Health Home Basics

Health Home Awareness Forum
Mount Sinai Performing Provider System
DSRIP
Health Home Overview

- Health Homes are a care management model that integrates and coordinates all primary, acute, behavioral health, and long-term services for Medicaid patients with chronic conditions. The program is administered by the Department of Health. Care manager oversees and coordinates access to all the services a members requires. They will develop a Care Plan that will address the patient’s medical, behavioral health and social service needs and then will work with the patient to get the most from that plan. (You can also access services for non Medicaid members and clients through the Mount Sinai Command Center.)

- A patient’s insurance doesn’t change and will be maintained—and his/her benefits and rights won’t change. It is a voluntary service and there is no impact on services if a patient does not enroll.
Health Home Overview

Services

- **Comprehensive Care Management**
  - A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

- **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 patient’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**
  - Patient’s individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

- **Referral to Community and Social Support Services**
  - The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

[https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cm_standards.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cm_standards.pdf)
Health Home Overview - Eligibility

Two of these  OR  One of these

• Alcohol and Substance Use Disorder
• Mental Health (e.g., Bi-Polar Disorder, Dementia, Depression, Schizophrenia)
• Cardiovascular Disease (e.g., CHF, Hypertension)
• Metabolic Disease (Chronic Renal Failure, Diabetes)
• Respiratory Disease (Asthma, COPD)
• Others (see appendix for full list)

• HIV/AIDS
• Adults: Serious Mental Illness (SMI)
• Children: Serious Emotional Disturbance (SED) or Complex Trauma
Health Home Structure

The Collaborative for Children & Families

Community Care Management Partners Health Home

Community Healthcare Network Health Home

Coordinated Behavioral Care

Mount Sinai Health Home

Queens Coordinated Care Partners, LLC

Billing, Tracking, Data Reporting, Quality Assurance

Managed Care Organizations

Care Management Agencies
Overview of Health Home eligibility

Active Medicaid status

Does your patient have an active Medicaid status?
This includes dual eligible, managed care, Special Needs Plans (SNP), Managed Long Term Care (MLTC), Health And Recovery Plan (HARP), Fully Integrated Duals Advantage (FIDA)

Functional need

Does your patient have two chronic conditions or one qualifying condition?

Demonstrated need

Is there a demonstrated need for care management services?
These needs are due but not limited to inadequate social support, medication non-adherence, frequent hospital and ED use, and homelessness

If your patient meets all three requirements, then he/she is eligible to be enrolled in a Health Home.

Contact the Mount Sinai PPS DSRIP Command Center at (1-844-674-7463)
Connecting to the DSRIP Command Center

Through our DSRIP Call Center, our Mount Sinai PPS staff is available to:

– Find out if your patient is eligible for a dedicated Health Home care manager
– Provide you with information to help you connect your patient with a Health Home to enroll and activate services
– Find out if your patient is already assigned to a Health Home care manager in order to reactivate services

Please have the following information on hand to provide the Command Center:

– Patient name
– CIN/Medicaid ID number
– Patient’s borough of residence
– Patient’s phone number
– Patient’s date of birth
– Patient’s preferred language

Call the DSRIP Command Center at 1-844-674-7463
Other services provided by the Command Center

▶ REAP

Resource, Entitlement and Advocacy Program (REAP), a Mount Sinai service that helps people navigate the health care system as well as obtain and maintain health coverage through the NYS of Health Marketplace and the NYC Medicaid office. REAP staff perform a comprehensive entitlements assessment for people seeking assistance with health insurance. Based on that assessment, they may be able to assist with other health, housing, disability, and nutrition needs.

– **How can REAP help?**
  - REAP can help find out if someone is eligible for Medicaid, Child Health Plus or commercial insurance plan through the New York State of Health insurance marketplace
  - If someone is not eligible for any government insurance programs, REAP will see if they are eligible for Mount Sinai’s Financial Assistance Program and help apply
  - REAP can also help with questions about Medicare as well as other public benefit programs like SNAP (food stamps), cash benefits like SSI & TANF (welfare)
  - You can access REAP through the Command Center or by calling them directly at 212-423-2800 on Monday through Friday from 9 am to 5 pm

▶ Connect your patients to local Community Resources:

– Our PPS can provide information on appropriate clinical, non-clinical and social support services for your patients through our Community Resource Guide. The resources are key to addressing the social factors that may impact your patient’s medical condition. For e.g. if your member or patient needs social services such as food pantry, you can search the resource guide and provide the member with a list of pantries near his/her location.

▶ Receive live support for your Community Gateway and DSRIP needs:

– Our PPS is available to answer questions about DSRIP, Mount Sinai PPS, and contracting for our partners.
  – Community Gateway assistance is available 24 hours, 7 days a week with technical questions and issues.
Next steps for accessing Health Home services

- Identify those Medicaid recipients (including Dual Eligible, FIDA, HARP, MLTC) Clients or Members who could benefit from these services.

