January's Care Management Webinar

Wednesday, January 15, 2025

CountyCare
A MEDICAID HEALTH PLAN

Eventa®

Outcomes for Life®

Enhanced Respiratory Care (ERC)

Agenda

- Program Tenets
- What is an ERC Unit?
  - Clinical Levels of Care
  - Why ERC?
- Eventa Quality Oversight
- Provider Requirements
- ERC Impact
- Partnership: From Referral to ERC Stay
- Admission Criteria
- Locations
- Getting the word out
- Next Steps/What to say?

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ERC Program Tenets:

Better for your **Members**

Better for your **Bottom Line**

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What is an ERC Program?

ERC Programs are specifically designed and licensed to care for high-acuity respiratory (vent and/or trach) patients within the walls of a **Skilled Nursing Facility** with a core focus on **Safety, Quality of Care, and Outcomes**.

Facilities must meet Minimum Requirements and Key Performance Indicators for Quality including:

- Improved medical oversight
- Improved staffing
- Improved use of technology
- Improved training and competencies
- Focus on quality outcomes, weaning, reduced complications, and hospital readmissions.
- Quality and Outcomes drive reimbursement based on performance

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ERC Clinical Criteria: Levels of Care

Chronic Ventilator

- Requires Invasive or Non-Invasive ventilation on a daily basis
- Continuous Pulse Oximetry & ETCO2

Weaning Ventilator

- Monitored with Continuous Pulse Oximetry
- ETCO2 checked & documented 1 hour after changes then every 4 hours
- Consistently & progressively weaning toward liberation

Sub-Acute Tracheal Suctioning

- Monitored with Continuous Pulse Oximetry
- ETCO2 checked & documented 1 hour after changes then every 4 hours
- Consistently & progressively weaning toward decannulation

Tracheal Secretion Management

- Must have a functioning tracheostomy with copious amounts of secretions (>25ml)
- Must require one of the following:
  - Suctioning q 3 hours or > 8 times daily
  - Utilizing and airway clearing device at least TID
  - Utilizing heated high flow molecular device

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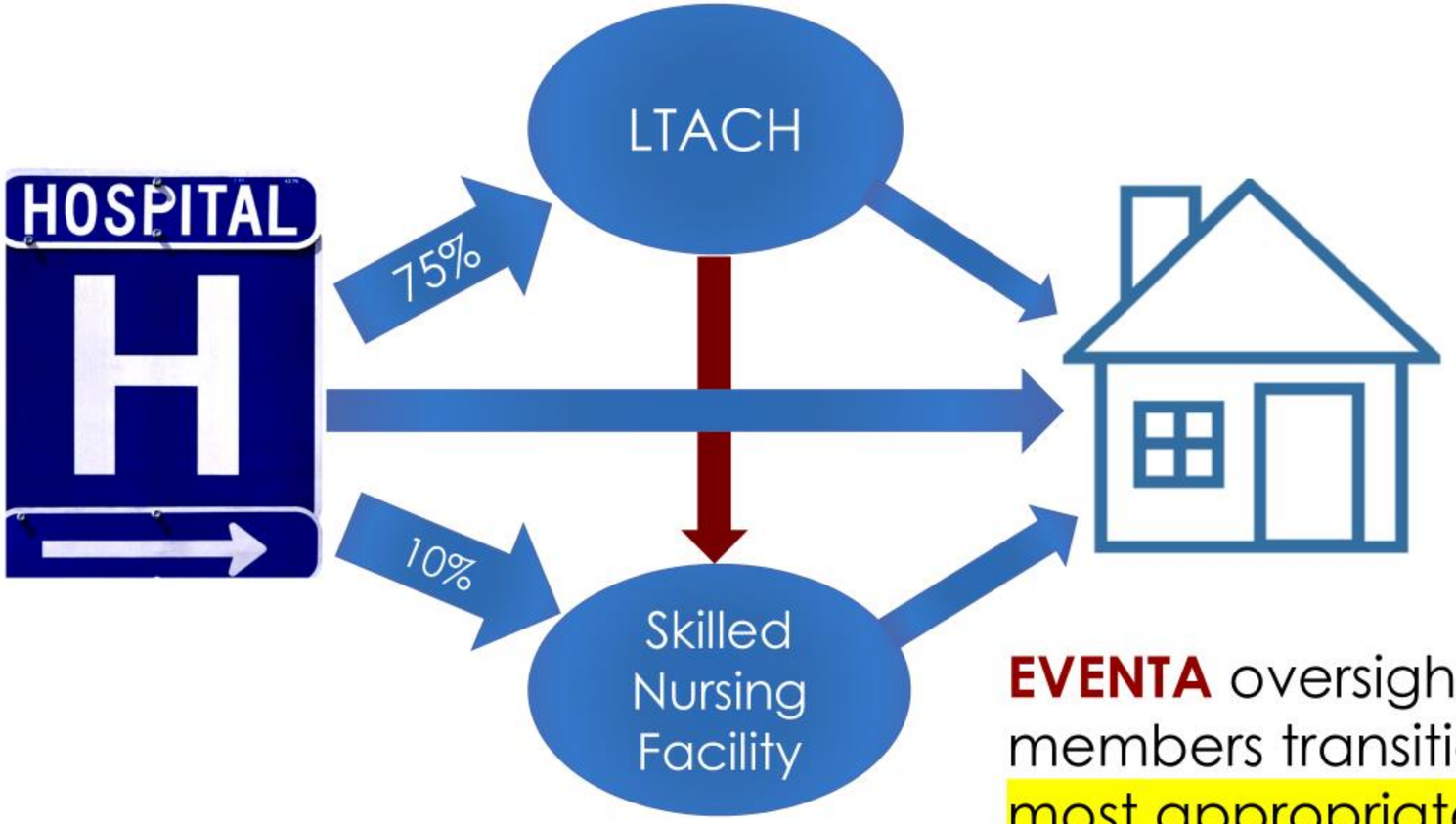
Why ERC? One Consideration

