MOLINA HEALTHCARE

Your Extended Family.

Reducing Readmissions in the Medicaid Disabled and Medicare SNP Populations

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LT's Story

I met this member in the hospital. He was disheveled and adamant about wanting to go home, as he saw no need for any help from anyone. He told me that "I just want to go home so I can smoke and drink beer!" Home is his delivery van, where he had been living for several years. He told me that he could manage his health "just fine" at home, and had no need for assistance. He was in the hospital for treatment of ulcers on both feet and his sacral area, MRSA, and Gangrene. Several of his toes had already been amputated, and he was unable to walk.

He was not interested in speaking with me or anything about the Care Transitions Program. I came back every day for 5 days to sit and talk with him, and finally he agreed to let me help him.
After he was discharged, I visited him in his van. It is an old, green delivery van with a sliding door. There are tarps on the front windows and on the passenger side is a sign saying "keep out". The area is small and untidy, with a television, a makeshift bed, a heater and full ashtrays on the floor. During my first visit with him, I wondered what I was doing there and how I could possibly help, but I stayed and hoped for the best. LT understandably has trouble asking for help and trusting others. I visited him nearly every week and little by little he began to open up to me.

We started with the basics of monitoring which symptoms meant he needed to see the doctor. Gradually and gently we covered what health goals he had. He wanted to get back to walking and to get outdoors more. He was able to ask for help showering, which he had not done since he was in the hospital, and so agreed to a home and community assessment. He is now off his antibiotics, is walking, and does not require another amputation. He is also considering moving out of his truck and into temporary housing.

When he reflects on how the past two months have been he says, "I couldn't walk before and now I can. I got wonderful help from the visiting nurse and Molina. I almost feel special. You don't know how lucky I am to have you come out. I am so grateful!"

About Molina Healthcare

- Founded in 1980 by C. David Molina, M.D.
- Mission: To promote health and provide health services to families and individuals who are lower income and covered by government programs
- Owns and operates 20 Primary Care clinics
- Manages healthcare services and health information technology for 4.3 million people on Medicare, Medicaid, and other government programs in 16 states

About the Members We Serve

- Medicaid enrollees with disabilities:
  - 45% have 3 or more chronic conditions
  - 49% have at least 1 mental illness
  - 5% have a substance use disorder
- Medicare dual-eligible enrollees[2]:
  - 52% have a mental illness
  - 38% have both mental illness & substance use disorder
- High rates of homelessness, poverty, and illiteracy

Readmission Statistics for Disabled Medicaid Enrollees

- Average Readmission Rates[3]:
  - National: 16.3%
  - WA State: 15.7%
- Mental illness and substance abuse increases readmission rate by 4 to 5 times[3]
- 50% readmitted within 30 days did not see physician between discharge and readmission[3]

Coleman Care Transition Model

- Care Transition Intervention (CTI) developed by Eric Coleman, MD, MPH at University of Colorado
- Model was developed and standardized with Medicare patients
- Explicitly states not for use with psychiatric conditions
- Implemented in 130 major healthcare institutions across the country

Coleman Model Results

- Goal: avoid unnecessary SNF placement, readmission, ER use, and Rx errors
- Statistically significant lower hospital readmission rates than control group within 30 & 90 days post discharge
- Multi-site randomized controlled trials have shown a 35% average reduction in readmissions

Coleman's Four Pillars of Care Transition

1. Patient Medication Self-Management
   - Knowledge of Medications
   - Medication Management System
2. Patient-Centered Record
   - Personal Health Record to facilitate communication and continuity across providers and settings
3. Follow-Up
   - Patient schedules and completes necessary visits with PCPs and specialists
4. Red Flags
   - Knowledge of signs and symptoms that condition is worsening and how to respond

Coleman's Care Transitions Process

- Transition Coach is RN who provides onsite discharge coordination and care transition from hospital to home or lower LOC
- Transition Coach caseload is 24-28 patients
- 1 inpatient visit before discharge
- Home visit post discharge within 48-72 hrs
- Follow-up phone calls at 7, 14, and 30 days post discharge

