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Health Home Serving Children
Medicaid Analytics Performance Portal
Children's HH Referral Portal

July 13, 2016 Updated for July 27, 2016

Overview of Today's Webinar

✓Health Home Serving Children Eligibility Criteria

✓MAPP and Health Home Tracking System (HHTS) Overview

✓MAPP Referral Portal

✓MAPP HHTS Changes and File Specifications

✓Questions

✓Appendix

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Health Home Serving Children Eligibility Criteria

Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid

- Medicaid members eligible to be enroll in a Health Home **must** have:
  - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
  - One single qualifying chronic condition:
    - ✓ HIV/AIDS or
    - ✓ Serious Mental Illness (SMI) (Adults) or
    - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home

- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria

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Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. 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.

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Prioritizing Enrollment of Children in Health Homes

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Prioritizing the Enrollment of Eligible Children in Health Homes October 2016 Begin Date for Enrollment

- To manage initial capacity (and provide time to build up capacity) Health Homes, LDSS, LGU, Care Managers and Plans, should prioritize the enrollment of children *that meet Health Home chronic condition eligibility and appropriateness criteria* and have the highest needs, including the following:
  - ✓ Children enrolled in OMH TCM care management programs that will convert to Health Home
  - ✓ Children on OMH Waiver waiting list (already Medicaid eligible), within 30 days of discharge from inpatient/residential/day treatment settings to participate in discharge planning
  - ✓ Children on TCM waitlist; [SPOA who refers to HH]
  - ✓ Children who are on the Bridges to Health Wait list,
  - ✓ Children in licensed congregate care,
  - ✓ Children that are within 3 months of foster care discharge,
  - ✓ Children enrolled in LDSS prevention services where foster care placement is imminent,
  - ✓ Children prescribed 3 or more psychotropic medications
  - ✓ Children who are within 30 days of discharge from inpatient, residential or detox setting
  - ✓ Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay
  - ✓ Children who have an ER referral but are not admitted for inpatient services; or are discharged with a recommendation for community follow up;
  - ✓ Children with multiple system involvement (child welfare, criminal justice)

- ❖ *Children in Early Intervention will begin to be enrolled March 2017 (when procedures for integrating EI and HH requirements have been established, with stakeholder feedback, and trainings provided).*

Enrollment

- OMH TCM programs that are converting to Health Home Care Managers will be able to enter the UAS environment prior to December 2016 to enter CANS-NY for existing clients

- Voluntary Foster Care Agencies in New York City that are working with a foster care child for which there is a current CANS-NY (which is identical to the modified CANS-NY tool employed in the Health Homes) and that is Health Home eligible may begin enter the CANS-NY tool on prior to December 2016

- All other providers will have access to the CANS-NY Assessment tool on December 2016

- The Department will provide further guidance, including VFCA that are serving children in foster care that would be appropriate for Health Home services

  - LDSS case review and approval prior to VFCA pre-population will be needed

- Further guidance will be given regarding prior access to the UAS

  - Once users have access to the HCS (Health Commerce System), UAS on-line training is available

PLEASE NOTE: *There is a UAS consent form "functional assessment consent form" that must be signed by the client/member prior to entering PHI in the UAS (Consent Training August 17th)*

Overview of the MAPP Health Home Tracking System (HHTS)

