HEALTHPARTNERS INSPIRE SNBC CARE COORDINATION WORK FLOW & REFERENCE GUIDE

Special Needs BasicCare (SNBC) is a voluntary program for disabled adults 18-64 years old. All waiver benefits (BI, CAC, CADI, and DD), personal care attendant (PCA) and private duty nursing (PDN) are not included in HealthPartners covered services. These services are covered by Medicaid fee-for-service managed through the member's county case manager. Regardless of waiver status, all members receive an initial & annual SNBC Health Risk Assessment (HRA) and coordination of their Medicare & Medicaid benefits. HealthPartners *Inspire* SNBC program does not integrate Medicare and Medicaid benefits; all Medicare (A, B & D) services and supports are managed outside of HealthPartners.
All counties, care systems and agencies contracted with HealthPartners to provide care coordination to HealthPartners *Inspire* (SNBC) members will be referred to as delegates for the purpose of this document.

Enrollment/Census	
✓ **Enrollment Information (Delegate)**	HealthPartners provides delegates with census reports and census change reports monthly. Census report: • Delegates will receive a monthly census report of all their members with active HealthPartners coverage delivered through our provider portal. HealthPartners will deliver this report as soon as possible after the first of each month. • The census report includes member contact information, PMI, DOB, gender, address, living setting, waiver status, and indicates if enrolled in the Restricted Recipient Program. Census Change report includes: • New members assigned to delegate • Terminated members • Changes in delegate assignment • Changes in living setting • HP coverage termination date Delegates are to notify HealthPartners of enrollment discrepancies based on reconciliation of their enrollment with census reports within 10 days of receiving their report. Notify SNBC leaders Ashley.k.horak@healthpartners.com and Jennifer.m.foster@healthpartners.com

Care Coordination Requirements	
	• Provide education • Provide resources/education for care giver support • Keep Responsible Parties and Guardians updated and informed • Assist with Primary and Specialty care access • Arrange the necessary supplies and equipment • Make appropriate and timely referrals • Oversee care transitions
Member Notification and Outreach	
✓ **Notification of Contact Persons**	Within ten (10) business days of Care Coordinator assignment or change of assignment, the Care Coordinator must provide the member with their name and telephone number. This information may be provided by letter, using HealthPartners SNBC CC Change letter, or by phone call. Member notification of assigned Care Coordinator must be documented in the member's case notes/file. Upon notification of assignment, the Care Coordinator contacts the member to introduce themselves, answer questions about the plan, and arrange for the in-person or telephonic care planning visit within 30 calendar days of the HRA date. The Care Coordinator will make best effort attempts to locate correct contact and demographic information. Efforts include but are not limited to: contacting the member's medical or behavioral care team, pharmacy, responsible party or legal guardian, online searches such as White pages.com, contacting waiver care manager if applicable, home-care agencies or other community base providers involved with member's care.
✓ **Outreach**	Contact attempts will include at a minimum 3 phone call attempts at different times of day and different days of the week and 1 Unable to Contact letter. Outreach attempts are to be documented in the member's case notes.
✓ **Voluntary Participation**	The Care Coordinator informs the member that participation in SNBC is voluntary. Member has the right to opt-out of care coordination. If this occurs for members with a delegate, return the member to the internal HealthPartners team.

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Privacy, Confidentiality, and Release of Information	
✓ **Privacy, Confidentiality**	In all communications with and about HealthPartners members, the Care Coordinator (CC) will abide by and use HIPAA- PHI protection practices for all communications with members and/or their responsible party, care team members, county partners, providers and others. All faxed information must include cover sheets, not including Protected Health Information (PHI) that incorporates a confidentiality statement for all fax transmissions. All emails containing PHI must be encrypted prior to sending. When making outbound telephone calls, care coordinator must verify 3 sources of identification to verify member authenticity, full name and 2 additional sources. Sources of information can include address, date of birth, PMI number, HealthPartners identification number, or telephone number. At the time of assessment, either face-to-face or telephonic, the Care Coordinator must obtain verbal authorization from the member, if applicable, to complete the assessment in the presence of other persons.
✓ **Authorization to Release Information**	The Care Coordinator will also obtain an authorization for release of information and/or authorization to disclose member information to any caregivers, family members or legal representatives who may need access or who we may need information from. The Care Coordinator will use an approved Release of Information form or the *HealthPartners Authorization to Disclose Protected Member and Health Information Form* and keep a copy in the member's file. The authorization is valid for one calendar year from the date it was signed and a new authorization will be obtained the following year upon reassessment. The Care Coordinator will discuss and share information only with authorized parties.
Working with Interpreters	
✓ **Interpreter Services**	Care Coordinators will use HealthPartners contracted interpreter services for home visits, the ATT Language Line for telephonic communications, and the TTY line for members who are deaf, hard of hearing. For contracted interpreter provider and ATT Language Line information see the SNBC Inspire Care Coordination web page on HealthPartners.com.
Out of Country Care	
✓ **Out of Country**	Care Coordinators will notify members that services outside the country are not covered by HealthPartners.
Enrollees with HIV/AIDS	
✓ **HIV/AIDS**	Members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act. Care Coordinators should be aware of the resource and assist members in accessing these services as applicable.
Tribal Community Members	

