Improving Case Management Using an HIE

2020 WISHIN Summit

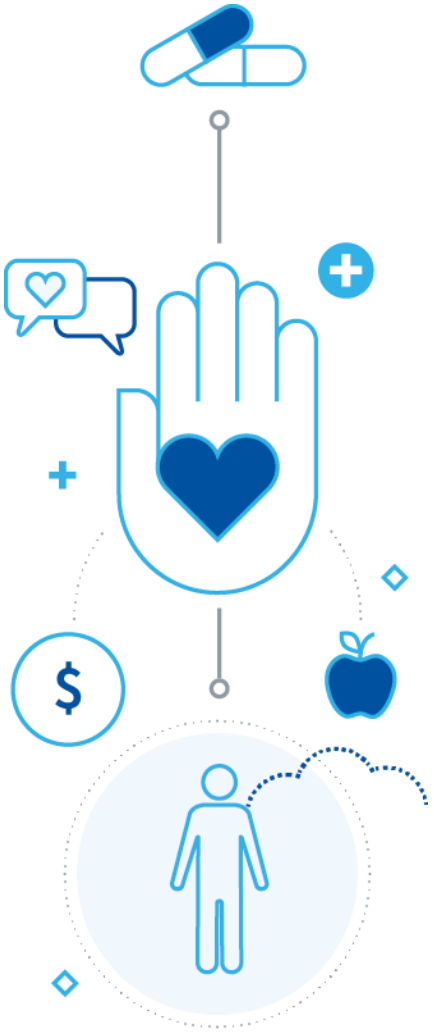
January 29, 2020

UnitedHealthcare®

Our mission

UnitedHealthcare Community Plan

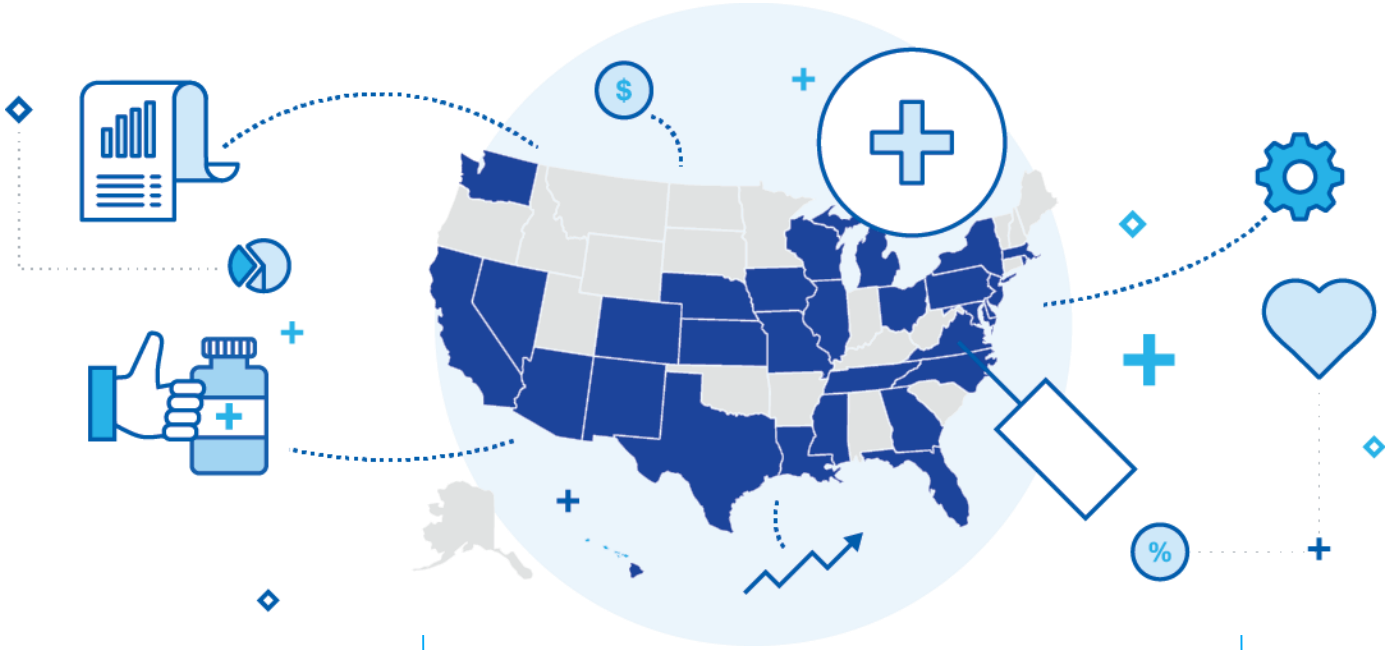
Helping people
live healthier lives
and helping make the
health system work
better for everyone.



