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INTRODUCTION AND BACKGROUND:
Health Homes of Upstate New York (HHUNY) is pleased to welcome your organization as a provider of Health Home Care Management Services in our network of providers. We look forward to working with you in providing services for our Health Home Enrollees. This document was created with consideration for the continued development of Health Home requirements from the State of New York. This document provides interim expectations for care management service provision with further standards being developed as guidance is provided from the State as well as consideration of the feedback we receive from our network partners.

Services provided to Health Home enrollees must be in compliance with New York State Regulations and Federal Law including compliance with New York State’s Plan Amendment and Medicaid regulations. All care management services that are billed either directly to Medicaid or to the Health Home for the purposes of Medicaid billing must meet Medicaid billing standards. Attached you will find copies of the Phase 2 and Phase 3 New York State Plan Amendments as well as the New York State Medicaid Updates, April 2012 and November 2012 Special Editions and December 2012 (relevant section), which provide further information relative to the provision of health home services. These documents may also be found on the Health Homes section of the NYS DOH website by following the link to the SPA at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm and the link to the Medicaid Updates at http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/medicaid_updates.htm.

Federal Law and State Regulations require providers to retain financial and health records necessary to fully disclose the extent of services, care and supplies provided to Medicaid enrollees. For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment.

HHUNY will provide updated information and care management requirements regularly to the Principal Contact indicated on your Network Provider Letter of Intent. Care Management Agencies are required to respond immediately to any guidance information provided by HHUNY or to changes in the rules governing Medicaid Health Homes. It is vital that Care Management Agencies inform HHUNY as to any changes in the principal contact including contact name, phone number, address and/or e-mail address by notifying your Health Home Provider Lead contact.
HHUNY CONTACT INFORMATION:

For any questions or assistance, please feel free to contact either your Health Home Provider Lead or the HHUNY office at 585-613-7665.

Huther Doyle Memorial Institute, Inc.
Serving: Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, and Yates
Contact: Robert Lebman, rlebman@hutherdoyle.com, 585-325-5100

Lake Shore Behavioral Health
Serving: Erie
Contact: Howard Hitzel, hhitzel@lake-shore.org, 716-842-0440

Onondaga Case Management Services, Inc.
Serving: Cayuga, Chemung, Cortland, Madison, Onondaga, Oswego, Tioga, and Tompkins
Contact: Shawna Craigmile, LCSW, scraigmile@ocmsinc.org, 315-472-7362 ext. 265

Chautauqua County Department of Mental Hygiene
Serving: Allegany, Cattaraugus, and Chautauqua
Contact: Patricia A. Brinkman, MBA, brinkmap@co.chautauqua.ny.us, 716-753-4104

Provider Network Questions:
Contact: Arlene Pitts, apitts@hhuny.org, 585-613-7646

Billing Questions
Contact: Sarah Larter, slarter@ccsi.org, 585-613-7687

Assignment Questions:
Primary Contact: Helen Warnick, hwarnick@hhuny.org, 585-613-7678

Community Referral Questions:
Primary Contact: Tracy Marchese, tmarchese@hhuny.org, 585-613-7642

Assignment/Community Referral Questions
Contact: Christine Mangione, cmangione@hhuny.org, 585-613-7652

NetSmart CareManager /IT Questions:
Contact: Derek Ross, dross@ccsi.org, 585-613-7683

Care Management Service Provision Questions:
Contact: Christine Mangione, RN, CCM cmangione@hhuny.org, 585-613-7652
Clinical Director
Contact: Sharon Bauer, sbauer@hhuny.org 585-613-7676
Program Director
SERVICE PROVISION:
Care Management Agencies that contract with HHUNY to provide Health Home Care Management must be fully aware of the rules and regulations that govern Health Home Care Management Services. Care Managers must be aware of the requirements of service provision in Health Homes and demonstrate competencies in the provision of those services.

Evaluating for eligibility and need:
Health Home resources should be prioritized for the neediest members. Assessment for referral should include three steps.

