BROOKLYN HEALTH HOME

Policies & Procedures Manual

Version 4.0 | July 2021

Table of Contents

PURPOSE

The purpose of this manual is to provide policy to care management providers serving the Brooklyn Health Home (BHH). This manual sets forth policy, procedure, and guidance designed to structure the activities of the care management network as outlined by the Health Home and the New York State Department of Health (DOH); as well as any other regulatory bodies relevant to the operation of the Health Home. The policies and procedures will guide and support the training and oversight of all personnel serving the Health Home network.

SCOPE

The BHH policy and procedure is relevant to all care management personnel (including administrative staff and any other personnel conducting activities related to BHH) serving the Health Home. The policy and procedure will be revisited at least annually, and amended as needed to reflect all relevant procedural changes, advancements, or modifications deemed necessary by the Health Home and/or any governing or regulatory bodies. Providers are responsible for familiarizing themselves with all Medicaid procedures and regulations for the Health Home program prior to rendering services. Providers are also responsible for remaining up to date on Medicaid, NYS DOH, and Health Home policy updates.

MISSION

Brooklyn Health Home's mission is to provide high quality, community-based care coordination as part of a clinically integrated network, serving Medicaid beneficiaries with complex needs by supporting their connection to and successful engagement with medical, behavioral, and social service providers.

HISTORY

The NYS DOH provides this overview of the Health Home program and its role in serving a high needs, high cost Medicaid population:

New York's Medicaid program serves over 5 million enrollees with a broad array of health care needs and challenges. While the majority of Medicaid enrollees are relatively healthy and only require access to primary care practitioners to obtain episodic and preventive health care, the Medicaid program also has several population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Navigating the current health care system can be difficult for relatively healthy Medicaid recipients and even more so for enrollees who have high-cost and complex chronic conditions that drive a high volume of high cost inpatient episodes. A significant percentage of Medicaid expenditures are utilized by this subset of the Medicaid population. Appropriately accessing and managing these services, through improved care coordination and service integration, is essential in controlling future health care costs and improving health outcomes for this population.

A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected. The health home services are provided through a network of organizations, providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home." (NYS DOH, 2012)

GOALS & OBJECTIVES

As published by the New York State Department of Health:

The goal of Health Homes is to improve care and health outcomes, lower Medicaid costs and reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid members. Health Homes is an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703, allows states under the state plan option or through a waiver, the authority to implement health homes effective January 1, 2011. The purpose of Health Homes is to provide the opportunity to States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness.

CONTACT INFORMATION

The Brooklyn Health Home
4802 10th Avenue
Brooklyn, NY
718-283-7722
www.thebrooklynhealthhome.org

24/7 Hotline:
1-800-356-7480
It is the policy of Brooklyn Health Home (BHH) that all Health Home members have access to information and support through the BHH Helpline. The Helpline is available 24/7 throughout the year for Health Home candidates and enrollees. The contact number is 1-800-356-7480 and can be found on all marketing and media materials.

Compliance Helpline:
1-844-787-9171
BHH uses a toll-free helpline, staffed by an outside company to provide a convenient and confidential way for an individual to report violations of the law or BHH policy or to seek guidance on a particular ethical issue. The BHH Compliance Helpline provides an alternative for use if someone is uncomfortable with talking with a supervisor or member of the BHH management team, or would prefer to report a concern anonymously. The toll-free Compliance is available 24 hours a day, 365 days a year.

RESOURCES

New York State Department of Health: Health Home website:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

New York State Department of Health: Health Home Provider Line:
518-473-5568

Health Homes Provider Manual: Policy and Standards
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm

New York State Department of Health: Health Home Forms and Templates:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/

Medicaid Update: *http://www.health.ny.gov/health_care/medicaid/program/update/main.htm*

BHH Policy No. 1.01: Required Agreements

Effective Date: 01/01/2012
Last Review Date: 07/20/2021

Policy: All required program agreements must be in place in order for a care management agency (CMA) to operate as provider in the Brooklyn Health Home (BHH) and outreach, enroll, or provide services to BHH members.

Procedure:

1. The Health Home Agreement must be signed by all network providers. This contract sets forth the relationship of the parties, the services that will be provided by each entity signing the agreement, the cost of the administrative services, insurance requirements, and appropriate indemnification and confidentiality provisions.

2. The Health Home Agreement must be accompanied by a Business Associate Agreement (BAA) that:
   a. meets the requirements established for the Health Home by NYSDOH under the provisions of Data Use Agreement 18-041M; and
   b. outlines the responsibilities of the covered entity and business associate regarding the sharing of protected health information, including NYS DOH Medicaid Confidential Data (MCD), accessed and/or shared for eligible and assigned NYS Medicaid members for the coordination of comprehensive Health Home services.

BHH Policy No. 1.02: Peer Specialist Role

Effective Date: 08/25/2015
Last Review Date: 05/04/2021

Policy: Peer specialists are recommended to fulfill roles that introduce lived experience with mental health/substance use/justice involvement as a form of support for health home members.

Procedure:

1. It is recommended that agencies employing peers utilize them in a caseload support role, but not to follow their own assigned panel of members.
    a. Caseload support should be provided under the guidance and oversight of the assigned care manager
    b. All rendered services must be documented in the care management platform and regularly reviewed by the assigned care manager or supervisor
2. Peer specialists are encouraged to share and utilize personal experiences to engage members in dialogue that promotes member retention and inclusion in care planning activities

3. Peer specialists may provide education about health homes, care management, and other service modalities (including social systems such as housing, jail, employment, or other resources relevant to the member)

4. Peer specialists may assist with outreach activities such as phone calls, letters, emails, and/or home visits

5. Peer specialists may provide caseload support through building and maintenance of a network directory that provides suggestions on various treatment and social service providers in the community

6. Peer specialists may provide transportation accompaniment (e.g., accompany a member to a routine doctor's appointment or counseling session)

7. Peer specialists may accompany care management staff to events such as hospitalizations or court hearings to provide additional support to the member

8. Peer specialists should be afforded opportunities for professional growth and development (e.g., attendance of trainings in the community, opportunities for advancement) as appropriate to work output, progress, and personal goals

BHH Policy No. 1.03: Outreach and Engagement Staff

Effective Date: 08/25/2015
Last Review Date: 05/04/2021

Policy: Outreach personnel may fulfill roles that support the building of the enrolled caseload through provision of outreach, retention, engagement, follow up, and other activities designed to locate, engage, and enroll Brooklyn Health Home (BHH) candidates.

Procedure:

1. It is recommended that an outreach caseload be maintained at a volume that can sustain meaningful and progressive attempts at engagement in a timely manner.

2. Outreach personnel are responsible for delivering "meaningful and progressive" outreach to all assigned candidates; ensuring that outreach modalities utilized are diverse in nature.

3. Outreach personnel are responsible for reviewing Medicaid eligibility of assigned candidates each month prior to rendering outreach services. Note that verification of Medicaid status is, in itself, not a stand-alone outreach activity but is an activity that should be included in documentation alongside other outreach activities (as is the use of any online search database used in efforts to identify or locate a member).

4. Outreach personnel are responsible for maintaining current knowledge of BHH, the services offered by the network, and an understanding of the public benefits/health care system in order to provide candidates with a thorough understanding of the services being offered upon outreach.

5. Outreach personnel are responsible for maintaining current knowledge of health home eligibility criteria, and should make note of the perceived conditions/factors which qualify an enrolled member for BHH enrollment.

6. Outreach personnel may document needs identified upon enrolling (e.g., completion of the DOH 5055) a new member to BHH services in the care management platform

7. Outreach personnel are to assist in and ensure the transition of an enrolled member from outreach services by reporting the new enrollment to the appropriate supervisor the day of enrollment. A supervisor must facilitate a prompt connection from outreach to care management staff.

8. Outreach personnel are responsible for upholding all documentation policies and protocols outlined by BHH, including the entry of any completed assessments or other tools.

9. Outreach staff are responsible for overseeing the assigned panel of candidates each month, verifying that those candidates whose outreach period has expired are submitted for closure in compliance with BHH policy & procedure.

10. Please refer to specific guidance and time frames for opt-outs/withdrawal of consent in those policies.

BHH Policy No. 1.04: Care Navigator Role

Effective Date: 01/31/2013
Last Review Date: 05/10/2021

Policy: If a care management agency employs the role, care navigators can be used to fulfill roles that support the activities of the care manager(s) in providing outreach, retention, engagement, follow up, and other administrative functions supporting the assigned BHH caseload(s).

Procedure:

1. CMAs may utilize care navigators in a support role in any number of models, for example, supporting a department, a team of care managers, or in a care manager-care navigator dyad. Care navigators may provide support for care management activities including making reminder calls, scheduling appointments, assisting with transmission of applications or updates, arranging transportation, etc.

2. Care navigators should not lead care conferences, but may provide peripheral support to the care team, and can provide interim updates to consented providers/care team members as needed to support the enrolled members.

3. Care navigators may prepare written case status updates, but should obtain approval from the care team lead prior to disseminating such materials.

4. Care navigators may complete applications for needed resources (e.g., housing, SSI/SSD, public assistance, Medicaid, etc.) in partnership with the member and with oversight (final approval) from the care team lead.

5. Care navigators may receive alerts on the assigned caseload and aid in following up with the admitting institution (e.g., hospital, jail, emergency department, etc.) and coordinating a site visit.

6. Care navigators may provide check-in calls in between care management appointments and provide reminders for any upcoming care management appointments, as well as conduct follow up calls after a missed appointment.

BHH Policy No. 1.05: Care Manager Role

Effective Date: 01/31/2015
Last Review Date: 05/11/2021

Policy: Care managers (CMs) are responsible for coordinating and overseeing the provision of integrated medical, behavioral health, and social service delivery for a caseload of members. Per the NYS DOH, each member must have "a dedicated care manager who is responsible for overall management of the patient's care plan…the care manager must be clearly identified in the patient record (e.g., care team) …and has overall responsibility and accountability for coordinating all aspects of the individual's care." Care managers must be discrete providers, completely separate from any other agency service line (e.g., a mental health therapist cannot also serve as a care manager).

Procedure:

1. BHH requires caseloads be determined in a manner that does not compromise the integrity of care provided to the assigned members and strongly recommends that CM caseloads not exceed 40 enrolled members per panel (with the exception of those populations whose caseload is otherwise mandated by DOH)
    a. Caseloads may be comprised of a mix of high, medium, and low need members
    b. Those care management agencies (CMAs) utilizing a "team" approach may have a slightly higher panel size as the CM works in close partnership with other assigned team members.
    c. Please refer to special populations policy for guidance on those caseloads (e.g., Adult Home Plus, Health Home Plus).

2. CMs are responsible for ensuring that all required assessments and consents are in place for each enrolled member.

3. CMs are responsible for building and maintaining positive relationships with the provider community.

4. CMs work with the member and the member's care team (as appropriate), to develop and implement a person-centered, integrated care plan, ensuring that this plan is shared across the care team and is inclusive of all member needs and goals (see Care Planning policy for more detail)

5. CMs oversee the building of the member's care team, establishing and maintaining positive rapport with all care team members.

6. CMs are responsible for securing referrals for needed services and supporting engagement with those services once obtained.

7. CMs are responsible for conducting care conferences and maintaining regular contact with the care team. (See Care Conferencing policy for more detail)

8. CMs are responsible for all crisis planning and response activities, seeking supervision as needed, and ensuring that the member is supported as they transition from one level of care to another.

BHH Policy No. 1.06: Supervisor Role

Effective Date: 08/25/2015
Last Review Date: 05/11/2021

Policy: Care management supervisors are responsible for providing structured support and supervision to the care management team, conducting quality assurance activities, and ensuring that the team is operating effectively and efficiently. For the purpose of this policy, "care management supervisor" may refer to those staff that oversee care management and/or outreach/navigation staff.

Procedure:

1. It is recommended that each CMA assemble a care management oversight team that is interdisciplinary in nature (e.g., incorporating medical & behavioral health expertise) for the purpose of providing adequate and comprehensive support and oversight of care management activities.

2. Care management supervisors are responsible for overseeing the daily activities of the interdisciplinary care management team, convening staff meetings, facilitating care conferences and discharge planning meetings as needed to ensure appropriate levels of care.

3. Care management supervisors are expected to support effective relationships with care providers (e.g., medical staff, behavioral health staff, legal representatives, etc.) in and out of the network in order to assist with the provision of needed referrals, information sharing, and resolution of conflicts.

4. Care management supervisors are responsible for engaging in regular quality assurance activities to verify that members are receiving appropriate levels of care, that documentation requirements are upheld, and that all policies and procedures of the Health Home and State are maintained.
    a. All members should be reviewed upon enrollment to verify health home eligibility criteria and to attest to the appropriateness of each enrollment, guiding clinical information gathering processes as needed
    b. Chart and utilization reviews should be conducted for enrolled members at regular intervals or as needed or requested by BHH and/or MCOs
    c. Care management supervisors are responsible for regularly reviewing assessments, care plans, and notes in the care management platform
    d. Quality assurance activities should include direct communication with members and/or consented collateral; contact with members is required for opt-outs and case closure reasons pertaining to member dissatisfaction or withdrawal of consent

5. Care management supervisors are responsible for maintaining current knowledge of Health Home policy and procedure (BHH, State, and Federal), and must ensure that this information is shared with the team and reflected in the service delivery model.

6. Care management supervisors must verify that required contact standards are being met and ensure appropriate utilization determined by member need.

7. Care management supervisors are responsible for overseeing the care transitions experienced over the course of a care management episode, including but not limited to:
    a. Transition from outreach to enrollment: verifying that newly enrolled members are prioritized and contacted by a care manager no later than one week following enrollment (if a member requests an appointment outside of this time frame, the request must be upheld and documented clearly)
    b. Discharge from a high level of care (e.g., hospitalization, incarceration)
    c. Transition from one level of care to the next (e.g., graduation or step-down, step up to HH+, etc.)
    d. Case closure (e.g., verification of opt-out status, withdrawal of consent, member dissatisfaction, etc.)

8. Care management supervisors are responsible for reviewing all critical events and incidents and providing

supervisory guidance as needed, including the identification and response to barriers to care (e.g., housing, finances, transportation, social support, knowledge of health conditions & medications, etc.)

9. Care management supervisors are responsible for ensuring that all staff are trained and engaged in professional development opportunities. Supervisors must ensure that all care management staff attend mandated BHH trainings (e.g., care coordination training) and should also be aware of trainings offered by entities that are relevant to the care of any special populations and facilitate the training of care management staff working with those members.

10. Care management supervisors must meet the State-mandated education and experience requirements for the enrolled population(s) served by their care management team. (See Health Home Plus and Adult Home Plus policies for more detail.)

BHH Policy No. 1.07: Conduct

Effective Date: 08/25/2015
Last Review Date: 05/10/2021

Policy: All care management staff representing the Brooklyn Health Home are required to maintain a professional, courteous, and respectful demeanor that reflects appropriate consideration for language, literacy, identity, and cultural preferences of each member/candidate and their family/support system.

Procedure:

1. Staff should wear an identification badge in a clearly visible location when conducting work activities.

2. Staff must treat all candidates, members, partners, and providers with courtesy, sensitivity and respect, demonstrating consideration for language, literacy, identity, and cultural preferences of all members and their family/support systems.

3. Communication (verbal and written) should be transparent, direct, objective, and thoughtful.

4. The use of physical force in any interaction with a member, staff, or community member is strictly prohibited.

5. Staff should wear comfortable, appropriate, and professional attire, taking care to be culturally sensitive to the diversity of the communities served.

6. Staff are expected to navigate situations where potential conflict may arise with professionalism and respect and, if necessary, to extricate themselves from the situation and seek the guidance of their supervisor immediately.

7. It is recommended that provider visits are arranged ahead of time with respect to the operations of the provider/clinic; when accompanying a member to a provider visit, staff should be respectful of the provider's time.

8. Participation in network meetings and workgroups should be thoughtful and solution oriented in nature, respecting the thoughts and opinions of others without being confrontational or demeaning in feedback.

BHH Policy No. 1.08: Workforce Safety

Effective Date: 09/08/2015
Last Review Date: 05/10/2021

Policy: BHH anticipates that the majority of core service and outreach delivery services are conducted via fieldwork. All care management staff representing BHH are required to use professional judgement and attention in maintaining personal safety in all care delivery activities. Each CMA is expected to identify and implement safety protocols that should include a system of checking in and emergency response plans.

Procedure:

1. Staff should wear an identification badge in a clearly visible location when conducting work activities.

2. Staff should complete a thorough review of available member information prior to meeting with a member (e.g., notes from previous sessions, updates to medications/diagnostic status, any crisis events that have occurred, etc.) and be familiar with any possible areas of concern as a means of de-escalation.

3. When needed or appropriate, it is recommended that staff conduct field activities in pairs of two (this "team" may be comprised of any combination of Health Home field staff e.g., peer, care manager, care navigator, outreach worker, and/or a supervisor). Activate device location services as often as possible, maintain a personal passcode on devices, and maintain a regular system of check-ins with your home office throughout the course of your work day. When conducting field visits, supervisors should always know the location of staff in the field.

4. Staff should be aware of their surroundings at all times and be familiar with the route of travel prior to setting out to a community meeting and avoid distractions such as hand-held devices/ listening to music/ leisure reading or other activities that might put the staff at risk of being approached unawares. Staff should also take measures to ensure that there is a direct exit route which is unobstructed when meeting in enclosed spaces.

5. Staff should pay attention to feelings of discomfort and be alert and aware of at least one exit, public safety officer, or other protective factor when traveling or conducting community visits.

6. Staff should allow adequate travel time to/from appointments, being mindful to include additional time when a meeting location is unfamiliar, or when inclement weather or large-scale events may be taking place which could add travel delays into the public transit system.

7. Staff should wear comfortable, appropriate, and professional attire that could accommodate the potential need to evacuate a situation quickly and/or travel in suboptimal weather conditions.

8. It is recommended to avoid carrying unnecessary costly items such as smartphones, tablets, laptops, jewelry, or handbags when traveling in unfamiliar communities and/or when relying on public transit.

9. Any incidents which threaten or compromise the safety of care management staff or a member should be immediately reported to a supervisor and subsequently escalated to BHH if further guidance or the submission of an incident report is required.

BHH Policy No. 1.09: Quality Assurance and Performance Improvement

Effective Date: 08/26/2015
Last Review Date: 07/16/2021

Policy: BHH's Quality Management Program (QMP) provides the infrastructure to monitor and evaluate for quality, efficiency and effectiveness of care coordination within the network. The identification of gaps in quality care will lead to the development of corrective action plans as appropriate. Noncompliance or failure to successfully complete corrective action plans may result in suspension of assignments, removal from the network, or other consequences.

Procedure:

1. Care Management Partners are expected to participate in the BHH Committee Structure, with appropriate representation on the following committees:
   a. Quality Committee
   b. Clinical Committee
   c. Business Operations and HIT Committee
   d. Care Manager Workflow Committee
   e. Supervisor Committee
   f. Care Conference
   g. Ad hoc committee by BHH staff

   Attendance is monitored, with the understanding that schedules may not permit attendance at each and every meeting. It is expected that, in addition to training provided by BHH, agency representatives at these meetings disseminate the policies, standards, and information developed and provided at the committee meetings to their staffs.

   Note: BHH's QA processes do not replace the need for each care management agency to design internal policy and procedure; and that BHH expects each care management vendor to implement a structured system of quality assurance and review that is available for the Health Home's review upon request

2. **Performance Monitoring**
   BHH Quality Management Program will provide objective and systematic oversight in monitoring and evaluating performance and adherence to policy and procedure at both the care management agency level and network level. BHH will commit the following resources and processes to support QMP activities and to ensure communication and collaboration between BHH and the network of providers:
   a. **Quality Committee**
      BHH's Quality Committee convenes monthly to review and discuss the network's performance and to develop Performance Improvement Plans (PIP). BHH management and leadership participate in the Committee alongside representatives from every CMA.
   b. **Operational Reports**
      BHH produces and distributes monthly Operational Reports that provide information on compliance with various process and protocol standards including but not limited to enrollment, completion of assessments, follow-up after hospitalizations, presence of care teams, the creation and updates of care plans, and encounter information. BHH expects the appropriate staff at the CMAs to review these reports in detail each month, identify performance gaps and areas for improvement, and implement action plans to correct any deficiencies. Any concerns about performance or about the data should be communicated in a timely manner to BHH. Below is a brief description of the reports made available to each CMA on a monthly basis:
      - **Operations Report:** provides patient level summary data that allow users to verify their patient census and to diagnose specific operational deficiencies. The operations report guidance document details the definitions and weights of each metric.

