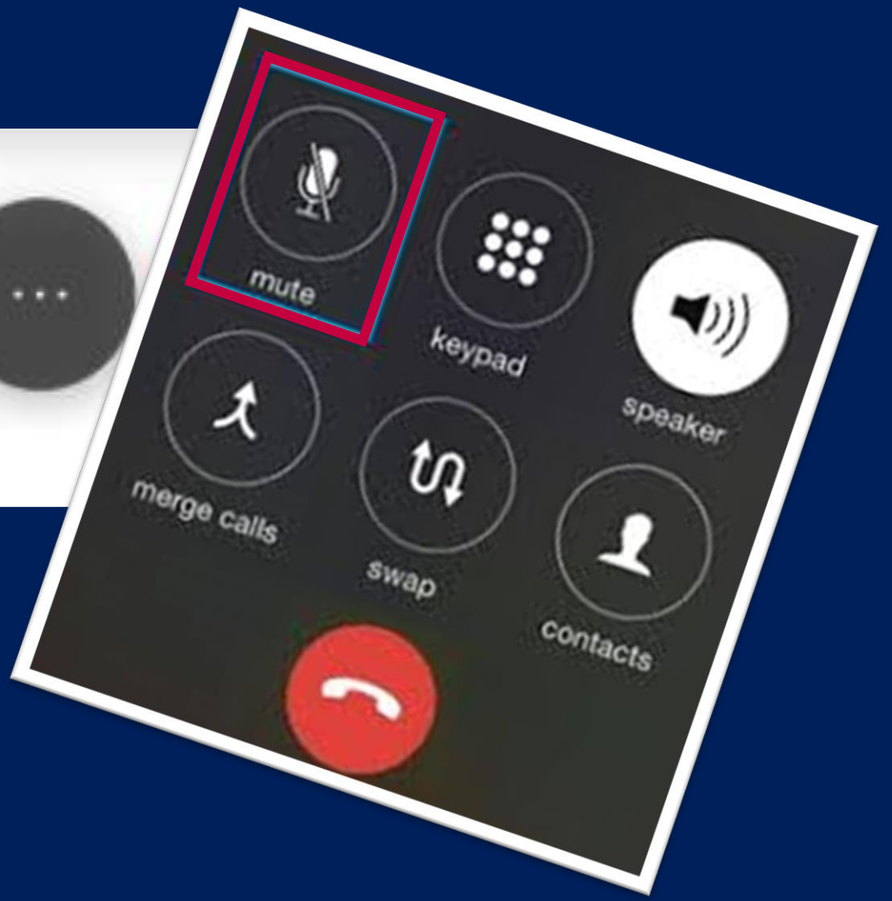

ucare®

Welcome!

Please mute your phone and computer microphone and disable your webcam during this presentation



UCare Connect/Connect + Medicare & MSHO/MSC+ 2nd Quarterly Meeting

June 15, 2022

Agenda

Reemo Health
Nicole Charboneau, Kristen Austrum & Andy Gonerka

UCare Triage Line & Access Line
Shelby Marshall

Member Engagement Specialists
Mai Vang

UCare Website Overview
Jenn Redman

Care Coordination Requirements
Dawn Sulland, Jenn Redman & Kristen Sagnes

Care Coordination Updates
Dawn Sulland

Reemo HEALTH

Personal. Connected. Health.

UCARE

JUNE 15, 2022

Reemo HEALTH

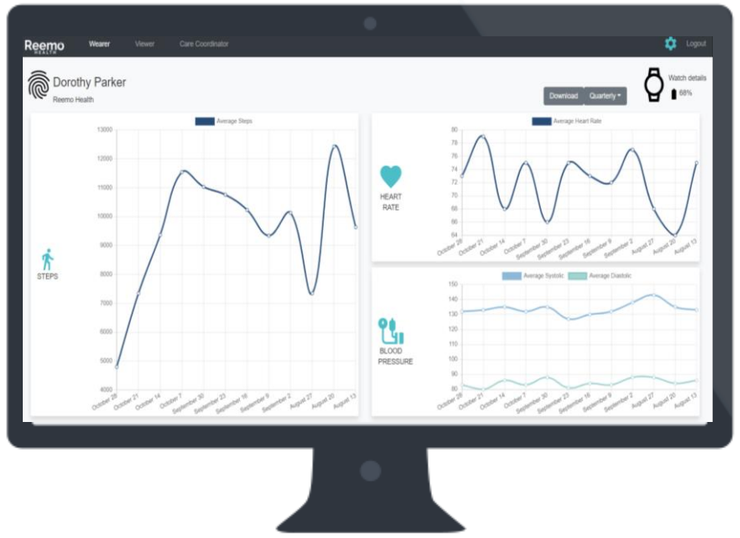
Overview

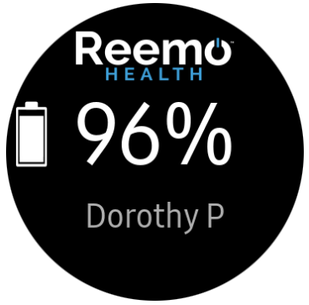
Device design and features

Watch functions

- Time, steps, heart rate, battery, messaging
- PERS

Portal





Messaging


Physical activity supports positive mental health
Do you need help with your watch?
Yes
No
Thanks. You will receive a call shortly
Healthy weight can lower risk of chronic disease
shot. Make an
sleeves when
Need help making a Dr. Appt?
Yes
No

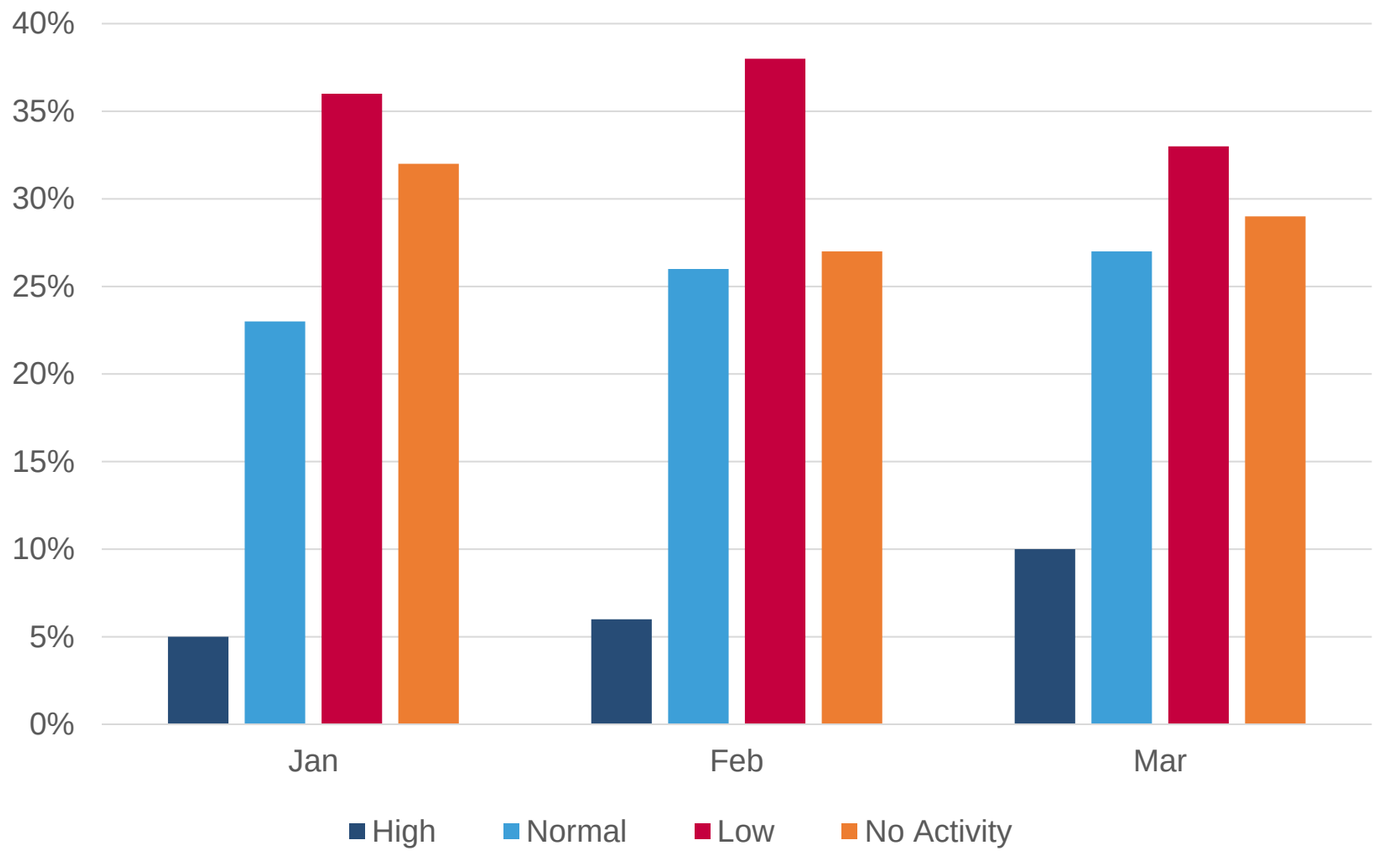
Reemo HEALTH

UCare Members

UCARE MEMBERS

Overview

Active members



Total UCare members: 526

Jan – March 2022: 89

Active Users: 52%

High Activity: 10,000 or more steps per week Daily average step count is at least 1,428.

