Building an Effective Plan of Care, Especially For The HARP Population

AHI Health Home Care Management Conference
Crowne Plaza
Lake Placid, New York
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MVP Health Care

MVP Health Care is a nationally recognized, community-focused, not-for-profit health insurer serving more than 700,000 members in New York and Vermont. Committed to the complete well-being of its members, MVP provides the tools and information they need to achieve better health and peace of mind.

Our Mission

MVP Health Care remains dedicated to our most fundamental promise…to ensure that our members will have access to quality health care and that their health care needs will be met.

Our Vision

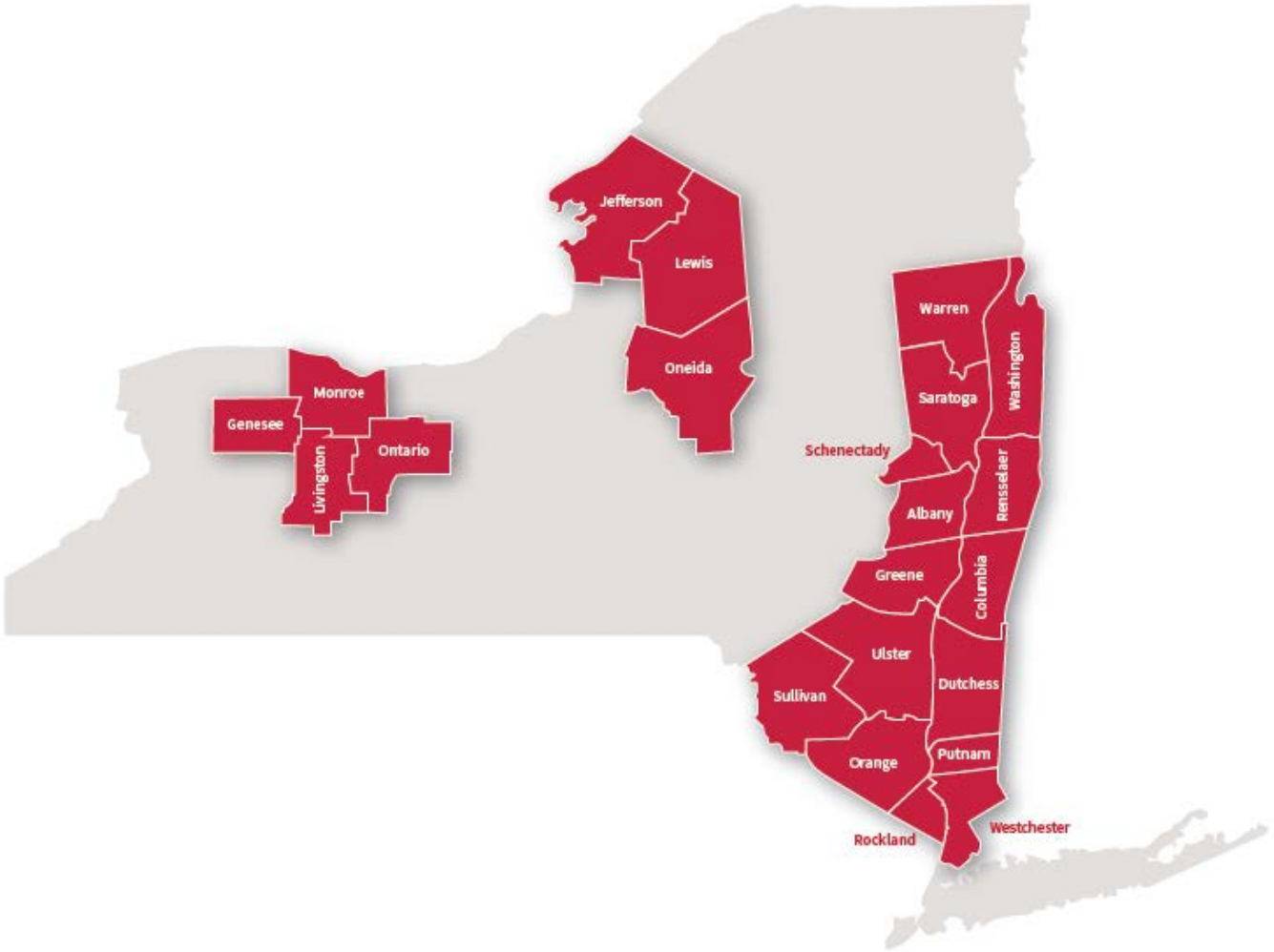
Creating healthier communities.

