

**Leading Healthcare Practices and Training:
Defining and Delivering "Disability-Competent Care"
Session V: The Individualized Plan of Care
Event ID: 701158**

Operator: Ladies and gentlemen, thank you for standing by and welcome to the Disability-Competent Care call. At this time all participants are in a listen-only mode. Later we will conduct a Question-and-Answer Session. Should you require assistance on today's call or if you would like to ask a question please press * then zero. As a reminder, this conference is being recorded. I would now like to turn the conference over to our host, Mr. Chris Duff. Please go ahead, sir.

Christopher Duff: Thank you, Lola, I appreciate it. On behalf of Lewin Group, the Institute for Healthcare Improvement and the Disability [Practice] Institute, I would like to thank you all for attending this fourth in our series on Disability-Competent Care. This presentation will be on care planning done by the Disability-competent interdisciplinary care team. As Lola stated my name is Chris Duff and I am the Executive Director of the Disability Practice Institute.

First I would like to orient you to this webinar platform. If at any time your slides are not advancing please push "F5" on your computer and that should get the slides moving again. There are two icon circles at the bottom of your screen. The one on your right is for you to be able to print out a PDF of the slides for the presentation for your use afterwards or if you prefer to go off paper while we are talking.

The other circled one, the red one of the left-side of the screen is for questions. So if at any time during the presentation please push the icon and type in your question. If it is about the technology of the platform someone behind the scenes will respond to your question in real-time. If you have a question about the presentation and would like to pose it to the presenters we will be compiling them throughout the webinar and will return to all of them during the Q&A session at the end.

This is the fifth in a series of eight webinars being presented through this fall, the previous four focusing on understanding the model of Disability-Competent Care and its key components. Secondly, understanding the perspective of persons with disabilities as they experience the healthcare delivery system. Third, providing care coordination with adults with disabilities and last week presented on Disability-competent primary care. All of those webinars are available on the website that we reference that the bottom of each of the slides if you wish to listen to or download any of those presentations.

Today we are focusing on care planning and Disability-competent interdisciplinary care teams and in subsequent weeks we will focus on managing transitions. That is next Tuesday, and on the 12th of November we will focus on coordinating flexible long-term services and support. We will conclude the series in early December with presentations on building a Disability-competent provider network and lastly talking about participant and provider readiness.

Each presentation will be 40 minutes in length with 15 minutes reserved for questions and answers. We will send you an email when this presentation is posted on the website. We hope you can join as many of these as possible and will forward the information to colleagues you think might be interested in the topic. We will also keep you informed of future webinars and products being produced through this initiative.

I would now like to step back just a moment to give you the genesis of this series and several other tools for integrating healthcare services for dual-eligible populations. The Lewin Group along with Institute for Healthcare Improvement in Cambridge have contracted with the Medicare and Medicaid Coordination Office, commonly known as the "duals office" at the Centers for Medicare and Medicaid Services.

This contract focuses on providing tools and technical assistance to providers that are seeking to integrate and better provide care for individuals who are eligible for both Medicare and Medicaid. As you are probably aware CMS has been introducing several initiatives over the past couple of years to provide financial incentive for integrated care and to improve and streamline care for dual-eligibles. This contract is to provide technical assistance to support these providers.

Lewin and IHI have in-turn partnered with the Disabilities Practice Institute to provide specific expertise in serving dual-eligibles with disabilities, the majority of whom are under age 65. This takes us to the Disability-Competent Care webinar series and our presentation today. We would like this webinar series to address your needs and questions regarding the delivery of Disability-Competent Care, addressing where you and your organization are on the road to this integration and care improvement.

So please submit questions in writing and we will additionally open up the phone lines at the end of the presentation for live questions. We are also asking you to fill out a short survey at the end of this webinar where we will be asking for feedback to make sure this series and our other efforts are meeting the mark in terms of what you need. Please also send us your ideas for future webinar topics and content either in the survey or to myself at my email address on the last slide.

I am now going to turn this over to Lynne Morishita who will introduce the presenters and review the webinar outline. Lynne has presented the last few webinars and she brings 35 years' experience with primary care and care coordination with medically complex populations. She along with June Isaacson Kailes and myself co-authored the Disability-Competent Care assessment tool that we have referenced throughout these webinars. To you now, Lynne.

