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Specialty Mental Health Care Management in Health Home for Adults

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Housekeeping

- All phones are currently muted
- We want you to share your thoughts and questions with us using the Q&A feature (do not use the chat box)
- Access the “Q&A” box in WebEx menu can be found:
  - At the right of your screen
  - If you are seeing circles at the bottom of your screen – select the one with “…” and select Q&A
  - If you expanded the view of the webinar to full screen, hover cursor over green bar at top of screen to see the menu
- Type questions using the “Q&A”
  - Submit to “all panelists” (default)
  - Please do not use Chat function for Q&A
- This webex will be recorded and slides will be shared

Agenda

- Specialty Mental Health Care Management
- Overview of designation of Specialty Mental Health CMAs
- Key Requirements for Specialty Mental Health Care Management
- Care Management Models that meet HH+ Requirements
- Technical Assistance
- Next Steps

Specialty MH Care Management for Adults

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Specialty Mental Health Care Management

- **Enhanced level of care management** in Health Homes, for high need members
- Care managers with **expertise in mental health**
- Direct OMH **Oversight** of Specialty MH CMAs
- Specialty MH Care Management Agencies to serve highest need adults with SMI – **HH+ SMI population**
  - Fulfill the local need to adequately support the highest need individuals (e.g., AOT)
  - Expertise, Experience, Knowledge of critical services

Goals of Specialty MH Care Management

- Improve **Health Home enrollment for high need individuals** living with SMI
- Ensure all HH+ SMI eligible members are **receiving HH+ level of support**
- Providing **mission-driven work** for CMAs
- More time spent with members and **collaborating with care team**
- Meaningful **member outcome** measures
- Addressing **service gaps** for members
    - Use of data to track and evaluate key outcomes (e.g., linkage to BH rehabilitation services)

Designation of Specialty Mental Health CMAs

Designation Performance Measures

Designation as a Specialty MH CMA is issued based on the CMAs performance serving their highest need SMI members

Designation Performance Measures:

- 50% or more of HH+ SMI Eligible members received HH+ level of care, **and**
- CMA identified at least 50% of their HH+ eligible members

Provisional Performance Measures:

- 1-49% of their HH+ SMI Eligible members received HH+ level of care
- 50% or more of their HH+ SMI Eligible members received HH+ level of care, **but** CMA identified *less* than 50% of their HH+ eligible members
- Serving AOT individuals
- Average of 2+ face-to-face contacts per month provided to high-risk high-need members

Specialty Mental Health Care Management Agency Attestation

- Designated SMH CMAs will need to submit attestation to affirm Specialty MH CMA status
- Completed attestations must be submitted via the Health Home BML and are due no later than **3/8/21** to continue to receive HH+ referrals
    - If a CMA cannot attest to all the standards, reach out to OMH
- CMAs will send a copy of the attestation to lead HH(s) and LGU(s)
- Currently, only SMH CMAs already serving AOT will continue to serve AOT

Specialty Mental Health Care Management Agency (MH CMA) Attestation to Serve Health Home Plus (HH+) Individuals with Serious Mental Illness (SMI)

OMH has established program standards to be met by designated Specialty MH CMAs in order to serve the HH+ SMI population. **All designated Specialty MH CMAs** are required to submit this writte attestation verifying their intention to provide Specialty Mental Health Care Management, and to having protocols in place for ensuring compliance with the required program standards. For full details, see th *"Health Home Plus for High-Need Individuals with Serious Mental Illness Program Guidance" (Re-issued February 2021).*

CMA Organization Name:	ABC Organization, Inc.	**Contact Person Name & Title:**	Betty White
Contact Person Phone:	518-555-5555	**Contact Person E-Mail**:	Bwhite@ABC.org

CMA Address(es) – *use multiple lines to list all CMA locations, if more than one (feel free to attach separate page if needed):*

CMA Name:	ABC Organization of Clinton	**MMIS #:**	034592	**Address:**	123 Main Street Plattsburgh NY, 12903
Count(ies) Served:	Clinton County	**Lead HHs:**	Upstate NY Health Home		
CMA Name:	ABC Organization of Essex/Franklin	**MMIS #:**	034555	**Address:**	45 Main Street Lake Placid NY, 12946
Count(ies) Served:	Essex and Franklin Counties	**Lead HHs:**	Lake Placid NY Health Home, Upstate NY Health Home		

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	Specialty MH CMA Standards To affirm CMA compliance with each standard, check box in left column.
☑	CMA has process for immediate assignment of HH+ eligible members to qualified care managers and the provision of HH+ services.
☑	CMA has process to ensure HH+ caseload sizes do not exceed the required ratio of 1 qualified care manager for every 20 HH+ recipients.
☑	CMA has process to ensure the minimum service intensity requirements outlined in the HH+ SMI program guidance are met.
☑	CMA has staff meeting the HH+ SMI Staff Qualification requirements, as outlined in the HH+ SMI program guidance.
☑	CMA has policy and procedure to ensure Supervisors and direct care management staff possess key core competencies for serving high need individuals with SMI, as outlined in HH+ SMI program guidance.
☑	CMA has a working relationship with the LGU/SPOA in their service county; see HH+ SMI program guidance for more detail.
☐	**For CMAs authorized to serve AOT,** CMA meets the additional requirements for serving AOT individuals, as outlined in HH+ SMI program guidance.

Certification and Acknowledgement

I certify, on behalf of my agency, that all information contained in this Attestation is accurate and true.

Betty WHite		2/24/21
CMA Director Name (print)	CMA Director Signature	Signature Date

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Key Requirements for Specialty Mental Health Care Management

Specialty MH Care Management Agencies

- Ensure access to HH+ for HH+ eligible individuals not yet enrolled in HH
    - Work with HHs and LGUs developing pathways for HH+ referrals
- Provide HH+ level of service to HH+ eligible members
- Build up workforce and model requirements to support HH+ level of care
- Collaborate with critical providers in the community for transitions in care and for ongoing care coordination of a high need population
- Continue whole health coordination – integrated care

Specialty MH Care Management Agencies

- Providing Person Centered Care
- Outcomes for mental health population:
  - employment
  - wellness
  - recovery
  - connectedness
  - social determinants of health
  - community inclusion

Workforce Qualifications

Specialty MH CMAs shall have staff with the education and experience appropriate to serve the high-need SMI population.

CMA Supervisors shall ensure care managers receive adequate support and access to resources that encourage development of skills necessary to improve quality of life and outcomes for high-need individuals with SMI.

