

What It Means to be a Downstream Care Management Agency within a Health Home for Children

May 26, 2015



Updated 5/27/15

Overview

- New York State, working with IPRO, has commissioned the New York Care Coordination Program to provide a series of Health Home trainings to assist Voluntary Foster Care Agencies in fulfilling their role as a downstream Health Home care managers for children in Foster Care
- Today's session is the first in a series of training sessions we will review at the close of today's discussion

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Introductions and Today's Presenters

- Adele Gorges, Executive Director, New York Care Coordination Program, Inc.
- John Lee, Director, New York Care Coordination Program, Inc.
- Christine Mangione, Clinical Director, New York Care Coordination Program, Inc.

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About the New York Care Coordination Program, Inc.

- The New York Care Coordination Program (NYCCP) is a not-for-profit organization governed by a board of directors consisting of county representatives, peer and family members and provider organizations.
- Numerous training programs, focusing on development of person-centered, recovery focused care management, have been provided since 2003 to various groups to facilitate understanding of what person-centeredness is and what a recovery-oriented system of care might look like.
- NYCCP brings the experience of providing Health Home administrative services to four adult health homes, operating collectively across a 22 county span, through a program within NYCCP called Health Homes United New York (HHUNY).



Person-Centered Recovery Focused Care Management for Adults has shown Good Outcomes

Full report for NYCCP Outcomes 2003-2010 available at www.carecoordination.org

Better Quality Care

- 46% decrease in emergency room visits per enrollee*
- 53% reduction in days spent in a hospital*
- 78% of enrollees report “dealing more effectively with problems” (2009 Enrollee Survey)

Better Social Outcome

- 31% increase in gainful activity*
- 54% decrease in self harm among enrollees*
- 53% reduction in harm to others*

* 2009 Periodic Reporting Form Analysis



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Person-Centered Recovery Focused Care Management for Adults has shown Good Outcomes

Lower Mental Health Costs

- A comparison of 2008 Medicaid mental health costs for Case Management and ACT populations in NYCCP counties to same populations in 6 comparison counties shows NYCCP:
 - 92% lower for inpatient services
 - 42% lower for outpatient services
 - 13% lower for community support
- The same study shows per person cost increase from 2003 – 2008 was 15% for NYCCP counties and 24% for comparison counties. (NYS OMH 2010)

Lower Mental and Physical Health Costs

- The cumulative rate of increase between 2003 and 2008 for Medicaid costs for case management recipients is 8% for Erie county and 13% for Monroe County, compared to a 20% increase for individuals in the classification of NYS SSI/Disabled-Rest of State. (CCSI 2010)



Today's Training: What It Means to be Downstream Care Management Agency

- Objective: Understand Medicaid Health Homes in New York State from the perspective of a Voluntary Foster Care Agency
 - What a designated Health Home does
 - What a downstream Care Management Agency does
 - How a designated Health Home and a downstream Care Management Agency work together effectively to provide Health Home Care Management Services

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Agenda

1. Brief Overview: Health Home Model for Children
2. Health Home Process Flow
3. Role of the Designated Health Home
4. Role of the Care Management Agency
5. Elements that will drive success for downstream Care Management Agencies
6. Reminder about future trainings
7. Questions and Answers

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Brief Overview: Health Home Model for Children



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What is a Health Home?

- Outgrowth of the Affordable Care Act
- It is a program that provides Care Management to Medicaid members that meet the Chronic Condition Eligibility Criteria
- All of the professionals involved in a member's care communicate with one another so that all needs are addressed in a comprehensive manner.
- Medical, behavioral health and social service needs are to be addressed in a comprehensive, integrated care planning process

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Why Health Homes?

What are the expected outcomes?

- Improve health care and health outcomes
- Lower Medicaid costs (over time for children)
- Reduce preventable hospitalizations and ER visits
- Avoid unnecessary care for Medicaid members
 - Right service at the right time
 - Avoid the escalation of services and costs from unmet needs

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Who is eligible for Health Home Care Management?

- Medicaid
 - Fee for Service
 - Managed Care
- Eligibility Criteria
 - Does the individual meet the revised eligibility criteria?
- Appropriateness
 - Not every Foster Care Child that Meets Health Home Eligibility Requirements will be appropriate for Health Home. Does Child need the Comprehensive Care Management Provided by Health Home ?

Current Health Home Eligibility Criteria and Proposal to Modify Health Home Eligibility Criteria (Modifications in *Bold*)

Person must be enrolled in Medicaid and have:

- Two or more chronic conditions or
- One single qualifying condition of
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) / Serious Emotional Disturbance (SED)
- **Trauma at risk for another condition (Requires CMS Approval)**

Chronic Conditions Include:

- ✓ Alcohol and Substance Abuse
- ✓ Mental Health Condition
- ✓ Cardiovascular Disease (e.g., Hypertension)
- ✓ Metabolic Disease (e.g., Diabetes)
- ✓ Respiratory Disease (e.g., Asthma)
- ✓ Obesity BMI >25 (**BMI at or above 25 for adults, and at or above 85th percentile for children**)
- ✓ Other chronic conditions (see DOH website for list of chronic conditions)
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

Appropriateness Criteria for Health Home Eligibility

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for Health Home care management. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has 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
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

Definition of Serious Emotional Disturbance (SED) – Health Home Eligibility Criteria

SED Definition for Health Home -SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

SED Definition for Health Home - DSM Qualifying Mental Health Categories*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

*Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.



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Proposed Definition of Trauma – Health Home Eligibility Criteria (requires CMS Approval)

Trauma at Risk for Another Chronic Condition

Trauma is defined as exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence, and physical and sexual abuse.

A child or adolescent who has experienced trauma would be defined to be **at risk for another chronic condition if they have one or more functional limitations** that interfere with their ability to function in family, school, or community activities, or they have been placed outside the home.

Functional limitations are defined as difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development.

