RESOURCES FOR INTEGRATED CARE
Resources for Plans and Providers for Medicare-Medicaid Integration

Care Coordination

DCC Pillars Webinar Series



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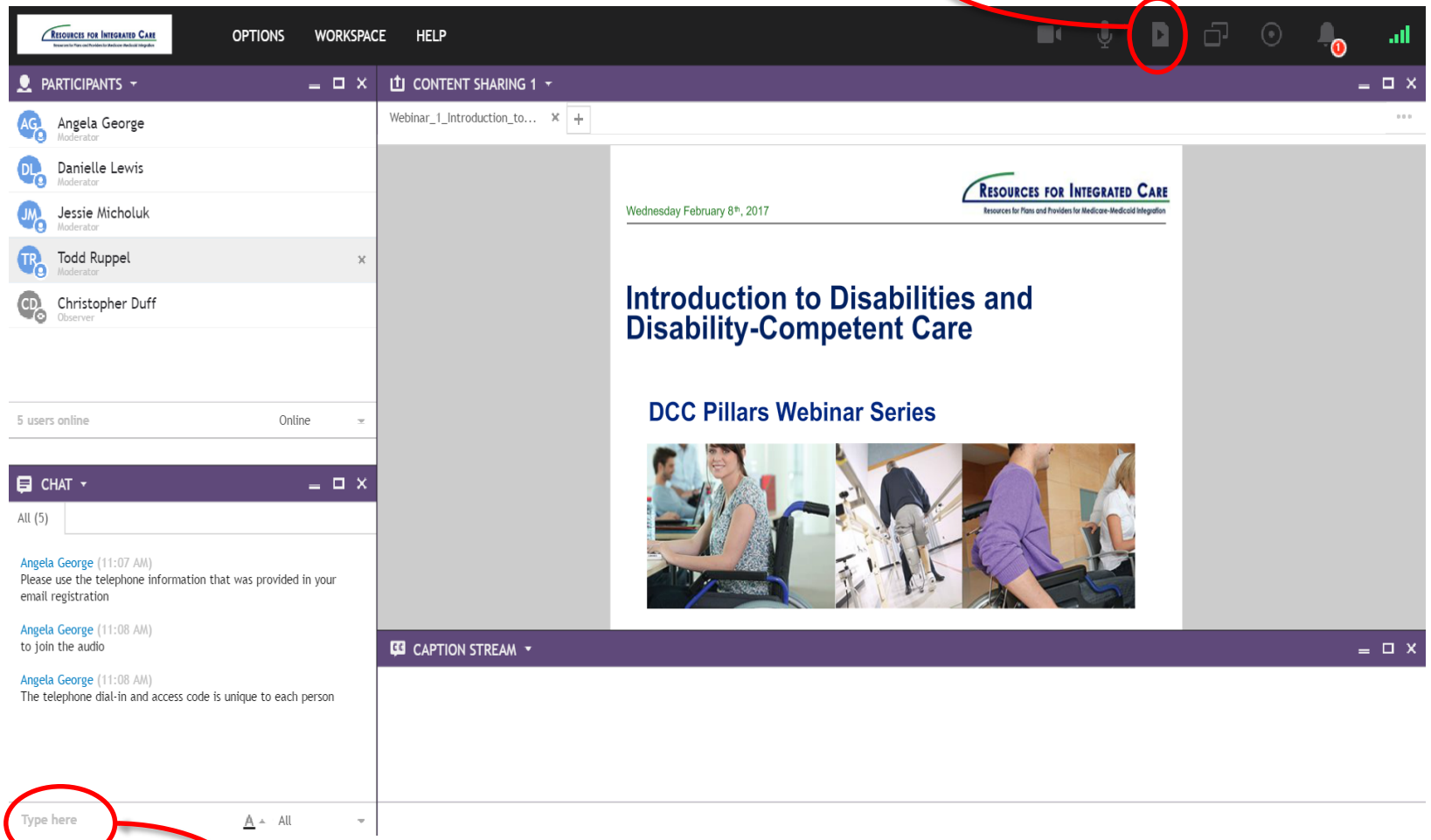

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Introductions

- Rachael Stacom, RN, ANP-BC
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  - Nurse Practitioner at Bronx Lebanon Multiple Sclerosis Center

- Christopher Duff
  - Disability Practice and Policy Consultant

Disability-Competent Care Webinar Series Overview

The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to create the "Disability-Competent Care Webinar Series".