Lynne Morishita: Thanks, Chris. Now I am going to introduce the speakers for today; Dr. Marilyn Luptak is an Associate Professor, Chair of the MSW Aging and Social Work Concentration and John A. Hartford Faculty Scholar in geriatric social work as well as Belle S. Spafford endowed chair in the College of Social Work at the University of Utah. A native of western North Dakota and graduate of the University of Minnesota Dr. Luptak brings more than 25 years of experience to her work to improve the health and wellbeing of vulnerable older adults and their families. Her scholarly activities address health and mental health care for older adults and their family caregivers in rural and urban settings, inter-professional education and collaborative practice and end-of-life care.

Kathy Thurston, who is going to be presenting about person-centered care planning, has over 30 years of experience in healthcare including home care, assisted living, school health, care coordination and case management across the age continuum. Her most recent experience includes developing and fostering partnerships with health plans, long-term care providers and other community-based providers and public programs to meet the needs of people with disabilities. She has a Bachelor of Science degree in Nursing from St. Olaf College and a Master's in Nursing and Health Systems Leadership from Bethel University.

Now I am going to hand the program over to Dr. Luptak after I describe the agenda. Dr. Luptak will describe the role and purpose of interdisciplinary care teams and some tips for how to train professionals to function in a healthy, productive interdisciplinary care team. Kathy Thurston will present how to do person-centered care planning from assessment to implementation of the care plan and evaluation to make revisions in that care plan. She will indicate adaptations in the care planning process in addressing adults with disabilities. Then we will follow with the Q&A session.

I will now hand the program over to Dr. Marilyn Luptak.

Marilyn Luptak: Thanks, Lynne. As Lynne said, my focus is really to focus in on the person-centered relational care management provided by interdisciplinary teams or most recently we seem to be evolving our terminology and thinking of them more as inter-professional care teams. So I may use those terms interchangeably. I am meaning generally the same thing.

Interdisciplinary collaboration really can be one of the most rewarding and challenging aspects of practice but increasingly with the Affordable Care Act and changes in our system it is increasingly essential regardless of the practice setting or the client population we are serving. Other components that are important, as Lynne touched on, is responsive primary care and having flexible long-term services and supports but we are really going to stay primarily focused on teams for teams for today's discussion.

So, I think it is helpful to start by just getting a general idea or definition of what teams mean. So I posted three quite different definitions. The first one just talks about a mechanism that formalizes joint action towards mutually-defined goals. That is a somewhat sterile kind of definition and I think if we look at the second one it feels a bit warmer and more relevant when we think about conducting teamwork within healthcare settings.

It is a small number of people with complementary skills and we are committed to a common purpose, performance goals and approach and we also hold ourselves mutually accountable. The third one, I like this very brief definition. It is actually a definition of interactions at the cellular level but I think it is at the core of what we are trying to accomplish when we are talking about teams. We give to and support each other and in turn we are nourished by one another.

Now, as we go forward I think it is always helpful to take a look back. So I wanted to talk briefly about where healthcare teams came from. Early on, thanks, next slide. Early on, in 1915 it was really Dr. Richard Cabot Lodge at Massachusetts General who said, "I think we need to have some teams." His initial teams were interesting make-up. They were medical doctors, educators

and social workers. Without going into detail we will fast-forward a bit. If we think about the time period after World War II certainly the VA systems were beginning to gear-up given the number of veterans who were returning back to the country.

But it was Dr. Martin Cherkasky in the Bronx at Montefiore Hospital who developed the first hospital-based home health program in 1947. They continued. They were known then, the home health program, as the "hospital without walls," and I think they are still talked about that way. If we fast-forward to the 1960's there were a lot of interdisciplinary educational experiences that were made available. The Federal Neighborhood Health Center programs used health teams in urban settings all around the country.

In the 1970's this is really where it is more relevant for me, there began to be more attention paid to the need to train interdisciplinary teams in geriatrics. We saw it rise up and get quite a bit of attention and then in the 1980's we saw it spiral downward and funding for teams and certainly the funding for training declined. But in the 1990's, and I would like to think we are still on that upward trajectory, we began to recognize that there was a need for teams in specialized areas and not surprisingly one of those areas, again, was geriatrics. So that resurfaced in the 1990's. Next slide.

One of the key things, or I think key efforts that came out of the 1990's was the geriatric interdisciplinary team training. You may hear me refer to it as GITT. It was the John A. Hartford Foundation who is committed to the care of older adults who made the decision to invest significantly in preparing students. Certainly they saw the need to prepare professionals but they choose to start by focusing on students to create some national training models with partnerships where we brought together educational institutions and also real-world providers of geriatric care.

There were three years of funding at eight sites around the country and I was lucky enough to be part of the University of Minnesota's GITT site where we immersed ourselves in this model. So each of these sites had clinical components which ranged from geriatric primary care to hospital-based services to hospice care. We really wanted to improve the academic responsiveness to the healthcare delivery system and of course also to create some well-trained graduates who could go out and work in the real world.

