POLICY: 1.000 CARE MANAGEMENT PROGRAM STANDARDS

All patient services should be provided and documented according to the Health Home Program Standards set forth in this policy.

Health Home Standards and Requirements

Standard/Phase	Time Frame	Documents/Forms
Outreach ▪ Welcome Letter ▪ Phone Calls ▪ Internet Search ▪ Street Outreach	4 Months in a rolling twelve (12) month period Actionable Information Needed to initiate outreach	HH Outreach Assessment HH Opt-Out Note Opt-Out (DOH 5059) Notice of Determination for Denial of Enrollment into the Health Home Program
Enrollment ▪ Confirm Eligibility ▪ HH Consent (DOH 5055) ▪ Healthix Consent ▪ Fact-GP ▪ CMA PHI	Within 5 Business days of patient opt-in	HH Consent (DOH 5055) Healthix Consent FACT-GP (Optional) HH Enrollment and Initial Assessment HML Assessment Notice of Determination for Enrollment into Health Home Program (DOH 5234)
FACT-GP (Optional) ▪ Face-to-face encounter ▪ Phone encounter (only at discharge)	▪ Annually; and ▪ At discharge (Optional)	FACT-GP (Optional)
Care Coordination ▪ Implement care management services	See Core Services and Billable Activities	Care Plan Activity Note
Assessment ▪ Face-to-face encounter or via phone ▪ Screen for medical health, behavioral health, and social needs	▪ Begin within 7 days of enrollment; and ▪ Complete within 60 days of enrollment	HH HH Comprehensive
Care Plans ▪ Face-to-face encounter or via phone ▪ Develop Care Plans to address needs that were identified in the assessment	▪ Complete in conjunction with Assessment; ▪ Update every 6 months (every 180 days); and ▪ Complete with Reassessment annually	Care Plans
Reassessment ▪ Face-to-face encounter or via phone ▪ Screen for medical health, behavioral health, and social needs and update patient's status	Annually	HH HH Comprehensive
Case Conferencing ▪ Face-to-face or phone conference with medical, behavioral health, or social service provider to confirm diagnosis, treatment, status, and/or discuss needed care coordination services	Every 6 months	HH Case Conference Assessment Care Plan Activity Note

Standard/Phase	Time Frame	Documents/Forms
Transitional Care (Patients in hospitals, nursing homes, jail, rehab, etc…) ▪ Face-to-face encounter or via phone ▪ Hospitalization F/U ▪ Discharge plan ▪ Update Care Plans	Within 2 days of notification of ED visit; or At least 36 hours after of patient's inpatient admission	Care Plans
HML ▪ Complete monthly	Monthly	High Medium Low (HML) MAPP Assessment
Continuity of Care	2 Months after no patient contact 3 Months Diligent Search 3 Months Continued Search Efforts (6 Months)	HH Continuity of Care Assessment
Withdrawal of Consent (DOH 5058)	HH transfer, case closure, patient declines services or moves out of service area.	HH Disenrollment Note Withdrawal of Consent (DOH 5058) Notice of Determination for Disenrollment from Health Home Program (DOH 5235)

CORE SERVICES AND BILLABLE ACTIVITIES

Each patient must be provided with the appropriate monthly core service(s) and contact requirement must be met based on patient 's acuity level and population type.

In addition to the "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations" document provided by the state, please review below to determine service types for progress notes.

Core Services	Activities
Comprehensive Care Management	▪ Intake/Assessment ▪ Assessment ▪ Reassessment ▪ Care Plan ▪ Crisis Intervention Planning
Care Coordination & Health Promotion	▪ Routine Medical Care Management Activities such as calling providers to discuss the patient's wellbeing, referring patients to medical and behavioral (mental and/or substance abuse) health services, and general medical discussions with client ▪ Scheduling appointments ▪ Accompanying patients to appointments ▪ All Case Conferences ▪ Advocacy for services and assist with scheduling of needed services ▪ Crisis Intervention
Comprehensive Transitional Care	▪ Work done with patients who are transferring in and/or to a setting outside the home (jail, hospitalization, treatment centers, nursing homes, rehabilitation centers, etc.). Patient must be in that setting 180 days or less in order to receive care management services.
Patient & Family Support	▪ Contacts with the family/collateral/caretaker on patient's behalf or to assist patient with issues ▪ Coordinating meetings with patient/family/providers (setting up interpretation services if needed) ▪ Referrals for family and or patient to non-medical services such as DSS, Housing, etc.
Referral to Community & Social Support Services	▪ Non-medical referrals for vocation, employment, training ▪ Any follow up for non-medical referrals ▪ Scheduling Transportation and follow-up

Contact Frequency:

Acuity Level	Population	Contact Requirement
Health Home Care Management	General Health Home	1 contact / month; 1 face-to-face every 180 days
Health Home High Risk Care Management	HARP	1 contact / month; 1 face-to-face as needed
	SNP	1 contact / month; 1 face-to-face as needed
	High Utilizers	1 contact / month; 1 face-to-face as needed
Health Home Plus	HH+ SMI	4 Contacts / month with at least 2 being face-to-face
	HH+ HIV	4 Contacts / month with at least 2 being face-to-face
	AOT	4 F/F Contacts / month
	AH+	4 Contacts / per month with at least 2 being face-to-face

- ***Contact notes must include:***

  Most recent medical visit/information (if applicable)

  Current status of patient's health (Emotional, Mental, and Physical)

  Any issues with health and overall wellbeing

  Any follow up with previously stated issues

- Intake, Assessments and Care Plans should be done face-to-face whenever possible

Progress Note Documentation:

- One of the CMA's primary goals is to identify and address barriers to accessing consistent care. Identified barriers to care should be used to inform interventions, and will be incorporated into each patient's Care Plan.
- Therefore, the Contact/Progress Notes should reflect identification of these barriers and activities to help patients achieve better health outcomes. Moreover, all documentation should also incorporate Care Plan goals and tasks.
- Progress notes should adhere to medical record standards listed below. All notes should be comprehensive, professional, grammatically correct, and easily understood. Abbreviations should be used with care; in general, words should be spelled out, unless the abbreviation is well known.
- Progress notes must be entered into ACD ***within 2 business days*** of the contact date.

Medical Record Standards:

Start time of contact / visit	Duration of contact
Contact Method	Location
Next scheduled visit / Follow up required (if any)	Key issues or immediate concerns

Disengaged

- A member is disengaged from CM services when attempted Standard CM activities for 2 months do not result in successful contact with the member.
- ***An unsuccessful contact is not sufficient for billing. If a patient cannot be reached, attempts to locate the patient through calling emergency contacts, providers, and social service agencies must be documented.***

Determining Successful and Unsuccessful Contacts

- ***Mail:*** All mail is unsuccessful **unless** the patient is in outreach where mail is successful.
- ***Fax:*** All fax transmissions are unsuccessful.
- ***Email:*** The initial email sent to the patient is coded as unsuccessful. When the patient responds, a progress note must written and coded as successful.
- ***Phone***: A successful contact is a verbal exchange between the patient and the care manager. Leaving a voicemail or speaking with a family member of the patient is not a successful contact.

NYP Health Home Assessment Workflow