DSNP CARE COORDINATION: ROLE OF CHC and BH MCO

UPMC HEALTH PLAN – TARA ULRICH, MSW, LSW, CCM (SENIOR DIRECTOR, MEDICAL MANAGEMENT)

UNITED HEALTHCARE – KIA MELLON, MSN, DNP (DIRECTOR OF CLINICAL OPERATIONS)

AETNA HEALTH INC PA - SHOSHANA ALTINTAS, LCSW, (SENIOR MANAGER BH MEDICARE CM)

BH Care Coordination for CHC Participant Post Discharge

- Dual Special Needs Plan (DSNP) care coordinators **notify the Behavioral Health (BH) Managed Care Organization (MCO)** of any inpatient event.
- **BH MCO and DSNP collaborate** to coordinate ongoing care needs of members.
- DSNP BH team contacts the BH MCO to schedule an **Interdisciplinary Care Team (ICT) meeting** to address member needs, available benefits and any additional concerns.
- DSNP BH team works closely with the BH MCO, the facility and the primary care manager to **arrange for a safe transition** to home or a lesser level of care when the member is medically stabilized.
- **Community Health Choices (CHC) MCO is also notified** at time of admission and discharge, and care/transition needs addressed through this process.

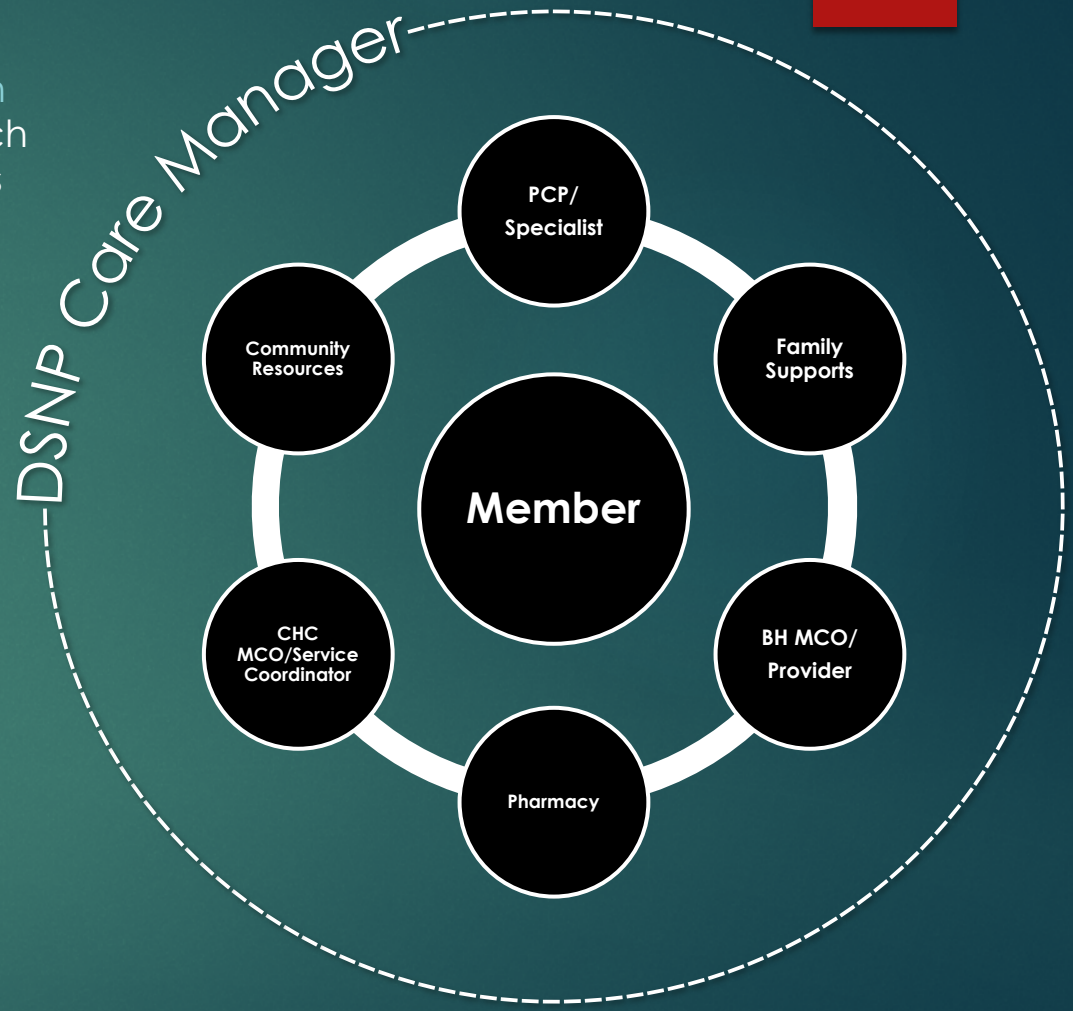
Inpatient Care Coordination through calls to discharge planner, facility utilization reviewer, and the member.

