Fully Integrated Duals Advantage (FIDA)

FIDA Provider Training

Prepared by Provider Training Stakeholder Workgroup

This presentation covers the following topics:

- Overview & Advantages of FIDA
- Eligibility and Enrollment
- Covered Benefits, Items and Services
- FIDA Model of Care
- Interdisciplinary Team (IDT)
- Comprehensive Assessment (UAS) and Person-Centered Service Plan (PCSP)
- Authorizations
- Grievance and Appeals
- Transition of Care
- Long-Term Services and Supports (LTSS)
- Community Resources
- Balance Billing
- Marketing
- Important aspects of the FIDA Plan

Overview & Advantages of FIDA

Overview of FIDA

- FIDA- Fully-Integrated Duals Advantage Program
- FIDA will consolidate the number of separate sources of coverage for dual eligible Participants to a single primary source
- Three Year Demonstration with enrollment and service delivery starting January 1, 2015
- FIDA will serve people eligible for Medicare, Medicaid and Long Term Care Services

How Will FIDA Improve Participants' Health and Quality of Life?

- Simpler for Participants!
  - Enrollees are referred to as Participants as they are participating in this demonstration.
  - Participants in FIDA will be able to get all their care through one health plan – this means one ID Card for all services!
- Better Overall Care Coordination
  - Participants in FIDA will have more individualized care plans and better supports to stay well and safe longer in their homes
- Better Communication among Providers, Caregivers and Participants
  - Everyone involved in the Participant's care knows what is going on – all the time!

Why Should Patients Enroll in FIDA?

FIDA eligibles are the most vulnerable population, who often suffer from lack of care coordination which leads to higher hospital admissions and higher risk of medication interaction.

Benefits of FIDA Participation
One card and one Plan for all health care services.
Interdisciplinary team (IDT) helps manage care to ensure that most coordinated care is delivered.
One FIDA Plan Care Manager ensures access to all care needs.
Can switch among FIDA Plans or switch back to an MLTC Plan up to once per month.
All IDT and FIDA Plan Utilization Management decisions are appealable.

Why Should Providers Participate in FIDA?

- FIDA provides an opportunity to deliver better care for your most vulnerable patients.
- FIDA provides opportunities to work more closely with other providers your patients see, ensuring better overall care.
- In the long-run, FIDA will save providers time as the FIDA Plan will help coordinate care and support the participant to be compliant with their care plan.
- The program expects to increase health care access, coordination and understanding for Participants and thereby decrease avoidable hospitalizations and urgent care visits.
- There is no need to bill multiple parties (e.g., NYS Medicaid, other health plans for cost sharing) as the FIDA Plan will pay providers in full.
- Encourage your patients to participate in FIDA so they can experience the benefits of better coordinated care.
- Primary Care Providers will find that the FIDA Model of Care is similar to the Patient Centered Medical Home method of organizing primary care.

How will providers be paid by FIDA Plans?

- Each FIDA Plan has their own claims submission process and must pay all clean electronic claims within 30 days of receipt and clean paper claims within 45 days of receipt.
- There is no need to bill multiple parties (e.g., NYS Medicaid, other health plans for cost sharing) as the FIDA Plan will pay providers in full.
- Each Plan must distribute a Participating Provider Manual (updated annually) to the providers in their Plan's network by January 1, 2015 with information containing (but not limited to) the following:
  - Participant information, rights and responsibilities
  - Quality improvement for health services programs
  - Provider billing and reporting practices
  - Claims and Encounter submission processes
- Plans must develop a plan for a fully integrated payment system as an alternative to the traditional fee-for-service method by July 1, 2015 (pay for performance, bundled payment, etc.). The alternative payment system will go into effect no earlier than January 2016.

Eligibility and Enrollment

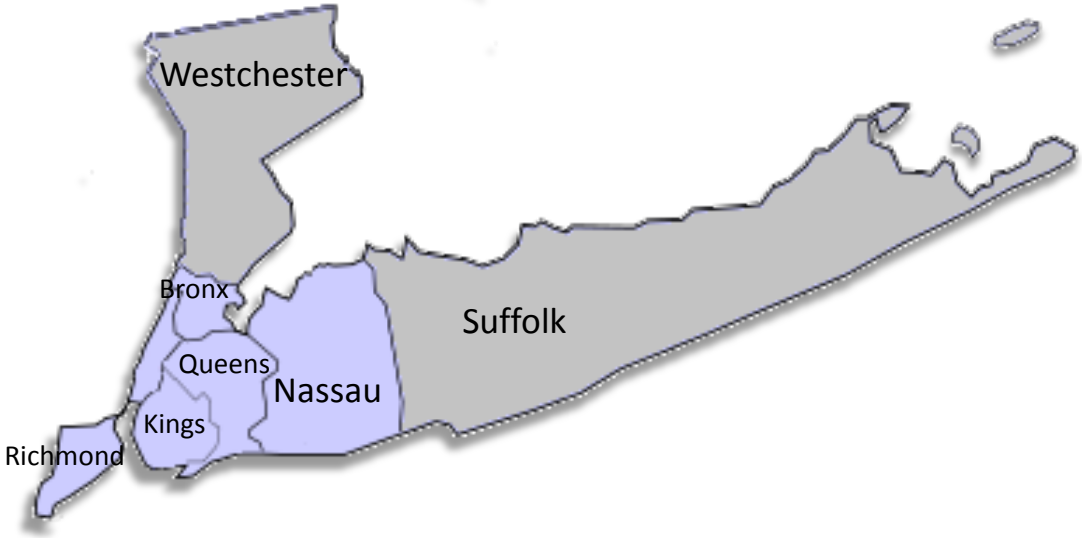
Eligibility for FIDA

Eligible Participants for FIDA must be:

- Age 21 years of age or older;
- Entitled to or enrolled in Medicare Part A, enrolled Medicare Part B, eligible to enroll in Medicare Part D, and receiving full Medicaid benefits;
- Living in a demonstration county:

  Region I: Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond, and Nassau.

  Region II: Suffolk and Westchester.



And meet one of the following three criteria:

- Are Nursing Facility Clinically Eligible and receiving facility-based LTSS,
- Are eligible for the Nursing Home Transition Diversion Waiver program, or
- Require community-based Long Term Supports and Services (LTSS) for more than 120 days.

Enrollment

- There are two types of enrollment for eligible individuals:
  - **Opt-in Enrollment** which is initiated by an eligible individual or the individual's authorized representative.
  - **Passive Enrollment** which is enrollment by the State which the eligible individual can decline by opting out.
- All enrollments (opt-in and passive) will be through the Enrollment Broker, New York Medicaid Choice (Maximus).
- Participants may disenroll at any time during the demonstration and return to their original or a different MLTC plan and can choose a Medicare Advantage Plan or Medicare Fee For Service with a Medicare Part D plan and it will generally be effective at the end of the month in which the disenrollment request is made.

Enrollment: Populations Eligible for Opt In Enrollment

- Individuals who are eligible for opt in enrollment to a FIDA plan, but excluded from passive enrollment are:
  - Individuals eligible for the Nursing Home Transition & Diversion (NHTD) 1915 (c) waiver
  - Native Americans but they may opt in to the Demonstration at any time;
  - Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable;
  - Aliessa Court Ordered Individuals;
  - Individuals enrolled in PACE;
  - Individuals enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals;
  - Individuals enrolled in Health Homes;
  - Individuals assigned to a CMS Accountable Care Organization (ACO) as of the point in time they would otherwise be included in the passive enrollment phase;
  - Individuals participating in the CMS Independence at Home demonstration; and
  - Individuals enrolled in Employer or Union Sponsored coverage for employees or retirees.

Enrollment Timeline

- Eligible individuals in Region I (NYC/Nassau County) will receive the FIDA Program Announcement Letter in December 2014. Region II (Westchester and Suffolk) implementation has been delaying until further notice.

- The FIDA Program Announcement Letter will be the first communication eligible individuals will receive notifying them of their eligibility for the FIDA Program and their ability to opt in to FIDA.

- Region I and II will receive a 90-day, 60-day, and 30-day Passive Enrollment reminder notices before their scheduled Passive Enrollment effective date. All notices will explain their right to opt-out of the program. The 60 and 30 day notices will state the name of the plan into which the person will be passively enrolled and will state the right of the person to pick a different plan (or opt-out).

- All initial enrollment contact should be between individuals and New York Medicaid Choice (MAXIMUS), the Enrollment Broker at **1-855-600-FIDA: TTY 1-888-329-1541,** Monday-Friday, 8:30am to 8pm and Saturday, 10am to 6pm, or **www.nymedicaidchoice.com** **.**

Click the links below for listing of FIDA Plans

New York City FIDA Plans

Long Island FIDA Plans

Covered Benefits, Items, and Services

Covered Benefits, Items, and Services

- All Items and Services provided under Medicare Part A
- All Items and Services provided under Medicare Part B
- All Items and Services provided under Medicare Part D
  - The integrated formulary must include any Medicaid-covered medications and prescription drugs and certain non-prescription drugs that are excluded by Medicare Part D. The Medicaid-covered medications and prescription and certain non-prescription drugs required for inclusion in the integrated formulary are those listed in the Medicaid State Plan. In all respects, Part D requirements will continue to apply.

Covered Benefits, Items, and Services, cont.

- All Covered medications, items and services provided under New York State Plan services (including Long-Term Services and Supports (LTSS)),
- Many home and community-based waiver services
- Other health and wellness services added to the Demonstration
- Four services are still available to Participants but not through the plan. These are available through Fee For Service and include:
  - Hospice
  - Out of Network Family Planning Services
  - Methadone Maintenance Treatment Program (MMTP)
  - Directly Observed Therapy for Tuberculosis Disease (TB/DOT)
- ***Please see Appendix A for a complete list of services available under FIDA***

FIDA Model of Care

FIDA Model of Care

- Model of Care
  - Integrate benefits and improve care coordination to bring together primary care physicians, specialists and community-based and facility-based long term supports and services who will focus on health, behavioral health and other social needs.
  - Create a comprehensive person-centered service plan (PCSP) designed to meet the health care needs of the Participant.
  - Promote independence in the community
  - Ensure adequate accessibility to health care services

Interdisciplinary Team (IDT)

Interdisciplinary Team (IDT)

- FIDA Plans are required to use an Interdisciplinary Team (IDT) approach to provide each Participant with an individualized comprehensive care planning process in order to maximize and maintain every Participant's functional potential and quality of life.
- The FIDA Plan is responsible for planning and arranging the IDT Meetings.
- The IDT, **led by the FIDA Plan accountable care manager**, will ensure integration of the Participant's medical, behavioral health, community-based or facility-based long term supports and services (LTSS), and social needs.
- The estimated time to conduct an IDT meeting will vary based on the Participant's needs, but it is expected to be between 30-60 minutes.
- The IDT composition will be based on a Participant's specific preferences and needs and each member will be sure to respect the Participant's linguistic and cultural competence and treat them with dignity.

Interdisciplinary team (IDT), cont.

FIDA Plan is required to have an IDT consisting of following team members:

- **Participant** and/or an authorized representative, family member, or a participant's friend
- **Primary Care Provider** (**PCP**) or a designee with clinical experience from the PCP's practice who has knowledge of the Participant 's needs
- **FIDA Plan Care Manager** – leads IDT and responsible for ensuring provision of care services
- **Behavioral Health Professional,** if there is one, or a designee with clinical experience from the professional's behavioral health practice who has knowledge of Participant's needs
- Participant's **home care aide(s**), or a designee with clinical experience from the home care agency who has knowledge of the Participant's needs
- Participant's **nursing facility representative**, who is a clinical professional, if receiving nursing facility care
- **Other providers** either as requested by the Participant or designee; or as recommended by the IDT
- The **RN who completed the Participant's Assessment**, if approved by the Participant or designee

IDT Responsibilities

- Each IDT member is responsible for:
  - Actively participating in the IDT service planning and care management process;
  - Attending meetings - whether in person, or by means of real-time, two-way communication, such as by telephone or videoconference;
  - Regularly informing the IDT of the medical, functional, and psychosocial condition of each Participant;
  - Remaining alert to pertinent input from other team members, Participants, and caregivers; and
  - Documenting changes of a Participant's condition in the Providers' own medical record for the Participant, consistent with policies established by the FIDA Plan.

IDT Responsibilities, cont.

- The IDT as a whole is responsible for making coverage determinations as part of service planning.
- All service plans developed by the IDT act as authorizations for those items and services contained within.
- After the first IDT meeting, the IDT must convene routinely, but not more than six months from the previous IDT meeting.
- These meetings may occur more frequently, since the IDT must reconvene after a Reassessment due to a qualifying trigger event (hospitalization, change in health status, etc.).

IDT Responsibilities, cont.

- IDT members must operate within their professional scope of practice appropriate for responding to and meeting the Participant's needs and complying with the state and federal licensure and credentialing requirements.
- When a care decision is required to be made by a provider with a certain licensure and/or certification, the ultimate decision always rests with the appropriately licensed or certified treating member(s) of the IDT.

IDT Responsibilities, cont.

By joining a FIDA Plan, the patient and the provider agree to participate in the IDT process!

