



# Monthly Care Coordinator Webinar:

## May 22, 2019



**CountyCare**  
HEALTH PLAN  
AN ILLINOIS MEDICAID HEALTH PLAN



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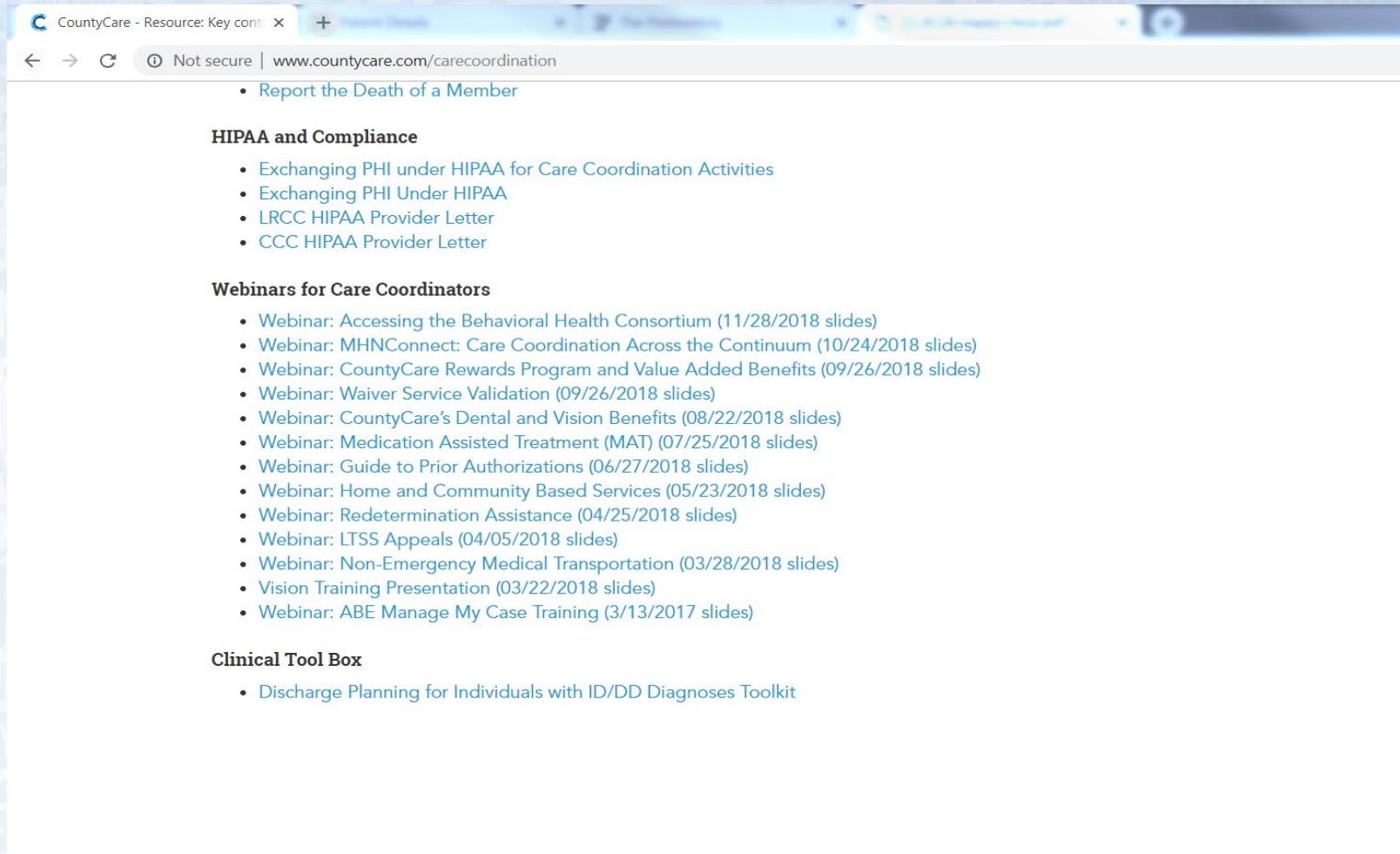


# Webinar Agenda

1. NTOCC Presentation
2. HEDIS Spotlight
3. Care Coordinator Thank You Spotlight
4. Questions



## Just a reminder...Visit CountyCare Care Coordination Website





# National Transition of Care Coalition (NTOCC)



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# Improving Transition of Care Across the Continuum of Care

Cheri Lattimer, RN, BSN

Executive Director

National Transitions of Care Coalition (NTOCC)

*CountyCare's Monthly Care Coordination Webinar*

*May 22, 2019*



# Meeting the Need of the Industry

- Founded on 2006
- Address the issues of poor transitions of care that negatively impact seniors
- Convene experts and apply evidence based clinical practice guidelines
- Mobilize resources to optimize appropriate coordination across all channels & care states
- Develop resources for the industry at no cost plus ensure they are available to all providers, patients and their family caregivers





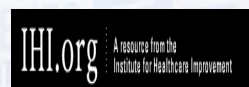
# NTOCC Becomes a Coalition 2007





# Diverse Organizations and Professionals Advise and Support NTOCC

These groups represent over 200,000 health care professionals, 11,000 employers and 30,000,000 consumers throughout the United States.





# NTOCC's Mission & Vision

## Mission

NTOCC's mission is to increase awareness about transitions of care among healthcare professionals, government leaders, patients and caregivers and to improve the quality of care, achieve safe and cost effective patient and family centric transitions and enhance clinical outcomes

## Vision

The NTOCC Vision is to achieve optimal transitions of care across the healthcare industry in collaboration with patients and families



# NTOCC Priorities

## Ensuring Focus on Transitions of Care & Care Coordination Improvement

- *Acute Care Readmissions*
- *Post-Acute Care*
- *Behavioral Health*
- *Chronic Care Management*
- *Opioid Abuse & Misuse*





# Health Care Needed A Transformation

*The Current Process Is Not Working*

***The Vision***

“To provide health care services and support to all consumers including health prevention, care coordination, and appropriate resource utilization. To promote quality of care to improve quality of life for our citizens. A commitment to processes that focus on education, consumer advocacy, clinical optimization of resources, patient safety, and technology to achieve superior clinical and financial outcomes with positive member and provider satisfaction”

**Critical  
Business  
Issues ?**

Needs

***Optimum Health***

***Fragmentation & Silo's of Care***

***Growing Cost of Chronic Care***

***Access to Care Options (24x7)***

***Inconsistent Approaches***

***Collaborative Team Practice***

***Whole Person Care Approach***

***Transitions of Care Facilitation***

***Technology Advancements***

***Regulatory/Gov't Imperatives***

***Premium Increases, MLRs and  
Provider Payment***



# Health Care Policy Brings Innovation, Creativity, & Opportunity

## New Models of Healthcare Delivery and Reimbursement

Patient-Centered Medical Home (PCMH) Primary Care Practices

Accountable Care Organizations (ACOs)

