

Interim NYS Health Home Provider Qualification Standards For Chronic Medical and Behavioral Health Patient Populations

Under New York State's approach to health home implementation, a *health home provider* is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

Section 1945 (h) (4) of the Social Security Act defines health home services as "comprehensive and timely high quality services" and includes the following health home services that must be provided by designated health home providers:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of HIT to link services, as feasible and appropriate.

While potential broader applicability exists, the following interim health home provider standards *focus on serving the enrollees with behavioral health and/or chronic medical conditions* and have not been specifically tailored for meeting the needs of the developmentally disabled or long term care patient populations.

General Qualifications

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.
2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.
3. Care coordination and integration of health care services will be provided to all health home enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.
4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.

5. Health home providers must meet the following core health home requirements in the manner described below*. Health home providers must provide written documentation that clearly demonstrates how the requirements are being met.

* Please note whenever the individual/ patient /enrollee is stated when applicable, the term is interchangeable with guardian.

<p>I. Comprehensive Care Management</p> <p>Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.</p> <p>1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.</p> <p>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.</p> <p>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.</p> <p>1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.</p> <p>1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.</p> <p>1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.</p> <p>1g. The individual's plan of care must included outreach and engagement activities that will support engaging patients in care and promoting continuity of care.</p> <p>1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.</p>
<p>II. Care Coordination and Health Promotion</p> <p>2a. The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.</p> <p>2b. The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.</p> <p>2c. The health home provider must describe the relationship and communication</p>

between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.

2e. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

2f. The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

2g. The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.

2h. The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

2i. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

2j. The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.

2k. The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

III. Comprehensive Transitional Care

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

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

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

3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager

verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.

IV. Patient and Family Support

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

4b. Patient’s individualized plan of care is accessible to the individual and their families or other caregivers based on the individual’s preference.

4c. The health home provider utilizes peer supports, support groups and self-care programs to increase patients’ knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.

4d. The health home provider discusses advance directives with enrollees and their families or caregivers.

4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

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

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

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

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available HIT and accesses 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 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. One example of such a tool is PSYCKES.

VII. Quality Measures Reporting to State

7a. The health home provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by NYS and CMS.

7b. The health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes as measured by NYS and CMS required quality measures.

Health home provider functional requirements (SMD 10-024)

Health home providers must demonstrate their ability to perform each of the following functional requirements. Document the processes used to perform these functions and the processes and timeframes used to assure service delivery takes place in the described manner. Documentation should also include a description of the proposed multifaceted health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensure patients appropriate access to the continuum of physical and behavioral health care and social services needs.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.

3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
4. Coordinate and provide access to mental health and substance abuse services.
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
8. Coordinate and provide access to long-term care supports and services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.