

The Lewin Group
Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid
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Betsy Bella: My name is Betsy Bella, and I am with The Lewin Group. Welcome to our webinar, *Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid*. This is the fourth session of our 2018 Geriatric Competent Care Webinar Series. Today's session will include a 60-minute presenter-led discussion followed up with about 30 minutes for Q&A among the presenters and participants. We are recording this session.

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If you have any questions now or throughout the presentation please feel free to enter them into the Q&A feature on the platform. We will address your questions during our -- with our speakers during the Q&A portion of this webinar.

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At this time I'd like to introduce our speakers. My name, again, is Betsy Bella. I'm a consultant at The Lewin Group with a focus on aging and disability policy, especially better integrating person-centered approaches into long-term services and supports and access. I'm also a credentialed person-centered thinking trainer.

Shawn Terrell, our next speaker, has over 20 years' experience in application and policy around person-center planning, thinking, and practice working in human services. Shawn maintains credentials as a person-centered thinking trainer and trains groups in the Washington, D.C. Human Services System.

Next we'll be hearing from Karen, Brittany, Lisa, and Andrea for a panel discussion. Karen is a member of MyCare Ohio Aetna. Brittany is a case manager. And then we also have Lisa Portune, who is a manager at the Council on Aging of Southwestern Ohio with a focus on case managers working on the MyCare Ohio program, and Andrea Price, the Manager of Clinical Services for Aetna Better Health of Ohio.

Here are our learning objectives for today's webinar. We hope that you'll learn about person-centered practices and approaches; the potential benefits and outcomes of person-centered practices and approaches; and opportunities to apply them in your own work.

We're going to start today's webinar with a few poll questions. Then we'll move into the presenter-led discussions, followed by Q&A and evaluation questions at the end of the webinar.

Our first question is getting cued up here. Which of the following best describes your professional area: healthcare administration; medicine/nursing/PA/other provider; pharmacy; social work; advocacy; or health plan management or staff? Go ahead and please select one of those items on your screen. We'll just give folks a few seconds to do that.

And this helps us to see who our audience is today. So, as you can see, it looks like we've got mostly a blend between providers and social workers today, as well as some healthcare administration folks and advocates, and a little bit of pharmacy, oh, and then plenty of health plan management staff, a few researchers, and some others. I think you'll all find this to be an engaging webinar that fits your roles.

Our next question, then, is in what setting do you work: health plan; ambulatory care setting; long-term care facility; home care agency; a community-based organization; consumer organization; academic/research; or other. And if you can't see the poll go ahead and refresh your screen. Thank you for submitting your response.

So, again, as we saw, we had a number of health plan managers, so that's also our most popular setting. And then we have some folks working in other settings, as well. Thank you.

So we've got one more question before we dive on in. We'd like to hear what person-centered means to you. In one sentence or less, please use the Q&A feature to write in how you define person-centered. We're just asking since there's a wide variety that you hear from folks.

We're seeing based on the person's goals and desired outcomes; what the person chooses; the person's in the middle of services; quality of care based on the patient; again, person being in charge of their plans, charge of their services; meeting the member's needs the way that they request it; individualized care; having the client or the patient drive the decisions. So you're seeing a lot of themes around the person's in control. Their preferences, how things best fit them

are taken into account, and revolving around every aspect of somebody's well-being, including cultural and medical, and then a lot about goals and encompassing the whole person. Great. Thank you so much.

So now we're going to have a presentation from Shawn Terrell of the Administration for Community Living. Shawn, I'll turn it over to you.

Shawn Terrell: Great. Thank you. Well, thanks for having me here, and I'm just going to go quickly to a couple of overview points on how we, and I think you underlined I can't speak for everybody in the Department of Health and Human Services, but I think generally this is certainly ACL's approach and starting point, in a way, and also I think we're really getting a pretty tight consensus around this around the department.

So, first, we need to really think about person-centered planning beyond just the fact or the sort of act of doing a person-centered plan with a person and/or their family and think about it beyond that. We've learned over the four decades or so that person-centered planning has been around in the home and community-based services world that if you just teach people how to do good planning with people what you end up is a good plan, but the implementation of those plans often falls apart.

And so we have a three-part thing. Can you go back to the slide real quick on this, the previous slide? Sorry. Yes, so we built it in, we build three things into this. There's a way of thinking about how we interact with people, and so we have to learn some thinking skills, and some tools to help us, sort of prompt us to stay disciplined, basically, in that perspective, which is very, very heavily focused on listening, not jumping to conclusions, being aware of our biases, and sort of really becoming a respondent to the individual.

Then there's a planning process, which we know is a necessary component to this, driven by the person, obviously. It's their plan, right?

And then there's some practice, where really everybody engaged in these systems, from the front-line worker doing personal assistance to ROA through IT people, people who do financing, need to have a basic understanding of what this is about and need to help support the systems change that is most generally necessary to implement a good plan and to give people the space and latitude to do so. And so that includes quality. It includes looking at your policies and procedures, looking at your reimbursement structure, etc. So it's really a systems, a whole systems approach that we're considering here.

You can go to the next slide. And so we're aware not that -- I guess we've been aware, but social determinants of health have been clearly established as important mechanisms to focus on in order to help improve and support general health and also specific, obviously, health conditions. And what's sort of interesting from the home and community-based services perspective is that home and community-based services, again, it's been around for 40 years, that's the focus is on social and cultural and sociopsychological sort of issues, and ecological issues, as well, for people.

And so we've been doing this for a long time, and the thing that sort of we want to keep a little bit of clarity on on this question is that most of the services that we provide in home and community-based services address one or more of the social determinants of health -- I circled a few of the subcategories within the broad categories of social determinants -- and that these services support, obviously, the health outcomes but also have an independent aspect to them, that having social relationships is good, meaningful social capital, social support, is good on its own terms. You don't really have to have the health outcomes in order to say that this is a good idea for people or that people need this and want this. That's just one example.

Having a job is good, having a place to live. These are obvious things that are independent of how they may or may not impact health, so that these -- luckily, there is overlap, but there is also that question of just helping support people in the way that they would like to live. In addition, sometimes these things do clash, and this is important in that we have to find the balance here to support people in finding that balance for themselves, for each person.

So, that's sort of a little bit of the interaction between these two concepts. Go ahead. Next slide, please.

So what we sort of have kind of a vision within ACL, and, again, we have a pretty broad consensus around these things, around some of the challenges that exist right now. For instance, one is people don't always know what to expect. There's not a lot of understanding out there about what to expect from the individual perspective from a person-centered planning process. We seek to sort of change that and create a bit of a demand for good, solid person-centered practices from the consumer side.