Integrated Health Delivery Systems

Population Health Management

Comprehensive Primary Care

Outcomes-Based Reimbursement With Shared Risk

Value Based Purchasing of Health Care Services

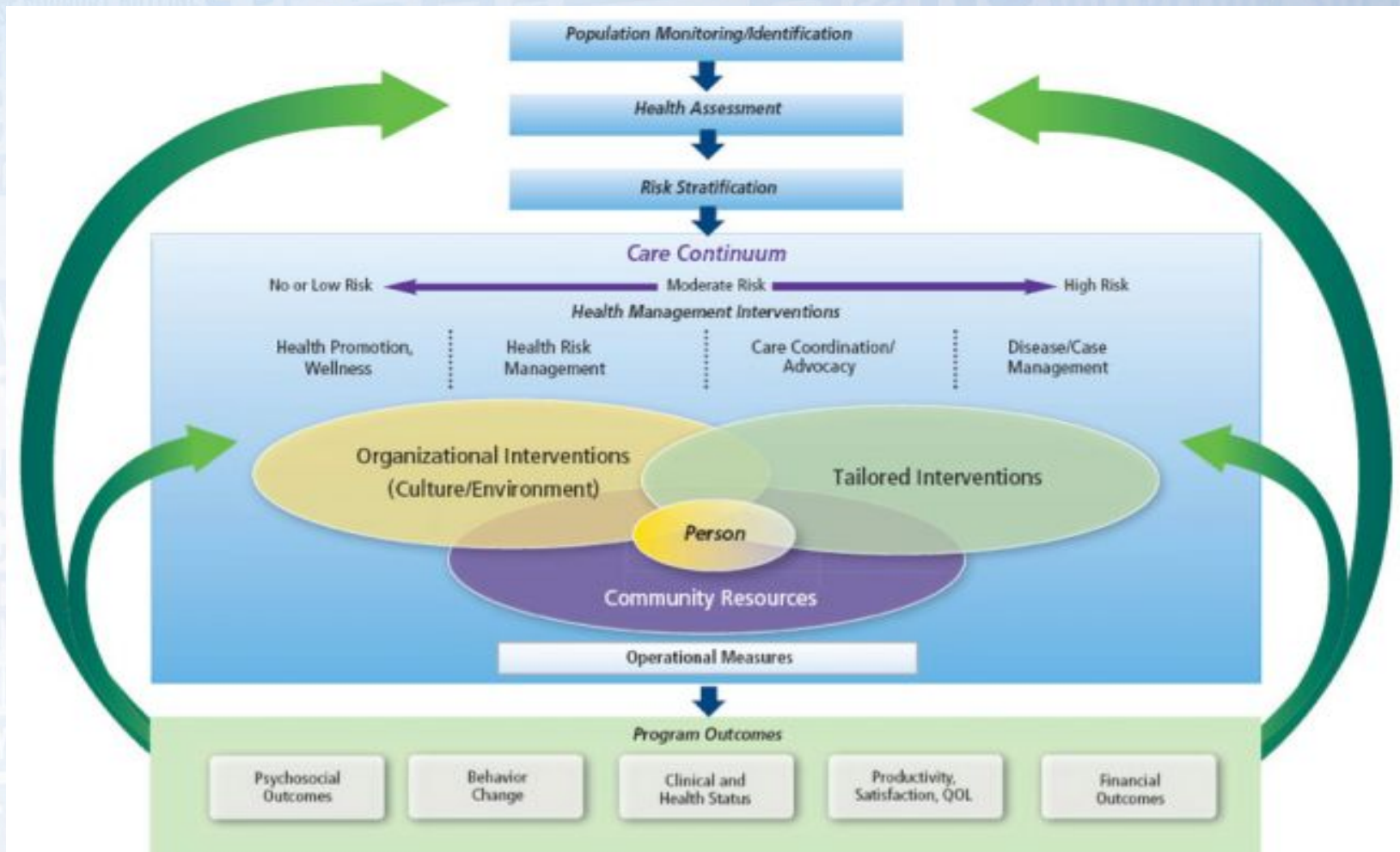


# What These New Models Require

Processes to promote evidence-based medicine, patient engagement, and care coordination, including:

- Patient-centered philosophy and operations
- Coordinated and integrated care
- Use of evidence-informed medicine
- Use of health information technology for data sharing/reporting capabilities
- Continuous quality improvement processes

# Population Health Conceptual Framework





# Moving Towards A Collaborative Care Model

Table 1

## Conventional vs. Collaborative Care

Conventional	Collaborative
Authoritarian	Collaborative
Autonomous practice culture	Team culture
Physician driven, with physicians accountable for care outcomes	Patient centered, with team members sharing responsibility for care outcomes
Episodic, fragmented	Continuous, coordinated
Primary care delivered in one-size-fits-all, 15-minute visits	Primary care delivered via individualized visits, phone calls, and online communication
Payment based on quantity (fee for service)	Payment based on value (considers both quality and cost)
Reactive, focused on illness	Preventive, focused on health
Communication is inconsistent	Communication is imperative

# Financial Concerns over Poor Care Transitions

*Hospital readmissions within 30 days after discharge are estimated to account for more than \$17 billion in avoidable Medicare expenditures.*





# Financial Costs of Poor Transitions

Suboptimal care transitions from the hospital to other care settings have been estimated to cost up to

