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Provider Qualification Standard	Provider Qualification Criteria	Additional Requirements	Review Criteria
I. Comprehensive Care Management:			
<p>1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency, and social service needs is developed.</p>	<p>Policy in place: Y/N</p> <p>Assessment includes the following elements:</p> <p>Medical _____</p> <p>Mental Health _____</p> <p>Chemical Dependency _____</p> <p>Social Service needs _____</p> <p>Initial POC, annual POC, interim POC _____</p> <p>Policy in place: Y/N</p> <p>Health Home and its care management agencies ensure enrollees meet eligibility criteria for Health Home services (two chronic</p>	<p>Health Home member records include a completed and timely FACT-GP and Functional Assessment completed initially and annually, and a comprehensive assessment completed upon enrollment and as determined by Health Home policy.</p> <p>(Section 4.3 Health Homes Provider Manual Version 2014-1)</p> <p>In determining member Medicaid eligibility, the provider is responsible to review the type of Medicaid coverage authorized, as well as any restrictions that may exist.</p> <p>(Section 6.1, Health Homes Provider Manual Version 2014-1)</p> <p>Health Home and its care management agencies ensure enrollees meet eligibility criteria for Health Home services (two chronic conditions or one single qualifying condition of HIV or SMI) and meet appropriateness criteria for Health Home services.</p> <p>Reference: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_hh_eligibility_policy.pdf</p>	<p>Requirements met:</p> <p><i>Obtain a copy of the Comprehensive Assessment template used by the Health Home, and frequency (if no template, Health Home is able to explain how assessment usage is regulated) _____</i></p>

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	<p>conditions or one single qualifying condition of HIV or SMI) and meet appropriateness criteria for Health Home services _____</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>Policy in place: Y/N</p> <p>Plan of Care includes the following elements:</p> <p>Medical _____</p> <p>Behavioral Health _____</p> <p>Rehabilitative _____</p>	<p>Additional Health Home Requirements</p> <p>B9. For all individuals enrolled in a Health Home, the plan of care must include the following specific elements:</p> <ul style="list-style-type: none"> a. The individual's stated Goal(s) related to treatment, wellness and recovery b. The individual's Preferences and Strengths related to treatment, wellness and recovery goals; c. Functional Needs related to treatment, wellness and recovery goals d. Key Community Networks and Supports; e. Description of planned Care Management Interventions and Time Frames; f. The individual's Signature documenting agreement with the plan of care; and g. Documentation of participation by all Key Providers in the development of the plan of care. 	<p>Requirements met:</p>

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Provider Qualification Standard	Provider Qualification Criteria	Additional Requirements	Review Criteria
	<p>Long Term Care _____</p> <p>Social Service Needs _____</p> <p>Identification of providers _____</p> <p>Managed Care Plan Contacts _____</p>	<p>B16. Health Homes shall ensure that the approved plan of care is reassessed at least annually and more frequently when warranted by a significant change in the member's medical and/or behavioral health condition. Such reassessment shall document the member's progress in meeting his or her goals from prior plans of care and shall be documented in the member's record.</p> <p>B17. The plan of care should be developed by experienced and qualified individuals.</p> <p>A separate care management record must be maintained for each member served and for whom reimbursement is claimed. In addition to the record requirements, the care record must contain:</p> <ul style="list-style-type: none"> • A copy of the member's signed consent form (DOH-5055); • An initial comprehensive assessment will be required. Reassessment will be required annually and/or if there is a significant change in the member's health/behavioral health or social needs status; • The FACT-GP© and the Health Home Functional Assessment is also required and should be administered at time of enrollment, annually and upon discharge from the Health Home • The initial care management plan and subsequent updates, containing goals, objectives, time frames, 	<p><i>Obtain a copy of Health Home's template of Care Plan (if no template, Health Home is able to explain how Care Plan usage is regulated) _____</i></p>

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		<p>etc. as agreed to by the member and the care manager</p> <ul style="list-style-type: none"> • Copies of any releases of information signed by the member; and • Medical/behavioral health and social service referrals made. <p>(Section 9.2, Health Homes Provider Manual Version 2014-1)</p>	
<p>1c. The individual (or their guardian) plays 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>Policy in place: Y/N</p> <p>Statement of agreement/Signature of individual or Guardian _____</p>		<p>Requirements met:</p>