- **Executive Summary:** uses graphic displays to illustrate each CMA's three-month performance trend in comparison to the network target and network average.
- **Care Management Platform Reports:** CMAs are encouraged to use the inventory of reports made available in BHH's care management platform to monitor various processes and administrative requirements.

c. Chart Audit

BHH conducts biannual chart audits to evaluate compliance with documentation standards, the development of quality care plans, and the application of appropriate care management interventions. BHH requires all care management agencies to audit 30 charts utilizing the BHH Chart Review Tool with the exception of those that have an enrollment of 60 members or less. These agencies will audit between 10 – 15 charts. Only supervisory level staff and QA/QI staff are authorized to conduct chart audits. Care Managers ***cannot*** audit their own cases. The chart review guidance document provides additional detail on the timeframes and requirements for conducting and submitting chart reviews.

CMAs are still expected to perform internal audits on a regular basis in addition to the biannual audit. Supervision, quality reviews, and incidents are some – but not all – triggers for chart review activities.

d. Bi-Annual Scorecard

BHH will issue biannual scorecards for each CMA that is reflective of their scores on each performance metric and assigned chart reviews. These scores will determine each CMA's tier status (Tier 1 – Tier 4).

Tier 1
• Exemplary performance • High level of efficiency in meeting BHH standards • May be designated as a "Mentor Agency" to share best practices
Tier 2
• Good performance • Continue to focus on sustaining high performance and identifying opportunities for improvement
Tier 3
• Satisfactory performance • There are some areas in need of improvement • Will be required to submit an improvement action plan to BHH
Tier 4
• Poor Performance • Will be required to submit a corrective action plan to BHH for approval and monitoring • May be subject to suspension of new assignments or other action during the performance improvement period.

CMA leadership is responsible for reviewing their biannual scorecard with the appropriate staff members to identify and prioritize areas in which there is room for improvement. Agencies in Tier 4 will be placed on a corrective action plan that will be closely monitored by BHH.

3. Adoption of the Care Management Platform

BHH requires full adoption of BHH's care management platform. This includes compliance with all documentation timeframes, timely updates to member demographics, consent and enrollment status, and care teams, timely entry of assessments, encounters, progress notes, and care plan issues, responsiveness to secure messages, and daily monitoring of alerts. BHH monitors IT adoption in various ways, including Operational Reports, sample chart reviews, and in response to complaints or inquiries from members, providers, or MCOs.

4. Training

BHH requires all care management staff working with BHH members to complete the 1199 Advanced Care Management modules. In addition, BHH requires staff to be proficient in the use of the care management platform, and to utilize training and refreshers made available by BHH staff and the Care Management Platform vendor. BHH provides training on policy, procedure, and workflows, in addition to training on how to generate, use, and interpret all available reports and analytics. Additional training, education, and supervision is expected to be provided by CMA supervisors and other leadership, and sought externally when deemed necessary (e.g., housing training provided by CUCS).

5. Outcomes

BHH will monitor outcomes related to health and utilization based on data made available by NYS and MCOs. These data sets will be shared with CMAs and, (in concert with the Operational Reports and the various reports available in the Care Management Platform that monitor process measures), be used to evaluate performance and develop action plans for improvement.

Data Sources

BHH may use the following date sources to monitor and evaluate care management activities:

- Center for Medicare and Medicaid Services (CMS)
- State Plan Amendment Quality Measures
- CMART data reports provided through the office of Quality and Patient Safety (OQPS)
- Medicaid Analytics Performance Portal (MAPP)
- Data sourced from Managed Care Organizations
- BHH's Care Management Platform via inventory of reports
- Incident and Grievances Reports
- Member experience surveys
- BHH Chart Reviews

6. Complaints, Incidents, and Grievances

As per the complaints, incidents, and grievance policy, as well as the Member Bill of Rights, members are entitled to high quality care coordination services. Understanding that certain complaints, incidents, and grievances will occur in the course of doing business, these reports will be analyzed for patterns and trends that reflect quality concerns, and may demonstrate the need for corrective action plans. CMAs must develop and maintain processes for self-monitoring for trends in grievance reports including action plans designed to reduce the likelihood of these events reoccurring on a regular basis. Complaints must be retained separately from the candidate/member case records. (*Refer to Policy 3.01 – Grievances & Incidents for details on how to identify, report, monitor, and resolve incidents.)*

Compliance Helpline:
1-844-787-9171

7. Department of Health (DOH) Reporting Requirements

CMAs are not required to manually submit data to DOH (e.g., CMART, HARP, Incident Reports, etc.). BHH conducts State reporting mandates on behalf of CMAs.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0003, Health Home Quality Management Program *(See Appendix)*

BHH Policy No. 1.10: Record Keeping Requirements

Effective Date: 01/09/2014
Last Review Date: 04/26/2021

Policy: CMAs are responsible for maintaining individual chart records to store documents reviewed and signed with each candidate/member served under BHH. Original documents must be stored for a period of six years following the closure of the case.

Procedure:

1. CMAs must ensure that all charts are stored in a secure manner that upholds all member privacy rights.

2. Copies of all originally signed documents must be maintained in their original state. For example:
   a. All completed consent forms (including the DOH-5055)
   b. Initial care plan with signature of member/representative
   c. Bill of rights
   d. Opt out form (DOH 5059)
   e. Withdrawal of Consent form (DOH 5058)
   f. Notices of Determination

3. Copies of all case specific documents should be stored electronically in the member's chart in care management platform.

4. Documents such as correspondence may be destroyed once the CMA has uploaded a copy of the document to the care management platform – OR – copied the content of the letter in a progress note.

NOTE: The requirement to maintain original signed documents may be modified in cases where e-signature methods are employed.

Reference:
NYS DOH Health Homes Provider Manual, 9.2 – Record Keeping Requirements *(See Appendix)*

BHH Policy No. 1.11: Health Home Billing and Payment

Effective Date: 12/01/2016
Last Review Date: 05/25/2021

Policy: BHH is the responsible billing entity for all contracted Care Management Agencies (CMAs) providing outreach and care management services under the auspices of BHH. BHH will follow the guidance provided by NYS DOH in the *Health Homes Provider Manual: Billing Policy and Guidance* and bill at the prevailing Health Home rate codes determined and set by NYS DOH.

Procedure:

1. Documentation in the Care Management Platform as described in "Outreach Standards" and "Core Service Delivery" establishes an Outreach, Enrollment, or Pend segment on the NYS Enrollment File in the MAPP Tracking System
    a. The Care Management Platform status creates health home segment type: Outreach, Enrollment, or Pend on the NYS Enrollment File and creates a billing instance. Although Outreach is no longer a billable service, documentation of outreach activity is still required.
    b. High, Medium, Low (HML) Assessments adjust acuity and set the billable amount for Enrollment or Pend (Diligent Search) segments
    c. No billing will occur after 60 days of enrollment without the existence of a signed care plan in the Care Management Platform
    d. No billing will occur without an appropriately completed and signed consent in the Care Management Platform

2. CMAs must ensure that all activity is documented appropriately according to the billing logic defined by BHH, i.e., member enrollment status, encounter type, and core service must all be correct and correspond to supporting documentation in the encounter note.

3. CMAs must ensure that all HMLs reflect accurate and up-to-date information and are supported by documentation.

4. BHH will submit a tracking file to MAPP on a regular basis as managed by the Care Management Platform.

5. BHH will submit a billing file weekly for activity documented in the Care Management Platform to the appropriate payer as indicated in the MAPP Tracking System and as managed by the Care Management Platform.

6. BHH conducts a regular review of claims to ensure encounters support the special population level of billing for Health Home Plus and Adult Home Plus members.

7. BHH will collect payment from Medicaid and Managed Care payers and disburse payments to the CMAs less administrative payments due within 15 days of receipt in accordance with NYS DOH standards.

8. BHH will regularly evaluate and reconcile the care management platform data against MAPP and resolve any identified discrepancies

Reference:
NYS DOH Health Homes Provider Manual, 5 – Billing
NYS DOH Health Home Billing *(See Appendix)*

BHH Policy No. 1.12: Background Check Requirements

Effective Date: 2/01/2020
Last Review Date: 7/14/2021

Policy: BHH and CMAs must ensure that the required background checks for BHH Care Managers and CMA employees are conducted in order to better protect members under the age of 21 and to help ensure their safety. BHH and CMAs must adhere to Chapter 57 of the Laws of 2018 which includes new statutory requirements related to Criminal History Record Checks (CHRC), Mandated Reporter requirements, and Statewide Central Register (SCR) Database checks.

Procedure:

The employer of record is the agency responsible for completing the required background checks.
BHH Care Managers and CMA employees must complete three (3) required clearances:

1. Staff Exclusion List (SEL) through the NYS Justice Center for the Protection of People with Special Needs (Justice Center)
    a. ➢ Per NYS Social Services Law 495.
    b. ➢ For BHH and CMA employees that will have regular and substantial contact with individuals under the age of 21.
    c. BHH and CMAs are responsible for registering an Authorized Person with the NYS Justice Center and meeting any additional requirements to ensure completion of the SEL checks.
    d. Authorized person(s) are the staff at each agency that can request SEL checks online and receive results via email.
    e. Employers are required to retain documentation of the result for each SEL check.

2. Criminal History Record Check (CHRC) through NYS Department of Health (DOH)
    a. ➢ Per NYS Public Health Law Article 28-E
    b. ➢ For unlicensed BHH and CMA employees who provide direct care to members under the age of 21 or have access to their property and belongings
    c. Employers of covered persons are responsible for requesting and processing the checks.
    d. Employers must ensure appropriate direct observation and evaluation of the temporary employees, effective July 1, 2019.
    e. Temporary employees are those whose CHRCs are pending.
    f. Per Chapter 57 of the Laws of 2019, effective July 1, 2019, temporary employees will not be able to provide direct care without supervision by an employee whose check has been successfully completed or by exempt staff.
    g. If an employee is later employed by another agency that requires a CHRC, the CHRC process will be expedited once the direct employer (the Health Home or Care Management Agency) submits their request for a CHRC. If the applicant has already been evaluated by DOH/CHRC, the direct employer will not receive a Live-Scan Request Letter. However, they will receive a letter of determination concerning employment eligibility. There is no additional fee in this situation and the expedited checks are typically processed in one (1) to two (2) weeks.
    h. The employer of record is responsible for the cost. These costs are statutorily prohibited from being passed on to the employee.
    i. There are some crimes which may statutorily disqualify a person from obtaining employment pursuant to Executive Law 845-b (5)(a). If the prospective employee has one of the listed convictions, he/she may only be approved for employment if the DOH determines, in its discretion, that approval of the application ... “will not in any way jeopardize the health, safety or welfare of the beneficiaries of such services.” This is a very high standard of review and the applicant will need to provide significant information to overcome a denial of employment eligibility. If the prospective employee’s convictions are for crimes other than those mentioned above, the DOH “may approve or disapprove the prospective

employee's eligibility for employment by the provider, consistent with article twenty-three-A of the correction law." See, Executive Law Sec. § 845-b (5) (b). The agency will receive CHRC Legal Determination Letters which are based on legal review of NYS and FBI criminal histories.

3. Statewide Central Register Database Check (SCR) through the Office of Children and Family Services (OCFS)
    a. ➢ NYS Social Service Law 424-a
    b. ➢ For BHH and CMA employees that that will have the potential for regular and substantial contact with members under the age of 21
    c. If the prospective employee is not found to be a confirmed subject of an indicated report, the employer will receive notification that the SCR has no record of the applicant being an indicated subject of a report of child abuse or maltreatment.
    d. If the prospective employee is found to be the subject of an indicated report, the SCR is required to send a letter informing the applicant of their due process rights. The applicant is given ninety (90) days to respond back to the SCR in writing that they want to exercise their due process rights through an administrative review and fair hearing process. If the SCR does not hear back from the applicant within that timeframe, the SCR will then notify BHH or CMA that the SCR has a record of the applicant being an indicated subject of a report.
    e. If BHH or CMA is notified that the SCR has a record of an applicant being an indicated subject of a report, the notification will not contain any details related to the report of abuse or maltreatment.
    f. An indicated SCR report is not an automatic exclusion from employment.
    g. BHH or CMA can request that the prospective employee sign an authorization for release of information allowing the prospective employer to request and obtain a copy of the indicated SCR report. After reviewing the records, it is the prospective employer's discretion as to whether they hire or do not hire the prospective employee.

4. Timeframes
    a. A provider must immediately, but no later than 30 calendar days after the event, notify the Department when:
        i. an individual is subject to CHRC via 103 submission; and
        ii. an individual is no longer subject to CHRC via 105 termination. Terminations include when an employee is no longer subject to CHRC; is no longer employed by the provider; employee death; or when a prospective employee is no longer being considered by the provider.
        iii. Upon receipt of the request for fingerprint (LiveScan), an appointment must be scheduled for the employee to be fingerprinted, along with indication of the method of payment.

5. Mandated Reporter Requirements
    a. BHH Care Managers and other applicable Health Home employees as well as other applicable agency employees are mandated to report suspected child abuse or maltreatment. Reports of suspected child abuse or maltreatment are to be made immediately by telephone, to the mandated reporter line at 1-800-635-1522. The mandated reporter line is available 24 hours a day, 7 days a week. This line is dedicated to mandated reporters. Please do not provide this number to the public, who can report child abuse or maltreatment by calling 1-800-342-3720. In addition to the report made by phone, the mandated reporter must complete a written form (form LDSS 2221A) and submit it, within 48 hours, to the child protective services of which the child resides.
    b. The Office of Child and Family Services offers free training online for mandated reporters that can be completed at any time of day, any day of the week. Upon completion of the online training, participants will electronically receive a certificate of attendance. There are no costs associated with this requirement.
    c. Free training for mandated reporters on the OCFS website: https://ocfs.ny.gov/main/cps/Mandated_Reporter_Training.asp
    d. Register for Mandated Reporter Training at the following link: https://www.nysmandatedreporter.org/RegistrationInstructions.aspx

6. Training Requirements
    a. The BHH Care Managers or Health Home Care Management Agency Human Resources staff are to receive training on these requirements to ensure that staff receive the appropriate required clearances and to ensure that BHH or CMA are in compliance.

7. Quality Monitoring and Oversight
    a. CMAs will ensure that the following records are retained, which will be subject to audit by the State:
        i. Criminal History Record Checks
        ii. Employers must retain the approval or disapproval letter for each employee, as well as the CHRC 102 (Fingerprint Consent Form), CHRC 103 (Submission Receipt), and CHRC 105 (Termination Form).
        iii. These letters are housed within the CHRC application in HCS. Please note that criminal history information cannot be shared.
        iv. Statewide Central Register Database Checks
        v. Employers must retain the results of each SCR check.
        vi. Employers must print or save the results to make sure they remain available.
        vii. Staff Exclusion List Checks: Employers must maintain the results of each SEL check. These results are sent via email.
        viii. Mandated Reporter: Employers must maintain the certificate of attendance that employees receive upon completion of the required training.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0010, Background Check Requirements for Health Home and Care Managers *(See Appendix)*

BHH Policy No. 2.01: Confidentiality

Effective Date: 01/31/2013
Last Review Date: 06/29/2021

Policy: All BHH members and candidates are protected under all privacy and confidentiality rights and rules initiated under the Federal 1996 Health Insurance Portability and Accountability Act (42 CFR 431.302, 42 CFR Part 2, 45 CFR Parts 160, 162 and 164, 45 CFR 155.260) the New York State Social Services Law Section 369 (4), Section 367b(4), the New York Mental Hygiene Law Section 33.13 and 33.16, Social Security Act,42 USC 1396a (a)(7), the New York Public Health Law Article 27–F, the Family Educational Rights and Privacy Act (FERPA) 34 CFR Part 99 as well as the regulation of Central Medicaid Services and all governing New York State regulatory bodies. All members and candidates have a right to confidentiality with regard to all protected health information (PHI) shared with and obtained by the care management provider as defined by Federal and State confidentiality laws. Sharing of PHI without appropriate authorization is prohibited.

Procedure:

1. Per the New York State Department of Health (NYS DOH):
    a. Health Homes are required by law to report any PHI breach as per the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414 which can be accessed on the US Department of Health Human Services website at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html
    b. Additionally, as per the Data Use Agreement (DUA), Health Homes are required to report any PHI breach involving a Health Home member that occurs within the Health Home or its network providers to the NYSDOH Privacy Office at: medicaid.data.exchange@health.ny.gov
    c. For more information about the Breach Notification 45 CFR §§ 164.400-414, refer to the US Department of Health and Human Services website at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html
    d. For information related to HIPAA Privacy Rules, refer to The Office of Civil Rights at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

2. All member charts, records, and information must be securely stored and safeguarded. Care management staff are responsible for upholding the following expectations as well as all HIPAA policies:
    a. Care management staff are not to share their care management platform login information with any other person or allow any other person to document, view, or alter information in the care management platform under an account other than their own.
    b. Secure electronic record systems and protect against unpermitted sharing of patient information (e.g., verify that computer monitors are not in plain view of officemates or visitors, that screens/computers are locked when the staff is not at their station or device).
    c. Secure portable electronic devices (smart phones, cell phones, tablets, laptops, etc.) with a personal passcode that is not shared with any other person.
    d. Ensure that patient identifying information is stored in a secure, encrypted fashion (e.g., do not save Word documents containing PHI on a desktop or in a file that is not password protected).
    e. Secure any printed materials so that PHI is not at risk of public view or dissemination (e.g., do not take PHI documents from the office unless required in the course of care management, de-identify documents where possible, and maintain safeguards to protect all confidential information from public view).

3. Each member and candidate must be provided access to the BHH Bill of Rights Policy.

4. Members and candidates have the right to a full review and explanation of BHH's confidentiality policies.

5. Care managers should be trained on mandated reporting requirements and regulations as they relate to reportable events.

6. Member/candidate information should only be shared when the consent form is in place and as clinically appropriate to coordinate care and/or execute care plan activities.

7. Member records and PHI should only be accessed as needed to coordinate care, conduct quality assurance/utilization reviews, or for other clinical purposes.

8. If a breach of confidentiality occurs, please refer to Brooklyn Health Home Compliance Policy: Notification of Breach of Unsecured Protected Health Information. CMAs shall be required to report any suspected breach to BHH by filling out the BHH Form: Breach of Unsecured Protected Health Information (PHI).

Please Refer to Relevant Statutes:

- Federal regulations for Health Information Portability and Accountability Act (HIPAA) 42 CFR 431.302, 42 CFR Part 2
- Health Information Portability and Accountability Act (HIPAA) 45 CFR Parts 160, 162 and 164
- Privacy and security of personally identifiable information 45 CFR 155.260
- New York State Social Services Law Section 369 (4), Section 367b (4)
- New York Mental Hygiene Law Section 33.13 and 33.16
- Social Security Act,42 USC 1396a (a)(7)
- New York Public Health Law Article 27–F
- Family Educational Rights and Privacy Act (FERPA) 34 CFR Part 99

Reference:
NYS DOH Health Homes Provider Manual, *(See Appendix)*

BHH Policy No. 2.02: Health Home Patient Information Sharing Consent (DOH-5055)

Effective Date: 01/31/2013
Last Review Date: 6/29/2021

Policy: CMAs are responsible for obtaining and updating all needed authorizations permitting the sharing of protected health information (PHI) for the purpose of coordinating care goals for all members. Health Home enrollment requires the completion of the DOH-5055 Health Home Consent Form.

Procedure:

1. Upon intake and enrollment into the Brooklyn Health Home (BHH), each member must be guided through completion of the DOH-5055 Health Home Patient Information Sharing Consent form.
    a. Staff are responsible for using the most current copy of the BHH DOH-5055 consent form. Members do not need to be re-consented with the 5055 each time the form is updated by BHH unless specifically directed to do so.
    b. All mandatory areas of the consent must be completed:
        - Page 1: Ensure that there is a mark in the box indicating that the patient agrees to join BHH. Patient name, date of birth; patient signature and date of signature; where applicable, printed name of legal representative/representative to patient must also be completed.
        - Page 3+: must include all care team members that the member agrees to include in care plan activities and referenced throughout the comprehensive assessment (including the Managed Care Organization, wellness activity groups/providers, special needs services including justice providers, rehab providers; any family members or other social supports identified by the member). Every consented individual and entity on page 3 must be initialed and dated by the member.
        - Per the NYS DOH, "…the DOH-5055 must remain up to date to reflect any change in service providers. If Health Home service providers have changed, Health Homes/care managers must add or delete provider names on page 3 of the DOH 5055 form. The revisions must be initialed and dated by the Health Home/care manager and the Health Home member."
            - BHH strongly recommends annual review of any changes to providers in conjunction with the annual comprehensive assessment. Reviews should be documented in the care management platform and the 5055 should be updated accordingly.

