Care Management User Guide

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Brooklyn Health Home

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

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

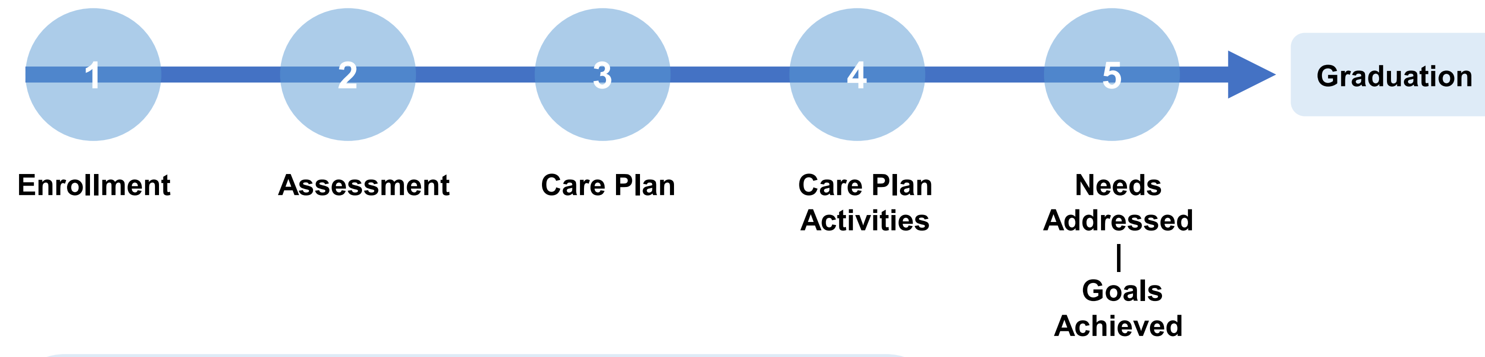
Care Managers:

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

Key Assistance

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

Enrollment Path



Encounters are activities/interventions driving care toward goals

Care Plans are the road map

Assessments are tools

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

Basic Points

Conduct

- You *MUST* treat all candidates, members, partners, and providers with **courtesy, sensitivity and respect, demonstrating consideration for language, literacy, identity, and cultural preferences of all members and their family/support systems**
- All communication should be direct, objective, thoughtful, and without jargon
- The use of physical force in any interaction with a member, staff, or community member is strictly prohibited

Courtesy

Respect

Professionalism

Field Visits: Safety Practices

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

Safety First, Always!

Records

✓ Charts must be stored in a secure manner that upholds all member privacy rights

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

✓ All signed documents must be maintained in the member's record

Confidentiality

✓ All member charts, records, and information must be securely stored and safeguarded

✓ Members and candidates have the right to a full review and explanation of Brooklyn Health Home's confidentiality policies

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

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

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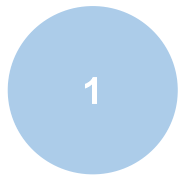
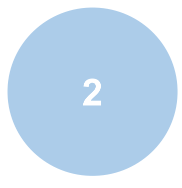
Enrollment Process

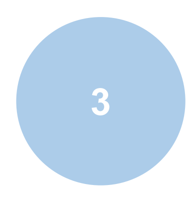
Confirm Eligibility



*Active Medicaid



Chronic Conditions



Appropriate Needs

Adverse Event Examples:

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

***Check RE codes for restrictions**

DOH Health Home Chronic Conditions Eligibility

Checklist

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

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

Enrollment Process

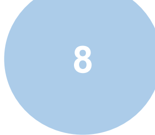
Start Enrollment Documentation

Informed Consent

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

Create New Enrollment (E) Segment w/ IA

Upload Enrollment Forms and Medical Documents



Obtain Current Medical Documents

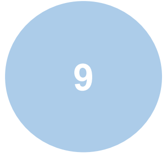
Checklist

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

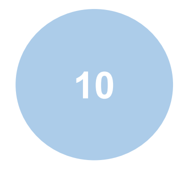
IA: Initial Appropriateness
- Primary Reason for Health Home Enrollment

Enrollment Process

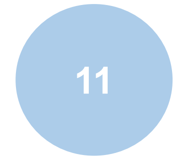
Continue Enrollment Documentation



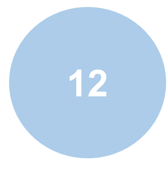
Create Enrollment Encounter



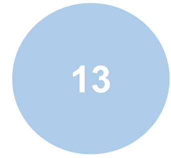
Create Plan of Care



Create Initial Comprehensive Assessment



Complete 1st Follow-up Encounter



Continue Comp Assessment + Plan of Care with Member

Checklist

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

Enrollment Need Areas

I want to be linked to

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

I need help managing

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

I want to apply for

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

I need help with

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

Person-Centered Care

Person Centered Care

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

Importance?

- Builds Rapport
- Increases Engagement
- Improves Participation in Services

Questions to Support Person-Centered Care

I'm interested in learning more about you……

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

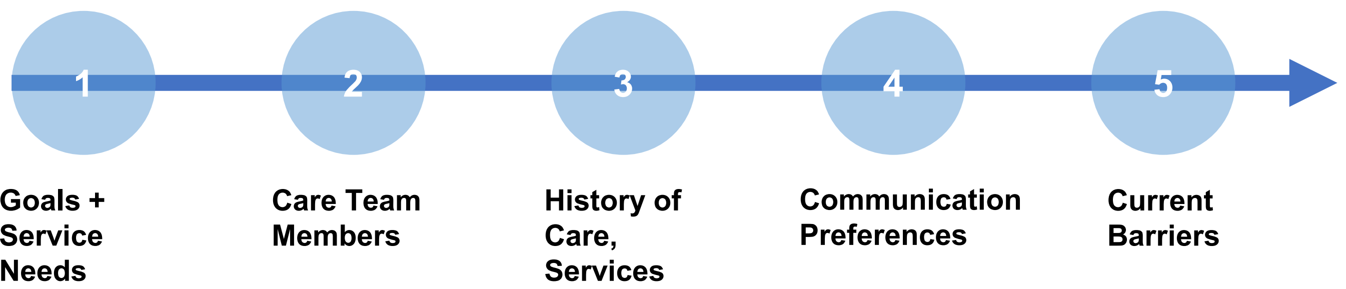
Give the Member a Voice!

Prioritize member's goals!

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

Initial Encounter (First 30 Days)

How can I help you today?



Goals + Service Needs

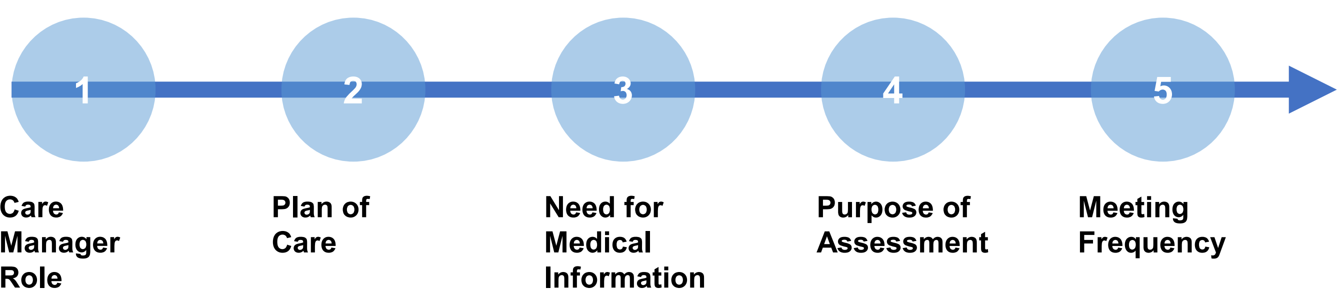
Care Team Members

History of Care, Services

Communication Preferences

Current Barriers

Do you have any questions about the Health Home Program?



Care Manager Role

Plan of Care

Need for Medical Information

Purpose of Assessment

Meeting Frequency

Initial Encounter (First 30 Days)

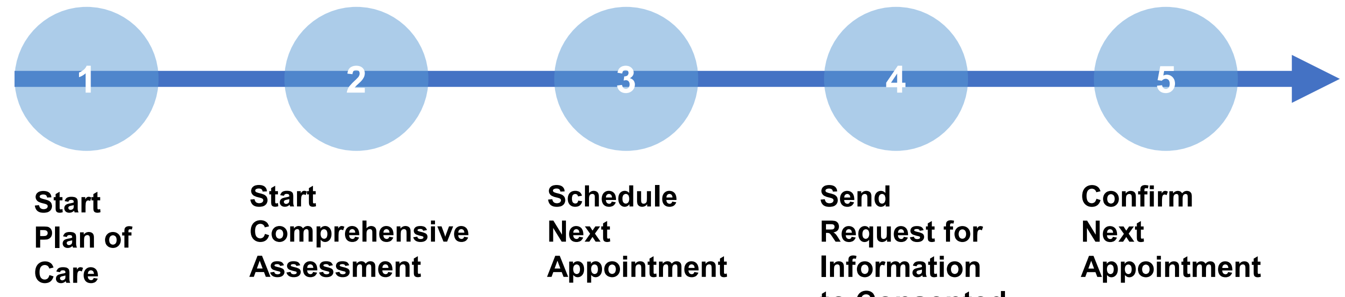
Care Manager Actions

Checklist

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

Initial Encounter (First 30 Days)

Care Manager Actions



Start Plan of Care

Start Comprehensive Assessment

Schedule Next Appointment

Send Request for Information to Consented Providers

Confirm Next Appointment

Checklist

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

BROOKLYN HEALTH HOME

Engagement Strategies

How to Engage a Member

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

Important Health Home Elements

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

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

Engagement Strategies

Engaging Member

Care Manager Actions

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

Open-minded

Empathetic

Respectful

Supportive

Engagement Strategies

Meeting Preparation

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

Level Setting

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

PREPARE YOUR MEETING SPACE

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

Clearly Outline Next Steps

Engagement Strategies

Next Up

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

Questions to Consider…

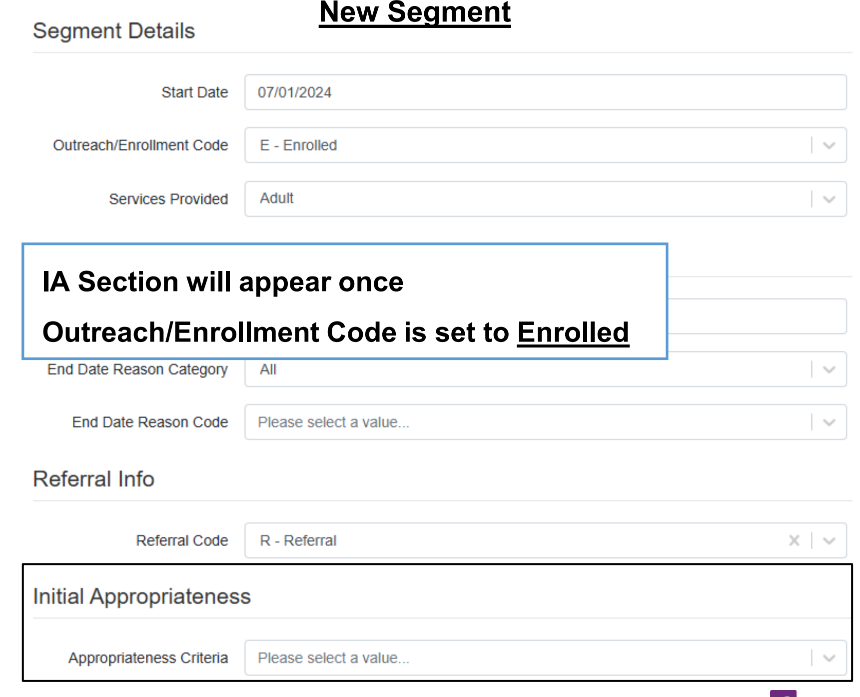
- What will member complete for the next meeting?
- What does the care team need to help the member complete?
- What did the member like about the meeting?
- What would they prefer to target for the next meeting?

Initial Appropriateness (IA)

Initial Appropriateness (IA) is used to document the primary reason for enrollment

Initial Health Home Eligibility Determination
An individual must be assessed and determined to have significant behavioral, medical, physical and/or social risk factor(s) that require the intensive level of Health Home Care Management services

- IA is determined when creating a new Enrollment Segment
- IA and the segment will track in MAPP when successfully synced



Initial Appropriateness (IA)

Initial Appropriateness (IA) Determination

IA Selected Should…..

