SPECIAL NEEDS PLANS: FOCUSING ON SOCIAL DETERMINANTS OF HEALTH AMONG DUALS

A report developed by the SNP Alliance and the Center for Consumer Engagement in Health Innovation at Community Catalyst

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SNP Alliance
A National Nonprofit Leadership Organization

The National Voice for Special Needs and Medicare-Medicaid Plans

SPECIAL NEEDS PLANS: FOCUSING ON SOCIAL DETERMINANTS OF HEALTH AMONG DUALS

The SNP Alliance *is a national membership organization of 27 health plans serving over 1.3 million high-risk individuals, through Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance works with members on policy and practice to advance integrated approaches in order to enable persons with serious chronic conditions, functional/behavioral needs, and social risk factors to receive coordinated care across multiple service providers according to needs and preferences, to optimize their health and well-being.*

The Center for Consumer Engagement in Health Innovation at Community Catalyst *brings the consumer experience to the forefront of health innovation in order to deliver better care, better value and better health for every community, particularly vulnerable and historically underserved populations.*

INTRODUCTION

The **SNP Alliance** and **Center for Consumer Engagement in Health Innovation** share a mutual interest in improving care, policies and systems for people who are dually eligible for Medicare and Medicaid.

These organizations came together in the summer of 2016 to share ideas on how to focus attention on the impact that social determinants of health and accompanying risk factors have on dually eligible beneficiaries. This report provides two case examples of special needs health plans that have identified these factors with their enrolled plan members and are striving to collaborate with providers and communities to address them.

PEOPLE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

Who are dual eligibles?

People who are simultaneously enrolled in both the Medicare and Medicaid programs are known as dually eligible beneficiaries, dual eligibles or, for ease of reference, duals (as used in this paper). This includes people who are 18-64 and eligible for Medicare by virtue of a disability, as well as people age 65-and-over who meet the age requirement for Medicare enrollment and who, because of their low-income qualification, are also eligible for Medicaid. *Duals are a growing population of over 11 million individuals with complex needs that require high levels of care.* These individuals tend to have high rates of chronic illness, with multiple conditions as well as long-term care and behavioral health needs. One in five of the duals live in institutional settings, such as a nursing facility or board-and-care home. Seventeen percent of the duals report that they have "poor health" as compared to only six percent of other (non-dual) Medicare beneficiaries.[1] Duals are also one of the highest cost groups when examining Medicare and Medicaid expenditures.[2]

The National Quality Forum Dual Eligible Beneficiaries Workgroup issued a report in June of 2016, noting that the health and social services needs of this population are compounded by poverty. They point out that: *The Medicare-Medicaid dual eligible population is a unique and diverse group generally characterized as "high-risk" because dual eligible individuals have a combination of complex clinical and behavioral conditions that are compounded by poverty. This is a particularly vulnerable population with 77% of individuals having*

> *"The Medicare-Medicaid dual eligible population is a unique and diverse group generally characterized as "high-risk" because dual eligible individuals have a combination of complex clinical and behavioral conditions that are compounded by poverty."*

Duals with Multiple Conditions (physical or behavioral)

2+ conditions	77%
3+	60%
4+	41%
5+	25%

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[1] Centers for Medicare and Medicaid Services (CMS), Medicare-Medicaid Coordination Office, *People Enrolled in Medicare and Medicaid: Fact Sheet*. March 2017. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

[2] Congressional Budget Office (CBO), *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Politics*. June 2013. Available at https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf.

*diagnoses across two or more condition groups of physical or mental illness, 60% having diagnoses across three or more, 41% having diagnoses across four or more, and 25% having diagnoses across five or more condition groups. **Spending for dual beneficiaries is disproportionately high.** Annually, dual beneficiaries comprise 20% of Medicare beneficiaries but account for 34% of the spending at approximately $500 billion and comprise 14% of Medicaid beneficiaries but account for 34% of spending at approximately $340 billion.[3]*

What are social determinants of health?

Social determinants of health – also known as social risk factors[4] – can significantly impact one's medical and health outcomes. The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work, and age.[5] Such characteristics are very important to consider within the dual population, as they compound the medical and behavioral issues that these individuals already face.

Recently a set of social risk factors were identified by an ad hoc committee of the National Academy of Sciences, Engineering and Medicine (Committee for Accounting for Socioeconomic Status in Medicare Payment Programs) – as being likely to impact health outcomes.[6] The committee identified a series of measureable social risk factors for potential use by Medicare as follows:

- Income/poverty status
- Education level
- *Dual eligibility*
- Non-White Race
- Ethnicity
- Language/limited English proficiency
- Nativity (non-U.S. birth place)
- Marital/partnership status
- Living alone
- Neighborhood deprivation – including lack of transportation
- Urbanicity
- Housing

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[3] The National Quality Forum, Measure Applications Partnership Dual Eligible Beneficiaries Workgroup, Draft Report. June 2016. Available at http://www.qualityforum.org/ProjectMaterials.aspx?projectID=73571.

[4] We use the term *social risk factors* in this Issue Brief, given adoption of the term by the Institute of Medicine/National Academies and the Assistant Secretary for Planning and Evaluation in recent reports.

[5] World Health Organization, Social Determinants of Health. Available at http://www.who.int/social_determinants/en/.

[6] National Academies for Sciences, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors, and Methods*. 2016. Available at http://nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs.aspx.

What kinds of social risk factors are more prevalent among the dual eligible population?

According to an analysis conducted by the Medicare Payment Advisory Commission (MedPAC), an independent congressional agency, and the Medicaid and CHIP Payment and Access Commission (MACPAC), a nonprofit legislative branch agency, the dual population is more diverse, and has more social risk factors than non-dual Medicare beneficiaries, and thus is much more vulnerable. Table 1 provides a summary view of some of these differences.[7]

Table 1. Demographic and Selected Social Risk Factor Differences between Dual and Non-Dual Beneficiaries (CY 2012)

CHARACTERISTIC	PERCENT OF DUAL BENEFICIARIES	PERCENT OF NON-DUAL BENEFICIARIES
Gender – Female	61%	53%
Non-White Race	42%	20%
Limitations in Activities of Daily Living (e.g., walking, eating)	57%	28%
No high school diploma	45%	16%
Income at or below 200% of federal poverty level	95%	37%
Lives in an Institution	21%	5%
Lives with spouse	16%	54%

Why is this important?

There two key reasons why this is important:

1) Dual status is a significant risk factor – in fact one of the greatest predictors of poor health status/health outcomes, as shown in several recent national studies.[8][9][10]

2) The multi-dimensional needs of duals require medical, non-medical, social support, and community-wide interventions.