2. Per the New York State Department of Health (DOH):
   By completing the DOH-5055 consent form, a member is agreeing to allow their health information to be shared among the consented Health Home partners and for the Designated Health Home to access the RHIO and PSYCKES and any other defined system for information.

   When completing any form with an individual/member, the care manager should:
   Give consideration to the member's level of understanding and comfort. Legal representation (e.g., guardian) should be involved as appropriate;
    a. Use the form in the language most suitable for the member. If the form is not available in the individual's chosen language, ensure the presence of an interpreter;
    b. Complete all sections of the form as indicated, using full name of Health Home, other entities, phone numbers, etc.;
    c. Review the completed form in full with member and confirm understanding prior to signing;
    d. Provide a copy of the completed and signed form to the member; and,
    e. Maintain the original signed form in the member's record.

A Health Home member may request to add/remove and/or limit access to information at any time. The care manager must ensure that:

a. Any changes or limitations specified by the member are clearly noted in the DOH-5055;
b. Page 3 should be completed in the same format to avoid confusion;
c. Each change is initialed and dated by the member and care manager.

3. Members should be offered and provided with a copy of the consent form upon completion/update and informed of their ability to modify and update the consent as needed.

4. In addition to storing an original copy in the member record, a copy of the completed consent form must be uploaded to the care management platform within 10 days of completion/update.

5. Care management staff are responsible for documenting enrollments that did not occur as a result of refusal to sign the consent form. CMs should confer with immediate supervisor upon member's refusal to sign the consent form for support and guidance.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
(See Appendix)

BHH Policy No. 2.03: Provider Two-Way Consents

Effective Date: 01/31/2015
Last Review Date: 6/29/2021

Policy: CMAs may share PHI in the presence of a two-way consent provided by another provider, or one obtained by the care management agency.

Procedure:

1. Providers not delivering care management services (e.g., physicians, counselors, clinics, hospitals, shelters, correctional institutions, facility social workers, etc.) may require completion of their agency consent forms as a precursor to sharing PHI. These providers are responsible for obtaining their own internal consents and may share those completed forms with the CMA to facilitate information sharing.

2. If a provider requests that a care manager obtains a provider-specific two-way consent form, care management staff must share the completed DOH-5055 with the provider and request that this consent form be used for the purposes of information sharing. If the provider insists upon using their own agency consent (or if the provider has not yet been added to the DOH-5055), the CMA must evaluate the request with the member, and if member agrees, support the completion of the form as needed.

3. If a provider submits a completed two-way consent form in the process of requesting an exchange of PHI, the CMA is responsible for carefully reviewing the document to identify the level of information sharing allowed. If possible, contact should be made with the member to verify their willingness to include the provider in care planning activities.
    a. CMAs must take steps to add the provider to the member's DOH 5055 Patient Information Sharing Consent form (page 3) once the member has expressed permission to include the provider in care team activities.

4. If the two-way consent form appears to meet HIPAA standards, information may be shared as outlined within the parameters of the supplied consent form. A copy of the consent should be stored in the member record.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
(See Appendix)

BHH Policy No. 2.04: Opt-Out Process

Effective Date: 08/25/2015
Last Review Date: 6/3/2021

Policy: Health Home candidates have the right to refuse or "opt-out" of Health Home services during a period of outreach and engagement.

Procedure:

1. Any engaged member who expresses a desire to refuse or "opt-out" during outreach and engagement must be offered the DOH-5059 Health Homes Opt-Out form
   a. The DOH-5059 must be completed by the member (or person acting on behalf of the member), the care manager, and must include the reason for opting out
   b. The member must be informed of the right to reconsider enrollment in the Health Home program, and be provided with instructions on how to request re-enrollment.
   c. A copy of the completed and signed DOH-5059 must be provided to the member upon request (mail, in person, etc.). An e-copy of the form should also be uploaded into the member's record in the care management platform.
   d. The CMA must document the engagement efforts and reason for the opt-out in the care management platform encounter note. If an outreach segment exists, the segment should be closed with the appropriate opt-out end date reason code.

   Note: The DOH-5059 is only used for individuals who have not completed enrollment (completion of the DOH-5055) into the Health Home. The Health Home Opt-Out form is not used if:
   a. The individual has enrolled in the Health Home program and has signed the DOH-5055 consent. In this case, the DOH-5058 withdrawal form must be used to withdraw the member's enrollment and end all information sharing previously approved by the member in the DOH-5055.
   b. The enrolled member requests transfer to another Health Home.

3. If a candidate expresses desire to opt-out, but is unable or refuses to complete the DOH-5059 form, staff should initiate the form and write "client refused signature" on the client signature line, retain a copy of the form, upload it to the care management platform, and document the refusal in a case closure note. A copy of the form should be provided to the client (e.g., by mail or in person) unless the client has stated that no further contact from the Health Home is warranted or wanted.

4. Supervisory review is a strongly recommended component of the opt-out process and supervisors should, whenever possible, attempt contact with the member within 1 week of the opt-out in order to verify the decision and provide information regarding future health home enrollment.

5. Per the New York State Department of Health (DOH):
   When completing any form with an individual/member, the care manager should:
   a. Give consideration to the member's level of understanding and comfort. Legal representation (e.g., guardian) must be involved as appropriate
   b. Use the form in the language most suitable for the member. If the form is not available in the individual's chosen language, ensure the presence of an interpreter
   c. Complete all sections of the form as indicated, using full name of Health Home, other entities, phone numbers, etc.
   d. Review the completed form in full with member and assure understanding prior to signing
   e. Provide a copy of the completed, dated and signed form to the member
   f. Maintain the original signed form in the member's record

Reference: NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
(See Appendix)

BHH Policy No. 2.05: Withdrawal of Consent (DOH-5058)

Effective Date: 08/26/2015
Last Review Date: 6/7/2021

Policy: CMAs are responsible for upholding a member's request to withdraw consent to communicate with providers, and should make every reasonable effort to obtain a completed DOH-5058 form to initiate and withdraw such consent for communication.

Procedure:

1. Upon a member's request to withdraw consent, CMAs must request completion of the DOH-5058 Withdrawal of Consent form. The DOH-5058 is only used for members who have already completed a DOH-5055 Patient Information Sharing Consent form (please see "Opt Out" policy for candidates that are in outreach status and wish to opt out of the program).

2. Information sharing and access to PHI must cease at the time of disenrollment. When possible, as part of the disenrollment process but before consent is withdrawn, staff must notify the care team of the member's withdrawal from the Health Home program and the effective date by which to end information sharing.

3. If a candidate expresses desire to withdraw consent, but is unable or refuses to complete the DOH-5058 form, staff should initiate the form and write "client refused signature" on the client signature line, retain a copy of the form in the care management platform, and document the refusal in the corresponding case closure note. A copy of the form should be provided to the client (e.g., by mail or in person). The enrollment segment should be closed with the appropriate end date reason code.

4. When closing the member's record, the CMA should provide member with contact information if the member chooses to re-enroll and additional resources to support the member in the community.

5. Per the New York State Department of Health (DOH):
   When completing any form with an individual/member, the care manager should:
   a. Give consideration to the member's level of understanding and comfort. Legal representation (e.g., guardian) must be involved as appropriate;
   b. Use the form in the language most suitable for the member. If the form is not available in the individual's chosen language, ensure the presence of an interpreter;
   c. Complete all sections of the form as indicated, using full name of Health Home, other entities, phone numbers, etc.;
   d. Review the completed form in full with member and assure understanding prior to signing;
   e. Provide a copy of the completed and signed form to the member; and,
   f. Maintain the original signed form in the member's record.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
(See Appendix)

BHH Policy No. 2.06: Health Home Notices of Determination and Fair Hearing Process

Effective Date: 12/01/2017
Last Review Date: 6/7/2021

Policy: CMAs must abide by DOH Policy HH0004, "Health Home Notices of Determination and Fair Hearing Policy."

Procedure:

1. BHH delegates the responsibility of providing Notices of Determination to the CMAs.

2. Notices of determination are required when members:

   - are enrolled in the health home program. Form DOH 5234: Notice of Determination for Enrollment
   - are denied enrollment in the health home program (the notice must include the reason for denial of enrollment) Form DOH 5236: Notice of Determination for Denial of Enrollment
   - are disenrolled from the health home program (this notice must be sent at least 10 days prior to BHH taking any action to end the member's enrollment segment). Form DOH 5235: Notice of Determination of Disenrollment

3. CMAs must immediately notify BHH upon enrollment, denial of enrollment or disenrollment of a member from BHH.

4. BHH will issue an adequate notice of decision to accept or deny an application for enrollment, and issue a timely and adequate notice of a disenrollment.

5. BHH will hold an informal Agency Conference with the member and their representative upon request of the member.

6. Notices may be provided by mail or in person, and may be included in a welcome packet.

7. The DOH forms must be used without modification.

8. BHH is available to support CMAs in the event of a fair hearing regarding one of the determinations outlined above.

9. CMAs must ensure that there is well documented evidence to support enrollment/disenrollment determinations when a Fair Hearing is scheduled, including, but not limited to: the signed DOH-5055 consent form; the updated Plan of Care; care record notes, medical documentation, as well as a written summary of the case; the applicable program policy upon which the decision is based; and a copy of the notice sent to the member. BHH requires that the additional supporting documentation requested be sent within a reasonable timeframe prior to the fair hearing.

10. Where necessary, BHH will attend the Fair Hearing, be familiar with the case, and have the authority to make binding decisions at the hearing including the authority to withdraw the decision.

11. CMAs must provide a copy of the evidence packet to the member or their legally authorized representative and provide copies of other documents from the member's case file upon request from the member or their legally authorized representative within 10 business days of receiving a Fair Hearing Notice. Additional supporting documentation requested should be sent within a reasonable timeframe prior to the Fair Hearing.

12. Notices of determination must be uploaded to the care management platform. CMAs must comply with the Decision after Fair Hearing as to enrollment or continued enrollment in the NYS Health Home Program.

13. Per the New York State Department of Health (DOH):
    When completing any form with an individual/member, the care manager should:
    a. Give consideration to the member's level of understanding and comfort. Legal representation (e.g., guardian) must be involved as appropriate;
    b. Use the form in the language most suitable for the member. If the form is not available in the individual's chosen language, ensure the presence of an interpreter;
    c. Complete all sections of the form as indicated, using full name of Health Home, other entities, phone numbers, etc.;
    d. Review the completed form in full with member and assure understanding prior to signing;
    e. Provide a copy of the completed and signed form to the member; and,
    f. Maintain the original signed form in the member's record.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0004, Health Home Notices of Determination and Fair Hearing Policy *(See Appendix)*

BHH Policy No. 2.07: Bill of Rights
Effective Date: 01/31/2013
Last Review Date: 5/27/2021

Policy: CMAs must inform members of their rights and responsibilities as participants of health home services.

Procedure:

1. CMAs must inform members of their rights and responsibilities as participants of health home services upon enrollment in written and oral form, and must share information regarding the grievance process for services rendered under BHH. CMAs must assist the member in reviewing and signing receipt of the Bill of Rights, and ensure the member is provided with a copy of the document.

2. The signed and dated copy of the Bill of Rights must be stored in the member's record and produced upon request by the member, BHH, or other regulatory agency.

3. If a member refuses to sign the Bill of Rights, CMAs must complete the Bill of Rights form by printing the member's name and date of review, and must write: "Client refused signature" on the signature line. A copy must still be offered to the member and stored in the member's record. Refusal to sign the document should be reviewed with a supervisor. CMAs should attempt to address all barriers to signing due to language or comprehension.

4. The blank Bill of Rights document may be shared with any requesting party by email, mail, or drop-off.

BHH Policy No. 2.08: Reportable Incidents

Effective Date: 1/31/2013
Last Review Date: 7/15/2021

Policy: Reportable incidents are those involving the member which have, or may have, an adverse effect on the life, health, or welfare of the member. BHH and its CMAs must monitor and collectively resolve incidents in order to secure the ongoing health, safety, and welfare of the member involved in the incident as well as for all members.

Procedure:

1. The New York State Department of Health has defined the following reportable incidents:
    a. Allegation of abuse, including:
        - Physical abuse
        - Psychological abuse
        - Sexual abuse/sexual contact
        - Neglect
        - Misappropriation of member funds
    b. Suicide attempt
    c. Death
        - Resulting from a suicide, homicide, or unexplained or accidental cause
        - Not related to the member's illness or disease
    d. Crime Level 1
        a. Arrests for a crime committed against persons (murder, rape, assault) ***or***
        b. Arrests for a crime committed against property (arson, robbery, burglary), ***and***
        c. Perceived to be a significant danger/concern to the community
        e. Missing person
            - Considered missing ***and*** a Law Enforcement Agency report was filed and issued
    f. Violation of protected health information (PHI)

2. CMAs must have a mechanism in place to recognize incidents as soon as possible and to inform supervisor, quality and compliance staff, and other leadership as per each CMAs internal reporting structure. This mechanism may include training all staff on the incident reporting policy and reportable incidents, and implementing an escalation policy to report all incidents to supervisory staff immediately upon discovery.

3. The DOH "Health Home Incident Reporting Form" must be completed in full and submitted to Brooklyn Health Home via secure messaging in GSI within 1 business day of discovering the occurrence of the incident.

4. The report should include:
    a. All known facts and circumstances of the incident
    b. Enrollment date
    c. Date and type of last contact
    d. Member's current location, if known

5. Upon receiving an incident report, BHH will:
    a. Review the report and ensure that it is complete
    b. Determine if the incident meets criteria for a reportable incident
    c. Submit the incident report to DOH within 1 business day of receipt
    d. Conduct a comprehensive chart review focused on the most recent comprehensive assessment, care plan, progress notes, and the prior 12 months of critical events, transfers and/or discharges
    e. Depending on the results of the chart review, BHH will follow up with the CMA, either with an email response for incidents that do not require further review, or to schedule a case conference for incidents that warrant additional follow up

6. The CMA must participate with BHH requests and requirements regarding the completion of chart reviews, case conferencing, and the provision of needed documentation.

7. Findings as a result of incidents may result in education, training, corrective action plans, or other remedies.

8. In accordance with DOH quarterly reporting requirements, BHH will analyze trends in incident occurrence and reporting and provide feedback and training to CMAs in response.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0005, Health Home Monitoring: Reportable Incidents Policies and Procedures *(See Appendix)*

BHH Policy No. 2.09: Information Sharing with Managed Care Organizations (MCOs)

Effective Date: 08/26/2015
Last Review Date: 07/01/2021

Policy: Care managers should utilize the support of Managed Care Organizations in establishing and coordinating care for all members.

Procedure:

1. As per the New York State Department of Health (DOH):
    a. In accordance with the Medicaid Managed Care contract, Section 20.3, medical records, which include protected health information, of an enrollee shall be confidential and shall only be disclosed to and by other persons within the MCO's organization, including Participating Providers such as contracted Health Homes and their downstream providers, only as necessary to provide medical care, which includes the provision of care coordination.

    b. The Department of Health has determined that in accordance with the Medicaid Managed Care Contract and all Federal and State laws and regulations regarding confidentiality that absent a specific consent from the enrollee, a MCO may share with a contracted Health Home (to which the enrollee has not yet signed a Health Home consent) the last 5 claims or encounter data (defined as: The last 5 claims are based on service date, and must fall within the criteria for Loyalty which is inpatient, primary care, ER, and case management.), as well as two years of loyalty analysis showing the Enrollee's provider history for the purpose of outreach and engagement of the Enrollee within a Health Home network.

    c. Nevertheless, if a MCO and a Health Home have a contract in place with a Business Associate Agreement (BAA), then a member Health Home consent is not required to share information beyond the 5 encounters and loyalty analysis between the MCO, the Health Home and their downstream providers, and the MCO's network providers because the Health Home is acting on behalf of the MCO and the member has signed a consent with the MCO when they enrolled. For instance, it would be permissible for the Health Home or their downstream providers to contact one of the MCO providers identified in the last 5 encounters, as long as he or she is a network provider, to get more information about the member. The disclosure of information should be limited to that which is a minimum necessary to provide medical care.

    Note: It is always up to a MCO or other provider's legal counsel to determine if it is appropriate to share protected health information (PHI) which is in their possession. If it is Medicaid data provided by the Department, then it is up to the Department whether disclosure is appropriate.

2. The Brooklyn Health Home requests that CMAs seeking information from a MCO during a candidate's outreach phase directs the contact request to the Health Home (unless that CMA has a direct BAA/DEAA allowing for exchange of information in place). The Health Home will attempt to contact contracted MCO plans, and will deliver any received information to the care management provider through secure messaging.

3. CMAs must pursue consent by including the managed care plan on the member's DOH-5055 (and 5055 updates/addendums)

4. CMAs should attempt to establish relationships with the managed care partner to include this entity as part of the care team (ensuring that critical event follow up, care transitions, and case conferences are conducted as needed to include the plan in the member's care status)

5. Service referrals should be coordinated with the plan to ensure that there are no coverage or network barriers that could delay or prevent access to needed services

6. Plan information should be verified regularly (at least every 90 days) through verification of eMedNY (ePACES) status. Changes in the member's MCO must be reflected in the consent (DOH-5055) and should be dated and initialed by both the member and care manager.

7. In the event that a member requests disenrollment and has withdrawn consent verbally, or through the completion of the DOH-5058, all HH partners and other entities approved in the DOH-5055, including the MCO, must be notified of the disenrollment and effective date to cease all access to/sharing of further PHI.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
(See Appendix)

BHH Policy No. 3.01: Health Home Eligibility Determination
Effective Date: 01/31/2015
Last Review Date: 01/31/2017

Policy: CMAs are responsible for ensuring that all outreach members are appropriate for Health Home enrollment *prior to* enrollment in care management services. Health Home eligibility must be reviewed throughout the member's enrollment as care plan goals are successfully achieved, and Medicaid eligibility should be checked monthly. Eligibility is comprised of three categories: Medicaid status, diagnosis, and appropriateness. Eligibility determinations must be conducted for all members, regardless of referral source, and must uphold the Health Home eligibility criteria outlined by the New York State Department of Health as documented herein:

Procedure:
Determining Eligibility for Health Home Services

1. Determine Medicaid eligibility. Medicaid reimbursement for Health Home services can only be provided to individuals who are enrolled in Medicaid. It is up to the provider to not only verify eligibility but to assure each that Medicaid is active and without any restriction/exception codes that are incompatible with health home. The care manager should assist the member in maintaining active Medicaid coverage as long as they are eligible.

2. New York State's Health Home diagnostic eligibility definition is as follows:
   a. Two (2) or more chronic conditions; or
   b. One (1) single qualifying condition: HIV/AIDS or a Serious Mental Illness (SMI)

   Note: Qualifying chronic conditions are listed here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_chronic_condition_update_dd_conditions.pdf

3. Determine appropriateness for Health Home services. Individuals who are Medicaid eligible and have active Medicaid and meet diagnostic eligibility criteria are not necessarily appropriate for Health Home care management. An individual can have two chronic conditions and be managing their own care effectively. An individual must be assessed and found to have significant behavioral, medical, or social risk factors to deem them appropriate for Health Home services. Determinants of medical, behavioral, and/or social risk can include:
   a. Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission);
   b. Lack of or inadequate social/family/housing support;
   c. Lack of or inadequate connectivity with healthcare system;
   d. Non-adherence to treatments or medication(s) or difficulty managing medications;
   e. Recent release from incarceration or psychiatric hospitalization;
   f. Deficits in activities of daily living such as dressing or eating;
   g. Learning or cognition issues

4. Clinical data should be used to verify medical and psychiatric diagnoses and supporting documentation should be uploaded to the care management platform. BHH recommends considering the following resources to obtain a member's diagnostic status (consent will be required for all providers, and should be offered to the provider upon presentation of the information sharing request):
   a. Managed Care Plans
   b. Emergency Rooms, Emergency Departments
   c. Outpatient providers
   d. MAPP, PSYCKES, HRA, or any other database system that can be legitimately accessed to obtain diagnostic information
   e. Inpatient units, residential treatment providers

f. Pharmacy providers

5. If an individual is determined not to meet diagnostic and risk eligibility criteria, outreach should cease or the member should be disenrolled from the Health Home and the care manager should make a referral to a more appropriate level of care. When an enrolled member achieves their goals and no longer meets appropriateness criteria (as determined by the care manager, supervisor, member, and care team), the case closure process should be followed.