At discharge, care coordination continues with member outreach within 2 business days, as well as BH MCO, CHC MCO, providers, and community resources as needed.

Once engaged in the BH Transition of Care program, the BH Care Manager works with the member **to identify their personal goals and connect to additional services** including access to healthy foods, financial assistance and access to safe and stable housing. Our BH Care Manager utilizes internal resources such **as Social Work, Pharmacy and Nurse Care Managers** to explore and address social determinants of health and medical health needs. If additional needs are identified, **care is coordinated with the BH MCOs and CHCs as needed.**

Care plan **goals are member-centric**, and with member consent, involve the member's family, caregivers, providers, and others. In addition, the DSNP BH Team ensures members have access to **BH follow up with in 7- and 30- days** of discharge from inpatient care.

Outreach occurs at intervals agreed upon by the BH Care Manager and member post engagement. The **member's progress is also measured** utilizing condition-specific behavioral health assessments.



BH Member Success Story

Positive Member Quote: "Thank you so much for all your help!"

MEMBER BACKGROUND

- Christine is a 70-year-old female referred to BH Case Management after in-patient mental health hospitalizations in February and May 2021. According to Christine, the hospital physician told her she had a psychotic episode.
- Christine has a diagnosis of Bipolar disorder. During her first in-patient mental health admission, she was voluntarily hospitalized after a suicide attempt. At the time of the second admission, she presented as psychotic, hyper-religious, and delusional.
- She was compliant with her psychiatric medications prior to both admissions, but reported experiencing poor sleep, racing thoughts and auditory hallucinations.
- Christine lives alone but has a supportive niece and close relationships with a few friends. She also receives home-health aide services d/t limited mobility and range of motion. This has been helpful in managing her activities of daily living.

CLINICAL SUPPORT

- I engaged Christine in the BH Case Management program on February 15th, which consisted of weekly outreaches and ongoing support and education.
- I educated Christine about her behavioral health diagnosis and medications. She is prescribed Lithium. I informed her about the importance of having her Lithium levels checked regularly. She eventually obtained a script from her PCP and is having the levels checked more regularly.
- I educated Christine about red flags and helped her to identify triggers. We developed a safety plan, which Christine agreed to follow if she began feeling symptomatic or her known triggers were present.
- We also worked on coping skills to improve the self-management of her symptoms.
- Christine maintained compliance with taking her medications and attending her out-patient appointments. She is now meeting with her prescribing psychiatric provider and therapist regularly.

MEASURABLE OUTCOMES

- Christine has not had any mental health hospitalizations since May 2021.
- Christine reported a significant improvement in the management of her behavioral health symptoms. She became less depressed and denied any further suicidal ideations or hallucinations.
- She was able to identify her triggers, which included poor sleep, an increase in depressive symptoms and the presence of hallucinations.
- She learned and implemented new coping skills, which include spending time with friends, spirituality and prayer, listening to music, and exercising depending on her physical limitations.
- SF-8 Health Survey Assessment was completed at the start of engagement and again at the end. Christine's score went from a 31.89 in January to a 50.19 at the end of July, a 57.38% improvement in quality of life.
- Two PHQ-9 Assessments were also completed at different times for comparison. Her initial PHQ-9 score was a 5. At the completion of the BH CM program, her score was a 2, a 60% decrease in depressive symptoms.

