ST PETER'S HEALTH PARTNERS	**Effective Date:** September 24, 2021

Category: **F. Special Programs**

Title: **4. Serious Mental Illness Health Home Plus (SMI 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 Serious Mental Illness (SMI) 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

***Central New York Psychiatric Center and its Correction-Based Mental Health Units (CNYPC)*:** State run psychiatric center and its mental health units located within New York State Department of Corrections prison system

***DOH 5055*:** Health Home Patient Information Sharing Consent Form; the State produced form for capturing consent for other providers as well as natural supports

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 two HH+ populations: HIV HH+ and SMI HH+

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

NYS OMH: New York State Office of Mental Health; one of the regulating State entities for Health Home Plus services

Serious Mental Illness Health Home Plus (SMI HH+): Intensive Health Home services for Members who are diagnosed with SMI and meet other eligibility criteria as stated in this policy.

***State Psychiatric Center (State PC)*:** Any psychiatric center in New York State regulated by the New York State Office of Mental Health (NYSOMH)

PROCEDURE

A. Care Management Agency Qualifications

1. Former NYS OMH Targeted Care Management (TCM) providers or NYS OMH Legacy providers are those who are able to serve individuals who qualify for SMI HH+ services. These agencies are identified on the Health Home Plus Attestation Form submitted by the Lead Health Home to NYS DOH and NYS OMH.

2. Agencies not meeting the requirements above may attest to their ability to serve the SMI HH+ population by submitting a request in writing to the Lead Health Home. Upon receipt of the request, CRHC will submit the required documentation to NYS OMH for approval. NYS OMH will designate or provisionally designate agencies based on data available in NYS systems and the attestation regarding agency structure to serve this complex population.

3. All agencies attested to serve the SMI HH+ population must have a working relationship with the Local Government Unit (LGU) or Single Point of Access (SPOA) in the counties served. Each agency must complete and submit the LGU/SPOA Working Relationship Form to the Lead Health Home verifying the working relationship. Separate forms are required for each county in which the SMI HH+ population in served by a CMA. A copy of the form can be found in Attachment A of this policy.

B. Supervisor Qualifications

1. Those supervising Care Coordinators serving the SMI HH+ population must be:
   a. a licensed level healthcare professional[1] with prior experience in a behavioral health setting
      OR
   b. a Master's level professional with two years prior supervisory experience in a behavioral health setting.

C. Care Coordinator Qualifications

1. Care Coordinators serving the SMI HH+ population must meet the education and experience requirements listed below.

Education Requirements and Years of Experience

Degree	Number of Years of Experience
Bachelors in an approved field	Two (2) years of experience
Masters in an approved field	One (1) year of experience
Credentialed Alcohol and Substance Abuse Counselor (CASAC)	Two (2) years of experience
Bachelor's or higher in any field	Three (3) years of experience **OR** Two (2) years of experience as a Health Home Care Coordinator serving the SMI SED population

2. Approved field for degrees, as referenced above, include the following.
   - Child and Family Studies
   - Counseling
   - Nursing
   - Physical Therapy
   - Recreation
   - Rehabilitation
   - Sociology
   - Community Mental Health
   - Education
   - Occupational Therapy
   - Psychology
   - Recreational Therapy
   - Social Work
   - Speech and Hearing

Experience Requirements

3. The experience referenced in section C1 above must include the following:
   a. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED;
      OR
   b. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services

[1] Licensed level healthcare professional includes: Physicians, Psychiatrists, Physician Assistants, Nurse Practitioners, Psychiatric Nurse Practitioners, Registered Professional Nurses, Licensed Practical Nurses, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Psychoanalysts, Licensed Creative Arts Therapists and Licensed Occupational Therapists.

essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

4. As additional training opportunities are identified for the Care Coordinators serving the SMI HH+ population, the Lead Health Home will ensure the appropriate staff are notified and encouraged to attend.

D. Staff Waivers

1. In rare circumstances, staff may have unique education and/or experience to adequately serve the high need behavioral health population but do not meet the updated qualifications outlined in this policy. Care Management Agencies and may apply for a waiver for such staff.

