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TO: Assertive Community Treatment (ACT) Teams

FROM: Nicole Haggerty, Director of Bureau of Rehabilitation Services and Care Coordination

SUBJECT: Discharge Workflow for ACT Recipients Enrolled in HARP

DATE: July 2016

With the October 2015 implementation of Behavioral Health Home and Community Based Services (BH HCBS) in NYC and start up for the rest of New York State October 2016, ACT teams now have greater ability to effect safe and supportive discharges from the ACT program through the availability of new services for those enrolled in a Health and Recovery Plan (HARP). While in many regions of NYS, ACT teams have served as the only mobile-outreach service model, BH HCBS bring alternative options to HARP beneficiaries wanting access to community based or mobile rehabilitation and treatment. This memo is intended to provide ACT teams a model workflow for enacting a planned discharge from ACT inclusive of BH HCBS.

All HARP beneficiaries must receive an HCBS Eligibility Assessment[1] upon enrollment in the HARP and annually thereafter. If an individual is receiving ACT services while enrolled in a HARP, the ACT team will assume responsibility for the HCBS Eligibility Assessment process for as long as the individual is receiving ACT services, irrespective of an individual's Health Home enrollment status.

ACT teams must access Uniform Assessment System (UAS) through the Health Commerce System (HCS) System:
ACT teams, in the role of Health Home Care Manager (HHCM), must ensure that all staff who will be required to conduct the New York State Community Mental Health Assessment (CMHA), HCBS Eligibility Assessment, or view the assessment outcomes, have access to the UAS environment through the HCS. This requires that staff have their own HCS user account with Trust Level 3 assurance and are assigned an appropriate user role. All staff who will conduct the assessment must complete the required "Understanding the Community Mental Health Assessment" course. This is an online, self-paced course that will take a user between 10 and 12 hours to complete. Additional training specific to administering the Eligibility Assessment is available to assessors who have already completed the "Understanding the Community Mental Health Assessment" course. As a first step, ACT teams should contact their HCS Coordinator within their respective agency to establish HCS user accounts.

[1] The HCBS Eligibility Assessment is a subset of the NYS Community Mental Health Assessment (CMHA).

Warm Hand-Off From ACT to Health Home (HH) Care Management:

ACT Teams are responsible for comprehensive discharge planning for individuals receiving ACT services. At the point that ACT providers are actively planning for an individual's discharge from ACT, the ACT Team will conduct an HCBS Eligibility Assessment to determine whether the individual will be eligible for BH HCBS post-discharge from ACT, and for which tier of BH HCBS the individual may qualify.

The ACT Team will initiate a referral to a Health Home for ongoing care management. If the individual is already enrolled in a Health Home, the ACT Team should work with that HH to refer to a Care Management Agency (CMA) within the individual's HH network. If the individual is not already enrolled in a HH, the ACT Team should contact the MCO to determine which HH's are in network. The MCO and in-network HH should then assist in referring the individual to a downstream CMA. Both the HCBS Eligibility Assessment and ACT Child and Adult Integrated Reporting System (CAIRS) discharge summary will be forwarded to the Health Home Care Manager (HHCM) to begin the process of a "warm hand-off."

Collaborative Discharge Planning:

ACT providers will engage in standard discharge planning processes, ensuring that individuals have access to necessary medical and behavioral health services via referrals, screenings, communication with Managed Care Organizations, and providing ongoing transition support for members. As services and supports are secured, ACT providers will ensure that the HHCM is involved in and informed of all referrals as they are secured for follow-up care.

Access to BH HCBS:

Concurrently, the ACT Team will be responsible for working with the individual to identify appropriate BH HCBS components and will collaborate with the individual and Managed Care Organization to identify in-network providers, and formulate an integrated Proposed Plan of Care (POC) to submit to the Managed Care Organization for Level of Service Determination. Upon receipt of that Determination, the ACT Team will work with the individual to identify preferred in-network providers and initiate assessments for BH HCBS approved services. As those screenings are completed, the BH HCBS providers will obtain prior authorization for ongoing services. At this point, post-discharge services have been identified, and ACT will transfer primary responsibility for the individual's care management to the HHCM. The newly assigned HHCM will be responsible for completing the New York State Community Mental Health Assessment and finalizing the Plan of Care (POC) inclusive of BH HCBS services (if the individual is eligible and BH HCBS are recommended) for dissemination to all appropriate parties, with ongoing communication between ACT providers and HHCM. This process should follow the **Expedited Workflow for Adult Behavioral Health (BH) Home and Community Based Service (HCBS) Referrals and Plan of Care** (link to follow as established).

