RESOURCES FOR INTEGRATED CARE

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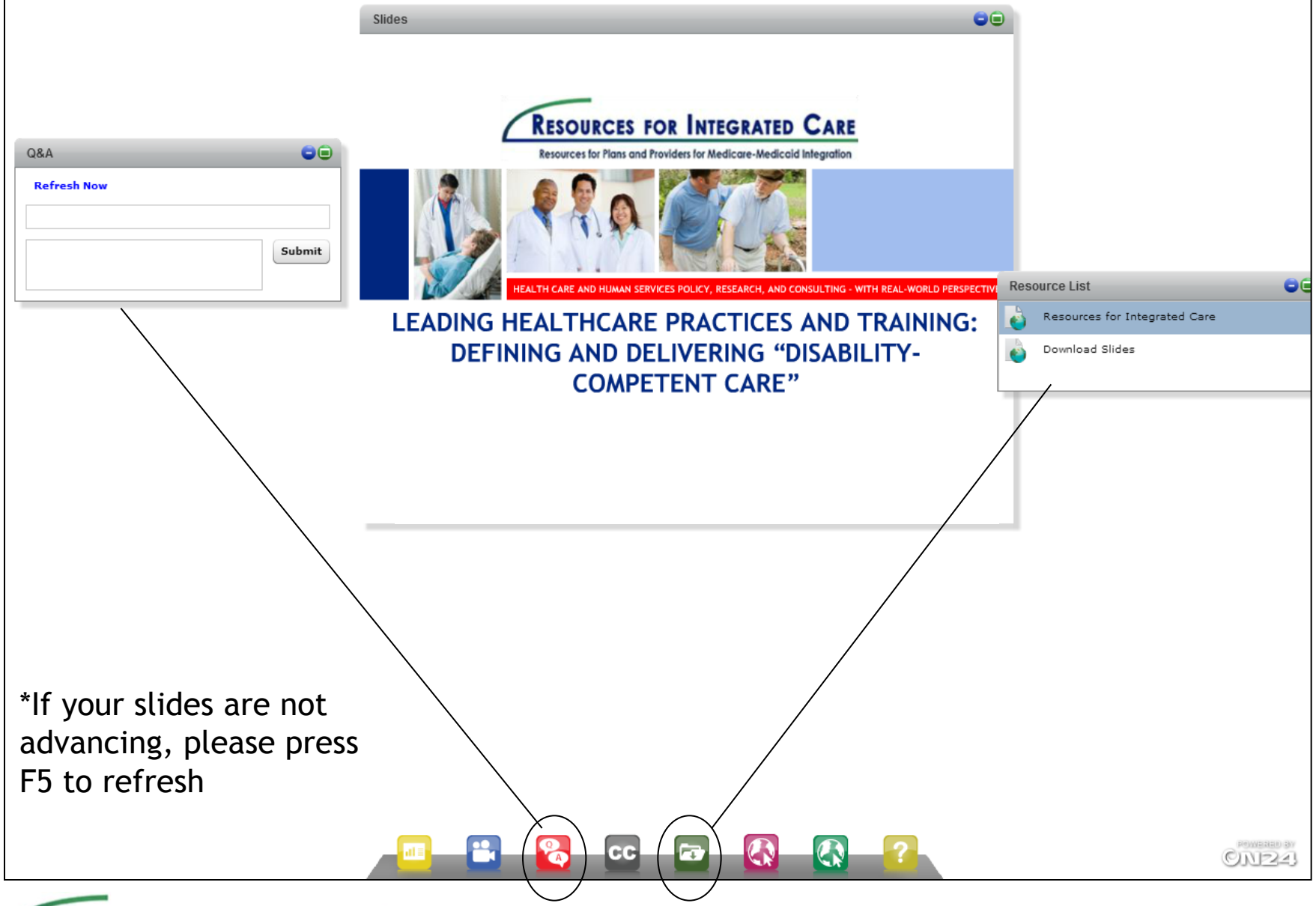
HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.