6. CMAs have 2 months from the date of enrollment (completion of the DOH-5055) to obtain diagnostic verification by way of clinical documentation as outlined in item 4 of this policy.

Reference:
NYS DOH, Eligibility Requirements: Identifying Potential Members for Health Home Services *(See Appendix)*

BHH Policy No. 3.02: Health Home Assignments and Referrals

Effective Date: 01/31/2013
Last Review Date: 05/25/2021

Policy: BHH will assign or refer Health Home eligible candidates according to NYS DOH and Health Home regulations and guidelines, as well as CMA capacity and standing.

Procedure:

1. BHH may receive referrals of potential HH members from NYSDOH and/or MCOs. *(MCO referrals are further described in policy 3.03)*

2. BHH will regularly survey organizations to assess capacity to engage members for care management services. CMAs are required to identify their capacity to accept new referrals. Capacity is assessed overall as well as at the population level, e.g., HARP, HH+, etc.

3. BHH staff will review each organization's request based on feasibility and availability of staff for assignment, and performance and adherence to BHH policies.

4. BHH staff will review the assignments and referrals for initial eligibility of the assigned candidates prior to CMA distribution. Eligible cases will be loaded into the Care Management Platform and prepared for assignment to the eligible CMAs.

5. BHH will share cleared assignments with the CMA
    a. BHH will provide all data provided by NYS DOH and MCOs to CMAs (including, but not limited to the member's last 5 encounters, additional contact information, physician, and pharmacy data when available)
    b. Data are sent via secure messaging as part of the CMA's assignment list file

6. CMAs are required to confirm receipt of the assignment list and to ensure that all assigned members are reviewed for Medicaid standing and Health Home compatibility prior to engagement (e.g., review of the PSYCKES, ePACES, and/or MAPP portals).

7. CMAs must notify BHH of any inability to serve assigned members as soon as knowledge of this inability becomes known. CMAs should notify BHH via email to the referring BHH staff if unable to take an assignment. BHH reserves the right to re-assign any unserved members to another CMA if capacity exists in order to expedite the provision of care and support to health home candidates.

8. For members that are directly enrolled by MCO and/or referred to the Health Home for engagement, CMAs are required to initiate follow-up within two business days. If CMA follow-up within two business days is not possible, the CMA must notify BHH immediately.

9. If a CMA accepts assignments and does not identify any barriers to initiating outreach services, BHH reserves the right to reassign.

10. BHH will monitor each organization's enrollment and retention rate.

11. BHH reserves the right to withhold assignments/referrals from CMAs experiencing performance issues related to response time, enrollment rates, retention rates, or quality of care.

BHH Policy No. 3.03: Managed Care Referrals

Effective Date: 09/10/2015
Last Review Date: 05/25/2021

Policy: Direct referrals from MCOs must be prioritized and responded to with efficiency and with adherence to all Health Home policies and procedures and MCO guidelines.

Procedure:

1. BHH may receive referrals of potential HH members from MCOs.

2. If the CMA is unable to accept an MCO referral for any reason, the CMA must report to BHH within one day of the referral attempt to request reassignment to another CMA. CMAs are expected to be able to initiate member outreach within two business days of the referral.

3. In the instance of an active hospitalization or inpatient stay, the CMA must make efforts to outreach the member within two business days to enroll the member.

4. CMA must comply with MCO and BHH requests to provide updates, share information, and collaborate on referrals.

5. Staff are encouraged to conduct a care conference with the MCO to identify:
   a. The reason for the referral
   b. The presence of any selected providers (e.g., primary care, specialty care, pharmacy, behavioral health)
   c. Any special requests/needs (e.g., language, safety concerns, etc.)

BHH Policy No. 3.04: Community-Based Referrals

Effective Date: 01/31/2013
Last Review Date: 5/10/2021

Policy: Care management personnel are encouraged to screen Health Home candidates through community connections for referral to the Health Home. All community-based referrals (CBRs) must be appropriately screened, evaluated, and processed with the Health Home's oversight.

Procedure:

1. The care management agency is responsible for obtaining a completed DOH-5055 Health Home Patient Information Sharing Consent form for each candidate

2. Once a candidate has been identified by the CMA, the CMA must communicate the following candidate information to the appropriate BHH personnel for approval
   a. Medicaid Identification Number (Required)
   b. Date of Birth
   c. Completed BHH Referral Form

   Note: If the CMA has the ability to verify eligibility (e.g., verify that the member is not currently assigned or enrolled to another Health Home via MAPP lookup) independently, that CMA may omit steps 2 – 3 from this policy.

3. All referral information must be submitted to BHH securely, either through secure fax or email.

4. It is strongly recommended that CMAs obtain enrollment approval from BHH personnel prior to entering the candidate into the care management platform, in order to avoid tracking and billing errors. Once BHH approval has been received, the CMA must complete the following steps:
   a. Enter the candidate into the care management platform within 3 business days of approval. If an error message is received stating the candidate already has a record in the care management platform, the CMA should reach out to the appropriate BHH staff for assistance in transferring the record to their agency.
   b. Follow all intake, documentation, and care planning policies as outlined by BHH.

   c. Record an intake contact note which summarizes the origin of the referral, the qualifying conditions of the candidate and known need areas.
   d. Ensure that all known providers are included in the DOH-5055 consent form and recorded within the care management platform care team within 7 days of approval/intake.

5. CMAs are responsible for obtaining, recording, and filing all needed documentation verifying member eligibility and appropriateness as outlined by the New York State Department of Health, prior to moving a candidate from outreach to enrollment within the care management platform or other reporting systems.

6. BHH Management will review each organization's performance and adherence to BHH policies. BHH retains the right to suspend upward enrollments based on these factors.

Reference:
NYS DOH Health Homes Provider Manual, 3.3 – Referrals *(See Appendix)*

BHH Policy No. 4.01: Health Information Technology (HIT) Overview

Effective Date:
Last Review Date: 7/20/2021

Policy: Use of the BHH care management platform is central to the Health Home model and to ensuring communication between providers. HIT is one of the core Health Home services and all CMAs are required to use BHH's care management platform to document care management activities.

Procedure:

1. BHH's care management platform provides an integrated suite of clinical care coordination, reporting, and billing applications delivered as Software-as-a-Service (SaaS) over secure internet connections. The platform is delivered securely across the internet, requiring minimal set up. The care management platform is provided to CMAs within the BHH network and must be used to document all BHH outreach and care management service delivery activities.

2. The system provides functionality for patient demographics, enrollment, consent, care team assignment, care plan including needs with goals and tasks, encounter notes, and assessments, alerts, tracking and billing, and reports to facilitate caseload management.

3. BHH's care management platform connects with the Regional Health Information Organization (RHIO) Healthix and through it to the Statewide Health Information Network for New York (SHIN-NY). This electronic event-driven Health Information Exchange (HIE) enables the upload to Healthix of BHH member demographics, enrollment, and consent information, and the download to and use within the care management platform of Healthix/SHIN-NY Clinical Event Notifications.

4. All care management documentation must take place in BHH's care management platform. Each CMA must have a designated administrative lead responsible for maintaining an updated user list and ensure that new staff receive training on how to document in and fully utilize the platform according to the staff member's user role. The administrative lead must also inactivate staff accounts upon staff separation and notify BHH when separations occur. The care management platform must contain all user information entered into the user profile.

5. Per the DUA, each CMA must maintain a list of authenticated users who have access to the care management platform and report this list quarterly to BHH.

6. Each CMA must ensure that care management staff are utilizing the care management platform as required, monitoring staff performance using available reports.

7. Each CMA must ensure that consents are in place to receive RHIO alerts.

8. System access is web-based and each user is responsible for ensuring that they are using the system on a secure device. Users are discouraged from using the "save password" feature on their devices as this may diminish the ability to keep passwords secure.

9. The care management platform will use multi-factor authentication to verify a user's account and allow access. Users must have access to an authentication method such as an authenticator application, text messaging, and/or email in addition to their user log-in credentials in order to access the care management platform.

Reference:
NYS DOH Health Homes Provider Manual, 7.3 – Single Care Management Record *(See Appendix)*

BHH Policy No. 4.02: Care Management Platform Utilization

Effective Date: 01/31/2013
Last Review Date: 07/13/2021

Policy: CMAs are responsible for maintaining current, accurate documentation in all member charts in the BHH care management platform.

Procedure:

1. As per the New York State Department of Health:
   Health Homes are responsible for assuring there is a single care management record that can be used and shared with members of the interdisciplinary team. Care collaboration and coordination will be supported by case reviews conducted on a regular basis and attended by all members of the interdisciplinary team as appropriate. The care manager will be responsible for overall management and coordination of the member care plan which will include medical, behavioral health and social service needs. The goal is to have the care management record available electronically at every point of care.

2. All CMAs contracted with BHH are required to fully adopt and implement the care management platform selected by BHH as the primary means for care management documentation.

3. All BHH CMA staff must be trained on the care management platform and are required to participate in ongoing trainings regarding updates and changes to the system.

4. All care management activities must be documented in the care management platform within 48 hours of the encounter.

5. CMA staff must refer and adhere to the policies and timeframes associated with documentation protocols.

6. Use of the New York State Medicaid Analytics Performance Portal (MAPP) does not replace the policy set forth requiring the utilization of BHH's care management platform as the primary mode of documentation. Documentation and utilization expectations for MAPP will be outlined in policy specific to that system.

7. All information recorded in the care management platform is protected health information (PHI) and must be treated as such.

8. CMA staff are not allowed to share their care management platform log-in credentials with any other person.

9. CMA staff are not to access or utilize the care management platform under any other user profile than their own.

10. CMA staff are responsible for entering and updating their user profile, including phone number, to ensure that reliable contact information is on record and accessible by care team members and BHH staff.

11. CMA staff are responsible for logging into the system daily to review and manage any clinical event notifications and utilize reports that are contained within the system.

12. Any technical issues or data-related errors that appear in the care management platform must always be communicated to the vendor in a timely manner, and if appropriate escalated to the BHH Product Manager or other BHH Staff.

13. CMAs are responsible for ensuring that all related documentation and signed documents relevant to the candidate/member's care are included and/or uploaded to the care management platform.

BHH Policy No. 4.03: Medicaid Analytics Performance Portal (MAPP)

Effective Date: 09/04/2015
Last Review Date: 01/31/2017

Policy: The Medicaid Analytics Performance Portal (MAPP) is a performance management system that will provide tools to the Health Home network to support providing care management for the Health Home population (NYS DOH). BHH expects each CMA to have at least one registered/active user to retrieve information needed to coordinate care management activities.

Procedure:

1. BHH's care management platform will remain the primary platform for all BHH documentation and data entry for all BHH serving care management staff, with MAPP serving as a supplementary platform used for the purpose of obtaining updated candidate/member information, assessing Health Home eligibility, and a means of reporting enrollment and billing to NYS agencies and MCOs.

2. Data entry in MAPP will be facilitated by BHH through its care management platform. CMAs are not to enter data directly into MAPP. Issues of unsynced patient records or MAPP errors should be reported to BHH for correction.

3. BHH expects that each CMA have at least one person responsible for accessing the information in MAPP. Examples of information that may be accessed in MAPP are:

a. Acuity scores
b. Diagnostic information
c. Medication information
d. Provider utilization information
e. Health Home affiliation including enrollment and assignment data
f. Contact information

4. CMA staff designated as "Health Home Workers" in the MAPP system must complete all New York State Department of Health mandated trainings prior to utilizing the system and complete any on-going training required to maintain access.

5. Use of the MAPP system is subject to all confidentiality laws, rules and regulations as established by the Federal and State government, and those policies and procedures of the BHH.

6. Use of the MAPP system and/or documentation in the MAPP system does not remove or alleviate the CMA's primary responsibility to record all activities within the care management platform.

BHH Policy No. 5.01: Outreach Methodology and Standards

Effective Date: 01/31/2013
Last Review Date: 05/24/2021

Policy: BHH requires that all outreach services are delivered in accordance with NYS DOH standards; providing all candidates with "progressive and meaningful" outreach that will most likely to lead to engagement in enrolled services.

Procedure:

1. CMAs must attempt to engage and enroll candidates within two business days of assignment. CMAs must report any expected or actual delays to BHH immediately.

   Barriers to outreach, including a language need that cannot be accommodated by the assigned agency, a lack of a valid phone number and/or address on the assignment file, and/or situations where a candidate has been engaged in discussions but is undecided about joining health home should be communicated by the CMA to the HH. BHH may provide assistance as follows:
   a. Language barriers: transfer to another network CMA
   b. Lack of contact information: Outreach to the MCO (where one exists)
   c. Medicaid coverage restrictions: Outreach to the MCO (where one exists)

   Note: Identification of language barriers are trusted to be derived from actual engagement (telephonic, face-to-face) with a candidate and/or their family members. Requests to transfer candidates due to language barriers will not be honored without evidence of attempted outreach services.

2. Alerts or notifications of discharge from MCOs, shelters, jails or other community-based referrals may prompt outreach as long as: the candidate is clear of any other health home enrollment and has active Medicaid. Candidates referred via alert or notification are expected to be engaged in outreach services immediately upon confirmation from the CMA that capacity is available.

3. Acceptable methods of outreach for health home candidates include:
   a. Telephonic outreach to candidate, known contacts/providers
   b. Written outreach to candidate, known contacts/providers
   c. Home visits
   d. Provider office visits
   e. Request of information from emergency rooms, hospitals, morgue(s)
   f. Contact with MCO
   g. Surveillance of communities where the candidate is known to frequent (e.g., asking store employees, shelter staff, or others for information about the candidate's whereabouts)
   h. Review of internal EHRs or scheduling systems for upcoming appointments

4. Face-to-face outreach is considered the most intensive form of outreach and should be implemented to increase the likelihood of enrollment.

   a. Each candidate must receive an outreach letter as long as a mailing address is available. If one is not available, an outreach letter must be provided once the member has been located. Per NYS DOH, the "Letter of Introduction" must include contact information for BHH, the CMA, and the Medicaid Help Line in the event that a candidate has any concerns related to the outreach process.

5. Requests for assistance from BHH in contacting MCOs for additional information should be submitted to the health home or MCO securely, using a template containing member name, Medicaid identification number, MCO assignment, and the information being requested. If requesting a new phone or address, the CMA should indicate the provided phone/address information to avoid transmission of duplicative data.

6. The successful engagement of some candidates may qualify the CMA for an incentive payment from the candidate's MCO. Candidates referred through Engagement Optimization Incentive plans should employ all methods of outreach for health home candidates and document in accordance with processes set by BHH and the MCO.

Reference:
NYS DOH Health Homes Provider Manual, 9.2 – Record Keeping Requirements *(See Appendix)*

BHH Policy No. 5.02: Documentation of Outreach Services

Effective Date: 01/21/2015
Last Review Date: 05/27/2021

Policy: All outreach services must be recorded in the care management platform within two business days of delivery/attempt.

Procedure:

1. All outreach activities must be documented with a segment and encounters.

2. When creating or updating an outreach record in the care management platform, select the appropriate referral source on the patient record. BHH recommends CMAs assign the outreach record to the outreach worker or navigator for tracking and reporting purposes.

3. The first outreach note in each chart should indicate the origin of the referral of the case (e.g., Health Home assignment, community-based referral/location of that referral, etc.) and anything known about the candidate's eligibility or need at the time of referral.

4. Each outreach note must describe the method of outreach used and the outcome of the effort.
    a. Documentation of unsuccessful attempts should include next steps – either a further attempt at outreach or case closure
    b. Documentation of successful attempts not resulting in enrollment should detail the outcome of the interaction, whether outreach/engagement attempts will continue, and/or why enrollment did not occur
    c. Documentation of successful attempts resulting in enrollment should include a summary of the interaction and all relevant information known about the member at that time, which may include providers, diagnoses, needs, alternate methods of contact, emergency contact, upcoming appointments, etc.

5. Outreach segments that will be ended for any reason other than enrollment should have an appropriate end date reason code (e.g., inability to locate member, member opted out, member moved out of state, etc.) and an encounter note detailing the reason for the case closure.

BHH Policy No. 6.01: Core Service Delivery
Effective Date: 01/31/2019
Last Review Date: 07/01/2019

Policy: Billable activity must include the provision of at least one core service, as defined below.

Procedure:

1. **Comprehensive Care Management (CCM) this category should be utilized after someone is consented or to re-establish connection:**
    a. Conduct assessment: Includes the completion of any Health Home, State, or agency mandated assessment tools (comprehensive, PHQ, MMSI, etc.)
    b. Complete/revise care plan: Activities that result in the development or modification/update of a member's care plan. Changes must be reflected in the CCP in the care management platform
    c. Consult with multidisciplinary team on care plan: Must include the care manager and at least 1 member of the care team (e.g., primary care physician, psychiatrist, therapist, specialist) in conversation resulting in the completion or revision of a member's care plan
    d. Conduct outreach and engagement activities (members that have consent): Activities initiated by the care manager in efforts to locate and establish or re-establish connection to an enrolled member. These activities should only be used in instances where reasonable efforts to establish connection with a member have gone without positive results (e.g., diligent search; see continuity of care policy)
    e. Prepare client crisis intervention plan: Engaging in conversation and activities that result in the establishment, revision, review or reinforcement of a plan designed to aid a member in maintaining safety and stability in times of crisis, wherein crisis is defined as any situation that directly threatens the safety of the member and/or community

2. **Care Coordination and Health Promotion (CCHP):**
    a. Coordinate with providers (secure necessary care, share case information): Sharing case related information via the messaging application in the Care Management Platform or other forms of communication with involved treatment partners in an effort to ensure that all involved parties are in possession of the most current case information to accurately identify the appropriate level of care. Also, may include reviewing and establishing needed appointments and coordination with providers that results in the securing of needed services.
    b. Link/refer member to needed services: Identification and securing of services and resources designed to meet the goals and objectives of a member's care plan.
    c. Conduct case conference with team to monitor/evaluate member status: Participating in/facilitating discussions with treatment providers to discuss member status updates and review or develop approaches to care. In particular, these discussions should take place after a critical event such as emergency department admission, hospital admission or discharge. The results of the case conference should be documented in the care management platform and communicated to the entire care team.
    d. Advocate for/assist with scheduling of needed services: Providing advocacy that results in the removal of barriers preventing the member from securing needed services.
    e. Monitor/support/accompany to scheduled medical appointments: Providing accompaniment to an outpatient or social service appointment, and/or verifying attendance of needed appointments by speaking with both the member and the office of the provider to verify outcomes and action plans; providing assistance that results in the mitigation of barriers which have/could prevent the member from being able to receive needed care.

f. Crisis intervention, revise care plan/goals as required: Activities taken to intervene in an active crisis situation that may result in the receipt of additional services and activities which must be incorporated into the care plan.
g. Coordinate/provide access to medical services: Activities that result in the receipt of needed medical services (e.g., assistance in locating a needed provider, assisting with scheduling an appointment, securing transportation assistance).
h. Coordinate/provide access to mental health services: Activities that result in the receipt of needed mental health services (e.g., assistance in locating a needed provider, assisting with scheduling an appointment, securing transportation assistance).
i. Coordinate/provide access to substance abuse services: Activities that result in the receipt of needed substance use services (e.g., assistance in locating a needed provider, assisting with scheduling an appointment, securing transportation assistance).

3. Comprehensive Transitional Care from inpatient setting:

a. Follow up with hospital/ED upon notification of a client's admission and/or discharge to/from an ED, hospital/residential/rehabilitative setting: After a hospital admission the care manager will visit the member within 2 business days or immediately after learning of the member's admission. The care manager will also work collaboratively with the hospital/residential/rehabilitative staff to exchange information and develop an individualized discharge plan for the member.
b. Facilitate discharge planning to ensure a safe transition/discharge that ensures care needs are in place: Actively engage in the discharge planning process with appropriate personnel of the treating agency; ensure that needs are reflected in the care plan.
c. Notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation: Contacting affiliated treatment providers to provide notification of the admission, treatment, and discharge plans surrounding a hospitalization event; securing follow up visits with needed specialists and providers; ensure that medication reconciliation has taken place across all providers.
d. Link client with community supports to ensure needed services are provided: Includes referrals to social support entities such as housing agents, community support groups, and/or any other community-based support programs that will provide value to the member's recovery process.
e. Follow-up post discharge with member/family to ensure member's care plan needs/goals are met: Conducting a family meeting involving the member and their (consented) family members to review changes to the care plan resulting from the acute treatment episode, and discuss modifications needed to promote ongoing health and wellness.