One of the programs that I want to highlight is Rush University. Of the eight programs funded in the 1990's they have continued to focus on interdisciplinary team training for the last 16 years and they have provided education. They have provided training. They have done applied practice programs in team-based geriatrics care. So if you go to their website there is just a whole host of resources. They have trained more than 4,000 advanced practice students and professionals in more than a dozen disciplines.

Over the last year they have been piloting an online GITT course that looks at learning competencies and knowledge. So we really have in a sense gone back to the future. Where we are today is thanks to the Affordable Care Act we have increased emphasis on person-centered care and inter-professional education and collaborative practice. And next slide.

I think this cartoon really does say it all. It is important to recognize as we talk about teams that a team of experts does not make an expert team. Our disciplines are very used to doing training in our own silos and we have limited understandings of one another's roles and I will have more to say about that as we move on. Next slide.

So one of the models that is out there and certainly there are a number of them, I wanted to just highlight the TeamSTEPPS model. TeamSTEPPS the STEPPS part stands for Strategies and Tools to Enhance Performance and Patient Safety. It is just one example of an approach to team care which was developed by the Agency for Healthcare Research and Quality, AHRQ and the Department of Defense. But it has all of the components in there of what I think is important. We need to be thinking about communication, the mutual support, and leadership. We need to be monitoring those situations. Again, we need to stay focused on the patient care or the participant care. Next slide, please.

So why does inter-professional practice and education matter? Well, research suggests that both participants and care providers who are involved in interdisciplinary teams experience clinical benefits. The evidence is there in terms of improved outcomes for care coordination and also in terms of comprehensive geriatric assessment. There is evidence to suggest that it promotes wellness and decreases acute care incidents which can be incredibly costly when they occur. Also interdisciplinary teams tend to have better access to resources. Next slide.

I really like this slide because it gives us a feel for teams can happen certainly at different levels within the way we provide care. If we think about inter-professional collaborative practice that may be where many teams are at. I think of that somewhat as being at those beginning stages of being a multi-disciplinary team. It really is when we have multiple workers coming together from different backgrounds who are working with the patients, families, care givers and communities to deliver good care. But if we make our way up that spectrum a bit we really ideally, I think, particularly if there are complex issues or consumers, clients, patients who have very complicated issues to be addressed we should be aiming more for inter-professional team-based care.

That is care that is actually intentionally created. This team is created very intentionally. It is usually a relatively small number of people and they are recognized by themselves and by others as having a collective identity and most importantly a shared responsibility to the participant or to groups of participants. It might be a palliative care team. It might be a primary care team. It could be an operating room team. But they are quite, quite sophisticated. I think of them more as a truly interdisciplinary team. We have also heard the language in the last few years which has kind of gone in and out of vogue is trans-disciplinary teams where they are working seamlessly together. Next slide, please.

Not surprisingly, given that we are focusing on the increasing need for teams to be effective practitioners, we need to again back it up and think about what do we need to do to prepare students or other trainees to do this appropriately. The Inter-professional Education Collaborative, we tend to call it IPEC, an expert panel came together in 2011 and focused on what are the core domain competencies that we really need for inter-professional collaborative practice.

In terms of values at some level that is a no-brainer. We work with individuals of other professions to maintain climates of mutual respect and shared values. Again, that notion that instead of just looking inward at our own profession we actually have to explicitly look outward. We need to respect the source of information from other people; from other disciplines or that information isn't going to be reciprocally respected when we share information.

In terms of roles and responsibilities it is really important that the knowledge that we have of our own role and the roles of other professions to be able to assess and address the healthcare needs of participants. I think one of the dangers is that we may come in with some negative stereotypes as we are forming teams of the other professionals' roles and without a doubt that can have an adverse effect on team functioning. I will say a bit more about that in a few minutes.

Communication I would say we could have this in bold and we could say, "Communication, communication, communication," because that is what really matters. Communicating with the participants, with the families, with the community and the other professionals in a responsive and responsible manner is what is essential to good team care. We do need to be able to be willing to work together.

Finally, that last domain in a sense brings all of these things together. I think one of the things to recognize is that conflict is going to be inevitable on teams and there is going to be a variety of opinions and we need to be able to regroup when we do have disagreements. Team members have to be willing to sacrifice some autonomy for the sake of the team. Next slide, please.

