Quality Management

Program BHH QMP Digest

[2024-2025]

Last Reviewed: *12/04/2024*

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Appendices

Mission

The **Brooklyn Health Home** (BHH) **Quality Management Program** (QMP) is dedicated to improving the health and well-being of our members by enhancing access to quality care and facilitating care coordination in a patient-centered care management approach. Furthermore, the BHH QMP is committed to cultivating a data-driven culture in which decision-making and strategies are supported by meaningful data, research, and best practices.

Vision

The BHH QMP aspires to provide a strong quality improvement infrastructure that supports activities aimed at improving the quality, efficiency, and effectiveness of care management services within the BHH network.

Purpose

The BHH QMP will provide objective and systematic oversight in monitoring and evaluating performance at the **Care Management Agency** (CMA) and network level. The BHH QMP will devote resources in helping to improve operational processes in a collaborative effort, which will in turn lead to positive health outcomes for members. The BHH QMP will ensure the accountability of the network to provide quality care, and compliance with BHH policies and procedures, along with federal and state regulations.

Goals & Objectives

- Develop a standardized evaluation and improvement process for BHH performance
- Develop and utilize tools and techniques to aide in the efforts to monitor, evaluate, and present data to the appropriate audience
- Develop and adhere to processes that assure compliance with all regulatory and oversight agencies
- Incorporate a collaborative quality improvement model within our efforts
- Plan and prioritize improvement efforts based on input from relevant stakeholders such as:
  - Community Care of Brooklyn (CCB)
  - BHH Leadership
  - Care Management Agencies
  - Managed Care Organizations
  - New York State Department of Health
  - Health Home Coalition and Committees
  - Health Home Members
- Foster a data driven culture within BHH
- Make safe and meaningful changes that will directly improve the quality and effectiveness of services provided to BHH members
- Identify, develop, and/or enhance activities that promote member safety and reduce errors
- Continuously monitor both clinical and process outcomes of BHH services
- Document and report the results of monitoring activities, barrier analyses, recommendations for improvement activities, and other program activities
- Disseminate performance data to promote empowerment and informed decision making
- Communicate with care management agencies about quality of activities, provide feedback on results of performance assessments, and collaboratively develop improvement plans
- Provide education, support, and guidance as needed for various evaluation and improvement processes

- Ensure the alignment of quality improvement initiatives with the BHH mission, vision, values, and goals
- Ensure the quality of care and service delivered to BHH members meet standards established by BHH policies and procedures and relevant regulatory agencies
- Ensure that systematic changes are derived from and supported by statistical evidence and informed by "best practices"
- Ensure the continuous dissemination of data to relevant parties
- Ensure open communication channels between leadership, staff and teams involved in quality improvement activities are effective and functional
- Ensure knowledge and clarity of quality improvement concepts, principles, methodologies, techniques, and tools

Authority & Responsibility

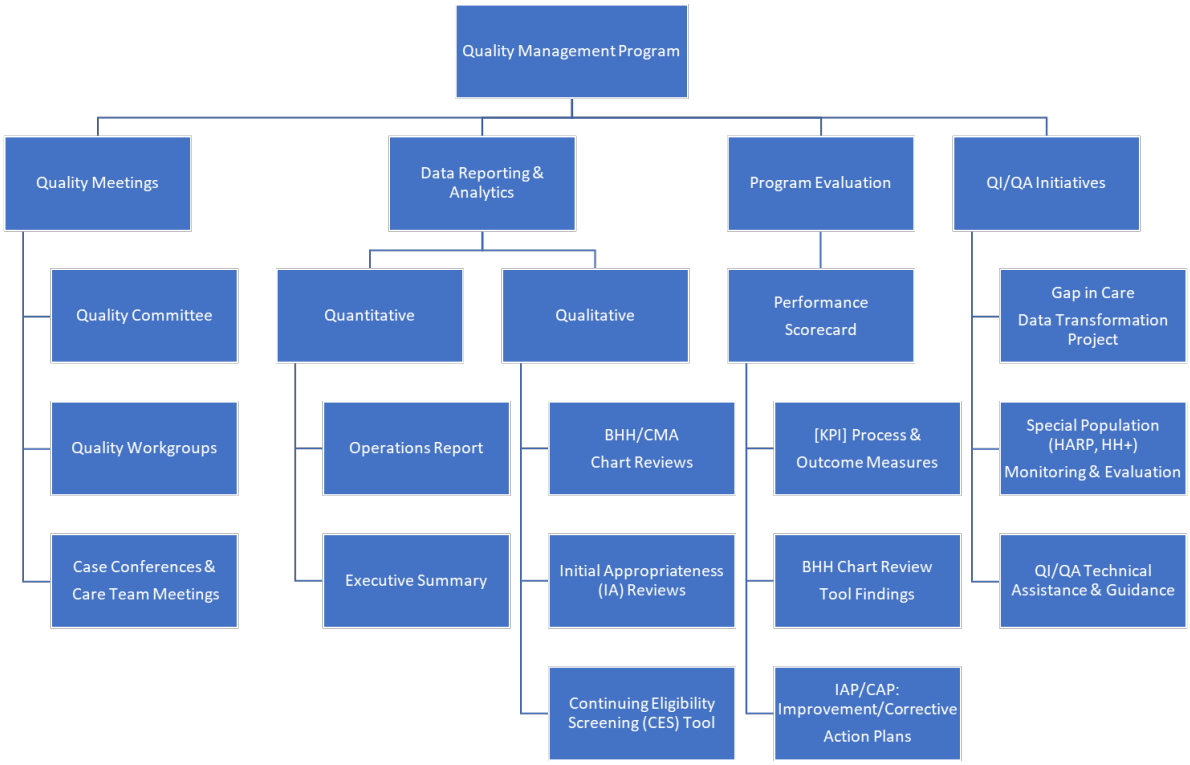
BHH assumes responsibility for the QMP and gives authority to the Clinical Operations and Quality Improvement Director as the individual to oversee QMP activities with support from BHH's leadership and management team and various network committees:

- Executive Director
- Vice President, Business Operations
- Clinical Director, Behavior Healthcare Management
- Director, Clinical Operations & Quality Improvement
- BHH Board of Directors
- Clinical, Business Operations and Health Information Technology Committee
- Care Manager Workflow Committee

BHH QMP Overview

The **BHH QMP** is comprised of:

- ❖ Quality Meetings
- ❖ Data Reporting & Analytics
- ❖ Program Evaluation
- ❖ Quality Improvement & Quality Assurance Initiatives



Objectives:

- Review Health Home program operations, analytics, and data reporting methodology
- Identify, develop, and implement QI/QA initiatives, plans, reports, tools, and supports
- Evaluate network performance
- Highlight findings, trends and discuss best practices

❖ Quality Meetings

The BHH QMP collaborates with network CMA partners via:

Quality Committee Meetings

A collaborative platform for BHH and CMA quality-focused staff to examine, develop, implement, and evaluate new/existing BHH workflows and network performance measures.

Quality Workgroups

An interactive structure designed to facilitate resource sharing, CMA feedback, and development of targeted QI/QA initiatives, projects, and/or reporting & analytical tools.

Case Conferencing & Care Team Meetings

An organized structure designed to facilitate and/or escalate collaboration among BHH, the member and their consented care team member(s).

Quality Committee

Purpose

The **BHH Quality Committee** was developed as a forum for the BHH network to review Health Home program processes, workflows and BHH QMP objectives and deliverables. Activities include, but are not limited to, the development and evaluation of process and outcome-based performance measures, as well as continuous quality improvement (CQI) strategies/projects.

Goals & Objectives

- Develop a support network for quality improvement initiatives
- Ensure the alignment of the BHH QMP with Health Home standards and requirements
- Ensure knowledge of and clarity around Quality Improvement concepts, principles, methodologies, techniques, and tools
- Disseminate information to relevant stakeholders on performance to promote empowerment and informed decision making
- Review and discuss findings, performance trends, patterns, and outcomes from BHH's inventory of reports, chart reviews and Biannual Performance Scorecards
- Develop, implement, and evaluate performance improvement projects
- Develop and share resources relevant to Care Management with each other, such as:
    - Workflow process solutions
    - Tracking systems
    - Resources and training material

Meeting Frequency

BHH's Quality Committee will convene quarterly. Meetings will occur in-person on the 2nd Tuesday, in the 1st month of each quarter, from 2:30 – 5:00 PM, unless otherwise noted.

Membership

Quality Committee Chair and Coordinator: Brian Timmermans, Director of Clinical Operations and Quality Improvement will have the following responsibilities:

- Manage the development and implementation of performance improvement projects, activities, ad-hoc reports etc.
- Review and disseminate performance data to key stakeholders
- Facilitate committee meetings
- Report on activities and findings of the Committee to BHH leadership and other relevant stakeholders

Each CMA is **required** to have (*at minimum*) (**1**) staff member to represent their agency at each meeting, which may have one of the following roles:

- Supervisor/manager
- Quality Improvement/Quality Assurance staff members
- Staff responsible for monitoring performance improvement activities for their organization
- Staff who want to learn about different QI/QA strategies and techniques for their organization

Quality Workgroups

Purpose

Quality Workgroups are created based upon BHH QMP needs and/or goals identified by BHH and the BHH Quality Committee. Workgroups are intended to support the identification, development, implementation, and evaluation of BHH QMP performance measures, QI/QA initiatives, as well as emerging programmatic policy changes.

Workgroup Frequency

Quality workgroups occur monthly or as often as needed based upon the needs, goals, and/or objectives of the BHH QMP.

Workgroup Objectives

- Share clinical, non-clinical resources and training materials
- Examine new/existing Health Home policy requirements and BHH workflows
- Develop, implement, and evaluate quality improvement initiatives, QI/QA projects, CMA pilots, reporting and analytical tools, devices, or mechanisms
- Evaluate network performance toward achieving BHH QMP objectives and Health Home program requirements

Workgroup Participation

Participation in Quality Workgroups is voluntary. However, CMAs are strongly encouraged to have *at least* (**1**) QI/QA staff and/or a prospective QI/QA staff in attendance for professional development.

Case Conferencing & Care Team Meetings

A **Case Conference** and a **Care Team Meeting** are pivotal mechanisms within the Health Home care management delivery model that helps to ensure enrolled members have access to needed medical and behavioral healthcare, social services, and support systems by reviewing member needs and/or goals among consented individuals (i.e. healthcare providers, family/social supports, emergency contact) who are involved in the members' care.

Over the course of enrollment, a (*formal*) case conference and/or an (*informal*) care team meeting may be requested by BHH, the member, the member's CMA, Care Manager, or a consented Care Team entity.

Instances where these meetings would occur include, but are not limited to:

- Development of a member's plan of care
- Response to an emerging crisis
- Response to an existing or a newly identified need, goal, diagnosis
- Follow-up to an emergency department or inpatient discharge, discharge planning
- Review of changes to medication and treatment regimen
- Address chart review or external audit findings

Member record documentation should support any/all care management activities completed inclusive of meeting purpose, objectives, outcomes, next steps, and new/actionable information obtained.

Note: A care team meeting may also be referred to as an interdisciplinary team meeting.

❖ Data Reporting & Analytics

The BHH QMP collects and analyzes both quantitative and qualitative data related to care management service delivery to BHH members, including, but not limited to:

Operations Report (Quantitative)

Robust monthly report focused on timely completion of program workflows, processes and defined continuous quality improvement objectives and deliverables

Executive Summary (Quantitative)

Intuitive quarterly report designed to provide CMA leadership with an illustrative and graphical representation of performance over time

BHH/CMA Chart Reviews (Qualitative)

Vigorous chart review process focused on the quality-of-service delivery, member need identification, goal setting and outcomes

Initial Appropriateness & Continuous Eligibility Screening (Qualitative)

Systematic eligibility screening processes that capture initial and continued program eligibility (i.e. current needs, connectivity to care, engagement), as well as an individual's preparedness for a care transition (i.e. step-down, case closure, graduation)

Data Reporting & Analytics Overview

The BHH QMP collects, analyzes, and evaluates data/information pertaining to the timely completion and documentation of Health Home care management activities and service requirements including, but not limited to, eligibility screening(s), member enrollment, member/care team contact frequency and engagement, assessments, care planning, clinical event response, care transitions, and disenrollment. Furthermore, the BHH QMP continuously monitors and evaluates the effectiveness of quality improvement initiatives and enhanced workflows developed in collaboration with key stakeholders to improve the quality of care provided to BHH members.

To monitor and ensure compliance with Health Home program policy and standards, care management best practices and BHH QMP objectives, monthly **Operations Reports** are developed and disseminated to CMA QI/QA staff. Reports are intended to provide each CMA with actionable information related to a specific HH workflow, deliverable or achievement. Reports should be used to identify *(report indicators)* where further action is required.

To monitor and evaluate whether defined care management services and/or actions were achieved, quarterly **Executive Summary Reports** are developed and disseminated to CMA leadership. Reports provide each CMA with an illustrative and/or graphical representation of performance measure results over time.

Performance measure results are calculated monthly and are incorporated into **Bi-Annual CMA Performance Scorecards** which examine a 6-month reporting timeframe and is inclusive of both quantitative (process/outcome measures) and qualitative findings (chart review findings).

Data Reporting & Analytics Overview (*Continued*)

Brooklyn Health Home QMP Elements	January	February	March	April	May	June	July	August	September	October	November	December
Reports & Analytics												
Operations Report	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*
Executive Summary			Q1			Q2			Q3			Q4
Performance Scorecard *Executive Summary + Chart Reviews*	Bi-Annual		→				Bi-Annual		→			
Continuing Eligibility Screening (CES) Report	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*
Qualitatative Reviews												
BHH Chart Reviews			Q1			Q2			Q3			Q4
Continuing Eligibility Screening (*CES) Tool*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*
QI Projects												
Gap in Care Action Plan	MCO Data: Prior Year			MCO Data: Current Year								
	BHH Identified (FFS) Current Year		→									
									M	*Monthly*		

Recent Changes & Updates

- **BHH Appropriateness Assessment / Review for Graduation (RFG) – Retired**
  - Review process transitioned to Continuing Eligibility Screening (CES) Tool (*Nov 2023*)
  - New BHH CES Report replaced initial BHH CES Tool Outcomes Tracker (*Nov 2023*)

- **Strength, Barrier, and Risk Factor Reports** - **Retired**
  - Report End Date: *12/31/2023*.
  - Indicators transitioned to Operations Report (*Jan 2024*)

Operations Reports

Purpose

The **BHH Operations Report** is designed to support the oversight of care management activities provided to BHH members. Reports provide each CMA with new, actionable data related to the timely completion and documentation of BHH QMP care management deliverables. Report findings provide insight into care management activities that need additional review and/or further action. CMA QI/QA staff should use report data to identify members who either do not meet or are at-risk of being non-compliant with program policies, standards, best practices and/or BHH QMP care management deliverables.

Goals & Objectives

- Support QI/QA review and monitoring processes
- Ensure timely completion and documentation of program workflows and requirements
- Identify areas in need of performance improvement
- Support decision making
- Develop continuous quality improvement projects and initiatives
- Improve key performance indicator (KPI) performance

Methodology

BHH Operations Reports are generated and disseminated to each CMA monthly. Report data is exported on the 3rd business day of the month and is inclusive of all data documented within BHH's care management reporting system, **Foothold Care Management** (FCM), at the time of data export.

Reports are developed at the beginning of each month and are distributed to identified CMA QI/QA contacts within **48** hours of report development to ensure timely action/response.

The BHH Operations Report contains a wide array of process and outcome-based report indicators that capture the completion status of defined BHH QMP care management activities. Report findings can be used to identify BHH QMP deliverables due, expired, and/or missing. Information should be used to ensure timely completion and documentation of performance deliverables and to drive performance of defined key performance indicators (*KPI*).

BHH QMP KPI are inclusive of Health Home program operational deliverable(s) and/or BHH QMP quality improvement processes. Report indicators, performance measures and KPI are intended to aid the timeliness, accuracy and quality of services provided and documented.

Operations Report Structure

The BHH Operations Report includes a summary table of findings, pivot (drill-down) tables, report filter(s), data slicer(s) and line level data/information.

Report findings capture member demographics, enrollment details, Care Manager assignments, and report indicators where additional action is needed/required.

Summary Table

The Summary Table provides a high-level overview of report findings for each report indicator. Report indicator values are aggregated and represent the total number of members where further action(s) and/or documentation is needed/required:

- Action and/or deliverable has not been met or documented in a timely manner
- Deliverables may be coming due, expired, or missing

Summary Table [*Excel tab*]

BHH Operations Report Summary Table

KPI Domain	Cohort	Report Indicator	Jul-24
Member Care Planning	***Newly Enrolled***	New Member w/ POC Signature MISSING	**126**
Member Assessments	***Newly Enrolled***	New Member w/ Comprehensive Assessment MISSING	**242**
Member Care Planning	***E 60+, Non-Pended***	Member Enrolled 60+ w/ NO POC Signature	**66**
Member Care Planning	***E 60+, Non-Pended***	Plan of Care NOT Updated within PAST 5 Mo	**601**
Member Assessments	***E 60+, Non-Pended***	Comprehensive Assessment NOT Completed within the PAST 11Mo	**831**
Member Assessments	***All E***	Comprehensive Assessment Marked Done, Completion PENDING	**124**

[Screenshot from BHH Operations Report (not inclusive of all report indicators)]

- Summary Table provides the following details:
    - [**KPI Domain**] – focus area reviewed
    - [**Cohort**] – members examined (specific to each report indicator)
    - [**Report Indicator**] – workflow specific deliverable/achievement
- Summary Tables provide a monthly snapshot/view of findings for each report indicator
    - Indicators focus on timely completion and documentation of Health Home operations, workflows, and engagement measures
    - Data is exported and shared at the beginning of the month
- Aggregated data values are static
    - member level data is accessible via the Pivot tab or line level data tables

Performance measures are calculated based upon completion and documentation of each report indicator within defined time parameters i.e. [**Report Indicator]:** 126 newly enrolled members are missing a POC Signature within initial 60 days of enrollment. [**Performance Measure]:** examines whether a newly enrolled member had a signed POC by the end of the report month (i.e. POC signature was due at the end of the Operations Report Month).

Drill-Down Tables

A major strength of the Operations Report is the tools' ability to enable the QI/QA staff/reviewer to identify and generate a list of members where additional support and/or action is required to meet a specific program policy, standard, and/or best practice.

Operations Report data/findings should be used to:

- Identify members where additional support and/or actions are needed
- Drill-down and/or stratify report findings by defined parameters
- Generate member lists where ≥ (**1**) report indicator is due, expired or missing
- Monitor workflows in need of improvement and/or corrective action
- Highlight potential errors/issues that may be attributed to a member or member cohort

PIVOT [*Excel tab*]

- Reviewers can select ≥ (**1**) Care Manager to create customized reports and action lists.
- If (**1**) or more Care Managers are selected, report findings will be updated.
  - i.e. Supervisor wants results for their Care Managers
- Users can double-click "*blue*" numerical values to auto-populate report indicator tables
  - Generated data tables/output will be specific to filtered criteria or selections
  - New tables will be generated in a new excel tab within the report workbook
- **Operations Report Indicators Table** will populate data for the entire CMA census:

Operations Report Indicators	
POC in 1st 60: New Member w/ POC Signature MISSING	
CA in 1st 60: New Member w/ Comprehensive Assessment MISSING	4

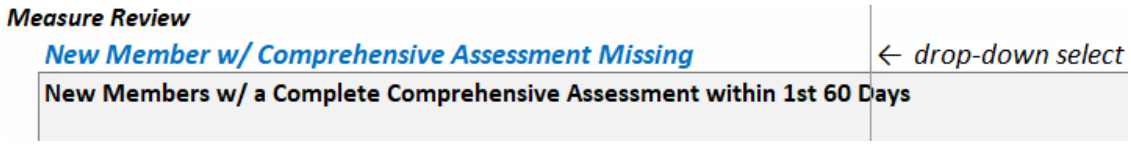
- **Care Manager Table** will populate data specific to the Care Manager selected:

Care Manager Name	Total Members
CM # 1	10
CM #2	29

Report Indicator Descriptions

KPI Descriptions [Excel tab]

The KPI Descriptions tab provides an overview of each report indicator, cohort reviewed, corresponding performance measure and measure description.



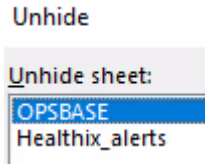
CMA QI/QA staff can utilize the drop-down menu to learn more about how a specific Operations Report Indicator relates to a specific Performance Measure.

Line Level Data

Monthly Operations Reports contain the following:

- **[OPSBASE]** – table consisting of all member demographics, CM assignment, enrollment details, and report indicators.
- **[Healthix_alerts]** – table consisting of all emergency department (ED) and inpatient (IP) discharge **Clinical Event Notifications** (CEN) received in the prior month (i.e. *Healthix*)

When distributed, both above data tables are hidden within the excel file. To access the line level data/data tables, reviewers can right click any open excel tab and select "*Unhide*."



For details regarding current BHH Operations Report Indicators, refer to **BHH Operations Report Guide**, located in **Appendix N**.

Executive Summary

Purpose

BHH Executive Summary Reports are designed to provide CMA leadership with an illustrative and/or graphical representation of their performance over time. Reports provide insight into the timely completion and documentation Health Home workflows, processes and BHH QMP performance objectives and deliverables.

Reports are inclusive of both process and outcome-based performance measures and contain a wide array of findings depicted via graphs, figures, and summary tables.

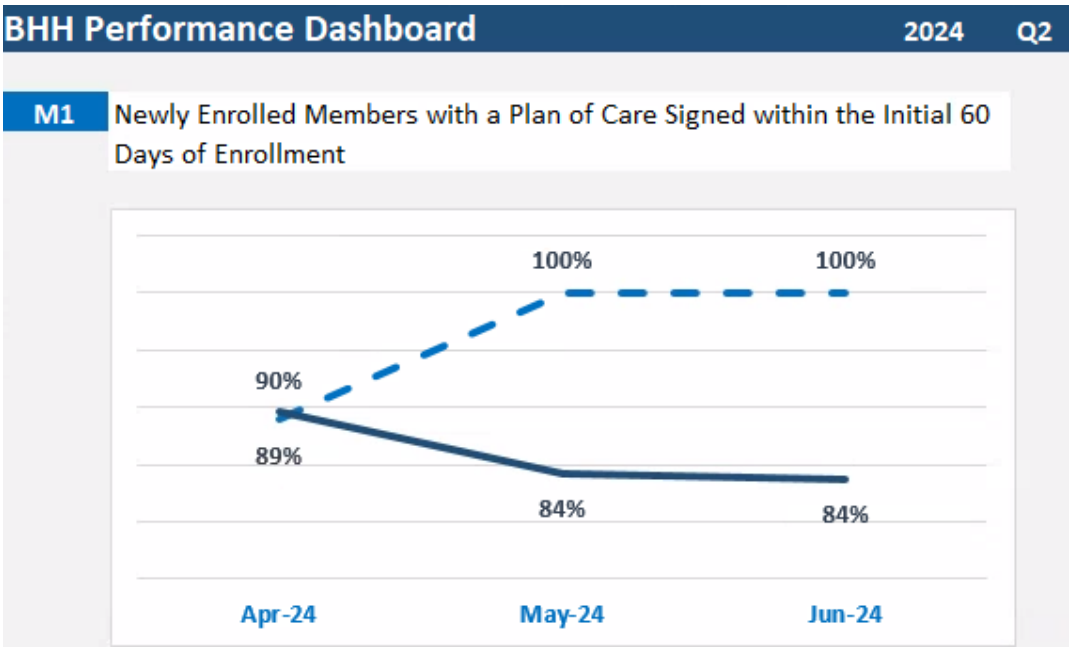
Goals & Objectives

- Provide CMA leadership with a tool to review and evaluate CMA performance
- Identify performance trend directionality (upward, downward, consistent)
- Identify potential trends, deficiencies, and/or staff training opportunities
- Support decision making and the development of CQI projects/initiatives

Methodology

Executive Summary performance measure results are calculated each month based upon data documented at the time of data export. Report data is exported on the 3rd business day of the month and is inclusive of all data documented within BHH's care management reporting system at the time of data export. Report findings/results are based upon the completion and documentation of specified care management services/actions from the prior reporting period.

CMAs should use the BHH Operations Report to identify (*report indicators*) where further action is required and use the Executive Summary Report findings to evaluate whether defined care management services/actions were achieved.



Executive Summary Reports provide CMA leadership with a tool to identify performance trends and evaluate their performance against past performance review periods, as well as against BHH network performance.

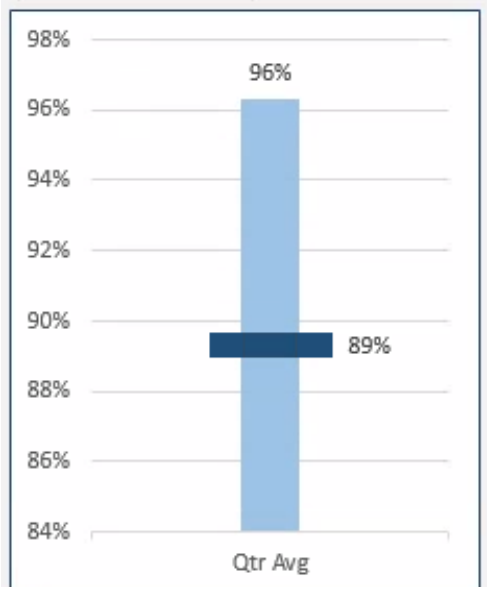
Example:

Above: CMA vs. BHH Monthly Results for a specific measure

Right:

Blue Bar: CMA Qtr. Avg Performance

Navy/Dark Line: BHH Network Qtr. Avg



For details regarding current BHH Operations Report indicators, refer to **BHH Operations Report Guide**, located in **Appendix N**.

BHH/CMA Chart Reviews

Purpose

The **BHH/CMA Chart Review** process is designed to improve the quality-of-care coordination activities and interventions being provided to BHH members. Through this process, the quality-of-care management activities documented within BHH member charts is examined via the BHH Chart Review Tool.

The **BHH Chart Review Tool** is an instrument designed to effectively target and evaluate compliance regarding documentation standards, identification of member specific needs and goals, development of a person-centered plan of care and application of appropriate care management activities and interventions geared toward addressing identified member specific needs and goals.

The BHH Chart Review tool will generate specific outcomes based upon each field selection. All applicable questions and/or question fields, inclusive of free text fields, should be answered based upon the information and activities documented within a member's chart to generate a comprehensive result. As a result, CMAs should verify that each question and/or question field appropriate to each member chart review is complete prior to submission.

Methodology

On a quarterly basis, each CMA will receive a BHH Chart Review Tool with a pre-populated list of member records for review. Records identified for review are randomly selected from (**1**) of (**6**) member cohorts, each based upon defined inclusion criteria.

Inclusion criteria definitions are based upon a wide array of factors including but limited to:

- Enrollment status (i.e. Currently Enrolled, Recently Disenrolled)
- Length of Enrollment (i.e. Newly Enrolled, Enrolled ≥ 1 year)
- Special Population Status (i.e. HARP, HH+, AH+, Criminal Justice)
- Evidence of Gaps in Care (i.e. MCO Data, PSYCKES Flag)
- High Utilization (i.e. Inpatient or Emergency Department Clinical Event Notification)
- Charts identified for secondary review (i.e. Priority Review, Low CR Score)

Example Breakdown:

Cohort (1)	▪ Enrolled ≥ 12 Months
Cohort (2)	▪ Enrolled ≥ 6 Months ▪ Evidence of a Gap in Care OR Clinical Event Notification(s) in Prior 12 Months
Cohort (3)	▪ Enrolled ≥ 6 Months ▪ HARP, HH+, AH+ Flag
Cohort (4)	▪ Enrolled ≤ 6 Months
Cohort (5)	▪ Disenrolled ≥ 3 Months
Cohort (6)	▪ Identified for Secondary Review ○ i.e. Member charts identified in Q1 will be re-assigned in Q3

Note: Member cohorts are subject to change based upon current BHH QMP goals.

Chart Reviewers

Chart reviews are to be completed by eligible CMA staff via the BHH Chart Review Tool. Eligible staff members include Supervisor level (*and above*) and/or QI/QA/Compliance staff who are familiar with current BHH policies and procedures and understand the activities and actions required over the course of effective care management services.

Activities documented may include the identification, communication and collaboration efforts between care team providers, the ongoing planning and completion of required assessments, person-centered plan of care goals and tasks, as well as appropriate care management actions to support the member and help address member needs effectively (i.e. follow-up activities following critical event and/or care transition).

- Reviewers should examine each assigned member chart in its entirety from the member's first engagement to current care coordination activities, if applicable.
- If a member record is no longer accessible in the care management reporting system, the CMA may request a replacement chart up to 2 weeks prior to the chart review submission due date.

Identified concerns, issues or events that may impact the wellbeing of the member and/or a disruption of care coordination service delivery should be brought to the attention of the supervisor/supervisory team assigned to the member being reviewed. Similarly, BHH will notify appropriate staff of such findings if applicable.

BHH Chart Reviews (Internal)

As part of the BHH chart review process, BHH conducts independent, concurrent chart reviews for a portion of the members identified and assigned to each Care Management Agency during each reporting period. Members identified for internal review are randomly selected from members meeting inclusion criteria and assigned to CMAs for review. At minimum, BHH will conduct (**2**) member chart reviews per CMA per quarter.

Internal reviews are used to:

- Analyze and validate chart review findings
- Identify and recommend actions and/or member-specific interventions
- Determine if additional support and/or clinical guidance from BHH is required

A comprehensive comparison analysis of chart review findings is conducted each reporting period to compare BHH and CMA chart review results, evaluate the quality-of-care coordination activities being provided and documented, as well as evaluate the effectiveness of the chart review process in identifying areas in need of improvement specific to both individual members and BHH CMA populations. Results are used to determine the difference in chart review findings being reported as well as the deviation between BHH and CMA chart review scoring results. Such findings will be used to determine qualitative measure scoring value(s) incorporated into BHH CMA Performance Scorecards.

Note: *Chart Review selection process and/or scoring methodology is subject to change based upon changes to Health Home program needs and requirements.*

Chart Review Submission

Member chart reviews are to be completed via the BHH Chart Review Tool and submitted to BHH via a secure/encrypted communication method.

- BHH staff will share a secure file request link approximately 2 weeks prior to due date

Each CMA will have approximately 8 weeks to submit completed chart reviews.

- Chart Review submission must occur no later than the date specified by BHH.
    - **No deadline extensions will be provided.**
    - **Failure to submit review(s) will result in negative scoring implications.**

Each CMA should validate their chart reviews before submitting to BHH to ensure that everything is complete.

- Any questions left unanswered and/or missing chart reviews will negatively impact the final score.
- CMAs will not be permitted to resubmit their chart reviews.

Note: Chart reviews should only be completed using the current BHH Chart Review Tool. Using older versions cannot be used for submission and/or accepted and may impact scoring.

- The structure and field name(s) within the Chart Review tool are specific and are not to be altered. Any changes or edits may yield negative scoring implications.

For additional instruction and important information regarding the BHH Chart Review Tool and review process, refer to the **BHH Chart Review Guide**, located in **Appendix O.**

Initial Appropriateness (IA)

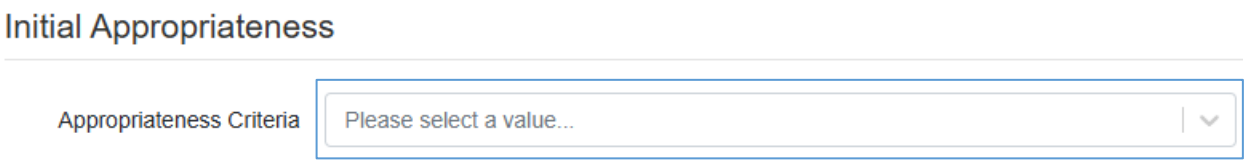
Purpose

The purpose of the **Initial Appropriateness** (IA) process is to capture accurate information regarding initial Health Home eligibility (i.e. member identified needs/goals).

- **IA** is used to document the primary reason for Health Home enrollment

For an individual to be enrolled, the individual **must** be assessed and determined to have significant behavioral, medical, physical, and/or social risk factors that require the intensive level of Health Home care management services.

IA is a **required field** when creating a new enrolled segment in the Care Management Reporting system, FCM:



Note: IA field will appear once Segment Details are selected (i.e. Start Date, O/E Code).

Reviewers should select the option that best captures a members need for program enrollment. The option selected should support the initial CM activities that will be worked on with the member at the time of IA determination.

- **NYS DOH:** Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program (ny.gov)

Continuous Eligibility Screening (CES)

Purpose

The purpose of the **Continuing Eligibility Screening** (CES) process is to capture accurate information regarding continuing Health Home eligibility (i.e. current need/goals, connectivity to care, engagement level) and an individual's preparedness for a transition of care (i.e. step-down, case closure, graduation).

Continuing Eligibility Screening (CES)

The CES process includes the use of the **CES Tool**, a decision support assessment designed to help CMAs identify members who either:

- Continue to meet Health Home program appropriateness

  OR
- May be a candidate for disenrollment
  - i.e. Step-down, step-up, graduation, case closure

The CES Tool's aim is to support enrollment decisions via periodic standardized screenings completed at established/specific time intervals.

Time intervals are based upon:

- Enrollment segment start date
- Member eligibility for enhanced Health Home care management services
  - Health Home Plus (SMI/HIV)
  - AOT
  - Adult Home Plus
- Initial/prior CES Tool completion dates and outcomes

CES Tool Components

The CES Tool is comprised of the following components:

- **Basic Eligibility**
  - Medicaid Insurance Status, Chronic Health Condition Validation
  - No disqualifying R/E codes
  - Guide to Restriction Exception (RE) Codes and Health Home Services
  - Medicaid Coverage Codes
- **Significant Risk Factors**
- **Additional Risk Factors**
  - General
  - Stability
  - Skill-based
- **Member Engagement**

CES Tool Outcomes

CES Tool outcomes are calculated based upon question fields selected and include:

Recommend Continued Enrollment

- Member would benefit from continued services; continue Health Home services
- Next CES Tool is due in **180** calendar days (*Approx. 6 months*)
- Outcome may be shared with the member. However, this is not a requirement.

More Information Needed

- An outcome of either "*Recommend Continued Enrollment"* OR "*Recommend Disenrollment"* was unable to be determined based upon data/documentation in member record

- Care Manager, Supervisor, and/or QI/QA staff are **required** to conduct further research, contact care team members to collect necessary information to generate an outcome of either "*Recommend Continued Enrollment"* OR "*Recommend Disenrollment"*
    - Contact and engage Member and/or Care Team
    - Member Search in PSYCKES
    - Case Conference with Consented Care Team
- Next CES Tool is due in **60** Calendar Days (*Approx. 8 weeks*)
    - *"Recommend Continued Enrollment"* OR "*Recommend Disenrollment"* **Required**
    - There cannot be (**2**) consecutive "*More Information Needed"* outcomes
    - Failure to complete a new CES tool may result in suspension of billing

Recommend Disenrollment

- A new CES Tool is **Not Required**
- Disenrollment to occur in **60** Calendar Days (*Approx. 8 weeks*) from the recommendation/outcome
    - Failure to disenroll a member may result in suspension of billing
- Once a "*Recommend Disenrollment"* outcome is determined, the CMA is **required** to review recommendation with the member and develop a transition plan (within the Health Home Plan of Care) to appropriately disenroll the member from the Health Home program. A transition plan should include:
    - Transition goal(s) to be worked on over time
    - Referrals to external services

- Provide (member specific) information about available services, community supports
- Provide information about re-enrollment
- Address member concerns about case closure and/or graduation
- Provide member copy of the **Notice of Determination of Disenrollment** (DOH 5235)

- All normal disenrollment processes, including appropriate notifications, forms and/or communication requirements are to occur
  - Disenrollment recommendation may yield either an involuntary (member does not agree) or voluntary (member agrees) disenrollment:
    - If a member is not in agreement, a DOH 5235 form would be used along with the disenrollment letter
    - If a member is not engaged, CMAs are to proceed with CES Tool recommendation and a DOH 5235 form is to be used selecting option: "***Other***" - "*Member is no longer engaged in Health Home Care Management Services as defined in the CES Tool*."
  - The reason(s) for disenrollment will vary by member and an appropriate segment end reason code should be selected:
    - **Code 14** – "*Enrolled HH member disengaged from care management services"*
      - Lack of engagement
    - **Code 21** – "*Member has graduated from HH program"*
      - No risk factors/only maintenance goals

CES Tool Completion

CES Tools may be completed by the Care Manager, Supervisor, or a QI/QA staff member. If completed by a Care Manager, Supervisory Review is **required**.

Supervisory Review

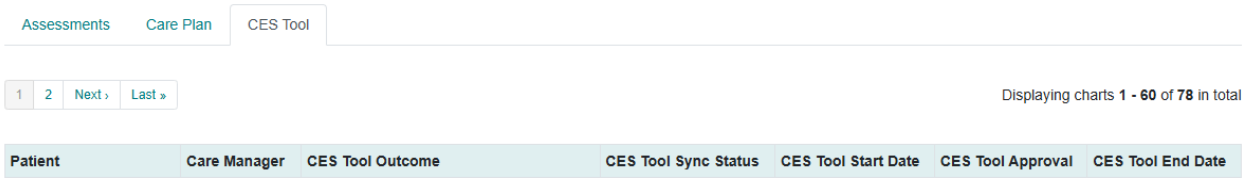
The Supervisor **must** document the outcome of this review in the member's record in a Supervisory encounter note within the care management reporting system.

- Encounter should provide a high-level summary of findings and/or rationale that supports CES Tool outcome
- All identified risk factors and/or reasons for continued eligibility should be well-documented within the member record - comprehensive assessments, plan of care, encounters etc.
- Supervisors and/or QI/QA staff are to examine CEST Tool findings and agree with outcome being documented prior to signing off/locking a CES Tool
    - If not in agreement with determination, the Supervisor and/or QI/QA staff must direct and/or support the Care Manager add missing documentation, examine certain need areas with the member that would update the CES Tool outcome
    - Example*:* Previously unknown information presents itself during the care transition period. A new CES Tool may be completed to update outcome.

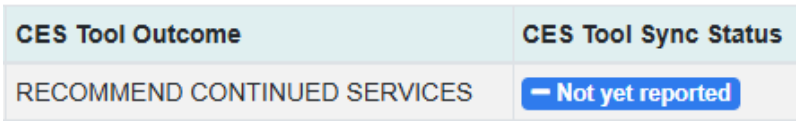
CES Tool Tracking & Monitoring

CES Tool completion dates, outcomes and expiration dates can be monitored via the care management reporting system, FCM, end user reports and the **BHH CES Reports**. Below provides a brief overview of FCM reports accessible to CMA Care Managers and QI/QA staff.

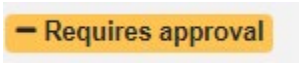
As of August 2024, QI/QA staff can utilize the Caseload Overview to review CES Tool data.



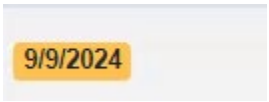
- CES Tool Outcome
- CES Tool Sync Status



- CES Tool Start Date (Date of Completion)
- CES Tool Approval (Supervisory Approval Needed if CM Completes)



- CES Tool End Date (Date CES Expires – Due Date as per Health Home Policy)
    - Past Due (Red) or Coming Due (Orange)



Note: FCM end user reports are subject to change. QI/QA staff should review the following resources for up-to-date system functionality:

- FCM Product Updates
- FCM Updates & Trainings
- Using Foothold Care Management

BHH Continuing Eligibility Screening (CES) Report

To support the timely completion of CES Tool screenings, as well as the timely disenrollment of members based upon a CES Tool recommendation, BHH developed the **BHH CES Report**.

