BENEFIT GUIDELINE: READMISSION PREVENTION

Service: Hospital Readmission Prevention (Community Companion Services)

Products:

Medica DUAL Solution® - Minnesota Senior Health Options (MSHO)

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Definition of Service:

The Readmission Prevention Community Companion Services Benefit ("Readmission Prevention Benefit") is available when an eligible member (hereafter "member") has been admitted to a hospital and meets the eligibility criteria outlined below. The benefit provides the member with Community Companion Services from Lutheran Social Service of MN (hereafter "LSS") upon discharge from the hospital. LSS works closely with the member to identify any questions the member may have following their discharge, completes a home safety assessment of the member's living setting, reviews discharge paperwork and identifies all member medications, and provides the Medica Care Coordinator (hereafter "CC") with documented information following each touch point with the member. This benefit supplements and supports the role of the CC during a member transition but does not replace the role of the CC or required activities the CC is responsible to complete. In providing Community Companion Services, LSS provides the CC with multiple documented updates of the member's progress and completion of required services. The Readmission Prevention Benefit provides Medica members with immediate support in the home, and ongoing communication with the member's CC, while working in a collaborative manner with the goal of reducing overall hospital readmissions.

Eligibility:

A member is eligible when **all** of the following criteria are met:

- Member has a current hospital admission, **and**
- Member's discharge plan is to return to a community living setting (e.g. long term skilled nursing facility or institutional placements are excluded), **and**
- Member appears on Daily Admission Report (DAR)

Covered:

Readmission Prevention Benefit includes:

- Up to four (4) phases of service within 30 days of member's discharge (see table below)
- Short-term home delivered meals for member not on Elderly Waiver or other county-based waivers
- Members can access the benefit multiple times per year for each qualified admission.

Not Covered:

- Member refuses to accept the benefit
- Services that are not solely for the member
- Services provided to the member while in an inpatient setting
- Home delivered meals for members on waivers

Referral Process:

LSS

- Medica provides LSS a list of eligible members using the DAR
- LSS conducts member outreach
- LSS advises Medica of members that accept the service
- Medica will create an authorization for services based on LSS notification
- CC will NOT need to complete a referral request form

Care Coordinators

- Care Coordinators can may also may make direct referrals to LSS.

In all cases where the member accepts the service the following steps take place:

- LSS emails CC the Readmission Prevention Community Companion Referral form
- CC returns completed Readmission Prevention Community Companion Referral form to LSS

Benefit Process:

- Readmission Prevention Community Companion Services require an authorization from Medica
- Following each phase, LSS contacts the CC with an update that includes the following:
  - **Phase 1** – Home Safety Assessment, Medication List review, home delivered meal order form assistance (only for non-EW members):
    - CC reviews Home Safety Assessment
    - CC reviews Medication List, reconciles concerns or questions, and makes MTM referral if criteria are met
    - For home delivered meals:
      - LSS confirms member waiver status with CC or through MN-ITs
        - Members on a waiver- LSS refers member to their CC to discuss waivered meals
        - Members not on a waiver- LSS asks CC complete referral request with 4 units of meals
      - LSS confirms with CC that the member is eligible and referral is completed then completes an order for two weeks of meals (when the member's situation warrants, meals may be ordered on a one week basis) through LSS Home Delivered Meals
      - Home delivered meals service includes a minimum of seven refrigerated or frozen meals (one meal per day), that equals one week of meals, up to a maximum of twenty-eight total meals or four weeks of meals
      - Menu is currently available through print from LSS
  - **Phases 2-4** – includes general updates from LSS to CC, who documents updates in case notes and follow up with members and providers as needed; when applicable, subsequent order(s) of meals
- CC documents all review work completed in the member's case notes

Phase 1	Phase 2	Phase 3	Phase 4
In- Home Visit #1	**Phone Call #1**	**In-Home Visit #2**	**Phone Call #2**
Review Personal Health Record (PHR)	Well-being check-in	Review personal goals achievement	Well-being check-in
Set personal goals	Review personal goals achievement	Review plan for follow up appointments	Review of second in-home visit
Share well-being tips	Share pertinent community resources	Update PHR if needed	Referral to community resources (includes LSS)
Review discharge order	Complete home delivered meal menu selections and ordering, if applicable	Complete home delivered meal menu selections and ordering, if applicable	Complete home delivered meal menu selections and ordering, if applicable
Plan follow up appointments	This table represents the activities LSS completes with the member starting with Phase 1. All four phases are completed within 30 days of member's discharge. If a member choses to opt out at any point within the benefit period, LSS immediately notifies Medica of the member's choice and which phases were completed.		
Review medication list(s)			
Conduct home safety assessment			
Complete home delivered meal menu selections and ordering, if applicable			

When to Submit a Request for Benefit Exception:

- This service is ineligible for BEI requests; members must meet eligibility criteria to receive this benefit

Considerations:

- This benefit does not replace any necessary or required visits/assessments that are completed by a Medica Clinical Care Coordinator
- If the member is in need of any community resources or referrals the Medica Clinical Care Coordinator is responsible for those actions

This Medica Benefit Guideline is for MSHO and is intended to guide service plan development. This reflects current interpretation of the product benefit set and/or parameters for obtaining services. Consult with Medica staff for further guidance or to vary from these recommendations.