VENT/TRACH patients often go straight to LTACH due to inadequate weaning validation and quality metrics by the SNFs.



EVENTA oversight ensures members transition to the most appropriate and cost-effective level of care available.

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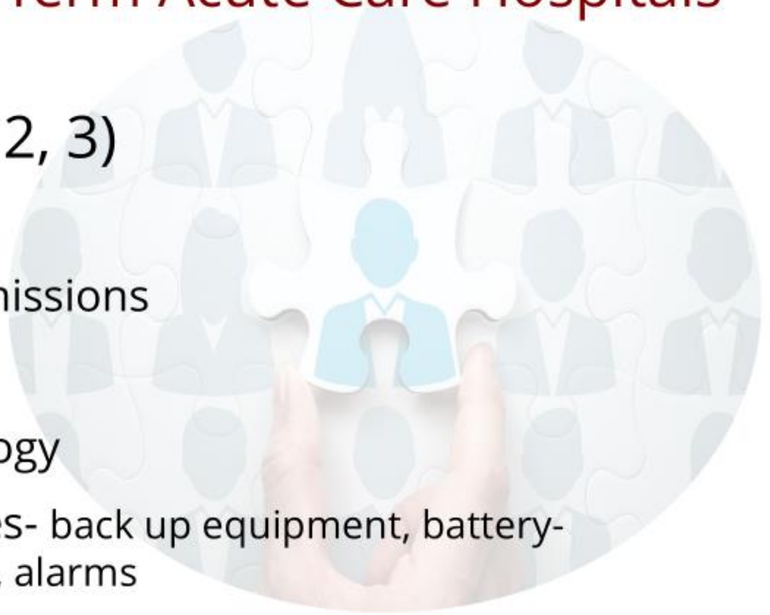
ERC Eventa Quality Oversight- Member Focused

- **Weekly** on-site evaluations by an Eventa Liaison (Respiratory Therapist) for status changes, clinical guidance, and updates.
  - Evaluations are then sent to Evolent for the appropriate Level of Care per diem
  - Calls for rounding/ high days/ high acuity patients
- **On-going** evaluations at the Acute Care and Long-Term Acute Care Hospitals for discharge planning to an ERC facility
- **Bi-annual** KPI audits for payment tiering (Level 1, 2, 3)
  - Ventilator Liberation
  - Trach Decannulation
  - Unexpected Death Rate
  - Staffing Ratios
  - Training and competencies of staff
  - ALOS to Wean
  - Hospital Readmissions
  - Infection Rate
  - Use of Technology
  - Safety Measures- back up equipment, battery-powered options, alarms



