

Strategies for the Implementation of Disability-Competent Care
The Care Management Relationship
June 24th, 2015 - Transcript

Christopher Duff: On behalf of the Lewin Group, I would like to welcome you to this presentation on the care management relationship, which is the last of our current series of the 2015 webinars. As Joan stated, my name is Chris Duff, and I'm a Disability Practice and Policy Consultant working with the Lewin Group. The Medicare and Medicaid Coordination Office at the Centers for Medicare & Medicaid services has contracted with Lewin to develop technical assistance and actionable tools to support providers in their efforts to deliver more integrated, coordinated care to Medicare and Medicaid enrollees.

First I'd like to introduce you to our platform for the presentation. If your slides aren't moving, please push F5 on your computer keyboard. Also, please note the icons at the bottom of the screen. The second icon from the right allows you to download the slides for this presentation. The Q&A window is open next to your slides. Please enter any questions you may have regarding material, and we look forward to discussing them during the Q&A portion of the presentation.

Beyond the Q&A feature, through which you can submit questions and comments at any time, we will be using instant polling to ask specific questions to help guide our presentation. To demonstrate the process, here's the first question: In what role are you currently working? As a care coordinator, in a supervisory or management position, as a navigator or direct provider (by that I mean a direct health care provider), as a consumer or advocate, or other? Please make your choices and click Submit. We would also like to solicit your opinion on this series, as well as past webinars and supplemental resources. Please take the time to complete our survey at the end of the webinar and send us your ideas for future topics and content. Contact information is listed at the end of this presentation.

Let me go back and review the results of the first polling question. As I expected, I think the majority of people are care coordinators, and then a lot of supervisory and management positions, because this -- the title is a little misleading -- we're really going to talk here about how does the care coordination team function? So I'm glad to hear there's a lot of people who are actually out doing it. So thank you for those responses.

This current series has consisted of eight webinars, all of which have been recorded and are available along with a PDF of the slides. We have about 25 or 26 of these in all, at the link listed below here, www.resourcesforintegratedcare.com, that's all one word, .com.

In 2013, we published a comprehensive disability-competent care assessment tool describing disability-competent care in three pillars. The first is individualized care coordination provided by an interdisciplinary care team. Second is the redesigned primary care delivery, and third is flexible long-term services and supports. This is our third webinar series [but acts as a] components of disability-competent care. Resources from past webinar series and this one are available at the website I mentioned before.

Most of us have been trained in a specific discipline -- nursing, occupational therapy, social work and others. We have specific skills and competencies that we bring to our participants. But very few of us have had training in working as an interdisciplinary team, or even pronouncing it, learning how to partner with colleagues to best serve our participants. Being a team doesn't just mean we perform our unique tasks on parallel tracks, or that we all work as one. We have a responsibility for our individual tasks, communication as needed with our peers, sharing in the success of the participants and accepting responsibility for the failures they experience. Today we're going to learn how this is done at ICS.

Today's webinar will be presented by an interdisciplinary team from ICS of New York. ICS has been in operation for over 15 years, starting originally as a managed long-term care plan in New York City, and more recently they've been offering an integrated dual-eligible plan for persons 18 and over. Their environments have been growing quickly. Their enrollment has been growing quickly over the last several years, requiring them to undertake extensive system and process redesign. Besides hiring and training several hundred additional staff, they have restructured their care management systems and functioning of their interdisciplinary care team. It is this experience that led us to ask them to present this webinar, for there are few organizations with their experience, serving a population of persons living in the community with significant functional limitations.

We have three presenters: Jean Minkel, Frachely -- sorry about that -- Peralta, and Nellie Merced. Jean will provide the foundational information on care coordination and the interdisciplinary care team, while Frachely and Nellie will discuss dual first-person stories. Jean has been with ICS for 15-plus years and trained as a physical therapist with a speciality in mobility and seating. She started the mobility and seating clinic, as well as a wheelchair maintenance and training program. Most recently, she has assumed responsibility for rehabilitation and coordination and care coordination at ICS. She has been in this field of habilitation for 20-plus years and has presented nationally and internationally on the topic of specialized rehabilitation technology and equipment.

To provide the presenters additional context, I'd like to ask one more polling question. How much experience do you have working as a member of an interdisciplinary care team? A great

deal, a moderate amount, minimal or no experience? If you could answer that now, I'll wait for just a second, and review the results before I turn it over to Jean for the presentation.

We can look at the results now. Oh, there's a lot more experience than I anticipated. That's great. That's very good. So, what I would hope is that you can bring that experience to the dialogued question-and-answer section we have at the end, so we can hear your experiences, if you do some things differently that might be of value to others, or you would hope that you could bring that forward in your question. So this gives me a sense, and the presenters a sense, that you have a little more foundation than we had anticipated, which I am very pleased with.