4. Individual and Family Support:

a. Develop/review/revise the individual's care plan with client/family to ensure that the plan reflects individual's preferences: Engaging with (consented) family members to include them in care planning activities and/or updates.
b. Consult with client/family on advance directives; educate on client rights and health care issues: Exchanging information with (consented) family members about a member's rights and options advance care planning and advance directives.
c. Meet with client/family, inviting any other providers to facilitate needed interpretation services: Delivering or coordinating access to services that provide needed interpretation services for a member and/or their family in order to remove barriers to care.
d. Refer client/family to peer supports, support groups, social services, entitlement programs: Making direct referrals for services designed to provide social and/or financial support to the member's family.

e. Coordinate/provide access to chronic disease management, self-management support to individuals and their families: Providing the member and/or their family members with referrals to services and programs in the community designed to provide information and support for people living with chronic diseases/conditions.

5. **Referrals to Community and Social Supports (RCSS):**
   a. Identify resources and link client with community supports: Activities that result in the receipt of a referral to services designed to support and/or enhance the member's social/community support and engagement. Care plan need areas/goals should be supported by appropriate referrals to services designated to provide the member with the opportunity to achieve health and wellness goals.
   b. Collaborate/coordinate with community-based providers to support effective utilization of services based on client/family need: Assisting with the removal of barriers that impede the member's ability to receive needed social supports.

6. **Searching:** This category is utilized when conducting outreach for a member who is not yet consented.

7. **Non-billable**: This category is utilized when information other than a core deliverable is being recorded in a chart. Typical instances of use include situations where there is a one way sharing of information (e.g., a voicemail is received or a letter is returned to sender) Examples included but are not limited to:
   i. Information about the Medicaid or Health Home assignment status
   ii. Information about an alert that was received
   iii. Information detailing a message left by the member or a provider for the care management staff
   iv. A supervisory note/case review
   v. On-line research (that does not result in the provision of an appointment, referral, patient education resource, etc.)

Reference:

NYS DOH Health Homes Provider Manual, (4) Standards for the Provision of Care Management Services
NYS DOH Health Homes Provider Manual, ((9.1.1) HH Minimum Billing Standards
NYS DOH, Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations (January 2021) *(See Appendix)*

BHH Policy No. 6.02: Documentation of Enrollment Activities

Effective Date: 01/21/2015
Last Review Date: 04/27/2021

Policy: All attempted and delivered services for enrolled members must be documented in the care management platform within two business days of delivery/attempt.

Procedure:

1. Each new encounter should be linked to a Care Plan Goal and Task

2. The following information must be included in every encounter entry:
    a. Encounter Date
    b. Mode
    c. Encounter Target
    d. Description of encounter
    e. Core Service (if encounter was successful)

3. Each enrollment note should:
    a. Clearly and concisely describe the encounter, including the purpose, intervention, and next steps (if unsuccessful, the note should indicate the follow up plan)
    b. Indicate care plan issues, goals, or interventions that were addressed in the encounter
    c. Be written in complete sentences
    d. Avoid shorthand, abbreviations, and/or jargon
    e. Place any direct feedback from the member in quotations and clearly indicate that this is information reported by the member
    f. Be composed in a person-centered manner
    g. Demonstrate a progression of activities that reflects relevance to the previous contact(s)

BHH Policy No. 6.03: Care Teams

Effective Date: 08/26/2015
Last Review Date: 04/27/2021

Policy: Care management personnel are responsible for assisting each member in building, updating, and maintaining an interdisciplinary care team.

Procedure:

1. As per the NYS DOH:
   Health Homes are responsible for assuring that their members receive all medically necessary care, including primary, specialty and behavioral health care.
   The building of the care team begins at enrollment and continues throughout the duration of the member's enrollment. The purpose of building a care team is to ensure that all of the member's needs are appropriately met.

2. All care team members must be documented in the care management platform. Each care team must include a **Care Manager** and a **Supervisor**.

3. In addition to a Care Manager and Supervisor, care teams must include the other clinical and non-clinical supports working with the member. *At minimum,* each care team must have:
   a. Primary Care Physician (required)
   b. Behavioral health professional (if the member has a behavioral health condition)

   Other care team members might include, but may not be limited to:
   a. Substance use counselor
   b. Medical Specialists (e.g., pulmonology, OBGYN, cardiology, endocrinology, etc.)
   c. Vocational case manager(s)
   d. Social worker(s) (e.g., hospitals, inpatient units, correctional settings, etc.)
   e. HCBS / CORE providers
   f. Peer
   g. Justice system oversight (e.g., probation, parole, court advocate, attorney, etc.)
   h. Prescription management providers
   i. Managed Care Plan representation
   j. Family member(s), friend(s), other identified primary support(s)

3. Care team members (healthcare providers, non-healthcare providers, personal supports, etc.) must be documented on the Health Home Patient Information Sharing Consent Form (DOH-5055) with member's consent. (Please refer to the Health Home Patient Information Sharing Consent policy for further guidance)

4. If a member refuses referral to a needed service (e.g., psychiatry), the care management team must seek supervisory oversight and if necessary, a case conference with BHH to review the identified need and barriers to care
   a. Care management staff must document the offered service, the member's declination, and if possible, the member's reasoning for declining the service (please refer to care planning policy for further guidance on documenting refusals of care)
   b. Efforts must be taken to work with the member to reduce resistance to care, ensuring that member is in receipt of provider contact information in the event of an emergency need (this may include the intended provider along with services such as urgent care and emergency departments)
   c. Member's declination should be documented in the care plan and include a target date to review and follow-up.

5. Care team members need to be included in care planning activities at regular intervals (please refer to care conferencing policy for further guidance). Inclusion of the care team may be achieved in many different ways:
    a. Care conferences
    b. Sharing a copy of the member's care plan
    c. Sharing written status update
    d. Participating in provider visits with the member

6. If a member identifies that they are no longer satisfied with the services being provided by a care team member, the care manager must take steps to identify the source of the dissatisfaction, and, where appropriate, participate in activities designed to repair the relationship. If unable to assist the member in repairing the relationship, the care management team must work to transition the member to a new provider, as per member's choice.

7. CMA staff are responsible for keeping the documented care teams up-to-date. This includes the addition and removal of providers working with the member, as well as any changes to the assigned Care Manager and Supervisor.

BHH Policy No. 6.04: Contact Standards

Effective Date: 08/26/2015
Last Review Date: 04/27/2021

Policy: The Brooklyn Health Home (BHH) expects that all enrolled members will receive a minimum of one core service per month, unless otherwise dictated by their special population designation and specific contact requirements. All core service delivery must be congruent to the level of member need, and all efforts are taken to maintain the clinical integrity and wellness of all members enrolled in BHH services.

Procedure:

1. Per NYS DOH Policy 1.4 "Federal Health Home Provider Functional Requirements":
   The Health Home model of service delivery supports the provision of timely, comprehensive, high- quality health homes services that operate under a whole person approach to care. The whole-person approach to care addresses all of the clinical and non-clinical care needs of the individual. Section 1945(b) of the Social Security Act requires providers of Health Home services to address/provide the following functional components.
   1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.

2. Although BHH expects that each member receives at least one core service per month, it should be noted that this guideline is a *minimum* standard. BHH expects that the amount of service delivery is congruent to the phase of engagement, level of need and special population requirements (i.e., Adult Home Plus, Health Home Plus, etc.).

3. Service delivery that results in at least one direct (face-to-face) contact per month is expected. BHH does not support or promote a telephonic care management model and requires regular direct contact with members. Members who are in step-down or on track for graduation may receive less frequent face-to-face care. Alternatively, newly enrolled members or members experiencing a crisis will require more.

4. Each contact with a member should be focused around a care plan need/goal area. If a new need/goal area arises during the appointment, the care plan must be updated to reflect this new information. Visit schedules may increase or decrease as needed to ensure that high priority care plan areas are prioritized and addressed quickly.

5. The intensity, frequency and mode of contact should be assessed and reassessed as progress, regress, or updates within the integrated care plan are made. The levels of contact must be discussed and agreed upon between the care manager, member and the rest of the care team.

6. BHH requires that all cases are regularly reviewed in clinical supervision, ensuring that members are receiving appropriate levels of care and contact with ongoing progress towards completion of care plan goals and graduation.

BHH Policy No. 6.05: Case Conferencing

Effective Date: 01/31/2015
Last Review Date: 04/27/2021

Policy: Care conferences facilitate effective care coordination by ensuring that care team members are engaged in information sharing and shared decision-making processes. BHH expects care conferences to be facilitated as part of routine care management activities and also in response to certain triggering events, described herein.

Procedure:

1. For the purpose of this policy, the term "care conference" refers to a discussion among the care manager and at least one other member of the care team, such as the primary care provider, psychiatrist, therapist, social worker, caseworker, managed care organization, probation or parole officer, clergy member, city agency member, family member, etc.

2. Care conferences should be held under the following circumstances:
    a. At enrollment. Care managers should make reasonable attempts to hold a care conference with providers when they enroll a new member.
    b. When a new care team member is added to the care team. Care managers should attempt to engage new providers or members of the care team. This provides an opportunity to get to know the care team and establish a collaborative, ongoing relationship. Importantly, laying this groundwork before a crisis is underway can form a solid foundation for working together.
    c. In response to – or anticipation of – both clinical and non-clinical critical events (defined in more detail below).
    d. When input from members of the care team would be helpful for member engagement in services, identification of goals, or progress toward goals.
    e. When the member's graduation or the step-down process to graduation from care management services is being considered and/or implemented.
    f. Any situation that other members of the care team should be apprised of – and involved in the response plan for – should precipitate a care conference.

3. Situations that may trigger a care conference include, but are not limited to:
    a. Emergency Department (ED) visit
    b. Inpatient medical or psychiatric hospitalization
    c. Hospital discharge
    d. Arrest, incarceration, release from incarceration
    e. Eviction or other event resulting in homelessness
    f. Physical or psychiatric decompensation
    g. Substance use/relapse
    h. Domestic violence incident
    i. Victim of a crime
    j. Harm to self or threat to harm self
    k. Harm to others or threat to harm others
    l. Legal crisis

4. An attempt to initiate/schedule a care conference should be made immediately (within 2 business days) upon learning of the event. The care conference should be held no later than 10 business days following the event.

5. Events that can be anticipated, such as a hospital discharge, or release from incarceration can trigger care conferences in advance for planning purposes. Furthermore, situations such as non-adherence to medication, rental arrears, or behavior indicative of a drug relapse that can potentially lead to a crisis must trigger a care conference.

6. Care conference can occur in-person, over the phone, or via videoconference.
7. Care conferences following a critical event should be structured around the circumstances of the event. A case conference should address:
    a. Why/how the event occurred
    b. The circumstances leading up to the event
    c. The current status of the member
    d. Developing a plan to keep the member safe/stable/healthy
    e. Developing a plan to prevent a similar event from occurring again

8. Care conferences should be followed with a communication sharing the outcome and/or next steps of the conference with the care team.

9. Care conferences (attempted and successful) must be documented in the care management platform. The encounter note must include the purpose, participants and outcome of the care conference.

10. Participants in a care conference must be consented care team members on the Health Home Patient Information Sharing Consent Form (DOH-5055).

BHH Policy No. 7.01: Assessments

Effective Date:
Last Review Date: 07/01/2021

Policy: All BHH members have standardized comprehensive assessments that identify medical, behavioral and psychosocial needs. The structured comprehensive assessments guide the start of care coordination services and the development of the member's care plan.

Procedure:

1. The standardized comprehensive assessments will be conducted after the member signs the Health Home Patient Information Sharing Consent Form (DOH-5055).

2. A comprehensive assessment (Biopsychosocial) is a uniform, mandatory tool that addresses the member's medical, behavioral, and social determinant needs and is inclusive of all NYS DOH requirements. The comprehensive assessment assesses for risk factors that include but are not limited to: HIV/AIDS; harm to self or others; persistent use of substances impacting wellness; food and/or housing and other instabilities using screening tools per BHH policy. The comprehensive assessment must be completed by the dedicated care manager through face-to-face encounters and cannot be completed telephonically.
    a. The care manager must begin the comprehensive assessment no later than 30 days from consent and must complete the comprehensive assessment within 60 days from the date of consent/enrollment. Care managers should include information from all available sources with consent of the member (i.e., providers, family and social supports, outside case managers and medical records).
    b. Information obtained while completing the comprehensive assessment should include diagnostic criteria and eligibility for Health Home enrollment.
    c. The comprehensive assessment must be re-administered every twelve months.
    d. Care Managers should continually evaluate changes in the member's status. Any changes that occur between annual reassessments should be recorded in the Care Plan (CP).
    e. Upon completion of the comprehensive assessment, care managers must enter narrative detail into the CP need and goals.
3. All assessment data captured outside of the Care Management Platform must be entered into the member record within two business days of assessment completion.
4. Care manager should refer to HARP policy for guidance on completion of the HARP eligibility assessment.
5. BHH may introduce new assessment tools as needed to meet changing program needs and State requirements. CMAs must follow shared guidance in the completion of these assessments.
6. All assessments may be shared with other members of the care team upon member consent.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0002, Comprehensive Care Management *(See Appendix)*

BHH Policy No. 7.02: Care Planning

Effective Date: 01/31/2013
Last Review Date: 07/15/2021

Policy: All members enrolled in BHH services must have a person-centered care plan that is reflective of the member's goals and involvement in its development and updated at regular intervals. The care plan serves as the action plan for all care management activities and should be reflective of care team involvement. Members and/or any consented care team member must be provided a copy of the care plan upon request.

Procedure:

1. Each member must have a single integrated care plan stored within the BHH care management platform and updated as member needs are reported/identified, no later than 30 days from enrollment but updated no less often than quarterly.
    a. The care plan must include member feedback wherever possible and include the member's goals, strengths, challenges, and barriers to care
    b. The care plan must reflect all completed assessments including informal assessments conducted throughout the course of regular care management activities/core service delivery
    c. The following areas must be taken into consideration and reflected in care plan needs/goals:
        - Key community networks & supports (e.g., religious/spiritual supports, self-help, family members, etc.)
        - Wellness and recovery goals (e.g., smoking cessation, specialized services and supports for needs such as cancer, diabetes, mental health, asthma etc.)
        - Any special cultural considerations that should be accounted for based upon the member's preferences/requests (e.g., support finding culturally based supports/activities in the community, access to providers and services that speak the member's language or observe the member's religious needs/preferences, etc.)
        - Any functional barriers to engagement in treatment and pursuit of identified goals.

    Note: Care plans, like assessments, should always address certain core domains, including but not limited to: mental health, medical health, substance use/recovery, housing, finances (including food security), relationship/social standings, legal/criminal justice needs, safety, and family needs.

    d. If a clinical concern area is identified through completion of an assessment, but the member does not wish for that concern area to be an active part of the care plan, the care management staff must reflect the concern, but may indicate that the need area is deferred due to client preference. Care conference with care team members should be initiated to form a strategy for monitoring the need area.
    e. The care plan must be written in a person-centered manner, and employ appropriate spelling and grammar (e.g., culturally sensitive/appropriate; avoiding overly technical jargon or shorthand abbreviations so that the member, collaterals, and any care team members can easily understand it)

2. The care plan must be revised and updated in the event of any critical event including but not limited to: a hospitalization, ED visit, an arrest/incarceration, the completion of an assessment tool, a new diagnosis or new medication, and/or a change in stability of housing or personal relationships.
    a. The care plan must be updated as identified goals and tasks are achieved; reviewed and updated at minimum, every 90 days from completion of the initial care plan
    b. Each goal must have a target date of completion associated with it. The date must be revised if the goal is not met by the target.
    c. The care plan may demonstrate continuance of already established goals/tasks, depending on member progress. If an active task remains unresolved after 90 days, the care management team must proactively engage the member about the barriers to task completion and, if warranted, defer or end that task to accurately reflect the member's needs/wishes.

3 The care plan should indicate the names of care team members responsible for supporting each care plan area/task (e.g., care manager, primary care doctor, therapist, etc.)

4 Per the NYS DOH, each care plan should speak to the member's level of family/social support, and where appropriate, family members (and/or caregivers) should be included as a part of the care planning process. Clearly document where/if family is not able to be included. For the purpose of this requirement, "family" should be defined as those individuals that the member feels are a part of their primary support network and does not stipulate blood relation (e.g., acceptable to include spouse, domestic partner, friends, etc.)

   If a family member, support, or caregiver wants a physical copy of the care plan and appropriate consent/authorization to share such materials with the party has been obtained from the member, the care management team should provide a printed copy of the document to the individual.

5 Per the NYS DOH, all care plans must demonstrate member review, understanding, and agreement through documentation in an encounter note and signature. Member signature can be documented in one of the following ways:
   a. Print a copy of the complete care plan, have member sign/date the final page and initial/date each page; scan & upload the document in the "Documents" tab of the member chart
   b. E-signature via signature pads or embedded technology

6 Successful completion of all care plan goals/tasks indicates that the member may be ready for gradual reduction in care management services and eventual successful completion of health home services; please see the case closure policy for further guidance on this process.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0008, Health Home Plan of Care Policy
Policy: HH0007, Member Disenrollment from the Health Home Program *(See Appendix)*

BHH Policy No. 8.01: Adult Home Community Transitions Program (Adult Home Plus/AH+)

Effective Date: 12/10/2015
Last Review Date: 7/19/2021

Policy: All downstream providers and care managers serving Adult Home class members who are transitioning to the community under the Stipulation and Order of Settlement, will meet specific criteria, receive specific training, maintain smaller caseloads than standard Health Home, and follow defined collaborative care planning processes. In addition to all standard care management policies and procedures, Adult Home Plus CMAs and Care Managers will follow all DOH guidance pertaining to the provision of care to Adult Home class members.

Procedure:

Adult Home Plus Care Managers must:

1. Have the experience and credentials defined by the State and outlined in the AH Plus Reference Guide. (*See Appendix*)

2. Maintain a 1:12 dedicated AH Plus caseload on an ongoing basis. When all eligible class members have been assigned, the caseloads may include other high need, high-risk individuals (e.g., HH+, CTI) being served by BHH outside of the Stipulation and Order of Settlement.

3. Provide face-to-face contact (or attempts) with the member *at least* four times per month (more if necessary) from the time of enrollment to at least six months following transition to the community. When a member is admitted to an inpatient setting (e.g., hospital, nursing facility, or rehabilitation facility) for any full month length of stay, the member's segment should be pended. During the months while segment is pended a single monthly encounter with the member or facility is still required. AH Plus level billing is allowable in the month transitioning into the facility and the month of discharge.

4. Maintain a minimum of monthly contact with the member's housing provider (more if necessary).

5. Serve as the single point of contact between members, Adult Home, Housing, Department of Health Office of Community Transitions (DOH OCT), Peer Bridgers, Managed Care Organization (MCO), health care providers and Managed Long Term Care Plans (MLTCPs), if applicable, and establish and maintain regular collaborative contact.

6. Begin Transition Planning Tool in PSYCKES portal and the Health Home Care Plan within 10 days of enrollment in order to plan for move. BHH recommends planning an interdisciplinary team care planning meeting at the start of care.

7. Adult Home Plus Care Managers and Supervisors are required to review and be familiar with all recommendations made in the Adult Home Resident Assessment Report (AHRAR) and In-Reach (When available). These recommendations should be incorporated into the Health Home Care Plan.

8. For members who have transitioned into the community, complete the "Graduation from AH Plus" section of the dashboard (Located within the PSYCKES portal) to determine whether the Adult Home Plus level of care management is required beyond the mandatory 6 months post move.