LONG-TERM SUCCESS

- Christine now has a good understanding of her Bipolar diagnosis and how the medications and compliance helps to effectively treat her condition.
- Christine reported a significant decrease in her behavioral health symptoms, including her depression. She reported ongoing stability at the completion of the BH Case Management Program and expressed feeling much happier than 6 months prior.
- She has a greater understanding of her triggers, how to manage them, and when to seek out support.
- Christine has become more aware of when she needs to seek out assistance. She will contact her mental health providers if she begins to become symptomatic.

Participants

- UPMC Health Plan – Tara Ulrich, MSW, LSW, CCM (Senior Director, Medical Management)
- UPMC Health Plan – Cynthia Lentz, BSN, RN (AVP, Population Health and Clinical Transformation)
- United HealthCare – Kia Mellon, MSN, DNP (Director of Clinical Operations)
- United Healthcare – Joyce Wale, LCSW (Regional Executive Director Behavioral Health)
- Aetna Health Inc PA- Shoshana Altintas, LCSW-C, (Senior Manager BH Medicare CM)
- Aetna Health Inc PA – Christine Compliment, LCSW CCM, (Senior Manager Clinical Health Services DSNP)

Care Coordination Between CHC MCOs and D-SNPs

Managed Long Term Services and Supports Meeting
Wednesday, January 5, 2022

Agenda

- ✓ Amerihealth Caritas, Cigna Health and HPP assigned question and presenters
- ✓ Overview of Medicare Model of Care
- ✓ Roles and Responsibilities of DSNP Plan
- ✓ Vignette – Coordinating Care between DSNP and CHC plans

- **Question #2**
  Can you share how you would arrange care for a CHC participant after being discharged from the hospital after a heart attack?
  Specifically, what role CHC and the BH MCO play.
  Please consider this person might have BH needs based on chronic health conditions, lifestyle changes, possibly retiring early, possible permanent disability, or other BH factors you can think of.

- **Presenters**

  Amerihealth Caritas: Nancy Becker, Director Population Health PA Medicare
  Cigna Health: Kim Kernan, Manager Care Management
  Mary Schou, Manager Care Management
  Health Partners Plans: Geri Boone, VP Medicare Clinical Program

Medicare DSNP Model of Care

- ✓ Special Needs Plans (SNPs) were created by Congress through the Medicare Modernization Act of 2003. SNPs are a type of Medicare Advantage Plan.
  - Full dual program
  - Partial dual program

- ✓ There are three types of SNPs that limit membership to specific types of enrollees:
  - Chronic Care
  - Dual Eligible
  - Institutional

- ✓ All Medicare Advantage Organizations that offer SNPs are required to submit a MOC for CMS approval.

- ✓ Model of Care (MOC) is designed to meet the specific health care needs of dual eligible beneficiaries for providing and coordinating services.

Roles and Responsibilities of DSNP Plans

- DSNP notify CHC plans daily of admit and discharge information

- DSNP collaborate and coordinate services with CHC plans based on:

  - **Health Risk Assessment –** performed based on DSNP Model of Care

  - **Discharge planning** – DSNP work with discharging facility to coordinate discharge planning needs. If needed, will encourage d/c planner to notify CHC plan for services not covered by Medicare.

  - **Transition of Care (TOC)**
    - reassess for changes in condition and discharge planning needs.
    - assist with making follow up appointments and obtaining medications
    - determine if member is receiving LTSS waiver services and if services need to be evaluated due to change in condition will notify CHC Service Coordinator to re-evaluate
    - if waiver services not in place and needed due to change in condition will make referral for waiver eligibility assessment

Roles and Responsibilities of DSNP Plans

- **Post discharge pharmacy referrals** are created by the Care Manager.
  - Goals developed by pharmacy are incorporated into the individualized care plan and shared with the CHC.
  - Significant medication changes are notified to CHC.