Molina Care Transition Program

- Began in December 2010
- Hired full-time RN with expertise in Care Transitions and trained by Dr. Coleman
- Established legal agreement with local hospital system
- Work with inpatient members onsite and post d/c
- Meet with hospital staff to problem solve and advocate for members

Re-Inventing the Care Transition Model

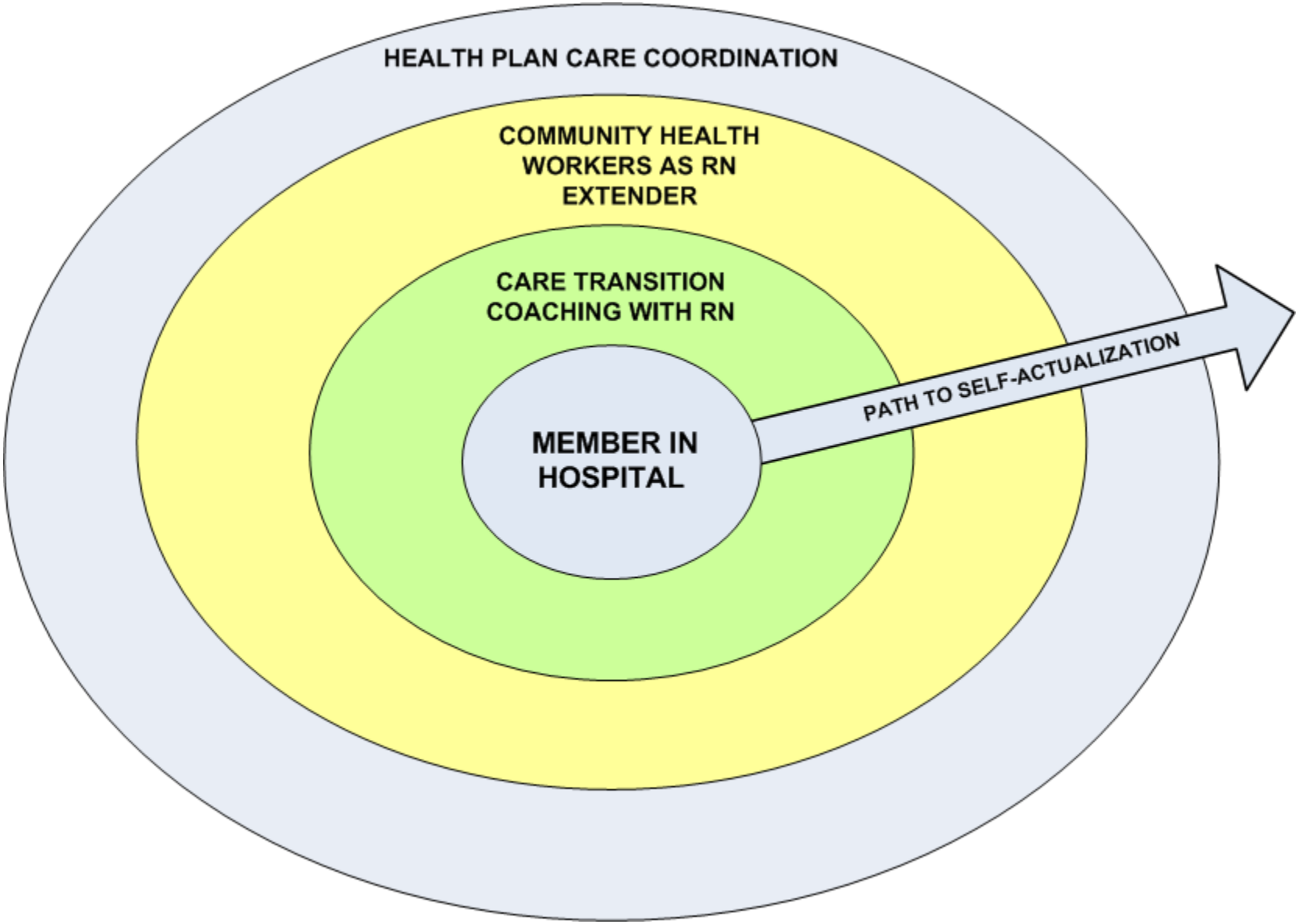
Found that using Coleman Model as suggested with fidelity was not working:

- Members refusing to be in program
- Members refusing home visits or after discharge communication
- Coleman materials too complex for members
- Health not as important to members as housing and food
- Untreated mental illness and substance use undermining success

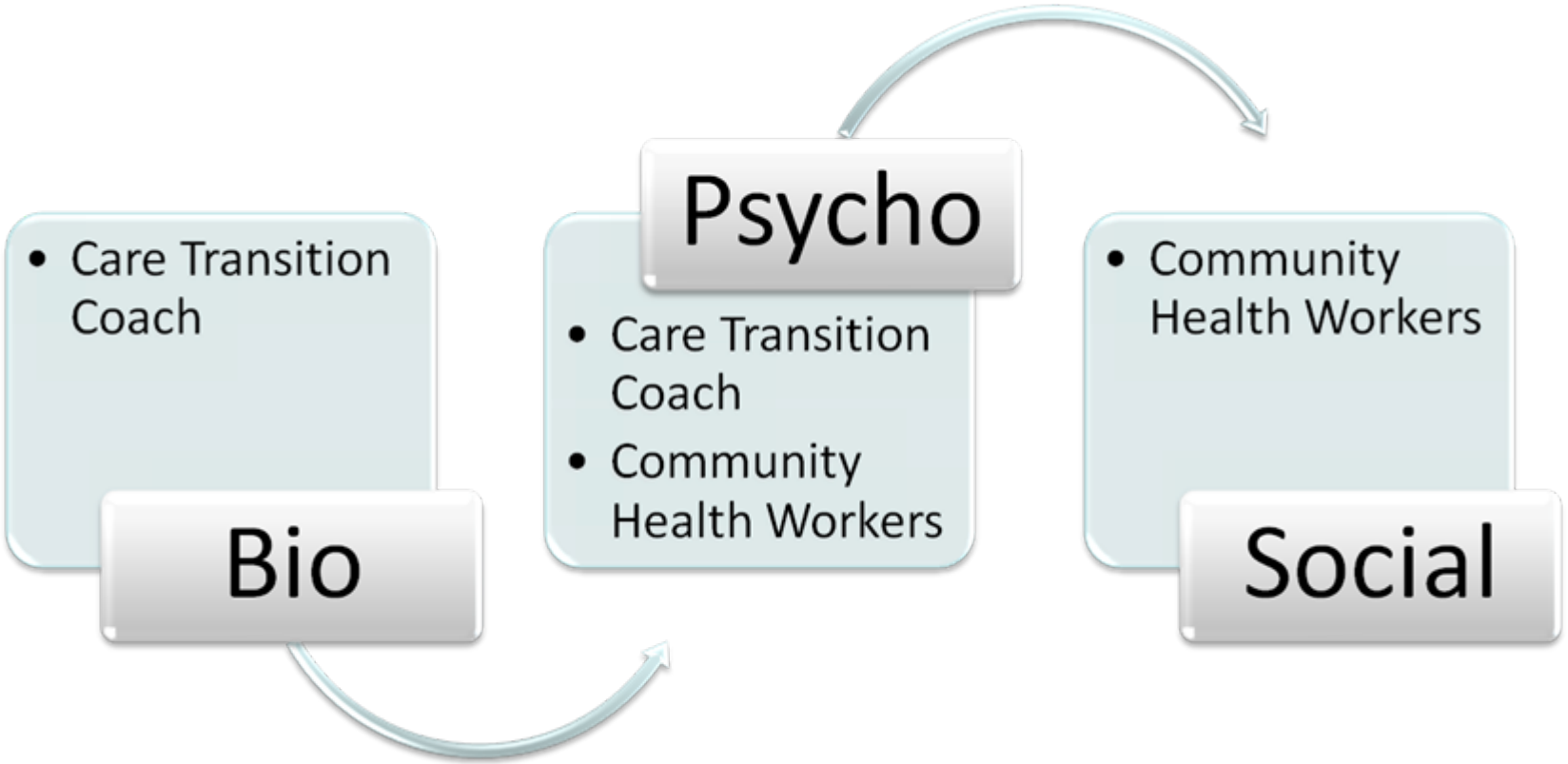
Differences from Coleman Model

- More than 1 meeting in hospital to gain trust
- More focus on basic needs like housing and food
- Heavy focus on psychiatric and substance use disorders
- Individualize the pillars and tools and use out of sequence
- Simplified tools for lower education level
- More than 1 in-person visit post discharge
- Less telephonic work- 75% done in person
- Lower caseload by 50%
- Time in program varies & can be up to 3 months
- Set smaller goals and complete less in each visit
- Only give Discharge Checklist, HRA & PAM in hospital
- Will arrange LTC evaluation and then take over setting up services
- Use of Community Health Workers as RN extenders

Care Transition Model for Medicaid Disabled & Medicare Dual Populations



Staff Focus


Bio
• Care Transition Coach
Psycho
• Care Transition Coach
• Community Health Workers
Social
• Community Health Workers

Community Health Workers

- Community Health Worker is a paraprofessional (outreach worker, peer counselor, health advocate/volunteer, etc) who acts as the RN extender to:
  - Help schedule appointments with PCPs and specialists
  - Arrange transportation
  - Help get prescriptions filled
  - Follow up with member on missed appointments
  - Help break down barriers to following care plan
