Care Management User Guide

Home

- Enrollment
- Consent
- Assessments
- Plan of Care
- Encounters
- Core Services
- Case Conference
- Critical Events
- Graduation

Brooklyn Health Home

BHH: Free service helping community members manage their medical needs, appointments and social services *ex. housing and food*

- Enrollment is ***Voluntary***
- Enrolled Members are assigned to a **Health Home Care Manager**

Care Managers:

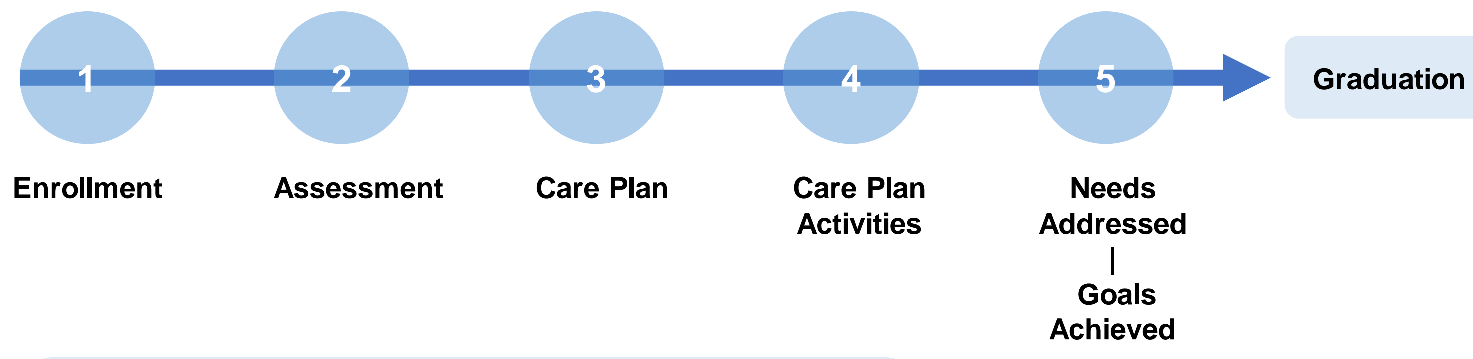
- **Communicate** with Medical, Behavioral Health and Social Service Providers
- **Assess** for New/Current Goals and Needs
- **Develop** a *Person-Centered* Plan of Care
- **Respond** to Important Life Events:
  - *Emergency Room Visits*
  - *Inpatient Stays*
  - *Changes in Employment and Education*
  - *Financial Hardships*
  - *Housing Crisis*

Key Assistance

- Scheduling Provider Appts
- Navigating the Healthcare System
- Communication with Healthcare Providers
- Better Access to Healthcare Services
- Creation of a Care Plan filled with Personal Goals
- Referrals to Social Services

Enrollment Path

Timeline



Encounters are activities/interventions driving care toward goals

Care Plans are the road map

Assessments are tools

Care Team Members (Including the Member) **are Co-Pilots**

Basic Points

Conduct

- You *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**
- All communication should be direct, objective, thoughtful, and without jargon
- The use of physical force in any interaction with a member, staff, or community member is strictly prohibited

Courtesy

Respect

Professionalism

Field Visits: Safety Practices

- Always inform your Supervisor prior to making a field visit, specifying which member and location
- Keep your phone on, and easily accessible
- Make Supervisor aware of your location

Safety First,

Always!

Records

- ✓ Charts must be stored in a secure manner that upholds all member privacy rights
- ✓ Copies of all case-specific documents should be stored electronically in the member's chart in care management platform
- ✓ All signed documents must be maintained in the member's record

Confidentiality

- ✓ All member charts, records, and information must be securely stored and safeguarded
- ✓ Members and candidates have the right to a full review and explanation of Brooklyn Health Home's confidentiality policies
- ✓ 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

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

Enrollment

Enrollment Process

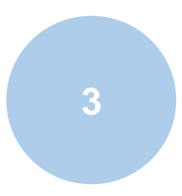
Confirm Eligibility

1

***Active Medicaid**

2

Chronic Conditions



Appropriate Needs

Adverse Event Examples:

- At-risk for Death, Disability, Injury
- Inpatient or nursing home admission
- Homelessness
- Recent Incarceration / Justice Involvement

***Check RE codes for restrictions**

Checklist

Chronic Conditions
❑ HIV/AIDS
❑ Serious Mental Illness (SMI)
❑ Sickle Cell Disease
❑ 2 or more Chronic Conditions

Appropriate Needs
❑ At-risk for **Adverse Event**
❑ Lacks Social, Family Support
❑ Medication/Treatment Issues
❑ Not Linked to Needed Healthcare
❑ Recent Transition to Community
❑ Difficulty with ADLs
❑ Concerned about Personal Safety

DOH Health Home Chronic Conditions Eligibility

Enrollment Process

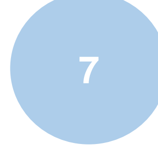
Start Enrollment Documentation

Informed Consent

5

Complete Forms:
- ✓ DOH 5055
- ✓ DOH 5234
- ✓ Bill of Rights

Create New Enrollment (E) Segment



Upload Enrollment Forms and Medical Documents

Obtain Current Medical Documents

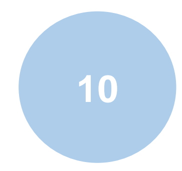
Checklist

Action Items
❑ Identify Goals, Needs and/or Reasons for Enrollment
❑ Identify Provider(s) and Care Team Members, or Needed Providers
❑ Submit Request for Medical Documentation with New/Current Consent Form
❑ Upload Proof of Eligibility + Supporting Documentation Collected to FCM
❑ Create New Enrollment Segment (*if applicable*)

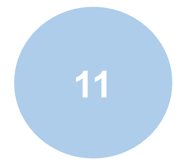
Enrollment Process

Continue Enrollment Documentation

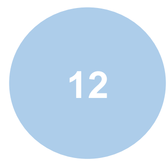
Create Enrollment Encounter



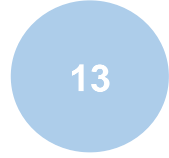
Create Plan of Care



Create Initial Comprehensive Assessment



Complete 1st Follow-up Encounter



Continue Comp Assessment + Plan of Care with Member

Checklist

Action Items
❑ Enter 1st Encounter or Enrollment Period Details in an Encounter Note
❑ Include Most Immediate Need(s) and Goal(s) in POC (*should include goals that are short in duration, achievable by Care Team Members within first 30-90 days and/or prioritized by member*)
❑ Record and Enter Known Data/Information to Initial Comp Assessment
❑ Follow-up with Member during Scheduled Appointment and Review/Complete Comp Assessment and Plan of Care (*if updates available*).

