L.A. Care HEALTH PLAN®
For All of L.A.

Interdisciplinary Care Team (ICT) Participant Competency Training Cal MediConnect 2022 – (print out of University content)

Person Centered Planning Process

Cal MediConnect is a pilot program to integrate medical care, long-term services and supports, coordination of behavioral health services and social services for people eligible for both Medicare and Medi-Cal. Person-Centered Planning is core to the pilot's goals of achieving integrated care.

L.A. Care and Delegates will use Interdisciplinary Care Teams (ICTs) for all members to develop a person-centered plan and to deliver individualized, integrated care.

An ICT is composed of knowledgeable, licensed, and (as appropriate) credentialed contracted and employed individuals involved or closely associated with the care of the member, based on the needs and preferences of the member.

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

Possible ICT members include, but are not limited to, the following:

- Member/Caregiver/Authorized Representative
- PCP and/or Specialist
- Behavioral Health Specialist, which may include, but is not limited to, a Specialty Mental Health Provider or a Substance Use Disorder Counselor
- Care Manager, Social Worker, Patient Navigator
- Specialized Providers such as Pharmacists
- County IHSS Social Worker
- CBAS Provider
- MSSP Coordinator
- IHSS Provider

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Each member is educated on the interdisciplinary care team concept, the ICT meeting process, and each member is offered to participate in an ICT meeting. The Care Manager leads the ICT and is responsible for organizing the ICT.

Where Does the ICT Meet?

- In a location most convenient for the member and ICT participants, frequently by phone.

When Does the ICT Meet?

- Meet initially to develop the ICP and at least annually thereafter
- When there is a change in the member's condition, including social change
- At the request of the member or provider

What Does the ICT Do?

- Analyze and incorporate initial and annual Health Risk Assessment (HRA) results into an Individualized Care Plan (ICP)
- Collaborate on the development and annual update of each member's care plan
- Ensure the member's care plan is shared among ICT members and across settings as appropriate
- Manage the member's medical /cognitive / psychosocial / functional needs and communicate to the member, caregiver (as appropriate, and PCP)
- Assess and address identified social service barriers to achieving ICP goals
- Assess members for access to long-term care services and supports that can enable them to remain in their homes and communities as long as possible
- Coordinate ICP integration addressing medical and social needs
- Engage members to self-direct their care
- Provide and support person-centered care coordination and planning
- Identify community-based resources and make referrals, as needed

How Does It Work?

Care Managers develop an initial **Individualized Care Plan (ICP**) within three months of member enrollment with L.A. Care. The Plan identifies the member's strengths, capabilities, and preferences and helps the member explore additional care options, including transitioning from a nursing facility to the community or long-term services and supports as appropriate.

ICPs are reviewed and discussed in the ICT meetings and the ICT participants weigh from their subject matter expertise perspective to help the care manager explore additional care planning interventions when appropriate. Meeting minutes track and

document meeting participants. Required confidentiality agreements maintain HIPAA compliance.

Member Rights
The member has the right to opt out or decline involvement in the ICP process. A member's decision not to participate will be documented in the member's record.

If member designates a proxy, L.A. Care and Delegate staff will follow established policies to confirm legal authority, including verbal consent from the member. Caregivers may fax or mail the legal documentation, which is filed in the care management record.

Member Engagement
The Care Manager will engage the member and their caregiver (as applicable) to actively design their care plan initially and at re-assessments by empowering members to identify successes or change self-directed goals. To support the member's involvement in the care planning process, the Care Manager provides the following information:

- Educational materials on the member's condition
- Information on how to involve caregivers and social supports in care planning
- Self-directed care options
- Information on how to access LTSS services if applicable, including In Home Supportive Services, Community Based Adult Services, Multipurpose Senior Services Program, etc.
- Other supports and/or alternative courses of care available

Upon request, information is provided in alternative formats and in their preferred written or spoken language.

The Individualized Care Plan (ICP)
The Care Manager maintains the ICPs which are electronically retained in a HIPAA compliant format within the Information Systems Department for a period of 10 years from the last date of creation. This member-centered care plan is a comprehensive document, developed in collaboration with the member's ICT participants, per member's preference.

The care plan includes, but is not limited to:

- Assessment of member goals and preferences, including primary language, cultural needs, health literacy, self-management goals, overall goals, and member's right to self-directed care
- Measurable objectives and timetables to meet medical, Behavioral health, social and long-term supports and service needs
- Timeframes for reassessment and updating the care plan, to be done at least annually or if a significant change in condition occurs

Care Coordination
Care Managers facilitate care coordination among ICT participants and community based service providers as needed. This can include the member's PCP, specialists, IHSS worker, MSSP care planner, and others involved in the member's care. The Care Manager shares the ICP with the ICT participants, including the member /caregiver and PCP.