So at this point I will go ahead and hand it over to Jean.

Jean Minkel: Chris, thanks so much. And thank you to the Lewin Group and CMS for the opportunity to share our experiences and, as Chris said in his introduction, ICS, Independence Care System, is a not-for-profit community-based system that really is designed around community. And it's a community of people that share the belief that people with disabilities and chronic conditions can and often should be the leaders of their care, and that the care is more comprehensive than just health care. It's really around the blend of social support in conjunction with health care needs. And that our members, as we call them, and we will reference as participants through this presentation, that our participants have unique needs and preferences, by having both physical disabilities with functional needs and chronic conditions that impact their ability to function independently. And for many of these folks, they're not looking for a cure. They're really looking for assistance to provide functional and mobility and a state of health that allows them community participation. So we frequently come back to our community, our community of ICS, and our community at large and the ability for our participants with disabilities and chronic conditions to achieve the greatest level of participation that they're able to.

We build that program -- if you can move to the next slide -- based on very similar definitions of care coordination that perhaps have been shared, if others have been listening to the series that Chris has been producing -- we have partners at Commonwealth Care Alliance, and Adam Burrows, in the last presentation, and it's really nice to see a variety of programs be able to implement some of the same principles.

So in our mind, the care coordination provides an oversight to the individual goals and preferences. And particularly when you work with somebody with a disability who's had a disability for a long time, they are the source of what has worked and what hasn't worked. And true success comes when you enter that as a partnership, and really are open to saying, you're the expert in your life, I'm here to help you in the areas where you've identified that some assistance could be helpful. We help coordinate that care by acknowledging one person, even one person

with the member, who can't fill in the whole spectrum, and that by working as an interdisciplinary team, having the assessments from our nurses that are done in the home, looking at both health and function, and bringing those assessment findings back to a support team that works in the office, as well as our social workers who really bring that social fabric and help us identify, how can we move some of the social determinants that are creating barriers to somebody both participating and achieving a level of health status? Because sometimes it has more to do with housing and transportation and access to a social community that's causing the isolation and decline in the health. Our care team really looks to develop a trusting relationship, which starts with that partnership. And our ability to build on that relationship is really based on facilitating or monitoring the interventions that were agreed to.

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As Chris mentioned, in the 15 years since we've been engaged in particularly community-based care, we've had many, many learnings. And one of the learnings is, if a good system exists in the community, we don't want to recreate it, we want to tap into it. So our current program is really a montage, I like to say, of the integration between what we do as an ICS internal interdisciplinary team, and how do we reach out and collaborate with the existing, both health care, social and skilled services that are already in the community?

So to put that into a visual, we are highly member- or participant-centric. Our assessments are done in people's home, looking at that person's functional capabilities. That information is brought back to the team, and our care manager, who is our largely social-work background, work directly one-on-one with our members. If it's a new member, there's an in-home, face-to-face, total psychosocial, where are the barriers, what can we help? If it's a long-term member, it's a check-in. Everything going well? Terrific!

And our nurses and social workers are working with the members in conjunction with -- and this was a very important learning. As much as we needed field-based staff, we needed a stable in-office, so that a member who's in need had a phone call that could address their need. So our care coordinators and support units are office-based, to allow for a much more rapid deployment of an issue. If somebody's wheelchair is broken down, they don't want to hear that the social worker's in the field. They want to know that they can get home and that a tech's going to be able to help them out.

We recognized that the dual of social programs and health care requires that we're in contact with people's primary care providers, and a large number of our members, because of their disability, also have a specialty network. And oftentimes, we're the community that's bringing the PCP in contact with the specialist, and the specialist in contact with the PCP. Our absolutely foundational partner in our success has been in the home care agency. Our home care workers

are our link. They are the folks in the home. They're able to give us great collaboration as to, is a planned intervention actually being implemented, or, best-laid plans, it's not really happening? And for our more elderly with multiple chronic conditions, we find that the health -- the home care worker is really our first eyes and ears. Now some -- Mrs. Jones isn't drinking as much as she used to. I can see that there's a bit more lethargy. We can be in direct communication with the PCP and create a system of care that's much more responsive than waiting for that problem to escalate.

