WALKING THE HARP WORKFLOW

Behavioral Health Transition to Managed Care

NYS Medicaid Redesign Team Initiative to achieve Triple Aim

- **Improving the patient experience of care.**
- **Improving the health of populations.**
- **Reducing the cost of health care per patient.**

•Members with the most significant mental health and substance abuse needs will have the option to enroll in a new benefit package, Health and Recovery Plans or HARP

HARP plans requirements:

- Connection to local providers and communities
- Address psycho/social issues, not just health issues
- Provide specialized behavioral health services, either by contracting or directly hiring staff
- Recovery focused

HARP Video

Workflow at a glance

01

NYS EA

02

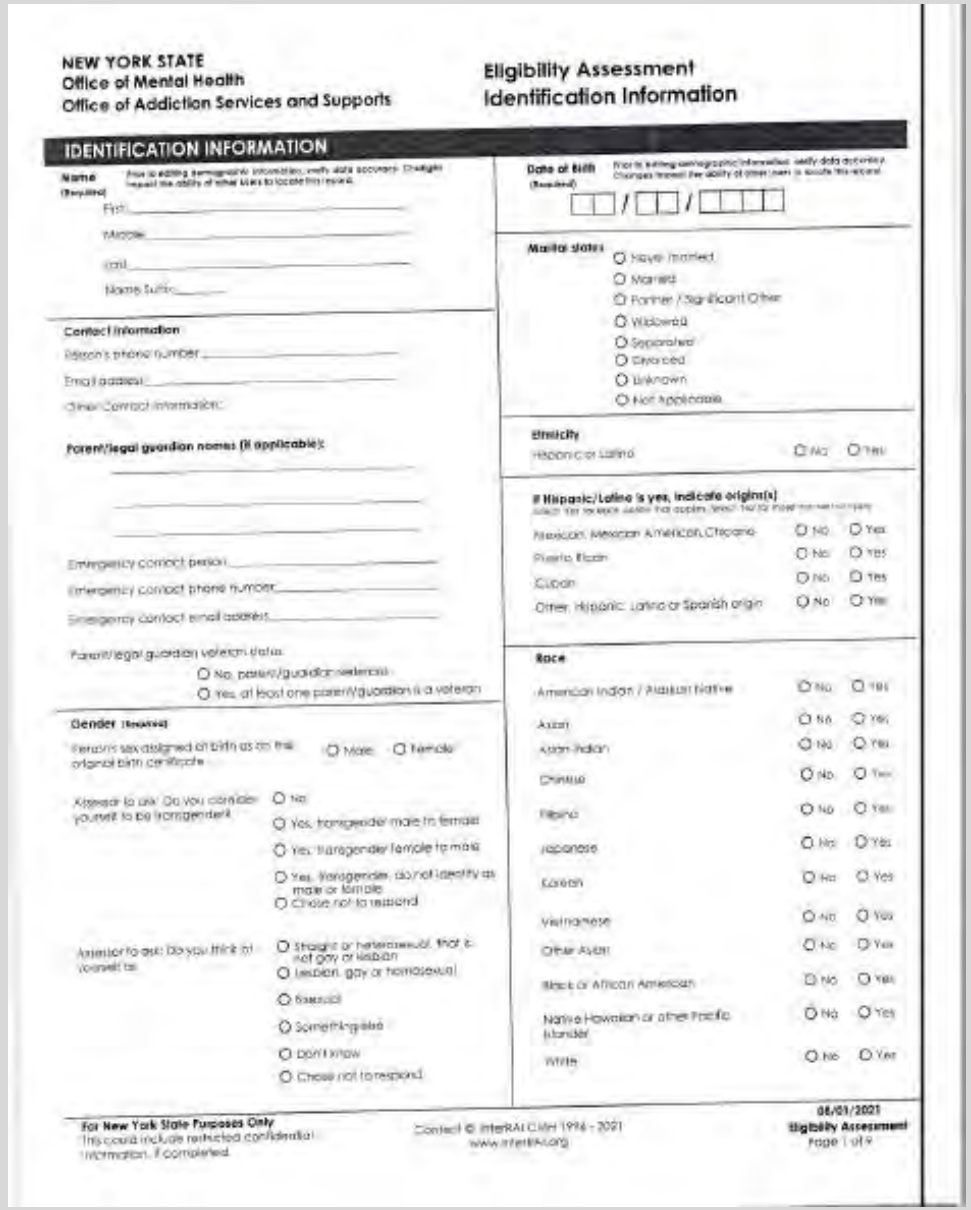
LOSD Request and linkage to HCBS services

03

HARP POC

The NYS EA

- Fill out as much as you can ahead of time
  - Can be used in conjunction with Comprehensive Assessment
- Conversational
  - Utilize Motivational Interviewing
    - Motivational Interviewing is a collaborative conversation to strengthen a person's own motivation for and commitment to change (use OARS)
      - Open-ended questions
      - Affirmations
      - Reflections
      - Summaries
- Use the NYS EA to help navigate the conversation
- Scoring



NEW YORK STATE
Office of Mental Health
Office of Addiction Services and Supports

Eligibility Assessment
Identification Information

IDENTIFICATION INFORMATION

Name (Required)
First
Middle
Last
Name Suffix

Date of Birth (Required)
__ / __ / ____

Contact Information
Person's phone number
Email address
Other Contact Information

Parent/legal guardian names (If applicable):

Emergency contact person
Emergency contact phone number
Emergency contact email address

Parent/legal guardian veteran status
- O No, parent/guardian veteran(s)
- O Yes, at least one parent/guardian is a veteran

Gender (Required)

Person's sex assigned on birth as on the original birth certificate: O Male O Female

Asked of all: Do you consider yourself to be transgender?
- O No
- O Yes, transgender male to female
- O Yes, transgender female to male
- O Yes, transgender, do not identify as male or female
- O Chose not to respond

Asked of all: Do you think of yourself as
- O Straight or heterosexual, that is, not gay or lesbian
- O Lesbian, gay or homosexual
- O Bisexual
- O Something else
- O Don't know
- O Chose not to respond

Marital status
- O Never married
- O Married
- O Partner / Significant Other
- O Widowed
- O Separated
- O Divorced
- O Unknown
- O Not Applicable