- Collect the demographic information from them.

- Call the Mount Sinai Command Center 844-674-7463 to enroll the client or member.
Appendix
What do the services mean?

- **Comprehensive Care Management:** Individuals who would benefit from a Health Home, assessing patients’ medical and non-medical needs, developing patient-centered care plans, and assigning roles in patient care. Patients and/or caregivers should be actively involved in the development of the care plan, which should reflect the health goals and values of the patient.

- **Care Coordination and Health Promotion:** Care coordination is carried out by a dedicated staff member who helps patients and providers follow the care plan. A care coordinator should help patients set and keep appointments, adhere to medication plans, and communicate with providers and family members. Care coordinators or managers also ensure effective cooperation and communication among providers. Health promotion is prevention-focused education and support for the patient and family, and it should be specific to the patient’s chronic conditions and risk factors.

- **Comprehensive Transitional Care:** Comprehensive transitional care involves coordination and follow-up among providers, caregivers, and the patient when she leaves an inpatient facility or is transferred. A patient who is moving from a hospital to her home or to a nursing home often has new care needs and new medications and therefore requires follow-up appointments.

- **Patient and Family Support:** Individual and family support services focuses on clear, effective, and culturally and linguistically appropriate communication among providers, the patient, and the patient’s family or caregivers. It also connects patients and caregivers with peer supports, including support groups, self-care programs, and peer specialists.

- **Referral to Community and Social Support Services:** Referral to community and social support services helps patients to obtain and maintain the non-medical resources they need to lead healthy lives. Health Homes should refer patients to resources such as long-term services and supports, disability benefits, nutrition assistance, education, housing, and legal services.

Source: [https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cm_standards.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cm_standards.pdf)
## List of Health Home Chronic Conditions

- Acquired or Congenital Hemiplegia and Diplegia
- Acquired or Congenital Paraplegia
- Acquired or Congenital Quadriplegia
- Acute Lymphoid Leukemia w/wo Remission
- Acute Non-Lymphoid Leukemia w/wo Remission
- Alcoholic Liver Disease
- Alcoholic Polyneuropathy
- Alzheimer's Disease and Other Dementias
- Angina and Ischemic Heart Disease
- Anomalies of Kidney or Urinary Tract
- Apert's Syndrome
- Aplastic Anemia/Red Blood Cell Aplasia
- Ascites and Portal Hypertension
- Asthma
- Atrial Fibrillation
- Attention Deficit / Hyperactivity Disorder
- Autism
- Benign Prostatic Hyperplasia
- Bi-Polar Disorder
- Blind Loop and Short Bowel Syndrome
- Blindness or Vision Loss
- Bone Malignancy
- Bone Transplant Status
- Brain and Central Nervous System Malignancies
- Breast Malignancy
- Burns - Extreme
- Cardiac Device Status
- Cardiac Dysrhythmia and Conduction
- Disorders
- Cardiomyopathy
- Cardiovascular Diagnoses requiring ongoing evaluation and treatment
- Cataracts
- Cerebral Palsy
- NOS Cerebrovascular Disease w or w/o Infarction or Intracranial Hemorrhage
- Chromosomal Anomalies
- Chronic Alcohol Abuse and Dependency
- Chronic Bronchitis
- Chronic Disorders of Arteries and Veins
- Chronic Ear Diagnoses except Hearing Loss
- Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses
- Chronic Eye Diagnoses
- Chronic Gastrointestinal Diagnoses
- Chronic Genitourinary Diagnoses
- Chronic Gynecological Diagnoses
- Chronic Hearing Loss
- Chronic Hematological and Immune Diagnoses
- Chronic Infections Except Tuberculosis
- Chronic Joint and Musculoskeletal Diagnoses
- Chronic Lymphoid Leukemia w/wo Remission
- Chronic Metabolic and Endocrine Diagnoses
- Chronic Neuromuscular and Other Neurological Diagnoses
- Chronic Neuromuscular and Other Neurological Diagnoses
- Chronic Non-Lymphoid Leukemia w/wo Remission
- Chronic Obstructive Pulmonary Disease and Bronchiectasis
- Chronic Pain Chronic Pancreatic and/or Liver Disorders (Including Chronic Viral Hepatitis)
- Chronic Pulmonary Diagnoses
- Chronic Renal Failure
- Chronic Skin Ulcer
- Chronic Stress and Anxiety Diagnoses
- Chronic Thyroid Disease
- Chronic Ulcers
- Cirrhosis of the Liver
- Cleft Lip and/or Palate
- Congestion Diagnoses
- Cocaine Abuse
- Colon Malignancy
- Complex Cyanotic and Major Cardiac Septal Anomalies
- Conduct, Impulse Control, and Other Disruptive Behavior Disorders
- Congestive Heart Failure
- Connective Tissue Disease and Vasculitis
- Coronary Atherosclerosis
- Coronary Graft Atherosclerosis
- Crystal Arthropathy
- Curvature or Anomaly of the Spine
- Cystic Fibrosis
- Defibrillator Status
- Dementia
- Depression
- Depressive and Other Psychoses
- Developmental Delay NOS / NEC / Mixed Developmental Language Disorder
- Diabetes w/wo Complications
- Digestive Malignancy
- Disc Disease and Other Chronic Back Diagnoses w/wo Myelopathy
- Diverticulitis
- Drug Abuse Related Diagnoses
- Ear, Nose, and Throat Malignancies
- Eating Disorder
- Encephalopathy
- Endometriosis and Other Significant Chronic Gynecological Diagnoses
- Enterostomy Status
- Epilepsy
- Esophageal Malignancy
- Extrapyramidal Diagnoses
- Extreme Prematurity - Birthweight NOS
- Fitting Artificial Arm or Leg
- Gait Abnormalities
- Gallbladder Disease
- Gastrointestinal Anomalies
- Gastrosomy Status
- Genitourinary Malignancy
- Genitourinary Stoma Status
- Glaucoma
- Gynecological Malignancies
- Hemophilia Factor VIII/IX
- History of Coronary Artery Bypass Graft
- History of Hip Fracture Age > 64 Years
- History of Major Spinal Procedure History of Transient Ischemic Attack

