PERSON-CENTERED CARE: CONTRACT EXAMPLES

The following are examples of the extent to which contracts reference and detail patient-centered care plans.

1. The first example, from New Mexico, provides some detail on the policies the contractor must have in place to ensure consumer direction in care planning.
2. The second example, from Tennessee, shows how brief and unspecific a reference can be – a few concise clauses in a 400+ page document.
3. The third example, from Wisconsin, shows how extensive the language can be. This excerpt, from the contract's care coordination section, discusses the range of ways that the state expects the enrollee to be included in his or her care plan.

New Mexico CLTS

From CLTS, Section 3.5, Quality Assurance

(I) **Standards for Consumer/Participant Direction**

The CONTRACTOR shall:

(1) Have and comply with written policies and procedures to ensure that a Member (also known as a consumer or participant), has direct involvement, control, and choice in assessing his/her own needs and identifying, accessing, and managing services and supports to meet those needs. When appropriate, families or representatives shall be involved in the process. In consumer/participant direction, the process shall also include a Member's active participation in making key service plan and service priority decisions as well as evaluating the quality of the services rendered.

(2) Recognize a continuum of different levels of informed decision-making authority, control and autonomy, to the extent desired by the Member, at any given point in the course of his/her participation in CLTS. These levels shall range from a Member choosing not to direct his/her services and instead deferring to trusted family members or representatives of his/her choosing; and

(3) Ensure that a Member can move across the continuum of decision-making, depending upon his/her needs and circumstances, and shall support the Member in his/her decision regarding the level of consumer/participant direction chosen.

TennCare (CHOICES)

From TennCare, section 2.9.6.1 Care Coordination, General.

The CONTRACTOR shall provide care coordination in a comprehensive, holistic, person-centered manner.

Wisconsin Family Care

From Wisconsin Department of Health Services, Division of Long Term Care, Section V, Care Management.

A. Member Participation

1. The MCO is required to ensure that each member has a meaningful opportunity to participate in the initial development of, and updating of, his/her member-centered plan (MCP). The MCO is required to encourage members to take an active role in decision-making regarding the long-term care and health care services they need to live as independently as possible.

The MCO is expected to assure that the member, the member's authorized representative and any other persons identified by the member will be included in the care management processes of assessment, member outcomes identification, member-centered plan development, and reassessment. The MCO shall provide information, education and other reasonable support as requested and needed by members, members' families or authorized representatives in order to make informed long-term care and health care service decisions.

2. Members shall receive clear explanations of:

a. His/her health conditions and functional limitations;
b. Available treatment options, supports and/or alternative courses of care;
c. The full range of residential options, including in-home care, residential care and nursing home care when applicable;
d. The benefits, drawbacks and likelihood of success of each option;
e. Risks involved in specific member preferences; and
f. The possible consequences of refusal to follow the recommended course of care.

3. The MCO shall inform members of specific conditions that require follow-up, and if appropriate, provide training and education in self-care. If there are factors that hinder full participation with recommended treatments or interventions, then these factors will be identified and explained in the member-centered planning process….

B. Interdisciplinary Team Composition

The interdisciplinary team (IDT) is the vehicle for providing member-centered care management. The full IDT always includes the member and other people specified by the member, as well as IDT staff. Throughout this article the term "IDT staff" refers to the social service coordinator, registered nurse and any other staff who are assigned or contracted by the MCO…

C. Member-Centered Planning Process

Member-centered planning is an ongoing process and the member-centered plan (MCP) needs to reflect the frequent changes experienced in members' lives. Member-centered planning will continue to evolve to reflect the growing relationship of mutual trust and understanding between the member and IDT staff and to adapt to changes in the member's outcomes and health status. Member-centered planning includes all the following processes…