Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Health Home Plus for SMI and AOT

Department: Health Home

Intended Population: Health Home Serving Adults

Effective Date: 4/1/2019

Review Date: 5/1/2020

Date Revised: 7/17/2019

Purpose of Policy

To describe who qualifies for Health Home Plus, describe the needed documentation from Health Home Service Providers, and the minimum service requirements and education to serve this population.

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to the AHI's Health Home program.
3. All questions regarding this policy or its implementation may be directed to the Health Home Director.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Health Home Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Health Home Policy.

Definitions

AHIHH: AHI Health Home, a designated lead Health Home by the New York State Department of Health

Health Home Network Partners: The group of medical, behavioral, social services, and other community-based organizations by which a Health Home Participant receives services to address needs identified on the comprehensive care management plan developed by the Health Home Participant's AHI Health Home Services Provider.

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Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management.

Health Home Service Provider: An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

Workforce member means Employees, board members, volunteers, interns, independent contractors, vendors, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity. This includes full and part time employees, affiliates, associates, volunteers, and staff from third party entities who provide service to the covered entity.

Single Point of Access (SPOA): The Single Point of Access (SPOA) is under the authority of the Local Government Unit (LGU) and Mental Hygiene law. SPOA is a critical entry point for the mental health service delivery system

SMI: Serious mental illness

AOT: Assisted outpatient treatment

Kendra's Law: effective since November 1999, is a New York State **law** concerning involuntary outpatient commitment. It grants judges the authority to issue orders that require people who meet certain criteria to regularly undergo psychiatric treatment.

HUD**:** Housing Urban Development

LGU: Local Government Unit

OMH Legacy provider: Former OMH Targeted Care Management (TCM) providers

HUD homeless definition: An individual who lacks a fixed, regular, and adequate nighttime residence. For example, the member 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 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.

Background

The Health Home Plus Program Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

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Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service established for defined populations with Serious Mental Illness (SMI) and /or Assisted Outpatient Treatment (AOT) who are enrolled in a Health Home (HH) program serving adults. To ensure the intensive needs of these individuals are met, AHIHH must assure HH+ individuals receive a level of service consistent with the requirements for caseload ratios, face-to-face visits, and minimum levels of staff experience and education. The differential monthly rate for HH+ is higher compared to the Health Home High Risk/Need Care Management and mainstream Care Management rates and is intended to appropriately reimburse for the intense and consistent support needed for this population. Providers who meet the requirements to serve the HH+ population must submit an attestation to AHIHH verifying they meet the criteria and can meet the necessary requirements to serve the population as set forth below.

Eligible Population

- Assertive Community Treatment (ACT) step down
- Individuals transitioning off AOT services to a lower level of service.
- Homeless - See definitions for HUD criteria
- History of an expired AOT order within the past 12 months
- Enhanced Service Package/Voluntary Agreement
- Must be identified by the Local Government Unit (LGU)
- An agreement signed by individuals otherwise considered for AOT by the LGU but agreeing that he/she will adhere to a prescribed community treatment plan rather than be subject to an AOT court order. These agreements are most frequently used as trial periods before initiating a formal AOT order. The agreement can also be used following a period of AOT when the individual is deemed ready to transition off an AOT order.
- Criminal justice involvement
- Release from Incarceration within the past 12 months and requires linkage to community resources to avoid reincarceration.
- Ineffectively engaged in care
- No outpatient mental health services within the last year and 2 or more psychiatric hospitalizations.
- No outpatient mental health services within the last 12 months and 3 or more psychiatric ED visits.

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- High utilization of inpatient/emergency department services
- 3 or more psychiatric inpatient hospitalizations with the past 12 months
- 4 or more psychiatric ED visits within the past year
- 3 or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar
- ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs
- SMI individuals who do not fall within at least one of the above high need categories could still be eligible for HH+ services based on the clinical discretion of the local SPOA and or Managed Care Organization (MCO)

Clinical Discretion

MCOs coordinate physical and behavioral health services for Medicaid Managed Care Plan enrollees. MCOs - including mainstream plans, HIV-SNPs and HARPs - have responsibility in ensuring high-need members have positive health outcomes and receive needed services.

The LGU/SPOA has oversight and responsibility for the high-need SMI population and ensuring their access to services best able to meet their needs. SPOA is uniquely qualified to make a recommendation for HH+ eligibility based on their current work triaging referrals for ACT and AOT, as well as the non-Medicaid behavioral health population.

