Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Health Home Care Transitions

Department: Health Home

Intended Population: Health Home Serving Adult and Children's

Effective Date: 1/6/2017

Review Date: 1/1/2019, 3/1/21

Date Revised: 6/4/2019; 9/1/2019, 3/1/21

Purpose of Policy

This policy is meant to tailor the Health Home, Managed Care Organization (MCO) and Health Home Care Management (HHCM) Standards for inpatient detox, inpatient medical or mental health stays, and emergency department visits. It is meant to promote clarity around expectations of care management staff for providing supports to individuals transitioning care.

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 Manager.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Health Home Care Transitions 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 Care Transitions Policy.

Definitions

Health Home Enrollee: A Health Home Candidate who has consented to participate in the AHI Health Home and is assigned to an AHI Health Home Care Manager.

POLICY AND PROCEDURE

Health Home Service Provider (HHSP): 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.

Care Management Record System: A structured 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.

DOH-5055: The standard Health Home consent form for individuals 18 years of age and older, as well as those who meet the criteria for being defined as adults in New York State.

DOH-5201: The standard Health Home information sharing consent form for individuals under 18 years of age, as well as those who meet the criteria for being defined as children in New York State.

NYSDOH: New York State Department of Health

NYSOASAS: New York State Office of Alcoholism and Substance Abuse Services

NYSOMH: New York State Office Mental Health

Workforce member means Employees, board members, volunteers, interns, independent contractors, vendors, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity. This includes full and part time employees, affiliates, associates, volunteers, and staff from third party entities who provide service to the covered entity.

Background

The Health Home Care Transitions 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.

POLICY

It is the policy of AHI Health Home to ensure Health Home Enrollees have appropriate coordination during, and after, times of care transitions, including, but not limited to, inpatient detox facilities, rehabilitation facilities, inpatient hospitalizations (medical and psychiatric), incarceration, and follow up from Emergency Department (ED).

POLICY AND PROCEDURE

It is Department of Health (DOH) policy for hospitals to notify Health Homes of admissions of Health Home enrollees and to make referrals as appropriate for Health Home eligible individuals. This policy is not meant to supersede that guidance.

PROCEDURE- INPATIENT DETOX

1. Upon discovery/notification of a Health Home Enrollee being admitted to an inpatient detox facility, the Care Manager shall contact the facility within one (1) business day.
    a. The Care Manager shall contact a nurse on staff at the Inpatient Detox facility to introduce him/herself and inform the nurse that the individual is enrolled in Health Home Care Management.
    b. The Care Manager shall transmit the DOH-5055 or the DOH-5201 as applicable to the appropriate person at the inpatient detox facility.

2. If the inpatient detox facility is located within 60 miles of the Care Manager's primary location, an in-person visit shall be scheduled if the individual is expected to be in inpatient status for an additional three (3) or more business days. If the inpatient detox facility is located more than 60 miles from the Care Manager's primary location, a phone or secure teleconference visit shall be scheduled if the individual is expected to be in inpatient status for an additional three (3) or more business days, contingent on the policies of the inpatient facility.

3. Contact with the Health Home Enrollee shall be scheduled in collaboration with the nurse overseeing the Health Home Enrollee's inpatient detox treatment, the Health Home Care Manager, and the Health Home Enrollee/ Health Home Enrollee's parent or guardian as applicable.

4. The Health Home Care Manager will schedule an in-person face-to-face contact with the Health Home Enrollee to take place within one (1) business day of discharge from a detox facility to ensure that the enrollee is aware of follow-up appointments and to provide supports for getting to appointments.
    a. This contact shall be scheduled prior to release from the inpatient detox facility in collaboration with the nurse overseeing the Health Home Enrollee's inpatient detox treatment, the Health Home Care Manager, and the Health Home Enrollee/ Health Home Enrollee's parent/guardian as appropriate/applicable.

5. For all individuals who shall be in an inpatient Detox for longer than 30 days, but under 6 months:
    a. The first month of the inpatient stay and the last month of the inpatient stay shall be billable at the enrolled rate if a core service was delivered the month of admission and comprehensive transitional care as a core service was delivered the month of the members discharge.

b. The member shall be pended due to inpatient stay in the Adirondack Health Institute Health Home (AHIHH) care management record system through a Contact Note – Please see Continuity of Care Policy for further guidance regarding ineligible settings.

c. Should the member remain in the facility longer than 6 months the member will need to be disenrolled from Health Home; please see the Health Home Disenrollment policy for further guidance.

PROCEDURE- INPATIENT HOSPITALIZATION (MEDICAL OR PSYCHIATRIC), REHABILITATION

1. Upon discovery/notification of a Health Home Enrollee being admitted to an inpatient facility, the Care Manager shall contact the facility within one (1) business day.
    a. The Care Manager shall contact the discharge planner to ensure the Care Manager is involved in the discharge planning process.
    b. The Care Manager shall transmit the DOH-5055 or the DOH-5201 as applicable to the appropriate person at the inpatient facility.