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[7] MedPAC and MACPAC, *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. January 2017. Available at http://www.medpac.gov/docs/default-source/publications/jan17_medpac_macpac_dualsdatabook.pdf?sfvrsn=0

[8] Assistant Secretary for Planning and Evaluation (ASPE), *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Payment Programs*. December 2016. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

[9] National Academies of Sciences, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment Programs: Identifying Social Risk Factors*. 2016. Available at https://www.nap.edu/catalog/23513/accounting-for-social-risk-factors-in-medicare-payment-criteria-factors; National Academies of Sciences, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors and Methods*. 2016. Available at https://www.nap.edu/catalog/21858/accounting-for-social-risk-factors-in-medicare-payment-identifying-social.

[10] Inovalon, *An Investigation of Medicare Advantage Dual Eligible Member-Level Performance on CMS Five-Star Quality Measures*. 2015. Available at http://www.inovalon.com/sites/default/files/documents/INV_Duals_Study_Report_(3%2026%2015)_v1%200%201.pdf.

Dual Status as Predictor of Poor Health Outcomes.

Dual status has been found to be a significant predictor of poor health outcomes in a number of national studies conducted from 2014-2016. In September 2015, CMS released findings from a RAND study that found dual status significantly lowered outcomes on 12 of 16 Star Rating measures.[11] It also found that disability status significantly lowered outcomes on 11 of 16 measures. An Inovalon study found similar results. Using data from smaller geographic units (9-digit zip code vs. 5-digit zip code), the Inovalon study found that characteristics of dually eligible enrollees explained 70 percent or more of the disparity in outcomes compared to non-dual eligible enrollees on five of eight measures. Significantly, dual eligible status lowered performance on the "all cause hospital readmission" measure, the only Medicare quality Star rating measure that is already adjusted for age, gender and co-morbidities. Lastly, even after adjusting for dual status and other factors, living in poverty further increased likelihood of readmission.[12]

More recently, a committee of experts organized by the National Academies of Science, Engineering and Medicine, analyzed social risk factors of Medicare beneficiaries and found that being dually eligible was significantly associated with poor health outcomes. Within their series of five reports, the committee called for attention to this factor in both quality measurement and value-based payment systems under Medicare. Another committee of the Assistant Secretary for Planning and Evaluation recently examined information from over 15.2 million Medicare beneficiaries (of which 18.2 percent were duals), and found that dual and disability status were the two greatest predictors of poor health outcomes.[13]

Furthermore, their analysis showed that the Medicare quality measurement and reporting system favored organizations that served populations with fewer social risk factors. In fact, across the types of Medicare organizations examined (hospital, health plan, ACO, physician group, special facility), organizations that disproportionately cared for beneficiaries with high social risk factors (e.g., dual status) were measured as performing worse using the existing Medicare quality measures and measurement rating system than their peers that had few beneficiaries with social risk factors. This performance inequity was seen even after adjusting for beneficiary characteristics, indicating bias in the measurement system itself and/or differences in treatment/processes of care for duals compared to non-duals.[14]

> *Dual enrollment (enrollment in both Medicare and Medicaid) was typically the most powerful predictor of poor performance among those social risk factors examined. For the most part, these findings persisted after risk adjustment, across care settings, measure types, and programs, and were moderate in size.*
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> *However, these analyses cannot determine why such patterns exist. Beneficiaries with social risk factors may have poorer outcomes due to a host of factors, including higher levels of medical risk, worse living environments, greater challenges in adherence and lifestyle, and/or bias or discrimination.*
>
> *Many of these factors, for both beneficiaries and providers, are not easily measured with current data. Yet understanding the "whys" is essential to finding lasting and meaningful solutions. There is clearly a need for more research in this area.*
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> (page 9 of the Executive Summary from the ASPE report)

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[11] Centers for Medicare and Medicaid Services, Center for Medicare, *Examining the Potential Effects of Socioeconomic Factors on Star Ratings*. September 2015. Available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Research-on-the-Impact-of-Socioeconomic-Status-on-Star-Ratingsv1-09082015.pdf.

[12] Inovalon at 8.

[13] ASPE at 8.

[14] Ibid. at 8-9

Such inequities affected payment, including quality bonus payments that were not available to special needs plans. Thus, the payment system further reduced resources available to safety-net providers and special needs plans to serve the highest-cost, most complex individuals – further exacerbating the inequities.

Needs of Duals are Multi-Dimensional.

Many of the health-related needs of the duals require non-medical interventions, such as social supports, housing, transportation and food. Given that these risk factors arise from many societal issues, such as unemployment and underemployment, racial inequities in our institutions and social systems, disparities in educational opportunities, lack of affordable housing and transportation, violence and poor planned/built environments, addressing these risk factors often requires collaborative efforts with partners within each community – so that solutions are locally designed and implemented.

These partnerships can extend across services, settings and systems among organizations that are serving many of the same people within a geographic region. Initiatives to address specific social risk issues such as lack of housing, high unemployment, or domestic violence may originate from consumer groups, government agencies, employers or health care coalitions. While it is difficult work and there are often no easy solutions, such initiatives can make a difference.[15]

Health plans that serve a high proportion of duals are collaborating with providers and agencies within the communities where the beneficiaries reside. For health plans, stability of enrollment is important – in order to develop the relationships with each dual member and work with a range of clinic, hospital, behavioral health, and social service providers typically utilized by dual members. Working together across these providers and systems, the plan seeks to capture information and seize on opportunities for prevention, better self-care, and to address living situations that affect health outcomes.

The health plan collects enrollment data and captures claims data which can be combined to identify higher-risk persons and encourage proactive response among providers with these individuals. Over time with a stable enrollment, the health plan can show trends, such as how persons with multi-dimensional behavioral health and medical needs interact with and utilize various medical and social support services and where there are gaps. Plans are working to connect these medical and administrative data sets to other demographic and socioeconomic data on enrolled members, such as living in a poor neighborhood or lacking social supports. This provides a more comprehensive picture of the dual population as a group. Such information can be combined with community health assessment surveys conducted by hospitals, with county or public health survey data, and with census or community asset data, so that a clearer picture of high-need areas emerge.

[15] Brennan Ramierz, LK, Baker, FA, and Metzler, M. *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*. Atlanta: Centers for Disease Control and Prevention, US Department of Health and Human Services. 2008. Available at https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf.

