An Overview of the Health Home Serving Children

Collaborative For
Children & Families

NewYork-Presbyterian
Performing Provider System

Webinar Logistics

- All attendees will be automatically muted and in listen-only mode for the duration of the presentation
- Participation is highly encouraged!
  - The speaker will take questions at the end of the webinar.
  - Please submit your responses to the polls during the presentation.
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- All slides and the audio recording will be made available on our website following the presentation
  - http://www.nyp.org/pps/resources/pps-webinars

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NewYork-Presbyterian Performing Provider System

- **Jodi Saitowitz, LCSW**, Executive Director of The Collaborative for Children and Families

- **Maria Moreno**, Manager of Integrated Delivery System Development in the Department of Community and Population Health at NewYork-Presbyterian Hospital

The Collaborative for Children & Families("CCF") is a growing, multi-agency coalition of organizations that have come together to better coordinate care for children and their families.

Who we are?

- CCF is an organization built on the partnership of 25 community based, voluntary agencies.
- CCF operates one of only three Health Homes Serving Children (HHSC) state wide.
- CCF is designated to serve children and their families in all five boroughs of **NYC**, **Westchester**, **Nassau & Suffolk** Counties
- Comprised **over 46 Care Management Agencies**.
- In addition to Care Management, CCF Membership represent a range of other direct services.

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OUR MEMBERS

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Our Relationships With Network Partners

- Network partner list of over 5,000 providers
- Our Network covers the entire range of behavioral, medical and social services.
- With a grant made possible from New York Community Trust, a comprehensive resource database bank is in development
- Coordinate regional meetings with External Network Partners
- RHIO connectivity with Healthix

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Our Partnerships With Adult Health Homes

NYP

Mount Sinai

CBC
TRANSFORMING COMMUNITY HEALTHCARE

BRONX-LEBANON HOSPITAL CENTER
HEALTH CARE SYSTEM

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Our Partnership with MCOs

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Care Management Capacity

12K	28K	1,300
Est. Enrollment # by Jan. 2018	Projected Enrollment	Est. # CMs for 28k Children

Range of Services that CCF Members offer

- Foster Care & Adoption
- Prevention Services
- Case Management
- Article 31 Mental Health clinics
- Article 28 Diagnostic & Treatment Centers
- CHHA - Skilled Nursing Services
- Community Schools & Education Programs
- Substance Use Treatment
- HIV/AIDS Prevention & Treatment
- After School & Summer Enrichment
- Job and Workforce Development

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Children & Youth in Foster Care

- Over 11,000 children & youth in foster care
- Categorically eligible for Medicaid
- History of childhood adversity, trauma, loss, abuse & neglect
- High prevalence of medical, behavioral, and developmental problems

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Service Utilization

According to the American Academy of Pediatrics, children in the foster care system use inpatient and outpatient mental health services at a rate of 15-20 times higher than the general pediatric Medicaid population.

Service Utilization

According to the CDC National Center for Injury Prevention and Control, children who were maltreated or were at risk for maltreatment had Medicaid expenditures more than **$2,600** higher annually than children who were not subject to, or at risk for, maltreatment

At Risk Children & Youth

- In 2013, there were **9,300** Article 10 (abuse and neglect) filings in NYC
- In 2013, there were **11,235** new Preventive Cases opened in NYC
- At risk children and youth present with similar physical and behavioral needs as those in foster care

