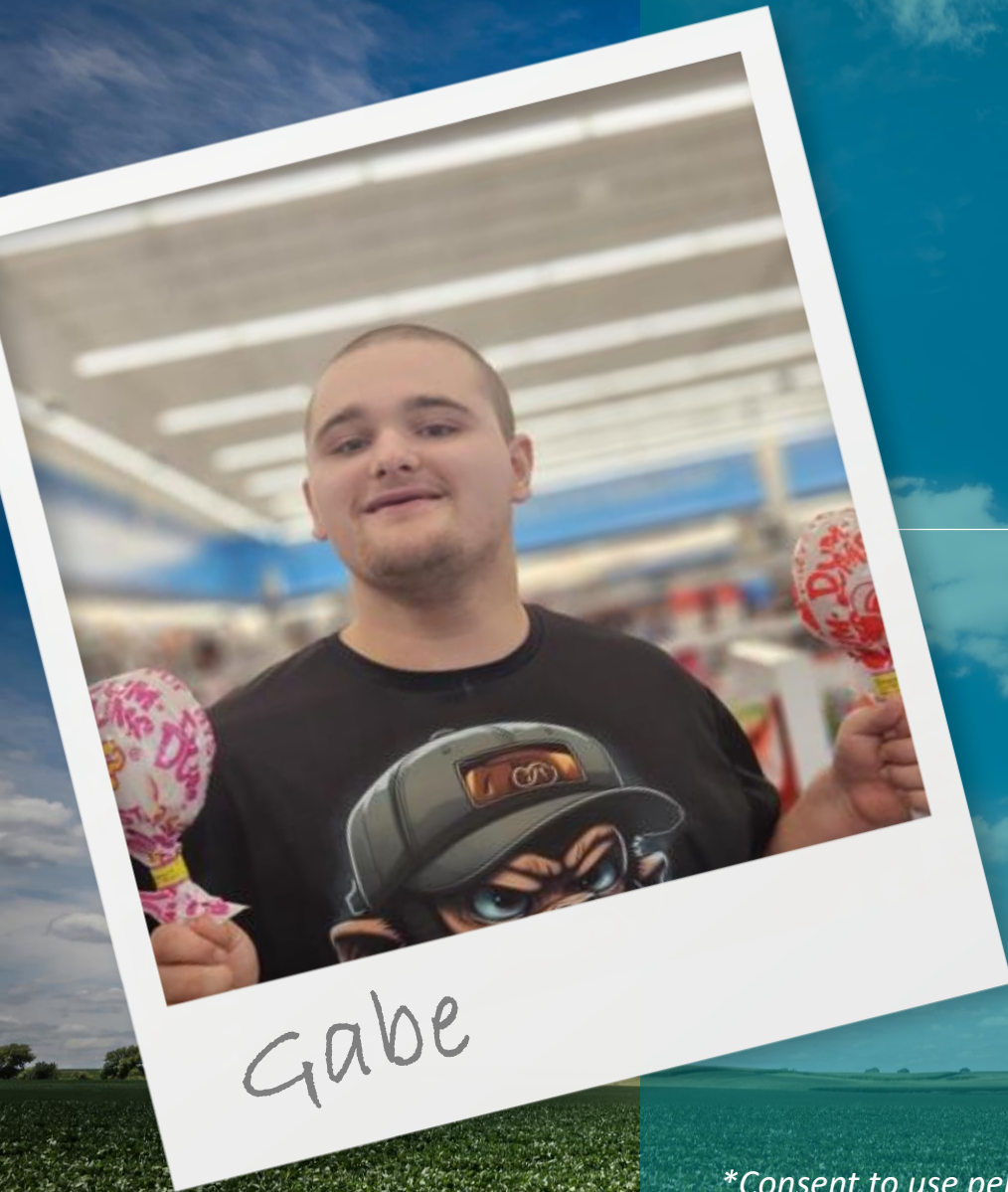




Gabe's Story*

A member and team's
journey from being
scared to being
SUCCESSFUL

**Consent to use personal information, personal story, and likeness / images have been obtained.*

Confidential and Proprietary



Meet Your Presenters



Christine Kayser

Christine Kayser
Manager, Healthcare Services
Molina Healthcare

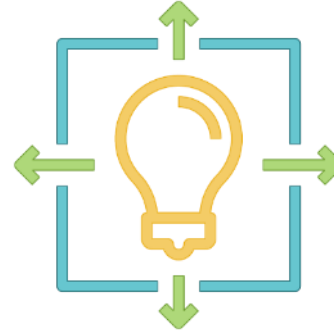


Jim Aberg

Jim Aberg
MAE Special Education
Retired IDD Provider
Still Working

Session Objectives

During this presentation, you will learn how one national health plan came together with numerous resources to deliver healthcare in a unique and individual way.