Enrollment Need Areas

I want to be linked to

- ❑ Primary Care Provider (Doctor)
- ❑ Dentist (Dental Care)
- ❑ Ophthalmologist (Eye Care)
- ❑ Specialty Provider
- ❑ Therapist
- ❑ Psychiatrist
- ❑ Harm Reduction Program
- ❑ Alcohol/Substance Use Program
- ❑ Support Group

I need help managing

- ❑ Medication & Treatment
- ❑ Medical Appointment Navigation
- ❑ Mental Health Symptoms
- ❑ HIV/AIDS Care (Viral Load / CD4 Monitoring)
- ❑ Diabetes Mellitus Type I/II
- ❑ Cardiovascular Disease
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Respiratory (Asthma, COPD etc.)

I want to apply for

- ❑ SSI/SSDI (SSA)
- ❑ SNAP (HRA)
- ❑ Public Assistance (HRA)
- ❑ Meal Delivery (Gods Love, Meals on Wheels)
- ❑ HASA (HRA)
- ❑ Housing – Low Income/Supportive Housing
- ❑ HEAP (HRA)

I need help with

- ❑ Obtaining/Renewing Insurance
- ❑ Obtaining Legal Services
- ❑ Education/Employment
- ❑ Housing Loss/Eviction Prevention
- ❑ Family / Social Support
- ❑ Managing Coping Skills
- ❑ Building a Safety Plan

Person-Centered Care

Person Centered Care

Ensures that the member is an active participant in care coordination services

Importance?

- Builds Rapport
- Increases Engagement
- Improves Participation in Services

Questions to Support Person-Centered Care

I'm interested in learning more about you……

- ❑ How can we support you?
- ❑ What goals are important to you?
- ❑ How can we work on that together?
- ❑ What do you hope to accomplish in our **work together?**

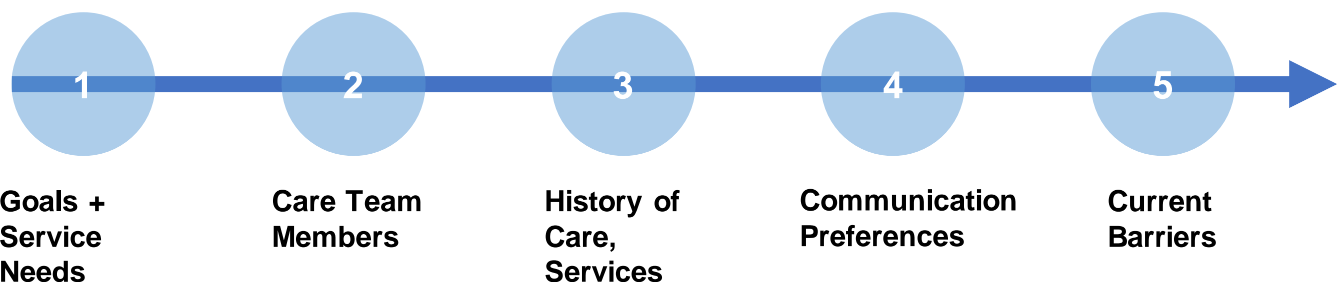
Give the Member a Voice!

Prioritize member's goals!

Do not focus ONLY on what you as the Care Manager think is important

Initial Encounter (First 30 Days)

How can I help you today?



Do you have any questions about the Health Home Program?

Initial Encounter (First 30 Days)

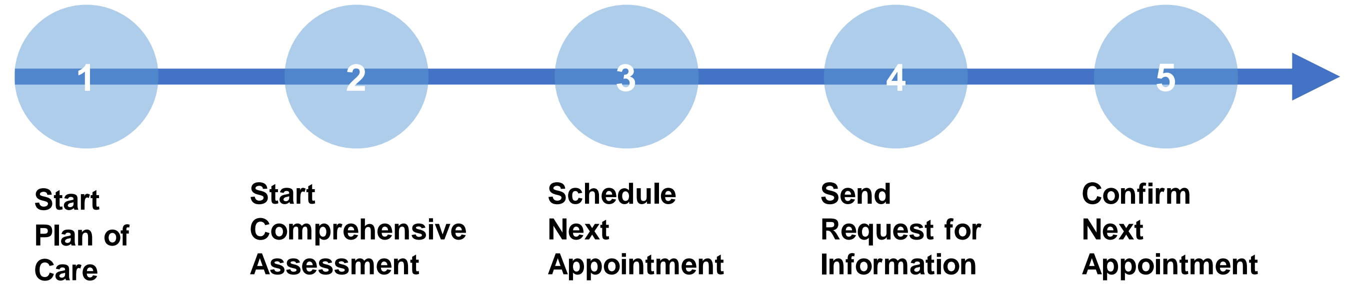
Care Manager Actions

Checklist

Data Sources
❑ PSYCKES
❑ Referring Source Details
❑ Discharge Summaries
❑ Lab Results
❑ Provider Notes
❑ Verify Medications - *prescription bottles*
❑ Letters from Social Security or HRA
❑ Lease or Utility bills (*Income and Expenses*)
❑ Care Conference with Providers

Initial Encounter (First 30 Days)

Care Manager Actions



Checklist

30 Days	60 Days	90 Days
❑ Enrollment Documents	❑ Confirm Medical Doc Request	❑ Review Prior Encounters
❑ Enrollment Encounter	❑ Complete F/U Appt	❑ Complete F/U Appt
❑ Initiate Plan of Care	❑ Complete Comp Assessment	❑ Update POC Activities
❑ Create Comp Assessment	❑ Continue POC Development	❑ Upload Signed Plan of Care
❑ Schedule Next Appt	❑ Document Core Services Provided	❑ Upload Diagnosis Verification(s)

Engagement Strategies

How to Engage a Member

- ✓ **Explain HH Services and Care Manager Role** Start Early on in Process
- ✓ **Set Reasonable Expectations** Goals Should be Appropriate for Member
- ✓ **Stress Importance of Collaboration** Member "Buy-in" Enhances Services
- ✓ **Identify Communication Preference** Method, Frequency, Name, Pronouns
- ✓ **Review Purpose of Every Visit/Encounter or Intervention**

Important Health Home Elements

- ❑ Contact Frequency
- ❑ Collaboration with Member and Providers
- ❑ Highlight Progress and Achievements Often

Schedule the Next Appointment or Follow-up Call at End of Every Encounter

Engagement Strategies

Engaging Member

Care Manager Actions

- ❑ **Active Listening**
  - Pay Close Attention to What the Member is Saying
- ❑ **Ask Clarifying, Open-Ended Questions**
- ❑ **Use Reflections**
  - Repeat or Paraphrase What you've Heard
- ❑ **Be Aware of Non-Verbal Cues**
  - Body Language, Tone of Voice, Facial Expressions and Posture
- ❑ **Manage our own Reactions and Expectations in an Encounter**

Open-minded

Empathetic

Respectful

Supportive

Engagement Strategies

Meeting Preparation

- ✓ **Review Prior Encounter Notes**
- ✓ **Review Plan of Care before Visit** *What is Outstanding?*
- ✓ **Upcoming Appointments**
- ✓ **Documents Pending / Signatures Needed**

PREPARE YOUR MEETING SPACE

Level Setting

- ✓ Meet Members Where They are At
- ✓ Keep Members Informed of What I am Doing
- ✓ Set Ground Rules about Participation
- ✓ Set Clear Objectives
- ✓ Keep Meeting Structured
- ✓ Clear Barriers in Beginning of Member Engagement

What would you like to talk about / work on today?