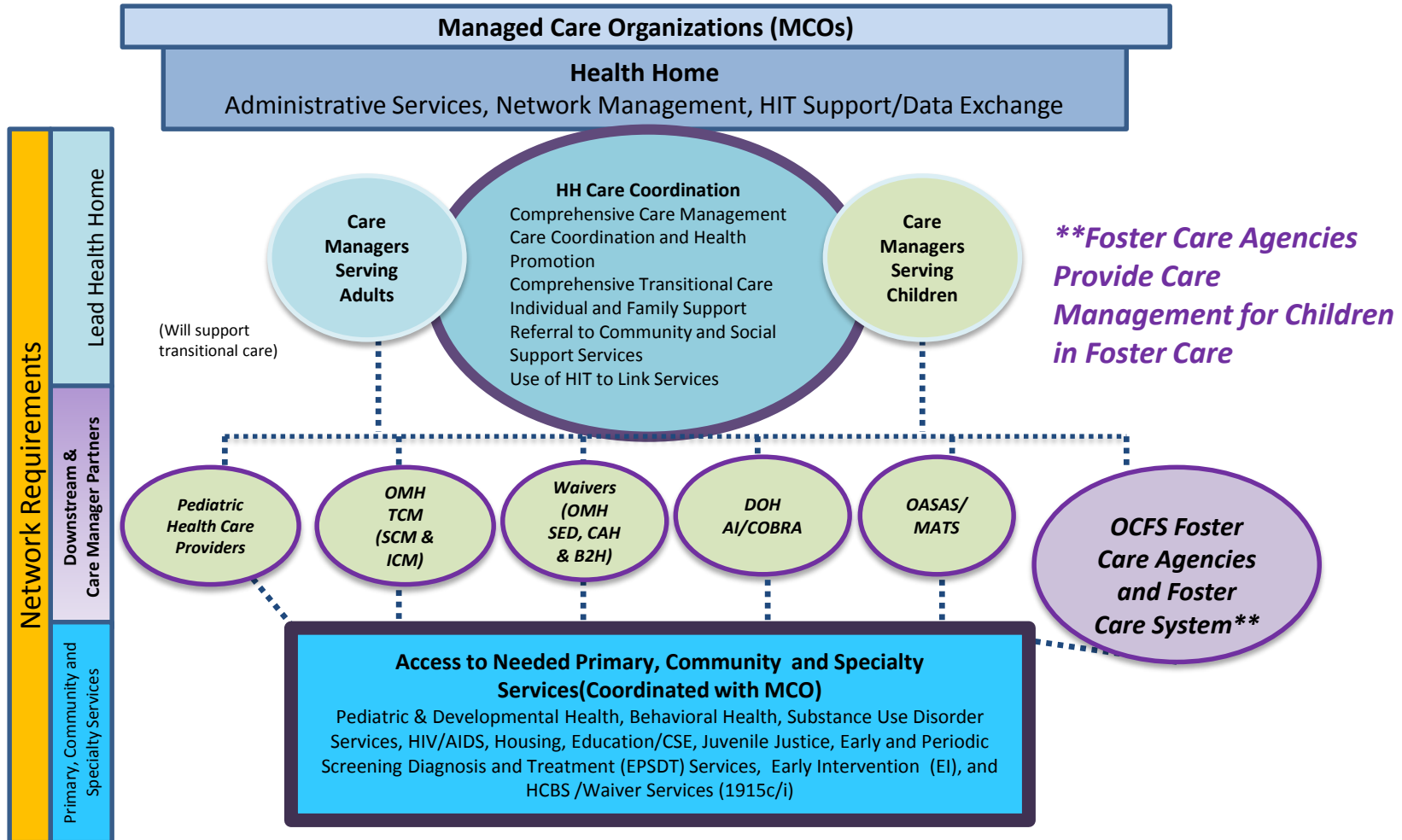


Key Role for Voluntary Foster Care Agencies and Local Departments of Social Services in Health Home Model For Children

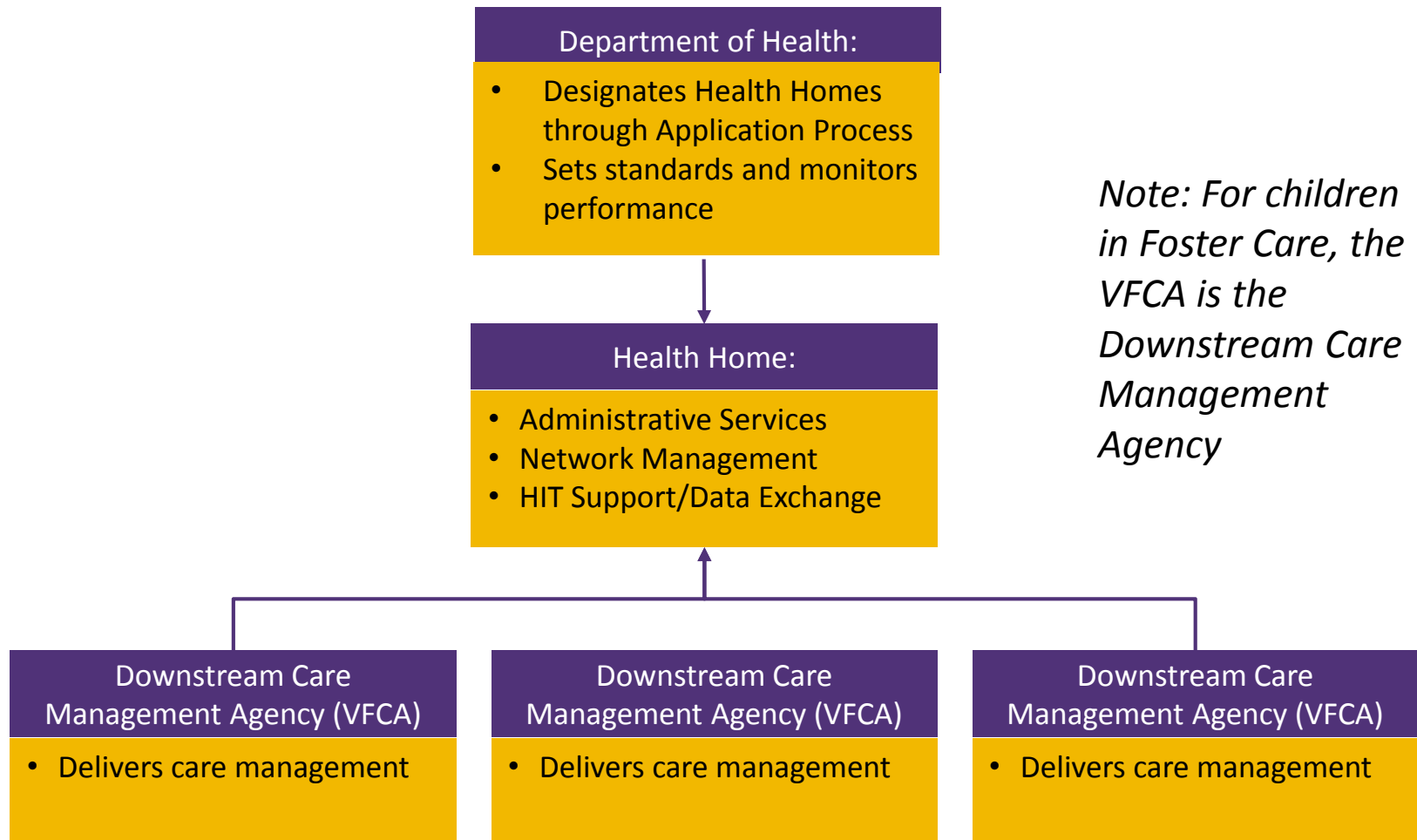
- For Foster Care, Health Home Model for Children includes a Key role for Local Departments of Social Services (LDSS) and Voluntary Foster Care Agencies (VFCA)
 - VFCAs provide Health Home care management for children in Foster Care
 - VFCAs may also provide Health Home care management for children not enrolled in Foster care or that transition out of Foster Care
 - LDSS provides consent to refer and enroll Foster Care children in Health Homes
 - LDSS assigns child to VFCA for purpose of providing Health Home care management; VFCA chooses and assigns to Health Home
 - Health Homes required to contract with VFCAs



