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

Managed Care Organization (MCO)

There can be multiple Health Home in an area / region

ASA Required between the MCO and the HH if there is a relationship

Lead Health Home (HH) A

CMA1  CMA 2  CMA 3  CMA 4  CMA 5  CMA 6  CMA 7

BAA Required between each HH and CMA if there is a relationship

BAA Required between each HH and CMA if there is a relationship

CMA8  CMA 9  CMA 10

Care Management Agencies (CMAs)

BAA Required between each HH and CMA if there is a relationship

The CMA can have a relationship with multiple Health Homes and would need a BAA with each

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 Homes Provide Six Core Care Management Functions

- Comprehensive Care Management
- Comprehensive Transitional Care
- Referral to Community and Social Supports Services
- Patient and Family Support
- Care Coordination and Health Promotion
- Health Information Technology

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

### 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

---

### 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).

---

*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.

---

**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.)
Many aspects of a child’s healthy physical and mental development rely on this secure attachment, a primary source of safety and stability. Wide-ranging, long-term adverse effects can include impairments in: physiological responses and related neurodevelopment, emotional responses, cognitive processes including the ability to think, learn, and concentrate, impulse control and other self-regulating behavior, self-image, relationships with others, and 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

- Physical Health
- Behavioral Health (Mental Health, Substance Use Services)
- School Supportive Services
- Referrals: community & social support
- HH Care Manager
- Patient & family support
- Transitional care services

Child/family

Patient & family support
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 an 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 benchmarks
- 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

School
- CPSE/CSE, Social Worker, School Nurse Guidance, IEP, 504-plan

Integration of Services providing better communication, effective treatment & cost reduction

Health Home Care manager
- POC
- Medical & Behavioral services
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
  o 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

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.)
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.

