



Health Homes

BEACON HEALTH OPTIONS

TOPICS

- > Overview
- > Health Homes vs Medical Homes
- > Population Criteria
- > Referrals to Health Homes
- > Health Home Assignments
- > Patient Information Sharing / Privacy
- > Core Services
- > Link to Health Homes Directory

Health Homes

What is it?

- > 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
- > A dedicated care manager oversees and provides access to all of the services an individual needs to assure that s/he receives 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
- > Health Home services are provided through a network of organizations — providers, health plans and community-based organizations.
 - > When all the services are considered collectively, they become a virtual Health Home

Health Homes

Background

- > Result of Medicaid Redesign Team (MRT), established by Governor Cuomo in Jan 2011
- > Goals
 - > Improve care and health outcomes,
 - > Lower Medicaid costs, and
 - > Reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid members.

Health Homes

Health Homes vs Medical Homes

- > The Patient Centered Medical Home (PCMH) is a model for care provided by physician-led practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages — acute, chronic, preventive and end of life — and a long-term therapeutic relationship.
 - > The physician-led care team is responsible for coordinating all of the individual's health care needs and arranges for appropriate care with other qualified physicians and support services.
- > The Health Home model of service delivery expands on the traditional medical home model to build linkages to other community and social supports and to enhance coordination of medical **and** behavioral health care with the main focus on the needs of persons with multiple chronic illnesses

The Health Home Care Management Model

- > Care Coordinators bring medical, behavioral health and social service providers together to build a holistic care plan for each participant
- > Places emphasis on collaboration and information sharing to promote preventative (versus reactive) interventions
- > Provides ongoing assessment and referral to customize the care delivery experience for each participant
- > Link and refer participants to needed services
- > Participant works in tandem with the care team and actively participates in goal setting
- > Ongoing collaboration between care providers
- > Delivers outreach to locate and re-engage participants
- > Crisis management and support

Health Homes Population Criteria

At least two (2) chronic Conditions

- > Must have at least two (2) chronic conditions or a single qualifying condition
- > Chronic includes:
 - > Overweight
 - > BMI of 25 or above
 - > Substance use disorder
 - > Heart disease
 - > Diabetes
 - > Asthma
 - > Hypertension
- > Single qualifier would be:
 - > HIV / AIDS
 - > A Serious and Persistent Mental Health Condition

Health Homes

Assessing Appropriateness for Health Home Referrals

- > Significant behavioral, medical or social risk factors which can be modified/ameliorated through care management including any of the following:
 - > Probable clinical 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 or psychiatric hospitalization
 - > Deficits in activities of daily living such as dressing, eating, etc.
 - > Learning or cognition issues

Health Homes

Other Factors to consider

- > Include a history of poor connectivity to care, including but not limited to:
 - > No primary care practitioner (PCP)
 - > No connection to specialty doctor or other practitioner
 - > Poor compliance (does not keep appointments, etc.)
 - > Inappropriate ED use
 - > Repeated recent hospitalization for preventable conditions either medical or psychiatric
 - > Recent release from incarceration
 - > Cannot be effectively treated in an appropriately resourced patient centered medical home
 - > Homelessness

Health Homes

Who Can Make Referrals To The Health Home

- > Hospitals are required to refer individuals with chronic conditions who seek care or need treatment in a hospital ER department
- > Criminal justice system
- > Court order clients for Assisted Outpatient Treatment (AOT)
- > State prisons
- > County and city jails
- > Institutes for Mental Disease
- > Managed care plans
- > Designated Health Homes
- > Clinics
- > Family members
- > Ground up referrals
 - > New referrals are being accepted from hospitals, prisons, community, housing, HRA., shelter, etc.
 - > These referrals are often referred to as “ground up” “Upwards” or “community referrals”

Health Homes

How are patients assigned to a health home?

