BlueCross BlueShield of Illinois

Model of Care / Medical Home (Person Centered Practice)

Blue Cross Community Health Plans SM (BCCHP)
Blue Cross Community MMAI (Medicare-Medicaid Plan)SM

Navigation Tips

- This presentation includes a voiceover
- To turn off sound, select the mute button 
- Click on the question mark button  in the lower right corner
  - To email a question
  - To view slide notes (read rather than listen to the presentation)

Training Modules for Blue Cross Community Health Plans (BCCHP) and Blue Cross Community MMIA

1. **Model of Care / Medical Home (Person Centered Practice) Overview**
2. Fraud, Waste and Abuse
3. Abuse, Neglect, Exploitation / Critical Incidents
4. Cultural Competency
5. Americans with Disabilities Act (ADA) / Independent Living
6. Medicare Parts C and D General Compliance Training (Mandated training for Medicare contracted providers, including MMAI contracted Providers)

What You Will Learn

1. Overview Blue Cross Community Health Plans and Blue Cross Community MMAI
2. Model of Care / Medical Home (Person Centered Practice)
3. Care Coordination and Interdisciplinary Care Team (ICT)
4. Health Risk Assessment (HRA)
5. Care Plan Development
6. Wellness Program
7. Annual Wellness Visit
8. ICT/Provider Communication Pathways
9. Behavioral Health Recovery and Mental Health Crisis

BCBSIL Medicare (MMAI) / Medicaid Programs

The Blue Cross and Blue Shield of Illinois products are known as:

- Blue Cross Community Health Plans[SM]
- Blue Cross Community MMAI (Medicare-Medicaid Plan)[SM]

MMAI Overview

Three-year demonstration plan testing an innovative payment and service delivery model. This unified delivery system:

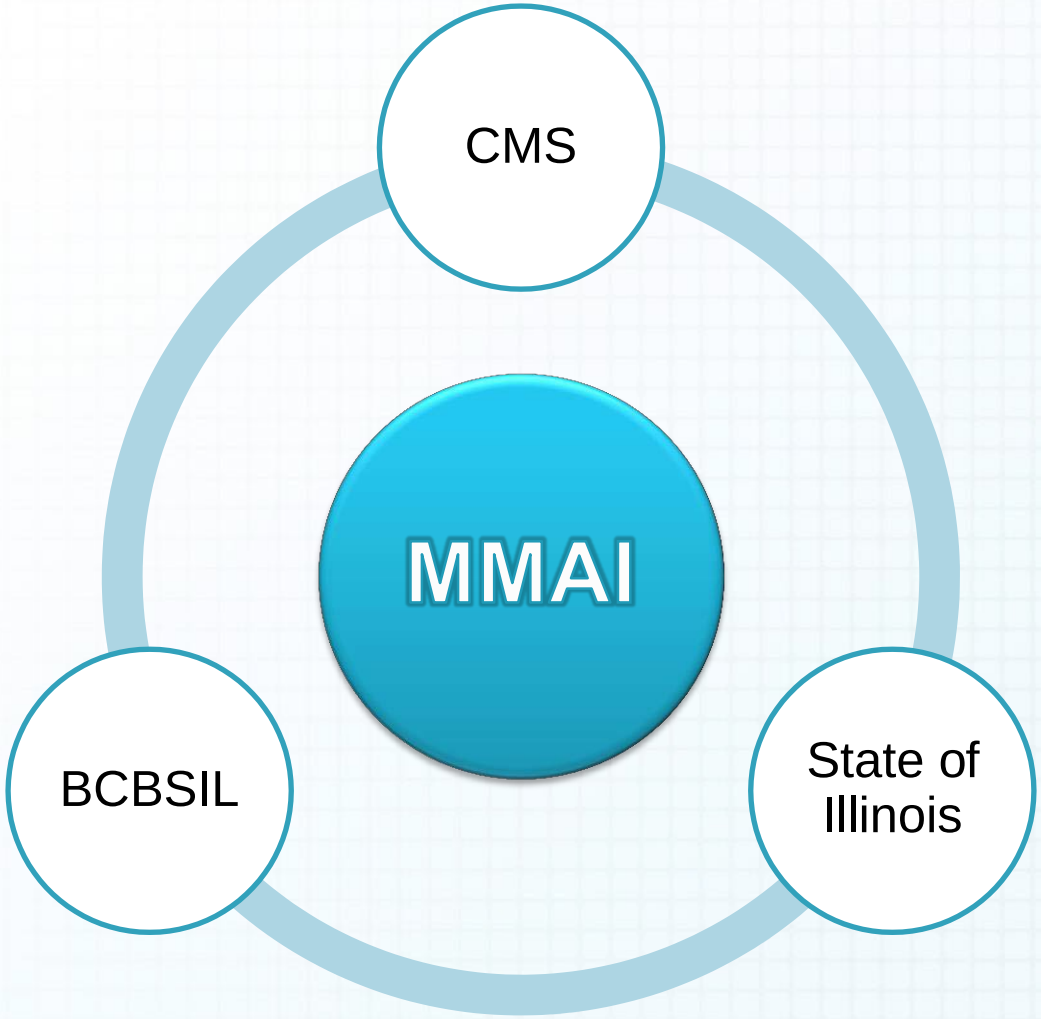
- Enables easier navigation of health services
- Alleviates fragmentation and improves coordination of services for dual members
- Focuses on person-centered care coordination and preventive care
- Enhances the quality of care
- Reduces costs to the federal and state governments
- Provides community support for member ongoing needs

MMAI Overview

MMAI applies to persons who are:

- Age 21 or older
- Entitled to Medicare Part A
- Enrolled in Medicare Part B and Part D
- Enrolled in Medicaid Aid to the Aged Blind and Disabled (AABD)

MMAI Overview



MMAI Overview

- MLTSS refers to the delivery of long term supports and services through Managed Care Organizations. It was designed to expand home and community-based services, provide better care coordination and ensure quality and efficiency.
- MLTSS is a mandatory program for dual eligible members who have elected to opt out of the MMAI program and are receiving long term supports and services in the community or at a facility.

MMAI Overview

The principles behind MLTSS:

- Help improve cost management of LTSS services
- Help transition members successfully from institutions into the community
- Help maintain members in the community with added supports to avert nursing home stays
- It is a State requirement for dual eligible members requiring LTSS services not enrolled in MMAI to enroll with a MCO offering a MLTSS product in order to continue receiving LTSS services.