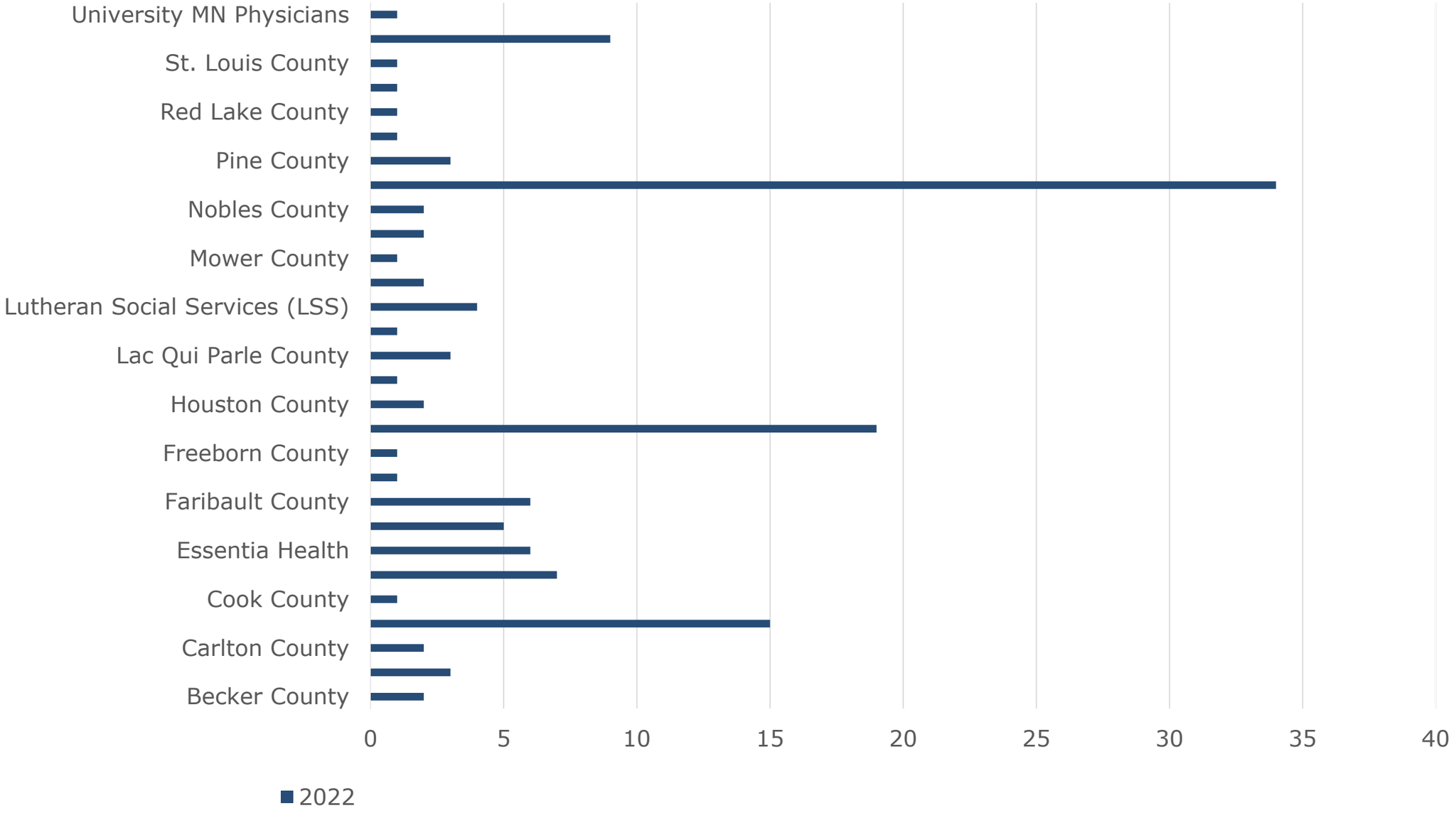
Normal Activity: Between 1,750 and 9,999 steps per week. Daily average step count is between 250 and 1,427.

Low Activity: Between 1 and 1,749 steps per week. Daily average step count is between 1 and 249 for the month.

No Physical Activity: No step data collected

UCARE MEMBERS

Demographics



UCARE MEMBERS

PERS Call-for-Help

	2021	2022
Inbound Calls	480	286
Unique Members Making Calls	337	155
Emergency Services Dispatch	74	26
Non-Emergency Calls	350	246
Actual Emergency Dispatch (confirmed medical emergency)	7	3

Reemo HEALTH

MEMBER FEEDBACK

83%

ENGAGEMENT

open watch messages

93%

SATISFACTION

respond that the Reemo smartwatch is easy to use

89%

VALUABLE

of members find Reemo useful to them

Reemo HEALTH

Care Coordinator Feedback

FEEDBACK

Single solution for health management, independence and care coordinator engagement

Chronic Condition

- Diabetes
- Heart failure
- Higher hospitalization rates

Active Living

- Stay active
- Get more steps
- Lose weight

Feel Safer

- Live alone
- Want to remain active
- Get out in community

FEEDBACK

Introducing Reemo

- Aligns with their goals (losing weight, more activity, controlling diabetes, etc.)
- Can help them feel safer in their home
- No set-up (truly no set-up)
- Free
- Other members have stated:
  - It has proven to be a wonderful “piece of mind”
  - They like that it isn’t a pendant to wear around their neck
  - It takes the stigma away from the Lifeline

Mental Health and Substance Use Disorder Triage Line

How Can We Help?

Customer Service

- Benefits/Eligibility
  - Pharmacy
  - Dental
  - Chiro Care
- Premiums
- Claims
- Materials/Mailings
- Transportation
- Appeals/Grievances

MSS Triage

Crisis Intervention
MSS Significant Needs/Complex
MSS Referrals
MSS Provider Network
MSS Case Management & Consultation
MSS Auth/Notifications
Community Resources

Hours of Operation

Monday thru Friday
8:00am – 5:00pm
Phone: 612-676-6533 / 833-276-1185
Fax: 612-884-2033 / 855-260-9710
Email: MHSUDservices@ucare.org.
Afterhours support for members is available through
UCare’s 24-hour nurse line.

Access Line

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?

