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Health Homes Serving Children

Readiness and Implementation Updates

April 7, 2016

Overview of Today's Webinar

- ✓ Timeline of Readiness Activities
- ✓ Health Home State Plan Amendment (SPA) Updates
- ✓ Enacted Budget
- ✓ Update Health Home Contingencies and Readiness Activities
- ✓ Health Home Eligibility Criteria – SED and Complex Trauma
- ✓ Prioritizing Enrollment of Children in Health Homes
- ✓ Standards for Health Homes Serving Children and Stakeholder Feedback
- ✓ Health Home Consent
- ✓ Billing Rules and CANS-NY
- ✓ Upcoming Training Schedule
- ✓ Questions



Timeline of Readiness Activities for Enrolling Children in Health Homes

Readiness Activities	Dates and Timeframes
Health Homes Contingently Designated to Serve Children Second Round of Applications Due and in January 2016 as a result of changes to Governance Structure of Applications reviewed in 2015	June 15, 2015 (13) March 17, 2016 (3)
Health Homes Signed Letters Accepting Designation and Agreement to Address Contingencies Due date for Second Round of Contingency Letters	June 30, 2015 (13) April 15, 2016 (3)
Other Readiness Activities of Contingently Designated HHs Serving Children (DEAAs, BAAs, CMA Network Lists, Provider Network Lists, Billing Readiness, HIT Requirements)	Ongoing
Various Training Webinars (Currently Available and New Trainings Schedule for the Spring/Summer) and MAPP Modifications for Children	Began in Early 2015 and Ongoing
Begin Enrolling Children in Health Home	October 2016





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Health Home State Plan Amendment (SPA) and Enacted Budget

April 7, 2016

State Plan Amendment – APPROVED TODAY



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Status of State Plan Amendment

- The State Plan Amendment – APPROVED by CMS
- Effective October 1, 2016, the SPA authorizes the following:
 - ✓ Use of modified CANS-NY Assessment (will be used to determine Health Home PMPM Rate)
 - ✓ Approval of High, Medium, Low PMPM Rates and Outreach and Assessment Rates
 - At CMS request, rates are approved under the SPA for the period October 1, 2016 to September 30, 2018 to provide opportunity to review rates
 - Will require State to submit amendment to extend/make permanent/modify

Per Member Per Month HH Care Management Rates for Children under 21 (non-Legacy Providers)

Acuity (CANS Algorithm)	Upstate	Downstate
High	\$750	\$799
Medium	450	479
Low	225	240
Outreach	135	135
Assessment	185	185



Status of State Plan Amendment

- The SPA authorizes the following:
 - ✓ Conversion of OMH TCM providers to Health Home, Approval of Rate Reconciliation Process for these Legacy Providers
 - Rate methodology discussed in June 8, August 25, and September 16, 2015 Webinars
 - DOH and OMH will be scheduling additional Webinars with OMH TCM providers to ensure smooth transition to Health Home
 - ✓ Referral, rather than assignment list, process for enrollment
 - ✓ Modifications to Health Home eligibility criteria for children: Serious Emotional Disturbance (SED) (Health Home definition) and Complex Trauma (CMA/SAMHSA definition) as single qualifying conditions for Health Home eligibility (will be discussed in more detail later in this presentation)
 - State requested Federal Match at 90% for SED and Complex Trauma and new conditions under the Health Home program
 - CMS authorized 90% for Complex Trauma only
 - To maximize the 8 quarters the State agreed to shift the effective date for enrollment to October 1, 2016 (with September date state would have lost two months of 90% Match)



Status of State Plan Amendment – Early Intervention

- The SPA authorizes the following:
 - ✓ Proposed approach for having the Health Home Care Manager serve as the Ongoing Service Coordinator for children enrolled in both Health Homes and the Early Intervention Program is acceptable to CMS
 - The State Health Home and Early Intervention staff have been meeting bi-weekly to identify the methods to integrate HH services with Early Intervention Ongoing Service Coordination and to provide trainings:
 - About each program – Health Homes and Early Intervention
 - Roles of Health Homes and Early Intervention Service Coordinators (Initial and Ongoing) for Children, including Early Intervention Administrative requirements for Health Home Care Managers who will fulfill the role of Ongoing Service Coordinators
 - The State will present, for discussion and feedback, to the Early Intervention Coordinating Council, representatives from New York State Association of County Health Officials (NYSACHO), and other stakeholders procedures for integration of Health Home and Early Intervention
 - ***The State expects that this work, including obtaining stakeholder feedback, will not be complete by the October Enrollment date and the enrollment of Children in Early Intervention that may also be eligible for Health Home will begin at a later date to be determined by the State***



Adopted Budget and Readiness Resources for Health Homes Serving Children

- In letter signed by Medicaid Director to address a variety of concerns raised through the course of Budget dialogue, the Office of Health Insurance Programs (OHIP) at the Department of Health, confirms it will:

“Work with Health Homes for Children to help identify and address start-up costs for implementing Health Homes for Children within available global cap resources for the Health Home Program.”

