Blue Cross Blue Shield Minnesota

NURSING HOME CARE COORDINATION

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AGENDA

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- Nursing Home Care Coordination
- Guidelines
- MSHO Supplemental Benefits
- Contact requirements
- Member & Provider letters
- NH HRA & Care Plan Review
- Review of facility care plan
- Transitional HRA
- Bridgeview
- Transitions of Care
- Transfers
- Continuity of Care when there's a change in Care Coordinator
- Discharge planning

NURSING HOME CARE COORDINATION

BlueCross BlueShield Minnesota

☐ I have asked to be invited to the member's care conferences.
☐ I have attended OR reviewed the most recent care conference notes. Care Conference Date:

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CARE COORDINATION GUIDELINES

BlueCross BlueShield Minnesota

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MSC+ Enrollees:

- Discuss SecureBlue MSHO product and provide enrollment resources, if applicable. See *SecureBlue MSHO Enrollment Resources* page on the website.

7. Complete the assessment requirements within the timeframes listed below. *See Contact Requirements* section.

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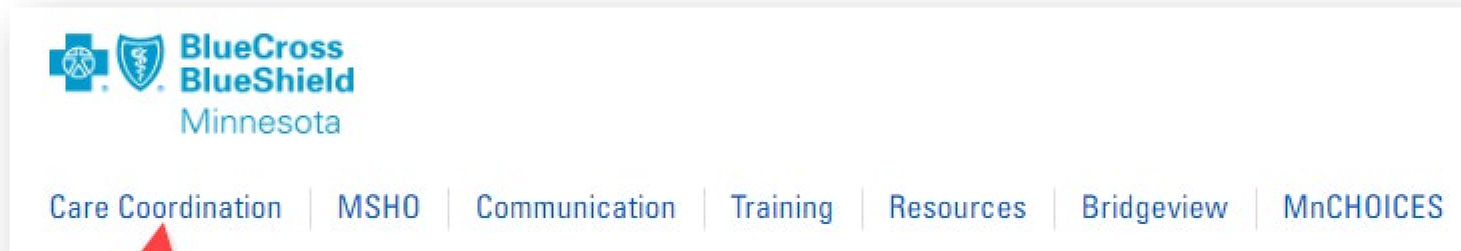
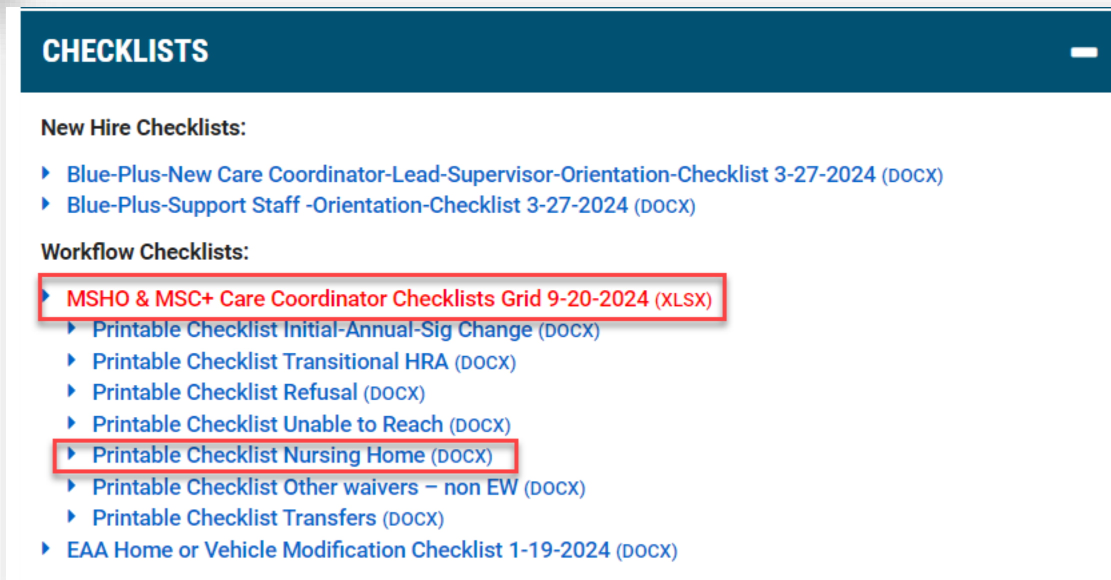
CHECKLIST