This slide and the next slide really talk about what are some of the components of effective team care. I think as we think about these things I also want to mention that as teams are developing some of you in the audience may be all from the same agency and you are at a developing stage of teams. But we like to think of development phases of healthcare teams as norming, storming, performing and then leaving. Or forming, norming, storming, performing and then leaving.

The first thing to do if you are looking at developing teams within your own settings is to ask the question, "Is an interdisciplinary team appropriate?" To be effective the other components are what are essential I think. You need to be able to both describe and demonstrate what is good team communication. That may vary from setting to setting. You need to be able to understand components of what is a functional assessment? Within that functional assessment who does what? If that person isn't available is there someone else who can do that appropriately?

We need to be able to utilize functional outcomes and truly establish participant-centered care plan goals. Kathy is going to say much more about that, I think, in a few minutes. We also need to truly be able to collaborate with the participant and the team members to make sure that the goals that are being put down on paper actually reflect the participant's preferences. That is always key. Next slide.

We need to also be able to recognize the strengths and the limitations of participant social networks and a physical environment. These are elements that certainly will influence how we develop our plans of care and again, what are the different responsibilities for the different team

members? What are appropriate service and supports along this continuum of care within the continuum?

It is also important to both at the point of assessment and ongoing to recognize that this is a process. It is not a product. We need to be able to recognize and address very chronic, complex problems in subsequent assessments for the participant and as we are reevaluating the plan of care. Next slide.

How do we create effective interdisciplinary team care? Here are just a few tips that I think are important for us to highlight to make this collaboration really work. I think in terms of articulating your role we need to be able to describe what our role is; both individual-to-individual. We had better be prepared to do it in group situations. It was one of the first and I think one of our key steps when we brought together and students from pharmacy, medicine, social work, nursing, and dietary in our GITT training in the 1990's was to first be sure that each discipline had an understanding of what the other disciplines could do.

When I think about nursing it is important to understand all of the different levels of nursing practice from LPNs to BSN's to Nurse Practitioners. So we spent a fair amount of time just helping people get comfortable. What are the different licensure requirements? All of that matters in terms of beginning to develop and respect one another. I think it is also really important and may be it seems really elementary but be familiar with what your job description is. What are the functions? What are the tasks? And be able to talk about those things with the other team members.

It is also really important to know what are your strengths. What specific contributions can you make to this interdisciplinary team process? How can you help improve client outcomes based on your skillset? It is also important not just to know about your own role but to understand the roles of the other disciplines. I think sometimes it is important to read practice setting information but even looking at consumer-oriented materials can help you understand what the responsibilities are of the other folks. Also, your colleagues are right with you. Ask questions of these interdisciplinary colleagues. Be sure you do understand their roles.

It is important to try to find common ground with your colleagues. I think if you can highlight the commonalities in your professional goals again what is at the center, what is at the bull's-eye, what is the bull's-eye of your target? We want to be able to relate things back to the client services and the organizational processes. It helps also I think to be able to identify where is there overlap in terms of your skillset with other members of the team when it comes to assessment and intervention?

Overlap means some people could perceive that as you need to protect your turf or you will lose ground. I see that as a real strength when we have more than one person on a team who can understand an issue and help develop a care plan based on the needs of the participant. It is also important I think to be able to connect with your colleagues in terms of some personal similarities. Your families, your hobbies that will help you come together as a team. We also need to be able to acknowledge the differences among disciplines and do that and be aware of

your own frame of reference. What are your assumptions and recognizing the strengths of each one of the disciplines.

Now this next bullet point in terms of addressing conflict we could spend probably half a day talking about conflicts. Again, recognize that it is inevitable. We need to be able to talk directly with the individual or individuals who are involved when conflict does surface. Try to avoid gossip and triangulation. I know that is easier to say than to do but it helps again if you deal directly with the individuals involved to talk through the issue. Try to reframe your colleague's issues as concerns and recognize again that this is about providing the best care possible to the participants and their families.

I think it is important to affirm the strengths of everyone involved and be willing to compromise without sacrificing what you see as essential. The final bullet point actually if you can be proactive in establishing and maintaining these relationships it means you are much less likely to have to be able to address conflict. But I think again one of the things that I was struck by our team in Minnesota because I felt like we quickly got to the point of being a very highly functioning interdisciplinary team was recognizing those personal connections appropriately so. But we had three members of our team who had very key people in their lives who were dying within the first six weeks of our team developing. That could have splintered us apart because we were coming and going. Instead I think we saw that as an opportunity to become even closer and support one another on those issues and it helped us every day from that point forward because we had gotten close fairly quickly and fairly honest with one another.

I think that is, next slide. I think that is a good place to stop. I will be available for questions when Kathy is done with her talking.

