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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
- Specialty Mental Health CMAs Designation Collaborative
- 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 MH CMA Provisional Designation

- CMAs who have been providing HH+ but not at the performance thresholds for designation
- Provisionally designated CMAs will develop an action plan for achieving the HH+ threshold needed for designation
- Technical Assistance and training available for CMAs
  - SMH CMA Designation Collaborative
  - OMH Technical Assistance
  - Training Resources

Specialty Mental Health Care Management Agency Attestation

- Provisionally designated SMH CMAs will complete attestations when they become designated
- Designated SMH CMAs will need to submit attestation to affirm Specialty MH CMA status
- CMAs will send a copy of the attestation will to lead HH(s) and LGU(s)
- Currently, only SMH CMAs already serving AOT will continue to serve AOT

Specialty MH CMA Standards

☐	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.

Specialty MH CMA Standards, Cont'd

☐	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(s) with the LGU/SPOA(s) in their service count(ies); 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.

Key Requirements for Specialty Mental Health Care Management

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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.)

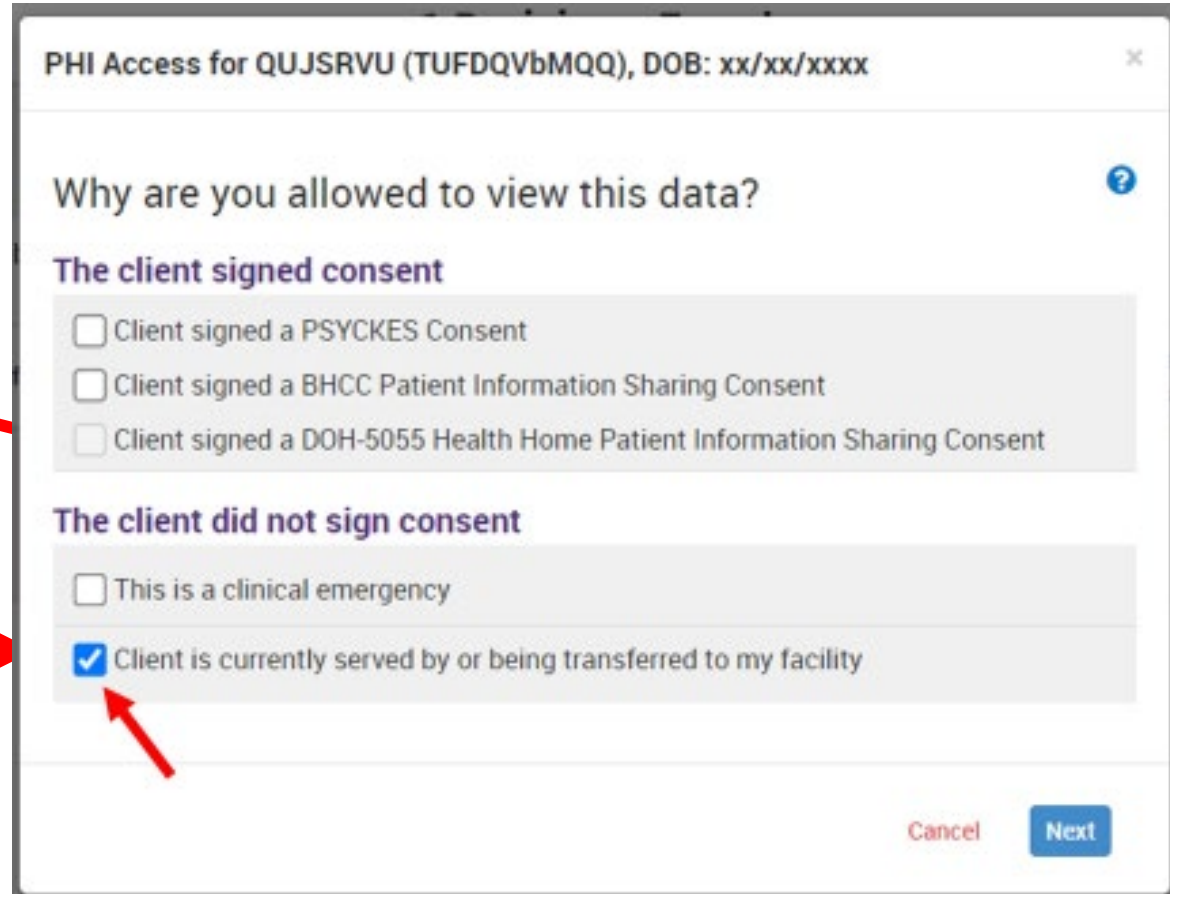
Using PSYCKES to Identify HH+ Eligible Members

