Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid

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

Credit Information

- For more information about obtaining CEUs or CMEs via the Centers for Medicare & Medicaid Service's Learning Management System, please visit: https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Person_Centered_Care
  - You will be required to complete a post-test; a link to this test will appear at the end of the presentation

Audio and Platform Information

- The audio portion of the presentation will automatically stream through your computer speakers. If you experience challenges with the audio, please click the phone icon at the bottom of the screen for dial-in information.
- If you are experiencing any technical difficulties with this platform, please use the Q&A feature for assistance or click the help button for additional information

Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid

Overview

- This is the fourth session from the “2018 Geriatric-Competent Care Webinar Series.”
- This session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussions.
- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com.

Accreditation

- **Individuals are strongly encouraged to check with their specific regulatory boards or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity.**
- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the Centers for Medicare & Medicaid Services (CMS).
- CMS is also accredited by the International Association for Continuing Education and Training (IACET). CMS complies with the ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation, the CMS is authorized to issue the IACET CEU.

Continuing Education Information

- **CMS is evaluating this activity for continuing education (CE) and continuing medical education (CME) credit. The number of credits awarded will be calculated following the activity based on the actual learning time. Final CE and CME information on the amount of credit will be available to participants within the Learning Management System (LMS) after the live activity.**
- Complete the post-test through CMS' Learning Management System with a score of 80% or higher by midnight on Monday, September 24, 2018

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO develops technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com.

Introductions

- **Betsy Bella**
  Consultant, The Lewin Group

- **Shawn Terrell, MS, MSW**
  Health Insurance Specialist,
  Administration for Community Living

Introductions – Panel Discussion

- **Karen, Aetna Member**

- **Brittany Woulms, LSW**

  Case Manager – MyCare Ohio Aetna Program, Council on Aging of Southwestern Ohio

- **Lisa Portune, MSW, LISW**

  Manager - MyCare Ohio Aetna Program, Council on Aging of Southwestern Ohio

- **Andrea Price, ADN, RN, CCM**

  Manager of Clinical Health Services, Aetna Better Health of Ohio

Learning Objectives

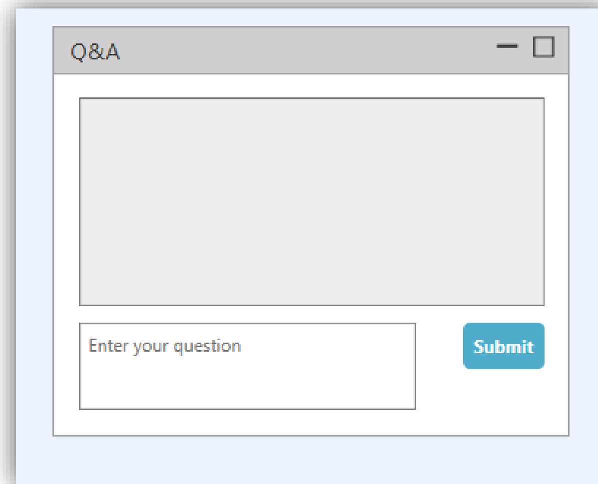
1. Define person-centered practices and approaches
2. Recognize the potential benefits and outcomes of person-centered practices and approaches including addressing social determinants of health
3. Identify opportunities to apply practical person-centered approaches to their own work

Webinar Outline

- Polls
- Administration for Community Living: Person-Centered Thinking, Planning, and Practice
- The Lewin Group: Person-Centered Approaches at Every Level
- Panel Discussion with Council on Aging of Southwestern Ohio and Aetna Better Health of Ohio
- Q&A
- Evaluation

Question for the Audience

- In one sentence or less, how do you define person-centered?
  - Enter your response in the Q&A feature on the lower left-hand side of your screen, and press "submit" to send it



Administration for Community Living (ACL): Person-Centered Thinking, Planning, and Practice

Shawn Terrell, MS, MSW

Health Insurance Specialist, Administration for Community Living

Administration for Community Living (ACL) Working Definition

- **Person-centered thinking**
  - Recognizes that people are experts in their own lives
  - Everyone can express their preferences and live a full life in their own community that they and the people who care about them have good reasons to value
- **Person-centered planning**
  - Identifies and addresses the preferences and interests that make up a desired life and the supports (paid and unpaid) needed to achieve it
  - It is directed by the person and supported by others selected by the person, who are independent of any service/support to be delivered in the plan
- **Person-centered practice**
  - Aligns service resources and systems that give people access to the full benefits of community living and delivers services in a way that facilitates achieving the person's desired outcomes

Social Determinants of Health: Major Drivers of Health Care Costs

Social Determinants of Health

Economic Stability	Neighborhood & Physical Environment	Education	Food	Community & Social Content	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expense	Safety	Early childhood education		Community engagement	Provider linguistics & cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditure, Health Status, Functional Limitations

Source: CMS Office of National Coordinator for Health

ACL Vision for Person-Centered Planning

- Everyone involved knows what to expect
- People who facilitate planning processes are competent
- Systems are configured to deliver services and supports in a manner consistent with person-centered values
- Quality measures are implemented for process fidelity, experience, and outcomes based on each person's goals
- Principles of continuous learning are applied throughout the system
- Support is formalized, and there are ongoing partnerships with people with disabilities and older adults in designing and implementing person-centered thinking, planning, and practices in systems

Person-Centered Approaches at Every Level

Betsy Bella

Consultant, The Lewin Group

This presentation includes person-centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at http://tlcpcp.com.

