

Model of Care Training

SPECIAL NEEDS PLAN (SNP)
MEDICARE MEDICAID PLAN (MMP)

Presentation for:
Provider Network



*Coverage for
every stage of life™*

Learning Objectives



- List the three overall goals of the Model of Care
- Describe population characteristics and special health needs of SNP/MMP patient
- Understand the important components of the care plan and team based care to improve care coordination for SNP/MMP patients
- Name two principles important to improve transition care management
- Identify three outcomes being measured to evaluate the Model of Care

Overall Goals of the Model of Care

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care, long-term supports and services (LTSS) and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, provider and health services
- Assuring appropriate utilization of services

Improve Health Status

- Improving patient health outcomes

Model of Care (MOC) and SNP/MMP Population



MOC - What is the Model of Care?

- The Model of Care (MOC) is the comprehensive plan for delivering our integrated care management program for patients with special needs
- It is the architecture for promoting quality, care management policy and procedures and operational systems.



MOC – Description of the SNP/MMP Population

- The MOC includes characteristics of the patients that Health Net and providers serve including social factors, cognitive factors, environmental factors, living conditions and co-morbidities
- The MOC also includes:
 - Determining and tracking eligibility
 - Specially tailored services for patients
 - How Health Net works with community partners

MOC – Health Net SNPs

Health Net has two types of SNPs:

- D-SNPs for patients that are dually eligible for Medicare and Medicaid known as the Amber SNPs
- C-SNP for patients with chronic and disabling disorders known as the Jade SNP - one or more of the following chronic diseases is required depending on the specific plan:
 - Diabetes
 - Chronic Heart Failure
 - Cardiovascular Disorders:
 - » Cardiac Arrhythmias
 - » Coronary Artery Disease
 - » Peripheral Vascular Disease
 - » Chronic Venous Thromboembolic Disorder

MOC – Health Net MMP

Health Net has a Medicare-Medicaid Plan (MMP) referred to as Cal MediConnect (CMC).

- The MMP is a “demonstration plan” that combines Medicare and Medicaid. It’s a three-way contract between CMS, Medicaid and Health Net as defined in Section 2602 of the Affordable Care Act.
- The goal of an MMP plan is to improve quality, reduce costs and improve the patient experience. This is accomplished by:
 - Ensuring dually eligible patients have full access to the services they are entitled
 - Improving coordination between the federal government and state requirements
 - Developing innovative care coordination and integration models
 - Eliminating financial misalignments that lead to poor quality and cost shifting

MOC – Medicare-Medicaid Plan

Eligibility rules can vary from state to state.

- General eligibility guidelines are that patients are eligible for Medicare and Medicaid and have no private insurance
- MMP patients have full Medicare and Medicaid rights and benefits
- The Medicare and Medicaid benefits are integrated as one benefit
- SNPs and MMPs follow a team based MOC, however, individual States may establish additional regulations and requirements for MMPs

MOC – Vulnerable Sub-Populations

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- **Complex and multiple chronic conditions** – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- **Disabled** – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- **Frail** – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- **Dementia** – patients at risk due to moderate/severe memory loss or forgetfulness
- **End-of-life** – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

MOC – Coordinate Medicare/Medicaid

Medicare and Medicaid benefits for D-SNPs and MMP should be coordinated:

- Patients informed of benefits offered by both programs
- Patients assisted to maintain Medicaid eligibility
- Patient access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when Health Net is contractually responsible
- Patients informed of rights to pursue appeals and grievances through both programs
- Patients assisted to access providers that accept Medicare and Medicaid

MOC – Benefits to Meet Specialized Needs

- **Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with patient and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP/MMP and region
- Additional benefits vary by region and type of SNP/MMP but may include **Dental, Vision, Podiatry, Gym Membership, Hearing Aides** or lower costs for items such as **Diabetic Monitoring supplies, Cardiac Rehabilitation**

MOC – Language/Communication Needs

SNP/MMP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication with negative impact on health outcomes. Services to meet these needs include;

- Office interpretation services – in-person and sign-language with minimum of 3-5 days notice
- Health Literacy – training materials and in-person training available
- Cultural Engagement – training materials and in-person training available
- Translation of vital documents
- 711 relay number for hearing impaired

MOC – Communication Systems



Integrated communication systems are necessary to implement the SNP/MMP care coordination requirements:

- An **Electronic Medical Management System** for documentation of care management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with enrollment, eligibility and coordination of benefit questions and able to meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate HRA results and new patient information to SNP/MMP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online

Care Management (CM)



CM - What is Care Management?

Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the patient and their caregiver's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost-effective outcomes.



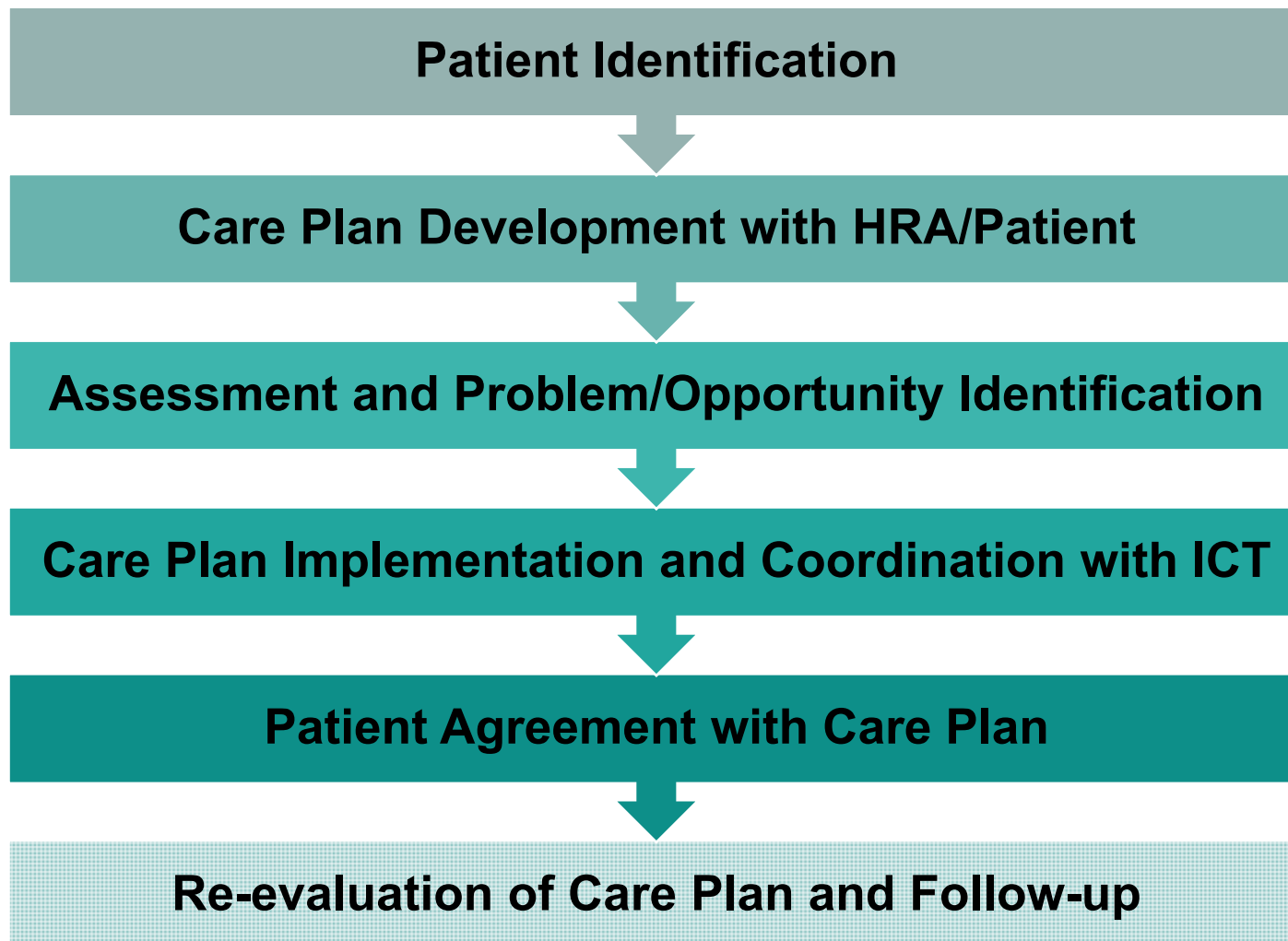
<http://www.cmsa.org/who-we-are/what-is-a-case-manager/>