- This is the fifth session of the seven-part series.
- Each session will be interactive, with 40 minutes of presenter-led discussion, followed by a 20 minute presenter/participant question and answer session.
- Video replay and slide presentation are available after each session at:

https://www.ResourcesForIntegratedCare.com/

DCC Pillars – Webinar Series

1. Understanding the DCC Model
2. Participant Engagement
3. Access
4. Primary Care
5. Care Coordination
6. Behavioral Health
7. Long Term Services and Supports

Agenda

1. The Interdisciplinary Team (IDT)
2. IDT communication
3. Implementation, management and oversight of the Individualized Care Plan (ICP)
4. Tailoring services
5. Health record
6. Critical areas for care coordination

Health Disparities

People with disabilities are more likely to:

- Experience worse outcomes and are less likely to receive the recommended care[1]
- Experience difficulties or delays in accessing the necessary health care, including primary care and timely follow up on equipment and supply needs
- Access barriers to recommended health screening tests[2] **(e.g., breast cancer, colorectal cancer or pap smears)**
- Not receive comprehensive preventive care **(e.g., BMI assessment, medication adherence, diabetes management, and annual flu vaccine)**
- Higher incidence of high blood pressure and hyperlipidemia

Sources: 1) Office of the Assistant Secretary for Planning and Evaluation. (2016). Report to Congress: Social Risk Factors and Performance under Medicare's Value Based Purchasing Programs
2) Disability and Health. Healthy People 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/ebrs

Social Factors

- Payers, including Medicare and Medicaid, are moving from traditional fee-for-service payment toward models that reward value over volume.
- Disability status and the health disparities are associated with poorer performance on measures that are linked to payment in value-based purchasing programs.
- On many measures of focus (e.g., cancer screenings, vaccinations, diabetes management), the clinical interventions are straightforward but communications and service delivery for people with disabilities stretch the disability competence of most providers.
- Improving outcomes for people with disabilities will have a direct impact on revenue for many providers and plans.
- DCC health coordination plays a significant role in addressing both the health disparities and social factors.

Source: 3) National Academies of Sciences, Engineering, and Medicine. (2017). *Accounting for social risk factors in Medicare Payment, Washington, DC*: The National Academies Press. doi: 10.1722

THE INTERDISCIPLINARY TEAM

Care coordination is team based, each member brings their unique competencies to benefit the participant with a comprehensive approach to care.

The Interdisciplinary Team (IDT)

