ST PETER'S HEALTH PARTNERS

Effective Date: January 1, 2023

Category: **C. Care Coordination**

Title: **3. Plan of Care**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ ____________________

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Capital Region Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

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PURPOSE

A Plan of Care is created for each Health Home Member enrolled in the Health Home. Informed by the results of the Comprehensive Assessment and Screening Tools, the Plan of Care is updated regularly to reflect the Member's needs. The Plan of Care includes any objectives and interventions identified by the Care Coordinator and the Member including, physical health, behavioral health and social services.

POLICY STATEMENTS

It is the policy of Capital Region Health Connections that each enrolled Member have a Plan of Care created within 60 days of enrollment into the Health Home. The Plan of Care must be updated annually, and more frequently as the circumstances of the Member's life and health change.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Capital Region Health Connections Health Home program.

DEFINITIONS

Care Team: Those who are involved in the Member's care or provide support for the Member's overall well-being; in addition to the Member and the Care Coordinator this may include additional CMA representation, providers, family member and supports for example

Comprehensive Plan of Care: The evolving document developed by the Care Coordinator and Member that outlines specific, concrete, step-by-step interventions and objectives to addressing the Member's needs or identified problems and achieving his or her desired overall goal; plan is updated as new needs or problems arise and previously identified objectives are met; the Member's strengths and barriers are identified in this document

Health Home Member: An individual who is enrolled in Health Home services

NYSDOH: New York State Department of Health; the regulating State entity for Health Homes

PROCEDURE

A. Plan of Care Development

1. The Plan of Care must be Member-driven, meaning it is developed with input from the Member whenever possible and includes the preferences, services and resources requested by the Member. The CRHC Member Acknowledgement Form (Attachment A) must be used to document Member participation in the development of the Plan.

2. The Member's family, caregiver or other supports must be involved in the development of the Plan of Care when appropriate and requested by the Member.

3. The Plan of Care must be based on the results of the Comprehensive Assessment at a minimum.

4. The Plan of Care must have at least one active medical, behavioral health or substance abuse goal.

5. The Plan of Care must be, to the extent possible, developed with input from the Member as well as the Care Coordinator and any other members of the Care Team.

6. The Member's identified barriers to managing his or her care must be identified in the Plan of Care. Through the provision of Health Home services, those barriers must be addressed to help the Member manage his or her own care.

B. Initial Plan of Care

1. The Initial Plan of Care should be completed within 30 days of completion of the initial Comprehensive Assessment, but must be completed within 60 days of active enrollment.

2. An individual is considered to be enrolled as a Health Home Member when the following have occurred:
   a. Medicaid eligibility has been verified,
   b. diagnostic criteria has been confirmed,
   c. appropriateness has been determined and documented (See Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility), and
   d. the Member agrees to participate in Health Home Care Coordination Program.

3. For all individuals enrolled in a Health Home, the Plan of Care or Member's electronic health record must include the following elements:
   a. the Member's stated **goal(s)** related to treatment, wellness and recovery,
   b. the Member's specific **Objectives and Interventions**, including **timeframes** for achieving those objectives and interventions.
   c. the Member's **preferences and strengths** related to treatment, wellness and recovery,
   d. the Member's identified **barriers** related to the achievement of goals and objectives,
   e. **functional needs** related to treatment, wellness and recovery
   f. key **community networks and supports**,
   g. description of planned **care management interventions and timeframes**,
   h. the Member's **signature** documenting agreement with the Plan of Care as evidenced by the presence of the Member Acknowledgement Form, and
   i. documentation of participation by all **key providers** in the development of the Plan of Care.

C. Plan of Care Updates

1. The Plan of Care should be modified in real time, meaning that as significant events occur and service needs or problems develop or are alleviated, the Plan of Care should be updated to reflect those changes. In CareManager, this updating would be done via a CareManager Note while the addition of new objectives or interventions would be documented as a Plan Amendment.

2. At a minimum, the Care Plan must be updated at least annually. In CareManager, this would be documented as an Annual Plan. Annual updates to the plan are required regardless of the Plan Amendments on file. The 12-month timeframes are calculated based on the Initial Plan of Care and the Annual Plans only.