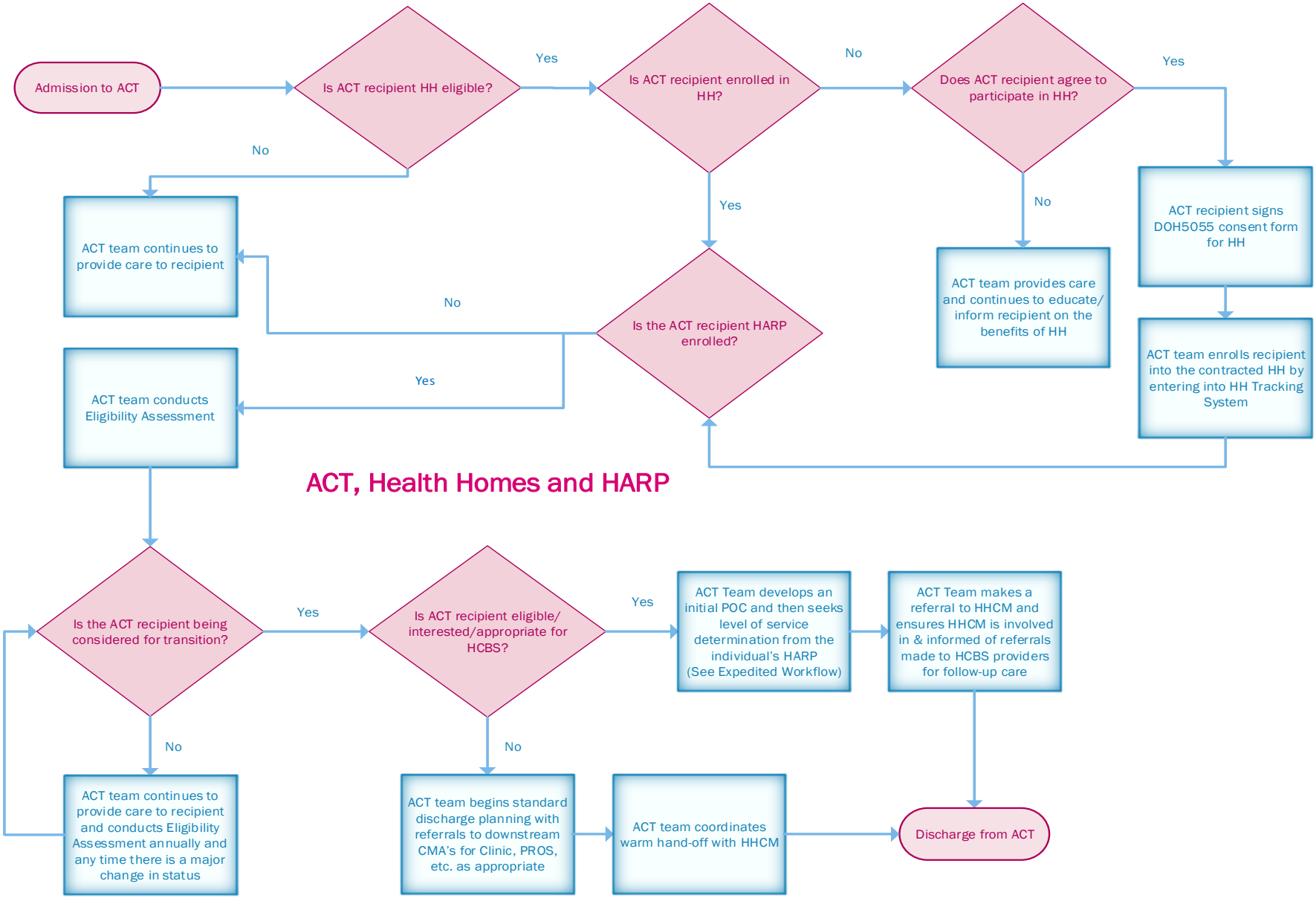
ACT Teams and HHCMs will share the responsibility for facilitating this workflow, and must clearly communicate and document which entity will take the lead at each step in the process. Service recipients should be involved at all decision points, and should be notified of all changes as they occur with opportunities for collaboration throughout the process.

Prior to discharge being finalized, ACT providers will take the lead in ensuring that all parties have been informed and understand the discharge plan, as well as the 90-day "follow-up period" that is part of the ACT model, wherein ACT services can be re-accessed if the individual requires a return to that level of care.

Upon full implementation of the DOH MAPP Health Home Tracking System (HHTS), individuals discharged from **ACT teams within a Health Home network will score as "high" under the new Health Home Care Management rates**. This is in effort to support these individuals in their transition from the more intensive ACT program to HHCM.

Please see the attached ACT in Health Homes graphic for additional support in transition planning.

Any questions related to the ACT program can be directed to Stacey Hale, Director of Care Coordination: Stacey.Hale@omh.ny.gov


Admission to ACT
Is ACT recipient HH eligible?
Yes
Is ACT recipient enrolled in HH?
No
Does ACT recipient agree to participate in HH?
Yes
No
Yes
No
ACT team continues to provide care to recipient
Is the ACT recipient HARP enrolled?
No
Yes
ACT team provides care and continues to educate/ inform recipient on the benefits of HH
ACT recipient signs DOH5055 consent form for HH
ACT team enrolls recipient into the contracted HH by entering into HH Tracking System
ACT team conducts Eligibility Assessment
ACT, Health Homes and HARP
Is the ACT recipient being considered for transition?
Yes
Is ACT recipient eligible/ interested/appropriate for HCBS?
Yes
ACT Team develops an initial POC and then seeks level of service determination from the individual's HARP (See Expedited Workflow)
ACT Team makes a referral to HHCM and ensures HHCM is involved in & informed of referrals made to HCBS providers for follow-up care
No
No
ACT team continues to provide care to recipient and conducts Eligibility Assessment annually and any time there is a major change in status
ACT team begins standard discharge planning with referrals to downstream CMA's for Clinic, PROS, etc. as appropriate
ACT team coordinates warm hand-off with HHCM
Discharge from ACT