MVP Health Care, through innovation and collaboration, will create the healthiest communities in the United States.

MVP® HEALTH CARE

MVP New York State Service Area Counties

for Medicaid Managed Care and Child Health Plus



MVP Case Management Guidelines

As adopted from the Case Management Society of America Standards of Practice, 2016

Definition of Case Management:

A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

- Minimizing fragmentation in the health care system, application of evidence-based guidelines in practice to promote collaborative care coordination, navigating transitions of care, and incorporating adherence guidelines and other standardized practice tools.
- Expanding and maximizing the contribution of the interprofessional collaborative health care team to planning care and services for individuals, improving the experience of those who are the recipients of professional case management services, and ensuring safe, quality and cost-effective outcomes.

Guiding Principles

- Client Selection Process
- Client Assessment
- Care Needs and Opportunities Identification
- Planning
- Monitoring
- Outcomes
- Appropriate Closure
- Facilitation and Collaboration
- Qualifications for Case Managers
- Cultural competency
- Legal
- Ethics
- Advocacy
- Cultural Competence
- Resource Management & Stewardship
- Professional Responsibility & Scholarship

True Integrated Care
A Winning Model!

- A model where everyone wins especially our members
- A philosophy adopted by administration, staff and partner stakeholders
- Active buy-in from our providers/CMAs
- A belief system
- A way of operating
- Physical integration of co-located staff
- Requires formal training
- Interdependence on each others staff
- Commonly shared goal
- Bilateral communication
- Systems compatibility

Who We Are

health options

We help people live their lives to the *fullest potential.*

INTEGRITY
We earn trust.

DIGNITY
We respect others.

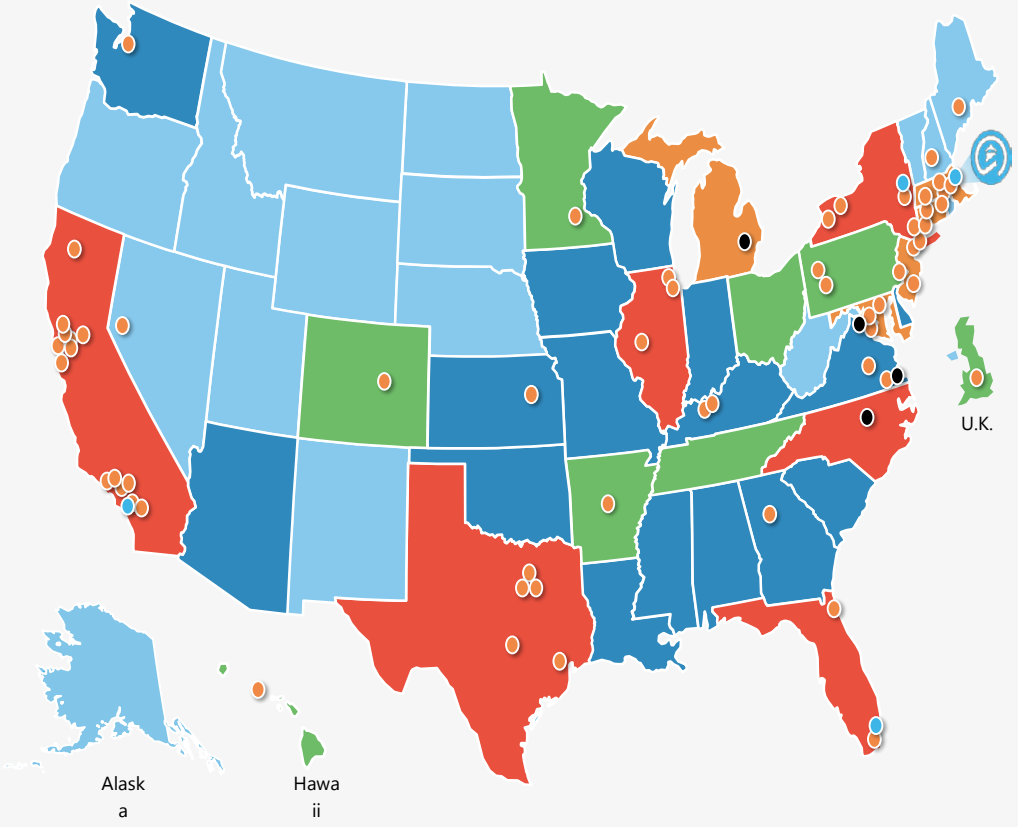
COMMUNITY
We thrive together.

