Health Homes Serving Children
and
Health Home Integration with Early Intervention

NYSAC Conference   September 19, 2016

Health Homes Serving Children

Agenda

Purpose of Today's Presentation:

PART I – What is a Health Home
- ✓ Medicaid Redesign
- ✓ NYS Health Home Model
- ✓ Health Home timeline and readiness activities
- ✓ Eligibility Criteria
- ✓ CANS NY and PMPM

Stakeholder Engagement
PART II – Health Home and Early Intervention Integration
- ✓ Roles
- ✓ Service Alignment
- ✓ Case Scenarios
- ✓ Becoming a HH CMA
- ✓ Next Steps

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Medicaid Redesign Team (MRT)'s Vision, Goals and Principles for Transforming the Delivery of Health Care for Children

- The Design and Implementation of Health Homes for Children is a component of the Medicaid Redesign Team's (MRT) Plan to Transform the Delivery of Health Care for children
    - MRT is a collaborative partnership among State Agencies, stakeholders, providers and advocates

- Vision and Goals for the Children's Medicaid Redesign
    - ✓ Keep children on their developmental trajectory
    - ✓ Focus on recovery and building resilience
    - ✓ Identify needs early and intervene
    - ✓ Maintain child at home with support and services
    - ✓ Maintain the child in the community in least restrictive settings
    - ✓ Prevent escalation and longer term need for higher end services
    - ✓ Maintain accountability for outcomes and quality

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Health Home: Benefits that Provides Comprehensive Care Management

✓ Health Home is an optional State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have chronic conditions – *there is choice*

✓ Health Home is a Care Management model that provides:

  ✓ Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services, and

  ✓ Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions

✓ In New York State, the Health Home model has been a central feature of the Medicaid Redesign Team (MRT) initiatives for adults and children, and overall efforts to integrate behavioral and physical health and social supports, transition the behavioral health benefit to managed care for children and adults, provide "Care Management for All," and reduce avoidable hospitalizations under the Delivery System Reform Incentive Payment (DSRIP) Program

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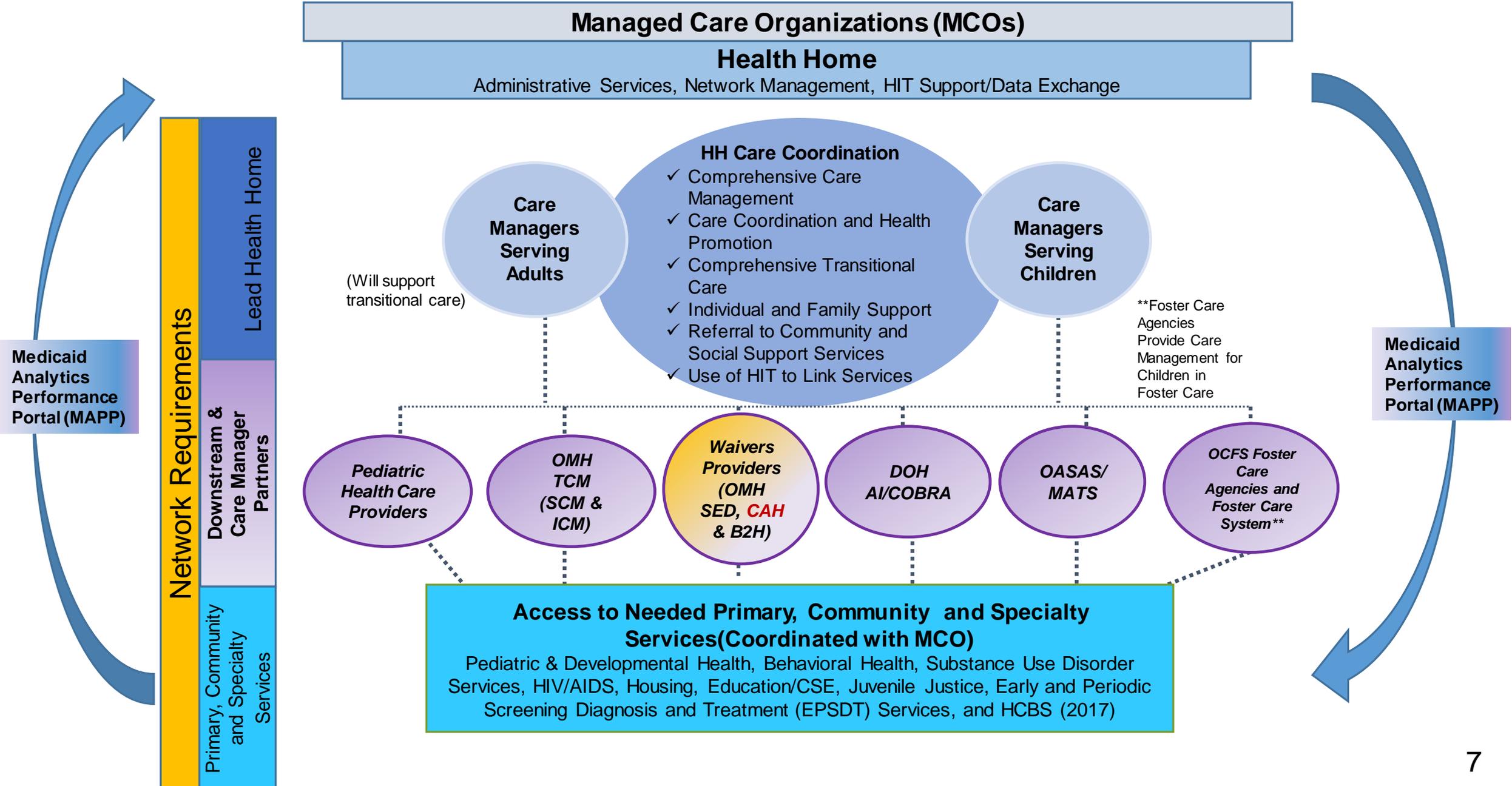
New York State Health Home Model

✓ Health Homes are led by one provider (single point of accountability) which is required to create a comprehensive network of providers to help members connect with:

  ✓ One or more hospital systems

  ✓ Multiple ambulatory care sites (physical and behavioral health, specialty providers for children and adults)

  ✓ Community and social supports, e.g., housing and vocational services

    ✓ Health Homes provide an opportunity to establish critical linkages and help break down silos of care by linking systems and programs (education, child welfare, early intervention) to comprehensive care planning

  ✓ Managed care plans

  ✓ The Health Home model has been designed to incorporate the expertise of existing care managers, including Early Intervention, Office of Mental Health Targeted Care Management (OMH TCM) providers that have and will operate under the Health Home program to provide care management and develop plan of care

✓ Health Homes were implemented across the State in January 2012 for adults and Health Home enrollment for children will begin in December 2016

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New York State Health Home Model for Children

Managed Care Organizations (MCOs)

Health Home
Administrative Services, Network Management, HIT Support/Data Exchange

Medicaid Analytics Performance Portal (MAPP)

Network Requirements

Lead Health Home

Downstream & Care Manager Partners

Primary, Community and Specialty Services

HH Care Coordination
- ✓ Comprehensive Care Management
- ✓ Care Coordination and Health Promotion
- ✓ Comprehensive Transitional Care
- ✓ Individual and Family Support
- ✓ Referral to Community and Social Support Services
- ✓ Use of HIT to Link Services

Care Managers Serving Adults

(Will support transitional care)

Care Managers Serving Children

**Foster Care Agencies Provide Care Management for Children in Foster Care

Medicaid Analytics Performance Portal (MAPP)

Pediatric Health Care Providers

OMH TCM (SCM & ICM)

Waivers Providers (OMH SED, CAH & B2H)

DOH AI/COBRA

OASAS/ MATS

OCFS Foster Care Agencies and Foster Care System*

Access to Needed Primary, Community and Specialty Services (Coordinated with MCO)
Pediatric & Developmental Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Education/CSE, Juvenile Justice, Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services, and HCBS (2017)

Enrolling Early Intervention Children in Health Home March 2017

- Health Homes Designated to Serve Children **will begin to enroll children December 2016**

- 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 has been approved by CMS
    - The State Health Home and Early Intervention staff have been meeting regularly to identify the methods to integrate HH services with Early Intervention Ongoing Service Coordination and to provide trainings
    - 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 expects that this work, including obtaining stakeholder feedback, will not be complete by the December Enrollment date and the enrollment of Children in Early Intervention that may also be eligible for Health Home* is scheduled in March 2017
    - Children who are receiving Early Intervention Service and Child Welfare Services as of December 2016 will not be eligible for Health Home Services at this time
    - New children who are involved with other TCM services or Child Welfare and would be eligible for Early Intervention, should be referred to Early Intervention Services as they will receive the expertise of Early Intervention service providers inclusive of Service Coordination (i.e. Care Management)

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Health Home Six Core Services

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 members 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.