Person-Centered Models

- Person-centered approaches is a broad category
- Several models exist to provide frameworks and tools to person-centered approaches. These often focus on specific settings or populations such as:
  - Charting the LifeCourse™
    - The LifeCourse™ Trajectory
  - Patient/Person and Family Engagement
    - Shared Decision Making
  - Wellness Recovery Action Plan®
    - Daily Plan
  - Person Centered Thinking©
    - Finding the Balance Between Important To and Important For
- All empower people to make decisions that work for them and focus on strengths with a goal of improved self-management

Addressing People's Needs: *Important For*

- Finding the balance between "Important To" and "Important For" is a framework for considering the whole person
- In our professional roles, we are responsible for activities that support people to:
  - Access services to treat chronic or acute conditions
  - Manage the receipt of health care services by coordinating appointments and supporting medication management
  - Address social determinants of health (e.g., transportation, safe housing, or employment)
- These activities are *important for* a person to be healthy and safe, but often may not lead to a meaningful life on their own

Addressing People's Preferences: *Important To*

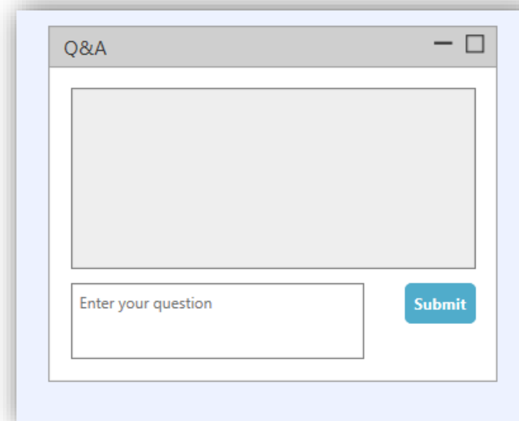
- Consider what makes a meaningful life for you. What brings you satisfaction, joy, comfort, and fulfillment?
  - Do you spend time with people who matter to you?
  - Do you feel respected for who you are?
  - Do you have control over big and small decisions in your life?
  - Do you spend time in places you enjoy?
  - What activities are enjoyable and meaningful to you?
  - Do you establish daily routines that work for you?
  - Do you prefer a fast-paced life or a slower rhythm?
  - What objects or things are meaningful to you or make your life easier?
- These questions begin to illustrate what is *important to* you

Balancing *Important To* and *Important For*

- The systems in which we work often focus heavily on health and safety
- To effectively be person-centered, we also need to focus on the aspects of a person's life that are meaningful to them
- *Important To* and *Important For* do not exist at the expense of one another; they do not present an "either/or" choice
- In fact, understanding what is *important to* a person helps us more effectively support the person to address what is *important for* that person
- **What does it look like when we address both**?

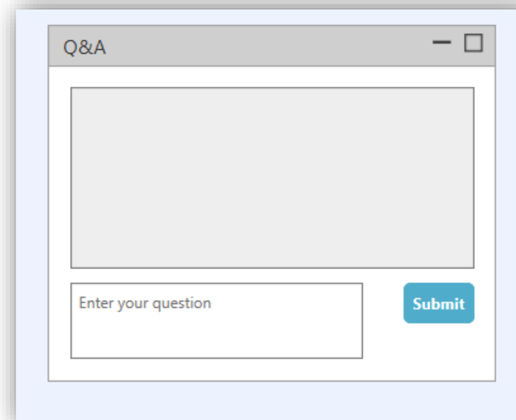
Balancing *Important To* and *Important For:* Jane

- **Scenario:** You are working with Jane, an older woman who is dually eligible for Medicare and Medicaid. She has several complex health conditions. You learn she lives alone on a limited income and she reports that she regularly misses meals. What do you do?



Balancing *Important To* and *Important For:* Jane Continued

- How would your approach change if you learned the following information about what is important to her?
  - Vegetarian for the last 20 years
  - Had a large family and considers meals a social activity
  - Cat recently died
  - Has several dental issues; she can only eat soft foods, and does not want others to know



Levels of Change to Support Person-Centered Practice

- Changes to support person-centered practice can happen at multiple levels
  - Federal and state policy changes
  - Organizational level changes - formal changes to processes, structures, and rules guiding how staff members work with individuals
  - Individual level changes - direct changes that staff members and others make in their day-to-day interactions and work