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<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>Policy in place Y/N</p> <p>Plan of care addresses needs of member _____</p>		<p>Requirements met:</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>Policy in place: Y/N</p> <p>Family Member/Other Supports _____</p> <p>Involvement in care plan _____</p>		<p>Requirements met:</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>Policy in place: Y/N</p> <p>Goals _____</p> <p>Timeframes _____</p> <p>Interventions _____</p> <p>Strengths _____</p> <p>Functional Needed _____</p> <p>Member's Signature _____</p>		<p>Requirements met:</p>
<p>1g. The individual's plan of care must include outreach and engagement activities that will</p>	<p>Policy in place: Y/N</p>	<p>Progressive outreach is conducted as described in the Medicaid Update Special Edition.</p>	<p>Requirements met:</p>

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<p>support engaging patients in care and promoting continuity of care.</p>	<p>Outreach is active, ongoing, and progressive ____</p> <p>Engagement is active, ongoing, and progressive ____</p> <p>Role of Managed Care has been included in policy ____</p>	<p>http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-11_spec_ed_final.pdf</p> <p>An outreach and engagement per member per month (PMPM) payment will be available for three months. If outreach and engagement is unsuccessful (defined as neither locating nor engaging the member during or after the three month period), the provider may continue outreach and engagement, but is not eligible to bill again for these activities until an interval of at least three months has elapsed since billing for outreach and engagement.</p> <p>Section 6.4, Health Homes Provider Manual Version 2014-1)</p> <p>Outreach letters must conform with the templates on the Health Home website</p> <p>Reference:</p> <p>http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/templates.htm</p>	

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		<p>•April 2012 Special Edition page 9:Introducing Health Homes - Improving Care for Medicaid Recipients with Chronic Conditions (PDF, 4.2MB, 20pgs.)</p>	<p>Obtain copy of the Outreach letter template(s) used by the Health Home to assure conformance with the templates on the Health Home website_____</p>

II. Care Coordination and Health Promotion:

<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>Policy in place: Y/N</p> <p>Coordination of Health Home services _____</p> <p>Support adherence to treatment recommendations _____</p> <p>Monitor patients' needs _____</p> <p>Evaluate patients' needs (prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services) _____</p> <p>Managed Care Involvement _____</p>	<p>Additional Health Home Requirements</p> <p>B1. Lead Health Homes must identify a single point of contact and establish communication protocols with Managed Care Organizations (MCOs).</p> <p>a) Health Homes must use information and performance data, including outreach and enrollment data, dashboards and other data made available through Medicaid Analytic Performance Portal (MAPP), and hold periodic meetings with care managers and MCOs to evaluate and improve performance.</p> <p>b) Health Homes should ensure care managers have access to other pertinent administrative data that may not be available in MAPP to inform real time decision making regarding outreach and engagement efforts.</p> <p>c) The Health Home should have an identified point of contact for community referrals including (but not limited to) those from Local Government Units (LGU's), inpatient settings, forensic releases, and community providers to coordinate timely linkage to a care manager, with special consideration for individuals receiving Assisted Outpatient Treatment</p>	<p>Requirements met:</p>
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	<p>FFS _____</p> <p>Arrangements are in place to accept referrals from hospitals and other providers as described _____</p>	<p>(AOT) and other specific populations as described in this document.</p> <p>B10. Health Homes that provide care management and direct services, must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.</p> <p>Federal authority to conduct Health Homes mandates that hospitals refer individuals with chronic conditions who seek care or need treatment in a hospital emergency department to Designated Health Home providers. Other referral sources may include the criminal justice system, court ordered patients for Assisted Outpatient Therapy (AOT), State prisons, county and city jails, mental health discharges/referrals from State operated psychiatric centers, Article 28 and 31 Hospitals, Managed Care Plans, Designated Health Homes, clinics, family members, health care providers, HIV providers, social service providers etc.</p> <p>The Health Home will accept referrals and follows the guidance described in the Medicaid Update Special Edition.</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</p>	<p>Policy in place: Y/N</p>	<p>Additional Health Home Requirements</p> <p>B6. Health Home care management providers must assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring Serious Mental Illness</p>	<p>Requirements met:</p>