The BHH CES Report captures actionable data/information related to initial/ongoing eligibility screenings based upon initial and/or prior CES Tool outcomes and completion dates.

Data is extracted from the care management reporting system, FCM, monthly on the 3rd business day of the month. BHH CES Report data/information includes, but is not limited to:

- Member Demographics
- Most Recent CES Tool
- Next CES Tool Indicators
- Disenrollment Indicators
- MAPP Billing Block Implementation Cohort Indicators

Report indicators are also shared via the monthly BHH Operations Report. Indictors should be used to identify members with an expiring CES tool, a potential billing block due to the absence of an initial or new CES tool date/outcome, as well as members on track for disenrollment.

NYS Health Home Resources Regarding the Continuing Eligibility Screening Tool

- **Health Home Policy and Updates (ny.gov)**

For additional details regarding current Continuing Eligibility Screening (CES) report indicators, refer to the **Continuing Eligibility Screening (CES) Tool Guidance**, located in **Appendix J**.

❖ Program Evaluation

The BHH QMP evaluates network performance via **CMA Bi-Annual Scorecards**. Performance scorecards are based upon quantitative (process/outcome) performance measures and qualitative BHH/CMA chart review results. Furthermore, the BHH QMP utilizes both **Improvement Action Plans** (IAP) and **Corrective Action Plans** (CAP) to collaborate with network providers to address performance goals and/or deficiencies.

Performance Scorecard

Individualized reports analyzing CMA performance data over time

Improvement Action Plan (IAP)

Strategic thinking platform designed to assist CMAs target improved quality-of-care for (**1**) or more specific performance goals

Corrective Action Plan (CAP)

Evaluation-based platform designed to target and address performance deficiencies related to (**1**) or more Health Home program requirement, workflow and/or QMP objective

Performance Scorecard

Performance Scorecards are distributed bi-annually to each CMA and incorporate both quantitative and qualitative data documented within BHH's care management platform to effectively evaluate the delivery and the quality-of-care coordination services being provided to BHH members. Scorecards will consist of a combination of process measures and quality review results from member record audits. Reviews will occur through multiple lenses and consist of active monitoring, analysis and evaluation of Health Home process requirements, workflows, and best practices to identify potential trends, strengths, weaknesses, and/or performance areas in need of improvement.

- Performance Scorecards are distributed biannually and comprised of (2) review components:
    - Process Measures (Quantitative)
    - Chart Review Results (Qualitative)
- Scorecard results should be used to drive performance improvement initiatives
- Scorecards include:
    - Breakdown of Process and Qualitative Measure Results
    - Network Ranking
    - Tier Status

CMA Performance Scorecard Tier Levels

Based on performance, CMAs may be asked to complete a Quality Improvement Plan. Lower performing agencies (*Tier 4*) will be required to complete a **Corrective Action Plan** (CAP). BHH provides guidance throughout this process. CMAs who receive a *Tier 3* status are strongly recommended to review outcome further with the BHH quality team. If needed, BHH may require a CMA to complete an **Improvement Action Plan** (IAP) if in Tier 3 and warranted.

The figure (*below*) provides an overview of performance tiers. Performance tiers will be identified during each Bi-Annual Performance Scorecard generation / reporting period and included on CMA performance reports.

Tier 1

- Exemplary Performance
- High level of efficiency in meeting BHH standards
- Some may be designated as "Mentor Agencies"

Tier 2

- Good Performance
- Continue to focus on sustaining high performance and identifying opportunities to for improvement

Tier 3

- Satisfactory performance with some areas in need of improvement
- Will be required to submit an improvement action plan to BHH if identified by BHH QI Team

Tier 4

- Poor Performance
- Will be required to submit a corrective action plan to BHH for approval and monitoring

CMA Performance Scorecard & Network Ranking Graph (*Historical Example*)

Biannual Scorecard

Care Management Agency	
Timeframe	

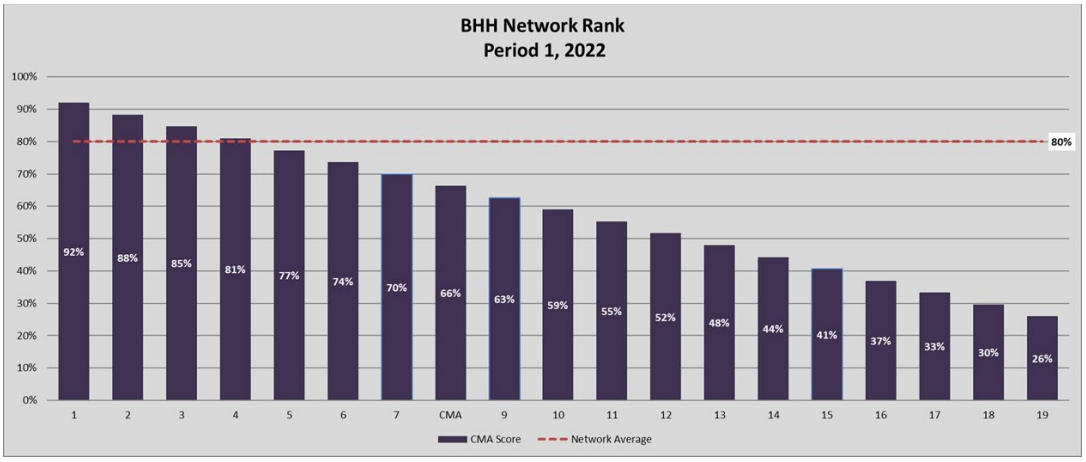
Scorecard Measure	Highest Possible Score	CMA Score
Process Measures	45%	0.00%
Qualitative Measures	55%	0.00%
Total	100%	0.00%

Performance Adjustment	Highest Possible Score	CMA Score
Sustained Performance	TBD	-
Overall Improvement	TBD	-
Total	TBD	-

CMA Final Adjusted Score	0.00%

Tier Status

	Scorecard Weight	Metrics	Possible Score	CMA Score	Performance to Date: CMA Score (Out of 100%)	Performance to Date: Network Average (Out of 100%)	Performance to Date: Performance Status
Process Measures	45%	Enrollment Status & Member Engagement	25%		0.00%	0.00%	
		Timely Completion of Comprehensive Assessments	15%		0.00%	0.00%	
		Timely Completion of Care Planning	35%		0.00%	0.00%	
		Healthix Alert Response Rate	20%		0.00%	0.00%	
		Billing Rate	5%		0.00%	0.00%	
		Total	100%				
		Composite Score					
		BHH Chart Review					
Qualitative Measures	55%	Documentation	10%		0.00%	0.00%	
		Comprehensive Assessment	30%		0.00%	0.00%	
		Plan of Care	30%		0.00%	0.00%	
		Member & Care Team Engagement	15%		0.00%	0.00%	
		Critical Events & Care Transitions	15%		0.00%	0.00%	
		Gaps in Care (Bonus)	5%		0.00%	0.00%	
		Overall Score	100%				
		Composite Score					
			CMA Total Score	0.00%			



- Scorecards performance is based upon both quantitative and qualitative data.
- Visual representation of results is subject to change based upon BHH QMP framework

For additional details, refer to **BHH Operations Report**, located in **Appendix N**.

Improvement Action Plan (IAP)

Purpose

The purpose of the **Improvement Action Plan** (IAP) is to identify need areas in which there are opportunities for improvement, to define the action steps to resolve those issues and to build a sustainability plan of maintaining optimal performance levels. The IAP is designed to be a supportive and collaborative process between BHH management and the CMA to develop and commit to a plan of improving the quality-of-care management services.

IAP Implementation

Reasons for an IAP Implementation:

- At the request of BHH management, a CMA can be selected to participate in a IAP if it is found that there could be value in developing a structured action plan to focus on areas in which there are opportunities for improvement
- A CMA can decide to place themselves on an IAP if they, through internal review, identified performance deficiencies for which they want BHH support
  Note: Action Plan template is a tool that can be used for all CMA's regardless of tier status and/or performance level.

IAP Process

Before IAP: If BHH is requiring a CMA to participate in an IAP, then they will be issued a pre-filled, IAP template with need areas identified through their Biannual Performance Scorecard. However, if a CMA decides to participate in an IAP, then they can select the areas they would like to focus on utilizing BHH's Action Plan template.

CMAs will be given (at minimum) two weeks to complete their IAP template for Months 1 – 3 with their action steps, monitoring and evaluation process, responsible staff members(s) and monthly targets. CMAs should use the allotted time to build their action plan with the relevant staff members. These action plans will be reviewed by BHH for feedback and approval.

During Months 1 – 3:

- The IAP process will last approximately 6 months. The IAP can be extended if necessary
- The IAP will be broken up into two 3 months segments, in which a check-in meeting is required at the conclusion of the initial 90 days with the BHH management team. Additional meetings and/or support can be given at the request of the CMA or BHH.
- Quarterly Check-ins will consist of:
    - A discussion of the corrective action steps taken to improve performance
    - A review of available reports including but not limited to the Operations Report, Executive Summary, BHH network tracking tools and FCM user reports.
    - A review of the level of progression toward goals
- CMAs may be subjected to a chart review that is to be performed by BHH staff at the conclusion of the initial 90 days.
    - A small sample of charts may be selected with attention to specific chart review areas that were flagged on the Biannual Performance Scorecard. The charts identified with the most deficiencies and/or flagged for supervisory review will be targeted as well.

During Months 4 – 6:

- Following the conclusion of the initial 90 days (Months 1 – 3), CMAs will be required to establish action steps and targets for Months 4 – 6 based on the results of the initial 90 days.
    - In the development of the Action Plan for Months 4 – 6, CMAs must consider current performance levels and what strategies were successful and unsuccessful.
    - CMAs may choose to modify or sustain action steps. It is important to build a plan to continue making improvements and to sustain good performance.
- This updated Action Plan will be reviewed by BHH for feedback and approval.
- CMAs can elect to have additional support and oversight from BHH in addition to the required quarterly check-in.

IAP Development

Action Steps: Outline the steps in which your CMA plans to take for Months 1 – 3 for each need area listed. Once you have completed the initial 90 days, continue, or update the action steps for the subsequent 3 months (Months 4 – 6). Steps can include but are not limited to:

- Utilizing operations reports to track performance and make corrections for flagged issues
- Revise supervisory structure
- Conduct staff trainings
- Implement weekly/monthly supervision etc.

Monitoring and Evaluation Process: CMAs must select a way to monitor and evaluate their level of progression towards goals for each need area.

- CMAs can utilize the Operations Reports, Executive Summaries, the reports available in FCM or any internal tracking tool(s) that has been utilized.

Responsible Staff Member(s): CMAs must identify the appropriate staff member(s) that will take lead on each need area in the Action Plan template.

Target Scores: Select incremental, target scores that your agency aspires to achieve in Months 1 – 3. Establish new target scores for Months 4 – 6 based on the results of the initial 90 days. If targets are achieved in the initial 90 days, new targets should continue to increase until you have reached 100%. The scores should be realistic and at a level that demonstrates sufficient progress. When establishing targets, it would be helpful to:

- Know and understand the current performance levels of your staff members
- Set incremental goals for each of the need areas
- In addition to monthly targets, they can be further broken down to weekly or daily if possible
    - Ex: Care management staff will complete (5) comprehensive assessments per week until all overdue assessments are complete.
- Consider how your CMA will track and monitor set targets
- Consider who, among your staff members, will take lead on certain need areas

Once your agency has completed the IAP template with your action steps and target scored for Month 1 – 3, it must be submitted to BHH for review and approval. Once the IAP is approved, they your CMA can proceed with the implementation of the IAP. Following the conclusion of

the initial 90 days, CMAs will be asked to complete and Action Plan for Months 4 – 6 that must also be submitted to BHH for review and approval.

What does a successful IAP look like?

A successful IAP can occur when some or all the following conditions are met:

- ✓ All or most performance targets have been met
- ✓ CMAs successful pass the random chart audit
- ✓ CMA demonstrates improvement in performance scores and elevates to a higher tier status
- ✓ Improved performance levels are sustained over time

CMAs that do not successful complete their IAP will have the opportunity to assess their performance, re-examine the methods used to make improvements and adjust accordingly as a new plan is developed for the next performance period.

Corrective Action Plan (CAP)

Purpose

The purpose of the **Corrective Action Plan** (CAP) is to identify need areas in which there are performance deficiencies, to define the corrective action steps to resolve those issues and to build a sustainability plan of maintaining optimal performance levels. The CAP is designed to be a supportive and collaborative process between BHH management and the CMA to develop and commit to a plan of improving the quality-of-care management services.

CAP Implementation

Reasons for a CAP:

- Achieving a Tier 4 status as per performance scorecard results
- As a result of a critical event or an incident report that is indicative of deficiencies in the delivery of care management services and/or insufficient resources (i.e., staffing and/or supervision)
- Member, DOH, MCO or other stakeholder identifying areas of potential concern
- At the request of BHH management, a CMA can be selected to participate in a CAP if it is found that there could be value in developing a structured action plan to focus on areas in which there are opportunities for improvement

CAP Process

Before CAP: CMAs will be issued an Action Plan template, pre-populated with the need areas that BHH would like your agency to concentrate efforts for improvement. CMAs can also add additional need areas to focus on and for which you would like BHH support.

CMAs will be given (at minimum) two weeks to complete their CAP template with their action steps, monitoring and evaluation process, responsible staff members(s) and monthly targets. CMAs should use the allotted time to build their action plan with the relevant staff members. These action plans will be reviewed by BHH for feedback and approval. The CAP will be broken up into 1-month segments in which a check-in is required with the BHH management team.

During CAP (Months 1-3):

- The CAP process will last approximately 3 months. The CAP can be extended if necessary
- The CAP will be broken up into 1-month segments in which a check-in is required with the BHH management team. Additional meetings and/or support can be given at the request of the CMA or BHH.
- The monthly check-ins will consist of
    - A discussion of the corrective action steps taken to improve performance
    - A review of available reports including but not limited to the Operations Report, Executive Summary, BHH network tracking tools and FCM user reports.
    - A review of the level of progression toward goals
- CMAs will be subjected to a chart review that is to be performed by BHH staff at the conclusion of the 90-day CAP.
    - A small sample of charts will be selected with attention to specific chart review areas that have been flagged in the Biannual Performance Scorecard. The charts identified with the most deficiencies and/or flagged for supervisory review will be targeted as well.

After the CAP (Months 4-6):

- Following the conclusion of the 90-day CAP (Months 1-3), CMAs will be required to establish action steps and targets for Months 4-6 based on the results of the 90-day CAP. In the development of the Action Plan for Months 4-6, CMAs must consider current performance levels and what strategies were successful and unsuccessful. CMAs may choose to modify or maintain same action steps for each need area. It is important to build a plan to continue making improvements and to sustain good performance.
- The updated Action Plan must be submitted to BHH for feedback and approval.
- The results of the 90-day CAP (Months 1-3) will determine the level of oversight and support from BHH that will take place during this period.

CAP Development

Action Steps: Outline the steps in which your CMA plan to take for each need area listed. Such steps can include, but are not limited to:

- Utilizing operations report to track performance and make corrections for flagged issues
- Revise supervisory structure
- Conduct staff trainings
- Implement weekly/monthly supervision, etc.

Monitoring and Evaluation Process:

CMAs must select a way to monitor and evaluate their level of progression towards goals for each need area. CMAs can utilize the Operations Reports, Executive Summaries, the reports available in FCM or any internal tracking tool(s) that has been utilized.

Responsible Staff Members(s): CMAs must identify the appropriate staff member(s) that will take lead on each need area in the Action Plan template.

Target Scores: Select incremental, target scores that your agency aspires to achieve in Months 1 – 3 during the CAP. Establish new target scores for Months 4 – 6 based on the results of the 90-day CAP. If targets are achieved during the CAP, new targets should continue to increase until you have reached 100%. The scores should be realistic and at a level that demonstrates sufficient progress.

When establishing targets, it would be helpful to:

- Know and understand the current performance levels of your staff members
- Set incremental goals for each of the need areas
- In addition to monthly targets, they can be further broken down to weekly or daily if possible
    - Ex: Care management staff will complete (5) comprehensive assessments per week until all overdue assessments are complete.
- Consider how your CMA will track and monitor set targets
- Consider who, among your staff members, will take lead on certain need areas

Once the development of the CAP is complete, it should be submitted to BHH for review and approval. Once the CAP is approved, CMAs can proceed with the implementation of the CAP. Following the conclusion of the CAP, CMAs will be asked to complete an Action Plan for Months 4 – 6 that must also be submitted to BHH for review and approval.

When can a CMA be considered for graduation from a CAP?

The successful completion of a CAP is determined on a case-by-case basis. The BHH management team must determine if the outcomes of the CAP are acceptable and can be sustained without danger of recurrence. A successful CAP can occur when some or all the following conditions are met:

- ✓ All or most performance targets have been met
- ✓ CMAs successfully pass the random chart audit
- ✓ CMA improves their performance scores and elevates themselves to a higher tier status
- ✓ Improved performance levels are sustained over time

CMAs that do not successfully complete the CAP will restart the 3 months cycle. CMAs that do not graduate from the CAP after two consecutive cycles or three non-consecutive cycles within 18 months will be subject to further disciplinary actions.

BHH Action Plan Template (IAP/CAP)

BHH Action Plan

Date(s) of Performance Review:		Care Management Agency:		Action Plan Status:	
Reporting Period/Timeframe:		Action Plan Type:		BHH Approval Status:	
Designated Tier Status:		Eligibility to Receive Referrals:		Date of Next Performance Review:	

Instructions: The following document includes a list of process measures and chart review areas in which performance fell below target and network average. The scores used to populate the "CMA SCORE" and "BHH AVG" for each of the process measures is sourced from the Executive Summary Report. This will allow your agency to closely monitor your own performance and level of progression on a monthly basis. The scores for the chart review results are provided by BHH biannually. These need areas do not require target scores, however a comprehensive plan to address these areas must be developed and monitored.

Please complete the Action Steps, Monitoring & Evaluation Process, the Responsible Person(s) and the Target Scores (when applicable) for Months 1 through 3 for each Need Area listed below and submit for BHH approval. If needed, a date for a follow-up performance review will be scheduled to monitor progression towards goals.

						For CMA Completion									For BHH Completion				
						90 Day Corrective Action Plan									90 Day Corrective Action Plan Results				
NEED AREA #	NEED AREA	PRIORITY LEVEL	ADDITIONAL COMMENTS	CMA SCORE	BHH AVG	ACTION STEPS *Choose steps that are concrete, measurable and attainable*	MONITORING & EVALUATION PROCESS	RESPONSIBLE STAFF MEMBER(S)	Month 1 Target	Month 1 Actual Score	Month 2 Target	Month 2 Actual Score	Month 3 Target	Month 3 Actual Score	Target Achieved?	Date Target Achieved	CMA FINAL SCORE	F/U Required?	Final Comments & Suggestions
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
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15																			
16																			

❖ QI/QA Initiatives

The BHH QMP aims to monitor and evaluate member access to medical, behavioral health, mental health, and social services. As part of the BHH QMP, data pertaining to member gaps in care and special population eligibility is collected, analyzed, and incorporated into QI/QA initiatives designed to improve access to both non-clinical and clinical services.

Gap in Care Data Transformation Project

Robust initiative designed to improve member connections to healthcare providers and services that can appropriately address member specific gaps in care

Special Population Monitoring & Evaluation – HARP

Data monitoring and evaluation process geared toward accurate and timely documentation of member eligibility (i.e. H-code), education of HCBS + CORE services, HCBS/CORE provider connections and service delivery

Special Population Monitoring & Evaluation – Health Home Plus (HH+), (SMI/HIV)

Data monitoring process geared toward accurate and timely identification of HH+ eligibility (i.e. PSYCKES, Clinical Discretion, BSQ), education and delivery of enhanced services

QI/QA Technical Assistance & Guidance

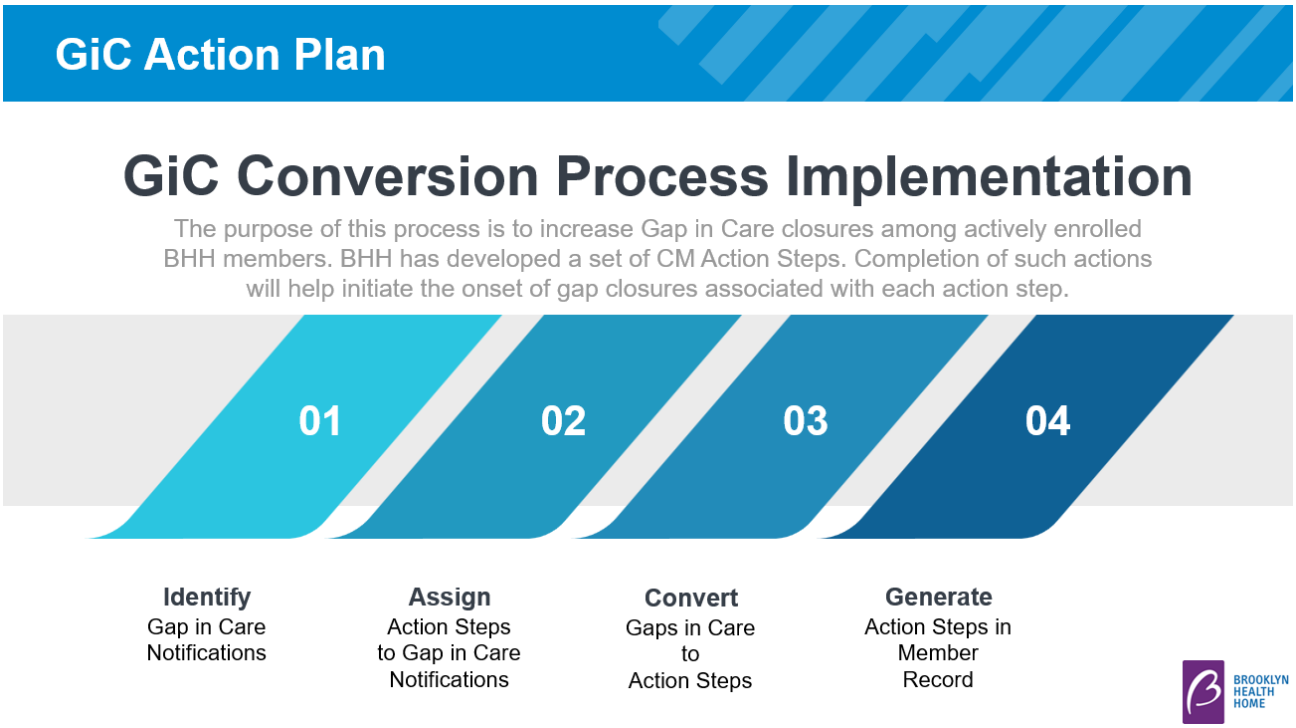
Continuous development of system and/or process specific guidance and supplemental materials designed for educational, practical applications/purposes

Gaps in Care Transformation Initiative

The purpose of the **Gap in Care Transformation Initiative** is to increase gap in care closure rates among actively enrolled BHH members by transforming gap in care data into Care Manager actions. Through this process, Care Managers will be able to better engage and direct members to a specific provider responsible for gap in care closure. Connection to primary care and preventative services such as annual physicals, dental health visits are key components.

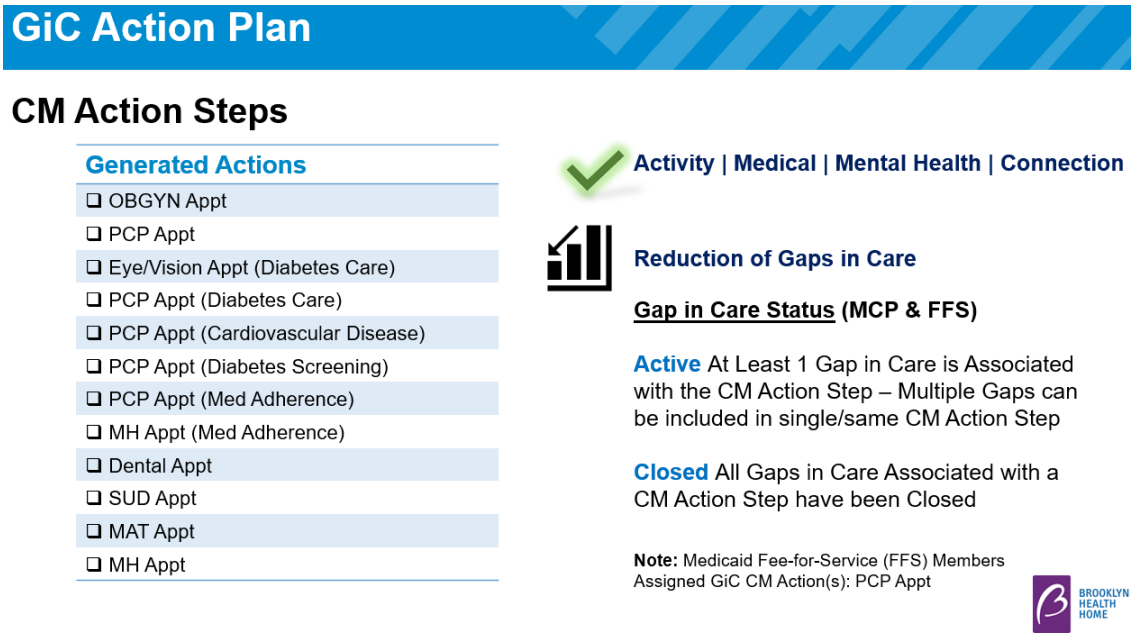
GiC Conversion Process Implementation:

- Identify Gap in Care Notifications from Managed Care Plans, Internal Review(s)
- Assign Action Steps to Gap in Care Notifications
- Convert Gaps in Care to Action Steps
- Generate Action Steps in Member Record



Overview of Care Manager Actions:

- Identify CM Action Steps Added to Member Record to Address 1 or More Gaps in Care
- Discuss CM Action Step (*Provider Connection*) with Member and/or Care Team Members
- Connect Member to a New Medical/Behavioral Health Provider
- Schedule Appointment with Current Medical/Behavioral Health Provider
- Confirm Appointment/Service Attendance with Current/New Provider

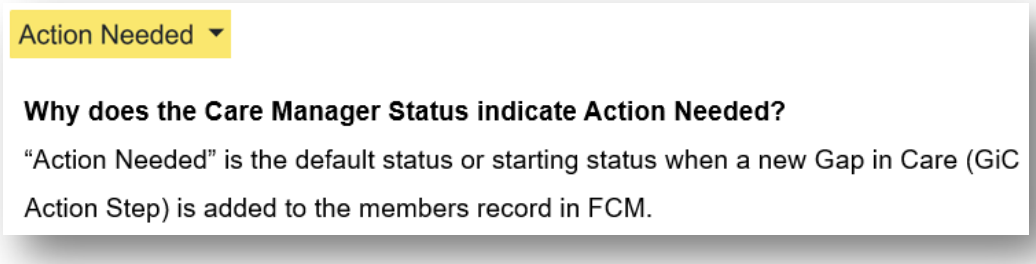


Note: FFS Members will be assigned a PCP Appt and Dental Appt CM Action.

Gap in Care Status:

- Each Gap in Care Action has both a Managed Care Plan Status and Care Manager Status
- Managed Care Plan status is dependent upon receipt of new data/information from contracted Managed Care Plans
    - Data is based upon processed claims and is disseminated periodically
- Care Manager Status should reflect the work being done with the member
- **GIC Action: PCP Appt** and **Dental Appt** is added for *Fee-for-Service (FFS) members*

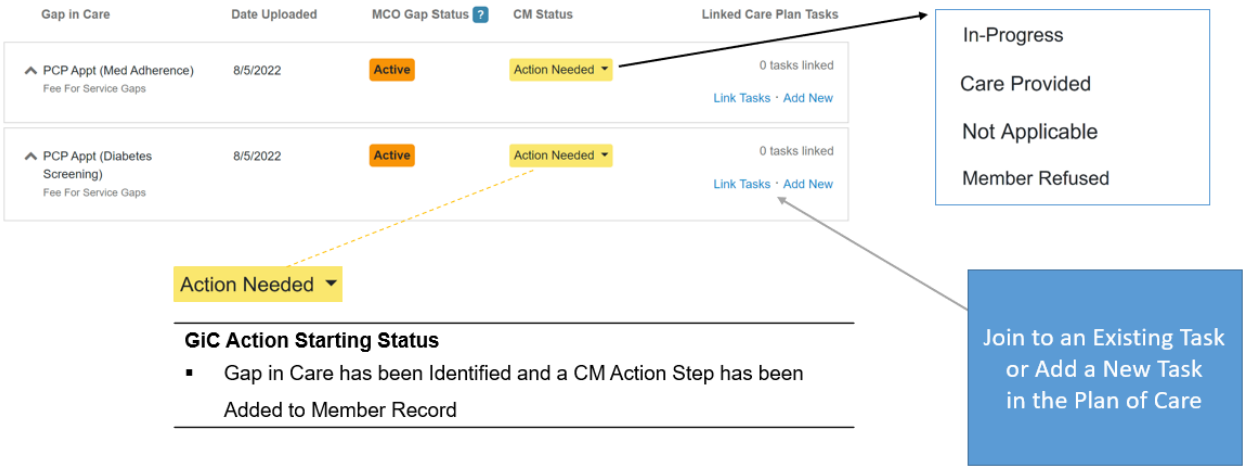
Action Needed ▾ **Default Status*	**GiC Action Starting Status** ▪ Gap in Care has been Identified and a CM Action Step has been Added to Member Record
In-Progress	▪ Care Manager has Started Discussion w/ Member about Provider/Service Connection ▪ Member Agrees to CM Action Step (*Connection*) to Address GiC ▪ CM Action Step (*Connection*) Scheduled, Confirmation or Outcome *Pending* ▪ Member Interested, but at Later Time – To be Reviewed with Member Intermittently **Documentation:** ✓ Add Action Step to Plan of Care | **NEED → GOALS → TASKS** ✓ Add and **Link Encounters** to NEED/GOALS/TASKS
Care Provided	▪ Member Completed CM Action Step, Connection Confirmed **Documentation:** ✓ Update Plan of Care with Completion Details (Remember to Link Encounters)
Not Applicable	▪ Member is Disengaged or Lost to Follow-up (LTFU) ▪ Member is Residing Excluded Setting, Currently in a Pended Segment ▪ GiC MCP Status Not Active (*Inactive Status*)
Member Refused	▪ Member Refuses/Not Interested in Completing Action Step



For additional resources and tools, refer to the **Gap in Care Action Plan – Care Manager Status Guidance** and the **Gap in Care Action Plan Tool**, located in **Appendix G** and **H**, respectively.

Gap in Care + Plan of Care Connections

Identified gaps in care should be reviewed and addressed with the member when appropriate. If a member is interested in the provider connection and/or completion of services related to the specific gap in care, the Care Manager should update the member's plan of care, connect (*link*) and document information throughout the member record. A Care Manager can update the CM Status and join an existing/new task in the members' plan of care:



MCO Gap Status is based upon data received from the member **Medicaid Managed Care Organization** (MCO). Gap in care closures are based upon submitted/processed claims which experience a significant lag. It is important to note that gaps in care will have a MCO Gap Status of "*Active*" until new information is imported into FCM which indicates either a gap in care has been "*Closed*" or has been "*Expired*" (i.e. member disenrolled/enrolled in different MCO).

If a provider connection and/or service has been completed and verified, it is important that the Care Manager update the member's record to reflect this achievement. Progress should be documented within the members gap in care CM Status and Plan of Care.

Special Population Monitoring & Evaluation: HARP

Purpose

The purpose of the **Special Population Monitoring and Evaluation of HARP** (HCBS/CORE) is to ensure eligible members are engaged, educated and if appropriate, connected to enhanced services within the community that can address member specific needs and/or goals.

Goals & Objectives

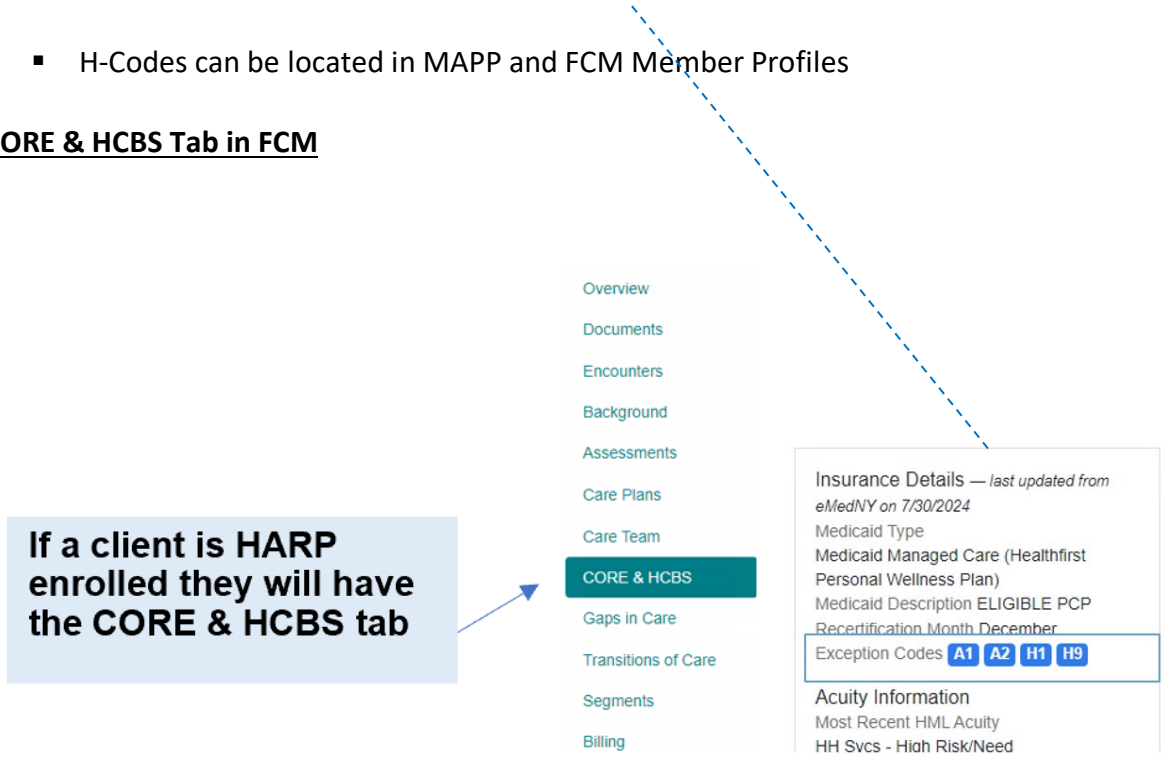
- Ensure potential HARP members (H-code: *H9*) are identified, engaged, educated and if interested, connected to a Medicaid Managed Care Plan, HARP
    - HARP stands for "*Health and Recovery Plan"*
- Engage, educate, and connect HARP eligible members to appropriate services
    - HCBS – "*Home and Community Based Services"*
    - CORE – "*Community Oriented Recovery and Empowerment Services"*
    - HARP Members can access **both** HCBS and CORE
- Review and verify accurate and timely documentation of HARP (HCBS/CORE) workflow
    - Member Interest of either HCBS or CORE (i.e. Encounter Note, HCBS + CORE Tab)
    - HCBS Eligibility Assessment (i.e. Outcome: Tier 1, 2 HCBS Determination)
    - Plan of Care / Level of Service Request (*LOSR*)
    - Level of Service Determination (*LOSD*)
    - HCBS and/or CORE Referral Details
- Incorporate HARP (HCBS/CORE) service connection (Goals/Needs/Tasks) to member Health Home plan of care

Note: HCBS and CORE follow (2) separate workflows. However, a member may be eligible and can receive both HCBS and CORE services.

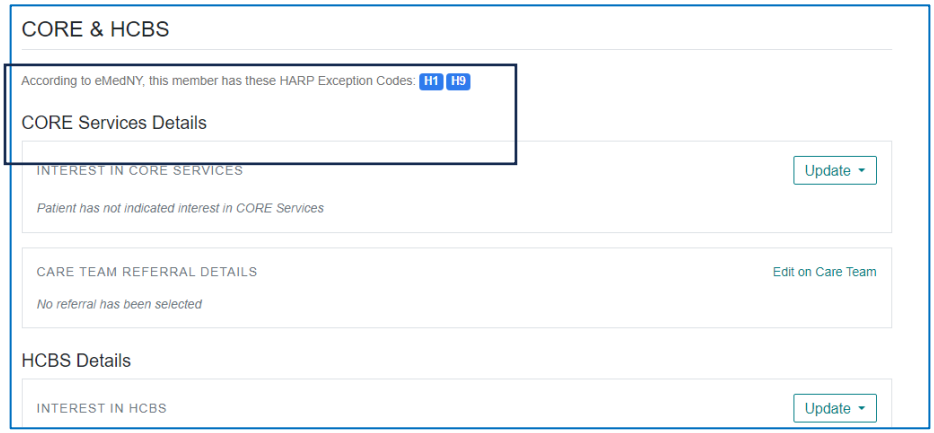
HARP Eligibility

- HARP Enrollment is evidenced by **H codes**
- H-Codes can be located in MAPP and FCM Member Profiles

CORE & HCBS Tab in FCM



Example: Above record has both a H9 and H1 code. Member was eligible (i.e. H9) and joined for HARP (i.e. H1). To verify, review MAPP, ePACES and the Medicaid Managed Care Plan details (Above).



If connected to HCBS and/or CORE, member record documentation should support linkage to services (i.e. DOH 5055 consented Care Team, Care Team tab)

H-Codes

Recipient Restriction Exception Code	Previous Description eMEdNY	Updated Description eMEdNY
H9	HARP Eligible – Pending Enrollment	BH High-Risk / HARP Eligible
H1	HARP Enrolled without HCBS	HARP Enrolled
H2	HARP Enrolled with Tier 1 HCBS	Tier 1 HARP BH HCBS Eligible
H3	HARP Enrolled with Tier 2 HCBS	Tier 2 HARP BH HCBS Eligible
H4	SNP HARP Eligible without HCBS	SHIV SNP BH High-Risk
H5	SNP HARP Eligible with Tier 1 HCBS	HIV SNP, Tier 1 BH HCBS Eligible
H6	SNP HARP Eligible with Tier 2 HCBS	HIV SNP, Tier 2 BH HCBS Eligible

- H9 – Member is eligible to be enrolled in a HARP
  - Care Manager should educate member about HARP (HCBS and CORE)
  - If member expresses interest, a Care Manager can assist member change their insurance plan and enroll in a MCO HARP
  - **NYS OMH Health and Recovery Plans (HARPs)**
- Once the insurance plan is changed, the members record will have a new H-code
  - H1 or H4
- H-codes are added to a member record and not removed
  - member may have a H9 and H1 code
  - Information should be verified and documented in record
- Member will have additional H-codes based upon HCBS Eligibility Assessment Results
  - H2, H3 or H5, H6

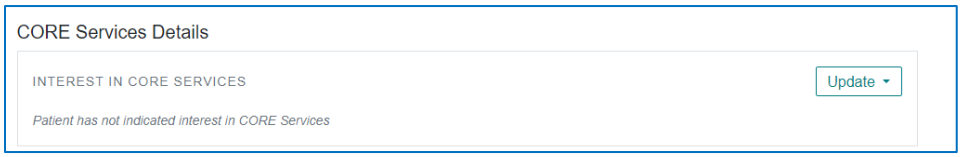
Note: HCBS Eligibility Assessment is required if the member is interested and wants to be connected to a specific HCBS service.

