CLNM Health Home Agency Application and Pre-Assessment of Readiness

This application is required for those New Mexico community mental health services providers who are certified by the State and who are eligible and seeking to become health homes for adults with Serious Mental Illness (SMI) and children with Severe Emotional Disturbance (SED). Please label all attachments submitted with this application with the appropriate application section title and number/letter.

Please mail your application to:
HSD/MAD Health Homes
P.O. Box 2348
Santa Fe, NM 87504-2348

Anticipated Start Date of Health Home Service:

I. Name of Agency

Name of Agency			**NPI Number:**
Physical Address	**City**	**Zip**	**County**
Contact Person	**Phone**	**Email**	
	( )		

Please provide the name and address for each service location that will provide Health Home Services
(make additional copies of this page as needed and attach to this packet)

Name of Individual Service Provider : **Anticipated Start Date of Health Home Service:** **NPI Number:**

Service Location Address	**City**	**Zip**	**County**
Contact Person	**Phone**	**Email**	
	( )		

Name of Individual Service Provider: **Anticipated Start Date of Health Home Service:** **NPI Number:**

Service Location Address	**City**	**Zip**	**County**
Contact Person	**Phone**	**Email**	
	( )		

Name of Individual Service Provider: **Anticipated Start Date of Health Home Service:** **NPI Number:**

Service Location Address	**City**	**Zip**	**County**
Contact Person	**Phone**	**Email**	
	( )		

Name of Agency: _____

II. Health Home Service Population

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: SMI/SED; County of residence, culture, age: child/adolescent/adult

III. Behavioral and Physical Health Integration

A. Accreditation and Certification

Identify current accreditations and/or certifications that demonstrate your Health Home's current or planned adherence to standards for integrated physical and behavioral health care. Please select one of the following:

☐ Current accreditation or recognition from___ _____, OR

☐ Plan to seek accreditation or recognition from the following and anticipated accreditation/recognition date___ _____

Please select all that apply from the following:

☐ CARF Integrated Behavioral Health/Primary Care Core Program Accreditation
☐ CARF Health Home Core Program Accreditation
☐ Joint Commission Behavioral Health Care Accreditation Program Primary Physical Health Care Standards, or Primary Care Medical Home or Behavioral Health Home Certification
☐ Council on Accreditation Integrated Behavioral Health and Primary Care Supplement Standards
☐ NCQA Patient-Centered Medical Home (Level 1) Recognition
☐ NCQA Patient-Centered Specialty Practice Recognition
☐ Equivalent accreditation, certification or recognition approved by the State of New Mexico

State or Federally designated:

☐ Behavioral Health Agency (BHA)
☐ Core Service Agency (CSA)
☐ Federally Qualified Health Center (FQHC)
☐ Community Mental Health Center (CMHC)
☐ Tribal 638 (638)
☐ Certified Community Support Service (CCSS)

B. Integrated Care Model, Health Home and Primary Care

Describe your planned behavioral health and primary care integration model. Describe the way your model will address how, what, when and where primary care is provided, and how the providers will collaborate in areas such as referrals, communication, information sharing and medical record management, staffing arrangements and supervision, and financial arrangements.

Include the following in your response: The level of behavioral and primary health care integration (see: http://www.integration.samhsa.gov/); your rationale based on your business model, market relationships, populations to be served, current capacity and how appropriate and feasible it is for your service population.

For applicants with ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded: Attach a copy of your agency service plan or program description for primary care services.

- **Applicants entering into a written integrated care agreement with a primary care provider for co-located coordinated care at each health home site:** Attach a copy of your agreements with primary care providers or describe how they will be developed and what will be included. Agreements must include the following: 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.

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

Use **Table A** to describe arrangements for ensuring behavioral and primary care capacity, including screening, treatment, and expanded access to services provided by the organization.

- **Complete this table once if you will implement the same model at all of your health home sites.**
- **If you are implementing different integrated care models in multiple sites, make additional copies of this table as needed.**

Health Home Site (A)	Expanded Access to Services (B)	Primary Care Screening & Treatment Model (C)	Integrated Care Model (D)	COMPLETE THIS COLUMN ONLY If Having an Ownership or Membership Interest in a Primary Care Organization Where Primary Care Services are Fully Integrated and Embedded: Projected Number of Health Home Consumers Served (E)	COMPLETE ONLY IF CO-LOCATED IN A PRIMARY CARE SETTING		
					Name of Primary Care Provider(s) If Co-located (F)	Location of Primary Care Provider(s) (G)	Projected Number of Health Home Consumers Served by Each Primary Care Provider If Co-located (H)
	☐ Additional Business Hours (e.g., evening or weekend hours) ☐ Same day appointments (i.e., open scheduling) ☐ Non-urgent clinical advice and triage by a live person 24 hours/7days a week (e.g., electronic access, email, etc.) ☐ Other:	☐ On-site ☐ Coordinated off-site	☐ Co-located ☐ Fully Integrated and Embedded/Owner-ship or Membership Interest				

