



DUAL ELIGIBLES

**Technical Assistance Tool
Introduction**

May 20, 2015

Presented by
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What is Alignment & How Do We Get There?



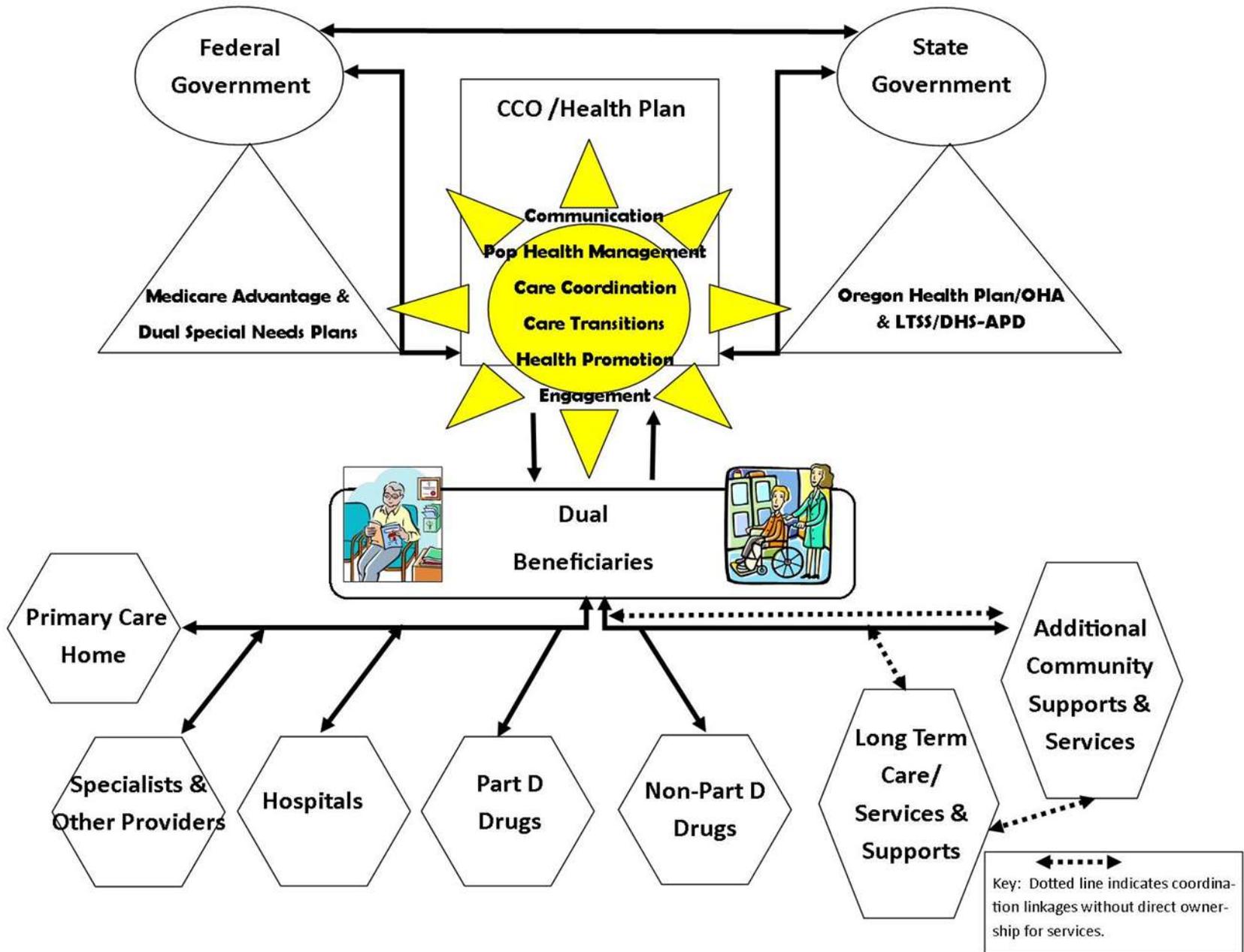
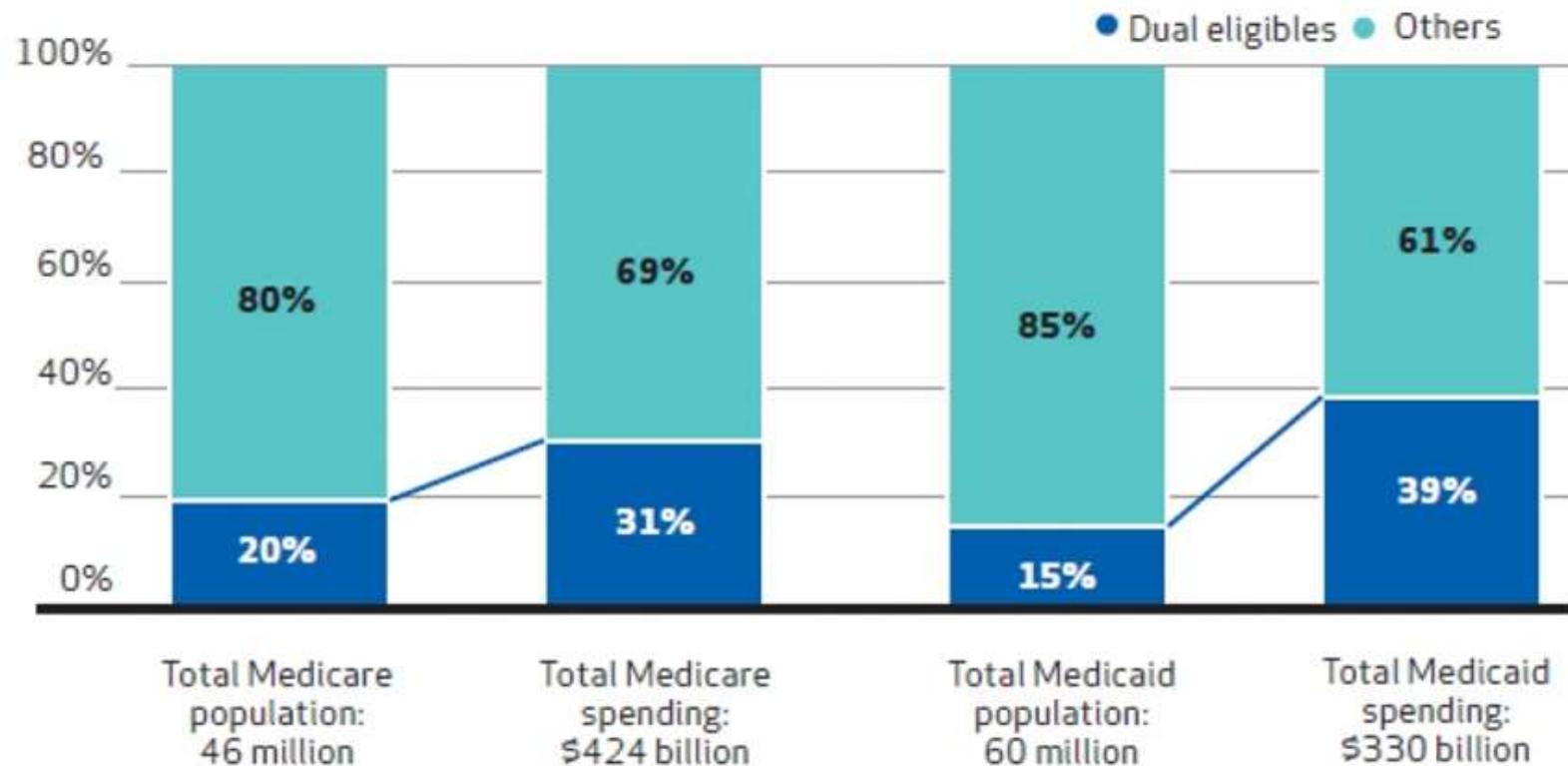


