Bassett Healthcare Network
Community Health Navigation

Policy/Procedure:	**Core Health Home Services & Care Management**
Reviewed and Accepted by:	John Migliore III & Brad A. Potter
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Date of Issue:	3/1/17
Date Revised/Reviewed:	10/1/17; 12/21/20; 2/3/21

Policy:

Bassett Community Health Navigation will ensure that eligible Members receive individualized, person-centered Health Home Services and ongoing coordination of collaborative healthcare services as identified in the Member's Plan of Care, and through continued assessment and management of the Member's healthcare needs.

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

Quality Management and Performance Improvement

Each CMA, within the Bassett CHN network, that provides Health Home Care Management and HCBS Services is required to comply with current internal policies pertaining to Core Health Home Services & Care Management requirements. Monthly quality reviews and performance improvement activities will include (but not be limited to) monthly audits (by Bassett CHN or CMA mandated spot checks) of member's POC and the following documentation(s);

- Completion of required documents (e.g., assessments, eligibility)
- Validation of qualified staff members and trainings
- Appropriate billing activities
- Ensuring member's POC was collaboratively produced and person-centered in focus
- Monitoring that each member's personal preference has been identified and documented
- Members receive Rights and Responsibilities document
- Notification of member's care team and outcome of case reviews
- Ensuring member's POC was updated and reviewed as required
- Ensuring referrals, evaluations, and assessments were sought and used to ensure eligibility to programs, with consideration for time as needed for waitlists and other barriers to service provision
- Ensuring appropriate training is provided to CMA's in response to outcomes identified through the Bassett CHN quality monitoring activities and Quality Management and Performance Improvement Committee guidance
- Ensure proper use of PHI, member consents, and confidentiality standards
- Ensure all other required and substantiating documentation, pertinent to service delivery is evident

Procedures:

A. Monthly Provision of Core Health Home Services for Enrolled Members

1. CHN is responsible for verifying each Member's current Medicaid coverage each month before providing services, and if applicable, current HARP-enrollment designation (H-Code).
    a. CHN will verify that the information in the Member's Care Management Record matches the most current insurance information obtained:

- Demographics: Identifier "Type" must reflect current HARP code, if applicable
- Eligibility: Health Plan Information ("Fee-for-service" or current MCO)

b. CHN upload documentation verifying current Medicaid eligibility to the Member's Care Management Record.

c. If it is determined that a member does not currently have verified Medicaid coverage, CHN will contact member to inform and assist the Member with contacting appropriate resources for Medicaid enrollment (i.e.: IPA Navigator, LDSS, or Medicaid Helpline).

2. CHN must complete at least one Core Health Home Service related to each Member's care and goal progress each month.
   a. Core Health Home Services and examples of each include:
      i. <u>Comprehensive Care Management</u>
         - Completing a comprehensive health assessment/reassessment which includes medical, behavioral, rehabilitative, long-term care and social service needs.
         - Completing/revising an individualized person-centered plan of care with the Member to identify the Member's needs/goals, and include the Member's family and social supports as appropriate.
         - Consulting with multidisciplinary team on Member's Care Plan/Needs/Goals
         - Consulting with Primary Care Physician or any Specialists involved in Care Plan.
         - Contact with Member to assess on-going emerging needs and to promote continuity of care and improve health outcomes.
         - Preparing a client Crisis Intervention/Management Plan.
      ii. <u>Care Coordination and Health Promotion</u>
         - Coordinating with Service Providers and Health Plans as appropriate to secure necessary care, share crisis intervention and emergency information.
         - Linking/referring member to needed services to support care services to support care plan/treatment goals, including medical/behavioral health care, patient education and self-help/recovery and self-management.
         - Conducting case reviews with interdisciplinary team to monitor and evaluate member status/service needs.
         - Advocating for services and assist with scheduling of needed services.
         - Coordinating with treating clinicians to ensure services are provided and to ensure changes in treatment or medical conditions are addressed.
         - Monitor, support, or accompany the Member to scheduled medical appointments.
         - Crisis intervention, revising care plan/goals required.
      iii. <u>Comprehensive Transitional Care</u>
         - Following up with hospitals/ER upon notification of a member's admission and/or discharge to/from an ER, hospital, residential or rehabilitative setting.
         - Facilitating discharge planning from an ER, hospital, residential or rehabilitative setting to ensure safe transition/discharge to where care needs are in place.
         - Notifying/consulting with treating clinicians, schedule follow up appointments and assist with medication reconciliation.
         - Linking member with community supports to assure that needed services are provided.
         - Following up post discharge with member/family to assist member care plan needs/goals.
      iv. <u>Member & Family Support</u>

