MSHO/MSC+ Institutional Care Coordination

Care Coordination Training Module #8

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Institutional Care Coordination- why is it important?

While our members who reside in facilities have a lot of support in place through the facility, it remains important for Care Coordinators to be an active member of the Interdisciplinary Care Team.

Care Coordinators bring an outside perspective with a focus on preventative health.

Care Coordinators can provide knowledge and assistance in regards to health plan information, assist with needed DME, community resources, etc.

Care Coordinators can assist in discharge planning and ensuring the member is in the appropriate living setting.

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Building relationships with Skilled Nursing Facilities

It is important for Care Coordinators to build a relationship with staff at facilities to ensure there is good communication between all of the Interdisciplinary Care Team.

Some tips:

- Set up an in-person meeting with the social workers and/or RN Managers to introduce yourself and explain your role.
- Attend Care Conferences regularly.
- Check in and talk with staff while you complete in-person assessments at the facility.
- Be sure you are providing appropriate updates to the facility staff so they are encouraged to do the same.
- Request access to the facility's Electronic Medical Record.

Care Coordination Requirements

Upon Enrollment (if applicable):

Initial member and facility contact within 10 days

Newly enrolled member is to be assessed within 30 days for MSHO and 60 days for MSC+ of admission by completing the Institutional Member Assessment.

Upon Admission:

Contact nursing facility, introduce self, and ask to be added to the care conference list.

Provide Nursing Facility Chart Coverage Guide MSHO or MSC+

Send OBRA Level I DHS-3426-ENG to facility.

Send DHS-5181-ENG to county financial worker to notify them of the living setting change and planned length of stay.

Complete Transition Log (required for MSHO, best practice for MSC+)

Complete Denial, Termination and Reduction (DTR) for EW and/or services, if applicable.
Care Coordinator must close a person's waiver program when they are admitted to an institution for 30 days or more (hospital, nursing facility, transitional care unit, inpatient mental health/substance use stay).

When is the Institutional Assessment used?

When an MSHO/MSC+ member has been a resident of a nursing home for more than 30 days.

Members considered to be “institutional” are shown on the full enrollment report to be in DHS designated living settings 41, 42 and 43.

If a member is due for their annual reassessment and is presently in a facility with discharge plans unknown, the Institutional Assessment can be used. MnChoice Assessment/HRA/LTCC can be completed upon discharge.

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MDS Info/SNF Care Plan Review

An important part of the Institutional Assessment process is reviewing the member's MDS and facility Plan of Care.

The Minimum Data Set (MDS) is a standardized assessment tool that measures health status in nursing home residents. MDS assessments are completed every 3 months (or more often, depending on circumstances) on nearly all residents of nursing homes in the United States. These assessments are performed and recorded by nursing home staff, and include information on a number of aging-relevant domains including functional and cognitive status, psychosocial functioning, geriatric syndromes, and life care wishes.

It is important to ensure that the Plan of Care addresses all of the members needs and concerns. If the Care Coordinator identifies any areas not addressed on the Care Plan, there is a goal section of the Institutional Assessment that must be completed.

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Institutional HRA

MSHO/MSC+
INSTITUTIONAL HEALTH RISK ASSESSMENT
&
CARE PLAN

Member Information		
Member Name:	Date of Birth:	Medica ID:
Facility Name:	Facility phone number:	Contact at facility (name, title, etc.):
Admission Date:	Room Number:	Medica Enrollment/Transfer Date:
Assessment and Care Plan Date:	Assessment Type: Select One	Date of the facility assessment:

☐ **I have reviewed the member's most recent facility assessment (MDS, etc.)**

☐ **The following assessment information was gathered by the care coordinator through interaction with the member/responsible party, facility staff, and chart review**

Member's Care Team (Interdisciplinary Care Team – ICT)	
Care Coordinator Name: Phone #:	Primary Physician: Clinic: Phone #: Fax #:
Legal Guardian/POA:	Legal Guardian/ POA Phone:
Authorized Rep (if different):	Authorized Rep Phone:
Other: Name and Relationship:	Other: Phone Number:

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The Institutional HRA is posted on the Care Coordination Hub.