- Next steps: Work with Health Homes and Department to identify resources and methodology for distributing resources to Health Homes serving children



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Updates on the Status of Readiness Activities of Contingently Designated Health Homes Serving Children (CD-HHSC), Care Managers and Plans

April 7, 2016

Overview and Status of Readiness Activities of Contingently Designated Health Homes Serving Children (CD-HHSC)

- Since December 2015, CD-HHSC have made substantial progress in moving towards readiness
- State has had periodic meetings with some of the CD-HHSC, including “new” HH that currently do not serve adults
 - ✓ State is in process of scheduling monthly readiness check in meetings with HHSC
- For most CD-HHSC, outstanding readiness activities primarily revolve around:
 - ✓ HIT Compliance – Updated written HIT policies, care management software
 - ✓ Billing Readiness – Billing software, Billing Certifications
 - Due date for submitting Billing Certifications is May 1, 2016 (adult and children Health Homes have to submit separate attestations)
 - ✓ BAAs – with a particular focus on BAAs with:
 - OMH TCM providers that will transition to Health Homes – need 100% linkage to ensure smooth transition.
 - Voluntary Foster Care Agencies that will be care managers for children that may be eligible for and enrolled in HH and also in foster care
 - ✓ Administrative Service Agreements (revised as January 2016) with Managed Care Plans
 - Due date for entering into revised ASAs for Health Homes that now serve adults July 1, 2016



Check List of Major Readiness Activities to be Completed by Health Homes (Updated as of 4/7/16)

HH	Contingency Response Letter	HIT Addressed**	Billing Readiness Attestation and Billing Software*	DEAA with DOH	OMH TCM Provider/BAA	VFCA/BAA	NPI and MMIS	ASAs	HH SPOC	NEW BAAs	CMA List/S POC	Finalized Partner Network List	Final Approval Letter
Adirondack Health Institute, Inc.	YES	Need to Submit Verifying Docs	YES	YES	5 Identified TCM/5 BAAs	4 Identified/3 BAA	YES	YES (4 signed)	YES	YES	YES	YES	NO
CNYHHN, Inc.	YES	Need to Submit Verifying Docs	NO	YES	11 Identified TCM/7 BAAs	14 Identified/7 BAAs	YES	YES (3 signed)	YES	YES	YES	YES	NO
Coordinated Behavioral Care, Inc.	YES	Need to Submit Verifying Docs	YES	YES	10 Identified TCM/9 BAAs	7 Identified/7BAAs	YES	YES (9 signed)	YES	YES	YES	YES	NO

*Note a separate billing readiness attestation is required for children

**Please see Slides 19 and 20 from September 24 Readiness Reviews of Contingently Designated HHSC Webinar

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm



Check List of Major Readiness Activities to be Completed by Health Homes (Updated as of 4/7/16)

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Niagara Falls Memorial Medical Center	YES	Need to Submit Verifying Docs	NO	YES	3 Identified TCM/2 BAA	4 Identified / 3 BAAs	YES	YES (4 signed)	YES	YES	YES	YES	NO
North Shore LIJ Health System	YES	Need to Submit Verifying Docs	YES	YES	1 Identified TCM/ 1 BAAs	7 Identified / 1 BAAs	YES	YES (6 signed)	YES	NO	YES	YES	NO
St. Mary's Healthcare	YES	Need to Submit Verifying Docs	NO	YES	2 Identified TCM/0 BAAs	10 Identified /3 BAAs	YES	YES (3 signed)	YES	YES	YES	YES	NO

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Catholic Charities of Broome County	YES	Need to Submit Verifying Docs	YES	YES	18 Identified /10 BAAs	7 Identified/ 5 BAAs	NPI: YES MMIS: YES Possible Name Change	YES (3 signed)	YES	YES	YES	YES	NO
Community Care Management Partners, LLC	YES	Need to Submit Verifying Docs	YES	NO	3 Identified /3 BAAs	4 Identified/ 4 BAAs	NPI: YES MMIS: NO	YES (9 signed)	YES	YES	YES	YES	NO
Mount Sinai Health Home	YES	Need to Submit Verifying Docs	NO	NO	11 Identified /1 BAAs	4 Identified/ 0 BAAs	YES	YES (6 Signed)	YES	NO	YES	YES	NO

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Children's Health Home of Upstate New York	YES	Requirements due 12/15/16	YES	YES	32 Identified TCM/ 30BAAs	32 Identified/ 28 BAAs	YES	NO	YES	YES	YES	YES	NO
The Collaborative for Children and Families	YES	Requirements due 12/15/16	YES	YES	13 Identified TCM/10 BAAs	29 Identified/ 25 BAAs	YES	NO	YES	YES	YES	YES	NO
Children's Health Home of Western New York (Kaleida Health)	YES	Requirements due 12/15/16	NO	YES	4 Identified TCM/3 BAA	4 Identified/ 4 BAAs	YES	NO	YES	YES	YES	YES	NO

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Greater Rochester Health Home Network LLC	YES	Need to Submit Verifying Docs	YES	YES	15 Identified TCM/8 BAAs	19 Identified/ 5 BAAs	YES	Yes (4 signed)	YES	YES	YES	YES	NO
Hudson River Health Care Inc.	Contingency Response Letter Due 4/15/16	Requirements due 3 months after contingently designated	NO	NO	11 Identified TCM/2 BAAs	11 Identified/ 0 BAAs	TBD	Yes (10 signed)	NO	NO	NO	NO	NO

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Montefiore Medical Center	Contingency Response Letter Due 4/15/16	Requirements due 3 months after contingently designated	NO	NO	17 identified TCM/ 0 BAAs	14 identified/ 0 BAAs	TBD	Yes (7 signed)	YES	NO	YES	NO	NO
Institute for Family Health	YES	Requirements due 3 months after contingently designated	NO	NO	NO	NO	TBD	Yes (4 signed)	NO	NO	NO	NO	NO