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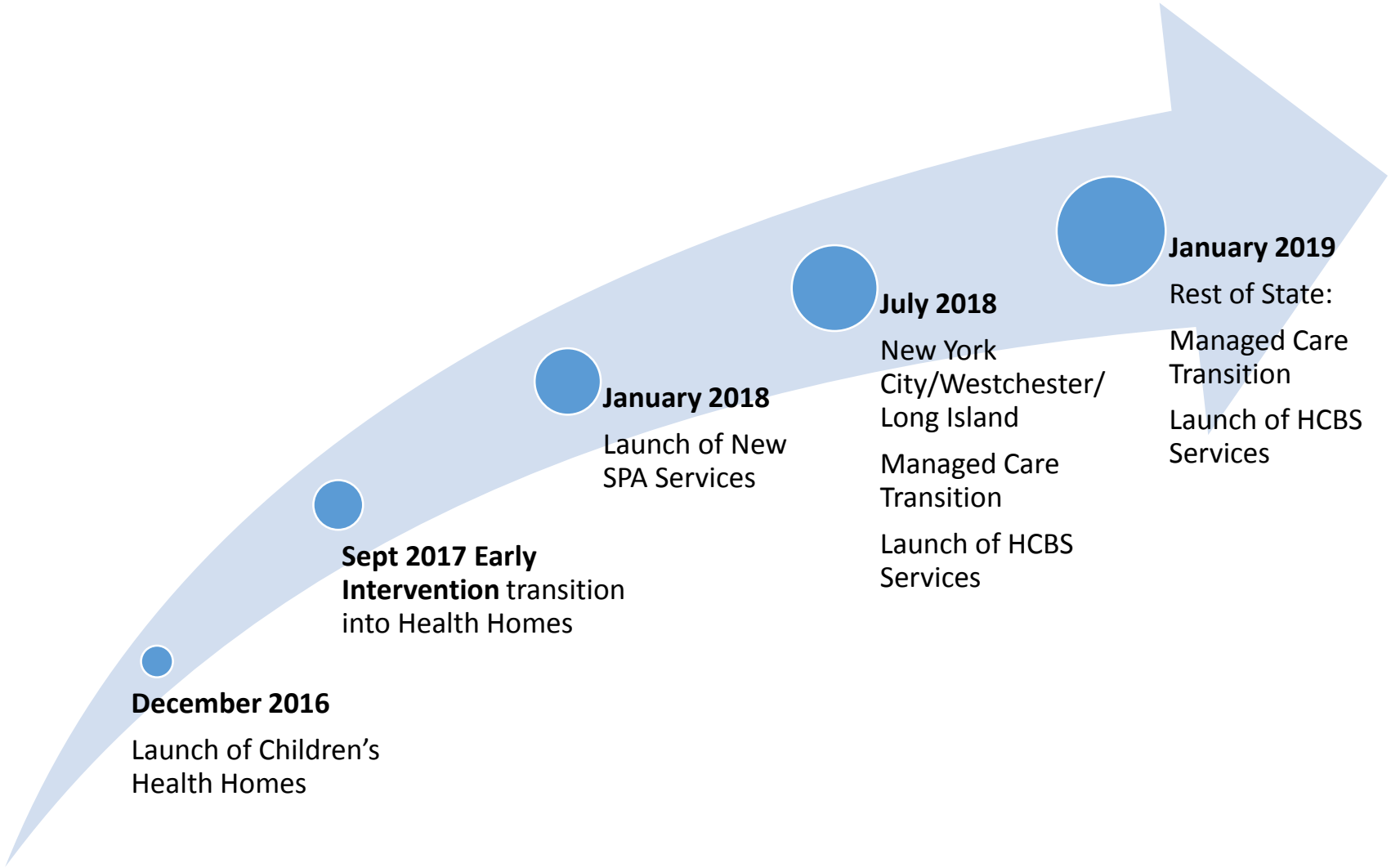
CHILDRENS TIMELINE



