Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Health Home Transfer

Intended Population: Health Home Serving Adults and Children

Department: Health Home

Effective Date: 5/1/2016

Date Revised: 11/5/2016; 4/17/2019; 5/1/2020; 6/1/2021; 11/1/2022; 12/1/2023

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 CMA's.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director
3. All questions regarding this policy or its implementation may be directed to the AHI Health Home Assistant 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.

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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.

a. If Health Home Enrollee or Health Home Candidate is moving/has moved out of Health Home Service Providers service region (Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington, and Saratoga Counties): or a Transfer to another Health Home Service Provider is requested or deemed necessary:

b. The current Health Home Service Provider will contact AHI via secure e-mail 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 to the HHSP for completion. The current CMA will send AHI the transfer form. 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 Service Provider via secure e-mail 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.

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j. If the Health Home Service Provider (HHSP) is disenrolling a member and transferring the member to another Health Home the HHSP will complete the requested Health Home's referral form and complete the referral process to the new Health Home. The HHSP will select the correct end reason in the members' record and communicate with the new Health Home for a warm hand off and supply requested documentation (as needed with consent from the member).
k. If you received a transferred member from another Health Home or Health Home Service Provider, the Health Home Service Provider will:
    - 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.
    - Ensure updated consents have been completed.
    - Confirm the members Eligibility for Health Home.
    - In the case of Children's Health Home, a new CANS-NY (initial) will need to be completed within 30 days.
    - 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.

Transfers to CCO/HH

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.

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.

The HHCM will work with the client to have the client add the new CCO/HH to the appropriate consent form.

The HHCM will work collaboratively with the CCO/HH to share any applicable information to ensure a warm handoff.

** For youth enrolled in HCBS Waiver and transferring to OPWDD please see the Health Home Serving Children Home and Community Based Services Transfer to OPWDD Policy**

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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.

Quality and Performance Improvement:

AHI Health Home will review a selection of cases from HHSP's during annual comprehensive audits 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: Assistant Director, Care Management and Health Home

Responsible Person: Health Home Service Provider

Reviewed By: Director, Care Management and Health Home

Approved By: Chief Compliance Officer

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Health Home Care Management Community Referral

Phone: 1-866-708-2912
Email: HealthHome@ahihealth.org(send encrypted only!)
Fax:518-615-1220

Type of Referral:	
☐ New Referral	☐ Transfer (Expected date of transfer):
Population:	
☐ Adult Health Home Referral	☐ Children's Health Home Referral

IF FAXING, PLEASE CALL TO CONFIRM RECEIPT - DO NOT RELY ON 'OK' FROM FAX MACHINE

Last Name		First Name			
Preferred Name:					
Medicaid CIN (REQUIRED):		DOB		Gender	
Consenter Name (referral to Children's Health Home)					
Address	Street		Apt.		
	Town	State	Zip		
Home Phone		Mobile Phone		Alt. Phone	
E-mail address					
If this is a referral to children's Health Home, please answer:					
Is the child's parent or guardian currently enrolled in Health Home?	☐Yes ☐No	Is the child currently in foster care?	☐Yes ☐No		

Referral Source			
Name		Title	
Agency		Phone #	
Address	Street		Apt.
	Town	State	Zip
Email Address			

Initial Eligibility Criteria (check all that apply)
☐ Two chronic conditions (specify): ☐ Mental Health Condition (Including Serious Emotional Disturbance) ☐ Substance Use Disorder ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ BMI at or above 85th percentile (for children) OR Over 25 (for Adults) ☐ Other: Specify , Specify
OR ☐ HIV/AIDS
OR ☐ Serious Mental Illness OR Serious Emotional Disturbance
OR ☐ Complex Trauma (Children's Health Home only)

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Member Information:	
Current Living Situation:	☐ Currently Homeless ☐ Currently housed ☐ At Risk of Homelessness ☐ unknown
Primary Diagnosis and/or ICD 10 Code (*if known*):	
Has the member ever experienced an incarceration?	☐ Yes ☐ No ☐ Unknown
Has the member experienced a recent hospitalization or ER visit?	☐ Yes ☐ No ☐ Unknown Date of Discharge:
Has the member experienced a recent inpatient stay for substance abuse treatment?	☐ Yes ☐ No ☐ Unknown Date of Discharge:
Is the member currently inpatient at a Hospital or Facility?	☐ Yes ☐ No ☐ Unknown
If yes:	Facility name:
	Anticipated Date of Discharge:
	Any additional information regarding their current setting:

Reason for the Referral/Transfer:

Safety Concerns		
☐ History of aggressive behavior with providers	☐ Access to firearms	☐ Infestation (bedbugs, etc.)
☐ Registered Sex Offender	☐ None	☐ Other:

Appropriateness Criteria (check all that apply)

- ☐ Unstable housing
- ☐ Lack of social/family supports/ disruption in family relationships
- ☐ Deficits in activities of daily living
- ☐ Non-adherence to treatments
- ☐ Inadequate connectivity with healthcare system and/or other systems of care
- ☐ Learning or cognitive issues
- ☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- ☐ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)