

Disability-Competent Care Learning Community Case Study:

Lessons in Enhancing Health Plan and Primary Care Coordination

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Introduction

This case study describes how a health plan, as part of a Disability-Competent Care Learning Community (DCCLC)¹, developed a co-visit model to support primary care providers in coordinating care for participants with disabilities. The health plan's work described in this case study, while still under development, contains lessons learned that may benefit other health plans.

Located in a large metropolitan area, the case study plan has offered a Medicaid managed long-term care plan for over ten years, and was just initiating a capitated Medicare-Medicaid Plan (MMP) through CMS' Financial Alignment Initiative at the time of the DCCLC. The case study focuses on the efforts of the plan to provide services under its MMP, which includes over 4,000 providers. The Disability-Competent Care Self-Assessment Tool (DCCAT)² was used by the plan at the launch of the learning community to evaluate its ability to meet the needs of adults with functional limitations and to identify strategic opportunities for improvement.

Taking the DCCAT

The plan's assessment team was organized by the Chief Operating Officer, and included the Vice President of Care Management, Medical Director, Care Coordination Manager, and a representative from the participant advisory council.³ After taking the self-assessment, the DCCAT results indicated they were performing well in many aspects of disability-competent care and had well-developed multi-disciplinary teams – generally referred to as a care team. The results did however indicate the need to integrate primary care providers into their care teams.

Developing an Improvement Plan

Based on a review of the DCCAT results, the health plan assessment team recommended that the organization focus its improvement efforts on ensuring that each participant has an Individualized Care Plan (ICP). The ICP is an integrated plan that includes the active participation of the plan participant, the health plan care manager, and the primary care provider. The health plan assessment team used a four-step approach to develop and implement its improvement plan.

- 1. Allocate Resources and Assign Responsibility:** this required buy-in from leadership and the alignment of the improvement plan with the strategic priorities of the organization. The plan's strategic priorities included ensuring that the needs of those with disabilities are identified and met.

To ensure sufficient resources were in place, the health plan Chief Operating Officer assigned the Vice President for Care Management to lead the effort. The Vice President for Care Management took responsibility for forming the improvement team, guiding the development and implementation of the improvement plan, and identifying how to measure the impact of the work.

¹ The Disability-Competent Care Learning Community (DCCLC) includes health plans that, supported by national experts in disability-competent care and in improvement science, take steps to close disability related service delivery gaps based on the results of an organizational self-assessment.

² [The DCCAT tool \(https://www.resourcesforintegratedcare.com/DCC_Self-Assessment_Tool\)](https://www.resourcesforintegratedcare.com/DCC_Self-Assessment_Tool)

³ [See Tip Sheet on Completing the Disability-Competent Care Self-Assessment Tool \(https://resourcesforintegratedcare.com/DCC_Self-Assessment_Tool\)](https://resourcesforintegratedcare.com/DCC_Self-Assessment_Tool)

- 2. Form an Improvement Team:** the team included those responsible for, and involved in, providing care and services related to the creation and management of the ICP, as well as plan participants themselves.

The Vice President for Care Management allocated staff to participate in the improvement team. Team members included the Care Coordination Manager, care managers, care coordinators, a data analyst, and a plan participant. Staff were selected based on knowledge of the care process, availability, and interest. The Care Coordination Manager provided day-to-day guidance for the improvement team.

The team created a work plan to assign tasks, ensure process changes were tested and refined, and track results through a team progress report. As the team began addressing new topics, other stakeholders were engaged in the process for subject matter expertise, including a primary care clinic leader, a primary care provider, and a clinic manager.

- 3. Set Short- and Long-Term Aims:** the improvement team, in consultation with the Chief Operating Officer, set clear and measurable aims for the improvement effort. Aims were later used as a framework to identify and map potential solutions.

The plan's short-term aims were to within the next six months: 1) engage at least 10 of its participants who receive primary care at a designated clinic in creating an ICP with the plan care manager and their primary care provider; and 2) assess the experience of participants and multi-disciplinary team members in the development and application of the ICPs.

The plan's long-term aims were to within the next 18 months: 1) create and sustain an ICP for each member that reflects their preferences; 2) incorporate medical care, long-term services and supports, and behavioral health needs where appropriate in each ICP; and 3) improve the quality of the participant experience in their care. Long-term aims were to be tracked and assessed annually with targets revised based on performance. While the health plan's improvement work is still underway, it expects to see a decrease in emergency department and hospital utilization, as well as improvements in the quality of the participants' experience of care.

- 4. Identify Solutions:** based on the DCCAT results the improvement team identified and tested solutions that would achieve their stated aims.

