Encompass
HEALTH HOME

Policy
&
Procedure Manual

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CATHOLIC CHARITIES OF BROOME COUNTY
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Care Management Policy #1 Program Description/Care Manager Qualifications

Effective Date: 3/1/15
Revised Date: 3/1/16, 9/1/16, 10/1/16

Policy: The Health Home Care Management program will maintain a current description of its program

A. Basic Premise

Encompass Health Home provides strength based, recovery-focused services which will assist adults and children that have met qualifying criteria for Health Home services via the Department of Health (DOH) standards, to identify and access needed medical and behavioral healthcare, social services, educational, financial, vocational, housing and other supports. In partnership with the Participant, their family supports and providers, coordination is provided to the most appropriate services to meet their expressed needs, improve health and well-being, and achieve maximum level of independence in the most appropriate and least restrictive environment.

Comprehensive Care Management utilizes an interdisciplinary team approach to create a person-centered, single plan of care, and address appropriateness, quality, adequacy, continuity and cost effectiveness of the needed supports, resources and services. Care Management provides oversight and coordination of the care plan to assure the delivery of high quality health and social support services.

B. Standards of Care Management

Care Management Agencies (CMA) will assist Participants residing in the community in accessing and navigating complex systems which may be barrier laden.

The Health Home Care Managers will provide Care Management including the five core services (exclusive of HIT) each month to meet minimum billing requirements: the mode of contact(s) may include, but is not limited to: face to face meeting(s) mailings, electronic media, telephone calls and case conferences.

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care
4. Patient and family support
5. Referral to community and social support services
6. Use of Health Information Technology (HIT)

Care Managers will utilize health information technology (HIT) to link services, communicate with providers, and track outcomes. The goal is to assist Participants in achieving a level of self-management of chronic conditions, to live in the most productive, least restrictive level possible, prevent unnecessary care and improve overall wellbeing.

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Case load sizes for Care Managers will be monitored, and efforts will be made to maintain them at the following standards:
Adult Case Loads: 1:40

Children's Case Loads:
Low: 1:40;
Medium: 1:20;
High: 1:12.

- Care Managers providing services to High acuity children, as determined by CANS-NY, are required to keep their caseload mix predominately to High acuity Children.

C. Care Manager Qualifications

The Care Manager functions as a member of an interdisciplinary team to provide care coordination to Health Home Participants. Caseloads will consist of Participants with Serious Mental Illness (SMI), Severe Emotional Disorder (SED), Trauma and/or multiple comorbid medical or substance abuse disorders. The Care Manager advocates for and supports Participants, engages with community agencies/healthcare providers and others on their behalf to ensure access to needed services to increase wellness self-management and reduce avoidable emergency room visits and/or hospitalizations.

All Care Managers will meet the following minimum qualifications. Variances from these standards will require prior approval from the Health Home. The State may waive such qualifications, on a selected basis and under circumstances it deems appropriate which may include care manager capacity issues.

Education:

- A Bachelor's of Science/Arts degree or NYS licensure and current registration as a Registered Nurse and 2 years of relevant experience; OR
- A Master's Degree with 1 year relevant experience
    - Degrees in Health or Human Services field preferred

Experience:

- Experience should be relevant to the skills needed to deliver the 6 Core Services and may include:
    - Providing direct services to persons diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse; OR
    - Linking persons who have been diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse to abroad range of services essential to successfully living in a community setting.
- Experience working with electronic health record systems preferred.

Skills:

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1. Working knowledge of best practices in care coordination within behavioral health or healthcare field.
2. Knowledge of Medicaid, Social Security and other entitlement systems.
3. Excellent interpersonal and organizational skills.
4. Good documentation and computer skills, with working knowledge of Microsoft Office.
5. Valid driver's license and the ability to legally operate a vehicle in NYS.
6. Familiarity with community agencies and resources.
7. Ongoing knowledge of current best practices to improve health and quality of life.

Health Home Care Managers that provide Care Management to children enrolled in the Early Intervention Program, through a provider approved under the Early Intervention Program, must meet minimum qualifications for EIP Service Coordinators per Section 69-4.4 of 10 NYCRR.

Adult Health Home Care Managers that perform NYS Community Mental Health (CMH) assessments or reassessments must meet additional qualifications. (See Policy #14: Adult HARP/HCBS Services.)

Training

- All Care Managers will participate in training activities prior to assignment of Health Home Participants. This includes, but is not limited to:
    1. HIPAA/HITECH-Confidentiality-Consents
    2. Care Coordination
    3. Outreach and Engagement Procedures
    4. Documentation Requirements: Assessments; Care Planning; Care Notes
    5. Electronic Health Record
    6. Billing Requirements
    7. RHIO/PSYCKES Access
    8. Medicaid Analytics Performance Portal (MAPP); Uniform Assessment System (UAS)
    9. CANS-NY(for Children): Minimal scores of 70% for Care Managers; 80% for Supervisors (updated annually)
    10. Mandated Reporting (updated annually)
    - Additional required training within the first 6 months includes:
        1. Motivational Interviewing
        2. Trauma Informed Care
        3. Person-Centered Planning
        4. Safety in the Community (Refresher annually)
        5. Cultural Competency/Awareness (Refresher annually)
        6. LGBTQ Issues in serving Children and Families
        7. Meeting Facilitation/Wraparound
        8. HARP /Community Mental Health Assessment (for Adults)
    - Other recommended training includes:

1. CPR
2. Domestic Violence
3. Blood borne Pathogens/HIV
4. Specific training relevant to special populations, chronic disease and wellness as needed

- Care Managers will participate in other trainings relevant to Care Coordination as they become available.
- CMA's are required to maintain supporting documentation of Care Manager/Supervisor qualifications and training, and submit to the Health Home upon request.
- The Health Home will request a training plan when a new Care Manager is added to Netsmart, to outline how training requirements will be met.

D. Supervision:

- The Health Home recommends a Supervisor to Care Manager Ratio of 1 to 5.
  - Alternate ratios will be reviewed subject to approval by the Health Home.
- Supervision will include oversight of the delivery of Core Services according to Health Home policy, and monitoring of the quality of services delivered to meet established polices and outcome requirements.

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Care Management Policy #2 Downstream Providers

Effective Date: 3/1/16
Revised Date: 9/1/16

Policy:
Encompass Health Home will ensure that selected downstream providers of Care Management services are contracted, trained and equipped to deliver quality Care Coordination, and monitor/improve on outcomes of all Health Home Participants assigned to their program.

Procedure:

A. Based on available Participant data, The Health Home will select and engage potential Downstream Providers of Care Management that meet Participant needs, and offer a level of expertise that will complement the existing Provider Network.
B. The Health Home will provide a "Toolkit", and will meet with potential providers to review Health Home requirements, policies, roles and expectations, and provide an opportunity to ask questions regarding service delivery.
C. Once mutual agreement has been reached, Providers will be forwarded and asked to sign and execute a Business Associate Agreement (BAA) and a Health Home Contract, and return them to the Health Home for further processing.
    a. The Health Home will forward BAA to NYS-DOH upon receipt
D. The Health Home will verify information with the Provider through contractual agreements, and may request information pertaining to:
    a. Existing Corporate Compliance, HIPAA-HITECH policies and staff Training;
    b. Current policies of existing Care Management Programs;
    c. Existing IT and EHR access;
    d. Providers ability to perform monthly Exclusion Screenings;
    e. Existing NPI and MMIS numbers;
    f. Care Management staff and qualifications;
    g. EMedNY access;
    h. Existing RHIO, CANS and/or PSYCKES access
    i. Existing access to Health Commence System (HCS) applications, MAPP and UAS-NY;
    j. Contact information/names of key staff.
E. Once the contract is signed, the Health Home will develop a plan with the Provider and key staff, to solicit information and assist with roll out. Information in the plan may include:
    a. Time frames and plan for implementation;
    b. Dissemination of Health Home forms and Health Home Policies and processes;
    c. IT Instruction on connecting to needed portals, secure messaging and electronic decision making tools;
        i. If already connected, Provider will share ID #'s for secure messaging.

ii. If connections are lacking, the Health Home will provide the documentation and guidance to assist with connection, and policies regarding the usage of information in Care Management.

d. A brief demo/instruction on Netsmart Care Management, and a review of its role in the Care Management process;
e. Billing overview;
f. Contact information for the Health Home, as well as existing Learning Collaborative and supports.

F. Based on need, the Health Home can create opportunities for "Shadow Days" for staff to observe current Outreach and active Care Management, to assist with the transition to care coordination.
   a. If the provider currently provides active Care Management, a review of the Health Home and contracted Managed Care Organization requirements/policies will be provided.

G. The Health Home will schedule needed training sessions for Netsmart. Required information requested for this training will include:
   a. Names of staff and their appropriate roles in Netsmart (**See attachment a**);
   b. Rosters of existing Care Management clientele, if applicable.
      i. Training may be conducted using actual client data if available, or test data in Netsmart.

H. The Health Home will schedule meeting(s) with Supervisory/QI/Billing staff, to review and/or train to:
   a. Billing and auditing processes and procedures;
   b. Monitoring expectations for services and outcomes;
   c. Documentation required by the Health Home;
   d. Schedule of needed ongoing Health Home support meetings.

I. Upon mutual agreement that the Provider is ready to assume Care Management responsibilities, The Provider will be assigned Health Home Participants through Netsmart.
   a. The Health Home will monitor Netsmart documentation, and provide feedback and additional training as needed.
   b. The Provider will immediately communicate with the Health Home, any issues or concerns regarding the provision of services, to assure that Participant needs are met.

J. At a minimum, the Provider will participate in quarterly Health Home meetings, to receive feedback and information from the Health Home, as well as report on issues regarding implementation, processes and/or quality of services.

K. Providers will provide ongoing documentation to the Health Home as requested.

Required	Required	Required	Required
FIRSTNAME	LASTNAME	EMAIL	DATE_OF_BIRTH

Required	Required		
GENDER	HIRE_DATE	LOCATION_NAME	LOCATION_ROLE

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Care Management Policy # 3 Care Management Assignment/Outreach & Engagement

Effective Date: 10/9/13
Revised Date: 4/8/14, 7/18/14, 10/31/14, 12/19/14, 10/22/15, 3/1/16, 9/1/16, 10/1/16, 11/17/16

Policy: The Health Home will promptly screen, process and enroll eligible Health Home candidates into a Care Management Program in a manner consistent with Managed Care agreements and New York State regulations.

Procedure:

A. Referrals/Assignments: Adults

1. Health Home Staff will download the Department of Health Adult assignment list daily via the Medicaid Analytics Performance Portal (MAPP) located in the NYS Health Commerce System (HCS).
2. Health Home Staff will merge the list with previous lists to sort out new candidates.
3. Community Referrals will be accepted through a Central Referral Process; the MAPP; from Care Management Agencies; as well as from other providers and individuals through a 24 hour referral process.
4. New Candidates will be entered into Netsmart-Electronic Health Record (EHR) by Health Home Staff to assign Candidates for follow up and Outreach and Engagement with a Care Management Agency (CMA).
    i. CMA will receive alerts when new Candidates have been assigned.
5. The Health Home will assign Candidates to a CMA based on several factors including but not limited to:
    i. Location;
    ii. Capacity;
    iii. Specialized needs of the Candidate;
    iv. Claims data;
    v. Loyalty: Candidate was previously served by the CMA, and provides a conflict free Care Management structure.
6. The Health Home will send out a welcome letter to the candidate within 3 business days of assignment, identifying the contact information for the CMA to which they have been assigned.
7. The Health Home will securely share necessary information with the CMA in order to initiate and enhance Outreach and Engagement activities.
8. If the CMA cannot serve the Candidate for any reason, they will inform the Health Home within 2 business days, so that Candidate can be re-assigned to an alternate CMA.

B. Referrals/Assignments: Children

1. Health Home referrals/enrollments for Children will be initiated through the MAPP Children's Health Home Referral Portal.
2. Authorized entities will have access to MAPP, to create an outreach/enrollment segment or an assignment for Children into a Health Home. Those entities will include:
    i. Health Homes;
    ii. Managed Care Plans;

iii. Care Management Agencies;
iv. Voluntary Foster Care;
v. Local Government Units (LGU) and SPOA's;
vi. Local Department of Social Services (LDSS);
vii. Future access will be extended to Schools, Physicians, ED's, EI and other systems of care that impact children.
    i. The Health Home and CMAs will educate all children providers regarding the process for contacting the Health Home, CMA, local SPOA or other authorized entity for the purpose of referring a Child/Family to Health Home services.
    ii. Referral process information will be clearly defined in Health Home brochures and on the Health Home website.

3. Authorized referring entities will obtain a Consent to Refer from the parent; guardian; legal representative; or self if 18-21, or married, pregnant or parent; prior to creating an assignment record. Although consent can be verbal, a written consent is recommended.
4. In the MAPP Children's Referral Portal, the referring agent will;
    i. Agree to the Terms and Conditions of making a referral/assignment;
    i. Indicate whether or not the child is in Foster Care;
    ii. Indicate that a consent to refer has been obtained, from whom, and their contact information;
    iii. Provide the Child's valid Medicaid number;
    iv. Indicate all the chronic conditions that would qualify the child for Health Home services, and that the Child meets the appropriateness criteria for Health Home Care Management (**See Health Home Eligibility Policy #4**);
    v. Provide the contact information of the referring entity;
    vi. Indicate whether the Parent or Guardian is enrolled in health Home services, and their Medicaid number if available.
    vii. Referring **Health Homes and/or CMAs** will identify current engagement with the child, and if Consent to Enroll has been obtained. If consent has been obtained, an enrollment segment will be indicated. If no consent, the CMA/Health Home will enter the child into an outreach segment.
    viii. Referring agents (**non-foster care**) will identify if the child is receiving current preventive services. If yes, they will enter the Providers NPI number if available.
    ix. **LDSS referring agents** of children in **Foster Care,** will select the Voluntary Foster Care Agency (VFCA) with whom the child will be receiving Care Management Services with.
    x. **VFCA referring agents** of children in **Foster Care,** will indicate if they will be serving as the Care Management Agency, or will indicate after discussion with LDSS, which VFCA will be the Care Management provider.
5. Once all information has been entered, it will be reviewed for accuracy prior to submission.

6. Health Home Staff will download the Referral/Assignment list daily via the Medicaid Analytics Performance Portal (MAPP) located in the NYS Health Commerce System (HCS).
7. New Candidates will be entered into Netsmart-Electronic Health Record (EHR) by Health Home Staff to assign Candidates for follow up and Outreach and Engagement with a Care Management Agency (CMA), if not already assigned.
    a. CMA will receive alerts when new Candidates have been assigned.
8. The Health Home will assign Candidates to a CMA based on several factors including but not limited to:
    a. Location;
    b. Capacity;
    c. Specialized needs of the Candidate;
    d. Claims data;
    e. Loyalty: Candidate was previously served by the CMA, and provides a conflict free Care Management structure.
        1. If it is felt by the Health Home, that the network lacks an appropriate CMA to meet the unique needs of a Child/Family, the Health Home will initiate a transfer to a Health Home who can provide the necessary care coordination for that Child/Family.
        2. Referrals received for Assisted Outpatient Treatment (AOT) or Assertive Community Treatment (ACT) Clients between the ages of 18 and 21 must be enrolled if eligible into an Adult Health Home.
            a. The Health Home will work with all Health Homes to route referral/assignments of ACT/AOT Clients between the ages of 18 and 21 to a Health Home offering contracted ACT/AOT services.
9. The Health Home will send out a welcome letter to the Child/Family within 3 business days of assignment, identifying the contact information for the CMA to which they have been assigned.
10. The Health Home will securely share necessary information with the CMA in order to initiate and enhance Outreach and Engagement activities.
11. If the CMA cannot serve the Child/Family for any reason, they will inform the Health Home within 2 business days, so that they can be re-assigned to an alternate CMA.

C. Outreach & Engagement

1. If not already enrolled, Candidates will enter into an Outreach and Engagement segment following referral.
2. All Candidates will be appropriately screened for Health Home eligibility by the CMA (**See Health Home Eligibility Policy #4**) if not verified previously by SPOA, referral source or Health Home.
    i. All efforts to determine and verify Health Home eligibility will be documented according to Eligibility Policy and Procedure.
    ii. If unable to determine Health Home eligibility, Outreach Staff/Care Manager will request Candidate to sign a Release of Information to contact service

provider(s) and obtain documentation necessary to verify diagnosis and/or risk factors that qualify them for Health Home Care Management as stated in the New York State Plan Amendment.
   a) CMAs will inform the Health Home of candidates that do not meet eligibility.
   b) The Health Home will provide guidance in determining the candidate's disposition.

3. CMAs will initiate outreach immediately, within 2 business days, if the assignment is received during the 1st to the 15th of the month. If received on/after the 16th, outreach can begin immediately, but may be initiated the following month to take advantage of the full month of outreach, but no later than the 5th business day the following month.
   i. CMAs should consider all information in determining the timeframe to begin outreach, including risk factors involved, candidates known needs, and AOT status.
   ii. If the candidate is currently inpatient or incarcerated, outreach will begin prior to discharge/release to coordinate discharge needs.
   iii. CMAs will inform the Health Home of any deviations from the timeframes, and will document efforts to follow accepted outreach standards.
4. CMAs will utilize available information to locate and engage with Candidate/Families to consent to Health Home services, if not yet obtained.
5. CMAs can reach out to Managed Care Organizations if applicable, to obtain additional information to assist with outreach efforts.
6. Candidates/Families will be prioritized based on available Medicaid data and Outreach Staff/Care Managers will initiate progressive Outreach and Engagement as follows:

   Month One:

   i. All Candidates/Families will be contacted to schedule an intake/orientation appointment. This may be accomplished through a letter to known address. Candidates/Families with phone numbers can also receive a call to attempt to schedule an appointment, either on site or at their address.
   ii. If contact is made, Outreach Staff/Care Manager will meet with Candidate/Family at appointment/orientation, and will provide an overview of the service and determine candidate's interest in program.
      a) Eligible Candidates/Families that initially refuse services, may be offered to be contacted by the CMA at a future date, should it be determined that their health status/condition will require future coordination.
         A. Candidates/Families that agree to be re-contacted will be placed in a latent status, if it is determined that contact is to be made more than 3 months later. (**See Latent Policy #22**)
         B. Outreach Staff/Care Manager will document the Candidates/Families request in Netsmart for future outreach.