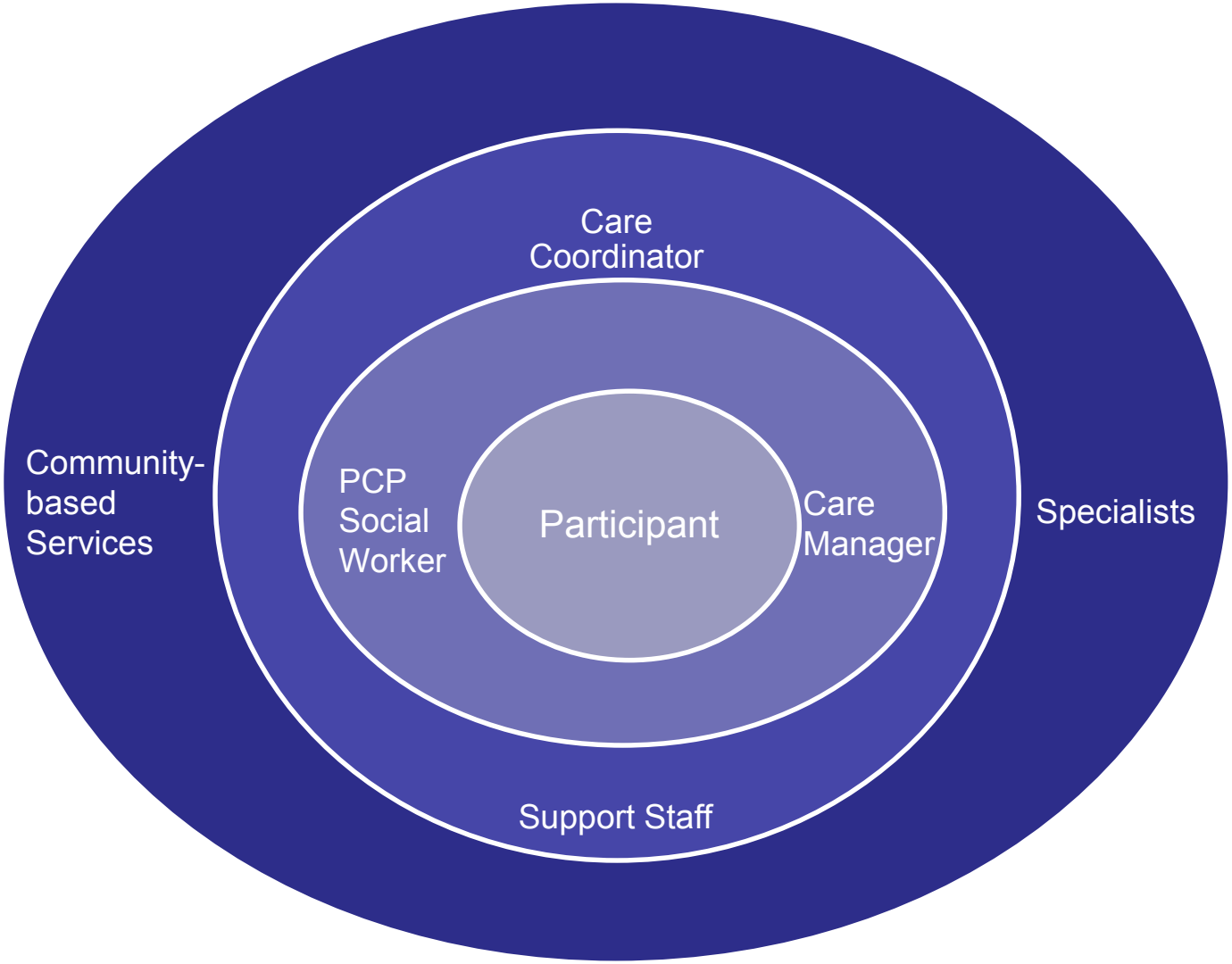
- Care coordination is provided by an interdisciplinary team (IDT); composed of persons with competencies in primary care, nursing, behavioral health and social work or community-based services.
  - Team members should understand and apply the concepts of disability-competent care[4].
  - Additional competencies (e.g., understanding the role of guardians when working with persons with ID/DD) may also be needed, based on the population being served.
- Care coordination provides oversight for the participant's care based on their goals and preferences.

Source: 4) Resources for Integrated Care website: https://www.resourcesforintegratedcare.com/concepts/disability-competent-care

Key Elements of Care Coordination

- Develop and maintain a trusting relationship
  - Understand the participant's capability and willingness to engage in their care.
  - Honor the participant's preferences and goals.
- Direct communication with the participant's support team upon their consent – family, home care workers, physicians and behavioral health specialists.
  - The participant should be included in the conversation whenever possible.
- Orchestrate necessary arrangements (e.g., appointments or Medicaid recertification, etc.) to facilitate the desired and needed care.

IDT Construct



Guidelines for the IDT

- Providers should have training and familiarity in providing disability-competent care and experience working with persons with disabilities.
- Roles and responsibilities should be clearly articulated and documented to ensure accountability and follow-through.
- A lead coordinator should be designated on the IDT.
  - Overall responsibility and accountability for the individualized care plan (ICP).
  - The lead role may change as the ICP is updated.
  - The relationship with the participant should be considered when choosing the lead; as they'll be the key communicator.

IDT Considerations

- The participant's primary language and any ethnic or cultural competencies should be considered when assigning them to an IDT.
- Participants should have the ability to designate a care partner (family member or close friend) to be involved in IDT-related or lead coordinator communications.
- The IDT collectively shares responsibility for the health and the well-being of each participant.
  - Expertise from each provider is shared with the participant so that they can make an informed decision.

IDT COMMUNICATION

IDT communication is key to the success of the team - which includes the participant, team, specialists and other involved parties.

Communicating with the Participant

- Value listening above all else.
  - Hear and understand the “real need(s)” being expressed by the participant.
- Begin communications from the participant’s perspective:
  - “What is most important to you?”
- Assess their understanding of their disability and functioning.
- Ask permission before offering health education and coaching.
- Ensure participants know how and when to reach out to the IDT for support.