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Components Required for SNF Participation

- Pulmonary or Critical Care Medicine Medical Direction with Care Plan Coordination
- Respiratory Therapists 24/7 to provide all respiratory care, device management
- Admission criteria with written assessment for ensuring stability prior to transfer from acute care
- Continuous Pulse Oximetry as indicated by level of care
- End Tidal CO2 as indicated by weaning criteria and level of care
- Alarms: Ventilator audible alarms with redundant alarms connected to emergency power
- Ventilators connected to generator via clearly marked wall outlets
- <u>Ventilators equipped with:</u>
  - Internal and/or external battery backup systems provide a minimum of eight (8) hours of power.
  - Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery-operated concentrators)
  - At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilator or with a tracheostomy
  - A minimum of one (1) patient-ready back-up ventilator which shall be available in the facility at all times
- Ventilator Technology to enable maximum mobility and Comfort: IE: < 15 pounds with various mounting options for portability
- An emergency preparedness plan specific to residents receiving ERC; must address total power failures (loss of power and generator), as well as other emergency circumstances.
- Written training program, including an annual demonstration of competencies, for all staff caring for residents receiving ERC.

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What difference can an ERC Program Make?

ERC Quality Indicator Comparison (Averages)*

	Before ERC	Current
Ventilator Wean Rate	8%	51.6%
Admit to Wean Days	100+	18.8
Unexpected Deaths	17%	0.80%
Decannulation Rate	Not Tracked	54.4%
Unplanned Hospitalization Rate	Not Tracked	20.1%
Infection Rate	Not Tracked	8.2%

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Referral Workflow

Evolent

Identifies candidate or Receives Referral from Hospital

- Early identification of potential ERC Member
- Include ERC Referral plan on communication with Acute Care/ LTACH
- Submits referral to Eventa including key contact person at Acute Care/ LTACH

EARLY IDENTIFICATION IS KEY!

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Receives Referral

Contact Acute Care/ LTACH Facility: If contact is not achieved after 3 attempts, contact the Unit Secretary with a visit notification

- Completes Visit including feedback to on-site CM/UM on qualification or any necessary follow up
- Notates person of contact and any follow-up needs on evaluation
- Submits evaluation to Evolent via email with summary
- If re-evaluation is required to meet ERC status, Eventa will follow up, unless directed otherwise, as indicated on the evaluation and a follow-up evaluation will be submitted.

Evolent

Receives Evaluation

Aids in facilitating an appropriate discharge

Updates Eventa on member's discharge status

CME

CME Notified

Outreach to member and/or family to notify of program candidacy and ERC Facility options for discharge

Critical Step in Program Success!

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How does the partnership work?

Evolent contracts with Eventa to provide Quality Oversight and Clinical Navigation for mechanically ventilated or tracheostomized Members identified for potential ERC admission.

Member is identified as Complex Care (Vent/ Trach) by the Evolent UM Team using tools and processes developed through collaboration

Evaluation Request is sent to Eventa. Eventa completes clinical review (virtually, clinical review, or face to face) at ACH, LTACH, or SNF

Eventa collaborates with Evolent UM Team,

Facility UM Team and Potential SNF to facilitate admission to an ERC Program

Once admitted to an ERC SNF, Eventa follows the patient to ensure quality of care meets ERC Standards for your Member

Eventa provides comprehensive clinical updates to the Evolent UM Team throughout the member's time in the program including during any incidental returns to Acute/LTACH care

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*Data as of 01/26/2024

ERC Admission Criteria

➢Non-respiratory organ dysfunction stabilized Criteria

- Sepsis treated & controlled
- Hemodynamically stable & no need for hemodynamic monitoring
- No uncontrolled arrhythmia or heart failure
- No uncontrolled hemorrhage
- Controlled blood sugars no higher than 200
- Renal function and acid base balance stable
- New trach in place for 72 hours
- Does not require a Complex IV regime

➢Nutrition Criteria

- Must have PEG if unable to pass swallow study

➢Restraint Criteria

- Free of Chemical Restraints
- Free of Physical Restraints for >24 hours
- IV sedation weaned to P.O. or per tube at least 24 hrs prior to admit

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➢Treatment plan for all medical conditions in place

- Will not require frequent treatment changes
- Can be implemented at alternate care site
- DVT prophylaxis in place Heparin vs. Coumadin
- Recent skin assessment
- Weight bearing status & therapy orders current
- All infectious conditions addressed

➢Respiratory Stability

- Safe and secure airway
- FiO2 less than 50%
- Sa02 greater than 90%
- PEEP less than 10
- Relatively stable airway resistance & lung compliance
- Oxygenation stable during suctioning & repositioning
- Non-ventilator patients stable off vent no less than 24 hours
- Stable ventilator settings

ERC Exclusions

The following criteria will not admit to an ERC Facility:

- Sex Offender
- Opioid or Opioid replacement therapy Chest Tubes
- Pharmaceutical Hemodynamic Pressures
- LVAD
- Chest Tubes
- Endotracheal Tube

Dialysis can be managed at the following facilities:

- Elevate Care Chicago North
- Generations Oakton
- Generations Regency

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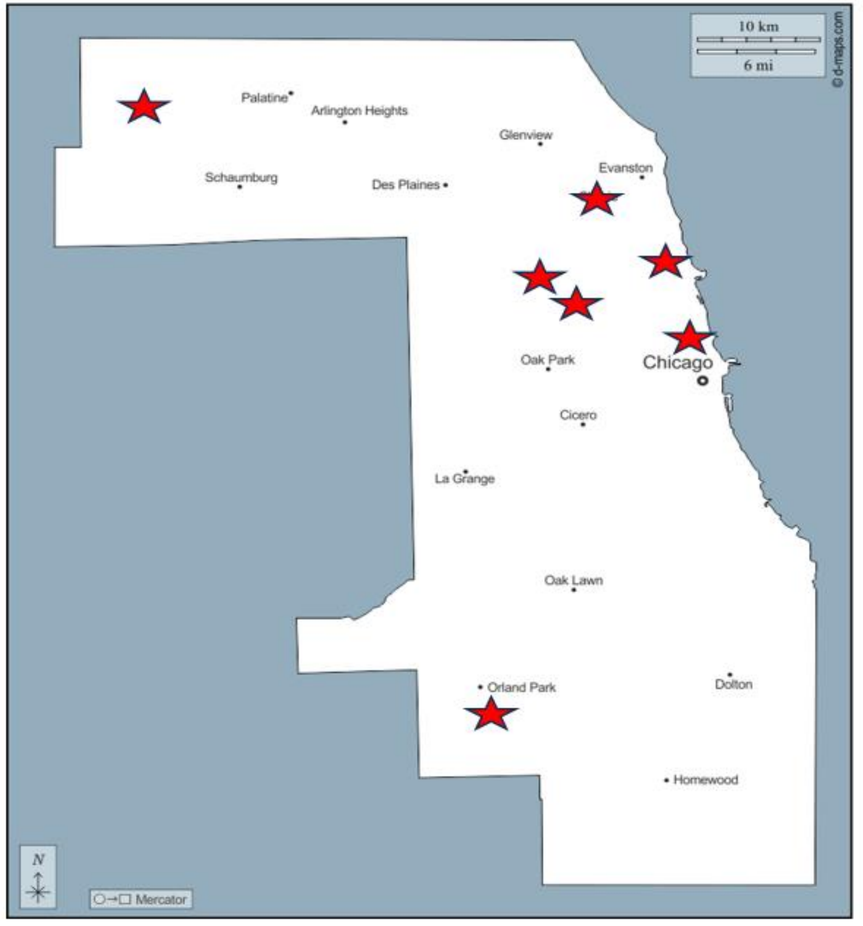
ERC SNF Locations

- Alden Barrington
- Alden Lakeland
- Alden Orland Park
- Elevate Care Chicago North
- Generations Oakton
- Generations Regency
- Warren Barr South Loop