**\$44,000,000,000**

Costs associated  
with poor  
transitions include



medication errors



complications from  
procedures

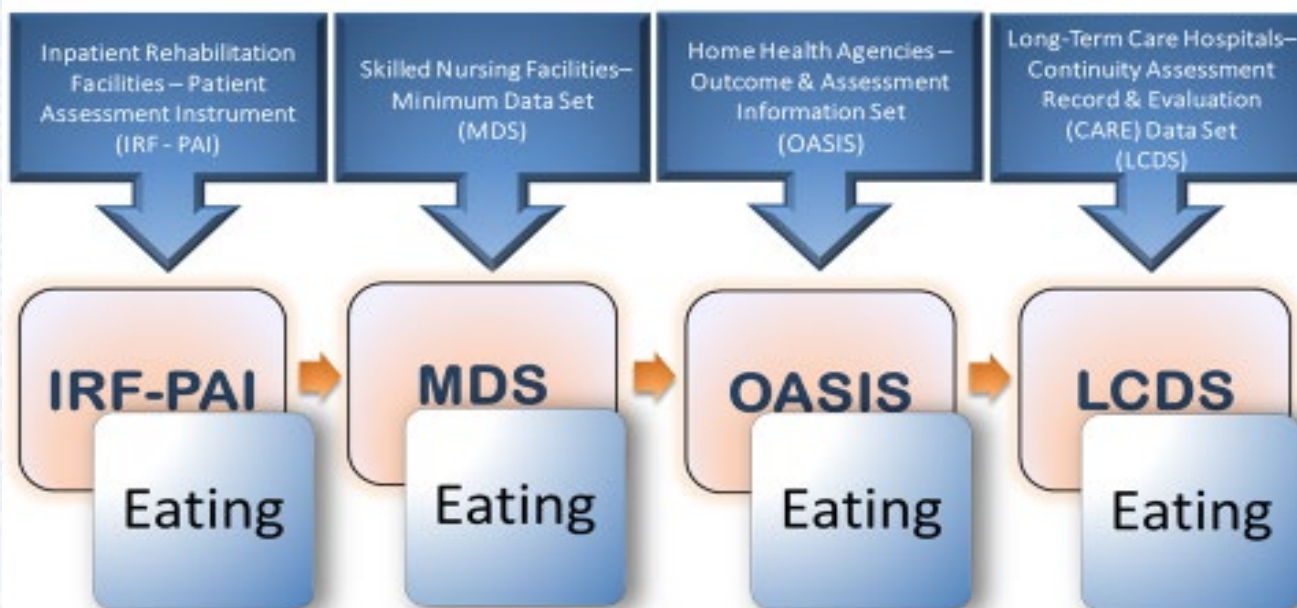


falls

New payment models – such as bundled payments and shared savings programs for Accountable Care Organizations – create financial incentives for providers to coordinate transitions and provide care in less intensive settings.

# IMPACT – Standardization of Assessment Data

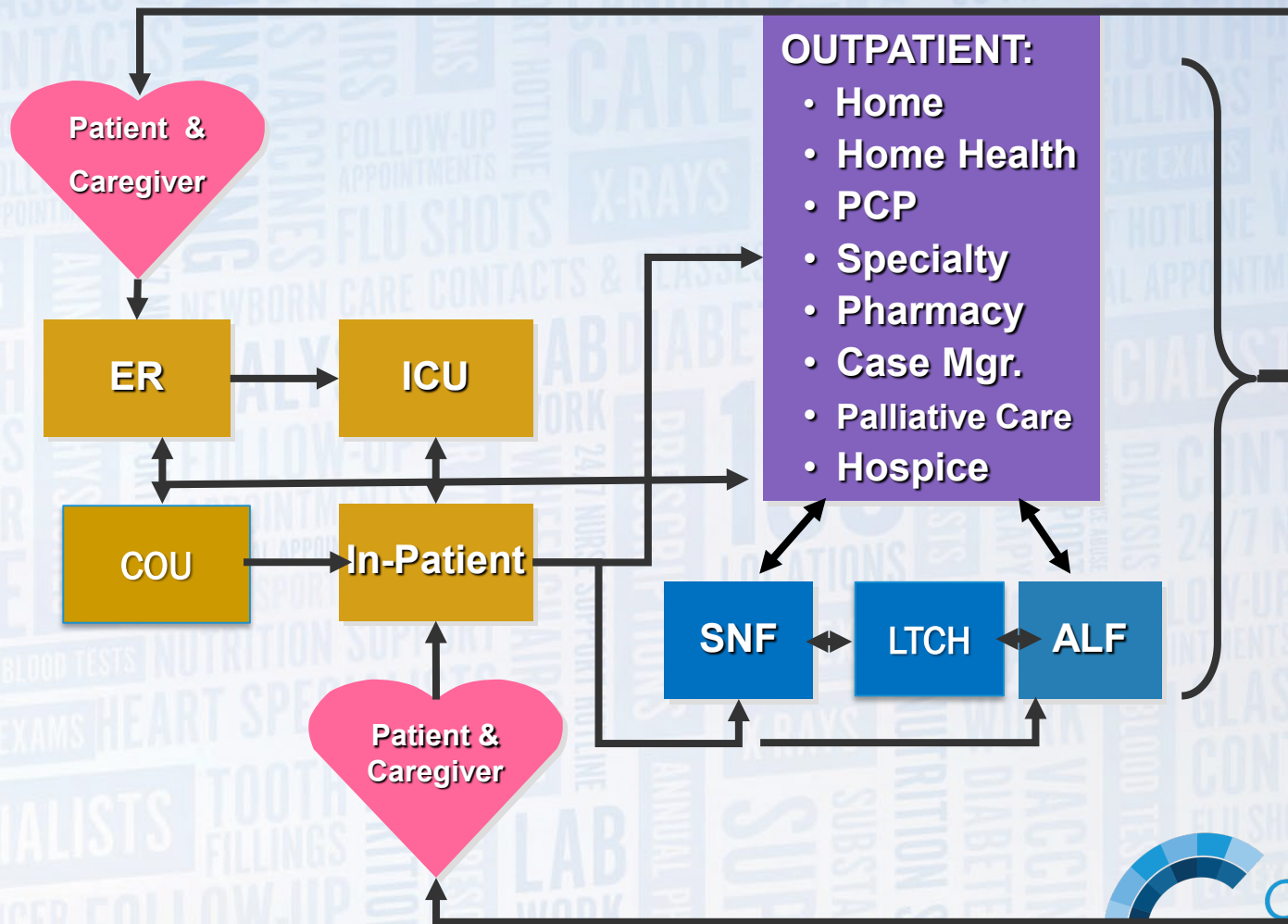
## Standardizing Function At The Item Level