Sharing a team's approach → How we are using person centered planning and thinking outside the box



Considerations for resources for the person being supported and the team



Inspire and encourage others to source and implement similar strategies in their own organizations



What is Person-Centered Thinking?

A way to discover, describe and assure
the desired life of the person who is supported

A set of skills that result in teams keeping the focus
on the person who needs support – not agency or
turf issues

A deliberate method to see the whole person, and
not focus “fixing what is wrong”

Based on the core belief that
all people have gifts to share

Stimulates community hospitality

Challenges practices that
perpetuate controlling relationships

Grounded in respect for dignity and completeness
of each person

Takes clarity, courage, and commitment

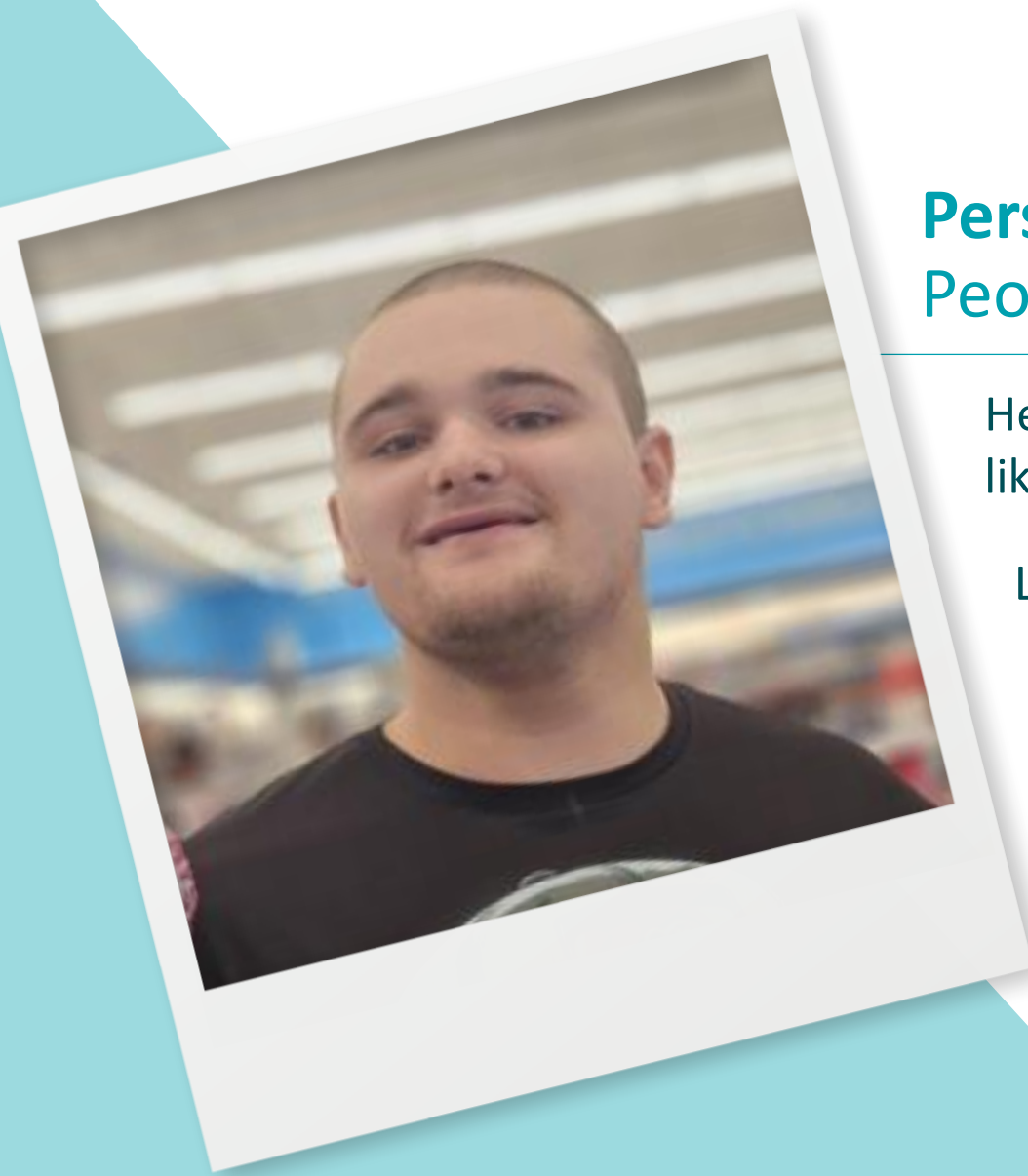
*The Learning Community for
Person Centered Practices