MLTSS Covered Services*

MLTSS Covered Services:

- **Adult Day Care**
- **Behavioral Health Services**
- **Electronic Home Response / EHR**
- **Home Health: RN, LPN, CNA, PT, OT, ST**
- **Home Delivered Meals**
- **Home Modification**
- **Homemaker Services**
- **Respite Care**
- **Substance Abuse Services**
- **Supportive Living Facilities**

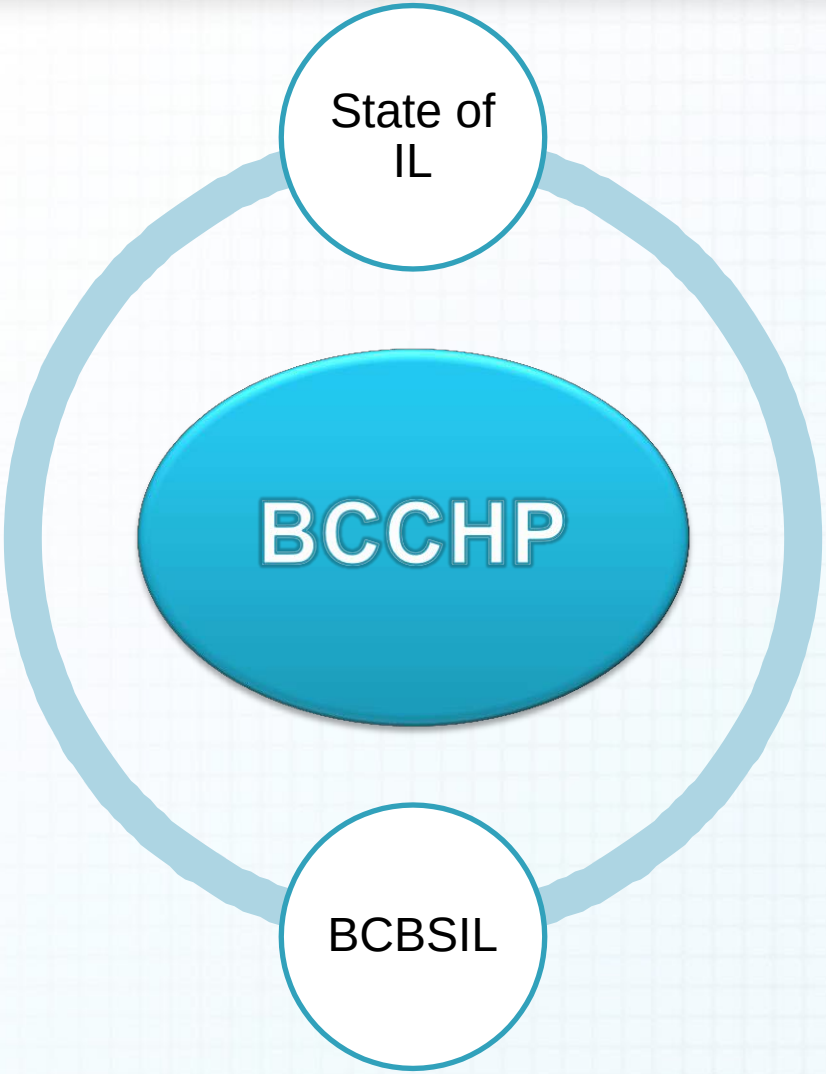
Long Term Care:

- **Developmental Training (Level I-III)**
- **Intermediate Care –** Recipients age 22-64 in institutions for Mental Disease (IMD), not members diagnosed with Mental Illness or Mental Retardation
- **Exceptional Care –** Available for brain injury waiver members only on a ventilator, optional to bill for services when Medicare stops billing
- **Custodial Residential Services**

Non-Emergency Transportation:
Private, Service Cars, Medicare, Taxicab, Non-Emergency Ambulance, Other

*Subject to the terms of the MLTSS Program

Blue Cross Community Health Plans (BCCHP) Overview

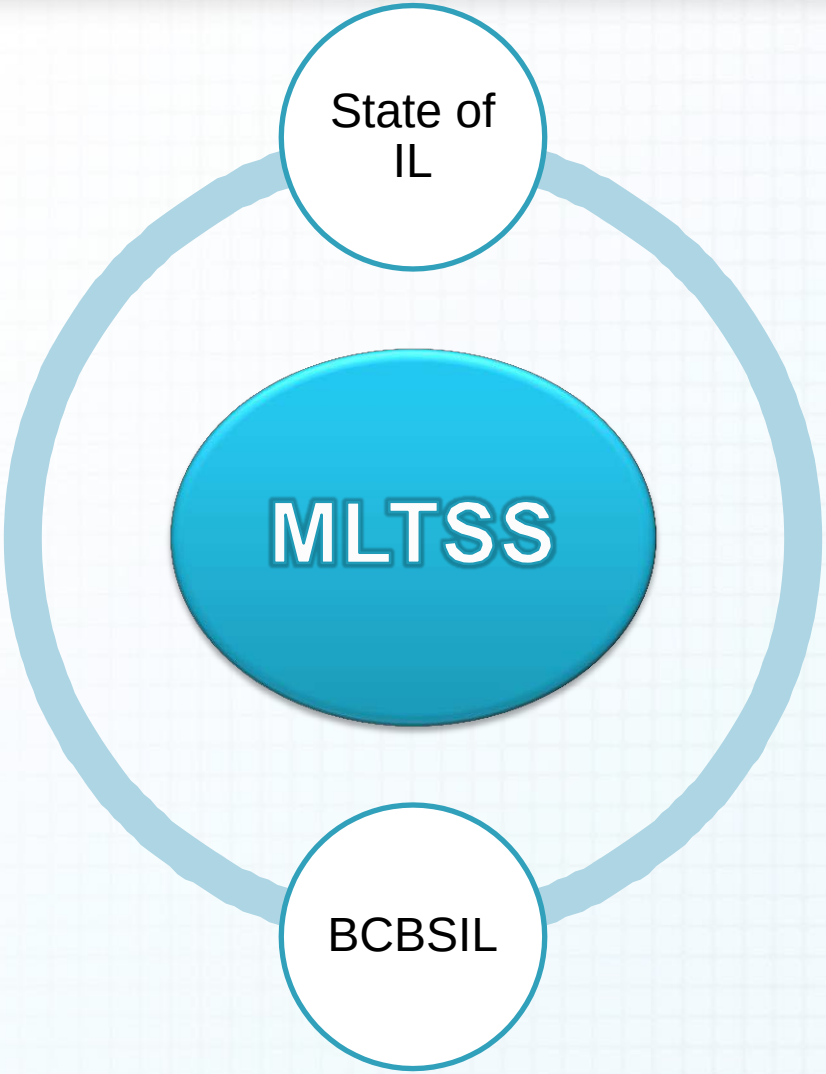


Blue Cross Community Health Plans (BCCHP) Overview

BCCHP offers comprehensive care to:

- Seniors and adults (19+ years of age and older) who are enrolled in Medicaid, includes Medicaid Waiver Members
- Children under the age of 19
- Parents/guardians living with, and caring for children age 19 or younger
- Pregnant women, mothers and their babies
- The Affordable Care Act (ACA) Expansion Population, ages 19-64 who meet the monetary (monthly income less than 138% of the federal poverty level) and non-monetary state guidelines.
- Adults (21+ years of age) who qualify for both Medicaid and Medicare and opted out of MMAI

MLTSS Overview



Blue Cross Community Health Plans (BCCHP) Additional Coverage Eligibility

Additional eligible members who meet all other criteria and are in the following Medicaid Waivers (SP2):

- Elderly
- Disabilities
- HIV/AIDS
- Brain Injury
- Supportive Living Services

Blue Cross Community MMAI Service Areas

BCBSIL MMAI Services Locations are in six Illinois Counties:

Cook

DuPage

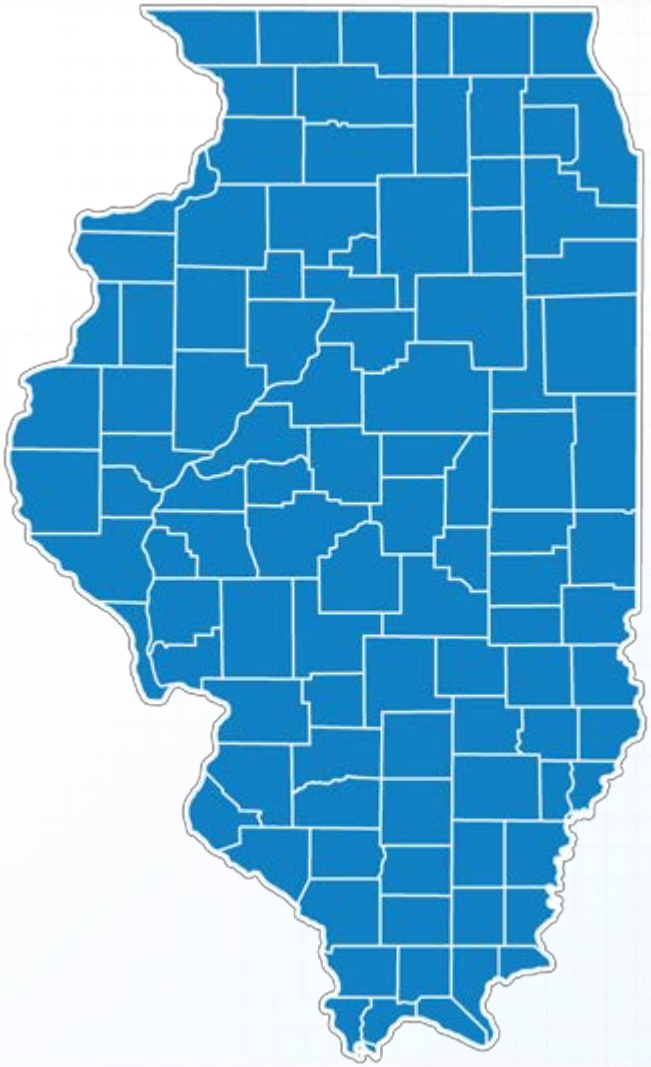
Lake

Kane

Will

Kankakee

Blue Cross Community Health Plans (BCCHP) Service Areas



Blue Cross Community Health Plans (BCCHP) is available in 102 Illinois Counties throughout the State of Illinois.

Blue Cross Community Health Plans (BCCHP) and Blue Cross Community MMAI - Enrollment

- **Illinois Client Enrollment Services (ICES)**
  - Processes all enrollments and disenrollments
  - Ensures unbiased education and information about health plans
  - Assists members in the enrollment process

- **Voluntary enrollment period**

- **Passive enrollment for members who have not selected a plan**

Blue Cross Community Health Plans (BCCHP) Enrollment and Disenrollment

- Allowed to change plans within the initial 90-day enrollment period
- Must remain enrolled in their plan for one year after the enrollment period; cannot switch plans
- Allowed to change plans during the annual 60-day enrollment period

Blue Cross Community MMAI Enrollment and Disenrollment

- Change plans within the initial 90-day enrollment period
- Switch plans/opt-out anytime on a monthly basis
- Plans received before the 12th of the month are effective on the first calendar day of the following month
- Plans received after the 12th of the month are effective on the first calendar day of the second month
- For LTSS Medicaid Waivers, members may opt-out of Medicare side of MMAI, but must remain enrolled in the same plan for Medicaid services for one year.

Managed Long Term Services and Supports (MLTSS) - Enrollment and Disenrollment

- Allowed to change plans within the initial 90-day enrollment period, but locked in after 90 days.
- Allowed to disenroll from MLTSS and enroll in MMAI at any time during the year.
- Dual eligible members requiring LTSS services and not enrolled in MMAI must enroll with an MCO offering an MLTSS product to continue receiving LTSS services or elect traditional Medicare and Medicaid.

Model of Care
Program Foundation and Philosophy

The underlying philosophy of the program focuses on the wellbeing of the member. The program is:

Person Centered and considers individual:

- Preferences
- Cultural needs
- Linguistic needs
- Potential to self-direct care

Holistic and considers:

- Cognitive needs
- Psychosocial, behavioral and functional needs
- Physical needs

Model of Care
Program Foundation and Philosophy (Cont)

Coordinated, using Health System Navigation to promote:

- Communication
- Collaboration
- Alignment

Integrated, using Health Care Delivery to stay:

- Connected
- Unified
- Multidimensional

Model of Care
Program Foundation and Philosophy (Cont.)

Team Based, inclusive and multidisciplinary including:

- Members
- Family/ Authorized representatives
- Providers
- Caregivers
- Community resources

Enrollee rights are respected; enrollees have the right to:

- Privacy and be treated with respect and dignity
- Be offered treatment options/ alternatives and participate in health care decisions
- Refuse treatment and have access to medical records; may amend /correct
- Be free from restraint/seclusion
- Receive information in an easily understood format

Model of Care – Primary Care Medical Home (PCMH)

A Primary Care Medical Home Program is a health care setting that facilitates collaboration between patients/family and a health care team including physicians, nurses, counselors, social workers, behavioral providers and other health care professionals as needed.

Care is facilitated by patient registries, information technology, health information exchange or other means to track key activities to ensure patients receive coordinated care when and where they need it.

Evidence-based medicine and clinical decision-support tools guide decision-making.

Patients actively participate in decision-making, and feedback is sought to guarantee patients' expectations are being met.

Model of Care – Primary Care Medical Home (PCMH)

The BCBSIL BCCHP and MMAI PCMH model for PCP practices includes, but is not limited to, the following criteria:

- Primary care services
- Management of chronic health conditions and acute illness care
- Health education and wellness programs
- Outreach to members for preventive and immunization services
- Outreach to members to reschedule after missing appointments
- Active participation with the BCBSIL Interdisciplinary Care Team for collaboration in the Plan of Care for members
- Provide or arrange for behavioral health services

Model of Care – Primary Care Medical Home (PCMH)

BCBSIL BCCHP and MMAI support the Primary Care Medical Home by offering PCPs an opportunity to participate in the PCMH program.

BCBSIL will provide a self-assessment tool to PCPs without PCMH accreditation under NCQA or Joint Commission, and shall ensure all PCP practices self-assess the following areas:

- Organizational capacity
- Chronic health condition management
- Coordination and continuity of care processes
- Community outreach knowledge and connections
- Data management
- Quality improvement

Model of Care – Primary Care Medical Home (PCMH)

Primary Care Practices may obtain additional information on the BCBSIL Primary Care Medical Home Program by contacting:

Telephone: 855-653-8126

Email: govproviders@bcbsil.com

Model of Care Principles

Know your member

Accessible and flexible service

Coordinated care

Share power and responsibility

Principles of Model of Care

Know your member:

- Beyond their diagnoses
- Medical history and social supports
- Feelings about care
- Preferred name
- Discuss health factor and concerns

Provider accessible and flexible service

- Available for all ages, abilities and diverse backgrounds
- Convenient times and locations
- Clear and concise information

Principles of Model of Care

Members are assigned a Care Coordinator who works to:

- Provide Care Management
- Assure efficient care transitions
- Assist with referrals
- Implement and monitor a Care Plan for members
- Maximize member outcomes

Share power and responsibility:

- Care as an equal partnership
- Members have options
- Structure care around member's goals

Care Coordination / Interdisciplinary Care Team (ICT)

The ICT is integral to the successful achievement of Blue Cross Community Health Plans (BCCHP) and Blue Cross Community MMAI member's health goals.

Interdisciplinary Care Team (ICT)

Led by a Care Coordinator, the ICT:

- Coordinates all benefits and services
- Assesses medical, behavioral health, long-term services and supports and social needs
- Provides managed care to members based on risk levels
  - Low Risk
  - Moderate Risk
  - High Risk

Care Coordinator Qualifications

- Clinical background for higher level needs
  - Registered Nurse
  - Licensed Clinical Social Worker
  - Experience working with elderly, persons with disabilities
  - Experience with person-centered planning

- Non-clinical background for lower level needs
  - Counselors
  - Peer Support Counselor

Interdisciplinary Care Team Members

The Care Coordinator is responsible for leading the care team and the provisions of care management.

