
ucare®

Connect & Connect + Medicare Care Coordination Meeting

November 19, 2020
Recorded WebEx

Agenda

- Transportation & Care Coordination – Trent Brier
- Matrix Overview – Cindy Radke
- Access Line – Elena Hawj
- 2021 Connect & Connect + Medicare Benefit Changes – Rob Burkhardt
- Member Satisfaction Survey – Dawn Sulland
- Housing Stabilization Services – Dawn Sulland
- Care Coordination Survey – Dawn Sulland
- Model of Care – Dawn Sulland
- Care Coordination Updates – Dawn Sulland

UCare Heathride Transportation

Manager : Trent B

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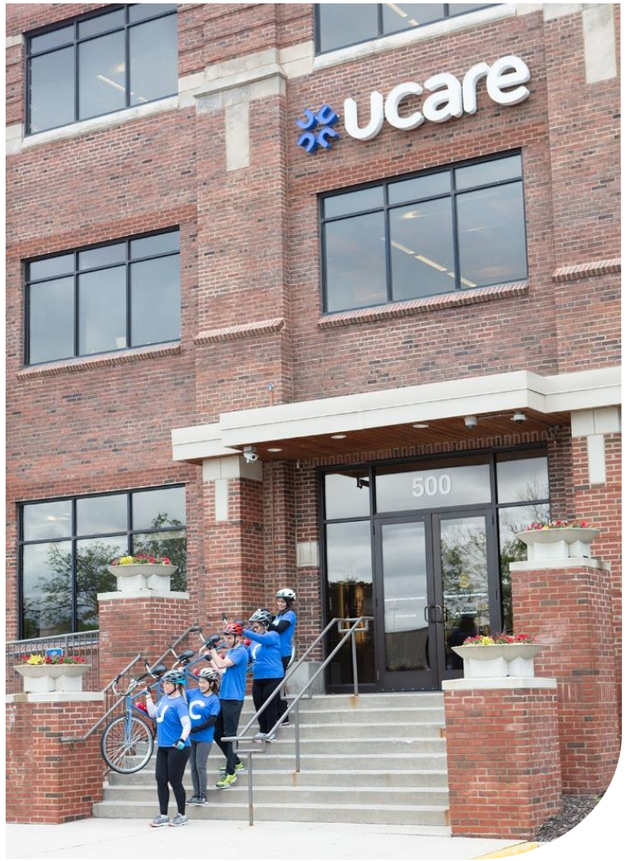
What is UCare transportation

- UCare transportation provides Vehicle medical transportation or bus passes for medical and dental needs for our members based on their UCare plan.
- Traditionally we book about 50-100k legs a month, we average about 1200-2000 calls a day, and we do on average 300-500 urgent same day rides per day .
- We are staffed for normal ride bookings Monday through Friday 7am to 8pm, Saturday and Sunday for urgent/emergency transportation 8am-8pm

Some terminology we use in Transportation

- Ambulatory = This is also known as common carrier or unassisted. This type of transportation is your common sedan with a driver, or volunteer driver services. There is no assistance or door to door service.
- STS transportation = This is also referred to as assisted. This includes lift/ramp vehicles, Stretcher vehicles, door to door assistance, unaccompanied minors, and protected. To use a STS vehicle we need a CON (certificate of Need) on file. This process is done when STS is requested.
- LDE = Long Distance exception. This is any transportation over 30 miles for a primary care, or 60 miles for any specialist care. This process includes verification of the appointments and referrals and takes at least 2 full business days to complete.
- CON = Certificate of Need. This is the paperwork we send to a member’s doctor to get authorization for STS transportation. While we wait for this paper work from the doctor we will set up a 60 day grace period to ensure we give the member the ride they need.



Best practices for booking a ride.

- For most rides it is best to call at least 2 business days before your appointment. This allows us to find an appropriate provider for the ride.
- Depending on weather and volumes we may not be able to provide same day rides. This typically happens on First day of the work week, First of the month, and inclement weather days.
- If the primary care provider is over 30 miles or the specialist care provider is over 60 miles we will need to process an LDE (long distance exception). We need at least two full business days to do the back end work on an LDE. Dental does not require an LDE but may require appointment verification
- Always have The member Name, Member (UCare) ID number, On file address and Phone number available when you call.

How we will book a ride.

- The process for booking a ride is very simple. You call with your information, the location for pick up, the location for the appointment, and a phone number the provider can reach the member at.
- If the ride is Same day, STS(assisted), or out of the 7 county metro area we will have to get verbal acceptance from the transportation company before we can book the transportation.
- Inside the metro for a common carrier (non-same day ride) we can book without the verbal acceptance from the Transportation provider.
- Depending on the ride we may need to verify the appointment or the prescription ready status before booking the ride.
- We use a software program that our transportation providers have access to, this allows us to quickly process the ride request.

Sanctions and Restricted recipient

If a member is found to be misusing the transportation services we may set them up on sanctions or restrictions.

Sanctions typically will be initiated with either a verbal warning or a written warning. Once the warning has been issued any future misuse of the transportation services will result in either a sanction or recommendation for restricted services. A sanction is one year from date of issue. Sanctions typically sets the member for bus pass only

If a member is put on restrictions they will be limited to only the approved primary, pharmacy, and ER set by the restricted recipient coordinator.

What happens if my ride doesn’t show?