SPECIAL NEEDS PLANS

Approximately one-third of all Medicare beneficiaries in the United States receive health insurance through a Medicare Advantage (MA) type of health plan. Special Needs Plans (SNP) are a subset of Medicare Advantage organizations and are specifically authorized and designed to meet special care needs of Medicare beneficiary subgroups. Though they are categorized as a type of Medicare Advantage plan, Special Needs Plans are required to provide additional benefits and services to their target populations and to implement enhanced care management according to tailored Models of Care (elements specified by CMS) to serve every enrollee. In addition, while beneficiaries enrolling in Medicare Advantage plans may be healthier, Special Needs Plans are required by law to enroll high-risk beneficiaries with defined characteristics. The plan types and subgroups of special needs plans include:

- *Chronic condition SNPs* (C-SNPs): serving persons with certain severe or disabling chronic conditions (e.g., HIV-AIDS, chronic heart failure, COPD, mental illness, etc.).

- *Institutional SNPs* (I-SNPs): serving persons residing in nursing homes or with comparable care needs in the community.

- *Dual eligible SNPs* (D-SNPs): serving persons covered by both Medicare and Medicaid (dually eligible), indicating low-income status and either disability and/or age 65-plus.

- *Fully Integrated Dual Eligible SNPs* (FIDESNPs) and *Medicare-Medicaid Plans* (MMPs) – which are a specific type of D-SNP and provide both Medicare and Medicaid benefits, including long-term services and support in a coordinated way, as congruent with state requirements.

Since being authorized by the *Medicare Modernization Act* of 2003, SNPs have grown substantially in number and enrollment. As of March 2017, a total of 582 SNPs had an enrollment of approximately 2.3 million beneficiaries – the vast majority of whom are duals.

National SNP Plan Numbers and Enrollment, March 2017[16]

	# OF PLANS	ENROLLMENT
Chronic Condition SNPs	123	332,517
Dual Eligible SNPs (All types)	377	1,937,857
Institutional SNPs	83	62,967
TOTAL	583	2,333,359

Special needs health plans are assisting efforts to move toward focusing on a population approach as well as addressing the unique needs of individual members in the communities they serve. For all involved (medical and social service providers, payers, quality measurement agencies, regulators, etc.), the structures and processes within Medicare and Medicaid have been set up primarily for the one-person, one-time episode of care/support. Benefits and eligibility are carefully defined and regulated. Episodes of allowable care are likewise defined by regulation and legislation – delineated in contracts between the state and the plan/providers and between the federal government and the plan/providers. Contracts must conform to specifications set by regulators, about what are allowable and defined

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[16] Centers for Medicare and Medicaid Services, *Special Needs Plan Comprehensive Report*. March 2017. Available at https:// www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.

services that can be offered to persons who are deemed eligible. As noted by the Congressional Budget Office in their Report to Congress, such restrictions "impede efforts to reduce costs and improve the quality of care for dual-eligible beneficiaries by more fully integrating that care."[17]

As they work with providers, public health and social service agencies, community groups and others to improve safety-net services in their communities, special needs health plans are seeking ways to improve outreach, member engagement, proactive follow-up, and better use of health care and social support services. Special needs plans are helping to bring attention to the need for more meaningful quality measures for the duals, greater benefit flexibility, and enhanced policy and regulatory support for integrating across settings and services on behalf of persons with multidimensional living, medical, emotional, social and behavioral health needs.

Moving toward a population-based focus means creating systems that can define, serve, measure, and act at a group level and that have greater flexibility to invest in population-wide efforts as well as individual service components. This requires developing new inter-connections between medical, social, government and payer entities in ways not yet fully understood. The special needs health plan is one entity that helps move in this direction, particularly recognizing the needs of the duals.

Much work needs to be done in communities across the nation. Working together on social issue(s) will provide greater resources to more effectively address the range of needs of duals – a diverse and vulnerable population. Duals are most likely to fall between the cracks of systems and siloes of care. Special needs plans are one partner willing to help advance their cause.

The two special needs plans featured in this report offering case studies are:

1) **Care Wisconsin**, a health plan based in Wisconsin with one type of special needs plan: a FIDE-SNP.

2) **UPMC**, a health plan based in Pennsylvania with three types of special needs plans: D-SNP, C-SNP, and I-SNP

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[17] CBO at 2.

Care Wisconsin Partnership

Two staff members, one each from Community Catalyst and the SNP Alliance, conducted a telephone interview with several staff members from Care Wisconsin Partnership, a health plan that operates a Fully Integrated D-SNP (serving over 1,500 dual eligible providing health care and long term care services to adults who meet nursing home level of care and are frail elders or have physical or intellectual disabilities), regarding aspects of how the health plan reaches out to and supports enrolled members who are dually-eligible and have social risk factors that impact their health outcomes. Care Wisconsin representatives also shared information about collaborative efforts with service providers and other stakeholders in communities that they serve.

Social Determinants of Health

Interviewers: What are the most frequent social determinants of health risk factors that you observe or hear about in your members?

Care Wisconsin: Our program is available for frail elders and adults with physical, intellectual and/or developmental disabilities, however over half of our members in the Partnership Program are adults with physical disabilities. We have a very small population of individuals with intellectual disabilities or developmental disabilities.

In terms of the most frequently observed social risk factors that our enrolled members are facing, we would say that finding accessible housing, accessing reliable and affordable transportation, and dealing with limited social supports are among the top social risk factors that we see and hear about from the dual members. Accessible housing includes not only the necessary physical and structural modifications to meet the needs for their disability, but also proximity to services and supports.

Factors that complicate and mitigate efforts to find housing for and with the individual are alcohol and drug dependencies (AODA) and mental health challenges. These are often intertwined and these factors exert a negative effect on finding accessible housing or transportation. They also impact who is available, willing, or able to assist the member. Many of our members have active AODA issues, making it difficult to get clear mental health diagnoses. Without a diagnosis from a mental health provider, we are unable to get the member the services and supports they need.

For example, it can be challenging to identify the appropriate level of supportive home care for a person with substance use issues if that member is likewise struggling with serious mental health issues. We have also seen the situation of having a person moving into an assisted living facility who then exhibits difficult acting out or behavioral issues. This type of behavior in the assisted living facility can place their housing at risk. Assisted living providers are not staffed to manage behavioral issues in their residents.

Interviewers: Do these risk factors differ between younger duals, people who are 18-64, and older duals who are 65 and over?

Care Wisconsin: Younger duals are probably more prone to these risk factors, particularly around housing. Younger duals tend to be more transient, which exacerbates housing issues. Our younger duals are also more likely to use illicit drugs. Our adult members with physical disabilities are more likely to have substance use issues on top of functional challenges that complicate housing. Frail elders in our program typically don't have as many issues with housing. Members over the age of 65 tend to

be more established in the community. If our older members do have housing challenges, they are likely to be alcohol or substance use-related. However both groups exhibit challenges with mental illness in about the same proportion.