- Capture a members need for Health Home enrollment
- Support the initial CM activities that will be worked on with the member

IA MUST be Documented:

- ❑ When a New Enrollment Segment is Created
  - At enrollment
  - Member transitions from a Diligent Search to Enrolled Segment

Resources:

- FCM - Initial Appropriateness Criteria
- NYS DOH Initial Eligibility/Continued Eligibility Requirements for HH Services

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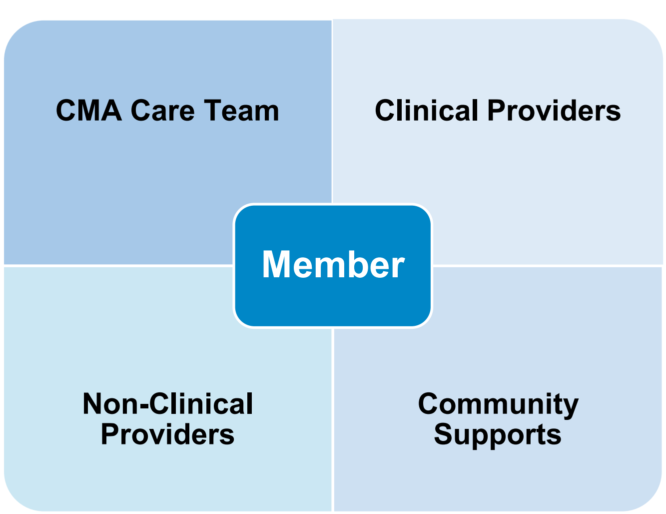
Health Home Consent

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



Consent Reasons

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

Communication is Key!

Health Home Consent

Enrollment Forms

BHH & Care Management Agency

- ❑ Patient Bill of Rights
- ❑ Code of Conduct

DOH Required Forms:

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

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

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

Key Objectives

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

Health Home Consent

1. Consent Forms DOH - 5055 DOH - 5234
2. Bill of Rights Code of Conduct
3. **Share** Enrollment Update with Consenting Providers
4. **Send** Completed Consent to Consenting Providers
5. **Schedule** Initial Contact with Consenting Providers

Consenting Providers

Required	Recommended
❑ Care Management Agency (**CMA**)	❑ Dentist
❑ MCO or Insurance Provider	❑ Eye Doctor
❑ Primary Care Physician (**PCP**)	❑ Specialists
❑ Main Healthcare Provider (*if not PCP*)	❑ Emergency Contact
❑ Mental Health Providers (*if applicable*)	❑ Family & Friends

Enrollment Process

Completing the DOH 5055 – *Health Home Patient Information Sharing Consent*

NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Consent

Brooklyn Health Home
Name of Health Home

By signing this form, you agree to be in the Brooklyn Health Home Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the Health Home.

The Health Home may get your health information, including your health records, from partners listed at the end of this form and/or from others through a computer system run by the Healthix, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health, and/or a computer system called TABS/CHOICES. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health treatment from your doctors and health care providers who are part of the Medicaid program. TABS/CHOICES is a computer system run by the New York State Office for People With Developmental Disabilities, that collects and stores information about your developmental disabilities.

If you agree and sign this form, the Health Home and the partners listed on this form are allowed to get, see, read and copy, and share with each other, ALL of your health information (including all of your health information the Health Home obtains from the RHIO and/or from PSYCKES and/or from TABS/CHOICES) that they need to give you care, manage your care or study your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions;
6. Developmental disability diagnosis and services; and/or
7. Sexually-transmitted diseases (diseases you can get from having sex).

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that use your health information and the Health Home must obey these laws and rules.

Please read all the information on this form before you sign it.

☑ **I AGREE to be in the** Brooklyn Health Home **Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through** Healthix RHIO and/or through PSYCKES and/or through TABS/CHOICES to give me care or manage my care, to check if I am in a health plan and what it covers, and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (If Applicable)	Relationship of Legal Representative to Patient (If Applicable)

DOH-5055 (03/18) p 1 of 3

Key Takeaways

Page 1: Member Printed Name, Date of Birth, Wet/Electronic Signature and Signature Date

- IF Legal Representative signs DOH 5055 – legal supporting documents is **required**

Page 3: Provider Full Name, Facility/Hospital

- Each consented Care Team member **needs** member initials and date added/removed

Copy this page as necessary to list all participating partners

Name of Health Home
☒ Brooklyn Health Home Member Initials:________ Date:________

Name of Your Care Management Agency
☒ Gold Medal CMA Member Initials:________ Date:________

Enrollment Process

Completing the DOH 5234 – Notice of Determination - Enrollment

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Notice of Determination for Enrollment in the New York State Health Home Program

Notice Date ______ CIN Number ______
Effective Date ______

Health Home

Name Brooklyn Health Home
Address 4802 10th Avenue, Brooklyn, NY, 11219
General Telephone Number for Questions or Help (800) 356-7480

Member

Name ______
Parent, Legal Guardian, Legally Authorized Representative, if any ______
Address ______

This is to advise you that effective ______ (Date)
this agency Brooklyn Health Home (Name of Health Home) has:

Enrolled you in the Health Home Program as of the effective date listed above.

- You are now able to receive Health Home Care Management Services
- You can change your Health Home or Care Management Agency at any time by contacting your Managed Care Plan, the Health Home listed above or the NYS Medicaid Help Line at 800-541-2831
- This is a voluntary program and you can disenroll at any time by contacting your Managed Care Plan, the Health Home listed above or the NYS Medicaid Help Line at 800-541-2831, unless you are legally required to participate in the Health Home program.

This action is taken under NYS SSL 365-I

Health Home Representative

Signature X ______

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

DOH-5234 (11/24) p 1 of 2

Key Takeaways

- ❑ Health Home Name:
  - **Brooklyn Health Home**
  - Not the CMA Name
- ❑ Health Home staff signs page 1
- ❑ Copy of document should be uploaded to member record and given to member
  - If unable, encounter note with reasoning is required
- ❑ Page 2 is **ONLY** completed if the ***member requests a Fair Hearing***

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Comprehensive Assessment

Q: What is the Assessment?

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

Risk Factors

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

Comprehensive Assessment Q&A

Assessment Starts at Enrollment!

Q: When is the Assessment conducted?

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

Q: How must the Assessment be completed?

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

Q: When must the Assessment be initiated?

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

Q: When must the Assessment be completed?

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

Comprehensive Assessment Q&A

Q: Who can I share the Assessment information with?

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

Q: When is the Reassessment Due?

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

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

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

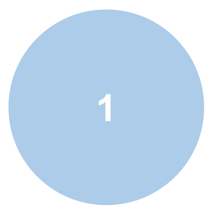
Q: I've completed the Assessment, now what ?

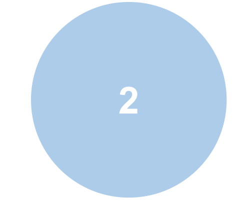
A: Member specific needs and goals should be used to develop the Plan of Care. Barriers and strengths should be documented in assessment summary and addressed in Plan of Care. All Assessment data must be entered into the member record within two business days of assessment completion.

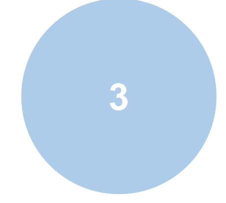
LOCK THE ASSESSMENT IN THE CARE MANAGEMENT PLATFORM

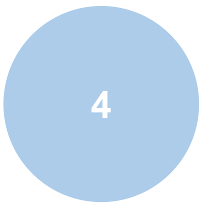
Comprehensive Assessment

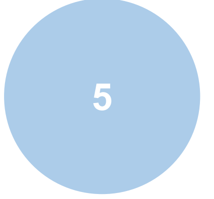
Key Summary Details











HH Linkage

How did the member connect to HH?

Program Eligibility

Why is member in need of HH?

Current Healthcare Needs

What can the CM help the member work on?

Past Healthcare Linkages and Care

What information is important to the work ahead?

What do we need to know to move forward?

Non-Medical Factors

What other elements are impacting the member meeting their goals?

Comprehensive Assessment

Identifying Member Needs

Assessment Summary Essentials

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

Transforming Identified Needs into Goals

Short-Term Goals!

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

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

Transforming Needs and Goals from an Assessment to a Plan of Care

Q: : Where do we identify member needs and/or goals?

Answer

- The member – the individual tells you what they want to work on or work toward achieving
- Referral / Referral Source - the person who referred the member; referral noted specific needs
- Information obtained during discussion(s) required to complete the comprehensive assessment.
- Details added in the additional notes section of the comprehensive assessment

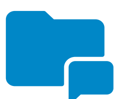
Tips:

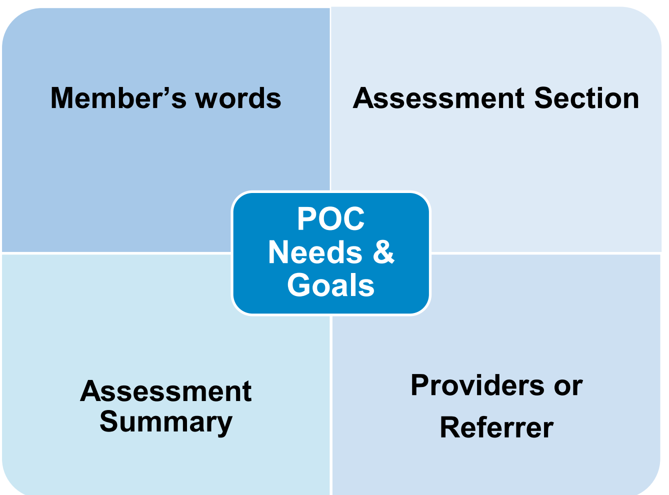
- If a need or goal is discussed - **Add to SUMMARY**
- If the member doesn't want to work on it, say so – Document!
- Member already working on it, note that too!
- Multiple needs/goals: Prioritize

Connect the Assessment to the Plan of Care

POC Needs & Goals

- Created with member, to work with them on what they want to work towards





Need

- the **"problem"** that a member would like to address

Goal

- the member's aim or objective, what they would like to achieve

Task

- the steps being done to help the member achieve their goals

For more information about **Person-Centered Care Planning, navigate to Plan of Care Section:**

Continuing Eligibility Screening (CES)

CES Tool

The CES Tool is intended to support enrollment decisions via periodic standardized screenings completed at established/specific time intervals

The CES Tool is designed to Identify members who either:

- ❑ Continue to Meet Health Home Program Appropriateness

OR

- ❑ May be a Candidate for Disenrollment [Step-down, Step-up, Case Closure, Graduation]

Time Intervals are based upon:

- ❑ Enrollment Segment Start Date
- ❑ Initial/Prior CES Tool Completion Date / Outcome
- ❑ Eligibility for Expanded Health Home Services
  - HH+, AOT, Adult Home Plus

Continuing Eligibility Screening (CES)

CES Tool

Gut Check

- **When a member is due for a new CES Tool, ask yourself a few simple question –** Is the member at risk if they disenroll?
- **What is the outcome? -** Is there justification?

Continued Services	More Information Needed	Disenrollment
▪ What is the need for service? ▪ Unfinished goals, documented needs? ▪ New Information Obtained? ▪ Gaps in care we are working towards closing?	▪ What information is needed? ▪ Where can we find it/when/how?	▪ Notes should include speaking to the member about disenrollment and next steps ▪ Providing resources ▪ How to enroll in the future, if necessary

Continuing Eligibility Screening (CES)

CES Tool

CES Tool Workflow

NEWLY Enrolled Members

- ❑ CES Tool is **Required** to be Completed **12 Months** after the Start of the Enrollment Segment

Continuous CES for Enrolled Members

- ❑ After the Initial CES Tool is Completed, the Most Recent **CES Tool Outcome** and **Completion Date** will decide when the Next CES Tool is Due

CES Tool Outcomes & Timelines

- ❑ ***More Information Needed***
  - 60 Days
- ❑ ***Recommend Continued Enrollment***
  - 180 Days / 6-Months
- ❑ ***Recommend Disenrollment***
  - 60 Days to Disenroll

Continuing Eligibility Screening (CES)

CES Tool Outcomes

More Information Needed

- ❑ **A NEW CES Tool is Required within 60 Calendar Days**
- ❑ **Next CES Tool Outcome has to be either:**
  - Recommend Continued Enrollment **OR**
  - Recommend Disenrollment

Checklist

- ❑ Add Review for Graduation Flag (RFG)
- ❑ Document outcome in encounter with plan to gather additional data/information
- ❑ Schedule Case Conference to obtain additional information
- ❑ Document additional needs (or lack of) in encounter note
- ❑ Add needs or graduation readiness tasks to care plan and linked encounters

Continuing Eligibility Screening (CES)

CES Tool Outcomes

Recommend Continued Enrollment

❑ **A NEW CES Tool is Required within 180 Calendar Days**

Checklist

❑ Document outcome in encounter note
- Justify outcome
- Detail remaining open care gaps, continued needs, etc.