New York State Health Home Model for Children



Health Home Organization Chart



Note: For children in Foster Care, the VFCA is the Downstream Care Management Agency

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Core Health Home Services - Delivered by the Downstream Care Management Agency

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of Health Information Technology to link services

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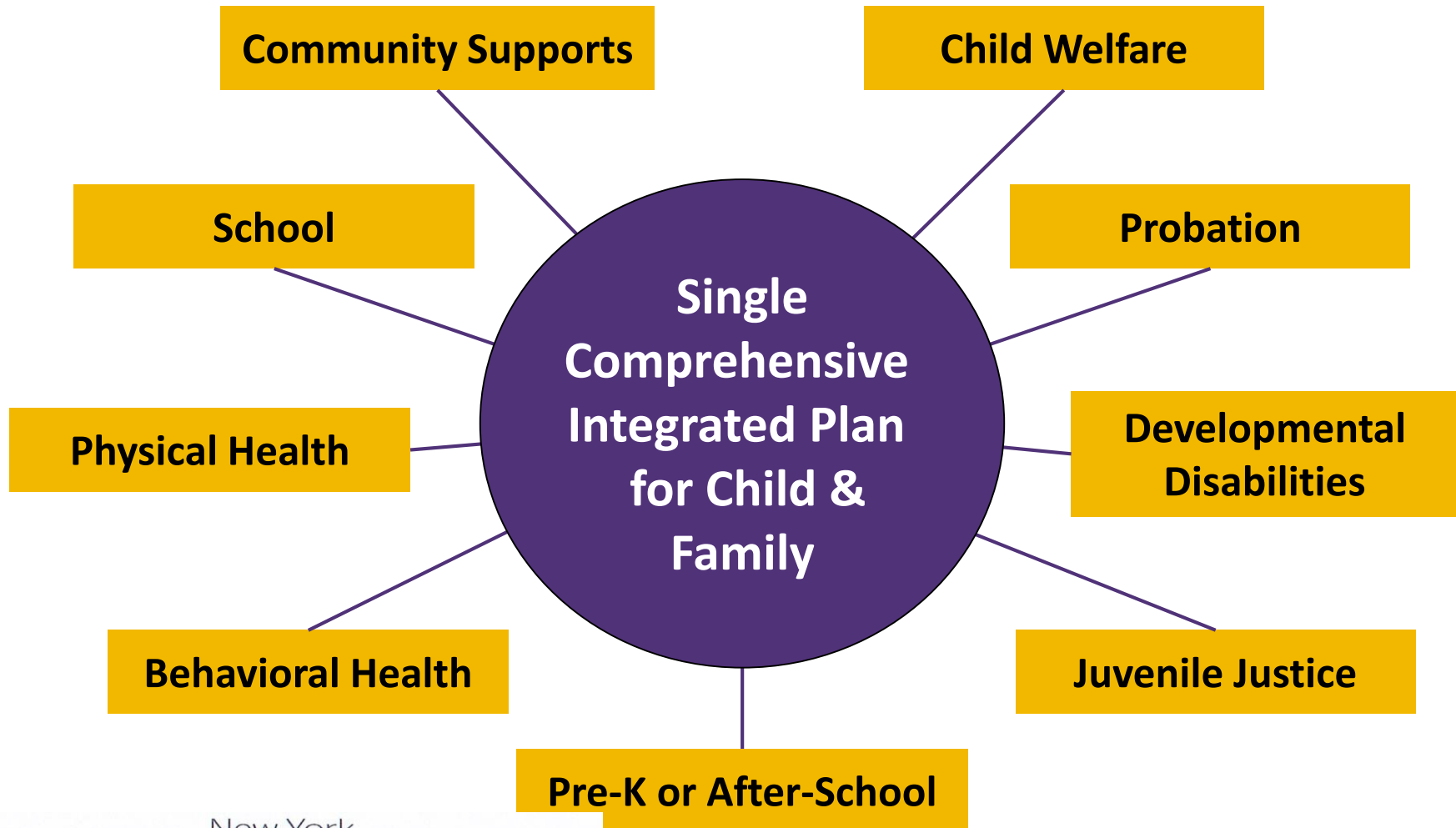


