CLMHD
Behavioral Health
Criminal Justice
Alert Tool
User Guide
(Data Matching Tool 2.0)

MAY, 2021
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PROJECT GOAL AND REVIEW

The Conference of Local Mental Hygiene Directors (CLMHD), representing the County Mental Health Commissioners/Directors of Community Services (DCSs), have long recognized that individuals affected by mental illness and/or substance use disorders often encounter the criminal justice system (i.e., arrests and incarceration) due in part to behaviors related to their untreated, or ineffectively treated, mental illness and/or addiction. Efforts to develop models which prevent repeat criminal justice involvement are priority policy items for county governments and sheriffs throughout the country.

One of the main barriers in re-connecting individuals who are involved with the criminal justice system with treatment is the inability to know when an individual becomes involved with criminal justice system and having the knowledge of what services they may have accessed prior. CLMHD developed a process in which a county can obtain criminal justice system data sets from various resources (i.e., Jail Rosters, Arraignment Lists, Police Blotters, VINE, etc.) to compare against a select number of indicators within the statewide Medicaid database, Psychiatric Services and Clinical Knowledge System (PSYCKES). The purpose of this process is to identify individuals involved with the criminal justice system, with Medicaid coverage, and who have received mental health and/or substance use treatment prior to their involvement with the system. The process will also identify those individuals that are eligible for, or enrolled in, Health and Recovery Plans (HARPs), and/or Health Homes (HHS). The Local Governmental Units (LGUs), or their designee, would then notify treatment providers who will facilitate a re-connection to those services.

Psychiatric Services and Clinical Knowledge System – PSYCKES

PSYCKES is a HIPPA compliant web-based platform developed by the Office of Mental Health (OMH). It includes five years of NYS Medicaid service claims data for behavioral health services - diagnoses, medications, outpatient services, hospital admissions, residential services, and involvement with a NYS operated Psychiatric Center, Medicaid Managed Care Organization (MMCO), Health Home (HH), Care Management Agency (CMA), Assistive Community Treatment (ACT) or Assisted Outpatient Treatment (AOT). All LGUs have state level access to the PSYCKES database.

The LGUs utilize PSYCKES to identify subgroups that are more likely to be at risk for poor outcomes based on past mental health/substance use service patterns, including involvement with the criminal justice system. This information is used to improve the delivery of behavioral health services, substance use disorder services, establish linkages between physical and behavioral health care, and perform quality improvement outreach to providers in their county, thus improving treatment practices.

Health and Recovery Plans – HARP

A HARP is a specialized Medicaid managed care product, providing coverage for an enhanced specified service package which helps to manage physical and behavioral health services in an integrated way. The enhanced services are designed to help overcome the cognitive and functional effects of these disorders, helping individuals live their lives fully integrated into all aspects of their community. These community-based resources have created a safety net which has helped the behavioral health system evolve from being primarily hospital-focused to one of community support. We believe that connecting people with community-based services and providing them the supports needed will reduce recidivism.
Health Homes – HHs
Health Homes are a Medicaid program that connects chronically ill individuals with care management services. The goal of a HH is to connect these individuals to a group of health care and services providers who ensure that individuals are receiving proper services, including connection to healthcare providers, help with housing, connection to needed medications, and linkage to other social services such as food, benefits and transportation.

Behavioral Health Criminal Justice Alert Tool

CLMHD engaged the support of Coordinated Care Services, Inc. (CCSI) and together we developed a protocol and a Behavioral Health Criminal Justice Alert Tool for LGUs to utilize in collaboration with their county jails and local criminal justice systems.

How to Access the Tool
The process of obtaining log-in credentials for the Behavioral Health Criminal Justice Alert Tool must be facilitated by the DCS. DCSs are responsible for identifying which individuals will have access to the Behavioral Health Criminal Justice Alert Tool.

DCSs should submit an Authorized User Request Form to CLMHD for usernames to be created and access to the tool to be granted. Completed Authorized User Request forms may be submitted to Francine Sinkoff at FS@CLMHD.ORG or Lisa Fiato at LF@CLMHD.ORG.

Once a Username has been created, the user will receive an email with a link to establish a password. Please note - this link will only be valid for 72 hours.

Steps Outlined below:

1. Reach out to local LGU/DCS to gain access to the Behavioral Health Criminal Justice Alert Tool (BHCJ Alert Tool).
2. Your local LGU/DCS will submit an Authorized User Request Form in order for you to be assigned a User Name. It is important that you’re DCS be aware of who is requesting access to the BHCJ Alert Tool.
3. Once a User Name is established, you will receive any email from “Behavioral Health Criminal Justice Alert Tool Administrator”. PLEASE NOTE – this email may go into your spam folder, please check. Password activation link will only be valid for 72 hours.
4. The email will state:
   a. An administrator for the Behavioral Health Criminal Justice Alert Tool has created a new account for you. Your username is: XXXX – Your User Name
   Please click here to set your password and confirm your account.
5. When you click to create your password you will have to enter it twice and when confirmed it will bring you to the home page of the BHCJ Alert Tool.

What is the Behavioral Health Criminal Justice Alert Tool?

The Behavioral Health Criminal Justice Alert Tool matches information from criminal justice system data sets to each of the following 3 (or 4) PSYCKES files (1 pair at a time):

1. HARP Eligible, not Enrolled (H9)
   i. This match identifies the criminal justice population that is eligible for HARP Status but not currently enrolled in HARP.
2. HARP Enrolled, not Health Home Enrolled
   i. This match identifies the criminal justice population that is HARP Enrolled but NOT in a Health Home (HH).
3. HARP Eligible/Enrolled All (H1-H9) AND Health Home Enrolled
i. This match identifies the criminal justice population that is HARP eligible or enrolled in HARP AND Health Home.

4. Additional PSYCKES file for consideration: OMH Unsuccessful Discharge

i. The Behavioral Health Criminal Justice Alert Tool can also be used to identify individuals who are being sought for re-engagement by an adult State-Operated outpatient mental health clinic or ACT Team. These are individuals whose outpatient care ended prematurely due to a loss of contact, refusal, incarceration, or another unplanned event. The OMH Sustained Engagement Support Team (SES) ensures that these individuals are prioritized for readmission to outpatient services, including access to expedited screening appointments.

ii. This match identifies the criminal justice population that is eligible for an expedited return to OMH State-Operated outpatient services.

iii. Please refer to the Clinical Summary Section for detailed steps on engaging the SES team.

BENEFITS OF BEHAVIORAL HEALTH CRIMINAL JUSTICE ALERT TOOL AND MATCHES

When identifying high need individuals who have behavioral health and/or substance use needs and connecting them with the appropriate supports and services, it will increase their success with remaining in their community and will assist in reducing recidivism with the criminal justice system.

- For criminal justice systems, recidivism could be decreased if individuals with complex behavioral health and/or substance use conditions are successfully and appropriately linked to community-based services prior to their return to the community.
- For LGUs, ensuring individuals with behavioral health and/or substance abuse needs that are involved with the criminal justice system receive appropriate supports and services.
- For the County Adult Single Point of Access (A-SPOAs), initiate referrals to A-SPOAs for improved engagement with, both Medicaid and Non-Medicaid, individuals to assist with connection to appropriate services/supports.
- For HARP, HHs and Care Management Agencies (CMAs), working with the LGU/SPOA and criminal justice systems can help facilitate linkage to services in the community.

INITIAL START-UP PROCESSES

The first step in successfully wrapping care coordination around the identified high need criminal justice population is establishing a working relationship with your local criminal justice system (i.e., Corrections
When establishing contacts and relationships with local Criminal Justice System resources:

1. Identify your primary contacts at your local criminal justice system entities you have identified for both the overall project and data extraction:
   
   a) Contact for Behavioral Health Criminal Justice Alert project lead – this is county-specific. This will be the main County contact person.
   
   b) Contact for data exchange – this is the individual sending and receiving files (Jail Rosters, Arraignment Lists, Arrests Records, matched data); this is most likely an IT department team member.
   
   c) Identify the entity that provides behavioral health services directly within the county jail and/or community services (including mental health and substance use).
      
      • Work with Behavioral Health Criminal Justice Alert Tool project lead (if applicable) to approve direct contact of the behavioral health service provider with matched individuals.
      
      • Contact for behavioral health service provider and/or re-entry/discharge planner - this will be your main contact to coordinate services for matched individuals.
      
      • Contact options for individuals being arraigned include the court clerk, assigned Health Home, Drug Court, or the Behavioral Health Provider listed in PSYCKES.

2. Establish appropriate data exchange agreements and protections:
   
   a) Before any names or data can be exchanged between criminal justice system entities and the LGU, a DEAA needs to be signed and processed. This may be county-specific, so it is recommended to consult with your legal department as needed. See Appendix A for a sample DEAA.
   
   b) A DEAA is also necessary if there is bi-directional communication (i.e., sharing names or information about an individual’s behavioral health services) occurring between the LGU and the local court system.
   
   c) It is essential to assure the proper exchange of PHI data for this project. This may include encryption (through your email provider, a web-based tool, etc.). Follow your existing protocols for exchanging PHI data.

3. Establish frequency for identified criminal justice system entities to send their data sets to the LGU (daily, weekly, etc.).
4. Identify which criminal justice system data sets make the most sense based on the needs of your county population (i.e., discharge/release roster, arraignment lists, arrests records, active inmates).

a) **Best Practice Tip: Use current list of inmates.** This allows for engagement, linkage and discharge planning before release. Also, it is easier to engage an individual when you know their whereabouts (prior to discharge). VINE (Victim Information and Notification Everyday) application can be useful in tracking changes in custody status.

b) **Consider using an Arraignment List to identify individuals whose arraignment is scheduled for that day.** Often, if a behavioral health resource is present at the arraignment, an individual can be released into their custody and begin the process of reconnecting to care. **A desired future state would be for courts to reach out to behavioral health resources as part of the arraignment process to engage individuals in care prior to incarceration.**

c) **Police Blotters and other types of arrest records are often available to the public via the internet or other applications.** Please see the Police Blotters and Applications section below.

### Potential Resources

Criminal justice system data sets (i.e., Jail Rosters, Arraignment Lists, Police Blotters, VINE, and other applications) are all potential sources that may be obtained through working relationships with corrections facilities, local court systems, District Attorney’s Offices, etc. Each data set can be helpful at different stages of the justice system involvement process.

