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

Category: **F. Special Programs**

Title: **2. Assisted Outpatient Treatment (AOT)**

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)

Contents

PURPOSE

The purpose of this policy is to ensure that all Assisted Outpatient Treatment (AOT) Health Home Members are served as required by New York State and that the Care Management Agencies and Care Coordinators providing services to these Members are qualified to do so.

POLICY STATEMENTS

Any Community Health Connections Health Home Members who meet the AOT eligibility requirements in this policy will be served by an agency and Care Coordinator who meet the State-mandated qualifications and caseload size to do so. Further, AOT Members will receive Health Home Service that are more intense than those provided to traditional Health Home Members. AOT Members will be identified in all reporting to Community Health Connections. The requirements in this policy do not replace any other Health Home policies, with the exception of Diligent Search Efforts. Agencies serving the AOT population must adhere to all Health Home policies in addition to the requirements listed in this policy.

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

***Assisted Outpatient Treatment (AOT)*:** Court order services for individuals diagnosed with a mental illness and assessed to be unlikely to live safely in the community without supervision; in addition to Care Coordination via Health Homes, court-ordered services may include outpatient treatment, medications and housing arrangements

***DOH 5055*:** Health Home Patient Information Sharing Consent Form; the State produced form for capturing consent for other providers as well as natural supports

Health Home Core Services: The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid, as defined by the New York State Department of Health. The categories of services include:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Member and Family Support
- Referral and Community and Social Support Services

Note: the sixth category of Health Home Core Service, "The use of HIT [Health Information Technology]" is <u>not</u> considered a billable service.

***Kendra's Law*:** New York State Mental Hygiene Law

NYS DOH: New York State Department of Health; the regulating State entity for Health Homes

NYS OMH: New York State Office of Mental Health; one of the regulating State entities for Health Home Plus services

PROCEDURE

A. Care Management Agency Qualifications

1. Former NYS OMH Targeted Care Management (TCM) providers or NYS OMH Legacy providers are those who are able to serve individuals who qualify for AOT services. These agencies are identified on the Health Home Plus Attestation Form submitted by the Lead Health Home to NYS DOH and NYS OMH.

2. Agencies not meeting the requirements above may attest to their ability to serve the AOT population by submitting to the Lead Health Home an Agency Evaluation and Plan for serving the population. Guidance for the development of the Agency Evaluation and Plan can be found in Attachment A.

B. Supervisor Qualifications

1. Those supervising Care Coordinators serving the AOT population must be:
   a. a licensed level healthcare professional (e.g., RN, licensed clinician, psychologist) with prior experience in a behavioral health clinic or care management supervisory capacity
   OR
   b. a Master's level professional with three years prior experience supervising clinicians or case managers who are providing direct services to individuals with serious mental illness or serious substance use disorders.

C. Care Coordinator Qualifications

1. Care Coordinators serving the AOT population must meet the education and experience requirements listed below.

Education Requirements and Years of Experience

Degree	Number of Years of Experience
Masters in an approved field	One (1) year of experience
Bachelors in an approved field	Two (2) years of experience
Credentialed Alcohol and Substance Abuse Counselor (CASAC)	Two (2) years of experience
Bachelor's or higher in any field	Three (3) years of experience **OR** Two (2) years of experience as a Health Home Care Coordinator serving the SMI SED population

2. Approved field for degrees, as referenced above, include the following.
   - Child and Family Studies
   - Community Mental Health
   - Counseling
   - Education

- Nursing
- Occupational Therapy
- Physical Therapy
- Psychology
- Recreation
- Recreational Therapy
- Rehabilitation
- Social Work
- Sociology
- Speech and Hearing

Experience Requirements

3. The experience referenced in section C1 above must include the following:
   a. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED;
   OR
   b. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

4. As additional training opportunities are identified for Care Coordinators serving the AOT population, the Lead Health Home will ensure the appropriate staff are notified and encouraged to attend.

D. Caseload Standards

1. The preferred caseload ratio for AOT enrollees should be one (1) staff to 12 AOT Members. The ratio is not permitted to exceed one (1) staff to 15 AOT Members. For the purposes of caseload stratification and resource management, a blended caseload of AOT and non-AOT is permitted however each AOT Member should be counted as four (4) non-AOT Members.

E. Member Eligibility for AOT

1. Only Members with an active AOT court order may be served under the AOT program type.

2. If the Member has an active and current AOT order at any time during the month, the AOT rate code may be billed, assuming all minimum requirements for AOT have been met (See Section G of this policy).