After an analysis of its current members' primary care relationships, it became evident that the majority of the plan's primary care providers were in small community-based clinics with low numbers of participants in each. This dispersed provider network made communication and coordination between the plan, participants, and primary care providers especially challenging. Based on its analysis, the improvement team decided to address these challenges by working with a single clinic network. It chose a small community-based clinic that provided primary care to one of its larger participant pools. This allowed the team to develop a single communication and coordination strategy that could easily be refined for clinics serving other participant subsets. The plan and clinic network leaders identified a primary care provider in the clinic who was enthusiastic about improving coordination and communication. The primary care provider and clinic nurse manager joined the expanded improvement team to collectively develop and implement a better model of care.

The expanded improvement team set out to address the challenge of involving primary care providers in the co-creation of an ICP. In assessing current practice, they found the health plan care manager was completing the nursing assessment and discussing the findings with the participant. The care manager and the participant would then create a care plan that included the participant's goals, questions, and concerns. Next, the care manager would include this information on the participant's medical record so it would be available to the primary care provider. However, on the day of the primary care visit, the participant's questions and concerns were not fully addressed.

The team's solution was to develop a care manager-supported primary care visit model (co-visit). The co-visit model required a care manager to attend the primary care visit with the participant. The co-visit is only used when the care manager and participant have jointly agreed that it would be beneficial. The outcome of the co-visit is the creation of the ICP, an integrated care plan that incorporates the needs and preferences of the participant, information and recommendations from the care manager, and the clinical assessment and treatment regimen developed by the primary care provider.

Testing and Refining the Improvement Plan

The plan trained its care managers in the skills needed for successful co-visits, such as engaging and preparing the participants, communicating the purpose of the visit to the primary care practitioner, and assisting participants during the visit. This also included the use of the SBAR Communication Tool (Situation, Background, Assessment and Recommendation), to make efficient use of the provider's time.⁴

Following the training, each care manager applied the skills with one participant and one primary care provider. In reviewing these visits, the team found that not all care managers were comfortable using the communication skills in the visits. Meanwhile, the primary care providers reported they did not receive sufficient information to assist the health plan and participant in co-creating the ICP. A dedicated care manager was appointed to focus on developing and testing the co-visit model to better support the needs of the primary care providers and participants.

Testing the co-visit model highlighted the need for improved communication prior to the visit between the primary care providers, clinic nurse managers and the health plan care manager regarding the purpose of the visit. Other improvements included ensuring that the assessment and discussion details were included in the medical record, preparing the participant to actively engage in the visit, and reviewing the ICP with all parties.

Outcomes

Early feedback from the care manager, participants, and the primary care providers has been positive. The process has resulted in better communication of participant needs, improved participant engagement in the development of their care plan, and demonstrated the value that the co-visit can bring to both participants and primary care providers.

⁴ Originally developed by the United States Navy as a communication technique on nuclear submarines, SBAR has been adopted around the world as a simple yet effective way to standardize communication between caregivers. More information can be found at the following website: <http://www.saferhealthcare.com/sbar/what-is-sbar/>

Lessons Learned

Lesson learned from the development and deployment of the co-visit model:

- Form a broad-based health plan assessment team. The DCCAT can be used most effectively to identify areas of strength and opportunities to improve care for persons with disabilities when leaders and staff at all levels of the organization, as well as plan participants, are involved in taking the self-assessment and contributing to the discussion of results.
- Align potential areas of focus for improvement efforts with the strategic priorities of the plan. Plan leaders selected the creation and use of an ICP for all participants as their improvement effort. This effort was easily tied into the plan's ongoing strategic priority to ensure that the needs of members with disabilities are identified and met.
- Assign clear responsibility and accountability for the improvement effort(s). Health plan leadership led the efforts to complete and analyze the DCCAT, selected the area of focus (primary care coordination), assigned responsibility for the improvement team, and met regularly with the team to provide guidance and support.
- Develop a comprehensive improvement plan. The health plan's improvement plan included short and long-term aims, measures to track progress, and steps to test and refine potential solutions.
- Strategically partner with key stakeholders. After analyzing the participant utilization patterns, the leaders of a small network of primary care clinics were included in the development of their improvement plan. Primary care providers and clinic staff participated in the design and testing of the co-visit model.
- Focus on learning and make adjustments along the way. The health plan learned from the early application of the improvement plan, and decided to further develop the intervention with a dedicated care manager. Their experience will enable them to eventually bring more care managers back into the process.

Ongoing Initiatives

The improvement team and plan leaders continue to develop the co-visit model with the dedicated care manager in partnership with the primary care clinic. The team plans to address several topics in the coming months which include the following:

- Develop criteria to identify participants who would benefit most from the co-visit model
- Build participants' confidence in managing their own care and their relationship with their primary care provider
- Identify the amount and type of information needed by the primary care provider prior to the co-visit, and
- Assess the number of co-visits a single care manager can attend.

Once the team determines how many care managers are needed to bring the co-visit model to other clinics, the plan will begin re-training current care managers and hiring additional care managers as needed. The health plan's goal is for all participants to have an ICP that reflects their needs and preferences. The health plan and the improvement team will track data on utilization and participant experience of care to determine if additional interventions are needed to meet its long-term aims.