NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Overview of Health Home Care Management Program for Children for NYS School Districts

October 24, 2017

Presentation Goal
What do School Personnel need to know about Health Homes?

I. Health Home Care Management for Medicaid Children and Children's Medicaid Redesign Initiative

II. Which Medicaid enrolled children may be eligible and appropriate for Health Homes

III. Important role school districts have in collaborating with Health Home care managers

IV. What services are provided by the Health Homes and how children/families can access them

V. Requirements for Consent to share information between districts and Health Homes (HIPPA and FERPA)

VI. Appendix – list of Health Homes and counties served

Overview of the Medicaid Redesign Initiatives and Health Home Services

Health Home Care Management is Part of Medicaid Redesign Team (MRT) Initiative to Improve and Transform Delivery of Health Care to High Needs Children in Medicaid

- The Design and Implementation of Health Homes for Children is a key component of the Medicaid Redesign Team's (MRT) Plan to Transform the Delivery of Health Care for High Needs 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

Health Home Optional Benefit that Provides Comprehensive Care Management – Integral Part of Medicaid Redesign Team Medicaid Transformation Initiatives

- Health Home care management facilitates key goal of Medicaid Redesign Initiatives to integrate behavioral and physical health and social supports and provide comprehensive, person centered care planning for Medicaid members with high needs a chronic conditions
- Health Home is an ***optional*** benefit that provides comprehensive care coordination and management to individuals with ***Medicaid*** who have certain ***eligible chronic conditions***
- 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
- Health Home enrollment is voluntary, and there is a choice of Health Home and care manager

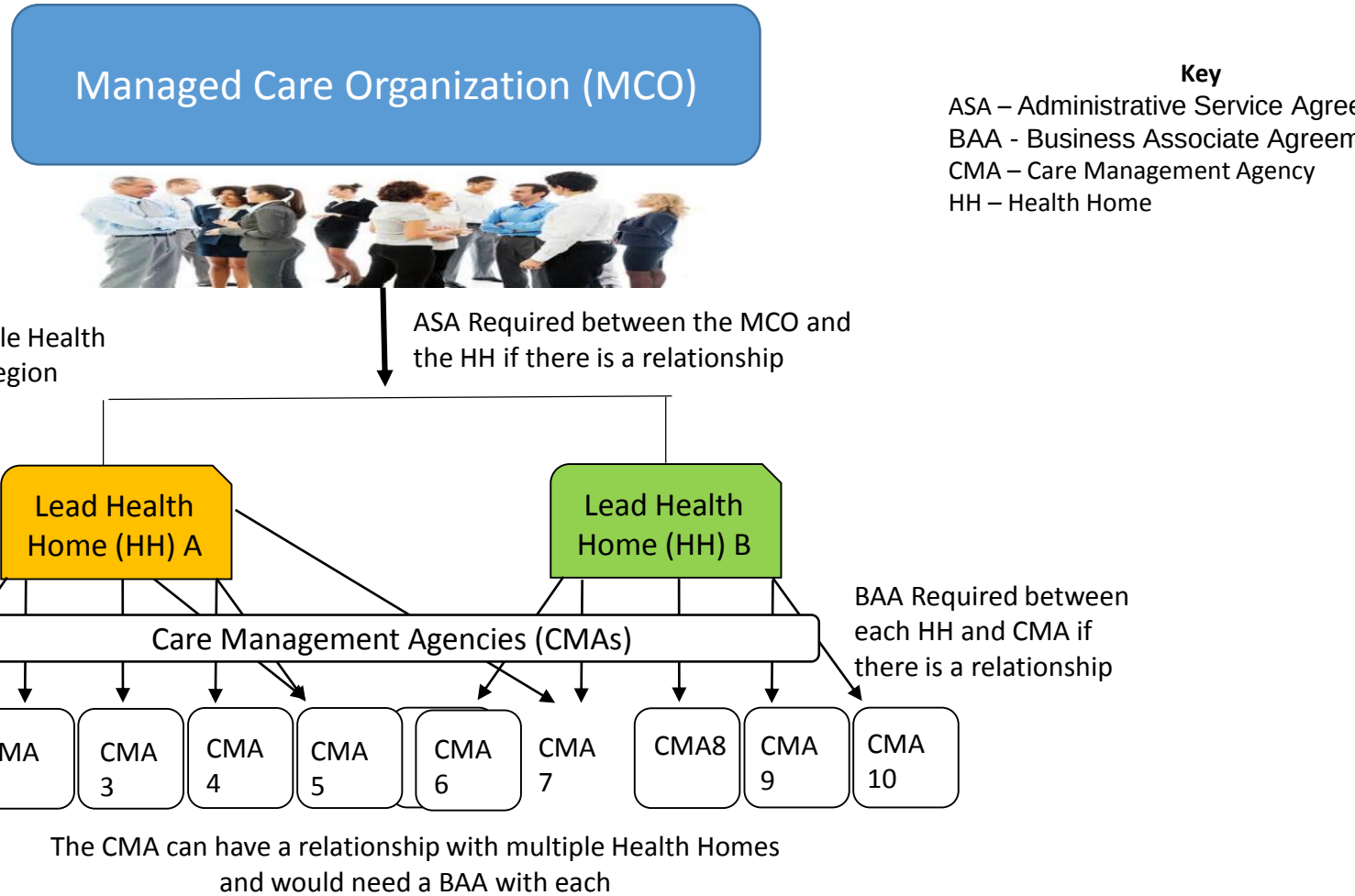
Health Homes Provide Care Management

- Health Home is not a place it is a ***Care Management model*** for Medicaid members who meet Health Home eligibility criteria

- Health Home care managers:
  - provide an enhanced level of care coordination and comprehensive care management
  - provide a multi-disciplinary team approach
  - person-centered (youth-guided and family-driven)
  - work with families to develop integrated care plans including: primary, acute, mental health and substance use services
  - provide linkages to community and social supports

- Health Homes are entities that generally contract with Care Management Agencies (CMAs) that provide care managers that deliver the six core services required under the Health Home model

Key Health Home Players and Relationships



Key

ASA – Administrative Service Agreement
BAA - Business Associate Agreement
CMA – Care Management Agency
HH – Health Home

Overview of the Six Core Health Home 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.