  - Empower member to access community resources for housing, food, clothing, employment, etc
  - Assist member to maintain Medicaid/Medicare eligibility and other financial resources as appropriate
  - Help member build a support system through family, friends, and community and faith-based organizations (churches, recreation centers, support groups, homeless shelters, missions, etc)

Coach's Toolbox

- Claims databases
- Care management software
- Predictive modeling tool
- Hospital chart and EMR
- PCP Communication Form
- Member Brochure
- After Hospital Discharge Checklist
- Personal Health Record (PHR)
- HRA and Patient Activation Measure (PAM)

Member Brochure

Care Transition Program

You are invited to participate in a new program with Molina Healthcare of Washington.

This is a service to help you:

- Understand and manage your medications
- Help you stay out of the hospital
- Make a plan for follow up appointments
- Help you figure out problems

A Care Transition Coach will visit you at the hospital and give you a Personal Health Record. The coach will tell you about the program while you are in the hospital and contact you after you leave.

You will work with the coach for four to six weeks to learn new ways to take care of your healthcare needs.

Personal Health Record

You will be given a Personal Health Record:

- To help you deal with your healthcare needs
- So you can write down all of your medications
- So you can have your questions ready when you go to see your providers

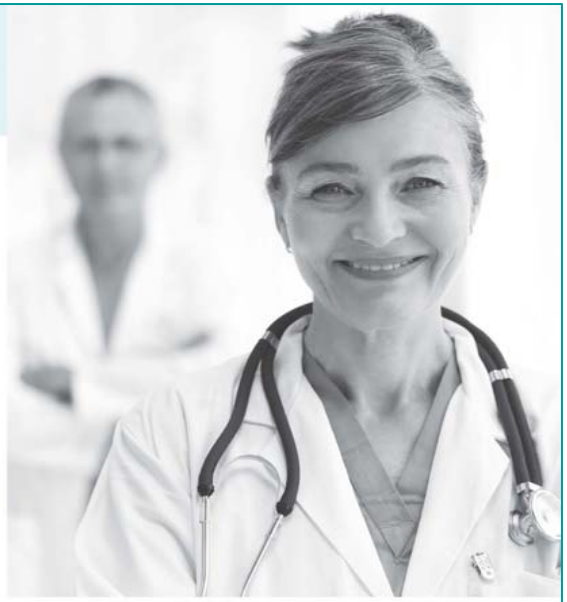
You will take this to all of your provider appointments.