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<p>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.</p>		<p>(SMI)/Substance Use Disorder (SUD) or co-morbid conditions, and patterns of acute service use.</p> <p>B14. Health Homes must provide care managers access to and information regarding training opportunities that include:</p> <ul style="list-style-type: none"> a) Marketing Health Home care management services; b) Typical care management needs of populations with multiple co-morbidities; c) Evidence-based methods for increasing engagement including Motivational Interviewing, Recovery-Oriented Practices, Person-centered Planning, role and benefits of Certified Peer Specialists/Peer Advocates and Wellness Recovery Action Plans; d) Outreach and engagement strategies for members who are disengaged from care or have difficulty adhering to treatment recommendations including individuals with histories of homelessness, criminal justice involvement, first-episode psychosis and transition-age youth; e) The availability and range of services that would be beneficial to Health Home members (e.g., Home and Community Based Services for HARP members and Assisted Outpatient Treatment); f) Training on any State required assessment tools. <p>Additional Health Home Requirements for AOT Enrollees</p> <p>C1. The Health Home will assign individuals to a Health Home care management provider within two business days from the day the MCO makes an assignment to the Health Home.</p>	
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		<p>C2. The Health Home care management provider will begin outreach within two business days after receipt of referral from a Health Home.</p> <p>C3. Individuals on AOT court orders must receive Health Home Plus services. Upon enrollment:</p> <ul style="list-style-type: none"> a) The Health Home care management provider must inform the Health Home when the recipient has been placed on court ordered AOT or when the court order has expired or has not been renewed (information provided in MAPP can be used to satisfy this requirement); b) The Health Home must inform the MCO of the member's AOT status (information provided in MAPP can be used to satisfy this requirement). <p>C4. Health Home care management providers working with court ordered AOT individuals must adhere to all Health Home Plus AOT Guidance issued by the State</p> <ul style="list-style-type: none"> a) Provide face-to-face contact four times per month b) Work with the LGU's AOT coordinator as per local policy; c) Comply with the court order and all statutory reporting requirements under Kendra's Law d) Have a caseload ratio no greater than 1:12 (i.e. 8.5% of a full-time Health Home care manager's available care management time if the caseload also includes non-Health Home Plus members. e) Meet the minimum personnel qualification standards listed in Health Home Plus guidance available at: http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf <p>C5. Health Home care managers must complete and submit all AOT reporting requirements to the Office of Mental Health (OMH) as required by AOT legislation</p>	<p>Requirements met:</p>
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		<p>and as currently reported in the OMH CAIRS (Child and Adult Integrated Reporting System).</p> <p>C6. Each Health Home must assure capacity to serve individuals receiving AOT. Individuals receiving AOT can be served by Care Management providers with the qualifications and experience as described above and in HH+ guidance, as well as through Assertive Community Treatment (ACT) teams.</p>	
<p>2c. The health home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).</p>	<p>Policy in place: Y/N</p> <p>Protection and appropriate release of Medicaid Confidential Data (MCD) _____</p> <p>PHI data send and receive process _____</p> <p>DEAAs in place _____</p> <p>BAAs in place _____</p>	<p>Designated Health Home providers have data exchange agreements with the Department, including the required subcontractor agreements with any network partners receiving member lists prior to members consenting to Health Home services.</p> <p>(Section 2.9, Health Homes Provider Manual Version 2014-1)</p>	<p>Requirements met:</p>
<p>2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.</p>	<p>Policy in place: Y/N</p> <p>Treatment conflicts defined _____</p>		

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	Managed Care Involvement_____		
<p>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.</p>	<p>Policy in place: Y/N</p> <p>Communication process between providers follows rules of sharing PHI _____</p> <p>Communication occurs between care manager, providers, and members _____</p> <p>MCO ASA in place _____</p>	<p>Health Homes are responsible for securing the completed member consent forms. New York State expects care managers to assist members in Health Homes in completing the Health Home Patient Information Sharing Consent Form, DOH 5055. Care managers should ensure members understand the form, read the form to the member, if necessary, and answer any questions.</p> <p>(Section 6.5, Health Homes Provider Manual Version 2014-1) DOH 5055, including any required translations, is used as described on the Health Home website _____.</p> <p>Consent is updated as required for new/changes in providers or others approved by member _____</p> <p>Consent updates are signed by member _____</p> <p>Reference: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/index.htm</p>	<p>Requirements met:</p>
<p>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.</p>	<p>Policy in place: Y/N</p>		

