Health Home At-Risk Intervention Program

IMPLEMENTATION TOOLKIT
For Health Homes
Last Updated: April 17, 2017

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# Implementation Toolkit for Health Homes: Health Home At-Risk Program

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HOW TO USE THIS IMPLEMENTATION TOOLKIT

This Implementation Toolkit: Health Home At-Risk Intervention Program was developed by OneCity Health to help New York State Department of Health (NYS DOH) designated Medicaid Health Homes and their subcontracted Care Management Agencies to collaborate with primary care practices to leverage Health Home At-Risk (or Health Home) services for the improvement of patient outcomes. This Toolkit explains the services that will be provided through the Health Home At-Risk program and provides Standard Operating Procedures for Health Homes expanding their eligibility criteria and in supporting robust care coordination with primary care practices.

The intended audience for this toolkit includes administrative and care coordination staff at Health Homes and Care Management Agencies.

A separate implementation toolkit has been created to guide primary care practices in building high-functioning interfaces with Health Homes in order to better coordinate patient care across a continuum of services.
OVERVIEW: HEALTH HOME AT-RISK PROGRAM

PROJECT OBJECTIVE

The Health Home At-Risk (HHAR) program builds on the Health Home model to include patients that do not qualify for care coordination services from New York State’s Medicaid Health Home program. These are patients who may have a single chronic condition (e.g. asthma, diabetes, hypertension), but are on a trajectory of decreasing health and/or at risk for developing another chronic condition. Providers may identify patients to refer to HHAR based on known social risk factors, behavioral health conditions requiring community based support, loss to follow up, and/or poor disease control management, as well as other factors that may necessitate care coordination services. The project will be implemented for all appropriate patients regardless of insurance status.

This project will expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care coordinators from Health Homes) to meet the individual needs of higher risk patients by:

- Extending care coordination services to patients who have one chronic disease and are at risk of worsening health
- Facilitating communication and coordination between primary care sites and Health Homes
- Enhancing the integration of social services into primary care, drawing on Health Home capabilities and the OneCity Health Performing Provider System (PPS) network

Participating primary care sites will have met NCQA 2011 accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by DSRIP Year 3. Participating Health Homes are lead Health Home agencies within New York City and their contracted partner Care Management Agencies who will expand their resources to include the Health Home At-Risk program.

⚠️ This toolkit describes functional roles for Health Home At-Risk care coordination and the liaising role between the primary care site and a Health Home. The functions described throughout this toolkit may be fulfilled by individuals with a variety of job titles.
HEALTH HOME AT-RISK POLICIES AND STANDARD OPERATING PROCEDURES

CRITERIA FOR HHAR ADMISSION

Patients who will be referred to the HHAR program may include those who have one chronic condition and appear to be at risk of worsening health, as evidenced by:

- Poor control of chronic disease and/or medication adherence despite primary care team intervention
- Newly diagnosed chronic disease and known needs relating to social determinants of health (e.g. housing insecurity/homelessness, transportation needs, domestic violence, etc.)
- Social risk factors that impede patient’s ability to self-manage
- Behavioral health conditions that require community-based support
- Loss to follow-up/2 or more missed appointments with provider
- Low health literacy/lack of understanding of chronic disease
- Missed follow up appointment post diagnostic procedure
- Frequent visits to the ED/recent inpatient stay

❗️ Health Home At-Risk services are intended for all appropriate Medicaid and uninsured patients. Individuals who are not eligible for Health Home enrollment due to an uninsured status and an inability to enroll in Medicaid may be referred to HHAR. Duplicative care management resources a patient may already be receiving should be determined prior to enrollment in HHAR.

Although the initial focus of this project is in the primary care settings, HHAR referrals may also be accepted from other clinical settings. Referrals may be identified and made to the HHAR program through other OneCity Health initiatives (e.g. Project 11, ED Care Triage, Care Transitions).

PATIENT IDENTIFICATION AND REFERRAL

Primary care sites will be asked to implement standard processes to identify and refer high-risk patients in need of care coordination, an integral component of strengthening primary care services provided to patients. In this project, these patients are initially known to have a single chronic disease and appear to have declining health and increasing health care needs.