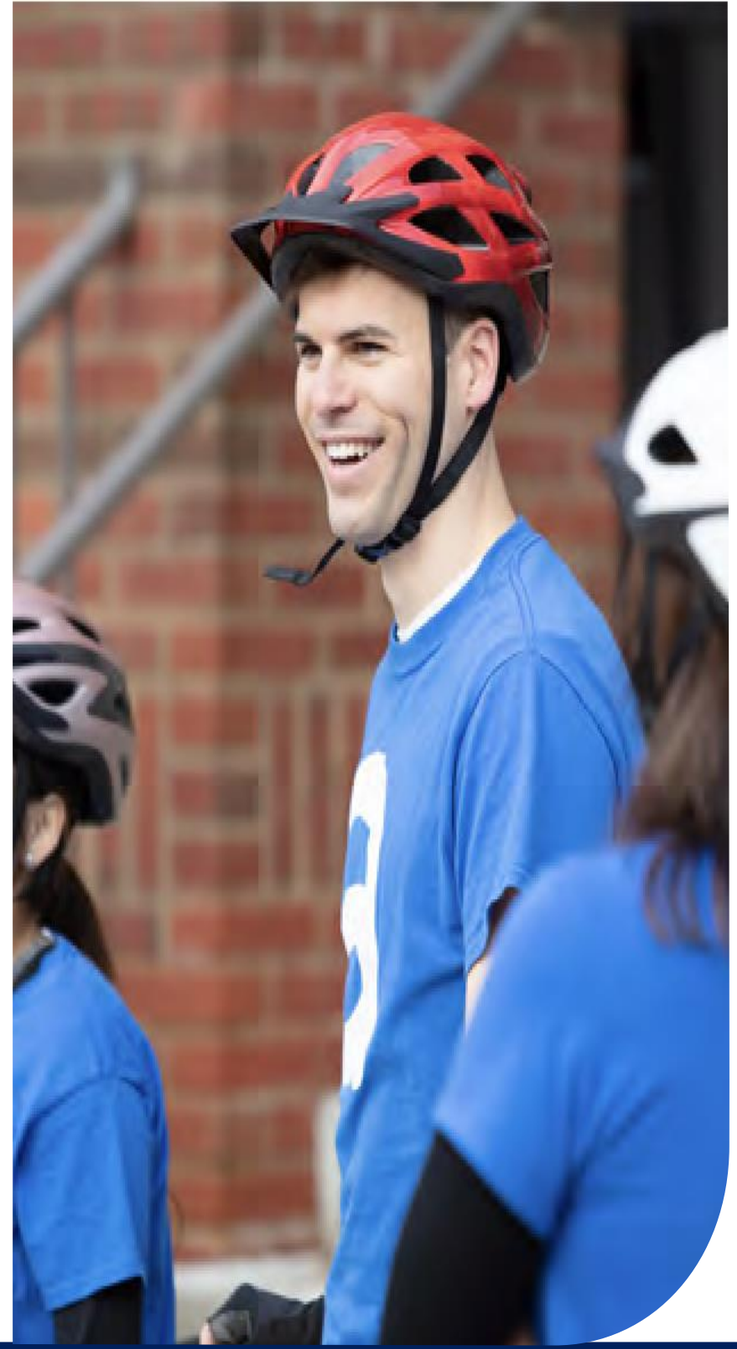
- Hopefully this doesn’t happen. But in the case it does UCare will call all providers in our network who have the ability to accommodate the ride.
- If we cannot find a provider to accommodate we will escalate the issue to our supervisor team who will also attempt to find a provider to accommodate.
- If that team is unable to find a provider able to accommodate we will escalate to our Provider team.
- In very rare cases we may not be able to get a provider we will DTR(denial, termination, or reduction of transportation services) the ride.

Working to make the transportation experience better for everyone.

- The UCare team is constantly looking at how we can improve the service to our members, care coordinators, partners, and providers
- We have implemented a new Transportation software in partnership with our transportation providers.
- We are currently working on multiple programs to increase efficiency in transportation ride booking and delivery.
- We encourage feedback and we act on it. We believe that every idea is worth listening to and we also believe in implementing ideas that can assist us in providing a better service.

Care coordinator pilot

- **We have created a pilot for Care Coordinators to call a special line.**
- **This line is only for Care Coordinators and is staffed by a special team.**
- **We are in the early phases of this pilot but have plans to expand at a rapid rate.**
- **We have a target of January 2021 to have all Care Coordinators using this new special line.**
- **We will keep the Clinical Liaisons informed to our progress.**



Thank you

Matrix Medical Services

November, 2020

Matrix Medical Network Services

- With the goal of meeting our members where they are, UCare has partnered with Matrix Medical Network for many years to provide in-home assessments conducted by a Nurse Practitioner.
- Matrix is a community based nationwide network of clinical providers that can meet members where it is most convenient. Service is delivered in-home, in skilled nursing facilities, and currently via telehealth.
- A visit can last up to one hour. The Matrix Nurse Practitioner conducts a comprehensive assessment of the member which includes medication adherence, social environment, current health state and other risk factors.
- Visit meets and exceeds Medicare requirements for an annual wellness visit.
- This visit can assist members with community resources, recommendations to primary care, close gaps in care, and overall improve a member’s quality of care.

Who may be contacted?

- Matrix offers the assessment to MSHO, UCare Medicare, EssentiaCare, and Connect + Medicare members.
- Not all members are offered this service.
- Members are reviewed via an algorithm and identified for outreach.
- Matrix is now offering the visit via telehealth.
- Great way to address health concerns and provide education during COVID.

The Healthy Home Visit includes:

- A comprehensive health and wellness assessment
- A full review of their medical history and medications
- Personalized recommendations for additional care, screenings, and resources if needed
- Answers to health questions including any questions about COVID-19 (Coronavirus) and guidance about testing and safety practices.
- Referrals to community resources.
- Communication to primary care.

