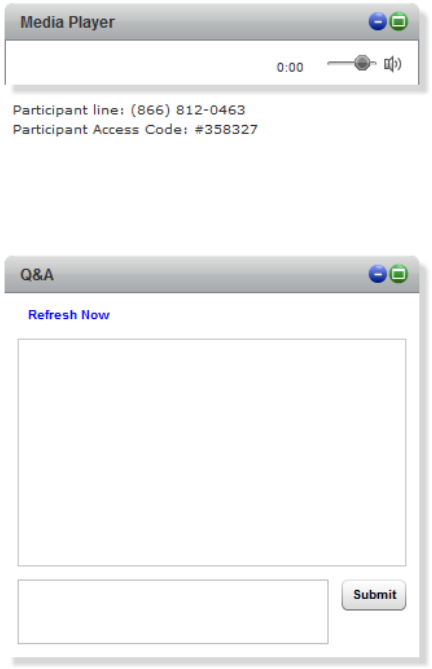
Strategies for the Implementation of Disability-Competent Care

Flexible Long Term Services and Supports



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



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Overview of Webinar Series

Strategies for the Implementation of Disability-Competent Care

- This series takes a fresh look at topics that were presented in the previous two webinar series, which are available for viewing at

  https://www.resourcesforintegratedcare.com/

- We aim to provide participants with updated information and the opportunity to discuss topical questions with leading healthcare professionals and subject matter experts. We hope you come prepared with questions and comments for this discussion.

- The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to create the eight-part weekly webinar series, **Strategies for the Implementation of Disability-Competent Care**.

Introductions

Presenters

Christopher Duff
Disability Practice and Policy Consultant

Joe Groshens
Founder, Relocation Specialists
Options for Independence

Carol Ambers
Relocation Specialists
Options for Independence

Webinar Agenda

- Explore the existing disconnect between medical care and Long-Term Services and Support (LTSS)
- Understand the role of LTSS in promoting and supporting the Triple Aim
- Learn the process of person-centered relocation and transition services
- Understand relocation services and the establishment of LTSS through the use of first person stories
- Audience questions

Context: The Opportunity for Integration

Health care has historically operated in silos:

- **Hospitals** (acute care) focus on returning persons to medical stability, and then discharging them to the community
- **Primary Care** has historically focused on responding to episodes of illness
- **LTSS** provides the support persons need to function in the community

The Triple Aim of health care can be fully achieved when the three services work together to support the goals of the participant and their return to life in the community

