetes mellitus, asthma, coronary artery disease, cirrhosis, oxygen dependency, and lives alone with his two dogs and minimal support.

On the days J. receives hemodialysis treatment, he would complain of chest pain and transfer to the ED for evaluation. J. would be admitted for observation and receive his hemodialysis, then sign out against medical advice to return home to care for his dogs. Despite exhaustive efforts by the inpatient care management and ED staff, J. would never agree to any community plans.

In July 2013, J. became a consenting member of Health Homes after receiving a referral from the ED. After the initial intake at J.'s home, the Health Home care manager engaged several agencies to assist him with multiple medical and physical care needs. Through Adult Protective Services, J. was afforded 60 hours a week of personal care in his home. In addition to personal needs, J. was not consistent in following up with PCP appointments and was discharged from several practices. With the Health Home care manager onboard, we were able to negotiate with a local PCP to accept him back. We would ensure he arrived for every one of his appointments and followed up on necessary specialty and lab work appointments.

Bridging gaps in needed care has tremendously improved the life of this member. Sometimes all it takes is one person at the helm to collectively see gaps through the member's eyes and assist in putting the pieces together. Despite J's multiple visits and stays, we really didn't know him until we met him in his home. That's when we were able to understand him and successfully develop a collaborative plan to improve his health and overall well-being.

Following his introduction to St. Mary's care manager, J.'s ED visits dropped dramatically, from 118 visits in 2012 to 13 visits in 2014.

About the Center for Health Care Strategies

The Center for Health Care Strategies is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Center for Health Care Strategies, Inc.
200 American Metro Blvd., Ste. 119
Hamilton, NJ 08619
www.chcs.org