Health Home Fact Sheet

What is a "Health Home"?

First, it is not a building. A Health Home is a group of health and community agencies that have agreed to work together to help people with many health issues get what they need to keep them healthier and safer in the community. Each person who joins gets a "care manager". A care manager will work closely with him/her to get the services he/she needs in his/her community. This service is being paid for through New York State Medicaid.

Why is this important for me?

You may be invited to join a Health Home if you have many health issues (including mental health), are having problems getting the care you need and are receiving Medicaid (either fee for service or in a health plan). If you are receiving special help (TCM, COBRA, MATS, CIDP), your care may already be changing to a Health Home. The Health Home care manager will work with you to understand what you need to stay healthy. You may need housing. You may need help getting enough food. You may need transportation. You may not have a primary care physician. You may have problems getting your medications or taking them. You may use the emergency room a lot or end up in the hospital often. Once the care manager knows what you need, he/she will work with you and the Health Home team to help you get those services and to teach you how to stay healthy.

What do I need to do?

If you are told that you can join a health home, make an appointment to meet with the care manager. The care manager will work with you to make a care plan. It is possible that the care manager will decide you are doing well and do not need this special help. Or you may decide it is not helpful to you. You will not lose any Medicaid benefits or services if you do not join. If you do join, you will work with your care manager and the team using the care plan to meet your health, safety and social needs.

If you have questions, please call the Medicaid Call Center at:

1-800-541-2831 (TTY 1-877-898-5849)

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6/12

Overview of Health Homes

Back Ground – Health Homes are mandated in NYS and are overseen by Department of Health (DOH) for an initial 3 year period. Both NYS and Managed Care Organizations will be monitoring the quality of Health Homes. Measurements will be based on HEDIS standards.

Goal: The goal of a Health Home is to provide a coordinated comprehensive medical and behavioral care to a patient with chronic conditions that assures access to appropriate services.

- To improve health outcomes
- Decrease hospital and ED use
- Promote use of Health Information Technology (HIT)
- Avoid Unnecessary Care

6 Core Services –

1. Comprehensive Care management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to community and social support services
6. Use of Health Information Technology (HIT)

Reassignment or Deactivation

- Can occur at the request of a care management agency
- Or if after a consult between the Health Home and Health plan it is determined that the Health Home is not:
    - Effectively providing or managing Health Home services
    - Not adhering to Health Plan protocols.

Referrals: Can be received by both the Health Plan and Health Home.

*MUST meet Medicaid eligibility and Health Home Criteria

*Health Plan Referrals – goal is to enroll the high risk population

*Referrals can also be accepted from other sources such as hospitals, and community agencies. (ex. Bottom up referrals)

Quality Measures: - Measures that are used by the state to assess the quality of care provided by the Health Home which include the following:

- Decrease in utilization associated with avoidable inpatient stays
- Decrease the utilization of ED visits
- Improve outcomes for participants with Mental Illness and Chemical Dependency
    - Follow up to hospitalization regarding outpatient visits at the 7 days, 30 days and 90 days mark for alcohol and chemical dependency detox.
    - Monitor for medication management related to antidepressants with a new diagnosis
    - Antipsychotics - adherence
    - Mood stabilizer adherence
- Improve disease related care for Chronic Care conditions
    - Asthma – medication management, use of controller medications
    - Diabetes- HBA1C, and LDL at least once
    - Cardiac – Anterior Myocardial infarction – prescribed a beta blocker, and LDL
    - HIV – at least 2 visits with PCP, viral load monitoring and syphilis screening for 18 years and older.
- Preventive Care
    - Chlamydia for women
    - Colorectal screening for 50 and older.

What is a Health Home?

A **Health Home** is a care management service model in which all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Who Is Eligible for a Health Home?

Health Homes are for people with Medicaid who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

- States can target health home services geographically
- States cannot exclude people with both Medicaid and Medicare from health home services

Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

Mjm 6/5/2014
http://healthaffairs.org/blog/2012/02/13/what-in-the-world-is-a-health-home/?cat=grantwatch.

Health home projects offer a more expansive view of health promotion and improvement than more physician-centric medical home concepts. Such projects also acknowledge that medical care alonje will be insufficient to ultimately achieve health equity for underserved populations. Patient and family engagement and self-management are seen as essential complements to clinical interventions. A health home prioritizes the voice of the patient and sees culturally sensitive prevention and primary care as the cornerstone for an integrated system of care.

What is Person Centered Care?

Part of the challenge in talking about health homes is that we believe some combination of all these concepts are often part of the conversation, whether acknowledged or unacknowledged, at least among professionals. But when most consumers think about what they'd want in a health home, we suspect that the innermost circle (or two) is often what they're talking about.

The center of the diagram portrays the doorway to the health home from a consumer perspective. What are consumers looking for? Based on our work with health centers and consumers, we speculate that they would likely list the following as priorities: respect in all interactions; friendly faces who know them and speak their language; convenient, attractive locations and hours; and a personal relationship with a provider they trust.

The next circle out (Enhanced Access) is often not at the top of the priority list of desired changes for providers but is very salient for consumers. Just like privately insured patients, safety-net patients want same-day appointments, after-hours access to urgent care, an advice line or online connection, and no long waits when they come in for care.

The next circle out (Person-Centered Medical Home) is where most of the energy of providers in innovative practices is going. It builds on the principles of provider teams, panel management, and patient self-care inherent in the Chronic Care model, informed by appropriate health information technology systems, such as electronic health records.

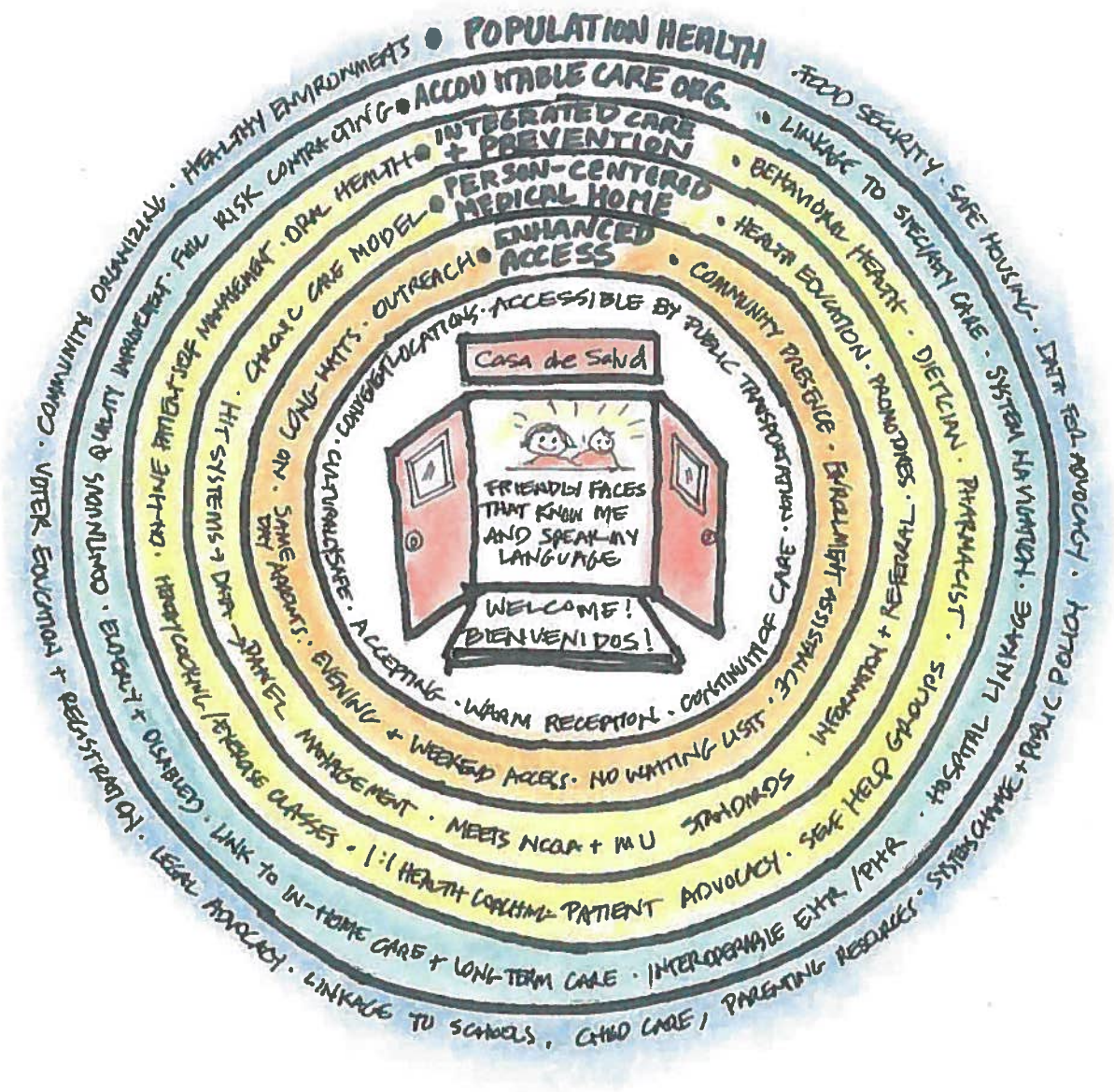
The fourth circle, "Integrated Care and Prevention," takes the basic patient-centered medical home model to a higher level of integration, incorporating behavioral health, oral health, and other special resources such as a dietician and pharmacist in the primary care setting. It also promotes wellness and patient self-care via support groups, one-on-one coaching, and exercise and cooking classes. Much effort is devoted to health education, including the use of innovative technologies to facilitate patient self-management at home or at work.

We have appropriated the "Accountable Care Organization" label for the fifth circle, to signify the importance of connecting primary care settings to specialty care, hospitals, and other elements of the health care system in as seamless a fashion as possible. This has long been a gaping hole in the safety net of most communities. Just exchanging data among clinics and hospitals has been impossible in most places. From a consumer perspective, ease of navigation of these elements of the system is key but highly problematic at present.

Finally, medical care and patient self-management alone will not be sufficient to advance health. It will take a shared commitment to primary prevention, including healthy environments and access to healthy food and safe housing, as well as advocacy to address other social determinants of health and wellness, to achieve the ultimate goal of providing a true health home.

We have used this diagram as the starting point for understanding how to build a Health Home savvy Case Management System.

Mjm 6/5/2014
http://healthaffairs.org/blog/2012/02/13/what-in-the-world-is-a-health-home/?cat=grantwatch.



Tom David
Community Clinics Initiative
April 2011

CCI.
T. David
April 2011

Mjm 6/5/2014
http://healthaffairs.org/blog/2012/02/13/what-in-the-world-is-a-health-home/?cat=grantwatch.

Section XI: Glossary of Terms

Glossary of Terms

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined.

Assertive Community Treatment (ACT): ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on improving an individual's quality of life in the community and reducing the need for inpatient care by providing intense, community-based treatment services by an interdisciplinary team of mental health professionals. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Assisted Outpatient Treatment (AOT): On August 9, 1999, the Governor signed Kendra's Law (Chapter 408 of the Laws of 1999), creating a statutory framework for court-ordered AOT to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. Under Section 9.60 of the Mental Hygiene Law, any AOT order must include either care management services or ACT services as part of a court-ordered treatment plan.

Business Associate Agreement (BAA): an agreement not to use or further disclose Protected Health Information other than is permitted or required by the agreement or as required by law. This includes using the appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the agreement. The agreement includes implementing administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates receives, maintains or transmits on behalf of the covered entity.

Behavioral Health Organization (BHO): an organization that will help to manage behavioral health benefits of Medicaid members, advocate to meet behavioral health needs and secure appropriate care management/transition plans.

Care Management: a process of coordinating and arranging for the provision of needed services in accordance with goals contained in a written care plan.

Client Identification Number (CIN): Medicaid Client Identification Number that is unique to each Medicaid beneficiary.

Claims Payment: a process within eMedNY that generates a payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied, and pended claims.

Computer Science Corporation (CSC): Computer Sciences Corporation, the fiscal agent for eMedNY.

Data Exchange Agreement Application (DEAA): an agreement to provide information supporting an applicant's request for the release of Medicaid Confidential Data (MCD) and to serve as the basis for assessing the appropriateness of releasing MCD.

Designated Health Home Provider: a provider approved and designated by NYSDOH as a Lead provider of Health Home services.

Dually Eligible Individual: an individual that qualifies and receives both Medicare and Medicaid.

eMedNY: Electronic Medicaid System of NY. Allows NY Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

Existing (TCM) Targeted Case Management Member: a member already receiving specific case management services before the implementation of Health Home (can be fee-for-service members or Managed Care Members).

Federally Qualified Health Centers (FQHCs): Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Fee-for-Service (FFS) Member: members that do not belong to a Medicaid Managed Care Plan and receive services from providers who are contracted with the State based on an agreed upon rate for services.

Functional Assessment of Cancer Therapy for General Populations (FACT-GP©): a generic CORE questionnaire that includes a 27-item compilation of general questions divided into four primary quality of life domains: physical well-being, social/family well-being, emotional well-being and functional well-being.

Health Commerce System (HCS): an electronic resource designed to protect the confidentiality of data by requiring that organizations adhere to NYSDOH health data security standards. This secure website can be used to send/request data and reports. The HCS is maintained by the NYSDOH Bureau of HEALTHCOM Network Systems Management.

Health Home Service Provider: a provider of Health Home Services that has a contractual relationship with a Health Home.

Health Home Services: services as defined in Section 1945(h)(4) of the Social Security Act including: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services; and the use of health information technology to link services as feasible.

Health Home Service Organizations: the collective list of Health Home Service Providers.

Health Home Participant: a Medicaid eligible candidate who agrees to receive Health Home services.

Health Home Eligible: a member who is assigned by the MCP or NYSDOH to a Health Home.

Health Information Exchange (HIE): the process of reliable and interoperable electronic health information sharing managed such that confidentiality, privacy and security of the information is maintained. A health information exchange is the platform that is used to manage this process and that has a number of functionalities to allow this secure management and exchange of data.

Legacy Slots: an approved number of slots that can be billed at the OMH TCM, COBRA TCM, or MATS program legacy rates that were established prior to implementation of Health Homes.

LGU: a Local Government Unit means a county, except a county within the city of New York, and the city of New York. The unit of local government is given authority by the government to provide local services. http://law.onecle.com/new-york/mental-hygiene/MHY041.03_41.03.html

Managed Addiction Treatment Services (MATS): initiative designed to improve the delivery of health care and other related services to Medicaid recipients requiring treatment for chemical dependence to move toward recovery and self-sufficiency through substance use treatment.

Managed Care Organization/Plan (MCO or MCP): a health maintenance organization/plan or prepaid health service plan, certified under the Public Health Law, that contracts with health care providers and medical facilities to provide care for members at reduced cost(s).

National Provider Identifier (NPI): an identification number assigned by the National Plan and Provider Enumeration System (NPPES).

Outreach and Engagement: case management that locates Health Home eligible members with the goal of engaging them in active Health Home services.

Regional Health Information Organization (RHIO): organizations of regional partners that may include hospitals, physicians, and Managed Care Organizations and others that oversee the infrastructure for the secure electronic exchange of clinical information.

Single Point of Access (SPOA): is a process led by a SPOA Coordinator that helps local governments achieve community-based mental health services that are cohesive and well-coordinated in order to serve individuals most in need. The SPOA manages access and utilization.

Targeted Case Management (TCM): a State Plan Service to assist eligible individuals (targeted by population and/or geographic region) to gain access to needed medical, social, educational and other services and include assessment, service plan development, referrals to services, monitoring and follow up.

Section XII: Summary of Charts and Tables

Figure 1

Health Home Minimum Billing Standards

Health Homes must provide documentation of carrying out at least one of the five core (exclusive of HIT) Health Home services per service 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, case conferences.

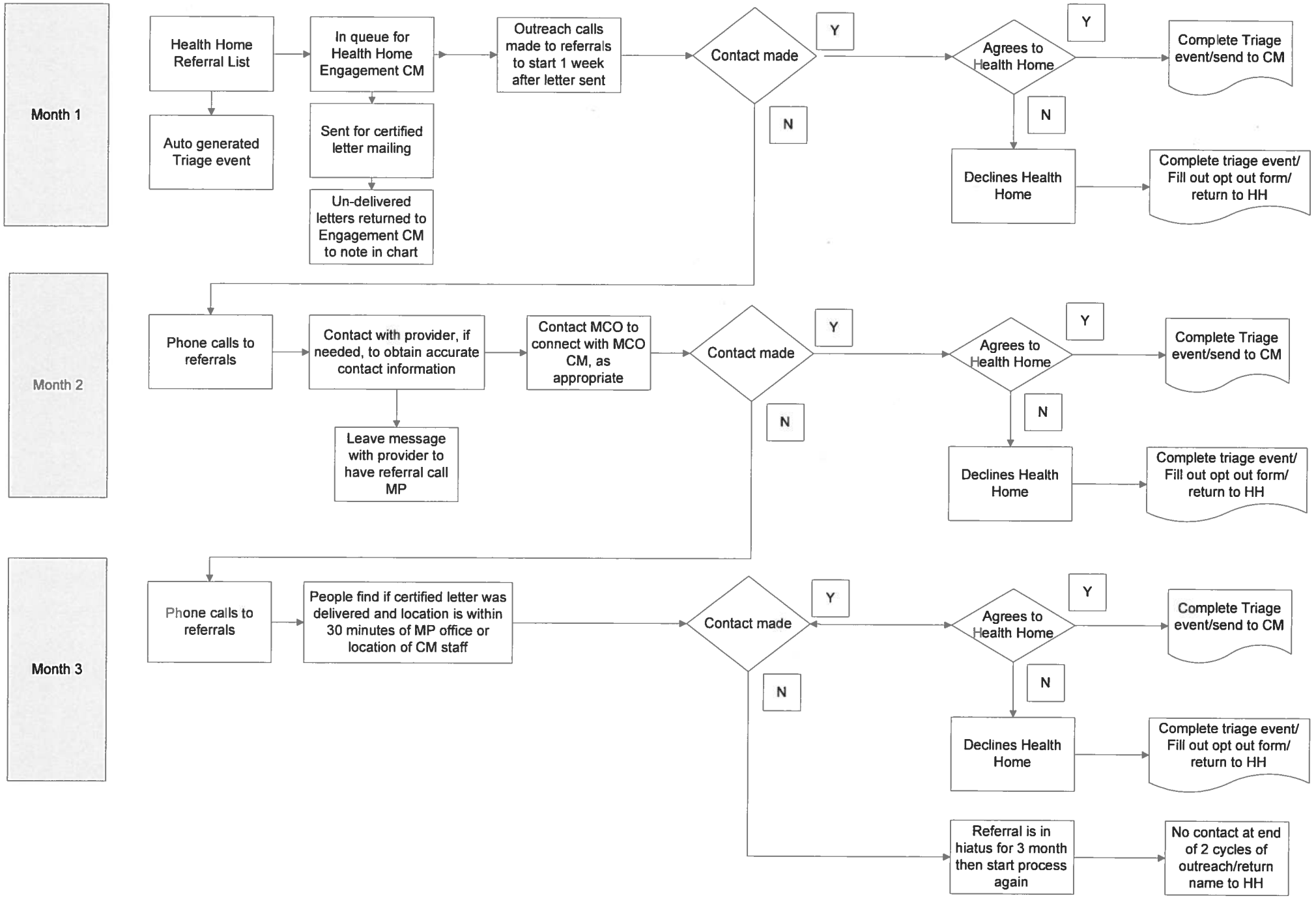
Active, ongoing and progressive engagement with the client must be documented in the care management record to demonstrate active progress toward outreach and engagement, care planning and/or the client achieving their personal goals. The State retains the right to review Health Home care records as required to assure that active services were being provided in each month for which a Medicaid payment was made for Health Home services

Core Health Home Services	Examples of Core Health Home Services/Interventions/Activities
Comprehensive Care Management	• Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long term care and social service needs. • Complete/revise an individualized patient-centered plan of care with the member to identify member's needs/goals and include family members and other social supports as appropriate. • Consult with multidisciplinary team on client care plan/needs/goals. • Consult with primary care physician and/or any specialists involved in the treatment plan. • Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improve health outcomes. • Prepare client crisis intervention plan.

Care Coordination & Health Promotion	• Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info. • Link/refer client to needed services to support care services to support care plan/treatment goals, including medical/behavioral health care; patient education and self help/recovery and self management. • Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs. • Advocate for services and assist with scheduling of needed services. • Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed. • Monitor/support/accompany the client to scheduled medical appointments. • Crisis intervention, revise care plan/goals required.
Comprehensive Transitional Care	• Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting. • Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to a safe transition/discharge where care needs are in place. • Notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation. • Link client with community supports to assure that needed services are provided. • Follow up post discharge with client/family to assist client care plan needs/goals.
Member & Family Support	• Develop/review/revise the individual's plan of care with the client/family to ensure that the plan reflects individual's preferences, education and support for self management. • Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed. • Meet with client and family, inviting any other providers to facilitate needed interpretation services. • Refer client/family to peer supports, support groups, social services, entitlement programs as needed. • Collaborate/coordinate with community based providers to support effective utilization of services based on client/family need.
Referral and community & social Support Services	• Identify resources and link client with community supports as needed. • Collaborate/coordinate with community base providers to support utilization of services based on client/family need.

