RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration

# Disability-Competent Care (DCC) Care Coordination: An Overview



# Resource Overview

- This brief presentation distills key information and content on Disability-Competent Care (DCC) care coordination from several resources produced by Resources for Integrated Care (RIC) in collaboration with disability practice experts.
  - Disability-Competent Care Coordination, March 8, 2017
  - Interdisciplinary Team Building, Management, And Communication, March 21, 2018
  - The Care Management Relationship Webinar, June 24, 2015
  - Building Partnerships between Health Care (Plans & Providers) and Community-based Organizations Webinar, April 1, 2014
  - Primary Care Co-Visit: Care Coordinators Tip Sheet
- The target audience for this presentation is health plans and providers who serve individuals dually eligible for Medicare and Medicaid to address any gaps in coordinating care for individuals with disabilities.
- The presentation will focus on the key elements of care coordination, the role of interdisciplinary teams, and strategies to improve care coordination.

# Support Statement

- This resource is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help individuals enrolled in both Medicare and Medicaid programs 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 individuals, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this resource.

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

# Learning Objectives

## This resource will emphasize:

- Key elements of care coordination
- Strategies to improve care coordination
- Understanding the role of interdisciplinary teams

# Agenda

1. Background
2. Critical Areas of Care Coordination
3. Strategies for Effective Care Coordination for Individuals Living with Disabilities
4. The Interdisciplinary Team (IDT)
5. IDT Communication
6. Tailoring Services

# Background

# Health Disparities

People living with disabilities are more likely to:

- Experience worse outcomes and are less likely to receive the recommended care.[1]
- Experience difficulties or delays in accessing the necessary health care, including primary care and timely follow up on equipment and supply needs.
- Encounter barriers to recommended health screening tests [2] (e.g., breast cancer, colorectal cancer or pap smears).
- Not receive comprehensive preventive care (e.g., BMI assessment, medication adherence, diabetes management, and annual flu vaccine).
- Have high blood pressure and hyperlipidemia.

**Sources:**1)Office of the Assistant Secretary for Planning and Evaluation. (2016). Report to Congress: Social Risk Factors and Performance under Medicare's Value Based Purchasing Programs
2) Disability and Health. Healthy People 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/ebrs

# Social Factors

- Payers, including Medicare and Medicaid, are moving from traditional fee-for-service payment toward models that pay for performance over volume.
- On many outcome measures (e.g., cancer screenings, vaccinations, diabetes management), the clinical interventions are straightforward, but service delivery for people with disabilities can be challenging for providers in this changing environment.
- Performance measures that demonstrate improved outcomes for people with disabilities will have a direct impact on revenue for many providers and plans.
  - DCC care coordination can improve performance measures and ultimately, lead to better outcomes for people with disabilities.

**Source:** 3) National Academies of Sciences, Engineering, and Medicine. (2017).*Accounting for social risk factors in Medicare Payment, Washington, DC*: The National Academies Press. doi: 10.1722 **https://www.ResourcesForIntegratedCare**8

# Critical Areas of Care Coordination

# Critical Areas of Care Coordination

- Care Transitions Planning
  - Involves developing a person-centered and individualized transition plan.
- Managing Transitions
  - Involves developing an appropriate course of action to carry out the transition plan and addressing all aspects of the transition process.
- Managing Medications
  - Involves the use of a central health record to facilitate medication management and reconciliation.
- Advance Directives Planning
  - Involves planning and discussions of end-of-life care issues with respect and sensitivity.

# Care Transitions Planning

- Care transitions typically refer to a move into or out of a care setting, such as a hospital or nursing facility.

- An important initial step is developing a person-centered and individualized transition plan that aligns with the participant's expressed desires and needs.

- Transitions have a much broader scope when involving people with disabilities, including:
  - Changes in care settings, providers, and medications;
  - Financial, housing, legal, and employment issues; and
  - Other factors affecting the participant's ability to live independently.

# Managing Transitions

- An important step is developing an appropriate course of action to carry out the transition plan.
  - Address all aspects of the transition process, including significant changes or issues that arise.
- Any transition represents an opportunity for potential errors and requires alertness by the IDT to oversee the transition process in order to identify opportunities to ensure the health and safety of the participant.
- Designate to an IDT member the responsibility of ensuring the successful completion of the transition and timely follow-up.
  - It is essential to understand the reasons for the transition and to coordinate follow-up appointments and medication management.
- IDT can use protocols or checklists to assist in managing the transition process.

# Managing Medications

- A central health record will facilitate medication management and reconciliation, improve participant safety, reduce adverse drug events, and improve medication adherence.

- The participant's functional status, health literacy, cultural beliefs, and any potential communication barriers should be taken into consideration when prescribing medications and should be documented in the central health record.