Sources of patient identification may include: primary care clinics and provider panels; existing or new population health registries; administrative data; identification of patients who are lost-to follow-up or with poor continuity of care among providers, bottom-up referrals from community partners. Additionally, other OneCity Health initiatives within partner sites may lead to patient identification and referral of high-risk patients to the HHAR project. Referrals made for the Health Home program may also result in enrollment into HHAR when more suitable; likewise, patients referred to HHAR may result in enrollment in the Health Home program when eligible.
Patient referrals will follow the same process as Health Home referrals. Patients may be identified and referred to a lead Health Home or directly to a Care Management Agency (CMA) or via warm-handoff to Health Home staff. Care coordinators will determine whether the patient should be enrolled in Health Home or the HHAR program based on eligibility requirements. Patients may also be identified and referred to a Health Home, CMA, or care coordinator using OneCity Health’s Care Management Screening Tool (See Appendix A: Care Management Screening Tool).

**COLOCATION**

Care coordinators may be physically co-located at a primary care site for a determined amount of time/days to enable warm handoffs and seamless care coordination and integration. Colocation may serve to support the formation of working relationships between the Primary care team and care coordinator and to enhance knowledge of primary care site resources. If a primary care site chooses to work closely with a particular lead Health Home or CMA, prior existing relationships will be considered.

A patient may choose to be referred to any lead Health Home or CMA within the OneCity Health Network and consideration of patients’ language capabilities, geographic region, prior relationship or experience working with a particular agency, etc. shall be considered when assigning patients. A patient will not be obligated to work with that particular care coordinator, CMA, or Health Home despite a colocation agreement.

Primary Care sites will consider the following prior to establishing colocation of a care coordinator: physical space for a care coordinator, clinic volume, security badge/clearance needed, phone/computer/wifi access, etc.

**COMMUNICATION AND COLLABORATION**

Communication between the primary care team and HHAR staff will be key to improving outcomes for shared patients.

Health Home lead agencies or their subcontracted CMAs will be expected to collaborate with primary care sites to educate staff on their capabilities including acceptance and screening of referrals and coordination and navigation of medical, behavioral health, social and family support services. Care Coordinators will make themselves available to primary care sites for regularly scheduled coordination sessions and ongoing communication needs.

Primary care sites will be asked to designate a primary care team member as a care management liaison. This individual will be a clinical member of the team and will serve as the interface between the primary care site and the Health Home (including the lead Health Home agency, CMA staff, and individual care coordinators). This role is meant to streamline communication between care coordinators and providers, while ensuring a communication feedback loop is present and both providers and care coordinators receive important patient care updates.
The role of the primary care site’s care management liaison will be to ensure a communication feedback loop is present and that providers and care coordinators receive important updates affecting patients’ care and care plans.

OUTREACH

Outreach will occur within four calendar days following receipt of a patient referral and may occur as needed for up to 30 calendar days. Three or more escalated and varied outreach attempts will occur during the first 30 days in order to engage the patient in HHAR services. If completion of a comprehensive assessment and care plan does not occur within 30 days of outreach attempts, outreach efforts will cease.

Standards of outreach, including protection of HIPAA and conducting escalated outreach as needed, will be consistent with those determined by the lead Health Homes. Examples of acceptable methods of outreach are either telephonic or face-to-face and include:

- Telephonic outreach to patient, known contacts/providers
- Home visits to identified patient home address
- Provider office visits
- Request of information from emergency room, hospitals, morgue(s)
- Contact with Managed Care Organization (MCO) (consent must be intact for MCO outreach)

CARE COORDINATION

Primary care sites will be provided with Health Home care coordination resources for their eligible patients through OneCity Health’s partnerships with lead Health Homes. The Health Home lead agencies will select subcontracted CMAs to provide care coordination services to primary care sites based on a
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track record of delivering high quality services, intake capacity, and interest in participating in this initiative.

HHAR staff are meant to enhance, not replace, primary care team functions and any existing care management resources. These additional resources can work closely with patients to address disease management and social determinants of health, including increasing linkages to community-based support. HHAR staff may be centrally based at a Health Home lead agency or at a subcontracted CMA, or co-located at a primary care site.

Care coordination for HHAR patients will comply with NYS’ standards for Health Home care coordination and health promotion, as outlined in the “Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations” [October 5, 2015].

