Greater Rochester Health Home Network

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Service Provider Fact Sheet

The Greater Rochester Health Home Network (GRHHN) was established to provide a network of organizations – care management providers and community-based organizations, working together with medical, mental health, and substance use disorder treatment providers in order to optimize health outcomes and quality of life for the most complex patients/individuals in our community. It is a NYSDOH Program which provides high quality care management services for Medicaid clients with complex medical and behavioral health conditions in a 13 county region.

Service providers including primary care providers, hospitals, pharmacies, clothing closets, transportation, food cupboards, utility assistance organizations, etc. are vital in supporting individuals in meeting their health goals and optimizing their quality of life. Service providers are funded through established funding streams which will not be disrupted through participation in GRHHN.

The role of service providers includes the following:

- Accept referrals for service from Health Home Providers of Care Management
- May be contacted to identify more current contact information to assist in finding potential enrollees.
- Are encouraged to submit referrals for their patients/clients who could benefit from GRHHN care management services
- Participate in the development of a plan of care for their patients/clients with a care team. The plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs. Effective collaborations between service providers and care managers help support the patient/client in achieving their goals.
- Participate in regular case review meetings and communicate with the care manager on an as needed basis regarding changes in the individual’s condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
- Work with the care manager to help ensure coordinated, safe transitions in care for individuals who require transfers in the site of care, including timely access to follow-up care post discharge and sharing information to help support their care in the new site of care.

The advantages of working with GRHHN include:

- Supporting your patients/clients in following your treatment recommendations.
- Helping to ensure your patients/clients attend your appointments.
- Identification of a single point of contact for information and care plan coordination with community-based services.
- Supporting your patients/clients in developing self-management support skills.
- Promoting appropriate use of the health care system to decrease unnecessary emergency department and inpatient use.

You can be a member of more than one Health Home network.