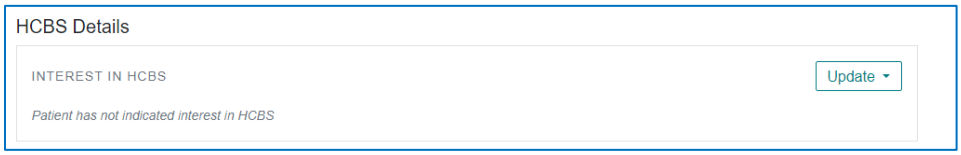
HARP (HCBS/CORE) Member Education

HCBS and CORE services are to be reviewed with appropriate Health Home members:

- At enrollment
- Annually

Member education and interest (outcome) for both HCBS and CORE is **required** to be documented in the member's record via encounter notes, the HCBS/CORE tab (see below), Comprehensive Assessments and the Health Home Plan of Care, if appropriate.

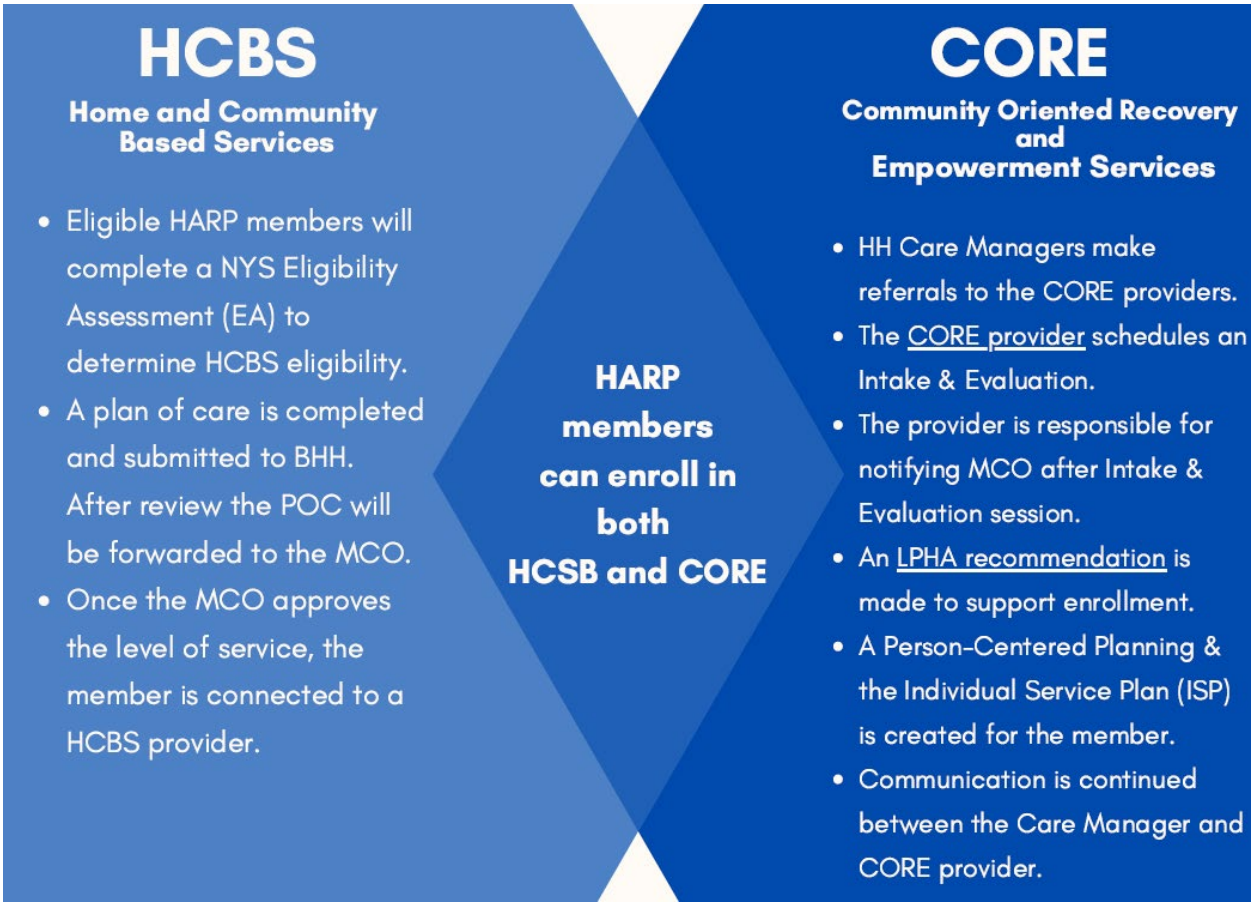




CORE Education - Review Questions:

CORE Education:

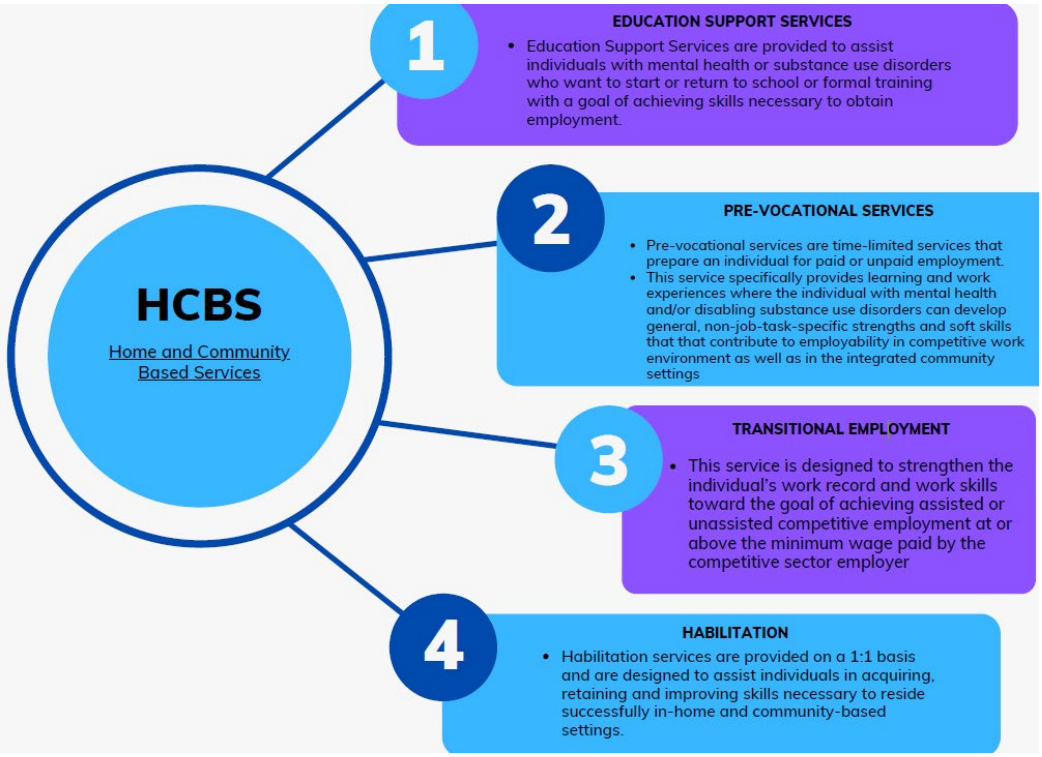
1. Was the member educated about CORE services?
    a. Date member was educated about CORE services?
2. Is the member interested in receiving CORE services?
3. What CORE services is the member interested in receiving?
4. Was the member's education and interest documented in the member record (encounter note, POC etc.)?



Resources:

- **CORE Providers**
- **LPHA Recommendation**
- **Behavioral Health (BH) High-Risk Eligibility Criteria**

HCBS Home and Community-Based Services



1. **Education Support Services**
   - Assist individuals who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment
2. **Pre-Vocational Services**
   - Time-limited services that prepare an individual for paid or unpaid employment and can help an individual develop general, non-job-task-specific strengths and soft skills
3. **Transitional Employment**
   - Service designed to strengthen the individual's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employment
4. **Habilitation**
   - Habilitation services are provided on a 1:1 basis and are designed to assist individuals in acquiring, retaining, and improving skills necessary to reside successfully in-home and community-based settings

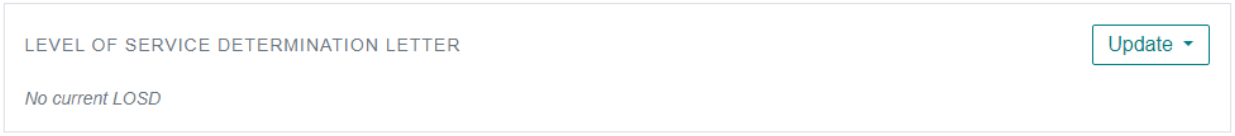
HCBS Workflow

Eligible HARP members will complete a **NYS Eligibility Assessment** (EA) to determine HCBS eligibility (i.e. Tier 1, Tier 2 Eligibility)

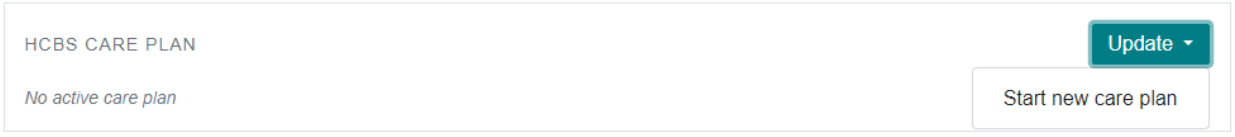
HARP POC/LOSR Submission Steps

HARP Members interested in HCBS are to complete the HARP Plan of Care/Level of Service Request (HARP POC/LOSR) in the CORE & HCBS tab

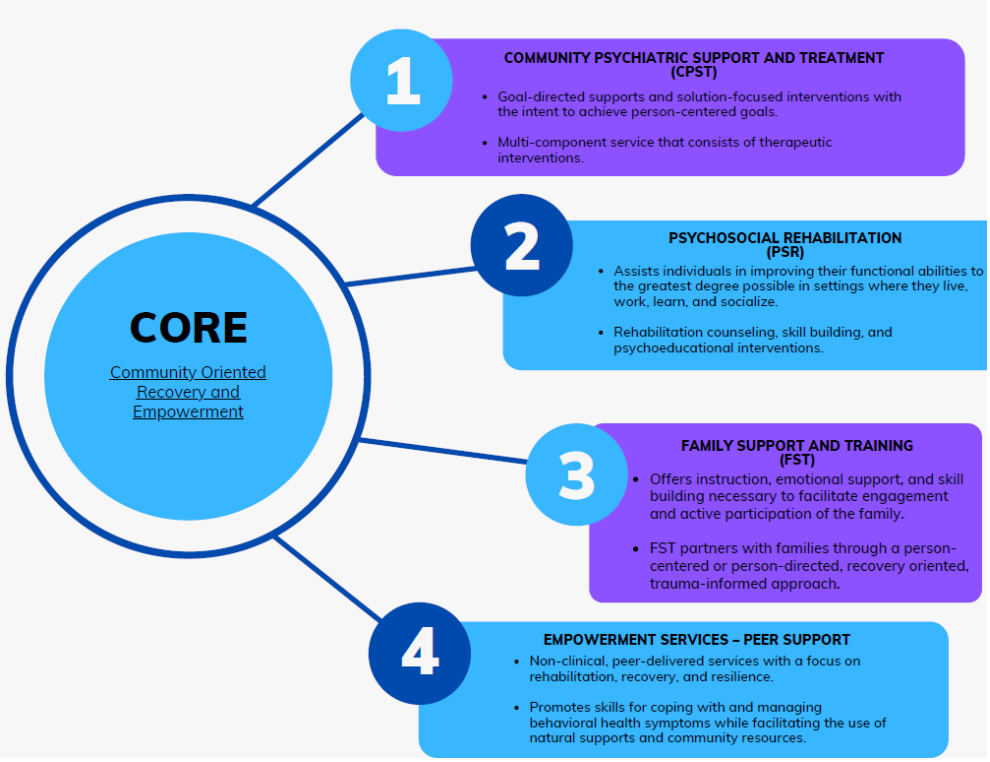
1. Care Manager completes the LOSR (*R – Request*)
2. Send the FCM member link to BHH
3. BHH send the LOSR (*Request*) to the correct MCO contact(s)
4. The MCO reviews the LOSR and makes determination
    a. MCO sends back formal letter – LOSD (*D – Decision*)
    b. Letter includes details about approved HCBS
5. BHH uploads the LOSD to the CORE & HCBS tab and send the link back to the requesting Care Manager and/or CMA contact(s)



6. Care Manager completed the full HARP POC



CORE Community Oriented Recovery and Empowerment



1. **Community Psychiatric Support and Treatment (CPST)**
   - Multi-component service aimed at helping an individual achieve person-centered goals via therapeutic interventions, goal-directed supports, and solution focused interventions
2. **Psychosocial Rehabilitation (PSR)**
   - Rehabilitation counseling, skill building and psychoeducational interventions designed to improve functional abilities in settings where they live, work, learn and socialize
3. **Family Support and Training (FST)**
   - Person-centered or person-directed, recovery-oriented trauma-informed approach consisting of instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family
4. **Empowerment Services – Peer Support**
   - Non-clinical, peer-delivered services with a focus on rehabilitation, recovery, and resilience that are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the use of natural supports and community resources

CORE Workflow

- HH Care Managers can submit referrals on behalf of members to CORE providers

CORE Referral Steps:

1. Care Manager makes referral for a CORE service
2. The CORE provider schedules an Intake & Evaluation
3. The provider notifies MCO after Intake & Evaluation session
4. An **LPHA recommendation** is made to support enrollment
    a. *LPHA – "Licensed Practitioner of the Healing Arts"*
5. **Person-Centered Planning & the Individual Service Plan** (ISP) is created for the member

CORE Linkage - Review Questions:

CORE Linkage:

1. Was a referral submitted to a CORE provider?
2. What date was the referral submitted?
3. What is the name of the CORE provider where the referral was sent?
4. What services were requested?
5. Was the member's linkage to CORE services documented in the member record (i.e. encounter note, POC)?

Data Monitoring & Evaluation

The BHH QMP collects and analyzes data regarding both the HCBS and CORE workflow from the care management reporting system, FCM, as well as from periodic BHH Chart Reviews.

Results are used to evaluate the timeliness and accuracy of documentation of both the HCBS and CORE workflow. In addition to BHH monitoring, each CMA is responsible for tracking and verifying compliance with Health Home program policies and standards related to HARP (HCBS/CORE) workflows. HCBS and CORE workflow requirements should be documented clearly and consistently throughout a member record (i.e. HCBS + CORE tab, member encounter(s), Comprehensive Assessment and Health Home Plan of Care).

Key Reporting Elements (HCBS):

1. Member Education and Interest
2. HCBS Eligibility Assessment
3. LOSR – Request for HCBS Services Sent to MCP
4. LOSD – Approval of Requested HCBS Services (by MCP)
5. Full HARP Plan of Care
6. Health Home Plan of Care – Need/Goal/Tasks Addressed by HCBS

Key Reporting Elements (CORE):

1. Member Education and Interest
2. Referral Details
3. LPHA Recommendation Documentation
4. Individual Service Plan Documentation
5. Health Home Plan of Care – Need/Goal/Tasks Addressed by HCBS

Special Population Monitoring & Evaluation: Health Home Plus (HH+)

Purpose

The purpose of the **Special Population Monitoring and Evaluation of Health Home Plus** (HH+) is to ensure eligible, high need/high-risk members are engaged, educated and if interested, connected to enhanced HH+ (SMI/HIV) care management services designed to appropriately address member specific needs and/or goals via added support and contact frequency.

Goals & Objectives

- Conduct ongoing reviews of Health Home Plus eligibility among enrolled BHH members
    - HH+ eligible members should be engaged and educated about services
    - Members may be found eligible via PSYCKES quality flag indicators and/or via other pathways such as clinical discretion.
- Evaluate HH+ services being provided to eligible members
    - Review the number of members identified as HH+ eligible, receiving HH+ level of services and members not correctly identified (i.e. further action needed)

HH+ Service Connection

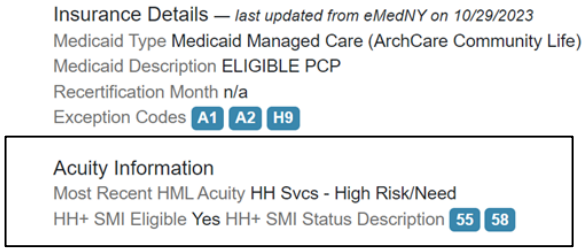
If appropriate, enrolled BHH members interested in HH+ services should be connected to a higher level of care to address their needs and goals.

- If a member is interested in receiving services but not currently enrolled with a CMA that has been designated as a HH+ provider, efforts should be made to transfer member to another CMA within the BHH network for services.

HH+ Eligibility Identification

HH+ eligibility status can be found in FCM via:

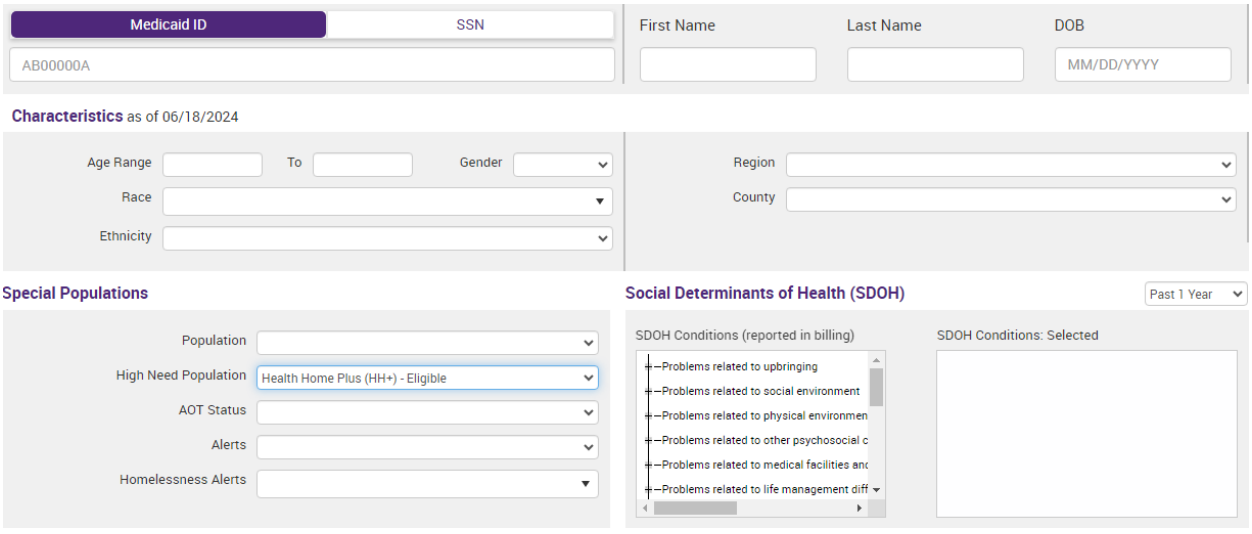
- Monthly billing support questionnaire details
- Individual Member Records:



PSYCKES quality flags can be used to determine members who are:

- Eligible for HH+ Services
- Received HH+ in the Past 3 Months
- Eligible for the "*Performance Opportunity Project"* (POP)

Example: PSYCKES High Need Population Search: Health Home Plus (HH+) Eligible



For additional information regarding PSYCKES Quality Flags, refer to the **BHH PSYCKES Quality Flag Guide**, located in **Appendix M**.

Health Home Plus (HH+) [SMI/HIV] Eligibility Table

HIV:	▪ Injection drug use and homelessness ▪ Injection drug use and 3+ in-patient hospitalizations in the last year ▪ Injection drug use and 4+ in-patient hospitalizations in the last year ▪ Virally unsuppressed ▪ Clinical Discretion ○ MCP OR Medical Providers
HIV/SMI:	▪ Homelessness (*HUD 1*) ▪ Last 12 Months: ○ 3+ in-patient hospitalizations ▪ **OR** ○ 4+ ED Visits ▪ HH+ Transitioning NYC AH+
SMI	▪ Homelessness (*HUD 1*) ▪ Last 12 Months: ○ 3+ psychiatric inpatient hospitalization **OR** ○ 4+ psychiatric ED visits ▪ 3+ medical inpatient hospitalization in past year w/ dx of Schizophrenia or Bipolar ▪ Ineffectively engaged in care: No Outpatient w/ ○ 2+ psychiatric hospitalizations **OR** ○ 3+ psychiatric ED visits) ▪ Clinical Discretion ○ MCP OR Medical Providers

Note: Above options mirror Health Home Plus Eligibility Question Response Fields within monthly Billing Support Questionnaires in the care management reporting system, FCM.

HH+ Eligibility & Service Monitoring

BHH developed a HH+ Eligibility tracking tool to help CMA's monitor and evaluate the steps being taken to identify, educate and when applicable, link members to HH+ services. The initial HH+ Tracking Tool was distributed with a list of members identified as HH+ eligible in PSYCKES.

- CMAs are to track progress being made to educate and link HH+ eligible members to services via the BHH tool and/or an internal tracking and reporting tool.
- CMAs are to add newly identified HH+ eligible members to their respective master tracking tool when applicable.

CMAs may continue to monitor and track HH+ processes using an internal tracker/tracking tool if HH+ eligibility process outcomes are measured:

- **Enrollment Status:** Enrolled, Pended, Diligent Search, Inactive, Outreach
- **Education Status:** Yes, No, Pending, Disenrolled, Transferred
- **Interested Status:** Yes, No, Pending, Future Interest, Service N/A
- **HH+ Recipient:** Yes-Assigned, No, Pending

Additional Review Processes

BHH conducts a review for HH+ services received > 11 months to flag for re-assessment and/or step-down to Health Home services. Additionally, HH+ eligibility and appropriate billing support questionnaire details are examined to ensure eligible members are appropriately identified and data documented within member records is accurate.

For additional guidance regarding HH+ (SMI/HIV) eligibility, refer to the **BHH P&P**.

QI/QA Technical Assistance & Guidance

The BHH QMP aims to continuously evaluate and develop system and/or process specific guidance/supplemental materials for educational and practical applications. Resources developed are designed to support the BHH network successfully deliver care management services to BHH members and aid key stakeholders in achieving programmatic requirements and QMP objectives.

Guidance materials include, but are not limited to:

- Strength, Barrier, and Risk Factor Guidance (Appendix F)
- Gap in Care Action Plan Guide & Tool (Appendix G/H)
- IA Codes and Criteria Guidance (Appendix I)
- CES Tool Guidance (Appendix J)
- PSYCKES Quality Flag Guide (Appendix M)

Appendices

Appendix A BHH Contacts

Name	Title	Email Address
Magdalena Gordon	Executive Director	magordon@maimonidesmed.org
Danielle Cuyuch	Vice President, Business Operations	dcuyuch@maimonidesmed.org
Latoya DaCosta	Sr. Program Manager, Population Health	idacosta@maimonidesmed.org
Rebecca Hoberman	Clinical Director, Behavioral Health Care Management	rhoberman@maimonidesmed.org
Brian Timmermans	Director, Clinical Operations and Quality Improvement	btimmermans@maimonidesmed.org
Matthew Caiazzo	Quality Analyst	mcaiazzo@maimonindesmed.org
Erin Huder	Population Health Program Associate	Ehuder@maimonidesmed.org

For inquiries and support regarding the BHH Quality Management Program, please contact

Brian Timmermans, Director, Clinical Operations and Quality Improvement.

Appendix B BHH Meetings

Reoccurring Meetings	Frequency	Point of Contact
Clinical, Business Operations & HIT Committee	Monthly	Magdalena Gordon / Danielle Cuyuch
Care Manager Workflow	Monthly	Rebecca Hoberman / Magdalena Gordon
Supervisory Workgroup	Quarterly	Rebecca Hoberman
BHH Case Conference	Monthly	Rebecca Hoberman / Magdalena Gordon
Quality Committee	Quarterly	Brian Timmermans

Appendix C Critical Events Management

Critical Events Management Checklist

Inpatient Hospitalization (Physical or Behavioral Health)	
1	Notify supervisor that a critical event has occurred.
2	Visit the member at the hospital. Gather information about the circumstances that led to the hospitalization. If consent has not been given for the hospital, attempt to obtain it during this visit.
3	Speak with the hospital staff (this may include attending physicians, nurses, social workers, discharge planners, etc.) about the member's status and the discharge plan. Ask questions and offer information about the member's history and community/home environment. Provide care manager and supervisor contact information to hospital staff.
4	Hold a case conference with members of the care team (this may include PCP, specialists, therapist, psychiatrist, and/or other providers). Inform the care team of the admission and ask how you, as thecare manager, can be helpful during and after the event. (See the case conference guidelines for additional detail).
5	Inform and include family members/emergency contacts as needed and appropriate (ensure consent is in place).
6	Remain involved in the discharge planning process, including securing needed services, equipment, resources, support, and follow up appointments for post-discharge.
7	Follow up with the member at least once a week for 4 weeks following discharge.
8	Ensure member attendance at the post-discharge follow-appointment with PCP, specialist, or psychiatrist (including arranging transportation, reminders, escorts, etc., as appropriate).
9	Update Care Plan.

ED Visit (No Admission)	
1	Notify supervisor that a critical event has occurred.
2	If the member is still at the ED when you learn of the event, attempt to meet the member at the ED.
3	Contact hospital staff to learn the circumstances surrounding the ED visit.
4	Hold a case conference with members of the care team (this may include PCP, specialists, therapist, psychiatrist, and/or other providers). (See the case conference guidelines for additional detail).
5	Inform and include consented family members/emergency contacts as needed and appropriate.
6	Provide resources and support to the member to prevent a future *avoidable* visit to the ED. This will varydepending on the reason for the ED visit – did the member need a place to sleep or eat? Was the member injured due to an unsafe living situation? Did the member run out of medication or did a medication error occur?
7	Ensure member attendance at any post-ED visit follow-appointment with PCP, specialist, or psychiatrist (Including arranging transportation, reminders, escorts, etc., as appropriate).
8	Update Care Plan.

Jail or Prison Admission	
1	Notify supervisor that a critical event has occurred.
2	Confirm receipt of alert with BHH staff.
3	Send letter to member at jail facility. See Justice Policies for additional detail.
4	Inform the care team of incarceration and hold a case conference to promote continuity of care and treatment post-release.
5	If consent is established with the facility social workers, conduct a case conference, and collaborate on discharge plan.
6	Update Care Plan.

Eviction Threat or Sudden Homelessness	
1	Notify supervisor that a critical event has occurred.
2	Work with the member and/or consented family to develop an eviction prevention action plan. Connect member to appropriate resources which may include legal services, rental/arrears support, APS, cleaningservices, etc.
3	Pursue alternative housing options.
4	Ensure a plan for emergency/temporary housing, including shelter referral, is in place.
5	Update Care Plan.

Missing Person	
1	Notify supervisor that a critical event has occurred.
2	Notify the police and file a missing person report if one has not already been filed.
3	Notify the care team members and MCO that the member is missing.
4	Search for the member. Call hospitals, the coroner's office, all consented collaterals, emergency contacts, check Webcrims, etc.
5	Update Care Plan.

Other Crisis (Suicidal Ideation, Domestic Violence, Threat to Others, etc.)	
1	Notify supervisor that a critical event has occurred.
2	Call 911 (if appropriate).
3	Create a safety plan for the member.
4	Provide members with resources and a hot line number for emergencies.
5	Notify and update the care team members as appropriate.
6	Continue frequent check-ins (daily, if necessary, until the situation is stabilized).
7	Update Care Plan.

Appendix D Discharges & Transfers Checklists

Case Transfer	
1	Remain connected to the member until their new care manager/CMA/Health Home is in place.
2	Obtain consent for the new care management agency.
3	Conduct a warm handoff.
4	If consent is established, securely share assessments and care plans with the new care manager, andpoint out any areas of particular concern or urgency.
5	If *receiving* a case transfer, conduct a chart review upon receiving the case and any documentation.
6	All transfer activities should be completed with 10 business days of identifying that a transfer is needed.

Case Closure/Discharge	
1	Notify supervisor to review and approve case for closure.
2	Enter a case closure note in the record. See the Case Closure Policy for additional detail. Update the Care Plan.
3	Complete a withdrawal form and store it in the member record.
4	Develop recommendations including referrals to other services and instructions identifying the processfor re-engaging in care management services should a future need present itself prior to the member's discharge.
5	Provide the member with case closure documentation including the follow up plans and recommendations.
6	Notify the member's care team members that the member is no longer receiving health home care coordination services.

Case Conference	
1	Initiate/schedule case conference within 2 business days of learning of a case conference triggering event.
2	Include at least one *external* member of the care team and/or an MCO representative in the case conference. Notify all other appropriate care team members of the conference and its outcomesfollowing the case conference.

Appendix E Diligent Search Checklists

Diligent Search Efforts	
1	Exhaust all "regular" care management efforts to engage member.
2	Notify supervisor that member has become disengaged from services and, if appropriate, declare the member Lost to Contact and initiate Diligent Search Efforts.
3	In each month of Diligent Search, perform a minimum of 3 activities to locate and engage member. Activities should vary in mode/type and be distributed throughout the month (e.g., phone calls and in-person attempts, outreach to the member as well as to collaterals, etc.) Month 1 must include notification to MCO (if applicable).
4	If member is successfully located at any time during Diligent Search, the appropriate steps for re- engagement must be taken: • In-person meeting with member to re-establish goals • Review and update member's contact information • Update care plan to meet member's needs • Develop plan to avoid disengagement in the future
5	If Diligent Search is unsuccessful, notify supervisor of inability to re-engage member and appropriately document the decision to Pend or Close member.

Appendix F Strengths, Barriers & Risk Factor Guidance

Strength, Barrier, and Risk Factor Guidance

Key Points:

- Strengths and barriers can apply to the member as a whole individual.
- Strengths and barriers may also apply to a member's specific need or goal.
- Risk Factors can help determine if the member is at risk of developing complications, co-morbid conditions (related conditions)

Strengths

Attributes that will help the member:

- Progress through their Plan of Care
- Cope with internal / external stressors
- Advocate on their own behalf
- Adhere to their medical, behavioral healthcare

Examples – Communication, writing, leadership skills | reliable, flexible, punctual, hardworking, creative, positive thinking

Barriers (*Obstacle | Limitation*)

Prevents an individual from receiving appropriate healthcare – primary care, preventative screening, dental care, vision care etc.

- Financial hardship – limited financial resources
- Geographical location – food insecurity, transportation burden
- Insurance / Service Access – loss of coverage
- Health literacy – understanding of diagnosis, condition, treatment instructions
- Language, education, or cultural barriers

Risk Factors

Attributes, exposures, or characteristics that increase the likelihood of a negative outcome (developing a disease, disorder, condition).

- Biological
  - Genetic predisposition
  - Family History of Medical Condition(s)
  - Poor response to medication(s) or treatment
  - Poor Sleep
  - Substance Use
- Psychological
  - Personality traits, thoughts, emotions, or attitudes that may lead to the development of a Mental Health Disorder
  - Absence of coping ability
  - Feelings of depression or hopelessness
- Family
  - Parents, spouse who use drugs, alcohol
  - Domestic Violence
  - Family who suffers from mental illness
  - Child abuse and/or maltreatment
- Community
  - Neighborhood poverty or violence
  - Household members, roommates, or neighbors who promote risk behaviors, increase access to drugs, alcohol
- Cultural
  - Differences in language
  - Preferences regarding medications, services, and/or treatments due to customs, religious beliefs, or preferences

Last Updated: *10/27/2023*

Appendix G Gap in Care Action Plan - Care Manager Status Guide

Action Needed (*Default*)

GiC Action Starting Status

Action Needed

- Gap in Care Identified by MCP or BHH (FFS Members)
- Review with Member "On Deck" (*forthcoming*)

In-Progress (GiC Active)

Member Engaged, Connection with Provider Started (Linkage Start)

- Member Engaged, Interested in being Connected to Provider or Service
- Referral to Provider Completed, Outcome Pending
- Appointment with Provider Scheduled, Result Pending

OR

Connection with New/Current Provider Deferred

- Member Interested, Prefers to Wait / Hold-off on Connection

Care Provided

Member Connected to Provider

AND

- Has been seen within past 3 months
- Attends appointments regularly with provider

Action Items

- ✓ Connect to New/Current Provider
- ✓ Schedule Next Appointment
- ✓ Contact for Appointment Reminder
- ✓ Confirm Results with Provider

Not Applicable

- Connection to Provider or Service No Longer a "Need" or GiC MCP Status *Inactive*
- Engagement Barrier Present: *Disengaged, Residing in an Excluded Setting, Pended Status, Out of Service Area etc.*

Member Refused

Member Declines Connection with Provider

Appendix H Gap in Care Action Plan Tool

Verify Connection or Current Needs for each Provider/Service

_____ **PCP Appt**

PCP Primary Care Physician

Physical, Annual Well-visit, Labs

_____ **OBGYN Appt**

OBGYN Obstetrician-genecologist

Cancer Screening, Well-visit, Labs

_____ **Dental Appt**

Dental General Dentist

Well-visits, Preventative Care

Connection to a Primary Care Physician (PCP): (**Y** / **N**)

Name: _____ Last Visit: _____ Note: _____

Connection to a Dentist/Dental Provider: (**Y** / **N**)

Name: _____ Last Visit: _____ Note: _____

Connection to a Vision/Eye Provider: (**Y** / **N**)

Name: _____ Last Visit: _____ Note: _____

_____ **PCP Appt (Med Adherence)**

Medication (Med) Adherence

Pharmacy Connection, Prescription Re-fills
Med Instruction Review with Care Team

Pharmacy/Delivery Services: (**Y** / **N**)

Name: _____ Last Pick-Up: _____ Next Refill: _____

_____ **PCP Appt (Cardiovascular Disease)**

Cardiovascular Disease

CVD Care. Treatment/Therapy, Testing

Cardiologist or Specialist: (**Y** / **N** / **N/A**)

Name: _____ Last Visit: _____ Note: _____

_____ **PCP Appt (Diabetes Care)**

_____ **PCP Appt (Diabetes Screening)**

_____ **Eye/Vision Appt (Diabetes Care)**

Diabetes Care Provider: (**Y** / **N** / **N/A**)

Name: _____

Labs (HbA1c): _____

Last Eye Exam (Date): _____

Neuropathy (Y/N): _____

Kidney Health Evaluation (Y/N): _____

Diabetes Care Diabetes Mellitus I/II

DM Care, Treatment and Monitoring

Pharmacy Connection, Prescription Re-fills

Diabetes Screening

Testing and Screening for DM

Podiatrist Neuropathy

Eye/Vision Ophthalmologist

Well-care visit, Screening

Connection to a Mental Health Care Provider: (**Y** or **N** or **N/A**)

Name: _____ Last Visit: _____ Note: _____

_____ **MH Appt**

_____ **MH Appt (Med Adherence)**

MH Mental Health Care

Provider Connection, Adherence to Care

Adherence to After-care/Discharge Plan

Attendance to F/U Appointments, Services

_____ **SUD Appt**

_____ **MAT Appt**

SUD Substance Use Disorder Treatment

MAT Medication-Assisted Treatment

Connection to a SUD or MAT Service/Provider: (**Y** or **N** or **N/A**)

Name: _____ Last Visit: _____ Note: _____

- ✓ **Link Gaps in Care Actions to Member Plan of Care (Goals, Tasks)**
- ✓ **Link New Encounters to Plan of Care (Goals, Tasks)**
- ✓ **Review and Verify Connection and Adherence to Linked Services**
- ✓ **Conduct Case Conference with Care Team**

Appendix I Initial Appropriateness (IA) Criteria

Initial Appropriateness (IA) captures a member's eligibility for the NYS Health Home program.

The below table includes IA codes and criteria for Adults/Both (*as of 9/1/2024*):

DOH Appropriateness Codes & Criteria

Appropriateness Code	Criteria	Program
10	**Adverse Events Risk:** Current H-code in EMEDNY (HARP Eligible/Enrolled)	Adults
11	**Adverse Events Risk:** Current POP flag in PSYCKES	Adults
12	**Adverse Events Risk:** Current Quality or HH+ flag in PSYCKES or equivalent from RHIO or MCO	Adults
19	**Healthcare Risk:** During the last 3 months, the member has been unable to schedule and keep their healthcare appointments (medical, psychiatric, etc.) and they do not know who their provider(s) is and how to contact their provider(s).	Both
20	**Healthcare Risk:** Member does not have at least one (1) of the following: Primary Care Provider, mental health provider, substance use provider, or provider to treat their Single Qualifying Condition (Complex Trauma, Sickle Cell Disease, Serious Emotional Disturbance/Serious Mental Illness, or HIV) or physical disability related to a neurologic, muscular, or neuromuscular condition.	Both
21	**Healthcare Risk:** Member has not seen their provider (e.g., PCP, BH, etc.) in the last year	Both
22	**Readmission/Recidivism Risk:** Released from inpatient Medical, Emergency Department, Crisis Stabilization, Residential Treatment Setting, Psych, or Detox within the last 6 months. Must specify name of institution and date of release	Adults
23	**Readmission/Recidivism Risk:** Released from Jail/Prison or other justice program within the last 6 months. Must specify name program and date of release	Adults
24	**Social Determinants Risk:** Current Intimate Partner Violence/Current Family Violence in the home of the member	Both

25	**Social Determinants Risk:** Member is experiencing food insecurity (due to financial limitations, ability to shop, access food site, dietary restrictions, etc.) and needs one of the following: • Emergency Food Assistance: Supplemental Nutrition Assistance Program (SNAP), Food Pantries, and Meals on Wheels • Women Infants and Children (WIC) for children under age 6 and pregnant/postpartum individuals.	Both
26	**Social Determinants Risk:** Currently homeless (HUD 1, 2, or 4) & for Transitional Age Youth, has no stable living arrangement (living with different friends/family)	Both
28	**Social Determinants Risk:** Member has had a change in guardianship/caregiver within the last 6 months	Both
30	**Social Determinants Risk:** Member (or caregiver, if Member is a child) needs and does not have one (1) of the following needed entitlements: • Medicaid Transportation/Access-a-Ride • Housing Supports (Section 8, Empire State Supportive Housing Initiative (ESSHI), New York Health Equity Reform (NYHER) Housing Supports) • Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Temporary Assistance for Needy Families (TANF) • Home Energy Assistance Program (HEAP) • Medical Entitlements (Medicare/Medicaid support) • Child Care Supports (for caregiver of enrolled children) • Early Intervention (Head Start or Special Education)	Both
31	**Social Determinants Risk:** Recent institutionalization or nursing home placement of member's primary support person within the last six (6) months and there is no other person to provide the same level of support.	Adults
32	**Treatment Non-Adherence Risk:** Member/care team member report of non-adherence…Must specify WHICH medication(s) and/or treatment(s) are involved	Both
33	**Treatment Non-Adherence Risk:** PSYCKES flag related to non-adherence or equivalent from RHIO or MCO	Both
34	Direct referral from Managed Care Organization (MCO), Local Government Units (LGU), Single Point of Access (SPOA), or county Local Department of Social Services.	Both
35	Direct referral from Adult Protective Services	Adults

Appendix J Continuing Eligibility Screening (CES) Tool Guidance

Purpose

The following guidance pertains to the **Continuing Eligibility Screening** (CES) process and tool. Information is inclusive of the CES implementation process, CES tool time parameters and MAPP billing block mechanisms.