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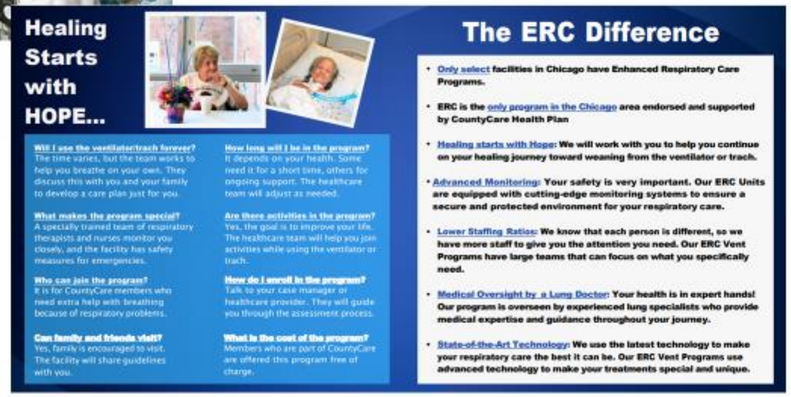
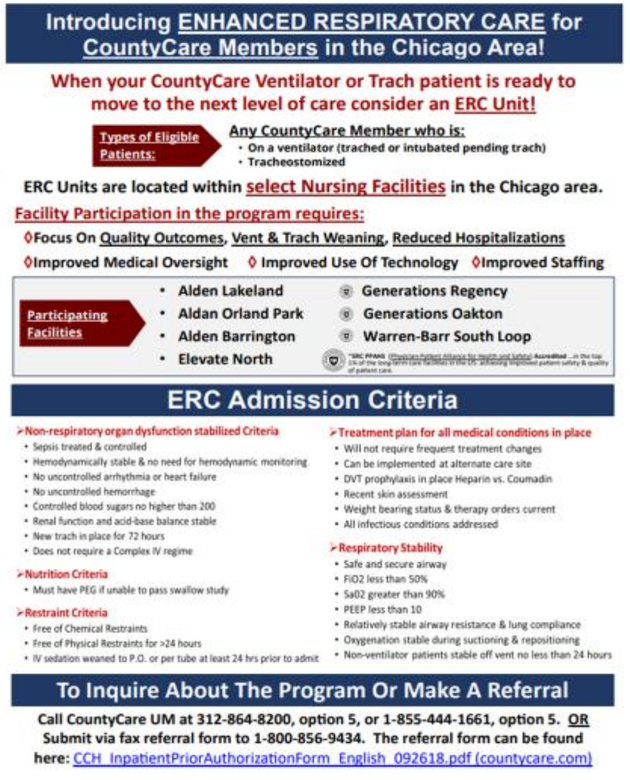
Getting the Word Out

Goal to improve admissions to **ERC SNF** vs *Non-ERC SNF* with increased visibility at the Acute Care and LTACH setting

Member and Family focused Brochure

Clinically focused Brochure for Acute Care and LTACH setting





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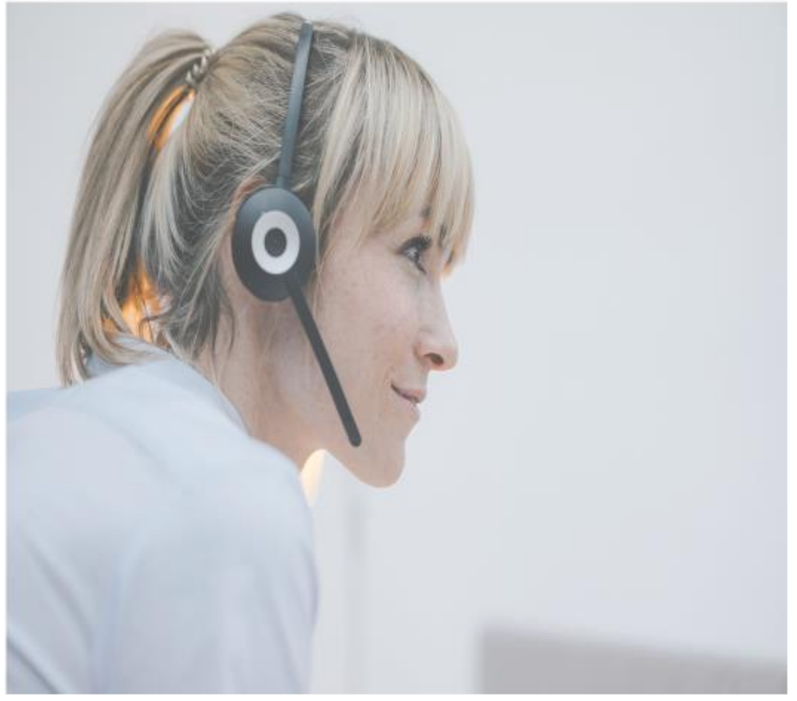
What to say?



Script for outreach to CM teams

Phone Script for call to Hospital Discharge Planner:

This is *<insert>* Care Manager for CountyCare. I am calling to notify you that *< insert member name>* has been accepted into our Enhanced Respiratory Care Program with Eventa.

Can you work with member's current facility and their family to educate them on option to discharge to one of our seven Enhanced Respiratory Care facilities in the program?

The ERC Program will give them added support for respiratory care to achieve outcomes such as weaning and reduced return to hospital visits.

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What to say?

If family or member asks why member needs ERC or to discharge to ERC SNF:

Eventa has been working closely with these seven VENT SNF facilities. Eventa is not employed by the facility which allows advocacy for the member with in-person visits and clinical oversight.

As an advocate, Eventa will provide the SNFs recommendations on the member's respiratory care to help optimize improved clinical outcomes for respiratory health (example--weaning off of the vent, decannulation, reduced return to hospital visits, etc).

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If family or member wants to know which SNFs to refer member to:

Our Enhanced Respiratory Program is offered at seven locations throughout the Chicago area to allow family visitation and participation in the member's care:

- **Alden Barrington**
- **Alden Lakeland**
- **Alden Orland Park**
- **Elevate Care Chicago North**
- **Generations Oakton**
- **Generations Regency**
- **Warren Barr South Loop**

If member wishes to receive the benefits of this program, they can transfer to one of these facilities.

You can contact your social worker or discharge planner at member's current facility to help coordinate this transfer, or I will contact them to notify that you (or member) wish to start transfer to an Enhanced Respiratory Care SNF.

Why Eventa…

- **Experience**: 40 years of post-acute care; founded and managed by Respiratory Therapists
- **Expertise**: 12 years of Long-Term Care and Population Health with ERC programs in Tennessee; over 25 years of outcomes-driven respiratory programs for high acuity patients throughout the world
- **Outcomes**: Proven outcomes with multiple providers and payers
- **Independence**: No affiliation with DME, HHA, or Manufacturing companies

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2024 – Eventa Leadership

Gene Gantt

President, CEO

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Scott Gantt

Vice President

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Kendra Mato

COO

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Katie Kirk

Director of Clinical Programs

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Leah Anderson

LTSS Manager

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HBIA/HBIS HSAG AUDIT REMEDIATION TRAINING

Kasey Reid, LCSW

Manager, Care Management

CM Oversight Team

1/15/25

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Agenda

1. HSAG Post-Implementation File Review Scores
2. Remediation elements per HFS Contractual Agreement

    1. IPOC will include, as appropriate, community resources.
    2. IPOC will include, as appropriate, the following elements: back up plan arrangements for critical service.
    3. IPOC will include, as appropriate, crisis safety plans for an enrolle with behavioral health conditions.
    4. The Enrollee Care Plan is signed by the enrollee or authorized representative.
    5. The enrollee was provided a copy of care plan upon completion a as requested.
    6. After the care plan was reviewed and updated, the health plan shared it with providers who are involved in providing covered services to the enrollee within 10 days.
    7. The case manager made timely contact with the enrollee or there valid justification in the record.

1. Q &A
2. Next Steps

Remediation Element

IPOC will include, as appropriate, community resources.

HealthChoice 2018-24-001, Section 5.15.1.4.12

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HSAG Feedback:

- Evidence that within care plan that enrollee was linked with community resources.

County Care/HFS Requirement:

- If the member reports a need: food, housing, utilities, transportation, etc., there should be information within care plan/note or CM system that indicates member was linked with appropriate services.

Recommendation:

- Address socio determinants of health and document within IPOC or CM system that member was referred/linked to community resources: Food Smart, housing, Modivcare, etc.

Remediation Element

IPOC will include, as appropriate, the following elements: back up plan arrangements for critical service.

HealthChoice 2018-24-001, Section 5.15.1.4.17

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HSAG Feedback:

- Evidence that back up plan arrangements for critical service.

