BUILDING A PERSON-CENTERED CULTURE OF CARE: Shared and Supported Decision-making and Goal-Driven Care
Tips for Using this Webinar Platform

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Building a Person-Centered Culture of Care

- This is the second webinar of the “2017 Meaningful Member Engagement Webinar Series”

- This session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presentations followed by 30 minutes of presenter and participant discussions

- Video replay and the slide presentation will be available after this session at: https://www.resourcesforintegratedcare.com
Building a Person-Centered Culture of Care

- Developed by:
  - The Lewin Group
  - Community Catalyst’s Center for Consumer Engagement in Health Innovation

- Hosted by:
  - The Medicare-Medicaid Coordination Office (MMCO)
    Resources for Integrated Care
Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) to ensure beneficiaries enrolled in Medicare and Medicaid 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 Medicare-Medicaid enrollees, MMCO is providing technical assistance and has developed actionable tools based on successful innovations and care models, such as this webinar.

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

- By the end of this webinar, participants will have an increased understanding of strategies for implementing:
  1. Supported decision-making, a process in which adults receive the help they need to understand the situations and choices they face so they can make life decisions for themselves without undue or overbroad guardianship.
  2. Shared decision-making, a collaborative process that allows individuals and their providers to make health care decisions together taking into account the values and preferences of the enrollee.
  3. Member goal-setting, goal-driven planning, and goal attainment measurement.
Building a Person-Centered Culture of Care

POLL 1
Which of the following best describes your professional area?

☑ Healthcare Administration
☑ Medicine/Nursing/Physician Assistant/Other Provider
☑ Pharmacy
☑ Social Work
☑ Advocacy
☑ Health Plan Management/Staff
☑ Other
Presenters

Jonathan Martinis, JD
Senior Director for Law and Policy
Burton Blatt Institute
Syracuse University

Sandra Fournier, MSN
LTSS Oversight Manager
Neighborhood Health Plan of Rhode Island

Laura Sankey
Staff Vice President of Operations-Complex Care
Centene Corporation

Robert Schreiber, MD
Medical Director, Primary Care Community-Based Programs, Innovation and Development
Hebrew SeniorLife

Janet Donnoe
Member
Supported Decision-Making: Everyone’s Right to Make Choices

Jonathan Martinis
Senior Director for Law and Policy
The Burton Blatt Institute at Syracuse University
Co-Project Director, National Resource Center for Supported Decision-Making
Agenda

- Explain why self-determination matters for people with intellectual, developmental or other cognitive disabilities, including older adults.
- Describe how supported decision-making works and where it is happening
- Share specific examples of supported decision-making in action
Rights = Choices

“I am my choices. I cannot not choose. If I do not choose, that is still a choice. If faced with inevitable circumstances, we still choose how we are in those circumstances.”

- Jean Paul Sartre
Rights = Choices
Choices = Self Determination

- Life control
- People’s ability and opportunity to be “causal agents . . . actors in their lives instead of being acted upon”
  - Wehmeyer, Palmer, Agran, Mithaug, & Martin, 2000
Benefits of Self-Determination

- People with greater self-determination are:
  - Healthier
  - More independent
  - More well-adjusted
  - Better able to recognize and resist abuse

-Khemka, Hickson, & Reynolds, 2005; O’Connor & Vallerand, 1994; Wehmeyer & Schwartz, 1998
And Yet: 2,000 Years and Counting

- Ancient Rome: “Curators” appointed for older adults and people with disabilities
- 5th Century Visigothic Code: “People insane from infancy or in need from any age . . . cannot testify or enter into a contract”
- Feudal Britain: Divided people with decision-making challenges into “idiots” and “lunatics” and appointed “committees” to make their decisions
“Plenary” or “Full” Guardianship

- Gives the Guardian power to make ALL decisions for the person
- Used in the VAST majority of cases
- “As long as the law permits plenary guardianship, courts will prefer to use it.”