People, which sort of begs the next thing, which is that people who facilitate the planning processes out to have some level of competency. They say, well, over time -- this is a vision statement, right -- would seek to create some clarity about what competency is and to make that as transparent as we can, just like we do with other professions, right? You need to be licensed as a social worker, etc.

Systems are configured, as we talked about, to deliver this things, that the whole systems are engaged in this process of transforming themselves to deliver things in a person-centered way, and qualitative, that we have to develop some quality measures, which we are in the process of developing quality measures around person-centered planning that meet the level of rigor, say, of an NQF endorsement or an NCQA kind of level of rigor, not sort of seat-of-the-pants, back-of-the-envelope kind of stuff, but real measures that you can hang value-based purchasing on, for instance.

And then there's a continuous learning effort that's involved in this that everybody's in a mode of trying to improve this in sort of platonic ideal thing. And then I would add one more point here which didn't make it on this slide, but that the people themselves who are end users of these systems, who use, need and use the services that support the life that they want to live need to be engaged at all levels of the systems that are transforming themselves, need to be highly part of the transformation process and need to be considered as partners in these processes.

I think that might be it for me.

Betsy Bella: Okay. Any closing thoughts for your presentation, Shawn?

Shawn Terrell: That it's really good work, and it feels good to do it, I think, once you get into it. If you are in this, if your heart is in this work, this is like the center of this. And so everything that you do, even if you're, again, in an administrative position, focusing on how this affects the end user, the person who needs these services and supports, and keeping that at the very front of your mind is highly rewarding. So I would just encourage it that way.

Betsy Bella: Thank you. So, as we just heard from Shawn, his presentation included ACL division for person-centered planning, including the idea of person-centered values. In this next section of the webinar I'm going to go ahead and talk more about person-centered values, approaches, and how change at all levels can impact long-term services and supports.

So when we talk about person-centered approaches, that's a broad category. You'll also hear terms like person-centered practices or even just person centeredness. Patient-centered or patient-first care fall under this, as well.

Several models provide frameworks and tools that can help guide person-centered approaches. These often focus on specific settings or populations such as the ones on this slide.

Charting the LifeCourse originated with families of children with developmental disabilities, but now people are using it more broadly with a variety of disability groups. One example of a LifeCourse tool is the LifeCourse Trajectory. This is an approach to person-centered planning which works with the person and family to identify a vision for a good life, and then it sets plans and supports to stay on track towards that good life.

Patient or person and family engagement is not a specific model, but that's the kind of terminology you'll frequently hear in healthcare systems. Shared decisionmaking is an approach for patients and their families that they can use to make decisions with the support of clinicians. Key to shared decisionmaking is providing patients with the information on the pros and cons of multiple approaches. This might include tools such as videos or pamphlets with information about potential healthcare decisions such as surgeries or care for specific conditions.

The Wellness Recovery Action Plan, or WRAP, is a peer-led process for people with serious mental health issues. Within WRAP people develop daily plans as part of the process which describes what someone looks like when they are well and what they need to do regularly to stay well. That includes things like journaling, getting enough sleep, or taking medications. It really varies with the person, a theme you'll see throughout person-centered models.

Person-centered thinking is applied across many populations. Like you heard earlier, people sometimes use this term to refer to person-centered approaches, but here it describes a set of skills and values developed by the learning community for person-centered practices.

Finding the balance between important to and important for is the core idea that guides use of the PCT skills and approaches. I'll get more into that in a minute.

These models and other models and approaches all empower people to make decisions that work for them and focus on strength. Shawn noted earlier the importance of recognizing people as experts in their lives and the goal of supporting the people to live the lives. And you all, when you responded to the polls, these were the kinds of things that you were also highlighting as you talked about what person-centered means to you.

So, talking about important to and important for, think of important to and important for and the balance between them as a framework for considering the whole person to guide your person-centered approaches. All of us use this every day in our own lives as we make tradeoffs to find the right balance for us between our passions and preferences with what keeps us healthy and safe.

So the things that are important for people are those that keep them healthy and safe. It's also things that people need to be accepted and valued by others within their communities. For example, if somebody goes out and soils clothes with holes in them, that's going to impact how people view them, so not doing that is important for most people.

Many of the people in our audience today work with others to support them to access services to treat their health condition; coordinate appointments and support medication management; connect them to services like transportation, housing assistance, food banks, and other things which help address social (inaudible) for mental health. People need these things to live the life they want, but if you only focus on important for, sometimes that can leave people healthy and safe, but ultimately kind of miserable.

So that's when we have to bring in important to, as well. If you think about what makes a life meaningful for you, you might think about what brings you satisfaction, joy, comfort, and fulfillment. The questions on this slide can help guide you to think about the things that are important to you. For example, do you spend time with people who matter to you? That might be your family, your friends, or others. Or, skipping down, do you feel respected for who you are? Do people value your contributions? Do they respect your cultural and religious values and beliefs?

Or looking at do you have control over big and small decisions in your life? What activities are enjoyable and meaningful to you, not just what someone thinks might be, but what you actually enjoy? And do you prefer a fast-paced life or a slower rhythm? And then what objects or things are meaningful to you or make your life easier? It could be something really practical like I don't know that I could get through a day without my cell phone, or it might be more about what it means to you, or the symbolism, like I might get pretty upset if I lost my wedding ring. So these questions begin to illustrate what's important to you. Sometimes they might seem like little things, until you don't have control over them anymore.

So, imagine you have a day off or you don't have any plans for the day. Are you the kind of person who's going to set an early alarm anyway? Or are you going to pull the curtains shut tight and sleep in?

Now, imagine that you're someone who needs some help to get out of bed and get ready for the day, where that might apply to you. Early risers, your aide is scheduled for 11 a.m. You will not be able to get up before then. Late risers, you live closer to where the aide starts their day, so your aide is showing up first thing in the morning, and they're going to wake you up right away. Think about how that would make you feel, how it would impact your day. Now, this isn't just one day now. This is going to happen every day. Taking what's important to someone into account can be as simple as scheduling appointments and supports at the times they prefer.

Health and safety are crucial elements to support people, but to effectively be person-centered we have to also focus on the aspects of a person's life that are meaningful to them. Sometimes when people first hear about person-centered approaches there's a concern that listening to people's preferences means using public dollars so people can get what people sometimes refer to as whatever they want. That's not what person-centered approaches are. It's about supporting people to make the kinds of tradeoffs we all make, to find a comfortable balance between what's important to us and for us.

Important to and for, they're not a direct dichotomy. They don't cancel each other out. To best find balance it really helps to figure out where they overlap, where what's important to someone encourages them to do what's important for them. Very few of us are willing to stick with something that's important for us unless we can tie it to something that's important to us.

