Hudson Valley Care

HEALTH HOME

Are you concerned about your Medicaid clients once they leave your office?

Are they receiving the social services they need? Are they adhering to their treatment plans? Do they need behavioral health care?

Hudson Valley Care Health Home services can decrease risk and improve outcomes for your patients in their communities where they live and work.

Hudson Valley Care Health Home services

Care coordination – *we manage*

We assign a dedicated care manager who manages your patient's medical and social needs through an individualized care plan. This includes coordinating and arranging services, supporting treatment and medication, and monitoring your patient's needs.

Care management – *we initiate*

Our care managers create, execute and update an individualized care plan that meets your patient's physical, mental health, substance abuse and social service needs. The care plan addresses family and caregiver needs, cultural considerations, and health literacy levels.

Transitional care – *we stay connected*

Through our relationships with Hudson Valley hospitals and medical facilities, we are promptly notified when your patient enters or is discharged from the healthcare system. We work with providers to ensure that patients have access and are connected to follow-up care in a timely fashion.

Community & social support – *we coordinate access*

Our network of care management agencies has years of experience and deep community knowledge. We actively manage appropriate referrals, access, engagement, and follow-up to social support services.

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Eligibility – who qualifies?

Our Health Home services help Medicaid patients that have:

- Two or more chronic conditions (for example: mental health, substance use, asthma, diabetes, heart disease, BMI > 25), or
- One condition, either HIV/AIDs or serious mental illness

With risk factors such as:

- Disconnection from the healthcare system (for example: no primary or specialty care provider)
- Non-adherence or difficulty managing treatment or medication
- Inappropriate ED use
- Repeated recent hospitalization for preventable medical or psychiatric conditions
- Recent release from incarceration
- Cannot be effectively treated by a patient-centered medical home (PCMH)
- Homelessness

If an individual has HIV or serious mental illness, they do not have to be determined to be at risk of another condition to be eligible for Health Home services. Substance use disorders are considered chronic conditions and do not by themselves qualify an individual for Health Home services. Individuals with substance use disorders must have another chronic condition to qualify.

Who we are

Hudson Valley Care is a coalition of 23 care management agencies serving six counties. We work together to support our members by providing comprehensive care coordination services for your Medicaid patients with two or more chronic conditions, HIV/AIDS, and/or serious mental illness.

Freeing you to treat your patient

With Hudson Valley Care, you can concentrate on conducting physicals, running tests, and actually treating your patient. Our care managers engage with each member to provide additional support, such as securing transportation, managing their appointments, helping them get their Medicaid recertified, educating them on the importance of taking their medication as prescribed by their doctor, and connecting them to social services such as housing, food stamps and other benefits.

Our services are reimbursed by Medicaid and managed care organizations. There is no cost to referring providers or to our members.

Contact Us

Contact Stephanie Griffith at sgriffith@hvcare.net or 1-800-768-5080 to find out more about Hudson Valley Care Health Home services or to make a referral.

Sally's story

Sally had a history of poor health compounded by a lack of access to medical care. Recently, at a local hospital, an ER doctor told her that her A1C level was extremely high. If she did not take care of her diabetes she could become seriously ill.

A hospital social worker referred Sally to Hudson Valley Care. Now Sally and her family have a care manager who is connecting Sally to the appropriate resources for housing and other services needed to normalize her life and the lives of her family.

Once Sally's life is stabilized, her care manager will work with Sally to lower her blood sugar through medication, dietary changes and exercise. With the help of Hudson Valley Care, Sally will soon be on the road to better health.

Referrals

If you think you have an eligible patient, securely send a referral form to sgriffith@hvcare.net or fax to 914-941-3270

Hudson Valley Care

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