MSHO SUPPLEMENTAL BENEFITS

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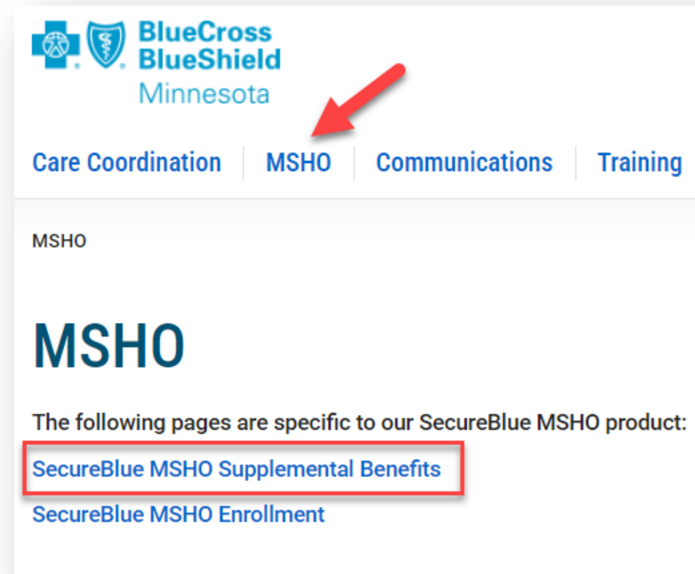

MSHO ENROLLMENT

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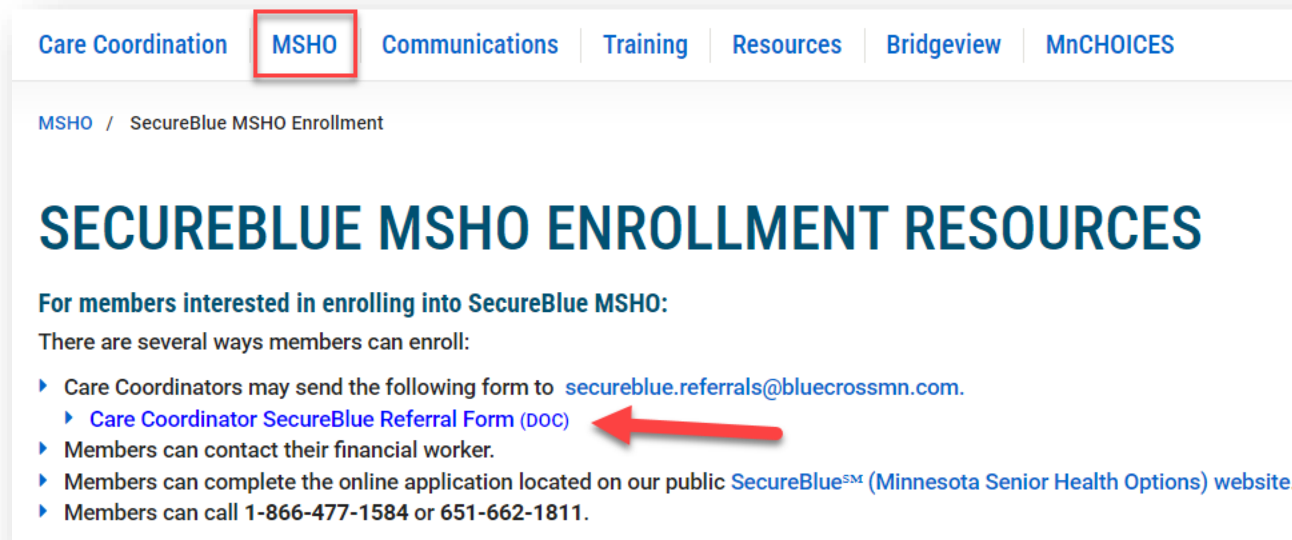
- CC's must discuss enrollment into MSHO for MSC+ enrollees initially and annually, if applicable.
- See website for resources and refer to MSHO Sales Specialist.