Kathy Thurston: Thank you, Marilyn. I am pleased to be talking with all of you today about person-centered care planning and hopefully my comments will provide you with some useful strategies and approaches for the work you do and help to make a difference in the lives of people with disabilities. First slide, please.

Like most people, adults with disabilities come with a variety of strengths, needs and hopes. Not all people with disabilities need intensive support and planning and are actually very capable of navigating on their own. Sometimes in our desire to help people with disabilities we as healthcare professionals forget this and move right into fixing it. I call it the fix-it mode. So it is important to start with an assumption that everyone is competent and independent and work with them as individuals to identify their strengths, hopes, needs or concerns.

From their perspective Marilyn did a nice job of weaving that into her talking about interdisciplinary team work. Many people with disabilities have been let down by the healthcare system. So first and foremost establishing trust is important but it might take some time. A good first step towards this is meeting with an individual in person, face-to-face in their community; somewhere they are comfortable. Now ideally this would be their home but sometimes there is another place that they might be more comfortable. It is really important to honor and respect that for them.

Healthcare professionals are taught to ask people questions usually via some kind of assessment tool or checklist to help determine a plan of care. The plan of care is typically filled with interventions and behavior changes from the perspective of the healthcare professional. It is designed to improve health and reduce the risk of further illness or injury and while these are all good things the person is not at the center of a plan like that and it doesn't necessarily include things that are important to them. That can only happen when we create space and time that allows them to tell their story.

So in addition to traditional health risk and safety questions we integrate strategies into the assessment and care planning process that help guide the person to tell their story and help the assessor listen. In other words, we tell staff to put the checklist down and just listen. We assess something called Patient Activation Measure on each recipient, each person that is referred to us. I will talk a little bit more about that later. We try to incorporate open-ended questions. We have actually written these into our assessment tools and allow time for the individual to respond to the open-ended questions.

I like to tell staff here to push their "pause" button and by that I mean truly physically touch the palm of their hand with their finger when they feel a need to talk, interrupt, correct or fix something that person is telling them. I think the reflex to do this is strong and for many of us it has been hardwired into our brain.

These are examples on this slide and the next of some questions that I think are very useful to elicit true, genuine responses from the person that you are meeting with, talking with, trying to understand and know. So, "What would you like to be different in your life?" An actual response to that question that we asked is, "I would like to be able to go visit my daughter and my grandkids but I am just too sick."

"What would it take for you to be able to travel to see them? Is there someone who helps you or supports you? How can I be of help to you in figuring this out? What is the best way for us to stay in touch about how you are doing?" So it is really about guiding that individual. In some cases giving them permission maybe for the first time to tell their story, to talk about their fears, to talk about their hopes, their dreams, and barriers that are getting in their way from realizing those things. And just, quite frankly, trying to better understand where they are coming from.

So when we open the door and actually allow someone the time and space to tell their story and fully participate [technical difficulty] it is important to expect and respect the dignity of risk. I will talk a little bit more about what I mean by that. Everyone needs enough control in their life to choose what they value and reject what they don't. That is true for everyone; each one of us.

But this is not a comfortable place for most of us in health and social work professionals. In particular when we see the person across the room as vulnerable or having special needs as we define them. We have to accept that some people might choose a path that might put them at greater risk of illness or injury. Everyone has the right to live with that kind of dignity of risk.

So in an effort to protect people from risk the healthcare and social safety systems have historically placed people with disabilities into environments that cut them off from opportunities

to grow, develop and take risks. For the most part we continue to build care and service plans from an avoidance-of-risk perspective. A key challenge for us as healthcare professionals now is to acquire the skills that will enable us to collaborate, truly collaborate with people. Maybe in particular people with disabilities to help them determine the right amount of risk for them.

So if I am a person living with a spinal cord injury I may choose to live with chronic wounds versus go through the difficult restrictions involved in complete wound healing. But I need to understand all of the pros and cons. Consider the typical scenario; a primary care provider is concerned about pressure wound complications for his or her patient. So the patient is referred to a wound clinic specialist where the primary goal of any treatment plan will be complete wound healing.

So is the person with the wound and the disability given a full picture of what this will mean for them? I don't think that is usually the case. So do they know they are going to get frequent wound care, maybe a couple of times a day? Possibly a negative pressure wound device placed on their body 24 hours a day? That they will be on bed rest with limited or no time out of bed? How does that all match up with what is important to them?

Is there a place of balance in between where we as the professionals and the team can help them manage within their risk of wound complications? If we start in a place that allows a person to tell their story and we really try to understand what is important to them it will lead to this kind of genuine, person-centered planning and allow for a level of risk, the dignity of risk.

