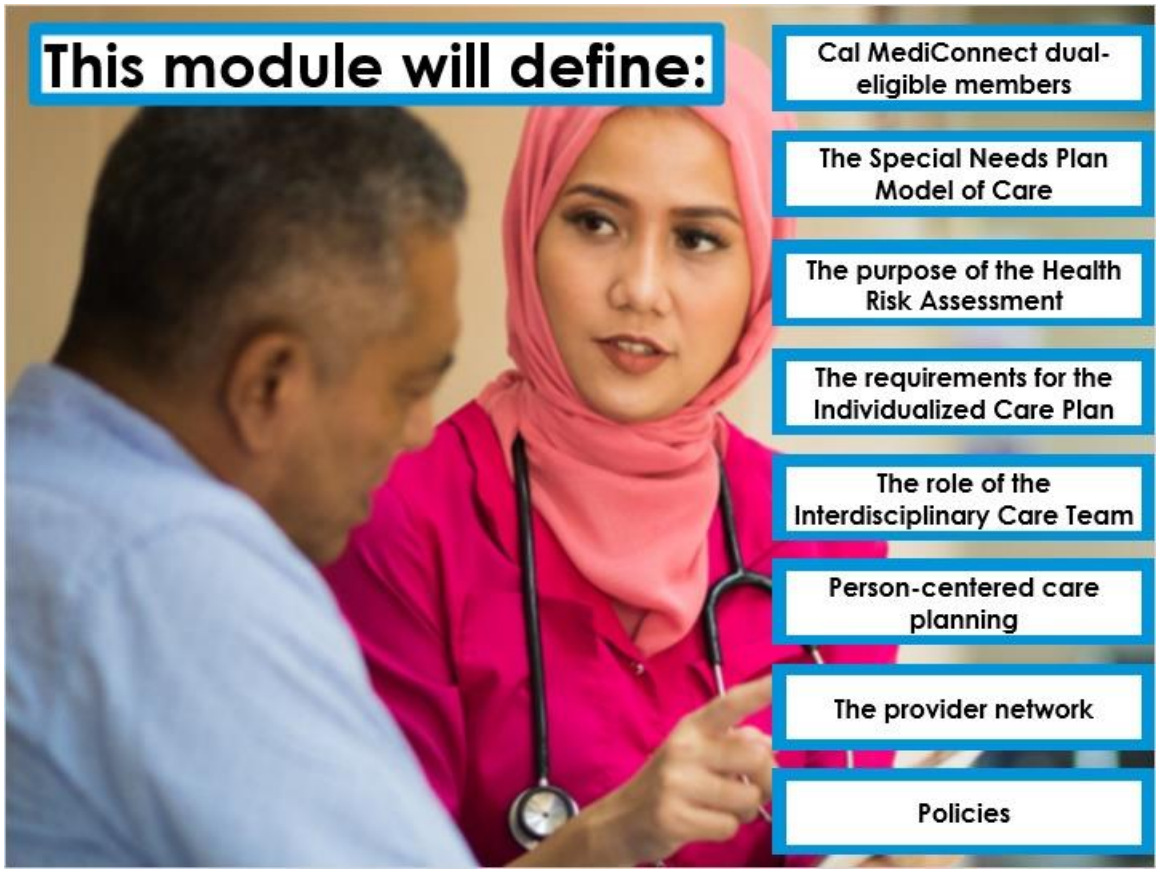
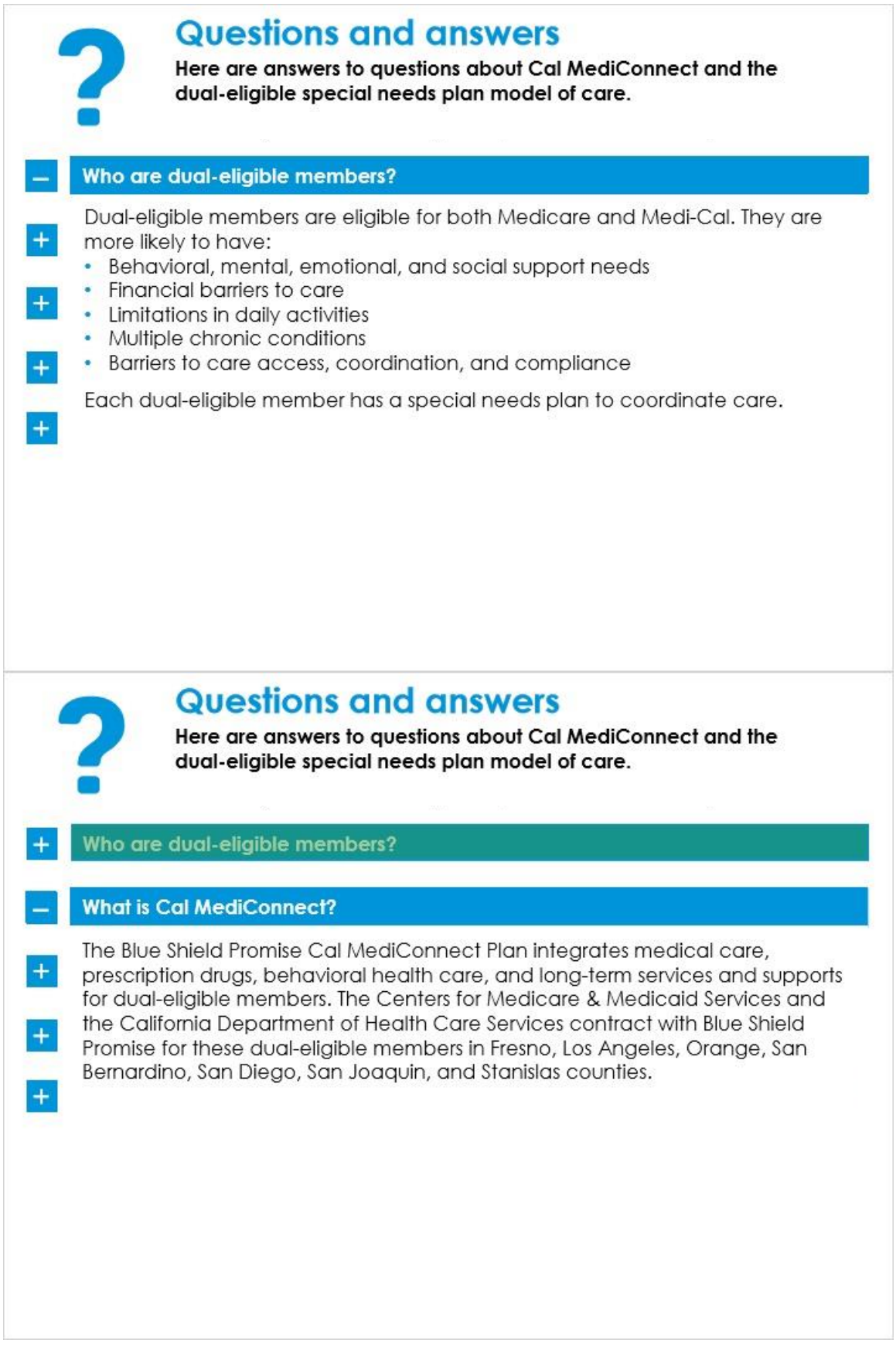
Cal MediConnect and Dual-Eligible Special Needs Plan



Cal MediConnect and Dual-Eligible Special Needs Plan



Cal MediConnect and Dual-Eligible Special Needs Plan

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

+ Who are dual-eligible members?
+ What is Cal MediConnect?
− What is the model of care for special needs plan members?