C. The Health Home will be informed of all Candidates/Families placed in latent status.

b) Adult Candidates that adamantly refuse the service will be designated as such through their signature on the New York State 5059 Opt Out form.
   A. Candidates that choose to opt out, will be provided with contact information for the Health Home, and encouraged to contact the Health Home if they want more information, or if they wish to discuss enrollment at a future time.
   B. If Candidate is not available to sign, Outreach Staff/Care Managers may fill out the form, and mail out a copy to attempt to attain signature. Information on re-engaging with the CMA/Health Home will also be included.

c) Child Candidate/Families that refuse Health Home services that had previously consented to referral, CMA will contact the referent to inform them of the Health Home refusal, prior to ending their segment referral portal in the MAPP, and will document the contact as an Opt out in Netsmart.

d) If Candidate/Family is undecided, they may be contacted again, with their consent, in month 2 for continued Outreach and Engagement.
   A. CMA may attempt an Initial Needs/Eligibility assessment with undecided Candidates/Families, to provide immediate assistance in an effort to engage them in services.

iii. If Candidates/Families do not respond to the letter or initial phone call, they may receive up to 2 more calls within the first month if number is available.
   a) Candidates/Families that do not have contact with Intake Staff/Care Manager during Month 1 will be targeted for continued Outreach and Engagement in month 2.

iv. If contact with the Candidate/Family is made, and they are in agreement to the service, Outreach Staff/Care Manager will begin the **enrollment process** as follows:
   a) Outreach Staff/Care Manager will conduct an Initial Needs/Eligibility Assessment.
      A. Outreach Staff/Care Manager will also administer the Health Home Fact-GP/Functional Assessment to Adult Health Home Candidate.
   b) Outreach Staff/Care Manager will have Candidates 18 years of age and older, sign New York State 5055 Health Home/PSYCKES consent, in their native language if requested, and will identify providers and other supports with whom information may be shared, by listing them, and initialing and dating each one on page 3 of the consent.

A. Candidates under the age of 18, who are parents, pregnant, married, or otherwise capable of consenting, will also sign the DOH-5055
B. Candidates who are later found to not meet eligibility, who have already signed a New York State 5055 Health Home/PSYCKES consent form, will be asked to sign the New York State DOH-5058, Withdrawal of Consent form.

c) Candidates under the age of 18 and their parent/guardian will be given and offered a review of the Health Home Consent FAQ form, prior to being asked to sign the Health Home Consent DOH-5200.
   A. Care Managers will also review the Health Home Consent Information Sharing form (DOH-5201); will assist in identifying providers and supports with whom information will be shared; and will obtain parental/guardian consent.
   B. Candidates under the age of 18 who are later found to not meet eligibility, who have already signed a New York State 5200/5201 Health Home Enrollment/Information Sharing consent forms, will be asked to sign the New York State DOH-5202, Withdrawal of Enrollment/Information Sharing Consent form.
   C. Consent forms for PSYCKES and RHIO's will be reviewed and signed by Candidates/Families under the age of 18, based on CMA Policy and procedures.
   D. Additional appointment(s) will be made to finish the Initial Needs/Eligibility Assessment and/or administer Health Home Fact-GP/Functional Assessment (Adults) and/or CANS-NY (Children).
   E. See ***Health Home Consents Policy #29*** for more information.

v. All Consents/Withdrawals/Opt out forms and Assessments will be scanned, uploaded and attached to the Plan of Care in the document section within 2 business days of signature.
   a) Consents/Withdrawals/Opt out forms will be forwarded to applicable Managed Care Organizations/Plans (MCO's) through the HCS or a secure messaging format per MCO requirements, but no less than weekly.
   b) Care Manager will record the appropriate Health Home and/or RHIO Consent in Netsmart to allow for activation of data sharing with the RHIO.
      A. If Health Home and/or RHIO Consent are withdrawn, Care Manager will record ending of Consent in Netsmart to

inactivate RHIO data sharing. (See **Policy # 12-RHIO Access**)

vi. All Outreach efforts will be documented in Netsmart by person making attempt or contact.

Month Two:

i. Assigned Outreach/Care Manager will continue phone calls to known numbers as well as attempt a face to face visit to known address(es).
   a) The CMA will utilize recent (if available) claims and encounter information from PSYCKES and/or RHIOS, as well as contact with MCO's to verify addresses and contact information if needed.

ii. Outreach/Care Manager will document all outreach attempts in Netsmart.

iii. If contact is made, and Candidate/Family agrees to admission to the Health Home then Outreach/Care Manager will follow the above steps for **enrollment**.

Month Three:

i. Outreach/Care Manager will attempt additional face to face contact and/or initiate additional forms of outreach which may include, but is not limited to:
   a) Calls to known providers; Managed Care Organizations/Plans; peer outreach; contact with family members or known advocates; Schools; Day cares; Jails; LGU/SPOA's; probation/parole personnel; homeless outreach services; Family Support Agencies; contact with area hospitals and emergency services; contact with Department of Social Services; contact with the Social Security Administration.

ii. Care Manager will document all outreach attempts in Netsmart.

iii. If **no contact** is made after month three, the CMA and Health Home will determine disposition:
   a) If felt that contact with Candidate/Family is likely, candidate may transition to a latent period for 90 days. Outreach may continue for Candidates/Families who remain eligible but undecided, but will not be billable.
      1) Other Candidates/Families who remain eligible, may remain latent for 90 days, after which outreach will be re-initiated for an additional 3 months, if reassigned to the Health Home.
      2) Candidates/Families may sign the DOH Consent forms and be enrolled at any time during the latency period.
      3) Candidates/Families placed in latent status, for whom Outreach will not continue, will be forwarded to the Health Home.

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b) The Health Home will inform DOH of Candidates/Families no longer eligible, Latent or who have refused services, via Health Home Member Tracking add/change records on the MAPP.

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Care Management Policy #4 Health Home Eligibility

Effective Date: 10/31/2014
Revised Date: 12/19/14, 10/7/15, 3/1/16, 9/1/16, 10/1/16

Policy: Encompass Health Home will utilize established resources and processes to screen and verify Health Home eligibility for all Participants, according to Managed Care Plans, Department of Health and Medicaid standards.

Procedure:

A. The Department of Health (DOH), Managed Care Plans (MCP), CMA's, Local Department of Social Services/Government Units (LDSS-LGU), SPOA's, Voluntary Foster Care Agencies (VFCA), Schools, other Providers the and Health Home will identify individuals who may be eligible for Health Home Services, based on current relationships, Medicaid claims and encounter data.

B. Individuals will be assigned/referred to the Health Home through the Medicaid Analytics Performance Portal (MAPP) located in the NYS Health Commerce System (HCS).

C. The Health Home will receive and screen assignments/referrals from MAPP and community providers for individuals who may be eligible for Health Home Services.
   1. The MAPP will validate Medicaid status of those assignments/referrals entered through the portal.
   2. The Health Home will verify Medicaid enrollment status/eligibility, MCP enrollment and lack of existing Health Home assignment of all community referrals prior to assigning to a Care Management Agency (CMA).
      i. Those Candidates that meet all other eligibility requirements, and are eligible but are not currently enrolled in Medicaid, may be assigned to a CMA for assistance in renewing/enrolling for Medicaid benefits.

D. Upon assignment, the CMA will assess each Candidate/assigned member for Health Home eligibility prior to and/or during Outreach & Engagement activities.
   1. The CMA will screen and confirm the Candidates diagnoses that qualify them for Health Home Services:
      i. A diagnosis of 2 or more qualifying chronic health conditions, defined as any of those included in the "Major" categories of the 3M Clinical Risk Groups (See attached);
         a) Documentation of chronic conditions as provided by health care providers. **or**
      ii. A single qualifying chronic condition:
         a) A diagnosis of a Serious Mental Illness (SMI) (**Adults**) and/**or** HIV/AIDS; **or**
         b) **For Children**: a diagnosis of Serious Emotional Disturbance (SED):
            1) Schizophrenia Spectrum and Other Psychotic Disorders;
            2) Bipolar and Related Disorders;

3) Depressive Disorders;
4) Anxiety Disorders;
5) Obsessive-Compulsive and Related Disorders;
6) Trauma-and Stressor-Related Disorders;
7) Dissociative Disorders;
8) Somatic Symptom and Related Disorders;
9) Feeding and Eating Disorders;
10) Gender Dysphoria;
11) Disruptive, Impulse-Control, and Conduct Disorders;
12) Personality Disorders;
13) Paraphilic Disorders; **or:**

c) History of Complex Trauma (**See Complex Trauma Policy #27**).

iii. The CMA will utilize recent (if available) claims and encounter information via consent from PSYCKES, CONNECTIONS, CANS-NY and/or RHIOS to verify and document qualifying diagnoses.

a) If recent clinical, verifying data is unavailable, the CMA will ask Candidate/Family to sign a Release of Information to contact service provider(s), and request medical records and/or assessments from Licensed Practitioners or trained professionals, verifying current qualifying diagnoses.
1) CMA's will contact the Health Home for assistance in obtaining necessary documentation to verify diagnosis as needed.

b) The CMA will document diagnosis verification in a Care Management progress note, on the Health Home Initial Needs/Eligibility Assessment (See attached), and will update the eligibility section in Netsmart.
1) All communication and efforts to verify diagnosis will be documented in the care management notes.
2) All documents obtained to verify diagnosis will be scanned and attached to the record in Netsmart.

2. The CMA will determine appropriateness for Health Home-Care Management services.

i. The CMA will complete an assessment for the presence of significant risk factors of medical, behavioral and/or social risks. This may include, but is not limited to:
a) A probable risk for adverse events;
b) Lack of or inadequate social/family/housing supports;
c) Lack of or inadequate connectivity to healthcare;
d) Difficulties with adhering to or managing treatments and/or medications;
e) Recent discharge from incarceration of psychiatric hospitalization;
f) Difficulties/Deficits in activities of daily living skills;

g) Learning or cognition issues;
h) Is concurrently eligible or enrolled, along with either a child or caregiver, in a Health Home.

ii. The Health Home/Care Management Program will document the presence of significant risk factors on the Health Home Initial Needs/Eligibility Assessment.

3. Care Management Supervisors will review and sign off on the Health Home Initial Needs/Eligibility Assessment to approve eligibility requirements.

E. Candidates/Families with immediate needs, or those in which verifying information is not readily available, will be assigned to Outreach/Care Manager, and billed at the Outreach & Engagement rate for up to 3 months, or until eligibility criteria has been verified and documented.

1. Those candidates that are determined to not meet eligibility will be dis-enrolled and referred to alternate Case Management services or SPOA based on need.

F. Ongoing Adult Health Home eligibility will be verified periodically through processes including, but not limited to:

1. Ongoing client assessments;
2. Utilization review processes;
3. Auditing of case files and assessments;
4. Analysis of available health care data;
5. Ongoing communication with MCP's and Primary Care Providers;
6. Billing records and claims.

G. Health Home eligibility/appropriateness for Children will be reassessed quarterly during the quarterly Plan of Care review.

Health Home Chronic Conditions
Acquired or Congenital Hemiplegia and Diplegia
Acquired or Congenital Paraplegia
Acquired or Congenital Quadriplegia
Acute Lymphoid Leukemia w/wo Remission
Acute Non-Lymphoid Leukemia w/wo Remission
Alcoholic Liver Disease
Alcoholic Polyneuropathy
Alzheimer's Disease and Other Dementias
Angina and Ischemic Heart Disease
Anomalies of Kidney or Urinary Tract
Apert's Syndrome
Aplastic Anemia/Red Blood Cell Aplasia
Ascites and Portal Hypertension
Asthma
Atrial Fibrillation
Attention Deficit / Hyperactivity Disorder
Autism
Benign Prostatic Hyperplasia
Bi-Polar Disorder
Blind Loop and Short Bowel Syndrome
Blindness or Vision Loss
Bone Malignancy
Bone Transplant Status
Brain and Central Nervous System Malignancies
Breast Malignancy
Burns - Extreme
Cardiac Device Status
Cardiac Dysrhythmia and Conduction Disorders
Cardiomyopathy
Cardiovascular Diagnoses requiring ongoing evaluation and treatment
Cataracts
Cerebral Palsy NOS
Cerebrovascular Disease w or w/o Infarction or Intracranial Hemorrhage
Chromosomal Anomalies
Chronic Alcohol Abuse and Dependency
Chronic Bronchitis
Chronic Disorders of Arteries and Veins
Chronic Ear Diagnoses except Hearing Loss
Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses
Chronic Eye Diagnoses

Chronic Gastrointestinal Diagnoses
Chronic Genitourinary Diagnoses
Chronic Gynecological Diagnoses
Chronic Hearing Loss
Chronic Hematological and Immune Diagnoses
Chronic Infections Except Tuberculosis
Chronic Joint and Musculoskeletal Diagnoses
Chronic Lymphoid Leukemia w/wo Remission
Chronic Metabolic and Endocrine Diagnoses
Chronic Neuromuscular and Other Neurological Diagnoses
Chronic Neuromuscular and Other Neurological Diagnoses
Chronic Non-Lymphoid Leukemia w/wo Remission
Chronic Obstructive Pulmonary Disease and Bronchiectasis
Chronic Pain
Chronic Pancreatic and/or Liver Disorders (Including Chronic Viral Hepatitis)
Chronic Pulmonary Diagnoses
Chronic Renal Failure
Chronic Skin Ulcer
Chronic Stress and Anxiety Diagnoses
Chronic Thyroid Disease
Chronic Ulcers
Cirrhosis of the Liver
Cleft Lip and/or Palate
Coagulation Disorders
Cocaine Abuse
Colon Malignancy
Complex Cyanotic and Major Cardiac Septal Anomalies
Conduct, Impulse Control, and Other Disruptive Behavior Disorders
Congestive Heart Failure
Connective Tissue Disease and Vasculitis
Coronary Atherosclerosis
Coronary Graft Atherosclerosis
Crystal Arthropathy
Curvature or Anomaly of the Spine
Cystic Fibrosis
Defibrillator Status
Dementing Disease
Depression
Depressive and Other Psychoses
Developmental Delay NOS / NEC / Mixed
Developmental Language Disorder

Diabetes w/wo Complications
Digestive Malignancy
Disc Disease and Other Chronic Back Diagnoses w/wo Myelopathy
Diverticulitis
Drug Abuse Related Diagnoses
Ear, Nose, and Throat Malignancies
Eating Disorder
Encephalopathy
Endometriosis and Other Significant Chronic Gynecological Diagnoses
Enterostomy Status
Epilepsy
Esophageal Malignancy
Extrapyramidal Diagnoses
Extreme Prematurity - Birthweight NOS
Fitting Artificial Arm or Leg
Gait Abnormalities
Gallbladder Disease
Gastrointestinal Anomalies
Gastrostomy Status
Genitourinary Malignancy
Genitourinary Stoma Status
Glaucoma
Gynecological Malignancies
Hemophilia Factor VIII/IX
History of Coronary Artery Bypass Graft
History of Hip Fracture Age > 64 Years
History of Major Spinal Procedure
History of Transient Ischemic Attack
HIV Disease
Hodgkin's Lymphoma
Hydrocephalus, Encephalopathy, and Other Brain Anomalies
Hyperlipidemia
Hypertension
Hyperthyroid Disease
Immune and Leukocyte Disorders
Inflammatory Bowel Disease
Intestinal Stoma Status
Joint Replacement
Kaposi's Sarcoma
Kidney Malignancy
Leg Varicosities with Ulcers or Inflammation

Liver Malignancy
Lung Malignancy
Macular Degeneration
Major Anomalies of the Kidney and Urinary Tract
Major Congenital Bone, Cartilage, and Muscle Diagnoses
Major Congenital Heart Diagnoses Except Valvular
Major Liver Disease except Alcoholic
Major Organ Transplant Status
Major Personality Disorders
Major Respiratory Anomalies
Malfunction Coronary Bypass Graft
Malignancy NOS/NEC
Mechanical Complication of Cardiac Devices, Implants and Grafts
Melanoma
Migraine
Mild / Moderate Mental Retardation
Multiple Myeloma w/wo Remission
Multiple Sclerosis and Other Progressive Neurological Diagnoses
Neoplasm of Uncertain Behavior
Nephritis
Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's
Neurofibromatosis
Neurogenic Bladder
Neurologic Neglect Syndrome
Neutropenia and Agranulocytosis
Non-Hodgkin's Lymphoma
Obesity
Opioid Abuse
Osteoarthritis
Osteoporosis
Other Chronic Ear, Nose, and Throat Diagnoses
Other Malignancies
Pancreatic Malignancy
Pelvis, Hip, and Femur Deformities
Peripheral Nerve Diagnoses
Peripheral Vascular Disease
Persistent Vegetative State
Pervasive Development Disorder
Phenylketonuria
Pituitary and Metabolic Diagnoses
Plasma Protein Malignancy

Post Traumatic Stress Disorder
Postural and Other Major Spinal Anomalies
Prematurity - Birthweight < 1000 Grams
Progressive Muscular Dystrophy and Spinal Muscular Atrophy
Prostate Disease and Benign Neoplasms - Male
Prostate Malignancy
Psoriasis
Psychiatric Disease (except Schizophrenia)
Pulmonary Hypertension
Recurrent Urinary Tract Infections
Reduction and Other Major Brain Anomalies
Rheumatoid Arthritis
Schizophrenia
Secondary Malignancy
Secondary Tuberculosis
Severe / Profound Mental Retardation
Sickle Cell Anemia
Significant Amputation w/wo Bone Disease
Significant Skin and Subcutaneous Tissue Diagnoses
Spina Bifida w/wo Hydrocephalus
Spinal Stenosis
Spondyloarthropathy and Other Inflammatory Arthropathies
Stomach Malignancy
Tracheostomy Status
Valvular Disorders
Vasculitis
Ventricular Shunt Status
Vesicostomy Status
Vesicoureteral Reflux

Catholic Charities of Broome County
Encompass Health Home
INITIAL NEEDS/ELIGIBILITY ASSESSMENT

Admission Date _____ **Care Plan Due Date** _____
60 Days from Admission date

Name _____ **DOB** _____
First MI Last

Address _____
Street Apt No

_____ _____ _____ _____
City State ZIP +4 County

Phone _____ _____ **E-Mail** _____
Home Cell

Gender ☐ M ☐ F **SSN** _____

☐ Medicaid # _____ ☐ Medicare # _____

SSI ☐ Yes ☐ No ☐ Pending $_____ SSD ☐ Yes ☐ No ☐ Pending $_____

☐ Public Assistance $ _____ ☐ VA $ _____ ☐ Pension $ _____

☐ Other _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

☐ Asian ☐ Black/African American ☐ Native American ☐ White/Caucasian

☐ Pacific ☐ Hispanic/Latin American ☐ Native Alaskan ☐ Other _____

Emergency Contact

_____ _____ _____
Name Phone Relationship

_____ _____ _____ _____
Street Apt No City State ZIP +4

Current Service Providers / Supports

Physician ☐ Yes ☐ No _____

Psychiatrist ☐ Yes ☐ No _____

Therapist ☐ Yes ☐ No _____

Substance Tx ☐ Yes ☐ No _____

Hospital Preference ☐ Yes ☐ No _____

Pharmacy _____

Landlord

_____ _____

_____ _____

_____ _____

_____ _____

COMPLETED FORMS

HH Consent ☐ Yes ☐ No FACT GP ☐ Yes ☐ No Functional Assessment ☐ Yes ☐ No PSYCKES ☐ Yes ☐ No

Catholic Charities of Broome County
Encompass Health Home

Identified Services / Immediate Needs

_____

_____

_____

_____

Referred To / Information Provided

_____

_____

_____

_____

Health Home Eligibility Verification

Active Medicaid ☐ Yes ☐ No

Qualifying Diagnosis confirmed ☐ Yes ☐ No *(*Attach supporting documentation)*

Source: _____

Significant Risk Factors

- ☐ Probable risk for adverse events
- ☐ Lack of or inadequate social/family/housing supports
- ☐ Lack of or inadequate connectivity to healthcare
- ☐ Difficulties with adhering to or managing treatments and/or medications
- ☐ Recent discharge from incarceration or psychiatric hospitalization
- ☐ Lack of or inadequate activities of daily living skills
- ☐ Learning or cognition issues
- ☐ Concurrently eligible or enrolled, along with either their child or caregiver in a Health Home

_____ _____

Client Signature Date

_____ _____

Care Manager Date

_____ _____

Supervisor Date

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #5 Assignment to Care Manager –Enrollment/Assessment

Effective Date: 9/24/13
Revised Date: 10/22/15, 3/1/16, 9/1/16, 10/1/16, 11/17/16, 12/1/16

Policy: Encompass Health Home Care Management will engage with enrolled Health Home Participants, and define their Health Home service needs through a comprehensive person-centered, strength based assessment process.

