Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #15: Health Home Billing

Effective Date: February 27, 2015
Revised Date: October 22, 2015, 5/1/16, 9/1/16

Policy: Encompass Health Home will assure that all eligible Participants are billed monthly, and payments are distributed according to Medicaid, Medicare, Managed Care Plans, Department of Health and Health Home standards.

Procedure:

A. Care Management Agency (CMA) Care Managers will document all Outreach & Active Care Management contacts throughout the month for each Participant.

B. The CMA will monitor care management notes throughout the month, and provide feedback to Care Managers regarding the quality of the notes, frequency of contacts and appropriate documentation indicating outreach or active care coordination.
   1. CMA Supervisors or designees will monitor and provide feedback to Care Managers regarding the appropriateness of care plan goals, recommendations for updates to the Plan of Care or Participant reassessment, and timeliness of required initial and required re-assessments.

C. Care Managers will complete High, Medium, Low (HML) Assessments:
   1. Adults: Within the first 2 business days of the month following the service month, The Care Manager or designee will complete the High, Medium, Low (HML) Assessment in Netsmart to reflect the Adult Participants previous months status, and determine the Participants rate code for the billing service month.
   2. Children: Care Managers will complete the CANS-NY Assessment as required to determine Child's HML.

D. The CMA will perform a pre-billing audit, and verify the necessary documentation in each Participant record, including:
   1. Either Outreach & Engagement activities were performed, Assessments were completed, or the provision of one or two of the following 5 Core Services occurred within the billing month, depending on service Tier (H-M-L):
      i. Comprehensive care management
      ii. Care coordination & health promotion
      iii. Comprehensive transitional care and follow-up
      iv. Individual & family support
      v. Referral to community & social support services;
   2. **Children:** 2 Core Services were provided including 1 face-to-face contact, as required for Medium and High acuity Child Participants; 1 Core Service for low acuity Child;
   3. **Adults**: 1 Core Service was provided;
   4. Assessments have been completed within the required timeframes;
      i. Children Participants will be billed at low acuity until completion of the CANS-NY Assessment.
      ii. CANS-NY Assessments not completed by end of month 2, will result in no billing for that month.
   5. Care Plans are complete and up to date for enrolled participants;
   6. All documentation is relevant to the Participant's/Family's goals.

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E. CMA Supervisor or designee will notify Care Managers immediately of needed corrective action and completion before submission of billing to Health Home.

F. CMA's will develop internal processes to verify accuracy and completeness of all documentation prior to billing.
   1. Once verified, CMA will send the Health Home Administrative Coordinator (HHAC) through secure e-mail or fax, a signed Attestation by the 5th business day of the month, indicating that billing may be initiated.
   2. CMA will notify the Health Home of any diversions from the expected time frames in order to hold billing for any Participants in which verification is not made.

G. On the 7th business day of the month, The HHAC or designee will download the Billing Support Upload File from Netsmart, which includes billing reports and HML Assessments, for upload to MAPP.

H. Billing for Managed Care Participants will be submitted through the Medicaid Analytics Performance Portal (MAPP) located in the NYS Health Commerce System (HCS).
   1. Participants will be screened for Medicaid eligibility prior to direct billing through the MAPP.
   2. The Health Home will submit a Billing Support Upload file to the MAPP by the Sunday before the 3rd Tuesday of the month.
      i. Health Home will make corrections as reported on the Error Report as needed, and will resubmit through the MAPP.
   3. Managed Care Plans (MCP) will access the MAPP to retrieve billing information.
   4. MCP will transmit billing information to eMedNY.
   5. Upon receipt of Medicaid payment to the MCP, MCP will send the Health Home a remittance statement, and will mail, or electronically deposit reimbursements within 14 days of receipt.

I. The Health Home will send the Billing Support Download File to MillinPro to sort and track billing data, and will complete a check request, to distribute payments and remittance statement to CMA, minus an additional contracted administrative fee, within 14 days of receipt from the MCP.

J. MillinPro will sort data for both Fee for Service Participants, and Participants covered under Managed Care Plans; as well as verify Medicaid status for each Participant.
   1. Following screening for Medicaid eligibility, Fee for service Participants will be direct billed through eMedNY by the 10th business day of the month.
      i. Upon receipt of Medicaid payment to the Health Home, Health Home will mail, or electronically deposit reimbursements minus a contracted administration fee to the CMA within 14 days of receipt.
         a. The Health Home will complete a check request, to distribute payments to CMA.

K. The Health Home will download completed billing projection reports from MillinPro and send to CMA by the 25th of the month.

L. It is the responsibility of the CMA, to monitor compliance according to established Corporate Compliance Plans, and to assure that billing is supported by appropriate documentation.

M. Billing will be held as pending if documentation for the month being billed is missing or incomplete. Late documentation will be completed as soon as possible, and Billing Attestations will be sent to the Health Home for processing.

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1. Claims held for incomplete/missing documentation will be billed the following month for reimbursement.

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Care Management Policy #16 Discharge/Disenrollment

Effective Date: 07/29/14
Revised Date: 09/15/14, 5/1/16, 9/1/16, 11/17/16

Policy: Encompass Health Home will disenroll Participants who no longer require or meet the eligibility for Health Home services, and will strive to transition Participants to alternate services as appropriate.

Procedure:
Appropriateness/Eligibility and Utilization:

A. Encompass Health Home Care Managers, in cooperation with Participants, Families, Managed Care Plans (MCP) and community providers/supports will assess Participants/Family utilization, need and engagement in services as required.
    1. Care Managers providing services to Children will conduct a quarterly review of the continued need for Care Management services. This will include, but is not limited to:
        i. Condition and stability of the Child;
        ii. Continued Eligibility;
        iii. Progress made towards established goals in the Plan of Care.
    2. Care Managers providing services to Adults will conduct a review in cooperation with the Comprehensive Assessment every 6 months.
    3. Care Managers will document reviews, and plan for subsequent needs for discharge.
B. Care Managers will make Supervisors aware of any issues affecting the ability to provide Core Health Home services to a Participant/Family within a calendar month.
C. Supervisors will assist Care Managers with issues related to re-engaging Participants/Family into services.
    1. The Health Home/CMA will make every effort to locate/re-engage with Participants/Family.
        i. Supervisors will assist with making outreach phone calls to Participants/Families;
        ii. Providers/MCP's will be consulted for guidance;
        iii. Letters will be sent out to Participants/Families with whom contact has been lost.
D. When efforts to engage prove unsuccessful, or billing cannot occur for a 3 month period, disenrollment may be an option.

Discharge/Disenrollment

A. Discharge Planning will occur when one or more of the following is identified:
    1. The chronic condition that made the Participant eligible for health Home is being self-managed and/or maintained;
    2. The Interdisciplinary Team and Participant/Family concurs that the Participant has met the goals identified on the Plan of Care and no longer requires Care Management;
    3. The Participant/Family has needs that are met by services, family and other supports, without the coordination of Health Home Care Management.

Care Management Policy #16 Discharge/Disenrollment

B. Other reasons that would prompt discharge/disenrollment include:
    1. Participant/Family is no longer eligible for Health Home and/or Medicaid;
    2. Choice: Participant/Family requests to opt out/dis-enroll;
    3. Participant/Family chooses to not collaborate with Health Home and/or providers;
    4. Participant/Family requests transfer to another Health Home/Care Management Provider;
    5. Participant/Family moves out of state/service area;
    6. Contact lost despite efforts to connect;
    7. Long term incarceration/institutionalization;
    8. Death.
C. Participant/Family that have been identified as appropriate for disenrollment will be discussed with the Supervisor/CMA.
    1. Supervisor may recommend additional outreach efforts to re-engage the Participant/Family.
    2. Managed Care Plans will be notified of efforts and/or plans to disenroll.
D. Participant/Family that have been determined to be appropriate for disenrollment/discharge will be sent a letter notifying them of the decision.
E. Care Managers will begin the disenrollment/discharge process:
    1. A pre-discharge note will be written in Netsmart, including the date that the Participant/Family was determined to be lost to services if applicable;
        i. Health Home may begin a three month period of outreach and engagement for Participant/Family determined to be lost to services.
    2. All providers will be notified;
    3. Care Managers serving Adults will complete Fact-GP/Functional Assessment, if applicable, and attach the document to the Plan of care in Netsmart;
    4. Plan of Care will be updated, including efforts to transition and link Participant/Family to needed follow-up services;
    5. Participant/Family will be asked to sign DOH-5058 (Adult) Withdrawal of Consent form, or DOH-5052 (Children) Withdraw of Health Home Enrollment and Information Sharing Consent;
        i. Child Participant/Family will be asked to also sign the DOH-5054 Withdraw Release of Educational Records if appropriate;
    6. Signatures will be obtained as needed on all discharge documentation;
    7. Care Manager will add discharge note to Netsmart;
        i. Discharge note will include a brief explanation of why the Participant is being discharged (including relevant progress made and goals attained); all Comprehensive Transitional Care activities provided during the discharge process; and efforts to refer and connect to services to meet ongoing or unmet needs.
    8. Care Manager will complete the HML assessment for the month of discharge;
    9. DOH-5058/DOH-5052 (and DOH-5054) will be scanned and attached to the Plan of Care in Netsmart;
    10. Billing will be forwarded to the Health Home Administrative Coordinator (HHAC);
    11. Disenrollment will be reported through the MAPP.

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Care Management Policy #17 Complaint and Incident Monitoring /Investigation
Effective Date: 11/03/2014
Revised Date: 11/1/15

Policy: Encompass Health Home will identify, investigate and resolve complaints and incidents to ensure Participants satisfaction; prevent re-occurrence; promote the ongoing delivery of quality services and protection of Participant rights; and maintain the health and welfare of Health Home Participants.

Procedure:

A. Participant Rights

1. The Health Home will send each Candidate a Welcome Letter within 3 business days of assignment to the Health Home.
   i. The Welcome Letter will include Health Home contact information; contact information for the Care Management Agency (CMA) which they have been assigned to; as well the Medicaid Consumer Help Line contact information required for filing concerns or complaints related to the outreach and the enrollment process.
   ii. The Health Home will also include a copy of the Health Home Participant Rights and Responsibilities.(**See attachment A**)
2. At enrollment, the Care Manager will verify Participants understanding of their rights and methods of filing a complaint/incident, and will request their signature at the time that they sign the Health Home Consent.
   i. Participants will be provided a signed copy of the Rights document.
   ii. Participants will be asked to sign a copy of the Health Home Participant Rights and Responsibilities on an annual basis.
3. Signed copies will be filed in the Participants record, as well as scanned and placed in the EHR.

B. Complaints/Grievances-Level 1

1. **Complaints** are defined as any dissatisfaction expressed verbally or in writing by a Participant or Participants designee, related to the provision of Health Home Care Management services or services identified in the Participants plan of care, that do not affect the health and welfare of the Participant.
   i. Examples include: customer service issues; complaints regarding a Care Manager; dissatisfaction with the plan of care.
2. All CMA's will establish formal complaint/grievance policies, and will provide those written procedures and contact information to the Health Home.
   i. Policies will address progressive methods and personnel responsible for managing complaints received, either verbal or written.
   ii. Policies will address responding to and beginning an investigation of all complaints, within 3 days of receipt.
   iii. Policies will include methods for tracking and responding to trends.

iv. Policies will reflect resolution of complaints within 30 days after the receipt of all necessary information, and no more than 45 days from receipt of the complaint.
v. CMA grievance procedures will be provided to each Health Home Participant through the Rights document. (**See attachment A**)

3. CMA's will be responsible for managing and responding to all complaints from their Participants or designees.
4. Care Managers will assist and advocate for Participants during their complaint or grievance process as appropriate
   i. Care Managers will refer Participants to necessary advocacy services as needed.
5. The Health Home will notify the CMA of complaints received regarding their services, within 3 days of receipt of the complaint.
6. Documentation will be maintained of all complaints received, separate from the Participants record, including efforts to resolve the complaint, timeframes of the resolution and the Participants satisfaction with the result.
   i. Individual complaints may be documented on the Health Home Complaint Form. (**See attachment B**)
   ii. Care Management Programs will document all investigations, resolution efforts and communication with Participant to resolve complaints according to established Grievance Procedures, and will provide copies of related documentation to the Health Home as requested.
   iii. All complaints will be documented and tracked on the ***Complaints and Incidents Tracking Form.*** (**See attachment C**)
7. The CMA will provide written notification of the outcome of the complaint to the Participant within 7 days of resolution.
   i. Written notification will include additional contact information, should the outcome fail to meet the Participants satisfaction.
   ii. Immediate resolutions to verbal complaints are considered resolved, and will not require formal written notification to the Participant.
8. Care Managers will be trained to recognize and immediately report complaints that appear as potential abuse situations as appropriate.
   i. Alleged abuse situations, and other complaints that after investigation by the CMA, are identified as a **level 2 or 3 incident**, will be processed as outlined below.
   ii. Complaints that potentially pose a risk to the Participants health and safety will be immediately investigated and addressed to assure the protection of the Participant, and documented as a level **2 or 3 incident**.
9. Any complaint not mutually resolved within 45 days at the CMA level, will be reported as a **formal complaint** and processed/addressed as stated below:
   i. CMA's will notify the Health Home Policy & Compliance Coordinator (HHPCC) of all **formal complaints** made by Health Home Participants, either written or verbal, regarding dissatisfaction with Health Home services or other

services identified in the Care Plan, including efforts made by the Care Manager/CMA to resolve the Participants issue(s)

a) CMA's will notify the HHPCC of formal complaints, within 3 days of identification.
b) All formal complaints will be documented on the Health Home Complaint Form, either by the participant or CMA staff, and forwarded to the Health Home, using secure messaging. (**See attachment B**)
c) The Health Home will work with the CMA to address the complaint, and provide guidance regarding additional investigative procedures.
d) The Health Home and CMA's will work collaboratively to resolve issues and complaints within 30 days of receipt of all information and no more than 45 days from receipt of the complaint.

10. Complaints that identify potential breaches of confidentiality will be forwarded to the CMA Privacy Officer for further investigation of potential HIPAA violations.
    i. Complaints that are determined to involve a breach of PHI, will be reported per HIPAA/HITECH policies, as well as reported to the NYSDOH Privacy Office.
11. The CMA and Health Home will maintain documentation of all Participant complaints, investigations, outcomes and Participant dissatisfaction, for review by regulatory bodies as appropriate.
12. The CMA and Health Home will monitor and analyze Participant complaints to track trends, and Care Management Program performance.
    i. The CMA will track and provide to the Health Home, a quarterly report identifying complaints received and subsequent outcomes
    ii. The Health Home will work with Care Management Programs to formalize corrective action as needed.
13. The Health Home will provide reports of any complaints on a quarterly basis to NYS DOH through the Health Home Portal/MAPP.