Comprehensive Assessment (UAS) and Person-Centered Service Plan (PCSP)

Comprehensive Assessment (UAS-NY)

- The initial Comprehensive Assessment (UAS-NY) is completed by the FIDA Plan Assessment Nurse in the Participant's home, hospital, nursing facility, or any other setting and must be completed using the NYSDOH Approved Assessment as outlined below:
  - 60 days from the effective date for community-based and facility-based individuals who are passively enrolled.
  - 30 days from the individual's enrollment effective date for all other Participants.
- The results of the Comprehensive Assessment will confirm the Participant's acuity, and be the basis for developing the Person Centered Service Plan (PCSP).

Person-Centered Service Plan (PCSP)

- Person-Centered Service Plan (PCSP) is a written document created by the IDT and housed in the care management record of the Participant which outlines all of the services the Participant needs and when, how, and by whom those services will be provided to Participant.
- The Person-Centered Service Plan includes specific health care goals to be achieved and the amount, duration, and scope of the covered services.
- The IDT is responsible for developing the first Person-Centered Service Plan within 30 days of conducting the Comprehensive Assessment and managing the on-going care plan.
- The Participant (or Authorized Representative) must physically sign a copy of the Person-Centered Service Plan.

Person-Centered Planning Process

In developing the Person-Centered Service Plan (PCSP), the IDT will:

- Assess the immediacy of the new Participant's services needs and include a description of the Participant's condition (Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), limitations, incontinence, cognitive impairment and health conditions as identified through the assessment
- Identify any existing care plans and service providers and assess the adequacy of current services, including any access or accommodation issues
- For new Participants to maintain continuity of care, keep current services in place for 90 days or until the new PCSP is finalized and implemented, whichever is later. The IDT (and the plan, outside of the PCSP process) can increase services if clinically warranted, but neither can decrease services during this continuity of care period.
- A detailed listing of all elements that the IDT must consider in the development of the Person-Centered Service Plan **is outlined in Appendix B**.

Person-Centered Planning Process, cont.

- The Person-Centered Service Plan is updated and revised at least every 6 months or within 30 days of one of following trigger events:
  - Hospital admission
  - Transition between care settings
  - Change in functional status
  - Loss of caregiver
  - Change in diagnosis
  - As requested by a member of the IDT who observes the changes that requires further investigation.
- Elements to consider in the Person-Centered Service Plan **can be found in Appendix B**.

Authorizations

Authorizations

- The IDT is responsible for creating the Person-Centered Service Plan (PCSP) which outlines each of the participant's care and services needs and provides the basis for all service authorizations.
- Before the initial Person-Centered Service Plan (PCSP) is developed by the IDT, authorizations for new services needed during the 90-day transition period may be made by the FIDA Plan through the Utilization Management process.
- Any additional/new services not included in the Person-Centered Service Plan (PCSP), which arise between IDT meetings/PCSP revisions, are also authorized by the FIDA plan Utilization Management process.
- Service authorizations made by the IDT may not be modified by the FIDA Plan

Authorizations

- The following Covered Items and Services cannot be authorized by the IDT. Prior authorization must be requested by a qualified specialist.
  - Preventive Dental X-Rays – Prior authorization required by the Participant's Dentist
  - Comprehensive Dental - Prior authorization required by the Participant's Dentist
  - Eye Wear - Prior authorization required by the Participant's Optometrist or Ophthalmologist
  - Hearing Aids - Prior authorization required by the Participant's Audiologist.
- Prior Authorizations are <u>not required</u> for many services, including but not limited to Emergency/Urgent care, formulary drugs, women's health. A complete listing of services that do not require any authorization **can be found in Appendix C** .
- IDT approval is not required for formulary medication/drugs, but the IDT may authorize medications/drugs during Person-Centered Service Plan (PCSP) development and all current and new medications/drugs should be discussed and documented on the Person-Centered Service Plan (PCSP).

Appeals and Grievances

Grievances

- A Grievance is an expression of dissatisfaction with respect to any aspect of the FIDA Plan's or Provider's operations, activities, or behavior regardless of whether remedial action is requested.
- Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the FIDA Plan, or failure to respect the Participant's rights
- A Grievance may be filed with the plan (this is an internal grievance) or with the Medicare/Medicaid Contract Management Team (this is an external grievance).

Appeals

- Appealing IDT Decisions - The Participant has the right to appeal the Person-Centered Service Plan (PCSP) and other service determinations even if he/she agreed to and signed the Person-Centered Service Plan (PCSP) and regardless of whether he/she voiced objection to the plan at the time of the IDT meeting.
  - Notification of a Participant's appeals rights will be provided through a single notice and will be attached to the PSCP.
- Appealing Plan Decisions – The Participant has the right to appeal Plan decisions made between IDT meetings.
- All notices will be integrated and will communicate the steps in the integrated appeals process, as well as the availability of the Independent Consumer Advocacy Network (ICAN), the Participant Ombudsman, to assist with appeals.
- If the Participant files an appeal related to a reduction or termination of services within 10 days of the plan's decision, the current level of benefits and services will continue, pending the appeal decision.

Transition of Care

Transition of Care

- For the first 90 days (or until the Person-Centered Service Plan (PCSP) is in place, whichever is later), Participants can:
  - Continue receiving any existing Covered Item or Service in place as of the effective date of their FIDA Plan enrollment
  - Maintain existing providers they've seen in past 6 months, regardless of whether those providers are in the plan's network. The FIDA Plan must make reasonable efforts to bring these providers into the FIDA Plan network.
  - Continue receiving a 90 days supply of drugs for participants in an outpatient setting when a refill of a non-formulary drug is requested and at least 91 days (and up to 98 days) for participants in a long term care setting.
- Longer Transition Benefits under FIDA
  - Participants in Nursing Homes can remain there for the duration of the FIDA Demonstration, regardless of whether those providers are in the plan's network
  - Participants with Behavioral Health Providers can keep these providers for the current episode of care (up to 2 years)

Long-Term Services and Supports (LTSS)

Long-Term Services and Supports (LTSS)

What are Long-Term Services and Supports (LTSS)?

- LTSS include a wide variety of services and supports that help people with disabilities meet their daily needs and improve the quality of their lives over an extended period.
- LTSS are services provided by non-medical staff such as home aids and community-based services including but not limited to:
  - Care transition assistance
  - Personal care assistance
  - Home care services (homemaker, housekeeping, meals, day services).
  - Consumer Directed Personal Assistance Services

- A listing of LTSS available under FIDA **can be found in Appendix D**.

Criteria for receiving Long-Term Services and Supports (LTSS)

- Individuals must meet one of the below criteria:
  - Are Nursing Facility Clinically Eligible and receiving facility-based long term services and supports (LTSS)
  - Are eligible for the Nursing Home Transition & Diversion (NHTD1915 (c) waiver)
  - Require community based long term care services for more than 120 days.

IDT's Roles and Responsibilities Regarding Long-Term Services and Supports (LTSS)

IDT will help to coordinate and facilitate the provision of the following:

- Educate Participant about LTSS resources including:
  - The option to have Consumer Directed Personal Assistance Services (CDPAS) which offers the Participant to select their own aides/care givers.
- Coordinate the authorization for, and referral to, appropriate behavioral health, community based and facility based LTSS resources
- Assist Participants to access Personal Care Services
- Monitor the appropriate provision and functional outcomes of LTSS
- Ensure that LTSS care services are documented and aligned with Person-Centered Service Plan (PCSP)

Long Term Supports and Services (LTSS) Help

- IDT will ensure that Participants are:
  - Having sufficient support to be able to live independently in the community
  - Maintaining or improving their health
  - Avoiding unnecessary hospitalizations, nursing home admissions, or service duplication

Balance Billing

Balance Billing

- FIDA Participants are not subject to co-pays, deductibles or co-insurance.
- FIDA Plan Contracted Providers may not balance bill any FIDA Participants for the cost of any covered services for any reason. Failure to comply could result in termination as a participating provider.
- Provider is required to educate their staff, including contracted billing services and affiliated providers concerning this contract requirement.

Marketing

Provider Marketing Activities

- Participating providers may:
  - Distribute written materials only if the contracted provider includes a list of all FIDA Plans with which the provider contracts.
  - Answer direct questions from patients asking about FIDA Plans they are associated with.
- Participating providers must:
  - Make sure marketing materials and activities are within parameters of the approved CMS marketing guidelines.
  - Report any marketing activity that may be considered a violation of such CMS guidelines

Click the link below to access the marketing guidelines for FIDA

Medicare Marketing Guidelines (MMG)

Someone Interested in FIDA? Refer this person to New York Medicaid Choice (Maximus)

Individuals who may be eligible for the FIDA program must be referred to New York Medicaid Choice (Maximus), NY State's Enrollment Broker:

- **1-855-600-FIDA : TTY 1-888-329-1541**
- Website: **www.nymedicaidchoice.com**
- Open Monday-Friday 8:30 am to 8:00 pm and Saturday 10:00 am to 6:00 pm

Independent Consumer Advocacy Network (ICAN) – FIDA Participant Ombudsman

General information about ICAN

- The Independent Consumer Advocacy Network (ICAN) is a program of Community Service Society, a non-profit organization funded by the State of New York.
- ICAN is not connected with any health insurance plan.
- ICAN help is free and confidential.

What ICAN does

- Answers questions about Medicare and Medicaid programs for people receiving long-term care (for example, home care or nursing home care)
- Gives advice about managed care options
- Solves problems with plans and providers (for example, doctors, hospitals, and pharmacies)
- Helps participants and enrollees with complaint or appeal processes

Need help? Call ICAN – the Participant Ombudsman

Individuals can contact the Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), for any help or questions:

- **1-844-614-8800 (TTY 711)**
- Website: **icannys.org**
- Open Monday-Friday 8:00 am to 8:00 pm
- Multiple locations through the region

Appendices

Appendix A – Benefits Comprehensive List

Abdominal Aortic Aneurism Screening
Adult Day Health Care
AIDS Adult Day Health Care
Ambulance
Ambulatory Surgical Centers
Assertive Community Treatment (ACT)
Assisted Living Program
Assistive Technology (State Plan and Supplemental to State Plan)
Bone Mass Measurement
Breast Cancer Screening (Mammograms)
Cardiac Rehabilitation Services
Cardiovascular Disease Risk Reduction Visit (therapy for heart disease)
Cardiovascular Disease Screening and Testing
Care Management (Service Coordination)
Cervical and Vaginal Cancer Screening
Chemotherapy
Chiropractic
Colorectal Screening
Community Integration Counseling
Community Transitional Services
Consumer Directed Personal Assistance Services
Continuing Day Treatment
Day Treatment
Defibrillator (implantable automatic)
Dental
Depression Screening
Diabetes Monitoring (Self-Management Training)
Diabetes Screening
Diabetes Supplies
Diabetic Therapeutic Shoes or Inserts
Diagnostic Testing
Durable Medical Equipment (DME)
Emergency Care
Environmental Modifications
Family Planning Services
Freestanding Birth Center Services
HCSS
Health/Wellness Education
Hearing Services
HIV Screening
Home Delivery and Congregate meals
Home Health
Home Infusion Bundled Services
Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs
Home Maintenance Services
Home Visits by Medical Personnel
Immunizations
Independent Living Skills and Training
Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)
Inpatient Mental Healthcare
Inpatient Mental Health over 190-day Lifetime Limit
Intensive Psychiatric Rehabilitation Treatment Programs
Inpatient Services during a Non-covered Inpatient Stay
Kidney Disease Services (including ESRD services)
Mammograms
Medicaid Pharmacy Benefits as Allowed by State Law

Appendix A – Benefits Comprehensive List

Medical Nutrition Therapy
Medicare Part B Prescription Drugs
Medicare Part D Prescription Drug Benefit as Approved by CMS
Medication Therapy Management
Mobile Mental Health Treatment
Moving Assistance
Non-Emergency Transportation
Nursing Facility (Medicaid)
Nursing Hotline
Nutrition (includes Nutritional Counseling and Educational Services)
NYS Office of Mental Health Licensed Community Residences
Obesity Screening and Therapy to Keep Weight Down
Opioid Treatment Services – Substance Abuse
Other Health Care Professional Services
Other Supportive Services the Interdisciplinary Team Determines Necessary
Outpatient Blood Services
Outpatient Hospital Services
Outpatient – Medically Supervised Withdrawal- Substance Abuse
Outpatient Mental Health
Outpatient Rehabilitation (OT, PT, Speech)
Outpatient Substance Abuse
Outpatient Surgery
Palliative Care
Pap Smear and Pelvic Exams
Partial Hospitalization (Medicaid)
Partial Hospitalization (Medicare)
PCP Office Visits
Peer-Delivered Services
Peer Mentoring
Personal Care Services
Personal Emergency Response Services (PERS)
Personalized Recovery Oriented Services (PROS)
Podiatry
Positive Behavioral Interventions and Support
Preventive Services
Private Duty Nursing
Prostate Cancer Screening
Prosthetics
Pulmonary Rehabilitation Services
Respiratory Care Services
Respite
Routine Physical Exam 1/year
Sexually Transmitted Infections (STIs) Screening and Counseling
Skilled Nursing Facility
Smoking and Tobacco Cessation
Social and Environmental Supports
Social Day Care
Social Day Care Transportation
Specialist Office Visits
Structured Day Program
Substance Abuse Program
Telehealth
Transportation
Urgent Care
Vision Care Services
"Welcome to Medicare" Preventive Visit
Wellness Counseling

Appendix B - Person-Centered Service Plan (PCSP) Elements

The FIDA Plan Care Manager works collaboratively with the Participant, family, significant other, PCP and other members of the Interdisciplinary Team to develop a Person-Centered Service Plan that includes:

- Short and long-term measurable goals and outcome measures
- Functional level and support systems target dates and outcome measures and progress toward goals
- Assurances of Participant rights, including rights to reasonable accommodations and the right to appeal accommodation decisions
- Accommodations for any religious or cultural customs
- Strategies, actions, services (including interventions) to be implemented including the person or provider responsible for specific intervention or services and frequency of such services or interventions
- Frequency of provider office visits
- Self management strategies
- Medical, psychosocial and behavioral health needs.
- Expected outcomes and timeframes
- Assistance with accessing services and arranging any needed tests, procedures or services or reasonable accommodations
- Identification of barriers to meeting goals or complying with care plan

Appendix B – Person-Centered Service Plan (PCSP) Elements Cont.

