2024 Dual-Eligible Special Needs Plan

Model of Care

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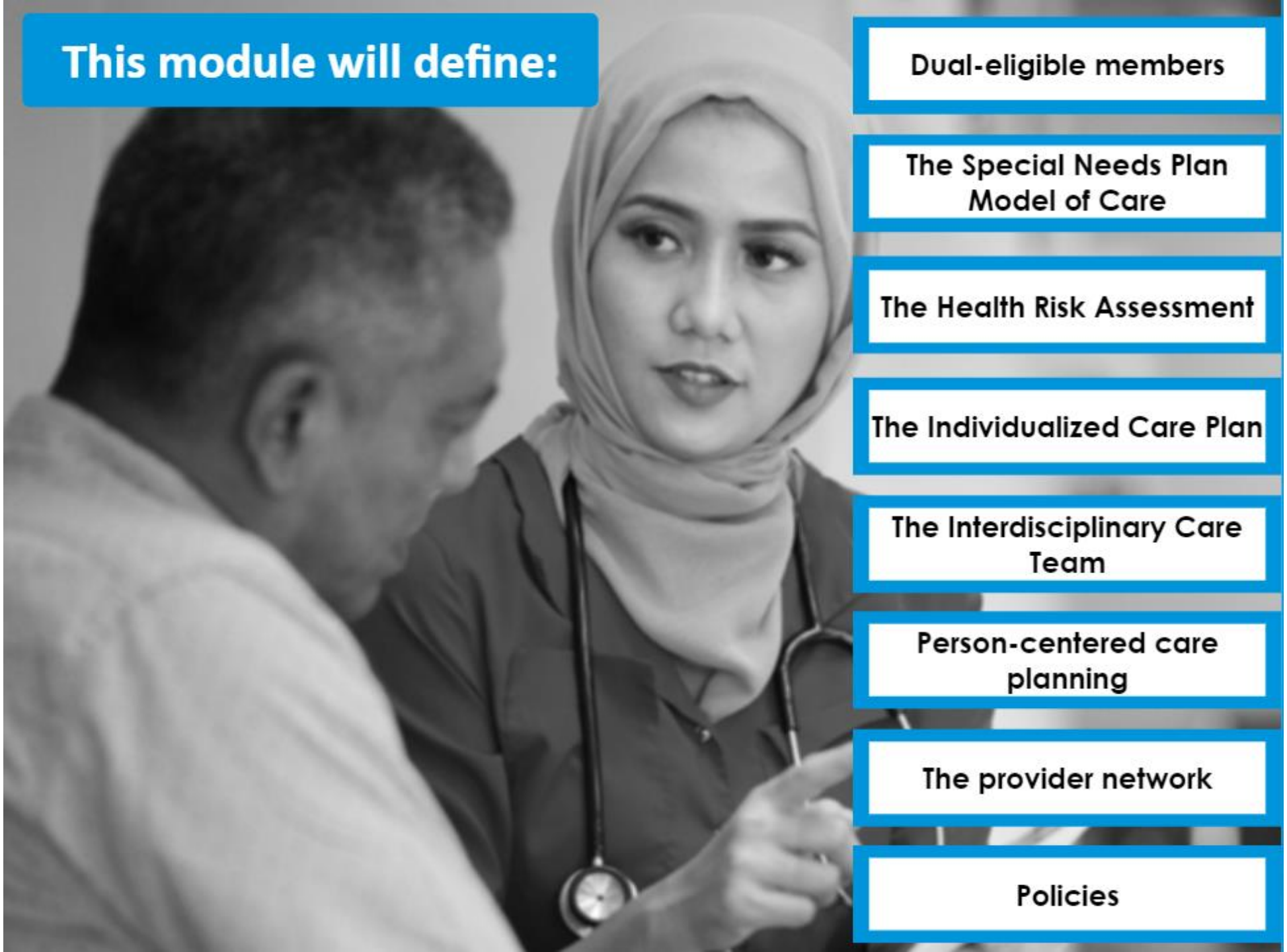

This module will define:
Dual-eligible members
The Special Needs Plan Model of Care
The Health Risk Assessment
The Individualized Care Plan
The Interdisciplinary Care Team
Person-centered care planning
The provider network
Policies

Questions and answers

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

Who are dual-eligible members?