The Blue Shield Promise Model of Care for Special Needs Plan members identifies:

- How various demographic factors combine to adversely affect health status
- Special services to meet the needs of the most vulnerable members
- Community partners such as Multipurpose Senior Services Program, the Alzheimer's Association, Area Agency on Aging, and In-Home Support Services to provide specialized resources

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

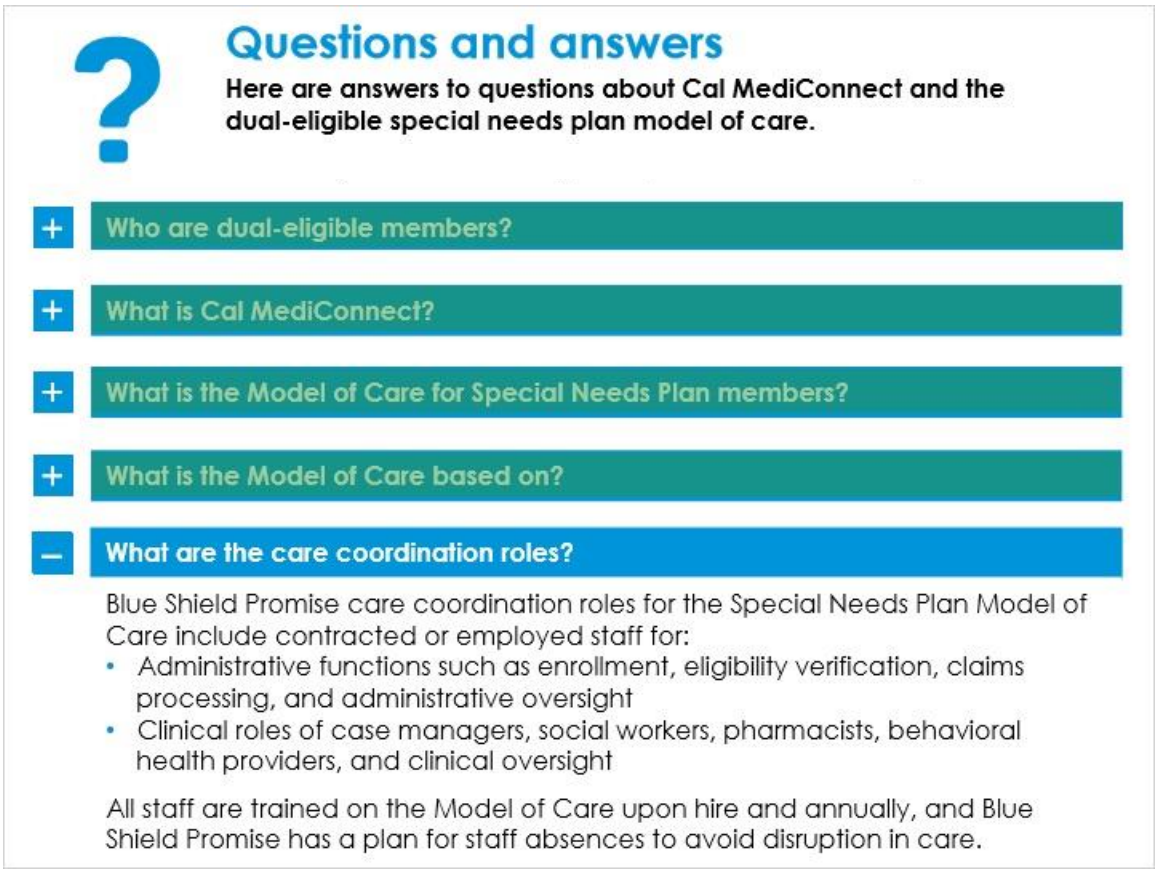
+ Who are dual-eligible members?
+ What is Cal MediConnect?
+ What is the Model of Care for Special Needs Plan members?

− What is the model of care based on?

To build the Model of Care for these members, we perform a population assessment that identifies age, gender, ethnicity, and:

- Prevalence of major diseases and chronic conditions
- Language barriers and health literacy
- Barriers to healthcare services associated with cultural beliefs or socioeconomic status
- The segment of the special needs population who are at the highest risk of poor health outcomes by looking at multiple hospital admissions, high pharmacy utilization, high costs, or a combination of medical, psychosocial, cognitive, and functional challenges

Cal MediConnect and Dual-Eligible Special Needs Plan



Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

+ Who are dual-eligible members?
+ What is Cal MediConnect?
+ What is the Model of Care for Special Needs Plan members?
+ What is the Model of Care based on?
– **What are the care coordination roles?**

Blue Shield Promise care coordination roles for the Special Needs Plan Model of Care include contracted or employed staff for:

- Administrative functions such as enrollment, eligibility verification, claims processing, and administrative oversight
- Clinical roles of case managers, social workers, pharmacists, behavioral health providers, and clinical oversight

All staff are trained on the Model of Care upon hire and annually, and Blue Shield Promise has a plan for staff absences to avoid disruption in care.

Who is the primary and secondary payer?

Medicare

Medi-Cal

Medicare is the primary payer and covers the following services:

- Physician
- Hospital
- Short-term skilled nursing facility

Medi-Cal is the secondary payer and covers the following:

- Medicare cost sharing
- Services not covered by Medicare
- Services delivered after Medicare benefits have been exhausted
- Most long-term care costs including longer nursing home stays and home and community-based services that prevent institutionalization

Health Risk Assessment (HRA)

What is the health risk assessment?

The Blue Shield Promise Cal MediConnect Plan attempts to complete health risk assessments for each dual-eligible member to identify medical, psychosocial, cognitive, and functional risks. The assessment is conducted by phone or face-to-face depending on the member's needs or preferences. After multiple attempts are made to directly contact the member, the survey is mailed.

Health Risk Assessment (HRA)

When is the health risk assessment completed?

The health risk assessment is completed:

- **Annually**, within 1 year of the last health risk assessment for all members
- Within **90 days** from date of enrollment for lower risk members or for those in a long-term care or nursing facility
- Within **45 days** from date of enrollment for higher risk members

After the Health Risk Assessment is conducted, the member's responses are incorporated into the Individualized Care Plan and communicated to the provider by fax or mail.

Health Risk Assessment (HRA)

The health risk assessment screens for:

- Health status including chronic health conditions and health care needs
- Clinical history
- Mental health and cognitive status
- Activities of daily living and instrumental activities of daily living
- Medication review
- Cultural and linguistic needs, preferences, or limitations
- Visual preferences or limitations
- Quality of life and life planning activities
- Caregiver support
- Available benefits
- Continuity of care needs
- Fall prevention
- Managed Long-Term Services and Supports, including Home and Community-Based Services

Activities of daily living and instrumental activities of daily living

Activities of daily living (ADL) consist of self-care tasks including:

- **Bathing and showering**
- **Personal hygiene and grooming**
- **Dressing**
- **Toilet hygiene**
- **Functional mobility (moving from one place to another)**
- **Self-feeding**

Instrumental activities of daily living (IADL) consist of independent living tasks including:

- **Cleaning and maintaining the house**
- **Managing money**
- **Moving within the community**
- **Preparing meals**
- **Shopping for groceries and necessities**
- **Taking prescribed medications**
- **Using the telephone or other form of communication**

Individualized Care Plan (ICP)

Overview

Components

Behavioral Health

In-Home Support Services

Individualized Care Plan overview

- The Individualized Care Plan is developed specifically for each member.
- The member, or their authorized representative, must be given the opportunity to review and sign the Individualized Care Plan or any amendments.
- The Individualized Care Plan must be at a sixth grade reading level, in alternative formats, and in the member's preferred written or spoken language.