The FIDA Plan Care Manager works collaboratively with the Participant, family, significant other, PCP and other members of the Interdisciplinary Team to develop the care plan that includes:

- Need for reasonable accommodations
- Development of schedule for communication and follow up with Participant
- Providing educational materials
- Making referrals to community agencies and non covered services
- Plan to access community resources and non-covered services including reasonable accommodation
- Participant's wishes in determining the place of service
- Participant choice of services (self direction or providers)
- Involvement of the Participant and caregivers
- Individualized back up plans
- Covered and coordinated services follow a written plan established and periodically reviewed by the Participant, IDT, their supports and designated POA. The care plan is monitored by the FIDA Plan Care Manager and is updated semi-annually or if there is any change in a Participant's health status at an IDT meeting.
- The IDT-developed Person-Centered Service Plan (PCSP) is documented by the Care Manager.

Appendix C: Prior Authorizations Not Required

Participants may directly obtain these Covered Items and Services without review, prior authorization, or approval:

- Emergency or urgently needed care
- Out-of-Network Dialysis when the Participant is out of service area
- Family planning and Women's Health specialists services
- Participants who are eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (lff/U) provider; covered services provided by that l{T/U provider, as long as that provider has the capacity.
- Primary Care Doctor Visits
- Immunizations
- Palliative Care
- Public health agency facilities for Tuberculosis (TB) Screening, Diagnosis and Treatment; including Directly Observed Therapy (TB/DOT)
- Cardiac Rehabilitation, first course of treatment (a physician or RN authorization for subsequent courses of treatment);
- Prescription drugs on the formulary, that do not require prior authorization or that are not on the formulary but for which a refill request is made for an existing prescription within the 90-day transition period
- Dental Services through Article 28 Clinics Operated by Academic Dental Centers
- Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services;
- Other Preventive Services
- Supplemental Education, Wellness, and Health Management Services

Appendix D - Long Term Supports and Services (LTSS) Available Under FIDA

- Home Health Care Services
- Personal Care Services
- Respite Care
- Adult Medical Day Care (including AIDS)
- Social Adult Day Care
- Environmental Supports (home modifications)
- Transportation
- Home Delivered/Congregate Meals
- PERS – Personal Emergency Response System
- DME and Repairs
- Audiology/Hearing Aids
- Orthotics/Prosthetics Procedures/ Devices
- Medical Nutrition Therapy
- Moving Assistance
- Home and Community Support
- Community Transitional Services
- Palliative Care
- Peer Mentoring/Delivered Services
- Independent Living Skills
- Structured Day Programs
- Assisted Living
- Oxygen
- Office Based Physical or Speech Therapy*
- Office Based Occupational Therapy *
- Rehabilitation Facility Admissions
- Skilled Nursing Facility Admissions

**After 20 visits*

Test Questions

TEST Questions

Overview

- ***FIDA will serve people eligible for:***
- ___Medicare
- ___Medicaid
- ___Long Term Care Services
- ___All of the above

TEST Questions

Eligibility & Enrollment

- ***Participants may disenroll at any time during the demonstration.***
- True or False

TEST Questions

FIDA Model of Care

Those who participate in the FIDA Model of Care include:

- ☐ ___Primary Care Physicians
- ☐ ___Specialists
- ☐ ___Community-Based supports / services
- ☐ ___Facility-Based supports / services
- ☐ ___All of the above

TEST Questions

<u>Interdisciplinary Team (IDT)</u>

- ***In addition to providers, the IDT team includes the Participant or Participant's Designee.***
- True or False

TEST Questions

Each member of the IDT is responsible for (check all that apply)

- ___Actively participating in the IDT service planning and care management process
- ___Attending meetings - whether in person, or by means of real-time, two-way communication, such as by telephone or videoconference
- ___Regularly informing the IDT of the medical, functional, and psychosocial condition of each Participant
- ___Documenting changes of a Participant's condition in the Providers' own medical record for the Participant, consistent with policies established by the FIDA Plan.

TEST Questions

Person-Centered Service Plan

Person-Centered Service Plan (PCSP) is a written document created by the IDT and housed in the care management record of the Participant which outlines all of the services the Participant needs and when, how, and by whom those services will be provided to Participant.

- ☐ True or False

TEST Questions

Authorizations

- ***Specialists such as Dentist, Optometrists, Ophthalmologists and Audiologists are responsible for authorizing preventive dental X-rays, comprehensive dental, eye wear and hearing aids, NOT the Plans' utilization management departments/processes.***
- True or False

TEST Questions

Grievances and Appeals

- ***The Participant has NO right to appeal the Person-Centered Service Plan and other service determination.***
- True or False

TEST Questions

Transition of Care

- ***Participants are allowed to continue receiving any covered item or service they were already receiving on the date their enrollment becomes effective with the FIDA Plan for at least 90 days from their effective date.***
- True or False

TEST Questions

LTSS

- ***Participants may receive Long Term Supports and Services (services provided by non-medical staff) such as home care services (housekeeping, meals) specific to their needs.***
- True or False

TEST Questions

Balance Billing

- ***FIDA Plan Contracted Providers may not balance bill any FIDA Participants for the cost of any covered services for any reason.***
- True or False

TEST Questions

Marketing

- ***Providers do NOT have to follow CMS marketing guidelines and can produce whatever material they want to distribute to patients.***
- True or False

Test Answer Key

Question	Answer
Overview	All of the Above
Eligibility & Enrollment	True
FIDA Model of Care	All of the above
Interdisciplinary Team (IDT)	True
Each Member of the IDT team is responsible	All apply
Authorizations	True

Question	Answer
Person-Centered Service Plan	True
Authorizations	True
Grievances & Appeals	False
Transition of Care	True
LTSS	True
Balance Billing	True
Marketing	False

FIDA Plan List

New York City

All FIDA Plans cover these services and more

Medicaid long term care – care from a nurse in your home, personal care (home attendants), home health aides, adult day health care, consumer directed personal assistance services, dental care, transportation, and other services.

All Medicare and Medicaid services – doctor office visits, hospital stays, Medicare Part D Drug benefits, mental health care, and more.

What else should I know?

You'll get all your care from a **Care Team** – your doctors, home care worker and other caregivers you choose and need. You will have a Care Manager who will make sure you get all the care you need.

You may call all the FIDA plans below from 8:00 am to 8:00 pm, seven days a week.

	Contact	Service Area
Aetna Better Health FIDA Plan	1-855-494-9945 TTY: 711 aetnabetterhealth.com/newyork	Brooklyn, Manhattan, Queens
AgeWell New York FIDA	1-866-586-8044 TTY: 1-800-662-1220 agewellnewyork.com	Brooklyn, Bronx, Manhattan, Queens
AlphaCare Signature FIDA Plan	1-855-632-5742 TTY: 711 alphacare.com	Brooklyn, Bronx, Manhattan, Queens
ArchCare Community Advantage FIDA Plan	1-844-471-0620 TTY: 711 ArchCareCommunityAdvantage.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
CenterLight Healthcare FIDA Plan	1-877-226-8500 TTY: 711 centerlighthealthcare.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island

Turn this page

FIDA Plans – New York City

	Contact	Service Area
EmblemHealth Dual Assurance FIDA Plan	1-855-283-2148 TTY: 711 emblemhealth.com/fida	Bronx, Brooklyn, Manhattan, Queens, Staten Island
FIDA Care Complete (affiliated with Centers Plan for Healthy Living, LLC)	1-800-466-2745 TTY: 1-800-421-1220 centersplan.com/fida/fida-mmp-members	Bronx, Brooklyn, Manhattan, Queens, Staten Island
Elderplan FIDA Total Care	1-855-462-3167 TTY: 711 elderplanfida.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
Fidelis Care FIDA Plan	1-800-247-1447 TTY; 1-800-695-8544 fideliscare.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
GuildNet Gold Plus FIDA Plan	1-800-815-0000 TTY: 1-800-662-1220 guildnetny.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
Healthfirst AbsoluteCare FIDA Plan	1-855-675-7630 TTY: 711 healthfirst.org/mmp	Bronx, Brooklyn, Manhattan, Queens, Staten Island
HealthPlus Amerigroup FIDA Plan	1-855-817-5789 TTY: 1-800-855-2880 healthplus.amerigroup.com/FIDA	Bronx, Brooklyn, Manhattan, Queens, Staten Island
ICS Community Care Plus FIDA MMP (Independent Care System)	1-877-427-2525 TTY: 711 icsny.org/care-plus	Bronx, Brooklyn, Manhattan, Queens
Integra FIDA Plan	1-855-505-5451 TTY: 711 intregraplan.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
MetroPlus FIDA Plan	1-844-288-3432 TTY: 711 metroplusmedicare.org	Bronx, Brooklyn, Manhattan, Queens

FIDA Plans – New York City

	Contact	Service Area
Montefiore Emerald Care FIDA Plan	1-855-266-8750 TTY: 711 montefiore.org/healthplans-medicare	Bronx
North Shore-LIJ FIDA LiveWell	1-855-776-7545 TTY: 1-877-486-2048 NSLIJHealthPlans.com/FIDALiveWell	Brooklyn, Manhattan, Queens, Staten Island
RiverSpring FIDA Plan (affiliated with ElderServe Health, Inc.)	1-800-950-9000 TTY: 1-866-236-5800 elderservehealth.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
SWH Whole Health FIDA (Senior Whole Health)	1-844-861-3432 TTY: 711 seniorwholehealth.com/FIDA	Bronx, Brooklyn, Manhattan, Queens
VillageCareMAX Full Advantage FIDA Plan	1-800-469-6292 TTY: 711 villagecaremax.org	Bronx, Brooklyn, Manhattan, Queens
VNSNY Choice FIDA Complete	1-866-783-1444 TTY: 711 vnsnychoice.org	Bronx, Brooklyn, Manhattan, Queens, Staten Island
WellCare Advocate Complete FIDA	1-855-595-2063 TTY: 1-877-247-6272 fida.wellcareny.com	Bronx, Brooklyn, Manhattan, Queens, Staten Island

QUESTIONS?
1-855-600-3432
TTY: 1-888-329-1541

What is the FIDA Program?
FIDA is a program that gives you all your Medicare and Medicaid benefits in one managed care plan. FIDA plans are the group of managed care plans that are part of the FIDA program. When you join a FIDA plan – you are also part of the FIDA program.

The FIDA Program is a partnership of New York State Medicaid and the Medicare Program.

FIDA Plan List-NYC-E-10-29-14

FIDA Plan List

Long Island

All FIDA Plans cover these services and more

Medicaid long term care – care from a nurse in your home, personal care (home attendants), home health aides, adult day health care, consumer directed personal assistance services, dental care, transportation, and other services.

All Medicare and Medicaid services – doctor office visits, hospital stays, Medicare Part D Drug benefits, mental health care, and more.

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AgeWell New York FIDA	1-866-586-8044 TTY: 1-800-662-1220 agewellnewyork.com	Nassau, Suffolk
CenterLight Healthcare FIDA Plan	1-877-226-8500 TTY: 711 centerlighthealthcare.org	Nassau, Suffolk
EmblemHealth Dual Assurance FIDA Plan	1-855-283-2148 TTY: 711 emblemhealth.com/fida	Nassau, Suffolk
Elderplan FIDA Total Care	1-855-462-3167 TTY: 711 elderplanfida.org	Nassau, Suffolk
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FIDA Plans – Long Island

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Healthfirst AbsoluteCare FIDA Plan	1-855-675-7630 TTY: 711 healthfirst.org/mmp	Nassau
Integra FIDA Plan	1-855-505-5451 TTY: 711 intregraplan.org	Nassau, Suffolk
North Shore-LIJ FIDA LiveWell	1-855-776-7545 TTY: 1-877-486-2048 NSLIJHealthPlans.com/FIDALiveWell	Nassau, Suffolk
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The FIDA Program is a partnership of New York State Medicaid and the Medicare Program.