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http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm



Information to Be Provided to Health Homes to Ensure VFCAs and OMH TCM Providers are Connected to Health Homes

To ensure VFCAs and OMH TCM Providers are in at least one Health Home Network, Health Homes will be provided the following information through email correspondence:

1. Specific to Voluntary Foster Care Agencies

- a) A list of VFCAs that the Health Home identified in their provider network list
- b) A list of VFCAs that the State identified in HH contingent designation letters
- c) A list of VFCAs listed on the HH CMA SPOC list
- d) A list of VFCAs within a Health Home network that do not have a BAA

2. Specific to OMH Targeted Case Management providers

- a) A list of OMH TCMs that the Health Home identified in their provider network list
- b) A list of OMH TCMs that the State identified in HH contingent designation letter
- c) A list of OMH TCMs listed on the HH CMA SPOC list
- d) A list of OMH TCMs within a Health Home network that do not have a BAA



Action Needed Administrative Services Agreement with Managed Care Plans

- Health Homes and MCOs newly entering into ASAs, including ***Health Homes newly designated to serve children***, will be required to use the revised version of the DOH Standard Agreement (revised as of January 2016) or Key Contract Provisions (February 2016) to develop customized contracts
- MCOs and Health Homes that make any material amendments to their ASA (develop customized contracts) will be required to resubmit the amended ASA for review and approval by the Department
- ASAs that only have the DOH revisions to an existing DOH approved ASA, will be permitted to simply file the revised ASA with the Department
- MCOs with existing approved ASAs have until July 1, 2016 to incorporate and file DOH revisions
- MCOs and HHSC should work together now to complete ASAs
- *State will be reviewing the overlap between service areas of HH and Plans to ensure access to HHSC*



Administrative Services Agreement with Managed Care Plans - RESOURCES

- Additional information regarding the MCO Roles and Responsibilities and the contracting process can be found at the Managed Care tab of the Health Home website:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm
- A complete list of Managed Care Plans, service areas and contacts for Health Homes can be found at the link below:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_manage_care_contacts.pdf



Medicaid Analytics Performance Portal, Health Home Tracking System (MAPP – HHTS) and UAS

- Phase 2 MAPP Modifications for Children – Go Live Date September 2016
 - Children’s referral portal, consent
 - Billing for children’s rates from CANS-NY algorithm and connectivity between MAPP and UAS
 - CANS-NY will be house in Uniform Assessment System (UAS)

MAPP Health Home Tracking System Training – Online training and instructor led webinars are offered depending upon the users role. Current courses focus on how to navigate and use the MAPP Health Home Tracking System (training does not include MAPP modifications for children).

UAS-NY Application Training for CANS-NY – Training is offered through online, self-paced courses that are focused on how to use the UAS-NY web-based application.

Training will be available at least 30 days prior to implementation



LGU/SPOA Action Required to Access MAPP

- Local Government Units (LGUs) and Single Point of Access (SPOAs) will have access to MAPP to make Health Home Referrals for Children
- To access MAPP, LGU/SPOAs must acquire access to Health Commerce System (HCS)
- The State has created HCS Organizational Accounts for LGUs/SPOAs – the State is now processing these account requests
- Each LGU/SPOA was requested to identify an HCS Director and two HCS Coordinators by March 11, 2016
 - Any LGU/SPOAs that has not done so, please submit the required form (distributed to LGUs on January 20, 2016) by close of business **April 8, 2016** – if you need the form please make a request by sending email to HHSC@health.ny.gov



LDSS Access to MAPP

- ✓ LDSS already have access to HCS which is required to access MAPP
 - LDSS will have access to MAPP to assign children in Foster Care to a VFCA
 - LDSS will be provided a list of Health Homes VFCAs are linked to (i.e., which VFCAs have a BAA with which Health Homes)



Health Homes Action Required to Verify CMAs Single Point of Contact (SPOC) and Business Associate Agreement (BAAs)

- On March 30, 2016, Health Homes SPOCs received an email correspondence requesting they verify their care management agency (CMAs) single point of contact (SPOC) list
 - HH Verification of the accuracy of the CMAs SPOC list is due to the Department on **April 13, 2016** by email HHSC@health.ny.gov
- Health Homes should verify that all CMAs in which they have an executed business associate agreements (BAAs) with, are also included in their CMA SPOC list – an email will be sent out requesting verification
 - Health Homes will need to ensure that BAAs are in place with all providers identified on their CMA SPOC list no later than **May 16, 2016**
- Any provider that is not included in the Health Home's CMA SPOC list **AND** does not have an executed BAA with the Health Home will not have access to MAPP



CMA's Required Actions for HCS Access

- Correspondence was sent to SPOC CMAs identified by HHs to provide next step guidance to obtain HCS Access
- HCS access is required to access MAPP
 1. If the Health Home CMAs **has** a valid MMIS ID number and is not set up in the HCS, the HH CMA SPOC received a correspondence on March 16, 2016 that provided instructions on how to set up an HCS Organizational Account
 2. If the Health Home CMA **does not have** a NPI and/or a MMIS ID number, the HH CMA SPOC received correspondence on March 14, 2016 with instructions on how to obtain an NPI and MMIS ID number – which are required to set up a Health Home CMA in HCS





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Health Home Eligibility Criteria

April 7, 2016

Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enroll in a Health Home **must** have:
 - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
 - One single qualifying chronic condition:
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) (Adults) or
 - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

* See DOH Website for list of chronic conditions

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

- Chronic Condition Criteria is **NOT** population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria

Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.



