“Keep my dog” and other simple member mandates

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Agenda

Introduction
• Organizational information
• Introduction of panelists

Foundation
• Approach
• Measures of success
• Goals & individualized care planning

Case Scenarios
• I want to keep my dog
• I want to work
• I want to be homeless

Summary
• Questions & answers
• Wrap-up
The foundation: Individualized care planning leads to preferred outcomes
Integrated Biopsychosocial Approach

**BIO**
- Diagnoses
- Pathology & pathophysiology:
  - Physical and behavioral health disorders
- Medical/dental treatments:
  - Medications, surgery
  - OT; PT; S&L Therapy
  - Dental treatments
- Alternative/Complementary Medicine

**SOCIAL**
- Family
- Circle of support
- Community: Social Connectedness
  - Locality
  - Cultural community
- Social Determinants of Health
  - Housing
  - Education
- Delivery system & CBOs
- Health disparities

**PSYCHO**
- Values, preferences & beliefs
- Readiness to change
- Level of activation
- Personality
- H/O Trauma/ACEs
- Psychological treatments:
  - Psychotherapies; ABA
  - Stress management
- Mind-Body Practices
Rules of care coordination engagement

- Comprehensive needs assessment
- Individualized care Planning
- Access to needed Services
- Communication and monitoring
Person- and family-centered care core concepts

Integrated Care Management (ICM) Strategy: Person-centered care

- Each member is assigned a well-trained case manager
- Face-to-face assessments and visits (at least 2 to 4 times per year)
- Biopsychosocial needs, personal preferences and other supports are identified
- Establish collaborative goals to support the member’s needs and preferences
- Services and supports provided by family and others are “supported”; not supplanted
Guiding principles of our program

- Use integrated, holistic approach rather than disease-specific or problem-focused
- Support members in the most integrated/least restrictive environment
- Facilitate transitions between systems of care
- Engage each member, recognizing his/her strengths, capacities, and addressing critical physical, behavioral environmental and social needs
- Employ evidence-based practices to create optimal outcomes for members
- Provide for access to a continuum of services and supports, based on complexities of individual member needs/outcomes
I have to keep my dog!
<table>
<thead>
<tr>
<th>What Matters to Our Members . . .</th>
<th>We Hear and Work With . . .</th>
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<tbody>
<tr>
<td>Understand who I really am</td>
<td>• I ran the place at work – now I can’t run the washing machine.</td>
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<td></td>
<td>• My dog and I are a team.</td>
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<td>• I like living by myself w/ Happy.</td>
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<td>• I don’t want anyone else around.</td>
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<td>• My kids have their own lives</td>
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<td>• I’m a survivor</td>
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<tr>
<td>Make it easy to move between levels and types of care</td>
<td>• I was fine until those blisters came back.</td>
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<td></td>
<td>• The leash gets wrapped around my legs and I’ve fallen.</td>
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<td></td>
<td>• Now I can only drive in town.</td>
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<tr>
<td>Help me get all the services/supports I need to achieve what is important to me</td>
<td>• I don’t feel comfortable going to church anymore – I can’t remember names.</td>
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<td></td>
<td>• I don’t like people going through my stuff. I worked hard for it.</td>
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I have to keep my dog!

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| Live where I want and with whom I want w/o compromising my health / safety | • I go nowhere without my dog.  
• I can do this all by myself – the old way. I don’t want computers or alarms.  
• I will stay here until I die – no nursing homes for me, they killed my mother! |
| My strengths, capabilities and resources are always part of the solution | • I have friends around here to walk my dog with – she needs exercise every day.  
• I love my kids but they are busy. |
| Care is more likely to do good than harm to people like me. | • What can my doctor do for me now? He’s quirky, but I don’t mind seeing him. |
Integrated support of members in their community - the Integrated Care Team

Member and her Dog

- Case Manager
- PCP / PCMH
- Daughters Son-in Law & Nephews
- Neighbors
- Happy (Dog)
- Friends
- Veterinarian
Ongoing collaboration and measures of success

Established joint goals with success measured by “team’s” health and well-being

Measures of success

• Return to “normal” weight (both member & Happy)
• Improved activity level, safety, medication adherence

Transitions . . .