Ethnicity
Hispanic or Latino: O No O Yes

If Hispanic/Latino is yes, indicate origin(s)
Mexican, Mexican American, Chicano: O No O Yes
Puerto Rican: O No O Yes
Cuban: O No O Yes
Other Hispanic, Latino or Spanish origin: O No O Yes

Race

American Indian / Alaskan Native	O No	O Yes
Asian	O No	O Yes
Asian Indian	O No	O Yes
Chinese	O No	O Yes
Filipino	O No	O Yes
Japanese	O No	O Yes
Korean	O No	O Yes
Vietnamese	O No	O Yes
Other Asian	O No	O Yes
Black or African American	O No	O Yes
Native Hawaiian or other Pacific Islander	O No	O Yes
White	O No	O Yes

IDENTIFICATION INFORMATION, continued

Primary Language
Select person's **preferred** language in day-to-day communication

- O English
- O Spanish or Spanish Creole
- O French
- O Chinese
- O Russian
- O Other, please specify

Language non-spoken

- O American Sign Language (ASL)
- O Alternative communication board or device
- O Idiosyncratic signs, gestures or behaviors
- O Written or printed
- O Tangible symbols
- O No non-spoken language
- O Other, please specify

Interpreter needed - adult/child/youth
- O No
- O Yes

Interpreter needed - parent/guardian
- O No
- O Yes

Veteran Status (for adults only)

Veteran
- O No
- O Yes

Spouse of Veteran
- O No
- O Yes

Prior to editing demographic information, verify data accuracy. Changes impact the ability of other users to locate this record.

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Medicaid Numbers Prior to editing demographic information, verify data accuracy. Changes impact the ability of other users to locate this record.

Medicaid number 1 ☐☐☐☐☐☐☐☐☐☐

Medicaid number 2 ☐☐☐☐☐☐☐☐☐☐

Medicaid number 3 ☐☐☐☐☐☐☐☐☐☐

Insurance Company(s)

Name
Numbers

Name
Numbers

Contact Information for Persons Who Need to be Present During Assesment

Name
Telephone Number(s)

Name
Telephone Number(s)

Comments

NEW YORK STATE
Office of Mental Health
Office of Addiction Services and Supports

Eligibility Assessment

REFERENCE DATE

Assessment Reference Date ☐☐ / ☐☐ / ☐☐☐☐

Reason for Assessment

- ☐ First Assessment
- ☐ Routine Reassessment
- ☐ Significant change in status reassessment
- ☐ Exit Assessment, covers last 3 days of services
  NOTE:HARP members - exit assessment is not required
- ☐ Eligibility denial/appeal
- ☐ Research

If reason is "Eligibility denial/appeal": please describe briefly:

Restriction Exception Codes

The Assessor has verified in eMedNY/ePACES that the individual has one of the following HARP-specific Restriction Exception (RE) codes: (H1, H2, H3, H4, H5, H6) ○ No ○ Yes

SPECIAL NOTE: You will not be reimbursed for the assessment if one of the specified Restriction Exception codes does not exist for the member at the time the assessment is performed.

Organization Which Conducted this Assessment

INTAKE AND INITIAL HISTORY

Individual receives any Adult BH HCBS, or received at any time in the prior 6 months ○ No ○ Yes

Religion

- ○ Roman Catholic
- ○ Mainline Protestant
- ○ Evangelical Protestant
- ○ Non-denominational Protestant
- ○ Historically Black Protestant
- ○ Eastern Orthodox
- ○ Latter-Day Saints (Mormon)
- ○ Unspecified Christian
- ○ Jewish
- ○ Muslim
- ○ Buddhist
- ○ Hindu
- ○ Other
- ○ No religion
- ○ Unknown

Residential/Living Status At Time of Assessment

- ○ Private home/apartment/rented room
- ○ DOH Adult home
- ○ Homeless - shelter
- ○ Homeless - street
- ○ Mental Health supported/supportive housing (all types)
  (Congregate Treatment, Congregate Support, CR/SRO, Apartment Treatment, SOCR, Family Care, Young Adult Housing, Congregate Supportive Housing, Scattered-Site Supportive Housing)
- ○ SUD Residential Program
  (OASAS Stabilization, Rehabilitation, Reintegration Treatment Programs)
- ○ SUD Permanent Supportive Housing
- ○ OCFS/ACS/DSS Community Residence Program
  (Family Foster Care Group Home, Therapeutic Foster Care)
- ○ Long-term care facility (nursing home)
- ○ Rehabilitation hospital/unit
- ○ Hospice facility/palliative care unit
- ○ Acute care hospital/unit
  Note: Do NOT include psychiatric wards of general or psychiatric hospitals here. These can be coded as "Other" and specified.
- ○ Correctional facility
- ○ Other, please specify

Living Arrangement - whom participant was living with at time of assessment

- ○ Alone
- ○ With spouse/partner only
- ○ With spouse/partner and other(s)
- ○ With child (not spouse/partner)
- ○ With parent(s) or guardian(s)
- ○ With sibling(s)
- ○ With other relative(s)
- ○ With non-relative(s)

Individual receives housing supports ○ No ○ Yes

Residential Instability

Residential instability over **LAST 2 YEARS** (e.g., evicted from home, 3 or more moves, no permanent address, homeless, living in shelter) ○ No ○ Yes

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Office of Mental Health
Office of Addiction Services and Supports

Eligibility Assessment

NYSEA ASSESSMENT INFORMATION

Mental Health Services

Time since last contact with community mental health agency or professional in LAST YEAR
e.g., psychiatrist, social worker (exclude this contact)
- O No contact in past year
- O 31 days or more
- O 30 days or less

Time since last psychiatric hospital discharge
Code for most recent instance in **LAST 90 DAYS**
- O No hospitalization within last 90 days
- O More than 30 days ago
- O 15 - 30 days ago
- O 8 - 14 days ago
- O Within last 7 days
- O Now in hospital
- O Not applicable (no prior admissions)

Number Psychiatric Admissions in LAST 2 YEARS
O None O 1 to 2 O 3 or more

Number Lifetime Psychiatric Admissions
- O None
- O 1 - 3
- O 4 - 5
- O 6 or more

Addiction Treatment History
Code for time since last discharge from addiction treatment program or service
- O 30 days or less (from this program)
- O 30 days or less (from another program)
- O 31 - 90 days
- O 91 days to 1 year
- O More than 1 year
- O Not applicable (no prior admission or service)

Inpatient stay for substance use disorder

Number of inpatient **rehabilitation** admissions for substance use disorder in the **past 6 months**
- O None
- O 1 - 2
- O 3 or more