ICT members include:

- Physicians
- Behavioral health
- Social workers
- Counselors and clinicians
- Pharmacists
- Community health workers
- Community-based support
- Family
- Caregivers

Interdisciplinary Care Team and The Population

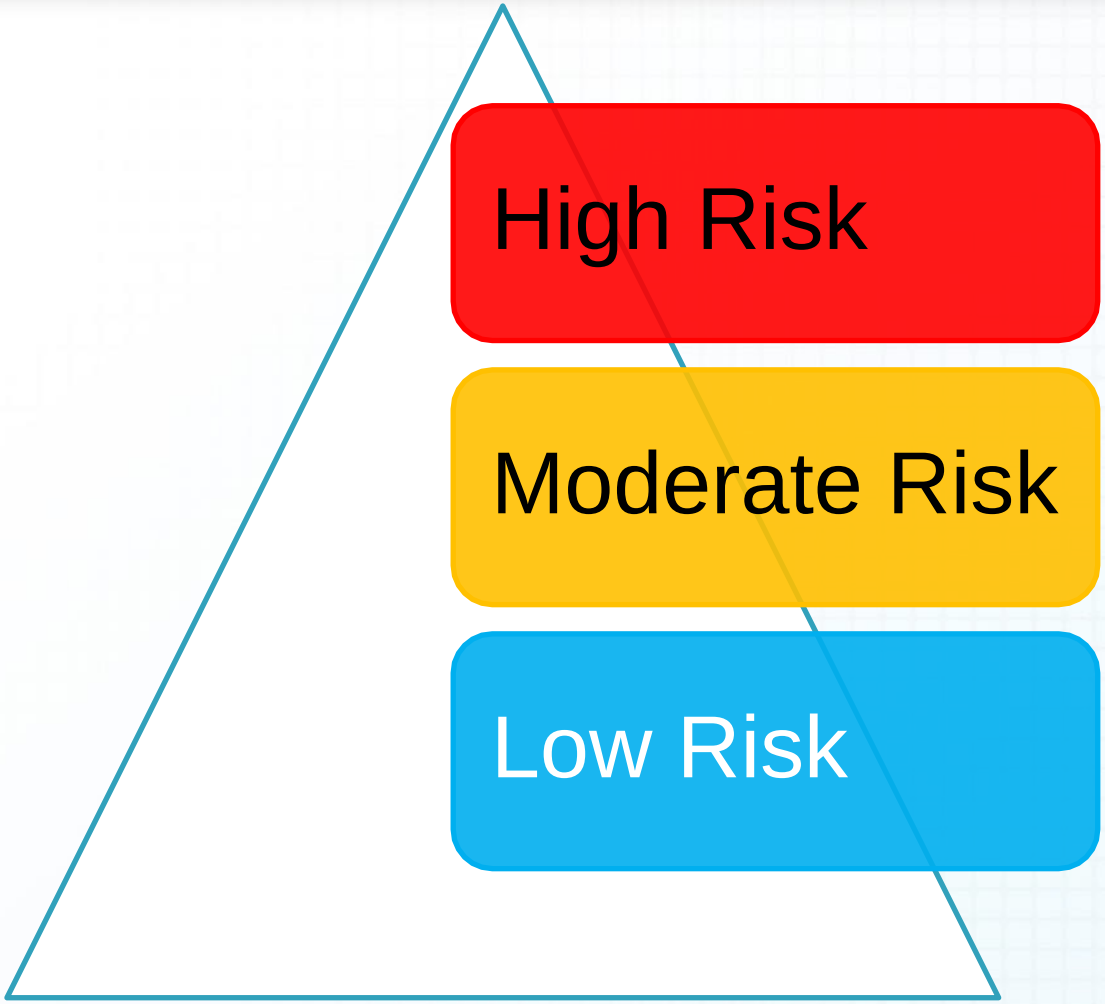
The Interdisciplinary Care Team is aware of the most predominant chronic conditions for the Illinois population; they include, but are not limited to:

- Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Hypertension
- Coronary Artery Disease
- Traumatic Brain Injury (TBI)
- Behavioral Health / Substance Abuse
- Depression, Dementia, Schizophrenia

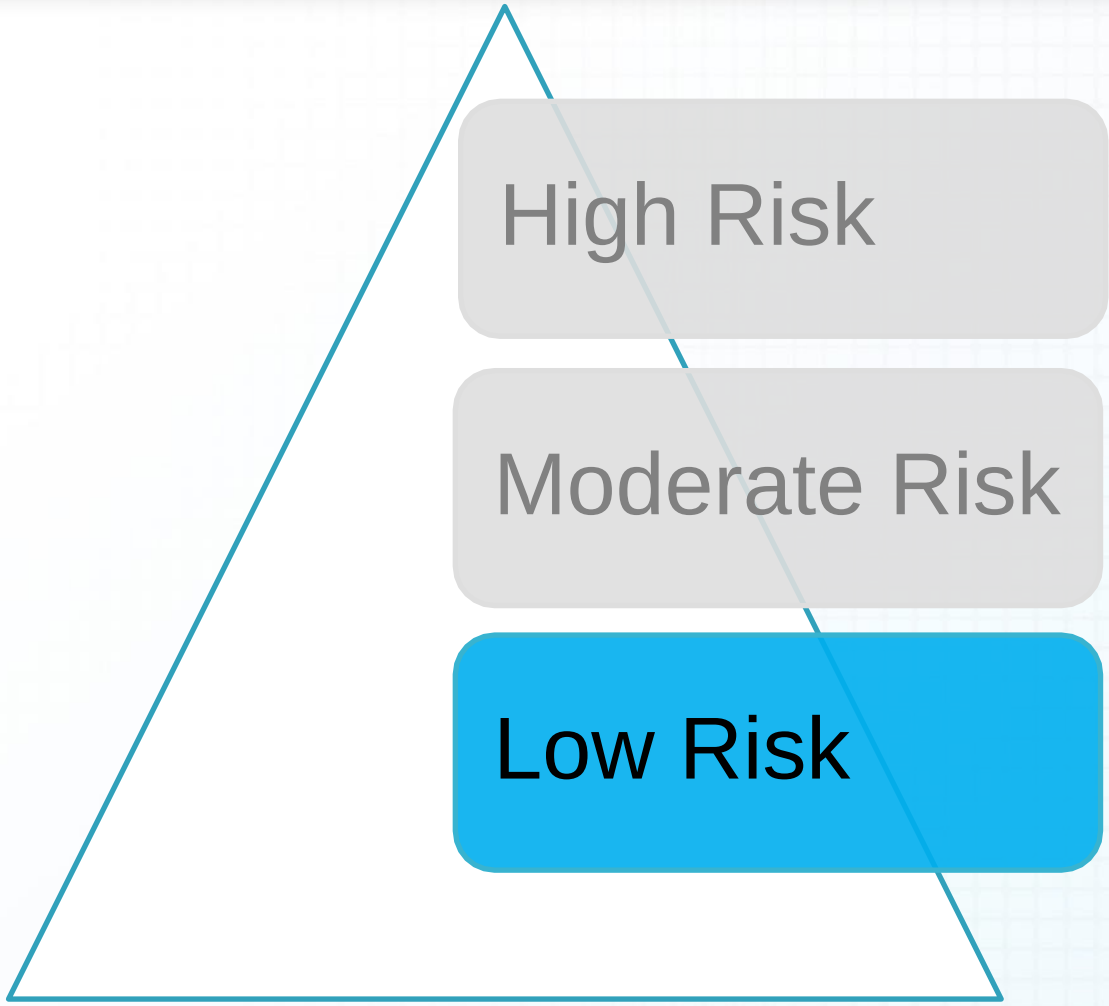
HEALTH RISK ASSESSMENT

Health Risk Assessment

Care Coordination – Risk Levels



Care Coordination – Risk Levels



- Prevention and wellness messaging
- Condition-specific education materials
- Monthly surveillance monitoring
- Telephonic support

