Health Home Checklist & Workflow

Outreach

Outreach (Month 1)

- ☐ Contact Referral Source (Within 2 Business Days)
  - Document in Notes
- ☐ Send Health Home Introduction Letter to Member
  - Document in Notes
  - Upload letter to Documents in Notes
- ☐ Contact client via phone & attempt to schedule Enrollment Meeting
  - Document in Notes
- ☐ Attempted Contact Continues throughout the duration of the month, if Member is not reached
  - Document in Notes
- ☐ Complete OBQ (HHUNY) in NetSmart by 25th of Month

Outreach (Month 2)

- ☐ Contact Client & Attempt to Schedule Enrollment Meeting
  - Document in Notes
- ☐ If unsuccessful:
  - Contact Referral Source
  - Contact Medical Providers
  - Research new Demographic Information
    - Document all attempts in Notes
- ☐ Complete 'Drop In' Visit to Clients Residence
  - Document in Notes

Enrollment

- ☐ Run ePACES to ensure Member is active with Medicaid
- ☐ Attend Initial Appointment
- ☐ If Client Does Not have Medical Documentation confirming Qualifying Conditions:
    - Obtain General VFI Consent Forms
        - Upload Consent to Chart
    - Fax General VFI Consent Forms to Provider to obtain Medical Documents
    - Obtain Medical Documents from Provider
        - Upload Medical Documentation to Chart
    - Schedule an Enrollment Appointment with Member
        - Document everything in Notes/Chart
    - Follow Enrollment Steps Below:
- ☐ If Client had Medical Documentation confirming Qualifying Conditions
    - Obtain Medical Documentation with Qualifying Conditions
        - Upload to Chart
    - Complete Eligibility Screening
    - Complete Demographic/Profile Page
    - Complete Problems List to reflect findings of Medical Documentation/Eligibility Screening
    - Complete DOH5055 Consent with all Providers
        - Upload to Chart
    - Complete DOH5234 (NOD)
        - Upload copy to chart
        - Provide a copy to member
    - Complete 'Rights and Responsibilities' Form
        - Upload to Chart
        - Provide a copy to member
    - Complete HealtheLink/RHIO Consent
        - Upload to Chart
    - Document Health Home Consent in chart (HHUNY/GRHHN)
    - Document Data Sharing Consent in chart (HHUNY/GRHHN)
    - Add Provider to Care Team Tab
        - Input Consents for ALL Providers listed on DOH5055 (HHUNY/GRHHN)
    - Add Social Supports
    - Create Initial POC (GRHHN)
    - Send Introductory Health Home Letters to Provider
        - Request Care Team Input needed for Comprehensive Assessment, Plan of Care & Case Review
        - Upload Letter into Chart
        - Document in Notes
    - Create an 'Enrollment Note' in Chart
        - Document the following:
            - Client agreement to receive HH Services
            - Documents Reviewed/Signed

        - Assessments Started/Completed
        - Summary of Eligibility Criteria Met
        - Key People involved in Care
        - Client's Current Providers
        - Summary of Care Management Needs
        - Identified Linkages to Services Needed
        - Initial POC Development (GRHHN Only)
        - Follow Up Plan
    - Send an 'Enrollment E-Mail' to Supervisors & HH Clerk Outlining Enrollment

Initial Assessments

(Comprehensive & Crisis)

- ☐ Complete Comprehensive Assessment within 30 days of Enrollment
  - Complete Face to Face
  - No Blanks left on Comprehensive Assessment
  - Obtain input from Providers
  - Upload to chart
- ☐ Complete Crisis Plan within 30 days of Enrollment
  - Provide a Copy to Member
  - If paper copy is completed:
    - Complete in Chart
    - Upload to Chart
- ☐ Complete Note Documenting completion of Assessments
  - Include the following:
    - What assessment was completed
    - Names/Roles of participants
    - Description of client participation
    - Status of Completion of Assessment
    - Summary of Findings relevant to Care Management Work
    - Plan of Care Development
    - Follow Up Plan

Case Review

- ☐ Complete Case Review within 60 Days of Enrollment
- ☐ Schedule a Case Review appointment with Provider
- ☐ Fax Provider Input/Attendance Request & Case Review Packet to Provider
    - Document attempts to contact provider/set up Case Review in note
    - If input/documentation received:
        - Upload to chart
        - Create note outlining input from Provider
        - Review provider input during Case Review
- ☐ Make Updates to POC based on Member/Care Team input
    - Obtain Signature on POC
- ☐ Document completion of Case Review in Notes
    - Include the following:
        - Names/Roles of participants
        - Care Team Input received
        - Description of client participation
        - Updates to POC/ New Plan of Care Development
        - Follow Up Plan

