Partnership Solutions

The Life Plan:

A Tool for Achieving Quality Outcomes

JULY 2025 | PROVIDER WEBINAR

WELCOME!

Welcome & Introductions

Life Plan and Life Planning Process

Quality Overview

Life Planning and Quality

Provider Collaboration

Positive Examples

Welcome & Introductions

WEBINAR FACILITATORS

Bridget Virkler: Network Development & Provider Relations Account Manager

WEBINAR Presenters

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Life Planning Process

The Life Planning process challenges us to look at the whole person.

- Explore what is important to the person: dreams, goals to be more independent etc..
- Explore what is important for the person including their safety, overall health and wellbeing
- Collaboration between care manager, providers, person and representative(s)
- Quality Principles guide this process

The Life Planning process is Ongoing.

- The Life Plan is the Guide to what the person wants
- Providers put the plan into action
- The IDT reviews and makes changes
- Always seeking to increase Quality Outcomes for the person

How do we define and measure Quality?

We define ***Quality*** as the degree to which services for the individuals and populations we serve increases the likelihood of ***desired outcomes.***

Healthcare Outcomes

Preventative care
Chronic medical and behavioral health
Reducing ER & inpatient utilization
Transitions of care

OPWDD Measures

Person-centered planning
Identifying risks; implement safeguards
Self-direction and employment

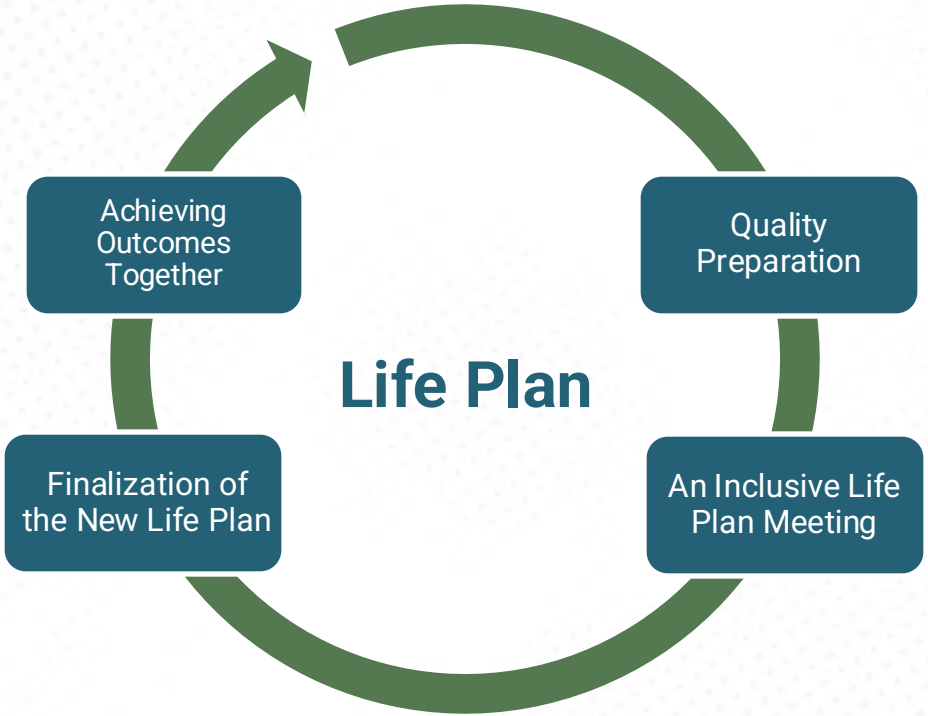
Internal Processes

Quality Management Plan
Quarterly record reviews
Quality improvement plans
Data & analytics framework

Publicly Reported

OPWDD CCO Profiles
NYSDOH Metrics
HEDIS

The Life Plan and Quality



Achieving Outcomes Together

- **Care Managers** play an ongoing role in ensuring Quality outcomes, including improving physical and behavioral health – regardless of residential setting.

- **Access to timely healthcare information** is a critical element of the CM role

CDNY Care Managers and our Healthcare Team ensure:

- Members attend Medical appointments
- Members have access to therapy services
- Support in Crisis situations
- Support to manage Chronic Conditions
- Response to acute and emergency situations/Hospitalizations
- Access to medical and specialty providers

- **Care Managers obtain OPWDD and community-based services based on the person's goals/outcomes by:**
  - Completing HCBS Waiver enrollment
  - Adding and changing Waiver services when needed
  - Work with IDT to find community-based programs

CDNY Quality Goals and Opportunities for Collaboration

ADVOCACY. EXCELLENCE. IMPACT.