Partnership - preview

- **Why** we chose to work together
- **How** we choose to work together
 - Roles & responsibilities
- Determining **when** the right time was to partner
- **Who** was going to be involved
- **What** were we going to define as successful outcomes



Person-Centered Planning: People want a LIFE, not a plan

Help people to discover what **a meaningful life** looks like for them

Looks at **non-clinical areas** of a person's life

Involves what is **both important to and for** the person

Focuses on individual **life choices, dreams, and desires**



Meet Gabe from North Central Iowa

Gabe (currently 22) loves to go for walks and going out to eat (his favorite foods are meatballs and chips). Gabe is a morning person. **His goal** is learning life skills like grocery shopping. **His mom and dad's goal** is for him to live in his own home with supports.

Developmental Milestones



Gabe's Journey

→ The path to realizing traditional care doesn't meet everyone's needs & learning what Gabe needs → Gabe's needs continue to change

Moved to Host Home After Graduation

Away from family into a home with others he did not know.

Gabe tries Traditional Daily SCL Home

Supportive Community Living home closer to Dad & family but still with people he did not know. Gabe started having more aggressive outbursts

ISTART/ PPSS Referral

Gabe & his dad demanded something better and more individualized for him.

911 called & Gabe back in ER

Discharge planning seems impossible, under Doctor's advice is kept in the ER.

Hospitalized – Discharge home with Dad

Within 6 months, Gabe was hospitalized due to 2nd degree burn & infected bite from housemate

Gabe has to leave SCL home & sent to ER

Home emergently discharged Gabe to the ER after incident involving law enforcement

Gabe back home living with Dad

Identified a previous staff member that wanted to learn how to support Gabe differently. This is successful for a while.

Multiple people try to help

Gabe, his dad, Molina CM & Medical Director, IA state teams hold weekly to daily calls trying to find alternative level of care to meet Gabe's needs.

Audience Participation

Think about what irritates you or makes you uncomfortable.

Things Gabe was experiencing daily:

- Unfamiliar noises
- Lots of background noise
- Unfamiliar people
- Unfamiliar and not home like setting
- No one to talk to or socialize with



Gabe's Turning Point

- **Gabe's team** now consists of Gabe, Gabe's parents, sometimes a state person would join the call and Molina staff (care manager, supervisor and manager) and others that wanted to support him to be successful.
- As Gabe's team met, even when he was at the hospital, **we thought of different ideas** to try to have **potential providers see Gabe as a person** and not just what was on paper:
 - We took videos and started submitting them with referrals;
 - Gabe still on waitlist for the I-START/PPSS
 - We continued to be in touch;
 - Throughout the process we spoke with Gabe's dad often. As we made referrals he talked about what he wanted and his dreams for Gabe, such as to be able to live in his own home. He talked about wanting to buy a house for Gabe.
- We started thinking about how to create a **safe and comforting environment** that Gabe would feel most comfortable in rather than him fitting into a provider's opening in a house.

Gabe's Turning Point

- We knew that it would take a lot of support and guidance but **began the process to use Consumer Choices Option (CCO), Iowa's self-direction option**, to provide daily Supported Community Living (SCL) in a home that Gabe's dad was purchasing.
 - Gabe and his dad had not had a good experience with typical daily SCL providers. This would give them choice in who was hired and how they worked with Gabe.
- **Gabe's dad** runs his own business but **was not prepared for the oversight** it takes to hire through CCO, even though he was committed it was still a challenge for him.
 - The team agreed we need to keep working toward a long-term solution.
- **A new level of care assessment** completed at discharge which results in a higher tier which means a higher rate for providers if they would consider him.
- Assistance to increase success with the hiring process: The CM team **developed screener questions** to assist Gabe's family to weed out people who might not pass the background check or have difficulties in filling out the paperwork and for documentation to get paid and follow Medicaid rules.