3. Billing for Core Service delivery may not occur if the Member's Plan of Care is not up to date by the end of the billing month. Should attempts to update the Plan of Care with the Member be unsuccessful, CMA's do have the option to update the Plan without the Member present so that billing can occur. In these rare circumstances, the Plan must be reviewed with the Member at the next opportunity. In instances in which a Plan is updated without the Member present, the Care Notes should reflect this situation. Sample text: *Member did not meaningfully participate in the development of the Plan of Care. Every attempt was made to collaborate with Member on the development, however [insert specific circumstances]. Care Coordinator will review POC with Member at next opportunity.*

4. When an Initial Plan of Care or Plan of Care update is completed or reviewed with the Member, the Health Home Member Acknowledgement Form (Attachment A) must be used to acknowledge Member participation in the Plan development. If the Plan is updated without the Member present, as noted in C3 above, the Member Acknowledgement Form must be signed by the Member when the opportunity arises to review the Plan with the Member.

D. Documentation of Plan of Care

1. All Plans of Care must be entered directly into the Member's electronic health record as an Initial Care Plan, Plan Amendment or Annual Plan.

2. Additional documentation in the Plan of Care is required for Member's who are HARP enrolled and who have been assessed using the Eligibility Assessment of the Community Mental Health Assessment. Please see Policy F1. Special Programs: HARP and HCBS Policies and Procedures for additional requirements.

3. Members must be offered a copy of his or her finalized Plan of Care and the Plan must be provided upon request.

4. Should the Member request that a copy of the Plan be provided to family members, caregivers, providers or other supports, copies must be provided to those parties with consent.

E. Staff Qualifications

1. Capital Region Health Connections will allow Care Management Agencies to set their own standards for the qualifications of Care Coordinators. At a minimum, Care Coordinators must have an Associate's Degree and experience working in the human services field, or a Bachelor's Degree.

2. New York State Department of Health, AIDS Institute and Office of Mental Health have established set criteria for staff serving Special Programs such as HARP, HH+ and AOT. These criteria include specific staff education requirements, experience, training, and supervision requirements. Please see those policies for the specific requirements for each program type.

For more on Staff Qualifications and Special Programs Staff Qualifications see:
Policy A1. Care Management Agency Staffing: Staff Training, Qualifications and Supervision
Policy F1. Special Programs: HARP and HCBS
Policy F2. Special Programs: Assisted Outpatient Treatment (AOT)
Policy F4. Special Programs: Serious Mental Illness Health Home Plus (SMI HH+)
Policy F5. Special Programs: HIV Health Home Plus (HIV HH+)

REFERENCES

New York State Department of Health (January 9, 2014). Health Home Provider Manual: Billing Policy and Guidance. (https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf)

New York State Department of Health (October 5, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations. (https://www.health.ny.gov/health_care/edicaid/program/edicaid_health_homes/docs/hh_mco_cm_standards.pdf)

Approving Official: Rachel Handler, MS CRC, LMHC		**Effective Date: January 1, 2023**
Key Sponsor: Janelle Shults, LMSW		
Reviewed By: Lindsay Homenick, MSW		**Original Date: May 1, 2017** **Reviewed/Revised Date:** ***Reviewed, No Revisions** ****Revised without Full Review**
Search Terms:		

Replaces: Documentation – Assessment, Re-assessment and Plan of Care
Care Coordination: Plan of Care (May 1, 2017)
Care Coordination: Plan of Care (October 1, 2017)
Care Coordination: Plan of Care (December 17, 2018)
Care Coordination: Plan of Care (December 1, 2019)

ATTACHMENT A: Health Home Member Acknowledgement Form

St Peter's Health Partners

Capital Region Health Connections

Health Home
2212 Burdett Avenue
Troy NY 12180
ph (518) 271-3301
fx (518) 271-5009
sphp.com

Complete this form each time one of the five activities listed below is completed.
More than one activity may be checked if more than one activity was completed during the visit.

Member Name: ____

Date of Acknowledgement: ____

The following annual activities were completed with the Member:
(Note each of these activities must be completed at least once annually)

☐ Health Home Consent Form Reviewed for Accuracy (DOH 5055)
☐ Health Home Member Bill of Rights Reviewed
☐ Comprehensive Assessment Annual Update Completed
☐ SDOH Screening Tool Annual Update Completed

☐ Plan of Care – I actively participates in the creation of my individual Plan of Care and agree with the Plan.

____ ____________________
Member Signature Date

____ ____________________
Care Coordinator Signature Date