For example, I know exercise is important for me, but it's hard to stay motivated, so I put books on hold at the library. Reading is important to me, so I'll walk back and forth to make sure I can keep reading what I want. So as we think about balancing important to and for, I'd like you to ask yourself what does it look like when we address both.

So let's think of an example to better understanding balancing important to and for. First we'll approach supporting someone in a more traditional, maybe not as person-centered way, because I'm only going to give you the information about what's important for Jane. So, Jane's a kind older woman who loves animals and lives alone. She has a limited income and several complex health conditions.

Jane's dually eligible for Medicare and Medicaid, and you're talking with her and she tells you that she regularly misses meals. Well, what do you do? So, go ahead back to the Q&A box where you responded to the question about what person-centered means to you and use a few words to tell us what you might recommend for Jane.

So we're seeing a lot of home-delivered meals and Meals on Wheels, including sending someone to check eligibility for us, providing a list of food banks. And then we've got some people who are looking into they want to find out why she's missing her meals to be able to make a more accurate recommendation, and, interestingly, asking her what she calls a meal, offering to set up grocery delivery. So it looks like we have some folks who already have their person-centered

hats on as they're thinking about exploring what Jane considers a meal or why she's missing her meals or looking at who in her support network can help her, and someone's looking into what other issues she may have, and we have two folks who are thinking about culturally appropriate or special dietary needs.

So if we go to the next slide here we can see some more information about Jane. So the question is how is it going to change your approach as you learn more about her. And those folks asking about special dietary needs, Jane's so glad you did, because she has been a vegetarian for the last 20 years. She had a large family and was accustomed to meals as a social activity. Jane's cat Snowball, they were together for the last 15 years, and after a long, happy life we've recently lost Snowball, and Jane can only eat soft foods because of some current dental issues, and she does not want others to be aware of her current diet.

You'll notice that these are all things about Jane rather than a list of what's important to her. As we learn more about people it helps us to uncover what's important to them. If you just ask someone "What's important to you?" it's only going to get you so far. The answers will probably be true, but big and generic, like family and my health. You should also check in with someone to make sure your assumptions about what matters to them are correct.

So if I'm having a conversation to Jane and she tells me she's been vegetarian for years I might follow up and ask her if it's important for her to stay vegetarian, and for Jane it really is. From our conversation with her we also now know it's important to her to eat with others as often as possible, especially now that her pet's gone, and how she's perceived by others is important to her, and she worries that her dental issues will make them think less of her.

So use the Q&A box to share how your approach might change now that you know more about Jane. Are you going to make different recommendations? Do you have more follow-up questions?

And there you're talking about meeting Jane where she is. Does she have depression that's affecting her eating habits? Discuss getting a proper vegetarian diet. Look into if she has a history of gardening, perhaps. We have some folks who are discussing recommending that she address her dental issues, which might help her to move forward. Yes, Jane does live alone. Look into a friendly visitor who might not be coming in for meals but who can provide some of that social interaction. All right. Looking into potential congregate meal programs, and maybe on the congregate meal programs placing her with other people who have to eat soft food so that she doesn't have to feel as worried about it. See about getting her connected to community support groups to help her with the loss of her cat.

So here you can see now that we know more about Jane or thinking about what's important to her as well as for her the suggestions kind of expands beyond just Meals on Wheels, are becoming more in depth, potentially more valuable for her. Someone's suggesting that maybe she could volunteer at a local garden. These are great. Thank you, everyone.

So nationally there are many states and organizations making plans and implementing innovations to become more person-centered. These changes can happen at multiple levels. For

each level we're talking in terms of who the authority is that starts the change, even though the actual guidance might be implemented by someone else.

For an organization such as care management or provider agencies or health plans, make formal changes to processes, structures and rules to require or encourage staff to use person-centered approaches. These are organization-level changes. And then there are changes at the individual level when people make direct changes in their day-to-day interactions and work. So we're going to get a little more into each of these levels.

In the last decade we've seen policy changes impacting the landscape in which providers and plans operate. These changes often come slowly, and they can take a long time to implement. But then, whether it's regulations or guidance, it can make a huge impact as organizations and individuals seek to follow them. In turn, as organizations become more person-centered, their approaches can impact future policies as agencies learn from high performers and seek to replicate their success more broadly.

The rules listed on this slide all require use of a person-centered planning process. So that includes the CMS HCBS Final Settings Rule, the reform of Requirements for Long-Term Care Facilities Final Rule, and the Medicaid and CHIP Managed Care Final Rule. So, whether it's facility-based care or home and community-based services, there's this move toward person-centered approaches. And then individual states as they seek to come into alignment and create a more person-centered network, they're also requiring person-centered training for staff such as care managers or implementing other kind of policies and guidance.

So when it comes to strategies for organizations, something that they can do is they can create opportunities for front-line staff to share what they've learned working with clients. Encouraging sharing at team meetings helps staff to learn from one another to best implement person-centered approaches. It goes back to what Shawn was saying about that idea of ongoing continuous learning.

Consider requiring community inclusion goals as part of care plans. This is one way that you can turn a care plan into a more person-centered care plan is by making sure you have goals that help promote community inclusion. This will vary depending on the person and what community they want to participate in, but some examples might be going to church on Sundays, meeting friends for a meal, or seeing their grandkids, or it might be finding meaningful employment.

Track case notes with an emphasis on capturing preferences the person shows or shares. If you think back to Jane, if she has some staff that come in to help her, tracking this information in the case notes is going to make the transition more seamless between staff. Consider the importance of sharing that she needs soft food to save her from having to tell everyone who assists her with meals. This will both save her time retelling her story, and especially since she has some embarrassment around it she might not want to have to repeat to everyone that she only eats soft foods.

If someone has Alzheimer's or dementia, capturing their preferences can be particularly useful, especially if you are working with someone who doesn't use words to communicate. As people

work with them and how they react and how -- if you take someone outside and they smile and they're excited about it, you can take note that Ms. Smith loves going outside. And it can sound like a small thing, but if then other staff know to follow through with that and to repeat those activities that add some joy to someone's life, it can make a big difference. Sometimes these kinds of case notes are referred to as a learning log approach. A medical practice may wish to develop a new shared decisionmaking tool such as a guide with information on different treatment options for a specific condition.

When it comes to strategies individuals can use, we're talking about changes somebody can implement in their day-to-day workflow to improve the experience of people receiving services. These are changes that people can implement without special permission. People who receive services can also implement change, for example, by advocating for themselves or being proactive about sharing their preferences.

Avoid the use of jargon. Some strategies people can use is avoid the use of jargon and acronyms and use plain language to make sure people understand the conversation and feel able to participate. To put them in control of their health and support decisions they need to have the information. If someone else controls the paperwork, they have the power in the relationship. Share notes and plans with the person, even if it's not required.