Step1- Assess eligibility: Must meet eligibility for Health home Services as described in the New York State Health home Plan Amendment (claims data should be used whenever available to verify medical and psychiatric diagnosis).

Must meet either A only or B only or two C to be eligible or ACT recipients with active Medicaid.

<table>
<thead>
<tr>
<th>Check</th>
<th>Category</th>
<th>Specify Diagnosis; Provide Available Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Serious mental illness</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Mental Health condition</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Substance Abuse Disorder</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>BMI &gt; 25</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Other Chronic Conditions (Specify)</td>
<td></td>
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</tbody>
</table>
Step 2 - Assess appropriateness for Health Home: Has significant behavioral, medical or social risk factors which can be modified/ameliorated through care management including any of the following:

Risk Factors - Check All that Apply

<table>
<thead>
<tr>
<th>Check</th>
<th>Category</th>
<th>Detail Indicating How Referral Meets the Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of or inadequate social/family/housing support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of or inadequate connectivity with healthcare system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-adherence to treatments or medication(s) or difficulty managing medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recent release from incarceration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recent release from psychiatric hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deficits in activities of daily living such as dressing, eating, hunger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning or cognition issues</td>
<td></td>
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</tbody>
</table>

Other factors to be considered to determine the suitability of Health home services include a history of poor connectivity to care, including but not limited to:

- No primary care physician
- No connection to specialty doctor or other practitioner
- Does not keep appointments
- Inappropriate ED use
- Repeated recent hospitalization for preventable conditions either medical or psychiatric
- Recent release from incarceration
- Homelessness

Step 3 - Initiate Referral: If the member meets criteria described in Steps 1-2, the referral can be made on the basis of this presumptive assessment.
Assignment:
Each Health Home Enrollee will be assigned one dedicated care manager who is responsible for overall management and coordination of the enrollee’s care plan, which will include both medical/behavioral health and social services needs and goals.

Health Home Care Management Service definitions are found in the State Plan Amendment with additional detail found in the Medicaid Update, April 2012:

Health Homes must provide at least one of the five core (exclusive of HIT)
Health Homes services per month to meet minimum billing requirements. The mode of contact may include, but is not limited to: face to face meeting(s) (no minimum requirement), mailings, electronic media, telephone calls, and case conferences. Active, ongoing and progressive engagement with the client must be documented in the care management record to demonstrate active progress toward outreach and engagement, care planning and/or the client achieving their personal goals. The State retains the right to review Health Homes care records as required to assure that active services were being provided in each month for which a Medicaid payment was made for Health Home services.

Outreach & Engagement: New York State Medicaid Update, April 2012 provides the following information regarding Outreach and Engagement:

The outreach and engagement Per Member Per Month payment will be available for three months. If outreach and engagement is unsuccessful (defined as not locating the member and/or not enrolling the member), the provider may continue outreach and engagement but may not bill again for these activities until the conclusion of a three-month interval.

Health Home Care Management Agencies are to begin outreach and engagement activities in a timely manner once they have received a Health Home enrollee assignment. For assignments received prior to the 15th of any month, outreach and engagement must begin within 5 business days of the receipt of the assignment. For assignments received later in the month, the Care Management Agency should consider the all information made available during the assignment process to determine how quickly outreach should begin, including, enrollee’s known needs and risk factors, as well as any requirements of the MCO for those who are enrolled in a managed care plan to determine if it is appropriate to defer outreach activities to the 1st of the following month. The following time lines must be adhered to for assignments of enrollees with an AOT order or for enrollees in an inpatient program at time of assignment:

AOT: Care Management Agencies receiving assignment of an enrollee who has an AOT order must begin Outreach and Engagement Activities within 3 business days of receiving the assignment.
**Inpatient Enrollees:** In instances when a Care Management Agency receives an assignment of an enrollee who is presently in an inpatient program, Outreach and Engagement Activities must begin within 3 business days of receiving the assignment or prior to the individual’s discharge, whichever is sooner with the intent being to connect with the enrollee prior to discharge.

The date these activities begin, as well as the specific activity, is to be clearly documented in the contact note.