Care coordination services will be provided for up to six months and will address social, behavioral, medical, coordination, adherence or self-management issues of a patient that cannot be addressed optimally within the primary care team. Services may include:

- Health promotion
- Support for ongoing medical management provided by primary care team
- Transitional care including appropriate follow-up from inpatient to other settings
- Patient and family support
- Referral to community and social support services
- Use of health information technology to link services

Evidence of two or more care coordination activities is expected each month, as documented in the care management software, and may include:

- Contacts (face-to-face or telephone)
- Health promotion activities
- Development of a care plan; and/or
- Active work towards achieving care plan goals

At a minimum, one face to face encounter must occur between the care coordinator and the patient during the first month of enrollment.

Because it is anticipated that the care coordination needs of HHAR patients may be less intensive than those enrolled in Health Home, it is likely that care coordination services provided to a HHAR patient will reduce in intensity over time based on patient need and provider input. Intensity and duration of care coordination services provided should be determined based on the patient’s needs, care plan developed, as well as regular input provided by the patient’s care team and/or care management liaison. While the majority of the care coordination occurrences may occur telephonically, at least one face-to-face meeting between the patient and care coordinator will occur.
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OneCity Health recommends that CMAs identify a care coordinator, when possible, to exclusively carry a HHAR caseload and that caseloads do not exceed 65 patients. If a care coordinator does carry a caseload that includes both Health Home and Health Home At-Risk patients (e.g. following an escalation from HHAR to Health Home enrollment so as not to disrupt patient continuity), consideration must be taken of the varying levels of services the patients may require and appropriate caseloads assigned.

A comprehensive care plan will be developed for each patient receiving HHAR services in order to engage him/her in care and to reduce patient risk factors. The care plan should be updated at least once every thirty days while a patient is enrolled in HHAR.

Note: Certain social risk factors may be identified during the assessment process and require the provision of more intensive care coordination services. The Health Home shall be compensated with an additional monthly add-on reimbursement if one or more of the following risk factors are identified (and verified by the Health Home with appropriate documentation):

- Homelessness (meets category 1 or 2 as defined by the United States Department of Housing and Urban Development)
- Incarceration within the past 12 months
- Inpatient stay for Substance Use Disorder (SUD) treatment within the past 12 months
- Inpatient behavioral health stay within the past 12 months

ASSESSMENTS AND CARE PLANS

A patient enrolled in the HHAR program requires the following assessments which should be completed within time frames indicated following referral:

1. Intake Assessment: within thirty calendar days of receiving patient referral (See Appendix B: Intake Assessment Tool).
2. Comprehensive Assessment: within 30 calendar days of enrollment (See Appendix C: Comprehensive Assessment Tool Guidance and Appendix D: Comprehensive Assessment Tool)*
3. Care plan: developed within 30 calendar days of enrollment

SUPERVISION

All care coordinators working with OneCity Health HHAR patients must have an identified supervisor within the CMA. If a care coordinator is collocated within a Primary Care site, an identified staff member within that site must assume responsibility for the coordinator while onsite.

CARE MANAGEMENT PLATFORM

To track referral and enrollment data for all of OneCity Health’s HHAR patients, CMAs will have the option to use a prescribed Centralized Care Management Systems (CCMS), GSI Health, or an alternative care management platform if already in use (which meets minimum standards for interoperability and reporting).
All CMAs choosing to use GSI will be provided access to and training in the platform. Only authorized personnel will have access to the clinical data in GSI. Authorized personnel will be assigned unique usernames and passwords and access levels will be administered by this specific individual log-on. Before access is provided to GSI, all staff must complete a full day training. Whenever an employee leaves or transfers, the employee’s user ID/password is disabled and access is no longer available to the database. Patient data in GSI is also protected under NYC Health + Hospitals Protected Health Information (PHI) policy.

To request user training in GSI Health, please contact the OneCity Health support desk at ochsupportdesk@nychhc.org or (646) 694-7090. A template will be provided that will ask for the name, title, work address, phone, email and gender of each user so that a training can be appropriately scheduled.

If a CMA elects to use another care management platform, it must be compatible with transfer of data to GSI and approved by OneCity Health. The Health Home lead will be responsible for collecting HHAR tracking data from the CMA and submitting it to OneCity Health on a monthly basis in a standardized format that can be aggregated and harmonized with data from GSI. Data will be due five business days after the end of the reporting month. All reports for HHAR activities will be run by OneCity Health via GSI. OneCity Health will provide all data points that must be collected (See Appendix E: Master Data Management Template).