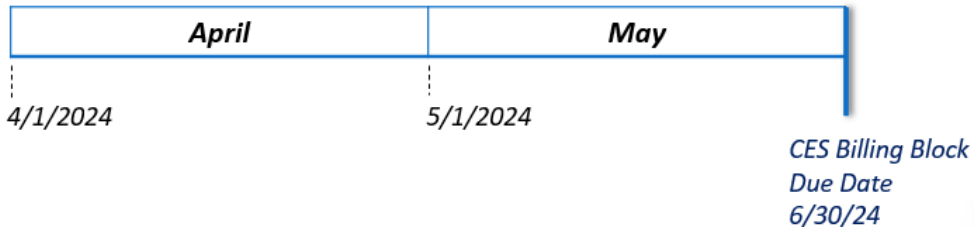
The CES Tool implementation plan includes the completion of an initial CES Tool for all enrolled (*non-pended*) members and a MAPP billing block mechanism focused on the timely completion of the CES Tool at defined time intervals.

- **CES Tool Start Date:** *November 2023*
- **CES Tool MAPP Billing Block Start Date:** *May 2024*

Initial MAPP Billing Block Cohort

Enrolled (*non-pended*) Health Home member with a segment start month of *11-November, 12-December, 01-January, 02-February, 03-March, 04-April*.

Members in this cohort will be able to bill for services in *April 2024* (w/o a CES Tool) but will not be able to bill for services in *May 2024* if a CES Tool is not complete by/prior to *5/31/2024*.



Note: MAPP billing logic provides a **1-month buffer** prior to MAPP billing block mechanism.

As per the Connection Between CES and Billing Instances in MAPP HHTS v.4, during the CES Tool implementation phase, **+1** segment month will be added each month until *October 2024*.

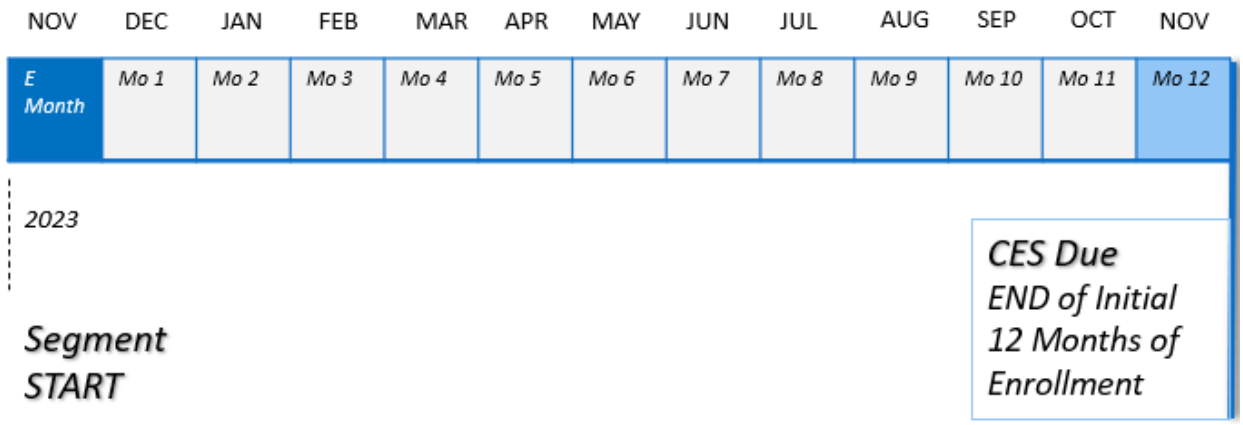
Segment Begin Date	Month of Segment Begin Date	*Last Month to Bill* w/o Initial CEST Outcome Submission	Cannot Bill for month ending w/ this date, or any subsequent months, until CEST submitted w CEST Start date that is equal to or prior to this date
11/1/XXXX	Nov	4/1/2024	5/31/2024
12/1/XXXX	Dec	4/1/2024	5/31/2024
1/1/XXXX	Jan	4/1/2024	5/31/2024
2/1/XXXX	Feb	4/1/2024	5/31/2024
3/1/XXXX	Mar	4/1/2024	5/31/2024
4/1/XXXX	Apr	4/1/2024	5/31/2024
5/1/XXXX	May	5/1/2024	6/30/2024
6/1/XXXX	Jun	6/1/2024	7/31/2024
7/1/XXXX	Jul	7/1/2024	8/31/2024
8/1/XXXX	Aug	8/1/2024	9/30/2024
9/1/XXXX	Sep	9/1/2024	10/31/2024
10/1/XXXX	Oct	10/1/2024	11/30/2024

- **May 2024** [Segment Month: *5/1/XXXX*, Billing Block Due Date: *6/30/2024*]
- **June 2024** [Segment Month: *6/1/XXXX*, Billing Block Due Date: *7/31/2024*]
- **July 2024** [Segment Month: *7/1/XXXX*, Billing Block Due Date: *8/31/2024*]
- **August 2024** [Segment Month: *8/1/XXXX*, Billing Block Due Date: *9/30/2024*]
- **September 2024** [Segment Month: *9/1/XXXX*, Billing Block Due Date: *10/31/2024*]
- **October 2024** [Segment Month: *10/1/XXXX*, Billing Block Due Date: *11/30/2024*]

Starting *November 2024*, initial CES Tool completion will follow policies and procedures for newly enrolled (*non-pended*) members where a member will be required to be assessed for continued appropriateness for the Health Home program at **12** months of enrollment.

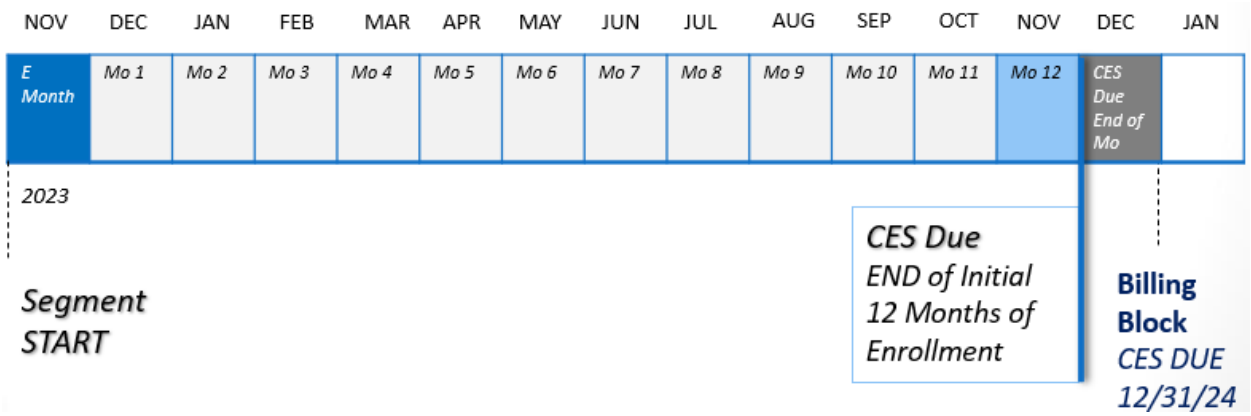
CES Tool Completion – New Members

The CES Tool is to be completed at least annually and every **6** months thereafter (i.e. Month 12, 18, 24) for all enrolled (*non-pended*) Health Home members. As per DOH Health Home policy, newly enrolled members with an enrolled segment start date of ***11/1/2023 or after***, are required to have their initial CES Tool completed in month **12** of enrollment.



Example: Member enrolled *11/1/2023* are required to have a CES Tool completed by *11/30/2024*.

As per MAPP billing logic, newly enrolled members with an enrolled segment start date of ***11/1/2023 or after***, will have billing blocked if an initial CES Tool is not completed by month **13** of enrollment. As illustrated, MAPP billing logic provides a *1-month buffer* prior to billing block.



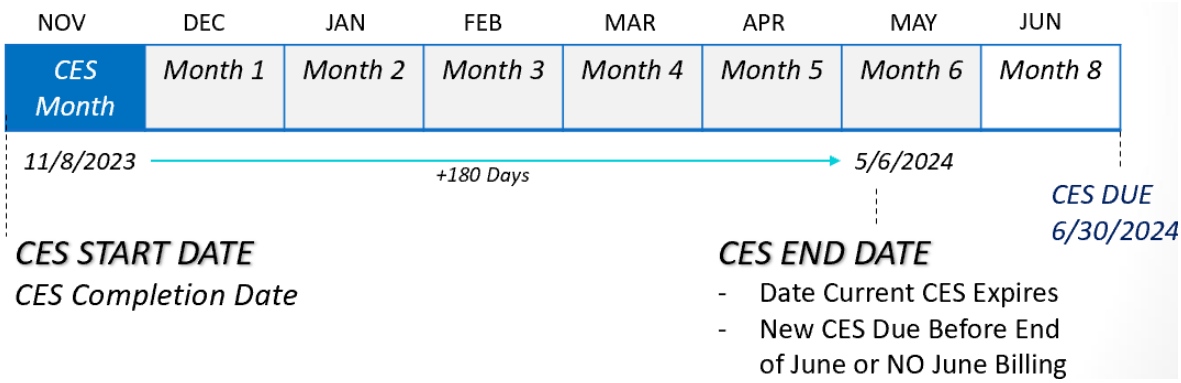
Example: Billing blocked in *December 2024* w/o a CES Tool prior to *12/31/2024*

CES Tool Completion – Existing Members (Continuous CES)

After an initial CES Tool is completed, subsequent CES Tool(s) are completed at specific time intervals calculated based upon the prior tool completion date and outcome.

Once a CES Tool is completed, a CES end date (*expiration date*) is calculated.

- CES end dates serve as due dates for the next CES Tool *(+ 60, + 180 calendar days*)
- Time calculations are based upon calendar days and not segment months
- CES end dates are used in MAPP reporting and billing logic



Important: As illustrated, CES tools are to be completed by the CES Tool end date/due date:

- As per DOH Health Home policy the member is to have a new CES Tool by *5/6/2024*.
- As per MAPP billing logic, failure to complete a new CES Tool by *6/30/2024* will result in a billing block for *June 2024*.

If a CES Tool is completed off cycle or earlier than its calculated due/expiration date, then the next due date and/or next steps (if "*Recommend Disenrollment"*) will be based upon the existing/most recent CES Tool recommendation (i.e. initial CEST due date no longer apply*)*.

Example: Newly enrolled member is due for their initial CES Tool in *November 2024* but has a CES completed in *July 2024* with an outcome of recommend disenrollment. The member's case is expected to be closed *Aug 2024*.

CES Tool Completion – Pended Members

Members in a pended segment (*Diligent Search, Pended (Excluded Setting)*) at the time their CES Tool is due/expiring are not required to complete a new CES Tool. Billing block mechanisms are not intended to occur for members in a pended status. However, after a return from pended status, a member is required to complete the following:

- Complete a CES Tool **12** months from creation of new enrolled segment start date/month
- Complete Plan of Care Requirements (mirroring newly enrolled member requirements):
  - **Signed Plan of Care within 60 Days** (*from new E Start Date*)
- **New Initial Appropriateness** (IA) within **28** days of re-enrollment

Billing logic should mirror methodology for initial and continuous CES Tool processes.

Disengaged Members

If a member is disengaged and their most recent CES Tool outcome is Recommend Disenrollment, the member should be moved toward disenrollment as per the recommendation outcome and disenrollment due date.

- The member should not be moved to a diligent search segment once a determination is made
- A new CES Tool should not be completed without the presence of new/actionable data or information not know at the time of the prior assessment

NYS Health Home Resources Regarding the Continuing Eligibility Screening Tool

- Health Home Policy and Updates (ny.gov)
- Guidance for Use of the Continued Eligibility for Services (CES) Tool (ny.gov)

CES Tool Completion – HH+, AH+, AOT

Members who are Health Home Plus (HH+ SMI/HIV), HH+ Eligible, or Adult Home Plus (AH+) at the time a CES Tool is due are **not required to complete the full** CES Tool. CES Tool logic will stop once the question regarding this exclusion cohort is selected. However, a CES Tool should be completed for all members for data tracking purposes.

Important: Health Home Plus and other exclusion cohorts are based upon information submitted in monthly billing support questionnaires (BSQ). MAPP/Billing logic are dependent upon BSQ data, not the special population question within the CES Tool.

As illustrated below, a change in the HH+ Pop field from "*M*" to "*A*" triggers a countdown of the grace period where billing block will not occur:

Change in HH+ Status

12 Mo *Includes 1st Month NOT Identified as HHPlus*

Example 2: HH+ Member (not AH)			
Member enrolled		1/1/2024	'A': not HH+ 'M': HH+ SMI – Expired AOT order within past year
Billing blocked w-o Initial CEST		2/28/2025	
HH+ per BSU		**3/1/24 to 6/1/24**	
BI DOS	**HH+ Pop**	**Need CEST to Bill?**	**BI DOS minus 365 days**
6/1/2024	M	No (within *grace* period)	6/2/2023
7/1/2024	**A**	No (within *grace* period)	7/2/2023
8/1/2024	A	No (within *grace* period)	8/2/2023
9/1/2024	A	No (within *grace* period)	9/2/2023
10/1/2024	A	No (within *grace* period)	10/2/2023
11/1/2024	A	No (within *grace* period)	11/2/2023
12/1/2024	A	No (within *grace* period)	12/2/2023
1/1/2025	A	No (within *grace* period)	1/2/2024
2/1/2025	A	No (HH+ within past year)	2/2/2024
3/1/2025	A	No (HH+ within past year)	3/1/2024
4/1/2025	A	No (HH+ within past year)	4/1/2024
5/1/2025	A	No (HH+ within past year)	5/1/2024
6/1/2025	A	No (HH+ within past year)	6/1/2024
7/1/2025	**A**	**Yes (past grace period & HH+ is 'A' in past year. Cannot bill unless CEST outcome submitted w CEST Start Date <=7/31/25 & CEST End Date >=7/31/25)**	**7/1/2024**

For additional details, refer to "Changes in HH+ and CEST" tab:

Connection Between CES and Billing Instances in MAPP HHTS v.4

Appendix K BHH Continuing Eligibility Screening (CES) Tool Report Guide

The BHH CES Report is generated monthly and aims to capture data/information related to the most recent Continuing Eligibility Screening (CES) Tool. BHH CES Reports capture:

Member Demographics	▪ **Care Management Agency** ▪ **Care Manager** ▪ **Medicaid ID** ▪ **Chart ID** ▪ **First, Last Name** ▪ **Segment Start** ▪ **Pended Status**
Most Recent CES Tool	▪ **CES Date** ▪ **CES Result:** ○ Recommend Continued Services ○ Recommend Disenrollment ○ More Information Needed ○ Not Applicable (*Excluded Special Pop Selected*) ▪ **Next CES Due Date** ○ Calculation based upon MAPP logic
Next CES Tool Indicators	▪ **CES Coming Due** ▪ **CES Expires this Month** ○ Prior CES Tool End Date is in Report Month ○ CES Due (*as per DOH Health Home Policy*) ▪ **CES Due** ○ Prior CES Tool End Date occurred in Prior Month ○ CES Due (*as per MAPP Billing Specifications*) ▪ **CES Overdue** ○ CES Tool was Due Last Month (*MAPP*) ○ Billing Block
Disenrollment Indicators	▪ **Disenrollment Due Date** ○ Calculation based upon MAPP logic ▪ **Closure Due in Report Month** ○ Calculated Disenrollment Due Date occurs in Report Month ▪ **Disenrollment Overdue** ○ Member Record Remains Open Past Calculated Disenrollment Due Date from Prior Month

Additional BHH CES Report Indicators

During CES Tool implementation, additional report indicators related to the implementation cohort will be included in monthly CES Reports. Implementation cohort is based upon segment start date as noted in **Appendix J** Continuing Eligibility Screening (CES) Tool Guidance.

MAPP Billing Block Implementation Cohort Indicators	▪ **Billing Block Cohort Member** ○ Identification based upon segment start date(s) outlined in MAPP specifications/logic ▪ **Billing Block Cohort Members Missing Initial CES Tool** ○ Indicates if a member included in the Billing Block cohort does not have an initial CES Tool

Note: MAPP Billing Block Implementation Cohort Indicators should be reviewed first to identify members who do not have an initial CES Tool. **Once a member has a CES on file within MAPP, the date of completion/outcome replaces the billing block cohort timeline/MAPP specs.**

- If a member completed a CES Tool prior to their respective billing block cohort segment month, the pre-existing/most recent CES Tool will determine the next CES Tool due date and potential billing block

Initial CES Tool Indicators

Initial CES Tool Completion Indicators	▪ Initial CES Tool Completion Indicators: ○ INITIAL CES Tool DUE THIS MONTH (*Members Enrolled 12 months*)

BHH CES Report Example:

CES DATE	CES RESULT	NEXT CES END DATE	CES EXPIRES THIS MONTH	CES DUE	CES OVERDUE	DISENROLLMENT DUE DATE	CLOSURE DUE THIS MONTH	DISENROLLMENT OVERDUE
1/30/2024	MORE INFORMATION NEEDED	3/30/2024			Yes			
2/6/2024	MORE INFORMATION NEEDED	4/6/2024		Yes				
11/2/2023	RECOMMEND CONTINUED SERVICES	4/30/2024		Yes				
11/8/2023	RECOMMEND CONTINUED SERVICES	5/6/2024	Yes					
3/8/2024	MORE INFORMATION NEEDED	5/7/2024	Yes					
12/1/2023	RECOMMEND CONTINUED SERVICES	5/29/2024	Yes					
12/20/2023	RECOMMEND CONTINUED SERVICES	6/17/2024						
4/19/2024	MORE INFORMATION NEEDED	6/18/2024						
4/29/2024	RECOMMEND DISENROLLMENT					6/28/2024		
3/26/2024	RECOMMEND DISENROLLMENT					5/25/2024	Yes	
2/28/2024	RECOMMEND DISENROLLMENT					4/28/2024		Yes

Note: Table structure subject to change

Note: CES End Date and Disenrollment Due Dates combined under CES End Date in MAPP File downloads. Due dates in BHH CES Report separated based upon workflow. However, billing block may impact member records if case not closed by calculated due date(s).

BHH CES Report Data Table Specifications

Column A - H	**Member Demographics**	*(see above descriptions)*
Column I	**CES Date**	*Most recent CES Tool completion date*
Column J	**CES Result**	*Most recent CES Tool outcome*
Column K	**Next CES Due Date**	*Calculated based upon most recent CES Tool completion date and outcome (mirrors MAPP logic)*
Column L	**CES Expires this Month**	*Most recent CES Tool end date expires this month / a **new CES Tool is required***
Column M	**CES Due**	*A new CES Tool is due this month to prevent billing block / a **new CES Tool is required***
Column N	**CES Overdue**	*A new CES Tool is required / billing block impact*
Column O	**Disenrollment Due Date**	*Calculated based upon most recent CES Tool completion date and outcome (mirrors MAPP logic)*
Column P	**Closure Due this Month**	*Calculated disenrollment due date occurs this month*
Column Q	**Disenrollment Overdue**	*Calculated disenrollment due date is past due / billing block impact*
Column R	**Billing Block Cohort**	*Current and prior cohort members*
Column S	**Billing Block Cohort (Missing CES)**	*Members who are expected to be impacted by the billing block*

Note: Table structure subject to change

Appendix L Appropriateness Criteria Assessment - Review for Graduation (RFG) [***ARCHIVED]***

The BHH Appropriateness Criteria Assessment was designed to evaluate a member's need for continued enrollment or possible step-down/graduation from the Health Home program.

RFG – Review for Graduation

BHH Identified: members identified for review will be assigned a "RFG" - Review for Graduation flag in BHH's care management platform. Member identification is based upon the following:

I. Member billing rates
II. Clinical Event (ER/Inpatient Discharge) Notifications or Alerts
III. Previous RFG Assignments

CMAs are to determine if members with an RFG flag continue to qualify for care management services or if the member might be ready to step-down, graduate, or discharge from the program.

CMAs should update member records to ensure documentation support the members actual need(s). CMAs are to complete the Appropriateness Criteria Assessment to confirm continued eligibility.

Following the completion of the Appropriateness Criteria Assessment, the RFG flag should be removed by the reviewer. Members identified/determined to be on the path toward graduation are to have patient flag in FCM changed to indicate Member on Track to Graduation (GRA), indicating that they are on a graduation track.

The Appropriateness Criteria Assessment is to be completed:

- When identified by BHH
- As needed, as determined by the CMA and/or member

Appropriateness Criteria Assessment

Section 1	Reason for Review		
Question		**Required**	**Dependent**
1	**Reason assessment is being completed.**	Yes	No
	1 Flagged by BHH to review for graduation (RFG)		
	2 Completion of all care plan goals		
	3 CMA Identified - considering graduation/step-down		
	4 Member Identified - considering graduation/step-down		
Section 2	**Identifying Continued Need**		
Question		**Required**	**Dependent**
1	**Is this member at risk for a serious adverse event (death, disability, etc.)?**	Yes	No
	1 Yes		
	2 No		
2	**What type of event is member at risk of?**	Yes	Yes (Q1, "Yes")
	1 Death		
	2 Disability		
	3 Inpatient or nursing home admission		
	4 Mandated services		
	5 Out of home placement		
	6 Other		
3	**If "Other" selected, please provide detail**	Yes	Yes (Q2, "Other")
	1 *Free Text*		
4	**Is there documentation of this risk in FCM?**	Yes	Yes (Q1, "Yes")
	1 Yes		
	2 No		
5	**Does this member have adequate social/family support?**	Yes	No
	1 Yes		
	2 No		
6	**Is there documentation of this lack of support in FCM?**	Yes	Yes (Q5, "No")
	1 Yes		
	2 No		
7	**Which of the following services does this member need assistance addressing?**	Yes	No
	1 Entitlements		
	2 Food insecurity		
	3 Safe and stable housing		
	4 Other		

8	**If "Other" selected, please provide detail** 1 *Free Text*	Yes	Yes (Q7, "Other")
9	**Is this service need documented?** 1 Yes 2 No	Yes	Yes (Q7)
10	**Is this member adequately engaged with their healthcare providers?** 1 Yes, adequately engaged in care 2 No, needs PCP or BH provider 3 No, unable to navigate treatment 4 No, ED or hospital high utilizer	Yes	No
11	**Is this member able to manage their medication/treatment independently?** 1 Yes 2 No	Yes	No
12	**Is there documentation of their medication/treatment management in FCM?** 1 Yes 2 No	Yes	Yes (Q11)
13	**Does this member have appropriate support to manage their activities of daily living?** 1 Yes 2 No	Yes	No
14	**Is the lack of appropriate support documented in FCM?** 1 Yes 2 No	Yes	Yes (Q13, "No")
15	**Has this member been recently released from incarceration/detention or inpatient stay?** 1 Yes, arrest/police contact 2 Yes, incarceration/detention 3 Yes, medical inpatient 4 Yes, psych inpatient 5 Nursing home 6 Residential SUD treatment 7 Other	Yes	No
16	**If "Other" selected, please provide detail** 1 *Free Text*	Yes	Yes (Q15, "Other")

Appendix M BHH PSYCKES Quality Flag Guide

The following provides an overview of PSYCKES Quality Flags.

Information includes:

- **Indicator Set**
- **PSYCKES QI Flag**
- **Indicator Definition**

Indicator Sets

- BH QARR - Improvement Measure
- General Medical Health
- General Medical Performance Tracking Measure (DOH)
- Health Home Care Management - Adult
- High Utilization - Inpt/ER
- High Mental Health Need
- Mental Health Placement Consideration
- MH Performance Tracking Measure (DOH)
- Readmission Post-Discharge from any Hospital
- Preventable Hospitalization
- Polypharmacy
- Treatment Engagement
- SUD Performance Tracking Measure (DOH)
- Vital Signs Dashboard - Adult

NOTE: BHH conducts periodic reviews of available PSYCKES QI Flag data and utilizes supplemental information to support new and existing QI/QA initiatives.

For additional details, refer to **PSYCKES Quality Flag Definitions** (source: PSYCKES)

Indicator Set: BH QARR - Improvement Measure

PSYCKES QI Flag	Indicator Definition
Adher-AP	The percentage of adults 18-64 years with a diagnosis of schizophrenia or schizoaffective disorder who had an antipsychotic medication available to them less than 80 percent of the time (based on prescriptions filled in the past 12 months, from the first antipsychotic prescription filled to the report date).
Adher-AD <12wks	The percentage of adults 18-64 years with a diagnosis of major depression who were started on an antidepressant medication but did not remain on any antidepressant for a minimum of 12 weeks in the past 12 months.
No HbA1c & LDL-C (DM & Schiz)	The percentage of adults 18-64 years diagnosed with both schizophrenia and diabetes who did not have both an HbA1c and an LDL-C test in the past 13 months.
No Gluc/HbA1c & LDL-C - AP	The percentage of children 0-17 with at least two prescriptions for an antipsychotic medication or one antipsychotic injectable at any time during the past 13 months who did not have both a blood lipid test (LDL-C or cholesterol test) and an HbA1c or blood glucose test, in the past 13 months.
No DM Screen - AP / No Gluc/HbA1c - AP	The percentage of adults 18-64 years with a diagnosis of schizophrenia or bipolar disorder with any oral or injectable antipsychotic medication during the previous 13 months, who did not have either an HbA1c or blood glucose test in the past 13 months.

Indicator Set: General Medical Health

PSYCKES QI Flag	Indicator Definition
No HbA1c-DM	The percentage of clients with diabetes without a monitoring test (HbA1c) in the past 13 months.
No DM Screen - AP / No Gluc/HbA1c - AP	The percentage of adults 18-64 years with a diagnosis of schizophrenia or bipolar disorder with any oral or injectable antipsychotic medication during the previous 13 months, who did not have either an HbA1c or blood glucose test in the past 13 months.
No Gluc/HbA1c & LDL-C - AP	The percentage of clients 0-64 with at least two prescriptions for an antipsychotic medication at any time during the past 13 months who did not have both a blood lipid test (LDL-C or cholesterol test) and an HbA1c or blood glucose test, in the past 13 months.
No Outpt Medical	The percentage of clients without any outpatient medical visits (office visit (non-BH), home service (non-BH), preventive service, medical exam, ob/gyn or prostate screening) in the past 13 months.

Indicator Set: General Medical Performance Tracking Measure (DOH)

PSYCKES QI Flag	Indicator Definition
Low Asthma Med Ratio (DOH)	The percentage of individuals ages 5 to 64 years identified as having persistent asthma and have an asthma controller (preventative) medication ratio of .49 or less during the measurement period.
Breast Cancer Screen Overdue (DOH)	The percentage of women ages 50 to 74 years who did not have a mammogram to screen for breast cancer during the measurement period.
Cervical Cancer Screen Overdue (DOH)	The percentage of women ages 21 to 64 years who were not screened for cervical cancer (cervical cytology or hrHPV) during the measurement period.
No Statin Therapy Med - CV (DOH)	The percentage of adults ages 21 to 75 years identified as having Clinical Atherosclerotic Cardiovascular Disease (ASCVD) who did not have at least one high-intensity or moderate-intensity statin medication dispensed to them during the measurement period.
Adher-Statin Therapy - CV (DOH)	The percentage of adults ages 21 to 75 years identified as having Clinical Atherosclerotic Cardiovascular Disease (ASCVD) who had a statin therapy medication available to them less than 80 percent of the treatment period.

Indicator Set: Health Home Care Management - Adult

PSYCKES QI Flag	Indicator Definition
HARP No Health Home	The percentage of currently Medicaid-eligible adults 21 and over who are enrolled in a Managed Care Health and Recovery Plan (HARP) but are not enrolled in a Health Home.
HARP No Assessment for HCBS	The percentage of currently Medicaid-eligible adults 21 and over who are enrolled in a Managed Care Health and Recovery Plan (HARP) but have not had an assessment completed to determine eligibility for Home and Community Based Services (HCBS).
HHPlus Not HH Enrolled	The percentage of Health Home Plus eligible adults who are not enrolled in a Health Home.
HHPlus No HHPlus Service > 12 mos	The percentage of Health Home Plus eligible adults that have not received a Health Home Plus service in the past 12 months, according to Medicaid billing or DOH MAPP.
HHPlus No HHPlus Service > 3 mos	The percentage of Health Home Plus eligible adults, that have not received a Health Home Plus service in the past 3 months according to DOH MAPP.
HHPlus Not Entered in MAPP > 3 mos	The percentage of Health Home Plus eligible adults, who are also enrolled in a health home, that have not been identified as Health Home Plus eligible in DOH MAPP in the past 3 months.

Indicator Set: High Utilization - Inpt/ER

PSYCKES QI Flag	Indicator Definition
10+ ER	The percentage of individuals with 10 or more ER visits for any cause (medical or behavioral health) in the past 13 months
10+ ER-MH	The percentage of individuals with 10 or more MH (mental health) ER visits in the past 13 months
2+ ER-BH	The percentage of individuals with 2 or more BH (Behavioral Health: MH and/or SUD) ER visits in the past 13 months.
2+ ER-MH	The percentage of individuals with 2 or more MH (Mental Health) ER visits in the past 13 months.
2+ ER-Medical	The percentage of individuals with 2 or more Medical ER visits in the past 13 months.
2+ Inpt-BH	The percentage of individuals with 2 or more BH (Behavioral Health: MH and/or SUD) inpatient stays in the past 13 months.
2+ Inpt-MH	The percentage of individuals with 2 or more MH (Mental Health) inpatient stays in the past 13 months.
2+ Inpt-Medical	The percentage of individuals with 2 or more Medical inpatient stays in the past 13 months.
4+ Inpt/ER-BH	The percentage of individuals with 4+ or more BH (Behavioral Health: MH and/or SUD) inpatient/ER stays past 13 months.
4+ Inpt/ER-MH	The percentage of individuals with 4+ or more psychiatric inpatient/ER stays in the past 13 months.
4+ Inpt/ER-Med	The percentage of individuals with 4+ or more medical inpatient/ER stays in the past 13 months.
Cloz Candidate	Diagnosed with schizophrenia and had 4+ ER/Inpatient stays for MH cause with no history of Clozapine in the past year. Excludes individuals with the following medical conditions in the past year: leukopenia agranulocytosis, neutrophil disorders, myocarditis, narrow angle glaucoma, malignant neoplasms, seizure disorders, Alzheimer's, or other degenerative brain disorders.
POP High User	Individuals enrolled in a Performance Opportunity Project (POP)-participating Managed Care plan with 3 or more mental health Inpatient visits OR 4 or more mental health ER visits OR a diagnosis of schizophrenia or bipolar and 3 or more medical Inpatient visits in the past in 12 months.
POP Cloz Candidate	Individuals enrolled in a Performance Opportunity Project (POP)-participating Managed Care plan who meet criteria for the POP High User flag and have a diagnosis of schizophrenia who have no evidence of clozapine in the past 6 months.

Indicator Set: High Mental Health Need

PSYCKES QI Flag	Indicator Definition
High MH Need	Individuals who meet one or more of the following criteria: ▪ AOT active or expired in the past year, ACT active or expired in the past year ▪ Intensive Mobile Treatment (IMT) in past year with MH diagnosis ▪ 3+ Inpt MH < 13 months ▪ 4+ ER MH < 13 months ▪ 3+ inpatient medical visits in past 13 months and have schizophrenia or bipolar past year ▪ Ineffectively Engaged No Outpt MH < 12 months & 2+ Inpt MH/3+ ER MH ▪ State PC Inpatient Discharge < 12 months ▪ CNYPC Release < 12 months ▪ HH+ Eligibility ▪ HH+ service within past year with MH diagnosis

Indicator Set: Mental Health Placement Consideration

PSYCKES QI Flag	Indicator Definition
MH Plcmt Consid	Individuals who meet one or more of the following criteria: ▪ OMH Housing history in past 5 years ▪ 1+ PROS services in past 5 years ▪ 1+ HCBS/CORE services in past 5 years ▪ Ineffectively Engaged – No Outpatient MH < 12 months ▪ Any history of forensic psych inpatient setting or forensic status in any OMH inpatient setting ▪ Any history of prison MH outpatient services ▪ Any history of mental health diagnosis or treatment in jail, AOT History: Active or Expired ▪ ACT enrolled or discharged in the past 5 years ▪ Intensive Mobile Treatment (IMT) in past 5 years ▪ 1+ inpatient MH past 5 years ▪ 1+ ER or inpatient visit in the past year with a suicide attempt/ suicide ideation/ self-harm code ▪ 3+ inpatient medical visits in past 1 year AND have schizophrenia or bipolar past year ▪ 4+ ER MH < 12 months ▪ Evidence of Supplemental Security Income (SSI) or Social Security Disability (SSD) and Any OMH Specialty MH Service in past 5 years

Indicator Set: MH Performance Tracking Measure (DOH)

PSYCKES QI Flag	Indicator Definition
No DM Screen - AP (DOH)	The percentage of adults ages 18 to 64 with a diagnosis of schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and did not have a diabetes screening test during the measurement year.
Adher-AD - Acute (DOH)	The percentage of adults ages 18 years and older with a diagnosis of major depression and newly started on an antidepressant medication who had less than 12 weeks of continuous treatment with the antidepressant.
Adher-AD - Recovery (DOH)	The percentage of adults ages 18 years and older with a diagnosis of major depression and newly started on an antidepressant medication who had less than 6 months of continuous treatment with the antidepressant following the first 12-week acute phase treatment period.
Adher-AP (DOH)	The percentage of adults ages 18 to 64 with a diagnosis of schizophrenia who were dispensed an antipsychotic medication and remained on that antipsychotic medication for less than 80 percent of their treatment time.
Adher-MS (DOH)	The percentage of recipients ages 18 years and older with a diagnosis of bipolar I disorder who had a mood stabilizer medication available to them less than 80 percent of the time (based on prescriptions filled in the past 12 months, from the first mood stabilizer prescription filled to the report date).
No DM Monitoring - DM & Schiz (DOH)	The percentage of adults ages 18 to 64 diagnosed with both schizophrenia and diabetes who did not have both an HbA1c and an LDL-C test during the measurement year.
No MH ED F/U 7d (DOH)	The percentage of Mental Health ED discharges among individuals ages 6 years and older that are not followed up by a Mental Health Outpatient visit within 7 days after the discharge.
No MH Inpt F/U 7d (DOH)	The percentage of Mental Health Inpatient discharges among individuals ages 6 years and older that are not followed up by a Mental Health Outpatient visit within 7 days after the discharge.
No MH Inpt F/U 30d (DOH)	The percentage of Mental Health Inpatient discharges among individuals ages 6 years and older that are not followed up by a Mental Health Outpatient visit within 30 days after the discharge.

No MH ED F/U 30d (DOH)	The percentage of Mental Health ED discharges among individuals ages 6 years and older that are not followed by a Mental Health Outpatient visit within 30 days of discharge.
No Engage after MH IP	The percentage of MH Inpatient discharges among individuals ages 6 to 64 years who did not receive five or more follow-up visits with a community-based mental health care provider within 90 days after discharge
No ICM after MH ED	The percentage of Mental Health ED/CPEP discharges among individuals ages 21 to 64 years identified as having high mental health needs (e.g., Health Home Plus (HH+) eligibility, Assertive Community Treatment (ACT) enrolled, or Critical Time Intervention (CTI) service use in any of the three months prior to an emergency department (ED) or Comprehensive Psychiatric Emergency Program (CPEP) admission) who did not receive high intensity care management services (e.g., HH+, ACT, or CTI service) in the calendar month following discharge.
No ICM after MH Inpt	The percentage of Mental Health Inpatient discharges among individuals ages 21 to 64 years identified as having high mental health needs (e.g., Health Home Plus (HH+) eligibility, Assertive Community Treatment (ACT) enrolled, or Critical Time Intervention (CTI) service use in any of the three months prior to an inpatient (IP) admission), who did not receive high intensity care management services (e.g., HH+, ACT, or CTI service)in the calendar month following discharge.
No CV Monitoring - CV & Schiz (DOH)	The percentage of adults ages 18 to 64 diagnosed with both schizophrenia and cardiovascular disease, who did not have a blood lipid test (LDL-C or cholesterol test) during the measurement year.
PQI 92 (DOH)	The percentage of recipients ages 18 years and older that have had an inpatient admission in the past 12 months due to one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.

Indicator Set: Readmission Post-Discharge from any Hospital

PSYCKES QI Flag	Indicator Definition
Readmit 30d - MH to MH	The percentage of individuals with a MH (Mental Health) hospitalization who had one or more MH re-hospitalizations within 30 days of discharge, in the past 13 months.
Readmit 30d - BH to BH	The percentage of individuals with a BH (Behavioral Health: MH and/or SUD) hospitalization who had one or more BH re-hospitalizations within 30 days of discharge, in the past 13 months.
Readmit 30d - Medical to Medical	The percentage of individuals with a Medical hospitalization who had one or more Medical re-hospitalizations within 30 days of discharge, in the past 13 months.
Readmit 30d - Medical to All Cause	The percentage of individuals with a Medical hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 13 months.
Readmit 30d - MH to All Cause	The percentage of individuals with a Mental Health (MH) hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 13 months.
Readmit 30d - BH to All Cause	The percentage of individuals with a BH (Behavioral Health: MH and/or SUD) hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 13 months.
Readmission (30d) from any Hosp: All Cause to All Cause *Flag Definition (as per PSYCKES Guidance)	The percentage of individuals with any hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 13 months.

Indicator Set: Preventable Hospitalization

PSYCKES QI Flag	Indicator Definition
PrevHosp-Asthma	The percentage of adults with one or more preventable hospitalizations due to Asthma in the past 13 months.
PrevHosp-Dehyd	The percentage of adults with one or more preventable hospitalizations due to Dehydration in the past 13 months.
PrevHosp-DM	The percentage of adults with one or more preventable hospitalizations due to Diabetes in the past 13 months.

Indicator Set: Polypharmacy

PSYCKES QI Flag	Indicator Definition
3AD	The percentage of individuals who were prescribed three or more antidepressant medications among patients prescribed any antidepressant medication.
2AD	The percentage of individuals who were prescribed two or more antidepressant medications in the same subclass among patients prescribed any antidepressant medication.
3AP	The percentage of individuals who were prescribed three or more antipsychotic medications among patients prescribed any antipsychotic medication.
2AP	The percentage of individuals who were prescribed two or more antipsychotic medications among patients prescribed any antipsychotic medication.

Indicator Set: Treatment Engagement

PSYCKES QI Flag	Indicator Definition
Adher-AD <12wks	The percentage of adults 18-64 years old with a diagnosis of major depression who were started on an antidepressant medication but did not remain on any antidepressant for a minimum of 12 weeks in the past 12 months.
Adher-AP	The percentage of adults 18-64 years with a diagnosis of schizophrenia or schizoaffective disorder who had an antipsychotic medication available to them less than 80 percent of the time (based on prescriptions filled in the past 12 months, from the first antipsychotic prescription filled to the report date).
Adher-MS	The percentage of adults 18-64 years old with a diagnosis of bipolar who had an antipsychotic or mood stabilizer medication available to them less than 80 percent of the time (based on prescriptions filled in the past 12 months, from the first antipsychotic or mood stabilizer prescription filled to the report date).