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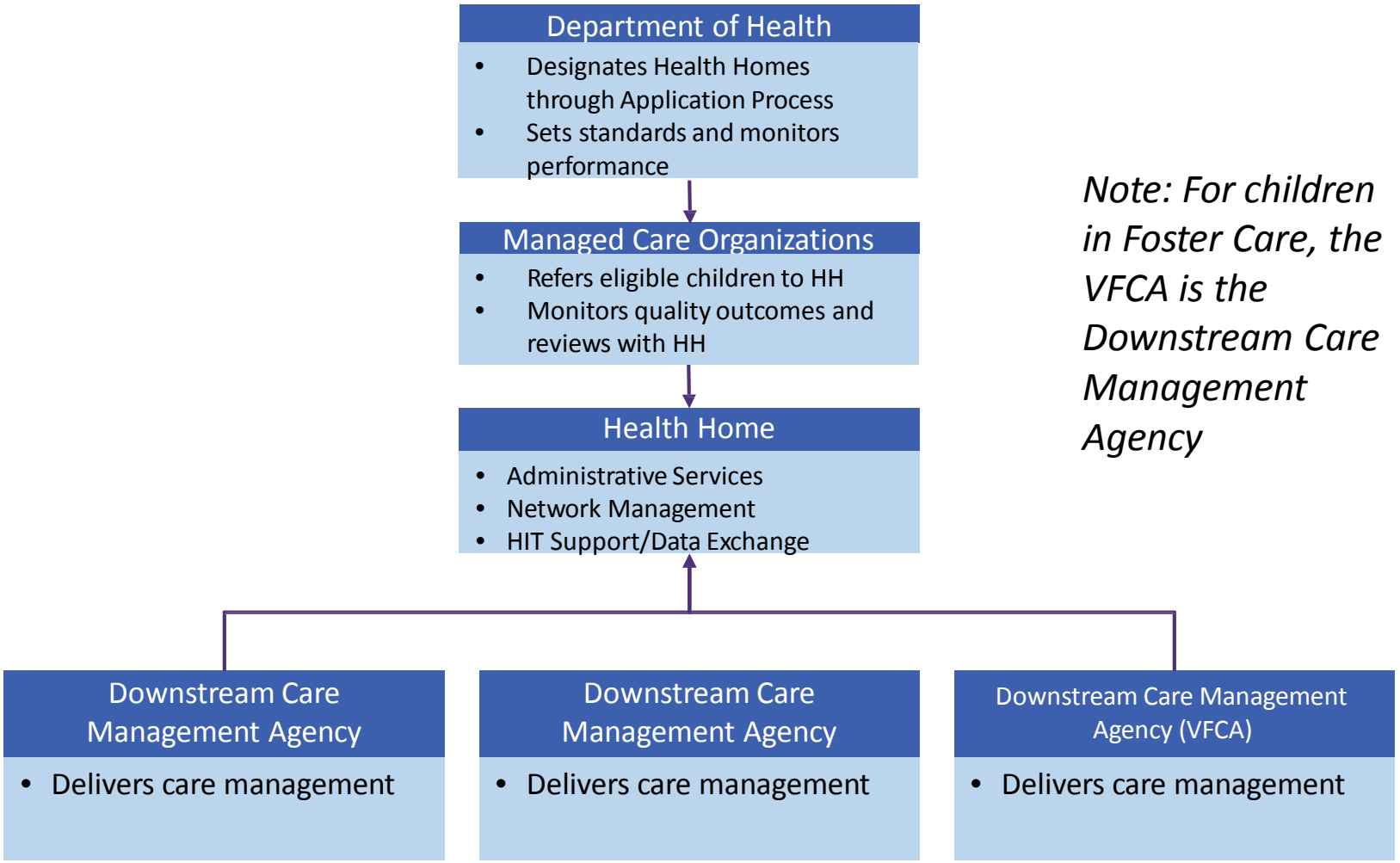
Health Home Organizational Chart



Note: For children in Foster Care, the VFCA is the Downstream Care Management Agency

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Why Health Homes? Why Now?

- Historically, children's case management systems were sometimes **fragmented.** Bringing all children's case management under health homes provides the opportunity to have "**no wrong door**".
- The Health Home will provide a dedicated care manager for children and families to help them communicate with the child's entire care team.
- The care manager will provide compassionate & individualized care coordination.
- The care manager will provide a simple plan linking together all the medical and behavioral services for the child and their family based on their individual needs.