- Frolik, 1998
When People Are Denied Life Control

Study after study shows that these individuals:

- “[F]eel helpless, hopeless, and self-critical”
  - Deci, 1975

- Experience “low self-esteem, passivity, and feelings of inadequacy and incompetency,” decreasing their ability to function
  - Winick, 1995
AND

People with intellectual and developmental disabilities who do **NOT** have a guardian are more likely to:

- Have a paid job
- Live independently
- Have friends other than staff or family
- Go on dates and socialize in the community
- Practice the religion of their choice
So, Where Do We Go From Here?

- If we know that:
  - Some people need more support as they age or due to disability
  - Guardianship can result in decreased quality of life, and
  - Increased self-determination leads to improved quality of life
- Then:
  - We need a means of INCREASING self-determination while STILL providing support
A Way Forward: Supported Decision-Making

“...a recognized alternative to guardianship through which people with disabilities use friends, family members, and professionals to help them understand the situations and choices they face, so they may make their own decisions without the “need” for a guardian.”

- Blanck & Martinis, 2015
Think About It

- How do you make decisions?
- What do you do if you are not familiar with the issue?
  - Taxes?
  - Medical care?
  - Auto repairs?
- What Do You Do?
IT IS HAPPENING: Legislation and Policy

- Laws in Texas and Delaware holding that guardianship should only be put in place if there are no less restrictive alternatives and recognizing Supported Decision-Making (SDM) as such an alternative.
- The U.S. Administration for Community Living funding the National Resource Center for Supported Decision-Making describing SDM as “an alternative to and an evolution from guardianship”.
- A report by the Virginia Secretary of Health and Human Services recommending that state law be amended to recognize SDM as a “legitimate alternative to guardianship”.
- The American Bar Association publishing a journal article calling for the increased use of SDM and a guide designed to help attorneys and others focus on SDM as an alternative to guardianship.
- The National Guardianship Association’s position paper stating that SDM should be attempted before imposition of a guardianship.
IT IS HAPPENING: Practice

- Court decisions like the “Justice for Jenny” case, which held that a young woman with disabilities had the right to use SDM instead of being put in a guardianship.
- Projects in Maine, New York, North Carolina, South Carolina, Minnesota, Wisconsin, Florida, Nevada, Idaho, Massachusetts and Tennessee to increase access to supports and services designed to help people avoid or be restored from guardianship.
It’s NOT JUST About Guardianship

- Opportunities to use Supported Decision-Making Are All Around Us
  - “Informed Consent” to medical care
  - “Person Centered Planning” in Medicare/Medicaid
  - “Student-Led” Individualized Education Plan
  - “Informed Choice” in Vocational Rehabilitation
  - “The Conversation” and “Five Wishes” for End of Life Planning
The Goal: Person-Centered Planning

- Person-Centered Planning MUST:
  - Address “health and long-term services and support needs in a manner that reflects individual preferences and goals”
  - Result “in a person-centered plan with individually identified goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others”

Using Supported Decision-Making to Create a Culture of Coordinated Support

State and system-wide agencies and organizations providing appropriate supports and services AND collaborating with others to coordinate, complement and supplement those services and supports.

-Gustin & Martinis, 2016
Coordinated Support in Action: Vermont

- Vermont Task Force “to create solutions and initiatives that transform practices in a way that brings a culture of collaboration”
- Includes consumers, families and representatives of the Provider, Legal, Educational, Employment, Advocacy, Mental Health, Aging and Developmental Disabilities communities
“If we create a Culture of Coordinated Support . . . service providers will . . . help people with disabilities dream and lead lives of independence and meaning. If we create a Culture of Coordinated Support, people with disabilities will have the same opportunities for success and security as their nondisabled peers. If we change the culture, we will change the world!”

-Gustin & Martinis, 2016
Key Takeways

- People with intellectual, developmental or other cognitive disabilities and older adults benefit greatly from increased self-determination.
- Guardianship is not the only option.
- Supported decision-making allows for collaboration in person-centered planning and build a culture of coordinated support.
Person-Centered Goals and Measuring Goal Attainment

Sandra L. Fournier, MSN, RN, CDDN, CBIS
Neighborhood Health Plan of Rhode Island
Agenda

- Discuss the importance of person-centered goals
- Discuss the components of eliciting person-centered goals and creating a plan to meet them
- Describe how Neighborhood Health Plan of Rhode Island measures person-centered goals
Goals