Workforce Qualifications

Education

- A Master's degree in one of the fields below* and 1 year Experience; or
- A Bachelor's degree in one of the fields below* and 2 years of Experience; or
- A CASAC and 2 years of Experience; or
- A Bachelor's degree or higher in any field with either: 3 years of Experience, or 2 years of HHCM experience serving the SMI or SED population.

Experience

Experience must consist of:

- Providing direct services to people with SMI, developmental disabilities, alcoholism or substance abuse, and/or children with SED; OR
- Linking individuals with SMI, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting.

Supervision

Provided by:

- Licensed level healthcare professional with prior experience in a BH setting; OR
- Master's level professional with 2 years prior supervisory experience in a BH setting.

*Qualifying education includes degrees featuring a major or concentration in social work, psychology, nursing, rehabilitation, education, OT, PT, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing, or other human services field.

Staff waivers

In rare circumstances, staff may have unique education and/or experience to adequately serve the HH+ SMI population but do not meet the HH+ Staff qualifications. HH CMAs may apply for a waiver for such staff.

Waivers are not intended to be the sole approach for expanding capacity in serving the HH+ SMI population.

Waiver requests can be submitted online:

Waiver of Qualifications for HH+ SMI and NYS EA Assessors for Adult BH HCBS

Eligible Population

Active AOT

History of expired AOT court order within the past year

Enhanced Service Package / Voluntary Agreement

State Psychiatric Center and CNYPC (Forensic) Discharges

ACT Step Down

High utilization of inpatient/ED services

- *Three (3) or more psychiatric inpatient hospitalizations within the past year.*
- *Four (4) or more psychiatric ED visits within the past year.*
- *Three (3) or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.*

Eligible Population

Homeless – HUD Category 1

Criminal Justice involvement:

- *Released from jail in the past year and incarcerated due to poor engagement in community services.*
- *Requires linkage to community resources to avoid reincarceration.*

Ineffectively engaged in care:

- *No outpatient mental health services within the last year and two (2) or more psychiatric hospitalizations; or*
- *No outpatient mental health services within the last year and three (3) or more psychiatric ED visits.*

Clinical discretion – SPOA / MCO

HH+ Eligibility

Eligible members can receive HH+ for 12 consecutive months starting from the point an individual's HH+ eligibility becomes known to the care manager and HH+ services have been provided.

- HH+ may continue for 12 more months, if the individual continues to meet eligibility and is supported in documentation.

- If the HH+ minimum service requirements are not provided in a given month, but all other requirements as outlined in HH+ guidance are met; and at least one (1) HH core service was provided, the HH High Risk/High Need Care Management rate may be billed.

Identifying Eligible Members

There are multiple ways to determine HH+ eligibility:

- Utilizing EHR and MAPP
- PSYCKES can be a key tool in identification, however someone might be HH+ eligible and not flagged in PSYCKES.
    - MAPP will be adding HH+ eligibility based on PSYCKES flag
- Care managers should be able to continuously identify HH+ eligibility as part of their knowledge of the member (i.e. hospitalization, increased needs, change in status, etc.).

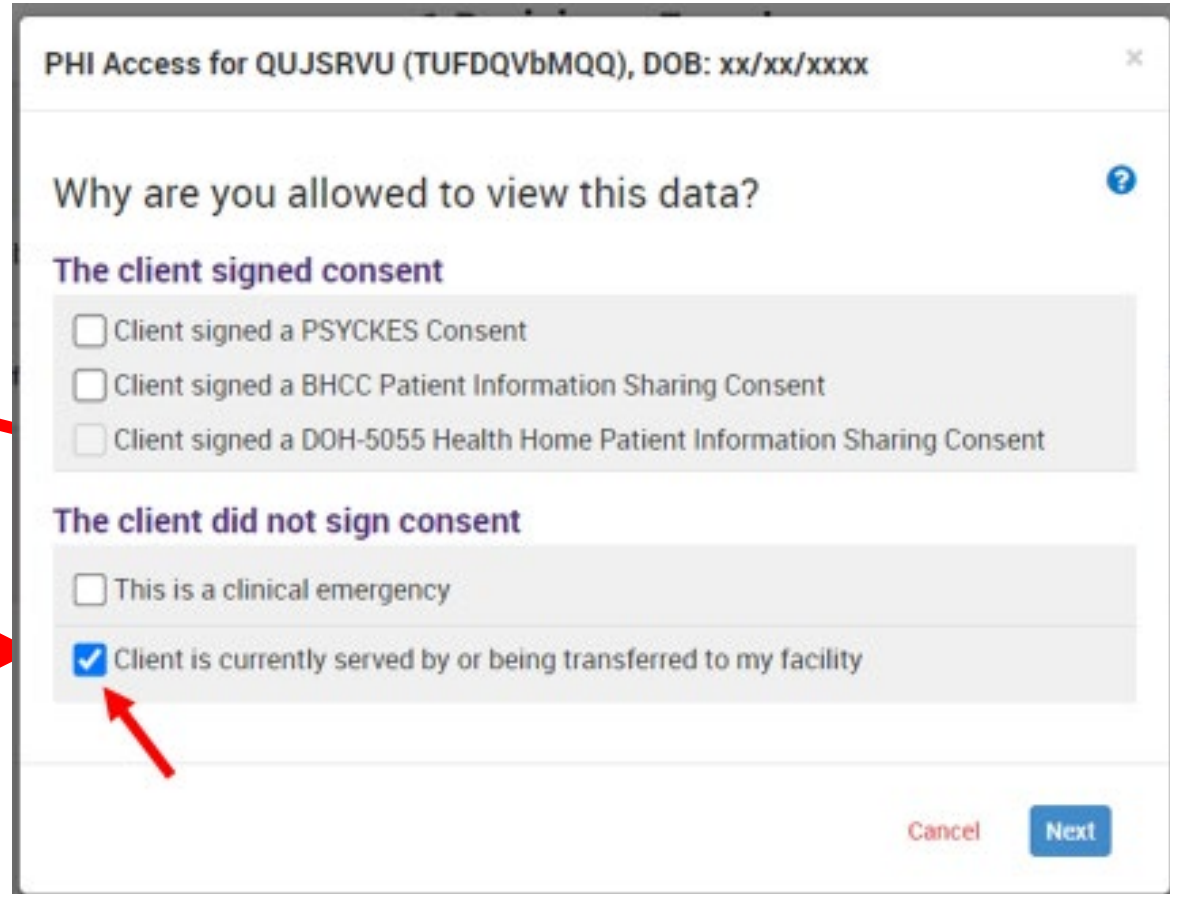
Using PSYCKES to Identify HH+ Eligible Members

PSYCKES can support identification of HH+ eligible members:

1. At the individual level by reviewing a Clinical Summary
2. At the group level by running a report via Recipient Search

Viewing HH+ Eligibility in the Clinical Summary

- A member or new referral's HH+ eligibility can be viewed in the PSYCKES clinical summary if:
  1. A signed 5055 has been obtained
  2. A member has a PSYCKES quality flag (96% of HH+ eligible members) and attestation of service has been selected
- Health Homes may use the second option for new referrals who have not yet signed the 5055, and can update consent once what 5055 is signed



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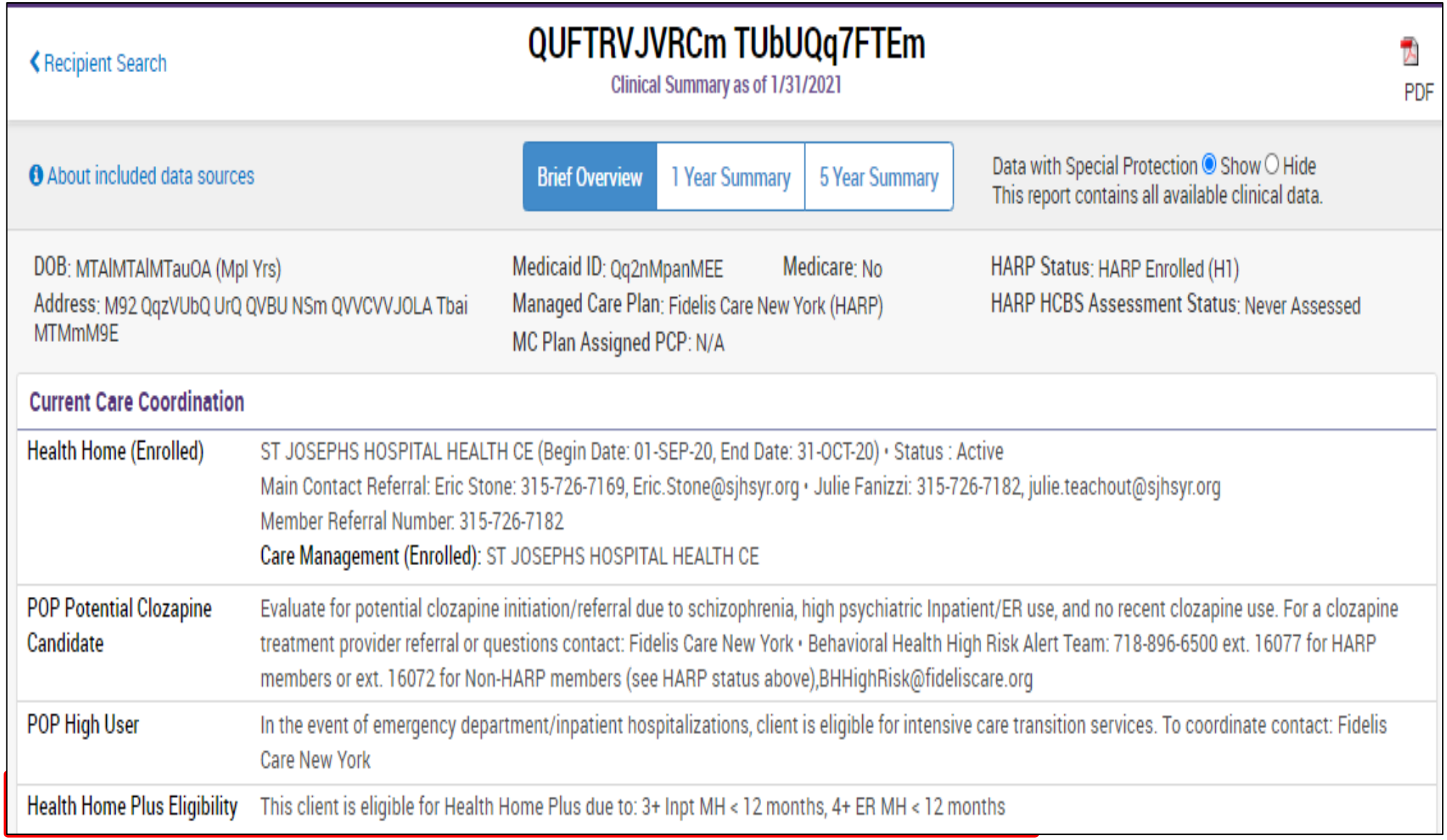
HH+ Alerts in the PSYCKES Clinical Summary

- HH+ eligibility appears at the top of clinical summary in the Care Coordination section
- The clinical summary (and PSYCKES reports) can be downloaded in Excel or PDF and printed



Recipient Search

QUFTRVJVRCm TUbUQq7FTEm

Clinical Summary as of 1/31/2021

PDF

About included data sources

Brief Overview | 1 Year Summary | 5 Year Summary

Data with Special Protection Show Hide
This report contains all available clinical data.

DOB: MTAlMTAlMTauOA (Mpl Yrs)
Address: M92 QqzVUbQ UrQ QVBU NSm QVVCVVJOLA Tbai MTMmM9E

Medicaid ID: Qq2nMpanMEE Medicare: No
Managed Care Plan: Fidelis Care New York (HARP)
MC Plan Assigned PCP: N/A