Independent Living and Recovery and Wellness Principles

The ICP is developed using the philosophy of independent living and principles of recovery and wellness.

Independent Living Philosophy
Care Management under the Independent Living Philosophy strives to empower individuals with the goal of member self-determination, self-management and full community integration. Its goal for the community is to achieve equal access through reducing and removing physical and societal barriers.

Recovery and Wellness Principles
Recovery and Wellness principles empower individuals to improve their health and wellness, live a self-directed life, and strive to reach their full potential. These principles focus on taking a holistic approach to the member's health, encompassing physical, mental, social and spiritual well-being.

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Accessibility and Accommodations

Providing care that meets the needs of seniors and people with disabilities is not only required by the laws but also an integral part of patient centered care. It leads to increased member satisfaction, improved quality of care and health outcomes and ultimately reduces health disparities.

Within the Independent Living Philosophy model, we shift our mindset about "disability" to broaden our understanding as:

The interaction of an impairment with environmental factors.

This idea allows us to focus on how to conquer environmental factors. It means that we cannot change the way people are, but we can change and make the environment more accessible for people who encounter environmental barriers.

Accessibility
In order to ensure equal and meaningful access to health care for people with disabilities, we need to make reasonable accommodations. Activity limitations vary among people with disabilities and accommodations need to be adjusted based on each member's needs and functional level. We ask for the member's choice of accommodation and honor their choice as much as possible. Please familiarize yourself with all the available auxiliary aids and services, accessible equipment and route in and around your facility.

- Auxiliary services and aids: TTY, American Sign Interpreter, large print, audio, etc.
- Accessible facilities and equipment: Accessible ramps, wide aisles, accessible parking space, wheelchair scale, etc.

"People First" Language
In addition to accessibility, it is important to provide care and services using respectful expressions and phrases for people with disabilities. As the name indicates, it puts people first and recognizes people with disabilities – first and foremost – as people.

Cultural Competency

Culture refers to shared values, norms, traditions, customs, history, and beliefs that are held by a group of people. Each one of us has a dynamic and unique cultural background that influences how we perceive health and illness, seek healthcare and express symptoms.

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Culture impacts every healthcare encounter and building the skills to effectively engage and communicate with diverse member populations is essential in healthcare delivery.

Cultural competency in health care refers to an ability to provide care that is respectful of members' diverse values, beliefs and behaviors, including tailoring care delivery to meet members' social, cultural, and linguistic needs.

Research shows that the use of culturally and linguistically appropriate services is a critical part of delivering quality health care services. Enhanced cultural sensitivity in the delivery of health care services will:

- Ensure equal and meaningful access to health care services
- Improve quality of care. leading to better health outcomes
- Increase member satisfaction
- Decrease unnecessary procedures and lower the cost of medical services

Diversity among L.A. Care Members
Approximately 40% of L.A. Care members have limited English proficiency - meaning they do not speak English as their primary language and have limited ability to read, speak, write, or understand English.

Core Competencies
In order to navigate the complexity of cultural differences, it is important to focus on three core competencies:

- Self-awareness: it means exercising awareness of how culture shapes who you are and how it shapes other people.
- Knowledge: it is important to learn about differences and the historical, societal, political, and religious influences that affect other people's worldview, as well as our own. Knowledge can be enhanced by continuous learning.
- Skills: we need to develop the ability to exercise our awareness and leverage our knowledge in navigating the cultural differences. Skills can be built and improved through cross-cultural encounters and ongoing training.

Cross Cultural Communication Skills
Here are eight simple tips you can apply to enhance communications when providing services or care.

- Build awareness of yourself and knowledge of the other
- Keep biases in check
- Ask open-ended questions
- Listen with empathy
- Practice attentive, active and affirmative listening
- Be open to new information
- Explain your own perceptions and knowledge
- Treat people as individuals

Beliefs about Health and Illness
Every member has their own view on wellness and approaches to healing. To develop a personalized care plan based on the cultural aspect, ask the member to explain his/her idea of health and illness, treatment preferences, use of home remedies, and diet restrictions.

Navigating Healthcare System
Navigating the healthcare system can be challenging. Members may have limited experience with the healthcare system and need help in understanding and accessing health care services.

Health Literacy Level
Health Literacy refers to the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions. There are many specialized terms and jargon used in the health care and medical fields, which could be difficult for the lay person to understand. Use plain and non-technical language that is easy for members to understand.