#### Jail Rosters

Jail Rosters provide a list of individuals who are currently held in custody. This roster is beneficial as it provides the information on individuals that could benefit from interventions prior to discharge from a facility. For example, an individual could be re-enrolled in Medicaid and reconnected to a previously utilized outpatient service prior to their release. This can assist with incarceration recidivism. Identifying connections and contacts with local county jail resource is integral to getting these lists.

#### Arraignment Lists

While Jail Rosters are helpful in identifying the whereabouts of current inmates, Arraignment Lists can be beneficial as they provide the information that is useful for interventions prior to conviction. For example, if a match occurs with an individual on an arraignment list, the local court system may try to connect the individual with appropriate services and supports prior to being released. This will also assists in reducing arrest recidivism. Identifying connections and contacts with your local court systems is integral to getting these lists. It is best practice to run the Arraignment List through the Behavioral Health Criminal Justice Alert Tool prior to the individual’s scheduled arraignment time. If possible, this list should be run in the morning and arrangements made for a team member to be present at the arraignment.

**Note:** Access to Jail Rosters and Arraignment Lists will vary greatly by county.
Examples of some individuals or organizations that may be able to provide Arraignment Lists include the Sheriff, District Attorney’s Office, Chief Court Clerk, Jail Mental Health Services Coordinators, Specialty Courts, Judges, and City Courts. Leveraging your existing relationships to gain access to this information is essential.

You should inform entities of how the data match process will be a mutually beneficial relationship between the Criminal Justice System and Counties by connecting individuals to appropriate care and reducing recidivism.

Police Blotters and Applications
Police Blotters (Arrest Records) are a book or document of arrests and other events that are documented by law enforcement as they occur. Most County Sheriffs share Police Blotters identifying who has been arrested the day before. This information is most often made available to the public via applications and websites that are specific to the crime’s location or responding police department. Community Providers can download these applications on their cell phones and check them daily to identify if an individual known to them was arrested. Providers can then reach out for help through their Agency or Public Defenders.

Examples of Police Blotters available to the public:


VINE (Victim Information and Notification Everyday)
VINE is a service through which the telephone or internet can be used to search for information regarding an individual’s custody status. VINE also allows users to register for telephone and email notifications when an individual’s custody status changes. Each state/county has their own toll free VINE phone number that can be found on the website ([www.vinelink.com](http://www.vinelink.com)). Having access to changes in custody status can assist Community Providers in locating an individual and beginning the outreach process. VINE FAQ’s can be found in Appendix E.

PSYCKES Access

1. All County LGUs have PSYCKES access.
   a) If your County needs to establish County-level PSYCKES access, contact the PSYCKES Help Desk at psyckes-help@omh.ny.gov.
   b) See also additional trainings, webinars and resources on the PSYCKES website: [https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/](https://www.omh.ny.gov/omhweb/psyckes_medicaid/about/).
   c) See also Appendix B for PSYCKES guidance on getting started

2. Identify who will navigate PSYCKES data extraction for this project:
a) This person should be proficient at navigating the PSYCKES database.

b) This project includes navigating recipient search, using identified filters, extracting files, and following up through clinical summaries.

Preparing the Files for the Data Matching Process

You will have 3 (or 4) files to extract from PSYCKES. The Behavioral Health Criminal Justice Alert Tool will match each file, 1 at a time, to the criminal justice resource and will creating 3 (or 4) separate files identifying matched, unmatched, and partially matched individuals. Use the guidance below to extract the 3 (or 4) PSYCKES files (see Step 5).

There are 3 main steps:

1. Extract PSYCKES data
   - Time – about 5 minutes to pull each file
2. Prepare criminal justice resource(s) and PSYCKES Files for Matches
   - Time – about 5-10 minutes to cleanse each file
3. Run Matches in the tool
   - Time – probably less than 5 minutes to run each file match, depending on size of files

Extract/Pull PSYCKES data

1. Log into PSYCKES.
2. Select PSYCKES Recipient Search feature.
3. Turn **De-Identify** off to identify clients (drag circle to the left).
4. Change Limit Results to 500,000.
5. **Pull PSYCKES Parameter – total of 3 to 4:**

   1. **For “HARP Eligible, not Enrolled (H9)” parameter:**
      
      i. Under *Characteristics* select HARP Status “Eligible Pending Enrollment (H9)” from the *HARP Status* drop down menu.

      ![Characteristics Menu](image1)

      ii. Go to *Services by Any Provider* and select your County name.

      ![Services by Any Provider](image2)

      iii. Select “Search”.

      iv. **Export** to Excel.

      ![Export to Excel](image3)

      v. Save file

   2. **For “HARP Enrolled, not Health Home Enrolled” parameter:**
      
      i. Clear filters.
ii. Under **Characteristics** select Quality Flag “HARP Enrolled – Not Health Home Enrolled” from the **Quality Flag** drop down menu:

![Quality Flag dropdown menu](image)

iii. Go to **Services by Any Provider** and select your County name:

![Services by Any Provider](image)

iv. Select “Search”.

v. **Export** to Excel:

![PDF and Excel icons](image)

vi. Save file.

3. “**For “HARP Eligible/Enrolled All (H1-H9) AND Health Home Enrolled” parameter:**

   i. Clear filters.

   ii. Under **Characteristics** select HARP Status “Eligible/Enrolled All (H1-H9)” from the **HARP Status** drop down menu:

   ![HARP Status dropdown menu](image)
iii. Go to Services by Any Provider:

1. Select your County name

2. Select Service Setting: expand Care Coordination drop down, ONLY select “Health Home – Enrolled (Source: DOH)”:
iv. Select “Search”.

v. Export to Excel:

vi. Save file.

4. **Additional Parameter: “OMH Unsuccessful Discharge”**: 
   i. Clear filters 
   ii. Under Characteristics select Alerts & Incidents “OMH Unsuccessful Discharge” from the Alerts & Incidents drop down menu:
iii. Go to *Services by Any Provider*
    1. Select your County name:

iv. Select “Search”.

v. Export to Excel:

vi. Save file.

You have successfully downloaded all 3 (or 4) PSYCKES files!
Prepare Criminal Justice System Data Set Files and PSYCKES Files for Match

The Behavioral Health Criminal Justice Alert Tool requires 3 specific data columns – Last Name, First Name, and date of birth (DOB). The guidance below describes how to format both criminal justice system data sets and PSYCKES files.

Please keep in mind that criminal justice system data sets are county and correction-facility specific, meaning there may be some additional steps needed that are not listed below. Use your data/IT support team, if you have one, to manipulate the criminal justice system data set to the expected format. If you do not have this level of support or need further support, please contact Lisa Howard-Fiato at lf@clmhd.org.

Some common steps are to split a “full name” column into Firstname and Lastname columns and convert DOB format to “Text” format. Please see the section below to guide you through formatting criminal justice resources and PSYCKES files.

Please note, your submitted criminal justice system data set may have more information than is needed. You will need only Name and DOB for this project. Any additional data is supplementary information. PSYCKES files also have data fields other than Name and DOB - you may find these additional columns useful as you work with the matched data.

For Each File (criminal justice system data set and PSYCKES)

1. Remove rows above the heading row – in this example, remove rows 1-6:

   ![Table Example](image)

2. If multiple line headers, remove all but 1 – be sure the remaining heading row has descriptive headers (applies to some criminal justice system data sets):

   ![Table Example](image)

3. Unmerge any cells that may be merged (applies to some criminal justice system data sets).
4. Sort data to find and remove blank rows within the data (applies to some criminal justice system data sets).

5. Search the name fields to remove suffixes such as JR, SR, II, III.

6. Hyphenated names need no special handling.

**Split Name (if not already split)**

1. Insert 4 blank columns after the column containing the full name – these will hold the split names and any initials.

2. Name the 1st two columns, LName and FName.

3. Copy the data in the full name column and paste it into the LName column (when split, LName will contain the last name).

4. With the LName column highlighted, select **Data→Text to Columns:**

   a. Choose ‘Delimited’; click ‘Next’:
b. Choose Comma and/or Space, whichever is needed for the split:
c. The cell value in ‘Destination:’ is the 1st data cell location in the LName column.
d. Click Finish:

![Convert Text to Columns Wizard - Step 1 of 3](image)

![Microsoft Excel](image)

e. Respond ‘OK’ – name will be split:

**DOB to Text Field**

1. If the DOB column is not ‘Text’ format:
   a. Insert 1 column next to the DOB column – ‘DOBText’.
   b. Place the following conversion formula in the DOBText column:
      i. `=TEXT(E2,"mm/dd/yyyy")`, where E2 is the cell of the 1st date of birth value in the original DOB column.
      ii. Propagate the formula through the data rows of the DOBText column.

The criminal justice system data set(s) and PSYCKES files are now ready to be matched.
Run Matches in Data Tool

You will be matching 3 (or 4) separate PSYCKES files to the same criminal justice system data set, running 1 set at a time.

1. Open the Behavioral Health Criminal Justice Alert Tool - [https://datamatch.clmhd.org](https://datamatch.clmhd.org):

   a. **Browse** for the JAIL spreadsheet.
   b. **Browse** for the PSYCKES specific indicator spreadsheet.
   c. **Press Upload**:

   ![Select Columns](image1.png)

   ![Select Columns](image2.png)

   d. Select Column Name pairs to match, press **Map** after each pair selection (LName pair, FName pair, DOB pair).
e. Once all 3 pairs appear in ‘3 Fields Required’ box, press **Compare** to see the matches.

![View Matches](image)

f. 3 tabs display – Full Matches, Partial Matches, Unmatched.

g. Press **Export** (not visible in screenshot) to browse to a folder and save the data to a spreadsheet.

**Engagement – What to Do with the Matches**

The primary goal of this Behavioral Health Criminal Justice Alert Tool and the matches is to improve coordination for individuals with mental health and/or substance use needs when they become involved with the criminal justice system. The risk of relapse, recidivism and hospitalization are very high in those first days/weeks/months following release from incarceration and/or the criminal justice system. People often remain disconnected from care if they are not linked immediately upon release.

It is important to recognize that each County LGU will have County-specific interventions and relationships that work for their population. There is no “one size fits all” approach to engaging individuals as they transition from incarceration back into the community or re-engaging with services/supports at the time of arraignment. However, after conducting a pilot project, the following activities, interventions, and approaches were identified as best practices:

1) **County SPOA involvement for discharge planning:**

   a) Determine if the individual may be eligible for Health Home Plus (HH+) level of care (LGU/SPOA clinical discretion). As stated in the Office of Mental Health (OMH) Health Home Plus guidance: (see Appendix D for full guidance).

      i) Per OMH/DOH Guidance - Criminal Justice involvement: Release from incarceration (jail, prison) within the past year and requires linkage to community resources to avoid re-incarceration.
ii) There is also a way to look at the Health Home Plus population in PSYCKES (HH+). During your PSYCKES data extract, you can consider pulling this additional parameter to narrow your focus to those that are Health Home Plus eligible.