Focus on and emphasize people's strengths rather than focusing on deficit-based support. A strengths-based approach treats people with more respect by recognizing their contributions. These could be past contributions such as the work someone did before retiring; present, even something such as telling jokes that make people around them laugh; or potential, like interest in volunteering.

A strengths-based approach provides opportunities or finds ways someone can begin to address the supports they need with what they or their friends and family can already provide. It also supports people to identify meaningful goals they want to work toward. Ask yourself what changes can I start making tomorrow to make a more person-centered approaches.

Each level impacts the others. (Inaudible) changing such as policies changing to require organizations to adopt new protocols inspire organizations to create new guidelines, develop new processes which individuals then implement. They also try new approaches to try new organizational changes.

When individuals, both staff and people who use services, share their learning back to the organization this can lead to new improvements in guidance organizationally. As organizations want to adapt, they can share their successes with others. These spread strategies inform policy-level changes. So that gets you all the way around the circle. But change can start at any point of the cycle, with any level.

Next we're going to hear from a panel of staff from Aetna and the Southern Ohio Regional Council on Aging and someone who uses their services, Karen. As you listen, think about how their efforts fit into the different levels of change and what strategies you could implement in your organization to move toward a more person-centered approach and ultimately system.

We introduced our panel at the beginning of the webinar, but we'll take a moment to reintroduce them. So, Karen's our Aetna member. Then from the Council on Aging of Southwestern Ohio, MyCare Ohio Aetna Program, we have Brittany Woulms, our Case Manager. Then Lisa Portune, the manager, and from Aetna Better Health of Ohio, their partner, we have Andrea Price, the Manager of Clinical Health Services. It sounds like we have plenty of people in our audience who share some similar roles in their organization.

Before we move into the panel, I'll just briefly introduce you to the two organizations. Aetna Better Health of Ohio serves approximately 24,000 adults cross the state who are dually eligible for both Medicare and Medicaid. And many of you know individuals dually eligible for Medicare and Medicaid have high rates of chronic conditions and long-term support needs. This means that they end up accounting for a disproportionately large share of Medicare and Medicaid expenditures.

Part of what's driving the move towards person-centered approaches is this kind of strength-based focus is especially helpful for managing chronic conditions and identifying long-term support needs. It can lower costs through integrating natural supports and community resources.

The Council on Aging of Southwestern Ohio is an Area Agency on Aging, or Triple A. Every state and U.S. territories has Triple A's. They form a network across the country to serve older adults locally in areas typically covering neighboring counties.

On the slide, you can see some of the services which the Council on Aging of Southwestern Ohio provides. Triple A's in other areas and states may provide different services depending on resources and local needs. Importantly, Triple A's have local community connections which allow them to connect people to resources where they live. If you're looking for a Triple A in your area there's a link there in the slide.

All right. So, kicking off our panel with a question for Andrea and Lisa, could you please briefly describe the partnership between Aetna Better Health of Ohio and Council on Aging of Southwestern Ohio and how it keeps people at the center of your work?

Andrea Price: Hi, this is Andrea. Ohio Medicaid requires health plans to coordinate with Triple A's on services, and our health plan has chosen to go beyond that. We decided to expand our partnership with Council on Aging of Southwestern Ohio and fully integrate service coordination and care management.

We have combined the waiver coordinator and care manager into one role to provide a more coordinated and streamlined approach to caring for our members. So this keeps -- this partnership keeps the member at the center, and the member just has one point of contact, their care manager. This helps them take care of their services rather than two different contacts. If the member has any question about their health plan the care manager can turn to their Aetna liaison, as each region has their own liaison.

Lisa Portune: And this is Lisa, and by having the care manager being fully delegated, as Andrea explained, the care manager really oversees the whole case, and therefore they're the single point of contact for the member. They work with the member to connect them with their social services and their community resources, which focuses on the member's social determinants of health. They work with the member to create that person-centered care plan, which includes goals for their medical needs and their social needs to support the member's desire to stay in their home as independently as possible. Our staff consists of both licensed social workers and nurses, and they use their clinical skills to engage our members in conversation to better assess their needs and desires for their lives.

Andrea Price: So Aetna provides the healthcare tools, the assessments for specific situations. We provide the insurance side of the business. We also provide behavioral health liaisons. We provide one point of contact for each Area Agency on Aging region to provide the identified needs and support. And we also provide metrics and data, dashboards and monitoring support transitions to big events. And we share aggregate data with the Council on Aging leadership electronically to continue improving quality for members.

We also examine claims to identify gaps and issues to provide supports to members and provide clear communication and data sharing between Aetna and Triple A so that people don't have to keep repeating their stories and information.

Lisa Portune: So, this is Lisa. Talking about that team approach, our care managers have direct access to their Aetna liaison to ask member-specific questions. We also have a process in the form of a formal case round to work collaboratively with Aetna to examine high-risk cases and determine the best approach to address those issues.

The care manager also coordinates with the member's doctors and providers to ensure services are being implemented and addresses the issues at hand. Those identified needed services are first discussed with the member to ensure that they both want and understand the benefit of those services that are being offered. So we work collaboratively to assist the member with their need.

Betsy Bella: Thank you, Andrea and Lisa. Now, what we just heard from them is a great example of governmental policy change leading to organizational change, the segments on the chart inside the green rectangle. Ohio's requirement that health plans partner with Triple A's led to Aetna and Southern Ohio partnering and creating the protocols they needed to do that, to keep people at the center of their work.

So our next question for the panel is aimed at Karen. How did Council on Aging of Southwestern Ohio and Aetna help you?

Karen: Hi. I was in a nursing facility for treatment for over a year, and I wanted to get back into the community. I'm a very independent person, and living independently at home was very important to me. I had all of my faculties, but physically I needed support. So when I got into my own home it was difficult, because I wasn't receiving any services. The AAA and Brittany were very helpful with setting up services I needed and the aid that I needed physically in the home.

My care manager has been really helpful getting me anything I need. I don't ever find myself waiting. She is very helpful. I know that I can always call her with any concern. They have gotten me transportation for appointments and necessary errands. Those things were very helpful, because without the transportation I wouldn't have been able to do a lot of this myself. This kind of program is very important to have for people like myself.

Betsy Bella: Thank you so much, Karen. That's a great example of balancing important to and for. The aide support and transportation that were important for you helped you return home and get some independence back, things that are important to you.

So, Brittany, what is a person-centered plan, and how do you create one?

Brittany Woulms: Hi. So, a person-centered plan is basically finding out the personal goals of the person, planning services which address their needs, their goals. And we monitor that plan by doing the short-term and long-term goals. We highlight their accomplishments. We want to make sure they know we're actually listening.