Triage and Engagement

Health Hom[illegible]utreach and Engagement
Process for [illegible]ferrals from Health Homes



monroe plan
FOR MEDICAL CARE

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Distribution of PHI to Health Homes for Individuals who have not conseted to joining a Health Home	Reference # 1174
Version: 3	Original Creation Date 10/16/2012
Document Owner: Kathleen Henehan	Effective Date: 02/25/2014
Approved By: Kim Hess	Approval Date: 02/25/2014

Policy: Based on the documentation received from NYS Department Of Health (DOH) Monroe Plan employees will follow all Federal and State laws when releasing PHI for a member assigned to a Health Home.

Scope: This policy will apply to all Monroe Plan employees.

Definition:
Health Homes - are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery expands on the traditional medical home models by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

DOH Documentation:

Policy for sharing Protected Health Information of Enrollees between the MCO and the Health Home Prior to the Member Signing a Health Home Consent.
In accordance with the Medicaid Managed Care contract, Section 20.3, medical records, which include protected health information, of an enrollee shall be confidential and shall only be disclosed to and by other persons within the MCO's organization, including Participating Providers such as contracted Health Homes, only as necessary to provide medical care, which includes the provision of care coordination.

The Department of Health has determined that in accordance with the Medicaid Managed Care Contract and all Federal and State laws and regulations regarding confidentiality that absent a specific consent from the enrollee, a MCO may share with a contracted Health Home (to which the enrollee has not yet signed a Health Home consent) the last five claims or encounter data, as well as two years of loyalty analysis

showing the Enrollee's provider history for the purpose of outreach and engagement of the Enrollee within a Health Home network

Procedure:
All requests for Medical records from a Health Home will be directed to the Compliance Department. The Compliance Department will work directly with Excellus to provide requested information to the Health Home per State and Federal guidelines.

Violations: Violation of this policy may result in disciplinary action up to and including termination for employees, termination of vendor, contractors or consultant contracts, or dismissal for interns and volunteers. Additionally individuals may be subject to loss of access privileges and/or civil or criminal prosecution.

Related Documents:
August 2012

Policy for sharing Protected Health Information of Enrollees between the MCO and the Health Home Prior to the Member Signing a Health Home Consent.

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References:
A. None

Case Management to Health Home Cases

July 3, 2014

Cases open to Case Management that **DO NOT receive waiver services, DO** meet the criteria for Health Homes** can be flipped to a Health Home status.

Existing cases can be "flipped" to Health Home following the process below:

1. Complete a "bottom up" referral to HHUNY using the referral form
    a. The HHUNY referral should be faxed or emailed to Tracy Marchese.
    b. The GRHNN must be sent through Direct Mail to GRHNN

2. Wait for a confirmation e-mail from HHUNY stating that the member has been accepted into the Health Home and assigned to Monroe Plan
    a. If you receive an e-mail from HHUNY that states the member belongs to the GRHHN, please send the "bottom-up" referral to the GRHHN via RHIO direct.
    b. If you receive an e-mail from GRHNN that states the member belongs to the HUNNY, please send the "bottom-up" referral to Tracy Marchese at tmarchese@HUNNY.org.

3. The approved referral will be sent to Triage and referring professional. Triage will start a Triage Event, tag the member entity with the specific Health Home name and send to CM once the referral is approved
    a. (for members already open to CM) Triage event should be completed entering the answer "no" when asked if a CM case will be opened. The reason will be 'Already linked to CM'. For members with an existing CM case the 'CM Type' on the case should be changed to 'Health Home Case Mgmt.'
        i. You should change the open case to a Health Home case as soon as it is approved. You will then have 30 days to obtain the necessary Health Home paperwork.

4. Cases newly opened to Health Home will need to have:
    a. Care Plan updated at time of opening
    b. Crisis Plan completed
    c. FACT-GP completed
    d. Health Home Information Sharing Consent/RHIO authorization

5. Health Home cases need to be reviewed every 6 months, starting from the date of the completion of the original care plan this should be done within your weekly team meetings with outreach.

6. Billable contacts must be documented, at minimum, each month. These contacts may include a conversation with the individual and/or their providers and/or written educational materials or correspondence that reflects the forward movement of the individual to meeting their goals. Continued case finding is not considered billable after 90 days. If you are unable to contact a HH referral within the 90 day period, contact your supervisor or the Manager for CM Services.

Health Home Case Management Structure and Flow

Referral for Health Home

Outreach to locate, discuss Health Home involvement, gain consent and administer the PAM

PAM Level 1-2

Outreach worker collects data for Case Manager to complete assessment

Based on PAM Level and individual identified goals, CM develops a Care Plan to be followed by OR worker and member

OR worker provides appropriate individual contacts and tracks individual activity towards goal achievement

OR monitors for any new claims or member reported bio-psycho-social changes that necessitate a change in focused condition or care plan

Case Manager contacts member via phone or in-person monthly, or more often, to provide condition specific education and/or coaching specific to members' condition(s)

PAM is re-administered every 90 days to evaluate individual progress as well as a review of the care plan to determine progress towards goals, re-prioritize goals or change case management interventions based on PAM score

As PAM score increases, the case manager will need to evaluate the need for condition specific teaching and coaching.

PAM Level 3-4

Outreach worker collects data for Case Manager to complete assessment

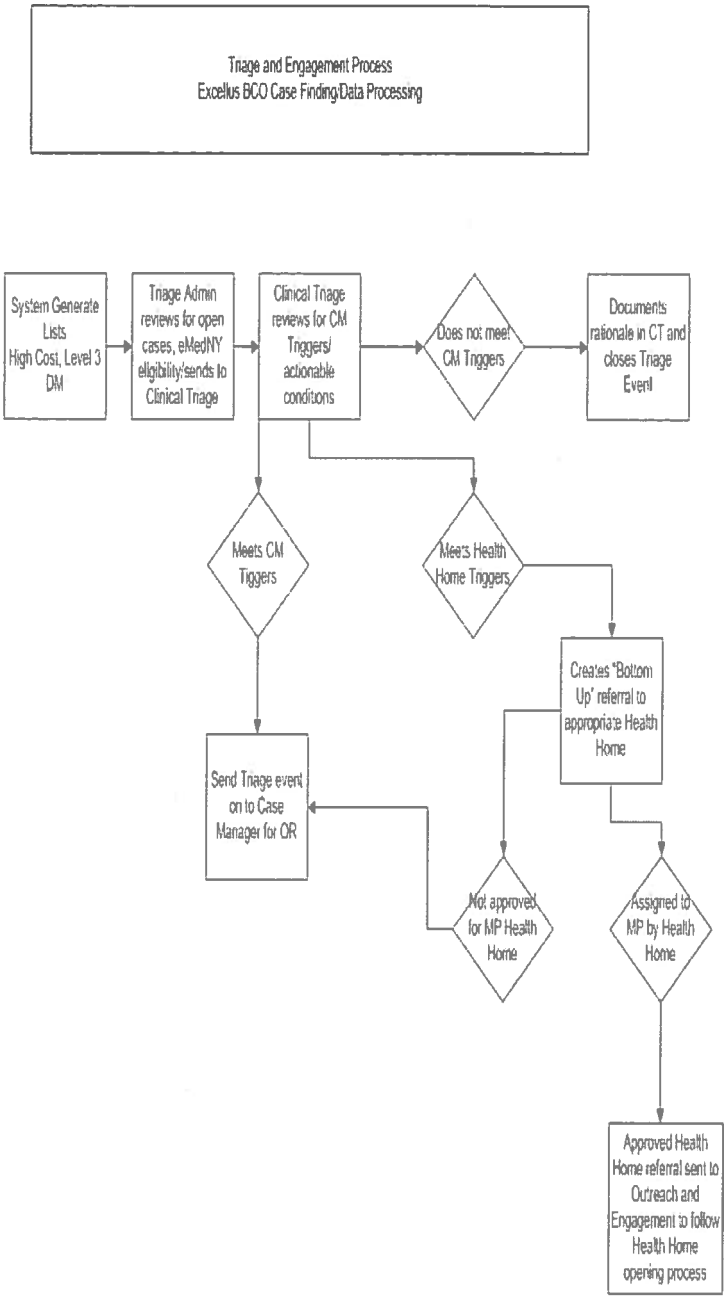
Based on PAM Level and individual identified goals, CM develops a Care Plan to be followed by OR worker, CM and member

OR worker provides appropriate individual contacts and tracks individual activity towards goal achievement

OR monitors for any new claims or member reported bio-psycho-social changes that necessitate a change in focused condition or care plan

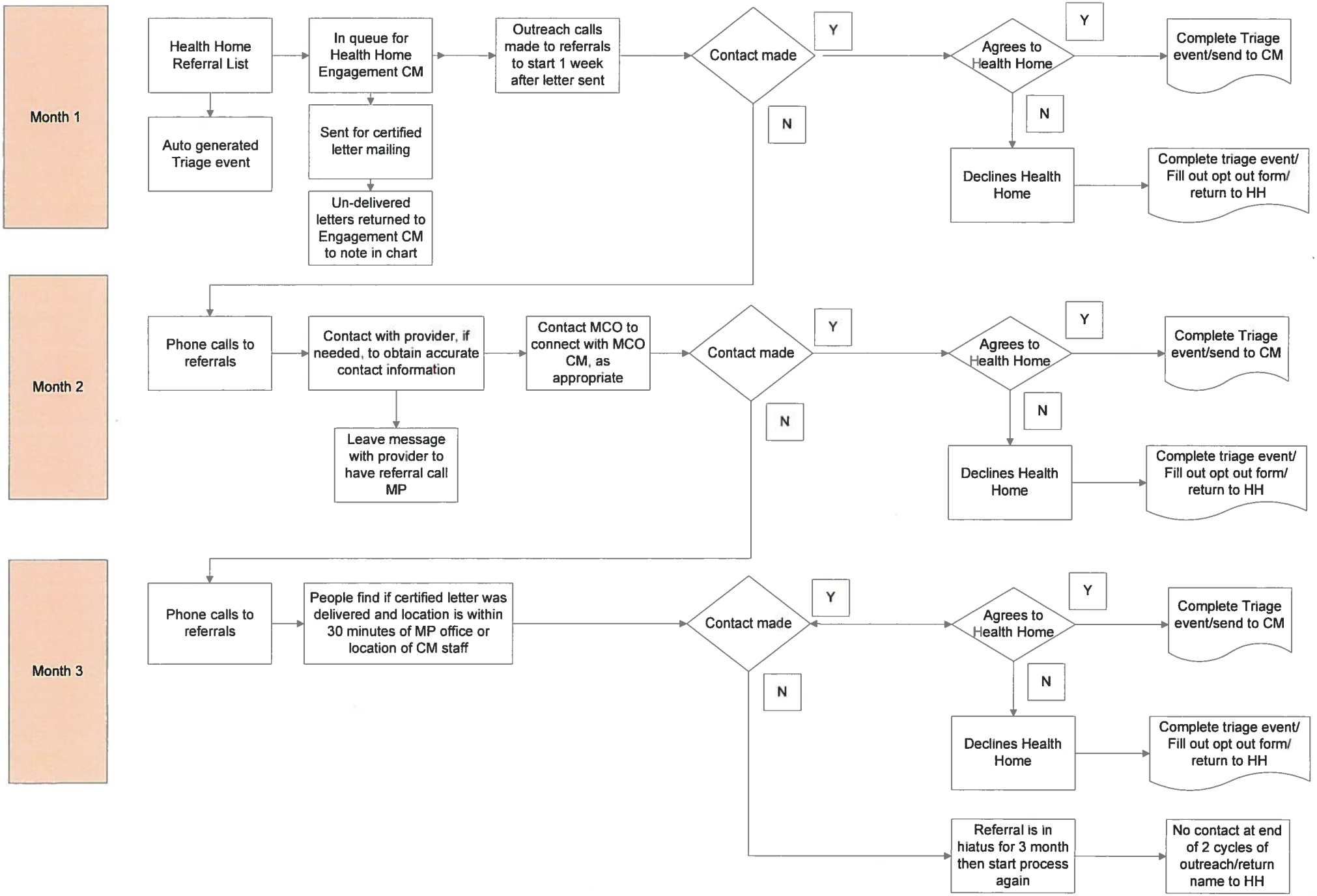
Case Manager contacts member via phone or in-person as needed to provide condition specific education and/or coaching specific to members' condition(s)

PAM is re-administered every 90 days to evaluate individual progress as well as a review of the care plan to determine progress towards goals, re-prioritize goals or change case management interventions based on PAM score


Triage and Engagement Process
Excellus BCO Case Finding/Data Processing
System Generate Lists
High Cost, Level 3 DM
Triage Admin reviews for open cases, eMedNY eligibility/sends to Clinical Triage
Clinical Triage reviews for CM Triggers/ actionable conditions
Does not meet CM Triggers
Documents rationale in CT and closes Triage Event
Meets CM Tiggers
Meets Health Home Triggers
Creates "Bottom Up" referral to appropriate Health Home
Send Triage event on to Case Manager for OR
Not approved for MP Health Home
Assigned to MP by Health Home
Approved Health Home referral sent to Outreach and Engagement to follow Health Home opening process

Triage and Engagement

Health Ho utreach and Engagement
Process for Referrals from Health Homes



Health Homes of Upstate New York

Alcohol & Drug Dependency Services — Beacon Health Strategies
Chautauqua County Department of Mental Hygiene — Huther Doyle Memorial Institute
New York Care Coordination Program — Onondaga Case Management Services

HEALTH HOMES OF UPSTATE NEW YORK – FINGER LAKES

COMMUNITY REFERRAL FOR HEALTH HOME SERVICES

Health Homes of Upstate New York – Finger Lakes (HHUNY-Finger Lakes) is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible individuals into HHUNY Health Home Services. Individuals must meet all eligibility requirements to be considered for enrollment.

HHUNY Finger Lakes Health Home Services Eligibility

1. Individual currently has active Medicaid; AND;
2. Individual resides in one of the following Counties: Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, or Yates County; AND;
3. Individual meets the NYS DOH eligibility criteria of: two chronic conditions, or HIV/AIDS and the risk of developing another chronic condition or, one or more serious mental illnesses; AND;
4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.

How to Make a Referral to HHUNY

1. Complete the attached Community Referral Application Form, including as much detail as possible to allow HHUNY to verify eligibility for health home services.
2. Attached a signed "Consent to Disclosure of Health Information" Form
3. Send the completed Application and Consent via secure e-mail or fax, or mail to:

HHUNY Community Referral Representative
Email: tmarchese@hhuny.org
Fax: 585-613-7670
Mail: Community Referral Specialist
New York Care Coordination Program - Health Homes of Upstate New York
1099 Jay Street, Bldg. J
Rochester, NY 14611

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the person in health home services. Health Home services are voluntary and the individual will be asked to consent during the outreach and engagement process.

If you have questions regarding the completion or status of this application, please contact: HHUNY Community Referral Representative at 585-613-7642

HHUNY also provides Health Homes Services in the counties of Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Cortland, Erie, Madison, Onondaga, Oswego, Tompkins, and Tioga, Please contact the Community Referral Representative to make a referral for services in any of these counties.

HHUNY Health Home Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	Cell Phone:	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Eligibility Category Information – Check All that Apply
Must meet either A only or B only or two C to be eligible

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness	
	B	HIV/AIDS & the risk of developing another chronic condition	
	C	Mental Health condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

Risk Factors - Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
	Lack of or inadequate social/family/housing support	
	Lack of or inadequate connectivity with healthcare system	
	Non-adherence to treatments or medication(s) or difficulty managing medications	
	Recent release from incarceration	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	

Narrative

Provide any additional information that may be helpful in assignment to a care management agency:

Specify Preferred or Recommended Care Management Agency, if any:_____

Contact Information for Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email:

PERMISSION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with medical treatment and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of health care services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION

1. The person whose information may be used or disclosed is:

   Name: _____.

   Date of Birth: _____.

2. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
2. This information may be disclosed to the persons or organizations listed in Attachment A.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
4. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
5. This permission expires on _____ (date).
6. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship _____.)

I give permission to use and disclose my records as described in this document.

_____

Signature Date

CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A

HHUNY FINGER LAKES

Health information may be disclosed for purposes of treatment to the people and organizations listed below.

- AC Center, Inc.
- Beacon Healthcare Strategies, LLC
- Catholic Charities Community Services
- Catholic Family Center
- Coordinated Care Services, Inc.
- Delphi Drug & Alcohol Services
- DePaul Community Services
- East House Corporation
- Excellus Health Plans
- Fidelis Care
- FLACRA
- Genesee County Mental Health Services
- Hillside Family of Agencies
- Huther-Doyle Memorial Institute, Inc.
- Ibero-American Action League
- John D. Kelly Behavioral Health Center
- L. Woerner dba HCR
- Lakeview Mental Health Services, Inc.
- Livingston County Mental Health Services
- Monroe County Office of Mental Health
- Monroe Plan for Medical Care
- MVP Health Care
- New York Care Coordination Program, Inc.
- New York State Office of Mental Health
- New York State Office of Alcohol and Substance Abuse Services
- Ontario County Department of Mental Health
- Orleans County Department of Mental Health
- Regional Primary Care Network/Rushville Community Health Center
- Rochester General Health System
- Rochester Rehab
- Schuyler County Community Services
- Southern Tier Environments for Living
- St. Joseph's Villa – Villa of Hope
- Steuben County Community Mental Health Services
- The Arc of Orleans County
- United Healthcare
- University of Rochester/Strong Memorial Hospital
- Wayne County - Wayne Behavioral Health Network
- Yates County Department of Community Services
- YWCA

Example Bottom up referral. for Finger Lakes.

HHUNY Health Home Community Referral Application

Identifying Information

Name: Matilda McTest	Date of Birth: 12/31/50	Gender: Female
Address: 121 Rocket Street Rochester, NY 14610	Medicaid CIN #: AA100032	
	Medicaid Managed Care Organization Name: Blue Choice option.	
	County of Residence: Monroe	
Phone:	Cell Phone: (585) 555-2222	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Eligibility Category Information – Check All that Apply

Must meet either A only or B only or two C to be eligible

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness	- ex Major depressive d/o, Bipolar, schizophrenia
	B	HIV/AIDS & the risk of developing another chronic condition	ex HIV c a super infection, AIDS -
	C	Mental Health condition	depression, anxiety PTSD.
	C	Substance Abuse Disorder	cocaine, opiates, alcohol, tobacco etc
	C	Asthma	bronchial asthma, etc.
	C	Diabetes	DM type I or II - uncontrolled etc
	C	Heart Disease	any cardiac - heart attack, arrhythmia
	C	BMI > 25	obesity / morbid obesity.
	C	Other Chronic Conditions (Specify)	HTN - any chronic condition except cancer.

* all of the above information can be gathered from claims & carve outs.

Risk Factors - Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	ex- inpt related to previous heart attack- or asthma exacerbation.
✓	Lack of or inadequate social/family/housing support	ex homeless, living in a rooming house- ø natural supports.
	Lack of or inadequate connectivity with healthcare system	- ø PCP - ø linkage to specialists,
	Non-adherence to treatments or medication(s) or difficulty managing medications	- not taking medications as ordered, do not understand medications.
	Recent release from incarceration	ex - just released from Monroe County
	Recent release from psychiatric hospitalization	ex Elmyra psych, RPC
	Deficits in activities of daily living such as dressing, eating, etc.	cannot eat, dress bathe without assistance
	Learning or cognition issues	TBI, cognitive impairment.

Narrative

Provide any additional information that may be helpful in assignment to a care management agency:

If being referred out any useful info that would be needed to the care management agency that is receiving

Specify Preferred or Recommended Care Management Agency, if any: Monroe Plan.

Contact Information for Person Completing Referral:

Name: your name	Title: your title
Organization: Monroe Plan	
Phone: your phone	Email: your email

MONROE COUNTY COMMUNITY REFERRAL FOR CARE MANAGEMENT

Community Referrals for Health Home Care Management for Medicaid and dual eligible Medicaid/Medicare persons and Mental Health and/or Substance Use (Behavioral Health) Care Management for persons not Medicaid eligible and/or not eligible for Health Home Care Management are now being accepted in Monroe County from providers, community organizations, individuals and/or family members.

- Health Home Care Management is being provided by Greater Rochester Health Home Network (GRHHN) AND Health Homes of Upstate New York – Finger Lakes (HHUNY-Finger Lakes) for eligible Medicaid and Medicaid/Medicare dual eligible persons.
- Behavioral Health Care Management is being triaged through the Monroe County Office of Mental Health for individuals with mental health and/or chronic substance abuse disorders who are not eligible for Health Home Care Management.

