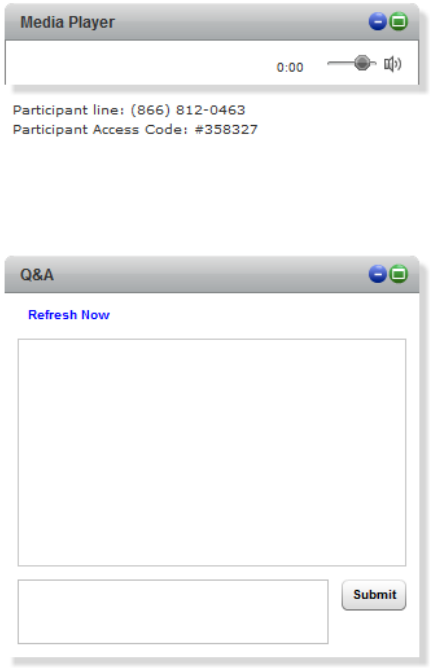
Strategies for the Implementation of Disability-Competent Care

The Care Management Relationship



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**.

Webinar Agenda

- Introduction of the Independence Care System (ICS)
- Defining Care Coordination and Interdisciplinary Teams (IDT)
- First-Person Stories
- Audience questions

Introductions

Presenters

Christopher Duff
Disability Policy & Practice
Consultant

Jean Minkel, PT
SVP, Rehabilitation and
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Independence Care System

Introductions

Presenters

Frachely Peralta
Sr. Nurse, Care Management
Independence Care System

Nellie Merced,
Social Work, Care Management
Independence Care System

Independence Care System

- A nonprofit, community-based agency, ICS at its core is a community of people-members, providers of care, staff and friends-who share a common vision and beliefs
- Persons with disabilities or chronic conditions:
  - Can often take the lead in planning and managing their own health care and social supports
  - Require a service system that blends social supports and health care services
  - Have unique needs and preferences that must be recognized and addressed