- When you log into the Recipient Search of PSYCKES, you can search the Health Home Plus population in 2 ways:

2) Under “Services by Any Provider,” expand “Service Setting – Care Coordination” and select “Health Home Plus”:
b) Connect with treatment providers and make appropriate referrals prior to release or at arraignment.

c) Assisting with Health Home referrals.

d) The individual will **NOT** need a HARP eligibility assessment. Given they are on your matched list, this identifies them as already HARP eligible or HARP enrolled (based on the PSYCKES parameters pulled for this project).

2) If Medicaid coverage has been suspended, contacting the CMA to notify of release:

   a) New York State suspends Medicaid coverage for inmates for the first 30 days of incarceration, rather than terminating Medicaid enrollment. Although Medicaid does not cover benefits provided to incarcerated individuals, health homes can be a significant resource upon reentry into the community for Medicaid-enrolled people who meet the health home eligibility and appropriateness criteria.

   b) LGUs often have a staff person who serves as a liaison to the medical and behavioral health providers in the jail. The LGU liaison could work with inmates whose incarceration re-entry date is known, learn what their needs are, and communicate those needs to a health home care manager and/or service provider to which the inmate was assigned prior to incarcerations. This will enable a warm handoff back to services upon release, provided Medicaid coverage is in place upon re-entry.
If Medicaid enrollment has been terminated, reestablish upon release from jail:

c) You should contact your local Department of Social Services (LDSS) office and ask for an expedited application based on the "Medicaid Suspension Law." You will probably be asked to recertify within 60 to 90 days after you are released.

d) Each County Local Department of Social Services (LDSS) may have its own process for re-establishing Medicaid. If you can establish a liaison within your LDSS it could improve this process. This liaison could possibly go on-site to the jails to complete an application if needed. This will ensure the individual completes the application process correctly.

e) The In-Person Assistors (IPA)/Navigator program is designed to meet the needs of New Yorkers by aiding in convenient, community-based locations. IPAs/Navigators provide culturally competent, linguistically appropriate, and disability accessible enrollment services. They are available at convenient times, including evenings and weekends, at no cost to enrollees.

   Please go to the link below to find an IPA/Navigator in your county:


f) Some Counties provide the option of the Medication Grant Program (MGP). This funding provides grants for the cost of medications and other services needed to prescribe and administer medication for individuals with a mental illness who leave the local jails, state prisons or hospitals and have applied for Medicaid. Currently the way the system works, many individuals who leave the jails, prisons and hospitals receive only limited supplies of medication until they qualify for Medicaid. The Medication Grant program provides funding to counties who participate to pay for the individual's mental health medications and services related to providing medication during their pendency of a Medicaid determination.

   • For an individual leaving jail, they may have a transition manager (or another designated jail employee) to make sure they complete a Medicaid application within seven days of release. The individual, either on their own or accompanied by a transition manager (or another designated jail employee) can then go to their local Department of Mental Hygiene to receive a Medication Grant Card. A Medication Grant enrollment form and a form indicating that the person qualifies for the Medication Grant Program must also be provided to the county.

   • Once Medicaid eligibility is determined, the individual would be disenrolled from the Medication Grant Program. Individuals who are enrolled in Medicaid would then use their Medicaid card for their pharmaceutical needs. For those people who are denied Medicaid coverage, counties will be encouraged to aid in assuring a smooth transition to other funding streams to support the medication needs of these individuals.
3) Look client up in PSYCKES and open their Clinical Summary:

   a) Identify if the individual is/was connected with a Health Home and/or Care Management Agency
      • Reach out to most recent/active Health Home/Care Management Agency

   b) Identify recent mental health and substance use service use (i.e. clinic services, outpatient treatment, detox)
      • Reach out to service providers, if applicable

4) Identify if the individual is/was connected with an OMH State-Operated outpatient program.

   i) If an individual is being sought by the OMH Sustained Engagement Support Team for reengagement in outpatient services, the following flag will be visible at the top of the Clinical Summary page:

   ii) The Sustained Engagement Support Team (SES) flag will indicate the State Psychiatric Center (PC) that most recently provided outpatient mental health treatment. It will also provide the following toll-free number that can be used to reach the Sustained Engagement Support Team:

      1-844-206-1796.

   iii) Upon calling this toll-free number, an automated message will provide instructions for selecting the State PC indicated on the SES flag. Once the number associated with that State PC has been entered, you will be connected with a member of the SES Team who is able to secure an expedited appointment for the individual to return to outpatient clinic services.
iv) Reach out to the Sustained Engagement Support Team (SES) for assistance in reestablishing mental health treatment.

a) See Appendix C for how to access the Clinical Summary and how to find this information.

5) Start engagement while in jail or at arraignment, when possible.

a) If your county jail provides behavioral health services in the jail, establish contacts for discharge/release and transition planning.

Conclusion

CLMHD developed the Behavioral Health Criminal Justice Alert Tool to assist with connecting or re-engaging an individual who has behavioral health and/or substance use needs and has become involved with the criminal justice system with appropriate supports and services. Using PSYCKES and established relationships with local criminal justice systems, LGUs will be better equipped to identify individuals who require a reconnection to care, thus reducing rates of recidivism and re-offenses. Questions regarding the Behavioral Health Criminal Justice Alert Tool or any information found within the User Guide can be directed to Lisa Fiato at LF@CLMHD.ORG.
APPENDICES

Appendix A – DEAA Template

- See Next Page.
- Please note: your County may have a county specific DEAA. Please consult with your legal department or representative. The following is a sample.
DATA EXCHANGE APPLICATION AND AGREEMENT  
(DEAA)

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DEAA Checklist

Please complete this form and include with completed DEAA.
It will help insure that the DEAA is complete before submission to NYSDOH.

DEAA

YES NO N/A

[ ] [ ] Have you carefully read all DEAA Sections 1 – 10?

[ ] [ ] Have you provided responses to all the questions in Sections 1 – 10?

[ ] [ ] Have you/your contractors and subcontractors read the Data Security Attestation (Section 9)?

[ ] [ ] Have you signed the Executory Clause (Section 1)?

[ ] [ ] Have your contractors and subcontractors signed the Executory Clause?

ATTACHMENTS to the DEAA

All Attachments to the DEAA are considered to part of the DEAA.

[Note: These may not apply to all requesters.]

A: Third Party Contractor Language/Amendment: NYSDOH Counsel has provided the legal and regulatory citations that MUST be included in your Agreement (i.e., MOU; MOA; Contract; Subcontract) with NYSDOH, contractors or sub-contractors, either in the original document or as an amendment to your Agreement. (See Section 9.)

B: HIPAA/Business Associate Agreement: You and your contractors must read and sign an unmodified version of this attachment, which is to be submitted with the completed DEAA.

C: Data Disposal Attestation Form: To be completed at end of project.

NOTE: NYSDOH requires that all vendors be aware of the special rules regarding the release of Medicaid Confidential Data (MCD) concerning persons with AIDS. (See Section 9.)

YES NO N/A
Have you read Attachment A?
Have you/your contractors read Attachment B?
Have you/your contractors signed Attachment B?
Have you read Attachment C?

1. APPLICANT INFORMATION:

A. Provide the name and title of the individual who can legally bind your company, agency or entity to the terms of this Agreement. The person who is named here must sign the Executory Clause. Also be sure to provide the legal name of the company, agency or entity, along with its address and telephone number. (See Section 10.)

Requester Name: ___________________________________________
Title: _______________________________________________________
Agency: _____________________________________________________
Address: ___________________________________________________
Telephone: ___________________________________________________  

Requester Name: ___________________________________________
Title: _______________________________________________________
Agency: _____________________________________________________
Address: ___________________________________________________
Telephone: ___________________________________________________  

Requester Name: ___________________________________________
Title: _______________________________________________________
Agency: _____________________________________________________
Address: ___________________________________________________
Telephone: ___________________________________________________

B. List the names of all staff, contractors and subcontractors who will have access to the data covered by this agreement. Also, identify staff responsible for the technical handling, data security, storage of the Medicaid Confidential Data/Protected Health Information (MCD/PHI). Please provide telephone numbers of individuals. (Note: You must inform us in writing of any new staff.)

Names:  Agencies:  Phone Numbers:
2. PURPOSE OF PROJECT AND DATA USE:

Please describe why MCD/PHI is necessary to perform this project. Use of MCD/PHI for any purpose other than that listed is prohibited, unless the prior written approval of the NYSDOH has been obtained. (Many questions can be answered with aggregate data.)

3. DELIVERABLES:

Please note that publications related to this data must be reviewed by the NYSDOH prior to publication. It shall be noted that conclusions in the publication are not those of the NYSDOH unless NYSDOH agrees to the content:

Please provide a brief description of the product to be produced as a result of obtaining Medicaid Confidential Data/Protected Health Information:

Please note the date that draft reports of this project will be transmitted to NYSDOH for review:

4. DATA ELEMENTS AND CLAIM FILES REQUESTED:

A. Specify the individual Medicaid record level data elements needed for this request:
B. Specify the dates of the claim files requested:

C. Indicate by what method you will access the data:

5. DATES OF THIS PROJECT:

List the beginning and end date of this project:

Begin Date:

End Date:

6. STORAGE & DISPOSAL OF MEDICAID CLAIMS DATA:

A. Storage of Data - How will the data be stored?

B. Disposal of Data - Confidentiality regulations requires that data be stored securely and destroyed, or returned, at the completion of this project:

1. Data will be:

   [ ] Returned ........................................... Date: _________
   [ ] Destroyed by shredding.......................... Date: _________
   [ ] Destroyed by crushing........................... Date: _________
   [ ] Destroyed by forensic cleaning............... Date: _________

2. If you elect to destroy the data, you must submit an affidavit specifying the date of destruction and the method/s of destruction. Further, the applicant agrees to accomplish the destruction of the data and the submission of the attestation within 30 days of the date set forth in Sect. 6.B preceding.

C. NYSDOH requires all agencies handling individual recipient data records to keep a record of data use. Additionally, NYSDOH reserves the right to audit such agency records on data outlined in this request to ensure compliance with this application.
C. This application shall be terminated by NYSDOH if any of the specified terms and conditions are not adhered to.