❑ Update care plan with continued needs and link to CES Tool Encounter Note

Continuing Eligibility Screening (CES)

CES Tool Outcomes

Recommend Disenrollment

❑ **Member disenrollment is to occur within 60 Days of outcome**

- Speak to member about graduation **immediately** – review everything that has been achieved and what is still needed to be independent after graduation (Include Care Team as appropriate)

Checklist

❑ Add On Track for Graduation Flag (GRA) - help track of members disenrollments

❑ Document outcome in encounter note – justify outcome, completed needs, etc.

- Link encounter CES tool note to care plan

❑ Update the Plan of Care with Graduation readiness tasks - have member sign care plan!

Continuing Eligibility Screening (CES)

CES Tool Outcomes

Recommend Disenrollment

- ❑ **Member disenrollment is to occur within 60 Days of outcome**

Graduation/Case Closure Goals

- ❑ Review remaining needs and goals with member
- ❑ Verify supports and services are in place
- ❑ Finalize POC
  - Update status of Graduation readiness tasks - Mark Complete once finished
  - member signs completed care plan

IF Comprehensive Assessment is due after “Recommend Disenrollment” outcome a new Comprehensive Assessment is not required:

- Encounter note explaining reasoning required

Continuing Eligibility Screening (CES)

CES Tool Outcomes

Recommend Disenrollment

- ❑ **Member disenrollment is to occur within 60 Days of outcome**

Reasons for Disenrollment

<u>Involuntary</u> - *member does not agree*

Code 14: Enrolled HH member disengaged from care management services

- Lack of engagement
- DOH 5235 is used if member does not agree

<u>Voluntary</u> - *member agrees* / Graduation

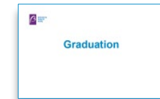
Code 21: Member has graduated from HH program

- No risk factors/only maintenance goals

Disenrollment Reason:

"***Other***" "*Member is no longer engaged in Health Home Care Management Services as defined in the CES Tool.*"

For additional details regarding graduation:



Enrollment

Enrollment Requirements

Initial Appropriateness (IA)

Consent

Assessments

Comprehensive Assessment

Continuing Eligibility Screening (CES) Tool

Plan of Care

Plan of Care Activities

Plan of Care & Encounter Linkages

HARP [HCBS + CORE]

HIV Care Management Goals

Encounters

Core Services

What are Core Services?

Billing Support Questionnaires (BSQ)

Documentation of Billable/Non-Billable Services

Case Conference

Critical Events

Graduation

Plan of Care

Plan of Care Activities

Plan of Care & Encounter Linkages

HARP [HCBS + CORE]

HIV Care Management Goals

Plan of Care

What is the Care Plan?

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

What does the Care Plan Include?

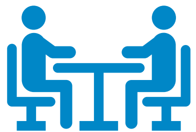
- ❑ **Need** Current Issue and what is going to be addressed
- ❑ **Need Note** Strengths, Barriers and/or Challenges
- ❑ **Goals & Tasks**
  - Short-term (< *6 months*)
  - Long-term *(> 6 months)*

Key Elements

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

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

Plan of Care



What Should We Ask the Member?

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

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

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

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

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

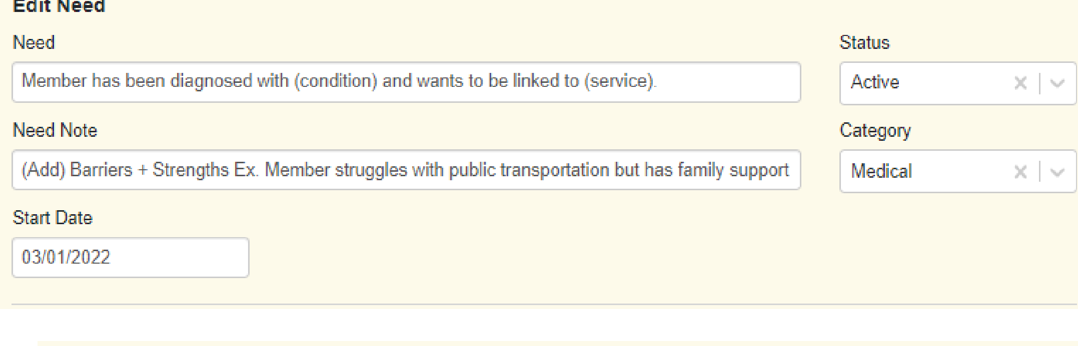
Plan of Care

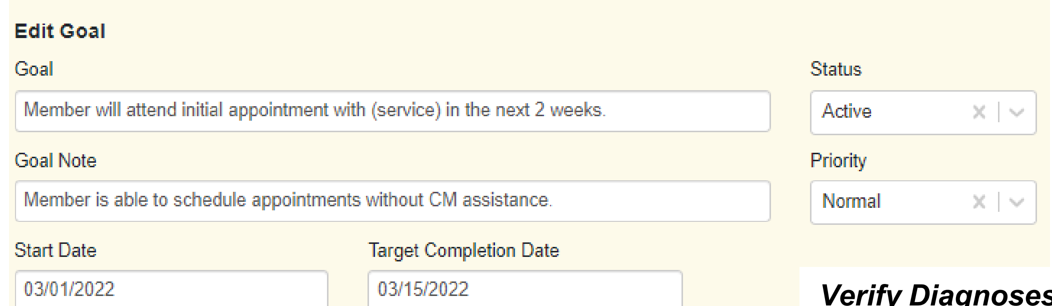
Elements of a Person-Centered Plan of Care

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

Plan of Care

Example





Key Elements

Need Note

- Additional Details about Specific Need
- Related Barriers and Strengths

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

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

Plan of Care

Strengths, Barriers & Risk Factors

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

Key Points

- ❑ Strengths, Barriers and Risk Factors may apply to the member as a whole individual OR be specific to member need / goal
- ❑ Risk Factors can help determine if the member is at risk of developing complications, co-morbid conditions

Plan of Care

Strengths, Barriers & Risk Factors

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

Key Points

- ❑ Strengths, Barriers and Risk Factors may apply to the member as a whole individual OR be specific to member need / goal
- ❑ Risk Factors can help determine if the member is at risk of developing complications, co-morbid conditions

Plan of Care

Strengths, Barriers & Risk Factors

Risk Factors

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

Biological	Psychological	Family	Community	Cultural
▪ Genetic predisposition ▪ Family Medical History Poor response to medication(s) or treatment ▪ Poor Sleep ▪ Substance Use	▪ Personality traits, thoughts, emotions, or attitudes ▪ Absence of coping ability ▪ Feelings of depression or hopelessness	▪ Family/Spouse who use drugs, alcohol ▪ Domestic Violence ▪ Family with SMI ▪ Child abuse and/or maltreatment	▪ Neighborhood poverty or violence ▪ Household members, or neighbors who promote risky behaviors	▪ Differences in language ▪ Treatment and/or Service Preferences due to customs, religious beliefs, or preferences

Plan of Care

Plan of Care is Updated **When:**

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

**Not All Critical Events*

Important Timeframes

Wet/Electronic Signatures

- ❑ Every 6 Months

Plan of Care Updates

- ❑ **Every 6 Months** *OR*
- ❑ When **Goals** and **Tasks** are:
  - ✓ Achieved
  - ✓ Reviewed
  - ✓ Updated

Plan of Care + Encounter Linkages

Linking the POC to a New Encounter:

Encounter Date
Select a date
Mode
Select...
Core Service ?
Select...

Is this in response to an admission or discharge? (Inpatient hospitalization, ED, rehab, detox, skilled nurse facility, or incarceration)
Select...

Notes

Select Each Existing Task that Applies to New Encounter

- ✓ Update Target Date
- ✓ Update Task
- ✓ Add New Details

Note: New Needs/Goals will need to be added within the Plan of Care

Active Care Plan Tasks
View Care Plan

Select all tasks associated with this Encounter: **0 tasks selected**

MEDICAL GOAL
Member will adhere to Diabetes Medication daily for the next month.
Add Task

ACTIVE TASKS

PATIENT
Member will develop daily reminders on member phone.
Target 7/15/2022

PATIENT
Member will keep log of missed doses, side effects and pain for 1 month.
Target 7/29/2022

CARE MANAGER
CM will contact member weekly to review medication adherence for 1 month.

Add New Task to a Existing Need/Goal in Active POC

Linking an Encounter to the Care Plan – Link

Plan of Care + Encounter Linkages

Linking & Connecting to Gaps in Care:

Gap in Care	Date Uploaded	MCO Gap Status ?	CM Status	Linked Care Plan Tasks
PCP Appt (Med Adherence) Fee For Service Gaps	8/5/2022	Active	Action Needed	0 tasks linked Link Tasks · Add New
PCP Appt (Diabetes Screening) Fee For Service Gaps	8/5/2022	Active	Action Needed	0 tasks linked Link Tasks · Add New

Action Needed

"Action Needed" is the default status or starting status when a new Gap in Care (GiC Action Step) is added to a member record

Join to an Existing Task or Add a New Task in the Plan of Care

Linking Gaps in Care to the Care Plan Training – Link

Plan of Care + Encounter Linkages

Gaps in Care Action Items

Action Needed	▪ 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: (a)** Add Action Step to Plan of Care | **NEED → GOALS → TASKS** **(b)** 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

Plan of Care + System Quality Flags

Asthma Medication Ratio (AMR)

Members assigned an AMR flag have been diagnosed with

❑ Asthma / Persistent Asthma

- **Symptoms:** Shortness of breath, chest tightness, wheezing, coughing, fatigue
- **Potential Triggers:** exercise, cold air, allergens, or respiratory infections

GOALS

❑ Ensure member has consistent access to both controller and rescue medications

- **Controller Medication:** helps manage and prevent asthma symptoms
- **Rescue Medication:** provides immediate relief during an asthma attack

❑ **AMR** measure seeks to ensure a member has more controller than rescue medications

- More than 50% (*at least half*) of medications dispensed are controller medications

Plan of Care + System Quality Flags

Asthma Medication Ratio (AMR)

Recommended Care Manager Actions

- ❑ **Pharmacy Review:** Identify member pharmacy and any transportation needs for refills
- ❑ **Access and Affordability:** Assess member ability to access and afford medications
- ❑ **Medication Education:** With the support of consented Care Team members, educate member and consented supports (i.e. emergency contact) about the difference between controller and rescue medications and emphasize the importance of using controller medications regularly to manage asthma
- ❑ **Care Coordination:** Communication between primary care physicians (PCP) and/or pulmonologist for test results, appointments, access to long-term Rx refills, treatment plans
- ❑ **Follow-Up:** Complete follow-up calls to review and ensure adherence and review if a member is using more rescue medications than controller medications

Plan of Care + System Quality Flags

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Members assigned an SAA flag have been diagnosed with

❑ Schizophrenia or Schizoaffective Disorder

- **Symptoms:** hallucinations, illogical thinking, memory impairment, incoherent speech

GOALS

❑ Ensure member is consistently following their prescribed antipsychotic medication regimen

❑ **SAA** measure seeks to ensure a member is dispensed and remains on an antipsychotic medication for at least 80% of treatment period

Why is this important? Adherence to medication regiment helps reduce risk of relapse, hospitalization, and other complications associated with schizophrenia

Plan of Care + System Quality Flags

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Recommended Care Manager Actions

- ❑ **Pharmacy Review:** Identify member pharmacy and any transportation needs for refills
  - Assist member set-up medication reminders/alerts/alarms on their phone
- ❑ **Access and Affordability:** Assess member ability to access and afford medications
- ❑ **Care Coordination:** Communication between behavioral health (BH) providers and primary care physicians (PCP) for test results and appointments
- ❑ **Medication Education:** With the support of consented Care Team members, educate member and consented supports (i.e. emergency contact) about importance of adherence
- ❑ **Follow-Up:** Complete follow-up calls to review and ensure adherence

Plan of Care + System Quality Flags

AMR & SAA Quality Flags

- ❑ **Members assigned a AMR and/or SAA flag can be identified via the FCM Charts Search:**

Charts

FILTER CRITERIA

Chart Type

Active As Of: 01/16/2025

Adult/Child: Adult

Segment Type

Medicaid CINs

Agencies & Staff

Health Home: × BHH

CMA

Supervisor

Care Manager

Patient Information

Zip Code: ZIP Code

City: City

Diagnoses

HARP ?

Patient Flags

AMR

Patient Flags: Asthma Medication Ratio

SAA

Patient Flags: Adherence to Antipsychotic ...

