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Institute for Healthcare Improvement

disability practice institute
Advancing Disability-Competent Care



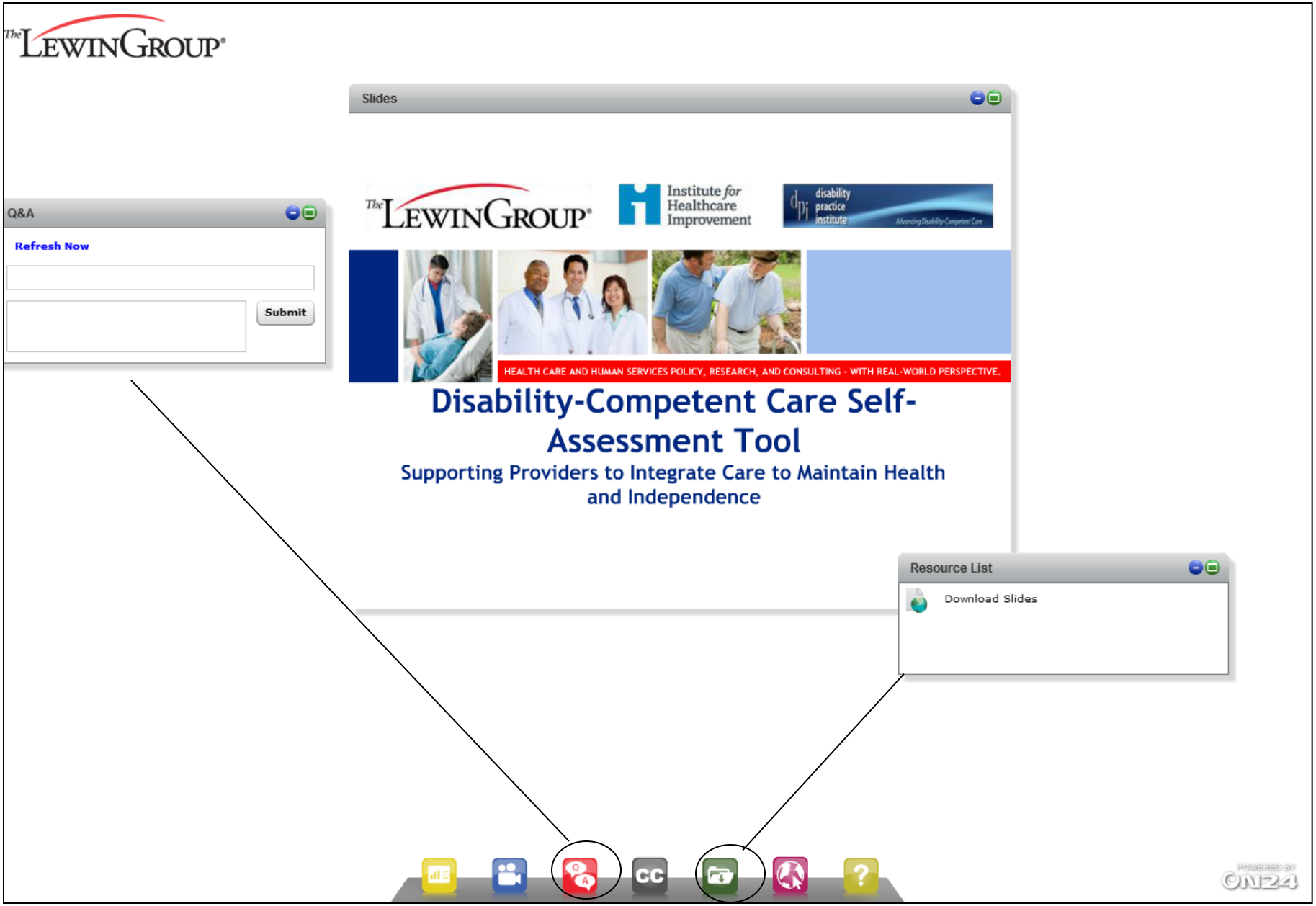
HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.

