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# Completing the BH HCBS Plan of Care

Person-Centered Planning & the Plan of Care

# Training Objectives

- ✓ Health Home Care Managers (HHCMS) will review the role of Person-Centered Planning in the development of the Plan of Care
- ✓ HHCMS will be able to identify state and federal guidelines and requirements regarding Plan of Care documentation
- ✓ HHCMS will see a sample of a completed, **person-centered, strengths-based, recovery-oriented** Plan of Care that identifies appropriate services
- ✓ Care Management Agencies (CMAs) will leave with a framework for developing a Plan of Care document that meets or exceeds all requirements



# Intro to Person-Centered Planning Concepts



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# Person-Centered Planning

SAMHSA (2015a) defines “Person-Centered Planning” as a **collaborative process** where service recipients participate in the development of goals and services provided, to the greatest extent possible. Effective person-centered planning strengthens the voice of the individuals, builds resiliency, and **fosters recovery**. The process of developing a person-centered Plan of Care is supported by the development of a partnership and process for collaboration between the Health Home Care Manager and the individual receiving services.



# Defining Recovery

“Recovery is a journey of healing and transformation enabling a person with a mental health or substance use problem to live a meaningful life in a community of his or her choice while striving to reach his or her full potential.”

(The Council on Quality and Leadership, 2010)



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# Behavioral Health & Recovery

“The adoption of recovery by behavioral health systems in recent years has signaled **a dramatic shift in the expectation for positive outcomes** for individuals who experience mental and/or substance use conditions. Today, when individuals with mental and/or substance use disorders seek help, they are met with the **knowledge and belief that anyone can recover** and/or manage their conditions successfully. ...**Hope**, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person’s recovery is based on his or her **strengths**, talents, coping abilities, resources, and inherent values.”

(SAMHSA, 2015b)



# Person-Centered Planning and Federal Requirements/Characteristics

The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision making authority to the legal representative.

This checklist may be used to determine whether the Person-Centered Planning process requirements have been met:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hcbs\\_fed\\_person\\_centered\\_planning\\_process.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_fed_person_centered_planning_process.pdf)



# Person-Centered Planning: The Logic of Building a Plan



(Adams, N. & Grieder, D., 2005)



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**Best Practice:** During the Person-Centered Planning process, the Care Manager needs to provide important information regarding services, supports, and resources in order to **enable the person to participate fully and effectively**. Some tips on how to provide this information include:

- ✓ Assess the person's knowledge and awareness of their chronic health conditions and treatment options
- ✓ Use appropriate, understandable language; avoid acronyms and abbreviations
- ✓ Provide visuals, including charts or diagrams when necessary
- ✓ Have copies of brochures for service providers and community resources (ask local organizations for extra copies of their marketing materials)
- ✓ Provide Fact Sheets on diagnoses and/or services
- ✓ If available, share outcome data from provider agencies
- ✓ Offer to share copies of this information with natural supports (parents, spouses, friends), if an appropriate release has been signed



# Additional Federal Documentation Requirements

In addition to following a person-centered planning process when developing the Plan of Care, each Health Home provider agency is responsible for ensuring that their Plan of Care template meets the Federal Documentation requirements found on the checklist below:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hcbs\\_poc\\_fed\\_rules\\_regs.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_fed_rules_regs.pdf)



# Federal Documentation Requirements

## The Plan of Care:

- ✓ Reflects that the setting in which the individual resides is chosen by the individual.
- ✓ Reflects the individual's strengths and preferences
- ✓ Reflects clinical and support needs as identified through an assessment of functional need
- ✓ Includes individually identified goals and desired outcomes
- ✓ Reflects the services and supports (paid and unpaid) that will assist the individual to achieve goals
- ✓ Reflects risk factors and measures in place to minimize them
- ✓ Is understandable (written in plain language) to the individual receiving services and supports

(Continued on next slide.)



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# Federal Documentation Requirements

- ✓ Identifies and lists the individuals(s) and/or entity(ies) responsible for monitoring the Plan of Care
- ✓ Is finalized and agreed to, with the informed consent of the individual in writing, and is signed by all individuals and BH HCBS providers responsible for its implementation
- ✓ Is distributed to the individual and other people involved in the plan
- ✓ Includes self-directed services, if/when applicable
- ✓ Prevents the provision of unnecessary or inappropriate services and supports
- ✓ Documents modifications based on risk assessment ([see federal guidelines for more information](#))



# Developing a Plan of Care



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# What is the Plan of Care?

The Plan of Care is a **roadmap** to behavioral and physical health and recovery. It guides the individual, his family and other natural supports, and providers toward achieving goals and positive outcomes. Based on a thorough assessment of the individual's **strengths**, preferences, barriers, and needs, the Plan of Care will indicate which paid and unpaid services and supports the person has chosen to receive.



