Flexible Long-Term Services and Supports

Leading Healthcare Practices and Training:
Defining and Delivering Disability-Competent Care

Flexible long-term services and supports (LTSS) programs, a key component of disability-competent care, are meant to help "participants" (i.e., individuals with disabilities) remain living in their homes and communities. They encourage participant choice, control, and access to a full array of quality services that help ensure independence, health, and quality of life. *Flexible LTSS require effective communication between medical and long-term care providers, participant-centered, inclusive, and coordinated individualized care plans, and support for participant's goals and priorities.*

Independence Care System (ICS) was formed to help persons with disabilities manage their long-term services and supports *(see insert for profile)*. They have demonstrated national leadership in developing unique and creative services tailored to working with adults and seniors with significant disabilities. This includes the integration of medical and home- and community-based care to implement fully integrated flexible LTSS.

Profile: Independence Care System

- Nonprofit, Medicaid managed long-term care plan serving adults with physical disabilities in New York City
- Includes about 650 members, half of whom are dually eligible for Medicare and Medicaid
- Serves members whose disabilities are primarily due to severe injury or degenerative neurological and muscular diseases

ICS has identified the following key features of flexible LTSS:

- **Bridge the communication gap between traditional medical model teams and long-term care teams:** To avoid poor communication that may hinder progress toward the participant's goals, teams can establish methods of communication, understand one another's roles and goals, and employ a mutual respect of one another's skills.
- **Employ comprehensive individualized assessments and care plans:** ICS conducts an in-home, functional assessment upon the participant joining the plan and every 180 days thereafter, performs focused risk assessments, and creates problem lists derived from those assessments to create an individualized care plan that reflects collaboration, the participant's goals, and respect for the participant's dignity of risk. ICS implements its interventions in six month intervals. The assessments provide a holistic understanding of that person's lifestyle.
- **Support the participant's goals and priorities:** At ICS, members of an interdisciplinary care team (IDT), who are service providers with various skills and backgrounds, are expected to work toward the shared goal of supporting the participant to live in their home or community by applying risk reduction behaviors and utilizing community-based supports, while respecting the participant's goals and dignity of risk.

ICS has also identified the following promising practices in LTSS:

- **The use of personal care assistance (PCA)**: Home care aides, personal care aides, and other PCA supports are key to enabling participants to stay in their homes since they are frequent contact with the participant and are in a good position to report changes in condition. They may also be hired and supervised by the participant in a consumer-directed model.

- **A focus on risks**: At ICS, care teams focus on pressure ulcers, respiratory impairments, and urinary tract infections – relatively prevalent conditions among their members. As such, specialists will work with participants at risk for those conditions to create interventions aimed at preventing the onset of those conditions.
- **Support for community functioning:** It is important that the LTSS care team support proper assessment, purchasing, maintenance, and repair of medical equipment, such as wheelchairs, with participants. The team may also engage in home visits to ensure that environmental modifications (e.g., ramps) are in place. Importantly, it is the care team's role to facilitate the participant's return or continued engagement in community activities and hobbies that interest them, as well as in employment trainings and opportunities. Supporting community functioning is important to combating the isolation that a participant may feel within their community.

Provision of flexible LTSS is guided by partnership, understanding, and respect to prevent secondary health conditions, maximize mobility, and provide community resources to support individuals with disabilities who choose to live in their home or community.

Additional Resources

Please visit the *Resources for Integrated Care* website (www.resourcesforintegratedcare.com) for the "Defining and Delivering Disability-Competent Care" webinar series which served as the basis for this brief and for other Disability-Competent Care-related resources including an interactive self-assessment tool.