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.

Health Home Six Core Service (Continued)

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

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

Health Homes Serving Children Standards
Six Core Services

Health Homes Provide Six Core Care Management Functions

- COMPREHENSIVE CARE MANAGEMENT
- CARE COORDINATION AND HEALTH PROMOTION
- COMPREHENSIVE TRANSITIONAL CARE
- HH Care Manager & HH Client
- REFERRAL TO COMMUNITY AND SOCIAL SUPPORTS SERVICES
- PATIENT AND FAMILY SUPPORT
- HEALTH INFORMATION TECHNOLOGY

Health Home care management is "whole-person" and "person-centered" and integrates a care philosophy that includes both physical/behavioral health care with family and social supports

Detailed description of activities that comprise the six core services available in Standards Document and Examples are Provided in Appendix of this Webinar

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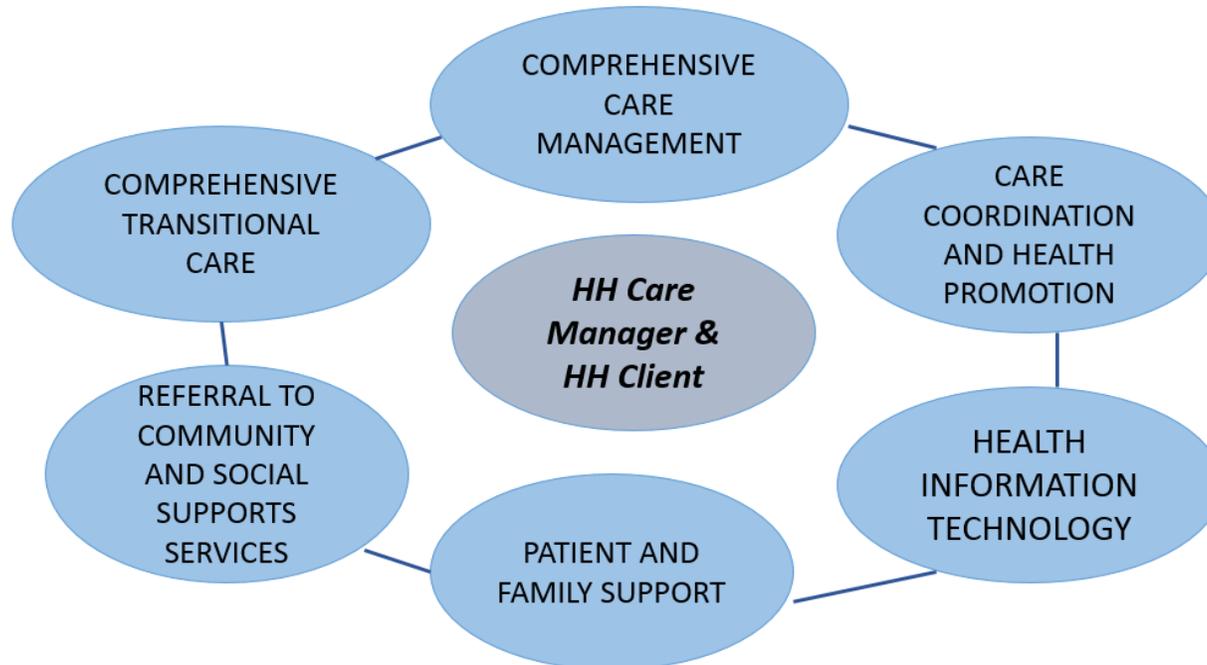
Health Homes Serving Children

- There are 32 Health Homes currently operating in New York that now serve adults
- 16 Health Homes have been contingently designated to serve children (HHSC), 13 of those currently also serve adults
  - The HHSC were contingently designated to provide them time, and the State time, to implement readiness activities – including network adequacy - care management relationships and children's providers, contracts (Administrative Services Agreements (ASAs)) with Managed care plans to provide Health Home services, billing readiness, HIT readiness
  - Health Home is a State Plan and Managed Care plan benefit – also Fee for Service (FFS)
- Who are they – Health Home Serving Children Contact
  Website http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
  - A list of HHSC, the counties they will be designated to serve children, and if applicable what counties they are designated to serve adults
  - A list of counties and the HHSC those children

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Readiness Activities Needed to be a Care Management Agency (CMA) BAAs and Sharing Protected Health Information

- Health Homes are required, by State and Federal Laws, to have Data Exchange Application Agreements with NYSDOH in order to share minimum necessary data *prior to obtaining signed informed consent*
- To facilitate outreach efforts (i.e., locating adult Medicaid members that have been identified as potentially Health Home eligible and placed on an assignment list – re: process in adult HH) the MAPP provides "minimum PHI for Medicaid members (i.e., CIN#, name, address, PHI from the last five claims and encounters)
- Although children will be enrolled in Health Homes through a referral process the minimum PHI information described above for Medicaid members that are children will be available in MAPP and may be used by Health Homes, care managers, and Plans to assist in the referral process and care planning

- To allow the limited PHI information for both children and adults to be shared prior to consent the following agreements must in place:
  - ✓ Data Exchange Application Agreements (DEAAs) between the New York State Department of Health and the lead Health Homes
  - ✓ **Business Associate Agreements (BAAs) between Health Homes and care management agencies (e.g. CAH providers)**
  - Existing Health Homes will need to enter into BAAs with any new care management agencies they contract with
  - Example BAA: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_deaa_5_25_2015.docx
  - Additional Details: See May 27, 2015 Webinar on DEAAs and BAAs http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/5_27_2015_children_webinar.pdf

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Readiness Activities Needed to be a CMA

To formalize as a Care Management Agency (CMA) and a Health Home relationship the following is needed:

- If you do not already have one, your organization will need to have a valid Medicaid Management Information Systems (MMIS ID) and National Provider Identifier (NPI #)

- Identify the Health Home(s) your organization wants to work with
- Your organization will have to identify a Single Point of Contact (SPOC) to receive correspondence from DOH regarding information and steps to proceed – you will provide your Health Home with a SPOC for your agency – the Health Home will relay that information to DOH
- Obtain an organization Health Commerce System (HCS) account by identifying a HCS Director and Coordinator (if not already established) to manage the staff that will need access to the HCS
  - HCS access is required to access the Medicaid Analytics Performance Portal (MAPP) and the CANS-NY which will reside in the Uniform Assessment System (UAS-NY)
  - Then a MAPP Gatekeeper will need to be identified to help track the roles and responsibilities of staff within MAPP
- Care Managers will need to be trained and certified in the CANS-NY assessment tool

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Health Home Eligibility Criteria and Appropriateness
and
MAPP Referral Portal
(Medicaid Analytics Performance Portal)

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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

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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.

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Complex Trauma – Single Qualifying Condition for Health Home

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.