Indicator Set: SUD Performance Tracking Measure (DOH)

PSYCKES QI Flag	Indicator Definition
No SUD ER f/u 7d (DOH)	The percentage of emergency room discharges for alcohol or other substance use disorder (SUD) among individuals ages 13 and older that are not seen on an ambulatory basis for treatment within 7 days of discharge.
No SUD ER f/u 30d (DOH)	The percentage of emergency room discharges for alcohol or other substance use disorder (SUD) among individuals ages 13 and older that are not seen on an ambulatory basis for treatment within 30 days of discharge.
No High Intensity f/u SUD 7d (DOH)	The percentage of high-intensity care substance use disorder (acute inpatient, residential treatment, or detoxification visit) discharges among recipients ages 13 years and older who did not have a follow-up visit/treatment with any practitioner for substance use disorder within 7 days of discharge.
No High Intensity f/u SUD 30d (DOH)	The percentage of high-intensity care substance use disorder (acute inpatient, residential treatment, or detoxification visit) discharges among recipients ages 13 years and older who did not have a follow-up visit/treatment with any practitioner for substance use disorder within 30 days of discharge.
No Utilization of Pharmacotherapy (DOH)	The percentage of recipients ages 13 years and older with a diagnosis of alcohol abuse or dependence who did not receive appropriate pharmacotherapy for this condition at any time during the measurement year.
No MAT Utilization - OUD (DOH)	The percentage of individuals ages 13 and older with Opioid Use Disorder (OUD) who did not initiate Medication Assisted Treatment (MAT) at any time during measurement year.

Indicator Set: Vital Signs Dashboard - Adult

PSYCKES QI Flag	Indicator Definition
Adher-AD - Acute (DOH)	The percentage of adults ages 18 years and older with a diagnosis of major depression and newly started on an antidepressant medication who had less than 12 weeks of continuous treatment with the antidepressant.
Adher-AD - Recovery (DOH)	The percentage of adults ages 18 years and older with a diagnosis of major depression and newly started on an antidepressant medication who had less than 6 months of continuous treatment with the antidepressant following the first 12-week acute phase treatment period.
Cloz Candidate	The percentage of individuals diagnosed with schizophrenia who had 4 or more emergency room visits or inpatient stays for mental health cause and who did not have any evidence of Clozapine in the past year. Excludes individuals with the following medical conditions in the past 13 months: leukopenia agranulocytosis, neutrophil disorders, myocarditis, narrow angle glaucoma, malignant neoplasms, seizure disorders, Alzheimer's, or other degenerative brain disorders. This is a Quality Improvement Indicator, run monthly on all available data as of the run date.
HHPlus No HHPlus Service > 12 mos	The percentage of Health Home Plus eligible adults that have not received a Health Home Plus service in the past 12 months, according to Medicaid billing or DOH MAPP. This is a Quality Improvement Indicator, run monthly on all available data as of the run date.
Adher-AP (DOH)	The percentage of adults ages 18 to 64 with a diagnosis of schizophrenia who were dispensed an antipsychotic medication and remained on that antipsychotic medication for less than 80 percent of their treatment time.
No DM Screen - AP (DOH)	The percentage of adults ages 18 to 64 with a diagnosis of schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and did not have a diabetes screening test during the measurement year.
No MH ED F/U 7d (DOH) - Adult	The percentage of Mental Health ED discharges among individuals ages 18 years and older that are not followed up by a Mental Health Outpatient visit within 7 days of discharge
No MH ED F/U 30d (DOH) - Adult	The percentage of Mental Health ED discharges among individuals ages 18 years and older that are not followed up by a Mental Health Outpatient visit within 30 days of discharge

No MH Inpt F/U 7d (DOH) - Adult	The percentage of Mental Health Inpatient discharges among individuals ages 18 years and older that are not followed up by a Mental Health Outpatient visit within 7 days after discharge.
No MH Inpt F/U 30d (DOH) - Adult	The percentage of Mental Health Inpatient discharges among individuals ages 18 years and older that are not followed up by a Mental Health Outpatient visit within 30 days after discharge.
Colorectal Screen Overdue (DOH)	The percentage of individuals, 50-75 years, who did not have appropriate screening for colorectal cancer.
Readmit 30d - MH to MH - Adult	The percentage of individuals with a MH (Mental Health) hospitalization who had one or more MH re-hospitalizations within 30 days of discharge, in the past 13 months. This is a Quality Improvement Indicator, run monthly on all available data as of the run date.

Sensitive Diagnosis (Information may be Restricted)

Indicator Set	Display Name	Indicator Definition
General Medical Performance Tracking Measure (DOH)	Overdue for Chlamydia Screening	The percentage of women ages 16 to 24 years who are sexually active and did not have a chlamydia screening during the measurement period.
SUD Performance Tracking Measure (DOH)	No Initiation of SUD Treatment	The percentage of discharges among individuals with a new diagnosis of alcohol or other substance use disorder (SUD) who did not initiate SUD treatment within 14 days of diagnosis
SUD Performance Tracking Measure (DOH)	No Engagement in SUD Treatment	The percentage of discharges among individuals with a new diagnosis of alcohol or other substance use disorder (SUD) who did not engage in SUD treatment as evidence by initiation of SUD treatment within 14 days of diagnosis and followed up by 2 or more additional visits for SUD treatment within 30 days of initiation visit.
SUD Performance Tracking Measure (DOH)	No Initiation of Opioid Use Disorder (OUD) Treatment	The percentage of discharges among individuals ages 13 and older with a new episode of Opioid Use Disorder (OUD) who did not initiate OUD treatment within 14 days.

SUD Performance Tracking Measure (DOH)	No Engagement in Opioid Use Disorder (OUD) Treatment	The percentage of discharges among individuals ages 13 and older with a new episode of Opioid Use Disorder (OUD) who did not engage in 2 or more visits of OUD treatment within 30 days of initiation visit.
SUD Performance Tracking Measure (DOH)	No Continuity of Care after Detox to Lower Level of Care	The percentage of inpatient detox discharges among individuals ages 13 and older who did not have follow up treatment in a lower level of care setting within 14 days.
SUD Performance Tracking Measure (DOH)	No Continuity of Care after Rehab to Lower Level of Care	The percentage of inpatient rehabilitation discharges among individuals ages 13 years and older who did not have follow up treatment in a lower level of care setting within 14 days
SUD Performance Tracking Measure (DOH)	No Initiation of Medication Assisted Treatment (MAT) for New Episode of Opioid Use Disorder (OUD)	The percentage of individuals ages 13 and older newly diagnosed with Opioid Use Disorder (OUD) who did not initiate Medication Assisted Treatment (MAT) within 30 days of the new OUD diagnosis index visit.
SUD Performance Tracking Measure (DOH)	Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) Not Sustained 6 Months	The percentage of recipients ages 18 to 64 years with a diagnosis of Opioid Use Disorder (OUD) during the measurement period, who had some Medication Assisted Treatment (MAT) but did not continue MAT for 6 months or had a gap in treatment greater than 7 consecutive days.
SUD Performance Tracking Measure (DOH)	No Medication Assisted Treatment (MAT) Following Opioid Related ED Visit – 30 days	The percentage of recipients ages 18 to 64 years that have had an emergency department (ED) visit with a diagnosis of Opioid Use Disorder (OUD) who did not have at least one prescription for appropriate pharmacotherapy within 30 days of discharge.

For additional details, refer to **PSYCKES Quality Flag Definitions** (source: PSYCKES)

Brooklyn Health Home (BHH)

Operations Report

Guide

Last Reviewed: 7/2024

BHH Operations Report Guide

Purpose

The purpose of the **BHH Operations Report Guide** is to provide details regarding the framework and methodology of the BHH Operations Report, Executive Summary and Bi-annual Performance Scorecard. Information provided should be reviewed to better understand report methodology, performance indicator/measure definitions, time parameters, as well as current QMP goals and objectives used to evaluate CMA and BHH network performance.

Methodology

BHH CMA network performance is continuously evaluated via reporting and analytical structures such as the monthly BHH Operations Report, the quarterly Executive Summary, and the bi-annual CMA Performance Scorecard. Report data incorporated into such reporting structures is exported monthly, on the 3rd business day of the month, from the care management reporting system, FCM.

As noted in the BHH QMP Guide,

> *" the BHH QMP collects, analyzes, and evaluates data/information pertaining to the timely completion and documentation of Health Home care management activities and service requirements including, but not limited to, eligibility screening(s), member enrollment, member/care team contact frequency and engagement, assessments, care planning, clinical event response, care transitions, and disenrollment. Furthermore, the BHH QMP continuously monitors and evaluates the effectiveness of quality improvement*

initiatives and enhanced workflows developed in collaboration with key stakeholders to improve the quality of care provided to BHH members.

To monitor and ensure compliance with Health Home program policy and standards, care management best practices and BHH QMP objectives, monthly Operations Reports are developed and disseminated to CMA QI/QA staff. Reports are intended to provide each CMA with actionable information related to a specific HH workflow, deliverable or achievement. Reports should be used to identify (report indicators) where further action is required.

To monitor and evaluate whether defined care management services and/or actions were achieved, quarterly Executive Summary Reports are developed and disseminated to CMA leadership. Reports provide each CMA with an illustrative and/or graphical representation of performance measure results over time.

Performance measure results are calculated monthly and are incorporated into Bi-Annual CMA Performance Scorecards which examine a 6-month reporting timeframe and is inclusive of both quantitative (process/outcome measures) and qualitative findings (chart review results).”

The following guidance provides detailed information regarding:

- BHH Operations Report
- BHH Executive Summary
- BHH Performance Scorecards

Operations Report

The **BHH Operations Report** is designed to provide CMA QI/QA staff with a tool to monitor and ensure compliance with Health Home program policy and standards, care management best practices and BHH QMP objectives. Reports are developed monthly and provide actionable information (*report indicators*) that can be used to identify where further action is required.

Overview of Operations Report Indicators

Member Enrollment

KPI Domain	Cohort	Report Indicator
Care Planning	Newly Enrolled	New Member w/ a POC Signature MISSING
Assessments	Newly Enrolled	New Member w/ a Comprehensive Assessment MISSING

Member Assessments

KPI Domain	Cohort	Report Indicator
Assessments	Enrolled 60+, Non-Pended	Comprehensive Assessment NOT Completed within the PAST 11 Months
Assessments	All Enrolled	Comprehensive Assessment Marked Done, Completion PENDING
Assessments	All Enrolled	Missing Strength, Barrier, or Risk Factor

Care Planning

KPI Domain	Cohort	Report Indicator
Care Planning	Enrolled 60+, Non-Pended	Member Enrolled 60+ w/ NO POC Signature
Care Planning	Enrolled 60+, Non-Pended	Plan of Care NOT Updated within PAST 5 Months
Care Planning	All Enrolled	NO Plan of Care and Encounter Linkage in PAST 2 Months
Care Planning	All Enrolled	NO Gap in Care (GIC) Care Manager Status Change
Care Planning	All Enrolled	No POC Signature within PAST 11 Months
Note: Member w/ No POC Signature within PAST 11 Mo to be phased into report structures (*tbd*).		

Member Engagement

KPI Domain	Cohort	Report Indicator
Engagement	Currently Enrolled, Non-Pended	NO Core Service Documented in Prior Month
Engagement	Currently Enrolled	NO Inperson Encounter Attempts in the PAST 5 Months
Engagement	Currently Enrolled	NO Inperson Encounter in the PAST 5 Months

Clinical Event Notification (CEN) Response

KPI Domain	Cohort	Report Indicator
CEN Response	All Enrolled	No Timely Clinical Event Notification (CEN) F/U in Prior Month (5 Day)

Eligibility Screening

KPI Domain	Cohort	Report Indicator
Eligibility Screening	All Enrolled	CES EXPIRES THIS MONTH
Eligibility Screening	All Enrolled	CES DUE THIS MONTH
Eligibility Screening	All Enrolled	CES TOOL OVERDUE
Eligibility Screening	All Enrolled	DISENROLLMENT DUE THIS MONTH
Eligibility Screening	All Enrolled	DISENROLLMENT OVERDUE
Eligibility Screening	All Enrolled	BILLING BLOCK COHORT MISSING CES TOOL
Eligibility Screening	Enrolled 11 Months	INITIAL CES TOOL DUE THIS MONTH
Note: Billing Block Cohort indicators to be archived at conclusion of CES Tool Implementation. Indicators related to initial CES Tool for newly enrolled members (*after 11/1/2023*) will be phased into existing report structures.		

Timely Billing

KPI Domain	Cohort	Report Indicator
Timely Billing	*Currently Enrolled, Non-Pended*	NO Timely Billing in Prior Month
Timely Billing	*Currently Enrolled, Non-Pended*	HHPlus, NOT Identified

Executive Summary

Executive Summary reports are developed and disseminated to each CMA to provide a mechanism for CMA leadership to monitor and evaluate whether defined care management services and/or actions identified in monthly Operations Reports were successfully achieved.

- Executive Summary Reports are distributed quarterly
- Reports include illustrative/graphical representation of performance results overt time

Overview of Performance Measures

#	Performance Measure
1	New Members w/ a Plan of Care (POC) Signature within 1st 60 Days
2	New Members w/ a Complete Comprehensive Assessment within 1st 60 Days
3	Members w/ a Plan of Care (POC) Update within the PAST 6 Months
4	Members w/ a Comprehensive Assessment Completed in the LAST 12 Months
5	Members w/ a Core Service Documented LAST Month
6	Members w/ an Inperson Encounter Attempt in the LAST 6 Months
7	Members w/ an Inperson Encounter in the LAST 6 Months
8	Members w/ a Plan of Care (POC) & Encounter Linkage in the LAST 3 Months
9	Members w/ at least (1) Gap in Care (GIC) who had a GIC status change
10	Members w/ Timely F/U Documented for at least (1) Discharge CEN in the Prior Month
11	Members w/ Strengths, Barriers and Risk Factors Added
12	Members w/ Timely Billing in Prior Month
13	HHPlus members Identified by CMA in Prior Month
14	Members w/ CES Tool Completed On-Time (DOH Policy)
15	Members Disenrolled On-Time (DOH Policy)
16	Newly Enrolled Members w/ CES Tool Completed within 1st 12 Months of Enrollment

Domain	Member Enrollment – Care Planning

[1] New Member w/ a POC Signature MISSING

Newly Enrolled Health Home members, in 3rd month of enrollment, who do not have a signed plan of care documented in the first 60 days.

- A plan of care w/ signature is due at the end of the report month.

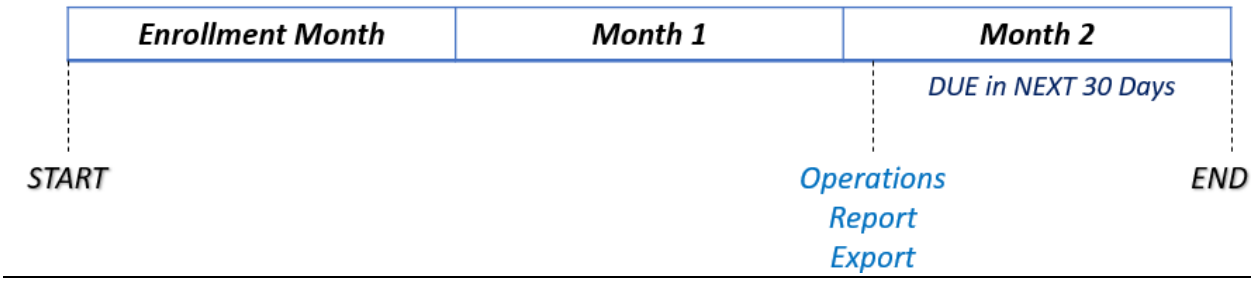
Review Cohort: *Newly Enrolled*

Report Indicator: Members enrolled [2] segment months prior

Performance Measure: Members enrolled [3] segment months prior

Note: Cohort excludes members with contiguous segments (i.e. P,DS to E segment)

Timeline / Time Parameters



Example: Enrollment Start: *6/1/2024*. Operations Report shared at the beginning of August 2024. Report identifies members who need a signed plan of care by the end of the report month: *8/31/2024*.

Note: Segment starts on the 1st of the month, regardless of start date within ***Enrollment Month***.

Performance Measure	
[1]	**New Members w/ a Plan of Care (POC) Signature within 1st 60 Days**

Newly Enrolled members, in 4th month of enrollment, who had a plan of care signature completed/documented by the end of the initial enrollment period.

Report Indicator: *POC in 1st 60: New Member w/ POC Signature MISSING*

Domain	Member Enrollment – Member Assessments

[2] New Member w/ a Comprehensive Assessment MISSING

Newly Enrolled Health Home members, in 3rd month of enrollment, who do not have a Comprehensive Assessment completed/locked in the first 60 days.

- A Comprehensive Assessment is due at the end of the report month.

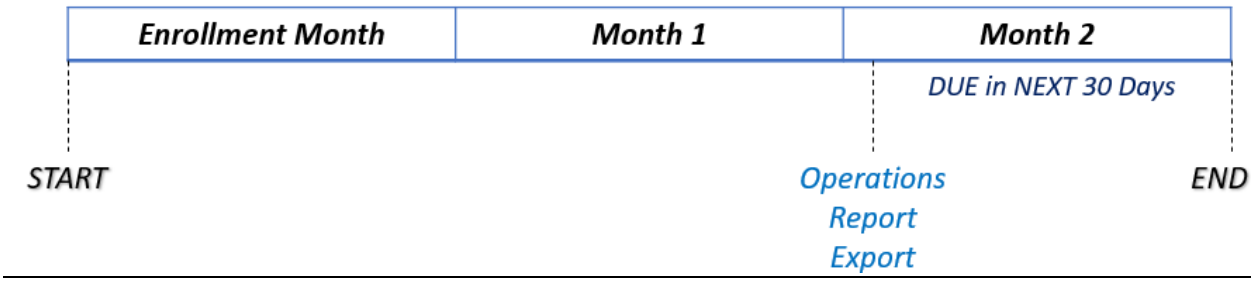
Review Cohort: *Newly Enrolled*

Report Indicator: Members enrolled [2] segment months prior

Performance Measure: Members enrolled [3] segment months prior

Note: Cohort excludes members with contiguous segments (i.e. P,DS to E segment)

Timeline / Time Parameters



Example: Enrollment Start: *6/1/2024*. Operations Report shared at the beginning of August 2024. Report identifies members who need a comprehensive assessment by the end of the report month: *8/31/2024*.

Note: Segment starts on the 1st of the month, regardless of start date within ***Enrollment Month***.

Performance Measure	
[2]	**New Members w/ a Complete Comprehensive Assessment within 1st 60 Days**

Newly Enrolled members, in 4th month of enrollment, who had a Comprehensive Assessment completed/locked by the end of the initial enrollment period.

Report Indicator: *CA in 1st 60: New Member w/ Comprehensive Assessment MISSING*

Domain	Member Care Planning

[3] Member Enrolled 60 + w/ NO POC Signature

Members enrolled at least [60] days who do not have a signed Plan of Care documented.

- A Plan of Care Signature is required.

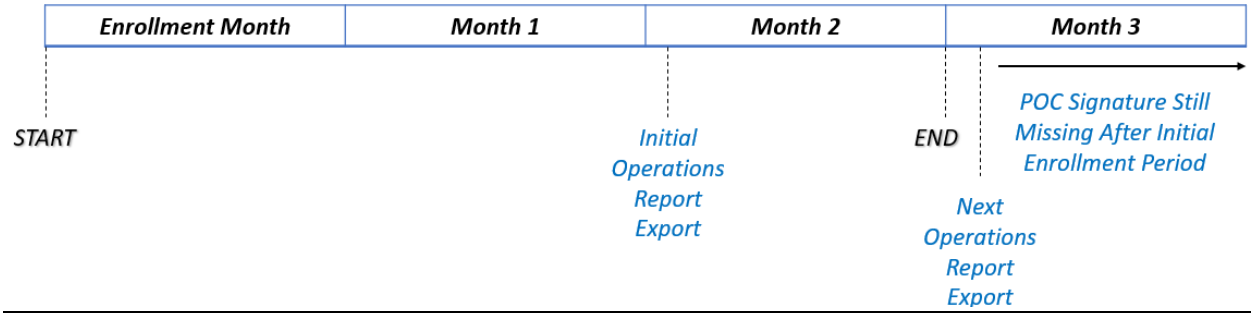
Review Cohort: *Enrolled 60+, Non-Pended*

Report Indicator: Members enrolled at least [60] days / [3] segment months

Performance Measure: Members enrolled at least [60] days / [3] segment months

Note: Report Indicator examines activity after the initial enrollment period among members enrolled ≥ [3] segment months

Timeline / Time Parameters



Example: Enrollment Start: *6/1/2024*. Operations Report shared at the beginning of September 2024. Report identifies members who still need a signed POC after prior report month due date: *8/31/2024*.

Note: Report indicator captures members transitioning from the newly enrolled member cohort and members enrolled ≥ [3] segment months.

Performance Measure	
	N/A

Note: Report Indicator can be used to drive Plan of Care (POC) signature completion rate (%).

Domain	Member Care Planning

[4] Plan of Care NOT Updated within the PAST 5 Months

Members enrolled at least 60 days who do not have a Plan of Care update in the past 5 months.

- A Plan of Care update is due by the end of the report month.

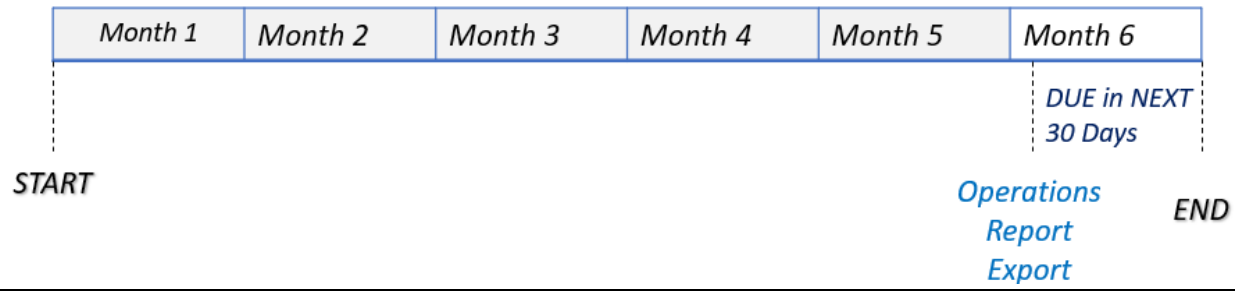
Review Cohort: *Enrolled 60+, Non-Pended*

Report Indicator: Members enrolled at least [60] days / [3] segment months

Performance Measure: Members enrolled at least [60] days / [3] segment months

Note: Report Indicator and Performance Measure examine activity after the initial enrollment period among members enrolled ≥ [3] segment months

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members who have not had a plan of care update in the prior 5 months (i.e. ≥ *3/1/2024*).

Note: The 6-month deliverable is specific to BHH Policy & Standards.

Performance Measure	
[3]	**Members w/ a Plan of Care (POC) Update within the PAST 6 Months**

Enrolled 60+, Non-Pended members with a plan of care update within the prior 6 months.

Report Indicator: *E 60+ Plan of Care NOT Updated within PAST 5 Mo*

Domain	Member Assessments

[5] Comprehensive Assessment NOT Completed within the PAST 11 Months

Members enrolled at least 60 days who do not have a completed/locked Comprehensive Assessment within the past 11 months.

- Comprehensive Assessment is due by the end of the report month.

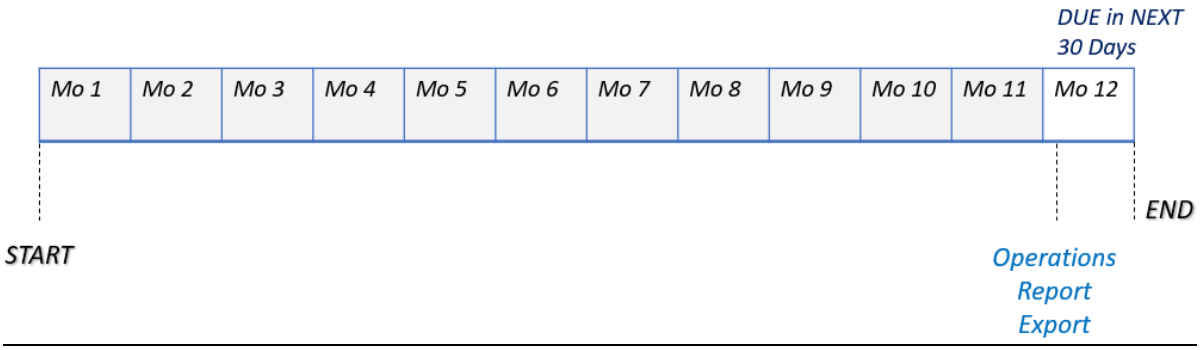
Review Cohort: *Enrolled 60+, Non-Pended*

Report Indicator: Members enrolled at least [60] days / [3] segment months

Performance Measure: Members enrolled at least [60] days / [3] segment months

Note: Report Indicator and Performance Measure examine activity after the initial enrollment period among members enrolled ≥ [3] segment months

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members who have not had a completed/locked Comprehensive Assessment in the prior 11 months (i.e. ≥ *9/1/2023*).

Note: Includes new/existing members missing an assessment ; re-assessment coming due/overdue.

Performance Measure	
[4]	**Members w/ a Completed Comprehensive Assessment in the LAST 12 Months**

Enrolled 60+, Non-Pended members with a completed assessment within the last 12 months.

Report Indicator: *E 60+ Comprehensive Assessment NOT Completed within PAST 11 Mo*

Domain	Member Assessments

[6] Comprehensive Assessment Marked Done, Completion PENDING

Enrolled members who have a Comprehensive Assessment marked as complete by the Care Manager which requires supervisory approval (locking) to be finalized/complete.

- Pending Comprehensive Assessment(s) should be reviewed/locked.

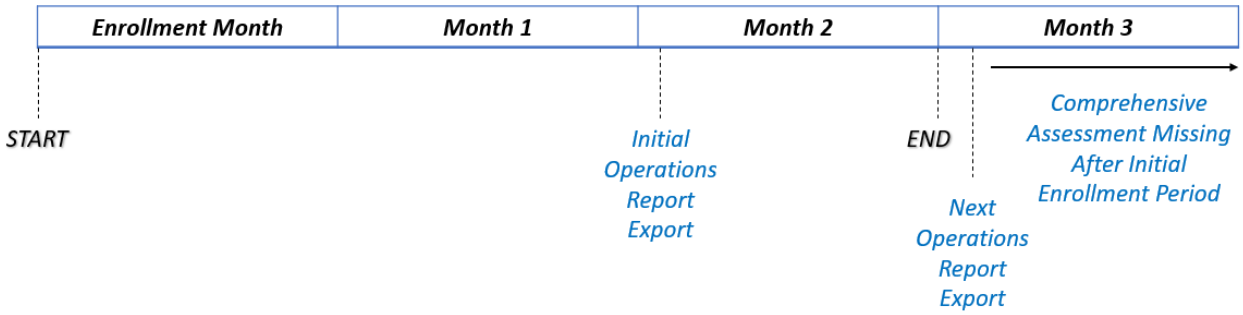
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*)

Performance Measure: N/A

Note: Indicator examines Comprehensive Assessments on or after *1/1/2023*

Timeline / Time Parameters



Example: Enrollment Start: *6/1/2024*. Operations Report shared at the beginning of September 2024. Report identifies members who still need a completed/locked Comprehensive Assessment after prior report month due date: *8/31/2024*.

Note: Report indicator captures members transitioning from the newly enrolled member cohort and members enrolled ≥ [3] segment months.

Performance Measure	
	N/A

Note: Indicator can be used to improve Comprehensive Assessment Completion Rate.

Domain	Member Engagement

[7] No Core Service Documented in Prior Month

Current, non-pended enrolled members with no documented core service in prior month.

- Results should be reviewed to ensure timeliness of core service documentation.

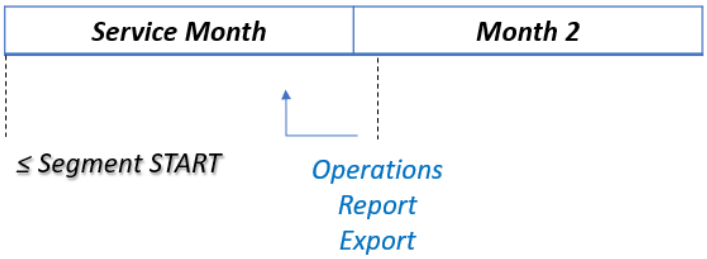
Review Cohort: *Current Enrolled, Non-Pended*

Report Indicator: Non-pended members with an enrolled segment as of prior month

Performance Measure: Non-pended members with an enrolled segment as of prior month

Note: Indicator examines Core Service delivery in prior month among non-pended, members with a segment start date on or before prior month

Timeline / Time Parameters



Example: Enrollment Start: *7/1/2024*. Operations Report shared at the beginning of August 2024. Report identifies members who were enrolled in prior month who did not have a documented core service.

Note: Report indicator excludes members with a segment start date (new enrollment) of report month and includes active members only.

Performance Measure	
[5]	**Members w/ a Core Service Documented LAST Month**

Current, non-pended enrolled members with no documented core service in prior month.

Report Indicator: *Current E, NO Core Service Documented in Prior Month*

Domain	Member Engagement

[8] No Inperson Encounter Attempts in the PAST 5 Months

Current enrolled members who had an in-person encounter (*successful or unsuccessful*) attempt documented within the prior 5 months.

- An in-person encounter should be attempted by the end of the report month.

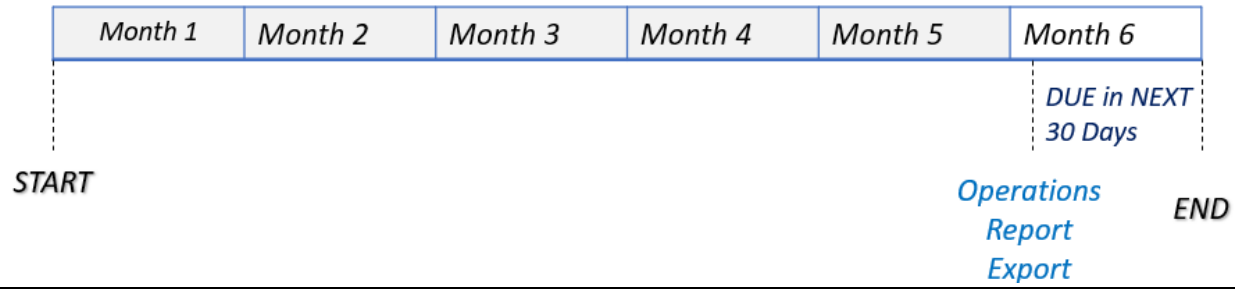
Review Cohort: *Current Enrolled*

Report Indicator: Members with an enrolled segment as of prior month

Performance Measure: Members with an enrolled segment as of prior month

Note: Indicator examines in-person encounters (*successful/unsuccessful*) among current enrolled members (*members enrolled in report month excluded*)

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members who have not had an in-person encounter (*successful/unsuccessful*) in the prior 5 months (i.e. ≥ *3/1/2024*).

Note: All encounters examined w/ target: member, regardless of setting (i.e. office, field, etc.)

Performance Measure	
[6]	**Members w/ an Inperson Encounter Attempt in the LAST 6 Months**

Current enrolled members who had an in-person encounter attempt (*unsuccessful/successful*) documented within the last 6 months.

Report Indicator: *Current E, NO Inperson Encounter Attempts in the PAST 5 Months*

Domain	Member Engagement

[9] No Inperson Encounter in the PAST 5 Months

Current enrolled members who had an in-person encounter (*successful*) attempt documented within the prior 5 months.

- An in-person encounter should be attempted by the end of the report month.

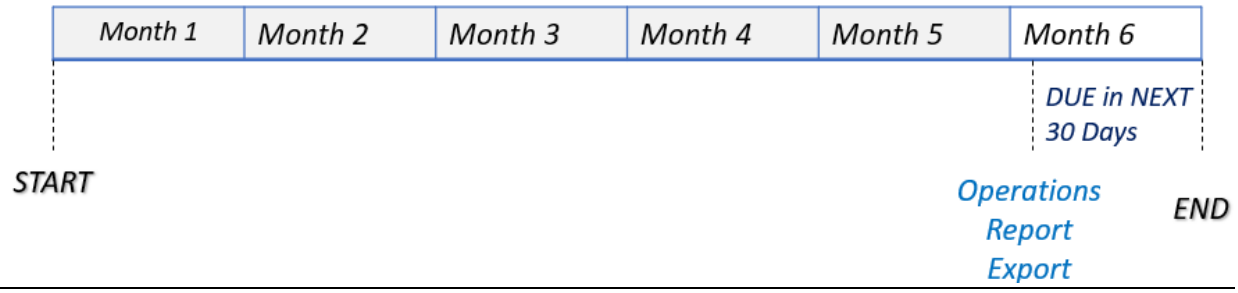
Review Cohort: *Current Enrolled*

Report Indicator: Members with an enrolled segment as of prior month

Performance Measure: Members with an enrolled segment as of prior month

Note: Indicator examines in-person encounters (*successful*) among current enrolled members (*members enrolled in report month excluded*)

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members who have not had an in-person encounter (*successful*) in the prior 5 months (i.e. ≥ *3/1/2024*).

Note: All encounters examined w/ target: member, regardless of setting (i.e. office, field, etc.)

Performance Measure	
[7]	**Members w/ an Inperson Encounter in the LAST 6 Months**
Current enrolled members who had an in-person encounter (*successful*) attempt documented within the last 6 months.	
Report Indicator: *Current E, NO Inperson Encounter in the PAST 5 Months*	

Domain	Care Planning

[10] No Plan of Care & Encounter Linkage in the PAST 2 Months

Current enrolled members who do not have at least (1) encounter linked to an active POC within the prior 2 months.

- A linked encounter to the plan of care is required by the end of the report month.

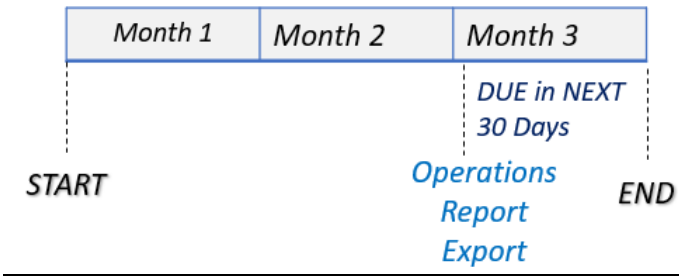
Review Cohort: *Current Enrolled*

Report Indicator: Members with an enrolled segment as of prior month

Performance Measure: Members with an enrolled segment as of prior month

Note: Indicator examines encounters linked to a member's plan of care

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members who have not had a plan of care and encounter linkage in the prior 2 months (i.e. ≥ 6*/1/2024*).

Note: Best practice - update plan of care and link corresponding encounter(s) monthly.

Performance Measure	
[8]	**Members w/ a Plan of Care (POC) & Encounter Linkage in the LAST 3 Months**

Current enrolled members with at least (1) encounter linked to an active POC within the last 3 months.

Report Indicator: *Current E, NO POC and Encounter Linkage in PAST 2 Months*

Domain	Care Planning

[11] No Gap in Care (GIC) Care Manager Status Change

Enrolled members who have at least (1) gap in care and no Care Manager status changes.

- Review gap in care with member and update CM status based upon outcome.

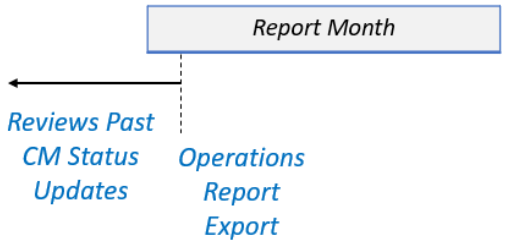
Review Cohort: *All Enrolled*

Report Indicator: Enrolled members with at least (1) gap in care

Performance Measure: Enrolled members with at least (1) gap in care

Note: Indicator examines if at least (1) gap in care CM status (*drop-down)* has been updated

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members with (1) or more existing gaps in care and determines if at least (1) has been updated.

Performance Measure	
[9]	**Members w/ at least (1) Gap in Care (GIC) who had a GIC Care Manager Status Change**

Enrolled members who have at least (1) gap in care and Care Manager status changes.

Report Indicator: *Enrolled Members w/ NO GIC CM Status Change*

Domain	CEN Response

[12] No Timely Clinical Event Notification (CEN) F/U in Prior Month (5 Day)

Enrolled members who had at least (1) discharge CEN in the prior month and did not have any timely follow-up activities documented within specified time parameters.

- Review members discharged w/o timely follow-up with appropriate staff to ensure follow-up care is provided and reinforce timely documentation

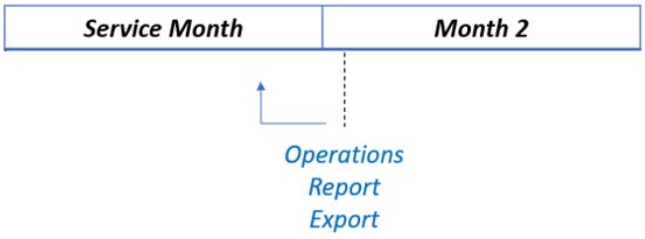
Review Cohort: *All Enrolled*

Report Indicator: Enrolled members with at least (1) discharge CEN in prior month

Performance Measure: Enrolled members with at least (1) discharge CEN in prior month

Note: Reviews if at least (1) (Emergency Department/Inpatient) discharge CEN had documented encounters w/ "AD" selected within specified time frames

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members with (1) or more discharge CEN in prior month and determines if there was timely follow-up documentation for at least (1) discharge notifications within time parameters (i.e. received date, discharge date, etc.).

Performance Measure	
[10]	**Members w/ Timely F/U Documented for at least (1) Discharge Clinical Event Notification (CEN) in the Prior Month**
Members who had timely follow-up for at least (1) discharge notification in the prior month	
Report Indicator: *Enrolled Members w/ NO CEN F/U in Prior Mo (5 Day)*	

Domain	Member Assessments

[13] Missing Strength, Barrier, or Risk Factor

Enrolled members who are missing at least (1) of the following required fields: Strengths, Barriers, or Risk Factors.

- Review/assess member-specific strengths, barriers and/or risk factors with member and document in record.

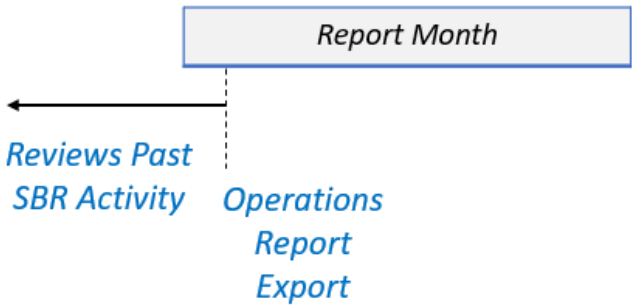
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*)

Performance Measure: All members with an enrolled segment (*no end date*)

Note: Indicator examines if all (3) fields are documented

Timeline / Time Parameters



Example: Operations Report shared at the beginning of August 2024 identifies members with (1) or more fields (*i.e. Strengths, Barriers, or Risk Factors*) missing.

Performance Measure	
[11]	**Members w/ Strengths, Barriers and Risk Factors Added**

Enrolled members who have all required fields: Strengths, Barriers, and Risk Factors.

Report Indicator: *Enrolled Members Missing Strength, Barrier, or Risk Factor*

Domain	Timely Billing

[14] NO Timely Billing in Prior Month

Current enrolled, non-pended members with no timely billing in the prior month.

- Review list of member w/o billing instance to verify BSQ completion.