CONTACT REQUIREMENTS

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Contact Requirements *All members must be notified of their Care Coordinator's information within 10 calendar days of enrollment notification or change in Care Coordinator.*		
Contact/year	**MSHO**	**MSC+**
Initial Assessment (includes product changes)	In-person w/in 30 days	In-person w/in 60 days
Annual Assessment	In-person within 365 days	
Mid-year contact	In-person or over the phone with the member or responsible party, or at a care conference	
Long Term Care Placement	Within 45 days of notification of LTC placement or within 365 days of previous assessment (whichever is sooner)	
Member Request	Member request for a MnCHOICES assessment must be completed within 20 calendar days of the request	

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MEMBER AND PROVIDER LETTERS

Which letter?	Send to whom?	When?
8.22 Intro Letter	Member	Within 10 calendar days of notification of enrollment
NH-ICF Post Visit Summary Letter – Intro to Primary Care Provider	Member’s PCP	Within 90 days of notification of enrollment following initial assessment and reassessment
8.35 Nursing Home-ICF Visit Summary Letter	Member or guardian/POA/responsible party if member not able to participate	Within 90 days following the assessment
8.35.01 Unable to Reach-NH-ICF Visit Summary Letter	Guardian/POA/responsibe party if member not able to participate and CC not able to reach above parties.	Within 90 days following the assessment if CC has been unable to reach member’s POA/responsibly party
Intro to Primary Care Provider	Member’s PCP	When there’s a change in Care Coordinator

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NH HRA & CARE PLAN REVIEW

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Assessments are required for the following:

- Initial (new enrollee or product change)
- Annual (within 365 calendar days)
- Member request for a community assessment
  - DHS rules: within 20 calendar days of member request

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NH HRA & CARE PLAN REVIEW

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- Demographics
- Review of advanced directives
- Member Care Team

Nursing Home/Intermediate Care Facility
Member Health Risk Assessment/Care Plan Review

Member Information

Name:	Bridgeview ID (8+ PMI): Member AGP ID:	Product Name: Choose One	Assessment Date:
Facility Name:	DOB:	Facility Admission Date:	
Facility Address:	Phone #:		
	Primary Diagnosis:	Assessment Type: ☐ Initial Health Risk Assessment ☐ Annual Reassessment ☐ Significant Change ☐ Other *See section V. for semi-annual contact* *See section VI. for Product Change*	
Is there an Advance Directive or Health Care Directive in place? ☐ Yes ☐ No Was Advance Directive/Health Care Directive discussed: ☐ Yes ☐ No If no, reason:	Check all that apply: ☐ Do not resuscitate (DNR) ☐ Do not hospitalize (DNH) ☐ No tube feedings ☐ Comfort Care Only ☐ CPR Comments:	☐ Do not intubate (DNI) ☐ No IVs ☐ No antibiotics ☐ No hospice ☐ POLST/Physician Orders for Life Sustaining Treatment	

I. Member's Care Team (Interdisciplinary Care Team-ICT)

Care Coordinator Name: Phone #:	Primary Physician: Phone #: Fax #:	Clinic:
Legal Guardian/POA:	Legal Guardian/POA Address/Phone:	
Authorized Rep (if different):	Authorized Rep Address/Phone:	
DD Case Manager (for those residing in ICF): Name:	Phone:	
If applicable, contact made with DD CM. Date:		

Ask member (if appropriate): Is there anyone else that you'd like to receive a copy of the 8.35 Nursing Home-ICF Visit Summary letter? ☐ Yes ☐ No If yes- name, address and relationship status?

Comments:

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NH HRA & CARE PLAN REVIEW

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Facility chart review

- Immunizations review
- Nutritional assessment
- Minimum Data Set (MDS)
- Annual PCP visit
- Care Plan review

II. Facility Chart Review

Care Transitions (Hospital/ER Visits in the last 6 months)

Reminder- see Care Coordinator Guidelines for TOC responsibilities

Hospital/ER: Dates:

Comments:

☐ Reviewed list of medications

Comments:

Immunization Review *9.03 Immunization Guidelines available on the Care Coordination website*

Vaccination/Immunization	Is Member up to date?	If not up to date, must include a note.
Flu	☐Yes	☐No
Pneumococcal	☐Yes	☐No
TDAP	☐Yes	☐No
Zostavax (Shingles)	☐Yes	☐No
COVID-19	☐Yes	☐No
<other>	☐Yes	☐No

Comments:

Nutritional Assessment:

Height Weight

☐ I have reviewed the current nutritional assessment

Comments/Recommendations:

od Status:

care

Immunization Review *9.03 Immunization Guidelines available on the Care Coordination website*