Interviewers: How do you identify these social risk factors among your enrolled members?

Care Wisconsin: Care Wisconsin conducts a health risk assessment on each individual when they enroll into our health plan. Assessments are usually completed in the member's home and provide information about social and environmental factors that cannot be obtained through a phone interview alone. In addition, we have worked to identify these social risk factors through on-going assessment at every point of contact with the member. We also rely on information received through the member's provider and any natural supports (family, friends, or guardians). During our weekly interdisciplinary care team meetings – consisting of registered nurses, care managers and nurse practitioners – we discuss major changes going on with a member, and work to continually identify and monitor risk factors affecting our members.

As part of our model of care, we reach out to our members frequently. We contact every member at least every three months and often much more frequently than that – particularly if the individual is exhibiting greater need based on utilization or on adverse health events. Frequent contact (much of it face-to-face) with the member is really our best mechanism to learn about social risk factors. We also develop relationships and formal communication with our outside providers. This allows us to gather more information and get a better picture of what the member needs.

Collaborations

Interviewers: Could you describe partnerships or collaborative efforts with others in the community to address some of the social factors for your duals?

Care Wisconsin: We have a long history of service in Dane County and the largest concentration of members receiving both healthcare and long term care services in this county. Collaborative efforts in other counties are underway using similar approaches, but we'll describe Dane County collaborative efforts as an example. We collaborate with the Dane County Community-Based Care Transition Coalition, Aging and Disability Resource Center (ADRC), Dane County Mobile Crisis, Dane County Care Center, all hospital systems, Madison Police Department, specialty clinics (e.g., advanced pain management), the Wisconsin Department of Human Services, Dane County Public Health, individual housing providers and hundreds of others. Some examples of some of our partnerships include the following:

(1) **Care Transitions:** The Dane County Community-Based Care Transition Coalition brings together supportive home care providers, residential providers, managed care organizations like ourselves, home health agencies, and participants from our main area hospital systems to discuss and address issues in the area. For example, the coalition collaborated on a plan around congestive heart failure, to improve care transitions from hospitals to discharge settings – such as transitional care, assisted living, home, or other settings. We had supportive home care and residential facilities at the table to discuss how we can ensure that the discharge placements and follow-up care meet the individuals' needs and that successful placements--such as if an individual lives in a residential facility and wants to return to that same unit--are protected. We used common education materials to improve consistency of information provided to the individual.

(2) **Mental Health:** We have partnerships with mental health providers, including Dane County Mobile Crisis, Dane County Care Center, and a specific mental health unit within the Madison Police Department. Dane County Care Center has a detox focus and addresses more of the "crisis in the moment," while with the Dane County Mobile Crisis we discuss housing, natural supports, informal supports, and programs available to members.

(3) **Housing:** For housing needs, we partner with the Wisconsin Department of Health Services (DHS), Dane County Public Health, and homeless shelters. The Wisconsin Department of Human Services is a key partner to identifying affordable housing options, particularly for our younger duals (18-64). We've also worked with Dane County Public Health when we have members who are finding that their housing is threatened by uncontrolled infestation of bedbugs or roaches. The public health department works with landlords to try to mediate these situations and ensure a member's housing is maintained and adequate.

(4) **Hospital systems:** We share documentations and reports as well as meet regularly with the hospital discharge planning groups at the various hospital systems. Right now, when a member is hospitalized, we send the hospital a summary of all the services the member is getting within a few hours. The contact information for those services includes: the member's pharmacy, mode of transportation, whether or not there is a home health agency, and direct contact number for the key contact staff member at Care Wisconsin. This greatly enhances the hospital discharge planners' knowledge of that individual and what supports and he/she has had prior to the hospital admission. We hope that this is improving discharge plans and helping to increase successful post-hospital experience of our Care Wisconsin members.

Results

Interviewer: What would you say is the most tangible or valuable result from working on some of these social risk factors and with these community partners?

Care Wisconsin: There are a number of impact areas and observed results – some of which can be measured and some which are harder to quantify.

Coordination of Care. First, we would note that our efforts to assist in sharing vital information enable us to prevent duplication of services, which is very time-consuming and costly for everyone, including the individual member. Too often, health care, behavioral health, and social services providers don't communicate with one another and they can end up duplicating care, care plans, or spending unnecessary time trying to look into options for an individual which ends up "reinventing the wheel" for that person – as that work has already been done. An interdisciplinary care team consisting of registered nurses, care managers, and nurse practitioners provides high touch care with the goal of empowering members to self-manage their health and well-being, and to keep members living in the community as long as possible (rather than living in institutions). When Care Wisconsin brings everyone to the table and develops a collaborative care plan, we're able to address member needs more quickly and efficiently. We've noticed that this proactive approach has reduced costs and burden on the individual.

While overall utilization patterns have not changed for hospitalizations and ED visits, the cost per hospitalization decreased 15.6% from 2014 to 2015. In 2016, the average hospital admission cost for the first 10 months was 4.5% higher than 2015, but 11.8% lower than the 2014 baseline average hospital cost. We would all prefer to prevent crisis situations from occurring. Getting together in terms of coordinating our care and support just makes sense. It is surprisingly hard to do in health care and social/behavioral health services in the present way these services are set up and regulated.

Quality Measures. Second, we note that another way to gauge results is to look at the quality measures which are set forth by Medicare and Medicaid. Medicare quality measures are set for managed care organizations at the federal or national level. These quality measures were designed to reflect the general Medicare population – usually persons age 65 and older and who largely mirror the majority population in terms of ethnicity, education, and income level. This population profile is actually quite different than the observed characteristics of the dually-eligible population that makes up the enrollment of Care Wisconsin's health plan. We're dealing with a much more vulnerable group of people, documented in our most recent risk adjustment score of 2.8 (1.0 is the average) – meaning that our members are almost 3 times higher in terms of complexity.. Our enrolled beneficiaries have multiple chronic conditions, social risk factors, and behavioral health challenges. In addition, a higher proportion are of advanced age – e.g., 80+ and meet the nursing home level of care in terms of functional status and care needs – a designation set by the State of Wisconsin.

Despite these differences, we're proud to say that we've been achieving notable measures on scores that are actually designed for the healthier general Medicare population. On a scale from 1 to 5 Stars, we have achieved the quality "4-Star" ratings under the Medicare quality measurement system – which puts us in the top portion of health plans in terms of performance. This is no small feat, as many of the Medicare measures focus on prevention activities which are important, but not the central quality indicator in our population. We're happy to help our members live in the community even though they have a high level of care needs. We note that only 4.3% of our members live in a nursing home, despite meeting a "nursing home certified" level of care. The types of services that are provided to keep people living in the community include supportive home care, transportation, adult day centers, employment services, skilled nursing services, and respite, to name a few. Most services can be self-directed, meaning the member receives a budget and makes his/her own decisions about who to hire and how to direct that service.