✓ **Tribal Assessments and Service Plans**	Care Coordinators will accept the results of home care assessments, reassessments and the resulting service plan developed by tribal assessors for Tribal Community Members as determined by the tribe. Referral to non-tribal providers for home care services resulting from the assessments must be made to providers within the HealthPartners network. This applies to home care services requested by Tribal Community Members residing on and off the reservation.
Members Turning 65 years of age	
✓ **Turning 65**	All SNBC enrollees who turn 65 must transition out of the SNBC program. To ensure these members who are turning 65 and need to transition to MSHO or MSC+ are making an informed decision and do not have gaps in care coordination, refer to the provider portal for instructions on the care coordinator's role in this transition and corresponding letter templates. Care Coordinators are notified, via a monthly report, of members assigned to them whom will be turning 65 in the next 90 days.
State Medical Review Team (SMRT)	
✓ **SMRT**	Members who are certified as disabled by the SMRT team should be encouraged to apply for Social Security Benefits. Care Coordinators should provide members with resources and support during this process. Contact HPSNBC_CC@healthpartners.com for additional information on the process or specific members.
Behavioral Health	
✓ **Behavioral Health**	For members who are in need of or engaged in behavioral health services, Care Coordinators are responsible for making referrals to and maintaining ongoing coordination and communication with the behavioral health provider(s). This is aligned with the basic Care Coordination function to coordinate care with any and all providers the member is involved with.
✓ **Behavioral Health Homes**	For members who are specifically engaged in Behavioral Health Homes (BHH) services, Care Coordinators are responsible for ongoing coordination and communication directly with the BHH team regarding assessments, care plans, and events such as ED visits, hospital admissions, post discharge plans, and transitions of care. For a detailed account of BHH services, see the link "DHS Behavioral Health Homes Website" on the Provider Portal.
✓ **Behavioral Health Resources**	Behavioral health resources can be found under "Behavioral Health" on the Provider Portal. HealthPartners Behavioral Health contact information can be found on the Key Contacts document on the Provider Portal.
✓ **Mental Health Crisis Resources**	Refer to the link on the Provider Portal "NAMI Mental Health Crisis Planning" for information on how support members who are experiencing a mental health emergency.

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Member Assignment	
✓ **Member Assignment (Delegate)**	Your HealthPartners member assignment may be for a new or existing SNBC member. In most instances, HealthPartners will have already completed the HRA, although some new members will be assigned needing an HRA completed. Within 10 business days of assignment, the Care Coordinator will provide the member with his/her name and contact information. This may be done via a phone call or the SNBC CC Change letter, found on provider portal, and should documented in the case notes.
Health Risk Assessment (HRA) The Health Risk Assessment includes questions designed to identify health risks and chronic clinical conditions including but not limited to: Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADLs), risk of hospitalization, need for primary or preventative care, need for dental care, mental health needs, rehabilitative services, and protocols for follow-up to assure that physician visits, additional assessments or care coordination interventions are provided when indicated.	
✓ **Health Risk Assessment Tool**	The Care Coordinator will complete a comprehensive health risk assessment using the DHS-3428H or other HRA tool approved by HealthPartners.
✓ **Timing**	The Care Coordinator will complete an initial HRA within 60 calendar days of enrollment, an annual HRA within 364 days of the previous assessment, and a change of condition HRA when a member experiences a significant change of health condition that is expected to alter the course of the member's services and care plan. Care Coordinators may use professional judgment to determine when a change of condition warrants completing another HRA.
✓ **Best Practices for HRA**	HealthPartners preferred method of assessment is face to face in the member's residence, and the Care Coordinator should emphasize the importance of meeting in person for purposes of HRA completion. If the member declines a face-to-face visit, the Care Coordinator completes the HRA by telephone or mails the member the HRA to complete and return. The Care Coordinator will use a person-centered approach when communicating with members, completing HRAs and developing care plans.

