Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Children's Plan of Care

Department: Health Home

Population: Health Home Serving Children

Effective Date: 12/5/2016

Review Date: 10/1/2020

Date Revised: 9/18/2018; 2/27/2019; 10/23/2019; 3/1/2021; 10/1/2021

Purpose of Policy

To increase coordination of care and to define the expected elements contained within the Plan of Care.

Scope

This policy applies to all AHI Health Home Service Providers that serve Children Health Home participants.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Plan of Care – Children's Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Plans of Care – Children's Policy.

Definitions

AHI HH: AHI Health Home, a designated lead Health Home by the New York State Department of Health

Child: A person under the age 21 who is not on AOT (Assisted Outpatient Treatment).

Health Home Network Partners: The group of medical, behavioral, social services, and other community-based organizations by which a Health Home Participant receives services to address needs identified on the comprehensive care management plan developed by the Health Home Participant's AHI Health Home Services Provider.

Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management.

Health Home Service Provider: An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

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Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

Core Health Home Services: The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid, as defined by the New York State Department of Health:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Member & Family Support
- Referral and Community & Social Support Services

Note: the sixth category of Core Health Home Services, "The use of HIT [Health Information Technology] to link services, as feasible and appropriate," is NOT considered a billable activity.

RHIO: Regional Health Information Organization

Background

The Children's Plan of Care Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

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It is the policy of the Adirondack Health Institute Health Home (AHI HH) that for each Health Home member, a care management plan is created and regularly updated that addresses identified needs, and that the care plan be made available via the Care Management Record System to the interdisciplinary team of providers.

The Health Home Plan of Care 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 Plan of Care to monitor the member's progress towards goals. Changes in goals and preferences, interventions, and member's needs should be documented in the Plan of Care.

The person-centered Plan of Care is created concurrently with the Health Home Comprehensive Assessment within 60 calendar days of enrollment. If for any reason an initial Health Home Plan of Care cannot be created within 60 calendar days of enrollment the Health Home Care Manager must clearly document in the member's record as to why the Plan of Care could not be completed and should identify a projected date for completion. You will not be able to Bill for Health Home Services if there is not an active Plan of Care in the member's Electronic Health Record. The Plan of Care must be amended at least every 6 months (concurrent with the CANS-NY assessment).

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It is the policy of the Adirondack Health Institute Health Home (AHI HH) that Health Home Service Providers are accountable for the below, recognizing that Health Home enrollees have choice in each of these areas:

- Engaging and retaining enrollees in care
- Coordinating and arranging for the provision of services
- Supporting adherence to treatment recommendations
- Monitoring and evaluating the enrollee's needs (including, but not limited to, prevention, wellness, medical, specialist, and behavioral health treatment, care transitions, social and community services, peer supports). These areas of accountability are to be documented in the care plan.

PROCEDURE: CARE PLAN ELEMENTS AND REQUIREMENT

1. The Health Home Service Provider (HHSP) will create and maintain a comprehensive care management Plan of Care for each Health Home Participant, that addresses needs identified in the comprehensive assessment and CANS-NY including but not limited to medical, behavioral health services, rehabilitative, long term care, and social service needs;
    i. The Health Home Participant, and/or legal guardian/representative, will be involved to the greatest degree possible in developing the care management plan and play an active and central role in the development and execution of their Plan of Care. They should agree with goals, interventions, and timeframes attached.
    ii. The Plan of Care must be written in plain language and in a manner that is accessible to the individuals with disabilities and persons with limited English Proficiency and should reflect the cultural considerations of the member.
    iii. Goals are to be decided with client and with client prioritization noted
    iv. The Plan of Care must contain goals and objectives that support the member's desire to address their qualifying diagnosis for Health Home (SED, SUD, HIV/AIDS, Chronic Conditions, Children's HCBS, Complex Trauma, etc.); as the member deems necessary.
    v. The care plan should reflect Health Home enrollee's preferences for education and support for self-management, self-help recovery and other resources as appropriate. Caregiver and family member preferences shall also be considered as directed by Health Home enrollee; this includes language preferences. AHI provides translation/interpretation services as needed via Language Link.
    vi. The Health Home Service Provider promotes evidence-based wellness and prevention by linking the Health Home member with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on child/youth's needs and preferences. All linkages to providers shall be documented in the member's Plan of Care.
    vii. The Plan of Care should identify appropriate referrals to community-based resources and should ensure engagement with these resources based on client preference

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viii. The initial care management plan will be completed within 60 calendar days from the date that the child/parent/guardian/legally authorized representative agrees for the child to enroll in active care management; 30 days from date of completion of the CANS-NY.

ix. The Plan of Care will include specific, measurable, and obtainable goals

1. The goals must be member stated wellness and recovery goals including:

    - Target timeframes for attaining goals
    - Strategies for how the desired goals will be achieved
    - Actions describing how goals will be achieved
    - Supports (paid and unpaid) that are needed to achieve the desired goals

2. Functional needs related to treatment, wellness and recovery goals (e.g. meal prep/needs assistance eating, etc.)

3. Barriers and strategies to overcome barriers related to achieving goals, including a description of planned care management interventions and time frames.