QUALITY ASSURANCE

Health Home leads will be responsible for assessing partner CMAs’ quality standing and capacity to accept HHAR patients on an ongoing basis. Consistent with the Health Home program, Health Home Leads will be expected to conduct appropriate quality assurance for CMAs and to implement corrective action plans as needed. Health Home leads are prohibited from providing HHAR assignments to CMA partners who are currently on suspension from receiving Health Home assignments.

REPORTING REQUIREMENTS

OneCity Health will report to the New York State Department of Health (NYS DOH) the total number of participating HHAR patients who completed a new or updated comprehensive care plan per 12 month period. (Duplicate counts of patients are not allowed per year).

Data will be downloaded by OneCity Health via GSI and submitted to NYS DOH on behalf of all partners. If not using GSIHealth, partner will submit data via approved Data Upload Template on a monthly basis.

TRAINING
HHAR staff are expected to be trained in accordance with existing Health Home standards in providing HHAR care coordination services prior to building caseloads. Trainings will be provided directly by the Health Home lead and/or by OneCity Health.

Health Homes are responsible for submitting to OneCity Health outlines describing trainings provided to care coordination staff. OneCity Health may request attendance sheets, including the name of CMAs and care coordinators trained.

At a minimum, trainings should include the following topics:

- Care Coordination basics with a concentration on documentation, conducting referrals, and medication reconciliation for the non-clinician
- Care Plan development (involvement of the care team and priority setting)
- Goal setting (identifying and meeting mutual goals)
- Case conference (how to lead/initiate a care conference with care team members particularly after critical events i.e. ED visit, hospital admission, incarceration, eviction, etc.)
- Chronic disease management (overview of chronic medical conditions)
- Motivational Interviewing
- Health Advocacy
- Navigating community resources (including those for the uninsured)
- Care Management Software*

*GSI Health Training will be provided by OneCity Health; trainings on alternative care management platforms will be provided by the lead Health Home.

DISENROLLMENT AND GRADUATION FROM HHAR

Graduating a patient from HHAR should be determined by the care coordinator in consultation with both the care team and the patient, and in consideration of whether the patient’s goals have been met. A patient can spend no more than six months in the Health Home At-Risk program. If a patient requires additional care coordination services following this period, eligibility for Health Home enrollment should be considered. A case conference with the patient’s care team or clinic’s care management liaison may also occur to explore alternative options.

Examples of reasons for disenrollment include:

- The patient no longer wants to be enrolled in the HHAR Program
- The patient becomes eligible for a NYS DOH Medicaid Health Home Program
- The patient neglects to respond to 3 escalated care coordination attempts over the course of 30 calendar days
- The patient has been enrolled in HHAR for six months
LOST TO SERVICE AND REENROLLMENT

If a HHAR patient is not engaged in care coordination service attempts for 30 days, this member will be considered lost to service.

A patient may enroll in HHAR more than once, as needed.

ESCALATION OF CARE: TRANSFER FROM HHAR TO HEALTH HOME

A patient should be transferred from HHAR to the Medicaid Health Home program if s/he develops a second chronic disease, HIV/AIDS and/or serious persistent mental illness (SPMI), and has active Medicaid. A HHAR patient with the above mentioned clinical requirements who is not eligible for Health Home due to inability to enroll in Medicaid should be transferred to Health Home if active Medicaid status is obtained.

INFORMATION SHARING AND CONSENT

HHAR staffs must document all referral and enrollment data for all OneCity Health HHAR patients in the care management system. OneCity Health will provide all interested partners with a centralized care management platform, GSI Health. A CMA may elect to use an alternate care management platform that is capable of exchanging data with GSI and is approved by OneCity Health.