CM - What is a Care Manager?

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the patient to navigate the healthcare system and collaborating with providers, their social support system, their community and other professionals associated with their care.



CM – Care Management Process Overview



CM – Care Management of Transitions

Patients are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health).

- Patients experiencing inpatient transition identified/managed (pre-authorization, facility notification, inpatient census)
- Important elements (diagnoses, medication reconciliation, treatments, providers and contacts) of care plan transferred between care settings before, during and after a transition
- Patient is able to communicate their health information to healthcare providers in different settings
- Patient educated on health status and self-management skills: discharge needs, meds, follow-up care, and how to recognize and respond to issues (discharge instructions, post-discharge calls)

CM – MOC Requirements

CMS requires all **SNP** and **MMP** members to have the following:



HRA

Health Risk Assessment



ICP

Individualized Care Plan



ICT

Interdisciplinary Care Team

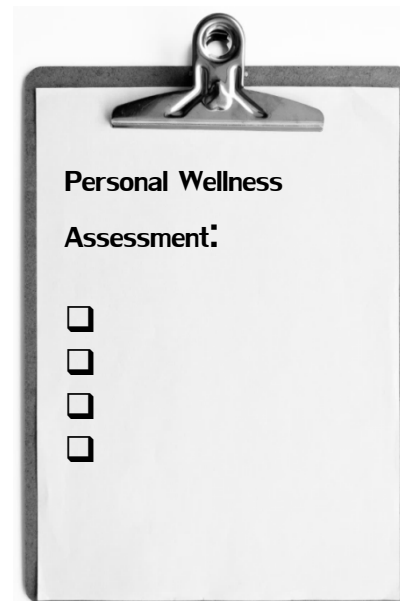
Health Risk Assessment (HRA)



HRA – Health Risk Assessment

- A health questionnaire that provides an overview of patient's health risks and quality of life
- Health Net attempts to complete the HRA within 90 days of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the patient's provider
- Clinical review of the HRA must be completed by a licensed staff member*
- Patients have the right to refuse to complete the HRA

* Licensed person includes RN, LCSW or MD




HRA – Key Elements

The HRA is a Medicare requirement for all SNP and MMP members. The assessment includes:

- Demographic data (e.g., age, gender, race)
- Self-assessment of health status and activities of daily living (ADLs)
- Functional status and pain assessment
- Medical diseases/conditions and history
- Biometric values (e.g., BMI, BP, glucose)
- Psychosocial risks (e.g., depression, stress, fatigue)
- Behavioral risks (e.g., tobacco use, nutrition, physical activity)

HRA – Utilization

- Encourage patients to complete HRA over telephone or by mail
- Explain the information helps the Care Manager and ICT to meet their healthcare needs
- Register for and check the provider portal regularly for new HRAs
- Use the HRA responses to stratify patient outreach


Your Personal Wellness Assessment

Tell us about yourself. Answering the questions below will help us personalize your care and services. This information will not change the health coverage you currently have. Everything you provide will be kept confidential. If you would rather speak with a care manager to complete this by phone, please call 1-800-275-4737 (TTY/TTD: 711). Be sure to have your insurance card, we will need your Member ID number from the front of the card.

*Indicates a required question

General Information

*Member Name (Last, First)

*Member ID *Date of Birth (MMDDYYYY)

On what date are these questions being answered (MMDDYYYY)?