Number of inpatient **detoxification** admissions for substance use disorder in the **past 6 months**
- O None
- O 1 - 2
- O 3 or more

Note: Outpatient services are not included here

Alcohol
Highest number of drinks in any "single sitting" in **LAST 14 DAYS**
O None O 1 O 2 - 4 O 5 or more

Number of days in **last 30 days** consumed alcohol to point of intoxication
- O None
- O 1 day
- O 2 - 8 days
- O 9 or more days, but not daily
- O Daily

Time Since Use of the Following Substances
0 = Never
1 = More than 1 year ago
2 = 31 days - 1 year ago
3 = 8 - 30 days ago
4 = 4 - 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Inhalants (e.g., glue, gasoline, paint thinners, solvents)	O	O	O	O	O	O
Hallucinogens (e.g., phencyclidine or "angel dust", LSD or "acid", "magic mushrooms", "ecstasy")	O	O	O	O	O	O
Cocaine or crack	O	O	O	O	O	O
Stimulants (e.g., amphetamines, "uppers", "speed", methamphetamine, prescription stimulant not prescribed)	O	O	O	O	O	O
Heroin	O	O	O	O	O	O
Other opiates, including synthetics (e.g., oxycodone, hydrocodone, or methadone not prescribed)	O	O	O	O	O	O
Marijuana not prescribed	O	O	O	O	O	O
Sedatives or anti-anxiety not prescribed	O	O	O	O	O	O

Intentional misuse of prescription or over-the-counter medication in LAST 90 DAYS (e.g., used medication such as benzodiazepines or analgesics for purpose other than intended)
O No O Yes

High Risk Consumption
Code for any dangerous pattern of consumption of substances during the **last 90 days** (e.g., excess alcohol consumption in 1 hour or less, injection of pharmaceutical agents, ingestion of hand sanitizer, antifreeze)
O No O Yes

Injection drug use - (Exclude Prescription Medications)
- O Never used injection drugs
- O Used injection drugs more than 30 days ago
- O Used injection drugs in last 30 days: did not share needles
- O Used injection drugs in last 30 days: did share needles

Overdose
Consumption of alcohol, drug, or narcotic in excess of that required to produce the desired effects resulting in significant acute morbidity and requiring medical treatment: overdose may be accidental or intentional

Code for most recent time of event
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Intentional Overdose O No O Yes

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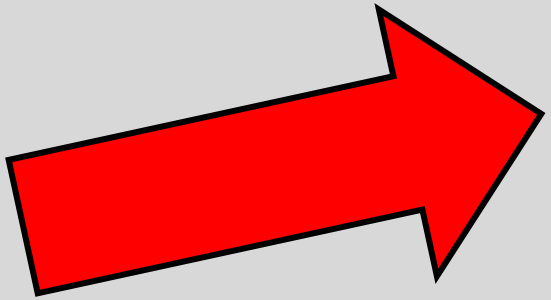

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Eligibility Assessment

Readiness for Change

Alcohol Use
Self-report readiness for change:
Ask "At this time, how ready are you for recovery and to stop or reduce...."

- ○ Ready to change
- ○ Thinking about change but not ready yet
- ○ Not thinking about change
- ○ Could not (would not) respond

Clinician believes that change is required ○ No ○ Yes

Substance Use (e.g., illegal drugs, misuse of legal drugs)
Self-report readiness for change:
Ask "At this time, how ready are you for recovery and to stop or reduce...."

- ○ Ready to change
- ○ Thinking about change but not ready yet
- ○ Not thinking about change
- ○ Could not (would not) respond

Clinician believes that change is required ○ No ○ Yes

Informal Support Network
Person has one or more family member(s) or friend(s) prepared to take an active role in supporting person's recovery efforts. ○ No ○ Yes

Uses Tobacco (including e-cigarettes, vaping and chewing)

- ○ No
- ○ Not in last 3 days, but is usually a daily user
- ○ Not a daily user, but used in the last month
- ○ Yes

Self-Injurious Ideation or Attempt - Code for most recent instance

Considered performing self-injurious act

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Most recent self-injurious attempt

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Intent of Any Self-Injurious Attempt Was to Kill Him/Herself ○ No ○ Yes ○ No attempt

Other Indicators of Self-Injurious Behavior
Family, caregiver, friend, or staff expresses concern that the individual is at risk for self-injury ○ No ○ Yes

Suicide Plan - in LAST 30 DAYS, formulated a plan to end own life ○ No ○ Yes

Violence: Code for most recent instance

Violent Ideation - (e.g., reports of pre-meditated thoughts, statements, plans to commit violence)

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Intimidation of others or threatened violence - (e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence)

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Violence to others - Acts with purposeful, malicious, or vicious intent, resulting in physical harm to another (e.g., stabbing, choking, beating)

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Police Intervention

Arrested with charges

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Incarcerated (i.e., jail or prison with overnight stay)

- ○ Never
- ○ More than 1 year ago
- ○ 31 days - 1 year ago
- ○ 8 - 30 days ago
- ○ 4 - 7 days ago
- ○ In last 3 days

Currently on Probation or Parole ○ No ○ Yes

Currently in Court Diversion/Support Program ○ No ○ Yes

Restraining Order(s)

- ○ Never present
- ○ Previous order(s), but none present now
- ○ Order(s) present

Community Treatment Order(s) e.g., Kendra's Law/AOT

- ○ Not present
- ○ Present

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Eligibility Assessment

Cognitive Skills for Daily Decision Making - Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear or activities to do) - Over Last 3 Days

- O Independent - Decisions consistent, reasonable and safe
- O Modified Independence - Some difficulty in new situations only
- O Minimally impaired - In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
- O Moderately impaired - Decisions consistently poor or unsafe; cues/supervision required at all times
- O Severely impaired - Never/rarely made decisions
- O No discernible consciousness, coma - Person is nonresponsive

Acute Change in Mental Status From Person's Usual Functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception) Code 'No' if symptoms are present but the onset was not sudden or unexpected O No O Yes

Independent Living Skills (Instrumental Activities of Daily Living - IADLs)