The following consent forms, and respective Health Homes, are required for all Health Home At-Risk enrollees:

1) New York Care Information Gateway (NYCIG) Regional Health Information Organization (RHIO) [formerly Interboro RHIO] Consent (All Health Homes)
2) NYC Health + Hospitals Authorization to Use, Receive and Disclose Health Information for Treatment, Payment and Healthcare Operations (Form TPO 2849) (H+H At-Home only)
3) Partner-specific HIPAA compliant consent (DSRIP Community Partners only (Non At-Home))

Care coordinators will verify consent forms were obtained and upload documents into the care management system. See the “Consent and Information Sharing Documentation Workflow for OneCity Health (Delivery System Reform Incentive Payment [DSRIP] Program)” and the “Summary of Documents Governing Sharing, Privacy and Confidentiality of Protected Health Information” forms for additional information and workflows.

WITHDRAWAL OF CONSENT/DIS-ENROLLMENT

The HHAR program does not require a patient to sign an enrollment form. As such, the patient does not need to sign a disenrollment form or withdrawal of consent form. If a member wishes to no longer be in the HHAR program or is lost to follow up, the care coordinator should close the patient in the care management platform, in accordance with Health Home protocol.
Many policies and procedures for the HHAR program may mirror those that the lead Health Homes have already established. These may include, but are not limited to:

OneCity Health
- HIPAA, Protecting Patient Information (PHI), and Notice of Privacy Practice (NPP)
- Activities around engagement
- Care planning
- Case conferencing
- Benefits assistance
- Care transitions
- Internal and external care coordination transfers
- Discharge planning, documentation standards
- After hours coverage
- Staff training
- Conflicts of interest

OneCity Health will request all Health Homes to submit copies of their Comprehensive Assessment, Care Plan, and Case Conference Policy prior to accepting patients.
# APPENDIX A: KEY TASKS CHECKLIST

## STEP 1: PREPARATION

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<tr>
<th>Key Tasks</th>
<th>Owner</th>
<th>Deadline</th>
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<tr>
<td>- Identify partner CMAs to provide HHAR services and assess capacity and scale-up staffing needs</td>
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<td>- Identify users to be trained in GSI, as applicable</td>
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<td>- Submit a copy of the Case Conference Policy and Comprehensive Assessment and Care Plan used</td>
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<td>- Receive approval from OneCity Health regarding alternative care management software system for Health Homes not using GSI and develop workflow for monthly data transfer to OneCity Health on the 5th of every month</td>
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## STEP 2: INTERVENTION DEVELOPMENT

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<th>Key Tasks</th>
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<th>Deadline</th>
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<tr>
<td>- CMA Staffing and resource needs addressed</td>
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<td>- Staff trained, in accordance with Health Home training standards</td>
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<td>- New GSI users scheduled for training, as applicable</td>
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<td>- Ensure colocation logistics (e.g. physical space for a care coordinator, clinic volume, security badge/clearance needed, phone/computer/wifi access, etc.) are addressed</td>
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<td>- Convene planning meetings with primary care partner to design a high-functioning interface</td>
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<td>- Educational presentations held for primary care sites, as needed, and culturally competent materials provided</td>
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<td>- Develop communication workflow with Primary Care site</td>
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## STEP 3: LAUNCH, SCALE, AND TRACK

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<th>Key Tasks</th>
<th>Owner</th>
<th>Deadline</th>
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<tr>
<td>- Communication and referral workflows between Health Homes/CMAs and primary care sites launched</td>
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<td>- Determine process for regularly monitoring workflows, referrals, and quality of HHAR services</td>
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### APPENDIX B: HEALTH HOME AT-RISK KEY ROLES AND RESPONSIBILITIES