Individuals must meet all eligibility requirements to be considered for enrollment. Please check the type of care management the person qualifies for:

☐ **Behavioral Health Care Management**	☐ **Health Home Care Management**
☐ 1. Individual is not eligible for Health Home Care Management services because: • Individual is not eligible for Medicaid; **OR** • Individual does not meet DOH eligibility criteria; **AND**	☐ 1. Individual meets the NYS DOH eligibility criteria of: • two chronic conditions, **OR** • HIV/AIDS and the risk of developing another chronic condition **OR**, • one or more serious mental illnesses; **AND**
☐ 2. Individual has a mental health and/or chronic substance use disorder; AND	☐ 2. Individual currently has active Medicaid or Medicaid and Medicare;
☐ 3. Individual resides in Monroe County AND	☐ 3. Individual resides or receives services in Monroe County; AND
☐ 4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.	☐ 4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.

How to Make a Care Management Referral:

1. Complete the attached Referral Application Form, including as much detail as possible to allow the Health Homes and Monroe County Office of Mental Health / Single Point of Access (SPOA) to determine eligibility.
2. Attach a signed "Consent to Disclosure of Health Information" Form
3. Send completed application and Consent via secure e-mail or fax, or mail to ONE of the following:

BEHAVIORAL HEALTH CARE MANAGEMENT	**HEALTH HOME CARE MANAGEMENT: HEALTH HOMES**	
Monroe County Office of Mental Health Priority Services	**GRHHN:** Greater Rochester Health Home **Greater Rochester Health Home Network**	**HHUNY:** **Health Homes of Upstate New York: Finger Lakes**
Lisa Babbitt lbabbitt@monroecounty.gov Phone: (585) 753-2874 Fax: (585) 753-2885 or (585) 753-5015 Mail: Monroe County SPOA 80 West Main St., 4th Floor Rochester, NY 14614	Deb Peartree grhhn@direct.rrhio.org Phone: 585-737-7522 Fax: 585-423-2806 Mail: Greater Rochester Health Home Network, Referral. 82 Holland Street Rochester, NY 14605	Tracy Marchese tracy.marchese@hhuny.org Phone: 585-613-7642 Fax: 585-613-7670 Mail: Community Referral Health Homes of Upstate NY 1099 Jay Street, Bldg. J Rochester, NY 14611

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and engage the person in care management services. Care Management services are voluntary and the individual will be asked to consent during the outreach and engagement process.

Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	E-Mail:	
Alternative Contact(s) Name, Phone #:		
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Eligibility Category Information – Check All that Apply
Must meet either A only or B only or two Cs to be eligible for Health Home Care Management

Check		Category	Specify Diagnosis; Provide Available Detail
☐	A	Serious mental illness	
☐	B	HIV/AIDS & the risk of developing another chronic condition	
☐	C	Mental Health condition	
☐	C	Substance Abuse Disorder	
☐	C	Asthma	
☐	C	Diabetes	
☐	C	Heart Disease	
☐	C	BMI > 25	
☐	C	Other Chronic Conditions (Specify)	

List Current Medical or Behavioral Health Treatment Providers, if Known:

_____

_____

Care Management Needs - Check All that Apply

Check	Category	Explain Factor and Care Management Need
☐	Probable risk for adverse event	
☐	Repeated ER/Inpatient Use, Including Avoidable ER Use	

☐	Lack of or inadequate social/family/housing support	
☐	Lack of or inadequate connectivity with healthcare system	
☐	Non-adherence to treatments or medication(s) or difficulty managing medications	
☐	Recent release from incarceration	
☐	Recent release from psychiatric hospitalization	
☐	Deficits in activities of daily living such as dressing, eating, etc.	
☐	Learning or cognition issues	
☐	Financial Needs	

Risk and Safety Concerns – Check all That Apply

Check	Concern		Check	Concern
☐	Suicidal Ideation		☐	History of Suicide Attempts
☐	Homicidal Ideation		☐	History of Violence
☐	Active Substance Abuse		☐	Unsafe Living Environment
☐	Other – Specify			

Provide additional information regarding Risk and Safety Concerns checked above.

Narrative

Provide any additional information that may be helpful in assignment to a care management agency. If known, include strengths and/or interests of the referred individual

Specify Preferred or Recommended Care Management Agency, if any:_____

Contact Information for Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email:

Permission to Use and Disclose Confidential Information

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with care management and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of care management services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

Consent to disclosure of health information

The person whose information may be used or disclosed is:

Name: _____.

Date of Birth: _____.

1. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
2. This information may be disclosed to the persons or organizations listed in Attachment A.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
4. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
5. This permission expires on _____ (date).
6. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship _____.)

I give permission to use and disclose my records as described in this document.

_____ _____

Signature Date

CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A

Health information may be disclosed for purposes of treatment to the organizations listed below. The following organizations provide and/or administer Care Management in Monroe County:

- Anthony L. Jordan Health Corporation
- Beacon Healthcare Strategies, LLC
- Behavioral Health Network (Rochester General Hospital)
- Catholic Charities Community Services
- Catholic Family Center
- Community Care of Rochester, Inc. DBA Visiting Nurse Signature
- Coordinated Care Services, Inc.
- Delphi Drug and Alcohol Council
- DePaul Community Services
- East House Corporation
- Epilepsy-Pralid, Inc.
- Finger Lakes Addictions Counseling and Referral (FLACRA)
- Greater Rochester Health Home Network (GRHHN)
- Health Homes of Upstate New York (HHUNY)
- Hillside Children's Center
- Huther Doyle Memorial Institute, Inc.
- Ibero-American Action League
- Jefferson Family Medicine
- L. Woerner, Inc. (dba HCR)
- Lifespan of Greater Rochester
- Monroe County Office of Mental Health
- Monroe Plan for Medical Care, Inc.
- New York Care Coordination Program, Inc.
- Rehabilitation Counseling & Assessment Services, LLC.
- Rochester General Health System
- Rochester Rehabilitation Center
- Steven Schwarzkopf Community Mental Health Center
- Trillium Health
- Unity Health System
- University of Rochester/Strong Memorial Hospital
- Villa of Hope
- YWCA

Example for Monroe County referrals.

Community Referral Application

Identifying Information

Name: Matilda McTest	Date of Birth: 12/31/50	Gender: female -
Address: 121 Rocket St Rochester, NY 14610	Medicaid CIN #: AA10037	
	Medicaid Managed Care Organization Name: Blue Choice option	
	County of Residence: Monroe	
Phone: (585) 555-2222	E-Mail: mbc's email	
Alternative Contact(s) Name, Phone #:		
Indicate any need for language/interpretation services; specify language spoken if other than English: any language other than English.		

Eligibility Category Information – Check All that Apply
Must meet either A only or B only or two Cs to be eligible for Health Home Care Management

Check		Category	Specify Diagnosis; Provide Available Detail
☐	A	Serious mental illness	ex. Major depressive d/o, Bipolar schizophrenia
☐	B	HIV/AIDS & the risk of developing another chronic condition	ex HIV, AIDS, HIV with a superinfection ex toxiplasmosis, Kaposi Sarcoma
☐	C	Mental Health condition	depression, anxiety, PTSD
☐	C	Substance Abuse Disorder	cocaine, opiates, alcohol, tobacco etc
☐	C	Asthma	Bronchial asthma etc
☐	C	Diabetes	diabetes type I or II - uncontrolled.
☐	C	Heart Disease	any cardiac - heart attack. arrythmia
☐	C	BMI > 25	obesity / morbid obesity
☐	C	Other Chronic Conditions (Specify)	

List Current Medical or Behavioral Health Treatment Providers, if Known:
PCP - Dr. Kennedy psych - Evelyn Brandon -

Care Management Needs - Check All that Apply

Check	Category	Explain Factor and Care Management Need
☐	Probable risk for adverse event	ex - inpatient, ~~ED~~ disability, death, SNF admission possible.
☐	Repeated ER/Inpatient Use, Including Avoidable ER Use	can be gathered from claims

☐	Lack of or inadequate social/family/housing support	homeless, undesirable living situation bugs - dangers etc. ø natural supports
☐	Lack of or inadequate connectivity with healthcare system	ø PCP, specialty care or ø linked to MH.
☐	Non-adherence to treatments or medication(s) or difficulty managing medications	not taking meds as prescribed, does not understand meds.
☐	Recent release from incarceration	just released.
☐	Recent release from psychiatric hospitalization	ex Elmyra psych, ø PC
☐	Deficits in activities of daily living such as dressing, eating, etc.	cannot dress, eat, or bathe independently.
☐	Learning or cognition issues	
☐	Financial Needs	

Risk and Safety Concerns – Check all That Apply

Check	Concern	Check	Concern
☐	Suicidal Ideation - > recent inpt for MH	☐	History of Suicide Attempts if known.
☐	Homicidal Ideation - >	☐	History of Violence - Domestic violence or criminal charges
☐	Active Substance Abuse - recent inpt for CD.	☐	Unsafe Living Environment
☐	Other – Specify		

Provide additional information regarding Risk and Safety Concerns checked above.

if checked above information should be included.

Narrative

Provide any additional information that may be helpful in assignment to a care management agency. If known, include strengths and/or interests of the referred individual

If being referred out any useful info that would be needed to the care management agency that is receiving.

Specify Preferred or Recommended Care Management Agency, if any: if recommending an agency otherwise should say mp.

Contact Information for Person Completing Referral:

Name: your name	Title: your title
Organization: Monroe Plan	
Phone: your phone	Email: your email.

To use when flipping a case.

Permission to Use and Disclose Confidential Information

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with care management and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of care management services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

Consent to disclosure of health information

The person whose information may be used or disclosed is:

Name: mbr. name.

Date of Birth: mbr DOB.

1. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
2. This information may be disclosed to the persons or organizations listed in Attachment A.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
4. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
5. This permission expires on n/A (date).
6. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship self.)

I give permission to use and disclose my records as described in this document.

mbr signature

Signature

Date

* if taking from another agency please have mbr indicate desire to change.

HHUNY example

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

HHuny - Huther Doyle institute
Name of Health Home

By signing this form, you agree to be in the HHUNY Huther Doyle memorial institute Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the Health Home.

The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the RHIO a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health treatment from your doctors and health care providers who are part of the Medicaid program.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO and/or from PSYCKES) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form, Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions; and/or
6. Sexually-transmitted diseases (diseases you can get from having sex).

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that use your health information and the Health Home must obey these laws and rules.

Please read all the information on this form before you sign it.

☑ **I AGREE to be in the** HHuny - Huther Doyle memorial institute **Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through** RHIO, or healthy Int or healthe connect **RHIO and/or through PSYCKES to give me care or manage my care, to** check if I am in a health plan and what it covers and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

mbr name printed
Print Name of Patient

mbr DOB
Patient Date of Birth

if mbr has a power of attorney.
Signature of Patient or Patient's Legal Representative

Date

Printed POA.
Print Name of Legal Representative (If Applicable)

relationship of POA to mbr.
Relationship of Legal Representative to Patient (If Applicable)

Details About Patient Information and the Consent Process

1. **How will partners use my information?**
   If you agree, partners will use your health information to:
   - Give you health care and manage your care;
   - Check if you have health insurance and what it pays for; and
   - Study and make health care for patients better.

   The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers must use.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. You can get a list of all the places and people by calling 1-800-855-613-7659 or talking to care manager. or talking to your care manager.

3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. **If I agree, who can get and see my information?**
   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a Health Home partner and who are involved in your health care; health care providers who are working for a Health Home partner who is giving you care; and people who work for a Health Home partner who is giving you care to help them check your health insurance or to study and make health care better for all patients. When you get care from a person who is not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider, may be given to them or seen by them.

5. **What if a person uses my information and I didn't agree to let them use it?**
   If you think a person used your information, and you did not agree to give the person your information, call one of the partners you have said can see your records or call HHUNY - Father Doyle Memorial Institute at 1800-613-7659. or the Medicaid Helpline at 1-800-541-2831.

6. **How long does my consent last?**
   Your consent will last until the day you take back your consent, or if you leave the Health Home program, or if the Health Home stops working.

7. **What if I change my mind later and want to take back my consent?**
   You can take back your consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners. If you agree to share your information, all Health Home partners listed at the end of this form will be able to get your health information. If you do not wish the Health Home partners listed on this form to get your health information, you need to take away your consent from the Health Home program. You can get this form by calling 1-800-613-7659.
   Your care manager will help you fill out this form if you want. Note: Even if you later decide to take back your consent, providers who already have your information do not have to give your information back to you or take it out of their records.

8. **How do I get a copy of this form?**
   You can have a copy of this form after you sign it.

HHUNY.

Health Home Name

Participating Partners

Copy this page as necessary to list all participating partners

Pt initials. date.

Patient Initials Date

list of providers + natural supports mbr should initial + date each entry.

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

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Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

Example GRHHN.

Print Form

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

Anthony L. Jordan Health Corporation on behalf of the Greater Rochester Health Home Network, LLC

Name of Health Home

By signing this form, you agree to be in the Anthony L. Jordan Health Corporation on behalf of the Greater Rochester Health Home Network, LLC Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the Health Home.

The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the ----------Rochester RHIO----------, a Regional Health Information Organization (RHIO). A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions; and/or
6. Sexually-transmitted diseases (diseases you can get from having sex).

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that use your health information and the Health Home must obey these laws and rules.

Please read all the information on this form before you sign it.

☑ **I AGREE to be in the** Anthony L. Jordan Health Corporation on behalf of the Greater Rochester Health Home Network, LLC **Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through** ----------the Rochester RHIO---------- RHIO to give me care or manage my care, to check if I am in a health plan and what it covers and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

mbr name printed
Print Name of Patient

pt DOB.
Patient Date of Birth

if mbr has a power of attorney
Signature of Patient or Patient's Legal Representative

Date

signature of POA.
Print Name of Legal Representative (If Applicable)

relationship if mbr signing.
Relationship of Legal Representative to Patient (If Applicable)

Details About Patient Information and the Consent Process

1. **How will partners use my information?**
   If you agree, partners will use your health information to:
   - Give you health care and manage your care;
   - Check if you have health insurance and what it pays for; and
   - Study and make health care for patients better.

   The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers must use.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. You can get a list of all the places and people by calling 585-737-7522 or talking to your care manager.

3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. **If I agree, who can get and see my information?**
   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a Health Home partner and who are involved in your health care; health care providers who are working for a Health Home partner who is giving you care; and people who work for a Health Home partner who is giving you care to help them check your health insurance or to study and make health care better for all patients. When you get care from a person who is not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider, may be given to them or seen by them.

5. **What if a person uses my information and I didn't agree to let them use it?**
   If you think a person used your information, and you did not agree to give the person your information, call one of the partners you have said can see your records or call Anthony L. Jordan Health Corporation on behalf of the Greater Rochester Health Home Network, LLC at 585-737-7522 or the Medicaid Helpline at 1-800-541-2831.

6. **How long does my consent last?**
   Your consent will last until the day you take back your consent, or if you leave the Health Home program, or if the Health Home stops working.

7. **What if I change my mind later and want to take back my consent?**
   You can take back your consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners. If you agree to share your information, all Health Home partners listed at the end of this form will be able to get your health information. If you do not wish the Health Home partners listed on this form to get your health information, you need to take away your consent from the Health Home program. You can get this form by calling 585-737-7522. Your care manager will help you fill out this form if you want. Note: Even if you later decide to take back your consent, providers who already have your information do not have to give your information back to you or take it out of their records.

8. **How do I get a copy of this form?**
   You can have a copy of this form after you sign it.

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9. Anthony L. Jordan Health Corporation on behalf of the Greater Rochester Health Home Network, LLC **Participating Partners**
   Health Home Name

Copy this page as necessary to list all participating partners

Patient Initials	Date
	Date

Name of Participating Partner	
AIDS Care, Inc. (DBA) Trillium Health	mbr initial
Anthony L. Jordan Health Corporation	
Care Team Connect, Inc.	
Catholic Charities of the Diocese of Rochester (DBA) Catholic Charities Community Services	
Catholic Family Center	
Delphi Drug & Alcohol Council, Inc.	
DePaul Community Services, Inc.	
East House Corporation	
Epilepsy & Pralid, Inc.	
Excellus Health Plan, Inc.	
New York State Catholic Health Plan, Inc., (DBA) Fidelis Care New York	
Hillside Children's Center	
Huther Doyle Memorial Institute, Inc. (DBA) Huther Doyle	mbr. initial date
Jefferson Family Medicine P.C.	
L. Woerner Inc (DBA) HCR	
Lifespan of Greater Rochester, Inc.	
Monroe Plan for Medical Care, Inc.	
MVP Health Plan, Inc.	
Monroe County	
Rehabilitation Counseling & Assessment Services, LLC	
Rochester General Hospital (Behavioral Health Network, Inc.)	
Steven Schwarzkopf Community Mental Health Center	
University of Rochester	
Unity Health System	
Community Care of Rochester, Inc. (DBA) Visiting Nurse Signature Care	
Greater Rochester Health Home Network, LLC.	
Peartree Health Strategies, LLC	
Burchman, Terrio, Gebhardt and Quist LLC.	mbr initial date

Name of Participating Partner

Copy this page as necessary to list all participating partners

Patient Initials mbr initial date Date

Rochester Rehabilitation Center, Inc.

Name of Participating Partner

any other provider or natural supports not included

Name of Participating Partner initial + date

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

Name of Participating Partner

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Name of Participating Partner

example.

ROCHESTER RHIO

Regional Health Information Organization

RHIO CONSENT FORM

Health Plan: Monroe Plan

In this Consent Form, you can choose whether to allow the above named Health Plan to obtain access to your medical records through a computer network operated by Rochester RHIO, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow the above named Health Plan to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, the above named Health Plan's staff involved in my care may see and get access to all of my medical records through Rochester RHIO."

If you check the **"I DENY CONSENT"** box below, you are saying "No, the above named Health Plan may not be given access to my medical records through Rochester RHIO for any purpose."

Rochester RHIO is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask the above named Health Plan for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- ☑ **I GIVE CONSENT for the above named Health Plan to access ALL of** my electronic health information through Rochester RHIO in connection with providing me any health care services, including emergency care.
- ☐ **I DENY CONSENT for the above named Health Plan to access** my electronic health information through Rochester RHIO for any purpose, *even in a medical emergency.*

  NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Rochester RHIO.

mbr name
Print Name of Patient

mbr DOB
Patient Date of Birth

signature of mbr or Power of attorney
Signature of Patient or Patient's Legal Representative

Date

Printed Power of attorney
Print Name of Legal Representative (if applicable)

relationship of power of attorney.
Relationship of Legal Representative to Patient (if applicable)

Effective 4/1/2011

Details about patient information in Rochester RHIO and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by the above named Health Plan **only** to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, the above named Health Plan may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Rochester RHIO. You can obtain an updated list of Information Sources at any time by checking the Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-7446.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve the above named Health Plans medical staff who are involved in your medical care; health care providers who are covering or on call for the above named Health Plan's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the above named Health or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed the above named Health Plan to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Rochester RHIO and persons who access this information through the Rochester RHIO must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time as the RHIO ceases operation.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to the above named Health Plan or to the Rochester RHIO. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on Rochester RHIO's website www.RochesterRHIO.org or by calling 1-877-865-7446. **Note: Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it.

example

New York State Department of Health
Medicaid

Health Home Opt-out Form

Attestation Statement

For use by Health Home eligible Medicaid client

☐ I have met with the care manager for either HHUNY or GRHHN.
Name of Health Home

who has explained the program to me and the care management services I can get. I have decided not to join at this time.

For use by care manager

☐ I have discussed HHUNY / GRHHN. - used for verbal opt out.
Name of Health Home

program with mbr name + CIN -
Name of Medicaid Member over the telephone. The benefits of membership were explained; however, the Medicaid client has decided not to join at this time.

Reason for Opting Out

give the reason for mbr opting out.

Signatures

I understand that I will not get a care manager or Health Home services, but I will still continue to get my Medicaid health care services.

Name of Member or Client's Legal Representative (print)	Original Signature	Date
if mbr opts out in person. mbr name.	mbr. signature	
Name of Health Home Care Manager (print)	**Original Signature**	**Date**
your name	your signature.	

NOTE

If you would ever like to get Health Home services contact the NYS Medicaid Program by calling the Medicaid Call Center at 1-800-541-2831.

If an open case & mbr ø longer wants to participate -

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Withdrawal of Consent

Monroe Plan
Name of Health Home Provider Organization

By signing this form I am saying that I do not want to be in the HHUNY / GRHHN. Health Home program.
Name of Health Home

Because I will no longer be in this Health Home program, by signing this form I am also taking away my permission for the Health Home to share my personal health information with providers and others in the Health Home program, including the Regional Health Information Organization (RHIO). If I signed a separate consent form with the RHIO, my permission to share my personal health information with providers and others through the RHIO will continue. I understand that the providers who already have my health information do not have to give it back to me or take it out of their records. But, Health Home providers may no longer get, see, read, copy and share my health information after the date I sign this form. I know that "personal health information" may include health information, mental health information, information about alcohol or substance abuse treatment, and/or HIV/AIDS information.

