Hospital to Community Transitions for Medicare-Medicaid Enrollees: Perspective from Two Experienced Health Plans

December 9, 2013
Agenda

• Welcome, Roll Call and Introductions
• Background on Care Transitions
• Health Choice Arizona Perspective – Katrina Cope and Donna Reynolds
• UCare Minnesota Perspective – Ceil Boesche
• Questions from States
• Wrap Up and Next Steps
Improving Hospital-to-Community Transitions for Medicare-Medicaid Enrollees: Lessons Learned from Health Choice

Integrated Care Resource Center Webinar
December 9, 2013
Agenda

• Health Choice Overview
• Pre-transition of Care Program
• Transition of Care Program Implementation
• Transition of Care Program Details
• Program Enhancements
• Health Choice Tips to Success
Health Choice Overview

• Health Choice is a subsidiary of IASIS Healthcare

• IASIS owns and operates:
  • 16 acute care hospitals and one behavioral health hospital
  • Several outpatient service facilities
  • More than 140 physician clinics
  • Medicaid and Medicare managed care plans in Arizona and Utah
  • The Health Choice Preferred Network in Arizona and Utah
Health Choice Overview

• Health Choice Arizona (Medicaid/AHCCCS)
  – 175,000 Medicaid members
  – Serving Arizona since 1990

• Health Choice Generations (D-SNP)
  – 5,300 Dual eligible members
    • Members have acute Medicaid only, not long term care
    • Average age of our members is 50 years of age
    • 30% of our total population also has a behavioral health condition
  – Serving Arizona since 2006

• Health Choice Insurance Company
  – 2014 Arizona Qualified Health Plan

• Health Choice Utah (Medicaid/UDOH)
  – 2,600 Medicaid members
  – Serving Utah since 2012
Arizona Service Area

2014 Service Area
Pre-Transition of Care Program

• Dual eligible Health Choice Arizona members were passively enrolled into the D-SNP plan in January 2006 to allow for coordination of prescription drugs.

• Took time to identify differences in managing dual eligible vs. Medicaid-only population.

• Became very clear this population needed additional focus pertaining to care coordination and delivery system navigation.

• Needed to establish a program which focused on medical, social and economic needs of our members.
  – Had to have staff in place to address and assist with all identified barriers.
Transition of Care Program Implementation

• In 2010, started the program to focus on:
  – High and under-utilizers
  – Post-acute/Emergency Room utilizers

• Care coordinators
  – Assist with social and economic barriers in addition to health care planning

• Provider engagement was key
  – Working with providers to keep open appointments
Transition of Care Program Implementation

• Coordination with hospitals is key to success
• Started with IASIS hospitals
• Expanded to other contracted hospitals
  – Currently coordinate care with all Health Choice Generations contracted hospitals
• Discuss common objectives and joint solutions
• Having a point of contact available and responsive to hospital representatives is critical
  – Need to deliver on what is promised
  – Common goal to improve health and decrease unnecessary utilization of services with improved collaborative discharge planning
Goals of the Health Choice Transition of Care Program

• Impact members at the point-of-service by engaging via phone as quickly as possible after notification:
  – Enhance the health care experience
  – Improve health outcomes to the member during a transition
  – Improve member/family engagement
  – Assist with navigation of the health care delivery system

• Enhance collaboration between the plan and providers

• Identify barriers to treatment, compliance and medication adherence
  – Work with the member, family and providers to overcome barriers
Inpatient Admission & Discharge Coordination of Care Cycle

1. Care Navigator will continue to provide care coordination for the next 30 to 60 days based on individual member need.

2. Member admitted inpatient – hospital provides admission information within 24 hours.

3. HC Care Navigator notifies PCP Office of admission via email.

4. HC Care Navigator will send log to office weekly identifying all discharged members.

5. If appointment was not scheduled by HC, office will contact member to schedule within 5 to 7 days.

6. HC Care Navigator contacts member, completes phone assessment & assist with scheduling appointment.

7. Care Navigator notifies PCP office of discharge, provides demographic facesheet & D/C summary if accessible.

8. Member discharged.
INPATIENT
ADMISSION & DISCHARGE
COORDINATION OF CARE CYCLE
Positive Feedback

• Health Choice conducts member satisfaction surveys to elicit feedback, as well as take advice to improve the program for our members

