Targeted Case Management in Managed Care

October 17, 2013

Better Lives for Aging and Disabled Persons in Kansas
- ❑ Self-Determination
- ❑ Greater Independence
- ❑ Competitive Employment
- ❑ Better Overall Care
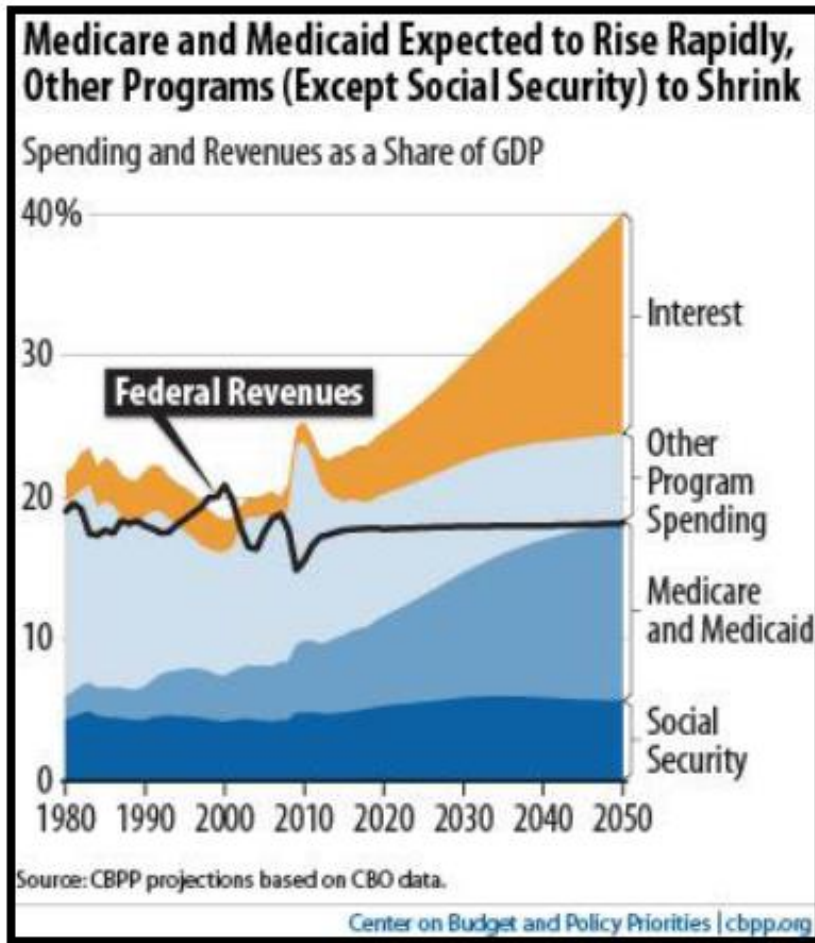- ❑ Improved Access to Services

Reality

- The demand for Long Term Supports and Services is growing.

- 87% of the 12 million Americans who need LTC receive it from unpaid Family Caregivers.

- Estimated annual value of unpaid care in 2009: $450 billion

Medicare and Medicaid

June 23, 2015

NASDDDS
National Association of State Directors of Developmental Disabilities Services

Top Service Challenges for States

- **People with challenging behavior – highest cost individuals**
  - Criminal offenses adjudicated and non-adjudicated
  - Sexual offenders
  - Mental health disorders
- **Waiting Lists**
  - Decreasing or minimizing use
  - Serving based on priority need or place in line
- **Managing Cost**
  - Equity
  - Fairness
  - Reasonableness
- **Implementing Promising Practices**
  - Person-Centered Practices;
  - Positive Behavioral Approaches;
  - Competitive Employment;
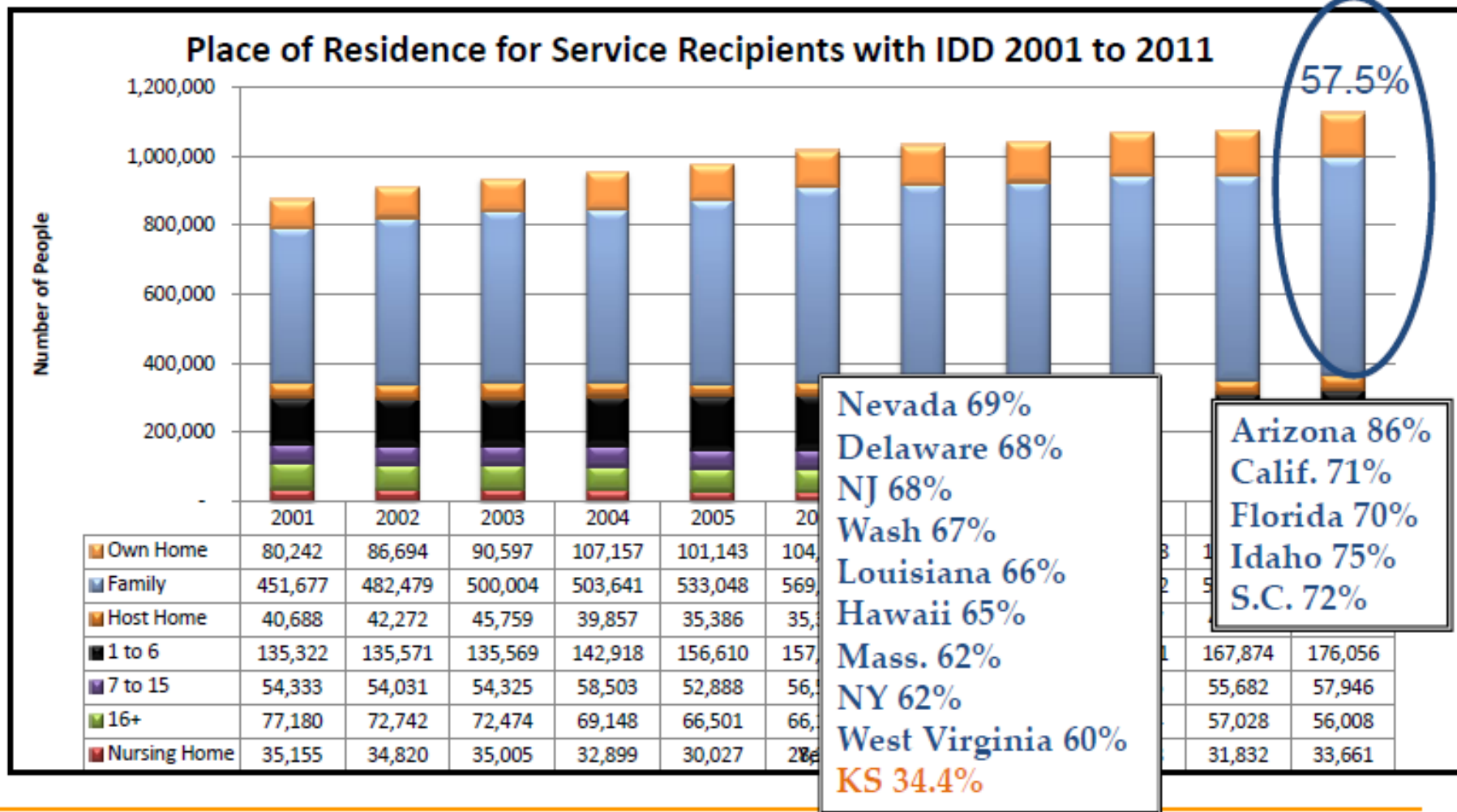- **People with significant medical care needs**

