

Policy Title: **Health Home Plan of Care Policy**

Policy number: HH0008

Effective date: August 1, 2019

Last revised:

Approved by:

Date:

Purpose: To establish standards and clear guidance regarding Health Home person-centered plans of care, which will inform NYS Health Home and Care Management Agency policies and procedures.

Policy

Health Homes serving adults and children will establish and maintain policies and procedures that are based on State policy, including how and when the Plan of Care (POC) is created, implemented, updated, and distributed for all consented Health Home members. In addition, Health Homes will have clear and focused POC training requirements and must maintain a quality assurance program to ensure compliance.

NOTE: For children who are under the age of 18 and cannot self-consent, wherever “the member” is stated for this document, it represents the member and their parent/guardian/legally authorized representative unless specifically noted otherwise.

Elements of a Health Home Plan of Care

The Health Home POC should be used as an active tool to guide day to day care management work, as well as to support the required collaboration with others listed in the POC (e.g., care team, MMCP) to monitor member progress towards goals. Changes in goals and preferences, interventions, and member needs should be documented in the POC.

The Health Home will ensure that an individualized, person-centered POC is created concurrently with the Health Home comprehensive assessment within 60 days of enrollment for all consented Health Home members, regardless of age. The Health Home care manager will be the single point of contact for the member's care coordination and will take full responsibility for the overall management of the member's POC.

The member (or their parent/guardian/legally authorized representative) must play a central and active role in the development and execution of their POC and must agree with the goals, interventions and time frames contained in the POC. The Health Home POC must contain goals and objectives that support the member's desire to address their qualifying diagnosis for Health Home; such as SMI, SED, SUD, HIV/AIDS or chronic conditions (for children HCBS needs) and other healthcare and social needs, as the member deems necessary. The POC must be written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency and should reflect the cultural considerations of the member. Person centered service planning guidelines may apply for some populations*.

For additional guidance on person centered service planning:

https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf

All plans of care must include the following:

- member’s strengths and preferences related to identified needs, goals and interventions;
- specific, measurable, and obtainable member-stated wellness and recovery goal(s), including,
 - target time frames for attaining goals;
 - strategies by which the desired goals will be achieved;
 - actions describing how the goals will be achieved; and
 - supports (both paid and unpaid) that are needed to achieve the individual’s desired goals;
- functional needs related to treatment, wellness and recovery goals (e.g. meal prep/needs assistance eating, etc.) as appropriate;
- barriers and strategies to overcome barriers related to achieving goals, including a description of planned care management interventions and time frames (e.g. Health Home Plus);

1 *Including 1915(c) Waivers, Mainstream Medicaid Managed Care Plans, HIV Special Needs Plans, Health and Recovery Plans, Partial Capitation Managed Long Term Care Plans, Fully Integrated Duals Advantage Plans, Program of All-inclusive Care for the Elderly Plans, the Medicaid benefits under Medicaid Advantage, and Medicaid Advantage Plus 2 Including, but not limited to: Community First Choice Option (CFCO), and for Clotting Factor when covered by managed care 3 Including, but not limited to: Children with Special Health Care needs 4 choices individuals have the information and support to make for themselves 5 42 CFR Part 441.540; 42 CFR Part 438.208; 1115 Demonstration; 42 CFR Part 441.301

- documentation of participation by all key providers (of the interdisciplinary team/care team) in the development and updating of the POC;
- outreach and engagement activities that will support engaging individuals in their care and promote continuity of care;
- the member’s signature documenting agreement with the POC (including a child who can self-consent or age-appropriate to participate, and/or their parent guardian, or legally authorized representative);

Use of Electronic Signatures: The practice of obtaining member signature via electronic means is acceptable as long as Health Homes and Care Management Agencies are in compliance with all applicable New York State and Federal laws. For more information refer to the following links:

<https://its.ny.gov/electronic-signatures-and-records-act-esra>;

<https://www.law.cornell.edu/uscode/text/15/chapter-96/subchapter-1>

For all children’s plans of care:

Children’s Health Home has 10 required elements of POC as outlined in the “*Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations*”

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

Subsequently, when working with the member and their family, the children's POC should reflect that the "*Health Home Comprehensive Assessment Policy*" appendix C: "*Required Components of the Health Home Comprehensive Assessment (Children)*" have been reviewed and obtained as part of the development of the POC.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

Additionally, there are specific HCBS POC requirements also as outlined below that will be required for all Health Home POC:

- emergency contact and disaster plan for fire, health, safety issues, natural disaster, or other public emergency;
- other service plans as appropriate, such as Early Intervention Individual Service Plan and foster care Family Assessment Services Plan, which should be reviewed by the care team and appropriate items incorporated as needed;
- for youth over age 14, goals developing a participant's capacity to live independently, and the identification of available resources; and
- transitioning youth – those that will be aging out and moving to adult services must include transitional goal and services; specifically:
 - As physically disabled participants reach their 17th birthday, the HH/II will begin to assist the enrollees in planning for transition to other services and/or programs
 - For Foster Care enrollees, eighteen months prior to reaching the enrolled child's 21st birthday, the HH/IE generates a Transition Plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for conducting the action steps.

Where information can be obtained and transferred from the Health Home comprehensive assessment, this information can be used to populate the person-centered POC. For example, the elements of the POC may be collected within different documentation gathered and stored in the electronic health record. The Health Home will provide direction to support CMAs in understanding the link of each document and how it fulfills the POC requirements.

The CANS-NY assessment tool does not meet comprehensive assessment requirements and will not be a substitute for a person-centered POC. Please review the CANS-NY reference guides on the Health Home website for additional guidance:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm

The member or their parent/guardian/legally authorized representative must sign and be provided a copy of their POC. Contingent upon the member's consent and upon request, the POC will be made available to:

- their family member(s) or other supports,
- care team members, and
- service providers

Contingent upon the member's consent, the POC will be distributed to:

- HCBS providers (children)
- BH HCBS providers (adults)

- Health and Recovery Plans (HARPs), when applicable
- HIV Special Needs Plans (HIV/SNPs), when applicable
- Medicaid Managed Care Plans, when the POC includes services requiring service authorization, e.g. children's HCBS

NOTE: For Health Homes serving children, under Section 2 on the **DOH-5201 Consent Form: Health Home Consent Information Sharing For Use with Children and Adolescents Under 18 years of Age**, there are special implications for the comprehensive assessment and POC. If a minor/adolescent is between 10 and 18 years of age and has elected to not share health information with a parent, guardian, or legally authorized representative (as indicated in Section 2 of DOH-5201), the care manager must complete a separate section/page of the POC with only the minor/adolescent and not with the parent, guardian, or legally authorized representative present. The care manager will only obtain the minor/adolescent's signature for this section/page of the POC. This separate section/page of the POC should not be given to the parent, guardian, or legally authorized representative. If the child has elected to share health information with a parent, guardian, or legally authorized representative (as indicated in Section 2 of DOH-5201), the care manager would not need to fill out a separate section/page of the POC. The POC would be signed by the minor/adolescent **and** the parent, guardian, or legally authorized representative. Minors/adolescents who are in the exception categories (minor/adolescent who is pregnant, parent, married or 18 years and older) are able to self-consent into health homes, and therefore would be allowed to sign their POC.

BH HCBS Plan of Care and Federal Assurances (HARP Adults Only)

For adults enrolled in a Health and Recovery Plan (HARP) or HIV Special Needs Plan (HIV SNP and HARP-eligible) for found eligible and being referred to adult Behavioral Health Home and Community Based Services (BH HCBS), the POC must be shared with the HARP. There are additional requirements regarding how the person-centered planning process is documented and incorporated into the Health Home POC. This is necessary for compliance with the CMS Final Rule (79 FR 2947). These requirements can be found on the Documentation Requirements checklist found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_fed_rules_regs.pdf

For more information regarding the development of an adult BH HCBS POC, please see *Adult BH HCBS Workflow Guidance*: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/workflow_guidance.htm

HCBS Plan of Care (Children Only)

For children who are found eligible for HCBS, care management of the member's POC will be by the Health Home or the Independent Entity Children and Youth Evaluation Services (C-YES) for members that opt-out of Health Home. HCBS eligible children do not need to prove Health Home eligibility and appropriateness separately.

For children who are determined HCBS eligible and were not previously enrolled in Health Home to have had a comprehensive POC, the Health Home care manager will initiate a preliminary POC with HCBS to meet the HCBS 30-day timeframe. Then ensuring that a completed person-centered Health Home POC is finalized with the member within the Health Home standard of 60-days from Health Home enrollment.

Home and Community Based Services that are identified will only be referred to designated HCBS providers, who will determine frequency, scope and duration for each individual HCBS. The Health Home care manager will ensure that frequency, scope and duration of each HCBS is outlined in the POC.

Frequency

Health Homes will ensure that the POC is reviewed and updated as necessary, more frequently as warranted by a significant change in the member's medical and/or behavioral health or social needs. At a minimum, the children's POC must be reviewed and updated, if necessary every six months concurrently with a CANS-NY assessment. The POC for adults must be updated at least annually; however, updating concurrently with the HML assessment is best practice.

If the member experiences a significant change in medical and/or behavioral health or social needs, the care manager must evaluate the member's current status including rescreening for risk factors as discussed in the *Health Home Comprehensive Assessment* policy. For children only, the CANS-NY must also be updated by choosing the assessment type of "CANS-NY prior to six months" when there is a significant life change.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

The member's agreement with the POC and updates made should be indicated in the POC.

Training

Health Homes must have policies and procedures related to training for staff on person-centered care planning, and how to reflect that in a POC.

Quality Management Program

Health Homes must have a person-centered POC quality assurance process in place to comport with Health Home policies and procedures as outlined in the *Health Home Quality Management Program* policy.

Use of Health Information Technology (HIT)

Health Home must have a structured, interoperable health information technology (HIT) system, policies, procedures, and practices to support the creation, documentation,

execution, and ongoing management of a POC for every member. The Health Home will use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the member's health information and POC to be accessible to care team.

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