ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #2 Downstream Care Management Providers

Effective Date: 3/1/16
Revised Date: 9/1/16, 4/4/17

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.
    1. 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:
    1. Existing Corporate Compliance, HIPAA-HITECH policies and required staff Training;
    2. Current policies of existing Care Management Programs;
    3. Existing IT and EHR access;
    4. Providers ability to perform monthly Exclusion Screenings;
    5. Existing NPI and MMIS numbers;
    6. Care Management staff and qualifications;
    7. EMedNY access;
    8. Existing RHIO, CANS-NY and/or PSYCKES access
    9. Existing access to Health Commence System (HCS) applications, MAPP and UAS-NY;
    10. 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:
    1. Time frames and plan for implementation;
    2. Dissemination of Health Home forms and Health Home Policies and processes;
    3. 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.
    4. A brief demo/instruction on Netsmart Care Management, and a review of its role in the Care Management process;

5. Billing overview;
6. 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" with other CMAs for staff to observe current Outreach and active Care Management, to assist with the transition to care coordination.
    1. 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.
    1. The Health Home will request required information for this training to be initiated on the Staff User Information Collection Tool including:
        i. Names of staff, e-mail addresses, identifying information and their appropriate roles in Netsmart;
        ii. The completion of necessary required training to begin Care Management;
        iii. Rosters of existing Care Management clientele, if applicable.
            a. 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:
    1. Billing and auditing processes and procedures;
    2. Monitoring expectations for services and outcomes;
    3. Documentation required by the Health Home;
    4. 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.
    1. The Health Home will monitor Netsmart documentation, and provide feedback and additional training as needed.
    2. 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. The Health Home will perform a site visit with the CMA within 3-6 months of assuming Care Management responsibilities to evaluate adherence to standards, verify completion of additional training requirements, approve CMA policies and provide additional guidance and instruction.

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

L. The Health Home will inquire with CMA monthly to determine current client capacity. In consultation with the Health Home, the CMA will as needed hire additional Care Managers and/or Supervisors to meet the needs of children and families in their areas.

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M. CMAs will request guidance or submit questions as needed to the Health Home by calling our toll free number 844-884-4999, or through email at encompasshealthhome@ccbc.net
    1. The Health Home will set up CMA access to “Giva”, which will be utilized to communicate and share information in a HIPAA compliant manner.