Disability-Competent Care Self-Assessment Tool

Supporting Providers to Integrate Care to Maintain Health and Independence

Presentation to Health Plan Staff

June 19th, 2013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HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.
Disability-Competent Care Self-Assessment Tool
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Webinar Agenda

- Purpose of today's Webinar
- Introductions
- Optional Resources:
  - The Disability-Competent Care Model
  - The Disability-Competent Care Self-Assessment Tool
- Answer audience questions about the Tool
- Invite recommendations on dissemination of the Tool and related resources

Purpose of Webinar

- Launch an optional resource for health plans seeking to integrate care for persons with disabilities

The Disability-Competent Care Self-Assessment Tool

http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DCCAssessmentTool.pdf

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Institute *for* Healthcare Improvement

Medicare-Medicaid Coordination Office,
Centers for Medicare & Medicaid Services

Introductions

Presenters

Rebecca Bills, MSW, LICSW - Medica Health Plan

Kerry Branick – CMS Medicare-Medicaid Coordination Office

June Isaacson Kailes - Disability Policy Consultant

Mary Kennedy - Association for Community Affiliated Plans

Rhondee Benjamin-Johnson, MD – The Lewin Group

Christopher Duff – Disability Practice Institute

Saranya Loehrer, MD – Institute for Healthcare Improvement

CMS Medicare-Medicaid Coordination Office (MMCO)

Established by Section 2602 of the Affordable Care Act

- Purpose: Improve quality, reduce costs, and improve the beneficiary experience.
  - Ensure Medicare-Medicaid enrollees have full **access** to the services to which they are entitled.
  - Improve the **coordination** between the federal government and states.
  - Develop **innovative** care coordination and integration models.
  - Eliminate financial **misalignments** that lead to poor quality and cost shifting.
- Demonstration, technical assistance and evaluation activities include:
  - Program Alignment Initiative
  - Access to Medicare data for Medicare-Medicaid enrollees
  - State Demonstrations to Integrate Care for Dual Eligible Individuals: Financial Alignment Initiative
  - Initiative to Reduce Avoidable Hospitalizations in Skilled Nursing Facilities

Association for Community Affiliated Plans

ACAP represents 58 Safety Net Health Plans with a combined enrollment of more than 10 million people.

- **A trusted authority** on publicly-sponsored coverage programs.
- **Advocates** for policies which support continuation and improvement of publicly-sponsored health coverage programs, particularly Medicaid managed care.
- **Supports** ACAP member plans' strategic and operational efforts to improve their quality, efficiency and competitiveness.