To get to that, though, it has to start with interviewing. It's not just checking boxes, which is easy to fall into, but finding out how things actually go for them. So with motivational interviewing, we make sure that members don't just answer the yes and no questions and they can actually share their experiences. We make sure that they know we hear them. We repeat things back to them quite often. That helps with catching any miscommunications.

We work to include any informal supports, like family, neighbors, or loved ones, into their plan to provide contingencies, so a backup plan for when they don't have anything. As far as providers go, the contingency plan helps to ensure that there's not a gap in care for the members and to keep them secure within their chosen environment.

So when we're meeting with the person and anyone else that they designate the person provides all of the information for the care plan. Family and friends generally provide secondary information, unless the individual is cognitively deficit. So they'll be our primary contact. In addition to collecting eligibility information, we perform a comprehensive assessment, which takes about one and a half to two hours to complete. Throughout the assessment we learn more about someone's strengths as well as the areas that they need support. This is typically where we pull some of the goals from, because, depending on how conversational a person is, it helps to highlight major needs.

We look for information on a person's environment, their clinical history and need for support in areas like self-care and medication. The data collected on social determinants generally includes the demographics, economic stability, education, social and community contacts, health and healthcare, neighborhood and built environment. For example, we make sure that all of our members have access to healthy foods, quality housing, transportation, physicians, water, utilities, and congregate activities.

Each member is going to have a different need. Common needs for our dually eligible members include homemaking assistance, transportation, and nursing services to help administer

medications. We also offer respite for caregivers so that they are able to continue doing what's important for them, as well.

As far as those people, typically our assessments, questions, they don't change, but we may word things differently for somebody who may not understand well, or for major cognitive impairment the caregiver can provide the response. But we want to make sure that when doing our assessments we're meeting people on their level.

Each member is given specific assessments that are related to their condition. We don't want to have lengthy assessments going through questions that aren't pertinent to that person. So for somebody with hypertension we would want to make sure we're reviewing that with them, and if somebody has diabetes we'll review that with them, so on and so forth.

Those questions are going to focus on that person's history, current readings, when they last spoke with their doctor, how they monitor the condition, what questions they may have. And that is also something that can lead to a goal. So, having health condition-specific questions allows us to be a little bit more centered on that individual.

Betsy Bella: Great. Thanks, Brittany. And, Karen, how does your care plan work for you?

Karen: Okay. I'm a very independent person, and my care plan and my personal goals were designed to get me back to my independence. I helped build this care plan. I wrote personal goals and work to accomplish them with the help of my care manager. My goal is to get better every day so I can get better starting with number one, my therapy. This will allow me to get back to walking without having a walker, get back to driving, get back to work. With the type of diseases I am dealing with, they have hindered me from walking, but I know if I work as hard as I can and follow the goals in my plan I can get back to that independence.

So goals aren't all just health-focused. I had some issues with provider staff. For instance, I have a goal related to boundaries and improving professional relationships with service providers because of previous issues in this area.

Betsy Bella: Thank you both. Brittany, how do you support people to make decisions?

Brittany Woulms: So, the support that I provide my members is finding out what's important to them. If it's not important to them they're not going to work on it. I make sure that they understand what we're doing. If they have things that are important to them that might be deemed risky -- for example, enjoying an adult beverage -- we're going to discuss the risk. But they're adults. They can make their own decisions. We just want to make sure that they do that educated, and we do that to the best of our ability.

If some risky choices may have a potential liability we're going to work with them to sign informed risk waivers. We let all the members know that services are optional. If they feel that it's not necessary or they no longer want it they may refuse that service. If they feel they need more they can ask for more. If they think things aren't going well one way they can let me know that they feel like it needs to change. So we make sure that they're aware of what they can

choose, how it's delivered, and that they can change things at any time. They just have to notify us.

For service delivery we provide a large variety of services. So if things aren't working well with one provider we can often at times try another. For example, instead of having somebody cook their meals, we can provide a home health aide to make sure they get their meal through home-delivered meals, refer them to a congregate meal sharing center. We make sure that they know there's options out there to best fit their needs.

Our connections with community organizations helps us to provide people with more options than what a healthcare plan can do alone. So we as an agency strive to be aware of the community resources in the areas that our members live, and we can often refer them to local churches, centers, agencies that can assist based on their needs. For example, a lot of our members may need assistance with home maintenance or repairs, such as lawn care, foundation, lighting, electricity, water, things like that. So we may refer them to a local agency called People Working Cooperatively and they can provide services under their seasonal program or have contracted laborers go out and assist, repair as needed.

Betsy Bella: Thank you so much. Yes, those partnerships with community organizations can be so valuable.

Andrea and Lisa introduced the organizational changes, and we just heard from Karen and Brittany how those led to Brittany implementing person-centered approaches, which then improved Karen's experiences. This demonstrates organizational changes leading to individual level changes, highlight by the green rectangle on the diagram. Let's hear a little more about the process of getting changes started. Andrea and Lisa, what did it take to get this partnership up and running? What did it take for a successful culture change?

Andrea Price: So, this was taking two separate entities with different expertise and combining them into a partnership to deliver the best care possible for the person. So Aetna has expertise with the health insurance, while Council on Aging has the community resources.

Lisa Portune: And this is Lisa. Talking about the importance of communication, as I stated before, that is absolutely vital between our Aetna waiver manager and the Triple A in order to address the issues and concerns that arise when working with our members. It can be as simple as how to get an unusual item for a member to something way more complex. This type of daily communication helps with the day-to-day processes.

Our Triple A management staff also meets monthly with the waiver manager and the Aetna provider services to discuss the larger system issues. As well, the Triple A management staff, along with other sites in Ohio, meet with the Aetna monthly to discuss new and to also review current processes. Along with all of that communication there is also a monthly communication between the Triple A CEO and the Aetna COO. So there are multiple layers of communication to ensure that we're addressing member need.

We also develop and share policies that clearly define our roles. Aetna and the Triple A's work together to develop those policies and procedures in order to ensure that they're implemented timely and that all parties have a clear understanding of the expectations. An example of this occurred when the members' risk stratification levels were shifted due to new guidelines by ODM. This was first discussed at our monthly meeting, and policies were reviewed, as well as a plan of transition for members to their new level based on the new guidelines.

The policy and processes were first defined at our meeting, and then each Triple A was able to take that information and create site-specific policies and inform the care managers, who were then able to discuss this with their members in the discussion and in the assessment with the members so that those levels of care were focused on and remain person-centered. What does the member believe they need to stay independent in the home with input and recommendations for support services from the care manager?