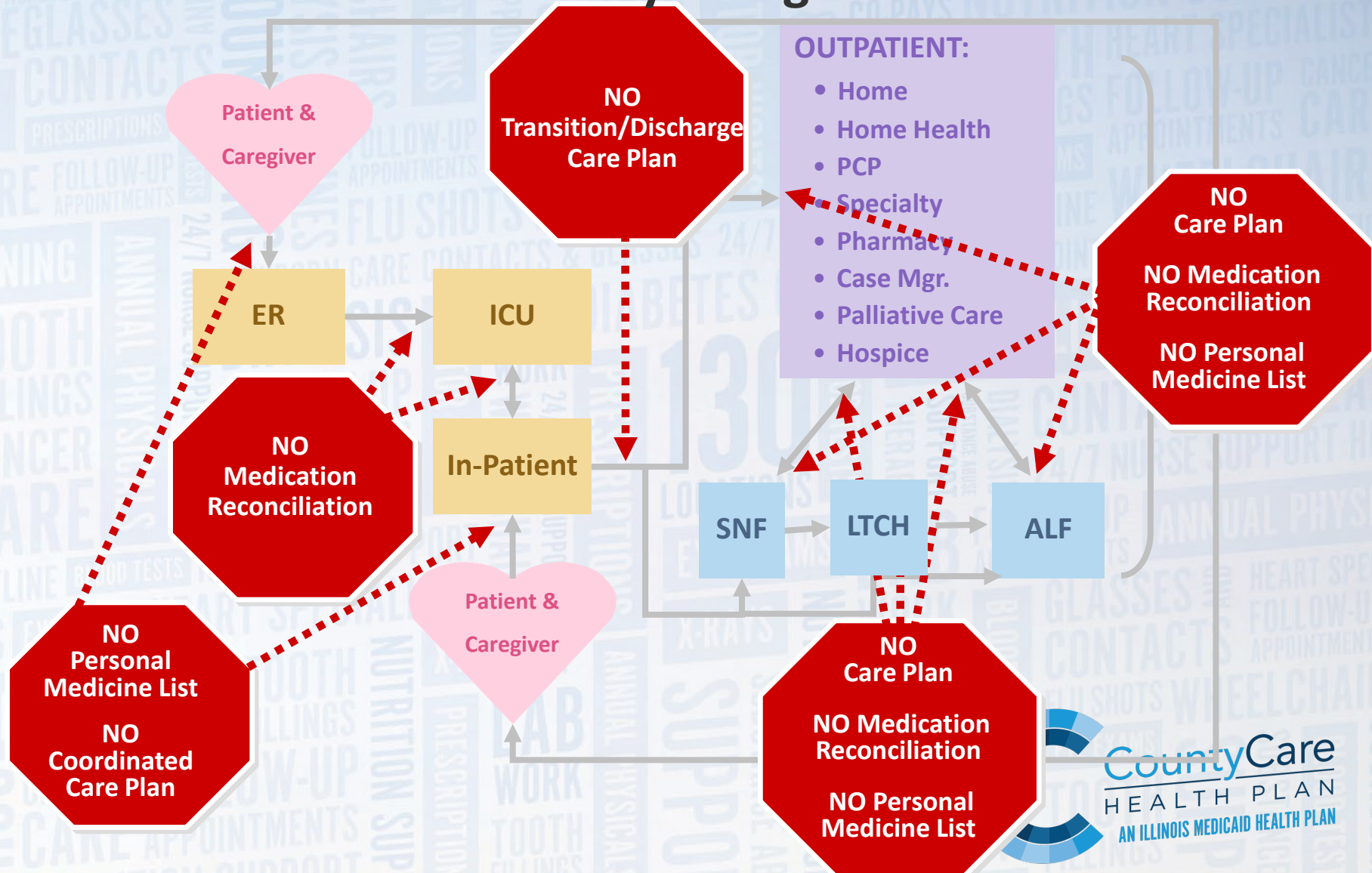
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# Transition Issues Dramatically Impact Patients & Their Family Caregivers



# Transition Issues Dramatically Impact Patients & Their Family Caregivers & Providers





# NTOCC's Seven Essential Interventions Categories

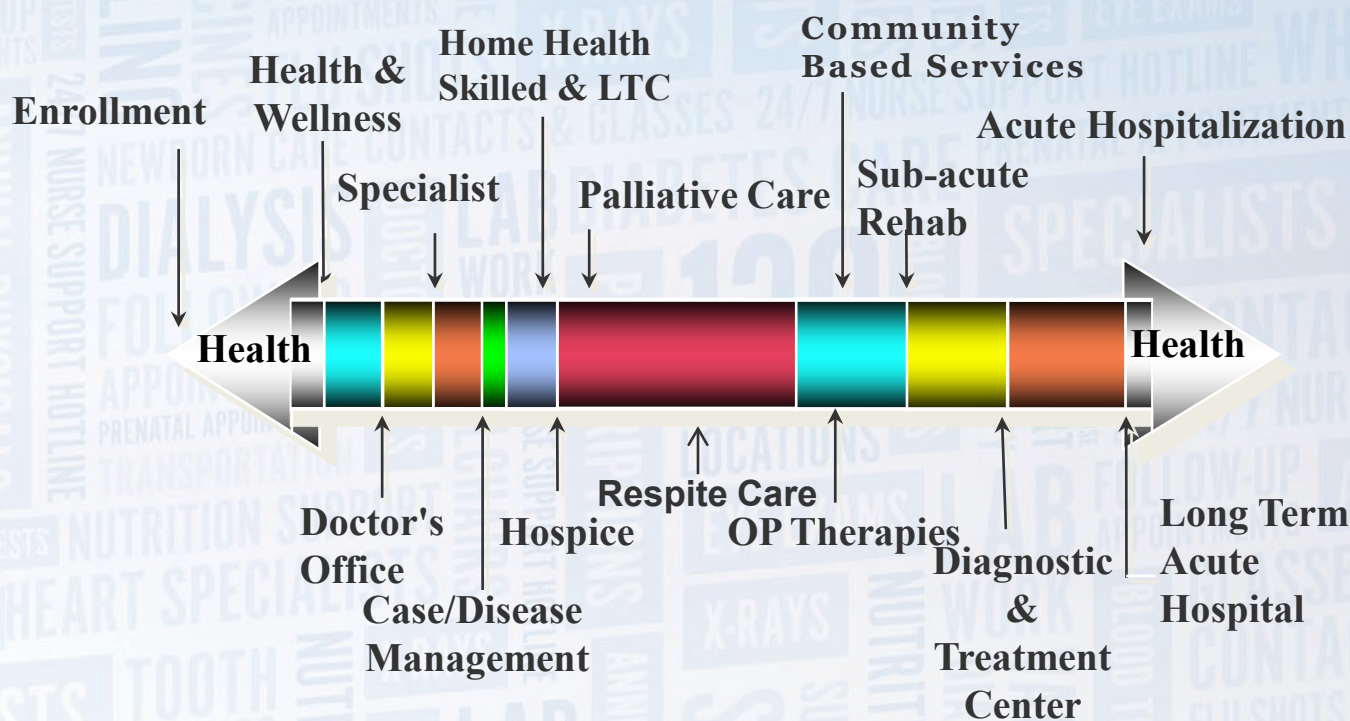
- 1 Medications Management
- 2 Transition Planning
- 3 Patient and Family Engagement / Education
- 4 Healthcare Providers Engagement
- 5 Follow-Up Care
- 6 Information Transfer
- 7 Shared Accountability across Providers and Organizations

<http://www.ntocc.org/Toolbox/browse/>



# Continuum of Care & Spectrum of Services

How will you coordinate care beyond your service?





