HEALTH HOMES of UPSTATE NEW YORK (HHUNY)

(HHUNY) Health Homes of Upstate New York

- Health Home of Upstate New York, is not a place; it is services provided through a network of health and community agencies that are committed to working together to help Medicaid members with serious and chronic physical and mental health issues receive supportive services. Together, we create a care plan and identify the needs of the individual. This ensures everyone involved understand and works together to successfully help the individual achieve their goals. The work of the Health Home is not just about improving the physical health, but also the mental and social health as well.

What is it?

HHUNY was formed in 2013

There are 4 Health Homes hubs in NY that each cover a different portion of Western NY

- Chautauqua County Department of Mental Hygiene- southern tier counties- Chautauqua, Cattaraugus, and Allegany County
- BestSelf Health Home Services - western counties- Niagara, Erie, Wyoming
- Huther Doyle- Finger Lakes counties -Orleans, Genesee, Monroe, Wayne, Livingston, Ontario, Yates, Seneca, Schuyler, Steuben
- Circare- Central New York counties -Oswego, Onondaga, Cayuga, Tompkins, Cortland, Madison, Chenango, Chemung, Tioga, Broome

Services are FREE for Medicaid recipients. Medicaid pays for Care Coordination services for those who are Medicaid eligible. It does not cost the individual anything to enroll.

What to Expect

- Individuals will be assigned a Care Coordinator who is trained to assess all the needs of the individual. Using a person center approach.
- The individual will receive support in areas that the individual may not have had known were available to them before in their area.
  - Such as, but not limited to:

    Help with finding doctors

    Help with making and maintaining appointments

    Assist with an facilitate transportation

    Assist with community resources in the area

    Link to health education services

    Family support

Plan of Care

- Our biggest tool for helping an individual is developing a plan of care(POC) with them.
  - The plan of care is made of their goal statement, strengths, barriers, objectives and interventions.
  - Goal Statement- what the individual wants to achieve in their own words through the program.
    - Be healthier, make more money, be more stress free etc
  - Strengths and Barriers-the things that will help and hinder them on working towards their goals.
  - Objectives-the measuring points of progress towards the goal statement
  - Interventions-breaking down the objectives into smaller manageable tasks split amongst the individual and their care team members.

Objective and Intervention Example

- Everyone has adherence goals so they make a good example
  - The point of adherence goals is to lessen emergency room and hospitalizations by maintaining regularly recommended check-ups with various providers. (Annual physicals with their primary dr., regular appointments with an endocrinologist for diabetes, Dentist, eye-exams and cancer screenings all fall under this.)
- Goal- Peter Parker will see his primary for his yearly check up
  - Interventions
    - Peter will schedule his appointment for his yearly physical independently
    - Primary dr. will be available to discuss any abnormal findings and make needed referrals.
    - Care Coordinator will assist in arranging or providing transportation.
    - Peter's Aunt, May will work with Peter to remind him to mark down his appointment time on the calendar

What are requirements of HHUNY?

- The individual must be a Medicaid recipient or believe they may qualify for Medicaid.
- Be at least 18 years of age
- Meet the following criteria points
  - Have one serious mental illness (SMI)

    OR
  - Have HIV and/or AIDS

    OR
  - At least two of the following chronic conditions
    - other mental health conditions, substance abuse disorder, asthma, diabetes, heart disease, BMI >25 or other chronic conditions as noted by a provider (chronic back pain etc) to mention a just a few. There are several

Qualifying Continued

- The qualifying conditions can lead into further risk factors that include but aren’t limited to
  - Lack of or inadequate social/family/housing support,
  - Lack of or inadequate connectivity with the healthcare system
  - Current inpatient
  - Recent release from incarceration or psychiatric hospital
- The Care Coordinator will seek information from the individual's providers to support the qualifying conditions as well as a list of current medications to verify requirements are met.

How do individuals make it to the HHUNY program?

- Our main source is via referrals.
  - Typically, from either a current provider or someone who would be considered a social support such as a social worker for the individual.
    - At times this could be a discharge coordinator at a hospital, a case worker with Cattaraugus County or Allegany County or a family member or friend.
  - Other agencies such as Office for the Aging
  - The individual themselves can refer themselves as a walk-in after hearing about us from any above source as well and decide to follow-up on their own.
  - HHUNY is a voluntary program but can be recommended through a probation officer and/or the court system to assist the individual in linking to resources that can help them maintain their independence in the community.

End Goal of the Program

- The end goal of the HHUNY program is to help individuals learn about and utilize the resources at their disposal
- Develop skills that allow them to live independently in their community.
- Get the assistance they need before it becomes a bigger issue.
  - To stop the revolving door at the Emergency Room
  - Prevent recidivism

Useful Links

- Online Self Referral Link- https://hhuny.org/Members/Make-a-Referral
- Online Community Referral Link- https://hhuny.org/Forms/HHUNY-Online-Community-Referral
- Or by completing the paper application below:

HHUNY Referral-form-7-22-20.pdf