I am aware that my personal health information will still be protected under New York State and U.S. laws and rules. The Health Home partners that currently have my health information must obey all of these laws.

I also am aware that ending my participation in the Health Home program will not prevent me from getting health care or other direct care management services.

Any previously signed Health Home Consent Forms signed by me are hereby revoked.

mbr or PoA must sign

Print Name of Patient

mbr DOB.

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Details about Patient Information and the Withdrawal of Consent Process

1. **How will partners further use my information?**
   Partners may no longer use your health information.
2. **What will happen to my health information?**
   Your health information will be kept by providers who already have your information, but still must protect it by following all New York State and U.S. laws and rules.
3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations are New York Education Law Section 6530(23), Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 and the federal confidentiality regulations in 42 CFR Part 2.
4. **Who can get and see my information after I withdraw my consent?**
   No one can obtain any new health information about you, but information that has already been disclosed cannot be taken back. People who can see health information already disclosed are: those that were part of the Health Home before you withdrew consent, like doctors and other people who work for a Health Home partner and who were involved in your health care; health care providers who are working for a Health Home partner who gave you care; and people who work for a Health Home partner who gave you care to help them check your health insurance or to study and make health care better for all patients. Also, when you got care from a person who was not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider may have been given to them or seen by them.
5. **What if a person uses my information and I didn't agree to let them use it?**
   If you think a person used your information, and you did not agree to give the person your information, call one of the partners you have said can see your records or call either HHUNY or GRHHN at _____ or the Medicaid Call Center at 1-800-541-2831.
6. **How long does my withdrawal of consent last?**
   Your withdrawal of consent will last until the day you sign a new consent to a Health Home.
7. **What if I change my mind later and want to participate in a Health Home and have my health information shared?**
   If you change your mind please let your health plan or former Health Home know that you are interested in being in a Health Home again.
8. **How do I get a copy of this form?**
   After you sign this Withdrawal of Consent Form, ask for a copy and it will be provided to you.

DOH-5058 (11/12)

What happens to my Primary Care Physician and Counselor?

The Health Home Care Manager shares the Care Plan that you have developed together with your physician, your counselor and other service providers. The Care Plan explains the work being done by the Health Home to support your goals.

What if I am a member of a Managed Care Organization?

Members of Medicaid Managed Care Organizations are eligible to receive Health Home Care Management. Once you complete the application and consent form, HHUNY will contact your Managed Care Organization to let them know.

Who pays for Health Home Services?

Medicaid pays for Care Management services for those who are eligible. It does not cost you anything to enroll.

HHUNY Partners

- Alcohol & Drug Dependency Services
- Chautauqua County Department of Mental Hygiene
- Huther Doyle Memorial Institute
- Onondaga Case Management Services
- New York Care Coordination Program (NYCCP)
- Coordinated Care Services, Inc. (CCSI)
- Beacon Health Strategies

HHUNY

Health Homes of Upstate New York

HHUNY-SOUTHERN TIER HHUNY-WESTERN
HHUNY-FINGER LAKES HHUNY-CENTRAL

1-855-613-7659
WWW.CARECOORDINATION.ORG

HHUNY

Health Homes of Upstate New York

Offering Comprehensive Care Management to Medicaid Recipients

"Life takes on meaning when you become motivated, set goals and charge after them in an unstoppable manner"- Les Brown

Let Health Homes of Upstate New York (HHUNY) assist as you begin the charge forward.

What is a Health Home?

Health Homes provide Care Management services to help make sure everyone involved in an individual's care is working well together and sharing information that is important in supporting a person's recovery. A Health Home Care Manager is expected to help coordinate not just medical, mental health, substance abuse services, but the social service needs of the individual as well.

How can the Health Home help me?

The work of the Health Home is about improving not just your physical health, but your mental health and your social health as well. The Health Home assists you to:

- Get involved in activities to improve and keep you healthy
- Obtain housing, legal assistance, food and other essential needs
- Learn more about meaningful social and community activities to include in your life
- Successfully move from one type of care to another
- Make sure everyone involved in your care understands your goals and the care plan created with you to help meet your goals.

Who is Eligible?

- Medicaid recipients, including those who are already members of a Managed Care Organization. Individuals who have both Medicaid and Medicare are also eligible.
- Those eligible need to meet one of the following conditions:
  - Two or more chronic health conditions, such as asthma, diabetes, heart disease, mental health condition or substance use disorder
  - A significant Mental Illness
  - Living with HIV/AIDs
- Referrals for HHUNY Care Management services can be made for individuals living in any of the following New York counties: Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Cortland, Erie, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne and Yates.

How is it different from other Care Management?

Health Home Care Managers are trained to consider all of your needs: the needs of the whole person. Therefore you receive support in areas you may not have had assistance with before including housing, legal assistance and becoming involved in social or community activities. The help you receive is driven by your goals and the needs you identify in meeting these goals.

Health Home Care Managers also visit you if you go into a hospital to help make sure your needs at the time of discharge are met.

What are the people that I would be working with like?

The Care Management staff members are caring individuals who talk with you about your goals, your needs and what will make your life meaningful. They also know where to go and who to talk with in order to make sure these needs are met as quickly as possible and you have the supports needed for recovery.

Who Do I Speak with if I have Questions?

If you would like to speak with someone about the Health Homes of Upstate New York (HHUNY) Care Management Program, please call 1-855-613-7659 and ask to speak with either Helen Warnick or Tracy Marchese. Both would be happy to answer any questions you might have and make sure you have a copy of the HHUNY Care Management Referral Form.

How do I Sign Up?

For information please call 1-855-613-7659. You will be offered assistance in completing an application and consent form.

New York
CARE COORDINATION PROGRAM

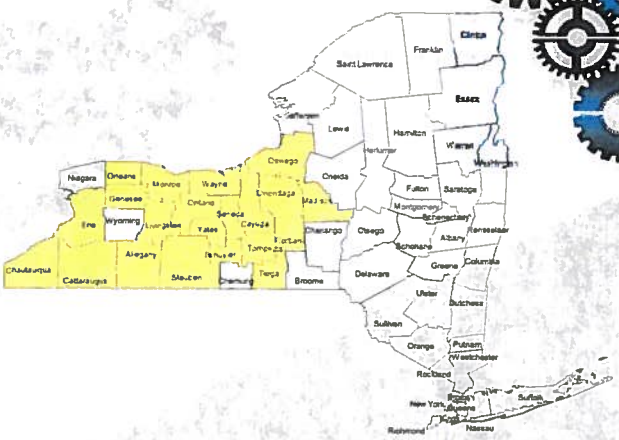
Creating a person-centered, recovery-focused system of care
WESTERN REGION BEHAVIORAL HEALTH ORGANIZATON
WITH BEACON HEALTH STRATEGIES, LLC AND COORDINATED CARE SERVICES, INC

Health Homes of Upstate New York
May 3, 2013

Health Homes of Upstate New York (HHUNY)

- Networked model for provider level care management, with a shared infrastructure
- Collaborative partnership – New York Care Coordination Program (NYCCP), Beacon Health Strategies, LLC, CCSI and four Health Home Provider Leads
- Provider Leads and Hubs:
  - Alcohol and Drug Dependency Services (ADDS) – HHUNY Western
  - Chautauqua County Department of Mental Hygiene – HHUNY Southern Tier
  - Huther Doyle Memorial Institute – HHUNY Finger Lakes
  - Onondaga Case Management Services – HHUNY Central

Health Homes of Upstate New York
23 counties, 3 urban, 18 rural



HHUNY Structure

- Initiative of NYCCP, building on the Western Region RBHO partnership between NYCCP, Beacon and CCSI with the addition of Health Home Lead Providers
- HHUNY collaboration unites the four regional hubs into a single governance and administrative structure
- Contractual relationships between partners align the areas of expertise of each party with the infrastructure functions to be performed
- Advisory Board with representatives from all partners guides the direction; working committees established for implementation planning tasks

Partner Roles/Responsibilities

- NYCCP - Partnership organization, infrastructure, administrative / management services
- Beacon – HIT systems and support, billing and claims payment, reporting, candidate assignment, call center, telephonic care management
- Health Home Provider Leads – DOH designated Health Homes; network and hub development; providers of network services; three provide community care management services

Partner Competencies – NYCCP

- Demonstrated improved client outcomes & reduction in costs for recipients of care coordination service across 7 counties (2002-2010)
- Achieved positive outcomes in pilot projects for integrated care management across physical and behavioral health and social service needs.
  - Complex Care Management pilot with Beacon Health Strategies, providing a foundation for health home care management
  - Earlier integration pilots in partnership with MCO's providing valuable lessons learned used to shape Complex Care Management pilot
- Development and implementation of curriculum, resources & training for person-centered practices, physical health/behavioral health integration
- Partner for development, coordination & delivery of training for 2 NYS DOH Workforce Retraining Initiative contracts for health home care management practice change for TCM and MATS providers
- Lead for Western Region RBHO in partnership with Beacon Health Strategies and CCSI

Partner Competencies – Beacon Health Strategies, LLC

- Managed Behavioral Health Organization serving commercial and public sector clients, with expertise in integration models
- Partner with Westchester County and Hudson Health in Chronic Illness Demonstration Program in Westchester County
- Partner with NYCCP in planning for development of managed systems of care in preparation for NYS Medicaid redesign
- Partner with NYCCP in complex care management pilot, providing CMSA certified expertise in integrated care management
- HIT systems and expertise including care management clinical applications, provider interface and connectivity and all administrative functions
- Partner with NYCCP and CCSI for Western Region RBHO

Partner Competencies – Huther Doyle Memorial Institute

- Provider of chemical dependency treatment and support services, including outpatient treatment programs, operating the only Hispanic culture/language free standing clinic in the western region and the only HIV-specific satellite OASAS clinic in upstate New York
- Approved by the Department of Health to open an Article 28 outpatient primary care clinic in 2013
- Community stakeholder in Monroe County and the Finger Lakes Region for 25+ years, providing leadership for collaborative efforts
- Expertise in serving HIV/AIDS and re-entry populations and general case management experience

Partner Competencies
Alcohol and Drug Dependency Services

- Provider of chemical dependency treatment and support services, including medical withdrawal and stabilization services, adult inpatient rehabilitation, residential, outpatient treatment, supportive living apartments, supported housing and adolescent residential rehabilitation and outpatient services
- Community stakeholder in Erie County for 30+ years, participating in numerous multi-agency collaborative projects
- Active partner in numerous research projects including many publications in medical and addiction journals
- Expertise in serving criminal justice population; partnerships with federal probation/parole, NYS Department of Corrections and Community Supervision, Erie County Probation, and WNY Drug Courts.

Partner Competencies: Chautauqua County Department of Mental Hygiene

- Local governmental unit for mental hygiene services, overseeing the mental hygiene system in Chautauqua County
- Largest provider of behavioral health services in the community, providing a range of treatment and support services. CCDMH has operated the adult Targeted Case Management Program serving 120 consumers at any point in time since 2001
- Partner in the NYCCP since its inception

Partner Competencies
Onondaga Case Management Services

- Provider of a range of behavioral health case management services, including TCM and ACT, peer mentoring programs and community-based treatment and support options for youth
- Long standing community stakeholder in Onondaga County, participating in and leading numerous community collaborations
- Expertise in serving homeless and forensic populations
- Participant in NYCCP since its inception

Benefits/Efficiencies

- Strong voice for 1/3 of NYS
- Economies of scale
  - Shared infrastructure – 4 Health Homes, 21 counties
  - Cost per person decreases as number of enrollees increases
- Standardized practice across health homes increases efficiency and decreases administrative burden for communities
- Efficiencies for RHIO connectivity – common practice, single entity to broker across RHIO's

Benefits/Efficiencies

- Hub concept blends local county and regional approaches
  - Unites the 3 largest upstate counties with 18 rural counties, allowing for more efficient/effective cross-county, regional network development to ensure service access
  - Draws upon local county relationships to ensure effective linkages with Departments of Social Services, Jails/Prisons and other county based community systems
- Ensures that rural counties have a viable health home; HHUNY is the sole health home in 15 of the 18 rural counties

Role of the WRBHO in Supporting Health Homes

- Notify inpatient providers when an admitted individual being reviewed by the WRBHO is enrolled in a Health Home or eligible for Health Home outreach
- Ensure the provider has contact information for the Health Home care coordinator.
- Contact Health Home care coordinators to review and assist with post-discharge follow-up as needed.
- Share past treatment history as found in PSYCKES and FlexCare
- Alert Health Home when Health Home member is admitted.
- Support community referrals to Health Homes

Implementation - Phase 2 In Process

- **Provider Agreements with Health Home Care Management Service Providers**
  - Converting TCM Providers
  - Other Providers of Health Home Care Management Services
- **Memoranda of Understanding with Network Partners**
  - Provider Network, other than providers of Care Management Services
- **Contracts with Managed Care Organizations**
- **Contracts with RHIO**

Implementation Phase 2 in Process

- **DEAAs for information sharing**
- **Development of Care Management Manual**
  - Assignment Protocol and Criteria
  - Community Referrals
  - Care Management Standards
  - Reporting Requirements – Tracking System; CMART
  - Billing Instructions
- **HHUNY Interim Care Management Standards - Complete**
  - Converting TCM Providers / Other providers of Health Home Care Management Services
  - Required core elements of the record, including assessment, service plan, referrals, communication
  - Practice guidelines
  - Policies and procedures
- **Communications Platform**
  - Working with RHIOs and others

Interim

CARE

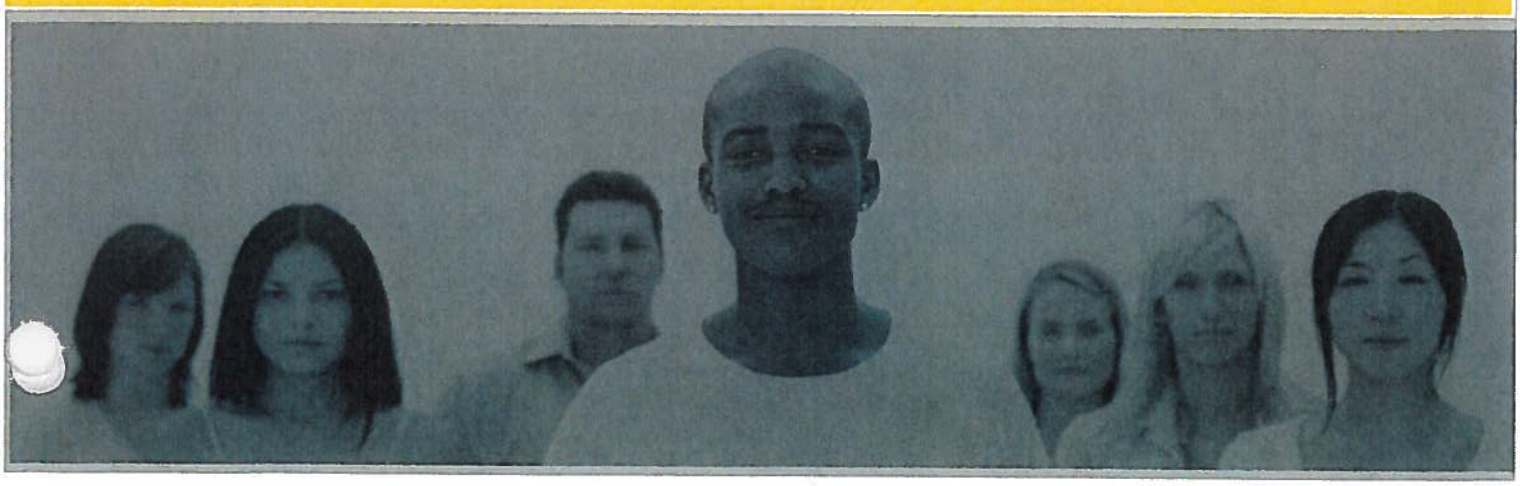
MANAGEMENT

STANDARDS

Health Homes of Upstate New York

Alcohol & Drug Dependency Services — Beacon Health Strategies
Chautauqua County Department of Mental Hygiene — Huther Doyle Memorial Institute
New York Care Coordination Program — Onondaga Case Management Services

Issue Date: March 1, 2013



HEALTH HOMES OF UPSTATE NEW YORK
Interim Care Management Standards
Issue Date: March 1, 2013

INTRODUCTION AND BACKGROUND:

Health Homes of Upstate New York (HHUNY) is pleased to welcome your organization as a provider of Health Home Care Management Services in our network of providers. We look forward to working with you in providing services for our Health Home Enrollees. This document was created with consideration for the continued development of Health Home requirements from the State of New York. This document provides interim expectations for care management service provision with further standards being developed as guidance is provided from the State as well as consideration of the feedback we receive from our network partners.

Services provided to Health Home enrollees must be in compliance with New York State Regulations and Federal Law including compliance with New York State's Plan Amendment and Medicaid regulations. All care management services that are billed either directly to Medicaid or to the Health Home for the purposes of Medicaid billing must meet Medicaid billing standards. Attached you will find copies of the Phase 2 and Phase 3 New York State Plan Amendments as well as the New York State Medicaid Updates, April 2012 and November 2012 Special Editions and December 2012 (relevant section), which provide further information relative to the provision of health home services. These documents may also be found on the Health Homes section of the NYS DOH website by following the link to the SPA at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm and the link to the Medicaid Updates at http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/medicaid_updates.htm.

Federal Law and State Regulations require providers to retain financial and health records necessary to fully disclose the extent of services, care and supplies provided to Medicaid enrollees. For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment.

HHUNY will provide updated information and care management requirements regularly to the Principal Contact indicated on your Network Provider Letter of Intent. Care Management Agencies are required to respond immediately to any guidance information provided by HHUNY or to changes in the rules governing Medicaid Health Homes. It is vital that Care Management Agencies inform HHUNY as to any changes in the principal contact including contact name, phone number, address and/or e-mail address by notifying your Health Home Provider Lead contact.

HHUNY CONTACT INFORMATION:
For any questions or assistance, please feel free to contact either your Health Home Provider Lead or the HHUNY office at 585-613-7665.

Huther Doyle Memorial Institute, Inc.
Serving: Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates, Genesee, Orleans, and Monroe Counties
Contact: Robert Lebman, rlebman@hutherdoyle.com,585-325-5100

Alcohol and Drug Dependency Services, Inc.
Serving: Erie County
Contact: William Burgin, William.burgin@addstx.org, 716 – 854-2997

Onondaga Case Management Services, Inc.
Serving: Cortland, Madison, Onondaga, Oswego, Cayuga, Tompkins, and Tioga Counties
Contact: Shawna Craigmile, LCSW, scraigmile@ocmsinc.org, 315-472-7362 ext. 265

Chautauqua County Department of Mental Hygiene
Serving: Allegany, Cattaraugus, and Chautauqua Counties
Contact: Patricia A. Brinkman, MBA, brinkmap@co.chautauqua.ny.us, 716-753-4104

Billing or Tracking Questions
Contact: Neilia Kelly, nkelly@ccsi.org, 585-613-7688

Assignment Questions:
Contact: Christine Mangione, RN, CCM , Christine.mangione@beaconhs.com, 585-613-7652

Care Management Service Provision Questions:
Contact: Shawna Craigmile, LCSW, scraigmile@ocmsinc.org, 315-472-7362 ext. 265

SERVICE PROVISION:
Care Management Agencies that contract with HHUNY to provide Health Home Care Management must be fully aware of the rules and regulations that govern Health Home Care Management Services. Care Managers must be aware of the requirements of service provision in Health Homes and demonstrate competencies in the provision of those services.

Assignment:
Each Health Home Enrollee will be assigned one dedicated care manager who is responsible for overall management and coordination of the enrollee's care plan, which will include both medical/behavioral health and social services needs and goals.

Health Home Care Management Service definitions are found in the State Plan Amendment with additional detail found in the Medicaid Update, April 2012:

> *Health Homes must provide at least one of the five core (exclusive of HIT) Health Homes services per 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, telephone calls, and case conferences. Active, ongoing and progressive engagement with the client must be documented in the care management record to demonstrate active progress toward outreach and engagement, care planning and/or the client achieving their personal goals. The State retains the right to review Health Homes care records as required to assure that active services were being provided in each month for which a Medicaid payment was made for Health Home services.*

Outreach & Engagement: New York State Medicaid Update, April 2012 provides the following information regarding Outreach and Engagement:

> *The outreach and engagement Per Member Per Month payment will be available for three months. If outreach and engagement is unsuccessful (defined as not locating the member and/or not enrolling the member), the provider may continue outreach and engagement but may not bill again for these activities until the conclusion of a three-month interval.*

Health Home Care Management Agencies are to begin outreach and engagement activities in a timely manner once they have received a Health Home enrollee assignment. For assignments received prior to the 15th of any month, outreach and engagement must begin within 5 business days of the receipt of the assignment. For assignments received later in the month, the Care Management Agency should consider the all information made available during the assignment process to determine how quickly outreach should begin, including, enrollee's known needs and risk factors, as well as any requirements of the MCO for those who are enrolled in a managed care plan to determine if it is appropriate to defer outreach activities to the 1st of the following month. The following time lines must be adhered to for assignments of enrollees with an AOT order or for enrollees in an inpatient program at time of assignment:

AOT: Care Management Agencies receiving assignment of an enrollee who has an AOT order must begin Outreach and Engagement Activities within 3 business days of receiving the assignment

Inpatient Enrollees: In instances when a Care Management Agency receives an assignment of an enrollee who is presently in an inpatient program, Outreach and Engagement Activities must begin within 3 business days of receiving the assignment or prior to the individual's discharge, whichever is sooner with the intent being to connect with the enrollee prior to discharge.