# The Plan of Care & Quality

A high-quality Plan of Care, developed within a Person-Centered, strengths-based, and recovery-oriented framework, will:

- ✓ Promote and instill **hope**
- ✓ Act as a resource (“roadmap”) to the individual and providers
- ✓ Engage the individual in recovery and forge a partnership between the individual and the HHCM
- ✓ Prevent a duplication of services and supports

*A high-quality POC should be **focused** on the individual’s goals and will improve the ability of other service providers to coordinate services, supports, and interventions.*



# The Process of Developing the Plan

## ✓ Ask questions:

- How would you describe yourself to someone who doesn't know you? What are your interests or hobbies?
- What is important to you in your life? Why?
- What are your hopes and dreams for the future? Are there any hopes or dreams from earlier in your life that you'd like to revisit?
- How does your behavioral health disorder affect your day-to-day life?
- How do you spend your days?





# The Process of Developing the Plan

- Are you satisfied with your living situation right now? Is there anything you'd like to change about your living situation?
- Are you interested in taking better care of your health? Would you like to improve your self-care?
- Who are the most important people in your life right now? Who do you spend your time with?
- What supports and services can help you get where you want to go?



# The Process of Developing the Plan

- ✓ Use of the Plan of Care template alone does not meet the requirements of the person-centered planning process, rather it should be used as a tool for documenting individual content in a person-centered way.
- ✓ A skilled HHCM will **facilitate** the Plan of Care meeting in such a way that the **relevant and necessary information is elicited** from the individuals and providers, and that may mean that you do not move through the document in a linear fashion.

***Best Practice:** When developing the Plan in partnership with the person, the HHCM should start work on Section 3 (BH HCBS Eligibility) & Section 6 (Goals, Preferences, & Strengths) before completing Sections 2, 4, & 5. This will ensure that the person's goals, preferences, and strengths guide the planning process.*



# The Process of Developing the Plan

- ✓ The CMA should be aware of what the state and federal requirements are, what the sample template includes, and what the agency's Electronic Health Record (EHR) includes. If discrepancies are identified, rely on state and federal guidance documents when determining whether your form meets minimum requirements.
- ✓ CMAs should advocate with your EHR provider for Person-Centered and Strengths-Based forms. Don't be afraid to request changes if the tools they provide do not meet your agency's needs.



# Sample Plan of Care

Person-Centered Planning in Action



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# Completing a Person-Centered POC

The following is an example of a person-centered Plan of Care using the [template](#) located on the DOH website. However, each CMA is responsible for ensuring that the template they adopt meets the Federal Adult Behavioral Health HCBS Person-Centered Planning Process Requirements/Characteristics and the Federal Adult Behavioral Health HCBS Plan of Care Documentation Requirements.

*You are encouraged to develop your own template or modify the one provided in order to meet and exceed these requirements.*



# Case Example

Mary is a 34 year-old single African American female who is **employed** as a food service worker and lives alone in her community in Albany, NY. Mary enjoys several **interests including playing the piano, writing poetry, reading, and watching movies**. She was recently assessed as **eligible for Adult Behavioral Health HCBS Services** on the NYS Community Mental Health Assessment. She is now seeking supports through the BH HCBS Waiver due to the recurrence of mental health symptoms. Mary has been **in recovery from a substance use disorder for five years**. Mary was encouraged to seek help by her supervisor at work because of **increased anger outbursts** over the last 6 months. She has held her **current job for 14 months**. Mary reports that she decided, on her own, to **stop taking medications** prescribed for the treatment of a **schizoaffective disorder** about six months ago. She reports that she was “feeling good” and that she believed that the medicines were causing her to gain weight and feel “dopey” during the day. Mary also has Type-2 Diabetes, and she believes her psychiatric medications were affecting her blood-glucose levels. While Mary has **maintained sobriety**, she is concerned that the recurrence of mental health symptoms may jeopardize the progress she has made.



# POC Cover Page

## Behavioral Health Home and Community Based Services (BH HCBS) PLAN OF CARE

*Click here to access the PLAN OF CARE Guidelines document.*

*Please contact the Care Manager at [abc@test.com](mailto:abc@test.com) if you need copy of PLAN OF CARE*

<i>Care Manager</i>	Jane Smith	<i>Organization</i>	Health Home XYZ, Inc.
<i>POC Meeting Location</i>	123 Main St., Albany, NY 12203	<i>Date</i>	01/21/2016
<i>Tel #</i>	518-555-1234	<i>Email</i>	abc@test.com
<i><u>InterRAI</u> Completion Date</i>	01/18/2016		
<i>Next Assessment Due on</i>	01/17/2017		



# Section 1: Demographic Information

## Section 1: Demographic Information

Individual Name	Mary Jones	Medicaid #/ CIN	AB12345C
Date of Birth	09/09/81	Gender	Female
Address	12345 Green St., Rm. 322 Albany, NY 12203	Home Phone #	N/A
Phone #	518-555-9876	Email	<a href="mailto:maryjones@email.com">maryjones@email.com</a>
Language	English	Religion	Non-affiliated

**Best Practice:** If the individual has guardian or Personal Representative, the CM should indicate that and should include their contact information in the Plan of Care.





# Section 3: BH Home and Community Based Services (BH HCBS) Eligibility

✓ Per the DOH HH Standards (10/05/15):

- documentation of the results of the HCBS Eligibility Screen must be documented on the Plan,
- for individuals eligible to receive HCBS, a Summary of the NYS Community Mental Health Assessment.

