Best Practices for Establishing Procedures for Referring Patients from Hospitals to the Health Home Program

Draft For Discussion Purposes

Presented to the Health Home MCO Workgroup

by the NYS DOH Health Home Program

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Health Home Program - Background

- Authorized under the Affordable Care Act by CMS.
- Implemented in January 2012 as part of the Governor's Medicaid Redesign Team (MRT) and "Care Management for All".
- New York's Health Home Program is collectively managed and administered by the:
  - Department of Health
    - Office of Health Insurance Programs (OHIP)
    - Office of Quality and Patient Safety
    - AIDS Institute
  - Office of Mental Health (OMH)
  - Office of Alcoholism and Substance Abuse Services (OASAS)

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Health Homes are a Care Management Model

- Health Homes are a care management model that consist of a network of care managers, health care providers and community support.

  - Health Homes are not a "place".

- Health Homes provide care management for high cost, high need Medicaid recipients with complex chronic health, and/or behavioral health needs (e.g., mental health, substance abuse, etc).

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Health Homes are a Care Management Model - continued

- Health Homes assign a care manager to members to facilitate and coordinate access to an inter-disciplinary array of medical care, behavioral health care, and community based social services and supports for individuals with chronic conditions.

  - Health records are shared among the Health Home's network of providers.

- Health Home care management is "whole-person" and "person-centered" and integrates a care philosophy that includes both physical/behavioral care and family and social supports to reduce costs and preventable hospitalizations while increasing quality and efficiency in NYS Medicaid program.

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Health Home - Core Services

- CMS requires that Health Home providers have the capacity to perform the following 6 Core Services:

  - Comprehensive Care Management
  - Care Coordination and Health Promotion
  - Comprehensive Transitional Care
  - Patient and Family Support
  - Referral to Community and Social Support Services
  - Use of Information Technology to Link Services

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NYS Policy Objectives of Health Homes

- Achieve the "Triple Aim" of improving health care, improving outcomes for populations, and reducing per capita costs" by:
  - Comprehensively addressing the complex needs of Medicaid recipients who qualify for Health Home services;
  - Effectively managing the health and behavioral health needs of complex high-cost populations;
  - Breaking down traditional silos in care delivery and creating partnerships that shape more coordinated health care delivery system,
  - Aligning incentives with quality and cost effectiveness
  - Bending the cost curve (i.e., reduce avoidable hospitalizations.

✓ **Hospitals, whether they are Health Homes, part of a Health Home network, and/or providers of health care to Medicaid recipients, play a key role in achieving these policy objectives.**

ACA Requirements for Establishing Procedures for Making Referrals from Hospitals to Health Homes

- Section 2703 of the Affordable Care Act (ACA) requires hospitals that are participating providers under the state plan or waiver to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated health home providers.

- This requirement applies to all hospitals, regardless of whether they participate in a Health Home provider network (i.e., it is a State Plan requirement for hospitals)

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Current Hospital Connectivity to Health Homes and Medicaid

- There are 32 Health Homes with a presence in 58 counties.

- Based on current Health Home network information, there are 190 hospitals in NYS:
  - All NYS hospitals serve Medicaid patients.
  - 125 hospitals are affiliated with Health Homes, either as a Health Home or part of a network.
  - 65 hospitals are not part of a Health Home network.

  However, these hospitals still fall under the ACA requirement and must establish procedures for making referrals to Health Homes.

- Behavioral Health Organizations (BHO) have been working with hospitals to facilitate linkages with Health Homes.

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Recommended Best Practices for Hospitals to Meet Health Home Referral Requirements

- ACA Requirement: Hospitals must establish procedures for referring patients that seek or need treatment in a hospital emergency department to a Health Home provider, but the ACA does not specify how hospitals should meet this requirement.

- The Department is not mandating a specific set of referral procedures that hospitals must follow to meet this requirement, but is working with Hospital Associations, HH/MCO Work Group, and other Stakeholders to:
  - Develop Best Practices for establishing referral procedures that ensure connectivity between Hospital patients that may be eligible for Health Homes, Hospitals, Health Homes and Plans.

