MODEL OF CARE TRAINING

2021

CENTRAL HEALTH MEDICARE PLAN

CENTRAL HEALTH MEDI-MEDI PLAN

Content

- Introduction to SNP
- SNP Model of Care
- CHMP SNP population and vulnerable population
- SNP Benefit
- Roles and Responsibility
- HRA
- ICT Team
- Care Transition process
- Provider Network
- Performance and health outcome measure

Introduction

SNP Types

- SNP is a special need plan. MA plan designs special and unique benefit package to meet the needs of our most vulnerable members
- CHMP offers 2 SNP types in 2021
- Dual eligible SNP(D-SNP)
- Chronic SNP (C-SNP)

Model of care

SNP Model of care

- MOC is the architecture for care management policy, procedures, and operational systems.
- The ACA requires that all SNPs have Model of Care (MOC) be approved by NCQA effective beginning January 1, 2012
- MOC are scored based on the content. Depending on the integrity of the MOC, D-SNP can be approved from 1 to 3 years and C-SNPs only receive approvals for a period of one year.
- CHMP currently has D-SNP approved for 3 years (2021-2023) & C-SNP approved for 1 year (2021).

MODEL OF CARE GOALS

- Improve beneficiary health outcomes through access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Assure cost-effective service delivery

MOC ELEMENTS

- Description of the SNP-specific Target Population
- Measurable Goals
- Staff Structure and Care Management Goals
- Interdisciplinary Care Team
- Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols
- Model of Care Training for Personnel and Provider Network
- Health Risk Assessment
- Individualized Care Plan
- Communication Network
- Care Management for the Most Vulnerable Subpopulations
- Performance and Health Outcome Measurement

CHMP SNP Population

D-SNP

- Members who have both Medicare and Medicaid
  - Also known as PBP 002 in Los Angeles (LA) and San Bernardino (SB)
  - Available to all Dual Eligible Beneficiaries in Ventura (009)
- Eligibility for 002 is limited to the following:
  - 1. Dual eligible beneficiaries eligible for enrollment in a Full Benefit D-SNP or who are enrolled in 002 as of 12/31/14.
  - 2. Dual eligible beneficiaries eligible for enrollment in a Full Benefit D-SNP or who are excluded from enrollment in Cal MediConnect as follows:
  - a.) Individuals under the age of 21;
  - b)Individual with other private or public health insurance;
  - c) Developmentally Disabled (DD) beneficiaries receiving services through a Department of Developmental Services 1915© waiver, regional center, or state developmental center;
  - d) Individuals with a share of cost – in community and not continuously certified;

D- SNP

- e) Individuals residing in one of the Veterans' Homes of California;
- f) Individuals residing in an excluded zip code per the MOU between the State and the CMS; and
- g) Beneficiaries in the following 1915(c) waiver: i. Nursing Facility/Acute Hospital Waiver; ii. HIV/AIDS Waiver; iii. Assisted Living Waiver; and iv. In-Home Operations Waiver.
- h) Intermediate Care Facility – DD Residents.

- 3. Dual Eligible Beneficiaries who were Members in 002 as of 12/31/14, who enroll in Cal MediConnect after 12/31/14 and choose to disenroll from Cal MediConnect, may return to 002.
- 4. A Members enrolled in 002 in a non-CCI county, regardless of enrollment date, who moves during the duration of the CCI Demonstration to a CCI county also covered by 002, may remain enrolled in 002.

C-SNP

- Members with chronic conditions
- Also known as PBP 006
- Available in Los Angeles (LA), San Bernardino (SB) and Orange County (OC) (partial)
- http://www.centralhealthplan.com/Discover/ServiceArea
- Chronic conditions need to be verified in order for members to be continually enrolled.
- Since 2016, C-SNP expanded to include the following:
- 1. Diabetes Mellitus
- 2. Chronic Heart Failure
- 3. Cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorders)

VULNERABLE POPULATION

CMS recognizes SNP beneficiaries will include vulnerable individuals:

- Frail individuals
- Disabled individuals
- Beneficiaries developing end-stage renal disease after enrollment
- Beneficiaries near the end-of-life
- Beneficiaries having multiple or complex chronic conditions
- Institutionalized individuals

SNP benefits

- Case Management- intimately involved in creating individualized care plans. Case management also assist in transition of care (TOC) across all different healthcare settings. Nurses are available 24/7.
- Home Visit Program- Nurse Practitioner, Physician Assistant, Registered Nurse, Licensed Vocational Nurse and Social Worker will visit high risk patients in their home environment to assess both medical and psychosocial needs.
- Self Management- necessary equipment for self management, such as blood pressure machine for members with chronic conditions such as high blood pressure or heart disease, blood sugar testing for diabetic patients, bathroom scale for members with qualifying chronic illnesses such as Cardiovascular Disorders (Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic Disorder), Chronic Liver disease with ascites or cardiac cirrhosis, Chronic Obstructive Pulmonary Disease COPD), Congestive Heart Failure (CHF), Dementia, Diabetes, and Stroke, medical alert systems for members enrolled in 002 and 006 at risk for falls, home safety equipment for members enrolled in 002 & 006 such as bathroom grab bars, shower chair, raised toilet seat, non-slip bath mat, handheld shower head for those with limited mobility and are at risk for falls
- Wellness Center- centrally located clinics run by NPs/PAs as a one stop shop for most preventive care located in Alhambra and City of Industry

SNP benefits (Cont.)

