UCare Connect
Bi-Annual Care Coordination Training

November 14th and 15th 2018
Agenda

• Welcome
• 2019 Benefit Changes-Robert Burkhardt
• Preventative Care, Incentives, and Health & Wellness-Cindy Radke
• Disease Management-Liz Sperr/Marie Sherwood
• Model of Care-Bobbi Jo Glood
• Care Coordination Survey-Bobbi Jo Glood
• Care Coordination Updates-Bobbi Jo Glood & Dawn Sulland
Connect, Connect + Medicare

2019 Benefit Changes – Nov Care Coordinator Training
DHS Contract Benefit Changes

**Substance Use Disorder** (SUD) – as defined in M.S. §245G.07, subd. 1,

- Comprehensive Assessment for SUD services (Rule 25 Assessment is available as well – member may choose)

- Peer recovery support services

- SUD treatment coordination services. SUD treatment coordination for SUD services is only for facilitation of referrals indicated in the SUD treatment plan and does not include coordination for medical services, except those identified in the SUD treatment plan.
DHS Contract Benefit Changes

• Preferred Drug List - Medicaid drugs only, effective July 1, 2019
  – MCOs can set their own Prior Authorization, quantity limits requirements w/in limits
  – Coverage of non-rebate drugs = admin cost for MCO

• Federally Qualified Health Center (FQHC), Rural Health Center (RHC) services will be billed directly to DHS as of 7/1/19

• Services in DHS-operated dental clinics will be billed directly to DHS as of 1/1/19

• Indian Health Services and 638 facilities will be billed directly to DHS
Connect, Connect + Medicare 2019
Benefits

Continuing supplemental benefits (both products):

• Silver Sneakers, fitness kits, FLEX
• Connect to Wellness Kits
• Whole Health Living discounts
• Mammogram, Colon Cancer, pregnancy smoking cessation incentive
• Car seats, MOMs prenatal, post partum incentive
• 12-21 C&TC incentive
• Community Education discounts ($15/class, unlimited)
2019 Connect + Medicare Benefits

New Connect + Medicare supplemental benefits

- Post-discharge medication reconciliation
- Electric toothbrush
- $25 face to face assessment incentive
Pharmacy Benefit Changes

• MSHO and Connect Plus Medicare will utilize the same formulary as other UCare Medicare plans in 2019
  - Uses 1 tier format instead of 5 tier format
  - Same formulary status for Part D drugs
• MSHO and Connect+ will keep same OTC formulary and benefit for 2019
• MSHO and Connect+ will maintain the same open pharmacy network that is in place in 2018
Preventive Care
<table>
<thead>
<tr>
<th>Screening for my health</th>
<th>Check if educational conversation took place with me</th>
<th>Goal is needed</th>
<th>Check if N/A, contraindicated, declined</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Annual Preventive Health Exam</td>
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<tr>
<td>Mammogram</td>
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<td>Colorectal Cancer Screening</td>
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<td>At Risk for Falls (Afraid of falling, has fallen in the past)</td>
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<td>Flu shot</td>
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<td>Tetanus Booster (Once every 10 years)</td>
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<td>Hearing Exam</td>
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<td>Vision Exam</td>
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<td>Dental Exam</td>
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<td>Aspirin Rx for Aspirin? (as directed by physician)</td>
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<td>Blood Pressure</td>
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<td>Cholesterol check</td>
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<td>Diabetic routine checks as recommended by physician:</td>
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<td>Nephropathy →</td>
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<td>Diabetic Eye exam →</td>
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<td>Cholesterol →</td>
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<td>A1C →</td>
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<td>Other:</td>
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<td>My Medications</td>
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<td>I need help with my medications?</td>
<td>Yes</td>
<td>No</td>
<td>N/A (no medications used)</td>
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<td>If yes, create a goal.</td>
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<td>Health improvement Referral</td>
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<td>Yes</td>
<td>Declined</td>
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<td>Diagnosis:</td>
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Adult Preventive Care – Connect members

- Breast Cancer Screening – Age 50-74
- Colorectal Cancer Screening – Age 50-75
  - In-home testing options
  - Colonoscopy – every 10 years.
- Diabetes Care
  - Dilated eye exam yearly
  - Kidney function testing (urine testing) yearly
  - A1c check yearly
- Annual Flu vaccine
- Annual Wellness Visits
Any Incentives?

- Breast Cancer Screening - $50.00 Target gift card

- Colon Cancer Screening - $25.00 Target gift card for Colonoscopy, Sigmoidoscopy and CT colonography.

