Guideline Name: Health Home Referral Guideline	**Effective Date**: December 1, 2016
Sponsor: Millennium Collaborative Care	**Type of Guideline**: Medical

Purpose and Applicability:

To set forth the standard requirements for Health Home Referrals for Millennium Collaborative Care PPS Partners. This policy will provide information about Health Homes, benefits of a Health Home, criteria, how to refer to a Health Home, and know how to confirm the status of a patient in a Health Home.

What is a Health Home?

Health Homes are not a place. They are Medicaid community care management services. Health Home serve eligible high need/high cost Medicaid beneficiaries with multiple and chronic conditions. Health Home enrollees receive a dedicated Care Manager who oversees and provides access to all the services an individual need to stay healthy, out of the emergency room and out of the hospital.

What are the benefits of a Health Home?

Health Home enrollees receive a dedicated Care Manager who oversees and provides access to all services an individual need to stay healthy, out of the emergency room and out of the hospital. Health Homes provide the following FREE services for eligible-Medicaid enrollees:

- Develop patient's personalized care plan.
- Help with better coordination of patient care
- Make sure everyone involved in patient's care is coordinating services.
- Understands patient's goals.
- Encourage activities that keep the patient healthy.
- Assist the patient with linkage to housing, legal assistance, food and other essential needs.

What is the criteria for a patient to be eligible?

Patients must be an active Medicaid recipient, including Managed Care Medicaid and those who have both Medicare and Medicaid.

What is the criteria necessary for a patient to be referred? Medicaid beneficiaries need to meet only one of the following conditions:

- Two or more chronic health conditions, such as asthma, diabetes, heart disease, mental health condition or substance use disorder.
- A significant mental illness with an associated functional impairment, such as: difficulty maintaining social relationships, difficulty with self-care.
- Living with HIV/AIDS.

How do I refer to a Health Home?

There are two options for referring to a Health Home. You can call the local Health Home directly or fax a completed Universal Health Home Referral Document.

- ALLEGANY
  - Chautauqua County Department of Mental Hygiene 585.613.7642

- ERIE
  - Health Home Partners of Western NY 716.566.4100
  - BestSelf Behavioral Health 716.710.4393
  - Greater Buffalo United Accountable Healthcare Network (GBUAHN) 716.247.5282

- CATTARAUGUS/ CHAUTAUQUA
  - Chautauqua County Department of Mental Hygiene 585.613.7642

- GENESEE
  - Huther Doyle Memorial 585.613.7642

- NIAGARA
  - Health Home Partners of Western NY 716.566.4100
  - Niagara Falls Memorial Medical Center 716.278.4647

- ORLEANS
  - Huther Doyle Memorial 585.613.7642

- WYOMING
  - Health Home Partners of Western NY 716.566.4100 2016

How will I know if a patient is already enrolled in a Health Home?

Patients enrolled in a Health Home can be looked up in your office using HEALTHeLINK

Access this link: http://wnyhealthecommunity.com Log in using your HEALTHeCOMMUNITY user ID and password. Click on the Patient Info Tab and scroll down to the provider's section (almost at the bottom of the page), if a patient is enrolled in a health home it will be listed in this section.

- If you do not have a HEALTHeCOMMUNITY account, you may sign up at the following link: http://wnyhealthelink.com/PhysiciansandSta-/HowToJoin/ Enrollment Forms *If the patient is on the outreach list or has not formally signed up with a Health Home, the Health Home would not show up in this section of HEALTHeLINK.
- Or call any of the Lead Health Homes for assistance

How will information be shared between my organization and the Health Homes?

A Health Home generally provide the patients physician a copy of the Health Home plan of care either faxed or mailed. For now, send progress notes in the format that makes sense for your organizations (i.e. email, fax, CCD, etc.).
A connectivity solution is being developed and progress updates will be made available to you.

MPA Language for DSRIP Year 2 Partners Deliverables:

Millenniums MPA partners have received a specific requirement that align with Integrated Delivery System project milestones which support Health Home integration within care settings, (protocols in place to support care transitions of care, protocols for care coordination, referrals to Health Homes and Health Home education) All aspects of milestone and deliverables must be completed by March 31,2017.

Resources:

The following documents can be accessed in the Reference section of Millennium Collaborative Care web site. www.millenniumcc.org:

- Millennium Collaborative Care Health Home Referral Guide
- Health Home 101 education power point
- Health Home Referral Document
- Health Home Fact Sheet

- Millennium Learning Center
    - Course: Health Homes-Case Management support for Medicaid recipients

Dates of Update:

Updated: June 2,2017 June 16,2017