Clearly Outline Next Steps

Engagement Strategies

Next Up

- Assess members feelings about meeting
- Assess your feelings about the meeting

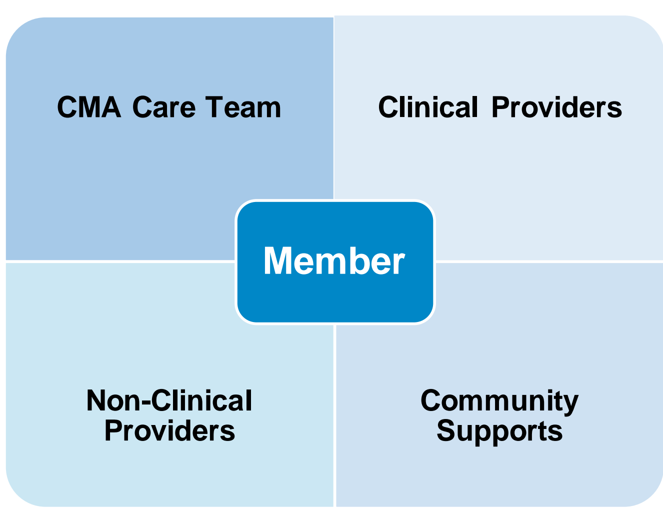
Questions to Consider…

- What will member complete for the next meeting?
- What does the care team need to help the member complete?
- What did the member like about the meeting?
- What would they prefer to target for the next meeting?

Consent

Health Home Consent

Member Care Team – Individuals involved in the health and well-being of the member



Consent Reasons

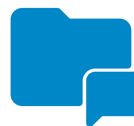
- ❑ **Access** to Healthcare
  Data/Information (*PSYCKES, RHIO*)
- ❑ **Communication** with Care Team
  Navigating Healthcare System
  - Case Conference
  - Data Sharing
  - Goal Planning
- ❑ **Support** from Care Team Members

Communication is Key!

Health Home Consent

Enrollment Forms

BHH & Care Management Agency



- ❑ Patient Bill of Rights
- ❑ Code of Conduct

DOH Required Forms:

- ❑ **DOH 5055** *Patient Information Sharing Consent*
- ❑ **DOH 5234** *Notice of Determination for Enrollment*

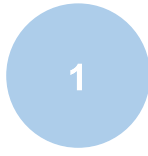
Informs members of their rights as a consumer of HH services, confirming enrollment and their right to a fair hearing

DOH 5234 Page 2 Completed for Fair Hearing Request
Complete if Member Does Not Agree with Notice of Enrollment

Key Objectives

- ❑ **Review** Current Care Team Members
- ❑ **Identify** Missing Care Team Members
- ❑ **Establish** Relationships and Program Structure
- ❑ ***Provide** Copy of Documents to Member **within 10 days of enrollment (in-person, mail, secure e-mail)*
- ❑ **Upload** Completed Documents to FCM

Health Home Consent



Consent Forms
DOH - 5055
DOH - 5234

2

Bill of Rights
Code of Conduct

3

Share Enrollment Update with Consenting Providers

4

Send Completed Consent to Consenting Providers

5

Schedule Initial Contact with Consenting Providers

Consenting Providers

Required
❑ Care Management Agency (**CMA**)
❑ MCO or Insurance Provider
❑ Primary Care Physician (**PCP**)
❑ Main Healthcare Provider (*if not PCP*)
❑ Mental Health Providers (*if applicable*)

Recommended
❑ Dentist
❑ Eye Doctor
❑ Specialists
❑ Emergency Contact
❑ Family & Friends

Home

Enrollment

Consent

Assessments

Plan of Care

Encounters

Core Services

Case Conference

Critical Events

Graduation

Assessments

Comprehensive Assessment

Q: What is the Assessment?

Answer
▪ Uniform tool that addresses the member's medical, behavioral, and social determinant needs
▪ Inclusive of all NYS DOH requirements
▪ Assesses for risk factors

Risk Factors

- HIV/AIDS
- Harm to Self or Others
- Persistent Use of Substances Impacting Wellness
- Food and/or Housing and other Instabilities using Screening Tools

Home

Assessments

Comprehensive Assessment Q&A

Assessment Starts at Enrollment!

Q: When is the Assessment conducted?

A: After member signs the Health Home Patient Information Sharing Consent Form (DOH-5055).

Q: How must the Assessment be completed?

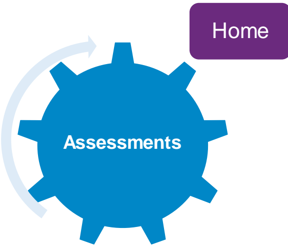
A: Through face-to-face encounters; it cannot be completed telephonically. Medical information including prescribed medications, lab results, diagnoses can be pulled from medical documents but should be reviewed with member during assessment.

Q: When must the Assessment be initiated?

A: Initiated in FCM within 30 days of obtaining the member's consent (DOH-5055) but the assessment process begins during the first encounter – assessing members immediate needs and goals

Q: When must the Assessment be completed?

A: Within 60 days from the date of consent/enrollment.



Comprehensive Assessment Q&A

Q: Who can I share the Assessment information with?

A: All Assessments may be shared with care team members if consented by the member.

Q: When is the Reassessment Due?

A: The Assessment must be re-administered every twelve months.

Q: What happens when the member's status changes? Should I update the Assessment?

A: You should continually evaluate changes in the member's status. Any changes that occur between annual reassessments should be recorded in the Care Plan.

Q: I've completed the Assessment, now what ?

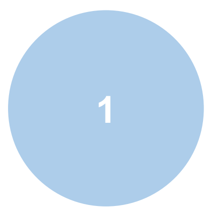
A: Member specific needs and goals should be used to develop the Plan of Care. Barriers and strengths should be documented in assessment summary and addressed in Plan of Care. All Assessment data must be entered into the member record within two business days of assessment completion.

LOCK THE ASSESSMENT IN THE CARE MANAGEMENT PLATFORM

Home

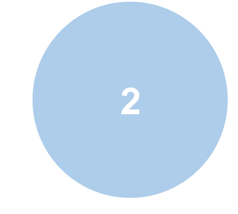
Comprehensive Assessment

Key Summary Details



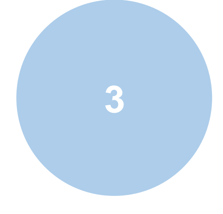
HH Linkage

How did the member connect to HH?



Program Eligibility

Why is member in need of HH?



Current Healthcare Needs

What can the CM help the member work on?

Past Healthcare Linkages and Care

What information is important to the work ahead?

What do we need to know to move forward?

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Non-Medical Factors

What other elements are impacting the member meeting their goals?