✓ **Leave Behind Information**	As part of or in addition to the HRA process, the Care Coordinator will provide information to the member or their responsible party including but not limited to: • Contact information for primary care clinic/provider • Contact information for Care Coordinator • Contact information for HealthPartners health plan member services and other key departments and/or services • Document the above information using HealthPartners Inspire My Important Contacts form, found on the provider portal. • Care Coordinators will use health actions/reminders at specified time frames in order to follow up on the member's health and well being • Preventive Care reminders, referrals, health education, care plan review o Immunizations o Preventive clinic visit
Unable to Complete HRA & Continued Outreach	
✓ **Declined HRA**	If a member declines an HRA or care coordination services, the Care Coordinator will document the decline in the member's case notes and on the HRA log to be returned to HealthPartners the following month.
✓ **Unable to Reach for HRA**	Three outreach attempts on three different dates and at differing times of day must be documented within 60 calendar days of enrollment and 364 days from the previously completed or attempted HRA. If outreach attempts are unsuccessful, the Care Coordinator will send the member the following: • SNBC Unable to Contact Letter with HRA attached • SNBC Language block • Self-addressed stamped business reply envelope • Care Coordinator's business card or contact listed in the letter Document unable to reach outcome in the member's case notes and on the HRA log to be returned to HealthPartners the following month.
Long Term Care Members Transitions between Community and Nursing Home Settings	
✓ **Community to NH Care Coordinator responsibilities**	HealthPartners internal Care System can provide care coordination services to institutionalized members. However, if a community member managed by a delegate is admitted to a nursing home (NH), the Care Coordinator has specific responsibilities. This includes overseeing care coordination responsibilities for the first 100 days of admission. This may include but is not limited to: • Completing PAS process as outlined below

	• Notifying SNF of your role and contact information • Completing an annual reassessment/care plan if due date falls within the first 100 days of SNF admission (keeps member on their 364 day assessment cycle) • Attending care conferences as needed including obtaining feedback regarding member's desire to return to the community • Assisting with discharge back to community • Communicating with member's primary care physician, care team and responsible party(s) as needed • Notifying HealthPartners SNBC internal Care Coordinators when member is approaching their 100th day of SNF admission @ Jennifer.m.foster@HealthPartners.com. Member will be reassigned internally at HealthPartners effective the 1st of the following month. • If the Care Coordinator is certain the member will be long term care they may transfer back to HealthPartners prior to the 100th day o Exception for when members are admitted to long term care for hospice care. The Care Coordinator should follow for the first 100 days.
✓ **PAS Process**	For a detailed description of Care Coordinator responsibilities related to the preadmission screening (PAS) process, see the Inspire SNBC Care Coordination website- PAS Process document located on the portal.
✓ **Nursing Facility Liability Days**	FYI only: Nursing home staff contact HealthPartners Utilization Management Department (UM) for notification and authorization of 100 day NF benefit by calling 952-883-6942, and toll free at 888-820-4168. HealthPartners UM authorizes NF skilled days and tracks NF liability days.
✓ **NH to Community Care Coordinator responsibilities**	HealthPartners is committed to a person centered care model which includes assisting our SNBC members to live in the least restrictive environment of their choice. Care Coordinators will provide assistance as needed for any nursing home resident who is planning to return to a community setting.

✓ **Relocation Assistance**	HealthPartners internal Care Coordinators will monitor nursing home (NH) residents for their interest in returning to a community setting and will work with the member, NH staff and waiver case manager, if applicable, to help facilitate this process. • Relocation assistance coordination will be provided for members returning to the community from LTC settings o Complete HRA o Complete DHS My Move Plan DHS-3936 o Refer to county for waiver services o Coordinate relocation assistance with the goal of meeting the member's needs safely in a community setting o Use all available resources to assist in meeting the members needs including informal supports and services o Develop comprehensive, member focused care plan
✓ **Hospital to NH**	Communicate and collaborate with the Senior Linkage Line and other social service staff to ensure that the Pre Admission Screening (PAS) process is completed for members entering a nursing facility. • Refer to PAS Process and Checklist documents for details.