Member Cell Phone Number () -

Member Email Address

Global Health / Safety

*In general, how would you rate your health?
 Excellent Very Good Good Fair Poor Unknown

Do you have a doctor or health care provider? Yes No Unknown

Have you seen your doctor or health care provider in the last 12 months? Yes No Unknown

Do you ever have any problems with transportation to your medical appointments? Yes No Unknown

*How many times have you been in the hospital in the last 3 months?
 None One time Two times Three or more times Unknown

*How many times have you been in the Emergency Department in the last 3 months?
 None One time Two times Three or more times Unknown

How many medicines are you currently taking that were prescribed by your doctor or health care provider?
 0 Prescriptions 1-3 Prescriptions 4-7 Prescriptions
 Greater than or equal to 8 Prescriptions Unknown

What is your height (enter response in feet/inches)?
 Feet 3 ft. 4 ft. 5 ft. 6 ft. 7 ft.
 Inches 0 in. 1 in. 2 in. 3 in. 4 in. 5 in. 6 in. 7 in. 8 in. 9 in. 10 in. 11 in.

What is your weight (enter response in pounds)?

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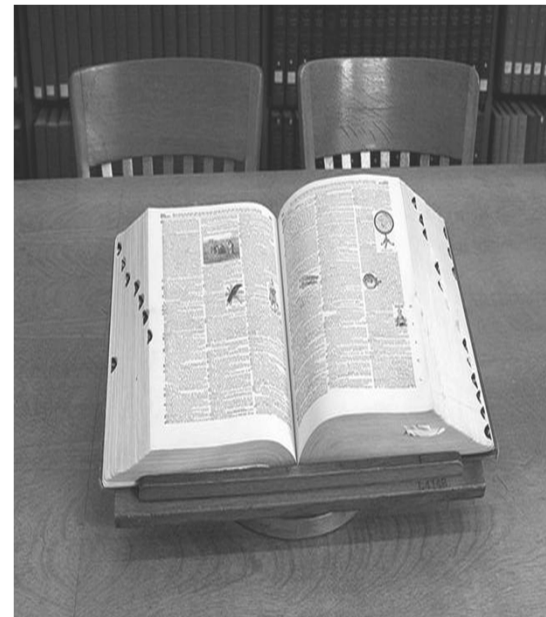
Individualized Care Plan (ICP)



ICP – What is a Care Plan?

Case Management Society of America defines a Care Plan as:

“A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; measurable goals to demonstrate resolution based upon the problem/need, timeframe, the resources available, and the desires/motivation of the client/family.”



ICP – Building Individualized Care Plans

Individualized care plans include, but are not limited to, the following:

- Establishing patient prioritized goals: what is important **TO** the patient and **FOR** the patient
- Identifying resources that might benefit the patient, including recommendations for the appropriate level of care
- Planning for continuity of care, including assisting the patient in making the transition from one care setting to another.
- Collaborative approaches to health and care management which can including the PCP, family or patient representative.
- Established timeframes for ongoing evaluation of patient's goals

ICP – Building Individualized Care Plans

Person Centered Care Plan

Problems

Communicated by the patient regarding their life, health, worries and behaviors

Goals

What the patient hopes to achieve regarding their health

Barriers

Lack of transportation, finances, housing, treatment side effects

Interventions

Actions to support problem resolution and support goal decrease stress

Note: ICP needs to be completed and updated by a licensed person.

