the procedures) during the exam. Kim prepares Suzie for the exam with teaching and coaching. Suzie is moderately anxious during the exam, but it is completed without incident.

Suzie goes all winter without a URI, and enjoys her new glasses. Kim updates Suzie's IICSP on the ICBR when changes occur so that any provider seeing Suzie can immediately see her current status.

INTEGRATED CARE HIGHLIGHTS

Member Experience

The person with dual eligibility is at the center of care planning and delivery and experiences seamless and carefully integrated care and support. Regardless of the number of involved parties, the member experiences care provided by an integrated group of providers who understand her needs and work together to address them. The member always has a single individual who is available and accountable to her for coordination of all services and for maintaining a single integrated plan. The group of providers also have a single individual at all times who is available and accountable to them for coordination of all services and for communicating the member's unique needs. There is no disruption of the existing services provided by the CMHSP and managed by the PIHP, and the member's medical care is more closely integrated with her intellectual/developmental disability services.

Relevant Elements of the Care Bridge

- Access to integrated current problem and medication list for all providers.
- Single Lead Coordinator who is:
    - Selected by the member and responsible to the member at all times;
    - Appropriately trained and responsible for an explicit set of care coordination functions.
- Timely communication between all providers, facilitated by the Lead Coordinator.
- Coordination with specialty care providers to accommodate member's unique needs.
- The ICO or PIHP provide cross-training to employees or contractors providing supports and services to the member.

Integrated Care Vignette # 4 (Roscoe)

Transition from Nursing Home to Community

Roscoe is a 71-year-old man who has resided in a nursing home for the past five years. He has had nine hospital admissions during that time, primarily for heart failure and pneumonia. Roscoe has emphysema, insulin dependent diabetes, congestive heart failure, and intermittent depression. He is very obese and uses oxygen at all times. Roscoe is on 15 prescription medications, managed by his nursing home medical attending physician. He is alert and engaged with his family of four daughters, and one, Ellen, is his payee and takes care of his bills.

Ellen brings Roscoe the information received in the mail about the integrated care program. Roscoe seizes on the information about transitioning people from nursing homes to community, as he is adamantly determined to live independently once again. Roscoe decides to enroll, and Ellen submits his application. The enrollment broker receives Roscoe's enrollment information. Reviewing the file provided by the state, the broker confirms that Roscoe resides in a nursing home and flags the enrollment record accordingly to forward to the Integrated Care Organization (ICO). The enrollment broker makes a preliminary determination that Roscoe's preliminary dominant need is based in long-term care.

Before the ICO can take action, Ellen phones the new member line and asks for care coordination assistance, as described in the ICO's literature. Ellen describes Roscoe's passionate desire to leave the nursing home, and his family supports this desire, though none of his children can accommodate Roscoe in their homes. The ICO assigns a preliminary lead coordinator (PLC) who locates the enrollment file, gathers utilization data from the data warehouse, and contacts Roscoe's daughter.

The PLC arranges for the family, Roscoe, other allies he selects, and the nursing home social worker who works with Roscoe to meet at the nursing home in order to create an Individual Integrated Care and Supports Plan (IICSP) that addresses Roscoe's wishes. The PLC also recognizes that Roscoe will need significant coordination of his supports and services and engages Rick, a care manager from the ICO, who will be permanently assigned to Roscoe's case. Rick attends the care planning meeting in the place of the PLC, who will no longer be involved.

The care planning team reviews and discusses Roscoe's medical history, his current Nursing Facility care plan, and his wish to live in the community. The daughters describe what supports they can and cannot offer, and together they develop a list of services and supports Roscoe would need. These include assistance in locating accessible and affordable housing, personal care and homemaker services, meals, durable medical equipment, transportation, medication management and administration support, a personal emergency response system, incontinence supplies, ongoing monitoring, and primary care medical home. Rick suggests a mental health consultation, but Roscoe declines it for the time being.

Rick explains that the ICO provides a continuum of Home and Community-Based Services (HCBS) that includes a Nursing Home Level of Care Assessment, which serves as the basis for identifying HCBS needs and coordination of HCBS services and supports[1].

At the end of the meeting, Roscoe decides that Rick should be his Lead Coordinator for the time being, who becomes responsible to all parties for coordinating services and on-going communication within and across the team. Rick establishes an electronic Individual Care Bridge Record (ICBR) on the ICO's web portal and grants the nursing home and Roscoe and his daughter Ellen access to it. He posts the IICSP, history, current issues list, allergies, and medication list on the ICBR.

Rick refers Roscoe's case to the ICO's HCBS contractor to assess Roscoe's ADLs and IADLs and to develop a proposed plan of HCB supports and services. The agency assigns Maggie as the Supports Coordinator. Maggie works closely with Roscoe, Ellen, and Rick to find and furnish housing for Roscoe. When housing is nearly finalized, the four of them and the nursing home social worker meet again to finalize Roscoe's community-based plan of services and supports. The agency has recommended the following services:

- One home delivered meal per day each weekday
- Two hours a day of personal care service each weekday
- Four hours of homemaker services a week
- Four hours a week of support for IADLs including banking and grocery shopping
- Portable oxygen, a walker, shower chair, toilet riser, and incontinence supplies
- An emergency response system
- Weekly nursing visit for one month, to set up oral medications and insulin and train Ellen to take over those functions.

The team discusses and agrees on the plan of services and supports. They discuss how the personal care and homemaker services will be managed.[2]

Rick obtains ICO authorization for the services, and Maggie initiates them. Roscoe's discharge date is set. Rick updates Roscoe's' IICSP on the ICBR. The nursing home physician writes prescriptions for 30 days of medications, which Ellen fills at the local pharmacy. Rick works with Roscoe to select a primary care physician and to schedule his first visit for one week after discharge. Rick arranges for non-emergency transportation to the office visit and assures Ellen that she can and should go with Roscoe. He forwards Roscoe's IICSP to the primary care office before the appointment and gives the office access to the ICBR.

Following a send-off party, Roscoe is discharged from the nursing home to his new apartment. The daughters decide to take turns sleeping on Roscoe's couch the first week he is in his new home and to gradually wean away until he is on his own. All his HCBS services begin as scheduled. After a complete exam by his new primary care provider and two fairly uneventful weeks at home, Rick arranges for a

[1] MDCH is considering ICO network requirements for HCBS; details are not finalized.
[2] MDCH is considering options for ICOs to assure access to Home Help services; details are not finalized.

face-to-face meeting to update Roscoe's IICSP. Maggie, Roscoe, Ellen, Rick, and the primary care nurse (by phone) participate. Roscoe identifies the following goals:

- Remain at home without accidents or unexpected illnesses
- Attend church on Sundays
- Keep his blood sugar under good control
- Get a cat

The team determines that his current services and supports are sufficient. Rick trains everyone on how to handle medical emergencies and changes in Roscoe's condition. Roscoe and the team decide that Roscoe does not need Rick's clinical involvement nearly as much as his success at home continues. They decide that Maggie should take over as his Lead Coordinator. The ICO provides Maggie with training in the duties and functions, pays for her services, and gives her access to the ICO ICBR. Maggie maintains monthly phone contact with Roscoe, coordinates services and supports as needed, and visits his home every six months to update his IICSP as necessary. She posts updates on any changes in Roscoe's condition and needs on the ICBR.

Roscoe lives in his apartment with his cat and achieves all of his health and life goals.

INTEGRATED CARE HIGHLIGHTS

Member Experience

The person who is dually eligible is at the center of care planning and delivery. His desire to move out of the nursing home is addressed by a competent multi-disciplinary team of community-based and clinical providers led by a HCBS contractor nursing facility transition worker, who work seamlessly to develop a challenging transition plan.

Relevant Elements of the Care Bridge

- Care coordinators and case managers move in and out of the process as the member's condition evolves but are all responsible to communicate with the integrated team.
- Single Lead Coordinator who is
    - Selected by the member and responsible to the member at all times
    - Appropriately trained and responsible for an explicit set of care coordination functions
- Timely communication between all providers, facilitated by the Lead Coordinator
- Timely and informed care transitions