Health Home Learning Collaborative

Person-Centered Planning for ICM Members

October 21, 2019
This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

Iowa Medicaid Enterprise
Pamela Lester
plester@dhs.state.ia.us
LeAnn Moskowitz
lmoskow@dhs.state.ia.us

Amerigroup
Sara Hackbart
sara.hackbart@amerigroup.com
David Klinkenborg
david.klinkenborg@amerigroup.com
Emma Badgley
emma.badgley@amerigroup.com

Iowa Total Care
Tori Reicherts
Tori.Reicherts@IowaTotalCare.com
Bill Ocker IHH
Bill.J.Ocker@IowaTotalCare.com
Lori Palm IHH
Lori.D.Palm@IowaTotalCare.com
Logistics

• Mute your line
• Do not put us on hold
• We expect attendance and engagement
• Type questions in the chat as you think of them and we will address them at the end.
AGENDA

1. Introductions
2. Person-Centered Planning Philosophy............................................Emma Badgley, AGP
3. Open Discussion..................................................................................All
   (Open discussion on current issues or barriers, potentially leading to future monthly topics)

   Coming up:
   – October 21, 2019 – Person-Centered Planning
   – November 18, 2019 – Chart Review Workbook
   – December 16, 2019 – Performance Measures
Health Home Service
Comprehensive Case Management

• Comprehensive Care Management means the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan which addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

Health Home Service
Comprehensive Case Management

- Comprehensive care management services include, but are not limited to the following activities:
  - Conducting outreach and engagement activities to gather information from the enrollee, the enrollee’s support member(s), and other primary and specialty care providers.
  - Completing a comprehensive needs assessment.
  - Developing a comprehensive person-centered care plan.

Learning Objectives

• Health Homes will have a clear picture of what the person-centered planning process looks like.

• Health Homes will have an understanding of the documentation requirements of a Person-Centered Treatment Plan based on Federal and Iowa Administrative Codes, DHS Provider Manuals, and the SPMI State Plan Amendment.

• Health Homes will understand the differences between goals and support.
A person-centered planning process leads to a person-centered care plan

- Health Home State Plan Amendments (SPA)
  - Health Home Providers will:
    - Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical related needs and services.

*Refer to Provider Standards of approved SPA*
Person-Centered Plan: Expectations

- Care plans will meet the standards of the accrediting or licensing body of the organization and incorporate person-centered values and activities
- This may include:
  - Federal Code
  - State Plans
  - DHS Provider Manuals
  - Iowa Administrative Code
    - CMH Waiver: Chapter 83, Chapter 90
    - Habilitation: Chapter 78

Source: CMS
Person-Centered Planning Process
Person-Centered Planning: Process

- Process-oriented approach to empowering people
- Focus is on people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them
Person-Centered Planning: Process

Person-centered service planning involves:

- The time needed to learn what is important to the individual and to support the individual in having control over the process and content
- Strengths-based development, language, and writing
- The inclusion of natural supports in the care planning process
- Articulation of clearly defined short-term and long-term personal goals with measurable objectives

Source: CMS
Person-Centered Planning: Process

Person-centered service planning requires:

• Commitment to the individual
• An individual-driven process that includes people who the individual wants to be involved with the planning process
• A plan that the individual cares about and includes the goals of the individual in his or her own words

Adapted from CMS
Person-Centered Planning: Outcomes

Quality person-centered service plans will ensure that planning leads to important outcomes

• People have control over the lives they have chosen for themselves
• People are recognized and valued for their contributions (past, current, and potential) to their communities
• People live the lives they want

Source: CMS
THE ROLE OF THE IHH
Person-Centered Planning: Role of the IHH

- Intensive Care Management (ICM)
  - Provided to member enrolled in an IHH who have Habilitation (non-waiver) eligibility and Children’s Mental Health (CMH) Waiver

- IHH team develops a “toolbox” of methods and resources that enables the member to choose their own pathways to success

- Timeliness of the IDT meeting
# 6 Core Services

<table>
<thead>
<tr>
<th>Health Home Service</th>
<th>Person-Centered Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Care Management</td>
<td>Oversight of care management plans and multiple references to addressing the whole person’s needs</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Conducting joint treatment staffing-meeting with multidisciplinary treatment team to plan for treatment and coordination</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Ensure that all personal health goals are included in person-centered care management plans Implementation of strengths-based individualized care plans addressing the needs of the whole child and family</td>
</tr>
<tr>
<td>Comprehensive Transitional Care</td>
<td>Identification and linkage to longer-term care and home and community based services</td>
</tr>
<tr>
<td>Individual and Family Support</td>
<td>Support and linkage to advocacy, self-help, treatment, and other services</td>
</tr>
<tr>
<td>Referral to Community and Social Support Services</td>
<td>Identify, link, and support for community resources and services</td>
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</table>
PERSON-CENTERED PLANNING: REQUIRED DOCUMENTATION
Social History