MMIS Entry of the HRA

Timeliness of when the assessment data is gathered and when it gets entered into Medicaid Management Information System (MMIS) is important. Per DHS MMIS entry manual for SNBC: *"Because this document plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC screening document information into MMIS. It is strongly recommended that no more than fourteen (14) calendar days lapse between completion of any HRA or case management activity and the submission of the data into MMIS."*

✓ **Care Coordinator responsibility**	Per contract with DHS, MMIS entry is required for all SNBC members. For new employees needing MMIS access, email completed MMIS forms found on the provider portal to HPSNBC_CC@healthpartners.com. All SNBC HRAs are entered into the MMIS 'H' screen. Note: for Initial Unable to Reach HRA's, the MMIS entry does not need to be completed until after the first 60 calendar days of enrollment. The MMIS health plan code for HealthPartners is **HPH.** The 3 scenarios when entry is required per HealthPartners' contract with DHS: ➢ Member has refused an assessment, or is unable to contact. Program type: #28, Assessment result #39 for decline of HRA or #50 for person not located, and activity type #07. ➢ Member has agreed to an assessment. MMIS entry of the screening document information is required. Program type: #28, Assessment result #35, Activity type #1 or #2. ➢ Member has entered the Nursing Home (NH) and placement is expected to be long term. MMIS entry of required fields is needed because state and federal requirements prohibit medical assistance payments for Nursing Facility (NF) services provided prior to completion of required preadmission screening. Please refer to the PAS Process and PAS Checklist located on the SNBC Inspire webpage for MMIS entry details which vary depending on if open to the waiver. Activity type would be 01 Telephone Screen. Communication of the NF admission should be made to the financial worker using the Case Manager/Financial Worker Communication Form (DHS 5181).

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Restricted Recipient Program	
✓ **Restricted Recipient Program (RRP) Description**	Restricted Recipient Program (RRP) program goals: • Improve patient safety, coordination of care, and improved member management of chronic pain issues RRP program services**:** • The member's provider network is restricted to <u>one</u> pharmacy, hospital, PCP/clinic, and Urgent Care. The member receives case management services to ensure continuity of care
✓ **RRP Case Manager**	Each member enrolled in the Restricted Recipient Program (RRP) is assigned a Case Manager who is a nurse or behavioral health specialist at HealthPartners. The member is given the HealthPartners' Case Manager's first name and phone number. The Care Coordinator should redirect members with questions about RRP or their provider restrictions to their RRP Case Manager at HealthPartners. SNBC members in our restricted recipient program are flagged on Monthly Census and Census Change reports. Care Coordinators are expected to collaborate with RRP Case Managers and consider them part of the interdisciplinary care team. **** At no time are <u>Care Coordinators to share the last name of a HealthPartners RRP case manager with RRP members</u> ****
✓ **Restricted Provider Info**	If a Care Coordinator would like to refer a member for consideration of RRP program enrollment, they may complete a HealthPartners Programs Referral Form located on the provider portal. If a Care Coordinator would like to locate a member's HealthPartners RRP Case Manager, they can call 952-883-6983, or toll free at 800-255-1886 and request this information. Provider restrictions are in MN-ITS for members in the RRP program. Care Coordinators must check MN-ITS for SNBC members and be aware of the member's provider restrictions.
Member Transfers	
✓ **Transfer Requirements**	Please note that a change in a member's residence, whether it be a move to a county outside of HealthPartners SNBC service area or outstate, does not automatically equate to a discontinuation of HealthPartners SNBC coverage for the member. The member's address must be changed at the county level and the member's termination must come through on monthly enrollment information received from DHS before coverage is terminated. It is the expectation that delegated agencies follow members until otherwise noted on their census report. Additionally, Care Coordinators may be required to transition members to another HealthPartners delegate for care coordination when a member or delegate experiences a change resulting in them needing to terminate provision of care coordination services. There are two types of transfers that Care Coordinators are responsible for.

