Welcome!

GAPS in Care

Minnesota Senior Care Plus (MSC+)
Minnesota Senior Health Options (MSHO)
Connect
Connect+ Medicare

October 15, 2024

Introduction: Gaps in Care

A Gap in Care is a missing preventative care measure identified using claims information for CT/Connect + Medicare and MSC+ and MSHO Members.

Star Ratings informs members about how UCare is doing in the quality of health services provided by UCare and our provider network.

Star Ratings support supplemental benefit offerings and help keep premium levels low for our members.

Using Gaps in Care Reports

Addressing Gaps in Daily Work

Annual Assessment

- Physical Health
- Preventative Care
- Vision

Support Plan

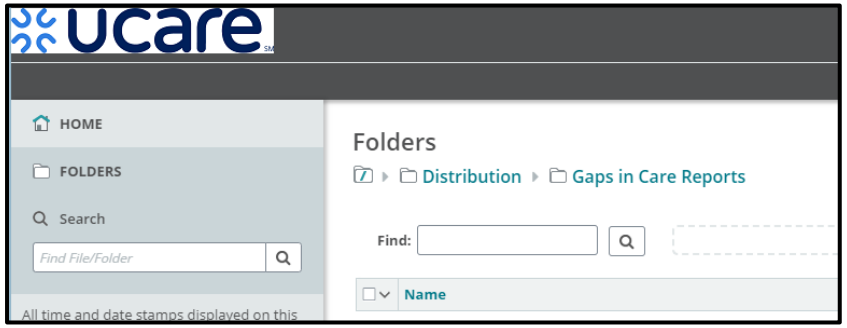
- My Goals
- Barriers to achieving goals

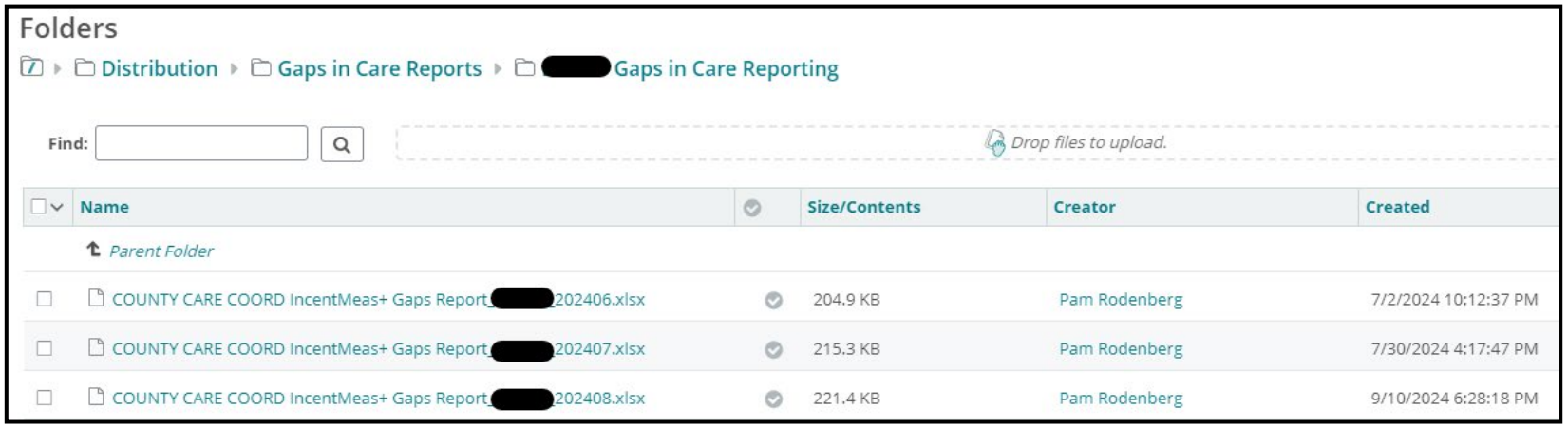
Transition of Care

- Address primary care
- Post-hospitalization follow-up care
- Mental health care visit after hospitalization

Gaps in Care Reports

Gaps in care reports provide claims information about preventative care services like annual wellness visits, colonoscopies, mammograms, and diabetic preventative visits completed over the past 12 months.