RESILIENCY
We overcome adversity.

INGENUITY
We prove ourselves.

ADVOCACY
We lead with purpose.

Beacon Health Options Footprint



MEMBERSHIP

- Over 2.5 Million
- 1,000,000 – 2,500,000
- 500,000 – 1,000,000
- 500,000 – 100,000
- Under 100,000

CENTERS

- Corporate Headquarters
- Regional Service Centers
- Corporate Operation Centers
- Engagement Centers

BROAD REACH IN THE US AND UK

5,000 employees nationally and in the U.K., serving 50 million people

LEADER IN QUALITY

NCQA- and URAC-Accredited Companies

KEY OPERATIONAL AREAS

- UM/CM
- QM
- IT
- Customer Service
- Data Analytics
- Reporting
- Processing
- Sales Support

LINES OF BUSINESS

- Commercial
- EAP
- Exchange
- Federal
- Medicaid
- Medicare

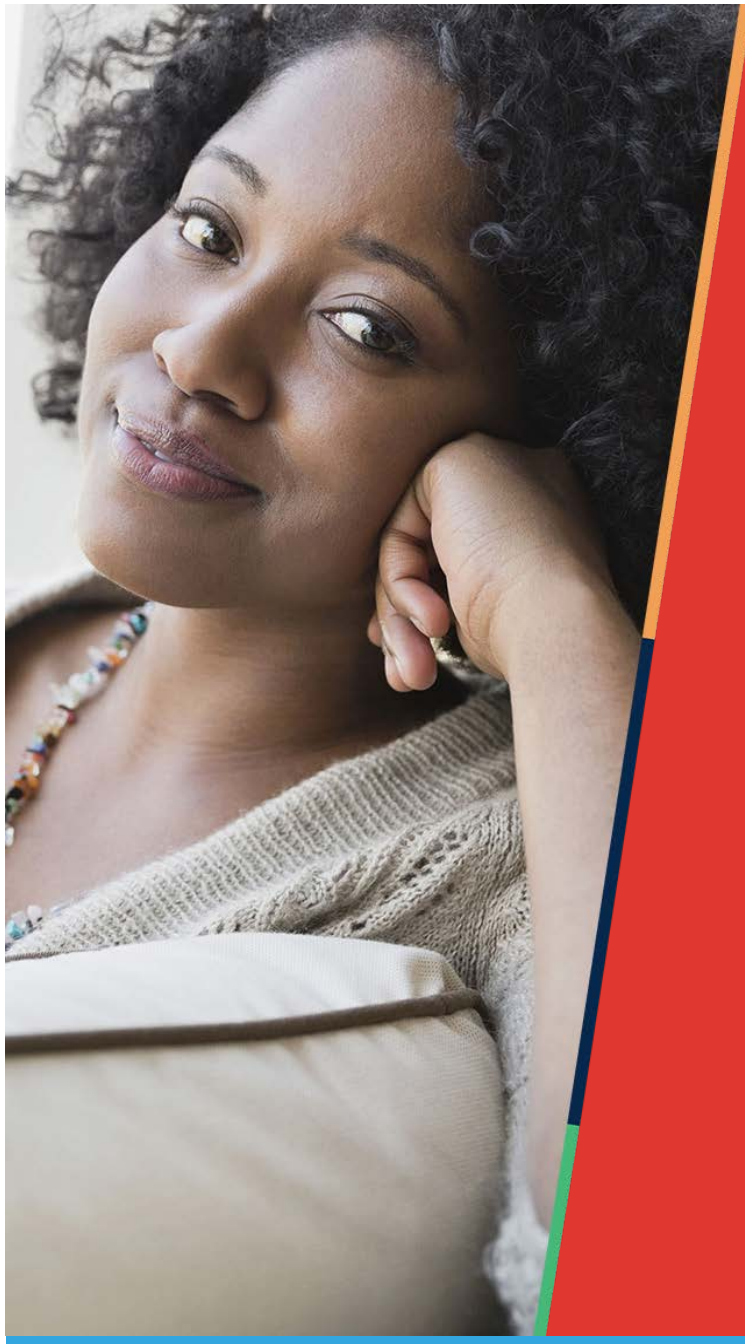
Co-located with MVP in Tarrytown, NY

MVP Products: Medicaid, QMP, HARP, CHP, and Essential Plan

20 Beacon Employees

- 7 Intensive Case Managers (ICMs)
- 8 Utilization Review Clinicians
- 4 Management Staff (Program Director, Clinical Director, Clinical Manager, & Team Lead)
- 1 Clinical Assistant

Beacon also has a large Service Center in Latham, NY which manages MVP's other products (Medicare, Commercial Insurance, Exchange).



Level of Service Determination & Plan of Care

The Level of Service Determination

In order to make a level of service determination request, the HH Care Manager will need to submit the following information to MVP/Beacon:

1. BH HCBS Tier Eligibility Determination (as determined by the NYS Eligibility Assessment).
2. All services the individual currently receives
3. The individual's recovery goal(s)
4. Specific BH HCBS recommendations
5. A copy of the completed Brief Eligibility Assessment

Submitting Level of Service Determination requests. Two methods:

1. Fax: 781-994-7136
