NY Health Home Coalition

The Key to Integrated Care
NEW YORK STATE
CARE MANAGEMENT COALITION

HEALTH HOMES IMPACT

HARRY

BEFORE HEALTH HOME

57 year-old male, diagnosed with end stage renal disease on hemodialysis, peripheral vascular disease, diabetes, hypertension, history of prostrate and thyroid cancer, COPD, Chronic pain. Lives alone in an apartment in urban area.

Uses a motorized wheelchair to ambulate. On dialysis for over 12 years, history of non-compliance.

He is also non-compliant with medications. Can be verbally aggressive and rude to clinical staff. He generally visits ER about the same time of night.

- Suspected related to anxiety, as in the past he had a stroke while going to the bathroom.

Health Home Referral indicated (Oct 2015):

- Does not take medications as prescribed
- Refuses to pour meds
- Continues to drink more liquid than he should, causing retention. He then does not stay for full dialysis appointment.
- Not receptive to support.
- Difficult to follow up with.
- 2015 – He had 137 ER visits.

AFTER HEALTH HOME

<u>High Impact Interventions</u>

- Case Conferences
- Care Coordination amongst multiple providers and health care systems
- Establishing a trusting and supportive relationship with Care Coordinator
- Care Coordinator attending appointments in support of Harry

<u>Success:</u>

- Longer stays at dialysis
- Obtaining a shower chair to assist with self care
- Connection with MLTC
- Pain Management
- Reduction in hospitalizations
- Attending appointments regularly
- Advocating for self for anti-anxiety medication (began in March)
- Allowing Care Coordinator to attend appointments

- 2016 – 108 ER visits
- Thru July 2017 – 36 ER visits

TONYA

Tonya is a 22-year-old African-American single female diagnosed with bipolar disorder and due to meningitis at the age of 12, has had the toes on her right foot amputated. Tonya was enrolled in October 2015. When Tonya entered the HHCC program, she had a lot of goals but felt stagnated due to limitations imposed by her amputation.

Throughout 2015 and 2016, coordinated care provider (CC) Wheat assisted Tonya with obtaining food stamps and getting connected to medical and mental health providers. Tonya began GED classes in the beginning of this year and completed an orientation with ACCESS-VR to further her education and career. Tonya recently had surgery on her foot and obtained specialized shoes to allow her more mobility.

With her new found freedom and confidence, Tonya was able to obtain employment and continue consistent engagement in MH treatment. CC Wheat also assisted Tonya with identifying and applying for housing opportunities to build on her independence.

KAYLA

Kayla is 23-year-old single mother, who is diagnosed with asthma, diabetes, obesity, sickle cell anemia, vitamin D deficiency, and depression. Kayla was enrolled in November 2016. At enrollment, Kayla was living in an unhealthy environment with her son and her mother. Kayla identified that a lot of her feelings of depression stemmed from her living situation. Ultimately, in January 2017, Kayla and her son were evicted. Kayla's son was able to stay with his father, while Kayla started couch surfing. At this time, Kayla was also disconnected from providers and frequently utilized the ER for treatment of her sickle cell diagnosis.

CC Okobi was able to assist Kayla with being linked to permanent providers at Brooklyn Plaza Medical Center, where she also receives behavioral health services. Kayla, a recent graduate of the Franklin Career Institute, has also landed a full-time job at TJ Maxx and a part-time position at Starbucks. CC Okobi assisted Kayla with obtaining SNAP benefits to supplement her income as well. Kayla has been stably housed for the last four months, has consistent income and is actively engaged with her medical and mental health providers.

MR. MARTINEZ

Mr. Martinez is an 87-year-old Hispanic senior from Queens who is diagnosed with hypertension, hyperlipidemia, coronary heart disease, chronic ischemic heart disease and depression. Mr. Martinez lives in a NYCHA apartment with his daughter and grandchildren and attends the Ridgewood Adult Day Center several times a week. Mr. Martinez was enrolled in February 2017. At enrollment, Mr. Martinez only requested assistance with being linked to a mental health provider, ophthalmologist, and transportation services. However, when CC Estevez accompanied Mr. Martinez to a PCP appointment in June, his primary care physician informed CC Estevez of concerns about Mr. Martinez's health and possible diagnosis of prostate cancer. Mr. Martinez's PCP had tried numerous times to engage Mr. Martinez in treatment, but he declined and chose not to attend appointments scheduled on his behalf. Mr. Martinez reported having no interest in seeking treatment or seeing any providers except his PCP.

While trying to consider what motivates Mr. Martinez, CC Estevez recognized how much he loves going to the Adult Day Center. **CC Estevez reached out to the center and was able to collaborate with his trusted providers at the program to finally engage him in treatment!**

Recently, Mr. Martinez attended appointments with a new urologist and GI specialist and is preparing to have a biopsy completed to determine the appropriate course of treatment. Thanks to CC Estevez's creative thinking and client-centered approach, Mr. Martinez is finally getting the treatment he needs to maintain his quality of life and be able to continue spending time doing what he loves at the Adult Day Center.