Medicaid Analytics Performance Portal (MAPP)
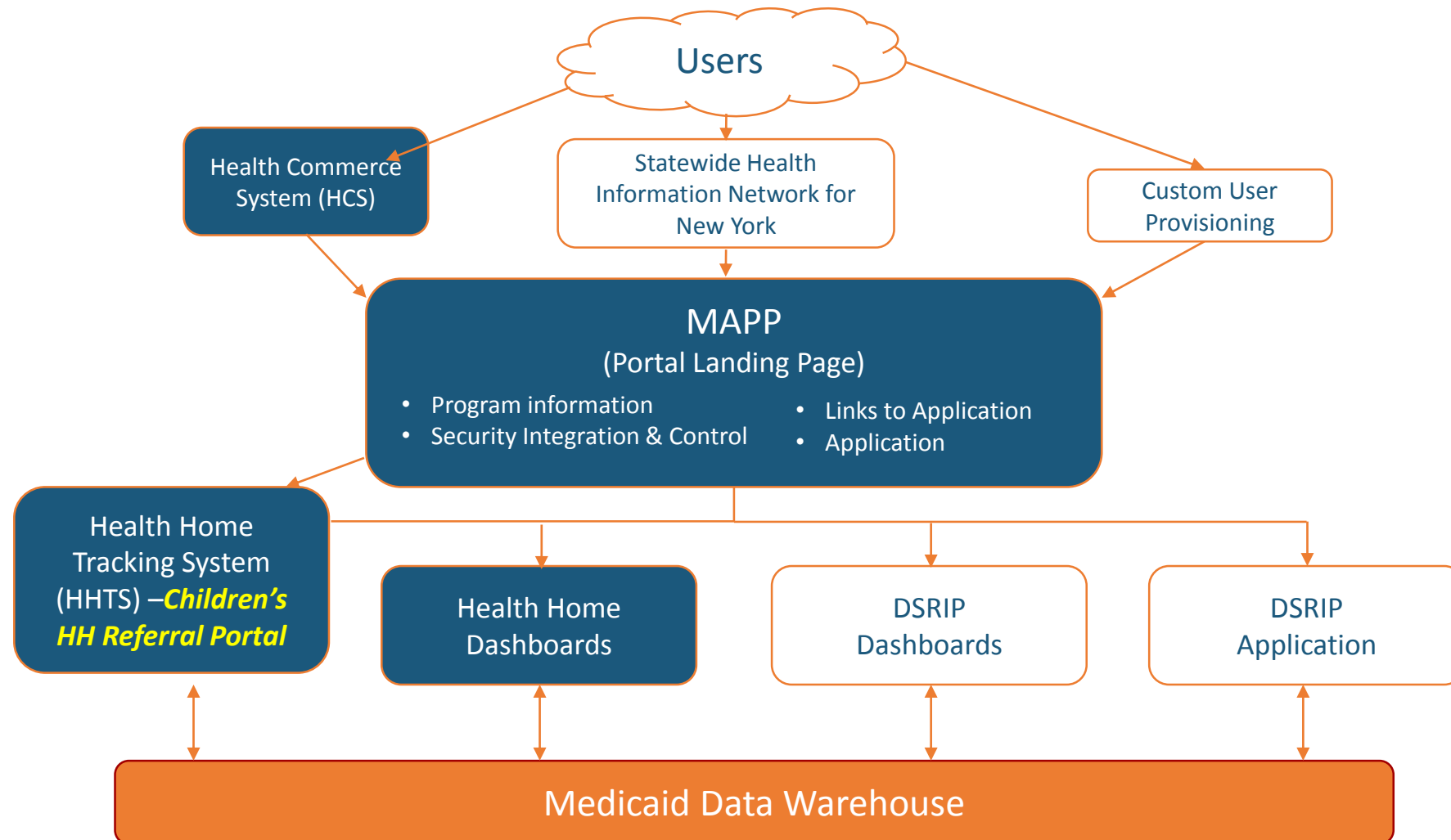
Health Home Tracking System

Provides online interface to the Manage Care Plans (MCP), Health Homes (HH), and Care Management agencies (CMA) to collaborate in real-time and track a member's status.

Users are able to:

- **Refer members to Health Homes**

- Upload/download member information & transactions

- Coordinate across MCPs, HHs, and CMAs using workflows & notifications

- View member's Medicaid information

MAPP Children's Health Home Referral Portal

Using MAPP to Refer Children to Health Home

- MAPP Children's HH Referral Portal must be used to refer (create an assignment with a referral record type), and enroll children in Health Homes

- The following entities will have access to the MAPP Children's HH Referral Portal on Day 1:
  - ✓ Managed Care Plans
  - ✓ Health Homes
  - ✓ Care Management Agencies/Voluntary Foster Care Agencies
  - ✓ LGU/SPOA
  - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)

Future Phases: Over time, the State will expand access to the MAPP Children's HH Referral portal by identifying and authorizing other entities that are natural points of contact in the systems of care that impact children to make referrals through the MAPP Referral portal (School Districts, county probation departments, pediatricians, emergency rooms, Early Intervention initial care coordinators, etc.)

