ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

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, 3/2/17, 3/29/17, 9/1/17

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

Procedure:

A. 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 SPOAs;
    vi. Local Department of Social Services (LDSS);
    vii. Future access will be extended to Schools, Physicians, EDs, EI and other systems of care that impact Children.
        i. The Health Home and CMA's 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 and referral form 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 Referred Children will be entered into Netsmart-Electronic Health Record (EHR) by Health Home Staff to assign Referred Child for follow up and Outreach and Engagement with a Care Management Agency (CMA), if not already assigned.
    a. CMA will receive alerts when new Referred Child has been assigned.
8. The Health Home will assign Referred Child to a CMA based on several factors including but not limited to:
    a. Location;
    b. Capacity;
    c. Specialized needs of the Child/Family;
    d. Claims data;
    e. Loyalty: Referred Child 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 network 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 Adult 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.
12. The CMA will notify the referral source within 48 hours of the assignment, to obtain necessary information to begin the outreach process.

B. Outreach & Engagement

1. If not already enrolled, Referred Child will enter into an Outreach and Engagement segment following referral.
2. All Referred Children 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 Referred Child/Consenter 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.
        a) CMA's will inform the Health Home of referred Children that do not meet eligibility.
        b) The Health Home will provide guidance to CMA in determining the referred Child'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 should begin immediately, but may be initiated the following month to maximize the full month of outreach, but no later than the 5th business day the following month.
    i. CMA's should consider all information in determining the timeframe to begin outreach, including risk factors involved, referred Child/Family known immediate needs.
    ii. If the referred Child 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 Referred Child/Family 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. Referred Children/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 Referred Children/Families will be contacted to schedule an intake/orientation appointment. This may be accomplished through a letter to known address. Referred Child/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 Referred Child/Family at appointment/orientation, and will provide an overview of the service and determine referred Child's interest in program.
   a) Eligible Referred Childs/Families that initially refuse services, can be offered, if agreed, to be contacted by the CMA at a future date, should it be determined that their health status/condition will require future care coordination.
      A. Care Manager will contact referral source regarding their initial refusal, to obtain additional assistance with engaging with Child/Family.
      B. Referred Childs/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**)
      C. Outreach Staff/Care Manager will document the Referred Childs/Families request in Netsmart for future outreach.
      D. The Health Home will be informed of all Referred Childs/Families placed in latent status.
   b) Child Referred Child/Families that continue to refuse Health Home services that had previously consented to referral, CMA will re-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.
      - Children 18 and older will be asked to sign the DOH-5059 Opt-Out form.
   c) If Referred Child/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 Referred Childs/Families, to provide immediate assistance in an effort to engage them in services.

iii. If Referred Childs/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) Referred Childs/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 Referred Child/Family is made, they are in agreement to the service and eligibility has been verified, Outreach Staff/Care Manager will begin the **Enrollment Process** as follows:
   a) Outreach Staff/Care Manager will conduct an Initial Needs/Eligibility Assessment. (See attached)

b) Outreach Staff/Care Manager will have Referred Child 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. Referred Child under the age of 18, who are parents, pregnant, married, or otherwise capable of consenting, will also sign the DOH-5055
    B. Referred Children 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) Referred Child 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) with Parents/Guardians; will assist in identifying providers and supports with whom information will be shared; and will obtain parental/guardian consent.
        - Care Managers will request to meet with the child to review section 2 of the 5201.
        - Parent/Guardians can consent to certain types of health care services including family planning; emergency contraception; abortion; sexually transmitted infection testing/treatment; and drug/alcohol services, but information can only be released if the child also consents in section 2.
    B. Referred Children 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 RHIOs will be reviewed and signed by Referred Child/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 the CANS-NY, and begin the Comprehensive Assessment process.

E. The CMA/HH will notify referral source within 48 hours of disposition determination.
F. 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 (MCOs) 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 MCOs to verify addresses and contact information if needed.
   b) CMA will contact referral source and /or MCO for needed assistance.

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

iii. If contact is made, and Referred Child/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/SPOAs; 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 Referred Child/Family is likely, referred Child may transition to a latent period for 90 days. Outreach may continue for Referred Child/Families who remain eligible but undecided, but will not be billable.

1) Other Referred Children/Families who remain eligible, may remain latent for 90 days, after which outreach will be re-initiated for an additional 3 months.
2) Referred Child/Families may sign the DOH Consent forms and be enrolled at any time during the latency period.
3) Referred Child/Families placed in latent status, for whom Outreach will not continue, will be forwarded to the Health Home.

b) The CMA/HH will notify referral source within 48 hours of disposition determination.

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