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UCare
Connect/Connect + Medicare & MSC+/MSHO

3rd Quarterly Meeting

September 12, 2023

Questions welcome!

Welcome!

ucare

Remember to mute your phone and computer microphone and disable your webcam during this presentation.

Mute Disable

Click to add notes

Mute Start video Share

Chat

from Jennifer Redman to all panelists: 12:45 PM
test question

To: All Panelists

Enter chat message here

Q & A

Participants Chat

12:55 PM
9/13/2022

Today’s Agenda

Time	Topic	Audience	Presenter
9:00–9:05am	Welcome	All	Clinical Liaisons
9:05-9:30am	Care Coordination Updates	All	Clinical Liaisons
9:30-9:40am	Return to Face-to-Face	All	Jennie Paradeis
9:40-10:00am	CC Survey	All	Kristen Sagnes & Dawn Sulland
10:00-10:20am	SMART Goals	All	Kristen Sagnes
10:20-10:35am	DTR, EVV, T2029, PCA	MSC+ & MSHO	Esther Versalles-Hester
10:35-10:45am BREAK			
10:45-11:05am	Transitions of Care	All	Jenn Redman
11:05-11:20am	Model of Care	All	Dawn Sulland
11:20-11:25am	Access Line	All	Alycia Lopez
11:25 am – 11:35 am	SOGI	All	Pleasant Radford, Jr

Care Coordination Updates

Presenter: Clinical Liaisons

Care Coordination Meeting Schedule

CEUs offered quarterly (optional)

Office hours (optional)

MSC+/MSHO and SNBC will be separate & offered at different times

Registration for events can be found in the monthly newsletter.

UCare Product	Meeting Type	Date & Time (Subject to change)
MSC+/MSHO and Connect/Connect + Medicare	Live Quarterly WebEx Meeting	September 12th, 9 am December 12th, 9 am
MSC+/MSHO and Connect/Connect + Medicare	CEU Event (optional)	November 28th, Announced in Oct
MSC+/MSHO	Office Hours (optional)	Oct 24th, 10:00-11:00
Connect/Connect + Medicare	Office Hours (optional)	October 24th, 1:30-2:30

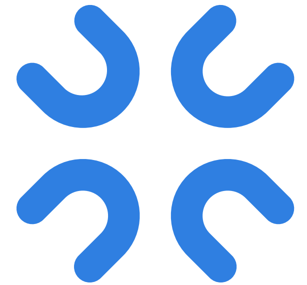
→ SAVE THE DATE ←

MN Encounter Alert Service (MN EAS)

In partnership with DHS, the Encounter Alert Service (EAS) allows providers (including care coordinators) serving Medical Assistance and Mn Care enrollees throughout the state to receive alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real time.

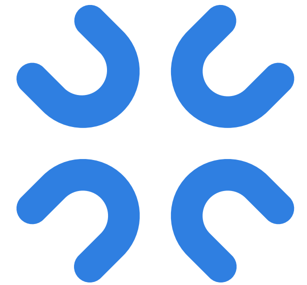
EAS Encounter Alert Service

MN Encounter Alert Service (MN EAS)



What are our delegates saying about the program?	
	The application is user friendly.
	Information is more accurate, and notifications are “real time”.
	MN EAS is a great way to find contact information for unable to reach members.
	A huge time saver! There are no surprises calling facilities to learn a member is not there. The system updates in “real time” as the member transitions.
	Real time notifications provide care coordinators the information needed to improve timely transition of care assistance.
	A small change to incorporate sending monthly member data – leads to overall improved efficiency and better service to members.

UCare Moving to EAS and Retiring DAR!



What are UCare's next steps with this system?

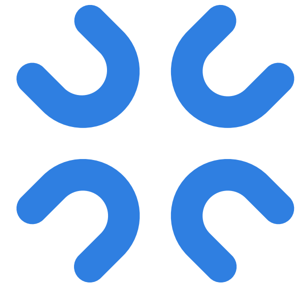
To ensure delegates receive more accurate and timely information, UCare will be retiring the Daily Admissions/Discharge Report (DAR) and will be moving to DHS's MN Encounter Alert Service (EAS) vendor Point Click Care, previously Audacious Inquiry (AI) by 1/1/2024.

What does this mean for your agency:

- If your agency is not already enrolled, please reach out to Nick.Regier@pointclickcare.com to receive information and system access information.
- Once enrolled, log on to the EAS site daily for your member alerts instead of using the DAR and Sec FTP!
- Begin TOC activities upon notification.
  - Do not need to check for notifications on non business days.
- Once a month – update EAS using your enrollment roster "All" tab to add/change assignment

NOTE: DHS obtains authorization from program participants for information to be shared with their providers in order to help coordinate the care received under Medical Assistance. The only users who can view data are legally authorized to do so under HIPAA laws and regulations.

UCare Moving to EAS and Retiring DAR!



Summary:

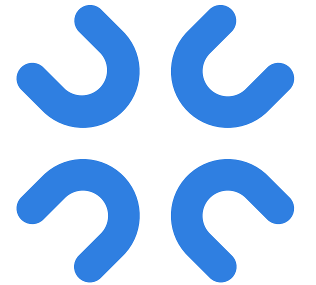
MN EAS will greatly improve the quality and timelines off admission and discharge information shared with care coordinators for assigned members.

UCare will be retiring the admissions/discharge information in the DAR at the end of 2024 and moving to MN EAS as it’s primary system for TOC notifications beginning 1/1/23.

Non participating hospitals/out of state notifications will continue to be provided using the Sec FTP DAR notifications.

We appreciate your questions – please inquire with your Clinical Liaisons if you need more information about this transition!

Gaps in Care Reports



What is a Gap in Care? A gap in care is a missing preventative care measure identified using claims information for Connect + Medicare and MSHO members.

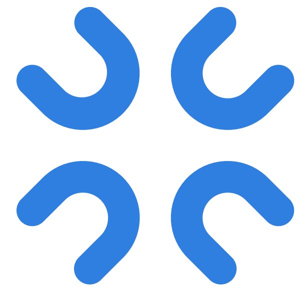
How are they useful? Gaps in care reports provide claims information about preventative care services like: PCP annual wellness visit, colonoscopy, mammograms, and diabetic preventative visits completed over the past 12 months.

If an item appears on the GAP report it means the person has not completed the preventative care measure – thus has a GAP IN CARE.

When there is evidence of a claim for a preventative care measure – the gap is closed. Closing a gap in a member's care helps ensure the member is receiving optimal medical care.

When will the report be available? UCare continues to make progress toward providing Gaps in Care reports to dedicated agency staff at each delegate via UCare's SecFTP. Reports should be available by October 2023. A recorded Gaps in Care training on the report will be shared once reports are available.

Medical Assistance Renewal Reminders

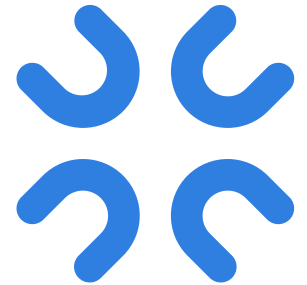


MA Renewals and Keep Your Coverage Team!

- UCare's Keep Your Coverage (KYC) team continues to actively outreach to members by way of live calls, interactive voice messages or mailings to inform members of their upcoming medical assistance renewal. The team is available to receive referrals from care coordinators to assist members with their MA renewal questions and paperwork. Referrals can be sent to:

- At this important transition time for our members, we are asking Care Coordinators to keep MA renewal at the forefront of your mind. UCare sent a Quarterly MA Future Renewal Date report in August and plan to send the next in October. The report will contain the month of renewal due and **MAXIS CASE NUMBER.** This can be used to reference the **DHS Renewal Lookup:** **(mnrenewallookup.com)** and by using information from the report, care coordinators can also confirm renewal information.

Medical Assistance Renewal Reminders



Care Coordination Role in assisting the member:

1. Review the Quarterly MA Future Renewal Date report sent out by UCare to be informed of members renewal. Use best judgment for additional outreach needed. Reach out to the members you believe would be at risk of not completing MA paperwork or who could benefit from support.

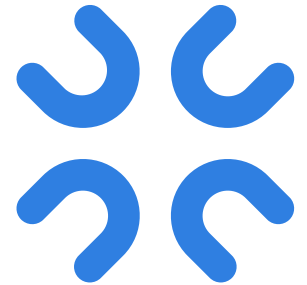
2. Ensure member's address is accurate and updated. Can expedite member address changes on the DHS-8354 as well as continue to send in the DHS- 5181 to the Financial Worker.

3. Ensure the member has received their MA renewal paperwork. All members should receive within 60 days of their re-enrollment.

4. Refer members to the UCare KYC team if needing assistance. KeepYourCoverage@ucare.org

5. Consistently address MA renewals at 6 month/mid-year updates and Annuals. Provide education about the importance of MA renewals at assessments and relay the supports available to help the member.

Assessment & Follow-up Reminders



Actionable attempts

Successful communication that the member can act upon.

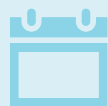
Investigative research is not considered an actionable attempt.

If UTR letters are returned by USPS, document and complete refusal process.

Safe disposal of medications form is required for **all members** residing in the community

Including members residing in supervised settings with medication management

Suggested documentation for MnCHOICES: Comments box near medications section

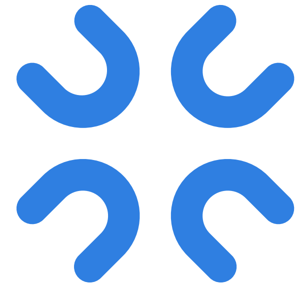


Six month & mid-year check-ins

Ensure these are completed timely.

Use a tracking system or reminders

Care Plan Reminders

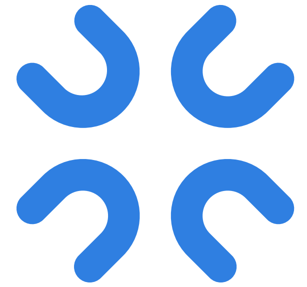


Care Plan should be shared with member, PCP, waiver CM and anyone else on the ICT the member agrees to have the Care Plan shared with.

Care coordinator's credentials included on the care plan signature page, e.g. RN, LSW

Update Care Plan at 6 months/mid-year or more as indicated in member's plan

MnCHOICES Access Requests



- UCare DHS System Access Request form located on the Care Management and Care Coordination Web page.
  - Always pull most updated form from the website to reduce back and forth communications to gather required access information.

- Reach out to securityliaison@ucare.org with access questions and concerns vs DHS Help Desk
- Add MMIS Access: New (No MMIS access with current role) Reactivate (Had access with current role that expired due to inactivity)
- Add Revised MnCHOICES Access (first time access for current role with revised MnCHOICES)
- Add MnSP Access for RS tools only (this is ONLY for the former MnCHOICES access and only for MSC+ and MSHO care coordinators needing to complete RS tools)
- Request change to user information (only used for significant user changes such as name changes, etc.)
- Terminate All Access (used when an employee leaves your agency and no longer needs access to any Ucare systems. Indicate what systems they had access to originally.)

UCare System Access Request Forms

SecFTP Access Request (Updated 5-12-23)
DHS System Access Requests

All MMIS & MnCHOICES Access Request

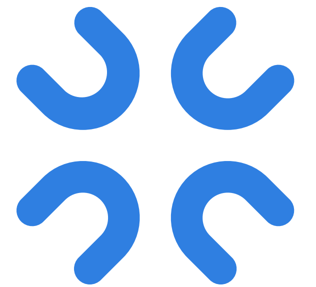
***Action Requested** (Select multiple if needed)

Add MMIS Access: New ☐ Reactivate	☐
Add Revised MnCHOICES Access	☐
Add MnSP Access for RS tools only (For use with former MnCHOICES application)	☐
Request Change to User Information (Name, Phone, Address, Supervisor, etc.	☐
Terminate All Access	☐

Worker Information
*** Required Fields**

Required fields must be completed to submit access requests.

MnCHOICES – Login Issues



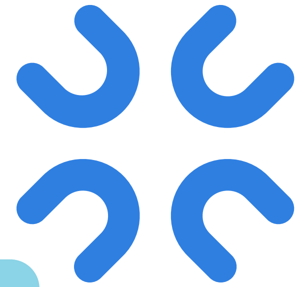
MnCHOICES: www.mnchoices.org

Clear cache, try multiple browsers, refresh browser

Check with MnCHOICES Mentor within your agency

Reach out to UCare Security Liaison at securityliaison@ucare.org for assistance with login issues

MnCHOICES Reminders



The time is now (starting July 10 – DHS launched slow roll out)

- All care coordinators should be practicing in MTZ
- All delegate agencies should have at least one care coordinator working within the revised MnCHOICES platform

MnCHOICES Requirements Grids

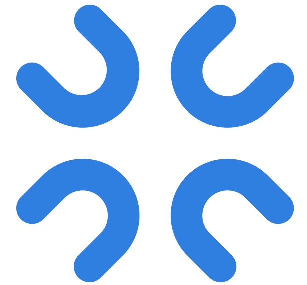
- MSC+ & MSHO MnCHOICES Community Requirements Grid
- Connect/Connect + Medicare MnCHOICES Requirements Grid

MnCHOICES signature page

- Signature page embedded within MnCHOICES should be utilized whenever possible
- Standalone signature page is available as a back-up if MnCHOICES signature page is not working

Once a member has an assessment completed in revised MnCHOICES platform, all future care coordination activities should continue within MnCHOICES

MnCHOICES – Help Needed



1

Review Current Functionality document in Help Center within MnCHOICES to determine if workaround is available.

Review other training resources in Help Center as appropriate

2

Check with delegate MnCHOICES Mentor & others within your delegate organization

Every delegate should have a MnCHOICES Mentor that works with UCare members

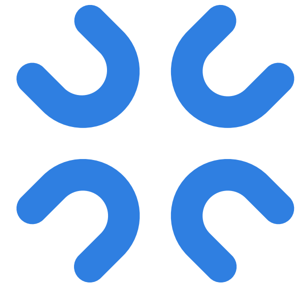
3

Reach out to Clinical Liaisons SNBCClinicalLiaison@ucare.org or MSC_MSHO_ClinicalLiaison@ucare.org

4

Clinical Liaison will provide direction if a MnCHOICES an submit a MnCHOICES Help Desk ticket when needed.

MnCHOICES – Additional Help



UCare MnCHOICES 9/14 Q&A Sessions

Connect/Connect + Medicare 1:00pm Register here

MSC+/MSHO 10:00am Register here

DHS Office Hours: 9:30-11:00am

2023: Oct. 6, Nov. 3, and Dec. 1

2024: Jan. 5, Feb. 2, March 1, April 5, May 3, and June 7

DHS MCO MnCHOICES Call-in Sessions: 9:30-11:30am

2023: Oct. 18 and Dec. 20

2024: Feb. 21 and April 17

Quarterly Meeting Feedback Survey: What can UCare do to support you in regards to MnCHOICES?

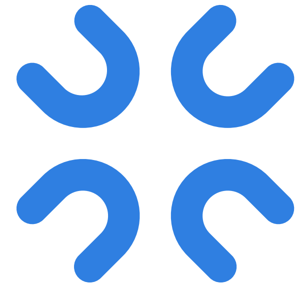
Housing Stabilization Services – Transition: Moving Expenses

- Housing stabilization services – transition: moving expenses expected to launch January 2024
- Moving expenses are only available to people receiving Housing Stabilization-Transition services **and are transitioning out of Medicaid funded institutions or other provider-operated living arrangements** to a less restrictive living arrangement in a private residence where the person is directly responsible for his or her own living expenses (own home).
- Moving expenses are non-reoccurring and are limited to a maximum of $3,000 annually.
- Moving expenses include:
  - Applications, security deposits, and the cost of securing documentation that isrequired to obtain a lease on an apartment or home
  - Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens
  - Set-up fees or deposits for utility or service access, including telephone,
  - electricity, heating and water
  - Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy
  - Necessary home accessibility adaptations

Face-to-Face Assessments

Jennie Paradeis, LPCC
Delegation and Enrollment Manager
Care Coordination and LTSS

Face-to-Face Assessments: Current State



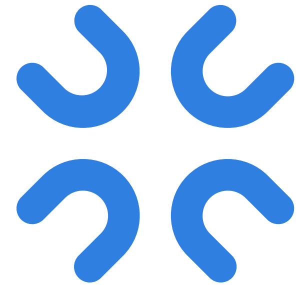
1/1/23: Assessments are to be documented that face to face was offered – All products

Member declines face to face: If member declines meeting in their home – consider meeting in neutral location i.e.: Library, coffee shop, lobby of apartment, CC office (if appropriate). Consider a tele-video virtual visit using HIPAA compliant technology. This would meet the face to face requirements.

Document face to face offered: Include education/options offered in member's case notes.

During the PHE, if all efforts to meet F2F (in-person and tele-video) are unsuccessful, a telephonic HRA may be completed. Documentation is key.

Face-to-Face Assessments: CMS and DHS



<u>In-person</u> requirements resume Nov. 1, 2023

<u>DHS requirements</u>

Beginning Nov. 1, 2023, lead agencies must meet minimum case management face-to-face requirements for people using:

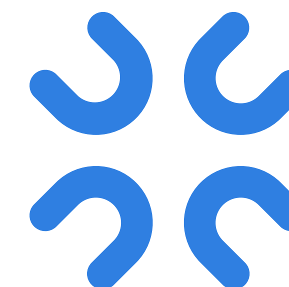
- Waivers (varies by waiver type)
- PCA services (in person only)

This applies to people whose waiver year ends on or after Nov. 1, 2023.

<u>CMS requirements</u>

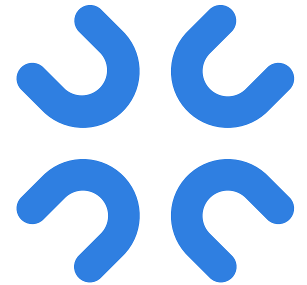
CMS also has its own face to face encounter requirements for MSHO and Connect + Medicare members.

Face-to-Face Assessments



In-Person Assessment/HRA	Televideo Assessment/HRA	Telephonic Assessment/HRA with documentation and member declined F2F
MSHO/MSC+ 3428H (No PCA, no EW, other waivers) – Initial/Annual	MSHO/MSC+ 3428H (No PCA, no EW, other waivers) – Initial/Annual	MSC+ 3428H (No PCA, no EW, other waivers) – Initial/Annual
MSHO/MSC+ EW without PCA - Annual	MSHO/MSC+ EW without PCA - Annual	MSHO/MSC+ EW without PCA - Annual provisional use only
MSHO/MSC+ MnCHOICES or LTCC (EW or PCA) - Initial		
MSHO/MSC+ Community Well with PCA Services - Annual		
MSHO/MSC+ EW with PCA – Annual		
MSHO/MSC+ Institutional – Initial/Annual	MSHO/MSC+ Institutional – Initial/Annual	MSC+ Institutional - Initial/Annual
Connect/Connect + Med - Initial/Annual	Connect/Connect + Med - Initial/Annual	Connect – Initial/Annual
		Connect + Med - Initial/Annual *with additional requirements/documentation

Face-to-Face Assessments – next steps



1. Please use the 3rd Quarterly Meeting Feedback Survey to submit your questions about return to Face to Face

2. Creating support tools including updating current Requirements Grids

3. We have scheduled dedicated time on September 28th, 2023 for a Q&A drop-in session from 10 am to 12 pm
   - MSC+ & MSHO at 10-11 am
   - Connect & Connect + Medicare 11 am-12 pm

Register here

Inquiring with U!

2023 Annual Care Coordination Survey

Inquiring with U: 2023 Annual Care Coordination Survey

Thank you for your participation in the care coordination survey! Your feedback matters and is incredibly valuable as we continue to grow and improve our care coordination services.

Participation went up by **37%** with **394** responses!

All areas-2022 compared to 2023

	Audits	Connect Navigators	DAR	Enrollment Coordinators - CM intake	Enrollment Coordinators - Connect Intake	Enrollment Rosters	Liaisons - Connect	Liaisons - MSHO MSC+	MSS triage line	Newsletter	PCA auths	PCC change process	Waiver Service Auths
2022	97.46%	84.38%	72.90%	90.07%	91.43%	52.27%	96.08%	88.54%	90.32%	96.55%	93.55%	79.57%	85.96%
2023	95.35%	98.28%	79.73%	93.98%	100.00%	67.02%	98.39%	89.50%	93.22%	96.53%	91.45%	86.76%	80.79%
	-2.11%	13.9%	6.82%	3.91%	8.57%	14.74%	2.31%	.96%	2.9%	-.02	-2.10%	7.19%	-5.17%

We heard you!

Last year we heard you say	What we did this year

• "Meetings are too long."	• We have shortened our quarterly meetings to 2-2.5 hours as much as we're able. UCare has required content that must be presented annually and at times we are unable to shorten
	  • Q1: 2.5 hours
	  • Q2: 2.5 hours
	• We will continue to be mindful of time and shorten quarterlies as we're able.

• "We need breaks during quarterlies."	• We have added breaks to quarterly meetings.
• "I don't work with both products and prefer separate meetings." • "I work with both products and prefer joint meetings."	• Some work with certain products while others work with all products. • It can be challenging to get presenters to attend two meetings. • Agendas are organized by audience and allow certain teams to exit early.
• We need more opportunities for optional trainings."	• Quarterly CEUs • Quarter office hours separated by product • Ad hoc MnCHOICES Q & A sessions
• "We need more Tools & Resources"	• We've created several job aids and resources posted to the website throughout 2022/2023.
• "We need more time for questions at quarterlies."	• We've answered all questions from quarterly chat that came in. • Those that were not answered live were sent out in Q & A format following the meeting.

Connect & Connect + Medicare

"Job aids are the most helpful"

"Job aids I find to be extremely helpful."

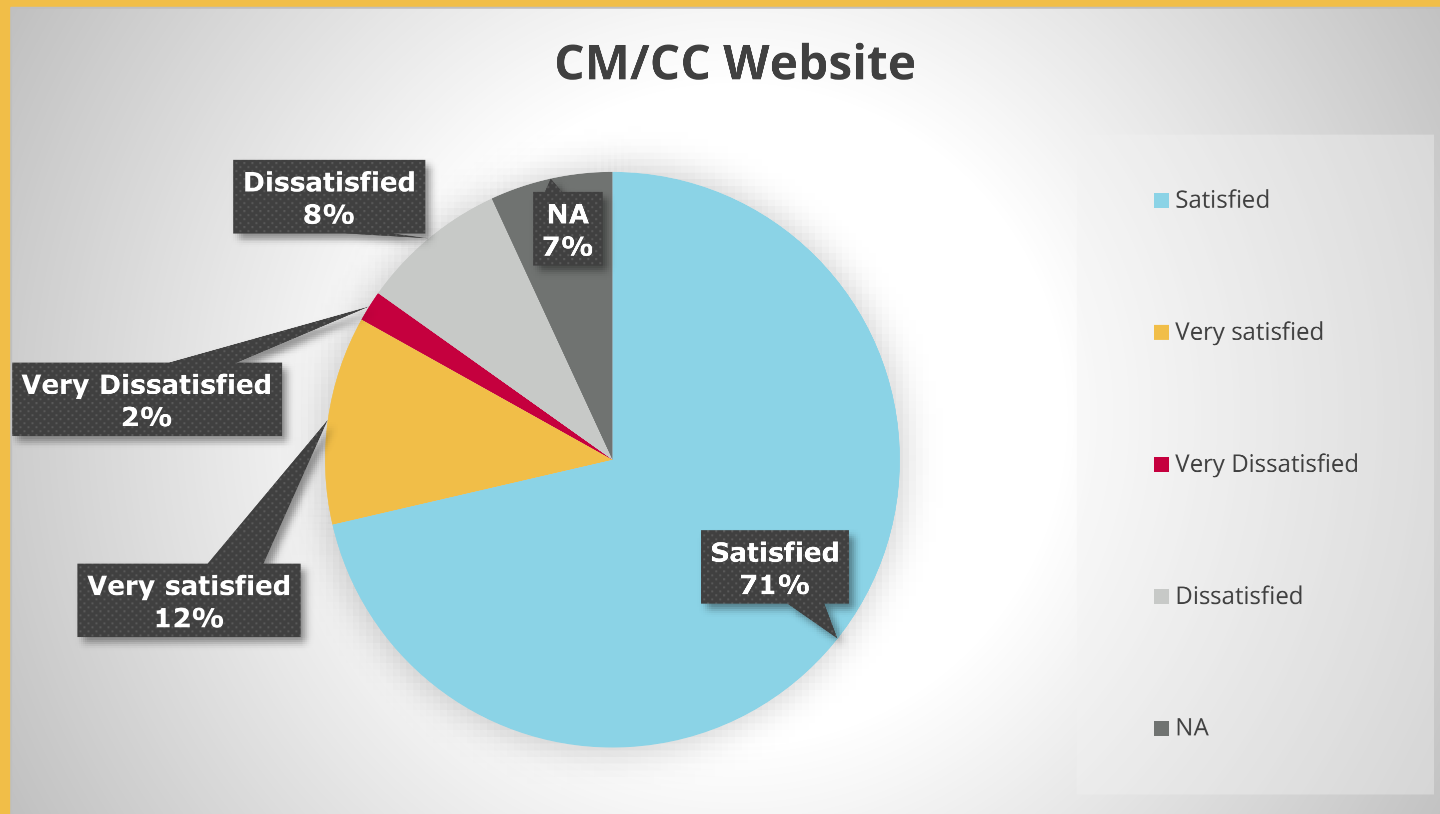
"The SNBC Liaisons are very knowledgeable and always quick to respond/support!"

We heard you say	What we're doing
Education on where to find things on the website	• We are working to update the Website Overview Training • Working in website overview into annual roadshow presentations • Adding more links in the newsletter to find referenced information.
Benefit Guide	• We are working with Health Promotions to implement your suggestions to the benefits grid. • We are developing an additional/ supplemental benefit guide searchable by diagnosis.
Member handouts	• Exploring pulling out one-pagers from member guide to be used as member handouts.

All Products

Website & Newsletters

- **Trending comments and feedback: “**Information is hard to find”
  - Care Coordination Website to was redesigned to make it more user friendly and intuitive for users.
  - This comes with change and adjustment learning a new layout.



Noteworthy Website WINS!

- “The changes over the past year to the website have been great.”
- “Seems to be more user friendly. Most of the time its fast and helpful.”
- “Always lots of good resource.”

Noteworthy Alerts & Newsletter WINS!

- “Helpful information with good reminders.”
- “This probably helps more than anything.”
- “Relevant information.”
- “Care coordinator updates are nice and easy to refer back to.”

All Products

Member Enrollment & PCC Assignment

Enrollment satisfaction went up by 15% since last year!

What we're doing:

- Continuing to work with development teams to improve accuracy and timeliness of rosters
- Pilot project to improve PCC accuracy
- High priority across departments
- Developing enrollment reconciliation job aid and trainings

MSC+ & MSHO

Waiver Service Authorizations

Noteworthy WINS!

- “I want to acknowledge the big improvements in this area. Much appreciated!!”
- “Very timely responses received for PCA authorizations!”
- “Improved communication if an authorization is not needed or if there is an issue. “
- “WAIVER APPROVAL TURNAROUNDS HAVE IMPROVED.”

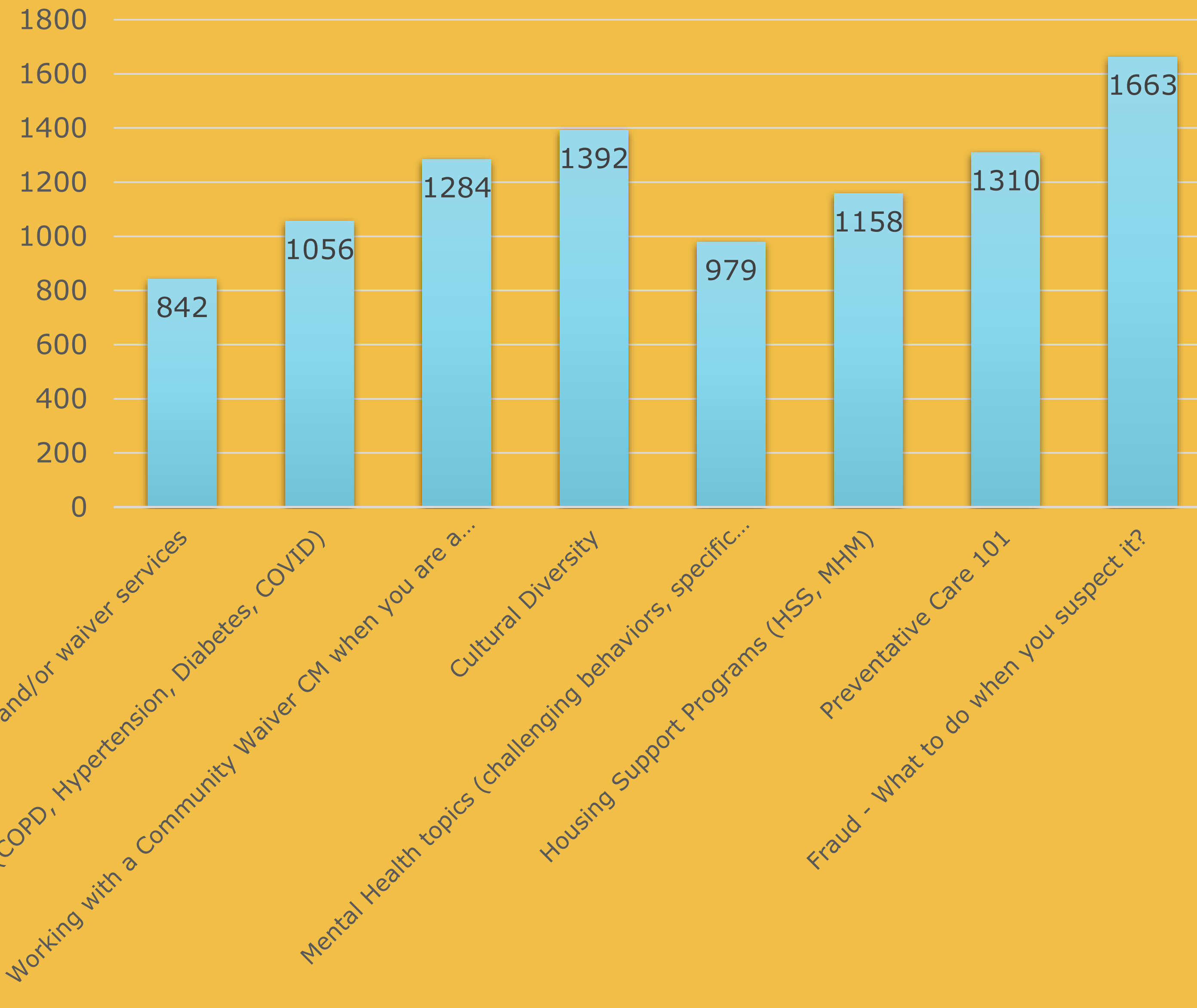
Action Items

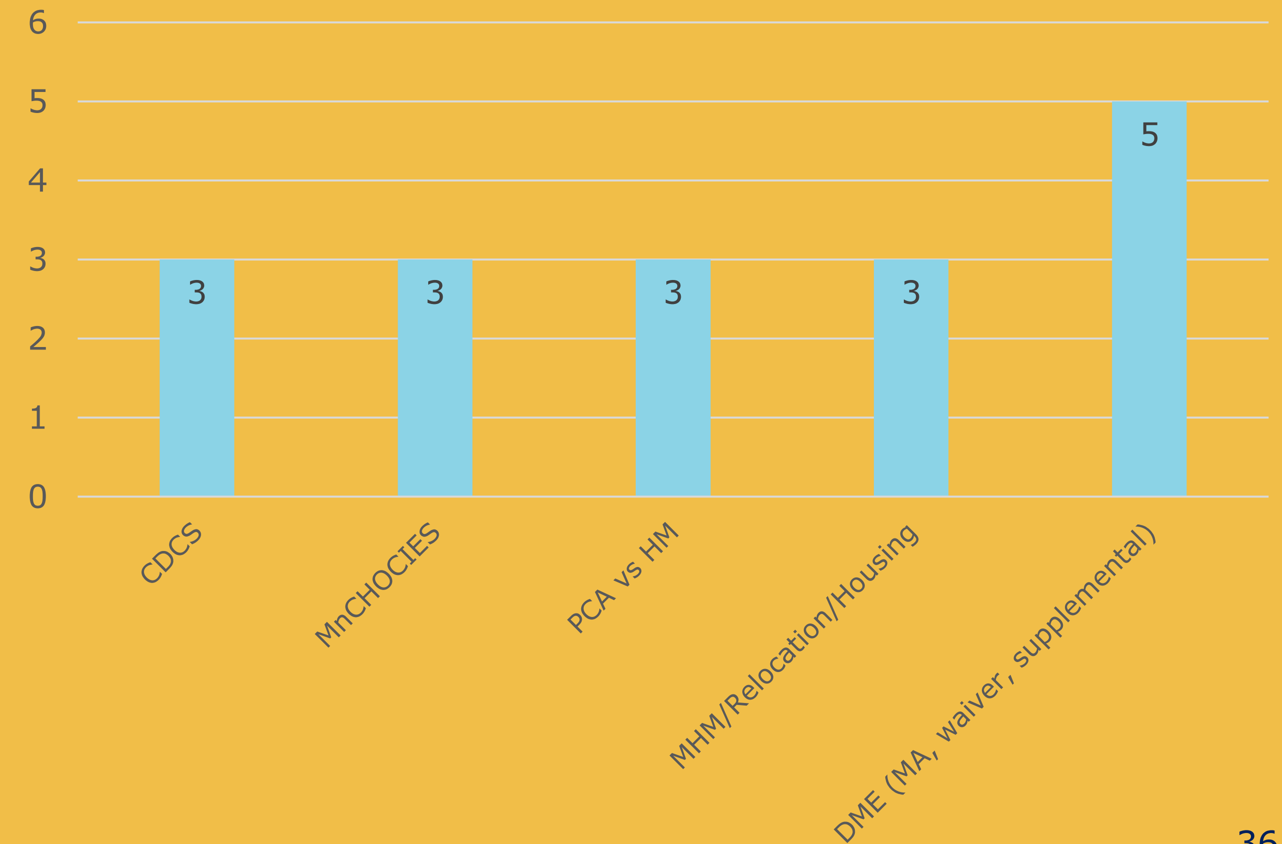
- This was identified as an area where UCare could make additional improvements and we will continue to look for additional ways to impact timeliness and responses regarding waiver service authorizations.

MSC+ & MSHO

We heard you say	What we're doing
Responses to emails can be vague	• Clinical Liaisons will be more thorough in responses
Requests for checklists/job aids	• Clinical Liaisons are continuing to work on expanding the current set of available job aids
Supplemental benefits education	• Clinical Liaisons are working with Health Promotion team to provide updated additional/supplemental benefits grids • Reach out to the Clinical Liaisons with any specific questions around supplemental benefits

Future Training Opportunities





Keep it coming!

We welcome you to continue providing feedback. We want to hear from you!

Some ways your feedback can make an impact:

- Annual CC survey
- Post meeting surveys
- Open communication with your Clinical Liaisons

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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 the assessment.
What tools can I use to help me?	• SMART Goals Job Aid • SMART Carte • Member Engagement Strategies Job Aid

SMART
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?

Example:

- Not Specific: To be pain free
- Specific: I will decrease my foot pain score from 8 to 4 within the next year.

SMART

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

Example:

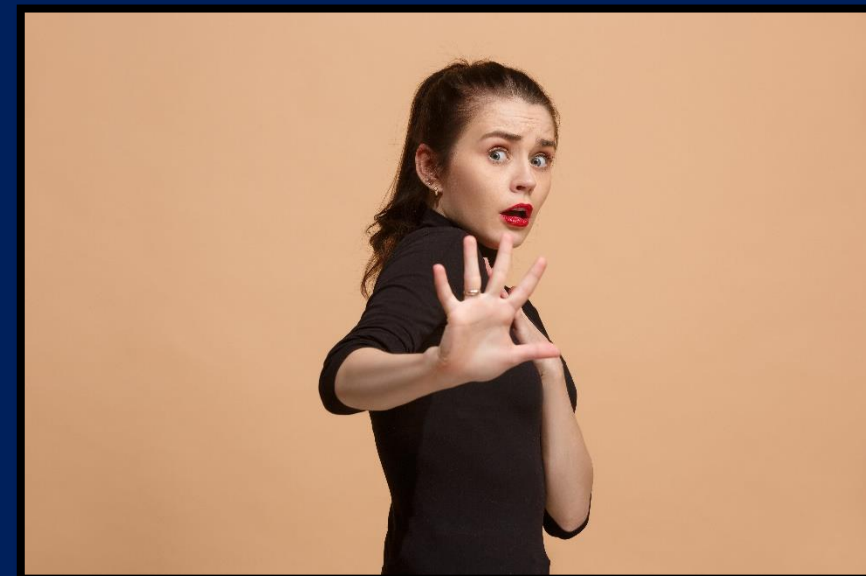
- Not Measurable: I will have a healthy blood pressure.
- Measurable: I will reduce my blood pressure from 140/90 to 130/80 by next review.

SMART
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.

Example:

- May not be 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.



SMART
Relevant

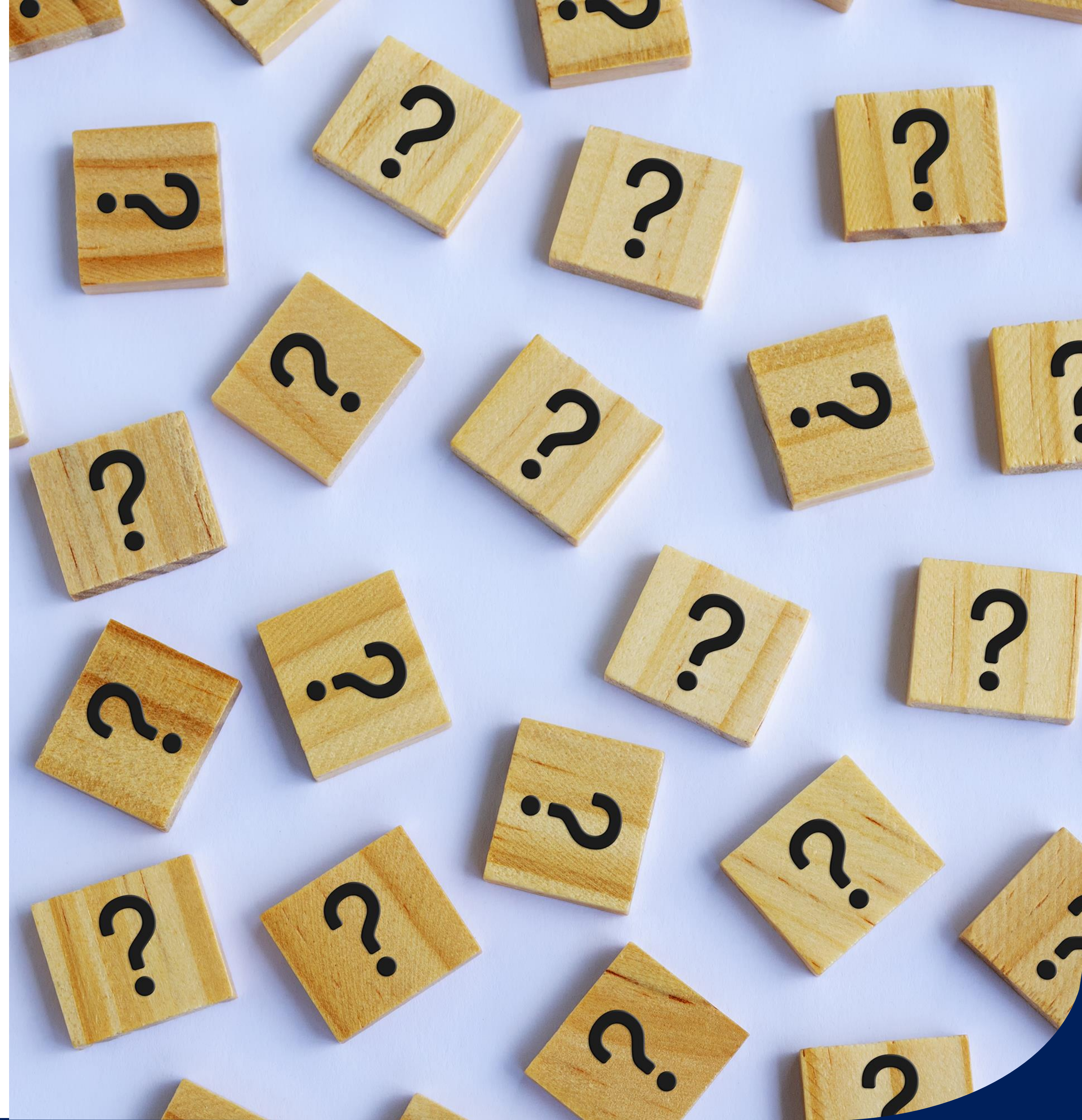
Think of answering the following questions…

- What is the big picture?
- What are the member's identified risks?
- Why is the member setting this goal?
- Is this goal relevant to the "why?"
- What is important to and 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.



SMART

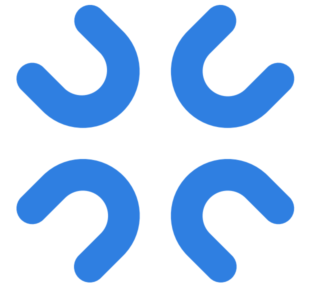
Time-bound

To properly measure member outcomes, goals should be time-bound. Time related parameters should be built into goals. Consider “When will the member achieve this goal?”

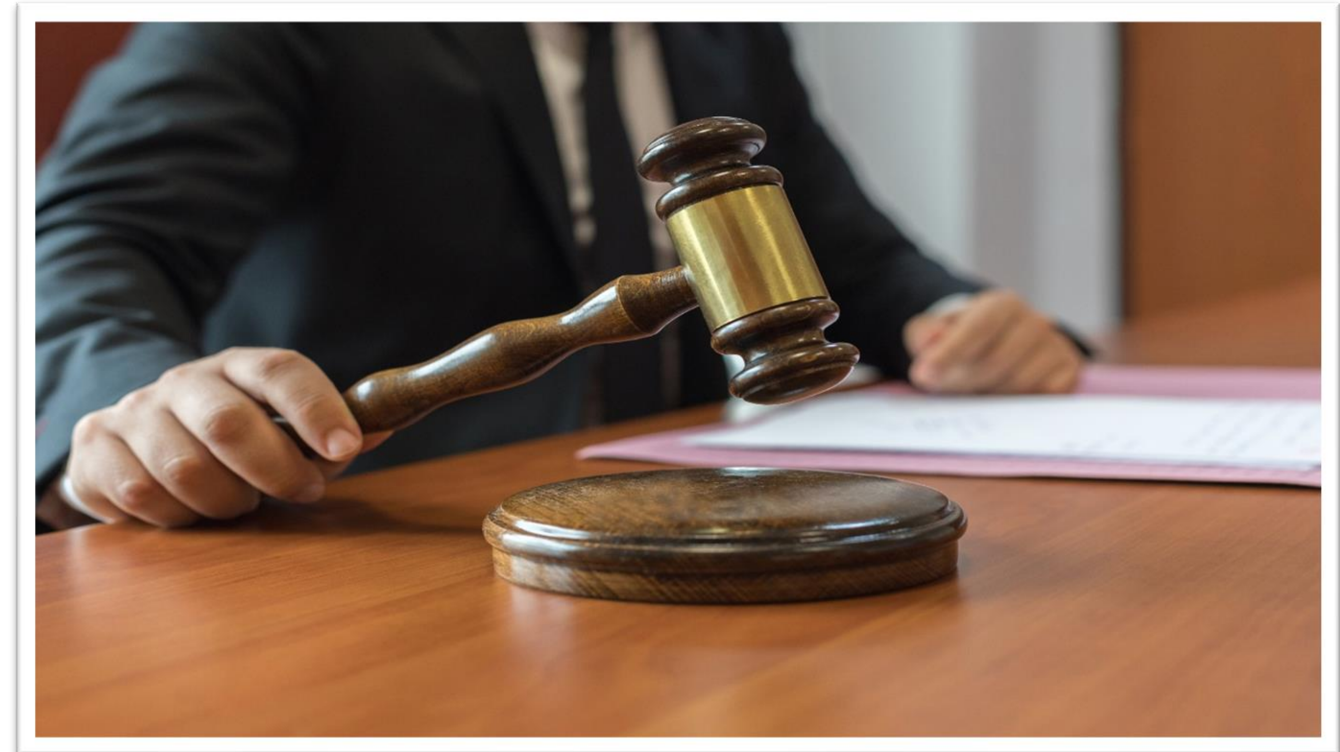
Example:

- Not time-bound: I will lose 10 pounds.
- Time-bound: I will lose 10 pounds within the next 6 months.

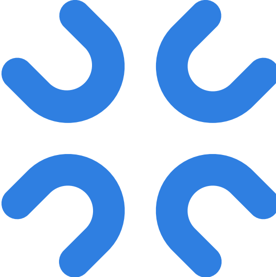
What are the requirements?



- 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.



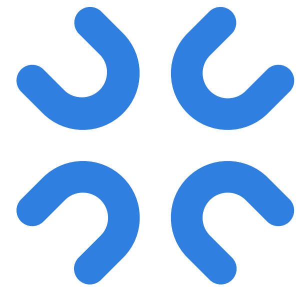
SMART Goal Sample: UCare Support Plan

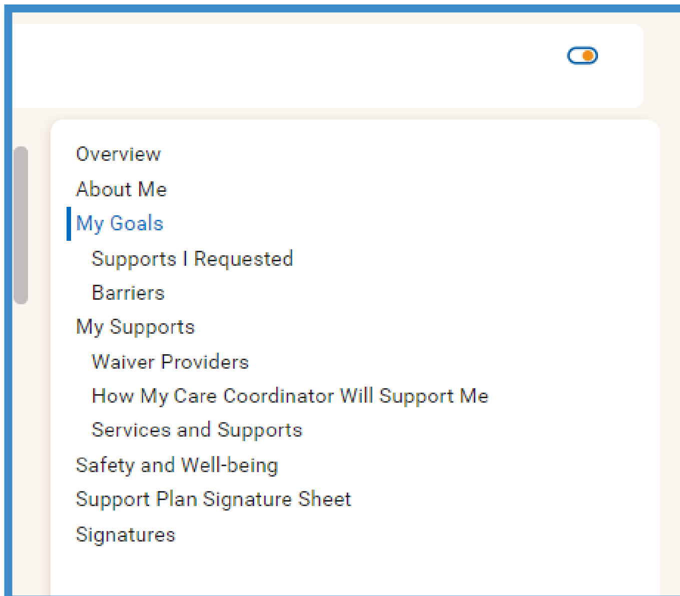


My Goals: ***Discuss with Care Coordinator, goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.***

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 next 6 weeks Fred commits to decreasing his sweets/ donuts to 1-2 times a week. Fred plans to take advantage of the new fitness benefit offered by UCare. He wants to use the gym at least 3 x week.	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 medication change. Continue goal.	2/24/23-SH/CC Goal Achieved Fred's A1c is 7

SMART Goal Sample: MnCHOICES Support Plan





1. **Supports I requested**
   - Type of intervention i.e. Transportation
   - Description of the support person needs to achieve the goal.
     - Intervention
       - What actions are being done?
       - Who is responsible for the actions?
2. **Barriers**
   - What gets in the way of achieving the member's goals?
3. **My Goals**
   - Create after supports and barriers are complete to avoid extra steps to back track.
   - Goals must still be in SMART format.

My Goals

Goal Statement
I would like to reduce my A1C to 7 or lower within the next year.

Target Date
When will this goal be accomplished?
08/19/2024

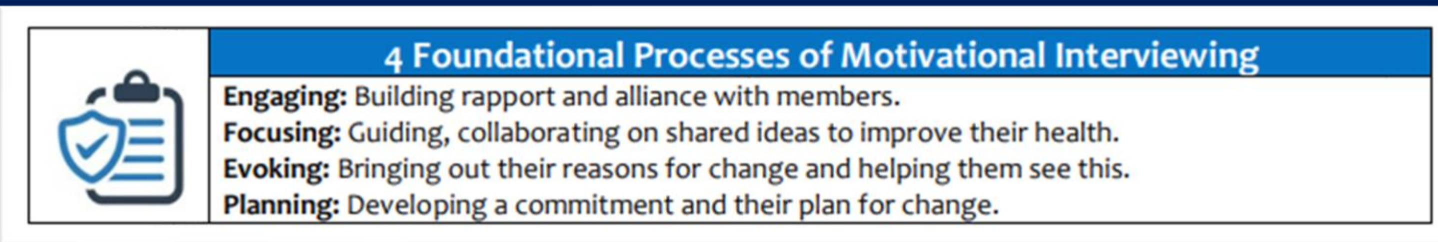
Priority
Medium

Selected Supports I Requested
Enter a description of the support the person needs to achieve the goal.