LEADING HEALTHCARE PRACTICES AND TRAINING: DEFINING AND DELIVERING "DISABILITY-COMPETENT CARE"

Session V: The Individualized Plan of Care

Presented to individuals working with persons with disabilities, particularly in a primary care context.

October 29th, 2013



*If your slides are not advancing, please press F5 to refresh

Overview of Webinar Series

- This is a continuation of the 3-part webinar series presented in September
- The second part of this series will explore:
  I. "Disability-Competent Primary Care" 10/22/2013 (Completed)
  II. "The Individualized Plan of Care" 10/29/2013 (Current webinar)
  III. "Managing Transitions" 11/5/2013
  IV. "Flexible Long Term Services and Supports" 11/12/2013
- Each presentation is about 45 minutes with 15 minutes reserved for Q&A
- Webinars are recorded; video and PDFs are available for use after each session at:

  https://www.resourcesforintegratedcare.com/

Disability-Competent Care Webinar Series

What We Will Explore in This Series:

- The unique needs and expectations of individuals with disabilities
- Disability care competency
- Person-centered care and interactions
- Preparing to achieve the *Triple Aim* goals of improving the health and participant experience of health care delivery while controlling costs in all work with adults with disabilities

What We'd Like From You:

- How best to target future Disability-Competent Care webinars to specific groups of healthcare professionals involved in all levels of the healthcare delivery process
- Feedback on these topics as well as ideas for other topics to explore in these webinars and subsequent resources related to Disability-Competent Care

Introductions

Presenters

Lynne Morishita
Nurse Practitioner, Geriatric and Disability Health Consultant

Marilyn Luptak,
John A Hartford Scholar in Geriatric Social Work & Asst. Prof., College of S.W., at the University of Utah

Kathy Thurston
Director of Care Coordination
AXIS Healthcare

Webinar Agenda

- Understand the role and purpose of care teams
- Disciplined professionals functioning as an Interdisciplinary Care Team
- The planning process for person-centered care
- The care planning process for adults with disabilities
- Audience questions

Care Planning Process

- Key components in the delivery of disability-competent care:
  - Person-centered (relational) care management provided by Interdisciplinary / Interprofessional Care Teams (IDT)
  - Responsive primary care
  - Flexible Long Term Services and Supports (LTSS)

Teams: Selected Definitions

- **Teamwork** is a mechanism that formalizes joint action towards mutually defined goals.
- A **team** is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable.
- Each gives to and supports every other and in turn is nourished by every other.

Historical Perspective: Health Care Teams

- 1915: A need for team of MD/Educator/SW at Mass General
- Post-WWII: Montefiore Hospital Home Health Program with teams
- 1960s: Interdisciplinary educational experiences created; health teams in federal Neighborhood Health Center Programs
- 1970s: Training for interdisciplinary teams in geriatrics
- 1980s: Funding for teams and training declined
- 1990s: Support for teams in specialized areas resurfaced