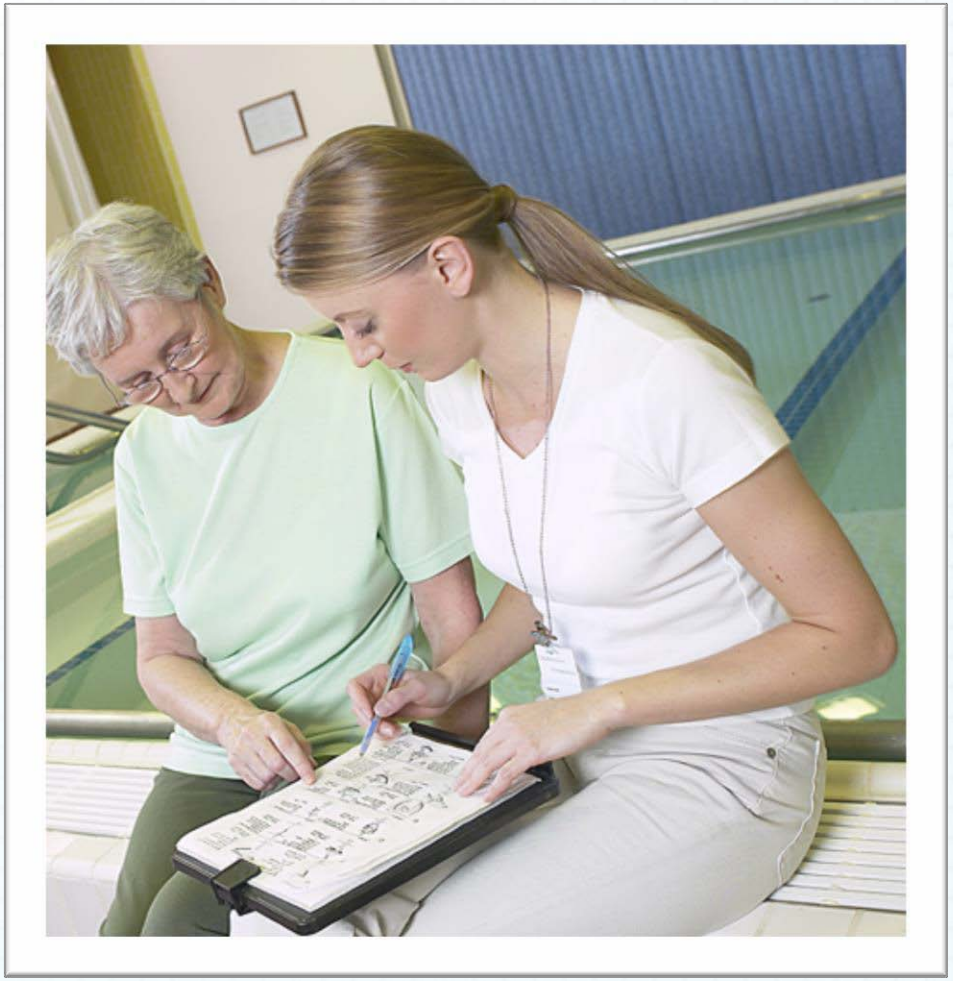
Care Coordination – Risk Levels

- Problem-solving interventions
- HRA at residence
- Quarterly plan reviews
- Monthly surveillance monitoring
- Telephonic and face-to-face support
- LTSS – Outreach and reassessment

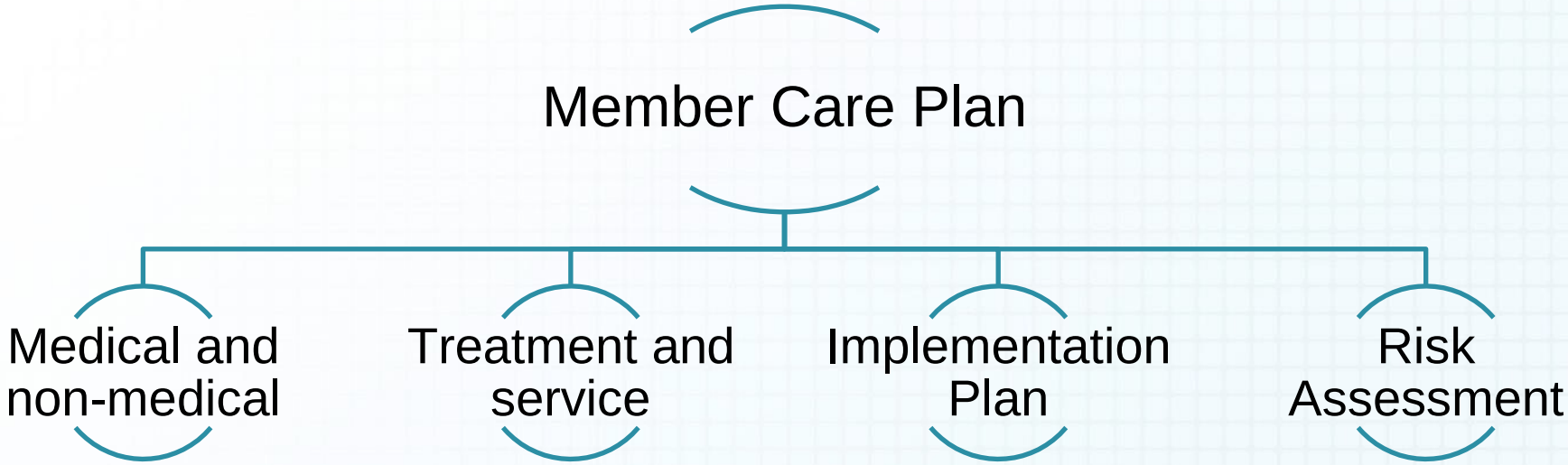
Care Coordination – Risk Levels

- Intensive care management
- HRA at residence
- Monthly plan reviews
- Monthly surveillance monitoring
- Contacted every 90 days
- Telephonic and face-to-face support
- LTSS – Outreach and reassessment

ICT Care Plan Development



Care Plan Development



Care Plan Development

Medical and non-medical needs:

- Service preferences
- Provider preferences
- Living arrangements
- Covered and non-covered services

Care Plan Development

Treatment and service goals:

- Actions and interventions
- Follow-up evaluation
- Collaborative approaches
- Desired outcomes
- Obstacles

Care Plan Development

Implementation needs:

- Standing referral
- Community resources
- Informal support
- Time frames
- Goal status
- Responsible parties

Care Plan Development

Implementation needs:

- Home visit schedule
- Critical service back-up plan
- Crisis plan
- Wellness plan