## Section 3: Behavioral Health Home and Community Based Services (BH HCBS) Eligibility

Results of BH HCBS screen:

- Eligible for Tier 1 BH HCBS only
- Eligible for Tier 2 BH HCBS (Full array)
- Not Eligible



# Section 6: Goals, Preferences & Strengths

- ✓ Per DOH HH Standards (10/05/15), the Plan must include the individual's stated Goals related to treatment, wellness, and recovery;
- ✓ Per Federal Documentation Requirements, the plan must:
  - reflect the individual's strengths and preferences;
  - Include individually identified goals and desired outcomes;
  - be understandable to the individual receiving services and supports (written in plain language)

**Best Practice:** When writing objectives, use the SMART formula (adapted here to fit a recovery-oriented framework):

**Specific, Measureable, Action-Oriented, Reflective, Time-Oriented**



## Defining Key Concepts

Goal: A statement of what the person is hoping to achieve (typically specific to a certain life domain). It should **affirm the person's choice** in how he or she wants to live, work, and/or enjoy his or her life.

Objective: Something that an individual will **do or change** while working toward achieving a goal. Objectives clearly represent steps toward the achievement of the goal. Objectives are a statement of the intended result.

Outcome: Outcomes are what was or was not done or achieved. Outcomes can be positive or negative. An outcome statement should tell the reader **what you intend to happen** as a result of meeting the objective.

Intervention: What the paid or unpaid supporter (staff) will do to support the achievement of objectives and goals. Services and supports are interventions.



<b>Goal #1</b> <i>I would like to continue working in my current job.</i>	
<b>Category</b> Employment	<b>Target Date</b> 06/30/16
<i>Past Efforts (Things that I have tried in the past to reach my goal)</i>	
I have worked at my job for 14 months. My supervisor is aware of my mental health diagnosis, and she has been supportive. However, my recent challenges with handling my anger and frustration at work have made it difficult to do my job well.	
<i>Objectives (The outcomes I want to achieve)</i>	
I want to provide excellent customer service to customers so that I don't lose my job. I want to learn how to manage my mental health symptoms in a way that doesn't interfere with my ability to perform essential job tasks. I want to effectively manage my anger and frustration at work.	
<i>Preferences (I would prefer that when I receive services the following is taken into account by the provider)</i>	
I need my service providers to have experience helping people with mental illness keep their jobs. I want my service providers to know about my benefits, and how working impacts them. I want my service provider to know what my job involves and what skills or techniques will and will not work in that setting.	
<i>Strengths (My strengths are)</i>	
I have had my job for 14 months. I am friendly and enjoy talking to customers. I have a supportive family. I have just over five years of sobriety, and I am in contact with my dual-recovery sponsor at least once a week. I know that if I were using again, I wouldn't have been able to keep my job for this long.	
<i>Potential Barriers (Things that make it hard for me to achieve these outcomes)</i>	
I was taking psychiatric medications for a long time, but the ones that helped my mental health made my physical health worse. I don't know how to manage my mental health symptoms without medication, but I don't want to go back on the old meds. I've tried some calming techniques before, but they're hard to use in high-pressure situations, like work. Dealing with my anger makes it hard to maintain my substance use sobriety, but I know that if I use alcohol or other drugs, it'll just make things worse.	



*Strategies (Things that I will do to address the barriers and achieve my desired outcomes)*

I want to work with an employment specialist who can help me keep my job. I will work on managing my symptoms using the Wellness Self-Management skills I learned in the hospital. I will talk to my psychiatrist about why I stopped using medications, and I will consider whether I should give it another try with different meds. I will continue attending my meetings with the dual-recovery 12-step group and will continue to call my sponsor when needed.

*Support(s) Needed (Who will help me reach my goal)*

Indicate if supports are to be provided by paid or unpaid provider and the frequency needed.

BH HCBS Ongoing Supported Employment will be provided to help Mary identify, practice, and use anger management coping skills in the work place. This is a paid provider.

BH HCBS Empowerment Services – Peer Support will be provided weekly to assist Mary with managing substance use triggers and cravings, particularly as they relate to stressors in the workplace. This is a paid provider.

Psychiatry will be provided by Mary's psychiatrist and psychiatric nurse practitioner. These paid supporters will work with her and her support network to identify whether changes should be made to her psychiatric medication(s). Clinical counseling and therapy will be provided by Mary's social worker, who will monitor her symptoms and provide support around functional deficits related to her recurrence of symptoms.

Mary's 12-step Dual Recovery support group will provide support and the opportunity for mutual-aid. Mary's sponsor will be available as needed to support her sobriety. Mary may attend meetings as frequently as needed, and has committed to attending at least one per week. This is an unpaid support.

**Best Practice:** Using the person's own language and "I" statements is empowering and conveys a sense of ownership over the outcomes listed.



**Goal #2**

*I would like to keep my weight under control. For me, this means between 135 – 150 pounds.*

**Category**

Health & Wellness

**Target Date**

08/31/16

**Past Efforts** *(Things that I have tried in the past to reach my goal)*

I keep reading about different diets on Facebook, and I try them, but then I quit after a day or two. I didn't have a problem managing my weight until they put me on Abilify. I was a skinny kid, but I'm always hungry now! Even when I don't eat a lot, my weight doesn't change, but my blood glucose levels drop.