FIDA Plan List-Long Island-E-10-29-14

FIDA Provider Training:

Cultural Competence

Learning Objectives

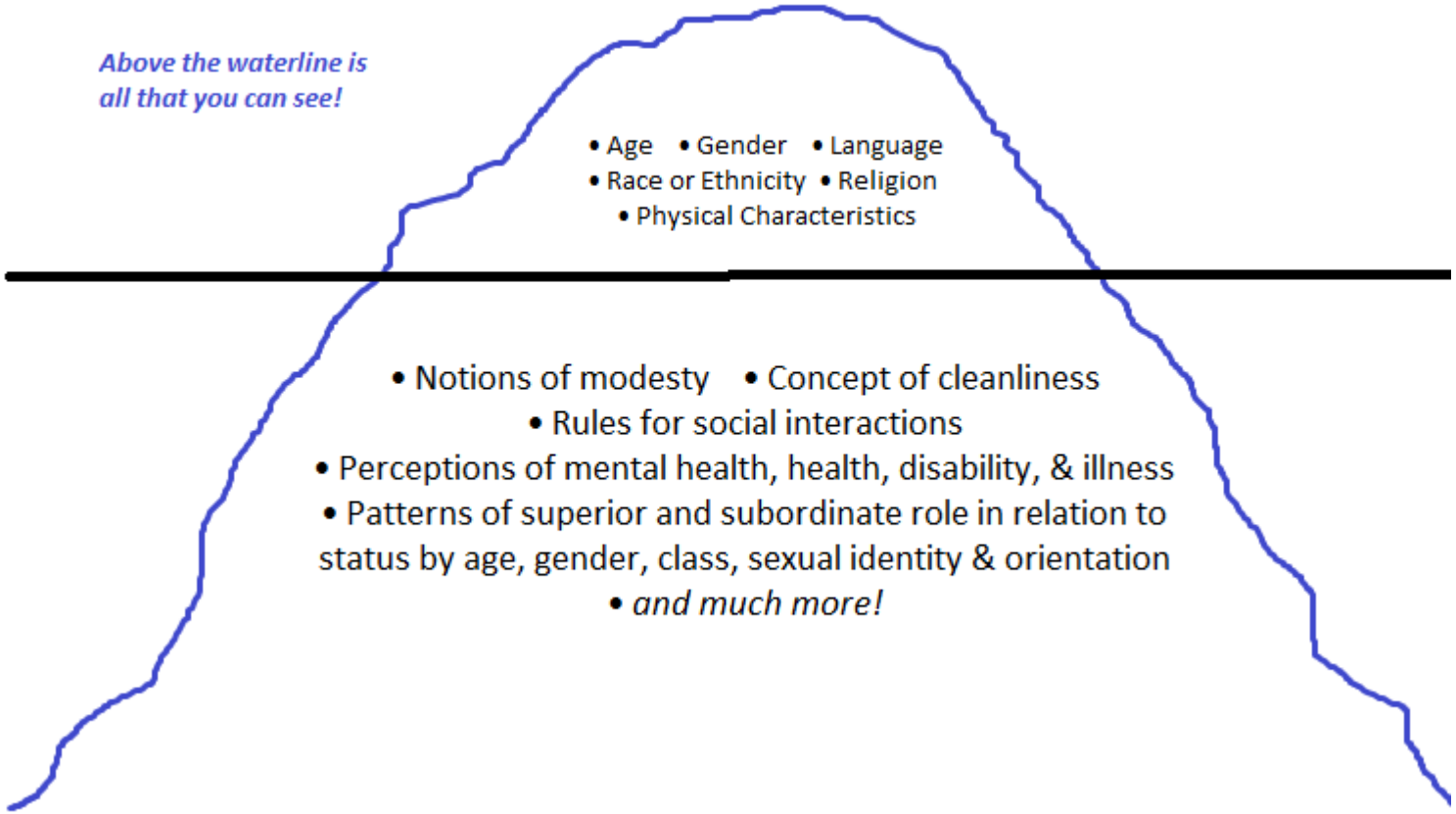
- What is cultural competency?
- Why is it important?

Culture

"Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups."

http://www.nih.gov/clearcommunication/culturalcompetency.htm

Culture is like an iceberg



Modified from Source: Beyond Culture (1976) by Edward T. Hall

Cultural Competence

Understanding those values, beliefs, and needs that are associated with a person's age, gender, sexual orientation, cultural, linguistic, racial, ethnic, and religious backgrounds, and congenital or acquired disabilities.

Cultural Competence

It is important to acknowledge that…

- cultural competence is an on-going process that also requires provider agility/balance between understanding general value systems without over-simplifying and also respecting unique individual needs.
- there is a continuum of competence, and that this definition must permeate at every level of service, including administrators, practitioners, and larger institutions for an agency or clinic to work towards "cultural competence."

Working towards cultural competence for providers

Cultural Competence includes:

- A set of skills to ensure appropriate, culturally sensitive health care
- An ability to interact effectively with people of different cultures and socio-economic backgrounds
- Obtaining cultural information and then applying that knowledge (cultural awareness)
- Adapting to different cultural beliefs by listening and learning about the person's beliefs about health and illness
- Recognizing the intersection of race, income, cultural beliefs, language proficiency, physical and cognitive disabilities, and/or sexual orientation should be considered and taken into account when providing patient-centered care and respecting the individual's wishes as they relate to how they identify themselves.

Are you able to check your personal biases and assumptions?

Are you able to check your personal biases and assumptions?

- All people can be influenced by personal biases which can take the form of conscious or unconscious prejudice and discrimination. Most people recognize its negative effect on human behavior, but few people are willing to acknowledge their own personal biases.

- There are various ways to address your personal biases:

  - Awareness - be aware of your reactions (positive and negative) towards different situations and individuals. These reactions can alert you to the possibility that subjective values may be at play and that alternate interpretations may be possible.

  - Education – seek new information about people of other races and cultures., especially those in the local community you serve. Many times this knowledge can help to disprove stereotypes you consciously or subconsciously have about others.

  - Attend a workshop or seminar on diversity issues or health equity, or work on a shared objective led by other people of different races or cultures. These activities can provide opportunities to perceive and control biases you may hold about other groups.

  - Relationships – working across cultures has its challenges. It is critical to foster trust and credibility, seeking ways to find common goals and empowering individuals from underserved communities to make their health decisions.

Culture influences how people seek health care and how they behave toward providers

Variations in patients' beliefs, values, preferences and behaviors impact:

- Patient recognition of symptoms
- Patient thresholds for seeking care
- Ability to communicate symptoms to a provider
- Ability of the provider to understand the meaning of what is presented by the patient
- Ability of the patient to understand the prescribed management strategy
- Patient expectations of care
- Patient adherence to preventive measures and medications
- Patient's perception of the value of prevention

Some populations may require modifications in service delivery…

Target populations	Consideration
Serious Mental Illness and Substance Abuse Disorders	Clarity in language and non-judgmental approach. Referrals to Mental Health providers.
Intellectual disabilities	Assistance with understanding. Materials written at a basic level.
Homeless	Non-judgmental approach and assistance/referrals for basic needs.
Complex Medical Needs , ex. Chronic diseases, HIV/AIDS, ESRD	Break down information in smaller pieces and prioritize. Determine priorities and needs from the patient perspective.
Physical disabilities	Ensure instructions can be followed or arrange for accommodations. Physical office and examination rooms should be accessible.
TBI/Dementia/Alzheimer's	Assess understanding and accommodate.
Elderly	Allow for more time with the patient. Speak clearly and face the patient.

Laws and Regulations pertaining to Limited English-Speaking Communities

Providers are legally obligated to communicate with FIDA participants who have Limited English Proficient (LEP).

- Title VI of the Civil Rights Act of 1964 - Prohibits recipients of federal funding from discriminating on the basis of race, color, national origin, gender, age, sexual orientation and disability

- 14 NYCRR section 633.1 and 633.4 - All persons shall be given the respect and dignity that is extended to others regardless of race; religion; national origin; creed; age; gender; sexual orientation; developmental disability; or health condition. An individual/family member cannot be discriminated based on their ability to speak English and this includes individuals who may be deaf and/or hard-of-hearing.

- Please visit the following website to review Governor Cuomo's Statewide Language Access Policy which mandates the provision of language access services **http://www.governor.ny.gov/news/no-26-statewide-language-access-policy**

Accommodations to improve communication

- Direct provision of interpreters for participants with LEP. Please visit the Community Resource page to find an interpreter service provider near you.
- Access to telephonic interpreting services or TTY lines available through participating FIDA health plans.
- Do not use friends or family as interpreters, except as requested by the client
- Printed materials in non-English languages with quality translation
- Availability of materials in Braille for the visually impaired or sign language services for the hearing impaired
- In-person assistance in completion of forms
- Flexibility in scheduling, extending appointment times for participants with LEP

Something else to consider about effective communication….

Despite the fact that a patient is capable of speaking English, it is important that health care providers are sensitive to the patient's *preferred* language. Communicating with a patient in the language they are most comfortable using can alleviate stress, prevent hostility, reduce misunderstanding and improve the overall patient experience.

If a patient with a cultural background different from yours has instances of missed appointments and/or unreturned calls, incomplete forms or misinformation regarding their health status or history, reach out to provide assistance in the patient's preferred language to help bridge the cultural barrier.

Benefits of Cultural Competence

- Expand your patient base by providing more culturally and linguistically appropriate care to a wider diversity of patients
- Deliver a higher quality of care to help your patients meet their health care goals, while honoring and respecting their cultural beliefs and practices
- Decrease clinical errors that may arise due to cultural and linguistic differences in communication and differences in health literacy
- Gain essential tools to help recognize and lessen the racial and ethnic health care disparities that persist in health

Be a culturally competent provider

Being culturally competent facilitates better outcomes for you and your patients!

Test your Cultural Competency

Cultural Competence Test Question #1 of 5

<u>True or False:</u>

- Culture is limited to one's race, religion, or ethnic background.

Cultural Competence Test Question #2 of 5

<u>True or False:</u>

- Individual cultural beliefs influence how patients interact with health care providers.

Cultural Competence Test Question #3 of 5

<u>True or False:</u>

- Provider's body language can influence how a patient perceives information given to him/her.

Cultural Competence Test Question #4 of 5

True or False:

- Providers may use telephonic interpreting services to assist in interpreting during encounters.

Cultural Competence Test Question #5 of 5

<u>True or False:</u>

- Cultural competence is an on-going learning and behavioral process which can positively contribute to provider/patient interactions.

Test Answer Key

Question	Answer
Culture is limited to one's race, religion, or ethnic background.	*False*
Individual cultural beliefs influence how patients interact with health care providers.	*True*
Provider's body language can influence how a patient perceives information given to him/her.	*True*
Providers may use telephonic interpreting services to assist in interpreting during encounters.	*True*
Cultural competence is an on-going learning and behavioral process which can positively contribute to provider/patient interactions.	*True*

Behavioral Health

Why is Behavioral Health Important for FIDA Providers?

- FIDA covers a broad range of behavioral health (BH) services and supports
- Every FIDA provider may be in a position to be the first person to identify a particular participant's need for BH services or supports
- All participating providers should be equipped with the skills, tools, and resources necessary to identify and respond effectively to BH needs

Prevalence of Behavioral Health Conditions

- 26% of all Medicare beneficiaries (more than 13 million) have some sort of mental health disorder including cognitive disorders.[1] 50% of duals 80 years and older have co-occurring physical and mental/cognitive conditions. [2]

- More than 50% of Dual/FIDA Participants have mental illness and/or cognitive impairments.[3]

- 56% of Medicare inpatient psychiatric patients are Dual Participants.[4]

- People with mental illness die younger than the general population, and have more co-occurring health conditions, such as hypertension, diabetes, heart disease, obesity, tobacco use and asthma. [4] Three out of five of Dual eligibles have multiple chronic physical conditions, and mental/cognitive issues.

- One in five adults with mental illness also have a co-occurring substance use disorder (SUD) [5]

http://www.medicareadvocacy.org/medicare-and-mental-health/

[1] The Social Security Administration, http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2011/ssi_asr11.pdf(Table 6, P. 25)

[2] https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf

[3] The Kaiser Family Foundation, Medicare's Role for Dual Eligible Beneficiaries, http://www.kff.org/medicare/upload/8138-02.pdf

[4] MedPAC, http://www.medpac.gov/transcripts/IPF%20presentation--October%202011--final.pdf

[5] http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

Common Behavioral Health Conditions & Symptoms in the FIDA Population

- A September, 2014 study by the Centers for Medicare and Medicaid Services reports that of their sample, 41% of Duals enrolled in FFS Medicare-Medicaid are diagnosed with behavioral health conditions. [6]

- The most common mental health conditions in the FIDA population are:
  - Depressive Disorders
  - Anxiety Disorders
  - Psychosis, including Schizophrenia spectrum disorders
  - Dementia or other neurocognitive spectrum disorders
  - *Substance Use*

Approximately 25% of home care recipients and 5% of older adults living independently in the community will score on the UAS-NY as high risk for Mood disorders; same percentage will score as medium risk.

Approximately 10% of persons receiving home care, and 7% of older adults living independently in the community will trigger for Tobacco & Alcohol Use in the UAS-NY

Please click below for important information on the signs and symptoms of common mental health disorders (Appendix B)

Coordinated & Integrated Care Work Best

- For Participants with co-occurring Mental and/or Substance Use Disorders, integrated care - the coordination of mental health, substance use, primary care services, and long-term services and supports - produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs. [7]
  - Decreased inpatient and ER use
  - Improved mental and physical health
  - Improved engagement in care and health literacy
  - Improved quality of life
- The FIDA Person-Centered Service Plan (PCSP) should address cognitive deficits, psychiatric and behavioral disturbances, and substance misuse and abuse.
- FIDA participants may require reasonable accommodations, such as changes to scheduling, extra time needed for an appointment, flexibility around punctuality. This includes those individuals with mental illness and substance use disorders (SUDs).