UCare's Access Line is available to all UCare members

Monday through Friday, 8:00am to 5:00pm

Contact Information:

Local and Tollfree Numbers

Access Line: 612-676-6811 or 1-833-273-1191

Member Engagement Specialists

Mai Vang, Quality Improvement Specialist - Stars

Position Overview

Dedicated staff to do telephonic outreach to our members due for certain preventative screenings and visits:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Osteoporosis Screening
- Annual Dental Visits
- Annual Wellness Visits
- Child & Adolescent Well Child Visits
- Kidney Health Evaluation for Patients With Diabetes
- Hemoglobin A1c Control for Patients With Diabetes
- Eye Exam for Patients with Diabetes

- Promotion and education on the importance of preventative care
- Assist in scheduling appointments, transportation, interpreter services and community resources
- Outreach expands across all UCare products

QI Member Engagement Specialists

Supports Star Ratings as well as

- Request For Proposals (RFP)
- Risk Adjustment
- Population Health initiatives
- Health Equity efforts
- COVID-19 response
- DHS Risk Corridor

Additional Services & Efforts

- Covid Vaccine Outreach
- Fit Kit
- Scorecard Mailer
- Incentive Voucher Mailings
- Providing additional customer service during outreach calls (NowPow)
- Referral to Health Promotions programing (member kits, car seats, breast pump, etc.)
- Disease Management Referrals
  - Diabetes
  - Asthma
- Referrals to Mental Health & Substance Use team
- Translation of Hmong/Somali IVR Scripts and recordings
- Substance Use Services

QI Member Engagement Specialists

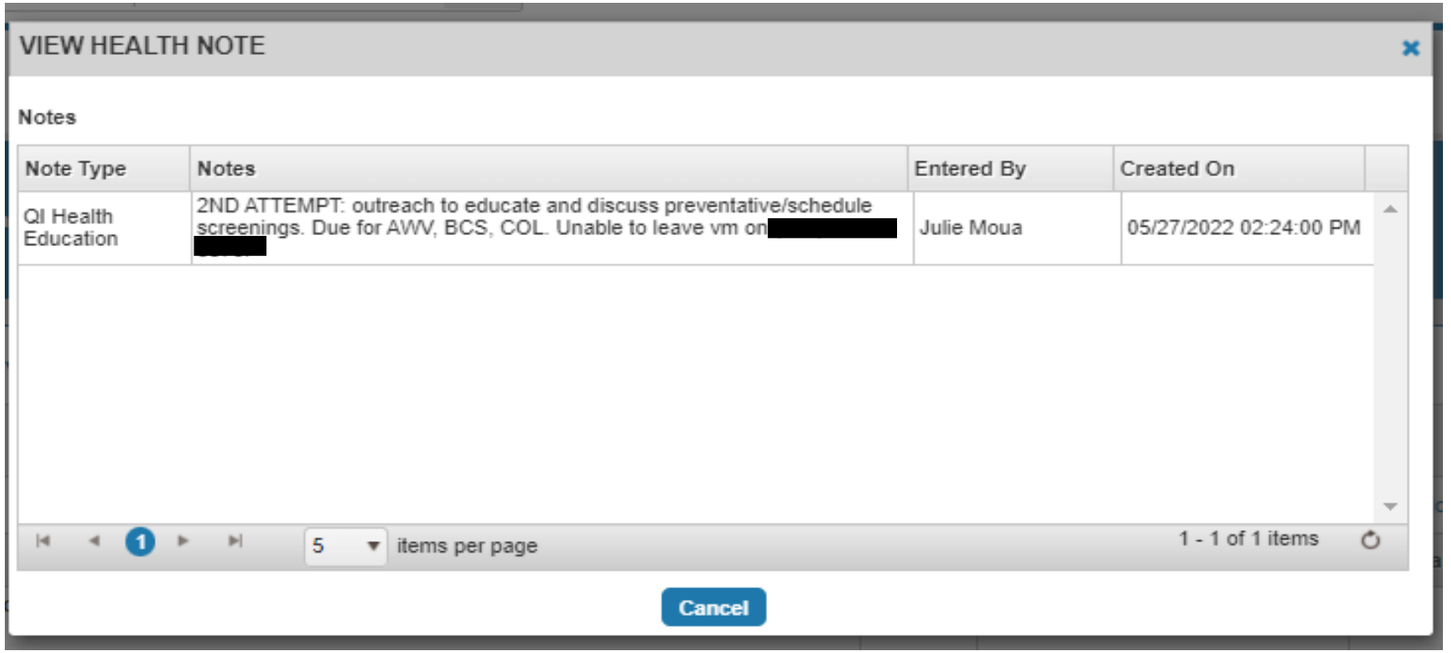
- **Julie Moua – Hmong Engagement Specialist**
  Supports Hmong speaking members
- **Awo Qasim - Somali Engagement Specialist**
  Supports Somali speaking members
- **Sarah Carlson – Native American Engagement Specialist**
  Supports Native American members
- **Cindi Kouame - Member Engagement Specialist**
  Supports all members

Average around 200 calls a week to members per Specialist.

GuidingCare Documentation

**For internal staff only*

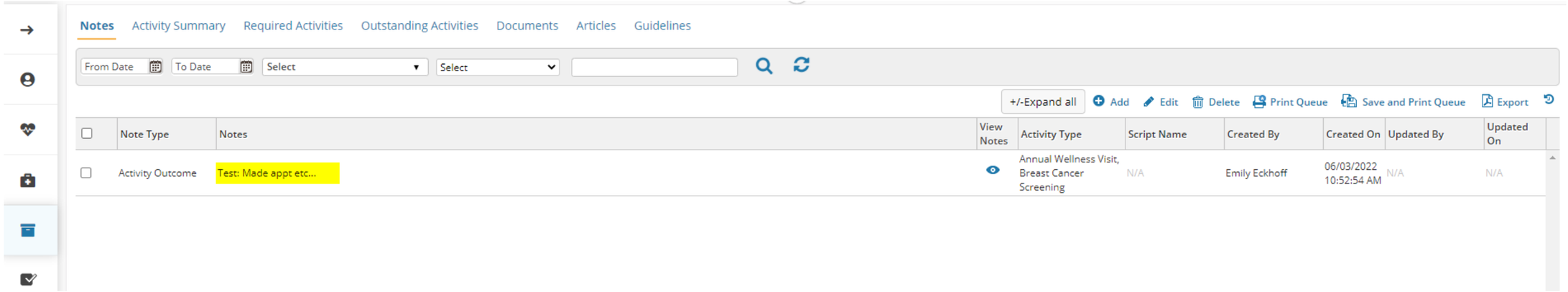
- All calls documented in GuidingCare.
- Note Type: QI Health Education



GuidingCare Documentation

**For internal staff only*

- New process
- Documentation of encounter found in activity record/note section



Lessons Learned from our Members

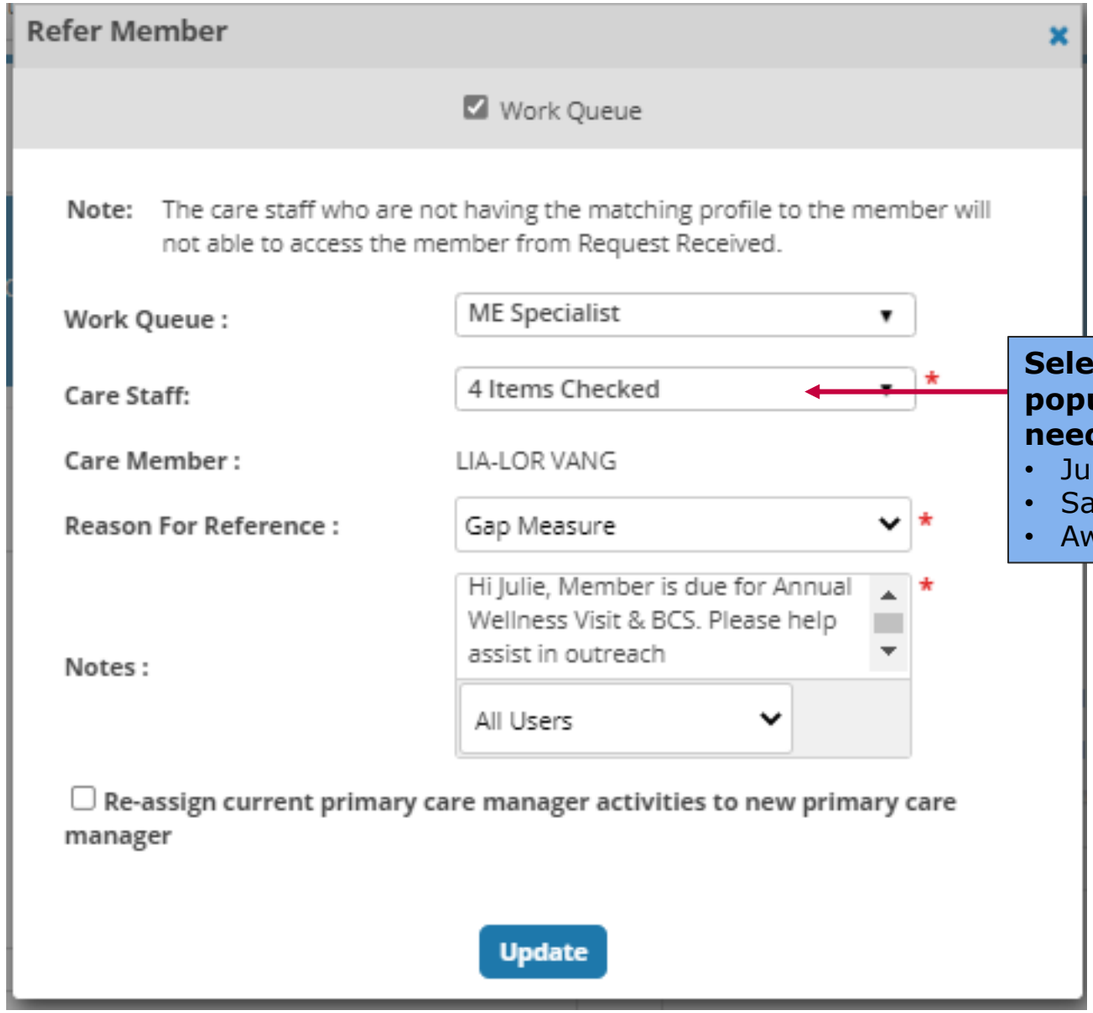
- Having someone some who speaks the member’s language and/or is from the member’s community increases rapport and trust, resulting in more success in understanding preventative screenings and scheduling appointments.
- Having knowledge of the religion and their beliefs is useful in knowing how to approach members on these services.
- Decomplicating long academic words is helpful when educating and connecting with members.
- Members appreciate UCare offered services and support in helping members understand and assisting their appointment for preventive health screening.

