Attachment A

Initiating Health Home Services: Care Manager Checklist

The checklist below is designed to assist Care Managers in ensuring the necessary actions items are completed to initiate a smooth transition into Health Home services for the individuals they serve. The purpose of completing these tasks is to educate enrollees and their families on Health Home services and to understand the current service needs of the enrollee and their family. The following activities are essential to the successful delivery of Health Home core services and will confirm continuity of care and identify additional areas for needed services.

These tasks must be completed in partnership with the Health Home enrollee and his/her designated representative, in either a face-to-face meeting or telephone conversation, and must occur between April 1, 2018 and July 31, 2018. Enrollment in the CCO/HH is effective: (enter date)

Step One: Information Gathering

Upon enrollment into the Care Coordination Organization/Health Home (CCO/HH), the Care Manager must complete the following steps for everyone on their case load:

☐ Obtain the enrollee's current Individualized Service Plan (ISP). This plan will remain effective until the initial comprehensive person-centered planning meeting is held to establish the enrollee's Life Plan.

☐ Obtain available OPWDD assessment information, including the DDP2 and CAS summaries, from the OPWDD IT system (Choices)

☐ Confirm and identify the members of the Interdisciplinary Team (IDT), in which the primary I/DD providers (i.e. residential, day, and community habilitation providers) are mandatory members.

☐ Confirm and identify all Providers responsible for providing care to the enrollee. These providers will include but are not limited to medical, behavioral health, specialists, I/DD services, Long Term Services and Supports, and social and community services.

☐ Schedule the date, time and location of the Life Plan review meeting and the IDT members who will be participating.

Date of Person-Centered-Planning Meeting: Click or tap to enter a date.

Step Two: Care Coordination Organizations/Health Homes (CCO/HHs) are required to provide the following six Health Home Core Services. The tasks referenced below are examples of core service activities that must be reviewed during the initial transition period to CCO/HH. Care Managers will be responsible for educating and identifying areas of service need for enrollees and their families.

Comprehensive Care Management

☐ Inform enrollee and their family of the care manager's responsibility to create, document, execute and update the individualized, person-centered plan of care.

☐ Identify enrollee's current service needs, providers, supports, goals, and engagement activities.

Care Coordination and Health Promotion

☐ Educate enrollee and their family on engagement and decision-making to promote independent living, as well as education on wellness promotion and prevention programs

☐ Coordinate and arrange for the provision of current and additional needed services and ensure treatment adherence.

Comprehensive Transitional Care (note: CCO/HH services may be billed to eMedNY within 30 days of discharge from a hospital or institutional setting.)

☐ Notify enrollee and their family of the established networks with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings.

☐ Is the enrollee currently residing in a health facility? (i.e. hospital or residential/rehabilitation setting?

☐ Yes ☐ No

If yes, are the appropriate procedures currently in place to ensure timely access to follow-up care post discharge? ☐ Yes ☐ No

Enrollee and Family Support

☐ Educate enrollee and their family on support and self-help resources to increase knowledge, engagement, self-management and to improve adherence to prescribed treatment.

Currently, does the enrollee and family require additional education and support services?

☐ Yes ☐ No

Referral to Community and Social Supports

☐ Advise enrollee and their family of available community-based resources and explain the care manager's role in managing appropriate referrals, access, engagement, follow-up and coordination.

Currently, does enrollee require additional community-based resource support?

☐ Yes ☐ No

Use of Health Information Technology (HIT) to Link Services

☐ Inform enrollee and their family of the purpose and utilization of HIT.

☐ Has the enrollee signed a consent to share personal information? ☐ Yes ☐ No

X _____

Care Manager Signature & Date

X _____

Individual/Family Signature & Date