Vaccination/Immunization	Is Member up to date?	If not up to date, must include a note.
Flu	☐Yes	☐No
Pneumococcal	☐Yes	☐No
TDAP	☐Yes	☐No
Zostavax (Shingles)	☐Yes	☐No
COVID-19	☐Yes	☐No
<other>	☐Yes	☐No

Comments:

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NH HRA & CARE PLAN REVIEW

BlueCross BlueShield Minnesota

Facility care plan review

- Includes recommendations/modifications, if applicable.
- Participation in member care conferences
- Review of any ancillary provider needs

Facility's Plan of Care:
☑ I have reviewed the facility Plan of Care and Goals.
Comments:

Confirm that the Facility Care Plan addresses each of the following items below. If the Care Plan does not address any of the items below, describe in the Comments below:

- ☐ Multidisciplinary
- ☐ Depression screening
- ☐ Socialization needs
- ☐ Preventive in focus
- ☐ Member/Family Participation
- ☐ Nutrition
- ☐ Holistic
- ☐ Skin Integrity
- ☐ Tobacco/Alcohol Use (if applicable)
- ☐ Fall risk
- ☐ Mental Health status

☐ Other:

Comments:

Care Coordinator should retain a copy of the reviewed care plan. Blue Plus may request a copy at any time.

I have recommended the following modifications to the facility care plan (to include areas of need the member has expressed or potential gaps in care):

Date	Recommendation	Outcome
Ex: 1-2-1234	*Member expressed the need for more exercise.*	*CC discussed with nursing staff to consider adding facility walking program to care plan.*

Comments:

☐ **I have asked to be invited to the member's care conferences.**
☐ **I have attended OR reviewed the most recent care conference notes.** Care Conference Date:

Comments:

Additional Care Providers seen in the last year, as appropriate:

Provider	Has member received the following services?	Check if Referral Needed	If no, must include a note.
Podiatry	☐Yes ☐N/A	☐	☐No
Psychiatry	☐Yes ☐N/A	☐	☐No
Dental	☐Yes ☐N/A	☐	☐No
Vision	☐Yes ☐N/A	☐	☐No
Hearing	☐Yes ☐N/A	☐	☐No
<other>	☐Yes	☐	☐No
<other>	☐Yes	☐	☐No

NH HRA & CARE PLAN REVIEW

- Member/Responsible Party Interview
- Desire to relocate to community
- Other CC tasks
  - Meet with member
  - Contact made with responsible parties (as applicable)
  - Discussion with facility staff
  - Supplemental benefits (MSHO members)
  - MSHO enrollment (MSC+ members)

III. Member/Responsible Party Interview

1. What are the most important things to you? (For instance, being social, music, family, having choices, etc.)
   <member/responsible party response>
2. What activities or things do you enjoy doing?
   <member/responsible party response>

   2a. Is anything needed to support or help you do these activities?
   <member/responsible party response>
3. Do you like where you live? ☐ Yes ☐ No **If no, what would you change?
   <member/responsible party response>
4. Would you like to live elsewhere? ☐ Yes ☐ No
   Comments:

☐ I have assessed this member's desires and/or ability to relocate back to the community or another facility.
Date Assessed:
☐ If appropriate, Home and Community Based Services (HCBS) options were discussed.
Comments:

IV. Care Coordinator Tasks

☐ Met with member, explanation of Care Coordinator role, addressed member concerns (if any).
Comments:

☐ Contact made with member's guardian, POA, or responsible party (required if member is unable to fully participate).
Date:
Comments:

☐ Discussion of member's status with facility staff.
Comments:

☐ Discussed MSHO Supplemental Benefits with MSHO members. *Resources available on the Care Coordination portal*
Comments:

☐ Discussed SecureBlue MSHO enrollment (MSC+ members only)
Comments:

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NH HRA & CARE PLAN REVIEW

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- Care Coordinator signature
- Assessment date
  - Date entered into Bridgeview
- Mid-year contact review

Additional Comments:

IV. Care Coordinator Signature (required)

Care Coordinator: **Organization:** **Date:**

V. Mid-Year Contact: Date

☐ Contact with member, addressed member concerns (if any).
Comments:

☐ Contact made with member's guardian, POA, or responsible party (required if member is unable to fully participate).
Date:
Comments:

☐ I have discussed any recent acute episodes or hospitalizations.
Comments:

☐ I have discussed any significant changes in condition or level of care.
Comments:

☐ I have assessed this member's desires and/or ability to relocate back to the community or another facility.
Date Assessed:

☐ If appropriate, Home and Community Based Services (HCBS) options were discussed.
Comments:

Are there any unmet needs/care concerns to follow up on? ☐ Yes ☐ No

Additional Comments:

V. Semi Annual Contact Care Coordinator Signature (required)

Care Coordinator: **Organization:** **Date:**

NH HRA & CARE PLAN REVIEW

- Transitional HRA
- For product changes only
- MSHO to MSC+ or MSC+ to MSHO

Cannot be used for initial Blue Plus enrollment

VI. 6.28.01 Nursing Home/Intermediate Care Facility Transitional Health Risk Assessment for Product Change

This section of the form is to be used only when a member changes Blue Plus Products (MSC+ to MSHO or MSHO to MSC+). Complete the section below and review the entire 6.15 Nursing Home/Intermediate Care Facility Member Health Risk Assessment/Care Plan Review form for any updates. This must be completed within the required assessment time frames for "new enrollees". The next annual assessment is due 365 days from the last full assessment date.
All member/authorized rep/physician letter requirements must be completed for product changes (see Nursing Home/Intermediate Care Facility Product Change section of the Nursing Home/Intermediate Care Facility Care Coordination Guidelines for complete details).

New Product: Choose One New Product Enrollment Date:

☐ Reviewed current 6.15 Nursing Home/Intermediate Care Facility Member Health Risk Assessment/Care Plan Review including facility chart as needed. Date:

☐ Reviewed status changes with facility staff as needed.

☐ Met with member or guardian, POA, or responsible party (required if member is unable to fully participate). Date:

Comments:

☐ Reviewed MSHO Supplemental Benefits with member or responsible party (as applicable)

☐ Contact made with DD Case Manager (for those residing in ICF), if applicable.

Additional Comments:

VI. **Product Change Transitional HRA Care Coordinator Signature (required)**		
Care Coordinator:	**Organization:**	**Date:**

ADDITIONAL ASSESSMENT GUIDANCE

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What to do if member is cognitively impaired and not able to participate in your interview/person-centered assessment?

- Review Section C/BIMS of MDS
- Contact with responsible party
- Interview of facility staff

Resident Identifier Date

Section C **Cognitive Patterns**

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code
0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code
Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

BRIDGEVIEW

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Care Coordination

- Enrollment
- Care Coordinator assignment
- Assessments due
- HRA entry
- Service agreement entry
  - Elderly Waiver
  - State Plan Home Care

Bridgeview COMPANY

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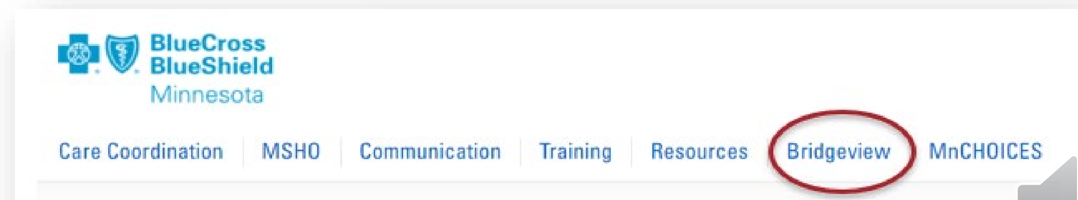
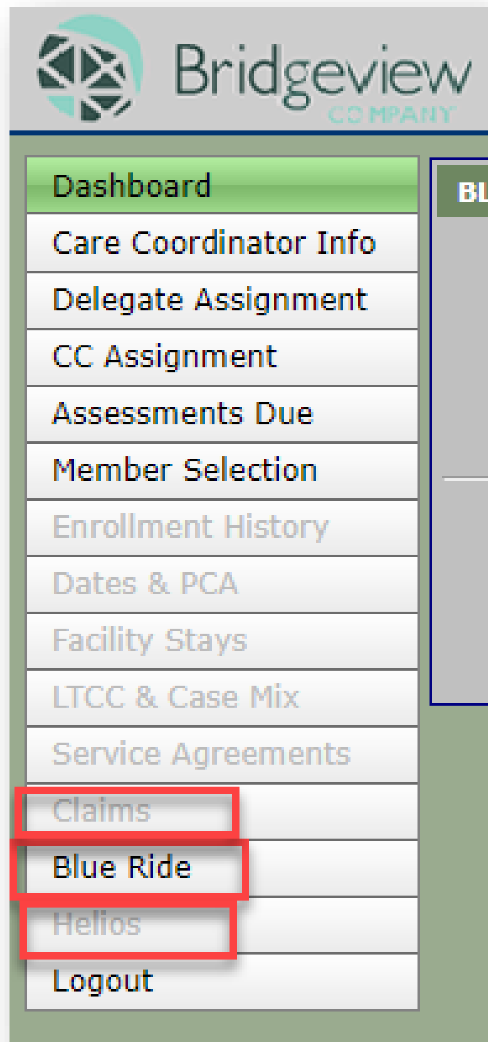
Bridgeview Care Coordination User Guide

