Cal MediConnect 2017

Model Of Care: Care Coordination Interdisciplinary Care Team (ICT)
Learning Objectives

• Define the L.A. Care Cal MediConnect (CMC) Model of Care
• Describe the Health Risk Assessment (HRA) Process
• Describe the Individualized Care Plan (ICP) Process
• Describe the Interdisciplinary Care Team (ICT) Process
• Identify various internal and external resources
• Discuss Member Transitions for Provider Changes
CMC’s Model of Care Goals

- Improve quality of care
- Reduce health disparities
- Meet both health and functional needs
- Improve transition among care settings
- Meet beneficiary needs, including the ability to self-direct care, be involved in one’s care and live independently in the community
- A more efficient and cost effective delivery system and improve care quality through care coordination
CMC Program Measurable Goals

• Improving access to essential services, such as medical, mental health, substance use, social services and supports including home and community based services

• Improving access to affordable care

• Assuring appropriate utilization of services

• Improving coordination of care through an identified point of contact

• Improving seamless transitions of care across healthcare settings, providers and health services

• Improving access to preventive health services

• Improving beneficiary health outcomes
CMC Program Measurable Outcomes

- Performance is measured annually
- Measurable goals may be analyzed more frequently as defined by the measure
- Established by CMS, DHCS or defined by L.A. Care’s Quality Improvement program
- Measured using the Plan, Do, Study, Act model of improvement
- Corrective Action Plans and Interventions
- Continuous quality cycle
- Analyzed by multidisciplinary team and approved by appropriate quality committees
- Goals not met – Quality Committees will perform root cause analysis to establish causal relationship for compliance with identified measures
CMC Care Management

We are a member-centric, high touch, community and team based care management program that address the holistic needs of members—including physical, behavioral, and social needs.
Member Centric Care Management Process

- Member Identification and Engagement
- Assessment - HRA and Case Management Assessment
- Individualized Care Plan
- Interdisciplinary Care Team
- Communication and Education
- Care Coordination and Advocacy
- Transitions of Care
- Evaluation of Care Management Plan and Follow up
- Termination of Care Management
L.A. Care will maintain an assessment process that will:

- Assess each new enrollee’s risk level and needs based on an interactive process such as telephonic or face-to-face communication. The HRA can also be mailed.
- Address the care needs and coordinate the Medicare and Medi-Cal benefits across all settings.
- Review historical Medicare and Medi-Cal utilization data.
- Follow timeframes for reassessment.
- Develop the initial Individualized Care Plan (ICP) using the HRA responses.
What Does The HRA Assess?

The HRA screens for:

- Health status, chronic health conditions/health care needs
- Clinical history
- Mental health and cognitive status, Activities of daily living (ADLs)/Instrumental activities of daily living (IADLs)
- Depression
- Medication review
- Cultural and linguistic needs, preferences or limitations
- Evaluate visual and health needs, preferences or limitations
- Quality of Life
- Life planning activities
- Caregiver support
- Available benefits
- Continuity of care needs
- Fall prevention
- Managed Long Term Services and Supports, including HCBS

This tool, along with other resources, is used to develop the Individualized Care Plan (ICP).
Full Integration Care Management System (FICMS)

- **Social**
  - Social Support
  - Living Situation
  - Finance
  - Health Literacy
  - Transportation

- **Functional Capacity**
  - Ambulation
  - Patient Activity Level (ADLs/IADLs)
  - Weight Loss
  - Falls

- **Chronic and acute Conditions**
  - Knowledge/awareness
  - Medication barriers
  - Trusted source of care
  - Engagement

- **Behavioral Health**
  - Feelings & Emotions
  - BH Medications
  - Having a trusted source of care

**LTSS**
- Social Work
- IHSS
- CBAS
- MSSP
- CPO

**PCP/PPG**
- Engagement & Partnerships
- TOC
- DM
- Pharmacy

**BH Resources:**
- BH Specialist
- Beacon
- DMH
Who Conducts An HRA?

• Personnel trained in the use of the assessment instrument
• For higher risk members, knowledgeable and credentialed personnel to review, analyze, identify and stratify health care needs, such as physicians, nurses, social workers, or behavioral health specialist
• Behavioral health vendor for members identified with a behavioral health disorder
• Contracted vendor for members residing in long-term settings
• Members may receive the HRA in a face to face setting, but most choose to be assessed over the phone.
Person Centered Planning

• The Person Centered Planning Process is the core concept of Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs)
• The planning process is intended to identify the member’s:
  • Strengths
  • Capacities
  • Preferences
  • Needs
  • Desired outcomes of the individual
• The planning process is directed by the family or individual with long term needs
• The family or individual freely chooses the participants who are able to serve as contributors to care
• The process enables and assists the individual in identifying and accessing a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting.
• The personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the individual’s plan of care.”
Basis for ICP

- L.A. Care uses the following to develop the ICP:
- Health Risk Assessment
  - Member information provided during care management planning to identify any necessary assistance and accommodations, including:
    - Educational material on conditions and care options
    - Information on how family members and social supports can be involved in care planning, as member chooses
    - Self-directed care options and assistance available
    - Information on accessing available MLTSS, including IHSS services if applicable
    - Available treatment options, supports, and/or alternative courses of care
    - Ability to opt out of the ICP process
Individualized Care Plan (ICP)

The ICP is a dynamic and person centered plan of care:

- Includes comprehensive input from the member, member’s caregiver, Primary Care Provider (PCP), specialists and other providers in accordance with member’s wishes.

- Identifies the member’s strengths, capacities, and preferences; provides additional care options, including transitions to a different setting

- Identifies the enrollee’s long term care needs and the resources available

The ICP must be developed within 30 days of the completed HRA.
ICP Essential Elements

- Health care needs including the medical, psychosocial and socioeconomic factors relevant to the member’s current health care status
- Individualized measurable goals (“SMART” goals), taking into account member/primary caregiver goals and preferences
- Appropriate involvement of caregivers
- Access to primary care, specialty care, durable medical equipment, medications, mental health and substance abuse providers, or other needed health services, including access and assignment to a Medical Home
- Services to optimize member health status, including assisting with self-management skills or techniques, health education, and other modalities
- Coordinated care across all settings, including outside the provider network and to ensure discharge planning
ICP Goals

• Goals are prioritized considering the member/caregiver goals, preferences and desired level of involvement in the ICP.
• In addition to the member’s self-reported outcomes, Care Managers will use health data to assess if member goals are being met.
  • Utilization data
  • Preventive health outcomes
  • HRAs
  • Pharmacy data
• The ICP is updated as necessary, reflecting if goals are met or not met.
• Care Managers are responsible for managing any barriers to the member meeting identified goals or complying with the ICP.
ICP Timing

The ICP will be reviewed and revised (at a minimum):
  – Annually
  – Upon notification of change in member status

The ICP is reviewed during ICT meetings.
  – In accordance with scheduled follow-up on member goals
  – Update frequency may change in response to routine and non-routine reviews and revisions, including required updates when members are not meeting their ICP goals
ICP Maintenance

Individualized Care Plans are maintained and electronically retained in a HIPAA compliant format within the Information Systems Department for a period of 10 years from the last date of creation.
About The “Interdisciplinary Care Team”

- Interdisciplinary Care Team (ICT) Definition
- Purpose of ICT
- Frequency of Meeting
ICT Definition

• A collaborative, multidisciplinary team.
• Analyzes and incorporates the results of the initial and annual health risk assessment into the care plan.
• Develops a collaborative Individualized Care Plan (ICP) and annually updates the member’s ICP.
• Manages the medical, cognitive, psychosocial and functional needs of each member.
• Communicates the ICP to all caregivers for care coordination.
• Coordinates with and facilitates referrals to the appropriate resources, medical, behavioral health or home and community based providers, i.e. MLTSS
ICT Roles

- The member is at the **center of the care planning process** and may choose to include clinical or non-clinical staff and/family or caregivers.
- **The member may also choose to exclude participants as part of their right to self-direct care.**

Possible ICT members include:

<table>
<thead>
<tr>
<th>Member/Caregiver/Auth.Rep.</th>
<th>County IHSS Social Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated PCP and/or Specialist</td>
<td>IHSS Provider with approval from member</td>
</tr>
<tr>
<td>Nurse</td>
<td>Pharmacist</td>
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<tr>
<td>Care Manager</td>
<td>Behavioral Health provider(s)</td>
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<tr>
<td>Social Worker</td>
<td>Other professional staff in provider network</td>
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<tr>
<td>Patient Navigator</td>
<td>MSSP Coordinator</td>
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</table>
ICT Lead

The Care Manager (Care Coordinator) is the Team Leader, responsible for organizing the ICT he/she is presenting in response to:

• Member or provider requests
• Negative events or needs identified via the Health Risk Assessment (HRA)
• Other previous assessments such as medical, MLTSS (IHSS, CBAS, MSSP), nursing facility and Behavioral Health assessments

The Care Manager assigned to the members’ risk level (High, Moderate or Low) is the responsible lead of the ICT presentation.
ICT Meetings

ICT Meetings are an avenue to:

- Discuss complex needs
- Identify linkages to home and community-based services
- Follow-up on utilization, level of care or specialized services
- Track types and numbers of referrals made
- Communicate with all stakeholders
When Does The ICT Meet?

- Meet initially to review/modify/approve the ICP and at least annually thereafter
- When there is an acute change in the member’s condition, including social condition
- At the request of the member
- If there is a Transition of Care
ICT Responsibilities

• Analyze and incorporate initial and annual HRA results into an Individualized Care plan (ICP)
• Assess and address identified social service barriers to achieving ICP goals
• Assess members for access to long-term care services and supports enabling them to remain in their homes and communities as long as possible
• Coordinate ICP integration addressing Social, Medical, Behavioral and Social needs
• Engage members to self-direct their care
• Provide and support person-centered care coordination and planning
• Identify community-based resources as needed and make referrals
• Assist with measuring effectiveness and extent to which care is managed
ICT Timing Requirements

• Care managers must develop an initial ICP within 30 business days of the initial Health Risk Assessment completion.

• ICPs are discussed with the ICT within 30 business days of completion of the ICP. Meeting minutes document PCP/member/caregiver participation.

• External participants will be scheduled to be called to ensure confidentiality. Signed confidentiality agreements will maintain HIPAA compliance.
Care Manager Involvement in the ICT

Care Managers facilitate care coordination between the ICT members. This includes:

• Communicating with rendering providers to share pertinent member information

• Ensuring ICT team follow-up within 5 calendar days for member linkage to appropriate service / provider.
  o Identified services and member health care outcomes are shared with the ICT team and PCP during the ICT planning discussions.
  o ICP changes are communicated to the ICT and PCP in writing or telephonically.
  o Members are informed and encouraged to discuss the changes with the PCP during the next scheduled visits.

• Coordinating services for urgent or emergent care needs (i.e. home safety assessments, medication reconciliations, home oxygen requirements, continuity of care with our of network providers, etc) identified prior to scheduled ICT discussions directly with the PCP or the Medical Director within 1 business day.

• Incorporating outcomes of the intervention into the ICP.
Provider Involvement in the ICP

All respective care providers are involved in ICP development, including but not limited to:

– Primary Care Provider
– Specialty Providers (including SNF)
– Behavioral Health Providers or Vendor
– MLTSS Providers (MSSP)
– IHSS provider, upon member consent
– Home and Community Based Providers (CBAS)
– Others (Regional or Specialty Care Centers)

Information can be exchanged via mail, facsimile, telephone, secured Email, and Provider portal (as available)
# Care Management ICP/ ICT Responsibility Matrix

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>ICP Requirement and Responsibility</th>
<th>ICT Requirement and Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong></td>
<td>ICP is required</td>
<td>If a need for an ICT is demonstrated during clinical review, or if the member requests one, an ICT is required</td>
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<td></td>
<td>PCP/PPG</td>
<td>PPG CM is the lead</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>ICP is required</td>
<td>If a need for an ICT is demonstrated during clinical review, or if the member requests one, ICT is required</td>
</tr>
<tr>
<td></td>
<td>PCP/PPG</td>
<td>PPG CM is the lead</td>
</tr>
<tr>
<td><strong>High/Complex</strong></td>
<td>ICP is required</td>
<td>ICT required</td>
</tr>
<tr>
<td></td>
<td>L.A. Care CM</td>
<td>L.A. Care CM is the lead</td>
</tr>
<tr>
<td><em>Default High= No claims received, assigned as High Risk initially, not able to complete HRA, remains High</em></td>
<td>Assign to L.A. Care CM team to monitor daily to weekly for encounter data, pharmacy activities, PCP activities, clinical notes, etc. Once any information is obtained, Coordinator will submit to clinical staff for review and determination risk level and follow algorithm above based on risk level.</td>
<td>Required to offer an ICT “when a need is demonstrated” or if the member requests one.</td>
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L.A. Care Oversight

L.A. Care Health Plan will monitor delegated entities’ compliance through analysis of reports and audits/monitoring activities according to the L.A. Care Utilization Management (UM) Procedure UM Delegation and Oversight.
Resources and Partners

- PCP
- Participating Provider Group
- Family Resource Centers.
- Managed Long Term Services and Supports
- Home and Community Based services
- Disease Management Programs
- Behavioral Health Programs
- Substance Use Programs
- Community Transitions
For Member Transitions Due to Provider Termination

When a provider has termed, member is assigned to another provider in the same practice unless otherwise requested by the member.
For Member Transitions To New Providers

For New Providers, L.A. Care Care Management
• Identifies providers from Member assessments, clinical reports, ICP discussions or utilization data

• Confirm all members of the ICP are aware of the new provider

• Provides the new provider is provided with ICT participation information and ICP, as defined by policy
For Member Transitions

For all Member transitions, the Care Manager or ICT member:

✓ Assists Member or responsible party in transitioning any necessary clinical and medication reconciliation

✓ Updates the Individualized Care plan to reflect the applicable provider, facility and/or services

✓ Shares the ICP with the ICT, member and caregiver
Authorities

- CMS National Financial Alignment Initiative
- NCQA Model of Care Review Process
- State of California Demonstration Proposal
References

• L.A. Care California Dual Eligible Demonstration Model of Care
• L.A Care Utilization Management/Care Management Program
Authorities

- Title ____, California Code of Regulations ("CCR"), Section(s) ________________
- Health & Safety Code, Section(s)______________________________
- DHCS Medi-Cal Agreement, Section(s)_________________________
- Current NCQA Health Plan Standards & Guidelines _____________
- Medicare Managed Care Manuals
- CMS Guidelines
- U.S. Statutes – Including Revisions (Examples: Social Security Act, Medicare Modernization Act, etc.)
- Plan Partner Services Agreement, Section(s) ____________________
- Provider Manual, Sections(s) _________________________________
For more information

- Your L.A. Care provider representative
- Cal MediConnect Provider Manual
- L.A. Care provider portal