HARP [HCBS & CORE]

Care Plan

HCBS Enrollment

- HARP stands for Health and Recovery Plan
- HARP is a Medicaid Managed Care Insurance Plan – manages access to additional community-based services and supports called HCBS and CORE
- HARP Enrollment is evidenced by H codes
- Insurance Details are located in each Health Home Member Profile

Insurance Details — *last updated from eMedNY on 7/30/2024*
Medicaid Type
Medicaid Managed Care (Healthfirst Personal Wellness Plan)
Medicaid Description ELIGIBLE PCP
Recertification Month December
Exception Codes A1 A2 H1 H9
Acuity Information
Most Recent HML Acuity
HH Svcs - High Risk/Need

If a client is HARP enrolled they will have the CORE & HCBS tab

Overview
Documents
Encounters
Background
Assessments
Care Plans
Care Team
CORE & HCBS
Gaps in Care
Transitions of Care
Segments
Billing

HARP [HCBS & CORE]

Care Plan

HARP 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

Behavioral Health (BH) High-Risk Eligibility Criteria - Link

HARP [HCBS & CORE]

HCBS

Home and Community Based Services

- Eligible HARP members will complete a NYS Eligibility Assessment (EA) to determine HCBS eligibility.
- A plan of care is completed and submitted to BHH. After review the POC will be forwarded to the MCO.
- Once the MCO approves the level of service, the member is connected to a HCBS provider.

HARP members can enroll in both HCSB and CORE

CORE

Community Oriented Recovery and Empowerment Services

- HH Care Managers make referrals to the CORE providers.
- The CORE provider schedules an Intake & Evaluation.
- The provider is responsible for notifying MCO after Intake & Evaluation session.
- An LPHA recommendation is made to support enrollment.
- A Person-Centered Planning & the Individual Service Plan (ISP) is created for the member.
- Communication is continued between the Care Manager and CORE provider.

Resources:

CORE Providers

LPHA Recommendation

HARP [HCBS]

HCBS

Home and Community Based Services

1. **EDUCATION SUPPORT SERVICES**
   - Education Support Services are provided to assist individuals with mental health or substance use disorders 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**
   - Pre-vocational services are time-limited services that prepare an individual for paid or unpaid employment.
   - This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings

3. **TRANSITIONAL EMPLOYMENT**
   - This service is 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 employer

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.

Resource: HCBS

HARP [HCBS]

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

HARP [CORE]

1 COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT (CPST)
- Goal-directed supports and solution-focused interventions with the intent to achieve person-centered goals.
- Multi-component service that consists of therapeutic interventions.

2 PSYCHOSOCIAL REHABILITATION (PSR)
- Assists individuals in improving their functional abilities to the greatest degree possible in settings where they live, work, learn, and socialize.
- Rehabilitation counseling, skill building, and psychoeducational interventions.

CORE
Community Oriented Recovery and Empowerment

3 FAMILY SUPPORT AND TRAINING (FST)
- Offers instruction, emotional support, and skill building necessary to facilitate engagement and active participation of the family.
- FST partners with families through a person-centered or person-directed, recovery oriented, trauma-informed approach.

4 EMPOWERMENT SERVICES – PEER SUPPORT
- Non-clinical, peer-delivered services with a focus on rehabilitation, recovery, and resilience.
- Promotes skills for coping with and managing behavioral health symptoms while facilitating the use of natural supports and community resources.

Resource:

CORE

HARP [CORE]

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

HARP [HCBS & CORE]

CORE & HCBS Workflow

❑ HCBS and CORE MUST be discussed occur on a periodic basis
- Education and review of services are required to occur **annually**

❑ HARP Members are able to receive both HCBS and CORE
- HCBS and CORE have (2) separate workflow

Member Education / Review of HCBS & CORE

❑ Outcome of discussion around HCBS and CORE services should be documented in the **CORE & HCBS** tab in each member record

Overview
Documents
Encounters
Background
Assessments
Care Plans
Care Team
CORE & HCBS
Gaps in Care
Transitions of Care
Segments
Billing

HARP [HCBS & CORE]

HCBS Workflow

- ❑ Eligible HARP members will complete a NYS Eligibility Assessment (EA) to determine HCBS eligibility
- ❑ 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

HARP POC/LOSR Submission Steps
❑ Care Manager completes the LOSR ▪ R stands for Request
❑ Send the FCM Link to BHH
❑ BHH sends the Request (LOSR) to the correct MCO contact
❑ The MCO reviews the LOSR, and makes a determination ▪ MCO sends back formal letter / LOSD ▪ D stands for Decision ▪ LOSD notes what HCBS services were approved
❑ BHH uploads the LOSD to the CORE & HCBS tab and sends the link back to the CM
❑ Care Manager completes full HARP POC

HARP [HCBS & CORE]

CORE Workflow

❑ HH Care Managers make referrals to the CORE provider

CORE Referral Steps
❑ Care Manager makes referral for a CORE
❑ The CORE provider schedules an Intake & Evaluation.
❑ The provider notifies MCO after Intake & Evaluation session.
❑ An LPHA recommendation is made to support enrollment.
❑ A Person-Centered Planning & the Individual Service Plan (ISP) is created for the member
❑ Communication is continued between the Care Manager and CORE provider.

HARP [HCBS & CORE]

CORE & HCBS Tab in Foothold

The member's HARP codes will also appear on the CORE & HCBS tab of the member's record as seen below

CORE & HCBS

According to eMedNY, this member has these HARP Exception Codes: H1 H9

CORE Services Details

INTEREST IN CORE SERVICES — Update

Patient has not indicated interest in CORE Services

CARE TEAM REFERRAL DETAILS — Edit on Care Team

No referral has been selected

HCBS Details

INTEREST IN HCBS — Update

Patient has not indicated interest in HCBS

CARE TEAM REFERRAL DETAILS — Edit on Care Team

No referral has been selected

HARP [HCBS & CORE]

CORE & HCBS Tab: Member Interest

- Once CORE & HCBS services have been discussed with the member, the member's interest or lack of must be documented on the CORE & HCBS tab in the corresponding sections

CORE & HCBS

According to eMedNY, this member has these HARP Exception Codes: H1 H9

CORE Services Details

INTEREST IN CORE SERVICES — Update

Patient has not indicated interest in CORE Services

CARE TEAM REFERRAL DETAILS — Edit on Care Team

No referral has been selected

HCBS Details

INTEREST IN HCBS — Update

Patient has not indicated interest in HCBS

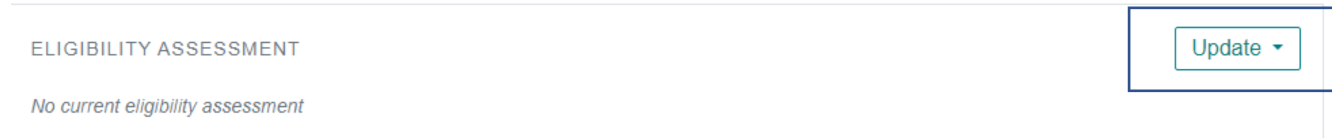
CARE TEAM REFERRAL DETAILS — Edit on Care Team

No referral has been selected

HARP [HCBS & CORE]

CORE & HCBS Tab: HCBS Eligibility Assessment

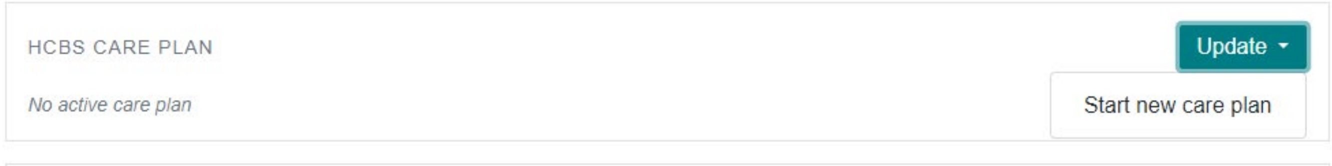
- ❑ If the client is interested in HCBS services the eligibility assessment must be completed by a certified assessor in the Uniform Assessment System (UAS)
- ❑ UAS is part of the Health Commerce System (HCS)
- ❑ Once an eligibly assessment has been completed in the UAS, it should be uploaded to the CORE & HCBS tab in Foothold



HARP [HCBS & CORE]

CORE & HCBS Tab: Plan of Care / Level of Service Request (LOSR)

- Once the eligibility assessment has been complete and client is found eligible for HCBS services the HCBS Care Plan should be completed on the CORE & HCBS tab
- Once the Care Plan is completed, the link to the client's record in Foothold can be sent to BHH for submission to the client's Managed Care Organization (MCO) for approval



HARP [HCBS & CORE]

CORE & HCBS Tab: Level of Service Determination (LOSD)

- ❑ Once the HCBS Care Plan has been submitted to the client's MCO for approval, the MCO will reply with a LOSD letter
- ❑ BHH will then upload this letter to the member's record in the corresponding section of the CORE & HCBS tab and will inform the CMA that the letter has been uploaded
- ❑ The LOSD letter will detail what HCBS services the client has been approved for and will often also include recommended HCBS providers

LEVEL OF SERVICE DETERMINATION LETTER

Update ▾

No current LOSD

Human Immunodeficiency Virus (HIV)

HIV is a viral infection that weakens the body's immune system by attacking white blood cells that are essential to the human body's ability to fight off infections

- HIV is diagnosed via diagnostic lab test(s) - **Viral Load Test**

CD4 (T-Cells)

- White blood cells that improve the body's ability to fight infections
  - Cells per cubic millimeter OR microliter of blood (*cells/mm3*) / (*μL*)
- CD4+T, T-helper, and T4 Cells
- **High CD4:** strong immune system
- **Low CD4:** weak immune system

Viral Load

- Quantity of HIV circulating in the blood
  - HIV RNA copies per milliliter of blood (*copies/mL*)
  - Diagnostic Labs: *Viral Load Test*
- **High Viral Load:** HIV (Unsuppressed)
- **Low Viral Load:** HIV (Suppressed)

Human Immunodeficiency Virus (HIV)

CD4 T-Cells

- ❑ Measures a Bodies Ability to Fight Infections
- ❑ Determines when to Start Antiretroviral Treatment (ART)
- ❑ Used to Evaluate ART Response

CD4 Cell Count	
Normal Range	> 500 cells/mm^3
Low CD4 Count	200 – 500 cells/mm^3
AIDS Diagnosis (CDC)	≤ 200 cells/mm^3

Viral Load

- Used to Diagnose Acute HIV infection
- Guides Treatment Plans
- Used to Evaluate ART Response

Viral Load	
Undetectable	20 copies/mL
Suppressed	≤ 1000 copies/mL
Unsuppressed	> 1000 copies/mL

What is AIDS? AIDS stands for <u>A</u>cquired <u>I</u>mmunodeficiency <u>S</u>yndrome

❑ Onset of clinical signs and symptoms caused by HIV - HIV causes AIDS

Human Immunodeficiency Virus (HIV)

Diagnostic Lab Examples

Viral Load

Lab:HIV-RNA, real time PCR(viral load) [Labcorp]

Collection Date	07/18/2022	01/25/2022
Order Date	07/18/2022	01/25/2022
HIV-1 RNA by PCR	80 (Ref Range: copies/mL)	90 (Ref Range: copies/mL)
log10 HIV-1 RNA	1.903 (Ref Range: log10copy/mL)	1.954 (Ref Range: log10copy/mL)

Labs may indicate that the Viral Load is Not Detected or HIV Suppression

HIV-1 Viral Load

Normal value: Not Detected cpy/mL

Value

Not Detected

CD4 Count

Lab:CD4/CD8 Ratio Profile (Inclu

Collection Date	07/18/2022
Order Date	07/18/2022
Absolute CD 4 Helper	653 (Ref Range: 359-1519 /uL)
CD4 Percent	19.8 L (Ref Range: 30.8-58.5 %)
WBC	5.5 (Ref Range: 3.4-10.8 x10E3/uL)
RBC	5.22 (Ref Range: 4.14-5.80 x10E6/uL)

*** BOTH CD4 and Viral Load Labs may have different:**

- **Ranges**
- **Units**
- **CD4 Terms**

Human Immunodeficiency Virus (HIV)

Treatment / Medication Goals

- ❑ **Connection to Infectious Disease Provider**
  - 3 – 4 visits per year
- ❑ **Treatment, Medication Adherence**
  - Antiretroviral Treatment (ART)
- ❑ **An undetectable HIV Viral Load**
  - *Less than* < 50 or 20 copies/mL

What is an Infectious Disease Specialist?