**Objectives** *(The outcomes I want to achieve)*

I want to get my weight back down to a healthy level. I want to manage my diabetes through lifestyle choices. I want to be able to climb the stairs to my apartment without stopping to taking a breath on the landing.

**Preferences** *(I would prefer that when I receive services the following is taken into account by the provider)*

I don't want them to talk down to me. I know a lot about healthy food and exercises, but I just can't stick to a plan. I want someone who's been through this before and was able to recover.

**Strengths** *(My strengths are)*

I know a lot about healthy food and exercising. I used to be really outdoorsy and did a lot of fun things before my symptoms started. I want to use my knowledge and experience to lead a healthier lifestyle.

**Potential Barriers** *(Things that make it hard for me to achieve these outcomes)*

When I get anxious about money and bills, or anything else, I sometimes binge eat. That makes my BG skyrocket, and then I have to take extra medications to control it. I get embarrassed by how difficult it is for me to get around, and sometimes it's hard to talk about my health with people if I think they don't really care. I've talked to so many doctors about my weight and my diabetes, but they don't care if my psych meds make me gain weight.

**Strategies** *(Things that I will do to address the barriers and achieve my desired outcomes)*

I want to start a structured eating plan that I read about recently, but I need someone to hold me accountable. I will use the MyFitnessPal app to track my calories and exercise. I will use the Wellness Self-Management skills I learned in the hospital to use healthy coping skills when I'm anxious, instead of binging on carbs like I do now. I will keep taking my BG levels regularly.



*Support(s) Needed (Who will help me reach my goal)*

Indicate if supports are to be provided by paid or unpaid provider and the frequency needed.

Mary's Primary Care doctor will monitor her weight annually. This is a paid support.

Mary's endocrinologist will monitor her blood glucose levels quarterly. Her endocrinologist will review the structured eating plan that Mary identified and will make adjustments with her to meet her medical needs. This is a paid support.

Mary will meet with a wellness coach at the YMCA to see if their services will help her meet her objectives. Mary receives financial aid for the cost of her YMCA membership; this is an unpaid support.

BH HCBS Peer Support will be used weekly to help keep Mary accountable to her plan, and to provide encouragement, support, and motivation. This is a paid support.

BH HCBS Psychosocial Rehabilitation will be used to help Mary learn the principals of shared decision making and to help her partner with her psychiatrist and other health care providers in finding medications that will work for her. Mary will learn skills related to health and wellness, including how the relationship between physical and behavioral health can impact each other and strategies for improving her overall health.



# Section 2: Clinical and Non Clinical Needs/ Services at the Time of Assessment

- ✓ Per Federal Documentation Requirements:
  - ❑ Plan must reflect clinical and support needs as identified through an assessment of functional need
  - ❑ Plan must reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of HCBS waiver services and supports.
- ✓ Per DOH HH Standards (10/05/15), the Plan must include functional needs related to treatment, wellness and recovery goals and key community networks and supports





**Best Practice:** When determining current Medical, Behavioral Health, and Social Service needs and current services, be thorough in examining all of the individual's current services and resources:

- ✓ What agencies and organizations is he/she connected to?
- ✓ Is he/she receiving any OMH or OASAS state-aid funded or grant-funded supports and services?
  - ❑ For example: OMH Ongoing and Integrated Supported Employment
- ✓ Does he/she receive support or resources through community groups/organizations?
  - ❑ For example: churches, food banks and community gardens, community centers, advocacy organizations, school groups, Employee Assistance Programs, cultural organizations, 12-step groups and other self-help groups, etc.
- ✓ Does he/she receive supports/services through another state or federal agency?
  - ❑ For example: ACCES-VR, OPWDD, OTDA, DOL, etc.



## Section 2: Clinical and Non Clinical Needs/ Services at the Time of Assessment



Medical Needs at the time of assessment											
Service	Provider Specialty	Provider Name	Organization	Address	Work Phone	Email	Service/ Diagnosis Code	Description	Prescription/ Unit	Frequency	Last visit date
Primary Care	Internal Medicine	Sally Johnson, MD	Baker St. Clinic	123 Baker St., Albany, NY 12203	518-555-0123	n/a		Preventative Care, Treatment & Referrals		Annually & PRN	09/07/15
Endocrinology	Endocrinologist	Robert Brown, MD	Albany Endocrinology Associates	456 Main St., Albany, NY 12203	518-555-4567	n/a		Monitoring and Treatment of Diabetes		Every 3 months	12/30/15
Podiatry	Podiatrist	Mark Green, DPM	Albany Podiatry Associates	6 Central St., Albany, NY 12203	518-555-3456	n/a		Toe-nail cutting and foot care		Every 2 months	01/13/15

[Click to add more Clinical/ non Clinical needs/ services](#)



Behavioral Health Needs at the time of assessment											
Service	Provider Specialty	Provider Name	Organization	Address	Work Phone	Email	Service/ Diagnosis Code	Description	Prescription/ Unit	Frequency	Last visit date
Medication Management	Psychiatry	Susan Doe, MD	Albany Psychiatry Associates	45 Central St., Albany, NY 12203	518-555-4321	n/a		Med management related to psychiatric disability		Annually & PRN	03/23/2015
Medication Management	Psychiatry	Kelly Mason, PNP	Albany Psychiatry Associates	45 Central St., Albany, NY 12203	518-555-4321	n/a		Med management related to psychiatric disability		Every 3 months	01/14/15
Clinical Counseling & Therapy	Social Work	Laura Jacobs, LCSW	Albany Psychiatry Associates	45 Central St., Albany, NY 12203	518-555-4321	n/a		Clinical treatment to address functional deficits related to psychiatric disability and h/x SUD.		Bi-Weekly	01/14/15