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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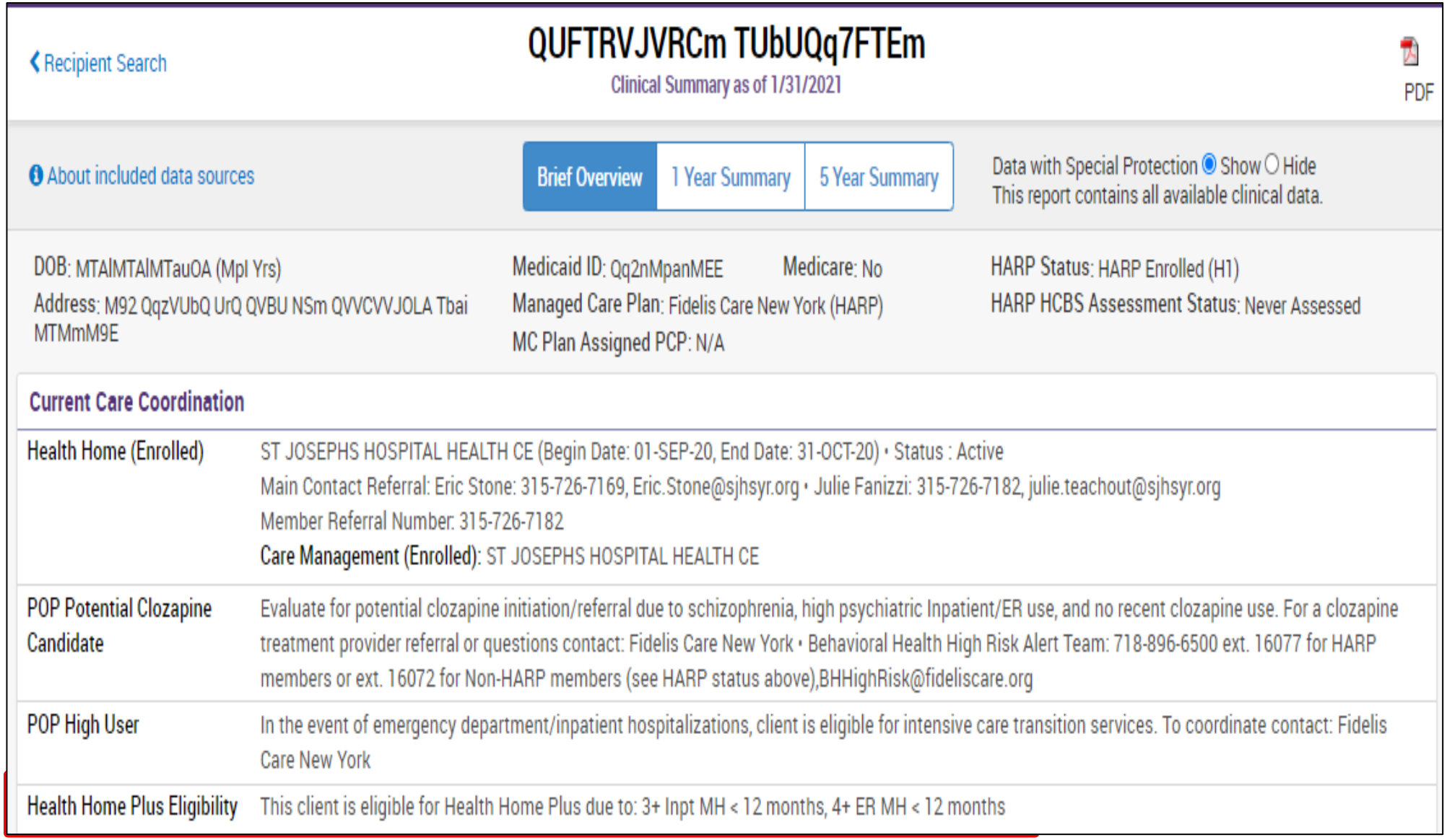
HH+ Alerts in the PSYCKES Clinical Summary

- 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

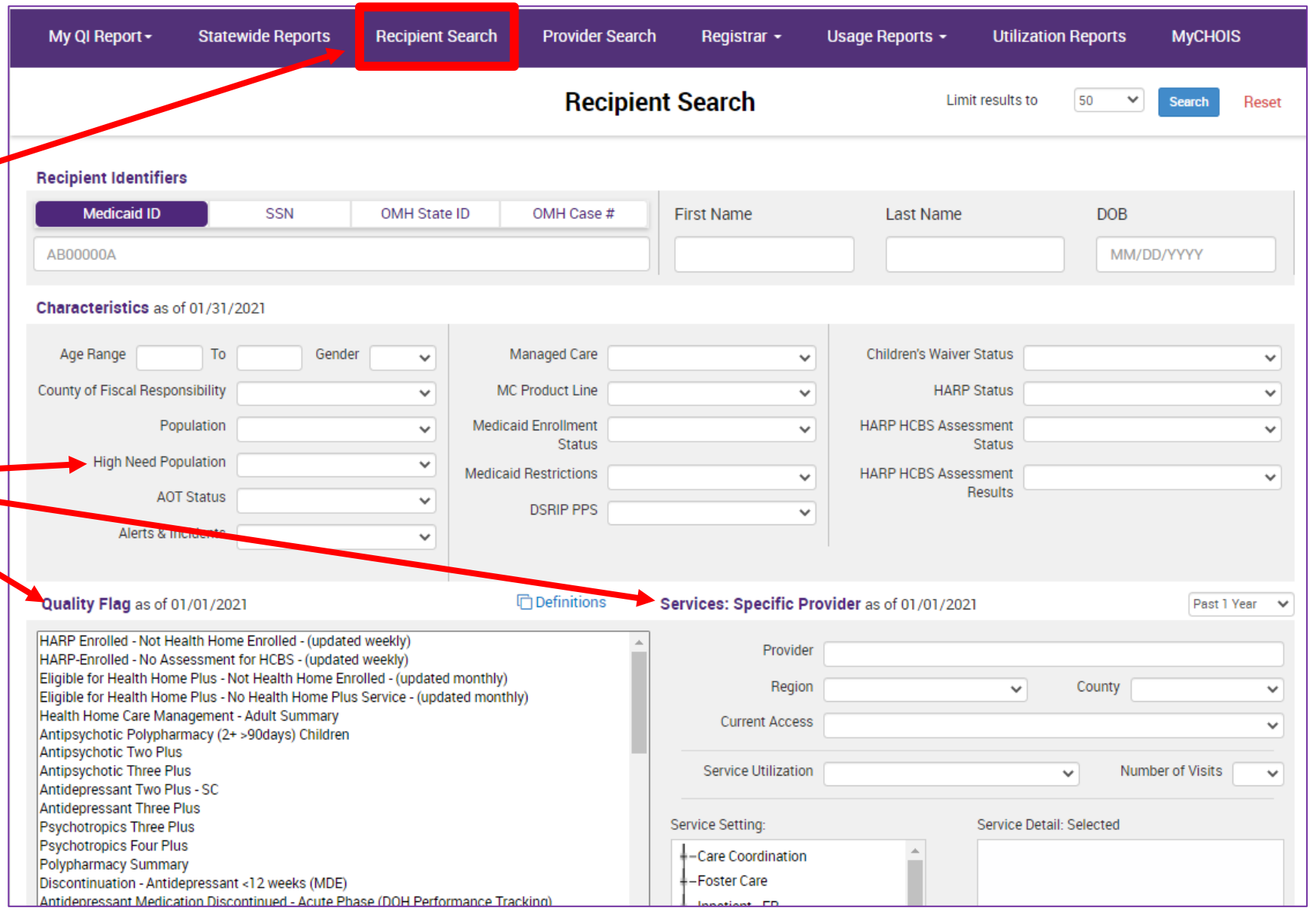
HARP Status: HARP Enrolled (H1)
HARP HCBS Assessment Status: Never Assessed