Individualized Care Plan (ICP)

Overview

Components

Behavioral Health

In-Home Support Services

Individualized Care Plan required components:

- Name and contact information for the member's primary care physician and any specialists
- Member goals and preferences
- Measurable objectives and timetables for medical and behavioral health services and long-term services and supports
- Time frames for reassessment: at minimum, annually or per current state or federal requirements

Individualized Care Plan (ICP)

- Overview
- Components
- Behavioral Health
- In-Home Support Services

Behavioral health required components

For members receiving behavioral health services, the Individualized Care Plan must include:

- Contact information of the county behavioral health provider
- An attestation that the primary care physician and county behavioral health provider have reviewed the information
- A record of at least one case review meeting that included the county behavioral health provider and documented the meeting date, participant names, and evidence of creation, or adjustment of, care goals

Individualized Care Plan (ICP)

- Overview
- Components
- Behavioral Health
- In-Home Support Services

In-Home Support Services components

For members receiving In-Home Support Services, the Individualized Care Plan must include:

- Contact information for the county social worker who has responsibility for authorizing and overseeing the member's in-home support services hours
- Contact information for the member's In-Home Support Services worker


Person-centered care
Blue Shield Promise Health Plan is committed to the provision of member care that:
Is provided in a manner that is sensitive to the member's functional and cognitive needs, language, and culture.
Member
Is offered in the least restrictive community setting, and in accordance with the member's care goals and Individualized Care Plan.
Allows for member and caregiver involvement (as permitted by the member) and accommodates and supports the member's self-direction.
Is provided in a care setting appropriate to the member's needs, with a preference for the home and community.

The interdisciplinary care team (ICT) is person-centered.

The interdisciplinary care team facilitates care assessment, planning, and management, as well as authorization of services and care transition. Members and caregivers are encouraged to participate. The team typically includes a case manager, social worker, pharmacist, medical director, and treating physician. Others are included based on member needs.

The ICT is built on the member's specific needs and preferences and is based on the Health Risk Assessment and Individualized Care Plan.

Member

The member can choose to limit or remove in-home support services providers, family members, and other caregivers on the team.

The ICT delivers services with dignity, transparency, individualization, and linguistic and cultural competence.

Blue Shield Promise requires individualized care teams to comprise knowledgeable team members on these key competencies*:

- **Person-centered planning**
- **Cultural competence**
- **Accessibility and accommodations**
- **Independent living**
- **Wellness principles**

* minimum - not limited to

Person-centered planning

Person-centered planning is the member-controlled method of selecting and using services that allows the person maximum control over his or her home and community-based services, including the amount, duration, and scope of services, as well as choice of providers.

Patient-centered planning

- **Recognizes the person as the expert**
- **Includes significant others**
- **Identifies hopes, interests, preferences, needs, and abilities**
- **Maximizes community connections**

Accessibility and accommodations

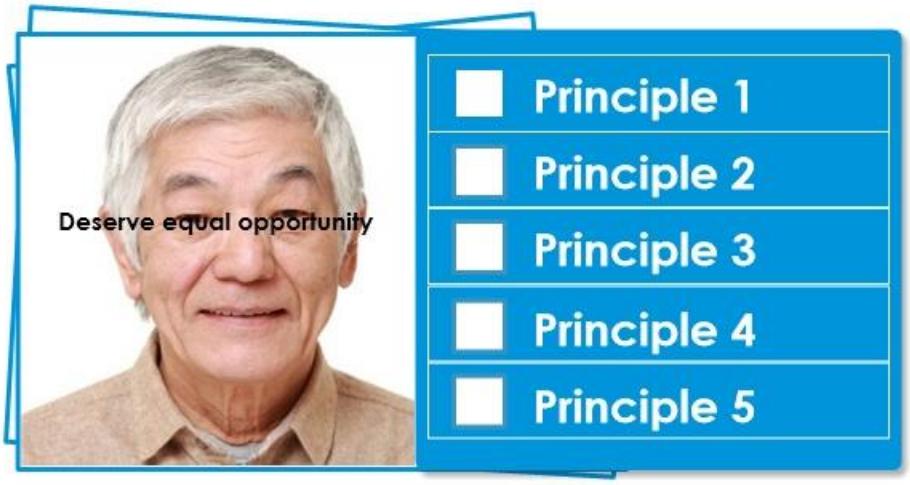
The Americans with Disabilities Act and Section 504 of the Rehabilitation Act require that health care providers provide individuals with disabilities full and equal access to their health care services and facilities.

Accessibility and accommodations checklist

- ✓ Parking spaces / curb ramps
- ✓ Barrier-free access from parking / loading zones to building entrance
- ✓ Wide doorways for safe access of wheelchair users
- ✓ Accessibility throughout public spaces within a facility
- ✓ Ample and accessible restrooms
- ✓ Accessible drinking fountains / service counters
- ✓ Raised tactile Braille signs in the office / elevators / restrooms
- ✓ Accessible exam rooms
- ✓ Accessible exam tables
- ✓ Accessible weight scales
- ✓ Transfer equipment to radiology (lift, stretcher, etc.)
- ✓ Communication and auxiliary aids

Independent living

The independent living philosophy emphasizes that people:



Independent living

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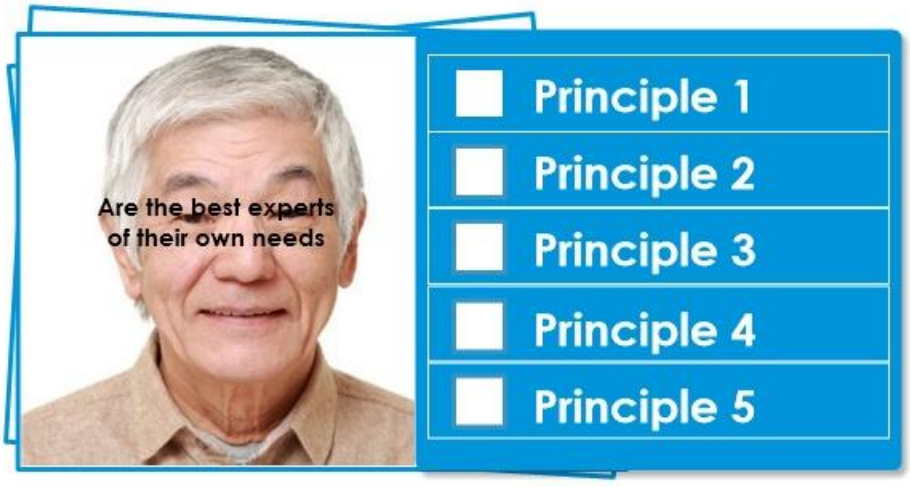

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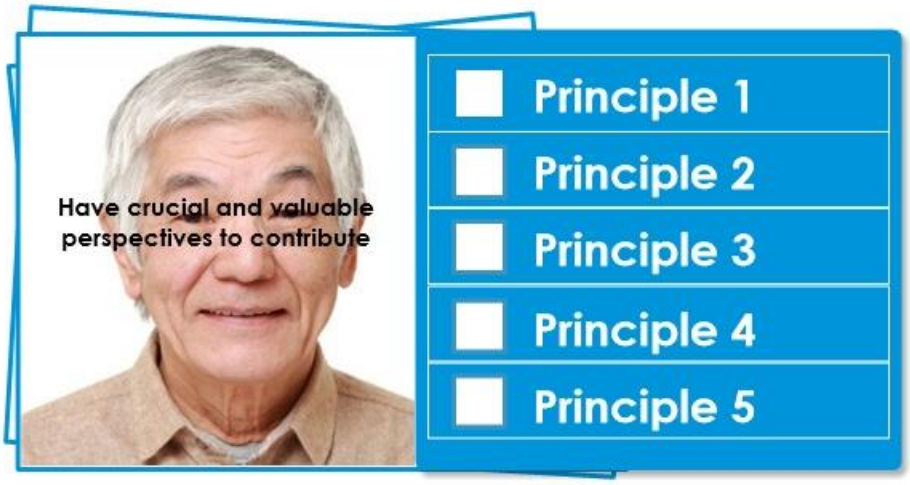