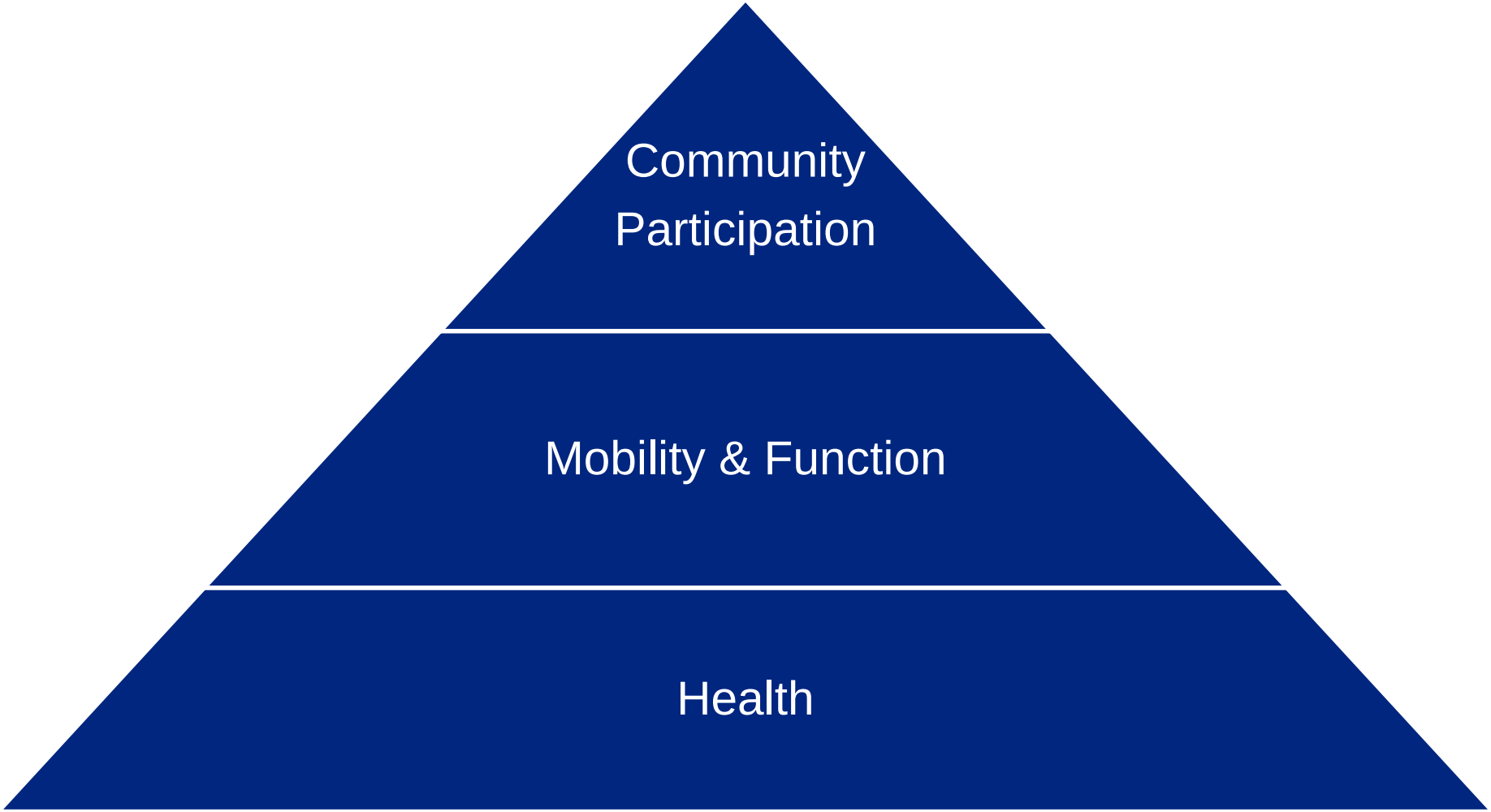
Community-Based LTSS

LTSS traditionally includes, but is not limited to:

- Personal care assistant / attendant
- Skilled nursing
- Home delivered meals
- Rehab therapies (occupational, physical, and speech therapies) – outpatient and in-home
- Durable medical equipment & disposable medical supplies
- Adult day health / social programs
- Complex rehab technology
- Community-based transportation
- Home modifications and social programs

Integrated Care & Supports

Hierarchy of Needs



The Mandate of the Olmstead Decision

- The Olmstead Decision of 1999, requires public agencies to provide opportunities for qualified persons with disabilities to reside in the most integrated setting
  - The 'integration mandate' is based on Tittle II of the ADA
  - In 2009, President Obama issued a proclamation launching the ‘Year of Community Living”, intended to fashion an effective, nationwide program to enforce the integration mandate
- Public agencies operationalize this mandate through relocation services and transition coordination, assist participants living in institutions to relocate to safe community options of their choosing

Establishing Person-Centered LTSS

The process of transition and relocation services are:

1. Person-centered assessment: get to know the individual, their goals, history. and needs
2. Developing a plan: based on participant goals
3. Implementation and follow-up: making sure the necessary supports are in place for the success of the participants goals

1) Person-Centered LTSS: Assessment

- Meet the participant where they live
- Help them identify their hopes and preferences
- Review options – type of setting, availability and location
- Identify required functional supports

2) Person-Centered LTSS: Developing a Plan

- Identify specific transition goals and outcomes, including actionable steps and timelines
  - Make sure the plan is based on the participant's goals and not those of the facility or family
  - Be realistic about community options, explain to the participant their goals may require an intermediary step

3) Person-Centered LTSS: Implementing the Plan and Follow-up

- Keep in close communication with the participant and identified support persons
- Support the participant in evaluating identified options
- Problem solve issues as they arise – advocating as needed
- Once the plan is finalized, communicate with all involved parties to assist and support the participant's success
- Identify and refer for LTSS services, ongoing care coordination as needed, and explore plans for the next steps in their lives

First Person Story: Calvin

Assessment

- Calvin is a 44-year old, divorced man and has two sons. He is currently living with quadriplegia resulting in minimal function
- He had been a successful businessman, managing sites in multiple states, making a good wage
- He spent his assets down to the Medicaid limit of $3,000, and was living on $94 / month while in the nursing facility
- Calvin was defeated – all he wanted was his own plan so he could have privacy and autonomy
- He needed to see some hope, a vision of what his life could be

First Person Story: Calvin

Plan:

- Needed employment to qualify for a Medicaid program so he had enough income to pay rent
- Find housing – a two bedroom so his sons could visit
- Chose to use Personal Care Attendant (PCA) hours in two shifts during the day and to spend nights alone

Implementation and follow-up:

- Facilitate apartment modifications and arrange for needed equipment
- Acquire specialized equipment for verbal phone access in case of a emergency during the night
- Calvin has successfully remained in the community – as he chose

First Person Story: Mr. Brown

Assessment:

- Mr. Brown was a 60 year-old gentleman who had lived with his mother for many years
- Upon her death, he moved into a nursing facility, where he lived for 4 months for an initial assessment visit
- Diagnosed with Obsessive Compulsive Disorder, Congestive Health Failure, and numerous bed bug bites
- He was fairly passive and socially isolated, and thought he needed to remain there for the rest of his life
- Met with Mr. Brown and established a relationship, and he agreed to look at some options in the community

First Person Story: Mr. Brown

Plan:

- Explore a range of living options, including group home, assisted living and independent living
- Work with Mr. Brown to see options for the future and to identify preferences and goals
- Continue discussing options with Mr. Brown and facility staff

Implementation and follow-up:

- Mr. Brown chose to move into an assisted living facility
  - He has his own apartment, supports as needed and opportunities for socialization
- Two years later: “Thank you for showing me that I can live in the community, I miss Mom, but have made friends and am happy”

Key Challenges to LTSS Planning

- The system is very complex – like a puzzle that keeps falling apart
- Financial challenges due to limited income and assets
- Availability of housing; especially affordable and subsidized
  - Assisted living settings are often inaccessible financially
- Providers not accepting applications from persons with a background of an eviction or felony
- Relationships are needed within the network of housing providers
  - Legal aid and Ombudsman are often required to understand the Olmstead Act (if needed)
- Persons with mental health issues are often perceived as socially challenging by other residents

Lessons Learned in LTSS Planning

- People lose their independence when entering an institution and are often seen as dependent
  - Individuals often takes on institutionalized behavior and self-image
- Hold the participant accountable and invested - in terms of achieving goals
- Almost anyone can relocate into the community – *if they choose*
  - There are very rare situation where this hasn't been successful
- Get beyond being frustrated with the dysfunctional system and learn how to navigate through it
- Providers need as much education as participants
- Getting an individual settled into a new place is only the first step, next is beginning to engage the community

Supporting Employment & Promoting Community Participation

- Social, educational, and artistic activities can be very helpful in combating isolation for participants
- Support continued involvement or return to favored activities:
  - Participation in church groups
  - Participation in arts programs – singing, dancing, etc.
  - Participation in family functions outside the home
- Part of individualized planning includes linkages to:
  - Dept. of Vocational Rehabilitation and Education
  - Community-based social centers
  - Disability sports programs

Summary

- Independence and achievement of life goals is a journey – not a destination
- All involved parties (participant, facility staff, family members) commonly need education and coaching
- Advocacy is a key part of relocation and transition work – for there are many conflicting systems and barriers
- Creating or linking with community resources to meet the participant's individual needs can decrease social isolation and ultimately improve health and quality of life

Audience Questions and Discussion

Next Webinar

"The Care Management Relationship"

Wednesday June 24th, 2015
2:00-3:00PM EST

Session VIII will:

- Explore the importance of establishing the relationship between each participant and the interdisciplinary care team
- Discuss the application of person-centered care planning in care coordination
- Use a first-person story to demonstrate delivering disability-competent care through an interdisciplinary team

Please respond to our survey!

Thank You for Attending

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  - Joe Groshens at jgroshens@optionsforindependence.com
  - Carol Ambers at cambers@optionsforindependence.com
- Disability-Competent Care Self-Assessment Tool available online at: https://www.resourcesforintegratedcare.com/

Resources and References

- Best practices for meaningful consumer input in health care delivery models
  - http://www.communitycatalyst.org/doc-store/publications/meaningfulconsumerinput_healthcaredeliverymodels.pdf

Disability-Competent Care Self-Assessment Tool

1. Relational-Based Care Management

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

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

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

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

Available at https://www.resourcesforintegratedcare.com/

Send Us Your Feedback

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

Please contact us with your suggestions at

RIC@Lewin.com

What We'd Like from You:

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