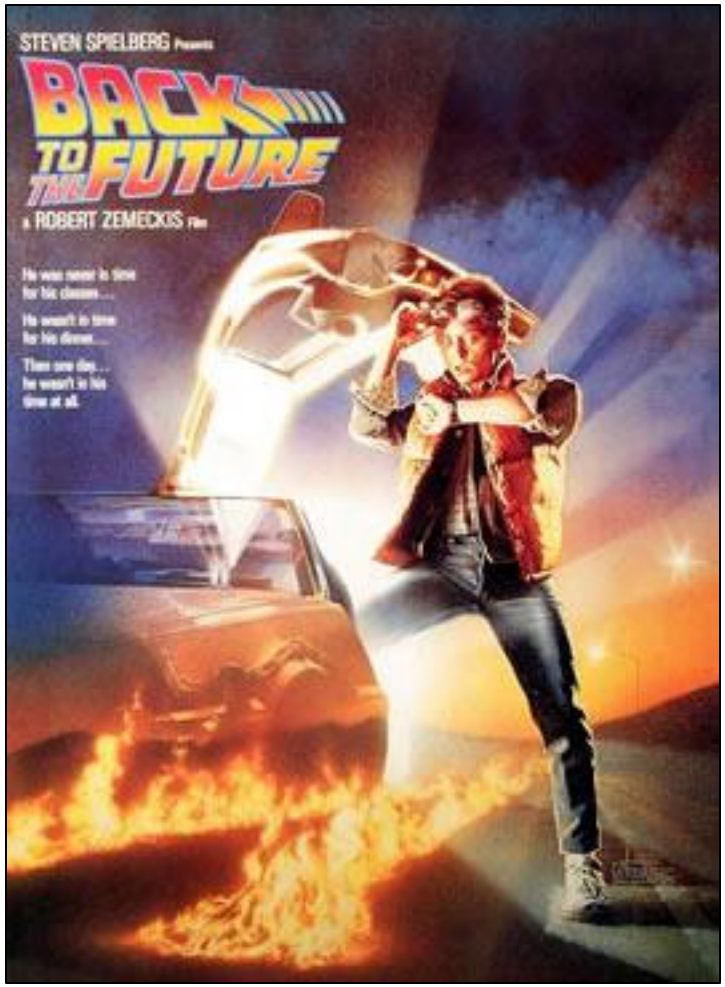
Historical Perspective: Geriatric Interdisciplinary Team Training (GITT)

Mid-1990s – the JA Hartford Foundation sought to improve care of older adults via GITT by:

- Creating national training models of partnerships between "real world" providers of geriatric care and educational institutions
- Improving academic responsiveness to the health care delivery system
- Developing well-tested curricula for GITT
- Creating a cadre of well-trained professionals competent in gerontology and interdisciplinary team skills
- Testing models of staff development training for practicing health professionals

Source: JA Hartford Foundation, 2001

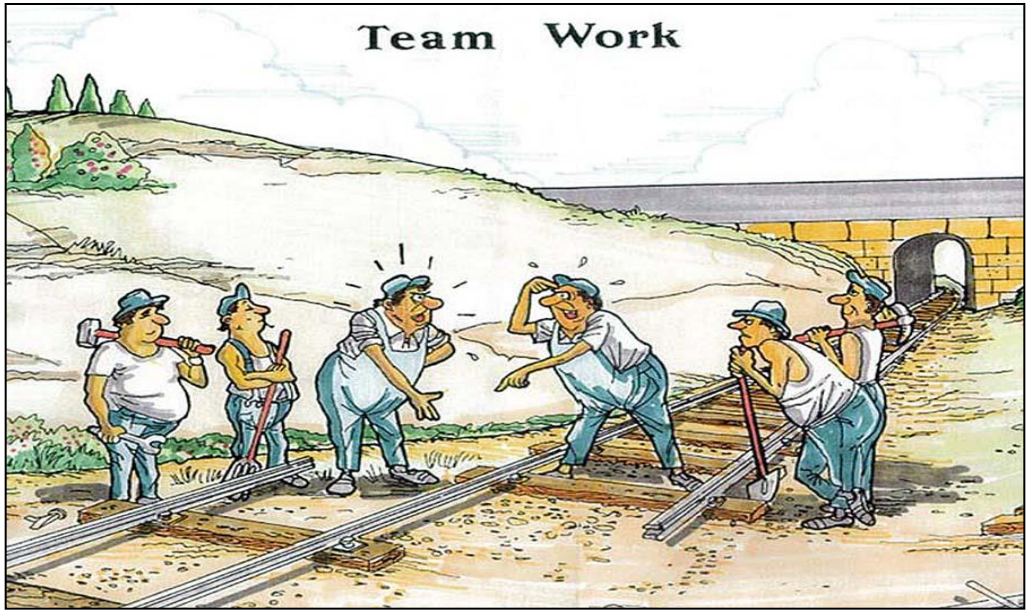
Historical Perspective: Back to the Future…



- 21st Century: Affordable Care Act (ACA) promotes person-centered care and interprofessional education and collaborative practice

Historical Perspective

Traditionally, each member of the health care team has trained in educational silos, perfecting his or her own skill set but with a limited understanding of each other's roles, each individual having a vast amount of experience ***but the team itself being a complete novice***.