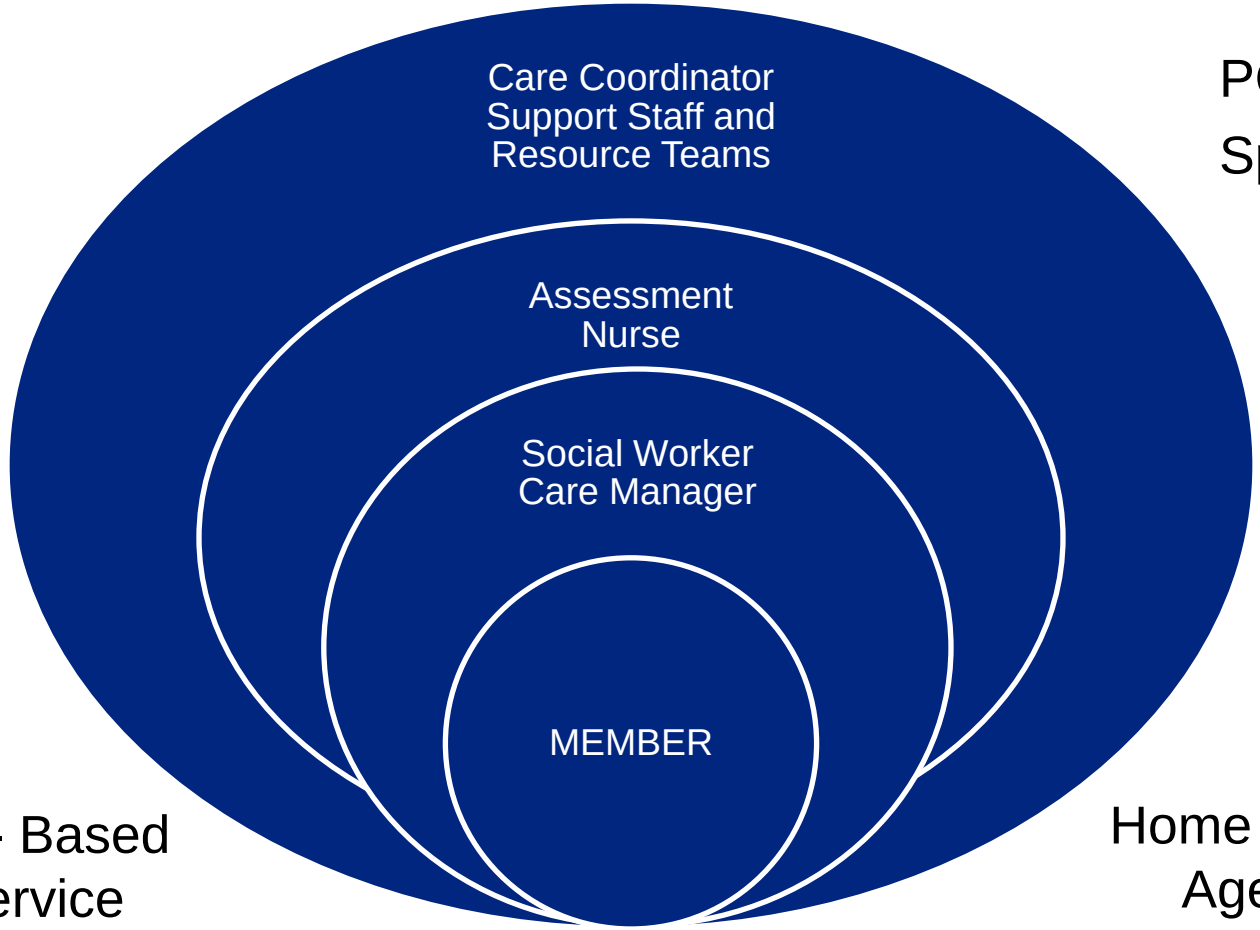
Defining Care Coordination

- Care Coordination provides oversight for participant's care and is based on individual goals and preferences
- At ICS, coordination is provided by an interdisciplinary team composed of disability-competent staff with backgrounds in social work, nursing, behavioral health, primary and rehabilitation care
- The Care team has ongoing contact with the participant to:
  - develop and maintain a trusting relationship
  - monitor / facilitate the implementation of Care Plan interventions which are identified and prioritized by the member and care manager

ICS Interdisciplinary Team Construct

Social Programs

PCP & Specialists



Community - Based Skilled Service

Home Care Agency

Key Elements of Relational Care Coordination

- Trusting relationship
- Honoring the participant's preferences and goals
- Direct communication with the participant's support team – family, home care workers, physicians and behavioral health specialists, with the member's consent
- Comprehensive, timely assessment and reassessment
- Participant is supported to continue to be or to become "self-directed", to the most extent possible

Allocating Team Resources

- Care Coordination requires a relationship with the participant
  - Self-Managing “Low Participants” – where the goal is to ensure ease of access (removal of ‘managed barriers’) and education
  - “Moderate Participants” who need episodic management which includes timely interventions
  - “High Participants” require a high level of care management involvement to ensure the delivery of needed care and supports, while addressing complicating factors

Interdisciplinary Team Process

- Appropriate comprehensive assessment and re-assessment in order to provide needed and wanted care and support
- Determine with the input of the participant, the intensity of Care Coordination service preferred and needed
- Individualized Care Plan – Person-Centered Service Plan (PCSP)
- Meet regularly with IDT to coordinate, prioritize and re-evaluate what is working and what is not working and revise the care plan with input of the participant
- Monthly contact with participant, if the participant has not already reached out for self-directed care coordination

First Person Story: Sam

Assessment:

- Participant is an 88 year old Caucasian male, he has a history (HX) of advanced Alzheimer's, Aphasia, and Coronary Artery Disease
- Participant resides in an apartment on the lower east side of NYC with his elderly spouse
- Functional limitations result in the need for home care services - 12 hours / 7 days a week

First Person Story: Sam

Presenting Issue:

- The daughter called to report that her mother was overwhelmed with nightly care
  - Sam was not sleeping well
  - He was getting out of bed frequently
- Sam's issue was subsequently impacting his wife's sleep
- Information was obtained by Sam's social worker care manager and brought to the team's senior RN to review the situation

First Person Story: Sam

Step 1: RN Assessment

- To get a clear view of situation, RN reached out to the spouse who stated her husband is toileted frequently at night and that he had periods of confusion and insomnia making it difficult to handle care at night
- Sam's spouse is elder and frail
- RN reviewed meds and noticed that Sam had no anti-anxiety meds or sleeping aids
  - These are ordered quite frequently for participants with Alzheimer's so they can rest if the person is losing the sense of differentiating between day and night, often referred to a being a "Sundowner"

First Person Story: Sam

Step 2: Intervention

- RN spoke to Primary Care Provider (PCP) to ask if a change in medications could be considered. It took a while to get through to the PCP but once contacted they identified:
  - Sam had been on these meds in the past and the family did not like the effects
  - At times Sam has refused to take his meds
- The PCP agreed that an alternative intervention could be implemented to increase the home care hours because of Sam's high-level of care and advanced Alzheimer's

First Person Story: Sam

Step 3: Revised Intervention

- RN spoke to both the spouse and daughter, who are very involved with care and decision making
- The daughter stated that she did not want to add any unnecessary meds to her father's regimen
- She added that they had tried these medications and it made him more confused and disorientated
- The family did not want to try any other meds / sleeping aids

First Person Story: Sam

Step 4: Plan

- The RN brought all information to team meetings. The team decided based upon the info obtained (PCP, spouse and daughter) that Sam would benefit from an increase in home care hours
- Sleep-in was considered but:
  - Sam is toileted more than 2-3 times a night
  - he gets up frequently
  - he requires regular attention during nights - which sleep-in aids could not provide
- Another consideration was the participant and his family would lose their current PCAs, with whom the member had a relationship for years