Gaps in Care reports are provided to dedicated agency staff at each delegate via UCare's SecFTP.

Gaps in Care Measures

- Annual Wellness Visit **(AWV)**
- Breast Cancer Screening **(BCS-E)**
- Colorectal Cancer Screening **(COL)**
- MN State Dental Withhold **(DEN)**

Preventative Measures

- Eye Exam for Patients with Diabetes **(EED)**
- Hemoglobin A1c Control for Patients with Diabetes **(HBD)**
- Kidney Health Evaluation for Patients with Diabetes **(KED)**
- Statin Therapy for Patients with Cardiovascular Disease **(SPC)**
- Statin Use for Patients with Diabetes **(SUPD)**

Diabetes & Cardiovascular Measures

Gaps in Care Measures

Admission & Transition Support Measures

- Transitions of Care - Patient Engagement **(TRC)**
- Follow-up after ED Visit for People With Multiple High-Risk (Chronic Conditions) **(FMC)**
- Plan All-Cause Readmissions **(PCR)**

- Medication Adherence for Diabetes **(UDA)**
- Medication Adherence for Hypertension **(URA)**
- Medication Adherence for Statins **(USA)**

Medication Adherence Measures

Measurement Year

Measurement years for STARS and HEDIS are calendar years. However, gaps remain closed for various periods of time. For example, an annual wellness visit is targeted for closure each year. Depending on which COL cancer screening a member completes, the COL gap can be closed for 3 to 10 years.

Tips

- Members will continue to appear on the reports each month until they receive the service requested in the current measurement year.
- The reports are created to show compliance status and to quickly notify CCs of the opportunity to intervene where gaps in care are present during the measurement year.

Preventative Measures

Annual Wellness Visit (AWV): Members 18 and older who had a preventive care medical office visit or an annual wellness visit in the current year.

Breast Cancer Screening (BCS-E): Members 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

Colorectal Cancer Screening (COL): Members aged 45-75 who have an appropriate screening for colorectal cancer (colonoscopy, flexible sigmoidoscopy, colonography/Cologuard, FIT kit or FOBT).

MN State Dental (DEN): All Members who received one preventative dental visit annually.

Diabetes & Cardiovascular Measures

Eye Exam for Patients with Diabetes (EED): The percentage of members 18-75 years of age who have diabetes (types 1 and 2) who had a retinal eye exam.

Statin Therapy for Patients with Cardiovascular Disease (SPC): The percentage of males aged 21-75 and females aged 40-75 who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and *Received Statin Therapy:* Dispensed at least one high-intensity or moderate-intensity medication during the measurement year

Hemoglobin A1c Control for Patients with Diabetes (HBD): The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following level: < 8.0 %.

Kidney Health Evaluation for Patients with Diabetes (KED): The percentage of members 18-85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR) during the measurement year.

Statin Use for Patients with Diabetes (SUPD): The percentage of members 40-75 years of age that have diabetes (types 1 and 2) who had statin prescribed and filled once during the measurement year.

Admission and Transition Support Measures

Transition of Care –Patient Engagement (TRC): The percentage of discharges for members 18 years of age and older who had a visit (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. The engagement (visit) cannot occur on the date of discharge.

Follow-up after ED Visit for People With Multiple High-Risk (Chronic Conditions) (FMC): The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Plan All-Cause Readmissions (PCR): For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that was followed by unplanned acute readmission for any diagnosis within 30 days and the predicted probability of acute readmission.

Medication Adherence Measures

Medication Adherence for Diabetes (UDA): Percentage of members ages 18 years or older who are adherent with diabetes medications at least 80% or more of the time they are supposed to be taking the medication in the measurement period.

