Health Home Service Certification Application
Guidelines

I. Name of Agency

On page one, provide the identifying information requested for your agency and list all the service locations where you will provide Health Home services.

The "Anticipated Start Date of Health Home Service" is July 1, 2017.

Put your agency's name on the top of each page

II. Health Home Service Population

The application requires that you "describe the population to be served through the Health Home based on data and your experience to date. Applicant must demonstrate an understanding of the eligible populations to be served in the Health Home by addressing key characteristics, including: Chronic medical conditions; SMI/SED; utilization rates; locations; age; and culture."

Review the definitions of SMI and SED (Criteria Checklists) provided in Appendix C.

Use the data derived from the Medicaid Claims Dataset for each of the counties you will serve.

Use your own utilization data regarding the numbers of adults served with SMI and the number of children and youth served with SED.

INSERT the following information in Section II. Health Home Service Population

Make a statement that you understand that the eligible populations include adults with SMI and children and youth with SED as described in the respective checklists found in Appendix C. [These Criteria Checklists include eligible diagnoses as well as criteria related to age, functional impairment, and duration.]

Make a statement that the data you are presenting on the key characteristics of each of these populations is derived from the Medicaid Claims Dataset, and is limited by the fact that it is based solely on the diagnosis and does not include the functional impairment or duration criteria found in the checklists.

Describe in a few sentences the data presentations in the attachment that came from the Medicaid Claims Dataset. For example, "As derived from the 2016 Claims Dataset, there were XX adults with a diagnosis of SMI in YY County. The ages of these adults… the race and ethnicity… the gender… Claims show X% with regular visits and Y% with medication visits. Chronic condition information shows…"

In the same manner, describe in a few sentences the data presentations in the attachment that came from your agency's utilization records.

Describe that you will work with the MCOs to identify both children and adults who are eligible for Health Home services.

ATTACH the following information and label it "Section II. Health Home Service Population"

Use the data summaries provided from the Medicaid Claims Dataset.

For each county you will serve, insert the data for adults with SMI diagnosis and the data for children and youth with SED diagnosis. Add a sentence or two that describes the data therein.

Using your utilization data for 2016, describe the number of adults with SMI (as defined in the Checklist) and the number of children and youth with SED (as defined in the Checklist) served by your agency. Include data on race, ethnicity, age, gender, claims (visits v. medication), and chronic conditions so as to align these data with the data provided in the Medicaid Claims Dataset. Also include a breakdown of these clients by MCO.

III. Behavioral and Physical Health Integration

A. Accreditation and Certification

COMPLETE the chart in Part A.

B. Integrated Care Model, Health Home and Primary Care

The application requires that you describe your planned behavioral health and primary care integration model.

INSERT the following in Section III. Behavioral and Physical Health Integration, part B. Integrated Care Model, Health Home and Primary Care

Specify who will provide primary care and other health services you are including.

If you own or have membership interest in a primary care organization where primary care services are fully integrated and embedded, you will say as such and **ATTACH** a copy of your agency service plan or program description for primary care services (labeled as Section III. Behavioral and Physical Health Integration – Scope of Services).

If your agency provides only behavioral health services, you will describe a model that includes MOAs or other formal agreements with primary care providers (including FQHCs) in your community and with the local hospital(s) and ER(s). Be specific about which primary care providers you will work with and specify if you will also establish agreements with specialty care and other providers such as dentists, chiropractors, acupuncturists, etc.

Describe the terms and roles in the MOA and **ATTACH** a copy of the MOA template **OR** describe how you will develop it and what it will include. Agreements must include the population to be served; referral arrangements; information that will be exchanged between the health home and primary care provider; and role of providers in coordinating and managing care, including integrated care plan development and updates, team meetings and communication protocols.

Describe your current or planned process/protocol for integrating care. This could include the following types of information.

Intake (for example:)

- How you will conduct initial medical screening using the screen in the BHSD Star CNA
- How you will give clients options for Advanced Directive
- How you will identify primary care health concerns
- How you will determine Health Home Eligibility and ask about Health Home opt-in
- How and when you will link to Health Home Care Coordinator
- How you will refer to current primary care provider or provider established through MOA

How you will exchange information between your agency and the primary care provider (electronic and otherwise)
How you will coordinate with the MCO on referral (confirmation of Health Home eligibility, level of care, completion of HRA, etc,)
How you will incorporate Treat First if applicable

Comprehensive Needs Assessment and Plan of Care (for example:)
How and when you will complete the Comprehensive Needs Assessment and Plan of Care as standardized in BHSD Star
How and when the Health Home Care Coordinator, client and PCP will meet
How and when Plan of Care will be updated with PCP information
How information will be shared on an ongoing basis

Referrals from ER
How behavioral health assessments will be completed and time frames when requested

Referrals from Primary Care Providers
How and from whom you will accept referrals

IV. TABLE A: Health Home Site(s), Integrated Care Model(s), Primary Care Capacity and Expanded Access

COMPLETE the table in Section IV.