[Click to add more Behavioral Health needs/ services](#)



Social Service Needs at the time of assessment												
Service	Provider Specialty/Relation	Provider Name	Organization	Address	Work Phone	Email	Service/Diagnosis Code	Description	Prescription/Unit	Frequency	Last visit date	Paid/unpaid
Care Management	Health Home	Jane Smith	Health Home XYZ, Inc.	123 Main St., Albany, NY 12203	518-555-1234	<a href="mailto:abc@test.com">abc@test.com</a>		Care mgmt. for health and behavioral health diagnoses		Monthly & PRN	01/21/16	Paid
Exercise Facilities & Coaching	Wellness & Exercise	YMCA	YMCA	1 E. Main St., Albany, NY 12203	518-555-1357	membership@ymca.org		Exercise facilities, wellness coaching, & classes		PRN	01/07/16	Unpaid (Financial Aid to cover cost)
Income	Social Security Admin.	SSA	SSA	456 Pine St., Albany, NY 12203	518-555-1111	n/a		Provides SSDI		Monthly	n/a	Paid
Dual-Recovery Mutual Aid Group	Dual Recovery (12-Step Group)	n/a	Albany County Dual Recovery	3245 Washington Ave., Albany NY 12229	518-555-3321	n/a		Provides support and mutual aid for substance use and mental health recovery.		PRN	n/a	Unpaid

**Best Practice:** The CMA should indicate on the POC which services and supports are current and which are in referral status or identified as needs.



# Section 4: Recommended BH Home and Community Based Services (BH HCBS)

- ✓ Per Federal Documentation Requirements, the Plan must reflect the services and supports that will assist the individual to achieve identified goals;
- ✓ Per the DOH HH Standards (10/05/15) for individuals eligible to receive HCBS, recommended HCBS that target the individual's identified goals, preferences, and needs must be identified on the Plan of Care.

**Best Practice:** Document not only the recommended services, but also the actual services that the individual agrees to pursue/receive. Once eligibility for services is established, the individual's informed choice is paramount and should be documented in the Plan of Care.



### **Caution regarding Plan of Care Approval Workflow & Section 4 of the POC:**

The frequency, scope, and duration of services are determined by the BH HCBS provider agency in collaboration with the individual, following a service-specific assessment. The BH HCBS Provider contacts the MCO to obtain *prior authorization* for frequency, scope, and duration. The MCO will then send an *authorization letter* to the HHCM and BH HCBS Provider. The HHCM will then update and implement the Plan of Care with this information, and share the updated Plan of Care with the MCO and individual. ([See Adult BH HCBS Plan of Care Approval Workflow for more information on this process.](#))

Therefore, when initially completing the Plan of Care meeting with the individual, the Care Manager may not know the frequency, scope, or duration for recommended services. The Plan of Care should be updated when this information is available.



## Section 4: Recommended Behavioral Health Home and Community Based Services (BH HCBS)

BH HCBS Recommended Providers/ Services										
Service	Provider type/ Specialty	Provider name	Organization Name & Address	Duration			Phone	Frequency	Email	Description
				Start Date	End Date	<i>Note if Continuous Service</i>				
Empowerment Services – Peer Support	Behavioral Health	<a href="#">Jake Smithers</a>	Albany Behavioral Health, Inc. 222 Brown St., Albany NY 12203	01/21/16		✓	518-555-9753	1 hour, twice weekly	<a href="mailto:jsmithers@abh.org">jsmithers@abh.org</a>	Provides engagement, support, & motivation for maintaining sobriety and reaching wellness goal.
Ongoing Supported Employment	Behavioral Health	Joan White	Albany Behavioral Health, Inc. 222 Brown St., Albany NY 12203	01/21/16		✓	518-555-4892	1 hour, biweekly	<a href="mailto:jwhite@abh.org">jwhite@abh.org</a>	Provides supports to sustain competitive and integrated employment, including skill-building related to workplace soft-skills.
Psychosocial Rehabilitation	Behavioral Health	<a href="#">Sally Maynard</a>	Albany Behavioral Health, Inc. 222 Brown St., Albany NY 12203	01/21/16	05/30/16		518-555-4232	1 hour, biweekly	<a href="mailto:smaynard@abh.org">smaynard@abh.org</a>	Provides rehabilitation interventions and support regarding health and wellness, including developing a constructive and comfortable relationship with health care providers.

[Click to add more services](#)



# Section 5: Interventions

- ✓ Per the DOH HH Standards (10/05/15), the Plan of Care must include a description of planned Care Management Interventions and timeframes

## Section 5: Interventions

Status	Duration	Start Date	Tests/ Treatment/ Service/ Referral	Service Description	Provider Name	Provider Specialty	Organization	Phone	Email	Address
In Process	Ongoing	01/21/16	Referral to BH HCBS Providers	Care Coordination	Jane Smith	HHCM	Health Home XYZ, Inc.	518-555-1234	<a href="mailto:abc@test.com">abc@test.com</a>	123 Main St. Albany, NY 12203

[Click to add more Interventions](#)





# Section 7: Risk Assessment and Mitigation Strategies

- ✓ Per Federal Documentation Requirements, the Plan must:
  - reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
  - document any modifications based on risk assessment, as identified above.