# Improving Care Coordination Means Improved Communication & Strong Team Collaboration

No one *Professional* has the total responsibility for care coordination – *it is a team effort*



# Creating the Collaborative Clinical Team



**Collaboration among physicians, pharmacist, nurses, case managers, social workers, allied health and supporting staff is critical to achieving the goals of the team, the organization and changing the way we deliver healthcare today**



# Role of the Professional Case/Care Manager

- A complete assessment of Medical, Behavioral, Social and Health system issues and concerns
  - Patient and family advocacy identifying and supporting patient preference
- Defining and improving educational & knowledge deficits
- Development of a plan of care that supports the patient and family in working with their care team, including SDOH
  - Collaboration with the pharmacist in developing the patients medication lists and understanding the medication regime
- Assisting the patient and family in recognizing “red flags” for symptom escalation
- Enhancing care coordination and access to care options
- Communication, motivational support, health coaching and clarification of miscommunication

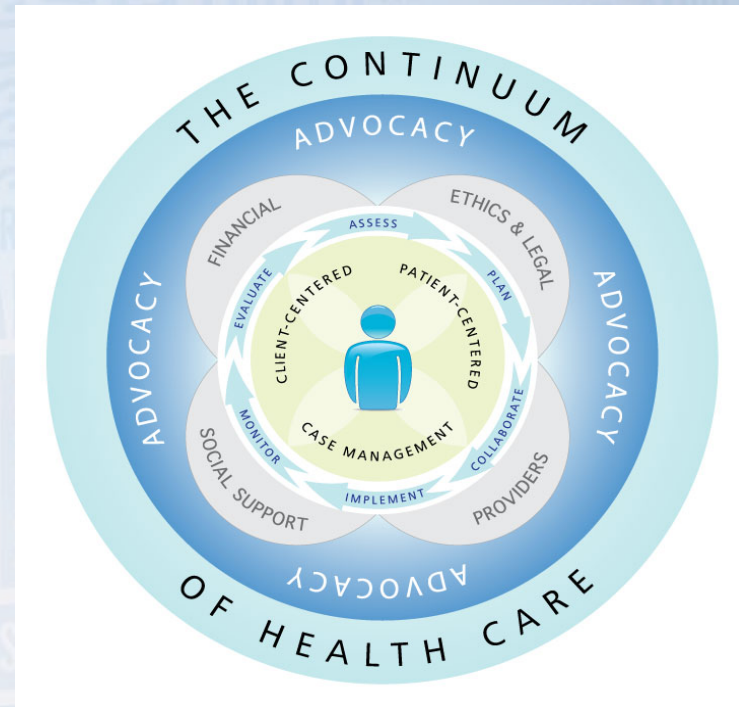


Figure 1

# Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

## Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations



# Innovative Health Information Technology

- Technology Enabled Transitions
- Using data analytics and the EHR to shift from event based treatment to continuity of care
- Standardization of patient assessment data
- Approach to a preventive medicine comprehensive wellness focus
- Integrated and interactive transfer of information in a timely and effective manner to providers, patients and family caregivers
- Understanding data in forming new interventions or programs
- Telehealth, remote health visits, & health wearables/monitoring
- Make it more than a financial business move but a focus of improving the patient-experience and becoming the change agent for a failing healthcare system





# Resources & Support for Improving Transitions of Care





# NTOCC.org



www.ntocc.org/



NATIONAL TRANSITIONS OF CARE COALITION

HOME

WHO WE SERVE

NEWS

EVENTS

ABOUT US



Visit the Consumer Tools & Information



## PATIENTS

Information for Patients and their Care Givers



## HEALTH CARE PROFESSIONALS

Tools, Resources, and Best Practices to Enhance Transitions of Care



## POLICY MAKERS

Resources for Policy Makers



## MEDIA

Information on Transitions of Care and NTOCC

YOU ARE HERE:

Home



TOC Compendium

Looking for tools or resources to help you learn



Evaluation Software

nonopioidchoices.org



# NTOCC Provides Tools & Resources for Patient and Family Caregivers

## Tool Highlights

- Guidelines for a Hospital Stay with Helpful Definitions  
*For Patient, Family, & Caregiver*
- Taking Care of MY Health Care  
*Français & Español*
- My Medicine List  
*Français & Español*
- Patient TOC Bill of Rights

**NTOCC**

### Cómo cuidar mi atención médica

Una guía para que usted o su cuidador sean activos en su propia atención o en la atención de otra persona.

Lleve este documento con usted toda vez que tenga una consulta con un prestador de servicios de salud (por ejemplo, un médico, enfermero(a), farmacéutico(a) o trabajador(a) social); acuda al hospital; o un centro de enfermería u otro establecimiento de atención médica; o reciba atención en su hogar. Usted tiene derecho a acceder a su información de salud personal. Esta guía le será de utilidad para: mantener un seguimiento de su información de salud, y puede ayudarle a prevenir otros problemas de salud.

Consulta con: \_\_\_\_\_

**NTOCC**

### Prendre Soins de MES Services Médicaux

Une guide pour vous ou votre professionnel de services médicaux à prendre une part active dans votre santé ou prendre soin de quelqu'un d'autre.

Apportez cela avec vous à toute consultation avec un professionnel de services de santé (par exemple, un médecin, un infirmier, un pharmacien ou un travailleur social); à l'hôpital; ou dans un centre de soins infirmiers ou un autre établissement de soins médicaux; ou si vous recevez des soins à domicile. Vous avez le droit d'accéder à vos renseignements personnels de santé. Ce guide vous sera utile pour: garder une trace de vos renseignements de santé, et peut vous aider à prévenir d'autres problèmes de santé.

**Mi Lista de Medicamentos**

Esta lista de medicamentos corresponde a: \_\_\_\_\_

Nombre: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Si debe comunicarse con ella, utilice: \_\_\_\_\_

este número de teléfono: \_\_\_\_\_

de correo electrónico: \_\_\_\_\_

Contacto de emergencia: \_\_\_\_\_

**My Medicine List**

Cette liste de médicaments est pour: \_\_\_\_\_

Nom: \_\_\_\_\_ Date de naissance: \_\_\_\_\_

Si vous avez besoin de m'appeler, utilisez: \_\_\_\_\_

ce numéro de téléphone: \_\_\_\_\_

cet e-mail: \_\_\_\_\_

Contact d'urgence: \_\_\_\_\_

La meilleure façon de contacter mon contact d'urgence est: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Je suis allergique à: \_\_\_\_\_

J'ai aussi des autres problèmes avec les médicaments: \_\_\_\_\_

**Maintenir My Medicine List actualisée:**

C'est très importante de maintenir cette information actualisée. Utilisez le cadre ci-dessous pour réviser et actualiser votre "My Medicine List". Vous pouvez faire cela avec votre médecin, pharmacien, infirmier, ou un autre professionnel de services médicaux.

Révisé par:	Révisé en:	Actualisé en:	Actualisé par:

**Questions pour mon médecin ou pharmacien:**

Utilisez la guide au verso pour remplir My Medicine List

ASHP Foundation

**HELPFUL DEFINITIONS**

To Help You Understand Your Health Care Better

**Case Manager:**  
Case managers work with people to get the health care and other community services they need, when they need them, and for the best value.

**Hospitalist:**  
Doctor whose primary professional focus is the general medical care of hospitalized patients. Activities include patient care, teaching, research, and leadership related to hospital medicine.

**Palliative Care:**  
Serious illnesses can cause physical symptoms, such as pain, nausea, or fatigue. You may also have psychological symptoms like depression or anxiety. The treatments for your disease may cause symptoms or side effects. Palliative care relieves symptoms without curing your disease.  
(www.nin.nih.gov/nin/groups/ncj/ncjpublications.html)

**Patient Advocate:**  
A person who helps a patient work with others who have an effect on the patient's health, including doctors, insurance companies, employers, case managers, and lawyers. A patient advocate helps resolve issues about health care, medical bills, and job discrimination related to a patient's medical condition.  
(American Cancer Society)

**A Patient's Bill of Rights:**  
This information lets patients know what their rights and responsibilities are while they are in the hospital. Most patient bills of rights stress the importance of strong relationships between patients and their health care providers and the key role patients play in staying healthy.

**Nurse Practitioner:**  
Registered nurses who are prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages.

**NPs take health histories and provide complete physical examinations; diagnose and treat many common acute and chronic problems; interpret laboratory results and X-rays; prescribe and manage medications and other therapies; provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance; and refer patients to other health professionals as needed.**  
(www.aacnp.org)

**Physician Assistants:**  
Health professionals who practice medicine as members of a team with their supervising physicians. PAs deliver a broad range of medical and surgical services to diverse populations in rural and urban settings. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and prescribe medications.  
(www.aapa.org)

**Social Worker:**  
These professionals help individuals and families cope with social and emotional factors affecting their health and well-being; diagnose and treat mental health problems; and help people obtain services.

**Transitions of Care:**  
Include situations in which a patient moves from a primary care doctor to a specialist, or moves within the hospital; moves from the emergency room to other hospital departments, such as surgery or intensive care; or when a patient is discharged from the hospital and goes home or to an assisted living arrangement or a skilled nursing facility.



# Additional NTOCC Tools, Resources, and Education for Providers



## APPENDIX C Elements of Excellence in Transitions of Care (TOC) TOC Checklist

\*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. Every element on this checklist may not be relevant to each provider or setting.

\*For purposes of brevity, the term *patient/client* is used throughout this checklist to describe the client and client system (or patient and family). The *patient/client* system (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client's informal support network. Depending on the setting in which the patient/client is receiving care, providers may wish to consider the following:



## Medication Reconciliation Elements

Suggested Common/Essential Data Elements for Medication Reconciliation

ASSESSMENT ON ACCESS TO CARE SETTING (E.G. HOSPITAL ADMISSION, NURSING HOME ADMISSION)				
Category	Element	Source(s)	Barrier(s)	Comments
Demographic	Name	Patient/caregiver	Cognitive status	Universally available unique identifier information
	Date of birth			
	ID Number			
	Gender			
	Contact information	Caregiver	Caregiver knowledge of patient	
Medications (active, taken chronically)	Caregiver name and contact information	Patient/caregiver		May also include time of transport of info
	Allergies/intolerances			
	Date of assessment	Interviewer		
	Name – generic/trade	Patient/caregiver	Patient/caregiver knowledge of complete medication list, cognitive status	
	Dose			
Other medications/OTC/herbal remedies/nutritional supplements/time-limited medications	Form			NDC will be used in automated systems – name + dose
	Frequency			
	Reason for use			
	Name – generic/trade			
	Dose			
Other elements for consideration	Form			Stop dates for short term medications
	Frequency			
	Primary language	Patient/caregiver	Patient/caregiver knowledge of complete medication list, cognitive status	
	Religious, cultural factors			
	Prescriber			
Medications	Compliance level			Variety of methods to provide info on compliance
Medical history	Known medical conditions			To be able to identify conditions that may not be treated
Primary health care provider	NPI#			

1



## Transitions of Care Measures

Paper by the NTOCC Measures Work Group, 2008

www.ntocc.org

Improving on Transitions of Care: How to Implement and Evaluate a Plan

## Improving on Transitions of Care: How to Implement and Evaluate a Plan



The National  
Transitions of Care Coalition

Last revised: April 30, 2008



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# NTOCC/PRIME Transitions of Care Pathways for Rare Respiratory Diseases

- 2 CE-accredited Pathways released in 2016, focusing on transitions of care for patients with
  - Pulmonary arterial hypertension (PAH)
  - Idiopathic pulmonary fibrosis (IPF)
- Provide disease-specific tools and resources for the interdisciplinary teams
- Available at [primeinc.org/toc](http://primeinc.org/toc)

CE = continuing education.

## SAFER TRANSITIONS, FEWER RE-HOSPITALIZATIONS WITH PAH:

AN INTERDISCIPLINARY  
GUIDE

## BETTER TRANSITIONS OF CARE TO BRIDGE GAPS, REDUCE HOSPITALIZATIONS AND READMISSIONS IN IPF

AN INTERDISCIPLINARY GUIDE FOR HEALTH  
SYSTEMS, CARE PROVIDERS, PATIENTS,  
AND CAREGIVERS

### Interprofessional Steering Committee:

**Cheri Lattimer, RN, BSN**  
Executive Director  
National Transitions of Care Coalition  
Washington, DC

**James E Lett, MD, CMD**  
Family Medicine Physician  
Medical Director  
Auror Consulting  
Rockville, MD  
Director of the National Board  
National Transitions of Care Coalition  
Washington, DC

**Christopher J Lettieri, MD, FACP,  
FCCP, FAASM**  
Colonial Medical Corps, US Army  
Pulmonary, Critical Care & Sleep  
Medicine, FBCB  
Pulmonary & Critical Care Medicine  
Consultant to the Surgeon General  
Professor of Medicine  
Uniformed Services University  
Bethesda, MD

