ST PETER'S HEALTH PARTNERS	**Effective Date:** August 1, 2022

Category: **F. Special Programs**

Title: **5. HIV Health Home Plus (HIV HH+)**

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 Capital Region Health Connections Care Management Agencies**

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

Contents

PURPOSE

The purpose of this policy is to ensure that all Health Home Plus (HH+) Health Home Members are served as required by New York State and that the Care Management Agencies and Care Coordinators providing services to these Members are qualified to do so.

POLICY STATEMENTS

Any Capital Region Health Connections Health Home Members who meet the HIV HH+ eligibility requirements in this policy will be served by an agency and Care Coordinator who meet the State-mandated qualifications and caseload size to do so. Further, HH+ Members will receive Health Home Services that are more intense than those provided to traditional Health Home Members. HH+ Members will be identified in all reporting to Capital Region Health Connections. The requirements in this policy do not replace any other Health Home policies. Agencies serving the HH+ population must adhere to all Health Home policies in addition to the requirements listed in this policy.

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

Health Home Core Services: The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid, as defined by the New York State Department of Health. The categories of services include:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Member and Family Support
- Referral and Community and Social Support Services

Note: the sixth category of Health Home Core Service, "The use of HIT [Health Information Technology]" is <u>not</u> considered a billable service.

***Health Home Plus (HH+)*:** An intensive Health Home service established for defined populations who are enrolled in a Health Home serving adults; there are three HH+ populations: HIV HH+, SMI HH+, State PC Discharge HH+

NYS AI: New York State AIDS Institute; one of the regulating State entities for Health Home Plus services

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

HIV Health Home Plus (HIV HH+): Intensive Health Home services for Members who are diagnosed with HIV/AIDS and meet other eligibility criteria as stated in this policy.

PROCEDURE

A. Care Management Agency Qualifications

1. All legacy COBRA HIV TCMs are eligible to provide HIV HH+ services. The Lead Health Home must attest that the Care Management Agency is in compliance with the staffing, caseload and training requirements laid out in the policy.

2. CMAs who are non-legacy providers may qualify to provide HIV HH+ services if they can attest to being an Article 28 or Article 31 provider, certified home health agency, community health center, community service program, or other community-based organization with:
   a. Two years' experience in the case management of persons living with HIV or AIDS **OR**
   b. Three years' experience providing community based social services to persons living with HIV or AIDS
      OR
   c. Three years' experience providing case management or community based social service to women, children and families; substance users; MICA clients; homeless persons; adolescents; parolees recently incarcerated; and other high risk populations **and** includes one year of HIV-related experience

3. Agencies wishing to attest to serve the population based on the requirements in Number 2 above may attest to their ability to serve the HIV HH+ population by submitting to the Lead Health Home an Agency Evaluation and Plan for serving the population. Guidance for the development of the Agency Evaluation and Plan can be found in Attachment A.

B. Supervisor Qualifications

1. Those supervising Care Coordinators serving the HIV HH+ population must have a:
   a. Master's degree in Health, Human Services, Mental Health, Social Work **and** one year of supervisory experience **and** one year of qualifying experience.
      OR

b. Bachelor's degree in Health, Human Services, Mental Health, Social Work **and** two years of supervisory experience **and** three years of qualifying experience.[1]

C. Care Coordinator Qualifications

1. Care Coordinators serving the HIV HH+ population must meet the education, and experience requirements as listed below.
   a. Master's or Bachelor's degree in Health, Human Services, Education, Social Work, Mental Health **and** one year qualifying experience
   OR
   b. Associate's degree in Health, Human Services, Social Work, Mental Health or certification as an R.N. or L.P.N. **and** two years qualifying experience.

2. If existing CMA staff have extensive experience working with the HIV HH+ population but do not meet the HIV HH+ education qualifications, the Health Home should be notified. Upon notification, the Health Home will contact AIDS Institute to request a waiver for the staff person. No new hires will be considered for waivers; this will only apply to existing staff.

D. Navigator / Community Health Worker / Peer Qualifications

1. Navigators, Community Health Workers or Peers serving the HIV HH+ population must meet the education requirements as listed below.
   - High School Diploma or GED
   - CASAC
   - Certification as a Peer
   - Community Health Worker

2. Navigators, Community Health Worker or Peers must also have the ability to read, write and carry out directions.

E. Staff Training Requirements

1. All staff serving the HIV HH+ population (Care Coordinators, Peers, Navigators and Community Health Workers) must complete all Core Competency Training (see list below) within the first 18 months of employment (or agency attestation if new staff are not hired, but the agency attests to serve the HIV HH+ population).