The date these activities begin, as well as the specific activity, is to be clearly documented in the contact note.

Health Home Care Management Agencies are to utilize information provided by the Health Home as well as various outreach methods to locate the individual who is eligible for Health Home Services including:

- Office based outreach (phone calls, letters, collateral contacts)
- Community based outreach
    - Enrollee's home/neighbors/landlord
    - Community locations (corner store, drop in centers, faith based organizations, etc.)
    - Last known service providers (doctors, hospitals, dentist, etc.)
    - Managed Care Organizations
    - Family members
    - Homeless shelters/social service providers
    - Jail/prison
    - LGU/SPOA and other community networking groups
    - Health Information databases (PSYCKES, Regional Behavioral Health Organization (RBHO), and/or the claims data provided from DOH in the Member Tracking System)

Health Home Care Managers are expected to provide, and document, progressively intensive outreach activities. Outreach and engagement may be billed for up to 3 months. If at the end of the 3 months the individual has not been located, and/or initially engaged, the Care Management Agency is to determine if efforts to locate the individual will continue beyond the initial 3 months. Billing for outreach activity shall be in compliance with NYS DOH guidelines.

Once a Health Home enrollee has been contacted, the Health Home Care Manager ensures the individual has a clear understanding about NYS Health Homes and the services available to them through Care Management. The Health Home Care Manager will consider how the individual understands this information based on their cognitive, language, and reading abilities.

HHUNY defines the ending of outreach and engagement and the commencement of ongoing care management as being the point where the individual is verbalizing willingness to participate in Health Home Services and the assessment process is able to begin. The date indicating the start of on-going care management must be documented in the contact note.

Opt-Out:
The Health Home program is voluntary and Health Home Care Managers need to be fully aware of NYS Health Home rules regarding an individual's ability to Opt-Out of Health Homes. For individuals considering opting out of Health Homes, the Care Manager is to ensure that the individual and their natural supports understand the benefits of participating in Health Homes and Care Management Services. It is important that the individual understand that they can continue to utilize Medicaid services if they opt-out of Health Homes and are informed about the process to re-enroll in Health Homes if they chose to do so in the future.

For individuals who decide to opt-out of Health Homes, the Health Home Opt-Out Form (DOH-5059) must be completed and signed either by the individual or the Health Home Care Manager. This form is attached and may also be found on the Health Homes section of the NYS DOH website by following the link:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/#optout.
The individual is considered dis-enrolled from Health Homes once the form is completed. The date the Opt-Out Form is signed must be indicated in the contact notes.

On-Going Care Management:
Care Management Agencies must assure that Core Health Home Services Interventions/Activities are being provided and documented monthly. Care Management Agencies are to ensure the following services are being provided as per the enrollee's needs:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Patient & Family Support
- Referral to Community & Social Support Services

Services coordinated in conjunction with the Health Home:
- ED visits
- Hospital inpatient
- Residential /Rehabilitation:
- Crisis Intervention Services:
- Linkages to acute & outpatient medical, mental health and substance use services:
- Linkages to community based social support services, including housing:

Please refer to the attached New York State Plan Amendment as well as the April 2012 New York State Medicaid update for further detail regarding Core Health Home Services.

MANAGED CARE ORGANIZATIONS:
HHUNY will make available to Care Management Agencies information regarding providing services to individuals who participate in a managed care plan. Care Managers must support Health Home enrollees in accessing services as allowed by their managed care plan.

CONSENT:
Securing Consent: Health Home Care Managers must be fully aware of NYS Health Home rules regarding the completion of the Health Home Patient Information Sharing Consent Form (DOH-5055). This form and instructions for its use are attached and may also be found on the Health Homes section of the NYS DOH website by following the link: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/#consent.
It is the Health Home Care Manager's responsibility to assure that the individual understands the information, has the opportunity to ask questions, and have the form made available in the individual's primary language (as made available by DOH). For individuals with concerns about the consent form, Health Home Care Managers are encouraged to seek engagement of others, utilize a supervisory consult, and/or peer services. It is important that the individual be fully informed about the consent process.

The Consent Form must be provided to all relevant parties and maintained in the care management record.

Withdrawal of Consent: An enrollee may withdraw their consent at any time by submitting a Health Home Information Sharing Withdrawal of Consent Form (DOH 5058). The submission of this form states the enrollee's decision to dis-enroll from the Health Home. This form is attached and may also be found on the Health Homes section
of the NYS DOH website by following the link:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/#withdrawal.

The Health Home Care Manager is responsible for notifying all relevant parties if a member withdraws their consent. The Withdrawal Form must be provided to all relevant parties and maintained in the care management record.

ON-CALL ACCESS:
New York State requires Health Home enrollees to have access to a Care Manager 24 hours / 7 days a week to provide information and emergency consultation. Care Management Agencies will ensure that a qualified Care Manager is available for this purpose and that enrollees are aware and have access to this service.

HEALTH HOME DOCUMENTATION:
Each Health Home Enrollee will have a single care management record which will minimally include the following documentation:

- Health Home Patient Information Sharing Consent Form and any additional consent forms
- Health Home Opt-Out Form (if applicable)
- Health Home Patient Information Sharing Withdrawal of Consent Form (if applicable)
- Comprehensive Assessment
- Plan of Care
- Plan of Care Review
- Contact Notes
- FACT-GP
- Health Home Functional Assessment

Comprehensive Assessment:
New York State Health Home requires that each enrollee has a Comprehensive Health Assessment completed, which is used to identify the enrollee's physical, mental health, chemical dependency and social services needs, as applicable.

HHUNY requires that the Comprehensive Assessment be completed within 30 days of the start of on-going care management. Appreciating the barriers and challenges that some of the enrollees experience, if the Care Manager is unable to complete the comprehensive assessment within 30 days, there must be documentation that details ongoing efforts to engage the individual in completing the assessment.

HHUNY requires that all of the following domains are addressed in the Comprehensive Assessment:

- Physical Health
- Mental Health
- Chemical abuse/dependency
- Housing, transportation, financial, employment, education
- Relationships, community involvement
- Identification of all current providers
- Enrollee identified barriers, strengths and priorities

On-going care management includes the process of re-assessing the individual's interests and needs.

Plan of Care:
New York State Plan Amendment requires:

- Each enrollee will have a comprehensive, individualized, patient centered plan of care. The plan of care will be based on information obtained from the comprehensive assessment. The plan of care will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable.

- The plan of care will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager, and other providers directly involved in the individuals care.
- The individuals plan of care must also identify community networks and supports that will be utilized to address their needs.
- Goals and timeframes for improving the patient's health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.
- Family members and other supports involved in the patients care should be identified and included in the plan and execution of care as requested by the individual.
- The plan of care must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care.
- The plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be based on changes in the patients need.

The Care Manager is responsible for developing an Interdisciplinary Care Team that includes the individual, treatment/care and support providers and others identified by the enrollee as important (i.e. family members, peers, natural supports). The Plan of Care is to be developed *with* the individual and the Care Team, including and integrating the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The Care Plan, and progress and updates to the Plan, are to be shared among all relevant parties, with the appropriate consents. Interim mechanisms for sharing the Care Plan may include transmission via secure e-mail or fax.

In addition to what is required by the State, HHUNY further requires the Plan of Care to include what is important to the individual, what goals they have for themselves, what strengths can be utilized in their Plan of Care, what barriers impede goal attainment, and what priorities and preferences the person has for care. Goals are to be written in the person's own words and reflect an overall goal the person wants for themselves. Strengths and barriers identified should be related to the goal. Objectives must be measurable, time specific, achievable, and based on barriers preventing attainment of the recovery goal. Interventions must address who will do what, where, and within what time frame. The Plan of Care must be written in a manner that is understandable to the individual (at their reading and comprehension level) and either translated into their primary language if they are unable to read English or translation services must be made available to ensure that the Plan of Care is understood and the information is effectively communicated to the individual. If the enrollee so chooses, a family member or natural support may be used to provide such translation.

The Plan of Care is to be completed 30 days after the completion of the Comprehensive Assessment. As with the Comprehensive Assessment, appreciating the barriers and challenges that some of the enrollees experience, if the Care Manager is unable to complete the Plan of Care within 30 days, there must be documentation that details ongoing efforts to engage the individual in completing the Plan of Care.

The Plan of Care is to be reviewed minimally every 6 months to monitor and evaluate individual progress and ongoing needs. These reviews will involve the Health Home enrollee and include discussion regarding their progress towards identified goals, the effectiveness and satisfaction of interventions identified in the Plan of Care, and address integration of new strengths/barriers identified. Plan of Care reviews shall also include dialogue (by phone and/or by use of conference tools) with involved service providers to assure that changes in treatment or medical conditions are addressed as well.

Contact Notes:
Health Home Care Manager's documentation must accurately and objectively reflect Health Home activities. Health Home Care Managers should consider all audiences when creating any documentation and assume that all involved in the Plan of Care, including the individual, will have access to the materials in the individual's care management record.

New York State requires the following to support billing each month:

- Outreach and engagement activities
- Active Plan of Care development
- Active Care Management according to the Plan of Care
- At least one of the five (excluding HIT) core Health Home services
- Care management activities that include face-to-face meeting(s), mailings, electronic communications and telephone calls.
- Care Management activities must demonstrate active progress in moving the Plan of Care forward toward achieving goals.

**Documentation that supports Medicaid billing MUST meet Medicaid requirements.*

In addition to documentation as required by the State, HHUNY requires the following to be included in each contact note:

- Clear identification of the Health Home Enrollee, to include the Health Home recipient ID #
- Full name of the individual providing the service
- Date service was provided
- Type of contact/service delivery (FTF, Phone, Correspondence)
- Identification of who participated in service delivery (meaning distinction between a client contact and collateral, as well as service provider meeting)
- Clear indication of which of the core services are being provided at time of contact.

Contact notes must be completed within 5 business days. Documentation of significant events (hospitalization, emergency health condition, arrest, etc.) that must be communicated to other service providers will be documented by the next business day. Changes to individual's contact information (phone number, address, etc) must be documented no later than 5 business days.

FACT-GP and the Health Home Functional Assessment:
New York State requires the FACT-GP and the Health Home Functional Assessment to be completed for each enrollee at enrollment, annually, and at discharge. (*To Note; at the time of this writing the State has indicated that the frequency of completion and reporting of these two documents is likely to change. Care Management Agencies must assure that the completion of these documents are compliant with the most current standards.*) Care Managers are to complete these documents as outlined in the Scoring Guidelines for FACT-GP/Health Home Functional Assessment. These documents are attached and may also be found on the Health Homes section of the NYS DOH website by following the link:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm.

These documents must be maintained in the care management record.

HEALTH HOME OUTCOMES AND QUALITY ASSURANCE:
New York State has defined Health Home Outcomes as indicated in the State Plan Amendment. Quality indicators are currently in development by the State. HHUNY will be developing a comprehensive Quality Assurance Plan based on the State's final quality indicators.

Care Management Agencies are strongly encouraged to develop internal tracking for the following outcomes:

- Rates of initial engagement and on-going engagement of Health Home enrollees
- Measure of State Plan Amendment Outcomes

HHUNY will be identifying training opportunities to improve services to Health Home enrollees. Care Managers will be required to either demonstrate having received applicable trainings previously or attend trainings required by HHUNY.

ADDITIONAL REFERENCE INFORMATION:
New York State Medicaid Health Homes:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

New York State Medicaid Updates:
http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/medicaid_updates.htm

New York State Plan Amendment:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm

Questions and/or comments regarding New York's implementation of health homes can be directed to hh2011@health.state.ny.us.

HHUNY
Health Homes of Upstate New York
HHUNY-SOUTHERN TIER HHUNY-WESTERN
HHUNY-FINGER LAKES HHUNY-CENTRAL

CARE MANAGEMENT RECORD AUDIT

Date of Audit:				
Care Manager:				
Reviewer:				
Client Identification Number:				
Standard	P.P	Score	N/A	Comments
Completion of forms **Guidance from DOH**: Computer/electronic records are secure and password protected. All confidential HIPAA information (paper and electronic) is secured against unauthorized access. (Includes eligibility files, signed consents, care plans, etc). The client's consent is to include the HH network & the individual's providers; is signed, dated and maintained securely.				
1. Eligibility determination has been completed.	1			
2. Documentation of HIV/Homeless status	1			
3. A consent for treatment form included and signed.	3			
4. Comprehensive Assessment, FACT GP and Health Home Functional Assessment is completed within 30 days of client's enrollment.	3			
5. Client's care plan completed, signed and dated	3			
6.. Care Management notes are completed, signed and dated	3			
7. Documentation of PHI is securely maintained.	3			
8. Files are maintained in organized fashion.	2			
9. Documentation is legibly written (when appropriate).	1			
10... Errors are corrected appropriately	1			
TOTALS	21			
Fiscal Accountability				
1. Income is verified	3			
TOTALS	3			
Assessment and Interventions **Guidance from DOH**: Comprehensive assessment is conducted to identify medical, mental health, chemical dependency and social service needs. CMA: -Provides coordination of care and services of post critical events, such as ED visits, hospital inpatient and/or residential/ rehabilitations setting, admission and/or discharge. -Has Multilanguage access and translation services. -Provides crisis intervention services as well as 27/7 telephone access to a care manager. -Links to acute and outpatient medical, mental health and substance use services.				
1. There is an identifiable Comprehensive Assessment form.	3			
2. The Comprehensive Assessment identifies the following:	1			

Insurance status	1			
Other professionals providing services	1			
Medical History	1			
Legal history	1			
Legal assistance history	1			
Source of social/emotional support	1			
Alcohol/drug use/history	1			
Mental health treatment/history	1			
Housing status/history	1			
Educational information	1			
Employment information	1			
Financial information	1			
Services offered/requested	1			
Total	16			
Standard	P.P	Score	N/A	Comments

Care Plan

Guidance from DOH: Policies and procedures are in place to create, execute, document and update an individualized person centered plan of care for each individual. A person centered care plan that integrates the continuum of care and social needs, goals, planned interventions is developed with the individual and available to the client, family/caregiver, multidisciplinary care tram and medical/behavioral health providers.

1. The care plan was developed within 30 days of client enrollment in Health Home.	3			
2. The client and care manager signed the care plan.	2			
3... The goals/objectives are outlined.	2			
4. The goals/objectives meet the assessed problems/needs.	2			
5. Agencies or professionals are specified as to whom will be providing which services.	2			
6. The client's involvement is noted.	3			
7. The plan involves family/significant others.	3			
TOTAL	17			

Care Plan Implementation

Guidance from DOH: An interdisciplinary team is in place to provide care management and coordination of integrated services. CMA has a structured information system, which includes executing a care plan; systematic follow up on the individual's treatment, services and referrals; and is available to the interdisciplinary team of providers.
A single dedicated care manager responsible for overall management of the care plan is identified.

1. Referrals have been identified in the plan.	2			
2. Referrals were made in a timely manner.	2			
3. The following are noted in the record:				
Provider name	1			
Type and length of stay	1			
Confirmation that services occurred	1			
4. There are no missing referrals or service gaps.	2			
5. Services that were denied or unavailable are noted.	3			
6. The documentation demonstrates the care manager has advocated obtaining needed services.	3			
7. There is evidence of coordination with other service providers.	2			
8. There are signed client consent forms to release information as appropriate.	3			
TOTAL	20			

Care Management Notes

1. The care management notes are accurate and factual.	2			
2. Entries are timely (within 48 hours)	2			
3. The care management notes are legible (for hard copy	2			
4. The care management notes active and progressive movement toward attainment of goals.	2			

5. The care management notes indicate frequency of contact (once/week; once/month; etc)	2			
6. Agency follow up contacts were made to ensure receipt of services/outcomes.	2			
7. There is documentation of follow-up on missed appointments.	2			
8. Crisis intervention is provided as necessary.	2			
9. Copies of correspondence are in file.	2			
10. If case is closed was it justified and appropriate and were referrals noted.	3			
TOTAL	21			Score:

E. Quality of Care

1. As a result of care management, it appears there was an impact in terms of:				
Improved self-sufficiency	2			
Improved quality of life	2			
Improved access to services	2			
Improved quality of care	2			
2. There was a positive impact to family/significant others.	3			
TOTAL	11			Score:

PP = Possible points

Total possible points: TBD

Minus Average N/A points: _____

Equals total possible score: _____

Comments:

HHUNY CM2.0 Training

Section 1 – Health Home Overview

Agenda

- Assignment
- Outreach & Engagement
- Enrollment
- Discharge
- Reporting/Billing

Assignment

DOH

- Assigns clients to HH

HHUNY

- Assigns clients to each agency

CMA Will Either

- Accept the client assignment
- Request the client be reassigned

Care Manager Supervisor

- Assigns the client to the Care Managers as appropriate

Outreach & Engagement

Mail
Email

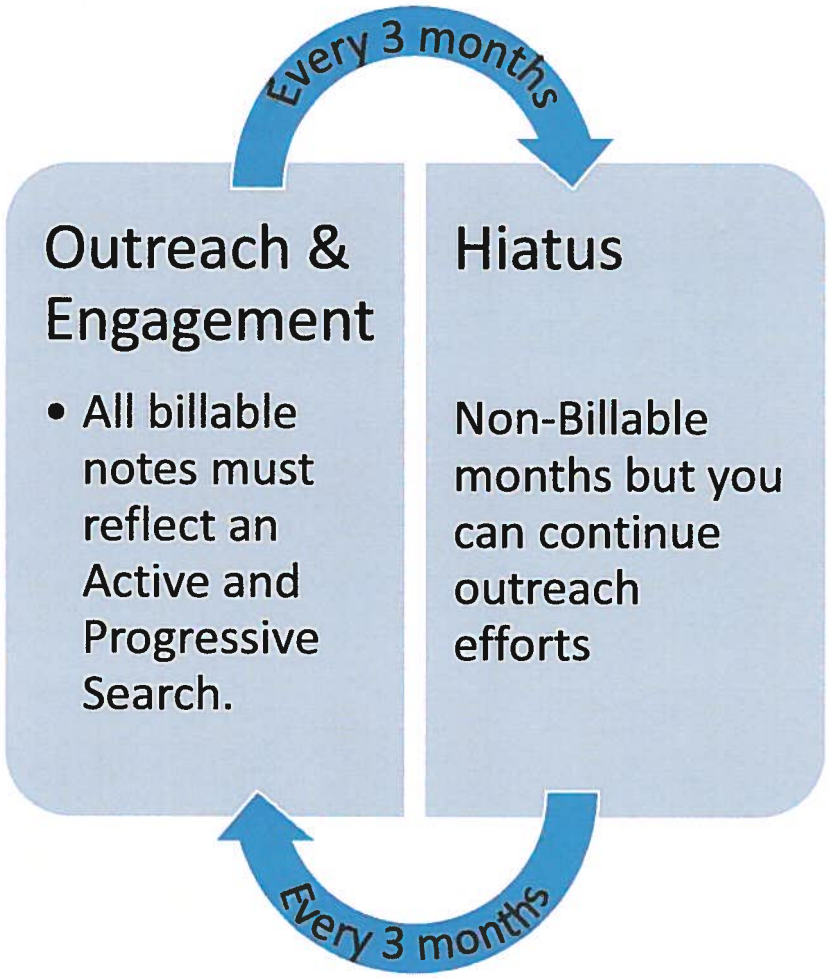
Text Message

Phone Call

Face to Face
or In Person

Documented in the Client Search Note

Hiatus


Every 3 months
Outreach & Engagement
• All billable notes must reflect an Active and Progressive Search.
Hiatus
Non-Billable months but you can continue outreach efforts
Every 3 months

Enrollment - General

Eligibility

- Medicaid eligibility check
- Work with the client to gain eligibility

Consent

- HH Consent
- DOH 5055 – Data Sharing Consent

Assessments

- Beginning of the Golden Thread…
- Comprehensive Assessment
- FactGP + HH

Enrollment – Care Plan

Care Plan Creation

Client Stated Goal
The client goal is what the clients primary focus is going to be on. It should be said in their terms and define what it is they hope to get out of the Care Management Services.

Client Strengths
The strengths allow you to build from an area that they see that they have power over

Client Barriers
You can address the barriers with them so they are aware that they may get in the way and help to develop a plan to overcome them.

Objectives and Interventions
What are you trying to accomplish and how are you going to accomplish it?

Enrollment – 5 Core Services

- Comprehensive Assessment
- Care Plan
- PCP/Specialist Consult
- Outreach & Engagement
- Crisis Plan
- Etc...