[7] http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

How Behavioral Health Needs are Identified

- ***By the FIDA Plan***
  - The UAS-NY Community Assessment screens, among other things, for depression, anxiety, alcohol and tobacco use, cognition, and other behavioral issues.
    - The UAS-NY will generate a Mental Health Supplement to further assess any triggered findings from the community assessment.
    - Pertinent findings should be discussed at the IDT meeting, and reflected in the PCSP with the participant's written consent.

- ***In Primary Care:***
  - Observation
  - Patient self-report (e.g. complaints of depressed mood, reporting physical symptoms of anxiety)
  - Use of free, valid, and reliable screening tools will improve your ability to quickly and reliably assess for some of the more common co-occurring mental health issues in your practice. They include:

How Behavioral Health Needs are Identified

- ***Please clink on the links below for additional resources that will assist you in identifying Behavioral Health needs***

  - Depression: PHQ-2/PHQ-9 http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9 (*see Appendix D for sample*)
  - Anxiety: http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
  - Drug & Alcohol Use (General): http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
  - Alcohol Use (60+ Years Old): http://www.ssc.wisc.edu/wlsresearch/pilot/P01-R01_info/aging_mind/Aging_AppB5_MAST-G.pdf
  - Mental Health Problems in Older Adults - http://www.cdc.gov/aging/pdf/mental_health.pdf
  - Suicide Risk: http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
  - *Additional screening tools and best practice information can be found at: http://www.integration.samhsa.gov/clinical-practice/screening-tools*

Mental Health Disorders/Symptoms: Depression

Many of these individuals will present to Primary Care complaining of the physical symptoms that limit their functioning (e.g. lack of motivation to complete projects, pulling away from friends or activities of interest)

Symptoms of Depression include:

- A depressed mood
- Insomnia (an inability to sleep) or hypersomnia (excessive sleeping)
- Fatigue or loss of energy
- Appetite or weight changes
- Poor concentration
- Markedly diminished interest or pleasure in almost or all activities nearly every day
- Feelings of worthlessness or guilt
- Hopelessness
- Recurring thoughts of death or suicide (not just fearing death)
- A sense of restlessness or being slowed down

Late Onset Depression (50+)

- ***Depression is not a normal part of aging***
- ***Depression in older adults complicates treatment of other illnesses and chronic diseases***
- ***80% of Depression cases in older adults are treatable***
- ***Risk factors for late-onset depression included widowhood, physical illness, impaired functional status, and heavy alcohol consumption [8]***

[8] http://www.cdc.gov/aging/pdf/mental_health.pdf

Mental Health Disorders/Symptoms: Anxiety & Panic

Most individuals with these symptoms will initially present to Primary Care for assistance

- Symptoms of Anxiety include:
  - Excessive worry about a number of events or activities
  - Restlessness, feeling on edge
  - Easy fatigue
  - Difficulty concentrating
  - Irritability
  - Muscle tension

- Symptoms of Panic include:
  - Palpitations, pounding hearts, accelerated pulse
  - Sweating
  - Trembling, shaking
  - Shortness of breath
  - Chest pain, discomfort
  - Nausea, abdominal distress
  - Dizziness, light headedness, faint
  - Fear of dying

Mental Health Disorders/Symptoms: Bipolar Disorder

Symptoms of Bipolar Disorder include:

Depressive Symptoms

- Sadness
- Hopelessness
- Suicidal thoughts/behavior
- Anxiety
- Guilt
- Sleep problems
- Low or Increased Appetite
- Low energy
- Loss of interest in activities that were once found enjoyable
- Problems concentrating
- Irritability
- Chronic pain with no cause
- Frequent absences/Poor performance at work or school

Manic Symptoms

For at least one week

- Abnormally and persistently elevated, expansive or irritable mood
- Increase in goal-directed activity
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Pressured speech; increased talkativeness
- Distractibility
- Racing thoughts
- Excessive involvement in activities that have a high potential for painful consequences (e.g. hypersexuality, shopping sprees, foolish business investments).

Mental Health Disorders/Symptoms: Psychosis

Psychosis

- Psychosis can present as a symptom in any of the aforementioned disorders (e.g. depression, bipolar disorder, substance use, unresolved medical conditions, etc.).
- It may also occur as a feature of delirium or other manifestations of an underlying medical condition.
- Symptoms of psychosis may include:
  - Impaired reality testing
    - Perceptual disturbances (e.g. auditory hallucinations)
    - Delusions (fixed, false beliefs)
  - Disorganized thought process
  - Disorganized speech
  - Disorganized behaviors
- Psychosis is a cardinal symptom of Schizophrenia
  - Diagnosis of Schizophrenia requires at least six (6) months of symptoms
  - Additional symptoms of Schizophrenia may include.
    - Abnormal motor behavior
    - Impairments in self-care
    - Impaired social and/or occupational functioning
    - Negative symptoms = an absence of something that should be there (e.g. facial expressions, variation in voice, descriptive speech)
- Psychosis should **always** be evaluated for underlying cause and appropriate treatment.

Mental Health Disorders/Symptoms: Dementia

- Dementia, is a progressive neurocognitive disorder. The most common form is Alzheimer's Disease. Symptoms include:
  - Memory impairment
  - Difficulty with recognition of familiar people/places/things
  - Restlessness
  - Aggression
  - Sleep disturbances
  - Wandering

Symptoms occur in about 50% (or higher) of individuals with dementia.

Approximately 85% of individuals receiving home care will score on the UAS-NY to monitor for or reduce risk of cognitive loss.

- Research has shown that elderly patients are especially at risk for the development of dementia. The identification of symptoms in the elderly may be obscured by the presence of multiple medical illnesses and medications. In order to prevent/minimize negative behaviors, we need to understand the communication of the person with dementia and it is helpful to look for and record any patterns of behavior. A nonpharmacological approach should be the first step in treating the psychotic symptom.
- Elderly patients presenting with psychotic symptoms require social, behavioral, and environmental interventions that are necessary for their safety and reorientation. However, some patients may need pharmacologic intervention in order to manage the behavioral disturbance that often results from the psychotic symptoms. This article reviews psychopharmacologic treatment strategies for managing psychotic symptoms in elderly patients.

Mental Health Disorders/Symptoms: Dementia

- ***Please see the links below for additional information***

- http://www.crisisprevention.com/Blog/June-2011/Treating-Psychotic-Symptoms-in-Persons-With-Dement
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC181181/

Mental Health Disorders/Symptoms: Substance Use Disorders (SUDs)

- Substance Use Disorder (SUD) is when an individual continues using a substance despite significant substance-related problems. These include cognitive, behavioral, and physiological symptoms:
  - An underlying change in brain circuits may persist beyond detoxification
  - Behavioral effects include repeated relapses and intense cravings
  - Disorder severity ranges from intoxication → use → abuse → dependence

- The criteria for these disorders follow a pattern of behaviors, leading to clinically significant impairment within a specified time course. Criteria are grouped as follows:
  - Impaired control: Desire, but inability to cut down; time spent obtaining, using & recovering, craving
  - Social impairment: Not filling major role obligations in deference to use
  - Risky use: Not solely the usage itself, but the individual's lack of abstaining from using the substance, despite the physical difficulty it is causing

- Pharmacological criteria (not required for diagnosis of SUD):
  - Tolerance: needing more to achieve same effect. Increased ability to tolerate negative effects (e.g. respiratory depression, sedation)
  - Withdrawal: symptoms that result when blood or tissue concentrations of a substance decline after prolonged, heavy use. The individual is more likely to use the substance to relieve the symptoms.

- Routine Screening for potential drug and alcohol use is a best practice. If evidence of an SUD exists, a Brief Intervention, and Referral to Treatment is indicated.

Mental Health Disorders/Symptoms: Substance Use Disorders (SUDs)

- ***For more information on SBIRT and screening for SUD, please click on the links below.***
  - Guide to Substance Abuse for Primary Care Clinicians: http://www.ncbi.nlm.nih.gov/books/NBK64827/pdf/TOC.pdf
  - SBIRT: http://www.integration.samhsa.gov/clinical-practice/SBIRT
  - Substance Abuse Among Older Adults: http://www.ncbi.nlm.nih.gov/books/NBK64419/pdf/TOC.pdf

Assisting FIDA Participants in Obtaining Behavioral Health Services

- Routinely using valid and reliable screening tools using (such as the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression) will help you identify who should be referred for further evaluation and treatment. *(See sample screening questions by clicking here – Appendix A)*

- Support effective care coordination by documenting and communicating necessary information to IDT members to integrate services and transition Participants' care between health care settings and health care providers.
  - Identify any current behavioral health services received by the Participant to ensure continuity of care
    - To support continuity of care, FIDA participants can keep their current behavioral health providers for up to two years for current episode of care.

  - Obtaining the FIDA participant's consent *before* you communicate any identified MH/SUD issues to the IDT will (a) improve their engagement in the recovery process, and (b) ensure their privacy rights are protected as consistent with HIPAA and 42 CFR Part 2 ***(see Appendix C for description of relevant privacy laws)***

- Support Participant's treatment plan as part of the Person-Centered Service Plan (PSCP) to ensure that both medical and non-medical health needs are met

Click below for a complete listing of behavioral health care benefits and Community Resources available under FIDA (Appendix D)

Appendix A: Preventive Health Questionnaire - PHQ-2/PHQ-9 Screening Questions

Over the last 2 weeks, how often have you been bothered by any of the following:

Not at all (0) **Several days (1)** **More than half the days (2)** **Nearly every day (3)**

1. Little interest or pleasure in doing things?……
2. Feeling down, depressed, or hopeless?……

These two questions comprise the PHQ-2. If a participant screens positive on one or both questions, continue to the PHQ-9

3. Trouble falling or staying asleep, or sleeping too much? …….
4. Feeling tired or having little energy?.....
5. Poor appetite or overeating?.....
6. Feeling bad about yourself - that you are a failure or have let yourself or your family down?……
7. Trouble concentrating on things, such as reading the newspaper or watching television?
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual? ……
9. Thoughts that you would be better off dead or of hurting yourself in some way? …….

Appendix B: Behavioral Health Covered Services

Medicare/Medicaid physical, behavioral healthcare and long-term supports & services	Integration of BH and enhancements to care/case management	Fully Integrated Duals Advantage (FIDA) Services

Including the following services:

- AIDS Adult Day Health Care
- Assertive Community Treatment (ACT)
- Assisted Living Program
- Assistive Technology
- Case Management for Seriously Mentally Ill
- Community Transitional Services
- Comprehensive Medicaid Case Management
- Consumer Directed Personal Assistance Services
- Continuing Day Treatment
- Day Treatment
- Family-Based Treatment
- Health and Wellness Education
- Home and Community Support
- Home Visits by Medical Personnel
- Independent Living Skills and Training
- Intensive Psychiatric Rehabilitation Treatment
- Medicaid Pharmacy Benefits -per State Law
- Moving Assistance
- OMH Licensed CRs
- Partial Hospitalizations
- Personalized Recovery Oriented Services
- Positive Behavioral Interventions and Support
- Social Day Care Transportation
- Structured Day Program
- Substance Abuse Program
- Telehealth
- Wellness Counseling

Appendix C: Confidentiality of Alcohol and Drug Abuse Patient Records

- In December, 2000, the Department of Health and Human Services (HHS) issued the "Standards for Privacy of Individually Identifiable Health Information" final rule (Privacy Rule), pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Subparts A and E.[1] Substance abuse treatment programs that are subject to HIPAA must comply with the Privacy Rule.[2 3]

- 42 CRF Part 2 protects all information about any person who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program.

- To be considered a Part 2 provider, providers must be both "federally-assisted" and meet the definition of a program under 42 CFR § 2.11. Physicians who prescribe controlled substances to treat substance use disorders are DEA-licensed and thus meet the test for federal assistance [42 CFR § 2.12(b)(2)]. This guidance also applies to substance abuse treatment programs that are also covered entities as defined by the Privacy Rule. ***For additional criteria please see question 10 of the Applying the Substance Abuse Confidentiality Regulations FAQs by clicking on the link below.***

- Programs may not use or disclose any information about any patient unless the patient has consented in writing (on a form that meets the requirements established by the regulations) or unless another very limited exception specified in the regulations applies. Any disclosure must be limited to the information necessary to carry out the purpose of the disclosure.

Appendix C: Confidentiality of Alcohol and Drug Abuse Patient Records

- ***Please visit the link below for consent form criteria***.
- Substance Abuse Confidentiality Regulations FAQs - http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs
- Consent Form Criteria - http://www.integration.samhsa.gov/operations-administration/Consent_Law_Comparison_Table.pdf

Appendix D: Community Resources

- Visit the FIDA portal for a full list of resources for providers to access when needed.
- The listing of resources includes such services as:
  - Housing, Health, Aging, Homelessness, Nutrition, WIC, Ryan White, Resources and Assistance for people with disabilities, Legal Assistance, Cell Phone Services, Food Stamps, Medicaid, Medicare, Social Security, Financial and Tax Assistance, Food Bank, Adult/Child Protective Services, Assisted Living, Court Ordered Services, Domestic Violence Services, Mental Health and Substance Abuse Services, Red Cross, Blood Services, Suicide prevention, etc…

TEST Questions

Behavioral Health

- ***Behavioral Health services are covered at no cost to the participant.***
- True or False

- ***Psychosis is associated ONLY with Schizophrenia.***
- True or False

- ***Routine screening for Substance Use Disorders is a best practice.***
- True or False

Test Answer Key

Question	Answer
Behavioral Health services are covered at no cost to the participant.	*True*
Psychosis is associated ONLY with Schizophrenia.	*False*
Routine screening for Substance Use Disorders is a best practice.	*True*

Disability Awareness & Training

For Providers and Staff

Learning Objectives

Educate Providers/Staff:

Understand and apply the Americans with Disabilities Act (ADA).