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Most People with IDD in Service Live with Family

Sustainability depends on how well we support families and support people with employment.

Most People with IDD in Service Live with Family

Place of Residence for Service Recipients with IDD 2001 to 2011

57.5%

	2001	2002	2003	2004	2005	20				167,874	176,056
■ Own Home	80,242	86,694	90,597	107,157	101,143	104,					
■ Family	451,677	482,479	500,004	503,641	533,048	569,					
■ Host Home	40,688	42,272	45,759	39,857	35,386	35,					
■ 1 to 6	135,322	135,571	135,569	142,918	156,610	157,				167,874	176,056
■ 7 to 15	54,333	54,031	54,325	58,503	52,888	56,				55,682	57,946
■ 16+	77,180	72,742	72,474	69,148	66,501	66,				57,028	56,008
■ Nursing Home	35,155	34,820	35,005	32,899	30,027	28,				31,832	33,661

Nevada 69%
Delaware 68%
NJ 68%
Wash 67%
Louisiana 66%
Hawaii 65%
Mass. 62%
NY 62%
West Virginia 60%
KS 34.4%

Arizona 86%
Calif. 71%
Florida 70%
Idaho 75%
S.C. 72%

Character of Home and Community Based Services

CMS acknowledged:

"Some individuals who receive Home and Community Based Services in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting."

CMS stated:

Using such settings to provide —home and community based services are contrary to the purpose of the 1915(c) waiver program.

Families are Not Group Homes

Families include parents; siblings; grandparents; other relatives

- – Are complicated.
- – Help each other; they sacrifice for one other;
- – Hurt each other; they apologize and forgive;
- – Have fun and celebrate with each other
- – Have secrets and things they don't talk about
- – Have troubles, get tired and discouraged
- – Do the impossible
- – Commit abuse and take advantage of other families members
- – Can't do everything
- – Have routines, customs and habits
  - • they have their way of doing things

Family is the context for everything

- – Personal outcomes will be influenced by the family

Most Integrated (IDEAL)

Everybody can live in the community.
- In family homes with support
- In their own homes
- In shared living
- Children and adults
- Employment
- Irrespective of medical or behavioral labels
    * People with trachs, g-tubes, suctioning, ventilators, medical frailty
    * People with behavioral reputations; criminal offenders

Reduce use of nursing homes, ICFs, larger settings

What's Important to Families

Access to Service – Eliminating Waiting Lists

Transitioning from school to adult life – a real job with needed supports

Support for families that is flexible, meets their needs and is consumer/family directed

Their sons and daughters having a good and happy life with friends, family, a valued role in the community

What happens to their sons and daughters when they die? Who will be there for them?
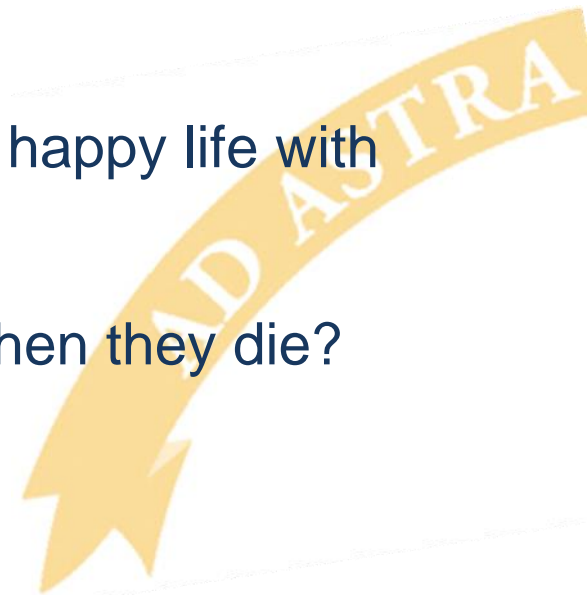
The goals of managed care are to provide better results through service and support coordination across multiple services and providers to meet individuals' needs.

