



SCAN 2022 SNP Model of Care (MOC) Training Frequently Asked Questions (FAQs)

Health Risk Assessment (HRA)

Frequently Asked Questions

Health Risk Assessment (HRA) FAQs

If there are no HRA in a week, how do we know none are available vs the trigger report was not able to go through	• It is possible that you did not have any "triggered" Members. But, it could also indicate an issue with the send/receive systems. Some of you may have done some past "trouble-shooting" with our SCAN colleague Liz Pena. She is also available to assist.
Considering recent audit and more scrutiny in plan of care are we to proceed with our current process of care planning top "problems/Dx" indicated in HRA? Is care planning based on HRA is it still identifying the top 3-5 most pressing conditions that the member can work on?	• We agree that it is a best practice to prioritize the member's top 3-5 concerns on the Care Plan. Please ensure that your documentation still indicates the other concerns that were identified, why they are pending/not included on the Care Plan, that the ICT is aware, and the plan to address them.
We frequently see undiagnosed "problems" on HRA and NFLOC's that then must be addressed in Care Plan. How are your nurses identifying these with no clinical documentation?	• Some information in the assessments are based on member's report. We don't always have the medical records available but during your review and if you confirmed with the PCP that the member does not have the diagnosis, you can document that in your system. The important thing is that it was followed up, addressed and documented.

scan HEALTH PLAN®

Individualized Care Plan (ICP)

Frequently Asked Questions

Individualized Care Plan (ICP) FAQs

Our process is to complete the ICP then conduct the ICT and modify the ICP if required after the ICT. Is there any concern with the order of how this is completed?	• This is not a concern, since it sounds like you would update the Care Plan if the ICT has additional recommendations. Just remember to always send the updated Care Plan to the member and PCP.
If we receive HRA, RN NFLOC, FCM NFLOC a month apart are we expected to ICT all 3?	• FCM NFLOC and RN NFLOC are considered one HRA and that is the latest HRA. If after receiving HRA you already presented it to the ICT and no additional concern identified in the NFLOC then one ICT would be sufficient. If there is a new concern in NFLOC that was not identified in the HRA, then ICT is needed
Why do we still have to mail care plans to members who go on hospice? Do you think this is difficult for them to read?	• CMS has advised that hospice enrollment is not an exception to completing the SNP requirements. Remember that members receiving hospice services, may still need non-hospice related care and this remains the responsibility of the assigned PCP and Medical Group. We recommend creating the Care Plan in collaboration with the member/caregiver and include language that is appropriate and sensitive to the member's status.
What if trigger is for ADL bathing and when we call pt they say they do not have problems bathing. Do we still need to do a care plan and take them to ICT?	• Please document that member denied needing assistance with bathing. This shows that the issue was addressed and member denied the concern. However, ICT and Care Planning are required elements to all SNP members.

scan HEALTH PLAN®

Individualized Care Plan (ICP) FAQs

If member does not want to be mailed a care plan, should we still go ahead? 2.Should we mail a care plan for unable to contact	• A Care Plan may still need to be mailed even if you are unable to reach the member. Because you are unable to speak to the member, you would need to rely on your clinical review and ICT to determine if an update to the Care Plan is needed. For example, you may notice in your clinical review that the member has missed the last 3 PCP appointments and has been to the ER twice in the last 6 months. This would be a good item to include on the Care Plan. If a member is adamant about not wanting to receive the Care Plan, we can honor that request, but be sure to document this clearly.
It seems to me that if a patient "Delines", that means they are not interested, they cleary said no "NO". Why is it that this is being pushed on them to have a CP mailed to their home. We are not doing this for the member it appears. We are ignoring their wish.	• Members have the right to decline to participate. Unfortunately, the CMS auditors were clear that while the member may decline to participate, it is important for all the ICT members to be aware of the identified issues/concerns. We would recommend including the decline into the Care Plan with info about what to do if they change their mind or need assistance in the future. This would inform all the ICT members, as well as provide the member with info in case they change their mind in the future.
Any recommendations for UTR care plans	• If you are unable to reach a member, you will need to rely on your clinical review and ICT to determine if the Care Plan needs to be updated. If you can determine that there has been a change of health status or some other significant issue through your clinical review, these are items that should be included in the Care Plan. You can include the failed contact attempts into the Care Plan and/or possibly create a cover letter that specifically addresses your inability to reach them, reason for the Care Plan, and how they can contact you if needed.

scan HEALTH PLAN®

Interdisciplinary Care Team (ICT)

Frequently Asked Questions

Interdisciplinary Care Team (ICT) FAQs

If patient declined to be a part of CCM, do we need to complete ICT ?

