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Proposed Interpretative Guidance for Health Home Provider Standards

NYS DOH, OMH, and OASAS request input from the Health Home MCO Work Group on the development of standards and best practices for the provisions of Health Home Services to members enrolled in mainstream Managed Care Plans and Health and Recovery Plans. The State Agency partners are proposing that the following standards be implemented as best practices and that timelines and approaches for possibly incorporating such standards and best practices in the ASA be discussed. The proposed new standards build upon the following existing requirements:

1. Existing ASA Agreements

2. Existing standards and qualifications for Health Homes including:
   a. Health Home Provider Qualifications; available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm
   b. Section 1945(h)(4) of the Social Security Act, Health Home Definition; available at: http://www.ssa.gov/OP_Home/ssact/title19/1945.htm

3. Previously posted DOH guidance regarding Managed Care Roles and Responsibilities; available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm

4. Managed care organization (MCO) standards related to Health Home care management that are being incorporated into MCO contracts as part of the 2015 behavioral health MCO rollout.

Proposed new interpretative guidance pertains to Health Home services for all Health Home eligible members, Health and Recovery Plan (HARP) enrollees, and Health Home Plus members.

PLEASE NOTE:

- The proposed guidance is not intended to prevent Health Homes and Plans from adding other guidance or elements to the ASA for which the Health Home and the Plan mutually agree.
- This document will be updated to incorporate future guidance related to Health Home care management activities for children and adolescents.

A. Identification and Outreach to Eligible Members

Reference standards: *Health Home ASA Article II, 2.2a*
Proposed interpretive guidance:

All Health Home Eligible Members	HARP Enrollees
The Health Home should: 1. Hire staff with experience locating and providing outreach to difficult to engage members; 2. Assign care managers to members based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring SMI/SUD or co-morbid conditions, and patterns of acute service use; 3. Use individuals with lived experience (peers) to support outreach and engagement; 4. Ensure that care managers have access to Health Home administrative data to inform real-time decision making regarding outreach and engagement efforts; 5. Communicate with managed care organization (Plan) staff to review Plan data regarding behavioral and general medical/surgical service use as indicated to support outreach and engagement; 6. Have communication protocols in place with Plans that allow Plan staff to contact the Health Home when the Plan is informed by a hospital of a member's admission to an emergency department or behavioral health inpatient unit; 7. Monitor the timeliness and success of care manager outreach and engagement efforts. The Health Home should track how outreach and engagement vary by member demographics, clinical characteristics and key social characteristics including housing stability/homelessness and criminal justice	1. Health Home staff working with difficult to engage HARP members should have experience working with individuals with serious mental illness and/or serious substance use disorders. 2. Health Homes should use behavioral health peers to support outreach and engagement for HARP enrollees. Health Home Plus 1. Health Home care managers working with Health Home Plus members must have a caseload ratio no greater than 1 staff to 12 Health Home Plus recipients – that is, each AOT/Health Home Plus will represent 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. 2. Care management provided to Health Home Plus members will always be delivered by a Health Home Care Management (HHCM) provider that prior to the Health Home initiative was an OMH-certified Targeted Care Management provider (HHCM legacy provider). 3. Individuals with Assisted Outpatient Treatment (AOT) court orders must receive Health Home Plus services. Upon enrollment: a. AOT individuals should either already be receiving CM services via a HHCM legacy provider or must be assigned to a legacy HHCM provider via the LGU AOT process; b. The legacy HHCM provider must inform the Health Home when the recipient has been placed on court ordered AOT or

involvement. The Health Home should also track outcomes broken out by care manager, provider agency, and Plan membership. The Health Home should use such tracking data to refine internal operations and guide quality assurance activities; 8. Have a process to evaluate and support performance improvement efforts for individual provider agencies based upon data reports describing timeliness and success of outreach and engagement efforts; 9. Have a process to share provider agency performance reports with managed care plans to support quality and performance improvement efforts.	when the court order has expired or has not been renewed; c. The Health Home must inform the Managed Care Plan of the member's AOT status. 4. Health Home care managers working with court ordered AOT individuals must: a. Provide face-to-face contact at least once a week; b. Work with the LGU's AOT coordinator as per local policy; c. Comply with all statutory reporting requirements under Kendra's Law. 5. Upon assignment of a new member with court ordered AOT to the Health Home, the Health Home must immediately assign the member to a care manager and begin providing Health Home Plus services. 6. Health Home care managers must ensure that transitions and service engagement comply with the members' AOT court order. 7. Health Home care managers must complete all AOT reporting to OMH as required by AOT legislation and as currently reported in the OMH CAIRS data system.

B. Comprehensive Assessment

Reference standards: *Health Home ASA Article II, 2.2b; Health Home Provider Qualifications, 1a*
Proposed interpretive guidance:

HARP Enrollees
1. For HARP members who are eligible for Home and Community Based Services, Health Home care managers will complete HCBS assessments. 2. HCBS reassessments must occur at least annually or when there is a change in status (such as inpatient admission) for HARP members receiving HCBS.