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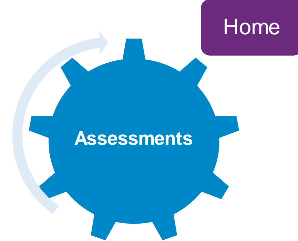
Comprehensive Assessment

Identifying Member Needs



Assessment Summary Essentials

- ❑ **Member Demographics** *Residence, Preferred/Best Method of Contact*
- ❑ **Connection to Health Home** *Referral, Length of Enrollment*
- ❑ **Purpose of Enrollment Member** *Needs + Goals, Gaps in Care*
- ❑ **Chronic Health Condition(s)** *Medical and Mental Health Diagnoses*
- ❑ **Medical + Mental Health** *Care Providers, Medication, Appt Adherence*
- ❑ **Risk Factors** *Inpatient History, Substance Use, Suicidal Ideation*
- ❑ **Social Services and Benefit Needs** *Food, Income, Rent Assistance*
- ❑ **Member Interactions** *Health Literacy, Level of Engagement, Triggers*
- ❑ **Education + Employment** *Historical Achievements, Interests, Goals*

Transforming Identified Needs into Goals

Short-Term Goals!

- ✓ Set Expectations Early
- ✓ Review Tasks Involved
- ✓ Assign Tasks to Members

Member wants to be linked to
(provider/service) **in order to** (*reason)*

Plan of Care

Home

Plan of Care

What is the Care Plan?

Think of it as a road map for the services we provide and link the member to!

What does the Care Plan Include?

- ❑ **Need** Current Issue and what is going to be addressed
- ❑ **Need Note** Strengths, Barriers and/or Challenges
- ❑ **Goals & Tasks**
  - Short-term (< *6 months*)
  - Long-term *(> 6 months)*

Key Elements

- ✓ Person-Centered
- ✓ Member should Agree and Understand
- ✓ Avoid technical jargon and abbreviations
- ✓ Include Community Supports and Collaterals (family, friends, support)
- ✓ Include preventative/wellness activities (Annual physical, dental visit, vision care)

"**Family**" individuals that the member feels are a part of their primary support network

Plan of Care

What Should We Ask the Member?

Short-term or long-term goals you are looking to accomplish in our work together?

Healthcare /employment/housing/ benefits barriers you are facing at this time?

Expectations of our work together while you are enrolled in Health Home services?

Change you would like to see in the next 90 days?

Is there anything I can help with your journey to wellness as your Care Manager?

Home

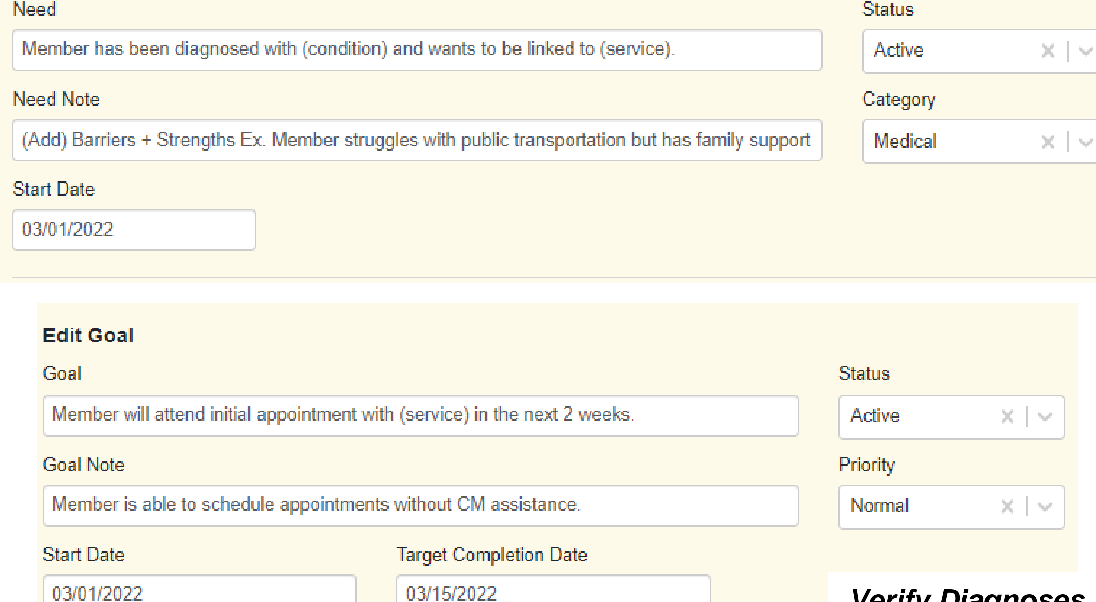
Plan of Care

Elements of a Person-Centered Plan of Care

	NEEDS	GOALS	TASKS
Purpose	▪ **Identified** from Assessment(s) ▪ **Member Specific** ▪ **What** is the *Need* ▪ **Why** is it a *Need*	▪ **Addresses the Need** *May Need > 1 Goal* ▪ **Time Specific** – *Set clear timeframes* ▪ **Collaborate** *Assign Roles*	▪ **Actionable**, Achievable ▪ **Short** in Duration ▪ **Related Directly** to Goal ▪ **Needed** to Complete Goal ▪ **Assigned to Member** and *Other Care Team Members*
Examples	Member is diagnosed with (*Chronic Health Condition*) and wants to improve ___________________.	To link member to (*Provider/Service*) in the next (#) of days/months. Complete case conference with (*Provider(s)*) next month to review ________.	**Goal:** *Complete Colonoscopy for Cancer Screening* Member will contact Care Manager on (Date) to confirm receipt of prep materials and instructions.

Plan of Care

Example



Care Plan

Key Elements

- **Need Note**
  Barriers and Strengths related to Member Need

Goals can be short or longer in duration if process will take months vs. weeks.

Verify Diagnoses, Medications, Care Team Members in Plan of Care during Re-Assessment period

Plan of Care

Plan of Care is Updated **When:**

- ✓ Hospitalization
- ✓ ED Visit
- ✓ Arrest/Incarceration
- ✓ Assessment Completion
- ✓ New Diagnosis
- ✓ New Medication
- ✓ Housing Stability Change
- ✓ Personal Relationship Change

**Not All Critical Events*

Important Timeframes

Wet/Electronic Signatures

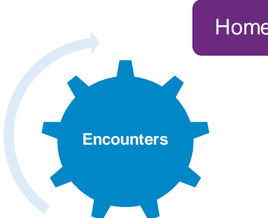
- ❑ Every 6 Months

Plan of Care Updates

- ❑ **Every 90 Days** *OR*
- ❑ When **Goals** and **Tasks** are:
  - ✓ Achieved
  - ✓ Reviewed
  - ✓ Updated