There is strong evidence that higher levels of patient activation lead to improved health and follow-through with recommended self-care. There is also evidence that demonstrates that activation levels can improve over time. The Patient Activation Measure is administered via a 13-question tool which scores people at one of four activation levels.

The questions on the scale are placed in order of difficulty. Beliefs about the patient role and basic knowledge about a health condition are important indicators of activation. Questions in the first section of the tool involve areas such as knowledge of medications, understanding what lifestyle changes need to take place as well as believing in self-care. Questions at the midpoint of the tool involve having confidence to know when medical care is needed and an ability to follow through on medical recommendations. Skills and confidence are developed over time.

Then finally questions in the last section of the tool indicate the highest level of activation. These include things like maintaining needed lifestyle changes, having that confidence to handle new situations or problems and keeping chronic illness from interfering with life activities. Measuring activation levels can also guide how to best approach someone while working through assessment care planning and ongoing care coordination needs.

For example, someone at Level I has little or no confidence that they can do anything to affect their health and outcomes. Self-care, that concept of self-care, doesn't mean anything to them. So you don't want to start with a long list of things that the person needs to change, start doing or stop doing because that will quickly overwhelm them. Next slide.

It is important to ask questions throughout the process that will help us gain awareness of people's daily routines and behaviors. We rely here in part on motivational interviewing techniques including things like active listening, reflective responses, open-ended questions, all to get us to meaningful responses to really elicit that and again really give someone permission and the space and time to come up with meaningful responses. So questions again about what is worrying them, are they afraid of anything or in a more positive vane is there something they would like to have different? Then use the information you get from that on a style log to help guide that individual to help identify one change that they would be willing and desire to work on or something (inaudible - microphone interference).

I am getting some static on my line. Am I still being heard? Okay. Alright.

Operator: I had to mute Mr. Duff's line.

Kathy Thurston: Okay. Thank you. Alright. Anyhow, so helping them to identify something they can monitor or change maybe over the next few weeks or maybe even just over the next few days to help them improve their health and function. Each small success builds confidence and activation and higher activation again leads to better outcomes. So using a kind of goal-attainment scale that will help capture even incremental improvement so that the individual can experience some level of success and get that feeling of mastery, success and confidence.

So guide the person to identify again that one thing to work on and set up a short timeframe; maybe a few weeks or a month to measure progress. As I said earlier, it is important to recognize that not all people with disabilities need the same level of support and planning. We have found it helpful to focus on risk areas, one being a history of frequent hospital admissions in the last six months and/or a low activation, a Level I activation, to identify the people who will likely benefit the most from targeted, person-centered care planning.

I would like to just tell you a story. I think that is the best way to pull it all together and I realize we are coming up on our time here so we will just walk through this relatively quickly before we go into Question-and-Answer. So Jane is a 38-year-old woman who had a stroke several years ago. She has a history of high blood pressure, chronic pain, longstanding mental health issues related to depression and her doctor recently told her that she now has a new diagnosis of Type II diabetes. She was given a list of things she needed to start doing when she left her appointment including monitoring blood glucose four times a day, major changes to her diet and daily oral medication to control her blood glucose levels.

A couple of weeks later her care coordinator learned from Jane that she was not checking her blood glucose, she was not taking her new medication and she continued to consume large quantities of pop and sweets. The coordinator used motivational interviewing techniques to explore more about why Jane was not following her new treatment plan and she allowed time for Jane to just talk about what was going on and what she was concerned about.

She was able to tell the coordinator that she really didn't want any more medications because she had a huge bunch of pills she had to take every day already. She was afraid of giving up the last few things that give her pleasure like pop and sweets and she was terrified of losing more of her

independence if she admitted she had diabetes. Actually the coordinator checked Jane's activation level that day too and found that it was way lower than when she previously checked it the year before and also learned that she had a follow-up appointment scheduled with her primary care physician but Jane did not want to go back to that doctor because he was the one who told her she had diabetes and gave her too many things to do and worry about.

So the coordinator offered to go with her and that helped Jane accept going back to that doctor and they made arrangements to do that. The coordinator requested additional time for Jane to meet with her physician so they were able to talk about all of Jane's concerns and during the appointment the coordinator and the physician worked with Jane so that she could identify a couple of things that she was willing to start working on. Jane said she would try to check her blood glucose daily and cut down on her intake of pop and sweets.