The intent of the Bridgeview web tool is to provide a data entry tool for Care Coordinators and support staff to assign care coordinators, retrieve enrollment reports and enter Assessments and Service Agreements for Blue Plus MSHO and MSC+ members.



BRIDGEVIEW



Claims

Blue Ride

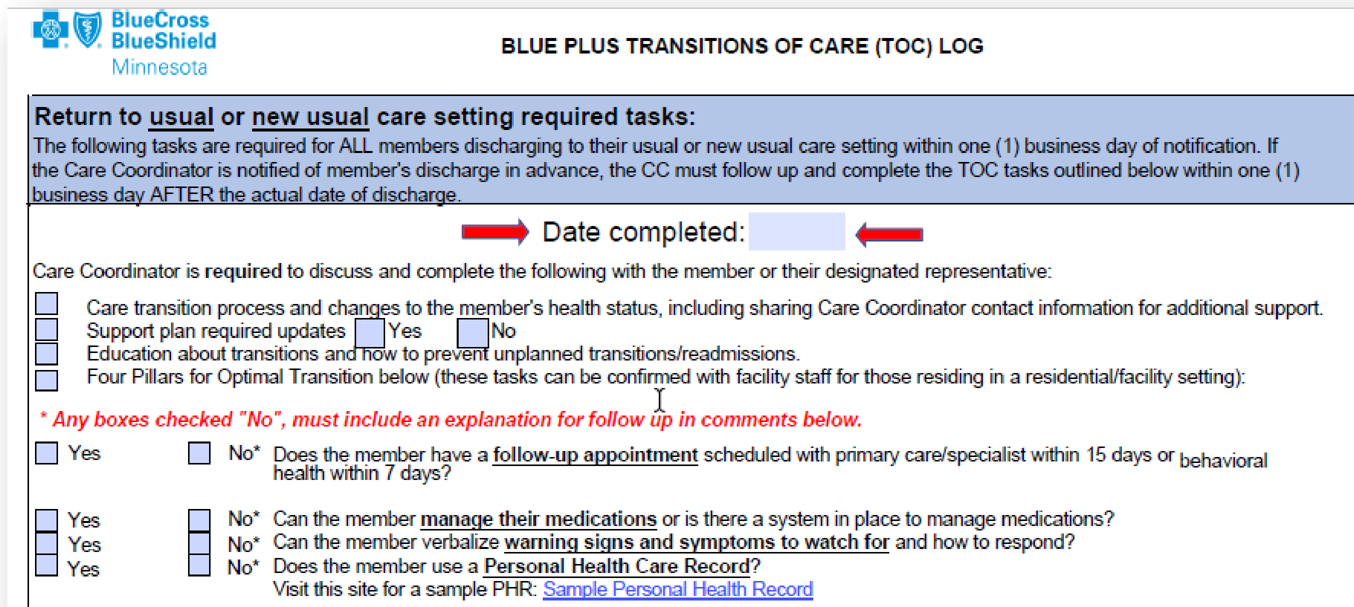
- Schedule medical transportation

Helios

- Prior authorizations
- Pharmacy claims

TRANSITIONS OF CARE

- Movement of member from one care setting admission to another (i.e., home to hospital, hospital to SNF, SNF to home) for both planned or unplanned admissions
- Tasks include following up with facility, notification to PCP, follow up with member post discharge, etc. TOC tasks are documented on our TOC log.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BLUE PLUS TRANSITIONS OF CARE (TOC) LOG

Return to usual or new usual care setting required tasks:
The following tasks are required for ALL members discharging to their usual or new usual care setting within one (1) business day of notification. If the Care Coordinator is notified of member's discharge in advance, the CC must follow up and complete the TOC tasks outlined below within one (1) business day AFTER the actual date of discharge.

