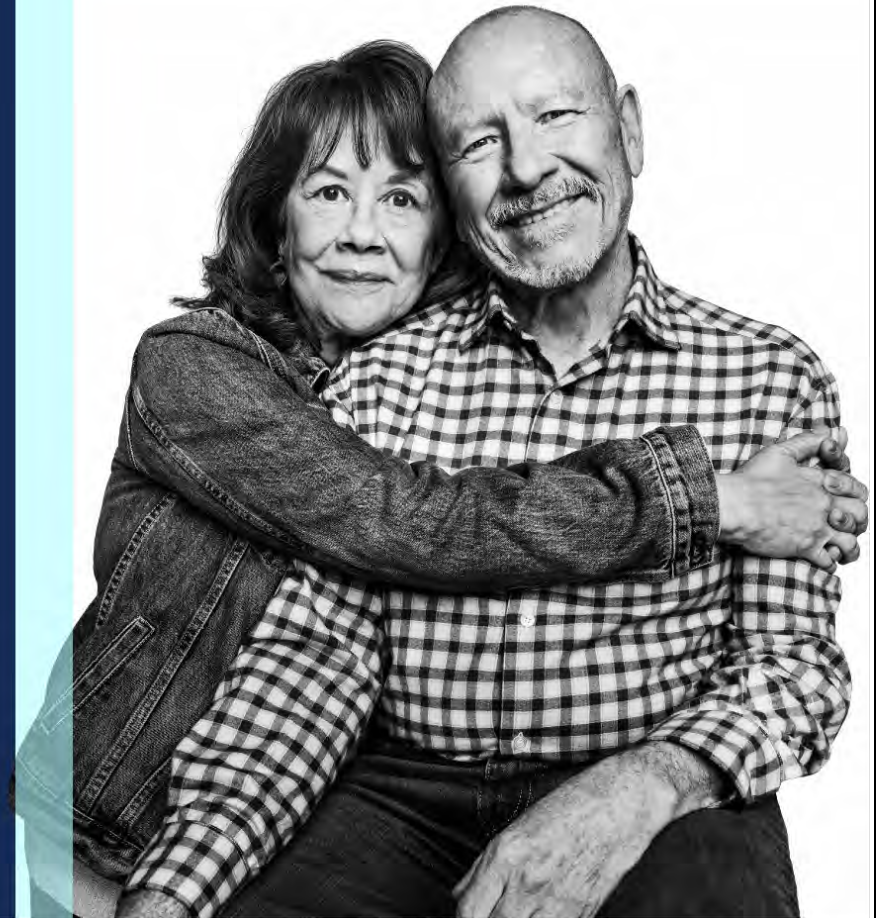




Dual-Eligible Special Needs Plan Model of Care

View the entire course to
earn credit for completion.

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A PowerPoint version of this document is available upon request. Please email ProviderExperience@blueshieldca.com and ask for the **Dual-Eligible Special Needs Plan Model of Care** PowerPoint presentation version of the training.



Welcome



Narration

Welcome to the course on Dual-Eligible Special Needs Plan Model of Care. The course will cover the following topics.

Course Topics



Dual-eligible
members



Special Needs
Plan Model of
Care



Health Risk
Assessment



Individualized
Care Plan



Interdisciplinary
Care Team



Person-centered
care



Provider network



Policies



Dual-eligible members

Answers to questions about dual-eligible special needs plan model of care

1 Who are dual-eligible members?

Eligible for both Medicare and Medi-Cal

They are more likely to have:

- Behavioral, mental, emotional, and social support needs
- Financial challenges
- Limitations in daily activities
- Multiple chronic conditions

Narration

Here are some answers to common questions about the dual-eligible special needs plan.

Who are dual-eligible members?

1. Dual-eligible members are eligible for both Medicare and Medi-Cal.

They are more likely to have:

Behavioral, mental, emotional, and social support needs; financial challenges; limitations in daily activities; and multiple chronic conditions.

Each dual-eligible member has an Individualized Care Plan to coordinate care.

Answers to questions about dual-eligible special needs plan model of care

1 Who are dual-eligible members?

2 What is the model of care for special needs plan members?

The Model of Care for Special Needs Plan members identifies:

- How various demographic factors combine to 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
- California Integrated Care Management Population (CICM)

Narration

What is the model of care for special needs plan members?

