ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #1 Program Description/Care Manager Qualifications

Effective Date: 3/1/15
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Policy: The Health Home Care Management program will maintain a current description of its program

A. Basic Premise

Encompass Health Home provides strength based, youth-focused services which will assist 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 Child, 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 a wraparound planning process to form an interdisciplinary team approach to create a 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:

Children's Case Loads:
Low/Medium Blend: 1:30;
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), Complex Trauma and/or multiple comorbid medical or substance abuse disorders. The Care Manager advocates for and supports Participants/Families, 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.

Care Management Agencies will conduct background checks on all Care Manager applicants, prior to employment. These will include, but are not limited to:

1. Exclusion Screening;
2. Criminal History Check;
3. NYS Statewide Central Register Database;
4. National Sex Offender Registry, including level 1 offenders;
5. Valid Driver's license and verification of safe driving record;
6. Reference checks and verification of appropriate education and experience.

*All Care Managers will meet the following minimum qualification for serving High acuity children. It is preferred that **all** Care Managers meet this standard, to accommodate possible variances in acuity. Variances from these standards will require prior approval from the Health Home. The State may waive such qualifications for serving High acuity children, on a selected basis and under circumstances it deems appropriate which may include care manager capacity issues. This will be initiated through submission of the DOH Waiver Request Form to the Health Home, with a copy of the Care Managers updated resume and list of relevant degree(s) and certificates.*

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

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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 children and families preferred.
- Experience working with electronic health record systems preferred.

Skills:

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 and training requirements for EIP Service Coordinators per Section 69-4.4 of 10 NYCRR found at: http://www.health.ny.gov/regulations/nycrr/title_10/part_69/docs/subpart_69-4.pdf (See Early Intervention Policy #30)

Training

- All Care Managers and Supervisors will participate in training activities prior to assignment of Health Home Participants. This includes, but is not limited to:
    1. HIPAA/HITECH-Confidentiality
    2. Health Home Consents
    3. Knowledge of Basic Care Coordination including: Outreach and Engagement Procedures; Documentation Requirements: Assessments; Care Planning; Care Notes; Billing Requirements; RHIO/PSYCKES Access
    4. Electronic Health Record-Netsmart
    5. Medicaid Analytics Performance Portal (MAPP); Uniform Assessment System (UAS)
    6. CANS-NY(for Children): Minimal scores of 70% for Care Managers; 80% for Supervisors (updated annually)
    7. Mandated Reporting (updated annually)

- Additional required training within the first 6 months includes:
  1. Motivational Interviewing
  2. Trauma Informed Care
  3. Person-Centered/Family Wraparound 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
- 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 and Supervisors will be given access to Relias Learning upon hire to complete required courses.
- The Health Home will assign other courses relevant to Care Coordination through Relias Learning as needed.
- The Health Home will share information about other relevant trainings as they become available.
  - CMAs are required to maintain supporting documentation of Care Manager/Supervisor qualifications and additional training completed outside of Relias Learning, and submit to the Health Home upon request.
  - The Health Home will monitor training requirements and provide support to the CMA as needed.

D. Supervision:

- The Health Home requires a Supervisor to Care Manager Ratio of 1 to 7.
  - Alternate ratios will be reviewed subject to approval by the Health Home.
- Supervision will include oversight of training requirements, the delivery of Core Services according to Health Home policy, and monitoring of the quality of services delivered to meet established policies and outcome requirements.
- The Health Home will monitor Supervisor ratios through monthly EHR auditing.