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

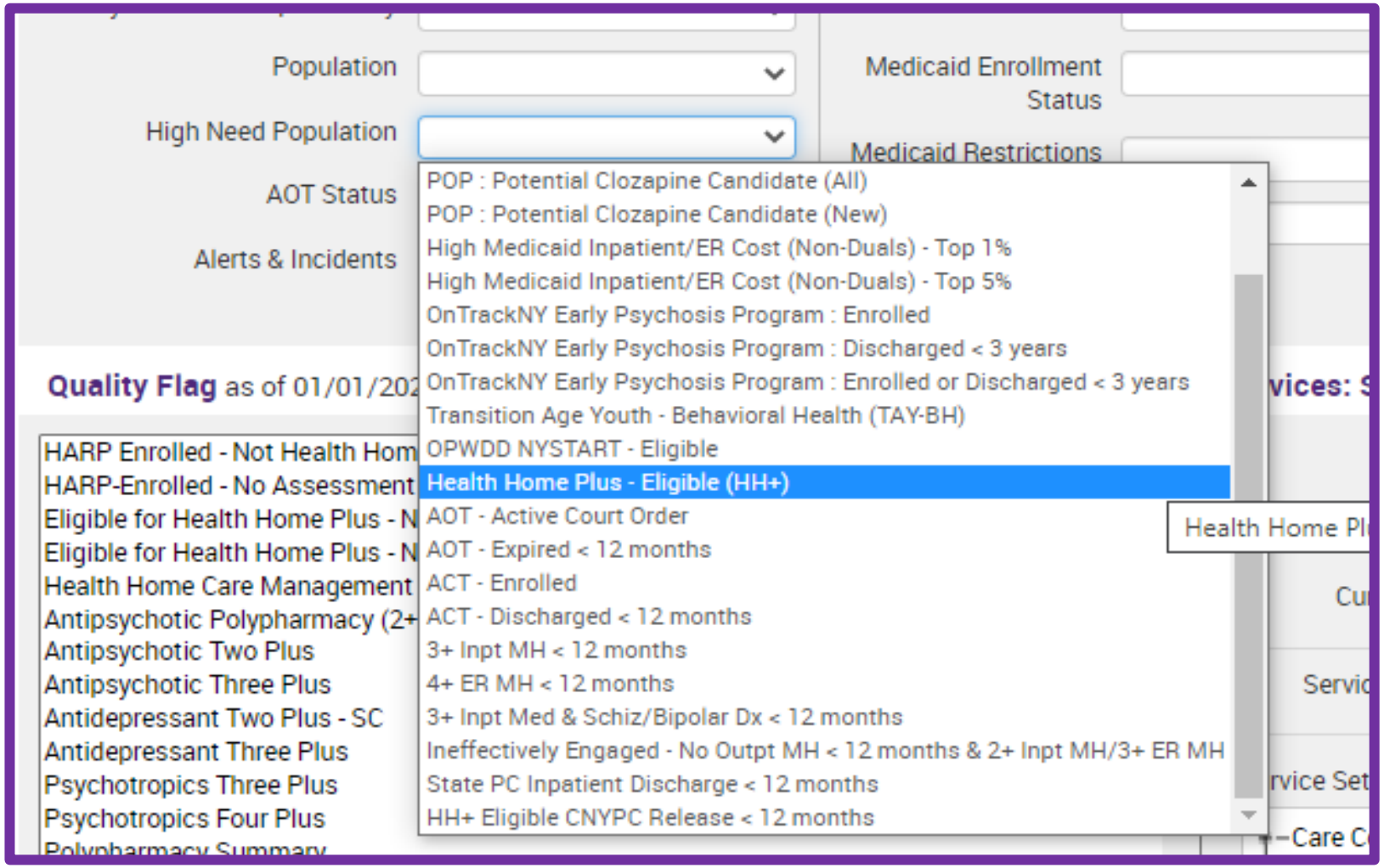
The Recipient Search screen in PSYCKES allows you to identify groups of people who meet your filter criteria



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+.