Engaging Members with Community Resources

- Matrix NPs educate enrollees to improve self care management… medical conditions, diet, exercise and lifestyle changes

- Health Plan CM Program Referrals for Members and caregivers; helping members find nearby services in their community

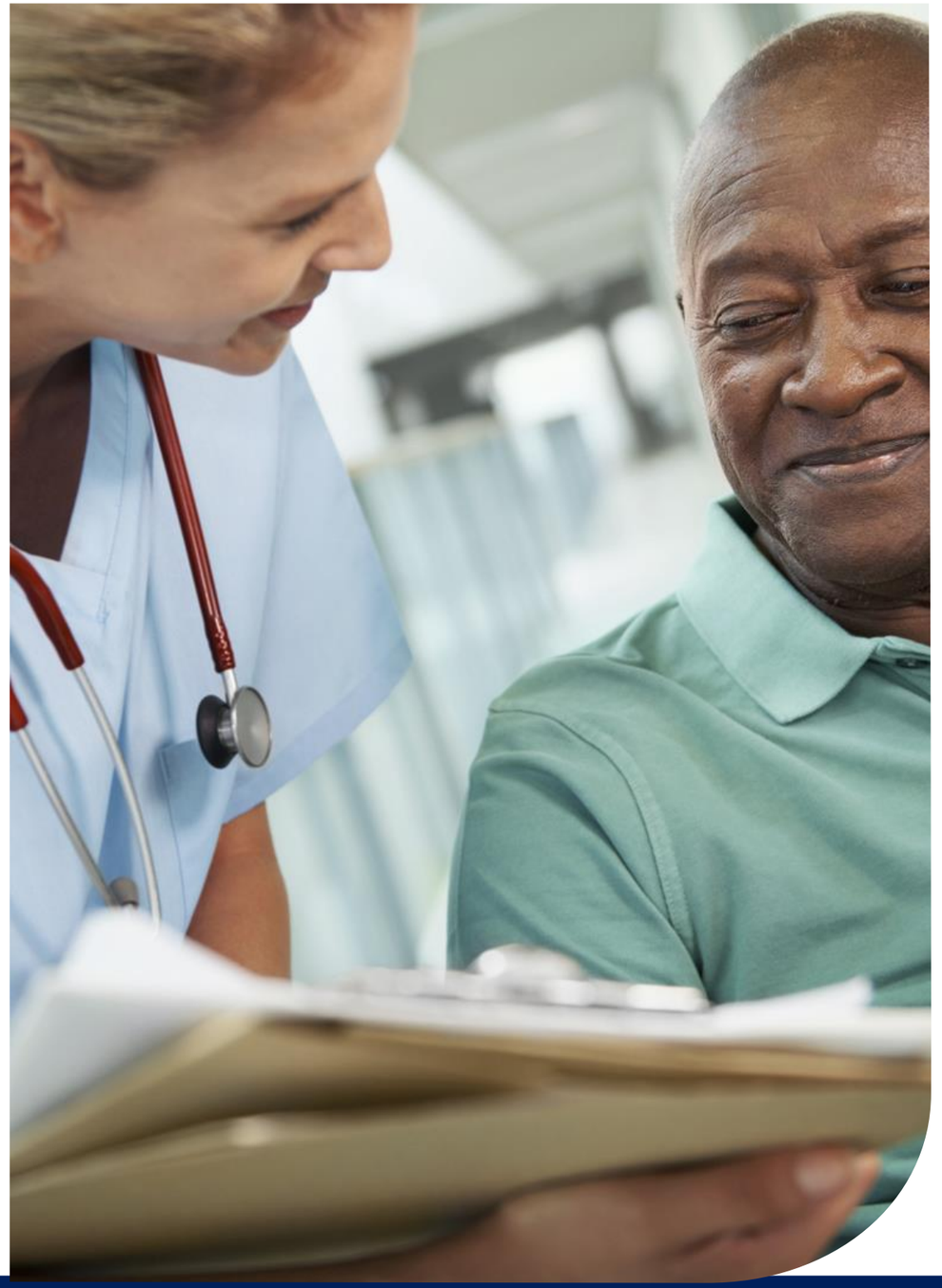
- Information Matrix gives on community agencies that can assist with reducing loneliness (activities, senior centers, senior congregate dining, etc.) and social determinants identified via In Home Health Assessments varies by region/state and includes:

What can you do?

If a member is contacted, encourage them to schedule a visit.

Matrix will work with primary care.

This is a great way to get questions answered they may have.




THANK YOU

Access Line

Elena Hawj, Operations Manager
Mental Health and Substance Use Disorder Services

Who are we?

Mental Health and Substance use Disorder Access Line

To assist our members with accessing care, we have added a phone line for members in need of a mental health or substance use disorder appointment.

Some benefits of this line:

- Triaging member’s appointment needs
- Assistance scheduling and confirming appointments
- Telehealth appointments for
  - Diagnostic Assessment
  - Psychotherapy
  - Comprehensive Assessments or Rule 25
  - Medication Management

When is this available?

December 1, 2020

UCare’s Access Line is available to all UCare members
Monday through Friday, 8:00am to 5:00pm

Contact Information:

Local and Tollfree Numbers

612-676-6811 or 1-833-273-1191

Questions...