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Care and Custody of Children in Foster Care

- The Health Home model for children recognizes that children in Foster Care are in the care and custody of Local Department of Social Services (LDSS) in Rest of State and the Administration for Children Services (ACS) in New York City

- In New York City ACS delegates its care and custody role to the VFCA

- For the purpose of making referrals, creating assignments with a referral record type, and selecting a Health Home for children placed in Foster care, the process in the MAPP referral portal gives this role to LDSS (outside of New York City) and to New York City Voluntary Foster Care Agency (via the ACS delegation)

- The referral and enrollment process for children in Health Home on following slides recognizes these roles with reference to LDSS/NYC VFCA

Scenario #1:
Referral Made by LDSS Upstate / NYC VFCA that is delegated by ACS
For Children in Foster Care

Only LDSS/NYC VFCA may create assignments with a referral record type (referrals) for Children in Foster Care

LDSS'/NYC VFCA that enters MAPP to make a referral will:

1. Accept the "Terms and Conditions" [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]
2. Identify if the child is in Foster Care (only a LDSS or VFCA may make a Health Home referral for a child in Foster Care)
3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

- The LDSS is the legally authorized representative

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Scenario #1: Continued
Referral Made by LDSS Upstate / NYC VFCA that is delegated by ACS
For Children in Foster Care

4. Provide the Medicaid CIN # for the individual being referred

5. Indicate the chronic conditions which, in your best informed judgement, you believe make the child you are referring eligible for HH

6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

7. Provide consenter's contact information (i.e., the LDSS)

8. Selects VFCA to be the CMA (NYC VFCA indicates if currently providing services to child)

9. Referrer receives notification referral submitted (NYC VFCA enters child into outreach or enrollment if currently providing services to child)

Scenario #1: Continued
Referral Made by LDSS Upstate / NYC VFCA that is delegated by ACS
For Children in Foster Care

Once the referral is submitted in MAPP:

- The MAPP System creates an assignment with a referral record type for the VFCA selected in the MAPP Referral Portal by the LDSS / NYC VFCA

- VFCA accepts assignment and selects Health Home it has contractual relationship with AND, if the child is enrolled in a Plan, a Health Home the Plan contracts with (If VFCA making referral is acting as the HH CMA, with Plan alignment, the VFCA can create an outreach or enrollment segment) or

- If the VFCA rejects assignment, with LDSS consent, the VFCA must suggest an alternative VFCA
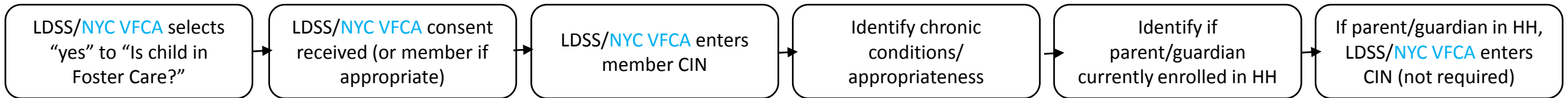
If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members
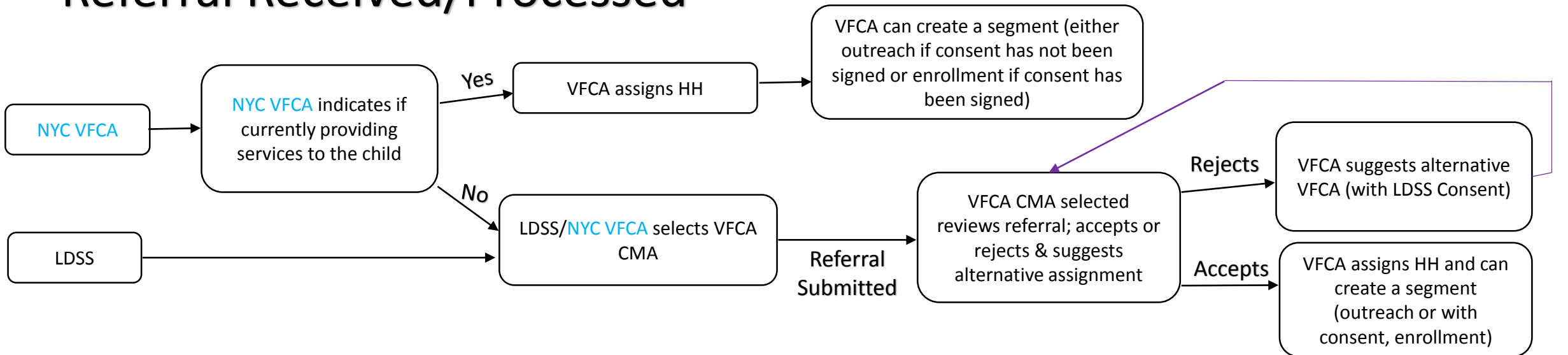
Scenario #1: Continued
Referral Made by LDSS Upstate / NYC VFCA that is delegated by ACS
For Children in Foster Care