Member Success Stories

- “I outreached to help schedule an annual wellness visit and colonoscopy for a member. Member provided insight on her struggles transitioning from her homeland to the US and was grateful that someone who spoke her native language was able to provide education and explain health services from UCare she was unaware of.
- “I helped a member schedule an appointment for a colonoscopy after completing member education on the importance of preventative screening. Member attended the appointment and found out he had prostate cancer. However, his prognosis was good and because it was detected early member would be fine after surgery. Member called me back and expressed how thankful he was for my in help scheduling an appointment for him.”
- “I provided preventative education to a member who had multiple outstanding gaps. Member was grateful and expressed she used to connect with someone form UCare who spoke Hmong but lost connection when the staff left UCare Member didn’t know who to call when she had questions or needed support. Member is happy and appreciates that she can continue to work with someone who speaks her native language.”

Referral to QI Member Engagements Specialist

- For internal staff only through GuidingCare
- Use referral process if you need assistance educating and/or scheduling a member for preventative screenings and visits.
- Member will be outreached within 48 hours of referral.



Select the MES based on population/language (if needed):

- Julie – Hmong
- Sarah – Native American
- Awo – Somali

Questions???

The More U Know?

UCare website resources to enhance Care Coordination

Jack of All Trades, Master of ….

CC as health educator

Care Coordinators often provide information, education, resources and guidance related to member's health. The CC is tasked with being a Jack of All Trades!

CC as the "outcome" improver!

In fact – the role of the Care Coordinator is to help members improve their health outcomes

Care Coordination Role:

The Care Coordinator assists members with motivation to complete evidence-based health activities that are shown to lead to healthier results, reduced hospitalizations and aids managing the cost of care.

UCare Website

Loaded with valuable tools and resources related to a variety of health conditions!

UCan:

- Gain knowledge of common diseases and conditions
- Support members to make informed health decisions
- Access tools to help members self manage conditions
- Locate additional benefits to support member’s goals

Health & Wellness

Programs and Services to help members lead healthy lifestyles!

- Fitness and Wellness
- Food and Nutrition Resources
- Pregnancy
- Rewards and Incentives
- UCare Member Perks
- Health Management

Health Management

Self Management resources to improve health outcomes!

- Diabetes Management
- Falls Prevention
- Mental Health and Substance Use Disorders
- Quit Smoking and Quit Vaping
- WW weight loss Local Workshop Voucher
- Medication Therapy Mgt (MTM)
- My Health Decisions! My favorite!

My Health Decisions

Empower members with topics and tools for managing health conditions

- Conditions:
  - Check Your symptoms
  - Learn Your Score
  - Make a Decision!

- Wellness and Prevention:
  - Falls, Eating Healthy, Sleep Problems and more!

- Life Stages
  - ACP, Women’s/Men’s Health, Senior Health, Sexual Health

- Explore more:
  - Substance Use, Complimentary Medicine, First Aid

Know your Numbers!

Health Journals

Routinely checking/recording health information, like blood pressure, blood sugars, weight, etc. can be a good indicator of engagement and motivation to improve health!

My Health Decisions Tracking Forms and Checklists provide a host of journal options to help your members track their health information. Great intervention for care plan goals!

Bookmark for Easy Reference

Health and Wellness
Fitness, Food, Rewards and Incentive, Health Mgt – Overview page.

Health Management
Diabetes, Fall, Mental Health & Substance Use, Quit Smoking, My Health Decisions! (my favorite)

My Health Decisions
Topics and Tools for various health conditions and situations. Health Tracking forms/checklists. Tools to help members make informed decisions! How cool is that!

Health Tracking Forms & Checklist
Printable checklists and diaries, plans to keep track of health.

Other good things

Care Management Home Page

SCROLL DOWN

- General CC Resources and References!
  - Interpreter instructions
  - Supplemental Benefits 2022 – how to access each benefit!
  - Where to go for care!
  - Follow up after hospitalization for mental illness – Hedis measure
  - Helping you be your best self! MSS Access and Triage Line flyer
  - Culture Care Connection – Learning more!

Care Management Manual

- #12 Disease Management
- # 13 Quality Improvement – DHS PIPS

Now U know!

Question?

SMART Goals

Creating SMART Person-Centered Goals

What is the purpose?	To provide guidance for creating SMART goals and define expectations in goal development.
Why is it important?	At the heart of SMART goal creation is what is important TO and FOR the member.
How will I know what goals to create?	The member's goals should mirror the identified risks, needs, and chosen supports expressed an agreed upon by the member during your assessment.
What tools can I use to help me?	• SMART Goals Job Aid • Past PPT presentations

Specific

- Being specific should answer the following questions:
  - What needs to be accomplished
  - Who is responsible for it?
  - What steps need to be taken to achieve it?
- Not Specific: To be pain free
- Specific: I will decrease my foot pain score from 8 to 4 within the next year.

Measurable

- Quantifying your objectives allow for tracking progress and identifying completion. Consider…
  - **Measurable verbs;** take, perform, complete, use, list, state, self-report, identify,
  - **Measurable rates;** 3 days/week, 8/10, 10 minutes per day, lab values
- Not Measurable: I will have a healthy blood pressure.
- Measurable: I will reduce my blood pressure from 140/90 to 130/80 by next review.