- Components of a goal
  - Goal statement - broad statement-intangible
  - Objective(s) - narrower statements with action that is measurable
  - Methodology
    - AMOUNT: Services that support the goal
    - SCOPE: Who, how, what, where, when
    - DURATION: How long the goal or objective will last and the services to support it
Person-Centered Goals

- Allow us to look at an individual in a different way
- Help the person gain control over his/her own life
- Increase opportunities for full participation in the community
- Help a person to recognize his/her own desires, interests and dreams
- Through team effort, help to develop a plan to turn dreams into reality
Meaningful Engagement

- The individual
  - Expresses expectations for care
  - Becomes an activated patient
  - Is engaged in the plan to reach the goals
Person-Centered Approach

- Moves from system-centered thinking
  - Focused on custodial care, treatment, filling slots/beds, placements and closures
- Focuses on identifying and meeting the person’s concept for quality of life
- Ensures that the experiences and outcomes that define quality of life for the person occur
Person-Centered Thinking

- Challenges us all to actively listen to the person to understand what they want for their lives
- Helps support the person in ways that will increase their success at living in the least restrictive environment and as independently as they are able
- Allows the person to participate to the extent desired
It’s a Process

- Not a one-time event
- The process of planning for a preferred future that requires a partnership with cooperation
- The individual and those identified as important to the person are full participants in this effort
- The individual and those identified as important to the person are given the full attention and respect of all the members of the team
Process

Step 1
Identify the goals, priorities and values of the individual

Step 2
Ensure that the goal is clarified
Process

Step 3
Identify steps to get to the goal and the resources necessary to succeed

Step 4
Identify the barriers and approaches to mitigation

Step 5
Empower the individual to implement the plan that will achieve the goal
Discovering What’s Important

- Identify desired personal outcomes based on the individual’s:
  - Interests
  - Strengths
  - Abilities
  - Desires
  - Preferences
Preferred Future

- **Explore**
  - History
  - Capabilities
  - Strengths
  - Preferences
  - Relationships
  - Barriers
  - Concerns
  - Problems
  - Life goals
Planning

- The planning process helps identify potential barriers to the goals and helps identify strategies to address the barriers before they inhibit progress
Scaling defines goals in a clear way and measures success toward the goal using a systematic approach.
Measuring Goal Attainment

By helping to break the goal down into multiple outcomes, success can be measured in increments.
Example: Creating Person-Centered Goals at Neighborhood Health Plan of Rhode Island

- Assessment completion with the person (and team members, if desired)
- Care plan development and goal setting with the person
- Care plan with goals is sent to the interdisciplinary team
  - Results in one care plan, developed with the person
- Assessments repeated every 3–12 months and following hospitalizations
- Telephone contact
- Other available resources: Community outreach specialist; housing specialists; physical therapist for Durable Medical Equipment evaluation and home modifications
Key Takeways

- Setting goals is essential to engaging individuals in their own care
- Goal-setting is a deliberate, ongoing process that happens with the individual
- Measuring goal-attainment should be accomplished by breaking it down into multiple measurable outcomes
Building a Person-Centered Culture of Care

Laura Sankey
Staff Vice President Operations-Complex Care
Centene Corporation
Agenda

- Organizational Structure
- Describe how the Fidelis/Concerto model supports person-centered planning
- Discuss the process for discovering what matters most to the member and creating a plan to address what matters
- Discuss other approaches used to promote person-centered care
Centene is one of the largest providers of Medicaid, Medicare Advantage, and other government-sponsored and commercial programs serving more than 11 million members across the country.

Fidelis SecureCare (Currently rebranding as Michigan Complete Health) is a subsidiary of Centene serving 2,300 members in the Financial Alignment Demonstration in the Michigan counties of Wayne and Macomb.