9. Participate in all required Health Home and State entity trainings and informational sessions.

10. Provide all required reporting including incident, capacity, and progress reports.

11. Document activities in Care Management Platform within 48 hours of Encounter.

12. Initiate the Care Plan within 10 days of enrollment and update care plan *at least* quarterly or as needed. Refer to Policy 8.02: Care Planning for additional requirements

13. All class members desiring transition to community living, who are enrolled in health home, must be provided AH+ level of care. This intensive care management will be reimbursed at the AH+ rate using code 1860. The Health Home care management services AH+ rate may be claimed by the CMA if all of the following apply:
    a. CMA signed the required attestation form and was approved as a designated AH+ CMA
    b. Class member is enrolled in Health Home
    c. Class member expresses desire to move, whether or not in-reach has occurred (excluding members with AL codes who have not yet been in-reached)
    d. Class member must be assigned to an AH+ care manager
    e. Class member has the required four face-to-face visits (or documented attempts), at minimum, per month
    f. For an enrolled class member who has expressed an interest in moving and does not have an in-reach completed, the care manager will have two months to bill the AH+ rate code (1860) until the in-reach is completed by the Housing Contractor

14. Graduation/Transfer to standard Health Home is determined by AH+CM and supervisor when AH+ level care management services are no longer necessary.

BHH will:

1. Assign class members based on in-reach received and/or early enrollments from Community Transition List (CTL) by providing CMAs with member name, CIN, MLTC/MCO, Adult Home, and ALP code. Member record will be created/updated in care management platform to reflect AH+ affiliation.

2. Participate in all required DOH Office of Community Transitions and Health Home calls

3. Provide quality assurance by reviewing documents and attestations required by DOH reference guide, including:
    a. Transition Planning Tool
    b. 5 Month Post-transition Assessment
    c. Care plans and Progress notes

4. Review, manage, and submit DOH documentation requests and reports timely, when applicable.
    a. Weekly In-Reach Report (WIRR)
    b. Community Transition List (CTL)
    c. Incident Report

5. Support communication between DOH HH, DOH OCT, MLTC/MCO, OMH, Housing Contractors, and CMAs.

Reference:
NYS DOH, Health Homes & Special Populations
NYS DOH, Adult Home Plus (AH+)
Guidance for Adult Home Plus Program (AH+) *(See Appendix)*

BHH Policy No. 8.02: Justice Involved Members

Effective Date: 08/26/2015
Last Review Date: 07/10/2019

Policy: BHH recognizes involvement with the criminal justice system as a critical event and expects an organized, supportive, and culturally sensitive response from care management agencies (CMAs) serving members who are included in this category.

Procedure:

1. In addition to all standard care management policies and procedures, BHH requires all CMAs to implement and adhere to the justice population specific policies, workflows, and guidance.

2. BHH encourages CMAs to seek and pursue training opportunities designed to enhance cultural competency in serving members who are affiliated with the justice system.
   a. CMAs are expected to be familiar with terminology and database tools common to the justice system (e.g., prison, jail, detention, arraignment, sentencing, parole, probation) and should utilize these tools as needed to engage/locate members (e.g., VineLink, WebCrims, Inmate Lookup, etc.)
   b. CMAs should become acquainted with and apply knowledge of trauma-informed approaches to assessment, care planning, and interventions for justice involved members

3. For members with justice system involvement, care management staff must include justice-specific care plan needs, goals, and tasks aimed at preventing re-arrests and recidivism.

4. Cases should not be automatically closed out as a result of a member's jail admission, but should trigger a series of care management tasks designed to assist the member in returning safely to the community.
   a. A member's incarceration may also be a reportable incident; please refer to the incident reporting policies
   b. A member may remain enrolled as long as their Medicaid coverage remains active. Members remaining in jail settings for 31 days or greater may experience a Medicaid suspension or termination. Upon Medicaid disruption, BHH advises a care conference to determine whether or not the care management segment will remain open.
   c. Members admitted to State or Federal correction settings (e.g., prison) will serve time that extends beyond 30 days and should be reviewed for case closure. All case closure policies & procedures must be adhered to
   d. Care management visits to correctional institutions are not mandated by BHH and should be made at the discretion of the CMA

5. Care managers must include justice system entities (e.g., probation, parole, treatment courts, alternative to incarceration, reentry programs, AOT, attorney) on the consent form, on the care team, and include them in care planning activities.
   a. Care managers must make all efforts to support members in adhering to legal mandates (AOT, parole, probation) while engaging in necessary community programs and treatment
   b. If a member refuses to allow consent for communication with justice system entities, care manager should seek supervisory support in working to reduce resistance. If supervisory support does not result in a satisfactory outcome, the CMA is responsible for seeking support from BHH personnel
   c. Care managers serving members engaged in justice case management models (e.g., TASC, LINK, AOT, specialty courts) should ensure that the care plan is reviewed with case management to avoid duplication of services or referral

6. Upon receipt of consent, legal representatives should be added to the member's care team.
    a. Care managers are responsible for conferencing with legal representatives to clarify any special mandates
    b. Care managers must request clear guidance from the legal representative on any reporting requirements
    c. Referrals to treatment and support services should be reviewed with the legal representative to ensure that no referrals are made that could violate the terms or conditions of the legal mandate

7. Care managers must inform consented legal entities of the care manger's role, and must establish a protocol for care team involvement
8. Care managers may provide required and objective reporting only and not subjective (opinion) reporting to any legal entities.
    a. Care managers are not to offer any sort of involvement in legal proceedings beyond provision of an objective (written) report which addresses the enrollment episode, care plan activities, and member progress/regress in those areas
    b. Any requests for participation in court proceedings must be reviewed with CMA legal and reported to BHH

9. Members involved in the criminal legal system must be flagged in the Care Management Platform with the appropriate flag (e.g., CJ, ATI, OPC)

Note: When appropriate, care managers may provide resources for consented family members impacted by the member's involvement with the criminal legal system.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
(See Appendix)

BHH Policy No. 8.03: Jail Admission Alert: Enrolled Members and Outreach Candidates

Effective Date: 08/26/2015
Last Review Date: 06/23/2021

Policy: CMAs overseeing BHH outreach candidates or enrolled members incarcerated or detained in an NYC Jail or detention center will receive an alert from BHH reporting on this event.

Procedure:

1. BHH staff will send a secure message to alert care management of a jail or detention facility admission.
    a. Alerts will be sent to the care manager and supervisor listed on the Care Team. The alert will include details of who to contact and next steps of the required workflow.
    b. CMAs must confirm receipt of the alert by replying to the secure message and must include the key staff involved in the member's Care Team.

    NOTE: Individuals are admitted to the jail typically for one of two reasons; a) detainment or b) sentencing. Sentenced members will have a concrete admission and release date identified by the court. Detained members are awaiting criminal proceedings and have not been sentenced. These members may be released from the facility rapidly, depending on the outcomes of court proceedings/review. Case status details can often be found by utilizing WebCrims or NYC Inmate Lookup websites.

Within one business day following alert

2. CMAs must ensure that the currently assigned care management staff is aware of the member's incarceration or detainment status.
3. CMAs must confirm receipt of the alert by replying to the secure message and must include the key staff involved in the member's Care Team.

Within three business days following alert

4. CMAs must notify Correctional Health Services (CHS) of member/candidate's Health Home status and request that CHS discharge planning obtain consent to communicate/share information. If member has already added NYC Health + Hospitals to the DOH 5055, this information should be shared with CHS to expedite the connection between the CM and discharge planner. BHH staff should be copied on this communication.

5. CMAs must review the member chart in preparation for care conferencing and/or outreach activities. The following areas should be reviewed:
    a. Enrollment status: Ensure that cases pending closure are reviewed with BHH personnel
    b. Patient Profile (to ascertain details surrounding the incarceration or detainment, as entered by BHH personnel)

    DOH 5055 Health Home Consent & Enrollment Form
    c. Care Team should ensure that all names and contact information for consented providers is at hand and ready for care conferencing with facility discharge planning staff
    d. Assessments
    e. Legal team contact information
    f. Notes (ensure that documentation is entered to highlight the incarceration and tentative plans for follow up)
6. CMA must attempt to obtain and document details about the member's arrest (e.g., nature of charges as reported on WebCrims website or other justice database)

Within five business days following alert

7. All consented and relevant care team members must be notified of the member's justice involvement
    a. A status update letter may be composed and shared, or, individual calls made. All efforts to inform Care Team members must be recorded in case notes.
    b. Where appropriate, doctors, therapists, and counselors overseeing medical and psychiatric care should be contacted to engage in a care conference designed to promote continuity of care and respond to the current episode post-release.
    c. Care plan must be updated to include information about justice status and anticipated needs in coordination with the member.
    d. Consented family members and social supports should be engaged in conversations to collect information about the arrest, if possible (and appropriate), and to discuss ways to support the member upon their return to the community. Care plan should be updated to reflect information gathered from these contacts.
    e. Care Managers must continue to address care plan issues where feasible until the member is released. If incarceration/detention is expected to extend past 90 days, contact BHH immediately to review case specifics.

If consent for communication between CMA & facility discharge planning is obtained

a. Establish contact with the CHS Discharge Planner, copying relevant BHH personnel, case conference (refer to case conference policy) and collaborate on discharge plan within 2 business days of notification of consent or as soon as CHS Discharge Planner is available.

    a. Discharge Plan should include appointments with pre-existing providers (unless the member requests otherwise); CMAs should assist in securing the needed follow up appointments.
    b. Where possible, the mental health follow up appointment should be secured within 3 business days of release and the care manager should be on-site to meet the member at that appointment where possible.

b. CM must document all scheduled appointments coordinated with Discharge Planning in Care Management Platform. CM should accurately maintain the status of these appointments after the member is discharged to the community.

Note: Refer to Continuity of Care Policy for members who must be pended due to incarceration.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0006, Continuity of Care and Re-Engagement for Enrolled Health Home Members *(See Appendix)*

BHH Policy No. 8.04: Jail Release Follow Up: Enrolled Members and Outreach Candidates

Effective Date: 08/26/2015
Last Review Date: 07/16/2021

Policy: CMAs, overseeing BHH outreach candidates and enrolled members incarcerated and subsequently released from jail are responsible for timely follow up attempts post-release.

Procedure:

1. BHH staff will notify care management providers to alert of a jail release.
    a. Alerts will be sent to the CM and supervisor listed on the Care Team, making it critical that Care Teams are kept current.

Within one business day following release notification

2. CMA must ensure that the assigned care management personnel are notified of the release and that contact information for that staff is current in the Care Management Platform (phone number, email address, business address).
3. CMA must confirm receipt of the alert by replying to the release notification. If the primary case contact was not included in the original alert, they should be added to the reply message.

Within two business days following release

4. *If a chart review was not conducted following receipt of an admission alert:* CMA must review the member chart in preparation for care conferencing and outreach activities. The following areas should be reviewed:

    a. If member was "Pended" due to incarceration status, update status to "Enrolled"
    b. Overview Page (to ascertain details about updated addresses, phone numbers, or Medicaid information as entered by BHH personnel)
    c. Care plan (must include information about justice status and needs; please refer to care planning policy for further information)
    d. Encounters (ensure that documentation is entered to highlight the release and tentative plans for follow up)

5. Efforts should be made to contact the member via telephone as soon as possible. A face to face should be scheduled.

6. All consented and relevant care team members must be notified of the member's release status:
    a. All efforts to inform care team members of release must be recorded in encounter notes.
    b. Doctors, therapists, and counselors overseeing medical and psychiatric care (including counseling, therapy, and medication administration) must be contacted to engage in a care conference designed to promote continuity of care and the current treatment episode post-release.

Within three business days following release

7. If contact with the member was not established, a home visit or visit to a provider should be made. Wherever possible, care management personnel should attempt to meet the member at their first follow up provider appointment in the community.

8. The member's care plan must be updated accordingly (refer to care planning policy).

First face to face contact post release

9. CM must work collaboratively with the member to update care plan to reflect the justice status (including arrest and charges, parole or probation status, etc.) and new issues and goals.

10. CM should attempt to obtain consent for parties relevant to the incarceration episode (e.g., CHS/H+H, defense attorney, other justice service providers), and update the DOH 5055 as appropriate.

11. Review the member's emergency contacts and their information.

For members who have suspended or inactive Medicaid

12. Members detained 31 days and longer will enter into "Medicaid suspension" status. The Medicaid should become unsuspended within a week after the member's return to the community. Attention should be given to the possibility of Medicaid suspension and safety plans for securing needed services if that situation arises post-release.

13. If a member misses his or her recertification appointment due to incarceration or other reasons, they may need to reapply for Medicaid coverage within the Human Resource Administration (HRA) offices upon return to the community.

BHH Policy No. 8.05: HARP (Health and Recovery Plan) Population

Effective Date: 12/10/2015
Last Review Date: 01/31/2019

Policy: All downstream providers, care managers, and assessors serving the HARP population will meet appropriate criteria, receive applicable training, and follow defined assessment and collaborative care planning processes.

Procedure:
Downstream care management providers must meet the following standards regarding:

Assignment

1. Outreach and enrollment of HARP eligible members should be prioritized when instructed by BHH.

2. Where applicable, HARP members should be assigned to dedicated HARP teams.

3. Downstream providers are responsible for checking eMedNY to verify HARP *enrollment*; only HARP enrolled members should receive the HCBS eligibility assessment.

Assessment

1. Ensure that staff that perform the NYS BH HCBS eligibility assessment meet the education and experience qualifications defined by NYS as follows:
    a. Education – a bachelor's degree in child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreation therapy, rehabilitation, social work, sociology, or speech and hearing; OR NYS licensure and current registration as a Registered Nurse and a bachelor's degree; OR a bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; OR a Credentialed Alcoholism and Substance Abuse Counselor (CASAC).
    b. Experience – two years' experience (a Master's degree in a related field may substitute for one year's experience) either providing direct services to persons diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse; OR linking persons who have been diagnoses with mental disabilities, developmental disabilities, alcoholism or substance abuse to a broad range of services essential to successfully living in a community setting.

2. Ensure that staff that perform NYS BH HCBS Eligibility Assessment receive appropriate training as mandated by NYS in order to access the UAS and specific training on the array of services and supports available (e.g., trainings regarding home and community-based services (HCBS)).

3. Staff performing NYS BH HCBS Eligibility Assessment must be supervised by a Master's level clinician.

4. For eligible members, the NYS BH HCBS Eligibility Assessment must be conducted face to face, no later than 90 days from Health Home enrollment. If member refuses to complete the Eligibility Assessment, refusal must be documented in the progress notes and a HARP/HCBS goal should be added to the Care Plan.

5. The NYS BH HCBS Eligibility Assessment *does not* take the place of the Brooklyn Health Home Comprehensive Assessment, which must still be completed.

6. The NYS BH HCBS Eligibility Assessment must be completed annually for all eligible members

Care Planning

1. Care managers must work collaboratively with, at minimum, the member, the care team, the HARP (MCO), and the HCBS providers to develop the HARP Plan of Care (POC).

2. The initial POC or the minimum required elements for a level of service request (LOSR), developed by the member and the care manager must be submitted to the MCO or BHH per MCO guidance within 14 days of the completion of the NYS BH HCBS Eligibility Assessment.

3. The POC must be created using the HARP POC Assessment Tool in the Care Management Platform or the NYS issued fillable PDF version, which meets all State and Federal requirements.

4. Care managers must facilitate and maintain communication with the MCO and the HCBS providers to obtain approval, level of service determination, and authorization and receipt of services.

5. Care managers must collaborate with the MCO to monitor implementation of the POC and to implement revisions when necessary.

6. The HARP POC *does not* replace the BHH CCP, which must still be in place for all HARP members and updated every 90 days at minimum.

7. All other BHH care management and documentation policies and procedures apply to HARP members.

BHH Policy No. 8.06: Health Home Plus

Effective Date: 06/01/2017
Last Review Date: 07/16/2021

Policy: All downstream providers, care managers, and assessors serving Health Home Plus populations (AOT, Expanded HH+, HH+ for Members with SMI, and HH+ for members with HIV/AIDS) will meet appropriate criteria for education, experience, service delivery, and caseloads. BHH must attest that CMAs are qualified and approved to serve a given HH+ population in order for CMAs to bill at the HH+ rate. BHH will only assign/refer members known to qualify for HH+ to agencies that are attested to serve the HH+ population.

Procedure:

1. Agencies requesting attestation under BHH must complete the attestation survey and submit required documentation for approval: member list, staff names and resumes, caseload structure

2. BHH reserves the right to revoke or suspend a CMAs ability to provide HH+ services or bill at the HH+ rate if minimum standards are not continuously met or if the CMA is not meeting other quality standards set by BHH.

3. CMAs must abide by all other applicable BHH policies and procedures in addition to the higher standards outlined below for the HH+ populations.

4. Downstream care management providers must meet the following standards regarding:

AOT

1. The CMA must inform BHH when a member has been placed on court ordered AOT or when the court order has expired or not been renewed.

2. BHH will inform the member's MCO of the AOT status.

3. The HH care manager must adhere to all HH+ AOT guidance issued by the State including:
   a. Provide face-to-face contact at least once a week
   b. Work with the LGU's AOT coordinator as per local policy
   c. Comply with all statutory reporting requirements under Kendra's Law
   d. Maintain a caseload ratio in compliance with AOT state guidance
   e. Meet the minimum qualification standards listed in HH+ guidance

4. The HH care manager must meet the following qualifications:
   f. Education: bachelor's degree in a listed field*; OR NYS teacher's certificate for which a bachelor's degree is required; OR NYS licensure and registration as a Registered Nurse and a bachelor's degree.
   g. Experience: four years of experience either: providing direct services to mentally disabled members; OR linking mentally disabled members to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatrics, social, educational, legal, housing, and financial services). A master's degree in a listed field* may be substituted for two years of experiences.

5. All AOT reporting requirements to the Office of Mental Health as required by AOT legislation and as currently reported in the OMH CAIRS system must be met.

Expanded HH+ (OMH State Psychiatric Center discharges and Central New York Psychiatric Center discharges as well as their satellite clinics)

1. Maintain a caseload ratio no greater than 1:20
2. Meet the minimum qualification standards listed in the State's HH+ guidance regarding:
    a. Education: bachelor's degree in a listed field*; OR NYS teacher's certificate for which a bachelor's degree is required; OR NYS licensure and registration as a Registered Nurse and a bachelor's degree.
    b. Experience: four years of experience either: providing direct services to mentally disabled members; OR linking mentally disabled members to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatrics, social, educational, legal, housing, and financial services). A master's degree in a listed field* may be substituted for two years of experiences.

HH+ for Members with Serious Mental Illness

1. Only CMAs designated by OMH as Specialty Mental Health Care Management Agencies (MH CMAs) and attested by BHH may provide HH+ service to the SMI population

2. CMAs must have a working relationship with the LGU/SPOA in their service county

3. Care managers must meet the minimum qualification standards listed in the State's HH+ guidance regarding:
    a. Education: bachelor's degree in a listed field*; OR NYS teacher's certificate for which a bachelor's degree is required; OR NYS licensure and registration as a Registered Nurse and a bachelor's degree; OR a bachelor's degree or higher in any field with five years of experience working directly with people with behavioral health diagnoses; OR a credentialed alcoholism and substance abuse counselor (CASAC)
    b. Experience: two years of experience either: providing direct services to people with SMI, developmental disability, or alcoholism or substance abuse; OR linking people with SMI, developmental disability, or alcoholism or substance abuse to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatrics, social, educational, legal, housing, and financial services). A master's degree in a listed field* may be substituted for two years of experience.
    c. Supervision: care managers must be supervised by a licensed healthcare professional with prior experience in a behavioral health clinical setting or care management supervisory capacity; OR a master's level professional with three years prior experience supervising clinicians and/or care managers providing direct services to people with SMI or serious substance use disorders
    d. CMAs interested in expanding their capacity to serve the Health Home Plus population may apply for a waiver. Agencies should be prudent in selecting staff to pursue a waiver of qualifications, and only be submitted for those staff whose unique qualifications allow them to adequately serve the population.
        i. Please submit all waiver requests online here: Waiver of Qualifications for HH+ SMI and NYS EA Assessors for Adult BH HCBS

4. Ensure that care managers receive adequate support, supervision, and resources to develop their skills in serving high-need individuals with SMI. Proficiencies must include:
    a. Conducting appropriate screenings and performing or facilitating more detailed assessments when needed
    b. Planning and coordinating care management needs
    c. Maintaining engagement with high-risk, high-need members who are often the most difficult to reach and engage

5. Understand the HH+ eligibility criteria for high-need SMI populations:
    a. Assertive Community Treatment (ACT) step down
    b. Enhanced service package/voluntary agreement
    c. Expired AOT court order within the past year
    d. Homeless
    e. High utilization of inpatient/ED services

f. Criminal justice involvement
g. Ineffectively engaged in care
h. Clinical discretion of SPOA and/or MCO

6. Maintain a caseload of 1:20. Acceptable models of care for mixed caseloads and team approaches are outlined in the OMH guidance.

