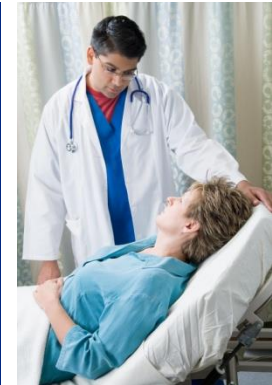


RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.

LEADING HEALTHCARE PRACTICES AND TRAINING: DEFINING AND DELIVERING “DISABILITY-COMPETENT CARE”

Session VII: Flexible Long Term Services and Supports

Presented to individuals working with persons with disabilities, particularly those working in home and community-based services

November 12th, 2013

Slides

RESOURCES FOR INTEGRATED CARE

Resources for Plans and Providers for Medicare-Medicaid Integration



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE

LEADING HEALTHCARE PRACTICES AND TRAINING: DEFINING AND DELIVERING "DISABILITY- COMPETENT CARE"

Q&A

Refresh Now

Resource List

- Resources for Integrated Care
- Download Slides

*If your slides are not advancing, please press F5 to refresh



Overview of Webinar Series

- Today's webinar is the last webinar in Part 2 of the “Leading Healthcare Practices and Training: Defining and Delivering Disability-Competent Care” webinar series
- The final part of this series will explore:
 - I. “Building a Disability-Competent Provider Network” 12/03/2013
 - II. “Preparing for New Roles and Responsibilities - Participant and Provider Readiness” 12/10/2013
- Each presentation is about 45 minutes with 15 minutes reserved for Q&A
- Webinars are recorded; video and PDFs are available for use after each session at:

<https://www.resourcesforintegratedcare.com/>

Disability-Competent Care Webinar Series

What We Will Explore in This Series:

- The unique needs and expectations of individuals with disabilities
- Disability care competency
- Person-centered care and interactions
- Preparing to achieve the *Triple Aim* goals of improving the health and participant experience of health care delivery while controlling costs in all work with adults with disabilities

What We'd Like From You:

- How best to target future Disability-Competent Care webinars to specific groups of healthcare professionals involved in all levels of the healthcare delivery process
- Feedback on these topics as well as ideas for other topics to explore in these webinars and subsequent resources related to Disability-Competent Care

Introductions

Presenters

Rachel Stacom

Sr. Vice President - Care Management
Independence Care System



Jean Minkel

Sr. Vice President - Rehabilitation Services
Independence Care System



Christopher Duff

Executive Director
Disability Practice Institute



Webinar Agenda

- The existing disconnect between medical care and long-term services and support
- Integrating and coordinating all health care services and supports
- Roles and responsibilities of the disability-competent interdisciplinary care team
- Understanding and supporting participant choices for community-based living
- Promising practices in community-based services and supports
- Supporting employment and promoting community participation
- Audience questions