- Developing/reviewing/revising the individual's plan of care with the member/family to ensure that the plan reflects individual's preferences, education and support for self-management.
- Consulting with member/family/caretaker on advanced directives and educate on member rights and health care issues, as needed.
- Meeting with member and family, inviting any other providers to facilitate needed interpretation services.
- Referring member/family to peer supports, support groups, social services, entitlement programs as needed.
- Collaborating/coordinating with community based providers to support effective utilization of services based on member/family need.

v. <u>Referral and Community & Social Support Services</u>

- Identifying resources/linking member with community supports as needed.
- Collaborating/coordinating with community base providers to support utilization of services based on Member/family need.

b. Service contact may be face-to-face, phone, mail, or electronic media contact
   i. Contact must be a two-way exchange. Mailed information or messages are not complete contacts unless the Member makes return contact as a result.
c. Service contact may be with the Member or any Collateral identified on the Member's DOH-5055 Health Home Information Sharing Consent Form.
   i. If a Collateral contact is completed, CHN must still attempt to make contact with the Member to inform/update on progress of actions taken on their behalf.

3. CHN must document all contacts and actions relevant to a Member's care in the Member's Care Management Record.
   a. Actions/Contacts meeting the requirements of a Billable Core Health Home Service must be documented as a Billable Note, as per Bassett CHN Care Management Record Documentation Guide.
   b. Actions/Contacts not meeting the requirements of a Billable Core Health Home Service must be documented as a Non-billable Note.

4. By the end of each calendar month, CHN will complete final documentation of monthly services for each member as follows:
   a. For enrolled Members who received Billable Core Health Home Services:
      i. Complete a Contact Summary Note which states/attests that the Member received Billable Core Services during the month.
      ii. Complete an HML Billing Questionnaire Assessment.
      iii. Additional supporting documentation is required to be uploaded into the Member's Care Management Record for specific conditions or status:
         - HIV
         - Homelessness
         - Incarcerated within the past year
         - Discharged from Inpatient Mental Health stay within the past year
         - Discharge from Inpatient Substance Abuse stay within the past year
         - Substance Abuse Disorder with Active Use & Functional Impairment
         - AOT or Expanded HH+ Status
   b. For enrolled Members who <u>did not</u> receive a Billable Core Health Home Service:
      i. Complete a non-billable Contact Note indicating CHN was unable to contact the Member or complete a Core Health Home Service.

ii. If a Member is unable to be contacted and does not receive a Core Service directly for two consecutive months, they will be considered disengaged from services and CHN shall follow additional procedures outlined in Lost Members, *Transfer of Service & Disenrollment Policy.*

B. Ongoing Care Management for Enrolled Members

1. CHNs will ensure active, ongoing and progressive engagement with Members to promote outreach and engagement, effective care planning, and helping the Member achieve the goals identified in their Plan of Care.
    a. Ensure the Member's consent is obtained and updated properly for any changes in providers, resources, or supports prior to sharing Protected Health Information.
        i. Ensure any changes to the DOH-5055 Form are signed & dated by the Member.
        ii. Obtain additional Consent Forms for individual Providers/Resources as needed.
    b. Update information in the Member's Care Management Record as changes occur:
        i. Demographics (Name, Address, Phone number, Identifier, etc.)
        ii. Eligibility (Medicaid/Insurance information)
        iii. Consent Forms (Must match current DOH-5055)
        iv. Problems (All current Health Conditions, Risk Factors, and Social Service Needs)
        v. Care Coordination (All Social Supports & Providers referred to current Problems)
    c. CHN will review and update the Plan of Care as needed to reflect changes in health conditions, identified needs and barriers, goals, interventions, and progress achieved.

1. CHN will monitor the Member's care needs and ensure sharing of information to facilitate collaboration between the Member, involved Healthcare and Service Providers, Caregivers, Family/Social supports, and the Member's MCO:
    a. Monitor/assist with scheduling and follow-up of Provider appointments
    b. Monitor/assist with scheduling transportation for appointments and services
    c. Monitor/assist with fulfilling written orders/prescriptions
    d. Monitor/follow-up on scheduled tests and prescribed treatments
    e. Monitor for changes in Health Conditions/Acuity
    f. Monitor for potential conflicts in treatment: If the CHN becomes aware of a potential conflict in treatment, the CHN will notify the Member, the involved Providers, and the Member's MCO within 24 hours. CHN will continue to coordinate with all parties to assist in resolution, including scheduling a Care Team Meeting if necessary. Examples of Conflicts in Treatment include:
        i. Contraindicated treatment: A provider prescribed a medication which may be contraindicated with a patient's usage of other medications or substance use
        ii. Conflict of treatment protocol: A provider prescribes treatment which may be in opposition to another provider's treatment or the Member's preferences

2. CHN will assist Members with identifying available Providers and Community Resources to meet identified needs, and will actively manage appropriate referrals to assist the Member with accessing and engaging with referred services to meet their needs.
    a. CHN must consult with the Member's MCO when referring to a new Provider
    b. CHN must inform the Member of available options and allow the Member to choose from available network Providers based on the Member's preferences.
    c. As referrals are made, CHN will update the Member's Care Management Record with related provider/resource information and documents.