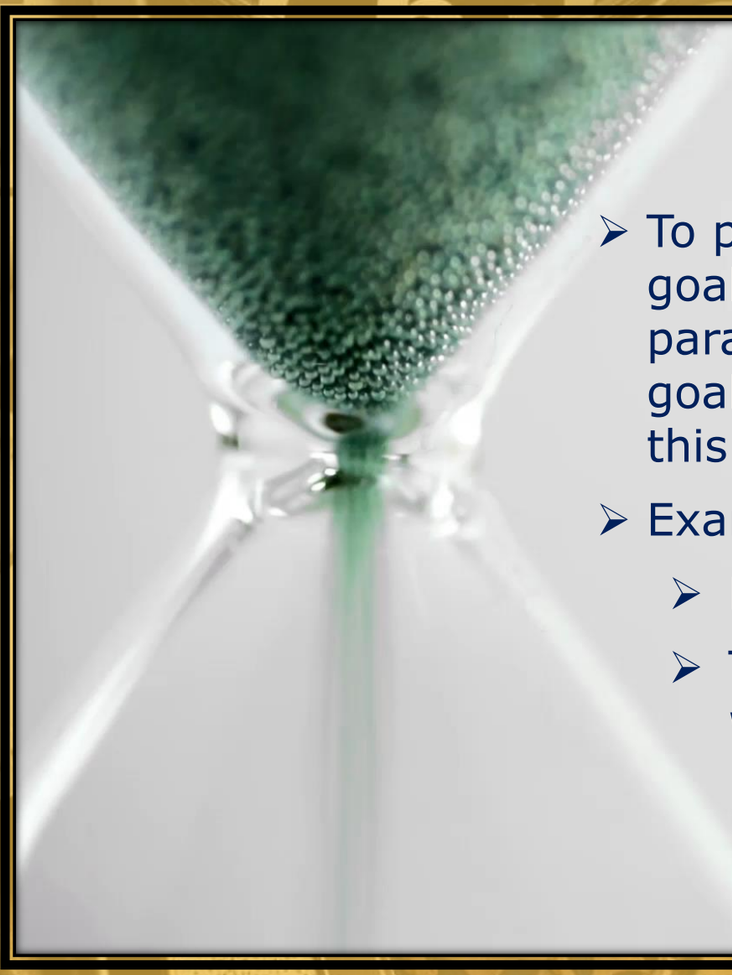
Attainable

- Goals should be realistic and reasonable to accomplish. Goals should remain member focused. If your member shares a personal goal that may not be achievable, consider starting on a small, more achievable goal to work toward a bigger objective.
  - Not Attainable: I want to be smoke free.
  - Attainable: I would like to reduce smoking from 15 cigarettes per day to 10 cigarettes per day within the next 6 months.

Relevant

- Think of answering the following questions…
  - What is the big picture?
  - Why are you setting this goal?
  - Is this goal relevant to the “why?”
  - What is important to/for the member?
- Example:
  - A person who regularly gets their annual exam but has a Gap in Care
    - Not Relevant: I will self-report completing annual exam.
    - Relevant: I will self-report completing a colonoscopy within 6 months.

Time-bound



- To properly measure your outcomes, your goals should be time-bound. Time related parameters should be built into your goals. As, “When will the member achieve this goal?”
- Example:
  - Not time-bound: I will lose 10 pounds.
  - Time-bound: I will lose 10 pounds within the next 6 months.

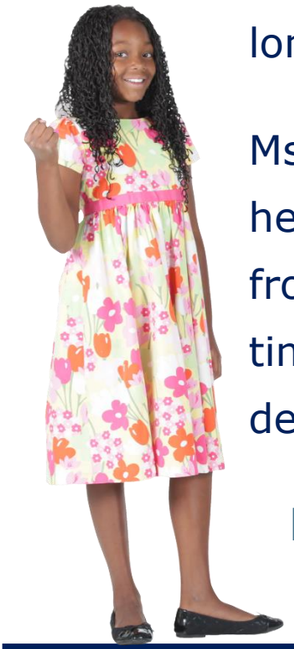
What are the requirements?

- At least ONE goal is High Priority.
- At least ONE goal is active/open on the current care plan.
- Goals are routinely reviewed at follow up contacts that are determined with the member during the assessment and based on the members needs. Every 6 months is a minimum requirement.
- Target Dates are adjusted during routine follow up contacts when the target date has been surpassed/exceeded.
- Goals are needed for risks identified during the assessment. If the member prefers no intervention it needs to be clearly documented on the Care Plan.

Scenario

Ms. Frizzle is a kind, resourceful, funny, eccentric, and intelligent person with an aptitude for science.

Some of her passions include learning, teaching and caring for the planet. She is a middle school teacher at Walkerville Elementary. Her pet Liz Ard and her students are very important to her. It is also important to Ms. Frizzle that she can continue driving her bus and going on field trips for as long as possible.



Ms. Frizzle's main health concerns are frequent dizziness, headaches, joint and muscle pain, and possible hallucinations from Carbon Dioxide exposure. Ms. Frizzle is a bit reckless at times. She is aware of the risks and not interested in decreasing her activities at this time.

Motto: Take Chances, Make Mistakes, Get Messy

Test your knowledge!

What SMART goals/interventions would you create for Ms. Frizzle?

Ms. Frizzle will get the Carbon Dioxide (CO_2) levels in her bus under 800ppm(parts per million) by six-month review.

- Ms. Frizzle will keep windows open during use when weather permits for ventilation.
- Care Coordinator will order a CO_2 meter.
- Ms. Frizzle will check CO_2 levels weekly with a CO_2 meter.

Ms. Frizzle will establish care with a pain specialist by target date.

- CC will send a list of INN pain clinics.
- Ms. Frizzle will choose a provider and schedule an appt.
- Care Coordinator will provide a pain log for Ms. Frizzle to use.

Ms. Frizzle will discuss dizziness and headaches with her Primary Care Physician (PCP) within three months.

- Ms. Frizzle will schedule an appointment with her PCP.
- Ms. Frizzle will reach out to CC if transportation is needed.
- Care Coordinator will follow up with Ms. Frizzle in 3 months to discuss a follow up plan.
- CC will notify PCP of Ms. Frizzle's concerns and follow up needs

Questions?

Care Coordination Requirements

- MSHO/MSC+ and Connect/Connect + Medicare
- June 2022

Agenda

- Transitions of Care-*Beyond the basics*
- HRA Timelines
- Unable to Reach & Refusal Members Updates
  - Actionable Attempts
- Transitional Health Risk Assessments

Transitions of Care(TOC)

Beyond the Basics!

Why is TOC Important?

- Moving between health care settings increases vulnerability:
  - Fragmented care due to lack of follow-up
  - Health care providers not communicating
  - Unsafe care due to changes with medication regimes or lack of medications, and self-management concerns
  - Risk of readmissions to hospital

- CMS requires all Medicare Advantage-Special Needs Plans to develop a process to coordinate care when members move from one care setting to another to avoid potential adverse outcomes.

Care Coordinators are key to preventing problems during transitions.

Providing Support

Care Coordinators act as a consistent support the member throughout the transition and to help prevent transitions:

- Educate members to avoid unnecessary ER visits & hospitalizations.
- Look for risks (falls, lack of preventive care, poor chronic care disease management) **& take action**.
- Sharing with hospital discharge planners the support and services the member currently has & assist with discharge planning.
- Identify challenges managing medications.
- Ensure crucial follow up appointments are completed with primary care or specialists in a timely manner.

Timeliness

- TOC tasks are completed w/in 1 business day for a reason.
- Why: The longer we wait to intervene, the less successful the care coordinator may be in filling in the gaps & identifying risks the member may be experiencing!
- The more likely the member is to become hospitalized.

Remember: We need to reach out to the member upon notification of initial TOC.

Transition of Care Focus Areas from CMS Audit

- Communication "It's all about the approach"
- Four Pillars of Optimal Transition
- Updating Care Plan
- Reviewing the DC Summary

Communicating with Receiving Setting

- **It's all about the Approach!**
- Be of service!
- Leaving a name / number will likely result in no response.
  - Avoid demanding “I need you to X Y Z”
  - Instead: State your role, how you can help with support, resources, supplemental benefits and as important – what you know about the member's current services or lack of services. (Verbal summary of the person care plan).
  - Document the details – Who did you speak with? What information was provided/received? Create a f/u plan.

PCP Communication

- Sharing updates about the patient's condition is an important part of the care coordinator role.
- Make it count! Missed opportunity if we fail to provide robust information to the member's PCP. Share the full care plan with Significant changes/new goals.
- The approach you use with the PCP or the PCP's nurse who receives the information matters!
- Add value to the PCP/patient care by providing the necessary information & updates to ensure continuity of care. What do they need to know?
- Remember: Document communication with other members of the ICT: Specialists, Waiver CM or Home Care Providers

Communication with Member/Authorized Representative Upon Return to Usual Setting

It really begins at the HRA: Educate about Transition assistance and what to expect from you as the care coordinator!

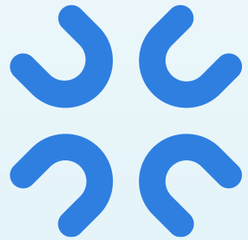
Reach out to the member, **upon return to their usual setting**, within **1 business day of notification** of the transition, to assess needs and prevent readmissions.

Outreach may be telephonic or face-to-face.