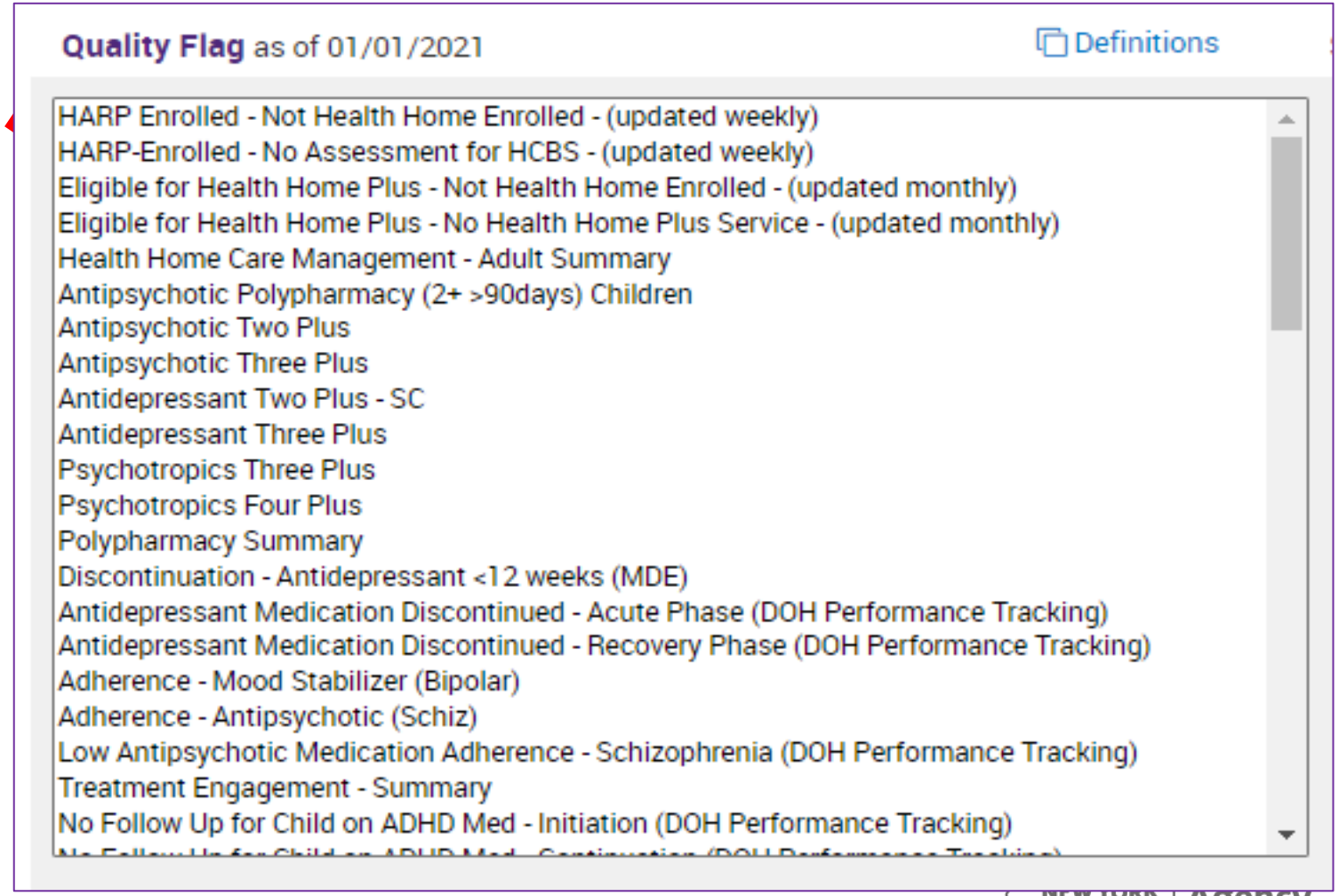


* Does not include eligibility due to homelessness or county referrals due to clinical discretion