Overview of the Six Health Home Core Services

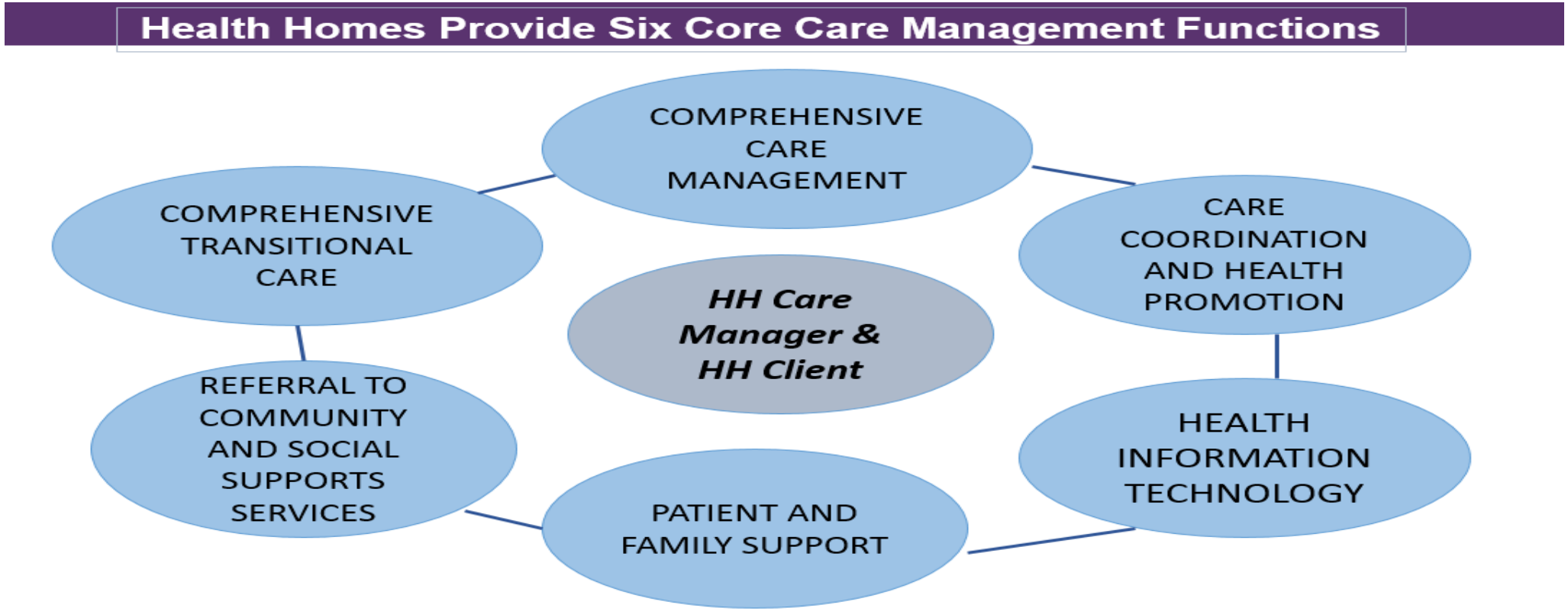
4. Patient and Family Support
   - Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

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

For detailed description of each core service please see: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

Health Homes Serving Children Six Core Services



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

Health Home Eligibility and Appropriateness Criteria

Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to 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://devweb2.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.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.

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
- Gender Dysphoria
- 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.)*

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,
   vi. relationships with others, and
   vii. dissociation

Determining Health Home Eligibility

- The Health Home care manager is responsible for documenting and verifying children meet the eligibility criteria, e.g., work with health care professionals to determine and document eligibility conditions
- The State has developed a set of forms and procedures for determining if a child has complex trauma (i.e., meets the Health Home definition of complex trauma)

Process to Determine Health Home Complex Trauma Eligibility

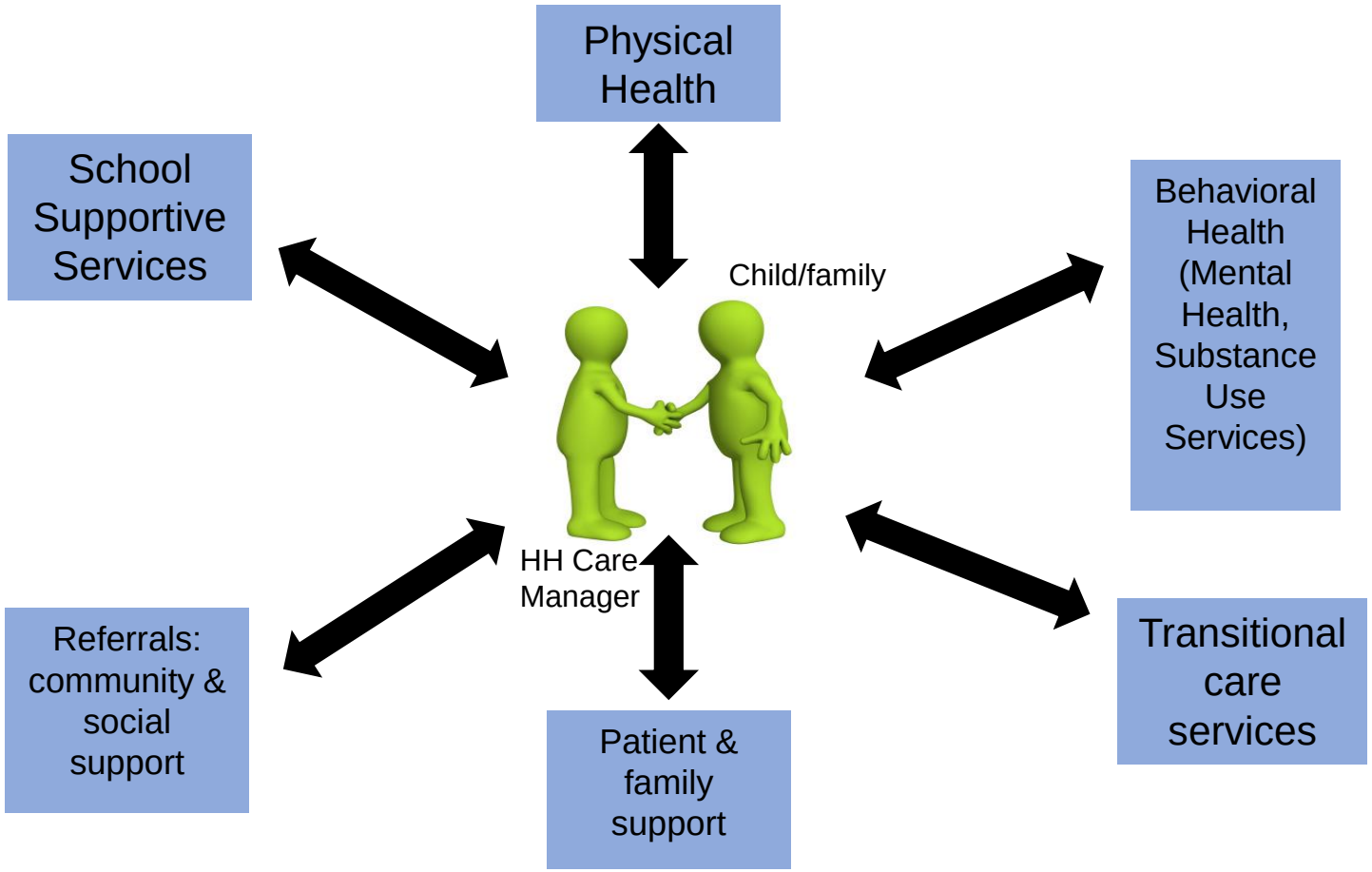
Need Identified by Non-Licensed Professional or Licensed Professional w/o access to tools