County Care/HFS Requirement:

- Members who are at risk, should have an individualized Back-Up Plan (Plan) to assist with minimizing any potential risk factors as part of the person-centered planning process.
- The plan assists the member, family members/authorized representatives, the care coordinator, and the providers(s) identify key contacts in case of an emergency or an urgent need of service for the member.

Recommendation:

- Document within IPOC the back up plan or within CM system for members who has any potential risk factors. For example: If member have unmet chronic condition that may cause them to go to the ER/hospital, we should be showing evidence that CC advised member to contact their PCP or Medical Home, and provide a list of urgent care facilities within their area.

Remediation Element

IPOC will include, as appropriate, crisis safety plans for an enrollee with behavioral health conditions.

HealthChoice 2018-24-001, Section 5.15.1.4.18

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HSAG Feedback:

- Evidence that a crisis safety plan for enrollees with behavioral health diagnosis.

County Care/HFS Requirement:

- An individualized plan is developed for members who have a behavioral health diagnosis or had a recent BH crisis/hospitilization.
- Plan includes linkage to their BH provider; CARES crisis line and other BH resources (NAMI; National Suicide Prevention Lifeline; Veteran's Crisis Line, etc.) for mental health emergencies.

Recommendation:

- Document within IPOC the crisis safety plan or within CM system.

Remediation Element

The Enrollee Care Plan is signed by the enrollee or authorized representative.
(HealthChoice 2018-24-001, Section 5.15.1)

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- **HSAG Feedback:**
- Evidence of signature from member or authorized representative or voice recording stating that member agrees w/care plan (IPOC).
- **County Care/HFS Requirement:**
- Member or authorized representative signature on IPOC.
- Voice/Verbal Recordings that state member's name, DOB, etc., and agrees with goals w/in care plan are acceptable to meet this element.
- Voice Recordings that state that member agrees w/care coordination is **not acceptable**.
- **Recommendation**
- Ensure that the audio recording is working properly and the sound quality is clear.
- *Reference CM Manual (IPOC Requirement section; pg. 72).*

Remediation Element

The enrollee was provided a copy of care plan upon completion and as requested.

(HealthChoice 2018-24-001, Section 5.15.1)

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HSAG Feedback:

- Evidence that a copy of IPOC was sent to member within record: ie; evidence of mailing, faxed, etc.

County Care/HFS Requirement:

- Document within a Care Plan Note that the IPOC was faxed, mailed, or sent to member if care management system does not have the capacity to show mailings/faxes.
- Check boxes within CM system that indicate that you shared the care plan w/member (if applicable) is not accepted.

Recommendation:

- Use specific note type: ex. Shared Care Plan and include verbiage in note.
- Document that interpreter/translator was used when sharing Care Plan that is not in member's preferred language.

Remediation Element

After the care plan was reviewed and updated, the health plan shared it with providers who are involved in providing covered services to the enrollee within 10 days.

(HealthChoice 2018-24-001, KA12 Amendment, Section 5.16)

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HSAG Feedback:

- Evidence to show that IPOC was shared with the Interdisciplinary Care Team within 10 days of reviews/updates.

County Care/HFS Requirement:

- IPOC shared with ICT within 10 days of developing care plan and any updates/reviews.
- Show evidence that care plan was shared with ICT via fax, mail, etc.
- Document in note within CM System that Care Plan was shared with ICT.

Recommendation:

- Update ICT within member's record to show the current/most up to dated ICT that are involved with member's care and show evidence that it was shared.

Remediation Element

The case manager made timely contact with the enrollee or there is valid justification in the record.

(HealthChoice 2018-24-001, Section 5.17.3)

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HSAG Feedback

- Evidence between case manager and member that ensures the member's health, safety and welfare and referrals are made to address any needs.
- Evidence of contact w/member at least every 90 days for Level 3 and 2 members and more frequent contacts based on member's condition/needs, ie., TOC event, referral needs, chronic conditions that are not being met or may lead to hospitalization.
- Face to Face every six (6 months) with case manager or ICT and evidence that goals w/in care plan are being addressed during those visits.

County Care/HFS Requirement:

- Each contact/visit with member should address IPOC goals, include any needs addressed in the HRA and/or any social determinants of health (housing, food, transportation, etc).
- Member's health safety and welfare should be addressed in contacts with member. Ex: TOC event, include verbiage that addresses any follow up appointments, medication adherence, DME needs, ext.
- Documentation/notes should include referrals to community resources.
- If the contact is F2F w/care manager or ICT, the goals of care plan should be discussed and documented within record.