PSYCKES HH+ QI Flags

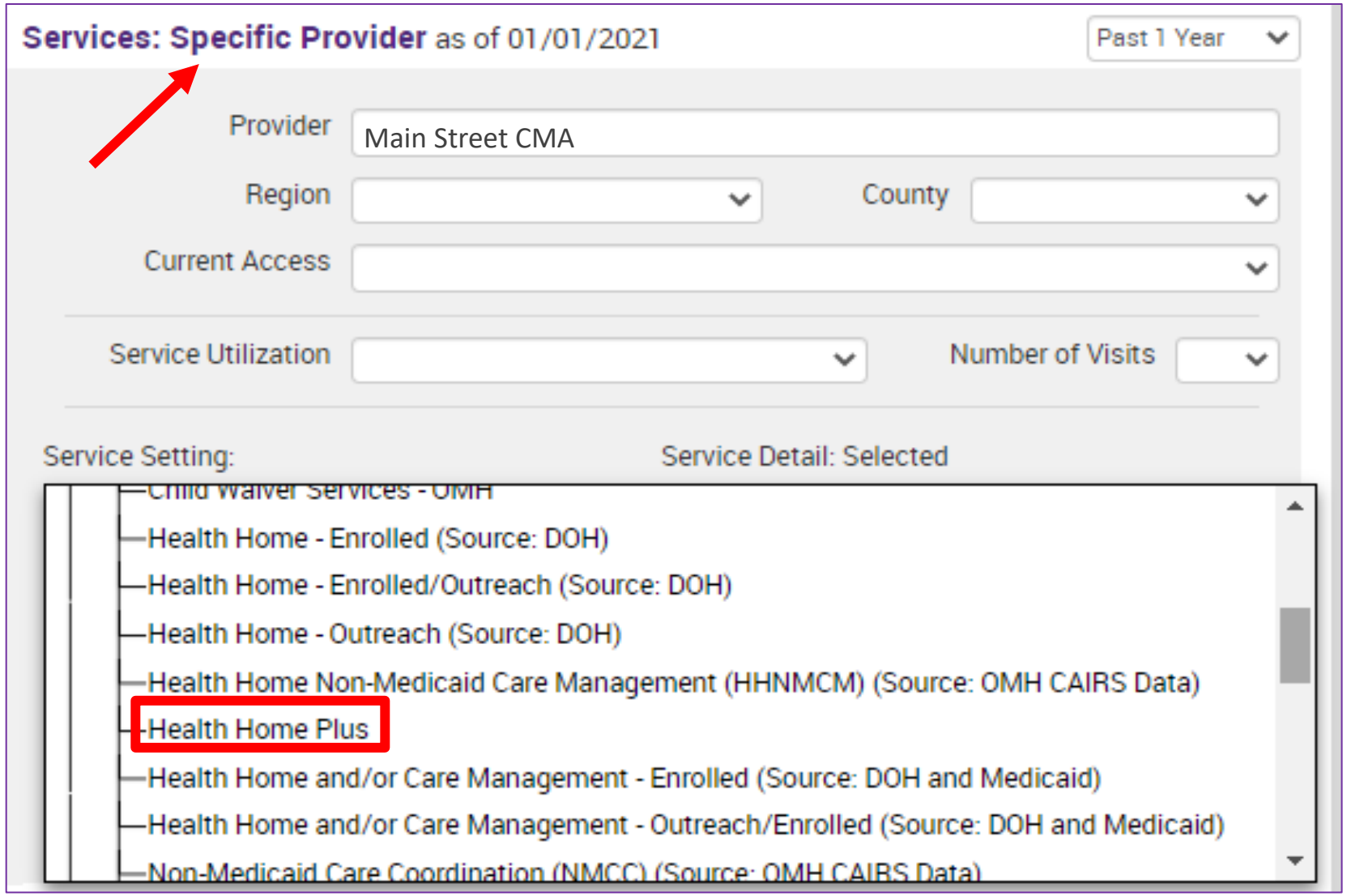
Breaks down the total list of HH+ Eligible members into:

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



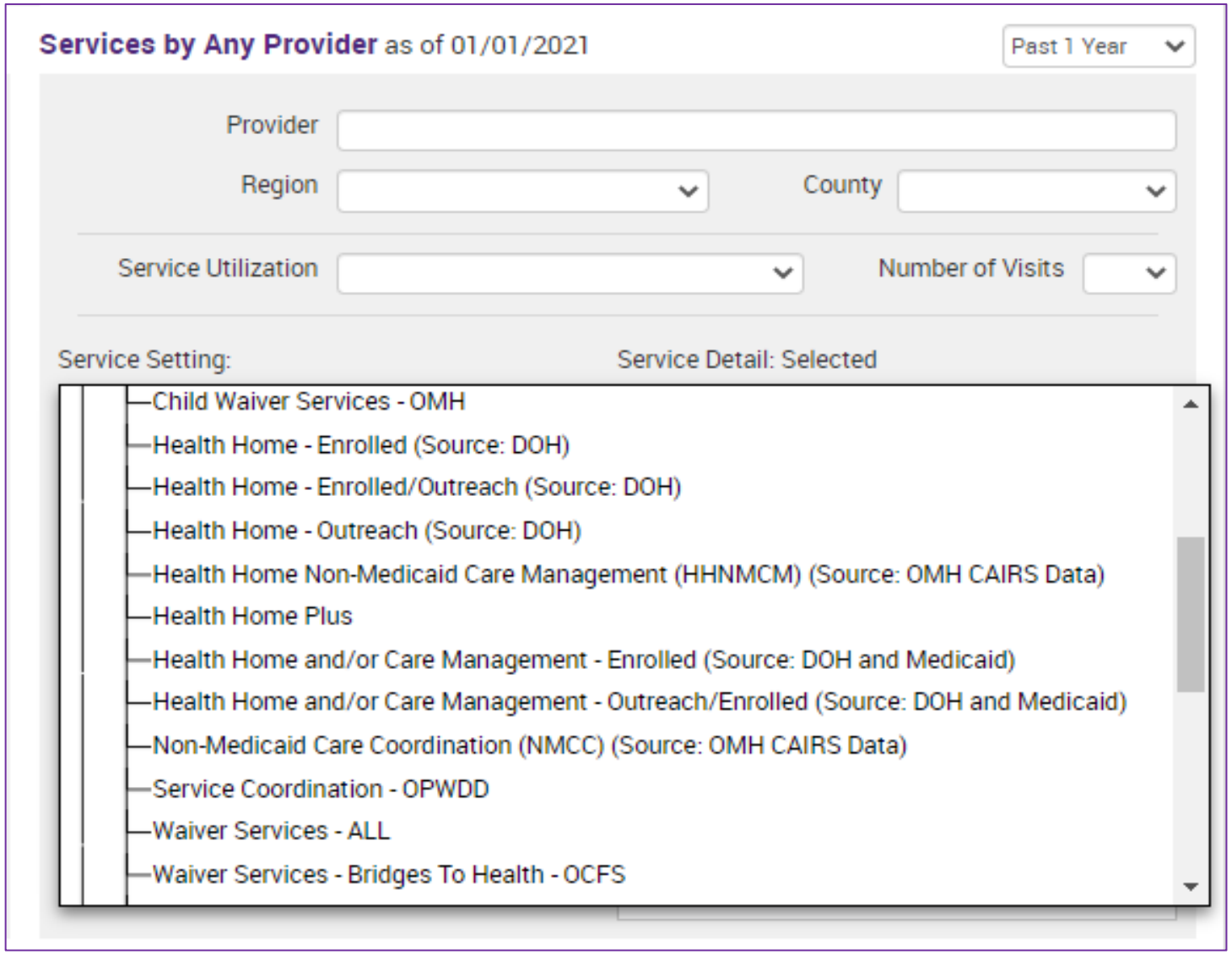
HH+ Filter by Specific Provider (Your Agency)

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

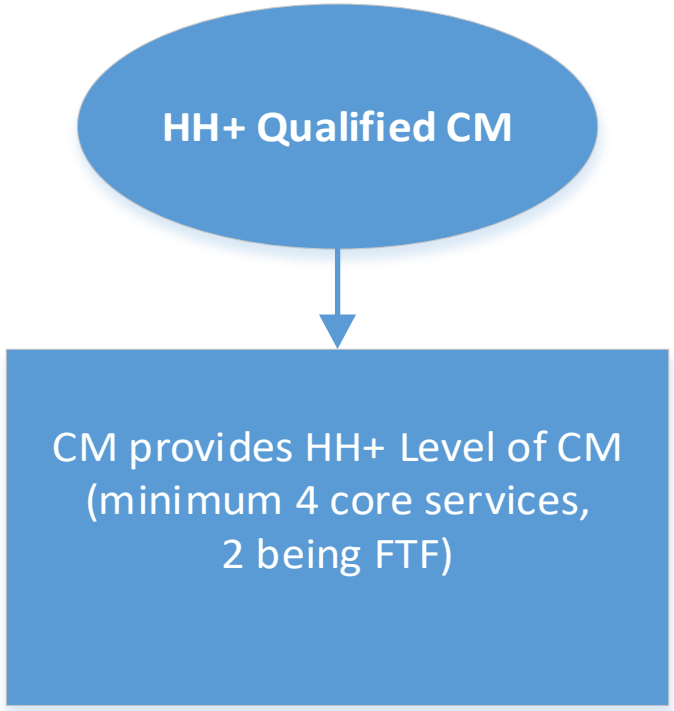
- caseload ratio is 1 Care Manager to every 20 HH+ members
- consider mixed caseloads and team approaches

Care Management Models that meet HH+ Requirements

HH+ Only Caseload

Model 1: HH+ Caseload

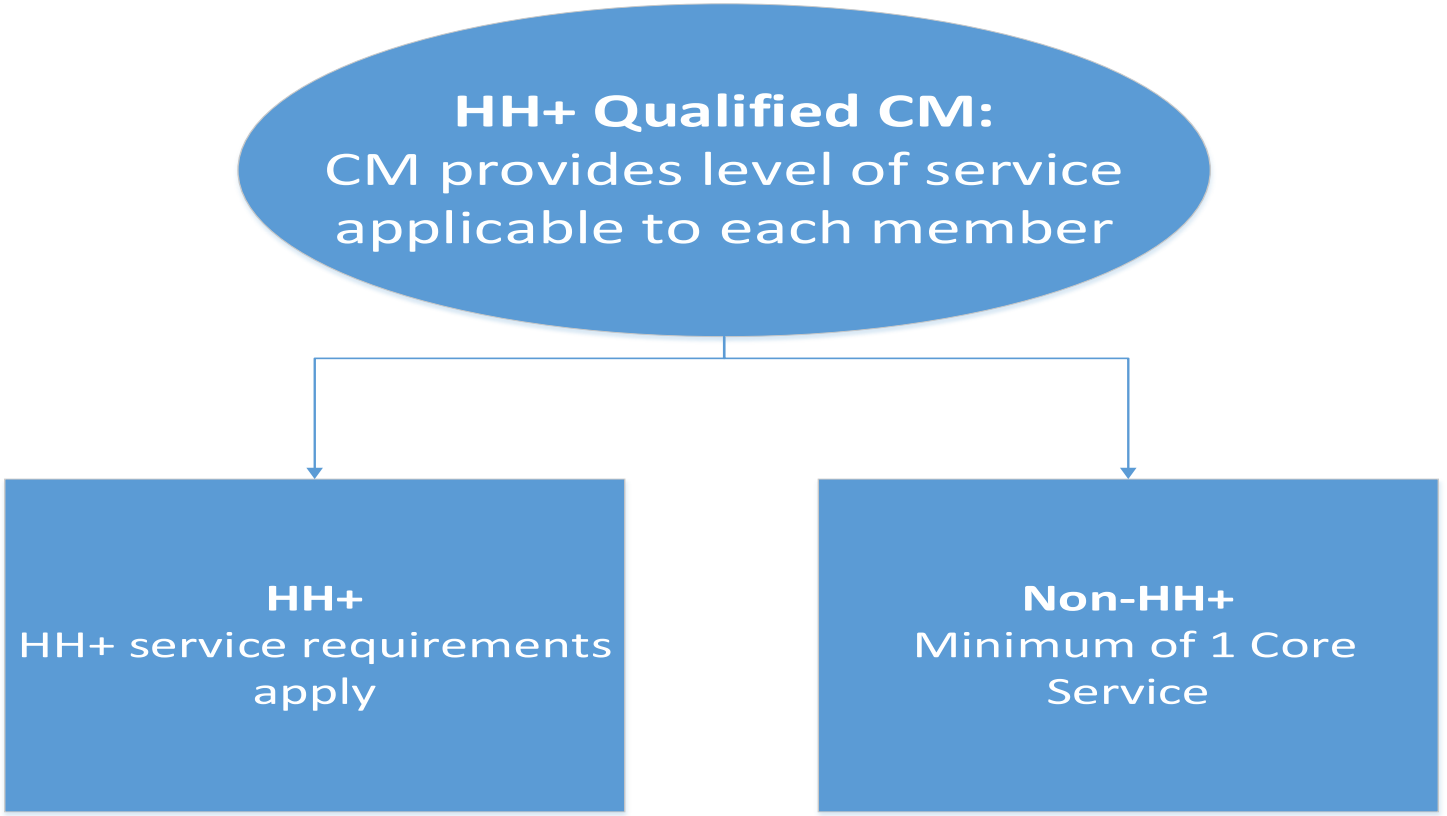
20 HH+ caseload served by CM



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

Model 4: Mixed Caseload – Team Approach

Mixed HH+ and non-HH+ Caseload served by Team

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

Other team member(s) could be:
RN, HHCM, Peer, etc

Service requirements met by Team, in accordance to POC

HH+
HH+ Service Requirements Apply

Non-HH+
Minimum of 1 core service per month

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SMH CMA Designation Collaborative

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Provisional Designation to Designation

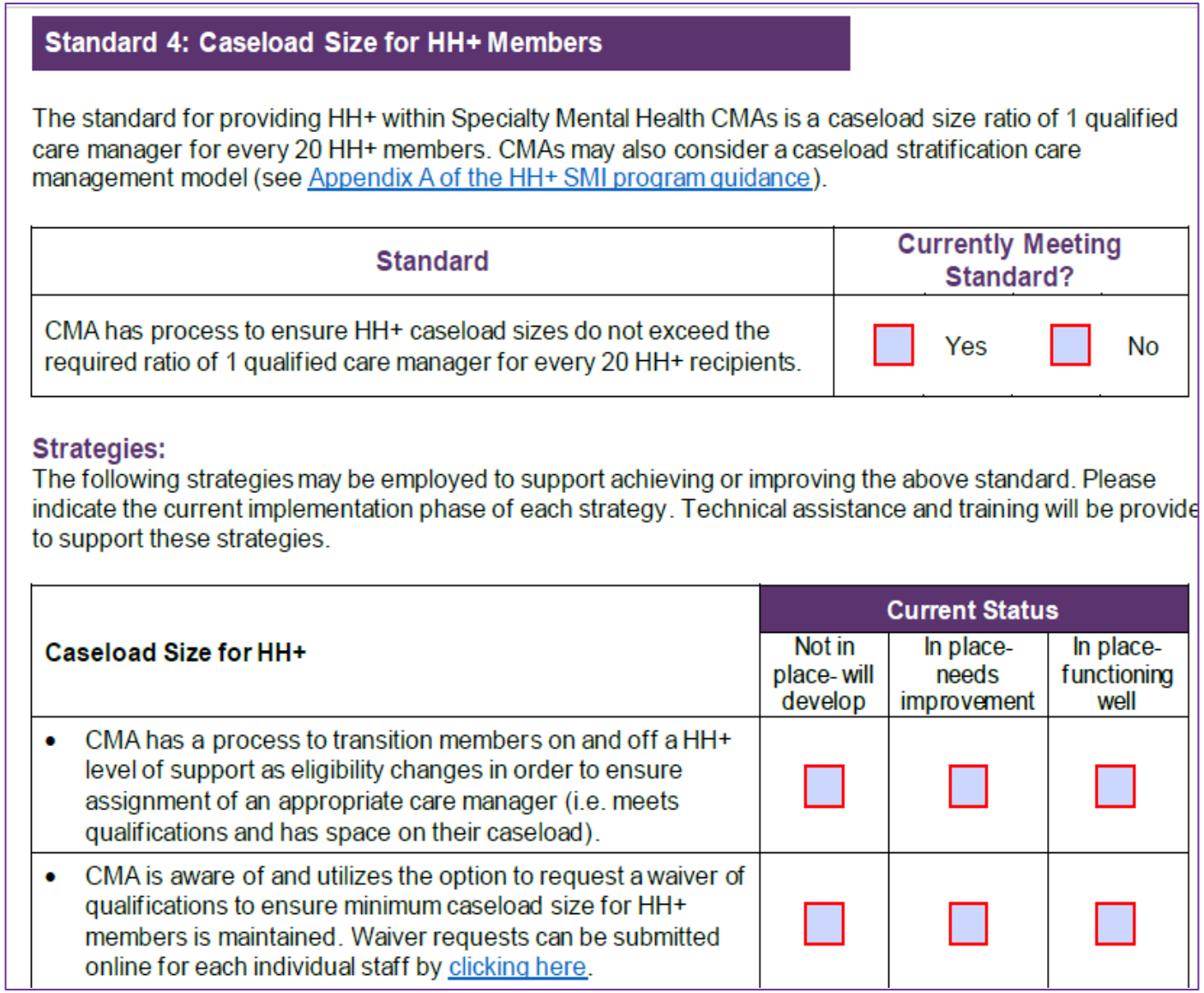
- Provisionally Designated CMAs are expected to increase HH+ enrolled and served:
  - CMA has identified at least 50% HH+ eligible members as HH+ eligible (per MAPP average over six months)
  - CMA has served at least 50% HH+ eligible members at HH+ level of service (per MAPP average over six months)
- To support reaching these goals, provisionally designated CMAs are required to participate in a SMH CMA Designation Collaborative

