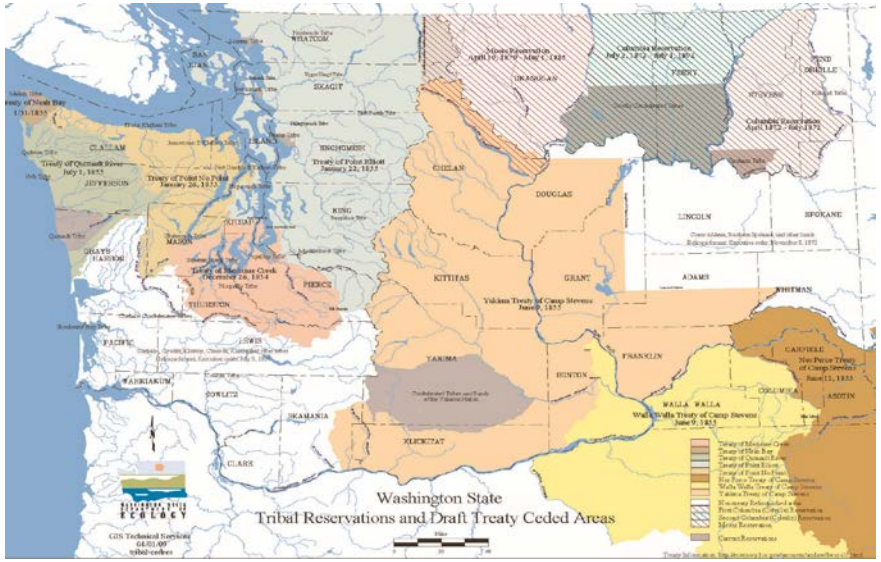
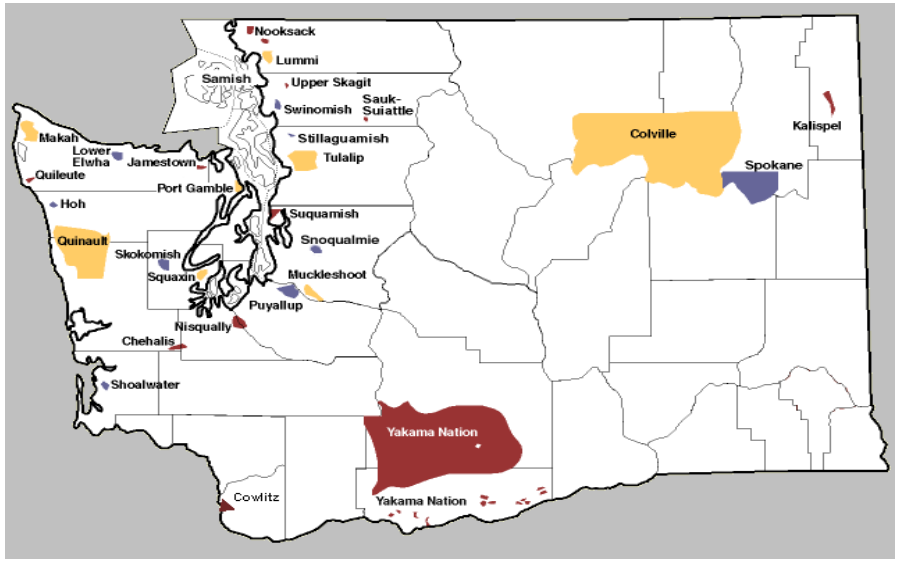
WA State 2020 Medicaid Integration Summit

November 4th, 2020

Day 2

Tribal Land Acknowledgement





As we gather virtually from various locations across the state of Washington, we humbly acknowledge that we are all meeting on the traditional territories of hundreds of Indigenous tribes.

GoToWebinar Housekeeping

- Attendee audio and video have been muted and will remain muted during the presentation.
- CHAT function for tech issues and comments.
- Q&A for questions to the presenters.
- This webinar will be recorded.

