N.C. Department of Health and Human Services

Shaping Our Future: A Synthesis of Long Range Services SWOT Sessions

A Medicaid Reform Initiative

What Brought Us Here Today?

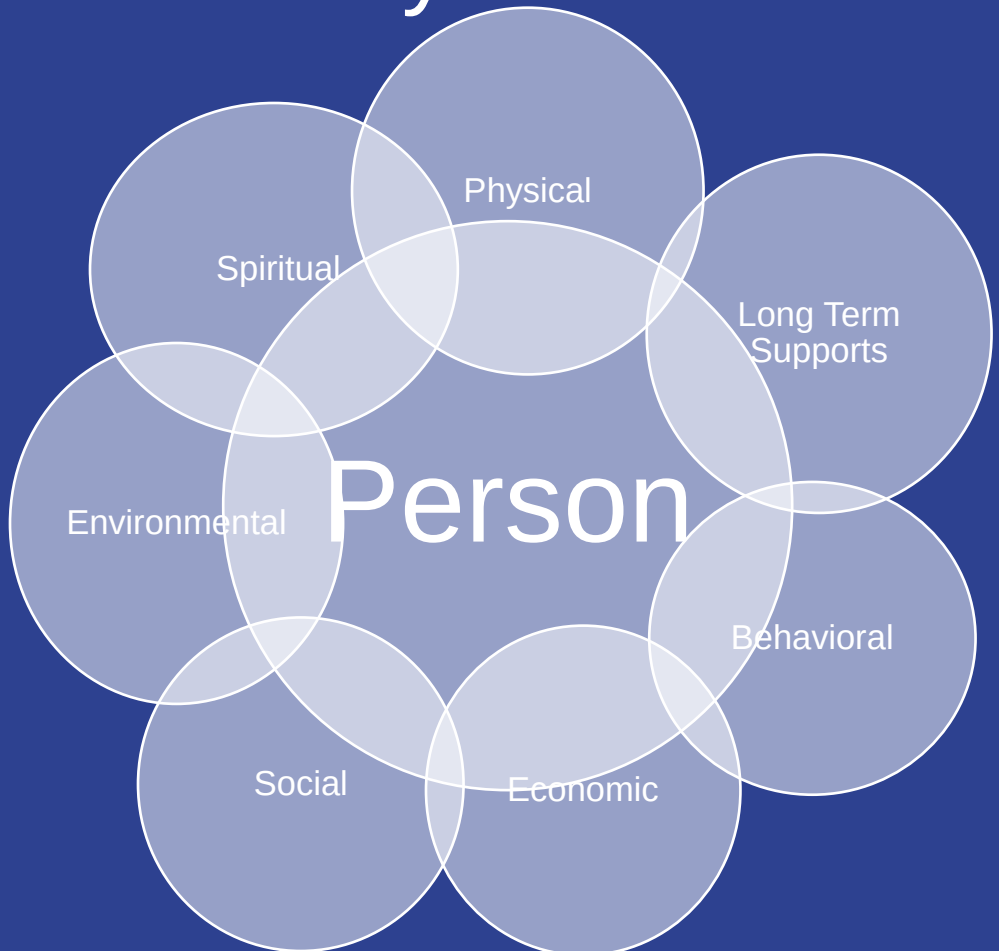
- *Shaping our Future* is the Long Term Services and Supports (LTSS) strategic planning effort under the Department's *Medicaid Reform* initiative.
- LTSS for this purpose= those services managed by DMA's Facility, Home and Community Services Section.
  - Long Range: CAP DA; CAP C; PDN; PCS; SNF; PACE
  - Intermittent: Hospice, HIT, Home Health and post-acute SNF
- AS part of strategic planning process, each services' stakeholder group (providers, families, beneficiaries, advocates and other state staff) conducted a SWOT.

What We Asked….