Encounters

Home



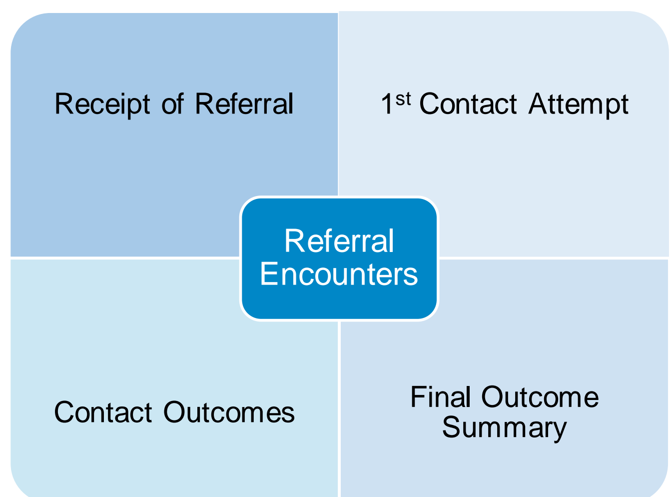
Encounters

Outreach Encounters Elements

- Referral Source
- MCO – Managed Care Plan
- # of Months Completed
- HARP Status
- Patient Contact Information Used
- Outreach Efforts
- Collaboration with Referral Sources (*if applicable*)
- Summary of Member Engagement
- Outcome
    - Member Reached
    - Interested in Enrollment
    - Health Home Appropriate for Member Needs
    - Outreach Next Steps

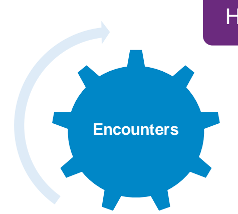
Outreach Encounter Activity

Recording Engagement Work



Encounters

Enrollment Encounter



What should be included?

Enrollment Details
❑ Member Demographic Information
❑ Date of Referral
❑ Referral Source Details
❑ Location of Enrollment
❑ Qualifying Conditions
❑ Documents Completed/Provided to Member
❑ Reasons for Enrollment (Needs + Goals)
❑ Services/Resources Needed
❑ Immediate Next Steps
❑ Additional Details/Comments

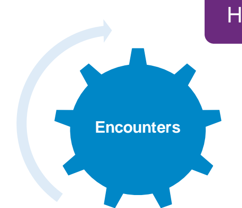
Key Achievements

- ❑ Schedule Next Appointment
- ❑ Contact Consented Providers
- ❑ Enrollment Update
- ❑ Request Medical Documents
- ❑ Complete Introductory Call
- ❑ Share DOH-5055
- ❑ Upload Consent and Enrollment Documents

What we want to Talk about/Work on Today?

Home

Encounters



Consented Provider Introductory Call

Key Steps

- ❑ Introduce Yourself
- ❑ Brief Summary of HH
- ❑ Ask how we can Help
- ❑ Share your Contact Details
- ❑ Thank the Provider/Staff

If unable to speak to provider, ask if message about enrollment and new services can be shared or put in members file.

Information to Collect for Newly Enrolled Member			
Contact Details	*WHO*	Contact: ______________________________ Best Telephone # _____________________ Best Hour to Call: _____________________	**1**
	WHERE	Name: ________________________________ Location: ____________________________ Borough: _____________________________	**2**
	APPT	Last Appt: ____________________________ Next Appt: ____________________________ Appt Frequency: ______________________	**3**
	GOALS	Needs (Provider Identified) ____ ____ ____	**4**
Notes:			

Encounters

Care Conference Encounter

What should we focus on?

Case Conference Details	
❑ **Situation + Goal(s)**	✓ *Reason(s)/Purpose for Conference*
❑ **Participants**	✓ *Care Team Members Involved/Present*
❑ **Location**	✓ *Where and/or How did the Conference Occur?*
❑ **Summary of Conference**	✓ *What was Reviewed or Discussed?* ✓ *Barriers, Strengths Identified* ✓ *New Clinical / Non-Clinical Needs* ✓ *Gaps in Care* ✓ *Next Steps*

Question…

How can we Assist the Member Meet their Goals?

What is Needed from the Care Manager or CMA?

What are our Next Steps or Actions?

Questions

Who was there?

Where did this Occur?

When did this Occur?

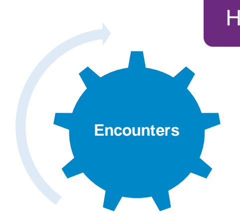
Why did this Occur?

What did you Talk About?

How will you Move Forward?

Home

Assessment Summary



Comprehensive Assessment Summary Points

What should be included in the Assessment Summary?

Current:

- ❑ Eligibility for Health Home Services
- ❑ Housing
- ❑ Social Supports, Benefits, Income
- ❑ Medical and Behavioral Healthcare Providers
- ❑ Treatment, Medications and Appointment Attendance History
- ❑ Goals
- ❑ Remaining Needs from Enrollment (or Prior Assessment)
- ❑ Strengths, Barriers to Remaining Needs

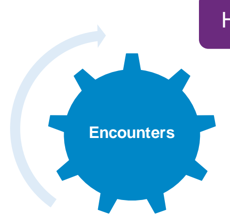
Key Reminders

- ❑ Care Team Members are Active
- ❑ Medication List is Up-to-Date
- ❑ Outstanding Labs, Procedures and Tests are Identified
- ❑ Assessments need to be locked

Supervisors are a great support and resource to tackle outstanding goals

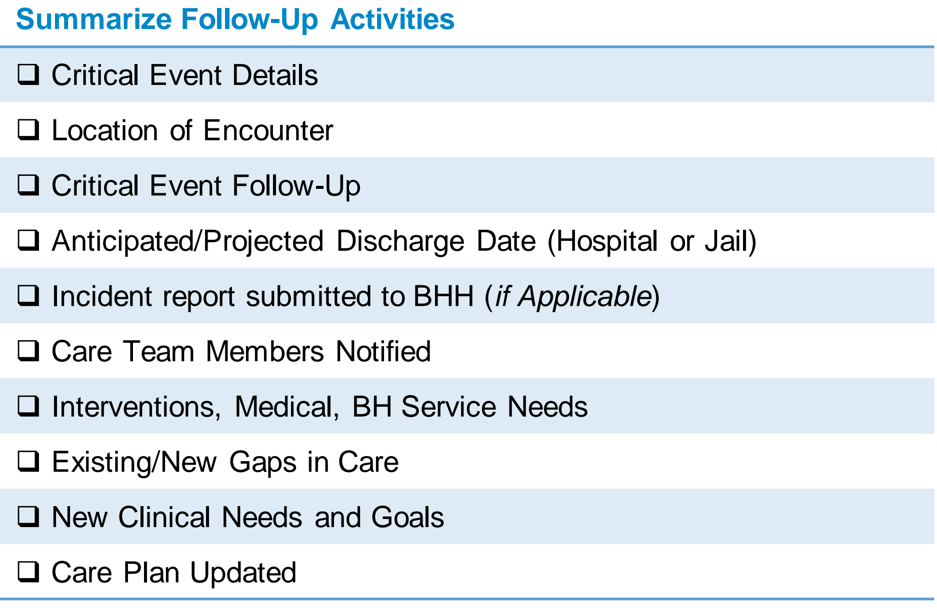
Home

Encounters



Critical Event Follow-Up Encounter

What Information should I collect?