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Health Home Care Management

Key: Cross-System Collaboration



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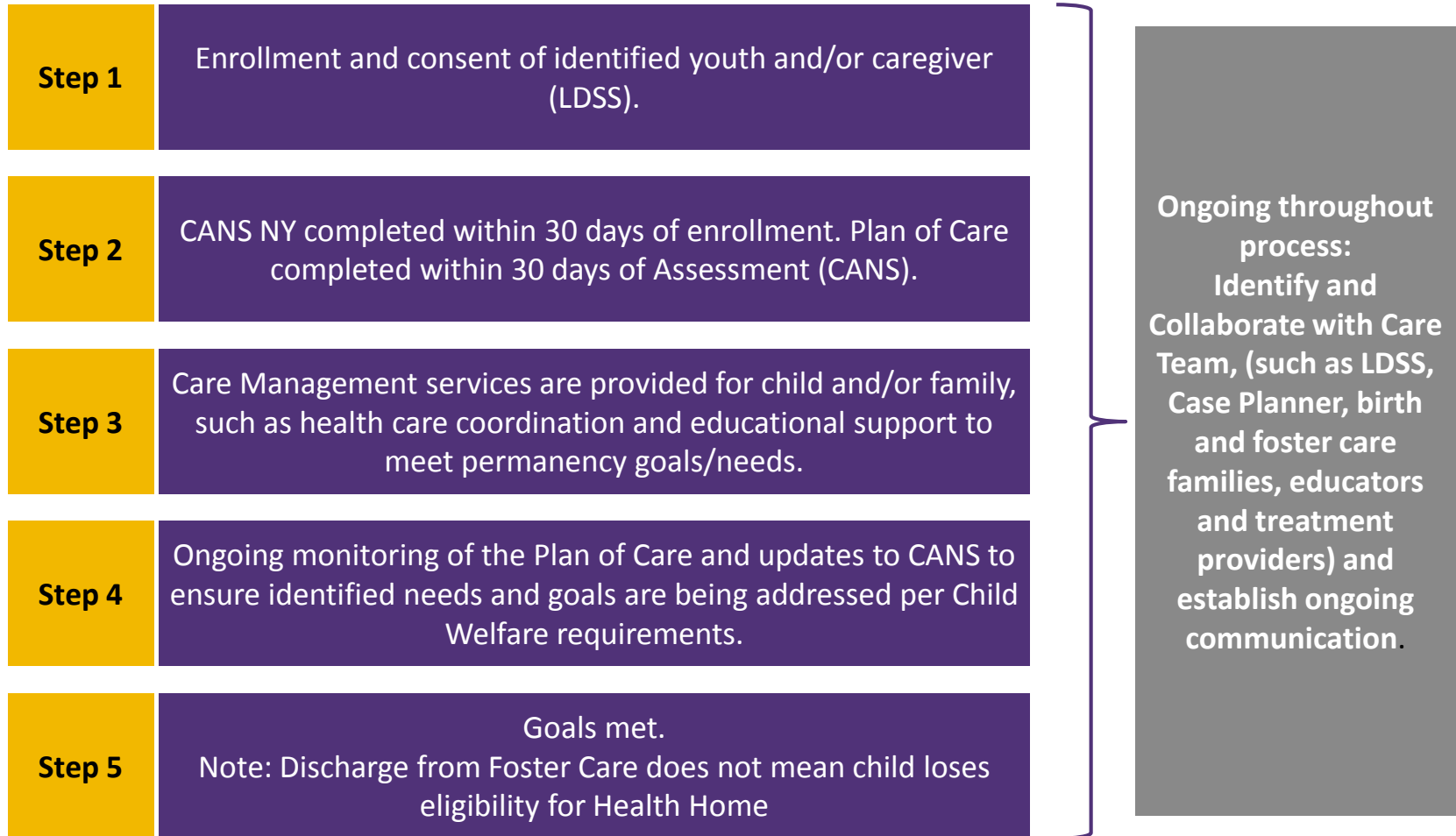
Health Home for Children Process Flow



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Health Home Care Management for Children and Families Served in the Voluntary Foster Care System



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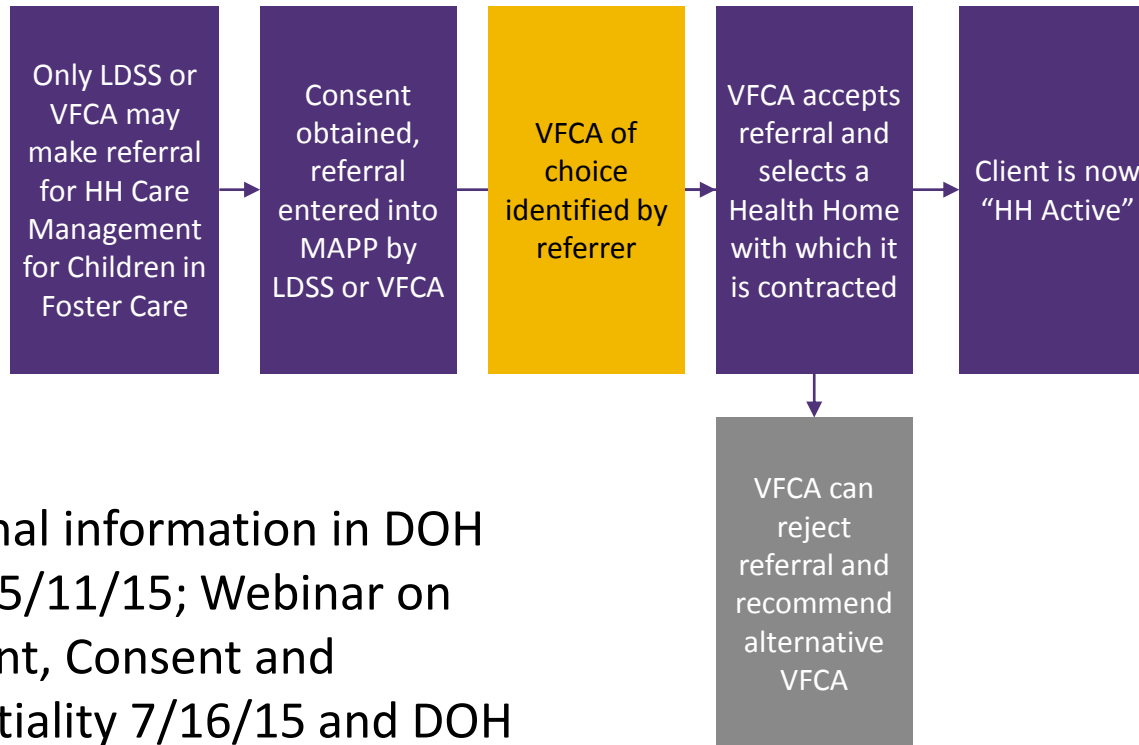
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Overview of Referral Process for Child in Foster Care* (Not MCO member)



