Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Health Home Plan of Care – Adult Health Home

Department: Health Home

Intended Population: Health Home Serving Adults

Effective Date: 9/21/2015

Date Revised: 10/23/2019, 5/6/2021; 10/1/2022;10/1/2023; 10/1/2024

DOH Policy Number: HH0008

Purpose of Policy

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

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director.
3. All questions regarding this policy or its implementation may be directed to the AHI Health Home Program Director.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Plan of Care - Adults 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 Plan of Care – Adults Policy.

Definitions

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

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.

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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.

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.

Brief CMHA: Community Mental Health Assessment

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.

HARP: Health and Recovery Plan

HCBS: Home and Community Based Services

MCO: Managed Care Organization

RHIO: Regional Health Information Organization

Background

The Plan of Care - Adults Program 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 (AHIHH) that each Health Home member receives a comprehensive assessment, that a care management plan be 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 Health Home Care Manager is the single point of contact in the member's care coordination and takes full responsibility for the overall management of the Health Home Plan of Care.

The person-centered Plan of Care is created concurrently with the Health Home Comprehensive Assessment within the first 56 calendar Days of Enrollment. If for any reason an initial Health Home Plan of Care cannot be created within 56 calendar days on enrollment the Health Home Care Manager must clearly document in the member's chart as to why an Initial Care Plan could not be completed within this timeframe and identify a future date for completion. The HHCM will not be able to bill for services if the Plan of Care is not completed within the 56-day timeframe. The Plan of Care must be amended at least annually, however should be updated more frequently as the member's needs change. Goals should be continuously updated to reflect added goals, achieved goals, and goals that need to be discontinued. If the Plan of Care is not updated every 365 days, the HHCM will not be able to bill for services.

It is the policy of the Adirondack Health Institute Health Home (AHIHH) 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 and gleaned from the member's comprehensive assessment.

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PROCEDURE: CARE PLAN ELEMENTS AND REQUIREMENT

1. The 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 the HARP eligibility assessment (if applicable) 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 (SMI, SUD, HIV/AIDS, Chronic Conditions, etc.); as the member deems necessary.

        For members living with HIV/AIDS the member must have a care team meeting once every 6 months. During this care team meeting the discussion and education on viral suppression must occur and be documented in the member's record.
    v. The care plan should reflect Health Home enrollees' preferences for education and support for self-management, self-help recovery and other resources as appropriate. Member preferences shall also be considered as directed by Health Home enrollees; 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 needs and preferences. All linkages to providers shall be documented in the member's plan of care.
    vii. The care plan should identify appropriate referrals to community-based resources and should ensure engagement with these resources based on client preference.
    viii. The initial care management plan will be completed within 56 calendar days from the date that the member agrees to enroll in active care management.

    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 Adult Protective Services, behavioral health specialists, rehabilitative, long-term care, peer supports, social service needs, and Primary Care Providers and/or specialists or their staff. The participation of all individuals contributing to the development in the Care Plan 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 members' Plan of Care should consist of the member's immediate needs pertaining to their Health Home Qualifying Conditions, considerations of specialty populations (HH+, HH+ Stepdown, HARP, CORE, and AOT) and appropriateness criteria for Health Home. The member's plan of Care should be reviewed with the member monthly and evaluated for needed updates; the POC should not consist of maintenance goals.
7. ***The member's signature documents agreement with the Plan of Care; the Plan of Care must be signed by the member and the signature MUST be on file***. Once signed, the member must be provided with 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
    - CORE Providers
    - Managed Care Plans when the Plan of Care includes services requiring service authorization, e.g., HARP HCBS

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 5055 form.

xi. The Care Manager will have face-to-face contact with the member within 24 hours of discharge from an inpatient detox, (when they are notified or become aware). The Care Manager will contact the member within 48 hours of discharge once notified of Emergency Department visit or discharge from an inpatient stay, etc.

1. If the Care Manager is aware that the member was admitted to a facility, he or she should make every effort to be part of the discharge planning process.
2. If a member is placed in an excluded setting the member's plan of care will need to be updated once the member is discharged from the setting.

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 care manager should discuss these scenarios with their supervisor. The Health Home care manager should also alert the Health Home who can help broker conversations with other members of the care team (i.e. the member's MCO) to coordinate a case conference.

2. The Plan of Care should be reviewed monthly to assure the member's currents need are being addressed and that the member is progressing towards goals. If the member is pended for Diligent Search, the HHCM and member will need to review the Plan of Care in place and ensure that it is still reflective of the member's needs and ascertain if the factors that led to disengagement are embedded in the Plan of Care. The Care Plan will be amended at least annually, or more frequently when warranted by a significant change in the member's medical or behavioral health condition. Amended plans must also be signed by the member. The member must have an amendment every 365 days in order to continue to bill for services.
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.
5. The Health Home Service Provider is responsible for developing an Interdisciplinary Care Team that includes: The member; 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.
6. 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.
7. The Health Home Service Provider should support continuity of care and health promotion through the development of a treatment relationship with the member and the interdisciplinary team of providers.
8. The Health Home Care Manager should be actively collaborating with the MCO (as applicable) to help and coordinate the member's care.

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PROCEDURE: INFORMATION SHARING

1. For members 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:
    i. Plan of Care requests made by the Health Home member and/or their care team members can be made by submitting requests to the Care Manager or AHI Health Home.
    ii. If a care team member is not able to access the Care Management Record System, he or she may pull care plan 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 Care Plan via a pdf shared through an encrypted e-mail or via another secure method.

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TRAINING:

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of the initial policy training, a future in-depth training will be developed and/or identified for Health Home Care Managers to gain an understanding of Evidence-based methods for writing an effective Plan of Care including Motivational Interviewing, Recovery-Oriented Practices, Person-Centered Planning, Self-Determination practices, and creating/writing SMART goals.

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 initial Plan of Care within 56 calendar days from enrollment may result in the HHSP not being able to bill for services or claims voided because of not being in compliance with this policy. Heath Home Service Providers that do not annually update the member's Plan of Care can be subject to billing implications as directed by the Lead Health Home.

Contact Person: Assistant Director, Health Home

Responsible Person: Health Home Service Provider

Reviewed By: Care Management and Health Home Director

Approved By: Chief Compliance Officer

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Appendix A
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