Bassett Healthcare Network
Community Health Navigation

| Policy/Procedure: | Health Home Outreach & Engagement |
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| Reviewed and Accepted by: | Congetta Carrig, Justin Honkala & Brad A. Potter |
| Approved by: | Justin Honkala |
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**Policy:**

Bassett Community Health Navigation will make progressive efforts to contact and engage with potential enrollees, upon their referral or assignment for Health Home Services. Efforts will be made to provide the Person with all available information to make an informed decision regarding enrollment in Medicaid Health Home service. Based on eligibility and level of need for services, potential enrollees will be referred to other appropriate services which meet their eligibility and level of need. If a Person is denied Health Home Enrollment due to ineligibility or other factors, the Person will be notified of their Fair Hearing Rights.

***CHN/CM refers to Community Health Navigators & Partnering Health Home Care Managers**

**Procedures:**

**A. Referrals Assigned for Health Home Outreach**

1. CHN must initiate and document Outreach/Search actions to contact newly assigned potential Members within three (3) business days of assignment, or sooner if the Person is determined by Referral Coordinator or service providers to be in need of emergency services/intervention.

2. Outreach will be conducted for up to two (2) months to attempt contact with a potential enrollee. During this time; the assigned CHN/CM will make progressive efforts to locate/contact and engage the Person as follows:
    a. During each Month 1 & 2 of Outreach/Search:
        i. Attempt to contact the Person by completing at least two of the following options:
            a) Attempt at least two (2) phone calls to the Person.
            b) Attempt a Face to Face visit at last known address.
            c) Send an Outreach Letter by mail. (Outreach Letters must conform to "NYS DOH Letter for Initial Enrollment in the Health Home Program" or "Bassett CHN Outreach Letter" Templates.)
            ** Additional options may be necessary to contact/locate the person, based on Information known at time of Outreach:
        ii. Conduct Online Jail/Inmate Record Searches for Persons who may be incarcerated. If a Person is found to be incarcerated, CHN will attempt to determine potential release date, and if possible, contact facility staff to obtain further information for Outreach. If incarcerated, determine if the Person's release date is lesser or greater than 6 months, to determine whether to continue outreach or opt-out.

iii. For persons known or thought to be homeless, check with shelters and possible frequented locations in the community to attempt contact.
iv. Contact the Referral Source to seek additional information to contact/locate Member and/or update on the outcome of the referral. (i.e.: Person enrolled, opted-out, was found ineligible, etc.)

3. CHN will document each attempt to contact the Person or any Outreach-related actions in the Person's Care Management Record within three (3) business days of the action.
   a. For all contacts/attempted contacts: Complete a Search Note (998-Information-Non-Billable)
      Select all fields as appropriate for the event:
      - Contact Date and Time
      - Contact Type
      - Contact Status: Select
      - Participants: Select the Participants involved in the Contact/Attempt
      - Target: Select Person(s) being contacted
      - Client Search Status - Select as appropriate, based on current status:
        - Continue Search – If no Contact has been made with Person
        - HH Consent Pending – If contact has been made, but not enrolled
        - Client Enrolled – If Member agrees to enroll and completed DOH-5055.
        - Client Opts out of HH Services – If Member does not want to enroll or any other reason that Member is not being enrolled.
   b. For Electronic Records or Online Searches: Complete a Contact Note (998-Non-Billable).

4. During the course of Outreach, CHN/CM will determine how to proceed based on outcomes of attempts to contact the person, as follows:
   a. <u>If the Person is unable to contacted/located by available methods by the end of Month 1, and there is no information that will likely result contact during the Month 2</u>:
      i. Opt-out the Person in the Care Management Record at the end of Month 1.
   b. <u>If the Person has been contacted, but not yet enrolled by the end of Month 1, or if there is information which may lead to contact in Month 1</u>:
      i. Continue Outreach for Month 2.
   c. <u>If the Person is contacted, and interested in HH services</u>:
      i. Continue with assessing eligibility and completing enrollment as per Bassett CHN Eligibility & Assessment Policy.
      ii. Also assess if translation services are needed for effective communication and services, and arrange for appropriate translation services to be provided as needed
   d. <u>If the Person is contacted, but not interested in HH services</u>: CHN will complete/upload the following to the Care Management Record:
      i. DOH-5059 Health Home Opt-Out Form (with appropriate section completed).
      ii. Search Note detailing the Person's choice to decline/opt-out of Health Home Services, and identifying the person's reason for opting-out, and any additional information regarding referral/linkage to other non-HH Services services.
   e. <u>If the Person is contacted and interested in enrolling, but found ineligible for HH Services</u>: CHN/CM will complete/upload the following to the Care Management Record:
      i. DOH-5236 Notice of Determination for Denial in the NYS Health Home Program

(Must be provided/sent to potential enrollee as Notice of Fair Hearing Rights)

ii. Search Note detailing the reasons for ineligibility, DOH-5236 being provided/sent to Member, and any alternate services referred.

f. If the Member is found to be in an Excluded Setting: the CHN/CM will contact the excluded setting who referred the individual (or verify through electronic records if contact is not possible) to obtain a facility discharge date. When possible, contact should be made with the potential Enrollee to determine interest in the Health Home program. The decision whether to continue with Outreach or Opt-Out will be based upon the Person's Facility Discharge Date and interest in Health Home Services.

*Netsmart will automatically Opt-Out the Person at the end of Month 2 of Search/Outreach, however, Outreach efforts do not need be limited to two months. Additional efforts may be attempted and documented in the Person's Care Management Record. If at any time, the Member is contacted and interested in Enrollment, contact Bassett CHN Systems Analyst or Referral Coordinator to re-activate the Person's status to Outreach/Search and assign the Person to the appropriate CMA/CM.

**B. Community Outreach Efforts**

1. Bassett Community Health Navigation Program will ensure that Outreach to potentially eligible populations and sources of referral are being conducted in the community, which shall include:
   a. Homeless Shelters and Services
   b. Jails/Correctional Facilities
   c. Providers & Community Agencies which serve Medicaid eligible persons

**Related Forms & Documents:**

- ◊ **Bassett CHN Care Management Record Documentation Guide**
- ◊ **Bassett CHN Outreach Letter**
- ◊ **NYS DOH Letter for Initial Enrollment in the Health Home Program Template**
- ◊ **DOH-5059 Health Home Opt-Out Form**
- ◊ **DOH-5236 Notice of Determination of Ineligibility for NYS Health Home Program**