**Source:** https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/eligibility_criteria_hh_services.pdf
List of Health Home Chronic Conditions

- HIV Disease
- Hodgkin's Lymphoma
- Hydrocephalus, Encephalopathy, and Other Brain Anomalies
- Hyperlipidemia
- Hypertension
- Hyperthyroid Disease
- Immune and Leukocyte Disorders
- Inflammatory Bowel Disease
- Intestinal Stoma Status
- Joint Replacement
- Kaposi's Sarcoma
- Kidney Malignancy
- Leg Varicosities with Ulcers or Inflammation
- Liver Malignancy
- Lung Malignancy
- Macular Degeneration
- Major Anomalies of the Kidney and Urinary Tract
- Major Congenital Bone, Cartilage, and Muscle Diagnoses
- Major Congenital Heart Diagnoses Except Valvular
- Major Liver Disease except Alcoholic
- Major Organ Transplant Status
- Major Personality Disorders
- Major Respiratory Anomalies
- Malfunction Coronary Bypass Graft
- Malignancy NOS/NEC
- Mechanical Complication of Cardiac Devices, Implants and Grafts
- Melanoma
- Migraine
- Mild / Moderate Mental Retardation
- Multiple Myeloma w/wo Remission
- Multiple Sclerosis and Other Progressive Neurological Diagnoses
- Neoplasm of Uncertain Behavior
- Nephritis
- Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's
- Neurofibromatosis
- Neurogenic Bladder
- Neurologic Neglect Syndrome
- Neutropenia and Agranulocytosis
- Non-Hodgkin's Lymphoma
- Obesity
- Opioid Abuse
- Osteoarthritis
- Osteoporosis
- Other Chronic Ear, Nose, and Throat Diagnoses
- Other Malignancies
- Pancreatic Malignancy
- Pelvis, Hip, and Femur Deformities
- Peripheral Nerve Diagnoses
- Peripheral Vascular Disease
- Persistent Vegetative State
- Pervasive Development Disorder
- Phenylketonuria
- Pituitary and Metabolic Diagnoses
- Plasma Protein Malignancy
- Post Traumatic Stress Disorder
- Prematurity - Birthweight < 1000 Grams
- Progressive Muscular Dystrophy and Spinal Muscle Atrophy
- Prostate Disease and Benign Neoplasms - Male
- Prostate Malignancy
- Psoriasis
- Psychiatric Disease (except Schizophrenia)
- Pulmonary Hypertension
- Recurrent Urinary Tract Infections
- Reduction and Other Major Brain Anomalies
- Rheumatoid Arthritis
- Schizophrenia
- Secondary Malignancy
- Secondary Tuberculosis
- Severe / Profound Mental Retardation
- Sickle Cell Anemia
- Significant Amputation w/wo Bone Disease
- Significant Skin and Subcutaneous Tissue Diagnoses
- Spina Bifida w/wo Hydrocephalus
- Spinal Stenosis
- Spondyloarthropathy and Other Inflammatory Arthropathies
- Stomach Malignancy
- Tracheostomy Status
- Valvular Disorders
- Vasculitis
- Ventricular Shunt Status
- Vescicostomy Status
- Vesicoureteral Reflux

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