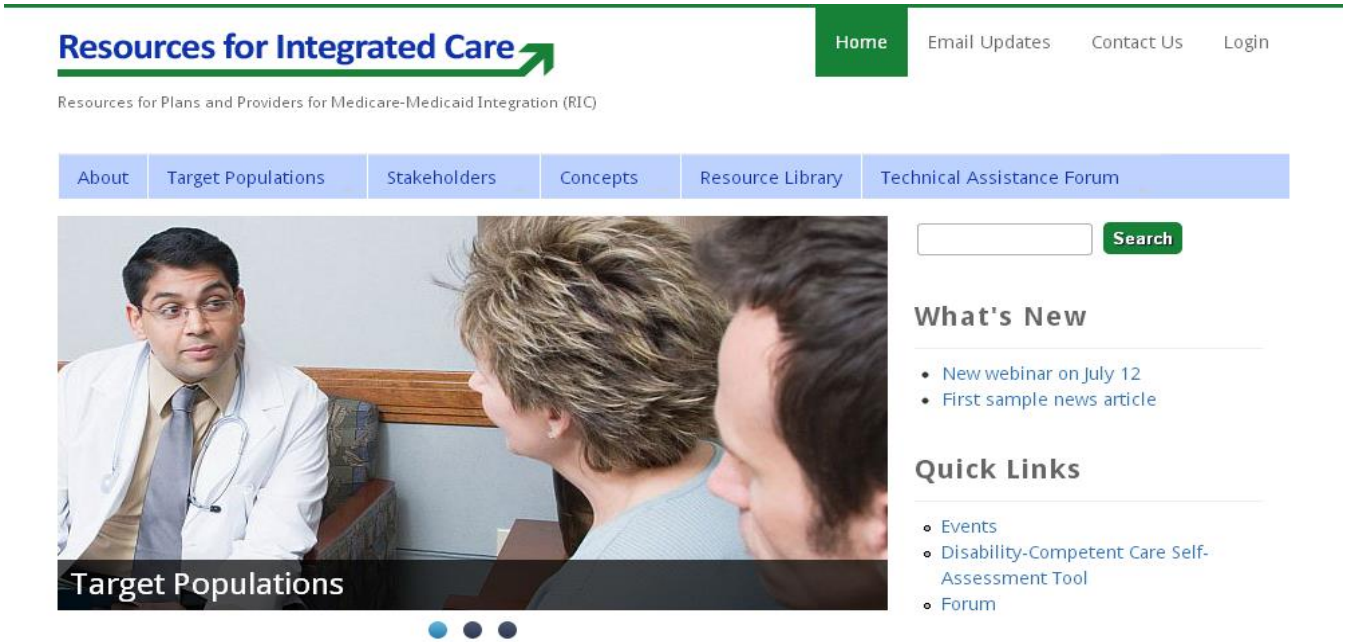
Technical Assistance (TA) to Providers to Integrate and Coordinate Care

- MMCO awarded a contract to Lewin and the Institute for Healthcare Improvement (IHI) to
  - Develop relevant and actionable TA resources and
  - Provide TA to selected provider organizations

- Providers include
  - Health plans
  - Home health agencies
  - Mental health centers
  - Primary care practices/groups
  - Hospitals

- We have targeted providers caring for adults with
  - Serious mental illness
  - Physical disabilities
  - Intellectual and developmental disabilities
  - Cognitive impairment and dementia

Technical Assistance (TA) Resources



Disability-Competent Care

Why is a New Approach to Care Needed?

- The prevalence of adults living with disabilities in the US is increasing
- Persons living with disabilities experience inadequate and fragmented care
  - Episode-based model of health care
  - Lack of patient engagement and participation
  - Limited health system infrastructure for coordination across multiple providers
  - Individual providers and system are not prepared to maintain function and achieve independence over time

Disability-competent care delivers care and supports for an individual's maximum function while addressing the barriers to timely and appropriate care

Disability-Competent Care Model: Origins

- Evolved out of 'lived' experience of persons with disabilities and three provider-led health plans working together for over 20 years
  - Commonwealth Care Alliance (Massachusetts)
  - Independence Care systems (New York)
  - Community Health Partnership (Wisconsin)

- Using Medicare and Medicaid funding and services, provider-led plans demonstrated fewer high cost, high acuity episodes (e.g., ER visits), increased member satisfaction and maintenance of independence in communities

- Model is applicable to providers caring for individuals with diverse needs and functional limitations

Disability-Competent Care Model: Costs and Benefits for Health Plans

Invest in:	Achieve:
▪ Staff training and development	Participant-centered care High-functioning care teams
▪ Primary care redesign	Personalized care Fewer high-acuity episodes

Disability-Competent Care Model: Key Features

Focus is on maximum function and independence

- Highly accessible and responsive primary care
- Interdisciplinary care team
- Participant-centered and relational care management
- Access to flexible, yet full range of long-term services and supports (LTSS)

June Isaacson Kailes, Disability Policy Consultant

Associate Director, Harris Family Center for Disability & Health Policy

- Contributing author to Disability-Competent Care Self-Assessment Tool
- Working with providers and health plans to design and improve health care delivery
- Bridging gap between lived experience of persons with disability as a user of the health care system

The Disability-Competent Care Self-Assessment Tool helps providers reduce barriers to care and meaningfully engage persons living with disability

Disability-Competent Care Model: Key Features

Highly accessible and responsive primary care

- Provided outside of traditional office settings
- Ensures timely and best practice care for conditions including urinary tract infections and upper respiratory infections
  - Prevents deterioration and secondary complications
- Nurse or Nurse Practitioner embedded in care team to deliver primary care ensures
  - Tight linkage to care planning across acute and long-term care services
  - More timely communication with general and specialty physicians

Disability-Competent Care Model: Key Features

Interdisciplinary Care Team

- Includes capacity for primary care and care coordination
- Core care team competencies are in behavioral health, nursing, and LTSS
- Team can access individual care plans and patient-level data at any time
- Implies team is trained to function as a unit: sharing and shifting roles over time

Disability-Competent Care Model: Key Features

Participant-centered and Relational Care Management

- Hinges on cultivating a relationship
- Views health broadly as optimal quality of life (e.g., housing, relationships, purpose, and community integration) and reaching one's goals and potential
- An individual's goals are the primary drivers of the care team's care processes and activities
- Has implications for staff training in
  - Motivational interviewing
  - Dignity of risk
  - Patient engagement and self-direction
  - Participant training in self-care and self-management

Disability-Competent Care Model: Key Features

Access to flexible, yet full range of long-term services and supports

- Involves identification of functional needs to prioritize and allocate resources
- May require investments in home modifications and resources (to prevent avoidable secondary complications or illness progression)
- Has implications for provider capacity to address requests for equipment and repairs in a timely manner
- Includes employment supports

The Disability-Competent Care Self-Assessment Tool

Why Develop a Self-Assessment Tool?

Support health plan providers to operationalize disability-competent care model with a framework and concrete actions

- Providers can use the Tool to:
  - Evaluate their present ability to meet the needs of adults with disabilities and
  - Identify opportunities for improvement and strategic allocation of resources

Disability-Competent Care Self-Assessment Tool: Iterative Development

- Drafted by Disability Practice Institute, Lewin, and IHI
- Content validity assessed by external experts
- Shared with three Medicare and Medicaid health plans to test face validity and ease of use (members of the SNP Alliance and the ACAP)

Disability-Competent Care Self-Assessment Tool: Structure

- Introduction to disability-competent care
- Three domains of care model
  1. Relational-based Care Management
  2. Highly Responsive Primary Care
  3. Comprehensive Long-term Care Services and Supports
- Each domain contains questions with corresponding descriptions and examples organized topically that enable a user to understand key processes
- Information on how to evaluate and interpret self-assessment results

Using the Tool

- Tool is intended for use by health plan or Health System (ACO) staff
- Typically completed by representatives from key functional areas (e.g., care management, network and provider development, outpatient utilization)
- Takes approximately two hours to complete
- Completed as a group or individually with opportunity to discuss results together

Tool Part 1: Self-Assessment

1. Relational-Based Care Management

Introduction | 1. Relational-Based Care Management | 2. Highly Responsive Primary Care | 3. Comprehensive Long-Term Care | Appendix A

Participant-centered care is based on the recognition that the participant is not merely a passive recipient of medical care but rather the primary source for defining care goals and needs. This type of care requires cultivating a relationship with the participant, seeing him or her as a whole person with hopes and preferences, and recognizing that the participant is oftentimes the best steward of resources. Inherent in participant-centered planning is also the concept of the dignity of risk [1] which honors and respects the participant's choices even if they are inconsistent with the recommendation of the IDT.

[1] Dignity of risk means the right of individuals to choose to take some risk in engaging in life experiences, even if that choice would not be one that a health professional would choose (e.g. choosing to smoke).