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

How various demographic factors combine to affect health status; special services to meet the needs of the most vulnerable members; community partners such as the Multi-purpose Senior Services Program, the Alzheimer's Association, Area Agency on Aging, and In-Home Support Services to provide specialized resources; as well as the California Integrated Care Management Population.

Answers to questions about dual-eligible special needs plan model of care

1 Who are dual-eligible members?

2 What is the model of care for special needs plan members?

3 What is the model of care based on?

The model of care is based on an assessment that identifies age, gender, ethnicity, and:

- Prevalence of major diseases and chronic conditions
- Language, cultural, and health literacy needs
- Highest risk of poor outcomes for those with multiple hospital admissions, high pharmacy utilization, and/or a combination of medical, psychological, cognitive, and functional challenges

Narration

What is the model of care based on?

3. The model of care is based on an assessment that identifies age, gender, ethnicity, and:

A prevalence of major diseases and chronic conditions; language, cultural, and health literacy needs; and the highest risk of poor outcomes for those with multiple hospital admissions, high pharmacy utilization, and/or a combination of medical, psychological, cognitive, and functional challenges.

Answers to questions about dual-eligible special needs plan model of care

- 1 Who are dual-eligible members?
- 2 What is the model of care for special needs plan members?
- 3 What is the model of care based on?
- 4 What are the care coordination roles?

Blue Shield 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

Narration

What are the care coordination roles?

4. Blue Shield 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 has a plan for staff absences to avoid disruption in care.



Special Needs Plan Model of Care

Who is the primary and secondary payer?

Medicare (primary)

- Physician
- Hospital
- Short-term skilled nursing facility

Medi-Cal (secondary)

- Medicare Part A and B premiums, deductibles, and co-payments
- Services not covered by Medicare
- Services delivered after Medicare benefits have been exhausted
- Most long-term care costs that include longer nursing home stays and home and community-based services that prevent institutionalization



Narration

In the Special Needs Plan model of care, Medicare is the primary payer and Medi-Cal is the secondary payer.

Medicare covers services provided by physicians, hospitals, and short-term stays at skilled nursing facilities.

Medi-Cal pays for Medicare Part A and Part B premiums, deductibles, and copayments. It also covers services that Medicare does not, as well as services delivered after Medicare benefits are exhausted. This includes most long-term care costs, such as extended nursing home stays and home and community-based services that help prevent institutionalization.



Health Risk Assessment




What is the HRA?

- Complete Health Risk Assessments (HRAs) for each dual-eligible member.
- Multiple attempts are made via phone or face-to-face, based on member needs or preferences.
- If direct contact fails, the survey is mailed in the member's preferred language.

Narration

Blue Shield's goal is to complete Health Risk Assessments for each dual-eligible member to identify medical, psychosocial, cognitive, and functional risks.

We make multiple attempts to conduct the assessment by phone or face-to-face depending on the member's needs or preferences. But we understand that some members may be reluctant to answer calls and feel more comfortable receiving a printed version of the HRA they can complete with family support. If we're unable to contact the member directly, the survey is mailed in the member's identified language preference.



When is the Health Risk Assessment completed?

- Complete an HRA within 90 days of enrollment and annually after that.
- The member's responses are incorporated into the Individualized Care Plan.

Narration

We ask that our members complete an HRA within 90 days of enrollment and annually after that.

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



What does the HRA screen for?

- Health status including chronic health conditions and health care needs
- Clinical history
- Mental health and cognitive status
- Activities of daily living (ADL) and instrumental activities of daily living (IADL)
- 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

Narration

The Health Risk Assessment screens for the following conditions. See the next slide for a complete list of ADL and IADL tasks.

ADL and IADL tasks

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 forms of communication



Individualized Care Plan



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 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.

Narration Overview

The Individualized Care Plan is created uniquely for each member.

The member—or their authorized representative—must be given an opportunity to review the plan, including any updates or changes.

To ensure accessibility, the Individualized Care Plan must be written at a sixth-grade reading level, available in alternative formats, and provided in the member's preferred written or spoken language.



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

Narration Components

The Individualized Care Plan is also required to include several key components.

The plan should include the name and contact information for the member's primary care physician and any specialists involved in their care.

It should also include the member's personal goals and preferences, as well as the member's measurable objectives and timetables for medical services, behavioral health services, and long-term services and supports.

It should include clear time frames for reassessment—at minimum, once a year or as required by current state or federal guidelines.



In-Home Support Services requirements

- 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.

Narration
In-Home Support Services

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.

