Effective Date: May 1, 2024

Category: K. Lead Health Home

Title: 1. Health Home Administration

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ ____________________

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

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PURPOSE

This policy is intended to outline the role and responsibility of the Lead Health Home, Community Health Connections.

POLICY STATEMENTS

It is the policy of Community Health Connections (CHC) that the Lead Health Home strives to ensure the stability, standardization and growth among the Care Management Agencies that

comprise the Health Home. The Lead Health Home will provide quality oversight to the agencies, including training and performance data and will ensure that the Community Health Connections complies with all State and Federal Health Home regulations.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

DEFINITIONS

Health Home Member: An individual who is enrolled in Health Home services

MAPP: Medicaid Analytics Provider Portal; system used by NYS DOH to communicate Member status, Member information and billing information

NYS DOH: New York State Department of Health; the regulating State entity for Health Homes

PROCEDURE

A. Health Home Operations

1. Community Health Connections (CHC) will ensure compliance will all NYS DOH reporting requirements, including but not limited to CMART, Patient Tracking, required data uploads to MAPP and billing communications. This reporting will be done in accordance with NYS DOH regulation and on behalf of all Care Management Agencies (CMA) that comprise CHC.

2. CHC will provide the platforms necessary for each Care Management Agency to document care coordination activities and to bill for those activities.

3. CHC will work to connect each agency to the local Regional Health Information Organization (RHIO) through the platforms described above. This RHIO connectivity will help CMAs in providing timely and quality services to Members.

B. Care Management Agency Support

1. To ensure standardization and across the agencies that comprise CHC, the Lead Health Home will provide a set of policies and procedures by which all CMAs must abide. These policies and procedures will be the standards by which CMA performance is measured, as outline in Policy H1. Quality Improvement: Quality Management Program. These policies will meet the State and Federal regulations for the Health Home program, at a minimum.

2. In an effort to help CMAs prepare for annual audits, CHC will provide monthly aggregate and Member-level compliance and outcome data to assist CMAs in focusing efforts to provide quality and timely services to Members. CHC will also conduct monthly topic-specific spot audits to help CMAs identify areas for improvements between formal, annual audits. For more on audits, see Policy H1. Quality Management Program.

3. CHC will strive to provide opportunities for training, engagement and information sharing. Such opportunities include the following.
   - Monthly Operations Meetings, including administration from each CMA during which time policies, NYS DOH requirements and the overall direction of the Health Home will be discussed
   - Quarterly Quality Sub-committee with representation from each CMA to address quality topics, including but not limited to the Quality Management Program and Member Satisfaction Surveys
   - Monthly or bi-monthly individual meetings with each CMA to discuss any concerns or questions brought forth by the CMA or the Lead Health Home
   - Regular training opportunities for all staff, including those hosted by CHC as well as those hosted by outside entities (i.e., NYS, MCOs, etc.) and promoted by CHC to Health Home staff

4. CHC will screen all referrals that come to the Lead prior to assigning them to CMAs (downstream referrals) for assignment to the most appropriate available CMA and for potential eligibility for the SMI HH+ program. Referrals suspected to meet criteria for SMI HH+ services will be sent to a CMA that is designated to serve the SMI HH+ population. Such referrals sent to agencies will be denoted as "***This referral appears to be Health Home Plus Eligible, please review and follow appropriate steps to confirm***" in the email with the referral attached. (For more on SMI HH+, see Policy F4. Special Programs: Serious Mental Illness Health Home Plus.)

5. CHC staff are a resource for CMAs when working on intense or complex cases. While such cases can be brought up during the monthly phone meetings referenced above, CMA staff are encouraged to reach out for guidance and input anytime there are concerning or situations regarding Members. Requests for discussions on complex cases should be made via the Complex Case Discussion Request Form (Attachment A). CHC will also participate in case conferences for cases when requested and schedules allow.

   For more on assignment of cases and complex case discussions referenced in B4 and B5 above, see the Complex Case Procedures document in Attachment B.

6. CHC staff will also support CMAs with required MCO notifications when Members are placed in Diligent Search Status or are closed and the CMA has no consent for

the MCO. In instances in which the Member refused to sign consent for the MCO, CHC will assist in the notification to the MCO of the Member's Diligent Search status or closure with the Health Home program. (For more on Diligent Search and Case Closure, see Policy C6. Care Coordination: Case Closure and Re-engagement.)

C. Health Home Network Connectivity

1. A large component of Care Coordination is Member connectivity to community providers. To help increase this connectivity, CHC will outreach agencies in the community to facilitate communications and foster partnerships on behalf of Health Home Members.

2. As agencies in the community are identified, partnerships will be sought to help promote timely access to services for Members. CHC will strive to maintain relationships with local hospitals, Local Government Units, shelters and other community-based providers who serve a similar population. CHC will provide a single point of contact for community-based organizations to maintain connections with the Health Home program.

D. Non-Medicaid Services

1. Whenever possible, Members should be referred to providers in the community who are Medicaid providers, meaning they accept Medicaid reimbursement for services provided to patients. At times, such service providers may not be available in the community. In those instances, the Lead Health Home should be notified so that the Lead Health Home can make agreements with non-Medicaid providers so that Member can receive any needed services.