TeamSTEPPS

TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety)

- Teamwork system jointly developed by DOD / AHRQ
- Designed to promote a safety culture and improve quality

Source: http://teamstepps.ahrq.gov

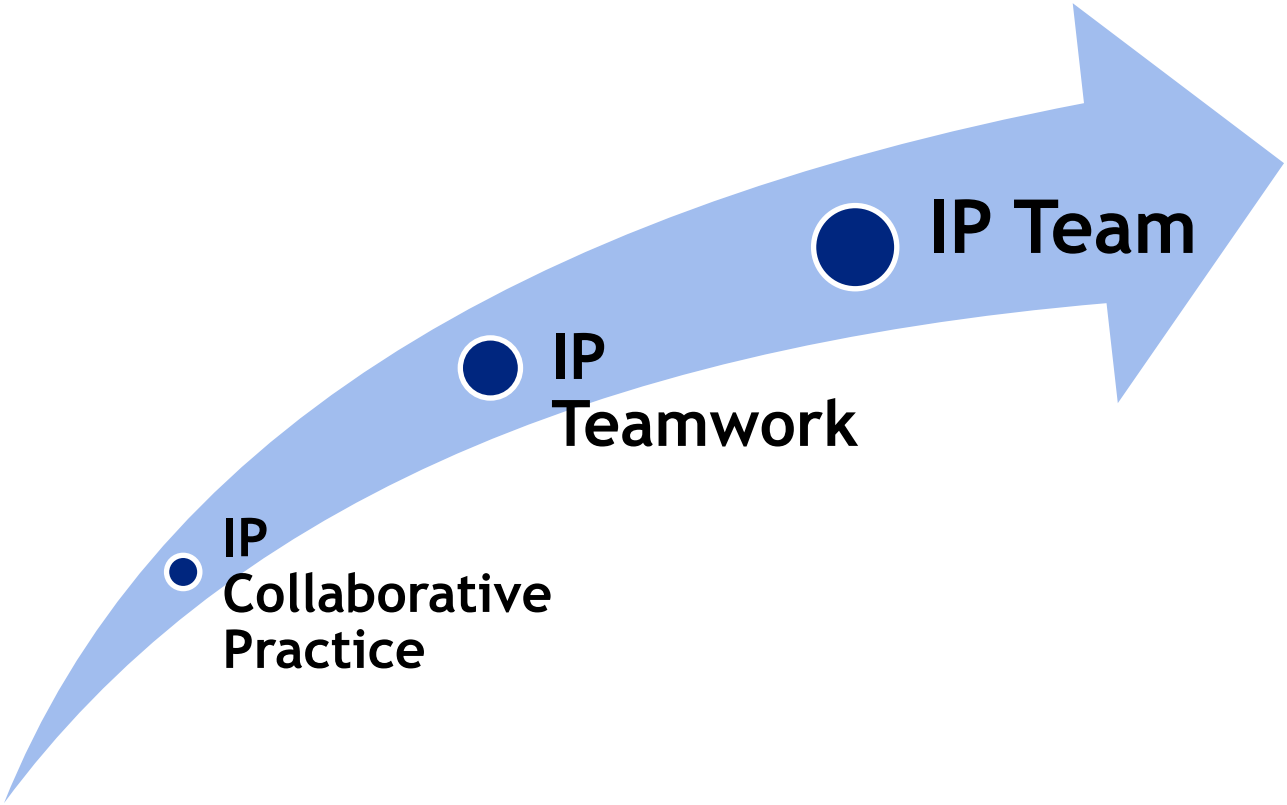
Why Does Interprofessional Practice and Education (IPE) matter?