- Yes, ICT is required by CMS whether the member declined to participate in case management or if unable to reach.

Do pharmacist review medications of accepted patient's only?

- If there is a concern regarding medications, whether member accepted to be in case management or not, this concern needs to be addressed to the pharmacist (if available) or to the PCP.

scan HEALTH PLAN®

Care Transitions (CT)

Frequently Asked Questions

Care Transitions (CT) FAQs

When (month and year) did SCAN implement the 30 day protocol?	• SCAN uses a 30-60 day protocol but you and your organization can determine your own CT Protocol. The examples we listed (Eric Coleman's Model, Boost, and Project RED) all average about 30 days or greater. SCAN adopted the Eric Coleman model around 2009.
It was mentioned that a Doctor, Pharmacist, or Registered Nurse is needed to complete a medication reconciliation, Would this mean than if we have LVNs would need to do this with some form of identification that an RN has reviewed this?	• Great question: Yes, the med reconciliation would be at the RN scope of practice.
For CT, Slide stated that follow up appts need to be scheduled within 5 business days of transition. If MD input is required for input to add on an appt time to their schedule but they are on vacation, will this cause a problem if we can not schedule the appointment until after the 5 days? Some physicians are very controlling over their schedules and add on appts can not be scheduled without the doctors approval.	• We understand that there will always be barriers to scheduling. As long as there is documentation regarding the delay and there is a point of contact directing the care during the delay, you will be good. Documentation is key across the board.

scan HEALTH PLAN

Care Transitions (CT) FAQs

Please go over the pharmacist requirements ICT again. Did you say the pharmacist need to document med review? What if there is no pharmacist available?	• If the member's concern is about medication, if pharmacist is available, the pharmacist can provide recommendation. If no pharmacist is available, the concern should be shared with the PCP.
Is the 30 days follow up a new requirement following a care transition?	• No, this is not a new requirement, we follow the Eric Coleman model with a 30 day follow up protocol. You may base the length of your intervention on member need/acuity. You can use any evidence-based program. i.e. Project Red, Boost, TCM.
Does SCAN require the Care Transition process for Complex (non-SNP) mbrs?	• No, SCAN does not require Care Transitions for Non-SNP Members. However, we suggest following the same or similar guidelines for transitions of care based on best practices.
Does SCAN require the MOC process be performed for the Complex (non-SNP) mbrs?	• No, SCAN does not require the MOC process be performed for Non-SNP Members. However, we suggest following the same or similar guidelines for transitions of care based on best practices.

scan HEALTH PLAN®

Care Transitions (CT) FAQs

Can you email us the detailed criteria for Care Transitions?

D. Care Transitions
1. Receipt of Discharge Information
2. PCP Communication
3. Patient Engagement
a. Evidence the POs CM or the hospital CM/Discharge Planner, etc. contacted the member and/or the member's representative prior to discharge to review the CT plan.
b. The plan of care (*this is not necessarily the Care Plan*) transferred between healthcare settings included Practitioner, procedures and treatments, diagnosis at discharge, medication list, testing results (complete/pending), MD orders.
c. The plan of care included documentation that identifies the Personnel (i.e., Care Manager) responsible for coordinating the care transition process *(including ensuring scheduling of follow up services and appointments)*.
d. The plan of care included evidence of collaboration with the facility, the member, the caregiver, discharge planners and others to identify needs and coordinate care.
e. The plan of care included that the team ensures there is an appropriate provider directing the member's care and any other providers who need to be aware of the transition are notified.
f. The PCP was notified of discharge within 5 business days from day of discharge.
g. Patient outreach was completed/attempted within 5 business days of discharge from one setting to another. (*A minimum of 3 separate telephonic attempts, on 3 separate days were made within the 5 business day timeframe*).
h. Patient coached regarding care transitions including, at least how and when to respond to warning signs/symptoms based on clinical guidelines.
i. Patient coached regarding care transitions including, at least ensuring post discharge MD follow up visits are scheduled within 5 business days of discharge.
j. Patient coached regarding care transitions including, at least Medication Reconciliation. (*Needs to be completed by RN, Pharmacist or MD*)
k. The plan of care included documentation that if there is an existing ICP and there was a change in health status that the ICP was updated.
l. The plan of care included documentation that if there is no existing ICP, and there was a change in health status that a new ICP was created.
m. The plan of care included documentation supporting the rationale for not updating the ICP. (*i.e., there is no change in health status, etc.*)
n. Was the newly created or updated ICP sent to the PCP?
o. Was the newly created or updated ICP sent to the member?
p. Evidence the staff will continue to follow the member for approximately thirty (30) days to ensure a safe transition of care, i.e. documentation of follow-up calls or other outreach attempts, etc. (*NOTE: If member declines participation in CM, mark NA and defer to POs internal protocol for outreach. PO to ensure, at minimum, member is scheduled for PCP follow up visit*).
Note: • ***Transition of care is considered a change in health status***, *ICP is required during care transition whether or not the member is open to case management.* • *If there is an existing ICP* ***and*** *if ICP didn't change, documentation must reflect that it was reviewed and no change is needed.*
Note: *the ICP must be updated if there is a change in health status even if there is a failed member contact.*

