Health Home Care Management Quick Facts

What is Health Home Care Management?

- The NYS Department of Health definition of a health home care management is, "a model of care management provided by community "care managers" who oversee and provide access to all of the services an individual needs to assure they stay healthy, out of the emergency room and out of the hospital. Care Managers build linkages to other community and social supports, and enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses. Health Home services are provided through a network of organizations including health care providers, health plans and community–based organizations. All of an individual´s providers communicate with one another so the individual´s needs are addressed in a comprehensive manner."

Who we are:

- Bachelor and master level Care Managers with experience in behavioral and physical healthcare, child welfare, foster care, early childhood education, substance use treatment, long-term care and more.

Who we serve:

- Clients with active Medicaid *AND*
- 2 or more chronic conditions *OR*
- Serious emotional disturbance (SED) or Serious Mental Illness (SMI) as determined by a licensed professional *OR*
- HIV/AIDS *OR*
- Complex trauma as determined by a licensed professional (children only) *AND*
- Significant behavioral, medical, or social risk factors that deem them appropriate for Health Home services.

What we do:

- Comprehensive Care Management Services:
  - Conduct outreach and engagement
  - Complete a strength and needs assessment within 30 days of enrollment and reassess every six months
  - Complete a comprehensive assessment within 60 days of enrollment and reassess annually
  - Complete a crisis intervention plan and comprehensive care plan within 60 days of enrollment and review/update every six months
  - Consult with multidisciplinary team on the client's care plan, needs and goals.
- Care Coordination and Health Promotion Services:
  - Support adherence to treatment recommendations
  - Link clients to needed services to support care plan goals
  - Conduct case reviews with interdisciplinary team
  - Coordinate with treating clinicians to ensure services are provided
  - Monitor, support, and accompany client to scheduled appointments
- Comprehensive Transitional Care Services:
  - Ensure continuity of care and comprehensive transitional care from service to service
  - Follow up with hospitals and ERs upon admission and/or discharge
  - Facilitate discharge planning
  - Notify and consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation
- Member Support Services:
  - Consult with client, the family and/or legal guardian on advanced directives and client's rights
  - Facilitate needed interpretation services
  - Refer client to peer supports, support groups, social services and entitlement programs
- Referral to Community and Social Support Services:
  - Identify available community based resources and link client and family with community supports as needed
  - Actively manage referrals, access, engagement, social supports, follow-up and coordination of services

Health Home Care Management Frequently Asked Questions:

Q: *Who should be referred to the Health Home program?*
A: Clients with physical and or mental health diagnoses that require on going treatment and:

- are at risk for an adverse event (e.g. death, disability, inpatient or nursing home admission, mandated preventive services or out of home placement);
- have inadequate social/family/housing support, or serious disruptions in family relationships;
- have inadequate connectivity with healthcare system;
- do not adhere to treatments or have difficulty managing medications;
- has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- has deficits in activities of daily living, learning or cognition issues; or
- are concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

Q: *Do clients have to be referred by a clinician?*
A: No. Anyone can make a referral, including family members, social supports, managed care organizations, school staff, etc.

Q: *Do referrals need to be sent to both the Health Home and the Care Management Agency?*
A: Unless referring to another agency of the client's choice, referrals can be submitted via email to carecoordination@liberty-resources.org or through Evolv.

Q: *Does documentation of a client's diagnosis have to be submitted at the time of referral?*
A: No. Care Managers are responsible for determining the client's eligibility, which often involves asking the referring clinician to provide proof of qualifying conditions. Providing supporting documentation with the referral can be helpful in expediting the enrollment process.

Q: *Can clients with commercial insurance or Child Health Plus receive Health Home care management?*
A: No. Members of the Health Home program must have active Medicaid. Clients who do not have Medicaid, but require assistance with their behavioral health needs may be eligible to receive support from a Liberty Targeted Case Manager.

Q: *Can a youth consent to Health Home services without parental permission?*
A: Youth ages 18 and older, or youth who are under the age of 18, but are pregnant, a parent, or married can self-consent.

Q: *What if a client is enrolled in a Health Home program at another agency, but wants a Care Manager at Liberty?*
A: The client/family should contact their current Care Management Agency, or the Health Home, and request a transfer.

Q: *How many cases do Care Managers serve?*
A: On average, Care Managers carry a caseload of 25-30 children/youth or 30-35 adults, depending acuity level.

Q: *How often do Care Managers meet with clients/families?*
A: Minimally, once per month, depending on acuity level.

Q: *How frequently do Care Managers need to consult with clinicians?*
A: The primary function of the Care Manager is to establish an integrated care team of service providers and supports who will collaborate to ensure that the client is accessing supports and services to reduce the risk of emergency room visits, hospitalizations and other out-of-home placements. Care Managers are required to conduct a case review with the Care Team within 60 days of enrollment and at least once annually. Our program's practice is to remain in frequent contact (at least once per month) with all members of the Care Team to discuss needs, strengths, and interventions to ensure continuity of care and encourage progress toward goals.

Q: *Who should be contacted with questions about Health Home referrals and services?*
A: Liberty Resources Health Home program can be contacted at 315-413-7606 or carecoordination@liberty-resources.org.