Date completed:

Care Coordinator is **required** to discuss and complete the following with the member or their designated representative:

- ☐ Care transition process and changes to the member's health status, including sharing Care Coordinator contact information for additional support.
- ☐ Support plan required updates ☐ Yes ☐ No
- ☐ Education about transitions and how to prevent unplanned transitions/readmissions.
- ☐ Four Pillars for Optimal Transition below (these tasks can be confirmed with facility staff for those residing in a residential/facility setting):

** Any boxes checked "No", must include an explanation for follow up in comments below.*

☐ Yes ☐ No* Does the member have a follow-up appointment scheduled with primary care/specialist within 15 days or behavioral health within 7 days?

☐ Yes ☐ No* Can the member manage their medications or is there a system in place to manage medications?
☐ Yes ☐ No* Can the member verbalize warning signs and symptoms to watch for and how to respond?
☐ Yes ☐ No* Does the member use a Personal Health Care Record?
Visit this site for a sample PHR: Sample Personal Health Record

TRANSFERS

Transfer: When an existing Blue Plus enrollee moves from one Blue Plus Delegate to another Blue Plus Delegate as a result of a change in living arrangement, move, or change in primary care.

Initiating Delegate responsibilities:

- Confirm the new Delegate by referring to 9.07 Care Coordination Delegate Listing and Contact Table
- Send form 6.08 Transfer in Care Coordination Delegate including all transfer documents (HRA, care plan, service authorizations, etc.)
  - See 6.08.01 Transfer in Care Coordination Delegation checklist
- Update the member's address, COR, and/or PCC in Bridgeview
- Notify the member's financial worker by completing DHS 5181
- Change is effective the 1st of the following month

TRANSFERS (CONT'D)

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Receiving Delegate responsibilities:

- Receiving Delegate will receive 6.08 Transfer in Care Coordination Delegation form as notification of the transfer. Receipt of this is official notification – not the enrollment report.
- Assign a CC in Bridgeview and notify the member by the 10th of the month (8.30 CM Change Intro letter may be used).
- Update Screening Document to reflect change in CC.
- Notify financial worker of assigned CC name.
- Notify physician using 8.28 Intro to Doctor Letter.
- Confirm the PCC is correct in Bridgeview.
- All assessment due dates remain the same.
- No transitional HRA is needed for Blue Plus to Blue Plus transfers.
- CC should review all transfer documents for completion.

For members who move out of our service area, please see Guidelines.