Medications

The coach will go over all of your medications with you. You and the coach will make sure you have the pills you need and who to contact for any medication questions you may have. Keep your medication list current and in your personal health record to take to all of your provider appointments.

Understanding your health conditions

One of the best ways to stay out of the hospital is to know the signs that you may be getting sicker and what to do if that happens. You and the coach will go over these signs to help you make a plan of what to do if that happens.



Follow up visits

After leaving the hospital you will need to let your provider know you were in the hospital. You may have special providers you need to follow up with to maintain your health. The coach will help you get ready for these visits if you need help.

Tips for self care

- Speak up if you have a question for your healthcare provider
- Learn about your health issues and needs
- Know what medicine you are taking and what it does
- Call your provider for your healthcare needs
- Call the Nurse Advice Line at (888) 275-8750 for additional healthcare questions

MOLINA® HEALTHCARE

After Hospital Discharge Checklist

This is a list of things that will help you with a safe hospital discharge. Review this list often during your stay and mark each item off when it is done.

- ❑ I know where I am going when I leave here
- ❑ I understand my health problems
- ❑ I know what problems to watch for
- ❑ I know who to call if things get worse
- ❑ I understand ways to keep my health from getting worse
- ❑ I understand what my medications are for and how to get them before I leave
- ❑ I know how to take my medication and what problems might happen
- ❑ I have the names and numbers of who I can call if I have healthcare questions
- ❑ I have written discharge instructions I can understand
- ❑ Someone I trust knows what I will need when I leave here
- ❑ I know what providers I will need to see when I go home
- ❑ I have a follow up appointment with my provider
- ❑ I have a way to get to my provider appointment

Your Molina of Washington Healthcare of Washington Transition Coach is: _____

Molina Healthcare Contact Numbers:

Member Services (800) 869-7165, Monday - Friday 8:00 a.m. – 5:00 p.m.

