



HHUNY

HEALTH HOMES OF UPSTATE NEW YORK
Empowering you. Expanding possibilities.

HARP and HCB Services Process Manual

Health Homes of Upstate New York

Health Homes of Upstate New York
BestSelf Health Home Services- Western Region
Chautauqua County Department of Mental Hygiene- Southern Tier Region
Circare- Central Region
Huther Doyle- Finger Lakes Region
New York Care Coordination Program

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What is HARP?

A HARP is a Medicaid managed care insurance plan that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use). HARPs also manage an enhanced benefit package of Behavioral Health Home and Community Based Services (BH HCBS) for eligible enrollees. BH HCBS provide opportunities for HARP members to receive rehabilitative and recovery services in their own home or community.

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HARP Eligibility and Enrollment

Care Management Agencies should verify Medicaid eligibility and enrollment status as a first step to verifying HARP eligibility for their Health Home enrolled members. Health Home clients who are not yet enrolled in the Health Home program should be enrolled into the Health Home program prior to starting the HARP process with them.

HARP eligibility is based on certain factors, such as past use of behavioral health services in Medicaid. NYS generates an updated list of people who are eligible for HARP every other month.

To determine the status of your client’s HARP eligibility, you should check either MAPP or ePACES

HARP eligibility status appears in e-PACES on an individual’s file in the restriction/exception code part of the report

The H RE Codes listed here give a description of where you client is at in the HARP process

	HARP Specific Restriction Exception (RE) Codes
RE Code	RE Code Description
H1	HARP ENROLLED W/O HCBS
H2	HARP ENROLLED WITH TIER 1 HCBS
H3	HARP ENROLLED WITH TIER 2 HCBS
H4	SNP HARP ELIG W/O HCBS
H5	SNP HARP ELIG With HCBS TIER 1 HCBS
H6	SNP HARP ELIG With HCBS TIER 2 HCBS
H9	HARP ELIG PENDING ENROLLMNT

Please see Appendix D for more information about HARP Status Clarification

Individuals can ask their treating providers to look up their eligibility status or they can call New York Medicaid Choice at 1-855-789-4277; TTY users: 1-888-329-1541

If your client is HARP ELIGIBLE (RE Code: H9):

Step 1: Have a conversation with your client about HARP and the benefits of HCB Services. Encourage and assist them to enroll into the program. Eligible individuals may choose to enroll in a HARP at any time, even if the individual previously chose to opt out or never received an enrollment notice. HARP enrollment is voluntary, and eligible individuals may contact New York Medicaid Choice to learn about available enrollment options

New York Medicaid Choice at 1-855-789-4277 TTY users: 1-888-329-1541

UNTIL YOUR CLIENT IS ENROLLED IN BOTH THE HEALTH HOME PROGRAM AND A HARP YOU CANNOT START THE HARP ASSESSMENT PROCESS

Step 2: Continue to follow Health Home timeframes and provide Health Home Care Management as you would for a non-HARP, mainstream Health Home member

Step 3: If your client **declines** to enroll in HARP services, you must:

1. Notify their MCO
2. Document their decline and your conversation with their MCO in a note in Netsmart CareManager
3. Complete the [General Assessment](#) (see “General Assessment” section for more guidance on how to complete this step)
4. Reassess client’s readiness for HARP at least every 6 months until the client agrees to enroll or is no longer eligible for a HARP or the Health Home program

Step 4: Update their [Program Type](#) in Netsmart CareManager to accurately reflect their HARP status if necessary (see “Selecting HARP Program Type” for more direction on how to do this step)

Step 5: Following the HARP Enrollment Process once they become HARP Enrolled

If your client is HARP ENROLLED (RE Code H1):

Step 1: Begin the HARP Assessment Process

Step 2: If your client **declines** to do an Eligibility Assessment, you must:

1. Notify their MCO
2. Document their decline and your conversation with their MCO in a note in Netsmart CareManager
3. Complete the [General Assessment](#) (see “General Assessment” section for more guidance on how to complete this step)
4. Reassess client’s readiness to complete the Eligibility Assessment at least every 6 months until the client agrees to complete or is no longer eligible for the HARP or Health Home program

Step 2: Update their [Program Type](#) in Netsmart CareManager to accurately reflect their HARP status if necessary (see “Selecting HARP Program Type” for more direction on how to do this step)

Step 3: Continue to follow Health Home timeframes and provide Health Home Care Management as you would for a non-HARP, mainstream Health Home member

Selecting HARP Program Type in Netsmart CareManager

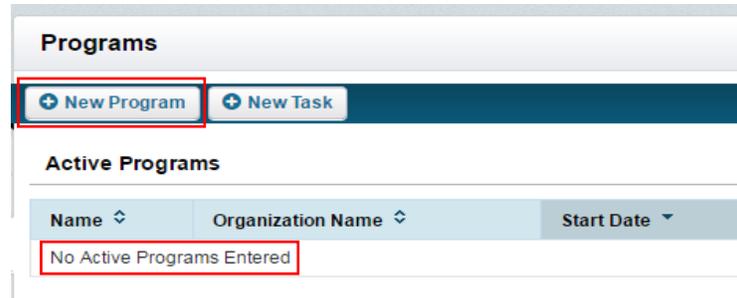
Program Type is a new feature within the Netsmart CareManager system. In order to view and use HARP HCBS documents within the system, your client must be identified as HARP Enrolled via Programs. When HHUNY creates your clients chart in Netsmart CareManager, any client that is identified as HARP Eligible within MAPP will be automatically added to the [HARPEL](#) program type in Netsmart CareManager. Clients that are identified as being HARP Enrolled will be added to the [HARPEN](#) program type.

Any changes in your clients HARP status after the initial creation of their chart will need to be manually completed by the Care Management Agency until the client is closed from the Health Home program at which time the current HARP program will automatically end date for you.

The steps listed below will walk you through how to add or update a program type within the system.

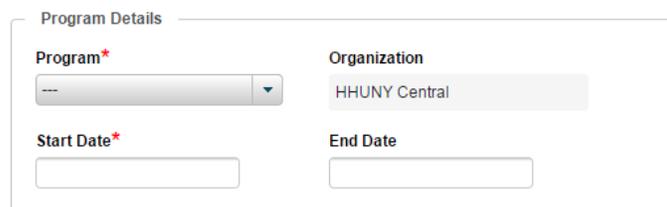
Please remember that Netsmart CareManager does NOT auto-update the program and the responsibility to ensure a client's chart contains up to date and accurate information falls on the Care Management Agency.

1. Navigate to the [Programs](#) page within a client's chart
If your client currently has an active program listed, skip to Step 3
2. If your client has no [Active Program](#) listed, click on [+New Program](#)



The screenshot shows the 'Programs' section of the Netsmart CareManager interface. At the top, there are two buttons: '+ New Program' and '+ New Task'. The '+ New Program' button is highlighted with a red rectangular box. Below these buttons is a section titled 'Active Programs'. Under this section, there is a table with three columns: 'Name', 'Organization Name', and 'Start Date'. The table is currently empty, and the text 'No Active Programs Entered' is displayed in the table area, which is also highlighted with a red rectangular box.

- a. Fill in [Program](#) and [Start Date](#)



The screenshot shows the 'Program Details' form. It has four fields: 'Program*' (a dropdown menu currently showing '---'), 'Organization' (a text field containing 'HHUNY Central'), 'Start Date*' (an empty text input field), and 'End Date' (an empty text input field).

- In the [Program](#) drop down select either [HARPEL](#) for HARP Eligible or [HARPEN](#) for HARP Enrolled, dependent upon the status of your client
- The [Start Date](#) should identify the date they became HARP Eligible or HARP Enrolled. This information can be found in MAPP. If this date precedes the date they were enrolled into the Health Home program, use the Health Home enrollment date

- If your client currently has an Active Program Listed that you need to update, click on the [View](#) button next to the [Active Program](#)

Active Programs 

Name	Organization Name	Start Date	End Date	Record of Origin	Actions
HARP Eligible	HHUNY Central	05/24/2017		Direct Entry	View

- End the current Program

- Select [Edit](#)

Programs

[+ New Program](#) [+ New Task](#) [Back](#) [Edit](#)

Created on 05/24/2017 11:14 AM EDT by Kristy Talbot
Updated on 05/24/2017 11:14 AM EDT by Kristy Talbot

Program Details

Program	Organization
HARP Eligible	HHUNY Central
Start Date	End Date
05/24/2017	

- Enter an [End Date](#) for the program that is currently listed

[+ New Program](#) [+ New Task](#) [Save](#) [Save & Close](#) [Cancel](#)

Created on 05/24/2017 11:14 AM EDT by Kristy Talbot
Updated on 05/24/2017 11:14 AM EDT by Kristy Talbot

Program Details

Program	Organization
HARP Eligible	HHUNY Central
Start Date*	End Date
05/24/2017	06/14/2017

- [Save and Close](#)

- Add a new Program type by clicking on [+New Program](#)

[+ New Program](#) [+ New Task](#)

Active Programs

Name	Organization Name	Start Date	End Date	Record of Origin
OLD HARP	HHUNY Central	05/24/2017	06/14/2017	Direct Entry

a. Fill in Program and Start Date

Program Details

Program*	Organization
---	HHUNY Central
Start Date*	End Date

- In the **Program** drop down select either **HARPEL for HARP Eligible** or **HARPEN for HARP Enrolled**, dependent upon the status of your client
- The **Start Date** should identify the date they became HARP Eligible or HARP Enrolled. This information can be found in MAPP. If this date **precedes** the date they were enrolled into the Health Home program, use the Health Home enrollment date

Completing the General Assessment

A client may decline to enroll into a HARP program despite being eligible for services or decline to complete an Eligibility Assessment despite being HARP enrolled. There must be notes in the system that support the fact that you had this conversation with the client. You must also track their denial via a [General Assessment](#) in the Netsmart CareManager system if the client:

1. Is HARP Eligible but declines to enroll into a HARP
2. Is HARP Enrolled but declines to complete an Eligibility Assessment

If the client is HARP Enrolled, completes the Eligibility Assessment but THEN declines HCB Services, you will document their decline at this stage on the [Service Level Request](#) form. (See Service Level Request section for more information on this)

In order to track a client's decline of a HARP or their decline to complete the Eligibility Assessment, you must complete a General Assessment when they initially decline the program or assessment and when you reassess the member for readiness to engage in a HARP or complete the Eligibility Assessment. Reassessment of readiness to engage should occur at least every six months for a client that declines a HARP or to complete the Eligibility Assessment.

