ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #20 Health Home/Care Management Transfers

Effective Date: 3/1/16
Revised Date: 9/1/16, 3/2/17

Policy: Encompass Health Home will collaborate with Care Management Agencies (CMA) and other Health Homes to ensure that Participant transfers incorporate a seamless process that provides appropriate continuity of care to promote continued health and well-being.

Procedure:
Participant transfers may be required for multiple reasons, including: moving to another location; Participant/Family request; a change of increased or decreased needs; a change in Participant condition; aging out of child services and other reasons that may be in the Participant's/Family's best interest.

A. When a Participant/Family informs the CMA that they intend to move outside of the CM's coverage area, the CMA will immediately notify the Health Home, and will begin appropriate discharge planning with the Participant.
    1. The Care Manager will initiate discussion with the Participant/Family regarding area of relocation, services needed, needed referrals; and will alert their supervisor as to the nature and timeline of the Participant's/Families relocation.
    2. The Participant/Family will be informed of the network of Health Home CMA's within the coverage area of their new location, as well as those that are available within other Health Homes, based on their unique, individual needs.
    3. The CMA will inform the Health Home of the Participants/Family's choice, who will then assign to another CMA within the network, or refer to alternate Health Home through the MAPP.
    4. The Care Manager will work with the Participant/Family and new CMA to refer and establish new services to ensure continuity of care.
    5. The Care Manager will document all coordination and transition/discharge planning services in Netsmart.
    6. The Health Home will request additional documentation from the CMA as needed.
B. When a Participant/Family requests a change in Care Manager, the CMA Supervisor will be notified of the request within 2 business days, and will perform a review of the appropriateness or need for a transfer.
    1. If appropriate, the Supervisor will re-assign the Participant/Family to a new Care Manager based on the Participant's needs.
        i. The Supervisor will assist the Participant/Family in establishing contact with the new Care Manager.
        ii. The Health Home will be made aware of any Care Manager changes via Netsmart.
    2. If a transfer is not warranted, the Supervisor will assist the Care Manager in re-engaging with the Participant/Family to reestablish an effective helping relationship.
C. If a Participant's needs/condition changes, the CMA experiences capacity issues, or it is determined that the Participant requires a specialized Care Management service not provided by the CMA, the Health Home will be notified for possible transfer to another CMA within the network, or regional Health Home that would best meet the Participants needs.
        i. Care Manager and/or Supervisor will initiate a conversation with the Participant/Family regarding needs, preferences, rationale and available options.

ii. If appropriate, the Health Home will contact the chosen CMA/Health Home regarding transfer proceedings, and will initiate communication between CMA's or with the new Health Home to facilitate the transfer.
iii. If the Health Home determines that a transfer in unnecessary, the Health Home will discuss this with the CMA Supervisor/Manager, and will suggest additional interventions that would benefit the Participant.
iv. Once a CMA transfer is completed, the new CMA will review the current circumstances of the Participant and the available documentation, to determine the need for CANS-NY reassessment and/or changes to the Plan of Care.
    a. Transfers to another Health Home-CMA would require a new Assessment Consent, and CANS-NY Assessment.

D. Transfers from Children to Adult Health Homes, will be initiated by the CMA, and coordinated by the Health Home, with an Adult Health Home that would best meet their needs.
    1. This will include those Children 18-21 who are identified for Assertive Community Treatment (ACT) and/or court ordered for Assisted Outpatient Treatment (AOT) services, and need to be enrolled into an Adult Health Home.
    2. Transfers to an alternate Health Home, will be initiated by a phone call to the chosen Health Home, where the referral can be entered, received and processed through the MAPP during the call.
    3. For ACT/AOT transfers, the Health Home will contact the Adult Health Home, and obtain feedback on their regional referral process.
        i. This may include the Health Home making a referral to the County Single Point of Access (SPOA) and/or contacting the Participants MCO for pre-approval for ACT services.

E. All Care Coordination efforts will be clearly documented in Netsmart.
    1. Discharges will be documented and implemented according to the *Disenrollment/Discharge Policy.*