ST. JOSEPH'S HEALTH A Member of Trinity Health; ST PETER'S HEALTH PARTNERS A Member of Trinity Health	**Effective Date:** April 1, 2024

Category: **C. Care Coordination**

Title: **1. Health Home Services**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

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PURPOSE

This policy is intended to provide a standard set of definitions of the services provided via the Health Home program. This policy applies to those Members who are enrolled in Health Home services.

POLICY STATEMENTS

It is the policy of Community Health Connections that all Health Home Members receive Care Coordination services in an effort to increase the Member's health and well-being. Care

Coordinators are expected to provide Core Services, as defined in this policy, and conduct case conferences as necessary with other providers involved in the Member's care to further coordinate care for the Member.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

DEFINITIONS

Health Home Core Services: five categories of services that are considered billable by New York State Department of Health; the five specific services are described in detail below with examples of interventions and services that may fall under each category

<u>Comprehensive Care Management</u>

- Assessment of preliminary service needs.
- Development of Plan of Care, including Member goal, objectives and interventions.
- Assignment of health team roles and responsibilities.
- Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions.
- Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines.
- Development and dissemination of reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery, and costs.

<u>Care Coordination and Health Promotion Services</u>

- Implementation of the individualized Plan of Care (with active member involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports.
- Appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and members or their family members.
- Health education specific to an individual's chronic conditions, development of self-management plans, education regarding the importance of immunizations and screening, providing support for improving social networks and providing health promoting lifestyle.
- Assist members to participate in the implementation of the Plan of Care and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

Comprehensive Transitional Care

- Streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use.
- Collaborate with physicians, nurses, social workers, discharge planners, pharmacists and others to continue implementation of the treatment plan with a specific focus on increasing members' and family members' ability to manage care and live safely in the community and shift the use of reactive care and treatment to proactive health promotion and self-management.

Individual and Family Support Services

- Advocating for individuals and families.
- Assisting with obtaining and adhering to medications and other prescribed treatments.
- Identifying resources for individuals to support them in attaining their highest level of health and functioning, including transportation to medically necessary services.
- Increasing health literacy and, ability to self-manage care.

Referral to Community and Social Support

- Provide assistance for members to identify, obtain, and maintain eligibility for community based resources, health care, benefits, housing, personal need and legal services.
- Care Coordinator actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.

PROCEDURE

A. Care Coordination Services

1. Care Coordination services should be:
    - *Patient-centered* and strengths based with the ultimate goal of empowering Members to stabilize their health independently or improve self-management activities;
    - *Comprehensive* and address the full range of a Member's needs;
    - *Accessible* in that the Member has access to the Care Coordinator or a designee;
    - *Responsive* in that all missed calls or appointments are addressed and rescheduled; and

- *Integrated* to facilitate the exchange of information and promote interdisciplinary dialogues among providers.

2. As a part of care coordination and Health Home services, Care Coordinators should be promoting wellness and prevention activities as appropriate and as advised by doctors and medical associates, to help Members achieve their optimum health.

B. Monthly Provision of Services

1. A Care Management Agency may bill for a Member only if a Core Service was provided and documented during that month, in accordance with Policy E1. Billing and Payment: Billable Services and Billing. See Attachment A: Health Home Core Services for more information on Health Home Core Services.

2. Regardless of Core Service provision, Care Coordinators are encouraged to conduct at least one (1) face-to-face visit with Member's each month. This frequency of in-person contacts may not be necessary or appropriate for all Member, however. The frequency of face-to-face contacts should be based on the Member's needs as outlined in the Plan of Care.

3. All services provided and contacts with Member or collaterals, regardless of whether they are billable, must be documented in the Member's electronic health record in CareManager.

4. Via Actionboards, reporting functionality in CareManager or other internally set up methods, Supervisors must help Care Coordinators identify Members who have not had a direct contact with a staff person in the past 30 days and notify the Care Coordinator immediately.

5. Upon alert, the Care Coordinator and Supervisor should determine if the Member is disengaged from Health Home services, meaning that the lack of contact despite multiple attempts is out of character for the Member. If so, the Member should be moved to Diligent Search status. (See Policy C6. Care Coordination: Case Closure and Re-engagement)

C. Acceptable Services

1. As a best practice, a text message or voicemail should not be the only service provided in a given month and these services alone are not billable. See Attachment B: Billable Services for guidance on what services are billable.