C. Incidents-Level 2

1. **Level 2 Incidents** are defined as an urgent issue, event, or action either perceived or an actual threat to a Participants health and welfare; or a dangerous action taken by or against the Participant by another individual.
    i. Examples of level 2 Incidents include, but are not limited to: Abuse/Neglect; death; serious injury; violations of rights; criminal activity/crime against a Participant; missing person; assault; domestic violence.
2. The Health Home/Care Management program will notify each other of any allegations or alleged incidents within 2 days of notification or discovery.
    i. Immediate steps will be taken and documented at notification to secure the Participants safety and security.
    ii. If the alleged incident occurs in or involves a licensed program, the licensed program will be notified within 24 hours and will assume the responsibility for reporting and investigation, per Justice Center or related regulations.
3. Upon notification, the Health Home will determine the focus and responsibility of the investigation.

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i. If assigned, the CMA will begin investigation immediately, utilizing trained investigators.
ii. The Health Home may assign an investigator to assist or monitor the CMA investigative process.
iii. The Health Home will participate in the investigation as needed, will track and follow up on all investigations, assuring they are completed correctly, and in a timely manner.
    a) The Health Home Policy & Compliance Coordinator or designee will notify DOH of issues and outcomes of the investigation as it progresses as requested.

4. Incidents will be documented on the ***Encompass Health Home Incident Report Form***, (**See attachment D**) and a copy forwarded to the Health Home, utilizing secure messaging.
    i. CMA's may use their own internal Incident Report forms, as approved by the Health Home.
    ii. All Incidents will be documented and tracked on the ***Complaints and Incidents Tracking Form.*** (**See attachment C**)
    iii. All documentation will be maintained separately from the Participants record.
    iv. Incidents that identify potential breaches of PHI will be forwarded to the CMA Privacy Officer for further investigation.
        a) Incidents that are determined to involve a breach of PHI, will be reported per HIPAA/HITECH policies, as well as reported by the Health Home to the NYSDOH Privacy Office at: caryl.shakshober@health.ny.gov
    v. The Care Management Agency will make all necessary initial notifications regarding the incident to appropriate Agencies, and will document all notifications on the Incident Report Form.
5. Investigations will be completed within 7 business days of the initial notification.
    i. CMA's will notify the Health Home if it is determined that more time is needed to complete investigations. The Health Home and the CMA will mutually determine an appropriate time frame, and will document accordingly on the Incident Report Form.
6. The Health Home Policy & Compliance Coordinator or designee will request an Investigation/Follow-up Summary and pertinent documentation, at the conclusion of the investigation, in order to provide necessary notifications and documentation to DOH and other entities as appropriate.
    i. The Health Home will review all investigations and determine whether the allegation is substantiated, within 7 days of receipt of the investigation material.
    ii. The Health Home will provide the CMA, final outcome documentation of the Health Home findings, and required corrective action if needed.
        a) The Health Home will work with Care Management Programs to formalize corrective action as needed, to prevent reoccurrence of incidents.
        b) Additional information or follow up actions required will be documented on the **Incident Follow-up Form**. (**See attachment E**)

7. The Health Home Policy & Compliance Coordinator or designee will monitor and analyze Participant incidents to track trends, issues with network providers and Care Management Program performance.
8. The Health Home will submit documentation as appropriate to the Health Home Incident Review Committee.
   i. The Incident Review Committee will meet quarterly, and provide feedback and recommendations as needed to the Health Home.
9. The Health Home Policy & Compliance Coordinator will provide reports of any incidents on a quarterly basis to NYS DOH through the Health Home Portal/MAPP.
10. Participants will be notified of results of the investigation per their request, with the approval of DOH.
    i. Participants will be informed of the procedure for expressing dissatisfaction of the outcome.
    ii. The Health Home will inform DOH within 24 hours of a Participants continued dissatisfaction, who will provide direction to the Health Home for further investigation or additional follow-up.
11. Level 2 incidents that are not closed after thorough investigation and review by the Health Home will be classified as a level 3, and forwarded to DOH for guidance. This may include incidents that:
    i. Document a Participants continued dissatisfaction with the outcome;
    ii. The Health Home in unable to determine appropriate findings;
    iii. Investigation revealed that incident should have been classified a Level 3;
    iv. Indicates negative findings related to activities of the CMA/HH, or network.

D. Incidents-Level 3

1. **Level 3 Incidents** require immediate involvement of NYSDOH, and involves the following:
   i. Homicides committed against or by the Participant;
   ii. Identification of a negative network trend impacting Participants;
   iii. Incidents in which the Health Home is unable to conclude findings;
   iv. Incidents in which determination was made that the CMA or HH negatively impacted a Participant and contributed to the incident.
2. The Health Home/Care Management program will notify each other of any Level 3 allegations or alleged incidents within 24 hours of notification or discovery.
3. Level 3 Incidents will be documented on the ***Encompass Health Home Incident Report Form***, (**See attachment D**) and a copy forwarded to the Health
4. Home, utilizing secure messaging.
   i. All Level 3 Incidents will also be documented and tracked by the HH and CMA on the ***Complaints and Incidents Tracking Form.*** (**See attachment C**)
5. The Health Home will notify DOH (through the Provider Line 1-518-473-5569) of all Level 3 incidents within 24 hours of discovery/notification.

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6. DOH will provide guidance and recommendations on the focus of initiating, or continuing an investigation; timeframe for completion; as well as additional notifications that may be required.
   i. The Health Home will communicate investigation plan with the CMA, and discuss and assign additional notifications that may be required.
   ii. If guidance is not provided by DOH on the timeframe for completion of the investigation, it will be completed no later than 10 business days of assignment.
7. The Health Home will participate in the investigation as needed, will track and follow up on all investigations, assuring they are completed correctly, and in a timely manner.
8. The Health Home Policy & Compliance Coordinator or designee will request an Investigation/Follow-up Summary and pertinent documentation, at the conclusion of the investigation, in order to provide necessary notifications and documentation to DOH and other entities as appropriate.
9. The Health Home will review investigation material, and document final outcome, including negative findings and needed corrective action.
   i. The Health Home will work with Care Management Programs to formalize corrective action as needed, to prevent reoccurrence of incidents.
10. After review, copies of all documentation will be forwarded to DOH within 3 business days of receipt, in a secure/encrypted manner.
   i. Upon review, DOH will notify the Health Home of their acceptance of the investigation, their determination, or the need for additional documentation or further investigation.
11. The Health Home Policy & Compliance Coordinator or designee will monitor and analyze Participant Level 3 incidents to track trends, issues with network providers and Care Management Program performance.

E. Complaints/Incidents During Outreach & Engagement

1. The Health Home will be notified of all complaints and Incidents that occur while a prospective Participant is engaged in Outreach, and not yet enrolled.
   i. The HH will document all notifications.
2. The Health Home will determine the need for investigation, based on the seriousness of the Complaint/Incident, and/or to determine if the actions or inaction of the HH/CMA contributed to the occurrence of the Complaint/Incident.
3. If investigation is warranted, the Complaint/Incident will be documented and monitored per the above procedures.

F. Incident Review Committee

1. The Health Home Incident Committee will review documentation and provide needed feedback to the Health Home regarding Complaint/Incident Management and quality of services.
2. The Committee will consist of Health Home Administration, CMA/Network representatives, and specialty providers as needed.

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3. The Committee will meet quarterly, and review past Complaints/Incidents to determine trends and needed follow-up not already identified.
   i. The Committee will convene to discuss serious events as needed.
4. The Committee will discuss additional preventive measures to prevent reoccurrence of Incidents/Complaints.
5. Committee feedback will be provided to CMA's as required.

G. Justice Center Reporting & Multiple Agency Involvement

1. Incidents and subsequent investigations may include the involvement of multiple Community and State Agencies, as well as MCO's.
2. The Health Home will coordinate investigations, and provide necessary information/documentation to facilitate the timely resolution of investigations that may be assigned to other entities.
3. Level 2 or 3 Incidents that occur or involve licensed programs/Agencies, may fall under the jurisdiction of the Justice Center, and will be reported and investigated per NYS regulations, by the licensed program.
   i. The Health Home will promptly report such allegations, including those that involve fraud and abuse to the Justice Center and the licensed program, and will document per above procedures.
4. The Health Home/CMA will cooperate with all external investigations, and will advocate for and support the Participant during the process as needed.

Catholic Charities of Broome County
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Rights & Responsibilities of Participants

Rights:

- The right be treated as a human being with dignity and respect;
- The right to be treated in a way that acknowledges and respects my cultural identity;
- The right to freedom from abuse and mistreatment;
- The right to an individualized care plan and full explanation of the services provided;
- The right to be informed and to participate in all phases of my treatment and care planning sessions;
- The right to discuss any dissatisfaction with the care manager and/or services I receive, and to pursue complaints through the grievance procedures stated below;
- The right to privacy and confidentiality of my information and identification;
- The right to request access to my own clinical records;
- The right to receive copies of signed Health Home and PSYCKES Consents, as well as other documents containing my signature;
- The right for services to be rendered and handled in a confidential, skillful, safe, and humane manner within a reasonable time frame;
- The right to request and include family, if applicable, in all phases of my treatment and recovery.

Responsibilities:

- Treat Care Manager with respect and dignity;
- Meet with Care Manager as often as needed to ensure needs are met;
- Keep appointments with Care Manager;
- Work towards recovery and improving my health , and becoming independent of care management;
- Sign Health Home and PSYCKES consents;
- Where applicable, sign releases of information regarding medical, psychological, psychiatric, family, social, educational and vocational information required for assessing my appropriateness for this program and continued stay;
- Inform Care Manager of changes in medications, doctors, treatments, changes in housing, changes in appointments;
- Be actively engaged in my ongoing treatment/care planning and reassessments with my Care Manager.

Grievance Procedure:

- Participants who feel that their rights have been violated, or who are dissatisfied with services provided to them, may first bring their concerns to the attention of their Care Manager.
- If concerns are not resolved, or if not comfortable with discussing concerns directly with the Care Manager, Participants may contact _____ at (xxx) xxx-xxxx.
- If Participants are dissatisfied or not in agreement with the response, or are uncomfortable with discussing their concerns with Care Management personnel, they may contact _____ at (xxx) xxx-xxxx.
- If Participants are dissatisfied or not in agreement with the response, or are uncomfortable with discussing their concerns with the Care Management Agency, they may contact the Health Home at (607) 729-9166.
- If Participants are dissatisfied with the response, or are uncomfortable discussing their concerns with any health Home personnel, they may contact the resources listed below.

To report an incident, or to report a violation of your rights, you may contact any of the following for assistance:

NYS Justice Center for People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310.
1-(855) 373-2122; TTY 1-(855) 373-2123

NYS Office of Mental Health
44 Holland Ave
Albany, NY 12229
1-(800) 597-8481

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Disability Rights NY, Inc.
725 Broadway Suite 450
Albany, NY 12207
1-(800) 993-8982; TTY 1-(518) 512-3448
E-Mail: DisabilityRightsNY.org

National Alliance for the
Mentally Ill (NAMI)
260 Washington Ave.
Albany, NY 12210
(518) 462-2000 or (607) 773-8229

NYS Department of Health
Corning Tower
Empire State Plaza Albany, NY 12237
1-(866) 881-2809

Medicaid Consumer Helpline
1-(800) 541-2831
New York Medicaid Choice
1-(800)-505-5678

NYS Department of Health
Bureau of Managed Care Certification and Surveillance
Complaint Unit Room 2019
Corning Tower ESP
Albany, NY 12237
1-800-206-8125
Or Email: managedcarecomplaint@health.state.ny.us

Participants may request a State Fair Hearing with the New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings by:

- Calling the state wide toll free number 1- (800) 342-3334 TTY 1-(877) 502-6155; OR
- Fax Number 1-(518) 473-6735; OR
- Complete the on-line application request form at http://otda.ny.gov/hearings/request/#online ; OR
- Write or mail a completed application to:
    - Office of Temporary and Disability Assistance
      Office of Administrative Hearings
      PO Box 1930
      Albany, NY 12201-1930
- If your request involves an issue about health benefits or services provided under your Managed Care Plan or Managed Long Term Care you can write to:
    - NYS Office of Temporary and Disability Assistance
      Office of Administrative Hearings
      Managed Care Hearing Unit
      P.O. Box 22023
      Albany, New York 12201-2023
- Participants that require assistance will receive support in filing their complaint, incident or request for a Fair Hearing from the Care Manager, Care Management Agency and/or designated Health Home staff.

My Assigned Care Management Agency is: _____.

My Care Manager is: _____.
Print Care Manager Name

_____ _____
Participant Signature **Date**

A copy of this signed document was provided to the Participant by _____,
Print Staff Name

on (Date) _____.

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Complaint Form

As a Participant of Encompass Health Home, you have the right to make a complaint regarding your Health Home services, and or violations of your Participant rights. Encompass Health Home, will not engage in any discriminatory or other retaliatory behavior against you because of this complaint. Please be as thorough and forthright as possible, and return this form to_____.