4. The Plan of Care creation should involve other members of the care team to integrate the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs. This includes but is not limited to Child Protective Services, behavioral health specialists, rehabilitative, long term care, peer supports, social service needs, and PCPs and/or specialists or their staff. The participation of all individuals contributing to the development in the Plan of Care shall be documented in the chart.

5. Outreach and engagement activities that will support engaging individuals in their care and promote the continuity of care.

6. The member's signature documentation agreement with the Plan of Care (including a child who can self-consent or age-appropriate to participate, and/or their parent, guardian, or legally authorized representative). Once signed the member, parent, guardian, or legally authorized representative must be provided a copy of the Plan of Care. Contingent upon consent and request the Plan of Care can also be provided to and distributed to:

    - Their family member(s) or other supports
    - Care team members
    - Service providers
    - HCBS Providers
    - Managed Care Plans when the Plan of Care includes services requiring service authorization, e.g. children's HCBS

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x. The HHSP will implement a systematic process for following up on tests, treatments, services and referrals that are incorporated in the care management plan.

    1. HHSP will utilize the Care Management Record System to determine if tests, treatments, services, and referrals were completed, as per the information entered into the Care Management Record System or via other means including telephonic, faxed, secure e-mail, and in-person communication with providers listed on the DOH 5201 form (for children under age 18) and the DOH 5055 form (for children ages 18-21)

        a. Educational providers identified on the DOH 5203 will be followed up with as required/appropriate.

    2. If follow-up information is not available in the Care Management Record System, the HHSP will contact the child's parent/guardian/legally authorized representative and/or the referral agency as appropriate to determine the status and document the outcome in the Care Management Record System.

    3. Because children often lack the ability to provide consent, information will be received from the RHIO for children under the age of 18 with the consent of the Parent/Guardian/ Legally Authorized Representative.

xi. The Care Manager will have a face to face contact the child and/or his/her family within 24 hours of discharge from an inpatient detox, (when they are notified or become aware). The Care Manager will contact the child and/or his/her family within 48 hours of discharge once notified of Emergency Department visit, inpatient stay, discharge from residential services, or detention, etc.

    1. If the Care Manager is aware that the child was admitted to a facility, he or she should make every effort to be part of the discharge planning process.

xii. Health Home Service Providers are not clinicians and may find themselves in a situation when conflicting treatment modalities are being recommended amongst providers. The Health Home Service Provider will need to discuss concerns with their supervisor immediately who can notify the Health Home as well for support. If the Health Home Service Provider finds conflicting treatment recommendations the HHSP can also contact the Managed Care Organization (if applicable) for support in solving treatment conflict.

2. The Plan of Care will have periodic reassessment based on the individuals needs and progress towards goals. The care management plan will be updated at least every six (6) months, or more frequently when warranted by a significant change in the member's medical or behavioral health condition.

3. Interventions, notes, and external documents related to care management activities will be logged no later than 3 business days following the interaction with the client/patient.

4. Interventions and activities shall consist of Core Health Home Services.

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5. All care plans are required to include the following elements:

- The child/youth's Emergency Contact and Disaster Plan for fire, health, safety issues, natural disaster, and other public emergencies.

  Each youth within 60 days of enrollment will need to have a Safety and Crisis plan completed as well as an Emergency Planning Assessment. The completion of these two documents should coincide with the development of the initial Plan of Care and should be reviewed/amended every six months. The Safety and Crisis Plan should be reviewed/updated each time a crisis occurs to ensure the plan information continues to be relevant.. Each time the plan is reviewed, the date of the review and any changes should be documented in the member's record.

