Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Health Home Outreach and Engagement

Department: Health Home

Intended Population: Health Home Serving Adults and Children

Effective Date: 9/21/2015

Review Date: 7/1/2021

Date Revised: 5/17/2019,
7/1/2020

Purpose of Policy

To describe the process and time frames for Health Home outreach services.

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to the AHI's Health Home program.
3. All questions regarding this policy or its implementation may be directed to the AHI Health Home Program Director.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Health Home Outreach & Engagement Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Health Home Outreach & Engagement Policy.

Definitions

Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for Care Management by AHI.

Health Home Candidate: An individual who has not yet agreed to care management within AHI Health Home and is assigned to an AHI Health Home Services Provider for outreach and engagement.

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Health Home Service Provider: An Organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/ or care management services.

MAPP: Medicaid Analytics Performance Portal.

Care Management Record System: A structed information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

Confirmed Current address: An address that has been verified by either

- The prospective member/ member's parent or guardian
- A family member
- A current provider

Health Home Core Services:

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to Community and Social Services
6. Use of Health Information Technology (HIT) to link to services *

* The use of HIT to link to services in not a billable activity

Purpose of Policy

The Health Home Outreach & Engagement Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

Procedure

a. Health Home Service Providers may begin providing outreach services to referrals upon entry to the Care Management Record System. Community referrals may be sent via MAPP in the case of children, and via means outside of MAPP for children and adults. Health Home outreach is no longer a billable service effective 7/1/2020. As of 7/1/2020 an Outreach Billing Questionnaire will no longer be required.

b. Referral sources must attest that a verbal consent was provided by the individual (if 18 or over) or his/ her parent or guardian (if under the age of 18, accept for those under the age of 18 and self-consenting) to allow the individual / guardian to be contacted by a Health Home Service Provider to share information about enrolling in the Health Home.
c. If an individual was referred to the Health Home and is unable to be reached, the referral source should be contacted to assist with connection and engagement.
d. The MCO and/or the Health Home can be contacted to help assist the Health Home Service Provider with locating/reaching the member.
e. The Health Home Service Provider may continue providing outreach services to candidates after the Outreach segment has ended in MAPP.
f. The purpose of Outreach is to locate the Health Home Candidate/ his / her parent / guardian, explain the services available to them under the Health Home program, answer any questions, and engage the person in active care management.
g. Health Home candidates who are homeless require an additional level of intensity for outreach and engagement. If an individual is found to be, or suspected to be, homeless, the Care Manager shall conduct outreach attempts at local shelters, hotels which offer temporary housing, food pantries, soup kitchens, and other potential resources which a homeless person may utilize.
    a. Due to privacy issues, the shelter may not be able to release information to the outreaching care manager, however the outreaching care manager can relay the information about the program in the hope that the staff can recommend this service to the potential enrollee to self-refer.
    b. The Care Manger should only approach individuals habitating in public areas only if he or she feels safe doing so.
h. Candidates who decide not to join the Health Home will be asked by the Care Manager and/ or outreach worker to complete, sign, and date the Health Home Opt-Out Form (DOH-5059). If the candidate is not present to sign the form, the care manger and / or Outreach worker completes the applicable sections and signs the form. The HHSP must upload the form in the members care management record.
i. The Health Home Service Provider will document all outreach activities in the members care management record.
j. The record will include a description of the activity / service provided, the date of service and the type of contact (face to face, telephone, mail, e-mail).
k. The HHSP may contact AHIHH to request additional or updated contact information for a prospective Health Home participant who is enrolled in a Medicaid Managed Care Plan (HARP [Health and Recovery Plan] or non-HARP). AHI Health Home will reach out to the Managed Care Organization within 48 hours via a secure method to obtain this information and will share it with the HHSP within 48 hours of receiving the information back from the Managed Care Plan.

l. The Outreach period ends, and Active Care Management begins when all of the following have occurred and are documented by the Health Home Service Provider in the client record:
   a. The Health Home program has been explained to the candidate / his / her family as applicable.
   b. The candidate has agreed to take part in the program. In the case of a child, the child's parent or guardian has agreed on behalf of the child and has signed the DOH- 5200 consent form. In the case of an adult, the members has agreed to enroll and has signed the DOH 5055 consent form. HHSP's must assure that Information Sharing Consent Forms include, at minimum; The name of the HHSP, the member's Medicaid Managed Care Plan (MMCP), if applicable, and a primary care physician and/or healthcare provider from whom the member receives the majority of his/her care (e.g. mental health, substance use, etc.) reflective of the chronic conditions the member was enrolled in Health Home program.