EXHIBIT 1

Dual-Eligible Beneficiaries: Enrollment and Spending in Medicare and Medicaid, 2008



SOURCES Kaiser Family Foundation analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use File, 2008; Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from fiscal year 2008 Medicaid Statistical Information System and CMS Form 64.

Kaiser Findings:

- Co-morbidity among dual eligibles is common and more likely for older duals.
- Three in five dual eligibles have multiple chronic physical conditions and 20% have more than one mental/cognitive condition
- Co-morbidity of physical and mental health conditions increases care complexity and poses additional problems in coordination and access to needed services
- A high percentage of duals relied on Medicare physician/outpatient services and Medicaid prescription drug coverage.
- More than 75 percent of persons with multiple conditions relied on Medicaid to pay for Medicare deductibles and co - payments for physician and inpatient services



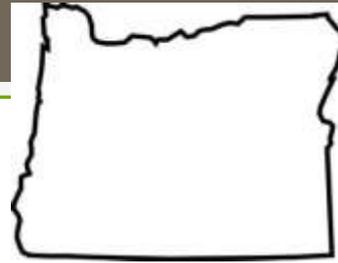
National Study That Increased Focus on Duals

Henry J Kaiser Family
Foundation Reports

Briefs: 2010, 2013



Oregon Invests In Coordinated Care Model



The Oregon Coordinated Care Model uses best practices to manage and coordinate care: The model is built on the use of evidence-based best practices to manage and coordinate care. This produces better care, improved outcomes (including a positive patient experience) and lower costs.