- The child/youth's History and Risk Factors as identified in the CANS-NY related to services and treatment, well-being and recovery.
- The child's/youth's functional needs as identified in the CANS-NY related to services and treatment, well-being and recovery.
- The child's/youth's and Caregiver's Strengths and Preferences as identified in the CANS-NY related to services and treatment, well-being and recovery.
- Identified Medicaid State Plan and Non-Medicaid Services must be family driven, youth guided, comprehensive and integrated to include Physical, Behavioral, Community and Social Supports.
- Choice of (a) service providers, (b) reason for the services, (c) intended goals, and (d) barriers which impede goal attainment.
- Key Informal Community Supports including and supports in place for the child/youth and family that address identified needs (n e.g. IEP, 504, and housing program).
- Description of planned Care Management Interventions (including Referral, Access, Engagement, Follow up, coordination of service and Timeframes. The child's/youth's transition plan including circumstances/services needed to transition from Health Home Care Management as needed, (e.g. transitions in education, employment, living situation, community functioning, hospital, treatment facility, foster care, to adult HH).
- Other service plans as appropriate, such as Early Intervention Individual Service Plan and Foster Care Family Assessment Service Plan, which should be reviewed by the care team and appropriate items incorporated as needed.
- For youth that are over the age of 14, the Plan of Care **MUST** include goals developing the member's capacity to live independently, and the identification of available resources.
- Transitioning age Youth – those that will be aging out and moving to adult services **MUST** include transitional goals and services; specifically:
  - .. For physically disabled member's reaching their 17th Birthday, the Health Home Care Manager will assist the member in planning for transitions to other services and/or programs
  - .. For members in foster care, eighteen months prior to reaching the member's 21st Birthday, the Health Home Care Manager will generate a transition plan

that identifies the action steps needed to connect the member with adult services and will identify the party responsible for each step.

6. The Health Home Service Provider is responsible for developing an Interdisciplinary Care Team that includes: The child/youth and family; Treatment/Care and services providers; informal and natural supports. The Health Home Provider has the option of utilizing technology conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect PHI.
7. Members identified as part of the Interdisciplinary Care Team should be listed on the consent form and have the Plan of Care shared with them.
8. The Health Home Service Provider support continuity of care and health promotion through the development of a treatment relationship with the child/youth and the interdisciplinary team of providers.
9. Interdisciplinary Team Meetings must occur:

    - During the completion of the initial CANS -NY and follow up CANS -NY to develop the Plan of Care
    - Health Home Service Providers can request an Interdisciplinary Team Meeting as needed
    - The child/youth and family can request an Interdisciplinary Team Meeting as needed.

10. Interdisciplinary Team Meeting Planning:

    i. The Team Meeting must be family driven and youth guided. The meeting must accommodate the child/youth and families schedule and availability.
    ii. The Family/child/youth/medical consenter should be an active team member and contributor to the Plan of Care
    iii. The Interdisciplinary Team Meeting can be held in conjunction with other meetings.

11. Interdisciplinary Team Meeting Attendance:

    i. The Health Home Service Provider must invite the child/ youth; Family/Medical Consenter; service providers; and other supports at the request of the family. – If a Care Team Member cannot attend the meeting than a Progress Note must indicate that the Health Home Service Provider invited them and made contact/attempted contact with them to gather input regarding the CANS-NY and Plan of Care.
    ii. Other Recommended invitees: Other Caregivers; designee from LDSS; Case Planner from the Foster Care agency

PROCEDURE: INFORMATION SHARING

1. For children age 18 and older, the care management Plan of Care will be made available to other members of the care team via one of the three below ways, listed in order of preferred method of access:

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i. Care team members will access the Plan of Care information via the Adirondack Health Institute's Health Home Care Management Record System.

ii. If a care team member is not able to access the Care Management Record System, he or she may pull the Plan of Care information via the regional health information organization (HIXNY, Health Information Exchange NY). Care team members who are HIXNY participants, to whom the patient has signed a HIXNY consent, will have access to the care plan via HIXNY.

iii. Care team members who are not HIXNY participants, including private individuals (family, friends, or other support persons designated by the patient), will be offered the Plan of Care via a pdf shared through an encrypted e-mail or via another secure method.

2. For children under age 18, access to the Plan of Care will be provided as follows for members of the care team for whom consent has been granted:

    i. Care team members including private individuals (family, friends, or other support persons designated by the child/parent/guardian/legally authorized representative), will be offered the Plan of Care via a pdf shared through an encrypted e-mail or via another secure method.

        1. Prior to sharing the Plan of Care, it will be reviewed by the care manager to ensure that only information the child/parent/guardian/legally authorized representative gave permission to share will be disseminated.

            a. Any information included on the care plan for which permission to share has not been granted to the receiving party will be redacted via electronic or manual means.

NOTE: 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 Plan of Care. 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 Plan of Care (Minor Protected Services Plan of Care Form) with only the minor/adolescent and not with the parent, guardian, legally authorized representative present. The Care Manager will only obtain the member's signature on this section of the Plan of Care. This separate section of the Plan of Care will not be given to the parent, guardian, legally authorized representative. If the member has elected to share health information with a parent, guardian, legally authorized representative (as indicated on page 2 of DOH-5201), the care manager will not need to fill out a separate section/page of the Plan of Care.