*Additional information in DOH Webinar 5/11/15; Webinar on Enrollment, Consent and Confidentiality 7/16/15 and DOH MAPPS Training Summer 2015)

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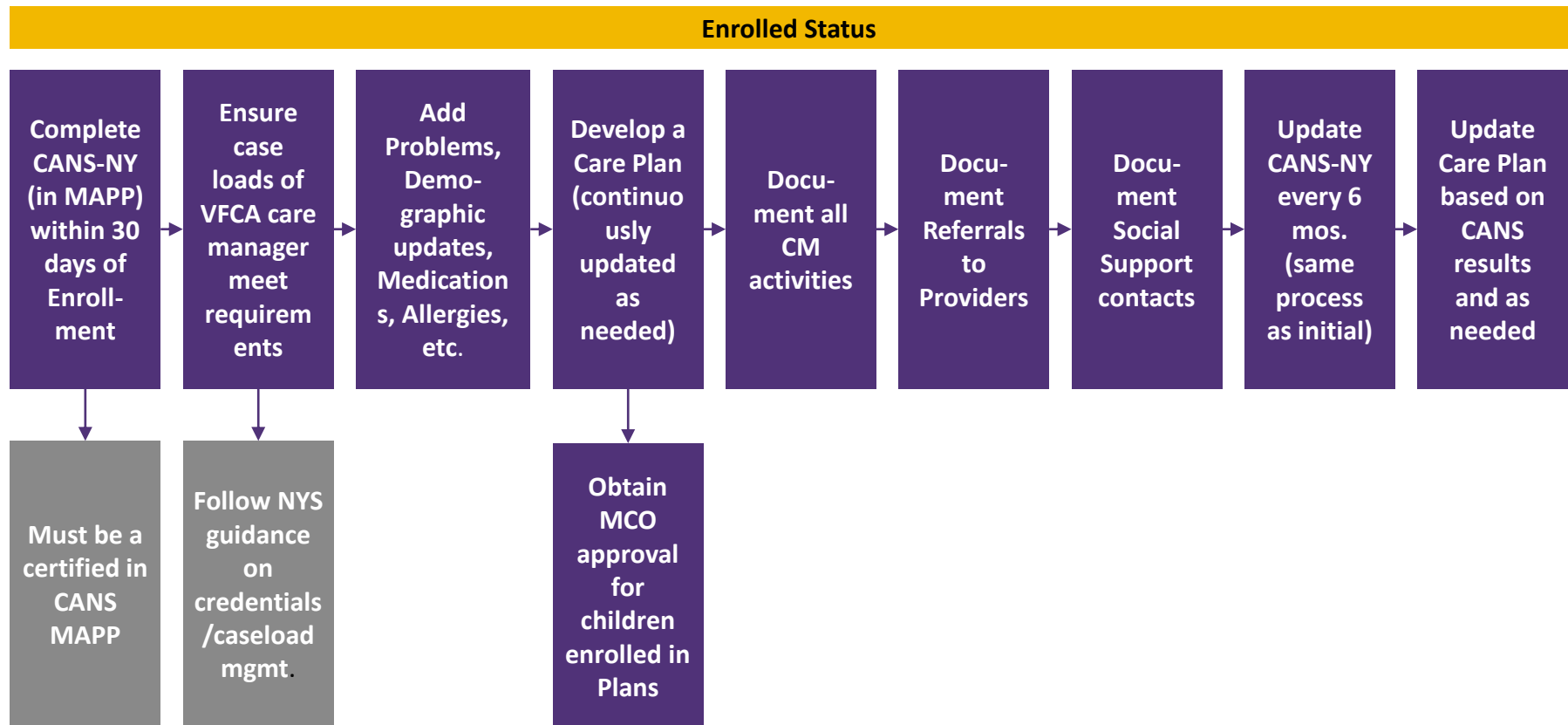
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Children's Health Home Process Part 2