Many Partners. Because we've incorporated this collaborative approach into our program and care model for many years, we're successful at partnering with many different service providers – even non-traditional supports in terms of health care and social services agencies. For example, in addition to collaborating with organizations, we also involve neighbors, transportation drivers and even food pantry volunteers at the table. It is fairly labor-intensive at the beginning to get all relevant providers and support people involved but we believe there's long-term value in taking this approach. We serve an increasingly complex population with greater needs and higher risks so we've had to figure out how to provide really intense collaborative practices within the resources we have. Inviting others to the table to partner is one key strategy.

Furthermore, we have seen a positive impact on the primary care physicians, complex care managers and emergency room care managers – they can be very frustrated by the siloes and barriers that are endemic as one tries to work across agencies, institutions, and sectors. By providing some support to work collaboratively and knowing how to navigate the various requirements, processes, and structures, we can assist these providers by offering support, information, and services to their patients, thereby reducing frustration and improving care outcomes.

Lessons/Future

Interviewer: What are some important lessons learned?

Care Wisconsin:
Workforce. We have learned that staff training, organizational support, data/information systems, and skills development around specific competencies are important.

It takes time and skill to build rapport with members. It isn't easy to ask staff to insert themselves in situations that are complex and muddled and try to straighten these out with the member. Our staff is becoming more engaged and we're providing them with opportunities for further training. Over the past year, we've been training our care management staff (nurses, care managers and nurse practitioners) to be competent in motivational interviewing – an active listening and member engagement approach that is widely recognized as a core skill – particularly with complex populations. Motivational interviewing is an important technique to identify what's really important to members and how we can help them achieve those goals. Another major training effort has been around advance care planning using an evidence-based model, Honoring Choices.

We also support our staff by emphasizing collaboration internally so that one person doesn't take full responsibility for the member. We have nurse practitioners, registered nurses, and care managers to ensure that a wide variety of knowledge and backgrounds are available for support and consultation internally. This work can be very draining. Sometimes individuals in these complex situations with a lifetime of challenges continue to make choices that are self-defeating. However, there are also those who make the most of the support and services that are being offered. We look for ways to make sure that staff members feel supported, have a flexible work environment, and find a work-life balance. One thing we've done to support staff and reduce frustration is to make sure that technology works as it should. We also have social activities and bonding events to build relationships and rapport among co-workers. These small things help staff be more productive and get the most satisfaction from their work.

Relationships. A key component of our approach is to focus on members as individuals and build rapport. Establishing a trusting relationship with a person takes time. However it is time well-spent, as many people we serve have had a lifetime of feeling misunderstood or disappointed by the health care community. In their eyes, the system has failed them. Perhaps providers in the past have meant well, but some have told them what to do and what problems they have created for themselves – in effect, shaming the individual for unhealthy lifestyles, noncompliance, or poor adherence to treatment plans. These individuals may have had many barriers to following through with treatment or service plans – and these barriers are not usually fully appreciated by the health and social support systems. Few providers have the time to fully partner with these individuals to understand them as persons or their living circumstances.

We strive to focus on our members as individuals and treat each person based on their unique circumstances. Every person is different and for them, each week and month can present different realities that they face-- it's crucial for us to keep this in mind. We emphasize to our staff that our care model supports addressing risk based on member need, and not just what we're contractually required to do.

Assessments. The assessment process and rapport-building with the individual is key. It is important to view assessments as on-going and not just the first time you meet a member. Assessments should be at every interaction whether it's over the phone, at home, a physician's office or in the hospital. Each of those interactions is an opportunity to see something new or recognize something that the member didn't feel comfortable sharing before. Collaborating with providers in each of these places is really important to piece together the member's story and develop a more complete picture of his/her needs. The assessment

should also be conversational. We encourage our staff to avoid reading off the list of the assessment questions and remember to have a conversation with the person in front of them. Listening, eye contact, and asking questions about their life, helps build trust with the individual. When our staff members conduct annual assessments in the member's home, we encourage them to go in pairs because one person may notice something that the other missed. Having two sets of eyes watching how that person interacts, how they move, and how they approach the assessment ensures that we have more than one viewpoint as we develop the collaborative care plan.

Future. In terms of the future, we are working toward a way that we can all share information – within privacy permissions – to improve the way we work together in real time across the community to support members. We are trying to find ways that providers can access our documentation systems and have these providers give us access to theirs. Although we don't have that capability yet, we're hoping our new care management software system will change that. We're working toward a data/information portal that providers can use to access information about our members within the guidelines of information sharing and collaboration and coordination processes established.

Sally's Story

"Sally" was a younger woman with diagnoses of unstable diabetes and renal failure. She required dialysis but wasn't following her care or treatment plan, leading to repeated hospitalizations and which severely compromised her health status. She had her own desires for managing her health condition and wanted to drive the process, and was particular about the extent to which she wanted any team members involved. After repeated hospitalizations, her health status was at a crisis level. At this point, Care Wisconsin gathered all providers in-person or by phone to discuss how best to work with Sally.

Sally's team identified many issues that served as barriers to Sally managing her own health concerns. First and foremost, her unstable housing situation caused her great anxiety and was a top priority. She had small children that needed proper attention and supports, and she worried about where they were going to stay. Addressing these concerns took priority over her medical concerns. The team worked with community providers to find her stable housing, and to make sure her children were connected to social workers and programs to meet their needs.

Sally also had mental health issues which hindered her ability to care for her physical health needs. Her team worked with her to begin addressing these issues, finding a therapist who was willing to meet with her at her home. The in-home therapist helped her establish better self-awareness and coping skills. She began to better articulate and identify what it is she really wanted to do for her medical concerns and to realize she had options. She felt more empowered to dictate priorities and be part of that process.

In finding ways to overcome barriers to care, Sally's team also considered her significant history of being abused. This drove her need to be the primary decision-maker for each step along the way, including deciding on how things get done. For example, in order to address her diabetes, she needed to keep her scheduled, routine dialysis appointments. The team worked with Sally to establish a schedule and dialysis center location that worked best for her.

