PHP

PARTNERS HEALTH PLAN

Overview of the Care Coordination LIFE PLAN

K.Haines MDDC Resource Fair Dec.2019

Topics Covered

- Overview of Care Coordination Services (PHP / CCO)
  - Care Manager
- Interdisciplinary Team (IDT)
  - Supporting circle of support to individual
- The IAM assessment
- The Life Plan

PHP Mission and Values

- Promoting wellness
- Supporting choice
- Integrating services
- Respecting diversity
- Promoting quality of life

- **PHP's current Plan offering is a FIDA, serving adults with I/DD who have both Medicaid and Medicare**
- **This FIDA Plan went live in April 2016. Are Care Teams have been creating Life Plans for almost four years now!**

Our mission is to protect the benefits and services that our members currently receive and to assist members with remaining in their homes and communities as long as possible.

PHP Plan Benefits Examples

Partners Health Plan will integrate all benefits, an example of some of the benefits offered are:

- Medicare Part A, B and D
- Medicaid Services
- OPWDD Services/ Waiver
- Long Term Supports and Services
- Behavioral Health
- Accessible Dental Vendors
- Accessible Vision Vendors
- 1 member ID card
- Dual Care Team with a licensed RN as the leader*
- Durable Medical Equipment/Prosthetic and Orthotic Supplies
- On staff DME specialist to assist with DME orders
- Accessible Hearing Vendors
- Non-emergency Transportation (community members)
- Individualized care model: The Life Plan
- Expedited Self Direction Services
- Web based Person-Centered Portal
- Clinical Pharmacy Program
- Telemedicine Program

Life Plan Philosophy

- What is the purpose of the Life Plan document ?
- How is it intended to assist coordination and integration of care ?
- What can it tell us about how to support someone?
- The Life Plan should be considered a living document that changes as a person's needs change.
- Its intention is to truly assist those around the individual to have the best understanding of how to support, serve, and advocate.

Best practice examples…

- Information in assessments and Life Plans, coupled with other medical data can assist an ER doctor in making quick decisions on care
- Life Plan information can help physicians who are supporting in-home telehealth, prior to heading to an ER in an acute situation
- Information on health history can assist an IDT in working out individuals supports for wellness, and how they can integrate with other services
- Information collected in the system (through the assessment and LP process) can assist with effective discharge planning so that folks do not spend more time in hospital settings; as well as reviews for medication/pharmacy needs
- Life Plans assist individuals and their IDT to identify proper pro-active health approaches, instead of reactive approaches, which can cause a person to miss time from their programs and activities, or jeopardize their current home environment

Care Coordination

- Care Management Team

- **CCO = CARE COORDINATION ORGANIZATION**
- **CCO's in our region include: Care Design NY, Tri County and ACA**
- **PHP's current FIDA Plan (Fully Integrated Duals Advantage) differs from the CCO Model in several ways**

Care Management Team (PHP Example)

WHO	RESPONSIBILITIES
Care Manager	-Conducts Assessment (upon intake, trigger events and annually) -Ensures a person receives necessary services decided upon at their Life Plan meeting -Approves (authorizes) all services being received -Reviews programs to ensure high quality service -Lead person for contact from Day Habilitation/Residences/ICF's in the event of Life changes/hospitalizations (contact number on the back of the member's card)
Care Coordinator	-Obtains DDP2, LOC, POM, ISP and Physical (updating as necessary) -Maintains contact with the Plan participant throughout the year -Responsible for flow of information between Care Management Team and programs -Does not exists for ICF members (since they retain their QIDP)

The Assessment & Life Plan

- I Am Assessment
  - Medisked
  - Life Plan
- Similarities to the ISP
- Interdisciplinary Team

I AM Assessment

- The I AM assessment is an OPWDD, DOH and CMS approved tool, used to determine a person's history, preferences, personal outcomes and hopes.
- The I AM assessment was developed to be I/DD specific. Woven throughout the I AM Assessment are CQL/POM related questions that will highlight POM related life goals for each member.
- The I AM produces a report of traditional health and safety requirements.
- The I AM Assessment addresses 28 areas and helps the IDT team determine which actions are needed or desired by the person to lead a fulfilling life.
- The I AM recommends specific services and supports to address members hopes and dreams as well as traditional health and safety requirements.
- The I AM is comprehensive, similar to a "UAS" in the medical field. At this time the I AM does not replace the CAS.