Levels of Change: Federal and State Policy

- In the last decade, there have been policy changes impacting the landscape in which providers and plans operate
  - Changes in regulations or guidance can make a large impact, requiring or encouraging changes to how organizations and individuals act
- Examples:
  - CMS Home and Community Based Services (HCBS) Final Settings Rule Medicare and Medicaid Programs [1]
  - Reform of Requirements for Long-Term Care Facilities Final Rule [2]
  - Medicaid and CHIP Managed Care Final Rule [3]
  - State policies requiring person-centered training for staff such as care managers

Source 1) 79 FR 2947
Source 2) 81 FR 68688
Source 3) 81 FR 27497

Levels of Change: Strategies for Organizations

- Create opportunities for front-line staff to share what they have learned in working with clients
  - Encourage sharing at team meetings
- Consider requiring community inclusion goals as part of care plans
- Track case notes with an emphasis on capturing preferences the person shows or shares
  - Particularly useful for people who do not use words to communicate
  - Sometimes called a “learning log” approach
- Develop and use shared decision making tools
  - For example, a guide with information on different treatment options for a specific condition

Levels of Change: Strategies for Individuals

- Individuals can implement changes in their day-to-day workflow to improve the experience of people receiving services
  - Some changes are possible even without a larger organizational level initiative
  - People receiving services can also implement change
- Avoid the use of jargon and acronyms and use plain language.
- Share notes and plans with the person even if it is not required
- Focus on and emphasize people's strengths rather than focusing on "deficit" based supports.
  - Recognize that everyone has something to contribute
- Ask yourself, "What changes can I start making tomorrow?"

Change Cycles through Levels

- Changes may be needed at all levels
- Each level influences ongoing change

Panel Discussion: Person-Centered Approaches

- Karen, Aetna Member
- Council on Aging of Southwestern Ohio, MyCare Ohio Aetna Program
  - Brittany Woulms, LSW, Case Manager
  - Lisa Portune, MSW, LISW, Manager
- Aetna Better Health of Ohio
  - Andrea Price, ADN, RN, CCM, Manager of Clinical Health Services

Aetna Better Health of Ohio – Who Are Our Members?

- Across Ohio, we serve 24,000 adults aged 18 or older who are dually eligible for both Medicare and Medicaid
  - Higher rates of chronic conditions and long-term support needs
  - The strengths-based focus of person-centered approaches is especially helpful for managing chronic conditions and identifying long-term support needs

Council on Aging of Southwestern OH: What is an Area Agency on Aging (AAA)?

- Network of ~620 organizations across the country who serve older adults in their local areas
- Most agencies serve a specific geographic area of several neighboring counties
- Services include
  - Nutrition (e.g., counseling, home delivered meals)
  - Caregiver support
  - Information & referral
  - Long-term care ombudsmen
  - Insurance counseling
  - Transportation
- Find your local AAA: https://www.n4a.org/

Panel Discussion Questions

1. **Could you briefly describe what the partnership between your organizations is, and how it keeps people at the center of your work?**

Andrea - Aetna Better Health of Ohio

Lisa - Council on Aging of Southwestern Ohio

Moving to Organization Level Change

- Ohio required health plans to partner with AAAs
- Aetna and Southern Ohio developed protocols to keep the people they serve at the center of their partnership and work
- Our panelists provided an example of changes at the organization level started by policy changes

Panel Discussion Questions

2. Karen, how did Council on Aging of Southwestern Ohio and Aetna help you?

Karen - Aetna Member

Panel Discussion Questions

3. **What is a person-centered plan, and how do you create one?**

Karen - Aetna Member

Brittany - Aetna Case Manager

Panel Discussion Questions

4. **How do you support people to make decisions?**

Brittany - Aetna
Case Manager

Moving from Organization to Individual Level Change

- Aetna and Southern Ohio developed requirements for person-centered care planning
- Case Managers work with people to design and implement
- Our panelists provided an example of changes at the individual level based on new policies at the organization level

Panel Discussion Questions

5. **What did it take to get this partnership up and running? What did it take for a successful culture change?**

Andrea - Aetna Better Health of Ohio

Lisa - Council on Aging of Southwestern Ohio

Panel Discussion Questions

6. What plans do you have to continue becoming more person-centered? Karen, what would you change?

Panel Discussion Questions

7. **What do you see as the greatest accomplishment of this program and approach?**

Moving from Individual to Organization Level Change

- Individuals, organizations, and eventually systems continue to adapt based on learning from previous changes

Person-Centered Approaches: Summary

- Moving to a person-centered system is a journey
- It takes partnership and cooperation from a variety of organizations
- Efforts are needed from individuals and from organizations for lasting change
- A person-centered system empowers and supports people to control their own lives to move toward the outcomes they and their families define as success

Questions

Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at: https://www.resourcesforintegratedcare.com

- For more information about obtaining CEUs via CMS' Learning Management System, please visit: https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Person_Centered_Care

- Questions? Please email RIC@lewin.com

- Follow us on Twitter at @Integrate_Care to learn about upcoming webinars and new products!

Webinar Evaluation Form

- Your feedback is very important! Please take a moment to complete a brief evaluation on the quality of the webinar. The survey will automatically appear on the screen approximately a minute after the conclusion of the presentation.