About Care Wisconsin

Care Wisconsin has been serving the community for 40 years. It was founded as an adult day center, and received an HMO license in 2005. It is now a nonprofit managed care organization that matches frail seniors and people with physical and intellectual disabilities to the health care and long-term care services and supports that they need. Care Wisconsin serves more than 10,000 individuals (members) in 40 counties across the state through four programs:

Family Care serves people with intellectual/developmental or physical disabilities and frail elders who meet functional eligibility and Medicaid eligibility criteria, providing long term care services.

Partnership provides both long term care and health care services to people with intellectual/developmental or physical disabilities and frail elders who meet nursing home level of care and are eligible for Medicaid; most members also receive Medicare and Partnership is a Fully Integrated Dual-Eligible Special Needs Plan.

Care Wisconsin Medicare Dual Advantage is a Dual Eligible Special Needs Plan for people who have both Medicare and Medicaid, providing only health care services.

Medicaid SSI Managed Care is a health insurance program providing health care services for people with a disability who receive Social Security Disability Income.

Care Wisconsin has strong local provider networks to help ensure that their enrolled members have choice, flexibility, and access to services they need.

For more information, see: https://www.carewisc.org/about

UPMC Health Plan

Two staff members, one each from Community Catalyst and the SNP Alliance, interviewed several staff members from UPMC Health Plan – a nonprofit plan that serves 22,000 duals through its D-SNP, *UPMC for Life Dual.* The interview explored aspects of how the health plan reaches out to and supports enrolled members who are dually-eligible and have social risk factors that impact their health outcomes. UPMC representatives also shared information about collaborative efforts with service providers and other stakeholders in communities that they serve.

Social Determinants of Health

Interviewers: What are the top social risk factors that you hear about and observe in your enrolled dually-eligible members?

UPMC Health Plan: What we have observed is that housing, transportation, and food insecurity are the top social risk factor issues among our dual members. Transportation, in particular, seems to be an issue with younger duals; however, UPMC does not currently measure this social risk factor by different age stratifications.

Interviewers: How do you identify these social risk factors among your enrolled members?

UPMC Health Plan: As an insurer, we do not have direct access to information regarding the housing status or living situation of our enrolled members. However, we identify these social risk factors in a few ways:

First, we conduct health risk assessments (HRA) for new members and on an annual basis thereafter. These HRAs include questions about the individual's living situation, current health status, social supports, food and nutrition, as well as what social services, in-home, behavioral health, and other assistance the person is receiving. HRAs are completed over the phone by our telephonic team, which is made up of case managers and social workers. Right now, social determinants of health risk factor issues are built into the HRA.

Second, we utilize community teams to conduct visits in the individual's home. We contact every member to offer to conduct a home visit. Our teams are comprised of case managers, social workers, non-clinical staff, and community health workers. Occasionally they also include a behavioral health specialist on the team. The teams conduct home visits to observe and assess the member's situation. The teams are able to see if the member lives alone and what kind, if any, of family or other community supports are available.

UPMC AnywhereCare
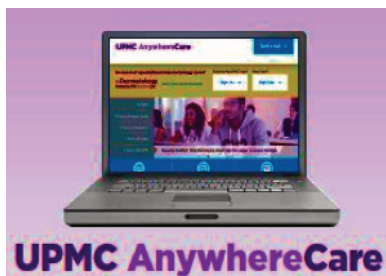
Third, we utilize our internal and extended network of professionals and partners and have set up a portal for these partners to provide us with information on the members' needs. We are able to provide the most recent HRA completed by the beneficiary as well as a personalized care plan. The community teams have support from pharmacy, telephonic case management, health management, wellness, and behavioral health team members.

The UPMC Anywhere Care database provides information across a range of services and is under the direction of the care management and community teams. Pharmacy staff members also have access to this database. In addition, Emergency Medical Technicians are able to access and view a more limited set of data – allowing them to have critical

information in case of emergency situations. In addition, the Area Agencies on Aging staff that are involved in supporting the members' needs in the community have the ability to document their support in the care management system database to ensure communication across the team.

Interviewers: What are the challenges to identifying and addressing social risk factors?

UPMC Health Plan: Identifying mental health risk factors is one challenge we face – and working with members who have complex physical as well as mental and behavioral health complications on top of daily living concerns. These members often feel overwhelmed. We have to take our cues from the person regarding what can be addressed at any given time. The member drives this prioritization.

Another challenge is health literacy – meaning the ability and capacity of the individual to fully understand his or her health conditions, underlying causes, expected progression, treatment plan, symptoms and side effects, if and when they arise. Health literacy is difficult to assess over the phone. It is often challenging for care management teams to fully determine an individual's level of understanding about his or her health conditions or treatment plan until they visit the individual at home. Often times, only then does it become clear that a person has difficulty interpreting the information and thus hampering their ability to follow the treatment plan. For example, perhaps the treatment plan instructions were written at too high of a reading level, or the information was simply too much to digest.

A third challenge revolves around individuals who are transient and have insufficient communication technology, such as a cell phone without minutes left before the end of the month, or a telephone landline that is disconnected. Further, it is difficult to maintain regular contact, either by phone or in-person, with members who have unstable housing. Sometimes that person is moving week-to-week or month-to-month from one friend or relative to another. There is not a way to track this person in the community. Sometimes UPMC Health Plan staff have to wait until the member initiates contact – often times in the ER or other hospital setting – before we complete additional assessments or take proactive steps.

Interviewers: Have you found any effective ways to find out or address these social risk factors?

UPMC Health Plan: Along with telephonic outreach, UPMC Health Plan finds particular value in face-to-face interactions. Community Teams build relationships with the members and are better able to understand the full picture of why a person may have difficulty following their diabetes care plan, for example. We have health coaches, too, who help individuals with wellness goals and assist them as they work to stay motivated and focused on their personal health goals. These relationships are important and help us stay in touch.

When a member transitions from the hospital to the home it is important to ensure that person feels supported and prepared for how he/she will manage care and daily needs. We focus on these transitions to support the family or friends who are part of the person's personal support system.

For example, prior to a hospital discharge, a transition coordinator will meet with the member and any family or natural support person (e.g., close friend) to better understand the situation that the member will be facing post-discharge. The family member or support person plays an important role and is actively engaged in helping to make the transition successful. We like to work with these family members and significant support people as soon as we can. In this way, UPMC Health Plan is able to help prepare for and align care management services to meet the patient and family needs.

To accomplish this, UPMC Health Plan utilizes an integrated documentation system where assessments are readily available to be reviewed and care plans may be edited. This system permits quick and efficient communication across the care management team (e.g. instant messaging). In this way, we tap into a variety of expertise/knowledge within the team. For example, when after repeated unsuccessful attempts to reach a member by phone he shows up in the Emergency Room or is admitted to the hospital, we have an automatic flag in the system which triggers the data/information system to notify the care management team immediately.

