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(Tufts) Unify Update to the Implementation Council
February 13, 2018
LTSS Program Overview

Role of the LTS Coordinator

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Agenda
Member Profile

* Population analysis

Assessment and Service Planning

* LTS C Engagement

Current State Assessment

* Process
* Quality

Best practice / ideas for consideration

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LTSS by membership
There are three pie charts depicting LTSS by membership

The first pie chart depicts Members Active At Any Point in 2017

* Members not receiving LTSS Services 3,208 or 73%
* Members receiving LTSS Services 1,205 or 27%

The second pie chart depicts Members Receiving LTSS Services by category, C1, C2, C3

* C1 223 or 19%
* C2 532 or 44%
* C3 450 or 37%

The third pie chart depicts Total 2017 Unify Population by “C” Rating

* C1 1,452 or 33%
* C2 2,294 or 52%
* C3 667 or 15%

Note: 27% of the population is receiving some form of LTSS and 37% of these members are C3s.

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Year over year comparison of Members with LTSS by Rating Category

This is a bar chart depicting the Percentage of Members Receiving LTSS Services by Rating Category and year.

The timeframe is from 2014 through 2017 and identifies the percentage of members who receive LTSS by year for each category, C1, C2, C3

C1 percentages:

2014 – 9%

2015 -18%

2016 -17%

2017- 16%

C2 percentages:

2014 – 18%

2015 -28%

2016 -27%

2017- 23%

C3 percentages:

2014 – 66%

2015 -75%

2016 -62%

2017- 67%

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Percentage of Members Receiving LTSS Services by Type

This is a bar chart depicting Percentage of Total Members Receiving Different LTSS Services during calendar year 2016 and 2017.

The categories and data are:

* Clinical Oversight Services (18% in 2016 and 17% in 2017)
* PCA/Skills Training (7% in 2016 and 8% in 2017)
* Homemaker/Laundry/Companion (7% in 2016 and 6.8% in 2017)
* Meals/Groceries (7% in 2016 and 7% in 2017)
* Personal Emergency Response System (3% in 2016 and 4% in 2017)
* VNA Services (4.5% in 2016 and 4% in 2017)
* GAFC/ADH/AFC (4% in 2016 and 4.2% in 2017)

Based on claims data, clinical oversight and care coordination services drive volume. This is driven by the member’s LTS C.

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2017 Total Inpatient and ED expense trends comparing members with and without LTSS

This is a bar chart, which depicts Median Cost for IP and ED for Members Receiving LTSS and Those Who Are Not

|  |  |  |  |
| --- | --- | --- | --- |
|  | C1 | C2 | C3 |
| IP Median PMPM W/LTSS | $2,173 | $1,202 | $1,749 |
| IP Median PMPM W/O LTSS | $1,147 | $1,103 | $2,100 |
| ED Median PMPM W/LTSS | $96 | $101 | $121 |
| ED Median PMPM W/O LTSS | $68 | $95 | $135 |

Inpatient and emergency room expenses are lower in C3 members receiving LTSS, while the opposite is true for C1 and C2 members

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ED utilization based on unique members with and without LTSS

This is a bar chart depicting the 2016 Number of ED Visits for Members with LTSS Services and for Members Without LTSS Services by visit frequency.

|  |  |  |  |
| --- | --- | --- | --- |
| Visit Frequency | With LTSS | W/O LTSS | Total |
| 1-4 | 498/83% | 742/90% | 1240 |
| 5-10 | 81/13% | 72/90% | 153 |
| 11-20 | 15/2% | 11/1% | 26 |
| 21+ | 7/1% | 3/0% | 10 |
|  | 601/42% | 828/58% | 1429 |

LTSS Services includes PCA, HM, Meals and Transportation. Transportation is the highest volume service among these members. Most of the population, with and w/o LTSS fall in the 1-4 visit range.

