Question & Answer (Q&A): Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid Webinar

Webinar participants asked these questions during the *Person-Centered Approaches to Support People Dually Eligible for Medicare and Medicaid* webinar held on September 6, 2018. We have edited speakers' responses for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website:
https://www.resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Person_Centered_Care

Featured Webinar Speakers:

- Shawn Terrell, MS, MSW, Health Insurance Specialist, Administration for Community Living
- Betsy Bella, Consultant, The Lewin Group
- Lisa Portune, MSW, LISW, Aetna Manager, Council on Aging of Southwestern Ohio
- Andrea Price, AND, RB, CCM, Manager of Clinical Health Services, Aetna Better Health of Ohio
- Brittany Woulms, LSW, Aetna Case Manager, Council on Aging of Southwestern Ohio
- Karen, Aetna Member

Q1: What are some examples of quality measures that have been developed to track person-centered planning?

Shawn Terrell: There are several quality measures for person-centered planning that are being developed in the federal space. The US Department of Health and Human Services (DHHS) prefers measures expressed as a rate that can be tracked over time, are reported by the person served, and track some aspect of system performance. The National Quality Forum (NQF) refers to these as Patient (Person) Reported Outcome Performance Measures (PRO-PM). NQF is the leading consensus based entity for health care quality measure endorsement for the DHHS.

Additionally, Human Services Research International (HSRI), through a partnership with the Administration for Community Living (ACL), developed, tested, and added person-centered planning questions to the National Core Indicators for people with intellectual or developmental disabilities. HSRI also developed a separate person-centered module for the National Core Indicators – AD for people with physical disabilities and older adults. Lastly, there are a number of person-centered planning measures included in the home and community-based services measure inventory, develop by the ACL-funded, Rehabilitation Research and Training Center for HCBS Outcome Measurement.

Q2: Is nonmedical transportation available for members, such as to and from church, or other community events?

Brittany Woulms: In the State of Ohio, nonmedical transportation is a waiver benefit. Dually eligible older adults may have free or low cost transportation benefits as part of their Medicaid health care coverage. States are required to provide non-emergency medical transportation (NEMT) to Medicaid beneficiaries, with exact coverage varying by state. To learn more about the transportation benefits covered in your state, you can contact your State Medicaid Agency through the following website: https://www.medicaid.gov/about-us/contact-us/index.html.

Q3: How does Aetna tailor person-centered care for their members with behavioral health needs?

Andrea Price: Aetna has behavioral health liaisons in each of the three regions we serve in Ohio (i.e., Toledo, Cincinnati, and Columbus metropolitan areas). Each region has a dedicated person who has connections to behavioral health providers, is familiar with the resources available in that region, and works closely with the case managers. When a member has a behavioral health need or a potential substance use problem, he or she can reach out to the behavioral health liaison. The behavioral health liaison can act as a consultant to connect the member to providers they need. In addition, we have bi-monthly substance use disorder rounds with our behavioral health liaisons. This helps our team to share resources and information about what is working and not working which enables us to better serve our members.

Q4: Do you encounter members who are reluctant to speak on the phone? What is the process of reaching members you cannot reach by phone?

Brittany Woulms: We accommodate members' preferences and abilities with face-to-face contact, emails, and sometimes texts depending on their level of comfort with technology. We try to collect as much contact information as possible from our members — whether they have a landline or cellphone, or if there is another point of contact like a family member, friend, or neighbor who we can reach. We also mail letters, contact providers, and drive to members' homes if we are unable to reach them by phone. If members continue to be unresponsive to our outreach efforts, we will try to find something of importance to them offered by our services to encourage them to participate. For members who have no desire to participate at all, we try to educate them on the plan and its services. If they do not want to participate, that is their choice, but we typically find out what is important to them when they are more engaged.

Q5: Are there specific strategies for person-centered interviewing?

Brittany Woulms: One component of person-centered interviewing is avoiding "yes" or "no" questions. Another technique is rephrasing questions so that you meet the member at their level. For example, instead of asking a member if they have hypertension you could say, "I see

where you reported that you have hypertension. Can you tell me when you were diagnosed with high blood pressure and what you know about it?" By allowing the member to open up about what they know, you can focus on improving what they do not know. Their responses can lead to further discussion, education opportunities, durable medical equipment requests, and specific member goals. This technique can apply beyond medical concerns; it can also assist with questions about demographics, geography, culture, etc.

In addition, finding some common ground can make the interviewee feel more at ease. For me, I have the advantage of being local. I like to share something about myself, in a small way, to garner more conversation outside of the standard questionnaire. It also helps to build rapport when we can talk conversationally with our members.

Betsy Bella: Many organizations use motivational interviewing techniques as a way to train staff to approach interviews in a more person-centered way. SAMHSA offers introductory resources focused on behavioral health care that can be used in other settings as well.

Q6: **How often do you visit in-person with your members? What is a typical caseload for case managers at Aetna?**

Lisa Portune: Members receive more in-person visits if they are at a higher level of risk. We have five different stratification levels in our program. Members at the highest intensive stratification level receive, at a minimum, one in-person visit every 60 days. On the other hand, we visit members in the lowest stratification level once a year at a minimum. Often times, case managers contact members more than the minimum number of times deemed by their stratification results. The Council on Aging partnership program offers integrated service coordination, which includes care management, and referral to community resources. Most of our members who are a part of this program are in the medium, high, or intensive level of risk, so we visit with these members more often.

Andrea Price: The typical caseload for case managers at Aetna is between 60 and 63 clients per case manager.

Q7: What are the different types of training or educational programs you provide to your associates and care managers on person-centered care?

Lisa Portune: Person-centered education is a crucial aspect of our training academy. When a care manager is hired, they spend roughly three and a half weeks learning the job, the policies, the procedures, and person-centered care planning. The trainees spend time looking through future cases they will receive, and working with their immediate supervisor to practice how they would implement person-centered care with each person. Then, after close supervision, they begin making initial calls to introduce themselves.

On an ongoing basis, we incorporate person-centered care into monthly trainings for all case managers.

Q8: How do you follow-up with clients after they are discharged from acute care settings?

Andrea Price: As soon as we know a client has been admitted to an acute care setting, we conduct a telephone call within 24 hours to discuss the reason for admission. Then, we keep close contact with the facility to determine the projected discharge date and the client needs at discharge. Then, we visit the client within three days of their discharge, unless the client prefers we wait.

Brittany Woulms: A client recently discharged from acute care may need a few weeks of additional support. We review the discharge plan with the client and make sure they understand everything. In addition, we ensure that they have transportation to upcoming follow-up appointments and communicate any concerns or needs with their interdisciplinary care team (PCP, RN, family caregiver, etc.). By intervening this way, we can often prevent hospitalization relapse.