**Kathleen Fraser, RN-BC, MSN,  
MHA, CCM, CRRN**  
Executive Director  
Case Management Society of America  
Little Rock, AR

**Liza Greenberg, RN, MPH**  
Senior Consultant  
Visiting Nurse Associations of America  
Senior Consultant  
Health Project Consulting  
Washington, DC

**Roy A Pleasants, II, PharmD, BCPS**  
Associate Professor  
Division of Pharmacy Practice  
Campbell University School of Pharmacy  
Burlington, NC  
Clinical Pharmacist  
Division of Pulmonary, Allergy,  
and Critical Care Medicine  
Duke University School of Medicine  
Durham, NC

### Contributing Author:

**Laura Simone, PhD**  
PRIME Education, LLC

**Michele Peters**  
IPF Caregiver  
PFF Ambassador  
PFF Support Group Leader  
Pulmonary Fibrosis Foundation  
Chicago, IL

**NTOCC** **CMSA** **PRIME**

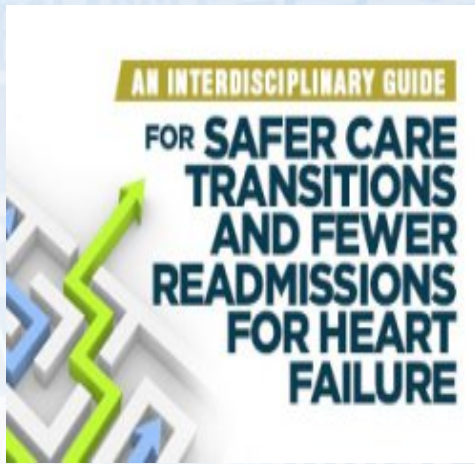
Accredited for 2.0 hours of ACME, ACPE, ANCC, and CCMC credit. For learning objectives, faculty, and accreditation information, please refer to pages 50-51. Please review this information before you start this activity.

There is no fee for this activity as it is sponsored by PRIME® through an independent educational grant from Genentech.

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# Heart Failure TOC Pathway



2.0 hours of ACCME, ACPE,  
ANCC, and CCMC credit

Developed in partnership with the NTOCC and led by a multidisciplinary advisory board, this Heart Failure Transitions of Care pathway provides essential interventions and tools to support system leaders and the interprofessional care team – including patients and their caregivers - in incorporating the latest evidence-based treatment and management approaches to ensure effective and safe transitions of care for patients with heart failure across healthcare settings.

Available At:  
[primeinc.org/toc](http://primeinc.org/toc)



# Partnerships Addressing The Issues Related Opioid Use

- **Voices for Non-Opioid Choices** – addressing access for patients to non-opioid therapies and financial payment for non-opioid therapies
  - NTOCC has partnered with Pacira, Venn Strategies and multiple associations building educational information and resources
  - Several DC fly-ins meeting with legislatures and regulators discussing the issues at hand and alternative options
- **Allied Against Opioid Abuse** – AAoA - a partner-based initiative to provide education and awareness to prevent abuse and misuse of prescription opioids
  - Developing educational resources and promoting their availability to consumers, pharmacists, healthcare professionals and other stakeholders
  - Identifying opportunities to educate pharmacists and providers to help reduce misuse and abuse of prescription opioids among patients
  - Educating consumers via point-of-sale pharmacy materials



