Training for Providers, Provider Office Staff and FDRs

DUAL SPECIAL NEEDS PLAN

CARE TRANSITIONS & CONTINUITY OF CARE

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COMMUNITY HEALTH CHOICE

Course Description

Course Name: Dual Special Needs Plan Care Transitions and Continuity of Care Issues for Providers, Provider Office Staff, and FDRs

Description and Target Audience: This course is an informational class for providers, provider office staff, and other FDRs serving Community's D-SNP members.

Learning Objectives: At completion of the course, you will understand Community's requirements for managing transitions and continuity of care, and the provider's role in transitions.

Agenda

Medicare D-SNP Care Transitions and Continuity of Care

1. Care Transitions
2. Continuity of Care Part C
3. Continuity of Care Part D

Care Transition

A care transition is the movement of a Member from one care setting to another as the Member's health status changes.

Care settings are:

- A private home
- Home with home health care
- Acute care hospital or Long Term Acute Care (LTAC) Hospital
- Skilled Nursing Facility (SNF)
- Other facility settings such as Nursing Home, Board & Care

Community's Responsibilities for Managing Transitions

The Community Case Manager is expected to assess member status, anticipate transition, and mitigate risks.

Mitigation may include:

- Educate Member on importance of adherence to treatment; brainstorm methods for compliance with meds, diet, etc.
- Send a Community Health Worker to the home
- Facilitate Member appointment with PCP
- Follow-up with Member to assess mitigation effectiveness

Transition from Hospital or SNF

Case Managers can take actions to reduce readmissions

Contact Member or primary caregiver promptly upon discharge to:

- Ensure understanding of signs and symptoms to return to hospital or call doctor
- Perform medication reconciliation
- Ensure ordered home care services or DME are in place
- Identify any barriers to compliance with post discharge plan
- Ensure post-discharge appointment is scheduled and follow up to confirm appointment was kept

Behavioral Health Aftercare Program for Mental Health Transitions

Behavioral Health (BH) Aftercare Program promotes a smooth transition to post-hospitalization mental health care by:

- Placing follow-up calls and mailing appointment reminder notices to the Member after discharge from the facility
- Confirming that the Member kept an outpatient appointment
- If the appointment was not kept, outreaching to the Member to schedule a follow-up appointment within 24 hours of the missed one
- Documenting all results of the Aftercare Program including numbers of appointments kept as scheduled, numbers of missed and rescheduled appointments, and numbers of appointments never rescheduled

Required Communication of the Individualized Care Plan (ICP)

Upon notice of an acute or rehabilitation admit, SNF admission, or initiation of home health services, Community must:

- Contact the facility's UR department or home health agency to discuss the Member's health status within 24 hours
- Coordinate with Community's Case Manager and the facility discharge planner when the discharge is anticipated
- Update the Individual Care Plan (ICP) and provide the ICP and other relevant info to the receiving facility/provider
- Ensure providers are fully knowledgeable and prepared to support the Member

Treating Provider's Responsibilities for Managing Transitions

Effective transitions for D-SNP members require providers to:

- Collaborate with the Community Case Manager and the Member's Interdisciplinary Care Team (ICT)
- Advise Community Case Manager and ICT when Member is at risk for transition and Community can assist with risk mitigation
- Recommend updates to the Individual Care Plan (ICP) as indicated by changes related to the transition or risk for transition

Continuity of Care - Part C

- Community ensures no gaps in care or services when new Members enroll in D-SNP
- New Members to Community's D-SNP have continuity of care rights to continue treatment with a non-contracted provider
  - Community identifies and transitions Members to their Community network providers as quickly as clinically appropriate

Continuity of Care: Providers leaving D-SNP network

When a Member's PCP or Specialist terminates from the plan:

- Community evaluates and takes steps to ensure continuity of care, and no gaps in care or services.
- When possible, Community authorizes continued care with the Provider for the completion of treatment or until the Member can be safely transitioned to a contracted provider.
- Such authorizations are typically for 30 days and may not be possible if the Provider has died, retired, lost medical license, received Medicare or Medicaid sanctions, or has moved outside the service area.
- Request continued authorization through the UM Process.

Continuity of Care - Part D

- Community ensures no gaps in care or services when new members enroll in D-SNP
- CMS requires plans to provide a 90-day supply of current medications whether or not the current medications are on formulary. These “transitional fills” apply to:
  - Retail pharmacy
  - Home infusion
  - Long term care
  - Mail-order pharmacy
- Transitional fill requirement does not apply to drugs covered under Part C.

Test your knowledge

1. Which of these are care settings:

a. A private home
b. Home with home health care
c. Acute care hospital or Long Term Acute Care (LTAC) Hospital
d. Skilled Nursing Facility
e. Other facility settings such as Nursing Home, Board & Care
f. All of the above

2. True or False: The assigned Community Case Manager is expected to anticipate care transitions and mitigate them when possible.

3. Which of the following described how a provider supports a D-SNP member with transition?

a. Collaborate with the Community Case Manager and the member's Interdisciplinary Care Team
b. Advise Community when member is at risk for transition and Community can assist with risk mitigation
c. Recommend updates to the Individual Care Plan (ICP) as indicated by changes related to the transition or risk for transition
d. All of the above

4. Which of the following actions is not expected to reduce the risk of readmission?

a. Ensure understanding of signs & symptoms to return to hospital or call doctor
b. Perform medication reconciliation
c. Ensure order home care services or DME are in place
d. Survey member about their satisfaction with hospital
e. Identify any barriers to compliance with post discharge plan
f. Ensure post discharge appointment is scheduled and follow up to confirm appointment was kept

Questions?

If you have any questions, please call Provider Services at:

713.295.5007

Toll-free: 833.276.8606

Thank you!

- We hope you found this *Dual Special Needs Plan Care Transitions and Continuity of Care Issues for Providers, Provider Office Staff, and FDRs* helpful.

- Please download this presentation and share it with others at your practice as appropriate.