Summarize Follow-Up Activities

- ❑ Critical Event Details
- ❑ Location of Encounter
- ❑ Critical Event Follow-Up
- ❑ Anticipated/Projected Discharge Date (Hospital or Jail)
- ❑ Incident report submitted to BHH (*if Applicable*)
- ❑ Care Team Members Notified
- ❑ Interventions, Medical, BH Service Needs
- ❑ Existing/New Gaps in Care
- ❑ New Clinical Needs and Goals
- ❑ Care Plan Updated

What will the Member Complete for Next Time?

Confirm Next Steps...

❑ **Upcoming Appointments**

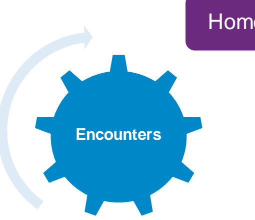
- ✓ Provider
- ✓ Location
- ✓ Barriers
- ✓ Travel Needs
- ✓ Contact Details
- ✓ Reminders

Schedule Reminder Calls

- ✓ **Before Appt –** Attending ?
- ✓ **After Appt –** Verify

Home

Encounters



Transfer Encounters

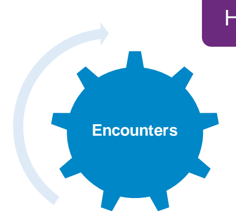
What happens if a case is transferred?

Transfer Details
❑ Type of Transfer
❑ Reason for Transfer
❑ Date of Transfer
❑ Transferring CM
❑ Name of New CM/CMA
❑ Description of Warm Handoff OR Reason(s) it did not occur
❑ Critical Information for New CM

Key Points

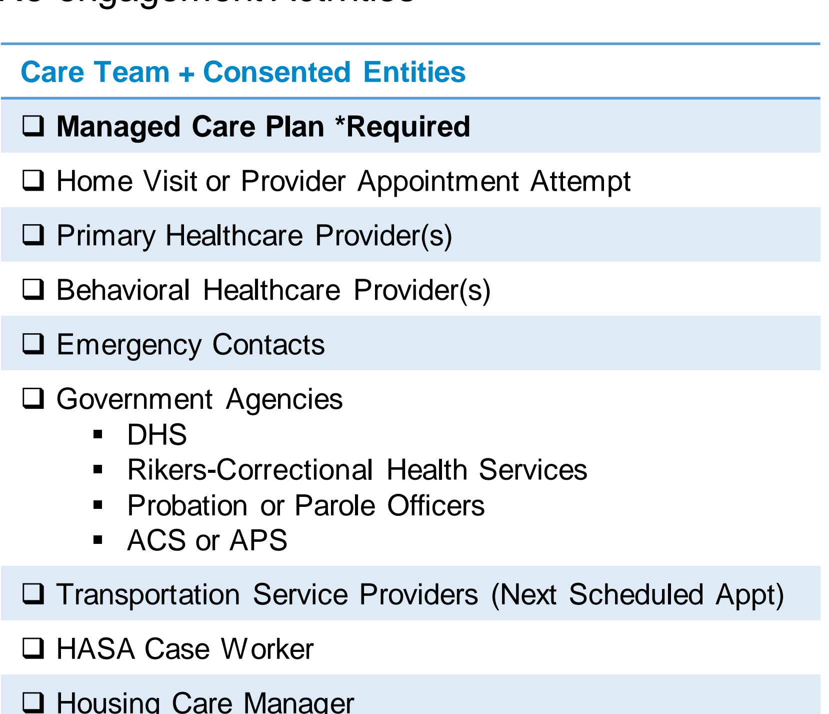
- ❑ Preferred Contact Method
- ❑ Information Sharing Restrictions
- ❑ Language Preferences
- ❑ Member Identified Interests
- ❑ Engagement Pattern(s)

Encounters



Diligent Search Encounter

Re-engagement Activities



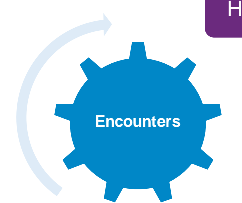
Care Team + Consented Entities
❑ **Managed Care Plan *Required**
❑ Home Visit or Provider Appointment Attempt
❑ Primary Healthcare Provider(s)
❑ Behavioral Healthcare Provider(s)
❑ Emergency Contacts
❑ Government Agencies ▪ DHS ▪ Rikers-Correctional Health Services ▪ Probation or Parole Officers ▪ ACS or APS
❑ Transportation Service Providers (Next Scheduled Appt)
❑ HASA Case Worker
❑ Housing Care Manager

IT/Research
❑ PSYCKES, Healthix, FCM CEN Alerts
❑ WebCrims, DOC Search
❑ Internal Search Databases
❑ MAPP

Plan Ahead Discuss and Include Action Steps in Member's Plan of Care if Member is Disengaged

Home

Encounters



Disenrollment Encounters

What should a case closure encounter include?

Case Closure Recap
❑ Enrollment Details
❑ Summary of Services Delivered
❑ Summary of Goals Addressed and Outcomes
❑ Reason for Case Closure
❑ Case Closure Documentation Uploaded
❑ Discharge Plan/Supporting Documents
❑ Care Team Members Notified
❑ Additional Details/Comments Specific to Member

Case Closure Activities

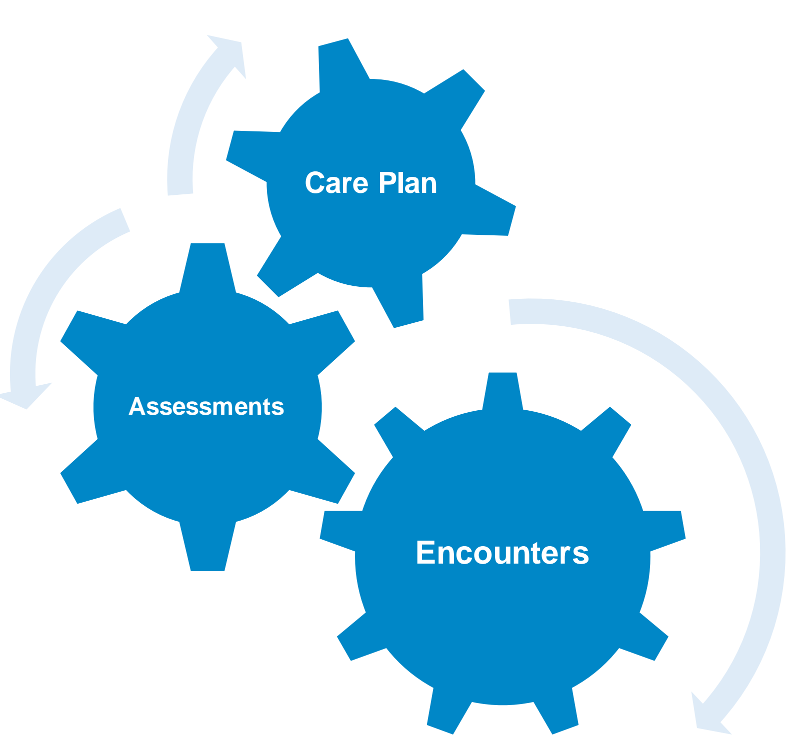
- ❑ Case Conference
- ❑ Supervision
- ❑ Verify Member Record Details are Up-to-Date