UPMC Health Plan also relies on relationships with community organizations that know and serve our member population. For example, we partner with Pittsburgh-based Community Human Services, a local non-profit agency and vendor of the U.S. Department of Housing and Urban Development, to fund "Cultivating Health for Success." The initiative is designed to integrate permanent supported housing, an assigned primary care medical home, and case management/care coordination to help provide stability for UPMC *for* You Medicaid or Special Needs Plan members. Since 2010, medical costs and unplanned care have declined among homeless individuals who gained stable housing through the initiative. Initiative participants who gained housing saw an average annual health savings of $6,384.[1]

Internally we have interdisciplinary care teams that help to break down siloes of care. The care management teams have meetings together with the case managers, primary care providers or medical directors, and pharmacists, for example, to review changes in health or social risk factor status. Care management teams also oversee communication and care coordination plans among the interdisciplinary care teams.

Collaborations

Interviewers: Could you describe partnerships or collaborative efforts with others in the community to address some of the social factors for your duals?

UPMC Health Plan: In a similar fashion as we do in the Cultivating Health For Success partnership, we collaborate with many partners, including Area Agencies on Aging (AAA), housing agencies, landlords, Emergency Medical Services (EMS), behavioral health providers, community support providers, and others.

In developing partnerships, UPMC Health Plan considers the geographic zip code area served by the organization, as well as that service provider's proximity to public transportation, any environmental barriers, and the type of programs and services offered – as compared to or matched up with what our enrolled members need. We seek to have a comprehensive set of services that fit our members' needs and preferences. We also look for gaps in care and duplication of services. We then approach the organization and meet with their case management team to figure how a partnership could be most beneficial for the member, the organizational partner, and for UPMC Health Plan.

Sometimes we work together on health events or collaborative initiatives such as: providing space for a mobile health and/or dental care van, co-leading an educational session or town hall meeting with a physician or other clinician providing practical and current information on a desired health topic of interest to the community, or co-sponsoring a health fair within a neighborhood setting.

With some service partners, like local AAAs, we have financial agreements in place. These formalized agreements, with specific structure and processes outlined, help clarify expectations around service,

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[1] Cultivating Health For Success Business Summary: Building the Foundation for Better Health Outcomes and Lower Cost. UPMC Health Plan Department of Health Economics. August 2015.

data sharing, privacy safeguards and protections for the member, as well as reporting, payment, quality, and other parameters. For example, the Community-Based Care Coordination Initiative (CBCCI) is a partnership between UPMC Health Plan and local AAAs to integrate certain aspects of medical and long-term care to provide optimal care coordination and management to members.

Implementing a formalized structure for partnerships allows providers and agencies to participate in a more substantive and connected way with the individual and with our accountable, population-health approach. These agreements can help with synergy and relationship-development between organizations, allowing for a bigger impact and for sustainability. Below are some examples of some of our partnerships.

Mental and Behavioral Health: UPMC Health Plan partners with Community Care Behavioral Health, a behavioral health managed care organization that is a part of the UPMC Insurance Services Division to support members with behavioral health needs. Our community team includes health specialists who go out into the community to provide screening and brief education about various conditions, such as depression. They conduct brief physical health screenings and will ask the member a few questions--such as in the Patient Health Questionnaire-2 or 9 (PHQ-2, PHQ-9). These are evidence-based risk screening tools to identify signs indicating depression. Once this screening is done, then those individuals who score above a certain level will be referred to behavioral health for follow-up.

Housing: For housing needs and in addition to partnerships like Cultivating Health for Success, we partner with housing agencies and high-rise landlords in the primary geographic area we serve. For the high-rises, UPMC Health Plan will conduct events with mobile vehicles and send a team to do flu shots, education, and encourage overall wellness. We often send a case manager or skilled social worker to these events to better develop a relationship with the member and partnering organization.

EMS: Through this partnership, we have utilized Emergency Medical Technicians (EMTs) to better understand the post-discharge living situation and also help conduct assessments of the member in the home. EMTs have limited access to member documentation, but they have been trained to meet with someone who may have a chronic condition and help them apply for eligible benefits. Currently, we are exploring different options to allow EMTs to offer more chronic care management and supportive assistance to individuals in their homes.

Transportation providers: UPMC Health Plan collaborates with transportation vendors in communities beyond our geographical reach to provide rides directly for members related to their non-emergency health care.

Interviewers: Have particular partners or strategies emerged as being key to addressing specific risk factors issues for your dual members?

UPMC Health Plan: Transportation is critical for members to get to and from primary care and specialists appointments as well as to the pharmacy to ensure proper medication adherence. UPMC Health Plan includes a transportation benefit allowing 20 trips for dual members per year, which is increased by exception. As mentioned, in communities where we do not have a van or ride service, we collaborate with external transportation vendors. Certain service agencies also have volunteers

providing rides, even collaborating with neighbors, family members or others in the community. The relevant transportation information is collected and stored in a database. Further, case managers have the flexibility to organize transportation for non-medical needs such as grocery shopping. Finally, social workers have the flexibility to seek authorization for services such as paying for an apartment to prevent eviction.

Results

Interviewers: What would you say is the most tangible or valuable result from working on some of these social risk factors and with these community partners?

UPMC Health Plan: First and foremost, certain results are tangible and measurable, while others, that are potentially quite valuable, are more difficult to quantify.

To measure results we first look at member satisfaction, participation rates, and member engagement. We share the responses with our community teams, care managers, and outreach staff. We get a better idea about what is valued by the individual. We look at member HRA completion rate and how much they are willing and able to engage in their care and care planning.

Second, we look at our relationships and collaborative care management efforts with our partners and providers. How are they responding? How are we building those service connections? One tangible way is through more efficient and effective communication and information-sharing vehicles.

We have had positive response to our information-sharing methods. Our partners and providers appreciate their ability to access the member's information where they are also involved in serving that person and have the authorizations needed. The comprehensive care plan, which incorporates many dimensions of the person's situation and has the member's needs, preferences, situation and priorities identified, is a valuable and tangible result of our work utilizing the HRA as a powerful tool. While we do not have the care plan in place solely to examine social determinant of health issues, such issues are raised within this care planning process. The ability to grant access to a wider range of partners has been an important milestone and we see that it reduces duplication and waste. The inefficiencies of chasing information are reduced. Individuals working together and in sequence to one another are more informed. Being able to share identified risk factors, as well as what the member wants to work on, streamlines efforts among the care management team, partners and members

Lessons/Future

Interviewers: What are some important lessons learned?

UPMC Health Plan: We have discovered some important lessons along the way – both what to do and what not to do.