MANAGED CARE

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Isaiah at our Family Reunion – August 2013

Move towards Managed Care

- Dramatic shift in State Medicaid programs away from Fee- for-Service towards Managed Care (and other bundled payment / outcome driven delivery models)

- In 2010, roughly _72% of Medicaid beneficiaries_ nationally were served in managed care / PCCM programs

- But managed care accounted for _only 30% of Medicaid spending_.

- 2011 & 2012 saw huge increase in States signaling that they would move their Medicaid programs to managed care

- In several cases – Kentucky, Louisiana, New Hampshire – negligible MC penetration, now adopting MC statewide

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Coordinated & Integrated Care

- Shift to MC part of a larger trend toward Integrated / Coordinated Care, including PCCM, Health Homes, ACOs, bundled payment strategies

- Recognition that we have done a poor job of addressing chronic disease . . . and an even poorer job of integrating physical / acute care with long-term care (*see* 2001 IOM report: Crossing the Quality Chasm)

- Medicaid-funded LTC delivery systems and §1915(c) home- & community-based (HCBS) waivers are almost completely estranged from the physical / acute delivery systems

- Federal / state funding for HCBS **emphasized / measured / paid for** deinstitutionalization, rebalancing, independent living, Olmstead compliance, participant-directed care

. . . but *not* health status / outcomes

Paying for Outcomes, Instead of Volume

- Shift to MC and MLTSS delivery systems is also driven by realization that unit-based FFS delivery system has failed, and is . . .

  - not keeping people healthy

  - not fulfilling promise of rebalancing

  - not sustaining expansion of independent living / home-& community-based alternatives to institutional care (nursing homes, ICF/MRs, IMDs)

- Extremely difficult to be integrated in the community, to live with independence & dignity -- if you're not healthy.

- Living alone and socially isolated on the couch . . . not what we originally had in mind.

- Recognition that we must reconsider patient-clinician relationships, realign reimbursement incentives and introduce accountability for outcomes & quality improvement, "experience of care", quality of life

CMS Expectations of Managed Care

1. Adequate Planning and Transition Strategies
2. Stakeholder Engagement
3. Enhanced provision of HCBS (ADA/Olmstead)
4. Alignment of Payment Structures with MLTSS Programmatic Goals
5. Support for Beneficiaries
6. Person-centered Processes
7. Comprehensive and Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

Not Being Able
To Speak...
Is Not The
Same As Not
Having Anything
To Say.

SUPPORT COORDINATION

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As a TCM

The Targeted Case Manager (TCM) plays a role in the IDD Program that directly affects the health and welfare of IDD participants and their ability to live in independently their homes/communities.

However, that role is limited by CMS guidelines.

June 23, 2015

Definition of TCM

- **Case management** consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. This includes primary care case management, which cannot be provided by a targeted case manager.

- "Targeted" case management services are those aimed specifically at special groups of enrollees such as those with **Intellectual/developmental disabilities** or chronic mental illness.

Care Coordination

"Care coordination" is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

COMPREHENSIVE AND INTEGRATED SERVICE PKG

Transitioning Support between Services and Settings

- Focus on what assists people to stay in their home and community

- Having an active life and meaningful day for prevention

- Begin discharge planning immediately when a person enters the hospital

- Identify what prevents psychiatric hospitalization:
  - Crisis avoidance; positive behavioral supports; medication management; employment

Comparison of Components

Targeted Case Management

- Assessment

- Development of a Plan of Care

- Referral and Related Activities

- Monitoring and Follow-Up Activities

Care Coordination

- Needs & Health Risk Assessment

- Plan or integration of interventions into a treatment plan

- Referral and related activities

- Evaluation and Monitoring of the plan & services
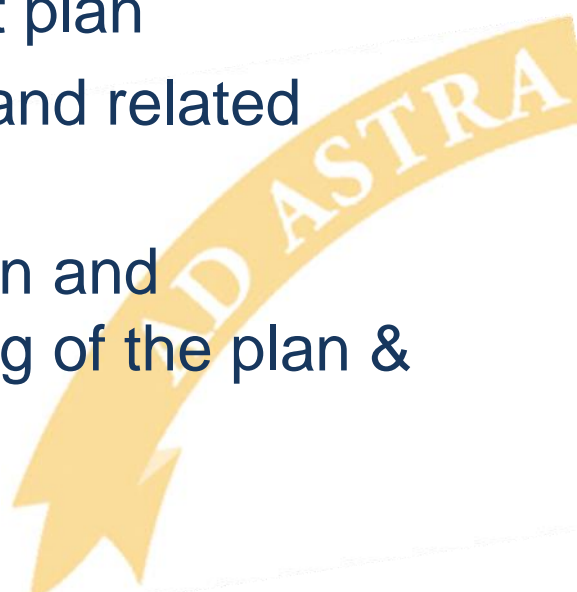
Assessment