• Here are a few statements received by the health plan:
  – “My care navigator provides me with prompt and attentive care”
  – “You are always so very helpful and knowledgeable”
  – “I don’t even remember your name. I just have you programmed as an angel.”
  – “It is very comforting to know she is only a call away”
Program Enhancements

• Program evolves over time – enhance as needed
• Concierge approach/model
• Hospital and facility coordination
  – Get 100% hospital admission notification
    • Information includes: Diagnoses, medications, treatment plan, health and physical
  – Receive 80% real-time ER census
  – Daily census for members in observation, acute, sub acute, and LTAC status
• Contract alignment
  – Network contracts aligned Medicare and Medicaid
  – Working with providers to contract with both lines of business improves continuity of care
• Meal-delivery benefit
  – In 2014, offering meal delivery as a supplemental benefit to members after an inpatient stay
Tips for a Successful Transition of Care Program

• Skilled care coordinators in place
• Contact members at the point of service – transient population
• Provider engagement
  – Offer after hours and same-day appointments
• Coordination with hospitals/facilities
• Ensure members get needed medications
  – Implement a pharmacy override if necessary
• Identify social barriers and assist
  – Limited income: Challenges paying for medication co-pays, housing and food
  – Relationships with community resources
Katrina Cope
Director, Medicare Operations
Kcope@iasishealthcare.com

Donna Reynolds
Medical Services Program Administrator
Dreynolds@iasishealthcare.com
Overview of UCare

- An independent, non-profit, health plan.
- Provides coverage to more than 300,000 members in Minnesota and 26 counties in western Wisconsin.
- Competitive Provider Network.
- Strong member representation and feedback:
  - 40% of board of directors are members.
  - Have three Member Advisory Committees (MHCP, Persons with Disabilities, and Medicare eligible seniors).
  - Conduct focus groups and satisfaction surveys
UCare is the largest Minnesota Health Care Programs health plan in Minnesota.
UCare Transition Management

- Minnesota Senior Health Options and Minnesota Senior Care Plus
  - All members assigned a care coordinator, acts as primary contact during care transitions.

- UCare Connect and UCare for Seniors
  - Transition management by RNs at UCare.
Transition Management
Prior to 2010

• Sporadic transition management – best practices not well described.
• Inconsistent knowledge and tools.
• Inconsistent documentation.
• Inconsistent notification of transitions.
Notification Processes

- Hospital notification of admits and discharges
  - Hospitals required to by contract to notify UCare of admissions - long standing requirement.
  - Even though required, hospitals don’t always do it timely.
  - Claims payment is the incentive.
    - claims configured to pay only when notification is in the system.
    - claims examiner enters a discharge date prior to claims processing.
- Requirements are similar for most Minnesota health plans.
Daily Admission Report

- Hospitals notify UCare of admissions.
  - Somewhat timely—usually within 1-5 days of admit.
  - Currently no immediate sanction for untimely notification.
- UCare posts daily admit report on secure website the next day
  - Provides certification number to each hospital for previous day’s admission notifications.
  - Provides care coordinator notification that admission occurred.
Transition of Care Collaborative

- Collaborative work began in 2010.
- Focused mostly on care coordinator efforts, less on improving hospital notification.
- 9 Minnesota health plans worked with Minnesota Department of Human Services
  - Identified best practices for transition management.
  - Developed consistent tools.
  - Provided state-wide care coordinator education.
- Revisions in 2012
  - Updated tools, education.
Care Coordinator Training

- Based on Coleman’s 4 Pillars of Transition Management
  - Medication self-management.
  - Timely primary care or specialist follow-up.
  - Knowledge of red flags.
  - Use of personal health record that individual or caregiver manages.
- Provided transition log and instructions.
- Reviewed care coordinator expectations about managing transitions.
UCare Transition Support Tools

- Daily admission report.
- Care coordination requirements grid.
- Transition management policy CLS-0265.
- Transition log and instructions.
- TOC Notification to PCP.
- Transitions of Care Toolkit.
- “What Do I Do If?” guide.
- Transition of Care brochure.
Transition of Care Toolkit

- On UCare’s website. Includes information on:
  - Resource topics.
  - Personal health record.
  - Health literacy information/training.
  - Depression information/training.
    - Screening questionnaires.
  - Substance abuse.
    - Screening questionnaires.
  - Falls prevention.
  - Cognitive screening.
  - Pain screening.
Transition Log Example