Best practices include:

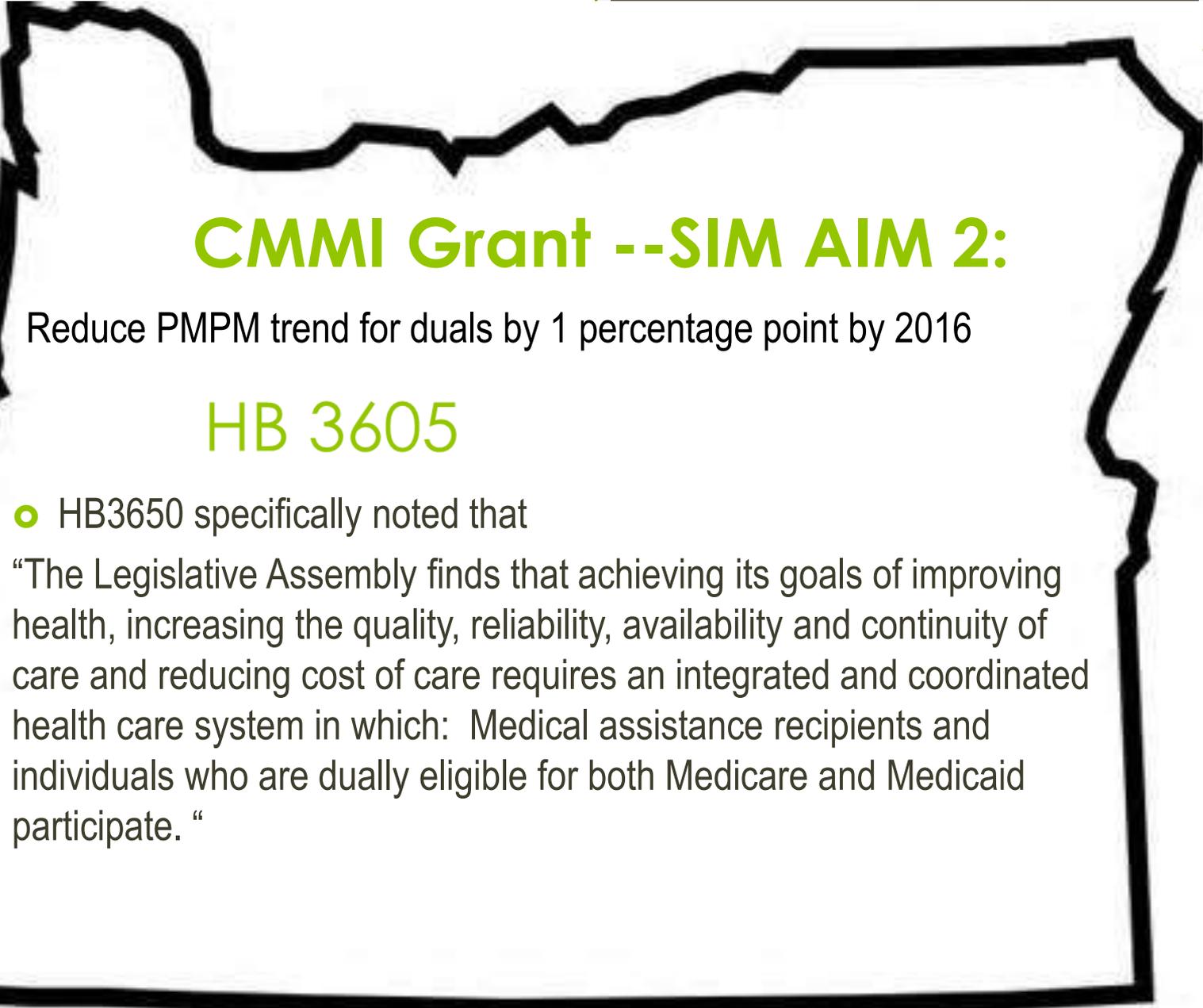
- Identification of a primary care clinician as the individual's regular source of care.
- Patient-centered primary care homes that provide team-based care. Care coordination through primary care homes is essential for patients with chronic health conditions.
- Behavioral, physical and dental health care integrated through evidence-based best practices.
- Evidence-based practices such as shared treatment plans and co-location of services are designed to maximize outcomes and efficiency, and eliminate waste.
- Providers and health systems use electronic health records and information exchange across care settings. These systems improve data accuracy, allowing for better patient care, while reducing costs associated with duplicate or unnecessary services.
- Value-based benefit design that create incentives for consumers to use evidence-based services.
- These services are the most effective for cost and quality, so they cost less for consumers, their employers or purchasers, and health plans.
- Culturally and linguistically appropriate care.

Oregon Health Policy Board, Oregon.Gov Key Elements of the Coordinated Care Model, Coordinated Care: The Oregon Difference

Addressing Health Reform Goals in Oregon for Dual Eligibles in CCOs

- Leverage the Oregon Coordinated Care model to create additional opportunities to address duals alignment for Oregon citizens with Medicaid and Medicare
 - Improve Medicaid/Medicare Alignment to improve care coordination through Oregon health reform model including patient centered primary care homes by January 2016.
 - Address Medicare-Medicaid administrative alignments and quality improvements, delivery system reforms, and address shared accountability for long-term care in Medicare-Medicaid and CCO-LTSS alignment activities.
 - Develop communications to increase member awareness of benefits of managed care/coordinated care.
 - Expand CCO care coordination model to Medicare to meet improved care coordination goals through enhanced Medicare-Medicaid affiliations.





