POLICY: 1.003 OUTREACH AND ENGAGEMENT

Outreach and engagement activities for assigned Medicaid patients eligible for Health Home services will be *active, meaningful, and progressive* and performed over a consecutive two-month period whereas the second consecutive month must be a face to face with the patient. Outreach and engagement procedures begin once patients assignments have been confirmed and finalized.

PROCEDURES:

Outreach and Engagement:

1. Outreach is only allowed 4 months in a rolling twelve-month period
2. Actionable information must be obtained to execute outreach on any given month.
3. Utilize the following acceptable actionable information:
    a. ED/Hospital Alert from MCO/NYPHH
    b. supplemental information from MCO/NYPHH (Updated contact information, provider information)
    c. referral from the NYP Health Home
    d. referral from Community Based Providers
    e. NYSDOH/MCO assignments
    f. member self-referral
    g. member reached and follow-up call or face to face encounter scheduled
4. Mail all assignments a Welcome Letter *within the first outreach month* by using the approved template in *Appendix C*.
5. Execute the following activities to engage the patient.
    a. make at least two attempts by phone
    b. perform online searches to obtain relevant demographic and contact information as needed
    c. reach out to care delivery (e.g., PCMHs) and social service collaborators
    d. conduct a PCMH visit
    e. conduct street outreach, which includes at least one home visit and/or PCMH/ER/hospital visit to be completed at any time during the two consecutive months
6. The second consecutive month of outreach must be a face to face
7. Utilize actionable information to guarantee face-to-face encounter on the second consecutive month and to justify outreach activities conducted.
8. At first contact with the patient, describe HH services using culturally appropriate language that also considers the patient's health literacy.
9. Once the patient has been engaged, confirm whether the patient declines or agrees to receive HH services.
10. For patients declining HH services, complete the opt-out form (DOH-5059), even when the refusal occurs over the phone. In completing the form, verify patients understand the form, which includes reading the form to patients if necessary, providing the form in patients' preferred language, and answering any questions. The opt-out form is currently available in the following languages:

English Chinese Haitian Creole

French	Italian	Korean
Russian	Spanish	

11. For patients found ineligible, CMA must provide patient a Notice of Determination for Denial of Enrollment into the Health Home Program (DOH 5236). Possible reasons for denial of enrollment or disenrollment from the NYS Health Home Program include:
    a. Ineligible for Medicaid – Medicaid is required for enrollment in Health Homes
    b. Member has Medicaid coverage type not compatible with Health Home (Emergency Coverage only, Family Planning only, Essential Plan etc.)
    c. Chronic Condition criteria not met
    d. Member does not meet the appropriateness criteria
    e. Member currently resides in an excluded setting (Residential Treatment Facility, Nursing Home, Incarceration etc.)
    f. Member is concurrently enrolled in another Health Home
12. Outreach billable months cannot exceed 4 months in a rolling twelve-month period

Conversion/Legacy Cases

- These cases include Medicaid patients previously enrolled in other state-funded care management service programs (e.g., HIV COBRA, OMH TCM, MATS). These patients are automatically converted to active HH enrollment within their existing CMA and assigned to a lead HH agency. No outreach activities will be necessary.

Documentation

1. All outreach activities must be documented in the HH Outreach Assessment at least once/month in Allscripts Care Director (ACD).
2. For patients declining HH services, electronically complete opt-out form (DOH-5059) in ACD.
3. Notice of Determination for Denial of Enrollment into the Health Home Program (DOH-5236)

APPENDIX C. Welcome Letter

Dear [Name of eligible patient]:

I am writing to welcome you to the New York State Health Home Program. The Department of Health set up the Health Home Program to offer you more services to deal with your health care needs so that you stay as healthy as you can be.

NewYork-Presbyterian (NYP) is one of the NYSDOH Designated Health Homes in your area. [**Name of Care Management Agency**] is one of the many health care and social services providers working with **NYP** to give you Health Home services.

With [**Name of Care Management Agency**], you will have a Care Manager who will work with your doctors to:

- pay special attention to your health care needs,
- make sure you get the medical services you need; and
- help you get social services you may need, such as housing and food.

These extra services are free. You will get these services only if you want them. The choice is yours.

A Care Manager will call you soon to give you more information and to answer any questions you may have about these extra services.

If you have questions or concerns, you can call **NYPHH** toll free at 1-855-201-9807.

Sincerely,

NewYork Presbyterian
Name of Care Management Agency