- Assess an eligible individual to determine service needs, including
  - Taking a consumer history
  - Identifying the individual's needs and completing the assessment instrument and related documentation; and
  - Gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the individual.
  - Documenting all pertinent information related to tasks completed.
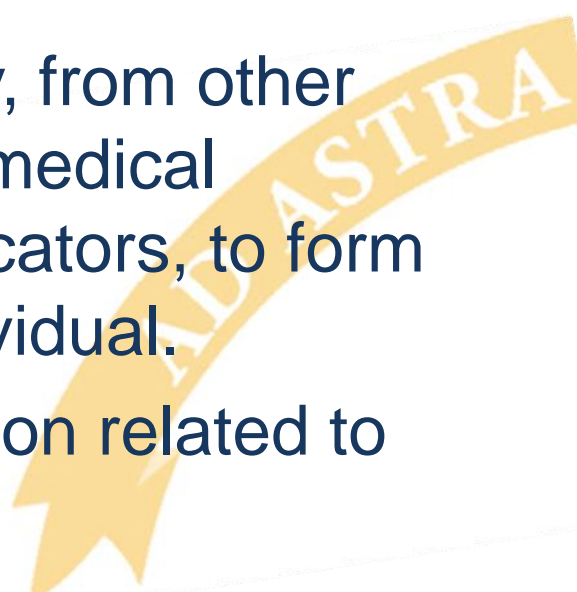
Development of a Plan of Care

- Develop a plan of care that:
  - Is based on the information collected through the assessment;
  - Specifies the goals and actions to address the medical, social, education, and other service needs of the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual and others to develop such goals, and identify a course of action to respond to the assessed needs of the eligible individual; and
  - Includes time spent discussing service options and alternatives, needs, and preferences of the consumer, services to be provided, authorized costs, and the implementation dates
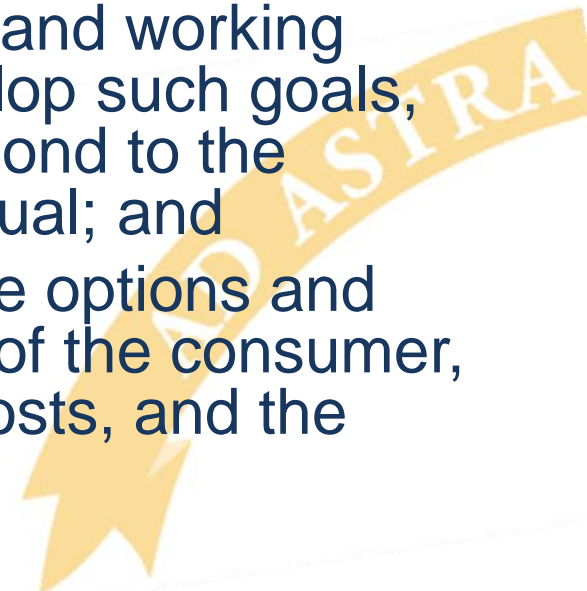
Referral and Related Activities

- Help an individual obtain needed services, including:
  - Activities that help link the individual with medical, social, or educational providers or that are capable of providing needed services,
  - Reporting abuse, neglect and exploitation for any suspected abuse, neglect or exploitation of the individual
  - Expanding the service options available by encouraging the informal supports and formal service providers to be more flexible or seeking new or non-traditional options
  - Promoting the enrollment of new providers on behalf of individuals
 - Documenting all pertinent information related to tasks completed

Monitoring and Follow-Up

- **Activities and contacts that are:**
    - Necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities.
    - Services are being furnished in accordance with the individual's plan of care;
    - The services in the care plan are adequate; and
    - There are changes in the needs or status of the individual as set forth in the POC;
    - Monitoring includes identifying changes in the needs and status of the individual;
    - Monitoring and follow-ups include making necessary adjustments in the care plan and service arrangements with providers;
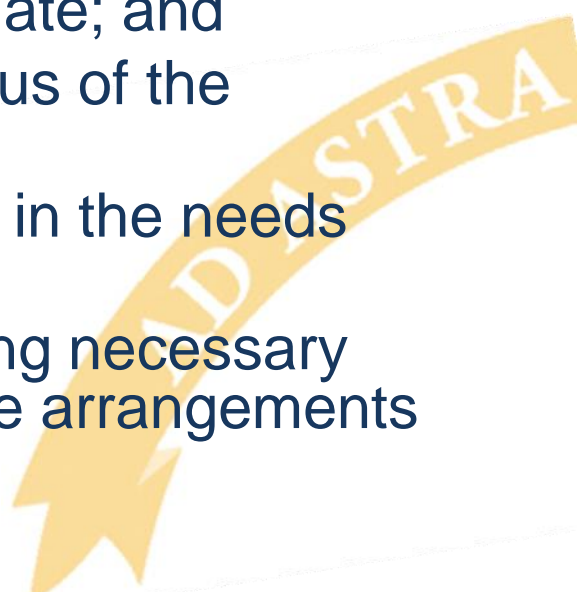
Transition

- TCM does not include transition services.
    - Transition services are limited pending a review of CMS guidance related to this service.
    - Transitions Services are limited to services provided when someone is transitioning from hospital, nursing facility or intermediate care facility, the service should be limited to assistance locating (referrals) and facilitating the process from institutional care to community. (referral component).
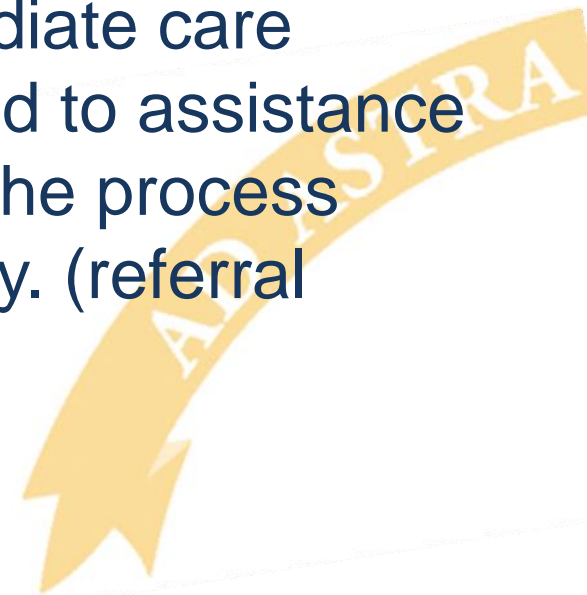
Transition (Cont.)