Independent living

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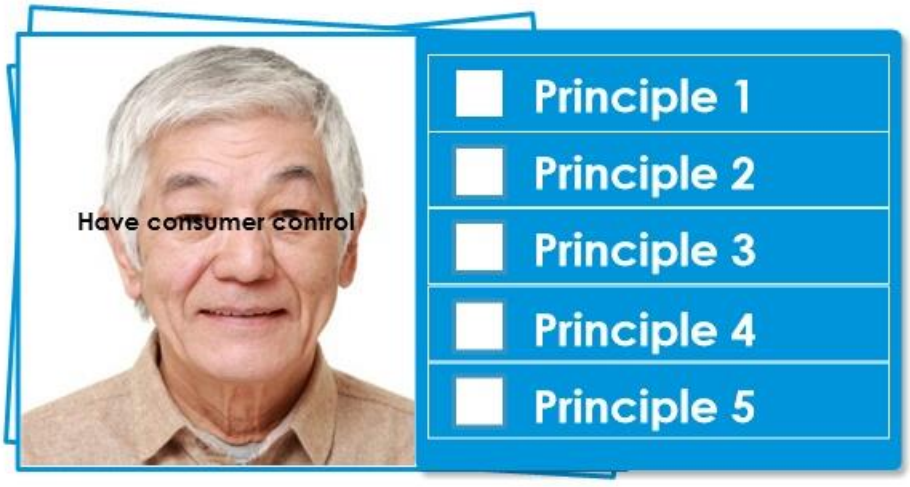
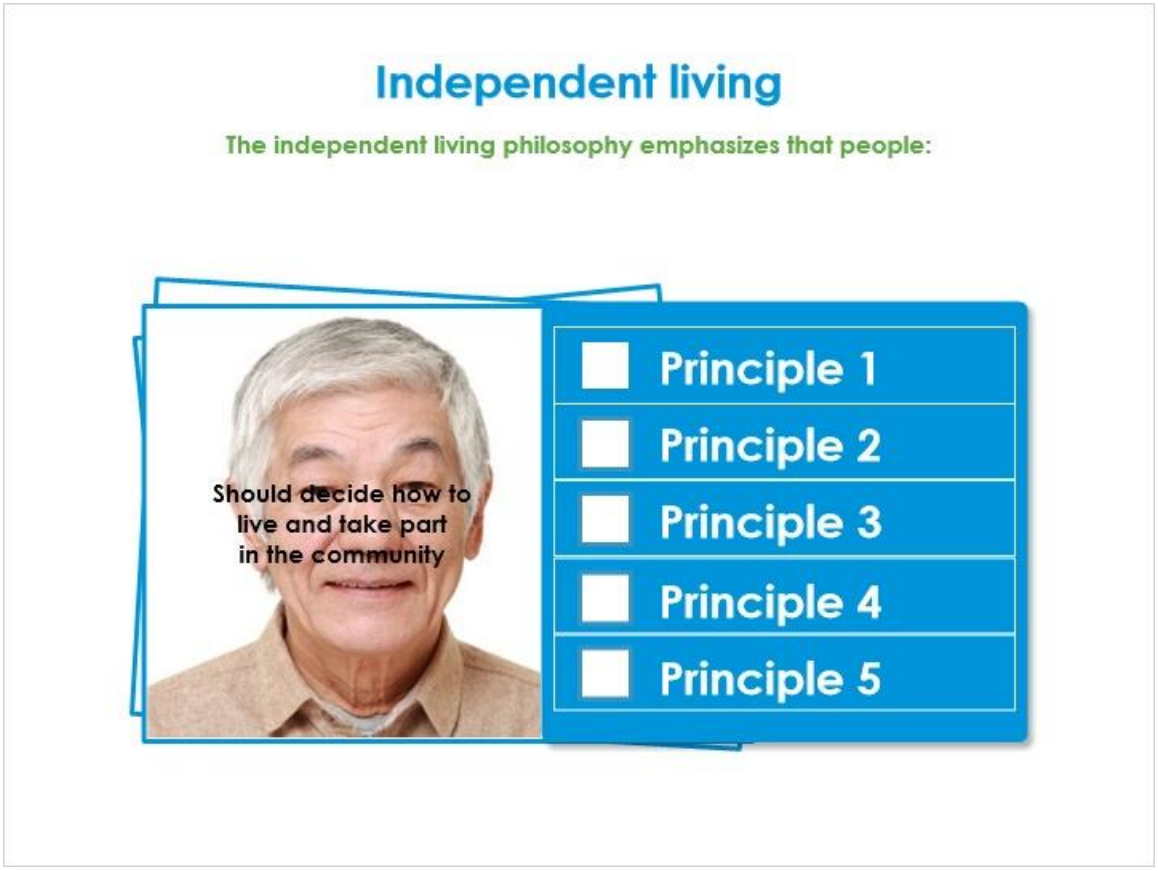



Independent living
The independent living philosophy emphasizes that people:
Should decide how to live and take part in the community
Principle 1
Principle 2
Principle 3
Principle 4
Principle 5

Wellness principles

1 2 3

Health includes a dynamic balance of physical, social, emotional, spiritual, and intellectual factors.

Wellness principles

1 2 3

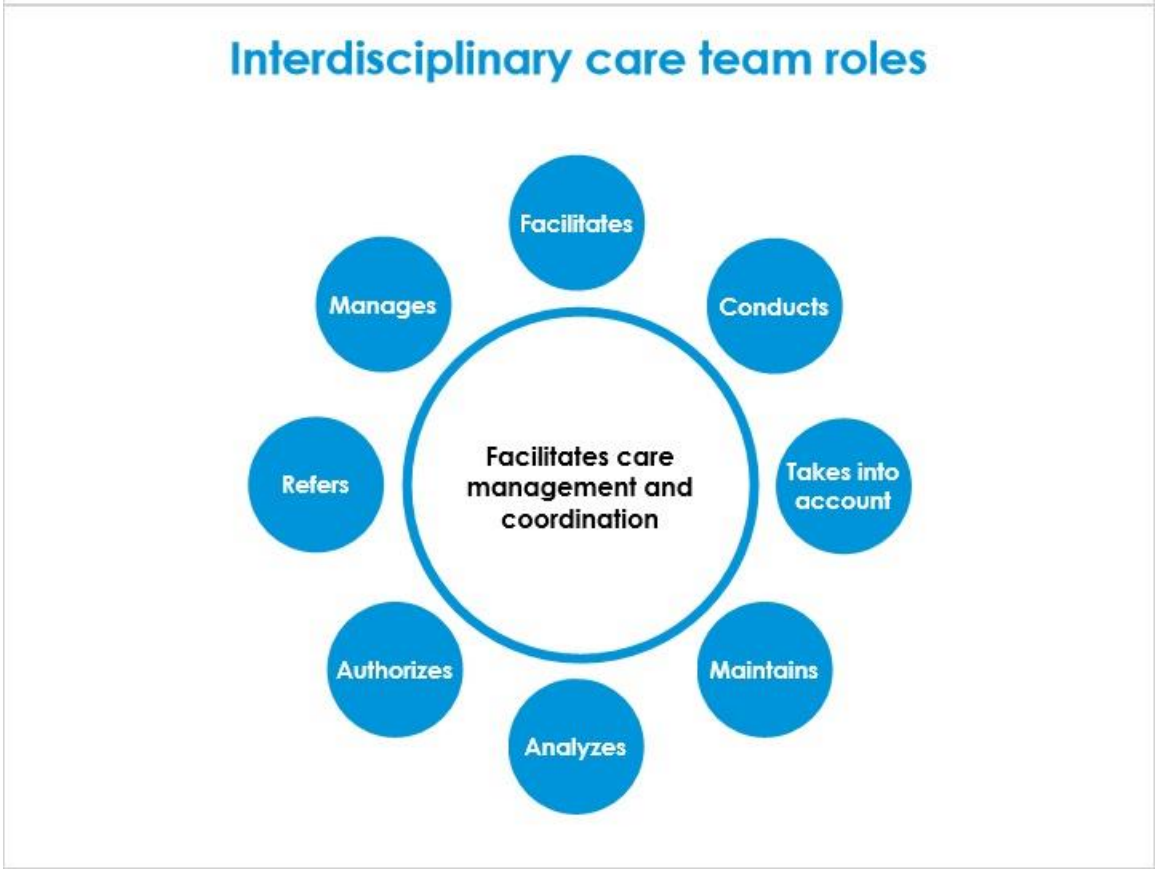
Physical exercise, good nutrition, stress-management, and social support are important for every one and health promotion activities are critical for people who are prone to a more sedentary lifestyle.