Procedure:

A. Upon assignment to a Care Management Agency/Program (CMA), the Candidate/Family/Participant will be assigned to Outreach Staff/Care Manager within 2 business days.
    1. Care Managers will be assigned based on experience, taking into consideration the Candidate/Participant's/Family's needs including but not limited to Mental Illness; Substance Abuse Disorders; Co-Occurring medical Conditions; Service use.
    2. CMA's will assure that assigned Care Managers do not have a financial interest or other existing relationship with a Participant/Family that would present a conflict of interest.
    3. The Care Manager will be responsible for overall management of a Participant's Plan of Care including communicating with providers, supports and coordinating services.
    4. Care Managers will be provided all Candidates/Participants/Families information, completed assessments and consents.
    5. Care Managers will access available Health Information Technology to obtain additional client data required for assessment and Care Management activities.
    6. If no previous contact between Care Manager and Participant/Family, Care Manager will initiate a meeting with enrolled Participants/Families within five business days, by contacting Participant/Family by face to face visit and/or telephone (and letter if necessary).

B. At initial meeting with enrolled Participant/Family, Care Manager will begin assessment through an interview process:
    1. Additional information regarding care management will be provided.
    2. An interactive discussion regarding Participant/Family continued interest in care management will be initiated.
        i. If Participant/Family no longer shows an interest in care management services, Care Manager will consult with Supervisor or other designated staff for guidance, and will consider engaging available supports such as Family and peer supports as needed.
    3. Participant/Family will be encouraged to share relevant information/history, expectations, preferences and goals of Care Management.
        i. This will include but is not limited to communication preferences, cultural and language needs, and involvement of current support network.

a) Care Management Agencies will utilize interpreter services and translated documents as needed to communicate with and share relevant information with the Participant.
b) The Health Home will assist Care Management Agencies with contracting with Language Services Associates (LSA) for phone/video interpretation and document services if needed.
c) The Participant's MCO may be contacted to assist with obtaining information and available cultural resources available through their network of services.

ii. Participant/Family involved with an educational institution, may be asked to provide consent to educational records, by signing the Health Home Consent Information Sharing Release of Educational Records form (DOH-5203).
   a) All consents will be scanned and attached to the Plan of Care in Netsmart.
   b) Consent for Participants under the age of 18 must be obtained from a parent/guardian.
   c) Participants 18 or older will sign their own consents.

4. Care Manager will ensure Participants/Families engagement in the interdisciplinary team.
5. Comprehensive/CANS-NY Assessments may begin at first appointment.

C. A **Comprehensive Assessment/CANS-NY Assessment** that identifies medical, behavioral, chemical dependency and social service needs/ supports will be conducted and completed within 30 days of enrollment.
   1. Care Managers will obtain consent from Participant/Parent/Consenter to initiate the CANS-NY Assessment, by completing the DOH-5230 Functional Assessment Consent.
   2. Participants/Families will be offered and encouraged to include Peers, Family Advocates, Parent Partners or other family supports through a Wraparound process during the assessment phase.
      i. When providing services to Children/Families, the involvement of Family Support Workers during the assessment phase may include the use of a Family Assessment of Needs and Strengths (FANS) to address Parent's/Caregiver's individual strengths and needs.
      ii. When completing the CANS-NY assessment, Care Managers will schedule and hold the initial Care Team Meeting during the 30 day assessment period, to include those individuals identified on the consent, and any other supports relevant to the assessment process.
   3. Assessments will at a minimum, address the following areas:
      i. Physical Health/Clinical History, including visual and hearing needs and risk factors;
      ii. Mental/Emotional Health, Trauma and Cognitive Functioning;
      iii. Medications;
      iv. Chemical Abuse/Dependency;

v. Housing, Transportation, Finances, Safety, Legal Issues, Employment/Education;
vi. Assessment of ADL's;
vii. Family Supports;
viii. Relationships and Community Involvement;
ix. Current Providers;
x. Presence of Advanced Directives;
xi. Barriers, Strengths and Preferences, including Cultural and linguistic needs.

4. Based on the Adult Comprehensive Assessment, additional assessments can be indicated as necessary to identify specific physical and/or behavioral health risk areas.
    i. These may include assessments/screenings for Adult Long Term Care; Substance Use Screenings; HIV Risk Assessments or Rehabilitative Care.
        a) If trained, Care Managers should conduct these assessments, or Participants will be referred to specialized providers to conduct additional assessments or risk screenings.
    ii. If the Comprehensive Assessment indicates possible depression, the Patient Health Questionnaire (PHQ-9) assessment will be completed in Netsmart.
    iii. If the Comprehensive Assessment indicates risk for substance use, trained Care Managers will complete the Screening, Brief Interventions and Referral to Treatment (SBIRT) tool.
        a) Each CMA will have at least 1 Care Manager trained to administer the SBIRT tool.
    iv. The Health Home will provide assistance and training resources for additional assessment tools as needed.
5. Follow-up Adult Comprehensive Assessments will be administered minimally every 6 months, or as needed to identify changing interests, preferences, needs and/or improvement.
    i. Reasons for early reassessment can include recent admission, discharge or transfer to/from hospital, residential setting, Long Term Care or Rehabilitation facility; achievement of goals; serious illness/injury; any change in their capacity/situation; court request; Participant request; Provider/MCO request.
    ii. Adult Fact-GP/Functional Assessment will be re-administered annually.
6. Children's CANS-NY assessments will be conducted at a minimum every 6 months, or as needed, based on significant changes in functioning, improvements or transitions.
    i. Reasons for early reassessment can include recent admission, discharge or transfer from hospital, residential placement or Foster

care; achievement of goals; serious injury/accident; change in caregiver, or their capacity/situation; court request.

ii. Additional documentation should be obtained and attached to the Plan of Care to support the CANS-NY assessment and subsequent HML rating.

i. If the CANS-NY assessment indicates the need for additional screenings to identify specific physical and/or behavioral health risk areas, such as HIV Risk or SUD, Care Managers, If trained, should conduct these assessments, or Participants may be referred to specialized providers to conduct additional assessments or risk screenings.

7. Completed assessments will be attached to the Plan of Care in Netsmart for view by Providers/Supports.
8. Care Managers will document the assessment process in a note(s) in Netsmart.
9. A Comprehensive Plan of Care including Participant/Family goals will be developed based on the CANS-NY/Comprehensive Assessment.
10. The Plan of Care will be a living document that may change as needed to align with the Participant's/Family's needs or goals, based on assessments and/or changes in condition.

D. Adult Participants will be also assessed to determine **Health and Recovery Plan (HARP)** eligibility for **Home and Community Based Services (HCBS),** by qualified Care Managers. (**See Policy #14-Adult HARP/HCBS Services**)

Encompass Health Home: Comprehensive Assessment

Assessment Date	
Entered by	

1. Participant Information

Participant Name	
What would you prefer to be called?	
Date of Birth	
Participant Address (House/Apt #, Street, State, Zip)	
Gender	
Medicaid ID #	
MCO	
MCO ID#	
CMA	
Acuity Score	

2. Eligibility

Have you been diagnosed with any of the following conditions? *Select all that apply.* ***Based on selected conditions, please be sure to follow-up with appropriate assessments/screenings to ensure comprehensive care.*** ***Comments****(Please identify providers, last date of visit and pertinent information regarding diagnostic status):*	☐ Alcohol or Substance Abuse ☐ Alzheimer's Disease ☐ Asthma ☐ Bipolar Disorder ☐ Cancer ☐ Chronic Obstructive Pulmonary Disease ☐ Congestive Heart Failure ☐ Coronary Artery Disease ☐ Depression ☐ Diabetes ☐ End Stage Renal Disease (ESRD) ☐ High BMI (>25) ☐ HIV/AIDS ☐ Hypertension ☐ Multiple Sclerosis ☐ Other Cognitive Impairment ☐ Schizophrenia ☐ Other Please Specify:_____ _____ _____ ☐ None

2.a.

Based on the completion of this section, please be sure to follow-up with appropriate assessments/screenings to ensure comprehensive care.	
What is your current HIV status? *Select the answer that applies.*	□HIV+/Asymptomatic □HIV+/Symptomatic □AIDS/CDC Defined
When were you diagnosed and by whom? *The diagnosing party may be added to the care team.*	
Who is your current treating physician/treatment facility?	
How often does your physician require bloodwork?	
What was the mode of transmission? *Select the answer that applies.*	□Prenatal □Sexual Contact □Hemophilia/coagulation disorder □Intravenous drug use □Transfusion recipient □Other ; please specify: _____
What is your most recent CD4 Count? *Include date of test.*	Date:
What is your most recent Viral Load? *Include date of test.*	Date:
Have you ever had any resistance testing? *Explain.*	
Are you currently adhering to a medication regimen? *Explain.*	
Are there any barriers to medication adherence? *Explain.*	
Are you currently participating in any research trials? *If yes, include name of trial, sponsor of trial, location and timeframe of trial, and contact person for trial.*	
Have you ever used any alternative therapies? *Explain.*	
Is/are your partner/partners aware of your HIV status?	□N/A
What is/are your partner's/partners' HIV status?	
Do you have any dependents and what is their HIV status?	
Do you wish to identify any social supports who are	

aware of your HIV status? *These individuals should appear as a member of the care team.*	
Have you disclosed your HIV status to those with whom may have or may be at risk of contracting HIV from you? *Explain.*	

3. Cultural/Linguistic Needs

What is your primary language?	
Do you require correspondence in a language other than English and if so, what?	
Do you require any form of communication accommodation and if so, what?	
What method of communication would you prefer throughout ongoing services? *i.e. email, text message, phone call, etc.*	
With what, if any, ethnicity and/or cultural group do you identify?	
Please describe any language/cultural barriers you experience in trying to get the care you need?	
What, if any, specific beliefs, preferences or customs do you have that may impact the way your healthcare is delivered?	
Have you ever felt discriminated against? Explain. *How has this impacted them?*	
Summary/Comments:	

4. Activities of Daily Living:

Do you currently need assistance with any of the following activities? Document additional information in the comments section or in specified areas throughout the assessment.

Activity	Yes I need Assistance	Comments
Bathing: *i.e. Can they get in and out of the shower/tub safely? Do they need physical assistance? Do they need adaptive equipment?*		
Dressing: *i.e. Do they have weather appropriate clothing for them/their family? Do they need physical assistance getting dressed?*		
Eating: *i.e. Do they have enough food for themselves/their family? Do they need physical assistance eating? Do they have any special dietary restrictions with which they have difficulty?*		
Meal Preparation: *i.e. Do they need physical assistance preparing food? Do they forget to turn the stove off? Do they need assistance following recipes?*		
Toileting: *i.e. Do they need adaptive equipment or sanitary items? Do they need physical assistance?*		
Walking: *i.e. Do they need adaptive equipment? Does this limit access to resources? Are they receiving any therapy?*		
Taking Medication: *i.e. Do they take them as prescribed? Can they remember to take them? Can they afford their co-pays? Can they get them filled at the pharmacy? Do they understand why they are taking them? Are they aware of the names, purposes and side effects of their medications?*		
Housekeeping Chores: *i.e. Are they physically able to complete the tasks? Do they need assistance?*		
Shopping and Errands: *i.e. Can they get to where they need to go? Are there barriers to completing errands? Can they shop within their budget?*		
Transportation: *i.e. Can they get*		

where they want to go? Are there physical barriers? Are their needs being met?		
Money Management: *i.e. Can they afford to pay their monthly expenses? Do they have/need/want a rep-payee? Can they make and follow a budget? Would they like to learn about money management?*		
Other:		
Summary/Comments:		

5. **Housing**

Where do you currently live? *i.e. apartment, house, shelter, with family/friend, homeless, etc.*	
Are you satisfied with where you are living right now? Why or why not?	
Do you feel safe where you are living right now? Why or why not?	
Is there anything that you would like to see change?	
Who else lives with you and what is your relationship with them? *Do they belong as part of the care team?*	
Summary/Comments:	

6. Transportation

What is your primary form of transportation?	
Is your primary form of transportation accessible when you need it?	
Is this form of transportation meeting your needs? Why or why not?	
What other transportation needs do you have?	
Summary/Comments:	

7. Health Literacy

Place an X to identify the appropriate response for questions a-f.

	Extremely	Quite a Bite	Somewhat	A Little Bit	Not at All
a. How engaged are you in your treatment?					
b. How confident are you in your ability to express your concerns to your health care providers?					
c. How well do you understand your diagnosis or condition?					
d. How well do you understand treatment recommendations?					
e. How easy is it for you to complete medical forms?					
f. How easy is it for you to learn new information about your diagnosis/condition?					
Summary/Comments:					

8. Mental Health Status and Cognitive Function

Based on the completion of this section, please be sure to follow-up with appropriate assessments/screenings to ensure comprehensive care.	
What symptoms or side effects, if any, do you have that effect how you live?	
Is fear, stress, or anxiety having a significant effect of your life? Explain.	
What are your early warning signs that things are becoming too stressful, deteriorating, or not going well for you that could be a sign of relapse?	
Who would you consider your supports? *Who would they like on their care team?*	
How would you describe yourself when you are feeling well?	
What treatments do you feel work best for you?	
Tell me about your medications *(For behavioral conditions). i.e. Do they like them; why or why not? Do they feel they are effective? How do they know if they are not working? Are they experiencing any side effects?*	
How often do you take your medications as prescribed?	
If "yes" was the response to any of the first three questions, please follow up by completing the PHQ-9.	

Place an X to identify the appropriate response for the following questions.

	This Week	This Month	This Year	More than a Year	Never	Unknown
Have you experienced any forgetfulness, difficulty concentrating or problems completing everyday tasks?						
Have you been bothered by feeling down, depressed or hopeless?						

Have you experienced feeling little interest of pleasure in doing things you typically enjoy?						
Have you physically tried to harm yourself?						
Have you physically tried to harm someone else?						
Have you been to the emergency room?						
Have you been hospitalized?						
If there was any response within the past year, follow up by completing the PHQ-9.						
Summary/Comments:						

9. Psychological/Social History

Place an X to identify the appropriate response for the following questions.

Based on the completion of this section, please be sure to follow-up with appropriate assessments/screenings to ensure comprehensive care.						
Have you....	**This Week**	**This Month**	**This Year**	**More than a Year**	**Never**	**Unknown**
Had suicidal thoughts						
Taken property without permission						
Damaged or destroyed property						
Created a public disturbance						
Verbally assaulted another person						
Physically abused another						

person						
Been a victim of physical or sexual abuse						
Wandered or ran away						
Been a victim of a natural disaster						
Experienced significant loss *(Per their interpretation, i.e. a loved one, a job, a home, physical ability, etc.)*						
If there was any response within the past year, follow up by completing the PHQ-9.						
Summary/Comments:						

10. Medical Status

Based on the completion of this section, please be sure to follow-up with appropriate assessments/screenings to ensure comprehensive care.	
How would you describe your health?	
What is important to you about your physical health?	
What concerns, if any, do you have?	
How would you describe the quality of your sleep? *i.e. Do they feel well rested? Do they have trouble falling asleep? Do they have trouble staying asleep? Do they have trouble waking up? How much sleep do they typically get? How much sleep do they typically need to feel well rested? Do they take any sleep aids?*	
Do you drink alcohol? *How often? For what purpose (socially, to get drunk, for fun)? How much?*	
Do you use tobacco products? *What kind? How often/much?*	
Have you attended a physical exam with your	

PCP within the past year? *Do you have a PCP? Do you have anything to report? Are there any barriers that have or would keep you from attending?*	
Have you attended a Dental appointment within the past year? *Do you have a PCP? Do you have anything to report? Are there any barriers that have or would keep you from attending?*	
What other appointments have you attended within the past year? *Select all that apply and identify and identify provider, date of appointment and outcomes if available.* ***Additional Comments:***	□ Audiologist; _____ □OB/GYN; _____ □Optical; _____ □ Asthma Management; _____ □ Diabetes Management; _____ □ Mammogram; _____ □ Colonoscopy; _____ □ Flu Vaccine; _____ □ Fall Risk Management; _____ □ Arthritis Management; _____ □ Medication Management; _____ □Other *(related to identified conditions; please specify)*; _____ _____
Do you have any additional ongoing medical concerns being treated by a specialist? ***Additional Comments:***	Medical Concern; _____ Treatment Provider; _____ Date of Last Visit; _____
Have you ever been tested for HIV/AIDS or other sexually transmitted diseases? Please describe any risk factors that would contribute to the necessity for the test.	
Are you currently taking any medications (for medical conditions)*? Do you feel they are effectively treating your illness; how do you know? How would you know if something wasn't right?*	
Do you have any problems with hearing, vision or speech? Explain.	
Do you follow through with treatment recommendations? Explain.	
Are you pregnant? □ Yes □ No	Current week of pregnancy: _____ Expected due date; _____ Provider; _____ Is it is high-risk birth? □ Yes □ No Explain; _____

Have you given birth within the past year? □ Yes □ No	Post Postpartum care provider; _____ Are you breast-feeding? □ Yes □ No
Summary/Comments:	

11. Substance Use

Based on the completion of this section, please be sure to follow-up with appropriate assessments/screenings to ensure comprehensive care.	
Do you have any alcohol/substance abuse issues or concerns? Explain.	
Are you ready to address these issues? Explain.	□N/A
What is/are your substance/s of choice?	□N/A
What is your frequency of use?	□N/A
Have you ever used needles to inject drugs? If yes, what, how often, and where are the needles obtained?	
How does this impact your life? *Have you ever missed out on work or other activities because of substance use? Does your use separate you from those you care about?*	□N/A
Has anyone else ever expressed concern about your substance use? Explain.	□N/A
Do you feel you rely on any substances to get through your day? Explain.	□N/A
Have you ever tried to cover up your substance use? Explain.	□N/A
Do you utilize any over-the-counter medications with great frequency? *Do you feel dependent on them? Is your doctor aware that you use them/has your doctor approved them?*	□N/A
Have you or are you currently in any substance treatment? *Do you utilize supports? i.e. AA, sponsor,*	□N/A

church group, etc.	
What are the barriers, if any, to addressing your substance use?	□N/A
Is there anyone in your support circle that would hinder your recovery? *If yes, identify and explain.*	□N/A
What is your motivation for wanting to address your substance use issues?	□N/A
If "yes" was the response to the first question, follow up by completing the SBIRT.	
Summary/Comments:	

12. Education/Vocation

What is your current education level?	
What was your most recent job?	
Are you currently employed? If so, what do you do and do you find it fulfilling?	
What was your most favorite job and why?	
If you are not employed, would you like to be?	
What kind of vocation are you interest in?	
What are your barriers to employment or finding a job you find fulfilling?	
Do you or would you consider volunteering? *What kind of volunteer work would like?*	

Are you currently in school or attending a training program? If so, for what?	
Would you like to pursue education or training? If so, in what area?	
What are your barriers to pursing additional education/training?	
Summary/Comments:	

13. Finances

What are your current sources of income/benefits*? i.e. SSI/SSD, veteran, housing, schooling, SNAP, etc.*	
Are the needs of yourself and family met each month?	
What bills do you pay each month?	
Do you have to borrow money to make ends meet? Explain.	
Is budgeting your money stressful for you?	
Do you have money left over each month? *For fun, savings?*	
Do you have a rep-payee? If so, who? *Are you happy with this arrangement?*	
Do you need any assistance managing money or benefits?	
Summary/Comments:	

14. Legal

Do you have any current or past involvement with the legal system? *Describe if agreeable.*	
Are you currently on parole or probation? *For how long? Total? Amount left? Conditions? Who is your assigned officer?*	
Do you have a living will or other advanced directives in place? Please describe.	
Do you have a Health Care Proxy or Power of Attorney? If so, who? *To be added to the care team.*	
Would you like assistance with establishing any of these plans?	
Do you have an Assisted Outpatient Treatment (AOT) plan? Describe if agreeable.	
Summary/Comments:	

15. Community Resources

Are you receiving assistance by a caregiver or community resource/professional service? *Select all that apply and please identify.*	☐ Caregiver; _____ ☐ Home Care Agency; _____ ☐ Meals on Wheels; _____ ☐ Veterans Administration; _____ ☐ Transport Services; _____ ☐ Church Support; _____ ☐ Respite Care; _____ ☐ Peer Service; _____ ☐ Social Support; _____ ☐ Child Care; _____ ☐ Family Support; _____ ☐ Other (*Please Specify*) _____
What services are being provided to you and how frequently?	
Are you happy with these services? Are they meeting your needs?	
How would you describe your motivation to get the assistance you need?	