2. If the individual is expected to be in inpatient status for an additional three (3) or more business days, an in-person visit is recommended but not required.

3. If the Health Home enrollee will be released to the community, the Health Home Care Manager will schedule a follow up contact via phone or face to face with the Health Home Enrollee to take place within 48 hours of discharge from an inpatient facility to ensure that the enrollee is aware of follow-up appointments and to provide supports for getting to appointments.
    a. This contact shall be scheduled prior to release from the inpatient facility in collaboration with the discharge planner, the Health Home Care Manager, and the Health Home Enrollee/ Health Home Enrollee's parent/guardian as appropriate/applicable.

    b. If the Health Home enrollee will be transitioned to a skilled nursing facility, rehabilitative facility, or another long-term care facility, the Care Manager shall determine, depending on length of stay and DOH guidance, whether the person should remain enrolled, move to a pended status in MAPP, or be disenrolled from Health Home.

    If the person is to be disenrolled, the Disenrollment Policy & Procedure shall be followed, particularly with respect to ensuring the enrollee has appropriate supports in place to support a successful discharge.

    c. The Health Home Care Manager shall participate in discharge planning and obtain a copy of the Discharge Plan and upload into the Care management record system in order to:

        1. Review upcoming appointments
        2. Medication reconciliation

3. Potential obstacles to attending follow up visits
4. Adhering to treatment plan

4. For all individuals who shall be in an inpatient status for longer than 30 days, but under 6 months:

    a. The first month of the inpatient stay and the last month of the inpatient stay shall be billable at the enrolled rate if a core service was delivered the month of admission, and comprehensive transitional care as a core service was delivered the last month of the members inpatient stay.
    b. The member shall be pended due to inpatient stay in AHIHH's care management record system through a Contact Note – Please see Continuity of Care Policy for further guidance regarding ineligible settings.
    c. Should the member remain in an inpatient status longer than 6 months the member will need to be disenrolled from Health Home; please see the Health Home Disenrollment policy for further guidance.

PROCEDURE- EMERGENCY DEPARTMENT

1. Upon discovery/notification of a Health Home Enrollee having a visit to an Emergency Department and being subsequently released to the community, the Care Manager shall follow up with the individual within 48 hours.
2. The care plan should be updated with information around the reason for the ED visit and remediation for reducing the client's reliance on this system of care going forward.

PROCEDURE- INCARCERATION

1. Upon discovery/notification of a Health Home Enrollee being incarcerated, the Incident Policy & Procedure should be followed.
2. If the individual is anticipated to be released within 30 days, the care manager should attempt to connect with the individual while incarcerated to make plans for release.
3. If the individual will be incarcerated beyond 30 days, but under 6 months, the individual will lose his/her Medicaid and must be Pended for the Health Home. Please see the Health Home.

    Continuity of Care Policy for more information on Excluded Settings. In the event the member will be incarcerated longer than 6 months the member must be disenrolled from the Health Home program; please see the Health Home Disenrollment Policy for further guidance.

DOCUMENTATION

1. Complete notes on contacts and attempted contacts with care team members and Health Home Enrollees in settings requiring transition shall be maintained in the Care Management Record System. This includes but not limited to:
    a. Discharge plan

b. Needed follow-ups, timeframes, and the person(s) responsible. This includes:
   i... Medication reconciliation
   ii... Follow up appointments
   iii... Care Manager follow up on appointments to ensure they were attended and, if not, working to have them rescheduled. If the Care Manager is having difficulty with engaging the member and/or the family they should seek support from their supervisor and/or the Health Home.
c. Involved individuals and their roles (including but not limited to providers, family members, community supports)

2. The care plan should be reviewed to ensure it is still applicable and relevant. If large-scale changes have occurred in an individual's circumstance which warrant significant changes to the care plan, the person should be comprehensively assessed and the care plan significantly revised.

REMEDIATION

1. Should the Care Manager not be able to connect with the individual during the requisite timeframes, he or she shall notify his/her supervisor.
2. If the facility is non-responsive to the Care Manager they should document the lack of connection and seek support from the Health Home in contacting the facility in question as appropriate to improve communication and processes.
3. The AHI HH may solicit assistance from NYSDOH, NYSOASAS and/or NYSOMH where needed to overcome communication barriers.

Quality and Performance Improvement

AHI Health Home will review a selection of cases from each HHSP's member attributions that have had a Hallmark Event/Admission Alert; i.e. ER visit. Each case will be assessed for completeness and adherence to the Health Home Policy. Any record found not have adequate documentation in the member's Electronic Care Management Record is expected to review this policy with their direct supervisor to ensure future adherence.

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 explore engagement techniques for non-compliant or disengaged members and/or their families; especially if they are non-committal to recommendations from specialists on the team (i.e. 7 day follow up and other appointments).

Contact Person: Director, Health Home and Care Management

Responsible Person: Health Home Service Provider

Approved By: Chief Operating and Compliance Officer