Stakeholder Feedback Regarding SED Definition and ADHD

- In December 2015, State proposed SED definition that included ADHD for children who meet the functional criteria for SED, **and are currently taking psychotropic medication**, AND have utilized any of the following services in the past three years:
 - Psychiatric inpatient
 - Residential Treatment Facility
 - Day treatment
 - Community residence
 - Mental Health HCBS Waiver
 - OMH Targeted Case Management
- In response to Stakeholders concerns the State has removed the currently taking psychotropic medications from the definition and clarified functional limitation criteria



SED Definition for Health Home - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

SED Definition for Health Home - DSM Qualifying Mental Health Categories*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- **ADHD for children who have utilized any of the following services in the past three years:**
 - **Psychiatric inpatient**
 - **Residential Treatment Facility**
 - **Day treatment**
 - **Community residence**
 - **Mental Health HCBS & OCFS B2H Waiver**
 - **OMH Targeted Case Management**

*Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

❖ Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)



Documenting Chronic Conditions Health Home Eligibility Criteria

- December 2015 Proposal for documenting Chronic Conditions – Stakeholders had no objections
- Care managers should document eligibility for Health Home that is based on chronic conditions (e.g., DSM-V, and other diagnoses of chronic conditions) by including in the care management record appropriate diagnoses made by Medicaid qualified providers that are licensed practitioners acting within their scope of practice
- **NOTE: CANS-NY tool by itself does not determine HH eligibility**



Documenting Health Home SED Eligibility Criteria

- Referrals for Health Homes care management services based upon the Health Home SED eligibility criteria will be documented by the HH Care Manager through the gathering of supporting information which must include:
 - A Health Home diagnosis from the Health Home's ***DSM Qualifying Mental Health Categories*** made by a licensed practitioner who can diagnose **AND**
 - A report from a licensed practitioner (clinicians, pediatricians, school social workers, etc.) the child meets the SED functional limitations requirements



Complex Trauma - CMS/SAMHSA Definition included in State Plan

This guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses.

Definition of Complex Trauma

- a. The term complex trauma incorporates at least:
 - i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
 - ii. the wide-ranging, long-term impact of this exposure.
- b. Nature of the traumatic events:
 - i. often is severe and pervasive, such as abuse or profound neglect;
 - ii. usually begins early in life;
 - iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
 - iv. often occur in the context of the child's relationship with a caregiver; and
 - v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
- c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
- d. Wide-ranging, long-term adverse effects can include impairments in:
 - i. physiological responses and related neurodevelopment,
 - ii. emotional responses,
 - iii. cognitive processes including the ability to think, learn, and concentrate,
 - iv. impulse control and other self-regulating behavior,
 - v. self-image, and
 - vi. relationships with others.



The SPA and Complex Trauma Discussions with CMS/SAMHSA

Part of our SPA discussions with CMS/SAMHSA included trauma as a single qualifying condition,

CMS/SAMHSA:

- Provided a definition of Complex Trauma, which is included in the SPA
- The Complex Trauma definition included in the SPA is different than what we proposed to CMS
- Per CMS/SAMHSA the Complex Trauma definition reflects the ACA authorization for the Health Home program which provides benefits to Medicaid members with chronic conditions – Complex Trauma is different than a child who experiences a traumatic event
- CMS/SAMHSA is also requiring the State develop procedures/approach for documenting and assessing if a child meets the Health Home Complex Trauma definition



CMS/SAMHSA Complex Trauma – Effects and Assessment

Essential Parameters Associated with Complex Trauma:

- Exposure to trauma leads to adverse prolonged effects
- Nature of trauma exposure is interpersonal; occurs in multiplicity and/or recurring traumatic events
- Multiple developmental impairments/diagnoses
- Multiple functional impairments (behavioral indicators of severity)

Screening and Assessment:

- The assessment of complex trauma involves **both** assessing the child's exposure to multiple or recurring traumatic events, as well as the wide-ranging and severe impact of this trauma exposure across domains of development. It is important that mental health providers, family members, and other caregivers become aware of specific questions to ask when seeking the most effective services for these children
- SAMHSA/CMS have provided a variety of documents to the State on Complex Trauma definition and assessment process
 - (CMS/SAMHSA has recommended tools identified by the National Child Traumatic Stress Network <http://www.nctsn.org/content/standardized-measures-assess-complex-trauma>)
- Along with today's Webinar these will be posted the DOH Health Home for Children Website



Stakeholder Feedback on Complex Trauma

- A group of stakeholders have requested the State seek to amend the CMS/SAMHSA definition and have recommended an approach for determining if a child meets the complex trauma definition
 - Stakeholder recommend changes to the definition requirement of multiple traumatic events and indicate that the notion of the number is not as relevant as the verified presence of a trauma history and functional impairments
 - Stakeholders also recommended an approach for determining complex trauma eligibility:
 - Focuses on functional assessment of trauma related events
 - Establishing a menu of validated instruments to document functional impairments
 - Identify other tools beyond those on NCTSN website for determining eligibility
 - Allow individual screenings to be done by qualified individuals, while charging licensed practitioner to aggregate, synthesize and interpret information to ultimately determine if a child meets the complex trauma definition



Next Steps

- Meet with Stakeholders making recommendation
- Present approach to CMS (end of May) to address
 - ✓ Who and what training/credentials are needed to determined complex trauma
 - ✓ What tools will/can be utilized to determine complex trauma
 - ✓ The procedures/approach for verifying and documenting complex trauma