Review Open/Active

- ❑ Gaps in Care
- ❑ Care Plan Goals

Core Services

Core Services



Key Takeaways

- ❑ Core Service is a successful encounter where one of the DOH defined services is provided (see following page)
- ❑ Core Services need to be documented in an encounter
- ❑ Core Service Encounters should be linked to Plan of Care
- ❑ Linked encounters should address:
  - ✓ Needs
  - ✓ Goals
  - ✓ Tasks

Core Services

Categories
Comprehensive Care Management
Care Coordination & Health Promotion
Comprehensive Transitional Care
Patient & Family Support
Referral to Community and Social Supports

Core Services

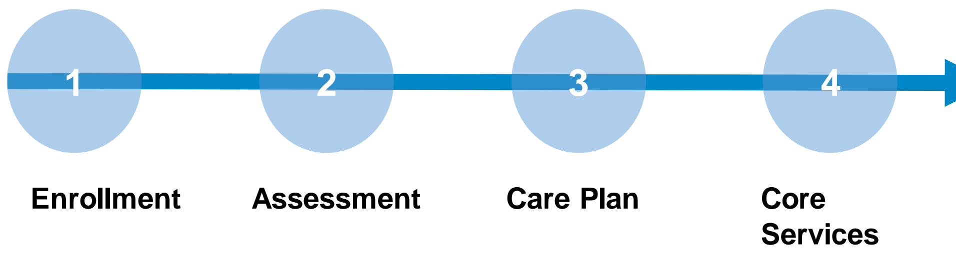
Encounters

Plan of Care

Encounter (Core Service) Frequency

- Monthly basis at a minimum OR more frequently based upon member needs or special program requirements

Document Each Encounter:



Core Services are successful encounters with a member or consented care team members that **push the Plan of Care forward**

Core Services

Comprehensive Care Management

Services centered around:

✓ Plan of Care, including completion of a Comprehensive Assessment

Elements
❑ Comprehensive Assessment
❑ Person-Centered Plan of Care (POC Development, Updates, Active Care Planning)
❑ Case Conferencing
❑ Collaboration with PCP, Specialist(s), involved in Plan of Care
❑ Crisis Intervention Planning

Every core service should further a Care Plan goal or need. If need isn't included, it should be added to the Care Plan

Documentation Reminders

❑ Include Provider Name, Contact Information

❑ Include Next Steps for Member

Core Services

Care Coordination and Health Promotion

Services centered around:

✓ Working with care team members to ensure services are focused on the member's current medical care needs and goals

Elements

- ❑ Coordination with providers about joint goals
- ❑ Referrals to services where member obtains an appointment and/or services received
- ❑ Care Conferencing and status updates with Care Team members
- ❑ Linkage to new provider(s), securing transportation services (present barrier)
- ❑ Navigating members to appropriate level of care and appointments

Case Conferencing **can help identify member needs and gaps the member may not be aware of**

Important Reminders

- ❑ Review Medication Adherence, Treatment
- ❑ Coordinate with provider to align goals

Core Services

Comprehensive Transitional Care

Services related to:

✓ Transitioning back into the community or member residence from a Hospital, Rehabilitation or Residential Treatment Facility

Elements
❑ Discharge Planning from Inpatient, ER, Hospital, Residential, Detention Facility etc.
❑ Care Conferencing with Care Team members and/or treating/attending clinicians, social workers etc.
❑ Linkage to community supports
❑ Member and/or support systems (emergency contacts) contact to review/verify discharge action plan

Important Reminders

❑ Contact Members within **48 hours** of

- Receipt of notification OR
- Awareness of admission

Member and/or support systems (*emergency contacts*) should be contacted to review/verify discharge action plan is being followed

Core Services

Patient and Family Support

Services that include:

✓ Emergency contacts (*family and/or caregivers*) consented on the DOH-5055

Elements
❑ **Sharing information or discussing a member's care plan**
❑ **Gathering feedback/input from family that can be used to help update plan of care**
❑ **Develop, review, or update Plan of Care with member and/or family, supportive members**
❑ **Engaging with member/family and provider to help facilitate interpretation services**
❑ **Referrals to support groups, supportive services and/or benefits**

✓ Family support can be important for very ill members and those in-hospice / at end-of-life.

✓ Confirm if there are Legal documents in place that enables an identified family member to act on their behalf. If not in place, member makes the decisions about their care and treatment.

Core Services

Referral to Community and Social Supports

Linkage to services designed to:

✓ Support and/or enhance the member's social and community support systems

Elements

❑ Two-way sharing of information related to plan of care goals and member needs

❑ Referrals/Linkage to:
- Food Pantries
- Support Groups (AA, NA)

❑ Research, Generation and Sharing of information related to:
- Nearby Religious organizations or services
- Potential providers near residence

Confirm member was linked and/or attended appointment/services

Case Conference

Case Conference

What Should We Ask the Provider?

Is the member prescribed medications they must adhere to taking?

For MH/Substance Use Treatment Members:

Is there a safety plan in place for this member that you can share?

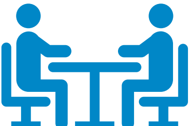
What is the frequency in which you meet with this person?

When is the next appointment?

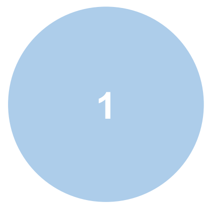
Is there anything I can do to help ensure this person remains compliant with their treatment plan?

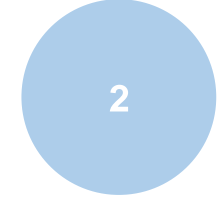
What is the treatment plan for this person?

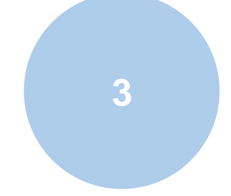
Case Conference

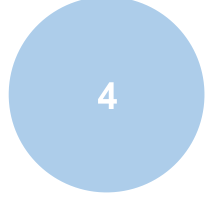


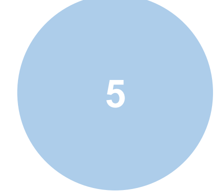
What Should We Ask the Provider?











Medication

Is the member prescribed medications they must adhere to taking?

Safety Plan

MH/Substance Use Treatment Members:

Is there a safety plan in place for this member that you can share?

Appt Frequency

What is the frequency in which you meet with this person?

When is the next appointment?

Care Manager Role

Is there anything I can do to help ensure this person remains compliant with their treatment plan?

Treatment Plan

What is the treatment plan for this person?

Critical Events

Critical Events

Checklist

Follow-Up
❑ Call the member
❑ Call Provider, Hospital, Social Worker or Facility
❑ Ask to help with Discharge Planning
❑ Request copy of Discharge Documents
❑ Connect to After-Care: ▪ PCP ▪ Behavioral Health Specialist ▪ MCO ▪ Social Worker ▪ Pharmacy (*medication pick-up/delivery*)

What Actions or Steps can be taken to Prevent a Visit or Stay in the Future? What led up to the critical event?