Health Home Care Management Agencies are to utilize information provided by the Health Home as well as various outreach methods to locate the individual who is eligible for Health Home Services including:

- Office based outreach (phone calls, letters, collateral contacts)
- Community based outreach
  - Enrollee’s home/neighbors/landlord
  - Community locations (corner store, drop in centers, faith based organizations, etc.)
  - Last known service providers (doctors, hospitals, dentist, etc.)
  - Managed Care Organizations
  - Family members
  - Homeless shelters/social service providers
  - Jail/prison
  - LGU/SPOA and other community networking groups
  - Health Information databases (PSYCKES, Regional Behavioral Health Organization (RBHO), and/or the claims data provided from DOH in the Member Tracking System)

Health Home Care Managers are expected to provide, and document, progressively intensive outreach activities. Outreach and engagement may be billed for up to 3 months. If at the end of the 3 months the individual has not been located, and/or initially engaged, the Care Management Agency is to determine if efforts to locate the individual will continue beyond the initial 3 months. Billing for outreach activity shall be in compliance with NYS DOH guidelines.

Once a Health Home enrollee has been contacted, the Health Home Care Manager ensures the individual has a clear understanding about NYS Health Homes and the services available to them through Care Management. The Health Home Care Manager will consider how the individual understands this information based on their cognitive, language, and reading abilities.

HHUNY defines the ending of outreach and engagement and the commencement of ongoing care management as being the point where the individual is verbalizing willingness to participate in Health Home Services and the assessment process is able to begin. The date indicating the start of on-going care management must be documented in the contact note.

**Opt-Out:**
The Health Home program is voluntary and Health Home Care Managers need to be fully aware of NYS Health Home rules regarding an individual’s ability to Opt-Out of Health Homes. For
individuals considering opting out of Health Homes, the Care Manager is to ensure that the individual and their natural supports understand the benefits of participating in Health Homes and Care Management Services. It is important that the individual understand that they can continue to utilize Medicaid services if they opt-out of Health Homes and are informed about the process to re-enroll in Health Homes if they chose to do so in the future.

For individuals who decide to opt-out of Health Homes, the Health Home Opt-Out Form (DOH-5059) must be completed and signed either by the individual or the Health Home Care Manager. This form is attached and may also be found on the Health Homes section of the NYS DOH website by following the link: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/#optout.
The individual is considered dis-enrolled from Health Homes once the form is completed. The date the Opt-Out Form is signed must be indicated in the contact notes.

**Lost to Service:**
Per the NYS Health Homes Provider Manual, a “Health Home member is considered Lost to Services when the Health Home is no longer able to locate the member to provider Health Home services. Lost to Services will be determined pursuant to policies and standards established by each Designated Health Home.” The designation of Lost to Services is specific to active enrolled individuals in the Health Home program who become unreachable. Upon determining an individual Lost to Services, any services rendered to relocate the individual will be billable at the Outreach/Engagement Health Home rate.

**NYS DOH Guidance:**
- NYS Health Homes Provider Manual – Section 3.8, Section 6.22,
- NYS Health Homes – Q&A - Population Assignment/Eligibility (Patient Tracking System) - Question 32

1. **HHUNY Lost to Service Policy:**
It is the policy of HHUNY to consider an individual to be Lost to Services if a care manager cannot successfully contact the member for 60 days past a missed schedule contact. The individual should be actively enrolled in the Health Home Program in order to be considered Lost to Services. This treatment does not pertain to individuals in the Outreach/Engagement segment.

Upon a missing appointment, there is an expectation that the care manager will immediately follow up with the member. Subsequent follow up with the member, available social supports, and referred providers should be made on a regular and progressive basis. The expectation is that the Care Manager would be actively attempting to re-engage the member in the program through all available venues. If all attempts to locate the member do not result in direct contact with the member...
for 60 days from the last scheduled contact, the member shall be determined Lost to Services.