Care Plan Development

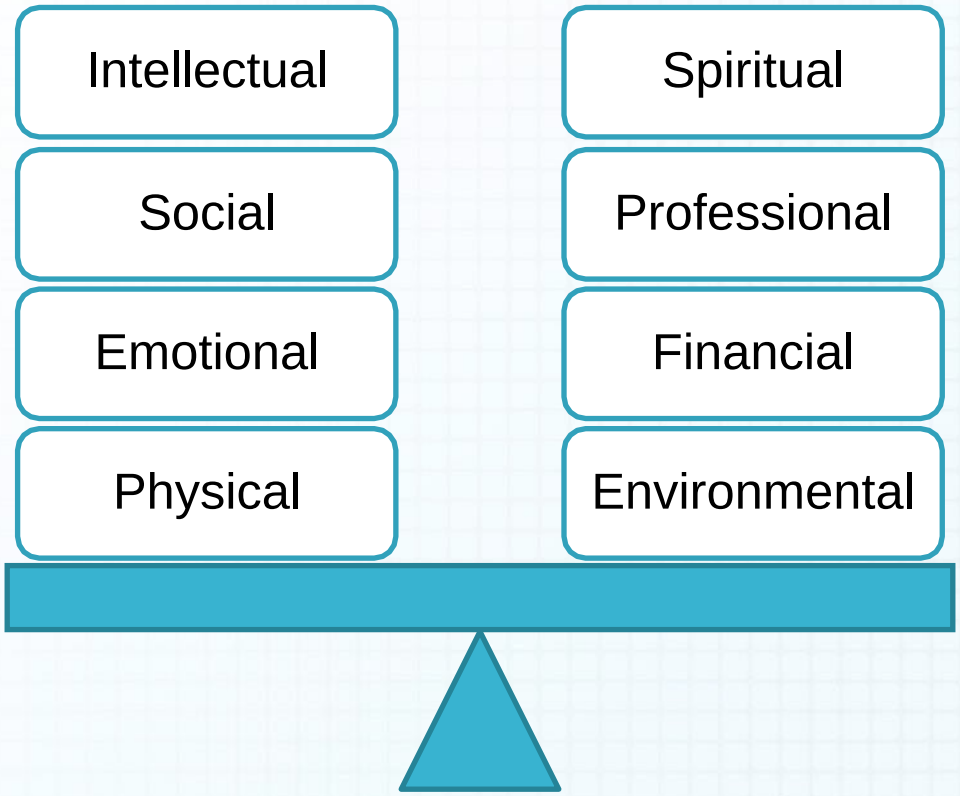
Risk Assessment:

- Potential for deterioration
- Risk comprehension
- Caregiver qualifications
- Residence appropriateness
- Behavioral or compliance risks

Wellness Program

Health and Wellness are Multi-dimensional

Balanced Total Well-being



How Health Care Professionals Impact Wellness

Help members understand:

1. Disease prevention
2. Early detection
3. Lifestyle modifications

How Health Care Professionals Impact Wellness

Care Coordinator

Develops a Wellness Plan as part of the Care Plan.

Annual Wellness Visit

Annual Wellness Visit

Benefits

1. Personalized health advice
2. Reduce health risk
3. Promote self-management and wellness

Elements of Annual Wellness Visit

1. Review health risk assessment

2. Establish medical/family history

Elements of Annual Wellness Visit

1. Review health risk assessment

2. Establish medical/family history

3. Identify current providers and suppliers

4. Perform routine measurements

Elements of Annual Wellness Visit

1. Review health risk assessment
2. Establish medical/family history
3. Identify current providers and suppliers
4. Perform routine measurements
5. Detect cognitive impairments

Elements of Annual Wellness Visit

1. Review health risk assessment
2. Establish medical/family history
3. Identify current providers and suppliers
4. Perform routine measurements
5. Detect cognitive impairments
6. Review functions and safety

Elements of Annual Wellness Visit

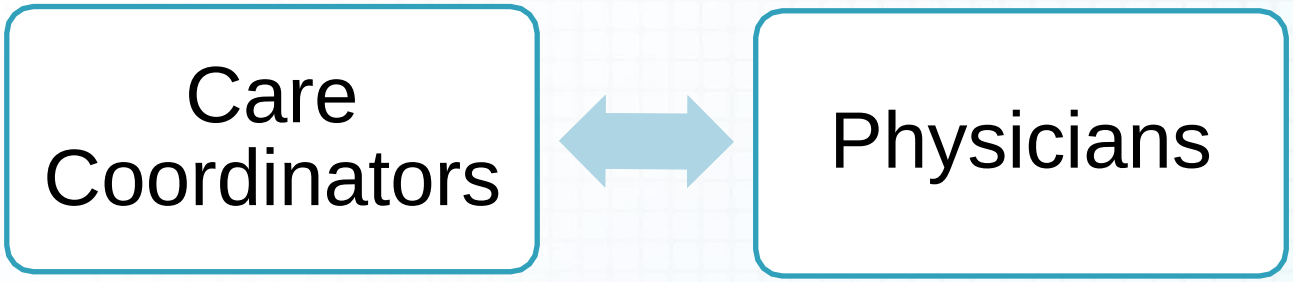
1. Review health risk assessment
2. Establish medical/family history
3. Identify current providers and suppliers
4. Perform routine measurements
5. Detect cognitive impairments
6. Review functions and safety
7. Establish risk factors and conditions

Elements of Annual Wellness Visit

1. Review health risk assessment
2. Establish medical/family history
3. Identify current providers and suppliers
4. Perform routine measurements
5. Detect cognitive impairments
6. Review functions and safety
7. Establish risk factors and conditions
8. Establish screening schedule

ICT and Provider Communication Pathways

ICT Provider Communication Pathways

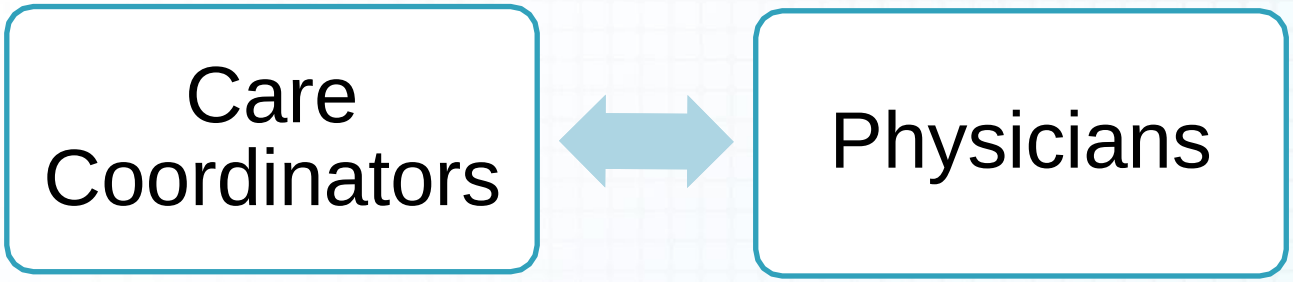


Member Care Plan

Identified medical conditions and established clinical criteria

Progress of goals and self-management

ICT Provider Communication Pathways



Community-based resources

Cross referrals between services

Community-based interpretive services

ICT Provider Communication Pathways

Collaboration:

- Telephone communication
- Joint provider on-site visits

ICT Provider Communication Pathways

Member Care Plan must include contact information:

- Physicians
- Other medical professionals
- Member and member's family members

Model of Care Behavioral Health Recovery

Each individual determines

his or her own pathway to recovery.

Behavioral Health Recovery

SAMHSA - The Substance Abuse and Mental Health Services Administration defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Principles of Behavioral Recovery

Principles of Recovery

Hope – Recovery emerges from hope and provides the essential and motivating message of a better future.