Day 2 Agenda

Session Title	Time
Care Coordination and Shared Care Planning	1:00 PM – 1:55 PM
Break	1:55 PM - 2:00 PM
Leveraging Telehealth to Advance Integrated Care	2:00 – 2:55 PM
Break	2:55 PM – 3:00 PM
Can Value-Based Payment Sustain Integrated Care?	3:00 – 4:00 PM

Care Coordination and Shared Care Planning

Susanna Petrie, RN, MSN, CCM, Tomhas Huhnke, Andrea Ray MS, LMHC, Jenna Bowman [Tulalip/Yakama] MSPS, MSCJ, PhDc, Tawna Reed Thomas M.A., MHP, LMHCA

November 4, 2020

Sea Mar
Community Health Centers
Clínica de la Comunidad

Transitions of Care

Care Coordination

By Susanna Petrie, RN, MSN, CCM

What We Do

Transitions of Care is a voluntary, 30-day case management program for active Sea Mar individuals who have been admitted to acute care with a medical diagnosis and will be discharged home to self care.

(Excluding OB, planned surgeries, and primary BH and SUD diagnoses)

Why We Do It

Trifecta of Good

- *Improving client outcomes*
- *Increasing revenue for Sea Mar*
- *Reducing penalties for hospitals*

Why TOC

Individuals who received medication therapy assessment and reconciliation had decreased readmission rates at 7, 14, and 30 days post discharge, with statistical significance at 7 and 14 days. Medication review versus comparison readmission rates were as follows: 7 days: 0.8% vs. 4% (*P* = 0.01); 14 days: 5% vs. 9% (*P* = 0.04); and 30 days: 12% vs. 14% (*P* = 0.29). Financial savings for Group Health per 100 individuals who received medication reconciliation was an estimated $35,000, translating to more than $1,500,000 in savings annually. Of individuals, 80% had at least one medication discrepancy upon discharge.

Journal of the American Pharmacists Association

Volume 53, Issue 1, January–February 2013, Pages 78-84

Why TOC

Program participants had a 50 percent reduced relative risk of readmission within thirty days of discharge and an absolute risk reduction of 11.1 percent. The program saved $2 for every $1 spent.

An Insurer's Care Transition Program Emphasizes Medication Reconciliation, Reduces Readmissions And Costs

Jennifer M. Polinski, Janice M. Moore, Pavlo Kyrychenko, Michael Gagnon, Olga S. Matlin, Joshua W. Fredell, Troyen A. Brennan, and William H. Shrank

Health Affairs 2016 35:7, 1222-1229

Workflow

Admission:

- Pull EDIE report
- Chart review
- Print demographic and med sheet to give to hospital
- Perform risk assessment at bedside
- Introduce Zones if appropriate
- Provide Ask Me 3
- Notify PCP of client status
- Schedule follow up appointment
- Schedule home visit for med reconciliation

Workflow

48 Hours Post-Discharge:

- Phone call within 2 business days of DC for ALL individuals
- Assess medication/transportation/DME needs
- Did provider get DC summary
- Verify home visit for med reconciliation

Workflow

7 Days Post-Discharge

- Provider appt if client is in Moderate to High Risk category and for most Medicaid/Medicare individuals
- Home visit for medication reconciliation
- Additional phone call if warranted

Workflow

Week 2 to 4:

- Provider appt before DC day 14 if not already done
- Phone call/home visit week 2 as determined by RN.
- Phone call/home visit week 3 as determined by RN.
- Phone call/home visit prior to day 29 post discharge.

Referrals

- Behavioral Health
- Substance Use Disorder Treatment
- Community Resources: Food Banks,
- Transportation: Bus passes, Dial-A-Ride, etc
- Long-term Case Management programs: Health Homes, Pathways, GRACE, CHAT
- Specialty Visit Coordination

Tools

Circle the following that are true	Points
Ten or more prescribed medications or discharge with new medications	6
Insulin, Oral Hypoglycemic	1
Anti-coagulants, dual anti-platelet therapy, digoxin	1
Narcotic	3
Oxygen and/ or nebulizer therapy	2
Positive Depression Screen or history of depression diagnosis	1
Principal admission diagnosis of cancer, stroke, DM, COPD, or Heart Failure	6
Principal admission diagnosis of deconditioning, failure to thrive, or malnutrition.	1
Mobility limitations: wheelchair, or bedbound, or ambulatory with motor skill dysfunction	1
Poor health literacy- History of treatment non-compliance, or inability to teach back	3
Lack of client support: absence of support for care, social isolation	1
Prior Hospitalization, non-elective > 6 in last 12 months	3
Prior Hospitalization, non-elective 3-5 admissions in last 12 months	2
Prior Hospitalization, non-elective 0-2 admissions in last 12 months	1
Documented history of Substance or Alcohol Abuse (NOT Primary Diagnosis)	3
Discharged with restrictions in diet/new dietary recommendations	3
Discharge Planner, Provider, Nurse Care Manager, Social Worker, or Care Manager Determination of higher needs (approval of TOC Program Manager REQUIRED)	6

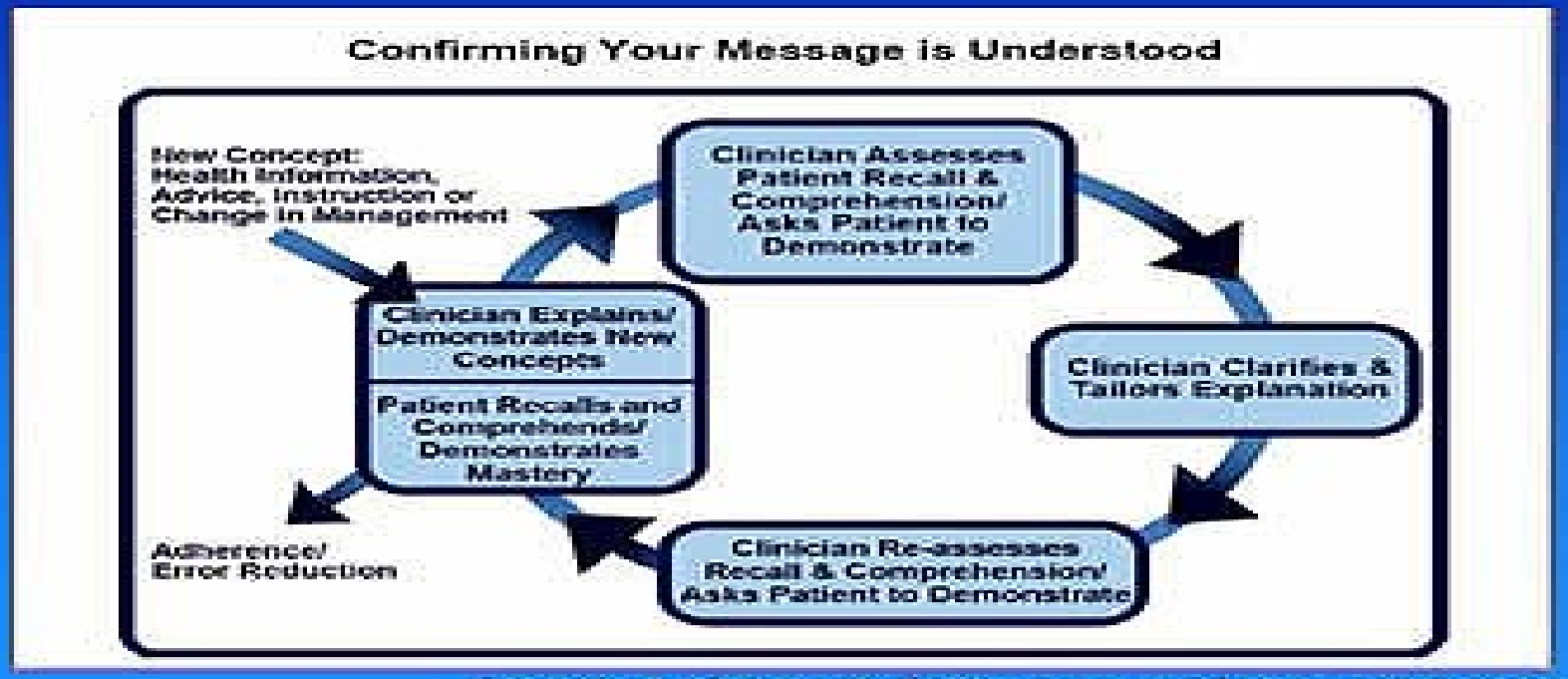
This tool is for the Care Coordinator to review for risks of readmission.

Tools


Every time you talk with a health care provider
ASK THESE 3 QUESTIONS
1
What is my main problem?
2
What do I need to do?
3
Why is it important for me to do this?

Tools

Teach-Back — Show Me Method



From the U.S. Health Resources and Services Administration

Success Stories

Client discharged to homelessness following traumatic MVA from which he sustained several facial/scalp lacerations and R hip dislocation, R anterior femoral head fracture underwent ORIF R femoral head just 4 days prior to discharge. Declined SNF/Rehab due to being primary caregiver of 3 elementary school aged children. Was discharged by wheelchair to "friend" who was not involved in discharge teaching. Discharge instructions lost immediately following discharge. Client experiencing poor short term memory. Hospital records not accessible due to client being admitted under alias and merging of records delayed by 2 weeks despite 3 requests by TOC. Client was not contacted by either orthopedics or trauma clinic for follow up care. Contacted discharge planner to address safety concerns regarding discharge plan. Scheduled follow-up appointments and reminded client day prior. Called client following each one for teach back. Assisted client in navigating healthcare system, due to poor health literacy and ongoing confusion/memory issues. Communicated with PCP regarding primary issues, requested relevant referrals. Referred to Pathways for long term care management, gave warm handoff to assigned CHW and coordinated care management during final week of TOC. Referred to BH r/t anxiety/depression and poor coping. Instructed client on Open Access process for BH if he is not contacted. Engaged in Motivational interviewing t/o engagement and strengths based support.

Pierce County

Success Stories

Client, mid-50s, African American, English speaking. Dx include: COPD, pulmonary edema with CHF, meth use, bipolar: A client who Summer has worked with on and off through several admissions down in Pierce County recently moved up to King County. Summer coordinated a warm hand off with me, to help client transfer her PCP to Sea Mar Kent. I also referred client to Health Homes, since her lead is contracted in King but had not been in Pierce, and set the client up with Hopelink transportation. Through Summer's consistent effort and support, this client has been following up with her specialists consistently, is engaging with me semi-regularly, and is beginning BH through Sea Mar, having identified underlying untreated bipolar as something that consistently trips her up. client may still have admissions and readmissions, given the severity of her medical, mental health and SUD issues – but she is clearly moving forward, engaging more and more with providers and gaining some control/empowerment over her health.

King County

Success Stories

Client had language barrier and was not connected with any programs. Assisted client with referral to nutritionist, Meals on wheels and Paratransit. Coordinating with Clinic care coordinator to make sure client understand how to use glucometer. Client had new hepatic lesion. Coordination MRI and f/u appts with GI. Client has low health literacy and limited knowledge about his medications and was not sure if he is taking it right way. Coordinating with clinic CC and changed client's pharmacy to a different one to be able to bubble pack for medications.

Whatcom County

Success Stories

Client had Multi inpatient visits to PHSJ hospital for COPD exacerbation. client is paraplegic. Client was reluctant before to get any services. Worked with RNCM @ PHSJ hospital, Health Home supervisor and NWRC hospital liaison to get client into COPES and referred client to Health Home for long term care coordination

Whatcom County

Success Stories

Client has language barrier, uninsured, ESRD, on dialysis and has ostomy bag. Worked with RNCM and PCP to get coverage for prescriptions under 340b prescription discount. Assisted client with free ostomy care supplies from ostomy closet in Kirkland. Assisted client in getting services from Home Health

Success Stories

When I began working with this client they had an A1C >10, they saw the RD and I helped to coach/reinforce healthy diet choices and medication adherence. The client now has an A1C of 4.9. Unfortunately, they have many other chronic health conditions and has frequent readmissions at Skagit Valley Hospital with hepatic encephalopathy related to autoimmune hepatitis. The client does not have and cannot get insurance and has been rejected for organ transplant d/t being undocumented during a stay at UW 8/30-9/5. The client is currently admitted to Virginia Mason. I have been following up with Virginia Mason inpatient SW to make sure that the medical staff are aware of her frequent and rapid decompensations and made it clear that to dc without intervention is likely to lead to a poor outcome. I also advocated for the client to receive a palliative care consult because although she has end-stage liver disease, her medical care has not addressed the terminal nature of her illness up to this point.

Peer Support Specialist & Integrated Care

Lived Experience and the WPC model in action

With: Tomhas Huhnke

- Peer Support Specialist, RC, botanist/optimist

Shared Care Planning

Andrea Ray MS, LMHC
Sr. Clinical Practice Performance Consultant, UnitedHealthcare

November 4, 2020

Agenda

- Background
- Definition of Shared Care Plan
- Benefits of Shared Care Plan
- Key Components
- Implementation

Background

- Washington is transforming to Integrated Managed Care in 2019 for the Medicaid population.
- A central component of health care transformation is improving the quality of care coordination, provided by clinicians to individuals.
- Care planning has a long history in acute care and institutional settings, and for individuals with complex needs (e.g., behavioral health, end-stage renal disease, intellectual and developmental disabilities, HIV/AIDS).
- In April 2015, the U.S. Department of Health and Human Services (HHS) convened a diverse group of stakeholders (physicians, nurses, policymakers, and client advocates) for a one-day listening session aimed at articulating a vision for Shared Care Planning.

Definition

A shared care plan is client-centered and designed to facilitate communication among members of a care team, including the client and providers. A shared care plan combines both behavioral and medical plans of care (treatment plans) to encourage a team approach to care.

Benefits of Shared Plan

A client has the opportunity to develop and negotiate their care plan, therefore transforming the relationship between individuals and providers.

A Shared Care Plan is a tool to exchange clinical information and reconcile medication.

Opportunity to coordinate with primary care, behavioral health and other members of the care team in order to improve quality of care outcomes.

Key Components

- A Shared Care Plan requires participation by multiple members of the care team and includes some or all of the following element:

  - **There are team roles and goals**. Team members are responsible for specific goals and tasks.

  - Includes those who have **permission to exchange information**

  - Documentation of the conversation with member regarding the **benefits of a shared plan, including risks, concerns and confidentiality**.

Key Components

- **Client education** about condition, treatments and self management.
- **List of medical treatments**, including pharmacologic (shared problem list and medication list) and **medication reconciliation**
- **Interventions** including psychotherapy, community groups and other non-pharmacologic behavioral health or substance abuse therapy or support. Include these provider and managed care case management roles in a client's care plan.

Key Components

- Shared care plan includes **counseling or coaching** with approaches such as motivational interviewing and behavioral activation. Behavioral activation is a therapy that works towards positive behavioral change by identifying current behavior and then more positive behaviors to replace them.

- **Tailored to the client/family context**. For example; client demographics, living situation and other social determinants. A list of family members with whom they have given permission to share information, member's profession and member's educational background.

Additional Components

- Cultural competency discussions such as a client's preferences for what he/she/they would like to be called by their care team including sexual identity; racial, religious, etc.
- Names and roles of community-based support or other outside services the member is receiving.
- A brief overview of member's health status at each episode of care
- Short-term and long-term health S.M.A.R.T goals and action plans. (Specific; Measurable; Attainable; Relevant; Time bound goals).

Additional Components

- **Advance Directives**
- Summary of **shared decision making** that has taken place.
- Description of **conflicts that arise and conflict resolution** strategies used.

Actions to Implement

Ensure access to both medical and behavioral specialists on your care team (co-location is best)

All prescribers are communicating regarding medications and shared medication reconciliation to enhance member safety.

Train staff on S.M.A.R.T goals

Train staff on Motivational Interviewing and Behavioral Activation

Special Populations

Shared care plans for those with intellectual disabilities or developmental disabilities requires consideration of other services the individual is getting and ensure communication with state agencies or those providers responsible for that member's accurate diagnosis and care treatment plan.

Shared care plans for children require consideration of additional services and care providers and school systems. Ensure that parents and other family are included in the shared care plan.

Shared care plans for children in foster care require collaboration with state agencies who retain medical guardianship as well as foster parents responsible for care.

Actions to Implement

- Ensure Behavioral Health Assessment are used in primary care setting
- Ensure Medical Assessment is used in behavioral health setting
- Train staff to use SBIRT, PhQ9 and other screening tools
- Have follow up mechanisms for all external referrals and care team stakeholders in place

Resource List

U.S. Department of Human Services, Agency for Healthcare Research and Quality

https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care/implementing-plan/develop-shared-care-plan

SAMHSA-HRSA Center for Integrated Solutions

https://www.integration.samhsa.gov/Brief_Intervention_in_PC,_pdf.pdf

The Arc, Washington State

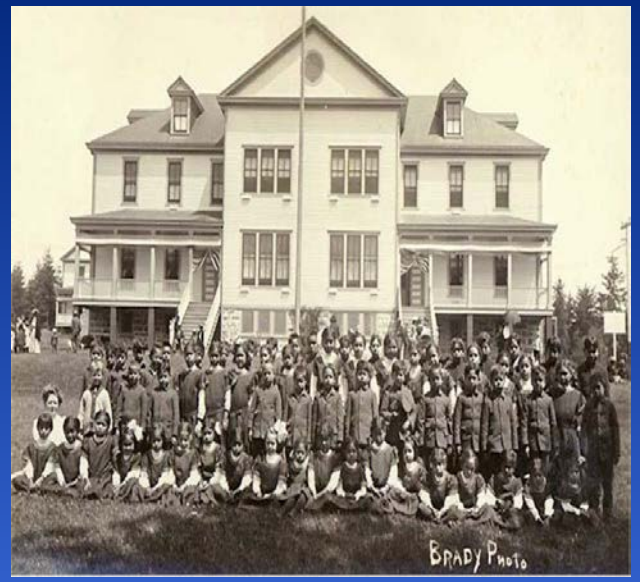
https://arcwa.org/

Washington State Department of Children and Family Services

https://www.dcyf.wa.gov/services/foster-parenting

Resources on reducing stigma with the language we use as professionals.

- https://www.samhsa.gov/sites/default/files/programs_campaigns/02._webcast_1_resources-508.pdf
- https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction
- https://everymind.org.au/mental-health/understanding-mental-health/language-and-stigma