Participants Name:
Address:
Phone:
E-mail Address:
Preferred method of contact?
Best time to be reached?
Date of alleged occurrence:
Date complaint was made:
Person who received the complaint:
Care Management Agency:
Name of Care Manager:

Details of the complaint: *(Please be as specific as possible with dates, times and the specifics regarding the complaint; discuss any action taken thus far; include the names, if any, of anyone in the agency with whom you have discussed this. Attach additional pages to this form if you need more room. Attach any documents that you believe pertain to this complaint.)*

___ Documents are attached (describe below):

_____

Participants Name (print): _____

Participants Signature: _____

Date: _____

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Complaint Form

If not completed and signed by the Participant, indicate relationship below:

Name of Individual who completed form: _____
Phone Number: _____

Relationship to Participant:

- ☐ Parent/guardian; Family Member of Participant
- ☐ Friend/Advocate
- ☐ Care Manager/Health Home Staff
- ☐ Provider
- ☐ Other (specify) _____

FOR OFFICE USE ONLY:

Date Received: _____ Time: _____
Notifications Made:
☐ DOH Date: _____
☐ Care Management Program Date: _____
☐ Lead Health Home Date: _____
☐ Other: _____ Date: _____
Complaint Processed/Investigated by: _____
Investigation Completion Date: _____
Outcome/Action Taken:

_____
_____
_____

Participant Notified of Outcome (Date): _____
By Whom: _____
Participant satisfied with outcome: ☐ Yes ☐ No
If No, additional steps to be taken:

_____
_____
_____

Catholic Charities
ENCOMPASS HEALTH HOME

Complaints and Incident Tracking Form

Time of dent/ laint	Care Management Agency	Participant's Name	Category	Level	Date/Time Reported to Health Home	Investigation Assigned To:	Date Investigation Concluded	Outcome	Appropriate Notification(S) Made (Y-N)	Needed Corrective Ac

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME

INCIDENT REPORT FORM

Care Management Agency: _____

DATE OF INCIDENT: _____ **DATE OF REPORT:** _____
TIME OF INCIDENT: _____ ___ AM ___ PM **LOCATION:** _____

DATABASE INFORMATION

Participant Name: _____ DOB: _____ ID Number: _____ SS#: _____

Diagnosis: _____

Medication(s): _____

_____

Participant #2 Name: (If applicable) _____ **DOB:** _____ **ID Number:** _____

INCIDENT INFORMATION

DESCRIBE INCIDENT: (Specify Who, What, When, Where, Why; **Include**: Information available prior to incident and most recent contacts with Care Manager; Preliminary Investigation Findings; Immediate Participant interventions/ protections performed if applicable)
If additional space is needed, please attach separate page

Date of Incident: _____ **Client Name/ID:** _____

INCIDENT CATEGORIES

LEVEL 2 INCIDENTS-ABUSE	OTHER LEVEL 2 INCIDENTS:		LEVEL 3 INCIDENTS: Requires NYSDOH Notification
***Allegation of Abuse/Neglect: (Reportable to Justice Center if a Licensed Program is involved)**	___ Death (Expected)	___ Motor Vehicle Accident	___ Homicide (Against or by Participant)
___ * Physical Abuse	___ Death (Unexpected)	___ Possession of a Deadly Weapon	___ Unsatisfactory Resolution of Level 1 or 2 Complaint/Incident
___ *Psychological Abuse	___ Other Crime	___ Robbery	___ HH/CMA contributed to Incident
___ * Sexual Abuse	___ Domestic Violence	___ Missing Person	___ Negative Trends Identified
___ *Neglect	___ DWI/DUI	___ Sexual Assault	
	___ Other Complaint Determined to be Level 2	___ Suicide Attempt	
	___ Fire Setting	___ Violation of Civil Rights	
	___ Illegal Sale/Possession of Narcotics	Verbal/Physical Aggression w/out life threatening injury	
	___ Injury		
	___ Other Incident w/Actual/Potential Adverse Effect on Life, Health, Welfare or Safety** Define:		

Date of Incident: _____ **Client Name/ID:** _____

NOTIFICATIONS:

Notified Party	Date/Time	Notified by Whom/Name of Contact/Description
Health Home		
NYS Department of Health		
Other Licensed Agency: _____		
Justice Center–VCPR		
Other State Agency: _____		
Child Protective Services/NYS Central Register of Child Abuse		
Adult Protective Services		
Family/Guardian/Other Qualified Persons		
Managed Care Plan		
Law Enforcement		
Parole/ Probation		
Mental Hygiene Legal Services		
Coroner/Medical Examiner		
Other Provider -		
Other -		
Other -		

Physician Notified Date: Physician Notified Time: AM PM

Signature of Person Reporting Incident: **Date:**

Supervisor/Manager Signature: **Date:**

HEALTH HOME REVIEW

Date Received: _____

___ **Reportable to JC** ____ **Reportable to DOH** **Date Investigation Determined/Assigned:** _____

Investigation Assigned to: **Investigators:** _____

___ **Health Home**

___ **Care Management Agency**

___ **Investigation to be completed by Other Licensed Agency:**

Date Investigation Completed: _____ ___ **Appropriate Procedures Followed**

___ **Follow Up/Corrective Action Recommended (See Below)**

Health Home Signature:				**Date:**	

CATHOLIC CHARITIES OF BROOME COUNTY
ENCOMPASS HEALTH HOME

INCIDENT REPORT FOLLOW-UP FORM

Care Management Agency: _____

Date of Original Report: _____ **Today's Date:** _____

Name/Title of Person Reporting Follow-Up: _____

Name of Client: _____ **ID#:** _____ **Age:** _____

Date Investigation Completed: _____

Incident Category: _____

Incident Required Re-Classification: ☐**Yes** ☐**No**

New Category: _____

☐ **Level 2** ☐ **Level 3**

Describe Investigation Process/Outcome and Additional Follow-Up/Corrective Action Taken Since Initial Report.

Include additional external reporting and notifications if applicable:

_____

Signature of Staff

Health Home Review:

☐ **Appropriate Resolution** ☐ **Follow Up/Corrective Action Recommended (See below)**

Health Home Signature:_____ **Date:** _____

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
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Care Management Policy #18 Adult Health Home Plus

Effective Date: 9/3/15
Revised Date: 2/1/16, 9/1/16, 12/1/16

Policy: Encompass Health Home will provide Intensive Health Home Services and monitoring to eligible Participants with Serious Mental Illness, consistent with NYS-Office of Mental Health (OMH) and Local Government Unit (LGU) requirements.

Procedure:

A. Qualifications for Care Management Agencies and Care Managers

1. The Health Home will assure and attest to Care Management Agencies (CMA) meeting the requirements for Health Home Plus (HH+) by completing and submitting the *OMH HH+ Funding Attestation.*
2. The Health Home will assure Care Managers providing HH+ services meet the minimum educational and experience qualifications and supervisory requirements:
    i. **Education:**
        - A bachelor's degree in any of the following: child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreation therapy, rehabilitation, social work, sociology, or speech and hearing, or other human service field; **OR**
        - NYS licensure and current registration as a Registered Nurse and a bachelor's degree; **OR**
        - NYS teacher's certificate for which a bachelor's degree is required; **OR**
        - A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; **OR**
        - A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

    ii. **Experience: Two years of experience (a Master's degree in a related field may substitute for one year's experience) either:**
        - Providing direct services to persons with Serious Mental Illness, developmental disabilities, or substance use disorders; **OR**
        - Linking persons with Serious Mental Illness, developmental disabilities, or substance use disorders to abroad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services.)

    iii. **Supervision** from a licensed healthcare professional (e.g. RN, Licensed Clinician, Psychologist) with prior experience in a behavioral health clinic or care management supervisory capacity; **or**
    A Masters level professional with 3 years prior experience supervising clinicians and/or Care Managers who are providing direct services to

individuals with Serious Mental Illness or serious Substance Use Disorders.

3. CMAs will assure caseload sizes for HH+ is maintained at 1:12-15 Participants.
    i. A caseload mix of HH+ and non-HH+ is acceptable if the HH+ ratio is less than 1:12. Caseload size should allow for adequate time to provide needed intensive HH+ services, while considering the needs of the non-HH+ Participants.

B. Assisted Outpatient Treatment (AOT) Health Home Plus (AOT-HH+)

1. Participants that are court ordered for Assisted Outpatient Treatment (AOT) will require an intensive level of Care Management services.
2. The Health Home will receive AOT Health Home Plus (AOT-HH+) referrals through SPOA, and will work with the LGU according to their AOT process to assign the Participant to a CMA designated to provide AOT-HH+ services immediately, within 3 business days.
3. AOT-HH+ Participants will be engaged and enrolled per Health Home policy/procedure.
    i. Children ages 18-21 that are on AOT status will be enrolled in an Adult Health Home in order to meet AOT- HH+ requirements.
    ii. For AOT Participants that may refuse Health Home enrollment, a copy of the AOT order will be obtained by the Health Home to allow enrollment and billing to occur.
    iii. The AOT order will not provide consent for data sharing of clinical information. This must be allowed through appropriate signed consents, obtained by the CMA.
        a. Without consent, limited clinical information can be shared for care coordination purposes only, as permitted by section 33.13(d) of the MHL.
4. CMAs will notify the Heath Home through the MAPP of Participants that are placed on AOT status after enrollment, so that they can be immediately transferred to a qualified AOT-HH+ Care Manager and/or CMA if needed.
5. The CMA will also inform the Health Home when a Participants AOT status has expired, or has not been renewed.
    i. The Health Home will update Managed Care Plans regarding the Participants AOT status when these changes occur.
6. The assigned AOT-HH+ Care Manager will develop the Plan of Care to include all categories of service identified on the court ordered AOT treatment plan.
    i. The AOT-HH+ Care Manager will provide necessary coordination with providers and services to promote positive outcomes for the Participant.
    ii. The AOT-HH+ Care Manager will consult with the treating physician and the LGU when the interdisciplinary team identifies needed additions or deletions of services on the AOT order, in order to petition the court for those changes.
    iii. The Plan of Care will be updated to reflect AOT order changes as needed.

7. AOT-HH+ Care Managers will provide a face-to-face contact with HH+ Participants at least 4 times a month, spaced if possible at 1 time a week.
8. If while providing visits, an AOT-HH+ Participant is not home, unavailable, cannot be located, or contacted within 24 hours of an unexplained missed appointment, they will be deemed missing.
    i. The AOT-HH+ Care Manager will clearly document the point in which the Participant moved to a missing status, and will notify the LGU within 24 hours of the determination.
    ii. The AOT-HH+ Care Manager will conduct a diligent search, and will continue efforts to locate and provide 4 contacts.
    iii. The AOT-HH+ Care Manager will clearly document all attempts to locate/contact, and will report all efforts made to the LGU.
    iv. The AOT-HH+ Care Manager and LGU will conduct a risk assessment and will determine any additional follow-up that is needed.
    v. Efforts to locate/contact will continue until the participant is located, or the court order expires or is no longer active.
9. The AOT-HH+ Care Manager will notify the LGU of any other difficulties in providing the 4 monthly face to face visits, in order to determine additional follow up efforts needed.
10. The AOT-HH+ Care Manager will ensure that all services and transitions are in compliance with the Participants AOT court order:
    i. Upon discharge from a hospital setting, AOT-HH+ Participants will be accompanied by the Care Manager to their place of residence.
    ii. Non-hospitalized AOT-HH+ Participants will be accompanied by the Care Manager from AOT court hearings to their place of residence, if possible.
    iii. When accompaniment is not feasible, the Care Manager will make phone contact with the Participant within 24 hours of the court hearing, and schedule a face to face contact within 3 days.
    iv. Within 2 weeks of a final court order, the Care Manager will schedule a meeting with all providers to review roles and responsibilities under the court ordered treatment/care plan, and develop a Plan of care to address the Participants needs and risk factors.
10. AOT-HH+ Care Manager/CMA will provide necessary reports to OMH and the LGU/AOT Program Director regarding each Participants treatment status.
11. AOT-HH+ Care Manager/CMA will provide assessment and follow-up data to OMH through the Child and Adult Integrated Reporting System (CAIRS) every 6 months.
12. The AOT-HH+ Care Manager will document all Care Management/Coordination activities into Netsmart.

C. Health Home Plus Expansion (HH+)

1. Potential Health Home Participants with a serious mental illness that have been discharged from an OMH State Psychiatric center (PC), or from Central New York Psychiatric Center (CNYPC) and its forensic mental health units, and are not enrolled in ACT, are eligible to receive intensive Care Management services through Health Home Plus (HH+) for up to 12 months post discharge.

   i. Participants who are receiving AOT HH+, are also eligible for HH+ for 12 months post discharge, or for as long as the AOT order is in place (whichever is longer).
   ii. Participants discharged to an OMH State Operated Community Residence (SOCR), will be eligible for Health Home services, but not at the HH+ rate. HH+ eligibility will occur for 12 months post discharge from the SOCR.
2. The Health Home will receive HH+ referrals, and will assign them to a qualified HH+ CMA within 3 business days.
3. The CMA will review the referral for eligibility and action needed to assure active Medicaid post discharge.
   i. Some Participants may have active OMH Medicaid during their inpatient stay that will require transition to the new Medicaid district following discharge.
4. The Care Manager will contact the discharge planner/referral source to schedule a discharge planning meeting, and begin engagement with the Participant.
   i. For Participants who have been readmitted to a State PC or CNYPC, the Care Manager will participate in the discharge planning process, and conduct a face-to-face visit within 48 hours of discharge, or 24 hours of discharge from a forensic facility.
5. HH+ Care Managers will provide a minimum of 4 Health Home Core Services per month, 2 of which will be a face-to-face visit.
   i. Additional face-to-face visit may be necessary to address immediate transitional needs following discharge, such as reestablishment of Medicaid benefits, and housing needs.
6. The HH+ Care Manager will document all Core Services, visits and Care Management/Coordination activities into Netsmart.
7. CMAs will notify the Heath Home through the MAPP of Participants that meet HH+ criteria after enrollment, so that they can be immediately transferred to a qualified HH+ Care Manager and/or CMA if needed.
8. The CMA will also inform the Health Home when a Participants HH+ status has expired.
9. The Health Home will update Managed Care Plans regarding the Participants HH+ status when these changes occur.

D. Health Home Plus Billing:

1. A unique rate code is to be used for HH+ services. This is to be superseded only for Medicaid Managed Care/HARP enrollees.
2. The Care Manager will document and attest that the minimum HH+ services were provided in Netsmart, through notes and the HML questionnaire.
3. The Health Home will generate a billing report from Netsmart, and HH+ rate codes will be directly billed to eMedNY through the MAPP by the Health Home.
4. Only those Participants reported in the AOT database tracking as on active AOT status will be eligible to be claimed at the AOT-HH+ rate. This rate applies as long as the Participant was in active status at some point during the month.

5. If the minimum 4 AOT-HH+ face to face visits do not occur due to a Participants missing status, billing at the AOT-HH+ rate may still occur, if efforts to contact/locate are clearly documented, as identified above.
6. If the diligent search activities cannot be reasonable completed during the month the Participant is deemed missing, the AOT-HH+ rate may still be billed as long as the process was initiated within AOT guidelines.
7. If the minimum 4 AOT-HH+ face to face visits do not occur for other reasons such as not being home or otherwise unavailable, billing may be allowed at the HARP/Non HARP (High) rate, as long as at least 1 face to face visit occurred.
8. **HH+:** If the minimum 4 core services and 2 face-to-face visits are not provided for HH+ Participants during a month, and at least 1 Health Home Core service was provided, billing may be allowed at the HARP/Non HARP (High) rate for that month.
    i. HH+ will be billed for 12 consecutive months post discharge.
    ii. If a Participant is readmitted to a State PC, CNYPC or SOCR, the 12 months starts over again post discharge.

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Care Management Policy #19 Health Home and ACT

Effective Date: 5/1/16
Revised Date: 9/1/16

Policy: Encompass Health Home will ensure that Participants enrolled in an Assertive Community Treatment (ACT) Program, or those referred to the service through the Health Home (HH), have an integrated Plan of Care and receive person-centered Care Management services per agreements, and regulatory requirements through the Office of Mental Health (OMH).