So again this was factoring in, it was important for her to start paying attention to this but it was also important for her to maintain some of the things that were really meaningful to her and valuable to her. Monthly appointments were set up and the coordinator went with Jane on each of those appointments. Skilled nursing was set up to expand the team of support for her and provided diabetic teaching and monitoring and then weekly calls from the coordinator with Jane and the nurse were provided really to see how things were going, really monitor her progress and provide encouragement.

So even though she didn't reach 100% of her goal, with these more targeted interventions and factoring in what was important for her and what was important to her she made significant improvement. She was checking her blood sugar usually five out of seven days. She reduced her pop and sweet consumption and her routine diabetic blood work improved and she was losing weight and now is able to identify what she wants to be working on and add to her list of goals and objectives.

So I just had a few summary statements but I think what we will do, Chris, I will hand it back to you since we are running short on time and we will go into Q&A.

Operator: I will try to open his line. Okay, Mr. Duff, your line is open.

Christopher Duff: Thank you, Marilyn, Kathy and Lynne for your presentations. Lola would you now open the line for questions and reinstruct people?

Question-and-Answer Session

Operator: Certainly. Ladies and gentlemen if you wish to ask a question from the phone lines please press * then zero. You will hear an acknowledgement tone and if you are using the speaker phone please pick up the handset. So for questions from the phone please press * then zero at this time.

Christopher Duff: Thank you. I am now going to jump in here with some questions we have gotten in writing. The first question, I think why don't we start with Kathy but I am sure both of you could answer, "How important is it for the team members to be face-to-face with each other?"

Or can they operate in some virtual manner such as telephone, email communications, conference calls or even web-based meetings?"

Kathy Thurston: I am happy to take that one. Actually much of the time our team work is done virtually and that is accomplished through phone calls, emails if there are appropriate encryptions and safeguards in place, conference calls is a method that we use a lot and we do actually have members where we are going on appointments with them and we are in-person with that recipient, their medical provider and occasionally care conferences where we bring a bunch of people together in person when things get very complicated. But it is very manageable with phone and email and those kinds of things.

Marilyn Luptak: This is Marilyn. I would echo what Kathy said. It really is in today's world much of what we do can be transmitted via technology. I do think there is value, though, to be able to bring teams together at various points in time especially as you are developing those relationships whether it is going that extra mile and having a time set aside as you are beginning to get to know one another. That can help you go a long way, I think, in having those trusting relationships as you move forward.

Christopher Duff: Here is a question that is a really great follow-up in your comment, Marilyn, about conflicts. This is really more different perspective from the team versus the participant or the consumer. "How do you handle significant variance in goals and priorities among the participants and members of the care team?"

Marilyn Luptak: I think you do it in a number of ways. Again, it helps if you have been able to do a little bit of development at the beginning point to be able to help people understand what the differing roles are and to continually remind people that this is about providing the best care possible to the participant. But I think you can also deal with it to some degree by starting with the areas where you do have agreement; the safe areas. Where do you agree, all of you come together and say, "This is the right plan of care?" Once you kind of establish that you can begin to go into some of those more difficult areas in terms of talking about this is what you see and this is what you see.

Again, if you can do it in the most non-judgmental way possible you are going to be able to smooth things over and move forward, I think. It is just not possible to have a really short answer to a question like that.

Christopher Duff: Kathy, do you want to add anything to that?

Kathy Thurston: Yeah. I agree. I think it is complicated. Again, having time to form relationships and echoing the value of being in-person at least periodically with that individual and the people who are supporting them, those are the things that over time make a difference when there is challenging situations that are worrisome to everyone.

Marilyn Luptak: One more thing I would add, conflict really is a natural part of teamwork and sometimes we see teams that are so afraid of dealing with conflict that they become immobilized.

It is healthy to be able to have disagreement and it can end up with much stronger care plans in the long run.

Christopher Duff: Kathy, I think your case, first-person story was just a great example. We all know what someone with diabetes needs to do. But that doesn't mean any of us are ready or able to do it today. You did a really good job kind of showing us how do you move the person along and I think that is the issue and it is based on the relationship.

Lola, do we have any questions online or on the phone?

Operator: We do. It will come from the line of Ellen [Rollands].

Ellen Rollands: Hello. Thank you for putting this on. My question is, you have many consumers – I'm in California -- who have a team at home. What I hear on the consumer coalition line is great fear of that team being removed from utilization for an agency-driven team. I have a spinal cord client that has a retired LVN as their primary care provider who has established relationships over 24 years in their injury to their hospital care plan. That client provided basis many more but not really prevalent. So their concern is not to lose that relationship as we move forward where the home care person is not respected in the team.