- 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

Health Homes provide Comprehensive Care Management



Health Home Care Managers Collaborating with Schools

Collaborations and Partnerships are Critical

- Integrating care and care management across children's systems of care, including the education system, is a key component of providing quality, comprehensive Health Home care management
- The ability to achieve this integration is dependent upon the degree to which Health Homes and schools collaborate, form partnerships and work together to address the needs of high needs children and help them thrive

Collaboration: Health Homes and the Education System

Care Managers should know:

- The child's involvement in school i.e. attendance and grades
- If the child's chronic conditions are impacting his/her school involvement
- If there are any special arrangements that are needed to assist the child in school due to their chronic conditions
- If the child is involved with the Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE)
- Whether the child has other behaviors or behavioral health needs that are impacting the child's school involvement
- The child's cultural and linguistic origin and provide competency in the populations they serve
- Other linkages or connectivity to services are needed to assist with school involvement

Health Homes and Special Education Coordination

There will be a number of occasions where Health Home Care Managers and Schools will cross paths, however it is more likely that it will be with children who are CSE/CPSE involved;

CSE (Committee on Special Education) /CPSE (Committee on Preschool Special Education) Recommendations:

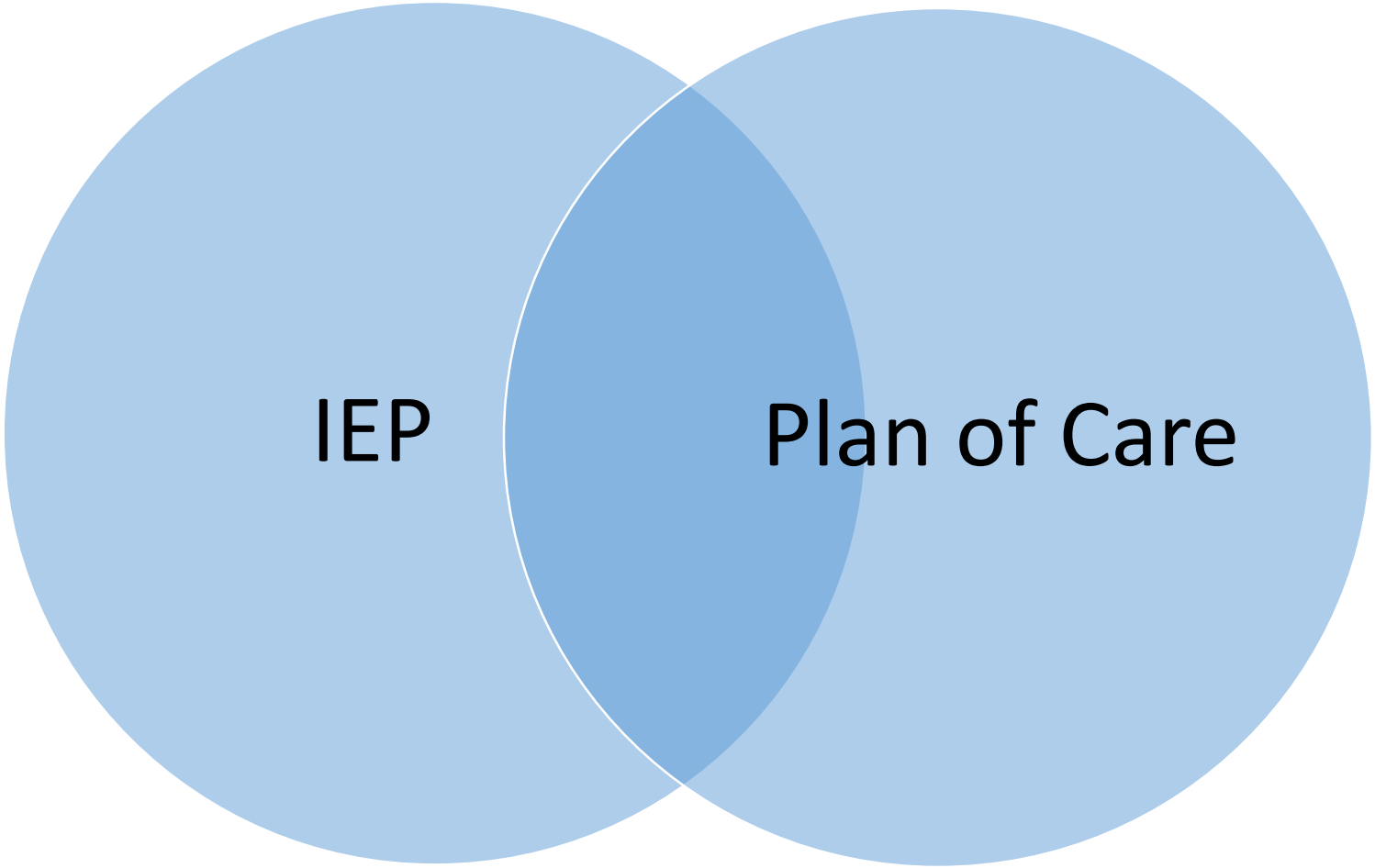
- Develop and encourage pathways for Health Homes and CSE/CPSE to collaborate and share information (with proper consent) to ensure development of comprehensive care plan that reflects Individualized Education Programs (IEP) and other needs
  - ✓ Help educate parents regarding Health Homes and available service support
  - ✓ Encourage parents to invite Health Home Care Managers to CSE/CPSE meetings
  - ✓ Share information with Health Home Care Managers to ensure coordination of care planning (with proper consent)

Health Homes Comprehensive Plan of Care

- By definition, Health Home eligible children will have comprehensive needs, which should be outlined in their Health Home comprehensive plan of care, of which the IEP would be important element to be considered.
  - ✓ Health Home/State Education Department consent forms are needed to authorize a sharing of educational records such as IEPs, Special Education Evaluation Reports (e.g. social history, psychological, classroom observation, other assessments that describe the physical, mental, behavioral and emotional factors that contribute to the disability)

- Health Home children may also be eligible for expanded State Plan services and Home and Community Based Services (HCBS) now underdevelopment

IEP and Health Home Plan of Care have consistent GOALS



What must be in an IEP?

- IEP Identifying Information
- Present Levels of Performance and Individual Needs
- Measureable Post-secondary Goals/Transition Needs
- Measureable Annual Goals, as appropriate, short-term objectives and bench marks
- Reporting Progress to Parents
- Recommended Special Education Programs and Services
- Coordinated Set of Transition Activities
- Participation in State and District-wide Assessments
- Participation with Students without Disabilities
- Transportation
- Placement Recommendation

What must be in a Health Home Plan of Care?

10 Elements of Care Planning are consistent with meeting the six core Health Home services

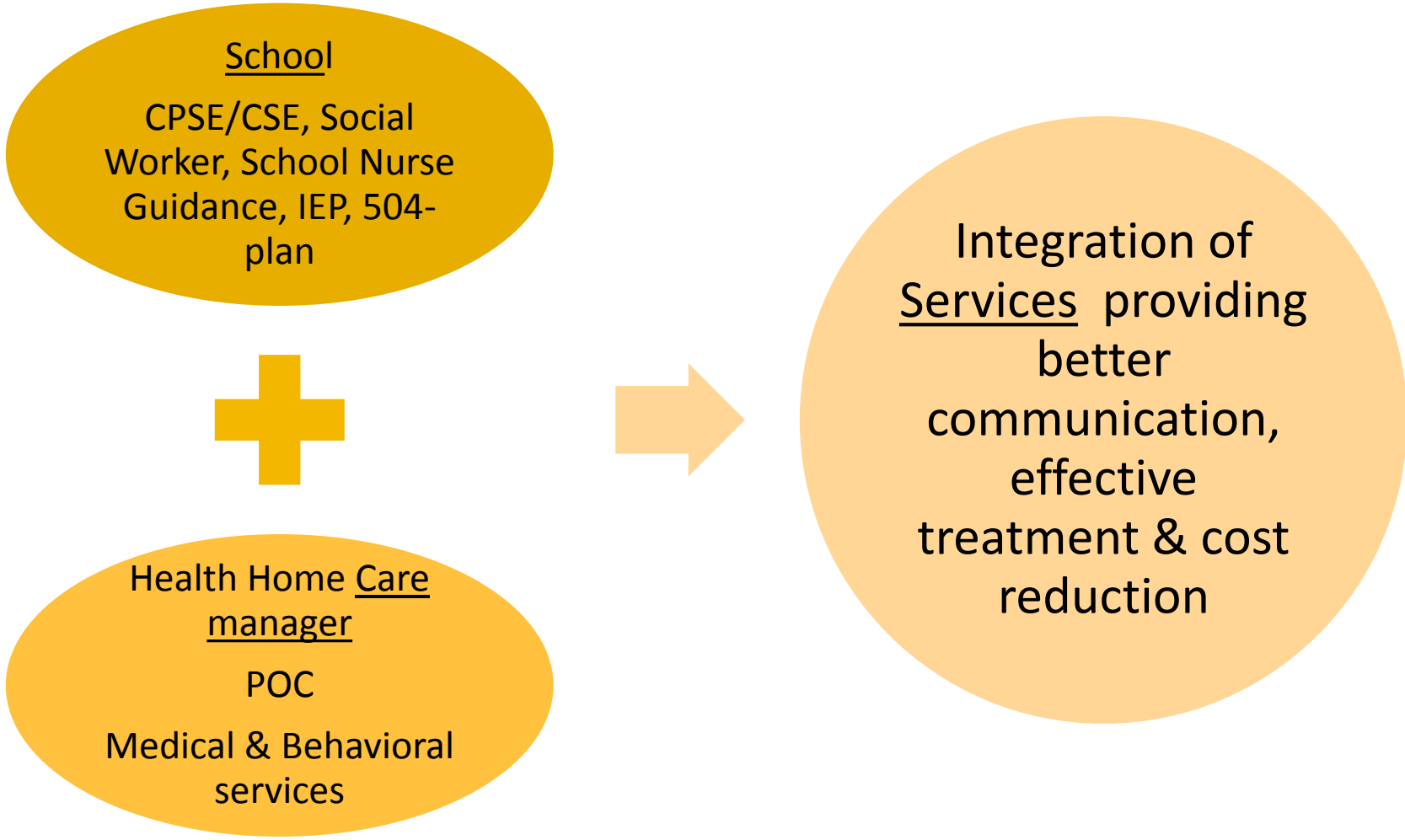
For all children enrolled in a Health Home, the plan of care must include the following specific elements:

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 services identified to meet needs, and should be comprehensive to include Physical, Behavioral Community and Social Supports, and Non-Medicaid services, including 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 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)

Schools and Health Homes Collaboration



Integrating Service Planning

A Health Home Care Manager can be an integral part of the School Team for children

- ✓ Has a 360 view point of the child and family
- ✓ Is aware of all involved professionals and providers for the child and family
  - Convenes a interdisciplinary team meeting on a regular basis
- ✓ Is aware of chronic conditions that may impact school performance
- ✓ Can assist the family to advocate for services
- ✓ Assess the families strengths and needs
- ✓ Develop a person centered plan of care
- ✓ Can share information to assist the school (with proper consent reference in upcoming slides)
- ✓ Has a focus of the child/adolescents overall health and wellbeing

How to Refer a Child for Health Home Care Management Services

Health Homes Serving Children

- There are 32 Health Homes currently operating in New York
- *16 of those Health Homes are designated to serve children (HHSC) and 13 of those currently also serve adults*
- *The following slides and web address provide the name of each HHSC, the counties they serve and a contact for making/receiving Health Home Referrals – this does NOT require the use of MAPP and is an expeditious path school district can use to make referral*

http://devweb2.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_children_designations.pdf

Using MAPP to Refer Children to Health Home

- MAPP, a State Department of Health System, includes a Children's HH Referral Portal
- The Children's MAPP HH Referral Portal is the vehicle to record referrals (create an assignment with a referral record type), and enroll children in Health Homes
- The following entities now have access to the MAPP Children's HH Referral Portal and can make a referral
  - ✓ Managed Care Plans
  - ✓ Health Homes
  - ✓ Care Management Agencies/Voluntary Foster Care Agencies
  - ✓ LGU/SPOA
  - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)
- ***Schools can contact Health Homes serving their county to make a direct referral to a Health Home – does not require access to MAPP***
- In the future, the State expects to 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.)

Process to Refer a child for Health Home Care Management

Referrals are made to Health Homes by community organizations, school districts, providers, or made directly by the CMAs or HHs

- Referrals can come from Doctors, Parents, social service agencies. Over time the State will include natural points of contacts for children like school districts.

Health Home Lead will refer member to Care Management Agency to verify Health Home eligibility and HH appropriateness

- CM will then provide the necessary assessments and recommend the needed to services for each member accordingly.

