Coming Home and Staying There: Improving Care Transitions for Dually Eligible Beneficiaries

Promoting Integrated Care for Dual Eligibles (PRIDE)

December 12, 2019

Made possible with support from The Commonwealth Fund
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Welcome from the Center for Health Care Strategies and The Commonwealth Fund

Independent Care’s (iCare) Follow to Home Program

Health Plan of San Mateo’s Community Care Setting Program

CareSource’s Care Management Model to Improve Care Transitions

Moderated Q&A
Welcome & Introductions
Today’s Presenters

Logan Kelly, Senior Program Officer, Center for Health Care Strategies

Tanya Shah, Vice President, Delivery System Reform, The Commonwealth Fund

Lisa Holden, Vice President, Accountable Care, Independent Care (iCare) Health Plan

Amy Scribner, Director of Behavioral Health, Health Plan of San Mateo

Jennifer Anadiotis, Director Integrated Care Post-Acute Strategy, CareSource

Jean Solomon, Director of Long Term Support Services, CareSource
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
About the Better Care Playbook

Robust online resource center offering the latest knowledge on evidence-based and promising practices for people with complex health and social needs

Provides practical how-to guidance to inform health system leaders, payers, policymakers and others on strategies to improve care for high-need, high-cost populations

Coordinated by the Institute for Healthcare Improvement and the Center for Health Care Strategies through support from six leading national health care foundations — The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.

www.BetterCarePlaybook.org
Promoting Integrated Care for Dual Eligibles

- **PRomoting Integrated Care for Dual Eligibles (PRIDE)**, supported by The Commonwealth Fund, is a learning collaborative of nine leading health plans to advance promising approaches to integrating Medicare and Medicaid services for dually eligible individuals.

- In the current phase of PRIDE, participating health plans are working with delivery system partners to implement innovative care delivery interventions.

- Participating health plans include BlueCare, CareOregon, CareSource, Commonwealth Care Alliance, Health Plan of San Mateo, Independent Care Health Plan, UCare, UPMC *for Life* Dual, and VNSNY CHOICE Health Plans.
Tanya Shah
Vice President,
Delivery System Reform

commonwealthfund.org
Dually Eligible Individuals are a High-Need Population

- 12 million individuals enrolled in both Medicare and Medicaid
- High prevalence of health conditions, functional limitations, and social risk factors
  - 70% have been diagnosed with three or more chronic conditions
  - 41% have a behavioral health disorder
  - Over 40% use long-term services and supports (LTSS)
- Account for high Medicare and Medicaid spending

Medicare and Medicaid are distinct programs that cover different benefits with different rules for payment.

- Misaligned incentives for payers and providers
- Lack of integration can lead to uncoordinated care, worse health outcomes, and higher costs

Dually eligible individuals experience higher rates of potentially preventable hospitalizations and readmissions for chronic conditions such as hypertension.

Greater need for care coordination across physical health, LTSS, and behavioral health needs, but less than 10 percent of beneficiaries nationwide are enrolled in integrated care models.

Transitions Across Care Settings are Particularly Problematic

- Transitions include moving between hospitals, post-acute or long-term care facilities, and home.
- Dually eligible beneficiaries are vulnerable to adverse health outcomes, potentially avoidable hospitalizations, and poor care coordination during transitions between settings and providers.
  - Must navigate separate Medicare and Medicaid benefit coverage across settings
- Wide variation among states in home- and community-based services spending versus nursing facility spending.

High-quality care transition support emphasizes person-centered care coordination and discharge planning across all settings and services.

» Goals include improved outcomes, increased follow-up care, reduction in avoidable hospitalizations and SNF admissions/readmissions, and increased Medicaid HCBS use.

Recent evidence informs new policy opportunities:

» Potentially avoidable hospitalization rates for dually eligible beneficiaries in long-term care facilities decreased by 31% between 2010 to 2015.

» Community-based Care Transitions Program showed that targeted transition services could significantly lower hospital readmissions and Medicare costs.

» New hospital and SNF admission notification requirement for Dual Eligible Special Needs Plans (D-SNPs) seeks to improve coordination of Medicare and Medicaid services between care settings for high-risk dually eligible individuals.

iCare’s Follow to Home Program

Lisa Holden, Vice President, Accountable Care, Independent Care (iCare) Health Plan
Innovative Strategies for Transitions in Care: Follow to Home

December 12th, 2019

The mission of iCare is to improve the quality of life for individuals with unique and complex medical, behavioral, and human service needs while providing value to our customers and stakeholders, and respecting the dignity of those we serve.
iCare was Established in 1994

- Co-owned by Humana and the Milwaukee Center for Independence
- Medicaid SSI
- Medicaid BadgerCare +
- Dual Eligible Special Needs Plan
- LongTerm Care Program
#1 Challenge - High Inpatient Costs and Readmissions
An opportunity to change the status quo from Readmission Prevention for 30 days to Readmission/Admission Prevention for 90 days.
The Follow to Home Model

- Offer post-discharge nursing support in the home for 90 days
- Contract with Home Health Agencies for nursing case management (not skilled nursing)
- Create an alternative payment model with case rates and bonus incentives
- Offered to members screened to be High Risk to Readmit
Follow to Home Checklist

- Home visit within 72 hours
- Environmental home assessment
- Medication Reconciliation
- DME in place and being used
- MD appointments scheduled with emphasis on post-discharge
- Patient Activation Measure (PAM) Survey
- And then... up to the HHA
- Payment for first visit in member's home
- Case Rate Payments at 30-60-90 days
- Bonus if no admission by 90 days
- 8 participating Community Based Home Health Agencies
- 10 Wisconsin Counties served
## 2019 YTD Follow to Home Outcomes

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<th>Category</th>
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Return on Investment

- **Net savings of > $1 million** for the first 83 members served by Follow to Home with 12 months of claims prior to the program and 12 months following the program.
- Consistent participation by the HHAs
- Scalable to the needs of our members
Expansion: Follow to Community for Mental Health/Homelessness

- Meet the member post-discharge wherever they live
- Collaborate with local shelters for a room to provide skilled nursing care
- Collaborate with the Follow to Home for ongoing case management
Health Plan of San Mateo’s Community Care Setting Program

Amy Scribner, PhD, Director of Behavioral Health, Health Plan of San Mateo
Current membership: 130,000
Duals members: 8,800

Our program serves one in five San Mateo County residents representing diverse, low-income individuals and families, seniors, people with disabilities, and children with complex medical conditions.
2012-2013

- Needs Analysis
- Market Research, and Make or Buy Decision, RFP

2014

- Contract with Institute on Aging & Brilliant Corners, Program Design

2015-2016

- Program transitions first 100 members and integrates into Whole Person Care

2017

- Program transition total reaches 150 and expands to include various level of care management

2018-2019

- Program include population expansion; over 250 members transitioned
Program Objective

*Intensive transitional case management and housing support services package designed to help members in/or at risk of long-term care return to (or maintain) community living*

**HPSM Aim:**

- Provide the greatest opportunity for members to return to or stay in the community with a highest quality of life
- Reduce utilization of long-term care
- Generate savings by reducing healthcare expenditures for this population
Member Centric Care

- Institute on Aging
- Brilliant Corners
- Member
- HPSM
- Primary Care Provider
- Community Based Providers
- Specialty Provider
Key Service Partners

• **Housing Supports: Brilliant Corners**
  – Housing search, assistance with affordable housing applications
  – Housing retention services
  – Contracts with Housing Authority

• **Intensive Case Management: Institute on Aging**
  – Assessment and facilitation of needed goods and services (care plan option services) to support the transition and/or prevent unnecessary institutionalization
  – Integration of medical/social/behavioral services and supports
  – A phased approach to care management
Evaluation

- Bi-Annual Program Evaluation by Moss Adams
- Quarterly Operations Reports
- Bi-Weekly Dashboards
- Annual Satisfaction Surveys
  - Client Satisfaction
  - Stakeholder Satisfaction
Program Outcomes

- 93% of all clients are still in the community
- 96% decrease in SNF costs
- This program is a strategic investment for HPSM
- While there is cost savings, it does not trickle down to HPSM
- Potential funding via CalAIM
Lessons Learned

• Allow for program ramp up and evolution
• Filling systemic gaps and breaking down barriers to support transitions or community longevity
• A focused and flexible housing approach
• Carve outs and program restrictions require upfront investments and improved coordination
KOJO’S STORY

“When I met my CCSP Social Worker, it was like she opened the door and let me in.”

- In 2014, Kojo was hospitalized for a stroke. He was paralyzed and diagnosed with expressive aphasia.