Person-driven – Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their individualized paths towards those goals.

Occurs via many pathways – Individuals are unique with distinct needs, strengths, preferences, goals, culture and backgrounds including trauma experiences that affect and determine their pathways to recovery.

Holistic – It encompasses an individual's worth life, including mind, body, spirit and community.

Peers and allies – Mutual support groups play an invaluable role in recovery.

Principles of Behavioral Recovery

Principles of Recovery

Relationships and social networks – Supporting relationships offer hope and encouragement. It also suggests strategies and resources for change.

Culturally influenced – Recovery should be culturally-based and influenced. Values, traditions and beliefs are keys in determining a person's successful recovery.

Addresses Trauma – Recovery is supported by addressing trauma. The experience of trauma is often a precursor to, or associated with, alcohol and drug use, mental health problems and related issues.

Families and Communities – Strength from families and communities serve as the foundation for recovery.

Respect – Respect involves community and social acceptance for people affected by behavioral health problems.

Model of Care and a Mental Health Crisis

What is a crisis?

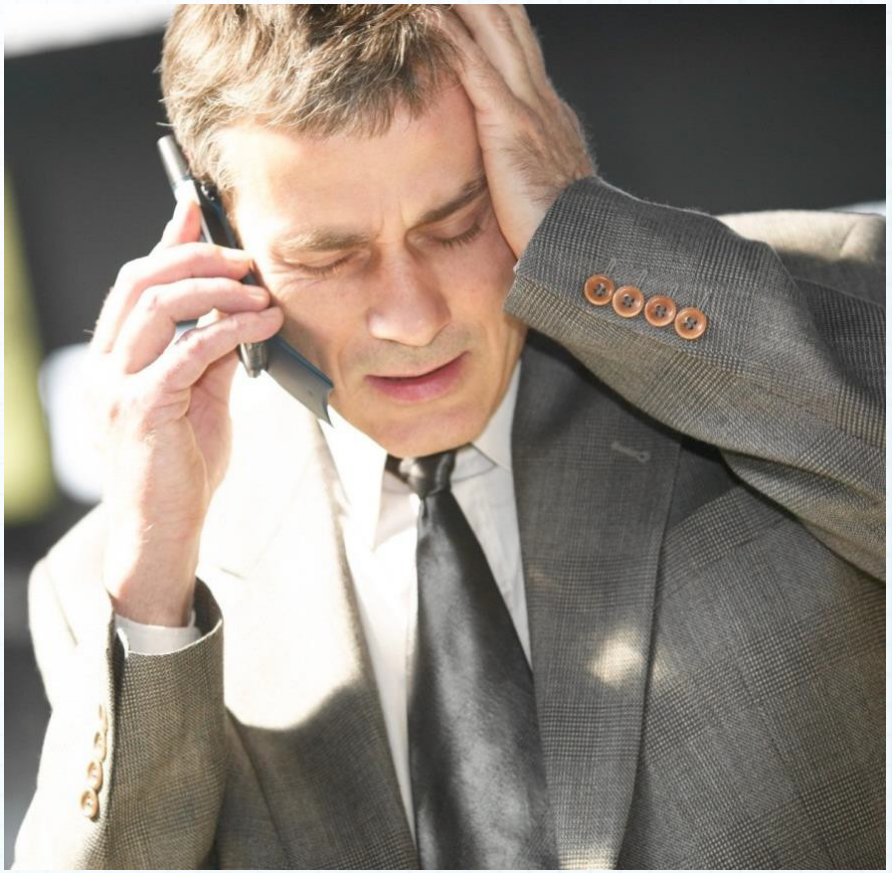
A **disruption** or **breakdown** in a person's or family's normal or usual pattern of functioning.

Model of Care - Elements of a Crisis

Crisis Indicators – Verbal

Verbal indicators

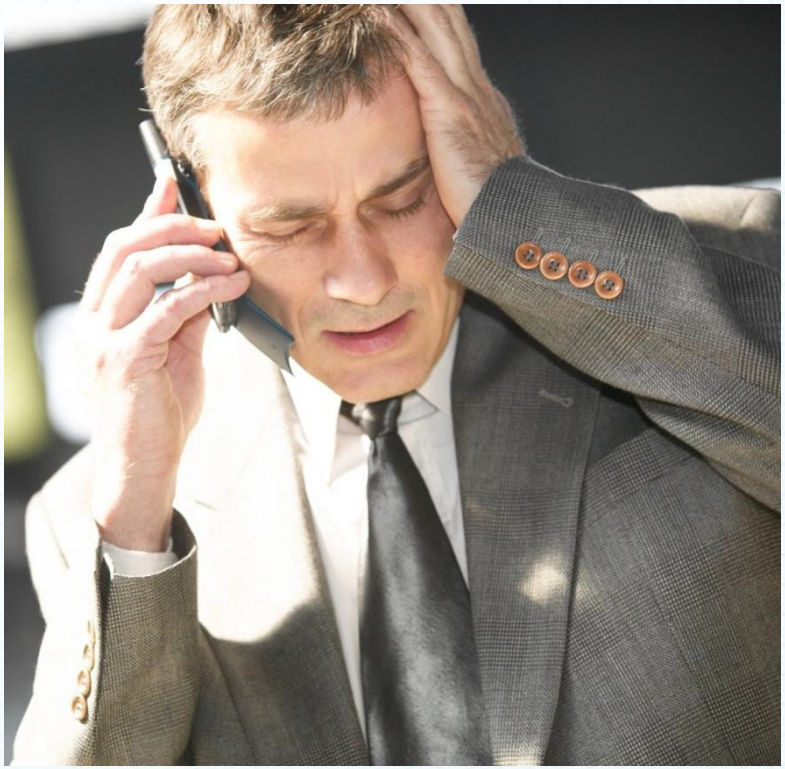
- “I have an emergency.”
- “I want to hurt myself!”
- “I want to hurt someone!”
- “I want to give up!”
- “People might be better off without me!”