- 1.1 Participant-Centered Practice
- 1.2 Eliminating Medical and Institutional Bias
- 1.3. Interdisciplinary Care Team (ICT)
- 1.4. Assessment
- 1.5. Individualized Plan of Care
- 1.6. Individualized Plan of Care Oversight and Coordination
- 1.7 Transitions
- 1.8 Tailoring Services and Supports
- 1.9 Advance Directives
- 1.10 Allocation of Care Management and Services
- 1.11 Care Partners
- 1.12 Electronic Health Record

Domain

1 RELATIONAL-BASED CARE MANAGEMENT

Participant-centered care is based on the recognition that the participant is not merely a passive recipient of medical care, but rather the primary source for defining care goals and needs. This type of care requires cultivating a relationship with the participant, seeing him or her as a whole person with hopes and preferences, and recognizing that the participant is oftentimes the best steward of resources. Inherent in participant-centered planning of care goals and needs is also the concept of the dignity of risk, which honors and respects the participant's choices even if they are inconsistent with the recommendation of the Interdisciplinary Team (IDT).

Elements and Sub-elements

1.1. Participant-Centered Practice

The participant's choices, preferences, and goals provide a foundation for his or her individualized plan of care (IPC), while respecting his or her dignity of risk. A trusting and respectful relationship between the participant and his or her care team is necessary to ensure decisions remain participant-centered.

1.1.1	**Do participants play an active role in their own assessment and care planning?** Participants commonly need support and coaching about the assessment and care planning process. A preliminary "get to know you" meeting can help establish the relationship so that the subsequent meeting can focus on the full assessment and care plan development. This support may be provided by peers or other individuals who are familiar with the assessment and care planning process and understand how it may be daunting and overwhelming.
1.1.2	**Does the care management staff develop an individualized, professional relationship with the participant, showing respect for the participant's preferences and for the dignity of risk?** Developing this trusting relationship generally requires an initial face-to-face interaction and includes discussion of the participant's goals, values, and preferences for his or her care.
1.1.3	**Are participants (and families or caregivers) involved in program planning and implementation to ensure a participant-centered focus?** Health plans and systems that provide disability-competent care have multiple avenues to engage participants in care planning and to seek their perspectives and ideas. These

Question and Description Example 1.1.1

1.1.1 Do participants play an active role in their own assessment and care planning?

Participants commonly need support and coaching about the assessment and care planning process. A preliminary "get to know you" meeting can help establish the relationship so that the subsequent meeting can focus on the full assessment and care plan development. This support may be provided by peers or other individuals who are familiar with the assessment and care planning process and understand how it may be daunting and overwhelming.

Elements and Sub-elements

1.5. Individualized Plan of Care

The IPC is the guiding document that identifies all the care, services, and supports for each participant. It is a living document, referenced and revised over time, depending on the needs and goals of the participant.