Code for PERFORMANCE in routine activities actually done by person around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 = Independent - no help, setup, or supervision
1 = Setup help only - providing or placing an article or device within reach of the person
2 = Supervision - oversight/cueing
3 = Limited assistance - help on some occasions
4 = Extensive assistance - help throughout task, but performs 50% or more of task on own
5 = Maximal assistance - help throughout task, but performs less than 50% of task on own
6 = Total dependence - full performance by others during entire period
8 = Activity did not occur - during entire period (DO **NOT** USE THIS CODE IN SCORING CAPACITY)

	PERFORMANCE 0 1 2 3 4 5 6 8	CAPACITY 0 1 2 3 4 5 6
Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)	O O O O O O O O	O O O O O O O
Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored	O O O O O O O O	O O O O O O O
Managing medications - How medications are obtained and organized (e.g. refilling medications, obtaining new prescriptions)	O O O O O O O O	O O O O O O O
Phone use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	O O O O O O O O	O O O O O O O
Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, in and out of vehicles)	O O O O O O O O	O O O O O O O

Member

Assessor

NEW YORK STATE
Office of Mental Health
Office of Addiction Services and Supports

Eligibility Assessment

Life Events - Code for most recent time of event

Codes: 0 = Never
1 = More than 1 year ago
2 = 31 days - 1 year ago
3 = 8 - 30 days ago
4 = 4 - 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Serious accident or physical impairment	O	O	O	O	O	O
Distressed about health of another person	O	O	O	O	O	O
Death of a close family member or friend	O	O	O	O	O	O
Child custody issues: birth or adoption of child	O	O	O	O	O	O
Conflict-laden or severed relationship, including divorce	O	O	O	O	O	O
Failed or dropped out of education program	O	O	O	O	O	O
Major loss of income or serious economic hardship due to poverty	O	O	O	O	O	O
Review hearing (e.g. forensic, certification, capacity hearing)	O	O	O	O	O	O
Immigration, including refugee status	O	O	O	O	O	O
Lived in war zone or area of violent conflict (combatant or civilian)	O	O	O	O	O	O
Witnessed severe accident, disaster, terrorism, violence or abuse	O	O	O	O	O	O
Victim of crime (e.g. robbery) - EXCLUDE ASSAULT	O	O	O	O	O	O
Victim of sexual assault or abuse	O	O	O	O	O	O
Victim of physical assault or abuse	O	O	O	O	O	O
Victim of emotional abuse	O	O	O	O	O	O
Parental abuse of alcohol or drugs	O	O	O	O	O	O

Peer Support Services (e.g. programs, staff)

Recite the following word-for-word to the individual and code his/her response:

Do you want to receive peer services? A peer specialist is someone who has had health care experience like yours and who has also been trained to give advice to help people achieve their goals. Peer specialists help people improve their overall health and relationships with friends and family, and also help people become more active and involved in the community they live in.

Would you like to be able to see a peer specialist to get this kind of help at any time in the next 12 months?

O No
O Yes
O Could not (would not) respond

Treatment Modalities

Code for treatment modalities offered or received in the **LAST 30 DAYS**, or to be initiated in the **next 30 days**.

0 = Not offered and not received
1 = Offered, but refused
2 = Not received, but scheduled to start within next 30 days
3 = Received 8 - 30 days ago
4 = Received in last 7 days

	0	1	2	3	4
Individual	O	O	O	O	O
Group	O	O	O	O	O
Family or couple	O	O	O	O	O
Self-help/consumers group (e.g. Double Trouble, Alcoholics Anonymous)	O	O	O	O	O
Complementary therapy or treatment	O	O	O	O	O
Day Hospital/Outpatient Program	O	O	O	O	O

Strengths - with specific reference to social support and disposition/personality.

Reports having a confidant	O No	O Yes
Consistent positive outlook	O No	O Yes
Strong and supportive relationship with family	O No	O Yes
Reports strong sense of involvement in community	O No	O Yes

Social Relations

Note: Whenever possible, ask person for his/her point of view

Codes:
0 = Never
1 = More than 30 days ago
2 = 8 to 30 days ago
3 = 4 to 7 days ago
4 = In last 3 days
8 = Unable to determine

	0	1	2	3	4	8
Participation in social activities of long-standing interest	O	O	O	O	O	O
Visit with a long-standing social relation or family member	O	O	O	O	O	O
Other interaction with long-standing social relation or family member other than face to face. (e.g., telephone, email, text, social media)	O	O	O	O	O	O

Person Prefers Change (when asked)

Recreational activities (e.g., type, number, or level of participation)
O No O Yes
O Could not (would not) respond

Relationships (e.g., establishing friendships, improving existing relationships)
O No O Yes
O Could not (would not) respond

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Office of Addiction Services and Supports

Eligibility Assessment

Employment Status - Refers to paid work, either part time or full time
- O Employed
- O Unemployed, seeking employment
- O Unemployed, not seeking employment

Employment Arrangements - Exclude volunteer work
- O Integrated (competitive) without supports
- O Integrated (competitive) with supports (e.g., Transitional employment, intensive supportive employment, ongoing supported employment)
- O Non-integrated (non-competitive)
- O Not employed

Compensation for Work - Exclude volunteer work
- O At or above minimum wage
- O Below minimum wage
- O No pay
- O Not employed

Volunteers - Works as a volunteer (e.g., for community service program or group) O No O Yes

Highest Level of Education Completed
- O No schooling
- O 8th grade or less
- O 9th - 11th grades
- O High school diploma or GED
- O Business or technical school
- O Some college, no degree
- O Associate's degree
- O Bachelor's degree
- O Graduate degree

Enrolled in Formal Education Program
O No O Part-time O Full-time

Average Hours Worked Per Week in the Past Month
Exclude volunteer work, vacation time or medical leave
- O At least 35 hours
- O 10 - 34 hours
- O 1 - 9 hours
- O None
- O Not employed

Risk of Unemployment or Disrupted Education
If person is not employed and not attending school, use "Not applicable"

Increase in lateness or absenteeism over **LAST 6 MONTHS**	O No O Yes O Not applicable
Poor productivity or disruptiveness at work or school	O No O Yes O Not applicable
Expresses intent to quit work or school	O No O Yes O Not applicable
Persistent unemployment or fluctuating work history over **LAST 2 YEARS**	O No O Yes O Not applicable

Employment Support Services
Recite the following word-for-word to the individual and code his/her response:

Do you want to receive job or employment services? A job coach or employment specialist helps people think about whether they want to start working again or do different work. Job coaches and employment specialists also recommend programs that help people find and keep jobs.