- **BH Referrals-** Care Manager determines BH need after a medical transition, assessment or reassessment.
  - Depression, anxiety, substance abuse, etc. are cause to engage our BH partners for collaboration and support.
  - DSNP BH CM ensures behavioral health outpatient treatment is in place and will consult with BH-MCO if more intensive/expanded behavioral health services would be beneficial.

- **Case Rounds-** complicated cases requiring multidisciplinary team input as determined by the Care Manager, will include an invitation to the CHC-SC.

- Telephonic information exchange and referrals between DSNP Care Managers and CHC MCO Customer Service and/or Service Coordinators.

Meet John Doe

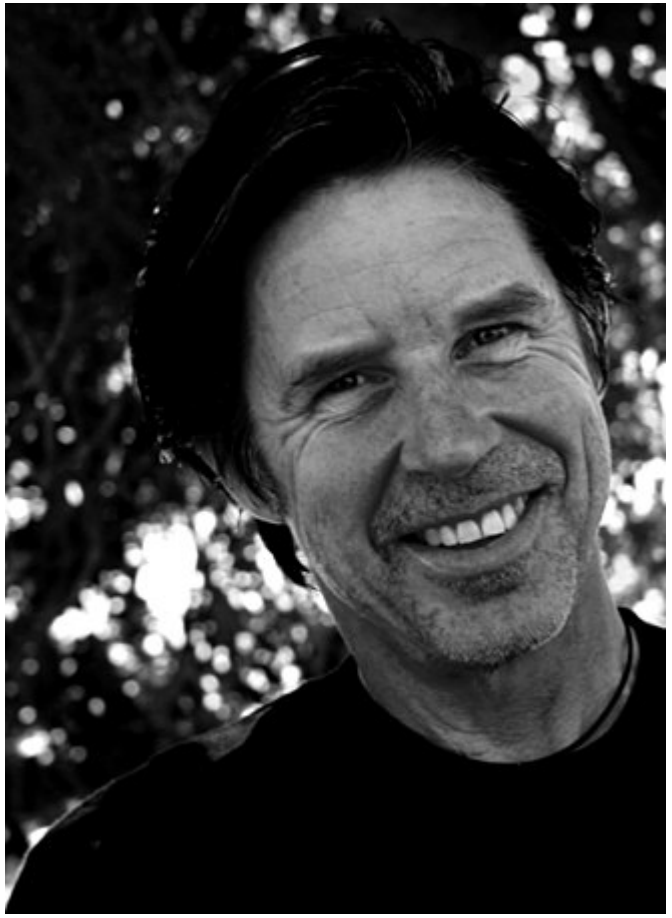
67 year old male

PMH: HTN, CAD, DM, HLD

Admitted to Mercy Fitzgerald on 12/21/2021 for chest pain with confirmed NSTEMI

Hospital course unremarkable, discharged to home on 12/23/2021 and reports fall

Lives alone



DSNP/DSNP Support of John Doe

- DSNP sends daily admission, discharge, and transition information to MCO
- UM care manager facilitates discharge planning with Mercy Fitzgerald social worker/care manager.
  - Case handed off to care management team via discharge referral
- DSNP CM verifies dual status and MCO partner and initiates collaboration via preferred communication method.
- DSNP CM performs post discharge outreach and reviews/updates assessments, reviews medications, determines barriers, supports, provides education, makes needed referrals (pharmacy/BH).

DSNP/DSNP Support of John Doe

- Upon outreach, CM learns of member's fall and that he only has 3 aid hours 3x/week and could benefit from additional hours given his recent cardiac event and fall.
  - DSNP CM notifies MCO SC of change in condition and member's need for more aid hours.