The SPOA/MCO may consider social determinant factors in relation to the individual's psycho-social needs. Some examples may include but are not limited to the following:

- An individual who is frequently at-risk for homelessness due to psycho-social related tendencies such as hoarding.
- Transition-age youth: Individuals transitioning out of child/adolescent services who require intensive care coordination through this transition.
- Individuals experiencing initial onset of mental illness without connection to mental health treatment.
- An individual's substance use is a barrier to engaging in community-based treatment and services.
- Individuals placed on an ACT waitlist who would benefit from enhanced care coordination while awaiting placement with ACT services. LGU/SPOA and MCO should work with the assigned HH+ Care Manager (CM)

Referral for Health Home Plus

Referrals can come from multiple sources including community providers, shelter outreach teams, ACT teams, forensics, MCOs, hospitals, etc. The referral source can supply documentation to support that the individual meets high need indicators for HH+.

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If the referral goes to the Health Home, the Health Home must ensure that the individual is assigned to a CMA qualified to serve the HH+ population. The Health Home shall ensure prompt assignment is made to allow the care manager the ability to participate in the planning process for continuity of care, whenever possible.

Referrals sent through SPOA should be assigned to the Health Home and/or HHSP who has attested to serve the HH+ population. The SPOA and Health Home are responsible to ensure that referrals are coordinated in a timely and efficient way for this high-need population to benefit from the intensive services. HHSPs must have a working relationship with SPOA and ensure protocols are in place to receive referrals.

HHSP Qualifications

HHSP's must receive endorsement from the LGU indicating the they have or will have a working relationship, as defined below, with the LGU within (3) months of the Health Home submitting the attestation form.

- A "working relationship" with SPOA includes:
- Demonstrated ability and willingness to accept high-need SMI referrals directly from the LGU/SPOA
- Participation in any county SPOA process or committee as applicable
- Knowledge of LGU/SPOA protocols and resources for accessing local mental health services
- Clearly defined communication standards between the CMA, SPOA, and HH **AND**
- The CMA must meet at least two (2) of the following criteria:
- The CMA is operated by an organization that provides OMH-licensed, (funded or certified services), in addition to care management for individuals with SMI. This may include but not limited to: mental health housing, Personalized Recovery Oriented Services (PROS), Article 31 Clinic, and ACT.
- The CMA currently serves individuals with SMI.
- The CMA demonstrates knowledge of the behavioral health managed care benefit package, and has working relationships/partnerships with the local mental health service delivery system including but not limited to: psychiatric inpatient units, mental health crisis and diversion services, mental health SPOAs, outpatient mental health treatment programs, rehabilitation services and housing.
- Only OMH Legacy providers are eligible to serve the AOT population

Staffing Qualifications *(See Staffing Qualifications Policy)*

HH+ shall always be delivered by a HHSP with staff who have the education and experience appropriate to serve the high-need, behavioral health population. The following Minimum Qualifications apply:

- A Bachelor's degree in 1 of the fields below

- NYS Teacher's certificate for which a Bachelor's degree is required; or
- NYS licensure and registrations as a Registered Nurse AND a Bachelor's degree; or
- A Bachelor's level education or higher in any field with 5 years of experience working directly with person with behavioral health diagnosis; or
- A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) **AND**
- 2 years' experience
- providing direct services to people with serious mental illness, developmental disabilities, or alcoholism or substance use; or
- linking individuals with serious mental illness, developmental disabilities, or alcoholism or substance use to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services); or
- 1 year of experience with a Master's degree in one of the listed education fields **AND**
    - Supervision from a licensed healthcare professional (e.g. RN, licensed clinician, psychologist) with prior experience in a behavioral health clinical setting or care management supervisory capacity; OR Master's level professional with 3 years prior experience supervising clinicians and/or care managers who are providing direct services to individuals with serious mental illness and/or substance use disorders.

<u>Staffing Models</u> (*See Caseload Ratios Policy)*

Preferred Caseload

- The preferred caseload ratio for HH+ members shall be 1 Care Manager to 12 HH+ members but should not exceed 1 Care Manager to 15 HH+ members.
  For the purpose of case load stratification, a caseload mix of HH+ and non HH+ is allowable if and only if the HH+ ratio is less than 12 members to 1 Health Home Care Manager.

Mixed Caseload (HH+ and non HH+)

- 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 12 members to one Care Manager. *Please refer to Staffing Qualifications Policy for additional HH+ staffing requirements.*

Team Approach

- Under this model, HH+ members can receive services by an array of staff members that is led by a primary care manager. Team members may include but not be limited to Registered Nurses, peers and/or additional Care Managers.
- The team caseload must maintain the ratio of 12 to 15 HH+ members per each Care Manager/FTE on the team. For every 30 HH+ members, the team must have at least one qualified HH+ Care Manager.

