

The New ICS Health Home

Helping You Keep Your Patients Healthy

Independence Care System (ICS) has opened New York State's first and only health home program with expertise in caring for people with physical disabilities, bringing the care coordination practices we have developed over almost two decades to Medicaid-eligible New Yorkers.

ICS members will receive:

- Help scheduling, keeping and following up on medical appointments
- When needed, someone to attend medical appointments with them
- A care navigator who can facilitate communication and information sharing among providers
- Education and encouragement to help members adhere to clinicians' instructions
- Guidance in setting goals and making a plan to reach them
- A comprehensive assessment, performed yearly and after significant changes in condition
- Access to a network of disability-competent primary care providers and accessible health screenings
- Assistance applying for and keeping important public benefits, such as Food Stamps (SNAP), Medicaid or housing subsidies
- Access to exercise and social programs to help them remain independent and engaged
- Help enrolling in health-enhancing programs such as smoking cessation or behavioral health services



*A health home is not a place where people live. It is a care management program for specific groups of Medicaid-eligible individuals, including those with multiple chronic conditions, who are at risk for poor health outcomes. The goal of a health home is to minimize those risks and to ensure members get the care and services they need to be as healthy as possible. **This may result in:***

- **Fewer trips to the emergency room**
- **Less time spent in hospitals**
- **Coordinated care across health care settings**

How it works:

Through care coordination that includes assessing and managing the many social determinants that affect our members' health, we help you, their clinician, and other providers achieve the best possible outcomes, while saving time and making the best use of available resources.

Having an ICS care manager and care navigator helps members:

- Adhere to their care plan at home
- Obtain services that can help them remain as healthy and as independent as possible, in the community where they live



Unlike a managed long-term care (MLTC) plan, the ICS health home does not pay for services such as home care, transportation, or medical supplies. Rather, the program provides an expansion of care coordination, filling in gaps usually not covered by MLTC. This includes the areas of primary and specialty care and behavioral health, as well as the coordination of various needed social support services. You do not need to be in a MLTC plan to enroll into a health home.

Clinicians who care for ICS members get help too. If you care for an ICS member who could benefit from some additional support, please let us know so that we can include the member's treatment goals in our plan of care.

You can reach an ICS care navigator by calling 1.877.ICS.2525.

Referrals

If you have a patient who might benefit by joining the ICS health home, please have them call ICS to see if they are eligible. That number is 1.877.ICS.2525.