Care managers are licensed social workers and nurses, as I previously said. They have competencies in person-centered care planning and in motivational interviewing and strong customer service. They use motivational interviewing when working with members to ensure that they are gathering all the necessary information. Care managers have all been trained and receive ongoing training in a variety of areas such as cultural diversity, disability awareness, accessibility and accommodations, independent living, recovery and wellness, waiver services, community resources, and risk and safety planning, just to name a few.

These trainings are provided in a variety of forms such as webinars and direct trainings. When we hire care managers, they first go through our training academy for three months, where they receive appropriate, intensive supervision as they learn how to implement the policies and procedures that we have just talked about. After the initial 30 days of training, only then do they receive a limited case load and have intensive supervision for the next 60 days.

Let's talk about shifting mindsets to focus on supporting members for self-determination. One of the first questions our care managers ask when working with members is what is it that you want to have or believe will help you have a better life. Care managers are trained to support self-determination for our members, meaning members have the right to make their own decisions. A lot of what we do and how we do it is about asking the member what they want, what they need, and identifying what resources are available to provide them with the life that they want.

Andrea Price: So we did have a few challenges when we went live with our partnership. The challenges were mainly around setting up data sharing. And Aetna, we have access to a lot of protected health information, so we wanted to make sure we only gave as much information to the Triple A's that they needed to do their job. We had to make sure that we protected and used HIPAA appropriately through that, as well.

So the Triple A's use a virtual desktop to help with that security to that protected health information, and so that can cause some little bit of hiccups with that going through the virtual desktop, etc., to access the information. So after a lot of initial technical issues we figured out how to solve for those technical issues and things are much smoother now.

Betsy Bella: Great. Thank you. What plans do you have to continue becoming more person-centered? Karen, what would you change? So first we'll start with Andrea. What plans do you have to continue becoming more person-centered?

Andrea Price: We just need to make sure that care managers continue to improve in motivational interviewing and support motivational interviewing, make sure members really set their own goals and care managers support them to reach those goals.

Lisa Portune: This is Lisa, and I, again, agree with Andrea that motivational interviewing is an absolute need. And that's how we get more of the detailed answers from members about what they want in their life. From a training perspective, it is important to understand the questions behind motivational interviewing when interacting with our members.

Brittany Woulms: Hi, this is Brittany. For me as the case manager one of the biggest challenges is really getting down to the layers of interviewing our clients to find out what's actually important to them. As Lisa had stated earlier, one of the first questions we ask them is what do you feel like you need to have a better life. And most people's response is to remain in their home. So really getting down into what they need to remain in the home.

To improve on motivational interviewing, we have many trainings both inside and outside of our organization. I've often attended the Ohio Association of Area Agencies on Aging conference, also known as O4A, cultural sensitivity trainings. That way I'm sure to be aware of what different backgrounds there are. We have the Collins Learning Center and other opportunities provided by local agencies to provide further training and understanding of the environment in which we work.

Betsy Bella: Thank you. Karen, what would you change?

Karen: In the past, home health aides have stolen from me. I know that with issues like this I can call Brittany. I feel like if the aides were educated, paid more, and treated better that I and everyone else would have much better care. All other services I am very pleased with. Personally, I don't even want an aide, but I know I need one. I know that with issues like this I can call Brittany, but we would prefer to not get here ever.

Betsy Bella: Thank you so much for sharing that, Karen. It helps to hammer home that idea of services and systems, they really can't be person-centered if people don't feel safe or are uncomfortable with aides or providers. We know with workforce shortages that people are often assigned whatever aides are available, and agencies are often desperate to hire people and get them working immediately. That goes back to your point about education and training. Turnover, then it goes ahead and makes the situation even worse. The staff leaves. They need to be replaced right away.

I wish we had time today to get into person-centered approaches to staffing. There are many approaches like improved training and working to find better personality matches between staff and people they support. This makes everyone's experience better, both for the person receiving services and the provider, and it's been shown to lower turnover. This is a great example of how

we need person-centered approaches in all parts of the system for people to really get person-centered support.

All right, panel. What do you see as the greatest accomplishment of this program and approach?

Andrea Price: Hi, this is Andrea. I believe helping people to stay in their homes as long as possible, pulling from the expertise of each organization. We help support that. We manage care while the Triple A connects to the community resources in order to do that.

Lisa Portune: And this is Lisa. Again, I agree. Supporting our members to live in their homes in a healthy environment and empowering them to manage their care, also connecting them with the resources that can make their life better.

Brittany Woulms: Hi, this is Brittany. Something that I see as a great accomplishment is that I get to see a lot of our seniors have more independence. I get to see them with their services in their homes that allow them to remain more independent and living in the home of their choice. I get to maintain good, solid relationships, build a rapport and trust and provide them with resources and choices so that they feel like they have power back into their lives.

Karen: And this is Karen. The ability to be at home and have my independence, that is the most important thing to me, and there is nothing like it.

Betsy Bella: Thank you so much to all four of you. And, Brittany, I just want to highlight in your response you were talking about how you get to have the stronger relationships, how you get to see them in their homes, and I just want to emphasize for our audience that when we talk about person-centered approaches we often focus on how it improves the lives of the people we serve, and that's incredibly important. Nothing's more important than what Karen is saying, to be able to achieve the most important things to them.

But it also makes people's jobs better. You get a lot more joy out of your work when you feel like you are achieving what you entered these fields to do, which is to support people to live better lives. Thank you so much.

So, again, thank you all for sharing. What we heard were some challenges and strengths, but both represent opportunities for further change. As individuals implement person-centered approaches they gain learning they can then share back with their organizations to drive further movement towards becoming a more person-centered organization.

There isn't a defined finish line for a completely person-centered organization. For example, our panel just shared how their organizations have already made a lot of progress to implement person-centered planning, and that has real impact on Karen's life and those of other participants. However, they all noted ways to continue growing, finding new ways to better serve people as individuals and to uncover their goals and preferences.

Karen's comment about age shows how that more people at all levels are involved the more person-centered that the services and organizations can become, from legislators making policy

to people on the ground working directly to provide services in a more person-centered way. Aetna, the Council on Aging and each member of our panel is working to build a better system using person-centered approaches.

So thank you again so much, to Karen, Brittany, Andrea, Lisa, and Shawn for your presentations and participation in the panel. This has been incredibly informative. Thank you to everyone for joining us today. With that, we now have a few minutes for questions from the audience.

At this time, if you have any questions for our speakers please submit them using the Q&A feature on the lower left of the presentation. Type your comment at the bottom of the Q&A box and press Submit to send it.

We actually already have some questions that have come in from the audience. There seems to be a lot of interest in the care manager training. So, Brittany and Lisa, we'd love to hear more from you. Somebody wanted to hear again what's included in your training and where they can learn more about it.