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Prioritizing Enrollment of Children in Health Homes

April 7, 2015

Prioritizing the Enrollment of Eligible Children in Health Homes October 2016 Begin Date for Enrollment

- To manage initial capacity (and provide time to build up capacity) Health Homes, LDSS, LGU, Care Managers and Plans, should prioritize the enrollment of children ***that meet Health Home chronic condition eligibility and appropriateness criteria*** and have the highest needs, including the following:
 - ✓ Children enrolled in OMH TCM care management programs that will convert to Health Home
 - ✓ Children on OMH Waiver waiting list (already Medicaid eligible), within 30 days of discharge from inpatient/residential/day treatment settings to participate in discharge planning
 - ✓ Children on TCM waitlist; [SPOA who refers to HH]
 - ✓ Children who are on the Bridges to Health Wait list,
 - ✓ Children in licensed congregate care,
 - ✓ Children that are within 3 months of foster care discharge,
 - ✓ Children enrolled in LDSS prevention services where foster care placement is imminent,
 - ✓ Children prescribed 3 or more psychotropic medications
 - ✓ Children who are within 30 days of discharge from inpatient, residential or detox setting
 - ✓ Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay
 - ✓ Children who have an ER referral but are not admitted for inpatient services; or are discharged with a recommendation for community follow up;
 - ✓ Children with multiple system involvement (child welfare, criminal justice)
- ❖ ***Children in Early Intervention will begin to be enrolled at a later date to be determined by the State (when procedures for integrating EI and HH requirements have been established, with stakeholder feedback, and trainings provided).***



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Standards for Health Homes Serving Children

April 7, 2016

Stakeholder Feedback Regarding Health Home Standards

On December 2015 a webinar presented additional proposed Health Home Standards for Stakeholder feedback

- State received a number of thoughtful comments and suggestions from Stakeholders
- All Stakeholder comments and suggestions were reviewed and discussed among the State Agency Partners
- Next several slides will provide reminders of Standards and review those additional standards presented in December



Reminder: Health Home Six Core Services

- ✓ Application for Serving Children in Health Homes, State Plan requirements, and current Health Home State standards, and signed contingency letters, currently specify in detail requirements for delivering Health Home care management
- ✓ Health Home policies and procedures must be documented, and reflect and adhere to these minimum requirements
- ✓ Health Homes applying to serve children were required to demonstrate how these core requirements would be tailored to meet the needs of children and families
- ✓ **The Appendix** includes detail list of each of the many requirements for meeting each of the core services – below is a high level summary

1. Comprehensive Care Management

A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

2. Care Coordination and Health Promotion

The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

Reminder: Six Core Services of Health Home - Continued

3. Comprehensive Transitional Care

The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

4. Patient and Family Support

- Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

5. Referral to Community Supports

- The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

6. Use of Health Information Technology (HIT) to Link Services

- Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible, to comply with the initial standards and final standards as required

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm



Reminder: Staff Qualifications Health Home Care Managers Serving Children

- Staff qualifications for care managers that serve children with an acuity level of “high” as determined by the CANS-NY must have:
 - A Bachelors of Arts or Science with two years of relevant experience, or
 - A License as a Registered Nurse with two years of relevant experience, or
 - A Masters with one year of relevant experience.
- For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply.
(Those qualifications are further described in the Appendix)



Staff Qualifications Health Home Care Managers Serving Children

- Health Homes may seek a waiver from the State for care managers that have demonstrated experience but do not meet the required criteria – *Stakeholders supported ability to seek waivers*
- The State will develop a process to review qualifications proposed under waivers submitted by Health Homes
- The staff qualifications standards are ***minimum*** requirements
 - Health Homes may establish staffing requirements that exceed these standards (e.g., to better serve the particular needs of the children the Health Home may serve)



Supervisor to Care Management Ratio Policies and Requirements

- December 2015 Webinar proposed a supervisor to care manager ratio of 1:5 – *Stakeholder feedback varied from supportive to too restrictive*
- To ensure quality supervisory oversight, State is recommending as a **best practice**, a supervisor to care manager ratio of 1:5, **however**:
 - ✓ Health Homes must establish and document their supervisor to care management ratios requirements for care management agencies
 - ✓ Health Homes should work with care management agencies to establish and review the workload expectations of supervisors to ensure oversight and documentation of the delivery of quality care management services (i.e., the work of supervisors must go beyond administrative functions related to personnel management).
 - ✓ State's performance management activities and re-designation process will review the relationship between Health Homes supervisor to care management ratios and the quality of care management being provided



Required Training for Health Home Care Managers and Supervisors

- Lead Health Homes are responsible for ensuring that care managers and supervisors are appropriately trained and that trainings and qualifications of care managers are appropriate and reflect the populations that care managers serve.
- Health Homes must document compliance with training requirements for Care Managers and Supervisors prior to the delivery of services and within six months of employment
- *Stakeholder feedback generally supportive of training requirements as proposed:*
- Required Training for care managers and supervisors - Prior to providing Health Home Care Management Services, (including outreach) to children or families
 - ✓ CANS-NY training and certification annually
 - ◆ Supervisors must be CANS-NY certified and must achieve at least a score of 80% or higher on exam
 - ◆ Care Managers must be CANS-NY certified and must achieve at least a score of 70% or higher on exam
 - ✓ Mandated Reporter training - <http://nysmandatedreporter.org/TrainingCourses.aspx> – 2 hour training is available at no cost
 - ✓ Consent - HIPPA/CFR 42/sharing of information
 - ✓ Trainings provided by State for Health Homes Serving Children