Elena Hawj, Operations Manager

Mental Health and Substance Use Disorders Services

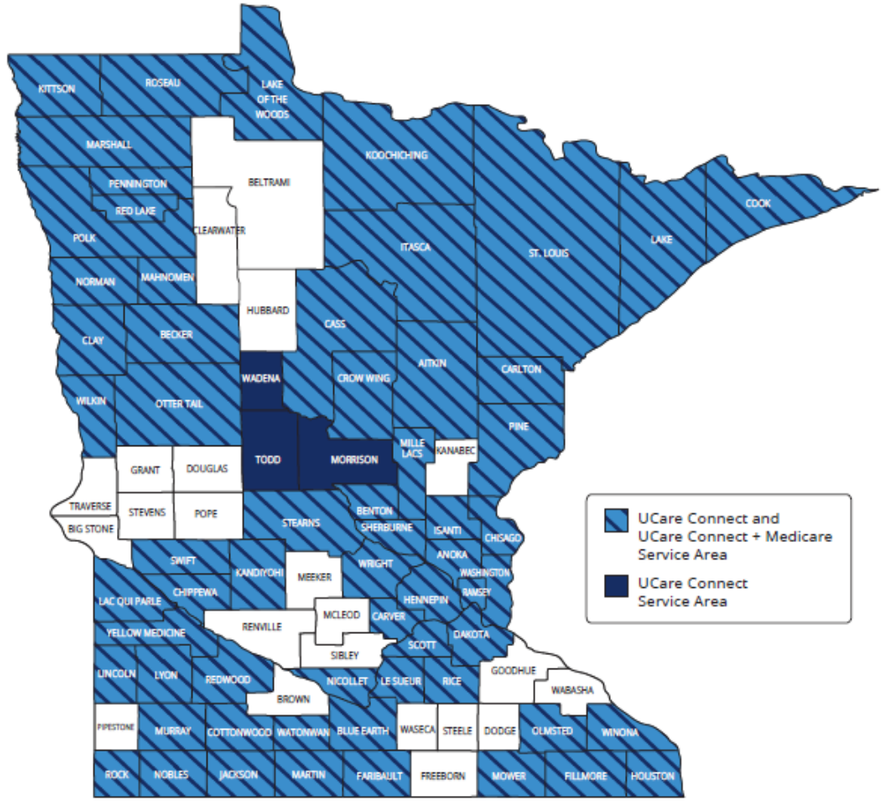
612-676-3652 | ehawj@ucare.org

2021 UCare Connect & UCare Connect + Medicare Benefit Changes

October 2020

Service Area

- UCare Connect available in Morrison, Todd & Wadena counties as of June 2020
- No change to UCare Connect or UCare Connect + Medicare service areas for 2021



What will / will not change

- What will not change:
  - Supplemental benefits covered in 2020 will continue in 2021
- What will change:
  - New supplemental benefits for Connect + Medicare

2021 Connect / Connect + Medicare Additional Benefits

2021 Changes in red

Fitness / Social Isolation support	Connect	Connect +
Silver Sneakers fitness membership, fitness kits	Y	Y
Up to 3 round-trip rides to gym / week NEW for 2021	**N**	**Y**

Mobility related	Connect	Connect +
Anti-glare eyewear lens coating – once / 2 years	N	Y
Routine foot care visit per month not related to a specific diagnosis already covered by Medicare.	N	Y

2021 Connect / Connect + Medicare Additional Benefits

2021 Changes in red

Readmission prevention	Connect	Connect +
Post-discharge medication review by pharmacist	N	Y

2021 Connect / Connect + Medicare Additional Benefits

Dental Coverage beyond Medical Assistance	Connect	Connect +
Additional dental exam (1/year)	Y	Y
Fluoride varnish (1 additional / year for members at risk for caries)	Y	Y
X-rays: Full mouth (1/5 yrs), bitewing, panoramic (1/ year)	N	Y
Root canal, root canal re-treatment (1/tooth/lifetime)	N	Y
Dental Sealants (1/year if sealant failed)	N	Y
Periodontal maintenance (up to four visits/year)	N	Y
Scaling and root planing (1/two years **in office**), **Gross removal of plaque, calculus**	N	Y
One **electric toothbrush** /**three** years, two replacement heads/year (comes w/ **adult Dental Kit**)	N	Y
Restorative – **crown (1/year)**	N	**1**

Additional Programs / Incentives

Additional Coverage	Connect	Connect +
Keep Your Coverage program – provides members with support for Medical Assistance eligibility renewal	Y	Y
Connect to Wellness kits – Stress Relief, Tai Chi, Sit & Be Fit and Latin Dance kits for whole body wellness	Y	Y
Community Education Discounts – up to $15 discount on most community education classes	Y	Y
Grocery Savings – save up to $50 a week at participating grocery stores with Healthy Savings, Shop and save when you buy select healthy foods, including milk, whole-grain bread, lean meat, eggs, yogurt, fruits, vegetables and more.	Y	Y
Whole Health Living online discounts on yoga, massage, Tai Chi and more	Y	Y
Incentives: Prenatal / Postpartum, dental, Child & Teen Checkup, cancer screening *(see health & wellness section of ucare.org)*	Y	Y
Incentives: Annual wellness visit, diabetes testing	**N**	**Y**

Connect/Connect+Medicare Member Satisfaction Survey

November 2020

Survey Overview

- Objective:
  - Assess member satisfaction with care coordination
  - Improve care coordination based on member feedback
- Topic Areas:
  - Satisfaction with care coordinator
  - Satisfaction with care plan
  - Input into care plan

Methodology

- **Random distribution of surveys**
  - Community members surveyed in July 2020
  - Members surveyed were in active care coordination
  - 21% response rate for Connect
  - 31% response rate for Connect + Medicare

Summary of Results

	CT	C+M
I know who my care coordinator is	91%	79%
My care coordinator is respectful	93%	87%
Overall satisfaction with care coordinator	94%	85%
CC makes it easier to stay in home – yes or sometimes	83%	67%
My care coordinator asks for input into care plan	88%	75%
My satisfaction with the care plan developed	87%	82%

Lower satisfaction rates reflected above were minimal in most cases. It is difficult to determine what impact COVID-19 and the transition to telephonic/virtual CC interventions may have had on these results.

Summary of Results (con't)

- Survey response rates consistent with those of 2019
- Most members satisfied with care coordinator and care plan development
- Most members indicate CC works with them to improve health
- Member comments indicated satisfaction – some CC's mentioned by name

I would recommend my care coordinator to other people

My care coordinator is wonderful!

Keep up the good work

Opportunities for Improvement

- Maintain efforts to help members know/remember health plan care coordinator and role care coordinator plays
  - Use term Ucare/health plan care coordinator to differentiate between other case managers member may have
- Encourage member involvement in care plan development

Thank you for all you do for our members!

Questions?