Communicating within the IDT

- Establish a protocol for communication - should the participant's needs or situation change on short notice.
- The IDT should identify a lead who is responsible for regular contact with the participant.
- Designate points of contact for any external primary care providers that the participant uses, as well as key providers.
- IDT should convene on a regular basis to discuss participant updates, new assessments and reassessment reviews.
  - Clear responsibilities and mutual trust will expedite meetings.

IMPLEMENTATION, MANAGEMENT AND OVERSIGHT OF THE ICP

Ongoing oversight and review of the ICP is needed to ensure plans are effective and being followed, preventive strategies are in place and revisions are made based on the participant's evolving needs.

Implementing the ICP

- The work of care coordination begins once the assessment is completed and the ICP is developed *(refer to webinar 2)*.
- Ongoing oversight and review of the ICP is needed to ensure:
  - Plans are effective and being followed.
  - Preventive strategies are in place.
  - Revisions are made based on the participant's changing needs or unforeseen barriers.
- Specific procedures need to be in place to notify team members of participant status changes – physical and emotional health, housing, caregivers and others.
- Setting automated alerts in the health record will aid in the follow-up of routine activities to ensure they are not missed.

Allocating Care Management

- Participants may need varying levels of care management support and assistance.
  - Foster independence and avoid dependence.
- The amount, nature and frequency of care should be based on the participant's needs.
  - Care should be discussed through the assessment process and noted in the ICP.
- Allocation of individual staff time and criteria for assigning and managing participant panel size (number of participants assigned to a care manager) also needs to be taken into consideration.
  - Has to be manageable to be successful.

TAILORING SERVICES

Specific services and supports listed in the ICP result from the completed assessments and are modified based on the preferences and needs of the participant.

Care Plan and Service Decisions

- Services should be customized to meet the individualized need(s) of the participant - taking into consideration their goals of care, level of function and environment.
  - This flexibility may be a short-term change in intensity, an alternative support or a more cost-effective alternative.
- The more flexibility the IDT has in allocating benefits the more successful they well be.
- Traditional 'defined benefits' may need to be modified to achieve the outcomes identified in the participant's assessment.
- To ensure consistency among the different IDT teams, it is important to have clear guidelines for this flexibility and to give authority and accountability for managing the support.

HEALTH RECORD

A comprehensive health record is composed of many elements to include: assessment(s), ICP, medication lists, referrals and authorizations, care management notes and other appropriate information.

Health Record Role in Care Management

- The IDT overseeing the overall care plan is responsible for having and maintaining a health record for each participant.
- Records needs to be available to the full team, and accessible to any staff providing on-call or after-hours support.
- Automated alerts need to be in place to bring all significant changes to the attention of the IDT and key providers.
- Plans or providers should identify a specific IDT member who is responsible for updating and managing the health records.
- Participant access to the health record can maximize participation and coordination.
  - Since the ICP is a living document it's optimal to give participants access to a web portal

EHR Role in Quality Control and Improvement

- The EHR can also serve to provide the IDT and key external providers quality and performance information:
  - Inpatient and ER utilization
  - Outcomes of appointments
  - Medication
  - Other data points for care coordination
- Data can be used to identify opportunities for improvement, either panel-based or larger sets of participants.
- Making information easily available to the IDT and providers can
  - Aid efforts to refine and improve services.
  - Reduce health disparities and result in improved medical interventions / outcomes.

CRITICAL AREAS FOR CARE COORDINATION

Care transition and medication management needs should also be addressed alongside assessment and care plan development and implementation.

Care Transitions

- Transitions generally refer to a move into or out of a care setting; such as a hospital or nursing home.
- Transitions take a far broader scope when working with persons with disabilities and can involve:
  - Changes in care settings, providers of care and medications;
  - Financial, housing, legal and employment;
  - Other changes which may affect the participant's ability to live independently.
- Any transition represents an opportunity for potential errors to occur and requires alertness by the IDT to identify and oversee the change to ensure the safety of the participant.

Managing Transitions

- Develop a transition plan for significant changes that address all aspects of the transition process.
- Use protocols or checklists that can help the IDT members manage key transitions.
- Designate the responsibility of ensuring the successful completion of the transition and timely follow-up to an IDT member.
  - It's important to understand the reasons for the transition and to coordinate follow-up appointments and medication management.