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If the member is unable to participate in the assessment, the Care Coordinator should contact the authorized representative to complete the Member Interview sections. You can also utilize the member's record at the facility and facility staff for the remainder.

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Follow Up Letters

Institutional Post-Visit Letter: mailed to member/authorized rep and facility.
PCP Letter: Faxed or mailed to PCP.

<Date>

Important Medica Information

<Member Name>
<Address 1>
<Address 2>
<City, state, zip>

Your Care Plan

Dear <Member name>,

I am your Medica Care Coordinator and I visited you at <SNF Name> on <date of assessment> to complete your Medica Health Assessment.

- ❍ I reviewed your Facility Care Plan and assessment and all identified needs have goals present
- ❍ I reviewed your Facility Care Plan and assessment and we identified these additional goal(s):
  - ______
  - ______

I will plan to follow up:

- ❍ Once a month
- ❍ Every 3 months
- ❍ Every 6 months
- ❍ Other ______

<Free text for member specific information.>

Questions?
If you have any questions or want to discuss your health care needs, call me at <CC phone number> <Monday-Friday> between <CC hours of operation>. TTY: **711**.

Sincerely,

<CC name>, <Credentials>
<County/Care System/Agency name>
<CC phone number>
<CC email address>

cc: member record, Skilled Nursing Facility

Medica DUAL Solution® is an HMO D-SNP that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in Medica DUAL Solution depends on contract renewal.

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<<today_date_mmmm_ddyyyy>>

<Doctor's Name>
<Clinic Name/Fax Number>
<Address>
<City>, <State> <ZIP>

Re: <Member Name>, <DOB>

Dear <Doctocr's Name>,

My name is <CC Name> and I'm the Medica Care Coordinator for <Member Name>. I can help members:

- Navigate through health care systems, manage transitions, and access home care services and other community-based resources
- Identify and set up any non-medical services that can help the member maintain or improve their health and well-being
- Answer health care coverage questions
- Communicate and coordinate with their Interdisciplinary Care Team

The most recent Health Risk Assessment with <Member Name> indicates the following<Free text-HRA identified needs/concerns (or if no needs identified, unable to contact member, or member declines assessment document that here)>.

Currently, <Member Name> is receiving the following services:

- Care Coordination
- <free text for services received>
- <free text for services received>

We also see you as an integral member of the Interdisciplinary Care Team. Please contact me with questions or input about this member's health care needs or plan of care.

<Free text-additional comments/concerns, etc.>

My Contact Information:
Call me at <phone> <Monday – Friday> between <9 a.m. - 5 p.m.> TTY/TDD: 711.

Thank you,

<Care Coordinator Name>, <Credentials>
<County/Care System/Agency name>
<CC phone number>

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Ongoing Care Coordination of Institutional members

Ongoing Care Coordination:
Complete Annual Institutional Member Assessment within 365 days from last assessment date
Complete Goals section of the assessment as appropriate.
Document Goal Monitoring and Outcomes on previous assessment goals as appropriate.
Evaluate member's desire to relocate back into the community, assist with discharge planning if applicable.
Complete necessary letter documentation (i.e. post-visit letter, PCP letter) within 30 days.
Provide Medica Leave Behind Document to member.
Attend care conferences as able.
***If your entity does not manage Long Term Nursing Facility members, the following applies: Members determined to be long term will be transferred to Medica Care System by day 100 of nursing facility admission. If CC is aware that nursing facility placement will be permanent, CC can initiate the transfer prior to the 100 days. CC must complete the Home and Community Based Services Case Management Transfer and Communication Form (DHS-6037-ENG) and send transfer requests to Medica via email SPPEnrollmentQ@medica.com or fax 952-992-2682

Resources

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Under Tools and Forms:

Institutional

- ↓ Institutional Member Assessment (Fillable PDF)
- ↓ Medica Nursing Home Checklist (DOC)
- ↓ Nursing Facility Chart Coverage Guide (PDF)

Care Coordinators will also utilize appropriate letters, policies, and trainings found on the Care Coordinator Hub.

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If you have questions regarding Institutional requirements, please reach out to your auditor or email MedicaSPPRegQuality@Medica.com.

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