RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration

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 III: The Care Coordination Relationship

September 17, 2013

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Overview of Webinar Series

- This is the third of three webinars to be presented in September:
  I. "Disability-Competent Care – What Is It and Why Is It Important" 9/4/2013
  II. "Understanding the Lived Experience of Disability" 9/10/2013
  III. "The Care Management Relationship" 9/17/2013
- Each presentation is about 45 minutes with 15 minutes reserved for Q&A
- Webinars are recorded and 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

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Webinar Agenda

- Defining Care Coordination
  - Relational Care Coordination
  - Establishing and maintaining participant relationships
- Lessons in Care Coordination research
- Introduction to Interdisciplinary Care Teams
- Composition of Interdisciplinary Care Teams
- Care Coordination process
- Audience questions

First Person Story: Carmen

- 45 yr. old woman living with quadriplegia since a car accident at age 14
- Lives independently with PCA support, and part time works as an academic researcher
- Medical conditions include: neurogenic bladder, history of skin breakdown, asthma and decreased pulmonary capacity
- Has a good network of specialists, but no primary care
- Averages 8-10 medications daily, prescribed by various specialists

Carmen's Recent Medical Experience

- Six hospitalizations over the last 18 months
- Including two with long intensive care stays for intubations and extended rehabilitation
- Admitting diagnoses included: pneumonia (X2), skin decubiti (X2)
- Relies on ER for primary care

Defining Care Coordination

- Care Coordination provides oversight for participant's care and is based on individual goals and preferences
- Coordination is provided by an interdisciplinary team composed of persons with competencies in primary care, nursing, behavioral health and social work or community-based services
- The Care team has ongoing contact with the participant to:
  - Frequently monitor medical and psychosocial conditions
  - Develop and maintain a trusting relationship

Lessons from the Medicare Coordinated Care Demonstration

- Thirteen-site Medicare Demonstration
- Practice-based care coordinators
- All staffed by experienced registered nurses or nurse practitioners

Source: Brown, R, Peikes, D, Peterson, G, Schore, J & Razafindrakoto, CM. (2012). Six features of the Medicare Coordinated Care Demonstration Programs that Cut Hospital Admissions. Health Affairs, 31 (6). 1156-1166.

Lessons from the Medicare Coordinated Care Demonstration

- Recommendations included:
    1. Face-to-face contact with patients
    2. Face-to-face contact with physicians
    3. Patient education
    4. Managing care setting transitions
    5. Communications hub
    6. Medication management

Lessons from the Medicare Coordinated Care Demonstration

- Findings suggest that programs with more in-person contacts were more likely than others to build trusting relationships, that resulted in:
  - Improved patient adherence to care plans
  - Additional needs and barriers bring addressed that entirely telephonic contacts had been unable to identify
  - More effective care by focusing on the highest risk patients, for whom the largest savings resulted

Source: Peikes, D, Peterson G, Brown RS, Graff, S, & Lynch JP. (2012). How Changes in Washington University's Medicare Coordinated Care Demonstration Pilot Ultimately Achieved Savings. Health Affairs, 31 (6). 1216-1226.

Lessons from the Medicare Coordinated Care Demonstration

Washington University redesigned their model

- Original intervention had no decrease in hospitalizations or cost
- Redesign included stopping remote care coordination, in order to do frequent phone and occasional in-person contacts in St Louis
- Care coordination efforts were focused on patients at highest risk for hospitalization
- Stronger hospital transition planning and medication reconciliation
- After redesign, the program reduced hospitalizations by 12% and monthly Medicare spending by $217 per enrollee—more than offsetting the program's monthly $151 care management fee

Care Coordination Relationship

- 1:1 in-home assessment with interdisciplinary care team
- NP completes complete history and physical exam
- Participant supports NP's offer to coordinate specialists
- Team works with participant to develop the care plan, integrating preferences and goals
- Discussion and education regarding urinary care
- Review of medications – modifications and education
- Regular visits and phone calls at defined intervals

Carmen's Care Coordination Opportunity

Integrating home and community-based supports

- Carmen hires and manages her PCA
- Seating and wheelchair assessments
- Home modifications
- Exercise class