Presented by Jenna Bowman [Tulalip/Yakama] MSPS, MSCJ, PhDc

Northwest Washington's Behavioral Healthcare Leader

compasshealth.org

SHARED CARE PLANNING

PLANNING the SHARE

SHARING the PLAN

SHARED CARE PLANNING

Implementation

Planning the Share

Process

Sharing the Plan

Implementation
Planning the Share

Not one size fits all

Implementation

Planning the Share

Coordination

Location

Inviting & Engaging Participants

Tools to Document

Sharing & Follow Up of Plan

Tracking of Progress

Implementation

Planning the Share

Coordination

Who are the change agents

- Who will coordinate
- Who will facilitate
- Who will oversee

What population

Implementation

Planning the Share

Location

Virtual

- Is technology available
- What conferencing tools

In person

- COVID safety measures
- Availability of space

Implementation

Planning the Share

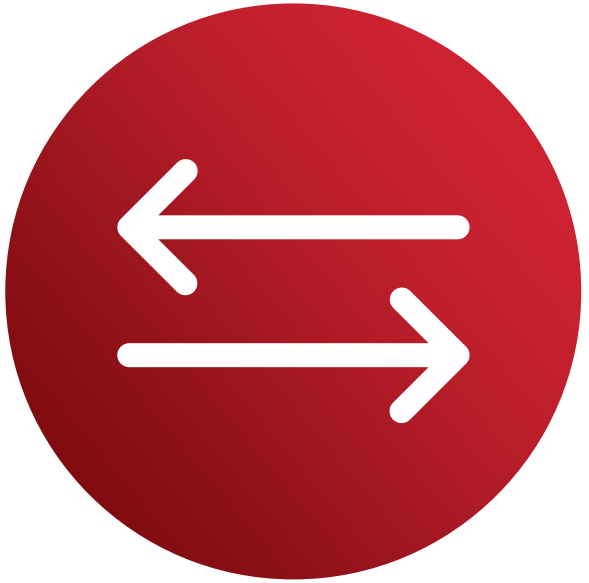
Inviting & Engaging Participants

What roles should be present

- Some participants or individualized

How to engage

- Elicit change and motivate
- Educate all participants



Implementation

Planning the Share

Tools to Document

Key components to a plan:

- Area of Focus
- Goals
- Strengths & Resources
- Action Steps
- Timelines

Implementation

Planning the Share

Sharing & Follow Up of Plan

Shared responsibility: How will copies be provided to each party

- Ensuring HIPAA at all points of sharing

Follow up: Will it be set standard or individualized or a combination

- How will this be tracked

Implementation

Planning the Share

Tracking of Progress

Data collection

Frequency

Review of data

PDSA (Plan, Do, Study, Act)

Process
Sharing the Plan

All phases of care

Process

Sharing the Plan

Process of Meeting:

Partnership

Acceptance

Compassion

Evocation

Closure

Process

Sharing the Plan

Process of Meeting

Partnership – this is your “intro”

- Client is expert of experience
- Participants expert in area
- Shared responsibility

Process

Sharing the Plan

Process of Meeting

Acceptance – review of confidentiality

- Setting safe environment
- Meeting client where they are at
- Respecting variety of viewpoints
- Acknowledge participants contributions

Process

Sharing the Plan

Process of Meeting

Compassion – start on strength

- Showing an understanding
- Shared understanding of roles

Process

Sharing the Plan

Process of Meeting

Evoke – identifying goals and action steps

- Inquire and bring out solutions
- Elicit ideas
- Identify and utilize current strengths

Process

Sharing the Plan

Process of Meeting

Closure – reflect back and “wrap up”

- Set clear steps
- Identify timelines
- Summarize who will do what, where, and when
- Set next meeting or follow up

Shared Care Benefits

Shared Care Benefits

Builds relationships

Increases professional knowledge and skills

Patient satisfaction

Efficient time and money

Community strengthening and improved health

ALONE WE CAN DO SO LITTLE; TOGETHER WE CAN DO SO MUCH

HELEN KELLER

COMPASS Health

Compass Health
Northwest Washington's Behavioral Healthcare Leader

THANK YOU

Tawna Reed Thomas M.A., MHP, LMHCA

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Questions and Answers

Amerigroup
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MOLINA® HEALTHCARE

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Thank you for joining us today.