ICP – Individualized Care Plan Problems



- Medical conditions not being well managed
- Ineffective pain management
- Cognitive deficits (dementia, brain injury)
- Unable to meet financial obligations (rent, utilities, food)
- Unsafe housing, lack of social support
- Lack of knowledge to self-manage health
- Lack of caregiver or family support
- Communication needs: language or sensory deficits
- Cultural or other beliefs interfere with prescribed treatment

ICP – Individualized Care Plan Problems

Review, prioritize and set problems

Risk



Member ability/willingness

Potential improvement

Potential complications

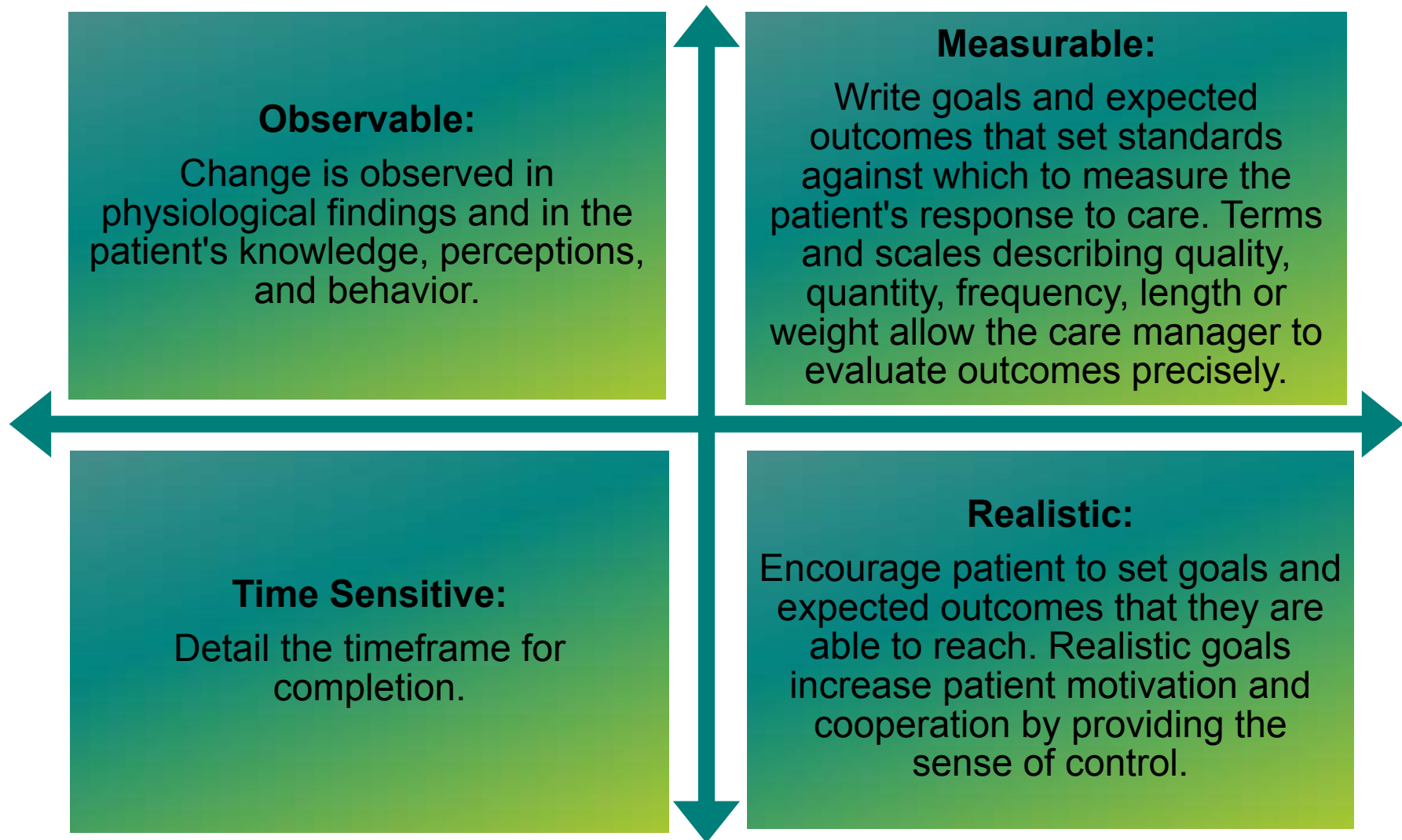
Improvement of quality of life

ICP – Member Centered Goals



- **Measurable goals** provide a clear description for the patient and care manager on how and when the goals have been achieved, patient behavior and improvement in health outcomes.
- **Goals and outcomes** reflect patient behaviors and responses expected as a result of nursing interventions. Write a goal or outcome to reflect a **patient's** specific behavior, not to reflect the **care manager's** goals or interventions.
- Each goal should address only **one behavior or response**. The outcome should be **measurable** and **evidence-based**.
- **Goals** can be short term or long term.