Gabe's Turning Point

- **We continue to have conversations** with our state partners and request an exception to policy to allow for employees to start working with Gabe prior to the background check coming back with the stipulation that they won't get paid unless they pass the background check. This was approved.
- **We write a second exception to policy** for the daily rate for CCO to match SCL daily rate. Gabe's level of care is at the highest tier for level of care with a traditional provider. This exception was approved.
- Finally, **a skeleton crew of CCO employees are hired**. Gabe's family helps to fill in gaps where they can and try to train staff. The Molina team realizes this is a gap and something the PPSS team can help with.....but Gabe is still on the waiting list. We have additional conversations with PPSS and convince them to start doing at least some consultations.



What's going on with Gabe?

- Staff are new and some don't make it very long
- Gabe is new to his **own** home
- **Gabe is having meltdowns daily.** Triggers start to be identified.
 - iPad not being charged
 - Internet going out
 - Food
 - Lighting
 - Routine
- Both need training and education to make this work

The PPSS program sends support- Jim Aberg, (a previous IStart director) to support the team in working with Gabe!

I-START/PPSS (Provider Prevention and Support Services) becomes a big part of the team!

- I-START (Iowa START) Services utilizes the National Center for START Services to strengthen efficiencies and service outcomes for people with IDD and mental health needs in the community.
- PPSS (Provider Prevention and Support Service) PPSS promotes systemic, person-centered approaches and provides outreach, training/education, clinical and systemic consultation, crisis plan development, 24/7 crisis support and follow up.

- 1st 2 Meetings:** →
2 Hours
Intake Crisis Plan
- Weekly/Bi-weekly:** →
1 Hour
- Bi-weekly/monthly:** →
1 Hour
- Monthly:** →
30-minutes to 1 Hour
- Monthly:** →
30-minutes
- Bi-Monthly** →
Meeting
- Inactive** →



Preventative Interventions

- PPSS meets frequently with Gabe and the care team!
- Open lines of communication
- Identify missing members of the team
- Try, try, and try again, until we all get it right!
- Move from a reactive to a proactive approach to services
- Dedication and participation from everyone



Biopsychosocial Model Real Life Example

Question for audience:

What do you believe to truly lead to this person's decline?

BIO	PSYCHO	SOCIAL
Seizures	Depression	No friends
Side effects of meds	Anxiety	No job
Constipation	Coping difficulties	Lonely
UTI	Mild ID	Bored
COPD	Communication difficulties	Bullied
Obesity	No self-esteem	No family
Low D-3 levels		No hobbies
		Refuses all supports

“

“If I had an hour to solve a problem, I'd spend 55 minutes thinking about the problem and 5 minutes thinking about solutions.”

- *Albert Einstein*

”

Food for Thought

Interpretation:

You can not solve what you do not understand.
This is why many behavior intervention plans do not seem to make a difference.

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Quick Action Needed!

- **Immediate goal:** We needed to quickly figure out how to prevent Gabe's physical aggression and property damage incidents. This will help to keep Gabe and staff safe, not have to worry about police involvement, and keep him out of the behavioral health unit. This would also be a way to help with staff retention. This was the most important thing to accomplish quickly!
- Gabe had experienced possible trauma due to his experiences in two different Supported Living residences and spending two months in the ER and behavioral health unit. He was being chemically and physically restraints leading to trauma. He lacked coping skills, experienced anxiety, and had moderate to severe executive functioning limitations.
- On the plus side, Gabe is residing in his own home with no roommates.
- Goal to better understand who Gabe is including verbal, nonverbal communications, relationships, what motivates and what irritates him
- Team approach-connection with Molina's CM (Alexis), Jim (PPSS), Gabe, Gabe's family

Quick Action Needed!

Person Interviewed	Information Gathered
Gabe	Gabe is telling people what he wants
Father/Guardian	Dad loves and cares about Gabe very much and only wanted the best for Gabe. He bought Gabe his own home so he could reside without any roommates at this time.
Mother	Showed concern for Gabe and very supportive
Molina Community Based Case Manager	Case manager was very knowledgeable and really knew Gabe's case well. Provided the Person-Centered Plan for review.
Special Education Teacher	She provided insight about Gabe from when he was in school. It was obvious that she cared about him.
Stepsister	She provided insight on Gabe from growing up and from her perspective as a sibling about how best to work with him.
ISTART	Reviewed the Initial START Cross-System Crisis Prevention & Intervention Plan.
Direct Service Staff (CCO staff)	Talked with staff while they were at Gabe's home. Shadowed them as they were supporting him. Observed staff interactions with Gabe closely, and Gabe's response to the staff. Would ask staff questions when Gabe had some down time.

Quick Action Needed!



Did an internal and external inspection of Gabe's home. Maintained detailed notes of the safety within the home with needed accommodations and safety measures to protect Gabe and staff.

Jim then worked one to one with Gabe to get to know him better. Paid very close attention to Gabe's responses to me.

Jim would interview and debrief with staff after any behavioral incident. Would ask the question: What was the first sign Gabe was going to be upset? After that, Jim would ask about the behavioral progression until he was no longer upset? A pattern was emerging. It was very important to learn how to *prevent* the physical aggression and property damage.

Jim worked with Gabe when he has aggressive and displaying property damage. All the interviews with many people who know and care about Gabe helped with the answer.

Whenever Gabe would bang the table, wall, or a surface with his fist, if staff tried to talk to him, try to redirect him, or try to verbally calm him, it really made things far worse. It was too much for him. He would get very aggressive at these times.

The Plan in Action

- We worked to ensure Gabe's home was as free as possible of things to throw or break when he was upset.
- We made sure there was a clear and unobstructed path through the kitchen, into the garage from the kitchen, out of the garage, outside to the front porch, and back into his home.
- We made sure things were always put away in the kitchen, so, he could not throw them if upset. Instructed staff not to turn their back on Gabe, to walk sideways always looking towards him until you could not see him any longer.
- Taught staff to never turn your back to him. All of this was to help prevent someone falling and getting hurt, if walking away from Gabe, or if he was throwing something.
- When Gabe banged his fist on something, staff immediately stopped talking to him. NO MORE TALKING! WALK AWAY FROM HIM!

The Plan in Action

- Staff had a designed route to follow to stay away from him after he banged something with his fist. Staff would follow this route either through the front door or garage door, depending on where Gabe was in his home when he banged his fist. They would continue to do this until at what point it appeared he was okay, and staff felt they could try to approach him to reengage with him.
- Staff then would approach Gabe, put their fist up for a fist bump. If he would hit at the staff hand, staff would stay away from him. If Gabe would fist bump this, this meant he was okay now. Staff could then start to talk and interact with him.
- This plan worked well if staff followed the plan and did not talk to him until he was okay.

Significantly lowered use
of physical restraints,
chemical restraints,
and restrictions for Gabe

Next steps!

- Gabe had an order for a PRN medication for symptom management, yet it could be too difficult for him to take it if he has already banged his fist. We still needed to figure out what precursor behaviors he displayed which were an indicator he may bang his fist.
- Developed a documentation form, MAR, Service Documentation Checklist, and sleep chart for staff to complete.
- Developed an initial script of routines for staff to utilize when supporting Gabe. The script was from the time he woke up in the morning until he went to bed.
- Utilized the concept of: “Take what you can get closest to what you want” (Dr. Tom Pomeranz).

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“Time after time, I have found that when people are taken seriously, when they are respected, when their behavior is interpreted, understood and responded to accurately, when they are engaged in mutual dialogue rather than subjected to unilateral schemes of ‘behavior management,’ somehow as if miraculously, they become more ordinary. I know a number of people who have had severe reputations who have shed them when those supporting them listened more carefully.”

- Herb Lovett, Ph.D. | University of New Hampshire

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Just look at Gabe now!



Gabe experiences significant accomplishments

Staffing is
consistent!

Zero
ER visits!

Speech Therapy
approved for
speech device!

Gabe is starting to
say some words!

Team meetings with
family, PPSS, &
Molina have
decreased to
monthly!

Gabe is starting to **do**
more things in the
community besides
car rides and walks!

Regular connection
with telehealth
Psychiatry @
University of Iowa

Learning more
life skills like
brushing his
teeth & greeting
guests

No use of
chemical or
physical
restraints or
restrictions

Continues to
live **in his own**
home for over
2 years &
counting

Agreeing
to allow
blood
work to
be drawn



Next steps with Gabe Up and coming!

- Gabe is working to strengthen his independence & continue to grow his life skills:
 - Helping more with everyday tasks, dishes, & laundry
- Next healthcare steps:
 - Getting dental work done
 - Speech therapy and device learning
- Continuous education with family and staff
- Continue to listen to Gabe on what he wants for his life

Questions & Answers

Citations & Resources

- National Center for START Services® [National Center for START Services® | Institute on Disability](#)
- The Learning Community for Person Centered Practices [The Learning Community for Person Centered Practices | TLCPCP.com](#)
- Elevate CCBHC <https://elevateccbhc.org/>