Foster Care Flow

| LDSS/NYC VFCA selects "yes" to "Is child in Foster Care?" | → | LDSS/NYC VFCA consent received (or member if appropriate) | → | LDSS/NYC VFCA enters member CIN | → | Identify chronic conditions/ appropriateness | → | Identify if parent/guardian currently enrolled in HH | → | If parent/guardian in HH, LDSS/NYC VFCA enters CIN (not required) |

Referral Received/Processed

NYC VFCA → NYC VFCA indicates if currently providing services to the child

Yes → VFCA assigns HH → VFCA can create a segment (either outreach if consent has not been signed or enrollment if consent has been signed)

No → LDSS/NYC VFCA selects VFCA CMA

LDSS → LDSS/NYC VFCA selects VFCA CMA

Referral Submitted → VFCA CMA selected reviews referral; accepts or rejects & suggests alternative assignment

Rejects → VFCA suggests alternative VFCA (with LDSS Consent)

Accepts → VFCA assigns HH and can create a segment (outreach or with consent, enrollment)

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Scenario #2:
Referral Made by an LGU or SPOA
Process for Making a Referral for Children NOT in Foster Care

LGU/SPOA users making a referral for a child that is **NOT** in Foster Care to a Health Home will be required to provide the following information:

1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]

2. Identify that the child is NOT in Foster Care

3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

4. Provide the Medicaid CIN # for the individual being referred

5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility

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Scenario #2: Continued
Referral Made by an LGU or SPOA
Process for Making a Referral for Children NOT in Foster Care

6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

7. Provide consenter's contact information

8. Referrer receives notification referral submitted

9. MCP or HH receives an assignment with a referral record type

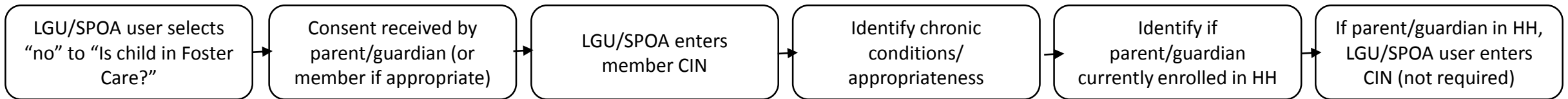* If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members
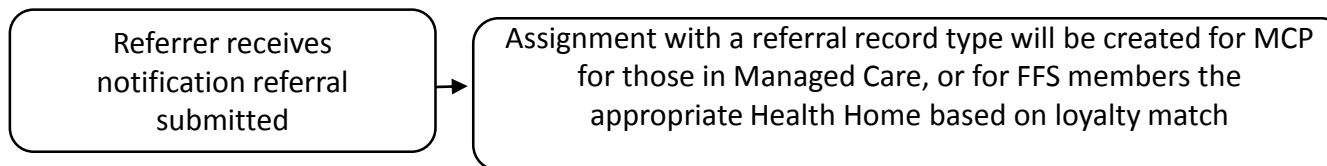
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Scenario #2: Continued
Referral Made by an LGU or SPOA
Process for Making a Referral for Children NOT in Foster Care

