NEW YORK STATE | Department of Health

# Equity Infrastructure Program: Participation in Expanded Health Home Enrollment Guidance Document

Updated: May 9, 2017

| | Required Evidence | Supporting Documentation of Activity Completion | Documentation Should Show |
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| **Participation in Expanded HH Enrollment** | Provide the following evidence (1) Develop a PPS-wide Health Home (HH) referral policy and procedure document **and** (2) show evidence of distribution and education on policy and procedure.<br><br>Evidence that average member time in outreach is reduced for Health Homes associated with the PPS as a result of improved cooperation of PPS partners | 1. Provide a copy of the developed PPS HH referral policy and procedure that includes HH eligibility criteria, referral process requirements and requirements for cooperation between PPS partners. (One-time deliverable).<br>**-AND-**<br>2. Document the distribution of the policy throughout the PPS including CBOs. Documentation should include process for direct distribution and/or posting on PPS website with PPS wide notification. (One-time deliverable).<br><br>3. Document the number of new HH eligible members in outreach by month from beginning of EIP program.<br><br>4. Document decreased length of time in outreach for new HH members based upon claims submitted for payment. (Ex: For each member engaged in a HH during a measurement month, document the number of prior months' claims were submitted for outreach activities). This should be documented monthly since inception of EIP program. | 1. Well-developed and inclusive policy.<br><br>2. Expectation that distribution will be widespread and includes CBOs, primary care practices and hospitals including ERs.<br><br>3. Show ongoing number of referrals. While there will be month to month variation, it should not taper off.<br><br>4. Show outreach time will decrease; expect a number of referrals should result in engagement within the same month. |
| | Programmatic documents associated with the implementation of a sustained community education program regarding Health Homes. CBOs are expected to be | 1. Document the specific activities undertaken each month to educate the community regarding Health Homes. Provide copies of any durable educational materials that have been produced.<br><br>2. Provide documentation of number of CBOs that were out reached to compared | 1. Show an ongoing number of community based activities including activities at CBOs, community activity sites such as Y's, churches, synagogues, mosques.<br><br>2. Show that Majority of CBOs should have been educated; hot spotting can be allowed but should not be exclusive. |

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| **Participation in Expanded HH Enrollment** | in partnership with Health Homes and provide support, but not duplicate activities supported by Health Home Development Funds. | to the total number of CBOs in the PPS. If specific CBOs were targeted, provide the rationale. (One-time deliverable)<br><br>3. Document number of persons referred to Health Homes from CBOs or assisted by the CBOs to enroll in Health Homes by month. | 3. Expect to see meaningful number of on-going referrals (with month to month variation, but referral should not taper off) |
| | Evidence of Health Home training sessions, including training on HARPs, provided to medical and mental health providers | 1. Provide documentation of the curriculum developed for Health Home training sessions including training on HARPs. (One-time deliverable)<br><br>2. Provide documentation outlining the training process undertaken in the PPS. If there was selectiveness in the training process, document the rationale. (One-time deliverable)<br><br>3. Provide numbers of trained medical and mental health providers by category. Include in the documentation the total number of personnel of each category within the PPS. (Could be one-time report or ongoing for limited number of months.) | 1. Show developed curriculum that is consistent with HH and HARP material on the DOH website.<br><br>2. Show an inclusive training process that will involve a majority of medical and mental health providers. Should include more than a one-time training, such as office based follow-up or ongoing refresher process.<br><br>3. Show that at least 75% of medical and mental health providers will receive Health Home training such that 100% of practices will have at least one professional knowledgeable about Health Homes and HARPs. |
| | Reports documenting an increase in participation **and** the resulting health outcomes of patients enrolled in the Health Home program | 1. Document the increased numbers of eligible members who engaged in Health Homes per month under EIP.<br><br>**-AND-**<br><br>2. Provide documentation of ED use and inpatient hospitalization by active HH members prior to outreach compared with post engagement. The organization should utilize members who were enrolled due to direct actions taken under EIP. | 1. The number of persons who are referred each month may vary, but, of that variable number, the same or greater percent should become engaged in the HH.<br><br>2. Expect to see involvement in HH care management will result in decreased avoidable use of the ED or inpatient services. |

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| **Participation in Expanded HH Enrollment** | Evidence from primary care practices, hospitals and post-acute settings demonstrating implementation of PPS-wide workflow model related to Health Home connectivity – one time only | 1. Provide written documentation of a policy from at least one primary care practice, hospital and post-acute facility.<br><br>**-AND-**<br><br>2. Provide attestations from all the primary care practices, hospitals, and post-acute facilities that an internal workflow process has been implemented. | 1. Work-flow model should show how members are identified and show the Health Home referral process.<br><br>2. One attestation is needed from all required entities. For primary care practices, only include practices with 5 or more practitioners. |