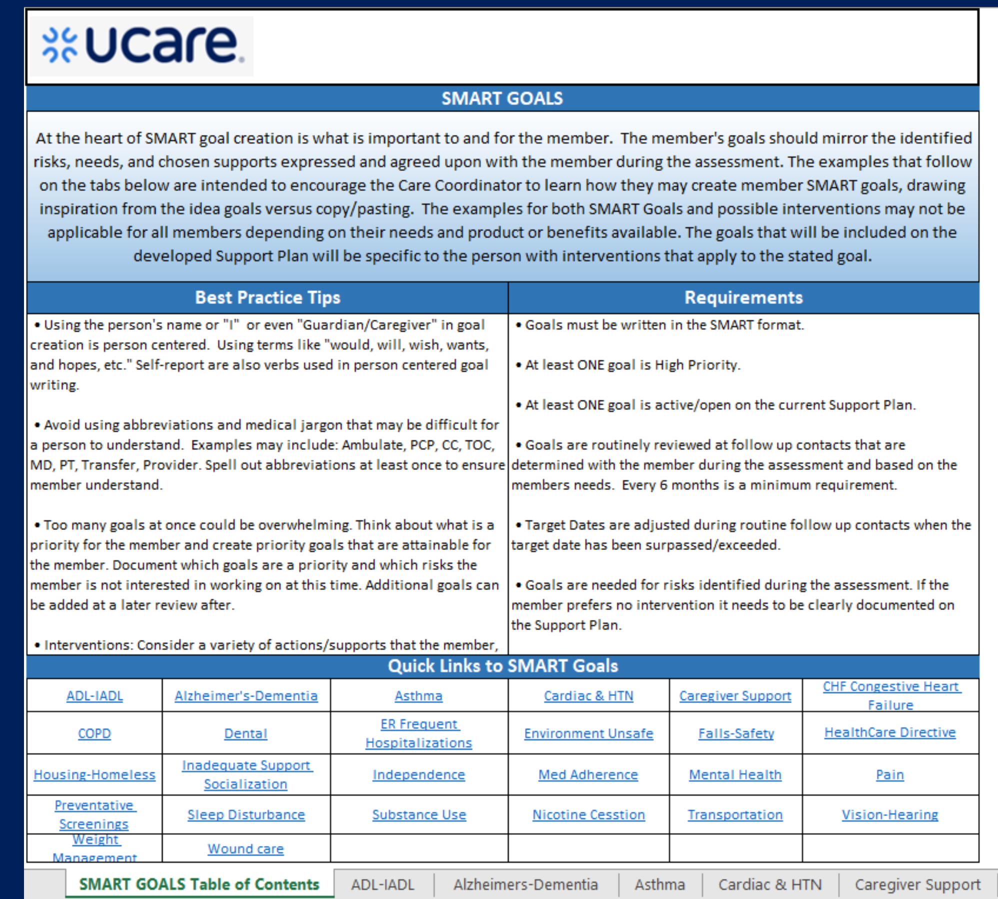
Name
Diabetes Management
Description
My Care Coordinator provided information about Disease Management coaching with UCare and completed a referral. I will work with my coach telephonically as scheduled. My wife will continue to assist with daily blood sugar monitoring and medication administration. My Care Coordinator will provide a list of in-network Endocrinologists. I will schedule and attend my first visit within the next 6 weeks. I will decrease the number of sweets/donuts to 1-2 times a week. I will obtain a One Pass gym membership and go to the gym at least 3 times a week. I will follow my doctor recommended low sodium, low carbohydrate, heart healthy diet.

Helpful Resources

[Member Engagement Strategies Job Aid](#)
[SMART Goals Job Aid](#)
[SMART Carte](#)



4 Foundational Processes of Motivational Interviewing
Engaging: Building rapport and alliance with members.
Focusing: Guiding, collaborating on shared ideas to improve their health.
Evoking: Bringing out their reasons for change and helping them see this.
Planning: Developing a commitment and their plan for change.



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SMART GOALS

At the heart of SMART goal creation is what is important to and for the member. The member's goals should mirror the identified risks, needs, and chosen supports expressed and agreed upon with the member during the assessment. The examples that follow on the tabs below are intended to encourage the Care Coordinator to learn how they may create member SMART goals, drawing inspiration from the idea goals versus copy/pasting. The examples for both SMART Goals and possible interventions may not be applicable for all members depending on their needs and product or benefits available. The goals that will be included on the developed Support Plan will be specific to the person with interventions that apply to the stated goal.

Best Practice Tips	Requirements
• Using the person's name or "I" or even "Guardian/Caregiver" in goal creation is person centered. Using terms like "would, will, wish, wants, and hopes, etc." Self-report are also verbs used in person centered goal writing. • Avoid using abbreviations and medical jargon that may be difficult for a person to understand. Examples may include: Ambulate, PCP, CC, TOC, MD, PT, Transfer, Provider. Spell out abbreviations at least once to ensure member understand. • Too many goals at once could be overwhelming. Think about what is a priority for the member and create priority goals that are attainable for the member. Document which goals are a priority and which risks the member is not interested in working on at this time. Additional goals can be added at a later review after. • Interventions: Consider a variety of actions/supports that the member,	• Goals must be written in the SMART format. • At least ONE goal is High Priority. • At least ONE goal is active/open on the current Support 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 Support Plan.

Quick Links to SMART Goals					
ADL-IADL	Alzheimer's-Dementia	Asthma	Cardiac & HTN	Caregiver Support	CHF Congestive Heart Failure
COPD	Dental	ER Frequent Hospitalizations	Environment Unsafe	Falls-Safety	HealthCare Directive
Housing-Homeless	Inadequate Support Socialization	Independence	Med Adherence	Mental Health	Pain
Preventative Screenings	Sleep Disturbance	Substance Use	Nicotine Cesstion	Transportation	Vision-Hearing
Weight Management	Wound care				

SMART GOALS Table of Contents | ADL-IADL | Alzheimers-Dementia | Asthma | Cardiac & HTN | Caregiver Support

SMART	
pecific	• 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:** Fred will decrease his foot pain score from 8 to 4 within the next year.
leasurable	• Quantifying your objectives allow for tracking progress and identifying completion. Consider measurable verbs; take, perform, complete, use, list, state, self-report, identify, and measurable rates; 3 days/week, 8/10, 10 minutes per day, lab values. • **Not Measurable:** I will have a healthy blood pressure. • **Measurable:** I want to reduce my blood pressure from 140/90 to 130/80 by next review.
ttainable	• 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 smaller, more achievable goal to work toward a bigger objective. • **Not Attainable:** Fred wants to be smoke free. • **Attainable:** Fred would like to reduce smoking from 15 cigarettes per day to 10 cigarettes per day within the next 6 months.
elevant	• 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 Gap in care. • **Not Relevant:** I will self-report completing annual exam. • **Relevant:** I will self-report completing my colonoscopy within 6 months.
ime-bound	• To properly measure your outcomes, your goals should be time-bound. Time-related parameters should be built into your goals. Ask, "When will the member achieve this goal"? • **Not Time-bound:** Fred will lose 10 pounds.

BEST PRACTICE TIP	SMART GOAL	INTERVENTION EXAMPLES
Goal: "I will self-report my diabetes being managed over the next year." This goal is not SMART as it is not specific to what is "managed". **Try this instead:** "Fred will have an A1C of [XX] or lower by next review."	Fred wants to have an A1C below {XX] within 12 months	• Fred commits to taking all [medications/insulin] as prescribed by [Dr. Name] to manage diabetes • Fred plans to follow up with scheduled labs as recommended by [Dr. Name] • Fred plans to continue learning about healthy eating/dietary recommendations from [staff/Medical Provider/Dietician/Care Coordinator] • Fred would like Care Coordinator to assist with scheduling annual eye exam • Fred has agreed to check feet daily for wounds - use mirror if unable to see bottom of feet • Fred has agreed to see a [podiatrist/diabetic educator/nutritionist/endocrinologist/ophthalmologist] • Fred will consider participation in Disease Management program • Care Coordinator encourages Fred to use fitness benefit to increase daily physical activity to 2-3 x week • Fred will receive staff assistance with daily blood sugars checks • I plan to track blood sugar readings in a log book • Fred plans bring glucometer to medical appointments for [Dr. Name] to review blood sugar readings • Fred is going to avoid eating after 7 pm • Care Coordinator will assist with obtaining new glucometer [or other DME] • Care Coordinator provided [education/testing/treatment] options and lifestyle choices to help gain symptom control • Care Coordinator has provided incentive voucher for diabetic lab work • Care Coordinator will make a referral to a home care agency for skilled nursing visits to help with monitoring and education by end of the month • Caregiver will attend all medical appointments with Fred • Staff will monitor and record blood sugars daily along with administer medications as prescribed
	Fred will self-report having a lower AM blood sugar [below XXX] by next review	
	It's important that Fred obtains a new blood glucose monitor within 3 months	
	I will lose [XX] pounds by next review to improve my diabetic health	
	I will walk two times per week by the next review	
	Fred will self-report checking blood sugars on a daily basis by the next review	
	Fred will self-report using the Nurse/Care Line before going to the Emergency Room for diabetic care needs over the next 6 months	
	Fred would like to have a list of nearest urgent care providers within the next three months	
	Fred will complete a diabetic eye exam within the next 6 months	
	Fred's caregiver will begin [completing/journaling] daily foot checks for possible wounds through next review	
	Fred will self-report managing his pre-diabetes by having an A1C below 6 over the next 12 months	

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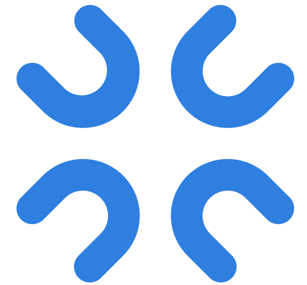
PCA/CFSS and EW Authorization process Update

Esther Versalles-Hester

PCA/CFSS



CFSS

- At this time there are no updates on CMS approval for CFSS however, DHS continues to move forward with workgroup meetings as well as drafts on proposed recommendations.

Status of Assessment

- For Care Coordinators following up on the status of an authorization, you may email the PCA team at ucarepca@ucare.org. Someone from the PCA team will be respond to your email within 1-2 business days.

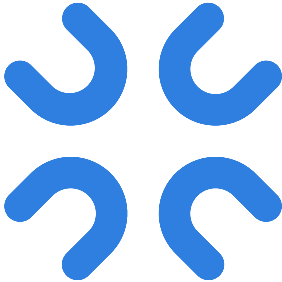
Forms

- UCare has updated the current PCA communication form to include a drop down when a MnCHOICES assessment has been conducted for PCA Services.

Authorizations

- In addition to the PCA communication from and when completing a MnCHOICES assessment, a copy of the "Assessment Results" and the "Support Plan" documents are needed to complete the authorization process.
  - The PCA team will provide a copy of the assessment results to the servicing PCA agency.
    - If you are experiencing problems printing off these documents, please contact the PCA team for assistance at 612 676-6705, option 2, option 4 for instructions.

Coming soon: Updated PCA Communication Form



Clear Form

PERSONAL CARE ASSISTANCE (PCA) COMMUNICATION FORM

FYI: Incomplete, illegal or inaccurate forms will be returned to sender. All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.

Form must be completed by UCare Care Coordinator.*

Fax form and relevant documentation to: 612-884-2094

For questions, call: 612-676-6705 (To reach a representative, choose option 2 and then option 4)

E-Mail: ucarepca@ucare.org

MEMBER INFORMATION:

Name: | Date of Birth:
Member ID: | PMI:

CARE COORDINATOR INFORMATION:

Care Coordinator Name:
Phone: | Fax:
Email:

REQUEST COPY OF MOST RECENT PCA ASSESSMENT

☐ Fax to Care Coordinator ☐ Secure Email to Care Coordinator

PCA SERVICES REQUESTED:

New or Current LTC/ EW Date Span: TO
Service Description: Select a Service
ICD-10 Code(s):
- PCA 45 Day Temp Increase (T1019 U6)
- Deny PCA Services
- Terminate PCA Services
- Reduce PCA Services
- Deny Early PCA Assessment
- Refusal/ Unable to Reach
- MnCHOICES PCA Assessment Approved
- MnCHOICES PCA Assessment Reduced
- MnCHOICES PCA Assessment Denied/ Termed
- Split PCA Hours Between Agencies

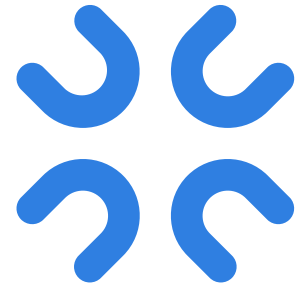
Approved PCA Unit
Start Date:
PCA Agency Name:
Phone:
Detailed description daily x 45 days):

CHANGE OF PCA AGENCY/ NEW AGENCY NOTIFICATION:

Current PCA Agency Name: | PCA Agency UMPI/ NPI #:
New PCA Agency Name: | PCA Agency UMPI/ NPI #:
Start/ Transfer/ Change Date:
Additional description for request:

PCA Communication Form- U8599 | Page 1 of 2

EW Waiver Service Approvals

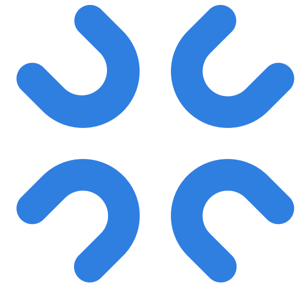


- For Care Coordinators following up on the status of an authorization, you may email the CLS Intake team at CLSInake@ucare.org. Someone from the Intake team will be respond to your email within 1-2 business days.

- For T2029 (Equipment and Supplies) please verify that the item is not covered under the members medical benefit.

  - There has been an increase of WSAF where the item is covered under the member Medicaid benefit based on information obtained on the DHS provider manual.
  - Most DME providers of EW services are also contracted with UCare. If a provider feels that the item may not be covered under the medical benefit, they should submit a predetermination request to UCare with supporting documentation.

Electronic Visit Verification

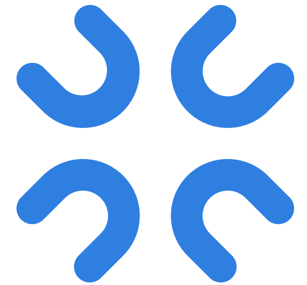


- DHS will begin to use electronic visit verification for home health services in October 2023 for fee-for-service **and managed care organizations** in October 2023. Providers, regardless of payer, should have received a welcome letter from DHS (PDF) outlining the next steps to begin using EVV.
- This next phase (October 2023) will include Skilled Nursing Visits and Home Health Aid as well as homecare PT, OT and ST services.
- Future phases will include remaining EW services such as homemaking and CFSS.
  - Intent of EVV is to ensure quality and program integrity as well by validating that services were actually delivered by using a variety of electronic methods like a phone call, smart phone application.

Transitions of Care (TOC)

Refresher: TOC Audit of 2022

Transition of Care Audit - 2022



Areas of Success:

- Timeliness
  - Sharing Care Plan/Support Plan with receiving setting within 1 business day of notification
  - PCP notifications of transition within 1 business day of notification
  - Communicating with member/rep
- Thorough notes documented on TOC Log
- Follow up tasks completed for transition notifications over 15 days

Opportunities for Improvements:

- Complete TOC Logs, as required
- Confirm transition occurred before completing tasks
- Care Coordinator communication with member/representative within 1 business day of return to usual setting
- Complete 4 Pillars upon return to usual setting. When marking "No" to one of the 4 Pillars, provide explanation in the comments or work to make it a “yes”

Why is Supporting Members in a TOC Important?

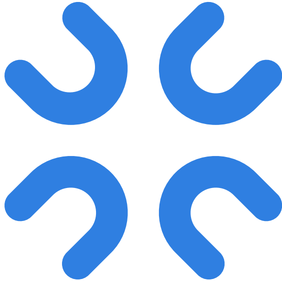
Moving between health care settings increases vulnerability:

- 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.

Transition of Care Focus Areas



Complete TOC logs, as required (Documentation)

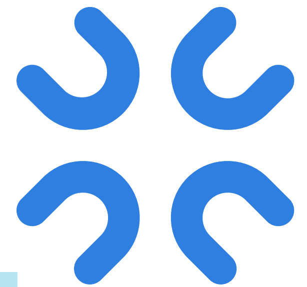
Notifying the PCP of transition within 1 business day of notification (phone/fax/EMR)

Sharing Support Plan with the receiving setting within 1 business day of notification

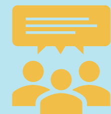
Communication with the member/representative within 1 business day of notification

4 Pillars of Optimal Transition & Support Plan Updates

Communicating with Receiving Setting

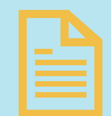


State your role, how you can help with support, resources, supplemental benefits and as important



What you know about the member's current services or lack of services.

Share a verbal summary of the persons support plan.



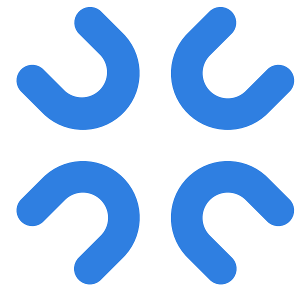
Document the details

- Who did you speak with?
- What information was provided/received?
- Create a follow-up plan.

PCP Communication

- The PCP communication must be completed via phone call, fax or EMR within 1 business day of notification of change in care settings.
    - Exception: if the PCP is the admitting physician – document accordingly.
- Sharing updates about the patient's condition is an important part of the care coordinator role.
- With significant changes, use your professional judgement if the support plan is reshared.

Communication with Member/Representative



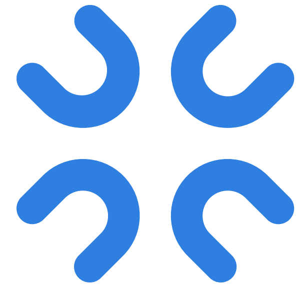
Reach out to the member, with each change in setting and **upon return to their usual setting**, within **1 business day of notification** of the transition, to assess needs and prevent readmissions.

Two actionable attempts or more per CC judgement.

Discussion should include:

- Care transition process
- Changes to member's health status
- Changes to Support Plan
- Services/supports needed
- Education about how to prevent unplanned transitions/re-hospitalizations
- How to reach CC
- **Upon return to usual care setting**: 4 Pillars to Optimal Transition Management

Four Pillars for Optimal Transition
Required upon return to 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 Mgt and CC 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

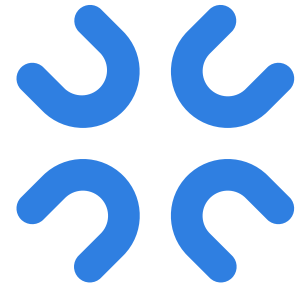
Pillar 3. Knowledge of Warning Signs

- 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 summary? 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 Support Plan



Complete tasks below when the member is discharging <u>TO</u> 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

<u>Four Pillars for Optimal Transition</u>:

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.*

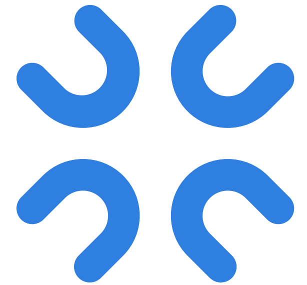
☒ Yes ☐ No **Have you reviewed the discharge summary with the member?** *If "No" provide explanation in comments.*

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

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

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.

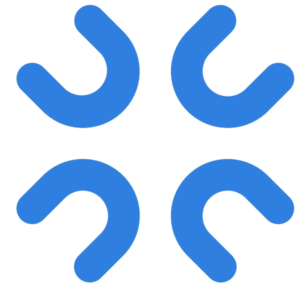
Updating the Support Plan



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	

Significant Change of Condition

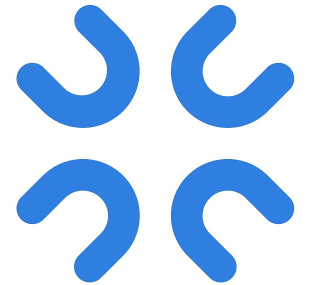


UCare requires care coordinators to conduct an HRA in the event of a significant change in a member's condition.

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

Document, Document, Document



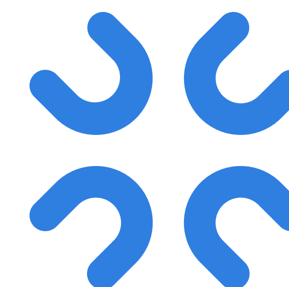
Member outreach at every transition. (2 or more attempts to reach member)

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

Document directly on the TOC Log

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
- AA/NA transportation

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

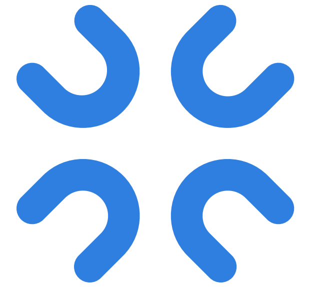
UCare Model of Care

Minnesota Senior Health Options

Connect + Medicare

Institutional Special Need Plan

Training Purpose



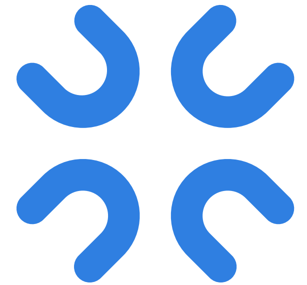
Provides information about Model of Care requirements for UCare's Special Needs Plans:

- Minnesota Senior Health Options (MSHO)
- Connect + Medicare
- Institutional Special Needs Plan (I-SNP)

Outlines the importance of your role as a provider or care coordinator on the interdisciplinary care team.

Explains how to interface with the care coordination team in the provision of care.

Delivering Coordinated, Appropriate Care

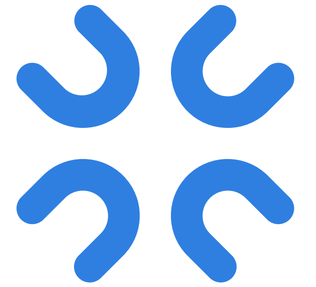


- The Model of Care (MOC) is UCare's care delivery model approved by the Center for Medicare and Medicaid Services (CMS).

- This course meets the CMS MOC provider training requirement for UCare's MSHO, Connect + Medicare, and ISNP products.

- This training will identify how you, as the provider of care, will support UCare's Model of Care and understand the CMS requirements for serving these members.

UCare's Model of Care (MOC)

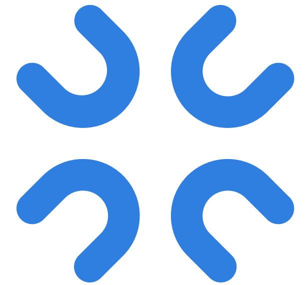


The MOC's overall goal is to drive improvements in health outcomes and quality of life for members.

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

Why does UCare have an MOC?



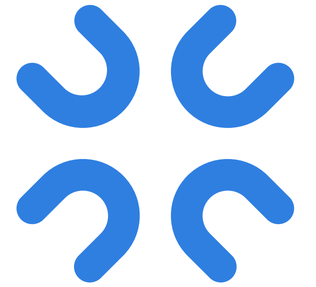
Required by CMS and has four components:

- Population description and characteristics
- Care coordination details
- Provider network that ensures adequate access
- Quality measures and process improvement goals

It helps provide:

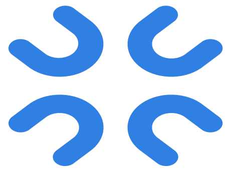
- Access to high-quality health services
- Coordination of all services needed
- Opportunities for involvement in the development of individualized care plans
- Care-transitions support to members and families
- Treatment in-place, in the most feasible, comfortable setting

UCare’s Special Needs Plans



Integrated products combining Medicaid and Medicare:

- Parts A, B, and D (pharmacy) plus Medicaid benefits
  - MSHO and Connect + Medicare require Medicaid benefits
- Members have one ID card
- One phone number for health plan questions:
  - 612-676-6830 or 855-260-9707



UCare's Special Needs Plans (SNP)

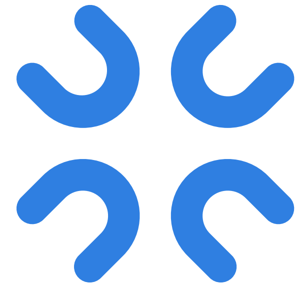
These plans serve members residing within UCare's service area:

Minnesota Senior Health Options Program serves elderly members who are dually eligible for Medicare and Medical Assistance, and 65 or older.