As we mentioned, many of our members, particularly our under-65 population, really embraced the opportunity to engage in social programs, particularly social programs that are for people with disabilities, often led by people with disabilities. And Nellie will speak to our spinal cord population, but having a young person know that they can go to a community of other young people dealing with functional disabilities has just been a huge benefit. And we link that when a particular person has a skilled need. There's a wound, they need wound care, we can connect them with a community-based skilled service. So if a network of care exists, we tap into it. If it doesn't exist, we will often bring it in-house and say, how can we meet this member's need on an individualized basis?

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So key elements: A trusting relationship. And I cannot stress enough, particularly for our members who have historically been in a somewhat disenfranchised role within the health care system, relying a lot on clinic-based services, really approaching the health care system with a, I have to fight for what I want, and we arrive and say, tell us what your barriers have been. And it's like, disarming at the beginning. So really working to develop that relationship that we really share the goal of maximizing community participation. You can only do that if you truly practice honoring the person's preferences and goals, and we really practice the dignity of risk. We pride ourselves on providing people the best information, education, and then stepping back and saying, how do you want to proceed? And that's a learning curve. It only works with direct communication, and we recognize that with the member's permission, we'll reach out. We need to involve behavioral health specialists, along with primary care, along with the home care agency. And not surprising to those in care coordination, it may come down to: Stop, we need everybody on the phone. We need everybody in the room. We need everybody to be hearing the same message at the same time.

On a regular basis, our nurses go out, and we have a 180-day reassessment cycle, and then those assessment findings are brought back to the team. The team really works directly in assessing, is this participant able to self-direct? Are they making independent decisions? Then we're in a facilitation mode. If this person really does need guidance and assistance, then we're either operating at a moderate level of care coordination or a high level of care coordination.

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We do make a very strong effort to allocate our team resources and really try and match our staff capabilities with our member needs. As we've mentioned, we have self-managing, low members. Some people that know more about their condition and their system of support, and I'm often saying, I learnt more from our members than often I can bring to some of our members. So having that total respect, that this person knows more about their disability, and if I pay attention I can learn from them. In that case, I'm in the facilitating mode. I'm trying to get the barriers out of the way so the person can get their needs addressed. And in equipment, this is an area where, someone's lived in a wheelchair for 30 years, I'm going to pay attention to what works for them.

For a moderate client, it's more episodic. If the home care worker's in place, if transportation's working, their day-to-day activities are absolutely fine. Maybe they get an infection, and now they really need some real support because they're not quite as adept at self-advocating and accessing a system when their routine gets interrupted.

Our high members -- and no surprise to anybody on the phone -- most of our high members have a combination of behavioral health issues in combination with both chronic illness and physical disabilities. But our high members require a high level of care coordination on an ongoing basis. And those are folks that we both check in on a regular basis, but equally important, we keep a very high level of internal communication, so that we know someone's escalated, we know what the issue is, and we try and be very consistent with the message that's going -- outgoing. And we can often bring somebody down, but if there's a breakdown in the internal communication, we'll see an immediate escalation. And it tends to be more on the behavioral side, which then may lead to an exacerbation of the illness, but the high folks tend to be folks that, if we're not consistent in our message, we can have an exacerbation.

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I'm going to very quickly go over the process, particularly if you're highly experienced. As I mentioned on a couple of occasions, our nurses go out and are doing 180-day functional and health assessments. If the person's been hospitalized, we do a post-hospitalization visit. If a family member reports a significant change in condition, we'll do a change-in-condition assessment.

We also entertain requests outside of a formal assessment, and we take that information, we bring it back to our team, and the team helps formulate a Person-Centered Service Plan. And really critical to the Person-Centered Service Plan is, what is it the member needs? How can we

eliminate the problem? If we all are working together, we can exchange ideas on what might be potential solutions.

And I think that's the biggest learning, when we migrated into an interdisciplinary team that was both care coordination supports, often our in-office people have some great ideas: Did anybody call the bike shop? It's in conjunction with our clinical expertise from our nurses, and our social workers, bringing the community resources and saying, oh, we can help somebody by introducing them to a social day program. So it's the cumulative and respectful, multiple ideas that we can then bring back to the member and say, which of these ideas do you want us to put into your plan as part of the implementation?

Once the plan is established, there's monthly communication. For some of our members, it's usually weekly or even more frequent. So if the person is reaching out to us, we know we're in communication with them. We'll reach out to members if we haven't heard from them in a month's time, and if someone is at risk for, potentially, a hospitalization or an escalation of a behavioral issue, we'll reach out on a more frequent basis, on a biweekly basis. That coordination, that monthly contact, it either confirms someone's member-led, they're moving along, there's no problem, or, it's an early activation that says, uh-oh, the standard aide is going on vacation, this could be a trigger, how can we stabilize the situation so that the person is as calm as they can be for the next couple of weeks while the aide is on vacation, just to give you an example.