1) Transfers within HealthPartners - coverage continues:
   - A move between nursing home and community status,
   - A change in member's county of residence, county is within HP's SNBC service area
   - A delegate or member requests reassignment
   - For members open to the waiver, are unable to be reached or decline HRA, transfer to Care Navigation

   a. The transferring Care Coordinator completes all sections of the HCBS Waiver, AC and ECS Case Management Transfer and Communication Form DHS-6037 and sends it to HPSNBC_CC@healthpartners.com prior to transition effective date.
   b. The Care Coordinator must also attach the following documents when available:
      i. Most recent HRA or LTCC/MnChoices (including medication list if separate)
      ii. Most recent HealthPartners Inspire (SNBC) Care Plan with signature page
      iii. OBRA Level I when applicable
   c. When the transfer is due to the member moving out of the delegated entities county, the Care Coordinator will send the DHS-5181 communication form to the county to inform them of the member's new address and date of move. The Care Coordinator will keep record of this in member's file and inform the member to update their address with the county and HealthPartners Member Services. The existing assigned delegate needs to continue to provide care coordination until a transfer effective date is communicated and reached.
   d. If transfer is due to member being open to the waiver or declining to complete an HRA but is actively engaged in care coordination and you feel it is in the best interest of the member to stay with current CC, complete a Care Coordination Exception form and submit to HPSNBC_CC@heathpartners.com.

2) Transfers outside of HealthPartners - coverage terminates:
   Care Coordinators are required to transition members to another health plan or local agency upon notification of termination of the member's HealthPartners coverage.
   - A change in health plan or fee for service Medicaid (HealthPartners' coverage termination)
   - A change in member's county of residence, county is outside of HP's SNBC service area

   a. The Care Coordinator completes all sections of the HCBS Waiver, AC and ECS Case Management Transfer and Communication Form (DHS-6037) and sends it to HPSNBC_CC@healthpartners.com or uploads onto the EDI provider portal within 10 days of notification.
      The Care Coordinator must also attach the following documents when available:
      i. Most recent HRA or LTCC/MnChoices (including medication list)
      ii. Most recent HealthPartners Inspire (SNBC) Care Plan with signature page
      iii. OBRA Level I when applicable

	b. In addition to the above documents, when the transfer is due to the member moving out of HealthPartners service area, the Care Coordinator will send the DHS-5181 communication form to the county to inform them of the member's new address and date of move. *The Care Coordinator will continue to provide needed care coordination until a Census Change report indicates member has terminated with HealthPartners.
Referrals: County Based Services	
✓ **Referrals under the Care Coordinator's Responsibility**	Referrals and/or coordination with county social service staff will be required when the member is in need of the following services: • Pre-petition screening • Preadmission screening for HCBS • County Case Management for HCBS • Child protection • Court ordered treatment • Case Management and service providers for people with developmental disabilities • Relocation service coordination • Adult protection • Assessment of medical barriers to employment • State medical review team or social security disability determination • Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases.
✓ **CC requirements for referrals to county or tribe for waiver services**	When referring a member to a County or tribe for evaluation for Home and Community Based Services (HCBS), PCA or PDN services, provide a copy of the HRA along with a completed HealthPartners Referral for Waiver, PCA, PDN form to the County. The Referral for Waiver, PCA, PDN form includes a summary of the member's strengths, needs, and services HealthPartners has authorized to meet the member's identified needs. It also outlines the member's need for services requested and alternatives explored to meet those needs. This form can be form found on the provider portal. • Contact the county, describe the member's needs and strengths. Provide a copy of the most recent HRA upon request • County Case Manager makes final decision

✓ **Home Care Referrals (Delegate)**

Home Care

- When home care is needed for skilled services such as wound care or ostomy management providers need to request prior authorization for services from HealthPartners Quality & Utilization Improvement (QUI) department ONLY when the number of visits exceed the limits in the chart below.
- When home care is needed for long-term custodial services such as for medication management, the Care Coordinator requests the service by submitting the Home Care Authorization Inquiry form ONLY when visits exceed the number of visits below per calendar year:
-

Service	**Codes**	**Visit limit per calendar year before auth is needed**
Skilled Nursing Visit- RN or LPN	T1030 , T1031	60
Home Health Aide	T1021	160

- Home health services must not duplicate other services the member is receiving such as Personal Care Assistant (PCA) services, or homemaker services that include personal care assistance.
- Care Coordinators must always collaborate with the member's waiver case manager, if applicable, to ensure services provided are complimentary rather than duplicative and that the member's service plan budget can accommodate Medicaid covered home-care services. Communicate home care services authorized to waiver case managers via the DHS-5841 form for "Managed Care Organization/Lead Agency Communication Form- Recommendation for State Plan Home Care Services." See HealthPartners coverage criteria on the provider portal for additional information.