Discussion should include:

- Care transition process
- Changes to member's health status
- Changes to care plan
- Education about how to prevent unplanned transitions/re-hospitalizations
- Provide CC contact info
- 4 Pillars to Optimal Transition Management

Returning Home: Communication when Transitioning Back to Usual Setting or "New" Usual Setting



Pillar 1. Follow- Up Appointment

- Ideally w/in 15 days of discharge or 7 days for mental health

- ASK: When is your follow up appointment?
- How are you getting to your appointment?
- Can I assist with making an appointment?
- Stress the importance of keeping the appointment and address barriers.

- *Reference: TOC Instructions on Care Mgr Home Page*

Pillar 2. Medication Self Management

- Determine if the member has a good understanding of medication regimen?

- ASK: Do you have all of your current medications?
- What changes were made to your medications?
- How do you remember to take them?
- Do you need help with setting up or taking medications?
- Consider a referral to SNV/HHA or MTM if eligible

Pillar 3. Knowledge of Warning Signs

- Is the member aware of the symptoms that indicate problems with healing or recovery?

- ASK: What are the warning signs that might tell you that you are having a problem?
- What should you do if symptoms appear?
- Who do you call if you have questions?
- Do you have those numbers readily available?
- Consider this a possible lead in question to Pillar 4!

Pillar 4. Personal Health Record

- Determine if the member utilizes a PHR

- ASK: Did you receive a copy of your discharge instructions? Let's review together 😉
- Remember to bring discharge instructions to f/u appointments.
- Attempt to obtain DC Summary if member does not have a copy (as able).
- Offer to assist with creating or providing a personal health record for tracking health information (IE: Med list, Vaccine hx, BP results, etc).

Updating the Care Plan

***Complete tasks below when the member is discharging TO their usual care setting within one (1) business day of notification.** *For situations where the Care Coordinator is notified of the discharge prior to the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm that discharge actually occurred and discuss required TOC tasks as outlined in the TOC Instructions. (This includes situations where it may be a 'new' usual care setting for the member. (i.e., a community member who decides upon permanent nursing home placement following hospitalization and rehab).*

Date completed: 6.6.2022 Communicated with member or their designated representative about the following: care transition process; about changes to the member's health status; support plan updates; education about transitions and how to prevent unplanned transitions/readmissions

Four Pillars for Optimal Transition:

Check "Yes" - if the member, family member and/or SNF/facility staff manages the following: If "No" provide explanation in the comments section.

☒ Yes ☐ No Does the member have a **follow-up appointment** scheduled with primary care or specialist? *(Mental health hospitalizations—the appt. should be w/in 7 days)*

For mental health hospitalizations: ☐ Yes ☐ No Does the member have a **follow-up appointment** scheduled with a mental health practitioner within 7 days of discharge?

☒ Yes ☐ No Can the member **manage their medications or** is there a system in place to manage medications *(e.g. home care set-up)*?

☒ Yes ☐ No Can the member verbalize **warning signs and symptoms to watch for** and how to respond?

☒ Yes ☐ No Does the member use a **Personal Health Care Record**? *Check "Yes" if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.*

☐ Yes ☒ No **Have you updated the member's support plan?** *If "No" provide explanation in comments.*

☒ Yes ☐ No **Have you reviewed the discharge summary with the member?** *If "No" provide explanation in comments.*

Comments: Fred had an apendectomy and has returned to baseline. No additional goals/interventions needed as current supports in place meet Fred's needs.

Notes from conversation with the member, provider, discharging and receiving facility (as applicable):

6.6.2022 - spoke with Susie Helpsalot at Fred's assisted living. Medications have been received and updated in Fred's MAR. Spoke with Fred this day as well who reports he is feeling good. He is able to walk with his walker w/o additional assistance. He is happy staff will resume assistance with AM/PM dressing. Fred expressed pain of 3/10 this day.

Updating the Care Plan

My Goals: ***Discuss with Care Coordinator, goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.***

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☒ Medium ☐ High	I would like to reduce my A1c to 7 within the next year.	Care Coordinator (CC) provided information about Health Improvement coaching with UCare. Fred would like to participate. CC to make referral. Wilma to continue to assist with daily blood sugar monitoring and medication administration. CC to provide a list of in network Endocrinologist to select a new provider. Fred and Wilma will schedule first visit within the	3/2/23	5/2/22 TOC Update SH Fred was hospitalized for low blood sugar. He was exercising and eating less, but didn't realize he was getting low and fainted while at the gym. CC recommended a continuous blood glucose monitor and will assist Fred with obtaining. Continue goal 9/28/22 6 mo Update SH Fred has been using his new blood glucose monitor and it's working well. He also established with his new Endocrinologist and had	

Care Coordination Resources for Transitions

MSHO Supplemental Benefit Summary:

- Readmission Prevention: Bath Safety Device, Individualized Home Supports w/ Training, Lifeline/PERS (Non-EW), Post DC Med Rec, Medication Toolkit, Post DC Meals, Post DC CHW,
- LSS Post hospitalization support
- Juniper Program (Well Being, Falls Prevention, Chronic condition self mgt)
- Caregiver Assurance (dx with dementia, MS, Parkinson's or ALS)
- Moving Home Minnesota

Connect/Connect + Medicare Supplemental Benefit Summary:

- Post Discharge Medication Reconciliation, Medication Toolkit
- Tobacco Cessation

Other Resources:

- Health Connect 360 (Disease Mgt Programs)
- Follow-up After Hospitalization for Mental Illness
- Helping You be Your Best Self (MH SUD help)
- Housing Stabilization Services
- Food and Nutrition
- Health Management Education (Diabetes, Fall Prevention, Blood Pressure, MH and Substance Use, Medication Therapy Management (MTM) My Health Decisions)
- Where to Go For Care
- Health Care Directive Information

Significant Change of Condition

UCare requires care coordinators to conduct an additional HRA in the event of a significant change in a member's condition.

All care coordinators are Qualified Professionals, and UCare depends on the use of their clinical, professional judgment to determine whether a change in condition or care transition warrants a reassessment.

Examples of situations where a COC reassessment may be needed include, but are not limited to:

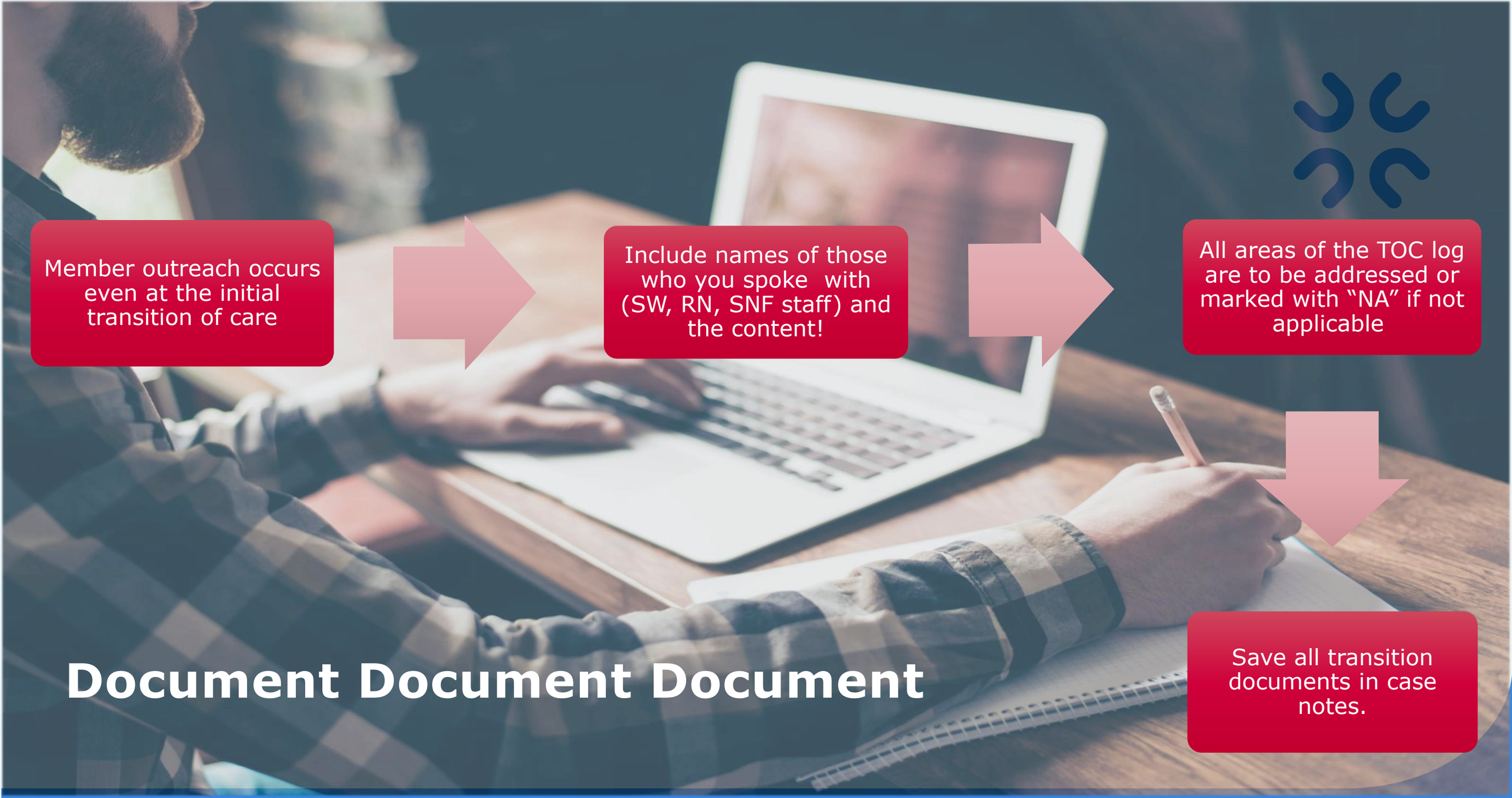
- Repeated falls
- Recurring hospital readmissions or emergency room visits
- Newly identified diagnosis
- Change in function with ADL or IADL's
- Significant exacerbation of pre-existing condition
- Change in Waiver case mix