Procedure:

A. The Health Home will maintain Health Home agreements with ACT programs within the service area, necessary for necessary data exchange.
B. ACT programs will continue to receive assignments/referrals though SPOA or the LGU.
    1. If a HH member is identified as appropriate for ACT services, Health Home will submit an ACT referral to SPOA/LGU.
        i. ACT will review and respond to referrals within the timeframes established by ACT regulations and the Health Home.
C. ACT clients that are not already enrolled, but appropriate for Health Home services, will be offered the service by ACT, and offered choice of contracted Health Homes within the region.
    1. ACT Clients between the ages of 18 and 21 must be enrolled if eligible into an Adult Health Home.
    2. The Health Home will work with all Health Homes to route referral/assignments of ACT Clients between the ages of 18 and 21 to a health Home offering contracted ACT services.
D. ACT HH Participants will complete and sign the Health Home Patient Information Sharing Consent Form (DOH-5055), identifying and initialing all providers and supports that they choose as members of their care team.
    1. ACT Service Coordinators are responsible for ensuring participant understanding of the consent process.
    2. Signed consents will be forwarded to the Health Home.
    3. DOH-5055 Consents will be updated as needed, no less than annually.
E. ACT Participants who opt out, or who choose to disenroll from the Health Home, will sign the DOH-5059 Opt out Form, or DOH-5058, Withdrawal of Consent form.
    1. These will be forwarded to the Health Home as required.
    2. The ACT program will continue to provide ACT services to clients who opt out, or disenroll from Health Home services.
F. ACT teams will meet and maintain ACT-OMH regulatory requirements; including but not limited to:
    1. Caseload requirements (10 per service coordinator);
    2. Use of best practices;
    3. Maintaining a team-based approach;
    4. Meeting the face-to-face participant contact requirements (at least 6 contacts per month);
    5. Completion of CAIRS reporting;

6. Meeting ACT billing requirements;
7. Meeting staffing qualification regulations;
8. Meeting interdisciplinary team composition regulations;
9. Maintaining regulatory community to office visit ratio.

G. ACT programs will utilize an Electronic Health Record (EHR) as a part of their record management.

H. In addition to the clinical record, ACT programs will ensure documentation of Care Coordination services in accordance with Health Home policy. See *Plan of Care* and *Care Coordination Policies*
   1. Assessments will be completed in a manner that fulfills Health Home requirements. See *Enrollment-Assessment* Policy.
   2. As a part of informed treatment planning, ACT will be contracted with local RHIOs (See *RHIO Policy*) as well as PSYCKES (See *PSYCKES Policy*) to inform their clinical decisions and treatment planning.
   3. ACT programs will comply with stipulations outlined as a part of an Assisted Outpatient Treatment (AOT) order. See *Health Home Plus Policy*.
   4. ACT programs will participate in the Community Mental Health Assessment Process with their Participants as requested, in accordance with the *HARP/HCBS Policy*.

I. Health Home Participants that are discharged from ACT services will be referred to another CMA if appropriate for continued Health Home services.
   1. ACT will notify the Heath Home of the impending discharge, and will work with the Participant to provide appropriate transitional services during the transfer process.
   2. If an ACT Participant chooses enrollment into another Health Home, ACT will notify the Heath Home, and submit needed discharge information.
   3. Follow-up will be completed within 90 days of transfer/discharge.

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Care Management Policy #20 Care Management/Health Home Transfers

Effective Date: 3/1/16
Revised Date: 9/1/16

Policy: Encompass Health Home will collaborate with Care Management Agencies (CMA) and other Health Homes to ensure that participant transfers incorporate a seamless process that provides appropriate continuity of care to promote continued health and well-being.

Procedure:
Participant transfers may be required for multiple reasons, including: moving to another location; client request; a change of increased or decreased needs; a change in participant condition; and other reasons that may be in the Participant's best interest.

A. When a Participant/Family informs the CMA that they intend to move outside of the CM's coverage area, the CMA will immediately notify the Health Home, and will begin appropriate discharge planning with the Participant.
    1. The Care Manager will initiate discussion with the Participant/Family regarding area of relocation, services needed, needed referrals; and will alert their supervisor as to the nature and timeline of the Participant's/Families relocation.
    2. The Participant/Family will be informed of the network of Health Home CMA's within the coverage area of their new location, as well as those that are available within other Health Homes, based on their individual needs.
    3. The CMA will inform the Health Home of the Participants/Family's choice, who will then assign to another CMA within the network, or refer to alternate Health Home through the MAPP.
    4. The Care Manager will work with the Participant/Family and new CMA to refer and establish new services to ensure continuity of care.
    5. The Care Manager will document all coordination and discharge planning services in Netsmart.
    6. The Health Home will request additional documentation from the CMA as needed.
B. When a Participant/Family requests a change in Care Manager, the CMA Supervisor will be notified of the request within 2 business days, and will perform a review of the appropriateness or need for a transfer.
    1. If appropriate, the Supervisor will re-assign the Participant/Family to a new Care Manager based on the Participant's needs.
        i. The Supervisor will assist the Participant/Family in establishing contact with the new Care Manager.
        ii. The Health Home will be made aware of any Care Manager changes via Netsmart.
    2. If a transfer is not warranted, the Supervisor will assist the Care Manager in re-engaging with the Participant/Family to reestablish an effective helping relationship.
C. If a Participant's needs/condition changes, or it is determined that the Participant requires a specialized Care Management service not provided by the CMA, the Health Home will be notified for possible transfer to another CMA within the network that would best meet the Participants needs.
        i. Care Manager and/or Supervisor will initiate a conversation with the Participant/Family regarding needs, preferences, rationale and available options.
        ii. If appropriate, the Health Home will contact the chosen CMA regarding transfer proceedings, and will initiate communication between CMA's to facilitate the transfer.

iii. If the Health Home determines that a transfer in unnecessary, the Health Home will discuss this with the CMA Supervisor/Manager, and will suggest additional interventions that would benefit the Participant.

D. Transfers from Children to Adult Health Homes, will be initiated the CMA, and coordinated by the Health Home.
E. Transfers to an alternate Health Home, will be initiated by a phone call to the chosen Health Home, where the referral can be entered, received and processed through the MAPP during the call.
F. All Care Coordination efforts will be clearly documented in Netsmart.
    1. Discharges will be documented and implemented according to the *Disenrollment/Discharge Policy.*
G. Once a CMA transfer is completed, the new CMA will review the current circumstances of the Participant and the available documentation, to determine the need for reassessment and/or changes to the Plan of Care.

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Care Management Policy #21 Safety

Effective Date: 5/1/16
Revised Date: 9/1/16

POLICY: Encompass Health Home will support the provision of Care Management services in a way that protects the health and safety of Participants and Care Managers, within environments where the physical well-being and the rights of all persons are protected.

PROCEDURE:

A. Care Management Agencies are encouraged to develop Safety Policies that address the known and anticipated risks, as well as recommended safety measures required during the performance of Care Management activities, both on site and in the community.
    1. Special attention should be given to those Care Managers providing Outreach and Engagement activities.
B. It is recommended that procedures address issues including but not limited to:
    1. Procedures for signing in and out of the office environment;
    2. When to refrain from making visits alone;
    3. Procedures to verify the safety of Care Managers when they are in the field;
    4. Procedures for making after hour or On-Call visits;
    5. When to do risk assessments;
    6. Procedures to address challenging or threatening behaviors;
    7. Procedures of when to include emergency personnel;
    8. Phone numbers and supports to contact when there is an emergency;
    9. Procedures to maintain a safe office environment, including procedures directed at the protection of Participants/Families/Visitors;
    10. Procedures for environmental hazards;
    11. Procedures to perform community field work safely.
C. It is required that all Care Management staff receive Safety Training, such as *OMH-Partnering for Safety,* or a similar curriculum.
    1. Additional training on safety measures are recommended including Bloodborne Pathogens; CPR/First Aid and Defensive Driving.
D. It is recommended that CMA's utilize technology such as agency cell/smart phones and GPS devices to assist Care Managers in performing their duties in a safe manner.
E. Procedures should involve processes for incident de-briefing, to examine situations that may occur, to initiate preventive measures and update policies.
F. The Health Home will review Incident Reports for evidence or lack thereof, of appropriate procedures for protecting the safety of Care Managers and Participants, and will offer feedback as needed.
G. The Health Home will provide necessary support and guidance on Safety as needed, during Provider Meetings and through assistance with policy development as requested.

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Care Management Policy #22 Lost to Service-Latency Process

Effective Date: 3/1/16
Revised Date:

Policy: Encompass Health Home will increase outreach efforts with those in latent status to engage and enroll into Health Home services; and will initiate innovative strategies to find and re-engage with participants deemed lost to service.

Procedure:

A. If after 3 months of Outreach and Engagement a prospective Participant/Family has not been found, or enrolled into Health Home services, they will be placed in a 3 month Latent status.
    1. Latency status will be established automatically by the Medicaid Analytics Performance Portal (MAPP) at the conclusion of three months of outreach without movement towards enrollment.
        i. Outreach and Engagement may be continued during the latent period, but cannot be billed. All outreach conducted during this period will be documented in Netsmart.
        ii. A prospective Participant may be enrolled into the Health Home at any time during the latency period.
    2. The CMA will document in Netsmart all Outreach efforts that were conducted for the 3 month period prior to the latent status, and will document when the Participant has moved into latency.
    3. Potential Participant/Family will be automatically reassigned to Outreach and Engagement by the MAPP after the latent period.
        i. Health Home designation will continue to be generated within the MAPP and may therefore reassign potential participants to a different Health Home from the latency period.

B. A Participant will be deemed as *Lost to Service* if a care manager has been unable to successfully contact the Participant/Family for a period of 60 days post scheduled appointment. This time frame may be conditionally extended if extenuating circumstances are documented within the Plan of care.
    1. Upon 24 hours of a missed scheduled appointment, the Care Manager will follow up with the Participant/Family to attempt to reschedule.
    2. If efforts to contact the Participant/Family are unsuccessful, the Care Manager will actively attempt to locate and re-engage with the Participant/Family. This may include sending letters, and contacting members of the Participant's Care team to determine whereabouts. All attempts to locate will be documented in Netsmart.
    3. Regular and progressive contact attempts will be made through the entirety of a 60 day period. All attempts will be documented, and may be billable at the enrolled rate so long as the re-engagement efforts are sufficient to support appropriate billing.
    4. If no direct contact with the participant is made within 60 consecutive days, the member will be deemed Lost to Service.
        i. The 60 day time frame will begin with the first documented missed contact.

ii. The participant may retain enrolled status through the end of the month in which the determination has been made.

5. When a Participant/Family is deemed Lost to Service, a note will be written in Netsmart, documenting this designation as well as summarizing all the efforts made to contact the individual within the previous 60-day period.
6. Commencing the 1st of the following month, Participant/Family given a Lost to Service designation will be re-designated to Outreach and Engagement for the purposes of locating and re-engaging the Participant/Family into care, and the CMA will begin billing at the Outreach and Engagement rate (provided three months has elapsed since the Participant was billed for under this designation).
    I. Billing may continue at the Outreach and Engagement rate for up to three consecutive months.
    II. All attempts to contact the Participant during Outreach and Engagement must be progressive and be thoroughly documented in Netsmart.

C. Disenrollment
    1. If the Participant/Family is still unable to be contacted after the three months of outreach and re-engagement, the Health Home will be notified and will provide additional guidance, or the Participant/Family may be disenrolled. *Please refer to the Disenrollment/Discharge Policy.*

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Care Management Policy #23 Health Home Referrals

Effective Date: 5/1/16
Revised Date: 9/1/16

Policy: Encompass Health Home will ensure that individuals referred to the Health Home will be assessed for eligibility and referred to a Care Management Agency that will best meet the Participants needs in a timely fashion.

Procedure:

A. The referral and Health Home assignment process for adults and children (participants under 21) will be accessed and automated in the Medicaid Analytics Performance Portal (MAPP).
    1. Direct referrals may be made by Health Homes, Managed Care Plans (MCP), Care Management Agencies (CMA), Local Department of Social Services (LDSS) and Voluntary Foster Care Agencies (VFCA).
        I. All Health Home referrals will be assigned, or approved by the MCP.
        II. The MCP will verify that their member is Health Home eligible and appropriate for services.
    2. Community Referrals for **Adults** will be received by the Health Home from individuals, Managed Care Plans (MCP), providers, CMA's or by way of a SPOA process.
        I. When a referral is received by the Health Home, they will check the Health Home portal to research possible existing Health Home affiliations.
    3. Community referrals for **Children** may be made by LDSS, LGU/SPOA and MCP's through access to the MAPP referral portal. These entities will be required to:
        i. Accept the "terms and conditions" regarding Health Home eligibility;
        ii. Identify if the child is in Foster Care;
        iii. Affirm and indicate that they have obtained consent to refer from the child's parent, guardian, legally authorized representative (DSS), or self (individual's 18-21 years of age or minors that are married, pregnant or a parent may provide consent on their own behalf);
            a. Although verbal consent is required, the Health Home requires that the CMA obtain a written consent for referral.
        iv. Provide the Medicaid CIN# for the individual being referred;
        v. Identify all of the child's chronic conditions that meet eligibility for Health Home;
        vi. Provide parent/guardian, legally authorized representative or individual's contact information;
        vii. Indicate whether the parent/guardian is currently enrolled in a Health Home;
        viii. Indicate whether the child is receiving Child Welfare Preventive Services.
            a. Foster Care referrals will be assigned by DSS to a VFCA, who will enter the Health Home referral into the MAPP.
    4. The referral agent will receive notification of referral submission.
    5. Upon submission of a child's referral to the MAPP, Health Home assignment will occur according to need and location. The Health Home will either accept the referral and assign to a an appropriate CMA, or reject the referral and suggest an alternative assignment.
    6. The Health Home will review all referrals within 2 business days of receipt.
    7. Those that require immediate attention will be assigned to a CMA able to respond within 24 hours of assignment.
    8. Referral sources will be notified of referral dispositions through the MAPP, or by the Health Home as appropriate.

Care Management Policy #23 Health Home Referrals

9. The Health Home will send prospective Participants a welcome letter, identifying the CMA assigned, and contact information.

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Care Management Policy #24 – Quality Assurance and Improvement (QA/QI)

Effective Date: 2/1/16
Revised Date: 9/1/16, 10/1/16

Policy:
Encompass Health Home will collect and review Health Home data and develop strategies designed to improve and maintain the quality of Participant services and outcomes, as well as the performance of contracted Care Management Agencies.

Procedure:

A. The Health Home will review data from multiple sources, to evaluate outcomes, quality, processes and CMA performance.
B. Information gained will be shared continuously with CMA's, during Provider Meetings, as well as one-on-one consultation with individual CMA's as needed.
    1. Provider meetings will be utilized additionally to share and develop best practices for the Health Home, and for providing CMA's with needed support and development.
C. CMA's will be trained on Health Home requirements during the orientation process, and instructed on the use of audit tools, required reporting and plan of correction processes.
D. QA/QI issues will be discussed as needed during regular Provider meetings.
E. The Health Home will review and monitor outcomes and performance based on the following processes:
    1. **State level** reports will be reviewed and assessed as follows:
        i. State Plan Quality Measures Report and Center for Medicare and Medicaid Services (CMS) Measures
            a. The Health Home will review data when received to determine Health Home performance regarding:
                1) Utilization associated with avoidable (preventable) inpatient stays;
                2) Utilization associated with avoidable (preventable) emergency room visits;
                3) Outcomes for persons with mental illness and/or substance abuse disorders;
                4) Appropriate disease-related care for chronic conditions;
                5) Appropriate delivery of preventative care.
            b. The Health Home will share results with CMA's to develop improvements on performance.
        ii. Medicaid Analytics Performance Portal (MAPP)
            a. MAPP dashboards will be accessed by the Health Home and CMA's to track agency performance, and gain insight into improving performance related to the population served.
            b. The Health Home will track trends in performance and will provide feedback and guidance to CMA's accordingly.
        iii. The HH will develop reports from Netsmart regarding Participant Care Management activities and Adult FACT-GP/Assessment scores and submit to DOH through the HCS portal, utilizing the Care Management Assessment Reporting Tool (CMART) on a quarterly basis.
            a. The Health Home will analyze turnaround CMART data from DOH in regards to engagement, frequency of contacts and services, and will review results with CMA's in order to develop additional strategies for improvement.

iv. The Health Home will share results of DOH audits/visits as they occur.