*Effective 1/1/2020, DHS is requiring that authorization for skilled nursing visits (SNV) must indicate if a registered nurse (RN) or a licensed practical nurse (LPN) will perform the visit. While this change will not impact the current process for SNBC, there may be updates to DHS forms requiring you to indicate RN /LPN.
For more information, refer to: DHS MN Changes in authorization of skilled nursing visits

Communications: County Based Services	
✓ **Coordinating services for members on a waiver**	Communication between an SNBC Care Coordinator and a member's waiver worker or Targeted Case Manager (TCM) is <u>essential</u> for continuity of care and best practices. The Care Coordinator should make every attempt possible to contact the member's waiver worker within initial month of enrollment to collaborate and communicate the member's care plan. When possible and appropriate, joint visits may be an option if it is in the best interest of the member.
✓ **Communications about Medical Assistance Home Care services**	Per DHS contract, Care Coordinators must communicate with a member's waiver worker if they want to implement any state plan services for the member. • The Care Coordinator will communicate with lead agencies (counties/tribes) the authorization of Medical Assistance home care services using the DHS-5841 form for Managed Care Organization/Lead Agency Communication Form-Recommendation for State Plan Home Care Services. • If needed, the Care Coordinator will also be responsible for sending a copy or summary of the member's SNBC care plan that includes the member's assessed needs and strengths. • The waiver worker must account and budget for these services in their service agreement.
✓ **Communications about Medical Assistance Eligibility**	Care Coordinators will be aware of upcoming Medicaid recertification dates and assist members to retain/regain Medical Assistance eligibility as needed, including contacting/working with the member's County Financial Worker as needed to ensure uninterrupted eligibility. The Census Change Report provided to each delegate monthly indicates the date a member's Medical Assistance eligibility terminated. The Care Coordinator will assist the member to reinstate eligibility prior to the date HealthPartners coverage ends. Reinstatement Reports will be generated daily to inform Care Coordinators when a member assigned to them within the last 90 days is reinstated and reassigned back to them as of the first of that month. If no daily report appears in the delegate portal, this means there is nothing on the report for that day. If the member experienced a break in coverage, they will not be automatically reassigned back to the previous care coordinator as they will identified as a New Enrollee and follow HP's internal process for New Enrollees. ***It is the responsibility of the Care Coordinator/Delegate to determine if an HRA or Care Plan was due during the period of ineligibility and activity must be completed within 30 calendar days of reinstatement date.*** ***If the MMIS entry was unable to be entered during the term month, the care coordinator is responsible for going back and ensuring the entry is complete. Delegates are expected to document in the member's file, the dates coverage was lost and regained for audit purposes.***

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Collaborative Care Planning	
✓ **Care Coordinator Responsibility**	The Care Coordinator will use HealthPartners Inspire (SNBC) Care Plan document unless an alternative care plan has been approved. Based on HRA results, care plans are developed and implemented in conjunction with the member and/or their responsible party, member's primary care physician or care team and when applicable, the waiver case manager and other members of the interdisciplinary care team.
✓ **Timing**	The Care Coordinator will complete the care plan within 30 calendar days of the HRA date, including mailing a copy to the member, the member's primary or specialty physician(s), and the member's waiver case manager. A copy of the care plan will be retained in the member's care coordination chart. *The final Care Plan completion date is defined by the date the copy of the Care Plan is mailed to the member, NOT the day the care plan was created.*
✓ **Care Plan Components**	The completed care plan will: • Include supports and interventions that addresses any safety or self-preservation risks identified, whether environmental or medical. • Incorporate unique member needs including primary care, acute care, long-term care, mental health, rehabilitative, dental, and social service needs. • Include covered Medicaid and Medicare home care services and services available through community resources • Indicate if the member is receiving home and community-based services (HCBS) or is in need of a referral to their county of residence for assessment for waiver services. • When applicable, include Personal Risk Management Plans including acknowledgment of risk for persons refusing recommended services to reduce personal risk and documentation of member's acceptance of the risk. • Identify follow up plan for goal review, reminders, care plan evaluation • Create new and/or update existing SMART goals and interventions to address conditions identified in the HRA and other unmet needs. • Include necessary signatures
✓ **Follow Up**	The Care Coordinator will indicate plans for follow-ups to review progression towards goals as well as assure primary and preventive care including dental, mental health needs, additional assessments or other care management interventions are provided as planned. HealthPartners expects Care Coordinators to use their professional judgement to determine when more frequent contacts are necessary and as indicated on the member's plan of care. Follow-up plan must include target dates for follow up outreach to be completed. Care Coordinators must complete follow up according to dates and timeframes noted in the care plan.