Person Centered plan of care includes medical & behavioral community care resources specific to meet members needs

- The elements of Care planning are consistent with meeting the six core HH services

Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
Adirondack Health Institute, Inc.	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington	Emily Walter ewalter@ahihealth.org (518) 480-0111 Ext. 6 Sarah Colvin scolvin@ahihealth.org
Catholic Charities of Broome County - Encompass Health Home	Albany, Allegany, Broome, Cattaraugus, Chautauqua, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates	Lori Accardi laccardi@ccbc.net (607) 729-9166 Tonya Brown tbrown@ccbc.net (607) 729-9166
Central New York Health Home Network (CNYHHN Inc.)	Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence	Jane Vail Jane.vail@cnyhealthhome.net (315)797-9057 ext.278

Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
Children's Health Home of Western New York dba Oishei Healthy Kids	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	Momba Chia mchia@kaleidahealth.org O:716-878-7807 C:716-359-2390 Kirsten Newby knewby@kaleidahealth.org O: 716-878-1354 C: 716-364-2380
Children's Health Homes of Upstate New York, LLC (CHHUNY)	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates	Nicole Bryl nbryl@hhuny.org O: 585-613-7644 C: 716-572-9858 Donna Fiscella dfiscella@childrenshealthhome.org O: 315-632-6195

Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
Collaborative for Children and Families	Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester	Jodi Saitowitz jsaitowitz@ccfhh.org O: 646-459-3971 C: (917) 213-0130 Lisa Peterson Lpeterson@ccfhh.org O: 646-459-3972 C: 646-799-8284
Community Care Management Partners, LLC (CCMP)	Bronx, Brooklyn, Manhattan, Queens	Phil Opatz Phil.opatz@vnsny.org O:212-290-6467 C: 347-452-9557
Coordinated Behavioral Care, Inc. dba Pathways to Wellness Health Home	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Amanda Semidey ASemidey@cbcare.org 646-930-8835 Janelle Chambers JChambers@cbcare.org 646-930-8851

Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
Greater Rochester Health Home Network LLC	Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming	Deb Peartree dpeartree@therihn.org (585) 737-7522 Ann Potter apotter@therihn.org (585)-350-1408
Hudson River HealthCare, Inc. dba Community Health Care Collaborative	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Westchester, Nassau, Suffolk	Andrea Hopkins ahopkins@hrhcare.org 845-803-3479 Katie Clay kclay@HRHCARE.ORG 914-734-8513
Institute for Family Health	Ulster	Michaela Frazier – Director mifrazier@institute.org O: 206-206-5200 x1360 C: 917-831-0334 Melissa Martinez – Director mmartinez@institue.org O:845-255-2930 C:347-947-0667

Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home	Bronx	Antonette Mentor amentor@monterfiore.org 914-378-6086
Niagara Falls Memorial Medical Center	Niagara	Vicki Landes Vicki.landes@nfmmc.org (716) 278-4147 Jennifer Mruk Jennifer.mruk@nfmmc.org (716) 278-4647
Northwell Health Home	Queens, Nassau, Suffolk	Christina Alonso Calonso1@northwell.edu Office Phone: (516) 600-1128 Cellular Phone: (516) 287-6046

Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
Mount Sinai Health Home Serving Children	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Alicia Korpi Alicia.korpi@mountsinai.org O:212-731-7841 C:646-856-5667 Arhima Jacobs Arhima.jacobs@mountsinai.org 212-241-3257
St. Mary's Healthcare	Fulton, Montgomery	Katerina Gaylord Katerina.gaylord@smha.org 518-841-3676 Charis Gray 518-841-3896 Graycm@ascension.org Sarah Eipp 518-841-3896 Sarah.Eipp@ascension.org

Health Homes Serving Children Enrollment Report 2017

***Please Note: Enrollment & Outreach data is reported as a point-in-time reference as of September 31, 2017**

Unique recipients since program inception 12,774

Health Home Name	12/2016	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017
ADIRONDACK HEALTH INSTITUTE IN	132	164	187	219	249	263	277	285	282	279
CHHUNY LLC	934	1,587	2,129	2,633	2,968	3,296	3,499	3,594	3,763	3,774
CHILDREN'S HEALTH HOME OF WNY	0	0	81	176	289	354	427	498	559	645
CNYHHN INC	44	42	48	62	72	105	136	158	185	193
COMMUNITY CARE MANAGEMENT PART	75	96	102	111	125	133	135	143	152	153
COORDINATED BEHAVIORAL CARE IN	584	763	961	1,192	1,358	1,499	1,586	1,669	1,769	1,801
ENCOMPASS FAMILY HEALTH HOME L	151	212	256	300	325	361	422	453	495	513
GREATER ROCHESTER HLTH HOME NE	20	25	28	34	36	40	43	43	49	54
HUDSON RIVER HEALTHCARE INC	281	443	497	547	593	649	699	726	740	760
INSTITUTE FOR FAMILY HLTH	2	3	4	17	28	36	40	43	43	42
MONTEFIORE MEDICAL CENTER	15	63	84	98	110	114	127	136	136	139
MOUNT SINAI HLTH HM SER CHILDR	0	0	40	64	104	143	178	197	219	209
NIAGARA FALLS MEM MED CTR	54	77	119	138	153	164	172	190	207	207
ST MARYS HEALTHCARE	68	83	92	94	102	105	108	114	120	121
THE COLLABORATIVE FOR CHILDREN	529	1,090	1,738	2,445	2,856	3,192	3,461	3,714	3,927	3,884

Health Home Consent

Consent is Required for Health Home Enrollment

- Health Home Serving Children program serve children/adolescent ages 0-21 years old

- Consent to enroll children in Health Home is required (DOH form 5200)
  - Individuals who are 18-21 years of age are able to legally consent for their own enrollment into a Children's Health Home program. Children and adolescents who are parents, pregnant, married, are legally able to consent for their own enrollment into a Health Home and share their protected health information (DOH form 5055)

- The Health Home Care Manager will obtain all required consent forms from the member and or parent, guardian or legally authorized representative for enrollment and information sharing with school districts and other involved providers