Improve preventative and transitional care

Reduce preventable inpatient stays and emergency room visits

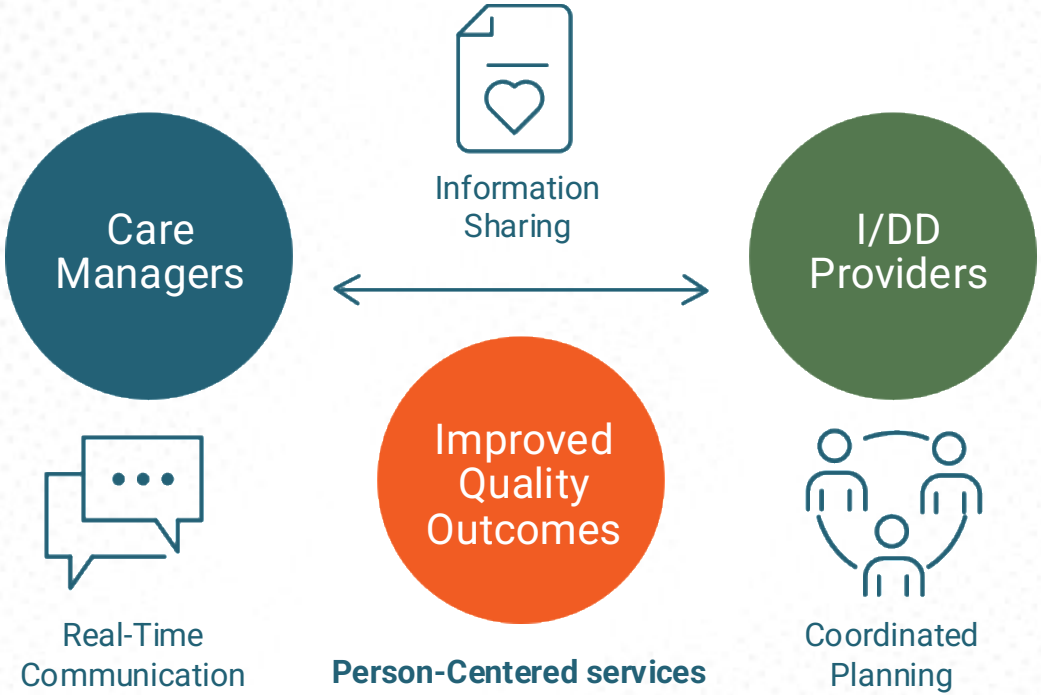
Improve outcomes (related to health, safety, and growth)

Enable individuals to live and be supported as independently as possible

Enable individuals to have meaningful community participation and improved quality of life

Provider Collaboration Increases Quality

ADVOCACY. EXCELLENCE. IMPACT.



Collaboration Example #1

Supporting a Member Through Complex Medical Needs

Overview: 61-year-old man with multiple chronic conditions and end-stage renal disease, faced seven hospitalizations in six months. Despite his health challenges, he valued his independence and continued to work part-time.

Key Provider/IDT/Care Manager Contributions to Quality Outcomes:

- Maintained person-centered planning, ensuring the member's voice guided decisions even during health crises.
- Ensured seamless care coordination across hospital, residential, and Care Design NY teams.
- Demonstrated strong documentation practices, including hospitalization forms and discharge summaries, working with provider to obtain needed information.
- Engaged the Health Care Management team and followed clinical recommendations.
- Facilitated nursing collaboration between Care Design NY and residential providers to monitor Jamal's progress.

Impact: This case highlights the power of comprehensive, coordinated, and person-centered care in supporting individuals with high medical needs—ensuring dignity, stability, and quality of life during a critical time.

ADVOCACY.
EXCELLENCE.
IMPACT.

Collaboration Example #2

Empowering a member to Live Independently with Support

Overview: 41-year-old man with Cerebral Palsy, lives independently using a Self-Directed budget. He receives Community Habilitation and Respite services to support his independence, safety, and community engagement.

Key Provider/IDT/Care Manager Contributions to Quality Outcomes:

- Initiated OT/PT services and secured mobility equipment, improving his independence and foot health.
- CM presented the person at Regional Rounds, engaged the Health Care Management Team, and coordinated across multiple systems.
- Coordinated with provider for regular foot and skin assessments, wound care needs, and explored long-term care options.
- Supported access to phone service and emergency alert systems.
- Worked with provider to connect to counseling, explored psychosexual therapy, and consulted MHLS on capacity to consent.
- Explored additional resources including APS, Disability Rights, and senior services to enhance his quality of life.

Impact: Member's IDT demonstrated a holistic, person-centered approach, ensuring his services are tailored to his goals and evolving needs - empowering him to live safely and meaningfully in the community.

ADVOCACY.
EXCELLENCE.
IMPACT.

QUESTIONS?

PHP PARTNERS HEALTH PLAN

CAREdesign NEW YORK