- Connect + Medicare members also have incentives for Diabetes care!

- Refer to Health and Wellness area of the website for information.

- Refer to the Health Management section under Health and Wellness for Diabetes information and resources.
What can you do?

• Discuss importance of screenings and options for screenings.

• Ensure members are aware of incentives available.

• Assist members in making appointments.

• Medication adherence is a key to good diabetic care.
Disease Management
Health Improvement Team

**Health Coaching**
Open: Diabetes and Heart Failure
Marie Sherwood: Diabetes
Melissa Horning: Integrated Coaching

**Asthma Educators**
Linda Bell: Telephonic asthma case management
Open: In home asthma assessments and telephonic case management

**Member Engagement Specialist**
Stephanie Carlson
Supports asthma, diabetes and heart failure
Disease Management Programs

- Asthma
- Diabetes
- Heart Failure
Disease Management Program Identification

- **Program identification**
  - **Daily:**
    - Emergency department/hospitalization admission notification
    - Referrals: self, provider, case manager, other caregiver
  - **Monthly:**
    - Claims and pharmacy utilization
    - HRA completer letters
  - **Quarterly:**
    - Predictive modeling report
Asthma Program Eligibility

• **At-risk Asthma program (IVR education calls):**
  - Members 5-64 enrolled in UCare for at least 11 months
  - ≤ 1 ED/IP event for asthma in 2 years and/or
  - ≥ 4 outpatient visits for asthma in 2 years and/or
  - At least 4 asthma medications prescribed in 2 years
  - Products: Connect, Connect +, MNCare, PMAP, Exchange

• **High-risk Asthma program (Asthma Action Program):**
  - Members 5-64 enrolled in UCare for at least 11 months
  - Recent ED/IP stay for asthma
  - At least 4 asthma medications prescribed in 2 years
  - An IVR “alert” indicating they may be struggling with their asthma
  - Products: Connect, Connect +, MNCare, PMAP, Exchange
Asthma: At-Risk (IVR Education Calls)

- **Program offerings**
  - Scheduled Interactive Voice Response (IVR) education calls
  - Two asthma care related questions per call (yes/no response)
    - Asthma knowledge and management
    - Members “alert” if response indicates they require follow-up by a RT

- **Target Population**
  - Adults
  - Pediatric

- **Program Overview**
  - Full program: 1 call a week (1 outreach, 2 attempts)
  - Maintenance program: 1 call every 30 days (1 outreach, 4 attempts)
  - Full program completion: transition to maintenance program
  - IVR asthma calls
  - An Annual Asthma Action Plan mailing
Asthma: High-Risk Program
(Asthma Action Program)

- **Program Overview**
  - Adults and pediatrics
  - Help members and families manage their asthma to lead a healthy lifestyle
  - RT and asthma educator serve as an extension to the members medical team
  - Highlights:
    - 12 month program (asthma case management, assessments of self-monitoring & med adherence)
    - One home visit (within 60 miles of metro area)
    - Phone call monthly for first quarter and then every other month
    - Asthma management tools: pillowcase covers, medication chambers
    - PCP receives notification when member enrolls in program
  - Additional opportunities:
    - One time education call
    - Pediatric referral to American Lung Association home assessment program

- **Gift Card Incentive:**
  - Adults: $10 per visit, $25 for program graduation. Maximum is $95
  - Children: $10 per visit, $25 for program graduation. Maximum is $95
  - Parents (enrolled at UCare) of children who are participating are eligible for same incentive as their participating child (parent receives incentive for only one child, but each child receives their own participation incentive)
Asthma: Referral Triggers

- Referral triggers:
  - Not using a rescue inhaler
  - Lack of Asthma Action Plan in place
  - Unsure of medications (purpose, names, etc.)
  - Does not identify with a PCP
  - ER use for any kind of medical assistance
• 5 year old boy and his mother
• ER event occurred, asthma educator engaged for enrollment
  ○ Conversation triggers: 5 yr old had pneumonia twice this year, mother unable to recall inhaler name and unsure of asthma triggers.
• Home visit with RT:
  ○ Mother didn’t understand difference between controller and rescue inhaler. Child played with inhaler and pumped all medication out. Mother didn’t ask for a refill because she thought controller and rescue meds were the same. Mother contacted pharmacy for refill.
  ○ Discussed asthma/environmental triggers.
• Follow up:
  ○ Member doing well, minimal to no asthma flare ups. Controller being used daily.
Diabetes
Diabetes Program Eligibility

