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The BH HCBS Plan of Care & Individualized Service Plan

A training for Care Managers and Recovery Coordinators

Webinar by OMH & OASAS, hosted by MCTAC, 9/26/18

Webinar Objectives

- Introduce principles of Person-Centered Practice and Recovery-oriented Goals
- Review Coordination of Adult BH HCBS –
  - Roles of Care Manager / Recovery Coordinator
  - Requirements for BH HCBS Plan of Care
- Review new State-Issued BH HCBS Plan of Care template
- Describe the role of the BH HCBS provider in contributing to the BH HCBS Plan of Care

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Principles of Person - Centered Practice

Person-Centered Practice

Partnering with and engaging an individual in a way that honors and respects their unique values, preferences, strengths, needs, and barriers.

Person-Centered Planning

Person-centered planning is a way to assist people needing HCBS services and supports to *construct and describe what they want and need to bring purpose and meaning to their life*.

(CMS, n.d.)

Person-Centered Planning in Behavioral Health

- Person-Centered Planning is about building **a roadmap to recovery**, not just getting services
- It provides an opportunity to **build an alliance and to collaborate** in developing goals and planning for supports and services
- **Strengths–based** and focuses on the individual's values, preferences, and goals
- Strengthens the voice of the individual, builds resiliency, and promotes recovery

Core Principles

- Affirms and respects **self-determination**, or the ability to make your own decisions
- Holistic approach to recovery planning – includes natural and paid supports (person in environment)
- Engagement, Partnership & Shared Decision Making: honors the individual's preferences for service delivery
  - The Care Manager / Recovery Coordinator ensures the individual is empowered and provided the ability to make **informed choices** about services and interventions (e.g. talk through the pros/cons of different service locations)

"All people grow through taking ***positive risks****. We need to support people in:*

- ✓ *Making life and treatment choices for themselves, no matter how different they look from traditional treatment,*
- ✓ ***Building their own crisis and treatment plans****,*
- ✓ *Having the ability to obtain all their records,*
- ✓ ***Accessing information*** *about medication side effects,*
- ✓ *Refusing any treatment,*
- ✓ *Choosing their own relationships and spiritual practices,*
- ✓ *Being treated with dignity, respect and compassion, and*
- ✓ ***Creating the life of their choice****."*

-Mary Ellen Copeland, Ph. D. (2000)

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How to Engage in Person-Centered Planning

Have conversations with the individual and get to know them; move beyond their diagnosis

- How would you describe yourself to someone who doesn't know you?
- What are your hobbies or favorite things to do?
- What would you like to do/achieve?
- Who are the important people in your life?
- What are the top 3 places where you spend most of your time?
- What is your typical good day is like? What about bad days?
- Ask what's working & what's not working with your current services?

How to Engage in Person-Centered Planning

- Identify “natural supports” in the individual’s life (family, friends, community groups) and ask the individual if they’d like to invite them to care planning meetings
- When selecting services and interventions, find the balance between “important to” and “important for”

PCP in Action: Example 1

Recovery happens when we balance Important To & Important For

These things are Important To me…	In order to achieve what's Important To me, it's Important For me to…
- Keep my apartment - Stay out of jail - Feel heard and respected by my service providers - Receive services that are close to my home or in my home - Receive services in my native language	- Meet with my rep payee to review my budget - Improve my household management skills, including keeping my apartment clean and pest-free - Keep in touch with my probation officer - Take my medications as prescribed - Make it to doctor's appointments and meetings with my care coordinator

Life Role Goals & Rehabilitation

Domains of Rehabilitation

Living

- Health & Wellness
- Household Management and Independent Living
- Accessing Community Resources & Supports

Working

- Getting and keeping a job
- Managing Symptoms at Work
- Benefits & Financial Management

Learning

- Going Back to School
- Learning a New Trade or Skill
- Getting a Degree or Certificate
- Self-Advocacy in School Environments

Socializing

- Building a Social Network
- Setting Healthy Boundaries
- Dating and Romantic Relationships
- Family Relationships

"For most of us, satisfying *everyday lives* means an engagement in the world across varied 'domains of community living' – family life, gainful employment, social connections, civic activity, recreational pursuits, staying fit, educational opportunities, religious involvement, and more.

We all make choices about what domains of life to emphasize for ourselves and which we choose to skip over or cannot prioritize just now.

