Policy/Procedure:	Plan of Care
Reviewed and Accepted by:	John Migliore III & Justin Honkala
Approved by:	John Migliore III
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Policy:

Bassett Community Health Navigation will ensure a Person-centered Plan of Care is developed for each enrolled member which includes the individual's stated goals, preferences and strengths, assessed and expressed needs, and which identifies key community networks and supports, planned interventions, and timeframes related to treatment, wellness, and recovery.

***CHN refers to Community Health Navigators & Partnering Health Home Care Managers**

Procedures:

A. Plan of Care Requirements for all Health Home Members

1. CHN must complete a Plan of Care for each Member as follows:
   a. Within 60 days of the Member's enrollment date
   b. Annually (within 12 months of last occurrence)
   c. As needed, based on changes in the Member's identified needs or health conditions, or when a Member adds, makes changes to, or discontinues identified goals/objectives.

   ** If unable to complete a Plan of Care as required, CHN must document the reason and the efforts made to engage the Member and gather information to complete the Plan of Care.

2. CHN will assist the Member to develop a Plan of Care from all relevant information:
   a. Available Health Records
   b. Motivational Interviews/Contacts with Member
   c. Bassett CHN Comprehensive Assessment
   d. Communication with the Member's Care Team:
      i. Primary Care Provider & Specialists
      ii. Community/Social Supports
      iii. Managed Care Organization

3. CHN will ensure the Plan of Care is written in a manner that is appropriate for a Member's reading and comprehension levels, and is understandable to the Member.
   a. Plans of Care will be written in the Member's primary language or translated to the member through approved translation services.
   b. Whenever possible, Plans of Care will be written in the words and vocabulary of the Member when stating goals, objectives, and interventions.

4. CHN will ensure that the Member's Plan of Care is developed to include all of the following information related to treatment, wellness, and recovery:
   a. All Identified Participants of the Member's Care Coordination Team:
      i. Member
      ii. Assigned CHN/Care Manager
      iii. Primary Care Physician/Nurse Practitioner
      iv. Behavioral Health Provider(s)
      v. Specialist Provider(s)
      vi. Identified Social Supports and Caregivers
      vii. Community Resources/Social Service Agencies
      viii. MCO (if the Member has Managed Care Medicaid)
   b. Identified Strengths
   c. Identified Barriers to Care
      i. Examples: Denial of Disease, Unwillingness to Engage in Treatment, Cognitive Impairments, Lack of Social Supports, Lack of Transportation, Cultural or Linguistic barriers, etc.)
   d. Identified Goals & Preferences of the Member
   e. Objectives & Interventions to address each of the following areas identified by the Member, Care Team, Comprehensive Assessments and available health records**:
      i. All Chronic Conditions and Health-related Problems
      ii. All Providers and Care Team Members involved in the Member's Care
      iii. Wellness and preventative care for any of the following conditions:
         - Asthma
         - Diabetes
         - Hypertension/Cardiovascular Disease
         - Smoking/Tobacco Dependence
         - HIV/AIDS
      iv. Identified Barriers to Care
      v. Identified Social Service & Healthcare Needs:
         - Housing
         - Food/Food assistance
         - Financial
         - Homecare services
         - Other identified Needs or Preferences
      vi. Engagement with CHN/HH Care Management services
         - Required/Preferred Care Management Contact
         - Completion of Annual Comprehensive Assessment
         - Participation in Annual Care Team Meeting

** When specific health conditions or problems are discussed with the Member and it is determined that the Member does not want to address specific conditions or problems, the lack of interest or refusal to address them in Care Planning must be clearly documented in the Member's Notes.

5. CHN will review the Plan of Care with the Member to ensure it meets the Member's approval.
    a. CHN will ensure the Member signs the Plan of Care to indicate approval.
        i. If any changes or modifications are made to the Plan of Care, the CHN will ensure the Member signs/initials revisions and updates.
        ii. If the Member is unable to sign, CHN will seek verbal approval and will document the member's verbal approval and reason for not signing.
    b. For Excellus MCO Members, the CHN must send the following documents to Bassett CHN Referral Coordinator via fax or encrypted email:
        i. DOH-5055 Health Home Patient Information Sharing Consent
        ii. Plan of Care

6. CHN will ensure the Plan of Care is available for review by the Member and consented participants of their Care Team (Providers, Social Supports, etc.).
    a. Ensure a copy is available in the Member's Care Management Record.
    b. Provide the Member with a copy.
    c. Provide the Member's consented Care Team participants with a copy as requested.