UCare Connect + Medicare Program serves members with disabilities between the ages of 18-64 who are dually eligible for Medicare and Medical Assistance.

ISNP serves members 18 or older who have Medicare and qualify for Nursing Home level of care. Members must have Medicare Part A, Part B, and Part D and live in the plan service area in a participating long-term care or assisted living facility.

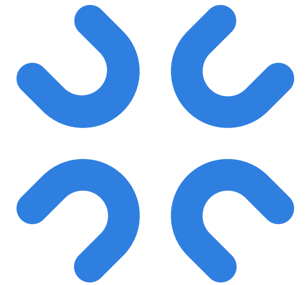
How do Members enroll?



Enrollment is voluntary, with several ways to enroll:

- Member’s county financial worker (MSHO or Connect + Medicare)
- Senior Linkage Line: 800-333-2433 (MSHO)
- UCare’s Enrollment Team: 612-676-3554 or 800-707-1711

MSHO Member Demographics



Age Range: 65-85+ years

- Female: 65%
- Male: 35%

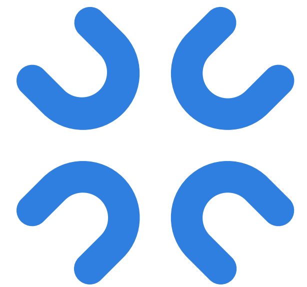
Living arrangements:

- Community: 40%
- Institutional: 13%
- Waiver: 47%

Race:

- Asian: 17%
- Black or African American: 19%
- Native American: 1%
- White: 59%

Connect + Medicare Member Demographics



Age Range: 18-64 years

- Female: 55%
- Male: 45%

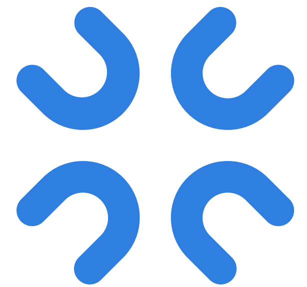
Living arrangements:

- 98% community
- 2% institutional

Race:

- White: 72%
- Black or African American: 14%
- Asian: 3%
- Native American: 3%

ISNP Member Demographics



Age Range: 65-85+ years

- Female: 65.58%
- Male: 34.42%

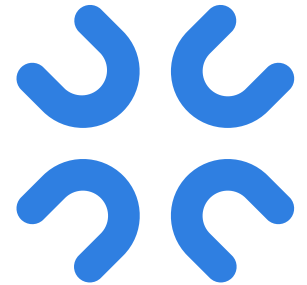
Living arrangements:

- 100% community residing in an Assisted Living or Long-Term Care Facility.

Race:

- Asian: 1.44%
- Black: 5.33%
- Hispanic: .88%
- Native American: 1.21%
- White: 90.19%

Vulnerable Populations



The Connect + Medicare population is comprised of:

- Disabled adults, diagnosed with a physical, developmental, mental illness, or brain injury
  - The majority of the population is diagnosed with serious and persistent mental illness
  - Most of the population have multiple complex, chronic conditions

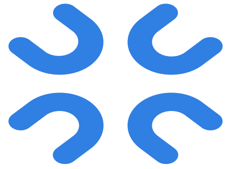
The I-SNP population is comprised of:

- Older adults that have diseases of aging that are both chronic, progressive, or degenerative
- Dealing with mobility issues or limitations in ability to function independently that are compounded by the existence of multiple co-morbidities and frailty
- Residing in an institutional setting (long-term care) or at a nursing home level of care (assisted living) and have been receiving or are expected to receive a nursing home level of care for 90 days or more
- Experiencing some degree of cognitive impairment

The MSHO Population is comprised of:

- Older adults, often frail
- At risk for readmission to hospital
- At risk for multiple chronic conditions and polypharmacy

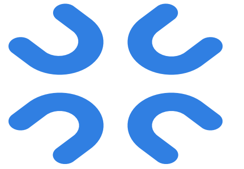
Care Coordinators



Qualified professionals:

- County Social Worker
- Independently Licensed Mental Health Professional:
  - Psychologist
  - Professional Clinical Counselor
  - Independent Clinical Social Worker
  - Marriage and Family Therapist
- Minnesota licensure:
  - Registered Nurse
  - Nurse Practitioner
  - Public Health Nurse
  - Physician Assistant
  - Physician
  - Social Worker

The Care Coordinator’s Role



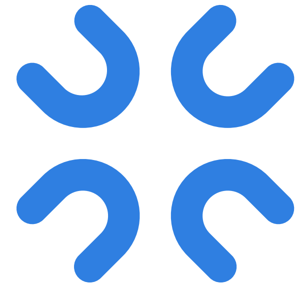
Every member is assigned a care coordinator

- The care coordinator partners with the member and their Interdisciplinary Care Team (ICT)
  - All Primary Care Physicians are considered an integral part of the member’s ICT
- The care coordinator is the primary point of contact ensuring ongoing communication between members of the Interdisciplinary Care Team

To find out who the member’s care coordinator is, call UCare’s Customer Service:

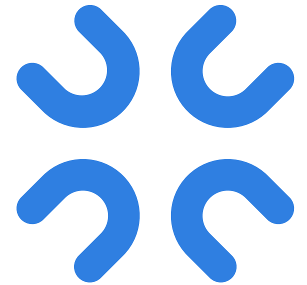
- **MSHO:** 612/676-6868 or 866/280-7202
- **Connect + Medicare:** 612/676-6830 or 855/260-9707
- **ISNP:** 612/676-6821 or 877/671-1054

Care Coordination



The Care Coordinator (CC) coordinates care and services for the member, including:	
	Annual health risk assessment (HRA) to evaluate members’ medical, psychosocial, cognitive, functional, and mental health needs.
	Creating an individualized, person-centered support plan addressing needs identified by the HRA.
	Closing gaps in care, improving quality of life, and meeting the member’s individual needs.
	Communicating with the Interdisciplinary Care Team (ICT), the team providing health care services for members.
	Facilitating care transition protocols.

Care Coordination Requirements



Care coordination services consist of a comprehensive assessment of the member's condition, the determination of available benefits and resources, the development and implementation of an individualized support plan with performance goals, monitoring, and follow-up.

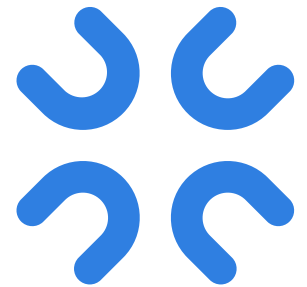
Care Coordinator Requirements and associated forms used for members on MSHO, Connect + Medicare, and ISNP product can be found here:

- MSHO Care Coordination
- UCare® - Care Coordination UCare Connect Plus Medicare
- I-SNP Care Coordination

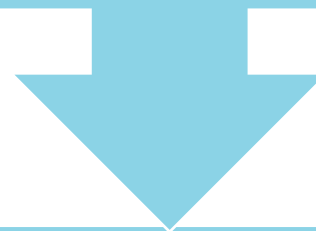
Additional UCare Care Coordination and Case Management resources can be found here:

- UCare® - Care Management Manual

Health Risk Assessment (HRA)



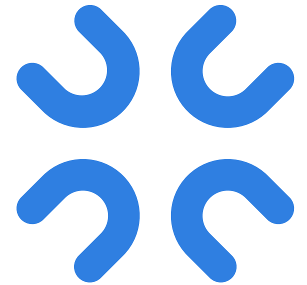
An HRA provides the Care Coordinator with pertinent information related to all MSHO, Connect + Medicare members', ISNP **medical, functional, cognitive, psychosocial, and mental health needs**.



The HRA provides insight into:

Determining member needs	How member manages their health	Needed supports to manage overall health	Identifying member concerns

Individualized Support Plan

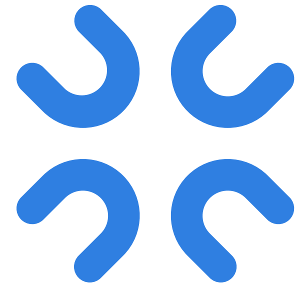


The person-centered information contained in the Support Plan is used to monitor gaps in the member's **medical, psychosocial, cognitive, functional and mental health needs**.

The focus is on preventive and maintenance health care services, disease-specific interventions, and health care service coordination. The support plan addresses needs identified in the HRA by:

- Prioritizing goals
- Identifying barriers and interventions
- Identifying and coordinating service needs
- Identifying ICT members
- Planning for care continuity, transitions, and/or transfers
- Updating progress made toward goals/plan
- Managing ongoing communication between teams

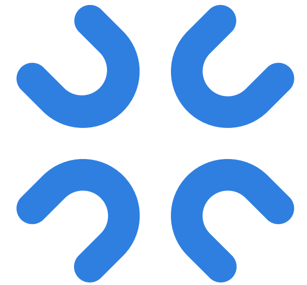
Interdisciplinary Team



The Interdisciplinary Team consists of:

- Member and/or appropriate family/caregiver
- MSHO, ISNP 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

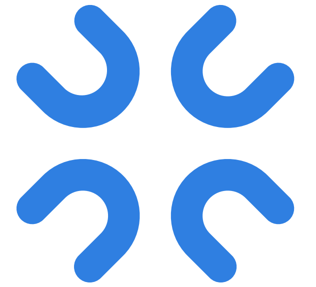
Care Transition Protocols



The overall goal is to improve transitions in order to reduce fragmented care and avoid re-hospitalizations. Care coordinators:

- Coordinate care, improve communication, and share / update the member's Support Plan
- Assist 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 skilled nursing facility to home
- Follow-up to ensure that the member understands:
  - Any health status changes, discharge instructions, and changes to medication(s)
  - That follow-up appointments are scheduled, including any transportation needs

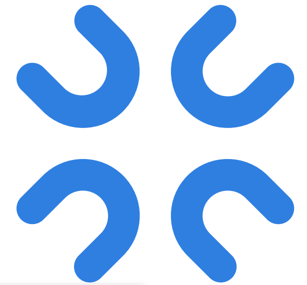
Provider Network



UCare's provider network meets a wide range of needs:

- Members may have care from any contracted provider without referral
- The network includes but is not limited to:
  - Primary Care Providers
  - Specialists and Specialty Care Clinics
  - Dental Providers

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

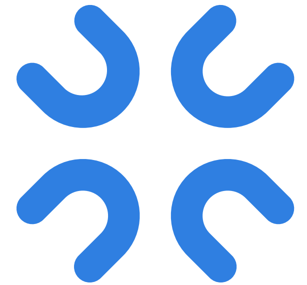
HEDIS, CAHPS, Stars, predictive modeling, and evidence based analytic tools

This information helps UCare to:

Annually evaluate the Model of Care

Identify improvements to be made for our members

Outcomes



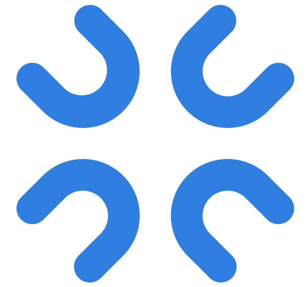
The overall goal of UCare's Model of Care is to employ interventions to drive improvements in health outcomes and quality of life for our SNP members.

UCare's Model of Care is designed to improve:

- Access to affordable, cost-effective health care, including medical, mental health, preventive, and social services.
- Care coordination through alignment of HRA, ICP, and ICT.
- Seamless transitions of care across healthcare settings, providers, and health services.
- Costs while assuring appropriate utilization of services for preventive health and chronic conditions.

UCare sets specific goals and health outcome objectives, that are measured at least annually. Our goals include preventive goal HEDIS measures, member satisfaction with the plan, improved access, seamless transitions, and improving coordination of care via HRA, ICP, and ICT.

Clinical Practice Guidelines (CPGs)



UCare has clinical practice guidelines to support good decision-making by patients and clinicians, and to improve health care outcomes.