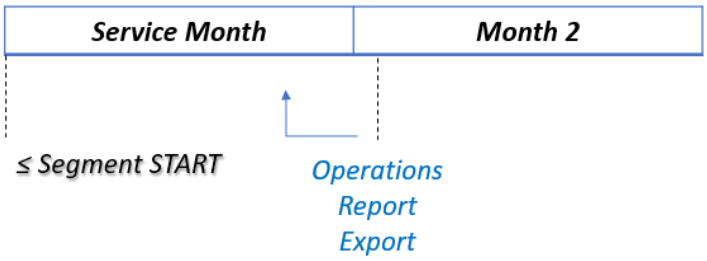
Review Cohort: *Current Enrolled, Non-Pended*

Report Indicator: Non-pended members with an enrolled segment as of prior month

Performance Measure: Non-pended members with an enrolled segment as of prior month

Note: Reviews if a billing claim has been generated (*as per data export date*)

Timeline / Time Parameters



Example: Enrollment Start: *7/1/2024*. Operations Report shared at the beginning of August 2024. Report identifies members who were enrolled in prior month who did not have a timely billing.

Note: Report indicator excludes members with a segment start date (new enrollment) of report month and includes active members only.

Performance Measure	
[12]	**Members w/ Timely Billing in Prior Month**

Current enrolled, non-pended members with a timely billing in the prior month.

Report Indicator: *Current E (Non-Pended), w/ No Timely Billing in Prior Month*

Domain	Timely Billing

[15] HHPlus, NOT Identified

Current, non-pended members identified as HHPlus eligible (as per PSYCKES or CMA) who were not correctly identified as HH+ eligible in prior month billing support questionnaire.

- Verify HH+ eligibility and make appropriate corrections to existing BSQs.

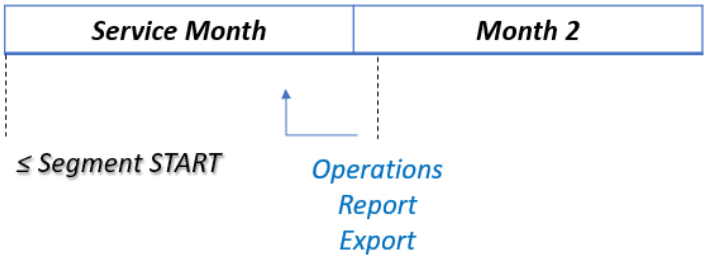
Review Cohort: *Current Enrolled, Non-Pended*

Report Indicator: Non-pended members with an enrolled segment as of prior month; identified as being eligible via PSYCKES + CMA (via billing support questionnaire)

Performance Measure: Non-pended members with an enrolled segment as of prior month; identified as being eligible via PSYCKES + CMA (via billing support questionnaire)

Note: Indicator identifies members with a BSQ that may not accurately capture eligibility

Timeline / Time Parameters



Example: Enrollment Start: *7/1/2024*. Operations Report shared at the beginning of August 2024. Report identifies members have been identified as HHPlus eligible (PSYCKES, CMA BSQ) and not correctly identified as eligible in the most recent BSQ.

Performance Measure	
[13]	**HHPlus Members Identified by CMA in Prior Month**
Current, non-pended members identified as HHPlus eligible (as per PSYCKES or CMA) who are correctly identified as HH+ eligible in the prior month billing support questionnaire.	
Report Indicator: *HHPlus (PSYCKES/CMA), NOT Identified*	

Domain	Eligibility Screening

[16] CES EXPIRES THIS MONTH

Enrolled members with a CES Tool due date/expiration date in report month.

- Complete a new CES Tool by the due date/expiration date in the report month.

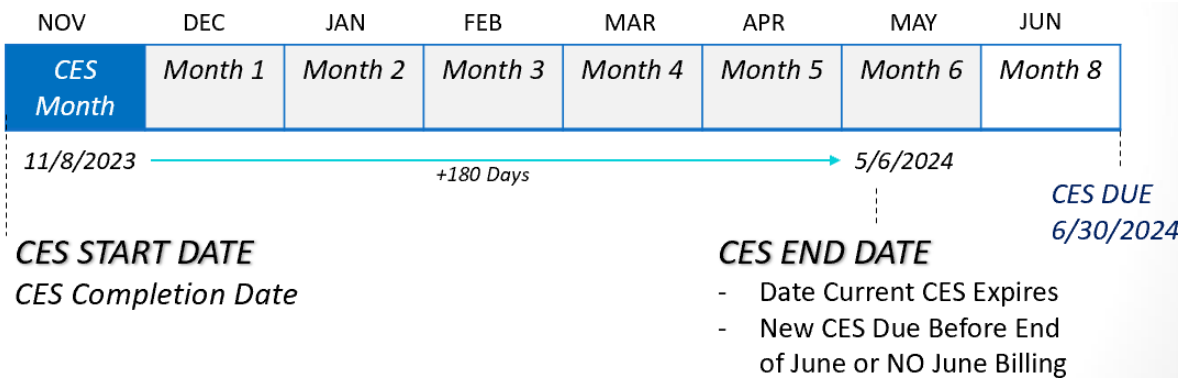
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*); most recent CES Tool expiration date in report month

Performance Measure: All members with an enrolled segment (*no end date as of export date*); most recent CES Tool expiration date in prior report month

Note: Indicator - CES Due in report month; Measure – CES completed prior to end of month

Timeline / Time Parameters



Example: Most recent CES Tool [Completion Date: 11/8/2024, Outcome: Recommend Continued Services]. Expiration Date: 5/6/2024 (+180 days); new CES Tool due as per DOH Health Home policy.

Performance Measure	
[14]	**Members w/ CES Tool Completed On-Time (DOH Policy)**

Enrolled members with a CES expiration date in the prior month who successfully completed a new CES Tool in the prior month.

Report Indicator: *CES Tool, CES EXPIRES THIS MONTH*

Domain	Eligibility Screening

[17] CES DUE THIS MONTH

Enrolled members with a CES Tool due date/expiration date in prior report month.

- Complete a new CES Tool by the end of the report month.

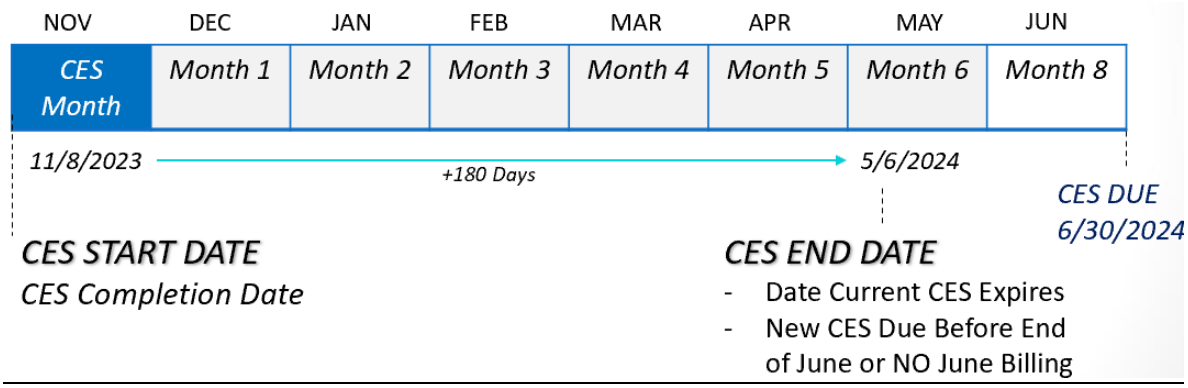
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*); most recent CES Tool expiration date in prior report month

Performance Measure: N/A

Note: Indicator - CES Due by end of report month (*as per MAPP Billing Specifications*)

Timeline / Time Parameters



Example: Most recent CES Tool [Completion Date: 11/8/2024, Outcome: Recommend Continued Services. Expiration Date: 5/6/2024 (+180 days) - new CES Tool due by 6/30/2024 to prevent billing block (*as per MAPP Billing Specifications*).

Performance Measure	
	N/A

Domain	Eligibility Screening

[18] CES Overdue

Enrolled members who were due for a new CES Tool (as per MAPP Billing Specifications) and does not have a CES Tool completed.

- Complete a new CES Tool to prevent further billing block implications.

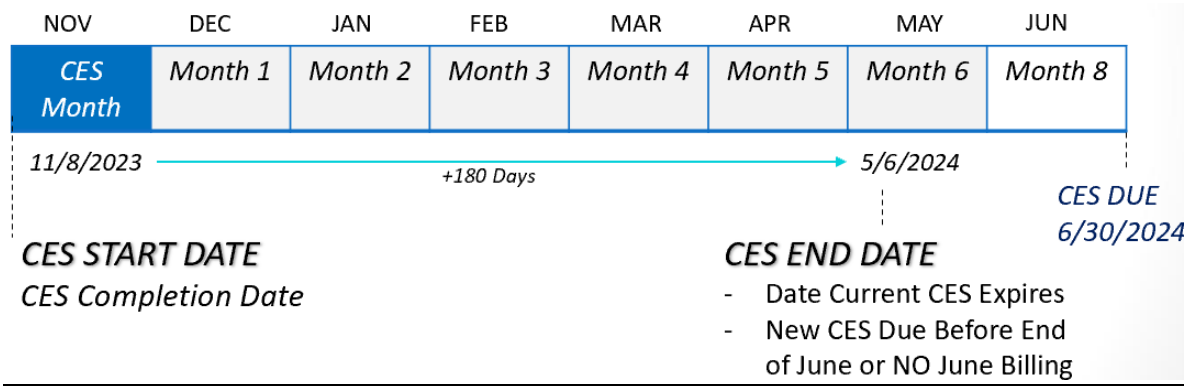
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*); most recent CES Tool (billing block) due date in prior report month

Performance Measure: N/A

Note: Indicator – CES past MAPP Billing Specifications due date, new CES Tool required

Timeline / Time Parameters



Example: Most recent CES Tool [Completion Date: 11/8/2024, Outcome: Recommend Continued Services. Expiration Date: 5/6/2024 (+180 days) - new CES Tool was due by 6/30/2024. A new CES Tool should be completed immediately in order to prevent further billing blocks.

Performance Measure	
	N/A

Domain	Eligibility Screening

[19] DISENROLLMENT DUE THIS MONTH

Enrolled members whose most recent CES Tool outcome is "Recommend Disenrollment" and have a disenrollment due date in the report month.

- Disenroll the member based upon CES Tool recommendation by closure due date.

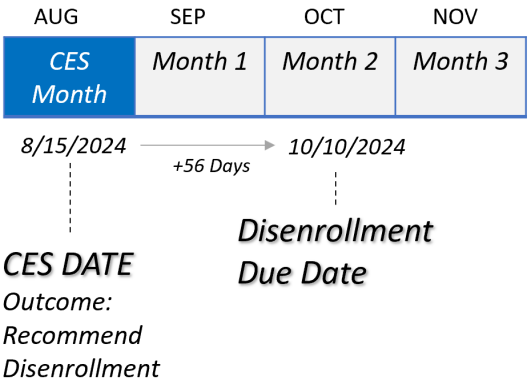
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*); most recent CES Tool / disenrollment date is in report month

Performance Measure: All members with a disenrolled segment (*end date as of export date*); most recent CES Tool / disenrollment date is in report month

Note: Indicator – Case closure due in report month; Measure – Case closed by end of month

Timeline / Time Parameters



Performance Measure	
[15]	**Members Disenrolled On-Time (DOH Policy)**

Members with a disenrollment due date in prior report month who were successfully disenrolled within the prior report month.

Report Indicator: *CES Tool, DISENROLLMENT DUE THIS MONTH*

Domain	Eligibility Screening

[20] DISENROLLMENT OVERDUE

Enrolled members whose most recent CES Tool outcome is "Recommend Disenrollment" and the disenrollment due date occurred in the prior month.

- Disenroll the member based upon CES Tool recommendation.

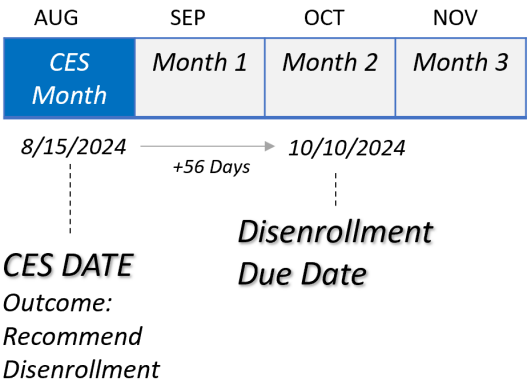
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*); most recent CES Tool / disenrollment date is in prior report month

Performance Measure: N/A

Note: Indicator – Case closure past due

Timeline / Time Parameters



Performance Measure	
	N/A

Domain	Eligibility Screening

[21] BILLING BLOCK COHORT MISSING CES TOOL

Members with a segment start month (of the MAPP billing block implementation cohort) who do not have an initial CES Tool completed.

- Complete an initial CES Tool for member.

Review Cohort: *All Enrolled*

Report Indicator: Enrolled members who meet inclusion criteria (segment start month)

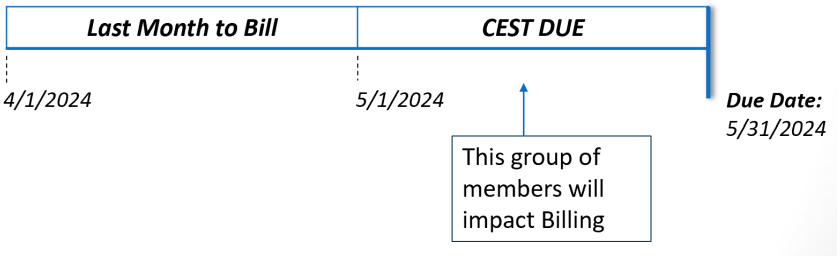
Performance Measure: N/A

Note: Initial Cohort: Segment months of 11-November, 12-December, 01-January, 02-February, 03-March, 04-April. +1 Month added/monthly until October 2024.

Important: Once a CEST Outcome has been submitted to the system for a member segment, the CEST start and end dates dictate when the next CEST is due to the system

- i.e. initial CEST due date no longer apply

Timeline / Time Parameters



Performance Measure	
	N/A

Note: Operations Report Indicator / Performance Measure to be phased out upon completion of the CES Tool / MAPP Billing Block implementation/

Domain	Eligibility Screening

[22] INITIAL CES TOOL DUE THIS MONTH

Members enrolled 12 months who are missing an initial CES Tool

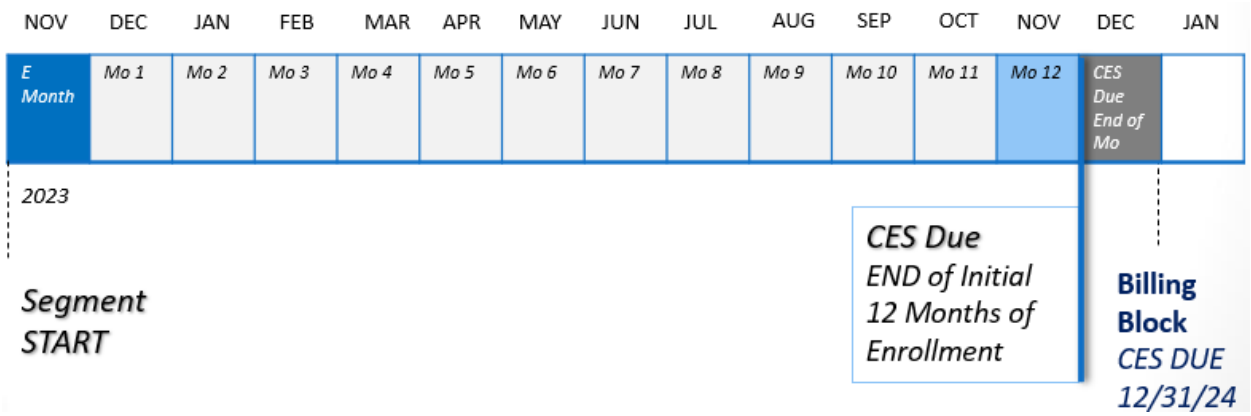
Review Cohort: *All Enrolled*

Report Indicator: All members with an enrolled segment (*no end date as of export date*) who has been enrolled 12 months

Performance Measure: All members with an enrolled segment (*no end date as of export date*) who has been enrolled 12 months

Note: Indicator - CES Due in report month; Measure – CES completed prior to end of month

Timeline / Time Parameters



Example: An enrolled member (enrolled at least 12 months) will need to have an initial CES Tool completed by the end of their 12th month of enrollment.

Note: Billing blocked in December 2024 w/o an initial CES Tool prior to 12/31/2024.

Performance Measure	
[16]	**Newly Enrolled Members w/ CES Tool Completed in 1st 12 Months of Enrollment**

Members enrolled 12 months who have a completed initial CES Tool by end of report month.

Additional Report Data

This section provides an overview of data points collected monthly by the BHH QMP.

Supplemental data/information is used in QI/QA initiatives and ad-hoc reports based upon new/emerging needs and goals.

Enrollment & Member Demographics

Enrollment Cohorts	
Total Enrollment	All members with an enrolled segment as of export date
Current Enrollment	Members with an enrolled segment as of prior month
Current Enrollment, Non-Pended	Members (E, Non-P) with an enrolled segment as of prior month
Enrolled 60 +	Members (E) enrolled at least (2) segment months
Enrolled 60 +, Non-Pended	Members (E, Non-P) enrolled at least (2) segment months
Enrolled, Pended	Members with an enrolled, pended segment
Enrolled, Pended (DS)	Members with an enrolled, pended (diligent search) segment
Newly Enrolled	Members enrolled (2) segment months prior to report month
Newly Enrolled	Members enrolled (3) segment months prior to report month
HARP Enrolled	Members enrolled in a Health and Recovery Plan (HARP)

System Flags are also examined periodically and may include:

System Flags	
Flag: HH+	Members with flag – Health Home Plus
Flag: SMI	Members with flag – Serious Mental Illness
Flag: H/A	Members with flag – HIV/AIDS
Flag: HOM	Members with flag – Homelessness
Flag: POP	Members with flag – Performance Opportunity Project
Flag: CTI	Members with flag – Critical Time Intervention
Flag: CRJ	Members with flag – Criminal Justice Involved
Flag: AH+	Members with flag – Adult Home Plus
Flag: AOT	Members with flag – Assisted Outpatient Treatment
Flag: ATI	Members with flag – Alternative to Incarceration
Flag: RFG	Members with flag – Review for Graduation
Flag: GRA	Members with flag – On Track for Graduation

Member Engagement

Member Contact Volume
Total # of Encounters in Prior Month (Total / Member-level)
Total # of Core Service Encounters in Prior Month (Total / Member-level)
Total # of Phone Core Service Encounters in Prior Month (Total / Member-level)
Total # of Video Core Service Encounters in Prior Month (Total / Member-level)
Total # of In-person Core Service Encounters in Prior Month (Total / Member-level)
Total # of In-person Encounters in Prior 6 Months (Total / Member-level)
Total # of In-person Encounter Attempts in Prior 6 Months (Total / Member-level)

Core Service (CS) Delivery
No CS in Prior Month (Among Cohorts: *Newly Enrolled, Current E and Current E, Non-Pended*)
Attempt, No CS in Prior Month (Among Cohorts: *Newly Enrolled, Current E*)
No Attempts in Prior Month (Among Cohorts: *Newly Enrolled, Current E*)

In-Person Contact
No In-Person Encounter in Prior 6 Months
No In-Person Encounter Attempts in Prior 6 Months

Comprehensive Assessments

Completion Rate Among Newly Enrolled
Newly Enrolled Members with No Comprehensive Assessment

Comprehensive Assessment Activity
No Comprehensive Assessment Completed within Prior 11 Months
No Comprehensive Assessment Completed within Prior 12 Months
Most Recent Comprehensive Assessment Completed Among E Members
Most Recent Comprehensive Assessment Completed Among E, Pended Members

Plan of Care

Plan of Care Creation
No Plan of Care Created (New)
No Plan of Care Created (All)

Plan of Care Update Activity
No POC Update within past 5 Months
No POC Update within past 6 Months
Plan of Care, Date of Most Recent Update

Plan of Care and Encounter Linkage
No Encounter Linkage to POC
No Encounter Linkage to POC in past 6 Months

Gap in Care

Gap in Care Status
Total # of Gap in Care Actions
Total # of Active Gap in Care Actions
Members with ≥ (1) Active Gap in Care Action

Gap in Care CM Status
Members with No CM Status Change

Strength, Barrier, and Risk Factors

SBR Documentation
Members with a Strength, Barrier or Risk Factor Missing
Members with at least (1) Strength Added
Members with at least (1) Barrier Added
Members with at least (1) Risk Factor Added

CEN Follow-Up

Healthix Follow-Up Activity
No Follow-up within 2 Days of ED Discharge Alert, Discharge
No Follow-up within 2 Days of ED Discharge Alert, Alert Receipt
No Follow-up Activities within 2 Days of ED Alert
No Follow-up within 5 Days of ED Discharge Alert, Discharge
No Follow-up within 5 Days of ED Discharge Alert, Alert Receipt
No Follow-up Activities within 5 Days of ED Alert
No Follow-up within 7 Days of ED Discharge Alert, Discharge
No Follow-up within 7 Days of ED Discharge Alert, Alert Receipt
No Follow-up Activities within 7 Days of ED Alert
No Follow-up within 2 Days of Inpatient Discharge Alert, Discharge
No Follow-up within 2 Days of Inpatient Discharge Alert, Alert Receipt
No Follow-up Activities within 2 Days of Inpatient Alert
No Follow-up within 5 Days of Inpatient Discharge Alert, Discharge
No Follow-up within 5 Days of Inpatient Discharge Alert, Alert Receipt
No Follow-up Activities within 5 Days of Inpatient Alert
No Follow-up within 7 Days of Inpatient Discharge Alert, Discharge
No Follow-up within 7 Days of Inpatient Discharge Alert, Alert Receipt
No Follow-up Activities within 7 Days of Inpatient Alert

CEN Volume and Follow-Up
Members with at least (1) CEN
No Clinical Event Notification (CEN) (ED/Inpatient Discharge) Follow-up

Billing

Timeliness of Billing Submission
Members with No Billing Submission in Prior Month (Among Cohort: *Current E*)
Members with No Billing Submission in Prior Month (Among Cohort: *Current E, Non-Pended*)
Billing Rate and Description in Prior Month
Identified as HHPlus Eligible (via either PSYCKES or CMA)
HHPlus Services Provided in Prior Month (among HHPlus Identified via PYCKES/CMA)
Identified as HHPlus Eligible via PSYCKES, but not in CMA (BSQ Submission)

Performance Scorecard

Bi-Annual CMA Performance Scorecards, also referred to as Performance Scorecards, are developed and disseminated to each CMA approx. every 6 months in order to illustrate progress and performance in meeting BHH QMP objectives and deliverables.

Reports provide CMA Leadership and QI/QA staff with enhanced visibility into both process measure performance and chart review findings.

Final performance scorecards are based upon:

[**Quantitative**] – Process & Outcome-based Performance Process Measures

- Calculated Monthly
- Operations Report "Report Indicators" can be used to improve performance (%)

[**Qualitative**] – Quality-driven, Chart Reviews via BHH Chart Review Tool

- Completed Quarterly, by BHH and contracted CMAs
- Randomly Selected Members (*based upon Cohort Inclusion Criteria*)
- BHH Chart Review [Main Tool]
- Workflow Specific Reviews:
    - Clinical Event Notification (CEN) F/U
    - HARP (HCBS/CORE)
    - Diligent Search
    - Disenrollment

[Quantitative] – Process & Outcome-based Performance Process Measures

- Scoring Weight: **45%**

Methodology

Process & Outcome-based Performance Process Measures represent **45%** of the total Bi-Annual Performance Scorecard. Results are based upon findings from the following elements:

- Completion of Member Enrollment Requirements
- Member Engagement
- Timely Completion of Member Assessments
- Timely Care Planning
- CEN Discharge Alert Response Rate
- Timely Completion of Eligibility Screenings
- Timely Billing

Performance Measure Domain Scoring Overview

#	Description	Weight
1	**Member Enrollment**	***15%***
2	**Member Engagement**	***20%***
3	**Member Assessments**	***20%***
4	**Care Planning**	***20%***
5	**CEN Discharge Alert Response Rate**	***10%***
6	**Eligibility Screening**	***10%***
7	**Timely Billing**	***5%***

Performance Measure Scoring Overview

Domain	Measure #	Measure	Sub weight
1	*1*	New Members w/ a Plan of Care (POC) Signature within 1st 60 Days	***40%***
	2	New Members w/ a Complete Comprehensive Assessment within 1st 60 Days	***60%***
2	*5*	Members w/ a Core Service Documented LAST Month	***40%***
	6	Members w/ an Inperson Encounter Attempt in the LAST 6 Months	***15%***
	7	Members w/ an Inperson Encounter in the LAST 6 Months	***45%***
3	*4*	Members w/ a Completed Comprehensive Assessment in the LAST 12 Months	***85%***
	11	Members w/ Strengths, Barriers and Risk Factors Added	***15%***
4	*3*	Members w/ Plan of Care (POC) Update within the PAST 6 Months	***45%***
	8	Members w/ a Plan of Care (POC) & Encounter Linkage in the LAST 3 Months	***30%***
	9	Members w/ at least (1) Gap in Care (GIC) who had a GIC Care Manager Status Change	***25%***
5	*10*	Members w/ Timely F/U Documented for at least (1) Discharge CEN in the Prior Month	***100%***
6	*14*	Members w/ CES Tool Completed On-Time (DOH Policy)	***80%***
	15	Members Disenrolled On-Time (DOH Policy)	***20%***
	16	Newly Enrolled Members w/ CES Tool Completed in 1st 12 Months of Enrollment	*--*
7	*12*	Members w/ Timely Billing in Prior Month	***75%***
	13	HHPlus Members Identified by CMA in Prior Month	***25%***

Note: If there are no new member enrollments within review period, scoring weight will be redistributed to corresponding domain.

[**Qualitative**] **– Chart Reviews via BHH Chart Review Tool**

- Scoring Weight: **55%**

Methodology

Qualitative Chart Reviews represent **55%** of the total Bi-Annual Performance Scorecard.

The total result is based upon chart review outcomes from the following review groups:

- New Chart Reviews (**83.3%**)
- Re-Assignment Chart Reviews (**16.7%**)

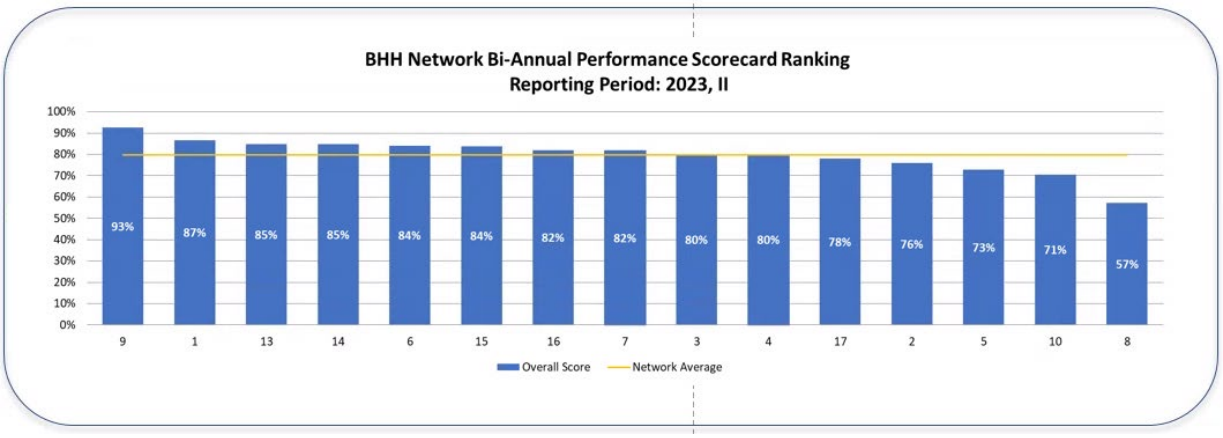
New Chart Reviews (*from current reporting period*)		
Weight: 83.3%	CMA Submitted Chart Reviews (*Independent*) Sub-weight: **60%** ▪ Average Chart Review Results from CMA ONLY	BHH & CMA Chart Reviews (*Joint*) Sub-weight: **40%** ▪ Average Chart Review Results from BHH and CMA

Re-Assignment Chart Reviews (*from current reporting period*)		
Weight: 16.7%	Initial Chart Reviews (*Initial Score*) Sub-weight: **83.3%** ▪ Average Chart Review Results from BHH & CMA CRs	Re-Assignment Chart Reviews (*Secondary Review Score*) Sub-weight: **16.7%** ▪ Average Chart Review Results from BHH & CMA CRs
Impact Score	[Initial Chart Review (Avg) Results] + [Secondary Review Score]	

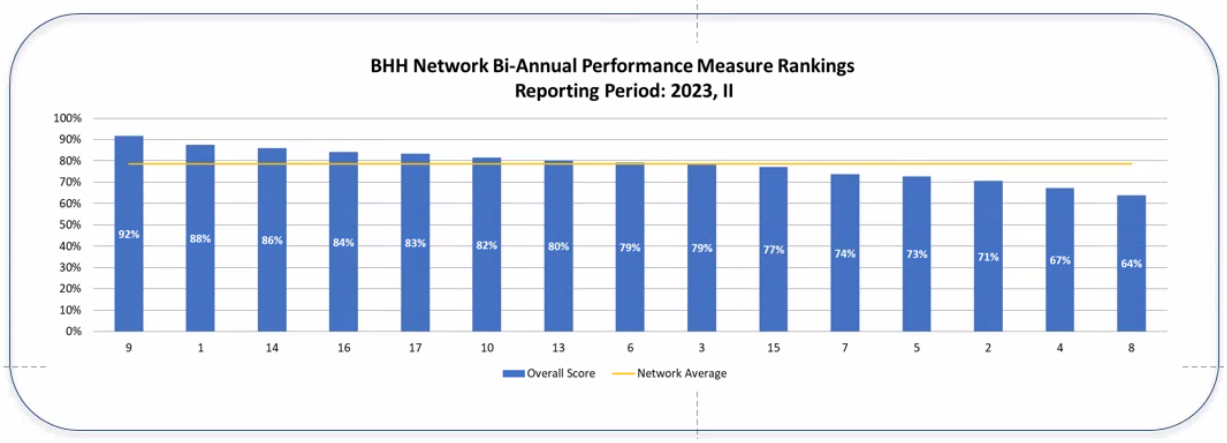
Note: 16.3% represents the proportion of re-assignment charts assigned in each reporting period. Scoring methodology last reviewed: *8/1/2024*. Methodology subject to change.

Scorecard Components – *Example from Reporting Period 2023, II*

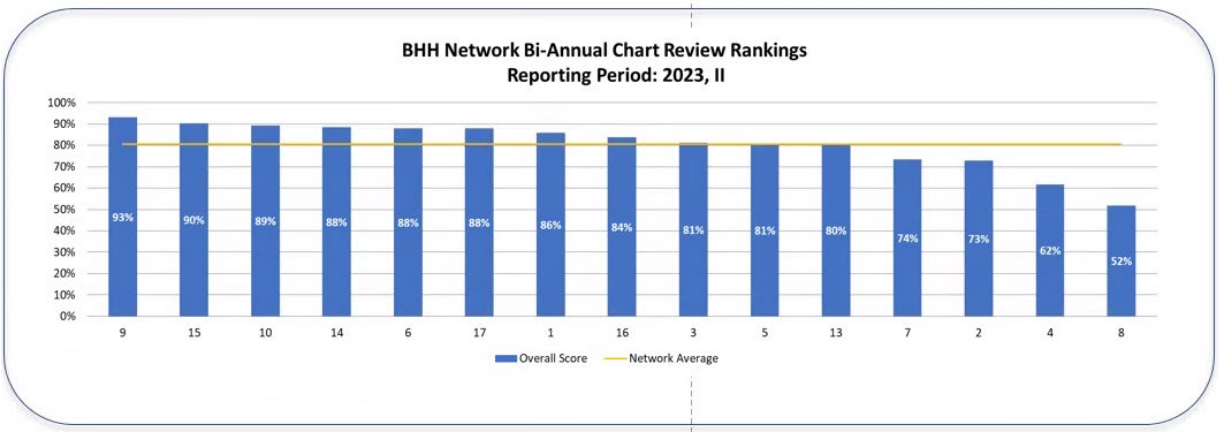
Network Ranking



Performance Measures Ranking



Qualitative Measures Ranking



Brooklyn Health Home (BHH)

Chart Review

Guide

Contents

I. BHH Chart Review Tool [Structure]

The BHH Chart Review Tool [HHSA] is comprised of the following distinct chart review tools:

A. Comprehensive Chart Review Tool
B. Sub_Chart Review Tool, Focus: Clinical Event Notification (CEN) Follow-Up
C. Sub_Chart Review Tool, Focus: CORE and HCBS (HARP)
D. Sub_Chart Review Tool, Focus: Member Disenrollment
E. Sub_Chart Review Tool, Focus: Diligent Search Activities

In addition, the tool contains the following resources and actionable elements:

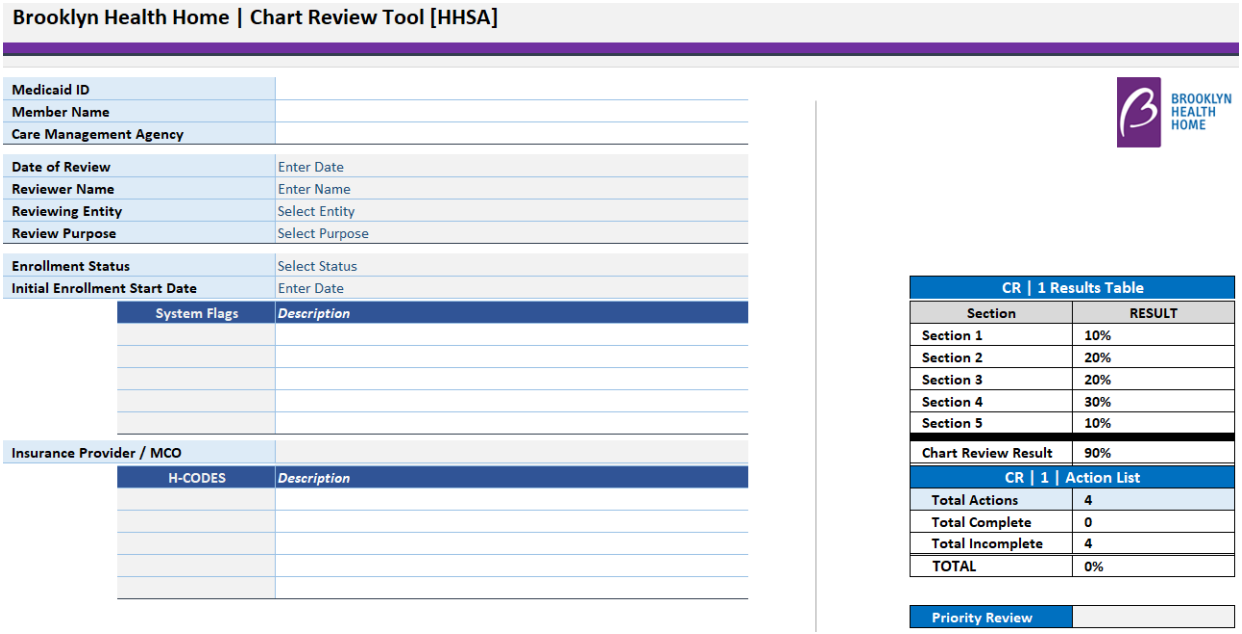
A. HH Appropriateness Table
- List of appropriateness codes and corresponding descriptions
- Information can be sorted by population, domain, etc.

B. Chart Review Notes
- Separate tabs connected to corresponding Comprehensive Chart Review Tools
- Additional location for Reviewers to capture chart review findings and make appropriate recommendations to the Care Manager to resolve and/or review further with the member and/or care team

C. Chart Review Action Lists
- List of actionable items that can be resolved by the Care Manager
- Items populate based upon responses in the corresponding Comprehensive Chart Review Tool
- Status of items due same date/time of subsequent Chart Review assignments

II. Comprehensive Chart Review Tool

Section A | Member Demographics & Enrollment Status



Brooklyn Health Home | Chart Review Tool [HHSA]

Medicaid ID	
Member Name	
Care Management Agency	
Date of Review	Enter Date
Reviewer Name	Enter Name
Reviewing Entity	Select Entity
Review Purpose	Select Purpose
Enrollment Status	Select Status
Initial Enrollment Start Date	Enter Date

System Flags	*Description*

Insurance Provider / MCO	

H-CODES	*Description*

BROOKLYN HEALTH HOME

CR | 1 Results Table	
Section	RESULT
Section 1	10%
Section 2	20%
Section 3	20%
Section 4	30%
Section 5	10%
Chart Review Result	90%

CR | 1 | Action List	
Total Actions	4
Total Complete	0
Total Incomplete	4
TOTAL	0%

Priority Review	

Figure 1. BHH Chart Review Tool [HHSA] Comprehensive Review Overview

Member Details

The following fields are pre-populated from the **CR|Summary Table**:

A. **Medicaid ID**
B. **Member Name**
C. **Care Management Agency**

Reviewer Details

The following fields are **required** to be completed by the ***Reviewer*** conducting the chart review:

D. **Date of Review**
   - Enter date [*mm/dd/yyyy*] the chart review was marked complete by the Reviewer
E. **Reviewer Name**
   - Enter Reviewer full name (first, last name)
F. **Reviewing Entity**
   - Select Reviewer's CMA, external organization or entity
G. **Review Purpose**
   - Select primary reason for conducting the chart review
   - Options: *Quality Review (QA/QI), Incident Report Follow-up, Corrective Action Plan Review, MCO Review, Other*

Enrollment Details

H. Enrollment Status

- Select the status of the member's enrollment at the time of chart review completion
- Options: *Enrolled, Pended, Diligent Search, HH Graduate, Closed*
  - HH Graduate and Closed populates Disenrollment Details (M, N, O)

I. Initial Enrollment Start Date

- Enter date [*mm/dd/yyyy*] member was first enrolled with current CMA, under BHH **[1]**
  - Example: Enrollment began April 2023 (1st Consent: 4/12/23, Segment: 4/1/23)

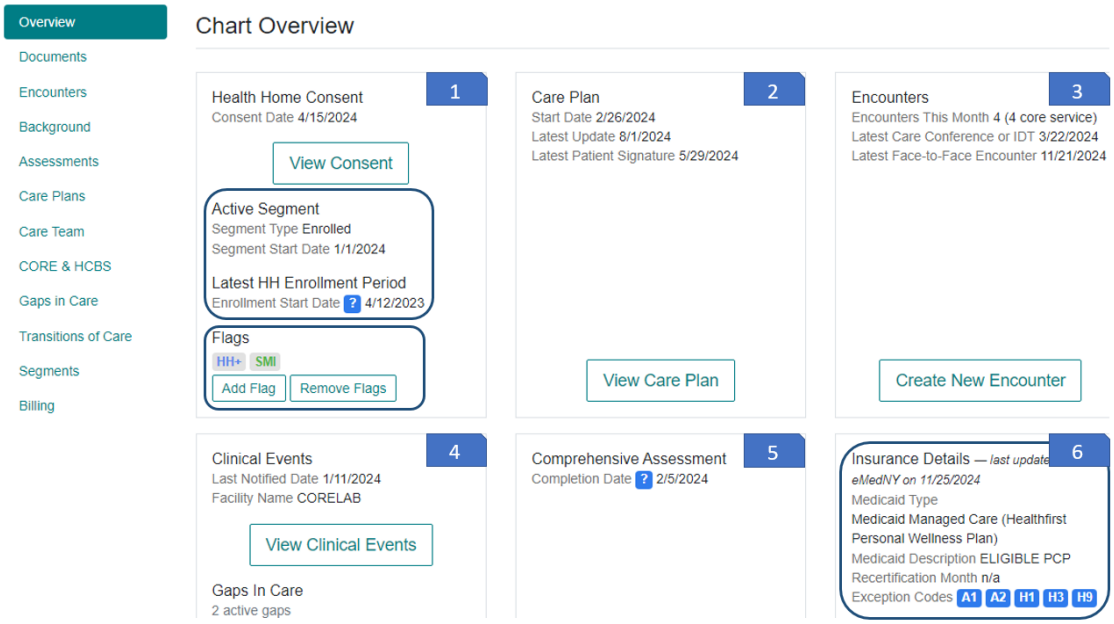


Figure 2. Member record *Overview* – primary view when opening a member chart. Information captured includes but is not limited to, enrollment status, enrollment start date, system flags, most recent clinical event notification, uploaded gaps in care, insurance status, exception codes, HARP (H) codes, as well as important dates concerning Health Home consent, care planning activities (creation/start date, last update date, last signature date) and the most recently completed comprehensive assessment. The left side panel of tabs contain additional details/data pertaining to each section. Note: Insurance Details are sourced from eMEDNY/ePACES.