Medication Adherence for Hypertension (URA): Percentage of members ages 18 years or older who are adherent with hypertension medications at least 80% or more of the time they are supposed to be taking the medication in the measurement period.

Medication Adherence for Statins (USA): Percentage of members ages 18 years or older who are adherent with prescribed statin medications at least 80% or more of the time they are supposed to be taking the medication in the measurement period.

Understanding the Gaps in Care Report

Report is divided into 5 tabs

- **Read Me:** Instructions, definitions, overview of the report
- **Gaps Detail**: Raw data, full report
- **Medication Adherence Detail:** only certain medications
- **Rates Summary**: Measure Key, Description, Numerator, Denominator, Rate, Year & Month
- **CY2024 Panel Members:** Current year population

Reference: Navigating Enrollment Rosters Using Excel

Gaps Detail Tab

Measures												
BCS-I	MostRecent BCS	COL	MostRecent COLColo	MostRecent COLFlexSig	EED	MostRecentEE	KED	MostRecentKE	TRC ENGAGEMEN	MostRecent TRC Engagement	DEN	MostRecentDE
0		0			1	10/17/2023	0	1/22/2024	NULL		1	2/14/2024
NULL		NULL			NULL		NULL		NULL		0	12/5/2023
NULL		0			NULL		NULL		NULL		0	1/4/2021
1	3/22/2024	1	3/29/2021		1	1/29/2024	0		NULL		1	1/22/2024

Annual Wellness Visits remain “0” until the member completes in the current year.

Non-Incentive Measures							
AWV	MostRecentAV	GSD (fka HBD)	MostRecentGSD (fka HBD)	SPCTHERAP	MostRecentSPCTherapy	SUPD-U	MedAdhereDiabetesStatus
0		1		NULL		1	
0	1/20/2022	NULL		NULL		NULL	ON SCHEDULE
0		1		NULL		NULL	
0		1		NULL		0	ON SCHEDULE - AT-RISK

0 = noncompliant for the measure

1 = is compliant for the measure

NULL = does not qualify for the measure

Medication Adherence

LAST_NAME	FIRST_NAME	BIRTH_DATE	SEX	MEASURE	NDC	DRUG_ID	LABEL_NAME	DATE_FILLED	MedAdhereStatinsCholesterolStatus
Boop	BETTY M	9/14/1934	F	STATINS	43598083105	ATORVASTATIN	ATORVASTATIN TAB 20MG	1/1/2024	BEHIND SCHEDULE - NOT POSSIBLE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	1/16/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	2/13/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	3/12/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	4/9/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	5/7/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	6/4/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	7/1/2024	ON SCHEDULE
Duck	DONALD	3/17/1939	M	STATINS	16714068403	SIMVASTATIN	SIMVASTATIN TAB 40MG	7/30/2024	ON SCHEDULE

Betty is out of compliance

Donald is on schedule! Good job Donald!

Measure Summary	Abbreviation
Annual Wellness Visit (18 + yr. completed AWV in the current year)	AWV
Breast Cancer Screening (50-70 yr. screening completed every 2 years)	BCS-E
Colorectal Cancer Screening (45-75 yr. completed per type of screening i.e.: colonoscopy every 10 years, Cologuard every 3 years)	COL
Annual Dental Visit (18 + yr. completed dental exam)	DEN
Annual Eye Exam with Diabetes (18-75 yr. w/DM dx completed retinal/dilated exam or w/in prior year or hx of bilateral eye enucleation completion)	EED
Annual Hemoglobin A1C with Diabetes (18-75 yr. w/DM A1C <8.0%)	HBD
F/U after ED visit with Multiple Chronic Conditions (18 + yr. f/u visit with provider w/in 7 days)	FMC
Annual Kidney Eval with Diabetes (18-85 yr. w/DM completed kidney eval)	KED
All Cause Readmissions (18 + yr. TOC to prevent readmission w/in 30 days of discharge)	PCR
Statin Use with Cardiovascular Disease (21-75 yr. w/ASCVD an received statin therapy – med adherence)	SPC
Statin Use with Diabetes (40-75 yr. w/ DM received statin therapy – med adherence)	SUPD
Transition of Care Patient Engagement (18 + yr. completed f/u visit with provider w/in 30 days of discharge)	TRC
Medication Adherence: Diabetes, Hypertension, Statins only (18 + yr. 80% compliant)	-