V. Primary Care Screening Checklist

COMPLETE the checklist in Section V.

The Primary Care Screening Checklist is a component of the Comprehensive Needs Assessment and is thus standardized. You need to indicate that you will conduct these screens by checking all the appropriate boxes. If you need to explain anything about your ability to conduct these screens, use the COMMENTS section.

VI. Partner/Provider Outreach and Engagement

You need to describe how you will reach out and engage providers and partners. This is about engaging providers other than those with whom you will have an MOA. These would be providers and other partners who would likely be a part of clients' plans of care and with whom you need to develop working relationships. Table B lists those providers and partners; you can add to this list as appropriate.

COMPLETE Table B in Section VI.

INSERT the following in Section VI. Partner/Provider Outreach and Engagement

Introduction

- Demonstrate you understand the importance of outreach and engagement. Provide a brief overview of why and how you will facilitate working relationships with providers/partners. Discuss the importance of ensuring that necessary services will be available and/or coordinated for Health Home members as part of their integrated care management.

Education and outreach

- Communication tools/strategies you will use (e.g., brochures, phone calls, face-to-face meetings)
- Content you will communicate (e.g., overview of Health Homes; description of services provided by Health Homes; why collaboration is critical in achieving integrated care goals and positive client outcomes; how clients will benefit by the collaboration, and more)

Providers and partners

- Summarize Table B ("the agency will develop relationships with {list}")

Information Exchange

- Types of information you will exchange with providers/partners

Role of providers in coordinating and managing client care – for example

- Participation in plan of care development, reviews, and revisions
- Participation in meetings
- Provision of services and supports
- Other

Accountability – discuss quality and other measures for both the Health Home and non-Health Home providers/partners

Performance tracking – how you will demonstrate successful outreach and engagement

Gaps Analysis - describe how you will conduct periodic "gap analyses" to identify gaps in network relationships and how you will engage and establish relationships to fill identified gaps.

Acknowledge NM Rules regarding information security

VII. Consumer Informed Consent and Orientation

INSERT the following in Section VII. Consumer Informed Consent and Orientation, Part A. Consumer Informed Consent

Describe the consumer informed consent you will use. Be sure to be specific about how it will incorporate Health Home specific language, e.g., explains what a Health Home is; what to expect in terms of integrated care coordination; how and with whom information will be shared; and so forth.

Specify that the consent will call out the client's choice to participate in the Health Home.

Describe who will review the consent with the client (likely the care coordinator) and when.

Describe where the form will be kept.

INSERT the following in Section VII. Consumer Informed Consent and Orientation, Part B. Orientation

Describe the type of written/documented Health Home service orientation informational materials you have or will develop (packets, video, etc.).

Describe the content to be included – e.g., what you can expect from the agency; what is expected of you; how integrated care coordination will work; what benefits can be expected with active participation; who to call if you have questions, and so forth.

Describe the process of actual orientation – who will review with client, how the orientation will play out, when it will be done.

VIII. Comprehensive Assessment, Care Planning and Care Coordination

INSERT the following in Section VIII. Comprehensive Assessment, Care Planning and Care Coordination, Part A. Comprehensive Assessment

State that you will use the NM Health Homes assessment tool and will meet all of the data and reporting requirements of HSD.

Describe any additional practices, tools and/or specific community based approaches you plan to use.

Describe data sources that will be used to complete the comprehensive assessment.

Describe how information from the assessment will be used to stratify individuals by categories of risk to develop behavioral, physical and other appropriate health interventions.

INSERT the following in Section VIII. Comprehensive Assessment, Care Planning and Care Coordination, Part B. Care Planning

State that you will use the CareLink NM Plan as required by HSD.

Describe any additional practices and tools you will include in Care Planning (See examples in application.)

INSERT the following in Section VIII. Comprehensive Assessment, Care Planning and Care Coordination, Part C. Care Coordination

Describe the care coordination processes you have or will bring up as a Health Home.

Discuss all the possible entities you will include (the application suggests, consumer, consumer's family members, caregivers, team members, PCP, specialists, social services and other providers).

Describe the major items you will coordinate (the application suggests tracking tests, referrals, scheduled appointments, follow-up, etc.) in implementing the care plan. Provide the following:

Describe communication protocols or policies that you have or will develop that outline information exchange between consumer, consumer's family members, caregivers, team members, PCP, specialists, and other providers.