7. MODIFICATIONS:

All modifications to this agreement must be submitted in writing to and approved by the New York State Department of Health, Office of Health Insurance Programs.

8. LIMITATIONS & LIABILITIES:

The New York State Department of Health will not be responsible for any loss due to data exchange.

9. ATTESTATION REGARDING PRIVACY/SECURITY OF MEDICAID CONFIDENTIAL DATA:

Applicant, contractors and subcontractors hereby agree to note all confidentiality language for Third Party Contractors found in Attachment A of the DEAA, and that these citations must be included in all MOU, MOA, Subcontracts or Contract.

Applicant recognizes that all Medicaid Confidential Data/Protected Health Information (MCD/PHI) is owned by NYSDOH, and agrees that applicant is designated as Custodian of the MCD/PHI released under this DEAA. Applicant will be responsible for, in its hands or in the hands of its contractors/subcontractors for use of MCD. Applicant will also be responsible for the establishment and maintenance of security, as specified in an attached HIPAA compliant Security Document, to prevent unauthorized use of MCD. The applicant represents and warrants that such data will not be disclosed, released, revealed or showed, or access granted to any person or entity other than those listed in Section 1 of this DEAA.

Any improper use and disclosure of MCD/PHI must be reported to our Privacy Coordinator.

Applicant agrees to establish and insure that its contractors/subcontractors, if any, establish appropriate administrative, technical and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use of or access to the data. The safeguards shall provide a level and scope of security that is not less that the level and scope of security established by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).
There should be no release of MCD/PHI unless written permission is received from NYSDOH. No individual claim-specific data in any form shall be combined or become a permanent part of another database or information sharing and retrieval system. Any use of individual recipient record data beyond this application must have the written approval of NYSDOH, Office of Health Insurance Programs.

Applicant, its contractors and subcontractors agree to sign the Federal Health Insurance Portability and Accountability Act / Business Associate Agreement (HIPAA/BAA), as found in Attachment B, which also meets the standards set by NYSDOH.

Applicant agrees that all staff identified as having access to the MCD/PHI in any BAA, MOU, MOA, Contract, Subcontracts must match the list contained in Section 1 of the DEAA.

Applicant agrees that the statement of work to be done in the BAA, MOU, MOA, Subcontracts or Contract must match that described in Section 2 of the DEAA.

Any description of destruction or return of MCD/PHI must match that as stated in the DEAA.

10. EXECUTORY CLAUSE: (MUST BE SIGNED & NOTARIZED):

CONFIDENTIALITY CERTIFICATION
BY

("Name of Applicant" and Office Held):
(Executory Clause):

It is understood by and between the parties that this Agreement shall be deemed executory to the extent of the resources available to NYSDOH Medicaid program and no liability on account thereof shall be incurred by the NYSDOH Medicaid beyond the resources available thereof.

To New York State Department of Health ("Department"):

The Applicant has requested the following Medicaid confidential data (describe data):
Section 1902(a) (7) of the federal Social Security Act and Section 369 (4) of the Social Services Law, require that Medicaid Confidential Data be treated as confidential and used or disclosed only for a purpose directly connected with the administration of the Medical Assistance program.

The Applicant certifies to the Department that the Applicant, its officers, employees, agents or subcontractors will adhere to these Medicaid confidentiality standards and provisions of the legal authority cited by the applicant. The Applicant will provide the following controls to ensure confidentiality of the data:

1. The data may be used only for the purpose listed in this Application.

2. Only listed Applicant staff that require the data to perform functions listed in this Application may be given access to the data. Such staff will be instructed by the Applicant in the confidential nature of the data and its proper handling.

3. The data will be secured in locked storage receptacles when the data are not under the direct and immediate control of an authorized Applicant staff member engaged in work under this Application.

4. The data, including any copies made by the Applicant, will be returned to the Department by the Applicant upon completion the Application purpose, or with prior written Department approval, the data may be destroyed by the Applicant after its use and a written confirmation provided by the Applicant to the Department of such destruction.

(Applicant): ______________________ makes this Confidentiality Certification and Executory Clause as a condition for receipt of confidential Medicaid information and to ensure maintenance of confidentiality and security of the data pursuant to the aforementioned laws.

Date: ______________________

Signature of Commissioner: __________________________

Signer’s Name (please print): ______________________

Organization: __________________________

Address: __________________________

State of ______________________

} ss.: 

County of ______________________
11. ATTACHMENTS:

Attachment A: Third Party Contractor Language
Attachment B: HIPAA Business Associate Agreement
Attachment C: Data Disposal Attestation Form

ATTACHMENT A

CONFIDENTIALITY LANGUAGE FOR THIRD PARTY CONTRACTS

The federal Center for Medicare and Medicaid Services (CMS) requires that all contracts and/or agreements executed between the Department of Health and any second party that will receive Medicaid Confidential Data must include contract language that will bind such parties to ensure that contractor(s) abide by the regulations and laws that govern the protection of individual, Medicaid confidential level data. This notification requires that you include the following language in this contract and all future contracts that will govern the receipt and release of such confidential data:

Medicaid Confidential Data/Protected Health Information includes all information about a recipient or applicant, including enrollment information, eligibility data and protected health information.

You must comply with the following state and federal laws and regulations:

- Section 367b(4) of the NY Social Services Law
- New York State Social Services Law Section 369 (4)
- Article 27-F of the New York Public Health Law and 18 NYCRR 360-8.1
- Social Security Act, 42 USC 1396a (a)(7)
- Federal regulations at 42 CFR 431.302, 42 C.F.R. Part 2
- The Health Insurance Portability and Accountability act (HIPAA), at 45 CFR Parts 160 and 164
Please note that MCD released to you may contain AIDS/HIV related confidential information as defined in Section 2780(7) of the New York Public Health Law. As required by New York Public Health Law Section 2782(5), the following notice is provided to you:

“This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for the release for further disclosure.”

Alcohol and Substance Abuse Related Confidentiality Restrictions:

Alcohol and substance abuse information is confidential pursuant to 42 C.F.R. Part 2. General authorizations are ineffective to obtain the release of such data. The federal regulations provide for a specific release for such data.

You agree to ensure that you and any agent, including a subcontractor, to whom you provide MCD/PHI, agrees to the same restrictions and conditions that apply throughout this Agreement. Further, you agree to state in any such agreement, contract or document that the part to whom you are providing the MCD/PHI may not further disclose it without the prior written approval of the New York State Department of Health. You agree to include the notices preceding, as well as references to statutory and regulatory citations set forth above, in any agreement, contract or document that you enter into that involves MCD/PHI.

ANY AGREEMENT, CONTRACT OR DOCUMENT WITH A SUBCONTRACTOR MUST CONTAIN ALL OF THE ABOVE PROVISIONS PERTAINING TO CONFIDENTIALITY. IT MUST CONTAIN THE HIV/AIDS NOTICE AS WELL AS A STATEMENT THAT THE SUBCONTRACTOR MAY NOT USE OR DISCLOSE THE MCD WITHOUT THE PRIOR WRITTEN APPROVAL OF THE NYSDOH.

Applicant/Contractor
Signature___________________________________________Date....../....../............

Name Printed: ______ Company: ________________________________

Applicant/Contractor
Signature___________________________________________Date....../....../............

Name Printed: ______ Company: ________________________________
Applicant/Contractor
Signature_______________________________________Date……/……/…………

Name Printed: ________________________________
Company: ________________________________
ATTACHMENT B

HIPAA Business Associate Agreement

To be signed by CONTRACTOR that uses or discloses individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

I.

A. “Business Associate” shall mean

B. “Covered Program” shall mean

C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and implementing regulations, including those at 45 CFR Parts 160 and 164.

II. Obligations and Activities of Business Associate:

A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.

B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT.

C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.

D. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:

1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;

4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and

5. Contact procedures for Covered Program to ask questions or learn additional information.

E. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Program, agrees to the same restrictions and conditions that apply through this AGREEMENT to Business Associate with respect to such information.
F. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.

G. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.

H. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program’s compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.

I. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

J. Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.

K. Business Associate agrees to comply with the security standards for the protection of electronic protected health information in 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312 and 45 CFR § 164.316.

III. Permitted Uses and Disclosures by Business Associate:

A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.

B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.

C. Business Associate may disclose Protected Health Information as Required By Law.

IV. Term and Termination

A. This AGREEMENT shall be effective for the term as specified in this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this AGREEMENT.

B. Termination for Cause. Upon Covered Program’s knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.
C. Effect of Termination.
   1. Except as provided in paragraph (c) (2) below, upon termination of this
      AGREEMENT, for any reason, Business Associate shall return or destroy all
      Protected Health Information received from Covered Program, or created or
      received by Business Associate on behalf of Covered Program. This provision
      shall apply to Protected Health Information that is in the possession of
      subcontractors or agents of Business Associate. Business Associate shall retain
      no copies of the Protected Health Information.
   2. In the event that returning or destroying the Protected Health Information is
      infeasible, Business Associate shall provide to Covered Program notification of
      the conditions that make return or destruction infeasible. Upon mutual agreement
      of Business Associate and Covered Program that return or destruction of
      Protected Health Information is infeasible, Business Associate shall extend the
      protections of this AGREEMENT to such Protected Health Information and limit
      further uses and disclosures of such Protected Health Information to those
      purposes that make the return or destruction infeasible, for so long as Business
      Associate maintains such Protected Health Information.

V. Violations
   A. Any violation of this AGREEMENT may cause irreparable harm to the STATE.
      Therefore, the STATE may seek any legal remedy, including an injunction or specific
      performance for such harm, without bond, security or necessity of demonstrating actual
      damages.
   B. Business Associate shall indemnify and hold the STATE harmless against all claims and
      costs resulting from acts/omissions of Business Associate in connection with Business
      Associate's obligations under this AGREEMENT. Business Associate shall be fully liable
      for the actions of its agents, employees, partners or subcontractors and shall fully
      indemnify and save harmless the STATE from suits, actions, damages and costs, of every
      name and description relating to breach notification required by 45 CFR Part 164 Subpart
      D, or State Technology Law § 208, caused by any intentional act or negligence of
      Business Associate, its agents, employees, partners or subcontractors, without limitation;
      provided, however, that Business Associate shall not indemnify for that portion of any
      claim, loss or damage arising hereunder due to the negligent act or failure to act of the
      STATE.