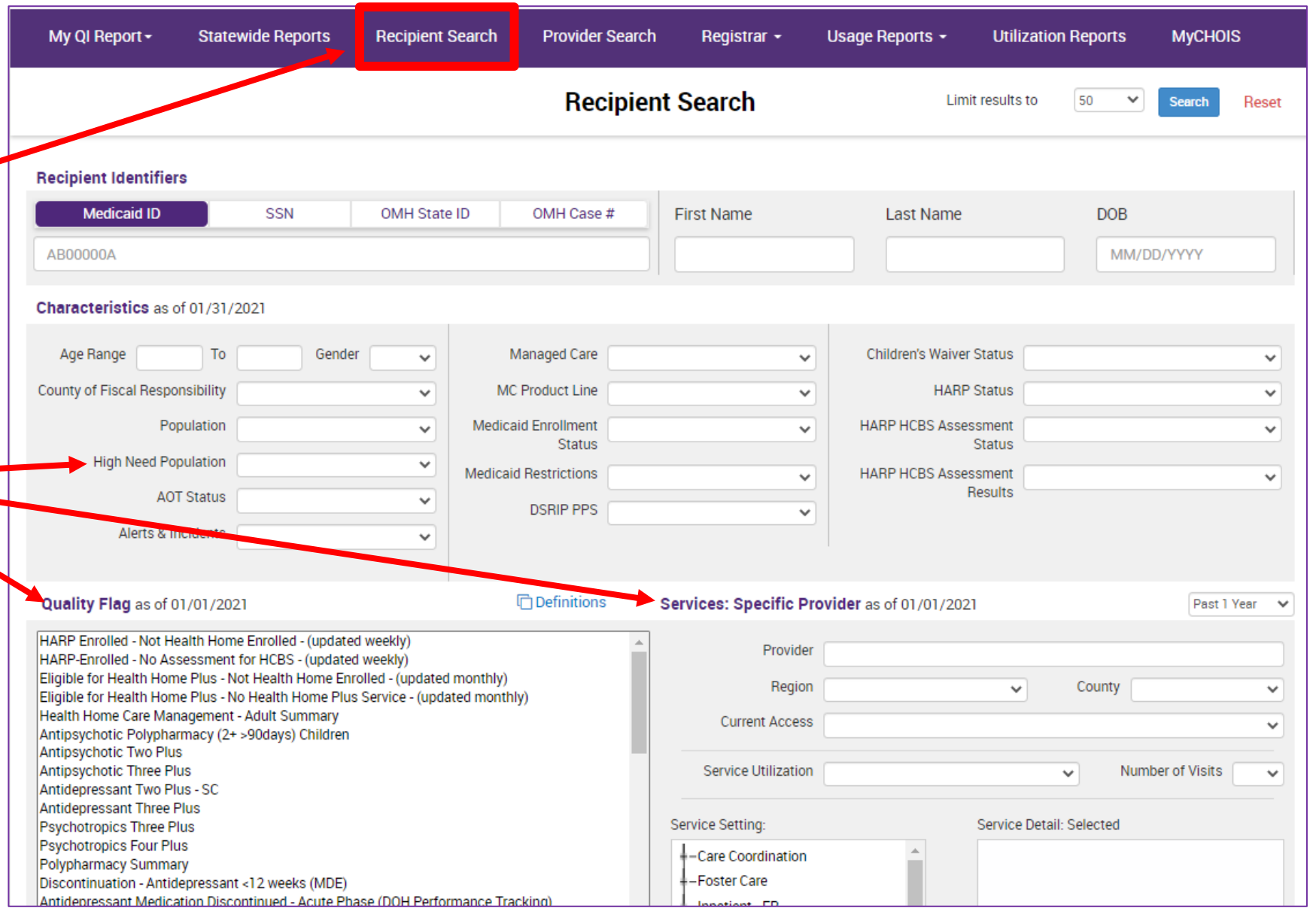
HARP Status: HARP Enrolled (H1)
HARP HCBS Assessment Status: Never Assessed

Current Care Coordination

Health Home (Enrolled)	ST JOSEPHS HOSPITAL HEALTH CE (Begin Date: 01-SEP-20, End Date: 31-OCT-20) • Status : Active Main Contact Referral: Eric Stone: 315-726-7169, Eric.Stone@sjhsyr.org • Julie Fanizzi: 315-726-7182, julie.teachout@sjhsyr.org Member Referral Number: 315-726-7182 Care Management (Enrolled): ST JOSEPHS HOSPITAL HEALTH CE
POP Potential Clozapine Candidate	Evaluate for potential clozapine initiation/referral due to schizophrenia, high psychiatric Inpatient/ER use, and no recent clozapine use. For a clozapine treatment provider referral or questions contact: Fidelis Care New York • Behavioral Health High Risk Alert Team: 718-896-6500 ext. 16077 for HARP members or ext. 16072 for Non-HARP members (see HARP status above),BHHighRisk@fideliscare.org
POP High User	In the event of emergency department/inpatient hospitalizations, client is eligible for intensive care transition services. To coordinate contact: Fidelis Care New York
Health Home Plus Eligibility	This client is eligible for Health Home Plus due to: 3+ Inpt MH < 12 months, 4+ ER MH < 12 months

Using Recipient Search: Identify Groups of Members

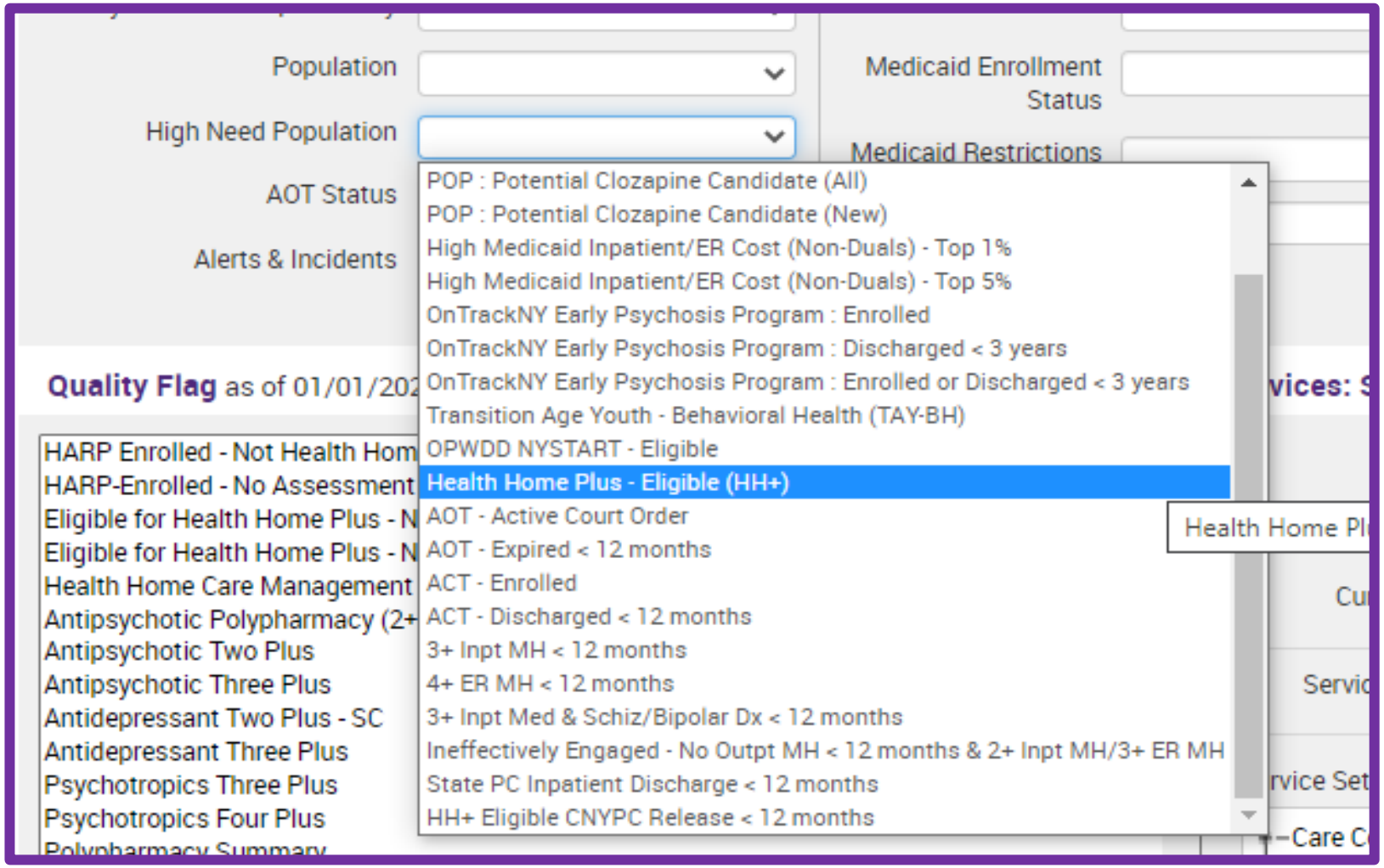
The Recipient Search screen in PSYCKES allows you to identify groups of people who meet your filter criteria