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Complex Trauma – Eligibility Tools and Process Finalized

- Eligibility tools and process for determining and operationalizing Complex Trauma in Health Home was developed by a Work Group of trauma informed care experts and stakeholder input

- SAMSHA/CMS have reviewed the tools and process and provided some suggestions to assist with improving the Tools
  - The Stakeholder work group discussed the suggestions and made some modest edits to some of the language included in the tools
  - Department is working with Work Group to finalize changes and post to the Website

- DOH is working to try to develop training for Complex Trauma and Health Homes including:
  - Process and tools for assessing Complex Trauma
  - How to work with children who have Complex Trauma within the Health Home Care Management
  - Development of the Plan of Care

Process to Determine Health Home Complex Trauma Eligibility

Need Identified by Non-Licensed Professional or Licensed Professional w/o access to tools

- Complete the Complex Trauma Exposure Screen

- Referral Cover Sheet

- Other family and child history and information obtained

  ➢ If positive for Complex Trauma (on Exposure Screen) – Referral can be made for HH

Eligibility determined by Licensed Professional with access to tools

- Complex Trauma Exposure Assessment Form

- Functional Impairment Assessment through the completion of the appropriate identified NCTSN guideline list of domain assessment tools

- Complex Trauma Eligibility Determination Form

- Other family and child history and information obtained

  ➢ If positive *Determination* of Complex Trauma – Referral can be made for HH and Child is Eligible for Health Home under Complex Trauma single qualifying condition

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Prioritizing the Enrollment of Children in Health Homes December 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 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, 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)

Access to MAPP: Health Homes, CMAs, MCP, LDSS' and LGU/SPOAs

- The following entities will have access to the MAPP Children's HH Referral Portal on Day 1:
    - ✓ Managed Care Plans
    - ✓ Health Homes
    - ✓ Care Management Agencies (e.g., Early Intervention Providers who become Health Home Care Managers)
    - ✓ LGU/SPOA
    - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)

Future Phases: Over time, the State will expand access to the MAPP Children's HH Referral portal by identifying and authorizing other entities that are natural points of contact in the systems of care that impact children to make referrals through the MAPP Referral portal (School Districts, county probation departments, pediatricians, emergency rooms, Early Intervention initial care coordinators, etc.)

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Medicaid Analytics Performance Portal (MAPP) Functionality for Children's Home

- MAPP is being modified for Health Homes Serving Children to include:

- MAPP Children's Health Home Referral Portal for Children (under 21)

  - ✓ MAPP Referral Portal must be used to refer (create an assignment with a referral record type) and enroll children in Health Homes

  - ✓ Community Referral (by LGU/SPOA and LDSS, and eventually others) for Assignment

  - ✓ Assignment and Enrollment by Health Homes, Plans and Care Managers

- Consent Management (Consent to refer, enroll, share information/ protected services)

- Billing Information

  - ✓ CANS-NY tool will be housed in UAS-NY and will interface with Medicaid Analytics Performance Portal (MAPP)

  - ✓ Algorithm to determine High, Medium, Low will be run against completed CANS-NY and information will be transmitted to MAPP

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Child and Adolescent Needs and Strengths Assessment-NY (CANS-NY) and Health Home Serving Children Per Member Per Month Rates

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CANS-NY and Health Home
(CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

- CANS-NY tool will be housed in UAS and will interface with Medicaid Analytics Performance Portal (MAPP) to provide billing information

- The CANS-NY assessment (as modified for New York) will be conducted by the Health Home care manager and will be used:
  - ✓ To assist in the development of the person centered care plan
  - ✓ Determine a care management acuity, using an algorithm run against the results of a completed CANS-NY, for purpose of determining Health Home per member per month rate tier (i.e., High, Medium, Low)
  - ✓ CANS-NY by itself will not determine Health Home eligibility
  - ✓ Note: the CANS-NY will also be employed to determine HCBS eligibility with transition to managed care beginning in July 2017

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CANS-NY and Health Home
(CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

The CANS-NY assessment tool is:

- A multi-purpose tool to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
- Developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.
    - Provides the care coordinator, the family, and service providers with a common language to use in the development, review, and update of the child's care plan.
- Designed to give a profile of the current functioning, needs, and strengths of the child and the child's parent(s) and/or parent substitute.

- *The CANS-NY tool was modified to include domains that better assess medically complex children*

- *Care managers may use assessment tools other than the CANS-NY to assist them in developing care plans for the child*

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What are the Health Home Per Member Per Month Rates for Health Homes Serving Children? What are case load requirements?

Per Member Per Month HH Care Management Rates for Children under 21 (non-Legacy Providers)		
Acuity for Determining PMPM (CANS-NY Algorithm*)	Upstate	Downstate
High	$750	$799
Medium	450	479
Low	225	240
Outreach	135	135
Assessment**	185	185

*"Rate Build" assumes case load assumptions of High: 1:12, Medium 1:20 and Low 1:40 *(Case load assumptions were developed only for the rate build and are NOT mandated case loads)*

- Goal of keeping case load ratios as low as practicable and to provide Health Homes and care managers flexibility in assigning children with various levels of needs/acuities
  - ✓Care managers serving "high" acuity children keep case load sizes predominantly to children of High acuity level
  - ✓Two Health Home services provided each month, one of which must be face-to-face contact for children of Medium or High acuity

** One time assessment fee – CANS-NY is required to be updated every six months, unless significant event in child's life occurs

Legacy care management payments will be developed for Children's Waiver Programs (e.g., CAH I&II as well as B2H, OMH Waiver) when they transition to Health Home – will be in effect for two-year period (OMH TCM providers also have Legacy approach to their rates)

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Quarterly Review Documenting Continued Need for Health Home Services

- No less than quarterly, care managers must actively review and document in the plan of care, the child's continued need for Health Home Care Management services

- Quarterly 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)

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

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.

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 consenter'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)

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Children's Health Home Training Webinars and Presentations can be found at :
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm

Webinars include:

August 24, 2016 Health Homes Serving Children Readiness Update

August 17, 2016 Consent Protocol

July 13 & 17 2016 REVISED MAPP Children's Referral Portal

June 29, 2016 Health Homes Serving Children Billing Guidance Final

April 7, 2016 Health Homes Serving Children Update: Readiness for Enrolling Children

December 16, 2015 Health Homes Serving Children Update: Readiness for Enrolling Children

April 29, 2015 Tailoring Health Home Model to Serve Children: Design and Implementation Updates

March 4, 2015 Health Home Implementation Webinar, Session #51 - Health Information Technology: Requirements for Health Homes

February 27, 2015 Commissioner's Advisory Panel - Tailoring Health Homes to Serve Children

July 9, 2015 Connecting to the Health Commerce System (HCS)

August 13, 2015 Overview for Care at Home I & II Providers

May 27, 2015 Data Exchange and Health Homes Serving Children: Data Exchange Application & Agreements for Health Homes Serving Children