Do you currently need assistance setting up services to help meet your needs? If so, what?	
Who would you say are the most important people to you and do you get to spend time with/talk to them? *Who do you want on your care team?*	
Do you wish you had closer relationships with any friends or family? Explain.	
Do you have someone you trust to talk to? Who?	
What kind of community activities do you participate in?	
What kind of community activities would you like to participate in?	
Do you utilize/or would you like to utilize any peer support services?	
Summary/Comments:	

16. Priorities

Of all the things we just discussed, is most important for you to work on right now?	
How can I help you accomplish this?	
What do you see as challenges to accomplishing this?	
What strengths do you have that can help you overcome these challenges?	
Is there anything else you feel is important for me to know about you?	

Summary/Comments *(Pull it all together)*:

Signature Page

Participant's Printed Name	**Participant's Signature**	**Date**

Care Manager's Printed Name	Care Manager's Signature	Date

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Care Management Policy #6 Integrated Care Plan Development

Effective Date: 11/21/2013
Revised Date: 10/22/15, 3/1/16, 9/1/16, 10/1/16, 11/17/16, 12/1/16

Policy: Encompass Health Home Care Management will coordinate an interdisciplinary team to develop an individualized Plan of Care for each Health Home Participant, designed to promote and improve their health and wellness.

Procedure:

A. Care Manager will schedule a **Care Team meeting** with Participant/Family and current Medical/Behavioral Health providers/supports, MCO, specialists and community supports forming an **Interdisciplinary Team** to develop the Plan of Care.
    1. Care Manager will schedule an Adult Care Team meeting Within 7 days of completion of the Adult assessment process.
        i. Subsequent Adult Interdisciplinary Team meetings will be held as needed at the request of the Care Manager; the Participant/Family; a provider; or minimally annually.
    2. The initial Team meeting for Children will be scheduled and held within the 30 day CANS-NY assessment period.
        i. Subsequent Interdisciplinary Team meetings will be held as needed at the request of the Care Manager; the Participant/Family; Guardian or Medical Consenter (including LDSS); a provider; or minimally during each CANS-NY update.
    3. All members of the Interdisciplinary Team will be invited to attend, and will be clearly identified in the Plan of Care.
        i. The Participant/Family will be invited/included in all meetings, as well as any provider/individual they wish to participate.
        ii. Meetings will be scheduled at times and in locations convenient to the Participant/Family.
        iii. Other members of a Childs team may include other family members or caregivers; representatives from LDSS, Foster care, Juvenile Justice programs, or any entity the Participant/Family wishes.
        iv. The Care Manager will make every effort to include a Childs Parent/Legal Guardian/Medical Consenter to be present at each meeting. If unable to attend, Care Manager will solicit their input to the Plan of Care before finalizing.
            a. No decisions or revisions to the Plan of care will be made without the consent of the Family/Legal Guardian/Medical Consenter.
    4. The care planning process will include the use of Wraparound principles, assisting and engaging Participants/Families to play a central role in developing the Plan of Care.
        i. Peers and/or Advocates will be utilized as needed to assist in engaging and supporting Participants/Families.
        ii. Participants/Families will be encouraged to develop goals that are of priority to them, and in their own words.
    5. Participant/Family will be encouraged to identify providers, additional family, caregivers or other supports for inclusion in the Care Plan development.
    6. Care Managers will request known Providers or representatives to assist in identifying care gaps, to be included in the Plan of Care.

i. Providers/Family/Caregivers unable to attend will be offered alternative methods of participation (such as phone or video conferencing) and/or asked to provide relevant feedback by other means in regards to needed care and support.

B. A Comprehensive **Plan of Care** including Participant/Family goals will be developed within 30 days of completion of the Comprehensive Assessment/CANS-NY, (and the Adult New York State Community Mental Health Assessment as appropriate).
   1. The Plan of Care will include, but is not limited to, all of the following elements:
      i. **History and Risk Factors** related to services, treatment, wellbeing and recovery**;**
      ii. **Preferences, Strengths and Barriers** related to development and attainment of the established goals. For Children this also includes caregivers preferences, strengths and barriers;
      iii. **Functional Needs** from assessments**,** related to services and treatment; documented as **Goals** related to the Participant's/Family's treatment, wellness and recovery; and **Objectives** that are measureable, person centered, written in the Participants/Families own words and work towards stated goals;
      iv. **Services** and **Key Providers/Supports** identified to meet physical, behavioral and community based/social support needs, and their roles related to the goals in the Plan of Care;
      v. **Key Informal Community Supports** such as neighbors or other family members that can meet an identified need;
      vi. **Emergency Contacts and Disaster Plan** for fire, health, safety issues, natural disasters and other emergencies**;**
      vii. **Care Management Interventions/Time Frames** including outreach/engagement, referrals, follow-up and needed care coordination to assist with goal attainment;
      viii. **Needed Transition Plans** involving education, treatment and Foster Care, as well as services needed to transition from Care Management as needed;
      ix. **The Participants/Medical Consenters signature**, indicating participation and agreement with the Plan;
      x. **Documentation of Participation of Participant and Key Providers/Family/Supports** in the development of the plan.
   2. For Children in **Foster Care**, the plan will reflect the Childs Foster Care Permanency goals.
   3. If unable to complete within 30 days, the Care Manager will document reasons, and identify strategy and ongoing attempts to engage with Participant/Family to complete the plan.

C. Using all assessment information, Participant/Family preferences, priorities and provider/supports input; appropriate goals and a Plan of Care will be developed with the Participant/Family to address physical, behavioral, rehabilitative, long term care and social support needs required for improved health and wellness.
   1. Care Managers will consult with Managed Care Organizations (MCOs) to explore services that offer health promotion education to further focus on wellness and self-management.
   2. Participants/Families will be asked to choose providers to meet established needs, and referrals to Health Home providers and supports will be initiated to address care gaps. MCOs will be utilized to assist in the referral process within their network, and for consultation of the availability of specialized care.
   3. Known Providers and appointments will be included in the Plan of Care.

4. Interventions, roles, responsibilities and time frames for improvement in the Participants health and wellbeing will be clearly identified.
5. Care Manager and Participant/Family will establish frequency of ongoing contact to include in Plan of Care.

D. After development by the Participant/Family, the Care Manager will review the Plan of Care with the Interdisciplinary Team to solicit any additional input.
   1. This may be accomplished verbally, or through secure electronic sharing.

E. The Care Manager will review final suggested Plan of Care with Participant/Family to assure it reflects agreed upon goals, and modify as needed.
   1. The Care Manager will obtain Participant/Family signatures to signify acceptance, and will provide Participant/Family with a copy.
      i. The Care Manager will assist the Participant in obtaining copies of clinical information that supports the assessment and Plan of Care process as requested.
   2. If Care Manager cannot obtain Participant/Family agreement with the Plan of Care, The Care Manager will work with the Interdisciplinary Team to make needed modifications to assist with gaining Participant/Family approval.
      i. If approval cannot be obtained after sufficient time has been spent revising the plan, Care Manager may need to discuss other options with the Participant/Family, including but not limited to, changing providers; or withdrawing from the Health Home if Participant/Family no longer desires the service.

F. Care Manager will assure completion of Plan of Care within 30 days of the assessment period, will document the development of the Plan of Care in Netsmart, and add all providers/team members to the Care Management application as part of the Interdisciplinary Care Team.
   1. Per consent, final Plan of Care will be provided to members of the Interdisciplinary Team, including the Participant, Family/caregivers and providers, through Netsmart, and/or other secure messaging/fax.
      i. If a Provider is not a current active user in Netsmart, The Care Manager will contact the Health Home for assistance in granting them access to the Care Management application.
   2. CMA's will share all completed Plans of Care with the Participant's/Family's MCO through Netsmart, and/or other secure messaging/fax or HCS.
   3. Plans of Care will be shared through the local RHIO when possible.
   4. If unable to complete the Plan of Care within the acceptable time period, reasons will be documented in Netsmart.

G. The Plan of Care will be periodically reassessed and updated by the Care Manager based on individual need:
   1. When there are significant changes in the Participants condition;
   2. When significant progress has been made;
   3. To reflect the addition or deletion of providers;
   4. To plan for needed transitions of care;
   5. Prior to hospitalization discharges;
   6. To reflect updated treatment;
   7. Per the request of Participant/Family, MCO and/or Care Team.
      i. Periodic reassessment of the Adult Plan of Care will be conducted by the Care Manager minimally every 6 months.

ii. Plans of Care that include Adult HCBS services will be updated every 90 days.
iii. Plans of Care for Children will be reviewed in conjunction with the quarterly review of the continued need for Care Management services, and updated as needed. (**See Policy #16-Discharge**)

8. Care Manager will notify providers/supports and MCO of updates and changes through Netsmart.
    i. Other methods of sharing the Plan of Care such as secure e-mail, RHIO and/or fax will be utilized as appropriate, while coordinating needed updates.

H. Additional Crisis Plans/WRAP Plans will be developed with Participants/Families simultaneously with the Plan of Care.
1. Crisis/WRAP Plans will identify at a minimum:
    i. Helpful supports;
    ii. Contact information, including emergency contacts and Providers;
    iii. Helpful interventions such as successful calming techniques;
    iv. Health needs/preferences and/or Advance Directives;
        a. Care Managers will review the types of Advance Directives available, and will assist in completing necessary documents based on need. This may include:
            1) Health Care Proxy (Appoints health care Agent);
            2) A living Will; and/or:
            3) A Do Not Resuscitate Order.
            4) Advance Directive documents will be scanned and attached to the Netsmart record.
    v. Preferred arrangements for pets and other family members in the home should Participant be away.
2. Crisis/WRAP Plans will be attached to the Plan of Care in Netsmart.
3. Crisis/WRAP Plans will be updated with Plans of Care as needed to reflect Participant/Family needs, life changes and preferences.

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Care Management Policy #7 Comprehensive Care Coordination and Management

Effective Date: 11/21/2013
Revised Date: 3/6/15, 10/23/15, 3/1/16, 9/1/16, 12/1/16

Policy: Encompass Health Home will build and maintain a provider network that meets the needs of the Participants, and works collaboratively to provide appropriate wellness, behavioral health, specialty and preventive care.
Encompass Health Home Care Managers will provide necessary Core Services, and will coordinate with an Interdisciplinary Team to ensure Participants/Families access and receive appropriate primary, preventive, specialty and emergency care to improve health and wellness and promote self-care.

Procedure:
Comprehensive Care Management

A. Care Managers will engage with Participants/Families and providers/supports to create, document, implement and update the Plan of Care. (**See Policy # 6-Plan of Care**)
B. Care Managers will utilize comprehensive assessments to identify medical, behavioral health, rehabilitative, long term care and social service needs in order to integrate a continuum of care into the Plan of Care, and will re-assess needs as necessary. (**See Policy # 5-Enrollment/Assessment**)
C. Care Managers will utilize Wraparound principles to ensure the Participant, their Family and/or supports are central to the development of the goals, objectives and timeframes in the Plan of Care.
D. Care Managers will ensure that all supports important to the Participant/family are involved in the development and implementation of the Plan of Care, according to the Participants/Families preferences.
E. Care Managers will identify and engage with all Providers and Managed Care Organizations (MCOs) directly involved in the Participants care in the Plan of Care.
F. Care Managers will integrate continual outreach and engagement strategies into the Plan of Care to provide ongoing support and assistance to Participants/Families.

Care Coordination and Health Promotion

A. Care Managers will maintain ongoing communication with Participants/Families, MCOs and providers/supports to update the Plan of Care. This may be accomplished through methods including: providing access to Netsmart; interoperability through the RHIO; the MAPP; fax or secure e-mail, phone or face to face contact.
    1. The Health Home and CMA will engage and build connections with community providers and support networks to foster collaborative relationships.
        i. The Health Home will maintain contractual relationships and agreements with MCOs, community providers and resources.
        ii. The Health Home will inform CMAs of these relationships, and provide access to lists of the available network of MCOs, providers and community resources by County on the Encompass website.

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2. Care Manager will follow-up on referrals made in order to link Participant/Family to needed services.
    i. Care Manager will work with MCOs to assure referrals are approved and are within the provider network.
    ii. Additional providers will be included in and granted access to the Plan of Care as appropriate.
3. Care Manager will add all scheduled appointments and tests to Netsmart, and will initiate tasks/reminders to provide necessary follow-up and care coordination.
4. Care Manager will assist Participants/Families in accessing services as needed, and will provide necessary information to providers/supports prior to scheduled appointments.
    i. When contacted by a Participant/Family regarding a behavioral/physical health complaint, Care Manager will assess and arrange a priority appointment (same day if possible) with a network provider as needed.
        a. The Participants MCO may be contacted for assistance in appropriate provider referrals and accessing priority appointments for its members.
        b. The Health Home will ask all providers within its network to attest through a signed acknowledgement, to the availability of priority appointments when needed.
            1) CMAs will notify the Health Home of any difficulties regarding accessing these appointments, so that the Health Home can address provider issues as needed.
5. Care Manager will promote the utilization of evidenced based wellness and prevention resources in line with Participant/Family preference and availability.
    i. This may include, but is not limited to:
        a. Smoking Cessation;
        b. Diabetes Management;
        c. Chronic Disease Self-Management;
        d. Other Self-Help recovery resources.
    ii. Care Manager will contact MCO to link Participant to available prevention supports within their network.
    iii. The Health Home will maintain a list of available MCO and community agencies offering self-help and wellness resources for review with Participants during development of the Plan of Care, and when indicated during re-assessment of needs.
    iv. The Health Home will make this list available to CMAs through the website.
6. Care Manager will follow up with providers/supports within 2 business days after appointments, to verify appointments were kept and will support Participants/Families in adhering to treatment recommendations.
    i. Care Manager will provide outreach within 24 hours of notification, to Participants who have missed appointments to assist with concerns and rescheduling with providers.

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ii. Care Manager will consult with MCO to assist with re-engaging with participant if needed, and/or contacting providers to assist in rescheduling missed appointments.

7. Care Manager will consult with providers/supports when treatment changes are warranted, and will communicate subsequent changes to the entire Interdisciplinary Team.
8. Care Manager will evaluate and link Participants/Families to necessary emergency care services or alternatives as appropriate.
    i. Care Manager will follow-up with Participant/Family within 24 hours of alert notification of visit to emergency services to coordinate recommendations, appointments and needed aftercare.
9. Care Manager will follow-up within 2 business days on scheduled tests, blood work and other treatments to assure appointments were kept.
    i. Care Manager will notify Participant/Family and Care Team of results and obtain input for needed changes to Plan of care.
10. Care Manager will monitor and evaluate effectiveness of interventions and communicate results to providers/supports and MCO through Netsmart, or other secure means.

B. Care Manager will meet with Participant/Family as identified in the Plan of Care, and document progress in Netsmart.
C. Care Manager will schedule and facilitate regular case review meetings with the Participant/Family and Interdisciplinary Team, as needed to provide health promotion and support continuity of care.
    1. At a minimum, Adult case review meetings will occur no less than annually, and will be scheduled ongoing as needed to support transitions and/or changes in a Participants status.
    2. Case review meetings for Children will be scheduled minimally every 6 months, in conjunction with the CANS-NY assessment.
    3. For Children in Foster Care, Care Manager will coordinate case review meetings in collaboration with LDSS and the VFCA.
    4. The use of secure electronic methods for meetings may be used as needed. This can include phone conferencing, or web solutions as provided by the Health Home.
D. Care Manager will update Plan of Care/Crisis/Wellness Plan as necessary, document all treatment recommendations and care coordination activities, and will communicate changes to the Interdisciplinary Team and MCO through Netsmart.
E. CMA will educate and assure all Participants, Families, providers/supports and emergency services are aware of phone numbers and procedures to access Care Manager 24/7.
    1. Care Manager will evaluate and coordinate after hours care, to avoid unnecessary emergency and inpatient services. (**See On-Call Procedure**)
F. CMA/Care Manager will continually monitor outcomes, share information regarding unmet needs, and solicit the input from MCO and the care team in order to make

necessary changes to the Plan of Care to improve the quality of care and reduce unnecessary utilization of services.

1. Care Manager will monitor and consult with the MCO and Interdisciplinary Team when conflicting treatment is observed in order to collaborate on the best option for the participant/Family.
    i. Participant/Family preferences will play a significant role in the decision making process.
    ii. The Care Manager will consult with the MCO for assistance in advocating for Participant preferences and mediating with providers as needed.

Comprehensive Transitional Care

A. The Health Home will maintain agreements and linkages with other Health Homes, providers, MCOs, supports, RHIOS, Hospital/emergency services, Local Departments of Social Services (LDSS), SPOA's, schools, jails, juvenile justice systems and rehabilitation settings allowing for necessary referral and communication for effective transitions of care, including transitions out of Health Home services, or Child-to-Adult levels of care.
    1. Agreements will require prompt notification to the Health Home of a Participants admission and/or discharge to/from their services.
B. The Health Home will identify current rosters of Participants through an interface with Regional RHIO's to assure prompt notifications/alerts to Care Managers should a Participant present at regional inpatient/emergency services.
    1. Health Home will forward notifications/alerts to the Care Management Agency/Care Manager, and will task Care Manager Supervisor in Netsmart Hallmark Events for follow-up.
    2. Care Manager will follow-up with Participant within 24 hours of alert notification of visit to emergency services to coordinate recommendations, appointments and needed aftercare.
    3. Care Manager will utilize RHIO information available after visit to determine needs and the mode of contact with Participant (in-person; phone call or both).
        i. Care Manager will follow-up with the emergency services program if sufficient information is not available.
    4. Care Manager will document follow-up in Netsmart, and will compete tasked event.
    5. Care Managers will utilize and respond to notifications/alerts through the MAPP, when it becomes available.
C. The Health Home will request all MCOs to submit weekly reports to the Health Home of Participant admissions or discharges to/from emergency services, inpatient units or rehab settings.
D. The Health Home will notify the CMA of all received information within 48 hours, and will monitor appropriate follow-up through audits and contact reports.
    1. A plan of correction will be written to improve CMA follow-up to alert notifications as needed.