Plan of Care

- ☐ Complete POC within 60 days of Enrollment (POC Development should be started with Client during Comprehensive Assessment)
    - Include the following:
        - Provider Team Input
        - Person Centered Goal Statement
        - Strengths & Barriers
        - Active/Monitoring Problems
        - Adherence Section for Preventive Screenings
- ☐ Review POC with Client
    - Review individually each Goal and Intervention
- ☐ Obtain POC Signature from Client
    - Upload to Chart (If Completed on Paper)
- ☐ Provide Signed POC to Client
- ☐ Provide Signed POC to Care Team
- ☐ Document Completion of POC
    - Include the following:
        - POC Development
        - Client Participation in Development
        - Changes/Additions/Deletions

Hallmark Events/Transitions of Care

- ☐ Receive Notification of following 'Hallmark Events':
  - Admission to following Settings:
    - Emergency Department
    - Inpatient Hospital
    - Residential Facility
    - Rehabilitation Setting
- ☐ Follow up with member within 2 Business Days
  - Document in Notes
  - Document in 'Hallmark Events' Tab (HHUNY/GRHHN)
- ☐ Communicate with Care Team regarding members admission
- ☐ Participate in Discharge Process
  - Communicate with Social Workers/Family Members/PCA Providers
  - Document (attempted) participation in Notes
- ☐ Communicate with member regarding Discharge Summary/Discharge Plans
- ☐ Update following Documents if necessary
  - Comprehensive Assessment
  - Plan of Care
  - Crisis Plan
- ☐ Upload Hospitalization Paperwork to Chart
- ☐ Follow Up with Member after discharge
  - Assist in setting up follow up appointments

Discharge

- ☐ Complete the following forms:
  - DOH5059 (Outreach Only)
  - DOH5058
    - Obtain Signature from Client
    - Provide a copy to client
    - Upload copy into Chart
  - DOH5235
    - 10 Days Notice
    - Provide a copy to client
    - Upload copy into Chart
  - Discharge Packet
    - Identify Discharge Plan/Transition Plan
    - Update Crisis Plan
      - Provide copy to client
      - Upload copy into Chart
- ☐ Inform Care Team of Discharge from Health Home Program
  - Document in Chart
- ☐ Complete 'Discharge' within the NetSmart System
- ☐ Send an E-Mail to Supervisors & HH Clerk Outlining the Disenrollment

Ongoing Workflow

- ☐ Member Contact
    - Care Manager to follow up on the following:
        - Health Updates
        - Medical Health Change in Conditions
        - Behavioral Health Change in Conditions
        - Appointment Attendance
        - Appointment Outcomes
        - Medication Changes/Updates
        - Medication Adherence
        - ED Visits
        - Hospital Inpatient Stays
        - Quality Metrics/Preventative Screenings Addressed
        - Crisis Intervention
        - Domestic Violence
        - Client Thought Content
            - Suicidal Ideation
            - Suicidal Intent
            - Hallucinations
            - Delusions
            - Homicidal Ideation
            - Homicidal Intent
            - Safety In Home
                - Update Crisis Plan if necessary
        - Use/Need for increased Services
        - Medical
        - Mental Health
        - Substance Abuse
        - Social Support
        - Housing
        - Improvement/Decline of Health
        - Transportation Scheduling
        - Housing
        - Finances
        - Legal Concerns
        - Status of Referrals/Applications
        - Check in on referral/application status if unknown
        - Check in on referral/application status, if taking longer than desired/usual
        - Daily Client Patterns/Habits
        - Care Plan Additions/Deletions/Modifications
- ☐ Provider Contact (Bi-Monthly)
    - Care Manager to follow up on:
        - Health Updates
            - Medical Health Change in Conditions
            - Behavioral Health Change in Conditions
            - Appointment Attendance

        - Appointment Outcomes
        - Medication Changes/Updates
        - Medication Adherence
        - ED Visits
        - Hospital Inpatient Stays
        - Quality Metrics/Preventative Screenings Addressed
    - Crisis Intervention
    - Use/Need for increased Services
        - Medical
        - Mental Health
        - Substance Abuse
        - Social Support
        - Housing
    - Improvement/Decline of Health
    - Status of Referrals/Applications
        - Check in on referral/application status if unknown
        - Check in on referral/application status, if taking longer than desired/usual
    - Care Plan Additions/Deletions/Modifications

Continuous Chart Updates/Monitoring

- ☐ Change Problems to Active/Monitoring/Inactive based on client input
    - Update Eligibility Screening as necessary
- ☐ Refer all problems to Provider(s) & New Providers
- ☐ Include all providers in Profile Tab/Care Team Tab
- ☐ Update DOH5055 as necessary
    - Add all members on DOH5055 to Care Team/Consent Tabs in System
- ☐ Update Crisis Plan as necessary

Notes Must Document ALL Communication/Attempted Communication with Member/Provider/Social Support or Other Care Team Member