# Advance Directives Planning

- Person-centered advance directives planning requires discussions of end-of-life care issues with respect and sensitivity.
  - Entails having a trusting relationship with the participant.
  - Includes sensitivity and awareness of cultural preferences or communication barriers.
  - Emphasizes person-centered planning and promotes participant autonomy in end-of-life decision-making.
  - Timing of discussions is critical-ideally not during a crisis.
- Specialized training is important for this discussion as participants generally benefit from coaching through the process.
- Advance directives should be reviewed at least annually, with copies provided to key medical providers.

# Strategies for Effective Care Coordination for Individuals Living with Disabilities

# Strategies for Effective Care Coordination

- Develop and maintain a trusting relationship.
  - Engage in direct communication with the participant.
  - Understand the participant's capability and willingness to be involved in his or her care.
  - Honor the participant's preferences and goals.
- Upon the participant's consent, engage in direct communication with the participant's IDT – family, home care workers, physicians and behavioral health specialists.
  - Whenever possible, include the participant in the communication with the IDT.
- Orchestrate necessary arrangements for desired and needed care
  - For example, appointments or Medicaid eligibility, etc.
- Camille's story

# The Interdisciplinary Team

# Interdisciplinary Team

- Care coordination involves the implementation, oversight, evaluation, and refinement of the participant's care. The work of care coordination begins once the assessment is completed and the individualized care plan (ICP) is developed with the participant.
  - Development of the ICP is based on the participant's expressed goals and preferences.
  - Ongoing oversight and review of the ICP with the participant is needed to ensure plans are effective and being followed, preventive strategies are in place, and revisions are made based on the participant's expressed and evolving needs.

# Interdisciplinary Team (continued)

- Care coordination is provided by an interdisciplinary team (IDT). Each member of the team, including the participant, brings his or her unique competencies to inform a comprehensive approach to the participant's care.
  - The IDT collectively shares responsibility for supporting the health and well-being of each participant in a collaborative, structured, and person-centered way.
  - Team members should understand and apply the concepts of disability-competent care.[4]

**Source:** 4) Resources for Integrated Care website: https://www.resourcesforintegratedcare.com/concepts/disability-competent-care

# Guidelines for IDT

- The participant's primary language, cultural beliefs, as well as his or her preferences, should be a primary consideration when assembling the IDT.
- IDT members should have training and familiarity in providing disability-competent care and experience working with persons living with disabilities.
- Roles and responsibilities should be clearly articulated and documented to ensure accountability and follow through.
- A lead coordinator should be identified for the IDT, whose main role is to be responsible for team oversight and accountable for the ICP; however, the role may change as the ICP is updated.
  - The lead coordinator serves as the key communicator between the IDT members, including the participant.

# IDT Communication

# IDT Communication

- Value listening above all else.
- Begin communications from the participant's perspective
  - "What is most important to you?"
- Assess the participant's understanding of his or her disability and functioning.
- Ask permission before offering health education and coaching.
- Ensure participants know how and when to reach out to other IDT members for support.

# IDT Communication among Team Members

- Establish a protocol for communication - should the participant's needs or situation change on short notice.
- The IDT should identify a lead who is responsible for regular contact with the participant.
- Designate points of contact for any external primary care providers that the participant uses, as well as any other key provider.
- IDT should convene on a regular basis to discuss participant updates, new assessments, and reassessment reviews.

# Tailoring Services

# ICP and Service Decisions

- Decisions made about a participant's care and services should acknowledge that the participant is the primary expert of his or her own life and care needs.
  - Person-centered care planning and service decisions should be customized and tailored to meet the participant's individualized preferences, goals and needs.
- Decisions should be made within the framework of respect for the participant's dignity of risk.
  - The participant has a right to identify his or her needs and make informed choices that may mean taking a calculated risk.
- The participant's needs and preferences will change over time, and services and care should be updated and modified accordingly.

# Additional Resources

# Additional Resources

- First-person stories
  - Camille's story
  - Sam's and Deb's story
- Effective Interdisciplinary Team Meetings (resource that includes an IDT meeting agenda template and a participant case review template)
- Primary Care Co-Visit Activities for Care Coordinators

# Sources

1. Office of the Assistant Secretary for Planning and Evaluation. (2016). Report to Congress: Social Risk Factors and Performance under Medicare's Value Based Purchasing Programs
2. Disability and Health. Healthy People 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/ebrs
3. National Academies of Sciences, Engineering, and Medicine. (2017).*Accounting for social risk factors in Medicare Payment, Washington, DC*: The National Academies Press. doi: 10.1722

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# Thank You!

- Questions? Please email RIC@lewin.com

# Send Us Your Feedback

Help us diversify our Disability-Competent Care trainings, resources, and other offerings – your input is essential!

Please contact us with your suggestions at

RIC@Lewin.com

**What We'd Like from You:**

- How best to target future Disability-Competent Care webinars, trainings, and other resources to health care providers and plans involved in all levels of the health care delivery process
- Feedback on this resource, as well as ideas for other topics to explore in additional resources related to Disability-Competent Care