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Questions and Discussion

Health Homes Serving Children Integration with Early Intervention

Stakeholder Engagement Session

Agenda

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- ✓ CANS NY and PMPM

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- ✓ Service Alignment
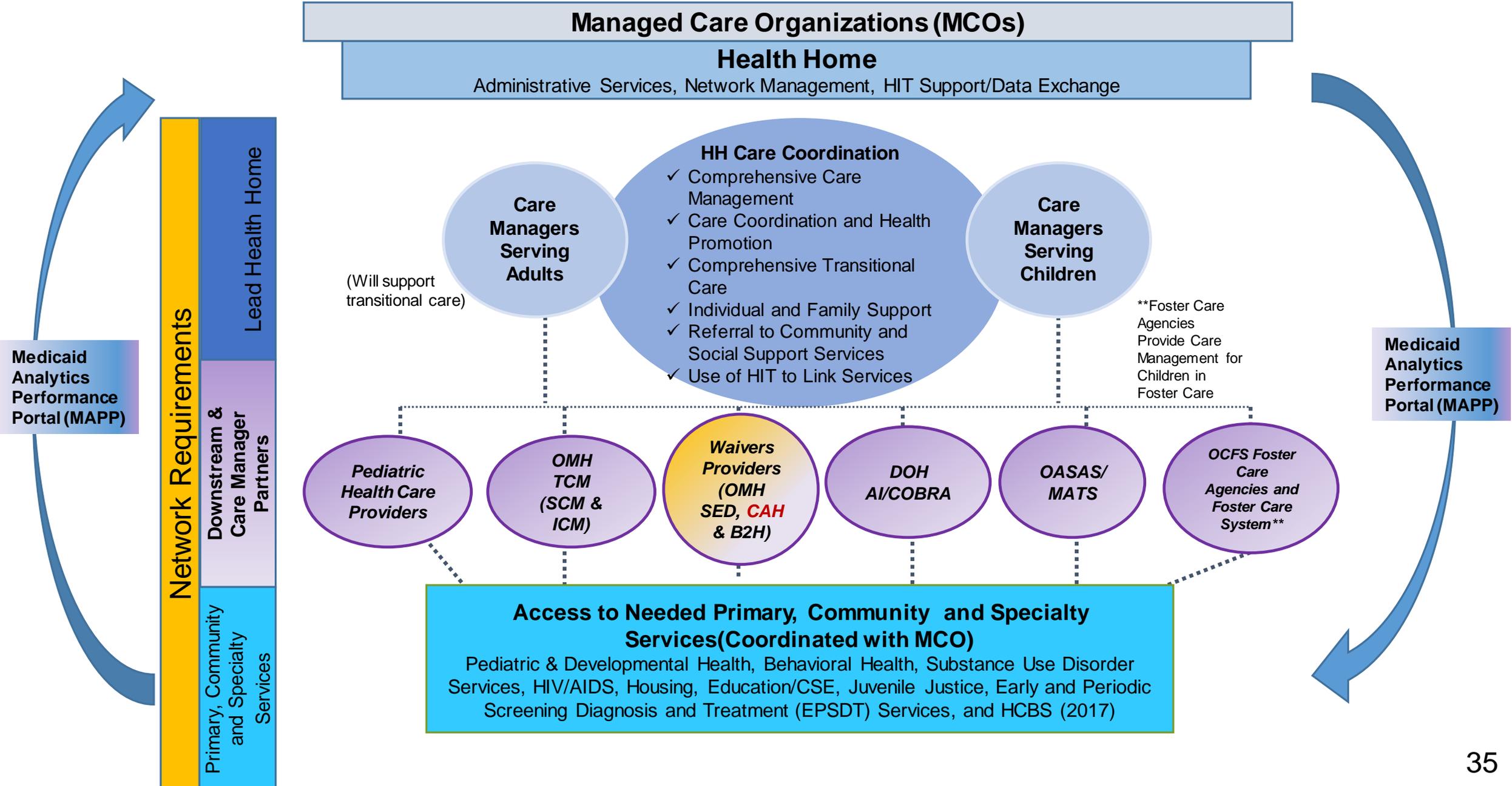- ✓ Case Scenarios
- ✓ Becoming a HH CMA
- ✓ Next Steps

New York State Health Home Model

✓ Health Homes are led by one provider (single point of accountability) which is required to create a comprehensive network of HH care management agency (CMA) providers to help members connect with:

✓ One or more hospital systems

✓ Multiple ambulatory care sites (physical and behavioral health, specialty providers for children and adults)

✓ Community and social supports, e.g., housing and vocational services

    ✓ Health Homes provide an opportunity to establish critical linkages and help break down silos of care by linking systems and programs (education, child welfare, early intervention) to comprehensive care planning

✓ Managed care plans

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✓ Health Homes were implemented across the State in January 2012 for adults and Health Home enrollment for children will begin in December 2

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New York State Health Home Model for Children

Managed Care Organizations (MCOs)

Health Home
Administrative Services, Network Management, HIT Support/Data Exchange

HH Care Coordination
✓ Comprehensive Care Management
✓ Care Coordination and Health Promotion
✓ Comprehensive Transitional Care
✓ Individual and Family Support
✓ Referral to Community and Social Support Services
✓ Use of HIT to Link Services

Care Managers Serving Adults

(Will support transitional care)

Care Managers Serving Children

**Foster Care Agencies Provide Care Management for Children in Foster Care

Pediatric Health Care Providers

OMH TCM (SCM & ICM)

Waivers Providers (OMH SED, CAH & B2H)

DOH AI/COBRA

OASAS/ MATS

*OCFS Foster Care Agencies and Foster Care System***

Access to Needed Primary, Community and Specialty Services (Coordinated with MCO)
Pediatric & Developmental Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Education/CSE, Juvenile Justice, Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services, and HCBS (2017)

Medicaid Analytics Performance Portal (MAPP)

Medicaid Analytics Performance Portal (MAPP)

Network Requirements

Lead Health Home

Downstream & Care Manager Partners

Primary, Community and Specialty Services

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Enrolling Early Intervention Children in Health Home March 2017

- Health Homes Designated to Serve Children will **begin to enroll children December 2016**

- 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 has been approved by CMS

  - The State Health Home and Early Intervention staff have been meeting regularly to identify the methods to integrate HH services with Early Intervention Ongoing Service Coordination and to provide trainings

  - 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 expects that this work, including obtaining stakeholder feedback, will not be complete by the December Enrollment date and the enrollment of Children in Early Intervention that may also be eligible for Health Home*** ***is scheduled in March 2017***

  - Children who are receiving Early Intervention Service and Child Welfare Services as of December 2016 will not be eligible for Health Home Services at this time

  - New children who are involved with other TCM services or Child Welfare and would be eligible for Early Intervention, should be referred to Early Intervention Services as they will receive the expertise of Early Intervention service providers inclusive of Service Coordination (i.e. Care Management)

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Goal of Health Home and Early Intervention Linkages

- ***Services Integration and comprehensive care planning for the child and family***

- To ensure Health Homes leverages and imbeds the expertise of Early Intervention providers in providing care management for infants and toddlers with disabilities, the State, required as part of its application to become a Health Home serving children, in Health Homes contingent designation letter, and the State's overall review of Health Homes readiness and network adequacy requirements,

  - ✓ Requiring each Health Home Serving Children to have linkage to current Early Intervention service coordination providers that want to become Health Home care management agency

- The State has been working to draft a design that utilizes the expertise of Early Intervention service coordination providers as well as other early childhood providers and existing care management agencies to ensure that there will be an adequate network of providers with capacity to serve the Medicaid Early Intervention eligible children.

  - ✓ The following slides outline the options to implement the integration of Children's Health Home with Early Intervention

    - ✓ Stakeholder feedback is essential to designing a integrated system to serve these children

    - ✓ Identification of participating EI service coordination providers and working with them on next steps to develop the design will be critical for launch **in March 2017**
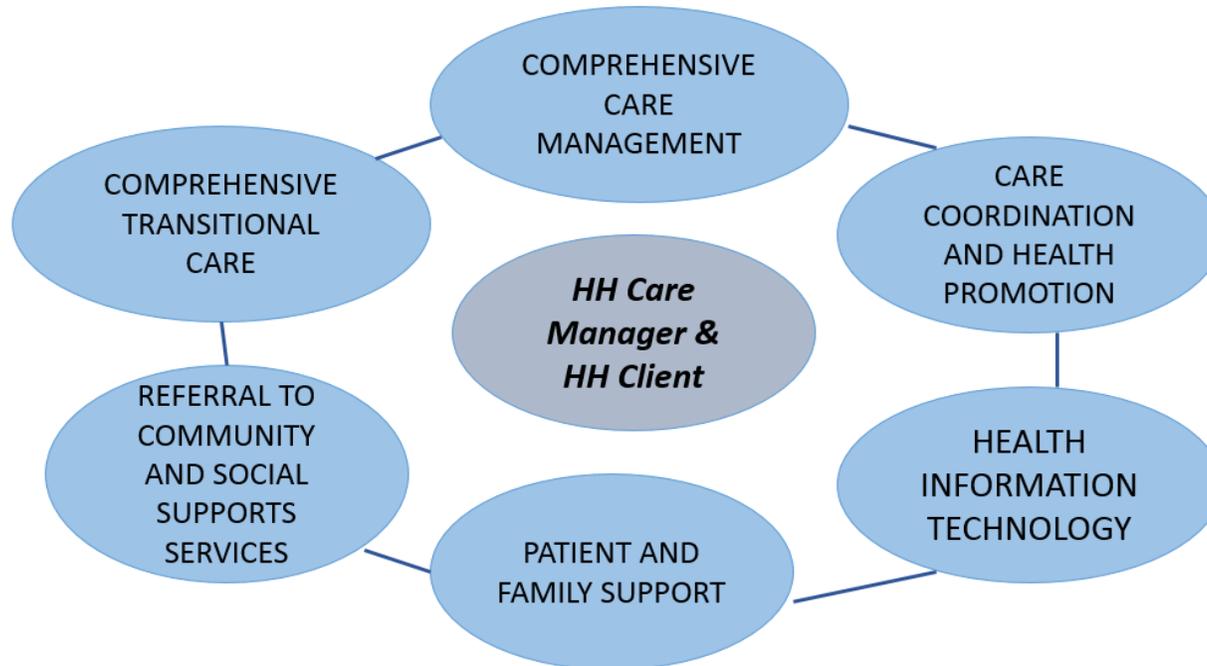
How do we integrate EI/HH services?