Name of Provider: _____

V. Primary Care & Behavioral Health Screening Attestation

The organization will assure the following screening and treatment services:

A. Initial health history and physical exam within one month of the first scheduled visit with the provider (if one has not been performed in the prior twelve months). ☐ Yes ☐ No

B. Collection of the following data points at any visit for a physical health check or a medication adjustment, but no less frequently than quarterly for higher levels of care coordination:

- Vital signs, including blood pressure, height, weight, calculation of body mass index, pulse, respiratory rate, and oxygen saturation level, as appropriate ☐ Yes ☐ No
- Current medications and drug allergies ☐ Yes ☐ No
- Current tobacco, drug, or alcohol use, including frequency and amount ☐ Yes ☐ No
- Suicidality, stress/anxiety, depression ☐ Yes ☐ No

C. Routine preventive screenings and tests for the following:

☐ Yes ☐ No Diabetes specific tests (e.g., a Hemoglobin A1c screening, retinal exam, foot exam and end organ assessment)
☐ Yes ☐ No Comprehensive Lab Tests (Blood glucose, CMP, CBC, Urinalysis)
☐ Yes ☐ No Lipid profile
☐ Yes ☐ No Medical Screening (Hepatitis C, HIV, STD's, Cardiac testing)
☐ Yes ☐ No Cancer screenings, including mammogram, pap test, PSA test, and a colonoscopy
☐ Yes ☐ No Annual routine dental examination
☐ Yes ☐ No Immunizations and, if necessary, updates to the immunizations
☐ Other: _____
Other: _____
Other: _____

COMMENTS:

VI. Partner/Provider Outreach and Engagement

Describe your provider outreach plan that will be used to communicate with and engage providers and entities with whom you do not have formal agreements, but with whom you need to develop effective working relationships to serve clients in the health home.

- The outreach plan should outline how the health home will educate providers about the services, goals and the value of the relationship or collaboration in the delivery of service components, and how and what type of information will be exchanged between the health home provider and the non-health home provider. The outreach plan should describe the role of the non-health home provider in coordinating and managing care to the consumer including but not limited to integrated care plan development and revisions and participation in meetings. The outreach plan should also describe how the HH and non-HH providers/partners will be accountable. The plan should include performance tracking of the success of your outreach and engagement, and periodic analysis of gaps in your networking.

Name of Provider: _____

Partner/Provider Outreach and Engagement (cont.)

Table B: Health Home Network Relationships

Please identify those providers that you have or will have relationships, collaborations or partnerships. Describe how those entities identified are appropriate to serve your health home population. Check all that apply.

- ☐ CMHC, FQHC, BHA
- ☐ Nursing Facility
- ☐ Pharmacy
- ☐ Criminal Justice/Juvenile Justice
- ☐ Psychiatric Inpatient Hospital
- ☐ Certified Home Health Provider
- ☐ Social Service Provider – housing, peer, etc.
- ☐ Indian Health Services (IHS)
- ☐ Medicaid Managed Care Organizations (MCOs)
- ☐ Specialty Care Provider
- ☐ Hospital
- ☐ Urgent Care Center
- ☐ Hospital Emergency Department, EMS
- ☐ Substance Abuse Treatment Provider
- ☐ Licensed Group Home or Adult Care Facility
- ☐ Other Mental Health Provider (RTC, ARTC, TLS)
- ☐ Other (Please Specify): _____
- Other (Please Specify): _____
- Other (Please Specify): _____

VII. Consumer Informed Consent and Orientation

A. Consumer Informed Consent

Provide assurance that your agency will utilize the state supplied registration system and informed consent specific to enrollment in the health home service prior to provision of services.

B. Orientation

Describe the written/documented health home service orientation informational materials you have or will develop. Materials must describe and confirm the process to orient and inform consumers regarding the benefits of active participation in the health home service.

Name of Provider: _____

VIII. Comprehensive Assessment, Care Planning and Care Coordination

- **Comprehensive Assessment & CLNM Service Plan**
- Provide assurance that you will use the NM Health Homes assessment and service planning tools.

- Describe any additional practices, tools and/or specific community based approaches you plan to utilize. Your response should include the following:
    - 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.
    - Describe any additional practices, tools and/or community based approaches you will utilize to complete and maintain a person-centered and customized care plan that addresses items such as: Identification of measurable goals and objectives; interventions with specific time frames for completion; provisions for acknowledging client and relevant others' (i.e., family, guardians, significant others) input, preferences, and level of involvement in the care plan.

- **Care Coordination**
- Describe how you will coordinate with consumer, consumer's family members, caregivers, team members, PCP, specialists, social services and other providers (i.e. tracking tests, referrals, scheduled appointments, follow-up, etc.) in implementing the care plan. Provide the following supporting documents:

- Describe your current or planned communication protocols or policies that describe information exchange between consumer, consumer's family members, caregivers, team members, PCP, specialists, and other providers.
- Describe your current or planned communication 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.).