J. Insurance Provider/MCO

- Select insurance provider/insurance type at the time of chart review completion
- Insurance details are located in the ***Overview*** **[6]**

K. System Flags

- Select flags assigned in member record from drop-down field(s) - ***Overview*** **[1]**
  - Flag selections will auto-populate corresponding ***Description***

L. H-Codes

- Select H-codes evident in the member record - ***Overview*** **[6]**
  - H-Code selections will auto-populate corresponding ***Description***

Disenrollment Details

The following questions will populate if **Enrollment Status** is either "*HH Graduate*" or "*Closed*".

If the member's case is closed during the assignment and/or active chart review reporting period, the Reviewer is to complete the entirety of the chart review tool and answer questions based upon the work completed prior to/during the disenrollment phase.

Retrospective review time periods should be adjusted based upon the disenrollment date. For example, if the member was disenrolled 11/30/2024 and a question asks if the member was seen by their provider in the past 6 months, 6/1/2024 would be the beginning of the review period. The review should examine if care management activities were documented in the past 6 months of active enrollment.

M. Segment End Date

- Enter date [*mm/dd/yyyy*] the member's case was closed

Figure 3. Member Segment Excerpt (*Member Record, Segments*)

N. Segment End Reason Code

- Select code selected during case closure
- Code should be located via **Segments**

O. Segment End Reason Description:

- No Action Required: Field auto-populated based upon code selected

Section 1 | Member Enrollment

Review of Initial Appropriateness (IA)

(1) What Initial Appropriateness (IA) criteria did the member meet at the time of initial enrollment?

- Select IA code documented at the time of Health Home enrollment
- If enrollment occurred prior to IA requirements or IA is missing in record, select the option that best captures the members immediate need(s) at time of enrollment
- Appropriateness Criteria details can be located via ***Segments***
  - Select *Details* in the segment being reviewed to view:

Figure 4. Member Segment Details Excerpt (*Member Record, Segments*)

- Additional details can be viewed after opening the segment by selecting "*Edit*"

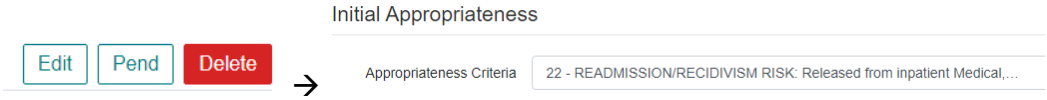


Figure 5. Member Segment Details - Edit Excerpt (*Member Record, Segments*)

- **[HH Appropriateness Table]**
  - Guide (filterable table) containing all appropriateness codes and definitions
  - Select **See List** to navigate to resource in Question (1)

CR Action List

(10) Initial Appropriateness Missing – Update Member IA

Initial Appropriateness Missing - Update Member IA	Yes	

Action Item:

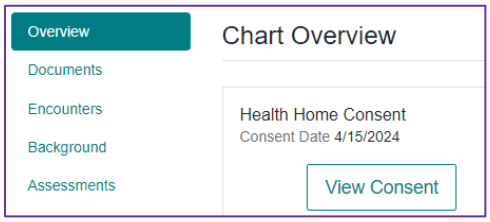
- Document IA and/or eligibility determination in the member record
  - IA may be documented via current/new segment, comprehensive assessment summary, supervisory encounter

Note: Action Item field is set to "Yes" value. Once IA is selected, item will be removed

DOH 5055: Patient Health Information Sharing Consent Form

(2) What is the current/most recent DOH 5055 consent date?

- Enter date of the current (most recently updated/signed) DOH 5055 consent form
- Details are located via ***Overview*** and ***Documents***
  - ***Overview*:**



- select date to navigate to file

Figure 6. Chart Overview – Consent [1] Excerpt (*Member Record, Overview*)

  - ***Documents*:**

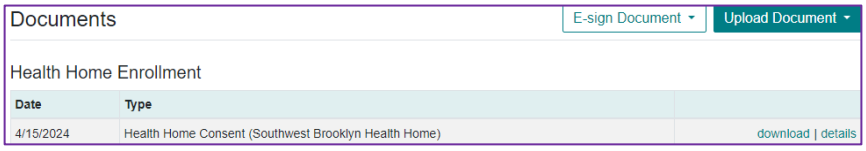


Figure 7. Health Home Enrollment Excerpt (*Member Record, Documents*)

- *Download* file; contents will be reviewed next in Question (2)

CR Action List

(1) DOH 5055 Missing: Obtain New DOH 5055

Description	Action Item	Resolved
DOH 5055 Missing: Obtain New DOH 5055	Yes	

Figure 8. Action List, Action Item (1) Excerpt

Action Item:

- Review current Care Team members with the member during next engagement
- Obtain informed consent based upon member choice
  - Healthcare and non-healthcare providers, inclusive of emergency contacts, family/social support systems integral to the overall care of the member and are a part of the member's plan of care should be reviewed with the member
  - If a member declines information sharing with a specific provider or entity, details should be clearly documented in the corresponding encounter note

(3) Is the most recent DOH 5055 form correctly completed AND uploaded to the member record?

- Review the contents of the DOH 5055 consent form and determine if there are any issues
- Question (3) provides a checklist of common issues found in prior review periods
- If an issue exists, Question (3) should be set to "No"
    - A "No" value will populate/require the Reviewer to select all evident issues

3	Is the most recent DOH 5055 form correctly completed AND uploaded to the member record?	No

Checklist	**If NO, what issues are present?**	*Select*
A	Member Signature, Initials, Dates Missing or Incorrect	Yes
B	Provider Descriptions Limited / Clarification Required	Yes
C	Document Upload Error OR Description Unclear	
D	Not Current BHH/DOH 5055 Version	

Figure 9. BHH Chart Review Tool [HHSA], Question (3) Excerpt

- Reviewer should examine contents of DOH 5055 to determine if the following are evident:
    - **[A] | Member Signature, Initials, Dates Missing or Incorrect**
        - ✓ Member signature and date, Consent box (*page 1*)
        - ✓ Member initials and date for **each** consented entity (*page 3+)*
    - **[B] | Provider Descriptions Limited / Clarification Required**
        - ✓ Confirm consented entities are clearly labeled
        - ✓ Care Team member details should include Full Name, Title/Provider Type, Office Location/Site Information/Associated Hospital (if applicable)
    - **[C] | Document Upload Error OR Description Unclear**
        - ✓ Confirm downloaded document is legible, accessible
        - ✓ Confirm all DOH 5055 pages are evident in file
        - ✓ Confirm document upload description is clear and will be easier to identify
            - If DOH 5055 is difficult to locate, Issue [C] should be identified
    - **[D] | Not Current BHH/DOH 5055 Version**
        - ✓ Confirm DOH 5055 version is a current BHH Version
        - ✓ BHH should be listed on pages 1 and 3

CR Action List

(2) Documentation Error: Update/Obtain New DOH 5055

Documentation Error: Update/Obtain New DOH 5055	Yes	
Update Signatures, Initials or Consent Dates	Yes	
Update Provider/Care Team Description(s)	Yes	
Re-Upload File / Update Description		
Complete New Consent via Current DOH 5055 Version		

Figure 10. Action List, Action Item (2) Excerpt

Action Item:

- Review identified consent issue(s) and make appropriate corrections
- Based upon the Reviewer's findings, a new DOH 5055 may be required

(4) Are ALL required providers consented on the current/most recent DOH 5055?

- Review the contents of the DOH 5055 consent form and determine if the following providers are listed / consented on the current DOH 5055:
  - **[A] Brooklyn Health Home** BHH consent (*w/ member initials/date*)
  - **[B] Care Management Agency** CMA consent (*w/ member initials/date*)
  - **[C] Primary Care Provider (PCP)** Provider name, title/provider type
  - **[D] Behavioral Health/Mental Health Provider** Provider name, title/provider type
  - **[E] Medicaid Managed Care Plan / MCO (Insurance)**
  - **[F] Expired - Medicaid Managed Care Plan / MCO (Insurance)**
    - Required question; if the member's insurance has changed/is no longer active, "Yes" value applies
- If member declined a provider linkage, "*Member Declined*" may be selected
  - Details must be documented in corresponding consent encounter note
- If at least (1) provider is missing, Question (4) should be set to "No"
  - Reviewer should select "Yes" for any provider missing
  - A "Yes" value will populate an action item

4	**Are ALL required providers consented on the current/most recent DOH 5055?** (list below)	No

Checklist	**If NO, which providers are missing? If declined, select "Member Declined"**	*Select*
A	Brooklyn Health Home	
B	Care Management Agency	
C	Primary Care Provider (PCP)	Yes
D	Behavioral Health/Mental Health Provider (If applicable)	
E	Medicaid Managed Care Plan / MCO or Other Insurance Plan	Yes
F	Expired Medicaid Managed Care Plan / MCO or Other Insurance Plan	

Figure 11. BHH Chart Review Tool [HHSA], Question (4) Excerpt

CR Action List

(3) Required Providers Missing: Update Consent Form

Required Providers Missing: Update Consent Form	Yes	
Brooklyn Health Home		
Care Management Agency		
Primary Care Provider (PCP)	Yes	
BH/MH Provider		
Medicaid Managed Care Plan / MCO	Yes	

Figure 12. Action List, Action Item (3) Excerpt

(4) MCP/MCO Expired: Update Consent Form

MCP/MCO Expired: Update Consent Form	Yes	

Figure 13. Action List, Action Item (4) Excerpt

Action Item:

- Review missing providers with member and make appropriate corrections
- Based upon the Reviewer's findings, a new DOH 5055 may be required

(5) Select ALL Care Team Members on the current/most recent DOH 5055?

(A) Provider Consented on DOH 5055?

(B) Provider Missing in Care Team?

(C) Provider Needs to be Added to Consent Form?

- Review the downloaded DOH 5055 consent form reviewed during Question (3)
- Identify and select ALL Care Team members / entities listed on the DOH 5055
    - Selections will identify additional fields to be completed by the Reviewer

5	Select ALL Care Team Members on the current/most recent DOH 5055?	Provider Consented on DOH 5055 (*Select All that Apply*)
	Care Team / Provider List	
A	CMA Supervisor	
B	CMA Assigned Care Manager	
C	Primary Care Provider (PCP)	
D	Behavioral Health/Mental Health Provider	
E	Medicaid Managed Care Plan | MCO Contact	
F	Emergency Contact | Family Member	
G	Dental Care | Dentist	
H	Vision Care | Opthalmologist	
I	Mental Health | Psychiatrist	
J	Mental Health | Therapist	

Figure 14. BHH Chart Review Tool [HHSA], Question (5) – Consented Providers Excerpt

Note: [A – E] are auto-populated based upon responses from Question (4). If question (4) is "Yes", all providers [A – E] will default to "Yes". If Question (4) is "No" and a provider is identified as missing, [A – E] will update in response to prior answer(s).

4	Are ALL required providers consented on the current/most recent DOH 5055? (list below)	No
Checklist	**If NO, which providers are missing? If declined, select "Member Declined"**	*Select*
A	Brooklyn Health Home	
B	Care Management Agency	
C	Primary Care Provider (PCP)	Yes
D	Behavioral Health/Mental Health Provider (If applicable)	
E	Medicaid Managed Care Plan / MCO or Other Insurance Plan	Yes
F	Expired Medicaid Managed Care Plan / MCO or Other Insurance Plan	

5	Select ALL Care Team Members on the current/most recent DOH 5055?	Provider Consented on DOH 5055 (*Select All that Apply*)
	Care Team / Provider List	
A	CMA Supervisor	Yes
B	CMA Assigned Care Manager	Yes
C	Primary Care Provider (PCP)	
D	Behavioral Health/Mental Health Provider	Yes
E	Medicaid Managed Care Plan | MCO Contact	

Figure 15. BHH Chart Review Tool [HHSA], Question (4 & 5) – Consented Providers Excerpt

- If a consented entity is not captured in the Care Team / Provider List, the Reviewer should document consented entity via [W] Other and enter name of provider via free text field

W	Other	*Enter (if applicable)*	

Figure 16. BHH Chart Review Tool [HHSA], Question (5) – Other Consented Providers Excerpt

- After All consented entities are selected, the Reviewer will review if the entities are accurately documented in the Care Team section of the member record
    - Member Record, ***Care Team*** should match details from the DOH 5055
    - Care Team details populate and can be edited in Plan of Care

5	Select ALL Care Team Members on the current/most recent DOH 5055?	Provider Consented on DOH 5055 (*Select All that Apply*)	Provider Missing in Care Team (*FCM Record*)
Care Team / Provider List			
A	CMA Supervisor	Yes	
B	CMA Assigned Care Manager	Yes	
C	Primary Care Provider (PCP)	Yes	
D	Behavioral Health/Mental Health Provider	Yes	
E	Medicaid Managed Care Plan | MCO Contact	Yes	
F	Emergency Contact | Family Member		
G	Dental Care | Dentist	Yes	Yes

Figure 17. BHH Chart Review Tool [HHSA], Question (5) – Care Team Missing Excerpt

- If a provider is missing, "Yes" value should be selected. If evident in record, leave blank.

CR Action List

(5) Missing Care Team Member: Update Consent Form

Missing Care Team Member: Update Consent Form	Yes	
Emergency Contact | Family Member	Yes	

Figure 19. Action List, Action Item (5) Excerpt

Action Item:

- Review recommended and/or missing providers with member and make appropriate corrections based upon member choice – support via corresponding encounter

- The next column seeks to determine if the Care Team/Provider should be added to the DOH 5055 based upon the completed chart review.
    - **Best Practice:** complete this section at the end of the review process to obtain a clearer picture of which providers the member is connected to, where connections are limited and/or where you believe further action could benefit the member address their needs/goals.
    - If no additions are recommend, the Reviewer should leave these fields blank

5	Select ALL Care Team Members on the current/most recent DOH 5055?	Provider Consented on DOH 5055 (*Select All that Apply*)	Provider Missing in Care Team (*FCM Record*)	Provider Needs to be Added to Consent Form (*Complete Last*)
Care Team / Provider List				
A	CMA Supervisor	Yes		
B	CMA Assigned Care Manager	Yes		

Figure 18. BHH Chart Review Tool [HHSA], Question (5) – Care Team Addition to DOH 5055 Excerpt

CR Action List

(7) Care Team Missing in Record: Update Care Team Section

Care Team Missing in Record: Update Care Team Section	Yes	
Dental Care | Dentist	Yes	

Figure 20. Action List, Action Item (7) Excerpt

Action Item:

- Update member record to reflect Care Team members listed on the DOH 5055

DOH 5234: Notice of Determination for Enrollment Form

(6) Is the DOH 5234 correctly completed and uploaded to the member record?

- Review uploaded documents in the Member Record, ***Documents***
- Confirm if the DOH 5234: Notice of Determination for Enrollment is uploaded and then download the file to review the contents of the form
- Question (6) provides a checklist of common issues found in prior review periods
- If an issue exists, Question (3) should be set to "No"

6	**Is the DOH 5234 correctly completed and uploaded to the member record?**	No

Checklist	**If NO, what issues are present?**	***Select***
A	Incorrect Health Home Name	Yes
B	Incorrect / Missing Fields	
C	Document Upload Description Unclear	
D	Form is Missing, Not Uploaded	

Figure 21. BHH Chart Review Tool [HHSA], Question (6) – 5234 Review Excerpt

- Review contents of DOH 5234 to determine if the following are evident:
  - **[A] | Incorrect Health Home Name**
    - ✓ Form indicates enrollment in Brooklyn Health Home, not CMA
  - **[B] | Incorrect / Missing Fields**
    - ✓ Dates, Medicaid ID
    - ✓ Health Home Name and contact information
    - ✓ Member details (name, address etc.)
    - ✓ Health Home staff signature (page 1)
  - **[C] | Document Upload Description Unclear**
    - ✓ Form label description is clear and upload location in Documents is correct
    - ✓ Form is easily accessible (*not located/hidden under different file name*)
  - **[D] | Form is Missing, Not Uploaded**
    - ✓ Form is uploaded to Documents in member record

CR Action List

(8) Documentation Error: Update DOH 5234

Documentation Error: Update DOH 5234	Yes	
Update Health Home Name to Brooklyn Health Home	Yes	
Add Missing Fields / Information		
Re-import and/or Re-name File Uploaded in Record		
Locate Previously Shared Form, Upload in Record		

Figure 22. Action List, Action Item (8) Excerpt

Action Item:

- Resolve reported issue via suggested Action Item
- Documentation changes (including document upload) should be supported via either a Supervisory Encounter or an appropriate addendum within the member chart

(7) Is there evidence to support the DOH 5234 was shared with the member?

- Review encounter details documented during initial enrollment period to determine if there is evidence to support that the member was provided a copy of the form
  - If missing from record, question response should indicate "No"

CR Action List

(9) Enrollment Notice Documentation Missing - Verify Activities

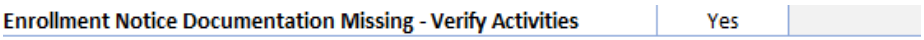


Figure 23. Action List, Action Item (9) Excerpt

Action Item:

- Review member record documentation (FCM/hard-copy) to determine if the member was provided a copy of the DOH 5234 during enrollment
  - If provided to member but not uploaded to member record in FCM, upload file and add Supervisory Encounter to support upload after initial enrollment period
  - If there is no evidence to support the form was completed and provided to the member, the *Resolved* field should remain *blank*

Verification of Eligibility Documents

(8) Are there Verification of Eligibility documents uploaded to the member record?

- Review ***Documents*** to determine if there is adequate evidence to support Health Home enrollment and billed services
- Documents should support member enrollment and be member-specific

CR Action List

(11) Eligibility Verification Documents Missing – ADD Documents

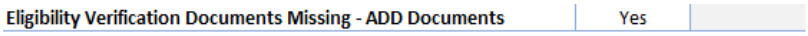


Figure 24. Action List, Action Item (11) Excerpt

Action Item:

- Collaborate with the member and/or Care Team to obtain required documents
- Upload required documents to Documents in member record

(9) Were there Verification of Eligibility documents uploaded within the 1st 90 days of enrollment?

- Review member record to determine if documents were uploaded to the member record Documents within the initial 3 months of Health Home enrollment
  - Uploaded Documents
  - Documented Encounter(s)

Enrollment Encounter

(10) Is there a complete Enrollment Encounter documented within the initial 30 days of enrollment?

- Review initial enrollment encounters (initial 60 days) and determine if enrollment Care Management activities were documented accurately and completely
- Review encounter details and determine if the following information is captured:
  - Member's Demographic Information
  - Referral Details
    - Referral Date
    - Referral Source
  - Location of Enrollment (i.e. residence, field, office etc.)
  - Member's Qualifying Conditions
  - Overview of Documents Completed, Signed, Provided to Member
  - Reason(s) for Enrollment (i.e. immediate needs, goals, long-term objectives)
    - Medical, Mental Health, Behavioral Health, Social Support Needed
  - Immediate Next Steps (i.e. initial action plan to address members immediate needs)

Initial Enrollment Reminders:

  - Health Home Contact Frequency Review
    - Identify preferred day(s), time(s), contact methods
    - Review if member would like to be scheduled for their next appointment
    - Review starting an appointment series to meet/communicate on a regular cadence – i.e. first Tuesday of every month
  - Contact Care Team members consented on the DOH 5055
    - Complete introductory call and inform provider about enrollment
    - Review opportunities for collaboration and
    - Request participation in development of members Plan of Care
    - Request current medical and/or non-medial documents (i.e. medical history, visit summary, lab results, SSI, SNAP Confirmations, Current Housing)

CR Action List

(12) Enrollment Encounter Missing – Verify Activities

Enrollment Encounter Missing - Verify Activities	Yes	

Figure 25. Action List, Action Item (12) Excerpt

Action Item:

- Review available member record documentation (FCM/hard-copy) to determine if there is evidence to support activities occurred but not documented accurately

Section 2 Comprehensive Assessment

Most Recent Assessment

(11) What is the current/most recently completed Comprehensive Assessment date?

- Enter date [*mm/dd/yyyy*] of the most recent Comprehensive Assessment **[5]**
  - Date displayed in **[5]** is the date the most recent Comprehensive Assessment was completed and locked or the (PDF) upload completion date

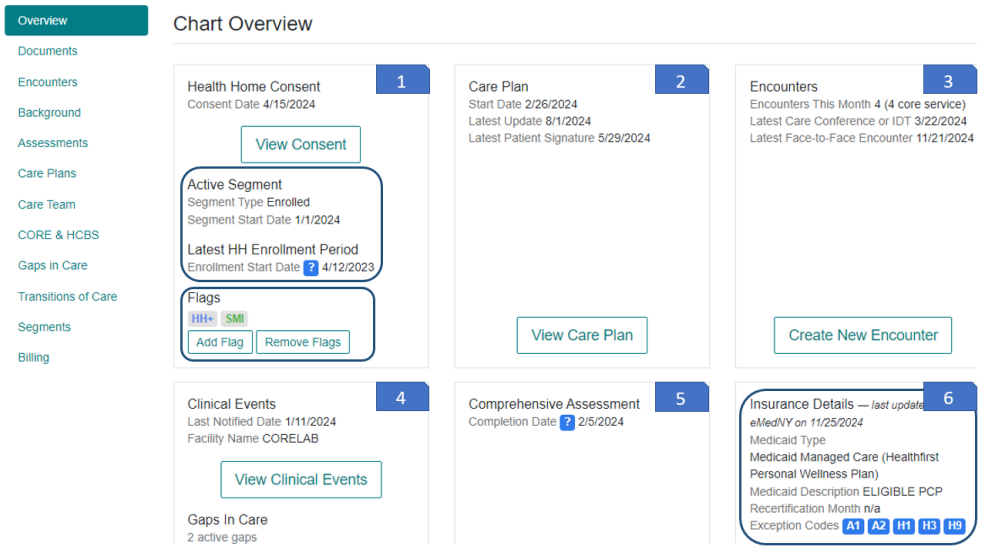


Figure 2. Member record *Overview*

- Comprehensive Assessment information can also be located via ***Assessments:***

Figure 26. Member record *Assessments*

CR Action List

(14) Comprehensive Assessment Missing: Complete Assessment

Comprehensive Assessment Missing: Complete Assessment	Yes	

Figure 27. Action List, Action Item (14) Excerpt

Action Item:

- Conduct Comprehensive Assessment via combination of in-person, virtual and telephonic
  - Contacting member's Care Team and/or requesting current medical and non-medical data/information prior to meeting member can help improve the accuracy and speed of the assessment documentation process.

Note: Action Item field is set to "Yes" value. Once date entered, action item removed

(12) Is the member's current/most recently completed Comprehensive Assessment expired (past due)?

- Review the most recent Comprehensive Assessment completion date
- Reviewer should determine if the most recent assessment was completed more than 12 months ago – this would make the current assessment expired
  - FCM's color indicators can be used to identify assessments coming due, overdue
  - Reviewers should examine history of assessment completion to verify activities
- If new Comprehensive Assessment is in-progress but not complete, the assessment is considered incomplete and Question (12) response is "No"
  - A "No" response will populate an Action Item in the members Action List

CR Action List

(15) Comprehensive Assessment Missing: Complete Re-Assessment

Comprehensive Assessment Missing: Complete Re-Assessment	Yes	

Figure 28. Action List, Action Item (15) Excerpt

Action Item:

- Conduct Comprehensive Assessment via combination of in-person, virtual and telephonic
  - Contacting member's Care Team and/or requesting current medical and non-medical data/information prior to meeting member can help improve the accuracy and speed of the assessment documentation process.

Assessment Summary

(13) Does the most recent Comprehensive Assessment Summary include ALL required elements?

- Review the contents of the most recent Comprehensive Assessment Summary
- Question (13) provides a checklist of information/details to be documented:

13	Does the most recent Comprehensive Assessment Summary include ALL required elements?		
Checklist	**Required Elements:**		
A	Member Demographics [i.e. Residence, Preferred Contact Method]		
B	Health Home Connection [i.e. Referral Details, Length of Enrollment]		
C	Health Home Eligibility		
D	Current Goals		
E	Current Healthcare Linkages		
F	Past Healthcare Linkages		
G	Non-Clinical Service Needs [i.e. SNAP, Income]		
H	Member Strengths, Barriers, Risk Factors		
I	Member Engagement [i.e. Engagement behavior, Health Literacy]		
J	Other	*Enter Text (if applicable)*	

Figure 29. BHH Chart Review Tool [HHSA], Question (13) – Summary Review Excerpt

- If all components are evident in the summary, Question (13) value is "Yes"
- If information is missing, limited or insufficient, Question (13) value is "No"

- A "No" value will populate/require the Reviewer to select all evident issues:

13	Does the most recent Comprehensive Assessment Summary include ALL required elements?		No
Checklist	**Required Elements:**		*Select IF Missing:*
A	Member Demographics [i.e. Residence, Preferred Contact Method]		
B	Health Home Connection [i.e. Referral Details, Length of Enrollment]		
C	Health Home Eligibility		
D	Current Goals		
E	Current Healthcare Linkages		
F	Past Healthcare Linkages		
G	Non-Clinical Service Needs [i.e. SNAP, Income]		
H	Member Strengths, Barriers, Risk Factors		
I	Member Engagement [i.e. Engagement behavior, Health Literacy]		
J	Other	*Enter Text (if applicable)*	

Figure 30. BHH Chart Review Tool [HHSA], Question (13) – Summary Issue Excerpt

- Reviewer should examine contents of the assessment summary and determine if the following information about the member is captured and clearly documented:
  - **[A] | Member Demographics** - i.e. housing, language and/or contact preferences
  - **[B] | Health Home Connection** - i.e. referral details
  - **[C] | Health Home Eligibility** - i.e. primary reason(s) why member is enrolled
  - **[D] | Current Goals** - i.e. goals the member want to achieve
  - **[E] | Current Healthcare Linkages** - i.e. providers member is currently connected to
  - **[F] | Past Healthcare Linkage** - i.e. past providers, disrupted services, or past attempts to help link member to provider(s)
  - **[G] | Non-Clinical Service Needs** - i.e. services the member is interested in receiving / will help the member's specific needs and/or goals
  - **[H] | Member Strengths, Barriers, Risk Factors** - i.e. supports strengths, barriers and risk factors identified in record
  - **[I] | Member Engagement** - i.e. current level of engagement, potential barriers
  - **[J] | Other (w/ free text)** - i.e. member specific details not captured]

CR Action List

(16) Summary Missing Information: Update in Next Assessment

Description	Action Item	Resolved
Summary Missing Information: Update in Next Assessment	Yes	
Add/Update: Member Demographics		
Add/Update: Health Home Connection	Yes	
Add/Update: Health Home Eligibility		
Add/Update: Current Goals		
Add/Update: Current Healthcare Linkages	Yes	
Add/Update: Past Healthcare Linkages		
Add/Update: Non-Clinical Service Needs	Yes	

Figure 31. Action List, Action Item (16) Excerpt

Action Item:

- Update existing assessment with missing information via an addendum OR
- Complete Re-Assessment

Identification of Member Needs + Goals

(14) Need + Goal Identification: Select ALL options where ≥ (1) Need or Goal is evident:

(A) Identified in Assessment Summary?

(B) Identified in Assessment Question?

(C) Documentation Issue?

- Question (14) is aiming for the Reviewer to select ALL *Need Categories* where there is at least (1) member specific need and/or goal in the most recent assessment
- Below is a list of ***Need Categories***:
  - Medical
    - Primary Care
    - HIV Care
    - Diabetes (i.e. Type I/II)
    - Cardiovascular Disease (i.e. Hypertension)
    - Respiratory Illness (i.e. Asthma)
    - High Utilizer [ER/Inpatient]
    - Medication Adherence
    - Appointment Navigation
    - Connection to Pharmacy
    - OBGYN
    - Cancer Screenings (i.e. Colonoscopy, Mammogram)
    - Vision
    - Dental
    - Podiatry
    - Vaccinations/Other Screenings
  - Mental Health:
    - Connection to Services [Therapist/Psychiatrist]
    - High Utilizer [ER/Inpatient]
    - Medication Adherence
    - Appointment Navigation
    - Other
  - Substance Use (i.e. drugs, alcohol, smoking cessation)
  - Housing
  - Income & Entitlements
  - Family / Social Support
  - Legal Services (i.e. advance directives, incarceration, immigration)
  - Activities of Daily Living (i.e. assistive devices)
  - Education
  - Health Literacy

- Employment
- Sexual Health
- Intimate Partner Violence
- Safety Planning
- Suicidal Ideation
- Violence/Homicidal Ideation
- Self-Neglect
- Other

14	Need + Goal Identification: Select ALL options where ≥ (1) Need or Goal is evident:	Identified in Assessment Summary:	Identified in Assessment Question:	Documentation Issue: *If Applicable*
Need Categories				
A	**Medical:** Primary Care			
B	**Medical:** HIV Care			
C	**Medical:** Diabetes (i.e. Type I/II)			
D	**Medical:** Cardiovascular Disease (i.e. Hypertension)			
E	**Medical:** Respiratory Illness (i.e. Asthma)			
F	**Medical:** High Utilizer [ER/Inpatient]			
G	**Medical:** Medication Adherence			
H	**Medical:** Appointment Navigation			
I	**Medical:** Connection to Pharmacy			
J	**Medical:** OBGYN			
K	**Medical:** Cancer Screenings (i.e. Colonoscopy, Mammogram)			
L	**Medical:** Vision			
M	**Medical:** Dental			
N	**Medical:** Podiatry			

Figure 32. BHH Chart Review Tool [HHSA], Question (14) – Need Identification Excerpt

Identified in Assessment Summary:

- Select "Yes" if the category is evident in the Comprehensive Assessment summary
  - A Need Category can contain more than (1) specific need or goal

Identified in Assessment Question:

- Select "Yes" if the category is evident in a Comprehensive Assessment question
- Need Categories should be selected if any of the below information is true:
  - Question response indicates a need/goal that can be addressed by Health Home Care Management activities
  - Question/sections corresponding to member's primary diagnoses are missing, limited or further follow-up is needed to answer
    - i.e. member is diagnosed with Hypertension and Diabetes but the assessment is missing lab results (BP, A1c etc.)
    - Care manager should follow-up with provider and/or member to obtain information/add to addendum
  - Status of review item/question is unknown and requires additional follow-up by the Care Manager to ascertain and confirm details
    - i.e. unknown/missing connection to a Dental care, HIV status is unknown (health literacy, testing recommended)

Note: Need Categories identified in both review areas should be selected. Identified needs are compiled and duplicate values are resolved in Section 4 Plan of Care. As a reminder, need/goals identified in Comprehensive Assessment questions should be expanded upon in the summary.

Documentation Issue:

- Select "Yes" if the Reviewer determines there is a documentation issue with the documented response and/or section in the Comprehensive Assessment

  Potential Issues:

  - Missing details – question response is unknown, missing/blank
  - Missing lab results – expected labs values are missing
  - Unknown Status – status of clinical or non-clinical item is missing
  - Inconsistent Info – conflicting details or suspected reporting errors
  - Other
- If no issue present, field can be left "blank"
- If the Reviewer identifies an issue that should be further examined and/or corrected, the Reviewer should select the issue from the available drop-down field(s)

+ Goal Identification: Select ALL options where ≥ (1) Need or Goal is evident: Need Categories		Identified in Assessment Summary:	Identified in Assessment Question:	Documentation Issue: *If Applicable*
A	**Medical:** Primary Care	Yes		Missing details
B	**Medical:** HIV Care		Yes	Unknown Status
C	**Medical:** Diabetes (i.e. Type I/II)	Yes		Missing lab results
D	**Medical:** Cardiovascular Disease (i.e. Hypertension)		Yes	

Figure 33. BHH Chart Review Tool [HHSA], Question (14) – Assessment Documentation Issue Excerpt

CR Action List

(17) Comprehensive Assessment Documentation Issues Indicated

Comprehensive Assessment Documentation Issues Indicated	Yes	
Medical: Primary Care - Missing Details	Yes	
Medical: HIV Care - Unknown Status	Yes	
Medical: Diabetes (i.e. Type I/II) - Missing Lab Results	Yes	

Figure 34. Action List, Action Item (17) Excerpt

Action Item:

- Need Category and Documentation Issue are combined in Action List Item
- Update existing assessment information via addendum or re-assessment

Section 3 | Encounter Documentation

Identification of Member Needs + Goals

(15) Need + Goal Identification: Select ALL options where ≥ (1) Need or Goal is evident:

(A) Identified in Encounter?

(B) Update Required in Next Assessment?

- Question (15) is aiming for the Reviewer to select ALL *Need Categories* where there is at least (1) member specific need and/or goal documented in an encounter.
  - Need Categories are the same as in Question (14)
- Need Categories selected in Question (14) will be highlighted.
- Reviewers should select all categories documented in the member record (encounters).

15	Need + Goal Identification: Select ALL options where ≥ (1) Need or Goal is evident:	Identified in an Encounter:	Update Required in Next Assessment
Need Categories			
A	**Medical:** Primary Care	Yes	Yes
B	**Medical:** HIV Care	Yes	
C	**Medical:** Diabetes (i.e. Type I/II)	Yes	Yes
D	**Medical:** Cardiovascular Disease (i.e. Hypertension)	Yes	
E	**Medical:** Respiratory Illness (i.e. Asthma)		
F	**Medical:** High Utilizer [ER/Inpatient]	Yes	Yes

Figure 35. BHH Chart Review Tool [HHSA], Question (15) – Encounter, Need Identification Excerpt

- Once a Need Category is selected, the Reviewer will be prompted/required to determine if the information is either missing from most recently completed comprehensive assessment or was identified after the most recent comprehensive assessment
- A "Yes" value should be selected if details regarding the Need Category should be added to the next Comprehensive Assessment in the member record
- If update is not required (information consistent throughout record), field left "blank"

CR Action List

(18) Need/Goal Identified in Encounters - Add to Next Assessment

Need/Goal Identified in Encounters - Add to Next Assessment	Yes	
Medical: Primary Care	Yes	
Medical: Diabetes (i.e. Type I/II)	Yes	
Medical: High Utilizer [ER/Inpatient]	Yes	

Figure 36. Action List, Action Item (18) Excerpt

Action Item:

- Document identified information regarding member need/goals in Re-assessment
  - Findings should be shared with Care Manager via supervision/1-on-1 and/or documented via supervisory encounter notes (*if applicable*)

Care Team Engagement

(16) Were Care Team Members contacted or included in the development of the Plan of Care?

- Review initial enrollment encounters to determine if the Care Manager collaborated with key primary Care Team members during the development of the members Plan of Care
- If collaboration did not occur in the development of the plan of care, field value is "No"
    - A "No" value will populate an Action Lit Item to further review collaboration

CR Action List

(33) Care Team NOT Involved I POC Development; Engage Care Team

Care Team NOT involved in POC Development; Engage Care Team	Yes	

Figure 37. Action List, Action Item (33) Excerpt

Action Item:

- Review current encounters to determine if there is evidence to support recent collaboration with consented Care Team members
    - Activities include Plan of Care development, updates, status changes
- Plan of Care should be updated based upon input and/or information from consented Care Team members involved in addressing the member's identified needs and goals

(17) In the past 12 months, did a (formal) Case Conference occur?

(A) Outcome/Next Steps Included in Encounter Note?

(B) Outcome/Next Steps Incorporated into the Plan of Care?

(C) Encounter(s) linked to Corresponding POC Elements?

17	In the past 12 months, did a (formal) Case Conference occur?	
	Case Conferences involve the Care Manager and 1 or more Care Team member. Encounter aims to (a) review member needs/goals, (b) coordinate services, (c) establish responsibilities for tasks to be completed	
A	Outcome/Next Steps Included in Encounter Note	
B	Outcome/Next Steps Incorporated into the Plan of Care	
C	Encounter(s) linked to Corresponding POC Elements	

Figure 38. BHH Chart Review Tool [HHSA], Question (17) – Case Conference Review Excerpt

- Review care management activities documented in encounters to determine if the Care Manager and/or Care Management Team (Care Manager, Supervisor) conducted a case conference with consented Care Team members to address (1) or more member needs
- If no evidence of a Case Conference in the past 12 months, field value is "No"
    - A "No" value will populate Action List Items to review and complete activity and document in record via (A), (B) and (C)

- If there is evidence of Case Conference in the past 12 months, field value is "Yes"
    - A "Yes" value will populate/require (A), (B) and (C) which examines if the outcome of the Case Conference was documented in the member record

17	In the past 12 months, did a (formal) Case Conference occur?	Yes
	Case Conferences involve the Care Manager and 1 or more Care Team member. Encounter aims to (a) review member needs/goals, (b) coordinate services, (c) establish responsibilities for tasks to be completed	
	If Yes, indicate if steps were completed?	*Select*
A	Outcome/Next Steps Included in Encounter Note	
B	Outcome/Next Steps Incorporated into the Plan of Care	
C	Encounter(s) linked to Corresponding POC Elements	

Figure 39. BHH Chart Review Tool [HHSA], Question (17) – Case Conference ("Yes") Review Excerpt

- The Reviewer should indicate if documentation is consistent throughout record and the outcome/next steps of the Case Conference is documented via a linked encounter note to the member's plan of care
    - Plan of Care tasks may be assigned to the Member, Care Manager or Care Team
- If value is "Yes", Action List Items are populated for (A), (B) and (C)
    - If marked complete ("Yes"), items will be updated/removed from the Action List

CR Action List

(34) No Formal Case Conference - Schedule and Complete Meeting

No Formal Case Conference - Schedule and Complete Meeting	Yes	
Add Outcome/Next Steps to Encounter Note	Yes	
Add Outcome/Next Steps to Plan of Care	Yes	
Link Encounter(s) to Corresponding POC Elements	Yes	

Figure 40. Action List, Action Item (34) Excerpt

Action Item:

- Contact Care Team members involved in addressing member identified needs and goals and request, complete and document outcome.
- Activities include, but are not limited to:
    - Review of emerging, existing member needs and goals
    - Plan of Care development and delegation of responsibilities/tasks
    - Future collaboration practices

(18) In the past 6 months, did the Care Manager collaborate with Care Team Members?

- Review the past 6 months of encounters to determine if the Care Manager collaborated with consented Care Team members to address (1) or more member needs
    - Activities include, but are not limited to: discussion with Care Team about appointment adherence, medication usage/access, service coordination (referrals)
    - A "No" value should be selected if no contact occurred or if there is only supportive care management services documented (i.e. speaking with medical office staff to confirm if member attended appointment; scheduling upcoming appointments)

(19) Is there evidence of PHI and/or member information sharing with a non-consented entity?