- "…**how** care is delivered is as important as **what** care is delivered"*
- Evidence supports effectiveness of IP care†
- Gap between training and practice realities
- Need "collaborative practice-ready" graduates*

* Inter-professional Education Collaborative Expert Panel (2011)
† Partnership for Health in Aging (PHA) Position Statement (2010)

Spectrum of Interprofessional (IP) Care

Progression towards fully intentional team-based care



IPEC Competency Domains

Interprofessional Education Collaborative (IPEC) Expert Panel convened in 2011, and developed core domain competencies for interprofessional collaborative practice:

- Domain 1: Values/ethics for IP practice
- Domain 2: Roles/responsibilities
- Domain 3: IP communication
- Domain 4: Teams and teamwork

Effective Interdisciplinary Team (IDT) Care

Source: GITT Interdisciplinary Team Training Pocket Card

Effective Interdisciplinary Team (IDT) Care

- Recognize the strengths and limitations of the participant's social network and physical environment and how these influence the care plan
- Understand the responsibilities of different team members
- Identify appropriate services and supports along the continuum of care
- Recognize and address chronic complex problems in subsequent assessments of the participant and the plan of care

Source: GITT Interdisciplinary Team Training Pocket Card

Making Interdisciplinary Collaboration Work

- Clearly articulate your role on the team
- Understand the role of other disciplines on the team
- Identify and seek common ground with your interdisciplinary colleagues
- Acknowledge the differences among disciplines
- Address conflict and don't let resentment accumulate
- Be proactive in establishing and maintaining collegial relationships

Source: National Association of Social Workers (NASW) (Winter 2013). "Making Interdisciplinary Collaboration Work, Tools and Techniques" Washington DC: NASW.


collaboration
is everything

Person-Centered Care Planning: Adults with Disabilities

- People with a high level of complexity (clinical and socio-economic) need care coordination & case management that factor in the interaction of conditions with the complexities of their life

- A respectful & genuine person-centered approach is a key component of effective care coordination

Care Planning Process: Person-Centered Approach

- To understand the person's basic requirement for happiness: What is important "to" them?
- To reduce / manage risk within that context: What is important "for" them?
- To advocate for the person by keeping them at the center of care & treatment planning

Care Planning Process: Person-Centered Assessment

Face to face assessment:

- Gather comprehensive health & safety information from and about the person
- Guide them to tell their story and LISTEN
- Listen for their experience and perceptions
- Listen for their hopes and dreams
- Measure patient engagement (activation)

Care Planning Process: Person-Centered Questions

- In your day to day life what, if anything, would you like to be different?
  - Why is that important to you?
- Is there someone in your life who supports / helps you?
- How can we be of help to you?
- Name 1 or 2 things you hope to accomplish

Care Planning Process: Person-Centered Follow Up Plan

- Who would you like to include in your circle of support?
- How will we work together?
- What is the best way to stay in contact?

Care Planning Process: Expect and Respect the Dignity of Risk

- Every person needs enough control within their lives to choose what they value, and reject what they do not
- Health care professionals tend to move away from the concept of dignity of risk when patients are elderly or have disabilities

Care Planning: Adults with Disabilities

Strategies That Make a Difference

Patient activation* & engagement

- Increasing someone's activation can improve health outcomes and access to care
- Knowing the level of activation guides the approach to care planning

* Development of the Patient Activation Measure (2006, Hibbard)

Care Planning: Adults with Disabilities

Strategies That Make a Difference

- Motivational interviewing*: listen, guide, elicit
- Targeted care planning for highest risk persons
  - Low activation and / or multiple admissions
  - Short term goals
  - Goal attainment scale to ensure some level of success

* Motivational interviewing in health care: Helping patients change behavior (Rollnick/Miller 2008)

First Person Story: Jane Assessment

Health and safety assessment

- 38 y/o female post CVA, Type 2 Diabetes Mellitus
- Hypertension, major depression, chronic pain
- Independent with ADLs; some IADL dependencies
- Limited informal supports, at risk of isolation

Primary health concern

- Adjusting to new diagnosed Type 2 Diabetes
- Not adhering to follow up care and treatment plan
- Denies that she has diabetes

First Person Story: Jane
Motivational Interviewing

Person-centered discussion using motivational interviewing and patient activation tools and strategies reveals:

- Low patient activation level*; will need to take small steps so she can experience success
- Does not want to give up the few things that give her pleasure: soda and sweets
- Does not want to add another medication because she is on so many
- Very scared she is losing more of her independence
- As a result she is not taking hypoglycemic agent, not checking blood glucose, eating whatever she wants

* The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and healthcare.