Compreh… Care Manag…

- Coordinate with service providers/health plans
- Refer client to needed services
- Advocate for services & assist with scheduling
- Etc...

- Follow up with Hospitals the client was admitted in
- Facilitate discharge planning
- Notify/Consult with treating clinicians
- Refer to community supports
- Etc...

Health Homes Provider Manual
Billing Policy and Guidance
Pg. 52-53
https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf

- Refere to peer supports, support group, ect.
- Etc...

Member & Family Support

client/family need

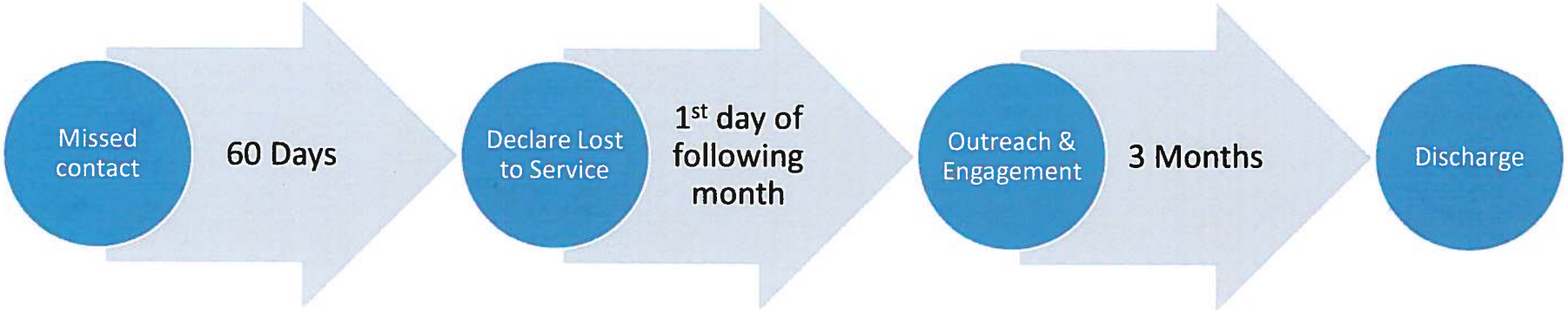
Referral and Community & Social Support

Enrollment – CareManager Note

CareManager Note

Core Service Type (1 of the 5)	Date of Service Type	Note on what was done associated with an Objective & Intervention

Enrollment – Lost to Service



Discharge

Standard Discharge	Transition from Health Home
	Client no longer desires services
	No longer eligible
	Etc…More information on page 40 of the HH Provider Manual
Rejection	Rejection needs to be prior to any activity done
	Client is Deceased
	Client is Incarcerated for period of 60 months or greater

Crimson Care Management Process

Crimson Care management is the computer software that has been chosen by the GHHRN as their electronic health record. To remain in compliance with the GHHRN's policies, Monroe Plan is required to input all data pertaining to both the outreach phase and case management phase into Crimson Care.

This includes, any consents, assessments, care plans, opt out forms etc. Any documents or notes that are placed in CaseTrakker MUST be copied and pasted into Crimson Care management.

1. During the outreach phase – the member will be in the outreach care program in Crimson Care.
   - The following information should be put into Crimson Care if known at the time of outreach.
     - Updated demographics
     - Medical diagnoses
     - Primary care providers
   - In addition all outgoing communication to try to engage members in the health home must be placed in Crimson Care.
   - All entity progress events must be copied and pasted into Crimson Care.
   - All letters will need to be attached to care notes.
   - Documentation should be completed according to MP policies.

2. Case management.
   - All assessments must be converted to a PDF and then attached to care notes with in Crimson Care management. Each care note has the capacity to attach 5 documents per note. This is to include –
     - The HAT
     - PAM

    - PHQ9
    - Suicide risk assessment if necessary
  - Action plan
  - Pain assessment
  - ACT
  - Care plan
  - Med List
  - Consents for both Health Home and RHIO, as well as MP consent
  - Crisis plan
  - Letters to PCP and member
  - Fax confirmation of care plan sent to provider

*The Fact GP will need to be inputted directly into Crimson Care management as well as CaseTrakker.

The allergy section on the face page should also be completed at this time.

Crimson Care Management Cheat Sheet 1.30.14

Care Management Agency Supervisor:

- View all new referrals on CARE PLAN tab
- Supervisors have 3 options:

1) **Reassignment Request from Care Management Agency** (*Example: You find that this client needs a male care manager and you have only females on staff and cannot serve them)*
   - Complete a "GRHHN Referral Reassignment" Care Note. Please provide the reason for your request for reassignment to assist with appropriate reassignment to another care management organization.
   - Mark the care note as sensitive information, viewable only by author and Primary Care Manager
   - Publish the Care Note and Select N/A for all encounter details, use generic dummy code
   - DO NOT CHANGE THE CARE PROGRAM
   - Remove your organization Office if applicable
   - Assign Deb Peartree as the Primary Care Manager
   - Deb Peartree will reassign the referral to another agency

2) **Health Home Rejection for FFS or MCO patients** (*Example: You know the patient is deceased or not Medicaid eligible prior to any outreach efforts)* *Communicate with Deb about these members*
   - **Do NOT put these patients in Outreach- they should be rejected before adding Outreach. If you have already put them into Outreach and performed Outreach activities, you should not use a rejection code!**
   - **You should not have any care notes entered in the system for that patient if you are rejecting them** *(they will show as activities on the billing report which contradicts the rejection code supplied for billing)*
   - End GRHHN Care Program w/ one of the following reasons:
     - Rejection: Change in Functional Eligibility
     - Rejection: Incarcerated
     - Rejection: Member Deceased
     - Rejection: Member Moved Out of Service Area
     - Rejection: Member Out of State
     - Rejection: Not Suitable for Health Home Assignment
     - Rejection: Other
     - Rejection: Patient of Inpatient Facility
     - Rejection: Transferred to another Health Home
       - You can add a note in the comment box when ending the program if needed
   - Add **"Discharged"** Care Program
   - Remove your organization Office if you added it
   - Leave yourself as Care Manager

3) **Assign the Referral to a Care Manager** (*Example: Patient is active Medicaid and can be referred to a Care Manager to start Outreach activities)*
   - Add Outreach Care Program *(this date begins your 3 month Outreach period)*
   - Add TCM-HH Care Program if applicable (Legacy providers only)
   - Add a Primary Care Manager from your agency by changing your name to that of your care manager (some Supervisors add themselves as secondary care managers)
   - Add your Care Management Office to the patient profile as needed

Note: Large organizations may have more than one office to reflect different provider populations, please select the correct Office that will need to have access to the patient (as in the case of providing coverage when you are out)

Care Manager:

- Patients will be assigned to you and will be in 2 Care Programs:
  - **Outreach + GRHHN/HHUNY** → *This means they are in Outreach phase*
    - If TCM patient then TCM-HH Care Program as well which is a billing indicator for Legacy providers only

- Document all Outreach Efforts using **"Outreach Contact"** care note
  - Tip: Utilize ToDo's to track monthly efforts
- Complete Encounter Details:
  - If no known Dx during Outreach, use Dx: 799.9 - Each encounter must have a Dx code
  - Check the box indicating it was an **"able contact"** meaning you were able to reach the member
    - Yes = You were able to reach the patient in person or on the phone
    - No = No contact or voicemail
    - NA= Does not apply to that activity
    - REQUIRED TO BE COMPLETED FOR REPORTING!!
  - Assign appropriate Outreach billing codes:
    - 1386: Use if the patient/member/client is Medicaid Managed Care or Fee For Service
    - 1851: Use if the patient/member/client is currently a legacy OMH TCM client
    - 1881: Use if the patient/member/client is currently a legacy COBRA TCM client

If Patient does not want Care Management Services:

- Complete a **"Discharge"** care note with the reason for their decision
- Scan in the signed Opt-Out form and attach to the **"Discharge"** Note (if the member refused to sign or opted out by phone, please note that information on the Opt-Out form before scanning)
- Complete the encounter details associated to the **"Discharge"** care note
- End Outreach Care Program with the most applicable *Reason* (CANNOT start w/ Rejected) → *These reasons codes are reported to NYS*
  - Refrain from using reason *"Other"* – it does not provide us good detail in reports
- End GRHHN Care Program with the same reason you ended Outreach
  - Make sure you do this on the same day
- Add **"Discharged"** Care Program with accurate date of discharge as the Care Program Start Date
  - Please note, if you select end reason: *"Member Deceased"*, it will not let you add Discharged Care Program and will put the patient into "Expired" status.
- Remove your office from organizations if it was added
- Keep yourself as the Care Manager
  - When looking at reports or patient rosters, filter out those patients in **"Discharged"** care program

If you cannot find patient within 90 day Outreach Period:

- Add Latent Care Program
  - DO NOT remove GRHHN or Outreach
  - **Hiatus Period** = Latent+Outreach+GRHHN Care Programs

Hiatus begins automatically for NYS on the 1st of the 4th month of Outreach
Example: Patient starts Outreach Care Program on 1/15, reports will show as Outreach beginning 1/1. Add Latent care program on 4/15, NYS will assume Hiatus as of 4/1. ToDo protocols will alert you to add Latent after 90 days of Outreach.

If patient is interested in Care Management Services:

- Complete the **Health Home Eligibility Screening Form** prior to enrolling
  - Answer all questions → Question #3 is a reportable CMART field
- <u>If patient is not eligible:</u>
  - Document explanation on Discharge Care Note
  - End Outreach & GRHHN Care Programs with reason: "Does Not Currently Meet HH Criteria"
  - Add Discharged Care Program
  - Keep yourself as Care Manager

- <u>If patient is eligible:</u>
- End Outreach Care Program w/ Reason Code: *"Member moved from Outreach to Enrollment Status"* → *Reportable Field*
- DO NOT end GRHHN or HHUNY care program
  - If you end them, the reports would look like they ended all engagement to NYS
- Add a DOH defined care program from the list below and mark it is as the **"Primary":**
  - Chronic Adult
  - Behavioral Health
  - Developmental Disabled
  - Children
  - Long Term Care
  - HH Substance Use
  - HH HIV

  No other care programs should be marked as "Primary" except for this list!!

  The start date for the primary care program indicates that the patient has been enrolled into HH services for reporting purposes. It is VITAL that the primary care program is added, if the care program is not marked as primary, the patient will not show as active & will not be billable*

  Check: Patient has agreed to HH services, Outreach care program has been ended, the patient should be enrolled into GRHHN or HHUNY and also a DOH defined HH care program as primary.

- If member agrees to share their information, complete a "Consent" Care Note by attaching the signed DOH 5055 to the care note
  - **Enter HH Consent Date to the GRHHN or HHUNY Care Program details if the member has agreed to share their information → reportable field that needs to be completed if consent was obtained**
  - Add Care Team members as appropriate
  - If member later declines to share their information, complete another "Consent" Care Note explaining that they decline and attach the signed DOH 5059 to the care note and remove care team members
- Complete Comprehensive Assessment Form
  - Complete Functional Assessment & scan it in
  - Complete FACT-GP, scan it in, score it, add data to the FACT-GP Worksheet
  - Add a Care Note any time you complete a form (or one care note if you complete all 3 in one visit) to make it a billable contact

- Build Care Plan (and Crisis Management Plan) & Patient Profile: Add goals, Edit Patient Profile details as needed, Medications, Allergies, Dx, Care Team Members, Add offices if needed, etc.
- Add Care Notes as appropriate:
    - **Outreach Contact-** Utilize during Outreach Phase to document your activities
    - **Advanced Directives** – Attach any advanced directives or document discussions
    - **Care Coordination Conference-** care team meeting or provider input is documented
    - **Care Plan Update** – Any contact that needs to be documented while enrolled/engaged
    - **Chemical Dependency-** 42 CFR Part 2 Data *(If used, add an additional care note for that visit w/ non-CD information in it and it will count as the billable contact)*
    - **Collateral Contacts** – Any contacts other than the patient
    - **Crisis Intervention-** Document a crisis, actions taken, and on-call issues
    - **Discharge Note** – Utilize when the patient is disenrolled from services
    - **GRHHN Referral Rejection-** Only to be used prior to beginning Outreach- Utilize when the care management organization does not accept the HH referral for a reason specific to the care management organization (e.g. capacity)
    - **Health Home Consent** – Attach all consents here including the DOH 5055, PSYCKES Consent or the RHIO Consent
    - **Medication Adherence-** Document Medication compliance/issues
    - **Transition Note-** Document why the patient needs to be transitioned to another HH
- Complete Care Note Encounter Details:
    - Assign appropriate Diagnosis - Each encounter must have a Diagnosis code
    - Check the box indicating it was an **"able contact"** meaning you were able to reach the member *(Now a required field)*
        - Yes- You were able to reach the patient in person or on the phone
        - No- No contact or voicemail
        - NA- Does not apply to that activity
        - REQUIRED TO BE COMPLETED FOR REPORTING!!
    - Identify the Contact Type *(Now a required field)*
        - Mail
        - Phone
        - In-Person
        - Other
    - Identify the Core HH Service Provided *(Now a required field)*
        - Comprehensive Care Management
        - Care Coordination & Health Promotion
        - Comprehensive Transitional Care
        - Member and Family Support
        - Referral & Community and Social Support Services
    - Identify the Health Home Intervention *(Now a required field)*
    - Assign appropriate Engaged billing codes:
        - 1387: Use if the patient/member/client is Medicaid Managed Care or Fee For Service
        - 1852: Use if the patient/member/client is currently a legacy OMH TCM client
        - 1881: Use if the patient/member/client is currently a legacy COBRA TCM client

If patient decides to disenroll or needs to be discharged from HH services after services have been provided:

- Complete a "Discharge" care note
- End primary care program with the correct reason (Cannot start w/ Rejection)
- End GRHHN Care Program with the same reason
- Remove all offices associated with the care team and all care team members

- Add "Discharged" Care Program
- Keep yourself as Care Manager

If you need to Change Care Management Agencies:

- Please contact Deb Peartree
- Do not end any care programs

Care Program Clarification:

Patient Population +	Patient Status	Primary Care Program
GRHHN HHUNY CMMI Community Patient TCM-HH	Outreach Latent Primary Care Program = Enrolled → Discharged	Chronic Adult Behavioral Health Developmental Disabled Children Long Term Care HH Substance Use HH HIV

Health Home Phases:

GRHHN or HHUNY + Outreach = Outreach

GRHHN or HHUNY + Outreach + Latent= Hiatus

GRHHN or HHUNY + A Primary Care Program= Enrolled

Discharged = Disenrolled, no longer receiving services

- TCM-HH can be added to any of these for Legacy patients only

Any other combination of care programs will result in a non-reportable/non-billable patient*

Crimson Care Management Reports
BTQ Activity File Care Manager Report

Activity Type:

0= Reject
1= Transfer
2= Outreach Activity
3= Discontinue Outreach
4= Signed Consent
5= Enrolled Service
6= Discontinue Enrolled Service
9= Demographic Update Only

Outreach Method:

1= email
2= phone
3= in person
4= billable outreach activity- not specified

Enrolled Service Method:

1= Comprehensive care management
2= Care coordination/health promotion
3= Comprehensive transitional care
4= Patient/Family Support
5= Referral to community/support services
6= Billable enrolled service activity-not specified

Enrolled Service Delivery:

1= email
2= phone
3= in person

Discontinue Reason Code: (When ending Outreach or Enrolled Service)

01= Transfer to another Health Home
02= Member Opted-Out
03= Changed Care Management Agency
04= Member Deceased
05= Member has a new CIN
07= Closed for disruptive or uncooperative behavior
08= Member moved out of service county
09= Member moved out of state
10= Change in functional eligibility
11= Incarcerated
12= Refused Consent (can only be used during outreach)
13= Patient of Inpatient Facility
14= Enrolled HH Patient Lost to Services
15= Patient dissatisfied with services

16= Inability to contact/locate patient
17= Found but not interested in enrolling in HH services
18= Found and expressed interest in HH but at a future date
19= Does not currently meet HH criteria
20= Switched Managed Care Plans
21= No longer requires HH services
22= Transition to FIDA (Fully- Integrated Duals Advantage) program
23= Member disenrolled
24= Member is no longer eligible for Medicaid
25= Member moved from Outreach to Enrollment Status
99= Other

QA Process:

1. Look for any blank Activity Type fields- if blank, review care program start/end dates in CCM to ensure the correct combination was used to produce an activity type
2. Review Activity Type for the following:
    a. Dates reflect the correct order
    b. Outreach to Enrolled →Outreach activity types (2), end of outreach segment (3), enrolled activity types (5), end of enrolled segment(6)
    c. Filter on Activity Types of 3 & 6 to confirm there is a discontinue end code for each
    d. If member enrolled from Outreach→ Code should be "25"
    e. If "3" and "6" show up more than once for one patient, need to review care programs for accuracy
    f. Reject Activity Type of "0" is only used when GRHHN care program is ended because rejected from Health Home prior to Outreach

Greater
Rochester Health Home
Network

Care Management Program

DRAFT

Table of Contents

Introduction

Rochester Integrated Health Network

The Rochester Integrated Health Network, Inc. (RIHN) was formed on May 12, 2011 and is dedicated to promoting the integration and coordination of quality, accessible and affordable medical and behavioral health care services for low income, uninsured and underinsured children and adults in the Rochester, New York region through the distribution of information and through collaborative improvement projects among its member organizations and community partners.

Member organizations are the following:

- Anthony L. Jordan Health Center
- Highland Family Medicine
- Rochester General Hospital
- Rochester General Medical Groups
- Rochester Primary Care Network
- University of Rochester Medical Center
- Unity Health System
- Unity Medical Groups
- Westside Health Services.

Advisory Organizations are the following:

- Excellus BlueCross BlueShield
- MVP Healthcare
- Finger Lakes Health Systems Agency
- Monroe Plan for Medical Care, Inc.

The Rochester Integrated Health Network determined the need to develop a Health Home with community providers in order to:

- create a program and processes that benefit the patients and community
- learn new ways to break down silos/integrate with care team partners across medical, mental health, substance abuse, and community-based service sectors
- optimize health outcomes and quality of life for the most complex patients/individuals in our community

Greater Rochester Health Home Network:

The Greater Rochester Health Home Network, LLC (GRHHN) was formed by the Rochester Integrated Health Network, Inc. (RIHN) to apply for Lead Health Home status on behalf of a community network of providers. GRHHN member organizations possess a collective history of working together over the past three years addressing issues impacting the most vulnerable in our community. The Greater Rochester Health Home Network, LLC (GRHHN) will be applying for the necessary Medicaid provider status and associated billing/provider numbers. Anthony L. Jordan Health Center agreed to apply on behalf of the Greater Rochester Health Home Network, LLC with direct pass-through of information, funds, and accountabilities as appropriate until transfer of Health Home status to the GRHHN is completed.

Greater Rochester Health Home Network Principles:

Principles were developed in order to guide program implementation to ensure that safety net patients are provided the support they need to optimize their health:

1. Health Home Assignment will be patient centered, experience -based and supportive of patient engagement:
   a. Assignment will be based on relationship with current primary (medical or behavioral health) caregivers
   b. If no current continuity relationship exists with a primary care provider or behavioral health provider, assignment will be based on geography or primary transportation routes
   c. A system will be available to allow providers to accept assignment and request reassignment if their patients/clients are assigned to another Health Home or care manager in error

d. Assignment will be utilized as a patient engagement tool supporting the individual's relationship with the primary provider's office*

2. Health Home care management providers should be financially viable with proven capability to manage the assigned patient volume to ensure appropriate service.
3. Health Home operation and contractual relationships will be designed to maximize efficiency:
   a. Limit administrative costs;
   b. Ensure transparency regarding administrative and service operation;
   c. Health Home assignment will be based on patient severity to ensure effective use of resources;
   d. Health Home services will not supplant currently reimbursed services;
   e. Available funds will be utilized as appropriate to pull in and support social services integration and primary provider care plan
4. Health Home participants will work collaboratively to ensure that the community IT infrastructure supports their needs.
5. Implementation will be patient-centered and engagement will be based on the unique goals and needs of the individual member/patient with inclusion of face-to-face contact for complex patients.

*Primary Provider - Any type of physician or specialist taking on the lead role of organizing the primary care and behavioral health services for a specific patient in total.

Greater Rochester Health Home Network Purpose:

- The Greater Rochester Health Home is a care management service system enabling all of an individual's caregivers to communicate with one another ensuring that member/patient's needs are addressed in a comprehensive manner. A Lead Care Manager oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. The health home builds linkages to other community and social supports, to enhance coordination of medical and behavioral health care in order to improve patient quality outcomes, reduce inpatient, emergency room, and total care costs.