## Section 7: Risk Assessment and Mitigation Strategies

### *Crisis Prevention*

*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?

I get really frustrated when I don't have the money to pay my bills. Collections calls and late notices from my utilities remind me that I'm not working, and I can't afford to live on my own without help from my parents. My heart will start to race, and my palms get sweaty. I sometimes cry and then can't stop.

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

I have to get out of my apartment when I get too upset. Being at home just makes it worse. Talking to my parents and sister helps. Going to the library and browsing the shelves is very relaxing. I have my WRAP plan posted on my fridge, and that has a lot of ideas about how I can distract myself.

Who can I call for support?

Name	Relation	Contact Info
Mom & Dad (Sadie & Jonah Jones)	Parents	518-555-3766
Daisy Black	Sister	585-555-1349
Mary Smith	Care Manager	518-555-1234
Dual-Recovery Sponsor (No name given)	Dual-Recovery Sponsor (No name given)	Contact info in in Mary's cell phone and posted on her refrigerator.



## Back-Up Plan

*If there is an emergency, call 911. A back-up 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 to 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
BH HCBS Peer Supports	Albany Behavioral Health, Inc.	518-555-9753	Monday – Friday, 8am-5pm
BH HCBS Intensive Supported Employment	Albany Behavioral Health, Inc.	518-555-4892	Monday – Friday, 8am-5pm
Clinical Counseling & Therapy	Albany Psychiatry Associates, Inc.	518-555-4321	On-call services are available 24/7
Any/all	Mom & Dad (Sadie & Jonah Jones)	518-555-3766	24/7
Dual-Recovery Group	Dual-Recovery Sponsor (No name given)	Contact info in in Mary's cell phone and posted on her refrigerator.	24/7



## Natural Disaster

*In the event of a natural disaster or an emergency, I will call the following people:*

<b>Name</b>	<b>Days/ Times Not Available</b>	<b>Phone</b>	<b>Will be able to assist with</b>
Mom & Dad (Sadie & Jonah Jones)	n/a	518-555-3766	Providing shelter, food
Jane Smith	weekends, after 5:30 M-F	518-555-1234	Coordinating services, making a plan
Red Cross, Albany Chapter	n/a	518-555-4444	Identifying resources, locating help

*In the event of a natural disaster or emergency, I will do the following (include securing medications, knowing the location of your nearest emergency department, care of animals or pets, etc.):*

- Call my parents and sister to let them know I am safe or if I need help
- Pack medications, clothing, my cell phone, and my Plan of Care
- Check the news for emergency safe places, like local schools or community centers, that have been opened
- Know where the closest hospital/ Emergency Department is



## *Plans for any other Emergency Situations*

*If my health or welfare is at risk by a dangerous or harmful situation, I will call the following people:*

<b>Name</b>	<b>Phone</b>	<b>Address</b>	<b>Relationship (relative, doctor, Care Manager, other)</b>
Mom & Dad (Sadie & Jonah Jones)	518-555-3766	346 Fountain Rd. Albany, NY 12203	Parents
Jane Smith	518-555-1234	123 Main St. Albany, NY 12203	Care Manager
Laura Jacobs, LCSW	518-555-4321	45 Central St. Albany, NY 12203	Social Worker



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

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



If a 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 risk.
- 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.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	

Intentionally left blank

*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:	



The Risk Assessment to Justify an Intervention/ Support to Address an Identified Risk must be completed *if the individual resides in a provider-owned or controlled residential setting and the following conditions are not met in that setting:*

- ✓ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- ✓ Each individual has privacy in their sleeping or living unit.
- ✓ Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- ✓ Individuals are able to have visitors at any time.

(CFR 441.301(c)(2)(iii))

Note: Guidance regarding HCBS Settings is forthcoming.



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# Section 8: Person-Centered Plan of Care Affirmation/ Attestation

- ✓ Per Federal Person-Centered Planning Requirements, the Plan must:
  - Include people chosen by the individual;
  - Include strategies for solving conflict or disagreement within the process;
  - Offer informed choices to the individual regarding the services and supports they receive and from whom; and,
  - Include a method for the individual to request updates to the plan as needed.





# Section 8: Person-Centered Plan of Care Affirmation/ Attestation (con't.)

- ✓ Per Federal Documentation Requirements, the Plan must:
  - Be finalized and agreed to, with the informed consent of the individual in writing, and be signed by all individuals and HCBS providers responsible for its implementation
  - Be distributed to the individual and other people involved in the Plan
- ✓ Per DOH HH Standards (10/05/15), the Plan must include:
  - The individual's signature documenting agreement with the Plan of Care;
  - Documentation of participation by all Key Providers in the development of the Plan of Care.



## Section 8: 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; 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 Albany Behavioral Health, Inc. 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.

