SNP Alliance
A National Nonprofit Leadership Organization

The National Voice for Special Needs and Medicare-Medicaid Plans

Implementing Improved Care for Special Needs Populations: A Planning Grant

Final Report – *February 2018*

The Special Needs Plans Alliance (SNP Alliance) received funding from The SCAN Foundation to conduct a planning and design effort on examining implementation of evidence-based care management or other best practices designed for special needs populations. The project timeframe was October 2017 to January 2018.

Project Purpose

To shape an implementation and evaluation initiative to examine one or more "better care practices" for specific complex chronic care populations enrolled in special needs health plans.

Participating Health Plans

Twelve SNP Alliance member health plans participated in a facilitated planning/design effort with emphasis on shared learning and decision making to meet the scope of work outlined. This "Design Team" was comprised of the following:

1. AmeriHealth Caritas
2. CareMore/Anthem
3. Care Wisconsin
4. Commonwealth Care Alliance
5. Gateway Health
6. Health Care Service Corporation (HCSC)
7. L.A. Care Health Plan
8. Medica Health Plan
9. SCAN Health Plan
10. South County Health Alliance
11. UPMC Health Plan
12. WellCare Health Plans

Process & Activities

Virtual Iterative Meetings - Led by the SNP Alliance, six conference call meetings were held in addition to iterative internal plan discussions conducted in-between each group meeting with "homework" sent to SNPA for aggregating results to capture common elements, themes, and direction. The group completed the following work:

- Identified 2 Sub-group Target Populations - Discussed key subgroup population needs and characteristics and crafted data element specification criteria which each plan used to "run their numbers" to see the potential volume of persons with these characteristics. This led to the identification of two key subgroups of the dually-eligible population for examining effective evidence-based programs:
  - BH Younger Group - Younger dually-eligible, physically disabled persons (18-64 YO), with significant behavioral/mental health condition, living in the community
  - Elder Group - Mid-range aged elders (65-79 YO), dually-eligible with 3 or more chronic conditions and some functional limitations, living in the community.

- Best Practices - With the sub-populations defined, the Design Team identified and reviewed relevant best practices and examined evidence on models and approaches. We began with relevant practices highlighted by the Commonwealth Fund and in sections of the curated web-based repository called the "Better Care Playbook" (www.bettercareplaybook.org)

- Key Focus Areas - The Design Team working group set particular focus areas of interest—how practices or programs addressed better self-care, social isolation issues, functional issues, and better primary and behavioral health preventive or wellness "follow-through" by the individual and in concert with their primary care provider and professional care management team members. The Design Team was interested in programs that integrated and aligned with the effective care management strategies that they have implemented already and that seek to cross services and settings, while also being tailored to the sub-population characteristics. The review was cursory, but provided enough information for the members to consider pros and cons of 14 programs (note this is not an exhaustive list).

- Possible Measures - The Design Team came to consensus on key focus areas and potential process and outcome measures. As they reviewed the programs, they looked for evidence of effectiveness or relationship of observed outcomes to the following (Note programs may not have had ALL of these outcomes, but they had promising results suggesting these could be positively affected):
  o Improved member/patient engagement and self-care
  o Improved medication and condition management, follow-up
  o Reduced depression
  o Reducing unnecessary or excessive transitions between settings of care
  o Better housing stability or reliability (Younger)
  o Reducing caregiver (family/friend) stress and/or increasing their confidence at home (Elder)
  o Reducing permanent nursing home placement (Elder)

In addition, the Team discussed their interest in opportunities for operational or systems improvement on:
  o virtual and inclusive care team interaction/function,
  o reduced duplication across care management functions/entities,
  o more effective team information exchange and learning around member's/patient's needs
  o strengthening connections/ care management relationships with key partners/providers

- Evidence–based Program Selection – Following their review process, there was a consensus by the Design Team to select one EB program for each subpopulation target group from among those reviewed. These EB programs were:
  o **CAPABLE** – Elder (Johns Hopkins University, developer/steward)
  o **CTI** -Critical Time Intervention – Younger/BH (Hunter College, Silberman School of Social Work, developer/steward)

- Implementation Framework and Systems – The Design Team considered (briefly) person-specific, organizational-level and systems-level issues and the contextual/sociological or environmental factors in which any program would be implemented. These elements were discussed at a broad-brush level in one of the calls—with further attention to be paid as the group determined the scope and parameters for an implementation pilot and evaluation metrics.

- Internal Plan Review/Alignment - Each health plan conducted an internal review of their current models of care and care management programs through internal discussions with their core teams to see where they already aligned or perhaps overlapped with one or both of these EB programs.

