



Your Extended Family.

Care Transitions for Medicaid Disabled and Medicare SNP Populations

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LT's Story

I met this member in the hospital. 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 he didn't need help because he could manage his health “just fine” at home. He was in the hospital for treatment of ulcers on both feet, MRSA, and Gangrene. Several of his toes were 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. There are tarps on the front windows and the small area had a makeshift bed, a heater and full ashtrays on the floor. 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 monitoring which symptoms meant he needed to see the doctor and eventually what health goals he had. He wanted to walk again, so we set up home care services.

He is now off antibiotics, is walking, and does not require another amputation. He is also considering moving out of his truck into temporary housing.

“I couldn't walk before and now I can. You don't know how lucky I am to have you come out. I am so grateful!”- LT



Statistics for Disabled & Dual-Eligible Enrollees

- Approximately 50% have a mental illness¹
- Over a third have both mental illness & substance use disorders²
- Mental illness and substance abuse increase readmission rates by 4 to 5 times³
- 50% readmitted within 30 days did not see physician between discharge and readmission³

Coleman Care Transitions Model

- Developed and standardized with Medicare patients
- States not for use with psychiatric conditions
- RN Transition Coach makes 1 inpatient visit before discharge
- 1 home visit post discharge within 48-72 hrs
- Follow-up phone calls at 7, 14, and 30 days post discharge
- 1 month program in total
- Focuses on medication management, patient record, follow-up provider visits, and red flags

Challenges

Found Coleman Model not working:

- Members refusing to be in program
- Refusing home visits or after discharge contact
- Materials too complex for members
- Housing and food more important than health
- Untreated mental illness and substance use

Molina Care Transition Program

- More than 1 meeting in hospital to gain trust
- Focus more on basic needs like housing and food
- Address mental health & substance use
- Simplified tools for lower education level
- More than 1 in-person visit post discharge
- Less telephonic work- 75% done in person
- Time in program varies & can be up to 3 months
- Arrange LTC evaluations and set up services
- Use Community Health Workers as RN extenders

Hospital Visits

RN Coach:

- Meet with member to explain program & build rapport
- Review *After Hospital Discharge Checklist*
- Help patient get their needs met before discharge
- Set up LTC assessment if indicated
- Advocate for member with hospital staff

CHWs:

- Help member with housing, food, and clothing

Post-Discharge Meetings

RN Coach:

- Meet with member in SNF, outpatient clinic, shelter, etc.
- Review all medications and health record with member
- Identify red flags and build response plan
- Communicate with PCP and specialists
- Prepare member for graduation from program

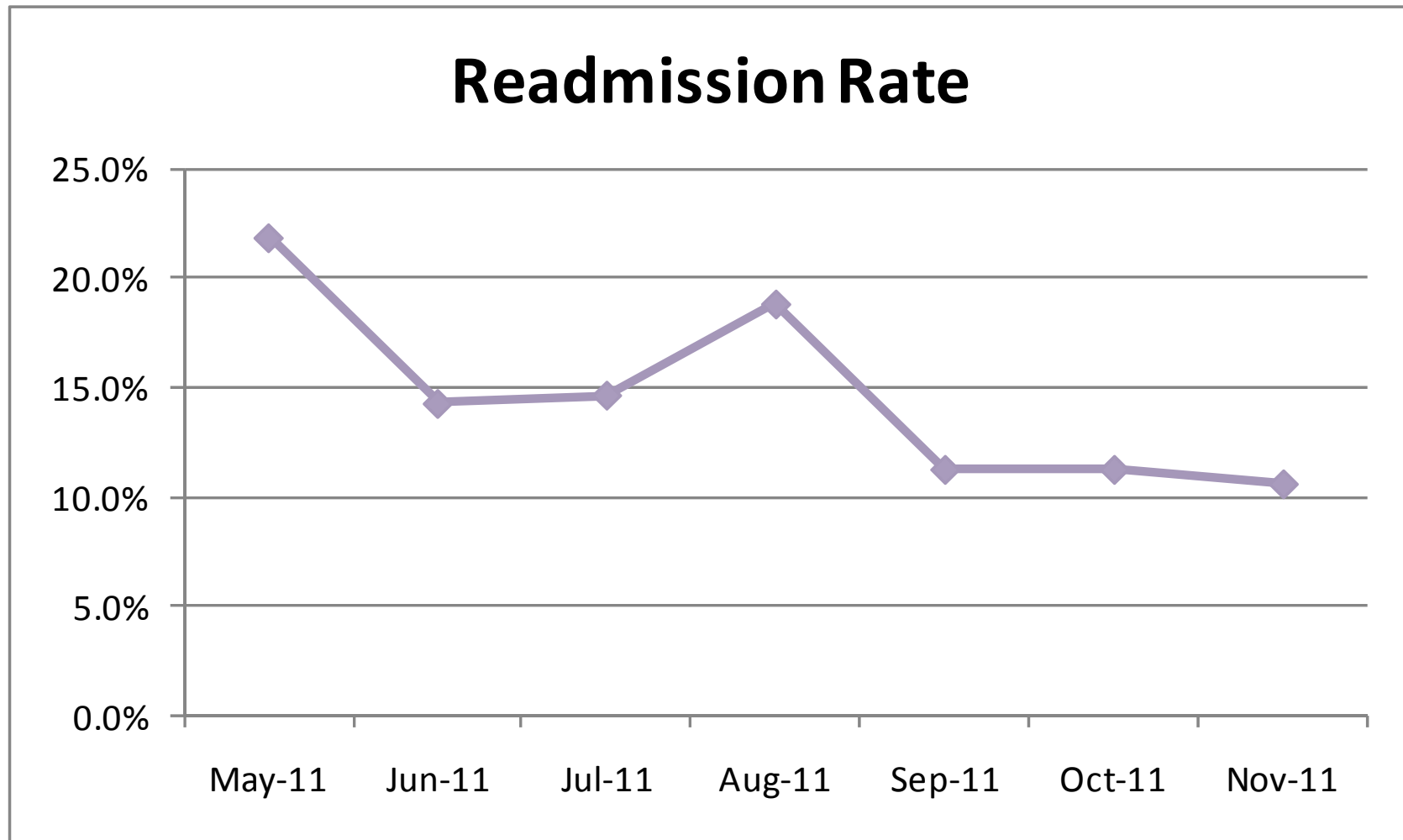
CHWs:

- Help schedule provider appointments, transportation, and fill prescriptions
- Help build support system with community organizations

Lessons Learned

- Members can be suspicious and distrustful
- Must build rapport with member in hospital
- Need to advocate for members with hospital staff
- Members are ashamed to have us in their homes
- Homelessness, illiteracy, mental illness, and substance abuse pose unique challenges
- Inspire hope and believe in the member

Outcomes



Reduced readmission rate in the past 8 months by over 50% and well below national average

References

- ¹Kronick, 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.
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- ³Gilmer, 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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