ConcertoHealth Inc. is a leading provider of primary care and supporting services for complex, frail, elderly and dual-eligible patients operating four clinics in Wayne and Macomb delivering care management and primary care services to Fidelis members.
The Fidelis/Concerto Model of Care

- Concerto operates as a delegated entity for Fidelis
  - Perform Level 1 Health Risk Assessments and coordinate the care of Fidelis members
- Concerto Physicians see Fidelis members in the clinic as well as in the community when appropriate
- Clinics are designed with the member in mind
- Cross collaboration within the clinic setting
  - Care Manager- Mix of RNs and LCSWs-Coordinate with AAAs and PIHPs
  - Primary care physician
  - Pharmacist- Performs medication reconciliation
  - Dietician
  - LTSS Coordinator- Works with AAAs
  - Disease management education
Person-Centered Training

- Centene has developed an internal three-day person-centered training curriculum
  - Defines Person Centered Life Plan
  - Disability Rights
  - Guardianship Alternatives
  - Cultural Competency
  - Person First Language
  - Communications styles and active listening techniques
  - Motivational Interviewing Techniques
- Fidelis participates in MDHHS State-provided-train the trainers offering
- Train staff to create a culture of person-centeredness that permeates throughout each department
Person-Centered Life Plan (PCLP)

- PCLP is “a process that guides exploration of, and action on, a member’s wants, needs and goals resulting in a balanced life plan, which allows the member choice over their own care and to live a satisfying life in their own community.”

- Instead of asking, “What’s the matter with you?” We need to be asking, “What matters to you?”
Finding Out What is Important TO the Member

- “Important To” = what is most valuable to you…

- It identify what makes you happy, proud, fulfilled, content, comfortable

- We also need to consider what is important to NOT be in a member’s life.
Determining What is Important FOR the Member

- “Important For” = what keeps you healthy and safe…
  - Education, preventative measures and provision of treatment and services to achieve or maintain optimal health
  - To be free of fear, safe in your own environment and obtain peace of mind
  - Being a valued member of your community
Questions to Consider

“Important To” choices could be:

- Who do I want to be in my care team?
- Who is important to me?
- When do I want my services?
- Where do I want my services?
- How do I receive my services?
- How do I want to spend my day?
- Where do I want to live?
- What services do I NOT want?
- Who needs to be out of my life?

Members also have the right to make “Important For” choices:

- Who are their providers?
- What is their treatment?
- The right to refuse treatment?
- The choice to self-report abuse?
- The choice to participate in events within their community?
- The right to live in the least restrictive environment?
The Role of the Care Manager

- Finding the **balance** is what Person-Centered Life Planning is all about

- Helping the member make good choices regarding not only “IMPORTANT TO”, but also “IMPORTANT FOR” choices.

- We need to remember that the member is the driving force of any person-centered life plan

- Our job is simply to help **guide the member**, and anyone the member wants to include as part of their team, **through the process**.
The Individual Integrated Care and Supports Plan (IICSP)

- Choice & Access - where to live, work, daily schedule, who to socialize with, etc.
- Community Inclusion & Employment
- Settings and Housing options
- Paid and Unpaid supports
- Cultural & Communication Needs
- Health, Safety & Welfare
- Individual’s Choice to Self-Direct Services
- Restrictive Interventions & Supports
- Rights & Responsibilities
- Who will monitor the plan and how often
Collaborative Care Planning and the Interdisciplinary Care Team (ICT)

- The ICT is person-centered and built upon the member’s specific preferences and needs
- The ICT delivers services with transparency, individualization, accessibility, respect, linguistic and cultural competence and dignity
- The ICT honors the member’s choice about his or her own level of participation
- Wherever possible, we include a person familiar with the needs, circumstances and preferences of the member when the member is unable to participate fully in, or report accurately to the ICT
Care Bridge

- Medicare-Medicaid Plans (MMP), Prepaid Inpatient Health Plans (PIHP), and providers are connected through Care Bridge, a web-based platform for information exchange that is used to coordinate supports and services.

- Care Bridge allows secure access to information and enables members, as well as the members of the ICT to use, and where appropriate, update information.