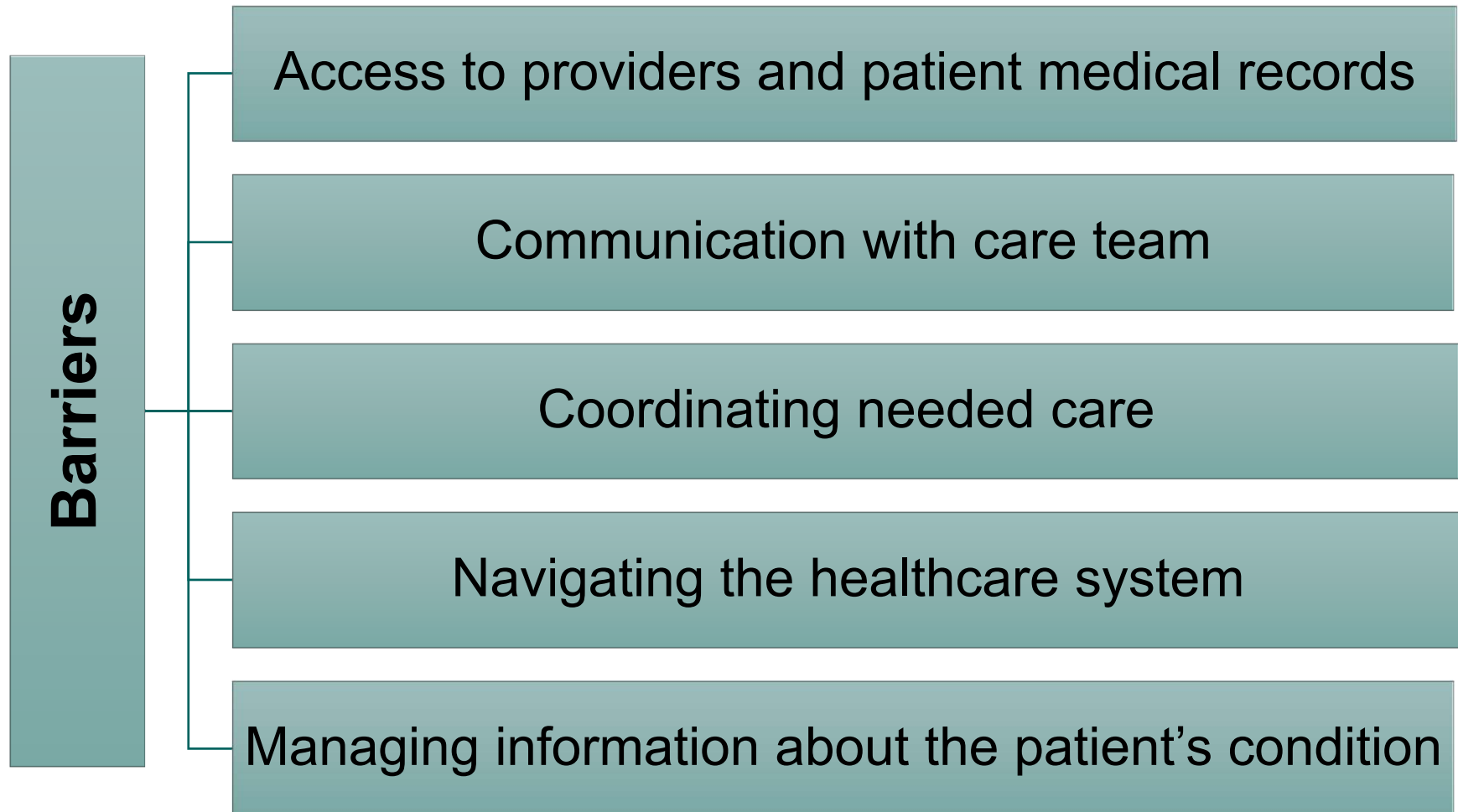
ICP – Member Centered Goals



ICP – Individualized Care Plan Steps



ICP – Individualized Care Plan Barriers



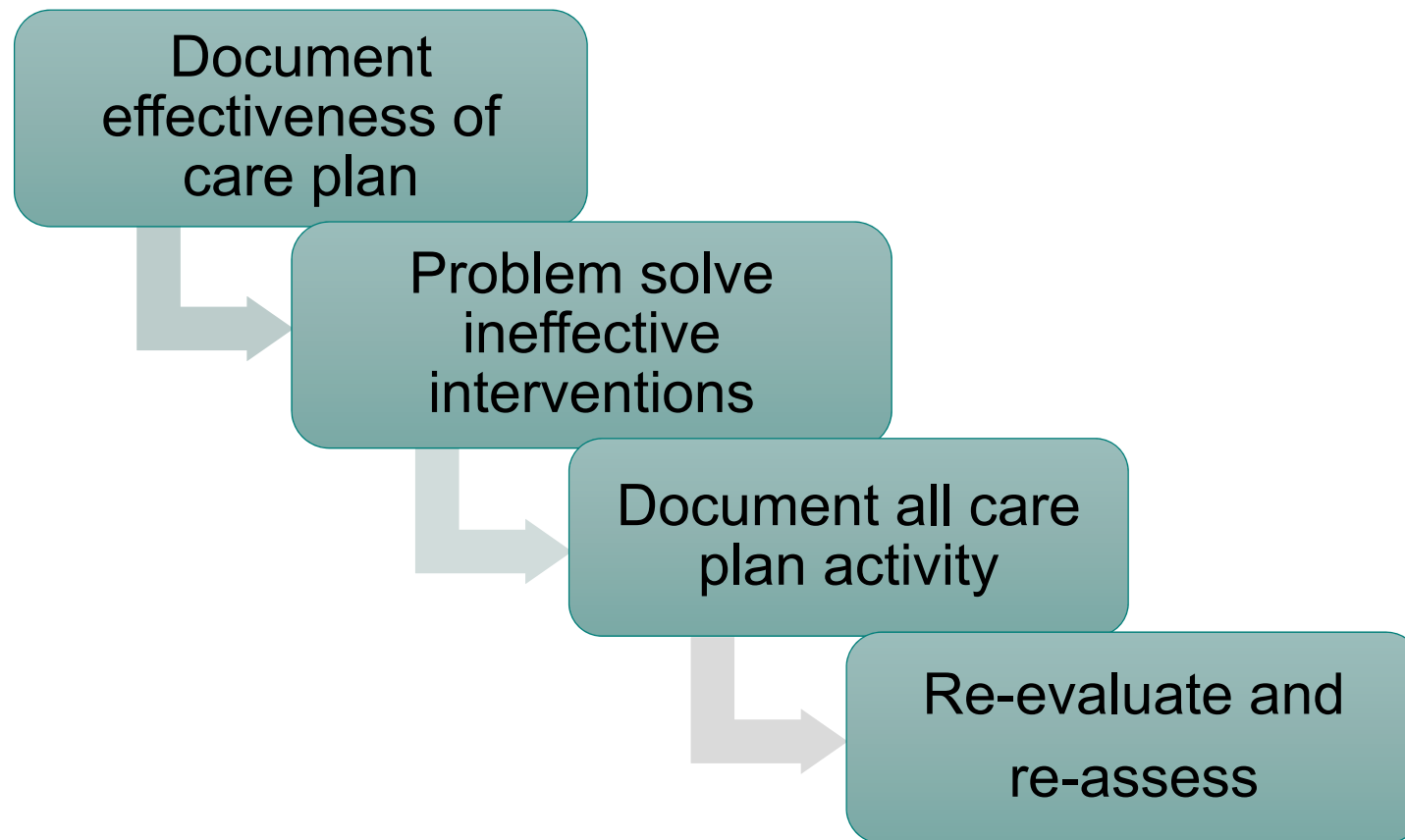
ICP – Individualized Care Plan Interventions

An intervention is an action to help the patient achieve their goals (including overcoming barriers)



ICP – Monitoring the Care Plan

The care plan is an active, dynamic document.