- What is Whole Person Care?
- Strengths: What are the strengths in our service delivery system that support *whole person care*?
- Weaknesses: What are the weaknesses in our service delivery system that impede whole person care?
- Opportunities: As our state moves toward service models that better encourage whole person care, what opportunities does this present?
- Threats: What threatens our efforts to build a service delivery system that promotes whole person care? Group recommendations for minimizing.

Whole Person Care Means…

The needs of the whole person are acknowledged in the service delivery system



Whole Person Care Means…

Considering the needs of the family caregivers.

"We work with a diverse population. When getting to what families need, we need to start at a basic level, because families needing services are already under stress."

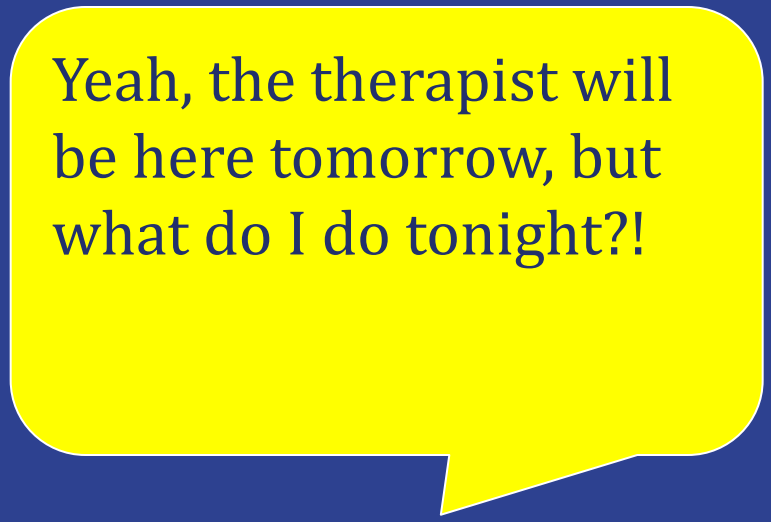
-family member/provider

Whole Person Care Means…

Individuals/families don't have to go looking in completely different systems, each with separate processes, and "don't have to choose between diagnoses" to get the care that is needed.

Additional Insight from Intermittent Group

Families need to have support immediately in order to prevent re-hospitalizations and re-institutionalizations.



Whole Person Care Means…

Individuals and families have a clear and consistent “ally” as they navigate the system.

What does the “ally” look like?

Strong, highly competent, consistent case manager or case management entity that follows the person through services and across lifespan and serves as the person’s/family’s ally.

possible role of family peers/parent coaches “guide by your side”

Whole Person Care is…

Seamless coordination of services across settings and across the lifespan that effectively ensures continuity of care.

What Does "Seamless" Look Like?

- People can keep the same supports as they grow older.
- Service design anticipates changing needs.
- Professionals talk to each other to better ensure they are making conflicting recommendations or are omitting key information.
- Particular note of transitions across settings, including out of hospitals.

"The person who helped me for years, can't talk to me anymore."
-family member

"People come with 100 pages of medical records, but there is a lack of information sharing about the patient."
-SNF stakeholder

Continuity of Care: A note about the service “cliff”

“It feels like it’s either full services or no services.”

--family member

- Some services currently have inability to adjust services gradually
  - Discourages people from working towards goals
  - Some families anxious about making clinically indicate changes, because afraid will lose ALL services.

Additional insight from Intermittent Group Whole Person Care Means…

- Ensuring provider flexibility in making treatment decisions.
  - Re: service limits, professions involved in care,
  - Streamline assessment processes
  - Minimize “false choices” between LTSS and Intermittent services.
  - Acknowledge that it’s not always clear what is chronic and what isn’t.

Whole Person Care Means…

- People have a collaborative assessment and planning process.
  - Better information, more practical and more equitable.
  - Assessments and planning efforts are "conversation based."
  - Integrate the assessor into the planning process.
  - Ensure assessor is using tool that is statistically valid and reliable.

"Not eight different meetings, but one meeting."
-family member

Whole Person Care Means…

"Part of whole person care is remaining connected to the community and not relying completely on state level support."