Housing Stabilization Services

Connect / Connect + Medicare Care Coordinator Role

Acronyms

- ACT: Assertive Community Treatment
- BI: Brain Injury
- CAC: Community Alternative Care
- CADI: Community Access for Disability Inclusion
- CC: Care Coordinator
- CSSP: Coordinated Services and Supports Plan
- DD: Developmental Disability
- DHS: Department of Human Services
- HFPCP: Housing Focused Person-Centered plan
- HRA: Health Risk Assessment
- HSS: Housing Stabilization Service
- ICF/DD: Intermediate Care Facility for people with developmental disabilities
- MA: Medical Assistance
- MCO: Managed Care Organization
- MHM: Moving Home Minnesota
- PSN: Professional Statement of Need
- RSC: Relocation Service Coordination
- SNBC: Special Needs BasicCare
- TCM: Targeted case manager

Care Coordinator Role

- The SNBC care coordinator role is not any different for HSS than the care coordinator role in identification and assistance in accessing any other service.
- There are no requirements for SNBC CC to conduct the HSS assessment or the person-centered plan.
- The SNBC Advisory Committee developed the SNBC Guiding Principles for the SNBC Managed Care Organizations (MCO). The principles included:
  - 1) health plan staff were to coordinate healthcare and community supports so the quality of life for people with disabilities is maintained and enhanced, and
  - 2) a common method needed to be used for assessing needs so that people with disabilities with similar needs as others have access to services (HRA).

- HSS is an important service as it is understood some disabilities make it difficult for people to search for or secure housing, interact with landlords/neighbors, and understand or follow a lease. The right supports, provided by a professional with knowledge and experience in housing can help resolve barriers some people face in finding and keeping housing.

Housing Stabilization Services (HSS) Eligibility Criteria

- A member is eligible for housing stabilization services if they meet all of the following needs-based criteria:
  - Be on Medical Assistance (MA)
  - Be 18 years old or older
  - Have a documented disability or disabling condition
  - Be assessed to require assistance with at least one of the following areas resulting from the presence of a disability or a long-term or indefinite condition.
    - Communication, Mobility, Decision-making or Managing challenging behaviors
  - Be experiencing housing instability.

Health Risk Assessment (HRA)

- The SNBC health risk assessment helps:
  - identify member needs,
  - identify any health problems that need immediate attention,
  - CC understand their members health risks and
  - CC monitor the members health status over time.
- The HRA includes questions about access to health care, living situations, and ADL/IADLs. As a tool it is used to identify individuals who might benefit from access to Medicaid paid services.
- The HRA does not assess need for Housing Stabilization Services.
- The HRA may help identify the members need for HSS and improve the access to services.

Identifying Connect/Connect + Medicare Members Who May Benefit From HSS

- By virtue of their enrollment in SNBC people enrolled in SNBC meet the following criteria which are also used for helping determine HSS eligibility:
  - On Medical Assistance (MA)
  - 18 years old or older
- Have a documented disability or disabling condition defined as one of the following:
  - Aged, blind, or disabled as described under Title II of the Social Security Act (SSI/SSDI)
    - People determined by a medical professional to have any the following conditions:
      - Long-term injury or illness
      - Mental illness
      - Developmental disability (including people on the developmental disability waiver)
      - Learning disability
      - Substance use disorder

Identifying Connect/Connect + Medicare Members Who May Benefit From HSS

Through the current health risk assessment care coordinators identify areas of need for which the member requires assistance and support the need for housing stabilization services.

If the member requires assistance with at least one of the following areas noted below this need supports the eligibility of the member for HSS.

- Communication
- Mobility
- Managing behaviors
- Making decisions

Identifying Connect/Connect + Medicare Members Who May Benefit From HSS

The other area of need that must be identified to access HSS is housing instability.

When reviewing the HRA they may be able to identify if the member is:

- homeless
- at risk of homelessness (including could become homeless without continued housing services)
- institutionalized (currently or within last 6 months) or;
- eligible for a waiver (a member with an institutional level of care is also deemed at risk of institutionalization).
- Currently transitioning or have recently transitioned from an institution or licensed or registered setting (for example: foster care, assisted living, board and lodge)

If the member meets any of these housing instability categories, the member has met this needs-based criteria.

<u>HRA Questions Identifying Risk of Housing Instability</u>

- Who do you currently live with?
  - Living with family, friend or significant other, group setting, homeless or would be homeless without current housing
- What is your current housing situation?
  - Homeless , Institution (ICF/DD, hospital, foster care, nursing facility, correctional facility)

Care Coordinator Identifies the Need for HSS

- Conversation with member to identify/verify need for housing support.
- Summarize and record in case notes what you have learned from the member associated with their current housing or need to move.
- Document the need for HSS in the member’s care plan.
- Record the member decision regarding accessing HSS.
- Identify resources available to member to assist with housing needs.
- Document support given to the member to obtain HSS.

Identify Resources Available to the Member to Assist with Accessing HSS

- Identify if the member is:
  - On a waiver for people with disabilities.
    - Brain Injury (BI) , Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Developmental Disability (DD)
  - Receiving targeted case management
    - Adult Mental Health, Child Mental Health, Vulnerable Adult/Developmental Disability
- If the member has MA case management services
  - The care coordinator would contact the:
    - Waiver case manager to confer with them regarding the members needs. It is the responsibility of the waiver case manager to update the coordinated services and supports plan (CSSP) with Housing Stabilization Services to support the member's access to HSS.
    - Targeted case manager (TCM), provided the member is not on a waiver, then the TCM completes the assessment and the Housing Focused Person-Centered plan (HFPCP) to support the member's access to HSS.
- Best practice is for coordinators to maintain open communication with the case manager.

Duplicative Services

If the member is receiving the following services HSS is not available to them as these services are duplicative of HSS:

- Assertive Community Treatment (ACT)
- Living in an institution receiving Relocation Service Coordination (RSC)
- Moving Home Minnesota (MHM)

If the Connect/Connect + Medicare Care Coordinator know who the RSC, ACT or MHM provider is they should contact the provider to share the member’s identified housing needs or concerns.

