New York State Medicaid Health Home Program Chart Review Tool

Health Home:	Date of Visit:
CMA:	Member ID #:

Section 1: Basic Member Information

1. Status of the member at the time of the review?
   Currently Enrolled ☐ [Enrollment Date: _____]

   Enrolled but lost to service ☐ [Last Contact Date: _____**]**

   Withdrawn, member withdrew consent ☐ [Date of DOH 5058: _____]

   Opt-Out, member chose not to enroll in services☐ [Date of DOH 5059: _____]

   Outreach ☐

   Disenrolled ☐ [Discharge Date: _____]
   Reason (please specify): _____

2. Initial eligibility criteria?
   Two Chronic Medical Conditions ☐ HIV/AIDS ☐ SMI ☐ SUD and Other ☐

   Please specify exact diagnosis: _____

   _____

   _____

3. Other pertinent criteria?
   HARP ☐ AOT ☐ ACT ☐ Health Home Plus ☐ Adult STIP ☐

4. Current member coverage?
   MCP ☐ _____ FFS ☐

5. How was the member referred to the Health Home?
   DOH Assigned ☐ Community Referral ☐ Legacy Conversion ☐ Unknown ☐

   Other (please specify) ☐: _____

   _____

   _____

Section 2: Outreach and Engagement

6. Was outreach conducted for this member?
   Yes ☐ No ☐ [SKIP TO SECTION 3]

7. Was outreach progressive (based on Medicaid update)?
   Yes ☐

No ☐ (Please Explain): _____

_____

_____

8. Did outreach lead to enrollment?
   Yes ☐ No ☐
   a. During which outreach cycle was the member enrolled?

First Cycle ☐		Second Cycle ☐
At which time point during this cycle was this member enrolled? Within 30 days ☐ Within 60 days ☐ Within 90 days ☐	**OR**	At which time point during this cycle was this member enrolled? Within 30 days ☐ Within 60 days ☐ Within 90 days ☐
Additional comments regarding outreach:		

Section 3: Required Forms and Documents

9. Patient Information Consent (DOH 5055) in file?
   Yes ☐ No ☐
   a. DOH 5055 signed and dated by the member?
      Yes ☐ [Date of **initial** consent: _____]
      No ☐ (Please Explain): _____

      _____

      _____

   b. DOH 5055 (page 3) lists all individuals and/or entities with which PHI information sharing is evident (*i.e.* specific providers, Care team, family members, *etc.*), with the member's signature or initials approving each one?
      Yes ☐
      No ☐ (Please Explain): _____

      _____

      _____

   c. If DOH 5055 was updated, did the member sign and date the update?
      Yes ☐ [Date of **most recent** update: _____]
      No ☐ (Please Explain): _____

      _____

      _____

      N/A ☐

d. Is there any evidence of a PHI or confidentiality breach (*i.e.* is there evidence that information was shared to a provider or family member not listed in the 5055 or in any other form of written consent)?

Yes ☐ (Please Explain): _____

_____

_____

No ☐

10. Completion date of **initial** comprehensive assessment: _____

a. How long after enrollment was the comprehensive assessment completed for this member?

1-30 days ☐ 31-90 days ☐ Greater than 90 days ☐ Not completed ☐

Additional comments : _____

_____

_____

b. Initial comprehensive assessment includes medical, mental health, substance use disorder, HIV/AIDS, and social service needs?

Yes ☐

No ☐ (Please Explain): _____

_____

_____

11. Completion date of **most recent** comprehensive reassessment: _____

a. Is the most recent comprehensive assessment greater than 12 months?

Yes ☐ No ☐

b. Comprehensive reassessment includes medical, mental health, substance use disorder, HIV/AIDS, and social service needs?

Yes ☐

No ☐ (Please Explain): _____

_____

_____

12. Are the following elements identified as part of the comprehensive assessment?

Language Preferences	Yes ☐	No ☐
Literacy	Yes ☐	No ☐
Cultural Preferences	Yes ☐	No ☐

Section 4: Plan of Care

13. Barriers to care identified? (Assessment of barriers [denial of disease, unwilling to engage in treatment, cognitive impairments, lack of social supports, cultural or linguistic barriers])
    Yes ☐ No ☐ N/A ☐

14. Barriers to care addressed and acted upon as needed?
    Yes ☐ No ☐ N/A ☐

15. Evidence of advance directives being explained to the member?
    Yes ☐ No ☐ N/A ☐

16. [FOR HARP MEMBERS ONLY] Was an HCBS Eligibility Assessment completed?
    Yes ☐ [Completion Date: _____]
    No ☐ (Please Explain):
    _____
    _____
    _____

17. [FOR HARP MEMBERS ONLY] If found eligible for HCBS, was the Community Mental Health Assessment completed?
    Yes ☐ [Completion Date: _____]
    No ☐ (Please Explain):
    _____
    _____
    _____

18. What services were identified as being needed by the member? [SELECT ALL THAT APPLY]

Medical		How were service needs identified? [MARK ALL THAT APPLY]				Incorporated in care plan?		
		In assessment	By care manager (outside assessment)	Member Requested	Other (Please Specify)	Goals?	Timeframes?	Interventions?
		Date:	Date:	Date:	Date:			
Primary Care Services	☐	☐	☐	☐	☐	☐	☐	☐
Home Care Services (e.*g.* home aid, nurse, *etc*.)	☐	☐	☐	☐	☐	☐	☐	☐
Physical Rehabilitation Services	☐	☐	☐	☐	☐	☐	☐	☐
SUD Services	☐	☐	☐	☐	☐	☐	☐	☐
MH Services	☐	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS Services	☐	☐	☐	☐	☐	☐	☐	☐
Social		In assessment	By care manager (outside assessment)	Member Requested	Other (Please Specify)	Goals?	Timeframes?	Interventions?
		Date:	Date:	Date:	Date:			
Housing	☐	☐	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐	☐	☐
Food	☐	☐	☐	☐	☐	☐	☐	☐
Financial	☐	☐	☐	☐	☐	☐	☐	☐