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E. Care Managers will provide coordination of needed admissions and discharges, and will provide timely updates to the Interdisciplinary Team.
    1. Through contractual agreements, local services and Providers will involve Care Managers in all discharge planning processes/meetings, to advocate for timely access to follow up care.
    2. Care Managers will advocate for and assure Provider and Participant/Family involvement in the Admission/discharge planning process.
    3. Care Managers will request written Discharge Plans from emergency/inpatient/rehabilitative services, and will provide information to MCO and Interdisciplinary team through Netsmart.
    4. Care Manager will provide follow-up with referrals and discharge recommendations.

F. Care Managers will contact and/or visit Participants/Families within 48 hours of notification or discovery of a transition/discharge, to plan and/or assure Participants access to follow-up care and assist in obtaining required treatments, medications, and/or interventions.
    1. This includes, but is not limited to unknown discharges from inpatient units; residential services; detention; emergency services; or other levels of care.
    2. Care Manager will follow-up with Provider and Participant within 2 business days of scheduled appointments to verify attendance.
    3. Care Manager will assist in rescheduling any missed appointments or planned interventions.
    4. The Care Manager will contact the MCO for assistance as needed to reengage with the Participant if unsuccessful in contacting after discharge or missed appointments.
    5. Care Manager will consult with and work with the MCO to coordinate needed authorizations and referrals, and determine appropriate transitional care.

G. Care Manager will update the Plan of Care in Netsmart as needed to reflect real time changes to the Participants health status, additional provider information and/or transfers of the location of care.
    1. Care Manager will notify the MCO and Interdisciplinary Team of changes, and obtain additional input for inclusion in the Plan of Care.

H. The Health Home will monitor transitions out of Health Home services, or to Adult Health Home services, to assure connections are made for a smooth transition to services that best fit the needs of the Participant/Family.
    1. Information will be utilized from the MAPP Referral Portal and MAPP notifications to coordinate needed transitions.

I. The Health Home will communicate quarterly with CMA's and Network Partners to assure transition notification procedures are in effect, and to assist with efforts to improve needed communication.

J. The Health Home/Care Managers will ensure continuity of care and prevent duplication of services by working collaboratively with Schools, Juvenile Justice, Local Departments of Social Services (LDSS), SPOA's, Voluntary Foster Care Agencies (VFCA) and other

systems of care, to ensure enrolled Participants (Children) and Families have access to and receive appropriate wellness, behavioral health, educational, specialty and preventive care when transitioning in and out of; and/or aging out of children's services.

1. For Child Participants in foster care; LDSS Case Managers, VFCA Case Planners and the Care Manager will work as a team to develop mutual goals for the Plan of Care, with input from families, involved systems, providers and supports.
2. Additional LDSS assessments/tools such as CONNECTIONS and the Family Assessment and Service Plan (FASP) will be used in addition to the CANS-NY to assess that all needs are met.
3. Care Manager will maintain the Plan of care and will make and follow-up on necessary referrals as needed, including those referrals made to services when transitioning out of the Foster Care System.
    i. Care Manager will document all information into Netsmart to share with the Interdisciplinary Team.
4. Care Manager will communicate with the LDSS Case Manager to provide all necessary information related to the child's health and wellness.
    i. The Health Home/Care Manager will consult with LDSS Commissioner for input should conflicting treatment recommendations occur.

Participant & Family Support

A. The Health Home/CMA's will ensure that Plans of Care reflect Participant/Families/Caregiver preferences and support for self-management, self-help recovery Peer supports and other resources/supports needed to aid in the attainment of Participant goals.
    1. Participants/Families/caregivers will be asked to include informal supports that are key to their support network, that address an identified need.
    2. Care Managers will assure Participant/Family preferences are also reflected in advance directives and WRAP/Crisis Plans. (**See Policy # 6-Plan of Care**)
    3. Participants/Families will be provided with access to or copies of their Plans of Care, at development and after each update.
        i. Care Manager will assist Participant/Family with obtaining access to necessary clinical information as appropriate.
B. Peer Parent/Youth Advocate services will be made available when possible, to provide Family education, need assessment and support towards established goals.
C. The Care Manager will invite all supports identified in the Plan of Care to participate in Interdisciplinary Team Meetings as requested by the participant/Family/Caregiver.
D. The Care Manager will assure that all face to face interactions and meetings are respectful of Participant/Family schedules and are held at locations convenient to them.
E. CMA/Care Manager will assure that the Participant/Family/Caregiver's cultural needs and language preferences are considered when making recommendations for additional supports and self-care programs.
F. Care Manager will update Consents and the Plan of Care as new Supports are recommended/required.

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G. Care Manager will consult with MCO for additional self-help resources available to the Participant/Family.

Referrals to Community & Social Supports

A. The Health Home will continually identify community providers and social support resources that would benefit Health Home Participants/Families, and will develop active partnerships through signed Provider Acknowledgements with these agencies/individuals.
B. Care Manager will assist in navigating through Community Support Systems such as Medicaid, Food Stamps, unemployment, and other chosen social supports.
C. As Participant/Family needs arise, Care Manager will complete referrals to appropriate partners, in line with the Participant/Family preferences.
D. Care Manager will track and follow-up on all referrals made, and will document dispositions in Netsmart.
E. Care Manager will assure successful transfer of needed information and linkage to community providers and partners.
F. Care Manager will follow-up with Participant/Family within 2 business days after initial meeting/appointment with new provider, to verify attendance and satisfaction of services provided.
G. Care Manager will update consents and the Plan of Care as new providers and treatment recommendations are added.

Care Coordination Protocols

A. Care Managers will assist Participants in addressing important health issues, and in making informed choices about their health care services.
B. Care Managers will utilize The Healthcare Effectiveness Data and Information Set (HEDIS measures) to guide them in the development of Plan of Care objectives, and in providing appropriate and effective Care Coordination.
    1. Care Managers will review Gap Reports sent by MCOs to further address gaps in care, and to document Participants willingness to address important health issues.
C. Care Managers will review appropriate care protocols with Participants, to assist them in obtaining necessary care, if agreed upon.
D. Care Manager will document Participants refusals of suggested care based on these measures.
E. The Health Home and/or CMA will notify MCOs of Participants refusals, or of any discrepancies in HEDIS outcomes, to obtain their assistance and recommendations for appropriate care.
    1. Preventive Care (Adults)
        i. Breast Cancer Screening age 50-74
        ii. Colorectal Screening age 50-75
        iii. Cervical Cancer Screening (age 21-64)
        iv. Screening for HIV (If risk is evident)
        v. Chlamydia screening for sexually active women (age 16-24)

vi. Diabetes screening for those diagnosed with schizophrenia or Bipolar disorder using antipsychotics
vii. Flu vaccinations
viii. Pneumococcal Vaccine for older adults
ix. Prenatal and postpartum care
x. Annual dental exam
xi. Eye Exams every 2 years or as required
xii. Linkage to a primary care Physician (annual exam and bloodwork ie: Hemoglobin; LDL-C)
xiii. Mental Health visits
xiv. BMI/Weight Assessments (18-74)
xv. Fall risk screening (older adults)
xvi. Advanced Directives

2. Preventive care (Children)
   i. Linkage to a primary care Physician
   ii. Well child visits up to 15 months old
   iii. Annual Well child visits at age 3, 4, 5 and 6
   iv. Adolescent age 12-21 annual well-care visits with PCP or OB/GYN
   v. Chlamydia screening for sexually active women (age 16-24)
   vi. BMI/Weight Assessments
   vii. Childhood/Adolescent Immunizations
   viii. Human Papillomavirus Vaccine for female adolescents
   ix. Lead Screenings before age 2
   x. Metabolic monitoring for those on antipsychotics
   xi. Mental Health visits
   xii. Annual dental exam
   xiii. Advanced Directives
3. Medication Management
   i. Annual monitoring for those on persistent medications age 18 and older
   ii. Follow-up care for children on ADHD medication
   iii. Medication management for those with Asthma
   iv. Anti-depressant medication management
   v. Adherence to Antipsychotic medications
   vi. Adherence to mood stabilizers
   vii. Medication management of anti-rheumatic drug therapy
   viii. Medication reconciliation post-discharge age 18 and older
   ix. Statin medication management for cardiovascular disease and COPD
   x. Medication management for diabetes
4. Health Care Monitoring
   i. Treatment for children with upper respiratory infections 3 months to 18 years of age
   ii. HIV/AIDS care:

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a. 2 PCP visits a year
b. Viral load monitoring
c. Syphilis screening (age 18 and older)

iii. Controlling High Blood pressure
iv. Diabetes Monitoring and care (type 1 and 2, and those with schizophrenia):
a. Hemoglobin and LDL-Cholesterol testing
b. Eye exam
c. Nephropathy screen
d. BP control
v. Chronic Obstructive Pulmonary Disease (COPD) care (spirometry testing)
vi. Cardiovascular monitoring (cardiovascular disease and schizophrenia)
vii. Follow-up care following a heart attack (beta-blocker treatment)
viii. Follow-up after ER visit

5. Behavioral Health Monitoring
i. Follow-up care after hospitalization for Mental Illness or detoxification
ii. Engagement in treatment after diagnosis of alcohol and/or drug dependence
iii. Screening for clinical depression and follow-up

Documentation-Care Notes

A. The Health Home/Care Managers will document all Outreach & Engagement Activities and Active Care Management contacts in Netsmart, within 2 business days of service provision.
1. All enrolled Participants will have a current Plan of Care and required initial assessments entered into the Netsmart.
i. Participants will be reassessed periodically to document significant changes in health or social service needs.
2. Each documented Active Care Management note for enrolled Participants will directly relate to the goals of the Participants Plan of Care, and will reflect the monthly provision of:
i. At least one Core Service (Adults and Low acuity Children), **or**:
ii. 2 Core Services (High and Medium acuity Children).
3. Care notes will identify the delivery of services and/or linkage to supports needed to address a whole person approach to care management.
4. Care notes will demonstrate how each core service was provided, by whom, and will show varying contact methods used month to month.
i. Core Services include:
a) Comprehensive care management
b) Care coordination & health promotion

c) Comprehensive transitional care and follow-up
d) Participant & family support
e) Referral to community & social support services

ii. Modes of contact will include face-to-face, mailings, telephone calls/texts, case conferences, and contact with collaterals or service providers.
   a) Care Managers providing services to Children with medium to high acuity, will provide and document 2 services a month, one of which will be a face to face with the Child.
   b) Care Managers providing services to Children with low acuity, will provide at least 1 service a month, and will vary modes of contact consistent to the needs of the Child/Family.
   c) It is recommended that those Adult Participants with high and/or medium level needs will receive a face-to-face visit monthly, or as needed to provide needed support and Care Management interventions.
   d) Care Managers are encouraged to provide Participants/Families with low needs, at least one face-to-face visit every 2-3 months to visually monitor their housing and overall health and wellness.

iii. All contacts with Participants/Families for the purpose of assessment and care plan development will be delivered and documented as a face-to-face contact.

5. Care notes will indicate ongoing contact with providers and supports in order to coordinate care as appropriate.

Service Dollars

A. Care Management Programs that are designated to utilize Service Dollars to meet immediate needs and specific service needs of Participants, will do so in a manner that supports the Participant in the achievement of their Plan of Care goals and objectives.
B. Service Dollars will be used for Emergency purchases and/or for Participant Specific (Planned) Services.
C. Emergency purchases will address immediate needs of a Participant, and will be time limited (less than 1 week).
D. Emergency purchases will generally address unanticipated needs. Efforts will be made first to access funds available from other sources, including but not limited to DSS, Medicaid or other community providers, prior to using Service Dollars.
E. Participant Specific service needs will address those that have been pre-planned and identified in the Plan of Care, as those purchases that will be required on a regular basis, or purchases that support the implementation of goals on the Plan of Care.
F. Care Managers will document all Service Dollar purchases by adding a note to the Participants record in the Netsmart.

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Care Management Policy #8 On-Call General Procedure

Effective Date: 9/18/13
Revised Date: 5/1/16

Policy: Encompass Health Home Care Management Agencies will provide all Health Home participants 24/7 telephone access to a Care Manager.

Procedure:

A. Upon enrollment, Participants will be provided with contact information for the Agency, the Care Manager, as well as alternate numbers that can be utilized after normal business hours, to address any general concerns, issues, or after hour referrals.
B. Participants will be educated on the use of all contact numbers, and Care Managers will re-review the information on a periodic basis.
    1. It is the responsibility of the Primary Care Manager to ensure that their Participants have been given the after hour's On-Call phone number, and are encouraged to use the Care Manager, or On-Call number as their first point of contact.
C. On-Call numbers will be clearly posted on business cards and other handouts.
D. Messages on Main phone numbers will direct Participants to the On-Call number after normal business hours.
E. Care Managers /Supervisors will notify On-Call Care Manager Staff daily of any ongoing issues with Participants that are carried over from normal business hours.
F. The On-Call phone will remain on at all times during non-business hours, weekends, and holidays. The On-Call Care Manager will receive and respond to all calls within 15 minutes.
G. When responding to the call, the On-Call Care Managers will do the following:
    1. Identify the situation or concern and provide needed information, support and assistance.
    2. If it is a routine medical issue, refer to Care Plan and/or assist Participant in contacting their primary care physician.
    3. Determine if a visit to a medical facility is warranted.
        i. If a visit is warranted, On-Call Care Manager will coordinate care with an available walk in clinic.
        ii. If there is a life threatening event the On-Call Care Manager will call 911 for emergency response to be sent to Participants address.
    4. On-Call Care Manager will utilize crisis and wellness plans (WRAP) and provide feedback and advise accordingly. If it is determined that the issue can be deferred to primary care physician then Participant will be advised as such, and will be assisted in scheduling a priority appointment.
        i. The On-Call Care Manager will follow-up with the Primary Care Manager, Direct Supervisor the next business day.
H. Documenting a Call:

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Care Management Policy #8 On-Call General Procedure

1. When receiving a call after hours, the details of the call will be documented in Netsmart under the Participants care notes.
2. The information will be shared with the Primary Care Manager and/or the Direct Supervisor or the entire Care Team.
3. The Primary Care Manager and/or Direct Supervisor will follow up with the Participant and/or provider the next business day.
4. The Primary Care Manager will update Plan of Care as needed to address any unmet needs.

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Care Management Policy #9 On-Call Crisis Intervention

Effective Date: 9/18/13
Revised Date: 5/1/16, 9/1/16

Policy: Encompass Health Home Care Management programs will provide 24 hour access to Care Managers to provide support and assist clients in obtaining needed interventions during crisis situations.

Procedure:

A. Upon enrollment, Participants will be provided with contact information for the Agency, the Care Manager, as well as alternate numbers that can be utilized after normal business hours, to address any general concerns, issues, or after hour emergencies.
B. Participants will be educated on the use of all contact numbers, and Care Managers will re-review the information on a periodic basis.
    1. It is the responsibility of the Primary Care Manager to ensure that their Participants have been given the after hour's On-Call phone number, and are encouraged to use the Care Manager, or On-Call number as their first point of contact for consultation regarding medical and behavioral health needs.
C. Care Managers /Supervisors will notify On-Call Care Manager Staff daily of any ongoing issues with Participants that are carried over from normal business hours.
D. After normal Agency business hours the On-Call number will be activated and available to address any general concerns or crisis situations. *(See On-Call General Procedure)*
E. When responding to an emergency/crisis call, On-Call Care Managers will do the following:
    1. Assess the crisis;
    2. Determine if a visit to an Emergency Program is warranted (if Participant is suicidal, homicidal or in physical distress);
        i. If Emergency visit is indicated, On-Call Care Manager will call 911 or instruct the caller to call 911 to be transported to the hospital; or will arrange for immediate transportation to emergency services.
            a. On-Call care Manager will accompany Participant to the Emergency visit if needed.
        ii. If Emergency visit is not warranted, then On-Call Care Manager will provide the necessary coordination, support, interventions and/or assistance to resolve the Participants issue.
            a. This may include contacting the Primary Care Physician to schedule a priority appointment; referring to an open walk-in clinic; arranging for immediate individual or family supports or respite services.
            b. The Participants Managed Care Plan can be contacted to assist with coordinating care with providers within the network, and securing primary appointments for its members.

iii. On-Call Care Manager will review with the Participant their Wellness Plan (if completed), Crisis/Safety Plan, their Plan of Care or emergency contacts for additional information and support.
iv. If appropriate, the On-Call Care Manager will provide identified interventions for deescalating the crisis.
v. If the need for an immediate resolution does not exist, then On-Call Care Manager and Participant will agree on the most viable, temporary solution. The On-Call Care Manager will contact the Primary Care Manager or Direct Supervisor to discuss, and relay pertinent information.
vi. Following the crisis, the Primary Care Manager will follow up with the Participant/Family to debrief, and develop prevention strategies to be added to the Plan of Care/Safety-Wellness Plan.

F. Documenting a Call:
1. When receiving a call after hours, the details of the call will be documented in Netsmart under the Participants care notes.
2. On-Call staff will then indicate if all Care Team Members will receive the notice or just the specific Care Manager and Direct Supervisor.
   i. The Primary Care Manager and/or Direct Supervisor will follow up with the Participant, treatment team and/or providers the next business day, to assist with appointments or other needed follow-up.
   ii. The Primary Care Manager will update Plan of Care as needed to address any unmet needs.

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Care Management Policy #10 - Health Information Technology

Effective Date: 5/1/16
Revised Date:

Policy: Encompass Health Home will ensure that Care Management Agencies (CMAs) meet the NYS Department of Health (DOH) and Statewide Health Information Network of New York (SHIN-NY) standards for health information exchange, to securely utilize Health Information Technology (HIT) to link services, communicate with providers, enhance quality of care, and positively impact outcomes for Participants.

Procedure:

A. Security Measures

1. Encompass will ensure that CMAs develop and adhere to standard security practices according to the Health Insurance Portability & Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH).
2. All Care Management staff will be trained to HIPAA –HITECH Privacy and Security Rules prior to requesting access to the EHR. (*see access process below*)
3. Internal practices that protect the confidentiality of protected health information will be utilized to include all methods of transmission: ability to view material; face to face communications; by phone; faxing; e-mail and postal mail.
4. Care Managers will be assigned unique user ID's and will create authenticated passwords to ensure users of the EHR system are appropriately identified.
5. Care Managers will keep all user IDs and password information confidential and secure.
    i. Care Managers will notify the Health Home should this information become compromised.
6. Encompass and CMAs will assure that devices that connect to Netsmart contain updated Anti-Virus and Malware software, and are maintained regularly by trained IT staff, including prohibiting the installation of unauthorized hardware/software on devices.
7. Systems and devices will be password protected, secured when not in use, and should be set to lock after at least 15 minutes of inactivity.
8. Care Management staff will assure that computer/device screens are shielded from view, and that all paper PHI information is contained in secure areas.
9. Encompass and CMAs will assure that all access to Participant information is limited to those with a need to know, to provide treatment, support or coordination of services.
10. Care Management Staff will refrain from saving confidential information on any portable device.
    i. Needed information or pictures on a device will be immediately saved to the Plan of Care, or a secure file and then immediately deleted from the device.
11. Encompass and CMAs will ensure all sensitive information is shared/transmitted securely, and encrypted when sent electronically.