- Partnership with patient's IPA - to engage patients in educational activities
- Medication Therapy Management
- Education Materials- all SNP members receive disease specific care plans.
- Opportunity to participate in interdisciplinary team meeting to promote members active participation in their plan care of care.
- Other benefits: depending on PBP member is enrolled in, may include but not limited to: transportation, dental benefits, vision benefit, gym membership, acupuncture, zero dollar copay for diabetic supplies, over the counter benefit allowance, and low copay for medication, international coverage etc.

ROLES AND RESPONSIBILITIES

ADMINISTRATIVE ROLES

- CEO
- CFO
- Marketing Director
- Member Services: verifies eligibility and process enrollment
- Provider Relations: act as liaison to physician group
- Contracting: assist in network development
- Claims: process claims

Clinical Staff Roles

- Medical Director- day to day supervision of clinical staff, chairperson of ICT meeting
- Director of Quality Management- works on QM projects
- Director of Special Needs Plan – works on MOC implementation
- Home Visit Team- NPs, PAs, RNs, LVNs, and SWs who visit high risk patients at home
- Diabetes Educator- education classes to DM members
- Lifestyle Coach- education classes for Pre-DM members
- Social Worker- assist NP/PA/RN/LVN to address psycho-social issues
- Nurse Practitioner/Physician Assistant/ Registered Nurse/Licensed Vocational Nurse: direct patient contact and liaison between patient and providers
- Case Manager- day to day implementation of care plans. Participates in ICT.
- Employed or Contracted Providers/Specialist/Mental Health Providers- participate in ICT to develop individualized care plans(ICP)

CASE MANAGEMENT ROLES

- Administer and coordinate benefits, plan information, and data collection and analysis
- Generate appropriate care plans for each SNP members
- Discuss care plans during ICT meetings
- Care coordination during care transition across all settings
- Point of contact for patients and physicians.
- Manage the delivery of services and benefits
- All case management staffs are trained extensively on SNP model of care.

HEALTH RISK ASSESSMENTS

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- Series of questions used to assess SNP members medical history, psychosocial history, functional status and behavioral health history
- Each question is scored
- Different scores will trigger stratification of members to determine their risk level
- Tier 1 (low risk) members
- Tier 2 (moderate risk) members
- Tie 3 (high risk) members
- Low, medium and high risk members are case managed telephonically
- Select Tier 3 members (high risk) with recent transition of care event or with poorly controlled comorbid conditions will be contacted by the SNP Coordinator and offered a home visit assessment by NP/PA and SW. If member declines a home visit, a care plan discussion by phone will be offered and a HRA will be completed, if one is due.

HEALTH RISK ASSESSMENTS

- MIPPA of 2008 mandated that MAOs conduct initial and annual health risk assessments for EACH beneficiary.
- To be completed within 90 days of enrollment and then annually
- HRA are conducted telephonically, face to face, or by mail. 3 telephone call attempts are made to contact member, followed by mailing of the HRA questionnaire as needed
- Members who are unreachable for initial or annual HRA are contacted at an interval of every 5 months
- HRA data is used to develop the individualized care plan
- HRA are communicated to members primary care providers.

INTERDISCIPLINARY TEAM (ICT)

ICT

- CHMP conducts HRA on all SNP members.
- Members are risk stratified based on their HRA.
- Members are informed and consent to case management. They have the option to opt out if desired.
- Case managers develop preliminary care plans for each unique member based on HRA.
- Select high risk members will be offered a home visit by any of the following providers: nurse practitioner/physician assistant/registered nurse/licensed vocational nurse and social worker prior to ICT meeting to address their unique needs.
- ICT team analyze and incorporate the results of the initial and annual HRA, and any additional NP/PA/RN/LVN & SW evaluation or interaction with providers. Individualized care plan (ICP) is developed for each member.
- ICT team is made up of clinical staff mentioned in previous slide.

ICT

- Meets on a weekly basis. All SNP members are discussed at least once during the year, depending on their health care needs.
- CHMP encourage members to participate in the development of their care plan, with focus on maintaining a prevention-oriented plan of care. After ICP discussion by phone or during home visit, voluntary participation of members are encouraged by extending an invite to attend ICT meetings.
- Care plans are communicated to primary care providers to keep them in the loop.
- Weekly ICT minutes are created by case managers and kept on file with CHMP.
- ICT team provides quarterly report on SNP progress, which is reported in quarterly UM committee meeting and annually to all stakeholders via newsletter and SNP update in the Public Website.

INDIVIDUALIZED CARE PLAN

INDIVIDUALIZED CARE PLAN

- Developed for each beneficiary by the respective interdisciplinary care team
- Input from HRA, case management, NP/PA/RN/LVN/SW, PCP and members/caregivers
- Reviewed and revised annually or when health status changes
- The individualized care plan includes:
  - Goals and objectives
  - Specific services and benefits to be provided that is tailored to members needs, self management plans and goals
  - Identify barriers and unique challenges
  - Measurable outcomes
  - Maintain care plan records to assure access by all stakeholders
  - Maintain records per HIPAA and professional standards
  - Measurable goal, both short and long term
  - Communicated to members/caregiver and providers

Individualized Care Plan

- C-SNP members also receive disease specific intervention and education classes
- Education classes and wellness visits by NP/PA are sometimes done in collaboration with delegated entities
- Education classes are usually conducted by various combination of NP/RN/PA, dietitian, podiatrist, physical therapist/trainer or ophthalmologist
- NPs/PAs spend extra time on disease focused counselling, teaching and Q&A sessions with members

CARE TRANSITION

Care transition

- All SNP inpatient are managed by inpatient case managers(CM)
- Inpatient CM coordinate discharge planning with hospitals to ensure all needs are met on discharge(home, home with services, skilled or custodial nursing homes, rehabilitation center)
- Admission and discharge notification are sent to patient/caregivers, IPA and PCP with brief description of hospital course and discharge needs
- High risk patients will be referred directly to home visit team
- Routine risk patients will receive follow up phone calls by inpatient CM at 1-7 days and 14-21 days as needed.
- The purpose of this call is to ensure patients understand their disease process, has post-discharge follow up, address any additional issues, contingency plan and medication reconciliation
- If patient is stable after 14-21 days, patient will be educated about self management
- If patient is still unstable after 14-21 days, they will be referred to the home visit team.

HOME VISIT TEAM

- Home visit team utilize the **Geriatric Resources for Assessment and Care of the Elders Model of Care (GRACE)**
- High risk case management with additional focus on **geriatric syndromes:**
  - Cognitive Impairment
  - Depression
  - Difficulty walking and Falls
  - Urinary Incontinence
  - Malnutrition and weight loss
  - Chronic Pain
  - Visual Impairments
  - Hearing Impairments
  - Medication Management
  - Health Maintenance
  - Advance Care Planning
  - Advance Directives
  - Caregiver Burden

Home Visit Team

- Team of NPs/PAs/RNs/LVNs and SWs
- Visits select high risk members at home to assess medical and psychosocial needs
- Conduct follow-up phone calls as needed between home visits
- Discuss patient in ICT to create an individualized care plan, in collaboration with ICT team members, PCP and patients
- Visits members at a pre-determined interval (depending on medical complexity) and also when there is a change in condition
- Referral comes from inpatient referral (as mentioned in care transition), HRA and outpatient referrals from PCP

PROVIDER NETWORK

Specialized Provider Network

- CHMP has a comprehensive network of PCP, specialist, mental health provider, and ancillary services that specifically meet the needs of our various SNP population.
- All network providers are trained on CHMP model of care
- Delegation Oversight Department at CHMP ensure compliance of delegated entities with all elements within the model of care. Credentialing Department ensures that contracted providers receive MOC training upon initial credentialing and re-credentialing

PERFORMANCE AND HEALTH OUTCOMES

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- CHMP must conduct QI program to monitor effectiveness of model of care
- CHMP QM department identifies measurable goals and collect data to determine if the goals of MOC have been met
- QM department is also responsible for HEDIS measures, annual QIP (quality improvement project) and CCIP (chronic care improvement program)
- All outcomes are communicated to stakeholders
- Corrective action plans are issued if goals are not met (i.e. changing policy and procedure, staffing, network expansion, etc.)

Examples of Data collected

- Inpatient bed days and readmission rate
- Improved self-management and independence
- Improved mobility and functional status
- Improved pain management
- Improved quality of life as self-reported
- Improved satisfaction with health status and health services.

Examples of data collected

- Improved access to medical, mental health, and social services
- Improved access to affordable care
- Improved coordination of care through a single point of care management
- Improved transition of care across health settings and providers
- Improved access to preventive health services

RESOURCES

- NCQA.ORG
- Model of care scoring guidelines
- www.cms.gov/Medicare/HealthPlans/SpecialNeedsPlans