Change in Condition Case Studies:

- **Example 1:** 62-year-old female was admitted to the hospital with DX of CVA with left side hemiparesis.
  - CC followed member along during her TOC and worked closely with the discharge planner at the hospital. It was evident that this member would be unable to return to her usual living arrangements of a one-bedroom apartment. Despite having HHC weekly and MH supports in place member needed extensive rehabilitation and a short-term nursing home stay was planned. Member was admitted to Bethesda Grand in the TCU.
  - Due to her extensive stroke and much needed rehab, CC completed a change in condition assessment as her ADL's and IADL's have changed, and they anticipated a 6-week rehab stay. CC worked closely with the TCU and attended care conferences.
  - After 2 month stay in TCU, the member was referred for CADI waiver and began receiving ILS, homemaking, weekly SNV and in home PT/OT.

- **Example 2:** THRA when reviewing the HRA/Support Plan with the member and care needs have changed drastically.
  - A new assessment was warranted.

- **Example 3:** A Member initially qualified for PCA at her annual assessment but chose not to utilize the services at that time/the family couldn't find a PCA with which they were satisfied.
- The member was hospitalized 5/4-5/17 d/t influenza A, bronchitis, and pneumonia. The member recovered from the illnesses but was a lot weaker and not back to 100%.
  - The member wanted to be reassessed for more PCA hours and additional services – HM, HDM, etc.



Member outreach occurs even at the initial transition of care

Include names of those who you spoke with (SW, RN, SNF staff) and the content!

All areas of the TOC log are to be addressed or marked with “NA” if not applicable

Save all transition documents in case notes.

Document Document Document

Thank you for all you do!!

HRA Timelines

365-day count – Refusals/UTR

Change on how to count refusal and unable to reach members for annual outreach implemented in 2022.

If a member is NEW and either refuses, or is unable to reach, the start of your 365 days, should start from **date of enrollment**, not from the date of refusal or from the 4th UTR contact or Refusal date.

Examples:

Member enrolls on 7-1-22, refuses initial HRA on 7-21-22. Start date for count of when annual outreach should occur by (365 days) is from 7-1-22. **Annual outreach/HRA needs to be completed by 6-30-23**.	Member enrolls on 8-1-22. 4 contact attempts made, last attempt on 8-25-22. Start date for count of when annual outreach should occur by (365 days) is from 8-1-22. **Annual outreach/HRA needs to be completed by. 7-31-23**

Reassessment Timeline

Initial assessment completed:

- Member is due for reassessment **within 365 days of completed HRA**

OR

Initial assessment resulted in a UTR or Refusal:

- Member is due for reassessment **within 365 days of original enrollment date**

All subsequent reassessments (*After year 2):

- Member is due for reassessment **within 365 days of most recent "activity date"**
  - UTR Activity date = date of last actionable attempt to reach member
  - Refusal Activity date = date member verbally refused/declined HRA
  - HRA completed = date HRA was conducted

Reassessment Timeline Examples

MSHO:

- **Example for UTR/Refusal:**
- **Member enrolls 6.1.22**
- **Year one**: All attempts due **within 30 days of enrollment**
  - **Example:** HRA or UTR/Refusal due by 6.30.22
    - **Activity Date Result:** UTR/Refusal completed on 6.12.22

- ***Year two:** All attempts to complete assessment due **within 365 days of enrollment**
  - **Example:** Previous UTR/Refusal therefore year two attempts to complete HRA or UTR/Refusal due before 6.1.23
    - **Activity Date Result:** UTR/Refusal completed on 5.20.23

- **Year three:** All attempts to complete reassessment due **within 365 days of most recent activity date**
  - **Example:** Year three HRA or UTR/Refusal due prior to 5.20.24

Reassessment Timeline Examples

Connect/Connect + Medicare:

Example for UTR/Refusal:

Member enrolls 6.1.22

- **Year one**: All attempts due **within 60 days of enrollment**
  - **Example:** HRA or UTR/Refusal due by 7.30.22
    - **Activity Date Result:** UTR/Refusal completed on 7.12.22

- ***Year two:** All attempts to complete assessment due **within 365 days of enrollment**
  - **Example:** Previous UTR/Refusal therefore year two attempts to complete HRA or UTR/Refusal due before 6.1.23
    - **Activity Date Result:** UTR/Refusal completed on 5.20.23

- **Year three:** All attempts to complete reassessment due **within 365 days of most recent activity date**
  - **Example:** Year three HRA or UTR/Refusal due prior to 5.20.24

Unable to Reach/Refusal Members Update

Unable to Reach

A minimum of four "actionable" attempts to complete the assessment must be made.

Contact attempts must be made to the member/authorized representative.

Best Practice: 3 attempts by phone (when the phone number allows for the CC to leave a voicemail) and a UTR letter. A good faith effort should be made to obtain a working phone number for the member if the number is unknown.

What is an "Actionable" Attempt?

Actionable Attempt:

An attempt to reach the member where the member can actively respond.

This includes:

- leaving messages to a known working number
- mailing letters to known addresses
  - Telephonic attempts are made at different dates and varying times
    - If completed on the same day, it is not considered a 2nd* attempt
  - Letters mailed on different dates to allow the member time to respond

Example: 3 voice messages to a known working number and 1 Unable to Reach Member Letter*

Example 2 (no working phone number): Document the phone number you attempted to reach and mail 4 separate UTR letters each 2-3 days apart

Not Actionable:

- Attempts to locate incorrect or missing numbers/addresses (IE: financial worker, MIIC, E.H.R's)
- Calling a non-working number or leaving a message at an unknown person's voice mail
  - The Welcome Letter is not an attempt to reach members

Update: Unable to Reach Support Plan

Updates to the UTR support plan for 2022:

- More documentation of involvement and attempts to involve ICT team.

2. Addition of goal template UPDATED GOAL! Posting 7.1.22

3. Documentation of outreach investigation

4. Expectation to send support plan to Provider (if aware of clinic).

- Provider Engagement Letter – should be sent to the provider when confirmed.

Update: UTR/Refusal Support Plan

- Documentation of goals for the member-text box provided. UPDATED GOAL posting 7.1.22.
- Ensure attempts to engage the ICT team are documented
- Utilize the provider engagement letter (if PCP confirmed).
- Utilize refusal letter to engage member.

Updated UTR & Refusal Support Plan SMART Goal

Rank by Priority	My Goals	Intervention
☐ **Low** ☐ **Medium** ☒ **High**	I will contact my Care Coordinator when I need assistance obtaining care or services over the next year.	Care Coordinator provided contact information including name and phone number.

Additional grey fillable box to add additional interventions as needed:
IE: Provided When and Where to receive Care, HCD Info or TOC Brochure.