2. Two of the required trainings must be completed annually. Those are **HIV Disclosure/Confidentiality** and child abuse and neglect **Mandated Reporter** training.

3. Annually, all staff must complete 40 hours of training related to serving the HIV population. To assist staff in meeting the 40 hour requirement, the AIDS Institute has provided a comprehensive list of training resources which can be found in Attachment B.

[1] Qualifying Experience is defined as verifiable work with the target populations: individuals with HIV, history of mental illness, homelessness or substance abuse.

Required Core Competency Trainings

Most core competency trainings are offered in multiple formats including in-person, webinar, and online training. Supervisors should use discretion and select the format that best fits the needs of individual staff. In-house trainings (staff meetings, in-service trainings, grand rounds, etc.) may be used for trainings, but must meet the basic elements of the core competency trainings.

a. Child Abuse and Neglect (annual update)
b. HIV Disclosure and HIV/AIDS Confidentiality Law Overview (annual update)
c. Role of Health Home Care Managers in Improving Health Outcomes for Clients living with HIV
d. Introduction to Co-occurring Disorders for Client with HIV/AIDS
e. Introduction to HIV, STIs, and HCV
f. Harm Reduction
g. Overview of HIV Infection and AIDS
h. Overview of STIs
i. LGBT Cultural Competency
j. Promoting Primary Care and Treatment Adherence for HIV Positive Individuals
k. Role of Non-clinicians in Promoting PrEP
l. Sex, Gender, and HIV/STIs
m. Ending the Epidemic
n. AIDS and Adolescence-The Changing Legal Landscape
o. Sexual Health
p. Transgender Health
q. Substance Use Disorder / Drug User Health

F. Caseload Standards

NYS AIDS Institute has approved three models for HIV HH+ caseloads. Two models are HH+ only models, while Model 3 describes the requirements for a mixed caseload (HH+ and non-HH+ on the same caseload). For additional information on options for caseloads, please see:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/health_home_plus_for_hiv.pdf

Model 1: HH+ with Care Coordinator Only

1. The caseload ratio for HIV HH+ enrollees when one Care Coordinator is serving a HIV HH+ caseload only may not exceed one (1) Care Coordinator to 15-20 HH+ Members.

Model 2: HH+ with Care Coordination Team (Team Approach)

2. A CMA may choose to use a team approach to serve a caseload consisting of HH+ individuals. However, use of this approach mandates the following requirements are met.
   a. The team model must include at least one (1) Care Coordinator along with one (1) or more peers, navigators or community health workers (CHW).
      i. One (1) Health Come Care Coordinator plus one (1) peer, navigator or CHW may serve a maximum of 25-30 HIV HH+ Members.
      ii. One (1) Health Come Care Coordinator plus one (2) peers, navigators or CHWs may serve a maximum of 35-40 HIV HH+ Members.
      iii. Under this model, the caseload may increase by ten (10) for each additional team member.
   b. One Care Coordinator may supervise no more than to (2) team members / staff.

Model 3: HH+ and non-HH+ Members (Mixed Caseload)

3. For the purposes of caseload stratification and resource management; a caseload mix of HH+ and non-HH+ is allowable. Medium or low acuity Members may be a part of the HIV HH+ Care Coordinator's caseload, especially at the beginning of forming the HH+ caseload and team, in rural areas where fewer cases occur or as Members move transition off HH+ services, but require continuity of care.

4. A Care Coordinator with ten (10) or more HH+ Members has a maximum caseload size of 40, inclusive of the ten (10) HH+ Members.

5. When the number of HIV HH+ Members is extremely low, the Supervisor should use discretion to build an appropriately sized caseload. For example, if a CMA has only three (3) Members eligible for HIV HH+, the Supervisor can work with the Care Coordinator to build a caseload that does not exceed NYSDOH caseload limits and allows for the HH+ members to receive the necessary intensive level of services.

G. Member Eligibility for HIV HH+

1. For a Member to be eligible to receive HIV HH+ services the Member must have **documentation of a diagnosis of HIV/AIDS** as well as one other of the criteria listed below. Documentation must be on file in the Member's electronic health record verifying the eligibility criteria.
   a. Not virally suppressed (viral load > 200 copies per mL)
      OR
   b. Have behavioral health conditions (serious mental illness or engage in intravenous drug use) regardless of viral load status
      AND
      i. Had three or more inpatient hospitalizations in the past 12 months **OR**

ii. Had four or more emergency room visits within the past 12 months **OR**

iii. Homelessness at the time of eligibility, according to HUD's Category 1 definition of homeless.[2]

2. Although rare, a medical provider or Managed Care Organization may refer an individual in need to the HIV HH+ program or request a continuation of HIV HH+ services for a Member whose viral suppression is not stable. It is common for individual who have recently become unsuppressed to need continued intensive support to ensure ongoing suppression.