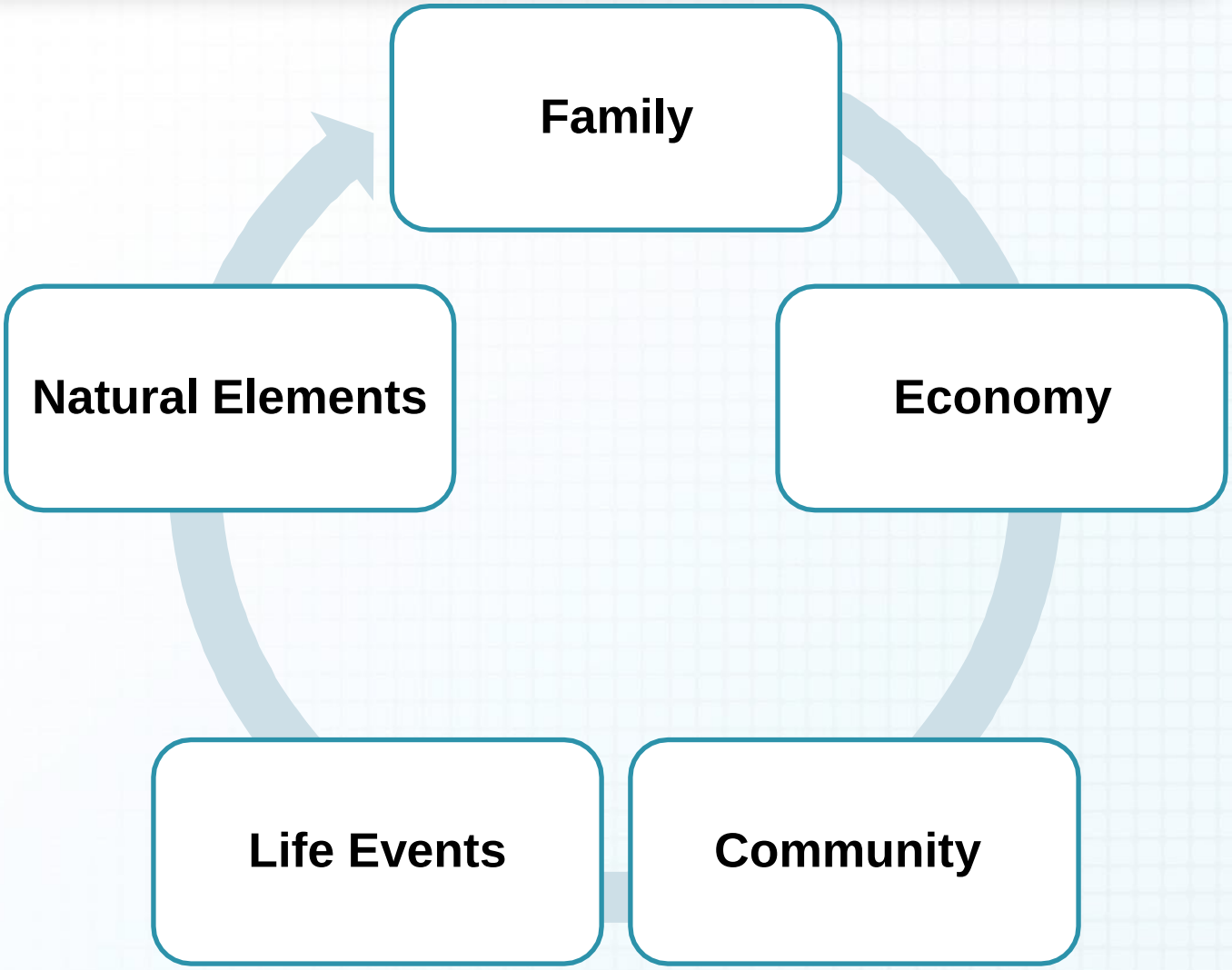
Crisis Indicators – Behavior

Behavioral indicators

- Giving away possessions
- Making arrangements
- Visiting loved ones
- Taking unnecessary risks

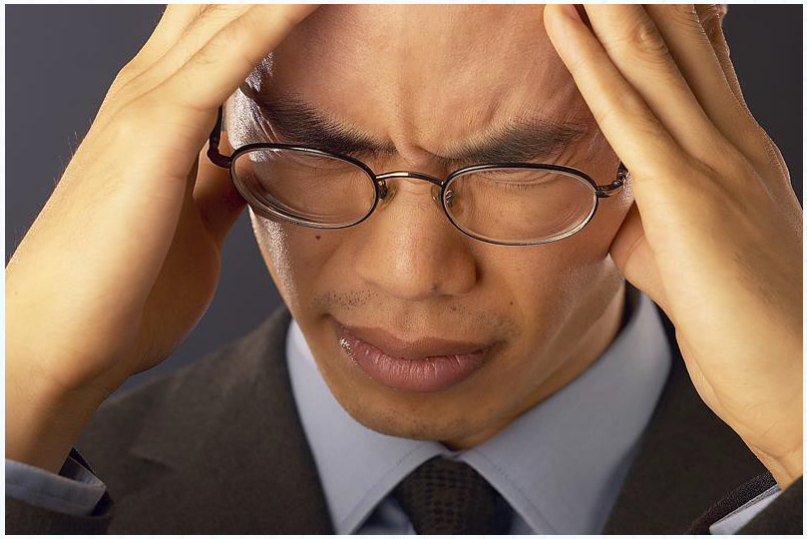


Situations Leading to a Crisis



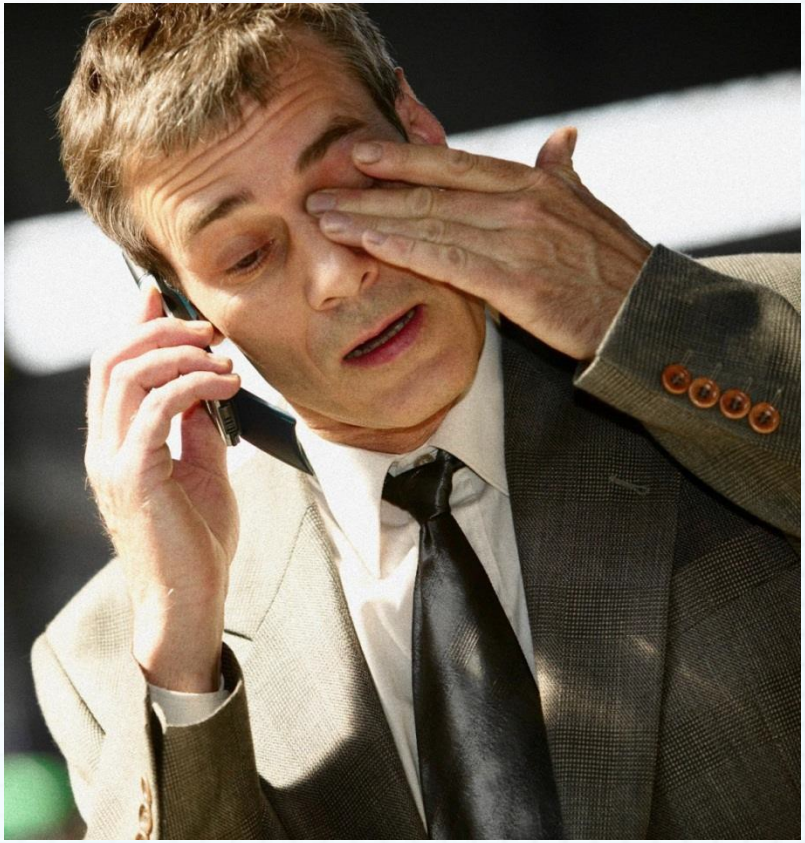
Handling a Crisis – in person

1. Be aware of your location and safety
2. If possible, have the individual call for help
3. Explain the process and how your team is going to help them feel safe
4. Provide structure and be genuine



Handling a Crisis – by phone

1. Do not put the caller on hold
2. Ask someone to call Emergency Medical Service (EMS)
3. Keep the person on the phone until the EMS arrives
4. Tell the caller you're sending someone to help



Who to Call

- If local emergency assistance is needed, call 911
- If help outside the state is needed, visit
  - www.usacops.com
- National Hopeline Network
  - 800-SUICIDE
- National Suicide Prevention Lifeline
  - 800-273-TALK

Children in Crisis

- If local emergency assistance is needed, call 911 or advise the parent or guardian to take the child to the nearest ER
- The BCBSIL Children's Mental Health Mobile Crisis Response Program also provides 24-hour telephonic crisis assessment and may dispatch a Children's Mobile Crisis Response provider to assess the child's needs and determine whether an inpatient behavioral health hospitalization is indicated
- The BCBSIL Children's Mental Health Mobile Crisis Response Program Hotline may be reached at **800-345-9049**

Thank you!

Blue Cross Community MMAI (Medicare-Medicaid) is provided by Blue Cross and Blue Shield of Illinois, A division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC's plan depends on contract renewal.

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