- ❑ Internal Medicine Medical Provider
- ❑ Extensive Training in the Diagnosis and Treatment of Infectious Diseases (HIV)

Viral Load / Lab Frequency

Initial Diagnosis: Greater Frequency of Labs	**Virally Suppressed:** Labs may be done every 6 months (confirm with provider)
Goal: Reduce Viral Load in first 6 Months	**Goal:** Continued Viral Load Suppression

Human Immunodeficiency Virus (HIV)

Treatment / Medication Goals

Antiretroviral Treatment (ART)

Medication regimen designed to:

- ❑ Slow down the replication of HIV
- ❑ Protect the immune system
- ❑ Prevent HIV from advancing to AIDS
- ❑ Reduce risk of HIV transmission

ART Goals:

- ❑ Suppress Viral Load (HIV Suppression)
- ❑ Improve Immune Function
- ❑ Decrease Inflammation
- ❑ ↓ Risk of Opportunistic Infections
- ❑ ↓ HIV-related morbidity and mortality

If a member is not virally suppressed, a Care Manager should:

- ❑ Verify connection to an Infectious Disease Provider
- ❑ Review adherence to current medication and treatment regimen

Human Immunodeficiency Virus (HIV)

Care Management Service Goals

HIV/AIDS - Care Management Activities

- ❑ Determine a member's HIV Status during the Comprehensive Assessment
  - If Unknown – gather documentation / labs to support HIV status
- ❑ Review member interest in HIV testing if status is known
  - IF interested – add need/goal to plan of care and work to link member to testing site
  - IF not interested - document in encounter note and review during next assessment
- ❑ IF HIV positive:
  - Confirm connectivity to an Infectious Disease Provider
  - Review adherence to medical appointments, ART, lab completion
  - Collect, review and document most recent lab results (CD4 and Viral Load)

Human Immunodeficiency Virus (HIV)

Care Management Service Goals

Health Literacy – HIV/AIDS

- ❑ Understanding of HIV/AIDS definitions
  - Educational Materials (Pamphlets, Provider or MCO Resources)
- ❑ Knowledge regarding the importance of HIV and STI testing and transmission risks
- ❑ Knowledge regarding PrEP and PEP access
- ❑ IF HIV Positive and prescribed ART – discuss medication regimen, side effects with infectious disease provider and member

PrEP – Pre-Exposure Prophylaxis (Resource: NYC Health)

- Prevents HIV infection prior to exposure

PEP – Post-Exposure Prophylaxis

- For individuals who have already been exposed to HIV and need treatment to prevent transmission

Home

Enrollment

Enrollment Requirements

Initial Appropriateness (IA)

Consent

Assessments

Comprehensive Assessment

Continuing Eligibility Screening (CES) Tool

Plan of Care

Plan of Care Activities

Plan of Care & Encounter Linkages

HARP [HCBS + CORE]

HIV Care Management Goals

Encounters

Core Services

What are Core Services?

Billing Support Questionnaires (BSQ)

Documentation of Billable/Non-Billable Services

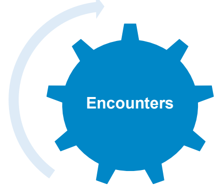
Case Conference

Critical Events

Graduation

Encounters

Encounters

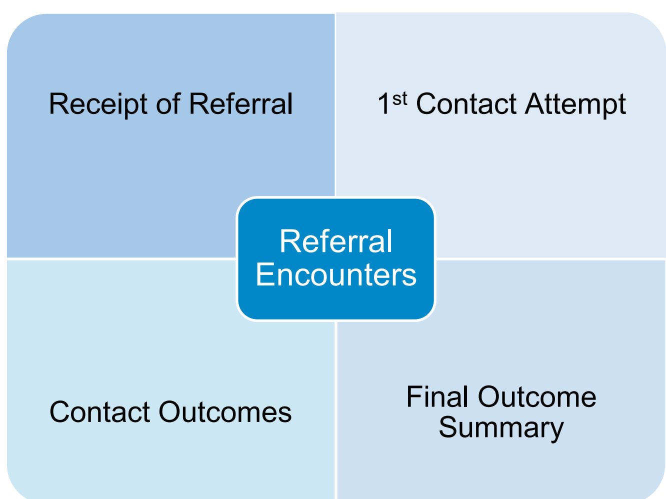


Outreach Encounters Elements

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

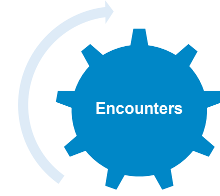
Outreach Encounter Activity

Recording Engagement Work



Encounters

Enrollment Encounter



What should be included?

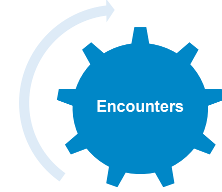
Enrollment Details
❑ Member Demographic Information
❑ Date of Referral
❑ Referral Source Details
❑ Location of Enrollment
❑ Qualifying Conditions
❑ Documents Completed/Provided to Member
❑ Reasons for Enrollment (Needs + Goals)
❑ Services/Resources Needed
❑ Immediate Next Steps
❑ Additional Details/Comments

Key Achievements

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

What we want to Talk about/Work on Today?

Encounters



Consented Provider Introductory Call

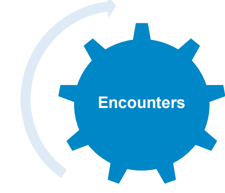
Key Steps

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

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

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

Encounters



Care Conference Encounter

What should we focus on?

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

Question…

How can we Assist the Member Meet their Goals?

What is Needed from the Care Manager or CMA?

What are our Next Steps or Actions?

Questions

Who was there?

Where did this Occur?

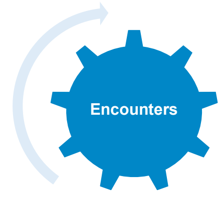
When did this Occur?

Why did this Occur?

What did you Talk About?

How will you Move Forward?

Assessment Summary



Comprehensive Assessment Summary Points

What should be included in the Assessment Summary?

Current:

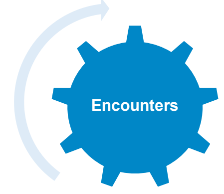
- ❑ Eligibility for Health Home Services
- ❑ Housing
- ❑ Social Supports, Benefits, Income
- ❑ Medical and Behavioral Healthcare Providers
- ❑ Treatment, Medications and Appointment Attendance History
- ❑ Goals
- ❑ Remaining Needs from Enrollment (or Prior Assessment)
- ❑ Strengths, Barriers to Remaining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

Key Reminders

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

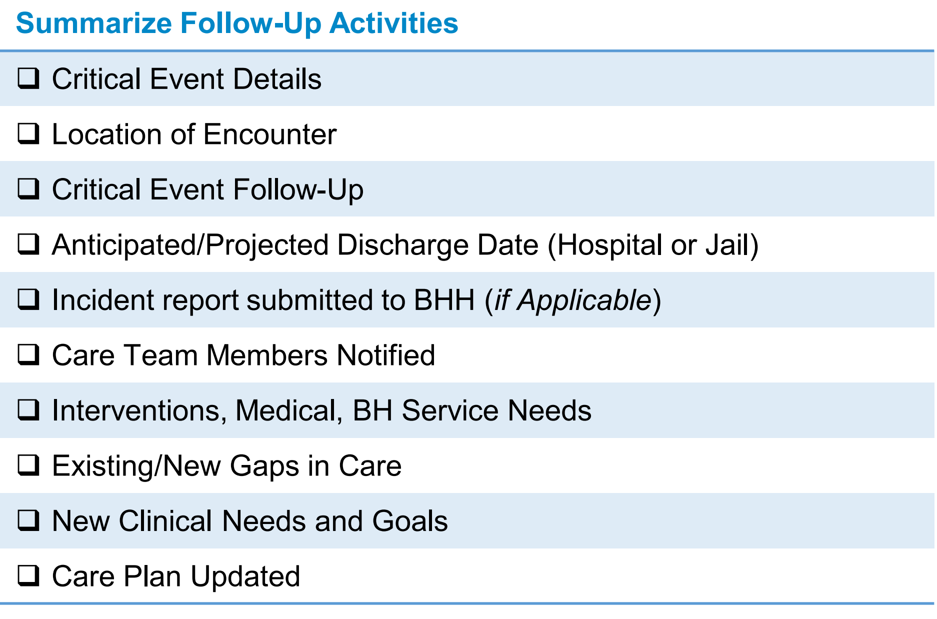
Supervisors are a great support and resource to tackle outstanding goals

Encounters



Critical Event Follow-Up Encounter

What Information should I collect?



Summarize Follow-Up Activities

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

What will the Member Complete for Next Time?

Confirm Next Steps...

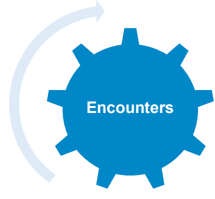
- ❑ **Upcoming Appointments**
- ✓ Provider
- ✓ Location
- ✓ Barriers
- ✓ Travel Needs
- ✓ Contact Details
- ✓ Reminders

Schedule Reminder Calls

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

Encounters

Transfer Encounters



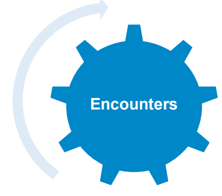
What happens if a case is transferred?

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

Key Points

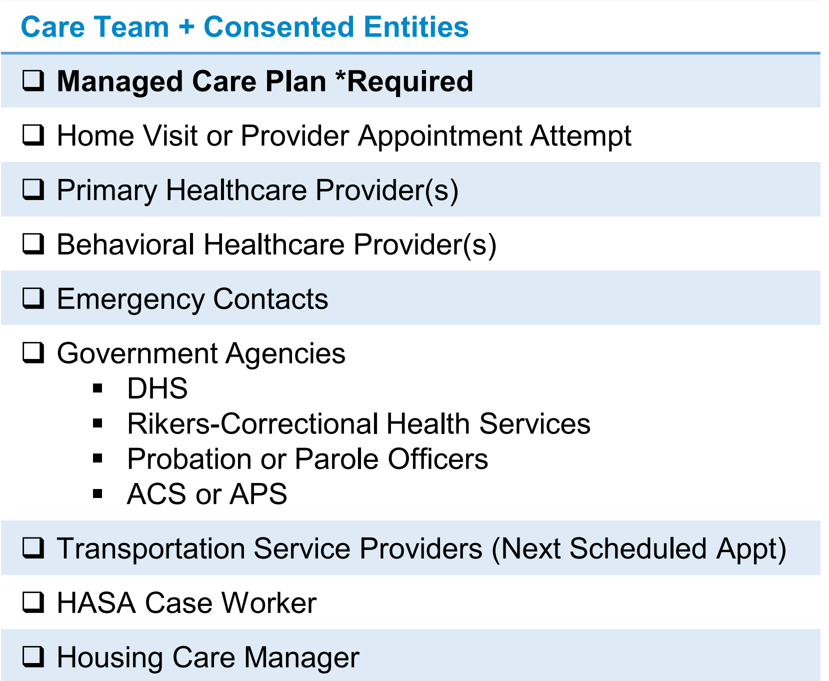
- ❑ Preferred Contact Method
- ❑ Information Sharing Restrictions
- ❑ Language Preferences
- ❑ Member Identified Interests
- ❑ Engagement Pattern(s)

Encounters



Diligent Search Encounter

Re-engagement Activities

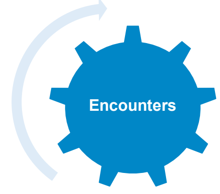


Care Team + Consented Entities
❑ **Managed Care Plan *Required**
❑ Home Visit or Provider Appointment Attempt
❑ Primary Healthcare Provider(s)
❑ Behavioral Healthcare Provider(s)
❑ Emergency Contacts
❑ Government Agencies ▪ DHS ▪ Rikers-Correctional Health Services ▪ Probation or Parole Officers ▪ ACS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

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

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

Encounters



Disenrollment Encounters

What should a case closure encounter include?

Case Closure Recap

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

Case Closure Activities

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

Review Open/Active

- ❑ Gaps in Care
- ❑ Care Plan Goals

Enrollment

Enrollment Requirements

Initial Appropriateness (IA)

Consent

Assessments

Comprehensive Assessment

Continuing Eligibility Screening (CES) Tool

Plan of Care

Plan of Care Activities

Plan of Care & Encounter Linkages

HARP [HCBS + CORE]

HIV Care Management Goals

Encounters

Core Services

What are Core Services?