INDIVIDUAL CARE TRANSITIONS LOG

<table>
<thead>
<tr>
<th>Name:</th>
<th>PMI #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO ID#:</td>
<td>MCO Name:</td>
</tr>
</tbody>
</table>

| Agency/County/Care System: |

<table>
<thead>
<tr>
<th>Date</th>
<th>Notification Date</th>
<th>Notified by:</th>
<th>Transition Date</th>
<th>Transition From:</th>
<th>Transition To:</th>
</tr>
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**Communication from CC/CM**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Date</th>
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<tbody>
<tr>
<td>Notified Member's PCP of transition</td>
<td>Date Completed</td>
</tr>
<tr>
<td>PCP Admitting Physician</td>
<td>Date Completed</td>
</tr>
<tr>
<td>Care plan shared with Receiving Setting</td>
<td>Date Completed</td>
</tr>
<tr>
<td>Other</td>
<td>Date Completed</td>
</tr>
<tr>
<td>Informed Member/Auth Rep about care transition process &amp; support person available</td>
<td>Date Completed</td>
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<tr>
<td>Other</td>
<td>Date Completed</td>
</tr>
<tr>
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<tr>
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**Other:** (In the Comments box describe who the person was, the method of communication, and why you communicated with this person. (I.e., communicated with Hospital Discharge planner by phone because member was non-responsive and authorized rep was not available).)
UCare conducts annual audit.

Sample size - 110 randomly selected transitions per product.

Based on:

- UCare transition requirements.
- NCQA Structure and Process Measure requirements.
## TOC Audit Results

<table>
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<tr>
<th>Measure</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tr>
<td>CC Notified of admission timely (within one business day of the transition).</td>
<td>63%</td>
<td>64%</td>
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<tr>
<td>TOC identified as planned vs. unplanned</td>
<td>16%</td>
<td>52%</td>
<td>61%</td>
</tr>
<tr>
<td>*Care Plan shared with receiving setting in 1 day</td>
<td>80%</td>
<td>73%</td>
<td>90%</td>
</tr>
<tr>
<td>*PCP notified in 1 day</td>
<td>78%</td>
<td>82%</td>
<td>93%</td>
</tr>
<tr>
<td>*Member/rep educated about process in 1 day</td>
<td>87%</td>
<td>80%</td>
<td>89%</td>
</tr>
<tr>
<td>*Member/rep communicated about changes in member health in 1 day</td>
<td>83%</td>
<td>84%</td>
<td>86%</td>
</tr>
</tbody>
</table>

*Compliance with tasks within one business day of care coordinator notification of the transition.
Challenges/Opportunities

- Timely notification to care coordinator – currently 63% within 1 day of transition.
- Inadequate documentation of transition tasks on log.
- Care coordinator training needs.
- Keep the focus on good transition management, vs. only on documentation of tasks.
Interventions Based on Audit Results

2012
- Developed “Transition of Care (TOC): “What Do I Do If Guide”.
- Article in Clinical Services Newsletter - October, 2012

2013
- Care Coordinator Training - “Improving Transitions Post-hospitalization-A Collaborative Approach to Transition Management”.
  - March 28, 2013, Minnesota Department of Human Services training
  - June 17, 2013, The Minnesota Age & Disabilities Odyssey training conference sponsored by the Minnesota Department of Human Services and the Minnesota Board on Aging.
- Transition of Care (TOC) Log (revised).
- Transition of Care log Instructions (revised).
- Review of care transitions during 2013 care coordinator training sessions.
Next Steps

- Ongoing care coordinator training and reminders.
- Ongoing collaboration with other health plans
  - Review Transition of Care process each year.
  - Update tools and forms as needed.
- Assess options for improved notification by hospitals.
Contact Information

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Questions & Answers
About ICRC

• Established by CMS to advance integrated care models for Medicaid beneficiaries with high costs and high needs

• Provides technical assistance (TA) to help states integrate care for: (1) individuals who are dually eligible for Medicare and Medicaid; and (2) high-need, high-cost Medicaid populations via health homes as well as other emerging models

• TA coordinated by Mathematica Policy Research and the Center for Health Care Strategies

• Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges