ST PETER'S HEALTH PARTNERS	**Effective Date:** February 24, 2023

Category: **B. Outreach and Engagement**

Title: **4. Health Home Consent**

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 Capital Region Health Connections Care Management Agencies**

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

Contents

PURPOSE

To ensure that Capital Region Health Connections Members have accurate and up-to-date consents on file so that Care Coordination activities can occur.

POLICY STATEMENTS

Communication is critical to Member engagement and improved health outcomes for Health Home Members. This policy outlines the consent process that aids that essential communication. A single Health Home consent that ensures compliance with state and federal regulations on privacy and confidentiality will be used.

The Health Home consent allows partners in the Member's Health Home team to share appropriate information to assist the Member in coordinating his or her care. This single signed consent opens the Health Home gateway of care to quickly meet critical care needs, build trust in accessing the system of care, and build self-reliance skills in managing health care conditions.

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

Data Sharing Consent: The name for the individual provider consents in CareManager; consent needs to be entered in CareManager under the Consent Tab after a Member provides consent for any entities

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

DOH 5236: Notice of Determination for Denial of Enrollment in the New York State Health Home Program; used when a Candidate is found to be ineligible or inappropriate for Health Home services

Health Home Candidate: An individual who is in active Client Search (Outreach) status, but who has not yet been enrolled in Health Home services

Health Home Consent: A Member's consent to be enrolled in and accept Health Home services as indicated by signing page 1 of the DOH 5055; in CareManager, this is filled out via a Client Search Note enrolling the Member

Health Home Member: An individual who is enrolled in Health Home services

Hixny**:** Healthcare Information Exchange of New York; the RHIO used by Capital Region Health Connections

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

PSYCKES: A HIPAA-compliant web-based application designed to support clinical decision making, care coordination, and quality improvement in New York State

***RHIO*:** Regional Health Information Organization; a health information exchange organization; offers real-time electronic access to patients' comprehensive medical history

PROCEDURE

A. Obtaining Consent

1. The DOH 5055: *Health Home Patient Information Sharing Consent Form* is the single consent form that will be used for all Care Team participants for which the Member grants consent. The Form can be accessed in eight languages via the NYS DOH website. (https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/index.htm)

2. The DOH 5055 consent gives consent for Member's information in Hixny and PSYCKES to be accessed as well as individual providers. This must be clearly communicated to Members signing the DOH 5055. If a Member chooses not to consent to Hixny, the Hixny withdrawal of consent (See Attachment A) must be completed to denote their withdrawal of the consent provide via the DOH 5055. The Hixny withdrawal must be attached to the Member's CareManager record in the Attachments.

3. The DOH 5055 gives all entities listed on page three (3) of the document permission to speak to one another regarding the Member's care. Staff must explain this to Members and ensure that only the appropriate entities are listed on page three (3) of the 5055. For example, property owners or other non-providers may not be appropriate for inclusion on the 5055. In those cases, a general HIPAA consent should be used in lieu of the 5055.

4. If a Member chooses to limit the information shared with a provider, but still wants to grant consent for the Care Coordinator to work with or consult with the provider, that provider should not be listed on the 5055. Again, a general HIPAA consent should be used in lieu of the 5055.

5. During Client Search, as appropriate, but at least once a Member enrolls in the Health Home, Care Coordinators should start to obtain consents via the DOH 5055 for any providers (behavioral health, medical, social service, substance abuse, MCO,

etc.) involved in the Member's care. This may include any natural or social supports such as family and emergency contacts who are involved in the Member's care.

6. Health Home Candidates will not be enrolled in the Health Home program until the DOH 5055 is signed by the Candidate. Without consent, Care Coordinators cannot share protected health information and thus provide care coordination services. Members are required to sign the consent so that all consented providers involved in the Member's care have access to the same information to better serve the Member. If a Candidate refuses to sign the DOH 5055 s/he will not be enrolled in the program and the DOH 5236: *Notice of Determination for Denial of Enrollment in the New York State Health Home Program* must be sent to the Candidate within five (5) business days of the refusal and determination not to enroll.

7. Consent is also required to obtain verification of eligibility for Health Home Services from a licensed provider, Managed Care Organization or Hixny prior to enrollment in the program. (For more information on required documentation prior to enrollment, see Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility and Policy B3. Outreach and Engagement: Health Home Outreach and Enrollment.)

8. The only exception to enrollment without the DOH 5055 in place is Members who are subject to an AOT order mandating them to Health Home Services and who refuse to sign consent. In these instances, a copy of the AOT order will be used to enroll the Member in Health Home services. The AOT order, however, does not substitute for the Member's consent to share clinical information. Absent such specific consent, the Care Coordinator may share clinical information for care coordination purposes to the extent permitted by section 33.13(d) of the Mental Hygiene Law, (https://www.nysenate.gov/legislation/laws/MHY/TEA33) which provides a limited treatment exception for the exchange of clinical information between mental health providers and Health Home and Care Management Agency staff. For more information on the AOT population, see Policy F2. Special Programs: Health Home Plus / AOT.