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Best Practices

#1: Hospitals should establish a process to ensure there is a clinically informed, presumptive assessment about Health Home eligibility, focusing on diagnostic criteria and appropriateness for the Health Home Program

A. Health Home Eligibility (diagnostic criteria)

✓ Persons enrolled in Medicaid with:
- At least **two** chronic conditions, **or**
- HIV/AIDS, **or**
- One serious mental illness

✓ Chronic conditions (defined by the 3M Clinical Risk Group (CRG) System of Chronic Illness) include, but are not limited to:
- Mental Health condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Obesity (BMI>25)

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Best Practices - continued

B: Assessing Appropriateness for Health Home

✓ The person has significant behavioral, medical or social risk factors and can benefit from comprehensive care management services, i.e., the person is:

- At risk for adverse event, e.g., death, disability, inpatient or nursing home admission
- Inadequate social/family/housing support
- Inadequate connectivity with healthcare system
- Non-adherence to treatments or difficulty managing medications
- Recent release from incarceration or psychiatric hospitalization
- Deficits in activities of daily living
- Learning or cognition issues

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An Example of Assessing Appropriateness for Health Homes

58 year old Medicaid recipient enters Emergency Room at 03:45 a.m. Saturday – Patient's first time in the Emergency Room.

- **Symptoms**: Angina with radiating pain to the jaw
- **Diagnosis**: Diabetes; Coronary Artery Disease
- **Social Assessment**: Lives in stable housing with spouse. Several involved family members locally. Socially active. Parish nurse visits monthly. Regular follow up with primary care physician and cardiologist, including nutritional support.
- **Outcome**: Clinical evaluation completed. Patient stabilized. Physicians notified of Emergency Room visit.

58 year old Medicaid recipient enters Emergency Room at 03:45 a.m. Saturday – Patient's third visit to the Emergency Room in the past 6 months for same issue.

- **Symptoms**: Angina with radiating pain to jaw
- **Diagnosis**: Diabetes; Coronary Artery Disease
- **Social Assessment**: Lives in homeless shelter. No family or informal supports available (son lives in California but estranged). Doesn't drive. Doesn't keep appointments with primary care MD. Inconsistent use and accessibility of medications. Poor diet.
- **Outcome:** Clinical evaluation completed. Patient stabilized. Physician notified. Health Home program discussed with patient and patient agrees to a referral. Referral to Health Home initiated.

Patient is clinically eligible for a Health Home, however the clinical and social assessment of the patient do not indicate a need for the intensive coordinated care management services provided by a Health Home.

Patient is clinically eligible for Health Home, and health history and social assessment indicate that the patient would benefit from the intensive coordinated care management services provided by a Health Home.

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Best Practices - continued

#2: Hospital should implement procedures throughout the hospital (e.g., the Emergency Room , inpatient , Home Care Agency, Dialysis Unit, Urgent Care, Outpatient Clinics, etc.) to refer patients to Health Homes.

#3: To the extent possible, Hospitals should ensure real-time referrals – critical to connecting with Health Home patients that may be transient and difficult to locate.

- ✓ Health Homes and hospitals should have procedures and contracts in place to receive and make hospital referrals on a 24/7 basis.

#4: Health Homes and Managed Care Plans need to actively collaborate, communicate, and participate in the development (where appropriate) and implementation of the Hospital's procedures for making Health Home referrals.

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Best Practices - continued

#5: Hospitals should notify Health Homes when patients who are already enrolled in a Health Home visit the Emergency Room or other service unit of the Hospital.

#6: Hospitals should also notify Managed Care Plans when patients who are already enrolled in a Health Home are admitted into the hospital.

#7: As deemed appropriate, hospitals should include other entities in the referral process (e.g., local government units such as, the Office of Mental Health's Single Point of Access (SPOA) and local Department of Social Services).

Best Practice Guidance for Hospital Referrals to Health Homes

To determine Health Home enrollment status:
*Ask the patient;
*Contact the patient's MCP (if applicable);
*Check the HIE system.