CONTINUITY OF CARE WHEN THERE'S A CHANGE IN CC

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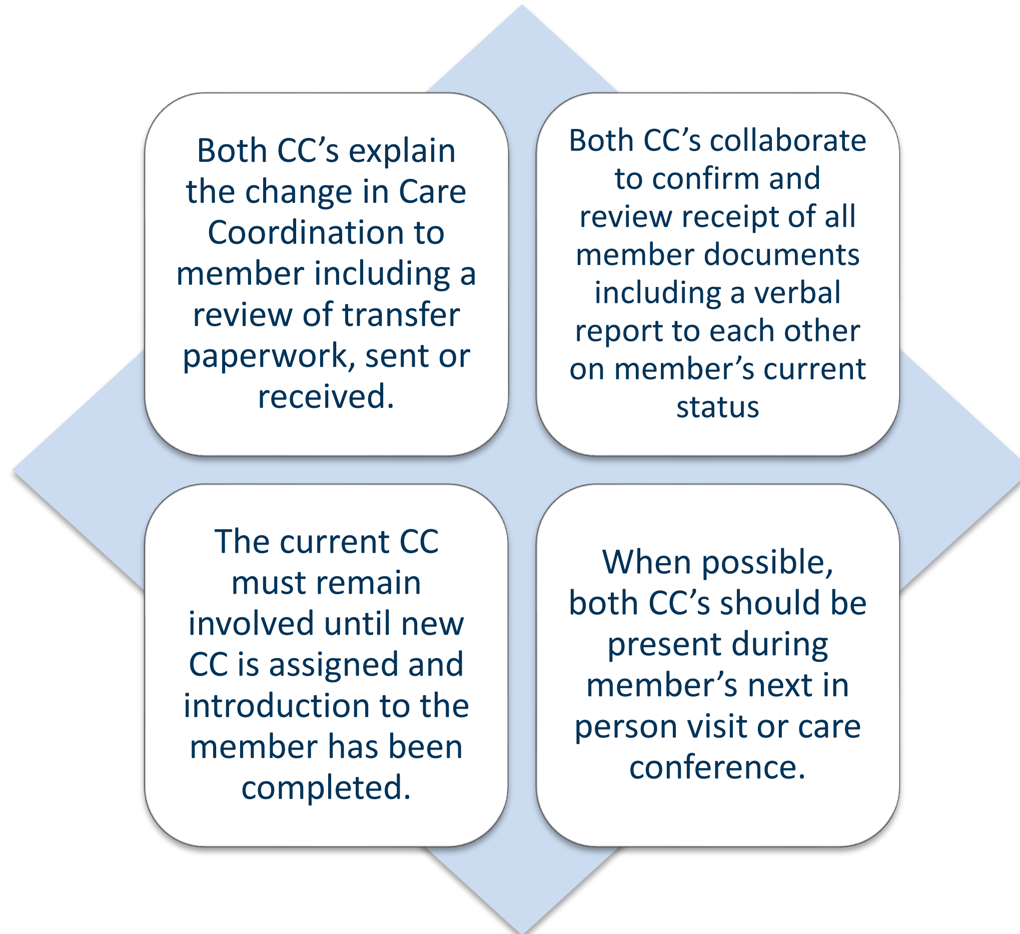
Internal change or transfer to another Delegate, the following best practices must be considered:



DISCHARGE PLANNING

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- Care Coordinator is required to coordinate completion of a MnCHOICES assessment within 20 calendar days of the member's request for Home and Community Based Services (Elderly Waiver). This is required even if the facility interdisciplinary care team disagrees with member's ability to return to the community.

III. Member/Responsible Party Interview

1. What are the most important things to you? (For instance, being social, music, family, having choices, etc.)
   <member/responsible party response>
2. What activities or things do you enjoy doing?
   <member/responsible party response>

   2a. Is anything needed to support or help you do these activities?
   <member/responsible party response>
3. Do you like where you live? ☐ Yes ☐ No **If no, what would you change?
   <member/responsible party response>
4. Would you like to live elsewhere? ☐ Yes ☐ No
   Comments:

☐ I have assessed this member's desires and/or ability to relocate back to the community or another facility.
Date Assessed:

☐ If appropriate, Home and Community Based Services (HCBS) options were discussed.
Comments:

This includes offering a MnCHOICES assessment if desired.

DISCHARGE PLANNING

- Focus of transition should be member-centric.
- If the community Care Coordinator is completing the community assessment for discharge planning, the expectation is both the nursing home and community Care Coordinator work together to ensure a smooth transition and hand-off of Care Coordination needs and tasks.
  - Nursing Home CC should be a part of the assessment process either in person or by phone.
    - Sharing of any and all historical information with the assessing Care Coordinator.
    - Sharing of member's needs and wishes with the assessing Care Coordinator
  - Both Care Coordinators must assure the member understands who the assigned Care Coordinator will be post-discharge including contact information.

RESOURCES

Relocation program options include:

- Relocation Service Coordination (RSC)
- Elderly Waiver Transitional Services
- Moving Home Minnesota (MHM)
- Housing Stabilization Services (HSS)

The overall purpose and goal of each program is to help seniors relocate from an institution to a lesser restrictive community-based setting with services and supports. For more details on each program, please see our “At a Glance – Relocation Resources” document on our website under Care Coordinator Resources on the resource page.

At a Glance – Relocation Resources				
*Unforeseen Circumstances apply to all programs below; email Partner.Relations@bluecrossmn.com for review, determination & next steps.				
Resource	Payer &Purpose	Program Eligibility Summary	Limitations	Billing Information

QUESTIONS?

Contact your assigned Partner Relations Consultant or email Partner.Relations@bluecrossmn.com.

THANK YOU! thank you!

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