• As outlined in Chapter 90, the assessment and reassessment activities include the following:
  • Taking the member’s history, including current and past information and social history in accordance with Chapter 24, and updating the history annually
  • Identifying the needs of the member and completing related documentation
  • Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member

Source: Iowa Administrative Code, Chapter 24
Social History, Continued

• Chapter 24 requires that the organization collects and documents relevant history information and organizes the information in one distinct document in a narrative format, reviewed and updated annually. The social history must include:
  • Relevant information regarding the onset of disability
  • Family, physical, psychological, behavioral, cultural, environmental, and legal history
  • Developmental history for children
  • Any history of substance abuse, domestic violence, or physical, emotional, or sexual abuse
# Core Standardized Assessments

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Ages</th>
<th>Required Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mental Health</td>
<td>0-3</td>
<td>CM Comprehensive Assessment (or modified PIHH)</td>
</tr>
<tr>
<td></td>
<td>4-20</td>
<td>interRAI-Child and Youth Mental Health (ChYMH)</td>
</tr>
<tr>
<td></td>
<td>12-18</td>
<td>interRAI-Adolescent Supplement (in addition to ChYMH)</td>
</tr>
<tr>
<td>Habilitation Services</td>
<td>16-18</td>
<td>interRAI-Child and Youth Mental Health (ChYMH)</td>
</tr>
<tr>
<td></td>
<td>19+</td>
<td>interRAI-Community Mental Health (CMH)</td>
</tr>
</tbody>
</table>

[https://dhs.iowa.gov/sites/default/files/1826-MC-FFS_Clarification_Assessment_Tools_Approved_HCBSServices.pdf](https://dhs.iowa.gov/sites/default/files/1826-MC-FFS_Clarification_Assessment_Tools_Approved_HCBSServices.pdf)
Qualified Assessors: Habilitation

• From the Habilitation 1915(i) HCBS State Plan Program- Individuals completing the comprehensive assessment must:
  – Be a Licensed master’s level mental health professional (LMSW, LISW, LMHC, or LMFT), or
  – Have a four-year health related degree, or
  – Be a Registered Nurse (RN) licensed in the State of Iowa, with a minimum of 2 years experience providing relevant services.
Qualified Assessors: CMH Waiver

- From the 1915(c) Children’s Mental Health Waiver: Individuals completing the comprehensive assessment must:
  - 1915(c) Children Mental Health Waiver: Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) complete the assessment tool.
Person-Centered Treatment Plan

• Federal Code indicates:
  – The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
• Requirement: Time-Frames
  – Person-centered treatment plan is revised at a minimum annually, when an individual’s condition changes or when requested by the member
    • The plan also includes a method for the individual to request updates to the plan
  – Person-centered treatment planning meeting is required to be held prior to the previous plan’s expiration
Person-Centered Treatment Plan

• Requirement: Interdisciplinary Team
  – Plan is developed through an interdisciplinary process
  – Includes people chosen by the individual (document who was chosen by the member)
  – The individual will lead the person-centered planning process where possible (document who was the lead as chosen by the member if the member chooses not to lead the process)
Person-Centered Treatment Plan

• Requirement: Interdisciplinary Team, cont’d
  – The Interdisciplinary Team (IDT) includes:
    • The member
    • IHH Care Coordinator
    • Any other individuals the member chooses, which may include:
      – Family members
      – Service providers
      – Other involved individuals
Person-Centered Treatment Plan

• Requirement: Is timely and occurs at times and locations of convenience to the individual (document who selected the time and location and rationale if needed)

• Requirement: Is understandable to the individual receiving services

• Requirement: Reflects cultural considerations
Person-Centered Treatment Plan

• Requirement (Habilitation): Service plan indicates members were informed of how to report suspected abuse, neglect, or exploitation

• Requirement (Habilitation): Process includes explaining to the member how to make a complaint about the member’s services or providers
Person-Centered Treatment Plan

• Requirement: Conflict Resolution/Conflicting Interests
  – Plan should document conflict resolution strategies for the member, as well as any conflicts of interest by the planning participants
Person-Centered Treatment Plan

• Requirement: Risk Factors & Crisis/Emergency Planning
  – Reflect risk factors (including health and safety) and measures in place to minimize them, including individualized back-up plans and strategies when needed
  – Note supports that are available in an emergency and a back-up plan should these supports not be readily available
Person-Centered Treatment Plan

• Requirement: Risk Factors & Crisis/Emergency Planning
  – CMH Waiver Specific:
    – After-hours contact info for all persons and resources identified for the member w/ an alternative contact or contact info for an on-call system
Person-Centered Treatment Plan

• Requirement: Setting
  – Reflects that the setting in which the individual resides/receives services was chosen by that person among all available alternatives
  – HCBS Residential Setting Member Assessment

• Required to be completed upon initiation of services and uploaded to IMPA annually thereafter

Person-Centered Treatment Plan

• Requirement: Setting
  – Records the alternative home and community-based settings that were considered by the participant. Document whether:
    • The member lives in the least restrictive setting feasible,
    • The member has a goal to move to a less restrictive setting, or
    • The member chooses their setting among other options
Person-Centered Treatment Plan