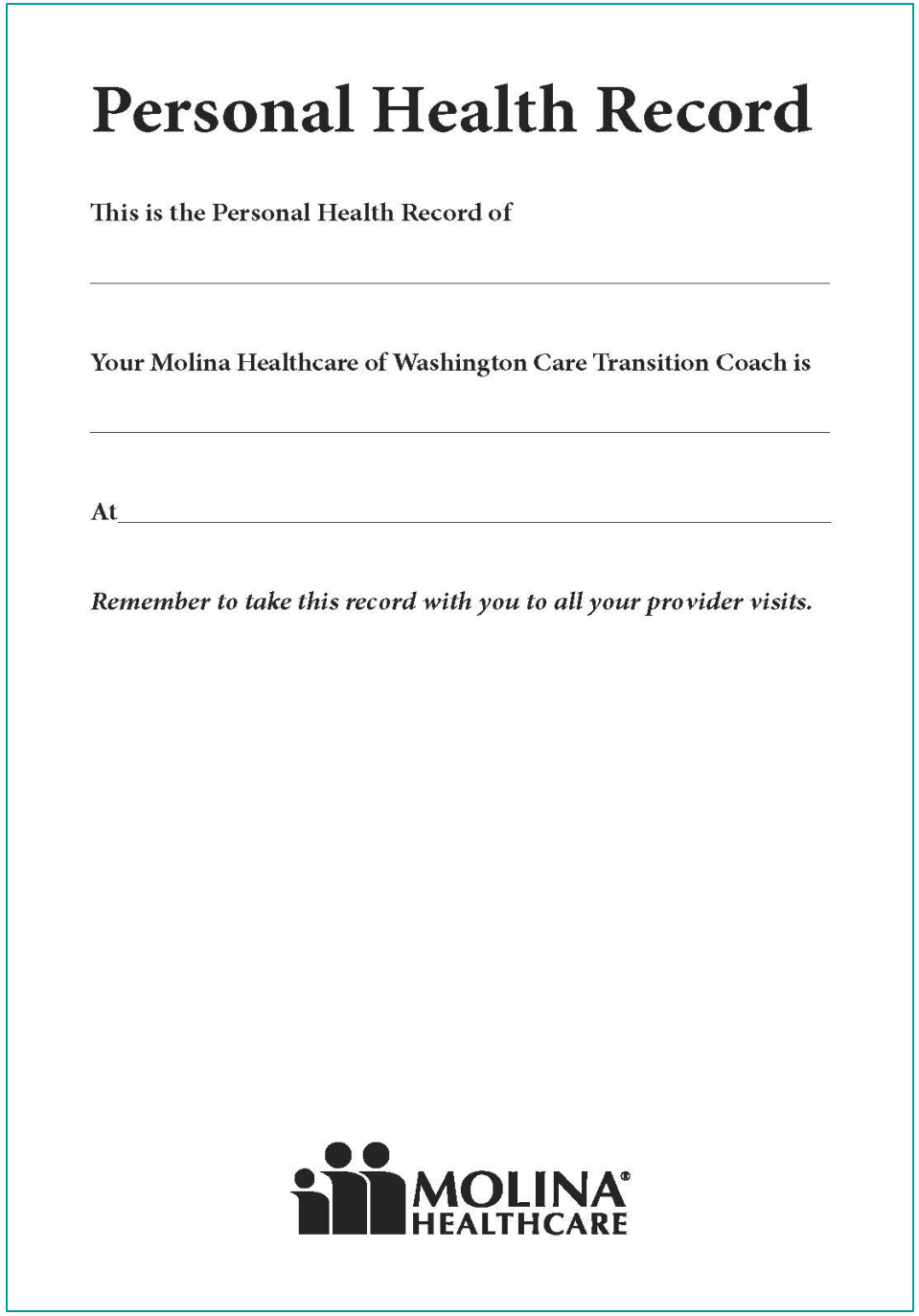
24 hour Nurse Advice Line (888) 275– 8750

Health Integration Team (800) 869–7175
Enter the extension of your assigned Health Integration Team staff member: _____

Molina Healthcare works to give you the best health plan possible

MRC Part #11-734
Approvals: MHW – 4/12/11 MPA - 4/19/11

8010WA0411



PHR Includes:

- Member, provider, and health plan contact information
- Self-care & personal health goals
- Medication record
- Recent hospitalizations
- Medical conditions and red flags
- Notes and questions to ask provider

Personal Information

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Who can help me?

Name: _____

Relation: _____

Home Phone: _____ Cell Phone: _____

Advance Directive/Living Will: Yes _____ No _____

Where located? _____

Provider Information

Primary Care Provider: _____

Phone: _____

Pharmacy: _____

Phone: _____

Other Providers: _____

_____

Molina Washington 24 Hour Nurse Advice Line – (888) 275-8750

Molina Washington Member Services – (800) 869-7165

Molina Washington Health Integration Team – (800) 869-7175

Medication Record For

_____

In order to be well and healthy, I will:

- Take this Health Record with me wherever I go – especially when I go to any provider appointment or the hospital
- Call my provider if I have any questions about my medications or if I want to change how I take my medications.
- Tell my providers about ALL medicines I am taking, with or without a prescription, including all over-the-counter drugs, vitamins and herbs
- Update my Medication Record with any changes made by my provider
- Know why I am taking each of my medications
- Know how much medicine to take and what time to take it
- Know about side effects and what to do if I have any

Medication Record

Name	Dose	Color	Shape	How often do I take it?	Why do I take it?	Who ordered the pill?	New? Yes/No

Allergies:

PAM

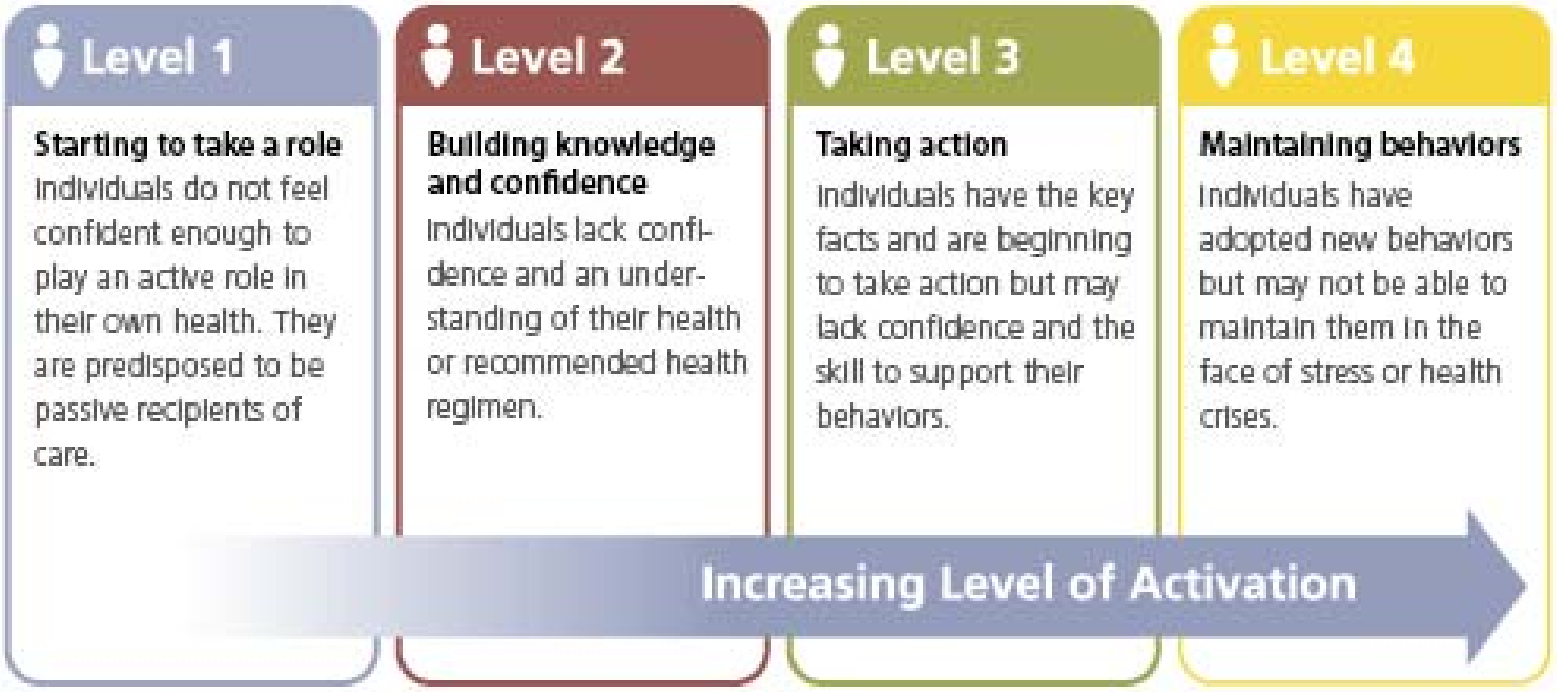
Patient Activation Measure, 13-Item

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. *Your answers should be what is true for you and not just what you think the doctor wants you to say*.