- **The Greater Rochester Health Home Network will:**
  - **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services -** GRHHN will utilize available utilization information and an assessment of the needs, strengths and goals of each enrollee, including available family/caregiver supports, preferred language, culture, and learning style. Based on this information a care plan will be developed to support optimal health outcomes through delivery of high quality care at the lowest cost at most appropriate site of care. GRHHN care managers will work to engage the individual and their family (based on the patient/client's consent), develop a trusting relationship, and support effective self-management. Services provided by GRHHN care managers will be in the appropriate language, literacy/numeracy level, and culturally appropriate to the needs and preferences of the individual enrollee and their family. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
  - **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines** - GRHHN will work to ensure that evidence-based clinical decision-making tools are embedded into network clinical provider EHRs to enable support of evidence-based care planning & clinical decision-making. The resulting treatment plans will be shared with the GRHHN Care Manager.
  -

    GRHHN will utilize available clinical provider treatment plan & an assessment of the needs, strengths & goals of the enrollee, as well as the patient's current state, to develop a care plan to identify gaps in care & the need for specific services to support optimal health outcomes. GRHHN care managers will work to ensure the enrollee is linked to appropriate clinical & support services; that appointments for services are made; that barriers appointments are identified and mitigated; & that enrollees are

supported in following provider recommendations. Interventions will be documented in the software to ensure information is available to the individual's care team.

- **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders -** GRHHN will utilize an assessment which will identify medical, mental illness and substance abuse risk factors. Comparison of the enrollee's current state to clinical provider treatment plans developed based on evidence based guidelines will identify prevention and health promotion opportunities. GRHHN care managers will then make appropriate linkages to the individual's primary medical or mental health or substance abuse service provider or to services in the community as appropriate. GRHHN care managers will work to ensure that appointments for needed services are made; that barriers to attending these appointments are identified and mitigated; and that the enrollee is supported in following the recommendations of service providers. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
- **Coordinate and provide access to mental health and substance abuse services -** GRHHN will utilize the results of the assessment and care planning process to identify the necessary medical, mental illness and substance abuse interventions. If mental health and substance abuse services are needed, the individual will be linked with GRHHN service network providers. Care managers will work to ensure timely appointments are provided, barriers to attending these appointments are identified and mitigated, patient/client attends the appointments, and follows-through on recommendations made by these providers. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
- **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings -** The GRHHN care manager will work to ensure effective transitions between one health care provider or setting and another as their needs change to optimize their health status, care outcomes, and reduce the potential for use of avoidable high cost services. Care Managers will be informed of a potential or actual transition event by the patient/client, provider, or hospital notification. Interventions are provided, tailored to the needs, strengths and resources available to the patient/client and may include patient education, self-management support, medication reconciliation, ensuring appropriate follow up care, identification and training in management of "red flag" issues, and tools for understanding and managing their current state. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
- **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families** - The GRHHN care manager will integrate self management support into all care management interactions and provide repetition and reinforcement as appropriate. Self management is the cornerstone for improved outcomes. In addition, a written plan for the patient/client by the medical or behavioral health provider is optimal in daily self management and recognizing and handling worsening conditions. The care manager will support the patient/client in advocating for written plans to support their self-management efforts and to share the written plan with their family/caregiver/support network. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
- **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services -** GRHHN will utilize an assessment which will identify the individual's needs, strengths and goals, and available family/caregiver supports. This information will be used to develop a plan of care with the patient/client. This will require identification of barriers to implementing the plan of care, and appropriate community, social support and recovery services to support optimal health outcomes. Linkage to appropriate recovery services, such as peer support programs, and other community support organizations will be made as part of the care plan implementation process. The care manager will engage the individual and appropriate family/caregivers with the patient/client's consent, in using these supports to implement the plan and modify it as appropriate. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.

- **Coordinate and provide access to long-term care supports and services** - The GRHHN care manager will assess the need for any long-term care supports or services that may be needed on a short-term basis to achieve care plan goals. Referral to long term care providers within the provider network will be made as appropriate. In the event that the patient/client had need of these services for longer than 120 days, the care manager would help transition the patient/client to the appropriate long-term care management program. Interventions will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
- **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services** - GRHHN care manager will utilize a comprehensive assessment of the clinical and non-clinical needs, strengths and goals, mental health, substance abuse and social needs of each enrollee, including available family/caregiver supports, preferred language, culture, and learning style. The care manager will also seek information from the patient/client, his/her primary care or behavioral health care providers, and any other care or community service provider involved in their care. This assessment information will be used to work with the patient/client in the development of a plan of care tailored to their goals and unique needs. Once approved by the patient/client, the care plan will be documented in the care management system to ensure access to the information is available to the members of the individual's care team.
- **Use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate** - GRHHN will pursue a 2-stage approach to sharing information. 1st stage: Internet-based interface to a care management system to ensure access to create, share, & update a care plan care; share patient information; support Care Team meetings; & support planning to address changes in status & gaps in care.

  2nd stage: require network clinical providers to use a Meaningful Use certified EHR & connect with the RHIO. Currently, RHIO connects Monroe County's health home providers & ADT feeds are sent in near real time to HIE and to practice EHRs. EHRs will integrate into patient records. RHIO provides interoperability with 16 EHRs. Software-As-A-Service-based EHR may be provided for providers. The most appropriate technology will be used to communicate the care plan & changes among the care team, patient/client, & their family/caregivers ranging from providing hard copies, faxing, & secure information technology exchange.

Program Goals:

- Broad, robust Health Home Provider Network - ability to meet needs of all facets of complex populations (e.g., Mental Health, Housing, Substance Use Disorder, etc.)
- Health Home eligible individuals will be assigned to Network Providers for care mgmt:
  - Assignment based on relationship with current caregivers
  - If no current continuity relationship exists with a care provider, assignment based on geography or primary transportation routes
  - Providers can request reassignment if their patients/clients are assigned to another Health Home in error
- The Health Home will be designed to maximize efficiency:
  - Minimize administrative cost to ensure sufficient allocation for actual direct care management services
  - Ensure transparency regarding administrative and service operation costs
  - Case loads based on patient severity to ensure effective use of resources and will be transparent
  - Care Management process will support integration between social services and provider care plan
- Collaborate to ensure that the Community IT infrastructure supports the needs of Health Home Providers to optimize patient services.
- Implementation will be patient-centered and engagement based on patient need with inclusion of face-to-face contact for complex patients.

Greater Rochester Health Home Network Scope:
Currently, Medicaid recipients are identified as eligible for Health Home services by New York State Department of Health. These individuals will have at least two chronic conditions, one chronic condition and at risk for another, or one serious and persistent mental health condition. Chronic conditions include mental health condition, substance abuse disorder, asthma, diabetes, heart disease, being overweight (BMI over 25), HIV/AIDS.

Health Home eligible individuals may be identified for potential service in the future based on:

- Claim or encounter data
- Hospital discharge data
- Pharmacy data, if applicable
- Data collected through the UM or DM programs, if applicable
- Data supplied by purchasers, if applicable
- Data supplied by member or caregiver, including self-referral, if applicable
- Data supplied by practitioners, including practitioner referral, if applicable

Responsibility and Structure:

A Greater Rochester Health Home Board Clinical Subcommittee comprised of Health Home network providers will work to develop care management policies and procedures, common assessment and care plan tools, and effective communication methods, including a Care Team meeting format. The result will ensure that each patient/client will have an individualized plan of care, appropriate care team who has access to that plan of care and a defined Lead Care Manager responsible for coordinating and documenting activities.

- Assessment
- Care Plan
- Care Team Meetings
- Interventions
- Transitions in Care
- Clinical Policies

A Greater Rochester Health Home Board Operations Subcommittee comprised of Health Home network providers will work with the Rochester RHIO, HEAL 17 grant recipients, OMH, and others to define optimum electronic connectivity and be responsible for IT and operations such as:

- Call Center/Member service
- Quality Assurance/Reporting
- Compliance
- Operational Policies

A Greater Rochester Health Home Board Finance Subcommittee comprised of Health Home network providers will be responsible for:

- Finance Policies
- Contracting
- Audit Function

Greater Rochester Health Home Care Management Partners:

In order to provide comprehensive and timely high quality services, Greater Rochester Health Home Network network has been developed to provide enrollees access to needed services. The network of care management provider partners include primary care providers, mental health and substance abuse service providers, Targeted Case Management and COBRA program providers, medical and behavioral health case managers, specialty case managers, (e.g. Certified Diabetes Educators, Registered Dieticians, Certified Asthma Educators, Pharmacists, etc.), and community service providers (e.g. Home Health Agencies, residential treatment facilities, etc.) depending on the needs and strengths of the individual.

Other support services available through a referral network, may be engaged to meet the individual's needs such as peer support services, housing, clothing closets, food cupboards, transportation, etc.

Role of Greater Rochester Health Home Care Management Partner Providers:

- Recruit and train care managers;
- Accept appropriate member assignment from GRHHN to provide Health Home services including:
    - Finding and engaging the individual in the Health Home program;
    - Obtaining consent for program enrollment and for sharing of patient information and treatment;
    - Comprehensive Care Management;
    - Care Coordination and Health Promotion;
    - Comprehensive Transitional Care - Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
    - Crisis intervention;
    - Patient and Family Support;
    - Linkage to community based social support services-including housing;
    - Linkage to acute and outpatient medical, mental health and substance abuse services;
    - Coordination with Primary/Specialty Medical care;
    - Ensuring Language access/ translation capability;
    - Ensuring 24 hour 7 days a week telephone access to a care manager;
    - Condition self-management related education; and
    - Assistance with housing, transportation, food, clothing, and other barriers to optimum health.
- Collaborate in the development and implementation of a shared plan of care;
- Participate in Care Team meetings;
- Document interventions and their effectiveness in a shared care management software tool;
- Provide reports as required to meet CMS and NYSDOH requirements; and
- Implement health IT functionalities and applications as required by the health home.

Role of Greater Rochester Health Home Care Management Service Providers:

- Accept appropriate referrals from GRHHN to provide services including:
    - Medical care;
    - Substance abuse treatment;
    - Mental health care;
    - Assistance with housing, transportation, food, clothing, and other barriers to optimum health.
    - Patient and Family Support;
    - Other Social Support Services;
- Collaborate in the development and implementation of a shared plan of care;
- Participate in Care Team meetings;
- Share information with other members of the Care Team as necessary to ensure the coordination and delivery of effective, whole-person care;
- Implement health IT functionalities and applications as required by the health home including:
    - A systematic process for documenting and following up on referrals;
    - All Meaningful Use eligible network clinical providers will be required to ensure their EHRs meet HIT standards and that they interface with the Rochester RIHO;
    - All Meaningful Use eligible network clinical providers will be required to ensure their EHRs meet the final HIT standards within 18 months of health home implementation.

Health Home Staffing:

The Lead Care Manager will be accountable for assessing the needs/strengths/goals of the individual enrollee, facilitating development & implementation of a care plan, identifying the appropriate team to assist in meeting the individual's needs, engaging the individual and their family or caregiver supports, assures access to medical and behavioral health care and community social supports, and evaluates/modifies the care plan as needed. Care Managers will be responsible for monitoring the Care Plan, scheduling Care Team Meetings, maintaining the required patient contact, and ensuring that the necessary documentation is completed.

Care Managers:

Qualifications will vary upon area of expertise and organization affiliation. Medical care managers will include registered nurses with current NYS license, behavioral health care managers will include MSW or NYS CASAC counselors with experience, outreach staff will have appropriate experience.

Care Manager Training/ Continuing Education:

Care Managers will receive an orientation to the Greater Rochester Health Home Network program, policies, procedures and requirements. Ongoing education on topics such as self management support, clinical condition management, transition care approaches, etc. will be provided by the GRHHN. Care Management Partner organizations are responsible to recruit, hire, orient and oversee the work of individual care managers.

Health Home Care Management Process:

1. NYS DOH and contracted MCOs will assign Medicaid recipients to the Anthony L. Jordan Health Center on behalf of the Greater Rochester Health Home Network, LLC (GRHHN) – or directly to GRHHN once eligible, and provide available data. If received by the Anthony L. Jordan Health Center, the list of assignees will be provided to the GRHHN.
2. The GRHHN will review the assigned individuals and available data to identify the dominant needs, historical use of services, and the zip code of residence of the individual and analyze this against the Health Home provider network capabilities and capacity.
3. The GRHHN will assign the individual to a specific Health Home provider organization to provide Lead Health Home Care Manager services through identification of a specific assigned Lead Health Home Care Manager.
4. The Lead Health Home Care Manager uses available information to find the individual, describe the Health Home services and benefits of participation, and seek their consent to participate in the GRHHN Health Home program.
5. Once the individual agrees to participate, the Lead Health Home Care Manager:
   a. Provides the member with the following written information about the program: How to use the services, how they became eligible to participate, and how to opt in or opt out.
   b. Completes an assessment.
   c. Drafts a suggested plan of care and discusses options at a Care/Service Team meeting with other Health Home providers or GRHHN Health Home service contractors using available information, gaps in care, etc. The suggested draft identifies potential red flags of condition change and describes appropriate patient/client as well as Care/Service Team response.
   d. The suggested plan of care is reviewed and modified with the patient/client to ensure it appropriately identifies and meets their goals and needs. The patient/client is asked for their approval of the plan and to identify barriers or challenges to implementation.
   e. The patient/client approved plan of care is implemented by the Care/Service Team under the leadership of the Lead Health Home Care Manager. The Health Home Care Manager provides self-management support, connection/referral to appropriate physical/mental health/substance abuse providers and community based organization supports to decrease barriers to attending appointments and following the plan of care, self-management support, red flag education, etc.
   f. The Lead Health Home Care Manager documents activities and elements necessary for quality improvement and to meet reportage requirements.
6. Service providers such as housing, transportation, food cupboards, clothing closets, etc. are engaged as appropriate to the needs of the individual.
   a. An existing Community Resource Guide will be enhanced through identification of gaps in service delivery as well as effective community based organizations.
7. A shared software system enables connection of Care Team members to address the needs of each individual enrollee.
8. The Care/Service Team is a patient/client-specific team working with the Lead Health Home Care Manager to coordinate care & service. The Care Team Meeting is used to:

a. Initiate the draft suggested plan of care and define the Care/Service Team.
b. Review patient/client progress at the frequency defined by the Care/Service Team (no less frequent than quarterly).
c. Modify goals and Care/Service Team membership as appropriate to the needs of the individual.
d. Share information (e.g. progress, barriers, new conditions, etc.) between Team members
e. Address crisis events such as emergency department visits or inpatient admissions or other crisis events to ensure planned crisis interventions are effective and to make necessary modifications of the Plan of Care or need for additional support services.

Outreach and Engagement

A concerted effort will be made to find and engage each member as expeditiously as the member's condition requires, but no longer than 30 days of assignment based on the information provided by the GRHHN and any information the Care Management provider organization may have. The care manager will attempt to establish a trusting relationship with the individual, describe the services available to them through the health home, and ask for their consent to participate in the GRHHN Health Home.

Assessment

A comprehensive assessment will be completed with every member who consents to participate in the GRHHN Health Home as expeditiously as the member's condition requires, but no longer than ___ days of their consent. The assessment may be completed through multiple contacts and with the assistance of the member's family or caregiver, with their consent. Assessment elements will be documented and will include:

- Initial assessment of members' health status, including condition-specific issues
- Documentation of clinical history, including medications
- Initial assessment of the activities of daily living
- Initial assessment of mental health status, including cognitive functions
- Initial assessment of life-planning activities
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of visual and hearing needs, preferences or limitations
- Evaluation of caregiver resources and involvement
- Evaluation of self-management skills including medication and equipment
- Evaluation of available benefits within the organization and from community resources

Health status

- During initial assessment, case managers evaluate the member's health status specific to identified health conditions and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes).

Clinical history

- The case management procedures document the member's clinical history, including disease onset; key events such as acute phases; and inpatient stays, treatment history and current and past medications.

Activities of daily living

- Care managers will evaluate the member's functional status related to activities of daily living such as eating, bathing, mobility, grooming, dressing, toileting, meal preparation, laundry, light housekeeping, shopping, using the telephone, managing money, and managing medications.

Mental health/cognitive functioning status

- During the initial assessment, care managers evaluate the member's mental health status, including psychosocial factors and cognitive functions such as the ability to communicate, understand instructions and process information about their illness. Key elements include:
  - Alert/oriented able to focus and shift attention, comprehends and recalls direction independently.

- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Life planning

- The case management plan includes an assessment of life planning activities such as wills, living wills or advance directives and health care powers of attorney. The organization must demonstrate that it has assessed whether a member has completed life-planning activities. A member's expressed will about treatment could influence a case management plan. If expressed life-planning instructions are not on record, the case manager determines if such a decision is appropriate during the first contact, based on the patient's circumstances. Providing life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Cultural, linguistic, visual and hearing needs, preferences or limitations

- The care management plan includes an assessment of characteristics that make it difficult for the care team to communicate effectively with the member, such as:
  - Health care treatments or procedures that are religiously or spiritually discouraged or not allowed
  - Family traditions related to illness, death and dying.

Caregiver resources

- During initial assessment, care managers evaluate caregiver resources such as family involvement in and decision making about the care plan, including:
  - Member is independent and does not need caregiver assistance
  - Caregiver currently provides assistance
  - Caregiver needs training, supportive services
  - Caregiver is not likely to provide assistance
  - Unclear if caregiver will provide assistance
  - Assistance needed but no caregiver available

Benefits

- The care management plan includes an assessment of the member's eligibility for health benefits and other pertinent financial information regarding benefits. These could include those covered by the organization as well as providers of benefits and services carved-out by the purchaser or supplementing those for which the organization has been contracted such as community mental health, EAP, disease management and wellness organizations, palliative care programs and other national or community resources.

Self management could include ensuring the member can perform the following:

- Activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)
- Instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances)
- Medication administration (e.g., oral, inhaled or injectible)
- Medical procedures/ treatments (e.g., changing wound dressing)
- Management of equipment (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)

Care Plan

The Greater Rochester Health Home Care Manager will develop of an individualized care management plan, including prioritized goals, that consider the member's and caregivers' goals, preferences and desired level of involvement in the case management plan. The case management plan is personalized to meet a member's specific needs and identifies the following:

- Prioritized goals
- Time frame for reevaluation
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfers
- Collaborative approaches to be used, including family participation

The prioritized goals are listed in order of importance regarding a member's situation or condition, as determined by the care management team. Prioritized goals consider member and caregiver needs and preferences.

Evaluating member social needs and personal preferences can drive activities, supports and case management service. Understanding these areas can be used to create individualized and person centered case management plans. Social and practical needs can include transportation, shelter and food. Personal preferences can include values and areas of interest such as, religious affiliations, social and vocational goal.

The following elements are integrated into the plan of care to ensure effective implementation:

- Identification of barriers to meeting goals or complying with the plan
- Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals
- Development of a schedule for follow-up and communication with members
- Development and communication of member self-management plans
- A process to assess progress against case management plans for members

Referrals to resources

Members may benefit from referral to available resources as part of benefits. The organization's case managers facilitate member referral to other health organizations, when appropriate.

Barriers

Care management procedures address any issue that may be an obstacle to the member receiving or participating in the case management plan. A barrier analysis can include issues such as language or literacy; lack of or limited access to reliable transportation; a member's lack of understanding of a condition; a member's lack of motivation; financial or insurance issues; cultural or spiritual beliefs; visual or hearing impairment; and psychological impairment. The health plan must document that issues of barriers was addressed, even if no barriers were identified.

An assessment of barriers examines a member's:

- Understanding of the condition and treatment
- Desire to participate in the case management plan
- Belief that participation will improve their health
- Financial or transportation limitations that may hinder the member from participating in care
- Mental and physical capacity to participate in care.

Source: *Lorig, K., Patient Education, A Practical Approach (Thousand Oaks, CA: Sage Publications, 2001) 186-192.*

Follow-up schedule

The case management plan includes a schedule for follow-up that includes, but is not limited to, counseling, referrals to a community based support program, education, or self-management support.

The care manager will document in the care plan when and how they will follow up with a member after facilitating a referral to a health resource (e.g., a phone call or secure e-mail to the participant confirming that the participant contacted the health resource organization).

Development and communication of self-management plans
Self-management plans are activities undertaken by members to help them manage their condition, and are based on instructions or materials provided to them or to their caregivers. In complex case management, "development and communication of the self-management plan" refers to the instructions or materials provided to members or their caregivers to help them manage their condition. These activities are designed to shift the focus in patient care from members receiving care from a practitioner or care team, to members providing care for themselves, where appropriate. Self-management activities are components of the care plan and do not require a separate plan or specific format. Member self-management activities include, but are not limited to:

- Maintaining a prescribed diet
- Charting daily readings (e.g., weight, blood sugar)
- Changing a wound dressing as directed.

Assessing progress
The care management plan includes an assessment of the member's progress toward overcoming barriers to care and meeting treatment goals. The care management process includes reassessing and adjusting the care plan and its goals, as needed.

