What Whole Person Care Means

A Summary of the Long Term Care and Intermittent SWOT Meetings Summer, 2014

NC Department of Health and Human Services Shaping our Future: LTSS Medicaid Reform



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

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 rehospitalizations and reinstitutionalizations.

Yeah, the therapist will be here tomorrow, but what do I do tonight?!

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, etc.
 - Streamline assessment process.
 - Minimize "false choices" between LTSS and Intermittent services.
 - Acknowledge that it's not always clear what is chronic and what isn't.

- 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

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

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