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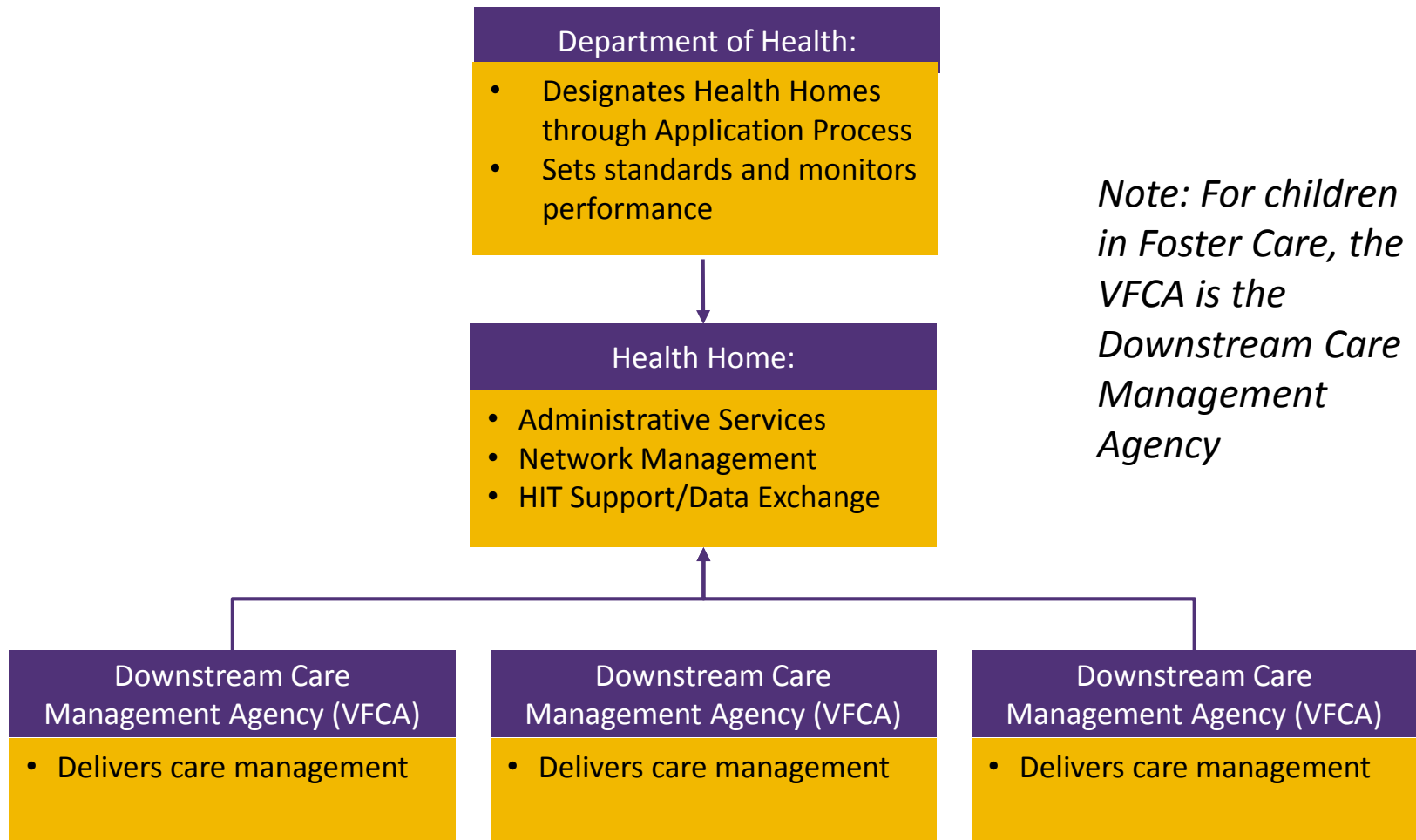
Role of Designated Health Home



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Health Home Organization Chart



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What is the Role of the Designated Health Home?

- **Network Management**

- Contract with Downstream Care Management Agencies
 - Contract spells out roles and responsibilities of the Designated Health Home and the Downstream Care Management Agencies
- Execute MOU's with a network of treatment providers, social service providers, and other community based organizations who will participate in comprehensive, integrated plan of care
- Interface with DSRIP Performing Provider Systems regarding participation of Health Homes in the chosen projects
- Contract with MCOs; maintain communication with MCOs about their enrollees



What is the Role of the Designated Health Home? (continued)

- **Administrative Services**

- Efficiently and effectively process referrals
 - Assign eligible individuals to Care Management Agency based upon experience and defined member characteristics
 - Have an identified point of contact for referrals
- Assure required data is submitted to the state (through MAPP)
 - Tracking (assignment, and segment) information
 - SMART
- Have processes in place for billing FFS and MCOs and making payments to downstream providers

What is the Role of the Designated Health Home? (continued)

- Evaluate and improve performance (processes and outcomes) through the use of data available in MAPP and other sources
- Assure care managers have access to other pertinent administrative data that may not be available in MAPP to inform outreach and engagement efforts
- Maintain DEAAs, BAAs, and other security



What is the Role of the Designated Health Home? (continued)

- Share information about training opportunities
 - Marketing of HH care management services
 - Evidence based practices
 - Outreach and engagement strategies
 - Service availability
- Develop policies and procedures to satisfy State standards
 - For responding when crucial events occur



What is the Role of the Designated Health Home? (continued)

- **HIT Support / Data Exchange**

- Work with Network to assure compliance with requirements for use of HIT to link services
- Implement Health Home IT Standards for Health Homes

Health Home providers will make use of available HIT and access data through the regional health information organization / qualified entities to conduct these processes as feasible, to comply with the initial standards cited in items 6a-6d for implementation of Health Homes. In order to be approved as a Health Home provider, applicants must provide a plan to achieve the final standards cited in items 6e-6i. within eighteen (18) months of program initiation or three (3) months

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Health Home IT Standards

Initial Standards

- **6a.** Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.
- **6b.** Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

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Health Home IT Standards (continued)

Initial Standards

- **6c.** Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.
- **6d.** Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

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Health Home IT Standards (continued)

Final Standards

- **6e.** Health Home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

Health Home IT Standards (continued)

Final Standards

- **6f.** Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

Health Home IT Standards (continued)

Final Standards

- **6g.** Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

Health Home IT Standards (continued)

Final Standards

- **6h.** Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).



Health Home IT Standards (continued)

Final Standards

- **6i.** Health Home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.