7. Provide a minimum of four health home core services per month, two of which must be face-to-face with the member.

8. Evaluate for continued HH+ eligibility after being served as a HH+ member for 12 months. Another 12 months of HH+ service/billing can occur if eligibility criteria persist and BHH reviews and approves the extension.

9. Communicate with MCOs regarding HH+ status of mutual members.

10. Ensure warm transfers to lower levels of care (e.g., high risk care management) when members are ready to step down from HH+, as determined by case conferencing with the member and care team.

HH+ for Members with HIV/AIDS

1. The CMA must meet the following criteria:
   a. Is a COBRA HIV TCM; OR
   b. Is an Article 28 or 31 provider, CHHA, community health center, community service program, or other CBO with:
      - Two years of experience in case management for people living with HIV/AIDS
      - Three years of experience providing community-based social services to people living with HIV/AIDS; OR
      - Three years of experience providing case management or community-based social services to women, children and families; substance users; MICA clients; homeless persons; adolescents; parolees; recently incarcerated; and other high-risk populations and includes one year of HIV-related experience

2. Care managers must meet the minimum qualifications and training requirements:
   a. Master's or bachelor's degree in health, human services, education, social work, mental health, and one year of qualifying experience**; OR
   b. Associate's degree in health, human services, social work, mental health, or certification as an R.N. or L.P.N. and two years of qualifying experience

3. Care navigators/community health workers/peers must meet the minimum qualifications:
   a. High school diploma or GED; OR
   b. CASAC; OR
   c. Certification as a Peer; OR
   d. Community Health Worker;
   e. AND ability to read, write, and carry out directions

4. Supervisors must meet the minimum qualifications:
   a. Master's degree in health, human services, mental health, social work, and one year of supervisory experiences and one year of qualifying experience; OR
   b. Bachelor's degree in health, human services, mental health, social work and three years of supervisory experience and three years of qualifying experience**

5. Maintain the maximum caseload ratio of 1:15. If peers/navigators/community health workers are used as part of a team model, the caseload may increase by 5 for each team member. One care manager can supervise a

maximum of two team members.

6. Step members down to high-risk care management after 12 months in the Health Home Plus program.

7. Provide the minimum service requirements including:
   a. At least four contacts per month, at least two of which are face-to-face
   b. Make home visits, at minimum, at assessment/reassessment, care plan revisions/updates, and every six months, or more frequently depending on the member's needs
   c. Case conference with all providers and the member every 6 months

8. Complete core competency training requirements within the first 18 months of employment and at least 70 hours annually for staff who have completed their first year of employment.

*Qualifying education includes degrees featuring a major or concentration in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

**Qualifying experience means verifiable work with target populations: individuals with HIV, history of mental illness, homelessness, or substance use.

The full State requirements and billing guidance for AOT and Expanded HH+ can be found here:
https://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf

Reference:
NYS DOH, Health Homes & Special Populations
NYS DOH, Health Home Plus (HH+)
Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness (February 2021)
(See Appendix)

BHH Policy No. 9.01: Alert Management
Effective Date: 08/26/2015
Last Review Date: 04/24/2019

Policy: Care managers and other care team members receive alerts via the Health Home Care management platform regarding critical patient issues. The alerts fall into six categories: Care Teams; Care Plans; Healthix (BHIX); Enrollment; Care Coordination; and Care Book. Care Managers have the ability to manage which alerts are displayed in the Alerts App on the Care management platform. The Alerts App Tip Sheet describes the alerts management process in detail. CMA staff also receive hospitalization alerts provided by MCOs. These alerts are distributed by network care navigators via the GSI messaging application.

Procedure:

1. Users have the ability to select which alerts they wish to receive. The exceptions to this rule are the Healthix alerts and the alerts regarding new issues in the coordinated care plan (CCP), which users MAY NOT choose to disable. See below for details regarding these exceptions. Users may modify alert preferences at any time.

2. Some alerts are highly actionable and time-sensitive. Therefore, the following alerts MAY NOT be disabled for any reason:
   a. Healthix Alerts. These alerts notify the care team when a member is: admitted or discharged from a hospital, an emergency department (ED), or a psychiatric ED; deceased; or incarcerated or released from incarceration. Please refer to the case conferencing and crisis response policies for further guidance
   b. Care Plan – New Issue. These alerts notify the care team when new issues are added to the coordinated care plan (CCP.)

3. Care managers are responsible for notifying care team members about the Healthix and Care Plan (New Issue) alerts.

4. In order for care managers, supervisors, care navigators, or any other administrative staff to receive alerts via the care management platform, they must be on the member's care team. CMAs are responsible for keeping the members listed on the care team current to ensure that alerts are received and managed appropriately.

5. Alerts received via the messaging application must be distributed by the recipient to the appropriate care manager and/or supervisor. Policy 11.04, Care Transitions, provides detailed information about the follow up procedures (including response timeframes) required when a member is seen in the ED, admitted or discharged from the hospital, or admitted or discharged from incarceration.

6. When an alert is received, care managers must refer to the applicable policies and protocols for acting on the information provided in the alert.

7. Alerts – received via the alerts application and the messaging application – must be monitored by CMA staff on a daily basis at minimum.

   NOTE: Please refer to any policies specific to alert response protocols for special populations (e.g., justice involved, adult home, HARP) in addition to this guidance

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0008, Health Home Plan of Care Policy *(See Appendix)*

BHH Policy No. 9.02: Crisis Response

Effective Date: 01/15/2013
Last Review Date: 07/15/2021

Policy: Care management personnel are responsible for completion of preventative safety planning activities as well as responsive safety planning as needed to support all BHH members. For the purpose of this guidance, "preventative safety planning" refers to activities designed to minimize the likelihood of a person experiencing circumstances that may lead to an immediate safety concern or hospitalization. "Responsive safety planning" refers to activities designed to provide support for a person following a crisis event such as hospitalization, safety concern, jail detainment/admission, eviction, or any other critical event.

Definition:
For the purposes of this document, the definition of "crisis" indicates any situation that compromises the candidate/member's preexisting diagnosis, symptoms, or optimal baseline of functioning. This includes but is not limited to events such as verbalized thoughts/feelings/plans to harm one's self or others, indication of victimization or abuse, trauma, arrest/incarceration, an increase in symptoms related to any medical or behavioral health condition, a lack of needed medications, a change in safety status (e.g., housing, domestic violence), or immediate loss of income, financial support (e.g., wages, entitlements) or housing.

Procedure:
1. Care management staff must initiate a preventative safety plan with at-risk members within 30 days of enrollment. The safety plan must be completed within 60 days of enrollment, and updated as events requiring crisis intervention arise.

2. Care management staff must ensure that all members are in receipt of the toll-free BHH hotline.

3. If a member experiences a critical event that is reported to the care manager, the care manager should complete an appropriate safety plan with the member immediately, but no later than 2 calendar days after learning of the event. The safety plan must be signed and dated by the completing care manager; a copy of the completed plan must be given to the member and the member's care team as appropriate to the given situation.

4. Both preventative and responsive safety plans should be uploaded into the care management platform. Additionally, all appropriate goals and tasks can be included in the care plan.

5. Follow up plans and referrals must be measurable, timely, and congruent to the level of need exhibited by the event and should also be included in the care plan.

6. The care management staff is responsible for ensuring that the member has access to 24/7 support until a time where the member identifies that the event has been satisfactorily resolved (this may include crisis support phone lines, local police stations, hospitals, etc.).

7. Any member experiencing a perception of imminent danger must be directed to phone 911 emergency services.

BHH Policy No. 10.01: Continuity of Care and Re-engagement for Enrolled Members

Effective Date: 01/05/2015
Last Review Date: 07/15/2021

Policy: The policy provides guidance to BHH and CMAs regarding measures that must be taken to locate and re-engage enrolled members upon determining that continuity of care management services has been disrupted, and to prevent the potential for future disengagement.

Scope

When a member's continuity of care is disrupted, the care management agency must initiate appropriate activities intended to more effectively locate disengaged members which, at minimum, will include involvement of the member's care team (e.g., member, CMA, CMA Supervisor, member's MMCP, BHH, family supports (including parent, guardian, legally authorized representative, and others approved by the member).

Billing

Depending on circumstances related to member location and re-engagement activities, certain Billing rules apply, must be followed, and are described within this policy. Supporting documentation must be in place showing evidence of CM activities related to search efforts, member re-engagement, retention, and disenrollment. *Reminder*: If a CM does not provide the minimum core services required for billing in a given month, then the CM must respond 'no' to the question 'Was a core Health Home service provided this month' in the monthly billing questionnaire. No billing is allowed for that month.

Critical Time Intervention (CTI)

CTI is a time-limited evidence-based practice that focuses on building a support network for members during a period of transition into the community from an excluded setting, or in preparation for disenrollment from the HH program. A CTI plan aids in community integration and continuity of care by helping the member to establish a stable system of community supports. CTI happens over a period of time to allow for observation of the member's support network and progress toward becoming more self-reliant to support a successful and long-lasting transition. Health Homes should include in policy the use of CTI to maintain retention and prevent disengagement of HH enrolled members, and to support successful disenrollment.

Diligent Search Efforts

As soon as a member is determined to be disengaged from care management services, efforts to locate and re-engage the member must be intensified beyond Standard CM activities (refer to Definition for Standard CM activities). Diligent Search Efforts are permitted for a period of up to three consecutive months*, determined by the CMA (*refer to instructions for Health Homes Serving Children (HHSC) on the following page) beginning the month in which the member is deemed disengaged from CM services, and must be managed by the CMA/CM as follows:

A. a minimum of three or more activities must be conducted during each month to locate and re-engage the member. Activities must be progressive in nature and vary to ensure all opportunities to locate members are exhausted;
B. in Month One, the CM must inform both the member's MMCP and HH collectively of the member's disengagement (this is considered one of three or more required activities);
C. additional Diligent Search Effort activities include, but are not limited to:
    a. attempting face to face visit to the last known address;
    b. phone contact with care and service providers;
    c. contacting Local Government Unit (LGU)/Single Point of Access (SPOA);
    d. contacting collaterals, emergency contacts and supports to include
    e. parent, guardian or legally authorized representative, family, etc.;
    f. contacting the member's Parole Officer or Probation Officer, if applicable;
    g. accessing online criminal justice resources (e.g., WebCrim);
    h. contacting schools;

i. contacting Methadone clinic;
j. reviewing hospital alerts, RHIO, and PSYCKES; and,
k. others, appropriate to the member and to support search efforts.

NOTE: If CMA/CM did not perform Diligent Search Efforts during any of the three consecutive months, then Billing cannot occur for that month(s).

D. if Diligent Search Efforts do not result in the location of the member, the member must be disenrolled from the HH program (refer to Section F. Member cannot be located).

Disengaged
A member may be deemed disengaged from CM services when Standard CM activities have been attempted but do not result in successful contact with the member. Before determining a member as disengaged from CM services, the CM should take into account usual patterns of behavior exhibited by the member known to result in inconsistent engagement or anticipated temporary disengagement (such as: a pattern of inconsistent attendance with scheduled appointments despite CM reminders; member is without stable housing and changes living arrangements frequently; member is often without access to a phone, etc.).

Excluded Settings
For the purpose of this policy, 'excluded settings' are defined as: inpatient, hospitalization, or residential facility; incarceration; nursing home, etc.

This also includes a psychiatric center in relation to individuals who are between 21 and 64 years of age and residing in the center.

Member Status
A member's engagement status may require changes in the MAPP HHTS during the course of search and re-engagement efforts based on CM activities as specified in this policy.

Standard Care Management Activities
Standard CM activities may include, but are not limited to: face-to-face visits, interactive communications via phone calls and/or electronic communications, direct contact with care team members, family/supports including parent, guardian, legally authorized representative, other collaterals, and so forth.

NOTE: Activities such as leaving a voice message, mailing a letter, and sending texts or emails are necessary activities to keep a member engaged in care management. However, if these methods do not result in a reply from the member, they cannot be considered CM core services.

Procedures
To meet the needs of any given member in a fully integrated person-centered care model, the CM must be able to engage with members and provide core Health Home services on a consistent basis. When engagement with the member does not occur, the CM needs to determine an appropriate course of action to take to locate and re-engage the member, for example: what steps will be taken? For how long? The CM must determine when the member is deemed disengaged from CM services, and initiate more intensive efforts to locate the member, as defined in this policy.

BHH must establish and maintain policies and procedures that address how a member is identified as disengaged from care management services; steps that must be taken to search for and re-engage disengaged members; specific timeframes associated with location and re-engagement efforts; acceptable billing practices; and quality monitoring activities.

A. Initiating Location and Re-engagement Activities (Diligent Search Efforts)

Upon first identifying a member as disengaged from CM services, the CM must initiate Diligent Search Efforts (refer to Definition), to include the following:

1. document all efforts taken to engage the member through Standard Care Coordination Activities and how the member was identified as disengaged from CM services.
2. notify the CM supervisor of member's disengagement and discuss the plan for conducting Diligent Search Efforts. (Refer to Section G of this policy: The Role of the CMA Supervisor).
3. document all Diligent Search Efforts taken to locate the member, including notification to the MMCP and/or HH, and the outcome of all activities.
4. During the period of Diligent Search Efforts, the member's enrollment segment in the MAPP HHTS must be in the "pended' status with a pend reason code of 05, "Pended due to Diligent Search Efforts."
5. Billing at the enrollment rate is allowed during the three months of Diligent Search Efforts, as long as the CMA can demonstrate that appropriate search efforts were conducted (refer to Definitions section for special rules related to HHSC).

B. Successful member location and re-engagement

Upon successful location of the member, the CM must assure timely re-engagement occurs.
The CM must:

1. discusswiththememberanyreasonsfordisruptionincontinuityofcareand possible resolution;
2. ensure all consents are still active and in place, or seek proper consents or make needed updates;
3. discuss with member's care team any issues identified to collaborate on possible ways to prevent reoccurrence and support member retention and safety;
4. evaluate and screen the member for additional risk factors, and complete appropriate assessments, as indicated;
5. update the member's plan of care if any changes are identified in member goals or service needs, and notify the member's care team;
6. conduct a case review with the CM supervisor and/or care team, as appropriate.
7. The CMA must create a new enrollment segment in the MAPP HHTS for the member, backdated to the first day of the month in which the member was located.
8. The CMA may resume billing at the enrollment rate for activities conducted to locate and re-engage the member.

C. When the member is located within an excluded setting

There may be instances when a member is located in an "excluded setting" and, therefore re-engagement of the member may not occur immediately. If the CM anticipates that the member will be in the excluded setting for more than six (6) months, then the CM should end date the member's segment with the appropriate end date reason code. The CM must follow procedures for disenrolling the member from BHH.

Process

If the CM anticipates that a member will be in an excluded setting for less than six (6) months, then the member can remain enrolled in the Health Home program in pended status for a period of six consecutive months to support member retention and opportunities for re-engagement. Use the following definitions to calculate the six (6) months.

For members located in an inpatient facility or nursing home, the six-month period begins on the date of admission into that setting. For incarceration, the six-month period is calculated beginning on the first day of incarceration.

For members expected to be discharged/released from the excluded setting within six (6) months of their admission date, a warm handoff/direct linkage to CM services is vital to support the safe transition and timely re-engagement of the member. The CM/CMA should prepare for the member's discharge/release by monitoring the member's status to assure participation in discharge planning procedures occurs.

To establish the likelihood of the member's discharge/release from an excluded setting within the six-month period, the CM must:

1. make contact with the member and/or discharge planning staff of excluded setting to provide notification of the member's HH enrollment, confirm the member's admission/incarceration date and anticipated length of stay in the excluded setting, and to collaborate on discharge planning procedures; NOTE: Upon identifying an enrolled member as incarcerated, the HHCM must contact the criminal justice setting to ascertain the length of anticipated sentence (less/greater than six months). Although this is not a billable HHCM activity, it is necessary to support the member's HH enrollment and continuity of care upon release (refer to the Member Status and Billing section of this policy).
2. document all communication(s) with the member and/or discharge planning staff, and outcomes, including potential for member's disenrollment from the HH program;
3. review outcomes with CM supervisor and establish plan for member re- engagement, or member disenrollment, if indicated;
4. notify the member's care team; and;
5. update member's plan of care accordingly.

Member Status and Billing

When a member is in an excluded setting, certain protocols apply related to the Member's Status in the MAPP HHTS and billing activities, as follows:

1. Making direct contact with the member and/or discharge planning staff of the excluded setting may be considered a core CM service as long as the CM can demonstrate proper contact was made for the purpose of the member's discharge/release from the excluded setting.
2. For the month in which the member enters the excluded setting, or the CM/CMA first makes contact with the member and/or staff of the excluded setting, the CMA may bill for CM services at the enrollment rate. The CMA must change the member's enrollment segment status to 'active' for this one month, resuming 'pended' status for subsequent months during which time billing may not occur.
3. For incarceration. If the HHCM performs a core service within the same month the member was incarcerated (e.g., conducts appropriate Diligent Search Efforts), the CMA can bill as long as the core service was provided PRIOR TO the date of incarceration. Any core service provided ON/AFTER the date of incarceration may not be billed for, and no billing is allowed for the remainder of the time the member is incarcerated.
4. The member's segment in the MAPP HHTS should be pended on the first day of the month immediately following the month in which the member was incarcerated.
5. During the period of time when the member is in the excluded setting, the member's segment in the MAPP HHTS must be in 'pended' status with the appropriate pend reason code. If an existing pend reason code does not adequately describe the excluded setting, the segment should be pended using pend reason code 04, "Pended due to Other" with a comment of "Excluded Setting" and specifying the type of setting.
6. In the thirty (30) days prior to the member's discharge from the excluded setting, if the CM/CMA participates in active discharge planning activities to re-engage the member, the member's enrollment segment must be changed to 'active' status and the CMA may bill for this month (this does not apply to members who are incarcerated).
7. Upon the member's discharge/release with successful re-engagement the CMA may maintain the member's 'active' enrollment status, and resume billing activities.

NOTE: CMs must use professional discretion when identifying opportunities to re- engage members whose discharge/release may require a period slightly longer than six months.

Member requests to disenroll from Health Home Program

A member may ask to disenroll from BHH at any time. If this should occur during re-engagement activities, the CM must:

1. evaluate the current state of the member and inquire whether the member's decision to disenroll is related to a complaint or dissatisfaction with an aspect(s) of the HH program. Provide follow up as appropriate;
2. provide critical time intervention accordingly;
3. follow procedures for a timely and safe disenrollment plan found in the following HH policy:
4. The CMA must end the member's enrollment segment with the last day of the month in which the member disenrolls using the most appropriate Segment End Date Reason Code.
5. Upon disenrollment of the member, all billing must cease. If a core service is provided in the month of disenrollment, billing can occur during that month

Member cannot be located

If after Diligent Search Efforts have been conducted the member is not located, the member must be disenrolled from the Health Home program. The CMA must end the member's enrollment segment using the most appropriate Segment End Date Reason Code (e.g., reason code #14 Enrolled Health Home member disengaged from Care Management services). Upon disenrollment of the member, all billing must cease.

The Role of the CMA Supervisor

The role of the CM supervisor is vital to ensuring appropriate activities were taken to locate and re-engage members determined to be disengaged from CM services.

The CM supervisor must:

1. ensure that the CM notifies their supervisor whenever a member is determined to be disengaged from care management services;
2. provide CMs with clinical and policy guidance to support all level of search efforts;
3. be actively involved in the decision to disenroll the member from the HH program;
4. participate in case reviews, as appropriate;
5. assure notification is provided to MMCP, and,
6. assure timely notification to HH occurs for the provision of Notice of Determination, where applicable.

Quality Management

NOTE: BHH evaluates patterns related to member disengagement within its own network and establishes Quality Monitoring activities to address issues identified.