CMMI Grant --SIM AIM 2:

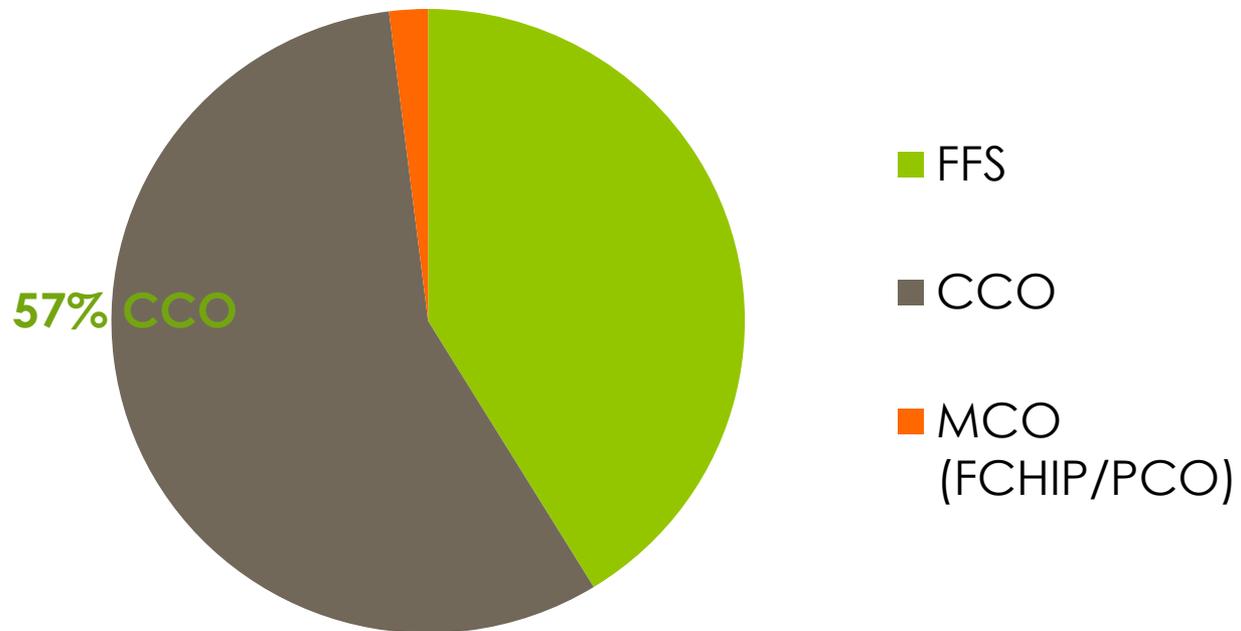
Reduce PMPM trend for duals by 1 percentage point by 2016

HB 3605

- HB3650 specifically noted that

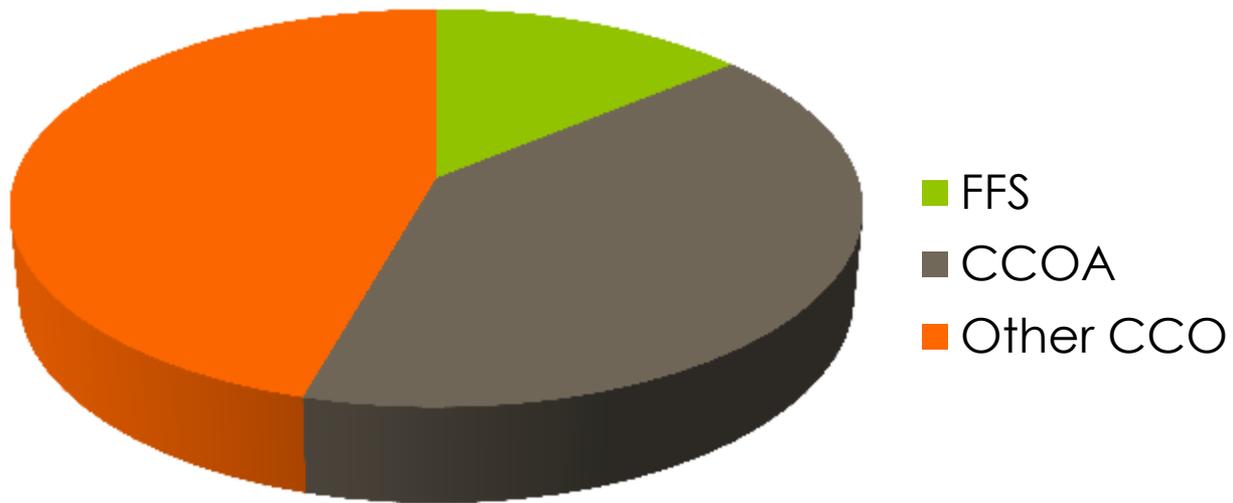
“The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability, availability and continuity of care and reducing cost of care requires an integrated and coordinated health care system in which: Medical assistance recipients and individuals who are dually eligible for both Medicare and Medicaid participate. “

Oregon Full Duals Enrollment in CCOs



Dec. 2014, OHA Health Analytics

Full Duals With LTSS in Managed Care



2014: Source Oregon DHS, APD

**86% CCO Enrolled
(40% CCOA)**

What is It?