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<tr>
<th>Individual/Group</th>
<th>Roles and Responsibilities</th>
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<tr>
<td><strong>Implementation Lead at Primary Care Practice</strong></td>
<td>- Engage, educate and lead others within the practice in the practice-level implementation</td>
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<td>- Engaging with clinical and administrative leadership to advocate for implementation time and resources, and to provide progress reports</td>
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<td></td>
<td>- Collaborating with OneCity Health and/or the Health Home Lead Agency to access support, training and materials for implementation</td>
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<td>- Ensuring that any necessary trainings are conducted for the primary care sites</td>
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<td>- Monitoring and troubleshooting implementation progress</td>
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<td>- Collaborating with clinical staff to ensure they have the tools and resources needed to successful comply with workflow and/or documentation</td>
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<td>- Providing feedback to OneCity Health regarding the design and implementation support for this transformation work</td>
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<td>- Designate a team member to serve as the Care Management Liaison (see description of this role in the Implementation Toolkit)</td>
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<td>- Assess patient need and when (days and hours) to collocate a care coordinator within the primary care clinic</td>
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<td>- Ensure Care Coordinator in incorporated into daily Huddles and pre-visit planning</td>
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<td><strong>Clinical Champion at Primary Care Practice</strong></td>
<td>- A physician/NP/RN who informs the design and implementation of the transformation work</td>
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<td>- Shaping design decisions that require insight into clinical care</td>
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<td>- Ensuring that processes are designed in a way that support providers’ work</td>
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<td>- Communicating to physicians and other clinical staff regarding their role in this transformation work and its potential impact on patient outcomes</td>
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<td></td>
<td>- Providing feedback to improve the design of this transformation work within the primary care practice</td>
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<tr>
<td></td>
<td>- Providing feedback to OneCity Health regarding the design and implementation support for this transformation work</td>
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<td></td>
<td>- Help incorporate Care Coordinator into daily Huddles and pre-visit planning</td>
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<tr>
<td><strong>Care Management Liaison at Primary Care Site</strong></td>
<td>- A clinical member of the primary care team who will serve as the primary point of contact on behalf of the primary care team with the Health Home and its care coordinators</td>
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<td>- Enable access to and continuity of communication between the primary care team and the Health Home care coordinators, in the interest of improving outcomes of their shared patients</td>
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| Care Management Liaison at Primary Care Site (cont.) | • Ensuring referrals are completed for patients identified as needing Health Home At-Risk (or Health Home) services  
• Scheduling regular times to communicate with the Health Home care coordinators to collaborate in meeting patients’ needs:  
  o Providing updates on treatment plans to the care coordinators, as needed (e.g., updated medication lists, self-management recommendations such as diet and exercise)  
  o Ensuring that the primary care team responds quickly to patient needs identified by the care coordinator (e.g., prescription changes, prior authorizations, referral forms, responses to side effects)  
  o Informing care coordinator of upcoming appointments and specialist referrals, so that the care coordinator can support the patient in attending such appointments  
• Arrange for direct conversations with physician and/or other key providers for complex cases |
| Care Coordinator | • Conduct outreach and enrollment of referred patients. Receive warm-hand offs during collocated hours in the primary care clinic  
• Provide care management services to help steer at-risk patients back on track  
• Provide regular updates to the care management liaison on patient enrollment status (enrollment, disenrollment, and graduation) and care plan updates. Conduct case conferences with the primary care team as appropriate  
• Participate in primary care clinic’s daily Huddles and conduct pre-visit planning |
| Lead Health Home Agency | • Provide quality oversight of care management services  
• Provide training for Care Coordinators  
• Ensure appropriate level of care management staff are available for the practice’s patients  
• Provide care management software and training  
• Monitor and track referral and enrollment data |
| OneCity Health | • Provide trainings and relevant supporting materials for Health Home and primary care staff  
• Conduct provider engagement and project buy-in throughout PPS network  
• Monitor and track referral and enrollment data via GSI Health  
• Provide reimbursements for care coordination provided and metrics met |
### APPENDIX C: SUMMARY OF HEALTH HOME AT-RISK PROGRAM REQUIREMENTS

#### Referral & Outreach
- **≤4 calendar days of receiving referral:** 1st outreach attempt to a referred patient must occur
- **≤30 calendar days of receiving referral:** Minimum of 3 escalated and varied outreach attempts must be made and documented
  - Outreach attempts should cease if a comprehensive assessment and care plan are not completed within 30 calendar days of receiving referral

#### Initial Assessment & Enrollment
- **≤30 calendar days of receiving referral:** Complete an initial/intake assessment for referred patients to determine eligibility and enroll patients as appropriate
  - Communicate update on enrollment status to referring primary care team
  - Upload appropriate consents upon enrollment (e.g. RHIO consent form, the New York City Health + Hospitals consent form, and any applicable Care Management Agency consent form)

#### Comprehensive Assessment & Care Plan
- **≤30 calendar days of enrollment:** Complete the comprehensive assessment and create a care plan
  - Document social risk factors tied to monthly add-on reimbursements as appropriate
  - Document care team, which at a minimum includes the assigned care coordinator and primary care provider