Level and intensity of care management:

- **Low need- stable in ambulatory care with episodic crisis or inpatient need**
  Low need individuals will receive a minimum of 4 contacts per month with the following interventions:
  - Introductory mailing/welcome letter with information about enrolling in the Program, community education/support programs, contact information, and self Management support materials
  - Follow up phone call to ensure receipt of materials; determine willingness to participate; obtain necessary consents/authorizations; verify address, demographics, primary care provider, and other providers. Also, identify preferred method of communication, language, and any accommodations necessary to ensure they are able to participate effectively in the program.
  - Assess needs/ strengths/goals, and provide suggested approach/plan of care
  - Engage appropriate interdisciplinary care members appropriate to needs
  - Follow-up referrals to community support services, mailings, and calls as appropriate
  - If unable to contact the individual by phone or letter, home visit attempts will be made.

- **Intermediate need- not as connected to ambulatory care, more frequent emergency room and inpatient use**
  Intermediate need individuals will receive a minimum of 6 contacts per month and appropriate face-too-face contact with the following interventions:
  - All low need interventions with home visit to engage, educate and counsel in self
  - Follow-up telephonic education and counseling with additional face-to-face contact as needed

- **High need- very unstable such as those serviced by OMH and HIV/AIDS COBRA TCMs and the MATS program**
  High need individuals will receive a minimum of 8 contacts per month and at least 2 face-to-face contacts with the following interventions:
  - All low and intermediate interventions with both telephonic and face-to-face contacts as needed to meet the needs of the patient/client.
  - Services may involve accompanying individual to provider and community base service appointments and home-based support in following through with recommended plan of care

Interventions

Comprehensive Care Management

Comprehensive Care Management provides support to address the medical & related psychosocial needs of enrollees in order to ensure positive outcomes in a cost effective manner. Care Managers develop relationships with the patient/client & works to understand their needs, strengths & goals. They coordinate & collaborate with medical & behavioral health providers & community resource service providers to ensure that patient/client needs are met & that barriers to receiving services have been identified & removed.

- The care management process that will be followed is designed to support goal identification & achievement & includes:
    - Use of available data to identify health risks & gaps in care;
    - Comprehensive assessments that incorporate medical, behavioral & psychosocial evaluations in problem identification;
    - Patient-centered care plan development that includes the patient/client & caregiver support in pursuit of achieving goals through appropriate interventions
    - Implementation of the care plan;
    - Monitoring intervention effectiveness & goal achievement;
    - Evaluating patient progress;
    - Outcome measurement & documentation in designated application(s).

Care Coordination and Health Promotion

Care Coordination is an advocacy process where the Care Manager works with providers within the health care system, evaluating & coordinating care along the health care continuum, to meet the needs of the patient/client. GRHHN Care Managers will collaborate with GRHHN providers and community services to ensure that patients/clients receive the health & barrier reduction services they need to decrease medical, behavioral health & social risk factors.

Health Promotion is incorporated in interactions with the patient/client, based on their goals & care plan to encourage health behaviors to enhance outcomes. Care Managers will be trained in self-management support strategies to help develop the knowledge & confidence needed to effectively manage their daily activities to enhance their health outcomes. Community & caregiver supports will be engaged as appropriate to support effective health behaviors.

Both processes are completed based on an assessment of the individuals' needs and goals.

Comprehensive Transitional Care

The GRHHN care manager works to ensure effective transitions between one health care provider or setting and another as their needs change to optimize their health status, care outcomes, and reduce the potential for use of avoidable high cost services. Care Managers will be informed of a potential or actual transition event by the patient/client, provider, or hospital notification. Interventions are provided, tailored to the needs, strengths and resources available to the patient/client and may include patient education, self-management support, enlisting the support of family/caregivers, medication reconciliation, ensuring appropriate follow up care, identification and training in management of "red flag" issues, and tools for understanding and managing their current state.

Patient and Family Support

GRHHN care managers will encourage patients to have their caregivers/family/peer supports involved in their self-management. Information about the patient's condition is provided to caregivers for whom the patient gives consent. This includes information about their condition, complications & chronic diseases to assist the patient's supportive persons to assist & promote self-care. This information is available in a variety of modalities: printed materials & telephonic outreach.

Services provided by GRHHN care managers will be in the appropriate language, literacy/ numeracy level, & culturally appropriate.

They encourage patients to communicate with their providers about their conditions, treatment, & barriers. Caregiver support will be engaged in attending appointments with patients to assist, advocate, & ensure clear understanding of recommendations. Print informational materials & community resources will be provided for caregivers to review & discuss with the patient.

Referral to Community and Social Support Services

The GRHHN care manager will identify barriers to effective use of the health care system or to appropriate self-management and work with the patient/client to identify appropriate barrier reduction strategies. Community support services such as housing, transportation, food cupboards, child care, clothing closets, etc. will be engaged as appropriate to the needs of the individual. Appropriate peer supports may also be engaged with the consent and approval of the patient/ client. In order to facilitate effective use of community resources, an existing Community Resource Guide will be enhanced through identification of gaps in service delivery and made available to care managers.

Crisis Intervention Process

Health Home Lead Care Managers will be notified of an emergency department visit or inpatient admission or other crisis event by partner hospitals or by the enrolled patient/client. Efforts to ensure that this information is accessed and that notification occurs as close to real-time as possible are in process. The Health Home Lead Care Manager will be required to contact the patient/client as soon as practicable after receiving notification.

The Health Home provides 24 hours per day, seven days per week telephonic access through a centralized system to support patients/clients in the event of a crisis in order to reinforce appropriate use of resources and optimal health outcomes (e.g. contacting medical or behavioral health providers during normal business hours or through after-hours on-call systems or use of urgent care centers, mobile crisis service, etc.).

Monroe County has a unique 311 system to support access & referral to crisis response services. The Health Home will work with network providers to develop an appropriate crisis management plan, using community resources, & ensure providers are aware of how to access community crisis response services.

Notification of emergency room and inpatient facility admissions/discharges:

- Patients/clients will have contact information to enable direct notification to the GRHHN Care Manager of any crisis event.
- GRHHN includes the three major hospitals in Monroe County who are required to report ED and inpatient admissions within 24 hours of the event. Initially, staff will acquire this information through phone calls or faxing, and will manually key it into care management software. When this information is available through the RHIO, an interface will be built between the RHIO and the care management software system.
- Currently, the Rochester RHIO connects Monroe County's health home providers. Through interfaces to the RHIO's HIE, hospital ADT feeds are sent to the HIE and are available directly to practice EHRs when patients provide consent & providers chose to subscribe for their patients. Each EHR platform will integrate this information into the EHR. This transfer is in near real time. The RHIO provides interoperability with 16 EHR vendor platforms.

Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. Distinguishing factors of complex case management:

- Degree and complexity of illness or condition is typically severe
- Level of management necessary is typically intensive

- Amount of resources required for member to regain optimal health or improved functionality is typically extensive

Quality Improvement / Program Evaluation

The GRHHN measures the effectiveness of its care management program annually. The GRHHN incorporate the following in its evaluation:

1. Assess the characteristics and needs of its member population and relevant subpopulations;
2. Review and update its care management processes to address member needs, as appropriate.
3. Review and update its care management resources to address member needs, if necessary.

The Greater Rochester Health Home Network will develop a system to collect and analyze data on the effective operation of the health home, establish a continuous quality improvement program, and collect and report on data annually. The report will evaluate the impact 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. GRHHN's Continuous Quality Improvement program will use at least three measures and will address:

- Identify the relevant process or outcome;
- Use valid methods that provide quantitative results;
- Set a performance goal;
- Identify measure specifications;
- Analyze results;
- Identify opportunities for improvement, if applicable; and
- Develop a plan for intervention and remeasurement.

The evaluation report will also include patient/member satisfaction with health home care management services. Satisfaction will be evaluated at least annually to ensure that health home processes and interventions are meeting their needs by:

- Obtaining feedback from members
- Analyzing member complaints and inquiries.

Reporting

The GRHHN Care Management Partner organizations will support timely and accurate completion of data collection and reporting elements for transmission to NYSDOH regarding Health Home services as required by the NYSDOH and CMS.

Health Information Technology

GRHHN will pursue a 2-stage approach to sharing treatment and care planning information:

- 1st stage: contract for infrastructure services including care management software allowing patient health information to be accessible to a team of providers. This will ensure care managers have access to create, share, & update a plan of care. Vendors under consideration have experience with sharing care management software programs over secure connections to do this. GRHHN will also partner with Rochester RHIO to coordinate medical, behavioral, & psychosocial support services for enrollees, once consents have been obtained. There are currently 16 EHRs connected to the RHIO's HIE.
- 2nd stage: require all network clinical providers to use a Meaningful Use certified EHR & connect with RHIO. Coordination with practice-based EMRs and HEAL 17 grant recipients will be pursued. Software-As-A-Service-based EHR may be provided for network providers.

Compliance with State, Federal, & Accreditation Requirements

The Greater Rochester Health Home Network shall comply with the requirements of the appropriate state and federal agencies and accrediting entities designated by contracted Health Plans or the New York State Department of Health, including the National Committee for Quality Assurance, New York State Public Health Law, and the Centers for Medicare and Medicaid Services and all other regulatory and accreditation standards.

Conflict of Interest

Greater Rochester Health Home Network staff, in the course of their outreach and care management activities with members, may come in contact with members who are known to them through either family, social situations or other work settings. In order to provide appropriate interventions, Greater Rochester Health Home Network staff will follow specified procedures to ensure objectivity in their interactions with members to avoid the appearance of impropriety.

Confidentiality

All clinical information used to conduct care management activities is considered confidential. Consent from the member is obtained to initiate care management services and no information is given out to any external sources without the members consent, unless the information is specifically required or permitted by law.

Written procedures are maintained to ensure that patient-specific data obtained during the case review process will be kept confidential pursuant to state and federal laws and shared only with the member, the member's designee and providers of care or service.

Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients.

All member-specific data will be maintained in secured storage containers at all times, and access is limited to Greater Rochester Health Home Network staff with a need to know. The Greater Rochester Health Home Network requires all employees and contractors to sign a statement of confidentiality annually.

1. The use of Protected Health Information ("PHI") is limited to the minimum necessary information as required to comply with the above delegated tasks. Signed Business Associate Agreements or Data Exchange Associate Agreement outlines the stipulations required by the HIPAA privacy regulations.
2. Safeguards to protect the information from inappropriate use or further disclosure are documented in policies which guide the use and protection of protected health information.
3. All vendors or contractors requiring access to protected health information to perform required services on behalf of Greater Rochester Health Home Network will be required to treat such information confidentially as described in the Business Associate Agreements and Data Exchange Associate Agreement between Health Plans or the NYSDOH and Greater Rochester Health Home Network.
4. Greater Rochester Health Home Network will provide individuals with access to their PHI. Greater Rochester Health Home Network shall provide members or their representatives with access to their PHI as described in the Business Associate Agreements and Data Exchange Associate Agreement between Health Plans and the NYSDOH and Greater Rochester Health Home Network.
5. Greater Rochester Health Home Network will inform contracted Health Plans and/or the NYSDOH if inappropriate use or disclosure of protected health information occurs.
6. Greater Rochester Health Home Network will ensure that PHI is returned, destroyed or protected if the delegation or contract agreement ends.

Communication Services
Greater Rochester Health Home Network maintains appropriate levels of communication services for care management staff, service providers, and members for its contracted/delegated care management activities.

Home or Facility Visits
When conducting member home or facility visits, Care Management Staff will identify themselves as working on behalf of the Greater Rochester Health Home Network and show picture identifications. They will schedule visits with members at least one business day in advance when possible. Upon a facility's request, they will register with the appropriate contact person for the facility before visiting a member or requesting assistance or information from a facility. Staff will obtain consent from the member or the member's designee before interviewing the member's family, or observing any health care service being provided to the member.

No Retaliation
No action will be taken that is intended to penalize members or providers for or discourage them from, refusing or withdrawing consent for care management services.

No Transfer of Liability
Greater Rochester Health Home Network will not transfer to a health care provider liability relating to its own activities, actions, or omissions.

Applicable licenses & Certificates
Greater Rochester Health Home Network shall maintain all applicable licenses and certificates required to perform delegated activities and maintain appropriate records with respect to those contracted or delegated activities for the duration of these Agreements and for six (6) years after its termination.

Delegation

In cases where activities are delegated to the Greater Rochester Health Home Network, a formal delegation agreement outlines the responsibilities of each party, reporting requirements, the process by which GRHHN is evaluated, and the consequences if obligations are not fulfilled. An annual evaluation of GRHHN's performance is conducted by the delegating entity. GRHHN will implement a collaborative process to ensure that delegated activities are performed in accordance with the delegation agreement and that all reporting requirements are met.

Written delegation documents are:

- Mutually agreed upon;
- Describe the responsibilities of the GRHHN and the delegating entity;
- Describe the delegated activities;
- Require at least semiannual reporting by the GRHHN to the delegating entity;
- Describe the process by which the delegating entity evaluates the GRHHN's performance:
- Describe the remedies available to the delegating organization if the GRHHN does not fulfill its obligations, including revocation of the delegation agreement.

The mutually agreed-upon document must include the responsibilities of the GRHHN and the delegating entity in terms specific to their relationship. Allocated responsibilities between the two parties include the following:

- Collection of data;
- Exchange of information;
- Form and content of meetings;
- Initiation of improvements;
- A list of the allowed uses of PHI;
- A description of safeguards to protect the information from inappropriate use or further disclosure:
- A stipulation that the GRHHN ensures that sub-delegates have similar safeguards;

- A stipulation that the GRHHN provides individuals with access to their PHI;
- A stipulation that the GRHHN informs the delegating organization if inappropriate use of the information occurs;
- A stipulation that the GRHHN ensures that PHI is returned, destroyed or protected if the delegation agreement ends.

Question	Answer
Q: Can chemical dependence issues go into behavioral health for the care plans?	They can but please use generic language in the Care Plan regarding CD information as the Care Plan is shared with Network Providers. The CD specific information should live in the Notes.
Q: How many days was it between Outreach/Engagement and Discharge when they are Lost to Services?	Lost to services only applies during the Enrollment segment and if you cannot find the client within 60 days of the last contact, on the first of the following month you should discharge them as "lost to services" and then you can put them back into Outreach & Engagment for 3 months and get paid at that rate to continue searching.
Q: If we are seeing folks in their homes and updated their plan in real time on a laptop or tablet, what is the timeframe for printing the plan and having them sign?	Use your discretion, but the next time you see them, they should be signing it.
Q: In regards to client moving from Enrolled to O/E will a new DOH 5055 and Fact GP + HH be required even if one was already done?	You should be reviewing the consent and updating it based on the new timeframe. You will need to add new consent data into the system as CM 2.0 ends the current consent upon discharge. The FACT-GP does not have to be redone because the state still sees it as the initial episode.
Q: Regarding CAreManager Note-iCMART reporting only allows for 1 core service reporting-can you still document more than 1 core service type in NetSmart?	Netsmart does allow you to check more than one but we are training that only is to be selected and only one will actually populate the CMART.
Q: we have providers working at our agency. If a HH patient is seen by one of our own providers, do we need to have patient sign consent for that internal provider?	You would add that Provider under Team Assignment as MD from your agency. As long as it's the same agency and the client is receiving services from the clinic, you should all set.
Q: So we no longer need for them to sign the "consent to disclose" which is currently part of the HH referral form. They give verbal consent in place of signing this?	The consent on the referral form is a consent for the individuals PHI to be shared with any of the named organizations on the form for purposes of HH referral. It is NOT a consent to HH services. Once the client verbally agrees to HH services before/after the referral is sent, you still want to obtain the DOH 5055 Data Sharing Consent to share the care plan and other information with downstream providers.
Q: when does the 30 day assessment time requiremnt begin? At verbal consent or at signed HH onsent?	Verbal consent, written data sharing consent isn't necessarily required if the client refuses. So when the Client Status changes to Enrolled from the Client Search Note.
Q: You said that if a person is incarceration for more than 60 months case be discharge. That means that we keep him open if is less tham that, even without giving services to the person?	No, it simply means you would "discharge" instead of selecting the Rejection: Incarceration end code when ending the segment.
Q: Is this system interfaced with the RHIO so that we can receive admission/discharge alerts etc?	A: It is not at the moment. That connectivity is planned after we go-live. The home screen with the alerts and such is there with the intent to have the alerts populated by the RHIO.

Q: supervisor's can't add a "task" to a staff member?	A: No, unfortunately. A supervisor can use the appointments to be able to send an action note directly to a care manager.
Q: Will we still get a list of updated Acuity scores from HHUNY or are we relying on Netsmart to get this. As we a converting member and need updates scores for our biling?	A: The acuity scores will be updated in Netsmart on a regular basis by HHUNY. You will be able to run a report to have an updated acuity score for each of the of your members, if it is available from DOH.
Q: Should we use otherconsent forms, as the DOH 5055 is only for health info. for example our locasl Dept of Social Services Dept for Mediciad will not talk to us if they are on the 5055 we need to complete and agency consent. So would we put them in the data sharing consent wtih the agency consents.	If DSS requires an additional consent for non-PHI information, that is a requirement by DSS that we can't control and you will most likely need to get that consent as well.
Q: As for the DSS consent question. We have added DSS to 5055 and when we sent them a copy to be able to talk with them, thye tell us that if we want to talk about helath info this consent would be fine, but to disucss Medicaid/Food stamp/ Cash assistance issues we need a different consent and we then use our agencies consent. So will that count for the data sharing consent section?	If DSS requires an additional consent for non-PHI information, that is a requirement by DSS that we can't control and you will most likely need to get that consent as well.
Q: Will you send a list of the Q/A from yesterdays and today's webinars to everyone?	A: Yes, we can make sure all of these questions and answers are sent out. We may also start posting some of these questions on the website as well.
Q: Do you have to wait the full 60 days for "lost to service"? for example if you do 30 days after the last contact and then go to O/E?	A: Our policy is to wait 60 days since the billing can still be done at the enrolled rate for this period if you are consistently trying to contact the client, including attempting collateral contacts as well. If you feel it necessary to end the enrollment segment earlier than 60 days, that would be up to your organization's policy.
Q: So we need to do an official care plan every 90 days. Or is it at enrollment, every 6 months, at discharge and then as needed?	A: We will be giving specific guidance on the timing with the updated Care Management Standards that you will be receiving at the in-person training. The care plan should be updated as needed, regardless of the timing with 90 days being the max amount of time it should be updated.
Q: can a non-mdcd client be entered into Netsmart?? we will still be required to serve those clients	A: (verbal) Only Health Home Members can be entered into Netsmart. If they are eligible for the Health Home program but do not have up to date medicaid coverage, you can work with the member to activate their Medicaid. But no other clients in other programs will be able to be entered into Netsmart.
Q: any way to imprt this from Psyckes?	No, you cannot.
Q: can you sync this to outlook calendar?	A: (verbal) No, the appointments will not sync to Outlook.

Q: For medications: What if start date and frequency is unknown?	A: Type Unknown and put the date as the reported date (today). Be sure to look in the RHIO or other areas to determine if the dates/sig is listed there.
Q: We are required to have a diagnosis necessary to bill for services. When we are sent a DOH list, there is limited information per individual on the list, and often there is no diagosis. When we are engaing in outreach and engagement activities for individuals from the DOH lists, how can we bill for these activities when there is no known diagnosis?	A: The diagnosis would be necessary for billing at the enrolled level, not for the outreach and engagement level. If an individual is agreeing to participate in the Health Home Program, they should have a qualifying diagnosis and it should be documented at that point. If you are doing outreach and engagement activities for those assigned from the DOH list, you would not need a documented diagnosis until you enroll the individual, Netsmart will use a generic diagnosis until enrolled.
Q: Can there be a second person with supervisory access for any one care manager provider?	A: The supervisor role in the system can be added to as many individuals in your agency as necessary.
Q: Do all care plans need to be entered into the Care Management 2.0 system in July when the system goes live, or can they be added as they are due for current active clients? ie: if an initial care plan was developed in April 2014, can it be added in the system in October 2014?	You need the objectives and interventions listed in the Care Plan and finalized prior to creating any CareManager Notes which are the notes you should be completing in the system for health home activities. So yes, because the system follows golden thread, you will need to load the current care plan into the system after July 1st.
Q: Does the County SPOA have access to view assisgnments to all care manager providers within a given county?	A: The County will be reviewing all assignments made by HHUNY prior to the assignments going down to the Care Management Agencies.
Q: Will Medicaid status be updated as it changes for us or do we need to update that info?	A: We will be doing an eligibility check in the system. If you do receive an update on the individual's Medicaid status, we would recommend that you update that infomation in the eligibilty section as there may be a delay in the internal eligibility check. Eligilbility verification is done upon import and then at each monthly billing cycle.
Q: If a care manager from this agency sees a client assigned to another care manager, do they need to be listed on the assigned team inorder to write a note on that client? We occasionally have other care managers work with a client if the assigned CM is unable to do it that day!	A: We are working to define the security roles so that the care managers can search for any client within your organization and then create a note. A care manager that is not assigned to the team would not be able to make any other changes to the chart, but would be able to cover easily through notes. If the covering Care Manager noted that additional changes needed to be made to the chart, he/she would need to inform the lead Care Manager for the client of the changes needed or be assigned specifically to the client.