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
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.