Children's Health Home of Upstate New York

Policy/Procedure: Plan of Care
Reviewed and Accepted by: CHHUNY Clinical Quality Committee
Approved by: CHHUNY Board of Directors
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Policy:

The Health Home person-centered plan of care (POC) provides the mechanism by which a member's comprehensive needs, goals, preferences, services and supports are documented and shared to facilitate coordinated care, inclusive of Home and Community Based Services (HCBS) should the member be found eligible. CHHUNY 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. 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 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.

NOTE: For children who are under the age of 18-years-old 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.

Procedures:

The initial Plan of Care is to be completed within 60 days from the enrollment date for Health Home members.

- Extenuating circumstances that may impact meeting this timeframe must be documented. Examples of extenuating circumstances include delay in discharge from a hospital, skilled nursing facility, or SUD rehabilitation. Poor engagement or difficulty reaching a member are not extenuating circumstances that would substantiate core service delivery. Health Home care managers must document core service delivery for billing to continue.

The Plan of Care is to be reviewed and updated as necessary but at a minimum of every six (6) months concurrently with a CANS-NY assessment, to monitor and evaluate progress and ongoing needs. 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 by utilizing a Comprehensive Assessment Update form and the CANS-NY Prior to Six Months when there is a significant life change and update the POC accordingly.

A. Documentation Standards

1. The Plan of Care must be written:
    a. In a manner that addresses reading and comprehension levels and is understandable to the youth/parent/legal guardian.
    b. In the child/youth and family's primary language or translated to the child/youth and family's primary language through translation services and/or the care manager.
    c. To reflect what is important and of priority to the child/youth and family. Goal statements, objectives, and interventions should be collaboratively created with the child/youth and family.
2. The Health Home POC must contain goals and objectives pertaining to a member's qualifying diagnosis such as SED, Complex Trauma, HIV/AIDS or chronic conditions; as the member deems necessary
3. The Plan of Care must be reviewed and signed each time it is updated by the youth and parent/legal guardian
    a. If the youth is unable or unwilling to sign, please document details in a note.
4. The Plan of Care must contain the following elements:
    - medical, behavioral health, developmental, educational, vocational, rehabilitative services, long term care, and social service needs, as applicable, determined through the comprehensive assessment, CANS-NY (children only) and member choice;
    - specific, measurable, and obtainable member-stated goal(s), including
        - preferences, and strengths related to treatment,
        - wellness and recovery, along with time frames;
        - 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 outcomes;
    - functional needs related to treatment, wellness and recovery goals;
    - barriers and strategies to overcome barriers related to achieving goals; • family members, community and natural supports involved in the individual's care and execution of the POC;
    - emergency contact and disaster plan for fire, health, safety issues, natural disaster, other public emergency (children's);
        - The Emergency Planning and Safety & Crisis Plan in Netsmart meet this standard even though they are not part of the electronic POC template and should be shared with the POC if necessary. They also need to be reviewed/updated every six (6) months when the Plan of Care is reviewed/updated.
    - documentation of participation by all key providers (of the interdisciplinary team/care team) in the development and updating of the POC;

- other POCs 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;
- outreach and engagement activities that will support engaging individuals in their care and promote continuity of care;
- 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. It must reflect the cultural considerations of the member;
- the member (or their parent/guardian/legally authorized representative) plays a central and active role in the development and execution of their POC and should agree with the goals, interventions and time frames contained in the POC;
- the member's signature documenting agreement with the POC (including a child who can self-consent, and/or their parent guardian, or legally authorized representative);
- for HCBS eligible members, HCBS identified services that outline frequency, scope and duration assessed, determined and supplied from the HCBS providers to the Health Home care manager must be outlined;
- for youth over age 14, the POC must include 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;
    - As physically disabled participants reach their 17th birthday, the HHCM 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 HHCM generates a transition plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for the conducting the action steps

B. Interdisciplinary Care Team

1. The Care Manager is responsible for developing an Interdisciplinary Care Team that includes:
    a. The child/youth and family
    b. Treatment/Care and service providers including primary care providers, specialists, behavioral health providers, community networks, and HCBS providers if applicable
    c. Individuals that are identified by the child/youth and family as important, e.g. other family members, peers, and natural supports.
2. With documented consents, the Plan of Care, including progress updates, should be shared with all relevant members of the Interdisciplinary Care Team upon request.
    a. Care Managers are required to share the Plan of Care with the child/youth and parent/legal guardian each time it is updated and any time it is requested by the child/youth or family. Care Managers should work with the child/youth to determine the preferred way to receive the Plan of Care.
        i. If a minor/adolescent is between 12 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 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.

b. CMAs can share a Plan of Care through a secure electronic messaging platform if a provider on the interdisciplinary team chooses to receive the Plan of Care that way or the Plan of Care can be printed and distributed to team members. Care Managers will inform the child/youth, parent/legal guardian and interdisciplinary team members of these options
c. The HCBS Plan of Care must be shared with HCBS Providers and MCOs. Please refer to the HCBS Eligibility & Plan of Care Process policy for further detail.

3. Interdisciplinary Team Meetings
    a. Interdisciplinary Team Meeting must occur as follows:
        i. During completion of the initial CANS-NY and Comprehensive Assessment process and during subsequent CANS-NY/Comprehensive Reassessments to develop updated Plans of Care
            1. These meetings can occur individually with team members as long as information is shared regarding the entire Plan of Care (as allowed by consent), with the expectation that at least one in-person Interdisciplinary Team meeting is held annually.
        ii. At the request of the Health Home Care Manager, the child/youth, parent, and/or medical consenter (including LDSS), based upon new information from another provider (e.g., primary care physician)
    b. Interdisciplinary Team Meetings – Planning
        i. A team meeting must be family driven, youth guided, scheduled to accommodate the child/youth and family and/or medical consenter attendance.
        ii. Every possible effort should be made by the Health Home Care Manager to have the family/medical consenter for the child/youth attend the team meeting.
        iii. The family/medical consenter for the child/youth should be an active member of the Interdisciplinary Team and contributor to the Plan of Care.
        iv. The Plan of Care should not be completed, nor other decisions made without the input of the family/medical consenter for the child/youth.

    Note: The Health Home Interdisciplinary Team Meeting can be held in conjunction with other required meetings in various systems, as long as the appropriate attendees are invited, and the meeting purpose and outcome is documented.

    c. Interdisciplinary Team Meetings – Attendance
        i. The Health Home Care Manager must invite:
            1. Family/medical consenter for the child/youth
            2. The child/youth (if age appropriate)
            3. Service providers for the child/youth, including medical providers and those from other child serving systems (e.g., education)
        ii. Other recommended invitees:
            1. Family members and other caregivers
            2. Representative of LDSS or DJJOY, or its designee for children in foster care
            3. Anyone the child/youth or family/medical consenter wishes to have participate.

Note: If an invitee from the recommended list cannot attend, then a phone conference or a summary report can be given, to ensure everyone's information and input is gathered.

HCBS Plan of Care

For children who are determined HCBS eligible, their POC must be completed no later than 30 days of HCBS/LOC Eligibility Determination. Health Home care managers can initiate an initial POC with HCBS to meet the 30-day timeframe ensuring that a completed person-centered Health Home POC is completed 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.

Quality Assurance and Monitoring:

CHHUNY will assure quality monitoring of the Plan of Care process through the Comprehensive Chart Audit process. This audit occurs every six (6) months for each CMA and focuses on the assessment findings and the development of the POC. Please refer to the Quality Program Policy for additional detail.

Policy Review:

This policy and its procedures will be reviewed yearly and updated as necessary to ensure that its general purposes are being effectively met.