ST PETER'S HEALTH PARTNERS

Effective Date: October 3, 2022

Category: C. Care Coordination

Title: 5. Case Transfers

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)

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PURPOSE

This policy seeks to outline the steps transfer a Member from one Health Home to another as well as from Care Management Agency to Care Management Agency within the Health Home. The processes are aimed at accommodating Member choice while not disrupting services to enrolled Members.

POLICY STATEMENTS

It is the policy of Capital Region Health Connections that Members be served by the Care Management Agency that can best meet the needs of the Member. When possible, Members will be given a choice in Care Management Agencies. In some instances, Members may request a transfer to a new Care Management Agency or Members may move out of the geographic service area covered by Capital Region Health Connections, requiring a referral to another Health Home. This policy seeks to define each situation and outline the steps that must be taken in each situation. Care Management Agencies may have policies that are more specific in place related to case closure; however, these policies must be followed at a minimum.

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

Assertive Community Treatment (ACT): integrated set of evidence-based practice treatment, rehabilitation and support services delivered by mobile, multi-disciplinary mental health treatment team; services are recovery-oriented and individualized to provide recipients with tools needed to obtain and keep housing, employment, relationships and relief from symptoms and medication side effects; population served includes:

- Individuals with serious mental illness (SMI)
- Individuals with treatment history that includes multiple psychiatric hospitalizations and emergency room visits
- Individuals with involvement in the criminal justice system
- Individual with co-occurring mental health and substance use disorders
- Individuals who are homeless
- Individuals who lack engagement in traditional outpatient services
- Individuals whose needs have not been met by traditional service delivery approaches

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 5235: Notification of Disenrollment in the Health Home Program; the State developed form that must be completed and sent to a Member prior to his or her case closing, regardless of the reason for closure

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 Member: An individual who is enrolled in Health Home services

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

PROCEDURE

A. Referral to a New Health Home

1. If an enrolled Member moves out of the area served by Capital Region Health Connections, the Care Management Agency serving the Member must close the Member's case in CareManager and complete the required paperwork in accordance with Policy C6. Care Coordination: Case Closure and Re-engagement.

2. The Care Management Agency (CMA) closing the case will be responsible for referring the Member to the Health Home in the Member's service area with the proper consent. A list of Health Homes in New York State can be found here. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm)

3. Whenever possible, a case conference between the accepting and releasing Health Home providers should occur to facilitate a warm handoff and prevent a disruption in the provision of Health Home services.

4. When consent is in place and the Member has Medicaid through a Managed Care Organization (MCO), the MCO must be notified that the services through Capital Region Health Connections will be ceasing, and the Member will be referred to another Health Home.

B. Care Management Agency Transfers Due to Member Behaviors

1. Prior to initiating a Care Management Agency (CMA) transfer due to concerns regarding a Member's behaviors, the CMA must discuss the concerns with the Member. Transfers due to behaviors should be a last resort. Some actions to take prior to pursuing transfer include reviewing the Member Rights and Responsibilities with the Member and completing a Statement of Understanding with the Member.

2. If attempts to manage the behaviors are unsuccessful, the Lead Health Home should be contacted. After discussing the case, the Lead Health Home may choose to contact the Member to address concerns, if appropriate.

C. Care Management Agency Transfers at Request of Members

1. At any point, a Member may request a transfer to another Care Management Agency (CMA) within Capital Region Health Connections. When a Member requests

a transfer to another CMA, the CMA must contact other CMAs to see which agency is able to take the case, considering the Member’s preferences whenever possible.

D. Care Management Agency Transfers Protocols

1. If a transfer is warranted for any reason, the CMA must contact other agencies to determine an agency that can accept the case and then discuss the transfer to the new agency with the Member to ensure the Member agrees to transfer to the new CMA.

2. Once the Member agrees to the transfer, the CMA must obtain consent for the receiving agency on the DOH 5055.

3. Prior to the transfer occurring, the case must be prepared for transfer. This includes all of the following.
   a. Obtain written consent for the new CMA on Page 3 of the DOH 5055
   b. Ensure all information in CareManager is up to date (notes, attachments, etc.)
   c. Schedule a case conference with the receiving agency to review the most recent Comprehensive Assessment, Plan of Care and Member concerns as well as the date of official transfer.
   d. Send a transfer letter to the Member with the details of the transfer (date, contact information for the new CMA and Care Coordinator, etc.)
   e. Inform the Lead Health Home of the transfer using the Case Transfer Request Form (See Attachment A).

4. The date of transfers must be the first day of the month due to restrictions in MAPP. Transfers cannot occur mid-month but can be backdated to the start of the current month.

5. Upon transfer, the receiving CMA should review relevant documentation, such as the most recent Comprehensive Assessments, Plan of Care and recent Care Notes to ensure an understanding of the Member's current situation and work done by the previous CMA to date.

Attachment B details the required steps for each type of CMA-to-CMA transfer.
Attachment C serves as a Quick Guide for handling case transfers.