- **At-risk Diabetes program (Warm Health):**
  - Members 18–75 diagnosed with diabetes & enrolled in UCare for at least 11 mos
  - Dispensed insulin or oral medication in the last 12-25 months and/or
  - Two office visits with a diagnosis of diabetes in the last 12-24 months and/or
  - One ED/IP for diabetes within the last 12-24 months
  - Products: all products
  - Exclusions: Members in Long Term Care Facilities, on hospice or have ESRD

- **High-risk Diabetes program (Health Journey):**
  - Members 18–75 diagnosed with diabetes & enrolled in UCare for at least 11 mos
  - Recent ED/IP for diabetes
  - Trigger an alert from IVR indicating need for more in-depth diabetes support
  - Products: all products
  - Exclusions: Members in Long Term Care Facilities, on hospice or have ESRD
Diabetes: At-Risk (IVR Education Calls)

- **Program offerings**
  - Scheduled IVR education calls
  - Two diabetes care related questions per call (yes/no response)
    - Condition monitoring and medical testing
    - Members “alert” if response indicates they require follow-up by a HC

- **Target Population**
  - Adults

- **Program Overview**
  - Full program: 1 call a week (1 outreach, 2 attempts)
  - Maintenance program: 1 call every 60 days (1 outreach, 4 attempts)
  - Full program completion: transition to maintenance program
**Program offerings**
- Regularly scheduled health coaching calls with a UCare Health Coach

**Target Population**
- Adults

**Program Overview**
- Partner with member to discover barriers, vision for future, establish short & long term behavior change goals, empower to achieve goals.
- Coaches utilize active listening, motivational interviewing and behavior change techniques
- PCP notified when member enrolls in the program
- Program tools:
  - A Health Journey book covering:
    - Clinic visit planning form, medication lists
    - Topics: living well, nutrition, cholesterol, heart attack, stroke, healthy heart, diabetes, kidney care, COPD
  - Behavior change tools: pedometer, diabetic bracelets, cookbooks
- Exclusions: members in Long Term Care facilities, on hospice or have a diagnosis of ESRD or on dialysis
Referral Triggers:

- Not compliant with medications or diabetic testing
- Unsure of medications (purpose, names, etc.)
- Does not identify with a PCP
- ER use for any kind of medical assistance
- Discusses failures to make health modifications in the past
Success Story

• Female; smoker; depression; homeless, living in shelter; emotional/stress eater; pain issues with knee and hip; morbidly obese; sleep apnea, not using c-pap; not following up with doctor for preventive visits/other medical needs

• 3 month goals:
  o Bariatric surgery within 3 months to get back on weight loss plan
  o Calling physician to get back on track with plan
  o Calling to get new sleep study to get back on track with c-pap
  o Quit smoking
  o Will have seen physicians, dieticians and counselors
1. Quit smoking by following plan to reduce tobacco use/nicotine gradually
2. Reports greater energy, endurance and lung stamina now
3. Lost 20 lbs by choosing to eat vegetables and fruits and by cutting out junk food
4. Walks halls, stairs, outside. Goes up stairs without stopping, walks 3 blocks without getting winded. Intentionally moves more in her day to stay active.
6. Eating smaller portions daily now.
7. Blood sugars are in the 90s with metformin only verses insulin.
8. Has seen physician in follow-up for A1c and to restart bariatric plan.
9. Enrolled in classes at shelter to help with transition to new housing.
10. Attends cooking classes at the shelter.
11. Greater self-reported self-confidence, self-efficacy, improved mood & depression has lessened.
12. Restarted counseling required for bariatric plan. Attends group work at shelter for support.
Heart Failure
Heart Failure: At-Risk (Healthy Hearts)

At-Risk Heart Failure program (Healthy Hearts):
- Weight bearing members
- Ages 18-89 years old
- Less than 2 heart failure ED/IP events in the past 15 months
- Current HF symptoms cause:
  - No limitation of physical activity
  - Slight limitation of physical activity
- Products: all products
- Exclusions: members in Long Term Care facilities, on hospice or have a diagnosis of ESRD or on dialysis
Heart Failure: At-Risk (Healthy Hearts)