Upon determination, the active enrollment segment will be ended and an outreach/engagement segment will begin. The member may be in the outreach/engagement segment for three months, during which the care manager shall continue outreach/engagement efforts in line with the standards set for that segment. If the member is not located within the three months of outreach/engagement, the member should be dis-enrolled from the Health Home program. Additional segments of hiatus and billable outreach are not appropriate for members Lost to Services. Continued attempts at contact would be at the Care Management Agency's discretion.

If the member is located and re-engaged in the health home program, he/she will be reinstated in an active enrollment segment.

Note: Billing for outreach/engagement after a client is determined lost to services is acceptable only if a three month period has lapsed since the Health Home last billed for outreach/engagement for the member. Billing will only start for outreach/engagement after three months have lapsed, possibly limiting the number of months of outreach that will be billed during the Lost to Services determination.

2. Lost to Service Procedure for Users of CareManager 2.0:
The timing for the 60-day count to determine Lost to Services shall begin the first day a contact is missed or the client is unable to be reached via the usual outlets. During the 60 days following a missed contact, attempts to re-engage the client should be active and progressive. Billing for this period would be done at the enrolled rate and efforts to re-engage the client should be done at the level that is sufficient for billing at this rate.

At 60 days from the missed contact, the client shall be considered Lost to Services. The client shall remain in the enrolled segment through the end of the month in which the determination has been made. Billing at the enrolled rate is acceptable during this month if a billable service has been achieved. A new discharge should be added in Netsmart, with a discharge date of the last day of the month with “Enrolled HH Patient Lost to Services” as the Reason for Discharge. This will create a tracking file in the system that will end date the enrollment segment the last day of the month in which the client was determined Lost to Services.

The client will start an outreach/engagement segment starting the first day of the following month. The client will need to be re-enrolled in Netsmart in the Client Search phase. A support ticket should be submitted to ITSupport@HHUNY.org to request a re-assignment of the client to begin the outreach segment due to the Lost to Services determination. During this three-month segment, billing at the outreach/engagement rate is acceptable if billable services have been provided based on the acceptable standards of outreach/engagement activities. If the client is
not found after the normal three months of outreach/engagement, the client shall be dis-enrolled entirely from the system. A Client Search Note should be used stating that the Client Opt-Out of Health Home Services, with the reason being “Inability to Contact/Located patient.”

If the member is located and re-engaged at any point in the outreach/engagement segment, a Client Search Note should be used to enroll the member in the Health Home Program to transfer the client back to an active enrollment segment. If the re-engagement is done after the three months of outreach/engagement, a support ticket should be submitted to ITSupport@HHUNY.org to request a re-enrollment of the client.

### 3. Lost to Service Procedure for Non-Users of CareManager 2.0:

The timing for the 60-day count to determine Lost to Services shall begin the first day a contact is missed or the client is unable to be reached via the usual outlets. During the 60 days following a missed contact, attempts to re-engage the client should be active and progressive. Billing for this period would be done at the enrolled rate and efforts to re-engage the client should be done at the level that is sufficient for billing at this rate.

At 60 days from the missed contact, the client shall be considered Lost to Services. The client shall remain in the enrolled segment through the end of the month in which the determination has been made. Billing at the enrolled rate is acceptable during this final month of enrollment if a billable service has been achieved. A change record should be submitted, end dating the enrollment segment the last day of the month in which the client was determined Lost to Services using the Segment End Date Reason Code 14 – Enrolled in Health Home Patient Lost to Services.

The client will start an outreach/engagement segment starting the first day of the following month. An add record should be submitted starting an outreach/engagement segment on the first day of the month following the lost to services determination. During the subsequent three-month segment, billing at the outreach/engagement rate is acceptable if billable services have been provided based on the acceptable standards of outreach/engagement activities. If the client is not found after the normal three months of outreach/engagement, the client shall be dis-enrolled entirely from the program.

If the member is located and re-engaged at any point in the outreach/engagement segment or thereafter, an add record should be submitted to transfer the client back to an active enrollment segment.