2. Waivers are not intended to be the sole approach for an agency looking to expand capacity in serving these populations. Agencies should be prudent in selecting staff to pursue a waiver of qualifications. Waivers should only be submitted for those staff whose unique qualifications allow them to adequately serve the population.

3. Waivers must be submitted to NYS online, via the form found here. (https://forms.office.com/Pages/ResponsePage.aspx?id=6rhs9AB5EE2M64Dowcge588RkoCaDulEmf42dSo2bc9URFo0WTVWUFhDVlBVNVJKNUtRV0pJVDBESS4u)

E. Caseload Standards

1. The preferred caseload ratio for SMI HH+ enrollees should be one (1) staff to 12 to 15 HH+ Members. The ratio is not permitted to exceed one (1) staff to 20 HH+ Members.

2. To help meet the changing and complex needs of the SMI HH+ population, Care Management Agencies may use different models of Care Coordination. Each model is described below.
   a. **Mixed Caseload (HH+ and non-HH+ Members):** For the purposes of caseload stratification and resource management; a caseload mix of HH+ and non-HH+ is allowable if and only if the HH+ ratio is less than 20 recipients to one (1) Health Home Plus (HH+) Care Coordinator. Caseload sizes should always allow for adequate time providing care management as outlined in this guidance to HH+ individuals while allowing for thoughtful consideration of the care coordination needs of non-HH+ recipients.
   b. **Team Approach:** A CMA may choose to use a team approach to serve a caseload consisting of HH+ individuals, whether HH+ Only or a Mixed Caseload. However, use of this approach mandates the following requirements are met:
      i. The team caseload must maintain the ratio of 20 HH+ individuals per each full time employee on the team. For every 40 HH+ individuals, the team

must have at least one qualified HH+ Care Coordinator. *For example, a team serving 50 HH+ individuals shall have two (2) qualified HH+ Care Coordinators on the team.*

ii. A qualified HH+ Care Coordinator must provide at least two (2) Health Home Core Services per month, one (1) of which must be a face-to-face contact with the HH+ individuals. The remaining contact requirements can be provided by the additional team members.

iii. A primary Care Coordinator meeting the staff qualifications outlined in Section C above to serve HH+ individuals shall be identified and will conduct the Comprehensive Assessment, develop the Plan of Care, and provide oversight regarding coordination of interventions in accordance with the Plan of Care.

For additional information and details on the NYS DOH caseload models, including suggestions for weighting caseloads, please see Appendix A in State Guidance, which can be found by visiting: https://omh.ny.gov/omhweb/adults/health_homes/hh-plus-high-need-smi-guidance.pdf

3. Care Management Agencies are permitted to exceed the number of legacy slots initially allotted to them in order to accommodate HH+ Members being referred.

F. Member Eligibility for SMI HH+

1. For a Member to be eligible to receive SMI HH+ services the Member must have documentation of a diagnosis of SMI as well as one other of the criteria listed in a-i below. Documentation must be on file verifying the eligibility criteria.
   a. Stepping down from an ACT program
   b. Recipient of an Enhanced Service Package / Voluntary Agreement: alternative to AOT; Members in this category are identified by the LGU.
   c. Stepping down from an AOT order within the last year
   d. Individuals discharged from State Psychiatric Centers (PC) and those released from Central New York Psychiatric Center (CNYPC) and its corrections-based Mental Health Units.
   e. Homeless – Must meet the Housing Urban Development's (HUD) Category One (1) Literally Homeless definition: An individual who lacks a fixed, regular, and adequate nighttime residence.[2]

[2] Has a primary nighttime residence that is a public or private place not meant for human habitation, such as:
- 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
- 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.

f. High utilization of hospital or ED services
   - Three (3) or more psychiatric inpatient hospitalizations within the past year.
     OR
   - Four (4) or more psychiatric ED visits within the past year, including Comprehensive Psychiatric Emergency Department for observation or other psych emergency or respite programs
     OR
   - Three (3) or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.