C. Plan of Care

Reference standards: *Health Home ASA Article II, 2.2d and 2.2e; Health Home Provider Qualifications, 1b—1h*
Proposed interpretive guidance:

All Health Home Eligible Members	HARP Enrollees
The Health Home Plan of Care should: 1. List all healthcare providers serving the member, including contact information; 2. Identify and provide contact information for the healthcare practitioner who is the member's primary treatment coordinator; 3. Document the member's goals, preferences, strengths, and needs in the Health Home Plan of Care, as well as recommended services; 4. Be completed within a reasonable time period that is defined in the Health Home's Plan of Care Policy and Procedures; 5. Be updated at least annually and whenever there is a significant change in the member's clinical status and/or social supports. Updates must include an assessment of the member's progress achieving identified goals.	When HCBS are being recommended for HARP enrollees, the Health Home Plan of Care additionally must: 1. Be completed within timelines established by NYS; 2. Include recommendation for specific HCBS that target the member's goals, needs and preferences.

D. Care Transitions

Reference standards: *Health Home ASA Article I, "Health Home Services" #3; Health Home Provider Qualifications, 2e, 2k, 3a, 3b*
Proposed interpretive guidance:

All Health Home Eligible Members

The Health Home should:

1. Ensure that Health Home care managers communicate with inpatient providers whenever a Health Home enrolled member is admitted (and the Health Home is notified of the admission) to share clinical information and support discharge planning;
2. Define high-risk member subpopulations (e.g., those with multiple recent prior hospitalizations/emergency room visits) for which Health Home care managers will be required to visit the member during hospitalization (when notified of the admission) and participate in care transition planning;
3. Collaborate with Plans to develop and implement protocols for intensive care transition initiatives for identified high-need populations;
4. Ensure that the member's primary medical and behavioral health practitioner(s) is/are notified whenever a member is admitted to an emergency department or inpatient setting, and that there is adequate communication between community based providers and the hospital treatment team;
5. Create a tracking program to monitor all Health Home enrolled member 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., member, 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 member at the hospital prior to discharge, and the date of the Health Home care manager's initial contact with the member following admission;
6. Work with NYS and counties to implement reentry programs for individuals transitioning from the criminal justice system;
7. Ensure warm hand-off including sharing assessment and care plan if member moves to another Health Home.

E. Member Referral and Follow-up

Reference standards: *Health Home ASA Article I, "Health Home Services"#5 and #6; Health Home Provider Qualifications, 3d and 5a—5c*
Proposed interpretive guidance:

All Health Home Eligible Members

The Health Home care manager should:

1. Contact members within 48 hours of discharge from an inpatient unit (when notified of the admission), or sooner if clinically indicated, to facilitate the care transition. This communication should include review of upcoming appointment dates and times, medication reconciliation and prescription refills, and potential obstacles to attending follow-up visits and adhering to treatment plan;
2. For Detox discharge the Health Home should attempt to make face-to-face contact during the stay and within 24 hours of discharge to ensure that the patient is aware of follow-up appointments and to provide supports to getting to appointments.

The Health Home should have policies and procedures related to management of crises that describe how care managers:

1. Identify potential stressors and triggers for crises and hospitalizations;
2. Identify persons and resources that provide support during crises and coach member to use these.

F. Staffing/Access

Reference standards: *Health Home Provider Qualifications, 2b, 2h, 2i*
Proposed interpretive guidance:

All Health Home Eligible Members	HARP Enrollees
The Health Home should: 1. Provide training on: a. Typical care coordination needs of populations with multiple co-morbidities; b. Evidence-based methods for increasing engagement including Motivational Interviewing, recovery-oriented practices, person-centered planning, role and benefits of certified peer specialists and Wellness Recovery Action Plans; c. Outreach and engagement strategies for members who are disengaged from care or have difficulty adhering to treatment recommendations including individuals with history of homelessness and criminal justice involvement; d. Availability and range of services that would be beneficial to Health Home members.	The Health Home should: 1. Provide additional training for staff members working with HARP enrollees on: a. The types and availability of Home and Community Based Services b. Assisted Outpatient Treatment c. HCBS Eligibility Screening & Assessments 2. Ensure adequate behavioral health leadership, supervisory capacity, and clinical experience for staff working with HARP members; 3. Ensure that Health Home staff working with difficult to engage HARP members have experience working with this population; 4. Ensure that Health Home Care Managers conducting HCBS assessments meet NYS qualifications. Health Home Plus Health Home care managers assigned to Health Home Plus members must meet the minimum qualification standards listed in Health Home Plus

2. Determine care manager caseloads based upon defined characteristics including, but not limited to, acuity, presence of co-occurring SMI/SUD or co-morbid conditions, patterns of acute service use, and care manager expertise. 3. Ensure that the caseload size is sufficient to allow for in person contact for Health Home members who are in need of intensive outreach and support.	guidance available at: http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf regarding: 1. Education**:** Bachelor's degree in a listed field (see guidance); OR NYS teacher's certificate for which a bachelor's degree is required; OR NYS licensure and registration as a Registered Nurse and a bachelor's degree. 2. Experience: Four years of experience either: Providing direct services to mentally disabled members; OR Linking mentally disabled members to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing, and financial services). A master's degree in a listed field (see guidance) may be substituted for two years of experience.

G. Patient Registry and Electronic Health Records

Reference standards: *Health Home Provider Qualifications, 6a—6i*
Proposed interpretive guidance:

All Health Home Eligible Members

The Health Home should have policies and procedures that describe:

1. Its HIT and electronic health record capabilities for:
   a. Making data regarding past use of general medical and behavioral health services available to care managers to support care planning and coordination; and
   b. Ensuring that care plans and service use information can be readily exchanged and accessible to other providers serving the member;
2. How it will use data for predictive modeling and risk stratification to identify members in need of enhanced monitoring and outreach;
3. How it will identify high-need members with notification flags in its electronic health record;
4. How it will ensure that all relevant privacy standards for data exchange are met.