HH+ Eligible Filter in High Need Population Dropdown

Gives the total list* of HH+ Eligible members at an agency.

- Includes clients who are eligible but not enrolled, enrolled but not served, and served.
- Ie., the entire pool of an agency's clients who can potentially be touched by HH+.

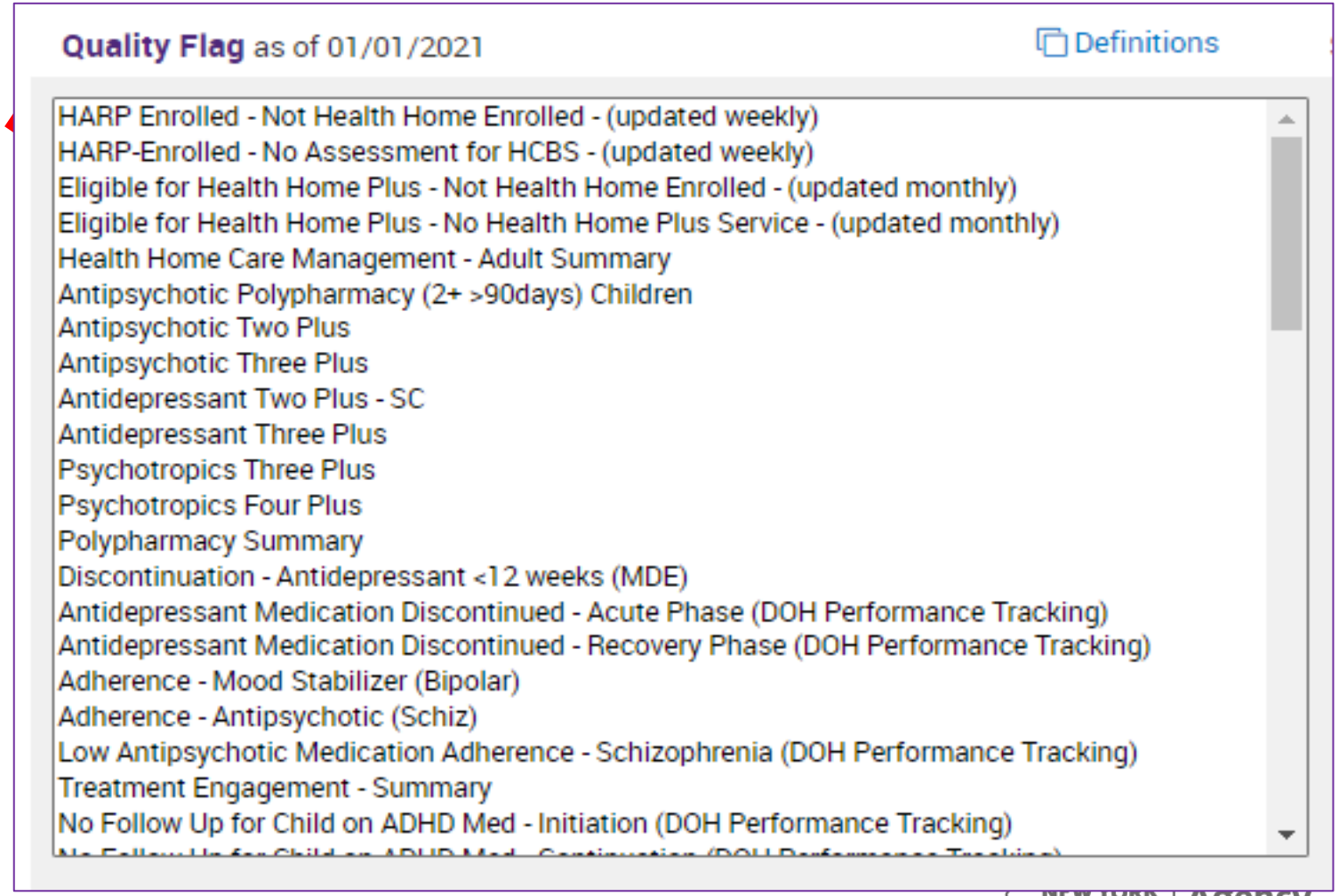


* Does not include eligibility due to homelessness or county referrals due to clinical discretion