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<p>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.</p>	<p>Policy in place: Y/N</p> <p>Case Review meeting timeline _____</p> <p>Case Review notes _____</p> <p>Necessary providers are involved _____</p> <p>Managed Care Involvement _____</p>	<p>The protection and appropriate release of Medicaid Confidential Data (MCD) and protection of PHI _____</p>	
<p>2h. The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.</p>	<p>Policy in place: Y/N</p> <p>24/7 information is up to date _____</p> <p>24/7 access to services _____</p> <p>Emergency/consultation services _____</p> <p>Managed Care Involvement _____</p>		
<p>2i. The health home provider will ensure the availability of priority</p>	<p>Policy in place: Y/N</p>		

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<p>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.</p>	<p>Appointments are: Scheduled with Appropriate Provider____ Scheduled Timely____ Member Compliance____ Care Manager Follow Up____ Managed Care Involvement____</p>		
<p>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.</p>	<p>Policy in place: Y/N</p> <p>Wellness services ____</p> <p>Prevention services ____</p> <p>Managed Care services/disease management link ____</p>		

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<p>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</p>	<p>Policy in place: Y/N</p>		
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III. Comprehensive Transitional Care

<p>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.</p>	<p>Policy in place: Y/N</p> <p>Hospital Referral and notification system in place (both in network and out of network) ____</p> <p>Residential/rehabilitation facility referral and notification system in place (both in network and out of network) ____</p> <p>Demonstration done to confirm system in place ____</p> <p>Managed Care Notification to Health Home ____</p> <p>Health Home Notification to MCP ____</p>	<p>B2. Health Homes must have policies and procedures in place for responding when critical events occur, including when an enrollee 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) when the enrollee is in crisis and presents at a location that provides additional opportunities to outreach to an enrollee. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts ____</p> <p>Additional Health Home Requirements</p> <p>1. Ensure that Health Home care managers communicate with inpatient providers whenever a Health Home enrolled client is admitted (and the Health Home is notified of the admission) to share clinical information and support discharge planning;</p> <p>2. Define client subgroups for which Health Home care managers will be required to visit the client during hospitalization (when notified of the admission) and participate in care transition planning;</p>	<p>Requirements met:</p>
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		<p>3. Collaborate with Plans to develop and implement protocols for intensive care transition initiatives for identified high-need populations;</p> <p>4. Ensure that the client's primary medical practitioner and/or psychiatrist is/are notified whenever a client is admitted to an emergency department or inpatient setting, and that there is adequate communication between community based providers and the hospital treatment team;</p> <p>5. Create a tracking program to monitor all Health Home enrolled client hospitalizations. At a minimum, the Health Home should document the dates of admission, date the Health Home was notified, who made the notification (e.g., client, family, hospital, other provider, or Plan), when the Health Home care manager was informed, whether the Health Home care manager communicated with the inpatient treatment team, whether the Health Home care manager visited the client at the hospital prior to discharge, and the date of the Health Home care manager's initial contact with the client following admission.</p>	
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<p>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.</p>	<p>Policy in place: Y/N</p> <p>Safe transition plan for in-network _____</p> <p>Safe transition plan for non-network _____</p> <p>Managed Care Plan involved in plan _____</p> <p>"Warm Handoff" Plan is in place</p>	<p>Additional Health Home Requirements</p> <p>Health Homes should:</p> <ol style="list-style-type: none"> 1. Work with populations transitioning from the Criminal Justice System. 2. Ensure warm hand-off if client moves to another Health Home. 3. If Health Home is participating in the transition of Adult Home residents to supported housing in connection with the State stipulated settlement, necessary processes and procedures are in place. 	<p>Requirements met:</p>
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	<p>for the following provider types: Local practitioners _____ Emergency rooms _____ Hospitals _____ Residential/rehabilitation _____ Inpatient Settings _____ Forensic settings _____ Providers _____</p> <p>Discharges or disenrollment from the Health Home _____</p>	<p>Additional Health Home Requirements</p> <p>If a member chooses to be in a different Health Home, they should notify their MCP or assigned Designated Health Home immediately. The transfer would be effective the first day of the next month. The Health Homes involved needs to discuss the timing of the transfer.</p> <p>(Section 6.9, Health Homes Provider Manual Version 2014-1)</p> <p>Requests for transfer are acted upon promptly ____</p> <p>Health Homes discuss the transfer and ensure that member choice is acted upon ____</p> <p>Health Homes are responsible for securing the completed Opt Out form (DOH 5059) as appropriate _____</p> <p>New York State expects care managers to assist members in Health Homes in completing the Health Home Patient Information Sharing Withdrawal of Consent Form, DOH 5058 as appropriate.</p> <p>Health Home and care managers should ensure members understand the form(s), read the form(s) to the member, if necessary, and answer any questions.</p> <p>(Section 6.5, Health Homes Provider Manual Version 2014-1)</p>	
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<p>3c. 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.</p>	<p>Policy in place: Y/N</p> <p>Follow up protocol includes: Outpatient providers____ Reassessment of Plan of Care ____ Care Coordination Structure ____ Procedure in place to avoid duplication of services ____ Managed Care Involvement____</p>		
<p>IV. Patient and Family Support</p>			
<p>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.</p>	<p>Policy in place: Y/N</p> <p>Patient____ Family/caregiver (if applicable)____ Education____ Support for self-management____ Self-help recovery____ Other resources as appropriate____</p>	<p>Additional Health Home Requirements</p> <p>B9. For all individuals enrolled in a Health Home, the plan of care must include the following specific elements:</p> <ul style="list-style-type: none"> a. The individual’s stated Goal(s) related to treatment, wellness and recovery b. The individual’s Preferences and Strengths related to treatment, wellness and recovery goals; c. Functional Needs related to treatment, wellness and recovery goals d. Key Community Networks and Supports; 	<p>Requirements met:</p>

