Promising Practices for Promoting Person-Centered Communication and Care Coordination

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Platform Tips

September 13, 2023

Promising Practices for Promoting Person-Centered Communication and Care Coordination



Overview

- This session will include presentations, followed by a panel discussion and live Q&A with panelists and participants

- Video replay and slide presentation are available after each session at https://www.resourcesforintegratedcare.com

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.
- To learn more about current efforts and resources:
  - Visit **https://www.resourcesforintegratedcare.com**
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Webinar Outline

- Introductions
- Learning Objectives
- Polls
- Background
- Speaker Presentations
  - My Choice Wisconsin (MCW)’s Approach to Care Coordination: Learning and Improvement in Action
  - Care Coordination & Communication: Inland Empire Health Plan (IEHP)’s Approach to Language Access
- Panel Discussion
- Audience Q&A
- Closing Remarks

Introductions

- **Kim Kunz**

  Director of Care Management Health Plan Programs, MCW

- **Karla Argandoña**

  Senior Analyst, IEHP

Learning Objectives

- Understand and implement actionable strategies for member outreach and engagement
- Identify approaches to structuring interdisciplinary care team communication and information sharing to promote care coordination
- Recognize strategies for facilitating continued member engagement during transitions of care

Poll

- In what care setting do you work?
  - Health Plan
  - Ambulatory Care Setting
  - Long-Term Care Facility
  - Home Care Agency
  - Community-Based Organization
  - Consumer Organization
  - Academic / Research
  - Other

Poll

- Which of the following best describes your professional area?
  - Health Plan Case Manager / Care Coordinator
  - Health Plan Customer Service
  - Health Plan Administration / Management
  - Medicine / Nursing / Physician Assistant / Other Provider
  - Pharmacy
  - Social Work
  - Advocacy
  - Other

Poll

- How familiar are you with communication-focused strategies to promote care coordination for dually eligible beneficiaries (e.g., supporting interdisciplinary care teams (IDTs), information exchange, hiring or contracting translation services)?
  - Very Familiar
  - Somewhat Familiar
  - Not Familiar

Background

Dually Eligible Beneficiaries Have Complex Care Coordination Needs

- Dually eligible beneficiaries:
  - Have a higher prevalence of complex health conditions and unmet social needs than their Medicare-only or Medicaid-only peers[1]
  - Are at high risk of fragmented care due to navigating multiple settings, care providers, and different coverage policies between Medicare and Medicaid[2,3]
- Care coordination for dually eligible beneficiaries refers to:
  - Managing care transitions
  - Coordinating benefits across the Medicare and Medicaid programs
  - Ensuring social needs are addressed

The Role of Communication Accessibility in Care Coordination

- Health plans and providers of dually eligible beneficiaries must meet communication accommodations aligned with federal regulations.[4]
- Communication accommodations include providing accessible formats tied directly to care coordination activities, such as health risk assessments and care plans.[5]
- Communication and language barriers are associated with decreased quality of care and poor clinical outcomes in the general Medicare population.[6]
- Dually eligible beneficiaries:
  - Are more likely to need communication accommodation relative to individuals only eligible for Medicare[7]
  - Represent 21 percent of the total population enrolled in Medicare or Medicaid with Limited English Proficiency (LEP)[8,9]

Resources for Integrated Care (RIC): Care Coordination Integrated Care Community of Practice (ICCoP)

- RIC hosted a care coordination learning community, the ICCoP, which:
  - Consisted of approximately 20 health plans serving dually eligible beneficiaries;
  - Included health plans serving diverse populations across the United States; and
  - Explored a range of care coordination topics, including communication-focused strategies for engaging hard-to-reach members and supporting seamless care transitions.
- Findings: Health plans participating in the ICCoP identified strategies to enhance care coordination and communication, including:
  - Increasing interdepartmental communication within health plans;
  - Developing dedicated teams to conduct member outreach or respond to member inquiries through multiple modalities (e.g., texting campaigns, expanding outreach to members during the evenings, use of personal assistance lines); and
  - Fostering community and health system partnerships to:
    - Promote member engagement and facilitate member access to community resources;
    - Support identification of member communication preferences and up-to-date contact information; and
    - Improve care transitions.