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Health Home Goals

- **Goal 1:** The main goal of the Health Home Model is to reduce inappropriate emergency room visits and inpatient stays and to ensure that your child makes regular progress toward a healthy tomorrow.

- **Goal 2:** Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders;

- **Goal 3**: Improve Disease-Related Care for Chronic Conditions.

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ELIGIBILITY-QUICK FACTS

Geography:	Statewide
Eligibility Criteria:	At least two chronic conditions OR one qualifying chronic condition: • HIV/AIDS • SED (Health Home Definition) • Complex Trauma (SMASHA DEFINITION)
Health Home Services:	• Comprehensive care management • Care coordination and health promotion • Comprehensive transitional care • Individual and family support services • Referral to community and social support services • Use of health information technology to link services
Launch Date of HH serving Children:	December 8th, 2016

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Enrollment and Assessment

- Agencies can identify children in existing programs who are eligible for Health Home services.
- Children will be assessed for **acuity** and **service eligibility**.
- The **CANS NY** will determine **acuity** and be used to **develop a care plan** based on **child and family needs.**
- Children from birth to 21 years old are eligible.
- Children in early intervention programs will be phased in on March 2016.

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Health Homes and Child Welfare

- NYS will promote and integrate Health Home coordination with the child welfare system.

- Collaboration will:
  - Enhance the stability, overall health outcome, and well-being of the child;
  - Ensure that safety, permanency, and well-being are addressed within the provision of Health Home services; and
  - Coordinate care plan development and execution.

- The Health Home care managers are expected to participate in the development of the FASP.

- The voluntary foster care agency will collaborate with the Health Home care manager on the development of the Health Home plan of care.

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Health Homes Core Services Definitions

Service	Scope
Comprehensive Care Management	A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed for the enrolled child.
Care Coordination and Health Promotion	The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a child's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
Comprehensive Transitional Care	The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
Patient and Family Support	Child's individualized plan of care reflects child and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.
Referral to Community Supports	The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
Use of Health Information Technology (HIT) to Link Services	Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible, to comply with the initial standards and final standards as required.

Appropriateness Criteria for Health Home Eligibility

Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- Has inadequate social/family/housing support, or serious disruptions in family relationships;
- Has inadequate connectivity with healthcare system;
- Does not adhere to treatments or has difficulty managing medications;
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- Has deficits in activities of daily living, learning or cognition issues, or
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

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CONSENT

Under Current Law and Regulations, Parental Consent, with only Limited Exceptions, is Required for Children to be Enrolled in Health Home

- All LDSS/VFCAs in NYC are able to consent for referral to the Health Homes for any eligible child despite the legal status of the child.
- The public health law (PHL) defines Health Home care management as a health service, and as such requires the consent of a parent, guardian or legally authorized representative to enroll minors in a Health Home and authorize information sharing among the minors' provider.
- Exception: A minor who is married, pregnant, or a parent can consent to enrollment into a Health Home and provide authorization to have their health information shared (the current consent form DOH 5055 would be used in these circumstances)

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Referral Mechanisms

There are basically 5 ways a Care Management Agency will receive referrals:

- From the Lead Health Home who receives the referral from a Hospital system or a community provider.
- As a VFCA in NYC under contract with ACS who refers its own Foster Care population directly into MAPP.
- As a former OMH TCM provider whose children will roll over automatically into HHs
- As a CMA that is assigned referrals in MAPP of children referred by MCOs, LDSS, or SPOA/LGUs
- As a CMA that has referred its own other eligible clients via GSIHealth.