Care Coordination Role and Responsibility

MSC+/MSHO and Connect/Connect + Medicare

Use Gaps in Care Reports!

Understanding how a member is using health care can provide Care Coordinators essential information to help members receive the best care!

Gaps and Measures are addressed in the day-to-day work of care coordinators

- Annual Assessment
  - Physical Health
  - Preventative Care
  - Vision, medications
- Support Plan
  - My Goals
  - Barriers to achieving goals: What gets in the way?
- Transition of Care
  - Address primary care
  - Post hospitalization follow up care
  - Mental health care visit after hospitalization

Prepare before a visit:

- Review for noted gaps from report
- Gaps data provides talking points for reminders, health education and the opportunity to assist with identifying obstacles and barriers the member may have in closing a gap

Assessment & Support Plan

Prepare before a visit:

- Review noted gaps from the report
- Address preventative care screenings during the assessment
- Assist with scheduling screenings
- Review barriers
  - Fear? Education? Transportation? Procrastination? Cultural beliefs?
- Review medication adherence – what's working well, or is support needed?
    - Consider Medication delivery

Support Plan

Create goals to achieve gap in care closure

Example:
I would like to have my Diabetic Eye Exam within the next 6 months.

Supports I would like:

- My care coordinator will review my vision and supplemental benefits
- My care coordinator will provide a list of options for eye exams within 3 weeks
- My CFSS worker will schedule my eye exam
- My care coordinator will arrange transportation to an eye exam

Mid-Year Review

Review goals and if not complete ask:
What's getting in the way of completing XYZ?"
Consider what interventions you can do to help the member remove barriers.

Importance of TOC

Care Coordinators (CCs) act as a consistent person to support the member throughout the transition, and to help prevent transitions:

- Educate to avoid unnecessary ER visits and hospitalizations.
- Identify risks (e.g., falls, lack of preventive care, and poor chronic care disease management) and take action.
- Share with hospital discharge planners the support and services the member currently has, assisting with discharge planning.
- Identify when a member may need assistance to manage their medications.
- Setting up crucial follow up appointments with primary care or specialists upon hospital discharge.

Resources: TOC Member Handout | TOC Scenarios

Care Coordinators are the key to supporting successful transitions for members.

Follow up after Emergency Room Visit

Best practice:

Educate on Where to go for Care

At assessment – explain if a person goes to ER – they should f/u with their provider for after care

Accessing EAS/PointClickCare daily or via reports provides the CC with real-time data when a member has an emergency room visit.

Resources

To Support Care Coordination & Members

Benefits by Condition

ucare

Member Benefits by Condition

The purpose of this grid is to start the coversation around a variety of member benefits UCare offers based on relevant diagnoses. Each diagnosis has a tab with suggested resources your member **MAY** be eligible for. This guide is not intended to replace eligibility guidelines or referral forms. All benefit eligibility **MUST** be verified by care coordinator prior to offering to members.

Best Practice Tips	Requirements
• Familiarize yourself with all UCare member benefits. • Educate members on appropriate services they are eligible to receive. • Be mindful of service duplication and avoid authorizing duplicitive supports	• Verify member eligibility piror to making referrals. • Only refer members to appropriate services to meet their health and safety needs. • Follow referral procedures outlined on the supplemental benefits grids and service referral forms.