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		<p>e. Description of planned Care Management Interventions and Time Frames; f. The individual's Signature documenting agreement with the plan of care; and g. Documentation of participation by all Key Providers in the development of the plan of care.</p>	
<p>4b. Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.</p>	<p>Policy in place: Y/N</p> <p>Access to care plan exists for the following: Member _____ Designees _____ Care Manger _____ Managed Care Plan _____ Others approved by Member _____</p>	<p>Additional Health Home Requirements</p> <p>B9. For all individuals enrolled in a Health Home, the plan of care must include the following specific elements:</p> <p>a. The individual's stated Goal(s) related to treatment, wellness and recovery b. The individual's Preferences and Strengths related to treatment, wellness and recovery goals; c. Functional Needs related to treatment, wellness and recovery goals d. Key Community Networks and Supports; e. Description of planned Care Management Interventions and Time Frames; f. The individual's Signature documenting agreement with the plan of care; and g. Documentation of participation by all Key Providers in the development of the plan of care.</p>	<p>Requirements met:</p>
<p>Provider Qualification Standard</p>	<p>Provider Qualification Criteria</p>	<p>Additional Requirements and Interpretive Guidance</p>	<p>Review Criteria</p>
<p>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,</p>	<p>Policy in place: Y/N</p> <p>Use of peer supports, support groups, and self-care programs for: Care transition or "bridger" services</p>		

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<p>and to improve adherence to prescribed treatment.</p>	<p>for hospitalized patients____ Outreach and engagement for patients who are disengaged from care ____ Navigating access and coordination of primary care or needed specialty care services ____ Assisting family and other key persons supporting patient's engagement in care ____ Crisis management ____</p>		
<p>4d. The health home provider discusses advance directives with enrollees and their families or caregivers.</p>	<p>Policy in place: Y/N</p> <p>Discuss Advance Directives with Enrollee____ Assess if member has Advance Directives in place____ Inform member of right to have Advanced Directives ____</p>		
<p>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.</p>	<p>Policy in place: Y/N</p> <p>Interpreter services available (both language and literacy) ____ Cultural needs addressed ____ Managed Care Plan able to provide services based on cultural needs of member ____</p>		

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<p>4f. The health home provider gives the patient access to care plans and options for accessing clinical information.</p>	<p>Policy in place: Y/N</p> <p>Care plan access for member _____</p> <p>Clinical information access for member _____</p>		
<p>V. Referral to Community and Social Support Services</p>			
<p>5a. The health home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.</p>	<p>Policy in place: Y/N</p> <p>Referral process _____ Referral line in-place _____ List of community-based resources _____ Managed Care involvement _____ HCBS provided to the member _____ HCBS provided in community _____</p>	<p>Real time client referrals will be accepted by Health Homes. Client referral for Health Home services may come from a variety of sources. Referrals are expected from OMH Local Government Units (LGUs), including Director of Community Services Single Point of Access (SPOA), Local Department of Social Services (LDSS), New York City Human Resources Administration (HRA), NYC HIV/AIDS Services Administration (HASA), NYC Department of Health and Mental</p> <p>Health (DHMH) and health care facilities and other providers.</p> <p>(Section 7.1, Health Homes Provider Manual Version 2014-1)</p> <p>The Health Home accepts referrals from agencies and follows the guidance described in the Medicaid Update Special Edition _____</p>	