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Staff Core Competencies

Supervisors will be responsible for ensuring care managers receive adequate support and access to resources that encourage development of skills necessary to improve quality of life and outcomes for high-need individuals with SMI. Supervisors and direct care management staff must be proficient in the following areas:

- Conduct appropriate screening and either performing or arranging for more detailed assessments when needed (e.g., high-risk substance use or mental health related indicators, harm to self/others, abuse/neglect and domestic violence). This includes the CMA's demonstrated ability to complete the required New York State Eligibility Assessment for Health and Recovery Plan (HARP) enrolled members.
- Plan and coordinate care management needs for high-need SMI individuals including:
- Navigating the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/ diversion, peer support services.
- Knowledge of the behavioral health managed care benefit package
- Ability to collaborates with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings. Addressing the quality, adequacy and continuity of services to ensure appropriate support for individuals' mental health and psychosocial needs.
- Must complete plans of care and coordinate with MCOs for HARP members utilizing the Home and Community Based Services (HCBS) benefit package.
- Maintain engagement with individuals who are often disengaged from care, have difficulty adhering to treatment recommendations, or have a history of homelessness, criminal justice involvement first-episode psychosis and transition-age youth. Key skills and practices to engage high-need SMI individuals include:
- Motivational Interviewing
- Suicide Prevention
- Risk Screening
- Trauma Informed Care
- Person-centered care planning and interventions
- Recovery-Oriented Approaches (e.g., WRAP)

Service Intensity

Program requirements for HH+ enrollees are to be carried out consistent with the existing "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations" guidance distributed by the Department of Health.

- A minimum of four (4) Health Home core services must be provided per month, two (2) of which must be face-to-face contacts, or more when the individual's immediate needs require additional contacts.
- AOT members must have four (4) Face to Face contacts per month.

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- The HH+ rate code can only be billed when all service level requirements are met and clearly documented in the individual's record.
- If the minimum service requirements are not provided in a given month, but all other requirements are met; and at least 1 Health Home core service was provided the High Risk/High Need rate may be billed.
- The HH+ rate code can be billed for 12 consecutive months starting from the point an individual's HH+ eligibility becomes known to the HHSP and HH+ program requirements have been met.
- If a HH+ individual continues to meet eligibility at the end of the 12-month initial time frame, HH+ billing may continue for 12 more months with updated supporting documentation and notification to the Health Home.
- Communicating with Managed Care Plans (MCOs) regarding HH+ individuals:
  o *AHIHH will alert the MCO when HH+ eligibility becomes known to the CM and HH+ services will be provided.*

Service Intensity and Documentation for AOT Members

This program, staffing and financial guidance applies only to individuals receiving court ordered Assisted Outpatient Treatment (AOT) who are enrolled in Health Home Care Management (HHCM). AOT involves a court order and, by statute, is overseen in part by the local government which, in most cases, sought the order.

- AOT members must have **four (4) Face to Face** contacts per month.
- All categories of service listed in the court-ordered AOT treatment plan shall also be included in the individual's integrated health home plan of care.
- If the individual with an AOT court order cannot be located and has had no credibly reported contact within 24 hours of the time the care manager received either notice that the individual had an unexplained absence from a scheduled treatment appointment, or other credible evidence that the AOT individual could not be located, the individual will be deemed Missing.

  Diligent Search for AOT ***Mus***t be conducted by the Health Home Service provider. A missing AOT individual is considered a significant event that must be reported to the LGU within 24 hours, following the LGU's protocol for reporting significant events.
  All member's currently on an AOT must have the current AOT order on file in the Care Management Record

- CMA must comply with the court order and all statutory reporting requirements under Kendra's Law
- Health Home care managers must complete and submit all AOT reporting requirements to the Office of Mental Health (OMH) as required by AOT legislation and as currently reported in the OMH CAIRS (Child and Adult Integrated Reporting System).

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Comprehensive Transitional Care

It is expected that the HH/CMA staff and the referral source will coordinate efforts in a way that provides for warm hand-off and/or immediate engagement working with high-need individuals. The care manager should initiate contact with the individual and/or referral source upon receiving the referral.

A warm hand-off is best practice to ensure optimal transition to HH+ services when an individual is being discharged/transitioned from either a program or facility. An introduction with the individual prior to discharge/transition can help orient the individual to HH+ services while allowing the care manager to be a participant in the discharge planning.