Language Barriers
Members with limited English proficiency face language barriers when accessing health care services. Unaddressed language barriers can compromise the quality of care and result in poor outcomes due to lack of understanding or misunderstanding in information exchanges. Language assistance services are not only one of the key components of patient-centered care but also regulatory requirements. Language assistance services must be provided to members at no cost and could include:

- 24-hour, 7-days a week Interpreting services
- Written member information materials in the member’s threshold language

- Auxiliary services and aids (e.g. TTY, American Sign Interpreter, large print, audio)

Please review policies and procedures on language assistance services at your organization or facility and familiarize yourself with how to access the services.

Language Assistance Services Requirements

- Post translated signage about no-cost interpreting services at key points of contact.
- Offer no-cost interpreting services to members.
- Never imply, request, or require members to provide their own interpreters.
- Strongly discourage the use of friends, family members, and especially minors as interpreters except in emergencies.
- Document member's preferred language, and the request or refusal of interpretation services in the medical record.
- Maintain appropriate qualifications on file for bilingual practitioners and office staff who communicate with limited English proficient members in a language other than English.

Working with Interpreters
Here are some tips to make your member encounters with an interpreter go smoothly:

- Have a quick briefing with the interpreter prior to the appointment or call. This is an opportunity to inform the interpreter on the nature of the encounter.
- An interpreted conversation requires more time. Plan accordingly and allow enough time for an appointment or call.
- You are communicating with the member using an interpreter. So remember to greet the member first, face the member if it is an in-person encounter. Speak in the first person. There is no need to say "Tell the member that I said..." You can address the member directly.
- Speak in a normal voice, not too fast or too loud.
- Give information in small chunks and pause after a full short sentence for the interpreter.
- Interpreters are trained in medical terminology; however, interpretation will be smoother if you avoid acronyms, medical jargon and technical terms. Use basic and plain language.
- Interpreter's job is to interpret everything you said. If there is anything that should not be communicated to the member, refrain from saying it.

Sensitivity to Cultural Differences Relevant to Delivery of Health Care Interpreting Services All aspects of members' culture have an impact on the interpreting services in healthcare settings. There may be different levels of comfort with interpreting services and

various interpreting technologies used. Please be respectful of members' needs and preferences of language assistance services while informing them of the importance of the qualified interpreting services and encourage the use of it.

- Member's cultural norm may affect their comfort level of having an interpreter at medical appointments.
- Member's gender or religion may affect preference for interpreter's gender.
- Member's familiarity level with technology may affect preference for type of interpreting services.

Long Term Services and Supports (LTSS) Programs and Eligibility

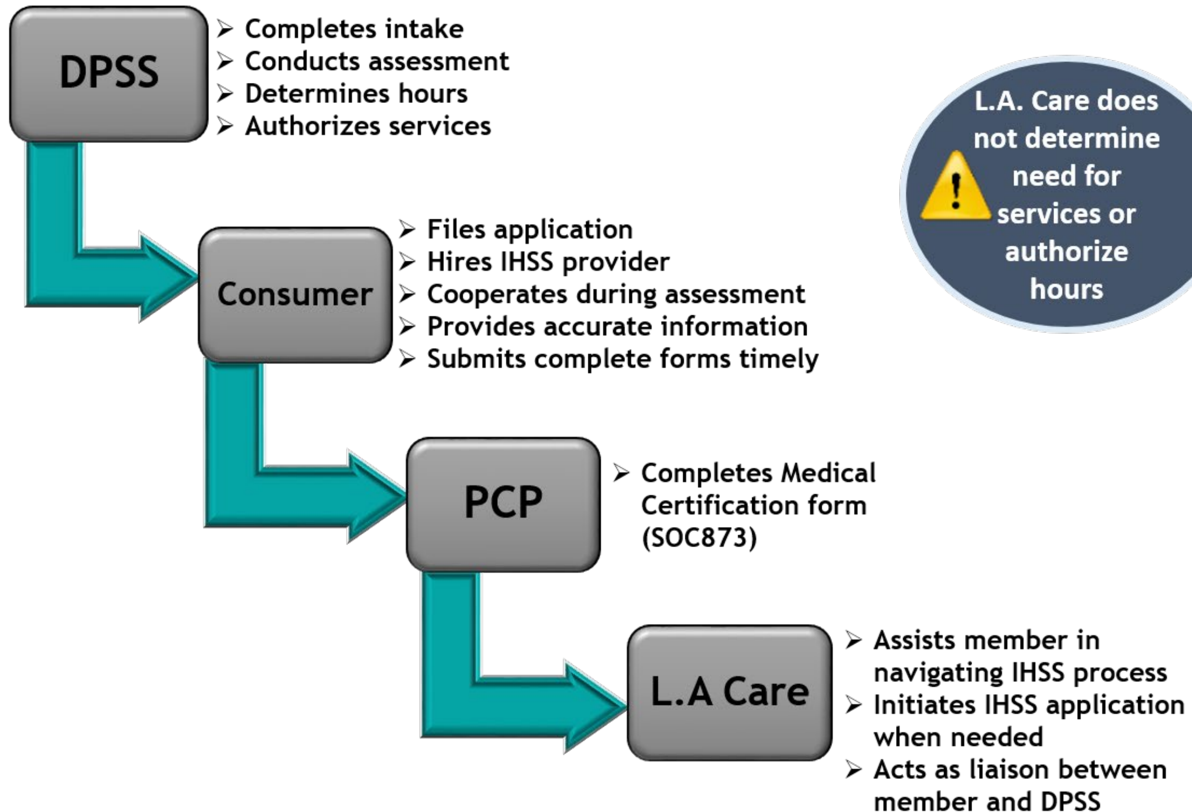
Managed Long Term Services and Supports (MLTSS) typically refers to a wide range of services that support people to live independently in the community.

What Services are Covered under MLTSS?

In Home Supportive Services (IHSS)
IHSS is a California state program that provides in-home care to low-income seniors and persons with disabilities, allowing them to remain safely in their home. All IHSS beneficiaries must:

- Be a California resident and living in their own home
- Receive or be eligible to receive Supplemental Security Income/State Supplemental Payment (SSI/SSP) or Medi-Cal benefits
- Be 65 years of age or older, blind, or disabled by Social Security standards
- Have a mild cognitive disorder such as dementia and need assistance with 2 activities of daily living (ADL)
- Submit a health care certification form (SOC 873) from a licensed health care professional indicating that they need assistance to stay living at home

Please see the process below for coordination with the County on IHSS.



Community Based Adult Services (CBAS)
CBAS is a program where members can go to a center during the day for assistance with their daily needs. All CBAS beneficiaries must be Medi-Cal beneficiaries age 18+ who meet one or more of the following criteria:

- At risk for nursing facility placement
- Have organic/acquired traumatic brain injury and/or chronic mental health condition
- Have Alzheimer's disease or other dementia
- Have mild cognitive impairment
- Have a developmental disability

CBAS can help members with the following services:

Core Services	Additional Services
Professional nursing and medication management	Physical, occupational or speech therapy
Therapeutic activities	Mental health/psychiatric services
Social services and/or personal care services	Registered dietician services
One meal offered per day	Transportation to/from center/residence

Long Term Care (LTC) Facility Services
LTC provides medical, social, and personal care in either a skilled nursing facility (SNF) or at home for members with medical or mental conditions who need constant, continuous care. LTC indicators include:

- At risk at home or in the community and need ongoing care in a SNF
- Need for prolonged nursing support and supervision (wound care, tracheostomy, G-tube, ventilator)
- Need help for walking, getting in/out of bed, bathing, dressing, feeding, using the toilet, special diets, and supervision of medicine

There are two types of LTC: Custodial Care and Skilled Care. Custodial care refers to services ordinarily provided by personnel like nurses' aides. The LTC custodial benefit only covers room and board. Skilled care refers to skilled nursing or rehabilitation services, provided by licensed health professionals like nurses and physical therapists, ordered by a doctor.

Multipurpose Senior Services Program (MSSP)
MSSP is an intensive case management program for seniors who are certified for nursing home placement but wish to remain at home. MSSP provides ongoing social and health care management and includes a waiver program with limited slots in L.A. County. Eligibility is determined by the local MSSP site based on state-set criteria. In order to be eligible for MSSP services, a beneficiary must:

- Be a Medi-Cal beneficiary age 65+
- Live within an MSSP service area
- Be certified for nursing home placement

Care Plan Options (CPO)
CPOs are additional services that L.A. Care may arrange and pay for beneficiaries who have Cal MediConnect. CPO is available to Cal MediConnect members only. All community resources must be exhausted and all CPO services must be authorized by L.A. Care prior to service. In addition, services must be provided through L.A. Care's contracted CPO provider network.

Examples of this service include:

- Respite care/provider support
- Additional Personal Care and Chore Type Services beyond those authorized by IHSS
- Home modification/maintenance
- Nutritional services
- Personal Emergency Response Systems (PERS)

You must attest that you have received and read this information before you can participate in an L.A. Care Cal Medi-Connect Interdisciplinary Care Team (ICT). Please click on the Agree button to attest that you have read and understand the above information (if you are within the online L.A. Care University module). Please use the attestation training log provided.

Note: ***If the delegate conducts their own Model of Care training, it must include:***

1. Person-centered planning processes;
2. Cultural competence;
3. Accessibility and accommodations;
4. Independent living and recovery and wellness principles;
5. Information about LTSS programs, eligibility for these services, and program limitations;
6. Coordination with counties on IHSS