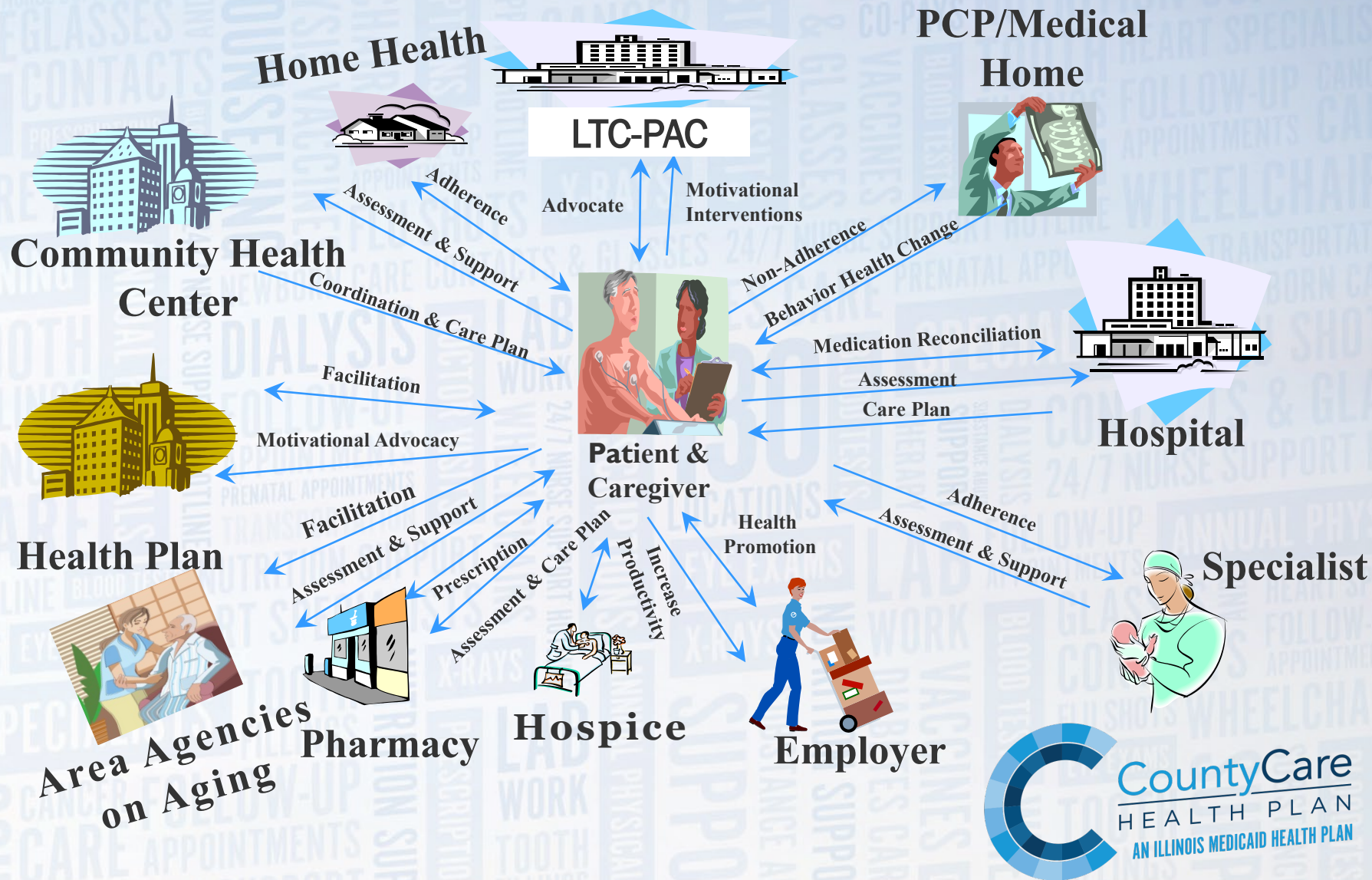


# Additional Resources

- IMPACT Newsletter
- Published Quarterly
- Address “Best Practices” in support of transitions of care (TOC)
- Discusses public policy issues that impact TOC
- Lists upcoming events
- Easy access by signing up as a subscriber
- Policy Alerts
- Newly Introduced Bills addressing TOC & Care Coordination (CC)
- New TOC or CC legislation
- Regulatory Changes or Implementation
- All subscribers receive the alerts



It is Complicated but Only Working Together as a Collaborative Team Addressing the Care Needs of the Patient & Family Caregiver Can Improve This Process





# Winning Strategies

- Focus on patient-centered care
- Continuous quality improvement
- Effective **Team** practice with financial and performance measure alignment including patient measures
- Commitment to data analytics to inform operational strategies/changes and improve utilization and quality
- Cultural sensitivity, social determinates and population health focus
- Transitions of care and care coordination at imperative and every level of care
- Integrating behavioral health care with primary care
- **Team** leadership and communication



# Transitions Of Care & Care Coordination Resources

- CAN – Caregiver Action Network- Family Caregiving Resources – [www.caregiveraction.org](http://www.caregiveraction.org)
- CAPS - Consumers Advancing Patient Safety – Toolkits [www.patientsafety.org](http://www.patientsafety.org)
- NTOCC - National Transitions of Care Coalition – Provider & Consumer Tools [www.ntocc.org](http://www.ntocc.org)
- CMSA - Case Management Society of America – CM Medication Adherence Guidelines & Disease Specific Adherence Guidelines, CMSA Standards of Practice – CKP - [www.cmsa.org](http://www.cmsa.org)
- ICM – Integrated Case Management - <http://www.cmsa.org/Individual/NewsEvents/IntegratedHealthManagementTraining/tabid/380/Default.aspx>
- AMDA's (Dedicated to Long Term Care Medicine™) Transitions of Care in the Long Term Care Continuum practice guideline - <http://www.amda.com/tools/clinical/TOCCPG/index.html>
- ACC and IHI – Hospital to Home – Reducing Readmissions, Improving Transitions - <http://www.h2hquality.org/>
- AHRQ – Agency for Healthcare Research and Quality - Questions Are The Answers – [www.ahrq.org](http://www.ahrq.org)
- NASW – National Association for Social Workers - <http://www.socialworkers.org/Resources>
- VNAA Blue Print for Excellence – [www.vnaablueprint.org](http://www.vnaablueprint.org)





# Contact Information

Cheri Lattimer RN, BSN - Executive Director NTOCC

Phone: 501-240-4677

Email: [cheri.lattimer@gmail.com](mailto:cheri.lattimer@gmail.com)

# HEDIS Measures

## Breast Cancer Screening (BCS)

Laurel Chadde

Performance Improvement  
Project Analyst, CountyCare



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# BCS HEDIS Measure Definition

- The percentage of women 50–74 years of age who had a mammogram performed between October 1, 2017 and December 31, 2019 to screen for breast cancer
- Women 52-74 years of age as of December 31, 2019 with continuous enrollment October 1, 2017 through December 31, 2019
- Exclusions:
  - Members with bilateral mastectomy or two unilateral mastectomies
  - Members 66 years of age and older as of December 31, 2019 with frailty and advanced illness during the 2019

# BCS Performance by CME

	HY2019/CY2018 Rate	HY2020/CY2019 Rate*	Percentile			
			50 <sup>th</sup>	60 <sup>th</sup>	75 <sup>th</sup>	Target 80 <sup>th</sup>
CME A	60.6%	51.3%	58%	61%	64%	66%
CME B	61.6%	48.5%				
CME C	56%	46.2%				
CME D	64.4%	55%				
CountyCare Overall	64.3%	51.2%				

\*YTD claims and eligibility data through 5/14/2019



# Member Barriers to BCS

- Last year CountyCare surveyed members on barriers to BCS. Top barriers identified:
  1. Do not have any symptoms, so do not believe I need a mammogram
  2. Transportation
  3. Other health priorities
  4. I have never been told I needed screening
  5. Fear of pain or danger caused by procedure
- Key takeaways:
  - Transportation
  - Education

# How can care coordinators help?

- Utilize care gap lists from Vision to identify patients in need of a mammogram
- Conduct member outreach and schedule the member for a PCP appointment, instruct the member to ask for a mammogram order
- Reference the mammography locations throughout Cook County list
  - [http://www.countycare.com/Media/Default/pdf/CCR\\_0135\\_Mammography\\_Locations-030519.pdf](http://www.countycare.com/Media/Default/pdf/CCR_0135_Mammography_Locations-030519.pdf)
- Assist members with using the CountyCare transportation benefits
- Motivate members with the CountyCare Rewards Program incentive
  - Members 40-74 years will earn \$25 when they get their mammogram
- Educate members about the importance of getting a mammogram and debunk misconceptions about the procedure



A smiling man with glasses and a goatee, wearing a blue shirt, against a background of medical terms. The text "Thank You Spotlight" is overlaid in large blue letters. The CountyCare Health Plan logo is in the bottom right corner.



A smiling man with glasses and a goatee, wearing a blue shirt, against a background of medical terms. The text "Thank You Spotlight" is overlaid in large blue letters. The CountyCare Health Plan logo is in the bottom right corner.

# Thank You!

**Angela Violante**, Nurse Care Coordinator, on her assistance with prompt facilitation of my member's HEAL application, who's Electricity was shut off.

If you have a care coordinator you want to give a special Thank you,  
Please email them to **[Lanisha.Thadison@cookcountyhhs.org](mailto:Lanisha.Thadison@cookcountyhhs.org)**





Questions?



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# *We need your Feedback!*

- Please take a short moment to complete the evaluation poll.
- Interested in a particular topic? Would you like to see it presented during this webinar?
- Please email your ideas to [Lanisha.Thadison@cookcountyhhs.org](mailto:Lanisha.Thadison@cookcountyhhs.org)





**Thank You!**



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