Would you like to be able to see a job coach or employment specialist to get this kind of help at any time in the next 12 months?
- O No
- O Yes
- O Could not(would not) respond

Education Support Services
Recite the following word-for-word to the individual and code his/her response:

Do you want to receive education support services? An education specialist helps people think about whether they want to go back to school or college or change their current school or college activities. Educational specialists can also recommend programs that help people make plans to go to school or college.

Would you like to be able to see an educational specialist to get this kind of help at any time in the next 12 months?
- O No
- O Yes
- O Could not (would not) respond

Person prefers change (when asked)

Paid employment (e.g., type, hours, pay)
O No O Yes
O Could not (would not) respond

Education/training
O No O Yes
O Could not (would not) respond

Finances

Because of limited funds, during the **LAST 30 DAYS** made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care
O No O Yes

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Eligibility Assessment

Psychiatric Diagnoses
(Mental Health and Substance Use Disorder)
DSM-IV and/or DSM-5 diagnosis/diagnoses
(patient-or medical-record reported)

List top four diagnoses/disorders. If possible, list in order of clinical importance.

1. _____
2. _____
3. _____
4. _____

COMMENTS

Intellectual Disability -
e.g., Down syndrome, phenylketonuria, fetal alcohol syndrome, autism, Rett's disorder, Tourette's disorder, mental retardation.

O No O Yes

Medical Diagnoses

Disease code
0 = Not present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, not receiving active treament

	0	2	3
Asthma	O	O	O
Diabetes mellitus	O	O	O
Hypothyroidism	O	O	O
Migraine	O	O	O
Traumatic brain injury	O	O	O
Heart disease	O	O	O
HIV/AIDS	O	O	O
Chronic Obstructive Pulmonary Disease (COPD)	O	O	O
Hypertension	O	O	O
High cholesterol or triglycerides	O	O	O
Tuberculosis (either active or newly confirmed inactive infection)	O	O	O
Hepatitis C	O	O	O

Assessment Outcome

Member's Choice to Participate in BH HCBS, if eligible

If determined eligible, would the member choose to participate in BH HCBS?

O No, the member would NOT choose to participate in BH HCBS

O Yes, the member would choose TO participate in BH HCBS

If yes, see BH HCBS next steps

If no, why would BH HCBS services be declined?

O Does not feel BH HCBS will help them reach their identified life role goal

O Receiving State plan service already meets their needs

O Residential setting is not considered home and community based, and there are no current plans to transition into a BH HCBS-compliant setting.

The care manager or other State designated assessor should inform the member that BH HCBS may be revisited at any time, should the member change their mind. At minimum, the care manager or State-designated assesor will revisit BH HCBS opportunities annually.

LOSD Request and linkage to HCBS services

- Will identify which HCBS services will support the individual client goals.
- Will need to be approved by the MCO to determine the HCBS services a client is eligible for.
- Will identify the client's choice for providers of the HCBS services
- Case conferencing with MCO, HCBS, CMA and client

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

Preliminary Plan of Care

Level of Service Determination Request

Date of Plan: _____ Member's Name: _____
Care Coordinator: _____ CMA: _____
Staff Completing Plan: _____ MCO: _____

Section 1: Member Information

Demographic Information

Member CIN: _____ Gender: ☐ Male ☐ Female ☐ Transgender
Date of Birth: _____ Phone: _____
Address: _____ Alternate Phone: _____
_____ Preferred Language: _____
Is the Member linked with any type of housing supports? ☐ No ☐ Yes, specify: _____
Note: Members in Supported and Enhanced Housing are eligible for HCBS with some restrictions
Members in Community Residences are not eligible for HCBS
Diagnoses: _____ _____
_____ _____

Section 2: BH HCBS Eligibility and Services

Results of HCBS Eligibility Screen:
☐ Eligible for Tier 1 HCBS Services ☐ Eligible for Tier 2 HCBS Services

Section 3: Member Goals and Related HCBS Services

In the table below, please specify the specific goals of the Member and the related HCBS service type. Goals should be written in the Member's words. Write in first person using "I" statements to reflect the Member's participation in the goals statements.

Goal	HCBS Service

Section 4: Current Services

Please provide a list of the services or supports the Member is currently receiving. ***If PROS involved, please note that specifically in the grid.***

Service Type or Support *(Counseling, Substance abuse groups, family support, etc.)*	**Agency**	**Provider Name**	**Start Date**	**Frequency** *(daily, weekly, etc.)*	**Paid or Unpaid Service/Support?**	
					Paid	**Unpaid**
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Section 5: Preferences Regarding your HCBS Services and Goals

Please note the Member's preferences for services (i.e. things the Member may want HCBS provider to know about them before intake).

Member Signature
Obtain signature if possible

Date

What happens next?