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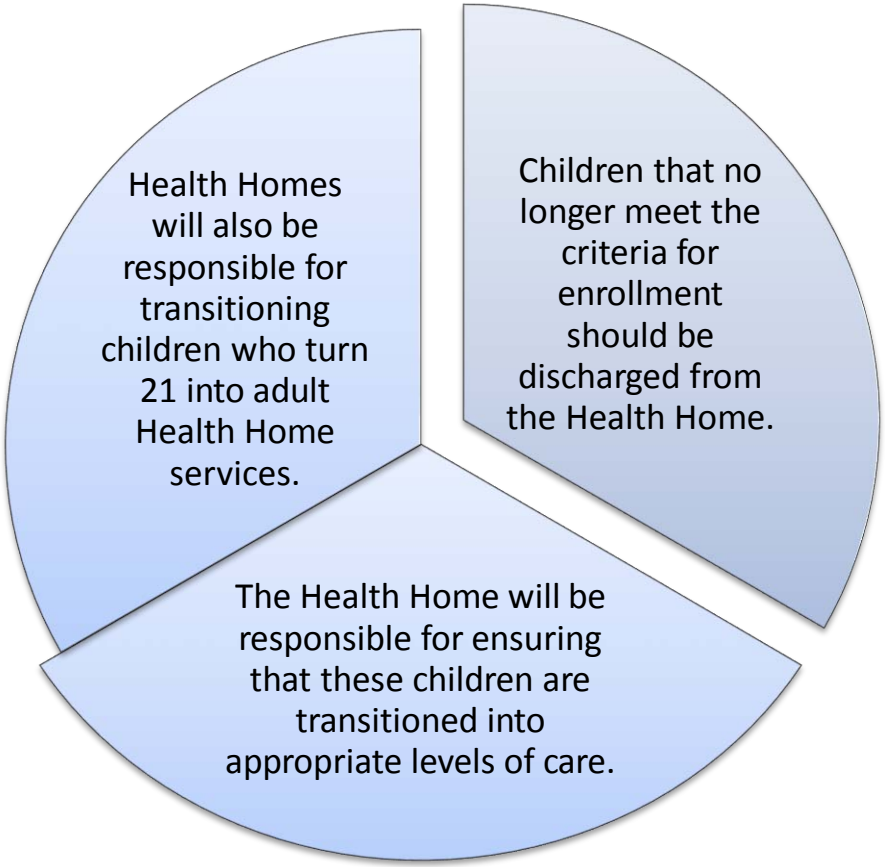
Disenrollment



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Children's Health Home Rates

- Effective October 1, 2016, the SPA authorizes the following Children's Health Home Rates for the period December 1, 2016 to September 30, 2018
- An algorithm applied to the CANS-NY tool determines if the rate that may be billed is High, Medium or Low – the algorithm will be calculated in the UAS and billing information will flow from UAS to MAPP

Per Member Per Month HH Care Management Rates for Children under 21 (non-Legacy Providers)		
Acuity (CANS Algorithm)	**Upstate**	**Downstate**
High	$750	$799
Medium	450	479
Low	225	240
Outreach	135	135
Assessment	185	185

Readiness Planning – Initial Client Volume

Prioritizing the Enrollment of Eligible Children in Health Homes October 2016 Begin Date for Enrollment

- To manage initial capacity (and provide time to build up capacity) Health Homes, LDSS, LGU, Care Managers and Plans, should prioritize the enrollment of children ***that meet Health Home chronic condition eligibility and appropriateness criteria*** and have the highest needs, including the following:
  - ✓ Children enrolled in OMH TCM care management programs that will convert to Health Home
  - ✓ Children on OMH Waiver waiting list (already Medicaid eligible), within 30 days of discharge from inpatient/residential/day treatment settings to participate in discharge planning
  - ✓ Children on TCM waitlist; [SPOA who refers to HH]
  - ✓ Children who are on the Bridges to Health Wait list,
  - ✓ Children in licensed congregate care,
  - ✓ Children that are within 3 months of foster care discharge,
  - ✓ Children enrolled in LDSS prevention services where foster care placement is imminent,
  - ✓ Children prescribed 3 or more psychotropic medications
  - ✓ Children who are within 30 days of discharge from inpatient, residential or detox setting
  - ✓ Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay
  - ✓ Children who have an ER referral but are not admitted for inpatient services; or are discharged with a recommendation for community follow up;
  - ✓ Children with multiple system involvement (child welfare, criminal justice)