VI. Miscellaneous
   A. Regulatory References. A reference in this AGREEMENT to a section in the Code of
      Federal Regulations means the section as in effect or as amended, and for which
      compliance is required.
   B. Amendment. Business Associate and Covered Program agree to take such action as is
      necessary to amend this AGREEMENT from time to time as is necessary for Covered
      Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and
      164.
   C. Survival. The respective rights and obligations of Business Associate under (IV) (C) of
      this AGREEMENT shall survive the termination of this AGREEMENT.
   D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a
      meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR
      Parts 160 and 164.
   E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business
      Associate acknowledges that it has been informed of the confidentiality requirements of
      Public Health Law Article 27-F.

FOR CONTRACTOR USE ONLY
Name:
Entity:
Signature: __________________________________________
Date: ________________________________________________

FOR CONTRACTOR USE ONLY

Name:
Entity:
Signature: __________________________________________
Date: ________________________________________________

FOR CONTRACTOR USE ONLY

Name:
Entity:
Signature: __________________________________________
Date: ________________________________________________

FOR NYS OHIP USE

Name:
Entity:
Signature: __________________________________________
Date: ________________________________________________

ATTACHMENT C

DATA DISPOSAL ATTESTATION FORM (HOLD UNTIL THE END OF YOUR DEAA)

AFFIDAVIT
State of ______________________________ ss.: County of ______________________________

1. My name is _______________________ and I reside at ________________________________

2. I am employed at ______________________, which is located at ____________________________

3. Medicaid Confidential Data, i.e., ____________________________________________________

were obtained from the New York State Department of Health pursuant to Data Exchange Application and Agreement (DEAA) No. __________. This DEAA was entered into for the following purpose:

__________________________________________________________________________________

This project was completed on: __________________.

4. I understand that this project specifically prohibits the use of the Medicaid data for any purpose, other than the purpose of which was stated in the DEAA, without the prior written approval of the New York State Department of Health, Office of Health Insurance Programs. As the project has been completed, I understand that the Medicaid data may no longer be used for any purpose whatsoever.

5. Please check one of the following responses regarding the return of Medicaid Confidential Data:

[ ] Previously returned on: _______________ (Include copy of cover letter to NYSDOH)
[ ] Date to be returned: _______________
[ ] Destroyed on: ___________________ (Include date)

6. I understand that there are civil and criminal penalties for violations of the following laws and regulations pertaining to the confidential nature of the Medicaid data: Section 367b (4) of the NY Social Services Law.

   • New York State Social Services Law Section 369 (4)
   • Article 27-F of the New York Public Health Law and 18 NYCRR 360-8.1.
   • Social Security Act, 42 USC 1396a (a)(7)
   • Federal regulations at 42 CFR 431.302.;42 C.F.R. Part 2
   • The Health Insurance Portability and Accountability act (HIPAA), at 45 CFR Parts 160 and 164.

7. I have retained none of the MCD/PHI disclosed to me under the above-referenced DEAA and I understand that any MCD/PHI that I might recall from memory remains confidential.

________________________________________
SIGNATURE

Subscribed and sworn before me on this _______ day of ________________, 20___.

________________________________________
NOTARY PUBLIC
Appendix B – PSYCKES Access Documentation

Step 1: Complete and return required documentation to PSYCKES Team

a) Provider completes “PSYCKES Access Online Contact Form” survey:
   https://www.surveymonkey.com/r/PSYCKES_Access_Contact_Form

b) Provider CEO (or another person who is legally authorized to bind the organization to the contractual terms) signs the Office of Mental Health (OMH) PSYCKES Confidentiality Agreement in which the organization acknowledges that PSYCKES provides access to Medicaid claims data and protected health information, and agrees to comply with all New York State and Federal privacy laws and regulations. Agreements will be countersigned by the OMH PSYCKES Director.
   ➢ Scan signed copy and email to psyckes-help@omh.ny.gov

“If organization already has a Security Manager to create PSYCKES users, skip to step 4”

Step 2: Complete registration in OMH Security Management System (SMS)

Access to secure OMH applications, including PSYCKES, is managed through an online SMS
   (for more information, see https://www.omh.ny.gov/omhweb/sms/).

a) OMH emails instructions to the CEO on how to electronically sign a Confidentiality and Non-Disclosure Agreement (CNDA). (This is separate from the PSYCKES-specific Confidentiality Agreement referenced in step 1b above.)

b) The CEO follows instructions provided in the email to electronically sign the CNDA.

Step 3: Designate one or more Security Manager

a) OMH emails the CEO with information and self-registration link needed to assign one or more SMS Security Managers.

b) CEO forwards email to person(s) who are to become Security Manager(s).

c) Staff follow instructions in email for online self-registration process as Security Manager.

d) OMH sends the Security Manager an email notification and a token (if needed, staff with existing OMH tokens will be able to use the same device).

e) The Security Manager follows instructions provided with the token.

In the future, providers wishing to designate additional staff as Security Managers should contact the ITS Helpdesk at healthelp@its.ny.gov to request that the email described in step 3a be resent.
Step 4: Security Manager enrolls PSYCKES users

a) Provider determines staff requiring PSYCKES access.
b) Security Manager creates an account in SMS (if needed; staff with existing OMH accounts in SMS and existing tokens will be able to use the same user ID and token). The Security Manager will need the following information to create accounts in SMS:
   i. Name and title
   ii. Existing OMH User ID, if any
   iii. E-mail address and mailing address of user (note: correct email of user is important)
   iv. Token preference (computer-based “soft” token or physical “hard” token)

c) Once the user account is created, the Security Manager uses SMS to grant access to PSYCKES by selecting the “PSYCKES-Medicaid” access option.
d) Upon creating user account, Security Manager chooses security token preference for that user (computer-based “soft” token or physical “hard” token).
   i. If a physical “hard” token is selected, OMH will mail it to the user’s security manager.
   ii. If a computer-based “soft” token is selected, OMH will email it directly to the user. Once received, the user will install the “soft” token onto their computer.

A policy for ensuring the protection of PHI should be shared with staff (e.g., staff must have HIPAA training before getting access to PSYCKES and login tokens should not be shared among staff; the organization’s existing policies may be sufficient but should be reviewed, and possibly modified, in relation to PSYCKES.

Step 5: Security Manager revokes PSYCKES access for staff no longer requiring access

If the individual no longer requires PSYCKES access or has left the organization, the Security Manager disables the user’s account in SMS. If the user had a hard (physical) token, the token should be mailed back to OMH. If the user had a soft (computer-based) token, the token should be removed from the user’s computer.
Appendix C – Accessing PSYCKES Clinical Summary

Search by parameter:

i. Log into PSYCKES

ii. Select PSYCKES Recipient Search feature

iii. Turn De-Identify off to identify clients (drag circle to the left)

iv. Change “Limit Results to 500,000”

v. Select your PSYCKES parameters/filters

vi. Select “Search”

vii. Click on the name (blue font) to open the clinical summary

viii. View in browser or Export

ix. You can export in PDF, Excel or CCD

x. Select the summary period (how far back the data goes): past 1 year, 2 years or “All” years (up to 5)
2. Search by Medicaid ID# or Name:
   i. Log into PSYCKES
   ii. Select PSYCKES Recipient Search feature
   iii. Enter the Medicaid ID # or First Name, Last Name and DOB into the top search bar
   iv. Select “Search”
   v. Click on the name (blue font) to open the clinical summary
   vi. View in browser or Export
   vii. You can export in PDF, Excel or CCD
   viii. Select the summary period (how far back the data goes): past 1 year, 2 years or “All” years (up to 5)
Description

Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service established for defined populations with Serious Mental Illness (SMI) who are enrolled in a Health Home (HH) serving adults. To ensure the intensive needs of these individuals are met, Health Homes must assure HH+ individuals receive a level of service consistent with the requirements for caseload ratios, face-to-face visits, and minimum levels of staff experience and education outlined below. The differential monthly rate for HH+ is higher compared to the Health Home High Risk/Need Care Management and Health Home Care Management rates and is intended to appropriately reimburse for the intense and consistent support needed for this population.

HH+ was first introduced in 2014, targeting the Assisted Outpatient Treatment (AOT) population enrolled in Health Home. In December of 2016, the HH+ population expanded to include individuals discharged from State Psychiatric Centers and those released from Central New York Psychiatric Center (CNYPC) and its corrections-based mental health units. Guidance identifying additional populations considered to have the highest care management needs within the SMI population was released in May of 2018.

This guidance document consolidates program requirements for all eligible HH+ SMI populations, includes updated staff qualifications to serve HH+ SMI as of November 2019, and an update to Care Management Agencies eligible to serve this population.
Eligible Population

HH+ services will be available for adults with SMI and who meet certain indicators for high need, such as risk for disengagement from care and/or poor outcomes (e.g., multiple hospitalizations, incarceration, and homelessness). These individuals may benefit from the enhanced support of HH+ for up to 12 consecutive months:

1) Individuals on a current AOT court order

2) Individuals identified by the Local Government Unit (LGU) as receiving an Enhanced Service Package pursuant to a Voluntary Agreement in lieu of AOT.
   
   o Such agreements may be signed by individuals who were otherwise considered for AOT by the LGU, but who agree to adhere to a prescribed community treatment plan rather than be subject to an AOT court order.
   
   o These agreements are most frequently used as trial periods before initiating a formal AOT order. The agreement can also be used following a period of AOT when the individual is deemed ready to transition off an AOT order.

3) Individuals with an expired AOT court order within the past year.

4) Individuals discharged from State Psychiatric Centers and those released from Central New York Psychiatric Center (CNYPC) and its corrections-based mental health units, except individuals that are discharged to an OMH State-operated residence located on Psychiatric Center (PC) campus grounds. These individuals are eligible for health home services, but not HH+, unless they are also subject to an AOT order.

When the individual is ready for discharge from the on-campus State-operated residence, the individual will then become eligible for HH+ for 12 consecutive months post-discharge from the residence.

5) Individuals transitioning off an Assertive Community Treatment (ACT) team to a lower level of service.

6) Individuals meeting the Housing Urban Development’s (HUD) Category One (1) Literally Homeless definition. Qualifying individuals lack a fixed, regular, and adequate nighttime residence, including individuals who:
   
   o Have a primary nighttime residence that is a public or private place not meant for human habitation, such as a car, park, sidewalk, abandoned building, bus or train station, airport, or camping ground;
7) Individuals with high rates of inpatient/emergency department (ED) services utilization. This population is typically known to staff in emergency departments, inpatient units, as well as to providers of other acute and crisis services. Individuals will have had one or more of the following:

- Three (3) or more psychiatric inpatient hospitalizations within the past year; or
- Four (4) or more psychiatric ED visits within the past year; or
- Three (3) or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.