But current research suggests that **many people with serious mental illnesses have little choice in this regard**: a variety of factors keep them at a distance from enjoying even the most basic elements of everyday lives" *(Baron, 2018).*

The Life Role Goal

- A “**life role**” may include any number of roles adults may have:
  - parent, grandparent, sibling, partner, spouse,
  - employee, co-worker, student, peer,
  - friend, community member, group member, volunteer, etc.

- The Life Role **goal** is all about finding the individual’s **motivation for wellness:**
  - What roles are important to them?
  - What impact does their behavioral health diagnosis have on their role functioning?
  - How can we support the individual in overcoming these behavioral health barriers?

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Life Role Goal Examples

Socializing:
"I will have a better relationship with my daughter."
"I will build a friend group I can depend on."

Working:
"I will get a promotion to shift manager at work."
"I will get a job in an office setting."

Learning:
"I will go back to school for my TASC diploma."

Living:
"I will remain living independently in my own apartment."
"I will manage my diabetes without medication."

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PCP in Action: Example 2

Member's Recovery Life Role Goals vs Objectives / Interventions

Member's Recovery Life Role Goals…	Objectives / Interventions…
- I will have a better relationship with my daughter. - I will remain living independently in my own apartment. - I will get a promotion to shift manager at work. - I will manage my diabetes without medication.	- I will enroll in a parenting skills class. - I will manage my finances / pay rent on time to maintain my apartment. - Utilize HCBS to learn management skills to help get promoted at work. - Receive education on managing diabetes from my care coordinator and attend doctor's appointments.

Rehabilitation & Treatment

- Rehabilitation and treatment **work hand-in-hand** to support the individual in achieving goals
- Some individuals will want and need both. Others will have a preference or need for only rehab or treatment.
- The Plan of Care can help support coordination across provider types so that rehab and treatment providers can work collaboratively to support whole health and wellness.

Coordination of Adult BH HCBS

Home & Community Based Services

A federal program that provides opportunities for Medicaid beneficiaries to receive services in their own home or community.

The **coordination of HCBS** comes with certain federal requirements:

- Conflict-Free Care Management & choice of providers
- Home and Community-Based settings (both residential & service setting)
- Person-Centered Planning process
- Integrated Plan of Care

In NYS, Adult BH HCBS is part of an enhanced benefit package available to those enrolled in a **HARP or HIV SNP**.

HARPs / HIVSNPs delegate the care coordination of Adult BH HCBS to **Health Homes** (HH) and contracted **Recovery Coordination Agencies** (RCA).

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Conflict-Free Care Management

- Federal rules for HCBS require individuals be offered **a choice of service providers**
- Agencies who employ both Recovery Coordinators (RC) / Health Home Care Coordinators (HH CM) and Adult BH HCBS Providers are required to have **separate supervisory structures and adequate firewalls** in place to ensure for conflict-free care management.
- An employee who performs or supervises the NYS Eligibility Assessment and care coordination of BH HCBS for an individual, may not provide or supervise HCBS to that same individual

BH HCBS & Federal Requirements

- **Documentation Requirements** for BH HCBS Plan of Care
  - The person–centered plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

- Requirements of BH HCBS **Person-Centered Planning Process**
  - The individual will lead the person–centered planning process where possible.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/bh_hcbs_checklists.htm

Coordination of BH HCBS

Recovery Coordinator / HH Care Manager Role:

Facilitate the care planning -

- Help member ID recovery goals
- Explore service options / educate

Linkage to BH HCBS –

- Working with the MCO
- Referrals to and coordination with BH HCBS providers

Develop the integrated BH HCBS Plan of Care meeting all federal requirements for BH HCBS plan of care, including scope, duration and frequency of BH HCBS.

Coordination of BH HCBS

The Plan of Care provides the **roadmap** of all services and supports in place to address the individual's established recovery goals.

RCA Role - **coordinate adult BH HCBS** / educate about benefits of HH.

HH CM - **coordinate full spectrum of service needs**, including coordination of BH HCBS.

- POC additionally indicates key **ongoing care coordination services** identified of the HH CM.

It is important for individual to understand the distinction between RC and HH services, in order to choose which level of coordination (s)he may need.

Integrating Person-Centered Planning into Practice

Effective Person-centered planning will result in a recovery-oriented Plan of Care that:

- Is driven by the member's goal with the services to support their goal
- Emphasizes member's preferences and strengths

Member is offered **informed choice** in services and providers.

PCP in Action: Example 3

Offering Informed Choice in Service Providers:

Do….	Don't…..
- DO ASK member for their preferences - DO consider where member receives other services - DO offer at least 2 providers for member to select from - DO check with MCO for list of in-network providers - DO provide information about the service providers (e.g., languages offered, location, specialties, best at..etc)	- DON'T refer member to your own organization's HCBS providers without offering choice of another provider - DON'T make HCBS contingent on "successful completion" of other services

BH HCBS Plan of Care

What is the BH HCBS Plan of Care?

A roadmap that serves as a guide to the individual *and* their providers toward attainment of the individual’s life role goal(s).

The state-issued Adult BH HCBS Plan of Care template is designed to meet the needs of all coordinating Adult BH HCBS – including Health Home managers.

Adult BH HCBS Plan of Care

Name of Individual:
Date of Birth:
MCO:
Lead Health Home:

Plan of Care Development Date:

PART 1: CONTACT INFO & RESIDENTIAL SETTING

Individual's Residential Address:
Individual's Phone Number:

PART 2: INDIVIDUAL NARRATIVE & GOALS

A. Individual Narrative

Updated BH HCBS Plan Of Care Template

Key features:

- Supports individual's engagement
- Supports collaboration
  - Including around transitions (e.g., ACT, supervised setting)
- Instructions are available

BH HCBS POC Template: Demographics & Setting

Adult BH HCBS Plan of Care

Name of Individual:		*MCO:*	
Medicaid CIN:		*Member ID:*	
Date of Birth:		*Lead Health Home:*	
BH HCBS Eligibility:		*HH CMA or RCA:*	

Plan of Care Development Date:

PART 1: CONTACT INFO & RESIDENTIAL SETTING

Provide setting and contact information for the individual. If the individual does not live in a community-based setting of their choice, the Care Manager/ Recovery Coordinator must support the individual with identifying a plan to move to the setting of their choice and document this in the Plan of Care.

Individual's Residential Address:	
Individual's Phone Number:	
Is the residential address provided above a community-based setting?	◯ Yes ◯ No
Does the individual want to live in this setting/ at this address?	◯ Yes ◯ No

BH HCBS POC Template: Individual Narrative

PART 2: INDIVIDUAL NARRATIVE & GOALS

A. Individual Narrative

The individual narrative should include a brief formulation of the NYS Eligibility Assessment, including the individual's diagnosis. Describe the individual's characteristics, skills, strengths, preferences, and behavioral health barriers and needs. Also include the individual's living arrangements, cultural traditions, and social relationships. Clearly document the individual's valued life roles.

BH HCBS POC Template: Goals

Adult BH HCBS Plan of Care

B. *Individual's Life Role Goal Statement(s)*

The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language. The "Desired Outcomes" should clearly state what will be achieved in the Individualized Service Environment, as documented in Part 3 of this Plan of Care.

Life Role Domain: ○ Living ◉ Working ○ Learning ○ Socializing

Goal:*

Desired Outcomes:

Target Date:

Life Role Domain: ○ Living ○ Working ○ Learning ○ Socializing

Goal:*

Desired Outcomes:

Target Date:

Goal should be written in the person's words (I-statements).

Desired outcomes - intended outcome of the supports the individual will receive while working toward their goal.

BH HCBS POC Template: Service Environment

PART 3: THE INDIVIDUALIZED SERVICE ENVIRONMENT

A. Natural Supports & Community Resources

List the unpaid natural supports & community resources the individual will access in support of their life role goal. These may include family, friends, neighbors, mutual aid/ self-help groups, community centers, faith communities, etc.

Support Provided*	Name of Support or Resource	Contact Information (Address, Phone, and/or Email)

B. Physical & Behavioral Health Providers

This section should include all physical and behavioral health (mental health and substance use) providers which support the individual in pursuing and attaining their life role goal, with the exception of Adult BH HCBS. This includes primary care, psychiatry and any Article 16, 28, or 31 Clinic providers. Documenting the frequency and duration will support integration of care and treatment with other providers.

Service Type*	Name of Provider	Frequency (if known)	Duration (if known)

Natural Supports / Community Resources

- Family & friends
- Self-help groups
- Community Centers
- Faith centers

Physical and BH Providers

- Primary Care
- MH / SUD Provider
- Specialty providers

BH HCBS POC Template: Service Environment

C. *Other Services, Resources, and Supports*

This section should include any additional non-HCBS services, resources, and supports that the individual receives which are not listed above. Only list the services and providers which support pursuit and attainment of the life role goal. Examples may include Social Security Disability Insurance (SSDI), Drop-In Centers, Psychosocial Clubs or Clubhouses, Ongoing and Integrated Support Employment (OISE), etc. It may also include services and supports paid for by other NYS agencies, including Department of Health, Department of Aging, ACCES-VR, Department of Labor, etc.

Service Type*	Name of Provider

Other Services, Resources and Supports to support attainment of life role goals. Examples include:

- SSDI / benefits
- Psychosocial clubs / Clubhouses
- ACCES-VR

BH HCBS POC Template: RC / HHCM

D. *Health Home Care Management / Recovery Coordination*

This section should document information about the HH Care Management Agency or Recovery Coordination Agency. For individuals receiving Health Home services, this section must include all Care Coordination interventions. There should be at least one intervention listed for each applicable objective.

Type of Service:	Health Home Care Management
Provider Agency:	
Care Manager/ Recovery Coordinator Name:	
Contact Information:	

Care Coordination Objectives and Interventions should only be completed for individuals enrolled in Health Home Care Management. For individuals NOT enrolled in Health Home and receiving Recovery Coordination only, this section may be left blank.

Care Coordination Objectives	Care Coordination Interventions (Scope)
☐Physical Health Objective(s):	☐Physical Health Interventions:
☐Mental Health Objective(s):	☐Mental Health Interventions:
☐Substance Use Objective(s):	☐Substance Use Interventions:
☐HIV/AIDS Objective(s):	☐HIV/AIDS Interventions:
☐Other Care Management Objectives:	☐Other Care Management Objectives:

Coordination of BH HCBS vs Ongoing Care Coordination

HHCM Objectives / Interventions:

- *Help member secure dental care*
- *Promote wellness and self-management of health care*
- *Assist with linkage to supportive housing*
- *CC to coordinate care team conferences to review member progress and updates (quarterly)*
- *CC to provide HH+ level of CM to support member's recent discharge from State PC and acclamation back into the community (4 x month / 12 month duration)*

BH HCBS POC Template: BH HCBS

Adult BH HCBS Plan of Care

E. Adult Behavioral Health Home and Community Based Services (BH HCBS)

This section should include all adult BH HCBS providers selected by the individual from a choice of in-network providers. The frequency, duration, and effective date may be added after receiving additional information from the providers and Managed Care Organization. Each HCBS should have at least one corresponding intended outcome from Part 2(B) of this Plan.

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

HCBS POC Template: Signatures

PART 5: ATTESTATION, SIGNATURES, ATTACHMENTS, & DISTRIBUTION OF THE PLAN OF CARE

The Care Manager/ Recovery Coordinator and Managed Care Organization are responsible for monitoring the Plan of Care. Revisions may be initiated by contacting the Care Manager /Recovery Coordinator. The Plan of Care must be reviewed at least annually and whenever the individual experiences a significant life event.

A. Person-Centered Planning Attestation

My signature on this Plan of Care attests that I agree with the following:

- ☐ I have been informed of my eligibility status for Adult BH HCBS.
- ☐ I understand that I have the choice of any qualified providers in my MCO's network and I have been notified of the providers available.

B. Signatures

The Plan of Care (and/or accompanying ISP) must be signed by the individual receiving services, his or her legal guardian (if applicable), the Care Manager/Recovery Coordinator, and all Adult Behavioral Health HCBS Providers. Signatures provided in this section will indicate that the individual and all other providers participating in this Plan of Care are in agreement with the Plan of Care.

Name	Title/Role	Signature	Date
	Individual Receiving Services		
	Personal Representative, if applicable		
	Care Manager / Recovery Coordinator		

BH HCBS POC Template: Attachments

Attachments to the HCBS POC:

- Crisis Prevention Plan
- Back-Up Plan
- Modifications Based on Risk Assessment
- BH HCBS **Individualized Service Plan** (ISP)

The ISP is included as a template BH HCBS providers can use to provide details to HH CM for scope, duration, frequency of HCBS.

Collaboration

Partnering with Key Stakeholders

- Central to the planning process is partnership among key "stakeholders" – this includes the Recovery Coordinator/ Care Manager, the member's family of choice, and any other treatment or rehabilitation providers
- After the BH HCBS Intake & Evaluation, there may be a need to refine or revise the member's life role goal, based on the person-centered assessment and planning process
- In some instances, the BH HCBS provider may recommend a different BH HCBS in order to meet the member's goal, for which the RC/CM may need to obtain a new Level of Service Determination

Who decides when changes are needed to the POC?

- It is critical that any changes to the goal or services on the POC are driven by the member's preferences and made with the member's support.
- The BH HCBS provider may recommend changes to the Plan of Care based on their evaluation process and conversations with the member; however, changes should not be initiated without the member's informed consent.

Cascading Documentation

Describes the relationship between the BH HCBS POC and the BH HCBS ISP:

- The POC provides an integrated overview of the services that will be provided to support the goal.
- The ISP complements the POC and describes in detail the level of support to be provided by the HCBS Provider Agency.
- The member's life role goal identified in the POC must be closely linked to the goal driving the ISP.

The BH HCBS Individualized Service Plan (ISP)

- The ISP sample template was designed to facilitate collaboration and cascading documentation between the Care coordinator of HCBS and HCBS Provider
- Use of the ISP template is not required for BH HCBS providers
- This template should be consistent with the ISP tech specs in BHIT-approved EHRs
- The concept of cascading documentation applies regardless of the tools/forms used

POC/ISP Cascading Doc. Examples

POC Life Role Goal	ISP Life Role Goal	Cascading Doc?
I want to work as a receptionist in a medical setting.	I want to work as a receptionist in a medical setting.	✓
I want to get a job.	I want to get a job with a living wage.	✓
I want to get a job.	I want to get a job in an office setting.	✓
I want to get a job.	I want to acquire the soft-skills needed to pursue competitive employment.	✓
I want to get a job.	I want to start volunteering.	✗
I want to get a job.	I want to improve my parenting skills.	✗
I want to get a job.	I want to improve my diabetes management.	✗

BH HCBS ISP: Provider Info and Goals

Adult BH HCBS Plan of Care

Plan of Care Attachment: BH HCBS Individualized Service Plan

Name of Individual:		*MCO:*	[Select MCO]
Medicaid CIN:		*Member ID:*	
Date of Birth:		*Lead Health Home:*	Not applicable
BH HCBS Eligibility:	Not Eligible	*HH CMA or RCA:*	

This document is completed by each Adult Behavioral Health Home & Community Services provider. Attaching it to the Plan of Care supports integration and coordination of services and is important for meeting CMS requirements.

Date of ISP Development:

Service Specific Information

Service Type:	N/A
Provider:	
Provider Agency Contact:	
Alternate Contact:	
Provider Address:	
Frequency & Duration:	

Individualized Life Role Goal & Intended Outcomes

The information below should come from the Plan of Care document. The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language.

Life Role Domain: ○ Living ◉ Working ○ Learning ○ Socializing

Goal:*

- As an attachment to the full POC, the ISP serves to describe the role of the BH HCBS Provider in supporting the member's acquisition of their life role goal.
- The ISP must include the frequency and duration of services.
- The goal should be clearly linked to the goal in the POC.

HCBS ISP: Supports

Strengths, Talents, Resources, & Abilities

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the individual's strengths, talents, resources, and abilities, as they relate to attainment of the goal.

Behavioral Health Barriers & Level of Support

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the behavioral health barriers and needs related to attainment of the individualized goals. Describe the level of support that will be required in order to achieve intended outcomes (e.g. staff modeling, role play, supervision, instruction, etc.).

- Focus first on the strengths, talents, resources, and abilities that you will leverage to support goal attainment
- Identify specific barriers to the goal related to the BH diagnosis
- Document the level of support required in order to achieve intended outcomes

HCBS ISP: Objectives and Services

Adult BH HCBS Plan of Care

HCBS Objectives & Scope

Document measurable objectives for HCBS that will support the individual in moving toward his or her goal and intended outcomes. Describe the scope of services (interventions and staff activities) that will support attainment of the objectives.

HCBS Objectives	Scope of HCBS (Service Components/ Interventions/ Modality)

Signatures

Signature of Individual Receiving Services: Date:

Signature of Adult BH HCBS Service Provider: Date:

Signature, Credentials (if applicable), & Title

- Document specific service objectives – things the member will do or accomplish as they work toward their goal.
- Describe the scope of the service that will support the objective. Which service components will be used? What interventions will be employed?
- Signed by member & qualified staff

Summary

- Person-Centered Practice is an approach to service planning and delivery that is intentional, respectful, and goal-driven
- Everyone in the planning process has a specific role, but the overall process is directed by the individual
- The BH HCBS POC is a comprehensive plan that ensures services are provided in a coordinated way
- The ISP should cascade from the POC, with a goal that is clearly linked

Resources

Baron, R.C. (2018). *Jump-Starting Community Living and Participation.* Temple University RRTC on Community Living and Participation of Individuals with a Mental Illness. Available at www.tucollaborative.org

Center for Practice Innovation (CPI): Learning Community

SAMHSA Person- and Family-Centered Care and Peer Support: https://www.samhsa.gov/section-223/care-coordination/person-family-centered