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

Name	Phone	Address	Relationship (relative, doctor, Care Manager, other)
Jake <u>Smithers</u>	518-555-9753	222 Brown St., Albany NY 12203	Peer Support Specialist
Joan White	518-555-4892	222 Brown St., Albany NY 12203	Employment Specialist
Betty Green	518-555-3958	222 Brown St., Albany NY 12203	Family Support Specialist
Sadie & Jonah Jones	518-555-3766	346 Fountain Rd., Albany, NY 12203	Parents
Laura Jacobs	518-555-4321	45 Central St., Albany, NY 12203	Social Worker



<i>Signature</i>	<i>Date</i>	<i>Print Name</i>
<i>Individual</i> <i>Mary Jones</i>	02/23/16	Mary Jones
<i>Legal Representative/ Guardian</i> N/A		N/A
<i>Care Manager</i> <i>Jane Smith, MSW</i>	02/23/16	Jane Smith, MSW
<i>Provider</i> <i>Jake Smithers</i> (Peer Support)	03/15/16	Jake <del>Smithers</del>
<i>Provider</i> <i>Joan White</i> (Ongoing Supported Employment)	03/15/16	Joan White
<i>Provider</i> <i>Sally Maynard</i> (Psychosocial Rehabilitation)	03/15/16	Sally Maynard
<i>Provider</i> <i>Laura Jacobs, LCSW</i> (Social Work)	02/26/16	Laura Jacobs, LCSW
<i>Provider</i> <i>Sally Johnson, MD</i> (Primary Care)	02/29/16	Sally Johnson, MD
<i>Provider</i> <i>Robert Brown, MD</i> (Endocrinology)	03/02/16	Robert Brown, MD
<i>Provider</i> <i>Mark Green, DPM</i> (Podiatry)	03/05/16	Mark Green, DPM
<i>Provider</i> <i>Susan Doe, MD</i> (Psychiatry)	03/05/16	Susan Doe, MD
<i>Provider</i> <i>Kelly Mason, PNP</i> (Psychiatry)	03/07/16	Kelly Mason, PNP

[Click to add Signature line](#)



# Section 9: Approved/Denied Services

## Section 9: Approved / Denied Services

Service	BH HCBS Peer Support		Service Status	Active						
MCO Approval Status	<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending		MCO Representative	Name: Albany Managed Care Group Representative: John Laurence						
Reason: Medically Necessary										
Date service started	Provider Specialty	Provider Name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency
01/21/16	Behavioral Health	Albany Behavioral Health	Albany Behavioral Health	222 Brown St. Albany, NY 12203	518-555-9753	jsmithers@abh.org		Provides engagement, support, & motivation for maintaining sobriety and reaching wellness goal.		1 hour, twice weekly
<a href="#">Hide Detail</a>										



Service	BH HCBS Psychosocial Rehabilitation	Service Status	Active
MCO Approval Status	<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending	MCO Representative	Name: Albany Managed Care Group Representative: John Laurence

**Reason: Medically Necessary**

Date service started	Provider Specialty	Provider Name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency
01/21/16	Behavioral Health	Albany Behavioral Health	Albany Behavioral Health	222 Brown St. Albany, NY 12203	518-555-4232	<a href="mailto:smaynard@abh.org">smaynard@abh.org</a>		Provides rehabilitation interventions and support regarding health and wellness, including developing a constructive and comfortable relationship with health care providers.		1 hour, biweekly

[Hide Detail](#)



Service	BH HCBS Ongoing Supported Employment	Service Status	Active
MCO Approval Status	<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending	MCO Representative	Name: Albany Managed Care Group Representative: John Laurence

**Reason: Medically Necessary**

Date service started	Provider Specialty	Provider Name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency
01/21/16	Behavioral Health	Albany Behavioral Health	Albany Behavioral Health	222 Brown St. Albany, NY 12203	518-555-4892	jwhite@abh.org		<a href="mailto:jwhite@abh.org">jwhite@abh.org</a>		Provides supports to sustain competitive employment, including skill-building related to workplace soft-skills.

[Hide Detail](#)



# Recipient Rights

## 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 these abuses at any time.
- I understand I may grieve and appeal at any time and have received information on how to do this.



**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 on):

- Receive the 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 individual's 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:

<b>Name:</b>	<b>Phone:</b>	<b>Location</b>
Laura Jacobs	518-555-4321	if at home
Jane Smith	518-555-1234	if in the community



# Housing Questionnaire

Documenting an Individual's Choice in Residential Settings



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# Housing & Federal Requirements

Federal Guidance requires that the Plan of Care reflects that the setting in which the individual resides is chosen by the individual. For example, “I want to live at \_\_\_\_\_. If I want to move, the following action steps were identified: \_\_\_\_\_.”

In order to comply with this requirement, **we recommend using the Housing Questionnaire as an attachment to the Plan of Care.** The first part of the Questionnaire can be completed before or during the Plan of Care meeting. The second part can be completed concurrently, or at a later date, and it can help with identifying and clarifying goals related to living environments and housing.