Kathy Thurston: This is Kathy. I would be happy to take that one. The circle of support around an individual is extremely important for all of us to become familiar with and be aware of and any kind of home care supports or community-based supports need to be held up and valued and full participants in the team in particular if that is that individual person's desire; if that has been working well for them we would want to capitalize on that. That is an extension. When we talk about team it is not always just this individual person with the health challenge, their care coordinator and their physician.

That is a tiny team and that is often enough but a lot of people have a whole host of formal and informal supports that help them live independently and be successful in the community and they are necessarily a part of that team.

Ellen Rollands: Okay. See the coordinator, is that an agency-driven only individual or is the coordinator possibly already in the home care team already? That is their question.

Christopher Duff: I think that is each state dual-[demo] varies a little on how they are structuring that. I know Massachusetts is having it one way. I actually know of a program in New York who will actually be presenting later on in the series where they actually have a member on the core team whose job it is to ensure communication with the home-based care givers and involved in engagement with them.

So I think a lot of this, I hear the fear that you are expressing that you have heard I hear commonly also. I think it is an appropriate fear. I think the challenge then becomes for the program provider, in this case an organization like Kathy's who is responsible for managing the care, to make sure they identify who is in the best position and has the appropriate resources to be able to be that primary coordinator and then support that person accordingly. But there is no

one, easy answer because each demo has slightly different rules and regulations that go with it, I am afraid.

Kathy Thurston: I would echo that Christopher.

Christopher Duff: Are there any other questions on the line?

Operator: That was it. No one else is queued up.

Christopher Duff: Well I do have one more question that I will take that came in. That is a question that I think Kathy can probably get to. Could you give us some specific examples, like Jane, it's about visibility of risk issues and how they are dealt with. I think some of that goes back to the last question we just had about fears of losing control. How does the team just remain sensitive, responsive and respectful of that?

Kathy Thurston: Speaking of Jane, having the medical provider accept that she was only going to check her blood sugar once a day and the only change she was going to make in her diet was reducing her pop, her sugar pop, not diet pop, her sugar pop and sweets and not start taking her medication was huge. That was not a small accomplishment to have that small team, that small circle of support embrace where she was coming from in order to move her ahead. We have lots more examples of much more complicated situations, probably much riskier in terms of living with chronic wounds and those kinds of things but again it is really finding the balance of finding a path that moves people forward but helps them get started and not be immobilized.

Whether they have a mobility impairment or not they are immobilized by the volume of changes they are being asked to make. I am not sure if I am getting at exactly what you are asking, Chris, but --

Christopher Duff: I think your first-person story was great with that because as a healthcare professional it would be very hard for me to step back. That is what the teams need to hold each other accountable for is our job isn't to make decisions for the person. Our job is to help inform and educate so that they make informed decisions.

Kathy Thurston: The reason the provider could agree to that is he had a relationship with his patient. They had been working together for a while and he knew that home care was going to be in there and providing updates and a care provider was going to be checking in and coming to appointments. So there was an envelopment of support around Jane that helped the healthcare provider be comfortable with that plan.

You can change all the factors and circumstances but that is what it takes and sometimes it is a lot more people involved and that is when it gets a lot more complicated.

Christopher Duff: Thank you. I think in closing here this is probably the whole general area of respect of choice, dignity of risk and dependence is probably the number one question we get across the board. I just had an email forwarded from California where an assisted living provider told someone they could no longer have their double bed. They had to have a hospital bed in

their room in their own apartment. She just felt like, "Oh my God, when I go in there I see this hospital bed," and it felt horrible to her. I think that is something that we have to struggle with and talk about and prepare providers across the country for.

We will certainly be doing more on that but if there are other subjects that you all have and you would like us to bring other programs in to talk about how they are handling it there is this massive system change we are all trying to make and there is no easy or right answer. There is just different strategies different people have used to try to get there. So please tell us in the evaluation or email any of us at the end of the presentation that on the last two slides those email addresses [technical difficulty].

With that, I would like to thank you all for participating in today's presentation. As I said at the beginning we have four more after today. The next two weeks and then the first two Tuesdays of December. Everyone who has signed up for the previous webinars or this one will receive an email notice about future webinars. We hope you can join us and please feel free to forward the information to other people who you think might be interested.

We hope you can take the time to also answer our evaluation, a short evaluation, that identifies [technical difficulty]. Again, I would like to thank all of our speakers for this presentation today and hope that you can join us next week for the presentation on managing transitions. Thank you very much.

Operator: Ladies and gentlemen that does conclude your conference for today. Thank you for your participation and for using AT&T Executive --