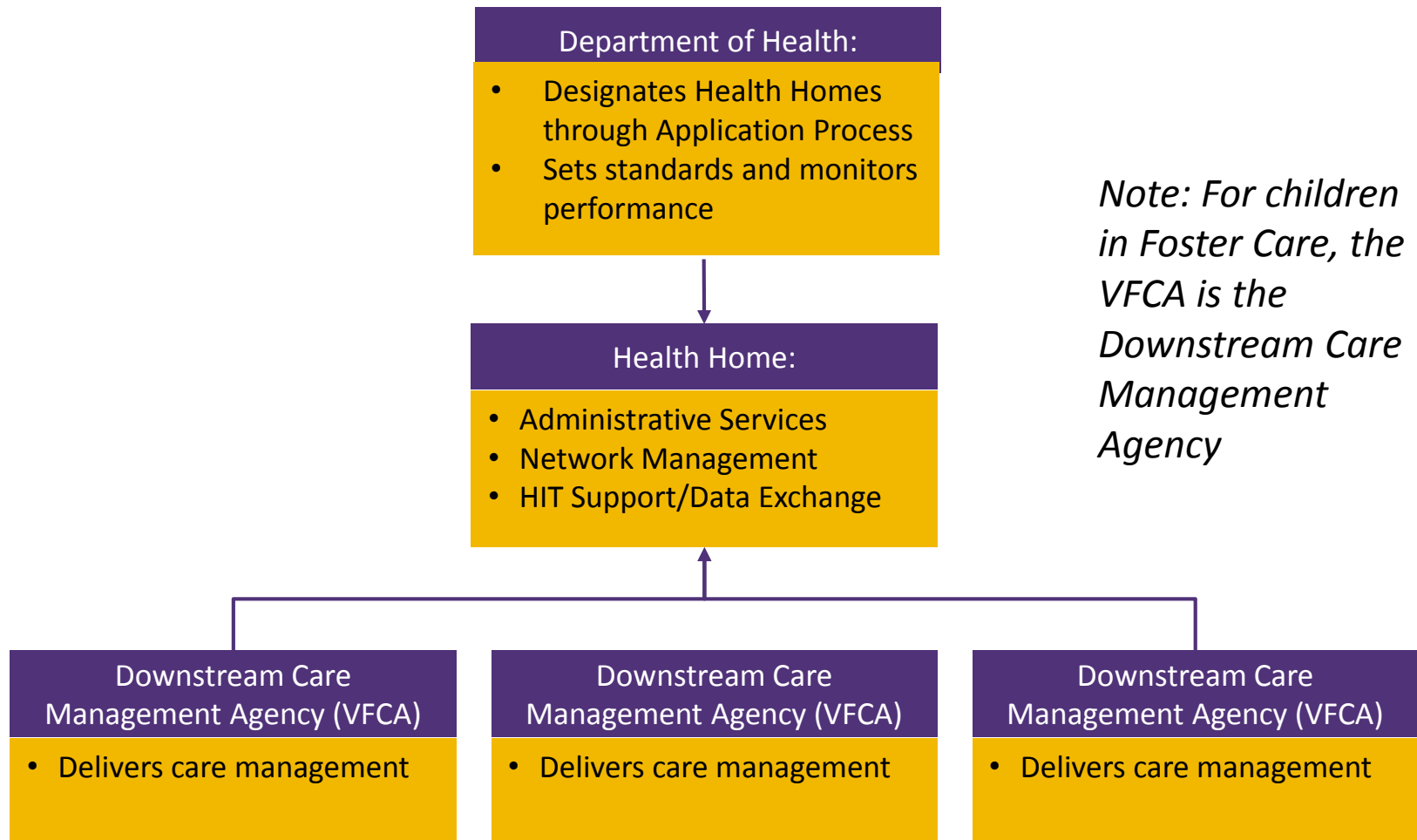
What is involved in being a Downstream Care Management Agency?



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Health Home Organization Chart



Note: For children in Foster Care, the VFCA is the Downstream Care Management Agency

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Getting started

- Contract with one or more Health Homes who are designated to provide services in the counties in which you wish to provide services
- Hire, train, transition staff with competency in care management
- Develop a plan for a Health Home Care Management line of business



Expectations of the Care Management Agency

- Deliver the six Health Home Core Services
 - Comprehensive Care Management
 - Care Coordination and Health Promotion
 - Comprehensive Transitional Care
 - Patient and Family Support
 - Referral to Community and Social Supports
 - Use of Health Information Technology to Link Services

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Core Service: Comprehensive Care Management

- Examples of activities include:
- Completing a comprehensive assessment (Using CANS-NY), inclusive of medical, behavioral, rehabilitative and long term care and social service needs.
- Completing and revising, as needed, the child's person centered, family-focused, plan of care with the child and family to identify the child's needs and goals, and include family members and other social supports as appropriate.

Core Service: Comprehensive Care Management (continued)

Examples of activities include:

- Participating with multidisciplinary team, primary care physician, and specialists on the child's needs and goals –including child welfare case planner.
- Conducting clinic and other outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes.
- Preparing crisis intervention plans.

Core Service: Care Coordination and Health Promotion

Examples of activities include:

- Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information.
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
- Coordinate case reviews with the child/family and interdisciplinary team, including the child welfare case planner to monitor/evaluate client status/service needs.

Core Service: Care Coordination and Health Promotion (continued)

Examples of activities include:

- Crisis intervention – revise care plan/goals as required.
- 24/7 availability to a care manager to provide information/emergency consultation
- Advocate for services and assist with scheduling of services.
- Monitor, support, and accompany the child and family to scheduled medical appointments.
- Provide conflict free case management.

Core Service: Comprehensive Transitional Care

Examples of activities include:

- Ensure comprehensive transitional planning when child is discharged from Foster Care or is discharged from Foster Care and remains in Health Home or is transferred to another Health Home
- Follow up with hospitals/ER upon notification of child's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
- Link child/family with community supports to ensure that needed services are provided.

Core Service: Comprehensive Transitional Care

(continued)

Examples of activities include:

- Follow up post discharge from Foster Care with child and family to ensure needed services are provided.
- Notify and consult with treating clinicians, including child's primary care physician, schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., schools and day care), and assist with medication reconciliation.

Core Service: Patient and Family Support

Examples of activities include:

- Develop, review, revise child's plan of care with child and family to ensure plan reflects child/family's preferences, education, and support for self-management.
- Consult with child/family/caretaker on advanced directives and educate on client rights and health care issues as needed.
- Meet with child and family, inviting any other providers to facilitate needed interpretation services.
- Refer child and family to peer supports, support groups, social services, entitlement programs as needed.



Core Service: Referral to Community and Social Support Services

Examples of activities include:

- Identify resources and link child/family to community supports as needed
- Collaborate and coordinate with community based providers to support effective utilization of services based on child/family need

Core Service: Use of Health Information Technology to Link Services

- Care Management Agency adopts HIT systems and practices as implemented by the designated Health Homes
 - MAPP
 - Health Home's Electronic Care Management Application
 - Direct use of application
 - Interface with CMA application
 - RHIOs



Expectations Placed Upon the Care Management Agency

- Use performance data in Medicaid Analytics and Performance Portal (MAPP) to evaluate and improve performance
- Contact enrollees within 48 hours of discharge from an inpatient unit (when notified or become aware of admission) to facilitate care transition

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Expectations Placed Upon the Care Management Agency (continued)

- Submit plans of care for review and approval by the enrollee's MCO
- Provide choice of at least 2 providers for services in the plan of care
- Deliver care management services based upon staff to caseload ratios established for the individual's acuity

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Expectations Placed Upon the Care Management Agency (continued)

- Develop Plans of Care that include the following elements:
 - Child and family stated goals
 - Child and family preferences and strengths
 - Functional needs
 - Key community networks and supports
 - Description of planned management interventions and time frames
 - Signature(s) documenting agreements
 - Documentation of participation by Key Providers in plan development