8) Individuals with criminal justice system involvement, including release from incarceration (jail, prison) within the past year. Eligible individuals require linkage to community resources to avoid reincarceration and may have been incarcerated due to poor engagement in community services and supports.

9) Individuals ineffectively engaged in care, as evidenced by:

- 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.

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1 OMH State-operated residence includes the following types: Transitional Living Residence (TLR), Transitional Placement Program (TPP), State Operated Community Residence (SOCR), and Residential Care Center for Adults (RCCA).

2 ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs.
10) Others based on clinical discretion: SMI individuals who do not fall within at least one of the above high need categories could still be eligible for HH+ services based on the clinical discretion of the local Single Point of Access (SPOA) and/or Managed Care Organization (MCO).

MCOs coordinate physical and behavioral health services for Medicaid Managed Care Plan enrollees. MCOs, including mainstream plans, HIV-SNPs and HARPs, have responsibility in ensuring high-need members have positive health outcomes and receive needed services.

The LGU/SPOA has oversight responsibility for the high-need SMI population and ensures access to appropriate services to meet their needs. The SPOA is uniquely qualified to make a recommendation for HH+ eligibility based on their current work triaging referrals for ACT and AOT, as well as the non-Medicaid behavioral health population.

The exercise of clinical discretion by the LGU/SPOA or MCO may be based on the consideration of social determinants of health or other factors, including but are not limited to:

- An individual who is frequently at-risk for homelessness due to psycho-social related tendencies such as hoarding.
- Transition-age youth: Individuals transitioning out of child/adolescent services who require intensive care coordination through this transition.
- Individuals experiencing initial onset of mental illness without connection to mental health treatment.
- An individual’s substance use is a barrier to engaging in community-based treatment and services.
- Individuals placed on an ACT waitlist who would benefit from enhanced care coordination while awaiting placement with ACT services. LGU/SPOA and MCO should work with the assigned HH+ Care Manager (CM) to assist with planning for other care that may be needed in the interim.

Care Management Agencies (CMAs) will need to develop a protocol for safely transitioning individuals on and off HH+ care management services, based on individual need. Individuals transitioning off from HH+ will receive the Health Home High Risk/Need Care Management rate for a period of six (6) months to support the transition to a less intensive level of care management.

3 ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs
Care Management Agencies (CMAs) Eligible to Serve HH+ Individuals

Effective March 8, 2021, only CMAs designated by the NYS OMH as Specialty Mental Health Care Management Agencies (MH CMAs) will be eligible to enroll newly referred individuals meeting HH+ SMI eligibility criteria. Only Specialty MH CMAs with authorization by the State, LGU and lead Health Home(s) will have the ability to accept referrals, serve and bill HH+ for individuals on AOT.

In the case where a HH member becomes HH+ SMI eligible while enrolled with a non-Specialty MH CMA, lead Health Homes shall ensure care managers are informing HH+ eligible members of their option to transfer to a Specialty MH Care Management Agency, and ensuring access to Specialty MH Care Management, as appropriate.

Attestation

All designated Specialty MH CMAs are required to submit written attestation to the NYS OMH, verifying their intention to provide Specialty Mental Health Care Management, and to having protocols in place for ensuring compliance with all required program standards outlined in this guidance.

Lead Health Homes must have formal policies and procedures to support HH+ service delivery and billing.

For more information on the attestation process, please visit the OMH website.

Staff Qualifications

HH+ shall always be delivered by a CMA with staff who have the education and experience appropriate to serve the high-need, behavioral health population under appropriate supervision. The following Minimum Qualifications\(^4\) apply:

**Education and Experience**

1. A Master’s degree in one of the qualifying fields\(^5\) and one (1) year of Experience; OR
2. A Bachelor’s degree in one of the qualifying fields and two (2) years of Experience; OR

\(^4\) CMA Supervisors who requested a waiver of qualifications needed to supervise HCBS Assessors and were approved prior to 11/15/16, will be considered qualified Supervisors for HH+ for that CMA. The CMA has the option to arrange for a licensed or Masters’ level professional within the organization to provide regular clinical supervision to the CMs, jointly with the care managers’ direct program supervisor. Care managers who requested a waiver of HCBS Assessor qualifications and were approved prior to 11/15/16, will be considered qualified to serve HH+ SMI individuals for that CMA.

**NOTE:** If a Supervisor or CM currently permitted to serve HH+ individuals (as described above) later leaves the agency, the CMA is required to replace them with new staff that meet the HH+ Staff qualifications.

\(^5\) Qualifying fields include education degrees featuring a major or concentration in: social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.
3. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR

4. A Bachelor’s degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population.

Experience shall consist of:
1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED; OR
2. Linking individuals with Serious Mental Illness, 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 (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

Supervision shall be provided by staff meeting either of the following qualifications:
1. Licensed level healthcare professional\(^6\) with prior experience in a behavioral health setting; OR
2. Master’s level professional with two (2) years prior supervisory experience in a behavioral health setting.

In rare circumstances, staff may have unique education and/or experience to adequately serve the HH+ SMI population but do not meet the qualifications outlined above. HH CMAs may apply for a waiver for such staff. Waivers are not intended to be the sole approach for an agency looking to expand capacity in serving the HH+ SMI population. Agencies should be prudent in selecting staff to pursue a waiver of qualifications, and only be submitted for those staff whose unique qualifications allow them to adequately serve the population.

Please submit all waiver requests online here: [Waiver of Qualifications for HH+ SMI and NYS EA Assessors for Adult BH HCBS](#)

IMPORTANT: Waiver approval alone does not authorize an agency to provide/bill for HH+ services; all other applicable requirements (e.g., HH+ Attestation) authorizing your agency for such still apply. HH CMAs who receive waiver approvals are responsible for notifying their Health Home(s) accordingly.

**Staff Core Competencies**

Supervisors and direct care management staff shall possess key skills and knowledge for serving high need individuals with SMI, including but not limited to the following areas:

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• Conduct appropriate screening and either performing or arranging for more detailed assessments when needed (e.g., high-risk substance use or mental health related indicators, harm to self/others, abuse/neglect and domestic violence).

• Create and leverage relationships with critical behavioral health service providers to plan and coordinate care management needs for high-need SMI individuals including:
  o Navigating the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/diversion, peer support services
  o Knowledge of the behavioral health managed care benefit package and coordinating care with MCOs (e.g., for HARP members)
  o Collaborates with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings
  o Addressing the quality, adequacy and continuity of services to ensure appropriate support for individuals’ mental health and psychosocial needs.

• Maintain engagement with individuals who are often disengaged from care, have difficulty adhering to treatment recommendations, or have a history of homelessness, criminal justice involvement, first-episode psychosis and transition-age youth. Key skills and practices to engage high-need SMI individuals include but are not limited to:
  o Motivational Interviewing
  o Suicide Prevention
  o Risk Screening
  o Trauma Informed Care
  o Person-centered care planning and interventions
  o Recovery-Oriented Approaches (e.g., Wellness Recovery Action Plans)

CMA Supervisors shall also be proficient in the following:
  o Target population management and outcomes
  o Supporting CMAs with members in crisis
  o Team planning and staff supervision
  o Addressing barriers in service access
  o Knowledge and understanding of OMH program policy requirements

Referral for Health Home Plus

HH+ referrals can come from multiple sources including community providers, shelter outreach teams, ACT teams, forensics, MCOs, hospitals, etc. The referral source can supply documentation to support that the individual meets high need indicators for HH+. If the referral goes to the Health Home, the Health Home must ensure that the individual is assigned to a Specialty Mental Health CMA. The Health Home shall ensure prompt assignment to allow the care manager the ability to participate in the planning process for continuity of care for individuals transitioning between care settings.

Referrals sent through SPOA should be assigned to a Specialty Mental Health CMA. The Single Point of Access (SPOA) is under the authority of the Local Government Unit (LGU) and Mental Hygiene law. SPOA is a critical entry point for the mental health service delivery system. The SPOA is responsible to ensure that referrals are coordinated in a timely and efficient way for this high-need population to benefit from the intensive services.
Specialty MH CMAs shall have a working relationship with the LGU/SPOA in their service county and ensure protocols are in place to receive referrals. A “working relationship” with SPOA includes:

1) Demonstrated ability and willingness to accept high-need SMI referrals directly from the LGU/SPOA
2) Participation in any county SPOA process or committee as applicable
3) Knowledge of LGU/SPOA protocols and resources for accessing local mental health services
4) Clearly defined communication standards between the CMA, SPOA, and HH.

**Program Requirements**

- Program requirements for individuals eligible for HH+ shall be carried out in a manner consistent with the existing “Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations” guidance distributed by the Department of Health.

- The required caseload ratio for HH+ enrollees shall be one (1) full-time employee (FTE) to 20 HH+ recipients.

- A minimum of four (4) Health Home core services shall be provided per month, two (2) of which must be face-to-face contacts, or more when the individual’s immediate needs require additional contacts. The HH+ rate code can be billed only when this requirement is met and clearly documented in the individual’s record.
  - For individuals with an active AOT court order, at least four (4) face-to-face contacts shall be made within the month. See below for additional program requirements that must be met in order to receive the HH+ rate for individuals on AOT.

- If the minimum service requirements are not provided in a given month, but all other requirements as outlined in this guidance are met and at least one (1) Health Home core service was provided, the Health Home High Risk/Need Care Management rate code may be billed for that given month.

- The HH+ rate code can be billed for 12 consecutive months starting from the point an individual’s HH+ eligibility becomes known to the CM and HH+ services have been provided.
  - For AOT individuals, the HH+ rate can be billed for as long as the court order is active.
  - If an individual eligible for HH+ continues to meet eligibility at the end of the 12-month initial time frame, HH+ billing may continue for 12 more months with supporting documentation.

  For example, an individual began receiving HH+ services in January after stepping down from ACT. In December, the CM determines they still meet HH+ eligibility due to three (3) inpatient psychiatric stays within the last year. HH+ services may continue another 12 months.

- Communicating with Managed Care Plans (MCOs) regarding HH+ individuals:
The CMA shall inform the Health Home when HH+ eligibility becomes known to the CM and HH+ services will be provided. For AOT individuals, the CMA shall inform the HH when a member has been placed on court ordered AOT, or when the court order has expired and has not been renewed.