Context: The Need for Integration

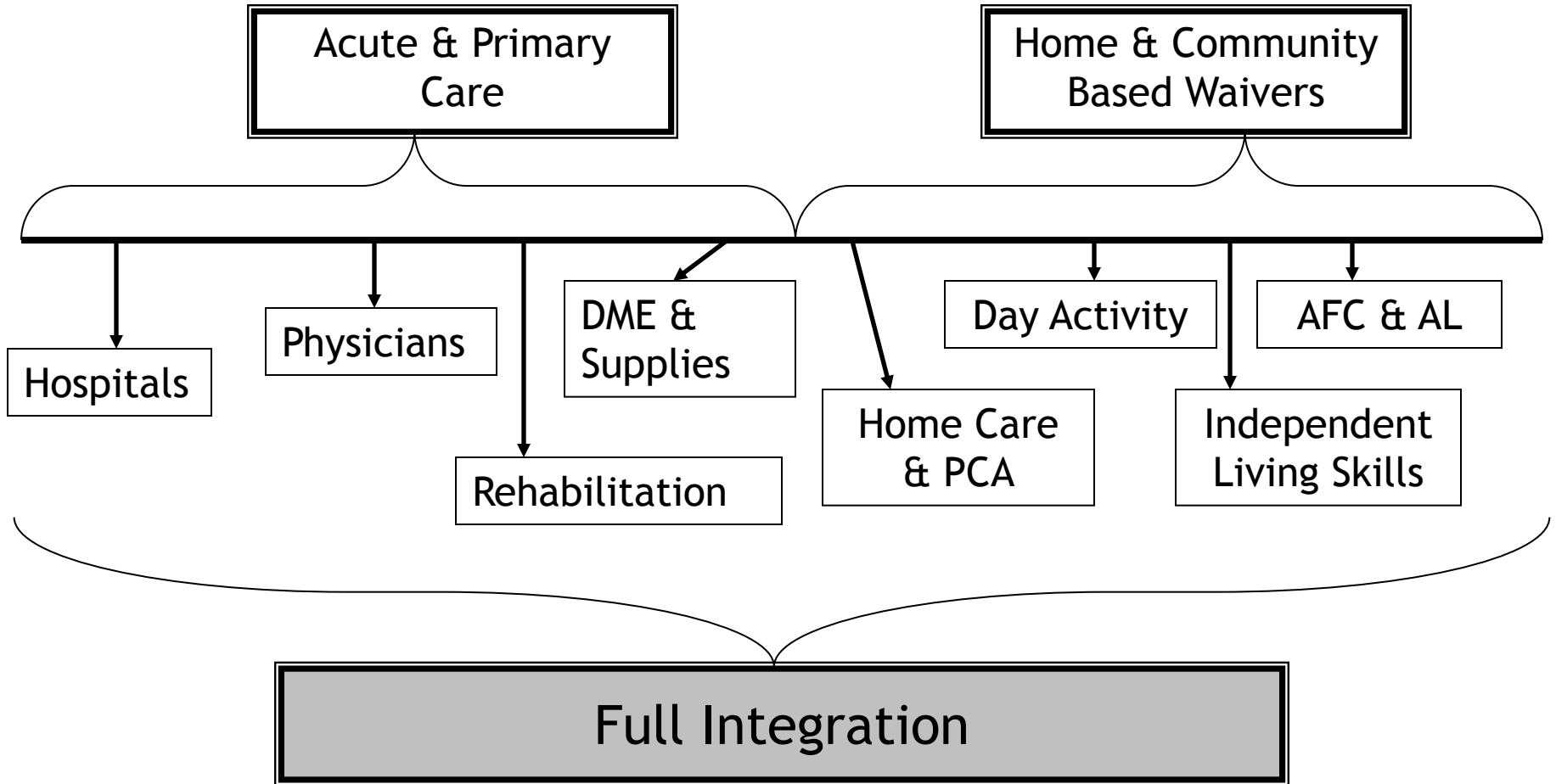
Medicare - is funded by the federal government as an entitlement / social insurance program, which mainly focuses on individuals 65 and older, though persons <65 are eligible if deemed permanently disabled

Medicaid - is jointly funded by the state or local and federal governments as an entitlement / social welfare program based on need and income. It usually covers children, pregnant women, parents of eligible children, seniors and individuals with disabilities.

For Medicare-Medicaid Enrollees: Different Benefits from Different Programs

Medicare	Medicaid
<ul style="list-style-type: none">■ Primarily acute care services, including:<ul style="list-style-type: none">■ Hospitalizations■ Physician visits■ Tests■ Procedures■ Prescriptions	<p>Primarily long-term services and supports (LTSS), including:</p> <ul style="list-style-type: none">■ Home health supports■ Transportation■ Personal care attendants■ Behavioral Health■ Long-term care / nursing facilities

Model of Integration



First Person Story: Peter

Peter is a 48 year old man diagnosed with multiple sclerosis.

- Diagnosed with paraparesis
- Utilizes a wheelchair for mobility

Recently hospitalized for 10 days due to urosepsis. During hospitalization, he developed a pressure ulcer and was diagnosed with hypertension. He was placed on a diuretic twice a day.

Returned home and is trying to cope with:

- Decrease in function due to recent immobility
- Increase in transfers to toilet due to medication
- Healing his wound

Integrated Care & Supports

Hierarchy of Needs



Community
Participation

Mobility & Function

Health

Redesigned Long-Term Care Services & Supports

LTSS includes, but is not limited to:

- Personal assistance, providing a home care worker
- Skilled nursing
- Adult day health programs
- Home delivered meals
- Rehab therapies - OT, PT, ST - outpatient and in-home
- Durable medical equipment & disposable medical supplies
- Complex Rehab Technology
- Community-based transportation, home adaptation, & social programs

Ensure network composition and capacity

Additional Disability-Competent health care services:

- Podiatry, optometry, nutrition, audiology, and dental

Gap in Integrating Health Care and Supports

- Communication gap between Traditional Medical Model Teams and Long Term Care Teams:
 - How does a doctor in an MS clinic deal with the person who is accumulating disability and losing function as a result of the disease process?
 - Discharge “to home” - the gold standard in acute rehab discharge planning! What really happens at home?