Billing Support Questionnaires (BSQ)

Documentation of Billable/Non-Billable Services

Case Conference

Critical Events

Graduation

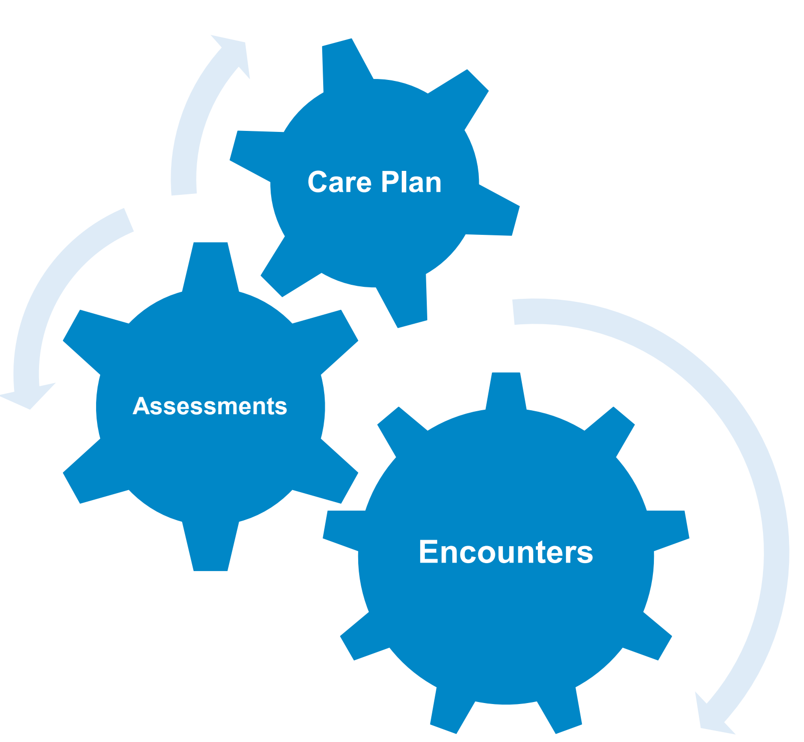
Core Services

What are Core Services?

Billing Support Questionnaires (BSQ)

Documentation of Billable/Non-Billable Services

Core Services



Key Takeaways

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

Core Services

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

Core Services

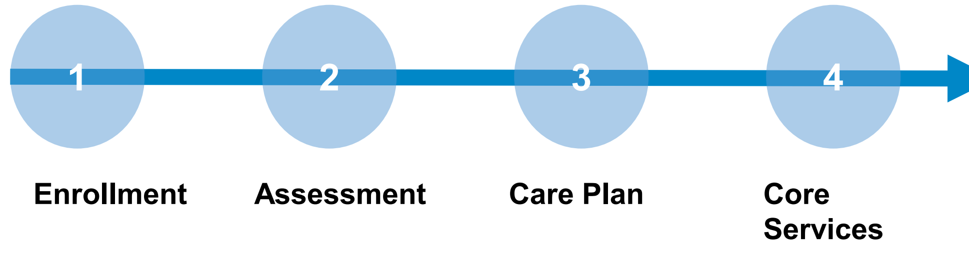
Encounters

Plan of Care

Encounter (Core Service) Frequency

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

Document Each Encounter:



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

Core Services

Comprehensive Care Management

Services centered around:

✓ Plan of Care, including completion of a Comprehensive Assessment

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

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

Documentation Reminders

❑ Include Provider Name, Contact Information

❑ Include Next Steps for Member

Core Services

Care Coordination and Health Promotion

Services centered around:

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

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

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

Important Reminders

❑ Review Medication Adherence, Treatment

❑ Coordinate with provider to align goals

Core Services

Comprehensive Transitional Care

Services related to:

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

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

Important Reminders

❑ Contact Members within **48 hours** of

- Receipt of notification OR
- Awareness of admission

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

Core Services

Patient and Family Support

Services that include:

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

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

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

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

Core Services

Referral to Community and Social Supports

Linkage to services designed to:
✓ Support and/or enhance the member's social and community support systems

Elements
❑ Two-way sharing of information related to plan of care goals and member needs
❑ Referrals/Linkage to: ▪ Food Pantries ▪ Support Groups (AA, NA)
❑ Research, Generation and Sharing of information related to: ▪ Nearby Religious organizations or services ▪ Potential providers near residence

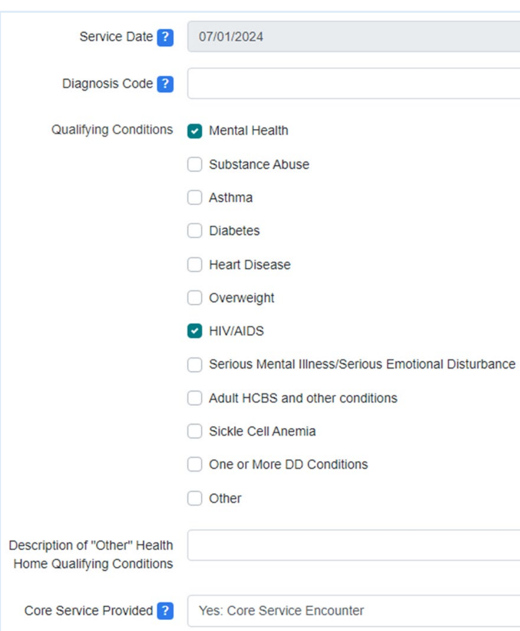
Confirm member was linked and/or attended appointment/services

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ)

Provides a single source of truth for Health Homes, CMAs, MCOs, and NYSDOH regarding the billing status of each member per month

- BSQs are **required** for Billing
- BSQs are also referred to as HMLs
    - HML: High-Medium-Low
- BSQs/HMLs are submitted monthly
    - Completed regardless of Core Service delivery
- BSQ/HMLs will only be available for members on the BHH enrollment file (Source: *MAPP*)
- Billing Rates are based upon BSQ Responses
    - 1873 [Standard HH Care Management]
    - 1874 [High Risk/Need HH Care Management]
    - 1853 [Health Home Plus (HH+)]
    - 1860 [Adult Home Transition]



Billing Support Questionnaire (BSQ)

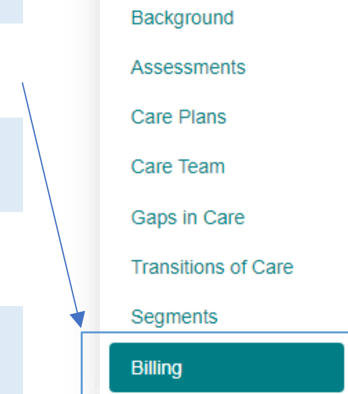
Billing Support Questionnaire (BSQ)

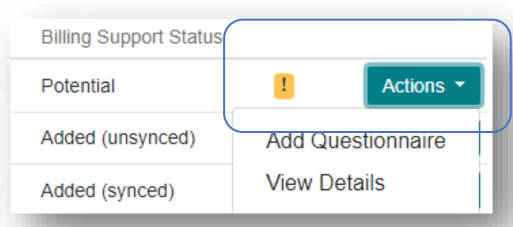
BSQ Elements
❑ Qualifying Conditions / Diagnosis Code
❑ Core Service Status
❑ HIV Status
❑ Housing Status
❑ Incarceration
❑ Inpatient Stays [Mental Illness, Physical, Substance Abuse]
❑ SUD Active Use
❑ Special Populations: AOT, ACT, Adult Home Plus, Health Home Plus (HH+)
❑ UAS Complexity

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

Navigation Steps
❑ Open Member Record
❑ Select **Billing** tab
❑ Navigate to **Actions** (Drop-Down)
❑ Select **Add Questionnaire**
❑ Answer BSQ Questions (**Member Specific**)





BSQ Questions may require research/review of External Information

- ✓ Clinical Event Notifications
- ✓ Diagnostic Lab Results
- ✓ PSYCKES Reports
- ✓ Provider Letters

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

BSQ Elements

- ❑ **Service Date**
  - Billing month
  - Date is 1st of each month [i.e. 7/1/2024]
- ❑ **Diagnosis Code / Qualifying Conditions**
  - Chronic Health Conditions / Selections should be verified and supporting documentation uploaded to member record in "***Documents***" tab
- ❑ **Core Service Provided**
  - Yes: Core Service Encounter
    - ➢ At least (1) CS Encounter **must** be documented in the member record for the billing month to prevent error
  - No

Service Date ?	07/01/2024
Diagnosis Code ?	
Qualifying Conditions	☑ Mental Health
	☐ Substance Abuse
	☐ Asthma
	☐ Diabetes
	☐ Heart Disease
	☐ Overweight
	☑ HIV/AIDS
	☐ Serious Mental Illness/Serious Emotional Disturbance
	☐ Adult HCBS and other conditions
	☐ Sickle Cell Anemia
	☐ One or More DD Conditions
	☐ Other
Description of "Other" Health Home Qualifying Conditions	
Core Service Provided ?	Yes: Core Service Encounter

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

BSQ Elements

- ❑ **HIV Status**
  - HIV Negative or Unknown
  - HIV Positive
    - ➢ HIV Viral Load
    - ➢ T-Cell Count (CD4)
- ❑ **Member Housing Status**
  - Not Homeless
    - ➢ HUD Category 1 in Past 6 Months
  - Homeless
    - ➢ HUD Category 1: Literally Homeless
    - ➢ HUD Category 2: Imminent Risk of Homelessness

HIV Status ? HIV Positive

HIV Viral Load ? < 200

HIV T-Cell Count ? > 200

IF HIV status (or lab values) are unknown:

- Educate member about testing, lab work
- Navigate to testing site/provider for labs

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

HIV

BSQ Documentation Examples

- ❑ **Diagnostic Lab Results**
- ❑ **Medical Records**
- ❑ **Documented Conversation from Collateral Contact**
- ❑ **Collateral Contact MUST be Documented as Service Provider or MCO**

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

Homelessness

BSQ Documentation Examples

- ❑ **Letter from Shelter or Other Homeless Housing Program**
- ❑ **Hospital Discharge Summary**
- ❑ **Eviction Notice**
- ❑ **Documentation from Local Homeless Management Information System**

Self-Report Sufficient Evidence for Initial 90 Days

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

BSQ Elements

- ❑ **Incarceration**
  - Not incarcerated within past year
  - Incarcerated within past year, but release date unknown
  - Incarcerated within past year
    - ➢ Incarceration Release Date
- ❑ **Mental Illness or Physical Health Inpatient Stay**
  - Not discharged from a mental illness OR physical inpatient stay within the past year
  - Discharged from an inpatient stay due to mental illness within the past year, but discharge date unknown
  - Discharged from a mental illness inpatient stay within the past year
  - Discharged from a physical health inpatient stay within the past year

Incarceration ? Incarcerated within past year

Incarceration Release Date ?

July 2024

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13

Mental Illness or Physical Health Inpatient Stay ?

Mental Illness or Physical Health Inpatient Stay ? Discharged from a mental illness inpatient stay w

Mental Illness or Physical Health Inpatient Discharge Date

July 2024

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13

y due to sut

BSQ should reflect most recent Release and/or Discharge Date

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

Incarceration

BSQ Documentation Examples

- ❑ **Release Papers**
- ❑ **Documentation from Parole/Probation**
- ❑ **Documented Conversation from Collateral Contact**
- ❑ **Report from Criminal Justice Database (i.e. Webcrims)**
- ❑ **Letter from Halfway House**

Self-Report Sufficient Evidence for Initial 90 Days

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

Inpatient (IP) Stay for Mental or Physical Illness

BSQ Documentation Examples

- ❑ **Hospital Discharge Summary**
- ❑ **Documented Progress / Encounter Notes**
- ❑ **Documentation of Mobil Crisis Episodes**
- ❑ **PSYCKES Report**
- ❑ **RHIO Alerts (Clinical Event / Healthix) (Admission/Discharge Information)**

Self-Report NOT Sufficient Evidence

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

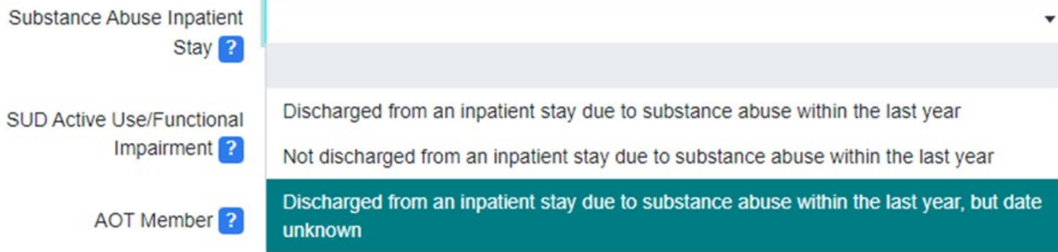
BSQ Elements

- ❑ **Substance Abuse Inpatient Stay**
  - Discharged from an inpatient stay due to substance abuse within the last year
  - Not discharged from an inpatient stay due to substance abuse within the last year
  - Discharged from an inpatient stay due to substance abuse within the last year, but date unknown
- ❑ **SUD Active Use/Functional Impairment**
  - Yes or No

Reminder

- ❑ **Follow Stages of Change**
- ❑ **Review Current Usage**
- ❑ **Discuss Readiness to Change Behaviors**
- ❑ **Person-centered Approach**

"Meet the member where they are at"



Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

Substance Use Disorder (SUD) Treatment Inpatient (IP) Stay

BSQ Documentation Examples

- ❑ **Hospital and Provider Discharge Summary**
- ❑ **Documented Progress Note**
- ❑ **Documentation of Mobile Crisis Episodes**
- ❑ **PSYCKES Report or MCO Confirmation**

Self-Report Sufficient Evidence for Initial 90 Days

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

Substance Use Disorder (SUD) Active Use/Functional Impairment

BSQ Documentation Examples

- ❑ **Based on Assessment and Information Collected from SUD Providers**
- ❑ **Probation/Parole**
- ❑ **Court Ordered Programs**
- ❑ **Domestic Violence Providers**
- ❑ **Local DSS**
- ❑ **Other Sources**

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

BSQ Elements
❑ **AOT Member** ▪ AOT Minimum Services Provided and Caseload Requirement Met
❑ **ACT Member** ▪ Yes / No
❑ **AH Member qualifies for Adult Home Plus Care Management** ▪ No or Unknown ▪ Yes

AOT Member ?

ACT Member

AH Member qualifies for Adult Home Plus Care Management

*Adult Home Plus

❑ **IF Yes, Additional Questions:**

AH Member qualifies for Adult Home Plus Care Management

AH Member transitioned to community

Ah Member Continues To Qualify

AH Member interested in transitioning

**To be completed if CMA serves Adult Home + * (MMC CMA)*

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

BSQ Elements
❑ **Expanded HH Plus Population** ▪ No ▪ Yes (next page)
❑ **HH Plus Minimum Services Provided and Caseload Requirement Met** ▪ No ▪ Yes

Expanded HH Plus Population

HH Plus Minimum Services Provided and Caseload Requirement Met

No

Yes, HIV: Virally unsuppressed

Expanded HH Plus Population: Yes

All members eligible for Health Home Plus

HH Plus Eligibility Should be Verified via:

- ✓ PSYCKES Reports
- ✓ Clinical Event Notifications
- ✓ Diagnostic Lab Results
- ✓ Provider Letters
- ✓ Clinical Discretion

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

- Expanded HH Plus Population

<table>
<tr><th>Yes, HIV:</th><th>Yes, HIV/SMI:</th><th>SMI</th></tr>
<tr>
<td>❑ 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</td>
<td>❑ Homelessness (HUD 1)

❑ Last 12 Months:
▪ 3+ in-patient hospitalizations
OR
▪ 4+ ED Visits

❑ HH+ Transitioning NYC AH+</td>
<td>❑ 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
▪ MCO OR SPOA

❑ Criminal justice involvement
❑ Discharged from state PC
❑ CNYPC release

❑ Act step down
❑ Enhanced service package/voluntary agreement
❑ Expired AOT order within past year</td>
</tr>
</table>

BROOKLYN HEALTH HOME

Billing Support Questionnaire (BSQ)

Billing Support Questionnaire (BSQ) Documentation

Health Home Plus

BSQ Documentation Examples

- ❑ PSYCKES Report
- ❑ Hospital Discharge Documents
- ❑ Diagnostic Labs
- ❑ Clinical Discretion Documents from External Source

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

QI/QA Review & Submission

Before Submitting the BSQ/HML, DID YOU…

❑ Review EVERY response

- Review responses that carried over from the prior month
- UPDATE responses if there are changes to the member's status

❑ Upload supporting documents if the member was recently hospitalized, homeless, had lab work, or discharged from jail/prison/rehab

- ADD Discharge Date and/or Release Date

Once all required fields have been completed and reviewed, select '<u>Create Billing Support Questionnaire</u>' to submit the BSQ

Create Billing Support Questionnaire

Billing Support Questionnaire (BSQ)

Completing a Billing Support Questionnaire (BSQ)

BSQ Documentation Requirements:

- BSQ Responses are required to be substantiated by supporting documentation from Care Providers, the Member, Family or Other 3rd Party Sources (Consented Care Team Members)
- Supporting Documentation is to be uploaded to the member record
- If supporting documentation is unavailable at time of BSQ completion, self-reported information can be used for:
  - Homelessness
  - Incarceration
  - Inpatient Stay for Substance Use (SUD) Treatment
- Self-reported information should be documented in Encounter notes and the members Plan of Care
  - Maintain Billing for **90 Days** until external documentation is obtained

Billing Support Questionnaire (BSQ)

Billing Errors

1 SQC/2 or more chronic conditions Reqd

Based on a MAPP Release in December 2022

This error means that either 1 Single Qualifying Condition should be checked off **or** at least 2 chronic conditions are required to be checked off on the member's BSQ.

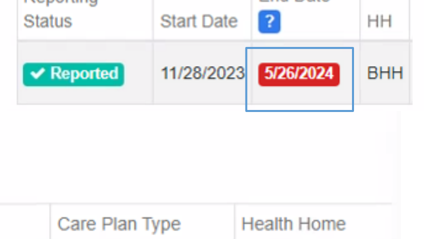
- **Single Qualifying Conditions:**
  - HIV/AIDS
  - Serious Mental Illness/ Serious Emotional Disturbance
  - Sickle Cell Anemia
  - Complex Trauma (under 21 years of age)

A common example of when this error is seen is when a member has *only* Mental Health checked off as their condition in the BSQ and no other conditions marked.

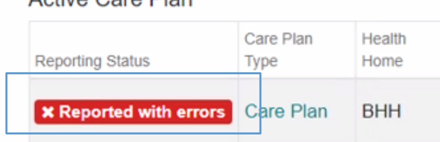
Reporting Status
Hover over to learn more about what steps need to be taken to troubleshoot error

Note: CES Tool End Date highlights CES Tools Coming Due/Expired

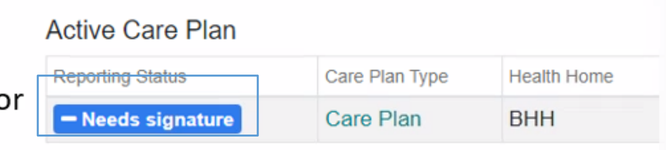
Existing CEST outcome for the member expired



Plan of Care Required error



or



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HIV Care Management Goals

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Case Conference

Case Conference

What Should We Ask the Provider?

Is the member prescribed medications they must adhere to taking?

For MH/Substance Use Treatment Members:

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

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

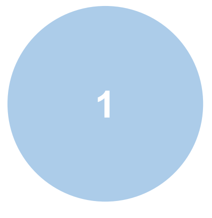
When is the next appointment?

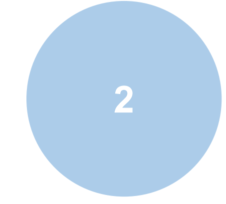
Is there anything I can do to help ensure this person remains compliant with their treatment plan?

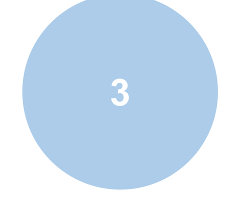
What is the treatment plan for this person?

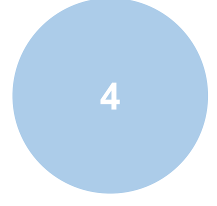
Case Conference

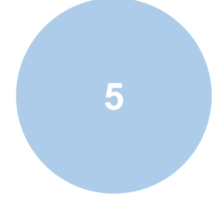
What Should We Ask the Provider?











Medication

Is the member prescribed medications they must adhere to taking?

Safety Plan

MH/Substance Use Treatment Members:

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

Appt Frequency

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

When is the next appointment?

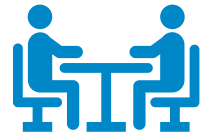
Care Manager Role

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

Treatment Plan

What is the treatment plan for this person?

Case Conference



What Should We Ask the Provider?

Case Conference topics reviewed will be member and may be specific to a particular chronic health condition.

Example:

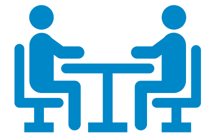
Diabetes Management

- Endocrinologist
- A1C Levels
- Dietary Changes

Behavior/Dietary Changes

- ❑ What are the **3 most important** things we can do to manage this condition?
- ❑ Should the patient change diet or have diet restrictions?
- ❑ Should the patient change or alter Exercise or physical activity?
- ❑ How does the patient take the medication?
  - Route: Ex: p.o (Orally)
  - Frequency: Ex: q.d. (Daily), q.h.s. (Before Bed)
  - Duration: Ex: q.4h (Every 4 Hours)

Case Conference



What Should We Ask the Provider?

Case Conference topics reviewed will be member and may be specific to a particular chronic health condition.

Example:

HIV

- Infectious Disease Provider
- Viral Load, CD4
- ART Schedule, Side Effects

HIV Medication Management

- ❑ What medications/treatments are available
- ❑ How does the patient take the medication?
    - Route: Ex: p.o (Orally)
    - Frequency: Ex: q.d. (Daily), q.h.s. (Before Bed)
    - Duration: Ex: q.4h (Every 4 Hours)
- ❑ Are there any side effects of this medication?
- ❑ Should medications be stopped if side effects occur?

  Is there an alternative treatment

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Case Conference

Critical Events

Graduation

Critical Events

Critical Events

Checklist

Follow-Up
❑ Call the member within **48 hours**
❑ Call Provider, Hospital, Social Worker or Facility
❑ Ask to help with Discharge Planning
❑ Request copy of Discharge Documents
❑ Connect to After-Care: ▪ PCP ▪ Behavioral Health Specialist ▪ MCO ▪ Social Worker ▪ Pharmacy (*medication pick-up/delivery*)

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

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

Event Details

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

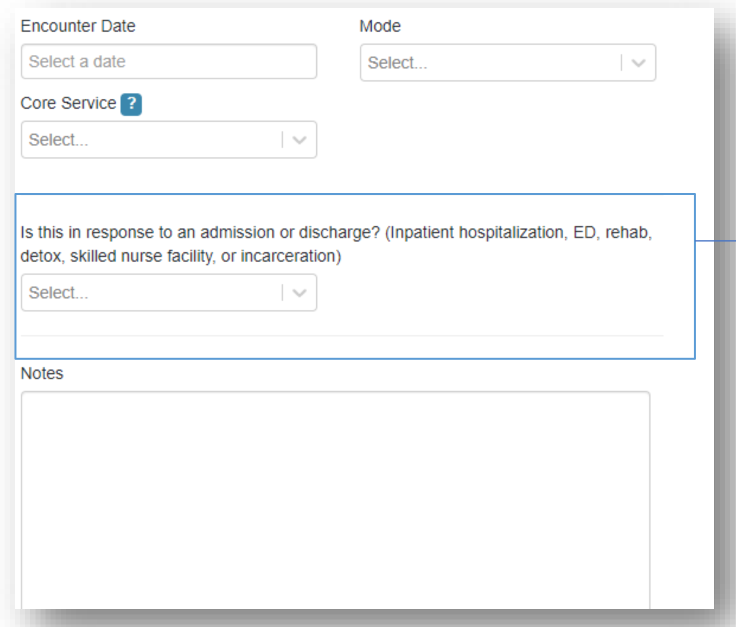
Key Takeaway Notes:

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

Critical Events

Checklist

Admission/Discharge (AD)



Key Takeaway:

- ❑ Select **Yes** - IF encounter is **directly** related to follow-up activities for an Emergency Department and/or Inpatient Stay Admission or Discharge
- ❑ Potential Sources:
  - RHIO/Healthix Clinical Event Notifications
  - MCO Notifications
  - Internal Reporting Systems

Critical Events

CEN Discharge Follow-up Guide

Clinical Event Follow-up Information			
Contact Details	*WHERE*	Hospital/Facility Name: ____________________ Location/Unit: ____________________ Borough: ____________________	1
	WHO	Primary Contact: ____________________ Telephone #: ____________________ Email: ____________________ Best Hour to Call: ____________________	2
	NEXT APPT	Discharge Date: ____________________ Last Appt: ____________________ Next Appt: ____________________ Appt Frequency: ____________________	3
	GOALS / NEEDS	____________________ ____________________ ____________________ ____________________	4

Notes:

BROOKLYN HEALTH HOME

Critical Event Follow-Up

As this person's Care Manager:

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

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

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

Are there discharge recommendations for this person?

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

Are there specific follow-up instructions for this person?