It should also include contact information for the member's In-Home Support Services worker.



Dementia care

- Primary care providers are encouraged to leverage the tools at [Dementia Care Aware](#) for detecting and managing cognitive impairment.
- If cognitive impairment is determined, a full diagnostic work-up is recommended leveraging the [Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease](#).
- Dementia care specialists are included in the development of the ICP whenever there is consent.
- Dementia care specialists must be trained in Alzheimer's disease and related dementias.

Narration

Dementia Care

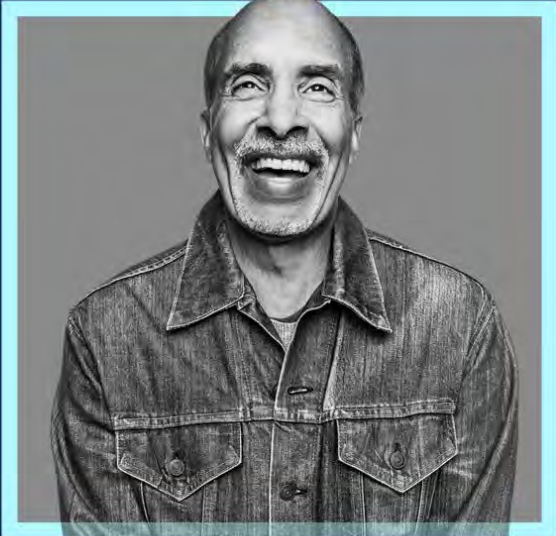
Primary care providers are encouraged to leverage the tools on the [Dementia Care Aware](#) website to help with detecting and managing cognitive impairment. If cognitive impairment is determined, a full diagnostic work up is recommended, leveraging the tools found in the [Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease](#).

Dementia care specialists are included in the development of the ICP whenever there is consent. They must be trained in Alzheimer's disease and related dementias, such as symptoms, progression, managing behaviors, caregiver stress, and community resources.



Person-centered care

Person-centered care



Members

Is provided in a manner that is sensitive to the member's functional and cognitive needs, language, and culture

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

Narration

At Blue Shield of California, care delivery is sensitive to each member's functional and cognitive needs, language, and cultural background. It is provided in the least restrictive community setting, aligned with the member's personal goals and their Individualized Care Plan.

Members—and their caregivers, as permitted—are actively involved with accommodating and supporting the member's self-direction. More importantly, care is offered in settings that best meet their needs, with a preference for the home and community.



Interdisciplinary care
team

Person-centered interdisciplinary care team (ICT)

Case manager	Medical director
Social worker	Treating physician
Pharmacist	Others based on member needs



Narration

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, and others are included based on member needs.

Person-centered interdisciplinary care team (ICT)

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



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.

Narration

A person-centered ICT approach helps members in these key ways.

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

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

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



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

- 1 [Person-centered planning](#)
- 2 [Cultural competence](#)
- 3 [Accessibility](#)
- 4 [Independent living](#)
- 5 [Wellness principles](#)

* minimum - not limited to

Narration

Blue Shield requires individualized care teams to have knowledgeable team members with these key competencies. See details for each one in the next slides.

Person-centered care planning



1

Recognizes the person as the expert

2

Includes significant others

3

Identifies hopes, interests, preferences, needs, and abilities

4

Maximizes community connections

Narration

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; and, maximizes community connections.

Cultural competence

1

Developing positive attitudes towards cultural differences



2

Gaining knowledge of different cultural practices and world views

3

Developing skills for communication and interaction across cultures



Narration

Cultural competence

Cultural competence is the ability to effectively interact with people across cultures. Cultural competence encompasses developing positive attitudes towards cultural differences; gaining knowledge of different cultural practices and world views; and, developing skills for communication and interaction across cultures.

Underlying cultural competence are the principles of trust, respect for diversity, equity, fairness, and social justice.



Accessibility and accommodations



Parking spaces



Curb ramps



Barrier-free access from parking



Wide doorways



Accessibility in public spaces



Ample, accessible restrooms



Accessible drinking fountains



Raised tactile Braille signs



Accessible service counters



Accessible exam rooms



Transfer equipment



Accessible exam tables

1. Sloped surface provides access to scale platform – no abrupt level changes at floor or platform.
2. Edge protection at drop-off.
3. Large platform to accommodate various wheelchair sizes.
4. Provide maneuvering space to pull onto and off scale.