3. For medical provider clinical discretion, there is no standard template for discretion provided by NYS DOH, however requests for HIV HH+ services from medical providers must include:
   a. Status of the Members viral load
   b. Factors that indicate the need for referral to the HIV HH+ program or continuation for HIV HH+ services including, but not limited to factors such as: newly diagnosed HIV status, viral load suppression is not stable, housing instabilities or poor adherence to treatment plans, for example.

4. HIV HH+ Members may stay in the HIV HH+ program for a maximum of twelve (12) months.

5. In cases in which extenuating circumstances exist, are documented and well justified, a Member may remain in the HIV HH+ level of service for an additional twelve (12) months.

H. HIV HH+ Program Requirements

1. HIV HH+ Members must be identified as such in the Programs section of CareManager, Capital Region Health Connection's electronic health record. When a Member's HIV HH+ eligibility runs out, the HIV HH+ Program must be end dated in CareManager. The addition or removal of the appropriate program type will serve as the CMA's notification to the Health Home of a Member's HH+ status.

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[2] has a primary nighttime residence that is a public or private place not meant for human habitation, such as;

o a car, park, sidewalk, abandoned building, bus or train station, airport, or camping ground; is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); **or**

o is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

2. The HIV HH+ Eligibility Checklist (Attachment B) must be completed and attached to the Member's record. This form serves as tracking for when a Member was deemed eligible and the supporting documentation to support eligibility.

3. A minimum of four (4) Health Home Core Services must be provided per month.
   a. At least two (2) of the four (4) Core Services must be delivered face-to-face with the Member.
   b. At least one (1) of the face-to-face contacts per month must be with the Care Coordinator.

4. Home visits must occur with the Member:
   a. At time of assessment for HIV HH+ services (i.e., when eligibility for HIV HH+ is being determined)
   b. At time of re-assessment for HH+ services (i.e., six month mark, see H5 below for more details on the six month re-assessment)
   c. At time of Plan of Care development or review

5. The re-assessment at six months, noted above in H4b, is not a full Comprehensive Assessment. A re-assessment must be conducted at the six (6) month mark at the Member's home to evaluate the viral load status and progress towards the Objectives listed on the Plan of Care. This re-assessment of progress and status will be written as a CareManager Note.

6. Case conferences with all consented providers and the Member must occur every six months, or more frequently as needed. This six month case conference must be a CareManager Note with an identified Target of "Multidisciplinary Team."

   This six month Case Conference should also be used as a time to gather information for the six-month re-assessment that details the progress towards Plan Objectives and Intervention as well as viral load status. Information gathered via the Case Conference and six-month re-assessment will inform the required six-month Plan of Care update.

7. The intent of the Health Home Plus program is to provide more intense services to Members identified as higher needs based on risk factors and diagnoses. Any factors or risk factors that deem the Member eligible for the HIV HH+ level of service must be addressed in the Member's Plan of Care and through monthly Core Service delivery. All documentation in the chart should reflect this more intense level of need and Care Coordinator response to that need.

I. HIV HH+ Billing

1. Care Management Agencies are only permitted to bill at the Health Home Plus rate code (1853) if the program requirements in Sections G and H above are met and documented in the Member's electronic health record and provided by the appropriate staff in terms of qualifications, training, supervision and role, if using the Team Approach to caseloads.

2. If the minimum service requirements listed in Section H above are not provided in a given month, but all other requirements are met and at least one (1) Health Home Core Service was provided by a qualified Care Coordinator, the CMA will bill the Health Home High Risk/Need Care Management Rate (1874) for that month.

3. It is the responsibility of the Care Management Agency to confirm that the Program Requirements in Section H above are met prior to submitting billing to the Lead Health Home. By responding "Yes" in the HML question "Were the minimum required HH+ services provided?" the CMA is confirming that the required services were delivered and documented.

4. Once a Member's no longer meets the eligibility criteria for HIV HH+, as described in Section E of this policy, billing at the HH+ rate must cease.