3. CHN will promote Member's education about their health conditions and their engagement in evidence-based prevention and wellness and available self-help recovery resources by linking Members with resources applicable to their health needs, such as:
   a. Smoking Cessation
   b. Diabetes
   c. Asthma
   d. Hypertension
   e. Other services based on individual needs and preferences

5. CHN will assist member with identifying and utilizing peer supports, support groups and self-care programs to increase enrollees' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

6. CHN must ensure monitoring and documentation of treatment for specific conditions as follows:
   a. Members with Asthma: Monitor and document adherence to prescribed treatment:
      - Prescription & use (as needed) of an inhaled short acting beta-2 agonist (rescue) inhaler
      - Prescription and daily use of an inhaled corticosteroid (controller) inhaler
   b. Members with Diabetes: Monitor and document adherence to prescribed treatments:
      - A1c levels checked at least every six (6) months
      - Microalbumin levels checked annually
      - Dilated Retinal Exam (DRE) completed annually
   c. Members with Hypertension/Cardiovascular Disease: Monitor and document adherence to prescribed treatment:
      - Beta blocker treatment initiated after a heart attack
      - Prescription and use of anti-platelet medication or daily Aspirin
      - Prescription and use of lipid lowering medication
      - Annual monitoring for patients on persistent medications (ACE/ARB, diuretic, digoxin)
   d. Members with HIV/AIDS: Monitor testing and obtain documentation of results
      - CD4 & T-Cell Counts
   e. Members with Substance Use Disorder: Active Use & Functional Impairment
      Monitor treatment and obtain verifying documentation for all three criteria:
      - Substance Use Disorder: The presence of six or more criterion of substance abuse disorder under DSM-V, which must include pharmacological criteria of tolerance and/or withdrawal; or non-compliance with Opioid Treatment Program or positive toxicology report for substance use; AND
      - Active Use: Positive lab tests for Opioids, Benzodiazepines, Cocaine, Amphetamines or Barbiturates; or CHN observation (with supervisory sign off) of continued use of drugs (including synthetic drugs) or alcohol; or non-compliance with an Opioid Treatment Program; or MCO report of continued use of drugs or alcohol; AND
      - Functional Impairment: Demonstration of a functional impairment including: inability to maintain gainful employment; or continued inability to achieve success in school; or documentation from family and/or criminal courts that indicates domestic violence and/or child welfare involvement within the last 120 days; or documentation indicating active Drug Court involvement.

7. CHN must complete the following with each Member annually (within 12 months of last occurrence):

a. Review and update DOH-5055 Health Home Patient Information Sharing Consent Form.
   i. CHN may choose to have Member edit a previous DOH-5055 or complete a new one.
b. New Bassett CHN Health Home Comprehensive Assessment
   i. HARP Members also require completion of a new BH HCBS Eligibility Assessment.
c. New PAM-10 Patient Activation Measure (If applicable)
d. Review and update the Member's Plan of Care, as per Bassett CHN Plan of Care Policy.
   i. HARP Members also require review and update of the BH HCBS Plan of Care.
e. Conduct a Care Team Meeting with the Member and participants of their Care Team.
   i. CHN will document occurrence of Care Team Meetings in the Member's Care Management Record Notes, including attendants, topics discussed, and outcomes/action plans determined.
f. SDOH Assessment

C. Additional Requirements for Members Experiencing Specific Healthcare or Life Events

1. When a CHN is notified or becomes aware that a Member is in crisis and presents at a location that provides additional opportunities to outreach to a Member, CHN will attempt to contact the Member immediately, and when possible, meet with the Member to provide support, as per the member's Crisis Management Plan and link/refer member to additional services as needed. Bassett CHN will consult with MCO provider (when applicable) to discuss life event, coordinate service delivery, and explore opportunities for medically necessary services.

2. When a CHN is notified or becomes aware that a Member is/was admitted to Emergency or Inpatient Care, such as when a Member:
   - Presents at a hospital ER/ED and is not admitted, or
   - Is admitted to ER/ED or inpatient hospital unit, or
   - Is admitted to Emergency or Inpatient Mental Health Care, including:
     - Admission to CPEP or other psychiatric emergency/respite programs
     - Mobile crisis programs that divert people from admission to MI inpatient
     - Inpatient admission for MI that includes transfer to other units for complex needs including physical health would qualify as an inpatient stay for MI. (e.g.: admitted to MH unit, transferred to a medical unit, then discharged.)
   - Is admitted to Inpatient Substance Abuse Treatment

   a. CHN must contact Members within 48 hours of discharge, or sooner if clinically indicated, to facilitate transition of care.
   b. CHN will ensure that the Member's Primary Care Provider and/or Psychiatrist are notified whenever a Member is admitted to an Emergency Department or Inpatient setting, and that there is adequate communication between community-based Providers and the hospital treatment team.
   c. CHN will obtain documentation of admission/discharge (Such as a Discharge Summary)
   d. When possible, the CHN shall engage in the discharge planning process, including the review of upcoming appointments, medication reconciliation, and potential obstacles to attending follow-up visits and adhering to recommended treatment plans.
   e. CHNs may provide Core Health Home Services and complete Billable Notes in the Member's Care Management Record during the month of admission and the month of discharge from inpatient care. During any interim months, it is expected that CHN will continue to engage with the Member to assess needs and plan for transition of care, but these interim months of inpatient stay are considered are Non-Billable. If the Member is expected to be hospitalized for more than 180 days, CHN will consult with

Supervisor/Operations Manager regarding transition of care and disenrollment of the Member.

f. During specific life and health related events (detox, inpatient admissions, hospitalizations, post-incarcerations, or other relevant excluded setting stays), the Plan of Care should be reviewed monthly, to assure the member's currents need are being addressed and that the member is progressing towards goals, including stabilization. The Care Plan will be amended at least annually, or more frequently when warranted by a significant change in the member's medical, behavioral health, or life event situation/ condition. Amended plans must be signed by the member, and supporting documentation, such as notes, should clearly identify the reasoning for the amendment.

3. When a Member is admitted to a Detox Facility for Substance Abuse:
   a. If possible, CHN must attempt a face-to-face contact with the Member at the facility during their stay.
   b. CHN must follow up with Member within 24 hours of discharge to ensure that the Member is aware of follow-up appointments and to provide supports for getting to appointments.
   c. CHN will obtain documentation of admission/discharge

4. When a Member is at imminent risk for homelessness or becomes homeless, including:
   - HUD Category 1: Member lacks a fixed, regular, and adequate nighttime residence, such as:
     - An individual who has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground
     - An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing);
     - An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided
   - HUD Category 2: The individual will imminently lose their housing:
     - Court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days
     - Having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days
     - Credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause]; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing.

   a. CHN will assist with referrals, coordination, and follow-up with appropriate resources and services to assist with obtaining housing, community services and resources to meet the Member's current needs.
   b. CHN will obtain documentation which verifies the Member as homeless or at risk for becoming homeless, such as: Letter from shelter or other homeless housing program, hospital discharge summary, Eviction Notice, documentation from local Homeless Management Information System.

5. When a Member becomes Incarcerated or involved with Criminal Justice System, such as Detention or arrest for charges not adjudicated or sentenced, Violations of probation/parole, Released on bail awaiting arraignment or other criminal justice status in which the person has ongoing criminal justice issues requiring care management intervention, such as Alternatives to Incarceration programs implemented by local jurisdictions, including drug or mental health court:
    a. CHN will obtain documentation of status, which may include release papers, documentation from parole/probation, documented conversation from collateral contact, print-out from criminal justice databases, letter from halfway house, or other documentation specifying involvement status
    b. If the event qualifies as an incident, CHN will complete Incident Report as per Bassett CHN Incidents Policy & Procedures.
    c. If the Member is expected to be incarcerated more than 30 days, CHN must consult with Supervisor for possible disenrollment, as the Member will become ineligible for Medicaid coverage after 30 days of incarceration.

6. CHN will document the details of any such critical health or life events into the Member's Care Management Record, including the following information:
    a. Dates of admission.
    b. Date the CHN was notified.
    c. Who made the notification (e.g., client, family, hospital, provider, or MCO)
    d. Whether the CHN communicated with the inpatient treatment/program staff.
    e. Whether the CHN visited the Member at the hospital or site prior to discharge.
    f. Date of the CHN's initial contact with the Member following admission.

7. CHN will upload the required verifying documentation to the Member's Care Management Record and ensure all efforts to monitor and coordinate follow-up care needs with the Member are documented in the Member's Care Management Record Notes.

8. CHN will update Consents for Sharing Information and Plan of Care as appropriate to manage and coordinate services with the Member's emerging healthcare and social needs.

9. In the event an enrolled Member becomes deceased, CHN will complete the following:
    a. Determine if the event qualifies as a Reportable Incident, as per Bassett Community Health Navigation Incident Reporting Policy.
        i. If the incident meets the definition of a Reportable Death, CHN will complete Reportable Incident procedures.
    b. Obtain documentation verifying the Member's status as deceased.
        i. Upload documentation to the Member's Care Management Record.
    c. Update Demographics Information in the Member's Care Management Record to indicate status as "Deceased".
    d. Complete Disenrollment procedures, as per Bassett CHN Lost Members, Transfer of Service & Disenrollment Policy.

D. Additional Care Coordination Requirements for AOT/HH+ Members

1. Assigned CHN must have at least four face-to-face visits per month with AOT/HH+ Members and ensure that at least one Billable Core Health Home Service is completed each month.

a. CHN must ensure timely delivery of Health Home services, including coordination of all categories of service listed in the AOT/HH+ treatment plan.
b. If an AOT Member is not home, did not show up for an appointment, or is otherwise not able to be located, the CHN must immediately inform the LGU representative as below.

2. CHN must have contact with the AOT/HH+ Member's LGU assigned representative at least weekly regarding assigned AOT Member's compliance or lack of compliance with treatment.
   a. CHN will notify the Director of Community Services (DCS), or designee, immediately when a person under an AOT court order has an unexplained absence in a treatment program or place of residence.
      i. CHN must also document the date and time he or she was notified by the treatment provider or housing provider that the individual was absent.
   b. CHN will contact any person or persons who may reasonably have knowledge of the AOT/HH+ Member's whereabouts within 24 hours of being informed that the Member's whereabouts are unknown.
      i. Efforts to contact persons who may have knowledge of the whereabouts of the Member must be documented in Notes, together with the results of that effort.

   c. If the AOT member has not been located within the initial 24 hour period, the CHN will be expected to continue trying to locate the member and contact the following within 48 hours of being informed that the members whereabouts in unknown:

      - Local hospitals
      - Morgues
      - Shelters
      - Local jails

   d. If the AOT/HH+ member cannot be located, and has had no credibly reported contact within 48 hours of the time the CHN received either notice that the patient has an unexplained absence from a scheduled treatment appointment or other credible evidence that an AOT/HH+ member could not be located, the member will be deemed missing.
      i. Efforts to contact persons who may have knowledge of the whereabouts of the Member must be documented in Notes, together with the results of that effort.

   e. Once the AOT/HH+ Member is deemed missing, it is expected that:
      i. CHN will file a missing persons report with local police within 72 hours after the initial notice of the AOT/HH+ member's unexplained absence, or receipt of any other credible evidence that an AOT Member may be missing
      ii. Once a person is determined missing, the care management program will be required to submit a Significant Event Report, consistent with OMH standards, to: The AOT/HH+ program and The DCS.

      CHN will make daily calls to the residence of the missing AOT/HH+ Member for the first three days after the person is deemed missing, and weekly calls thereafter for the duration of the order, or until the missing AOT member is located. Such contacts may occur more frequently, to the extent appropriate, considering the circumstances of the particular case.

      The CHN will make weekly calls to local hospitals, shelters, morgues and jails in search of the missing Member for the following 2-month period, and thereafter as appropriate, for the duration of the order.

      The CHN will provide the AOT/HH+ Program with weekly updates concerning efforts to locate the missing AOT/HH+ Member, and the results of such efforts.

If and when the Member is located, the CHN will be expected to promptly notify the AOT/HH+ Program.

3. Navigators must report assessment and follow-up data to the NYS Office of Mental Health (OMH) through the Child and Adult Integrated Reporting System (CAIRS) at 6-month intervals.

4. CHN/CMA must ensure communication with the AOT/HH+ Member's Managed Care Plan:
    a. Navigators must inform Operations Manager or Referral Coordinator in the event an enrolled Member is newly placed on court-ordered AOT, or if a court order has expired and has not been renewed.
    b. Operations Manager or Referral Coordinator must inform the Managed Care Plan of the Members' AOT/HH+ status.

Related Forms & Documents:

- ◊ **DOH-5055 Heath Home Patient Sharing of Information Consent**
- ◊ **Bassett CHN Health Home Comprehensive Assessment**
- ◊ **AHC HRSN SDOH Assessment**
- ◊ **PAM-10 Patient Activation Measure**
- ◊ **Bassett CHN Care Management Record Documentation Guide**
- ◊ **Annual Recertification Checklist**