✓ **Informed Choice**	The Care Coordinator will also assist the member and/or their responsible party to maximize informed choice of services and control over services and supports.
✓ **Technology**	The Care Coordinator will make recommendations, if appropriate, of how technology or equipment might increase independence or reduce reliance on human assistance (including assistive devices, augmentative communication devices, home modifications and other devices).
✓ **Durable Medical Equipment**	HealthPartners is contracted with HomeLink for durable medical equipment. See Key Contacts Guide on the provider portal for more information.
✓ **Home Care Referral Parameters**	Referrals for **covered home health services** go directly to the provider agency. Home care providers are responsible for obtaining the appropriate service authorization above and beyond visits limits per grid on page 13. For members with Medicare part A, the home-care provider must meet Medicare requirements and bills Medicare directly. When a need **for non-covered home health services** is identified, submit a Benefit Exception Inquiry form, located on the provider portal, per the benefit exception process.
✓ **Benefit Exception**	HealthPartners will consider making exceptions to standard benefits. Please see the Benefit Exception Instructions and Inquiry form on the provider portal.
Dental	
✓ **Dental**	Reports sent to delegates on a monthly basis for members who have 12 months of continuous enrollment include the following: • Date of latest dental exam • If *Latest Dental Exam* column is blank, there has not been a dental claim in over 1 year Review current report prior to outreach for annual HRA • If able to complete HRA/Care Plan with member either F2F or telephonically, discuss importance of annual dental exams o Assist with facilitating dental appointment as needed • If member declines annual HRA and unable to discuss preventative dental care with member: Mail Dental Outreach letter and Oral Care Tip Sheet • Annual Outreach/Unable to Contact: Mail Unable to Contact letter with health survey attached , Dental Outreach Letter and Oral Care Tip Sheet • Next Outreach/Unable to Contact: Mail Dental Outreach Letter and Oral Care Tip Sheet • Complete SNBC Access CC Tool and/or document dental outreach attempts and actions in member case notes.

	See additional dental resources on the provider portal.
HRA and Care Plan Log	
✓ **Delegate Reporting Requirement**	Refer to the HRA and Care Plan Log on the provider portal for further details. See 'Read Me' tab for instructions.
Identification of Clinically Complex Members	
✓ **Registry Reports**	HealthPartners has their own predictive algorithms based on claims data. Since many SNBC members have Medicare, we are not able to identify a portion of our population as being high risk. The following are sources of identification: • Disease management registry reports identify members as high or low risk with asthma, COPD, CHF, diabetes, or CAD • Utilization reports: ER and Inpatient Notification • HRA results • Presence of dual diagnosis (both mental and chemical dependency) • Presence of bipolar disorder or schizophrenia • Presence of severe depression with psychiatric hospitalization
Working with Clinically Complex Members	
✓ **Clinically Complex**	If a Care Coordinator needs additional support managing the complex condition(s) of their members, the Care Coordinator may do one or more of the following: • Refer the member to HealthPartners SNBC team for Intensive Case Management or consultation • Refer to Disease and Case Management programs by completing the HP Programs Referral form on the provider portal • Request member be reviewed at Complex Case Rounds for consultation led by HP's Medical Director • Care Coordinator should refer to the Key Contacts Guide located on the provider portal for referral details Registry reports gives the Care Coordinator an awareness of who has a diagnosis of core conditions identified as low and high risk • CHF, Diabetes, CAD, COPD, Asthma • Review report prior to completing an HRA/Care Plan or follow up call