Non-Foster Care Flow

| LGU/SPOA user selects "no" to "Is child in Foster Care?" | → | Consent received by parent/guardian (or member if appropriate) | → | LGU/SPOA enters member CIN | → | Identify chronic conditions/ appropriateness | → | Identify if parent/guardian currently enrolled in HH | → | If parent/guardian in HH, LGU/SPOA user enters CIN (not required) |

Referral Received/Processed

| Referrer receives notification referral submitted | → | Assignment with a referral record type will be created for MCP for those in Managed Care, or for FFS members the appropriate Health Home based on loyalty match |

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Scenario #3:
Referral Made by a HH or CMA/VFCA
Process for Making a Referral for Children NOT in Foster Care

HH or CMA/VFCA users making a referral for a child that is **NOT** in Foster Care to a Health Home will be required to provide the following information:

1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]

2. Identify that the child is NOT in Foster Care

3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

4. Provide the Medicaid CIN # for the individual being referred

5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility

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Scenario #3: Continued
Referral Made by a HH or CMA/VFCA
Process for Making a Referral for Children NOT in Foster Care

6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

7. Provide consenter's contact information

8. ***HH or CMA/VFCA user indicates they have been engaged and in communication with the child and wants to enroll the child in the Health Home or has already obtained consent to enroll***

9. HH or CMA/VFCA enters the child in an outreach segment (i.e., consent to enroll has not yet been obtained) or in an enrollment segment (i.e., consent to enroll in Health Home has been obtained)

    • If the HH or CMA/VFCA is not engaged and in communication with the child and will not be serving as the HH CMA, the referral will be submitted to either the Managed Care Plan for members in Managed Care, or for FFS members, the appropriate Health Home based on loyalty match

10. MCP or HH receives an assignment with a referral record type

* If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members
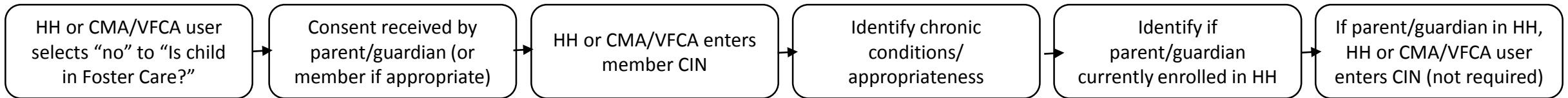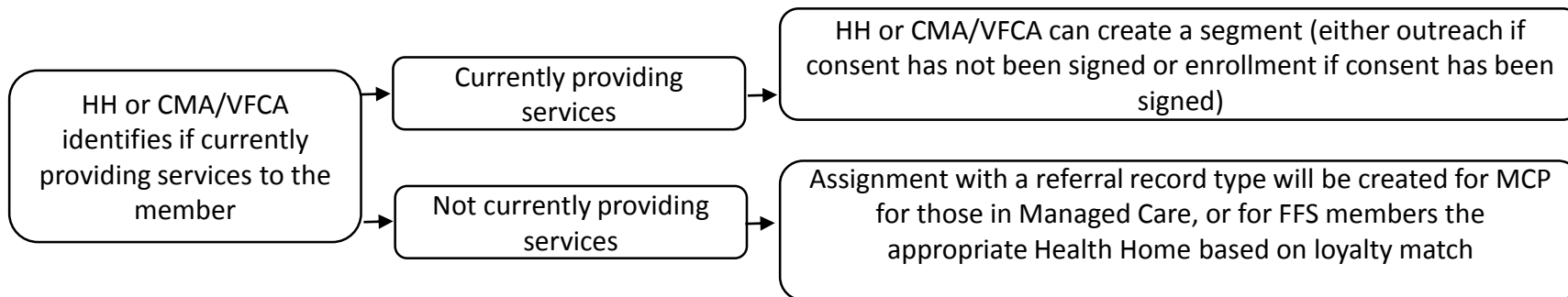
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Scenario #3: Continued
Referral Made by a HH or CMA/VFCA
Process for Making a Referral for Children NOT in Foster Care