If the member is located and re-engaged at any point in the outreach/engagement segment, a Client Search Note should be used to enroll the member in the Health Home Program to transfer the client back to an active enrollment segment. If the re-engagement is done after the three months of outreach/engagement, a support
On-Going Care Management:
Care Management Agencies must assure that Core Health Home Services Interventions/Activities are being provided and documented monthly. Care Management Agencies are to ensure the following services are being provided as per the enrollee’s needs:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Patient & Family Support
- Referral to Community & Social Support Services

Services coordinated in conjunction with the Health Home:

- ED visits
- Hospital inpatient
- Residential /Rehabilitation:
- Crisis Intervention Services:
- Linkages to acute & outpatient medical, mental health and substance use services:
- Linkages to community based social support services, including housing:

Please refer to the attached New York State Plan Amendment as well as the April 2012 New York State Medicaid update for further detail regarding Core Health Home Services.
MANAGED CARE ORGANIZATIONS:
HHUNY will make available to Care Management Agencies information regarding providing services to individuals who participate in a managed care plan. Care Managers must support Health Home enrollees in accessing services as allowed by their managed care plan.
CONSENT:
Securing Consent:
Health Home Care Managers must be fully aware of NYS Health Home rules regarding the completion of the Health Home Patient Information Sharing Consent Form (DOH-5055). This form and instructions for its use are attached and may also be found on the Health Homes section of the NYS DOH website by following the link: http://www.health.ny.gov/health_care/medicaidprogram/medicaid_health_homes/forms/#consent. It is the Health Home Care Manager's responsibility to assure that the individual understands the information, has the opportunity to ask questions, and have the form made available in the individual's primary language (as made available by DOH). For individuals with concerns about the consent form, Health Home Care Managers are encouraged to seek engagement of others, utilize a supervisory consult, and/or peer services. It is important that the individual be fully informed about the consent process.

The Consent Form must be provided to all relevant parties and maintained in the care management record.

Withdrawal of Consent:
An enrollee may withdraw their consent at any time by submitting a Health Home Information Sharing Withdrawal of Consent Form (DOH 5058). The submission of this form states the enrollee’s decision to dis-enroll from the Health Home. This form is attached and may also be found on the Health Homes section of the NYS DOH website by following the link: http://www.health.ny.gov/health_care/medicaidprogram/medicaid_health_homes/forms/#withdrawal.

The Health Home Care Manager is responsible for notifying all relevant parties if a member withdraws their consent. The Withdrawal Form must be provided to all relevant parties and maintained in the care management record.
ON-CALL ACCESS:
New York State requires Health Home enrollees to have access to a Care Manager 24 hours / 7 days a week to provide information and emergency consultation. Care Management Agencies will ensure that a qualified Care Manager is available for this purpose and that enrollees are aware and have access to this service.
HEALTH HOME DOCUMENTATION:
Each Health Home Enrollee will have a single care management record which will minimally include the following documentation:

- Health Home Patient Information Sharing Consent Form and any additional consent forms
- Health Home Opt-Out Form (if applicable)
- Health Home Patient Information Sharing Withdrawal of Consent Form (if applicable)
- Comprehensive Assessment
- Plan of Care
- Plan of Care Review
- Crisis Plan
- Contact Notes
- FACT-GP
- Health Home Functional Assessment

Comprehensive Assessment:
New York State Health Home requires that each enrollee has a Comprehensive Health Assessment completed, which is used to identify the enrollee’s physical, mental health, chemical dependency and social services needs, as applicable.

HHUNY requires that the Comprehensive Assessment be completed within 30 days of the start of on-going care management. Appreciating the barriers and challenges that some of the enrollees experience, if the Care Manager is unable to complete the comprehensive assessment within 30 days, there must be documentation that details ongoing efforts to engage the individual in completing the assessment.

HHUNY requires that all of the following domains are addressed in the Comprehensive Assessment:

- Physical Health
- Mental Health
- Chemical abuse/dependency
- Housing, transportation, financial, employment, education
- Relationships, community involvement
- Identification of all current providers
- Enrollee identified barriers, strengths and priorities

The HHUNY Comprehensive Assessment document is attached.

On-going care management includes the process of re-assessing the individual’s interests and needs.

Plan of Care:
New York State Plan Amendment requires:

- Each enrollee will have a comprehensive, individualized, patient centered plan of care. The plan of care will be based on information obtained from the
comprehensive assessment. The plan of care will be required to include and integrate the individual’s medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable.

- The plan of care will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager, and other providers directly involved in the individual’s care.
- The individual’s plan of care must also identify community networks and supports that will be utilized to address their needs.
- Goals and timeframes for improving the patient’s health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.
- Family members and other supports involved in the patient’s care should be identified and included in the plan and execution of care as requested by the individual.
- The plan of care must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care.
- The plan of care will include periodic reassessment of the individual’s needs and goals and clearly identify the patient’s progress in meeting goals. Changes in the plan of care will be based on changes in the patients need.

The Care Manager is responsible for developing an Interdisciplinary Care Team that includes the individual, treatment/care and support providers and others identified by the enrollee as important (i.e. family members, peers, natural supports). The Plan of Care is to be developed with the individual and the Care Team, including and integrating the individual’s medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The Care Plan, and progress and updates to the Plan, are to be shared among all relevant parties, with the appropriate consents. Interim mechanisms for sharing the Care Plan may include transmission via secure e-mail or fax.

In addition to what is required by the State, HHUNY further requires the Plan of Care to include what is important to the individual, what goals they have for themselves, what strengths can be utilized in their Plan of Care, what barriers impede goal attainment, and what priorities and preferences the person has for care. Goals are to be written in the person’s own words and reflect an overall goal the person wants for themselves. Strengths and barriers identified should be related to the goal. Objectives must be measurable, time specific, achievable, and based on barriers preventing attainment of the recovery goal. Interventions must address who will do what, where, and within what time frame. The Plan of Care must be written in a manner that is understandable to the individual (at their reading and comprehension level) and either translated into their primary language if they are unable to read English or translation services must be made available to ensure that the Plan of Care is understood and the information is effectively communicated to the individual. If the enrollee so chooses, a family member or natural support may
be used to provide such translation. The Plan of Care must be reviewed and signed by the enrollee.

Particular attention should be paid to developing plans that address periods of transition such as a discharge from an inpatient setting back to the community and discharge from the Health Home.

The Plan of Care is to be completed 30 days after the completion of the Comprehensive Assessment. As with the Comprehensive Assessment, appreciating the barriers and challenges that some of the enrollees experience, if the Care Manager is unable to complete the Plan of Care within 30 days, there must be documentation that details ongoing efforts to engage the individual in completing the Plan of Care.

The Plan of Care is to be reviewed minimally every 6 months to monitor and evaluate individual progress and ongoing needs. These reviews will involve the Health Home enrollee and include discussion regarding their progress towards identified goals, the effectiveness and satisfaction of interventions identified in the Plan of Care, and address integration of new strengths/barriers identified. Plan of Care reviews shall also include dialogue (by phone and/or by use of conference tools) with involved service providers to assure that changes in treatment or medical conditions are addressed as well.

**Example of Plan of Care**

<table>
<thead>
<tr>
<th>Problem/Needs</th>
<th>Goals</th>
<th>Objectives</th>
<th>Interventions</th>
<th>Person/Agency Responsible</th>
<th>Activity Done</th>
<th>Goals Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. H. lacks current medical care; her arthritis, her cloudy vision, her forgetfulness have not been evaluated recently</td>
<td>“I want to be healthier and feel better so that I can play with my grandchildren”</td>
<td>Mrs. H will have a physical exam within 6 weeks</td>
<td>Identify potential PCPs, discuss preference with client and schedule appt for Physical Exam with preferred provider.</td>
<td>PCP</td>
<td>5/12/14</td>
<td>Yes</td>
</tr>
<tr>
<td>CM will schedule appointments &amp; arrange for transportation based on PCP recommendations and client preference</td>
<td>PCP/Specialists involved as required (Provide specific info, such as names and specialty) CM to provide support to implement and facilitate communication between providers.</td>
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</tbody>
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**Crisis Plan:**
The Crisis Plan is a guide to give members, providers, families and communities critical concepts and components of good crisis planning, stimulate thinking about the crisis preparedness process and provide examples of promising practices.