g. Criminal Justice involvement: Release from incarceration (jail, prison) within the past year and requires linkage to community resources to avoid re-incarceration. Eligible individuals have been incarcerated due to poor engagement in community services and supports.

h. Ineffectively engaged in care:
   - No outpatient mental health services within the last year and two (2) or more psychiatric hospitalizations
     OR
   - No outpatient mental health services within the last year and three (3) or more psychiatric ED visits, including Comprehensive Psychiatric Emergency Department for observation or other psych emergency or respite programs

i. Clinical Discretion of the MCO or SPOA

2. The definition of SMI for Health Home services includes the following.

   Diagnosis of one of the following:
   Psychotic Disorders: F21, F22, F23, F20.81, F20.9, F25.0, F25.1, F06.2, F06.0, F06.1, F28, F29
   Bipolar Disorders: F31.11, F31.12, F31.14, F31.2, F31.73, F31.74, F31.9, F31.0, F31.31, F31.32, F31.4, F31.5, F31.75, F31.76, F31.9, F31.81, F34.0, F06.33, F06.34, F31.89
   Obsessive-Compulsive Disorders: F42
   Depression: F34.8, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F233.3, F33.41, F33.42, F33.9, F34.1, N94.3, F06.31, F06.32, F06.34, F32.8, F32.9, F34, F32.08
   Anxiety Disorders: F41.9, F41.0, F41.1, F44.81, F40.0, F43.10
   Personality Disorders: F60.0, F60.1, F60.3, F60.04, F60.5, F60.6, F60.9, F60.81, F21

   AND

   An extended impairment in function as evidenced by one of the following:

   a. Marked difficulties in self-care such as personal hygiene, diet, clothing, avoiding injuries, securing health care, or complying with medical advice; or

b. Marked restrictions of activities of daily living such as maintaining a residence, getting and maintaining a job, attending school, using transportation, day-to-day money management, or accessing community service; or
c. Marked difficulties in maintaining social functioning such as establishing and maintaining social relationships, interpersonal interactions with primary partners, children and other family members, friends, or neighbors, social skills, compliance with social norms, or appropriate use of leisure time; or
d. Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner in work, home, or school setting. Individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in task, or require assistance in the completion of tasks.

3. Individuals who are otherwise eligible, but are receiving Assertive Community Treatment (ACT), are <u>not</u> eligible for the SMI HH+ rate because they are billed at the ACT rate code.

4. Members are eligible for SMI HH+ services for 12 consecutive months from date of eligibility.

5. If the SMI HH+ Member continues to meet SMI HH+ eligibility at the end of the 12-month initial timeframe, the Member can receive SMI HH+ services for an additional 12 months with supporting documentation.

6. At the end of each 12-month period, if a Member continues to meet eligibility for SMI HH+, s/he is eligible to continue receiving the HH+ level of care. The ongoing need year after year must be clearly demonstrated in the Members record via the Plan of Care and Core Service provision.

7. Care Management Agencies must have protocols in place for safely transitioning Members on and off SMI HH+ care coordination services, based on individual need.

G. MCO and SPOA/LGU Clinical Discretion Requests

1. For instances in which a Member does not meet the criteria listed in F1(a-i) above, the CMA may request the case be approved by the MCO or SPOA/LGU.

2. For MCO approval, the CMA should contact the Member's Managed Care Organization (MCO) and obtain approval in writing to be uploaded with the Eligibility Checklist.

3. For SPOA/LGU approval, the following procedure must be followed.

a. The CMA conducts an internal review of case with Care Coordinator and Supervisor to ensure documentation is up to date and reflects the need for HH+ services.
b. The Clinical Discretion Request Form (Attachment B) is completed and sent to Lead Health Home with the required external documentation
c. The Lead Health Home reviews the case and ask question or provide feedback to the CMA, if clarifications are needed
d. The Lead Health Home brings case to SPOA/LGU for team review
e. The Care Coordinator and Supervisor are notified of decision.

H. SMI HH+ Referrals

1. The Lead Health Home will work collaboratively with the respective County Single Point of Access (SPOA) or Local Government Unit (LGU) to ensure that SMI HH+ Members are assigned to a CMA that is approved to serve those populations. Assignment to the appropriate CMA will happen as soon as possible after receiving the referral.