Required Training for Health Home Care Managers and Supervisors

- Required training for care managers and supervisors within **six months** of employment or from first date care managers or supervisor provide any Health Home care management services (including outreach).
 - ✓ Engagement and Outreach (e.g., Motivational Interviewing)
 - ✓ Safety in the Community (e.g., conducting home visits, partnering with law enforcement, carrying cell phones, communication with supervisor, awareness of surroundings)
 - ✓ *Free to providers, offered by OMH and similar training being developed by OCFS*
 - ✓ Trauma Informed Care
 - ✓ Person Centered Planning
 - ✓ Cultural Competency/Awareness
 - ✓ LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Bisexual/Transgender/Questioning Families
 - ✓ Meeting Facilitation



Reminder: Case Loads and Required Face-to-Face Meetings

- Care Managers providing services to “high” acuity children (as determined by the CANS-NY Health Home billing algorithm) are required to keep their caseload mix predominantly to children of the High acuity level
- Medium and high acuity children (as determined by the CANS-NY Health Home billing algorithm) will be required to provide two Health Home services per month, ***one of which must be a face-to-face encounter with the child.***



Elements to be Included in all Plans of Care for Children

- Elements of Care Planning are consistent with requirements of the six core Health Home services (see Appendix)
- Health Homes must document their POC requirements
- *Stakeholders supportive of proposed POC elements*
- The Plan of Care (POC) elements are the minimum standards required for POCs - Health Homes may expand the required POC elements

**Note: there may be other POC requirements established by CMS for POCs that include Children's Home and Community Based Services (HCBS) that will become available in 2017 as part of the transition of the behavioral health benefit to Managed Care for Children*



10 Elements to be Included in all Plans of Care for Children

- For all children enrolled in a Health Home, the plan of care (POC) must include the following specific elements and be consistent with the requirements of the six core services:
 - 1) The child's **Emergency Contact and disaster plan** for fire, health, safety issues, natural disaster, other public emergency.
 - 2) The child's **History and Risk Factors** related to services and treatment, well-being and recovery.
 - 3) The child's **Functional Needs** related to services and treatment, well-being and recovery.
 - 4) The child's and caregivers' identified **Strengths and Preferences** related to services and treatment, well-being and recovery.
 - 5) *Medicaid State Plan and Non-Medicaid services identified to meet child's needs – must be person-centered, comprehensive and integrated to include Physical, Behavioral Community and Social Supports. Plan must also document the indication of choice of (a) Service Provider, (B) Reason for the Service and (C) Intended Goals.*



Elements to be Included in all Plans of Care for Children - Continued

- 6) Key Informal **Community Supports**. This would include any supports in place for the child/family that address identified needs (Ex. Family's neighbor is available for support as needed and is aware of child/family's needs, but is not assigned a specific task to reach a goal).
- 7) Description of planned **Care Management Interventions** (including Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Timeframes.
- 8) The child's **Transition Plan** including circumstances/services needed to transition from Health Home Care Management as needed (e.g., education, living situation, employment, community functioning, hospital, treatment facility, foster care)
- 9) Documentation of participation by **inter-disciplinary team** (all Key Providers) in the development of the plan of care.
- 10) The **Child's Medical consentor's Signature** documenting agreement with the plan of care. (referencing *DOH 5201* Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age)



Inter-Disciplinary Plan of Care Team Meetings

- Current Health Home Standard:
 - The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the ***interdisciplinary team*** on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.
- Interdisciplinary team meetings must occur as follows:
 - Interdisciplinary team meeting must occur during completion of the initial full CANS-NY and during subsequent CANS-NY updates to develop the plan of care
 - All other interdisciplinary team meetings should occur as frequently as needed and determined by the Health Home Care Manager
 - At the request of the Health Home Care Manager, and/or the child/parent/guardian/medical consentor (including the LDSS), based upon new information from another provider (e.g., primary care physician).



Inter-Disciplinary Plan of Care Team Meetings - Planning

- A Team Meeting must be person centered focused, scheduled to accommodate the child and parent/legal guardian/medical consenter attendance.
- Every possible effort should be made by the HH CM to have the Parent/Legal guardian/Medical Consenter for the Child to attend the Team Meeting.
- The Parent/Legal guardian/Medical Consenter for the Child should be an active member of the inter-disciplinary team and contributor to the Plan of Care.
- The Plan of Care and other decisions should not be completed without the input of the Parent/Legal guardian/Medical Consenter for the Child.

The HH Inter-disciplinary Meeting can account for other required meetings in various systems, as long as the appropriate attendees are invited and the meeting purpose and outcome is documented.



Inter-Disciplinary Plan of Care Team Meetings - Attendance

The Health Home Care Manager must invite:

- Parent/Legal guardian/Medical Consenter for the Child
- The Child (if age appropriate)
- Service providers for the child, including medical providers and those from other child serving systems (e.g., education)

Others recommended to be invited to attend Team Meetings:

- Family members and other caregivers
- Representative of LDSS or DJJOY, or its designee for children in foster care
- Representative from the voluntary case planning agency for children in foster care
- Anyone the child or parent/legal guardian/medical consenter wishes to have participate

If an invitee from the recommended list cannot attend then phone conference and or a summary report can be given, to ensure everyone's information and input is gathered.