2. **Managed Care level** reports will be reviewed and assessed as follows:
   i. The Health Home will review reports received from Managed Care Organizations identifying specific gaps in care for Participants. These reports will be inclusive of performance measures under the Quality Assurance Reporting Requirements (QARR) and will be evaluated and shared with the appropriate CMA's, who will report back to the Health Home, measure taken to fill identified care gaps.
   ii. MCO's who are accredited through National Committee for Quality Assurance (NCQA) will provide the Health Home with performance and compliance results based on NCQA standards through audits, evaluations of Healthcare Effectiveness Data and Information Set (HEDIS) and other measures.
   v. MCOs will monitor performance of the Health Home and CMA's through auditing, and the use of oversight tools and outcome measures.
   vi. The Health Home will follow-up with CMA's as needed to address and reduce care gap trends as well as provide guidance and recommendations as necessary.

3. **Health Home level** monitoring will occur as follows:
   i. Health Home outreach and engagement, case record and billing audits will be conducted with CMA's minimally on a bi-annual basis. In addition, the Health Home may conduct a comparison audit with records that have been previously reviewed by the CMA. These audits will assist in ensuring quality assurance is being maintained throughout the CMA internal auditing process. The audit results will be shared to provide feedback and support, and the Health Home will assist the CMA in developing a corrective action plan if necessary. Follow up to the corrective action plan will be provided as documented. *(See attached audit tools)*
   ii. The Health Home will track CMA complaints and incidents to monitor CMA performance as well as incident trends. The Health Home will provide assistance regarding resolution of complaints and incidents per the *Complaints/Incident Policy*.
   vii. An annual satisfaction survey of Health Home Participants will be conducted. The Health Home will distribute surveys to CMAs during a determined time period, and will request they be returned to the Health Home for evaluation. Surveys will be used to identify levels of satisfaction with care Management services as well as the perceived value of the service that is offered. Results from the surveys will be analyzed by the Health Home, and shared with CMA's as part of the Quality Improvement cycle.
   viii. The Health Home will perform a site visit with the CMA within 3-6 months of initial Participant assignments to evaluate adherence to standards, and provide additional guidance and instruction.
      a. Site visits may also be conducted in conjunction with documented corrective action plans.

4. **Care Management Agencies** will be responsible for developing internal monitoring/auditing protocols for case records, Adult HCBS processes, outreach and engagement, complaints/incidents and billing functions. The CMA will utilize the Health Home audit tools, and will report quarterly audit outcomes to the Health Home. CMA's will distribute QA information from their audits, the Health Home and other oversight agencies to Care Managers as needed, in order to improve individual Care Manager performance.

Care Management Policy #24 – Quality Assurance and Improvement (QA/QI)

i. CMA's will have a plan to review and audit Participant records. These audits will be conducted on a sample that is representative of the whole and will include records from all Care Managers, as well as Participants enrolled and in outreach.
ii. The Health Home will review CMA audits, provide feedback, and offer assistance with developing individualized corrective action plans that may be required for areas that do not meet minimal standards.
    1. Health Home will follow up with the CMA after corrections have been made, to assure understanding of needed corrections, and to offer feedback for sustaining performance.
    2. Additional corrective action measures regarding CMA performance will be formally developed as needed.
        a. CMA performance may impact additional Participant assignments until identified improvements occur and are sustained.
iii. CMA's will develop processes to evaluate Participant utilization of services, and continued need for services.
    1. Reviews for adult participants will be completed no less than annually and may be completed and documented in conjunction with the interdisciplinary team meeting.
    2. Reviews will be completed no less than quarterly for children, and can occur as part of the Wraparound.
iv. CMAs will investigate and resolve complaints and incidents to ensure Participants satisfaction; prevent re-occurrence; promote the ongoing delivery of quality services and protection of Participant rights; and maintain the health and welfare of Health Home Participants as indicated fully in the *Complaint and Incident Monitoring/Investigation Policy.*
v. It is recommended that the CMA conduct a Participant satisfaction survey at a minimum frequency of once a year, in addition to the survey conducted by the Health Home, at an interval that does not interfere with the Health Home Survey. These surveys will elicit specific CMA feedback and suggestions for improvement of service delivery, and assess whether the Participants feel the services they receive aid them in the attainment of their goals.
    1. The CMA will report on survey results, revealing trends and action steps to improve care. These reports will be sent to the Health Home Policy and Compliance Coordinator.
vi. CMAs will provide regular supervision for employees at all levels. Supervision will include identifying strengths and how to best utilize them as well as identifying areas in need of improvement.
    b. Supervision outcomes will be documented and reevaluated at least annually.
    c. Remediation or training will be provided to address any areas in need of improvement as appropriate.

F. **Health Home QA Committee**
    1. The Health Home will meet with CMA representatives, on at least an annual basis, to focus on issues related to quality. These meetings will provide education, guidance and information specific to the identified needs of CMA's to assist them with targeting identified areas for improvement.

2. The meeting will provide additional feedback to the Health Home to develop additional quality measures as needed, and will provide CMA's an opportunity to share best practices with other CMA's within the Health Home.

G. **Corporate Compliance**

1. CMAs will have an active Corporate Compliance program inclusive of the following:
   i. Written standards of conduct, policies and procedures that demonstrate the CMA's commitment to compliance implementation;
   ii. Designated Compliance Officer to monitor and enforce standards;
   iii. Regular training and education on corporate compliance and those standards specific to the CMA, Health Home and billing;
   iv. Periodic internal monitoring and compliance audits;
   v. Monitoring of both internal and external audits to detect potential for compliance-related issues.

ENCOMPASS HEALTH HOME

ADULT CASE RECORD AUDIT TOOL

Participant: **Admission Date:** **Date of Audit:** **Auditor:** **Score:**

STANDARD	Yes	No	NA	Located In:		Recommendations	Additional Comments
ELIGIBILITY				Chart	EHR		
Recent claims and clinical data document the following: 1. Current Medicaid recipient, **AND**; 2. Two or more chronic medical conditions. (can include SUD) **AND/OR;** 3. Seriously mentally ill, **AND/OR;** 4. HIV/AIDS, **AND;** 5. Presence of Significant Risk Factors □ Medical □ Behavioral □ Social							
ADMISSION							
Participant identification verified by: A) One form of photo ID of an individual known by the Agency; **OR** B) Two forms of ID (one of which needs to be a photo). *Chart contains ID or scanned copy of Medicaid card, Insurance card and photo ID on CM platform*							
Completed DOH-5055 including list of participating providers **OR** completed DOH 5059 Opt-out form *(Please indicate which in comments section)*							
Annual update of DOH-5055 *This should include the Participants dated signature next to each provider.*							
Completed PSYCKES Consent Form, if applicable							
Other Completed Releases of Information if applicable:							

ADULT CASE RECORD AUDIT TOOL

Releases Cont'd: □ Signed by Participant □ Dated by Participant □ Witnessed □ Purpose Identified □ Properly executed							
Notice of Privacy Practices □ Signed by Participant at admission □ "Received by" completed							
Health Home Rights and Responsibilities □ Completed at admission □ Signed by Participant and Staff							
Health Home Rights and Responsibilities reviewed and signed annually							
ASSESSMENT/RE-ASSESSMENT							
Initial Needs/Eligibility Assessment completed signed by: □ Participant □ Care Manager □ Supervisor							
Initial FACT-GP/ HH Questionnaire completed							
Annual update of FACT-GP/HH Questionnaire completed							
Comprehensive Assessment *Completed within 30 days of Admission.*							
Follow up Assessment *updated every six months* ***or*** *as needed*							
CARE PLAN							
Initial Plan of Care □ *Completed 30 days from assessment* □ *Signed by Participant* □ *Signed by Care Manager* □ *Signed by Supervisor.*							

ADULT CASE RECORD AUDIT TOOL

Plan of Care is related to one of five HH Core requirements which include: 1. Comprehensive Care Management 2. Care Coordination and Health Promotion 3. Comprehensive Transitional care. 4. Individual and Family support. 5. Referral to community and social support.							
Plan of Care links the goal, objectives and interventions with identified problems.							
Plan of Care identifies reasonable timeframes for each intervention.							
Strengths and Barriers Identified for the goal							
Plan of Care identifies involvement, and role of Care Team members *Are there identified care team member with whom collaboration is not taking place?* *Is there mention of potential care team members in care notes that have not been added to the team?*							
Plan of Care is updated at a minimum of every 6 months or as needed to reflect transitions or changes in Participant's status							
CARE NOTES							
Care notes correspond to the Plan of Care and identify the HH Core Services provided.							
Care Notes document active and progressive movement towards objective and goal obtainment.							
Care Notes document							

ongoing coordination of care with service providers							
Documentation shows that Care Team Members have been provided or granted access to the Plan of Care.							
Documentation demonstrates efforts to coordinate Multidisciplinary Team meetings at least annually □ *Identify date of last meeting in notes.*							
Care Notes identify efforts to provide necessary transitional care *(This includes but is **not limited to**: attending discharge meetings, ensuring follow-up appointments are made, contacting the pharmacy, contacting family or other care team members.)*							
Care Notes identify ongoing communication with identified community supports *(i.e. family, friends, spiritual support)*							
Care notes contain date of contact, type of contact and location of contact.							
Care notes are documented by the person who provided the service.							
HARP/HCBS							
Brief interRAI completed within 10-21 days of HH enrollment							
NYS Community Mental Health Assessment completed within 30-90 days of enrollment							
Re-assessment completed at least annually and/or when there is a significant change in the participant's status							
Plan of Care sent to MCO for approval within designated timeframe							
Plan of Care includes: □ Documentation of Eligibility							

□ A summary of the full CMHA □ Recommended HCBS Services *(Must contain at least 1)* □ Service Types: Scope; Modality; Location; Duration; Frequency □ Participant signature □ Care manager signature □ All HCBS Provider signatures							
Plan of Care approved by MCO							
Plan of Care updated at least every 90 days and/or when needed to reflect changes							
Care notes reflect communication with HCBS Providers outlining the Assessment/Plan of Care process							
DISCHARGE							
FACT- GP/HH Questionnaire was conducted if applicable.							
Signed Health Home Disenrollment Form (DOH-5058)							
Supportive documentation for discharge present in care notes							
Completed discharge note with the following: □ Explanation of why the participant is being discharged □ Summary of all care coordination activities during the discharge process □ Efforts made to connect participant to services to meet ongoing needs							

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Care Management Policy #25 Health Home Development Funds

Effective Date: 5/1/16
Revised Date:

Policy: Encompass Health Home will utilize Health Home Development Funds (HHDF) with integrity and within their designated purpose as outlined in the State Plan Amendment (SPA), to enhance and support the basic infrastructure development of the Health Home and to provide resources to leverage opportunities regarding:

- The improvement of outreach and enrollment efforts, including HARP candidates;
- The alignment of the Performing Provider System (PPS) activities as related to the Delivery System Reform Incentive Payment (DSRIP) projects and the over-arching goal of reducing avoidable hospitalizations;
- The development of the Catholic Charities Heath Home serving Children, including child enrollment;
- The use of Health Information Technology (HIT) for furthered improvement of care and payment processes.

Procedure:

A. All HHDF will advance the directives and requirements of Catholic Charities Health Home.
B. HHDF will not duplicate, or be used for purposes which other direct funding sources are available.
C. Health Home will discuss HHDF with Care Management Agencies (CMAs) as well as Providers during Provider meetings, to collaborate and identify appropriate uses of HHDF for the Health Home.
    1. Discussions will be recorded on the Provider Meeting minutes.
    2. CMA's will be reminded regarding opportunities that are available, that HHDF may be requested for.
    3. CMAs will be reminded on how to request HHDF for relevant activities.
D. HHDF will be authorized for the following purposes:
    1. Member engagement and Health Home promotion; examples include but are not limited to:
        i. Targeting strategies for conducting outreach to engage and enroll specific population;
        ii. Developing marketing materials;
        iii. Initiative to improve communication and collaboration;
        iv. Workforce training, both initial and ongoing; examples include but are not limited to:
            a. Cross disciplinary training;
            b. Support training in care management;
            c. HIT/EHR training for Care Managers to facilitate use of the Health Home supported HIT.
        v. Clinical connectivity and health information technology (HIT) implementation; examples include but are not limited to:
            a. Purchase of electronic hardware;
            b. Development of electronic interfaces;
            c. Hiring IT consultant.

vi. Joint governance technical assistance; examples include but are not limited to:
    a. Collaboration with regional partners;
    b. Quality improvement and assurance programs assisting with reporting compliance and improving efficiency and member outcomes;
    c. Support for targeted local learning collaboratives.

E. CMA's that request HHDF, will adhere to the following:
    1. Completion and submission (for prior purchase authorization) using the *Provider Expense Reimbursement Request Form*, and *Contract Provider Certification Form*, to the Health Home. (*See Attached Forms);*
    2. The Health Home will review the request, confirm the appropriate use of HHDF, and will notify the CMA of approval;
    3. After purchase, the CMA will submit expenditure receipts and a completed *Provider Expense Reimbursement Request Form* to the Health Home;
    4. The Health Home will forward reimbursement to the CMA for pre-authorized expenditures.

F. The Health Home will receive quarterly lump-sum payments through the Statewide Financial System (SFS) with a descriptor of DSRIP-HH SFT 2014.

G. The Health Home will electronically submit reports to the DOH, providing an assessment of plans of use for HHDF as required.
    1. The Health Home will provide DOH semi-annual reports on HHDF use until the complete utilization of HHDF.

HEALTH HOME EXPENSE REIMBURSEMENT
CONTRACT PROVIDER CERTIFICATION FORM

As a lead Health Home in Broome County, Catholic Charities of Broome County has been awarded funding from the Department of Health to benefit downstream providers including making interconnectivity improvements needed to provide health home care management to individuals assigned to and enrolled in Catholic Charities Health Home.