m. Should two months of outreach efforts not be successful the Health Home Service Provider will end active outreach unless the HHSP has actionable Information and believes the candidate has potential for immediate enrollment.
   a. Actionable Information is defined as Information that supports face to face contact and engagement of an individual.
      - Members assigned by Managed Care Plans
      - Community based referrals
      - An alert or notification that a member has been located in a shelter, jail, or other institution.
      - Member has been located and agrees to meet with HHCM
      - An appointment to meet with a HHCM has been set up by referent
      - New information such as a new phone number or address that would increase the likelihood of a face to face contact.
   b. AHI will reassign the prospective member should actionable information become available for the member or keep the member in a disenrolled status.
   c. The Health Home communicates if a person is eligible for a new segment of outreach.
   d. If a Health Home Service Provider does not have the capacity to re-engage in outreach at the time at which the prospective Health Home client again becomes eligible through actionable information, the Health Home Service Provider shall notify AHI within 2 business days. AHI may, depending on capacity, reassign those prospective members to another Health Home Service Provider.

n. In the case of an adult or self-consenting child, should a Health Home Service Provider who has conducted outreach efforts to someone who has been referred and no contact in Month One or Two of Outreach, the Health Home Service Provider should disenroll the individual with the reason code "inability to contact / locate individual". In the case of Self-Consenting

Children under the age of 18 the Health Home Service Provider must notify the referral source of the outcome of Outreach.

o. In the case of a child, should a Health Home Service Provider who has conducted outreach efforts to Child / Youth / Family / Legal Authorized Representative who has been referred and no contact in Month One or Two of Outreach, the Health Home Service Provider should disenroll the individual with the reason code "inability to contact / locate individual". The referral source must be notified of the outcome of Outreach.

p. Any member who a Health Home Service Provider has conducted Outreach for and through the Outreach process with the member has been found to not meet the Health Home Eligibility the DOH-5236 must be issued to that member and documented in the members care management record.

Outlining expectation for the Prospective Adult Health Home Enrollee with a history of abusive / inappropriate behavior

Prospective Health Home enrollees who have a history of abusive or inappropriate behavior may be entitled to receive Health Home Care Management but may have expectations carefully reviewed with him/ her before the individual makes the decision to enroll. This may be provided to the prospective enrollee via a document both the prospective enrollee and Care Manager Supervisor sign.

These expectations may include:

- A warning about how abusive or inappropriate behaviors may result in termination of Health Home Care Management Services.
- An outline of Health Home Enrollee's responsibilities including but not limited to:
    - Scheduling one's own transportation, medical appointments, and other appointments (as appropriate based on enrollee's capabilities. Support may be provided by Care Manager to facilitate enrollee's independence in these areas.)
    - Planning for necessary activities such as grocery shopping (as appropriate based on enrollee's capabilities. Support may be provided by Care Manager to facilitate enrollee's independence in these areas.)
    - Following up on medical and behavioral health professionals' directives, with assistance from Care Manager
    - Applying for needed social services (as appropriate based on enrollee's capabilities. Support may be provided by Care Manager to facilitate enrollee's independence in these areas.)
    - Showing up to scheduled appointments with the Care Manager on time or calling the Care Manager to cancel

- Establishing goals for one's self in any area including medical health, behavioral health, or social
- Working towards goals that the enrollee has set for him/ herself

Quality and Performance Improvement

In order to ensure that progressive, meaningful outreach is being provided, records will be examined based on the criteria established in Appendix B of this policy and procedure. Should the record from the HHSP not indicate sufficient progressive outreach, additional records will be reviewed. Feedback will be given to Health Home Service Provider related to the outcome of the progressive outreach review. Agencies not meeting standards will need to present AHI with their internal QA process for specify ways they are improving their process and specify ways they are improving their progressive outreach activities systematically.

Training

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of the initial policy training a future in-depth training will be developed to understand acceptable outreach efforts and engagement techniques such as Motivational Interviewing and provided to all care management staff.

Contact Person: Director, Care Management and Health Home

Responsible Person: Health Home Service Provider

Approved By: Chief Operating and Compliance Officer

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APPENDIX A

Quality Assurance Measures for Outreach

ADULTS	
Were a variety of methods used to connect with the client, if needed?	☐ Yes ☐No ☐ N/A
Where Outreach attempts active and progressive in nature in order to connect with the member?	☐ Yes ☐ No ☐ N/A
If the member was not located during Outreach, did the CMA utilized the MCO to help support Outreach efforts?	☐ Yes ☐ No ☐ N/A
If the individual was found ineligible for Health Home was the Notice of Denial issued DOH-5236?	☐ Yes ☐ No ☐ N/A

CHILDREN	
Were a variety of methods used to connect with the Parent / Guardian, if needed?	☐ Yes ☐No ☐ N/A
Were Outreach efforts progressive in nature to connect with the Parent / Guardian, if needed?	☐ Yes ☐ No ☐ N/A
If Outreach was unsuccessful did the CMA utilize the MCO to help support Outreach efforts?	☐ Yes ☐ No ☐ N/A
Was the referral source contacted, to discuss the results of Outreach?	☐ Yes ☐ No
If the child/youth was found ineligible for Health Home was the Notice of Denial issued: DOH-5236?	☐ Yes ☐ No ☐ N/A