PSYCKES HH+ QI Flags

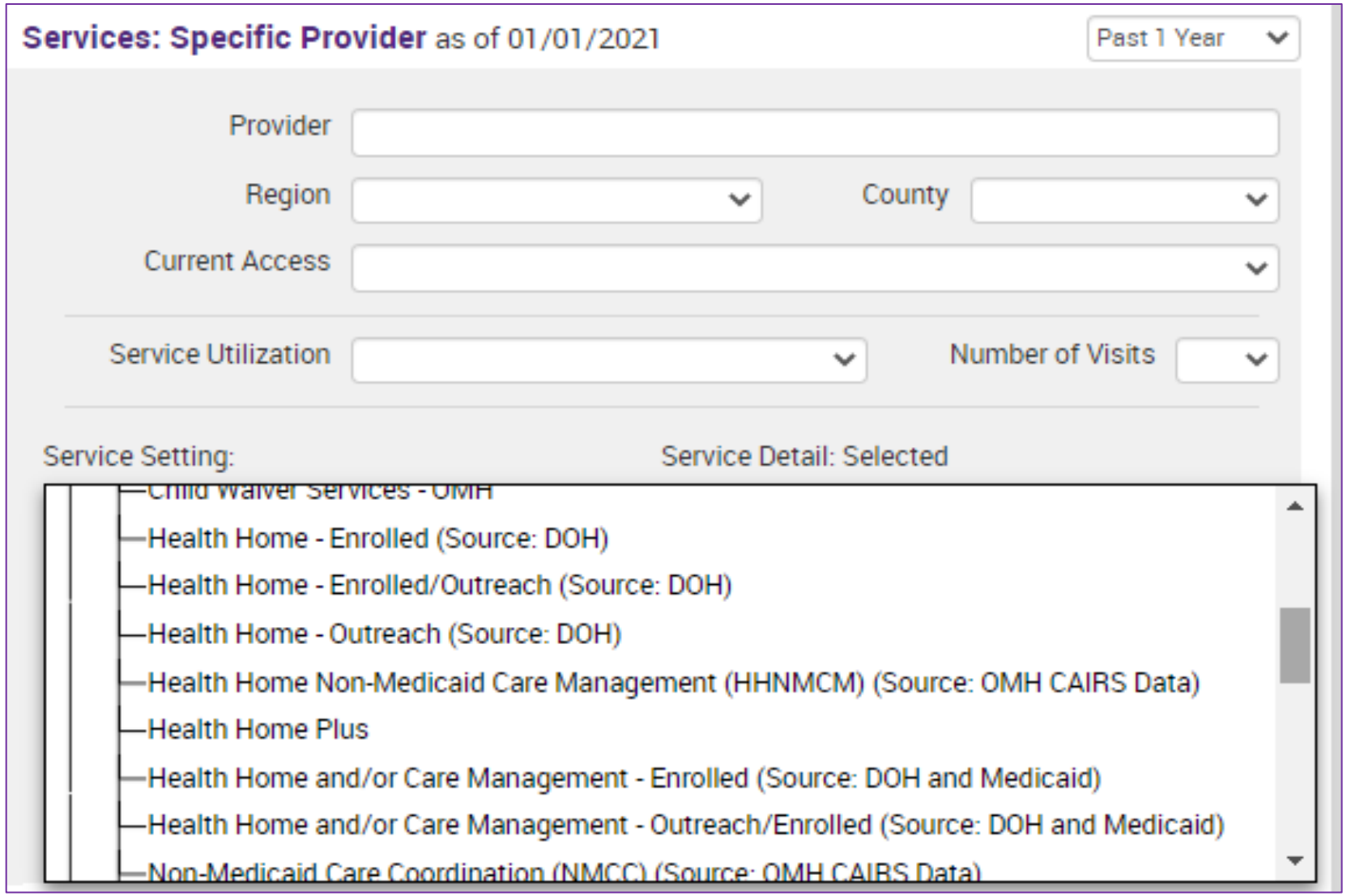
Breaks down the total list of HH+ Eligible members into:

- Eligible for HH+ but not HH enrolled
- Eligible for HH+ but not served (regardless of enrolled vs not enrolled)



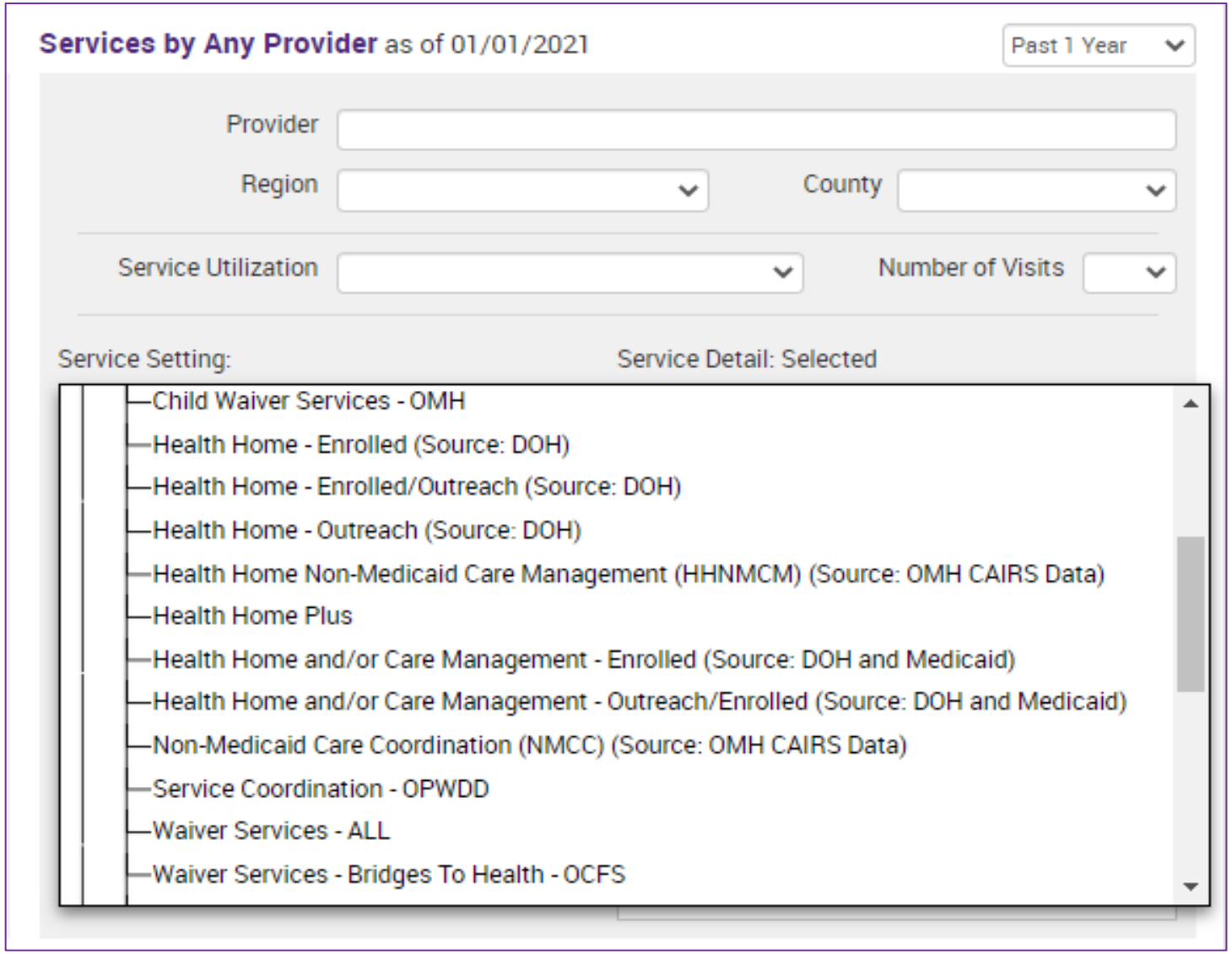
HH+ Filter by Specific Provider (Your Agency)

Pulls in anyone who received HH+ Services from your agency in the past year.