REFERENCES

New York State Department of Health (October 5, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

Approving Official: Senior Vice President, Population Health, Advocacy		**Effective Date: May 1, 2024**
Key Sponsor: Regional Health Home Director		
Reviewed By: Regional Health Home Operations Manager		**Original Date: May 15, 2018** **Reviewed/Revised Date: May 1, 2024** ***Reviewed, No Revisions** ****Revised without Full Review**
Search Terms:		
Replaces: Lead Health Home: Health Home Administration (May 15, 2018) **Lead Health Home: Health Home Administration (January 3, 2022)**		

Attachment A: Complex Case Discussion Request Form

Community Health Connections is pleased to offer support or guidance on complex cases. To request a case discussion, please complete page 1 of this form and submit it to *Lauren.Selmon@sphp.com*

Requestor (Name and CMA):	Date:
Member Name:	Chart Number:

Case Background *(Please provide a brief synopsis of case including diagnoses and reasons for discussion request; information can be in bullet form)*

Actions to Date *(Please describe the steps taken to meet Member's needs to this point)*

Barriers to Date *(Please list any barriers encountered to meet Member's needs to this point)*

Member's Strengths and Protective Factors

Providers *(check if Member has any of the following connections and indicate provider name, include any social supports that may be relevant)*	
☐ MCO:	HARP? ☐ Yes ☐ No
☐ Mental Health:	
☐ Substance Use:	
☐ Medical / PCP:	
☐ Housing Provider:	
☐ Other, please specify:	
☐ Other, please specify:	
☐ Other, please specify:	

Most Recent Case Conference	
Providers/Member/Supports in Attendance:	Date:
Outcome of Case Conference:	

Action Plan Information	
Recommendations for Next Steps:	Owner:

Attachment B: Complex Case Procedures

Community Health Connections (CHC) Administrative Staff are pleased to provide support and guidance on cases that are complex in nature. The following pages outline CHC's approach to identifying such case and the support provided.

Definition of a Complex Case / Referral

No two Members are the same and therefore the definition of what makes a case or referral complex will vary from Member to Member. Some factors that may contribute to the complexity of a case or referral are as follows.

Potential Characteristics of a Complex Referral

- Recent Release from State Facility or Jail with a SMI Diagnosis
- History of violence
- Sex offender status
- High Risk / Unsafe Behaviors
- High utilization (ER or Inpatient) within last three months
- Homeless with a SMI Diagnosis

Potential Characteristics of a Complex Case

- High utilization (ER or Inpatient)
- Lack of meaningful engagement in treatment or medication compliance which results in uncontrolled diagnoses
- Complex diagnoses
- High Risk / Unsafe Behaviors
- Acute psychiatric symptoms
- Lack of providers willing to work with Member
- Safety concerns (homicidal ideations, suicidal ideations)
- Housing instability due to past (sex offender status, fire setting)

The factors above are not an exhaustive list of what might make for a complex referral or case. Candidates or Members may also have multiple factors that lead to case complexity and the need for Lead Health Home support.

Referral Procedures

If a referral is suspected to meet criteria for SMI HH+ eligibility, the referral will be sent only to an agency designated to serve the SMI HH+ population. CMAs must still verify the eligibility using the SMI HH+ Eligibility Checklist. Such referrals sent to agencies will be denoted as "***This***

referral appears to be Health Home Plus Eligible, please review and follow appropriate steps to confirm" in the email with the referral attached.

Once reviewed and deemed ready for assignment, CHC will reach out to the agency identified as best suited to take the referral. As needed, a case conference will be scheduled around the time of assignment with the accepting agency, Lead Health Home representatives, the referral source and any other pertinent providers or agencies.

Enrolled Case Procedures

As cases are identified as complex in nature, supervisors are encouraged to reach out to the Lead Health Home for support. The Lead Health Home may be able to assist in identifying additional community resources that may be helpful or simply provide an alternate perspective on the case.

To initiate a request for a Complex Case Discussion, the request form (See Attachment A) should be completed and sent to the Community Liaison. The Lead Health Home Director and Community Liaison have set aside one hour every other week to schedule discussions as requests are submitted (Wednesday from 1:00 to 2:00). Should a meeting be needed prior to the next scheduled, set aside time for discussion, an earlier meeting can be scheduled.

The request form requires a summary of the work done on the case to date, including barriers, the Member's strengths and preferences as well as others involved in the Member's care or treatment. It is highly recommended that this form be completed with the Care Coordinator and Supervisor to ensure that the case is reviewed internally before bringing it to the Lead Health Home. Additionally, a case conference with providers is highly recommended prior to the discussion request; the form asks for the date of the last meeting with providers.

During the call, the agency representatives (Care Coordinator or Supervisor) will present the case and next steps will be identified by all participants. The second page of the Complex Case Discussion Request Form will be filled out and sent by the Lead Health Home, summarizing the identified next steps and who has ownership over those steps. From there, correspondences will continue via email and an additional meeting can be held if warranted.

Points of Contact for Complex Referrals or Cases

The points of contact at the Lead Health Home are as follows for complex referrals or cases.

Complex Cases	Lauren Selmon, Community Liaison	Lauren.Selmon@sphp.com	518-271-5037
Complex Referrals	Jerrie Gamble, Office Supervisor	Jerrie.Gamble@sphp.com	518-271-3301