Recommendation:

- Develop a template that includes verbiage that addresses member's health, safety and welfare within contact notes w/member as well as referrals made to address the needs.

Q & A

Thank You.

Member Incentive Program Updates

Ashley Tolliver

January 15, 2025

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Visa Rewards Changes effective 1/1/2025

Reward	Current Requirements	New Requirements	Reward frequency
Redetermination Reward	Members who complete their redetermination paperwork receive $40.	Removal of reward effective 1/1/2025.	NA

Additional Incentive Changes:

Category	Current Benefit	Proposed Benefit
FoodCare Nutrition Program	Unlimited dietician visit	Maximum 1 visit per month unless members meets specific criteria. Final proposal TBD (visit frequency may change).
Sleep Safe Kit	Members complete 4 prenatal visits to qualify for Sleep Safe Kit delivery to their home.	Pregnant members can call Member Services to request a Sleep Safe Kit with no additional requirements.

Vision Supplemental Benefits

Member Demographic	Current Benefit	New Benefit
Adult	Glasses, once every 2 years and $100 allowance	Glasses once every 1 year and $125 allowance
Adult	$100 for contacts every 2 years in place of glasses	$300 for contacts every 1 year in place of glasses
Child	$100 for glasses every year	$125 for glasses every year
Child	$100 for contacts every year in place of glasses	$300 for contacts every 1 year in place of glasses

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Member Incentive Program

- **CountyCare Rewards Card Program**
- When a member or their children goes to the doctor for certain services, CountyCare will send them a CountyCare Visa Rewards card in the mail.
- Members can use the funds to buy, pay for or purchase from most places Visa is accepted. This includes, but is not limited to: gas, utilities, internet, clothing, groceries or transportation.

Reward - 2024	Amount
Annual Health Risk Screen (HRS)	$50 per member per year
Care Management Annual Satisfaction Survey	$15 for members enrolled in care management that complete annual satisfaction survey
PCP Annual Check-Up	$50 per member per year.
Well-Child Visits up to 15 months	$50 for visit in the first 30 days after birth and $10 for each of the next five visits
Prenatal Visits	$50 for 1st trimester visits; 10 per visit for 2nd & 3rd trimester; limited to 14 visits **AS OF 11/1/23**
Post-Partum Visit	$50 for seeing doctor within 21 to 56 days after delivery **AS OF 11/1/23**
Childhood immunizations (ages 0-24 months)	$10 per immunization up to 10
Mammogram (Female 45-74)	$50 per member per year.
Colorectal Cancer Screening (ages 45-70)	$50 per member per year.
Cervical Cancer Screening (Female ages 21-64)	$50 per member per year.
Annual Diabetic PCP Visit and Screening	$25 when member gets annual blood tests and urine screens
Statin Drug	$25 for members with diabetes and pick up their first statin drug prescription (one-time)
Flu Shot	$75 per member per year, 24 months and younger; $25 for members above 2 years
Notification of Pregnancy	$50 for completing and submitting the form.
Behavioral Health Follow-up Visit	$100 for follow-up within 7 days after an ER visit or hospital inpatient BH stay $50 for follow-up between 8-30 days after an ER visit or hospital inpatient BH stay
Hospital Admission Follow-up Visit	$20 for follow-up with your doctor within 14 days of inpatient stay
COVID-19 Vaccinations	$50 for first vaccine, $10 for second vaccine, $10 for boosters AS OF 1/1/23
Tdap Vaccine	$25 for members between 10-13 who receive vaccine
Meningococcal Vaccine	$25 for 1st vaccine, $10 for booster (Members 11+)
HPV Vaccine	$25 for first vaccine, $50 for 2nd vaccine; (Members between 9-13)
Diabetic Eye Exam	$25 for members with diabetes who complete eye exam

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Announcements

- Next webinar is February 19th, 2025!
- Slides posted on CountyCare Care Coordination Webpage:
  - http://www.countycare.com/carecoordination
- Have feedback? Ideas for future topics? Please share!
  - https://redcap.link/23k1fzzb

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- Please email questions/concerns: stephanie.nickles@cookcountyhealth.org