Care Management Policy #10 - Health Information Technology

B. Single Electronic Plan of Care

1. Encompass will utilize Netsmart Care Manager as a centralized Electronic Health Record (EHR) to create, document, execute, and update Plans of Care.
    i. The process for access, training, and use include but are not limited to the following:
        a) CMA Supervisor will submit a New User request to the Health Home, identifying Agency; address; staff name; date of birth; gender; hire date; user role; e-mail address; phone number.
        b) Health Home/HIT Director will send new user an e-mail, to validate e-mail address and user identity.
        c) Health Home will provide new user a general overview of the Netsmart platform and process.
        d) Health Home will assign a username and temporary password, and send an activation e-mail to the new user.
        e) New user will log in and create new password. The password should contain contains at least 8 characters, both upper and lower case characters; and should contain at least one number or special character (such as @, #, $, %).
            1) Passwords will be changed every 90 days.
        f) Health Home will assign new user to the Training Site in Netsmart, and will verify successful completion of tasks.
        g) Once training has been completed, user will be granted access to the live site.
    ii. CMA's will inform the Health Home of information that affects the status of all users immediately, to prevent access by those who no longer have a need to access due to job changes or terminations.
    iii. CMA's will submit to the Health Home, no less than quarterly, a list of current care Management Staff/ Netsmart users, for reconciliation of user access.
2. All Care Management contacts and Participant focused activities will be documented in Netsmart.
3. Consents, assessments and other Participant information will be scanned when completed and attached to the Plan of Care.

C. Regional Health Information Networks (RHIOs)

1. Encompass will connect to RHIOs within its service areas to utilize updated health information for ongoing Care Management.
2. It is a best practice recommendation that CMAs independently contract with local RHIOs to further enhance their HIT network and improve the continuity and quality of care.
   See RHIO Policy.

Care Management Policy #10 - Health Information Technology

D. Medicaid Analytics Performance Portal (MAPP)

1. The MAPP will be used to facilitate access to critical health care information from disparate systems to further promote and improve quality of care.
2. CMAs will complete a DOH approved Business Associate Agreement with the Health Home to access the MAPP.
3. CMA's will identify and notify the Health Home of their Single Point of Contact.
4. CMA's will submit organization information to DOH to set up access, and establish MAPP accounts for all users and roles.
5. All users will complete MAPP training that has been assigned based on role.
6. Ongoing trainings will be available through DOH and are recommended as best practice.

E. Evidenced Based Clinical Decision Making Tools (PSYCKES, CANS-NY)

1. The Health Home supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. At a minimum, the use of PSYCKES is recommended to gain clinical information required to develop an individualized Plan of Care.
   CANS-NY is a required tool for assessing children's strengths as well as Plan of Care needs.
   i. **Psychiatric Services Clinical Knowledge Enhancement Systems (PSYCKES)** is a HIPAA-compliant web-based application providing access to Medicaid claims data and will be used for the purpose of clinical decision making and quality improvement.
      a) CMAs will complete an application, and enter into a contract/confidentiality agreement with the Office of Mental Health, to allow PSYCKES access. (*See PSYCKES Access materials)*
      b) CMAs will establish a PSYCKES implementation team/plan and commit to implementation within their organization.
      c) CMAs will develop policies and procedures that align with that of PSYCKES, including necessary auditing to assure appropriate use and access.
      d) CMA's will train relevant staff regarding PHI access, policies, procedures and confidentiality.
   ii. **Child and Adolescent Needs and Strengths-New York (CANS-NY)** is an assessment tool to be used to identify and address the multi-system needs of children and adolescents. This assessment requires initial and yearly certification. The certification process includes but may not be limited to:
      a) Completion of required training through the CANS-NY training website.
      b) Completion of a training test with a score of 70% or better for general use and 80% or better for Supervisors.

c) Completion of annual recertification.

F. Auditing

1. Audits of HIT usage will be conducted quarterly by CMAs to ensure all information is accessed and utilized appropriately.
2. Any breach or suspected breach will be reported to the Privacy Officer and investigated immediately.
3. Breaches will be reported to the Health Home per Business Associate Contracts.

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Care Management Policy #11 PSYCKES Access and Usage

EFFECTIVE DATE: 3/18/13
REVISED: 1/12/15, 5/1/16

POLICY: Encompass Health Home-Care Management Agencies will utilize OMH-PSYCKES according to established contracts and policies, to support clinical evaluation, care planning, coordination of care and quality improvement activities.

AGENCY ACCESS:

A. The Health Home will assist CMA's in the process of contracting and gaining access to PSYCKES data.
B. CMA's will designate a Lead Registrar and Security Manager, responsible for managing access to all secure OMH applications.
    1. CMA will contact OMH Help Desk to make request;
    2. OMH will e-mail CMA a self-registration link;
    3. CNA will forward link to proposed Security Manager Staff;
        i. Staff will follow instructions for registration;
    4. OMH will forward new Security Manager E-mail notification and Soft Token (if needed);
    5. New Security Manager follows instructions to activate token, if needed.
C. PSYCKES Provider Contact Form is faxed/e-mailed to PSYCKES-Help.
D. CMA will sign and return the OMH Confidentiality Agreement to PSYCKES – Help:
    1. Agreement will be countersigned by PSYCKES Director and returned.

USER ACCESS:

A. CMA's will identify staff that require access to PSYCKES, and notify the Lead Registrar:
    1. Team Leaders will assure that Staff are trained in HIPAA and relevant security/password polices within 30 days of employment, and prior to requesting PSYCKES access;
        i. All PSYCKES Training will be documented and maintained as part of the Staff file;
        ii. Lead Registrar will determine the type of access needed, and will track all users and their access type.
B. Lead Registrar will complete requests for PSYCKES Access:
    1. Lead Registrar will identify the type of access requested:
        i. Clinical PSYCKES Data; or
        ii. Clinical PSYCKES Data and Registrar/Consent Module.
C. Security Manager will upon request, enter the new user into the OMH web based Security Management System (SMS).
D. OMH will send user an e-mail containing a "Soft Token", and instructions for downloading software and importing the Token to the user's device.
    1. User/Staff will be sent 2 e-mail messages from OMH containing:
        i. 1-Software link;

ii. 2-A text file for importing the Token and creating a PIN.
a. Existing users will retain their original PIN.

E. User will contact the Security Manager to complete activation process:
1. Staff will not share their user ID, password or Hard Token with anyone, and will assure it is kept in a secure location.

TRAINING:

A. All users will be trained in the use of PSYCKES within 30 days of activation.
B. Users will be assigned relevant PSYCKES webinars to view.
C. Following the webinars, hands on training will be provided by staff who have completed the PSYCKES Train-the-Trainer presentation.
D. All training will documented on the PSYCKES Core Competencies Checklist, and retained in the Staff file.
E. Additional training will be provided as needed, as it becomes available.

PASSWORD SUPPORT:

A. Users will be blocked from accessing PSYCKES after 3 unsuccessful attempts to log into the system.
B. Security Manager will enter the OMH-SMS and re-set the user password.
C. User will receive an e-mail message from OMH, identifying new password.

REMOVAL/REVOKE ACCESS PROCEDURE:

A. When a user's employment is terminated, or when it is determined that a user no longer requires access to PSYCKES due to a change in job duties, the Lead Registrar will be notified.
B. The Lead Registrar will obtain the user's Hard Token (if applicable), forward it to the Security Manager, and request PSYCKES Access be revoked.
C. The Security Manager will deactivate user from the OMH-SMS.
D. Security Manager will mail user Hard Token to OMH, if applicable.
E. Users will log into the PSYCKES application at least once every 6 months, to avoid having access revoked.
1. OMH will e-mail user as a reminder prior to revoking access.

PSYCKES USAGE:

A. Care Management Agencies will utilize Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to assist in integrating clinical information into the development of Plans of Care, and to assist in effective care coordination.
B. Upon receipt of the Health Home referral, Intake Staff will conduct a Participant search when indicated in PSYCKES. Participant search is indicated based on existence of mental health diagnosis and Medicaid eligibility.
1. The New York State DOH-5055 Health Home/PSYCKES consent form will be utilized to authorize access for Adults.
2. The PSYCKES Consent form will be utilized for Children.

3. A copy of Medicaid card will be obtained to verify Medicaid identification number.

C. At Health Home intake, identification will be verified by obtaining 2 forms of valid identification, which may include: Social Security Card; Birth Certificate; Naturalization papers; United States Military identification card with picture; Drivers/Non-Driver's identification; Medicaid card (with picture on it), current passport or :
   1. If the Participant is already known to the Agency, 2 forms of identification are not required.
   2. If the Participant is known by another Agency, they can verify identification.

D. Participants will be asked to sign a New York State DOH-5055 or PSYCKES Consent form to allow access to the Medicaid Claims Data stored in PSYCKES, and will be given a copy of signed consent.
   1. Adult Participants who do not wish to allow access to PSYCKES data, may cross out, initial and date the 3 areas on the DOH-5055 consent that refer to PSYCKES access.
   2. If Adult Participant decides to allow access at a later date, the Participant will be asked to sign the PSYCKES Consent Form.

E. If upon intake, behaviors or conditions are observed that could indicate a Public Health Emergency as defined by Mental Health Law including, but not limited to danger to self or others; sudden onset of symptoms or immediate need for treatment, Intake Staff will alert designated personnel, who will determine the need to access PSYCKES for critical information. If the need for immediate intervention exists, the designee will access and document the rationale in the Participants record.
   1. Emergency PSYCKES access expires in 72 hours, after which time the Care Manager will again attempt to obtain consent from the participant and will document results.
   2. When consent is obtained the document will be given to the Lead Registrar for input into PSYCKES for data exchange.
   3. The original New York State DOH-5055 /PSYCKES Consent form or Withdrawal form will be scanned into protected server file and attached to the Participant record in the EHR. A copy of the consent will be filed securely in a centralized filing cabinet.

F. The Lead Registrar will input consent data to the PSYCKES program to allow further access by Care Managers, if appropriate. If consent is not given:
   1. Registrar will access PSYCKES to review the presence of any quality flag indicators.
   2. If quality flag indicators are present, the Registrar will print out information relevant to the last year, including clinical information, pharmacy data and labs, to provide to the Care Management Team.
   3. Care Manager will repeat attempts to obtain consent at least quarterly.

G. CMA will evaluate data available regarding the Participant in the PSYCKES program for at least the last year of claims. Summaries will be printed and and

3. A copy of Medicaid card will be obtained to verify Medicaid identification number.

C. At Health Home intake, identification will be verified by obtaining 2 forms of valid identification, which may include: Social Security Card; Birth Certificate; Naturalization papers; United States Military identification card with picture; Drivers/Non-Driver's identification; Medicaid card (with picture on it), current passport or :
   1. If the Participant is already known to the Agency, 2 forms of identification are not required.
   2. If the Participant is known by another Agency, they can verify identification.

D. Participants will be asked to sign a New York State DOH-5055 or PSYCKES Consent form to allow access to the Medicaid Claims Data stored in PSYCKES, and will be given a copy of signed consent.
   1. Adult Participants who do not wish to allow access to PSYCKES data, may cross out, initial and date the 3 areas on the DOH-5055 consent that refer to PSYCKES access.
   2. If Adult Participant decides to allow access at a later date, the Participant will be asked to sign the PSYCKES Consent Form.

E. If upon intake, behaviors or conditions are observed that could indicate a Public Health Emergency as defined by Mental Health Law including, but not limited to danger to self or others; sudden onset of symptoms or immediate need for treatment, Intake Staff will alert designated personnel, who will determine the need to access PSYCKES for critical information. If the need for immediate intervention exists, the designee will access and document the rationale in the Participants record.
   1. Emergency PSYCKES access expires in 72 hours, after which time the Care Manager will again attempt to obtain consent from the participant and will document results.
   2. When consent is obtained the document will be given to the Lead Registrar for input into PSYCKES for data exchange.
   3. The original New York State DOH-5055 /PSYCKES Consent form or Withdrawal form will be scanned into protected server file and attached to the Participant record in the EHR. A copy of the consent will be filed securely in a centralized filing cabinet.

F. The Lead Registrar will input consent data to the PSYCKES program to allow further access by Care Managers, if appropriate. If consent is not given:
   1. Registrar will access PSYCKES to review the presence of any quality flag indicators.
   2. If quality flag indicators are present, the Registrar will print out information relevant to the last year, including clinical information, pharmacy data and labs, to provide to the Care Management Team.
   3. Care Manager will repeat attempts to obtain consent at least quarterly.

G. CMA will evaluate data available regarding the Participant in the PSYCKES program for at least the last year of claims. Summaries will be printed and and

provided to assigned Care Manager, who will utilize information to develop Plan of Care.

1. Direct Supervisor will monitor quality flags/outcomes monthly and will recommend additional interventions during individual Supervision and Team meetings.

H. CMA/Care Manager may access PSYCKES quarterly and/or prior to Plan of Care review to facilitate ongoing care coordination and to assist with verifying improved Participant outcomes, necessary for discharge.
    1. Direct Supervisor will continue to monitor quality flags/outcomes and will recommend additional interventions during individual supervision and Team meetings.

I. If at any time, a Participant wishes to change or withdraw their PSYCKES consent, they can complete the "PSYCKES Withdrawal Consent form", or a new DOH-5055 Adult consent indicating necessary changes. The changes will be forwarded to the Lead Registrar who will access PSYCKES within 2-3 business days and indicate the changes or withdrawal. The new consent will be attached to the EHR.

J. DOH-5055/PSYCKES Consent and any printed clinical summaries will be attached to the EHR.

K. PSYCKES use will be monitored for appropriate use by those who are authorized.
    1. Lists of current users will be reviewed and maintained by the Lead Registrar.
    2. Rosters of consenting/non-consenting clients will be maintained by Lead Registrar.
    3. At a minimum, quarterly usage reports will be generated and compared to Participant and user information to assure PSYCKES is used for its intended purpose.
    4. Reports will verify that there is consent for every participant whose record has been reviewed.
    5. Unauthorized access or use will constitute a violation of privacy laws, and will result in disciplinary action.

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Care Management Policy #12 RHIO Access and Usage

EFFECTIVE DATE: 3/1/15
REVISED DATE: 5/1/16, 9/1/16, 10/1/16

POLICY: Encompass Health Home will link to and utilize Health Information Exchange (HIE) data to support clinical evaluation, care planning, coordination of care and quality improvement, in a manner that is compliant with HIE Policies, and the current and future versions of the Statewide Policy Guidance of standards and technical approaches governing health information exchange.

PROCEDURE:
ACCESS: Adults:

A. The Health Home will be responsible for contracting with RHIO's within its service area for data sharing, and maintaining agreements and policies relevant to activation and connections to the EHR (Netsmart).
B. Care Management Agencies (CMA) are encouraged to contract with RHIO's within their service area to further enhance data sharing necessary for effective care coordination.
    1. CMA's will follow RHIO policies/HIPAA-HITECH requirements, and will develop Agency policies and procedures for granting/managing staff access, consenting, confidentiality, use and protection of information and auditing requirements.
    2. RHIO users will be fully trained prior to access, and will be documented and maintained as part of the Staff's file.
C. Authorized users will utilize RHIO's as a Data User only, and will notify RHIO of any necessary modifications, including the addition of Data Supplier status when appropriate.
D. At Health Home intake, identification of candidate/Participant 18 or older will be verified by obtaining 2 forms of identification, which may include: Social Security Card; Birth Certificate; Naturalization papers; United States Military identification card with picture; Drivers/Non-Driver's identification; Medicaid card (with picture on it), current passport or:
    1. If the candidate/ participant is already known to the Agency, 2 forms of identification are not required.
    2. If the candidate/ participant is known by another Agency, they can verify identification.
E. Candidate/Participant will be asked to sign Adult Health Home consent DOH 5055 in their native language if requested, to allow for coordinated services and interoperable health information exchange:
    1. Candidate/ participant will be informed of the 2 distinct functions of the consent;
    2. Candidate/ participant will be informed of the Core Health Home partners, including the MCO, within the network that will be included in their Plan of Care, and identified on the consent;

i. Participant will have the option of granting or denying consent to the RHIO information for other network partners

3. Candidate/ participant will be informed of their rights concerning their protected health information, including procedures on withdrawing consent;
4. Candidate/ participant will be offered a copy of complete consent.

F. When consent is obtained the document will be given to the Lead Registrar for input into the RHIO for data exchange, and to allow further access by Care Managers and network partners.
   1. Lead Registrar will Search client by name/date of birth;
   2. Lead Registrar will confirm client identity, and input the appropriate consent option (Permit) into the RHIO;
   3. Lead Registrar will conduct a Patient Data Search;
   4. Lead Registrar will create a Clinical Document by selecting options for required data;
   5. Lead Registrar will print document and give to Care Manager or designee;
   6. The original Health Home Consent or Withdrawal form will be scanned into protected server file and attached to the Participant's chart in Netsmart;
   7. Completed Consents will be transmitted to RHIO upon request;
   8. Health Home consent will be provided to the MCO as applicable.

G. If the participant refuses to sign the consent, then the following procedure will be implemented:
   1. Intake/Care Manager will indicate on referral that Participant declines consent, and will notify the Supervisor;
   2. CMA will continue to educate the Participant regarding the consent process, and the benefits of HIE in relation to quality of care and service provision.
   3. Care Manager will repeat attempts to obtain consent at first contact, and at least monthly thereafter during the outreach and engagement period.

H. If at any time, a participant wishes to change or add additional providers to their consent; Care Managers will assist in completing additional consent pages.
   1. Participants will initial and date all additional Providers added to Consent;
   2. Changes will be forwarded to the Lead Registrar who will transmit updated consent to the RHIO upon request.
   3. Updated consent information will be offered to the participant, scanned into protected server file and attached to the Participant's record in Netsmart.

I. If at any time, a participant wishes to withdraw their consent, they will complete the "Withdrawal of Consent Form", (DOH-5058).

1. The withdrawal will be forwarded to the Lead Registrar, who will input the appropriate consent option (Unspecified) into the RHIO.
2. Lead Registrar will transmit updated consent to RHIO upon request to indicate the withdrawal.
4. The withdrawal will be offered to the participant, scanned into protected server file and attached to the Participant's record in Netsmart.
5. Registrar will maintain a list of all participants who have authorized affirmative consent.