The Technical Assistance Tool Duals Alignment Roadmap

- **Executive Summary** of Key Areas
- **Checklist for Self-Assessment** – review of best practices for each Key Area
- **Planning Form**—Allows you to select areas and internally track
- **Reference List**
- **Personalized Technical Assistance** with Tool
—Schedule with Jennifer at 503-945-6800
or Jennifer.B.Valentine@state.or.us



Duals Alignment: Key Areas To Address



- Communication*
- Population Health Management (Using Data!)*
- Care Coordination*
- Care Transitions*
- Health Promotion*
- Engagement*
- Health Equity & Social Determinants of Health Lens Across All These Areas*
- Administrative Policies and Leadership*
- Comprehensive Networks *
- Assess Beneficiary Experience*

***Key Attributes of High-Performing Integrated Health Plans for Medicare-Medicaid Enrollees”; [Center for Health Care Strategies Brief](#), August 2014*

1. Communication

- C1) Adopt integrated communications for duals
- C2) Adopt communication best practices to improve health literacy and member engagement
- C3) Establish communication protocols for information sharing across CCO-MA/SNP plans or CCO-LTSS to improve care coordination for dual eligible members
- C4) Support development of protocols and training for front-line communications staff to improve communication to dual eligible members
- C5) Monitor improvements in customer satisfaction with communication
- C6) Ensure providers are fully aware of CCO work to improve duals care coordination, billing issues, and reduce administrative burdens.
- C7) Develop communication channels with stakeholders around service delivery system improvements to address the diverse needs of all plan enrollees.



2. Population Health Management



- PHM1) Plan Level Population Health Monitoring
- PHM2) Support Provider Practice Level Population Health Monitoring
- PHM3) Utilize clinical data to monitor population health
- PHM4) Monitor outcome and quality measures

3. Care Coordination

- CC1) Identify and prioritize high needs members
- CC2) Develop Individualized Care Plans
- CC3) Engage primary care homes in care coordination where applicable with supports from CCO
- CC4) Plan for Care Transitions process
- CC5) Engage Individuals, Caregivers, and Identify preferences
- CC6) Establish and Maintain Care Teams through a locally-driven, collaborative process, ensuring team membership meets regularly to address care needs of individual members

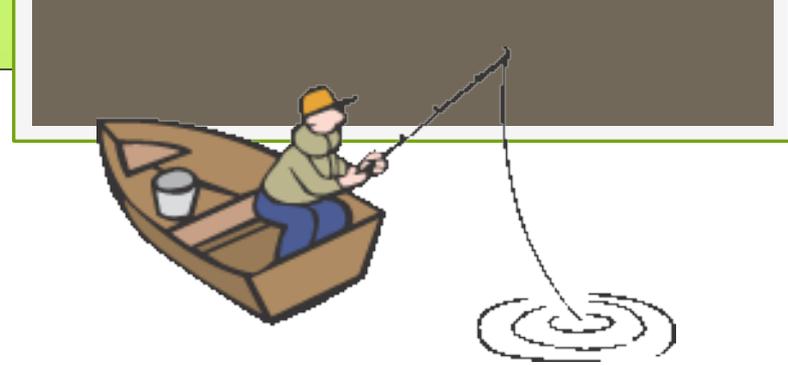


3. Care Coordination-cont'd



- CC7) Engage LTSS Innovator Agents to help work through challenges or to engage targeted planning and conversations between CCO and LTSS, DD and senior advocate partners
- CC8) Monitor Care Teams and document care coordination improvements/outcomes
- CC9) Establish provider and care coordination role relationships and regular interactions process
- CC10) Promote provider relationship building across care domains by encouraging primary care, LTSS and behavioral health to co-participate in learning collaboratives and care conferences for complex care patients.
- CC11) Promote care team continuing education concerns around specific geriatric and disability health needs (i.e. education on how to assess for cognition, manage dementia, assess for falls, engage family/friend caregivers, assess need for social support and interactions, etc.)