NYS EA scored and entered in UAS-NY located in the Health Commerce System

Prelim POC completed with identified goals and HCBS

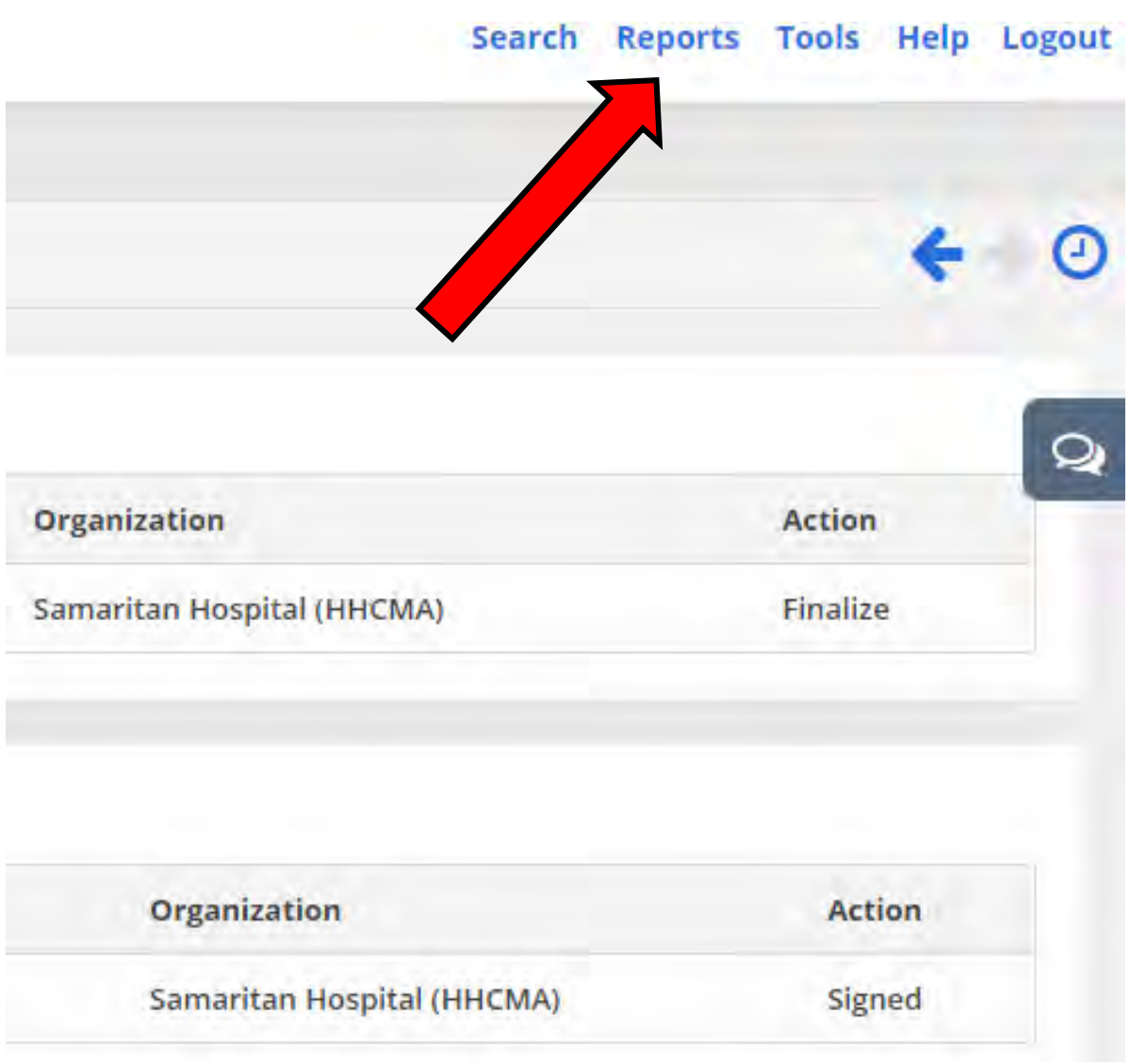
Submission to MCO

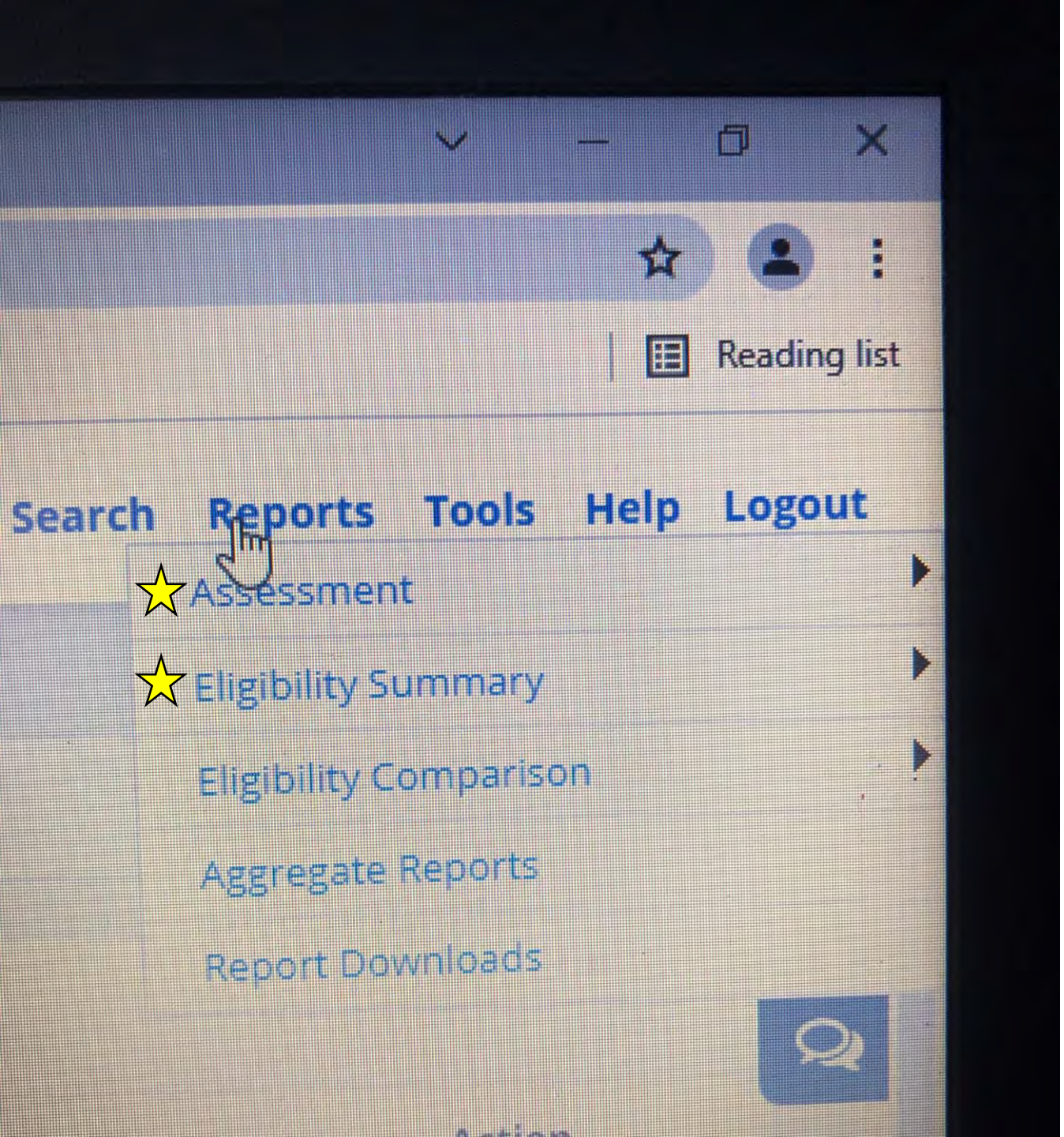
- DOH 5055
- Specific MCO release if applicable
- NYS EA Report
- NYS EA Summary Report
- Preliminary POC