19	Is there evidence of PHI and/or member information sharing with an non-consented entity?	
A		
B		
C		

Figure 41. BHH Chart Review Tool [HHSA], Question (19) – Invalid PHI Sharing Review Excerpt

- Review member record documentation to determine if there is evidence of communication and/or data/information sharing with a entity (healthcare/non-healthcare) not currently consented on the DOH 5055
    - If there is evidence, Question (19) field value is "Yes"

19	Is there evidence of PHI and/or member information sharing with a non-consented entity?	Yes
	If Yes, indicate which providers/entities need to be added to the DOH 5055:	
A	Primary Care Provider (PCP)	
B		
C		

Figure 42. BHH Chart Review Tool [HHSA], Question (19) – Invalid PHI Sharing ("Yes") Review Excerpt

- A "Yes" value will prompt/require the Reviewer to specify the entity missing
    - If missing, Reviewers can select entity from available options via drop-down field(s)
    - Each selection will populate an Action List Item

CR Action List

(6) Invalid PHI Sharing [Priority]: Consent Update Required

Invalid PHI Sharing [Priority]: Consent Update Required	Yes	
Primary Care Provider (PCP)	Yes	

Figure 43. Action List, Action Item (6) Excerpt

Action Item:

- Review missing providers with member and make appropriate corrections
- Based upon the Reviewer's findings, a new DOH 5055 may be required

Note: Brooklyn Health Home compliance staff should be contacted if there is evidence of data/information sharing with an entity not consented via Health Home consent form(s).

Section 4 | Plan of Care

Active Plan of Care Review

(20) What is the current/most recent Plan of Care start date?

- Enter start date [*mm/dd/yyyy*] for the current Plan of Care **[2]**
  - Date(s) displayed in **[2]** include: Start Date (Creation Date), Latest Update (date of most recent update) and Latest Patient Signature

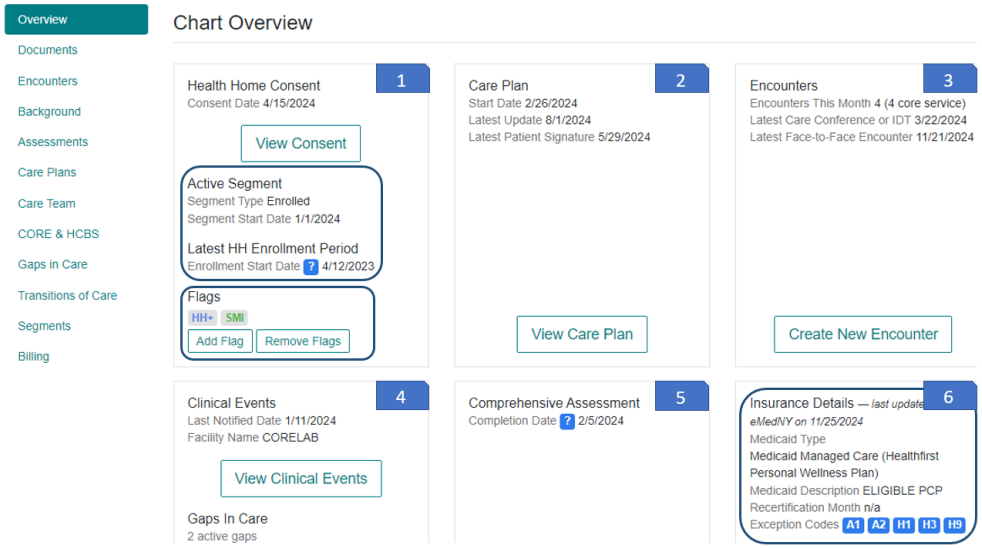


Figure 2. Member record *Overview*

- Plan of Care information can also be located via ***Care Plans:***

Figure 44. Member record *Care Plans*

CR Action List

(19) Plan of Care Missing: Develop New Plan of Care

Description	Action Item	Resolved
Plan of Care Missing: Develop New Plan of Care	Yes	

Figure 45. Action List, Action Item (19) Excerpt

Action Item:

- Create new Plan of Care based upon member specified needs/goals and from input/feedback from consented Care Team members

Note: Action Item field is set to "Yes" value. Once date entered, action item removed

(21) Has the Plan of Care been signed by the member within the past 6 months of active enrollment?

- Review the most recent/current Plan of Care and determine if the member signed the Plan of Care in the past 6 months of enrollment
- Historical signed plan of care version(s) can be accessed by selecting **"Info"** (*top right*)

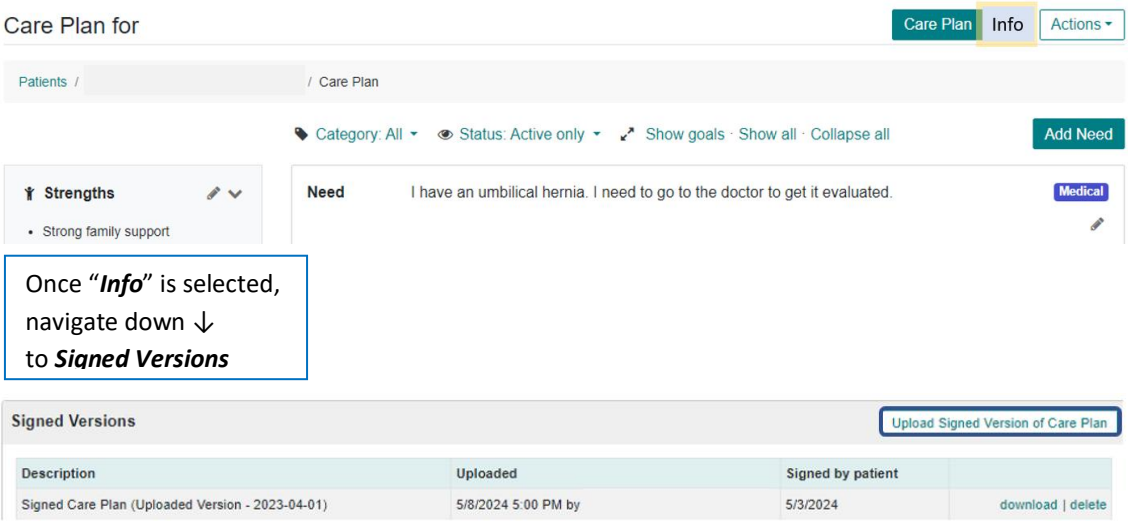


Figure 46. Member Care Plan Information

- Reviewers should download the signed plan of care version to verify member signatures and/or the quality/accessibility of the file uploaded
- Plan of Care signatures can also be obtained via e-signature:

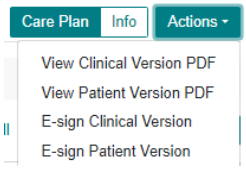


Figure 47. Plan of Care Actions, E-Sign Functionality

CR Action List

(20) No Plan of Care Signature in Past 6 Months: Obtain Signature

No Plan of Care Signature in Past 6 Months: Obtain Signature	Yes	
Review and Update Plan of Care; Obtain New Member Signature		

Figure 48. Action List, Action Item (20) Excerpt

Action Item:

- Identify member needs and goals; translate to Plan of Care elements
- Discuss and/or collaborate with Care Team providers
- Review developed Plan of Care product with member
- Upon member agreement, complete required signature fields
  - E-sign Care Plan
  - Wet Signature via paper/hard-copy version – PDF upload

(22) Below are ALL Need Categories selected in the previous review sections. Selected categories may ≥ 1 need/goal. Select the current status of each category in the member's Plan of Care. Status will determine if category populates in the below review sections.

(A) Status

(B) ≥ 1 Need or Goal Missing from Plan of Care

(C) If Missing from Plan of Care, Have CM Activities been Completed to Address Needs/Goals

22		**Below are ALL Need Categories selected in the previous review sections.** *Selected categories may ≥ 1 need/goal.* **Select the current status of each category in the member's Plan of Care.** *Status will determine if category populates in the below review sections.*	**Status**
	A	Medical: Primary Care	
	B	Medical: Cancer Screenings (i.e. Colonoscopy, Mammogram)	
	C	Mental Health: Medication Adherence	

Figure 49. BHH Chart Review Tool [HHSA], Question (22) – Plan of Care Need/Goal Status Review Excerpt

- Identified Need Categories from the review of the most recently completed Comprehensive Assessment and documented Encounters populate in Question (22)
- **(A) Status** - determine if need(s) and/or goal(s) previously identified are active/included in the member's plan of care
    - **Status Options:**
        - Active
        - Addressed
        - Self-Managed
        - Care Team Managed
        - Deferred
        - Declined
        - Abandoned
        - Missing
    - Active, Addressed, Self-Managed, Care Team Managed, Deferred selections will populate in Questions (23), (24) and (25) and require (B)

22		**Below are ALL Need Categories selected in the previous review sections.** *Selected categories may ≥ 1 need/goal.* **Select the current status of each category in the member's Plan of Care.** *Status will determine if category populates in the below review sections.*	**Status**	**≥ (1) Need or Goal Missing from POC**	**IF MISSING from POC,** Have CM Activities been Completed to Address Needs/Goals
	A	Medical: Primary Care	Active		
	B	Medical: Cancer Screenings (i.e. Colonoscopy, Mammogram)	Declined		
	C	Mental Health: Medication Adherence	Missing		

Figure 50. BHH Chart Review Tool [HHSA], Question (22) – Plan of Care Review Excerpt

- **(B) ≥ 1 Need or Goal Missing from Plan of Care** – populates/is required if the Plan of Care does not address ALL needs and/or goals in the Need Category selected
- **(C) If Missing from Plan of Care, Have CM Activities been Completed to Address Needs/Goals** – populates/is required if Need Category is "*Missing*"

22	Below are ALL Need Categories selected in the previous review sections. *Selected categories may ≥ 1 need/goal.* Select the current status of each category in the member's Plan of Care. *Status will determine if category populates in the below review sections.*		Status	≥ (1) Need or Goal Missing from POC	IF MISSING from POC, Have CM Activities been Completed to Address Needs/Goals
	A	Medical: Primary Care	Addressed	Yes	
	B	Medical: Diabetes (i.e. Type I/II)	Missing		No
	C	Medical: High Utilizer [ER/Inpatient]	Active		
	D	Medical: Dental	Self-Managed	Yes	

Figure 51. BHH Chart Review Tool [HHSA], Question (22) – Plan of Care Issues Excerpt

CR Action List

(21) One (1) or More Need / Goal Missing from Plan of Care

(1) or More Need / Goal Missing from Plan of Care	Yes	
Medical: Primary Care	Yes	
Medical: Dental	Yes	

Figure 52. Action List, Action Item (21) Excerpt

Action Item:

- Identify member needs and goals; translate to Plan of Care elements
- Engage member an initiate care management services to address need(s) and/or goal(s)
- Review inclusion of missing member need(s) and/or goal(s) in Plan of Care

(28) Missing from Plan of Care; No Care Management Activities

Missing from Plan of Care; No Care Management Activities	Yes	
Medical: Diabetes (i.e. Type I/II)	Yes	

Figure 53. Action List, Action Item (28) Excerpt

Action Item:

- Identify missing member need(s) and/or goal(s) that have not been addressed
- Engage member an initiate care management services to address need(s) and/or goal(s)
- Review inclusion of missing member need(s) and/or goal(s) in Plan of Care

(23) Plan of Care – POC Contents Review:

(A) ALL Documented Needs are Accurately Defined *What is the Need? Why is it a Need?*

(B) ALL Documented Needs have Person-Centered Language *"I Statement", "Member"*

(C) ALL Goals/Tasks Documented Follow S.M.A.R.T Framework *"Specific, Measurable, Achievable, Relevant, Time-bound"*

23	Below is a List of ALL Identified/Active Needs (*from above*):	Plan of Care Contents Review		
		ALL Documented Needs are Accurately Defined *What is the Need? Why is it a Need?*	ALL Documented Needs have Person-Centered Language *"I Statement", "Member"*	ALL Goals/Tasks Documented Follow S.M.A.R.T Framework *"Specific, Measurable, Achievable, Relevant, Time-bound"*
	Identified Needs			
A	Medical: Primary Care			
B	Medical: High Utilizer [ER/Inpatient]			
C	Medical: Dental			

Figure 54. BHH Chart Review Tool [HHSA], Question (23) – Plan of Care Contents Review Excerpt

- This section reviews the contents of the existing Plan of Care and aims to determine if the Plan of Care captures the Needs and/or Goals identified in the member record
- Review the contents of the current Plan of Care and review the (3) components:
  - **(A) ALL Documented Needs are <u>Accurately Defined</u>**
    - Need should be clearly defined and provide the reader with information about the need being addressed
    - What need is being addressed?
    - Why is this need being addressed? (or what is the goal/achievement)
  - **(B) ALL Documented Needs have <u>Person-Centered Language</u>**
    - Language should be written in the member voice
    - Examples may include utilization of "I statements"
    - Language should indicate what need the member has chosen to address
  - **(C) ALL Goals/Tasks Documented Follow <u>S.M.A.R.T Framework</u>**
    - Specific, Measurable, Achievable, Relevant, Time-bound
    - Reviewers should determine if documented goals and tasks are appropriate for the member (member choice, stage of change etc.)
    - Goals and tasks should aim to address need over time and should be tailored to the member and their current health literacy and ability to navigate the healthcare and non-healthcare system
    - In most instances, smaller tasks and goals may be required
- A "Yes" or "No response is required for each Need Category / (*cells will be highlighted*)
- "No" values will populate and Action List Item in the corresponding chart review results

23	Below is a List of ALL Identified/Active Needs (*from above*):	Plan of Care Contents Review		
		ALL Documented Needs are Accurately Defined *What is the Need? Why is it a Need?*	ALL Documented Needs have Person-Centered Language *"I Statement", "Member"*	ALL Goals/Tasks Documented Follow S.M.A.R.T Framework *"Specific, Measurable, Achievable, Relevant, Time-bound"*
	Identified Needs			
A	Medical: Primary Care	No		
B	Medical: High Utilizer [ER/Inpatient]			No
C	Medical: Dental		No	

Figure 55. BHH Chart Review Tool [HHSA], Question (23) – Plan of Care Content Issues Excerpt

CR Action List

(22) Plan of Care Need(s)/Goal(s): Update Need Definition

Plan of Care Need(s)/Goal(s): Update Need Definition	Yes	
Medical: Primary Care	Yes	

Figure 56. Action List, Action Item (22) Excerpt

(23) Plan of Care Need(s)/Goal(s): Update Person-Centered Language

Plan of Care Need(s)/Goal(s): Update Person-Centered Language	Yes	
Medical: Dental	Yes	

Figure 57. Action List, Action Item (23) Excerpt

(24) Plan of Care Need(s)/Goal(s): Update SMART Framework

Plan of Care Need(s)/Goal(s): Update SMART Framework	Yes	
Medical: High Utilizer [ER/Inpatient]	Yes	

Figure 58. Action List, Action Item (24) Excerpt

Action Item:

- Identify, review and incorporate recommended updates into the existing Plan of Care
  - Member collaboration is pivotal to this process
  - If applicable, Care Team members should be contacted to further collaborate
- Review and obtain member signature after Plan of Care changes are made
  - Corresponding encounter(s) should contain information about updates/changes and member involvement (discussion, feedback, recommendations, signatures etc.)
  - If member declines, information should be details in encounter(s)

(24) Plan of Care - Care Coordination Activities Review:

(A) Connectivity: Member is Connected to Provider(s) or Service(s) that can Address Identified Needs

(B) Intensity (Prior 6 Mo): Care Management Activities have been Completed to Address Identified Needs

(C) Intensity (Prior 6 Mo): Plan of Care Progress has been Achieved *Tasks/Goals completed*

- This section reviews care coordination activities documented in the member record
- The Reviewer should evaluate and identify instances where the member would benefit from enhanced, increased and/or alternative service delivery
    - Goal is to help Care Manager direct efforts/focus to address member needs via increased intensity of care management services

24	Below is a List of ALL Identified/Active Needs (*from above*):	Care Coordination Activities Review		
		Connectivity Member is Connected to Provider(s) or Service(s) that can Address Identified Needs	**Intensity (Prior 6 Mo)** Care Management Activities have been Completed to Address Identified Needs	**Intensity (Prior 6 Mo):** Plan of Care Progress has been Achieved *•Tasks/Goals completed*
Identified Needs				
A	Medical: Primary Care			
B	Medical: High Utilizer [ER/Inpatient]			
C	Medical: Dental			

Figure 59. BHH Chart Review Tool [HHSA], Question (24) – Care Coordination Activities Review Excerpt

- The Reviewer is responsible for determining:
    - **(A) Connectivity: Member is Connected to Provider(s) or Service(s) that can Address Identified Needs**
        - Need(s) and/or goal(s) are addressed and/or will be address by a provider and/or Care Team entity
        - Response values are: “Yes”, “No”
        - A “No” value will populate Action List Items
    - **(B) Intensity (*Prior 6 Mo*): Care Management Activities have been Completed to Address Identified Needs**
        - Activities designed to address identified need(s) and/or goal(s) have been recently completed (in the past 6 months of service)
        - Response values are: 0 – NONE, 1 – LIMITED, 2 – MODERATE, 3 – HIGH
        - 0 – NONE, 1 – LIMITED values will populate Action List Items
    - **(C) Intensity (*Prior 6 Mo*): Plan of Care Progress has been Achieve**
        - Activities designed to address identified need(s) and/or goal(s) have been recently completed (in the past 6 months of service) AND have been marked as complete in the Plan of Care
        - Response values are: 0 – NONE, 1 – LIMITED, 2 – MODERATE, 3 – HIGH
        - 0 – NONE, 1 – LIMITED values will populate Action List Items

24	Below is a List of ALL Identified/Active Needs (*from above*):	Care Coordination Activities Review		
		Connectivity Member is Connected to Provider(s) or Service(s) that can Address Identified Needs	**Intensity (Prior 6 Mo)** Care Management Activities have been Completed to Address Identified Needs	**Intensity (Prior 6 Mo):** Plan of Care Progress has been Achieved *•Tasks/Goals completed*
Identified Needs				
A	Medical: Primary Care	No		
B	Medical: High Utilizer [ER/Inpatient]		1 - LIMITED	
C	Medical: Dental			1 - LIMITED

Figure 60. BHH Chart Review Tool [HHSA], Question (24) – Care Coordination Activities Result Excerpt

- Progress and intensity will vary by member and their unique need(s) and/or goal(s)
- Reviewers should consider unique characteristics of the member chart when determining if the intensity of services is appropriate to address the identified need(s) and/or goal(s)
    - i.e. member choice, engagement level, need/goal priority, external barriers

CR Action List

(25) Plan of Care Activity: NOT Connected to Service/Provider:

Plan of Care Activity: NOT Connected to Service/Provider:	Yes	
Medical: Primary Care	Yes	

Figure 61. Action List, Action Item (25) Excerpt

(29) Limited CM Activities (Prior 6 Mo): ↑ Interventions/CM Activities

Limited CM Activities (Prior 6 Mo): ↑ Interventions/CM Activities	Yes	
Medical: High Utilizer [ER/Inpatient]	Yes	

Figure 62. Action List, Action Item (29) Excerpt

(30) Limited POC Progress (Prior 6 Mo): ↑ Interventions/CM Activities

Limited POC Progress (Prior 6 Mo): ↑ Interventions/CM Activities	Yes	
Medical: Dental	Yes	

Figure 63. Action List, Action Item (30) Excerpt

Action Item:

- Review provider and/or service connection(s)
    - Assist member navigate system and/or complete referral process
    - Care Team members should be contacted to further collaborate
- Re-address identified need(s) and/or goal(s) to increase activities performed
- Review current status of Plan of Care goals and/or tasks and update accordingly

(25) Plan of Care - Engagement Review:

(A) Frequency: Contact w/ Care Team Members to Review or Discuss Member Needs/Goals

(B) Frequency: Contact w/ Member to Review or Discuss Needs/Goals

- This section reviews care coordination activities, specifically collaboration and communication with the Member and the member's consented Care Team members in relation to each identified Need Category
- The Reviewer should evaluate and identify instances where the member would benefit from enhanced, increased and/or alternative service delivery
    - Goal is to help Care Manager direct efforts/focus to address member needs via increased frequency of engagement with member and care team
- The Reviewer is responsible for determining the frequency with **(A)** the Care Team and **(B)** the member regarding the identified Need Category (needs/goals)
    - Review of communication and/or collaborative efforts in the past 6 months
    - Response values are: 0 – Never, 1 – Very Rarely, 2 – Rarely, 3 – Occasionally, 4 – Frequently, 5 – Very Frequent
        - 0 – Never, 1 – Very Rarely, 2 – Rarely values will populate Action List Items

25	Below is a List of ALL Identified/Active Needs (*from above*):	Engagement Review	
		Frequency Contact w/ Care Team Members to Review or Discuss Member Needs/Goals	**Frequency** Contact w/ Member to Review or Discuss Needs/Goals
Identified Needs			
A	Medical: Primary Care	0 - Never	0 - Never
B	Medical: High Utilizer [ER/Inpatient]	1 - Very Rarely	1 - Very Rarely
C	Medical: Dental	2 - Rarely	3 - Occasionally

Figure 64. BHH Chart Review Tool [HHSA], Question (25) – Engagement Review Results Excerpt

CR Action List

(31) Limited Engagement w/ Care Team Regarding Need/Goal:

(32) Limited Engagement w/ Member Regarding Need/Goal:

Limited Engagement w/ Care Team Regarding Need/Goal:	Yes	
Medical: Primary Care	Yes	
Medical: High Utilizer [ER/Inpatient]	Yes	
Medical: Dental	Yes	
Limited Engagement w/ Member Regarding Need/Goal:	Yes	
Medical: Primary Care	Yes	
Medical: High Utilizer [ER/Inpatient]	Yes	

Figure 62. Action List, Action Item (31), (32) Excerpt

Action Item:

- Review member and Care Team engagement frequency and/or preferences and document outcome/next steps in encounter(s)
- Increase frequency of member engagement/contact to address need(s) and/or goal(s)
- Re-address identified need(s) and/or goal(s) to increase activities performed

Section 5 | Member Connectivity & Eligibility Review

Annual Wellness Care Check

(26) Based upon available data/information, please evaluate the member's connection to the following providers/services:

(A) Linked to a Provider

(B) Documented Visit w/ Provider in Last Year

- **Medical: Primary Care, Dental Care, Vision Care, Podiatry**

- This section should be completed at the conclusion of the Chart Review
- The Reviewer is to determine if the member is connected to each of the listed providers
- The Reviewer will determine if the member visited each provider within the review year
  - If member declined, select "Member Declined"
  - A "No" value will populate an Action List Item

26	Based upon available data/information, please evaluate the member's connection to the following providers/services: *Determine if the member is currently connected to the provider* *Determine if the member has been seen by the provider within the past 12 months*	*Linked to a Provider*	*Documented Visit w/ Provider in Last Year*
A	**Medical:** Primary Care	No	
B	**Medical:** Dental Care	Yes	No
C	**Medical:** Vision Care	Yes	Yes
D	**Medical:** Podiatry	N/A	

Figure 65. BHH Chart Review Tool [HHSA], Question (26) – Wellness Provider Check Excerpt

CR Action List

(26) Wellness Provider Linkage: Service/Provider Connection Missing

Wellness Provider Linkage: Service/Provider Connection Missing	Yes	
Medical: Primary Care	Yes	

Figure 66. Action List, Action Item (26) Excerpt

(27) Wellness Provider Linkage: No Annual Visit Completed

Wellness Provider Linkage: No Annual Visit Completed	Yes	
Medical: Primary Care		
Medical: Dental Care	Yes	

Figure 67. Action List, Action Item (27) Excerpt

Action Item:

- Review provider connection with member
  - If interested, assist member connect to provider and validate connection/referral
  - Document outcome and/or member interest, as well as plan of care update(s) in corresponding encounters

Continued Eligibility Review

(27) Based upon your review, does the member currently meet eligibility criteria for the Health Home program?

- This question should be completed at the conclusion of the Chart Review
- The Reviewer should determine if there is sufficient evidence to support and/or sustain Health Home enrollment
  - Chronic Health Condition(s)
  - Appropriateness Criteria
  - Insurance Status
- If the Reviewer determines that the member does not qualify for the Health Home program, field value selected will be "No"
  - A "No" response will create an Action List Item
  - Member record/case should be presented to assigned Care Manager and Supervisor and a review of findings should occur
  - If it is determined that the member case should be closed, the CMA is expected to complete all required disenrollment processes and procedures as outlined in the BHH Policy & Procedures

CR Action List

(13) Program Eligibility Flagged - Review Health Home Appropriateness

Program Eligibility Flagged - Review Health Home Appropriateness	Yes	

Figure 68. Action List, Action Item (13) Excerpt

Action Item:

- Review chart review results and findings with current CMA Care Manager, Supervisor
- Conduct internal review and/or QA/QI processes
- If determination is made to close member case, continue to follow all disenrollment requirements as outlined in policy
- If determination is made to keep case open, corresponding encounter(s) should be documented which provide justification for continued enrollment

III. Sub-Chart Review Tools

CR | CEN Follow-Up

CR | CEN Follow-Up is a sub-chart review tool built into the **BHH Chart Review Tool [HHSA]**.

Purpose: Examine care management activities documented following a member discharge.

- Reviewers will evaluate the (2) most recent discharge events.
  - Events should be distinct from each other.
- Reviewers will identify discharges events based upon data source: ***Healthix*** Clinical Alerts.

Review Steps:

1. Identify the (2) most recent discharge events
   - ***a. Clinical Events***

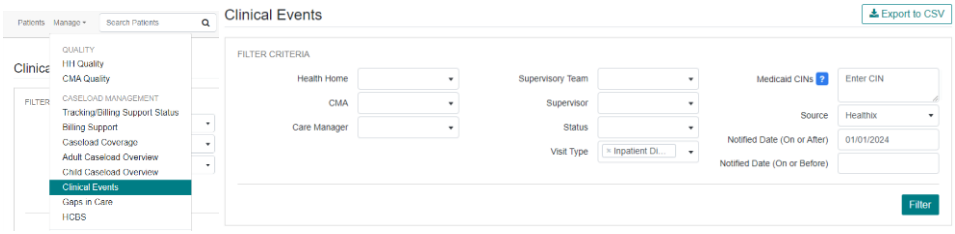


Figure 69. FCM, *Clinical Events*

   - ***b. Member Record, Transitions of Care***

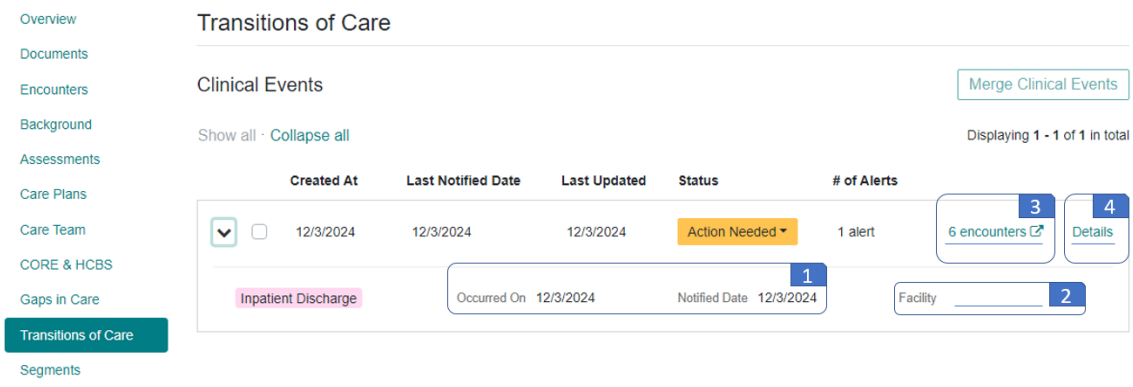


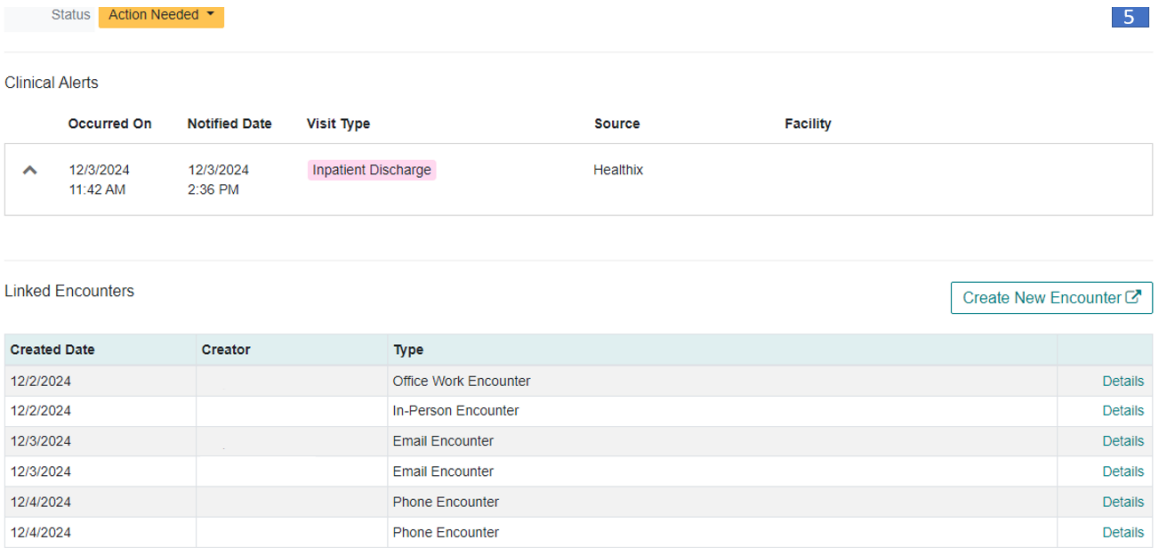
Figure 70. FCM Member Record, *Transitions of Care*

1. Dates [discharge date], [notification date] associated with event **[1]**

2. Facility where member was discharged **[2]**
   a. Additional facility information may be located via **[4]**

3. Total number of linked encounters for discharge event
   a. Selecting **[3]** will navigate Reviewer to all linked encounters

4. Details link that navigates the Reviewer to the corresponding Clinical Event Details **[5]**
    a. Additional Facility Information
    b. **Observation**s – details/data pertaining to event
    c. **Linked Encounter Summary** (**Note:** *Details* link will navigate to selected Encounter)
    d. **Status** selection (**Note:** Status can also be updated from Transitions of Care)



Note: ***Create New Encounter*** method will auto-select the corresponding Clinical Event.

Status Options:

- *Action Needed*
- *In-Progress*
- *Care Provided*
- *No Action Needed*
- *Member Refused*

Note: Default Status is "Action Needed"

2. Enter **Reviewer Details**
    a. Reviewing Entity
    b. Reviewer Name
    c. Review Date

3. Enter **Discharge Event Details**
    a. Discharge Date
    b. Facility

4. Complete review of documented care management activities:

Initial Response
Initial 48 Hours: ○ Encounter Note Acknowledging Receipt of Discharge Alert ○ Contact Attempt w/ Member Documented ○ Successful Contact w/ Member Documented ○ Contact Attempt w/ Facility Documented ○ Successful Contact w/ Facility Documented

Note: Selections should be based upon activities following discharge and/or notification date

Care Coordination Activities
Discharge Plan: ○ CM Team was involved in discharge planning prior to discharge ○ CM Team received and uploaded copy of Discharge Paperwork ○ Care coordination activities completed post discharge ***7Day/30 Day:*** ○ Member connected to Medical/Mental Health Services

Note: The 7 day and 30 day question aims to examine if the member was seen by provider(s) following discharge event.

CEN F/U Documentation
CEN Event Details: ○ Status Updated ○ Linked Encounters Documented ○ Alerts Merged Successfully ○ Encounter and Plan of Care Tasks Linked

Additional Information:

- If there is evidence of a care management activity documented in the member record, a "Yes" value should be selected for the corresponding question
- Reviewer Details and Discharge Details are incorporated into the scoring and are required
- 7/Day/30Day provider follow-up is incorporated into the scoring based upon completion
- Results are visible in the CR | Summary tab

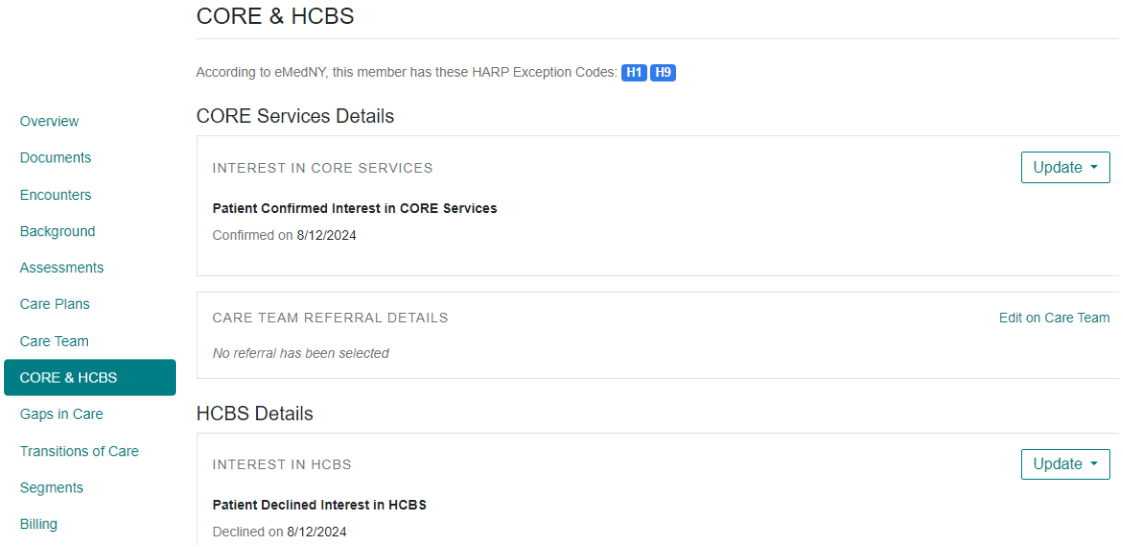
CR | CORE_HCBS

CR | CORE_HCBS is a sub-chart review tool built into the **BHH Chart Review Tool [HHSA]**.

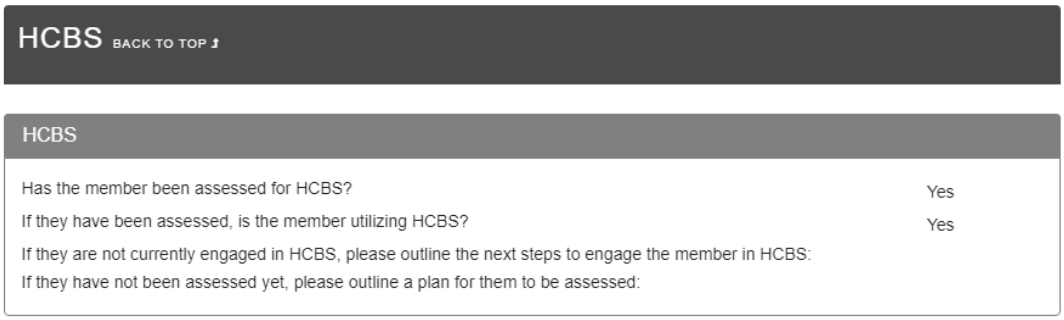
Purpose: Examine care management activities documented pertaining to the HCBS and CORE processes among identified HARP members.

Review Steps:

1. Review documented HARP (HCBS & CORE) documentation in the member record:
    a. Member Record, CORE & HCBS



    b. Most Recent Comprehensive Assessment



2. Complete review of documented care management activities:

Member Education
○ **Educated about HCBS/CORE** • Evidence of education via documented encounters ○ **HCBS/CORE Services Reviewed within the Last Year** • Evidence of service package via documented encounters ○ **HCBS/CORE Interest Documented in the HARP Tab**

HCBS
Current or Past Interest in HCBS (*Yes/No*) **If Yes:** ○ Is there a NYS Eligibility Assessment in Record? ○ Is there evidence of past or current HCBS services being provided? **If Yes:** ○ Has the NYS Eligibility Assessment been Completed Annually? ○ Has the POC been shared with the Members MCP? ○ Is there a Level of Service Determination (LOSD) in record? ○ HCBS Service – select primary service

CORE
Current or Past Interest in CORE (*Yes/No*) **If Yes:** ○ Has a Referral been made to CORE? ○ Is the evidence of past or current CORE services being provided? ○ HCBS Service – select primary service

Additional Information:

- Results are visible in the CR | Summary tab
- If data is documented in the member record but not reflected in the CORE & HCBS tab, documentation is incomplete
    - Information should be evident and consistent throughout entire member record

CR | Disenrollment

CR |Disenrollment is a sub-chart review tool built into the **BHH Chart Review Tool [HHSA]**.

Purpose: Examine care management activities documented pertaining to case closure requirements.

Review Steps:

1. Review documentation in the member record to determine completion of disenrollment activities:
    a. Member Record, Documents
    b. Member Record, Encounters
    c. Member Record, Plan of Care
    d. Member Record, Segments

2. Complete review to determine evidence of the following disenrollment care management activities:

Disenrollment Activities

○ End Date
○ End Reason Code
○ End Reason Code Description
○ **Encounters:**
  ○ Discharge Encounter in member record
  ○ CM collaborated with Care Team during process
○ **Plan of Care:**
  ○ Status of goals, tasks and needs updated
  ○ Discharge and/or safety plan added/updated
○ **DOH 5235:**
  ○ Successfully Uploaded to Member Record
  ○ Contains the name of the Health Home (BHH)
  ○ Issued a minimum of 10 days prior to (involuntarily) disenrollment
○ **Member Notice:**
  ○ Disenrollment letter on agency letterhead in record
  ○ Evidence that letter was provided to member
○ **Segment Closure:**
  ○ End Date Reason Code matches reason for disenrollment
○ **CEST Outcome:**
  ○ Member was disenrolled due to CES Tool
  ○ CES Tool outcome documented in member encounter(s)

Note: "Yes" value used IF there is evidence of an activity, document and/or workflow being completed.

CR | Diligent Search

CR |Diligent Search is a sub-chart review tool built into the **BHH Chart Review Tool [HHSA]**.

Purpose: Examine recent diligent search activities documented in the member record.

Review Steps:

1. Review documentation in the member record to determine most recent P, DS segment timeframes:
    a. Member Record, Segments

2. Review completed diligent search care management activities documented prior to, during and after the most recent P, DS segment timeframe:
    a. Member Record, Encounters
    b. Member Record, Documents
    c. Member Record, Plan of Care

3. Complete review to determine evidence of the following disenrollment care management activities:

Diligent Search Activities
○ DS Segment Start Date ○ **Month 1:** ○ Encounters indicate member is considered to be disengaged ○ CM initiated and documented Diligent Search Efforts ○ ≥ 3 progressive engagement attempts documented ○ **Month 2:** ○ > 1 month of Diligent Search was performed ○ Additional progressive engagements attempts were documented ○ **Outcome:** ○ Member was located via Diligent Search Efforts ○ Member was successful re-engaged and enrolled ○ CM completed all steps of the re-engagement process ○ **Documentation:** ○ CM completed all steps of the disenrollment process ○ Appropriate segment end date reason code used

Note: if member was re-engaged and is still enrolled, disenrollment questions should be set to "N/A.