To complete the General Assessment, you must:

1. Navigate to the [Assessments](#) page, click [+New Assessment](#)
2. Select [General Assessment](#)



3. Complete the General Assessment

General Assessment

Assessment Date* 07/21/2017

Assessment Type* ---

Score* []

Other []

Notes []

- **Assessment Date:** The date that you discuss with your client and they opt to either not enroll into the HARP program or decline to complete the Eligibility Assessment. Ensure there is a note documented in the system for this date that supports the decision of the member
- **Score:** Mark as NA
- **Assessment Type:** Under assessment type, you will select the type of denial.

General Assessment Created on Updated on

Assessment Date* 07/21/2017

Assessment Type* ---

Score* []

Notes []

DOH Composite Score
Eligibility Diagnosis
HARP Eligible, Declines HARP Enrollment
HARP Enrolled, Decline Eligibility Assessment
Outpatient Rank
Risk Score

HARP Eligible, Declines HARP Enrollment
HARP Enrolled, Declines Eligibility Assessment

- **Other:** Leave blank
 - **Notes:** You may write any comments you have in this section
4. Click [Save and Close](#)
 5. Reassess your client's readiness to either engage in a HARP or complete an Eligibility Assessment at least once every six months until member is ready to move forward with the HARP program as eligible. **Notes must support the Care Managers efforts to encourage the member to engage in the HARP program including the sharing of information about and benefits of the program as well as services available.**
 6. A new General Assessment should be completed, as applicable, to capture the member's continued decline to move forward in the HARP process at each review.

Starting the HARP Enrolled Process

Once your client is HARP Enrolled, agrees to the assessment process and you have updated your program type in Netsmart CareManager, you are ready to begin the HARP Enrolled process with your client.

1. Remember that throughout the entire HARP process with your client **you must continue to follow and meet all mainstream Health Home standards and timeframes** including completion of a comprehensive assessment, crisis plan, identifying and working with a care team and developing a person-centered plan of care that will later be included on the full HARP Plan of Care. (Reference the HHUNY HARP Workflow Guidance for further clarity about HARP Plan of Care requirements)
2. You must complete the [DOH-5055 Health Home Information Sharing Consent](#) **prior to** completing the Eligibility Assessment within the UAS-NY system.

The DOH-5055 templates specific to your Health Home can be found here:

<https://hhuny.org/CareManagementPortal/Forms>

Please Note:

- The DOH-5230 and DOH-5032 are NOT required to assign a case load in the UAS-NY or to complete the Eligibility Assessment
 - The UAS-NY does NOT need to be listed on the DOH-5055 in order to access the UAS-NY system
3. Update documentation in Netsmart CareManager

It is important that you update Netsmart CareManager before beginning the process for requesting HCB Services since many of the components of the HCBS forms pull in data from other sections within the system.

- a. Verify [Demographic](#) information including address and phone number
 - b. Add diagnosis and social health problems which the client agrees to address with the assistance from the Health Home Care Manager
 - c. Add social supports and providers to your [Care Coordination](#) page
If you do not do this step, you will have incomplete information on your Service Level Request form. When referring a problem to a provider on your [Care Coordination](#) page, you must also complete the [Services Provided Section](#). (See Services Provided Section for further detail on how to complete this step.)
4. Complete the HARP HCBS Eligibility Assessment in the UAS NY

Completing the Eligibility Assessment

Eligibility for receiving HCB Services is determined through an assessment, called the New York State Eligibility Assessment, conducted by Health Home care managers. The Eligibility Assessment is located in the Uniform Assessment System for New York (UAS NY) application within the HCS environment.

Remember the DOH 5055 Patient Information Sharing Consent MUST BE completed PRIOR TO completing an Eligibility Assessment.

Within the UAS-NY, users will be able to participate in the training needed to complete the Eligibility Assessment with HARP enrolled clients.

Users who want access to the UAS-NY environment must have:

- Trust Level 3 Assurance
- Be assigned at one of the below roles:

CMHA Role Name	Generally Intended For
CMHA-15	Administrative Support Staff: build and maintain organization's case list and run reports to support organization's business processes.
CMHA-40	Assessors: add, conduct and finalize an EA.
CMHA-45	Assessor Supervisors: conduct an EA and review and manage assessments conducted by other staff and generate reports for their organization.
CMHA-50	Managers: review assessments, workflow and run administrative reports for their organization.

More information:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/uas_support_for_users.pdf

The Eligibility Assessment is due within 10 days, but not longer than 21 days of an individual's enrollment into the Health Home program or a HARP, whichever is their most recent enrollment date. MAPP will identify your client's start date for the HARP program (see Appendix E for more guidance about "[HARP Status in MAPP](#)")

Per the Department of Health, the Eligibility Assessment must be completed:

1. At minimum, annually and when there is a significant change in status for the member
2. Even if the member resides in an ineligible setting
3. Even if the HCBS are not accessible to the member or have a wait list

You MUST upload the completed "[Eligibility Assessment Report](#)" and the "[Eligibility Summary Report from Eligibility Assessment](#)" form into the Netsmart CareManager system as attachments.

- The "Eligibility Assessment Report" attachment description should be labeled as "[HARP Eligibility Assessment MM/DD/YY](#)" with the MM/DD/YY representing the date the Eligibility Assessment was completed with the client
- The "Eligibility Summary Report from Eligibility Assessment" attachment description should be labeled as "[HARP Eligibility Assessment Output MM/DD/YY](#)" with the MM/DD/YY representing the date the Eligibility Assessment was completed with the client

Once you have completed the Eligibility Assessment you will use the "Eligibility Summary Report from Eligibility Assessment" to identify which tier of services your client is eligible to receive and which services they would benefit from. This information will assist you in completing the [Service Level Request](#) form.

Completing the Services Provided section:

1. You must refer all problems entered into the system to a provider who is assisting in addressing the problem with the client
 - a. Navigate to your [Care Coordination](#) Page
 - b. Under [Referrals Needed](#) locate a problem that needs to be referred
 - c. Select [Actions](#) and click [Refer](#)
 - d. If your problem is already referred out but you just need to update the [Services Provided](#) section, locate your problem under [Referred Problems](#), select [Action](#) and click [Edit Referral](#)

Provider Referrals Refer Multiple Problems to Provider

Referral Status Filter: All Problem Status Filter: All Show Not Needed

Search Problems...

Referrals Needed

Problem	Problem Type	Problem Onset	Problem Status
Inadequate community resources	Social Health	Adult	Active

Refer Not Needed Actions

2. This will open your [Referral section](#)
 - a. **Provider:** the name of the person or professional who is addressing the problem. You can select from the list of available providers or add a custom entry
 - b. **Consent Status:** Add a consent if the provider is on the DOH-5055. If the provider is NOT on the DOH-5055 this should prompt a discussion with the client to determine why
 - c. **Referral Status:** Identify that status of linkage between the provider and client
 - d. **Referral End Date:** Only fill this out if the client and provider no longer work together

3. Complete the [Services Provided Section](#)
 - a. **Description of Services Provided:** Document what type of service the provider offers to the client such as Primary Care, HCB Service, Cardiology, Benefits and Entitlements, etc.
 - b. **Frequency of Services Provided:** Document how often is the service provided such as monthly, annually, every 2 weeks or as needed, etc.
 - c. **Duration of Services Provided:** Document how long the services will be provided for such as for 2 months, for a year or ongoing if there is not an expected end date
 - d. **Paid Service:** Document "Yes" if this is a service that either the client or their insurance has to pay for them to receive
 - e. **Last Visit Date:** Document when the client was last served by the provider.

Save Cancel

Provider * Doug Lindke

Consent Status None Entered Add Consent

Referral Status * Referral - Accepted

Referral Start Date * 05/24/2017

Referral End Date

Comments

Services Provided

Description of Services Provided podiatrist

Frequency of Services Provided monthly

Duration of Services Provided ongoing

Paid Service Yes No

Last Visit Date 05/09/2017

Completing the HCBS Service Level Request Form



After the Care Manager has updated Netsmart CareManager, completed the Eligibility Assessment and determined that the individual is eligible for and interested in a referral to HCB Services, they must complete and submit a [HCBS Service Level Request Form](#) (SLR) to the individual's MCO for review. The MCO reviews the request and will issue a [Service Level Determination](#) back to the requesting Care Manager.

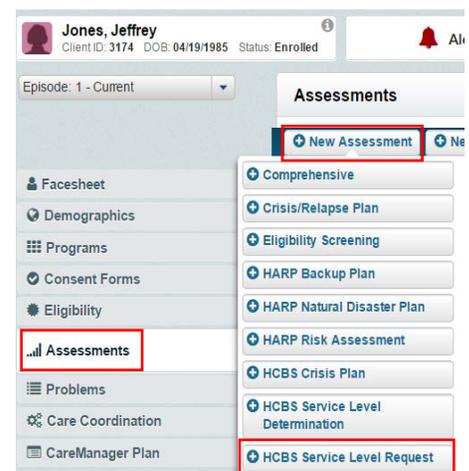
At minimum, the SLR must include the following information:

- All services the individual currently receives
- The HCBS Tier eligibility determination
- The individual's recovery goal
- The specific HCBS recommended by the Eligibility Assessment or requested by the client

The MCO will review the information provided and issue a [Service Level Determination](#) within 3 business days of receipt of all information needed (as listed above) but no more than 14 days of the request. The MCO may extend this time by up to 14 days, if the MCO needs more information and the extension is in the individual's best interest.