Section 2402(a) of the Affordable Care Act



- **Definition of Person-Centered Planning:** It is helpful to know the DHHS definition of standards for person-centered planning and self-direction in the Affordable Care Act
- Person-centered planning is a process directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. PCP should involve the individuals receiving services and supports to the maximum extent possible, even if the person has a legal representative
- PCP should also include family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include
- The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The role of agency workers (e.g., options counselors, support brokers, social workers and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during planning.
- The person's goals and preferences in areas
 - Family and friends • Housing • Employment • Community integration • Behavioral health • Culture • Social activities • Recreation • Vocational training • Relationships • Language and health literacy • Other community living choices

Care Coordination Accountability

- Communication
 - Interpersonal Communication
 - Information Transfer
- Facilitate Transitions—Across Settings, As Needs Change
- Assess Needs and Goals—Completes/Analyzes Assessments
- Create a Proactive Individualized Plan of Care
- Comprehensive Care Team involvement (including LTSS)
- Monitor, Follow-up, and Respond to Change –manage, follow-up, track (i.e. tests, referrals, etc.)
- Support Self-Management Goals, Personal Preferences
- Link to Community Resources
- Align Resources with Patient and Population Needs—Arrange wide array of needed services



Broad Approaches to Care Coordination Linked to Health Care Improvements

- Teamwork Focused on Coordination – facilitate interdisciplinary team meetings and communication
- Health Care Home
- Care Management
- Medication Management
- Health IT-Enabled Coordination



Transitional Care

- According to a 2003 position statement issued by the American Geriatrics Society, transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.
- Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, patients' homes, primary and specialty care offices, and long-term care facilities.
- Transitional care is based on a comprehensive plan of care and the availability of healthcare practitioners who are well trained in the care of complex acute and chronic illness and have current information about the patient's goals, preferences, and clinical status.
- It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition.



coordination

4. Care Transitions



- CT1) Adopt Evidence-based Care Transition Models/Initiate Care Transition Programs and policies to ensure positive care transitions (effectively targeted for high-risk beneficiaries, ROI shows can be as high as 250%).
- CT2) Expand care transitions models to extend to address whole person health (i.e. innovative functional-and lifestyle-oriented programming beyond traditional health benefits covered by health care).
- CT3) Engage traditional health workers such as patient navigators, peer wellness counselors or community health workers to support transitional needs
- CT4) Create communication and technology mechanisms to share patient needs with multiple provider teams that include primary care, LTSS, behavioral health, community-based services, and others as identified for specific patient care needs
- CT5) Designing systems and processes to rapidly and effectively respond to changes in patient conditions [especially to avoid use of unnecessary services, particularly emergency department visits or hospitalizations, ensuring all partners receive needed communication to respond]

Care Fragmentation

- During an episode of illness, care may become fragmented when different components of a health delivery system(e.g. different professionals and different institutions) work independently of one another, or worse, at cross purposes
- When multiple providers operate independently with no single plan of care, older patients in particular may be adversely affected.
- This fragmented care can result in conflicting recommendations regarding chronic disease self-management, confusing medication regimens with a high potential for error and duplication, inadequate follow-up care, and inadequate patient and caregiver preparation to receive care at the next healthcare setting
- Families and informal caregivers can become frustrated and overwhelmed.
- Furthermore, care fragmentation may lead to greater hospital and emergency utilization, with their associated higher costs of care.

“Development and testing of a measure designed to assess the quality of care transitions”, E.A. Coleman, J.D. Smith, J.C. Frank, T. B. Eilertsen, J.N. Thiare, A.M. Kramer, International Journal of Integrated Care – Vol. 2, 1 June 2002 – ISSN 1568-4156

Challenges When Patients & Families Are “On-Their Own” with Care Coordination

- Older patients and their caregivers do not experience their care in discrete episodes according to the arbitrary divisions of the healthcare system.
- Rather, they experience their care in a continuous manner irrespective of the particular setting care in which it is delivered.
- Because they are the only common thread weaving across the health care continuum, the management of care across healthcare settings has, by default, become the responsibility of older patients and their caregivers.
- To accomplish this task, they need to be adequately prepared for their course of treatment, understand how they can positively influence the management of their illness, know who to contact when they need answers to health related questions, and be encouraged to assert themselves when their needs are not being properly met.

“Development and testing of a measure designed to assess the quality of care transitions”, E.A. Coleman, J.D. Smith, J.C. Frank, T. B. Eilertsen, J.N. Thiare, A.M. Kramer, International Journal of Integrated Care – Vol. 2, 1 June 2002 – ISSN 1568-4156

Effective care transitions include:

- Communication between the sending and receiving clinicians regarding:
 - A common plan of care
 - A summary of care provided by the sending institution
 - The patient's goals and preferences (including advance directives)
 - An updated list of problems, baseline physical and cognitive functional status, medications, and allergies
 - Contact information for the patient's caregiver(s) and primary care practitioner
- Preparation of the patient and caregiver for what to expect at the next site of care
- Reconciliation of the patient's medication prescribed before the initial transfer with the current regimen
- A follow-up plan for how outstanding tests and follow-up appointments will be completed
- An explicit discussion with the patient and caregiver regarding warning symptoms or signs to monitor that may indicate that the condition has worsened and the name and phone number of who to contact if this occurs



"Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs", EA Coleman, Journal of the American Geriatrics Society, 51:549-555, 2003

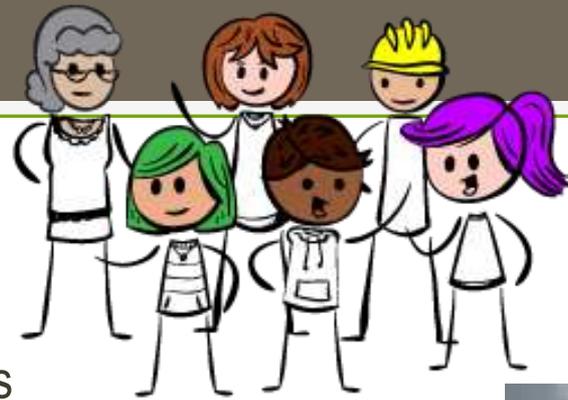
5. Health Promotion/ Chronic Disease Management



- HP1) Create effective referral and feedback loops to ADRC or Public Health Evidence-Based Health Promotion Programs
- HP2) Promote chronic disease self-management skills and self-care efficacy (i.e. such as patient/family centered simulations for home care skills) for all dual eligible clients with at least one chronic condition
- HP3) Utilize pro-active health risk assessments that include social, home, community supports and functional health status to tailor medical and non-medical supports and care supports
- HP4) Work closely with your CCO's community advisory council(s) and local non-profits regarding access to community-based health promotion programs for dual eligible members

6. Engagement

- E1) Adopt strategies to reach members, including homeless and “hard-to-reach” members
- E2) Engage member and family/caregiver in care conferences and care planning
- E3) Develop strong member outreach mechanisms, consumer friendly member services (e.g., call systems), and provide patient navigators, advocates, ombudsmen to support and assist clients



Benefits of Engagement

○ For Providers

- Increased insight into member health history and status
- Gain cultural insight into care planning
- Assessment and documentation support
- Improved Quality of Care
- Increased Member Satisfaction and Retention
- Achieve health outcomes

○ For Members

- Reduction in barriers to access
- Preventive health measures and improved support
- Increased access to health-related information
- Better health awareness, patient activation, self-care and well-being
- Compliance with care regimens, medications higher



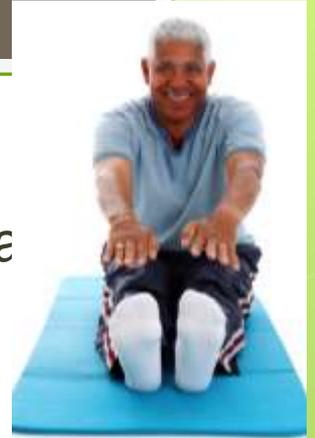
“Taking the Long View: How Well Do Patient Activation Scores Predict Outcomes Four Years Later?”



- Abstract --Med Care Res Rev June 2015 72: 324-337
- J.H. Hibbard, J. Greene, Y. Shi, J. Mittler, D. Scanlon
- This study uses a large panel survey of people with chronic conditions (n = 4,865) to examine whether a baseline patient activation measure predicts outcomes 4 years later, and whether changes in patient activation measure scores are associated with changes in outcomes.
- The findings indicate that the benefits of health activation are enduring, yielding benefits in the form of better self-management, improved functioning, and lower use of costly health care services over time. Furthermore, the findings indicate that when activation levels change, many outcomes change in the same direction. Patient activation seems to be an important and modifiable factor for influencing chronic disease outcomes; health care delivery systems can use this information to personalize and improve care.

7. Health Equity

- HE1) Identify and recognize cultural practices and beliefs that impact care planning and member preferences
- HE2) Ensure member access to information/materials through use of trained interpreters, translated materials, materials with appropriate health literacy levels, and alternative formats as necessary
- HE3) Promote care team continuing education concerning best practice methods to meet health equity goals and improve cultural sensitivity/competency of care
- HE4) Analyze population health data specific to dual eligibles as well as CCO core health outcomes measures by race, ethnicity, disability status, zipcode, and income
- HE5) Healthcare Delivery to Address Health Inequities



8. Administrative Policy Approaches/Leadership



- A1) The culture of the health plan should reflect a commitment to integrated care
- A2) Adopt recognition and organizational policies which encourage examination of non-medical factors (which have been proven are as powerful as medical factors in determining health care utilization)
- A3) Administrative leadership drives plan decisions and policy development to focus on commitment to high performance in key quality indicators applicable to specialized member populations/services
- A4) Leadership demonstrates commitment to implementing and disseminating best practices throughout the plan and the network/s (through mechanisms such as formal staff development, education and training programs, and/or regular use of outside experts with focus on building plan-wide competencies and best practices)