- CM also learns that member is dealing with feelings of sadness and loss of interest in activities after his hospitalization and fall.
  - CM places BH referral and collaborates outreach to member with BH social worker.

- Member reports new medications to treat his cardiac conditions and would like more information on these new meds.
  - CM places pharmacy referral for post discharge medication reconciliation

DSNP/DSNP Support of John Doe

- CM ensures PCP and cardiologist follow up appointments are scheduled and member has transportation scheduled through plan vendor

- CM determines if member has not yet received his COVID-19 vaccination and member verbalizes desire to get it now that he has been hospitalized.
  - CM is able to schedule first dose with local pharmacy or other community resources and arrange free transportation through plan vendor.

- DSNP CM and BH social worker develop individualized care plan and shares that with the MCO SC requesting the PCSP in return.

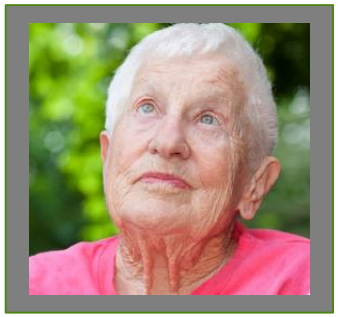
What questions do you have?

Thank you for your attention

January 2022 MLTSS D-SNP Presentation

Telling the Value Story

SNP Care Management involves member touch points in 4 key care activities



Rachel is a 73-year-old dual-eligible member.

She **wants to be more independent**, but improving her well-being is tough due to her **worsening physical and behavioral health** and **financial worries.**

She suffers from **congestive heart failure, diabetes, and moderate depression**, but has a primary care doctor who is engaged in her care. She recently broke her hip and is being discharged home from an LTC facility.

She's grateful her niece visits, but feels she's a burden to her, especially when she **needs groceries.**

Care Activity	IDENTIFY RISKS	PLAN OF CARE	PROVISION OF CARE	TRANSITION MGMT.
	1 Contact member 2 Conduct, evaluate & disseminate Health Risk Assessment (HRA)	3 Risk stratify member 4 Complete Individual Care Plan (ICP) 5 Create Interdisciplinary Care Team (ICT)	6 Recurring care manager outreach 7 ICT provider outreach, as necessary	8 Pre-admission plan 9 Post-discharge screening, with updated HRA, ICP, ICT, and medication reconciliation 10 Post Transition PCP and/or Specialist appointments

Mitigating Risk for our Members

SUCCESS IS DRIVEN BY 4 DIFFERENTIATORS…

		PEOPLE	PROCESS	TECHNOLOGY
COORDINATION OF BENEFITS	▪ Care manager ensures member understands and receives full scope of **benefits from Medicare & Medicaid**	✓		✓
TAILORED LEVELS OF OUTREACH	▪ Care manager provides d**ifferentiated approaches** based on member acuity *(e.g. greater frequency of care management calls for higher acuity)*		✓	
BREADTH OF ICT SERVICES	▪ Broad scope of internal **clinical resources** *(e.g. BH specialist, social worker, pharmacist, dietician, care coach, various specialists)*	✓		
ENHANCED COLLABORATION WITH ICT	▪ Care manager deeply collaborates with closely aligned ICT partners, communicating on **platform to track and share** activities for documentation	✓		✓

Interventions for Success

- Special Supplemental Benefit for the Chronically Ill (SSCBI)
- In-Home Wellness Assessments (IHWA)
- Disease-Specific Best Practices (DSBP)
- Pharmacy Services
- In Home Preventative Health
- Regionalization of the Care Management team

BH Coordination in SNP

Risk Assessment, Education, Resolve Access to Care

Safety planning is completed if risk is present, including contact with local emergency services.

Focus is on education of symptoms and short term resolution planning until member can see a local provider or telehealth provider.

Our Care Coordinators utilize resources available to reduce or eliminate access to care issues including the utilization of telehealth services as appropriate.

Education on 24/7 crises management

Call Cadence

Care Coordinators call members as often as needed to resolve the issues presented.