Tip Sheet on Completing the Disability-Competent Care Self-Assessment Tool

November 2015

Institute *for* Healthcare Improvement

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The Disability-Competent Care Self-Assessment Tool (DCCAT) was developed to help health plans evaluate their current ability to meet the needs of adults with functional limitations and to identify strategic opportunities for improvement. This tip sheet is intended for health plan leaders and providers who are responsible for organizing and coordinating the completion of the DCCAT. The DCCAT can be found on the Resources for Integrated Care website (https://www.resourcesforintegratedcare.com/dcc-self-assessment.)

The tool contains a description of each of the three pillars of disability-competent care (Relational-Based Care Management, Highly Responsive Primary Care, and Comprehensive Long-Term Services and Supports), self-assessment questions for each component, and an interpretive guide for analyzing the results. Tips identified throughout this document are based on the experiences of the first Disability-Competent Care Learning Community.[1] Leaning Community team members who took the self-assessment used the results to identify areas of focus to improve care for participants with disabilities.

Preparing for the Self-Assessment

This phase requires obtaining leadership sponsorship, identifying the assessment team, and preparing the team to conduct the assessment.

1. Engage Executive and Senior Leadership

Executive and department level leaders are responsible for assessing the level of disability-competent care and taking action to address identified gaps. To begin, leaders should identify a well-rounded team that represents key stakeholders. Overarching process guidance should be provided, as well as clear expectations regarding timeline, intent, and scope.

2. Define the Scope of the Self-Assessment

Many plans offer a wide array of products and services for their participants. Deciding on the scope of the self-assessment is an important first step for leaders. Defining the scope will inform the creation and inclusion of team members to involve in the self-assessment. Plans using the self-assessment tool for the first time are encouraged to apply it broadly to all program areas. The results can then serve as a baseline for short-term and long-term planning.

[1] The Disability-Competent Care Learning Community (DCCLC) is a national initiative funded by the CMS Medicare Medicaid Coordination Office (MMCO) through a contract with The Lewin Group. The DCCLC was designed and delivered by the Institute for Healthcare Improvement (IHI). The DCCLC includes eight health plans that, supported by national experts in disability-competent care and in improvement science, completed the DCCAT and are taking steps to begin to close service delivery gaps based on the results of their self-assessment.

3. Assemble a Team to Complete the Self-Assessment

The team taking the self-assessment should include an executive leader or sponsor (someone responsible for program design or strategic planning), managers and direct service providers, and ideally a plan participant, family member, or caregiver. Other staff can be engaged for specific input in the self-assessment process.

While leaders set the agenda for change, it is important to involve staff who know the functions firsthand, as well as how reliably these services are provided to participants. Involving direct service providers, such as care coordinators and their managers, in completing the self-assessment not only provides more accurate information, but also sends the message to other staff in the organization that leaders are serious about identifying and addressing gaps in services or care.

Inviting external providers and participants to complete the self-assessment, obtaining feedback from already established participant or stakeholder advisory councils, and conducting participant focus groups are all effective methods for obtaining information from participants about the current levels of disability-competent care.

The specific individuals to be included in the self-assessment team will differ among organizations depending on the size, type of services, programs offered by the plan, and its organizational structure. Some examples include:

- For a large multi-payer plan (e.g., multi-state or regional plan): Senior Strategic Initiatives Analyst, Vice President of Program Services, Medical Director, Clinical Manager, Care Coordination Manager, Care Coordinator, and a representative from the plan's participant advisory council.
- For a local health plan (e.g., state, county or metropolitan area plan): Chief Operating Officer, Vice President Care Management, Medical Director, Care Coordination Manager, and a representative from the plan's participant advisory council.

Expected timeframe: This phase may take from two to four months to complete depending on the size and complexity of the organization and its leadership structure.

Taking the Self-Assessment

This phase involves conducting the assessment, consolidating and discussing results, and sharing findings within the larger organization.

1. Have Each Team Member Complete the Self-Assessment Individually

It is often best to have each team member complete the self-assessment individually. This allows everyone an opportunity to consider their own experience and knowledge independently before hearing from others. Alternatively different sections can be completed by different members of the team, and the results compiled and reviewed afterwards.

2. *Synthesize Input from the Self-Assessment Team*

If possible, everyone who has taken the self-assessment should be brought together to clarify and deepen the team's understanding of the results. The desired outcome is an honest and thorough assessment of the current system so opportunities for improvement can be identified. The discussion accompanying the team's review of responses is often enlightening and creates a rich picture of the health plan's current performance. For example, leaders and staff from one program area may not have a full understanding of the services provided in other programs. The experience of plan participants offers an especially valuable perspective on the potential gaps in care or service delivery.

The entire team, or selected team members, then synthesize the discussion and make recommendations to plan leadership for setting priorities and plans for action.

Expected timeframe: This phase may take from two to three months to complete in order to fully discuss and synthesize the results

Developing and Implementing an Improvement Plan

This phase involves identifying and prioritizing areas for improvement, developing a plan, organizing an improvement team, gathering pre-intervention data, completing the intervention, and then refining the intervention and applying it to a larger scale.

1. *Align the Selected Focus Area with the Strategic Priorities of the Health Plan*

A selected area of focus may be within an entire domain as described in the DCCAT (e.g., Relational-Based Care Management, Highly Responsive Primary Care, or Comprehensive Long-Term Services and Supports) or may include a specific area within a particular domain, such as building primary care network capacity. Health plan leaders should consider the strategic priorities of the plan in selecting an area of focus for building disability competence.

For example, participating in demonstration programs for Medicare-Medicaid enrollees often means that health plans need to develop or expand their programs and services to meet the needs of large numbers of participants with complex needs, including functional and physical limitations. Identifying elements from the self-assessment can help address the needs of the population and enhance the ability of the plan to successfully complete the requirements of the demonstration initiatives.

2. *Consider a Sequence of Initiatives*

The self-assessment process may identify multiple opportunities for improvement. Health plan leaders may find it difficult to choose a single area of focus. One strategy is to compile a list of all potential topics and categorize them into buckets based on area of focus and resource intensity. The improvement team can then prioritize the list using a number of criteria such as beginning with a topic where there is the greatest need for improvement, one where there is a lot of passion or will, or one

where improvements can be accomplished relatively quickly. The team can then create a timeline for expanding the work to include additional topics in the future.

For example, a plan may decide to focus on increasing the number of participants with documented advance directives because it is an important part of their participant assessment process and can be accomplished relatively quickly. The plan will then be able to build on this initial effort by focusing on other more complex issues, such as care coordination or integrating long-term services and supports.

3. *Leverage Motivation and Will*

The self-assessment process will likely identify areas that have been of long-standing interest to staff members, stakeholders, or participants, as well as surface new issues previously not discussed or considered. Identifying areas of synergy between the elements of the self-assessment and where the passion for change resides within the organization or among other stakeholders can serve as a solid foundation for prioritizing goals and creating a workplan. For example, input from a stakeholder or participant advisory council may spark new or renewed commitment for addressing a particular gap in services.

Motivation and will can also be enhanced through communication. Communicating the results of the survey to a broad group of staff and leaders and creating an agenda for change should be part of the improvement plan. Sharing participant and staff stories captured during the self-assessment process about how current services impact the lives of plan participants is an excellent communication strategy to galvanize energy and commitment to the improvement work.

4. *Create a Plan and Carry Out the Improvement Work*

Once the results of the self-assessment have been synthesized and an area of focus selected, plan leaders create an action plan to close the identified gaps in services. Recommended steps in the action plan include:[2]

Allocate Resources, Assign Responsibility and Establish Accountability

Plan leaders need to ensure there is dedicated staff time to design and deliver process changes. Additional organizational resources may be required, including information systems, communications, member relations, and process improvement support. Designating someone at the senior leadership level to provide overall guidance and who is accountable to the plan leaders for the results is a foundational element for a successful improvement effort.

Form an Improvement Team

[2] More detailed information about how improvement teams organize and carry out their work can be found on the IHI Website at: http://www.ihi.org/Topics/ImprovementCapability/Pages/GettingStarted.aspx

The senior leader responsible for the effort forms a team that includes the staff and stakeholders involved in the selected area of focus. The team is led by a manager or program leader who serves as the day-to-day leader to coordinate and manage the work of the team.

For example, a team that is working to improve coordination with primary care might include health plan senior leaders, the day-to-day team leader, care managers and coordinators, as well as community partners (including plan participants, primary care clinic leaders and providers, clinic managers, and other stakeholders as appropriate).

Set an Aim

An effective aim for improvement includes a statement of what the organization intends to accomplish within a specific timeframe (e.g., how much improvement by when). The following is a sample aim for a plan that is working on improved coordination with primary care:

Our short-term aim is within the next six months, at least 10 of the plan's participants with disabilities who receive primary care at a designated clinic, will have a co-created person-centered service plan (PCSP) that reflects member preferences and incorporates medical care, long term services and supports, and behavioral health where appropriate. We expect that the creation and use of PCSPs in this targeted group of participants will:

- *increase the number of selected participants with PCSPs from the current level of 2 to a total of 10; and*
- *result in 90 percent of participants, plan staff, and primary care providers (participating in the testing) responding each month to a survey question: The process of co-creating a PCSP is working well.*

Our long-term aim is over the next two years to ensure 100 percent of participants with disabilities will have a co-created PCSP that reflects their preferences and incorporates medical care, long-term services and supports, and behavioral health where appropriate. We expect the creation and use of PCSPs will:

- *reduce unnecessary emergency department visits by our participants with disabilities by 40 percent and avoidable hospitalizations by 50 percent; and*
- *increase the percent of participants reporting (e.g., on a patient experience survey) that their needs and preferences are being met by the health plan by 20 percent.*

Establish a Measurement System

Health plan measures will track the progress made in reaching the goals outlined in their aim statement. Generally measurement criteria should be quantitatively based, easily definable and clearly mapped to aim statement objectives.

Measures for the short-term aim given above are:

- *Number of participants each month with a co-created PCSP in their record;*
- *Percent of participants, plan staff, and primary care providers (participating in the testing) responding each month to a survey question: The process of co-creating a PCSP is working well.*

Measures for the long-term aim given above are:

- *Emergency Department and hospital utilization rates for participants with disabilities (reported monthly);*
- *Number of participants with disabilities with a co-created PSCP in their record (reported monthly);*
- *Percent of participants with disabilities responding to a survey question: My needs and preferences are being met by the health plan (reported monthly).*

Testing and Refining the New Process

The team begins by deepening its understanding of how participant care plans are currently created and the extent of participant, health plan staff, and primary care provider coordination. A number of methods can be used to do this including: collecting and analyzing data, creating a flow diagram of the steps in the process, and gathering information from participants about their experience through interviews or observation. The team then identifies a number of process changes that will help the plan reach their goal. They begin by carrying out small tests (e.g., with one participant and one care coordination and primary care provider) and then gradually expanding the number and scope of the changes based on the results of the testing (as shown by the measures).

Leaders continue to provide oversight and guidance throughout the process, ensuring the team has the resources and support needed to achieve improvement in service delivery for plan participants.

Expected timeframe: Creating a plan, organizing, and beginning the improvement work may take two to six months to complete. Another three to six months are often needed to refine the work and apply the new processes throughout the organization.