Other (Please Specify):	☐	☐	☐	☐	☐	☐	☐	☐
HARP		In assessment Date:	By care manager (outside assessment) Date:	Member Requested Date:	Other (Please Specify) Date:	Goals?	Timeframes?	Interventions?
HCBS	☐	☐	☐	☐	☐	☐	☐	☐
Other		In assessment Date:	By care manager Date:	Member Requested Date:	Other (Please Specify) Date:	Goals?	Timeframes?	Interventions?
Evidence based wellness and prevention services (*e.g.* smoking cessation, diabetes, asthma, and hypertension)	☐	☐	☐	☐	☐	☐	☐	☐
All specialists pertinent to the member clearly listed in the plan of care (*e.g.* podiatry, *etc.*)	☐	☐	☐	☐	☐	☐	☐	☐

19. Is there evidence in care plan the individual is receiving or in the process of receiving all identified services (in Question 18)?
    Yes ☐[SKIP to 20] No ☐

a. **IF NO**, is there evidence that the CM acknowledged and has attempted to address need, regardless of if the client decided to engage in services?
    Yes ☐ No ☐

Please indicate below what identified need(s) (from question 18) is **NOT** being addressed and provide a brief explanation as to how you came to this conclusion. **[ALL SECTIONS LEFT BLANK WILL BE COUNTED AS BEING ADDRESSED OR NOT APPLICABLE].**

Medical		Please explain
b. Primary Care Services	☐	
c. Home Care Services (*e.g.* home aid, nurse, *etc*.)	☐	
d. Physical Rehabilitation Services	☐	
e. SUD Services	☐	
f. MH Services	☐	
g. HIV/AIDS Services	☐	
h. Social		Please explain
Housing	☐	
Transportation	☐	

Food	☐	
Financial	☐	
Other (Please Specify):	☐	
i. HARP		Please explain *(e.g., CMA awaiting LOSD from MCO, referral to HCBS made and member awaiting intake, HCBS intake completed but awaiting authorization from MCO, etc.).*
HCBS (specify):	☐	
Other		Please explain
j. Evidence based wellness and prevention services (*e.g.* smoking cessation, diabetes, asthma, and hypertension)	☐	
k. Specialists (*e.g.* podiatry, *etc.*)	☐	
l. Language Preferences	☐	

m. Literacy	☐	
n. Cultural Preferences	☐	

20. Is there evidence that the care plan is being updated as needed (*e.g.* if goals are either added, achieved or discontinued are those changes being reflected in the plan of care)?
    Yes ☐
    No ☐ (Please Explain): _____

21. If a member identified family/caregiver involvement, have member preferences been acted upon? (*E.g.* member wants updates to mother, is there evidence in the chart to support the mother receiving updates?)
    Yes ☐ No ☐ N/A ☐

22. Evidence that individual plays central/active role in the development of care plan (*i.e.* would you consider the services provided by the CM as person-centered)?
    Yes ☐
    No ☐ (Please Explain): _____

Section 5: Ongoing/Reassessment and Transition of Care

23. Evidence of coordination/collaboration with care team members?
    Yes ☐
    No ☐ (Please Explain): _____

    a. Evidence of care team meetings occurring?
       Yes ☐
       No ☐ (Please Explain): _____

       N/A ☐

24. Did the member experience an ER visit, inpatient stay, and/or incarceration since being enrolled in the Health Home?
    Yes ☐ No ☐ [SKIP to 25] N/A ☐ [SKIP to 25]

    a. If Yes, was there evidence that the HH CM: [SELECT ALL THAT APPLY]

Date of ER/ Inpatient stay/ Incarceration	CM First Contact Date	CM participated in discharge plan	Discharge date	Date of CM follow-up post discharge	Discharge plan adherence	Readmission within 30 days of discharge (Indicate Date)	Care Plan Updated
		☐			☐	☐	☐
		☐			☐	☐	☐
		☐			☐	☐	☐
		☐			☐	☐	☐
		☐			☐	☐	☐

25. Documentation of transfer from CMA to CMA or HH to HH?
    Yes ☐ No ☐ N/A ☐

26. Evidence of discharge plan from Health Home program including referrals to services or programs with appropriate follow-up to confirm the plan is being implemented
    Yes ☐ No ☐ N/A ☐

    a. If member was lost to service discharge, is there evidence that a discharge summary was created?
       Yes ☐ No ☐

       i. **<u>If YES</u>**:

          1. Was the summary shared or communicated to the care team members?
             Yes ☐ No ☐
          2. Did the CM forward discharge notice to the member?
             Yes ☐ No ☐

<u>Section 6: Interaction with Managed Care</u>

27. Evidence that the CM utilizes the Managed Care Plan's provider network when referring the member to medically necessary services?
    Yes ☐ No ☐ N/A ☐

28. Evidence that the CM actively collaborates with the managed care plan as needed for coordinating care (*i.e.* is there evidence that CM consulted with the MCP for referrals made out-of-network? For HARP members, did CM obtain a LOSD for BH HCBS referrals? *etc.*)
    Yes ☐ [Please specify type of contact: _____]

No ☐ (Please Explain): _____

_____

_____

N/A ☐

29. Was the MCP utilized to support outreach?

Yes ☐ (Please Explain): _____

_____

_____

No ☐ (Please Explain): _____

_____

_____

N/A ☐

Member ID #: _____

Overall Findings

Reviewer signature: _____

Reviewer print name: _____

Reviewer agency: _____