Lisa Portune: So, this is Lisa. We have a training academy. So when a care manager is hired they spend about three and a half weeks simply learning the job, the policies, the procedures, person-centered care planning. They spend time looking through cases that they will receive, verifying the information is there, working a plan with their immediate supervisor on what they should ask when they go out, what that looks like.

And then under close supervision they start making those initial calls to introduce themselves. They initially get 30 cases, and then 30 days later they get another 15, and 30 days after that they are brought up to their full caseload of 60 with another 15. We watch their progress. We monitor their cases to ensure that they're doing everything that they're supposed to be doing, the requirement, making sure that it's timely, making sure that their documentation is thorough, so that we can catch and correct their performance before it falls off the rails and so that they can understand what the expectations are as we move forward.

Betsy Bella: Thank you so much. And then is there any information about trauma-informed training with the care manager training?

Lisa Portune: Yes, that's one of the topics that is covered and that they receive in training.

Brittany Woulms: Yes, there's been a lot of work lately around the role of trauma-informed interactions in person-centered approaches.

Betsy Bella: Great. We've got someone who says, "You mentioned behavioral health liaisons." Can you elaborate on how you work with mental health and substance use needs?

Andrea Price: Hi, this is Andrea. Aetna has behavioral health liaison in each region. We serve three regions of Ohio. So each region has a dedicated person who has connections to behavioral health providers, is familiar with what resources are in that region, and so they work with the care managers, and if someone is having a behavioral health need or they're having a potential

substance use problem they reach out to the behavioral health liaison, who acts as a consultant and helps them get connected to those providers.

Betsy Bella: Thank you. All right, we've got some questions about sort of the beginning of the partnership. First of all, how long has this partnership been in existence between Aetna and the Triple A?

Andrea Price: So, we went live on June 1, 2014, so a little over four years.

Betsy Bella: Thank you. And do you have any strategies you'd recommend for initiating collaboration between health plans and Triple A's?

Andrea Price: You know, there's no such thing as over-communication, so I think communication is key, making sure you're just talking almost multiple times a day. I think that's been the key. Lisa, do you have anything?

Lisa Portune: Oh, I would absolutely agree. Having our monthly waiver manager meetings are vital, to be able to bring up what's working and what's not. And I would say we're probably conversing through 15, 20 emails per day, whether that's about a process that's working, a process that's not working, but also member-specific issues when we come up against a barrier that we need to figure out a way to get around. So we are working closely together, and as soon as barriers are identified they're talked about and you're using all of the knowledge at the table across agencies.

Betsy Bella: Thank you. All right. And then do you have an idea about how many folks served in the program also have intellectual or developmental disabilities?

Lisa Portune: No, I am not sure of that data. However, I do not believe that our program serves that population. We may have a few, but it's not a big segment of our population.

Betsy Bella: That makes sense. All right. Do you have examples or templates of care plans that use plain language?

Andrea Price: We do not have templates of care plans that use plain language. We do do a lot of care planning training, and in that training we do talk about that the care plan is for the member. They receive a copy of it. And it needs to be in language that they understand and that they can follow so they understand their goals, because they're goals that they work to create.

Betsy Bella: Absolutely. And, of course, the importance of the care plan needs to match the individual, so it's hard to get too prescriptive in your template. All right. Okay. Looking through the questions. Another one is do you do your care management in person, over the phone, or both? And what are the requirements for number of contacts and frequency?

Lisa Portune: We do both. Mainly our care management is in person, but we also touch base on phone, too. But all our members get at least an opportunity for in-person visits each year. The amount of contact they get depends on their stratification. We actually have five different

stratification levels in our program. The most intensive members with that stratification, their minimum in-person visits would be every 60 days, down to the most minimal stratification, called monitoring, their stratification only prescribes once-a-year visits. With our partnership with Council on Aging, most of our members are in that medium, high, or intensive level, so they get seen more often.

Betsy Bella: Great. Thanks. What's your process if you have difficulty reaching a member on the phone? This might be a question for Brittany.

Brittany Woulms: Okay, so often with members we try to get alternative contacts. So if they have a land line, a cell phone, a daughter, a son, a neighbor, a friend, we try to get as much information as possible to reach them. If all else fails we'll try to reach the provider. We'll drive by their house. We do everything we can short side of stalking to get ahold of somebody. And all of it, it's really for their benefit, to make sure we're meeting their needs. If we are not communicating with them, they're not communicating with us, it's not going to be beneficial towards their plan. So, also we send letters, everything we can really do, different modes, to get ahold of them.

Betsy Bella: Great. Thank you. Well, and that actually segues nicely into someone had a question about this seems like a really great approach for folks like Karen who are really engaged, but what do you do if you're working with someone who's not as engaged? How do you provide person-centered care to them?

Lisa Portune: So, if their lack of engagement is cognitive it's usually going to be goals focusing on the caregiver. If they're not engaging because that's just their personality, try to find something that is important to them, so I have a member who really enjoys smoking her cigarettes. The goal would be doing it safely, education on enjoying her habit safely. It could be that simple. The members who have no desire to participate at all, we try to educate them that this is their plan, this is their services. It is voluntary. If they don't want to participate that's their choice. But typically once we find out what's important to them they're more engaged.

Betsy Bella: That makes perfect sense, the idea of meeting people where they are and demonstrating to them that this is a meaningful program that they can gain from and then allowing them to make the ultimate choice on whether or not they want to engage in it. Perfect. Okay. We've got some questions about motivational interviewing. We're going to go ahead and share a link to a SAMHSA resource. That's the Substance Abuse and Mental Health Services Agency. They've got some resources for motivational interviewing there. But either Shawn or our panel, are there any other motivational interviewing resources you'd like to call out for folks listening in?

Shawn Terrell: No, I don't have anything specific around motivational interviewing. I think I mean, it's an evidence-based model with some pretty specific training requirements. That is my understanding.

Betsy Bella: Then are the southern Ohio case managers all certified in motivational interviewing or working through that process or using the concept?

Lisa Portune: The care managers are using the concepts at this point.

Betsy Bella: Okay. Great. Other than requiring health plans and Triple A's to collaborate, were there additional supports from the state of Ohio?

Andrea Price: I don't understand exactly what they're looking for there, but, yes, there are different criteria they put in this plan. But as far as collaborating with a certain organization, that's the only organization they required us to collaborate with. Aetna just went a step further with their collaboration.

Betsy Bella: Great. And that actually connects to another question asking if southern Ohio has a similar relationship with other carriers that they work with in the same capacity.

Andrea Price: Yes, we do, actually. We work with a competitor, as well.

Betsy Bella: And my understanding from our previous conversations is that the steps of person-centeredness in some of your other programs doesn't go quite as deep, since, as Andrea just mentioned, you all really took this partnership and pushed it further to support the people you serve.