If at any time, changing needs of the member require additional HCB Services, a new Service Level Request form should be completed for the newly requested services only and submitted to the MCO. You would then follow the same process for the newly requested service, update the Plan of Care as appropriate and await a Service Level Determination form.

1. Navigate to the [Assessments](#) page, click [+New Assessment](#)
2. Select [HCBS Service Level Request](#)



To complete the [HCBS Service Level Request](#) assessment you must complete all fields within the form and then submit the form to your client's Managed Care Organization
For more information on how to submit your SLR to your client's MCO, please see Appendix C

Client Information and Agency Information

★ Client Information		★ Agency Information	
Client Name	CIN #	Care Manager	Agency
Jeffrey Jones	IH35252V	Kristy Talbot	AIDS Community Resources Inc
Client Address	Client Phone	Care Manager Phone	Care Manager Email
123 Lilac Dr, Erie NY 14625	Home: 716-332-4859		ktalbot@hhuny.org
Client Gender	Refresh	Managed Care Organization	Refresh
Female		MEDICAID Excellus BlueCross BlueShield	

Your [Client Information](#) and [Agency Information](#) will automatically populate for you. To verify that all information is up to date, you can click the [Refresh](#) buttons

1 & 2. Eligibility Screen

1) Date of NYS Eligibility Screen*	Status*
<input type="text" value="06/16/2017"/>	<input type="text" value="Draft"/>
2) Eligibility Determination	
<input type="text" value="--"/>	
--	
Tier 1	
Tier 2	
Not Eligible for HCBS services (no further option available)	
Member Declined HCBS at this time	

- Date of NYS Eligibility Screen:** This date should reflect the date you completed the Eligibility Assessment with the client
- Status:** Keep the status of your SLR in draft until you complete all questions
- Eligibility Determination:** Select the option that identifies which Tier of services your client is eligible for or if they are either not eligible or decline services
 - If your client is not eligible or declines services, your form will be considered complete and you should change the [Status](#) to final and [Save and Close](#)
 - If your client **DECLINES** HCB services after being determined eligible to receive HCBS via the Eligibility Assessment, you must reassess for readiness to engage in services at least once every 6 months. This does **NOT** mean you must redo the Eligibility Assessment every six months. The Eligibility Assessment should be completed annually even if the member previously declined HCBS. Notify your client MCO of any decline of services.
 - If your client is eligible for Tier 1 or Tier 2 services, the remainder of the form will become available to fill out

Housing Verification

3) Housing Verification

a) Is the address listed above, a setting chosen by the individual (does the individual want to live in the above setting?)

Yes

No - Housing Questionnaire is optional but may be completed at this time

b) The address is: (1) a nursing home; (2) an institution for mental diseases; (3) an intermediate care facility for individuals with developmental disabilities; (4) a hospital; (5) an OMH licensed Congregate Treatment Site (Community Residence); or (6) any other location that has the qualities of an institution, as determined by New York State

Yes - Stop HCBS Services unless client is eligible to complete the risk assessment

No

In order for a client to be eligible for HCB Services, they must not reside in institutionalized or community residence settings. **Please note, per DOH directive, even if a member lives in an ineligible setting, you must still complete the Eligibility Assessment annually.**

- a. **Is the address listed above a setting chosen by the individual?:** If the client is living in a residence that they did not choose to live in or if they do not currently want to live where they are currently residing, select “No” to this question. This does NOT impact their ability to receive HCB services but should prompt you to discuss housing services with your client. Additionally, you have the option of completing the Housing Questionnaire at this time. If you do complete the Housing Questionnaire, you document in notes and upload the completed questionnaire into Netsmart CareManager with the description “HCBS Housing Questionnaire MM/DD/YY” with the MM/DD/YY representing the date of completion.

Please see the following link to access the Housing Questionnaire:

<https://hhuny.org/HHUNY/media/Webinars/Housing-Questionnaire.pdf>

- b. **Residency Type:** If your client resides in any of the housing types listed below, they are not currently eligible for HCB Services and you should not proceed with the HCBS process
- i. Nursing Home
 - ii. Institution for Mental Diseases
 - iii. Intermediate Care Facility (ICF)
 - iv. Hospital
 - v. Congregate Treatment Site (Community Residence)
 - vi. DOH Adult Home
 - vii. Location that has qualities of an institution

In the future, if the state changes residency requirements, your client may become eligible and you would be required to complete the HCBS Risk Assessment

For more information from the state about the Federal Settings Rule please see:

<http://ctacny.org/sites/default/files/MCO%20and%20HH%20Guidance%20Memo.pdf>

HCBS Services

Part 1: Selecting Services

All HCB Services available to HARP members are listed under **Question 4: Which HCB Services would your client benefit from access to in the future**

4) Which HCBS services would your client benefit from access to in the future?

Tier 1 and 2				
Service Categories	Client Requested	Eligibility Indicated	N/A	
Transitional Employment	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Educational Support Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Pre-Vocational Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Empowerment Services - Peer Supports	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Ongoing Supported Employment	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Intensive Supported Employment	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Non-Medical Transportation	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Tier 2 Only				
Service Categories	Client Requested	Eligibility Indicated	N/A	
Psychosocial Rehabilitation	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Community Psychiatric Support and Treatment Habilitation	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Family Support and Training	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Short-term Crisis Respite	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>
Intensive Crisis Respite	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="button" value="Clear"/>

- TIER 1 and 2:** Dependent upon your client’s need identified through the NYS Eligibility Assessment, they will qualify for either a Tier 1 or Tier 2 level of service. Clients that qualify for Tier 2 are eligible to receive all available HCB Services. Clients that qualify for Tier 1 are eligible to only receive a selected range of services primarily dealing with Employment and Educational services
- Service Categories:** These are the approved Health and Community Based services available to clients enrolled in a HARP
For further information on the different services please visit the following website:
<https://www.omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf>
- Client Requested:** Select any services your client identifies as being interested in receiving. This will open up the Service Form for the selected service. See Part 2 for guidance on completing this step. If a service is both client requested and eligibility indicated, select eligibility indicated
- Eligibility Indicated:** Select any services your client is eligible for as indicated through the Eligibility Assessment. This will open up the Service form for the selected service. See Part 2 for guidance on completing this step. If a service is both client requested and eligibility indicated, select eligibility indicated
- NA:** Select if the service is not requested or indicated. All services automatically default to NA
- Clear:** If you make an error in selection or on your form, you can select Clear to quickly void the form and data

HCBS Services

Part 2: Service Form

When selecting the HCB Services your client is interested in pursuing by either clicking [Client Requested](#) or [Eligibility Indicated](#), you will see that a form opens up below the selected service. The form must be completed for every service selected

4) Which HCBS services would your client benefit from access to in the future?

Tier 1 and 2				
Service Categories	Client Requested	Eligibility Indicated	N/A	
<input checked="" type="radio"/> Transitional Employment	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="button" value="Clear"/>

Why is it needed?

Problems Addressed
None

Past Efforts

Preferences & Strengths

Outcomes I want to achieve

Barriers to achieving the outcomes

All responses in the service form must tie back to the specific HCB service being requested.

For more information about what is involved and offered through each service, please see the HCBS Manual:

<https://www.omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf>

- a. **Why is it needed?** Write a narrative about why the client needs the service selected and what they hope to gain from being in the service. Please ensure that the need directly ties back to the service type and description per the HCBS Manual
- b. **Problems Addressed:** You will see a drop down of any problems you have previously entered into the Netsmart CareManager system and marked as active or requiring Care Manager assistance. Select the diagnosis or problem that will be addressed through this service. If you did not enter the problem into the system prior to completing the SLR, then you must:
 1. Save your SLR as a draft
 2. Navigate to your problems page and enter in the diagnosis or problem that will be addressed
 3. Save and Close
 4. Navigate to your assessments page and view the draft SLR
 5. Select Edit
 6. Your problem should now appear in the drop down

- c. **Past Efforts:** Write a narrative about any work your client did in the past or any services they previously accessed to address their need, problem or diagnosis. This can include such things as linking with community resources, provider or therapy based assistance, independent actions they've taken or any attempts they have made to move towards their outcome
- d. **Preferences & Strengths:** Identify any strengths or preferences that relate to the service selected. Strengths should identify the internal and external resources and attributes your client brings to the table. A good strengths inventory is personal to the client and includes such things as abilities, values, motivational factors, resources and relationships. These should later be brought over to the Strengths section of their Plan of Care
- e. **Outcomes I want to achieve:** The stated Outcome must be related to the service selected and follow the **S.M.A.R.T** guidelines

Specific/ Simple, Measurable, Attainable, Realistic/ Relevant and Time-Framed

They should indicate what the client, not the providers, will do or achieve and what the desired result of change in status, abilities, skills or behaviors will be as a result of participation in the service selected

For more guidance on how to develop a SMART outcome/objective, please view Appendix E: SMART Worksheet

- f. **Barriers to achieving the outcomes:** Identify any barriers that are stopping the client from reaching their desired outcome. They can include such things as personal needs, family issues and resource needs a client has. Barriers must be related to the service selected

Education/ Employment Service

For any client that has agreed to Education Support Services, Pre-Vocational Services, Intensive Supported Employment, and/or Ongoing Supported Employment, you must verify if they are opting to receive HCB Services, pursue support from ACCESS-VR or both. If your client did not link with these services, select NA

— 5) If Education support services, Pre-Vocational Services, and/or Intensive Supported Employment or Ongoing Supported Employment are selected above, please complete the following:

The Health Home Care Manger (HHCM) is responsible for facilitating the Member's informed choice in education and/or employment support services. The following selection should be made by the Member, based on an informed choice, if any education and/or employment support services were selected. Based on the information provided to me by my Care Manager, I have chosen to:

Receive services through the Home and Community Based Services (HCBS) Waiver designated agency. The Behavioral Health Home and Community Based Services identified in this Plan of Care are not available to this individual under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) (i.e. ACCESS-VR).