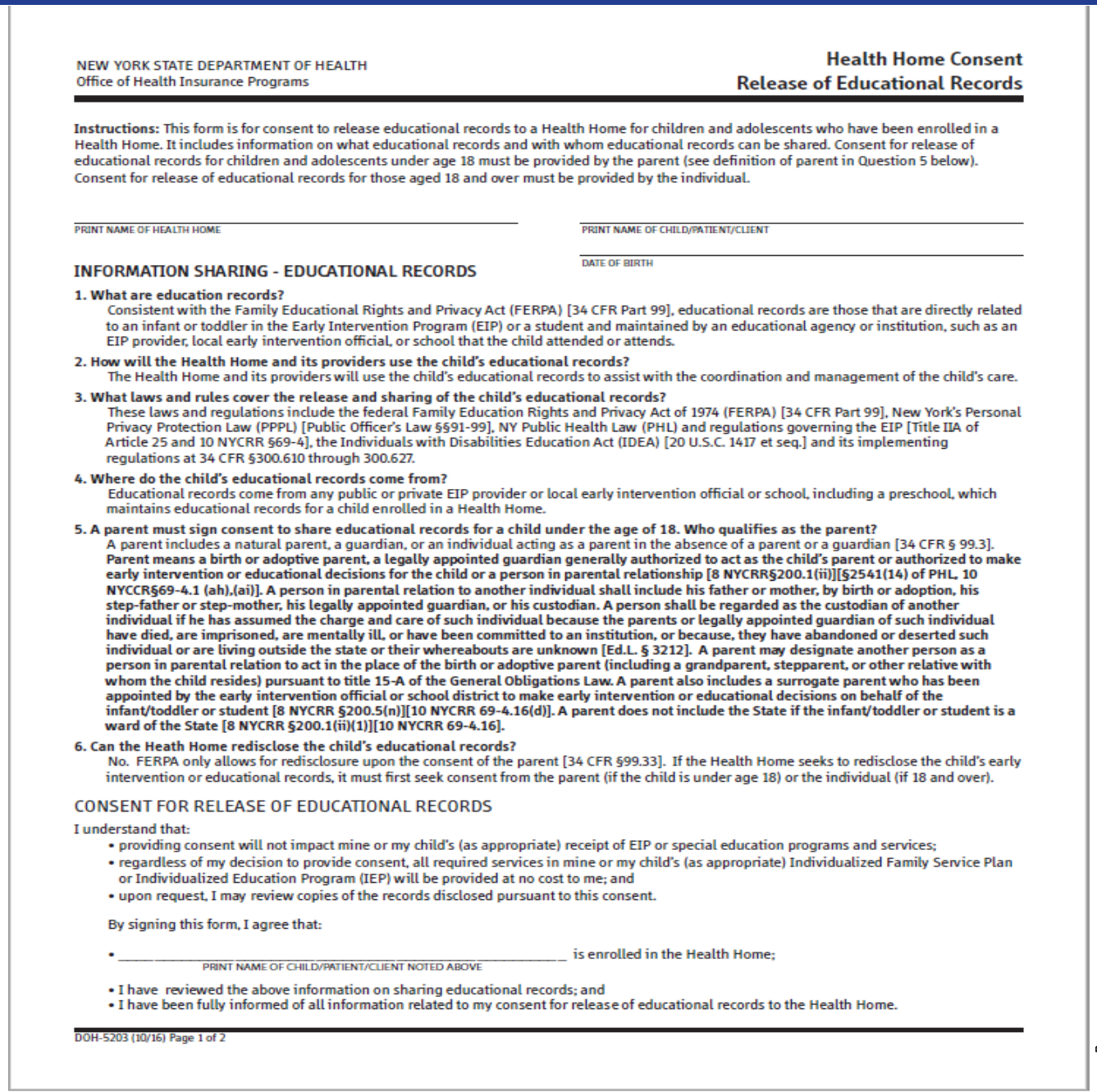
- ***Note: Educational Systems must have written consent consistent with FERPA to make a referral to a Health Home (follow school policies and procedures)***

Consent is Required to Share Enrolled Member Information

- Consent to Share Information in Health Home (DOH form 5201)
  - This form has two sections, section one for the parents, guardians or legally authorized representative to complete and section two for the child/adolescent to complete separately with the Health Home care manager and not with the parents, guardians, or legally authorized representative

- Consent to Release Educational Records (DOH form 5203)
  - To be completed by the parent of a child/adolescent under the age of 18 (see definition of parent on the consent form) or the child/adolescent if 18 years of age or older, to consent to share education records.
  - The definition of parent in DOH 5203 is also different from other Health Home consent forms. Please refer to DOH 5203 for the complete definition of parent, guardian or legally authorized representative.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/consent_forms-templates.htm



NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Health Home Consent
Release of Educational Records

Instructions: This form is for consent to release educational records to a Health Home for children and adolescents who have been enrolled in a Health Home. It includes information on what educational records and with whom educational records can be shared. Consent for release of educational records for children and adolescents under age 18 must be provided by the parent (see definition of parent in Question 5 below). Consent for release of educational records for those aged 18 and over must be provided by the individual.

PRINT NAME OF HEALTH HOME

PRINT NAME OF CHILD/PATIENT/CLIENT

DATE OF BIRTH

INFORMATION SHARING - EDUCATIONAL RECORDS

1. What are education records?
Consistent with the Family Educational Rights and Privacy Act (FERPA) [34 CFR Part 99], educational records are those that are directly related to an infant or toddler in the Early Intervention Program (EIP) or a student and maintained by an educational agency or institution, such as an EIP provider, local early intervention official, or school that the child attended or attends.

2. How will the Health Home and its providers use the child's educational records?
The Health Home and its providers will use the child's educational records to assist with the coordination and management of the child's care.

3. What laws and rules cover the release and sharing of the child's educational records?
These laws and regulations include the federal Family Education Rights and Privacy Act of 1974 (FERPA) [34 CFR Part 99], New York's Personal Privacy Protection Law (PPPL) [Public Officer's Law §§91-99], NY Public Health Law (PHL) and regulations governing the EIP [Title IIA of Article 25 and 10 NYCRR §69-4], the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1417 et seq.] and its implementing regulations at 34 CFR §300.610 through 300.627.

4. Where do the child's educational records come from?
Educational records come from any public or private EIP provider or local early intervention official or school, including a preschool, which maintains educational records for a child enrolled in a Health Home.

5. A parent must sign consent to share educational records for a child under the age of 18. Who qualifies as the parent?
A parent includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian [34 CFR § 99.3]. **Parent means a birth or adoptive parent, a legally appointed guardian generally authorized to act as the child's parent or authorized to make early intervention or educational decisions for the child or a person in parental relationship [8 NYCRR§200.1(ii)][§2541(14) of PHL, 10 NYCCR§69-4.1 (ah),(ai)]. A person in parental relation to another individual shall include his father or mother, by birth or adoption, his step-father or step-mother, his legally appointed guardian, or his custodian. A person shall be regarded as the custodian of another individual if he has assumed the charge and care of such individual because the parents or legally appointed guardian of such individual have died, are imprisoned, are mentally ill, or have been committed to an institution, or because, they have abandoned or deserted such individual or are living outside the state or their whereabouts are unknown [Ed.L. § 3212]. A parent may designate another person as a person in parental relation to act in the place of the birth or adoptive parent (including a grandparent, stepparent, or other relative with whom the child resides) pursuant to title 15-A of the General Obligations Law. A parent also includes a surrogate parent who has been appointed by the early intervention official or school district to make early intervention or educational decisions on behalf of the infant/toddler or student [8 NYCRR §200.5(n)][10 NYCRR 69-4.16(d)]. A parent does not include the State if the infant/toddler or student is a ward of the State [8 NYCRR §200.1(ii)(1)][10 NYCRR 69-4.16].**

6. Can the Heath Home redisclose the child's educational records?
No. FERPA only allows for redisclosure upon the consent of the parent [34 CFR §99.33]. If the Health Home seeks to redisclose the child's early intervention or educational records, it must first seek consent from the parent (if the child is under age 18) or the individual (if 18 and over).

CONSENT FOR RELEASE OF EDUCATIONAL RECORDS

I understand that:

- providing consent will not impact mine or my child's (as appropriate) receipt of EIP or special education programs and services;
- regardless of my decision to provide consent, all required services in mine or my child's (as appropriate) Individualized Family Service Plan or Individualized Education Program (IEP) will be provided at no cost to me; and
- upon request, I may review copies of the records disclosed pursuant to this consent.