BHH assures quality monitoring activities are in place and include:

- reasons for member disengagement using the lens of avoidable versus unavoidable events;
- appropriateness of care management efforts used to locate, reengage and retain members;
- timelines were followed and met;
- maintenance of Member Status;
- billing procedures were followed;
- involvement of CMA Supervisor;
- update to the member plan of care in response to changes in service needs or identified risk factors, as needed;
- timely notification to MMCP and BHH;
- appropriate notification to member's care team;
- members not located;
- members that could not be re-engaged in CM services (e.g., excluded setting longer than six month);
- members disenrolled from BHH; and,
- appropriate training is provided to BHH and CMA staff in response to outcomes from quality monitoring activities.

Reference:

NYS DOH Health Homes Provider Manual

Policy: HH0006, Continuity of Care and Re-Engagement for Enrolled Health Home Members *(See Appendix)*

BHH Policy No. 10.02: Case Transfer

Effective Date: 01/09/2014
Last Review Date: 06/07/2021

Policy: All members transferred between levels of care, service providers, or Health Homes must receive support from the care management personnel which promotes a continuance of care.

Procedure:
When moving a member from one CMA to another or one health home to another, the applicable procedures below must be followed to facilitate the seamless transition of information and care.

Transfer between care management agencies within the Brooklyn Health Home network

When a need (or perceived need) to transfer a member from one CMA to another within BHH arises (e.g., language barriers, geographic parameters, clinical needs, member request):

1. The existing CMA must report such need to BHH personnel in a secure manner as soon as the need for transfer is identified.
2. The existing CMA (transferring care manager or their supervisor) must remain connected to any actively engaged member until a time where the member has been introduced to their newly assigned care manager. If a safety concern presents, this must be immediately reported to BHH personnel.
    a. Consent for communication between the existing and new CMA should be obtained as soon as possible

3. Once the transferring care manager is connected to the new CMA (in receipt of contact information for the new CMA), all remaining transfer activities must be completed within 10 business days of program identification that a transfer is needed.
    a. In the event that activities cannot be completed within the required timeframe due to circumstances outside of the transferring care manager's control (e.g., a member or agency does not respond to outreach attempts), the care manager must promptly notify BHH personnel of the status for further support and guidance

4. The transferring care manager must facilitate an introduction between the member and their new care manager (either telephonically or in person) for all actively engaged members
5. The new CMA is responsible for conducting a chart review to ensure that all needed documents are present and up-to-date in the member's record. Any deficits should be addressed immediately. Areas to review include, but are not limited to:
    a. Demographic and contact information data
    b. 5055 consent
    c. Care team composition
    d. Presence of up-to-date assessments
    e. Care plan
    f. Encounter notes up-to-date including a note explaining the purpose and plan for case transfer

6. The transferring care manager must identify deficit areas (e.g., inability to locate contact information for a provider) prior to the case transfer and highlight actionable areas that the new CMA will need to prioritize

7. Where consent is obtained, the transferring care manager (or other care management personnel as deemed appropriate by the overseeing manager/supervisor) must ensure that all assessment, care plan, and consent forms are securely transmitted to the new CMA and participate in a care conference providing a summary of case specifics to date

8. Please note: changing a CMA assignment has implications regarding MAPP/Health Home segments and billing. CMAs should work together to ensure that member transfers correspond with the start of a new business

month, so that a clean segment break can occur. The receiving CMA should be assigned as the CMA in the care management platform as soon as the transfer is complete, and should ensure that care management activities are documented appropriately. When member transfer cannot take place at the start of a new month, the CMAs will determine with the Health Home who will "claim" payment for care management activities in the month of transfer.

Transfer from the Brooklyn Health Home to another Health Home network

Transfers between Health Homes must be facilitated in a manner that allows the member to begin enrollment with the new Health Home by the first business day of the subsequent month that the transfer request was initiated. The transfer to the new Health Home may begin as either referral or warm handoff, depending on the level of connection that is forged between the member and the new Health Home during the transition period.

When a need (or perceived need) to transfer an enrolled member from the Brooklyn Health Home to another Health Home network arises (e.g., language barriers, geographic parameters, clinical needs, member request) the procedures to be followed are the same as 1-8 above.

Refer to the case closure policy for final documentation requirements.

Reference:
NYS DOH Health Homes Provider Manual, 4.8 Member Changing Health Home/CMA
Policy: HH0007, Member Disenrollment from the Health Home Program
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
Policy: HH0008, Health Home Plan of Care Policy *(See Appendix)*

BHH Policy No. 10.03: Case Closure/Disenrollment

Effective Date: 08/25/2015
Last Review Date: 07/10/2019

Policy: BHH records must accurately document the engagement status for all members. Records for members who are no longer eligible or appropriate for Health Home services must be closed out timely.

Member Eligibility for Case Closure:

1. Members that have successfully completed all care plan goals, deny any further or ongoing needs, and are confident in their ability to navigate ongoing health and life needs autonomously and without Health Home support should be reviewed for consideration for case closure or graduation.
    a. Members should be "titrated" down through periods of incrementally reduced contacts with the care manager.
    b. Each member must be provided with the appropriate connections/referrals/linkages in the community before the member's case is closed. These referrals and connections should be made and documented by the care manager as a part of ongoing care planning activities prior to complete closure.

2. Members that are no longer Medicaid eligible or possess a coverage type not compatible with Health Homes should be reviewed for case closure.

    Note: This is not the same as when a member's Medicaid coverage has lapsed. When a lapse in coverage occurs, the CM should make every effort to assist the member in recertifying Medicaid to maintain coverage.

3. Members that are being closed due to a need for a different level of care (e.g., MCO care management, ACT, AOT, inpatient treatment) must be supported through referral process entirely. The new provider contact should be included in the care team and care plan activities as needed to support the member's transition from health home care management to the new service before the care manager closes the case completely.

    Note: Members who are on court-ordered AOT must *not* be disenrolled from the Health Home Program without approval from the Local Government Unit (LGU)/SPOA.

4. Members may be closed out for other reasons not listed above; please see procedures below for additional detail.

Procedure:

5. Members eligible for case closure must be flagged for supervisory review and approval within 3 business days of receipt of knowledge of the case closure eligibility.
    a. Supervisory review should be conducted no later than 5 business days following submission for supervisory review and approval.

6. When a member is approved for discharge, the responsible CMA staff must record a case closure note in the member's record. The case closure note should summarize:
    a. Date of referral & referral source
    b. An overview of the care episode (needs, goals, accomplishments)
    c. Identification of the factors leading to case closure
    d. The name of the supervisor approving case closure
    e. The reason the case is closing (the end date reason code that will be selected in Care Management Platform)
    f. Any closing referrals/connections that were made and whether these connections were successful or not (e.g., whether the member followed through with the referrals); if connections were not successful, why

they failed, and what the care manager did to try to support the success of the referral (e.g., member refused, care manager attempted to explain benefits of referral, etc.)

g. The member's refusal or inability to participate in the disenrollment process, if applicable
h. The effective date of the case closing
i. The completion of the withdrawal of consent form (DOH-5058), if applicable
j. The issuance of the Notice of Determination (NOD) to the member and the method by which it is sent (mail, in-person, email, or any other method specifically requested by the member)
k. Note: unless a core service (e.g., the provision of referrals for follow up) was delivered, "case closure" notes should be entered with the core service "non-billable"

7. The case closure reason selected in Care management platform must uphold the rationale outlined in the guidance table provided within this policy.

8. Care management personnel must review their panel at least monthly to verify that all retained members are actively engaged in either outreach or care management activities; any members found to be disengaged from services must be engaged in the case closure process immediately.

9. The Brooklyn Health Home requires additional supervisory assistance for candidates and members exiting the program for the following reasons:
   a. Transfer
   b. Disruptive/uncooperative behavior
   c. Lost to services
   d. Patient dissatisfied with services
   e. Member dis-enrolled
   f. Opt out
   g. Graduation

   *In these cases, the supervisor must review the circumstances leading up to the case closure request, verify that all means of care management interventions have been exhausted, and confirm that no further interventions can be reasonably applied to avoid the closure. Wherever possible, the supervisor should make an effort to contact the member directly to review and verify the reasoning for closing the case.

10. Members experiencing incarceration and/or inpatient hospitalization or residential treatment may be eligible for care management services for up to 90 days of service in the correctional or hospital setting. Neither incarceration nor hospitalization should result in an automatic case closure, but should trigger case conference activities involving BHH staff if necessary to determine the most clinically appropriate course of activities for the given situation. See also: Continuity of Care Policy.

Reference:
NYS DOH Health Homes Provider Manual
Policy: HH0007, Member Disenrollment from the Health Home Program *(See Appendix)*

BHH Policy No. 10.04: Care Transitions

Effective Date: 01/31/2017
Last Review Date: 6/15/2021

Policy: BHH members must receive structured support and follow up during all aspects of care transitions.

Procedure:

1. Care managers (CMs) must follow all policies related to case conferencing, care planning and alert response during a member's hospitalization/incarceration. All members must be directed towards the most stable and supportive housing option available to them immediately upon release.

2. CMs must review the consent form (DOH-5055) to ensure that all appropriate resources are included and must update the consent as needed to include any newly acquired treatment providers, resources, or supports.

3. CMs must work with the member (and consented supports) in collaboration with their supervisor and care team providers to develop and implement monitoring plans that include enhanced CM involvement until the care team determines that the member has returned to baseline.

4. For care transitions that involve referrals to a higher level of care (e.g., substance use outpatient care to inpatient care), CMs are required to ensure that the care team is expanded to include new treatment providers, that the member is well informed of the transition plan, and that the member is supported throughout the transition.

5. CMs should consider the following guidelines (not an exhaustive list) regarding care transitions:

Discharge from Medical Hospitalizations – OR – long term facilities supporting medical stabilization

6. Within 1 business day of release, ensure that the member:
    a. Has all needed medications and understands the medication schedule
        i. Note: Member should be assessed for mobility and comfort traveling to pharmacy, organizing multiple medications and confidence in adhering to medication schedule. If barriers exist in any of these areas, pharmacy needs should be transferred to a delivery program that will customize the organization, packaging, formulation, and delivery preferences to a method most suitable for the member in collaboration with prescribing provider or appropriate clinician
    b. Has the ability to keep track of scheduled follow up appointments and reliable plans for support in reaching each of those appointments (appropriate mode of transportation, need for care manager, care navigator, family, or other involved support to accompany member to appointments)
    c. Has a copy of discharge papers/summary
    d. Has an appointment scheduled with a primary care doctor, and any specialists related to the conditions associated with the cause of hospitalization (e.g., pulmonology, neurology, endocrinology, etc.).
        i. Note: appointment should be scheduled within 1-2 days following release from the hospital, but the immediacy of the appointment date/time will be determined by the provider
    e. Any consented family members (or social supports) should be provided an overview of the discharge summary and follow up plan, and be given information about available family supports (e.g., diabetes support group, informational sessions hosted by managed care or doctors, cancer support groups, etc.).

Within 5-7 business days of release, ensure that member:

    a. Has access to information about wellness activities and programs that will promote medical stability (e.g., smoking cessation, diabetes management, high blood pressure management etc.)
    b. Care conference with care team has been scheduled
    c. MCO, if applicable, has been included in discharge and aftercare debriefing

Continues to demonstrate understanding in managing follow up plans (medication, appointment) and is showing appropriate progress in recovery member in collaboration with provider or appropriate clinician

d. Has attended scheduled follow up visits – OR – has promptly rescheduled any missed appointments
e. Medication is obtained and member is adherent to medication regimen

Discharge from Mental Health Hospitalizations – OR- long term facilities supporting mental health needs

7. Within 1 business day of release, ensure that member:
    a. Has all needed medications and understands medication schedule
        i. Note: Member should be assessed for mobility and comfort traveling to pharmacy for refills, organizing multiple medications, and confidence in managing adherence to medication schedule. If beneficial, pharmacy needs should be connected to a delivery program that will customize the organization, packaging, formulation, and delivery preferences to a method most suitable for the member
    b. Has a system of organization for noting any scheduled follow up appointments
    c. Has a copy of discharge papers/summary
    d. Has an appointment scheduled with a mental health provider and psychiatrist with reliable plans for support in reaching each of those appointments (appropriate mode of transportation, need for care manager, care navigator, family, or other involved support to accompany member to appointments)
        i. Note: appointment should be scheduled within 1-2 days following release from the hospital, but the immediacy of the appointment date/time will be determined by the provider
        ii. Psychiatry appointments must be secured in a manner that ensures medication regimen will carry forward without disruption
    e. Any consented family and social supports are provided an overview of the discharge summary and plans
    f. Completion of a safety plan that clearly identifies triggers/factors that led to the hospitalization and methods for managing such factors.
        i. Safety plans should be completed on hard copy, a photocopy given to the member, and original stored in the Care Management platform
        ii. Safety plan must include information about support services such as crisis hotlines available to the member

Within 5-7 business days of release, ensure that member:

a. Has followed through with all scheduled appointments or promptly rescheduled those appointments
b. Medication is obtained and member is adherent to medication regimen
c. Has access to wellness support activities such as NAMI groups, clubhouse, or other activities designed to promote the member's comfort and growth in their community while managing mental health needs
d. Care conferencing has been completed/scheduled

Substance Use Disorder/Abuse Related Hospitalizations – OR- long term facilities supporting substance use recovery needs

8. Within 1 business day of release, ensure that the member:
    a. Has all needed medications and understands medication schedule; if being connected to a methadone maintenance program, ensure that program is consented, member is familiar with medication disbursement schedule/expectations, and has reliable means of traveling to/from appointments
        i. Note: Member should be assessed for mobility and comfort traveling to pharmacy, organizing multiple medications and confidence in adhering to medication schedule. If barriers exist in any of these areas, pharmacy needs should be transferred to a delivery program that will customize the organization, packaging, formulation, and delivery preferences to a method most suitable for the member in collaboration with prescribing provider or appropriate clinician
    b. Has a system of organization for noting any scheduled follow up appointments
    c. Has a copy of discharge papers/summary
    d. Has the ability to keep track of scheduled follow up appointments and reliable plans for support in reaching each of those appointments (appropriate mode of transportation, need for care manager, care

navigator, family, or other involved support to accompany member to appointments). If a co-occurring mental health need is present, adhere to mental health discharge guide in this policy alongside this substance use recovery specific policy and confer with supervisor, as needed.

e. Any consented family and social supports are provided an overview of the discharge summary and plans and provided with information about family support (e.g., Nar-Anon, Al-Anon)
g. Completion of a safety plan that clearly identifies triggers/factors that led to the hospitalization and methods for managing such factors.
    i. Safety plans should be completed on hard copy, a photocopy given to the member, and original stored in the Care Management platform
    ii. Safety plan must include information about support services such as crisis hotlines available to the member
    iii. BHH strongly recommends family and social supports be engaged in the recovery process
f. Member is aware of local self-help groups and schedules (e.g., AA, NA, Nar-Anon, etc.)

<u>Within 5-7 business days of release, ensure that member:</u>

a. Has followed through with all scheduled appointments or promptly rescheduled those appointments
b. Medication is obtained and member is adherent to medication regimen
c. Has access to wellness support activities as noted above
d. Care conferencing has been completed/scheduled

9. Monitoring activities must continue for the member and their family for as long as needed to ensure stabilization and secure connection to the appropriate level(s) of care and needed resources. Any disruptions in progress should include immediate supervisory oversight/support, and if needed, support from BHH.

10. Ensure that every member is continually re-assessed for appropriateness for care management services alongside other service modalities such as ACT, and verify that the member is receiving the best possible level of care/support for their unique needs and situation.

BHH Policy No. 10.05 Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings

Effective Date:
Last Review Date:

Policy: This policy specifically addresses steps that must be taken to manage new referrals from excluded settings of potentially eligible Health Home members. When a CMA receives a referral of an individual in an excluded setting identified as potentially eligible for HH, BHH must initiate appropriate activities intended to support collaboration with the individual and the staff of the excluded setting for the purpose of discharge planning and HH enrollment.

Definitions

Excluded settings: For the purpose of this policy, excluded settings are those not compatible with Health Home enrollment. Examples of excluded settings include but are not limited to: nursing homes, inpatient settings such as psychiatric centers; institutions, residential facilities (RTC, RTF). Please refer to the Guide to Restriction Exception (RE) Codes and Health Home Services for a description.

Procedure:
The referral of an adult in an excluded setting may be received by a HH/CMA at any time prior to the individual's anticipated discharge date. However, for the purpose of this policy, billing for HHCM activities related to discharge planning is restricted to the thirty-day period prior to the individual's discharge.

HHCM activities related to discharge planning and transition must not duplicate usual discharge planning activities performed by the excluded setting. Acceptable HHCM activities include: meeting face to face with the individual; working directly with staff of excluded settings for the purpose of discharge planning (e.g., confirm discharge date; attend discharge planning meetings; discuss discharge plan to establish post discharge needs; etc.), confirming the individual meets all eligibility requirements for HH enrollment with documented evidence; obtaining Health Home consent to complete the enrollment process; and so forth.

Billing
Certain billing rules apply regarding HHCM activities related to discharge planning from an excluded setting, as follows:

- Billing may only occur for appropriate discharge planning activities conducted in the thirty-days prior to the individual's discharge from the excluded setting.
- One billing instance is allowed for HHCM activities performed during the time the individual is in the excluded setting awaiting discharge.
- The HHCM must maintain documented evidence of all activities conducted to support billing. Such documentation must include proof of eligibility to support HH enrollment, and a completed and signed Health Home consent.

Health Home MAPP-HHTS Process
Once a referral has been made and accepted by BHH/CMA, the assigned HHCM will contact the excluded setting who referred the individual to establish a tentative discharge date and the needs of the individual.

After the HHCM meets with the individual, determines that the individual meets HH eligibility, and obtains appropriate Health Home Consent for enrollment, an enrollment segment can be opened in the MAPPHHTS.

For Potential Discharges Delayed Beyond the Expected Thirty Day Period
If for some reason discharge cannot occur on the expected date, the HHCM bills for the month that contact was made with the excluded setting in preparation for the discharge prior to obtaining information of a delayed

discharge. If HH eligibility had been determined with HH consent to enroll, then the HHCM will pend the segment until the month of discharge and HH core services begin.

If HH eligibility has not yet been determined with HH consent to enroll, the HHCM can indicate to the excluded setting to make another referral within 30 days of discharge or continue the individual in assignment or outreach status (which ever status the individual was in when learning of the delayed discharge) without any HH billing.

Training

BHH ensures that adequate training guidance is provided on conducting activities related to managing referrals of potential Health Home eligible individuals in excluded settings, including timeline limitations, documentation requirements, and acceptable billing practices.

Quality Management

BHH ensures that quality monitoring related to managing referrals of HH-eligible individuals newly referred from excluded settings are in place in accordance with the standards outlined in the Health Home Quality Management Program policy HH0003, which can be accessed on the Health Home Policy and Updates webpage.

Reference:

NYS DOH Health Homes Provider Manual

Policy: HH0011, Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings *(See Appendix)*

Appendix

New York State Department of Health (NYSDOH), Health Home Program Provider Manual (July 2019)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm

NYS DOH Health Homes Provider Manual
Policy: HH0003, Health Home Quality Management Program
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/quality_management_program_policy.pdf

NYS DOH Health Homes Provider Manual
(5) Health Home Billing
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

NYS DOH Health Homes Provider Manual
Policy: HH0010, Background Check Requirements for Health Homes and Care Managers
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0010_background_checks_policy.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0009, Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0009_phi_and_consent_policy.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0004, Health Home Notices of Determination and Fair Hearing Policy
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh0004_fair_hearing_nod_policy.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0005, Health Home Monitoring: Reportable Incidents Policies and Procedures
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh0004_fair_hearing_nod_policy.pdf

NYS DOH
Eligibility Requirements: Identifying Potential Members for Health Home Services
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

NYS DOH
Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations (January 2021)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0002, Comprehensive Care Management
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0008, Health Home Plan of Care Policy
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0008_plan_of_care_policy.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0007, Member Disenrollment from the Health Home Program
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0007_member_disenrollment_policy.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0006, Continuity of Care and Re-Engagement for Enrolled Health Home Members
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0006_continuity_of_care_policy.pdf

NYS DOH, Health Homes and Special Populations
Webpage:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/hh_plus.htm

NYS DOH, Adult Home Plus (AH+)
Guidance for Adult Home Plus Program (AH+)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/ah_plus_policy_procedure.pdf

NYS DOH, Health Home Plus (HH+)
Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness (February 2021)
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/hh_plus_high_need_smi_guidance.pdf

NYS DOH Health Homes Provider Manual
Policy: HH0011, Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0011_hhcm_activities_billing_protocol_excluded_settings.pdf