Disenrollment from a Children's Health Home

- *Stakeholders supported criteria – made suggestions reflected below*
- Appropriateness for Health Home must be continuously monitored and evaluated
- No less than quarterly, care managers must actively **review and document** in the plan of care the child's needs for Health Home Care Management services
- Reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered Health Homes:
 - The child no longer needs the intense level of care management services provided by the Health Home. Discharge planning will begin when one or more of the following exists:
 - ✓ The chronic condition(s) that made the child eligible for Health Homes are being managed and or maintained,
 - ✓ All parties concur the child has met the goals of his/her Plan and is stable enough to no longer require the services of a Health Home care management,
 - ✓ Has service and support needs that can be met by **family/guardian** and services without the intensive level of HH care management
- The Care Manager can and should review if the child needs the intense level of care management provided by a Health Home regardless of the acuity used to determine HH PMPM rate (High, Medium, Low)
- The CANS-NY can assist with the development of the plan of care, however it does not determine when a child is discharged from a Health Home (e.g. a child with a CANS-NY medium acuity can be discharged)

Disenrollment from a Children's Health Home - Continued

Other Disenrollment criteria:

- Choice: Whether the child/guardian providing consent and family **is no longer interested in Health Home services**
- The child no longer meets the eligibility criteria for Health Home (i.e., does not meet the chronic condition eligibility criteria).
 - *A child that does meet the criteria but is stable/ no longer needs intensive level of Health Home services can be/should be discharged*
- The child is no longer eligible for Medicaid (Health Home may continue to work with the member that is in and out of Medicaid but may not bill while member is not enrolled – may retroactively bill for services provided in prior 90 days if later deemed eligible and enrolled)
- The child has moved out of New York State
- Individuals who are 18 year of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice to disenrollment



Next Steps – Under One Umbrella

- Incorporate Children Health Home Standards into the Health Home Standards Document
- Update Health Home Provider Manual to reflect enrollment of children in Health Homes
- Draft a Medicaid Update Article





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Health Home Consent Forms for Children Finalized

A Detailed Consent Webinar will be presented at a later date

April 7, 2015

Children's Health Home Consent Forms are FINAL

- There are *five* forms developed for children (under 18 years of age) and one FAQ
 1. **(Required)** *DOH 5200* Health Home Consent/Enrollment/For Use with Children Under 18 Years of Age
 2. **(Required)** *DOH 5201* Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age
 3. *DOH 5202* Health Home Consent/Withdrawal of Health Home Enrollment and Information Sharing Consent Form/ For Use with Children Under 18 Years
 4. *DOH 5203* Health Home Consent/Information Sharing/Release of Educational Records
 5. *DOH 5204* Health Home Consent/ Withdrawal of Release of Educational Records Health
 6. Health Home Consent: Frequently Asked Questions
 - ✓ Additional consent training will be provided this Summer
 - ✓ Current training is available on DOH Website
- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_forms.htm





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Billing Rules and CANS-NY

A Detailed Billing Webinar will be presented at a later date

April 7, 2016

General Billing Rules

- State will provide detailed Webinar on billing this Summer – following billing rules intended to address stakeholder questions
- The date of service on Health Home claims submitted to NYS Medicaid must be the first of the month for the services that were provided during that month. For example, if services are provided on October 13, 2016, the date of service on the Health Home claim will be October 1, 2016.
- Health Homes that are not designated to serve children who enroll children (anyone under 21) must bill at the adult rate which is determined using the High, Medium, Low clinical/functional indicators assessment (monthly adult billing questionnaire).
 - MAPP will not provide adult serving Health Homes access to the CANS-NY acuity billing approach
- Effective October 1, 2016, adults enrolled in a Health Home designated to serve children will be billed using a separate, High, Medium, Low clinical/functional indicators assessment (monthly adult billing questionnaire)



Health Home 5 Core Billable Services

Health Home Billable Services include (refer to appendix):

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives; and
5. Referral to community and social support services if relevant



General Billing for CANS-NY

- Upon enrollment, the Health Home will bill a “low” acuity rate until the CANS-NY is complete and the High, Medium, Low acuity is determined – more detail on this to be provided in Billing Webinar.
- Health Homes will be expected to meet best practice standards by completing the CANS-NY 30 days from the date of enrollment.
- Health Homes can bill a one-time assessment fee (\$185) per child per Health Home enrollment upon *completing* the full CANS-NY (there is no fee paid for re-assessment).



Outreach

- Outreach and HML PMPM rate cannot each be billed in the same month. The HML PMPM can begin to be billed in the month the child is enrolled
- A flat outreach fee (\$135) may be billed for three consecutive months, provided the Health Home is attempting to engage the child and family and outreach efforts are progressive to engage and enroll the child into Health Home.
- If the outreach is not successful during the three consecutive months (i.e., the child is not enrolled in Health Home, consent has not been provided to enroll), outreach may not be billed during the next three months (the hiatus period)
 - Health Homes may continue outreach and efforts to enroll during the hiatus period but they may not bill. If the child is enrolled in the 5th month, for example, the care manager may bill the Low rate until the completion of the CANS-NY and acuity is determined



Reasons for Early Reassessment

- CANS-NY must be completed every 6 months from the date of the last completion, unless the following occurs requiring the CANS-NY to be completed sooner than 6 months:
 1. Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
 2. Service plan or treatment goals were achieved
 3. Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
 4. Child has been seriously injured or in a serious accident
 5. Child's (primary or identified) caregiver is different than on the previous CANS
 6. Significant change in caregiver's capacity/situation
 7. Court request
- There is no fee paid for re-assessments (one-time fee)