Critical Event Follow-Up

Grouping Clinical Event Notifications (CEN)

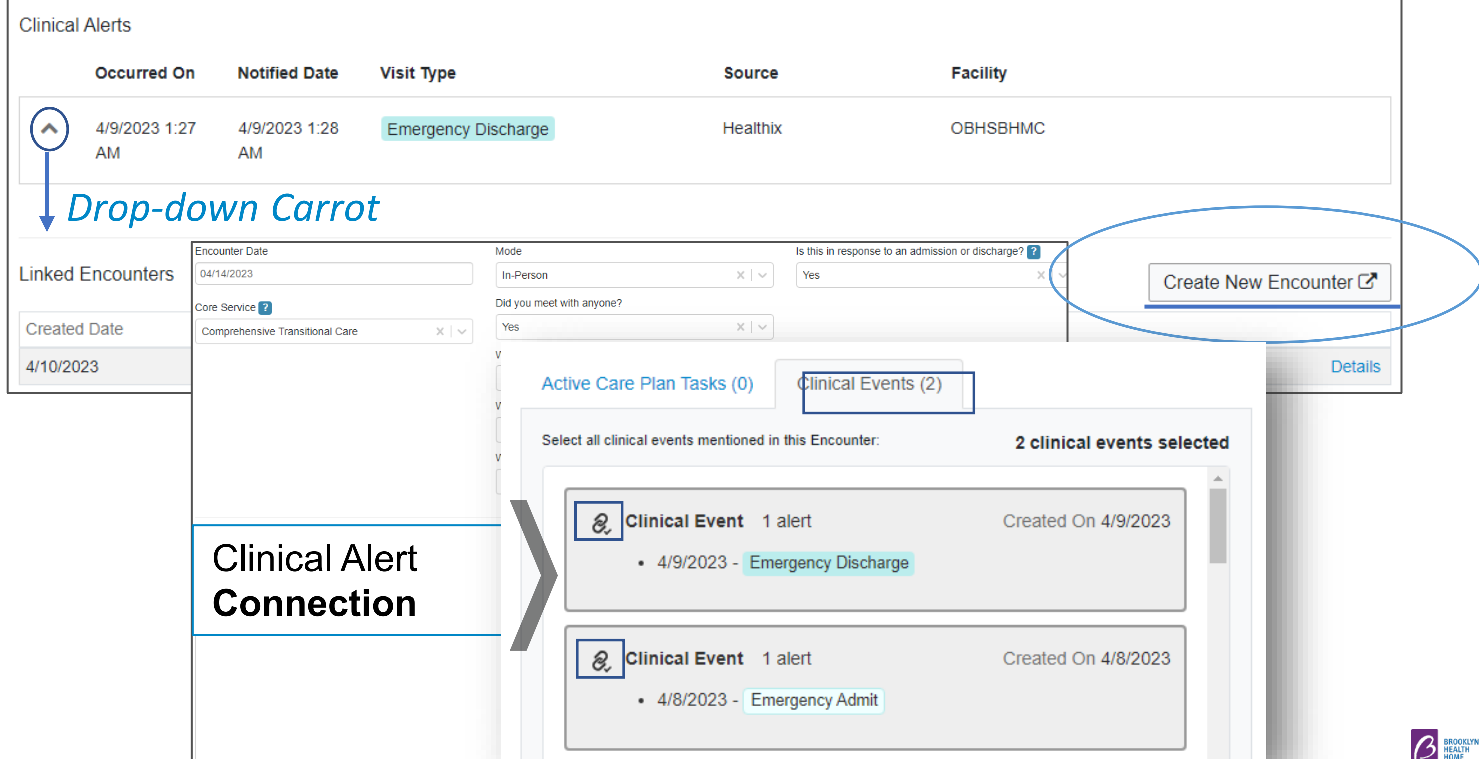
Status: Similar to Gaps in Care CM Status Drop-down Options

Highlight (Below): Multiple Encounters Linked to CEN Alerts!

	Created At	Last Notified Date	Last Updated	Status	# of Alerts		
☐	4/9/2023	4/9/2023	4/10/2023	Care Provided	1 alert	1 encounter	Details
☐	4/8/2023	4/8/2023	4/10/2023	Care Provided	1 alert	1 encounter	Details
☐	3/24/2023	3/24/2023	3/28/2023	In-Progress	1 alert	1 encounter	Details
☐	3/16/2023	3/16/2023	3/17/2023	In-Progress	1 alert	2 encounters	Details
☐	3/16/2023	3/16/2023	3/17/2023	In-Progress	1 alert	2 encounters	Details

Critical Event Follow-Up

Grouping Clinical Event Notifications (CEN)



Critical Event Follow-Up

Grouping Clinical Event Notifications (CEN)

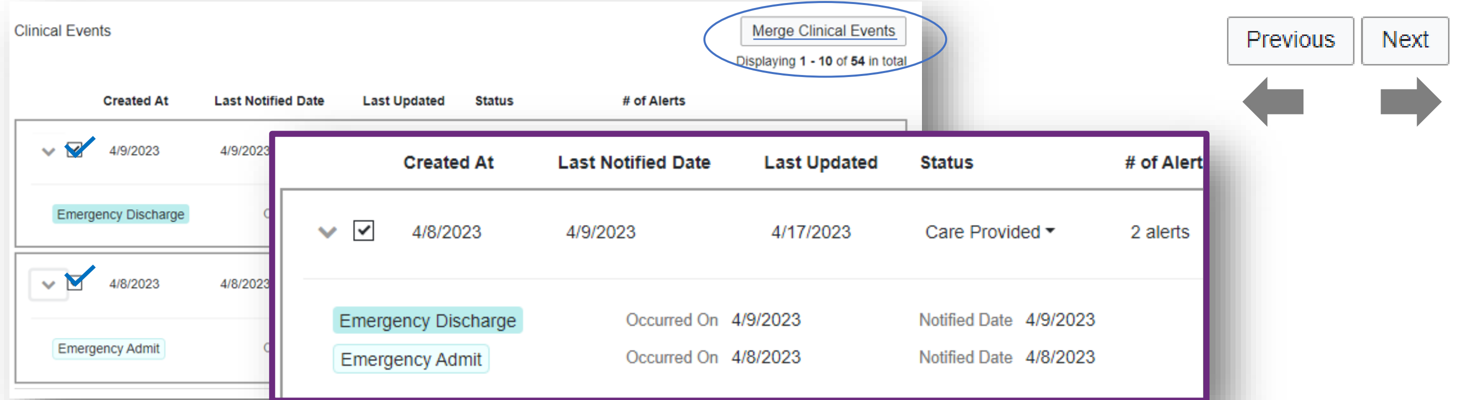
	Created At	Last Notified Date	Last Updated	Status	# of Alerts		
Join	4/9/2023	4/9/2023	4/10/2023	Care Provided	1 alert	1 encounter	Details
	Emergency Discharge	Occurred On 4/9/2023		Notified Date 4/9/2023		Facility OBHSBHMC	
	4/8/2023	4/8/2023	4/10/2023	Care Provided	1 alert	1 encounter	Details
	Emergency Admit	Occurred On 4/8/2023		Notified Date 4/8/2023		Facility OBHSBHMC	
Join	3/24/2023	3/24/2023	3/28/2023	In-Progress	1 alert	1 encounter	Details
	Inpatient Discharge	Occurred On 3/24/2023		Notified Date 3/24/2023		Facility OBHSBHMC	
	3/16/2023	3/16/2023	3/17/2023	In-Progress	1 alert	2 encounters	Details
	Transfer to Inpatient	Occurred On 3/16/2023		Notified Date 3/16/2023		Facility OBHSBHMC	
	3/16/2023	3/16/2023	3/17/2023	In-Progress	1 alert	2 encounters	Details
	Emergency Admit	Occurred On 3/16/2023		Notified Date 3/16/2023		Facility OBHSBHMC	

Critical Event Follow-Up

Grouping Clinical Event Notifications (CEN)

Key Takeaway:

- ❑ View Alert History for Single Occurrence/Stay
  - Collapsing carrots reveal alert details
  - View merged alerts in order
- ❑ Merge Function Combines Linked Encounters into a Single Thread of Information
  - Select **Details - to view an individual encounter**
  - Select "***Previous***" or "***Next***" to read through linked encounters (order of engagement)



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Graduation

Graduation

Graduation

Engaging a Member to Review Graduation:

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

Key Takeaways

CMA Contact Information

Disenrollment Resources

Transition/Discharge Plan

Graduation Documents

Graduation Achievement (Disenrollment) Letter on <u>CMA Letterhead</u>

DOH Form DOH-5235*

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

Graduation

Step by Step: Is the Member Ready for Graduation?

Review:

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

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

Key Actions

- ✓ Case Conference
- ✓ Visual Meeting with Member

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

Graduation

Care Management Graduation Connection Grid

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

Autonomy: Ability to Act or Function Independently

Graduation

Care Transition Step Developer

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

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

Include Details Specific to Service Provider or Community Services

Graduation Checklist

Connected to Healthcare Services

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

Progress toward Personal Goals

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

Manages and Adheres to Treatment/Medication(s)

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

Reduced Risk for Adverse Events

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

Positive Community + Social Support

✓ Family, Friends, Peers, Food Access, Transportation

Disenrollment Process

Completing the DOH 5235 – Notice of Determination - Disenrollment

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Notice of Determination for Disenrollment in the New York State Health Home Program

Notice Date ______________________ CIN Number ______________________

Effective Date (10-day Notice Required) ______________

Health Home

Name Brooklyn Health Home

Address 4802 10th Avenue, Brooklyn, NY, 11219

General Telephone Number for Questions or Help (800) 356-7480

Member

Name ______________________

Parent, Legal Guardian, Legally Authorized Representative, if any ______________________

Address ______________________

This is to advise you that effective ______________ (Date) this agency Brooklyn Health Home (Name of Health Home) will

Disenroll you from the Health Home Program

You do not meet the criteria necessary for continued enrollment and you are being disenrolled from the Health Home Program, as of the effective date listed above, for the following reason(s):

- ☐ You no longer meet the Health Home chronic condition eligibility criteria. You must have either:
  - Two or more chronic condition OR
  - One single qualifying chronic condition (see list of single qualifying conditions on page 3 section A)
- ☐ You no longer have the appropriate type of Medicaid Coverage for Health Home Services.
- ☐ You do not require Health Home Care Management Services because you no longer meet the appropriateness criteria listed below on page three (3), section B.
- ☐ You currently reside in an excluded setting (e.g., Residential Treatment Facility, Nursing Home, Incarceration etc.)
- ☐ You have currently met all of the non-maintenance needs and goals outlined in your Plan of Care.
- ☐ You have moved out of New York State.
- ☐ You can no longer be served due to issues that affect your safety, health and welfare or that of the care management staff.
- ☐ You are concurrently eligible or enrolled, along with your caregiver/guardian in another Health Home.
- ☐ You have disengaged from Health Home Care Management Services and cannot be located or contacted for reengagement.
- ☐ Other (please specify): ______________________

This action is taken under NYS SSL 365-l

Health Home Representative

Signature: X ______________________

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

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Key Takeaways

- ❑ Health Home Name:
  - **Brooklyn Health Home**
  - Not the CMA Name
- ❑ Health Home staff signs page 1
- ❑ Copy of document should be uploaded to member record and given to member
  - If unable, encounter note with reasoning is required
- ❑ Page 2 is **ONLY** completed if the ***member requests a Fair Hearing***

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Initial Appropriateness (IA)

Consent

Assessments

Comprehensive Assessment

Continuing Eligibility Screening (CES) Tool

Plan of Care

Plan of Care Activities

Plan of Care & Encounter Linkages

HARP [HCBS + CORE]

HIV Care Management Goals

Encounters

Core Services

What are Core Services?

Billing Support Questionnaires (BSQ)

Documentation of Billable/Non-Billable Services

Case Conference

Critical Events

Graduation

Resources

Resources

Links

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

Potential Document Application Requirements:

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

Roles

Peer Specialist | Caseload Support

As a Peer Specialist, you are encouraged to:

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

Outreach & Engagement Staff | Caseload Support

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

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

Care Navigator | Caseload Support

As a Care Navigator, you are encouraged to:

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

Care Manager

As a Care Manager, you are responsible for:

- Ensuring that all required assessments and consents are in place for each enrolled member and uploaded in the Care Management Platform
- Building and maintaining positive relationships with the provider community
- Working with the member and the member's care team (as appropriate), to develop and implement a person-centered, integrated care plan, ensuring that this plan is shared across the care team and is inclusive of all member needs and goals
- Overseeing the building of the member's care team, establishing and maintaining positive rapport with all care team members

Supervisor

As a Supervisor, you are responsible for:

- Being a staff member of the care management oversight team that is interdisciplinary in nature (e.g., incorporating medical & behavioral health expertise) for the purpose of providing adequate and comprehensive support and oversight of care management activities

- Overseeing the daily activities of the interdisciplinary care management team, convening staff meetings, facilitating care conferences and discharge planning meetings as needed to ensure appropriate levels of care

- Supporting effective relationships with care providers (e.g., medical staff, behavioral health staff, legal representatives, etc.) in and out of the network in order to assist with the provision of needed referrals, information sharing, and resolution of conflicts

- Engaging in regular quality assurance activities to verify that members are receiving appropriate levels of care, that documentation requirements are upheld, and that all policies and procedures of the Health Home and State are maintained

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