3. AOT court orders take precedence over the SMI HH+ expanded population. Members will become eligible for SMI HH+ services once the AOT order is expired or not renewed. All Members stepping down off AOT are eligible for the SMI HH+ expanded population for 12 months following AOT.

4. The Member is no longer eligible to receive AOT services once the AOT court order has expired, or the order is not renewed.

F. AOT Referrals and Enrollment

1. The Lead Health Home will work collaboratively with the respective County Single Point of Access (SPOA) or Local Government Unit (LGU) to ensure that AOT Members are assigned to a CMA that is approved to serve those populations. Assignment to the appropriate CMA will happen as soon as possible after receiving the referral.

2. While the AOT Court Order specifying the need for Health Home services serves as consent to enroll a Member in Health Homes, the Court Order does not take the place of Health Home consent to share clinical information via the DOH 5055. Absent the DOH 5055, the Care Coordinator or others on the team, may share clinical information for care coordinator purposes to the extent permitted by section 33.13(d) of the Mental Hygiene Law, which provides a limited treatment exception for the exchange of clinical information between mental health provider and Health Homes. For more information on consent requirements see Policy B4, Outreach and Engagement: Health Home Consent.

G. AOT Program Requirements

1. The Member's AOT court order must be attached to the Member's electronic health record.

2. All categories of service listed in the court ordered AOT treatment plan must be included in the Member's Health Home Plan of Care.

3. AOT Members must be identified as such in the Programs Tab of CareManager, Community Health Connection's electronic health record. When a Member's AOT order is expired or not renewed, the AOT Program must be end dated in CareManager. The addition or removal of the appropriate program type will serve as the CMA's notification to the Health Home of a Member's AOT status.

4. Once assigned, the CMA should provide Health Home Care Coordination services as soon as possible, including participation in the pre-release or discharge planning for the individual whenever possible to ensure continuity of services for the individual, if applicable.

5. Health Home Members who are under an AOT court order must receive at least four (4) Core Services per month, which must be delivered face-to-face. The AOT rate code can only be billed when this minimum requirement is met and the contacts are

clearly documented as Core Service delivery in accordance with policy C1. Care Coordination: Health Home Services, in the Member's record.

6. Because Member's served under an AOT court order are mandated into Health Home services, AOT Members will not be placed in Diligent Search Efforts status or Excluded Setting status.
   a. Instead of DSE, CMAs must follow OMH guidance for reporting someone as missing (See Section H of this policy)
   b. Instead of Excluded Setting, CMAs must follow OMH guidance for maintaining contact when the Member is in an acute care facility or is incarcerated (See Section I of this policy)

7. Care Management Agencies must complete and submit all AOT reporting requirements to NYS OMH as required by the AOT legislation and as currently reported in the NYS OMH Child and Adult Integrated Reporting System (CAIRS). This may include weekly contacts regarding the AOT Member's compliance or lack of compliance with treatment.

H. AOT Missing Persons Reporting Requirements

1. Care Coordinators must document in the electronic health record the date and time of receipt of any notice regarding an AOT Member not showing for an appointment, or any other credible evidence that an AOT Member cannot be located and may be missing.

2. An AOT Health Home Member is considered missing when he or she has had no credibly reported contact within 24 hours of the Care Coordinator receiving notice that the person had an unexplained absence from an appointment. Upon this classification, a Missing Person Report must be filed with the local police within 24 to 48 hours.

3. Upon discovering that an AOT Member may be missing, the Care Coordinator must contact any persons who may reasonably have knowledge of the AOT Member's whereabouts. Such contacts should happen within 24 hours of the discovery of the missing person status. All efforts to contact persons with knowledge of the AOT Member's whereabouts must be documented in the electronic health record.

4. If the AOT Member is not located within the first 24 hours, the second 24 hours should be spent calling hospitals, morgues, shelters and jails in an attempt to locate the Member. All attempted and successful contacts must be documented in the electronic health record.

5. Once an AOT Member is deemed missing, the Care Coordinator must complete the Significant Event Report and submit it to the AOT program as well as the Director of Community Services. NYS DOH Health Home incident reporting requirements also apply to this population. For more information on Health Home Incident Reporting see Policy D2. Critical Events and Incidents: Incidents and Complaints.