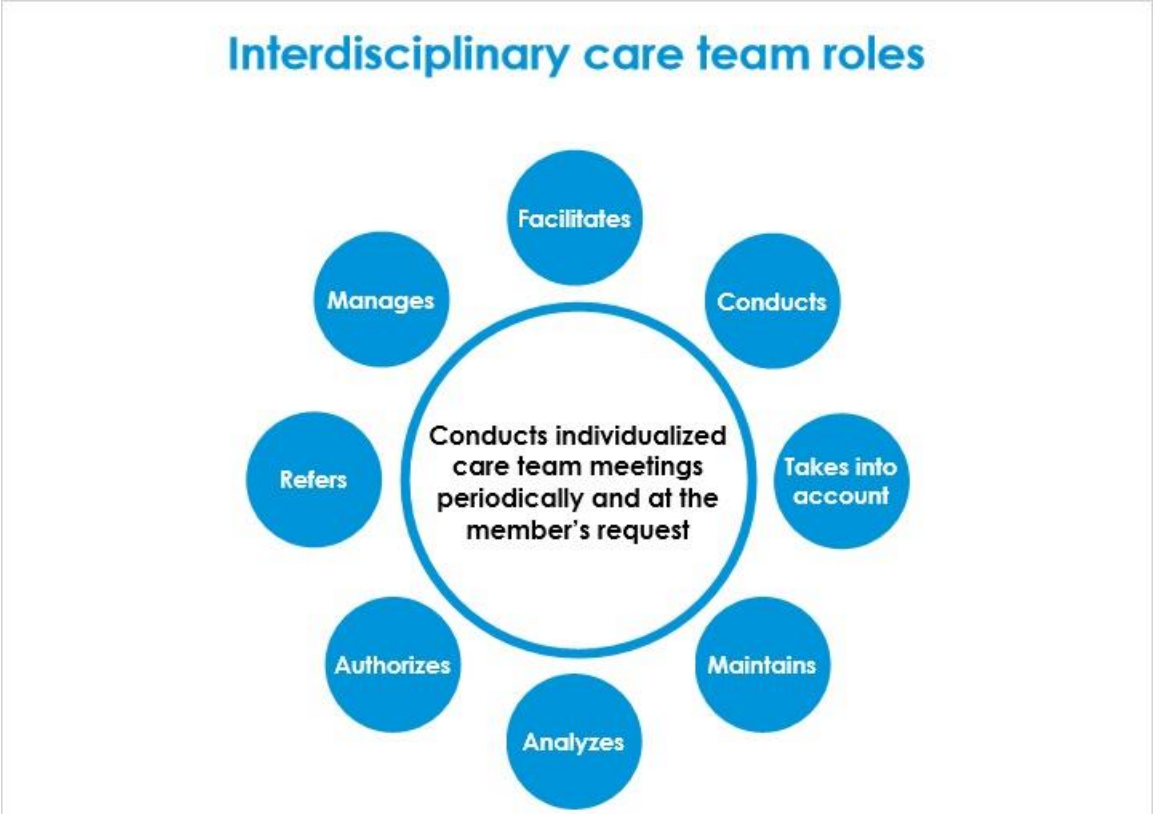
Wellness principles

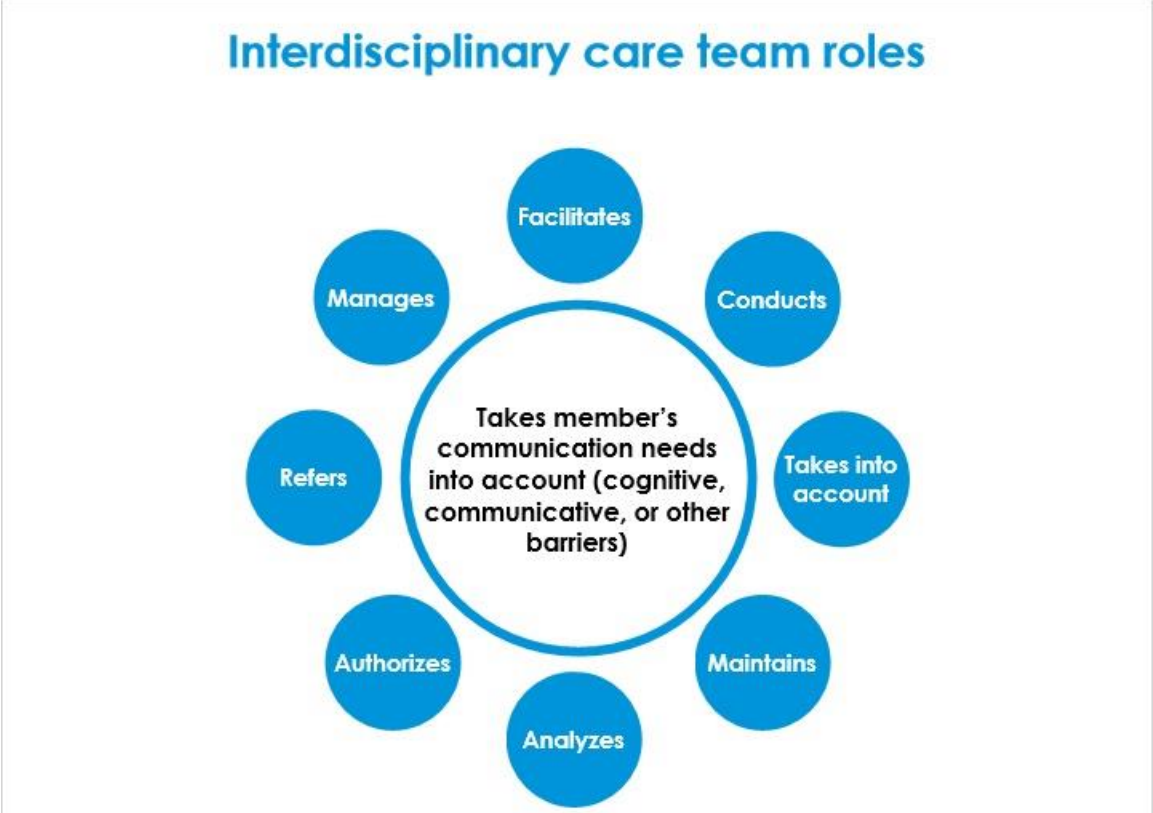
1 2 3

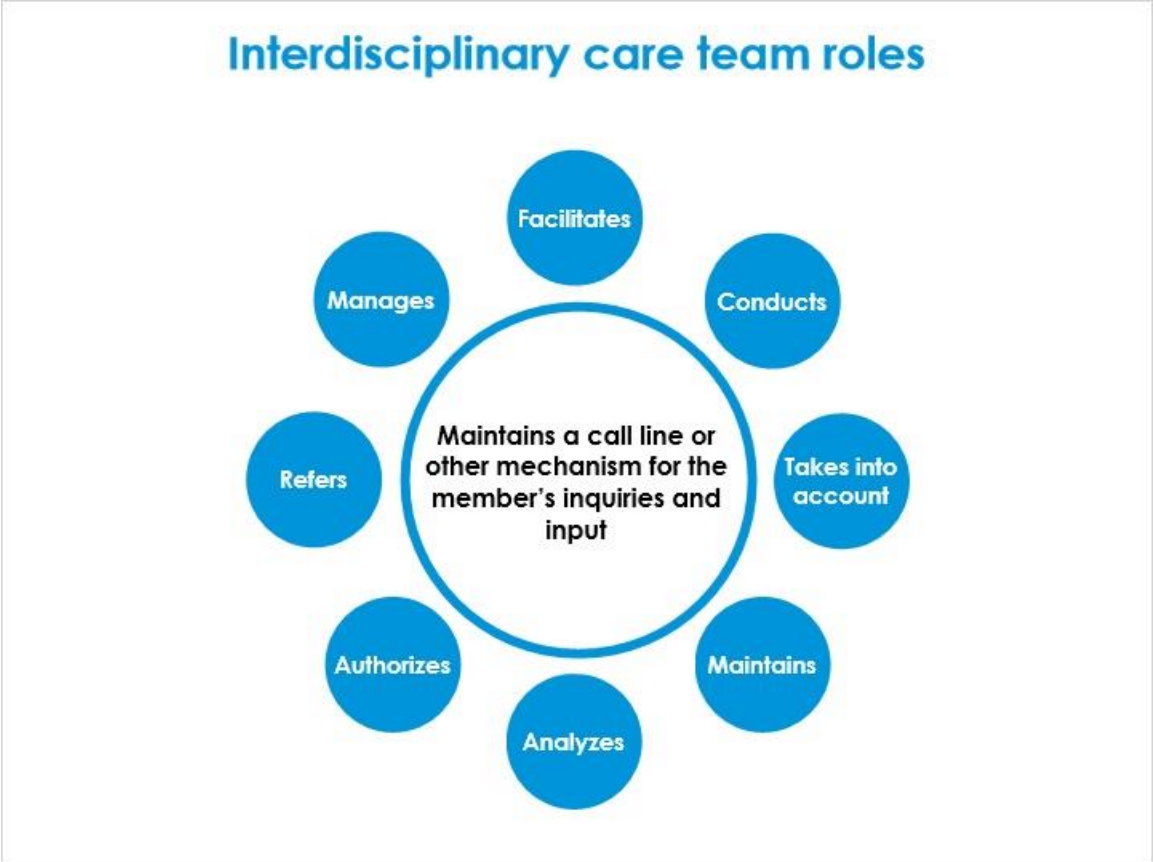
Providers can be of tremendous assistance in helping people select and practice tailored health promotion behaviors to increase their level of well-being.