Progress note completed Care Manager attached specific HARP/HCBS objective/goal, upload all documents

Enter results into Care Manager under Assessment Tab, then General Assessment

- There are 6 options based on the process of HARP/HCBS member is at


Search
Reports
Tools
Help
Logout
Organization
Action
Samaritan Hospital (HHCMA)
Finalize
Organization
Action
Samaritan Hospital (HHCMA)
Signed



- Output to PDF and save

MCO determination of LOSD-Request (Prelim POC)

- MCO will send a LOSD to care coordinator and member approving HCBS
- HCBS providers will be listed on LOSD
- Discussion with member about providers
- Update 5055

Referral to HCBS

- Send Adult BH HCBS Referral form to HCBS provider along with following documents:
  - Updated 5055 to include HCBS provider
  - NYS EA
  - NYS EA Summary Report
  - Prelim POC
  - LOSD from MCO

Adult Behavioral Health Home & Community Based Services Referral Form

Date of Referral: _____ ***Updated by the RPC 10/4/18***

Referring Person	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Health Home Care Coordinator/ Recovery Coordinator Information	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
HCBS Participant Information	**First Name**		**Last Name**	
	Soc. Sec. #		**Address**	
	Phone #		**Alternate Phone #**	
	Email Address		**Date of Birth**	
	Primary Language			

HCBS Participant Health Care Information	**Managed Care Organization (MCO) Name**		**MCO ID #**	
	MCO Contact Name		**MCO Phone Number**	
	MCO Contact Email		**Medicaid CIN Number**	
	Primary Diagnosis & ICD 10 Code		**Secondary Diagnosis & ICD 10 Code**	

Any Known Safety Concerns? *(Criminal Record, History of Violence, Weapons in the Home, Sex Offender, General Concerns, etc.):* ☐ *N/A*

Referred HCBS Service(s):

☐ **Habilitation**	☐ **PSR**
☐ **Pre-Vocational Services**	☐ **Family Supports & Training**
☐ **Community Psychiatric Supports and Treatment (CPST)**	☐ **Empowerment Services (Peer Supports)**
☐ **Short Term Crisis Respite**	☐ **Intensive Crisis Respite**
☐ **Transitional Employment**	☐ **Intensive Supported Employment**
☐ **Ongoing Supported Employment**	☐ **Education Support**

Any Identified Service Restrictions Surrounding Client Availability? ☐ *N/A*

Below sections are for HCBS Service Provider Affiliate to Complete: **Date Received:**

BH HCBS Provider Assigned		***Date Assigned***	
BH HCBS Supervisor			

HCBS AGENCY INFORMATION:

AGENCY NAME: _____ **POINT OF CONTACT:** _____

PHONE: _____ **FAX:** _____

E-MAIL: _____

HCBS engagement with member

- HCBS provider has up to 3 visits within 14 days to determine scope, frequency and duration of requested services
- HCBS provider submits request to MCO for approval
- HCBS provider develops ISP (Individualized Service Plan)
- HCBS provider sends to care coordinator

HARP POC

- **Person-Centered Care**: Services should reflect an individual's goals and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the persons overall wellbeing and full community inclusion.
- **Recovery-Oriente**d: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, employment, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.
- **Integrated**: Services should address both physical and behavioral health needs of individuals. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness

HARP POC Video

BH HCBS Plan of Care (POC)

BH HCBS PLAN OF CARE Requirements document

Background and Use of this Template – Updated August 7, 2019:

This template was created by the Capital Region RPC and was based from elements included in the original State Adult BH HCBS plan of care (POC) template. This is not intended to be a stand-alone document and is only recommended as a best practice in addition to the HCBS Individualized service plan. For access to the State issued Adult BH HCBS POC Template, please click here.

Section 1: Behavioral Health Home and Community Based Services (BH HCBS) Eligibility

Person Completing POC:	**Organization:**
Phone #:	**Email:**
Lead Health Home:	**Results of BH HCBS screen:** ☐ Eligible for Tier 1 BH HCBS only ☐ Eligible for Tier 2 BH HCBS (Full array) ☐ Not Eligible
Eligibility Assessment Completion Date: **Next Assessment Due:**	

Preferences Regarding HCBS Services and Goals: *Please note the Member's preferences for the services (i.e. things the Member may want HCBS provider to know about them before intake)*

Complete the following two items, only if an education or employment support service (Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, and/or Education Support Services) is included in the Plan of Care.

The Health Home Care Manager (HHCM) is responsible for facilitating the Member's informed choice in education and/or employment support services. The following selection should be made by the Member, based on an informed choice.

Based on the information provided to me by my Care Manage, I have chosen to (please select only one option):

- ☐ Receive services through the Home and Community Based Services (HCBS) Waiver designated agency;
- ☐ Pursue support from ACCES-VR; or,
- ☐ Receive services through the BH HCBS Waiver *and* pursue separate and non-duplicative services through ACCES-VR

If BH HCBS education and/or employment support services are chosen by the Member, the HHCM must affirm the following:

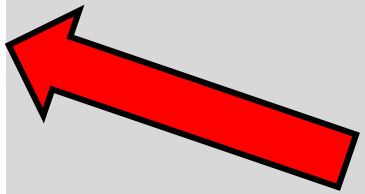
☐ The Behavioral Health Home and Community Based Services identified in this Plan of Care are not available to this individual under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) (i.e. ACCES-VR).

Section 2: Demographic information

Individual Name		MCO, Member ID, & Medicaid #/CIN	
Date of Birth		Gender	
Address		Home Phone #	
Cell Phone #		Email	
Language		Religion	

Is the address listed above a setting chosen by the individual? (Does the individual want to live in the above setting?)	☐ Yes ☐ No
The address listed above is not: (1) a nursing home; (2) an institution for mental diseases; (3) an intermediate care facility for individuals with developmental disabilities; (4) a hospital; (5) an OMH licensed Congregate Treatment Site (Community Residence); or, (6) any other location that has the qualities of an institution, as determined by New York State.	☐ Yes ☐ No

****** If the individual does not wish to live in his or her current setting, the CM should assist in developing a plan to facilitate a move. The Housing Questionnaire may be used as a tool to assist with this process.***



Section 3: Clinical and Non Clinical Services at the Time of Assessment

Behavioral and Medical Health Needs (e.g., Mental Health Treatment, Addiction Treatment, and PCP Information)											
Service	Provider Specialty	Provider name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency	Last visit date
					NA	NA	NA		NA		
					NA	NA	NA		NA		
					NA	NA	NA		NA		

Section 4: Health Home Care Management/Recovery Coordination Agency

Status	Tests/ Treatment/ Service/ Referral	Service Description	Provider Name	Provider Specialty	Organization	Phone	Email	Address
		Care managment		Health Home Case Manager	Alliance for Positive Health			

Section 5: Risk Assessment and Mitigation Strategies

Crisis Prevention Plan

It is often helpful to be aware of events, feelings, thoughts and sensations that are early warning signals for an emotional crisis. If I begin to experience them, I can use the following plan.