Medication Management

- Many participants are on multiple medications, prescribed by numerous providers.
  - Ensure participants understand the reason for taking each medication.
- Based on the participant's ability, a care coordinator may need to assist in keeping track of medications.
- A central health record will minimize polypharmacy (simultaneous use of multiple drugs).
- Disability needs to be taken into consideration when prescribing medications (e.g., diuretics, insulin injections).
- A pharmacist consultation may be beneficial due to potential medication interactions.

Advance Directives

- Disability-competent care requires discussions on advance directives and end-of-life care issues with respect, sensitivity and awareness.
  - Entails having a trusting relationship with the participant.
  - Timing discussions is critical- ideally not during a crisis.
  - Consideration of functional status.
- Specialized training is important for this discussion as participants generally benefit for coaching through the process.
- Having a proxy or health care advocate ensures participant wishes are honored in the event their decision making capacity is lost.
- Advanced directives should be reviewed at least annually, with copies provided to key medical providers.

Camille's Story

- Camille is a 35 year old woman who is a self-described artist, advocate and pet owner. Most of her family lives out of town; however, she maintains contact with family and friends via the internet.
- Camille is on the autistic spectrum, has hearing and vision loss, a thyroid disorder (recently diagnosed), and recent weight gain which has caused difficulty walking due to swollen legs and pain.
- Her conditions recently led to a long hospitalization. The hospital recommended Camille go to a rehabilitation facility for therapy and specialty care.
- Camille, upset with the possibility of losing her apartment, cats and current lifestyle adamantly refused admittance into the rehabilitation facility.

Camille's Story Continued

- Her IDT respected her choice and worked with her to develop a plan for additional education and supports at home.
- Her IDT was modified to include home care services, more visits to her primary care physician and teaching her personal assistants to help her exercise.
- Camille begin to understand the connections between her weight gain, thyroid problems, leg swelling and skin issues.
- Camille also learned to use the local paratransit system to join community classes and see new friends.

CONCLUSION

Supporting and maintaining participant health and well-being is dependent upon having providers that can meet their needs in terms of availability, timeliness and disability competence.

Key Takeaways

- Care coordination is the 'glue' that keeps health care services and supports working with and for the participant.
- It is based on a relationship of trust and respect.
- Care coordination is not a specific person but a function or role. The person(s) performing the role vary based on the specific need or issue needing to be addressed
- Communication is key to success – with the participant, within the team, with care partners and others involved.

AUDIENCE QUESTIONS & DISCUSSION

Send Us Your Feedback

Help us diversify our series content and address current Disability-Competent Care training needs – your input is essential!

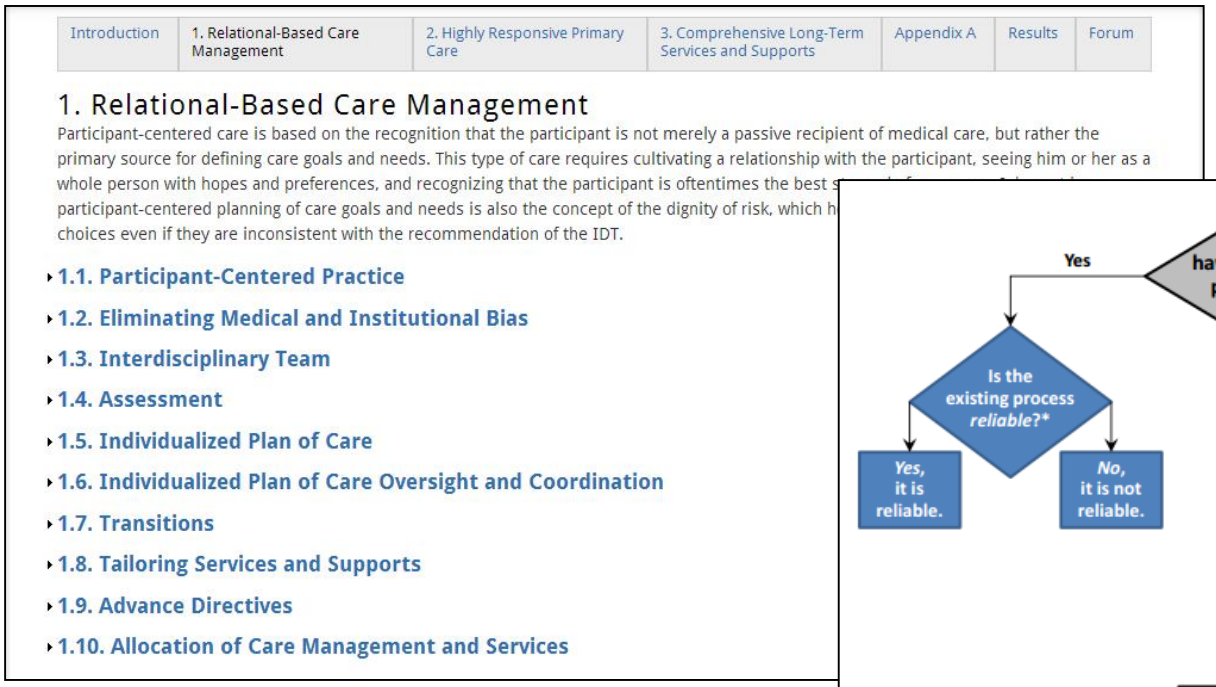
Please contact us with your suggestions at