- Transition services can begin during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration.

- For covered, short-term institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge.

- Payment would not be available until after the person leaves the institution, has been assigned with the case management provider, and is receiving medically necessary services in a community setting.
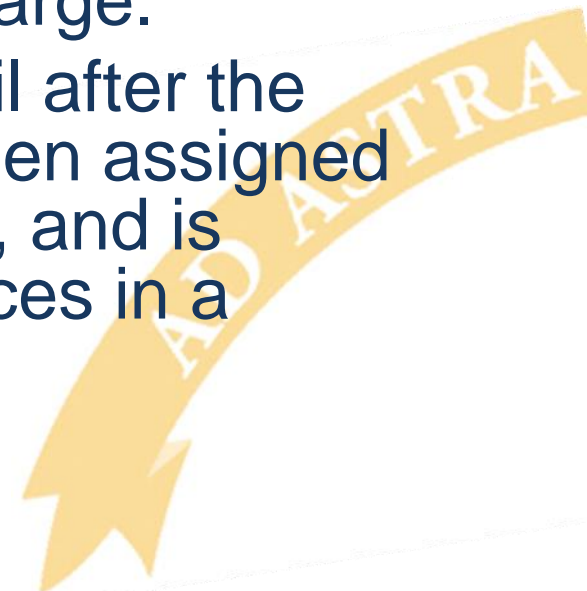
Documentation

- Case records shall include:
  - The first and last name of the individual receiving the services;
  - The name of the service;
  - The date the service was provided(mm/dd/yy);
  - Location of the service provided;.
  - The component of case management service provided;
  - The amount of time, including start and stop time that indicates a.m. or p.m. or the 2400 hour clock.
  - TCM legibly-printed name and signature on each page of the case log
 - The TCM must initial each case log entry.

Tasks that are NOT components of TCM

- Targeted Case Management does not include Direct Services.
  - Direct Services including, but not limited to:
    - Counseling for mental health or other issues
    - Transportation or Child Care
- Transition services for individuals who are inmates of public institutions.
- Training Residential and Day Services staff on BSP & PCSP beyond the PCSP meeting
- TCM Administration Tasks
- Administrative Activities integral to other non-medical programs and fundamentally non-Medicaid entities such as:
  - Foster Care or Guardianship, Probation or Parole
- Legal Representation
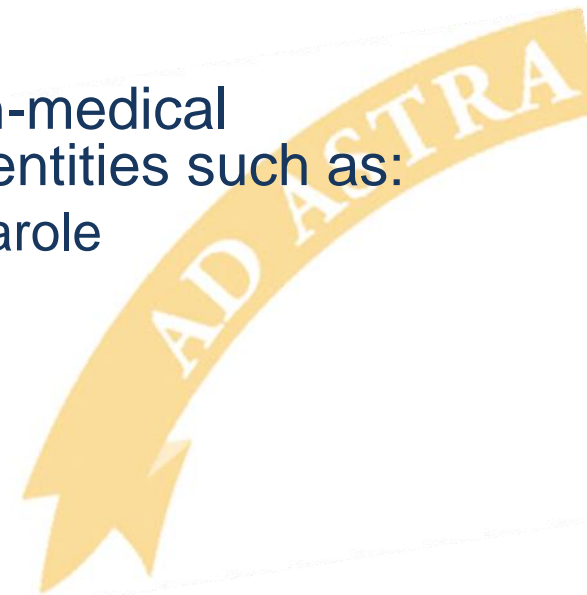
Goals of All Types of CM

- Greater independence on the part of individuals and families in accessing and linking to appropriate services and supports.

- CM always focus on working themselves out of a job with each individual on their caseload.

- CM always looking for other less formal supports, e.g family, social services, etc. that will replace the mental health system.
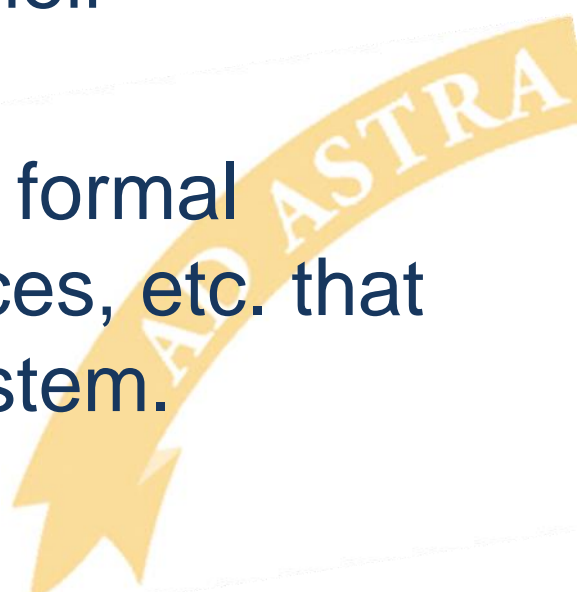
COMPREHENSIVE & INTEGRATED SERVICE PKG.

- **Individual is self-abusing by hitting their head; is aggressive toward others; does not have speech.**

  Integrated Assessment:

  Medical conditions that cause pain: sinus; migraine; broken bones; abdominal condition; medication side effects; dental pain;

  Behavioral Health: sleep and mood charting; functional assessment;

  Social: Abuse and/or neglect; loneliness; boredom

From the assessment, create an integrated intervention and positive plan

Coordination works with TCM

Development of a specific plan of care (based on information collected through the assessment. process)

• The plan lists the goals and actions necessary to address the medical, social, educational and other services the individual needs.