2. New referrals must be screened for SMI HH+ eligibility. CRHC will screen all referrals that come to the Lead prior to assigning them to CMAs (downstream referrals). If a CMA receives a referral directly from a community-based organization, including internal agency referrals (upstream referrals) the CMA must screen the referral for HH+ eligibility. Information in the referral (housing status, diagnoses, etc.) should be used along with PSYCKES flags to determine if someone is HH+ eligible. If the Candidate is HH+ eligible and the CMA is not attested to serve the HH+ population, the referral must be sent to the Lead for assignment to a HH+ attested CMA.

3. As agencies identify currently enrolled Members who may meet one of the HH+ criteria above, the agency must offer the HH+ level of services to the Member. If the agency is not attested to serve the SMI HH+ population, the Member must be offered a transfer to an agency who can provide that level of care. The decision to receive HH+ services and transfer to a different agency to receive HH+ services is the Member's decision, but they must be provided the option.

I. SMI HH+ Program Requirements

1. SMI 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 SMI HH+ eligibility runs out, the SMI 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.

2. The SMI HH+ Eligibility Checklist (Attachment C) 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. A Care Management Agency (CMA) may choose to develop their own form as long as the eligibility is captured on the CMA-specific form.

3. A minimum of four (4) Health Home Core Services must be provided per month, two (2) of which must be face-to-face contacts. The HH+ rate code (1853) can only be billed when this minimum requirement is met and the contacts are clearly documented as Core Service delivery in accordance with Policy C1. Care Coordination: Health Home Services, in the Member's record.

4. Care Management Agencies must communicate with the Managed Care Organization regarding HH+ Members. At a minimum, communication with the MCO must occur as a Member becomes eligible for HH+, when eligibility for HH+ expires and as Members experience significant status changes or significant events that may impact Member care.

5. If the SMI HH+ Member is also under an AOT order, at least four (4) face-to-face contacts must be made within the month, in accordance with Policy F2. Special Programs: Assisted Outpatient Treatment (AOT). AOT program requirements must always be followed ahead of any HH+ program requirements. Once the AOT order is expired or not renewed, the Member will become eligible for SMI HH+ for a period of 12 months.

J. SMI HH+ Billing and HML

1. Care Management Agencies are only permitted to bill at the Health Home Plus rate code (1853) if the program requirements specific in Section G above are met and documented in the Member's electronic health record.

2. If the minimum service requirements listed in Section G 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 G 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. Regardless of whether a CMA is billing for HH+ services or is attested to serve the HH+ population, any enrolled Members deemed eligible for SMI HH+ must be identified as such on the HML assessment.
   a. Question 12 will indicate YES for anyone identified as eligible for SMI HH+.
   b. Question 12a will indicate YES only if the CMA is attested to serve the HH+ population and has met the requirements to bill as outlined in this policy.

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

6. Members transitioning off the SMI HH+ services will receive the Health Home High Risk/Need Care Management Rate (1874) for a period of six (6) months to support the transition to a less intensive Care Coordination.

REFERENCES

New York State Department of Health, Office of Mental Health and Office of Alcoholism and Substance Abuse Services (September 18, 2019). Updated Staff Qualifications to Service HH+ SMI and Assessor Qualifications for Administering the NS Eligibility Assessment for Adult BH HCBS.
(https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_bh/docs/updated_hh_plus_quals_9.2019.pdf)

New York State Department of Health and Office of Mental Health (February 2021), Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness.
(https://omh.ny.gov/omhweb/adults/health_homes/hh-plus-high-need-smi-guidance.pdf)

New York State Department of Health (July 11, 2016). Definition of Serious Mental Illness for Health Home Eligibility.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/smi_definition_for_health_home_eligibility.pdf)

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: September 24, 2021**
Key Sponsor: Janelle Shults, LMSW		
Reviewed By: Lindsay Homenick, MSW		**Original Date: April 1, 2019** **Reviewed/Revised Date:** **April 1, 2019** ***Reviewed, No Revisions** ****Revised without Full Review**
Search Terms:		