-PCS Stakeholder

Whole Person Care Means…

- A more unified data set...
- Unified quality and performance metrics….
- All used to evaluate outcomes related to health, cost and quality of life.

Which requires….

- An IT system that allows different entities to communicate and incorporate information.
- Examples of models include: CCNC Analytics, CAP IT system through (“ECAP”), Division of Public Health

Right now, we can’t see what other services a shared client may be getting.

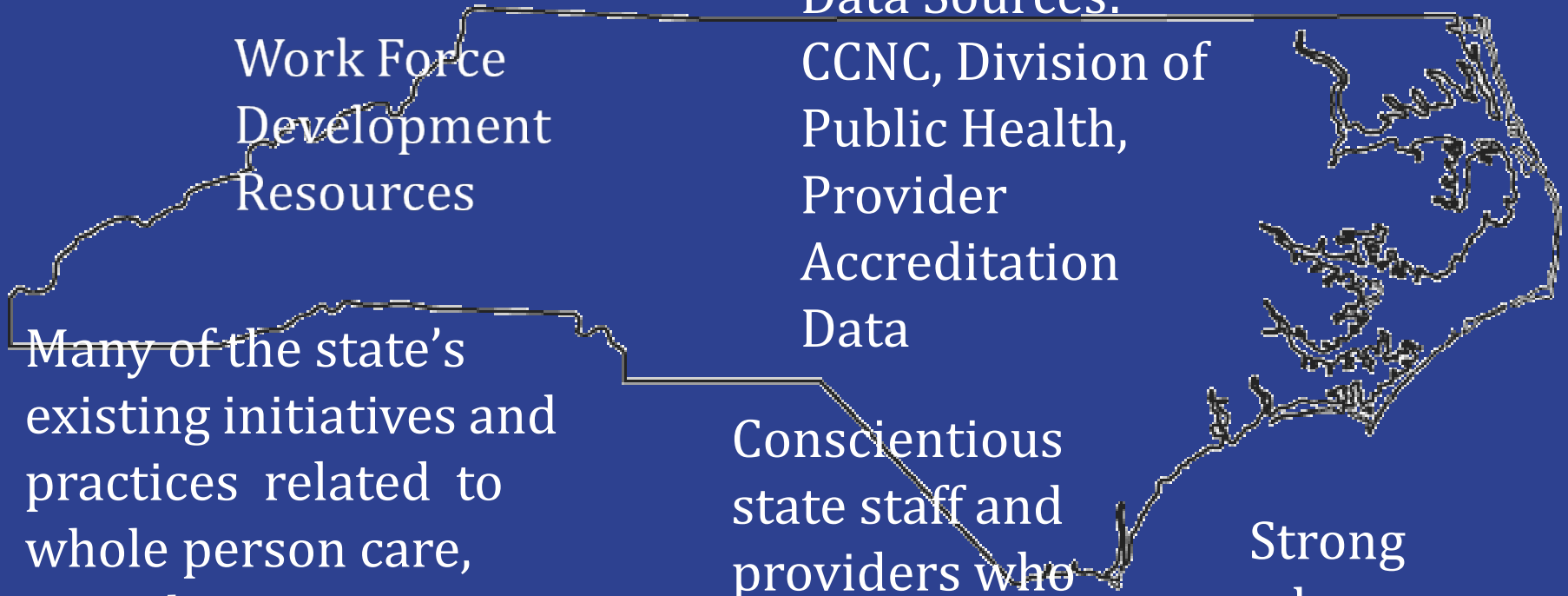
--state employee

Strengths to Build On….

Theme: Build processes that promote individual and family empowerment and responsibility

- Look to families to recommend their own solutions.
- Families can help identify ways to make system more efficient.
- Ensure supports promote family unification and involvement.
- Promote self-directed options.
- Make sure needs of family caregivers are integrated into the assessment process.
- Recognize the role the system and providers play in helping family members “plan for the future.”

Theme:
We Have Some Great Resources to Pull From in NC



Work Force Development Resources

Data Sources: CCNC, Division of Public Health, Provider Accreditation Data

Many of the state's existing initiatives and practices related to whole person care, accreditation, training, etc.