The Crisis Plan does not provide a cookbook approach to crisis preparedness. Each member has his/her own personal needs and can include cultural, religious, and ethnic factors important to the member. “**Is there something about your culture you’d like to share? Is there something that would be important for someone who’s giving you support to know?**”

**Example:** Jehovah’s Witnesses do not accept blood transfusions or donate or store their own blood for transfusion.

Crisis Planning is a continuous process in which all phases of the plan are being reviewed and revised. Good plans are never finished. They can always be updated based on changing to meet the member’s needs. Crisis plans should be updated with Care Plans or if a member as any significant life changes. Example: **Member moving to a new to a new apartment may affect the member community resource in his/her crisis plan, which will need to be update to new community.**

**A crisis plan is designed to provide guidelines for a practical preparedness and action that is adaptable for any crisis situation.**

**The Purpose of Crisis Plan (From the individual’s perspective):**
“The purpose of a Crisis Plan is for you to create a plan you and or your providers can access when you are having a hard time. The best time to work on this document is when you are doing well. While those may not be the times you want to think about a crisis, it can be beneficial for you should you ever need to access crisis services in the future. You can fill this out alone or in conversation with someone else. This is simply a guide, it is YOUR crisis plan, use it however you would like. The Crisis Plan is to help you figure out ways to stay healthy and avoid crisis”.

**Who participates in developing an Individual Crisis Plan: Who is involved in person centered planning?**
The focus person and whoever they would like can be involved. It is best when there is a facilitator and a person to record what is being shared. The facilitator should be a person that is neutral and unbiased, leads the group through the process, handles conflict and assures equal opportunity for all to participate. Others that may be included are parents/guardians, other family members, friends, professionals, and anyone else who has a personal interest in the person.
**Getting Started with Developing Crisis Plan with Member:**
The Crisis Plan should be completed within 30 days of enrollment, face to face with the member. A good time to develop a crisis plan is when developing the member’s care plan and completing the comprehensive assessment.

**Practical Information on Crisis Planning: Create a Crisis Plan**
People can still experience a crisis when they have utilized the best resources available. It is important to have a written plan in place in case of a crisis. A good plan will:

- Identify people willing to help
- List the phone numbers of the mental health providers and the mental health crisis team
- Include a list of current medications and their dosages
- Identify key words or calming techniques that have worked in the past
- Health Needs: Are there things regarding the member’s health that you need to be mindful of; for instance, dietary restrictions, or allergies? Another example is c-pap breathing machine.
- Emergency Contact: Who would the individual like to have notified if in a crisis? Are there limits they would like set around this? For example, “I would like you to call my emergency contact if I can’t speak for myself, however, if you are able to converse with me, please ask my permission to contact this person. ~or~ only contact this person if my life is at risk.”
- Directions to Home: This is helpful if the plan is given to a crisis team, peer organization, or others who may come to your home to support the member.
- Service Providers: Are there some providers the member wants contacted during a crisis? Are there some they may need support around contacting?
- Pets: If the individual has pets, what are the arrangements if they have to be away from home?
- Children: If children are living with the member what are the arrangements during a crisis or if they have to be away from home?

**Contact Notes:**
Health Home Care Manager’s documentation must accurately and objectively reflect Health Home activities. Health Home Care Managers should consider all audiences when creating any documentation and assume that all involved in the Plan of Care, including the individual, will have access to the materials in the individual’s care management record.

New York State requires the following to support billing each month:
- Outreach and engagement activities
- Active Plan of Care development
Active Care Management according to the Plan of Care
At least one of the five (excluding HIT) core Health Home services
Care management activities that include face-to-face meeting(s), mailings, electronic communications and telephone calls.
Care Management activities must demonstrate active progress in moving the Plan of Care forward toward achieving goals.

*Documentation that supports Medicaid billing MUST meet Medicaid requirements.