- > The State will use a combination of the following to assign Medicaid enrollees to Health Homes:
 - > 3M™ Clinical Risk Group (CRG)
 - > an algorithm that predicts hospitalizations, and
 - > behavioral health indicators
- > When possible, assignments are based on
 - > existing relationships with ambulatory, medical and behavioral health care providers or health care system relationships,
 - > geography, and/or
 - > qualifying condition
- > Members have the ability to “opt out”

Enrollment

- > Lists of individuals are then assigned to a Health Home where key providers are in network
- > Health Homes Conduct Outreach and subsequent Health Home Care Coordination with Individual's consent
- > An Acuity Score is calculated by the State based on the individual's Medicaid utilization cost and other risk factors that will be entered into MAPP by Health Homes CMA
- > Health Homes are then paid a PMPM rate based on acuity scores to provide care coordinator for this individual

Referral for Care Coordination

- > All Medicaid recipients that require Care Coordination must be enrolled in a Health Home
- > Recipients that opt-out of Health Homes will not be eligible for Care Coordination
- > Recipients can decline consent for information sharing
- > Providers to assist with locating members for outreach: Share demographic information
- > Real time referrals- Improved Engagement and Outreach

Opt Out/Change of HH

- > Clients can “opt out” of a Health Home or switch Health Homes at any time
- > The forms for both can be found online in many languages on the State’s webpage
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/
- > If a client is on an AOT order then Care Coordination or ACT would be part of their order and they would not be able to disenroll

Health Homes

Information Sharing / Member Consent

- > One of the main reasons for the Health Home is the ability to share information.
- > Members must sign a DOH Health Home Patient Information Sharing Consent form (DOH-5505)
 - > This consent allows a member's health information to be shared among the consented Health Home partners involved in their care and also serves as the RHIO (Regional Health information Organization) consent form for Health Homes partnering with a RHIO
- > Until the form is signed, the Health Home care manager can only work one-on-one with the member.

Health Homes

Core Services

- > Health Home providers must have the capacity to perform core services specified by Centers for Medicaid Services
 - > Health Homes MUST provide at least one of the first five (5) core functions (exclusive of HIT) per month to meet billing standards

Core Functions:

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 services
6. Use of **Health Information and Technology** to link services
 - > **HIT**

Core Health Home Services

1 – 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 patient to identify patient's needs/goals, and include family members and other social supports as appropriate.
- > Consult with multidisciplinary team on client's 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 improved health outcomes.
- > Prepare client crisis intervention plan.

Core Health Home Services

2 – 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 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 as required.

Core Health Home Services

3 – Comprehensive Transitional Care is Heart Failure?

- > Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- > Facility discharge planning from an ER, hospital/residential/rehabilitation setting to ensure a safe transition/discharge that ensures care need are in place.
- > Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
- > Link client with community supports to ensure that needed services are provided.
- > Follow-up post discharge with client/family to ensure care plan needs/goals are met.

Core Health Home Services

4 – Patient & 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.

Core Health Home Services

5 – Referral to Community & Social Support Services

- > Identify resources and link client with community supports as needed.
- > Collaborate/coordinate with community base providers to support effective utilization of services based on client/family need.

Core Health Home Services

6 – HIT Requirements for Health Homes: Use of health information and technology to link services

- > Health Homes are required to comply with initial standards in order to be a designated Health Home provider:
 - > Provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.
 - > Provider has a systematic process to follow-up on tests, treatments, services, and referrals which is incorporated into the patient's plan of care.
 - > Provider has a health record system which allows the patient's health info and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventative services.
 - > Provider makes use of available HIT and accesses data through the RHIO/qualified entity to conduct these processes, as feasible.

Health Homes must plan to achieve the final standards below within 18 months of program initiation:

Provider has structured interoperable health info technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan to care for every patient.

Provider uses an electronic health record system that qualifies under the Meaningful use provisions of the HITECH Act, which allows the patient's health info and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

Provider will be required to comply with the current and future version of the Statewide Policy Guidance.

Provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in care plan.

Provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.

Linkage/Access to HCBS

- > InterRAI
- > Integrated Functional Assessment to that identifies need for HCBS services and medical care needs
- > All HARP members will be screened by Health Home Care Management Providers for HCBS service via InterRAI screen
- > Members that screen positive on the initial screen, Full InterRAI assessment complete
- > Plan of Care Developed by Health Home CMS- Identifies strengths, needs, preferences and specific HCB services (specific providers, must include choice of HCBS providers)
- > Plan of Care approved by Managed Care
- > InterRAI must be complete to access HCBS

Health Homes

Interactive Map by County

- > https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/