REFERENCES

New York State Department of Health and AIDS Institute (May 2022). Health Home Plus Program Guidance for Individuals with HIV
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/health_home_plus_for_hiv.pdf)

New York State Department of Health and Office of Mental Health (Not Date). Health Home Plus FAQ.
(Not available online)

New York State Department of Health (October 2, 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: Rachel Handler, MS CRC, LMHC		**Effective Date: August 1, 2022**
Key Sponsor: Janelle Shults, LMSW		
Reviewed By: Lindsay Homenick, MSW		**Original Date: July 1, 2019** **Reviewed/Revised Date:**
Search Terms:		***Reviewed, No Revisions** ****Revised without Full Review**

Replaces: F5. Special Programs: HIV Health Home Plus (HIV HH+) (July 1, 2019)

ATTACHMENT A: CMA Guidance for HH+ Evaluation and Plan

St Peter's Health Partners
Capital Region Health Connections

Health Home
2212 Burdett Avenue
Troy NY 12180
ph (518) 271-3301
fx (518) 271-5009
sphp.com

"Health Home Plus (HH+) is an intensive Health Home Care Management Service Established for specific populations diagnosed with HIV/AIDS and Serious Mental Illness (SMI). In order to ensure their intensive needs are met, HH+ members should be served at a level of intensity consistent with requirements for caseload rations, reporting and minimum levels of staffing experience and education."
~ NYS DOH Health Home Plus Guidance

Health Homes are required to attest to NYS DOH which of their Care Management Agencies are well positioned to do this work. To support the attestation process, we are asking agencies that are interested to evaluate their programs and submit a plan to CRHC Administrative team for review and consideration.

If you are interested in serving the Health Home Plus expanded population, we encourage you to review the materials listed below to evaluate your agencies readiness, as well as identify opportunities for development.

- NYS DOH Attestation (*please note there are two - HH+ SMI and HH+ HIV*)
- Program Requirements
- Report Card
- Actionboards
- QMP Reports
- Investigation feedback (rec'd post incident)
- Caseload Sizes

Once you have reviewed the information, please submit a plan that includes:

- Agencies quality assurance plan. This should include monitoring of:
  - Core Service Delivery
  - Comprehensive Plans of Care that are member centered and reflect the need for the intensive care coordination
  - Caseload sizes
  - Annual trainings on Core Competency
- Opportunities for program development
- Ability to staff up

We also encourage you to include a SWOT analysis (*Strengths, Weakness, Opportunities and Threats*)

ATTACHMENT B: Core Competency Training Resources

Agency / Organization	Link / Email
AIDS Institute Training Centers	https://www.hivtrainingny.org/Home/AboutUs
AIDS Institute Training Initiative	https://www.hivtrainingny.org
Empire Justice Center	https://empirejustice.org/training/
Legal Action Center	https://www.lac.org/work/what-we-do/technical-assistance
NYS Office of Children and Family Services	http://nysmandatedreporter.org/TrainingCourses.aspx
NYS Clinical Education	Initiativesupport@ceitraining.org
National Council for Mental Wellbeing	Communications@TheNationalCouncil.org
Mountain West AETC	aetcinfo+uw.edu@ccsend.com
National Coalition on Sexual Health	https://nationalcoalitionforsexualhealth.org
Health HIV	https://healthhiv.org
MCTAC	mctac.info@nyu.edu

ATTACHMENT C: HIV HH+ Eligibility Checklist

St Peter's Health Partners
Capital Region Health Connections

Health Home
2212 Burdett Avenue
Troy NY 12180
ph (518) 271-3301
fx (518) 271-5009
sphp.com

Please complete the following form outlining what factors made the Member eligible for HIV HH+ rate of service. Please note that eligibility must be re-confirmed every 12 months. The completed form should be attached to the Member electronic health record along with the supporting documentation.

Member Information
Chart Number:
Care Coordinator:
Person Completing Form:
Date of HH Enrollment:
Date of HH+ Eligibility Confirmation:

Verification of Eligibility (Required)		
	Eligibility Requirement	**Supporting Documentation on File**
☐	HIV+ Diagnosis (Required)	

AND

One of the eligibility criteria on the next page must also be selected for the Member to be eligible for HIV HH+ level of care.

Must have at least ONE of the following boxes checked and supporting documentation on file to be eligible for HIV HH+ for 12 months		
	Eligibility Requirement	**Supporting Documentation on File**
☐	Not virally suppressed	
☐	☐ Diagnosed SMI or Intravenous Drug Use **AND** ☐ Three or more Inpatient Hospitalizations OR ☐ Four or more Emergency Room visits OR ☐ Homelessness[1]	
☐	MCO Clinical Discretion	
☐	Medical Provider Clinical Discretion[2]	

1. Homelessness is defined as: has a primary nighttime residence that is a public or private place not meant for human habitation, such as;
    a. a car, park, sidewalk, abandoned building, bus or train station, airport, or camping ground; is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); **or**
    b. is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. For medical providers, there is no standard template for clinical discretion, but clinical discretion requests from providers must include both of the following items.
    a. The status of the Member's viral load
    b. Factors that indicate the need for referral to HH+ or a continuation of HH+ services such as: new diagnoses of HIV, viral load suppression is not stable, housing instabilities, poor adherence to treatment plans, etc.