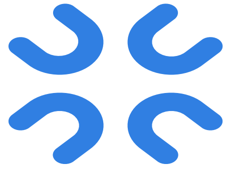
Medical CPGs:

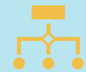
- Asthma Diagnosis and Management
- Care of Older Adult
- Diabetes: Type 2 Diagnosis and Management
- Management of Heart Failure in Adults
- Obesity for Adults: Prevention and Management
- Prenatal Care
- Preventive Services for Adults
- Preventive Services for Children and Adolescents

Mental Health and Substance Use CPGs:

- Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder
- Assessment and Treatment of Children and Adolescents with Depressive Disorder
- Treatment of Patients with Major Depressive Disorder
- Management of Posttraumatic Stress Disorder and Acute Stress Disorder
- Treatment of Opioid Use Disorder
- Treatment of Patients with Schizophrenia
- Treatment of Patients with Substance Use Disorders

Summary





Care coordination is only one component of UCare's care model.

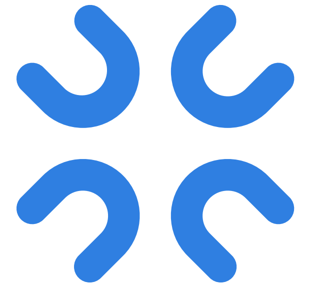
The UCare Model of Care applies to MSHO, Connect + Medicare, and ISNP which currently serves around 23,000 members.

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.

Next Steps



Complete

Please complete the attestation on UCare’s website and return to the MOCAttestation@ucare.org for proof of completion.

Reach out

- If you have any questions, please reach out to:
  - ISNP – ISNPprogramcoordinator@ucare.org
  - MSHO – msc_msho_clinicalliaison@ucare.org
  - Connect + Medicare – SNBCclinicalliaison@ucare.org

Mental Health and Substance Use Disorder Triage & Access Lines

Alycia Lopez

Who are we?

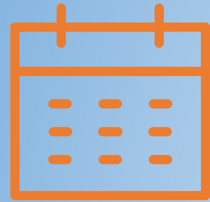
Mental Health and Substance use Disorder Access & Triage Lines

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
- Works with members and providers to send In-Network MH/SUDS provider resource list
- Assistance scheduling and confirming appointments (Access exclusive)
- Telehealth appointments for
  - Diagnostic Assessment
  - Psychotherapy
  - Comprehensive Assessments
  - Medication Management
  - Assessing for ICBS Referrals, MSS CM, PMAP etc.

When is this available?



UCare’s Access & Triage Lines are available to all UCare members

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

Afterhours support is available through Ucare’s 24-hour Nurse Line

Contact Information:

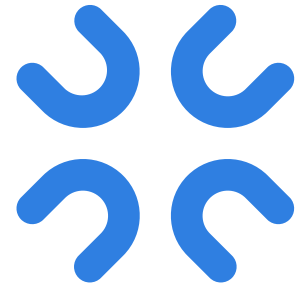
Local and Tollfree Numbers

- Access Line: 612-676-6811 or 1-833-273-1191
- Email: MHSUDaccess@ucare.org
- Triage Line:612-676-6533 or 1-833-276-1185
- Email:MHSUDtriage@ucare.org

SOGI Data

Pleasant Radford Jr.

Background



Purpose: To improve health outcomes for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people, we must fully understand the structural barriers to health, the impact of these structures on health outcomes, and the ways in which we can disrupt these trends.

Goal:

- To expand the collection and systems integration of SOGI data within UCare data systems;
- Create an updated document process and baseline report on how we can collect, store and retrieve SOGI data in UCare data system by October 2023

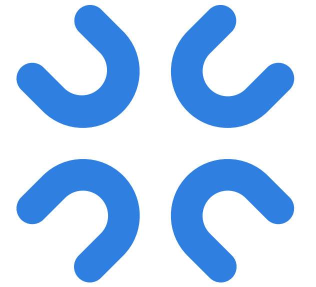
Audience: All UCare members

SOGI data inputs: PDHI Health Risk Assessments, Customer Services (FUSE Application), Off-Cycle Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, Zipari UCare Member Portal, Guiding Care, QRyde Transportation Software, Customer Relationship Management (CRM) Software

Key question themes: sex assigned at birth, pronouns, gender identity, and sexual orientation

Project timeline: April 2023 - present

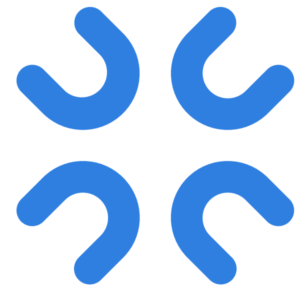
Structure



SOGI Core Committee

- Data Uses, Storage and Collection
- Use Cases and Training

Data Uses Team Goals



Build, test and map data fields in UCare enterprise data warehouse to receive, store and retrieve health risk assessments

→ Build API pathways between FUSE, GuidingCare, Transportation and other vendors to retrieve and display data

→ Recommend a source of truth for SOGI data

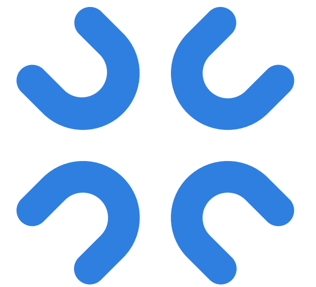
→ Generate report that indicates how UCare employee can retrieve SOGI data (*pronouns must be displayed by October 2023)*

→ Determine how we gather all the SOGI data from PDHI and member portal in the enterprise data warehouse

→ Create algorithm to filter data (e.g., most recent data) as necessary from original source to source of truth

→ Create a model to illustrate how SOGI data is collected, stored and retrieved within UCare systems

→ Consider ethical implications of imputing data from claims and other data sources



Use Cases and Training Team Goals*

Normalize topics and language around SOGI with all employees

Update UCare privacy and data security training to include SOGI content

Develop and disseminate best practices and FAQs to PDHI

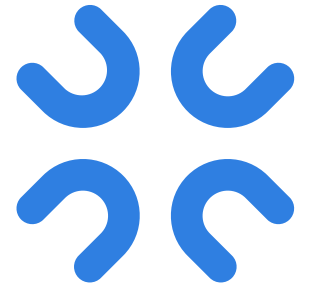
Incorporate SOGI questions/content into quarterly trainings for care coordinators and case managers

Establish workflow and conduct staff training for how member-facing staff should notify employees of updates

Gather business requirements on which business units will use SOGI data and how

*Equity & Inclusion Department will provide support

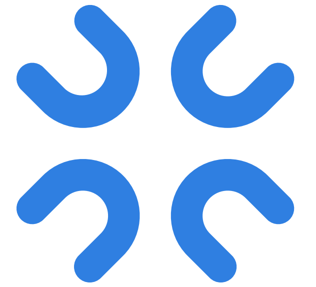
SOGI questions: sex assigned at birth



What sex was originally listed on your birth certificate?

- Male
- Female
- Intersex
- X
- Unknown
- Choose not to disclose

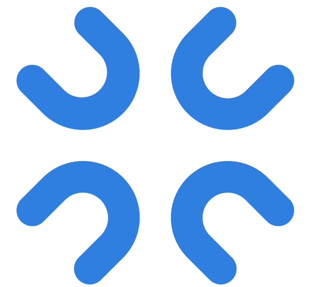
SOGI questions: gender identity



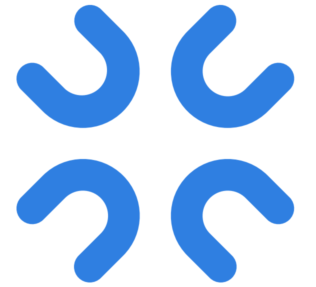
- What is your current gender identity?
  - Agender
  - Male
  - Female
  - Genderqueer, gender fluid, gender non-binary
  - Transgender male/trans man/female-to-male
  - Transgender female/trans woman/male-to-female
  - Two spirit
  - Additional gender category or other, please specify ____________________
  - Choose not to disclose

SOGI questions: pronouns

- What are your pronouns?
  - He/him/his
  - She/her/hers
  - They/them/theirs
  - Other, please specify ______________________
  - Choose not to disclose

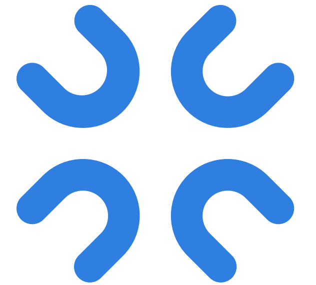


SOGI questions: sexual orientation

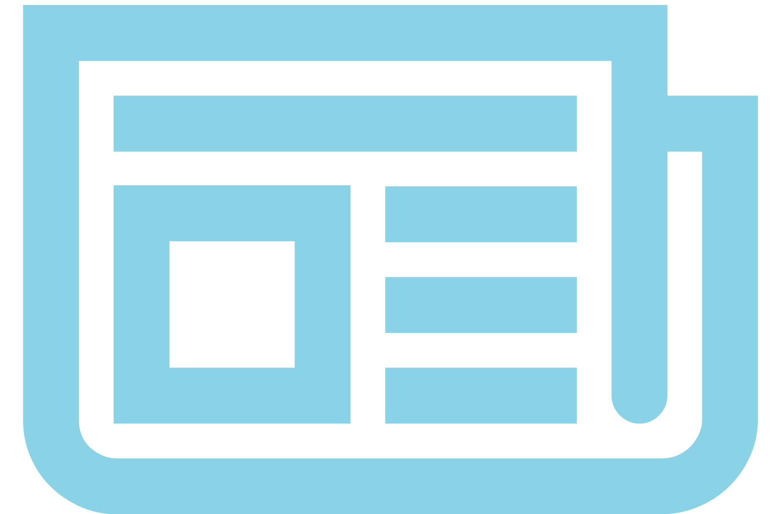


- Do you think of yourself as:
  - Asexual
  - Bisexual
  - Gay
  - Heterosexual/straight
  - Lesbian
  - Pansexual
  - Queer
  - Questioning
  - Other, please specify ____________________
  - Do not know
  - Choose not to disclose

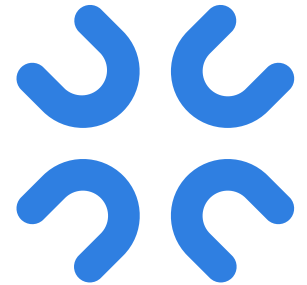
Common FAQs



- Why is UCare collecting this information?
- Are all members being asked to provide their sexual orientation and/or gender identity information?
- Do I have to share my sexual orientation and/or gender identity data?
- Is UCare required to collect sexual orientation and gender identity data due to State of Minnesota regulation?
- What will UCare do with the information I provide for the following categories?
- Who will have access to my sexual orientation and gender identity data if I do share it?
- Where can a UCare member, provider or external partner turn if they have additional questions about health equity for LGBTQIA+ communities?



Next Steps/Follow Up



- If you have questions about the SOGI implementation process, you can contact Pleasant Radford, Jr (SOGI team project manager) at pradford@ucare.org
- If UCare members, providers or other external partners have additional questions about health equity for LGBTQIA+ communities, please check out the following list below:
  - Centers for Disease Control and Prevention
  - National LGBTQIA+ Health Center at Fenway Health
  - Rainbow Health
  - UCare member's provider

Thank you for your feedback!

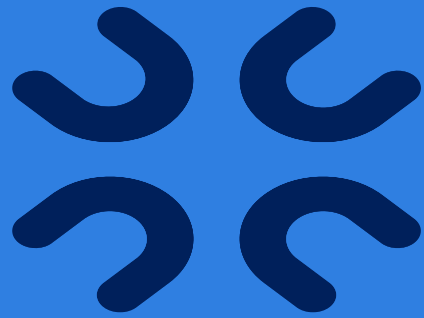
[Care Coordination Meeting Feedback Survey]

3rd Quarterly Meeting Feedback Survey

Thank you for completing this confidential Quarterly Meeting Feedback Survey. Your feedback helps to improve content and quality of information provided to you.

1. Please rate the following topics presented:

	Very helpful	Helpful	Somewhat helpful	Not helpful	N/A
Care Coordination Updates	○	○	○	○	○
Care Coordination Survey	○	○	○	○	○
SMART Goals	○	○	○	○	○
CLSIntake Updates	○	○	○	○	○
Model of Care	○	○	○	○	○
Access Line	○	○	○	○	○



Questions?

Connect/Connect + Medicare

- SNBCClinicalLiaison@ucare.org
- 612-676-6625

MSC+/MSHO

- MSC_MSHO_Clinicalliaison@ucare.org
- 612-294-5045