Care Coordinator Role in Housing Stabilization Services

- When the member does not have a MA case management (e.g. waiver/targeted /or vulnerable adult- developmental disability/ child welfare case manager) the care coordinator is responsible to:
  - Assist the member in finding a housing consultant through the Minnesota Health Care Programs Provider Directory
    - Search for Home and Community Based Services
    - Subtype “Housing Stabilization Services”
  - Support the member with choosing a housing consultant
  - Support the member with contacting the housing consultant

Assessments for Housing Stabilization Services

- Professional Statement of Need (DHS-7122)
  - Primary pathway onto the services
  - The easiest pathway onto housing stabilization services
  - Care coordinators should support the member with having one completed
    - Care Coordinator can not sign the PSN unless they have the qualifications as noted in Section 2 of the form.
- MnCHOICES/LTCC
  - Assessment pathway for people who require other long-term services and supports they are not already receiving.
  - Care coordinators should support the member with connecting with the county to get a MnCHOICES assessment if the member needs Housing Stabilization Services and other long-term services and supports.
- Coordinated Entry
  - Assessment pathway for people experiencing homelessness
    - This pathway is not yet implemented across the state.
    - Care coordinators should connect people to the PSN whenever possible along with coordinated entry support when possible.

Expectations of the Care Coordinator

- Document in the members care plan the name of the chosen housing consultant.
- Monitor the member’s progress with the housing consultant provider and chosen housing sustaining or transition providers.
- Transportation to this service is part of the Medical Assistance benefit. Follow the current UCare transportation processes to assist the member in arranging transportation.
- Care Coordinator questions regarding HSS will be addressed by the UCare clinical liaisons.
- Refer HSS providers to the UCare Provider Assistance Center for billing questions.

Transportation

- Covered Transportation Service
  - Transportation to the HSS provider office, as well as transportation to a community location where the HSS provider will be providing HSS services
    - e.g. the apartment member is touring with HSS provider
  - If a HSS plans to provide transportation to a member receiving HSS services, and intends to bill UCare for this transportation, the HSS Provider must also be a DHS enrolled transportation provider.
  - Refer transportation provider to the UCare Provider Assistance Center for billing questions.

Additional Resources

- DHS Websites
  - Housing Stabilization Services Policy Page
    - Important Program Announcements Section
    - Sign up for the DHS mailing list to receive announcements
  - MHCP Provider Manual
  - MHCP Provider Directory
    - Search under Home and Community Based Services
    - Subtype “Housing Stabilization Services”
- Frequently Asked Questions Document (PDF)
  - This is updated monthly
- Person-Served Workflow (DHS-7347)
- Housing Benefits 101 (mn.hb101.org)
- Helpful tools for people served, including benefits look-ups, budgeting pathways, and general information about Housing Stabilization Services (brochure/visual aids) Webinars
  - General Overview (recorded) on Housing Benefits 101
  - Policy Page (PDF only)
- Allowable Documentation for Housing Stabilization Services Eligibility Requests Guidance

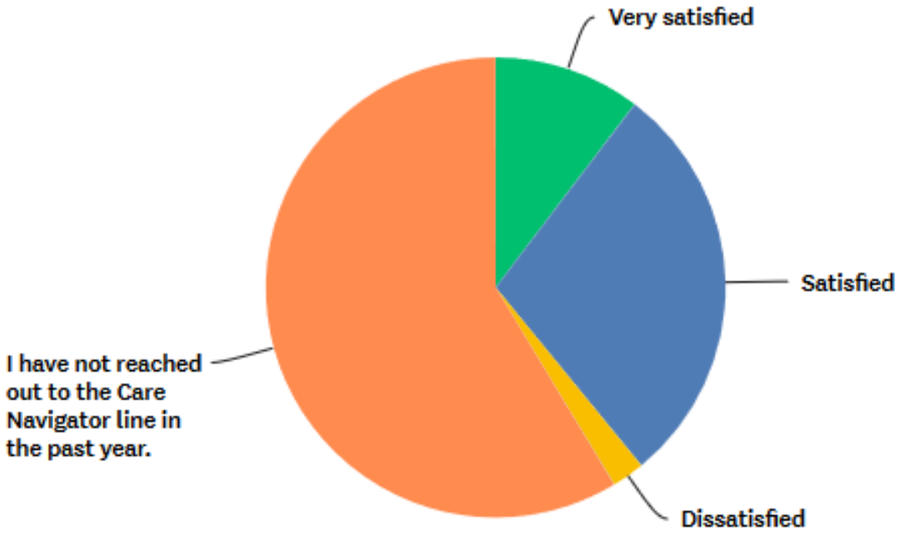
2020 Connect/ Connect + Medicare Care Coordination Survey Results

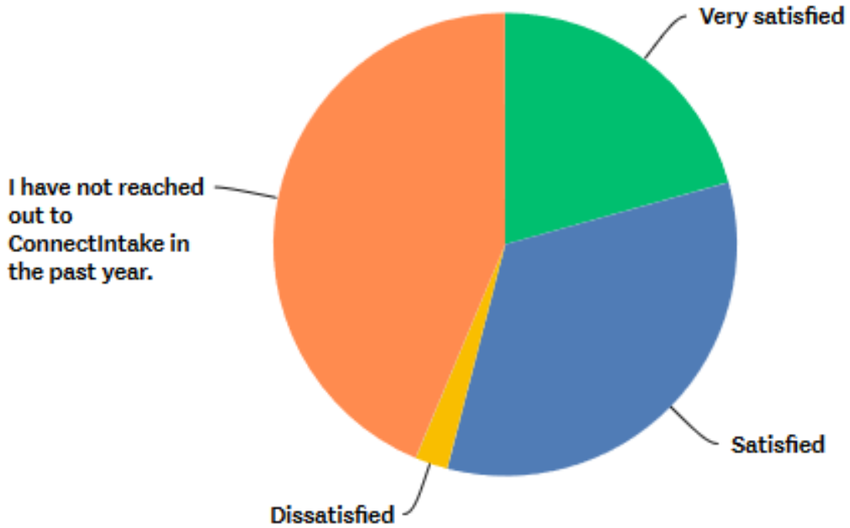
November 2020

We had nearly a 50% response rate!