Conscientious state staff and providers who want to do the right thing.

Strong advocacy communities

And some of our weaknesses supporting *whole person care*…

Theme:
The Critical Need for Meaningful Data

- Who is getting served and who needs services but may not be getting them?
- How do we measure *return on investment (ROI)* in LTSS services?
- How do we track prevention and compare against alternatives?
  - Hospitalization avoidance
  - Institutionalization
  - Lower health outcomes
- What are the true costs of providing whole person care?
- Difficult to conduct whole person data analysis—inability to track care across services.
- No uniformity in dataset.

Theme: Challenges in Making Sure People Understand Their Options

- Front line staff don’t always know what options are available.
- Web-based information is also fragmented and often confusing for families.

Theme:
Assessments in services remain fragmented and are frequently not conducted in real time.

Theme: The Critical Role of Workforce Development

- Workforce continuity promotes whole person care: families have peace of mind, staff know person well and can recognize the subtleties in preferences and support needs.
- Direct workforce challenges:
  - Keeping up with hospitals related to reimbursement and clout
  - Ensuring RNs are competent in the realities of home-based LTSS (misconception “it’s a step down before retirement,” lack of training, “I’m just here to do meds”)
  - Need for stronger examination of scope of practice.
- Need for workforce analytics
- Workforce Opportunities:
  - Build off current good practices (i.e. simulation, College of Direct Support).
  - Partnering with community colleges to push people into tracks that we need in the system.
  - Build education track enhancement.
- Nurture direct support workforce. “We’re competing against McDonald’s”
- Opportunity to better leverage technology (Simply Home, Rest Assured)

Theme: Better Ensure Services are Flexible and Robust

- Need for flexibility in case management function to better meet the changing dynamics over the course of a person's life.
- Rates and service definitions don't always reflect what a person actually needs or the fact that needs may fluctuate daily.
- Examine the link between rate cuts and continuity of care.
- Build capacities to better serve folks who have complex/multifaceted needs (TBI, individuals with mental health with attendant care needs, etc.)

We have an Opportunity to…

- Support a cultural shift in keeping people in the least restrictive, most cost effective setting possible.
- Build stronger provider networks.
- “By lowering the silos and integrate care and create information that is available to right provider at the right time will allow us to meet the goal of whole person care.”

Insight and Questions as We Move Forward….