Pursue support from ACCESS-VR

Receive services through the BH HCBS Waiver AND pursue separate and non-duplicative services through ACCESS-VR. The Behavioral Health Home and Community Based Services identified in this Plan of Care are not available to this individual under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) (i.e. ACCESS-VR).

N/A

Goal Statement

You must document what the client hopes to achieve or gain through the HARP program and in accessing HCB Services. It should be tied back to the services they have selected to engage in

— 6) Goal Statement

What does your client hope to achieve or gain through the program?

Current Service Summary

The Current Service Summary captures any services your client is currently linked to or engaged with. In this section you will see a listing of all the problems currently marked as Active or needing Care Manager assistance AND are actively referred to a provider, meaning there is no end date to the referral. If you add or update any problems while working on the SLR, you can select [Refresh](#) to update your data.

You must submit a HHUNY Help Desk ticket if provider contact information is incorrect.

7) Current Service Summary

[Refresh](#)

Schizoaffective disorder

Service Category	Service Paid?	Service Type/Specialty
Behavioral Health	Paid	

Provider Name/Organization

Nicholette Thomas

Provider Address

60 East Amherst St Buffalo New York 14214

Provider Phone

Services Provided Description

one:one therapy

Service Frequency

twice a month

Last Visit Date

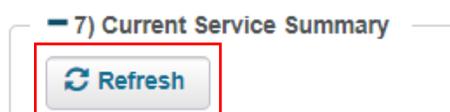
07/03/2017

Most categories will automatically populate for you. If you did not complete the [Services Provided](#) section at the time of referring the problem to a provider on the Care Coordination page, you must:

1. Save the SLR form as a [draft](#)
2. Navigate to your [Care Coordination](#) page and update the [Services Provided](#) section for any [Problem](#) missing this data
3. Return to your [Assessments](#) page and locate the draft SLR form
4. Click [View](#)
5. Click [Edit](#) and your form will again be available to continue



6. Navigate to the current service summary and select [Refresh](#)



Signatures

Per DOH and OMH, a signature on the Service Level Request is no longer required for submission to the MCO.

Signatures continue to be required on the final HARP POC (Health Plan Summary)

Submission

Once your SLR is completed, we recommend that you save it in draft and submit it to the MCO. Once you complete any necessary changes requested by the MCO and it is approved, mark it as final and save.

The SLR must be submitted within 10 days from completion of the Eligibility Assessment and no longer than 20 days. How to submit the SLR will vary dependent upon the MCO your client is linked with.

Yourcare HARP/HCBS Documentation MUST be submitted via the HHUNY Help Desk at <https://support.hhuny.org>.

For further guidance on how to submit your HARP/HCBS Assessment and Plans of Care, please see [Appendix C](#).

Next Steps...

Once your SLR has been submitted to the MCO, you will need to await the [Service Level Determination](#) form to be returned to you by the MCO. During this time, it is recommended that you:

1. Continue to follow Health Home timeframes and provide Health Home Care Management as you would for a non-HARP, mainstream Health Home member
2. Continue to complete the additional assessments that must be completed for a HARP client including:
 - a. HARP Backup Plan
 - b. HCBS Crisis Plan
 - c. HARP Risk Assessment (only as required)
3. Start to create a Plan of Care ([Initial Plan](#) or [New Plan Amendment](#)) to address needs identified through the Comprehensive Assessment, Eligibility Assessment and HCBS process

Once you receive the Service Level Determination form back from the MCO, you should begin to complete the [HCBS Service Level Determination](#) form within the [Assessments](#) tab in Netsmart CareManager.

HARP Backup Plan

The Backup Plan assists a client in locating help in an emergency situation or if regularly scheduled worker(s) cannot provide the member with care, services, or supports. **HARP enrolled clients that are accessing HCBS must have a Backup Plan completed within 60 days from the date the client was both Health Home and HARP enrolled and agreed to the HARP HCB Services.**

To complete a Backup Plan in Netsmart Care Manager you must:

1. Navigate to the [Assessments](#) page, click [+New Assessment](#)
2. Select [HARP Backup Plan](#). This will open up your Backup Plan



3. Complete Assessment Date and Status

HARP Backup Plan

Assessment Date*	Entered By
<input type="text" value="07/12/2017"/>	<input type="text"/>
Assessment Status*	Finalized By
<input type="text" value="--"/>	<input type="text"/>

- **Assessment Date:** This should identify the date the HARP Backup Plan was completed with the client
- **Entered By:** This will automatically populate for you once the document is saved
- **Assessment Status:** This should be left in draft until the plan is finished. You will then switch the status to final and save
- **Finalized By:** This will automatically populate for you once the document is saved

4. Input contact information for individuals the client can access in case of an emergency

HARP Backup Plan

Assessment Date* **Entered By**

Assessment Status* **Finalized By**

HARP Backup Plan

Backup Plan

If there is an emergency, call 911. A backup plan assists with locating help in an emergency situation or if regularly scheduled worker(s) cannot provide you care, services or supports. The backup plan will indicate: whom I will call, including service needs, and phone number, plans for service animals or pets and plans for preparing for a disaster.

I will talk with backup 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 contact one of the individuals listed below if my regularly scheduled worker(s) does not report for his/her scheduled time. (Example: provider, friends, family, previous workers, church members, other volunteers.)

Service*	Contact*	Phone*	Availability*	
<input type="text" value="Service"/>	<input type="text" value="Contact"/>	<input type="text" value="555-555-5555 ext. 230"/>	<input type="text" value="M-F"/>	<input type="button" value="X"/>
<input type="button" value="Add Row"/>				

Service: Indicate the type of service that will be provided or the role of the person listed

Contact: The name of the person and or agency identified

Phone: List the phone number for the contact. You should make every effort to obtain a phone number but if they do not have a phone number or it is unknown, please mark it as such

Availability: Identify when (times and days) that are they available to the person

Add Row: Clicking on Add Row will allow you to add additional contacts to the plan

: The red X will delete the row you have just added

If the contact has more than one phone number or a different phone number for different times of the day, you can enter the contact twice and adjust the phone number, address or times.

Service*	Contact*	Phone*	Availability*
<input type="text" value="Food/Shelter"/>	<input type="text" value="Mom- Kathy Jones"/>	<input type="text" value="555-555-5555"/>	<input type="text" value="M-F 8-5pm"/>
<input type="text" value="Food/Shelter"/>	<input type="text" value="Mom- Kathy Jones"/>	<input type="text" value="555-123-4567"/>	<input type="text" value="Saturday and Sunday"/>

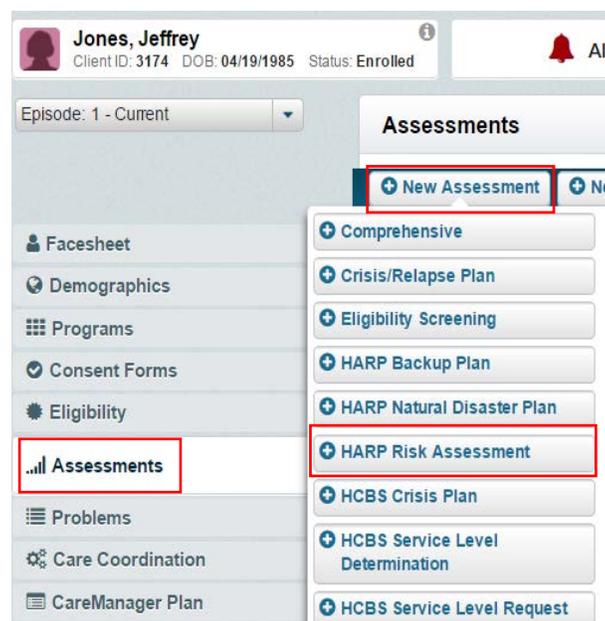
5. Once your Backup Plan is completed, change the [Assessment Status](#) to [Final](#) and [Save and Close](#)

HARP Natural Disaster Plan

Per DOH and OMH, the HARP Natural Disaster Plan is no longer required

HARP Risk Assessment

The HARP Risk Assessment has been created in Netsmart CareManager, however, it is not applicable at this time to the HARP Process. In the future, the Risk Assessment should be completed for any client that is enrolled in a HARP, wants HCBS, but lives in a residential setting that is currently not compatible with HCB services. HHUNY will notify Care Management Agencies when the Risk Assessment becomes applicable. Until then, you will not be able to see the Risk Assessment option in your drop down box Netsmart CareManager.



HCBS Crisis Plan

The Crisis Plan for HARP and mainstream members is the same. You do not need to complete the Crisis Plan twice. All Health Home members must have a Crisis Plan completed within 60 days of enrollment and reviewed, at minimum, every 6 months or after a significant event.