My Choice Wisconsin's Approach to Care Coordination: Learning and Improvement in Action

Kim Kunz

Director of Care Management Health Plan Programs

my choice WISCONSIN

My Choice Wisconsin (MCW)

- MCW is a managed care organization that serves government-funded programs to seniors and adults with disabilities in over 50 Wisconsin counties; programs include Family Care Partnership, Family Care, Medicaid Supplemental Security Income (SSI), and Medicare Dual Advantage.
- MCW offers two plans for dually eligible beneficiaries:
  - Fully integrated dual eligible special needs plan (FIDE-SNP):
    - Integrates Medicare and Medicaid acute and primary health, long-term care, and waiver services through a Medicaid contract with the Wisconsin Department of Health Services
    - IDT includes case manager and registered nurse (RN), and others engage as needed (e.g., nurse practitioners, dieticians, and behavioral health providers)
  - Coordination-only dual eligible special needs plan (CO D-SNP):
    - Enrolls full benefit dually eligible beneficiaries and provides Medicare acute and primary health services while coordinating care across the continuum through collaboration with Medicaid providers; includes additional supplemental benefits
    - Members are assigned a care coordinator; RN and others are engaged as needed

Plan Demographics

- Total dually eligible member population:
  - 1,400 members in the FIDE-SNP
  - 800 members in the CO D-SNP

Dually eligible member characteristic	Population Percentage
Female vs Male	64% vs 36%
Age: 18-64, 65-81, 82-100 years	39%, 40%, 21%
Race/Ethnicity: White/Caucasian African American Unknown/Other	 76% 12% 12%
Language: English, Spanish, Unknown/Other	93%, 2%, 5%

- Beneficiaries who enroll in MCW's Dual Advantage program (the CO D-SNP) are often also enrolled in the Family Care (58 percent) or SSI (20 percent) programs within MCW to ensure they receive comprehensive services through these FIDE-SNP plans.

MCW Care Coordination, Communication Challenges, and Strategies to Meet Population Needs

- Common challenges in providing care coordination for dually eligible beneficiaries include:
  - Complex care needs of beneficiaries characterized by multimorbidity, mental health conditions, and social deprivation
  - Limited health literacy
  - Workforce shortages and fluctuations in enrollment and case load sizes
  - Barriers to accessing up-to-date member information
- MCW's strategies to meeting dually eligible beneficiaries' care coordination and communication needs include:
  1. Building capacity within matrixed IDTs
  2. Leveraging health information exchange (HIE) and community care plans (CCPs) to support coordination
  3. Implementing initiatives to address health literacy and cultural competence

Strategy 1: Building capacity within matrixed IDTs

MCW IDT Composition and Activities

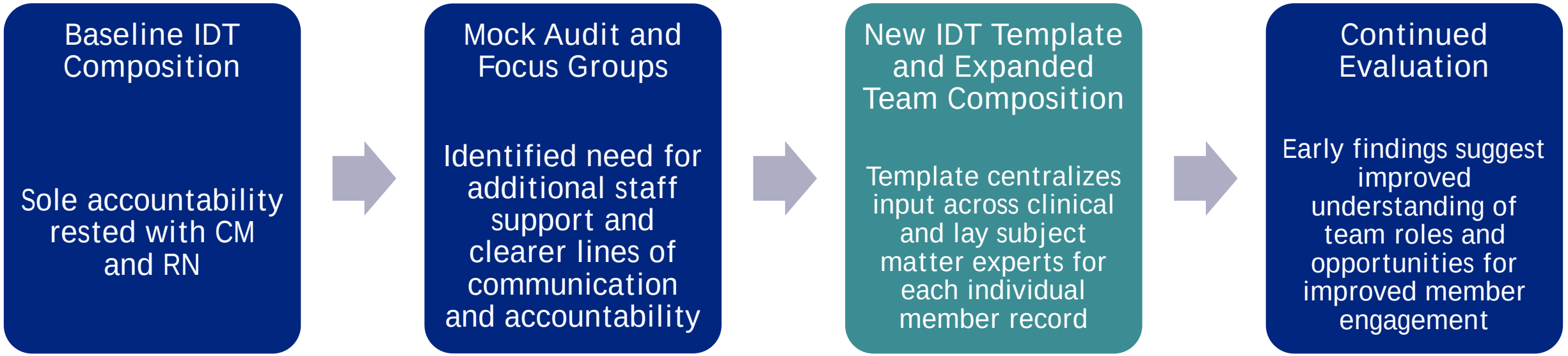
- MCW's IDT composition includes:
  - Case Manager (CM) and RN
  - Subject matter experts – including nurse practitioners (NPs), physician assistants (PAs), and pharmacists – who are consulted to partner and care for beneficiaries with complex needs
- IDT care coordination activities include, but are not limited to:
  - Creating and updating care plans as needed, based on beneficiary preferences and changes in conditions
  - Setting health and safety goals
  - Accessing the providers and treatments that the beneficiary needs
  - Coordinating appointments
  - Accessing beneficiary benefits, including supplemental benefits
  - Connecting beneficiaries to food, housing, or community resources[10]