Non-Foster Care Flow

| HH or CMA/VFCA user selects "no" to "Is child in Foster Care?" | → | Consent received by parent/guardian (or member if appropriate) | → | HH or CMA/VFCA enters member CIN | → | Identify chronic conditions/ appropriateness | → | Identify if parent/guardian currently enrolled in HH | → | If parent/guardian in HH, HH or CMA/VFCA user enters CIN (not required) |

Referral Received/Processed

| HH or CMA/VFCA identifies if currently providing services to the member | → | Currently providing services | → | HH or CMA/VFCA can create a segment (either outreach if consent has not been signed or enrollment if consent has been signed) |
| | → | Not currently providing services | → | Assignment with a referral record type will be created for MCP for those in Managed Care, or for FFS members the appropriate Health Home based on loyalty match |

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Scenario #4:
Referral Made by a Managed Care Plan
Process for Making a Referral for Children NOT in Foster Care

MCP users making a referral for a child that is **NOT** in Foster Care to a Health Home will be required to provide the following information:

1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]

2. Identify that the child is NOT in Foster Care

3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

4. Provide the Medicaid CIN # for the individual being referred

5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility

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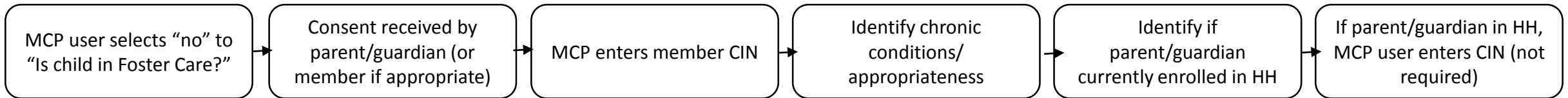## Scenario #4: Continued
Referral Made by a Managed Care Plan
Process for Making a Referral for Children NOT in Foster Care

6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

7. Provide consenter's contact information

8. Referrer receives notification referral submitted

9. MCP creates an assignment with a referral record type to Health Home

* If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

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Scenario #4: Continued
Referral Made by a Managed Care Plan
Process for Making a Referral for Children NOT in Foster Care

Non-Foster Care Flow

| MCP user selects "no" to "Is child in Foster Care?" | → | Consent received by parent/guardian (or member if appropriate) | → | MCP enters member CIN | → | Identify chronic conditions/ appropriateness | → | Identify if parent/guardian currently enrolled in HH | → | If parent/guardian in HH, MCP user enters CIN (not required) |

Referral Received/Processed

| Referrer receives notification referral submitted | → | MCP creates an assignment with a referral record type to Health Home |

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Scenario #5:
Referral Made by Future Phase Entity (Pediatricians, School Districts, etc.)
Process for Making a Referral for Children NOT in Foster Care

Until additional entities have access to the MAPP Children's HH Referral portal, anyone wishing to make a referral to a Health Home Serving Children should contact the entities that will have immediate access to the referral portal:

- The following entities will have access to the MAPP Children's HH Referral Portal on Day 1:
  - ✓ Managed Care Plans
  - ✓ Health Homes (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm)
  - ✓ Care Management Agencies/Voluntary Foster Care Agencies
  - ✓ LGU/SPOA
  - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS

Children in Early Intervention

- Children in Early Intervention prior to the March 2017 implementation will not be able to be referred to or enrolled in Health Homes.

- If the referring entity enters a CIN for a child that is/has received Early Intervention services within the last six months, the system will display the following error message:

    - "The member is/has received Early Intervention Targeted Case Management within the last six months. This rate code is not compatible with the Health Home Program."

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Children with Existing Segments or Assignments

- If a referring entity enters a CIN for a child that already has a pending or active assignment record with an MCP, a HH and/or a CMA within the MAPP HHTS, the referring entity will receive the following error:

    - "WARNING: Information contained in the MAPP HHTS indicates the individual you are trying to refer is already participating in the Health Home Program with the following organizations: <<Managed Care Plan Program Name and ID, Health Home Program Name and ID, Care Management Agency Program Name and ID>>."

- The referring entity will be able to send a message through the MAPP HHTS to the organization(s) that already has a relationship with the member (an assignment, referral or outreach/enrollment segment).