Procedures for Contract Providers:

1. Complete request form
2. Complete certification form
3. Send forms to Catholic Charities attention Julie Smith with quotes and/or purchase orders attached
4. Upon receipt of approved request, items requested may be purchased
5. Attach approved request to invoice and return to Julie Smith
6. Reimbursement will be made within 30 days

CERTIFICATION

The equipment requested is needed for Care Management for the following reasons:

Signature Printed Name Date

HEALTH HOME CONTRACT PROVIDER EXPENSE REIMBURSEMENT REQUEST

ATTN: JULIE SMITH

Catholic Charitites of Broome County
290 Front St
Binghamton, NY 13905

Requsition for approval and payment

Requesting organization: _____

Requested by: Name/Title: _____ **Signature:** _____

Contact number: _____

Date submitted: _____

				CCBC ONLY		
Description of Item	**Qty**	**Price**	**Amount**	**Yes/No/Comments**	**Sign/Initial**	**Date**

TOTAL _____

Copies of Quotes must be attached to initial request
Copies of invoices must be attached for payment

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Care Management Policy #26 Confidentiality

Effective Date: 3/1/16
Revised Date: 9/1/16

Policy: Encompass Health Home will ensure that all providers of Care Management Services ensure confidentiality and privacy in regard to history, records, and discussions about Participants served. All Participant information maintained by Care Management Agencies, will be will be protected and managed in accordance to New York State laws, Federal Laws and Health Home Standards: New York State's Mental Health Confidentiality statute (section 33.13 of the Mental Hygiene Law); NYS Public Health Law Article 27-F; 42 Code of Federal Regulations Part 2; HIPAA Privacy Rule (45 CFR Parts 160 and 164).

Procedure:

A. All Care Management Agencies (CMA) will enter into a Business Associate Agreement (BAA) with the Health Home, identifying responsibilities of both parties in the use and disclosure of Protected Health Information to perform Health Home/Care Management services.
B. CMA will develop policies and procedures that address responsibility and guidelines to adhering to all confidentiality laws.
    1. CMA will update their policies as changes in laws occur.
    2. All Care Management staff will be trained to, and demonstrate their understanding of confidentially laws and security measures prior to access to any confidential Health Home information or electronic platforms.
    3. Care Management Staff will be re-trained as changes to the law develop, or annually, whichever occurs first.
        i. Documentation of training will be maintained in personnel records.
C. All Health Home Participants will sign a Health Home Consent, and will identify those individuals or providers with whom the CMA may communicate and coordinate services with.
    1. Consents will be updated as required to add additional individuals/providers, or to revoke permissions per the Participants request.
    2. Changes to the Consent Sharing information including the addition or deletion of individuals/providers, will each be initialed and dated by the Participant/Consenter. A review of individuals identified for data sharing will be conducted no less than annually with the Participant, and updated as needed.
    3. If Participant chooses to revoke consent from the CMA, but not the Health Home, the consent will be updated by the CMA, to indicate those parties that the Participant has revoked their consent from. The updated consent will be attached to the EHR.
    4. When a Participant chooses to revoke consent from the CMA **AND** Health Home, a Health Home Withdrawal of Consent Form will be completed and signed, if possible.
D. All sharing of Participant information will be limited to the minimum amount necessary to support outreach efforts, engagement and the effective coordination of services.
E. CMA will develop and adhere to accepted practices to maintain security of protected information while conducting business under the Health Home. This will include, but is not limited to:

Care Management Policy #26 Confidentiality

1. All electronic transmission of protected information will be encrypted.
2. All paper disclosures will be accompanied by a statement prohibiting re-disclosure of information.
    i. All disclosures will be documented according to Privacy law standards.
3. All verbal disclosures will be related to the provision of Care Management services, and limited to those who are involved with the Participants care, or are determined to have a need to know.
4. When faxing confidential information, a cover sheet will be used, containing a confidentiality statement.
    i. Fax machines used to send and receive Health Home information will be kept in a secure location.
5. All portable electronic devices utilized by Care Management Staff will be password protected/encrypted for Health Home use.
    i. Portable electronic devices will not be used to store confidential information , unless they are encrypted.
    ii. Missing or stolen devices will be reported to the CMA immediately, and the Health Home informed.
6. All confidential/protected information will be stored on premises in a locked, secure area, and limited to those who require access.
    i. CMA's will determine staff access based on role and necessity.
    ii. CMA's will develop policies and protocols to ensure security and confidentiality, if the need, if any, presents to transport any records outside of the premises.
7. Access to Electronic Health Records (EHR) will be assessed based on role and need to know protocols.
    i. Staff access to Health Home EHR, will be coordinated through the Director of Health Information Systems (DHIS).
    ii. Access passwords issued to Care Management staff will be kept confidential, and not shared with anyone
        a) CMA will notify DHIS immediately if passwords have become compromised.
    iii. Care Management staff will access electronic records in a secure location, and will utilize secure internet connections.
    iv. CMA's will notify the DHIS immediately when roles change, or access is no longer required.
    v. CMA's will maintain a list of Staff, roles and access levels, and will submit to the Health Home upon request.
    vi. Access to other platforms containing confidential information, will be coordinated by the CMA, and use monitored per confidentiality agreements.

F. Violations of privacy, or breaches of confidential Health Home information, will be reported to the Health Home according to BAA contracts, and addressed according to CMA Policies and applicable privacy laws.
    1. Investigations will be conducted, and Participants notified if applicable.

G. Security audits will be conducted by the CMA, and forwarded to the Health Home upon request.

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Care Management Policy #27 Complex Trauma

Effective Date: 9/1/16
Revised Date:

Policy: Encompass Health Home Care Management Agencies will assess indicated children for the single qualifying chronic condition of Complex Trauma, and will develop and implement a Plan of Care that includes trauma informed services to meet their unique needs.

Procedure:

A. Definition:

1. The term complex trauma incorporates at least:
    i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and;
    ii. The wide-ranging, long-term impact of this exposure.
2. Nature of the traumatic events:
    i. often is severe and pervasive, such as abuse or profound neglect;
    ii. usually begins early in life;
    iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
    iv. often occur in the context of the child's relationship with a caregiver; and;
    v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
3. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
4. Wide-ranging, long-term adverse effects can include impairments in:
    i. physiological responses and related neurodevelopment;
    ii. emotional responses;
    iii. cognitive processes including the ability to think, learn, and concentrate;
    iv. impulse control and other self-regulating behavior;
    v. self-image, and;
    vi. relationships with others.

B. Screening and Assessment Guidelines:

1. The assessment of Complex Trauma will involve assessing the Child's exposure to multiple recurring traumatic events, as well as the wide ranging and severe impact of this trauma exposure across domains of development.
2. Children will be assessed for a wide range of symptoms (beyond PTSD), risk behaviors, functional impairments and developmental derailments.
3. Information will be gathered using a variety of techniques such as clinical interviews, standardized measures and behavioral observations.
4. Information from a variety of perspectives will be solicited including but not limited to the child, parents/caregivers, teachers and other providers.

5. The Complex Trauma Assessment; Functional Impairment Assessment & Eligibility Determination will be conducted by a licensed, clinically trained Professional, which includes the following;
    i. Licensed Masters Social Worker (LMSW);
    ii. Licensed Clinical Social Worker (LCSW);
    iii. Psychologist;
    iv. Psychiatrist;
    v. Licensed Psychiatric Nurse Practitioner (LNPP);
    vi. Licensed Marriage & Family Therapist (LMFT);
    vii. Licensed Mental Health Counselor (LMHC);
    viii. Pediatrician/Family Medicine Physician or Internist *with specialization in Behavioral Health.*
        a. Ideally the assessment should involve a multi-disciplinary approach.
6. Care Management Agencies will assure that the Licensed Professional conducting the Complex Trauma Assessment is not the Health Home Care Manager.

C. Referral/Assessment Process:

1. Individuals who wish to refer a Child to the Health Home based on Complex Trauma as the single qualifying condition, will first complete the *Complex Trauma Exposure Screen,* based on all available information.
    i. This can be completed by a Non-Licensed Professional or a Licensed Professional.
2. If by screening it is determined that the Child has been exposed to Complex Trauma, the Referent may submit a referral to the MAPP, and indicate the Complex Trauma diagnosis.
    i. If the Referent does not have MAPP access, they may contact a referring Entity that can enter the referral such as LDSS, LGU, MCO, CMA or the Health Home.
3. The Referent will then complete the *Complex Trauma Referral Cover Sheet*, and forward Cover Sheet, completed Exposure Screen, and consent to the Health Home through secure messaging.
4. Once received, the Health Home will assign the Child to a CMA, and forward completed documentation.
5. The CMA will assign a Licensed Professional to initiate and complete the *Complex Trauma Exposure Assessment Form.*
6. If Child is deemed positive for exposure, the Licensed Professional will complete a *Functional Impairment Assessment*, using a National Child Traumatic Stress Network (NCTSN) approved assessment tool, and will link the Childs exposure to a functional impairment.
7. If Child is found to meet the Complex Trauma eligibility, the Licensed Professional will complete the *Complex Trauma Eligibility Determination Form.*
    i. If the Referent is a licensed Professional, they may complete **ALL** the above assessments and Trauma eligibility determination **prior** to making

the referral in MAPP, and submit all documentation to the Health Home at the time of referral.

ii. The Health Home will then forward all supporting documentation to the Assigned CMA, who will verify the Complex Trauma diagnoses, as well as any other presenting chronic conditions.

8. The CMA will then assess for Health Home appropriateness, and will begin process for enrolling the Child/Family into health Home services.
9. All documentation will be scanned an attached to the Plan of Care in Netsmart.
10. The Care Manager will refer to all supporting documentation, and utilize a multi-disciplinary approach to create a Plan of Care that is relevant to the diagnoses of Complex Trauma, and meets the Child's unique complex needs.

NEW YORK STATE | Department of Health

Complex Trauma Exposure Screen (CTES)

Please indicate whether the child experienced the following types of traumatic events using all available information (e.g. self- or caregiver report, review of records, etc.). Conduct a ***brief*** interview with the child *only if you do not already have enough information to make a determination about complex trauma exposure*. To avoid undue distress, ask only about types for which you do not already have information. If information for a particular trauma is known, *do not request additional details from the child* for that type. For example, if the child has a documented history of physical neglect, endorse "Y", and move on to the next category. *Once the presence of 2 or more trauma types has been reported (or 1 lasting greater than 6 months), discontinue the interview portion of the assessment.*

Sources of Information (check all that apply): ☐ Parents/Caregiver ☐ Chart/Records Review ☐ Child/Youth Report ☐ Other (specify):

Prompts/Questions (suggested prompts/questions for assessing trauma exposure within each category)	**Trauma Type**	**Present? Y/N**	**> 6 mos?**
Was there a time when adults who were supposed to be taking care of you didn't? Has there ever been a time when you did not have enough food to eat? Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?	**Physical/Emotional Neglect** Or **Emotional Maltreatment**		
Have you lived with someone other than your parents/caregiver while you were growing up (because they couldn't take care of you or you were kicked out)? Have you ever been homeless? This means you ran away or were kicked out and lived on the street for more than a few days? Or you and your family had no place to stay and lived on the street, or in a car, or in a shelter?	**Displacement**		
Have you lost a primary caregiver through death, incarceration, deportation, migration, or for other reasons? Have you been left In the care of different people due to parental incapacity or dysfunction, even if your primary place of residence did not change? Have you had two or more changes in your primary caregiver or guardian, either formally (legally) or informally?	**Attachment Disruption**		
Has anyone ever made you do sexual things you didn't want to do, like touch you, make you touch them, or try to have any kind of sex with you? Has anyone ever *tried* to make you do sexual things you didn't want to do? Has anyone ever forced you (or tried to force you) to have intercourse?	**Sexual abuse** **Sexual assault/rape**		
Have you ever been hit or intentionally hurt by a family member? If yes, did you have bruises, marks or injuries?	**Physical Abuse**		
Have you ever *seen* or *heard* someone in your family/house being beaten up or Have you ever *seen* or *heard* someone in your family/house get threatened with harm?	**Domestic violence**		
Have you ever *seen or heard* someone being beaten, or who was badly hurt? Have you seen someone who was dead or dying, or *watched or heard* them being killed? Has anyone ever hit you or beaten you up (physically assaulted you?) Has anyone ever threatened to physically assault you (with or without a weapon)?	**Community Violence (chronic)** or **Interpersonal Violence (episodic)**		
Did other children often tease or insult you, put you down, or threaten you physically? Did they spread lies about you or turn other people against you?	**Bullying**		
Have you or anyone in your family been involved in, or *in direct danger* from a terrorist attack, war, or political violence?	**Terrorism/War/ Political Violence**		
Has anyone ever stalked you? Did anyone ever try to kidnap you?	**Stalking/Kidnapping**		
Is there anything else really scary or very upsetting that has happened to you that I haven't asked you about? Sometimes people have something in mind but they're not comfortable talking about the details. Is that true for you?	**Other trauma**		
Number of different types of traumas experienced (total # Trauma Types = Yes)			
Number of chronic traumas experienced (total # Trauma Types Experienced for more than 6 months			

If number of Trauma Types = 2 or greater: ⟹ Refer child to Health Home for Further Assessment.
If 1 Trauma type lasting > 6 months (i.e. chronic): ⟹ Refer child to Health Home for Further Assessment.

* Prompts derived from Trauma History Checklist & Interview.