8. Administrative Policy Approaches/Leadership, cont'd

- A5) Alternative Payment Models/ Incentives and/or Penalties: (discussion with OHA recommended to be sure approaches meet CMS regulations)
- A6) Leadership leads implementation of organizational person-centered approaches and policies for serving clients. [Member experience of care overall including 1) Getting needed care & getting care quickly 2) Seamless experience of care across CCO, Medicare and LTSS providers 3) Consumer experience and satisfaction]
- A7) Lead development of business associate agreements to enhance Medicare Advantage (MA) and MA Dual Special Needs Plan (DSNP) and CCO communication

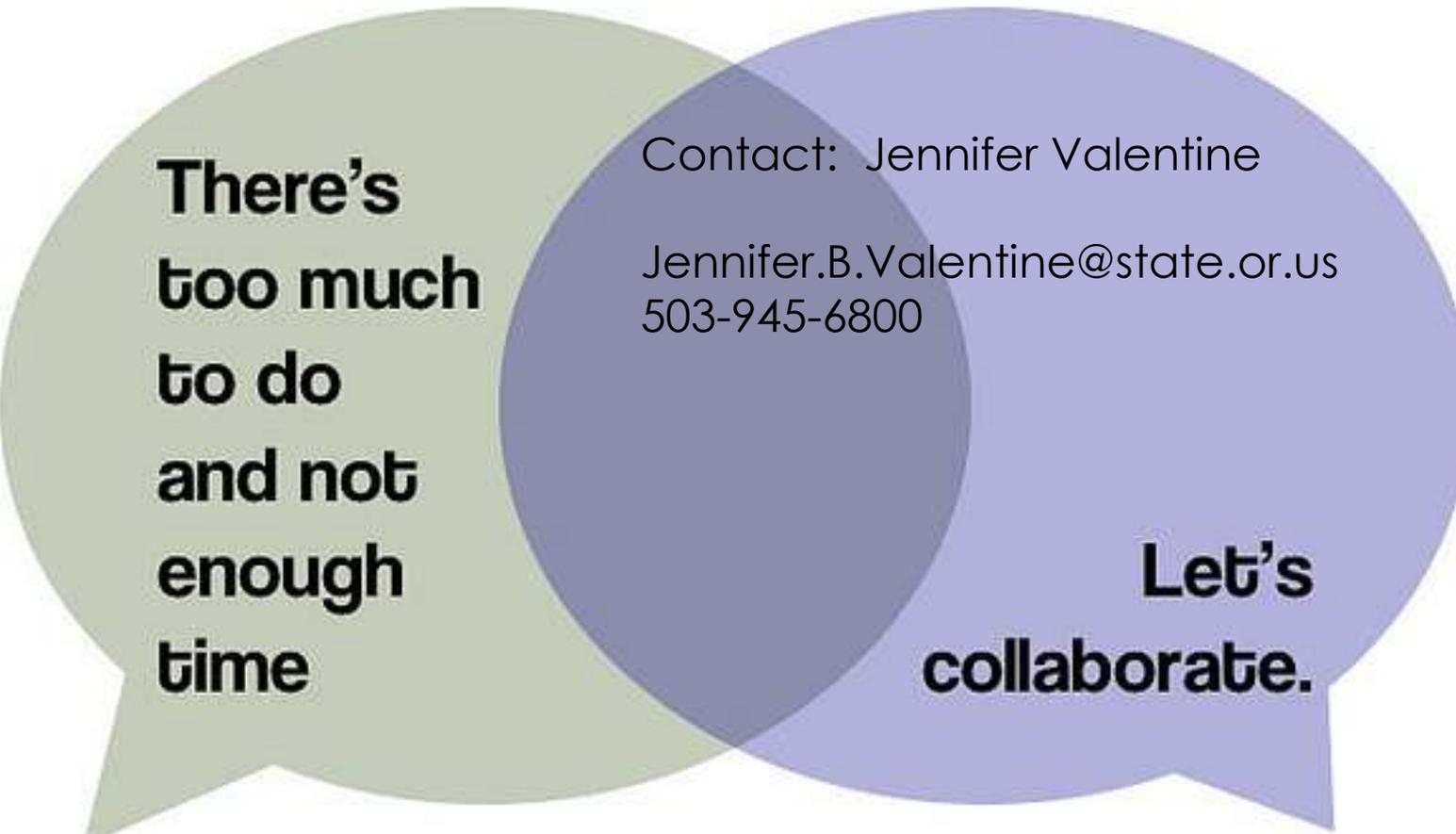


Important Notes:



- The Dual Eligible Technical Assistance tool is flexible and adaptable to each CCO's specific needs
- Technical Assistance available to you at request from June 2015 – August 2016 through SIM funding
- Not required, but meant to assist you in meeting your goals for the Triple Aim specifically around dual eligibles you serve!
- Consultation is free!





**There's
too much
to do
and not
enough
time**

Contact: Jennifer Valentine

Jennifer.B.Valentine@state.or.us
503-945-6800

**Let's
collaborate.**

let's collaborate



Any Questions?



Don't Miss:
More detail on TA tool will be
presented for discussion
at June 17, 2015 Meeting