First Person Story: Sam

Step: 5 Implementation

- Participant's family is in agreement with the plan of care - PCA assistance at night
  - The change in home care services was communicated to the Paraprofessional Coordinator on the IDT team, who updated the authorization for service and informed the Home Care Agency
- Documentation of each step had been entered into the Care Management software system
- A split shift (2 PCA, each working 12 hours) hours was initiated

First Person Story: Sam

Outcomes and Results

- Sam's wife reports that he has been assisted very well throughout the night hours
  - Sam is still waking up various times at night. The PCAs are able to care for him and he gets along with them
- His wife expressed being very thankful for the split shift service as Sam is now getting the proper care needed due to his condition
- The wife reports she is getting rest and as a result is able to assist effectively during the day and with decision making

First Person Story: Mark

Assessment:

- Mark is 36 year old male
- He acquired his Spinal Cord Injury (S.C.I.) in a motor vehicle accident at the age of 10
- His mother was the driver, and had expired at the scene of the accident in his native home of Puerto Rico
- He has been a member of ICS (on and off) since 2000

First Person Story: Mark

History with ICS:

- Intensive community-based care management provided by an RN and social worker to address a stage 4 wound
- Three failed skin flap surgeries, before a behavioral health specialist was brought in to meet with Mark
- He had never grieved the loss of his Mother, due to his own acquired SCI resulting from the same accident

First Person Story: Mark

History with ICS:

- Mark had been consistent in attending to his needed medical visits at an Internal Medicine clinic
  - Clinic was part of an academic medical center clinic with revolving staff
- He had repeated Hx of U.T.I's
  - Various concerns with catheterization and hospital clinic

First Person Story: Mark

Re-enrollment:

- After a short time of incarceration in Miami for a few months, Mark was not allowed to return to New York for three years, while on probation in Miami
  - He reported not having any medical follow-up or supplies while on probation and residing with family
  - This resulted in two sacral wounds near his testicles
- He was allowed to return to NY to complete his probation, and has started to re-acclimate himself with his past routine
- Mark contacted ICS and requested to be re-enrolled with for Care Management Services

First Person Story: Mark

Plan:

- He is currently residing with his father and reported that his relationship with his father is not at its best
- Mark has submitted an application for a subsidized apartment
- Mark initiated medical appointments, returning back to familiar medical services
- He scheduled appointments at Hospital Internal Medicine and wound clinics
- Mark was able to meet with a Social Work Care Manager (SWCM) to provide the needed prescriptions and supplies
- He initiated wheel chair repairs

First Person Story: Mark

Implementation and Follow-up:

- Goal:
  - Follow-up with SWCM - reconnecting and re-acclimating himself to the new policy and procedure as a member with ICS
  - To have his own residence
- Care Plan:
  - Social Worker, Care Manager to link to with a PCP, to work collaboratively with SCI clinic
  - SWCM to assist in applying to Vocational Rehab for trade training

First Person Story: Mark

Community and Social Program

- Connected participants with community services day program for social outlet and an exercise program especially designed for persons with a physical disability

First Person Story: Mark

Mental Health

- On the surface Mark may not appear to need mental health services but a deep-dive would reveal differently
- SWCM plans to have this discussion, because they noted Mark is now working to get back to “the normal” he once knew but still has a sense of vulnerability which is concerning

Care Management Team Lessons Learned

- Value Listening:
  - To hear and understand the “real need” being expressed by the participant
  - To hear and understand what interventions can be offered by team members from different disciplines
- Ask of the participant: “What is most important to you?”
  - How can we as a Care Management Team help you gain or keep what is most important to you?

Lessons Learned (con't)

- As a team, always close the loop
  - "Doing something" and not let others know what you are doing, is not always helpful.
  - Just keeping people informed – even if there is *no progress* – is **critical** to care coordination!

Summary

- Care coordination is the first and foremost relationship and success will not be achieved without knowing what is important to the participant
- The team functions as one – though each participant has their own unique roles and responsibilities
- Communication between all involved – participant, their support persons, PCP, IDT, and specialty providers

Audience Questions and Discussion

Thank You for Attending

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  - Gretchen Nye at gretchen.nye1@cms.hhs.gov
  - Kerry Branick at kerry.branick@cms.hhs.gov
  - Christopher Duff at chrisduff2@gmail.com
- Disability-Competent Care Self-Assessment Tool available online at:

  https://www.resourcesforintegratedcare.com/

Resources and References

- Complex Care Management Toolkit, California Quality Collaborative
  - http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ComplexCareManagementToolkit.pdf
- National scan of innovative and successful approaches to managing care for patients with complex, chronic conditions, Center for Health Care Strategies
  - http://www.chcf.org/publications/2013/07/complex-care-program-overviews

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