# Housing Questionnaire

## Housing Questionnaire Plan of Care Attachment

<i>Individual Name</i>	Mary Jones	<i>Care Manager</i>	Jane Smith
<i>Housing Questionnaire Completion Date</i>	01/18/16		
<i>Individual's current residence (include type of residence, agency or organization affiliated, if any, and address):</i>	12345 Green St., Rm. 322 Albany, NY 12203		

**Note: This questionnaire is to be completed by the Health Home Care Manager in collaboration with the individual receiving services and his or her treatment and support team (if applicable).**

*I want to live at (answer may include specific address or location, including the individual's current address):*

I'm not sure. I like my apartment, but sometimes my neighborhood can be loud and it's hard for me to get to the grocery store.



**If the individual has expressed a desire to move or consider moving, complete questions 1 – 11 below.**

*1. What is your current living situation?*

- Alone                       With a roommate                       With family                       Homeless

*1A. If not alone, when was the last time you lived in your own place?*

---

*2. Do you prefer to live by yourself, with a roommate, or with family?*

- Alone                       With a roommate                       With family                       I haven't given much thought to living in my own place

*3. Are you willing to share an apartment with a roommate?*

- Yes                       No

*4. Are you willing to live without a roommate?*

- Yes                       No



5. How would you describe your current living condition/ environment?

My apartment is big and I was able to buy some furniture for it with a voucher from DSS. I keep it clean and tidy, so I don't want a roommate who would mess that up. The only thing I don't like is the noise from the street and being so far away from stores and doctors' offices.

6. What do you enjoy about where you live?

I like that I have my own space. I know some of my neighbors, and they watch out for me. The library is close by, and I can go there to use the computer.



*7. What do you wish to change about where you live?*

I'd like to be closer to the store and my doctors' offices. I have to walk a couple of blocks to the bus stop and then take a bus or two any time I need to go somewhere. If the bus were closer, I'd be able to get places quicker.

*8. In what neighborhood or town in New York do you prefer to live?*

Albany, I guess. I don't know about neighborhood. I like my neighborhood, but maybe something closer to Colonie would be more convenient.

*8A. Why do you prefer this neighborhood or town?*

I was raised here, and it's close to my family.

*8B. List the County of this preferred location?*

Albany County



9. How important are the following to you?	Not important	Somewhat important	Very important
✓ Location is near services, recreation, and transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
✓ Having a pet	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
✓ Being able to have a car and parking	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
✓ What floor your place is on (list):	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
✓ Having privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
✓ Having people around that you can talk to	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
✓ Living near a grocery store	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
✓ Living near my workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
✓ Living near my family	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
✓ Living near my church	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
✓ Living near my provider agency	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
✓ Living near a pharmacy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

*Other things that are important to you:*

I like to be as independent as possible. I don't want to rely on my parents for rides. I do like that in my current apartment, I know who my neighbors are and they watch out for me. And it's close to work, so that makes things easier.





10. Do you need anything to assist you to move around your house or apartment?

Yes


No

10a. If yes, what do you need:

No steps     Wheelchair ramp     Elevator

Assistive device(s) for visual impairments

Assistive device(s) for hearing impairment

Disability  Accessible Unit

Other assistance not noted: \_\_\_\_\_



*11. If I want to move, the following action steps have been identified (based on this Housing Questionnaire and my Plan of Care:*

If I decide I want to move when my lease is up, I know I can contact my Care Manager to find out more about the housing services that might be available through OMH or community organizations.

I can contact the Department of Social Services to find out if I am eligible for affordable housing or other subsidies.

I can contact a local PROS program to see if they can help me with a housing goal, or I can work with my BH HCBS Peer Support Staff to find a new place to live. I can also request BH HCBS Family Support & Training to talk to my parents about what my options are, and how I can be supported during a move.

I will need to save money for a security deposit.

If I decide to move, I will need to give my landlord 30 days' notice.



In this example, the CM completed the Housing Questionnaire with Mary because she expressed ambivalence about her current housing. After completing the Questionnaire, Mary decided that she may consider moving in the future, but not at this time. If she decides to move, Mary has concrete action steps identified to help facilitate that process.



# Person-Centered Planning Indicators



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# Indicators of Effective PCP

- ✓ The person feels welcomed and heard
- ✓ The person has authority to plan and pursue his own vision
- ✓ The assessment of needs is fair and accurate
- ✓ The assessment and planning process include conversations around personally defined “quality of life”
- ✓ Planning is responsive to changing priorities, opportunities, and needs

(CQL, 2010)



# Questions?



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# Resources for Providers

NYSDOH Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations (10/05/15):

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hh\\_mco\\_cm\\_standards.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

BH HCBS Plan of Care Template

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hcbs\\_poc\\_template.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_template.pdf)

BH HCBS Plan of Care Federal Rules and Regulations Checklist

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hcbs\\_fed\\_person\\_centered\\_planning\\_process.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_fed_person_centered_planning_process.pdf)

Federal Adult Behavioral Health HCBS Person-Centered Planning Process Requirements/ Characteristics

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hcbs\\_fed\\_person\\_centered\\_planning\\_process.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_fed_person_centered_planning_process.pdf)

*Person Centered Planning: Practice and Resources* (although developed for PROS programs, this workbook may prove helpful when implementing person-centered planning in the Plan of Care development process)

[https://www.omh.ny.gov/omhweb/pros/Person\\_Centered\\_Workbook/](https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/)

The Council on Quality and Leadership (CQL).

<http://www.c-q-l.org/>



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