2. Email (secured): TarrytownBeacon@beaconhealthoptions.com

Behavioral Health Home and Community Based Services (BH HCBS) Plan of Care

The Plan of Care (POC) is designed to focus on integrating behavioral and physical health and recovery. It guides the individual, his family and other natural supports, and providers toward achieving goals and positive outcomes.

Both Health Home and Adult BH HCBS provider should have copies of Plan of Care in their records.

The state issued Federal Adult Behavioral Health HCBS Plan of Care (POC) Documentation Requirements.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_fed_rules_regs.pdf

If the POC template is not used, the items listed on the documentation requirements form can be incorporated into the HCBS POC per federal rules and regulations.

Each CMA is responsible for ensuring that the template they adopt meets the Federal Adult Behavioral Health HCBS Person-Centered Planning Process Requirements and the Federal Adult Behavioral Health HCBS Plan of Care Documentation Requirements.

Federal Documentation Requirements

The Plan of Care:

Reflects that the setting in which the individual resides is chosen by the individual.

Reflects the individual's strengths and preferences

Reflects clinical and support needs as identified through an assessment of functional need

Includes individually identified goals and desired outcomes

Reflects the services and supports (paid and unpaid) that will assist the individual to achieve goals

Reflects risk factors and measures in place to minimize them

Is understandable (written in plain language) to the individual receiving services and supports

Federal Documentation Requirements Continued

Identifies and lists the individuals(s) and/or entity(ies) responsible for monitoring the Plan of Care