6. For missing AOT Members, the Care Coordinator must:
   a. make daily calls to the residence of the missing AOT Member for the first three days after the Member is deemed missing, and weekly calls thereafter for the duration of the order, or until the missing AOT patient is located. Such contacts may occur more frequently, to the extent appropriate considering the circumstances of the particular case;
   b. make weekly calls to local hospitals, shelters, morgues, and jails in search of the missing patient for the following 2-month period, and thereafter, as appropriate, for the duration of the order; and
   c. provide the AOT Program with weekly updates concerning efforts to locate the missing patient, and the results of such efforts.

7. Once an AOT Member is located, the CMA must promptly notify the AOT Program.

I. AOT Acute Care Setting Contact Requirements

1. The CMA staff are expected to maintain contact with AOT Members and their providers while they receive inpatient services.

2. If the AOT Member is in an acute-care setting, the minimum one face to face contact per week is expected to continue.

3. If the AOT Member is in a longer-term setting or incarcerated, the CMA is expected to have contact with the Member once per month.

4. The CMA is also expected to have weekly contact with mental health providers/staff at the facility where the AOT recipient is located.

J. AOT Billing

1. Care Management Agencies are only permitted to bill at the Health Home Plus (HH+) rate code (1853) if the program requirements specific in Section G5 above are met and documented in the Member's electronic health record.

2. If a Care Coordinator serving an AOT Member made efforts in a month to provide four (4) face-to-face contacts and the individual was not home, did not show up for the appointment or was otherwise not available, the CMA may bill for the Health

Home High Risk/Need Care Management Rate (1874) for that month only if at least one (1) Health Home Core Service was provided.

3. If a Care Coordinator serving an AOT Member made efforts in a month to provide four (4) face-to-face contacts and was unable to due to Missing status, the HH+ rate code (1853) can continue to be billed as long as the diligent search procedures referenced in Section H above are followed and clearly documented in the electronic health record.

4. When an AOT Member is in an acute care setting, as outlined in Section I of this policy, the CMA is permitted to bill the HH+ rate code (1853) the month the Member enters the setting and the month the Member is discharged/released from the setting as long as the four (4) face-to-face contacts were made. For months the Member is in the setting, billing is not permitted.

5. It is the responsibility of the Care Management Agency to confirm that the Program Requirements in Section G and H above are met prior to submitting billing to the Lead Health Home. By responding "Yes" to the question "Were the minimum required AOT services provided?" serves as attestation that the CMA has provided and documented the services required.

6. Once a Member's AOT order is not renewed or expires, billing at the HH+ rate code (1853) must cease.

REFERENCES

New York State Department of Health and Office of Mental Health (October 11, 2016). Health Home Plus (HH+) Program Guidance for Assisted Outpatient Treatment (AOT). (http://www.omh.ny.gov/omhweb/adults/health_homes/aot-hh-guidance.pdf)

New York State Department of Health (October 2, 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 Office of Mental Health (February 2014). Assisted Outpatient Treatment Program: Guidance for AOT Program Operations Reissued February 2014. (http://www.omh.ny.gov/omhweb/guidance/adult-services/guidance-for-program-operation.pdf)

Key Sponsor: Regional Health Home Director		
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Search Terms:		***Reviewed, No Revisions** ****Revised without Full Review**

Replaces: Special Programs: Health Home Plus / AOT (May 1, 2017)
Special Programs: Health Home Plus / AOT (March 15, 2018)
Special Programs: AOT (April 1, 2019)

ATTACHMENT A: CMA Guidance for AOT Evaluation and Plan

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Health Homes are required to attest to NYS DOH which of their Care Management Agencies are well positioned to work with the AOT population. To support the attestation process, we are asking agencies that are interested to evaluate their programs and submit a plan to CHC Administrative team for review and consideration.

If you are interested in serving the AOT population, we encourage you to review the materials listed below to evaluate your agencies readiness, as well as identify opportunities for development.

- NYS DOH Attestation
- Program Requirements
- Report Card
- Actionboards
- Case reading trends
- Investigation feedback (rec'd post incident)
- Case load sizes

Once you have reviewed the information, please submit a plan that includes:

- Agencies quality assurance plan. This should include monitoring of:
    - Core Service Delivery
    - Comprehensive Plans of Care that are member centered and reflect the need for the intensive care coordination
    - Caseload sizes
    - Annual trainings on Core Competency
- Opportunities for program development
- Ability to staff up

We also encourage you to include a SWOT analysis (*Strengths, Weakness, Opportunities and Threats*)