ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #6 Integrated Care Plan Development

Effective Date: 11/21/2013
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Policy: Encompass Health Home Care Management will coordinate an interdisciplinary team to develop an individualized Plan of Care for each Health Home Participant/Family, designed to promote and improve their health and wellness.

Procedure:

A. Care Manager will schedule a **Care Team meeting** with Participant/Family and current Medical/Behavioral Health providers/supports, MCO, specialists and community supports forming an **Interdisciplinary Team** to develop the Plan of Care.
    1. The initial Team meeting for Children will be scheduled and held within the 30 day CANS-NY assessment period.
        i. Subsequent Interdisciplinary Team meetings will be held as needed at the request of the Care Manager; the Participant/Family; Guardian or Medical Consenter (including LDSS); a provider; or minimally during each CANS-NY update.
    2. All members of the Interdisciplinary Team will be invited to attend, and will be clearly identified in the Plan of Care.
        i. The Participant/Family will be invited/included in all meetings, as well as any provider/individual they wish to participate.
        ii. Meetings will be scheduled at times and in locations convenient to the Participant/Family.
        iii. Other members of a Childs team may include other family members or caregivers; representatives from LDSS, Foster care, Juvenile Justice programs, or any entity the Participant/Family wishes.
        iv. The Care Manager will make every effort to include a Childs Parent/Legal Guardian/Medical Consenter to be present at each meeting. If unable to attend, Care Manager will solicit their input to the Plan of Care before finalizing.
            a. No decisions or revisions to the Plan of care will be made without the consent of the Family/Legal Guardian/Medical Consenter.
    3. The care planning process will include the use of Wraparound Core Principles, assisting and engaging Participants/Families to play a central role in developing the Plan of Care.
        i. These Principles include:
            a. The process is **Family Driven**;
            b. **Community Based**;
            c. **Team Supported**: everyone is united in a collaborative effort;
            d. **Unconditional Care**: If the plan isn’t working, change the plan;
            e. **Strength-Based**: Services are focused on strengths and competencies;
            f. **Individualized Care**: Interventions and supports are available to “wrap” services around the needs of the Child/Family;

g. **Culturally Competent**: Services are delivered with an understanding of the family, and the cultural framework in which they exist.

ii. Youth/Family Peers and/or Advocates will be utilized as needed and available to assist in engaging and supporting Participants/Families.

iii. Participants/Families will be encouraged to develop goals that are of priority to them, and in their own words.

4. Participant/Family will be encouraged to identify providers, additional family, caregivers or other supports for inclusion in the Care Plan development.
5. Care Managers will request known Providers or representatives to assist in identifying care gaps, to be included in the Plan of Care.
   i. Providers/Family/Caregivers unable to attend will be offered alternative methods of participation (such as phone or video conferencing) and/or asked to provide relevant feedback by other means in regards to needed care and support.

B. A Comprehensive **Plan of Care** including Participant/Family goals will be developed within 60 days of enrollment, simultaneously with the Comprehensive Assessment process.

1. The Plan of Care will include, but is not limited to, all of the following elements:
   i. **History and Risk Factors** related to services, treatment, wellbeing and recovery**;**
   ii. **Preferences, Strengths and Barriers** related to development and attainment of the established goals. This also includes caregivers preferences, strengths and barriers;
   iii. **Functional Needs** from assessments**,** related to services and treatment; documented as **Goals** related to the Participant's/Family's treatment, wellness and recovery; and **Objectives** that are measureable, youth/family focused, written in the Participants/Families own words and work towards stated goals;
   iv. **Services** and **Key Providers/Community Supports** identified to meet physical, behavioral and community based/social support needs, and their roles related to the goals in the Plan of Care;
   v. **Key Informal Community Supports** such as neighbors or other family members that can meet an identified need;
   vi. **Emergency Contacts and Disaster Plan (Assessment)** for fire, health, safety issues, natural disasters and other emergencies**;**
   vii. **Care Management Interventions/Time Frames** including outreach/engagement, referrals, follow-up and needed care coordination to assist with goal attainment;
   viii. **Needed Transition Plans** involving education, treatment and Foster Care, as well as services needed to transition from Care Management as needed;
   ix. **The Participants/Medical Consenters signature**, indicating participation and agreement with the Plan;

Care Management Policy #6 Integrated Care Plan Development

x. **Documentation of Participation of Participant and Key Providers/Family/Supports** in the development of the plan.

2. For Children in **Foster Care**, the plan will reflect the Childs Foster Care Permanency goals.
3. If unable to complete within 60 days, the Care Manager will document reasons, and identify strategy and ongoing attempts to engage with Participant/Family to complete the Assessment process and the plan.
4. The Health Home and CMA will monitor inclusion of all the plan elements through audits conducted through Netsmart.