Quality Assurance

Best practice is that the HHSP's should immediately upload supporting documentation within the members electronic health record, but no later than 90 days. Because supporting documentation for homelessness and SUD can be more difficult to gather, HHSP's can request additional time to gather such documentation. In the interim, the members eligibility status can be substantiated via client self-report or care manager observation so long as it is documented in the members record. Examples of acceptable supporting documentation are as follows:

- **HIV Status:** Lab results, medical records, or documented conversation from collateral contact (must a service provider or MCO that can confirm lab results and/or have access to the individual's medical record.
- **Homelessness:** Letter from a shelter or other housing program, hospital discharge summary, eviction notice, or self-report. Observation by care manager and documentation of this observation in progress notes and care plan that reflects the intensity of service needs to address this category.
- **Incarceration:** Release papers, documentation from parole/probation, documentation of collateral contacts, print-out from criminal justice database, letter from halfway house, or self-report (for 90 days).
- **Inpatient Stay for Physical Illness:** Hospital discharge summary, documentation of collateral contact of a provider who can verify patients discharge (Note must include: name of contact, title, contact information). Print out from PSYCKES. RHIO alerts or MCO confirmation.
- **Inpatient Stay for Mental Illness:** Hospital discharge summary, documentation of collateral contact of a provider who can verify patients discharge (Note must include: name of contact, title, contact information). Print out from PSYCKES. RHIO alerts or MCO confirmation.
- **Substance Abuse Disorder Active:** Based on assessment and information gathered by the care manager from substance abuse providers, probation/parole, court ordered programs, DSS, or other sources.

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HH+ Attestation

HHSP's are responsible for submitted a written attestation to AHIHH verifying that they can and will meet all the staffing and operational requirements set forth in this policy. *Please see attached HHSP attestation form.*

HH+ Stepdown Requirements

HHSP's must work with members to devise a Stepdown plan prior to transitioning off of HH+. The member's needs, goals, and objectives should be considered when setting new service level expectations. HHSP's should assist members in developing a plan that assures appropriate service level intensity.

Health Home Service Providers can bill at an enhanced rate while transitioning a member off HH+. The HHSP will indicate on the member's HML that they are part of the HH+ Expanded Population and "NO" the minimum core services were not met. This will trigger the HML to be billed out at the 1874 Rate code ($360.00). The HHSP may bill at this rate code for a period of 6 months.

Quality and Performance

Each month AHIHH will review select HML's for Health Home Plus billing and adherence to this policy. The Care Management Record will be reviewed to ensure proper HH+ supporting documentation is present in the record and the service needs are reflected in the member's Plan of Care.

Training

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of the initial policy training a future in-depth training will be developed to understand Health Home Plus eligibility/qualifying conditions, guidance on how to serve this population, and engagement techniques such as Motivational Interviewing and provided to all care management staff.

Contact Person: Director, Care Management and Health Home

Responsible Person: Health Home Service Provider

Approved By: Chief Operating and Compliance Officer

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HH+ for SMI Examples of Eligibility Documentation

Population/Sub-Population	Examples of Documentation Sources
Homelessness	• Letter from shelter or other homeless housing program • Hospital discharge summary • Eviction notice • Documentation from local Homeless Management Information System (HMIS) • Documentation in a Care Plan and Progress notes would maintain this billing category for 60 days.
Criminal Justice Involvement	• Release papers • Documentation from parole/probation • Print-out from "WebCrims" or other criminal justice database • Letter from halfway house
3 or more Medical Inpatient hospitalizations (Schizophrenia or Bipolar)	• Hospital discharge summary • Print out from PSYCKES • RHIO alerts of inpatient admission • MCO confirmation of admission
3 or more Inpatient Psychiatric hospitalizations	• Hospital discharge summary • Print out from PSYCKES • RHIO alerts of inpatient admission • MCO confirmation of admission
4 or more Psychiatric ED visits	• Hospital discharge summary • Print out from PSYCKES • RHIO alerts of inpatient admission • MCO confirmation of admission
Assertive Community Treatment (ACT) step down	• Documentation of Discharge from ACT
Enhanced Service Package (ESA)	• Copy of ESA agreement
Expired AOT within the past year	• Copy of expired AOT order
Active AOT	• Active AOT order
CNYPC Discharge / State PC Discharge	• Discharge paperwork
Clinical Discretion SPOA/MCO	• SPOA/MCO Attestation
Ineffectively Engaged	• Hospital discharge summary • Print out from PSYCKES • RHIO alerts of inpatient admission • MCO confirmation of admission

See Caseload Ratios Policy for an Additional Desk Guide

See Staffing Qualifications Policy for an Additional Desk Guide