#### Care Coordination
- Encounters (may occur telephonically or in-person)
  - At least 1 face to face encounter will occur within the **first 30 days of enrollment**
  - At least 2 care coordination activities will be documented every 30 days
- Document progress of care plan goals throughout enrollment at least once every 30 calendar days
- Prior to graduation, at least one case conference with primary care team should be conducted

#### Graduation or Disenrollment
- **Enrollment in Health Home At-Risk cannot exceed six months**
- Graduation should be determined in consultation with the care team and the patient, and in consideration of whether the patient’s goals have been met
- If patient becomes eligible for NYS DOH Medicaid Health Home, patient will be enrolled as appropriate
### HEALTH HOME AT-RISK VS. HEALTH HOME REQUIREMENTS

<table>
<thead>
<tr>
<th></th>
<th>Health Home</th>
<th>Health Home At-Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial outreach attempt</td>
<td><em>To be completed by Health Home in accordance with its internal guidelines</em></td>
<td>• ≤4 calendar days of receiving referral</td>
</tr>
<tr>
<td>Escalated outreach</td>
<td><em>To be completed by Health Home in accordance with its internal guidelines</em></td>
<td>• Minimum of 3 escalated and varied outreach attempts must occur within ≤30 calendar days of receiving referral</td>
</tr>
<tr>
<td>Initial Assessment &amp; Enrollment</td>
<td><em>To be completed by Health Home in accordance with its internal guidelines</em></td>
<td>• ≤30 calendar days of receiving referral</td>
</tr>
<tr>
<td>Comprehensive Assessment &amp; Care Plan</td>
<td><em>To be completed by Health Home in accordance with its internal guidelines</em></td>
<td>• ≤30 calendar days of enrollment</td>
</tr>
</tbody>
</table>
| Encounters                           | *To be completed by Health Home in accordance with its internal guidelines* | • At least 1 face to face encounter will occur within the first 30 days of enrollment  
• At least 2 care coordination activities will be documented every 30 days |
| Care Coordination                    | *To be completed by Health Home in accordance with its internal guidelines* | • Document progress of care plan goals at least once every 30 calendar days        |
| Enrollment Period                    | *To be completed by Health Home in accordance with its internal guidelines* | • Enrollment in Health Home At-Risk cannot exceed six months                        |
APPENDIX D: CARE MANAGEMENT SCREENING TOOL

Care Management Screening Tool

Please tell us how we can better help you be healthy.

To determine which resource best fits your needs, please complete the following form.

**Patient Information**

Name: ____________________________  Date of Birth: ________  Gender: _________

Phone Number 1: ____________________________  Preferred Language: ____________________________

Phone Number 2: ____________________________  Email Address: ____________________________

Address (if homeless, note the shelter/drop in center or place patient may be contacted):

__________________________________________

Additional Comments: ____________________________________________________________

☐ Check this box if you had:
  • 3 or more Emergency Room visits or hospital stays in the last 6 months (for your own health problems – do not count accompanying a family member or friend, excludes pregnancy)

☐ Check this box if you:
  • Have medical problems, such as: asthma or other breathing problems; diabetes; heart disease; or other long term medical problems
  • Have 5 or more different medications that you take every day
  • Feel you are less able to care for yourself this year than last year (cook, clean, shop, or get to a doctor’s office)
  • Have problems with your mood or feelings, do you feel sad or anxious

☐ Check this box if:
  • You currently have a problem with alcohol and drug use
  • You are homeless, or you worry that you could become homeless soon
  • You worry that you will run out of food
  • You do not feel safe at home
  • You were in jail or prison anytime in the last year
  • It is hard for you to take your medications or do what your doctor asks
  • You miss some of your doctors’ appointments
  • You have trouble remembering what people told you
  • You have trouble reading instructions from your doctor
**For Staff Use:**

Name of Person Making Referral: ________________
Organization: __________________________
Phone Number: ____________________________
Email: _________________________________

If Box 1 is checked, refer for care management assessment (regardless of other answers).
If BOTH Box 2 and Box 3 are checked, refer for care management.

Otherwise, the patient does not qualify for care management referral. In this case, please file form but do not refer. Provide further information or linkages as per your organization’s protocol.

When you refer for care management:
- [ ] Tell the patient that someone will call them.
- [ ] Send this referral form to the organizations below. Upon assessment by a care coordinator, a patient may be enrolled in care management.