- **Program offerings**
  - Telephonic health coaching with a UCare health coach

- **Program Overview**
  - Partner
  - Set personal health behavior goals (i.e. to lower sodium, weight tracking, fluid retention plan)
  - PCP receives notification when member enrolls in the program
  - Program tools:
    - A Health Journey book covering:
      - Clinic visit planning form, medication lists
      - Topics: living well, nutrition, cholesterol, heart attack, stroke, healthy heart, diabetes, kidney care, COPD
    - Behavior change tools: bathroom scale, wrist blood pressure cuff
### Heart Failure: High-Risk (Medtronic)

**High-risk Heart Failure program (Medtronic):**

- Members regardless of weight bearing status.
- Age 18 and older
- MSHO members, regardless of utilization
- More than 2 heart failure ED/IP events in the past 15 months
- Current HF symptoms cause:
  - Marked limitation of physical activity
  - Severe limitation of physical activity
- Products: all products
- Exclusions: members in Long Term Care facilities, on hospice or have a diagnosis of ESRD or on dialysis
Heart Failure: High-Risk (Medtronic)

- **Program Overview**
  - A talking scale to assess daily weight and HF symptoms via Q & A
    - Available in English, Hmong, Spanish
  - Member data transmitted to Medtronic RN for triage, assessment and follow up
    - If member data suggests a flare up of HF PCP is contacted
  - Monthly RN calls
    - Education on HF, co-morbid condition(s) and lifestyle management
    - *New in 2017:* Stars preventive measure reminders
  - PCP notified when member enrolls in the program
  - Additional info: Dashboard access to view member activity
Heart Failure: Referral Triggers

- Referral Triggers:
  - Not compliant with medications or daily weight check ins
  - Unsure of medications (purpose, names, etc.)
  - Frequent pneumonia and respiratory infections
  - Excessive salt and fluid intake
  - Does not identify with a PCP
  - ER use for any kind of medical assistance
Success Story

- Female, 76
- Diagnoses: CHF, HTN, CAD, Afib, heart attack, high cholesterol, arthritis, sleep apnea
- Enrolled after ER/IP event
- Member goals: To learn about HF, low salt diet and how to safely incorporate exercise.
- Main concerns: devastated/shocked/disbelief with new diagnosis of CHF; initially didn’t want to use HF terminology; wants to feel better to do things she enjoys; wants to reduce anxiety of feeling like her heart may not hold out; overwhelmed with shopping for low salt foods and realized she needed to make changes.
- At graduation: confident with shopping for groceries, preparing meals and exercising routinely (joined SilverSneakers, has friend to exercise with)
Program Referrals
Program Referral Process

- Members can self refer by calling DM phone line

- Referral Form
  - [https://ucare.org/providers/Resources-Training/Pages/DiseaseManagement.aspx](https://ucare.org/providers/Resources-Training/Pages/DiseaseManagement.aspx)
DM Contact Information

- **Phone Line**
  - 612.676.6539
  - 1.866.863.8303

- **Email**
  - [DM Educ@ucare.org](mailto:DM Educ@ucare.org)

- **Fax**
  - 612.884.2467
UCare Model of Care
Minnesota Senior Health Options (MSHO)
&
*UCare Connect* + Medicare
2018
UCare’s Model of Care (MOC)

- Overall goal of the MOC:
  - Drive improvements in health outcomes and quality of life for members.

- UCare’s MOC is designed to:
  - Increase access to affordable, cost-effective health care.
  - Improve coordination of care.
  - Ensure seamless transitions of care.
  - Manage costs.
UCare Special Needs Plans (SNP)

- **Minnesota Senior Health Options (MSHO):**
  - The MSHO program serves elderly members who are dually eligible for Medicare and Medical Assistance and are 65 years or older.

- **Special Needs Basis Care (UCare Connect + Medicare):**
  - The *UCare Connect* + Medicare Program serves members with disabilities who are dually eligible for Medicare and Medical Assistance under the age of 65.
UCare Special Needs Plans

- Integrated products combining Medicaid & Medicare
  - Parts A, B & D (pharmacy)
  - Members have one ID card
  - One phone number to call for health plan questions

- Over 14,000 members currently enrolled
  - 12,250 with MSHO
  - 1,780 with UCare Connect + Medicare
Why does UCare have a MOC?

