The following workflow follows CRHC Policies and Procedures B2. Outreach and Engagement: Medicaid and Health Home Eligibility and B3. Outreach and Engagement: Health Home Outreach and Enrollment.

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| Outreach/Client Search  |
| ☐ Contact the Community Referral source within two (2) business days of receiving referral to:* 1. inform the referral source that the referral was received and outreach efforts are commencing and
	2. obtain any updated or pertinent information about the Candidate that would assist in engaging the Candidate in services.
 |
| ☐ Begin outreaching the Candidate within five (5) business days of referral assignment. |
| ☐ Conduct a minimum of three (3) engagement activities to locate and enroll the Candidate. These activities should be varied and specific to the Candidate's location, situation and available contact information. |
| ☐ Before the end of Month 1 of Outreach determine, with your supervisor, if Month 2 Outreach will be pursued, or if the Candidate’s case will be closed in CareManager. |

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| Enrollment Requirements*These steps apply to Candidates who are interested in enrolling in Health Home services.* |
| ☐ Obtain a signed DOH 5055 Consent Form (Required for Health Home enrollment). |
| ☐ Ensure medical or mental health documentation is received confirming Candidate's diagnostic eligibility. |
| ☐ Conduct the Intake Assessment with Candidate to determine appropriateness and immediate needs. |
| ☐ Complete the Initial Appropriateness Screening to document appropriateness and immediate needs. |
| ☐ Provide the completed DOH 5234 Notice of Determination for Enrollment form to the Candidate and upload a copy into CareManager.  |
| ☐ Review the Welcome Letter and Member Bill of Rights with the Candidate. The last page should be signed and uploaded into the CareManager. |
| [ ]  If a Member is deemed ineligible or inappropriate for Health Home Services, the DOH 5236 Notice of Determination for Denial of Enrollment form must be completed and provided to the Candidate. A copy must also be uploaded into CareManager.  |
| ☐ Contact the Referral Source to let them know if the Candidate enrolled in services or not. |

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| CareManager Documentation |
| ☐ Document a Client Search Note enrolling the Member once diagnostic eligibility and appropriateness confirmed and Member signs the 5055. The note should detail the visit with the Member, including the paperwork completed and a summary of the Member's needs. ☐ Add the Health Home Consent when prompted to when saving the enrollment note. The date of the consent should be the date the Member signed page 1 of the 5055.  |
| Complete each Tab of Candidate’s/Member's electronic health record: ☐ Demographics – all sections completed / updated ☐ Programs – Add program for AOT, HH+, HARP, Non-Medicaid, etc. if applicable ☐ Consents – Add Health Home and Hixny Consent (use the date the Member signed the 5055)☐ Eligibility – Add MCO information or Medicaid as the primary insurance if no MCO☐ Problems – Add verified diagnoses☐ Social Supports – Add if applicable  |
| Ensure the following are uploaded to the Member’s Chart:☐ Community Referral (if one was received) ☐ All three pages of the DOH 5055 ☐ Care Coordinator signed copy of the DOH 5234☐ Signed last page of Member Bill of Rights☐ Proof of Diagnoses (Problems) to support eligibility |
| ☐ Once enrolled and until 60 days passes or the Plan of Care is developed, use a Contact Note with the Service Code: ‘Billable Contact – Initial 60 Days Only’ for any Core Services provided. This will allow for billing prior to the Plan of Care being completed in CareManager.  |

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| Enrolled  |
| Within 30 days of Enrollment:☐ Complete the Comprehensive Assessment with the Member.☐ Complete the CAGE-AID with all Members.☐ Complete the MMS with Member if not connected to a Behavioral Health provider or no known BH Dx.☐ Complete the C-SSRS with Member if history or concern for suicidality.☐ Complete the SDOH Screening Tool (can also be done with Plan of Care by 60-day mark). |
| Within 60 days of Enrollment:☐ Complete the Comprehensive Plan of Care with the Member.☐ Documents all Core Services going forward as a CareManager Note. |

Your Care Management Agency may have additional steps or tracking requirements.

Please consult with your supervisor for internal CMA policies.