Transitional Health Risk Assessment

THRA

THRA

Transitional Member Health Risk Assessment (THRA) may be completed in lieu of a new HRA when the care coordinator has obtained an HRA/Care Plan that was completed in the previous 365 days and the member is able to be reached within 30 days of enrollment.

Situation	MSHO/MSC+	SNBC
Product Changes: MSC+ to MSHO MSHO to MSC+ Connect to Connect + Connect + to Connect	**YES**	**YES**
Transfer from one delegate to another Same health plan	**YES**	**YES**
Other MCO to new MCO (Medica MSC+/MSHO to UCare MSHO/MSC+ Medica SNBC to Connect/Connect+)	**YES**	**NO**
Fee for Service to MSHO/MSC+ with MnCHOICES assessment in the last 365 resulted in EW opening	**YES**	NA
New* to UCare (MSHO, MSC+, Connect, Connect +) *No assessment in the last 365 days.	**NO**	**NO**
From SNBC to MSHO	**NO**	NA
Internal CC changes from one peer to another	**NO**	**NO**
Transfer Documents **NOT** Received	**NO**	**NO**
Transfer Document Received, but member is UTR/Refusal at time of attempted THRA: What to do? Update the current Support Plan. **SNBC:** Returns UTR/Refusals to UCare	**NO**	**NO**

Special Notes on THRA

- By completing the THRA the CC is adopting this assessment and Care Plan as their own. Use professional judgement to determine if a new HRA is needed (IE: Incomplete HRA/Care Plan or significant change in condition)

- If unable to obtain the HRA/Support Plan that was completed within the last 365 days, the CC is required to complete a new HRA and Support Plan within the required timeframe for their product.

IMPORTANT: THRA activity dates do not reset the annual reassessment dates. The reassessment date should remain the date of the original assessment that was received by the CC.

It's the details that matter!

- Obtain and review the current HRA and Support Plan received from the previous (sending) CC.
- Complete 4 “actionable attempts” to reach member to review current HRA/Support Plan. THRA may be completed in person or via phone.
- Complete the Transitional Health Risk Assessment form within 30 days of enrollment and attach to the most current HRA.
- Document the review with the member/authorized representative in case notes.
- Update HRA/Support Plan with any necessary changes/updates to goals etc.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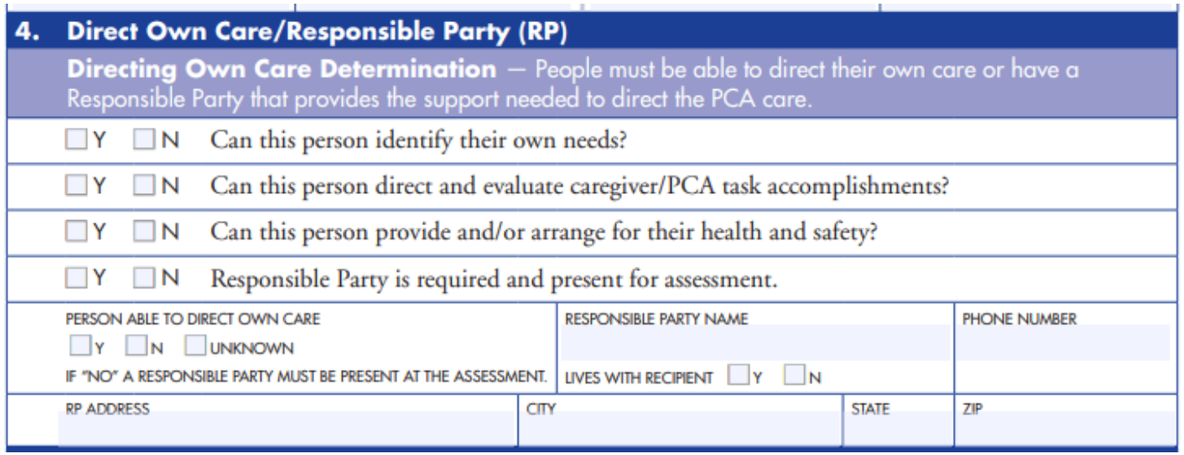
Care Coordination Updates

Dawn Sulland

PCA Updates and Reminders

- Responsible Party
  - An RP is defined in Minnesota statute 256B.0659. subd, 9 and 10 as a person who is at least 18 years old and capable of providing the support necessary to help the person receiving PCA services to live in the community when the person is assessed as unable to direct their own care.
- The case manager identifies the need for a responsible party during the assessment and service planning process.



4. Direct Own Care/Responsible Party (RP)

Directing Own Care Determination – People must be able to direct their own care or have a Responsible Party that provides the support needed to direct the PCA care.

☐ Y ☐ N	Can this person identify their own needs?
☐ Y ☐ N	Can this person direct and evaluate caregiver/PCA task accomplishments?
☐ Y ☐ N	Can this person provide and/or arrange for their health and safety?
☐ Y ☐ N	Responsible Party is required and present for assessment.

PERSON ABLE TO DIRECT OWN CARE	RESPONSIBLE PARTY NAME	PHONE NUMBER
☐ Y ☐ N ☐ UNKNOWN IF "NO" A RESPONSIBLE PARTY MUST BE PRESENT AT THE ASSESSMENT.	LIVES WITH RECIPIENT ☐ Y ☐ N	

RP ADDRESS	CITY	STATE	ZIP

- As a reminder, if a member in unable to direct their own care (which at times is identified in the behavioral section of the assessment) , then a RP may be required.

Community First Services and Supports (CFSS) Updates

Although DHS has communicated an implementation date of no sooner than 8/1/2022, they are preparing to move to CFSS in late summer 2022.

- When the federal government approves CFSS, DHS will provide information about the transition plans and time frame. Managed care organizations will transition people at their yearly reassessment to ensure there is no disruption of services. As the start of CFSS approaches, DHS will communicate with people who use and provide PCA and CSG services, lead agencies and other interested parties.
  - DHS submitted the 1915(i) and 1915(k) state plan amendments to the Centers for Medicare & Medicaid Services (CMS) on March 18, 2022. CMS has at least 90 days to review the amendments, request changes and approve the plans.
- DHS has posted information regarding CFSS that addresses the following topics found in this link Community First Services and Supports / Minnesota Department of Human Services (mn.gov)
  - CFSS Service Models
  - Timelines
  - Eligibility
  - Training
  - Meetings
  - FAQ

UCare continues to stay updated on DHS communication regarding implementation and is prepared upon CMS approval and DHS direction to finalize the project plan for implementation readiness.

Updates regarding CFSS will continue to be provided during this implementation period.

Elderly Waiver Reminders

- **Authorizing Elderly Waiver Services**
  - As the care coordinator it is your responsibility to use your professional judgement to ensure that member's meet the criteria in the CBSM for the service you are completing and submitting a Waiver Service Approval Form (WSAF).
  - As the member's care coordinator, you are authorizing any service on the WSAF. UCare does not review WSAF for appropriateness or approval.
- **Waiver Service Providers**
  - UCare does not contract with Elderly Waiver service providers.
  - Members may receive Elderly Waiver services from any provider that is enrolled with DHS to provide the service and set-up to bill UCare as an Elderly Waiver service provider.
  - Care coordinators can find providers that are enrolled with DHS at MNHelp.info.

Reminders

Transportation

- As has been communicated, same day/next day rides have been challenging to provide due to the lack of staffing and availability of providers. After 4pm, transportation for next day requests are considered a same day ride due to the turnaround time as providers are closing for the day, unable to receive requests.

Model of Care (MOC) Reminder

- As a reminder, all new Care Coordinators need to review the MOC presentation within 90 days of hire and annually thereafter. After viewing, the attestation needs to be returned to UCare. You can find the attestation form here.

Care Coordination Survey

- The 2022 Care Coordination Survey will be sent out to all MSHO/MSC+ and Connect/Connect + Care Coordinators in July via SurveyMonkey.
- Individual responses are confidential and helps identify areas where UCare can potentially improve current processes.

A huge thank you to everyone who provided documentation in a very short turn-around-time for the CMS audit!!

Questions?

Connect/Connect + Medicare: SNBCClinicalLiaison@ucare.org or 612.676.6625

MSHO/MSC+: MSC_MSHO_Clinicalliaison@ucare.org or 612.294.5045