Best Practices for Maximizing IDT Capacity

- Involvement of subject matter experts (e.g., NPs, PAs, pharmacists) to assist with increasing interventions and improving outcomes for complex beneficiaries
- Clear roles and areas of accountability
- Intentionally small case loads per IDT
  - FIDE-SNP: Average 50-55 beneficiaries per case load (accounts for travel to home visits)
  - CO D-SNP: Average 100-120 beneficiaries per case load
- Create a culture of learning, collaboration, and staff retention, including:
  - Proactive approaches to continuous quality improvement and assurance (e.g., IDT staff focus groups, mock audits)
  - Opportunities for individual professional growth (e.g., regular communication to staff about training opportunities, lunch and learn opportunities)

IDTs: Case Example of Quality Improvement in Action

- In December 2022, MCW developed a new template approach and used the process below to refine the structure and activities of IDTs.
- The template approach outlines when additional members are added to care team meetings; lists their position, discipline, and credentials; and helps support team communication.
- Members of the IDT leave the meeting with clear expectations regarding next steps.



Lessons Learned from IDTs

- Team composition works best if it is flexible
  - Subject matter experts can participate in beneficiaries' care coordination team as needed
- Evaluate case load sizes on an ongoing basis
  - Acuity with new enrollments can impact the care coordination work volume
- Fully integrated plans show promise for better beneficiary engagement
  - MCW experienced more engagement and calls back from beneficiaries in the fully integrated plan
- Maximizing IDT capacity supports the maintenance of good communication with beneficiaries

Strategy 2: Leveraging HIE and CCPs to support coordination

Best Practices for Leveraging HIE to Receive Timely Health Encounter Data

- MCW contracts with WISHIN, Wisconsin's state-designated health information exchange (HIE).
- Leveraging HIE data:
  - WISHIN sends MCW's information technology team a daily data file of beneficiaries' health care encounters that is directly integrated into the MCW care management documentation system.
    - MCW also sends real-time messages about beneficiary events at an acute or post-acute facility (e.g., admission, discharge, visit, medical leave of absence, or death).
  - MCW's care management documentation system notifies relevant IDT members to assist with timely care coordination for the beneficiary (e.g., early discharge planning, timely transfer to lower acuity settings, scheduling follow-up appointments).

CCPs Support Care Coordination and Communication

- The community care plan (CCP) provides a pathway of communication between the beneficiary and other health care providers to achieve the desired health care goals, and is created in collaboration with the beneficiary, the beneficiary's primary care physicians, and all other IDT staff that surround that beneficiary.
  - CCPs include background on the beneficiary's condition, contextual circumstances, and beneficiary goals, as well as the names, contact information, and roles for all IDT members.
- CCPs can assist with preventing acute exacerbations or readmissions for complex beneficiaries.
- CCP development process:
  - IDT members work proactively with NPs and PAs to identify, diagnose, and manage treatment plans for high-risk beneficiaries.
  - NPs and PAs lead the development of CCPs and maintain the medical plan of care in collaboration with the primary care provider (PCP).
  - PCP keeps record of the CCP and awareness of the plan across all medical systems involved in a beneficiary's care.
- Efforts are underway to integrate CCPs into the HIE.