Please send completed referral form to lead Health Home or participating Care Management Agency.
APPENDIX E: CASE CONFERENCE GUIDE

What is a Case Conference?

A Case Conference is a discussion among the care manager and at least one other member of the core team, such as the primary care provider, psychiatrist, therapist, social worker, case worker, or even a probation or parole officer or clergy member. A case conference can be held in response to- or in anticipation of- both clinical and non-clinical scenarios. Case conferences can occur in person, over the phone, via videoconference, or via the dashboard messaging app.

The PCP/ designee should participate in a case conference

What are some circumstances that could trigger case conference?

Case Conference should occur in response to certain triggering events. Situations that other members of the care team should be apprised of- and involved in the response plan for- should precipitate a case conference. Situations that may trigger a case conference in the 30 day-transitions period include but are not limited to:

- An emergency department visit
- An inpatient medical or psychiatric hospitalization
- An arrest
- An eviction or other event resulting in homelessness
- Physical or psychiatric decompensation
- Substance abuse relapse
- Domestic violence incident
- Harm to self or others, or threat of harm to self or others
- Patient is a victim of a crime
- Legal crisis

What should be discussed during a case conference?

Since case conferences occur around specific events, the discussion should be structured around the circumstances of the event. A case conference should address:

- Why/ how the event occurred
- The circumstances leading up to the event
- The current status of the patient
- Developing a plan to keep the patient safe
- Developing a plan to prevent a similar event from occurring again
When should a case conference occur?

An attempt to initiate/schedule a case conference should be made immediately (within 2 business days) upon learning of the event

Case Conference Example: Patient is hospitalized during the 30 day transition period.

Discuss the circumstances that led to the ED visit. The team may consider

1. Was the most recent primary care appointment broken or kept?
2. Was the visit precipitated by any of the following?
   - A medication error or other adverse drug event
   - Uncontrolled pain or psychiatric symptoms
   - Overwhelmed family care givers
   - Homelessness or other housing crisis
   - Substance use
   - Domestic violence

3. Whether the patient has palliative or end-of-life needs

4. Whether the patient has advance directives (DNR, DNI, MOLST)

Discuss how the ED visit could have been avoided

If the visit could have been avoided, evaluate the 30 day transition plan and make necessary changes. For example, ensure follow-up with PCP, arrange for respite for family caregivers, provide more education for the patient on managing their condition, provide additional medication management services, increase frequency of contact by Transition Manager, and consider referral to the Health Home to ensure the patient is followed after the 30 day transition period is over.

Follow up:

- Send a message to the team summarizing the case conference and next steps
- Document the case conference in GSIH.
APPENDIX F: HITE RESOURCE GUIDE

Website: [http://www.hitesite.org/](http://www.hitesite.org/)

The Health Information Tool for Empowerment is an online directory offering information on more than 5,000 health and social services available to low-income, uninsured, and underinsured individuals in the Greater New York area. HITE helps people connect to vital community services quickly and easily. The directory offers information on community services throughout all of New York City and Long Island in the following categories: Optical, Financial, [Health Care & Medicine](#), [Immigrant Support](#), Abuse, School, [Social Services](#), [Transportation](#), and [Wellness & Prevention](#).

HITE is a program of the not-for-profit Foundation affiliate of the [Greater New York Hospital Association (GNYHA)](#).

APPENDIX G: ONECITY HEALTH PARTNER LIST

See the [OneCity Health website](http://www.onecityhealth.org/partners/) for links to several different resources regarding the hundreds of partners that are part of the OneCity Health Performing Provider System.

APPENDIX H: HELP DESKS

GSI HEALTH HELP DESK FOR THE HEALTH HOME AT-RISK DASHBOARD

Telephone Number: 1-888-594-4612

Email Address: [Help@GSIHealth.com](mailto:Help@GSIHealth.com)

Hours of Operation: Monday through Friday 7am to 10pm ET

ONECITY HEALTH SUPPORT DESK

If you have any questions, please contact the OneCity Health support desk:

Phone Number: 646-694-7090

Email: ochsupportdesk@nychhc.org, with the subject line “Health Home At-Risk Question”

Hours of Operation: Monday through Friday from 9am to 5pm ET