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		<p>Policies and procedures are in place for accepting and processing referrals from agencies_____</p>	<p>Requirements met:</p>
<p>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.</p>	<p>Policy in place: Y/N</p> <p>Contractual agreement list received by Health Home matches DOH list (Compare DOH list with Health Home list of DEAA and/or other appropriate agreements) _____</p>	<p>Additional Health Home Requirements,</p> <p>B8. The Health Home and MCO must establish clear lines of responsibility to ensure services are not duplicated.</p>	<p>Requirements met:</p>
<p>5c. The plan of care should include community-based, social support services as well as healthcare services that respond to the patient's needs and contribute to achieving the patient's goals.</p>	<p>Policy in place: Y/N</p> <p>Care plan has following services: Community-based _____ Social supports _____ Other services based on unique patient needs and goals _____</p>	<p>Additional Health Home Requirements</p> <p>B9. For all individuals enrolled in a Health Home, the plan of care must include the following specific elements: a. The individual's stated Goal(s) related to treatment, wellness and recovery b. The individual's Preferences and Strengths related to treatment, wellness and recovery goals; c. Functional Needs related to treatment, wellness and recovery goals d. Key Community Networks and Supports; e. Description of planned Care Management Interventions and Time Frames;</p>	<p>Requirements met:</p>

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		<p>f. The individual's Signature documenting agreement with the plan of care; and g. Documentation of participation by all Key Providers in the development of the plan of care.</p>	
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VI. Administrative Requirements

<p>A1 Measurement of the process and outcome of the Health Home Program will be necessary to understand the value of the overall program and the efficacy of any one component. Measurements also will guide any improvement process. Care management metrics will be assessed in two ways: process metrics collected using the HH-CMART described above, and quality outcome metrics. The New York State outcome metrics are provided in the SPA and will generally be derived by the Department of Health (DOH) using the Medicaid claims and encounter database. CMS has also issued Health Home Core Quality Measures for assessing the health home service delivery model.</p>	<p>Policy in place: Y/N</p> <p>Management of complaints and incidents as directed in guidance on the DOH Health Home website _____</p> <p>Health Home Webinar conducted October 1, 2014 with policy updates presented October 14, 2015. Policy posted on DOH HH website.</p>	<p>The Health Home has established a continuous quality improvement program, and collects and reports 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. (#11, CMS State Medical Director Letter) _____</p> <p>Health Home takes an active role in monitoring the quality of care management services provided by its network partners _____</p>	<p>Requirements met:</p>
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<p>(Section 4.5, Health Homes Provider Manual Version 2014-1)</p>			
<p>A2. Designated Health Homes provide the Department of Health an updated organizational partner list upon initial designation and on an ongoing basis as needed.</p> <p>(Section 2.5, Health Homes Provider Manual Version 2014-1)</p>	<p>Policy in place: Y/N</p> <p>Health Homes updates network of providers and supports ____</p> <p>Knowledge of and access to the Health Home network list by CMAs</p>		
<p>A3. If a Health Home intends on making changes to their originally approved Health Home application and designation letter then a Health Home Notification Letter attesting to the applicable revision(s) must be completed, signed by the Health Home CEO/Executive Director, and submitted to the Department of Health for review.</p>	<p>Policy in place: Y/N</p> <p>Acknowledging process for notification to DOH of any changes as per DOH policy _____</p>	<p>Health Home provides evidence that it is clearly identified in signage, agency's website, member and provider communications ____</p> <p>Health Home confirms that phone/referral line is in place and current ____</p> <p>Health Home to confirm that contacts are up to date as represented on the Health Home website _____</p>	<p>Requirements met:</p>