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Training Opportunities

April 7, 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	To Be Scheduled In April
Billing Procedures Webinar	May/June
Consent Protocol and Process (Supplement to Current Recorded Training Now Available)	June
CANS-NY In-Person Trainings <ul style="list-style-type: none"> • CANS-NY Video Recorded Training Provided by Dr. John Lyons Will Also Be Made Available 	Albany - 6/22 & 6/23/16 NYC – 7/12 & 7/13/16 Rochester – 8/18 & 8/19/16 NYC - 8/29/16 & 8/30/16
Other trainings being planned: Early Intervention, Care At Home, and OASAS, OMH Services	
Foster Care Case Worker and Health Home Care Manager Roles	Summer 2016
School Districts Training to Health Homes	July 19, 2016
Child Welfare Training for Health Homes	Summer 2016
County Probation Offices and Health Homes	Summer 2016
Trauma Informed Care	TBD
Training for Pediatricians	TBD
MAPP HH Tracking System – Gatekeeper/User Access and Training	August, September
UAS-NY Access Organizational Readiness for CANS-NY	August, September
Health Home 101 to School Districts Health Professionals	September, October

Health Home Serving Children Trainings Available Now

- Recorded Webinars and Power Points Available at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm

Topics Include:

- ✓ Health Home Implementation Updates
 - ✓ OMH TCM Transition to Health Home
 - ✓ Information for Care at Home Providers and Health Homes
 - ✓ Connecting to the Health Commerce System
 - ✓ Data Exchange Agreements and Business Associate Agreements
 - ✓ Consent Policy and Procedures
 - ✓ Referral and Health Home Assignment Process for Children
 - ✓ Health Information Technology Requirements for Health Homes
- Foster Care: Defining Collaborative Roles of LDSS Case Managers, VFCA Case Planners and Health Home Care Managers
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_vfca_webinars.htm



MCTAC Readiness Trainings: Behavioral Health Transition to Managed Care

- Technical assistance training for Managed Care Transition, including new State Plan Service and HCBS Services presented by MCTAC and Executive and Senior Staff Leadership from OMH, OASAS, DOH and OCFS providers.
 - 3/21 Long Island (PM)
 - 3/22 New York City (AM & PM offerings)
 - 3/31 Poughkeepsie (PM)
 - 4/1 Albany (AM)
 - **4/12 Buffalo (AM)**
 - **4/13 Finger Lakes (AM)**
 - **4/14 Syracuse (AM)**

Still opportunity to sign up and attend:

<http://mctac.org/page/events/article/childrens-system-transformation-forums-march-21-april-19-statewide/>



Updates, Resources, Training Schedule and Questions for Health Homes Serving Children

- Send questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



Subscribe to the Health Home Listserv

- Stay up-to-date by signing up to receive Health Home e-mail updates

- Subscribe

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

- Health Home Bureau Mail Log (BML)

https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action



Questions?



APPENDIX



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Early Intervention EIP Service Coordinator Qualifications

For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR may apply. Those qualifications are as follows:

A minimum of one of the following educational or service coordination experience credentials:

- (i) two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
- (ii) one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
- (iii) one year of service coordination experience and an Associates degree in a health or human service field; or
- (iv) a Bachelors degree in a health or human service field.

Demonstrated knowledge and understanding in the following areas:

- (i) infants and toddlers who may be eligible for early intervention services;
- (ii) State and federal laws and regulations pertaining to the Early Intervention Program;
- (iii) principles of family centered services;
- (iv) the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
- (v) other pertinent information.



Standards: Six Health Home Core Services

1. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.

1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. **1c.** The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.

1g. The individual's plan of care must include outreach and engagement activities that will support engaging patients in care and promoting continuity of care.

1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need



Standards: Six Health Home Core Services - Continued

2. Care Coordination and Health Promotion

- 2a.** The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
- 2b.** The Health Home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The Health Home care manager is clearly identified in the patient record. Each individual enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.
- 2c.** The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
- 2d.** The health home provider must define how patient care will be directed when conflicting treatment is being provided.
- 2e.** The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
- 2f.** The Health Home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
- 2g.** The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI. **2h.** The Health Home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
- 2i.** The Health Home provider will ensure the availability of priority appointments for Health Home enrollees to medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
- 2j.** The Health Home provider promotes evidence based wellness and prevention by linking Health Home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- 2k.** The Health Home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.



Standards: Six Health Home Core Services - Continued

3. Comprehensive Transitional Care

3a. The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The Health Home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.

3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.

3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.



Standards: Six Health Home Core Services - Continued

4. Patient and Family Support

- 4a.** Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.
- 4b.** Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.
- 4c.** The Health Home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.
- 4d.** The Health Home provider discusses advance directives with enrollees and their families or caregivers.
- 4e.** The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
- 4f.** The Health Home provider gives the patient access to care plans and options for accessing clinical information.



Standards: Six Health Home Core Services - Continued

5. Referral to Community and Social Support Services

5a. The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.



Standards: Six Health Home Core Services - Continued

6. Use of Health Information Technology (HIT) to Link Services

Initial Standards

6a. Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

6c. Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

Final Standards

6e. Health Home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

6f. Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

6g. Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance, which includes common information policies, standards and technical approaches governing health information exchange.

6h. Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. Health Home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance

