

**UCare Institutional Special Needs Plan Care Coordination (CC) Requirements**

**Effective 01.01.2025**

All UCare Institutional Special Needs Plan members are automatically enrolled in care coordination and receive care coordination until disenrollment. The assigned Care Coordinator (CC) must have an active Minnesota license with a degree in Social Work or as a Registered Nurse with experience in long-term care and eldercare. Care coordination incorporates case management and consists of a comprehensive assessment of the member’s condition, the determination of available benefits and resources, the development and implementation of an individualized care plan with measurable goals, and monitoring and follow-up, as described in the grid below.

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| **Initial Assignment** | | The Care Coordinator (CC) will:   * Introduce themselves to the member through face-to-face contact, letter, or phone and document in the member record. Best practice is for this to occur within 10 calendar days of initial assignment. * If contact is by letter, it must be on UCare’s approved “Welcome Letter” format found on UCare’s website. | |
| **Initial Contact** | | The CC will:   * Make a minimum of 4 (four) attempts to contact the member or the member’s designated representative within the month of enrollment to introduce care coordination and schedule the Health Risk Assessment (HRA). * Contact member by phone, face-to-face, on different days, and at different times, and/or by using the “Unable to Contact Letter” on UCare’s website. * All attempts must be documented. See “Unable to Contact” section if applicable. | |
| **Health Risk Assessment (HRA)** | | The CC will:   * Engage the member per the “Initial Assignment” and “Initial Contact” section. * Complete an HRA assessment within 30 days of enrollment, answering all questions and sections or, as appropriate, marking them as “not applicable” or “unable to respond.”   + In the event the member is unable to participate in the HRA or provide all the needed information, other sources may be used to complete the HRA such as the designated representative, member’s facility record or facility staff. * HRA is completed annually at minimum (within 365 days of previous assessment), but also with any change in condition. A change in condition is “a shift in the individual’s health, function, or psychosocial condition that either causes an improvement or deterioration.” See “Change in Condition” section for more details. * Confirm member’s risk level was assessed at every assessment – initial, annual and when there’s a change in condition. * The CC must document and share the risk level from the HRA with the Provider, and confirm the Provider agrees with the risk level assessment. * Work with the Primary Care Provider (PCP) to schedule and complete a comprehensive assessment within 90 days of enrollment. * The HRA must either be UCare’s “Health Risk Assessment” form found on UCare’s website or a pre-approved HRA form presented by the delegate. * Enter all HRA reassessments on the monthly I-SNP Part C Assessment Log. * See “Unable to Contact” section if applicable. * Best practice: complete HRA in-person. | |
| **Unable to Contact** | | If the CC is unable to contact the member or the designated representative within 30 days of the enrollment date, or within 365 days from the last HRA assessment, the CC will:   * Document all four (4) attempts to reach the member or their designated representative including the various contact methods used. At least one attempt must be by using the “Unable to Reach” letter which is located on the UCare website. | |
| **Provider Comprehensive Assessment** | | * Provider must conduct their Comprehensive Assessment within 90 days of enrollment and annually thereafter. It includes a thorough head-to-toe of the member as well as information on the following categories: psychosocial, medical (current and chronic conditions, treatments, exercise, self-care, etc), service utilization at all settings, functional status, other issues such as cognitive or sensory impairment, and recent life changes.   The member is assigned a risk level based on their physical complexities which then dictates how often they are visited or monitored.   * The CC must document and share the risk level from the HRA with the Provider, and confirm the Provider agrees with the risk level assessment | |
| **Entry of Assessments on Monthly I-SNP Part C Logs** | | The CC is required to:   * Enter all HRA assessments and reassessments on the monthly I-SNP Part C Assessment Log. * Submit the I-SNP Part C Assessment Log to [assessmentreporting@ucare.org](mailto:assessmentreporting@ucare.org) by the 10th calendar day of the following month. | |
| **Individualized Plan of Care (IPOC)** | | The CC is required to:   * Lead the creation, implementation, and updates to the “Individualized Plan of Care” (IPOC) utilizing the HRA * Use UCare’s approved “Individualized Plan of Care” (IPOC) form found on UCare’s website or a pre-approved IPOC form presented by the delegate. * Develop the IPOC with the member and/or their designated representative and the PCP at a minimum.   + Collaborating with additional members of the Interdisciplinary Care Team (ICT) to develop the IPOC is best practice but not required.   + The ICT meeting for IPOC development needs to occur during a face-to-face encounter, which is either in-person or through a visual, real-time interactive telehealth encounter. * Assure the goals are written as SMART goals- (Specific, Measurable, Attainable, Realistic, and Time-bound). * Assure the goals are relevant to the specialized needs of the member. * Assure the goals are prioritized using high, medium or low with at least one goal ranked as high priority. * Assure that the IPOC is a carefully tailored plan that identifies the following elements:   + Type of treatment and support services needed to allow the member to effectively cope and manage their health.   + Interdisciplinary Care Team (ICT), including their roles and responsibilities. At a minimum, the ICT includes the care coordinator, the member or the member’s designated representative, facility and the PCP. ICT members may also include all other health and service providers as needed, as long as they are involved in the member’s care for current health problems.   + Prioritized needs and conditions and intended treatments/interventions.   + Member strengths, supports and services.   + Areas of risk or worsening symptoms. * Confirm conversation is had around Advanced Directives. * Review and revise the IPOC at least annually with the ICT during a face-to-face encounter, which is either in-person or through a visual, real-time interactive telehealth encounter. Update IPOC with each significant change of condition, and lack of movement on goals after any care transition or upon request from the member or their designated representative.   + Provide status and the outcomes of the goal “Close/update/Goal met/ Not met” along with documentation of the progress/outcomes of the goal Ie: *Goal continued into next year’s care plan as member continues to need PT* or *Goal met; member’s authorized rep reports no falls since the last check in MM/DD/YYY* * Document that the IPOC was provided/offered to the member or designated representative following completion. * Include and document the collaboration with the PCP and ICT. * As possible, obtain the signature of the member or designated representative on the IPOC. Document if unable to do so and why. * Provide and document that the IPOC is provided to the PCP and any involved providers*\**. * Communicate updates with members of the ICT and any involved providers*\** as needed and at least annually. Document these exchanges in the member record.   *\*These may include but are not limited to: specialty care providers, social workers, mental health providers, nursing facility staff, and others performing a variety of specialized functions designed to meet the member’s physical, emotional, and psychological needs.* | |
| **Ongoing Contact with the Member, Visits and Care Plan Updates** | | The CC will:   * Determine the appropriate engagement frequency with the member or designated representative as influenced by the members risks, needs, and the necessary involvement from all care contributors (i.e. health care system, PCP, CC). Contact with member, designee or facility needs to occur at least monthly. * Update the IPOC and share those updates with all ICT members who are involved in the direct care of the member at the facility. See IPOC section. * Address, coordinate care and communicate any changes in condition to involved care providers. These communications may require immediate contact using telephonic or secure messaging, secure/urgent emails, faxing, or other predetermined forms of information exchange. | |
| **Interdisciplinary Care Team (ICT)** | | **Definition:** Each ICT member has designated roles and responsibilities and all members are expected to work together and are to ensure the member and/or their designee is engaged in care planning and agreeable to the interventions outlined in an IPOC.  The Interdisciplinary Care Team Goals:   * Ensure timely responsiveness to the I-SNP members and/or their designee identified   needs and preferences for health interventions.   * Ensure the engagement of the I-SNP member and/or their designee in all decisions   regarding their health and wellbeing.   * Ensure that the member and/or their designee experiences care and services that are   coordinated and monitored for impact.  The Interdisciplinary Care Team Core Members:   * I-SNP member and/or designee * Primary Care Physician/Nurse Practitioner * Designee from the facility known to the member * Care Coordinator   Ad-Hoc Interdisciplinary team members:   * Specialists / consultants involved in the member’s care on a routine basis. * Others, as appropriate and designated by the member with special interest and able to   address specific care needs or deliver member requested services.  Participation considerations:   * Participation methodology is flexible: in-person, telephonic, written communication/input,   secured email exchanges, WebEx, or other technology. | |
| **Primary Care Clinic (PCC) change/Care Coordination Change (change in delegate)** | | The current CC completes the following:   * Confirm desired PCC with the member/legal representative. * Complete the “Primary Care Clinic (PCC) Change Request” form located on the UCare website and submit to UCare.   + UCare will notify the sending CC if the transfer has been denied. * The sending entity is responsible for care coordination until the transfer effective date indicated on the PCC Change Request form. * The sending CC sends transfer documentation (HRA, IPOC, comprehensive assessment) to the receiving entity.   The new CC will:   * Notify the member or designated representative of their name and phone number.   + Notification can be done by phone or letter and be documented in the member record. If by letter, the CC must use UCare’s approved “Change in Care Coordinator Letter” found on UCare’s website. * CC completes HRA, PCP completes comprehensive assessment, CC schedules face to face ICT meeting for IPOC development. | |
| **Change in Care Coordinator (same delegate)** | | * New CC notifies the member or designated representative of their name and phone number. Document contact.   + Notification can be done by phone or letter and be documented in the member record. If by letter, the CC must use UCare’s approved “Change in Care Coordinator Letter” found on UCare’s website. | |
| **Actions When a Member Moves** | | If a member moves out of an I-SNP partnered facility the CC is required to:   * Validate with the member or designated representative’s desire to relocate. * Reach out to the I-SNP Program Coordinator at [ISNPProgramCoordinator@ucare.org](mailto:ISNPProgramCoordinator@ucare.org) to inquire if the new location is an I-SNP facility or Non-I-SNP Facility * If a member moves and remains within an I-SNP partnered facility, the CC is required to:   + Confirm if the CC will remain the same or if a change in CC is required. See **“Change in CC”** section. * See “ **Primary Care Clinic (PCC) change/Care Coordination Change (change in delegate**”)If the new location determined an I-SNP Facility * If new location is determed as a Non I-SNP Facility the CC will reach out to UCare Sales Team 612-676-6821 or email them at [SNPSales@UCare.org](mailto:SNPSales@UCare.org). to engage the member or designated representative and determine next steps. See” Disenrollment “Scenario 3” section. * See Disenrollment for all other scenarios when a member moves. | |
| **Actions for When a Member Dies** | | The CC is required to:   * Submit a “Member Death Notification Form” located on the UCare website and submit it to UCare. | |
| **Change of Condition** | | **Definition**: Any change in the health of the member that triggers an increase or decrease in the need for services. This could include changes in Activities of Daily Living (ADL’s), Instrumental Activities of Daily Living (IADL’s), or changes due to a major health event, an emerging need or risk, worsening health condition, or when current services do not meet the member’s needs. Ultimately, it’s defined as “a shift in the individual’s health, function, or psychosocial condition that either causes an improvement or deterioration.”  When the CC is notified of a significant change of condition the CC will:   * Complete a new HRA. * Confirm the PCP is aware of the change of condition. * Coordinate and/or contribute to a clinical assessment as performed by a PCP either face to face or via telephone. * Develop the IPOC with the member and/or their designated representative, the PCP, and members of the Interdisciplinary Care Team (ICT) following the completion of the HRA and the Primary Care Provider’s (PCP) comprehensive assessment.   + The ICT meeting for IPOC development needs to occur during a face to face encounter, which is either in-person or through a visual, real-time interactive telehealth encounter. * Work alongside the member, facility staff and provider team to develop a plan of action. * Facilitate and/or contribute to a discussion to determine next best steps (new orders, Care in Place arrangements, transfer to a higher level of care). * Communicate the plan to involved providers and member’s ICT. | |
| **Care in Place** | | **Definition:** A supportive, temporary care arrangement that allows care to be provided in the member’s usual setting or residence, or skilled nursing facility, that would avoid transitions to the ER/hospital acute care setting. This determination would need involvement of the CC and PCP.  When a Care in Place arrangement is under consideration, the CC should assess and consider the following:   * That an acute change of condition has been proactively identified in which the member has deviated from their baseline in physical, cognitive, behavioral or functional domain. * The change in condition does not require critical care services or services only available in a hospital setting. * The identified non-acute or sub-acute facility has the capabilities to deliver the care in place arrangement at the needed level of care. * The care needed from the care in place arrangement can be supported by available and qualified staff with the expertise to monitor members status and evaluate response to treatment. * Member and/or designee agrees to a care in place arrangement, including an acknowledgement of any out of pocket costs. * If the care in place arrangement requires an advancement to a skilled nursing level of care (but not yet acute level), this will trigger Medicare’s Part A benefits.   + This scenario will require notification to UCare’s Utilization Review department within 24 business hours of the transition.     - The CC should encourage the receiving facility to call UCare’s Utilization Review department @ 612-676-6705.     - The CC also may utilize UCare’s website containing authorization forms ([UCare® - Medical Services Authorizations Medicare](https://www.ucare.org/providers/authorization/med-svcs-medicare-auths)) which can be emailed ([HCM\_fax@ucare.org](mailto:HCM_fax@ucare.org)) or faxed (612-676-2499) to UCare. | |
| **Transitions of Care** | | **Definition:** If the member has had a change of condition that warrants a higher level of care for treatment, the member will be transferred to an appropriate facility to manage member needs (i.e. hospital, TCU, SNF).  The CC will perform the following when notified of the change in condition:   * Ensure the transition process is initiated. * Complete UCare’s approved “I-SNP Transitions of Care Log” on UCare’s website. Any other I-SNP Transition Log formats must be approved by UCare prior to use. * Reach out to facility staff involving them in the planning and coordination. * Notify the PCP, if they are not already aware of the transition, within 1 business day of CC notification. * Contact member/representative to discuss transition, member health and plan of care. This must be within 1 business day of notification. * Make the member’s current support plan/IPOC available to the receiving setting within one business day of notification of the transition. * Encourage the receiving facility to call UCare’s Utilization Review department @ 612-676-6705.   + Guide the facility to UCare’s website containing authorization forms ([UCare® - Medical Services Authorizations Medicare](https://www.ucare.org/providers/authorization/med-svcs-medicare-auths)) which can be emailed ([HCM\_fax@ucare.org](mailto:HCM_fax@ucare.org)) or faxed (612-676-2499) to UCare. * Incorporate POLST or end of life preferences as appropriate. * Collaborate with the member or the member’s designated representative, PCP, and facility in initiating a discharge plan on the day of admission, reflecting short and long-term goals of the interventions. * Help identify care needs that may require increased intervention/services upon discharge. * Update the IPOC to include transition dates, changes in member’s status or goals related to change of condition. * Post discharge, care coordination may include assessment (either in person or via phone) that addresses goal setting, symptom management, medication management, IPOC update, review of monitoring schedule and engagement of involved caregivers. An updated IPOC will be provided to the member/authorized designee and ICT. * CC will document transition management activities on the TOC log, IPOC and/or in the member notes. Documentation will include:   + Coleman 4 Pillars (Upon transition back to usual living environment):     - Assist member to schedule a follow up appointment with PCP within 7 days of discharge and specialists within 14 days as appropriate.     - Assure a medication review was completed and documented in member’s personal record and facility chart.     - Communicate with the member or designated representative about early warning signs, transition process, changes to member health status/plan of care within 1 business day of discharge.     - Assist member to maintain a personal health record with documentation that discharge summary has been communicated to facility staff. * ICT meeting should be scheduled within 30 days post discharge.   + Consistent contact with the PCP.   + Member wishes and safety.   + End of Life preferences have been discussed and acknowledged. * Monitor member at least weekly for 4-6 weeks OR until member has stabilized OR the plan of care becomes focused on End-of-Life Care needs at which time the IPOC will be updated. | |
| **Disenrollment** | | Generally, any disenrollment questions from the member can be directed to UCare Sales Team 612-676-6821 or emailed to them at SNPSales@UCare.org.  Disenrollment scenarios and the associated Care Coordinator’s actions are as follows:  **SCENARIO 1:** If a member no longer requires a nursing home level of care, the CC will:   * Align with the member to validate their wishes to remain in the I-SNP. * Contact UCare Sales:   + If they would like to remain in the I-SNP plan.   + If they would not like to remain on the I-SNP plan. * Provide supportive transition activity to assure smooth handoff to next care team, as needed.   **SCENARIO 2:** If a member wishes to switch from I-SNP to another plan, the CC will:   * Contact UCare Sales   **SCENARIO 3:** If member moves to a Non-UCare I-SNP partnered facility, the CC will:   * + Notify ISNP Program Coordinator of members request to initiate disenrollment.   + The Care Coordinator will follow the member for 90 days and complete all Care Coordination Tasks until the member terms from enrollment. * Provide supportive transition activity to assure smooth handoff to next care team, as needed.     **SCENARIO 4:** If the member now qualifies for Medicaid, the CC will:   * Contact UCare Sales.   **Scenario 5**: If the member moves out of state   * CC will provide Member Services phone number: 612-676-3600 to the Member or Designated Rep to inform Ucare of new address * Member should contact 1-800-Medicare to find a new plan in their area. * Care Coordinator will inform the I-SNP Program Coordinator at ISNPProgramCoordinator@ucare.org   + Please provide:     - Members First Name and Last ame     - UCare ID     - DOB     - New Address     - Move date | |
| **Coordinating with Local Agencies** | | The CC is required to:   * Make referrals and/or coordinate care with county social services and other community resources as needed. | |
| **Documentation Notes** | | The CC is required to document in the member’s care coordination record:   * All evidence that care coordination requirements as stated in this document are being met. * All attempts of any of the requirements that were attempted but not completed. | |
| **Policies and Procedures** | | UCare and Care Coordination Delegates are required to:   * Have policies and/or procedures that support all the above stated requirements. | |
| **I-SNP Model of Care Training** | | The CC is required to:   * Complete the I-SNP Model of Care training within 3 months of hire and annually thereafter. * Assure there is documented attestation as proof of completing the training. UCare reserves the right to request these attestations as needed. | |
| **Safe Disposal of Medications** | | * At initial and annual reassessment (if the member is taking any medications), and resides in an Assisted Living, the Care Coordinator is required to provide verbal (when possible) and written information on the safe disposal of prescription drugs that are controlled substances. * Document the discussion of safe disposal including that the member was provided the “Dispose of Medications Safely” form found on the UCare website. | |