• The Individual (child or adult) should be an active participant (remember they are more likely to engage if active participant)

• The CM plan should address the same goals and objectives as the comprehensive plan of care – A TCM should work closely with a Care Coordinator to create a plan that meets an individual's needs
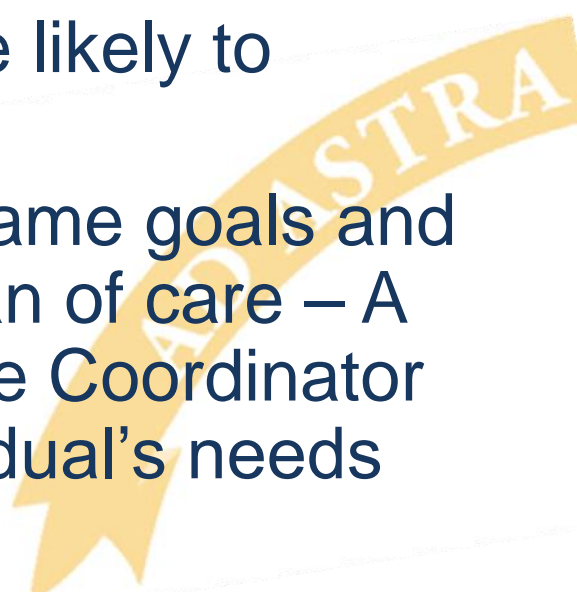
Keeping the Promise to the Person

June 23, 2015

Keeping the Promise

June 2009

In 2009, a group of self-advocates defined "home" and "community" and shared their vision for the future.

"We believe that when our country recognizes —the right of individuals to live independently, enjoy self-determination, make choices, contribute to society, pursue meaningful careers and enjoy full inclusion and integration in the economic, political, social, cultural and educational mainstream of American society (as in the Rehabilitation Act of 1973 as amended, 29U.S.C.794), that we will indeed be in control of own lives."

When taken together these promises made to citizens with developmental disabilities establish a clear national purpose:

❑ Increasing self-determination and personal control in decisions affecting people with developmental disabilities and their families

❑ Providing opportunities for people with developmental disabilities to live and participate in their own communities

❑ Improving quality of life for individuals and families as they define it for themselves

❑ Supporting families as the most important and permanent unit of development, protection, and lifelong assistance to persons with developmental disabilities

❑ Investing in each individual's developmental potential and capacity to contribute in age-related roles as productive and respected community members

❑ Ensuring access to sufficient, high-quality health and social supports to protect each person's health, safety, rights, and well-being

❑ Moving people with developmental disabilities out of poverty by significantly increasing opportunities for real work with real pay

Measuring Progress

MANAGED CARE IS

more than a financing mechanism.

Defining quality outcomes for people with disabilities
- Seeking opportunities for integrating care
- Improving independence and self-determination
- Working and living in the community with strong relationships
- Focusing on the person: their dreams, hope and desires
- Collaborating together to find innovative solutions

PROGRESS

supporting more people and their families in the community

Innovation

- Building a resilient community infrastructure
- Beware of "locking in" to set models
- Service designs & support strategies that enable people to get what they need not just what is available
- Policy that stimulates and supports innovation
- Improving access to services and providers
- Forging creative and productive partnerships
- Promoting use of natural and community resources

Big House State Op ICF-MRs

Community ICF-MRs

HCBS Waivers Comprehensive & Specialty Waivers

Supports Waivers

State Funded Family Support Services

Employment

The idea is to nudge a system to be person-centered, to support families, and involve people in their community.

Nudging the System

DEMAND

People with Developmental Disabilities (1% of the population)

NASDDDS

Person-Centered is a Process

- It is a process for both planning and service delivery, not an instrument or tool

- Person centered means conducting all activities from the person's point of view – what is important to them