- Following hospitalization he went to a SNF for rehab but plateaued and got stuck with no place to discharge to.

- In early 2015 he enrolled in CCSP. He moved from the SNF to a large RCFE in the network.

- Kojo has lived there since 2015. It is home. He attends an adult day health program, is happy, and has a lot to live for.
CareSource’s Care Management Model to Improve Care Transitions

Jennifer Anadiotis, Director of Integrated Care Post-Acute Strategy, and Jean Solomon, Director of Long-Term Support Services, CareSource
Transitions: WHAT MATTERS MOST
Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

CARESOURCE

• A nonprofit health plan and national leader in Managed Care
• 30-year history of serving low-income populations across multiple states and insurance products
• Currently serving members in Georgia, Indiana, Kentucky, Ohio, and West Virginia
• 4,300+ employees located across 30 states

1.8M members
# IHI Age-Friendly Health System

## What Matters
Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to end-of-life care, and across settings of care.

## Medication
If medications are necessary, use age-friendly medications that do not interfere with What Matters, Mobility, or Mentation across settings of care.

## Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.

## Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.
COMMUNITY WELL TRANSITIONS

• Three populations including a dedicated Behavioral Health Team

• Community Well (CW)
  o 65% of the population
  o Goal to prevent illness or change in health condition
  o Focus on assessment, screening, education, health promotion

• Partner with community-based organizations such as the Area Agencies on Aging (AAA) to achieve access, quality, member satisfaction, and efficiency.
# Ensuring Access Post-Discharge to Home- and Community-Based Services

## Goals
- Identify members that may benefit from Home- and Community-Based services (HCBS)
- Support CW members during post-acute care transitions to ensure access to services and Level of Care (LOC)

## Tools
- Devised brief screening tool to identify potential HCBS need
- Administered during each mandatory contact and post-significant change event assessment and follow up

## Outcome Measures
- Improve quality metrics
  - Admissions/readmissions
  - Primary Care Physician (PCP) follow up
  - Medication reconciliation etc.
- Enhance member satisfaction
- Lower overall costs

## Collaboration
- Detailed workflows with the AAA’s to ensure seamless transition
OUTCOMES & LESSONS

Measured Results

• Approximately 85% of CW members who apply for waiver services meet the enrollment criteria

• Annually, between 4% and 5% of CW population members successfully enroll in to HCBS services

Lessons Learned

• Implement formal screening tool earlier

• Allow for additional education and refinement of transition workflows
LONG-TERM CARE REBALANCING

• Long-Term Care (LTC) members are defined as living in the nursing home for 100+ days

• Goal of rebalancing is to help LTC members move from the nursing home setting to the least restrictive environment with necessary supports and services

• HCBS services, state programs, durable medical equipment, and other community resources are often needed for transitions to be successful
REBALANCING: PROCESSES

**Identification and Assessment of members**
- Specific screening tool is used to assess for cognitive, physical, and psychosocial needs as well as the availability of housing and finances to support community living
- Screening occurs for the entire population annually and as needed based on member goals

**Use of a designated Care Manager (CM)**
- Allows CM who has connections to the nursing facility to help navigate the discharge planning process and meet with/observe member needs
- CM can implement applications for LTSS and other resources earlier in the discharge planning process

**Use of HCBS, Community Resources, and Programs**
- Allows members to receive needed services and supports in the community and successfully transition from the NF setting
- Improves member satisfaction and safety throughout the transition process
OUTCOMES & LESSONS

Outcomes
• Annually, 3 to 4% of the LTC population transitioned to the community
• 70% of members who transitioned remained in the community 100+ days

Lessons Learned
• Transitions require active discharge planning and the involvement of all stakeholders
• Education about care needs and resources to both the member and family/caregiver is critical before, during, and after the transition
• Members often need to relearn community living skills
• Using designated CMs in the LTC facility to support discharge planning resulted in a higher number of successful transitions
BONNIE’S STORY

• Bonnie had lived in the NF for more than 6 years

• She had multiple health issues and required significant assistance with care

• Bonnie’s Care Manager assisted her in applying for waiver services and was available to support her through the transition process

• Bonnie was able to move from the nursing home with HCBS services and now lives in the community

• Watch Bonnie’s story: https://vimeo.com/348841275
Question & Answer
Questions?

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Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
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- Have you published a study about your complex care program?

The Playbook welcomes content submissions to help spread best practices in complex care.

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