Replaces: F4. Special Programs: Serious Mental Illness Health Home Plus (SMI HH+) (October 1, 2019)
F3. Special Programs: State Psychiatric Center and CNYPC Discharge Health Home Plus (State PC Discharge HH+) (April 1, 2019)
F4. Special Programs: Serious Mental Illness Health Home Plus (SMI HH+) (April 1, 2019)
F4. Special Programs: Serious Mental Illness Health Home Plus (SMI HH+) (July 1, 2020)
F4. Special Programs: Serious Mental Illness Health Home Plus (SMI HH+) (May 3, 2021)

ATTACHMENT A: LGU/SPOA Working Relationship Form

Local Government Unit (LGU)/Single Point of Access (SPOA) and Care Management Agency (CMA) Working Relationship Form)

Per the Department of Health (DOH)/Office of Mental Health (OMH) requirements to serve the Health Home Plus (HH+) for Serious Mental Illness (SMI) populations, Health Homes must verify CMAs either have an existing working relationship (or are in process of developing one within (3) months) for HH+ Care Coordination with the LGU/SPOA in their service county. This form can be used by LGUs/SPOAs to document that a CMA has a working relationship with the LGU/SPOA in their service area. If establishing a new relationship, contact with the LGU/SPOA should be made prior to completing this form.

Local Government Unit (LGU/SPOA):

County: _____

Lead Contact Name: _____

Lead Contact Telephone Number: _____

Lead Contact Email: _____

Care Management Agency (CMA)

CMA Name: _____

Lead Contact Name: _____

Lead Contact Telephone Number: _____

Lead Contact Email: _____

Lead Health Home (HH)

HH Name: Capital Region Health Connections

Lead Contact Name: Lindsay T. Homenick

Lead Contact Telephone Number: 518-271-3608

Lead Contact Email: Lindsay.Homenick@sphp.com

Per DOH/OMH Guidance, a "working relationship" with LGU/SPOA includes:

LGU/SPOA Please check all that apply below:

1. Demonstrated ability and willingness to accept high-need SMI referrals directly from the LGU/SPOA
   CMA meets this criteria: ☐ **YES** ☐ **NO**

2. Participation in any county SPOA process or committee as applicable
   CMA meets this criteria: ☐ **YES** ☐ **NO**

3. Knowledge of LGU/SPOA protocols and resources for accessing local mental health services
   CMA meets this criteria: ☐ **YES** ☐ **NO**

4. Clearly defined communication process between the CMA, SPOA, and HH
   CMA meets this criteria: ☐ **YES** ☐ **NO**

5. Please list additional **CMA** contacts if needed:

6. Please list additional of **Health Home** contacts if needed

Local Government Unit Representative

Name

Title

County

Date

ATTACHMENT B: SMI HH+ LGU/SPOA Clinical Discretion Request Form

Please complete this form as best you can and submit the form along with a copy of the DOH 5055 listing the local SPOA/LGU to your local SPOA/LGU contact. Please do not hand write forms.

Member Information	Referral Source Information
Name:	Date of Referral / Request:
DOB:	Name:
Medicaid CIN:	Title:
Address: *(Please include facility name, if applicable)*	Agency:
	Email:
	Telephone:
Living Situation: Choose an item.	
SMI Diagnosis:	DLA 20 Score:

Education Level	Current Employment Status	Number of Hours Worked Per Week
Choose an item.	Choose an item.	Choose an item.