- Balancing what others believe is important for the person against their right to self-determination
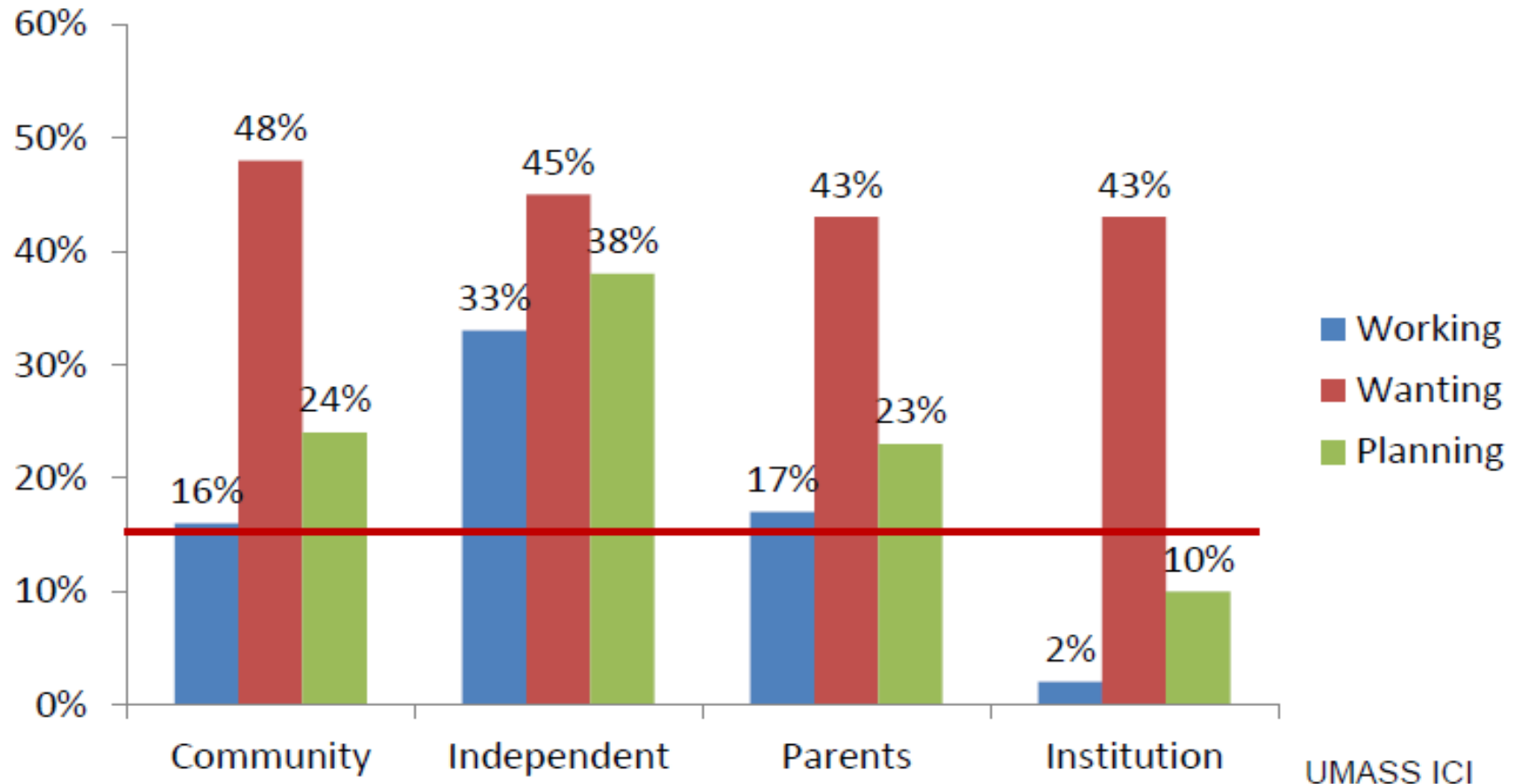
Focus on the Person

- Employment
- Choice
- Self-Determination
- Independence
- Relationships
- Community
- Self-Advocacy
- Skill Development
- Relationship-Based Living Arrangement
- Assistive Technology

Plans Don't match people's desire to work

NASDDDS
National Association of State Directors of Developmental Disabilities Services

Enhancing Person-Centered Planning

- There is a wide variation in mental abilities, behavior and physical development in individuals with Down syndrome [any IDD]. Each individual has his/her own unique personality, capabilities and talents. In other words, people with Down syndrome are not all the same; just like individuals in the typical population are NOT all the same – Noah's Dad (blog)

Happy
Down
Syndrome
Awareness
Month!

Person Centered Practices

The person wants to be a fireman.

–Determine why.

Status? Uniform? Excitement?

Honor family history? Image of strength? They like the fire house?

- The person-centered plan developed explores:
  - Opportunities to visit the fire house
  - Opportunities to volunteer
  - Opportunities that include wearing a uniform
 - Joining a gym to increase physical strength

Example (Cont.)

- The person needs to reduce weight (Types II Diabetes) but is not motivated.
    - Create opportunities for enjoyable physical exercise (get a dog to walk; start a dog walking business; volunteer with the park service (uniform and name badge and exercise)
    - Offer cooking classes that are appealing to the person
    - Education about diet
    - Counseling by nutritionist
    - Join Weight Watchers

Self-advocates Networking

Have you gone to a self-advocacy meeting?

30%
Yes, I have gone to a self advocacy event

70%
No, I have not gone to a self advocacy event
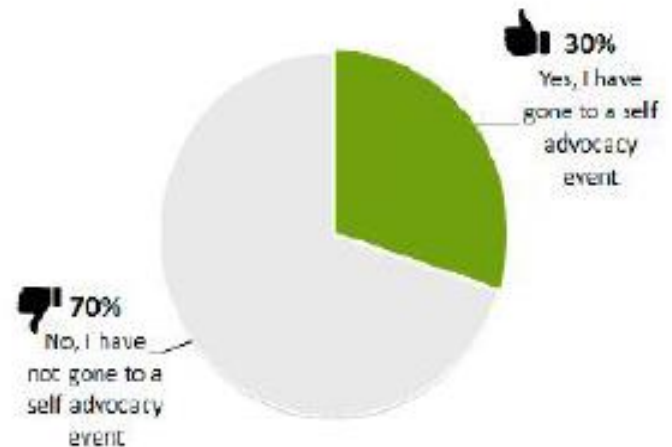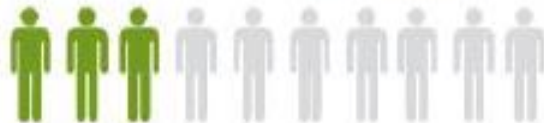
NCI tells us **3** out of every **10** people say they **have gone to a self-advocacy meeting.**

Challenging Behaviors

- Undiagnosed or untreated mood disorder
- Undiagnosed or untreated post traumatic stress
  - Sexual abuse >75%
  - Exclusion, rejection, bullying and humiliation 100%
  - Frustration from awareness of limitations
- Undiagnosed or untreated depression
  - Biological
  - Environmental/social – loneliness
- No knowledge of neurological challenges i.e. Autism, Fragile X etc.
- Result of assessments, support models and practices that are not person-centered
- No awareness of treatment options
  - DBT
  - EMDR