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 barriers to care
- Limitations in daily activities
- Multiple chronic conditions
- Barriers to care access, coordination, and compliance

Each dual-eligible member has a special needs plan to coordinate care.

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

The Blue Shield 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 dual-eligible special needs plan model of care.

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

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

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.

Who is the primary and secondary payer?

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?

Blue Shield 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

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.

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 (see next slide)
- 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 forms of communication

Individualized Care Plan (ICP)

Overview

Components

In-Home Support Services

Dementia Care

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.
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
IHSS	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
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 tools in the **Assessment of Cognitive Complaints Toolkit for Alzheimer's Disease**. Dementia care specialists should be included in the development of the ICP whenever there is consent. Dementia care specialists must be trained in Alzheimer's disease and related dementias including symptoms, progression, managing behaviors, caregiver stress, and community resources.

Person-centered care

Blue Shield 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 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

See following slides for information on each

* 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

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
- Developing skills for communication and interaction across cultures

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

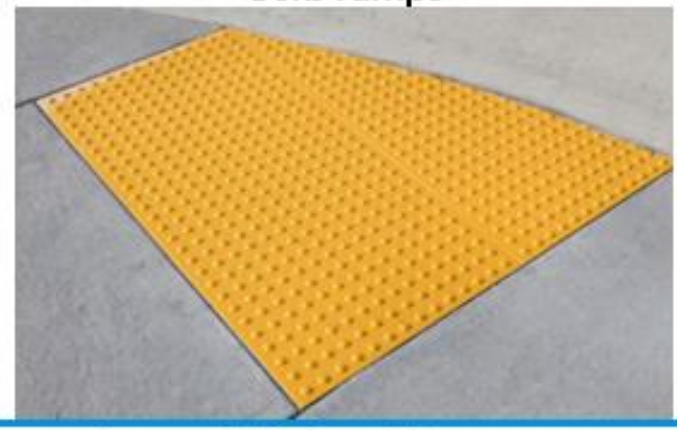
Accessibility and accommodations

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.

- Parking spaces
- Curb ramps
- Barrier-free access from parking
- Wide doorways
- Accessibility in public spaces
- Ample, accessible restrooms
- Accessible drinking fountains
- Accessible service counters
- Raised tactile Braille signs
- Accessible exam rooms
- Accessible exam tables
- Accessible weight scales
- Transfer equipment
- Communication & auxiliary aids

