Success Story

Health Home Partners of Western New York Align for Successful Care Management

Results Show 181% Increase in Primary Care Utilization and 32% Decrease in ED Usage

Health Home Partners of Western New York (HHPWNY), located in Buffalo, is a Medicaid Health Home partnership that brings together a wide range of care services across the region to deliver comprehensive medical, behavioral, and social service care to the population. An early adopter of Medecision's Aerial® Health Coordinator population health management platform and long-standing client, HHPWNY has been an innovator in implementing value-based care programs. The partners—Catholic Health, Evergreen Health Services, and Spectrum Human Services—collaborate to deliver care to the community's most needy and high-risk patients, with each partner offering leadership in a specialty expertise, including behavioral health, youth disorders, and HIV and AIDS programs in addition to medical.

Each partner has a stake and a voice, bringing diversity and a range of experience to the partnership. This is what gives HHPWNY its strength—an alignment of purpose under a single umbrella while each partner retains its identity in the community. This alliance shows the power of successful care management: different organizations working together and transforming the model of care, with measurable results. Using Health Coordinator as an enabling technology, HHPWNY successfully achieved a 181% increase in primary care utilization and 32% decrease in emergency department (ED) usage, verified via a NY state Medicaid Health Home redesignation audit.

Working Together to Implement an Effective Care Management Approach

HHPWNY strives for a consistent care model so that cases are managed the same throughout the Health Home. The organization credits its quality of results to the clinical leadership team—the brain trust of the Health Home that includes all three partners and drives consistency throughout the care management agencies (CMAs). The decisions made at the clinical level impact the majority of members HHPWNY serves, so providing a uniform standard of care and making the information available to all downstream providers so they can support the care plan makes a difference.

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2x+	Health Home Enrollment
32%	Decrease in ED Usage
181%	Increase in Primary Care Utilization

"While each organization has its own fingerprint, Health Coordinator enables collaboration and communication between agencies and helps us operationalize our infrastructure, care teams, and caseloads," said Kevin Beckman, Director of Health Home Operations for HHPWNY. "Having everybody on the same platform helps us ensure that quality standards are being met and that the information within Health Coordinator is understood and interpreted with a single voice. This model is what really works."

Patients are assigned when a referral is received based on preference, as well as where the patient is located and how well the strengths of each partner aligns with the patient's needs. Because all care management functionality is in a single platform, transferring to another CMA and care team is an easy assignment change—even if the CMA is from an entirely different agency. "Medecision has done a great job helping us align the CMAs to use our custom assessment as the glue that holds everything together," said Beckman. "As we manage individual patients, it doesn't matter what CMA they are assigned to—all organizations approach documentation the same way and patients can transfer back and forth. At a high level, our CMAs are communicating."

Custom Workflows and Assessments Trigger Action

To support the specific needs of the population, HHPWNY worked with Medecision to develop a custom assessment that leveraged their expertise with the patients and tracks the specific information required for the Department of Health. The answers to specific questions in the assessment serve as triggers in the care plan, and the data from the assessments can be analyzed to identify populations they can target for condition-specific intervention.

Health Coordinator also provides alerts that enable the HHPWNY team to follow up after critical events, including ED visits, according to policy guidelines.

"With Health Coordinator, we can respond to issues in real-time that we would have had to wait weeks to be notified about," said Kathleen Donaldson, Director of IT Home- and Community-Based Care at HHPWNY. "Technology is changing the arena for how organizations are alerted to critical information."

Another strength of HHPWNY's model is the ability to go where the patients are, using Aerial Health Coordinator to make real-time updates to the care plan in the field. Health Coordinator, accessible through standard browsers and through a mobile app, delivers integrated and timely information to care team members across multiple inpatient, ambulatory, and community-based settings, providing real-time information on critical events and required actions to smooth care transitions and facilitate post-acute care.

"We're able to put boots on the ground to meet with patients wherever they are," said Donaldson. "Health Coordinator's ability to update patient information and document encounters in real-time improves how we serve our patients and makes our job easier."

Interoperability Supporting Diverse Data

Aerial Health Coordinator coexists with EHRs and other tools used by HHPWNY, integrating a wide range of diverse data into a single care plan that can be accessed by all partners. Health Coordinator extends the applicability of the EHR, enabling collaboration across the care continuum and the tracking of not only what is happening now, but what needs to happen in the future to support a patient's health.

"Instead of relying on EHRs to document what has happened, Health Coordinator allows us to be proactive—to predict rather than react," said Beckman. "Having the data really helps us to analyze and look forward."

This capability enables HHPWNY to manage the whole patient, including the between-care activities and settings that significantly impact patient outcomes.

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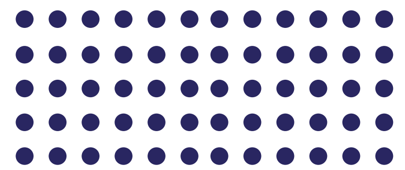

Improving the Model of Care across the Network

To improve its care model, HHPWNY analyzes results from the disparate business entities to provide insight into how to close care gaps, strategically identify at-risk patients, and allocate resources where they make the most impact. “Analysis enables us to see where we are, and have an understanding of how we do what we do and why,” said Beckman. “The analysis evaluates the trends and helps us figure out whether we’re doing the job right and whether we need to change.”

Before the HHPWNY network was all on the same system, some organizations were unable to audit internally to follow guidelines because they were unable to pull the needed information from the system. Over time, HHPWNY’s partner organizations began to embrace Health Coordinator’s capabilities—including care coordination, population management, and reporting—and leverage them to improve their operations.

“While not all our quality measures are required by the state, our partners saw that they make sense from a best practice point of view and that they were unable to do that with the other systems they were using,” said Beckman. “The greatest selling point was using Health Coordinator and seeing it in action.”

Aerial Health Coordinator Supports Successful Redesignation

To improve outcomes and prepare for Health Home redesignation, HHPWNY began gap analysis a year before its scheduled Health Home redesignation process. Not only was Health Coordinator configured to support the information required for redesignation, but HHPWNY put in place policies to make sure that they were following the guidance on a daily basis.

“Medecision helped us more clearly understand the guidance and policies of the Department of Health and other state agencies, and make sure the guidance was reflected in our policies to steer what we do every day and the direction that we’re going,” said Beckman. “Leveraging Medecision’s expertise in New York’s healthcare policy really helped—when the guidance changed, Medecision was already doing the work.”

HHPWNY partly credits its success to the consistent approach to care management across the partnership, particularly having all organizations supported by a single platform. “We saw a marked improvement when we got everybody on Health Coordinator,” said Beckman. “We could see everything—and could check quality, billing, validation reports, and enrollment. Having everybody on the same system was amazing.”

The audit process proceeded smoothly, with auditors receiving their own user IDs with easy and fast access to all the information they needed. “Because Health Coordinator drives processes, the auditors could tell we were doing what we were supposed to be doing and adhering to the guidance from the state,” said Donaldson.

The results back it up. During the period under review, enrollment in the Health Home more than doubled. Auditors found that the Health Home worked with care managers, providers, and care plans to increase primary care utilization by 181% and decrease ED usage by 32%. These numbers are a testament to HHPWNY’s dedication to leveraging technology to hone their processes and workflows to improve outcomes for patients.

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