POLICY: 1.006 Care Coordination

Each HH patient is assigned a dedicated and qualified care manager (CM) to implement and document all care coordination activities, which must be aligned with patient's medical, behavioral health and social services needs as detailed in the patient's Care Plan.

CARE COORDINATION

What is Care Coordination?

Care coordination is an important aspect of care management and refers to a deliberate organization of services to meet a patient's care needs. It is meant to foster collaboration amongst all persons involved in the patient's care and bridge existing gaps in the patient's care. For Health Home patients, care coordination aims to address the patient's medical, behavioral health, and social needs and brings together the patient and his or her medical, behavioral health, and social service providers, and family and other supports as needed.

The main goal of care coordination is to ensure that the patient receives the most cost-effective, efficient, and high-quality care needed to become and stay as healthy as possible. This requires appropriately (1) obtaining patient's preferences for his or her care, (2) mobilizing personnel and other resources to meet the patient's needs and (3) facilitating a timely and thorough sharing of relevant patient health information and personal preferences between all persons involved in the patient's care.

What is the Role of Care Management Agencies (CMAs) in Care Coordination?

Care Management Agencies (CMAs) are responsible for providing care coordination services to Health Home (HH) patients. The CMA assigns each patient a dedicated Care Manager (CM), who oversees and is responsible for all aspects of the patient's care; this includes providing the HH care coordination and health promotion, patient and family support, and referral to community and social support core services (see *Core Services and Billable Activities* table). Through effective care coordination, CMs can empower patients to better understand their health, access high-quality, and efficient care and take appropriate action to improve their health. Key aspects of care coordination include:

- Advocating for medical, behavioral, and social services on behalf of patients and linking patients to these services as needed;
- Following and supporting patients as needed to ensure they remain appropriately engaged in in their care and adherent to their recommended care;
- Facilitating on-going communication and coordination between the members of the patient's care team and involving the patient in the decision-making process in order to minimize fragmentation of services;
- Implementing health promotion efforts, such as educating the patient, the family or caregiver, and members of the health care delivery team about treatment options, community resources, and psychosocial concerns so that timely and informed decisions can be made
- Empowering the patient to problem-solve by exploring options of care, when available, and alternative plans, when necessary to achieve desired outcomes
- Striving to promote patient self-advocacy and self-determination
- Most importantly, building relationships that foster advocacy, hope, independence, move the patient along the continuum of health; and
- Assisting the client in the safe transitioning of care to the next most appropriate level

PROCEDURE:

Care Coordination

1. Policies and procedures are to be in place to assign qualified care managers (CMs) to HH patients and establish appropriate training and supervisory structures.
    1.1. CMs are to have basic, primary care management skills (*see Appendix D and Care Management Training and Education Requirements*).
    a. CMs must meet all educational and experience requirements, and be supervised and trained as determined by the NYSDOH.
    b. Assignments of CMs must take into consideration:
        i. The CM's level of experience and existing caseload;
        ii. The extent of patient's health and social needs;
        iii. The patient's preference for location and language;
        iv. Whether the patient has any co-occurring Serious Mental Illness or Substance Use Disorder or other co-morbid condition; and
        v. How often the patient utilizes acute care services.
2. CMAs that provide care coordination and direct medical, behavioral health or social services to their assigned patients verify that the providers fall under different supervisory structures (e.g., the CM responds to the HH Director, while the medical provider/physician report to the Chief Medical Office).
3. CM's information is clearly documented in the patient's record on ACD.
4. Confirm that CMs are providing at least one core service each month a patient is enrolled in HH (see Core Services and Billable Activities table for more information).

Use of Peers

5. Establish a process for identifying community-based resources (e.g., peer support groups, self-care programs), referring patients to these services, and confirming patients have access to and are engaged in these services.
    a. It is the expectation of CMAs to utilize peers, support groups and programs to improve patient knowledge regarding their disease, utilization of community based resources, and development of self-management skills.
    b. Peers may also be used to re-engage patients in needed services and assist in care transitions.

Developing MCO Relationships

6. CMAs are expected to develop key relationships with Managed Care Organizations (MCOs). CMAs must leverage communications with MCOs to make appropriate referrals for medically necessary services, particularly with HARP patients and obtaining LOSD for BH HCBS referrals (please see HARP policy). Additional opportunities to work collaboratively with MCOs include:
    a. Receiving referrals for Health Home Care Coordination
    b. Obtaining updated contact information when conducting outreach
    c. Notification of status changes in care (Continuity of Care, ED/ Inpatient visits, ect.)
    d. Conducting Patient Centered Care Planning activities (case conferences, explanation of services, prior authorizations)

Establishing 24/7 Access to Care Management Services

7. Establish a system to provide patients' access to their CM as well as information and emergency consultation services 24/7.
    a. The NYPHH will also have 24/7 access available.
        i. During the day, when patients call the toll free number(212-342-0454), one of the NYPHH staff will address their needs.
        ii. After 5:00 pm and on the weekends, patients who call the toll free number will be redirected the Community of Population Health's access and scheduling after hours vendor.
            1. If the patients presents with a medical /urgent need, the on call provider is contacted and will follow up with the patient.
            2. If the patient's need is not urgent and / or determined as a care coordination service
                a. The call center will provide contact information for the Care Management Agency designated service
                b. The encounter will be emailed to the NYPHH
                c. The NYPHH will contact the Care Management Agency designated contact the next business day
                d. The Care Management Agency must follow up with the patient no later than 48 hours after notification from NYPHH
8. Secure appointments for patients in a timely manner within the patient's HH provider network and conduct necessary follow-up to verify patients went to their appointments.
9. Policies and procedures must be in place for CMs to address any patient-related treatment conflicts or barriers.
10. Link patients to wellness and prevention services such as smoking cessation, chronic illness-specific (e.g., asthma, diabetes), and addiction recovery resources, as needed.
11. Perform case conferencing as needed (please see policy on Case Conferencing for more information).
12. Discuss, educate and confirm advance directives (e.g., DNR, Health Care Proxy) with patients and their families or caregivers, and should be properly documented.
13. Consider patient's language, literacy and cultural preferences when providing any care coordination services.
14. Conduct on-going case reviews with all CMs to evaluate overall care coordination services being provided to patient.

- **Documentation**
    1. All care coordination services provided must be documented in the Care Plan Activity Note section on ACD.

APPENDIX D: Primary Skills of Care Managers

- Positive relationship-building
- Negotiation Skills
- Attention to cultural competency
- Plan and organize effectively
- Knowledge of health care services and health care delivery systems
- Effective written/verbal communication
- Understanding the consent and client confidentiality processes at NYP
- Use of critical thinking and analysis skills
- Promote client autonomy and self-determination
- Knowledge of clinical standards and outcomes