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

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

The elements of Care planning are consistent with meeting the six core HH services.
<table>
<thead>
<tr>
<th>Health Home</th>
<th>Counties Designated to Serve Children</th>
<th>Designated Contact for Children's Designated Health Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adirondack Health Institute, Inc.</td>
<td>Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington</td>
<td>Emily Walter <a href="mailto:ewalter@ahihealth.org">ewalter@ahihealth.org</a> (518) 480-0111 Ext. 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sarah Colvin <a href="mailto:scolvin@ahihealth.org">scolvin@ahihealth.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tonya Brown <a href="mailto:tbrown@ccbc.net">tbrown@ccbc.net</a> (607) 729-9166</td>
</tr>
<tr>
<td>Central New York Health Home Network (CNYHHN Inc.)</td>
<td>Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence</td>
<td>Jane Vail <a href="mailto:Jane.vail@cnyhealthhome.net">Jane.vail@cnyhealthhome.net</a> (315)797-9057 ext.278</td>
</tr>
<tr>
<td>Health Home</td>
<td>Counties Designated to Serve Children</td>
<td>Designated Contact for Children’s Designated Health Home</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Children’s Health Home of Western New York dba Oishei Healthy Kids</td>
<td>Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming</td>
<td>Momba Chia</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:mchia@kaleidahealth.org">mchia@kaleidahealth.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O:716-878-7807</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C:716-359-2390</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kirsten Newby</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:knewby@kaleidahealth.org">knewby@kaleidahealth.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O: 716-878-1354</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 716-364-2380</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:nbryl@hhuny.org">nbryl@hhuny.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O: 585-613-7644</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 716-572-9858</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Donna Fiscella</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:dfiscella@childrenshealthhome.org">dfiscella@childrenshealthhome.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O: 315-632-6195</td>
</tr>
<tr>
<td>Health Home</td>
<td>Counties Designated to Serve Children</td>
<td>Designated Contact for Children’s Designated Health Home</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Collaborative for Children and Families</td>
<td>Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester</td>
<td>Jodi Saitowitz</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:jsaitowitz@ccfhh.org">jsaitowitz@ccfhh.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O: 646-459-3971</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: (917) 213-0130</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lisa Peterson</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Lpeterson@ccfhh.org">Lpeterson@ccfhh.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O: 646-459-3972</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 646-799-8284</td>
</tr>
<tr>
<td>Community Care Management Partners, LLC (CCMP)</td>
<td>Bronx, Brooklyn, Manhattan, Queens</td>
<td>Phil Opatz</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Phil.opatz@vnsny.org">Phil.opatz@vnsny.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>O:212-290-6467</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: 347-452-9557</td>
</tr>
<tr>
<td>Coordinated Behavioral Care, Inc. dba Pathways</td>
<td>Bronx, Brooklyn, Manhattan, Queens, Staten Island</td>
<td>Amanda Semidey</td>
</tr>
<tr>
<td>to Wellness Health Home</td>
<td></td>
<td><a href="mailto:ASemidey@cbcare.org">ASemidey@cbcare.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>646-930-8835</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Janelle Chambers</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:JChambers@cbcare.org">JChambers@cbcare.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>646-930-8851</td>
</tr>
<tr>
<td>Health Home</td>
<td>Counties Designated to Serve Children</td>
<td>Designated Contact for Children’s Designated Health Home</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Greater Rochester Health Home Network LLC</td>
<td>Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming</td>
<td>Deb Peartree <a href="mailto:dpeartree@therihn.org">dpeartree@therihn.org</a> (585) 737-7522</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ann Potter <a href="mailto:apotter@therihn.org">apotter@therihn.org</a> (585)-350-1408</td>
</tr>
<tr>
<td>Hudson River HealthCare, Inc. dba Community Health Care Collaborative</td>
<td>Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Westchester, Nassau, Suffolk</td>
<td>Andrea Hopkins <a href="mailto:ahopkins@hrhcare.org">ahopkins@hrhcare.org</a> 845-803-3479</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Katie Clay <a href="mailto:kclay@HRHCARE.ORG">kclay@HRHCARE.ORG</a> 914-734-8513</td>
</tr>
<tr>
<td>Institute for Family Health</td>
<td>Ulster</td>
<td>Michaela Frazier – Director <a href="mailto:mifrazier@institute.org">mifrazier@institute.org</a> O: 206-206-5200 x1360 C: 917-831-0334</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melissa Martinez – Director <a href="mailto:mmartinez@institute.org">mmartinez@institute.org</a> O:845-255-2930 C:347-947-0667</td>
</tr>
<tr>
<td>Health Home</td>
<td>Counties Designated to Serve Children</td>
<td>Designated Contact for Children’s Designated Health Home</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home</td>
<td>Bronx</td>
<td>Antonette Mentor&lt;br&gt;<a href="mailto:amentor@monterfiore.org">amentor@monterfiore.org</a>&lt;br&gt;914-378-6086</td>
</tr>
<tr>
<td>Niagara Falls Memorial Medical Center</td>
<td>Niagara</td>
<td>Vicki Landes&lt;br&gt;<a href="mailto:Vicki.landes@nfmmc.org">Vicki.landes@nfmmc.org</a>&lt;br&gt;(716) 278-4147&lt;br&gt;Jennifer Mruk&lt;br&gt;<a href="mailto:Jennifer.mruk@nfmmc.org">Jennifer.mruk@nfmmc.org</a>&lt;br&gt;(716) 278-4647</td>
</tr>
<tr>
<td>Northwell Health Home</td>
<td>Queens, Nassau, Suffolk</td>
<td>Christina Alonso&lt;br&gt;<a href="mailto:Calonso1@northwell.edu">Calonso1@northwell.edu</a>&lt;br&gt;Office Phone: (516) 600-1128&lt;br&gt;Cellular Phone: (516) 287-6046</td>
</tr>
<tr>
<td>Health Home</td>
<td>Counties Designated to Serve Children</td>
<td>Designated Contact for Children’s Designated Health Home</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Mount Sinai Health Home**       | Bronx, Brooklyn, Manhattan, Queens, Staten Island | Alicia Korpi  
Alicia.korpi@moutnsinai.org  
O:212-731-7841  
C:646-856-5667  
Arhima Jacobs  
Arhima.jacobs@moutnsinai.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