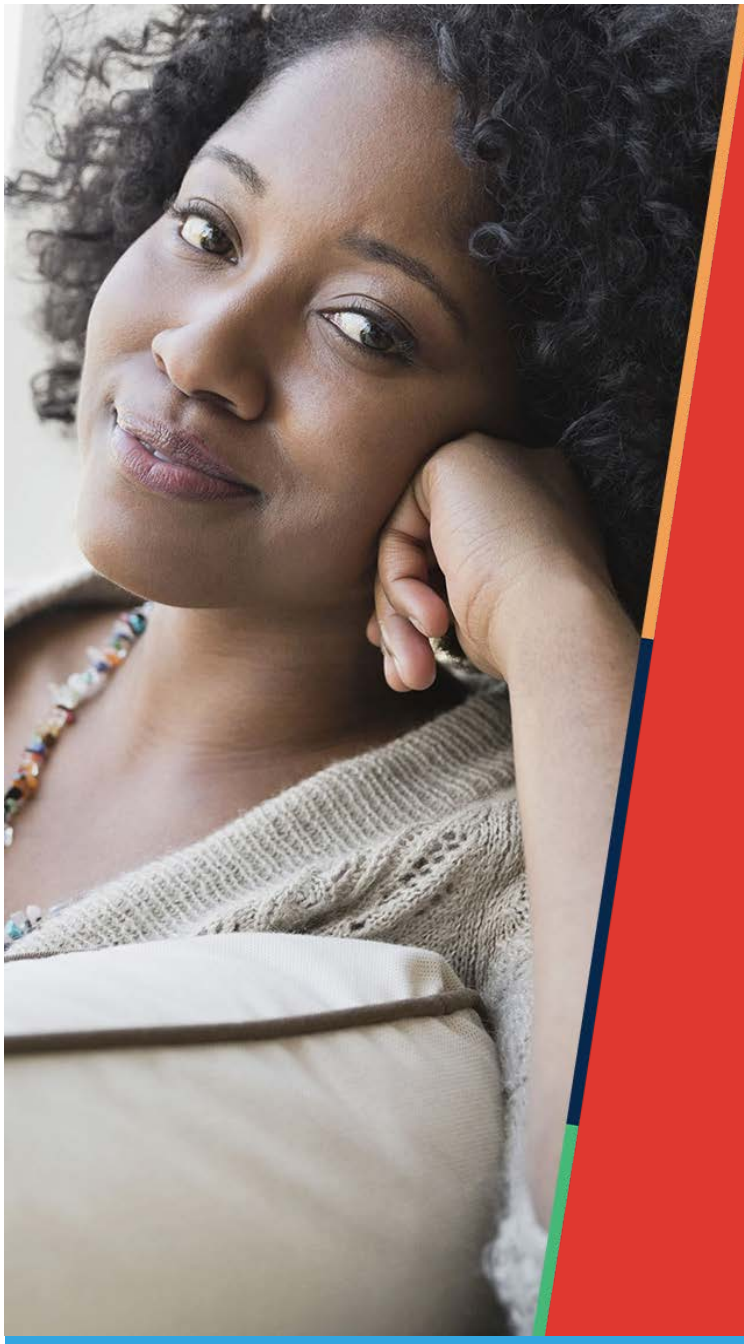
Is finalized and agreed to, with the informed consent of the individual in writing, and is signed by all individuals and BH HCBS providers responsible for its implementation

Is distributed to the individual and other people involved in the plan

Includes self-directed services, if/when applicable

Prevents the provision of unnecessary or inappropriate services and supports

*The findings of the NYS Eligibility Assessment and Community Mental Health Assessment are tools that you can use to inform the Plan of Care



Person-Centered Planning

Person-Centered Planning

SAMHSA (2015a)

- “Person Centered Planning” is a collaborative process in which service recipients participate in the development of goals and services that will be provided to them.

- Effective person-centered planning strengthens the voice of the individuals, builds resiliency, and fosters recovery.

- To enable person to participate fully and effectively:

-Use understandable language, avoiding acronyms and abbreviations

-Assess the persons knowledge of their chronic health condition and treatment options and provide fact sheets on their diagnoses and services available

**A high quality POC should be focused on the individual’s goals and will improve the ability of other service providers to coordinate services, supports, and interventions.*

When developing the POC…

Ask questions such as:

- What is important to you in your life?
- What are your hopes and dreams for the future?
- How does your behavioral health disorder (symptoms) affect your life?
- What do you do with your time?
- Who are the most important people in your life?
- What supports and services can help get you where you need to go?
- Would you like to improve your self-care?

POC Development

- A skilled Health Home Case Manager will facilitate the POC meeting in such a way that the relevant and necessary information is elicited from the individuals and providers, and that may mean that you do not move through the document in a linear fashion.

- The state suggests when developing the plan in partnership with the person, the HHCM should start work on **Section 3 (BH HCBS Eligibility) and Section 6 (Goals, Preferences, & Strengths) before completing Section 2, 4, & 5**.This will ensure that the persons goals, preferences, and strengths guide the planning process.

- The person-centered 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.

- Therefore, it is suggested that all recorded responses be in the first person due to the person centered nature of these services.

- Use N/A where information is not obtained or applicable.

Section 3: Behavioral Health Home and Community Based Services (BH HCBS) Eligibility

Per the DOH HH Standards (10/05/15):

- ☐ The results of the HCBS Eligibility Screen must be documented on the POC.
- ☐ For individuals eligible to receive HCBS, include a summary of the NYS Community Mental Health Assessment.

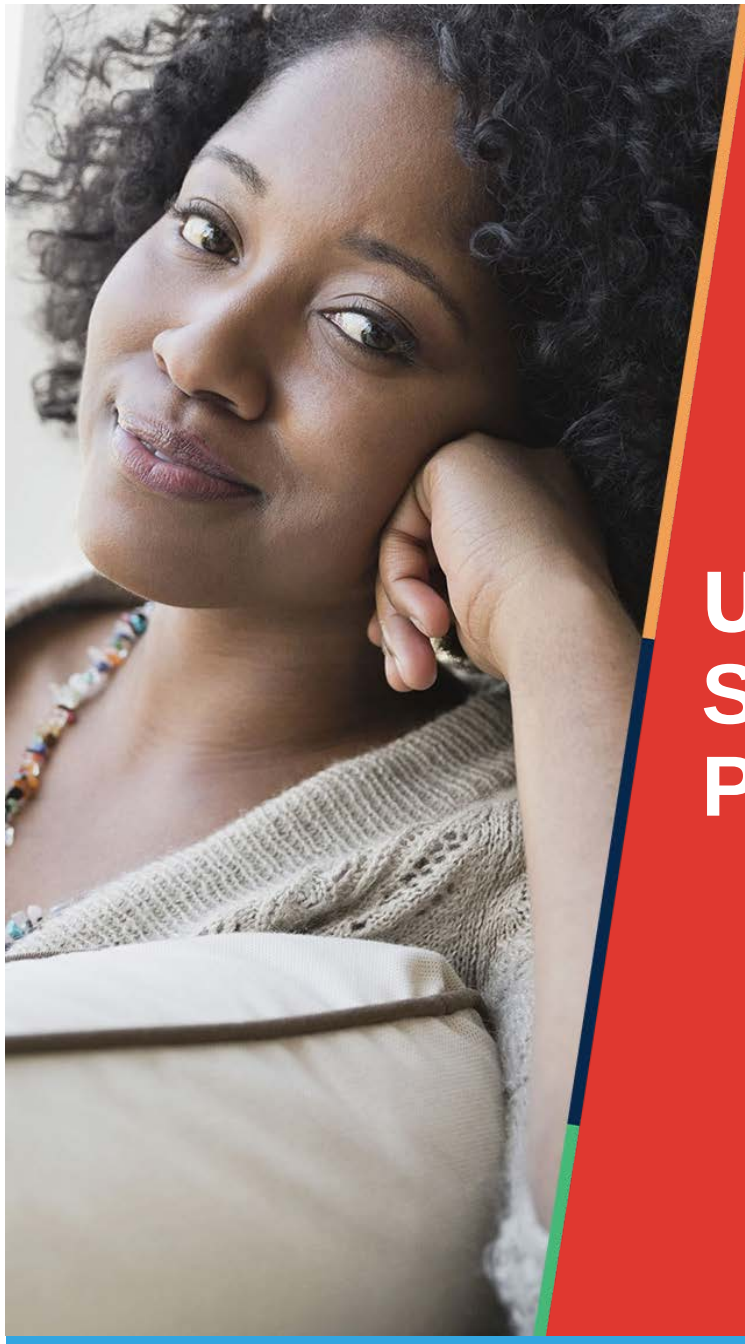
Select the appropriate results from the BH HCBS Eligibility screen:

Section 3: Behavioral Health Home and Community Based Services (BH HCBS) Eligibility

Results of BH HCBS screen:

- ☐ Eligible for Tier 1 BH HCBS only
- ☒ Eligible for Tier 2 BH HCBS (Full array)
- ☐ Not Eligible

<- Element required for a Level of Service Determination by the HARP



Using SMART Goals for Section 6: Goals, Preferences and Strengths

Section 6: Goals, Preferences and Strengths

Per DOH HH Standards (10/05/15), the Plan must include the individual's stated Goals related to treatment, wellness, and recovery;

Per Federal Documentation Requirements, the Plan of Care must:

☐Reflect the individual's strengths and preferences;

☐Include individually identified goals and desired outcomes;

☐Be understandable to the individual receiving services and supports (written in plain language)

What is a SMART Goal?

Not knowing how to properly set up goals can lead to a feeling of failure and can impact self esteem and motivation.

Incorporate the SMART technique by setting goals that are specific, measurable, achievable, realistic, and time limited.

The SMART goal planning model may increase a persons chance of turning their goal into reality and enjoying success.

It is important to ensure that the goals developed are specifically tailored to address the individuals needs.

Creating SMART goals can help achieve this.

Creating SMART Goals

SMART	Term Definition
Specific	Identifies a task to accomplish or a behavior to improve
Measurable	Provides clear measures that indicate how you will know that you have achieved your goal
Achievable	Offers both a challenge and a realistic target that is practical and achievable
Realistic	To be realistic, a goal must represent an objective toward which you are both *willing* and *able* to work.
Timely	Defines a timeframe for completion; either how often will you do a task or by when you will have completed it

Person-centered goal implementation provides…

Goal: A statement of what the person is hoping to achieve (typically specific to a certain area in the persons life).

- **Personal Interests**

  ex) I would like to learn how to play an instrument

- **Personal Desires**

  ex) I would like to one day work in a kitchen at a restaurant

- **Personal Needs**

  ex) I would like help managing my mental health symptoms

- **Personal Circumstances**

  ex) My parents want me to get a job and live on my own

- **Personal Assistance**

  ex) dressing, grooming, eating

SMART Goals Verses Non-SMART Goals

Specific
Goals must be something that can be described and understood easily by others – finite conditions, not general feelings.
Bad example: I will work on job skills.
Good example: I will learn how to complete a resume.

Measurable
Whenever possible, use numbers or percentages to mark achievement of the goal.
Bad example: I want to go on interviews soon.
Good example: I want to go on 3 interviews within the next three months.

Achievable
Goals should be a challenge to obtain but not impossible to achieve. A goal is achievable if it is something the person knows they can do.
Bad example: I will go to my sobriety meetings 100 % of the time.
Good example: I will Increase my attendance at sobriety meetings by 25 % in the next three months.

Realistic:
Member is encouraged to set goals they will be able to accomplish and to start small with what they can do.
Bad example: I will run a marathon by next week.
Good example: I will run a full mile by the end of the month.

Timely
Goals must have an end date to push members to work harder. How else will you know when to check performance?
Bad example: I will improve my social skills by winter.
Good example: I will improve my listening skills by January 1, 2016.

Case Example: "Amanda"

Amanda is a 39 year-old single Filipino-American female who is unemployed. She lives in an area where she feels unsafe and she feels it is too far from her sister – who she identifies as her primary support. Amanda had enjoyed volunteering at an adult day care center when she was in her 20's. She is interested in seeking employment but first she wants to return to volunteer work to "get her feet wet." She is 5'5" and weighs 180 pounds. She is prescribed medications for the treatment of schizoaffective disorder. She reports having difficulty maintaining a healthy weight since she started taking Zyprexa. She sees a psychiatrist on a monthly basis, and sees her therapist once a week. She feels between being on the right medications and seeing her therapist has helped her stay out of the hospital. She is now able to do things she used to enjoy such as reading mystery novels and gardening. Her 8th and most recent hospitalization occurred in January 2016.

Section 6: Goals, Preferences and Strengths

Goal # 1	Goal is to explore volunteer opportunities available. *<- element required for a Level of Service Determination by the HARP*
Category	Employment
Target Date	April 2016

Past Efforts (Things that I have tried in the past to reach my goal)

In the past I volunteered at an Adult Day Care but did not return due to feeling overwhelmed.

Objectives (The outcomes I want to achieve)

I would like to be out of the house 3 days a week and help others in the community

Preferences (I would prefer that when I receive services the following is taken into account by the provider)

I would like to volunteer in Manhattan and as close to home as possible.

Strengths (My strengths are)

I like to observe others and when I learn something new I will not give up easily. I am also loyal and compassionate.

Potential Barriers (Things that make it hard for me to achieve these outcomes)

Concern I will not have enough knowlegde to complete the task required of me.

Strategies (Things that I will do to address the barriers and achieve my desired outcomes)

I will ask questions and learn from those who know best.

Support(s) Needed (Who will help me reach my goal)

Indicate if supports are to be provided by paid or unpaid provider and the frequency needed

Pre-vocational support will be provided for Amanda by a paid provider. Habilitation support will be provided to Amanda by a paid provider. Paid support will also be offered to Amanda by her Psychiatrist to manage her medication.

Click to add more Goals

Goal # 2 I would like to apply for a change in NYCHA housing. I would like to live closer to my family and feel safer.	
Category Habilitation	**Target Date** April 2016
Past Efforts (Things that I have tried in the past to reach my goal) I went to a building manager to apply for a transfer. This did not end successfully.	
Objectives (The outcomes I want to achieve) I would like to obtain stable housing in an area closer to my family within the next few months.	
Preferences (I would prefer that when I receive services the following is taken into account by the provider) I would prefer to be in lower Manhattan, near my family, and away from people who use drugs publicly.	
Strengths (My strengths are) I observe my surroundings and try to avoid dangerous places. Moving will help me continue to do this.	
Potential Barriers (Things that make it hard for me to achieve these outcomes) I give up when things aren't easy and I fear I may stay in a bad environment.	
Strategies (Things that I will do to address the barriers and achieve my desired outcomes) I can look to my therapist for guidance and keep reminding myself that I can make positive changes.	
Support(s) Needed (Who will help me reach my goal) Indicate if supports are to be provided by paid or unpaid provider and the frequency needed Pre-vocational support will be provided for Amanda by a paid provider 1 hr. 1xweekly. Habilitation support will be provided to Amanda by a paid provider for 1 hr. 2x weekly. Paid support will also be offered to Amanda by her Psychiatrist to manage her medication on an ongoing basis.	

<- minimum element required for a Level of Service Determination by the HARP

Goal #3: I want to lose and maintain a healthy weight

Category: Health and Wellness	**Target Date** April/10/2017

Past Efforts (Things that I have tried in the past to reach my goal) In the past, I stopped taking my medications because I was gaining weight but I was unable to control my symptoms and I had to go back to the hospital. I have tried different diets. Sometimes I lose weight, but I just gain the weight back.

Objectives (The outcomes I want to achieve) I want to learn how to make better food choices, lose 20 pounds by May 10, 2017, and maintain a healthy weight that my doctor recommends.

Preferences (I would prefer that when I receive services the following is taken into account by the provider) I do not want to join a gym. I am open to other ideas for exercising. I do not want to change my medication.

Strengths (My strengths are) I am motivated to learn. I want to learn about making better food choices. I can seek out help if I am struggling.

Goal #3 (continued)

Potential Barriers (Things that make it hard for me to achieve these outcomes) I get easily frustrated and give up when I feel like I am failing at something. When I am stressed I like to eat junk food.

Strategies (Things that I will do to address the barriers and achieve my desired outcomes) I will ask my sister to come with me to my next primary doctor's appointment on 11/17/2016 to talk about my worries about weight gain. I will also speak with my psychiatrist about my weight gain. I will join a "Mall Walkers" group with my sister - we will start going two times a week – Tuesdays and Thursdays.

Support(s) Needed (Who will help me reach my goal) My sister Julie will come with me to appointments and exercise with me. My primary doctor, Dr. Smith, my therapist Arlene, and my psychiatrist, Dr. Walker.

Resources

- **BH HCBS Plan of Care Federal Rules and Regulations Checklist**

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

- **Behavioral Health Home and Community Based Services (BH HCBS) Plan of Care Template**

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

- **Federal Adult BH HCBS Person-centered Planning Process Requirements**

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

- **Person Centered Planning:** Practice and Resources (although developed for PROS programs, this workbook may prove helpful when implementing person-centered planning in the Plan of Care development process)

https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/

Contact Numbers For MVP and Beacon

MVP (for members): (844) 946-8002. Members can obtain information regarding their medical and behavioral health benefits.

Submitting Level of Service Determination requests. Two methods:

1. Fax: 781-994-7136
2. Email (secured): TarrytownBeacon@beaconhealthoptions.com

When submitting these HARP HCBS Assessments to Beacon, please include:

1. All services the individual currently receives,
2. The BH HCBS Tier eligibility determination,
3. The individual's recovery goal(s), and
4. The specific BH HCBS recommended
5. The scoring worksheet used to determine eligibility

For additional questions/assistance regarding the submission process please contact:

- Stacey Butler, LCSW; Clinical Team Lead, (781) 994-7140
  Stacey.Butler@beaconhealthoptions.com
- Jill Francesconi, LMSW; Manager of Clinical Services, (781) 994-7501
  Jill.Francesconi@beaconhealthoptions.com
- Zelesther Cay, LMSW, RN-BC; Director of Clinical Services, (781) 496-4075
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Together,

WE can make a difference

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on Twitter at @MVPHealthCare.

MVP® HEALTH CARE