- Required by CMS & DHS & has four components:
  - Population description & characteristics
  - Care Coordination details
  - Provider Network to ensure adequate access
  - Quality Measures & Process Improvement goals

- It helps provide:
  - Appropriate access to primary & specialty care providers
  - Integrates care coordination based on a member’s Health Risk Assessment
  - Ensures members receive individualized care plans
  - Encourages and provides care transition support to members & families
Care Coordination

- The care coordinator (CC) coordinates care and services for the member which includes:
  - Face-to-face Health Risk Assessment (HRA) annually which is used to evaluate members’ health risks, gaps in care and quality of life.
  - An individualized, person centered care plan.
  - Facilitating access to affordable care such as: medical, preventive, mental health and social services.
  - Communicating with the Interdisciplinary Care Team (ICT), a team of professionals involved with the member to coordinate and provide health care services.
- Care Coordinators are Qualified Professionals
  - Registered Nurses, Nurse Practitioners and Social Workers
The care coordinator assists members, families, facilities, providers, or others with planned and unplanned transitions from one care setting to another. Examples include: Transition from hospital to home or nursing facility.

Goal is improved transitions to reduce fragmented care and avoid re-hospitalizations.
Provider Network

- UCare’s provider network meets a wide range of needs.
- The network includes, but is not limited to:
  - Primary care providers
  - Specialists
  - Primary and specialty clinics
  - Dental providers
- The member may receive care from any contracted provider without referral.
- Model of Care training is offered annually to all providers, delegates and UCare employees.
Clinical Practice Guidelines (CPGs)

- UCare adopts clinical practice guidelines to support good decision-making by patients and clinicians to improve health care outcomes, and meet state and federal regulatory requirements.

- CPGs are available on our provider website.
UCare collects and analyzes data and reports from a variety of sources to:

- Annually evaluate the Model of Care.
- Identify improvements to be made for our members.
Care Coordination is one component of our care model.

UCare has two products with care coordination services – MSHO & UCare Connect + Medicare which currently serves around 14,000 members.

Care coordinators work with members, families and providers on transitions of care with a goal of reducing re-admissions.

UCare uses data and reports to evaluate the Model of Care annually.
UCare Contacts

- Provider Assistance Center
  - Phone: 612-676-3300

- Clinical Liaison
  - 612-294-5045
  - clinicalliaison@ucare.org
2018 Care Coordination Satisfaction Survey Results

November 2018
Care Coordination Satisfaction Survey

Thank you all for taking the time to complete the survey.

• 309 responses to:
  – Questions regarding care coordination, training, notifications, audits, enrollment, authorizations
Please rate your satisfaction with day-to-day responses to your questions/concerns in the following areas within Clinical Services:

- Clinical Care System Liaison for care coordination
- Clinical Intake Line for waiver services authorization
- Clinical Intake Line for PCA questions
- UCare Connect Intake Line (Care Navigator's)

Survey results shown in a bar graph with the following categories:

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied
- Not applicable
How would you rate the following resources to MSHO, MSC+ and UCare Connect products?
How satisfied are you with the content and clarity of the following?
What we are doing!

• Evaluating the phone numbers, recorded messages, and prompts within the Clinical Services Department.

• Provided feedback for the new website:
  – Dates are being added to identify when a document is updated
  – Too many “clicks” to get somewhere
  – Enhance search function

• 2019 Supplemental benefits will be shared at the 4th Quarterly.

• Process improvement discussions on Care Coordination Enrollment Rosters will begin 1st quarter of 2019.
Care Coordination Updates
UCare Connect & UCare Connect + Medicare Requirement Grids

- Updated 9.1.18
  - Revisions highlighted in yellow (initial rollout) and green (midmonth rollout).
  - Introduced 3428H:
    - 3428H replaces the UCare Connect HRA.
When to Call Customer Service

• Care Coordinators or Members should call Customer Service when there are questions about their plan or coverage.
  – Customer Service has the ability to look at the member’s individual coverage and provide accurate information on their plan and what could possibly be covered.
  • Phone: 612-676-3395
What do Care Navigators do?

- Care Navigators can provide assistance in:
  - Finding/changing primary care providers or primary care clinics
  - Education about preventative care such as: annual preventative exams, vaccinations, and screenings
  - Referrals to Health Improvement programs for heart failure, asthma, or diabetes, chronic kidney disease, if criteria is met
  - Obtaining information regarding the various Incentive programs
  - Asset in identifying in network providers i.e. DME
WebEx’s Available

- Advanced Directives
- Care Coordination Enrollment, Daily Authorization and Reports
- Smart Goals
- Transitions of Care

These are located on the UCare website in “Care Coordination Trainings” in the “Care Coordination Topics” drawer.
Clinical Liaisons

- 612.294.5045
- clinicalliaison@ucare.org
Questions?