NYC HEALTH+ HOSPITALS | INSIDER

JANUARY 29, 2018

NYC Health + Hospitals/ At Home Brings Quality Care to the Community

When individuals require specialized care beyond the walls of our patient care locations, the NYC Health + Hospitals/At Home division of our health system steps up to the plate.

Vickie Norvell

Vickie Norvell, Chief Executive Officer of At Home, talks about why staff should refer patients to At Home and their initiatives to advance linkages to primary care and access to essential social services to improve overall health outcomes.

What kind of services does NYC Health + Hospitals/At Home provide?

At Home brings health care to our patients where they live with the goal of decreasing preventable inpatient admissions and ED visits. Our staff helps patients learn to self-manage their conditions and connects them to needed community resources.

As a Certified Home Health Agency serving more than 1,300 patients per month, we offer care that helps patients manage their illness or injury and enables them to stay at home. That care includes nursing, rehabilitation, and social work services. We also operate a Health Home, a state initiative designed to support Medicaid recipients who are managing significant chronic medical and/or behavioral conditions in the community. As one of the largest Health Homes in the state, we provide community-based assessment, care planning, and linkage to primary care and community resources to more than 9,000 Health Home members.

Care coordination is essential to keeping patients healthy in their homes and communities. How does At Home help meet this need?

Our care coordination experts provide integrated care planning, case conferencing, and referral services for individuals managing chronic medical and behavioral health needs, often complicated by factors such as food insecurity, homelessness, poverty, and justice system affiliation. Our services are designed to promote connection to primary care and other outpatient services, while reducing reliance on EDs and hospitalizations for conditions that are best managed in outpatient settings.

Can you share a few examples of recent collaborations or exciting developments?

We have partnered with three hospitals (NYC Health + Hospitals/Bellevue, NYC Health + Hospitals/Elmhurst, and NYC Health + Hospitals/Queens) to more systematically connect patients considered "high" utilizers of inpatient and emergency care with At Home services. Additionally, our home care division will soon implement a behavioral health nursing program to create a more seamless transition for patients with diagnoses such as major depression and bipolar disorder to the home setting, as well as strengthen the link between behavioral and physical health.

Why should staff refer patients and families to At Home over other home health agencies?

Every referral to At Home keeps our patients on the same care continuum and in the hands of NYC Health + Hospitals' high-quality, dedicated providers. Because we offer an integrated menu of home care and care coordination services, we can ensure that even those with the most complex needs get the appropriate care where and when they need it. By working together, we can help patients get and stay healthy in their homes and communities, disrupting the cycle of costly and preventable inpatient stays and ED visits.

What's the easiest way for staff to refer patients and their families to At Home?

To connect your patient to At Home, we can accept referrals through Allscripts, under NYC Health + Hospitals/At Home, or you can just send an email to AtHome**[Your Facility]**@nychhc.org. For example, AtHomeHarlem@nychhc.org or AtHomeJacobi@nychhc.org.

We look forward to partnering with you.