1. Navigate to the [Assessments](#) page, click [+New Assessment](#)
2. Select [Crisis Plan](#)



3. Complete Assessment Date and Status

Crisis Plan	
Assessment Date*	Entered By
<input type="text" value="07/13/2017"/>	<input type="text"/>
Assessment Status*	Finalized By
<input type="text" value="---"/>	<input type="text"/>

- **Assessment Date:** This should identify the date the Crisis Plan was completed with the client
- **Entered By:** This will automatically populate for you once the document is saved
- **Assessment Status:** This should be left in draft until the plan is finished. You will then switch the status to final and save
- **Finalized By:** This will automatically populate for you once the document is saved

4. Complete “Section 1”

Section 1

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? What does a crisis look and feel like to you?^{*}

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

- **What are my triggers:** Give a narrative of situations or circumstances that cause the client stress, may cause them to relapse or feel emotionally insecure. It can include places, people or things that upset them
- **How do I know when I am upset:** Give a narrative of signs, feelings and actions that a client identifies as being indicative of being in crisis or unstable
- **What activities can I do to feel better:** Include any things the client typically does or people they call to calm down or feel safe during a crisis

Who can I call for support?

Add Support

New Contact

Is there anyone you do NOT want involved if you find yourself in crisis?^{*}

What should be done for you during a crisis?^{*}

What do you NOT want done during a crisis?^{*}

What is your hospital of choice?^{*}

Is there anything else you would like to add to these arrangements?^{*}

- **Who can I call for support:** This field will pull over any people that have been added to your social support contact page. You can also add a new contact through your Crisis Plan and it will link back to your contacts page. When adding a new support through your Crisis Plan it will verify that you want to add the contact. Select any social supports that are part of the Crisis Plan
- **Anyone you do NOT want involved:** List anyone the client does not want contacted during a crisis. This may be family members, friends, providers or agencies
- **What should be done:** Identify what the clients identifies as the best response during a crisis. This may include contacting a specific person on their behalf, notifying a provider or therapist or reminding them to go for a walk.
- **What do you NOT want done:** List anything the client does not want done during a crisis. This may include things such as they don't like to talk on the phone when feeling stressed or do not want to be examined by a male doctor when in crisis
- **Hospital of Choice:** List what hospital or emergency facility the client would most like to be taken to in the case of an emergency. This may include different facilities for different types of crisis
- **Anything Else:** Identify any other information the client wishes to add that has not already been addressed

5. Signature

Once the Crisis Plan is completed, you must obtain a signature from the Client.

You have the option of electronically signing the form within the Netsmart CareManager system or obtaining a manual signature.

The screenshot shows a web form for electronic signing. At the top, there are two tabs: 'Mouse' (selected) and 'Topaz'. Below the tabs is a large rectangular box labeled 'Signature*'. Underneath this box are two buttons: 'Clear' and 'Done'. Below the signature box is a text input field labeled 'Client Signature Printed Name*' containing the text 'Jeffrey Jones'. To the right of this field is a 'Date' field, which is currently empty. At the bottom left, there is a checkbox labeled 'Signed on paper' which is currently unchecked.

Electronic Signature

- 1) Ensure all sections of the form are completed and mark the status as [Final](#)
- 2) This will enable you to electronically sign the document. You can sign with a Topaz signature pad, your mouse or your finger if you are using a device with a touch screen
- 3) The name of the person signing the form under [Client Signature Printed Name](#) will automatically default to the name of the Client
- 4) The form will automatically date it according to the date it is signed
- 5) Once you sign, select [Done](#). You will have the option to [Resign](#) if you note an error
- 6) Click Save and Close

Manual Signature

- 1) Ensure all sections of the form are completed and mark the status as [Final](#)
- 2) Select [Client Signed Plan](#) under the signature field
- 3) Click [Save](#)
- 4) Click [Print](#)
- 5) Obtain a signature on the printed document. HHUNY does not accept signature pages. The signature must be on the actual document
- 6) Upload the signed document into Netsmart CareManager as an [attachment](#). Follow the HHUNY naming convention when filling in the description field. The Crisis Plan should be identified as "[Crisis Plan MM/DD/YY](#)" with the MM/DD/YY representing the date the client signed the document

Please reference the Crisis Plan manual for further information:

<https://hhuny.org/HHUNY/media/HHUNYPDFS/Manuals/Crisis-Plan-Manual.pdf?ext=.pdf>

HCBS Service Level Determination

After you submit the [Service Level Request](#) to the Managed Care Organization, they will review all documents and requested services, confirm if the requested services are appropriate for the client and then respond to the Care Management Agency with a [Service Level Determination](#) (SLD). The MCO is directed to respond with a SLD within 3 business days of receipt of all information needed but no more than 14 days of the request. The MCO may extend this time by up to 14 days, if the MCO needs more information and the extension is in the individual's best interest.

The MCO will work with the Health Home Care Manager toward resolution of any issues impeding approval for services. If the MCO ultimately determines to deny a service request, the MCO will issue a denial of services determination with applicable appeal and fair hearing rights. The Health Home Care Manager will follow up with the client should this be the case.

The Service Level Determination (SLD) form will indicate which services the client was approved to engage in. You may receive more than one SLD if more than one HSB Service was requested.

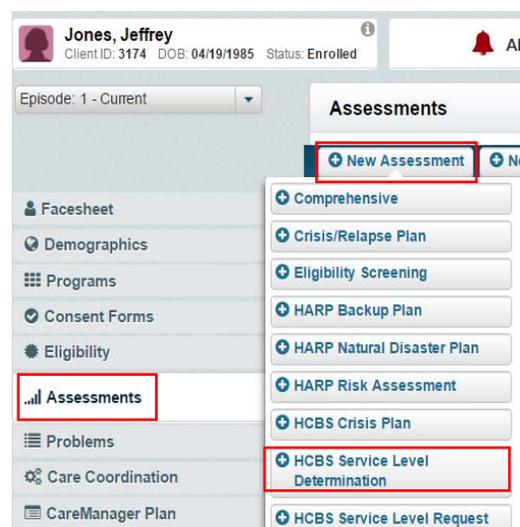
Within **FIVE DAYS** of receipt of the Service Level Determination from the MCO, the Care Management Agency must:

1. Complete the SLD in Netsmart CareManager
2. Submit referrals to the HCBS providers chosen by the client. See Referrals to HCBS for more guidance on this step

The Service Level Determination should not be mistaken for an authorization for services, but rather the MCO's agreement with the level of HCBS proposed.

If at any time, changing needs of the member require additional HCB Services, a new Service Level Request form should be completed for the newly requested services only and submitted to the MCO. You would then follow the same process for the newly requested service, update the Plan of Care as appropriate and await a Service Level Determination form.

1. Navigate to the [Assessments](#) page, click [+New Assessment](#)
2. Select [HCBS Service Level Determination \(SLD\)](#)



3. Complete Assessment Date and Status

HCBS Service Level Determination

Assessment Date*	Entered By
<input type="text" value="07/17/2017"/>	<input type="text"/>
Assessment Status*	Finalized By
<input type="text" value="---"/>	<input type="text"/>

- **Assessment Date:** This should identify the date the HCBS Service Level Determination was completed in Netsmart CareManager
- **Entered By:** This will automatically populate for you once the document is saved
- **Assessment Status:** This should be left in draft until the form is finished. You will then switch the status to final and save
- **Finalized By:** This will automatically populate for you once the document is saved

4. Complete HCBS POC Summary

HCBS POC Summary - Service Level Determination

Date Received by MCO:	Date Submitted to MCO:
<input type="text"/>	<input type="text"/>
MCO Contact Person/Approver:	
<input type="text"/>	

- **Date Received:** This should identify the date the HCBS Service Level Determination was received from the member's managed care organization
- **Date Submitted:** This should identify the date the HCBS Service Level Request was sent to the MCO
- **MCO Contact:** This should identify who the contact person is at the MCO. This information should be included on the SLD you receive from the MCO

The SLD completion and Referrals to HCBS providers must occur within five days from the date in which the MCO returned the SLD to the Care Management Agency.

5. Complete MCO Approvals and Denials

Which HCBS services were approved/denied by the MCO?

Tier 1 and 2

Transitional Employment

MCO Approved MCO Denied Not Requested

Education Support Services

MCO Approved MCO Denied Not Requested

Pre-Vocational Services

MCO Approved MCO Denied Not Requested

For each service, select the appropriate response type.

- **MCO Approved:** Select for any service that was requested on the SLR form and approved by the MCO on the SLD form
- **MCO Denied:** Select for any service that was requested on the SLR form and denied by the MCO on the SLD form
- **Not Requested:** Select for any service that was not requested

6. Denials

For denials or if a client declines an approved service, please explain why and what action plan will be taken?

For any HCBS denials by the MCO or the client, complete a narrative explaining why and what, if any, follow up is needed.

If the MCO determines to deny a service request, the MCO will issue a denial of services determination with applicable appeal and fair hearing rights. The Health Home Care Manager will follow up with the client should this be the case.

7. Once your SLD is completed, change the [Assessment Status](#) to [Final](#) and [Save and Close](#)

Referrals to HCB Service Providers

Once the Service Level Determination is received from the client's MCO, the Care Management Agency has **five days** to work with the client to:

1. Choose their preferred HCBS provider
2. Contact the HCBS Providers
3. Schedule the first appointment

Care Manager should remember to add selected HCBS Providers to the [Care Coordination](#) page in Netsmart CareManager.

Within 14 days of receiving the referral for services, the HCBS Provider must complete an assessment of the client and submit an authorization for services to the MCO. The HCBS Provider will work with the MCO to obtain an Authorization of Services. The HCBS provider and MCO will inform the Care Management Agency of the scope, duration and frequency of services being provided.

During this time, the Care Management Agency should be working on and completing the Plan of Care with the client. As always, there must be notes documenting any work the Care Manager has done to get the client linked with HCB Services and complete the Plan of Care.

Plan of Care

The NYS DOH defines the plan of care as “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.”