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Health Home Staff to Caseload Ratios

Tier (CANS)*	Benchmarks for Caseload Ratios (Ratios are NOT Mandated / Assumed in Rate Build)	Care Management Service Requirements	Care Management Qualifications
High	1:12	Mandate 2 HH services/month, 1 must be face-to-face with youth; Caseload must be predominantly most/all high-acuity	Bachelor's of Science or Art w/2 yrs. relevant experience; OR Registered Nurse with w/2 yrs. relevant experience ; OR Masters w/1 yr. relevant experience CM working with EI have specialized qualifications
Medium	1:20	Mandate 2 HH services/month, 1 must be face-to-face with youth	No mandated qualifications identified, but expectation is assigned care manager has experience and skills needed to serve client and deliver the six Health Home core services
Low	1:40	Must demonstrate 1 HH service/month to bill	No qualifications identified , but expectation is assigned care manager has experience and skills needed to serve client and deliver the six Health Home core services

* Modified CANS NY determines tier HH PMPM rate

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Strategies that will drive success for Downstream Care Management Agencies



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Strategies for Success

- Outcomes
 - Make certain the care management staff have a clear understanding of NYS expected outcomes for Health Homes
- Staff Competencies
 - Have staff participate in all relevant training opportunities; those offered by both the State and your Health Home
 - Periodically assess the competencies of staff providing services
 - Periodically complete chart reviews (internal clinical audits)

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Strategies for Success (continued)

- Finance
 - Understand rate structure for Health Home services
 - Understand policies and procedures, including administrative fees and billing processes, of designated Health Homes with which you are contracted
 - Develop your program budget; track revenues and expense monthly against the budget
 - Monitor accounts receivable for HH Care Management services

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Strategies for Success (continued)

- HIT
 - Have process for monitoring accuracy of data submission into MAPP or any other IT application being used
 - Regularly track Care Management capacity in order to make certain you are well positioned to accept additional referrals from LDSS
 - Understand how to take full advantage of the RHIO in your area to enhance communication with Care Team Members (Be attentive to consent considerations for children)

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Strategies for Success (continued)

- Relationships
 - Build collaborative relationship with the Health Home Lead Agency
 - Build collaborative relationships with Medicaid MCOs in your service area. Periodically request feedback.
- Comply with HIPAA, and special consent rules that relate to children (Review webinar offered by State on May 18)

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Strategies for Success (continued)

- Quality
 - Assign person or team for Quality Improvement -- assessing your agency's performance, developing a game plan for improvement and reviewing impact
 - Use MAPP performance information to focus Quality Improvement activities (both process and outcomes)
 - Monitor achievement of new Quality Measures for Children (using MAPP reports, Health Home reports or Agency reports)
 - Appropriate Treatment for Children with Upper Respiratory Infection
 - Appropriate Treatment for Children with Pharyngitis
 - Childhood Immunization Status
 - Immunization for Adolescents (Combination 1)
 - Annual Dental Visit
 - Well-Child Visits in the First 15 Months of Life
 - Well-Child Visits in the 3rd, 4th, 5th & 6th Year

Strategies for Success (continued)

- Monitor achievement of new Quality Measures for Children (using MAPP reports, Health Home reports or Agency reports (cont.)
 - Adolescent Well-Care Visits and Preventative Care
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index
 - Follow-up After Hospitalization for Psychiatric Reasons
 - Medication Management for Asthma 75% (ages 5 – 18)
 - Asthma Medication Ratio (ages 5 – 18)
 - Follow Up Care for children Prescribed ADHD Medication: Initiation and Continuation
 - Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Strategies for Success (continued)

- Monitor achievement of new Quality Measures for Children (using MAPP reports, Health Home reports or Agency reports) (cont.)
 - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics
 - Lead Testing



Schedule of Technical Assistance to be Offered

Categories of Health Home for Children Technical Assistance

Category	Audience
Overview of Health Homes	Leadership and Care Managers
Administrative Track	Agency Leadership Team
Care Manager Track	Care Management Supervisors and Care Managers

New York

CARE COORDINATION PROGRAM

Creating a person-centered, recovery-focused system of care



**Department
of Health**

**Office of Children
and Family Services**

TENTATIVE Health Home for Children Training Schedule

Topic	Webinar or F2F	Date(s)
INTRODUCTION		
Overview of Health Homes	Webinar 10AM-1PM	May 14
ADMINISTRATOR TRACK		
What It Means to Be a Downstream Provider	Webinar 1-2:30PM	May 26
Outcomes and Quality Assurance	Webinar 1-2:30PM	June 23
Finances and Billing	Webinar 1-2:30PM	July 21
Policies and Procedures for NYS Children's Health Homes	Webinar 1-2:30PM	August 18
CARE MANAGER TRACK		
Comparison and Differentiation of the Roles of Care Managers, Case Managers and County Case Planners	Webinar 1-2:30PM	June 18
Enrollment, Consent and Confidentiality	Webinar 1-2:30PM	July 16
Supervision (Care Manager Supervisors only)	Webinar 1-2:30PM	July 20
Completing Assessment, Developing the Care Plan	F2F (9)	July 27-Sept. 17
Final Wrap-up	Webinar 1-2:30PM	October 15
Implementing and Re-evaluating the Care Plan	Webinar 1-2:30PM	November 5
Overview of Motivational Interviewing	Webinar 1-2:30PM	December 3

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Questions?

For additional information:

- Visit: NYSDOH Health Homes and Children
http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
- Visit: CTAC Technical Assistance for OCFS Agencies
<http://www.ctacny.com/ocfs-technical-assistance.html>



For additional questions:

- General E-mail: OCFSta.info@nyu.edu
- Terri Greco, Project Director, Foster Care Technical Assistance Program, IPRO tgreco@ipro.org
- Adele Gorges, NYCCP agorges@ccsi.org
- John Lee, NYCCP jlee@ccsi.org
- Submit any questions/comments on Health Homes Serving Children to hhsc@health.ny.gov . All submitted comments should include “Your Organization Name” and “Partner Network/Downstream Care Management Agency ” in the subject line.