The Health Home shall inform the MCO of the individuals’ HH+ status.

**Additional Program Requirements for Individuals on AOT**

The following program requirements apply to all individuals with a current AOT court order:

- Individuals receiving court ordered AOT will be assigned to a CMA with behavioral health expertise or otherwise qualified to serve HH+ individuals, through the Local Governmental Unit’s (LGU) AOT process.
  - In many counties, SPOA may be included in the process by which the LGU assigns AOT individuals to a CMA.
  - If an individual already receiving HH care management in the community is later ordered to AOT, the LGU shall ensure that the care management agency serving that individual is eligible to serve AOT as described in this guidance. If the CMA is not eligible, the LGU shall direct a transfer to a CMA with the appropriate experience. It will then be the responsibility of the CMA to promptly notify the Health Home of the CMA transfer.

- At least four (4) face-to-face contacts shall be made within the month. **The HH+ rate code can be billed only when this requirement is met and clearly documented in the individual’s record.**

- If the care manager made diligent efforts to provide four (4) face-to-face contacts and the individual was not home, did not show up for an appointment or was otherwise not available, the CMA shall report all efforts made to the LGU using notification procedures developed by the Local Government Unit (LGU).
  - If the individual was not able to be seen, continued communication with the LGU should be made in order to determine what additional follow-up efforts may be required. All efforts must be documented in the individual’s record.
  - If at least one (1) Health Home core service was provided by a qualified care manager and the above requirements have been completed:
    - The Health Home High Risk/Need Care Management rate code may be billed for that given month.

- If the individual with an AOT court order cannot be located and has had no credibly reported contact within 24 hours of the time the care manager received either notice that the individual had an unexplained absence from a scheduled treatment appointment, or other credible evidence that the AOT individual could not be located, the individual will be deemed Missing. **A diligent search shall commence, as outlined in the OMH guidance “Assisted Outpatient Treatment Program: Guidance for AOT Program Operation” (Reissued February 2014).**
If the care manager made effort to provide four (4) face-to-face contacts and was unable to due to missing status, HH+ rate can continue to be billed as long as the diligent search procedures referenced above are followed and clearly documented in the individual’s care management record. The individual’s record shall also clearly indicate when the determination was made that the individual was missing. The diligent search shall continue until either the person is located, or the court order is no longer active.

- If all activities for performing a diligent search cannot reasonably be completed within the same month the individual is deemed missing, the HH+ rate may still be billed for that month so long as the diligent search process commenced within timeframes specified in AOT Program Operation guidance.

- A missing AOT individual is considered a significant event that must be reported to the LGU within 24 hours, following the LGU’s protocol for reporting significant events. The CMA shall maintain continued communication with the LGU in order to determine what additional follow-up efforts may be required. All communication shall also be documented clearly in the individual’s record.

- When the examining physician includes HHCM in the court ordered treatment plan and the individual refuses to enroll in the Health Home, a copy of the AOT order shall be made available to the Health Home, which will then be able to enroll the individual and bill the HH+ rate code. However, the AOT order does not substitute for the individual’s consent to share clinical information. Absent such specific consent, the HHCM may share clinical information for care coordination purposes to the extent permitted by section 33.13(d) of the Mental Hygiene law, which provides a limited treatment exception for the exchange of clinical information between mental health providers and Health Homes.

- The CM will work with the LGU to ensure timely delivery of services listed in the court order. Such services shall include coordination of all categories of service listed in the AOT treatment plan.

- All categories of service listed in the court ordered AOT treatment plan shall also be included in the individual’s integrated health home plan of care.

  o The CMA and/or other members of the treatment team shall consult with the treating physician and the LGU’s Director of Community Services or County AOT coordinator, who can then petition to the court for any material change needed to be made to the AOT treatment plan. Any additions or deletions of categories of service are considered material changes.

  o Changes needed to other services in the HH plan of care that are not listed in the AOT treatment plan (e.g., primary care services not listed in the AOT treatment plan), are not considered material changes and therefore do not require consultation with the LGU.

- Health Homes and Care Management Agencies shall be familiar with the statutory basis of the AOT program, or Kendra’s Law (§9.60 of NYS Mental Hygiene Law), including the requirement that care management is a mandatory service category on every court-ordered treatment plan. This guidance outlines the contact requirements for care management.
The CMA shall comply with all reporting requirements of the AOT Program as established by the LGU. Localities may have their own requirements that are above the minimum contact standards of four times per month. Additionally, the CMA shall report assessment and follow-up data to the Office of Mental Health (OMH) through the Child and Adult Integrated Reporting System (CAIRS) at 6-month intervals.

**LGU Requirements for AOT**

The LGU is responsible to operate, direct, and supervise their County’s AOT program and work in collaboration with the CMA to arrange or provide for all categories of AOT services. As part of these responsibilities the LGU:

- Uses their established system to respond to and investigate all AOT referrals;
- Ensures that the services in the treatment plan are made available and monitors delivery of these services.
- Monitors the AOT individuals served;
- Follows the county-specific procedure for implementation of MHL section 9.60 removal orders;
- Follows their established system for notification regarding AOT recipients who are missing within 24 hours, diligent search, removal orders, and missing person report (see link below for detail); and
- Uses their established system to be notified of all significant events and reports them to OMH as required (see guidance “Significant Event Reports: Care Manager Reporting of Significant Events Related to Assisted Outpatient Treatment (AOT) Court Orders” for details); and
- Provides data to OMH as required.

More details on the AOT Program and reporting requirements can be found on the OMH website.

**Comprehensive Transitional Care**

It is expected that the HH/CMA staff and the referral source will coordinate efforts in a way that provides for warm hand-off and immediate engagement for high-need individuals. The care manager should initiate contact with the individual and/or referral source upon receiving the referral.

A warm hand-off is a best practice to ensure optimal transition to HH+ services when an individual is being discharged/transitioned from either a program or facility. An introduction with the individual prior to discharge/transition can help orient the individual to HH+ services while allowing the care manager to participate in discharge planning.

For individuals transitioning from a State PC/CNYP, State PC Discharge planning staff or CNYP Pre-Release Services staff should, whenever possible, initiate referrals to a Health Home prior to discharge. State PC/CNYP staff shall first obtain a signed Authorization for Release of Information from the individual, providing consent for a HH referral to be made. In some counties, referrals to Health Home services for individuals being discharged from State
PCs/CNYP can go through SPOA, in which case, State PC/CNYP staff can contact the local government unit (LGU) to facilitate a referral to SPOA.

- It is imperative that State PC/CNYP staff make referrals to SPOA in advance of discharge, in order to allow for a warm hand-off and more immediate care manager engagement prior to discharge.

- State PC/CNYP staff shall verify and include the individual’s Medicaid eligibility status in the referral, as well as the specific follow-up action needed post-discharge to help ensure the individual’s Medicaid is activated as soon as possible.
  - See Appendix B: “Discharge Scenarios for 21 – 64-Year-Old Inpatients”. For example, if the individual’s Medicaid was suspended while inpatient or incarcerated and determined that the individual will need to reinstate Medicaid through the local Department of Social Services upon discharge, State PC/CNYP staff shall indicate such status and the follow-up needed in the referral being made to the HH.

- For most individuals age 18 - 21 (transition age youth) who are inpatients in a State PC, OMH (Medicaid District 97) will have opened a Medicaid case to cover the inpatient stay. If the youth had coverage prior to the inpatient admission and the case remained open, upon discharge the youth would have an OMH Medicaid case for the inpatient stay as well as an open local district or NYC HRA case. Following discharge, the OMH case would close and the local district/NYC HRA would be notified to resume the youth’s coverage.
  - If the youth did not have Medicaid coverage prior to admission, or the Medicaid coverage was closed or expired during the inpatient stay, the OMH Medicaid coverage would transition to the new district of responsibility upon discharge. Youth who have coverage through NYSoH may have to reapply for coverage upon discharge, or their coverage may also continue uninterrupted.

- The OMH Medicaid case generally remains open for the month of the person’s discharge and the following month during the transition process. Care managers should confirm that coverage is transitioned to the new Medicaid district.

- For most adults age 65 or older who are inpatients in a State PC, OMH (Medicaid District 97) will have opened a Medicaid case. Following discharge, that coverage is transitioned to a local district or NYC HRA. The OMH Medicaid case generally remains open for the month of the person’s discharge and the following month during the transition process. Care managers should confirm that coverage is transitioned to the new Medicaid district.

- For CNYP discharges only: In NYC, most individuals being released from CNYP will initially be referred to an OMH-dedicated forensic transitional case management team. The forensic care management team will later refer the individual to a Health Home for ongoing care management and should work with the HHCM to ensure that a warm hand-off is coordinated. The HHCM will provide HH+ for the remainder of the 12-month period that the individual is eligible for HH+. 
Once assigned to a CMA, the CMA shall provide immediate delivery of HHCM services, including participation in the pre-release/discharge planning process whenever possible, to support a warm hand-off.

- For individuals already enrolled in a HH and being discharged from a State PC or CNYP, the CMA shall participate in the discharge planning process and have a face-to-face contact with the individual within 48 hours of discharge. Current best practice indicates that face to face contact with an individual within 24 hours of release from a forensic facility is pivotal to successful engagement for this population.
- Coordination of care will likely include the reestablishment of Medicaid benefits for this population, so that individuals have immediate access to all services on their plan of care.
- For individuals being released from prison with Parole, the health home care manager should establish contact as soon as possible with the Parole Officer to coordinate efforts for helping the individual follow their mental health discharge plan, which will include care management.

**Care Management Models That Meet HH+ Requirements**

To meet the changing and complex needs of the HH+ population, CMAs may utilize different models of care management to affect successful transitions, continuity of care and improved outcomes. CMAs have the option to adopt any of the following models of care management offered below. See also, Appendix A. To ensure HH+ individuals on a given caseload receive the required level of service, certain parameters will apply.

**HH+ Only Caseload:**
One FTE qualified care manager serves a caseload of no more than 20 HH+ individuals.

**Mixed Caseload (HH+ and non-HH+ individuals):**
For the purposes of caseload stratification and resource management; a caseload mix of HH+ and non-HH+ is allowable if the HH+ ratio is less than or equal to 20 HH+ recipients to one (1) qualified Health Home Care Manager. Caseload sizes should always allow for adequate time providing care management as outlined in this guidance to HH+ individuals while allowing for thoughtful consideration of the care coordination needs of non-HH+ recipients.

**Team Approach:**
A CMA may choose to use a team approach to serve a HH+ Only caseload or a Mixed caseload of HH+ and non-HH+ individuals. If a CMA uses a team approach, the following requirements must be met:

- The team caseload must maintain the ratio of 20 HH+ individuals per each FTE on the team. For every 40 HH+ individuals, the team must have at least one (1) qualified HH+ care manager. For example, a team serving 50 HH+ individuals shall include two (2) qualified HH+ care managers.
- A qualified HH+ care manager must provide at least two (2) Health Home core services per month, one (1) of which must be a face-to-face contact for HH+ individuals. The remaining contact requirements can be provided by the additional team members.
• A primary care manager meeting the staff qualifications outlined above to serve HH+ individuals shall be identified and will conduct the Comprehensive Assessment, develop the Plan of Care, and provide oversight regarding coordination of interventions in accordance with the Plan of Care.

**Billing and Tracking Guidance**

CMAs will use either the MAPP Health Home Tracking System or the Health Home’s own system (which then feeds into MAPP HHTS) to attest that billable services were provided (minimum required HH+ services or HHCM core service) in a given month. The MCOs will use the MAPP HHTS billing support to pay the Health Homes. Health Homes will bill eMedNY for Health Home enrollees who are not enrolled in Medicaid managed care. Health Homes will then reimburse the CMA, less any contracted administrative fee.

• There is a unique rate code for HH+ services (1853).
• There is one HH+ payment rate for Downstate and one for Upstate:

<table>
<thead>
<tr>
<th>Rate Code</th>
<th>Rate Description (OMH) HH+</th>
<th>Monthly HH+ Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1853</td>
<td>Downstate (applicable to Dutchess, Putnam, Rockland, Westchester, Nassau and Suffolk counties, and New York City.)</td>
<td>$800</td>
</tr>
<tr>
<td></td>
<td>Upstate (applicable to all counties other than Downstate)</td>
<td>$750</td>
</tr>
</tbody>
</table>

• The HH+ rates were added to lead Health Home rate profiles in eMedNY effective December 1, 2016 to allow lead Health Homes to bill on behalf of Care Management Agencies providing HH+ services.

• The Department of Health (DOH) Medicaid Analytics Performance Portal (“MAPP”) will be used to identify individuals as HH+.
  o MAPP users will be prompted in the monthly HML questionnaire with the question “Is the member in the AOT population?” If the user responds “Yes”, the user is then prompted with “Were the minimum required AOT services provided?” By responding “Yes”, the CMA attests that the minimum service requirements for AOT HH+ have been provided.
  o MAPP users will also be prompted in the monthly HML questionnaire with the question “Is the member in the expanded HH+ population?” If the user responds “Yes”, the user is then prompted with “Were the minimum required HH+ services provided?” By responding “Yes”, the CMA attests that the minimum service requirements for HH+ have been provided.
- This data will additionally be used by OMH for oversight purposes. It is important that CMAs accurately complete this data in MAPP monthly.

Questions may be submitted to SpecialtyMH_HHCM@omh.ny.gov.
Appendix E – VINE FAQ’s

VINELink Frequently Asked Questions

What is VINE?
Where is VINE available?
Do I subscribe to or pay for this service?
How do I search for an offender and register to receive notification using VINELink?
Why can’t I access VINELink?
What web browsers does VINELink support?
Why can’t I find a particular offender?
What does ‘non-participating county’ mean?
How do I locate information about a Federal inmate?
How frequently do you receive offender information?
Is Charge and Warrant information available on VINELink?
Can you remove or change offender information on your website?
Why did I not receive notification on my AOL address?
What is the ‘Caller ID’ number and ‘Sender Email’ address?
Are offender photos on VINELink?
How do I stop receiving unwanted notification calls?
Can I find historical data on an offender?
Does VINELink support Spanish web content?

What is VINE?

VINE (Victim Information and Notification Everyday) is a service through which victims of crime can use the telephone or Internet to search for information regarding their offender’s custody status and register to receive telephone and e-mail notification when their offender’s custody status changes.

Telephone Registration
You can use the telephone to search for and register to receive notification about the custody status of an offender -- each state/county has their own toll-free VINE phone number.

Web Registration
You can search for and register to receive notification about the custody status of an offender via VINELink at www.vinelink.com.

For more information about VINE, including state/county toll-free numbers, please go to www.appriss.com/VINE.html.

Where is VINE available?

VINE is currently available in 46 states. If the inmate for whom you’re searching is in custody at a corrections facility that participates in VINE, you should be able to locate custody information on VINELink (www.vinelink.com).
Do I subscribe to or pay for this service?

VINELink is not a paid service. It is completely FREE to the public.

We are aware of other services that ask you to “subscribe to” or “pay for” their information.

We assure you, we are in no way affiliated with those services.

How do I search for an offender and register to receive notification using VINELink?

Please note that you may register to receive notification for custody status changes only for offenders currently in custody.

To use VINELink to search for an offender in custody, please follow these steps:

1. Go to www.vineline.com
2. Click on the state in which the offender is housed.
3. Choose the Search & Register tab across the top of the navigation page.
4. Select the Facility or Facilities that you would like to search, type in the Offender Identification number or the full Last Name and at least the first initial of the First Name, then click Search.
5. Verify the information for the offender that matches the person for whom you search.

To use VINELink to register to receive notification about changes in an offender’s custody status, please follow these steps:

1. Complete steps 1 through 5 above.
2. Click on the magnifying glass icon under the Register/Details column next to the appropriate offender.
3. On the Offender Details screen, choose your Method of Registration, then click Continue.
4. Complete the required information for registration.
5. Click Register.

Why can’t I access VINELink?

If you’re having trouble accessing VINELink, you may need to clear your browser cookies and temporary Internet files. To do this:

1. Open Internet Explorer and go to Tools, Internet Options. The General tab appears.
2. In the Browsing History section, click the Delete button. The Delete Browsing History screen appears.
3. In the Temporary Internet Files section, click the Delete Files button. Click Yes to confirm the deletion.
4. In the Cookies section, click the Delete Cookies button. Click Yes to confirm the deletion.
5. Click Close, then click OK to exit the Internet Options screen.
6. Restart your browser and try to access VINELink.

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If this does not resolve your issue then you may need to add VINElink to your Internet Explorer browser’s Trusted Site list using the following steps:

1. Open Internet Explorer and go to Tools, Internet Options.
2. Click the Security tab, click on Trusted sites, then click the Sites button.
3. In the Add this website to the zone: box, type http://www.vinelink.com, click Close, and OK.
4. Restart your browser and try to access VINElink.

If this does not resolve your issue, please contact our service center directly for further assistance.

Note: The service center phone number is listed at the home page of each state’s site.

What web browsers does VINELink support?

VINElink supports the following web browsers: Internet Explorer (IE) 6.0 & 7.0 and Firefox 2.0.

Why can’t I find a particular offender?

VINElink provides information regarding offenders who are currently in custody or who may have been recently released from custody.

If you do not find the person for whom you search, please call the facility where you believe the offender to be housed and inquire about the status of his/her custody.

What does ‘non-participating county’ mean?

VINE is available in 42 states through various different types of agreements. Even in ‘statewide’ programs, not each and every county participates in the VINE program. Some counties do not have jail facilities and therefore do not report any information. In other states, individual counties support their own contract for VINE. If you do not see your county listed, then it is currently a non-participating county. Please contact your local jail for offender information.

How do I locate information about a Federal inmate?

VINE does not receive information regarding federal inmates. However, the Bureau of Prison’s website, www.bop.gov, has an “Inmate Locator” that provides information on any Federal Inmate.

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How frequently do you receive offender information?

Our standard transaction time is every 15 minutes for jails and twice each day for prisons. This may vary depending upon the jail activity and the resources the facility has on site to update the data. Most always, the data is current within 15 minutes.

However, if you have reason to believe the data is out of date, you should call the jail directly for an update and invoke your personal safety plan. Do not depend solely on VINE or any other program for your safety.

Is Charge and Warrant information available on VINELink?

VINE does not receive charge information from all facilities and therefore it is not always available to be displayed on VINELink. We recommend that you call the facility in which you believe the offender is housed and inquire about the charges for the offender.

VINE does not track outstanding warrants. However, Appriss, provider of the VINE service, is working directly with several states to provide VINE Protective Order, a product that allows PO petitioners to receive notification when the warrant is served.

Can you remove or change offender information on your website?

VINE – Victim Information and Notification Everyday, is funded and provided by local and state agencies for the purpose of notifying victims upon a change in their offender’s custody status. We provide this service as a third party and do not have the ability to remove or alter offender data in the database.

However, we work closely with the agencies to ensure data integrity and accuracy. If you have found incorrect data on the VINELink site, please call your local Department of Correction or jail facility to report the inaccuracy to them directly so that they might make the change in their database as appropriate.

Why did I not receive notification on my AOL address?

First, please verify that your email address is correctly registered with VINE for the inmate in which you are seeking notification.

It’s possible that VINE email notifications could be perceived as “spam” by AOL. Please verify that your Mail Controls are not blocking VINE’s email address or domain. The email notifications will come from vine@globalnotifications.com. You may also want to add this address to your address book to ensure that VINE mail is allowed to be delivered. Also, please check your spam folder to ensure your spam filters have not caught any mail incorrectly.

What is the ‘Caller ID’ number and ‘Sender Email’ address?

When you receive a notification from VINE, you will see the following telephone number on your caller ID: 502-213-2798. If you register for email notification, you will receive a message from the following email address: vine@globalnotifications.com

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Are offender photos on VINELink?

VINELink now has the ability to display offender photos. This is a configurable option and your particular state and/or agency may or may not have this feature enabled at this time.

How do I stop receiving unwanted notification calls?

Please call the toll-free number associated with the state where the offender is being housed and select the option to speak with an operator. Please provide the state in which the offender is housed, as well as the phone number that is being called. With this information we’ll be able to research the problem and assist with getting the notification calls stopped.

Can I find historical data on an offender?

VINE - Victim Information and Notification Everyday, tracks an offender’s in-custody status and date of release only. Historical data is not available. Offenders are deleted from our database usually within two weeks of release.

Does VINELink support Spanish web content?

Yes. VINELink supports Spanish web content on the National Resources Tab. VINELink also supports Spanish at the state level. This is a configurable option and your particular state and/or agency may or may not have this feature enabled at this time.

Return to the VINELink Frequently Asked Questions on page 1.