Quick Links to Benefits

Cardiac & HTN	Dental	Diabetes	Falls Prevention	Foot Care	Maternity Management
Medication Management	Mental Health & Substance Use	Migraine Management	Other	Pain Management	Readmission
Respiratory & Lungs	Vision & Eyeware	Weight & Fitness Management			

Care coordinators provide education about member benefits that can help members achieve their goals to close gaps in care.

Did U Know?

UCare's Benefits by Condition and Additional and Supplemental Benefits provide CCs information on additional criteria and how to access benefits.

Reference: Benefits by Conditions | Additional and Supplemental Benefits

*Benefits are subject to change

Gaps in Care Incentives

UCare members with a gap in certain preventative care may be eligible for an incentive voucher.

View rewards and incentives by product at UCare Rewards and Incentives page

- Examples: Mammogram, Colon Cancer screening, Dental exam and A1C check.

NOTES:

- Members must have their Provider sign the voucher prior to returning it to UCare
- Vouchers apply to current members enrolled at the time of the exam
- Limit 1 reward per calendar year per incentive
- Earned Rewards added to Healthy Benefits+ Visa card
- Benefits may change yearly
- Incomplete or ineligible vouchers will be returned

Care coordinators can request an incentive voucher is mailed to a member by reaching out to wellness@ucare.org. Please do not print and distribute.

Incentives (CT, CT+MED, MSC+, MSHO)

Screening or Exam	Measure	Incentive
Annual Wellness Visit*	AWV	$25
Mammogram Screening	BCS-E	$50
Colon Cancer Screening**	COL-E	$50
Dental Visit	DEN	$25
Blood Glucose A1C test	HBD	$30
Dilated or retinal Eye Exam	EED	$30
Annual Urine Protein Test	KED	$30

*CT and CTM age criteria up to age 21
**Complete colonoscopy, sigmoidoscopy; and at-home tests do not qualify for a reward

Cologuard Screenings

A colonoscopy is the preferred screening, and is good for up to 10 years, but a home test kit may be an alternative option for those hesitant to go in for the procedure and at average risk for colorectal cancer.

*Cologuard is an initiative for colorectal cancer screenings, in partnership with Exact Sciences