Creating the Plan of Care for your client can occur at any time throughout the process of linking your client to HCB Services once the Health Home Comprehensive Assessment is completed however it must be completed within 30 days of receipt of the MCO Authorization for Services but no more than 90 days from HARP enrollment. When creating your plan of care, include not only objectives and interventions to address needs identified through the main assessment process (comprehensive assessment, eligibility screen, etc.) but also any objectives or interventions that are needed to address the next steps of the HARP HCBS process and your work with HCBS providers. You should also include strengths, barriers and outcomes that were identified through the HCBS process.

The Plan of Care must be developed in a “conflict free” manner, meaning the person conducting the assessment and developing the plan of care cannot direct referrals for service only to their agency or network. The person must have choice among available providers. New York State has CMS approved safeguards to ensure that all conflict free requirements for the HCBS HARP benefit are met.

All services listed in the Plan of Care are made available to the individual only as actually ordered by the service provider and authorized by the MCO (in accordance with the MCO’s service authorization requirements and procedures). Individuals must be given a choice of HCBS providers from the MCO’s network and **there must be documentation in the Plan of Care that choice was given to the individual**. MCOs will assist in identifying which HCBS providers in their network are ready to receive referrals.

Creating a Care Plan in Netsmart CareManager

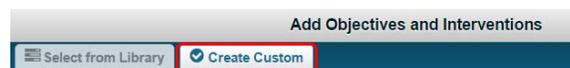
The Plan of Care (New Plan Amendment) within Netsmart CareManager will be the same for both HARP and non-HARP Health Home members. It must:

1. Meet all mainstream health home plan of care requirements including being person centered, supported by assessments and include the care team
2. Include objectives and interventions related to needs identified through the mainstream assessment process (comprehensive assessment, eligibility screening, etc.)
3. Include objectives and interventions related to the HCB Services being requested or accessed
4. Relate to information from the Service Request summary section on the SLR including the strengths, preferences, barriers, outcomes, etc.

To create a Plan of Care in the Netsmart CareManager system you must:

1. Go to [CareManager Plan](#) tab
2. Click on [+Initial Plan](#) or [+New Plan Amendment](#)
3. All data from the previous plan will transfer onto the [New Plan Amendment](#)
4. The [Plan Start Date](#) should reflect date of completion
5. Update [Goal Statement, Strengths & Preferences and Barriers](#)
6. Add client specific [Objectives](#) and [Interventions](#)

- a. Click the [Objectives/Interventions](#) button
- b. Click the [Create Custom](#) button



- c. Select the appropriate **Category** and then type in your [Objectives & Interventions](#) associating them to a [Problem](#)
 - d. Only [Problems](#) within the same category will appear to select from, except for *Adherence & Care Coordination* categories; they show all [Problems](#)
 - e. Click [Save](#) and the [Objectives & Interventions](#) are added to the care plan
7. Add **Target Dates** within the care plan for each Intervention. Target dates should NOT all be set for 6 months out but instead be an accurate reflection of when you hope to have the intervention completed by or the span of time it will cover
 8. Review the Care Plan with the client
 9. Mark the care plan as [Client Reviewed](#)



10. Once the Care Plan is completed, you must obtain a signature from the Client.

You have the option of electronically signing the form within the Netsmart CareManager system or obtaining a manual signature.

Mouse Topaz

Signature*

Clear Done

Client Signature Printed Name* Jeffrey Jones

Date

Signed on paper

Electronic Signature

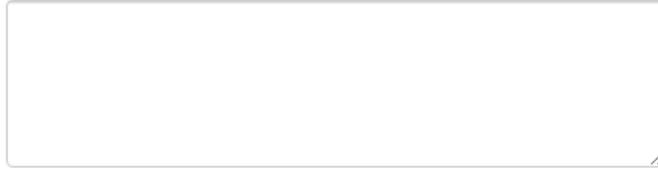
- 1) Ensure all sections of the form are completed and mark the status as [Final](#)
- 2) This will enable you to electronically sign the document. You can sign with a Topaz signature pad, your mouse or your finger if you are using a device with a touch screen
- 3) The name of the person signing the form under [Client Signature Printed Name](#) will automatically default to the name of the Client
- 4) The form will automatically date it according to the date it is signed
- 5) Once you sign, select [Done](#). You will have the option to [Resign](#) if you note an error
- 6) Click Save and Close

Manual Signature

- 1) Ensure all sections of the form are completed and mark the status as [Final](#)
- 2) Select [Manual](#) under the signature field
- 3) Click [Save](#)
- 4) Click [Print](#)
- 5) Obtain a signature on the printed document. HHUNY does not accept signature pages. The signature must be on the actual document
- 6) Upload the signed document into Netsmart CareManager as an [attachment](#). Follow the HHUNY naming convention when filling in the description field. The Care Plan should be identified as "[Plan of Care MM/DD/YY](#)" with the MM/DD/YY representing the date the Plan of Care was completed.

HCBS Goal Statement

Client Goal Statement*



Your Goal Statement should be a statement of what the person is hoping to achieve from both the Health Home program and through HCB Services. It should affirm the person's choice in how he or she wants to live, work and/or enjoy his or her life. You should review the identified goals on the SLR form and pair these statements with the conversations you've had with the member to develop your goal statement.

Goal statements should be broad and long term. Questions you can ask your client to help direct the conversation about what their goal may be are:

- What is most important to you?
- What do you want to change?
- What do you want to gain from this program?
- If things in the future are much better for you, what would be different?

HCBS Strengths and Barriers

Clients Strengths and Preferences



Client Barriers



Strengths and Preferences:

Strengths and preferences should identify the internal and external resources and attributes your client brings to the table and any preferred methods of treatment or care. A good strengths inventory is personal to the client and includes such things as abilities, values, motivational factors, resources and relationships. You should review the identified strengths and preferences on the SLR form and pair these statements with the conversations you've had with the member to develop this list.

Questions to ask your client

- What are you good at? What are some of your accomplishments?
- What has worked for you in the past?
- Who supports you?
- What do you enjoy doing?
- How would your best friend describe you?

Barriers:

Barriers should identify what stands between the individual and their goals for the future or hinders their pursuit. They should include such things as personal needs, family issues and resource needs. Objectives should reflect the removal or resolution of barriers. You should review the identified barriers on the SLR form and pair these statements with the conversations you've had with the member to develop this list.

Questions to ask your client

- What is getting in the way of achieving your goal?
- What keeps you from doing _____ tomorrow?

HCBS Objectives and Intervention

Objectives:

Objectives should be milestones along the route toward reaching the goal and removing barriers. They should indicate what the client, not the providers, will do or achieve and identify a client driven outcome. Objectives indicate the desired result of change in status, abilities, skills or behaviors.

A commonly used prompt says objectives should be **S.M.A.R.T-**

Specific/ Simple, Measurable, Attainable, Realistic and Time-Framed

For more guidance on how to write a SMART objective, please see Appendix F: Writing SMART

Interventions:

Interventions are the activities, steps, actions and services provided by the members of the team including providers, social supports and community supports that will assist the client to achieve their goals and objectives.

Interventions should indicate who will do what, when, where and how often. Interventions should reflect the Core Care Management Services provided by the Care Manager as well as services provided by other members of the Care Team.

- Describe the modality or type of service or activity
- Identify who is responsible for the activity by name, role, function or discipline
- Specify the frequency, intensity and duration
- Specify the location when appropriate/known
- State the purpose, intent or impact (Adams, Grieder, 2005, page 156)

Source:

Adams, N., & Grieder, D. (2005). Treatment Planning for Person-centered Care: The Road to Mental Health and Addiction Recovery: Mapping the Journey for Individuals, Families and Providers. Academic Press.

NYS Health Plan Summary: Components

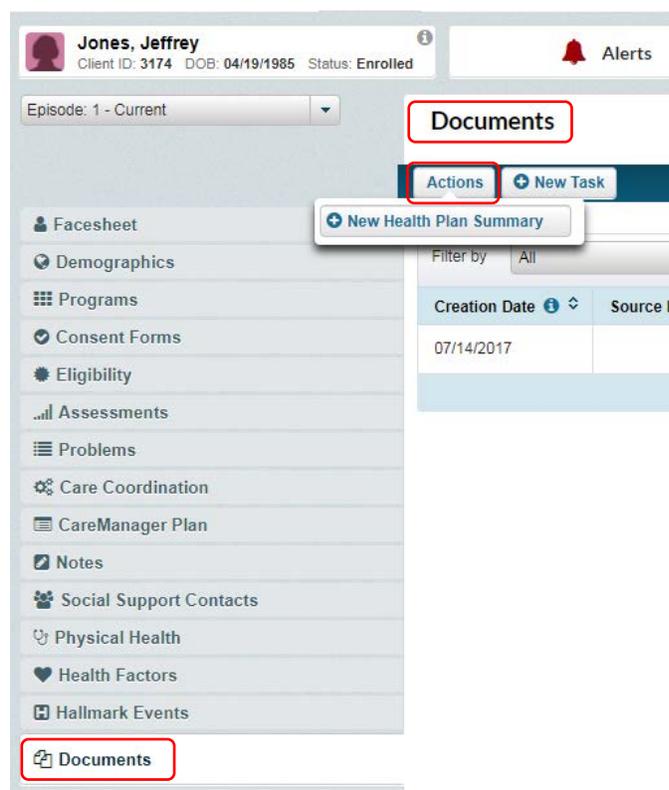
A full HARP HCBS Plan of Care must be submitted to the MCO within 90 days from the client's enrollment into the HARP program or Health Home program, whichever is the more recent date.

Information from several documents and forms within Netsmart CareManager are combined together to create the finalized HARP HCBS Plan of Care. These components include:

1. Demographic Information
2. Care Team- Care Manager, mainstream providers, MCO and social supports
3. Assessment dates and data
4. Level of Service Request
5. Level of Service Determination
6. HCBS Providers and Services
7. Problems/ Diagnoses
8. Plan of Care (New Plan Amendment)

Netsmart CareManager combines all these fields together for you into one single document called the [Health Plan Summary](#). Once you've completed the different steps outlined in this manual for a client enrolled in HARP and have created your plan of care, you must create the Health Plan Summary. You must create and resign a new Health Plan Summary any time you update a member's Plan of Care and resubmit the updated document to the MCO.