- Is there any alignment among Early Intervention service coordination roles, responsibilities and goals with that of the Health Home Care Management Agency?

Health Homes Serving Children Standards Six Core Services

Health Homes Provide Six Core Care Management Functions

COMPREHENSIVE CARE MANAGEMENT

COMPREHENSIVE TRANSITIONAL CARE

CARE COORDINATION AND HEALTH PROMOTION

HH Care Manager & HH Client

REFERRAL TO COMMUNITY AND SOCIAL SUPPORTS SERVICES

HEALTH INFORMATION TECHNOLOGY

PATIENT AND FAMILY SUPPORT

Health Home care management is "whole-person" and "person-centered" and integrates a care philosophy that includes both physical/behavioral health care with family and social supports

Detailed description of activities that comprise the six core services available in Standards Document and Examples are Provided in Appendix of this Webinar

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Early Intervention Service Coordination

- Coordinate Early Intervention services

- Development and monitoring of the Individualize Family Service Plan (IFSP)

- Participate in IFSP meetings to develop the child's and family's service needs

- Arrange for EI service providers

- Maintain documentation of all service coordination activities in the child's record, including circumstances that impact timeliness

- Coordinate, facilitate, and monitor the delivery of services to ensure they are being delivered in a timely manner in accordance with the IFSP

- Develop the transition plan to preschool or other appropriate supports and services and complete the required transition steps and services

Alignment in Core Services

- Is there any alignment among Early Intervention roles, responsibilities and service coordination goals with that of the Health Home Care Manager?

  - The following parallels exist between EI and HH
  - ✓ **Coordinate and arrange provision of integrated services**
  - ✓ **Develop and implement a care plan/IFSP**
  - ✓ **Support adherence to treatment recommendations**
  - ✓ **Monitor and evaluate clinical and functional outcomes**
  - ✓ **Identify and facilitate use of community resources**
  - ✓ **Develop a comprehensive transition plan**

Health Home Serving Children Care Manager Qualifications

- ***What are the qualifications of Health Home Care Mangers?***
- 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.**
- 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)

NOTE: Health Homes are required to ensure that care managers have the expertise required to serve particular child's needs (e.g., medically complex, serious emotional disturbance, complex trauma etc.)

Various *DRAFT* Options for Providers

✓ Early Intervention Providers who provide Service Coordination (Initial and or Ongoing) can also become Health Home Care Management Agency
  • Service Coordination providers would need to meet HH Care Management Agency (CMA) standards and requirements
  • Service Coordination who become HH CMAs need to affiliate with a lead Health Home and be in their network

✓ Health Home Care Management agency can also become an Early Intervention service coordination provider
  • HH CMA would need to be approved by DOH as a Early Intervention provider for service coordination and meet all EI standards and requirements

✓ Early Intervention service coordination provider could contract with a Health Home or HH Care Management Agency
  • Would need to establish clear roles, responsibilities and integration of service delivery to limit confusion to the family
  • Would need to establish a payment arrangement, as both entities can not bill for service coordination (Medicaid Target Case Management)

DRAFT PROCESS SCENARIOS
for Stakeholder Feedback

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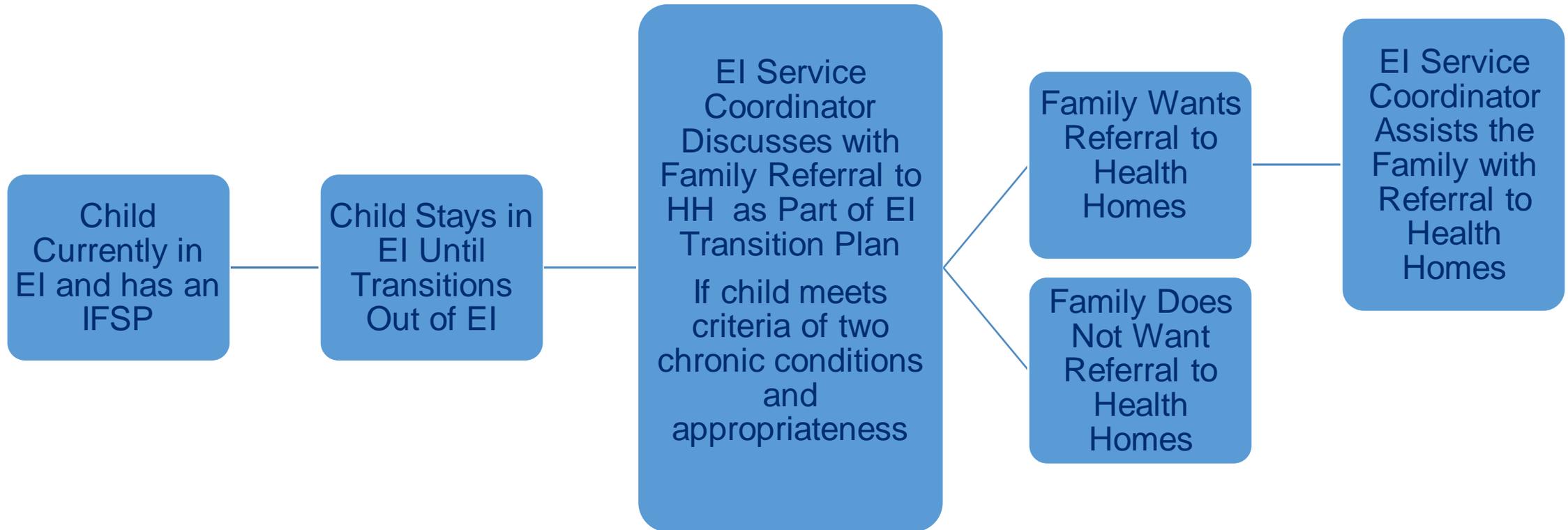## Early Intervention Children December 2016 through March 2017

- Child in EI with an Individualized Family Service Plan (IFSP)
  - Stay in EI until transition out of EI
  - Child has an Ongoing Service Coordinator (OSC)
  - For EI children who will be transitioning out of EI during this time period, the OSC should assess if they believe the child might be eligible for Health Home Services
  - OSC will discuss with family possible referral to HH as part of the child's EI transition plan

REFERRAL TO HEALTH HOMES AS PART OF EARLY INTERVENTION TRANSITION PLAN

Child Currently in EI and has an IFSP

Child Stays in EI Until Transitions Out of EI

EI Service Coordinator Discusses with Family Referral to HH as Part of EI Transition Plan