Specialty MH Designation Collaborative Components

- SMH Designation Collaborative Staff:
  - Prabu Vasan, PSYCKES Project Manager
  - Joohee Suh, PSYCKES Research Assistant
- Collaborative activities will include:
  1. Action Planning and Quarterly Check-In
  2. Monthly Reporting
  3. Technical Assistance

Action Planning

- Action Plans help CMAs identify current strategies that support designation and develop an implementation plan for improvement
  - CMAs with multiple CM programs are required to complete one plan for each in collaboration with the CMA leadership team
  - Plans should be submitted in the PDF (not printed out) via the Health Home BML by **March 15th**
  - Once you submit your Action Plan, CMAs can immediately begin identified improvement activities



Standard 4: Caseload Size for HH+ Members

The standard for providing HH+ within Specialty Mental Health CMAs is a caseload size ratio of 1 qualified care manager for every 20 HH+ members. CMAs may also consider a caseload stratification care management model (see Appendix A of the HH+ SMI program guidance).

Standard	Currently Meeting Standard?
CMA has process to ensure HH+ caseload sizes do not exceed the required ratio of 1 qualified care manager for every 20 HH+ recipients.	☐ Yes ☐ No

Strategies:
The following strategies may be employed to support achieving or improving the above standard. Please indicate the current implementation phase of each strategy. Technical assistance and training will be provide to support these strategies.

Caseload Size for HH+	Current Status		
	Not in place- will develop	In place- needs improvement	In place- functioning well
• CMA has a process to transition members on and off a HH+ level of support as eligibility changes in order to ensure assignment of an appropriate care manager (i.e. meets qualifications and has space on their caseload).	☐	☐	☐
• CMA is aware of and utilizes the option to request a waiver of qualifications to ensure minimum caseload size for HH+ members is maintained. Waiver requests can be submitted online for each individual staff by clicking here.	☐	☐	☐

Quarterly Check-Ins

- After the Action Plan is submitted, an initial Quarterly Check-In will review current CMA workflows and identify targeted Action Steps for the next 3 months
- Subsequent Quarterly Check-In calls with the Collaborative Team will review progress on Action Items, review CMA data, troubleshoot any barriers, and develop next steps to move towards designation

Monthly Reporting

- CMAs will submit a brief monthly report to identify progress to date on implementing strategies
    - Reporting is online via Surveymonkey
- CMAs will be asked if the implementation of priority strategies are:
    - In place
    - In progress
    - Not yet started
- Submitted data will help inform Quarterly Check-In calls and TA needs
- Additional information on monthly reporting will be forthcoming

Technical Assistance

- CMAs will receive a calendar of technical assistance that will provide training and support for achieving designation strategies
- TA supports will be provided via live and recorded webinars, office hours and support documents
- Some examples of planned TA:
  - PSYCKES 101 and other methods to identify HH+ members
  - Understanding care management models and how to implement
  - Using MHPD
- CMAs will identify which TA supports they will use as part of their Quarterly Check-In Action Items

Next Steps

Next Steps

1. Provisional Designation Action Plans Due on **3/15/21**
2. After Plan submission, Prabu will reach out to schedule initial Quarterly Check-In call
3. Begin implementation of Action Plan
4. Continue to provide HH+ level of care to HH+ eligible members

2021 Timeline	Key Steps
March 8th	• Designated Specialty MH CMAs submit Specialty MH CMA Attestations to NYS OMH • HH+ SMI referrals shall only be assigned to designated Specialty MH CMAs with submitted attestations.
March 15th	• Provisionally Designated CMAs submit proposed Action Plan for meeting designation criteria, for OMH approval. • Provisionally Designated CMAs may receive HH+ SMI referrals, with a submitted Action Plan for formal designation.
March 15 – October 15	• CMAs complete implementation activities, as reviewed during applicable Kick-Off webinar. • Provisionally Designated CMAs must also participate in OMH PSYCKES learning collaborative and technical assistance activities, as identified in the CMA's agreed upon Action Plan for formal designation.
March 1 - November 1	• Provisionally Designated CMAs only: OMH evaluates CMA progress towards meeting designation criteria. • As Provisionally Designated CMAs meet the State HH+ performance benchmark for designation, CMAs will submit Specialty MH CMA Attestations to NYS OMH and will receive OMH Specialty MH CMA Designation Notification letter shortly after.

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!