HH+ Filter by Any Provider

Pulls in anyone served by your agency who received HH+ Services from any provider in the state in the past year.



Referrals and Identification of HH+ Eligibility

Policy:

Individuals referred to Health Home and meeting HH+ SMI eligible criteria will **ONLY** be assigned to Specialty MH CMAs.

Referrals should be reviewed for HH+ eligibility

- developing ways for identification of HH+ eligibility
- working with HHs
- process for identification of individuals with potential for HH+

Increasing high need referrals

- Working with LGUs, HHs, hospitals, CPEPs, MH provders
- Have a strong policy in place for referral/intake process

Documentation for HH+ Eligible

Specialty MH CMAs will continue to document services and bill HH services through the lead HH.

- DOH Billing and Documentation Guidance remains applicable
- Referral sources can supply documentation to support if an individual meets high need indicators for HH+.
- PSYCKES HH+ eligibility indicator can serve as supporting documentation of HH+ eligibility

Service Requirements

Specialty MH CMAs will offer HH+ level of service to all members eligible for HH+.

Minimum Service:

- 4 HH Core Services per month, 2 must be face-to-face contact
    - For AOT individuals: 4 face-to-face contacts per month

Face-to-Face Contacts

Best Practices to ensure meeting minimum requirements:

- schedule ahead - agreed upon appointment times
- provide appointment reminders/call ahead to verify appointment
- make sure to have ALL contact information to reach members (e.g. spends time at parent's house often, have parent's number for contact)
- involve collaterals where applicable (consent)
- work around members schedule and preferences
- consider availability (evenings, weekends)
- allow for flexibility (rescheduling, time change)
- build rapport and trust
- make appointments meaningful to the member

Caseload Size

Specialty MH CMAs shall maintain small caseloads when HH+ members are included

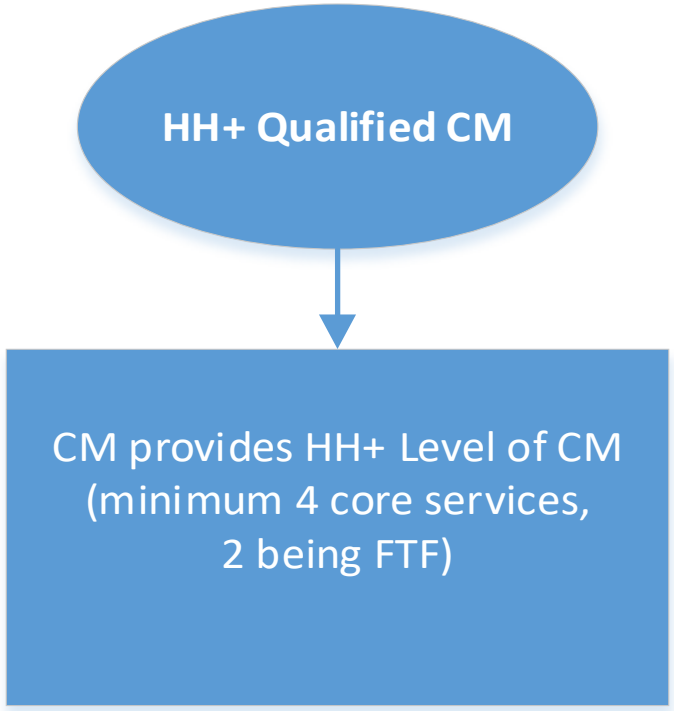
- caseload ratio is 1 Care Manager to every 20 HH+ members
- consider mixed caseloads and team approaches