ACCESS:Children

A. RHIO information for children will be accessible for children **under 10 years of age** with parental consent, or for those **18 and older**.
B. The Health Home will be responsible for contracting with RHIO's within its service area for data sharing, and maintaining agreements and policies relevant to activation and connections to Netsmart.
C. Care Management Agencies (CMA) are required to contract with RHIO's within their service area to further enhance data sharing necessary for effective care coordination.
    1. CMA's will follow RHIO policies/HIPAA-HITECH requirements, and will develop Agency policies and procedures for granting/managing staff access, consenting, confidentiality, use and protection of information and auditing requirements.
    2. RHIO users will be fully trained prior to access, and will be documented and maintained as part of the Staff's file.
D. Authorized users will utilize RHIO's as a Data User only, and will notify RHIO of any necessary modifications, including the addition of Data Supplier status when appropriate.
E. At Health Home intake, candidate/Participant/Consenter identification will be verified by obtaining necessary forms of identification, which may include: Social Security Card; Birth Certificate; Naturalization papers; United States Military identification card with picture; Drivers/Non-Driver's identification; Medicaid card (with picture on it), current passport or:
    1. If the candidate/Participant is already known to the Agency, additional forms of identification are not required.
F. Candidate/Participant/Consenter will be asked to sign the relevant RHIO consent in their native language if requested, to allow for coordinated services and interoperable health information exchange:
    1. Candidate/Participant/Consenter will be asked to sign 2 RHIO consents: 1 for the CMA, and 1 for the Health Home.
    2. Candidate/Participant 18 or older will be asked to sign Adult Health Home consent DOH 5055.

1. Candidate/Participant/Consenter will be informed of their rights concerning their protected health information, including procedures on withdrawing consent;
2. Candidate/Participant/Consenter will be offered a copy of complete consent.

G. When consent is obtained the document will be given to the Lead Registrar for input into the RHIO for data exchange, and to allow further access by Care Managers.
   9. Lead Registrar will Search client by name/date of birth;
   10. Lead Registrar will confirm client identity, and input the appropriate consent option (Permit) into the RHIO;
   11. Lead Registrar will conduct a Patient Data Search;
   12. Lead Registrar will create a Clinical Document by selecting options for required data;
   13. Lead Registrar will print document and give to Care Manager or designee;
   14. The original RHIO consent will be scanned into protected server file and attached to the Participant's chart in the Netsmart;
   15. Completed Consents will be transmitted to RHIO upon request;

H. If the Participant/Consenter refuses to sign the consent, then the following procedure will be implemented:
   4. Intake/Care Manager will indicate on referral that Participant/Consenter declines consent, and will notify the Supervisor;
   5. CMA will continue to educate the Participant/Consenter regarding the consent process, and the benefits of HIE in relation to quality of care and service provision.
   6. Care Manager will repeat attempts to obtain consent at first contact, and at least monthly thereafter during the outreach and engagement period.

I. If at any time, a Participant/Consenter wishes to withdraw their consent, they will complete the appropriate RHIO form, for the CMA and the Health Home.
   3. The withdrawal will be forwarded to the Lead Registrar, who will input the appropriate consent option into the RHIO.
   4. Lead Registrar will transmit updated consent to RHIO upon request to indicate the withdrawal.
   6. A copy of the withdrawal will be offered to the Participant/Consenter, and the Health Home consent withdrawal will be scanned into protected server file and attached to the Participant's record in Netsmart.
   7. Registrar will maintain a list of all participants who have authorized affirmative consent.
   8. Participant/Consenter may reactivate their RHIO consent at any time.

J. Once the Participant turns 10 years of age, the consent status will default to "Unspecified", and information will not be able to be accessed.

K. When a Participant turns 18, they may re-consent through the DOH-5055, and CMA's may access information that was entered into the RHIO during the black-out years.

USE OF RHIO:

A. Authorized Users may access RHIO's as needed to review the health information of a Participant for purposes consistent with their consent, and Plan of Care.
B. All access will adhere to established Policies and Procedures, as well as those governing RHIO access.
C. Access will be limited to the specific information required for facilitating needed care coordination, follow-up and to assist with verifying improved outcomes, necessary for discharge.
D. Authorized Users will assure the physical security of locations when accessing RHIO's.
E. At no time, will Authorized Users access a participant's information in RHIO's without the appropriate affirmative consent.
F. Authorized Users will be monitored for appropriate use through supervision and regular audits.
G. Authorized Users found to violate acceptable use policies will be subject to disciplinary action.
H. Unauthorized access or use will constitute a violation of privacy laws, and can result in individual fines, in addition to disciplinary action.

AUTHORIZED USER AUDITS:

A. CMA will conduct audits by reviewing the Consent/User Reports received from the RHIO as requested.
    1. Audits will confirm Consent Forms are on file for Participants whose information was accessed.
    2. Audits will confirm that Authorized users who have accessed information, have done so for authorized purposes.
B. Health Home and CMA will document findings of all audits, and maintain reports for a period of not less than 6 years;
C. Health Home and CMA will notify RHIO, in writing, of findings, and of any access that occurred outside of acceptable use policies and procedures, including suspected or actual breaches.
    1. Care Management Programs will follow established HIPAA-HITECH procedures to report, investigate, mitigate and perform necessary notifications;

REMOVAL/REVOKE ACCESS PROCEDURE:

Care Management Policy #12 RHIO Access and Usage

A. When an Authorized User's employment is terminated, or when Supervisors become aware that a user no longer requires access to a RHIO due to a change in job duties, the Supervisor will notify the Lead Registrar.
B. The Lead Registrar will notify RHIO of Authorized User changes as they occur.

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
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Care Management Policy #13 Managed Care Organizations

EFFECTIVE DATE: February 12, 2014
REVISED: 3/13/14, 11/13/14, 12/19/14, 5/1/16, 9/1/16, 12/1/16

POLICY: Encompass Health Home (HH) will contract with and provide Health Home services to participants/enrollees of Medicaid Managed Care Health Plans, consistent with New York State Department of Health Regulations, Managed Care Organization (MCO) agreements and provider manuals.

PROCEDURE:

COMMUNICATION:

A. The Health Home will partner with MCO and share Participant information needed for collaborative care coordination, engagement and successful outcomes, and will assure that services are not duplicated.
B. The Health Home will utilize the MCO as a resource for Participant information including demographics, claims data and resources for wellness, preventive and specific disease protocols.
C. The Health Home will involve the MCO in the development of the Plan of Care, and subsequent updates.
D. The MCO will communicate promptly information related to Participants admission/discharge from care, or when presenting at and receiving services from an emergency program, to assure appropriate transitional care is provided.
E. The MCO will regularly share performance information with the Health Home related to specific gaps in care.
    a. The Health Home will share related information with MCAs and will report follow-up activities back to the MCO.
    b. The MCO will provide needed guidance to assist the Health Home in quality improvement.
F. The MCO will share information regarding Participant complaints, and will work with the Health Home to resolve Participant issues.
G. The Health Home will utilize the MCO for educational information related to specific chronic disease progression and treatment.

PARTICIPANT ASSIGNMENT:

A. Encompass Health Home (HH) will provide current capacity availability to Managed Care Plans (MCO) at least monthly, to define new participant assignment availability.
    1. HH will submit monthly, by the last business day of the month, the Provider Network Update file, identifying the monthly slot capacity to accept new assignments, through Secure File Transfer via the Health Commerce System (HCS).

i. Capacity will be reported to Excellus through secure/encrypted E-Mail: crc.snmm@excellus.com
ii. Capacity reporting will be specific to each County served.

B. MCO will review eligible members received from DOH via the MAPP, will assign participants to the HH, and report final assignments to the Department of Health (DOH) daily through the MAPP.
C. The MCO will verify eligibility for all Health Home assignments.
D. DOH will make available assignment file for the HH, via the MAPP.
E. The MCO will send the Participant a welcome letter informing them of their Health Home enrollment and assignment.
F. Health Home will download the Assignment File from the MAPP at least on a daily basis, and begin outreach and engagement services.
G. The HH will send a letter to the participant (if address known), welcoming them to the HH, and informing them of their Care Management Contact information.
H. Candidate referrals received by the HH from other sources, will first be checked for assignment information via the MAPP.
    1. HH will review and verify MCO members for Medicaid and Health Home eligibility.
    2. If questions arise, HH may contact the MCO by phone to discuss the eligibility of MCO member referrals received from other sources.
I. HH will begin Outreach and Engagement activities within 3 business days of the Participant's assignment.
    1. Outreach and engagement will continue for a period of no more than 3 months.
    2. Outreach and engagement period will cease if Participant/Family refuses to sign consent.
J. HH will explain and obtain HH Consent from Participant/Family, and will forward forms to the MCO as requested through secure/encrypted messaging on a weekly basis.
    1. E-Mail Address: crc.snmm@excellus.com (Excellus)
    2. MCO will be included as a Core Partner on all member consents.
    3. Participant will transition to Active Care Management upon receipt of signed consent, and documentation verifying Health Home eligibility.
K. HH will notify DOH of enrollments, outreach and engagement status and assignment rejections by submitting member tracking files daily through the MAPP.
    1. MCO will monitor outside referrals, rejections and updates through the MAPP for their members.
L. HH will provide the MCO any updated/changed information required to track the status of each participant within 3 business days of receipt.

Care Management Policy #13 Managed Care Organizations

DISENROLLMENT/OPT OUT:

A. During the intake process, HH will ensure that Participant is made aware of the Adult Opt Out (DOH-5059) and Consent Withdrawal forms and processes.
B. HH will forward Opt Out forms/Consent Withdrawals to the MCO through secure/encrypted messaging on a weekly basis, should Participants decide against enrollment, or choose to disenroll.
    1. HH will notify all Providers involved in Participants plan of Care of their consent withdrawal.
C. Participants will be informed that they may request the MCO to de-activate their HH status, or re-assign them to another HH.
D. If at any time the HH is unable to locate a Participant enrolled in HH services for a 60 day period, they will be determined to be Lost to Services.
    1. Commencing the 1st of the following month after determination of Lost to Services, the HH may initiate Outreach and Engagement activities to locate the participant and re-engage in services.
        i. HH will submit a change record on the member tracking file, to indicate to indicate Lost to Services; and an add record to indicate that outreach and engagement has been initiated.
    2. If after 3 months outreach and engagement is unsuccessful, the Participant will be dis-enrolled, and the MCO notified.
E. HH will consult the MCO if participant does not engage in HH services or adhere to the plan of care, to determine appropriateness of placement.
F. HH will notify DOH/MCO of discharge/disenrollment, when participant is no longer in need of HH services through the MAPP.

PROVIDER NETWORK:

A. Catholic Charities HH will establish and manage a list of Care Management Providers and Community Partners that will provide services within the Health Home network.
    1. HH will utilize service providers appropriately per written provider agreements in the delivery of HH services.
B. HH will submit via the HCS Application, a Provider Network Update file to the MCO monthly, by the last business day of the month.
    1. Provider Network Update file will be reported to Excellus through secure/encrypted E-Mail: crc.snmm@excellus.com
    2. HH will identify any changes to Lead HH information including:
        i. Tax ID numbers;
        ii. Name changes;

iii. NPI number;

C. HH will update and submit via the HCS Application, a HH Network Partner Upload File to the MCO when Provider/Partner network changes occur.
    1. HH will provide changes to the HH Network Partner Upload File no less than 15 days prior to the effective date of the change.
D. HH will utilize the MCO's network of providers when arranging for participant services.
    1. HH will communicate with MCO to expand network providers as needed.
    2. Care Managers will coordinate referrals for specialty providers through the participants Primary Care Physician.

RECIPIENT RESTRICTION PROGRAM (RRP)

A. All Health Home candidates will be screened for Medicaid eligibility through the MAPP.
    1. Those candidates that are enrolled in the RRP will be noted and the restrictions evaluated.
B. Candidates in the RRP that are not enrolled with a MCO will be assisted by the Care Manager, and Primary Care Provider if applicable, with choosing and enrolling into a plan that best meets their needs.
C. Care Managers will abide by the restrictions and selected providers when arranging for health care needs and services.
D. Care Managers will consult with the MCO and the Participants Primary Care Provider when additional non-emergency care needs are identified.
    1. The Primary Care Provider will determine if the needs can be met by the current providers.
    2. If not, upon approval from the MCO, the Primary Care Provider will complete a referral for needed services.'
        i. Excellus Provider Referral Requests: 1-800-919-8810

SCOPE OF SERVICES: MEMBER TRACKER UPDATES:

A. HH will provide Core Health Home Services to participants enrolled in the MCO.
    1. Comprehensive Care Management;
    2. Care Coordination and health promotion;
    3. Comprehensive transitional care;
    4. Patient and family support;
    5. Referral to community and social support services.
B. After receiving the weekly assignment list, HH will locate and provide outreach and enrollment services to MCO participants.

C. HH will update DOH daily regarding participant's status of outreach and engagement activities; enrollments; active care management services; correction of reporting errors; rejections; disenrollment and new referrals, through uploading the member tracking files through the MAPP.
D. MCO will access member tracking files through the MAPP to monitor participant activity.

QUALITY METRICS-CMART REPORTING:

A. HH will report Participant Care Management activities and Adult FACT-GP/Assessment scores to DOH through the HCS Application, utilizing the Care Management Assessment Reporting Tool (CMART) on a quarterly basis.
B. MCO will monitor HH performance for Participants, by downloading the reported information from DOH.

BILLING:

A. The Health Home will direct bill for HH services through eMedNY.
    1. Following appropriate notification, HH will transition to billing all Participants through the MCO for MCO participants.
B. See Billing Procedure.

QUALITY OVERSIGHT:

A. MCO will monitor the performance of HH and provider network through oversight tools, quality measures and site visits.
B. HH will pro-actively audit and monitor services, to assure on-going, continuous improvement efforts.

BREACH & SECURITY INCIDENT NOTIFICATION:

A. CMA's will notify the Health Home, and respond to and investigate suspected or known privacy and security incidents according to the *Breach Notification and Risk Assessment Actions and Response,* and *Security Incident Reporting, Risk Assessment, & Response* policy and procedures.
B. Following the confirmation of any breach of a MCO's confidential or protected health information, they will be notified within 24 hours of discovery.
    1. If a reported security incident did not rise to the level of a breach, Health Home will inform the MCO of the incident within 5 days of discovery as it relates to implementing improvements to the security and handling of the MCO's information.
C. Within 5 days of the discovery, the Health Home will provide written notification to the MCO which shall include:

1. A brief description of what happened, including the date of the breach and date of discovery if known, who made the non-permitted access, and who received the information;
2. A description of types of unsecured protected health information involved in the breach (ie: full name, social security number, date of birth, diagnosis, etc);
3. A description of what the CMA did to investigate the breach, what was done to mitigate the harm to individuals, and action taken to prevent further non-permitted access or disclosure;

D. The Health Home will cooperate with the MCO in any investigation into a privacy or security incident to meet the MCO's obligation under HITECH and any other security breach notification laws.

MANAGED LONG TERM CARE (MLTC):

A. Participants, who are engaged in a MLTC plan, may receive Health Home services to address needs not provided under the MLTC benefit.
B. The Health Home will contract with MLTC Plans in the service area by signing an Administrative Health Home Service Agreement (ASA), outlining in-plan services and respective responsibilities of the MLTC plan and the Health Home.
C. Once a referral is received and assigned, the Health Home Care Manager will provide Outreach and Engagement, and enroll the member into the Heath Home.
D. The Health Home Care Manager and MLTC will each conduct a Comprehensive Assessment, to assess appropriate needs for each service.
E. The Care Manager and MLTC Coordinator will discuss the collaborative approach for the Participant, and will document the collaboration on the "Care Planning and Coordination for MLTC and Health Homes" Form. (See attached)
    1. The "MLTC/Health Home Care Coordination Agreement" form will also be completed to outline services needed and provided by each entity. (See attached)
    2. The Plan of Care will be attached when completed to the "Care Planning and Coordination for MLTC and Health Homes" form, and will be filed in the Participant's record.
    3. The "Care Planning and Coordination for MLTC and Health Homes" Form will be completed during each reassessment of needs to ensure continuity of care and clear collaborative roles in providing Care Management.
F. The Health Home Care Manager and MLTC Plan will collaboratively develop the Plan of Care.

Care Management Policy #13 Managed Care Organizations

1. Clear roles and responsibilities will be clearly outlined in the Plan of Care, and documented in Netsmart, including a determination of which party will serve as the lead Care Manager, and which party has service authorization responsibility.
2. This decision will be based on the primary needs of the Participant, whether they be primarily behavioral health (Health Home) or long-term health care related (MLTC).

G. The Care Manager will provide Health Home services that fall outside the scope of the services provided by the MLTC plan, and will work collaboratively with the MLTC plan to prevent duplication of services.

H. The Care Manager and MLTC Plan will communicate regularly to share needed information to update the Plan of Care as required.
   1. The MLTC Plan will be included in all Interdisciplinary Team Meetings.
   2. Any determinations to discharge from Health Home services will be made jointly, and discharge planning will include those services that would continue through the MLTC plan.

I. Care Manager and MLTC Coordinator will work together to assure outcomes and quality measures are met.

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
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Care Management Policy #13 Managed Care Organizations

EFFECTIVE DATE: February 12, 2014
REVISED: 3/13/14, 11/13/14, 12/19/14, 5/1/16, 9/1/16, 12/1/16

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E. The MCO will regularly share performance information with the Health Home related to specific gaps in care.
    a. The Health Home will share related information with MCAs and will report follow-up activities back to the MCO.
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F. Health Home will download the Assignment File from the MAPP at least on a daily basis, and begin outreach and engagement services.
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Care Management Policy #13 Managed Care Organizations

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    1. Following appropriate notification, HH will transition to billing all Participants through the MCO for MCO participants.
B. See Billing Procedure.

QUALITY OVERSIGHT:

A. MCO will monitor the performance of HH and provider network through oversight tools, quality measures and site visits.
B. HH will pro-actively audit and monitor services, to assure on-going, continuous improvement efforts.

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B. Following the confirmation of any breach of a MCO's confidential or protected health information, they will be notified within 24 hours of discovery.
    1. If a reported security incident did not rise to the level of a breach, Health Home will inform the MCO of the incident within 5 days of discovery as it relates to implementing improvements to the security and handling of the MCO's information.
C. Within 5 days of the discovery, the Health Home will provide written notification to the MCO which shall include:

1. A brief description of what happened, including the date of the breach and date of discovery if known, who made the non-permitted access, and who received the information;
2. A description of types of unsecured protected health information involved in the breach (ie: full name, social security number, date of birth, diagnosis, etc);
3. A description of what the CMA did to investigate the breach, what was done to mitigate the harm to individuals, and action taken to prevent further non-permitted access or disclosure;

D. The Health Home will cooperate with the MCO in any investigation into a privacy or security incident to meet the MCO's obligation under HITECH and any other security breach notification laws.

MANAGED LONG TERM CARE (MLTC):

A. Participants, who are engaged in a MLTC plan, may receive Health Home services to address needs not provided under the MLTC benefit.
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C. Once a referral is received and assigned, the Health Home Care Manager will provide Outreach and Engagement, and enroll the member into the Heath Home.
D. The Health Home Care Manager and MLTC will each conduct a Comprehensive Assessment, to assess appropriate needs for each service.
E. The Care Manager and MLTC Coordinator will discuss the collaborative approach for the Participant, and will document the collaboration on the "Care Planning and Coordination for MLTC and Health Homes" Form. (See attached)
    1. The "MLTC/Health Home Care Coordination Agreement" form will also be completed to outline services needed and provided by each entity. (See attached)
    2. The Plan of Care will be attached when completed to the "Care Planning and Coordination for MLTC and Health Homes" form, and will be filed in the Participant's record.
    3. The "Care Planning and Coordination for MLTC and Health Homes" Form will be completed during each reassessment of needs to ensure continuity of care and clear collaborative roles in providing Care Management.
F. The Health Home Care Manager and MLTC Plan will collaboratively develop the Plan of Care.

