

POLICY AND PROCEDURE

Title: Health Home Transfer

Intended Population: Health Home Serving Adults and Children

Department: Health Home

Effective Date: 5/1/2016

Review Date: 5/1/2020; 6/1/2021

Date Revised: 11/5/2016; 4/17/2019

Purpose of Policy

Sometimes it becomes necessary to initiate a transfer across Health Home Service Providers (HHSPs) and/or Health Homes. Reasons include, but are not limited to:

- Health Home Enrollee or Health Home Candidate moves county of residence
- Health Home Enrollee or Health Home Candidate/Health Home Enrollee or Health Home Candidate's parent/guardian requests a transfer
- Member is dissatisfied with current service provider
- Member has cultural or linguistic needs that cannot be met by current provider
- CMA unable to serve the enrollee for various reasons

This policy describes the process and timeframes for Health Home transfers.

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 Director.

Statement of Policy

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



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Definitions

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.

AHIHH: AHI Health Home

Health Home Candidate: a person who is potentially eligible to become a Health Home Participant and is assigned by an MCO or NYSDOH to AHI or who has been referred to the HHSP or to AHIHH.

Health Home Enrollee: a person who meets the eligibility criteria for Health Home and has agreed to enroll.

“Assignment” and “Re-Assignment”: the process by which a Health Home Candidate is assigned to an AHI Health Home Services Provider or re-assigned from one AHI Health Home Services Provider to another AHI Health Home Services Provider.

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.

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 Transfer Program 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 the Adirondack Health Institute Health Home (AHIHH) to ensure that transfers occur in a manner that benefits Health Home Enrollees.



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- a. If Health Home Enrollee or Health Home Candidate is moving/has moved out of AHIHH service region (Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington, and Saratoga Counties): or a Transfer to another Health Home or Health Home Service Provider is requested or deemed necessary:
- b. The current Health Home Service Provider will contact AHI via secure e-mail or via phone with the below information within two businesses days from the time the transfer is determined:
 - I. Client CIN
 - II. Member Status
 - III. Anticipated date of case closure by current agency
 - IV. New County of residence
 - V. Care Manager Name and contact information
- c. AHI will contact the Health Home or Health Home Service Provider designated for services in the new county of residence within two business days to secure their referral from, or obtain AHI HH Transfer form from, the current Health Home Service Provider.
- d. If the individual is an adult and in outreach, contact AHI to have the referral given to another agency.
- e. If the individual is enrolled or has recently been disenrolled after being in an enrolled status, AHI will send the new Health Home's referral form the HHSP for completion. The HHSP will need to obtain verbal or written consent from the individual; or in the case of a child, his/her parent or legal guardian to complete the referral.
- f. AHI will send the completed form to the new Health Home or Health Home Service Provider via secure e-mail or fax and will communicate the requested transfer date.
- g. No PHI can be shared with the new HH or HHSP unless the member has consented on the DOH-5055 or DOH-5201. The current Health Home Care Manager should obtain consent for the new Health Home or Health Home Service Provider prior to the request to transfer.
- h. The current Health Home Service Provider must document in the client's record the discussion regarding the reason for the Transfer and client's preferences.
- i. The current Health Home Service Provider will contact the new provider to ensure a warm hand off as well as provide current copies of assessments and plans upon request.
- j. If you received a transferred member from another Health Home or Health Home Service Provider, the Health Home Service Provider will:
- k. Document in the Care Management record system the receipt of the referral and the referral source. In the case of Children, the Health Home service provider must contact the referral source.
 - l. Ensure updated consents have been completed.
- m. Confirm the members Eligibility for Health Home.



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- n. In the case of Children's Health Home: If the Transfer occurs within AHI HH the Care Manager must add the youth to their case list in the UAS and confirm the next due date for the CANS-NY. The next CANS-NY will not be an initial CANS-NY; it will be a reassessment at 6 months or prior to 6 months (if a significant event has occurred). If the youth is transferred from another Health Home a new CANS-NY (initial) will need to be completed within 30 days.
- o. Within 60 days a comprehensive assessment and Plan of Care will need to be completed. If the information from previous assessments and Plan of Care is relevant and accurate and with member consent these historical documents can be used.
- p. Transfers to CCO/HH
- q. Transfer that will be made to a CCO/HH will not follow the above procedure. The currently assigned HHCM is responsible for coordinating with CCO/HH to ensure continuity of care for the client.
- r. The HHCM and the new CCO/HH will work together to determine the disenrollment date from AHI HH to ensure there is no overlapping billing between the two Health Homes.
- s. The HHCM will work with the client to have the client add the new CCO/HH to the appropriate consent form.
- t. The HHCM will work collaboratively with the CCO/HH to share any applicable information to ensure a warm handoff.

Supervisors Role:

The role of the HHSP supervisor is to assure that HHCM activities support appropriate procedures to transfer members from one HHSP to another and/or another Health Home.

The HHCM supervisor must:

1. Discuss the transfer and provide clinical and policy guidance to the HHCM related to the transfer process.
2. Participate in case reviews and sign off, as appropriate.



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Quality and Performance Improvement:

AHI Health Home will review a selection of cases from each HHSP's member attributions that have had a member with the end reason "Transferred to another Health Home or CMA". 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 understand how to properly transfer members to provide continuity of care and the highest quality of care management services.

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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Attachment I



AHI Health Home Care Management Inter-Agency Transfer Form

Phone: 1-866-708-2912
Fax: 518-615-1220

IF FAXING, PLEASE CALL TO CONFIRM RECEIPT

Form containing fields for Last Name, First Name, Medicaid Client ID#, Requested Start Date, Mailing address, Physical address, Phone number, Secondary phone number, E-mail address, KEY AREAS OF FOCUS UPON TRANSFER, REFERRAL INFORMATION, ELIGIBILITY CRITERIA, and CONSENT.