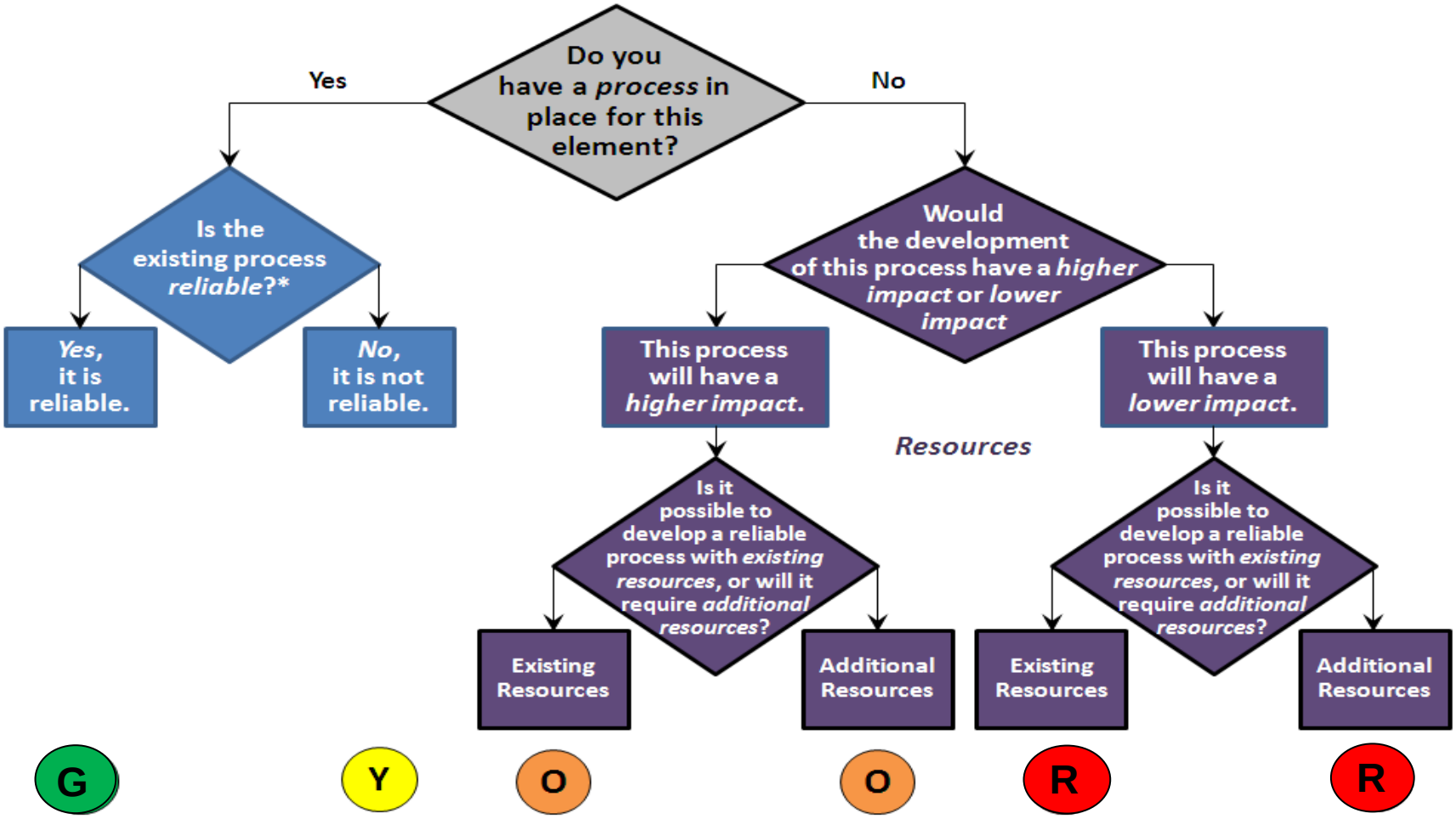
1.5.1	**Are the participant's care goals, action steps to meet those goals, and proposed interventions to overcome identified challenges documented in the IPC?** IDT members need to be trained in working with and guiding participants in identifying their personal goals — medical, social, or other (see 1.1.1 above).
1.5.2	**Does the IPC contain specific documentation on what care and support services are being provided, by whom, and by when?** Disability-competent organizations ensure that accountability and timeframes are built into the IPC and can serve as triggers for automated reminders to IDT members.
1.5.3	**Does the IPC contain documentation of all formal (paid) and informal (unpaid) care and supports needed?** A checklist of such formal and informal providers may include: primary and acute care, preventive care plans, behavioral (mental and chemical) health services, rehabilitation therapists, patient education, transportation, personal care, housing with support services, care requested/specified by specialist physicians, pre-employment training and employment supports, and other long-term support services.
	Do IDT members ensure that participants understand and feel empowered to accept, negotiate, modify, or appeal changes made to their IPC?

