ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #7 Comprehensive Care Coordination and Management

Effective Date: 11/21/2013
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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 the CANS-NY and other assessments to perform a Comprehensive Assessment to identify medical, behavioral health, developmental, rehabilitative, risk areas, 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 medical 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/Family 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/Families 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.

ii. Care Manager will consult with MCO to assist with re-engaging with Participant/Family 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/interdisciplinary meetings with the Participant/Family and Interdisciplinary Team, as needed to provide health promotion and support continuity of care.
    1. Case review meetings for Children will be scheduled minimally every 6 months, in conjunction with the CANS-NY assessment.
    2. For Children in Foster Care, Care Manager will coordinate case review meetings in collaboration with LDSS and the VFCA.
    3. 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 Plan/Disaster 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 the MCO and 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.

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i. Participant/Family preferences will play a significant role in the decision making process.
ii. If needed, the Care Manager will schedule an Interdisciplinary team Meeting with Participant/Family and those Providers who can provide guidance and collaborate toward a resolution of the conflicting treatment.
iii. 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), SPOAs, 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 RHIOs 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/Family 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 (if available) after visit to determine needs and the mode of contact with Participant/Family (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 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.
E. Care Managers will provide coordination of needed admissions and discharges, and will provide timely updates to the Interdisciplinary Team.

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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/Family 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/Family 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), SPOAs, 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.

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

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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/Families in addressing important risk areas and health issues, and in making informed choices about their health care services, in collaboration with the Interdisciplinary Team.
B. Care Managers will utilize assessments and 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 Participant/Family willingness to address important risk areas and health issues.
C. Care Managers will review appropriate care protocols with Participants/Families, to assist them in obtaining necessary care, if agreed upon.
D. Care Manager will document Participant/Family refusals of suggested care based on these measures.
E. The Health Home and/or CMA will notify MCOs and providers, of Participant/Family refusals, or of any discrepancies in HEDIS outcomes, to obtain their assistance and recommendations for appropriate care.
    1. Child Preventive Care
        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. Linkage and access based on assessment of risk to PrEP and PEP for HIV Prevention
        vii. BMI/Weight Assessments

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viii. Childhood/Adolescent Immunizations
ix. Flu vaccinations
x. Human Papillomavirus Vaccine for female adolescents
xi. Lead Screenings before age 2
xii. Metabolic monitoring for those on antipsychotics
xiii. Prenatal and postpartum care
xiv. Mental Health visits
xv. Annual dental exam
xvi. Advanced Directives

2. Medication Management
    i. Annual monitoring for those on persistent medications age 18 and older
        a. Digoxin: Serum Potassium; Serum Creatinine; Serum Digoxin monitoring tests
        b. ACE Inhibitors & ARB (Angiotensin Receptor Blocking Agents): Serum Potassium; Serum Creatinine monitoring tests
        c. Diuretics: Serum Potassium; Serum Creatinine monitoring tests
    ii. Follow-up care for children on ADHD medication
    iii. Medication management for those with Asthma
    iv. Anti-depressant medication monitoring during first 3 months
        a. Response to medication
        b. Development of side effects
        c. Clinical condition
        d. Issues of safety
    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
3. Health Care Monitoring
    i. Treatment for children with upper respiratory infections 3 months to 18 years of age
    ii. Testing for children with Pharyngitis
    iii. HIV/AIDS care:
        a. 2 PCP visits a year
        b. Viral load monitoring
        c. Syphilis screening (age 18 and older)
    iv. Controlling High Blood pressure
    v. Diabetes Monitoring and care (type 1 and 2, and those with schizophrenia):

a. Hemoglobin A1c and LDL-Cholesterol testing
b. Yearly retinal eye exam
c. Annual Nephropathy screen (urine protein test)
d. BP control

vi. Appropriate prenatal and postpartum care
a. Routine prenatal visits
b. Linkage to a pediatrician
c. Postpartum depression screen

vii. Chronic Obstructive Pulmonary Disease (COPD) care (spirometry testing)
viii. Cardiovascular monitoring-Cholesterol testing (cardiovascular disease and schizophrenia)
ix. Follow-up care following a heart attack (beta-blocker treatment)
x. Follow-up after ER visit

4. Behavioral Health Monitoring
i. Follow-up care after hospitalization/ER visit for Mental Illness or detoxification (7 and 30 day)
ii. Engagement in treatment after assessment of risk or diagnosis of alcohol and/or drug use or 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 (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 Family centered 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) 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 Plan of Care 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.

Monitoring

A. CMAs will conduct case record and billing audits to ensure documentation and contact standards are being met.
   1. The CMA will notify the Health Home of any discrepancies that affect monthly billing.
B. CMA's will submit quarterly reports to the Health Home detailing their audit outcomes and plans of correction, if warranted.
C. The Health Home will conduct semiannual audits, including comparison audits of records previously audited by the CMA, to ensure quality of the CMA audits.
D. The Health Home will provide guidance on accurate documentation of core services as needed.

Service Dollars

A. Care Management Programs that are designated to utilize Service Dollars to meet immediate needs and specific service needs of Participants/Families, will do so in a manner that supports the Participant/Family in the achievement of their Plan of Care goals and objectives.
B. Service Dollars will be used for Emergency purchases and/or for Participant/Family Specific (Planned) Services.
C. Emergency purchases will address immediate needs of a Participant/Family, 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.

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E. Participant/Family 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.