The Care Coordination Relationship

Leading Healthcare Practices and Training:
Defining and Delivering Disability-Competent Care

Disability-Competent Care coordination facilitates integrated oversight of care that is guided by the participant's goals and preferences. It is based on a trusting relationship between the participant and providers built on frequent interactions between participant and interdisciplinary care team.

The **interdisciplinary care team (IDT)** is responsible for care coordination that is achieved through the inclusion of team members of varying disciplines, mutual respect given to the unique knowledge and skills of those members, and shared responsibility for the improved health and happiness of the participant. The team is composed of a primary care provider (which may be a nurse practitioner, physician's assistant, or physician), behavioral health specialists, social workers, and physical and occupational therapists. The IDT works closely with caregivers, including personal care assistants and community programs (e.g. Meals on Wheels). A nurse practitioner generally serves as the care coordinator. The behavioral health specialist(s) performs assessments and refers the participant to an appropriate provider for care when necessary. The social worker(s) addresses concerns about an array of issues that may directly or indirectly affect health, such as housing, finances, insurance, food stamps, crisis management, social life, personal care attendants, and possibly durable medical equipment (DME). Some IDTs include DME coordinators, who are non-clinical personnel who ensure that a participant's equipment is in order.

The **care coordination process** begins with a face-to-face meeting between the IDT and the participant to discuss the participant's health care goals and preferences. With this information and information from a comprehensive needs assessment, the team develops an **individualized plan of care**. The participant is involved in every step of the planning process. The plan of care is a live, dynamic document that is reevaluated periodically. The IDT meets regularly and communicates with the participant at established intervals to develop a trusting relationship.

The care coordination function of the IDT is based on the following:

- An individualized plan of care that reflects the participant's goals and preferences
- Active involvement of the participant
- Direct and frequent communication between the care coordinator and participant about any concerns
- A focus on the independent living philosophy
- Avoidance of the medical model of care
- Respecting a participant's dignity of risk
- Visiting the participant in the home or community to ensure independence
- Remaining culturally-sensitive and language-competent
- A trusting relationship between the participant and the care coordinator
- 24/7 availability

- Timely intervention

Additional Resources

The Disability-Competent Care Model is based on the lived experiences of persons with disabilities and over 20 years of experience at three health plans. For more information, please visit the *Resources for Integrated Care* website (www.resourcesforintegratedcare.com). There you will find the "Defining and Delivering Disability-Competent Care" webinar series, which was the basis for this brief and other resources on the Disability-Competent Care Model.