Benefits of Cologuard

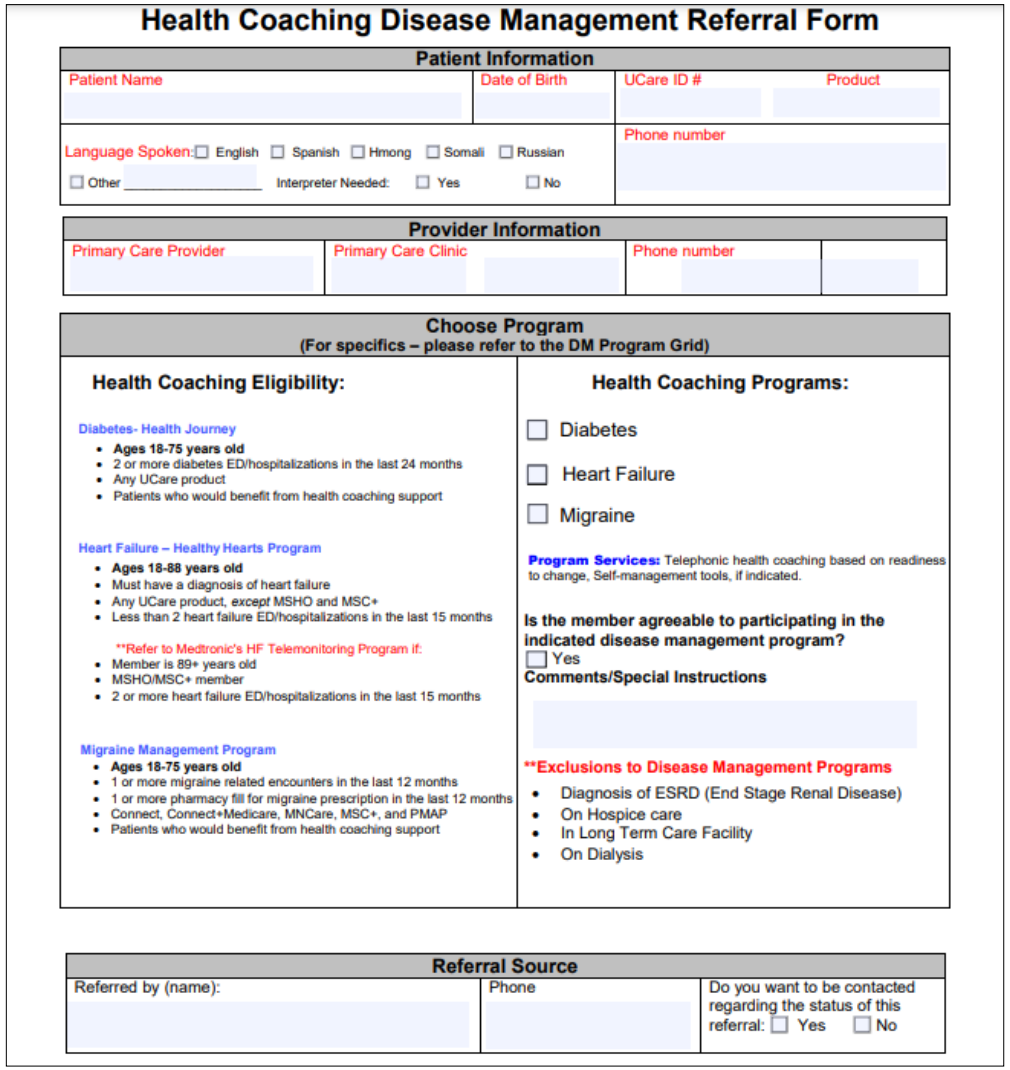
- Can be completed in place of a colonoscopy and in the comfort of a member's home
- Covered as a preventative health benefit with no out-of-pocket cost to the member
- Repeated every 3 years.
- Results are provided to the member, provider (as applicable), and UCare

Requests: Eligible members can have Cologuard sent to their homes

- Eligible MSHO and Connect + Medicare members can opt in to receiving a kit. Order requests can be sent to ucarequality@ucare.org.
- Eligible Connect and MSC+ members were sent a Cologuard kit. If assistance is needed, please call Exact Sciences Laboratory Customer Care team at 1-844-870-8870.
- Members may want to discuss with Primary Care Provider for appropriateness.

*Home test kits are not eligible for rewards and incentives

Disease Management Programs



Health Coaching Disease Management Referral Form

Patient Information

Patient Name	Date of Birth	UCare ID #	Product

Language Spoken: ☐ English ☐ Spanish ☐ Hmong ☐ Somali ☐ Russian ☐ Other _____ Interpreter Needed: ☐ Yes ☐ No

Phone number

Provider Information

Primary Care Provider	Primary Care Clinic	Phone number	

Choose Program
(For specifics – please refer to the DM Program Grid)

Health Coaching Eligibility:

Diabetes- Health Journey
- **Ages 18-75 years old**
- 2 or more diabetes ED/hospitalizations in the last 24 months
- Any UCare product
- Patients who would benefit from health coaching support

Heart Failure – Healthy Hearts Program
- **Ages 18-88 years old**
- Must have a diagnosis of heart failure
- Any UCare product, *except* MSHO and MSC+
- Less than 2 heart failure ED/hospitalizations in the last 15 months

**Refer to Medtronic's HF Telemonitoring Program if:
- Member is 89+ years old
- MSHO/MSC+ member
- 2 or more heart failure ED/hospitalizations in the last 15 months

Migraine Management Program
- **Ages 18-75 years old**
- 1 or more migraine related encounters in the last 12 months
- 1 or more pharmacy fill for migraine prescription in the last 12 months
- Connect, Connect+Medicare, MNCare, MSC+, and PMAP
- Patients who would benefit from health coaching support

Health Coaching Programs:

☐ Diabetes

☐ Heart Failure

☐ Migraine

Program Services: Telephonic health coaching based on readiness to change, Self-management tools, if indicated.

Is the member agreeable to participating in the indicated disease management program?
☐ Yes
Comments/Special Instructions

**Exclusions to Disease Management Programs
- Diagnosis of ESRD (End Stage Renal Disease)
- On Hospice care
- In Long Term Care Facility
- On Dialysis

Referral Source

Referred by (name):	Phone	Do you want to be contacted regarding the status of this referral: ☐ Yes ☐ No

Health Journey

Diabetes Program

MSC+, MSHO, Connect, and Connect + Medicare

Ages: 18 to 75 years old
- 2 or more diabetes ED/hospitalizations in the last 24 months
- Members who would benefit from health coaching support

Heart Failure Program

MSC+, MSHO, Connect, and Connect + Medicare
- Ages 18-88 years old
- Must have a diagnosis of heart failure
- 1 or more heart failure ED/hospitalizations in the last 15 months
- Members who would benefit from health coaching support

More information regarding disease management support resources can be found here:
UCare® - Disease Management

Cecelia Health Coaching

- Support from a Certified Diabetes Care & Education Specialist (CDCES)
- Member communications for engagement:
  - letter, email, webpage, phone calls
- 6 months of health coaching
- Diabetes education, goal setting, medication adherence, gaps in care closure
- Enrolled members may access an endocrinologist via virtual visit

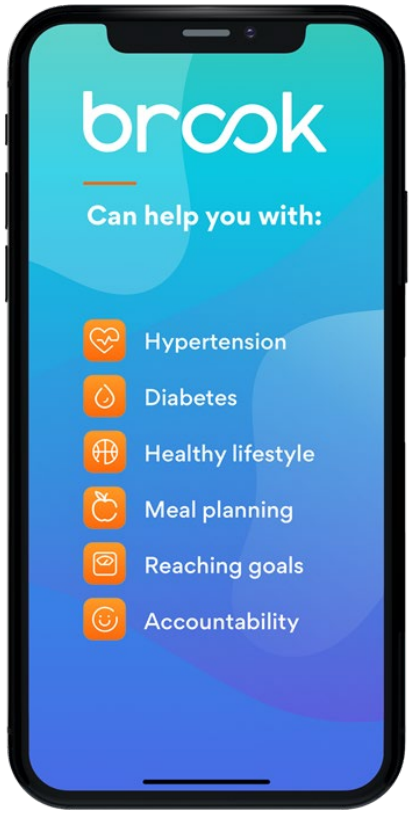
Referrals:

Members with diabetes are provided outreach by UCare and offered Cecelia Health.
Care coordinator role: discuss if member is connected with Cecelia Health and provide more information.

Reference: Web link and information on Care Coordination webpage Benefits, Perks & Member Handouts Spark:
https://signup-ucare-referral.ceceliahealth.com/

BROOK Health Companion App

UCare partners with Brook to help members manage your diabetes, blood pressure and other chronic conditions from their phone with the Brook Health Companion. Available at no cost, this app lets members chat with dietitians and health experts in real time to help members turn health goals into sustainable habits.



Keep accountable
Chat with health coaches 24/7, 365 days a year. No appointment needed.

Improve your numbers
Get support with weight, blood sugar, blood pressure and more.

Reach health goals
Discover what works best for you and get help sticking to it.

Get active
Find ways to fit activity into your daily life and track your progress.

Eat right for you
Work with dietitians to find the best meal plan for you.

Get helpful reminders
Schedule reminders to take your medication and check your blood sugar or blood pressure.

Reference: Brook app downloading instructions available at ucare.org/brook

Juniper Evidence-Based Health Education Classes (MSHO)

Statewide network of community and evidence-based classes at no cost to eligible MSHO members

Classes Include:

- ❑ Falls prevention
- ❑ Self-management of arthritis
- ❑ Chronic pain
- ❑ Diabetes
- ❑ Active living
- ❑ Tai ji Quan

No authorization required!