E. Transfers from Assertive Community Treatment (ACT)

1. Members served under the Assertive Community Treatment (ACT) program are not eligible for Health Home Services. In instances in which Members are no longer in need of ACT services, their cases will be transferred to a Care Management Agency for Health Home Care Coordination services.

2. When Members are transferring from ACT to Health Home Care Coordination, the ACT service provider should contact the accepting CMA to facilitate a warm handoff, including letting the accepting CMA know what referrals/linkages have been made on behalf of the Member and a discharge summary from ACT services.

3. There is a 90 day "follow-up period" that is part of the ACT model, wherein ACT services can be re-accessed if the individual requires a return to that level of care.

4. The Lead Health Home should be contacted if a re-assessment for ACT services is needed.

REFERENCES

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 Office of Mental Health (August 20, 2014). ACT Programs and Health Homes: Assertive Community Treatment Program (ACT) Joining Health Home (HH) Networks
(https://www.omh.ny.gov/omhweb/act/health-homes-networks.pdf)

New York State Office of Mental Health (2007). ACT Program Guidelines 2007.
(https://www.omh.ny.gov/omhweb/act/program_guidelines.html)

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Attachment A: Case Transfer Request Form

ST PETER'S HEALTH PARTNERS
Capital Region Health Connections

Health Home
2212 Burdett Avenue
Troy NY 12180
ph (518) 271-3301
fx (518) 271-5009
sphp.com

Please submit the completed checklist to Lauren.Cramer@sphp.com to complete a case transfer from CMA to CMA.

Transfer Information	
CareManager Chart Number:	
Releasing CMA:	
Accepting CMA:	
Date of Transfer: ***Must be the first day of the month*	

Please confirm that the following requirements for transfers have been met and documented prior to form submission.

Transfers Requirements	
☐	Member was informed in writing of transfer, including receiving agency and effective date. *Supporting documentation must be on file.*
☐	CareManager documentation is complete (notes, upload documents, update demographics, complete HML – if billing for the month)
☐	Assessment and Plan of Care are up to date ☐ If not, status and barriers were communicated to receiving CMA
☐	Case Conference occurred between releasing and receiving CMAs manager or director. *Conference must be documented in CareManager.* Date of Conference: Mode of Conference:

Attachment B: CMA to CMA Transfer Protocols

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The following steps must be taken to ensure a smooth transition from CMA to CMA and to minimize any disruption in services to the Member.

Due to communications between CareManager and MAPP and the Health Home billing structure, all transfers must occur on the first day of the month

	Transfers Due to Member Behaviors
☐	Discuss Concerns with Member
☐	• Review Member Rights and Responsibilities
☐	• Complete Statement of Understanding with Member
☐	If concerns persist, Contact Lead Health Home
☐	• Lead Health Home will contact the Member, if appropriate

	Transfer Protocols (followed regardless of reason for transfer)
☐	Identify CMA to accept case
☐	• Contact CMAs to determine who can take the case
☐	• Discuss transfer with Member, letting Member know which agency is taking case
☐	Prepare case for transfer to new CMA
☐	• Obtain written consent for the new CMA on Page 3 of the DOH 5055
☐	• Ensure all information in CareManager is up to date (notes, documents, etc.)
☐	• Schedule call or case conference with receiving agency to review most recent Comprehensive Assessment, Plan of Care and Member Concerns as well as the date of transfer. *Note: The date of transfer must be the first day of the month.*
☐	• Send transfer letter to the Member with the details of the transfer (date, contact information for new CMA and Care Coordinator)
☐	Submit the Case Transfer Request Form to CRHC for transfer to occur in CareManager
☐	New / Receiving CMA:
☐	• Review Assessment and Plan of Care with Member
☐	• Review note documentation from previous CMA

Attachment C: Case Transfer Quick Guide

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sphp.com

When transferring a case to another CMA within CRHC, please be sure to DO the following BEFORE submitting the Transfer Request Form

- ✓ Ensure written consent for the receiving agency is on Page 3 of the DOH 5055.
- ✓ Have a case conference – at a minimum – with the receiving agency. Best practice is for warm handoffs (i.e., in person meetings with the Member) to ensure continuity of care.
- ✓ Identify the transfer date, which MUST be the first day of the month, as specified on the Transfer Request Form.
- ✓ Inform the Member in writing of the transfer date and contact information for the receiving CMA.
- ✓ Ensure all documentation is finalized in CareManager (Notes, Plans, Assessments, HML) and up-to-date (Plans and Assessments) and all attachments are uploaded.

Do NOT do the following when transferring a case within CRHC

- ✖ Do NOT discharge the case in CareManager – leave the Member in enrolled status.
- ✖ Do NOT submit a referral to the Lead Health Home or receiving CMA.
- ✖ Do NOT pursue a transfer if the Member is not engaged with the releasing CMA (delaying consent).
- ✖ Do NOT pursue a transfer for any Members in DSE or Excluded Setting.
- ✖ Do NOT send in the Transfer Request Form until all required steps are completed; sending in the form is the last step in the transfer process.