In addition to documentation as required by the State, HHUNY requires the following to be included in each contact note:
- Clear identification of the Health Home Enrollee, to include the Health Home recipient ID #
- Full name of the individual providing the service
- Date service was provided
- Type of contact/service delivery (FTF, Phone, Correspondence)
- Identification of who participated in service delivery (meaning distinction between a client contact and collateral, as well as service provider meeting)
- Clear indication of which of the core services are being provided at time of contact.

Contact notes must be completed within 5 business days. Documentation of significant events (hospitalization, emergency health condition, arrest, etc.) that must be communicated to other service providers will be documented by the next business day. Changes to individual’s contact information (phone number, address, etc) must be documented no later than 5 business days.

**FACT-GP and the Health Home Functional Assessment:**
New York State requires the FACT-GP and the Health Home Functional Assessment to be completed for each enrollee at enrollment, annually, and at discharge. Care Managers are to complete these documents as outlined in the Scoring Guidelines for FACT-GP/Health Home Functional Assessment. These documents are attached and may also be found on the Health Homes section of the NYS DOH website by following the link:

These documents must be maintained in the care management record.
HEALTH HOME OUTCOMES AND QUALITY ASSURANCE:

New York State has developed a set of goal-based quality measures against which Health Homes will be evaluated. These measures include:

- **Goal 1:** Reduce utilization associated with avoidable (preventable) inpatient stays
- **Goal 2:** Reduce utilization associated with avoidable (preventable) emergency room visits
- **Goal 3:** Improve outcomes for persons with Mental illness and/or Substance Use Disorders
- **Goal 4:** Improve disease-related care for chronic conditions
- **Goal 5:** Improve preventive care

For each of these goals, indicators in the following categories have been, or are being, developed: Clinical Outcomes, Experience of Care and Quality of Care. Once the indicators are finalized by the State, all care Management Agencies will receive the information.

Health Homes of Upstate New York has created the framework for a Quality Assurance Program that will support the achievement of the above outcomes. The Plan will be further expanded as additional information is received from the State concerning additional metrics to be assessed as well as reporting expectations. The **Four Step Quality Assurance and Outcome Initiative** is outlined below:

**Step 1: Review of Care Management Agency procedures tied to critical HHUNY Care Management practices**

- HHUNY will be asking Care Management Agencies to provide documentation of practices critical to care management quality and outcomes.
- HHUNY will review the practices and offer feedback when necessary based upon best practices.
- Practice areas of focus will include: community outreach, completion of assessment, development and practices tied to the use Multi-disciplinary Care Team, Managed Care Organization (MCO) communication, care plan sign off and coverage.
- Additional practices will be reviewed over time
- Training programs will be developed based upon opportunities for improvement identified during the practice review.

**Step 2: Record review, including review of Health Home Care Plans**

- Care plans, Crisis Plans and Care Management records will be reviewed periodically to assess the quality of the documentation.
- Feedback will be provided to improve compliance with documentation requirements.
- Training programs will be developed based upon opportunities identified during the record review.
Step 3: Development, distribution and review of Care Management Agency Performance Reports

- HHUNY’s ability to provide Care Management Agencies with performance reports will be greatly increased once NetSmart CareManager is operational beginning in July 2014. Work is now underway to outline reporting formats that will provide the Care Management Agencies with feedback tied to process measures, time frame measures as well as quality measures.
- New York State is also developing a Health Home report set using Medicaid claims and encounter data. Once available, the information obtained will be shared with all Care Management Agencies.

Step 4: Care Management training.

- A number of in-person and webinar trainings have already been provided to Care Management Agencies by HHUNY. As practices, records and reports are reviewed, additional training programs will be developed to support improved Health Home Care Management outcomes.

HHUNY will continuously update Quality Plan as additional information is received. Question concerning the HHUNY Quality Assurance and Outcome Initiative should be directed to the HHUNY Clinical Director at 585-613-7652.
ADDITIONAL REFERENCE INFORMATION:
New York State Medicaid Health Homes:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

New York State Medicaid Updates:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/medicaid_updates.htm

New York State Plan Amendment:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm

Questions and/or comments regarding New York's implementation of health homes can be directed to hh2011@health.state.ny.us.