If child meets criteria of two chronic conditions and appropriateness

Family Wants Referral to Health Homes

Family Does Not Want Referral to Health Homes

EI Service Coordinator Assists the Family with Referral to Health Homes

DRAFT Early Intervention referral to Health Home during ISC

Scenario A (ISC): Initial Service Coordinator (ISC) refers child for Health Home services

✓ ISC and Evaluation team will assess whether they believe the child meets HH eligibility criteria and appropriateness

    o If the team believes the child is eligible for HH, the EI ISC will:

- Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll

- Refer the child through the HH Referral Portal and identify the family's chose of an EI OSC-Health Home Care Manager through the Medicaid Analytics Performance Portal (MAPP) (alignment with the child's managed care plan must occur)

  - If the EI ISC provider also provides EI OSC-HH CM, this agency will be able to maintain the referral as long as it is the family's choose

- The referral will ideally occur during the initial IFSP development within a 45 day timeline

- Parental consent for Health Home services must be obtained by EI OSC-Health Home Care Manager prior to child's enrollment into Health Home

- ISC may bill for ISC services and IFSP activities prior to HH enrollment

- The enrollment into HH will occur at the same time as EI ongoing service coordination would begin
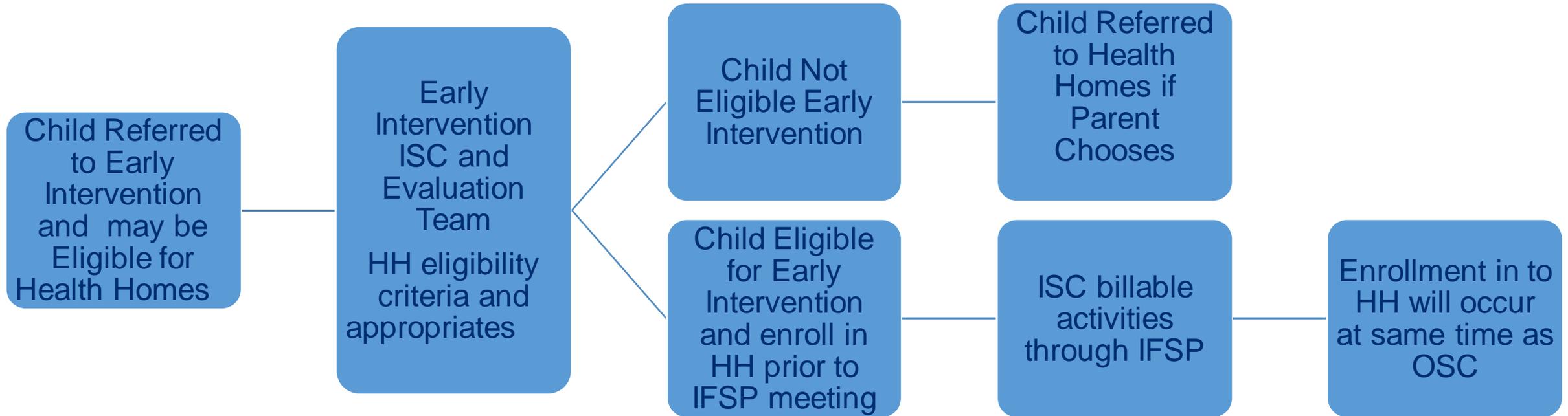
DRAFT Early Intervention referral to Health Home during OSC

Scenario B (OSC): EI Ongoing Service Coordinator (OSC) refers child for Health Home services

✓ During the implementation of Health Homes and or through periodic reviews and assessments of the child, the IFSP team may believe the child meets HH eligibility criteria and appropriateness

- **Option #1**: If the EI OSC provider also provides HH Care Management services, the EI OSC will:

  - Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll

  - Refer the child through the HH Referral Portal and open the HH case with an enrollment segment through the Medicaid Analytics Performance Portal (MAPP) (alignment with the child's managed care plan must occur)

  - Child continues to have the same EI OSC to preserve continuity of care and limit multiple points of contact

  - Once child is enrolled in Health Home, the EI OSC will end billing for EI services coordination and begin billing for Health Home Care Management services based on acuity

  - This scenario includes those children who initially do not want to be referred to HH but later choose to join

DRAFT Early Intervention referral to Health Home during OSC

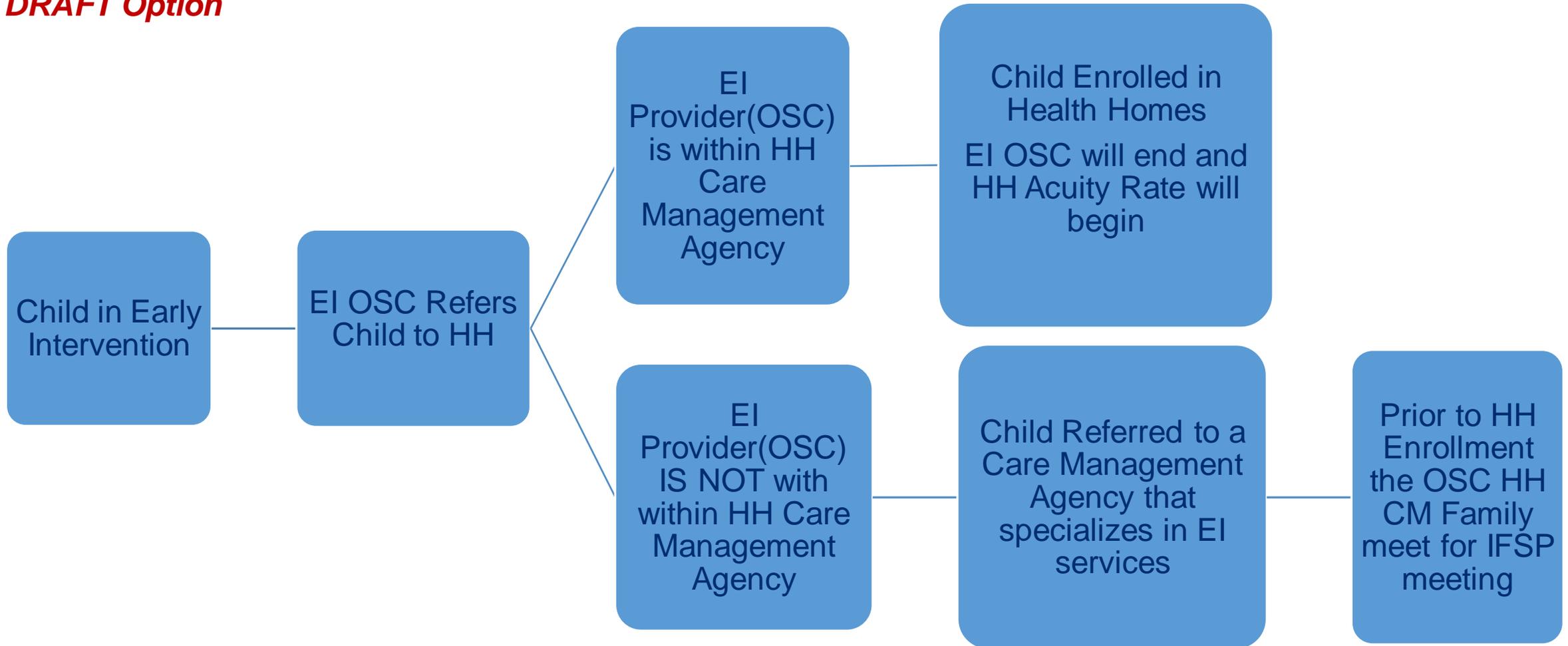**Scenario B (OSC):** EI Ongoing Service Coordinator (OSC) refers child for Health Home services

✓ During the implementation of Health Homes and or through periodic reviews and assessments of the child, the IFSP team may believe the child meets HH eligibility criteria and appropriateness

- **Option #2**: If a EI OSC provider *does not* also provide HH Care Management services, EI OSC will:

  - Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll

  - Refer the child through the HH Referral Portal and identify the family's chose of an EI OSC-Health Home Care Manager through the Medicaid Analytics Performance Portal (MAPP) (alignment with the child's managed care plan must occur)