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Children with Existing Segments or Assignments

MAPP HHTS Changes and File Specifications -

For Existing Adult that will Serve Children

- Most MAPP HHTS files will be updated to include at least one field to accommodate either system enhancements or new fields for the children's program.

- There will be three new system files that will allow HHs/CMAs to create, modify or withdraw all consent record types and MCPs/HHs/CMAs to download all consent information. These files will apply to both children and adults.

  - 1) Consent Upload File; 2) Consent Error File; 3) Consent Download File

- The MAPP HHTS File Specifications Document will be updated to include these file changes by August 15, 2016.

  - The current MAPP HHTS File Specification Document is posted to the MAPP section of the website (link below). The Health Home community will be notified when this document is updated through the Health Home listserv.

  - MAPP section of Health Home website: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm

MAPP HHTS Changes for Children –

For Existing Adult that will Serve Children

- All children **MUST** be manually entered into the Children's Referral Portal. **There is no Children's Referral Portal file.** Using the Children's Referral Portal, a user will manually create **EITHER** an outreach/enrollment segment **OR** an assignment with a referral record type **for all children entering into the Health Home Program**.

- A HH/CMA **WILL NOT** be able to create an outreach or enrollment segment via the Children's HH Referral Portal if the child has a pending or active assignment record with the child's MCP and/or another HH/CMA. The Children's HH Referral Portal allows the referrer to send a message to the MCP/HH/CMA with the pending or active assignment record.

- HH/CMA users **WILL CONTINUE** to be able to create a segment for adult members that are not currently assigned to their HH/CMA by uploading a Tracking File Segment record containing a value of 'R' in the Referral Code field.

- HH/CMA user **MAY** create an outreach/enrollment segment for a child using a Tracking File Segment Record file if the child is currently assigned to that HH/CMA.

- A HH/CMA **WILL NOT** be able to submit a Tracking File Segments Record file to create a segment for a child that is not currently assigned to that HH/CMA, even if the record contains a value of 'R' in the *Referral Code* field.

- Only adult members will be accepted through the existing Create Referral/Segment portal.

Questions?

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Subscribe to the HH Listserv

- Stay up-to-date by signing up to receive Health Home e-mail updates

- Subscribe
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action

Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569

- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
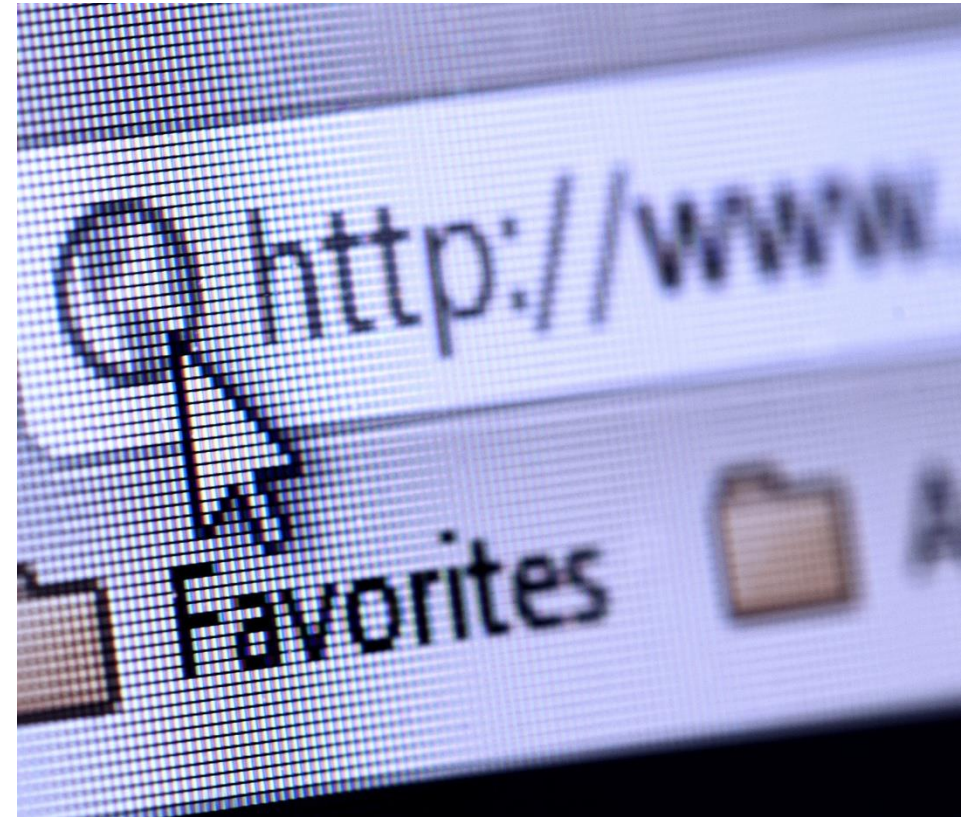
APPENDIX

