Active Care Management / Core Services

Active Care Management is characterized by the delivery of DOH defined core services which engage the client towards the achievement of their personal goals. Core services must be active, progressive and ongoing. Care Management Agencies must provide at least one of the five core (excluding HIT) services per member, per month.

The six (6) Core Health Home services are:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care
4. Individual and family support
5. Referral to community and social support services
6. The use of HIT to link services

The Core Health Home services are expected to assist in coordinating and supporting continuity of care during the following events:

- ED Visits
- Hospital Inpatient stays
- Residential and Rehabilitation Stays
- Crisis Intervention
- Use or need for acute and outpatient medical, mental health and substance abuse services
- Use or need for community based social support services, including housing

The mode of contact for core service delivery may include but is not limited to:

- Face to face meetings
- Mailings
- Electronic Media
- Telephone calls
- Case conferences

The goal of these core services is to:

- Ensure access to appropriate services
- Improve health outcomes
- Reduce preventable hospitalizations and emergency room visits
- Promote use of Health Information Technology (HIT)
- Avoid unnecessary care

Health Home providers will be required to maintain written documentation that clearly demonstrates how these core requirements are being met.
Core Service Intervention and Activity Examples

Comprehensive Care Management

- Complete a comprehensive health assessment and reassessment
- Complete and revise an individualized patient-centered plan of care
- Consult with multidisciplinary team on client care plan, needs and goals
- Consult with primary care physician and any specialists involved in the treatment plan
- Conduct client outreach and engagement
- Prepare client crisis intervention plan

Care Coordination and Health Promotion

- Coordinate with service providers to secure necessary care
- Share crisis intervention and emergency info
- Link client to needed services to support care plan goals
- Conduct case reviews with interdisciplinary team
- Advocate for services and assist with scheduling of needed services
- Coordinate with treating clinicians to assure that services are provided
- Monitor, support and accompany the client to scheduled medical appointments
- Crisis intervention

Comprehensive transitional

- Follow up with hospitals and ER’s upon admission and/or discharge
- Facilitate discharge planning
- Notify and consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation
- Link client with community supports to assure that needed services are provided
- Follow up post discharge with client and family to assist with care planning

Individual and family support

- Develop and review an individual’s plan of care with the family
- Consult with client and client’s family on advanced directives and client rights
- Refer client and family to peer supports, support groups, social services, entitlement programs
- Collaborate and coordinate with community based providers to support utilization of services

Referral to community and social support services

- Link client with community supports as needed
- Coordinate with community base providers to support utilization of services

The above is a limited list of the identified core services descriptions. For a more extensive and complete listing of core services please see Health Home Care Management Responsibilities (Draft: July 31, 2014).
Health Homes of Upstate New York

HHUNY-Central (Onondaga Case Management Services)
HHUNY-Finger Lakes (Huther Doyle Memorial Institute)
HHUNY-Southern Tier (Chautauqua County Department of Mental Hygiene)
HHUNY-Western (Lake Shore Behavioral Health)

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Policy:

For all Health Home Care Managers to provide comprehensive Core Health Home Services (Comprehensive Care Management; Care Coordination & Health Promotion; Comprehensive Transitional Care; Member & Family Support; and Referral; Community & Social Support; and the use of HIT to link services, as feasible and appropriate) in a person-centered, high quality and timely manner in accordance with Section 1945 (h) (4) of the Social Security Act and the New York State Department of Health, Health Homes Provider Manual.

Procedures:

I. Core Health Home Services

Each member enrolled in the Health Home for Upstate New York will have a dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the member’s care ensuring compliance with delivery of the Core Health Home Services. The care manager is responsible to document all core services in the electronic record.

A. Comprehensive Care Management Services

1. The primary Health Home Care Manager will complete a comprehensive health assessment inclusive of medical, behavioral, rehabilitative and social service needs within 30 days of enrollment and complete a yearly re-assessment. If the member goes through a major life change, the Department of Health requires the assessment be redone.

2. The primary Health Home Care Manager will create an individualized person-centered plan of care with the member to identify member’s needs/goals and include family members and other social supports as appropriate within 30 days of enrollment and revise every 6 months. The
The individual’s plan of care must integrate the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual’s care.

3. The Health Home Care Manager will consult with multidisciplinary team on client care plan/needs/goals.

4. The Health Home Care Manager will consult with primary care physician and/or any specialists involved in the treatment plan, including timeframes for improving the member's health and identifying interventions that will produce the desired effect.

5. The Health Home Care Manager will continue to conduct outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improve/maintain health outcomes.

6. The Health Home Care Manager and member will develop an individualized client crisis intervention plan within 30 days of enrollment.

B. Care Coordination & Health Promotion Services

1. The Health Home Care Manager coordinates with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency information.

2. The Health Home Care Manager will assist with linking the member or making referrals to needed services to support care services, and support care plan/treatment goals, including medical/behavioral health care; patient education and self-help, recovery and self-management.