By signing this form, I agree that:

- _____ is enrolled in the Health Home;
  PRINT NAME OF CHILD/PATIENT/CLIENT NOTED ABOVE
- I have reviewed the above information on sharing educational records; and
- I have been fully informed of all information related to my consent for release of educational records to the Health Home.

DOH-5203 (10/16) Page 1 of 2

Health Home Consent Information Sharing Release of Educational Records (DOH 5203)

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Health Home Consent
Withdrawal of Release of Educational Records

Instructions: This form is to withdraw (take away) consent (permission) to release educational records (which includes Early Intervention Program records) for children and adolescents who have been enrolled in a Health Home. Withdrawal of consent for release of educational records for children under age 18 must be provided by the parent. Withdrawal of consent for release of educational records for those aged 18 and over must be provided by the individual.

PRINT NAME OF HEALTH HOME

PRINT NAME OF CHILD/PATIENT/CLIENT

DATE OF BIRTH

By signing this form, I am saying that I no longer want _____
PRINT NAME OF SPECIFIC SCHOOL/LOCAL EARLY INTERVENTION OFFICIAL/EARLY INTERVENTION PROGRAM PROVIDER(S)

to share educational records for _____ with the following:
PRINT NAME OF CHILD/PATIENT/CLIENT

NAME OF HEALTH HOME

NAME OF HEALTH HOME CARE MANAGEMENT AGENCY

NAME OF PHYSICIAN

OTHER

OTHER

By signing this form, I understand that:

- I am taking away my permission to share educational records with these above named providers;
- the providers who already have this educational information do not have to give it back or take it out of their records;
- educational records must no longer be shared with the above named providers effective on this date;
- this information will still be protected under New York State and U.S. laws and rules;
- withdrawing consent will not impact mine or my child's (as appropriate) receipt of Early Intervention Program or special education programs and services; and
- all required services in mine or my child's (as appropriate) Individualized Family Service Plan or Individualized Education Program (IEP) will be provided at no cost to me.

For children under age 18:

PRINT NAME OF CHILD'S PARENT

SIGNATURE OF CHILD'S PARENT

DATE

For individuals aged 18 and over:

PRINT NAME OF CHILD/PATIENT/CLIENT

SIGNATURE OF CHILD/PATIENT/CLIENT

DATE

DOH-5204 (10/16) Page 1 of 2

Health Home Consent Withdrawal of Release of Educational Records (DOH 5204) – Page 1

Details about Patient Information and the Withdrawal of Consent for Educational Records

1. A parent must sign consent to withdraw (take away) permission to share educational records for a child under the age of 18.

Who qualifies as the parent?

A parent includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian [34 CFR § 99.3]. Parent means a birth or adoptive parent, a legally appointed guardian generally authorized to act as the child's parent or authorized to make educational decisions for the child or a person in parental relationship [8 NYCRR§200.1(ii)] [§ 2541(14) of Public Health Law (PHL), 10 NYCCR§69-4.1 (ah),(ai)]. A person in parental relation to another individual shall include his father or mother, by birth or adoption, his step-father or step-mother, his legally appointed guardian, or his custodian. A person shall be regarded as the custodian of another individual if he has assumed the charge and care of such individual because the parents or legally appointed guardian of such individual have died, are imprisoned, are mentally ill, or have been committed to an institution, or because, they have abandoned or deserted such individual or are living outside the state or their whereabouts are unknown [Ed.L. § 3212]. A parent may designate another person as a person in parental relation to act in the place of the birth or adoptive parent (including a grandparent, stepparent, or other relative with whom the child resides) pursuant to title 15-A of the General Obligations Law. A parent also includes a surrogate parent who has been appointed by the early intervention official or school district to make educational decisions on behalf of the infant/toddler or student [10 NYCRR 69-4.16(d)], [8 NYCRR §200.5(n)]. A parent does not include the State if the infant/toddler or student is a ward of the State [8 NYCRR §200.1(ii)(1)] [10 NYCRR 69-4.16].

2. How will providers further use this information?

Providers may no longer share or use this educational information.

3. What will happen to these educational records?

This educational information will be kept by providers who already have this information, but they still must protect it by following all New York State and U.S. laws and rules.

4. What laws and rules cover how this child's educational information can be shared?

These laws and regulations include the federal Family Education Rights and Privacy Act of 1974 (FERPA) [34 CFR Part 99], New York's Personal Privacy Protection Law (PPPL) [Public Officer's Law §§91-99], NY Public Health Law (PHL) and regulations governing the Early Intervention Program [Title IIA of Article 25 and 10 NYCRR §69-4], the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1417 et seq.] and its implementing regulations at 34 CFR §300.610 through 300.627 and Parts 300 and 303.

5. Who can get and see this educational information after I withdraw this consent?

As of the date this form is signed, those included on this form will no longer get any new educational information, but information that has already been shared cannot be taken back.

6. What if a person uses this educational information without permission?

If you think a person used this educational information without permission, the parent or eligible student may send a written complaint with the Family Policy Compliance Office under the Family Educational Rights and Privacy Act (FERPA) to the following address:

U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-8520

For additional information about how to submit a complaint see http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html or call 1-800-872-5327.

7. How long does my withdrawal of consent last?

Your withdrawal of consent will last forever.

8. What if I change my mind later and want to share educational information again?

If you change your mind, you must sign a new Consent to Release Educational Records.