B. Required Review and Update of Plan of Care

1. CHN must ensure review and update of the Member's Plan of Care as follows:
    a. When changes in goals, objectives, or interventions are identified.
    b. When changes occur in the Member's health conditions or identified needs.
    c. Must be reviewed & updated annually after enrollment (within 12 months of last occurrence).

2. CHN will update the Member's Plan of Care as follows to reflect current identified needs.
    a. Elicit input of the Member's Care Team (Providers, MCO, Supports, etc.)
    b. Clearly document the Member's progress in meeting goals, objectives & interventions.
    c. Make appropriate changes in the Plan of Care, as applicable:
        i. Updates to the Member's identified team of Providers, Services, and Supports.
        ii. Updates to the Member's Health Conditions & Care Needs.
        iii. Updates to the Member's Strengths, Barriers, and Preferences.
        iv. Updates to the Member's identified Goals, Objectives, Interventions & Timeframes.

C. Additional Plan of Care Requirements for HARP Members Eligible for Home and Community Based Services (HCBS)

1. HARP Members must have an HCBS Eligibility Assessment completed before proceeding with Plan of Care development, as per Assessment & Eligibility Policy and Procedures.
    a. If HCBS Eligibility Assessment results indicate a HARP member is eligible for Tier 1 or Tier 2 HCBS services, and the member selects to receive any of those services, the CHN must:
        i. Develop a Plan of Care in the Member's Care Management Record system which, in addition to meeting the requirements of a HH Plan of Care, also includes objectives and interventions which address the following:
            - Referral and engagement with HCBS Service providers.
            - Development of a BH HCBS Plan of Care with the Member/Care team.

   ii. Develop a Behavioral Health Home and Community Based Services (BH HCBS) Plan of Care based on information obtained from Comprehensive Assessments, Person-centered discussions with the Member, the Member's care team and selected HCBS providers, and available health information.

b. A BH HCBS Plan of Care is not required if the HARP-enrolled Member:
   i. Is determined to be ineligible or is not approved for HCBS services.
   ii. Declines all HCBS services offered.

2. When the BH HCBS Plan of Care is completed, CHN will submit required documents to the Member's MCO, as specified in the Bassett CHN HARP/HCBS MCO Approval Protocol.

3. After the Member's MCO issues a Determination of Approval for selected HCBS services, the CHN will facilitate referrals to the selected HCBS providers and assist the Member's participation in HCBS provider assessments as necessary.
   a. HCBS Providers will develop Individual Service Plans for each HCBS service, determining the scope, frequency and duration of each service, and submit them to the Member's MCO for approval. CHN is responsible for maintaining contact with HCBS Providers to share information.

4. When HCBS Individual Service Plans have been approved, the CHN will continue to review and update the BH HCBS Plan of Care based on information from the Member, Care Team, and selected HCBS providers.
   a. The updated BH HCBS Plan of Care is to be completed within 90 days of the HARP Member's Bassett CHN enrollment date or subsequent designation as HARP-enrolled.
   b. CHN must also send a copy of the updated BH HCBS Plan of Care to the Member's MCO, as per protocol specified in the Bassett CHN HARP/HCBS MCO Approval Protocol.

D. Additional Plan of Care Requirements for AOT/HH+ Members

1. Assigned CHN must ensure that all categories of service listed in the member's court-ordered AOT/HH+ treatment plan are included in the Member's Plan of Care.
   a. Any additions or deletions of *categories of service* are considered "material changes" and the assigned CHN must consult with the treating physician and the LGU's Director of Community Services or County AOT coordinator, who can then petition to the court for any material change needed to be made to the AOT/HH+ treatment plan
   b. Changes needed to other services in the HH Plan of Care that are not listed in the AOT treatment plan (e.g., primary care services), are not considered material changes and therefore do not require consultation with the LGU.

Related Forms & Documents:

◊ **Bassett CHN Care Management Record Documentation Guide**
◊ **BH HCBS Plan of Care**