• After 2 years, transition to Memory Care Assisted Living
• Keeping the dog
  • Initial daily visits with Happy with ongoing access
  • Member controls when and where
  • Open adoption of Happy by family acquaintance
I want to work!
Meaningful employment
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<tr>
<td>Understand who I really am</td>
<td>• Lives at home with parents who accept him for who and where he is and work tirelessly to support his goals</td>
</tr>
<tr>
<td></td>
<td>• Past success using plans to reach his goals, exceeding others’ expectations</td>
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<tr>
<td>Make it safe &amp; easy to move between levels or types of care</td>
<td>• He will do the best he can – Let’s find the right place to support him.</td>
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<td>• He knows what he wants and to help with planning and goal setting to get there</td>
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<tr>
<td>Help me get all the services/supports I need to achieve what is important to me</td>
<td>• He’s Interested in food services</td>
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<td>• We need someone to support him. There are vocational experts in the community</td>
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<td>• I can do it if I keep practicing</td>
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## I want to work!

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<td>Live where I want and with whom I want w/o compromising my health / safety</td>
<td>• He feels supported in new environment</td>
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<td></td>
<td>• He’s learning the job – with support by his coach, social cueing and repetitive skills</td>
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<tr>
<td>My strengths, capabilities and resources are always part of the solution</td>
<td>• I fixed all the carrots by myself.</td>
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<td></td>
<td>• (Store owner) came in today – He said I’m doing good!</td>
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<td></td>
<td>• Mom, it would help if I could drive.</td>
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<tr>
<td>Care is more likely to do good than harm to people like me</td>
<td>• I’m doing it by myself!</td>
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<td></td>
<td>• I have my schedule</td>
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<td>• I’m working today</td>
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Integrated support of members in their community - the Integrated Care Team

- Social Worker
- Vocational Specialist
- Community partner
- Job Coach
- Case Manager
- School District

I Want to WORK
Ongoing collaboration – meeting needs through meaningful employment

Established joint goals – Training and preparation to work in the community, attain and sustain employment.

Measures of success: Quality of life, maintain support
- Same job for 11 years – using computer to print schedule
- Development of new skills – drives to work

As his work requirements and situations arise
- Assure reintroduction of coach is available to assist with patterning new cues and new situations
- Ongoing communication & evaluations w/ community partner
- Transitioning case to Div. of Dev. Disabled for ongoing case management
I choose to be homeless!
# I choose to be homeless!

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| Understand who I really am | • My Mom doesn’t understand what I need right now  
• I can do this without her help  
• My friends are there for me when I need them |
| Make it safe & easy to move between levels or types of care | • I sometimes prefer to stay with friends or at a shelter when Mom and I don’t get along  
• Just because I don’t sleep in the same bed every night doesn’t mean I don’t need some help |
| Help me get all the services/supports I need to achieve what is important to me | • I will work to keep minutes on my cell phone so my workers can call  
• I will only use the services when I need them  
• I want to introduce you my friends and give you their phone number so you can get in touch with me |
I choose to be homeless!

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<td>Live where I want and with whom I want w/o compromising my health / safety</td>
<td>• This usually doesn’t last long</td>
</tr>
<tr>
<td></td>
<td>• I’ll be back home soon</td>
</tr>
<tr>
<td></td>
<td>• I want keep my services</td>
</tr>
<tr>
<td>...My strengths, capabilities and resources are always part of the solution</td>
<td>• This is really hard but I need my independence</td>
</tr>
<tr>
<td></td>
<td>• I’m so very thankful that my friends are close by</td>
</tr>
<tr>
<td>Care is more likely to do good than harm to people like me</td>
<td>• Without this team pushing me, I don’t know where I would be</td>
</tr>
</tbody>
</table>
Integrated Support of members in their community - The Integrated Care Team

- Mom
- Dept. of Rehabilitation Services
- Housing Locator
- Case Manager
- Personal Care Attendant
- Friends

I am Homeless

Homeless Mom Case Manager Dept. of Rehabilitation Services

Housing Locator

Friends

Personal Care Attendant
Ongoing collaboration – allowing him to decide where he lays his Head at night

Established joint goals – Working together to set up Personal Care Attendant services where he spends his time. Creating a trusting environment that allows for bumps in the road.

Measures of success:

• Met goals of care plan – from instability to independence
• Gained autonomy - He put himself on multiple waiting lists for low-income housing in his neighborhood after gaining the confidence that he can execute a strong plan.

As his needs changed:

• Understanding his rights to make decisions
• Trusting his ICT to meet other medically related needs
Individualized care planning leads to preferred outcomes
In Summary . . .

Our Foundation

• Bio-psychosocial approach & systems of care
• Member-centric measures of success
• Prioritized goals & individualized care planning

Individualized Care Planning In Action

• My dog and I - *Choice and control*
• Meaningful work and independence - *Workforce*
• Services where I lay my head – *Service delivery*

Moving Forward

• Questions & answers
• Wrap-up
Thank you

**Integrity**
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**Caring**
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