ST PETER'S HEALTH PARTNERS	**Effective Date:** April 1, 2019

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 Capital Region 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 Capital Region 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 Capital Region 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 Capital Region 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 receiving AOT.

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
   a. Bachelor's degree in one of the following fields below or another human services field:
      - 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

   OR
   b. A New York State teacher's certificate for which a bachelor's degree is required
   OR
   c. NYS Licensure and current registration as a Registered Nurse and a bachelor's degree
   OR
   d. Bachelor's level education or higher in any field with five years of experience working with persons with behavioral health diagnose
   OR
   e. A Credentialed Alcohol and Substance Abuse Counselor (CASAC).

Experience

a. Two years of experience (a Master's degree in a related field may substitute for up to one year or experience) either:
   i. Providing direct services to persons with serious mental illness, developmental disabilities or alcohol or substance abuse
   OR
   ii. Linking persons who have serious mental illness, developmental disabilities, or alcohol or substance abuse to a broad range of services essential to successfully living in a community setting.

2. 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 all other HH+ expanded populations (SMI HH+, State PC Discharge HH). Members will become eligible for a HH+ expanded population once the AOT order is expired or not renewed.
   State PC Discharge HH+
   If the AOT Member is also being released from a State Psychiatric Center (State PC) or OMH's Central New York Psychiatric Center (CNYPC) or one of its Correction-Based Mental Health Units (located within designated DOC facilities), making him or her eligible for the State PC Discharge HH+ population, the AOT order will take precedence over the State PC Discharge HH+ program. Once the AOT order is expired or not renewed, the Member may be eligible for the State PC Discharge HH+ program if the Member was released from the State PC or CNYPC within the most recent 12 months. For more information on State PC Discharge HH+, see Policy F3.

State Psychiatric Center and CNYPC Discharge Health Home Plus (State PC Discharge HH+).

SMI HH+

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, Capital Region 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. Rather, CMAs must follow OMH guidance for reporting someone a missing (See Section H of this policy).

H. AOT Reporting Requirements

1. 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).

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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;
   c. provide the AOT Program with weekly updates concerning efforts to locate the missing patient, and the results of such efforts; and
   d. provide weekly updates to the appropriate NYS OMH Program Manager.

I. 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. 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.

5. 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)

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