- The tool helps to integrate the member’s physical and behavioral health and connects providers that might not otherwise have collaborated previously.
Supportive Decision-Making

- Concerto care management staff is able to explain all program services and health care options to Fidelis members
  - The member has a right to translation services
  - Member may have a designated representative/supporter

- For those being seen in the clinic the care manager and PCP are able to present this information jointly and answer any questions the member may have
Self-Determination Options

- Members are informed of the option to self-direct their own services. The LTSS Coordinator explains the choice to self-direct their services when their IICSPs are created or updated.
  - Self-direction of services is voluntary.
  - Plan provides an overview of the supports and resources available to assist the members to participate in self-direction to the extent they choose.
- Members can consider arrangements
  - Individual budget (with the assistance of a fiscal intermediary)
  - Employ workers (hire and manage)
  - Contract with providers
- LTSS Coordinator is available to help inform, navigate, connect and refer members using these arrangements that support Self-Determination.
Success Story

The member was discharged from the hospital and was adamant that she didn’t want to live in a nursing home and leave her husband alone in the home.

A Level 1 reassessment was performed and a referral was made for additional LTSS assessments. Member was eligible and approved for waiver services including personal care services, environmental modifications, wheelchair, stair lift and non-medical transportation.

Daughter brought her mother to clinic to see PCP and CM. She said with tears in her eyes, “No one in our life has helped us like you have. Getting all these services for our mom has helped keep my parents together in the house they have lived in for 48 years.”
Key Takeaways

- Staff training on person-centered care must be robust and deliberate
- Care team members need to engage in a process with the member to find out what’s important to (and for) her/him
- Care team members should proactively offer members supported decision-making and self-determination options for LTSS beneficiaries
Supported Decision-Making and Goal-Driven Care for Older Adults

Rob Schreiber MD, AGSF, CMD, Hebrew SeniorLife
Janet Donnoe, Member
Agenda

- Provide an overview of the Vitalize 360 Program
- Explain how Vitalize 360 can be used with beneficiaries in all settings
- Provide a member perspective through Janet’s story: how providers worked with one older adult to understand her goals/values, which then guided her care plan
Dr. Schreiber discloses he is the Medical Director of the Vitalize 360 Program.
Vitalize 360 Core Components

- Resident Engagement
- The Meaningful Conversation
- Assessments and Software
- Coach and the Interdisciplinary Team
- Vitalize Plan and What Matters Most
- Follow up: Activation, Quarterly, Annual
Older adult as CEO of their health and wellness. Members...

- Set meaningful, relevant and impassioned goals
- Maintain a fulfilling purpose in life
- Are empowered to reach their goals and full potential
- Receive consistent coaching to achieve the “best life”
Vitalize 360 and the Triple Aim

- Sustain health and vitality long into later years of life
- Improve outcomes and health of populations
- Maximize a person’s potential for vitality, reduce healthcare costs and improve value
The Vitalize Process

1. First appt.: COLLAGE Assessment reflection with Wellness Coach
2. Between appointments, resident is asked to reflect on life and personal goals
3. Resident achieves their goals; goals not attained are revised; new goals developed
4. Resident receives ongoing support and coach follow-up
5. Second appt.: Development of resident's personal goals and action with Coach
6. Share plan with others, including healthcare provider and family

Resident receives ongoing support and coach follow-up.

Resident achieves their goals; goals not attained are revised; new goals developed.

Between appointments, resident is asked to reflect on life and personal goals.

Resident receives ongoing support and coach follow-up.

Second appt.: Development of resident's personal goals and action with Coach.

Share plan with others, including healthcare provider and family.

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Second appt.: Development of resident's personal goals and action with Coach.

Share plan with others, including healthcare provider and family.
Vitality Plan

- Life Goal is connected with values, strengths, accomplishments and forms foundation for plan
- What Matters Most
- Facilitate realistic goals that relate to resident strengths and challenges (informed by Coaching Summary report)
Five Health Related Values Domains

- Functioning
- Health
- Connection
- Life Enjoyment
- Engagement - Sense of Purpose
Outcome Reports

- Individual, community and population level
- Nine primary indicators gathered through validated measurement tools of InterRai-Health and Social Checkup and Lifestyle Survey
- Composite risk adjusted score to compare populations
Composite Scores
Key Takeaways

- Need to have patient engagement strategy that is holistic
- Focus on What Matters Most rather than what is the matter
- Medical providers need to help individuals make healthcare decisions based on their goals and values
- Shared decision-making is a natural byproduct of this approach
Janet’s Story of What Matters Most
Thank You!
Questions
Thank you for joining our webinar. Please take a moment to complete a brief evaluation on the quality of the webinar.