First Person Story: Jane
Assessment to Care Planning

- Interdisciplinary team: Jane, Primary Care Provider (PCP), Care Coordinator and Home Care Nurse
- Care Coordinator accompanies Jane to PCP appointment
- Her "team" collaborates to establish a realistic plan that addresses:
  - What is important to her
  - What is important for her

First Person Story: Jane
Realistic Person-Centered Plan

- Jane's goals:
  - Check her BG daily
  - Reduce intake of soda pop
- Skilled nurse home visits to teach her how to monitor BG and nutrition
- Care Coordinator calls Jane and nurse weekly: coaching & monitoring progress toward goals
- Care Coordinator accompanies Jane to her PCP follow up appointments for 3 months

First Person Story: Jane
Outcomes at 3 Months

- Checking her blood glucose 5 days/week
- Reduced her intake of soda, resulting in weight loss and lower glucose readings
- Jane identifies that she has diabetes
- Jane identifies feeling much better
- Jane's more engaged with her health and health care, as shown by activation level* increase from 1 to 3 (out of 4)

* The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and healthcare.

Summary

- Person-centered assessment and planning looks at both what is “important for” and “important to” the individual
- It is essential to establish a relationship and build on mutual respect and trust
- Carefully planned, intentional interventions that are person-centered will foster better engagement and health outcomes

Audience Questions

Webinar Evaluation Survey

Next Webinars

"Managing Transitions"

Tuesday, November 5th, 2013

2:00 – 3:00PM Eastern

Session VI will focus on:

- Introducing the Transitional Care Model, and understanding the importance of managing transitions
- Understanding the need for managing non-medical transitions, including emotional, familial, social, vocational, financial, and housing

Targeted audience:

- Individuals who work with persons with disabilities, in particular those working in long term care, inpatient and home care settings

Next Webinars

"Flexible Long Term Services and Supports"

Tuesday, November 12th, 2013

2:00 – 3:00PM Eastern

Session VII will focus on:

- Integrating and coordinating all health care services and supports,
- Understanding the roles and responsibilities of the disability-competent interdisciplinary care team

Targeted audience:

- Individuals who work with persons with disabilities, in particular home and community-based service providers

Thank You for Attending

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  - Jessie Micholuk at jessie.micholuk@lewin.com
  - Kerry Branick at kerry.branick@cms.hhs.gov
- Disability-Competent Care Self-Assessment Tool available online at: https://www.resourcesforintegratedcare.com/

Resources & Reference

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Disability-Competent Care Self-Assessment Tool

1. Relational-Based Care Management

Introduction | 1. Relational-Based Care Management | 2. Highly Responsive Primary Care | 3. Comprehensive Long-Term Care | Appendix A

Participant-centered care is based on the recognition that the participant is not merely a passive recipient of medical care but rather the primary source for defining care goals and needs. This type of care requires cultivating a relationship with the participant, seeing him or her as a whole person with hopes and preferences, and recognizing that the participant is oftentimes the best steward of resources. Inherent in participant-centered planning is also the concept of the dignity of risk [1] which honors and respects the participant's choices even if they are inconsistent with the recommendation of the IDT.

[1] Dignity of risk means the right of individuals to choose to take some risk in engaging in life experiences, even if that choice would not be one that a health professional would choose (e.g. choosing to smoke).

- 1.1 Participant-Centered Practice
- 1.2 Eliminating Medical and Institutional Bias
- 1.3. Interdisciplinary Care Team (ICT)
- 1.4. Assessment
- 1.5. Individualized Plan of Care
- 1.6. Individualized Plan of Care Oversight and Coordination
- 1.7 Transitions
- 1.8 Tailoring Services and Supports
- 1.9 Advance Directives
- 1.10 Allocation of Care Management and Services
- 1.11 Care Partners
- 1.12 Electronic Health Record

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