Care Coordination Components

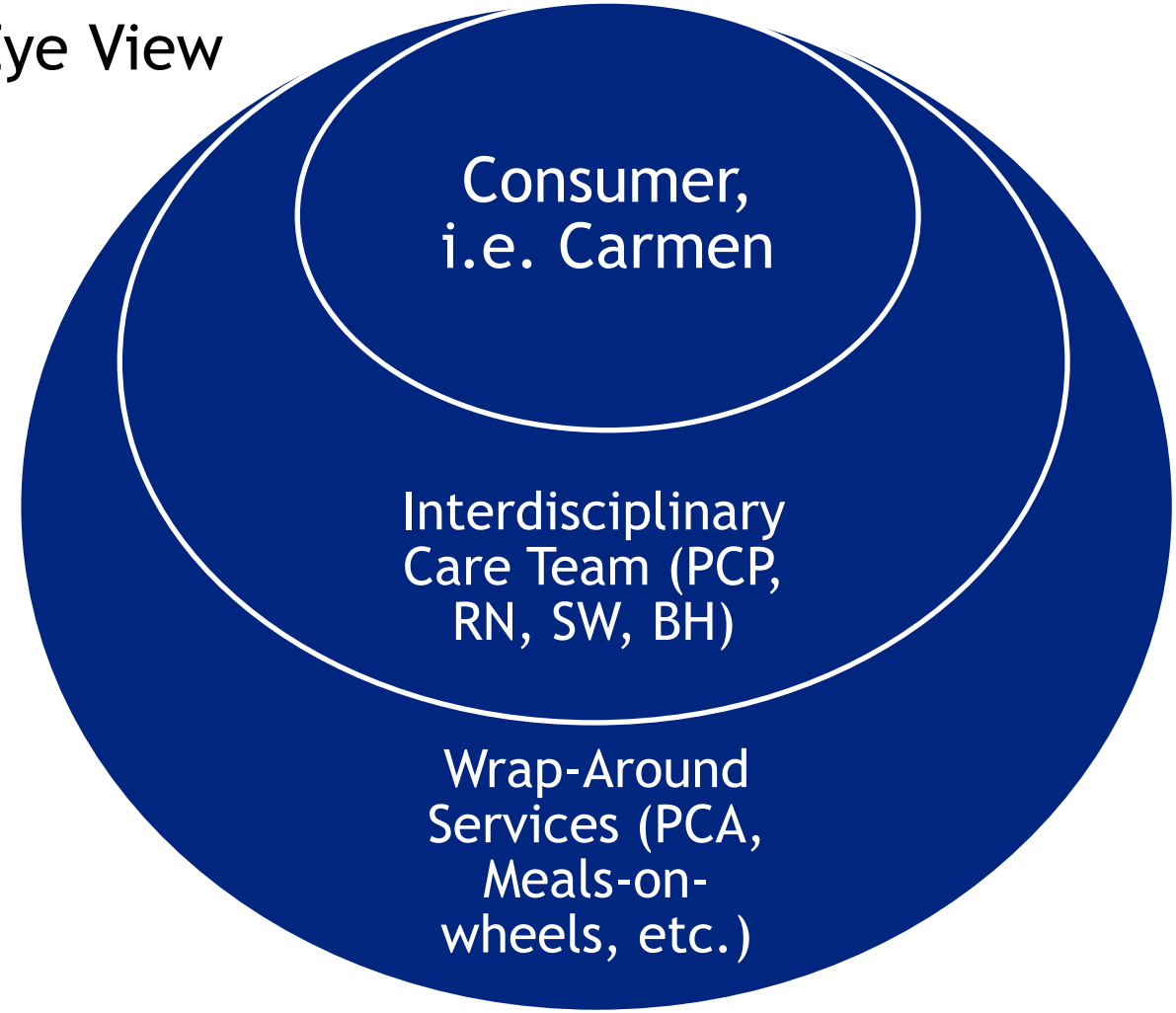
- Comprehensive, timely assessment and reassessment
- Personalized plans of care, incorporating the individuals' health care goals and preferences
- Coordination of decision-making across all settings of care and support
- Designated coordinator with experience in working with persons with disabilities
- Participant-centered care and support team, involving family, clinicians and caregivers – identified by the member
- Respect for the dignity of risk and informed decision-making

Key Elements of Relational Care Coordination

1. Trusting relationship
2. Honoring the participant's preferences and goals
3. Direct communication with the participant's physicians
4. Comprehensive, timely assessment and reassessment
5. Contact with caregivers, with the consent of the participant
6. Participant is coached when to call
7. Commonly entails regular visits with weekly calls

Interdisciplinary Care Team

Bird's Eye View



Composition of Interdisciplinary Care Team

Clinician	Functions
NP/MD	Comprehensive assessments, care plan development and management, 1st responder, care coordinator, 24 hour care availability. Integrates specialty and hospital care, complex care management, 24 hour call
Behavioral Health Specialist	BH assessment, BH care plan development, BH network management.
SW/LTSS Specialist	Response to housing, eligibility, crisis management issues etc.
Rehabilitation Specialist	Functional care plan development, monitoring and management.
DME Coordinator	Management and allocation of medical equipment supplies.