What are my triggers (what people, places, or things upset me); how do I know when I am upset?

What activities can I do to feel better (for example, take a walk, listen to music, or watch TV)?

Who can I call for support?

Name	Relation	Contact Info

Emergency Plan (In the event of an emergency, natural disaster, etc.)

If there is an emergency, call 911. *An emergency plan assists in locating help in an emergency situation or if regularly scheduled worker(s) cannot provide you care, services, or supports. The back- up plan will indicate: whom I will call, including service needs, and phone numbers, plans for service animals or pets, and plans for preparing for a disaster.*

I will talk with back-up workers about their availability and my care needs before an emergency comes up. I understand that I may only get my most serious needs met in an emergency.

I will call/ contact one of the individuals listed below if my regularly scheduled worker(s) does not report for his/ her scheduled time. (Examples: provider, friends, family, previous workers, church members, other volunteers).

Service	Contact	Phone	Availability
			M-F

Risk Assessment to Justify an Intervention / Support to Address an Identified Risk

If a risk is identified address items A – H below:

If risk is identified, complete the following:

A. Identify the specific and individualized assessed need.
B. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
C. Document less intrusive methods of meeting the need that have been tried, but did not work.
D. Include a clear description of the condition that is directly proportionate to the specific assessed need.
E. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
F. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
G. Include informed consent of the individual or legal representative or guardian.
H. Assure that interventions and supports will cause no harm to the individual.

Include a narrative addressing all items A-F and H if an intervention is utilized:

A.	No Risks identified
B.	
C.	
D	
E.	
F.	
G	
H	

By signing below, I agree with the use of this intervention or support to address the identified risk. I will watch and make sure that the interventions and support do not harm me in any way.

Recipient:		Date:	
Legal Representative/Guardian:		Date:	
Care Manager:		Date:	
Care Manager Supervisor:		Date:	

Section 6: Person-Centered Plan of Care Affirmation / Attestation

The Care Manager and MCO are responsible for monitoring, on a regular basis, whether the services in the Plan of Care are being delivered as outlined in the Plan of Care and whether those delivered services meet the needs of the individual. The Care Manager will contact the Recipient routinely to ensure that the Recipient's goals, preferences, and needs are being met. The Recipient may call the Care Manager at any time to initiate changes or discuss the quality of care of the services listed in the Plan of Care. If at any time a provider or the Recipient becomes aware of unnecessary or inappropriate services and supports being delivered, he/she is obligated to contact the Care Manager and discuss a change in the Plan of Care.

Commitment to Confidentiality and Support:
By signing this form, I agree to maintain Recipient confidentiality; I affirm that I participated in the development of this Plan of Care and the Recipient was given choices in selecting providers; I support the goals of the Recipient below; I acknowledge that I understand and approve the content of this Plan of Care; and I have a copy of this Plan of Care.

Release of Information: I consent to the release of information under the BH HCBS program, so I may receive services. I understand that the information included on the Plan of Care will be released to _____ and service providers listed below to enable the delivery of services and program monitoring. I understand that my Care Manager shall not release my record in the absence of written authorization from me or my representative.

MCO

I affirm to share my PLAN OF CARE with following individuals:

Name	Phone	Address	Relationship (relative, doctor, Care Manager, other)

Documentation of Informed Choice: My signature below affirms that I have been informed by my Care Manager of the benefits of receiving supported education and employment services through the Behavioral Health Home & Community Based Services (BH HCBS) Waiver and ACCES-VR, as documented in Section 3 of this Plan of Care.

Signature	*Date*	*Print Name*
Individual		
Legal Representative/Guardian		
Care Manager		
Provider:		
Provider:		
Provider		

Recipient Rights for Individuals Receiving Behavioral Health Home and Community Based Services (BH HCBS)

I qualify for BH HCBS which are essential to my health and welfare and may be provided to me within the program limits. My signature below indicates that I agree with the following:

☑ I have been informed that I am eligible to receive services.
☑ I understand that I may choose to remain in the community and receive the services, as designated in my Plan of Care.
☑ I understand that I have the choice of any qualified providers in my plan's network and I have been notified of the providers available.
☑ I understand that I have the right to be free of abuse, neglect, and exploitation and to report of these abuses at any time.
☑ I understand I may grieve and appeal at any time and have received information on how to do this.
☑ I have been offered a choice of settings in which I can receive BH HCBS.

Please ensure that your Care Manager has reviewed the Plan of Care with you and has provided a copy of this Plan of Care to you before signing.

My choice is to (check one):

☑ Receive BH HCBS as indicated on the attached Plan of Care.

☐ Refuse the recommended services

Recipient Signature	**Date**
Representative Signature	**Date**
Care Manager Signature	**Date**

Abuse, Neglect, Exploitation

Physical Abuse: Non-accidental contact which causes or potentially causes physical pain or harm

Psychological Abuse: Includes any verbal or nonverbal conduct that is intended to cause emotional distress

Sexual Abuse: Any unwanted sexual contact

Neglect: Any action, inaction or lack of attention that results in or is likely to result in physical injury; serious or protracted impairment of the physical, mental or emotional condition of an individual

Exploitation: The illegal or improper use of an individual's funds, property, or assets by another individual. Examples include, but are not limited to, cashing an individual's checks without authorization or permission; forging an individual's signature; misusing or stealing an individuals' money or possessions; coercing or deceiving an individual into signing any document (e.g. contracts or will); and the improper use of guardianship, conservatorship or power of attorney

I understand what abuse, neglect and exploitation mean.

If I believe I am at risk of harm from or experience abuse, neglect, or exploitation, I know that I should contact:

Name	Phone	Location
		if at home
		if in the community

In their own words….

- HCBS Video for Care Coordinators and Providers – YouTube