Accessible weight scales



[Communication and auxiliary aids](#)

Narration
Accessibility

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. Here is a list of accessibility and accommodations. Click on the communication and auxiliary link for more details about the ADA requirements for effective communication.

Independent living



Have consumer control



Are the best experts of their own needs



Have crucial and valuable perspectives to contribute



Deserve equal opportunity



Should decide how to live and take part in the community

Narration
Independent living

The independent living philosophy emphasizes that people, have consumer control; are the best experts of their own needs; have crucial and valuable perspectives to contribute; deserve equal opportunity; and, they should decide how to live and take part in the community.



Wellness principles

1

A dynamic balance of physical, social, emotional, spiritual, and intellectual factors

2

Tailored health promotion behaviors to increase their level of well-being

3

Physical exercise, good nutrition, stress-management, and social support



Narration
Wellness principles

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

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

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

Interdisciplinary care team roles

Facilitate care management and coordination

Conduct individualized care team meetings periodically and at the member's request

Take member's communication needs into account (cognitive, communicative, or other barriers)

Maintain a call line or other mechanism for the member's inquiries and input

Analyze and incorporates health risk assessment results into the Individualized Care Plan

Help coordinate services and transitional care with Primary Care Physicians and other providers

Refer members to other agencies when needed (e.g., long-term support and services or behavioral health services)

Manage information flow for care delivered outside the primary care site



Narration

The role of the interdisciplinary care team is to facilitate care management and coordination, as well as conduct individualized care team meetings periodically and at the member's request. They also take member's communication needs into account, such as cognitive, communicative, or other barriers.

ICT teams also maintain a call line or other mechanism for the member's inquiries and input; they analyze and incorporate health risk assessment results into the Individualized Care Plan; and help coordinate services and transitional care with Primary Care Physicians and other providers.

It's essential that ICT teams also refer members to other agencies when needed. For example, long-term support and services or for behavioral health services. And, the ICT team should manage the information flow for care delivered outside the primary care site.



Interdisciplinary care team (ICT) participants

Required

- Member or authorized representative (whenever possible)
- Care coordinator (case manager, social worker, or behavioral health specialist)
- Medical expert (PCP, specialist, Blue Shield of California medical director, or licensed nurse practitioner)
- County In-Home Supportive Services (IHSS) social worker (if receiving IHSS)

Optional*

- Specialized providers (PT, OT, etc.)
- County behavioral health providers
- Disease management specialists
- Public program coordinators
- Pharmacist
- Health educator
- [Long-term care providers](#)
- [Dementia care specialists](#)

Includes Long-Term Services and Supports providers (Community Based Adult Services, Multipurpose Senior Services Program, etc.)

*As needed or approved by member

Interdisciplinary care team communication

- 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

Narration

Here is a list of required and optional participants for the ICT.

Blue Shield invites participants to attend the virtual ICT meetings, either by telephone or fax. Meetings are typically held Monday through Friday during normal business hours and can be scheduled upon request.

Blue Shield also facilitates information flow between members, interdisciplinary care team participants, and physicians, in a few ways. Through documentation in the care management system and member's Individualized Care Plan; through regular telephonic communication with member, caregiver or provider; in written interdisciplinary care team meeting minutes; or through a member data dashboard that includes utilization and pharmacy data.

See details for long-term providers in the blue box.

Details for dementia care specialists are in the next slide.



Dementia care specialists ✕

A trained dementia care specialist should be included on ICTs for members living with dementia when a member has documented:

- Wandering
- Home safety concerns
- Poor self-care
- Behavioral issues
- Difficulty taking medications as prescribed, or challenges managing co-existing conditions

Narration

Dementia care specialists

When a member has documented wandering, home safety concerns, poor self-care, behavioral issues, difficulty taking medications as prescribed, or challenges managing co-existing conditions—such as difficulty with activities of daily living (ADLs) or instrumental activities of daily living (IADLs)—then the interdisciplinary care team should include the member’s caregiver and a trained dementia care specialist with the member’s consent.



Dementia care specialists

A trained dementia care specialist should also be included on ICTs for members living with dementia who also:

- Have two or more co-existing conditions
- Have moderate to severe behavioral issues
- Frequently use healthcare resources
- Live alone or lack adequate caregiver support
- Have moderate to severe functional impairment

Narration

A trained dementia care specialist should also be included on the ICT for members living with dementia who meet any of the following criteria:

They have two or more co-existing conditions; they exhibit moderate to severe behavioral issues; they frequently use healthcare services; they live alone or lack adequate caregiver support; or they have moderate to severe functional impairment.