Question and Description Example 1.5.1

1.5.1 Are the participant's care goals, action steps to meet those goals, and proposed interventions to overcome identified challenges documented in the Individualized Plan of Care (IPC)?

Interdisciplinary Team (IDT) members need to be trained in working with and guiding participants in identifying their personal goals – medical, social, or other (see 1.1.1 above).

Evaluation Framework Linked to Organization Processes, Impact, and Resources



*Reliability is defined as a "failure-free operation over time." In health care, it is feasible to achieve 95% reliability for the majority of care-related processes. One simple way to assess reliability is to predict if five front-line individuals are able to accurately describe the process in the same way. If you are not confident that all five individuals are able to do so, evaluate this process as not reliable.

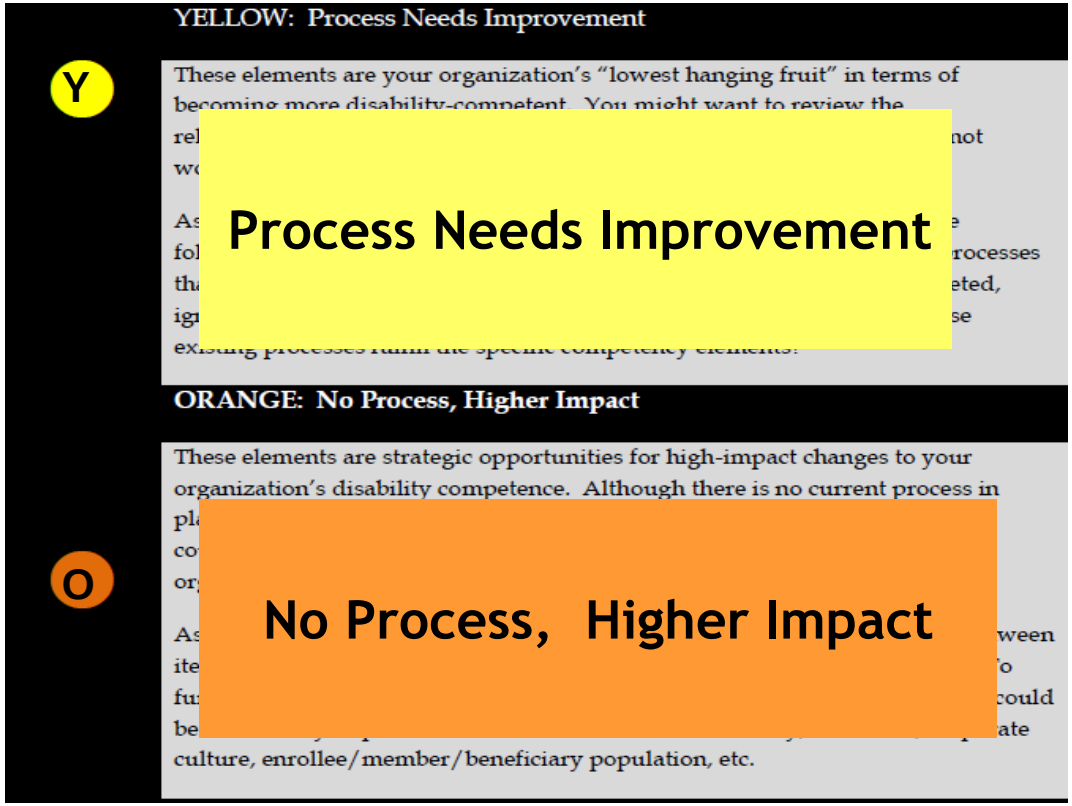
Electronic Evaluation Form

	A	B	C	D	E	F
1		Process	Reliable	Impact	Resources	Notes
2	**1. Relational-Based Care Management**					
3	**1.1 Participant-Centered Practice**					
4	1.1.1	Yes	Yes			
5	1.1.2	Yes	No			
6	1.1.3	No		Higher	Yes	
7	1.1.4	No		Lower	No	
8	1.1.5					
9	**1.2 Eliminating Medical and Institutional Bias**					
10	1.2.1					
11	1.2.2					
12	1.2.3					
13	1.2.4					
14	**1.3 Interdisciplinary Team**					
15	**1.3.1 Composition**					
16	1.3.1.1					
17	1.3.1.2					
18	1.3.1.3					
19	1.3.1.4					
20	1.3.1.5					
21	1.3.1.6					
22	1.3.1.7					
23	**1.3.2 Communications**					
24	1.3.2.1					

Interpreting Self-Assessment Results

ASSESSMENT CATEGORY	PROCESS	RELIABILITY	IMPACT	RESOURCES	Interpretation
G	Y	Yes	–	–	Reliable process for the element. No further action required.
Y	Y	No	–	–	There is a process for this element, but it is not yet reliable.
O	N	–	Higher	Yes	Could create a reliable process with existing resources and will have a higher impact on the population you serve.
O	N	–	Higher	No	Require additional resources to create a reliable process and will have a higher impact on the population you serve.
R	N	–	Lower	Yes	Could create a reliable process with existing resources but will have a lower impact on the population you serve.
R	N	–	Lower	No	Require additional resources to create a reliable process and would have a lower impact on the population you serve.

Interpreting Self-Assessment Results



Users can review their results for

- Individual questions or
- All questions within a topic (e.g., Participant-Centered Practice, Interdisciplinary Care Team)

Health Plan Feedback on Tool

- Health plans 'testing' Tool found it useful to understand areas where their care was optimal as well as areas for improvement
- Health plans 'testing' Tool, planned to :
  - Revisit primary care network accessibility
  - Address their internal processes and documentation regarding advanced directives
  - Tackle "low hanging fruit"

Rebecca Bills, Medica Health Plan

- Tool provided "validation" in what we are doing well
- Obtained new ideas to adopt within our organization
- Voluntary nature promoted honest assessment
- Identified areas for improvement:
  - ***Interdisciplinary care team approach.*** Could we redefine how this is done and further define expected documentation around it to take more credit for work that is being done through more "virtual" means?
  - ***Disability awareness of contracted providers.*** MN DHS provider and dental access survey required survey done in 2010 and 2012. How is this data being used to improve network/access?
  - ***Transportation.*** Additional work to identify unique transportation needs and challenges of the under 65 population with disabilities

Audience Questions

Tool Dissemination and Additional Resources

Spreading the Tool

- Our goal is to make Tool widely available to all interested health plans and other stakeholders
  - Free and voluntary
  - Paper and web-based versions (Hosted on CMS, Project websites)
  - Shared Tool with HHS staff
  - Upcoming webinars with disability advocates and State Medicaid staff

Sharing the Tool and Increasing Use

- How might we make the Tool widely accessible to health plan staff?
- How might we increase plans' use of the Tool?
- Are there other providers or stakeholders that may find the Tool or related resources helpful?

Companion Disability-Competent Care Resources

- Nine-part webinar training series on Disability-Competent Care model components featuring
  - Clinical examples and
  - Implementation advice from experienced providers and persons living with disability
- Focused Self-Assessment Tool for home care agency or primary care providers
- For more information regarding the Disability-Competent Care training series, please contact Jessie.Micholuk@Lewin.com

Audience Questions

Webinar Evaluation Survey

Thank You for Attending

- Disability-Competent Care Self-Assessment Tool available through a link on the MMCO website:

http://cms.gov/Medicare-Medicaid-Coordination/Medicare-MedicaidCoordination.html

- For more information contact:
  - Laura Dummit at Laura.dummit@lewin.com
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  - Christopher Duff at Cduff@disabilitypracticeinstitute.org
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- Slides and audio archive available after webcast