Community Referrals for Health Home Services

Real time client referrals are accepted into the Health Home program from community sources. Federal authority mandates that hospitals refer to Health Home services eligible individuals with chronic conditions who seek care or need treatment in a hospital emergency department. Referral for Health Home services may come from a variety of other sources, including but not limited to, the criminal justice system, state prisons, county and city jails, Mental Health Discharges/Referrals from State Operated Psychiatric Centers, Article 22 and 31 hospitals, managed care plans, designated Health Homes, converting case management programs, clinics, health care providers, HIV providers, social service providers, etc.*

Potential members do not have to be on NYSDOH assignment lists or be approved by NYSDOH in order to be accepted for Health Home referral. The referring entity should document that the individual presumptively meets Health Home services qualifications as outlined in the State Plan Amendment (HIV/AIDS or one serious, persistent mental health condition or two chronic conditions including substance use disorders, diabetes, asthma, heart disease, HIV/AIDS, overweight (BMI >25). The referral can be made based on the presumptive assessment and the individual will be enrolled in the Health Home for a comprehensive assessment. A fee for service member can be referred to the lead Health Home for this comprehensive assessment; a managed care member can be referred to either the lead Health Home or the appropriate managed care organization for assignment for the comprehensive assessment. If the comprehensive assessment reveals that the individual does not meet Health Home services criteria, the individual must be transitioned to an appropriate level of care.

Consideration should also be given to prioritizing members based on acuity and the risk of the individual experiencing an adverse event, (e.g., death or disability, or admission to nursing home or hospital) to focus initial Health Home resources to our neediest members. If NYSDOH has established the acuity score for the individual, that acuity score will determine the rate. If there is no acuity score on file for the individual, the rate will be based on the statewide average acuity score until a member-specific score can be established from claims and encounter data. A workgroup of Health Homes and MCPs are developing additional provider guidance for determining Health Home eligibility which will include a formula for quantifying acuity and risk.

This additional guidance will be published shortly. Factors that are being considered for quantifying acuity and risk include:

- No primary care practitioner (PCP);
- No connection to specialty doctor or other practitioner for their condition;
- Poor compliance (does not keep appointments, etc);
- Inappropriate Emergency Department use;
- Repeated recent hospitalization for preventable conditions either medical or psychiatric;
- Recent release from incarceration;
- Cannot be effectively treated in an appropriately resourced patient centered medical home; and
- Homelessness.

Table F on Page 10 provides an overview of the interim referral process.

*See page 10 for additional guidance on making priority referrals to converting case management programs.

TABLE F: INTERIM HEALTH HOME REFERRAL GUIDANCE
STEP 1 - ASSESS ELIGIBLITY: Must meet eligibility for Health Home services as described in the New York State Health Home State Plan Amendment (claims/encounter or other clinical data should be used whenever available to verify medical and psychiatric diagnoses).
o Two chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, or other chronic conditions, OR; o One qualifying chronic condition (HIV/AIDS) and the risk of developing another, OR; o One serious mental illness.
STEP 2 - ASSESS APPROPRIATENESS FOR HEALTH HOME: Has significant behavioral, medical or social risk factors which can be addressed through care management.
o Probable risk for adverse event, e.g., death, disability, inpatient or nursing home admission; o Lack of or inadequate social/family/housing support; o Lack of or inadequate connectivity with healthcare system; o Non-adherence to treatments or medication(s) or difficulty managing medications; o Recent release from incarceration or psychiatric hospitalization; o Deficits in activities of daily living such as dressing, eating, etc.; o Learning or cognition issues.
STEP 3 - INITIATE REFERRAL: If member meets criteria described in Steps 1 and 2, the referral can be made on the basis of this presumptive assessment.
o Referrals for FFS members are made to the lead Health Home, referrals for plan members can be made directly to the MCP or to the lead Health Home to make the MCP connection. o Health Homes and MCPs have access to assignment information in the HCS portal and should check an individual's assignment status prior to making a referral. If the individual is already assigned to a Health Home, that Health Home should be contacted to discuss the appropriate course of action. o If a comprehensive assessment reveals that the individual does not meet Health Home services criteria, the individual must be transitioned to an appropriate level of care, such as a Patient Centered Medical Home (PCMH). o Detailed instructions on how to use the Health Home Member Tracking System to make a referral can be found in the Health Home Member Tracking System specifications document on the Health Home website.