- Care coordinators complete referral or member registers at https://yourjuniper.org/

MSHO Members can request rides from Health Ride for up to 3 round-trip rides/week for Juniper classes or One Pass participating health clubs.

Additional Benefits

MSHO **Non-EW**

Post-Discharge Meals
Two meals a day for up to four weeks

Qualifying Conditions: Not eligible for EW and following inpatient hospital or SNF stay

Limitations: Designated provider is Mom's Meals
Authorization Required: Mom's Meals MSHO Supplemental Benefit form

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Lifeline/PERS
Personal Emergency Response System

Criteria: Not eligible for EW and history/risk of falls

Limitations: None. Any DHS enrolled PERS provider can provide
Authorization Required: MSHO Supplemental Benefit Request form

MSHO **Non-EW** or MSHO at Elderly Waiver budget max

Home and Bath Safety Devices
$750/year for specific items

Qualifying Conditions: MSHO members with risk/history of falls

Limitations: Allowed Home & Bath Safety Devices. See Additional and Supplemental Benefits for list of covered items

Authorization Required: MSHO Supplemental Benefit form

Member Kits by Product:

MSHO:
Stress & Anxiety Kit
Memory Kit

MSC+/MSHO:
Strong & Stable Kit

Connect/Connect + Med:
Connect to Wellness (all)

MSHO/Connect + Med:
Medication Toolkit
Adult Dental Kit

	MSHO	MSC +	CT	CT + M	
 Sleep Aid (Aromatherapy)	x		x	x	MSHO: Order Form CT/CT+Med: Wellness@ucare.org
 Smart Home Device (Amazon Echo)	x		x	x	MSHO: Order Form CT/CT+Med: Wellness@ucare.org
 Stress Reduction (UV Light etc.)	x		x	x	MSHO: Order Form CT/CT+Med: Wellness@ucare.org
 Weighted Blanket Kit				x	CT+Med: Wellness@ucare.org
 Adult Dental Kit (electric toothbrush)	x			x	MSHO/CT + Med: Order Form
 Dental Kit (battery toothbrush)			x	x	CT/CT+Med: Wellness@ucare.org
 Strong & Stable Fitness Kit	x	x			MSC+/MSHO: Order Form
 Fitness Kit			x	x	CT/CT+Med: Wellness@ucare.org
 Medication Toolkit	x			x	MSHO/CT+Med: Order Form
Memory Support Kit A **All:** photo album, memory training game, motion sensor light, voice-controlled alarm clock and brain books	x				MSHO: Order Form
Memory Support Kit B **Pick One:** animatronic cat, animatronic dog, animatronic baby boy, animatronic baby girl, one button radio, Twiddle Muff, 5-pound weighted blanket	x				MSHO: Order Form

Closing a Gap in Care

Review barriers with members:

What gets in the way of completing the exam?
Look for ways to overcome barriers.

- Cologuard options
- Education of what to expect
- Request incentives be sent to member
- Create a goal to close Gaps
- Assist with scheduling appointments when at the visit

Assistance with Medication Adherence

- TIP: Obtain ROI for MD or pharmacy
- Request a med list from MD to review
  - Check for adherence
  - Is the med dc'd or no longer taking
- MTM referral as appropriate
- SNV for medication set-up and management
- Mailed medication options, coordinate pharmacy pickup for all meds

Review EAS/PCC for Emergency Room use

Coordinate services, referrals and DME

Clinical Liaison Contacts

Email: MSC_MSHO_Clinicalliaison@ucare.org

Phone number & toll-free phone number:
612.294.5045 Toll free: 866.613.1395

Email: SNBCClinicalLiaison@ucare.org

Phone number & toll-free phone number
612.676.6625 Toll free: 833.951.3190