UnitedHealthcare Community & State

UnitedHealthcare Community Plan

In **partnership** with state and local community organizations we offer innovated managed care health plans for the economically disadvantaged, the medically underserved, and those without the benefit of employer-funded health care coverage.



70+
Health care contracts managed

Serving **6.6M** people in **30** states plus Washington D.C.

12,000+
Employees

2020 Service Area

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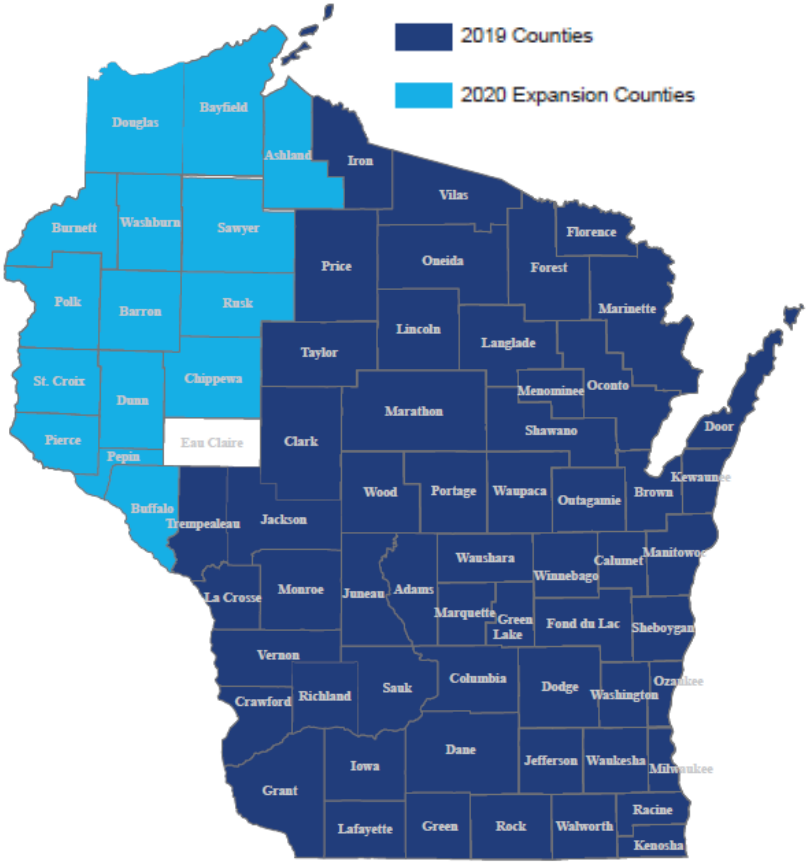
Dual Special Needs Plan Service Area



Medicaid Service Area

December 2019 Membership

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Product	Membership
BadgerCare+ (CLA)	31,583
BadgerCare+ (TANF)	116,966
Medicaid SSI	18,631
Dual Special Needs Plan	21,576
Total Membership	188,756

BadgerCare Plus: A plan for pregnant women, children to age 19 and adults who meet income requirements. (childless adults are a sub group)
Medicaid SSI: Available to Wisconsin residents who receive Supplemental Security Income (SSI). The program offers extra support to adults with special health care needs or a disability.
Dual Special Needs Plan: For people who have Medicare Parts A & B and Medicaid. Offers more benefits and features than original Medicare.

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- **Daily ADT Feed – Began 2015**
  - Data integration with care management system to create “alerts” for ED, admissions and discharges
  - Access to data for outreach (now replaced by Pulse)

- **Pulse access May 2018**
  - Care Management Access
  - Inpatient UM access
  - Real time appointment verification
  - Medications
  - History
  - OB provider engagement
  - Care Summaries
  - Lab
  - Rx

WISHIN Pulse

- **4th Quarter 2019**
  - Expansion to Medicare & Retirement population

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Success Story

Member identified as pregnant upon enrollment. Member is high risk with previous poor birth outcome. Maternity case manager views member record in WISHIN. Notes that member is seeing multiple doctors and PCP continues to prescribe opiates.

Case manager consults with OB and other providers to establish a coordinated treatment plan. Member engages in MAT.

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Engagement

Angela Lauffer RN, BSN, MPH

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Health Assessment Team Responsibilities:

- Complete Health Risk Assessments on SSI members within first 60 days of enrollment (first line of contact)
- Complete Health Risk Assessments on low risk SSI members.
- Obtain a list of member's medications, providers and recent ER visits.
- Goal is to complete HRA's on at least 75% of all new members.

