CAREdesign
NEW YORK

Attention: Discharge Planning & Transitions of Care Teams

Important **discharge planning requirements** for individuals with Intellectual and/or Developmental Disabilities (I/DD) enrolled in Health Homes.

Many New York State residents with **Intellectual and/or Developmental Disabilities (I/DD)** are enrolled in **Health Home Care Management** because of their complex **health needs** and **chronic conditions**.

If a Health Home member **has been admitted** to the hospital, **their Health Home Care Manager is critical** to the care and discharge planning process.

New York State **Health Home enrollees** and/or their legal guardians **have provided consent for sharing Protected Health Information (PHI)** with their Health Home Care Manager.

This consent form is **authorized by the New York State Department of Health** and is available to be shared, as requested.

Why does this matter to me?

Coordinating with the Health Home Care Manager can:

- Reduce Readmissions
- Reduce Cost
- Promote Quality Health Outcomes

Therefore, **it is critical that you provide the Health Home Care Manager with the transition of care information throughout the course of the admission and immediately upon discharge** to ensure their coordinated and safe post-hospital recovery.

Please note that If you admit a person enrolled in the Care Design NY Health Home, you may contact us by phone:
Monday – Friday 8:30 am – 5:00 pm: 518-235-1888
After Hours: 877-855-3673

Please post this message in the department for all discharge planning team members to read and follow.
You may contact the Care Design NY Healthcare Team if you have questions: healthcaremanagement@caredesignny.org.
You may also visit the New York State Department of Health website for information on Health Homes: www.health.ny.gov.

To learn more about Care Design NY visit CareDesignNY.org, or email providerrelations@caredesignny.org.