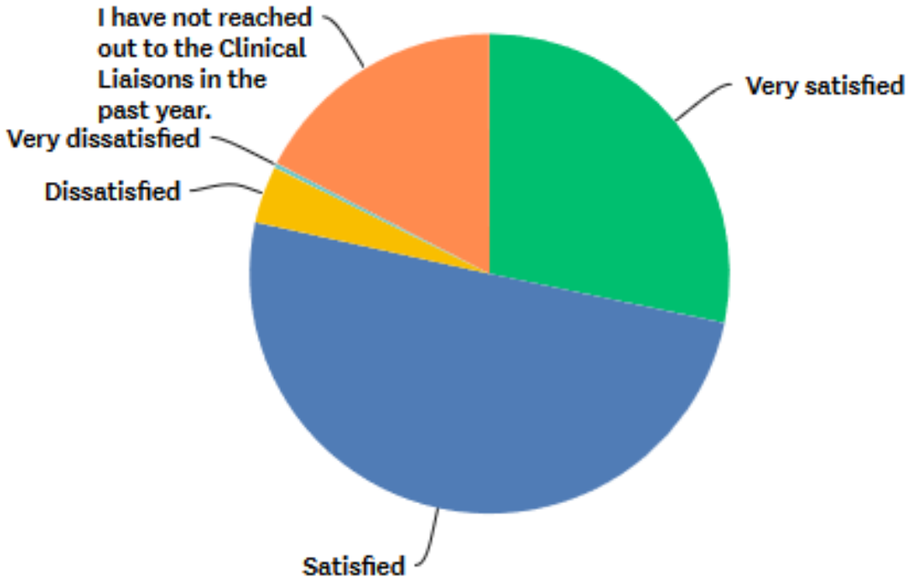
Thank you to everyone for taking the time to respond to the survey!

Care Navigator & Connect Intake

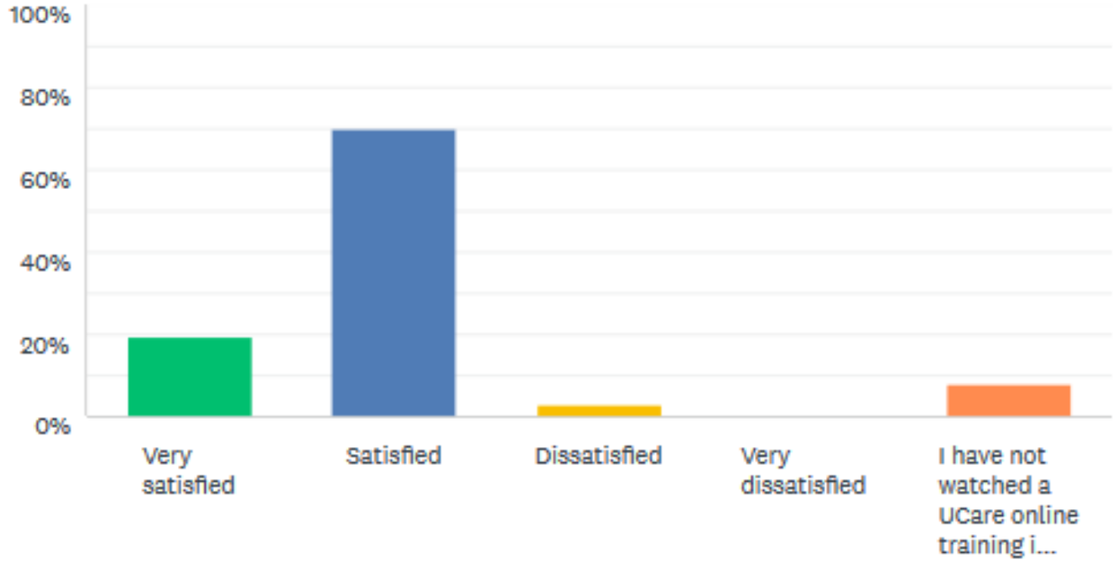




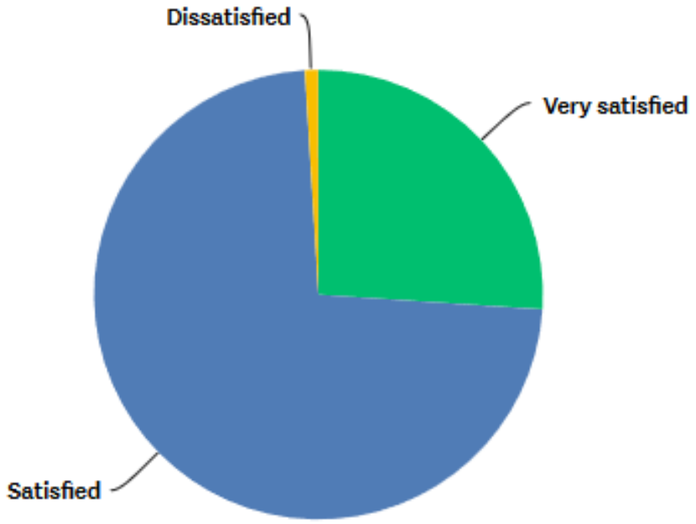
Clinical Liaisons



Please rate your satisfaction with UCare's online trainings on Care Coordination topics.



Satisfaction with UCare's Alerts & Newsletter



Care Coordination Survey Results

What we heard:

- Care Navigation Line wait times:
  - Phone #:612-676-6502 or 1-877-903-0062
    - Option to leave a message for callback.
    - Messages can be returned same day.