Provider network

Provider network



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



Behavioral health providers



General and subspecialty surgeons



Long-term service and support providers



Ancillary health providers such as physical, speech and occupational therapists



Tertiary care physicians

Narration

Blue Shield has a specialized network of providers to meet the needs of Special Needs Plan dual-eligible members. Here are a few specialties included in the provider network.



Care coordination

Coordination requirements:

- Care planning and management documentation
- Interdisciplinary team input
- Transition information
- Assessments
- Waivers and authorizations

Care coordination resources

Blue Shield's [Provider Connection](#) website, or call the provider line at:

(800) 468-9935


Narration

Blue Shield uses the Individualized Care Plan, Health Risk Assessment, and invitations to Interdisciplinary Care Team meetings to implement Special Needs Plan care coordination requirements such as, care planning and management documentation, interdisciplinary team input, transition information, assessments, and waivers and authorizations.

Our Customer Service Center is ready to assist with enrollment, eligibility and benefit questions, and can connect members to their Clinical Services Coordinator, who can coordinate all the member's providers and services.

Other member and provider communications such as newsletters, educational outreach, and provider updates are distributed online or by mail, phone, or fax.

Find more care coordination resources at Blue Shield's [Provider Connection](#) website or call the provider line at (800) 468-9935.



Care transition

Home transition


Ensure the member is familiar with:

- Self-management tools and assisting
- Scheduling a follow-up appointment
- The primary care physician

Narration

After the member has transitioned to the usual setting of care (typically the home), the Care Manager discusses the discharge plan with the member and/or caregiver.

This includes ensuring that the member is familiar with self-management tools and assisting; scheduling a follow-up appointment; and the primary care physician.



Care transition

Skilled Nursing Facility (SNF)

- A copy of the updated Individualized Care Plan is faxed to the SNF.

Primary care physician (PCP)

- The PCP is notified by fax of all care transitions.

Narration

When a member discharges to their home, a copy of the updated Individualized Care Plan is faxed to the skilled nursing facility; and the primary care physician is notified by fax of all care transitions.



Policies

Provider network policies and procedures

1

Blue Shield 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

Narration

1. Blue Shield ensures network providers meet standards of care.

Providers comply with Special Needs Plan Model of Care training—when they join the network and every year after that.

They hold active licenses and certifications.

They join the member's interdisciplinary care team when needed.

They include relevant clinical information in the member's individualized care plan.

And, they follow care transition protocols.

When a member has complex healthcare needs, providers can request an exception to clinical practice guidelines.

Provider network policies and procedures

2

To ensure the use of evidence-based clinical practice guidelines, Blue Shield:

- Approves select clinical practice guidelines
- Communicates our approved guidelines to the network via provider communications and/or the provider website
- Reviews our member education materials annually to ensure consistency with our approved clinical practice guidelines
- Requires medical groups and practitioners to use evidence-based nationally approved clinical practice guidelines
- Monitors compliance through Healthcare Effectiveness Data & Information Set (HEDIS) reports

Narration

2. To ensure the use of evidence-based clinical practice guidelines, Blue Shield approves select guidelines and communicates them to our network through provider communications and, or the provider website.

Member education materials are reviewed annually to confirm alignment with approved guidelines. Medical groups and practitioners are required to follow nationally recognized, evidence-based guidelines.

Compliance is monitored through Healthcare Effectiveness Data and Information Set reports.

Provider network policies and procedures

3

Utilization management compliance is monitored through:

- Annual review of group utilization decisions
- The member appeals process
- Review of patient medication profiles in the [Medication Therapy Management Program](#)

Narration

3. Utilization management compliance is monitored through an annual review of group utilization decisions, and the member appeals process.

It is also monitored through a review of patient medication profiles in the [Medication Therapy Management Program](#). Click the link for more details about medication therapy management.



Quality improvement

Special Needs Plan Model of Care

- Based on specific Healthcare Effectiveness Data and Information Set (HEDIS) health outcome measures
- More information at [quality and patient safety improvement](#)

Narration

Blue Shield has a quality improvement plan specific to meeting the healthcare needs of mode of care members that is based on outcome measures specific to the Healthcare Effectiveness Data and Information Set. 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 at the link for [quality and patient safety improvement](#).



Thank you