If the statement does not apply to you, circle N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I understand my health problems and what causes them.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11.	I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12.	I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Activation is Developmental



Medicaid population segmentation

25-35%	20-25%	20-30%	20-25%

Higher Readmission Rates for the Low Activated

PAM® OUTCOMES				
	Level I	Level II	Level III	Level IV
Proportion	23%	38%	23%	15%
+ Change	83%	40%	16%	NA
-Change	0%	60%	16%	25%
No Change	17%	0%	66%	75%
Rehospitalization	16%	10%	0%	0%

Source: QualityNet Conference Dec 2010. Alabama Quality Assurance Foundation (QIO)

Before Hospital Visit

RN Coach:

- Receive daily inpatient census from hospital
- Include everyone unless in critical care
  - Common conditions include: COPD, CAD, CHF, GI, Diabetes, Asthma, Renal Failure, Infectious Disease, Severe Mental Illness, Chemical Dependency
- Conduct pre-visit claims review
- Review hospital EMR
- Prioritize by discharge date

During Hospital Visit

RN Coach:

- Review hospital chart
- Meet with member to explain program, build rapport, and explain coach's role
- Give member brochure and administer HRA & PAM
- Review *After Hospital Discharge Checklist* and help patient get their needs met before discharge
- Schedule first after d/c visit if possible; if not, call post d/c to schedule
- Set up LTC assessment if indicated

CHWs:

- If member is homeless, work to find housing
- Speak with member to find out preferences and other needs like clothing and food

During Post-Discharge Meetings

RN Coach:

- Meet with member in SNF, outpatient clinic, shelter, van, friend/relative's home, clean & sober room, etc
- Review all medications with member, including OTC
- Help member to review and update PHR
- Coach member to his/her level of activation
- Identify red flags and build response plan
- Help member to schedule with PCP and specialists as needed
- Encourage member to use PHR with PCP
- Prepare member for graduation from program

CHWs:

- Follow up with needs identified during visits (i.e., medi-sets, clothing, transportation, etc)

After In-Person Meetings

RN Coach:

- Send *PCP Communication Form*
- Transfer care to CHWs

CHWs:

- Re-administer PAM
- Follow up on any additional non-medical needs
- Transfer care back to health plan staff for continued support (i.e., LTC services and care coordination)

Lessons Learned

- Members are inconsistent with follow through and drop in and out of program
- Managing health is often not the priority for members
- Building rapport with member while in hospital is critical
- Members can be suspicious and distrustful of us
- Can take longer than 72hrs to do post d/c visit b/c members are transient and their lives are disorganized
- Members are ashamed to have us in their homes
- Members tend to lose tools or not use as intended
- Homelessness, illiteracy, mental illness, and substance abuse pose unique challenges

More Lessons Learned

- Need to work closely with hospital staff so we are seen as an asset and not an intrusion
- Stakeholders (hospital staff, family members, etc) have varied expectations of Care Transition Coach's role
- Important to integrate this program with health plan Care Coordination
- Flexibility, patience, and compassion are required of staff
- Inspiring hope and believing in the member is key to building self-efficacy
- Take a "trial and error" approach- acceptance of failure is needed

Outcomes & Next Steps

- April readmit rate is 44% lower month over month and 18% lower year over year
- Also seeing reduced ER use, increased outpatient primary care use, and increased PAM scores for members enrolled in program
- Plan to expand to other area hospitals and psychiatric inpatient facilities

Success Factors

- Remaining member-centric
- Including community support services
- Taking a holistic approach
- Expanding RN coach role through use of CHWs and health plan staff
- Sharing the hope for self-actualization

References

[1]Kronick, R. G., Bella, M., & Gilmer, T. P. (2009). *The Faces of Medicaid III: Refining the portrait of people with multiple chronic conditions.* Center for Health Care Strategies.

[2]Kasper, J., O'Malley Watts, M., & Lyons, B. (2010). *Chronic disease and comorbidity among dual eligibles: Implications for patterns of Medicaid and Medicare service use and spending*. Kaiser Commission on Medicaid and the Uninsured.

[3]Gilmer, T. & Hamblin, A. (2010). *Hospital readmissions among Medicaid beneficiaries with disabilities: Identifying targets of opportunity.* Center for Health Care Strategies.

Questions and Comments?

Thank You!

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