I AM Assessment

When does it take place?

- An initial I AM Assessment is conducted with the member within their first 30 days of enrollment. Following that, reassessments are routinely conducted annually or as necessary following a precipitating event. The member can also request another assessment during the year.

Who is involved?

- The Care Manager is responsible for conducting the I AM with the member. The Care Coordination may attend the assessment meeting and assist with collecting data. If a member chooses, they are welcome to invite others to be present for the I AM as well.

Medisked

Medisked Coordinate is a Care Management Platform specifically created for the I/DD population. It brings all the elements of I/DD care coordination together, in a person-centered way:

- Create / edit / store complete member care plans and service delivery information.
- Create and track plan authorizations and expiration
- Maintains assessment data, including individuals' needs, services needed, and plan/goal progress
- Auto-generate suggested plans of care based on assessment results
- Generates assignments for provider and service specific plans
- In-depth monitoring of quality of service delivery
- Client portal access to view information and plans – allows for sign off and communication

The Life Plan

- OPWDD, with the assistance of Partners Health Plan, has developed a person-centered care and service planning and delivery approach with a focus on member choice, improved health/service outcomes, and timely access to high-quality medically necessary services, supports, and habilitation in the least restrictive setting. The result is the creation of a customized "Life Plan" for each member.

- The Life Plan was designed to integrate preventive and wellness services, medical and behavior healthcare, personal safeguards and habilitation to support each person's personal dreams in one comprehensive document.

The ISP and the Life Plan

- The Life Plan replaces the ISP document but contains all of the same information; it meets all of the regulatory requirements of the ISP.

-Name of the person
-Date of Meeting
-Medicaid Number or CIN Number
-The Narrative Sections
-Funded Services/HCBS Waiver Services
-Required Information for HCBS Waiver Services
-Signatures
-Attachments
-All of the supports and services necessary to help the person live a successful life

- The PHP Life Plan was created to integrate all services *(DD Waiver Services, Medical, Equipment and natural supports).*

Life Plan Structure

- The Life Plan is comprised of 6 comprehensive sections:
  - Assessment Narrative Summary
  - Personal Outcomes
  - Health & Safety Supports Individual Protective Oversight Plan (IPOP)
  - List of Services
  - Member Supports
  - Summary Section

Interdisciplinary Team

- Each member has an Interdisciplinary Team (IDT). The IDT participates in the areas of the care coordination process, including assessments and reassessments, Life Plan development, and authorizations.
- Mandatory membership of the IDT is comprised of the participant (plan member), their family or designated representative/chosen advocate, the primary providers of DD services (day hab., res hab., etc.).
- In addition to the mandatory members the team may include professionals (including those licensed in various disciplines such as doctors, psychologists, speech therapists, etc.) and the member's chosen natural supports.
- Although the Care Manager is the author of the plan, the IDT works together through meetings and communication in order to compose the content of the document.

Section 1: Assessment Narrative Summary

SECTION I

ASSESSMENT NARRATIVE SUMMARY

This section includes relevant personal history and appropriate contextual information, as well as skills, abilities, aspirations, needs, interests, reasonable accommodations, cultural considerations, meaningful activities, challenges, etc., learned during the person-centered planning process, record review and any assessments reviewed and/or completed.

Section I is the ISP equivalent of the Narrative Section. The Life Plan just takes it one step further by breaking the narratives down into 6 categories: Introducing Me, My Home, My Work, My Health and Medications, My Relationships and My Happiness.

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- These narratives first appear throughout the assessment as open-text fields, encouraging the person to describe in detail how they feel about many aspects of their life. This information will contribute to the individual's Life Plan.
- The narratives are meant to be written in first-person language using the voice of the individual. The exception is the My Health - Medications section, which is to be completed by the facilitator or care manager.

Section 2: Personal Outcomes

SECTION II

PERSONAL OUTCOMES

This section includes measurable/observable personal outcomes that are developed by the person and his/her circle of support using person centered planning. Provider goals and corresponding staff activities have been developed to meet each PHP Goal/Valued Outcome. Please refer to provider plans for specific goals and staff activities/actions. Evidence of achievement will be reflected in monthly notes from assigned providers.

CQL Personal Outcome Measure (POM)	PHP Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	TimeFrame	Special Considerations

Section II is the personal outcome section. This section was designed to represent personal goals that participants would like to work toward achieving. The valued outcomes/goals are attached to CQL Personal Outcome Measures. These goals are identified during the initial interview and assessment process, as well as through a face-to-face meeting with each person's Interdisciplinary Team (IDT), which includes: the individual and his or her representative/advocate, care coordinator, and primary provider(s) of DD services who have knowledge of their desired outcomes and service needs, as well as other people of his or her choosing (e.g., residential supervisors, friends, and others involved in the participant's care).

Where do POMS come from?

POMs represent the person's dreams for their life including: My Human Security, My Community, My Relationships, My Choices, and My Goals.

There may be more than one Goal and corresponding Action under a POM. This will be reflected on a person's life plan.

Section 3: Health & Safety Supports

SECTION III

HEALTH & SAFETY SUPPORTS INDIVIDUAL PROTECTIVE OVERSIGHT PLAN (IPOP)

Compilation of all supports and services needed for person to remain safe, healthy and comfortable across all settings (must meet Part 686 requirements for IPOP, since certification requirements not being waived). Provider goals and corresponding staff activities have been developed to meet each PHP Goal/Valued Outcome. Please refer to provider plans for specific goals and staff activities/actions. Evidence of achievement will be reflected in monthly notes from assigned providers.

PHP Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Section III is the personal safeguard section. Included here are actions needed to keep individuals safe and healthy, including health care, nutrition, fire safety, and personal supports, among others. A person may also choose a needed safeguard as a personal goal to increase independence, such as self-administration of medication or learning to travel safely within the community (e.g., ride the bus or subway).

Section 4: List of Services / Authorizations

SECTION IV LIST OF SERVICES								
Authorized Service	Provider / Facility	Effective Dates	Unit	Qty	Per	Total Units	Prior Approval #	Comments

LIST OF SERVICES ADDENDUM

This section shows services that have been approved /authorized and can include I/DD Waiver services such as Day Hab or Supported Employment; and in the case of PHP will include certain medical services such as personal care or durable medical equipment.

Section 5: Contacts & Supports

SECTION V MEMBER SUPPORTS			
Name	Role	Address	Phone

This section includes a list of both formal and natural supports, such as the member's doctors, dentist, family members, waiver service provider staff, and therapists.

Section 6: Summary

SECTION VI
Summary of IDT Meeting:
I get the last word:

This is the section set aside for comprehensive notes from the team meeting. It documents what was said, who was in attendance and accompanying signatures. Unique to the Life Plan is a section called, “I get the last word”, where the member and/or their advocate get a chance to openly discuss their thoughts about the meeting and their Life Plan. The plan was developed to be as person centered as possible.

IDT Meeting Attendance				Date:	
IDT Role	Name	Attendance	Comments	Plan Approval Signature	Date
Member					

Portal

The PHP Provider Portal is the primary method of information sharing between PHP and in-network I/DD providers not using an Electronic Health Record/Agency Management Platform integrated with PHP. You do not need to utilized Medisked to access the Portal, it is a web-based system, available to all agencies.

The PHP portal is a digital cabinet for core team members to access essential documents for each member. If you are part of a member's 'circle of support' you may be granted access to the member's portal by the Care Team. There are various functions within the PHP Provider Portal:

- Forms
- Periodic Summaries
- My Assessments
- My Plans
- the Message Center

Contact Information

View this!

https://opwdd.ny.gov/news_and_publications/brochures_managed-care-evolution-supports-and-services

Our Website:

www.phpcares.org

Thank you for attending!