• Requirement: Setting, cont’d
  – Habilitation Specific:
    • For members receiving home-based habilitation in a licensed RCF of 16 beds or fewer, or any residential setting where habilitation services are provided, the plan must document the member’s opportunities for independence (employment, community life, etc.) and community integration (document what options were discussed)
Person-Centered Treatment Plan

• Requirement: Setting, cont’d
  – Habilitation Specific:
    • The member’s living environment at the time of enrollment;
    • The number of hours per day of on-site staff supervision needed by the member; and
    • The number of other members who will live with the member in the living unit.
Person-Centered Treatment Plan

- Requirement: Setting, cont’d
  - Habilitation Specific:
    - Identifies for member’s receiving prevocational or supported employment services:
      - The member’s prevocational or supported employment setting
      - The number of hours per day of on-site staff support needed by the member, and
        - For prevocational services where the member is earning subminimum wages, documentation that counseling, information, and referral regarding integrated community employment has been provided.
        - For small group employment, the number of members working in the group with the member and the number of hours of work per week.
        - For individual supported employment, the number of hours of employment per week and the number of hours of on-site staff support needed by the member per week.
Person-Centered Treatment Plan

- Requirement: Reflects the individual's strengths and preferences
- Requirement: Reflects desired outcomes
- Requirement: Reflects clinical and support needs as identified through an assessment of functional need
Person-Centered Treatment Plan

• Requirement: Goals
  – Includes individually identified goals which are observable or measurable, with desired outcomes
  – Identifies interventions and supports needed to meet those goals with incremental actions steps
  – Identifies individuals responsible for carrying out interventions
Person-Centered Treatment Plan

• Requirement: Goals, Cont’d
  – Goals and services in the plan should reflect what the member states they want to accomplish, also taking into account information from the InterRAI, social history, and past treatment history
  – Habilitation Specific: Includes goals related to community living
Person-Centered Treatment Plan

• Requirement: Freedom of Choice
  – Include the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan (document evidence that the case manager identified activities to encourage the consumer)
  – Offers informed choices to the individual regarding the services and supports they receive and from whom
  – Participants are encouraged to meet with providers before choosing a provider
Person-Centered Treatment Plan

• Requirement: Services
  – Plan documents the offer of choices to the member regarding services and supports the member receives and from whom
  – Plans must include the services the member is set to receive, the funding source (including Medicaid and non-Medicaid), service provider, timeframes, and amount of services to be received
    • Includes natural supports
    • CMH Waiver Specific: Plan should include the provider rate for service
Person-Centered Treatment Plan

• Requirement: Services, Cont'd
  – Prevents the provision of unnecessary or inappropriate services or supports
  – CMH waiver specific: Document services identified to meet the needs of the member which the member declined to receive
  – Includes a separate, individualized, anticipated discharge plan that is specific to each service the member receives
Person-Centered Treatment Plan

Requirement: Rights Restriction Documentation

- Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- The need for the restriction.
- The less intrusive methods of meeting the need that have been tried but did not work.
- Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- The informed consent of the member.
- An assurance that the interventions and supports will cause no harm to the member.
- A regular collection and review of data to measure the ongoing effectiveness of the restriction.
Person-Centered Treatment Plan

• Requirement: Signatures
  – The plan must be signed by the individual and/or individual’s guardian/representative, IHH Care Coordinator/Case Manager, and all other providers responsible for implementation of the plan.
  – This must be done within 30 calendar days of initiation of the plan
Person-Centered Treatment Plan

• Requirement: Distribution
  – Distributed to the participant and other people involved in the plan (document when this was done)
SAMPLE TREATMENT PLANS
Accepted Treatment Plans

<table>
<thead>
<tr>
<th>Lead Entity</th>
<th>Amerigroup Template Accepted?</th>
<th>Individual IHH Template Accepted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>Yes</td>
<td>Yes *Only if the plan has been approved by Amerigroup and meets all expected standards</td>
</tr>
<tr>
<td>Iowa Total Care</td>
<td>Yes</td>
<td>Yes *Based on audit findings, the IHH will be responsible for any missed elements</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>Yes</td>
<td>Yes *Based on audit findings, the IHH will be responsible for any missed elements</td>
</tr>
</tbody>
</table>
Resources

- **Core Standardized Assessments**
  - IL 1826-MC-FFS

- **HCBS Residential Settings Member Assessment**
  - Assessment Tool
  - IL 1904-MC-FFS

- **Rights Restrictions**
  - IL 2014-MC-FFS
Resources

• Home and Community Based (HCBS) Habilitation Provider Manual

• Home and Community Based Services (HCBS Waiver) Provider Manual
  – https://dhs.iowa.gov/sites/default/files/HCBS.pdf

• 1915 (i) HCBS Habilitation Program

• 1915 (c) Children’s Mental Health Waiver
Questions?
Open Discussion
Thank you!