Care Management Models that meet HH+ Requirements

HH+ Only Caseload

Model 1: HH+ Caseload

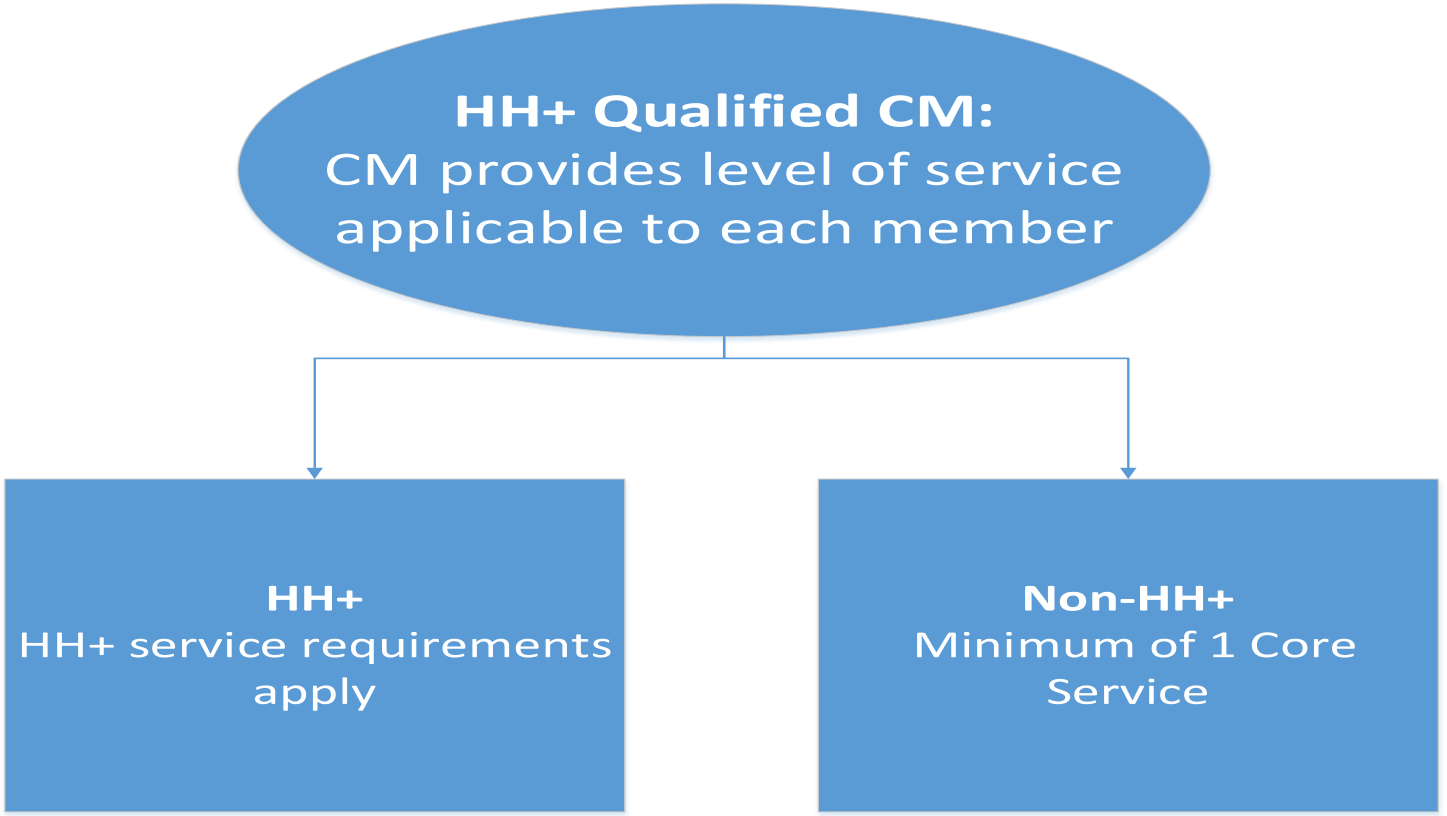
20 HH+ caseload served by CM



HH+ Mixed Caseload

Model 2: Mixed Caseload – CM

Mix of HH+ and non-HH+



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HH+ Team Approach

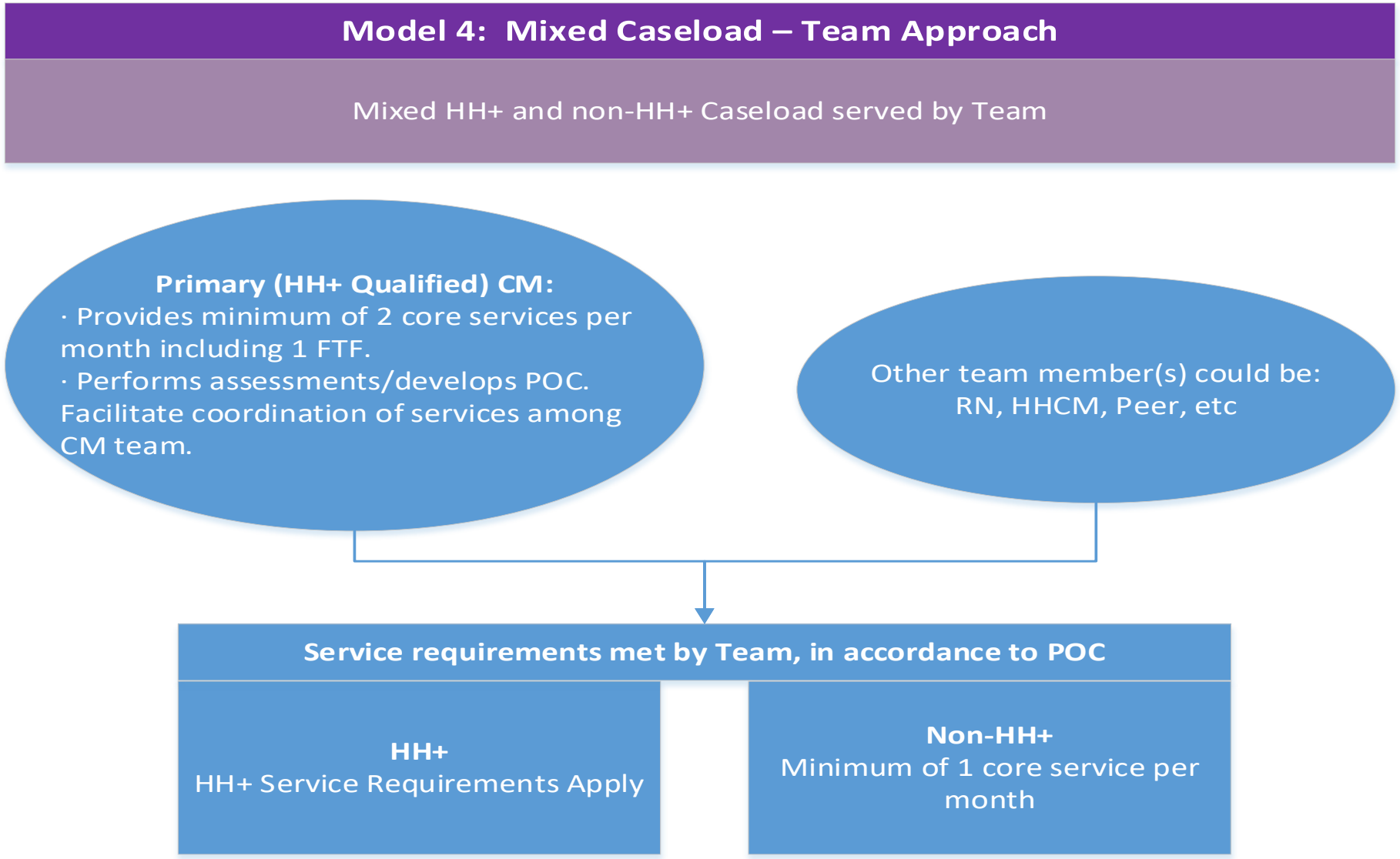
Model 3: HH+ Only Caseload - Team Approach

20 HH+ individuals can be served per every 1 FTE team member.
Minimum HH+ Service Requirements met by team.

Primary (HH+ Qualified) CM: Provides minimum of 2 core services per month including 1 FTF. Performs assessments/develops POC. Facilitates coordination of services among CM team.

Other team members could be:
RN, HHCM, Peer, etc

HH+ Mixed Caseload – Team Approach



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Designated SMH CMAs Technical Assistance

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Designated SMH CMAs Technical Assistance

- Access to a calendar of TA supports provided via live and recorded webinars, office hours and support documents
    - Examples of planned TA: PSYCKES 101 and identifying HH+ members; Understanding care management models; Using MHPD
- Individual technical assistance by OMH as requested
- Quarterly Data provided to monitor performance

Next Steps

Next Steps

1. Designated Specialty MH CMAs submit attestation by **3/8/21**
2. Participate in Technical Assistance as needed
3. Continue to provide HH+ level of care to HH+ eligible members

Questions

Questions regarding Specialty MH Care Management may be sent to the Health Home BML - Subject: **Specialty Mental Health Care Management.**

https://apps.health.ny.gov/pubpal/builder/email-health-homes

Q & A

Thank You!