	• For those members who are high risk, ask how they are managing their chronic disease or if they feel they need more help/education • Using our clinical care guides found on the provider portal as a reference, talk with members regarding how they are managing their chronic condition(s) and determine if the condition seems well managed or not • Use the guides to help you provide support or education & to create a goal in the members care plan • If it is evident member is not managing their chronic condition(s) well, verify that they are seeing a primary care physician, if not, and facilitate a clinic visit • If they are connected with a primary care physician, and not managing their condition well, and the care coordinator would like additional support, contact our internal team at HPSNBC_CC@healthpartners.com for next steps
✓ **ER Reports**	Claims report of all ER visits for the past 12 months are provided monthly • Review prior to completing an HRA/Care Plan or scheduled follow up with your member • Discuss with member events leading up to ER visit, determine if there are barriers in place or if alternative services would have been more appropriate: o Dental reasons- facilitate dental clinic visit o Provide listing of close Urgent Care Clinics o Facilitate Primary Care Visit
✓ **Complex Case Rounds**	HealthPartners facilitates bi-monthly medical clinical rounds for members identified as complex, usually noted by high utilization patterns and are not clinically well-managed. The goal is to assist the care coordinator in problem solving barriers and identifying interventions. Additionally, HealthPartners facilitates bi-monthly Behavioral Health rounds for members identified as complex, usually noted by high utilization patterns and are not clinically well-managed. The goal is to assist the care coordinator in problem solving barriers and identifying interventions. • Attendees may include: HealthPartners Medical Director/Doctor, Care Coordinators, Behavioral Health Specialists, and SNBC leadership. To request participation, email Jennifer.m.foster@HealthPartners.com • CCs will be notified of members HP selects for complex rounds ideally two weeks prior to the date of rounds. CCs are also encouraged to identify complex cases for case rounds. Upon notification, CCs are expected to complete the Complex Case Review Form and submit to Jennifer.m.foster@HealthPartners.com at least one week prior to scheduled discussion to allow adequate time for attendees to review case details.
✓ **Fast Track Interventions**	Interventions to manage several common conditions are available to Care Coordinators on the provider portal.

HEALTHPARTNERS INSPIRE SNBC CARE COORDINATION WORK FLOW & REFERENCE GUIDE

Care Transitions	
✓ **Care Transition Activity**	The Care Coordinator will help to facilitate safe care transitions for members experiencing a transition from one care setting to another with an emphasis on supporting safe discharges to help members prevent avoidable readmissions and poor health outcomes.
✓ **Inpatient Case Managers: Behavioral Health & Medical**	Admission notification reports are distributed daily. If no report is generated, it's due to no identified inpatient members. HealthPartners Inpatient Case Managers (IPCM) follow members' progression of care during hospitalization. • IPCMs will send discharges summaries to the Intake Fax number you provided to us • Our inpatient team may identify members that are appropriate to receive complex case or disease management. When this occurs, you will be contacted by our internal SNBC team to discuss the members care. • Behavioral Health Case Managers will contact Care Coordinators about post-discharge support for behavioral health admissions. Upon notification of the member being admitted to the hospital or other health care facility including Transitional Care Unit (TCU) or Nursing Home (NH), the Care Coordinator will document care transition support and interventions in case notes. HealthPartners does not require use of a care transition documentation log. Delegates will be required to produce care transition documentation at time of annual DHS SNBC audit.
✓ **Care Coordinator Responsibility**	Care Transition activities are to be completed by the Care Coordinator in the following situations and episodes of care: <u>At time of admission</u> • Outreach to member/Responsible Party(RP) at time of admission o Let them know you will be their support person • Contact primary or specialty physician and notify him/her of admission • Communicate with discharge planner to ensure they are aware of the member's services and providers and assist with any discharge needs as applicable. <u>At time of discharge back to regular setting</u> • Outreach to member/RP • Identify barriers & close gaps in the discharge plan. See Care Coordination best practice interventions below. • Inform primary or specialty care physician of discharge and communicate any identified barriers • Discuss follow up appointment(s) and potential barriers (i.e. transportation) It is important to note that all members, regardless of the type of transition, receive support/discharge planning from their Care Coordinator.

✓ **Best Practice interventions**	Care Coordination best practices interventions: the following situations should be addressed and documented in the Care Coordinator's notes when managing care transitions: • Member is at high risk for readmission and/or health complications once discharged back to their regular setting that may be due to: o Health literacy issues o Medication non-adherence o Poor understanding of worsening signs and symptoms of their post discharge condition o Comorbidities o Cognitive impairment impeding post discharge success o Member is lacking adequate formal/informal supports and services o Barriers are present such as transportation, non-adherence, access to follow up care, etc. o Inadequate housing
Audits	
	At a minimum, HealthPartners will conduct annual care plan audits and report results to DHS. See Audit Protocol and Audit Protocol Checklist on the provider portal for more information. Delegates identified as a High Performer in a previous audit may be eligible to skip one audit cycle. This status will be determined and communicated by HealthPartners' Compliance Specialist.