2. Research or faxing of documentation does not count as a Core Service without supplemental communication with a provider or documentation of a successful client encounter.

D. Non-Medicaid Services

1. Whenever possible, Members should be referred to providers in the community who are Medicaid providers, meaning they accept Medicaid reimbursement for services provided to patients. At times, such service providers may not be available in the community. In those instances, the Lead Health Home should be contacted so that agreements can be made with non-Medicaid providers so that Member can receive any needed services.

REFERENCES

Medicaid State Technical Assistance (December 2015). Health Homes (1945 of SSA/Section 2703 of ACA) Frequently Asked Questions Series II.
(https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-section-2703-faq.pdf)

New York State Department of Health (October 5, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

New York State Department of Health (January 9, 2014). Health Home Provider Manual: Billing Policy and Guidance.
(https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf)

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Attachment A: Health Home Core Services

Comprehensive Care Management

- Completion of comprehensive assessment of preliminary service needs
- Development of individualized Plan of Care, including Member goal, objectives and interventions and include family and other social supports as appropriate.
- Consult with multi-disciplinary team on Member's Plan of Care, needs or goals.
- Consult with Primary Care or any specialists involved in the Member's care.
- Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines.
- Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care & improved health outcomes.
- Prepare client crisis intervention plan.

Care Coordination and Health Promotion Services

- Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.
- Implementation of the individualized Plan of Care (with active Member involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports such as patient education, self-help/recovery and self-management.
- Appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and members or their family members.
- Health education specific to an individual's chronic conditions, development of self-management plans, education regarding the importance of immunizations and screening, providing support for improving social networks and providing health-promoting lifestyle.
- Assist members to participate in the implementation of the Plan of Care and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.
- Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs.
- Advocate for services and assist with scheduling of needed services.
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
- Monitor/support/accompany the client to scheduled medical appointments.
- Crisis intervention, revise care plan/goals as required.

Comprehensive Transitional Care

- Follow up with hospitals/ER upon notification of a Member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to ensure a safe transition/discharge that ensures care needs are in place.
- Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
- Link Member with community supports to ensure that needed services are provided.
- Follow-up post discharge with Member/family to ensure Member Plan of Care needs/goals are met.

Member and Family Support Services

- Develop/review/revise the individual's Plan of Care with the Member/family to ensure that the Plan reflects individual's preferences, education and support for self-management.
- Consult with Member/family/caretaker on advanced directives and educate Member on rights and health care issues, as needed.
- Meet with Member and family, inviting any other providers to facilitate needed interpretation services.
- Refer Member/family to peer supports, support groups, social services, entitlement programs as needed to help promote health literacy and ability to self-manage care.

Referral to Community and Social Support

- Provide assistance for members to identify, obtain, and maintain eligibility for community based resources, health care, benefits, housing, personal need and legal services.
- Care Coordinator actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- Collaborate/coordinate with community base providers to support effective utilization of services based on client/family need.

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Attachment B: Billable Services

The delivery of one of the five (5) Health Home Core Services (exclusive of HIT) can be delivered via the following means.

Electronic Communications (email and text messages)

- Electronic communications including emails and text messages are considered billable if one of the Health Home Core Services are provided **and** a response is received from the Member, provider, provider's staff member or another individual who is a part of the care team.

Phone Communication

- Phone communication is billable if one of the Health Home Core Services are provided by speaking with the Member, provider, provider's staff member or another individual who is a part of the care team.

- If a voicemail is left and is returned by the Member, provider, provider's staff member or another individual who is a part of the care team.

Face-to-Face Communication

- All face-to-face communication with a Health Home Member, provider, provider's staff member or another individual who is a part of the care team or any other collaterals shall be considered billable when a Core Service is provided.

The below services are **not** considered billable.

- Mailing a letter.
- Emailing a Member without receiving a response.
- Texting a Member without receiving a response.
- Receiving information from or regarding a Health Home Member, including letters, faxes, voicemails and emails.
- Leaving a single voicemail for the Member, provider, provider's staff member or another individual who is a part of the care team.
- Any interaction with or on behalf of a Member that does not provide one of the five (5) Health Home Core Services, regardless of mode of delivery, is not considered billable.
- Contact made solely to "check-in" with the Member when a Health Home Core Service is **not** provided.