Care Coordination Survey Results

Confusion regarding the care navigator role:

- Care Navigators can assist with:
  - Searching for an in-network provider
  - General questions about medication requests
  - Assistance navigating Connect/Connect + Medicare
  - Finding the member’s care coordinator
  - Obtaining information about UCare programs
  - Delta Dental contact information

UCare Model of Care

Minnesota Senior Health Options (MSHO) & UCare Connect + Medicare
2020

Training Purpose

- To provide information about the Model of Care requirements for UCare Dual Special Needs Plans MSHO and UCare Connect + Medicare, as required by the Centers for Medicare and Medicaid Services (CMS)
- To outline the importance of your role as a provider or care coordinator of the MSHO and Connect + Medicare interdisciplinary care team
  - Explain how you may interface with the care coordination team in the provision of care

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’s 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 who reside within UCare’s service area

Special Needs Basic Care (UCare Connect + Medicare):

- The UCare Connect + Medicare Program serves members with disabilities who are dually eligible for Medicare and Medical Assistance between the ages of 18-64 who reside within UCare’s service area

To be eligible, members must:

- Be Medicare and Medicaid eligible
- Have Medicare Part A and B
- Meet the age requirements per product

UCare's Special Needs Plans

Integrated products combining Medicaid & Medicare:

- Parts A, B, and D (pharmacy)
- Members have 1 ID card
- One phone number to call for health plan questions

Over 17,000 members:

- 13,400 MSHO
- 3,530 UCare Connect + Medicare

Member Demographics

MSHO

- Average Age:76 years
- Age range: 65-110 years
- 66% Female/ 34% Male
- Living arrangements:
  - 36% community
  - 16% institutional
  - 48% waiver

UCare Connect + Medicare

- Average Age: 48 years
- Age range: 19-65
- 55% Female/ 46% Male
- Living arrangements:
  - 98% community
  - 2% institutional

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 upon a member's health risk assessment
- Ensures members receive individualized care plans
- Encourages and provides care transitions support to members and families

How do Members enroll in MSHO or Connect + Medicare

- Enrollment is voluntary
  - Ways to enroll:
    - ✓ Member's county financial worker
    - ✓ UCare's Enrollment: 612-676-3554 or 800-707-1711
    - ✓ Senior Linkage Line: 800-333-2433 (for MSHO)

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

Care Coordinator’s Role

- Every MSHO member is assigned a care coordinator
- Connect + Medicare members are assigned a care coordinator based upon their assessed need
  - The care coordinator partners with the member and their Interdisciplinary Care Team
    - All Primary Care Physicians are considered an integral part of the member’s interdisciplinary care team
  - The care coordinator is the primary point of contact ensuring ongoing communication between members of the Interdisciplinary Care Team
- To find out who the care coordinator is for a member, call UCare’s Customer Service:
  - MSHO: 612-676-6868 or 866-280-7202
  - Connect + Medicare: 612-676-6830 or 855-260-9707

Interdisciplinary Team

- The Interdisciplinary Team consists of:
  - Member and/or appropriate family/caregiver
  - MSHO or Connect + Medicare care coordinator
  - Primary Care Provider
  - Other providers appropriate to specific health needs (Specialists, Mental Health Providers, Palliative Care Team, Pharmacist, etc.)
  - Others included as identified by the member and others on the team

Home and Community Based Services

- MSHO members may qualify for Home and Community Based Services (HCBS)
- HCBS allow flexibility and creative alternatives for members to remain their homes/community vs. a nursing facility
- Some of the services funded through HCBS are:
  - Skilled Nurse Visits (SNV)
  - Home Health Aids (HHA)
  - Personal Care Assistant (PCA)
  - Homemaking
  - Adult Day Centers

Care Transition Protocols

- Care coordinators 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
- Care coordinators follow up with the member to:
  - Discuss their health status changes and discharge instructions
  - Ensure that follow up appointments have been scheduled
  - Ensure member understands any changes in their medications
- Overall goal is to improve 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 have care from any contracted provider without referral
- Model of Care training is offered annually to all providers, delegates and UCare employees

Quality Measurement & Performance Management

UCare collects and analyzes data and reports from a variety of sources to measure plan performance which include:

- Claims, utilization, pharmacy, demographic information
- HEDIS, CAHPS, Stars, predictive modeling, and evidence based analytic tools

This information helps UCare to:

- Annually evaluate the Model of Care
- Identify improvements to be made for our members

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 UCare’s provider website

Summary

- Care coordination is one component of UCare's care model
- The UCare Model of Care applies to MSHO & Connect + Medicare which currently serves around 17,000 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.
- Providers play an important role as a member of the Interdisciplinary Care Team

Care Coordination Updates

Care Coordination Enrollment Rosters

The new Care Coordination Enrollment Rosters have been sent out for 4 months now.

We want to acknowledge that this is a new process and there will be some issues as we continue with them and the process will continue to improve as time goes on.

Thank you all for your understanding as we continue to evaluate and make changes.

Care Coordination Requirements Grids

- The care coordination requirements grids will be updated effective 1.1.2021.
- The updated requirements grids will be sent out to leadership at each delegate in mid-December for review.
- The updated requirements grids will be posted to the website in January.

Monthly Activity Log - Reminders

- The Monthly Activity Log will be updated for 2021.
- Monthly Activity Log training in the *Care Coordination Topics* drawer on the Care Coordination Trainings page
- Please ensure the Monthly Activity Log is completed as indicated in the training.

Clinical Liaison Contact

- Email
  - Clinicalliaison@ucare.org
- Phone number & toll-free phone number
  - 612-294-5045
  - Toll free: 866-613-1395
  - When calling please supply the following
    - Contact person’s name, phone, and email.
    - A detailed description, including:
      - Member’s name and date of birth.
      - Member’s UCare ID# or PMI #.
      - UCare product (MSHO, MSC+, Connect + Medicare or Connect).
      - Question pertaining to care coordination.

Thank you!