3. The Health Home Care Manager will conduct case reviews with interdisciplinary team to monitor/evaluate client status and service needs.

4. The Health Home Care Manager will advocate for services and assist with scheduling of needed services.

5. The Health Home Care Manager will coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.

6. The Health Home Care Manager monitors, supports and may accompany the client to scheduled medical appointments.

7. The Health Home Care Manager will respond to member crisis, intervene as appropriate and revise care plan and/or crisis plan if indicated.

C. Comprehensive Transitional Care Services

1. The Health Home Care Manager will follow up with hospitals or emergency rooms upon notification of a client’s admission and/or discharge to/from an emergency room, hospital, residential or rehabilitative setting.

2. The Health Home Care Manager will facilitate discharge planning from an emergency room, hospital, residential or rehabilitative setting to a safe transition/discharge where care needs are in place.

3. The Health Home Care Manager will notify and/or consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation.

4. The Health Home Care Manager will assist with linking the member with community supports to assure that needed services are provided.
5. The Health Home Care Manager will follow up post discharge with client/family to assist client care plan needs and modify goals and interventions when appropriate.

D. Member & Family Support Services
   1. The Health Home Care Manager will develop, review and revise the member’s plan of care with the client/family to ensure that the plan reflects individual’s preferences, education and support for self-management.
   2. The Health Home Care Manager will consult with the member, the family and/or caretaker on advanced directives and educate on client rights and health care issues, as needed.
   3. The Health Home Care Manager will meet with the member and family, inviting any other providers to facilitate needed interpretation services.
   4. The Health Home Care Manager will refer the member or family to peer supports, support groups, social services, entitlement programs as needed.
   5. The Health Home Care Manager will collaborate and/or coordinate with community based providers to support effective utilization of services based on member and family need.

E. Referral and Community & Social Support Services
   1. The Health Home Care Manager will identify resources and link client with community supports as needed.
   2. Collaborate/coordinate with community base providers to support utilization of services based on client/family need.

II. Documentation Requirements

All services provided by a Care Manager are documented within their agency’s designated electronic record of source.

III. Billing Requirements

A. For HHUNY to bill for a month of service, the Health Home Care Manager must have provided and documented at least one of the five Core Health Home Services.
B. HHUNY also requires a finalized Attestation Note be completed each month by the Care Management Agency verifying that the Core Health Home Service provided was active, ongoing and progressive.

IV. Quality Assurance Process:

A. See Quality Assurance Policy
B. Billing: Prior to claim submission a Core Service/Attestation Report is run to identify records that are missing a note or are in draft, those records will not pull for billing.

Policy Review:
This policy and its procedures will be reviewed yearly and updated as necessary to ensure that its general purposes are being effectively met.
Active Care Management Workflow

1. Provision of Services

2. Did services provided qualify as a core service?
   - Comprehensive Care Management
   - Care Coordination and Health Promotion
   - Comprehensive Transitional Care
   - Individual and Family Support
   - Referral to Community and Social Services

   - No

3. Did services engage the client toward their goal(s)
   - Yes
   - No

4. Can services be described as:
   - Active
   - Progressive
   - Ongoing

   - No

5. Continue Active Care Management

   - Yes

   - Does not qualify as a billable Health Home service
     Reattempt Active Care Management

   - No
Health Home Care Manager Responsibilities
Draft: July 31, 2014

Comprehensive Care Management
Completes a comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed. The plan of care:

- Integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved.
- Clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.
- Clearly identifies family members and other supports involved in the patient’s care. Family and other supports are included in the plan and execution of care as requested by the individual.
- Clearly identifies goals and timeframes for improving the patient’s health and health care status and the interventions that will produce this effect.
- Includes outreach and engagement activities that will support engaging patients in care and promoting continuity of care.
- Includes periodic reassessment of the individual needs and clearly identifies the patient’s progress in meeting goals and changes in the plan of care based on changes in patient’s need.

Assures that the individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

Care Coordination and Health Promotion
Engages and retains health home enrollees in care. Includes: coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient’s needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

Discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

Facilitates effective collaborations between primary care, specialist and behavioral health providers.

Supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

Establishes regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect PHI.

Facilitates priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

Promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.
Comprehensive Transitional Care

Helps ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.

Assures timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.

Patient and Family Support

Assures that the plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

Assures that the plan of care is accessible to the individual and their families or other caregivers based on the individual’s preference.

Utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

Discusses advance directives with enrollees and their families or caregivers.

Communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

Provides patient access to care plans and options for accessing clinical information.

Referral to Community and Social Support Services

Supports effective collaborations with community-based resources, which clearly define roles and responsibilities.

Assures that the plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.

HHUNY: July 31, 2014