New York State Health Home Program Chart Reviews Attachment B			
Health Home: Catholic Charities of Broome County		**Date of visit: June 14 – 15, 2016**	
Chart Review question	**% of (-) Finding**	**Finding**	**Unique Identifier(s) CCOB=Catholic Charities of Broome County FRS=Fairview Recovery Services OLOL=Lourdes Health Home**
13. Comprehensive Reassessments includes medical, mental health, Substance Use Disorder, HIV and Social Service needs.	39%	11 out of 28 did not meet this requirement	CCOB-03, CCOB-08, OLOL-002 OLOL-08, OLOL-10, OLOL-11, FRS-01, FRS-03, FRS-09, FRS-11, FRS-12
15. FACT-GP Reassessments completed.	22%	7 out of 31 did not meet this requirement	CCOB-08, OLOL-06, OLOL-07, OLOL-08, OLOL-10, OLOL-11, FRS-01, FRS-03, FRS-09, FRS-11, FRS-12
17. Health Home Functional Reassessment completed.	28%	8 out of 28 did not meet this requirement	CCOB-06, CCOB-08, OLOL-01, OLOL-06, OLOL-07 , OLOL-10, FRS-03, FRS-09
18. Language literacy/cultural preferences identified as a part of the comprehensive assessment	21%	7 out of 33 did not meet this requirement	CCOB-06, CCOB-03, OLOL-01, OLOL-07, OLOL-12, FRS-03, FRS-10
19. Preferences addressed and acted upon as needed?	25%	8 out of 32 did not meet this requirement	CCOB-06, CCOB-02, CCOB-03, , OLOL-07, FRS-01, FRS-08, FRS-10, FRS-11
22. Barriers to care addressed and acted upon as needed.	31%	9 out of 29 did not meet this requirement	CCOB-09, CCOB-10, OLOL-08, FRS-01, FRS-04, FRS-08, FRS-09, FRS-10, FRS-11
26. Regarding Behavioral Health/Mental Health services/providers, there is evidence in care plan the individual is receiving or in the process of connecting to specified services?	22%	5 out of 23 did not meet this requirement	OLOL-02, OLOL-09, FRS-01, FRS-02, FRS-10
27. SUD services/providers identified.	21%	4 out of 19 did not meet this requirement	OLOL-02, FRS-03, FRS-08, FRS-12
28. There is evidence in care plan the individual is receiving or in the process of connecting to specified services?	40%	8 out of 20 did not meet this requirement	OLOL-02, OLOL-09, FRS-01, FRS-03, FRS-07, FRS-08, FRS-10, FRS-12
29. HIV Services/Providers identified?	100%	3 out of 3 did not meet this requirement	CCOB-02, OLOL-06, FRS-07

New York State Health Home Program Chart Reviews Attachment B			
Health Home: Catholic Charities of Broome County		**Date of visit: June 14 – 15, 2016**	
Chart Review question	**% of (-) Finding**	**Finding**	**Unique Identifier(s) CCOB=Catholic Charities of Broome County FRS=Fairview Recovery Services OLOL=Lourdes Health Home**
30. There is evidence in care plan the individual is receiving or in the process of connecting to specified services?	66%	2 out of 3 did not meet this requirement	CCOB-02, FRS-07
35. All health care services pertinent to the member are listed (e.g. specialists, etc.)?	29%	8 out of 27 did not meet this requirement	CCOB-06, CCOB-02, CCOB-08, CCOB-10, OLOL-01, OLOL-02, FRS-09, FRS-11
36. There is evidence in care plan the individual is receiving or in the process of connecting to specified services?	24%	6 out of 25 did not meet this requirement	CCOB-02, CCOB-10, OLOL-02, OLOL-03, FRS-09, FRS-11
39. All necessary evidence based wellness and prevention services pertinent to the member are listed (e.g. smoking cessation, diabetes, asthma, and hypertension)?	31%	7 out of 22 did not meet this requirement	CCOB-02, CCOB-06, CCOB-10, FRS-07, FRS-09, FRS-11, FRS-12
40. There is evidence in care plan the individual is receiving or in the process of receiving specified services?	40%	9 out 21 did not meet this requirement	CCOB-02, CCOB-03, CCOB-10, OLOL-02, FRS-07, FRS-09, FRS-10, FRS-11, FRS-12
43. Goals, interventions, and time frames for improving member's health and status included?	42%	13 out of 31 did not meet this requirement	CCOB-02, CCOB-03, CCOB-07, CCOB-09, CCOB-10, OLOL-02, OLOL-03, OLOL-04, OLOL-05, OLOL-06, FRS-03, FRS-07, FRS-09
44. Evidence of involvement by guardian (caregiver), family member, or others selected by member?	22%	4 out of 18 did not meet this requirement	CCOB-07, OLOL-06, FRS-02, FRS-11
46. Evidence of rights explained to member (e.g. advance directives)?	59%	16 out of 27 did not meet this requirement	CCOB-02, CCOB-03, CCOB-04, CCOB-07, CCOB-08, CCOB-09, OLOL-01, OLOL-03, OLOL-04, OLOL-05, OLOL-06, OLOL-10, FRS-03, FRS-04, FRS-05, FRS-11
47. Evidence of coordination/collaboration with care team members?	37%	11 out of 30 did not meet this requirement	CCOB-07, CCOB-09, CCOB-10, OLOL-02, OLOL-04, OLOL-06, OLOL-07, FRS-01, FRS-02, FRS-07, FRS-09
50. Plan of Care identifies progress toward successful accomplishment of goals or appropriate	38%	11 out of 29 did not meet this requirement	CCOB-07, OLOL-02, OLOL-03, OLOL-04, OLOL-09, FRS-02, FRS-05, FRS-08, FRS-09, FRS-11, FRS-12

New York State Health Home Program Chart Reviews Attachment B			
Health Home: **Catholic Charities of Broome County**		**Date of visit: June 14 – 15, 2016**	
Chart Review question	**% of (-) Finding**	**Finding**	**Unique Identifier(s) CCOB=Catholic Charities of Broome County FRS=Fairview Recovery Services OLOL=Lourdes Health Home**
adjustment of goals?			
52. Intervention needed to improve health is occurring?	40%	11 out of 27 did not meet this requirement	CCOB-06, CCOB-07, CCOB-09, CCOB-10, OLOL-02, OLOL-09, FRS-01, FRS-02, FRS-09, FRS-11, FRS-12
53. Appropriate plan(s) exist for transition back to community from hospitalization, ER, inpatient stay, and/or incarceration are in place and being carried out?	33%	6 out of 18 did not meet this requirement	OLOL-03, OLOL-08, OLOL-10, FRS-05, FRS-11, FRS-12
56. Evidence of discharge plan from Health Home program including referrals to services or programs with appropriate follow-up to confirm the plan is being implemented and necessary modifications are made?	41%	5 out of 12 did not meet this requirement	CCOB-02, CCOB-09, FRS-01, FRS-02, FRS-05

NEW YORK STATE | Department of Health

Complex Trauma Referral Cover Sheet

Referral of a Child/Youth with Complex Trauma as a Single Qualifying Condition in order to Establish Eligibility for Health Home.

Required Information

Child's Name:
DOB:
Child's Current Address:
Medicaid #:

Parent/Guardian Name:
Address:
Phone:

Referral Source Name:
Agency (if appropriate):
Address:
Phone:

Relationship:

Medical Consent: (if Different)
Name:
Address:
Phone:

Date of Referral:

Complex Trauma Exposure Screening Form (attach screen)

Completed By:
Date of Screening:

Reason for Referral (Brief narrative, please include any details on events, behaviors, etc. that prompted the referral):

Optional/Desired Information

Completion of this cover sheet and the complex trauma exposure screen is sufficient for referral. Providing the following information may facilitate timeliness of the referral.

Last School Attended
Name:
Address:
Contact Person:

Foster Care / DCYF
County / Agency Name:
Address / Phone:
Contact Person:

Primary Care / Pediatrician
Name:
Address / Phone:

Behavioral Health
Provider Name:
Address/Phone:
Contact Person:

Other Collateral
Provider Name:
Address / Phone:
Contact Person:

Attached Documentation
Psychiatric
Psychological
Medical / Physical
School Information
Other:

NEW YORK STATE | Department of Health

Complex Trauma Exposure Assessment (CTEA)

Please indicate whether the child experienced the following types of traumatic events using **all** available information (e.g. self- and caregiver report, clinical interviews, review of records, standardized instruments, etc.). Please review and complete each category. Include significant details and characteristics of the event where indicated, including the child/adolescent's role in the event (i.e., victim or witness), as well as additional information, such as the child's relationship to the perpetrator, or the extent of a child's injuries in the "additional details" column. *When interviewing the child, it is important to be sensitive to the child's level of distress and ensure that the child does not feel pressured to reveal or discuss details they are not ready to disclose.* When conducting the CTEA to determine the presence of complex trauma exposure, *you do not need to inquire about specific characteristics of each trauma*, however, if information is offered/obtained, note it in the "Characteristics" column. When conducting the CTEA as part of a clinical interview during the course of treatment, and once a therapeutic relationship has been established, the clinician can inquire about additional trauma details.

It will not always be clear whether a particular event rises to the level of a Trauma, or would be better categorized as a significant stressor (but not a Trauma). Therefore, you will have to use your clinical judgment to determine whether an event qualifies as a Trauma. Some traumatic events may fit in more than one category (for example, physical bullying could also be considered to be an assault). When this happens, please choose the one category that you feel *best describes* the traumatic event. Any time you endorse the box labeled "other", please specify or elaborate. After you have endorsed "Y", that a trauma has occurred, note whether it was experienced for more than 18 months, and provide the child's actual ages during which the trauma occurred (e.g., ages 6-8, 11-15, or 9, 13, 14 if multiple discrete events).

Please note, for young children (ages 0-5) a determination of "chronic" exposure can be made for periods less than 18 months. For infants and very young children, especially those birth to three years of age, clinical judgment can be applied to reflect: a) the duration of trauma relative to their lifespan (e.g., a child who is 12 months of age may only have been exposed to traumatic events for 6 months, which is half of their lifespan), and b) the critical developmental period of these young children who are fully dependent on adult caregivers. After completing this assessment, determine whether the child/adolescent has been exposed to complex trauma based on *interpersonal traumas* experienced or witnessed. Additionally, assess for the presence of non-interpersonal traumas (but do not include these in the complex trauma determination).

Sources of Information (check all that apply): ☐ Parents/Caregiver ☐ Child/Youth Report ☐ Chart/Records Review ☐ Structured interview ☐ Standardized Instrument (list all): ☐ Other (specify):

INTERPERSONAL TRAUMAS

Prompts/Questions (suggested questions for assessing trauma exposure within each category)	Present? Y/N	> 18* mos?	Age Range	Characteristics (check all that apply)	Additional Details (e.g. relationship to perpetrator)
Psychological Maltreatment (Emotional Abuse or Neglect) Did a parent or other adult in the household often ... Curse at you, insult you, put you down, or humiliate or ridicule you? Act in a way that made you afraid that you might be physically hurt? Withhold love or affection? Did an adult ever intentionally hurt a family pet or animal?				☐ verbal abuse ☐ emotional neglect ☐ extreme/harsh (non-physical) punishment	

Prompts/Questions (suggested questions for assessing trauma exposure within each category)	**Present? Y/N**	**>18* mos?**	**Age Range**	**Characteristics** (check all that apply)	**Additional Details** (e.g. relationship to perpetrator)
Neglect (assuming adequate financial and social programs exist...) Was there a time when adults who were supposed to take care of you didn't? E.g.: Fail to get you proper medical care? Did not give you clothing or shelter? Didn't give you enough food to eat? Didn't make sure you were safe? Leave you alone for long periods of time (e.g. days) without supervision? Strongly discouraged or prevented you from getting an education? Or did not try to make sure you went to school?				☐ victim ☐ witness ☐ physical ☐ medical ☐ educational	
Displacement Have you lived with someone other than your parents/caregiver while you were growing up (because they couldn't take care of you or you were kicked out)? Have you ever been homeless? This means you ran away or were kicked out and lived on the street for more than a few days? Or you and your family had no place to stay and lived on the street, or in a car, or in a shelter?				☐ runaway ☐ foster care placement ☐ forced to leave by caregivers ☐ poverty (no home) ☐ political violence (war, etc)	
Attachment Disruption Have you lost a primary caregiver through death, incarceration, deportation, migration, or for other reasons? Have you been left in the care of different people because your caregiver couldn't or wouldn't take care of you, (even if you still lived in the same place)? Have you had two or more changes in your primary caregiver or guardian, either formally (legally) or informally?				☐ caregiver mental illness ☐ caregiver substance use ☐ caregiver medical illness ☐ other parental incapacity/dysfunction (specify: _____)	
Sexual abuse Has anyone *in a position of power or authority* (e.g. caregiver, teacher, coach, religious leader), ever made you..... • Do sexual things you didn't want to do, like touch you, make you touch them, or have any kind of sex with you (including intercourse, oral sex, etc)? • Ever *tried* to make you do sexual things you didn't want to do? • Ever forced you to look at pornography, took pictures of you in sexual situations or forced you to watch them do sexual things. *Did you see or hear other people being forced to do sexual things by someone in a position of power?*				☐ victim ☐ witness ☐ penetration ☐ injury ☐ attempted abuse only ☐ pornography perpetrator: ☐ caregiver ☐ sibling ☐ religious professional ☐ coach/teacher/mentor ☐ other: _____	
Sexual assault/rape (not otherwise included in "sexual abuse" above) Has anyone ever made you or someone else... • Do sexual things you didn't want to do, like touch you, make you touch them, or have any kind of sex with you (including intercourse, oral sex, etc)? • Ever *tried* to make you do sexual things you didn't want to do? *Did you see or hear other people being forced to do sexual things.*				☐ victim ☐ witness ☐ penetration ☐ injury ☐ attempted only ☐ stranger ☐ date rape ☐ weapon used	

Prompts/Questions (suggested questions for assessing trauma exposure within each category)	**Present? Y/N**	**> 18* mos?**	**Age Range**	**Characteristics** (check all that apply)	**Additional Details** (e.g. relationship to perpetrator)
Trafficking/Commercial Sexual Exploitation Have you ever traded sexual services for money, food, drugs, or anything valuable (even if someone else took the valuable things)? Have you worked doing sexual things (like at a club, for a movie, or where you lived)? Has anyone made you take pictures or make videos in your underwear or naked?				☐ prostitution ☐ sexual trafficking ☐ confined, held captive ☐ pornography	
Physical Abuse Have you ever been hit or intentionally hurt *by a caregiver or sibling*? If yes, did you have bruises, marks or injuries? Did you ever receive very harsh physical punishments, like kneeling on something hard and painful, or holding heavy things until your arms hurt? *Did you see or hear other children receiving very harsh punishments or being intentionally hurt by a caregiver?*				☐ victim ☐ witness ☐ serious injury ☐ object/weapon used perpetrator: ☐ caregiver ☐ sibling ☐ other: _____	
Domestic violence Have you ever *seen* or *heard* an adult in your family/house being beaten up by their partner or spouse, or have you ever *seen* or *heard* an adult in your family/house get threatened with serious harm by a partner or spouse? Have you been physically harmed or threatened by a boyfriend/girlfriend?				☐ victim ☐ witness ☐ serious injury ☐ homicide ☐ object/weapon used	
Physical Assault/Interpersonal Violence (Episodic) - (not as a result of DV) Have you ever *seen or heard* someone being beaten, or who was badly hurt? Have you ever seen someone who was dead or dying, or *watched or heard* them being killed? Has anyone ever hit you or beaten you up (physically assaulted you?) Has anyone ever physically threatened you or *tried* to physically assault you? Have you ever seen a *close* relative or friend physically threatened?				☐ victim ☐ witness ☐ >1 assault ☐ attempted only ☐ weapon used ☐ injury ☐ homicide ☐ suicide ☐ stranger ☐ relative/friend ☐ event occurred in school ☐ occurred while living in a violent community	
Community Violence (Chronic) - *i.e., living with constant neighborhood danger* Did you live or go to school in an area where there was a lot of violence (e.g., where you heard gunshots or people fighting or getting jumped)? Did you live or go to school in an area where it wasn't safe to leave the house or building? Did you live in an area with a lot of gang violence or drugs?				☐ > 6 mos. ☐ 1-2 yrs. ☐ 2-4 yrs. ☐ > 4 yrs. ☐ serious injury ☐ homicide ☐ threatened w/weapon ☐ gang-related	

Prompts/Questions (suggested questions for assessing trauma exposure within each category)	**Present? Y/N**	**> 18* mos?**	**Age Range**	**Characteristics** (check all that apply)	**Additional Details** (e.g. relationship to perpetrator)
Terrorism/War/Political Violence Have you, a *close* relative or friend been involved in, or in *direct danger* from a terrorist attack or war. Or, been involved in, or directly affected by, political violence resulting in mass injuries?				☐ death ☐ injury ☐ relative ☐ friend	
Stalking/Kidnapping Has anyone ever stalked you? Have you ever been kidnapped? Did anyone ever *try* to kidnap you?				perpetrator: ☐ relative ☐ stranger ☐ other: _____ ☐ stalked ☐ kidnapped ☐ weapon used ☐ injury ☐ custody dispute	
Bullying (ongoing pattern vs. episodic/occasional difficulties with friends) Did other children/adolescents *often*... • Curse at you, insult you, put you down, or humiliate or tease you? • Physically intimidate or bother you (e.g. trip, shove you, break or destroy your things), or act in a way that made you afraid that you might be physically hurt? • Do things to turn people against you or isolate you (e.g. spread lies/rumors)?				☐ cyber-bullying based on: ☐ sexual orientation/identity ☐ race/ethnicity ☐ religion ☐ gender	
Other trauma Is there anything else really scary or very upsetting that has happened to you that I haven't asked you about? Sometimes people have something in mind but they're not comfortable talking about the details. Is that true for you?				☐ specify: _____	
Number of different types of interpersonal traumas experienced (total # Trauma Types endorsed "Yes")					
Number of chronic interpersonal traumas experienced (total # Trauma Types Experienced for more than 18 months*)					

If number of Trauma Types = 2 or greater: ⟹ Child has had exposure to Complex Trauma. Assess for impairment in Complex Trauma Domains

If 1 Trauma type lasting > 18* months (i.e. chronic): ⟹ Child has had exposure to Complex Trauma. Assess for impairment in Complex Trauma Domains

* *For young children* (ages 0-5) "chronic" can be endorsed for traumas lasting less than 18 months

Prompts derived from Trauma History Checklist & Interview and NYS Complex Trauma Workgroup. Trauma Categories and Characteristics adapted from Trauma History Profile. The determination as to whether or not the child/adolescent has been exposed to complex trauma should be based on exposure to *interpersonal traumas* only. However, an assessment of non-interpersonal traumas will create a more comprehensive picture of the child's trauma history and provide important clinical information regarding additional exposures that may impact the child's functioning.

