How Health Homes are Helping New Yorkers:

In February, the Health Home Coalition is publishing 28 Stories in 28 Days about how Health Homes have helped New Yorkers. Go to our website for all these amazing stories: www.hhcoalition.org

Jeremy's Story

It was five years ago that Jeremy's life took a turn for the worst. He had his first panic attack during the holiday season after losing a really good job. His relationship was falling apart and the stresses of the city were getting to him. He felt as if he had no one to turn to. He described it as being alone in a crowded room. He was diagnosed with depression and then turned to substance use.

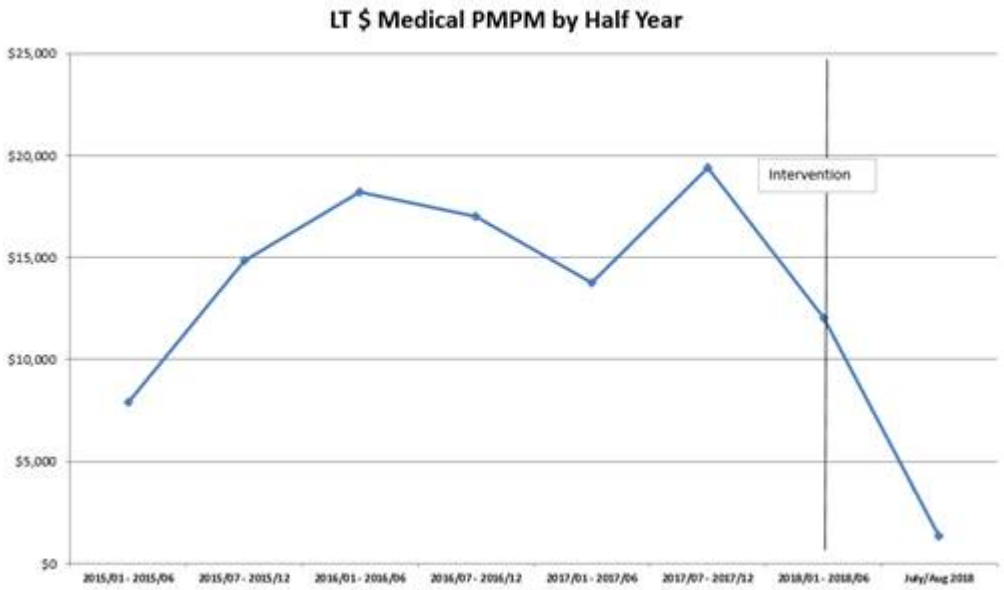
Jeremy sought help from various places; however, nothing seemed to work until he met Marie, a Health Home Care Manager from Community Healthcare Network. Marie came into Jeremy's life and helped him begin to recover. Marie listened to Jeremy and worked with Jeremy to address his health, financial and social issues. She helped him navigate the healthcare system and get the appropriate care he needed. Since meeting Marie, Jeremy has a stable job and is in recovery.

Watch Jeremy tell his story by clicking here!

LT's Story

LT is known to many in St. Peter's Health Partners (SPHP) in the Capital Region and the community at large. For years, LT went to the emergency room for his dialysis as opposed to receiving it in the proper setting of a hemodialysis (HD) center and he had become the most expensive patient in the SPHP system. Many of the SPHP team members have helped in caring for LT over the years. LT needed someone to sit with him during his HD

sessions in the ED, to help ensure his visit was without incident because he occasionally exhibited disruptive and aggressive behaviors. During one of these visits, he was referred to the Health Home. They identified his anxiety as a root cause of his disruptive and aggressive interactions. Over the course of the following months, his Health Home Care Manager built trust with LT and convened team meetings with all of LT's care team. They met several times to work together to create a plan that ultimately worked on directly addressing the Dialysis Center's issues and LT's issues. With the help of his Care Manager, LT started at the Center on July 1, 2018 and is still receiving dialysis at the Center. Since then, LT has only been to the ED once and hospitalized once. LT continues to have support from his Care Team coordinated by his Health Home Care Manager. LT's Nephrologist states that he is in much better health now with consistent HD treatment. He is also better able to manage his behaviors. Not only has this transition benefited LT's overall health, it has also dramatically reduced the cost of his care: In 2017 his total cost of care was $332,880.16 (137 ED visits and 3 inpatient visits) for the full year. In the 3rd Quarter of 2018, post intervention by the Health Home Care manager, his total cost of care was $5,431.



Learn more about Capital Region Health Connections Health Home, click here.

Kyara's Story

Kyara is a teenage girl with uncontrolled Type 1 Diabetes. She also struggles with obesity and depression. Kyara often finds herself acting out and exhibiting aggressive behaviors towards her loved ones. To get her the help she needed, Kyara was enrolled in Encompass Health Home, where she met her Health Home Care Manager—Amanda. Amanda worked with both Kyara and her family to develop a care plan based on Kyara's goals. To achieve Kyara's goal of losing weight, Amanda helped get her a treadmill and Kyara's family a gym membership. Amanda even helped Kyara's family in purchasing a vehicle to help them get to the local grocery store and gym. In the first month, Kyara lost ten pounds! Additionally, Amanda coordinated with Kyara's providers to get her diabetes under control and manage her depression. Both Kyara and her family consider Amanda part of their family. As her health improved, so did her performance in school and her relationship with her friends and family. Amanda continues to encourage Kyara and provide her with support she needs to achieve all her goals.

