POLICY & PROCEDURE
Medical Services

Policy Title: Individual Care Plan – Medicare-Medicaid Plans (MMP)		
Policy No: 90.2.22	Original Date: 3/13	
Effective Date: 12/18	Revision Date: 12/18	Revision No: 1
Department Head: Date:	Medical Services/P&T Committee: Date:	
P&P Committee: Date:	Department(s): UM	

PURPOSE:

To develop an Individual Care Plan (ICP) for enrollees that promotes a person and family centered process that fosters timely access to appropriate coordinated health care services and community resources that will enable the enrollee to attain and or maintain personal health goals and preferences.

POLICY:

A health risk assessment (HRA) will be conducted on all enrollees. Based on the results of the risk level derived from the HRA, an individualized care plan with measurable objectives and timetables will be developed with the involvement of the enrollee and/or caregivers. This process will be multi-faceted with consideration given to the: physical, cognitive, social, emotional, cultural, community and family status of the enrollee; and with the goal of meeting the enrollee's medical, behavioral health and long-term support needs.

Blue Shield Promise will assure that the enrollee receives any necessary assistance and accommodations to prepare for, and fully participate in, the care planning process, which includes providing the enrollee with:

a. Educational material on his or her conditions and care options;
b. Information on how family members and social supports can be involved in care planning, as the enrollee chooses;
c. Self-directed care options and assistance available to self-direct care;
d. Information on how to access available LTSS, including IHSS services if applicable;
e. Available treatment options, supports, and/or alternative courses of care; and
f. The ability to opt out of the individualized care plan process.

Essential elements incorporated into the individualized care plan include, but are not limited:

a. Enrollee goals and preferences

b. Measurable objectives and timetables to meet medical needs
c. Behavioral health and long-term support needs; and
d. Timeframes for assessment and re-assessment

Blue Shield Promise will specify:

a. The frequency for individualized care plan review and revision (at minimum, upon change of health status or annually), including a discussion on how health data is used to assess whether goals and objectives are being met;
b. The engagement of enrollees and/or their representatives to play an active role in designing their care plan;
c. The frequency for updating the individualized care plan, in response to routine and non-routine reviews and revisions, including required updates when enrollees are not meeting their individualized care plan goals.

Blue Shield Promise will promote a patient-centered planning process that identifies the strengths, capacities, and preferences of the enrollee and provides additional care options, including options as appropriate for transitioning a person from a nursing facility to the community. The planning process also identifies the enrollee's long-term care needs and the resources available to meet those needs.

Blue Shield Promise's individualized care plan process will promote the use of the least restrictive and most inclusive setting the enrollee chooses, as appropriate to provide care. The goal is for the enrollee to live as independent, dignified and as optimal in optimal in quality as possible.

PROCEDURE:

Individualized Care Plan:

A health risk assessment will be performed on all enrollees. The HRA will be the starting point for the development of the individual care plan. This assessment will serve as the basis for further assessment needs that may include, but are not limited to, mental health, substance use, chronic physical conditions, incapacity in key activities of daily living, dementia, cognitive status, and the capacity to make informed decisions.

The ICP process is supported by an interdisciplinary care team (ICT) comprised of professionals, from diverse fields that are knowledgeable in the person centered planning process, cultural competence, accessibility and accommodations, independent living and recovery, chronic disease management and other wellness principles.

The ICT works in a coordinated fashion toward a common goal for the patient. As part of this process enrollees and/or their representatives will participate in the development and review of the ICP. The final ICP will reflect the enrollee's preference in options that promote use of the least restrictive or most inclusive care setting that the enrollee chooses.

The Blue Shield Promise ICP process consists of three major components:

- Problem identification
- Strategies and interventions
- Goals that are based on achievable outcomes and measured for progress.

Definitions:
Problem: The “problem” is an identified problem the member is experiencing. Initial problem identification is triggered by the member’s specific answer to an HRA question.

Intervention: A strategy to specifically target how to address the associated problem.

Goal: an expectation as to what needs to be achieved to adequately resolve the identified problem. The goal is designated as either a short term or long term goal depending on the nature of the problem.

ICP Categories:
The ICP format which lists the problems, interventions and goals are grouped into six distinct categories. Each HRA question with an associated problem also identifies the specific category. The categories are:

- Clinical
- Functional
- Psycho/social
- Preventive Measures
- Compliance

Individual Measures:
Specific measures to address the enrollee’s identified issues are achieved through multiple methods. When Blue Shield Promise receives the completed HRA data, the specific measures are delineated through indicating factors identified from question responses to the HRA. This information is entered into an electronic data base that generates question response specific reports to produce the ICP and planned activities for the measures as follows:

- Identification of medical care needs, including primary care, specialty care, durable medical equipment (DME), medications and other needs with a plan for care coordination
- Referrals to appropriate community resources and agencies for any of the following: mental health, personal care, housing, meals, energy, assistance, developmental disabilities, the process will include referral for assistance from social worker, case manager or complex case manager depending on number of issues identified and assist member with appropriate referrals.
- Involvement with caregiver: identified via response to HRA questions. Depending on the scope of the caregiver issues or to assess for caregiver needs and/or involvement this would be processed by either the social worker, and/or case manager.

- Facilitating timely access to provider network, DME, medications, referrals to assess physical and cognitive barriers and assignment for home management.
- Facilitating communication among health care providers, including mental health and substance abuse providers to ensure member is receiving appropriate care.
- Assistance to optimize member health status, health education, etc: Depending on the nature of the members identified needs these issues will be addressed by either or a combination of case management, complex case management, disease management and health education department.
- Coordination of medical across all settlings including outside of provider network, discharge planning when admitted to a hospital or institution: These issues will be include the involvement of a nurse case manager to ensure appropriate coordination of medical care and ensure appropriate discharge planning and follow up post discharge. This process includes notifying the PCP of the admission and subsequent discharge needs.

Assessment Time Frames:
For enrollees indentified by the risk-stratification mechanism or algorithm as higher-risk, the assessment tool shall be used within 45 calendar days of enrollment.

For enrollees in nursing facilities or those identified as lower-risk for the purpose of developing individual care management plans, the assessment shall be used within 90 calendar days of enrollment.

Reassessments will be conducted at least annually, within 12 months of last assessment, or as often as the health of the enrollee requires.

Member's who experience changes in health status such as increased use of Emergency Room Encounters or hospitalization, will be candidates for earlier reassessment.

REFERENCES/AUTHORITIES:

1. CMS-CA MOU for Medicare-Medicaid Enrollees
2. SB 1008 Senate Bill, Chapter 33