Document exposure to non-interpersonal traumas in the space provided below, but *do not include these exposures* when making a determination of complex trauma.

NON-INTERPERSONAL TRAUMAS

Prompts/Questions (suggested questions for assessing trauma exposure within each category)	**Present? Y/N**	**> 18 mos?**	**Age Range**	**Characteristics** (check all that apply)	**Additional Details**
Disaster (Natural or Man-made) Were you, or a *close* friend or relative, ever in a disaster where your/their life was in danger? For example, like in a hurricane, earthquake, tornado, flood, building collapse, or plane/train accident?				☐ victim ☐ witness ☐ natural ☐ man-made	
Medical Trauma (Illness or Injury) Have you ever been in the hospital or been treated for a serious injury (e.g. from a car accident or dog bite) or life-threatening illness? Has a sibling or caregiver ever had a serious injury or life threatening illness?				☐ self ☐ sibling ☐ caregiver ☐ death ☐ accident/injury ☐ life-threatening illness	
Other Life-Threatening Traumas (not requiring medical attention) Have you ever... been in a scary car accident or serious fire? been unable to breath (e.g. from an asthma attack or choking on something)? nearly drowned? Is there anything else that has happened to you that was life-threatening but didn't require medical attention?				☐ car accident ☐ fire ☐ impaired breathing ☐ other: _____	
Number of different types of non-interpersonal traumas experienced (total # Trauma Types = Yes)					

Prompts derived from Trauma History Checklist & Interview and NYS Complex Trauma Workgroup. Trauma Categories and Characteristics adapted from Trauma History Profile.

NEW YORK STATE | Department of Health

Complex Trauma Eligibility Determination Form

Children's Eligibility for Health Home Care Management services on the basis of Complex Trauma is based on three criteria. All three must be present in order for a child to be determined eligible. In addition to eligibility, the child must separately be determined *appropriate* for Health Home Care Management in accordance with current DOH guidance.

Child Name: DOB: Medicaid#:

CMA: Health Home: Date:

I. Complex Trauma Exposure

Based on the Complex Trauma Exposure Assessment (CTEA), has the child been exposed to multiple interpersonal traumatic events, or at least one chronic interpersonal trauma lasting 18 months or more?* Yes No

* *For young children (ages 0-5) a determination of "chronic" exposure can be made for periods less than 18 months*

Exposure Category	Present? Y/N	Chronic? Y/N	Comments (onset, duration, description)
Psychological Maltreatment (emotional abuse/neglect)			
Neglect			
Displacement			
Attachment Disruption			
Sex Abuse			
Sex Assault			
Trafficking/Commercial Sexual Exploitation			
Physical Abuse			
Domestic Violence			
Physical Assault/ Interpersonal Violence			
Community Violence			
War / Political Violence			
Stalking / Kidnapping			
Bullying			
Other			

II. Functional Impairments

Based on the use of validated assessment instruments in accordance with the process developed by DOH, and based on at least one face-to-face interview, is the child experiencing functional impairments in at least two of the following categories, or acute impairment in at least one category? Yes No

Impairment Category	Present? Y/N	Acute? Y/N	Instrument / Method	Comments (onset, duration, description)
Physiology / Neurodevelopment				
Emotional Response				
Cognitive Processes				
Impulse Control / Self-Regulation				
Self-Image				
Relationships with Others				

III. Links between Traumatic Exposure and Experience of Functional Impairments

- *In your professional opinion, are the Functional Impairments listed in Section II resulting from, or linked to, the Trauma Exposure described in Section I?* Yes No
- *Are these Functional Impairments best explained as being a result of, or exacerbated by, Complex Trauma, and not as the result of some other diagnosis or developmental delay?** Yes No

**As long as complex trauma is present, the addition of a co-morbid disorder or diagnosis does not disqualify the child.*

Comments:

IV. Eligibility Determination

As a licensed professional acting within my scope of practice, I find that the child referenced herein

- ❑ ***IS***
- ❑ ***IS NOT***

experiencing Complex Trauma in accordance with the definition approved by CMS for Health Home eligibility purposes.

Print Name: Credential: License #:

Signature: Date:

Attachments:

- Referral Cover Sheet
- Medical Consent
- Trauma Exposure Assessment
- Functional Impairment Assessment Materials (list)
- Collateral / Background Materials Provided (list)

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #28 Cultural Competency and Awareness

Effective Date: 9/1/16
Revised Date:

Policy:
Encompass Care Management Agencies (CMA) will promote activities to improve Participants access to, engagement with, and retention in culturally competent physical and behavioral health care services, as well as enhance the quality of their care through improved communication and services tailored to their needs and preferences.

Definition:
Culture is described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements including personal identification; language; thoughts; communications; actions; customs; beliefs; values and institutions specific to ethnic, racial religious, geographic, or social groups. For providers of health services, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease and the delivery of health services. The concept of cultural respect has a positive effect on Participant care. ~ National Institute of Health

Procedure:

A. CMA will develop a Cultural Competency Plan addressing the unique cultural needs for the area they service. At a minimum, this will include, but is not limited to:
    1. Hiring and retaining Care Managers and Peer Staff reflective of the diversity in the area;
    2. Initial and ongoing yearly training in Cultural Competency, and the use of evidenced based practices for the cultural populations in area served, to increase awareness, knowledge and skills;
    3. Practices that recognize, value, affirm and respect the culture of each Participant/Family served;
    4. Strategies to target underserved cultural groups in the area;
    5. Building relationships with culturally valued community providers, traditional healers and supports;
    6. Assuring the inclusion of Family and/or Participant-valued persons in the Plan of Care process;
    7. Regular assessment of Participants/Family cultural needs and preferences;
    8. The use of medically trained interpreter services and document translation when appropriate;
    9. Assessment of the effectiveness of services provided to all Participants, including those previously underserved.
B. The Health Home will assist CMA in their Cultural Competency Plan as needed, will monitor effectiveness during quality audits, and provide feedback as needed.
C. The Health Home will disseminate relevant training information as it's received to all CMAs.
D. The Health Home will assist in linking the CMA to cultural and linguistic resources as appropriate.

Catholic Charities of Broome County
ENCOMPASS HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #29 Health Home Consents & Record Retention

Effective Date: 9/1/16
Revised Date:

Policy: The Health Home will assure that Care Management Agencies utilize appropriate consent forms for all Participants/Families, in order to protect and respect the rights of Participants, Parents, guardians, legally authorized representatives and minors; and to protect the health information, educational records and other forms of personal information shared during the course of the provision of Care Management services.

Procedure:

A. Children

1. **Consent to Refer**
   - I. When making a referral to Health Home, the referent must first obtain consent from the Child (self-consent if 18-21, or under 18 and a parent, pregnant or legally married), or the child's parent, guardian, or legally authorized representative.
   - II. Although verbal consent is allowed, the Health Home recommends that a written consent be obtained.
   - III. After receiving consent, the referent will verify by checking the "consent to refer" box in the MAPP referral portal.
2. **DOH-5200 Consent Enrollment Form**
   - I. Used to enroll children under the age of 18 into Health Home services (unless child is a parent, pregnant or legally married: See DOH-5055).
   - II. Signed ONLY by the parents, guardians or legally authorized representative (ie:LDSS)
   - III. Will be accompanied by the ***Health Home Consent Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age*** Form, that will be provided to the parent/guardian, and reviewed prior to signing the DOH-5200.
3. **DOH-5201 Consent for Sharing of Information**
   - I. For use for children under the age of 18
   - II. Section 1 to be completed by the parent, guardian or legally authorized representative
   - III. Section 2 to be completed by the Child, **without** the presence of the parent, guardian or legally authorized representative
     - i. Children have the right to keep private any information about services that they have consented for.
     - ii. Consent to share information of protected services is applicable to children 10 or older.
     - iii. Children may choose to share information of protected services with the parent/guardian. Declinations will be documented in the MAPP.
     - iv. If the child is unable to complete section 2, it will be left blank.

4. **DOH-5202 Consent to Withdrawal of Health Home Enrollment and Information Sharing**
    I. For use for children under the age of 18 (unless if 18-21, or under 18 and a parent, pregnant or legally married: see DOH-5058)
    II. Signed ONLY by the parents, guardians or legally authorized representative (ie:LDSS)
5. **DOH-5203 Consent for Education Records**
    I. NYS Education requires a separate consent to release education records.
    II. Parent, guardian or legally authorized representative will sign the form for <u>all</u> children under 18, if child is still a dependent.
6. **DOH-5204 Consent to Withdrawal Education Records**
    I. To withdraw permission to release or discuss educational records for children enrolled in Health Home
    II. Parent, guardian or legally authorized representative will sign the form for <u>all</u> children under 18, if child is still a dependent.
    III. Children 18 or older can self-consent.
7. **DOH-5055 Health Home Information Sharing and Enrollment Consent (Adult Form)**
    I. Will be used for children 18 or older who can self-consent, or for children under 18 and a parent, pregnant or legally married.
    II. Does not require a parent, guardian or legally authorized representative to sign, or be present to enroll.
    III. Authorizes enrollment, as well as data sharing and access to the RHIO and PSYCKES.
8. **DOH-5058 Consent to Withdrawal of Health Home Enrollment and Information Sharing (Adult Form)**
    I. Will be used for children 18 or older who can self-consent, or for children under 18 and a parent, pregnant or legally married.
    II. Does not require a parent, guardian or legally authorized representative to sign, or be present to dis-enroll.
9. **DOH-5230 Functional Assessment Consent**
    I. Consent must be obtained before completing the CANS-NY Functional Assessment.
    II. Care Manager must obtain consent to conduct the CANS-NY functional assessment from the parent, guardian, legally authorized representative or the child if they can self-consent. Without obtaining this consent, care managers will be unable to complete a CANS-NY in the Uniform Assessment System-NY (UAS-NY).
10. **PSYCKES**
    I. Consent to access clinical information in PSYCKES, (unless DOH-5055 was signed).
11. **RHIO**
    I. Consent to access clinical information in regional RHIO for children under 10 with parental consent, (unless DOH-5055 was signed)

Care Management Policy #29 Health Home Consents & Record Retention

B. Adults

1. **DOH-5055 Health Home Information Sharing and Enrollment Consent**
   - I. Will be used for Adults 18 or older enrolling into the Adult Health Home
   - II. Authorizes enrollment, as well as data sharing and access to the RHIO and PSYCKES.
2. **DOH-5058 Consent to Withdrawal of Health Home Enrollment and Information Sharing**
   - I. Will be used for Adults 18 or older dis-enrolling from the Adult Health Home, and RHIO and PSYCKES access.
3. **DOH-5230 Functional Assessment Consent**
   - I. Used to consent to the Adult HCBS assessment process.
   - II. Used for all Medicaid members, children and adults to complete an Assessment Tool within the Uniform Assessment System-NY (UAS-NY).

C. When New Consents are Required:

1. The Participant changes Health Homes;
2. The Participant/Family dis-enrolls and re-enrolls;
3. The Participant turns 18 years old, if they have not previously self-consented;
4. Child gets married, becomes pregnant or becomes a parent;
5. The Participant's authorized consenter has changed (for children under 18);
6. The Participant changes schools/districts

D. When New Consents/Information Sharing are Updated:

1. When needed to add or delete members of the Interdisciplinary Team;
2. After review during an Interdisciplinary Team Meeting;
3. Consenter will be asked to review the consent form bi-annually or as needed to assure all providers and supports are current

E. Completing/Updating Information Sharing

1. Consenter will identify providers and supports to be listed with whom they request information to be shared;
2. Consenter will initial and date after each providers name;
3. Consenter will cross out any providers and supports that are no longer involved, and will initial and date each change

F. Record Retention

1. Participant records (electronic or hardcopy), including consents, Plan of Care, assessments and documentation supporting eligibility and appropriateness for Health Home services will be retained for 7 years after discharge/death, or 7 years past the Participants eighteenth birthday, whichever is longer.
2. Administrative documents, such as audits, incident reports, meeting minutes and financial records will be retained for 7 years.
3. Participant Reports/Data Files containing medical treatment and/or billing information (electronic or hardcopy), will be retained for 7 years or 7 years past the Participants eighteenth birthday, whichever is longer.

4. Care Manager Documentation supporting qualifications and required Training will be retained for 7 years after termination.
5. Written policies, procedures & standards will be retained for 7 years after superseded.
6. All written policies and procedures as required by the Health Insurance Portability and Accountability Act of 1996 are required to be maintained in writing for at least 6 years from the date of its creation, or the date when the document was last in effect, whichever is later.
7. Upon termination of agreement for a CMA to provide Care Management services under the Health Home, the CMA will return or destroy all protected health information in their possession, and will retain no copies for its records, unless a mutually agreed decision with the Health Home has been reached to retain information, and limit its use and disclosure.