Describe your plan to address routine information exchange to ensure that collaboration and communication occurs between consumer, consumer's family members, caregivers, team members, PCP, specialists, other providers and payors.

Describe how you will coordinate care (e.g., assist consumer in obtaining health care, including primary, acute and specialty medical care, mental health, substance abuse services and developmental disability services, long- term care and ancillary services; perform medication management, including medication reconciliation; track tests, referrals and follow-up as necessary, etc.).

Describe the role of the Care Coordinator

Describe steps and benchmarks for care coordination (timing and frequency of contact, etc.)

State something to the effect that you will work with MCOs to establish respective care coordination requirements and compliance tracking as established under Centennial Care. Please include in your response your approach to coordinating with MCOs to accomplish compliance.

ATTACH your Business Continuity/Disaster Management Plan (or describe how you will develop it.)

IX. Health Promotion

INSERT your answers to the questions in Section IX Health Promotion

Describe your health promotion program for Health Home members including:

1. How client-level clinical data are used to address health promotion programming (e.g., information from your EHR, other records). If applicable, describe that some health promotion activities would be offered for all members (not specifically derived from clinical data).
2. Describe specific courses you intend to offer to Health Home members or if not yet known, the topics to be covered.
3. Other programs or initiatives you have or will bring up for Health Home members (e.g., evidence-based, evidence-informed, best, emerging and/or promising practices related to smoking cessation, nutrition, chronic disease management, etc.).

X. Comprehensive Transitional Care

INSERT the following in Section X. Comprehensive Transitional Care

Describe how you will facilitate and manage comprehensive transitional care and follow up (e.g., inpatient-to-inpatient, residential and community settings, to prevent unnecessary inpatient admissions, inappropriate emergency department use and other adverse outcomes).

Describe the role of the Care Coordinator, how you will handle information exchange and coordinated discharge planning, etc. Include processes for:

- Receiving timely notifications of admissions/discharges as well as receiving discharge records.
- Follow up with primary care, specialists and social services.
- Medication review and reconciliation.
- Risk assessment (e.g., potential for re-admission/re-institutionalization, non-adherence to care plan.
- Revisions to comprehensive care plan to integrate transition/discharge plan.

XI. Culturally and Linguistically Appropriate Services

INSERT the following in Section XI. Culturally and Linguistically Appropriate Services

Describe how your agency will ensure that the health home service is delivered in a manner that is culturally and linguistically appropriate, including how you will address staff training, recruitment and hiring, provisions for communication modalities (e.g., hearing or visual impairment), and other activities. You could discuss how you approach cultural and linguistic appropriateness in your written or audio-visual client materials, your use of interpreters, etc.

XII. Data Sharing and Information Management for Care Management and Coordination

INSERT the following in Section XII. Data Sharing and Information Management for Care Management and Coordination

1. Describe how you will use data from a variety of sources to inform and support comprehensive and timely care management and care coordination.

   Describe the sources and types of health data you currently receive or expect to receive as a Health Home (including from Medical Assistance Division/HSD and other state agencies; behavioral, primary care and specialty providers; inpatient facilities; long term support service and social service agencies, and MCOs.

2. Describe how you will integrate hospital admission, discharge, utilization and other data into routine Health Home operations.

3. Describe how you will systematically follow up on tests, treatments, services and referrals, and how you will incorporate them into client's plan of care.

4. Describe relevant certified health record solutions, databases, and data management protocols for documentation and bi-directional information sharing.

XIII. Team Composition

COMPLETE Table C to describe your staffing model.

INSERT a description of the specific expertise that aligns with the type of team designated in column one of Table C.

ATTACH position descriptions for each of the required health home team members (if you need to develop job descriptions, see staffing requirements as specified on Pages 10-11 on the NM CareLink Policy Manual). There is a place on the application form to insert comments as needed about the development of job descriptions.

XIV. Quality Improvement/Performance Measures & Outcomes

ATTACH your organizations' quality improvement program description/plan.

INSERT:

2. A description of how health home services are or will be incorporated into this quality improvement plan.

3. Assert that you are able to collect, monitor and report the health home performance measures as identified by the state, OR describe the barriers and challenges and how you will address them.

   Include the job title of the staff person responsible for oversight of performance measures and quality improvement.

XV. Health Information Technology

CHECK the applicable elements that apply to your use of health information technology.

INSERT your responses to:

1. Describe the extent to which the health home and its various sites share a common electronic record system.
2. Describe if and how the health home participates in a Health Information Exchange (HIE) network e.g., direct exchange or bi-directional query based exchange; and if not currently participating in HIE, what plans are being developed to participate in HIE.

XVI. Health Home Service Attestation

Complete and sign.