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So I'd really like to turn over now to my colleague Frachely and give you an example of how the system really works by using a first-person story. Thank you, Frachely.

Frachely Peralta: Thank you, Jean. As Jean said, my name is Frachely Peralta, and I'm a senior nurse from Independence Care System. So this is my story:

Mr. Sam, he came to us, to Independence Care System. Actually, his enrollment date was March 1st of last year. And he is 88 years old, a Caucasian male. He has a history of Alzheimer's, aphasia, coronary artery disease, and he had had a previous stroke that consequently left him with the aphasia. He resides in an apartment on the lower east side with his elderly spouse. She's about 82 years old, a very, very nice lady and very, very involved in the care of her spouse, Mr. Sam.

The functional limitations resulted in the need for the member to receive, in conjunction with the support of the spouse, 12 hours seven days a week. The agreement was that we would provide the day care, the day services, and then the spouse would assist on the member at night.

The presenting issue, and the reason why it came to myself for review, was that the daughter called us, Independence Care System. She actually called the care manager, which is a social worker, to report that her mother was really overwhelmed with the night care for Mr. Sam, that he wasn't -- she reported that he was not sleeping well, and that he was getting in and out of bed quite frequently throughout the night. And consequently, she wasn't getting enough rest. She was just exhausted. And it was, at this point, affecting her health and her well-being, which we also want to protect.

Information, as stated before, was obtained from the social worker and brought to myself via the senior -- because we work as a team and we always communicate with each other and get opinions from each other to see what's the best intervention for each and every one of our members.

So the initial step that was taken for Mr. Sam was that we needed to get a clear picture, a complete picture, of what exactly, in detail, was happening with Mr. Sam at night. So a phone call was made to the spouse, and she -- her name is Deborah -- and we started to talk about what the condition or what was happening with Mr. Sam at night. She explained that he was just very confused, that he would want to get up and go to the bathroom, that he just was not -- was restless, at some points, and he always wanted to try and get out of the bed. As stated before, because the spouse is elder and frail, and she's a very, very tiny person, physically speaking, also, so you would just tend to think, how will she be able to get him, even, back to bed, if he, God forbid, fell out?

So the first thing that I noticed was, upon review of the medications for the member, he did not have any medications, no anti-anxiety medications and no sleeping aids, which, as care coordinators, we know that for people who have advanced Alzheimer's, is very frequently used medications to calm them down because they do frequently sundown. And also, medications to assist on his sleeping at night to prevent them from getting exhausted from their confusion as a result of the Alzheimer's. So upon noticing this, the second intervention was now to speak to the primary care doctor in charge of the member's care to find out if we can possibly add a sleeping aid or an anti-anxiety medication to the member's regimen, and if that was something that was considered previously in the past.

It took a little while to get through to the primary care doctor, Dr. S., but after multiple attempts, Dr. S did get back to me, and we were able to have a discussion over the phone. Doctor was very, very familiar with the case. Doctor was very nice. She explained that they had tried sleeping aids in the past, and that the result was not favorable to the member, that it was causing him to be too lethargic, in the family's opinion, and just not -- it was causing the member not to be himself, which the family did not appreciate. So they decided to discontinue the medication

and to just basically deal with the symptoms, or the effects, of the Alzheimer's. And also, she also reported, the doctor, that at times Mr. Sam would also refuse to take medications. The primary care doctor actually spoke -- we ended up talking about the interventions that us as Independence Care System have put in place, the hours that were currently put in place, and the primary care doctor agreed to the fact that she thought that the hours that we needed to provide night care, to assist the member but also to assist the fragile elder wife with the member's care.

After the discussion, now with the spouse and also now with the primary care doctor, then I also -- we also reached out to the daughter, who is very involved. And she is actually one of the primary care-givers, and also decision-makers, who assist in decision-making. Her name is Ellen, and also Phyllis, but Ellen is the main one involved in the care. She is the one here in the state of New York. She also was very concerned about the condition of the mother, because they want to protect her sanity and protect her health as well.

So once all the information was obtained, we have weekly ID team meetings. Our weekly meetings are Wednesdays from 9:30 to 12:30 p.m., and I was -- we were able to bring the information over to what was going on with the case, the conversation with the spouse, the conversation with the primary care doctor, and the conversation with the daughter. So we all agreed at that point that the best intervention to be taken in this case was to provide the member with a night care, which is a split shift.