1. Navigate to your documents page
2. Under the [Documents](#) heading you will see an [Actions](#) button
3. Select Actions and [New Health Plan Summary](#)



Once the summary is created, you will see it contains the different fields from throughout the Netsmart Care Manager system. It is divided into different sections:

Health Plan Summary

Demographic Information

Individual Name Jones, Jeffrey	CIN # IH35252V	DOB 04/19/1985
Address 123 Lilac Dr, Erie NY 14625	Phone (Primary) 716-332-4859	Email
Language	Religion	

Managed Care Organization

Plan Name MEDICAID Excellus BlueCross BlueShield (Active: 06/23/2015 - 12/31/9999)	MCO Contact Talbot, Kristy
--	--------------------------------------

Care Team

Care Management

Health Home HHUNY Central	Care Management Agency AIDS Community Resources Inc
Primary Care Manager Talbot, Kristy Email: ktalbot@hhuny.org Phone Number:	Care Manager Supervisor

- **Demographic Information**
- **Managed Care Organization:** This section will contain your clients MCO and MCO Contact
- **Care Team:** Information about the different members of a clients care team including their assigned Care Management Agency and Care Manager, community supports, social supports and their providers paired with the problems they are addressing. If a provider is listed on the Care Coordination page as being active, you should see them listed here. They are sorted into physical, behavioral and social health categories
- **Assessment Information:** Completion dates for the comprehensive assessment, eligibility assessment and the HCBS Determination Level (Tier 1 or 2)
- **Plan of Care:** Components of your plan of care including goal statement, strengths, barriers, objective and interventions
- **Additional Documents:** Data from the Crisis Plan, Risk Assessment, Backup Plan and Natural Disaster Plan
- **Other Information:** This will contain your answers to the housing questions through the HCBS documents

NYS Health Plan Summary: Affirmation/Attestation

Once the Health Plan Summary has been completed, the Care Manager should share it with the client and their family and ensure agreement with the information and services offered. 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
- Include a method for the individual to request updates to the plan as needed.
- 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

Additionally, NYS DOH HH Standards (10/05/15) direct that 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

The final sections of the Health Plan Summary assist to meet the federal and state requirements including:

1. Abuse, Neglect and Exploitation
2. Recipient Rights for Individuals
3. Commitment to Confidentiality and Support

These sections along with the rest of the Health Plan Summary must be reviewed with the client and signed off on by both the client or guardian and their Care Manager. Additionally, it is the Care Management Agency's responsibility to ensure that the Health Plan Summary is shared with other members of the care team and if possible, acquire a signature from them as well.

Abuse, Neglect, Exploitation

A client must attest to their understanding of what abuse, neglect and exploitation mean as you will see defined within the Netsmart CareManager system.

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:

No Contacts Entered.

[Add Contact](#)

To complete this section:

1. Ensure your client has an understanding of what abuse, neglect and exploitation mean and then check the box attesting to this fact
2. Enter in any contacts available to the client should they find their self at risk of harm

If I believe I am at risk of harm from or experience abuse, neglect or exploitation, I know that I should contact:

Name*

Location*

Phone*



[Add Contact](#)

- a. Click [Add Contact](#)
- b. Enter the contacts [Name](#), where they are [located](#) and their [phone](#) number. All fields are required
- c. Additional contacts can be added by selected [Add Contact](#)

Recipient Rights for Individuals

Once a client has completed the first stages of the HARP HCBS process and developed a Plan of Care, they must understand and agree to their rights in regards to receiving services and then attest to the fact that they have both reviewed the plan of care and have received a copy of their plan of care.

Recipient Rights for Individuals Receiving BHHCBS

Recipient Rights for Individuals Receiving BHHCBS*

- 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 indicated 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 any of 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:*

Receive BH HCBS as indicated on the attached Plan of Care Refuse the recommended services

To complete this section:

1. The rights for member's receiving HCB Services are listed with check boxes next to each one. Review them all with your client and check them off once your client understands and agrees
2. If your client agrees to all their rights and services, select "My choice is to receive BH HCBS as indicated on the attached Plan of Care"
3. If your client does not agree to all their rights or does not want services, select "My choice is to refuse the recommended services"
 - a. If this option is selected then it is assumed you will have a conversation with your client and assist to resolve areas of concern. If they still do not wish to engage in services you will stop the HARP HCBS process, make the MCO aware and reassess for readiness at least every six months. This must be documented within your notes.

Commitment to Confidentiality and Support

Commitment to Confidentiality and Support

By signing this form, the Member, Care Manager, and Care Team agree that we have participated in the development of the content; the member was given choices in selecting providers; and the member was given a copy of this form.

Release of Information: Member has consented to release information as indicated in the Care Team section for those providers or social support contacts with "Consent to Share Information Received" marked as Active (per DOH-5055). Member is aware that the information included on this form will be released to those listed in the Care Team section and signature will be requested.

If applicable, the member signature below also affirms the member has been informed by the Care Manager of the benefits of receiving supported education and employment services through BH HCBS Waiver and Access-VR as indicated in the Service Level Request document.

The Commitment to Confidentiality and Support indicates that the entire Care Team, including the member, have chosen and agreed to the services being provided and have received a copy of the final form. Additionally, it verifies that the member has consented to share information with their care team. By signing the Health Plan Summary form, the client is agreeing to the Commitment to Confidentiality and Support.

Signature

Once the Health Plan Summary is completed, you must obtain signatures from both the Client and/or Guardian and the client's assigned Care Manager.

You have the option of electronically signing the form within the Netsmart CareManager system or obtaining a manual signature.

The screenshot displays the 'Signatures' section of a web application. It features two main columns: 'Client Signature*' and 'CareManager Signature*'. Each column has a large, empty rectangular area for the signature. Below each signature area are 'Clear' and 'Done' buttons. At the bottom of the form, there are two rows of input fields. The first row is for the 'Client Signature Printed Name*' (containing 'Jeffrey Jones') and a 'Date' field. The second row is for the 'CareManager Signature Printed Name*' (containing 'Kristy Talbot') and a 'Date' field. At the top of the form, there are two sets of tabs: 'Mouse', 'Topaz', and 'Manual'.

Electronic Signature

1. Ensure all sections of the form are completed and mark the status as [Final](#)
2. This will enable you to electronically sign the document. You can sign with a Topaz signature pad, your mouse or your finger if you are using a device with a touch screen
3. The name of the person signing the form under [Client Signature Printed Name](#) will automatically default to the name of the Client and the name of the assigned Care Manager. Update as necessary
4. The form will automatically date it according to the date it is signed
5. Once you sign, select [Done](#). You will have the option to [Resign](#) if you note an error
6. Click Save and Close

Manual Signature

1. Ensure all sections of the form are completed and mark the status as [Final](#)
2. Select [Manual](#) under the signature field
3. Click [Save](#)
4. Click [Print](#)
5. Obtain a signature on the printed document. HHUNY does not accept signature pages. The signature must be on the actual document
6. Upload the signed document into Netsmart CareManager as an [attachment](#). Follow the HHUNY naming convention when filling in the description field. The SLR should be identified as "[HARP Health Plan Summary MM/DD/YY](#)" with the MM/DD/YY representing the date the client agreed to and signed the document

Additional Signatures

If you are able to acquire additional signatures from members of the client's care team, they must sign the paper version of the Health Plan Summary and then the Care Manager would upload the signed copy into the client's chart as an attachment. Follow the HHUNY naming convention for the HARP Health Plan Summary- Care Team member's signature "[HARP Health Plan Summary- CT Signature MM/DD/YY](#)" when uploading copies signed by members of the care team into the system. Please ensure that you have notes documented in the system that capture the work you do to request and acquire signatures.

The Review Process

Once your HARP Plan of Care and Health Plan summary are finalized, you are tasked with ensuring they remain up to date and reflective of your client's changing needs and that you continue to complete the Eligibility Assessment annually or after a significant event.

Feature Coming Soon!

Annual Eligibility Assessment

The HARP/HCBS Eligibility Assessment must be completed annual or after a significant event.

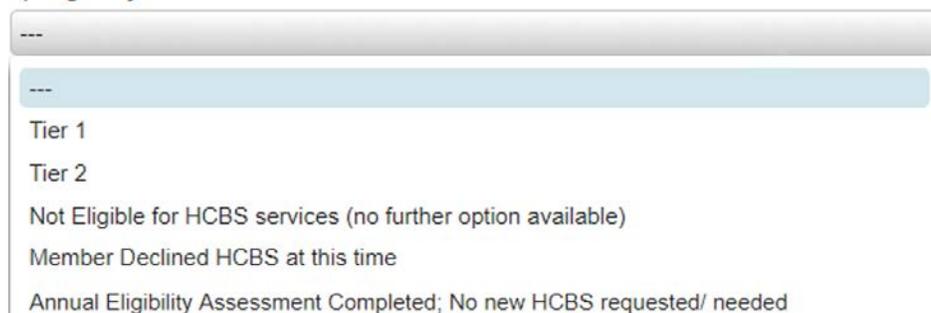
The Eligibility Assessment should be completed annually even if the member does not want to pursue HCB services. If the member declines to complete the Eligibility Assessment, notes must show an emphasis placed on encouraging the member to complete the assessment and the benefits of HCBS.

The Care Manager must document a member's decline to complete the Eligibility Assessment under General Assessments. See General Assessment section for more details about completing this step.

When an Annual Eligibility Assessment is completed, it must be documented on the SLR form along with any new services the member is eligible to receive.