CCP Example

- Background
  - A beneficiary has increased hospitalizations, advancing diastolic heart failure, long-standing type 2 diabetes, stage 4 chronic kidney disease, and chronic obstructive pulmonary disease; likely nearing end-stage heart failure.
  - Some areas for intervention are noted, though the beneficiary's care goals need clarification and ongoing discussion to guide the treatment plan, hospitalization use, and overall care.
- IDT Activities
  - Include name, organization, contact information
    - RN, CM, PCP, Specialists: NP; Cardiology; Endocrine; Kidney Clinic; Other (e.g., skilled nursing, therapies, supportive home care)
    - Other to include information of any pertinent community supports
- Beneficiary's Goals and Aligned Strategies and Interventions
  - Remain in her own home; avoid hospitalizations
  - Minimize medical appointments that require reducing diuretics, which impact urinary incontinence and quality of life
  - Consult specialists and other providers regarding beneficiary goals

Strategy 3: Implementing initiatives to address health literacy and cultural competence

An Organizational Culture that Values Cultural Competence

- Cultural competence is a core component of education and training for all care management and care coordination staff. Culturally and Linguistically Appropriate Services (CLAS) are defined as:

  "…services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients. CLAS is a way to improve the quality of services provided to all individuals, which will ultimately reduce health disparities and achieve health equity."[11]

- Partnerships with community organizations help infuse cultural competence into the design, implementation, and evaluation of policies and practices and ensure cultural and linguistic appropriateness.
  - Established a collaborative partnership with the Beacon - a resource center for people experiencing homelessness. The Beacon assists with housing and navigation services, while offering a mail center, identification assistance, and access to phones, a computer lab, and courses. A care coordinator visits the Beacon weekly to engage members.
  - Engaged Nurse Disrupted to create a telehealth mental health treatment option for members. MCW sponsors hours for community members to receive services, and this partnership helps address transportation issues, caregiver responsibilities, emergency department overcrowding, and health care staffing shortages. MCW is tracking member engagement and impact to well being, as telehealth promotes respect and privacy for members.

MCW Health Literacy Workgroup

- In early 2023, MCW created a Health Literacy Workgroup to develop, implement, and evaluate a formalized plan to improve health literacy among beneficiaries and build awareness about the importance of this issue throughout the organization.
  - A new health literacy screening tool is on track for implementation by January 1, 2024.
- MCW supports member input and education on the topic of health literacy to improve care coordination and outcomes.
  - All written materials are developed at a 6th grade reading level.
- Demographic data, including member language needs or preferences, are tracked in an internal data system and analyzed for the purposes of improving data accuracy and reliability, and evaluating the impact of CLAS standards on health equity and outcomes.
- The Health Literacy Workgroup is also responsible for proactively ensuring MCW meets CMS requirements for digital health literacy for Medicare Advantage enrollees, namely:
  - Screening Medicare members for digital health literacy level, and
  - Offering digital health education programming to beneficiaries and documenting types of education received.[12]

Care Coordination & Communication: IEHP's Approach to Language Access

Karla Argandoña

Senior Analyst

IEHP

IEHP
Inland Empire Health Plan

IEHP and Demographics

- IEHP is a large Medicaid health plan and not-for-profit Medicare-Medicaid plan.
  - 1.6 million members
  - Over 7,000 providers and 3,000 team members serve IEHP members
- IEHP serves low-income individuals and families in San Bernardino and Riverside County in California.
  - Over 30,000 members are dually eligible
  - One-third of dually eligible members speak Spanish as their primary language
    - Five percent of dually eligible members who speak Spanish have an alternative format request

Real World Scenarios – How Would You Respond?

- A member who is blind calls and wants access to a provider directory in Braille.
- A member with low vision is unable to memorize their member ID number.
- A member with low vision states that they can no longer receive their materials in an audio CD because their CD player broke.
- A member's caregiver has LEP and needs an American Sign Language (ASL) interpreter at an impromptu visit to an urgent care center.
- A behavioral health provider refuses to see a non-English speaking member because they do not believe therapy will work when an interpreter is needed.

Examples of Creative Solutions That May Benefit Members and Plans

- A provider directory in Braille may cost $25K and would be incredibly difficult to navigate.
  - Offer an e-format directory instead
  - If a member does not have appropriate hardware, offer access to a device like a laptop or similar
- Services like transportation vendors may require a member's ID number before setting up service.
  - A small recording device can be provided for members to record their ID information
    - Offer encryption, password, or security options
- Broken CD Player
  - Can be easily replaced, consider audio files if a member has a computer or MP3 capable device like a smartphone

Examples of Creative Solutions That May Benefit Members and Plans (cont.)

- Urgent cares are primary care sites, but unlike hospitals most do not have video remote interpreting devices or in-person interpreters for beneficiaries or caregivers who use ASL.
  - Consider purchasing devices for the network and offer access to VRI service via a vendor
- Behavioral health therapy takes time and it's a journey.
  - Inform behavioral health providers about the need to serve beneficiaries with LEP
  - Work with interpreter vendors to provide one or more interpreters for members seeing behavioral health providers long-term

IEHP Strategies to Meet Population Needs

Examples of IEHP's approach to meeting dually eligible members' communication and care coordination needs include:

1) Building health plan infrastructure and staff capacity to track and meet member communication preferences
2) Leveraging key partnerships to align communication and care coordination strategies

Strategy 1: Building health plan infrastructure and staff capacity to track and meet member communication preferences

Evaluate Health Plan Communication Accessibility Infrastructure

- Identify internal health plan stakeholders with the capacity to identify and track member communication accommodation needs
  - Information Technology
  - Healthcare Informatics
  - Enrollment Unit
  - Language Access Team (@IEHP - Independent Living & Diversity Services)
  - Care coordinators and member outreach teams
- Ask: Do you have a dedicated team focused on communication accessibility?
  - Do they have capacity to review quality?
  - Do they train and promote services equitably?
  - How do they collaborate with internal partners and care coordination teams?
- Identify the type of language access requests
  - Alternative format request (e.g., standing request, one-time request)
  - Spoken or sign language access (e.g., in-person, telephonic, video remote)

Build Health Plan Communication Accessibility Infrastructure

- Strategies for promoting member access to communication accommodation:
  - Educate all teams on access (e.g., care coordination teams and case management, grievance and appeals, sales, member services)
  - Establish an in-person interpreter vendor relationship
    - Regardless of visit type, set in-person interpretation as the default and only use video remote or telephonic interpretation on an as-needed basis
    - May provide additional benefits for plans (e.g., reducing waste, fraud, internal resources, improving reporting for quality programs)
  - Set alternate format thresholds
    - Develop processes for large print communications via standard in-house or print vendor
    - Establish approaches for producing large Braille documents (e.g., investment in e-formats)

Strategy 2: Leveraging key partnerships to align communication and care coordination strategies

It Takes a Village: Identify and Build Key Partnerships

- Consider network provider collaboration to support member communication and care coordination
  - Pharmacy benefit manager
  - Independent physician association
  - Urgent care settings
- Invest in vendors and strong service-level agreements across all contract services to build robust language resources
  - Develop internal auditing and monitoring processes
- Work with partners that members trust to identify, develop, and implement solutions to meeting member care needs
  - Community-based organizations (e.g., local Center on Deafness, resource centers serving large volumes of individuals with LEP)

Panel Discussion

Karla Argandoña

Senior Analyst, IEHP

Kim Kunz

Director of Care Management
Health Plan Programs, MCW

How does staff retention and capacity building contribute to the success of the care coordination and communication at your organization?

Karla Argandoña

Senior Analyst, IEHP

Kim Kunz

Director of Care Management
Health Plan Programs, MCW

How does your organization support dually eligible individuals and their caregivers in expressing their communication preferences?

Karla Argandoña

Senior Analyst, IEHP

Kim Kunz

Director of Care Management
Health Plan Programs, MCW

How has your organization established successful partnerships to support your communication or care coordination efforts?

Karla Argandoña

Senior Analyst, IEHP

Kim Kunz

Director of Care Management
Health Plan Programs, MCW

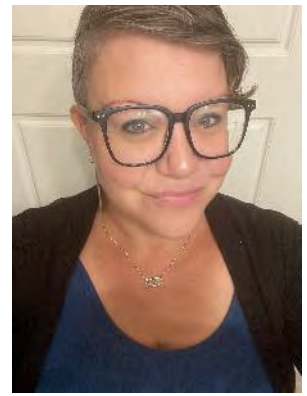
Poll

- Which of the strategies described by the presenters are you most likely to consider implementing at your own organization?
  1) Staff capacity building (e.g., care coordination competencies, cross-departmental collaboration, training relevant to communication accommodation)
  2) Leveraging HIE and CCPs to support communication of beneficiary care needs
  3) Implementing initiatives to address health literacy and cultural competence
  4) Building health plan infrastructure to track and meet beneficiary communication preferences
  5) Building key partnerships (e.g., with community-based organizations) to align communication and care coordination strategies

Questions and Answers

Kim Kunz

MCW



Karla Argandoña

IEHP

Thank You for Attending!

- The video replay and slide presentation will be available at https://www.resourcesforintegratedcare.com

- Questions? Please email RIC@lewin.com

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Upcoming Webinar

- **Title:** Intellectual and Developmental Disabilities and Behavioral Health: Leveraging Person-Centered Approaches
- **Date:** September 27, 2023, from 2:30-4:00 pm ET
- **Learning Objectives:** By the end of this webinar, participants should be able to:
  - Recognize the impact that siloed systems of care have on efforts to implement effective care coordination and care planning strategies.
  - Apply person-centered approaches for identifying behavioral health conditions in individuals with I/DD and understand the lived experience of individuals with both diagnoses.
  - Recall holistic care coordination strategies that support the unique needs of and improve outcomes for adults with I/DD and behavioral health conditions.
  - Identify the roles that community-based organizations can play to address social determinants of health and strengthen provider networks.

Webinar Evaluation Form

- Your feedback is very important! Please take a moment to complete a brief evaluation on the quality of the webinar: https://www.surveymonkey.com/r/5S9N5FD
- We would also like to invite you to provide feedback on other RIC products as well as suggestions to inform the development of potential new resources: https://www.surveymonkey.com/r/BW2H79Y

RIC Resources

- Community Care Plans – Spotlight on My Choice Wisconsin
  - This blog post highlights the efforts MCW is taking to build relationships with local hospital systems and community organizations to promote integrated care and improved health outcomes for their dually eligible beneficiaries.
- Resources To Help Health Plans Meet Communication Accessibility Requirements And Population Needs
  - This resource guide summarizes existing regulations and resources to aid health plan and provider organizations in implementing organizational strategies, policies, and practices to support communication accessibility and health equity.
- Determinants Of Health (SDOH) Promising Practices For Utilizing Motivational Interviewing (MI) To Improve Care Coordination And Address Social
  - This webinar explores how MI can improve communication in integrated care settings and improve relationships between health plans, providers, and dually eligible beneficiaries; promote the increased utilization of MI and person-centered techniques to better engage members and understand the complex lifestyle factors that impact health behaviors; and encourage the improvement of member retention rates as well as health outcomes for dually eligible beneficiaries.
- Identifying And Meeting The Language Preferences Of Health Plan Members
  - This webinar provides an overview of strategies health plans can use to assess and meet diverse language preferences.

RIC Resources

- Updated DCC-START Resource Guide – now available!
  - The Disability-Competent Care Self-Paced Training Assessment Review Tool (DCC-START) is intended to assist health plans, health systems, and health care provider organizations strengthen their efforts to provide integrated, coordinated care to their members with disability. The DCC-START assesses an organization's Disability-Competent Care (DCC) training materials and identifies opportunities for augmentation and enhancement.
  - The DCC-START complements the Disability-Competent Care Self-Assessment Tool, which is used by health plans and organizations to evaluate their DCC capabilities.
  - The updated DCC-START Resource Guide provides a detailed list of resources that can be used to address the opportunity areas identified by the DCC-START.

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