B. Consents for Referrals and Providers

1. When referrals are made on behalf of Members to new providers, a general HIPAA consent is required to be obtained.

2. If the Member engages with the provider and that provider becomes part of the Member's Care Team, it may be appropriate to obtain consent for that provider via the DOH 5055.

3. If a provider contacts the Care Coordinator to coordinate care on behalf of a Member, consent must be on file before information on the Member is released to the provider. This consent may be the DOH 5055, a HIPAA consent, or a consent obtained by the provider who is reaching out.

4. For the purposes of initial Health Home engagement and discussions with the referral source, if there is no consent from the referral source, the Member's status in the program (enrolled, opted out, unable to contact) may be shared with the referral source. If ongoing collaboration will occur with the referral source, consent should be obtained via the DOH 5055 or HIPAA consent, whichever is most appropriate.

C. Completing the DOH 5055 Consent

1. Each Member must complete the following fields on page one (1) of the DOH 5055 in order to enroll in the Health Home program.
   - Printed Name of Patient
   - Patient Date of Birth
   - Date
   - Signature of Patient or Legal Representative
   - Printed name of Legal Representative if applicable
   - Relationship of Legal Representative to Patient, if applicable

2. In addition to the information above, staff must complete the fields on page one (1) that require filling in "Capital Region Health Connections" and "Hixny" the local RHIO. It is highly encouraged that this information be pre-populated on all consent forms so that it is not overlooked.

3. Each DOH 5055 consent must list the phone number for Capital Region Health Connections (518-271-3301) on page two (2) of the consent form. The use of forms with this information pre-populated is highly encouraged.

4. Each Member must initial and date the top of page three (3) of the consent form and "Capital Region Health Connections" must be listed in the Health Home Name field. It is encouraged that this information be pre-populated on page three (3).

5. Care Coordinators must review the DOH 5055 form with the Member explaining that by completing the consent form the Member is agreeing to allow his or her health information to be shared among the consented providers listed on page three (3) and the Health Home. Care Coordinator should ensure Members and Candidates clearly understand what signing the consent means and read the consent to Candidates and Members when warranted.

6. All providers and supports the Member grants consent for must be listed individually starting on page three (3) along with the date consent was granted for each

individual or agency as well as the Member's initials indicating consent. When a provider is added to the 5055, that provider must be contacted to be notified that consent was obtained to coordinate care.

7. The Care Management Agency in which the Member is being enrolled must be listed as a provider on page three (3) of the DOH 5055.

8. In an effort to engage Managed Care Organizations (MCO) in the services provided to Health Home Members, Care Coordinators must ask those individuals with an MCO to grant consent for staff to speak to the MCO. MCOs are helpful resources for obtaining information on Members, including diagnostic information for eligibility purposes as well as helping to located Members who are lost to services and collaborating on complex cases. If the Member refuses to grant consent for the MCO, this must be noted in the case notes in the Candidate or Member's chart in CareManager, but does not prevent enrollment into the program. (For more information on the MCO role in Health Home Services see Policy I1. Contacts and Communication: MCO Communication.)

D. Documentation of Consent

1. When a Member enrolls in Health Home services, the Health Home Consent must be entered into CareManager via the Consents Tab, or via the Client Search Note that enrolls the Member in Health Home Services (staff will be prompted to add this consent when enrolling Members in CareManager).

2. Unless a Member signs a Hixny Withdrawal of Consent form, the Hixny Consent must be entered into the Care Manager Consents Tab as an Electronic HIE Data Sharing Consent. Without this consent entered, Hixny Provider Portal access will not be granted, and alerts will not be received. (For more information on Hixny see Policy I3. Contacts and Communication: Hixny Communication.)

3. The current paper copy of the Member's DOH 5055 must be uploaded to CareManager as an attachment via the Documents section.

E. Updating Consent

1. Each Member must have only one copy of the DOH 5055. The DOH 5055 consent should be viewed as a constantly evolving document. Care Coordinators are strongly encouraged to bring the consent and review it routinely with Members to ensure the most up to date providers and supports are listed. Additional blank copies of page three (3) may be added to accommodate the ever-changing nature of the form.

2. New providers and supports involved in a Member's care can and should be added directly to the DOH 5055 form with the name of the provider and the date consent was granted if the Member chooses to grant consent for the new provider or support. As new providers are added to page three (3) of the 5055, those providers must be contacted and notified that consent was obtained to coordinate care.