We did consider -- I just want to throw it out that we did consider live-in services for the member, but because of the fact that he gets up so frequently throughout the night, he would not have qualified for a live-in because live-ins are supposed to get rest at night, at least five to six hours of rest, and it wasn't going to happen with this case. So a split shift was the best intervention in this case. Afterwards, we followed up. He also, another point for not having a live-in, was that he's had his aides for a very long time, and they wanted to continue with the same aides, and these same aides were not going to be able to provide the live-in services or the staying overnight. So that was two points to be taking into consideration when considering the live-in services.

So the plan, basically, was that when we all met we all made the determination together, as a team. We got in contact with the Paraprofessional team, and then the hours were initiated. We spoke to the wife recently, and the wife reported that she is getting better sleep, that she's resting much better, that she feels very content and pleased with the services at night, that the aides have been doing a great job with toileting, keeping him clean at night, and also redirecting him when he wants to get out of bed. So a very positive outcome. I also want to add that this has also improved her state of well-being, and this way she can be a better decision-maker for the member.

Okay, thank you very much for your time.

Jean Minkel: Frachely, thanks so much. We really appreciate it. And we'd now like to share with Nellie, her first-person story related to Mark.

Nellie Merced: I'm going to speak to you regarding Mark. Mark is a 36-year-old male. He acquired a spinal cord injury in a motor vehicle accident at the age of 10. His mother was the driver --

Christopher Duff: Excuse me, Nellie, can you move closer to the phone? Thank you. Sorry.

Nellie Merced: 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 with ICS on and off since 2000, and since being a member with ICS, Mark had been receiving intensive community-based care management provided by an RN and social worker to address a stage 4 wound, and having three failed flap surgeries before a behavioral health specialist was brought in to meet with Mark.

Since being assigned Mark's social worker, I had gotten the sense that Mark had never grieved the loss of his mother, due to his own acquired spinal cord injury resulting from the same accident. Mark had been consistent in attending his needed medical visits at an internal medicine clinic. Clinic was part of an academic medical center with a revolving staff. He had repeated histories of UTIs and various concerns with catheterization and hospitalizations in clinic. After a short time of incarceration in Miami for a few months, Mark was not allowed to New York for three years, while on probation in Miami. He had reported to me not having any medical followup in Florida, or supplies, while on probation and residing with family.

Mark was allowed to return to New York to complete his probation and had started re-acclimating himself with past routine, only to return to New York with the result of two sacral wounds near his testicles, which (inaudible) said they were very painful. Mark contacted ICS and requested to be re-enrolled for care management services. He was currently residing with his father and reported that his relationship with his father is not at its best. Mark has resubmitted an application for a subsidized apartment and hopes to have his own residence very soon. Mark initiated medical appointments, returning back to familiar medical services. He has scheduled appointments at a hospital internal medicine for a wound clinic. Mark was able to meet with me as a social worker to provide the needed prescriptions to provide his urology and medical supplies. He also initiated wheelchair repairs, requesting to be provided a new manual wheelchair.

My goal as a social worker with Mark is reconnecting, re-acclimating Mark to the new policy and procedure as an ICS member, to have his own residence and to be free of recurring wounds

and UTIs. As a social worker with Mark, I definitely want to say that he has definitely taken the initiative to partake and making sure that he connected with his medical doctor, and collaborating with us, with the clinic, and making sure that his wheelchair is running well and that he takes care of those wounds that definitely can get worse if he doesn't take care of it.

But also, as a social worker, I think one of the most important parts and the roles that I've taken, in monitoring Mark, is making sure that his mental state of mind is doing well. I think one of the things that I was concerned about when he returned, that he literally lost track of time, from three years being in -- on probation while in Miami.

One of the things that I want to make sure that I reconnect Mark is the goal of vocational rehab and training, which one of the greatest things that we had here was an access day program, so that's the first thing I connected Mark with to make sure that he partakes, and it is keeping him busy and making sure he gets back into a realm of exercise and a routine with a lot of the guys, the young men like himself, to make sure that he stays healthy. I just want to make sure that he stays in a positive pathway that releases him over to becoming more financially independent as well. Actually one of the things I also want to connect Mark -- one of the reasons that led to his incarceration was a financial loss that he definitely had to struggle with, and trying to find himself educationally, trying to find something that he can do. So one of the things I definitely want to make sure that Mark takes is that he gets himself into a vocational school, takes the training, where I can hopefully help him find a job. Thank you.

Jean Minkel: Thank you so much to Nellie and to Frachely. And we actually chose these two cases to illustrate when communication works well and when maybe it doesn't work so well. And Mark was particularly interesting in that we have worked with him over several years, over 10 years now, and the identification of the lack of grieving of his mom was absolutely essential to finally getting his initial wounds healed. It took three flap surgeries for the team to really say, this isn't really about his skin. There's something else going on here. And he wasn't connecting to his body, and he probably wasn't connecting to his body because he always related to the injury to the loss of his mom. And when that was really addressed, he matured. He got engaged in some activities. But when he came back to New York, one of the first things he did was to reach back to ICS, recognizing that coordination of care, and he falls, definitely -- right now he's in our high level. We'd like to move him towards being member-led. He certainly has the capacity.