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<p>(Section 2.10, Health Homes Provider Manual Version 2014-1)</p>			
<p>A4. Rate codes are billed for Health Home services consistent with State Requirements</p>	<p>Policy in place: Y/N</p> <p>Supporting HH billing requirements _____</p>	<p>Health Homes must provide at least one of five core (exclusive of HIT) Health Home services per</p> <p>Month to meet minimum billing requirements. The mode of contact may include, but is not limited to: face to face meeting(s) (no minimum requirement), mailings, electronic media and telephone calls and case conferences.</p> <p>Active, ongoing and progressive engagement with the member must be documented in the care management record to demonstrate active progress towards outreach and engagement, care planning and/or the member achieving their personal goals. Except for member interviews to make assessments and plans, case contacts do not need to be all face-to-face encounters. They may include contacts with collaterals or service providers in fulfillment of the member's plan.</p> <p>The Health Home policies support active engagement with members _____</p>	<p>Requirements met:</p>

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		<p>Health Home policies exist to require face to face contacts with members to perform assessments and develop care plans _____</p> <p>Health Home requires that care managers have the appropriate expertise and credentials based upon defined characteristics of members, including, but not limited to, acuity, presence of co-occurring SMI/SUD or co-morbid conditions and patterns of acute service use _____</p> <p>Caseload size is appropriate to support active, ongoing and progressive engagement with the member and allow for sufficient contact for members who are in need of intensive outreach and support _____</p> <p>B13. Health Homes must submit claims to MCOs within 120 days after the date of service to be valid, however, there is nothing to preclude the MCOs and the Health Homes from agreeing to other terms which are more favorable to the Health Home. *</p>	
<p>A5. DOH will prioritize and assign fee for service members directly to Health Homes. DOH will provide MCPs with a suggested Health Home assignment for MCP members. MCPs are encouraged to use this information to supplement their own data for use in assigning their members to a Health Home.</p>	<p>Health Homes access assignment lists and make assignments to care management agencies promptly _____</p>	<p>Additional Health Home Requirements</p> <p>B5.As a best practice, after receipt of a referral from a Health Home, Health Home care management providers should begin outreach immediately if the Health Home sends an assignment list during the 1st to the 15th of the month. If Health Home sends an assignment list on the 16th of the month or later outreach can begin immediately or the following</p>	<p>Requirements met or alternative process in place that ensures prompt distribution of assignment lists (describe):</p>

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<p>(Section 6.3, Health Homes Provider Manual Version 2014-1)</p>		<p>month but no later than the 5th business day of the following month. Health Homes shall require documentation from Health Home care management providers regarding any failure of the care management provider to commence outreach.</p>	
<p>A6. A Health Home member is considered Lost to Services when the Health Home is no longer able to locate the member to provide Health Home services. Lost to Services will be determined pursuant to policies and standards established by each Designated Health Home.</p> <p>Health Homes must document in the member's care management record the date of determination of Lost to Services and follow-up attempts to contact while billing for outreach and engagement. The Health Home may bill for another three months of outreach.</p> <p>(Section 3.8 , Health Homes Provider Manual Version 2014-1)</p>	<p>Health Home has a policy to determine when members are lost to service _____</p> <p>Health Home members lost to services as defined by the Health Home are billed for outreach for an additional three months_____.</p>	<p>Additional Health Home Requirements</p> <p>B19.Health Homes shall undertake the following engagement efforts for members lost to follow-up:</p> <ul style="list-style-type: none"> a) The Health Home shall have policies and procedures to identify members who have not received a Health Home core service for a period of two (2) consecutive months; b) The Health Home shall have policies and procedures to ensure documentation of reasonable efforts by the Health Home to find members lost to follow-up and re-engage them; c) Upon request, the Health Home shall provide the State with documentation of Health Home's efforts to engage members in care; d) The Health Home shall make best efforts to conduct outreach to members who are homeless to assure that services are accessible and to identify and reduce barriers to treatment 	<p>Requirements met:</p>

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<p>A7. The Health Home should be engaging in activities to ensure adequate behavioral health leadership, supervisory capacity, and clinical experience for staff working with HARP members</p>	<p>Provide additional training for staff members working with HARP enrollees on:</p> <ul style="list-style-type: none"> a. The types and availability of HCBS Services _____ b. Assisted Outpatient Treatment _____ c. HCBS assessments _____ 		
<p>A8. The Health Home should have policies and procedures related to management of crises that describe how care managers identify and respond to crisis situations.</p>	<p>Policy in place: Y/N</p> <ul style="list-style-type: none"> 1. Identify potential stressors and triggers for crises and hospitalizations _____ 2. Identify persons and resources that provide support during crises and coach client to use these _____ 3. Will be available for 24 hour response to clients in crisis. _____ 		