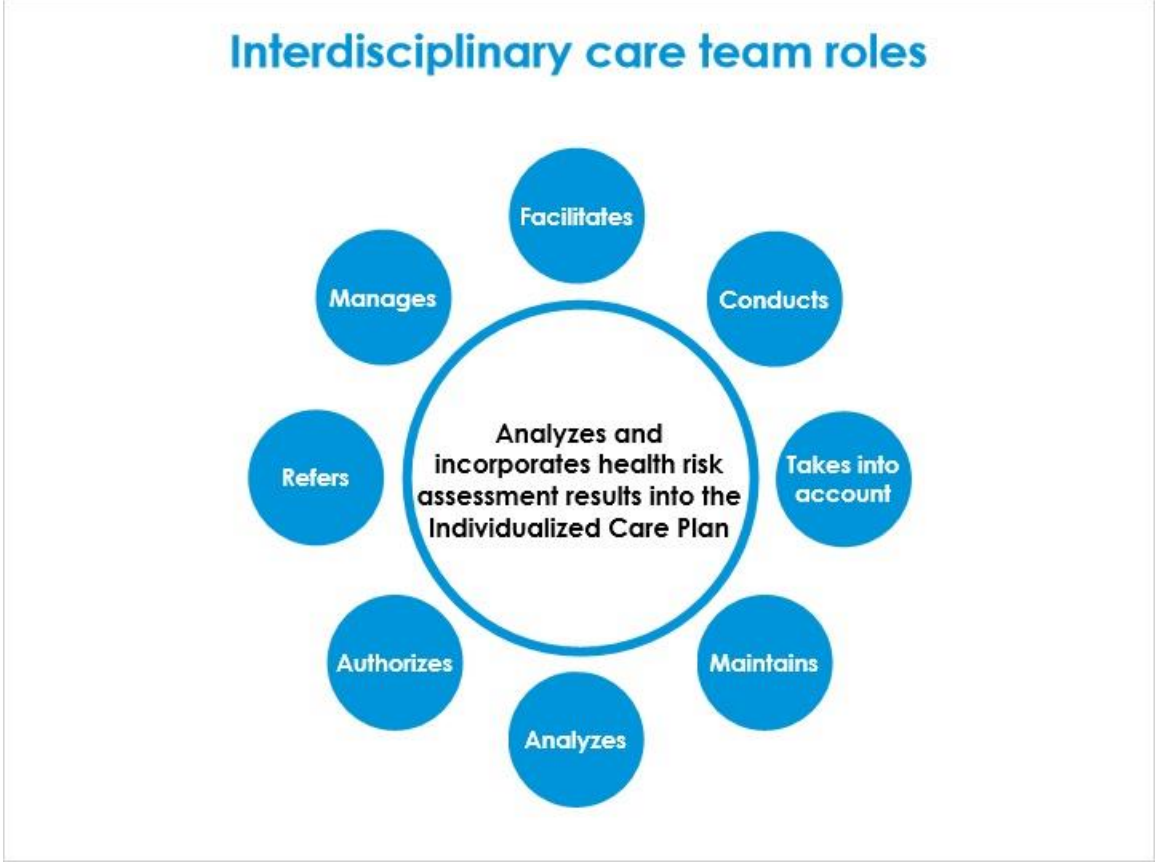

Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages

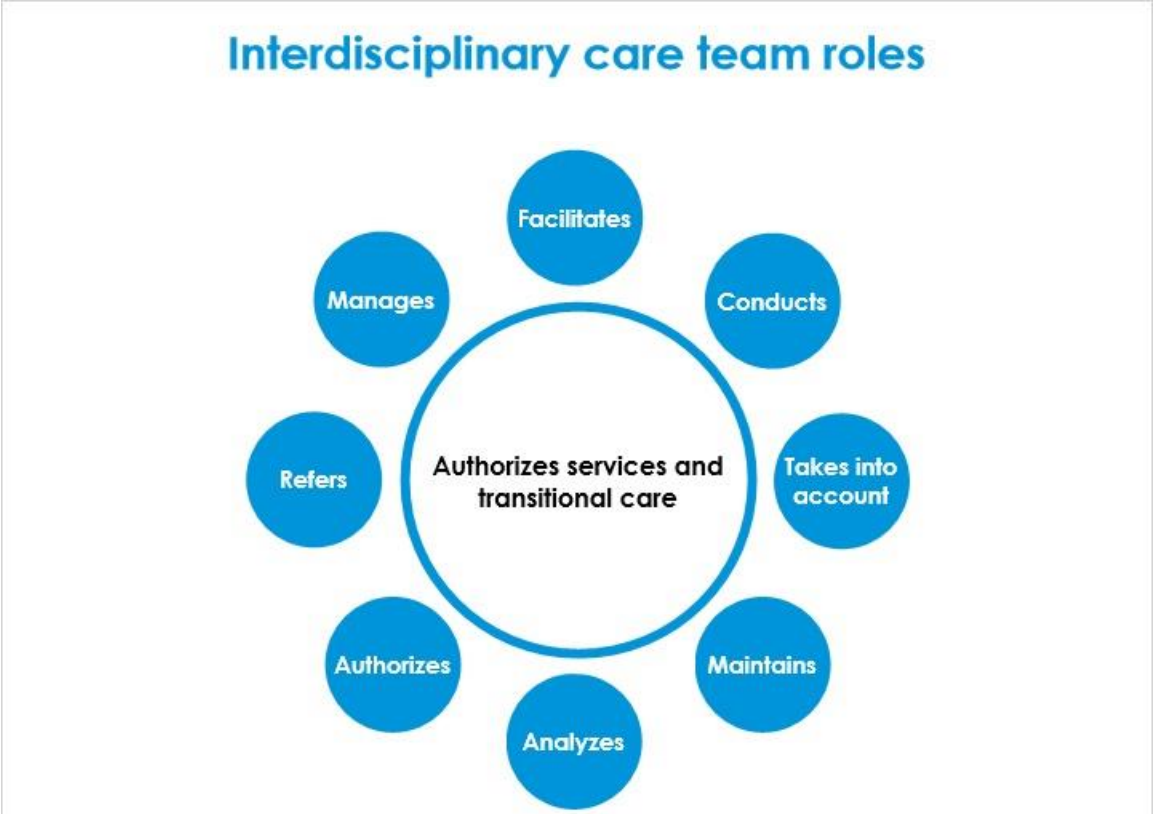

Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Facilitates care management and coordination


Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Conducts individualized care team meetings periodically and at the member's request


Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Takes member's communication needs into account (cognitive, communicative, or other barriers)

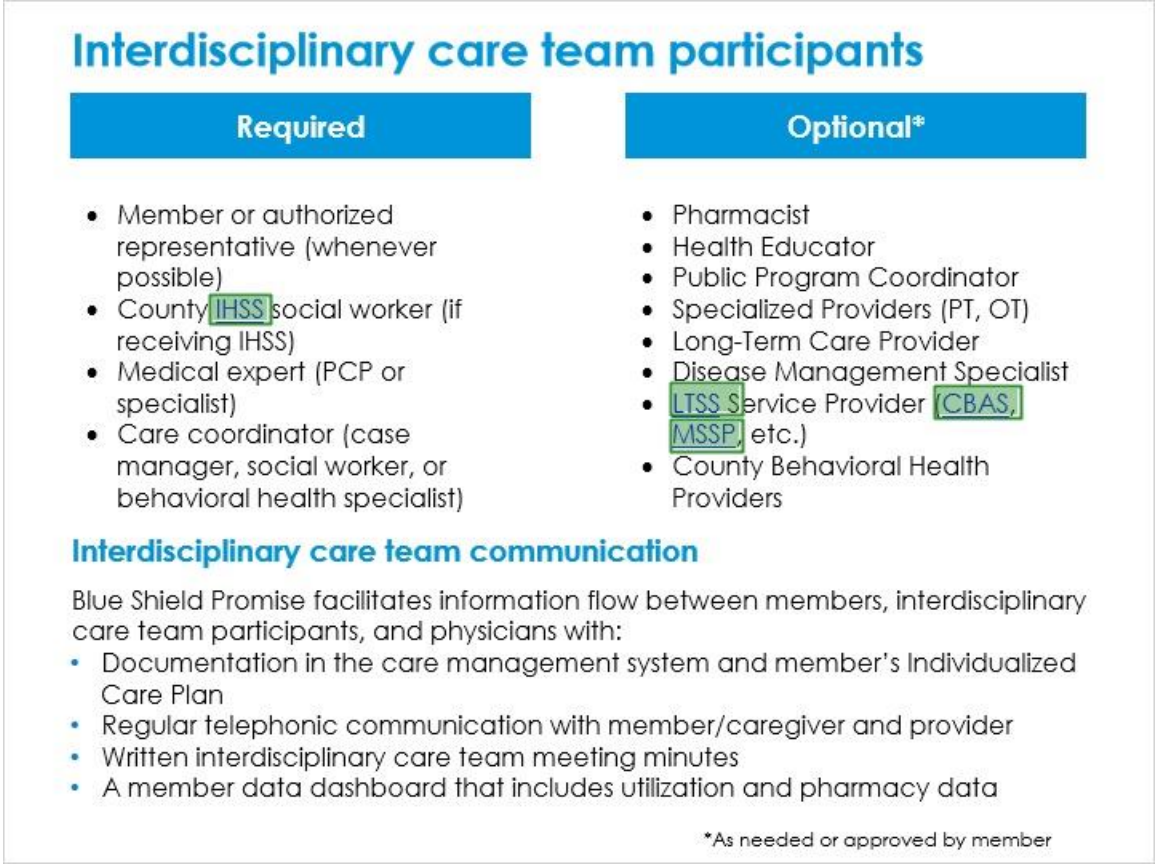

Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Maintains a call line or other mechanism for the member's inquiries and input


Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Analyzes and incorporates health risk assessment results into the Individualized Care Plan


Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Authorizes services and transitional care


Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Refers members to other agencies when needed (e.g., long-term supports and services or behavioral health services)


Interdisciplinary care team roles
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Manages information flow for care delivered outside the primary care site



Interdisciplinary care team participants

Required	Optional*
• Member or authorized representative (whenever possible) • County IHSS social worker (if receiving IHSS) • Medical expert (PCP or specialist) • Care coordinator (case manager, social worker, or behavioral health specialist)	• Pharmacist • Health Educator • Public Program Coordinator • Specialized Providers (PT, OT) • Long-Term Care Provider • Disease Management Specialist • LTSS Service Provider (CBAS, MSSP, etc.) • County Behavioral Health Providers

Interdisciplinary care team communication

Blue Shield Promise facilitates information flow between members, interdisciplinary care team participants, and physicians with:

- Documentation in the care management system and member's Individualized Care Plan
- Regular telephonic communication with member/caregiver and provider
- Written interdisciplinary care team meeting minutes
- A member data dashboard that includes utilization and pharmacy data

*As needed or approved by member

IHSS = In-home support services

LTSS = Long-term services and supports

CBAS = Community-based adult services

MSSP = Multipurpose Senior Services Program

Provider network

Blue Shield Promise Health Plan has a specialized network of providers to meet the needs of Special Needs Plan Cal MediConnect dual-eligible members.

Internists, family practitioners, geriatricians, endocrinologists, cardiologists, oncologists, pulmonologists

Provider network

Blue Shield Promise Health Plan has a specialized network of providers to meet the needs of Special Needs Plan Cal MediConnect dual-eligible members.

Behavioral health providers

Provider network

Blue Shield Promise Health Plan has a specialized network of providers to meet the needs of Special Needs Plan Cal MediConnect dual-eligible members.

Long-term service and support providers

Provider network

Blue Shield Promise Health Plan has a specialized network of providers to meet the needs of Special Needs Plan Cal MediConnect dual-eligible members.

General and subspecialty surgeons

Provider network

Blue Shield Promise Health Plan has a specialized network of providers to meet the needs of Special Needs Plan Cal MediConnect dual-eligible members.

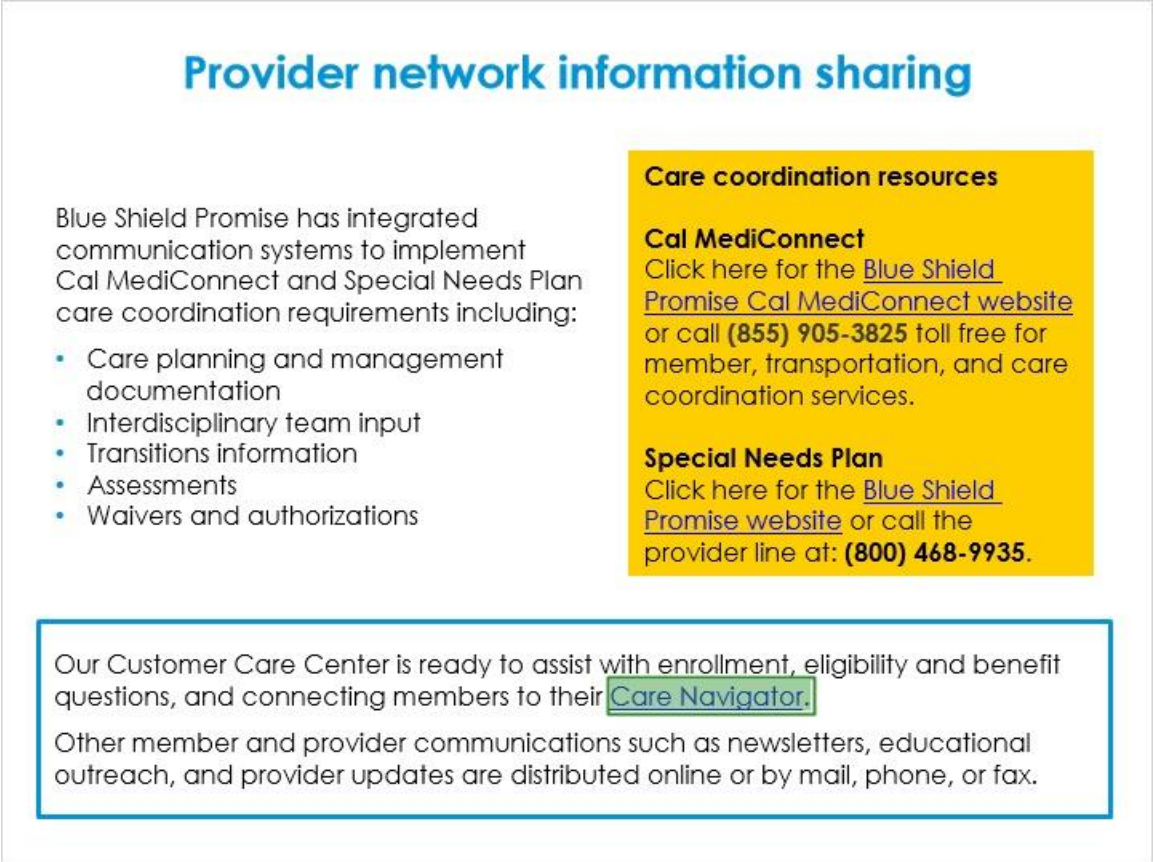
Ancillary health providers such as physical, speech and occupational therapists