And Nellie mentioned the access day program, which was really a program brought together by young adults with physical disabilities, and particularly with significant disabilities -- folks with functional quadriplegia, wheelchair riders, who found that they couldn't just go to the fitness club and get the kind of physical activity they wanted. They didn't have access to a computer system. They weren't sure how to get housing. And they created a community for themselves

and said, we as a group can offer support to our peers. And we as ICS support our members, and particularly somebody like Mark, to say, let's get plugged right back in to the community that's going to give you the best support, in conjunction with your primary care and your specialists. So we get the wounds healed, we get you back, and I think for Mark the real success is, now, he's home with dad, he'd really like to have his own apartment, and housing in New York City takes care coordination. So a real mark of success will be when he is able to get his own apartment and connect with his community at large.

So Chris, we're open to questions, either by either case, or our system of care in general.

Christopher Duff: Great. Thank you, Jean, Frachely and Nellie. I appreciate -- that was just an excellent presentation, and it stimulated a lot of questions. Before we go to the questions, I'd like to open the phone line. So Joan, could you give instructions to the participants on how to call in a question?

Joan: Yes, sir. Ladies and gentleman, if you'd like to ask a question, please press star, then 0, on your phone. You will hear an acknowledgement tone. If you are using a speakerphone, please pick up the handset before pressing the numbers. If you wish to remove yourself from queue, please press the pound key. Once again, if you'd like to ask a question, please press star, then 0. One moment for the first question, please.

Christopher Duff: Thank you. While we're waiting for those questions, a whole bunch of questions have come in, and it's all around the functioning of the team. So I've kind of restructured them and reordered them a little just to kind of give some premise.

First of all, you did say that you have regular team meetings. You talk about meeting one day a week, I think it was Wednesday, from 9:30 to 12:30. Do you have structure for those meetings, or do you -- how do you make use of that time in the most effective way to make sure you cover all that needs to be covered?

Jean Minkel: So I'll jump in, and then I'll ask my colleagues to add. Our teams each have a team leader, and the team leader will draft an agenda during the week that looks at those members who have the most acute needs, whether it's because of a hospitalization, an unstable home care situation, a grievance, that -- the squeakiest wheels often get the most attention. And what's very nice about the agenda development is, as we mentioned, our team is constructed with both in-office people -- so our care coordination managers -- along with our paraprofessional supports. So the paraprofessional may be the one that heard somebody was hospitalized because we got word that the home care worker wasn't needed the next day. So our sources of information become highly variable. Any care manager who's been in a home, met with a member, or a nurse who's done an assessment, they may come forward and say: Oh! I saw a red flag and I really

want to be sure we're all on the same page. Or: You know, I've been working with this member and working with this member and working with this member, and nothing seems to change. Anybody have any ideas? So it's a real tap-in to other people around the table who may have a different perspective or a different set of tools.

So we do set up the agenda for individual member-case conferences, and we often say, well why does that happen? Well why does that happen? Well why does that happen? To try and, what we say, unpack the problem, so that it may be that the nurse is concerned about a persistent redness, but we find out the cushion's been flat, and the request went in a week ago, but it got lost in the computer system, and we can escalate the problem to get an intervention, but it's often with the team, with the computer, and sharing the information: Well I put that Rx in; can somebody follow up? And each case conference ends up with next steps, who's responsible, and when will the report back be?

Christopher Duff: Great, thank you very much. I think a lot of what I hear that gets lost in teams is that, as you said, the squeaky wheel. The one person out of the entire panel that drives everyone nuts gets all the attention, and the quiet ones, who may be having a lot of issues --

Jean Minkel: Right.

Christopher Duff: So I'm glad to see some structure in that. So as I said, there's a lot of questions, but I'm going to kind of go through these questions in order of process. So, member enrolls, first thing you do is, the nurse, case manager, goes out and does an assessment. He or she then, it sounds like, brings that -- the results of that assessment back to the care team. Now, does the social work assessment get done before the care team review, or are they kind of done on parallel tracks?