Confirm: Next Appointments, Referrals Sent, Next Steps in Treatment Process

Event Details

- Date of Alert
- Date of Event (Admission, ER Visit)
- Location of Event (Hospital, Facility)
- Duration of Event (Projected Discharge)
- Discharge Date
- Reason for Event (Diagnosis, Event, Test)

Key Takeaway Notes:

- Who did you call?
- Who did you speak to?
- What was the outcome of the phone call?

Critical Event Follow-Up

As this person's Care Manager:

How can I best coordinate after this event and avoid future events for this person?

What are the next steps I should be aware of as the person's Care Manager?

What are the ways that this event can be prevented in the future?

Are there discharge recommendations for this person?

Has the person's entire care team been made aware of this event?
Who can I contact to inform?

Are there specific follow-up instructions for this person?

Graduation

Graduation

Engaging a Member to Review Graduation:

- ❑ Highlight Achievements
- ❑ List Needs Addressed + Goals Completed
- ❑ Graduation Documents
- ❑ Summarize Current Status of
  - Connection to Healthcare Services (PCP, Vision, Dental)
  - Connection to Community/Social Supports
  - Transition Plan/Discharge Plan Details

Key Takeaways

CMA Contact Information

Disenrollment Resources

Transition/Discharge Plan

Graduation Documents

Graduation Achievement (Disenrollment) Letter

DOH Form DOH-5235*

*** <u>Upload</u> to FCM Documents Section**
Before Ending Segment and Disenrollment Encounter

Graduation

Step by Step: Is the Member Ready for Graduation?

Review:

1. Enrollment Encounter
2. Most Recent Comprehensive **Assessment Summary**
3. Plan of Care **Goals**
4. ER + Inpatient **Utilization**
5. Active **Gaps in Care**

Provided Services Checklist
❑ Initial Needs Addressed
❑ All Goals Completed
❑ No Outstanding Needs OR **NEW** Needs
❑ Gaps in Care Addressed

Key Actions

- ✓ Case Conference
- ✓ Visual Meeting with Member

- ✓ Verify No Outstanding Needs
- ✓ Plan in Place to Address Future Gaps

Graduation

Care Management Graduation Connection Grid

Steps	Yes	Notes
Schedules + Attends Appointments	✓	
Able to Discuss Care, Medication Usage/Issues	✓	
Medical/BH Care Involved, Being Managed	✓	
Actively Engaged with Supports	✓	
Benefits Maintained/Employed/on Education Path	✓	
Not At-Risk of Losing Housing/Shelter	✓	
Not At-Risk of Hospitalization/Frequent ER Visits	✓	

Autonomy: Ability to Act or Function Independently

Graduation

Care Transition Step Developer

Transition Plan | Discharge Plan Details			
Elements	Upcoming Recertifications	→	▪ Medicaid Health Insurance ▪ Benefits (SNAP, SSI, SSD, HASA)
	Care Team Member Details	→	▪ CMA Contact Information ▪ Contact Details (PCP, MH) ▪ Office Locations ▪ Pharmacy Information
	Upcoming Healthcare Dates	→	▪ Next Annual Physical ▪ Next Prescription Pick-Up/Delivery ▪ Next Scheduled Appointments
	Application and Benefit Portal Login(s)	→	▪ Housing Web Portals ▪ Benefits (HRA, SSA) ▪ Transportation Details

Step-Down Needs can be Addressed by Lower Level of Care or Service

Include Details Specific to Service Provider or Community Services

Graduation Checklist

Connected to Healthcare Services

- ❑ PCP (Primary Care Physician)
- ❑ Dental Provider (Dentist)
- ❑ Eye Doctor (Ophthalmologist)
- ❑ Specialty Providers
- ❑ Behavioral Health Providers
- ❑ Home Health Aid

Progress toward Personal Goals

- ❑ Education
- ❑ Employment
- ❑ Nutrition & Wellness
- ❑ Navigation of Healthcare System

Manages and Adheres to Treatment/Medication(s)

- ❑ Adherent to Medication
- ❑ Refill(s) Prescriptions on Schedule
- ❑ Appointment Scheduling
- ❑ Identifies Reactions to Medications
- ❑ Uses Coping Mechanisms
- ❑ Navigates Transportation Services

Reduced Risk for Adverse Events

- ❑ Connected to Substance Use Program
- ❑ Reduction/Lack of ER/Inpatient Events
- ❑ Connected to/Stable Housing in Place
- ❑ Safety Plan and Resources in Place

Positive Community + Social Support

✓ Family, Friends, Peers, Food Access, Transportation

Resources

Resources

Links

Social Security Administration	Human Resources Administration	Nutrition Programs
Supplemental Security Income (SSI)	*Public Assistance (HRA)*	**Meal Delivery:**
Supplemental Security Disability Income (SSDI)	*SNAP (HRA)*	*Meals on Wheels*
	HASA (HRA)	*God's Love We Deliver*
	HEAP (HRA)	

Potential Document Application Requirements:

- ✓ **Identity** Social Security Card, NYS Driver's License/ID Card, Birth Certificate, Passport etc.
- ✓ **Medical** Medicaid ID, Other Insurance/Pharmacy ID Cards
- ✓ **Income** Pay Stubs, Benefits Letter(s)/Card(s), Bank Statements, etc.
- ✓ **Residency** Lease/Rental Agreement, Letter from Landlord etc.)

Roles

Peer Specialist | Caseload Support

As a Peer Specialist, you are encouraged to:

- Share personal experiences to engage members in dialogue to develop a relationship with the member that promotes retention and inclusion in care planning activities
- Provide education about health homes, care management, and other service modalities, and should assist with outreach activities such as phone calls, letters, emails, and/or home visits
- To provide caseload support through transportation accompaniment (e.g., accompany a member to a routine doctor's appointment or counseling session), or by accompanying care management staff to events such as hospitalizations or court hearings to provide additional support to the member

Outreach & Engagement Staff | Caseload Support

As a staff member of Outreach and Engagement, you are encouraged to:

- Sustain meaningful and progressive attempts at engagement in a timely manner
- Deliver "meaningful and progressive" outreach to all assigned candidates
- Review Medicaid eligibility of assigned candidates each month prior to rendering outreach services

Care Navigator | Caseload Support

As a Care Navigator, you are encouraged to:

- Providing support for care management activities such as making reminder calls, scheduling appointments, assisting with transmission of applications or updates, arranging transportation, etc.
- Providing peripheral support to the care team, and can provide interim updates to consented providers/care team members as needed to support the enrolled member

Care Manager

As a Care Manager, you are responsible for:

- Ensuring that all required assessments and consents are in place for each enrolled member and uploaded in the Care Management Platform
- Building and maintaining positive relationships with the provider community
- Working 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
- Overseeing the building of the member's care team, establishing and maintaining positive rapport with all care team members

Supervisor

As a Supervisor, you are responsible for:

- Being a staff member of the 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

- 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

- Supporting 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

- 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