Care Management Policy #13 Managed Care Organizations

1. Clear roles and responsibilities will be clearly outlined in the Plan of Care, and documented in Netsmart, including a determination of which party will serve as the lead Care Manager, and which party has service authorization responsibility.
2. This decision will be based on the primary needs of the Participant, whether they be primarily behavioral health (Health Home) or long-term health care related (MLTC).

G. The Care Manager will provide Health Home services that fall outside the scope of the services provided by the MLTC plan, and will work collaboratively with the MLTC plan to prevent duplication of services.

H. The Care Manager and MLTC Plan will communicate regularly to share needed information to update the Plan of Care as required.
   1. The MLTC Plan will be included in all Interdisciplinary Team Meetings.
   2. Any determinations to discharge from Health Home services will be made jointly, and discharge planning will include those services that would continue through the MLTC plan.

I. Care Manager and MLTC Coordinator will work together to assure outcomes and quality measures are met.

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #14 Adult HARP and HCBS Services

Effective Date: 5/1/16
Revised Date: 9/1/16, 10/1/2016, 11/15/16, 12/1/16

Policy: Encompass Health Home will contract/coordinate with Managed Care Health and Recovery Plans (HARP), to qualify/enroll participants with behavioral health needs; and to conduct Community Mental Health Assessments to determine enhanced Home and Community Based Services (HCBS) available to Participants 21 and older, and develop a recovery oriented, person-centered Plan of Care to meet their special needs.

Procedure:

A. Staff Assessor Qualifications:

1. **Adult Care Managers designated to complete HARP/*NYS Community Mental Health (CMH) assessments or reassessments must meet the following qualifications:***
   i. **Education:**
      a) A bachelor's degree in any of the following: child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreation therapy, rehabilitation, social work, sociology, or speech and hearing, or other human service field; **OR**
      b) NYS licensure and current registration as a Registered Nurse and a bachelor's degree; **OR**
      c) NYS teacher's certificate for which a bachelor's degree is required; **OR**
      d) A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; **OR**
      e) A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).
   ii. **Experience: Two years of experience (a Master's degree in a related field may substitute for one year's experience) either:**
      a) Providing direct services to persons with Serious Mental Illness, developmental disabilities, or substance use disorders; **OR**
      b) Linking persons with Serious Mental Illness, developmental disabilities, or substance use disorders to abroad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services.)
      c) Experience working with electronic health record systems preferred.
2. Supervisors must meet HCBS qualifications as:
   i. A licensed healthcare professional (e.g. RN, Licensed Clinician, Psychologist) with prior experience in a behavioral health clinic or care management supervisory capacity; **or**
   ii. A Masters level professional with 3 years prior experience supervising clinicians and/or Care Managers who are providing direct services to individuals with Serious Mental Illness or serious Substance Use Disorders.
3. Care Management Agency will forward to the Health Home, A completed Assessor/Supervisor Qualification Checklist, and documentation supporting the completion of the CMHA training, for each Care Manager designated to conduct the HARP Assessments. (see Attached Checklists)

i. All documentation supporting Care Manager/Supervisor qualifications (i.e. copies of degrees or transcripts) and training will be maintained by the CMA in agency personnel records, and will be provided to the Health Home upon request.

4. Care Managers that received a DOH waiver of qualifications prior to 11/15/16, will meet qualifications to do HCBS assessments.
   i. Waived Care Managers and Supervisors, who leave their Agency and move to another CMA, must meet the above qualifications.

B. Training and Supervision:

1. Qualified Care Managers/Supervisors will complete on-line training on conducting the Community Mental Health Assessment (CMHA) through the Uniform Assessment System (UAS-NY).
1. All Care Managers will obtain specific training for the designated assessment tool(s), the array of services and supports available, and the client-centered service planning process.
2. Adult Care Managers completing CMH Assessments will receive supervision from a credentialed Supervisor. Training is required in assessment of individuals whose condition may trigger a need for HCBS and supports, and an ongoing knowledge of current best practices to improve health and quality of life.

C. Assessment-Plan of Care Process:

1. Adult Participants will be asked to sign the DOH-5230, Functional Assessment Consent, prior to initiating the HCBS assessment process.
   i. Care Managers will educate Participants regarding the need to consent to be assessed and to receive available HCBS services.
   ii. Participants may withdraw their consent at any time, by signing the withdraw section at the bottom of the consent.
2. Adult Participants 21 years and older will be assessed to determine HARP eligibility for HCBS by completing the Community Mental Health Assessment (CMHA) Brief interRAI Assessment within 10-21 days of Health Home enrollment.
   i. This will determine eligibility for:
      a) Tier 1: HCBS services Employment Support, Education Support and Peer Support Services; **or**
      b) Tier 2 HCBS services: The Full array of HCBS Services: All of Tier 1 and Psychosocial Rehabilitation, Community Psychiatric Support, Habilitation, Family Support & Training
   ii. This may be done telephonically or face to face.
3. If eligible, Care Manager will discuss with Participant, their goals, and how available HCBS services may address unmet needs, using a Person-Centered planning approach.
4. Care Manager will review list of in-network HCBS providers that are available to the Participant, for their selection.
5. Upon their agreement on HCBS Services, Care Manager will develop/update the approved HCBS Plan of Care, recommending Participant chosen HCBS, and will upon Supervisory approval, forward to the Health Home.
   i. At least 1 HCBS service must be included on the Plan of Care for eligible Participants.

ii. The Health Home will review the Plan of Care, and will forward it to the appropriate Managed Care Plan (MCP) for Level of Service (LOS) determination within 14 days of enrollment.
iii. MCP will review Plan of Care, and if approved will issue a Level of Service Determination within 3 business days (but no later than 14 days after receipt) and authorize referrals for chosen HCBS Provider(s) assessment/evaluation.
iv. MCP will contact Providers to confirm referral readiness, and will pre-authorize 3 visits.
    a) MCP may opt to have the Care Manager contact the HCBS provider to confirm readiness.
v. Care Manager will initiate referrals for HCBS services.
vi. HCBS Provider will assess within 3 visits over 14 days, and collaborate with MCP and Care Manager to determine scope and frequency of services.
vii. MCP will issue HCBS Authorization letter to the HCBS Provider and the Care Manager.
viii. HCBS Provider will contact Care Manager within 3 business days of receipt of Authorization Letter, to report on engagement, and to finalize scope of services.
ix. Care Manager will update Plan of Care to include required HCBS details, and will obtain signature from participant and all identified providers.
    a) All updated Plans of Care will forwarded via secure messaging to the Health Home to be shared with the MCP.

6. Simultaneously with the above approval process, the Care Manager will conduct the full New York State Community Mental Health Assessment within 30-90 days of enrollment.
    i. Every effort will be made to conduct the assessment in one day, during a face-to-face visit.
    ii. The assessment will be signed by the Care Manager to finalize the document.
7. Care Managers will conduct HCBS full reassessments at least annually, and/or when there is a significant change in the Participant's status.
    i. Care Managers will conduct the Community Mental Health Assessment (CMHA) Brief interRAI (Eligibility) Assessment annually to verify continued eligibility for HCBS.
8. Completed assessments will be attached to the Plan of Care in Netsmart for view by Providers/Supports.
9. The Care Manager will assist the Participant in engaging with the HCBS Provider(s) as needed.
10. The Care Manager will provide ongoing monitoring of the Plan of Care, and will provide coordination with all HCBS providers.
    i. Care Manager will assure Participant receives services reflected in the Plan of Care, and that Participants choices and preferences are respected.
11. Care Managers will update the Plan of Care every 90 days, to reflect changes in services and approvals.
    i. Updates may include changes to frequency, scope and/or duration of HCBS services as needed.
    ii. Care Managers will communicate with MCP and HCBS providers to assure services are approved and not interrupted.

iii. Updated Plans of Care will be provided to the Participant, Health Home, and HCBS Providers that have been determined to be a part of the Participants interdisciplinary team, evidenced by inclusion on the Health Home Consent form.
   a) The Health Home will submit updated Plans of Care to the MCP for approval.

12. Participants may refuse suggested HCBS, and will continue to receive Care Management through the Health Home.
    i. Refusals of HCBS will be documented in a note in Netsmart.
    ii. Care Managers will encourage the inclusion of HCBS during the update process.

D. ACT and HCBS

1. ACT Care Managers will complete the Community Mental Health Assessment (CMHA) Brief interRAI Assessment at enrollment, annually or when there is a significant change in the Participant's status, including discharge from ACT services.
2. Once a Participant is discharged from ACT and transitions to a CMA, the CMA will complete the full New York State Community Mental Health Assessment within 30-90 days of enrollment, and will follow the above process for developing the Plan of Care.

E. HCBS Documentation:

1. The HCBS Plan of Care will include the following elements:
   i. Documentation of eligibility (Not eligible; Tier 1 Eligible; eligible for Tier 1 and 2);
   ii. A summary of the full CMHA;
   iii. Recommended HCBS that targets the Participants goals, preference and needs.
   iv. HCBS Service type: scope, modality, location, duration and frequency;
   v. Outcomes and results in measureable terms;
   vi. Signature of Participant and each HCBS provider.
2. Care Managers will document the assessment/Plan of Care process in a note(s) in Netsmart.
3. Care notes will reflect collaborative communication with HCBS providers and the MCP.

F. Monitoring:

1. Care Management Agencies will monitor the workflow of HCBS Plans of Care, and will ensure accuracy of the CMHA and that time frames are met.
   i. CMA's will perform auditing to assure standards are met;
   ii. CMA's will notify Health Home of any barriers or challenges in the process;
   iii. Health Home will perform spot audits of work flows, and will provide guidance for improvement if needed.

G. Non Health Home Participants

1. The Health Home may contract with an MCO, to conduct the Eligibility and Community Mental Health Assessment for HARP Members that opt out of Health Home. Qualified Care Managers will develop a HCBS Plan of Care for those members, according to the process above, according to plan requirements. In addition, contracts will identify Health Home involvement in annual reassessment.

CATHOLIC CHARITIES OF BROOME COUNTY
ENCOMPASS HEALTH HOME
HCBS Assessor Qualification Checklist

NAME OF CARE MANAGER: _____

CARE MANAGEMENT AGENCY: _____

APPROVAL EFFECTIVE DATE: _____

Above Care Manager/job candidate meets the qualifications listed below for conducting the Community Mental Health Assessment/Reassessment for HARP Participants (Check appropriate qualifications):

EDUCATION:

___ **A Bachelor's degree in any of the following (Circle one):** Child and Family Studies; Community Mental Health; Counseling; Education; Nursing; Occupational Therapy; Physical Therapy; Psychology; Recreation Therapy; Rehabilitation; Social Work; Sociology; Speech & Hearing;

Or

___ NYS licensure and current registration as a Registered Nurse by the New York State Education Department and a Bachelor's Degree;

Or

___ A Bachelors level education or higher in any field with five (5) years of experience working directly with persons with behavioral health diagnosis: _____;

Or

___ A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

***Care Manager must meet one of the above criteria.**

EXPERIENCE:

Two (2) years' experience (A Master's degree in a related field may substitute for one (1) years' experience) either:

___ Providing direct services to persons diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse;

Or

___ Linking persons who have been diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse to a broad range of services essential to successfully living in a community setting.

***Care Manager must meet one of the above criteria.**

WAIVER REQUESTED (Date): _____:

___ Approval received from OMH dated _____ (see attached).

TRAINING:

___ Completed NYS Community Mental Health Assessment Training (Date): _____ (see attached).

Care Manager Signature: _____ **Date:** _____

Verified By: _____ **Date:** _____
Supervisor/Human Resources

August 2016

CATHOLIC CHARITIES OF BROOME COUNTY
ENCOMPASS HEALTH HOME
HCBS Supervisor Qualification Checklist

NAME OF SUPERVISOR: _____

CARE MANAGEMENT AGENCY: _____

APPROVAL EFFECTIVE DATE: _____

Above Supervisor/job candidate meets the qualifications listed below for Supervising the Community Mental Health Assessment/Reassessment and Plan of Care for HARP Participants (Check appropriate qualifications):

EDUCATION:

___ **A Bachelor's/Master's degree in any of the following (Circle one):** Child and Family Studies; Community Mental Health; Counseling; Education; Nursing; Occupational Therapy; Physical Therapy; Psychology; Recreation Therapy; Rehabilitation; Social Work; Sociology; Speech & Hearing;

And

___ Current NYS licensure and registration as a Clinician by the New York State Education Department.

EXPERIENCE:

___ Minimum of 2 years of experience connecting individuals with behavioral health diagnoses to services in New York State and/or 2 years of experience providing direct service to persons diagnosed mental disabilities, developmental disabilities, alcoholism and/or substance abuse;

And

___ Prior experience in a behavioral health clinical or care management supervisory capacity.

***Supervisor must meet all of the above criteria.**

WAIVER REQUESTED_____:

___ Approval received from OMH dated_____ (see attached).

TRAINING:

___ Completed NYS Community Mental Health Assessment Training (Date): _____ (see attached).

Care Manager Supervisor Signature: _____ **Date:** _____

Verified By: _____ **Date:** _____
Supervisor/Human Resources

August 2016

Waiver Request Form: HCBS Eligibility Assessor/Supervisor Qualifications

Health Homes and Health Home Care Management Agencies may request a waiver of the established HARP and HCBS assessor qualifications through the NYS Office of Mental Health Division of Managed Care on a case-by-case basis. The Medical Director, Division of Managed Care, NYS Office of Mental Health or designee will review and respond to the request.

Section 1: To be completed by Care Management Agency applicant

Applicant information

Care Management Agency_____

Address_____

_____

_____

Contact person name_____ Title_____

Phone_____Email_____

Information re assessor or supervisor for whom waiver is being requested

Assessor/Supervisor Name_____Title_____

1. Describe the assessor's/supervisor's educational background:

2. Describe the assessor's/supervisor's relevant experience:

3. Describe the assessor's/supervisor's relevant completed training:

Nature of requested waiver

Please select all compulsory qualifications for which a waiver is requested:

___**Education**: A bachelor's degree in any of the following: child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreational therapy, rehabilitation, social work, sociology, or speech and hearing; OR NYS licensure and current registration as a Registered Nurse and a

bachelor's degree; OR a Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; OR a Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

___ **Experience:** Two years' experience (a Master's degree in a related field may substitute for up to one year of experience) either: A) Providing direct services to persons with serious mental illness, developmental disabilities, alcohol or substance abuse; OR B) Linking persons who have serious mental illness, developmental disabilities, alcohol or substance abuse to a broad range of services essential to successfully living in a community setting.

___**Training and Supervision:** Specific training for the designated NYS Community Mental Health Assessment (full interRAI) tool, the array of services and supports available, and the person-centered service planning process. Training in assessment of individuals whose condition may trigger a need for HCBS and other supports, and an ongoing knowledge of current best practices to improve health and quality of life; Mandated training on the NYS Community Mental Health Assessment tool and additional required training; Must have supervision from a licensed clinician with prior experience in a behavioral health clinical or care management supervisory capacity.

Justification for requested waiver

1. Clearly state the reason for waiver request:

2. Please explain why the agency's current staffing lacks the appropriate credentials:

3. Please review plans to train current staff and hire qualified staff to meet standards for HCBS assessors. Include timeframes for expected completion dates:

Signature of applicant

Name (please print): Title Date

Section 2. To be completed by Health Home

Health Home information

Health Home Name_____

Address_____

_____

_____

Contact person name_____ Title_____

Phone_____Email_____

Justification for requested waiver

1. Please comment on the reason for the waiver request:

2. Please indicate the Health Home's plans to support the CMA's efforts to address staffing needs. Include timeframes for expected completion dates:

_____

Signature of Health Home lead

_____	_____	_____
Name (please print):	Title	Date

Submission Instructions: Upon completion by the lead Health Home agency, this form should be submitted to the Office of the Medical Director, OMH Division of Managed Care. Please email completed waiver requests to dacohen@nyspi.columbia.edu .

For completion by NYS Office of Mental Health Division of Managed Care

I have reviewed this request and understand the impact on the HCBS assessment process. Based on my review:

___I approve this waiver request

___I do not approve this waiver request

___Conditional approval with the following terms:

Comments and recommendations for the Care Management Agency:

Comments and recommendations for the Health Home:

Signature

Name (please print): Title Date

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Functional Assessment Consent

Instructions: This form must be completed by the individual being assessed if they are 18 years of age or older, or by the child's parent, guardian, or legally authorized representative or by a voluntary foster care agency caring for such child if the child is under 18 years of age and does not meet the circumstances below*. Legally authorized representative is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information". A voluntary foster care agency means "an agency under contract with NYC Administration for Children's Services to provide foster care."

*[Please note, children who are parents, pregnant, and/or married, and who are otherwise capable of consenting, should also use and complete this form.]

NAME OF INDIVIDUAL BEING ASSESSED

NAME OF HEALTH HOME - ADULT OR CHILDREN (CIRCLE ONE)

INDIVIDUAL'S DATE OF BIRTH

A Functional Assessment (FA):

- ☑ Determines eligibility for Behavioral Health, Home and Community Based Services (BH HCBS) for individuals 21 years and older
- ☑ Determines eligibility for Health and Behavioral Health, Home and Community Based Services (HBH HCBS) for individuals up to the age of 21
- ☑ Identifies strengths and needs for HBH HCBS and Children's Health Home
- ☑ Identifies Children's Health Home assessment results

The FA is used to gather information for a Plan of Care, which must be developed for anyone who qualifies for HCBS and/or is enrolled in a Health Home. The FA will be completed in the Uniform Assessment System-NY (UAS-NY), a secure statewide database that captures and stores identifying information and completed assessments for each individual that receives services. Stringent security controls protect the information and restrict access to only those persons authorized as needed to inform services delivery. If an FA has been received in the past, that FA will also be reviewed in order to ensure the best services are provided. As the payor of Medicaid services on your behalf, New York State will also have access to your health information.

For individuals 21 years and older in need of services, the FA determines eligibility for BH HCBS and is used to gather information to develop a Plan of Care.

For individuals up to the age of 21 in need of services, a FA is required to document the individual's functional limitations in order to determine eligibility for HBH HCBS. The FA is also used to determine the Children's Health Home assessment results for individuals enrolled in a Children's Health Home and is used to gather information to develop a Plan of Care.

In order to best serve you or your child, we need to conduct a functional assessment. The FA will be completed annually for individuals 21 and older, every 6 months for individuals under 21, or sooner if a significant life event occurs.

Please sign below to indicate whether or not you give consent for a FA to be completed on you or your child.

☐ I understand the purpose of the Functional Assessment and give consent for a Functional Assessment to be completed by

NAME OF PROVIDER

on me or my child (circle one). I further understand that my consent is voluntary and can be withdrawn at any time.

☐ I do not give consent for a Functional Assessment to be completed on me or my child (circle one). I understand by not giving consent for a Functional Assessment, I may not have access to Home and Community Based Services.

PRINT NAME OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

SIGNATURE OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

DATE

We greatly appreciate your involvement in this process. If you have any questions regarding this process please call

at

☐ By checking this box, I am withdrawing my consent to have a functional assessment conducted.

PRINT NAME OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

INDIVIDUAL'S DATE OF BIRTH

SIGNATURE OF INDIVIDUAL/PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE/VOLUNTARY FOSTER CARE AGENCY

DATE