Widen Awareness:

The ADA affords persons with disabilities the right to reasonable accommodation.

Disability Continuum:

Understanding that disability exists along a continuum and is a function of the interaction of impairment with external, social, economic structural and other environmental factors.

Disability Does Not Equal Poor Health:

Learn to distinguish the need for accommodations from symptoms of poor health.

Section I: Disability Competent Care

Objectives of this section:

- Understand impact of disabilities on access to health care services
- Help providers improve disability-competent care delivery skills

Defining Disability

Under the Americans with Disabilities Act (ADA), a person with a disability is:

- A person with a physical or mental impairment that substantially limits one or more major life activities (e.g., breathing, walking, concentrating, etc.)
  - See Appendix A for definition of major life activities
- A person with a record of such physical or mental impairment
- A person who is regarded as having such impairment

- *Click **here** for Appendix A: Major Life Activities Definition*

Important Facts about Disabilities

- Each person's experience is different
- Some people are born with a developmental disability
- Traumatic experiences can cause a disability.
- Adult onset of the disability
- Chronic conditions can become disabling

Understanding Impact of Chronic Conditions

- Chronic conditions may call for accommodations in the health care setting just as other disabilities may
- For example, individuals diagnosed with chronic conditions (e.g., diabetes, dementia, heart disease, arthritis, etc.) may:
  - experience activity limitations such as difficulty walking, seeing, understanding, or communicating
  - need for accommodations such as physical accessibility as well as accessible communications
  - may have activity limitations related to vision
  - require accommodation of functional vision limitations such as providing care instructions in large print or audio formats
  - may experience an activity limitation that affects understanding and/or communication

*Click **here** for Appendix C: Impact of Chronic Conditions in Appendix C*

John: Living with Dignity*

1. Understand his Story

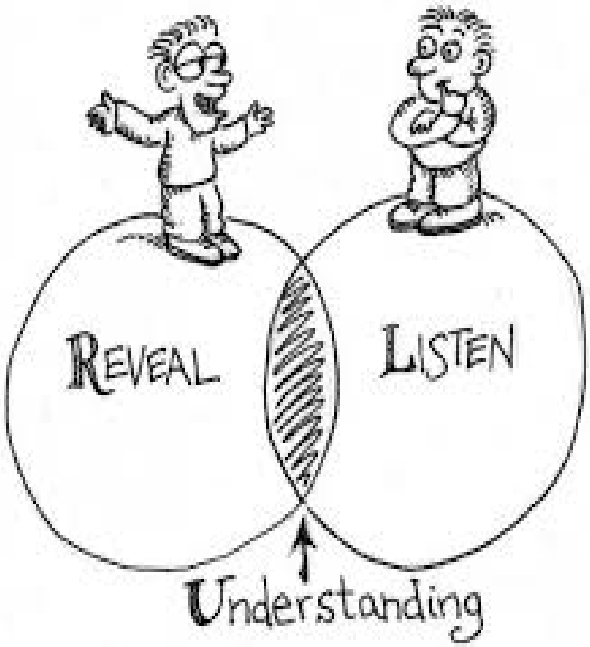
- 56 year old male with severe arthritis, obesity
- Limited mobility
- Depression and anxiety
- Dependent with most ADLs; some IADL dependencies
- Good emotional support system, but lives alone and has no one close by
- Recurrent cellulitis and skin breakdown
- Recurrent UTIs and hospital admissions
- No longer able to bear weight or transfer out of bed to chair

*https://www.resourcesforintegratedcare.com/sites/default/files/Presentation%20-%20Dignity%20of%20Risk%20-%20Disability-Competent%20Care.pdf

John: Living with Dignity cont.

2. Understand what is important to him

- It is very important that he remains in his own home
- He wants to stay out of the hospital
- He is anxious about going to medical appointments
- He does not want to discuss weight or the need for weight loss
- He is able to call for help if need be



John: Living with Dignity cont.

3. Develop a plan

- Collaboration of his IDT team* to establish a realistic plan that addresses both what is important to and for him
- Plan focused on the areas that John wanted to change, staying out of the hospital, and respected John's choice to risk living alone and with inability to get out of bed
- Team has begun talking about life-sustaining treatment plans and factoring in John's desire to remain in his home
- Personal Care Service Plan (PCSP) developed and agreed upon

**Interdisciplinary Team (IDT) includes: John, his Primary Care Provider, Personal Care Assistant (PCA), John's sister and the FIDA Plan Care Manager*

John: Living with Dignity cont.

4. Implement the Plan

- PCP, PCAs, family accepted and respected what was important to John
- PCP accepted and respected John's living with the risk of complications from immobility, obesity and living alone
- John agreed with the Personal Care Service Plan to work on some things that are important for him to prevent skin breakdown and manage UTIs at home
- FIDA Care Manager provides support; and Assessment conducted in his home in 6 months to evaluate his condition and minor modifications made to his Personal Care Service Plan (PCSP) with another IDT team meeting

John: Living with Dignity cont.

5. Outcome

- No skin breakdown
- No hospital admissions for 12 months
- Remains in his own home with support of PCA, homemaking and emotional support from family and friends

People with Disabilities: Health Care Needs

- People who have both Medicare and Medicaid may have significant health needs, or are more likely than Medicare beneficiaries to be in fair or poor health and have significant functional limitations
- Within the dual eligible population, there are four identifiable high needs groups:
  - adults under age 65 with physical or sensory disabilities
  - those 65 or older with multiple chronic conditions and functional limitations
  - individuals with serious psychiatric disabilities and/or drug or alcohol disorders
  - individuals with cognitive limitations including intellectual and/or developmental disabilities or dementia

*Click **here** for Appendix B: Common Disabilities Table*

People with Disabilities: Health Care System Concerns

- Barriers: People with disabilities face physical and other barriers at provider sites, such as architectural barriers, inaccessible exam tables and weight scales, lack of interpreters, inflexible office procedures

*To learn more about the study go to http://webhost.westernu.edu/hfcdhp/wp-content/uploads/ProvPrimeCare.pdf

People with Disabilities: Health Care System Concerns

- Barriers: A survey of primary care physicians found that almost 20 percent were unaware of the Americans with Disabilities Act and 45 percent were not aware of its architectural requirements. Physicians receiving training on disability issues were in the minority*

OR

People with Disabilities: Health Care System Concerns

- Negativity: People with disabilities report being treated unfairly at practitioner offices because of their disabilities - they face negative attitudes and lack of knowledge about treating people with their disabilities. This is consistent with other reports finding inadequate preparedness to provide health services to people with disabilities

"There is no reason for someone like you to be tested for AIDS"

"My, aren't you cute"

"Getting a mammogram is hard for you so you can just skip it"

"You don't have to worry about osteoporosis because you can't walk"

To learn more about the study go to http://webhost.westernu.edu/hfcdhp/wp-content/uploads/ProvPrimeCare.pdf

Health Disparities

- Research shows people with disabilities are more likely to:
  - have heart disease, stroke, diabetes, or cancer than adults without disabilities
  - experience difficulties with delays and barriers in receiving health care
  - live in poverty
  - experience material hardship
  - experience food insecurity, such as hunger
  - have difficulty paying rent, mortgage and utilities
  - be disproportionately represented in racial and ethnic minority groups
- Health promotion and prevention activities seldom target people with disabilities resulting in inadequate receipt of preventative diagnostic testing they may require
- Historically care has focused on the disability at the expense of a primary care focus—looking at the essential body systems

Health Care Access

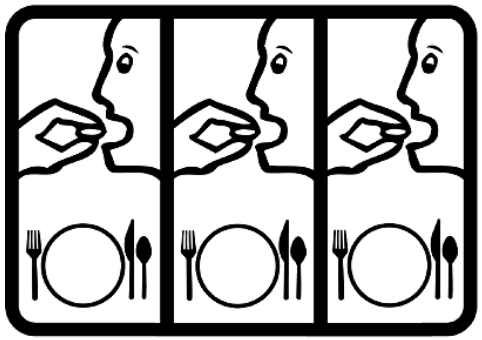
Some people may be unable to open a door, climb stairs, fill out a form, or see or hear, as a result of disability. For people with disabilities, getting health care can be difficult because of lack of access.

- Programmatic accessibility , meaning the services programs, and activities of a public entity must be “readily accessible to and usable by” people with disabilities” is as important as physical accessibility

Health Care Access

- Accessibility may need to be provided in an array of areas such as:
  - Communication—hearing impaired, blind, intellectual disability—may require more time, alternative materials
  - Physical—wheelchair accessible, counter heights
  - Medical Equipment—scales, exam tables, chairs, patient transfer lift
  - Programs—procedures, practices

Take 3 times with meals



Taking Positive Actions

- Providers must ensure that physical, communication, and programmatic barriers do not inhibit participants with disabilities from obtaining all covered Items and services

Sign Language Interpreter?

yes no

- For example, programmatic access can be providing:
  - flexibility in scheduling as an accommodation
  - quiet spaces and/or help in filling out forms
  - extra time for instructions or explanations of care
  - interpreters for those who are hearing impaired or whose first language is not English
  - materials in alternate formats, including the option of large print or electronic Text-to-Speech programs or persons with visual impairments

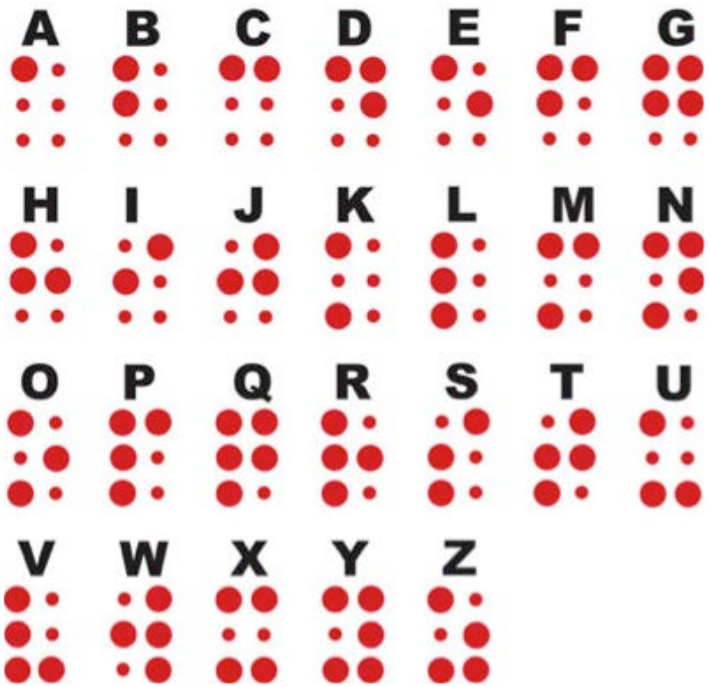
Removing Barriers to Care: Physical Barriers

Meet Accessibility Requirements:

- Ensure there are no obstructions in pathways that would inhibit free movement
  - 36” paths of travel that can narrow to 32” for no more than 2 feet
  - Remove all furniture and garbage cans, magazine stands, etc. that obstruct movement
- Physical locations, waiting areas, examination space, furniture, bathroom facilities and diagnostic equipment must be accessible. Examples include but are not limited to adjustable exam tables and accessible weight scales (platform/roll-on scales)
- Routes of travel are easily navigable and accessible. (*i.e.*, stable, slip-resistant)

Removing Barriers to Care: Communication Barriers

- Interpreters for people with hearing and/or visual impairments,
  - e.g., sign language
- Readily accessible auxiliary aids and other services provided in appropriate circumstances
  - Braille, large print, audio tapes, color and symbol signage etc.
- Staff training on sensitivity issues related to people living with disabilities
- Simple language for medical instructions and forms
- Quiet spaces for people to fill out forms or read instructions
- Flexible appointment availability



Removing Barriers to Care: Attitudinal Barriers

- Lack of understanding or sensitivity may also lead to incorrect or discriminatory assumptions about people with disabilities
- These assumptions have led some providers to believe that people with disabilities do not have a good quality of life
- Examples of attitudinal barriers include:
  - People with developmental disabilities do not feel pain, therefore do not require anesthesia
  - People who are hearing impaired have cognitive deficits
  - Women with disabilities do not require reproductive counseling and care because they're likely not sexually active
  - People with mobility disabilities will not profit from exercise or nutrition programs
  - People with disabilities cannot make informed decisions about their own care

Independent Living Philosophy

- The Independent Living Philosophy can be incorporated into the FIDA Person-Centered Service Planning process for Participants with disabilities.
- When making care planning decisions, bear in mind that:
  - Participants should be empowered to make their own choices, including making their own mistakes.
  - Participants are the best experts on their needs, and should take the initiative, individually and collectively, in designing and promoting better solutions.
  - Participants can have high quality of life and can be self-directing.
  - Participants have the same right to participation, to the same range of options, degree of freedom, control and self-determination in everyday life and life projects as all individuals.

Awareness and Etiquette

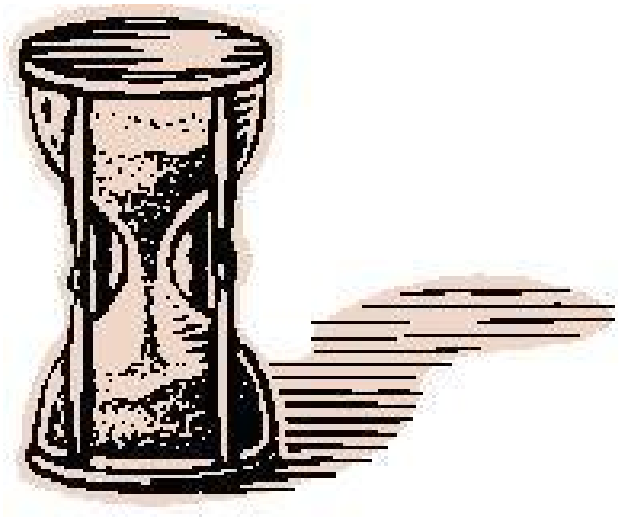
Understanding the needs of individuals with disabilities and offering common courtesy…

General Considerations In Treating Persons with Disabilities

- Do not refer to the individual's disability unless it is relevant to treatment
- Ask the person with the disability what they need to access their care, for example
  - "Do you need some help changing?"
  - "Would you like me to explain anything about the medications I've just prescribed?"
  - "Is there anything about our conversation that you did not understand?"
- Avoid asking personal questions about their disability
  - If the information is required be sensitive and respectful
- Use person first language when addressing the person, for example
  - "a person with a disability" rather than "a disabled person"
  - "a person who uses a wheelchair" rather than someone who is wheelchair bound
  - "a person who is blind" rather than the blind person

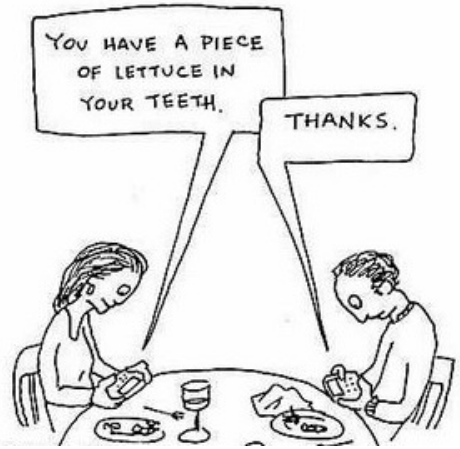
People with Cognitive Disabilities

- Prepare instructions or information in simple language
- If someone is having difficulty understanding you, repeat yourself using different words, without showing frustration
- Be *patient*
- Break up your ideas into smaller, manageable bits of information that can easily be remembered--*KEEP IT SIMPLE*
- Be considerate without being patronizing
- Keep all conversations at the appropriate level (adult to adult)



People with Hearing Impairments

- Make eye contact with the person you are speaking to
- If the person is not facing you, a gentle tap on the shoulder will assist you in announcing your presence
- Face the person you are speaking with; speak naturally and clearly
- If there is a break down in communication, write down what you are attempting to convey
- People who are hearing impaired or have hearing impairments often use texting to communicate—offer this option as needed
- If the person is accompanied by an interpreter, make sure you speak to the person, not their interpreter



People with Visual Impairments

- Always make your presence known
  - Be sure to greet the person who may not know you are there
  - Use the person's name to whom you are speaking so they are aware you are speaking to them
- Talk directly to the person who is blind, not through their companion
- Ask before interacting with any guide dog or service animal - they are working animals, not pets
  - Never take a guide dog or service animal from their owner

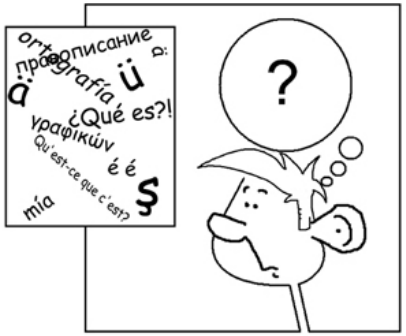
- Always ask a person if they would like help or for you to guide them to a destination
  - If they say yes, ask how best to help. If they say no, accept your help is not necessary
    - some people will hold your elbow
    - others may want to hold your shoulder
    - others may prefer verbal cues
  - Pulling at or steering a person is never appropriate, it is *dangerous* and disrespectful

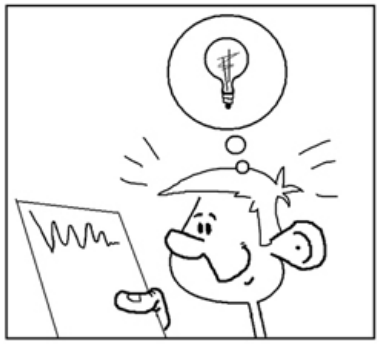
People with Speech Disabilities

- People with speech disabilities know that they can be hard to understand, particularly over the phone; they are used to repeating themselves or figuring out other ways of communicating
  - Never pretend to know what a person is saying
- Admit when you do not understand what the person is saying to you--if you get some of what is being said, repeat what you eard and ask the person to repeat the rest
  - If you still don't understand, ask the person if there is another way you can communicate
- Do not finish their sentences for them--allow them time to say and express their thoughts and wishes

People with Learning Disabilities

- Ask the person the best way for them to get information
  - e.g., in writing; on tape; other?
- Ask the person whether they need help reading & filling out forms
- Use simple language for all instructions & information
- Break down complicated tasks or concepts into smaller bits
- Ask the person if they need a quiet environment or more time to complete a task
- Tell the person that you will be available to help if and when they need help
  - e.g., I can read the forms for you; I can explain anything you don't understand; etc.
- Remember that this person has the same intellectual capacity as any other patient

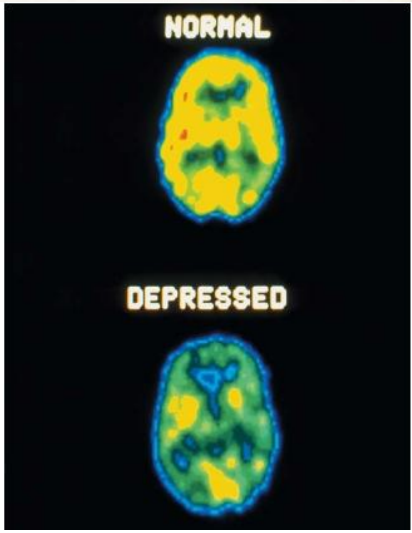




People with Psychiatric Disabilities

Psychiatric disabilities may affect the ability to think, feel, relate to others, and/or handle the stress of daily life. Often "attitude" in people with psychiatric disabilities comes from the feeling of being unheard or of not being respected.

- Recognize that psychiatric disabilities are usually invisible
- Try not to make assumptions about any psychiatric disability
  - Ask what is happening before you make a judgment
  - For example, both sleepiness and irritability can be signs of a medication side effect
- Ask the person with a psychiatric disability what he/she needs to make him/her most comfortable
- Avoid making judgments or decisions on how to treat someone before you ask what would be best for them
- Do not make negative assumptions about the person's abilities and potential



People who use Wheelchairs

- Ask the person who uses a wheelchair if they would like assistance before you jump in to help *(your help may not be needed or wanted)*
  - If they say, yes, ask how you can help; if they say no, accept that your help is not necessary
- A wheelchair is part of a person's personal space
  - Do not lean on a person's wheelchair or put anything on the wheelchair without the person's permission
- Take steps to ensure needed materials are within reach of someone that uses a wheelchair
- If your conversation will last more than a few minutes, consider sitting down in order to maintain similar eye level

Section II: Americans with Disabilities Act (ADA)

Objectives of this section:

- Americans with Disabilities Act Requirements
- How to Comply

The Americans with Disabilities Act - The Civil Rights Laws

- The Americans with Disabilities Act (ADA), the landmark disability rights law passed in 1990, prohibits discrimination against people with disabilities in five major areas:
  - employment, state and local government, public accommodations transportation, and communication

- The ADA provides a basic right of "reasonable accommodation" for a person with a disability to be afforded access to health care, examples include:
  - Providing an e-mail or text appointment confirmation for a person with a hearing loss
  - Access to a patient lift for a wheelchair rider needing to get out of the chair for an examination
- All governmental activities of public entities are covered, even if they are carried out by contractors

The Americans with Disabilities Act - Olmstead Decision

- All care must be provided in compliance with the ADA and Olmstead – a Supreme Court decision that requires care to be delivered in the most integrated setting
- The intent and spirit of the law is that people with disabilities have the right to participate with their nondisabled peers in all aspects of society, including access to health care

  "..No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

The Americans with Disabilities Act - Olmstead Decision

- The Court found that unjustified institutionalization, isolation, and segregation of people with disabilities was illegal discrimination

- Affirmative steps must be taken to ensure that people with disabilities are treated in a non discriminatory manner

The Americans with Disabilities Act - Olmstead Decision

- The intent and spirit of the law is that people with disabilities have the right to participate with their nondisabled peers in all aspects of society, including access to health care

  "..No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

Section III: Abuse, Neglect, and Exploitation

Objectives of this section:

- Help providers understand obligations to identify and respond to incidents of participant abuse, neglect, or exploitation

Abuse, Neglect, and Exploitation

- Providers can help identify, prevent, and report abuse, neglect, financial exploitation, including:
  - Inappropriate antipsychotic drug use, usually as a means of chemical restraint;
  - Failure to abide with legal requirements for patient choice, including:
    - The right to be involved and participate in care planning;
    - The right to refuse care, even if refusal is viewed as detrimental; and,
    - The right to individual preferences (e.g. dining, toileting, grooming);
  - Failure to respect patients' privacy;
  - Failure to provide for patients' dignity and quality of life, as mandated by law;
  - Medication mismanagement;
  - Physical and verbal abuse; and,
  - Insufficient provision of care needed to maintain highest practicable level of independence (e.g. putting someone in a diaper in place of providing assistance with toileting).

Abuse, Neglect, and Exploitation

- Long Term Care Ombudsman Program (LTCOP)
  - This program investigates and resolves complaints and concerns about long term care facilities such as adult homes, skilled nursing facilities, nursing homes and assisted living residences.
  - For specific providers by county, visit: http://www.ltcombudsman.ny.gov/Whois/directory.cfm
- Independent Consumer Advocacy Network (ICAN)
  - This ombudsman program provides FIDA Participants with free, confidential assistance.
  - ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org
- Adult Protective Service (APS)
  - This is a state-mandated case management program that arranges for services and supports for physically and/or mentally impaired adults who are at risk of harm.
  - For contact information by county, visit: http://www.nyc.gov/html/hra/html/services/adult.shtml

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- www.ada.gov/ada.fedresources.htm
- www.ada.gov/olmstead/olmstesad_about.htm
- www.ncd.gov
- www.ncsd.org
- www.who.int/mediacentre/factsheets/fs352/en
- www.wid.org

Appendix

A: Major Life Activities

B: Specific Disabilities, US Census Bureau

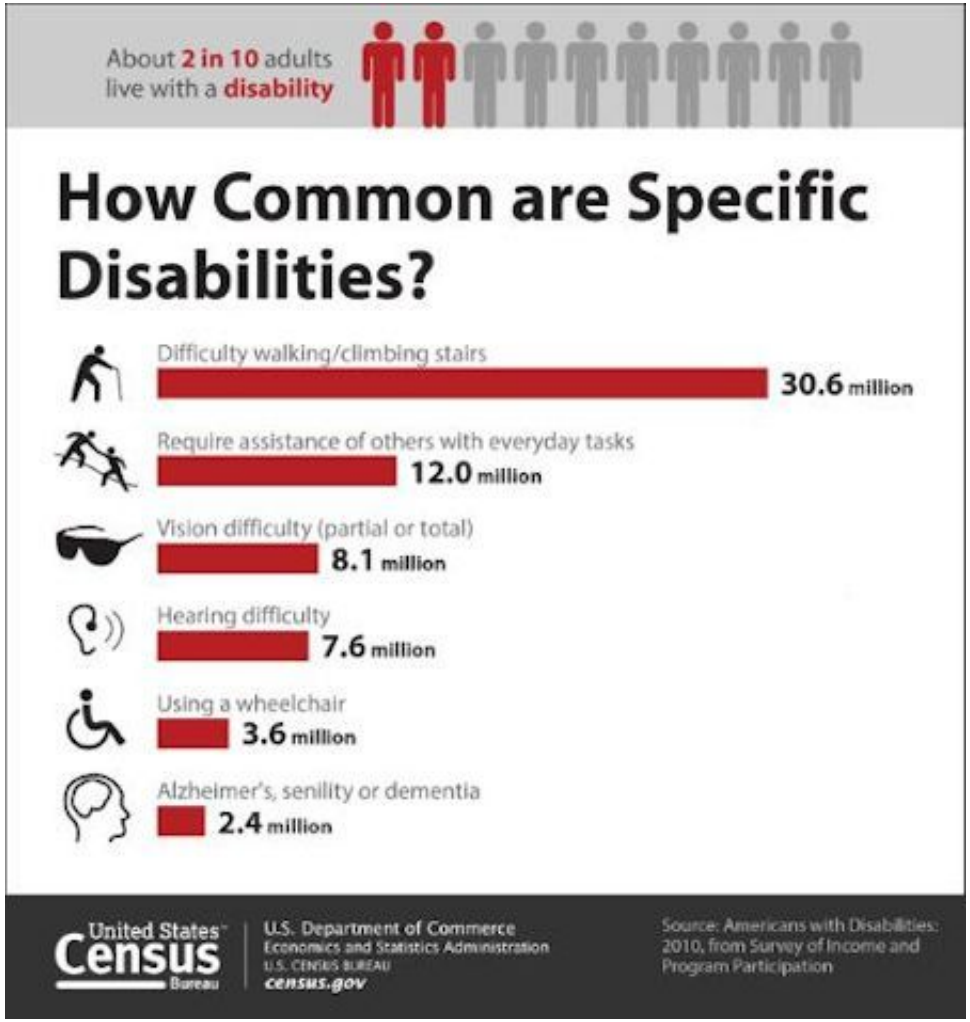
C: Chronic Conditions

1. Facts
2. Dual Eligible Prevalence, *bar chart*
3. Dual Eligibles-Multiple Conditions, *chart*

Appendix A – Major Life Activities

- **In general**
  - …major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working
- **Major bodily functions**
  - …a major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions
- Source: http://www.law.cornell.edu/uscode/text/42/12102