C. Using all Comprehensive Assessment information, Participant/Family preferences, priorities and provider/supports input; appropriate goals and a Plan of Care will be developed with the Participant/Family to address physical, behavioral, educational, rehabilitative, long term care and social support needs required for improved health and wellness.

1. Care Managers will consult with Managed Care Organizations (MCOs) to explore services that offer health promotion education to further focus on wellness and self-management.
2. Participants/Families will be asked to choose providers to meet established needs, and referrals to Health Home providers and supports within their MCO network will be initiated to address care gaps. MCOs will be utilized to assist in the referral process within their network, and for consultation of the availability of specialized care.
3. Known Providers and appointments will be included in the Plan of Care.
4. The Care Manager will review specific risks, prevention and disease management protocols with the Participant/Family, and incorporate applicable and agreed upon prevention/disease management objectives within the Plan of Care. (See Policy #7: Care Coordination Protocols)
5. Interventions, roles, responsibilities and time frames for improvement in the Participants health and wellbeing will be clearly identified.
6. Care Manager and Participant/Family will establish frequency of ongoing contact to include in Plan of Care.

D. After development by the Participant/Family, the Care Manager will review the Plan of Care with the Interdisciplinary Team to solicit any additional input.

1. This may be accomplished verbally, or through secure electronic sharing.

E. The Care Manager will review final suggested Plan of Care with Participant/Family to assure it reflects agreed upon goals, and modify as needed.

1. The Care Manager will obtain Participant/Family/Consenter signatures to signify acceptance, and will provide Participant/Family with a copy.
   i. The Care Manager will assist the Participant/Family in obtaining copies of clinical information that supports the assessment and Plan of Care process as requested.
2. If Care Manager cannot obtain Participant/Family/Consenter agreement with the Plan of Care, The Care Manager will work with the Interdisciplinary Team to make needed modifications to assist with gaining Participant/Family approval.

i. If approval cannot be obtained after sufficient time has been spent revising the plan, Care Manager may need to discuss other options with the Participant/Family, including but not limited to, changing providers; or withdrawing from the Health Home if Participant/Family no longer desires the service.

F. Care Manager will assure completion of Plan of Care within 60 days of enrollment, will document the development of the Plan of Care in Netsmart, and add all providers/team members to the Care Management application as part of the Interdisciplinary Care Team.
   1. Per consent, final Plan of Care will be provided to members of the Interdisciplinary Team, including the Participant, Family/caregivers/Consenter and providers, through Netsmart, RHIO and/or other secure messaging/fax.
      i. If a Provider is not a current active user in Netsmart, The Care Manager will contact the Health Home for assistance in granting them access to the Care Management application.
   2. CMA's will share all completed Plans of Care with the Participant's/Family's MCO through Netsmart, and/or other secure messaging/fax or HCS.
   3. Plans of Care will be shared through the local RHIO when possible.
   4. If unable to complete the Plan of Care within the acceptable time period, reasons will be documented in Netsmart.

G. The Plan of Care will be reassessed and updated by the Care Manager based on Individual/Family needs:
   1. When an event triggers a CANS-NY Reassessment and/or Abbreviated Comprehensive Assessment;
   2. When there are significant changes in the Participants condition;
   3. When significant progress has been made;
   4. To reflect the addition or deletion of providers;
   5. To plan for needed transitions of care;
   6. To reflect updated treatment and the appropriate Participant/Family and Care Team response;
   7. Per the request of Participant/Family, MCO and/or Care Team.

H. Plans of Care for Children will be reviewed in conjunction with the quarterly review of the continued need for Care Management services, and updated as needed. (**See Policy #16-Discharge**)
   1. Care Manager will notify providers/supports and MCOs of updates and changes through Netsmart.
      i. Other methods of sharing the Plan of Care such as secure e-mail, RHIO and/or fax will be utilized as appropriate, while coordinating needed updates.

I. Additional Safety/Crisis Plans (Assessment) will be developed with Participants/Families simultaneously with the Plan of Care.
   1. Safety/Crisis Plans will identify at a minimum:
      i. Helpful supports;
      ii. Contact information, including emergency contacts and Providers;
      iii. Helpful interventions such as successful calming techniques;

Care Management Policy #6 Integrated Care Plan Development

- iv. Health needs/preferences and/or Advance Directives;
  - a. Care Managers will review the types of Advance Directives available, and will assist in completing necessary documents based on need. This may include:
    1) Health Care Proxy (Appoints health care Agent);
    2) A living Will; and/or:
    3) A Do Not Resuscitate Order.
    4) Advance Directive documents will be scanned and attached to the Netsmart record.
- v. Preferred arrangements for pets and other family members in the home when Participant/Family is away.

2. Safety/Crisis Plans will be added through the Assessment process in Netsmart.
3. Safety/Crisis Plans will be updated with Plans of Care as needed to reflect Participant/Family needs, life changes and preferences.