Make a clinically informed, presumptive assessment about eligibility:

Step 1: Does patient have:

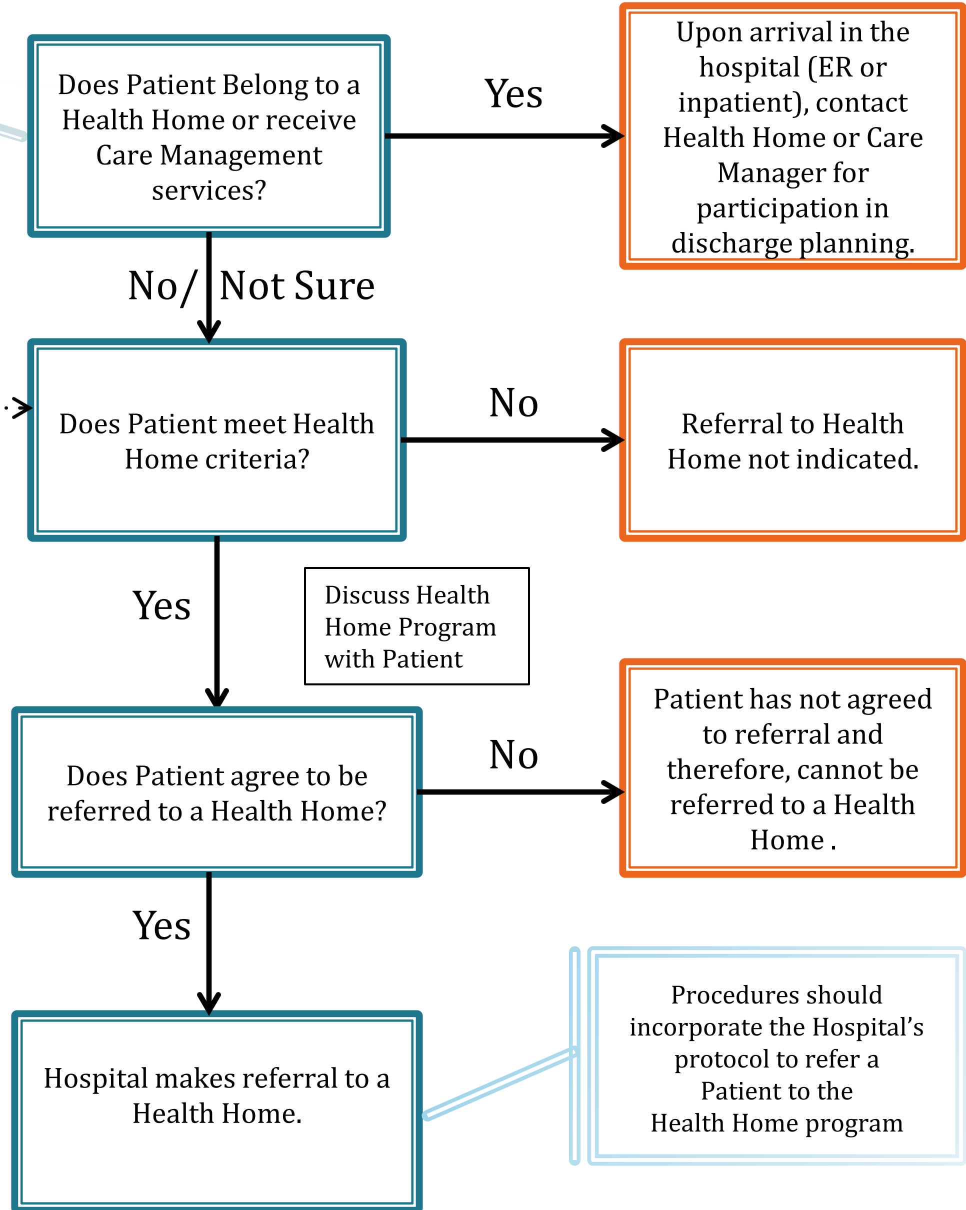
- Two chronic conditions including , but not limited to: mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI>25, or other; **or**
- HIV/AIDS ; **or**
- One serious mental illness

AND

Step 2: Assess Appropriateness for Health Home
Does patient have significant behavioral, medical or social risk factors such as:

- At risk, for adverse event (e.g. death, disability,
- inpatient or NH admission)
- Inadequate social/family/ housing support
- Inadequate connectivity with healthcare system
- Non-adherence to treatment or difficulty
- managing medications
- Recent release from incarceration or psychiatric
- hospitalization
- Deficits in activities of daily living (ADLs)
- Learning or cognition issues

NOTE: Hospitals should contact SPOA/LGU as deemed appropriate.



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Next Steps

- Obtain feedback from MCO Work Group on approaches for ensuring collaboration among Health Homes and Hospitals and Plans regarding development and implementation of Hospital referral procedures

- Prepare Webinar for New York's Hospitals

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