  - Prior to HH enrollment the OSC, HH CM, child's family, and IFSP team must meet to discuss child's IFSP

  - The EI OSC will bill for this meeting and date will be determined in which the enrollment into HH will begin so the EI OSC-HH CM can start to bill
    - Low acuity until CANS NY is completed
    - CANS NY Acuity level as enrollment and complete CANS NY can be simultaneous

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CHILD In EARLY INTERVENTION - MAY BE ELIGIBLE FOR HEALTH HOMES
March 2017
DRAFT Option

Child in Early Intervention — **EI OSC Refers Child to HH**

EI Provider(OSC) is within HH Care Management Agency — **Child Enrolled in Health Homes / EI OSC will end and HH Acuity Rate will begin**

EI Provider(OSC) IS NOT with within HH Care Management Agency — **Child Referred to a Care Management Agency that specializes in EI services** — **Prior to HH Enrollment the OSC HH CM Family meet for IFSP meeting**

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DRAFT Transition Planning

Child transitions out of Early Intervention - it is determine the child no longer needs EI services, or, the child ages out of EI services

If not already in a HH CM
✓ The child is determine to meet HH eligibility criteria and appropriateness

- o **Option #1**: If a EI OSC provider is also a HH Care Management Agency, follow option #1 of Scenario B of referral during OSC on previous slide

- o **Option #2**: If a EI OSC provider ***does not*** provide Health Home services or cannot transition with the child, EI OSC will:

  - ▪ Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll

  - ▪ Information will be provided to EI OCS regarding which providers are EI OSC - HH CMA and interested in serving children transitioning out of EI

    - ▪ Relationship will be made between providers for a smooth transition (warm hand off)

  - ▪ Referral will be made through the MAPP Referral Portal

  - ▪ EI OSC (that is not also a HH CMA) must meet with HH CM to debrief on child's care management history (Part of transition Plan)

If already in a HH
- ▪ Continue child's HH care management without EI OSC service provision

- ▪ HH CM will conduct a new CANS NY to re-assess care management care plan

- ▪ Ideally the child and family will continue with current EI OSC-HH Care Manager that had been providing services

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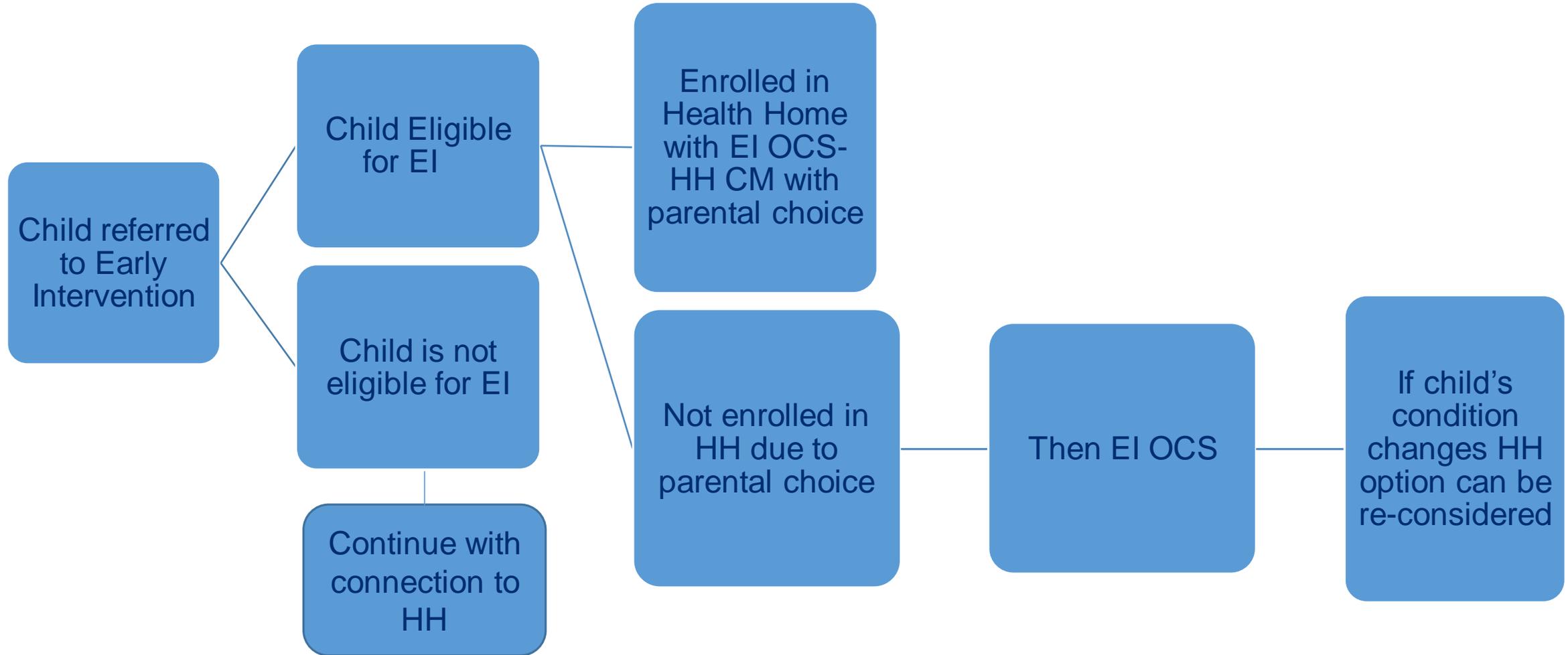
Enrolled HH Children Eligible for EI Discussion and Consideration for Feedback

✓ If children are already enrolled in a Health Home and possibly eligible for Early Intervention, leads to complications in:

- Billing
- Continuity of Care and a number of touch points with the family
- Transitional concerns

✓ Considerations:

  ✓ Prior to enrollment in HH, assess whether the child might be potentially eligible for EI services, make referral to EI

  ✓ If children ages 0-3 years old are refer to a HH, HH CMA should assess if potentially eligible for EI services and make that referral during HH outreach

  ➢ This would lead to:

- Early Intervention expertise being utilized
- Initial Service Coordination intact
- Limit above complications
- Focus on ongoing service coordination integration with HH

Enrolled HH Children Eligible for EI Discussion and Consideration for Feedback

Child referred to Early Intervention

Child Eligible for EI

Child is not eligible for EI

Continue with connection to HH

Enrolled in Health Home with EI OCS-HH CM with parental choice

Not enrolled in HH due to parental choice

Then EI OCS

If child's condition changes HH option can be re-considered

Scenario: Benefits & Challenges of Integration

Benefits:

- **Reduced** system complexity through single point of contact for families

- **Reduced** duplication of services

- **Increased** continuity of care

- **Increased** accuracy in periodic assessments

- **Expanded** array of services

- **Enhanced** community relationship between Care Manager and service providers

Challenges:

- Training OSC to become HH CM
- Training for HH CM regarding EI
- Determining staff capacity needs
- Limited capacity during initial role out
- Becoming part of a Health Home network and oversight
- Network Adequacy
- Billing Processes
- Health Information Technology (HIT)
  - MAPP
  - CANS NY
  - NYEIS

Steps to Become a Health Home Care Management Agency

Readiness Activities Needed to be a CMA
Contracts and BAAs

To formalize your care manager Health Home relationship with Health Home after identifying the Health Home(s) your organization wants to work with the following will be needed:

- A Business Associate Agreements (BAAs) between Health Homes and care management agencies must be established
- Your Health Home may engage you in other business documents to establish Health Home care management relationship

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Readiness Activities Needed to be a CMA

To formalize your care manager Health Home relationship with Health Home after identifying the Health Home(s) your organization wants to work with the following will needed:

- If you do not already have one, your organization will need to have a valid Medicaid Management Information Systems (MMIS ID) and National Provider Identifier (NPI #)
- Identify the Health Home(s) your organization wants to work with
- Your organization will have to identify a Single Point of Contact (SPOC) to receive correspondence from DOH regarding information and steps to proceed – you will provide your Health Home with a SPOC for your agency – the Health Home will relay that information to DOH
- Obtain an organization Health Commerce System (HCS) account by identifying a HCS Director and Coordinator (if not already established) to manage the staff that will need access to the HCS
  - HCS access is required to access the Medicaid Analytics Performance Portal (MAPP) and the CANS-NY which will reside in the Uniform Assessment System (UAS-NY)
  - Then a MAPP Gatekeeper will need to be identified to help track the roles and responsibilities of staff within MAPP
- Care Managers will need to be trained and certified in the CANS-NY assessment tool

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Key Roles in the Health Commerce System (HCS)

- Single Point of Contact (SPOC) – At your option can be the same person you provided to Health Home

- HCS Director

- HCS Coordinator

- MAPP Gatekeeper

- Training will also be provided

For further information regarding roles in the Health Commerce System, please refer to MAPP/HCS Webinars at
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm

Next Steps:

- ✓ Stakeholder Engagement
- ✓ Obtaining Stakeholder Feedback
  - NYSAHCO
  - EICC
  - EI providers doing service coordination
  - Health Homes
  - Health Home Care Management Agencies
- ✓ Surveying providers interest in providing HH CM and EI OSC services
- ✓ Planning steps for Implementation
  - Cross Training of requirements, responsibilities and standards
  - Approved EI provider process
  - Becoming part of a Health Home provider network
  - CANS NY Training
  - Systems training of NYEIS, HH CM systems, and DOH systems (i.e. MAPP)

Questions and Discussion

Subscribe to the HH 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

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Updates, Resources, Training Schedule and Questions

- Please send any 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

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Health Homes Serving Children
List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application

- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

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Health Homes Serving Children
List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services

- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency

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APPENDIX

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1. Comprehensive Care Management

Lead Health Home must have planning, and policies and procedures in place to ensure care managers create, document, execute and update an individualized, person-centered plan of care for each individual.

1a. A comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) 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 individual'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 individual'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 individuals in their care and promoting continuity of care.

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

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Examples of activities that constitute providing **comprehensive care management** under the Health Home model include:

• Completing a comprehensive assessment, inclusive of medical, behavioral, rehabilitative and long term care and social service needs.

• Completing and revising, as needed, the child's person centered, family-focused, plan of care with the child and family to identify the child's needs and goals, and include family members and other social supports as appropriate.

• Consulting with multidisciplinary team, primary care physician, and specialists on the child's needs and goals.

• Consulting with primary care physician and/or specialists involved in the treatment plan.

• Conducting clinic outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes.

• Preparing crisis intervention plans.

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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 individual'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 individual's plan of care. The Health Home care manager is clearly identified in the individual's 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 the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

2d. The heath home provider must define how 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 information and care needs across providers and to monitor outcomes and initiate changes in care, as necessary, to address the individual's needs.

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Examples of activities that constitute providing **Care Coordination and Health Promotion** under the Health Home model include:

• Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information.

• Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.

• Conduct case reviews with the child/family and interdisciplinary team to monitor/evaluate client status/service needs.

• Crisis intervention – revise care plan/goals as required.

• Advocate for services and assist with scheduling of services.

• Monitor, support, and accompany the child and family to scheduled medical appointments.
• Provide conflict free case management.

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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 individuals 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 enrollee, 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 individual attended the appointment, and a plan to outreach and re-engage the individual in care if the appointment was missed.

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Examples of activities that constitute providing **Comprehensive Transitional Care** include:

• Follow up with hospitals/ER upon notification of child's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.

• Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.

• Link child/family with community supports to ensure that needed services are provided.

• Follow up post discharge with child and family to ensure needed services are provided.

• Notify and consult with treating clinicians, including child's primary care physician, schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., schools and day care), and assist with medication reconciliation.

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4. Patient and Family Support

4a. Enrollee's individualized plan of care reflects individual and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

4b. Enrollee'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 enrollees' 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 Heath 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 individual access to plans of care and options for accessing clinical information.

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Examples of activities that constitute providing **Patient and Family Support** under the Health Home model include:

• Develop, review, revise child's plan of care with child and family to ensure plan reflects child/family's preferences, education, and support for self-management.

• Consult with child/family/caretaker on advanced directives and educate on client rights and health care issues as needed.

• Meet with child and family, inviting any other providers to facilitate needed interpretation services.

• Refer child and family to peer supports, support groups, social services, entitlement programs as needed.

5. Referral to Community and Social Supports

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.

Examples of activities that constitute making **referrals to Community and Social Support Services** include:

• Identify resources and link child/family to community supports as needed

• Collaborate and coordinate with community based providers to support effective utilization of services based on child/family need

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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 cited in items 6a.-6d for implementation of Health Homes. In order to be approved as a Health Home provider, applicants must provide a plan to achieve the final standards cited in items 6e-6i within eighteen (18) months of program initiation.

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 (http://health.ny.gov/technology/statewide_policy_guidance.htm) 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.

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Early Intervention

ISC
• Primary point of contact for family from time of referral to initial IFSP
• Assists family with applying for any health benefit programs for which they may be eligible
• Coordinates the planning of beneficiary's evaluation and helps parents select an evaluator
• Coordinates with medical and health care providers
• Attends and participates in the Initial IFSP meeting
• Completes all required third party insurance forms and paperwork
• Enters recipient insurance information into NYEIS
• If child found not eligible; refer family to other recommended community programs and resources
• If child found eligible; ensures that the IFSP contains a statement of measurable results/outcomes expected to be achieved for pre-literacy and language skills, as developmentally appropriate for the child

OSC
• Upon being chosen by the parent, the OSC must consult with ISC to identify family issues or needs that could impact provider assignment, such as demographics, language and scheduling needs
• Review IFSP developed at the initial IFSP meeting to understand the child's and family's service needs
• Make referrals to providers for needed EI services and other services identified in the IFSP, and schedule appointments for children and families
• Attend all IFSP reviews and participate in team discussions to identify and incorporate the family's concerns, priorities, and resources
• Maintain documentation of all service coordination activities in the child's record, including circumstances that impact timeliness
• Coordinate, facilitate, and monitor the delivery of services to ensure they are being delivered in a timely manner in accordance with the IFSP through: home visits, telephone contacts, and meetings with the parent and service providers to foster collaboration and integration of services
• Coordinate the performance of any additional evaluations and assessments
• Conduct follow-up activities to ensure that appropriate services are being provided and that the IFSP consistently reflects the family's current priorities, concerns, and resources
• Periodically discuss and update in NYEIS the family's Medicaid or commercial insurance coverage and transmit this information to the child's service providers and the department of fiscal agent
• Attends the 6-month reviews and annual evaluations of the IFSP; or at more frequent intervals at the request of the parent or if conditions warrant
• When child is in foster care, keep the Local Department of Social Services' case worker informed of the child's progress
• Develop the transition plan to preschool or other appropriate supports and services and complete the required transition steps and services

Service Alignment

1) Coordinate and arrange provision of services

2) Support adherence to treatment recommendations

3) EI, administer 6 month reviews/ HH, 6 month CANS assessments

4) Monitor and evaluate beneficiary needs

5) Identify community based resources

6) Develop transition of care plan

Findings:

• EI OSC and HH CM overlap in several major service area categories

• Notable dissimilarities lie in areas if Health Information technology and methods of data collection

Health Homes

HH CM
• Engage and retain health home enrollees in care

o Coordinate and arrange for the provision of services; support 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 care plan.

• Referral to Community and Social Supports

o Identifies available community-based resources and actively managed appropriate referrals, access, engagement, follow-up and coordination of services

• Patient and Family Support

o Utilize 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.

• Use of Health Information Technology

o Employ systematic process to follow-up on tests, treatments, services and referrals which is incorporated into the patient's plan of care.

• Comprehensive Transitional Care

o Establish policies and procedures 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