They determined there was good alignment with these two EB programs, though they identified possible barriers to implementing exactly as specified and discussed the need for translation or adaptation of the two programs for implementation in their systems and with their network of providers.

Possible barriers identified included: policy/regulatory restrictions around LTSS service delivery, existing home visit team composition and workflows, capacity and staffing levels, and member service enhancements (ability to tailor and pilot with a subgroup of members without applying/offering to all similar members).

▪ Resources & Capacity – Plans considered additional internal and external resources which would likely be needed to pilot the EB program and conduct an evaluation as framed (local pilot with national learning cohort and implementation evaluation measures). Training, additional staffing support, provider capacity enhancements, and data analytic supports were identified.

Criteria Developed to Assess EB Programs

Review/Selection Criteria for EB Programs

Considerations for the Approach

- There is a conceptual/theoretical link between desired outcomes and practice/approach/program
- Practice or approach has been tested (with rigor) at least once and reported in the peer-review literature –(experimental or quasi experimental design)
- There are defined components, processes, and clarity on resources required (and a protocol or guideline)
- Approach crosses/affects sites of care/settings/services
- Approach has implications at the person, plan, and provider level (at a minimum)
- There is organizational commitment and strong perceived value to the approach
- There are key partners with belief/perceived value in the approach

Considerations for Measuring Results

- The desired result/outcome can be measured
- Current data elements/sources are sufficient to measure most of the intended results
- Standardized instruments are used for any new data elements/collection
- At a minimum, measures of implementation effectiveness as well as measures of results at the person (by subgroup aggregated) and plan level can be assessed and reported

Shared Learning & Value

Several health plans provided feedback on the value of this 4-month SNP Alliance "Implementing Improved Care" exploratory planning grant:

L.A. Care Health Plan Team: Working in the Design Team reminded me that despite the regional variations and health plans perspectives our members face common challenges. Working with this team gave me the opportunity of direct exposure to a wide and rich net of ideas and experiences across the country. Through the collective approach we were able to quickly go through the multitude of ideas and resources and select a robust EB approach with a high degree of confidence.

South Country Health Alliance Team: *The opportunity to actively engage in in the design of a project with other health plans across the United States to support "better care practices" for duals and complex chronic populations has been a worthwhile investment. The facilitation of foundational discussions has encouraged plans to evaluate current practices within our Models of Cares and determine how our own quality and clinical services align with existing evidenced-based care models. Analysis of existing health plan approaches pertaining to outreach, assessment and care management for the identified populations/EB practices demonstrated alignment of health plan practices in most areas and provided tremendous insight into areas to strengthen for a national pilot.*

HCSC Health Plan: *The value for me was hearing other ideas and programs which have been used and learning about new EBP's.*

UPMC Health Plan Team: *We saw exceptional value in this planning process. Due to the short nature of the timeframe, each call was focused, energy was given to the right place and decisions were made. This forced us to think carefully internally, but also marry our thinking with the group as much as possible. We look forward to the next planning phase to discuss the more operational aspects of how to make this work, but this first phase was necessary to flesh out the right populations and interventions, from a high level, to potentially test further. We also appreciated the ability to talk openly about how this might work without having to make an immediate commitment to a certain path. SNP Alliance and Deb led a great process and we hope to continue the planning phase, if possible.*

SCAN Health Plan Team - *This pilot project pushed us to think outside the box to come up with innovation approaches to service the special needs populations, and aligns with our health plan's mission of keeping members healthy and independent!*

Gateway Health Plan Team - *It has been a great experience to discuss the challenges and best practice approaches with many other SNP's. The discussions were incredibly collaborative as we all have the common goal of providing high quality care and services to those individuals we serve.*

Commonwealth Care Alliance Health Plan Team: *The value of working on the project was that it was a wonderful collaboration and enabled all of the disparate plans to see that we share the desire to see evidence based practices inform our work with complex patients.   As always, it is reassuring to see that we share some of the same challenges and joys in taking care of this population.*

Next Steps

Most of the health plans expressed interest in continuing this kind of learning collaborative, however only five of these plans felt they had sufficient capacity currently to participate in a pilot of one of the two chosen EB programs to determine value and contribution toward the stated process and outcome goals—and to discern implementation barriers and catalysts. This will comprise the next phase of work—crafting two EB pilot implementation and learning cohorts (three plans for CAPABLE and two plans for CTI) to pilot test at the local level with national facilitation and evaluation.

For more information, contact Deborah Paone, DrPH, MHSA, Project Lead for the SNP Alliance at debpaone1@gmail.com. See also: www.snpalliance.org