IDD & BH is common

By the Numbers

- ~ 32% of individuals with IDD have a mental illness
- ~53% take 1 of 4 medications for mood disorder, psychotic disorders, anxiety, behavior
- ~64% take at least 1 psychotropic medication

Person-Centered Options

- Referral to a specialist
- Application of positive behavior supports
- Early identification of physical, medical, social or other factors
- Alternative activities
- Identification of environmental stressors
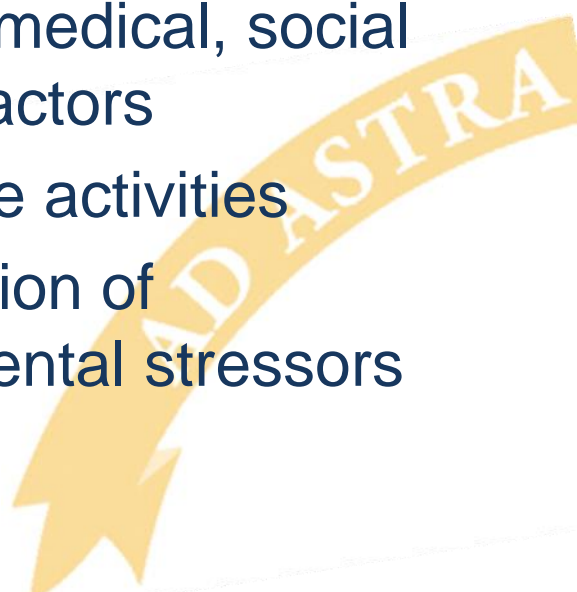
Hang On

CMS Assurances

- Administrative Authority
- Level of Care
- Qualified Providers
- Service Plan
- Health and Welfare
- Financial Accountability

State's Role

- State staff with expertise in I/DD as well as managed care.
- Ensuring that people with disabilities and families have access to information about the plans and a problem resolution process.
- Ensuring that statutes, rules, policies and everything that stakeholders developed over the decades are followed?
- Conducting oversight and imposing corrective actions.
- Public reporting on the performance of MCOs and licensed providers.
- Staying engaged with stakeholders.

State's role (Cont.)

- Monitoring feedback from program participants through complaint systems, hotlines, consumer surveys & outreach sessions with stakeholders

- Operational and financial reviews

- Enhanced expectations increase innovation & build capacity in lifespan supports.

- Network plan approval and oversight

- Review outcomes data: increase in community living, decrease in large residential services and institutions reported quarterly

Quality

- Assessments are comprehensive
- Performed by qualified evaluator
- Participant involved
- The POC signed
- Goals and preferences noted and included
- Timely
- Emergency plans are understood
- Service delivery is monitored
- Record review, observation and interviews

PERFORMANCE OUTCOMES

- Assessments
- Health and Safety Risks
- Participation in Planning
- Plan of Care Meets Needs & Preferences
- Plan of Care Service Initiation & Timelines
- Protection of Participant in Emergency
- Participant Choice
- Participant Needs Are Met
- Participants Are Safe

AGENCY PERFORMANCE OUTCOMES

- Qualified Staff

- Competent case managers

- Consistent stable workforce

- Efficient/Effective Operation

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Participants are involved in Planning

The participant and those authorized to represent him are involved in planning to the fullest extent. Participants are given sufficient support and guidance in the planning process.

How do we know?

- Assessment, POC documentation & TCM provides evidence of participant/representative involvement.
- The POC is signed by the correct person(s).

Participant Needs Are Met

- Problems accessing POC services are clearly identified and addressed in a timely manner.

- Plans of Care are updated when warranted by changes in participant needs.

- Is there evidence that all of the activities above are performed?

June 23, 2015

Participants are Safe

- All critical incidents are identified and addressed.

- Is there evidence that participants are asked monthly about critical incidents.

- Is incident reporting and resolution completed according to the timelines and processes in the Critical Incident Policy (Adverse Incident Reporting AIR).

- Does the annual POC renewal include an annual assessment of critical incidents and strategies to address prevention of future incidents.

Participants are protected in the event of an emergency

- Effective and current emergency plans are in place.

- Effective and current back-up staffing plans are in place.

- Does the TCM/Care Coordinator provide evidence that plans and agreements are up to date throughout the year?

Critic al Incidents

- Abuse or Exploitation
  - Physical
  - Sexual
  - Psychological
  - Financial
  - Emotional
- Neglect
  - Including self-neglect
- Inappropriate sexual contact

- Suicide/Attempted Suicide
- Unexpected Death
  - Includes unexplained death not related to medical condition
- Serious Injury
  - Loss of limb or function
- Natural Disaster
- Misuse of Medications
- Elopement

Mandatory Reporting to APS is still required

When in doubt … Report. www.kdads.ks.gov

June 23, 2015

Critical Incidents

- ## What is a critical incident?
  - An adverse event or incident that potentially result in serious outcomes
- ## When is it appropriate to report?
  - The consumer is participating is a KDADS operated program
  - Reside on any premises owned or operated by a provider or facility licensed by KDADS
- ## Where do I send the report to?
  - Adverse Incident Report (A.I.R) web based tool at www.aging.ks.gov

Nothing about me without me.

Cathy, 45, has a killer freestyle and is a jazz connoisseur

For More Information

Visit our website regularly
www.kdads.ks.gov

We will be posting consumer and family information, IDD Pilot updates, education and Q&A opportunities and more!

Go to the **PROVIDER** tab to access training materials, policies, procedures, and key links

June 23, 2015

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