Case Management

Frequently Asked Questions

Case Management FAQs

Does the CM continue following members who are under Hospice care? Do the same documentation requirement apply to hospice members?

- It is not necessary to continue to follow when the member's transition to Hospice. However, documentation of the transition needs to occur.

scan HEALTH PLAN®

Monitoring and Oversight

Monitoring and Oversight FAQs

Root Cause Analysis - what if it was an human error. They knew the regulation, knew the timeline but it was accidently missed. How do we respond	•Even if it is human error you are still expected to identify the root cause. The reason why the timeline was missed, is there a lack of oversight, do reminders need to be done, add a monitoring process, etc. How you will prevent this from happening in the future.
If we are completing all required components... and let's say the last component was an ICT to occur.. But the member terms with us and no longer with our group.. would we get penalized if we didn't complete that component?	•You will not be penalized as long as your documentation clearly demonstrates the plans for ICT within your compliance time frames and the reason it was not completed.
But, when did SCAN implement that requirement that is new and now on your audit tool?	•Following members for approximately 30 days was added to the 2022 tool as it reflects the timeframe for most CT protocols, is in our MOC and the highest risk of readmission for older adults is 30 days post-acute. We consider this a best practice.
During a recent audit the group received the new audit tool after the audit look back period. Because the new tool has had added elements are we held to the scoring of the new audit tool with the added elements?	•Yes, you are accountable for the current audit tool elements when the look-back period is in prior year. We review and revise the tool yearly around Q3 and we send out the revised tool to delegates in Q1 of 2022. This year the tool was emailed in March.

scan HEALTH PLAN®

SNP MOC Training

SNP MOC FAQs

Are PCP's for SCAN SNP members required to take this training as they are a part of the ICT?	• Yes, PCP who is taking care of our SNP members are required to have MOC training.
A few of my caregivers were not able to log on and I forwarded them my invite. Will they still get credit for attending?	• We want to make sure that everyone who attended today gets credit. Work with your Delegation Oversight representative to ensure that their participation gets documented.
Who do we submit our internal SNP training to at SCAN for review?	• Please send your SNP MOC training deck to DO Submissions mailbox for approval; Delegated Oversight <DOversight@scanhealthplan.com>
Can the IPA offer MOC or do all have to take SCAN MOC.	• If groups want to develop their own deck, they submit their training to SCAN Delegation Oversight • Per MOC: Provider groups can provide SNP training in the most appropriate manner for their networks, which can include using SCAN training materials, printed materials, watching the webinar, or attending in-person training.
What is required if the IPA only manages the Medicare portion of the Medi-Medi member	• The group still needs to participate in either the SCAN Provided Annual training or the group's own SNP MOC training as they are part of the Interdisciplinary Team providing care to the SNP members.

scan HEALTH PLAN®

Frequently Used Acronyms

ADL	Activities of Daily Living
APL	All Plan Letter
AWV	Annual Wellness Visit
CAP	Corrective Action Plan
CHF	Congestive Heart Failure
CM	Case Management
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CSNP	Chronic Condition Special Needs Plan
CT	Care Transitions
CVD	Cardio Vascular Disease
DHCS	Department Of Health Care Services
DM	Disease Management
DSNP	Dual Eligible Special Needs Plan
ER	Emergency Room
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Questions
FIDE	Fully integrated dual eligible
HCP	Health Care Plan
HCS	Health Care Services
HRA	Health Risk Assessment
IADL	Instrumental Activities of Daily Living
ICP	Individualized Care Plan
ICT/IDT	Interdisciplinary Care Team
IHA	Initial Health Assessment
ISNP	Institutional Special Needs Plan
LTSS	Long-Term Supports and Services
MA	Medicare Advantage
MAPD	Medicare Advantage Prescription Drug
MFT	Managed file Transfer
MOC	Model of Care
NFLOC	Nursing Facility Level of Care
PCP	Primary Care Physician
PDP	Prescription Drug Plan
POM	Provider Operations Manual
SHA	Staying Healthy Assessment
SNP	Special Needs Plans
UM	Utilization Management

scan HEALTH PLAN®