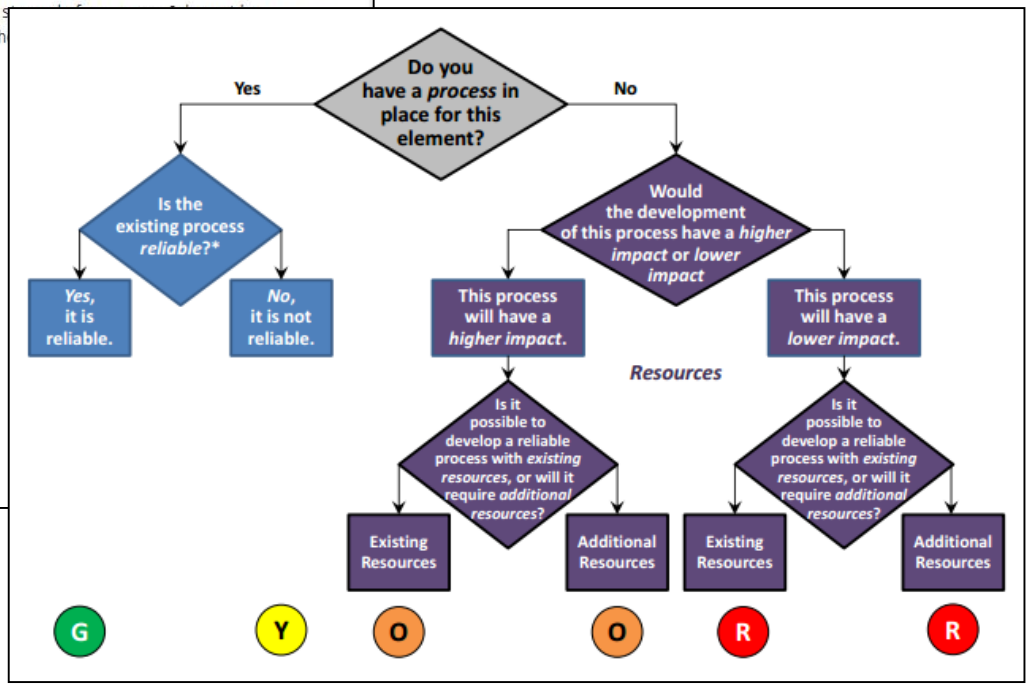
RIC@Lewin.com

What We'd Like from You:

- How best to target future Disability-Competent Care webinars to health care providers and plans involved in all levels of the health care delivery process
- Feedback on these topics as well as ideas for other topics to explore in webinars and additional resources related to Disability-Competent Care

Disability-Competent Care Self-Assessment Tool





Disability-Competent Care Self-Assessment Tool available online at:
http://www.ResourcesForIntegratedCare.com/

Next Webinar

Disability-Competent Care Webinar Series

Disability-Competent Behavioral Health

Wednesday March 15th, 2017
2:00-3:00PM ET

Thank You for Attending!

The LEWIN GROUP®

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  https://www.resourcesforintegratedcare.com