Nellie Merced: It's almost -- I'm sorry -- it's almost like parallels. Definitely I like when the nurses go in and they know that there is an -- some immediate concern, and something that we should step in sooner than later. And then we just collaborate on what I need to do to initiate anything that would need to be done for a member before anything escalates that would require any hospitalizations or a behavioral health concern with the home care workers, or etc. We like to coordinate everything together, in retrospect, and making sure that we're on the same page, and making sure that the whole team and other services within the company are there to provide the member with anything that he or she may need. And --

Jean Minkel: Go ahead, Frachely.

Frachely Peralta: I'm getting the idea that maybe they want to see, like, the system of how everything works from the beginning until the end.

Christopher Duff: That would be really helpful, yeah. That's exactly what I was trying to go through.

Frachely Peralta: Right, that is correct. So as the colleagues were saying, what happens is that the member gets evaluated by the nurse, an assessment gets done, that nurse then determines, right, in the computer, then with the tools that we use, determines the amount of hours that the member would be receiving of PC services, if they need OT, PT, whatever referrals they need. It gets entered into the system. That member gets assigned now to a team, a social worker/care manager, and that social worker/care manager now has 30 days. Within 30 days, she has to complete what's called a -- what Jean mentioned before, which is a Person-Centered Service Plan, where everything is reviewed. The hours are reviewed, the current problems or what currently the member is dealing with that needs attention. And then goals and interventions come out of that, where a plan is in place of the things that will be worked on, you know, initially. So that's really how it goes.

The weekly meetings that we have, as Jean was stating, I just want to reiterate, we focus a lot on hospitalizations. Which members, which can range anywhere from 20 to 25 members a month, that pretty much get hospitalized, from the teams, and we review, each week, those members and what was the reason for the hospitalization, to see if those hospitalizations can be prevented in the future. And right, so the re-hospitalizations can be prevented.

Jean Minkel: So Chris, I think one additional piece is, the assessment that's used here in New York is called the UAS. It's the Universal Assessment System. And that system is built to help identify triggers of risk. And our nurses then help prioritize, based on their assessment, what the social worker may bring to the member's attention, that this is a risk; is there an area that you needed a further education on, or is it something you're perfectly aware of, not interested in advancing your physical activity, but you really do want to have access to the bus system? So the assessment includes, where are the areas of risk, what are some potential interventions, and that's where the social worker then meets one-on-one and says, we can offer you this tool chest, but what is it that you are most interested in? Those person-centered interventions are then put on the care plan and are monitored monthly. And every six months is the reassessment process.

Christopher Duff: Great, that's very helpful. And that really addresses a lot of the questions we've had. Another thing is, so you bring these -- this information back to the team, not only every six months, but upon a crisis of some kind. A hospitalization, or whatever it may be, eviction, whatever it may be. How, and you talked about the three levels of care coordination, or intensity, and that's something I hear plans across the country struggling with. How do you do that? And then, how do you assign caseloads, even though we don't like the term cases, per se, it kind of depersonalizes it. So explain to me how you determine levels and how that then plays out

in practice, and how that then plays out to assignment of a panel of people who a group of people follow, if you understand what I'm trying to say.

Jean Minkel: Sure, absolutely. If it were a perfect science, we would be happy to write the paper and distribute it to all that are on the call.

Christopher Duff: Yeah.

Jean Minkel: It is not a perfect science, but a piece that, particularly with our historically physically disabled population, there is absolutely a component of, how activated is this person in their own care? And we have two poles that are easily identified. We have a group of people that are very articulate about their impairment, about the strategies that work for them, about their own system of care, and they're really looking for facilitators.

And at the other end of the spectrum, then, Mark in his early days as a member, you can imagine a 19-year-old who has been 10 years without coordinated services, he was completely lost. And it was very fundamental to -- he didn't really understand what a spinal cord injury was. So when we meet people who really need some peer-to-peer education, some disability competency education, some self-advocacy education, they may start as a high or a moderate, but really, one of our goals, and what we often think about long-term relationships, how do we move people to becoming more member-led?

Now we have others, particularly our elderly chronic care and/or some of our progressive disabilities. We have a large community of folks with multiple sclerosis. They may start as being very well-versed in their disability, their functional limitations are fairly limited, they can function quite well in the community, but because of the progressive nature of the disability, and increasing cognitive impairment, we need to provide more support to allow them to stay a) healthy and b) in their homes. So, Frachely described Sam, but Sam's real community of support was his wife and his daughters, and that if anything happened to his wife, he would really move from family-led to higher, if not a high level of support. So it's both fluid and a regular check-in. Is the person's system of support in place? So I think, if we had to define the characteristics of the low members, it's people who are self-advocates, effective self-advocates, who are aware of their own impairment, know their own system of care, and have a community for whom they can depend.