- Attach your Business Continuity/Disaster Management Plan or describe how you will develop it.

Name of Provider: _____

IX. Wraparound Intensive Care Coordination for Children

Do you intend to implement High Fidelity Wraparound intensive care coordination for children? If so, do you commit to:

- ☐ Utilize a dedicated, full-time care coordinator who works with a small number of children and their families.
- ☐ Provide frequent, weekly contact required for children, crisis response, and other cross-system needs of children, with ratios that do not exceed 1:8 to 1:10 care coordinators to families.
- ☐ Bring together all key stakeholders to create a plan that builds upon strengths and underlying needs and uses adult relationships and behavioral health services to meet the family's goals.
- ☐ Coordinator participating in the eighteen-month NM Wraparound CARES Immersion Training and Coaching Program.

X. Health Promotion

Describe your health promotion program for HH members including:

1. How client-level clinical data are/will be used to address health promotion programming
2. Specific courses you intend to offer to HH members
3. Other programs or initiatives you have or will bring up for HH members (e.g., evidence-based, evidence-informed, best, emerging and/or promising practices related to smoking cessation, nutrition, chronic disease management, etc.).

XI. 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).

The applicant should describe 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 service plan to integrate transition/discharge plan.

Name of Provider: _____

XII. 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, provisions for communication modalities (e.g., hearing or visual impairment), and other activities.

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

1. Describe your capacity and strategies for using data from a variety of sources to inform and support comprehensive and timely care management and care coordination. Address the sources and types of health data that 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 managed care organizations (MCOs).

2. Describe your ability to integrate hospital admission, discharge, utilization and other data into routine health home operations.

3. Describe your systematic processes for following up on tests, treatments, services and referrals and incorporating them into client's plan of care.

4. Describe the relevant certified health record solutions, databases, and data management protocols for documentation and bi-directional information sharing among providers, team members and agencies as part of ongoing care planning and coordination.

XIV. Team Composition

Applicant should complete **Table C** to describe its staffing model.

Explain how the professional competencies and expertise of the health home team will align with and serve the needs of the identified health home service population.

Attach position descriptions for each of the required health home team members.

Name of Provider: _____

Table C: Health Home Team Composition

Please provide team compositions and descriptions in the table below.
A health home service provider shall utilize an integrated, multidisciplinary team to deliver health home service.
Please complete the table below for number of teams, estimated caseloads, health home team members, staff credentials, and staffing ratios.

Team Description (e.g., generalist team, high-need child and adolescent team, etc.)	Estimated Caseload	Clinical Supervisor			Health Promotion Coordinator			Care Coordinator			Peer Support Specialist			Total Team FTEs	Total Team Ratio
		Cred	Ratio	FTE	Cred	Ratio	FTE	Cred	Ratio	FTE	Cred	Ratio	FTE		
A															
B															
C															
D															
E															
F															
G															
H															
I															
J															

Name of Provider: _____

XV. Quality Improvement/Performance Measures & Outcomes

1. Attach your organizations' quality improvement program description/plan.

2. Describe how you have incorporated health home services into this quality improvement plan.

3. Describe your readiness to collect, monitor and report the health home performance measures as identified by the state. Include the job title of the staff person responsible for oversight of performance measures and quality improvement.

XVI. Health Information Technology

A. Electronic Health Information

A health home provider must at the time of designation implement and actively use Health Information Technology as evidenced by the following criteria (check all that apply):

- ☐ Receipt of structured laboratory results
- ☐ Utilization of continuity of care records
- ☐ Share information with MCOs (BHSDStar for CLNM HH)
- ☐ Receive real-time ER utilization (EDIE)
- ☐ Participation in a Health Information Exchange
- ☐ Use of the CLNM Services module for capture of utilization data and care coordinator reminders
- ☐ Prism risk management system

Other: Please describe

Describe the extent to which the health home and its various sites share a common electronic record system.

Name of Provider: _____

XVII. Health Home Service Attestation

The undersigned certifies that the information submitted in this Health Home Service Provider Application and any attached pages are true, accurate, and complete. The Health Home applicant agrees to comply with all current and future State and Federal laws, rules, regulations and statutes concerning Health Home Service delivery, including but not limited to: Payment, operations, confidentiality of records, staffing, managed care collaboration and service taxonomy.

The Health Home applicant also agrees to notify the Human Services Department (HSD) within 10 Days if any changes should occur as a Health Home Service Provider in the following areas: Accreditation, certification, behavioral and physical health integration arrangement, health home staffing level as contained in this application, collection and reporting of required health home outcomes data, Health Information Technology requirements, capacity to provide all components of health home service delivery and ability to serve all eligible population in the designated service area.

Provider: _____

Authorized Signature: **Date:**

Title: _____ _____

Print Name: _____ **Title:** _____ _____