Bridging the Gap - Partnership and Communication Between Participant and Providers



- Establishing methods of communication
- Mutual understanding
- Mutual respect

Integrated Health Care & Supports

Comprehensive individualized assessment and care plan

- In-home, functional assessment conducted by an RN at intake to the plan and every 180 days thereafter
- Focused risk assessments for:
 - Pressure sore development
 - Respiratory distress
 - Urinary tract infections

Integrated Care & Supports

Comprehensive individualized assessment and care plan

- Creation of problem list as an outcome of the assessment visit:
 - Problems identified through the functional components of assessment
 - Participant specified problems with:
 - Health, mobility and / or community participation

Comprehensive Individualized Assessment & Care Plan

Development of Individualized Care Plan as a result of:

- Collaboration of RN, SW, IDT and participant to establish prioritization of problems
- Identification of desired outcomes - goals of the Care Plan
- Respect for the dignity of risk by the participant
- Implementation of selected interventions focused on a 6 month interval

Supporting Participants in their Goals and Priorities

- Roles and responsibilities of the disability-competent interdisciplinary care team (IDT):
 - Participant, and family / friends as available
 - Nurses
 - Social Workers
 - Care Management Coordinators
 - Paraprofessional coordinators
 - Senior aide

Supporting Participants in their Goals and Priorities

- Resource supports - specialists available for all teams
 - Wound care
 - Rehab services
 - Transitions in care
- Understanding and supporting participant choices for community-based living
- Shared goal: support the participant to continue to live in their own home.
 - Risk reduction behaviors
 - Community-based supports

Respect that people can make informed decisions that do not appear to be in their best interest.

Promising Practices in LTSS

Personal Care Assistance (PCA) - An *essential* service

- The primary support to allow participant to stay in their home
- Level and frequency of service determined as part of the Functional Assessment
- Beyond the immediate family, the PCA has the most frequent contact
- The PCA, if trained and given permission, can be the first to identify changes in condition
- Collaboration with an IDT team provides the PCA a responsive outlet to whom he/she can report the change in condition
- May be hired and supervised by the participant in a consumer-directed model

Promising Practices in LTSS: Focus on Risks

Specialists in pressure ulcer prevention and intervention

- Broad risk assessment measurement
 - Braden Risk Scale rates risks across 6 Factors - sensory perception, moisture, activity, mobility, nutrition, and friction and shear
 - Use of the Braden Risk Scale for all participants every 180 days
 - The lower the score, the higher the risk
 - As the score lowers, the assessment should be administered more often
 - Braden scores are reported by RNs to the IDT team with each assessment

Promising Practices in LTSS: Focus on Risks

Specialists in pressure ulcer prevention and intervention

■ Suggested interventions to promote prevention

Social worker care managers are provided a list of suggested interventions to offer to participants at moderate to high risk for skin breakdown:

- Access to a skin inspection mirror
- Use of a moisture barrier topical lotion
- Request for pressure mapping to measure the interface pressure between buttock and support surface - wheelchair cushion, bed and/or bathroom equipment
- Reposition / turning schedule, increased protein in diet, discourage sleeping in wheelchair

Promising Practices in LTSS: Focus on Risks

Respiratory Impairments

- Suggested interventions to promote prevention:
 - Education to participants and aides
 - Flu shot offering to all participants
 - ST: swallowing evaluations
 - Pneumonia shot offering to all participants
 - Recommendation of a Cough-Assist:
assist participants with ineffective cough



Promising Practices in LTSS: Focus on Risks

Urinary Tract Infections

- Focused assessments for participants with neurogenic bladders:
 - Assess technique used for emptying bladder
 - Assess frequency of emptying
- Interventions include:
 - Participant education and training on technique and frequency, along with hydration
 - Introduce tip catheter

Promising Practices in LTSS: Supporting Community Functioning

Expert wheelchair assessments, purchase, maintenance and repair

- “Expert therapists” who embrace the partnership with the participant in the process of equipment recommendation:
 - Individual interviews
 - Home visits
 - Therapist has the tools - participants have knowledge of past experience and desired outcomes

Joint participation in the process, joint responsibility for the outcome

Promising Practices in LTSS: Supporting Community Functioning

- Expert wheelchair assessments and purchase
 - Consumer purchasing experience
 - Matching individualized product recommendations to functional need



Promising Practices in LTSS: Supporting Community Functioning

- Wheelchair maintenance and repair is critical to keep individualized equipment running
- On-the-road repairs
- In-house maintenance workshop: Jiffy Lube for wheelchair users
- Loaner wheelchair if needed and feasible



Promising Practices in LTSS: Supporting Community Functioning

- Environmental modifications requiring home visits



Promising Practices in LTSS: Supporting Community Functioning

- Environmental modifications requiring home visits



Promising Practices in LTSS: Supporting Community Functioning

- Environmental modifications



Promising Practices in LTSS: Supporting Community Functioning

- Outcome of integration of supports



Supporting Employment & Promoting Community Participation

- Social/educational/artistic activities to combat isolation
- Support continued involvement or return to favored activities:
 - Participation in church groups
 - Participation in arts programs - singing, dancing, etc.
 - Participation in family functions outside the home
- Part of individualized care planning includes linkages to:
 - Dept. of vocational rehabilitation - education and employment
 - Community-based senior centers
 - Disability sports programs