Parking spaces

Curb ramps



Barrier-free access parking

Wide doorways

Accessibility in public spaces

Ample, accessible restrooms

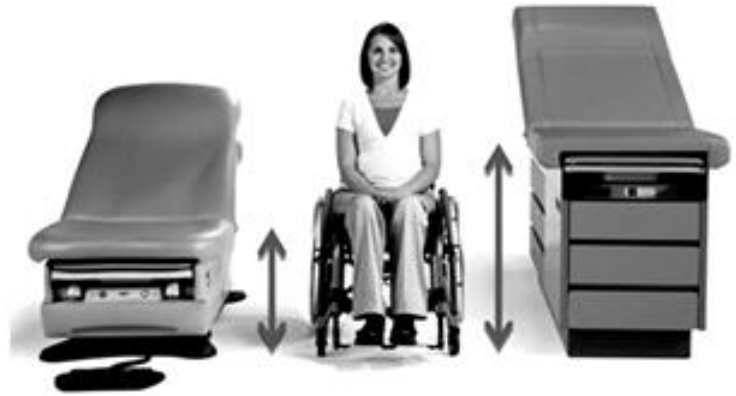
Accessible drinking fountains

Accessible service counters

Raised tactile Braille signs

Accessible exam rooms

Accessible exam tables

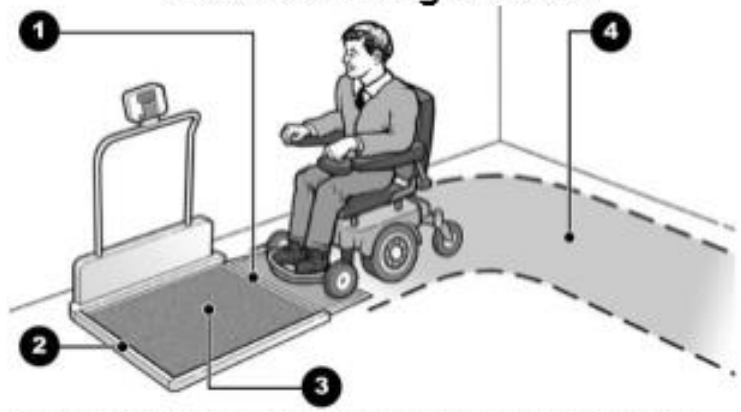


Accessible Transfer Height Range of 17 to 19 inches

versus

Fixed Height or "Box" Typically 32 inches

Accessible weight scales



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.

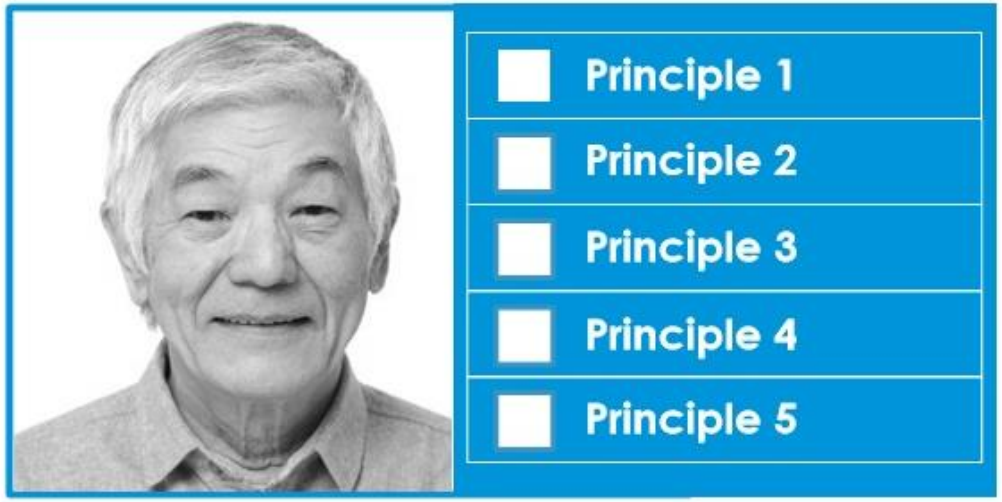
Transfer equipment

Communication & auxiliary aids

Communication and auxiliary aids

Independent living

The independent living philosophy emphasizes that people:

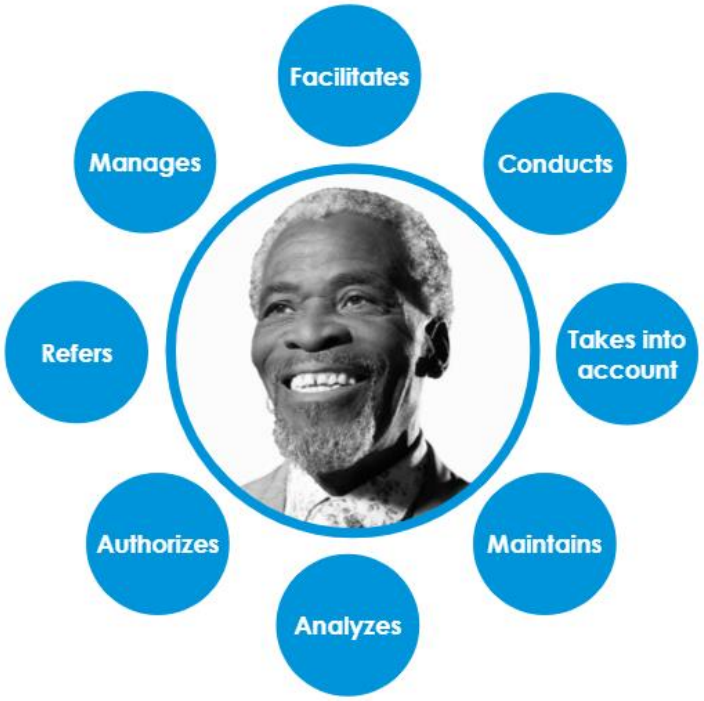


Principle 1	Deserve equal opportunities
Principle 2	Are the best experts of their own needs
Principle 3	Have crucial and valuable perspectives to contribute
Principle 4	Have consumer control
Principle 5	Should decide how to live and take part in the community

Wellness principles

1	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.
2	Health includes a dynamic balance of physical, social, emotional, spiritual, and intellectual factors.
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	Facilitates care management and coordination
Conducts	Conducts individualized care team meetings periodically and at the member's request
Takes into account	Takes member's communication needs into account (cognitive, communicative, or other barriers)
Maintains	Maintains a call line or other mechanism for the member's inquiries and input
Analyzes	Analyzes and incorporates health risk assessment results into the Individualized Care Plan
Authorizes	Authorizes services and transitional care
Refers	Refers members to other agencies when needed (e.g., long-term supports and services or behavioral health services)
Manages	Manages information flow for care delivered outside the primary care site

Interdisciplinary care team (ICT) participants

Required	Optional*
• Member or authorized representative (whenever possible) • Care coordinator (case manager, social worker, or behavioral health specialist) • Medical expert (PCP or specialist) • County In-Home Supportive Services (IHSS) social worker (if receiving IHSS)	• Specialized providers (PT, OT, etc.) • County behavioral health providers • Disease management specialists • Public program coordinators • Long-term care providers • Dementia care specialist (see next slide) • Pharmacist • Health educator

Interdisciplinary care team communication

Blue Shield invites participants to attend the virtual ICT meeting either telephonically or by fax. Meetings are typically held Monday-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 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

Dementia care specialist

Whenever a member has documented wandering, home safety concerns, poor self-care, behavioral issues, medication adherence problems, inability to manage co-existing conditions or activities of daily living (ADLs) or instrumental activities of daily living (IADLs), the interdisciplinary care team (ICT) should include the member's caregiver and a trained dementia care specialist whenever there is consent.

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
- Moderate to severe behavioral issues
- High utilization of healthcare resources
- Live alone or lack adequate caregiver support
- Have moderate to severe functional impairment

Provider network

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

Internists, family practitioners, geriatricians, endocrinologists, cardiologists, oncologists, pulmonologists
Behavioral health providers
Long-term service and support providers
General and subspecialty surgeons
Ancillary health providers such as physical, speech and occupational therapists
Tertiary care physicians

Provider network information sharing

Blue Shield has integrated communication systems to implement Special Needs Plan care coordination requirements including:

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

Care coordination resources

Click here or the Blue Shield website or call the provider line at: **(800) 468-9935**.

Our Customer Service Center is ready to assist with enrollment, eligibility and benefit questions, and connecting members to their Clinical Services Coordinator.

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

Care transition timeline

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

Hospital	SNF	Home	PCP

Hospital	After notification of a hospital admission a copy of the Individualized Care Plan is faxed to the hospital.
SNF	After discharge from a hospital to a skilled nursing facility (SNF), the discharge orders/care plan are faxed to the skilled nursing facility.
Home	When the member is being transitioned to the usual setting of care(typically the home), the Care Manager discusses the discharge plan with the member and/or caregiver. This will be followed within two to four 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.
PCP	The primary care physician (PCP) is notified by fax within three business days of all care transitions.

Provider network policies and procedures

Policies and procedures

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

Clinical practice guidelines

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

- 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

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

Quality improvement for the special needs plan model of care

Blue Shield 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 website.

You have completed the course!

Thank you!