Andrea Price: Yes, we're full-service coordinators.

Betsy Bella: All right. And then how long do people typically stay in the program?

Andrea Price: So, they are members as long as they're dually certified, so they have Medicare and Medicaid, and they live in the service area of Ohio that we serve, and they choose to be our members. They do have choice, so if they don't like the way we do things they do have an option to go to one of our competitors. So they stay in our membership typically for years.

Betsy Bella: And someone specifically wanted to know, Karen, how long have you been a part of the program.

Karen: About a year and a half, two years.

Betsy Bella: Then if folks lose their Medicaid eligibility and have to leave the program, is there a process for helping them leave?

Andrea Price: So, if they lose Medicaid eligibility, the state of Ohio, Ohio Department of Medicaid, would disenroll them from our plan, but we do, the care managers, as they see that someone's going to lose eligibility, do help them transition and find the resources they need to transition safely.

Brittany Woulms: Wonderful, Andrea, I wanted to build on that a little bit. We have a specialist that pulls a report, and typically we know when our members are going to be recertifying every year, so we can have that discussion of hey, look out for that piece of mail. Let me know if you

have any questions. This is XYZ on what you need to be doing to try to prevent that from even happening.

Betsy Bella: Okay. Thank you. All right. We've got a question that's a little bit about how you use your creative thinking. What would you say if the member's answer for what they want most is money to eat healthy since they do not like the foods offered from community resources?

Lisa Portune: So, Brittany, you may have some more ideas about this, but we do try to explore what they consider to be healthy foods and what they like. It could be different providers. We have, I don't know, probably about 10 different providers for home-delivered meals, and they can try different ones for their taste. And then we also have community resources like food pantries. And then we can help transport them to maybe some farmers' markets, as well. Brittany, do you have anything that you would like to add to that?

Brittany Woulms: Well, it was kind of dual fold, because they're saying what would you do to have more money to have healthier foods. What is healthy foods to them? Is it fresh? Is it frozen? Is it canned goods? Is it salt-free? Is it sugar-free? We really have to get down to what is healthy. And as far as the monetary things, we can discuss financial planning to an extent on making sure they're aware of budgets, maybe referring them to somebody who could help a little bit more with budgeting, because it may just be that they're spending their money in ways that they wouldn't realize, and they could have that money for healthy foods. So it's difficult to really pinpoint that because there are so many different factors that could be healthy and more money.

Betsy Bella: The two of you there, you've really just demonstrated the importance in person-centered approaches of thinking outside the box and also getting to the underlying issues. Sometimes we talk about the difference between fixing and supporting. Fixing is when you throw a patch on something. Supporting is when you look at what are the underlying issues. How can we address things at the root to give people the support they need most?

As long as we're on the topic of responding to requests from people, how would you help a member whose main concern is pain management, specifically asking for stronger pain medication?

Brittany Woulms: So, as our members age, or anybody, really, pain becomes a common factor of life, and pain for everybody is going to be different. For our members we do have a pain assessment we go through. We look at their pain tolerance, how often they have pain, what does their pain feel like, is there anything in this world that can make it better. We look at all factors, not just medicinal. If they've never had a pain specialist maybe educate them on having that discussion with their doctor, letting them know of the local doctors that are around them that do provide pain specialism. And then if they're already on that narcotic or other pain medication talk to them about communication skills so they can learn to express better ways of how they're managing their pain with their doctor, what's working, what's not working. Again, it is really going to go back to the individual.

Betsy Bella: Great. Thank you. You mentioned earlier in the panel dashboards, especially around things like transitions and big events. How do you follow up with patients that have been discharged from acute care settings?

Andrea Price: So, as soon as we know someone has been in an acute care setting, we do a telephone call within 24 hours trying to reach them and trying to just contact them and touch base with them about the event. And then we keep close contact to find out when they're going to be discharged, what needs they would have at discharge. And then we actually go out and visit them within three days of their discharge. So we do that unless the member prefers us to wait a little bit longer because they're working with therapy or something of that nature. So it is very vital. That's a very sensitive time for a member. A lot of changes going on. They have a lot of needs. And we have to really stay on top of that. Brittany may can speak about it from a care manager point of view.

Brittany Woulms: Andrea pretty much hit the nail on the head. We do the 24-hour call. We go out to see them at their preferred schedule, but typically before three days. When anybody gets out of an acute facility, whether they're young or old, great health, poor health, they feel pretty rough, and so we want to make sure that things are being met as far as their needs go. An individual may need additional help for a couple weeks because of whatever reason put them in the hospital in the beginning. We review their discharge plan with them. As we talked earlier, we mentioned clear language. We want to make sure they're understanding things. Oftentimes our members may not even understand their diagnosis because it says hypertension instead of high blood pressure, or they might not understand their medications, so we're really about going through the plan, making sure they understand it, referring them back to their doctors, making sure they have transportation to upcoming appointments that are follow-ups for that hospitalization or acute nursing facility stay.

Betsy Bella: Thank you. All right. I know we've touched on it before, but just since we've had a few people ask, can you please repeat for folks on the phone about how many people does a care manager work with at any given time, so size of caseloads?

Andrea Price: Our goal in southwest is to have caseloads between 60 to 63.

Betsy Bella: All right. Thank you. And then how do you support and best work with people who frequently use the emergency room and how do you identify people who maybe have higher healthcare risks?

Brittany Woulms: So, as Andrea said earlier, we review claims. When people have multiple emergency room visits we're going to be able to see what they're going for. We ask at every face-to-face if they've had an emergency room visit, how often are they going, what are they going for, educating them on calling the 24-hour nurse hotline, going to an urgent care, seeing if we can't get them into a same-day appointment with their doctor, and showing that they have transportation to get to that same-day appointment. A lot of people don't realize that those things may take care of their emergent issue than going to the emergency room in and of itself.

Betsy Bella: That's a great example of empowering people with the skills and information they need to use a lower cost approach rather than jumping into the emergency room, which I'm sure applies across other things that you do, as well.

All right, we are one minute from closing. I'd like to thank all our speakers again. We did collect questions as they came through. If you have any additional questions for Shawn or myself or our panel, or comments, please email RIC@lewin.com.

The slides for today's presentation, a recording, and a transcript are going to be posted to the Resources for Integrated Care website shortly.

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Thank you so much again for joining us today. Please complete our brief evaluation for our webinar so that we can continue to deliver high-quality presentations and improve on the webinars we offer. If you have any questions for us, please email us at RIC@lewin.com.

Thanks again to all the speakers, Shawn, Karen, Brittany, Andrea, Lisa. Have a wonderful afternoon, and thank you so very much for your presentation.