In the moderate folks, someone may have a few of those components, may be learning advocacy skills, may have some disability or condition awareness, but they have really fragile support network. And if one thing goes out of play, they're in need of a net pretty quickly.

And the folks at the high end largely lack the social support. They may lack the cognitive skill, and they may lack the -- we often refer to the skill, will and ability. They may really not have the patient activation level that really allows them to be leading their care. They're really needing to be led.

Christopher Duff: Thank you very much. Joan, are there are any quick questions on the line?

Joan: No, sir, no questions at this time.

Christopher Duff: Okay. Real quickly, Jean, the tool that the New York State has you using is the universal assessment survey, is that it?

Jean Minkel: System, yes.

Christopher Duff: System. UAS, Universal Assessment System.

Jean Minkel: Right.

Christopher Duff: Great. And the -- another question is roughly, in terms of a care team, interdisciplinary care team, how many members does that team follow?

Jean Minkel: We -- our teams average between 500 and 600 members per team, and we have, again, evolved to a couple of different models, if you will. Nellie referenced that she's a social worker on our spinal cord team, so we have four, what we call specialty teams. So, multiple sclerosis, spinal cord injury, dementia are 3 condition-based teams, and we put those together recognizing that that population of members had a unique set of both health and social support needs. And then from a cultural competency perspective, when our population grew, we had a very large contingent of Russian-speaking members, and it became very obvious to us as an organization that we needed a Russian-speaking team, not only for the language, but for the cultural awareness --

Christopher Duff: Community, yeah.

Jean Minkel: What our Russian consumers were expecting and really wanting from a care management team. Our other teams are what we call borough-based teams. So they may be people with more chronic conditions who are well-connected to the primary care doc in their neighborhood, they know who the podiatrist is, they want to be able to go to the adult day program in their neighborhood, and so we really try in our care team to really know, what are the community supports in that neighborhood? And those are folks that, once the home care is

stable, it's usually the community with the home care worker. And they tend to have a greater number of 600 members or so on their panel.

Christopher Duff: Is it safe to say that some of these panels, let's say, your MS team or your borough-based teams, may have multiple social workers or multiple nurses?

Jean Minkel: Oh absolutely. So, we have --

Christopher Duff: Okay, so it's not a ratio of 1:800 for each of those positions, it -- okay, just wanted to make sure. So you do teams -- that's really helpful to hear how you structure the teams, and that what's nice about that is you're really following your members, what are their needs, and then how can you team kind of around their unique needs?

Jean Minkel: Exactly. The ratio is a little bit based on the complexity of the member. So for our low and family-led members, it's a roughly 1:100. The care manager is managing about 100 members. Our moderates are 75, 80-ish, and our lows -- sorry, our highs -- our most complex -- are, ideally, it's in the 30, depending on our staffing at any one time, it can be 30 to 45 when we tap our colleagues for support and assistance.

I'd also, Chris, if we could go back just a couple of slides before we wrap up.

Christopher Duff: Yeah.

Jean Minkel: There were a couple of lessons learned that I didn't want to lose sight of. Because I think we often think about care coordination as what we do, what are the things we're doing, and yet, one of the most important lessons I think we've learnt over the last couple of years is really, how well are we listening? If you can go back one more slide. It's the ability to listen and hear and understand, what's the real need being expressed? And we've often found that asking the open-ended question, you know, what is it that I can do to help you? Where are you having your problem? That uncorks what's really going on. And that's where we've found that the social determinants are as big a contributor as understanding that you need a flu shot and you need to have a colonoscopy. It's really, do you have a social network to help you in a time of need? And we've learnt in real patient-centered care, asking the question, what's most important to you?

And our responses are all over the place. We have some incredibly well-connected members who, the world comes to them. Their home is the hub of their universe. And we have other members who are so isolated because they think a person in a wheelchair can't get anywhere. And when we ask them what's most important to you: Oh, I'd love to be able to go to the movies. I'd love to be able to play cards with some people. Great, we have Friday night hang-out. We have Thursday night at the movies. We have an artist workshop. Wow, I didn't know

that there was a community that I could be in touch with! So as much as we do, we really want to be sure we're listening, and that we're communicating broadly.

Christopher Duff: Thank you very much. This was a phenomenal presentation, Nellie, Frachely and Jean. I appreciate it very much.

I need to wrap this up now; we're at the end of our hour. In fact, actually, over just a bit. There are a few questions we received that we were unable to answer, and we will make sure they are answered offline by the presenters. Everyone who was signed up for this webinar and this series will receive notice of future webinars or tools or other resources we're able to provide. I would again like to thank our speakers, and we look forward to continuing this work to support demonstration across the country. Goodbye.