NY Adult BH HCBS Records

Effective Date: September 28, 2024

General Documentation

Question	
01	Each member has a separate record.
02	Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.
03	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.
04	The record is clearly legible to someone other than the writer.

Intake/Evaluation

Question	
05	Referral Process There is evidence that the provider agency responded to the referral inquiries of member within at least 14 days of receiving referral inquiries.
06	The provider agency uses intake and evaluation tools that are specific to Adult BH HCBS.
07	The intake and evaluation results include frequency, scope and duration.
08	The intake and evaluation process is person centered and lasts from 1-3 visits depending on each member's unique needs and preferences.
09	If there is evidence during the intake and evaluation process that the member chooses not to proceed with BH HCBS services there is evidence in the record that the CM and MCO are notified.
10	The Adult BH HCBS Community Mental Health Assessment is in the record and includes: reason for starting services, the members perception about their current family/social supports is documented.
11	The Mental Health Assessment includes: case formulation, primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments.
12	The BH HCBS Community Mental Health Assessment is updated at least annually and/ or when life changing events occur.

Person-Centered & ISP

Question	
13	The member is engaged in a process of person-centered planning to discuss their goal , their strengths, preferences, and barriers, and their level of support needed to achieve their goal.
14	The member's goal in the Individualized Service Plan (ISP) is clearly linked to the member's goal in the full BH HCBS plan of care (POC).
15	The ISP clearly documents the intended frequency, intensity, duration, and scope of services.
16	The member, and when appropriate, family of choice and other supporters ae invited to all service planning meetings.
17	There is evidence in the record that the individual was actively involved in the development of the ISP.

ISP/Person Centered Care

Question	
18	There is evidence that the member and provider participated and agreed to the ISP/POC.
19	The ISP/POC is reviewed, updated, changed as needed by member and provider, but no less than annually with provider and member participation and agreement.

Coordination & Collaboration

Question	
20	There is evidence that the BH HCBS provider maintains regular communication with the MCO, Health Home Care Manager (HHCM) or the Recovery Coordinator (RC).
21	There is evidence that the BH HCBS provider has shared the recommended frequency, scope, and duration for services with the HHCN or RC.
22	The provider agency has an effective system in place to communicate with the MCO and or the HHCM/RC around member service usage and combined hours caps (e.g., TE/Pre-Voc).
23	The case record includes a consent release of information where applicable.

Service Del. & Documentation

Question	
24	Recovery Oriented_The services support the acquisition of person-centered goals and are provided based on the principle that all individuals have the capacity to recover from mental illness and SUD as evidenced by language used in evaluations, service plans, and encounter / progress notes.
25	Trauma Informed Care_ Services are delivered with a trauma-informed approach that is supportive and avoids re-traumatization. All services engage individuals with the assumption that trauma has occurred in their lives.
26	Flexible and Mobile_Services are adapted to meet the specific and changing needs of each member, using service delivery approaches to best suit each member's needs and preferences.
27	Flexible and Mobile_Service locations whether onsite or off site, are chosen with respect to the member's informed choice.
28	Documentation of Service Delivery_Documentation of face to face service delivery includes the required element: Name of HARP member Served.
29	Documentation of face to face service delivery includes the required element: Type of service provided.
30	Documentation of face to face service delivery includes the required element: Date of service provided.
31	Documentation of face to face service delivery includes the required element: Location of service.
32	Documentation of face to face service delivery includes the required element: Duration of service, including start and end times.
33	Documentation of face to face service delivery includes the required element: Description of interventions to meet POC goals.
34	Documentation of face to face service delivery includes the required element: Outcome(s) or progress made toward goal achievement
35	Documentation of face to face service delivery includes the required element: Follow up/next steps.
36	Documentation of face to face service delivery includes the required element: Name, qualifications, and dated signature of staff delivering service.

Service Specific_Habilitation

Question	
37	Habilitation Service Only__Interventions included in the ISP are designed to assist the member in acquiring and improving skills such as communication, self-help, household management, self-care, socializing, personal adjustment, relationship development, and use of community resources. services do not exceed 250 hours per calendar year.
38	Habilitation Service Only_Services are provided on a 1:1 basis with the member.