3. Any time a new provider is added to the DOH 5055 or a HIPAA consent is obtained, the paper copies must be uploaded to the Member's record in CareManager via the Documents section.

4. If a Member would like to withdrawal consent for a single provider listed on the DOH 5055, the provider's name must be crossed out and the Member's initials along with the date of the withdrawal of consent should be listed next to the withdrawn consent. The paper copy indicating the withdrawal must be uploaded to the Documents section of CareManager.

5. Any time a provider is removed from the written consents (DOH 5055 or HIPAA consent), those consents must be ended in the Consents Tab in CareManager. Effective February 2023, no new provider consents will be entered, however previously entered consents must be updated for data integrity purposes.

6. Annually, based on the time of enrollment into the program, the Care Coordinator must review the DOH 5055 consent. The Health Home Member Acknowledgement Form (Attachment B) should be used to document annual events as they occur. Any other consents obtained should be reviewed with the Member at this time.

F. Withdrawal of Consent

1. If a Member would like to withdrawal consent for a single entity listed on the DOH 5055, the steps in Section E, 4-5 of this policy.

2. If a Member chooses to withdraw all consents, the Member is essentially choosing to withdraw for the Health Home program and the closure procedure outlined in Policy C6. Care Coordination: Case Closure and Re-engagement must be followed.

To assist Care Coordinators in completing consents correctly the Health Home Consent Guide is available on the Health Home website.

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). (https://www.omh.ny.gov/omhweb/adults/health_homes/aot-hh-guidance.pdf)

New York State Department of Health (August 3, 2016). Health Home Weekly Webinar. (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_webinar_8_13_16.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)

New York State Department of Health (April 2012). April 2012 Medicaid Update Special Edition, Volume 28, Number 4. (https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04_pharmsped_edition.htm)

New York State Office of Mental Health (June 2, 2004). Assisted Outpatient Treatment Program: Guidance for AOR Program Operation Reissued February 2014. (https://www.omh.ny.gov/omhweb/guidance/adult-services/guidance-for-program-operation.pdf)

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Search Terms:		***Reviewed, No Revisions** ****Revised without Full Review**

Replaces: Consent Policy and Procedure
Outreach and Engagement: Health Home Consent (May 1, 2017)
Outreach and Engagement: Health Home Consent (February 15, 2018)
Outreach and Engagement: Health Home Consent (March 2, 2020)

Hixny

ATTACHMENT A: Hixny Withdrawal of Consent

Withdrawal of Consent
Capital Region Health Connections

I have previously signed a Patient Consent Form that granted Capital Region Health Connections access to my medical information through Healthcare Information Xchange of New York ("Hixny"). At this time, I no longer want Capital Region Health Connections to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to Capital Region Health Connections only. I understand that if I wish to withdraw my consent granting other Hixny organizations that participate in my treatment access to my medical information, I must do so by contacting these other Hixny Participants directly.

2. I understand that, by checking one of the boxes below, I am either denying Capital Region Health Connections the right to access my medical information ***even in case of emergency,*** or I am granting emergency access to my medical information:

   ☐ **I do not wish my medical information to be available to Capital Region Health Connections, even in the case of an emergency.**

3. I understand that this Withdrawal of Consent will not affect or undo any exchange of my medical information that occurred while my original consent was in effect.

4. I understand that my withdrawal of consent for Capital Region Health Connections does not affect any consent(s) that I may have previously given to other Hixny Participant(s). These will remain in effect until I specifically withdraw them by contacting these other Hixny Participants directly.

5. I understand that it may take several days to process this Withdrawal of Consent.

6. I understand that no Hixny Participant can deny me medical care as a result of this Withdrawal of Consent. I also understand that my health insurance eligibility cannot be affected this Withdrawal of Consent.

_____	_____
Print Name of Patient	Patient's Date of Birth
_____	_____
Signature of Patient/Patient's Representative (if patient is unable to sign)	Date
_____	_____
Print Name of Patient's Representative	Relationship of Patient's Representative

ATTACHMENT B: Health Home Member Acknowledgement Form

Members of Trinity Health

Community Health Connections
Member Acknowledgement Form

Complete this form each time one of the four activities listed below is completed.
More than one activity may be checked if more than one activity was completed during the visit.

Member Name: _____

Date of Acknowledgement: _____

The following annual activities were completed with the Member:
(Note each of these activities must be completed at least once annually)

- ☐ Health Home Consent Form Reviewed for Accuracy (DOH 5055)
- ☐ Health Home Member Bill of Rights Reviewed
- ☐ Comprehensive Assessment Annual Update Completed
- ☐ SDOH Screening Tool Annual Update Completed

- ☐ Plan of Care – I actively participates in the creation of my individual Plan of Care and agree with the Plan.

_____ _____
Member Signature Date

_____ _____
Care Coordinator Signature Date