Rising Risk: Variables to Consider for Referral *Please provide your best estimates over the past 180 days* *If you do not know the information, you may leave it blank. If the number of contacts/days is zero, please record zero*	
Number of Police Contacts:	Number of Chemical Dependency Crisis Contacts:
Number of Court Appearances:	Number of Chemical Dependency Detox Contacts:
Number of ED visits (medical):	Number of Shelter Days:
Number of ED/Crisis visits (mental health):	Number of Days not in the Community:
Number of Ambulance Trips:	

Rationale for HH+ Services *Please provide a detailed reason why the Member is in need of HH+ Services. Please be sure to include previous supports or services that have been unsuccessful in mitigating need. Attach any supporting documentation.*

Anticipated Goals / Objectives / Outcomes *Please provide a description of what will be worked on with the Member to address the needs listed above. Please attach the Member's most recent Health Home Plan of Care.*

Alerts / Safety Concerns

Medical Conditions *Please list any known medical conditions or special needs, OR attach the Member's Problem list from CareManager.*

Persons Affiliated with the Member	
Name	**Affiliation**

Risk Assessment *Please rate the overall risk of the Member*	
1. None ☐ 2. Low ☐ 3. Moderate ☐ 4. High Alert ☐ 5. Imminent ☐ 6. Unknown ☐	**Key:** 1. None=Stabilized at baseline; symptoms and stressors well managed by current treatment and supports. 2. Low=Experiencing some mental health symptoms and life stressors. 3. Moderate=Requires additional community supports and/or is currently experiencing problematic symptoms or stressors. 4. High Alert=Requires intensive support. Absence of intensive supports will likely require hospitalization. 5. Imminent=Severe risk, unsafe in the community. Requires secure inpatient program, hospitalization.

Hospitalizations *Please record the number of days the Member has been hospitalized or in placement at a Mental Health facility in the past 180 days*					
☐ 0 Days	☐ 1-5 Days	☐ 6-10 Days	☐ 11-25 Days	☐ 26+ Days	☐ Unknown

Incarceration *Please record the number of days the Member was incarcerated in the past 180 days*					
☐ 0 Days	☐ 1-5 Days	☐ 6-10 Days	☐ 11-25 Days	☐ 26+ Days	☐ Unknown

Substance Abuse Impairment Scale	
Choose an item.	Specify Drug of Choice and Use Patterns:

Other / General Comments *Please provide any other information that may be applicable to the decision and attach any supporting documentation.*

Care Coordinator Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Supporting Documentation Attached	
Health Home Plan of Care (Required)	☐ Attached
Health Home 5055 Consent (Required)	☐ Attached
Problems List from CareManager (Required if Medical Conditions not listed in this form)	☐ Attached **OR** ☐ Medical Conditions listed
Documents supporting the rationale for HH+ level of service	☐ Attached (optional)
DLA 20 Assessment, if applicable	☐ Attached ☐ N/A

LGU/SPOA Use Only	
LGU/SPOA Approval: ☐ Yes ☐ No	Name and Title of Representative:
Date of Approval/Denial:	Signature:
Justification for Approval/Denial:	

ATTACHMENT C: SMI 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 SMI 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:
Assigned Care Coordinator:
Person Completing Form:
Date of HH+ Enrollment:
Date of HH+ Eligibility Confirmation:

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

AND

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

Must have at least ONE of the following boxes checked and supporting documentation on file to be eligible for SMI HH+ for 12 months		
	Eligibility Requirement	**Supporting Documentation on File**
☐	ACT Step Down	
☐	Enhanced Service Package / Voluntary Agreement	
☐	History of expired AOT order in the last year	
☐	Discharged from State Psychiatric Centers or Central New York Psychiatric Center (CNYPC) and its corrections-based Mental Health Units	
☐	Homeless *(Must meet HUD Category 1, Literally Homeless, definition)*	
☐	High utilization of Inpatient or Emergency Department services ☐ Three or more psychiatric inpatient hospitalizations in the last year OR ☐ Four or more psychiatric ED visits in the last year OR ☐ Three or more medical inpatient hospitalizations within the last year AND diagnosis of Schizophrenia or Bipolar	
☐	Criminal Justice Involvement *(Release from incarceration within the past year and requires linkage to community resources to avoid re-incarceration)*	
☐	Ineffectively engaged in care ☐ No outpatient mental health services within the last year and 2 or more psychiatric hospitalizations OR ☐ No outpatient mental health services within the last year and 3 or more psychiatric ED visits	
☐	MCO Clinical Discretion	
☐	LGU/SPOA Clinical Discretion	