Service Specific _Ed. Support

Question	
39	Education Support Service Only_The ISP clearly documents the link between the member's education-related goal and obtaining employment with the skills/knowledge acquired through pursuing school or formal training.
40	Education Support Service Only_Interventions included in the ISP support the member in completion of school or formal training, Interventions included in the ISP are necessary to enable the member to integrate more fully into the community and to ensure the health, welfare and safety of the member.
41	Education Support Service Only_Services are provided 1:1.

42	Education Support Service Only_Members receive support navigating the non-duplicative benefits and services available through ACCESS-VR that can support their educational attainment.

Service Specific_Pre Voc

Question	
43	Pre-Vocational Service Only_Interventions included in the ISP provide learning and work experiences where the member can develop general, non-job-task-specific strengths and soft skills that contribute to employability in completive work environment as well as in the integrated community settings.
44	Pre-Vocational Service Only_Services are provided 1:1.

Service Specifc_Trans Employ.

Question	
45	Transitional Employment Service only_Interventions included in the ISP are designed to strengthen the member's work record and work skills toward the goal of achieving assisted or in a an assisted competitive and integrated employment.
46	Transitional Employment Service only_The member has access to time-limited employment and on-the-job training in one or more integrated settings.
47	Transitional Employment Service only_Services are provided 1:1.
48	Transitional Employment Service only_Members are given information on evidence-based supported employment practices, including Individual Placement and Support.

Service Specific_Int. Supp. Em

Question	
49	Intensive Supported Employment Service Only_Interventions included in the ISP consist of intensive supports that enable individuals to obtain and keep competitive employment at or above minimum wage.
50	Intensive Supported Employment Service Only_Interventions are provided with fidelity to the Individual Placement and Support (IPS) model of supported employment.
51	Intensive Supported Employment Service Only_Services are provided 1:1.

Service Specific_Ongoing Supp.

Question	
52	Ongoing Supported Employment Service Only_Interventions included in the ISP are individualized, person centered services providing supports to members who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.
53	Ongoing Supported Employment Service Only_Services are provided 1:1.

Eligibility/Discharge

Question	
54	NYS Eligibility Assessment at a is valid for one year from the date of completion_There is evidence that the member receiving BH HCBS at a minimum have an assessment completed annually for all HARP members and determine functional impairment and continued need for BH HCBS.
55	There is evidence that members are enrolled in a Health Home or if the member opted out of HHCM, there is evidence the member is connected to a recovery coordination agency (RCA) for ongoing assessment and care planning requirements for BH HCBS.
56	There is evidence that discharge planning occurs at admission.
57	There is evidence that if a member is discharged from BH HCBS, the member achieved their goal (s) and no longer wants to pursue the goal.
58	There is evidence that if a member is discharged from BH HCBS, the member no longer wants to pursue the services.
59	Was the member transferred/discharged to another clinician or program? This is a non-scored question.
60	If the member was transferred/discharged to another clinician or program, there is documentation that the communication/collaboration occurred with the receiving program.

61 There is evidence that if a member is discharged from BH HCBS, the discharge information, status and plans have been shared with the Health Home and MCO/HARP.

62 If the member was transferred/discharged to another program, there is documentation that the member/ guardian refused consent for release of information to the receiving program.

63 There is evidence that if a member is discharged from BH HCBS, if the ADULT BH HCBS Provider recommended referrals for additional or future services, it is documented in the record.

64 The reason for discharge is clearly identified.

65 The discharge plan summarized the reason (s) for BH HCBS services and the extent to which the BH HCBS POC goals were met.

66 The discharge/aftercare plan described specific follow up activities.

67 When a member discontinues services, a full review of the case, including an assessment of the level of risk is completed an d efforts are made to re-engage the member.

68 There is evidence that if a member is discharged from BH HCBS, if the ADULT BH HCBS Provider recommended referrals for additional or future services, there was collaboration with the Health Home Care Manager (the HHCM is responsible for the referral process and updating the POC).

69 When a case closes due to a member discontinuing services, written corresponded is sent to the member related to service resources.

70 If the member transferred/discharged from the service, there was evidence the transition was coordinated with other appropriate agencies and/or supports .

71 The discharge plan summarizes the reason(s) for BH HCBS Services, and the extent to which the POC goals were met.

72 The BH HCBS Records are completed within 30 days following discharge.