Provider network

Blue Shield Promise Health Plan has a specialized network of providers to meet the needs of Special Needs Plan Cal MediConnect dual-eligible members.

Tertiary care physicians

Cal MediConnect and Dual-Eligible Special Needs Plan



Blue Shield Promise Cal MediConnect website

Blue Shield Promise website

Care Navigator = Coordinates all the member's providers and services

Care transition timeline

Blue Shield Promise adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital | SNF | Home | PCP

Within one day of notification of an admission to a hospital, a copy of the current Individualized Care Plan is faxed to the hospital.

Care transition timeline

Blue Shield Promise adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital | **SNF** | Home | PCP

Within one day of discharge from a hospital to a skilled nursing facility (SNF), the discharge orders/care plan are faxed to the skilled nursing facility.

Care transition timeline

Blue Shield Promise adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital	SNF	Home	PCP

When the member is being transitioned to the usual setting of care (typically the home), the case manager will discuss the discharge plan with the member and/or caregiver. This will be followed within two business days by a phone call to ensure the member is familiar with the appropriate self-management tools and to assist with scheduling a follow-up appointment with the primary care physician.

Care transition timeline

Blue Shield Promise adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital	SNF	Home	PCP

The primary care physician (PCP) will be notified by fax within three business days of all care transitions.

Provider network policies and procedures

Policies and procedures

Blue Shield Promise ensures that network providers:

- Comply with special needs plan model of care required training upon joining the network and annually thereafter
- Have active licenses and certifications
- Are part of the member's interdisciplinary care team as needed
- Incorporate relevant clinical information in the member's ICP
- Follow care transition protocols
- Can request exception to clinical practice guidelines for members with complex healthcare needs

Clinical practice guidelines

Compliance

Provider network policies and procedures

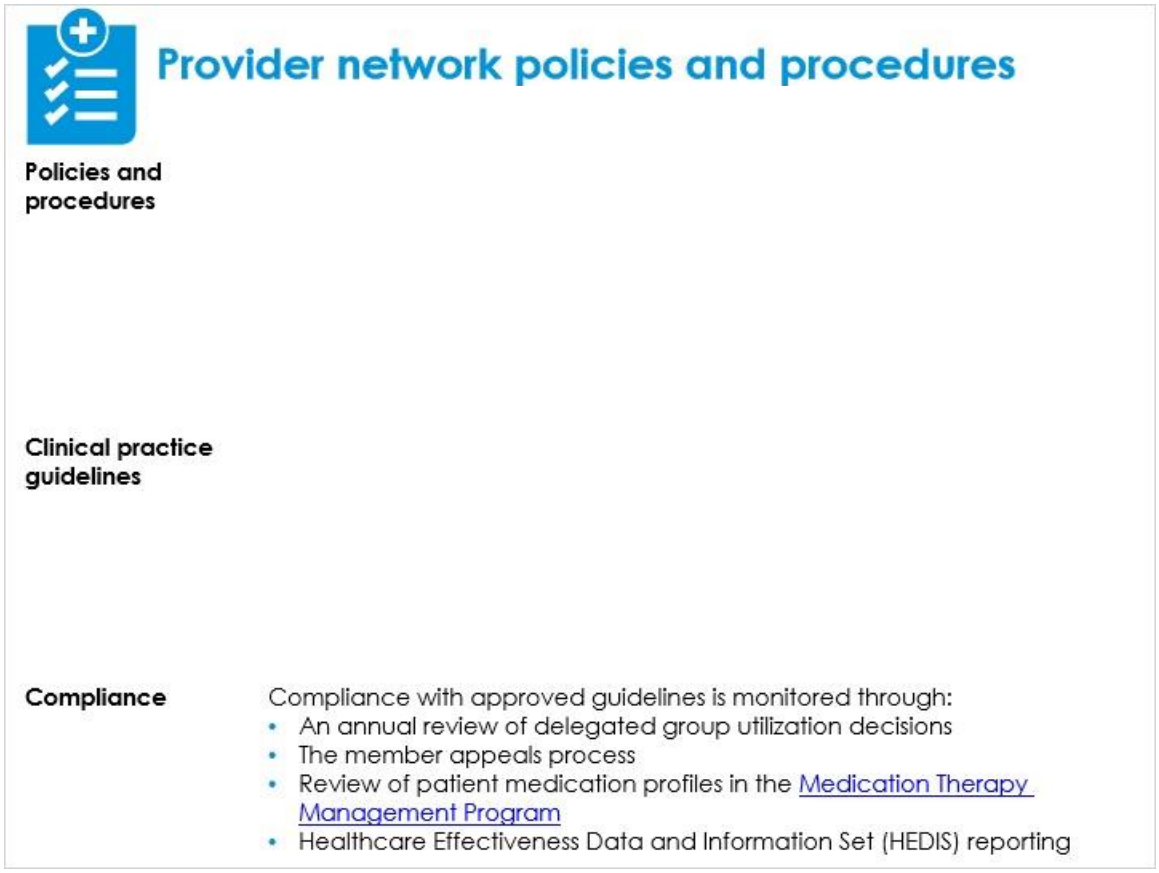
Policies and procedures

Clinical practice guidelines

To ensure the use of clinical practice guidelines, Blue Shield Promise:

- Requires medical groups to use evidence-based nationally approved clinical practice guidelines
- Approves all clinical practice guidelines annually
- Communicates approved guidelines to the network via provider communications and the provider website
- Reviews member education materials annually to ensure consistency with approved clinical practice guidelines

Compliance



Provider network policies and procedures

Policies and procedures	
Clinical practice guidelines	
Compliance	Compliance with approved guidelines is monitored through: • An annual review of delegated group utilization decisions • The member appeals process • Review of patient medication profiles in the Medication Therapy Management Program • Healthcare Effectiveness Data and Information Set (HEDIS) reporting

Medication Therapy Management Program

Quality improvement for the special needs plan model of care

Blue Shield Promise has a quality improvement plan specific to meeting the healthcare needs of model of care members based on specific Healthcare Effectiveness Data and Information Set (HEDIS) health outcome measures and special needs plan member satisfaction surveys. These findings are used to modify the model of care quality improvement plan on an annual basis. Providers and stakeholders may view the quality improvement plan on the Blue Shield Promise website.

Blue Shield Promise website