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Health Assessment Team

This team uses WISHIN for:

- Alternative phone numbers and addresses for those hard to find members.
- Real time lab results
- Medication reconciliation and adherence
- Providers, past appointments and upcoming appointments

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Success Story: Healthy Birth Outcomes Member

- 19 y/o African American female without a phone number on State file.
- Member had delivered a baby within previous month. Member without a PCP, dental or vision provider. Member wanted to become established as a patient at local FQHC.
- Member reported some difficulty paying for living expenses.

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Success Story: Healthy Birth Outcomes Member

WISHIN Value:

- Case Manager was able to obtain member's contact information for initial contact through WISHIN.
- Case Manager realized member had recently delivered a baby and had gaps in care that needed to be addressed.
- Member was provided with food/clothing/#211/MTM information.
- Member was enrolled in the Healthy Birth Outcomes Case Management Program and is working with Case Manager to schedule needed appointments.

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Success Story: Member without a phone

- 62 year old male with a history of diabetes, heart disease and polysubstance abuse (member has been sober for several years) without a phone number on State file.

- Case Manager went to member's home to complete Health Risk Assessment with member.

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Success Story: Member without a phone

WISHIN Value:

- Case Manager was able to locate a phone number for member's sister through WISHIN.
- Case Manager was able to arrange a time through member's sister to go to the member's home in order to complete the Health Risk Assessment.
- Case Manager has assisted member with scheduling preventative care services and is assisting member in getting a Safelink phone for future use.

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Success Story: Senior Spanish Speaking Couple

- Elderly Spanish speaking couple (92 y/o and 86 y/o) without a phone number on State file.

- Husband has Dementia, Epilepsy, Urinary Incontinence, Insomnia, and Arthritis.

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Success Story: Senior Spanish Speaking Couple

WISHIN Value:

- The couple's phone number was found through research in WISHIN
- Both husband and wife were able to engage in Case Management services and had multiple needs.
- Case manager is working with member's wife to coordinate PCW services and to obtain incontinence products for her husband.

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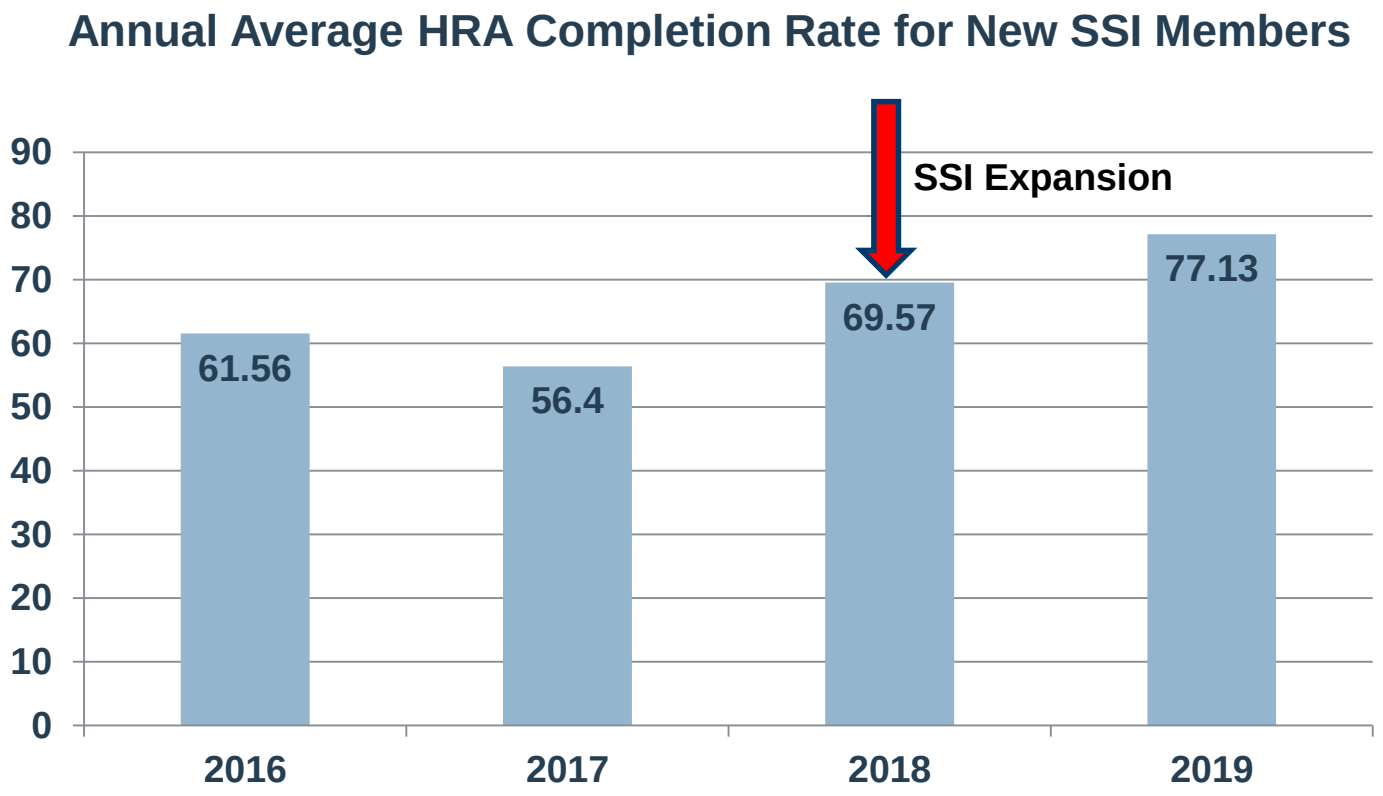