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Population Analysis: Summary

* In 2017, 27% of our Unify Population received some form of LTSS service.
* C3s had the highest proportion of members receiving services at 67%, while the C1s had the lowest proportion receiving LTSS, at 15%.
* This trend has been consistent year over year.
* The most utilized services, excluding assessment, were PCA Services, Homemaker/Laundry/Companion services, Meals, and Adult Day Health services.
* Compared to C1 AND C2 members, the C3 members with LTSS had lower inpatient and ED costs

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 Access: How members are referred to an LTS C

1. The care manager completes a comprehensive assessment, including an initial LTSS screen.
2. As part of this assessment, all members are offered an assessment for LTSS services. If the member agrees, a referral is made to the ASAP or ILC and an LTS C outreaches the member and schedules the appointment
3. The LTS C completes the assessment (social/functional) and discusses a service plan based on what the member wants and needs.
4. Once the LTS C assessment and service plan is completed and services are authorized, the care manager and LTS C create a shared care plan that the member has agreed to and care coordination begins.
5. The LTS C becomes a part of the member’s ICT and serves as the member’s advocate.
6. The LTS C participates in any activities that support the embers needs, including case conferences, transitions in care plans, clinical meetings, joint home visits, etc.

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Challenges: Members who refuse a referral to the LTS C

1. Not all members agree to an LTSS assessment.
2. Members who refuse an assessment for services are not consistently offered an LTS C.
3. Cases are closed if there are no active LTSS services, but LTS C will remain active if the care manager feels the member is at risk
4. We have an opportunity to reassess current work flows and ensure all members are offered an LTS C even though they may not be interested in an assessment

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Process: Education/Training about the benefits of receiving LTSS and the role of the LTS C is ongoing

This slide shows Education as an image surrounded by Member, Leadership, Staff/clinical/admin, and Providers; all depicted as box categories. Each has accompanying topics.

Leadership:

* Formal presentations
* Informal dialogue

Staff/clinical/admin

* Orientation
* Ongoing training
* Webinars
* ASAP/ICL clinical
* Staff meetings
* Joint visits with LTSC
* Care conferences
* Rounds

Providers:

* Onboarding process
* ICT participation
* Care Transitions
* Website/Provider

Member:

* Enrollment
* Assessment
* Reassessment
* Care Planning
* Care Coordination
* Care Transitions
* ICT Participants

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Process: Quality and Opportunities for Improvement

The chart is below:

|  |  |
| --- | --- |
| Satisfaction:* *No formal system of measurement*
* Measures in process (mega-rule, NQF)
* Feedback process and documented
* ASAP/ILC clinical and admin meetings
* Consistently offer LTSS assessment
* CAC / feedback/ follow-up
 | Regulatory Compliance:* TATs
* Processing prior auths.
* Response to member referral to CBO
* Receipt of assessment/service plan
* Decision determination
* Access
* Resumption of services post d/c
* *No consistent referral to LTS C*
 |
| Integration w/ care team:* Clinical meetings
* ICT
* Transitions
* CM/LTS C collaboration well documented
* Joint visits (assessment/outreach)
* New functional assessment
* *Access and availability variable*
 | **Improvement / Follow-up*** **Measure satisfaction**
* **Focus on role of the LTS C**
* **Modify assessment tool**
* **Identify additional supports for BH members**
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Process: Best practices/How the IC can help…

The chart is below:

|  |  |  |
| --- | --- | --- |
| Access | Integration | BH Members |
| * Leverage members and member stories in promoting LTSS over handouts
* Promote LTS-Cs as much as the services themselves
* Promote the benefit of having an LTS-Cs
* Opportunity to increase peer support through more education
* Promote ILC services
 | * Increase provider education and awareness to drive LTS-C utilization
* Focus on positive outcomes associated with LTS-C utilization
* Provider promotion of LTS-C services may influence utilization
 | * Community-based BH partners are a critical component of the members care plan
* This is an opportunity for more education and outreach to provider stakeholders
* Many BH members have medical disease burden that impact ADLS
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