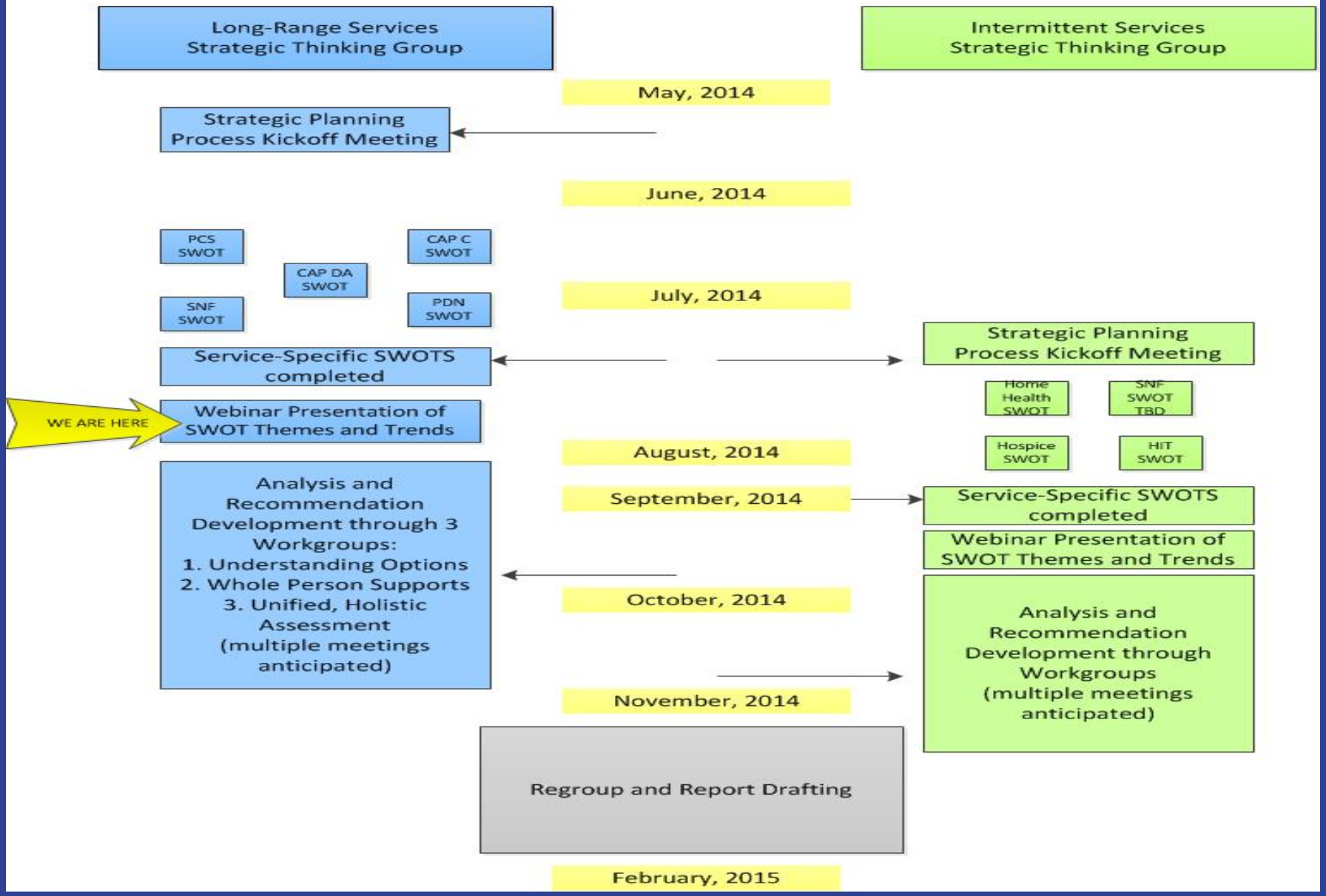
- As we explore new service models, what has been the experience in other states?
- How do we ensure we don't rush this process and also not lose momentum?
- How do we make sure what we build, we can afford?
- How do we ensure the local DSS workforce has the resources to effectively advise beneficiaries and ensure services activation practices are responsive?
- How do we ensure systems can be responsive to the need for innovation?

"I've been on so many committees and looked at the same efforts. It would be a shame to fail to look at the work that has already been done."
--SNF stakeholder

“Don’t forget who we’re working for.”

Next Steps

Shaping Our Future:
Medicaid LTSS Strategic Planning



Organizing Our Work: Preliminary Workgroup Design

Information about Options	Whole Person Supports	Unified, Holistic Screening & Assessment
• Will focus on points of access and options counseling • Co-chaired by Mardy Peal and Heather Burkhardt	• Will focus on practices that better integrate physical and behavioral systems into LTSS • Co-chaired by Bob Atlas and Trish Farnham	• Will examine methods for developing unified assessment tool • Co-chaired by Sabrena Lea and (invited) Pam Silberman

All groups will incorporate workforce and IT capacity considerations.

Upcoming Meetings

- Intermittent Services Strategic Thinking Group Kick Off: 9:00-11:00, Wednesday, July 23rd
  - Dix Campus
  - Travel reimbursement available for beneficiaries and families.
- Intermittent SWOTs through August
- Workgroups to begin late August.

How to Stay Informed

- *Shaping our Future* materials posted on Medicaid Reform Website: http://www.ncdhhs.gov/medicaidreform/
- To Register for Intermittent Services Kick Off (limited space) or to make a commitment to join a workgroup, please email Laura Ross at:
  - Laura.m.ross@dhhs.nc.gov

Thank You!