The Date of the NYS Eligibility Screen should indicate the date the annual Eligibility Assessment was completed with the member.

2) Eligibility Determination



The image shows a screenshot of a dropdown menu titled "2) Eligibility Determination". The menu is open, showing several options. The first option is "Tier 1", followed by "Tier 2". Below these are three options that are currently selected or highlighted: "Not Eligible for HCBS services (no further option available)", "Member Declined HCBS at this time", and "Annual Eligibility Assessment Completed; No new HCBS requested/ needed".

If the member does not have any new needs or is ineligible to receive any additional services, then the Care Manager should select "Annual Eligibility Assessment Completed; No new HCBS requested/needed"

If new needs are identified, select the Tier level of the member as indicated by the Eligibility Assessment and complete a new SLR. Follow the process for "Completing the HCBS Service Level Request Form".

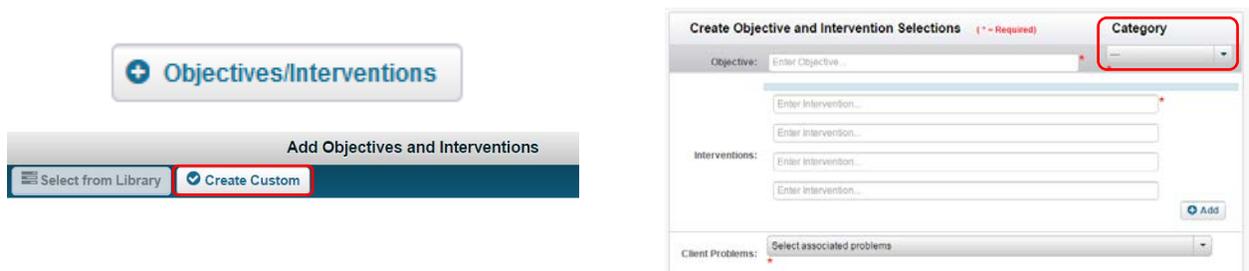
Review and Monitoring the Plan of Care

The Care Manager and the MCO monitor and ensure that the client is receiving the HCB Services reflected in the Plan of Care. The Care Manager should revise the Plan of Care when necessary to incorporate the client's input and choice and after the completion of an Eligibility Assessment.

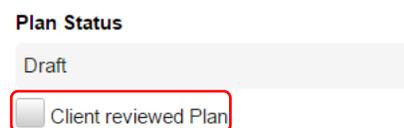
When the Plan of Care is revised, the client must be aware of and agree to the changes and it must be resubmitted to the MCO for review.

The first step to revise or update your HARP HCBS Plan of Care is to ensure that all problems and providers in the system are up to date. Add and or change problems as needed and refer any new problems or changes with providers on the [Care Coordination](#) page. Once you have updated the chart, you will next create a [New Plan Amendment](#). To do this, you must:

1. Go to [CareManager Plan](#) tab
2. Click on [+New Plan Amendment](#)
3. All data from the previous plan will transfer onto the [New Plan Amendment](#)
4. The [Plan Start Date](#) should reflect date of completion
5. Update the [Goal statement](#), [strengths & preferences](#), [barriers](#) as needed
6. Add or update client specific [Objectives](#) and [Interventions](#)



7. Add **Target Dates** within the care plan for each Intervention. Target dates should NOT all be set for 6 months out but instead be an accurate reflection of when you hope to have the intervention completed by or the span of time it will cover
8. Review the Care Plan with the client and obtain a signature
9. Mark the care plan as [Client Reviewed](#)
10. [Save & Close](#) final Copy



Once you have updated Netsmart CareManager to reflect any changes, you can again recreate the Health Plan Summary from your Documents page. You will then acquire new signatures and resubmit to the MCO and other members of the care team.

You must review the Plan of Care, at minimum, every six months.

Appendix A: NYS HARP/HCBS References

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

<https://www.omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf>

<https://hhuny.org/HHUNY/media/Webinars/Housing-Questionnaire.pdf>

https://www.emedny.org/ProviderManuals/Transportation/PDFS/HARP_Guidelines_Non-Medical_Transportation.pdf

Appendix B: HARP Status Clarification

Email sent by HHUNY June 9, 2017

First, HARP is a type of plan that is provided by an MCO. Health and Recovery Plan (HARP) is only available for specific members that are identified by DOH.

1. If a Medicaid enrollee is "HARP Eligible" the individual will have an RE Code of H9 and is eligible to enroll in a Health and Recovery *Plan* but has not done so yet, which means they are not yet eligible for HCB services and the Care Manager should be working with the member to enroll them in a HARP if the member is interested
2. It is up to the Care Manager to explain the benefit of the HARP to the member and the additional services they can potentially receive if they enroll into a HARP. Here is the HCBS Manual that explains each service in detail for your review to help guide this discussion: [HCBS Manual](#)
3. ***A Care Manager should NOT complete an Eligibility Assessment in UAS or a Service Level Request for HCBS (HARP POC) until the member is HARP ENROLLED***
4. If a member declines HARP enrollment, this must be clearly documented in detail in the member's chart and you should be notifying the MCO- documentation indicating who you contacted at the MCO should be included. You must also then reassess the client every six months to see if their willingness to engage has changed if they are still H9. This must also be clearly documented within a note
5. If a member would like to enroll in a HARP, please follow the instructions here (provided by Fidelis but can be used for most MCOs) to help assist the member: [HARP Enrollment and Recertification FAQ](#)
6. Once a member elects to enroll in a HARP with an MCO, then the member is considered HARP Enrolled and will have an RE Code of H1, which means the member is enrolled in a Health and Recovery Plan (HARP) and not receiving HCB services. It has nothing to do with Health Home enrollment status. A member can be assigned to you already in a HARP but not yet enrolled in the Health Home
7. It is up to the Care Manager to diligently review the HARP status of their members. Agencies can also download Enrollment Files or My Member files from MAPP to review HARP status for all of their current Members on one file!

A client's HARP status does not automatically update in Netsmart CareManager

8. Once a member has enrolled in HARP, you can complete the Eligibility Assessment and Service Level Request for HCBS
9. Once a member is HARP Enrolled and is receiving HCB services, then the member's RE Code will be H2- Tier 1 or H3- Tier 2
10. Members have to recertify annually for Medicaid coverage and Care Managers should assist with this process to ensure continuity of services (please see additional information on the Fidelis guidance which again can be generalized for most MCOs)

Reminders:

1.) You should only be serving HARP members if your agency has attested to meeting the requirements to serve HARP members. If you are unsure if your agency has attested to this, please contact HHUNY.

2.) If a member becomes HARP Eligible or HARP Enrolled while they are assigned to your agency, and your agency is not attested to meeting the HARP requirements, HHUNY will contact you.

3.) It is possible for a member to be HARP Enrolled one day and then HARP Eligible the next, keep a close eye on Medicaid end dates and assist the member in the recertification process.

Appendix C: HARP Status in MAPP

HARP Status in MAPP:

There are two areas in MAPP that you can find the HARP R/E code affiliated to the member and the dates affiliated with the R/E code.

Member CIN Search

Search for the member by CIN, click on the member's name to open the Member Search Report. In the R/E Code Details field, you will see the HARP R/E Code (H1-H9) and the begin/end date for each code.

Medicaid End Date Coverage Code Description 30-CLIENT IS ELIG FOR MCAID AND ENROLLED IN A PCP (P)

Print

Last 5 Unique Providers

Service Date	Provider	Address 1	Address 2	City	State	Zip	Phone
7/3/2017	WESTERN NEW YORK MEDICAL PRACTICE	1415 PORTLAND AVE STE 445		ROCHESTER	NY	14621-3022	5859223785
5/26/2017	UNITY HOSPITAL ROCHESTER	1555 LONG POND RD		ROCHESTER	NY	14626-4122	7167237000
4/18/2017	UNITY HOSPITAL ROCHESTER	1555 LONG POND RD		ROCHESTER	NY	14626-4122	7167237000
4/1/2017	HUTHER-DOYLE MEM INSTITUTE	360 EAST AVE		ROCHESTER	NY	14604-2638	
2/15/2017	A C M MEDICAL LABORATORY INC	160 ELMGROVE PARK		ROCHESTER	NY	14624-1359	5854292246

Member's R/E Code Details

R/E Code	Begin Date	End Date
H3	4/1/2017	7/31/2018
H1	8/1/2016	12/31/9999

Health Home History

Assigned Health Home	Care Management Agency	Type	Status	Direct Bill	Start Date	End Date
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Member Case

Click on Member's name to go to Personal Information, select R/E Code Details in the list on the right side of the screen.

Home Personal Information Cases Administration

Personal Information

Last 5 Services

R/E Code Details

Notes

Chronic Conditions

R/E Code Details

Member's R/E Code Details

R/E Code	Begin Date	End Date
84	3/26/2010	4/30/2010
84	9/21/2010	9/30/2012
86	9/21/2010	9/30/2012
96	4/30/2009	7/31/2017
H1	8/1/2016	12/31/9999
H3	4/1/2017	7/31/2018
H9	4/1/2016	7/31/2016

Appendix D: Writing SMART

What is their objective or outcome they want to reach:
1. Specific. What will the objective accomplish? How and why will it be accomplished?
2. Measurable. How will you measure whether or not the objective has been reached (list at least two indicators)?
3. Achievable. Is it possible? Have others done it successfully? Do you have the necessary knowledge, skills, abilities, and resources to accomplish the objective? Will meeting the objective challenge you without defeating you?
4. Realistic. What is the reason, purpose, or benefit of accomplishing the objective? What is the result (not activities leading up to the result) of the objective?
5. Time Framed. What is the established completion date and does that completion date create a practical sense of urgency?
Revised Objective: