ST. JOSEPH'S HEALTH A Member of Trinity Health ST PETER'S HEALTH PARTNERS A Member of Trinity Health	**Effective Date:** July 1, 2025

Category: **C. Care Coordination**

Title: **3. Plan of Care**

Applies to:

☐ St. Peter's Health Partners (SPHP)

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

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

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

Contents

PURPOSE

A Plan of Care is created for each Member enrolled in the Health Home. Informed by the results of the Comprehensive Assessment and Screening Tools, the Plan of Care is updated regularly to reflect the Member's needs. The Plan of Care is integral to the Health Home model, goals and services that are provided. The Health Home Plan of Care is a comprehensive, individualized, and person-centered living document that changes over time depending on the Member's needs. It should be used as an active tool to guide day-to-day care management

work and support the required collaboration among providers and others approved by the Member.

POLICY STATEMENTS

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

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

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

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

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

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

PROCEDURE

A. Plan of Care Development

1. The Plan of Care must be Member-driven, meaning it is developed with input from the Member whenever possible and includes the preferences, services and resources requested by the Member.
2. Plans of Care must be signed off on by the Member to be considered finalized by State and Federal auditors. Member signatures on Plans can be captured one of two ways.

a. Members may electronically sign the Plan of Care in CareManager. This is done by finalizing the Plan, then having the Member sign using the computer mouse in the text box that appears at the bottom of the Plan in CareManager.
b. For CMAs and Care Coordinators who are unable to capture signatures electronically, the "Manual" option should be selected in the signature text box that appears once the Plan is finalized. When Manual is selected for the signature, the CHC Member Acknowledgement Form (Attachment A) must be used to document Member participation in the development of the Plan.

Member signature either electronically in CareManager or via the Member Acknowledgement Form is required for all Plan updates (Initial, Annual and Amendments).

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

4. The Plan of Care must be based on the results of the Comprehensive Assessment and Screening Tools at a minimum.

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

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

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

B. Initial Plan of Care

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

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

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

4. In addition to the above, the Plan of Care must address the Initial Appropriateness criteria that made the Member eligible for Health Home services unless the needs associated with the Initial Appropriateness criteria have been resolved by the time of the Initial Plan of Care creation.

C. Plan of Care Updates

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

2. At a minimum, the Care Plan must be updated at least annually, every 365 days. In CareManager, this would be documented as an Annual Plan. Annual updates to the Plan are required regardless of the Plan Amendments on file. The 365-day timeframes are calculated based on the Initial Plan of Care and the Annual Plans only.

3. Billing for Core Service delivery may not occur if the Member's Plan of Care is not up to date, meaning the Annual Plan was finalized within 365 days of the Initial Plan or previous Annual Plan. Should attempts to update the Plan of Care with the Member be unsuccessful, CMA's do have the option to update the Plan without the Member present so that billing can occur. In these rare circumstances, the Plan must be

reviewed with the Member at the next opportunity. In instances in which a Plan is updated without the Member present, the Care Notes should reflect this situation. Sample text: *Member did not meaningfully participate in the development of the Plan of Care. Every attempt was made to collaborate with Member on the development, however [insert specific circumstances]. Care Coordinator will review POC with Member at next opportunity.*

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

5. Plans of Care must also be updated when the Member experiences a significant life event. These might include, but are not limited to:
   a. a new diagnoses or significant change in Member functioning,
   b. a the time of a Care Transition, or
   c. a change to SDOH needs such as loss of a caregiver or housing.

6. If the Annual Plan is due or coming due, updates for a significant life event should be documented as the Annual Plan of Care. If the Member is not due for an Annual Plan update, the Plan Amendment will be used to capture the update.

D. Documentation of Plan of Care

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

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

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

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

E. HCBS in the Plan of Care

1. For Members who are enrolled in Health and Community Based Services, it is necessary for the Plan of Care to include Health and Community Based Services identified or chosen by the Member to help them attain their goals. Once the Health and Community Based Services provider has met with the Member and it is agreed that the service(s) will address the Member's needs, the Health and Community Based Services provider will determine Frequency, Scope, and Duration for each individual Health and Community Based Services. The Care Coordinator will ensure the approved Frequency, Scope, and Duration for the Health and Community Based Services is then identified on the Health Home Plan of Care.

F. Staff Qualifications

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

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

For more on Staff Qualifications and Special Programs Staff Qualifications see:

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

REFERENCES

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

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

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Search Terms:		***Reviewed, No Revisions** ****Revised without Full Review**

Replaces: Documentation – Assessment, Re-assessment and Plan of Care
Care Coordination: Plan of Care (May 1, 2017)
Care Coordination: Plan of Care (October 1, 2017)
Care Coordination: Plan of Care (December 17, 2018)
Care Coordination: Plan of Care (December 1, 2019)
Care Coordination: Plan of Care (January 1, 2023)
Care Coordination: Plan of Care (September 1, 2024)
Care Coordination: Plan of Care (January 1, 2025)

ATTACHMENT A: Health Home Member Acknowledgement Form

ST. JOSEPH'S HEALTH
A Member of Trinity Health

ST PETER'S HEALTH PARTNERS
A Member of Trinity Health

Complete this form each time an Initial or Annual Plan is completed or updated. This form must be uploaded to CareManager to denote Member participation in the Plan of Care and note documentation should reflect Plan completion / updated as well.

Member Name: _____

Date of Acknowledgement: _____

☐ I actively participated in the creation / updated of my individual Plan of Care and agree with the Plan.

_____ _____
Member Signature Date

_____ _____
Care Coordinator Signature Date