We learned to assess the implementation of the proposed roles, duties, processes of care, and information-sharing strategies that are all components which come into play when trying to create a team-based approach to care and support. For example, we learned that when starting a new initiative, the department leads/physicians and other key stakeholders must be involved in reviewing the processes, pathway, and expected results. This helps to reveal potential challenges, avoid taking unnecessary steps and streamline processes where possible.

Especially for high risk individuals, we have also learned that in-person or in-home visits are critical to understanding the full spectrum of needs. However, we do face resource capacity issues. We are still

working on determining the case load and capacity limits of community teams to complete in-person visits within a time window that allows us to be proactive with the individual. Given travel time, scheduling, and other barriers, figuring out how many members can be reached each day is challenging, but it is important for securing appropriate and efficient staffing and for supporting our workforce.

We learned that sending EMTs into the hospital to see a patient does not work as well as we hoped. In our experience, it is not the time or place (in hospital) for the EMT to meet with the individual and conduct an assessment of post-hospital needs.

We also learned that while technology is often an asset, it is also cumbersome at times – especially in working across settings, disciplines, and siloes. It is one component of the solution, but not the whole solution, to providing more integrated care.

Interviewers: What practices would the health plan like to improve and/or expand in the future?

UPMC Health Plan: Technology investments are important to link across divides. We are in conversations with our key hospitals so that they can access our documentation systems, in the same way they do for us. Although we do not have that capability yet, we hope that our new care management software system will change this. We also aim to build on our provider portal and offer providers as much information on our members as possible. Our goal is to continue to build information bridges.

Interviewers: Do you have any advice you would give to other plans looking to incorporate similar practices for their member?

UPMC Health Plan: Yes. We would offer the following thoughts and suggestions:

- Develop some kind of community team model that partners with local agencies and other community stakeholders as much as possible. Developing relationships and a shared understanding of the needs, preferences, and characteristics of these members, as well as a clear understanding of the service capabilities and particular strengths of the agencies, is vital to making the partnership work.

- There is great value in building rapport with the member, particularly individuals with complex medical, behavioral and social risk factors. There is great value in social work to build these relationships. This work is quite labor-intensive, so a willingness to expand your work force is important.

- Remember to look at the family as a whole and not just the member. During assessments, identify different family members and their strengths and abilities to address various needs. These individuals can affect each other positively or negatively. What happens to one, affects all. For example, if the head of the household is not taking care of her/himself, then we know the likelihood that children receive their medications and attend doctor visits decreases over time.

Jane's Story

"Jane" (not her real name) was a 48-year old woman who had multiple chronic conditions, including chronic obstructive pulmonary disease, congestive heart failure, hypertension, diabetes, kidney disease, asthma, and was obese. She was also diagnosed with depression.

Jane lived in a small 3-unit apartment building owned by her uncle. A cousin lived in the apartment above. Jane's main support person was her mother. In addition, Jane had a beloved dog and cat. She used a wheelchair and walker to get around and had a nasal oxygen tank at home, as well.

Routine telephonic outreach had not been successful in engaging Jane for care coordination. However, when Jane was admitted to the hospital with unspecified heart failure, the community-based care management team was able to begin to engage her. Members of the team met with Jane at her bedside and initiated a plan for coordinating care for her planned discharge. She was treated and discharged with approval to receive a number of services at home and to get medical transportation to/from appointments and for follow-up care.

While Jane agreed to receiving a home visit after her discharge and to getting home health care, the home care manager was unsuccessful in reaching Jane to set up a time to come. Jane called about a week later and said that she had changed her phone number; she was having trouble paying her phone bill and had gotten a disposable phone. The home care manager visited Jane the next day.

During this visit, Jane and the home care manager ("Carol") had a thorough conversation. During this visit, Jane made it clear to Carol that her goal was to stay in her current living situation and to try to live independently. Carol was able to see Jane in her living environment and assess her needs, such as access to her home, safety of her surroundings, and view her supplies on hand, including medications. Carol talked to Jane about how to manage follow-up care. For example, she explained how to get medication prescriptions filled, which Jane had not done, how to use the medication pillbox and her nasal oxygen. Because Carol identified that Jane was having difficulty with activities of daily living such as mobility, bathing and dressing, she arranged for Jane to receive in-home services. She also arranged transportation for follow-up appointments that Jane would schedule on her own.

Jane explained several other complications in her life. She was separating from her partner, needed some legal advice, and had to identify a Power of Attorney – in the event she could not make her own medical decisions. In addition, her uncle, who owned the building in which Jane lived, had recently died without a will, thereby leaving the ownership of the building in question. Discussing all of this was clearly upsetting to Jane.

Though this visit was promising, Jane was re-admitted to the hospital within two weeks. Upon review of her situation and of records, it was clear that Jane had not kept her appointment with the primary care physician and had not filled all of her medications. During the visit, additional issues were discovered, including a cancer diagnosis. Jane denied that she had cancer and declined additional diagnostic tests. She did allow for a home visit from Carol after

Jane's Story (continued)

discharge, but declined all assistance during the visit. Over time, however, as Carol built a trusting relationship with Jane, she was able to engage her in discussions about goals and about options for housing, health care, and support services.

Carol also involved Jane's mother, who was very supportive, and affirmed her right to make her own decisions. At this meeting, Jane agreed to consider visiting a new primary care physician and was willing to speak by phone with a therapist as a first step. She also agreed to consider housing options that would allow her to keep her pets and to remain near to her mother. Thereafter, Jane began to utilize the transportation assistance for primary care visits. She also saw a new pulmonologist she had requested and started using a different assistive breathing device.

Jane continues to make progress, with the support of both her mother and Carol.

About UPMC Health Plan

UPMC Health Plan, headquartered in Pittsburgh, PA, is owned by the University of Pittsburgh Medical Center, and is part of an integrated health care delivery system. UPMC Health Plan offers a full range of health insurance plans, covering over 3 million individuals. UPMC for Life Dual, the largest stand-alone 4-Star D-SNP in the nation and 17th largest D-SNP overall, provides coverage for over 22,000 dually-eligible Medicare and Medicaid enrollees. It provides additional benefits beyond Medicare services, including: prescription drug coverage, routine dental, hearing, and vision services, fitness center membership, transportation, meals after a hospital stay, and an allowance for bathroom safety products such as raised toilet seats and shower chairs. UPMC also offers health coaches for people with complex medical or behavioral health needs. Enrolled members are invited to participate in an assessment which yields a customized care plan, developed with the individual and a Care Manager from UPMC.

For more information, see: https://www.upmchealthplan.com/snp/

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