Watch Kyara and her mom tell their story by clicking here!

Learn more about Encompass Health Home.

Sharon's Story

Sharon is a 35-year old woman from the Hudson Valley. She lost her job in 2008 and has been having difficulties keeping a full-time job since. Unable to make her rent payment, Sharon lost her home and has been struggling to find stable housing. She had been diagnosed with mood and borderline personality disorder. She also has a history of substance use. Sharon has been admitted to the hospital frequently since she has had difficulty engaging in mental health treatment and following her primary care physician's recommendations. In the past, Sharon has resisted help.

Last time Sharon was admitted to the hospital, she got a referral to the Community Health Care Collaborative (CCC) Health Home run by Hudson River HealthCare. Through CCC, Sharon was able to meet her Health Home

Care Manager—Karen. Karen patiently worked with Sharon to understand that there will be days that she needs other people's help and that is ok. Karen started to attend medical appointments with Sharon to facilitate positive conversations between Sharon and her physician which helped her successfully follow her medication regimen and her physician's instructions. Sharon, who was once adamant against engaging in active care activities, started to attend group and individual therapy sessions, and a substance use treatment program. Karen helped Sharon find a job my making appointments with the Westchester County Employment Center and find stable housing in an Apartment Treatment Program.

Since Sharon started working with the CCC Health Home, she is in recovery from her substance use disorder. She is now better able to manage her mental health conditions thanks to the coping mechanisms she has learned and continues to engage in group and individual therapy. Sharon also successfully completed her certification as Peer Specialist and now holds a part-time job at a community-based care management provider. She is living on her own and spends her free time volunteering at a clinic.

Learn more about the Hudson River HealthCare's Community Health Care Collaborative here.

Carlos' Story

Carlos is an 87-year old living in a New York City Housing Authority (NYCHA) apartment. He spends most of his time with his daughter and grandchildren, with whom he lives, and frequents an Adult Day Center several times a week. Given his multiple diagnoses of hypertension, hyperlipidemia, coronary heart disease, chronic ischemic heart disease, and depression, he was referred to a Health Home.

Upon enrollment, Carlos requested assistance connecting to a mental health provider, ophthalmologist, and transportation services; however, his Health Home Care Manager, Sofia, suggested she also accompany him to his primary care appointments. At one of his appointments, Carlos' primary care physician relayed concerns regarding Carlos' health and a possible diagnosis of prostate cancer. Carlos' physician had attempted to engage Mr. Hernandez

numerous times, but his attempts were to no avail. With Carlos' permission, Sofia worked with Carlos' trusted team at the Adult Day Center, to engage him in treatment that worked for him. Carlos is now working with his new urologist and gastroenterologist specialist to prepare for his biopsy and determine the appropriate course of treatment. Mr. Hernandez is hoping to get the appropriate treatment, so he can continue to live with his daughter and grandchildren and attend the Adult Day Center with his friends for much longer.

Ella's Story

Ella is an 18-year old girl who spent several years in the child welfare system. She was removed from her home because of childhood trauma and abuse and dropped out of school in the eighth grade. With no friends or family, she was forced to live on the streets once she aged out of the child welfare system. Ella would live off her earnings from her part-time job at a local supermarket and her Supplemental Security Income (SSI) benefits, if she received them. She was struggling with alcoholism and several behavioral health conditions, including bipolar disorder and post-traumatic stress disorder (PTSD). Ella has also suffered from a first-degree heart blockage due to some medication she was given as a child. She frequented the emergency room when she was younger for her behavioral health disorders and attempted suicides and had been involved with the local Mental Health Court.

Eventually, Ella was enrolled in Health Home Partners of Western New York/Spectrum Human Services, where she met her Health Home Care Manager—Diana. Diana and the rest of the Care Team used an intensive, person-centered, care transition approach that focused on engagement, working with Ella to identify her immediate needs, and coordinating her care. Shortly after enrolling at Health Home Partners of Western New York, Ella found out she was pregnant. After careful consideration, Ella decided she wanted to carry her child to term and become a good parent. Diana respected Ella's decision and worked to support her. Together, they reached out to Ella's mother and worked to restore her relationship with her mother. In doing so, Ella was able to move in with her mother. Ella's Health Home Care manager connected her to an outpatient mental health and substance use treatment center. She started to attend her appointments regularly and followed through

with her providers' recommendations. Ella began to stabilize and she was able to get the appropriate prenatal care she needed. Ella recently delivered a healthy baby girl and now lives with her mother and her daughter.

Learn more about Health Home Partners of Western New York here.