Supporting Employment & Promoting Community Participation

Social Programs and Special Events

- Artists on Wheels Program:
 - Drawing and Painting from Life
 - Crafts with Liz
 - The R-tist and the Ideas U Know
 - One Man's Junk is Another Man's Treasure
 - Basic Jewelry Café
 - Knitting and Crocheting Circle
 - Music for Everyone
- Health and Wellness
 - Women's Support Group
 - Young Women's Support Group
 - Weight Watchers
- Social Programs
 - Creative Writing Circle
 - Friday Night Hangout
- ISC Social Program
 - Movies at ICS
 - Bingo ICS
 - Friday Night Hangout
- Special Events and Outings to NYC attractions

Independence
care system

Summary

- Medical providers and long-term care providers must work together to address the individual's needs and improve health.
- The prevention of secondary health conditions in people with physical disabilities is imperative.
 - Prevention of pressure ulcers, respiratory infections and urinary tract infections (UTIs) can increase life expectancy.
- Maximizing mobility by use of complex rehab devices and environmental modifications can allow people with physical disabilities access to their community.
- Creating or linking with community resources to meet the participant's individual needs can decrease social isolation and ultimately improve health and quality of life.



Audience Questions

Webinar Evaluation Survey

Next Webinars

The final presentations in our series will explore the following concepts:

- “Building a Disability-Competent Provider Network” - 12/03/2013
 - Understanding the importance of supporting the participants’ existing, productive, specialty relationships
 - Identifying and promoting accessibility within a large provider network
- “Preparing for New Roles & Responsibilities - Participant and Provider Readiness” - 12/10/2013
 - Preparing the participant through coaching, role modeling, training sessions, support groups, and more
 - Preparing and training a broad provider network - learning from examples of successful models and strategies

You will receive an invitation to sign up for these soon!

Thank You for Attending



- For more information contact:
 - Christopher Duff at: cduff@DPIInstitute.org
 - Rachael Stacom at: stacom@icsny.org
 - Jean Minkel at: minkel@icsny.org
 - Jessie Micholuk at RIC@lewin.com
 - Kerry Branick at kerry.branick@cms.hhs.gov
- Disability-Competent Care Self-Assessment Tool available online at:
<https://www.resourcesforintegratedcare.com/>

Resources & References

Your Independence Comes First

- http://www.icsny.org/sitemanagement/wpcontent/uploads/2012/08/ICS_eng_DISABILITY_web.pdf

Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities

- <http://www.icsny.org/sitemanagement/wp-content/uploads/2012/10/BreakingBarriers.pdf>

Summary - Essential Elements of Managed Long Term Services and Supports Programs

- <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf>

Summary - Essential Elements of Managed Long Term Services and Supports Programs

- <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8079-02.pdf>

Transitioning Long Term Services and Supports Providers Into Managed Care Programs

- <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/Transitioning-LTSS-.pdf>

Putting Consumers First: Promising Practices for Medicaid Managed Long-Term Services and Supports:

- http://www.communitycatalyst.org/doc-store/publications/putting_consumers_first_LTSSmanagedcare_execsummary.pdf

Disability-Competent Care Self-Assessment Tool

1. Relational-Based Care Management

[Introduction](#)

[1. Relational-Based Care Management](#)

[2. Highly Responsive Primary Care](#)

[3. Comprehensive Long-Term Care](#)

[Appendix A](#)

Participant-centered care is based on the recognition that the participant is not merely a passive recipient of medical care but rather the primary source for defining care goals and needs. This type of care requires cultivating a relationship with the participant, seeing him or her as a whole person with hopes and preferences, and recognizing that the participant is oftentimes the best steward of resources. Inherent in participant-centered planning is also the concept of the dignity of risk [1] which honors and respects the participant's choices even if they are inconsistent with the recommendation of the IDT.

[1] Dignity of risk means the right of individuals to choose to take some risk in engaging in life experiences, even if that choice would not be one that a health professional would choose (e.g. choosing to smoke).

- ▶ [1.1 Participant-Centered Practice](#)
- ▶ [1.2 Eliminating Medical and Institutional Bias](#)
- ▶ [1.3. Interdisciplinary Care Team \(ICT\)](#)
- ▶ [1.4. Assessment](#)
- ▶ [1.5. Individualized Plan of Care](#)
- ▶ [1.6. Individualized Plan of Care Oversight and Coordination](#)
- ▶ [1.7 Transitions](#)
- ▶ [1.8 Tailoring Services and Supports](#)
- ▶ [1.9 Advance Directives](#)
- ▶ [1.10 Allocation of Care Management and Services](#)
- ▶ [1.11 Care Partners](#)
- ▶ [1.12 Electronic Health Record](#)

<https://www.resourcesforintegratedcare.com/>