Please see the Desk Guide for the Minor Protected Services Plan of Care Form

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HCBS Plan of Care

For Children who are found eligible for Home and Community Based Services (HCBS), development of the member's Plan of Care will be by the Health Home Care Manager. HCBS eligible children do not need to prove Health Home eligibility.

For Children who are determined HCBS eligible and were not previously enrolled in a Health Home, the Health Home Care Manager will develop an initial HCBS Plan of Care within 30 calendar days. The HHCM will also ensure that the Health Home Plan of Care is completed within the first 60 calendar days of enrollment.

When a member needs access to HCBS, members will only be referred to a designated HCBS provider, who will determine frequency, scope, and duration for each HCBS service. The Health Home Care Manager will ensure that the frequency, scope, and duration is recorded for each HCBS service in the Health Home Plan of Care.

Please see the Children's Waiver & HCBS Policy for further guidance

TRAINING:

This policy will be disseminated for review and questions before a policy training is given at the following monthly Health Home Office Hours. If more time is needed outside of office hours a training will be developed to understand the purpose and function of the Plan of Care, recovery and harm reduction oriented, person-centered care planning, as well as evidence-based methods for increasing engagement such as motivational interviewing in AHIHH's Learning Management System and assigned to all care management staff.

Additionally, AHI HH will make additional training opportunities know to the AHI HH network regarding typical care management needs for specific populations and for those members with co-morbidities.

Quality and Performance Improvement:

To promote a culture of learning and continuous quality improvement, monitoring and oversight within the AHIHH network***;*** AHI Health Home will review a selection of cases from each HHSP's member attributions. Each case will be assessed for completeness and adherence to the Health Home Policy. Any record found not have adequate documentation in the Plan of Care is expected to promptly add documentation to the member's chart and additional cases will be reviewed from each HHSP if needed. Failure to complete the Plan of Care within 60 calendar days from enrollment may result in the HHSP not being able to bill for services or claims voided as a result of non-compliance with this policy.

Contact Person: Care Management and Health Home Director

Responsible Person: Health Home Service Provider

Approved By: Chief Operating and Compliance Officer

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Appendix A

Interdisciplinary Team Meeting Planning Checklist

Team Meeting Reason		
☐ Plan of Care Development	☐ Service Provider Request	☐ Child/Youth/Family Request

Have you invited the following people?	
Child/ Youth	☐Yes ☐ No
Family/Medical Consenter	☐Yes ☐ No
Other service providers	☐Yes ☐ No ☐ N/A
Other Caregivers	☐Yes ☐ No ☐ N/A
Designee from LDSS	☐Yes ☐ No ☐ N/A
Case Planner from a Foster Care Agency	☐Yes ☐ No ☐ N/A

NOTE: If a Care Team Member cannot attend the meeting a Progress Note must indicate that the Health Home Service Provider invited them and made contact/attempted contact with them to gather input regarding the CANS-NY and Plan of Care.

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Appendix B
Creating Goals in the Plan of Care

Goals can be broken down into different domains:

- **Interests**
  - I would like to learn how to play an instrument.
- **Wants**
  - I would like to one day work in a kitchen at a restaurant.
- **Needs**
  - I need help managing my mental health symptoms.
- **Personal Circumstances**
  - My parents want me to get a job and live on my own.
- **Personal Assistance**
  - I need help getting dressed, grooming, and eating.

The goals we create should strive to be SMART. SMART goals are developed with the input of the member; it makes sure the goal is specifically tailored to address the individual's needs.

SMART	Term Definition
Specific	Identifies a task to accomplish or a behavior to improve
Measurable	Provides clear measures that indicate how you will know that you have achieved your goal
Achievable	Offers both a challenge and a realistic target that is practical and achievable
Realistic	To be realistic, a goal must represent an objective toward which you are both *willing* and *able* to work.
Timely	Defines a timeframe for completion; either how often will you do a task or by when you will have completed it

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Appendix C

Minor Protected Service Plan of Care

Minor/Adolescent Plan of Care

Child/ Youth Name_____
Child/ Youth NSID or CIN_____
Completed By_____
POC Finalization Date_____

Objective	
Intervention	**Target Date**
Problem Addressed	

Are there any safety or risk concerns related to the member's protected services?

☐ No safety or risk concerns identified ☐ Yes there is a safety risk or concern

If so, please including information on the need, action, and people involved.

_____
_____

_____ _____
Member Name Member Signature

Date_____

_____ _____
Care Manager Name Care Manager Signature

Date_____