Interdisciplinary Care Team

Core Values

- Participant-centered
- Ensure participant dignity of risk taking
- No medical & institutional bias

Interdisciplinary Care Team

The IDT will maintain maximum function - health, wellness, & life in community as participant chooses.

- Provides care & support needed at any time in life, in any setting
- Centered towards participant's goals and preferences
- Facilitates personal care services
- Allocation of care coordination intensity & support varies
- Plan of care (oversight & coordination)
- Weekly communication

Interdisciplinary Care Team

Process:

- Appropriate comprehensive assessment and re-assessment in order to provide needed and wanted care and support
- Determine with the input of the participant, the intensity of Care Coordination service preferred and needed
- Individualize Care Plan
- Teach participant when to call the Care Coordinator
- Meet regularly with IDT to coordinate, prioritize and re-evaluate what is working and what is not working and revise the care plan with input of the participant

Common Practices in DC Care Coordination

1. Culturally sensitive care coordination approaches
2. Flexible benefit packages, beyond contractually mandated Medicare and Medicaid services
3. Frequent monitoring of members with chronic conditions
4. Emphasis on patient education and patient self-management programs
5. Care coordination structures for dealing with particularly complex cases
6. Centralized information systems for sharing information across providers

Interdisciplinary Care Team

Integrating Home & Community-Based Services

- Build upon the principles of the use of flexible funding of community based services and supports
- Personal care services using either the participant-directed or agency model
- Wheelchair purchasing, fitting, seating, and maintenance
- Equipment and technology to maintain or improve functional independence
- Flexibility to use alternatives to traditional home-based supports
- Safeguards to eliminate institutional bias
- Respect for the dignity of risk and informed decision-making

Interdisciplinary Care Team

IDT Meeting Structure

- Occurs weekly and attended by entire team
- Agenda is prioritized:
  - Review of participants who have been to the ER or hospital
  - Discussion of participants who are not stable
  - Discussion of participant's needs and preferences that require further problem-solving
  - Routine reassessments

Allocating Team Resources

First Step: Stratify the Population

Traditional approaches (the science) are based on risk profiles

- Diagnoses
- Utilization history – avoidable hospitalizations and ER visits

Other approaches (the art)

- Existence of co-existing or secondary factors - family supports, economic challenges, age, cognitive
- Member preferences

Allocating Team Resources

Levels of Care Coordination

Care Coordination requires a relationship with the member

- Self-Managed – where the goal is to ensure ease of access (removal of 'managed barriers') and education
- Episodically Managed – where the goal is timely intervention
- Continually Managed – where the goal is prevention and ensuring the delivery of needed care and supports, while addressing complicating factors

Summary

- Care coordination must be face-to-face to develop trust, so they call when first experiencing early symptoms
- Target those most at risk for hospitalization with particular focus on transitions and medication management for continuous care coordination
- Ongoing oversight as needed, varied by individual
- Direct communication lines must be open with the patient's physician, unless the NP is the primary care provider

Audience Questions

Webinar Evaluation Survey

Next Webinars

The next 3-part webinar series in October will focus on:

- "Providing Disability-Competent Primary Care"
  - Redesigning primary care delivery to serve adults with disabilities
  - Preventing avoidable hospitalizations and episodes of illness
- "Disability-Competent Care Planning: The Individualized Plan of Care"
  - Exploring the Interdisciplinary Care Team and introducing the Care Planning Process
  - Aligning care coordination resources with the unique needs of each participant
- "Flexible Long Term Services and Supports"
  - Integrating and coordinating all health care services and supports
  - Understanding and supporting participant choices for community-based living

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.

What We'd Like From You:

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Thank You for Attending

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- Disability-Competent Care Self-Assessment Tool available online at: https://www.resourcesforintegratedcare.com/

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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