❖ ***Children in Early Intervention will begin to be enrolled at a later date to be determined by the State (when procedures for integrating EI and HH requirements have been established, with stakeholder feedback, and trainings provided).***

Source: DOH April 9 Webinar

Health Home Staff to Caseload Ratios

Tier*	Suggested Caseload Ratio	Care Management Service Requirements	Care Management Qualifications
High	1:12	Mandate 2 HH services/month, 1 must be face-to-face with youth; Caseload must be most/all high-acuity	Bachelor's of Science or Art w/2 yrs. relevant experience; **OR** Registered Nurse with w/2 yrs. relevant experience ; **OR** Masters w/1 yr. relevant experience CM working with EI have specialized qualifications
Medium	1:20	Mandate 2 HH services/month, 1 must be face-to-face with youth	No mandated qualifications identified, but expectation is assigned care manager has experience and skills needed to serve client and deliver the six Health Home core services
Low	1:40	Must demonstrate 1 HH service/month to bill	No qualifications identified , but expectation is assigned care manager has experience and skills needed to serve client and deliver the six Health Home core services

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Staying Informed-Making a Referrals to CCF

To make a referral to the Collaborative for Children & Families (CCF)
Visit our Website and download our Community Referral Form
www.ccfhh.org

Or E-mail: info@ccfhh.org
or call us at
212-444-5437

NYP staff: For additional education or training regarding the Health Home Serving Children, please contact Maria Moreno at mam7045@nyp.org or 347-880-1851.

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Upcoming Webinars from NYP PPS and Collaborators:

Register Here: http://www.nyp.org/pps/resources/pps-webinars

Health Literacy and Teach-Back Techniques: Overcoming Barriers to Adherence

Thursday, April 20, 2017 from 2:00 PM - 3:00 PM EST

This presentation will feature **Dodi Meyer, MD**, Director of Community Pediatrics and Associate Professor of Pediatrics at Columbia University Medical Center, and **Emelin Martinez**, Program Manager for the Health Education and Adult Literacy (HEAL) Program and Reach Out & Read at NewYork-Presbyterian Hospital.

We want to hear from you! Please contact ppsmembership@nyp.org with any feedback.

Presenter Biography

Executive Director, Collaborative for Children and Families

Jodi Saitowitz brings more than 25 years of experience in child welfare to her role as Executive Director of The Collaborative for Children and Families (CCF). CCF was recently designated by the NYS Dept. of Health (DOH as to operate a Health Home Serving Children(HHSC). Prior to being appointed as the Executive Director of CCF she served as the Associate Executive Director at one of the city's most specialized non-profit child welfare agencies. In addition, Ms. Saitowitz served as the Director of Bridges to Health (B2H) for the Administration for Children's Services (ACS). Ms. Saitowitz is a trauma, risk, and crisis management expert, certified in human resource management and clinical social work. As a clinician for many years, Ms. Saitowitz worked as a psychotherapist in one of the largest Residential Treatment Facilities (RTF) in the state of Maryland. She also served as a member of the NY State Medicaid Redesign Team (MRT) Children subcommittee and closely partnered with the Office of Mental Health (OMH), the Office of Children and Family Services (OCFS), and the Office of People with Developmental Disabilities (OPWDD) to improve supports for children with special needs. Ms. Saitowitz is an accomplished public speaker and trainer on child welfare, adoption, and mental health issues for children and families. She has an undergraduate degree in social work from Colorado State University and a Masters in clinical social work from the University of Maryland.

Thank you for attending!!!

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