Appendix B – Specific Disabilities



Appendix C-1 Chronic Conditions: Facts

Conditions such as high blood pressure, high cholesterol, heart disease and diabetes highly prevalent among Medicare beneficiaries, and over 50% of beneficiaries have multiple chronic conditions

Multiple chronic conditions increase the risks for poor outcomes such as mortality and functional limitations as well as the risk of high cost services such as multiple hospitalizations and emergency department visits

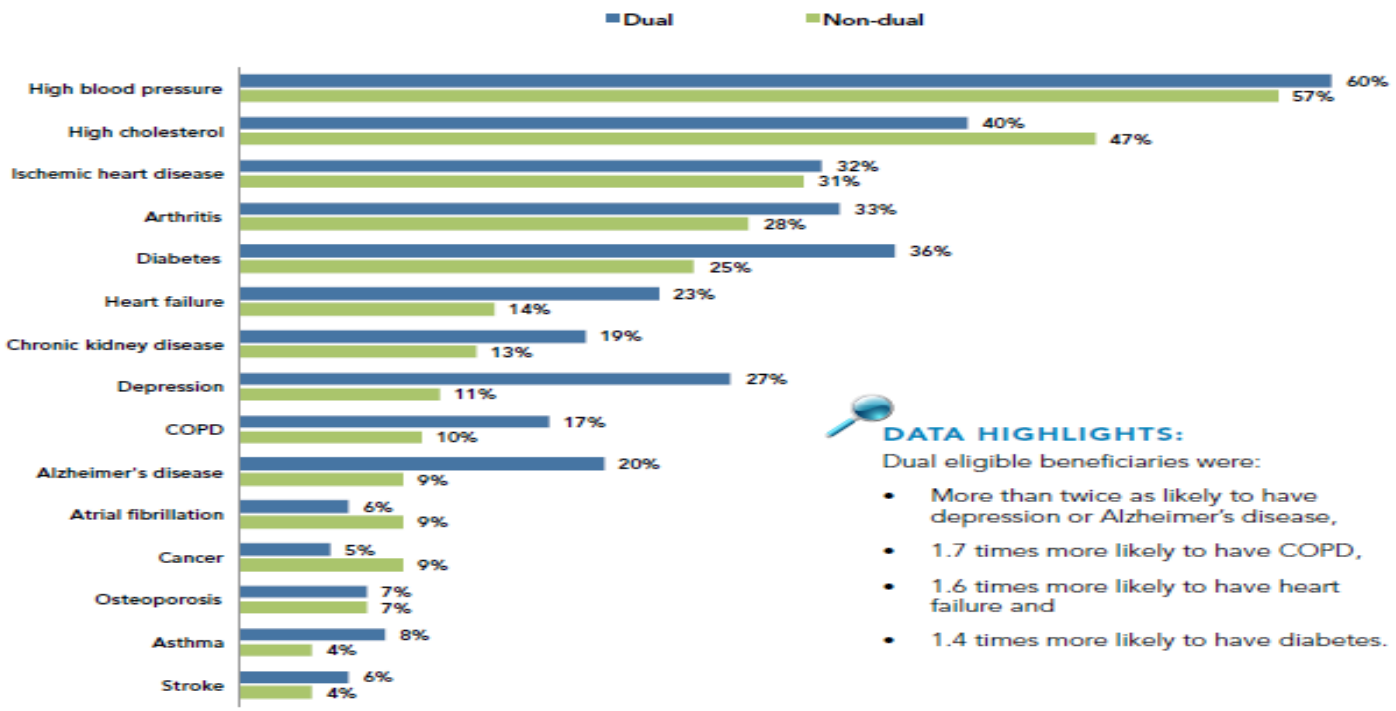
Chronic conditions tend to be more prevalent among beneficiaries eligible for both Medicare and Medicaid benefits

Increase in prevalence of depression is seen in individuals with chronic conditions and the elderly

Appendix C-2 Chronic Conditions: Dual Eligible Prevalence

"Most chronic conditions were more prevalent for dual-eligible beneficiaries"

Figure 1.1d *Percentage of Medicare FFS Beneficiaries with the 15 Selected Chronic Conditions by Dual Eligibility Status: 2010*



DATA HIGHLIGHTS:

Dual eligible beneficiaries were:

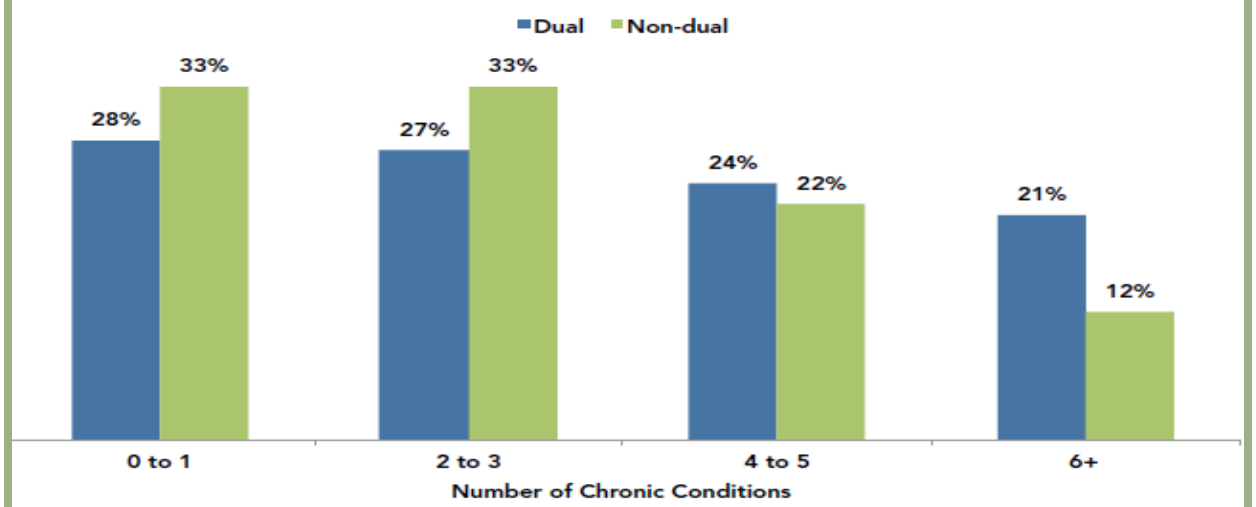
- More than twice as likely to have depression or Alzheimer's disease,
- 1.7 times more likely to have COPD,
- 1.6 times more likely to have heart failure and
- 1.4 times more likely to have diabetes.

SOURCE: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book, 2012 Edition. Baltimore, MD. 2012

Appendix C-3 Chronic Conditions: Dual Eligibles-Multiple Conditions

"Dual-eligible beneficiaries were more likely to have multiple chronic conditions"

Figure 1.2e *Percentage of Medicare FFS Beneficiaries by Number of Chronic Conditions and Dual Eligibility Status: 2010*



DATA HIGHLIGHTS:

- Seventy-two percent of dual-eligible beneficiaries had two or more conditions compared to 67% of non duals.
- Dual-eligible beneficiaries were 1.7 times as likely to have 6 or more chronic conditions.

SOURCE: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book, 2012 Edition. Baltimore, MD. 2012.

Test Questions

<u>Disability Awareness</u>

1. Disability equals poor health

   True or False

2. Programmatic accessibility is as important as physical accessibility

   True or False

3. What is the landmark disability rights law passed in 1990, prohibiting discrimination against people with disabilities

   a. The Americans with Disabilities Act (ADA)

   b. The Civil Rights Act

Test Answer Key

Question	Answer
Disability equals poor health	*False*
Programmatic accessibility is as important as physical accessibility	*True*
What is the landmark disability rights law passed in 1990, prohibiting discrimination against people with disabilities	*The Americans with Disabilities Act (ADA)* *The Civil Rights Act*

Recovery and Wellness Provider Training

Section I

Recovery

Recovery

- **Recovery** has been identified as a primary goal for behavioral health care.
- The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has defined Recovery as **the process of change through which individuals improve their health and wellness, live a self directed life, and strive to reach their full potential.**
- **A Recovery Oriented System of Care (ROSC)** is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with mental health conditions and/or with alcohol and drug problems.
- **The FIDA Person-Centered Service Planning process should serve as a ROSC for Participants.**

Components of Recovery

Supporting a Life in Recovery

- SAMHSA has further identified four major dimensions that support a life in recovery:
  - **Health:** Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
  - **Home:** A stable and safe place to live.
  - **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
  - **Community:** Relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

- SAMHSA has also identified ten guiding principles of recovery (1-2):
  - **Recovery emerges from hope:** The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.
  - **Recovery is person-driven:** Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience.

Guiding Principles of Recovery

- SAMHSA has also identified ten guiding principles of recovery (3-4):
  - **Recovery occurs via many pathways:** Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families.
  - **Recovery is holistic**: Recovery encompasses an individual's whole life, including mind, body, spirit, and community.

Guiding Principles of Recovery

- Guiding principles of recovery continued (5-7):
  - **Recovery is supported by peers and allies**: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community.
  - **Recovery is supported through relationship and social networks**: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
  - **Recovery is culturally-based and influenced**: Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery.

Guiding Principles of Recovery

- Guiding principles of recovery continued (8-10):
  - **Recovery is supported by addressing trauma**: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues.
  - **Recovery involves individual, family, and community strengths and responsibility**: Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery.
  - **Recovery is based on respect**: There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

FIDA Supports a Recovery Oriented System of Care

- FIDA seeks to make the health care system more recovery oriented and participating providers can take many steps to ensure that participants experiencing mental health conditions and/or substance use disorders are able to access recovery.

- FIDA participating providers should:
  - Ensure that services are delivered with an eye to the four dimensions of recovery (health, home, purpose, and community).
  - Employ shared decision making tools in planning for mental health and/or substance abuse treatment services.
  - Involve peer specialists in the care planning and delivery. Peer specialists are qualified persons with self-identified lived experience in recovery from mental illness and/or substance use disorders.
  - Participate in National Recovery Month events and distribute National Recovery Month resources in offices and other settings.

Section II

Wellness Principles

Wellness Principles

- Six dimensions of Wellness contribute to positive growth and wellbeing
  - **Physical** – a person's body functions properly and ability to maintain a healthy quality of life
  - **Social** – a person's interactions with others and ability to maintain positive relationships
  - **Mental** – a person's ability to process information and act accordingly
  - **Emotional** – a person's coping, adjusting and adapting mechanisms
  - **Spiritual** – belief in some force or dynamic other than human that can provide peace and harmony
  - **Environmental** – one's surroundings, habitat and occupation

Wellness Principles

- Wellness is an active process that promotes health and well-being. It involves healthy eating, exercise, stress management, education, health screening, cultivation of supportive interpersonal relationships, and other interventions focusing on the whole person.
- Wellness Program interventions are active, outcomes-oriented, and positive.
- Wellness Program interventions may enhance health, prevent illness, and reduce the need for some future treatments.

Wellness Principles

- Goals of Wellness Programs include:
  - Understanding that people with disabilities can lead long, healthy lives;
  - Elevating the importance of health and wellness;
  - Providing information on steps people can take to improve health; and,
  - Providing knowledge and tools to treat the whole person with dignity.
- Wellness Programs give people more control over their health.

Please visit the FIDA Portal Community Resources Page, Wellness Tab for more.

TEST Questions

Recovery and Wellness

1. **The four dimensions supporting recovery are:**
    a. Health, Home, Purpose, and Community
    b. Stability, Friendship, Sobriety, and Employment
    c. Treatment, Compliance, Medication, and Coverage
    d. Communication, Engagement, Support, and Wellness

TEST Questions

Recovery and Wellness

2. Recovery pathway: (true or false)

a. An individual's path to recovery is the same for everyone, including from different cultures and backgrounds.

TEST Questions

Recovery and Wellness

3. Characteristics of a successful wellness program include:

a. Programs that promotes health and well-being.

b. Programs that promote healthy eating, exercise, and stress management.

c. Programs that involve education, health screening, and the cultivation of supportive interpersonal relationships.

d. All of the above

Test Answer Key

Question	Answer
The four dimensions supporting recovery are:	*Health, Home, Purpose, and Community*
An individual's path to recovery is the same for everyone, including from different cultures and backgrounds.	*False*
Characteristics of a successful wellness program include:	*All of the above*