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- WISHIN has increased our Outreach Coordinators success rate in reaching members within the first 90 days of enrollment to complete the Health Risk Assessment.

- WISHIN has helped UHC to increase our SSI HRA completion rates on newly enrolled members by 20% over the last three years.

- This helps us get members into case management faster in order to help members obtain needed services as soon as possible

- WISHIN has helped Outreach Coordinators obtain more accurate health history including medications, recent ER visits, hospitalizations and provider visits.

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Case Management / Care Coordination

Kim Danko RN, BSN

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Wisconsin Interdisciplinary Care Team (WICT)

This is a high intensity level of case management for our most challenging Members with high utilization. This is a team approach with the core team consisting of an RN, Social Worker with Behavioral Health background and Community Health Worker.

This team uses WISHIN for:

- Alternative phone numbers and addresses for those hard to find Members.
- Real time lab results
- Medication reconciliation and adherence
- Providers, past appointments and upcoming appointments

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Member success story

- 29 y.o. female Member inpatient for BH
- UHC Liaison reviewed WISHIN prior to meeting with member and completed the HRA with Member at the visit
- Based on information in WISHIN and gained from the HRA, Member was referred to WICT Case Management Team
- UHC is working with Member on stable housing
- UHC has met Member at a food pantry

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Emergency Department Educational Program

This is a team of Social Workers and an RN who case manage our high Emergency Department utilizing members. The team works with Social Workers and Discharge Planners in the local Emergency Departments to assist with educating Members on appropriate utilization of Emergency Departments and making sure each Member has a PCP. They will also make referrals to Community Paramedics.

This team uses WISHIN to see:

- Real time ED visit and send a CHW to see the Member
- Which EDs our Members are frequenting
- Real time lab results
- Scheduled follow up appointments after an ED visit

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Member success story

We have a strong working relationship with the ED Case Managers but at times they can be so busy they are unable to call when one of our high utilizers shows up in their ED

- EDEP CM reviews WISHIN daily for the top 20 ED Utilizers
- EDEP CM noted 52 y.o. male member was in the ED
- UHC met with Member in the ED
- Member was referred to a Case Manager
- Members ED utilization has decreased so that they are no longer in the top 20.

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Transitional Care Management

This team consists of nurses contacting members that have had recent inpatient discharges. They complete Post Hospital Health Assessments and review discharge plans with members. They can then determine the level of case management the member may need.

This team uses WISHIN for:

- Alternative contact information
- Discharge dates and care summary information
- Medication reconciliation
- Verifying follow up PCP and Specialist appointments and to see upcoming appointments

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Member success story

- 61 y.o. female member
- TCM reviewed WISHIN prior to Member contact
- TCM contacted Member and completed a post hospital assessment
- Member told TCM why she did not have meds
- Member was referred to Case Management
- Member now gets all her medications delivered
- Member continues to be engaged with Case Manager

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What our Case Managers are saying about WISHIN

- “I’m able to determine the quantity of pills that members receive in a prescription fill. This helps me determine if they have challenges with adherence when I’m in their home doing a count. It also helps me determine an estimated refill date.”
- “It reveals the results of toxicology screens (and other helpful labs like A1c) that would likely not be shared so I know what challenges a member may be facing.”
- “I use WISHIN for looking up new inpatients, review their labs, medications, f/u appointments, complete list of their medications, you can find their providers, you can find more complete information on their inpt dx, you can find their discharge dates, you can review their ER use.”
- “I feel it is very user friendly and doesn’t take time to pull up MBRs in the system.”
- “Great communication tool with outside providers involved with mbrs (ie CSP caseworkers, PCP staff)…..can communicate mbr’s recent activity with them”
- “I love WISHIN!”

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