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

Health Home Consent Information Sharing
Release of Educational Records (DOH 5203)
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 to the absence of a parent or a guardian (24 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[b][f]). A person in parental relation to another individual shall include his father or mother, by birth or adoption, his stepfather or stepmother, his legally appointed guardian, or his custodian. A person shall be regarded as the custodian of another individual if he has assumed the care and control of such individual because the parents or legally appointed guardian of such individual have died, 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 of the child’s residence, are unknown (ECL § 322). 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, step-parent, 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 office or school district to make educational decisions on behalf of the infant/child or student (10 NYCRR § 441.1[a]). A parent does not include the State if the infant/child or student is a ward of the State (8 NYCRR §200.1[b][3][f]).

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?

4. What laws and rules cover this child’s educational information?

Third party laws and regulations include the Federal Family Education Rights and Privacy Act (FERA) (20 U.S.C. 1232g) and its implementing regulations, the New York State Education Law (NYSL) and its implementing regulations covering the Early Intervention Program (18 NYCRR § 441.7 et seq.) and its implementing regulations at 34 CFR 300.600 through 300.650 and 20 U.S.C. 1232g).

5. Who can get and see this educational information after I withdraw this consent?
As of the date this form is signed, these included on this form will no longer get any new educational information that has already been shared cannot be asked for.

6. What if a person uses this educational information without permission?
If you think a person used this educational information without permission, you must sign a written complaint with the Family Policy Compliance Office under the Family Educational Rights and Privacy Act (FERA) in the following address:

U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-8320

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 can I get a copy of this form?
After you sign this Withdrawal of Release of Educational Records, a copy will be given to you.
Resources
Health Home Serving Children (HHSC) Website
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:
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
<table>
<thead>
<tr>
<th>Health Home</th>
<th>Designated to Serve Children</th>
<th>Current Designation to Serve Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central New York Health Home Network (CNYHHN Inc.)</td>
<td>Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence</td>
<td>Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence</td>
</tr>
<tr>
<td>Children's Health Home of Western New York dba Oishei Healthy Kids</td>
<td>Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming</td>
<td>N/A</td>
</tr>
<tr>
<td>Health Home</td>
<td>Designated to Serve Children</td>
<td>Current Designation to Serve Adults</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Collaborative for Children and Families</td>
<td>Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester</td>
<td>N/A</td>
</tr>
<tr>
<td>Community Care Management Partners, LLC (CCMP)</td>
<td>Bronx, Brooklyn, Manhattan, Queens</td>
<td>Bronx, Manhattan</td>
</tr>
<tr>
<td>Coordinated Behavioral Care, Inc.</td>
<td>Bronx, Brooklyn, Manhattan, Queens, Staten Island</td>
<td>Brooklyn, Manhattan, Staten Island</td>
</tr>
<tr>
<td>Health Home</td>
<td>Designated to Serve Children</td>
<td>Current Designation to Serve Adults</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Hudson River HealthCare, Inc. dba Community Health Care Collaborative</td>
<td>Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Nassau, Suffolk Sullivan, Westchester</td>
<td>Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Nassau, Suffolk, Sullivan, Westchester</td>
</tr>
<tr>
<td>Institute for Family Health</td>
<td>Ulster</td>
<td>Ulster</td>
</tr>
<tr>
<td>Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home</td>
<td>Bronx</td>
<td>Bronx</td>
</tr>
<tr>
<td>Health Home</td>
<td>Designated to Serve Children</td>
<td>Current Designation to Serve Adults</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Mount Sinai Health Home Serving Children</td>
<td>Bronx, Brooklyn, Manhattan, Queens, Staten Island</td>
<td>Manhattan</td>
</tr>
<tr>
<td>Niagara Falls Memorial Medical Center</td>
<td>Niagara</td>
<td>Niagara</td>
</tr>
<tr>
<td>Northwell Health Home</td>
<td>Queens, Nassau, Suffolk</td>
<td>Queens, Nassau, Suffolk</td>
</tr>
<tr>
<td>St. Mary’s Healthcare</td>
<td>Fulton, Montgomery</td>
<td>Fulton, Montgomery</td>
</tr>
</tbody>
</table>