9. How do I get a copy of this form?

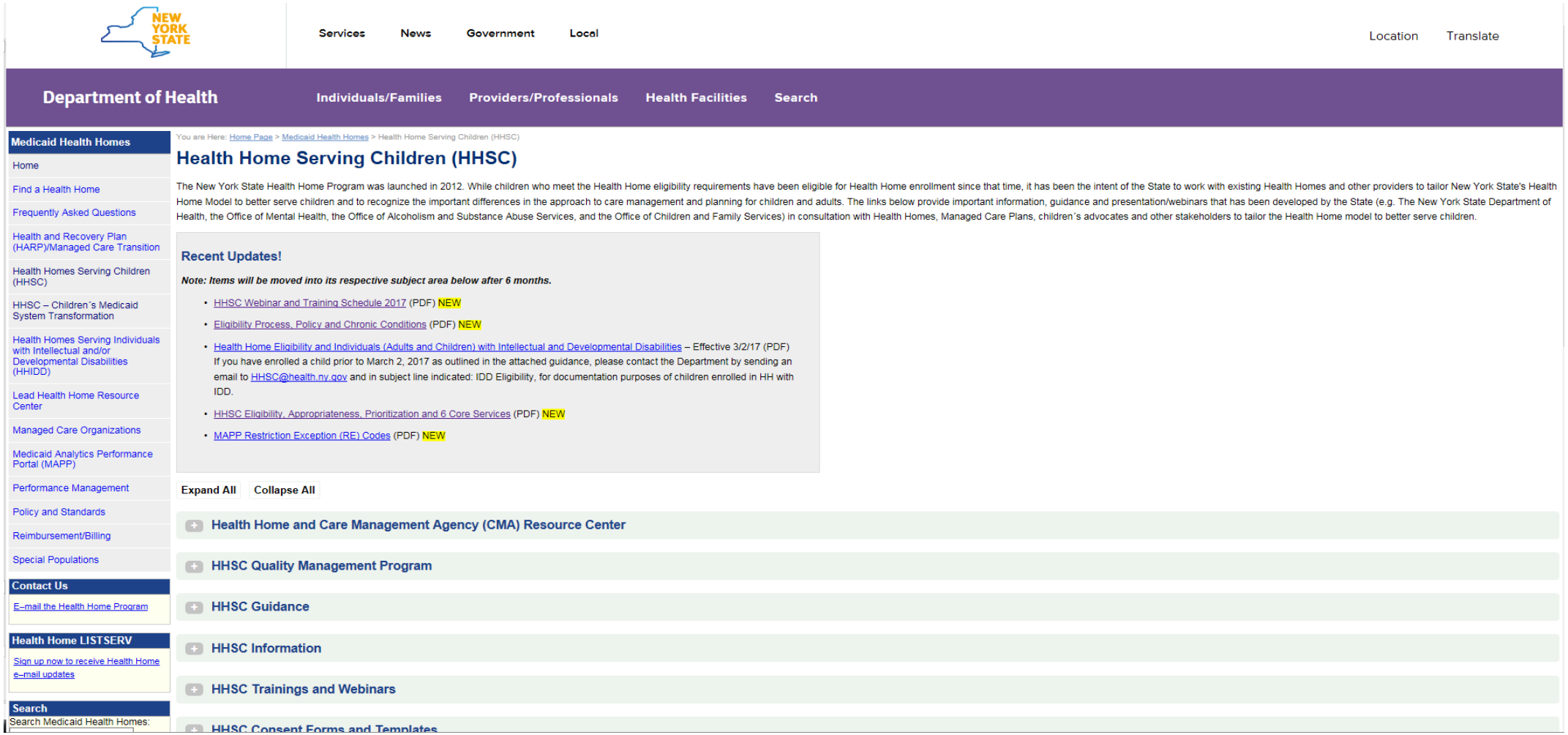
After you sign this Withdrawal of Release of Educational Records, a copy will be given to you.

Health Home Consent Withdrawal of Release of Educational Records (DOH 5204) – Page 2

Resources

Health Home Serving Children (HHSC) Website

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm



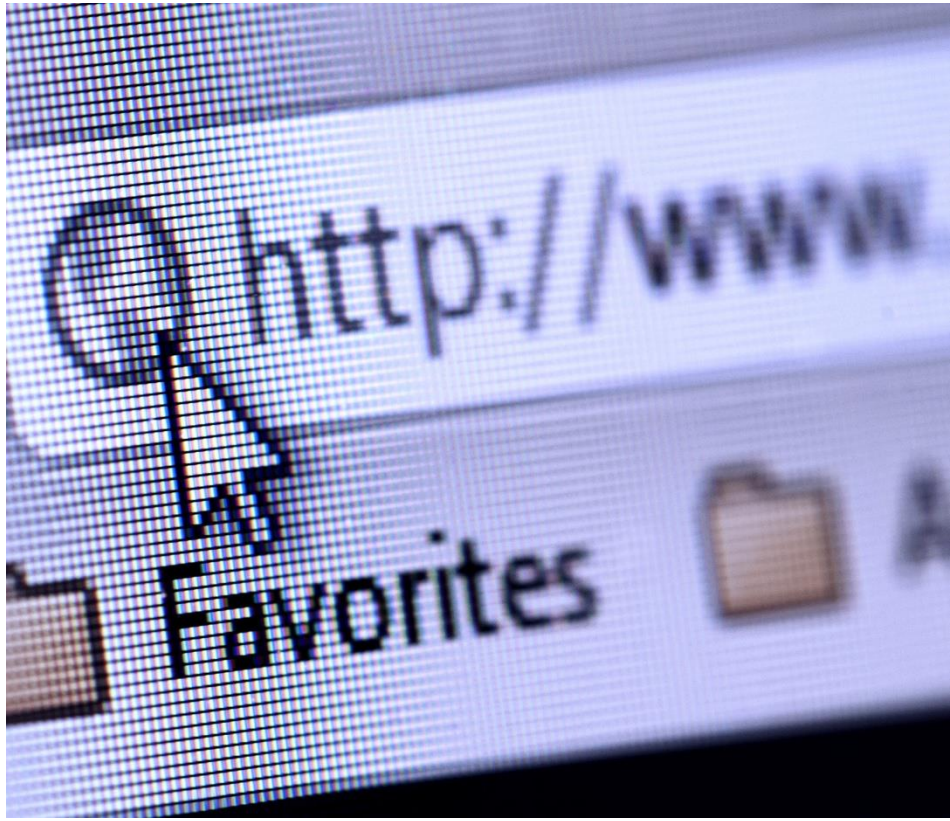
Questions and Discussion

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:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm



Appendix

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

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

Health Home	Designated to Serve Children	Current Designation to Serve Adults
Adirondack Health Institute, Inc.	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington
Catholic Charities of Broome County - Encompass Health Home	Albany, Allegany, Broome, Cattaraugus, Chautauqua, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Warren, Washington, Wyoming, Yates	Broome
Central New York Health Home Network (CNYHHN Inc.)	Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence	Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence
Children's Health Home of Western New York dba Oishei Healthy Kids	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	N/A

Health Home	Designated to Serve Children	Current Designation to Serve Adults
Children's Health Homes of Upstate New York, LLC (CHHUNY)	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates	N/A
Collaborative for Children and Families	Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester	N/A
Community Care Management Partners, LLC (CCMP)	Bronx, Brooklyn, Manhattan, Queens	Bronx, Manhattan
Coordinated Behavioral Care, Inc.	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Brooklyn, Manhattan, Staten Island

Health Home	Designated to Serve Children	Current Designation to Serve Adults
Greater Rochester Health Home Network LLC	Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming	Monroe
Hudson River HealthCare, Inc. dba Community Health Care Collaborative	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Nassau, Suffolk Sullivan, Westchester	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Nassau, Suffolk, Sullivan, Westchester
Institute for Family Health	Ulster	Ulster
Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home	Bronx	Bronx

Health Home	Designated to Serve Children	Current Designation to Serve Adults
Mount Sinai Health Home Serving Children	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Manhattan
Niagara Falls Memorial Medical Center	Niagara	Niagara
Northwell Health Home	Queens, Nassau, Suffolk	Queens, Nassau, Suffolk
St. Mary's Healthcare	Fulton, Montgomery	Fulton, Montgomery