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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
- **Gender Dysphoria**
- 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
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD for children who have utilized any of the following services in the past three years:
  - Psychiatric inpatient
  - Residential Treatment Facility
  - Day treatment
  - Community residence
  - Mental Health HCBS & OCFS B2H Waiver
  - OMH Targeted Case Management

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. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas:

- 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).

❖*Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)*

*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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Complex Trauma - CMS/SAMHSA Definition included in State Plan

This guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses.

Definition of Complex Trauma

a. The term complex trauma incorporates at least:
   i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
   ii. the wide-ranging, long-term impact of this exposure.

b. Nature of the traumatic events:
   i. often is severe and pervasive, such as abuse or profound neglect;
   ii. usually begins early in life;
   iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
   iv. often occur in the context of the child's relationship with a caregiver; and
   v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.

c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.

d. Wide-ranging, long-term adverse effects can include impairments in:
   i. physiological responses and related neurodevelopment,
   ii. emotional responses,
   iii. cognitive processes including the ability to think, learn, and concentrate,
   iv. impulse control and other self-regulating behavior,
   v. self-image, and
   vi. relationships with others.

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Health Home Serving Children (HHSC) Training Schedule – JUNE and JULY 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	JUNE & JULY 2016
Information on the NYS Child Welfare System and Defining the Collaborative Roles for HH and CMAs	June 1st
Complex Trauma draft proposal review to obtain stakeholder feedback	June 8th
Information regarding OASAS Programs, Services and Addiction for HH and CMAs	June 15th
CANS-NY - In person training - Albany School of Public Health Auditorium	June 22nd & 23rd
Health Home Serving Children Billing Guidance	June 29th
CANS-NY - In person Training - NYC – 90 Church St	July 12th & 13th
MAPP Referral Portal	July 13th
Care at Home (CAH) I & II	July 27th

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Health Home Serving Children (HHSC) Training Schedule – AUGUST 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	AUGUST 2016
Child Welfare interface with Health Home Serving Children - Roles and Responsibilities	August 10th
Health Home Serving Children Consent Process	August 17th
CANS-NY In person Training - Rochester Training - Hillside Family of Agencies	August 18th & 19th
Health Home Serving Children outreach, eligibility and appropriateness determination	August 24th
CANS-NY - In person training - NYC – 90 Church St	August 29th & 30th
OMH TCM program transition	August 31st

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Health Home Serving Children (HHSC) Training Schedule – SEPTEMBER 2016

Schedule of Upcoming Trainings – Health Homes Serving Children	SEPTEMBER 2016
Health Home Serving Children 101 for Early Intervention Providers	September 6th
Early Intervention Services and System for HH and CMAs	September 7th
MAPP training - MAPP HH User, HH CMA, MAPP for LDSS, LGU, SPOA, DOH and State partner users	Three weeks prior to go live TBD
Health Home Serving Children 101 for HIV and AIDS providers	September 20th
Information and education from the AIDS Institute for HH and CMAs	September 21st
UAS training environment and how to use the system	Available once user has HCS account provisioned roles
UAS 1300 - Using the UAS to conduct CANS assessments	TBD
UAS 1500 - Understanding the CANS assessment	TBD
UAS 1820 - CAPS and SCALES	TBD
UAS 1850 - CANS Assessment Outcomes	TBD

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Health Homes Serving Children
List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application

- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

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Health Homes Serving Children
List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services

- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency

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