ICP – Updating the Care Plan

- Update the patient's care plan when changes in condition or transitions of care (TOC) occur
- Close problems, goals and interventions accurately using:
 - Claims data
 - Prescription drug event (PDE)
 - Lab, radiology etc.
- All updates are documented and communicated as needed



Interdisciplinary Care Team (ICT)



ICT – Interdisciplinary Care Team

Person Centered
Coordination

Three Part
Process

Ensures
Understanding

Documentation

Ensures Integration
of Service

Empowers

ICT – Interdisciplinary Care Team

The Interdisciplinary Care Team is developed based on patient needs/requests and facilitate:

- Access to appropriate and person-centered care
- Multidisciplinary approach to support Integrated Care Management
- Development of a comprehensive plan of care
- Communication regarding individualized care plan



ICT – Membership



The Care Manager leads and determines ICT membership with the patient and can include:

- Patient/caregiver
- Medical Expertise*
- Social Services Expertise*
- Behavioral Health as indicated*
- Pharmacist
- LTSS Coordinator
- Nursing Facility Representative
- Discharge Planner
- PT/OT/ST
- Community agencies
- Other health care professionals

*Indicates minimum required

ICT – Regular Meetings

ICT meetings are conducted at least annually and more frequently based on the patient's needs. They can be in the form of:

- Virtual/Conference calls
- In-person meetings (Grand Rounds)
- Inpatient facility care conference



ICT – Patient Centered

The patient should attend or be kept informed of ICT meeting outcomes and identify preferences for ICT members. Example:

[Add Note](#)

As part of our care coordination we will be having a care team meeting to discuss your health care needs. Who would you like to attend this meeting with you? Check all that apply

- PCP
- Specialist
- Home Health
- Therapist
- Pharmacist
- Caregiver
- Authorized Representative
- Clergy
- Family member / neighbor
- Other

* Does the member display any cognitive impairment such as problems with memory, trouble communicating, etc.? Yes No

ICT – Must be documented

Example: ICT Conference Note

Note Type: Interdisciplinary Care Team Conference_V1

Note Category: * Admin Note

Encounter Date: 09/09/2015

Interdisciplinary Team meeting conducted on: 09/09/2015

Location/Method of IDCT: Facility/Clinic

Reason for conference: Initial

Communication needs: -- Select --

Member was invited to ICT: Yes

Member's health care provider was invited to ICT: Yes

Interdisciplinary care team members participating in meeting::

Member: Yes

Member designee: -- Select --

Case Manager: Yes

Behavioral Case Manager: -- Select --

Primary Care Provider: -- Select --

Long term supports and services: Yes

Medical Director: -- Select --

Pharmacy: Yes

Disease Management: -- Select --

Facility discharge planner: -- Select --

Occupational/Speech/Physic: Select

Quality Improvement (QI)



QI – Quality Improvement Program

Health Plans offering a SNP/MMP must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met
- Collecting SNP/MMP specific HEDIS® measures
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness
- Communicating Model of Care outcomes to stakeholders

QI – Data Collection



Data is collected, analyzed and evaluated from multiple domains of care to monitor performance and identify areas for improvement:

- Health Outcomes
- Access to Care
- Improve Health Status
- Implement MOC
- Health Risk Assessment

- Implement Care Plan
- Provider Network
- Continuum of Care
- Delivery of Extra Services
- Communication Systems

QI – HEDIS® Measures



Data is collected, analyzed and evaluated at the SNP and MMP level to monitor performance. Measure examples:

- Colorectal Cancer Screening
- Spirometry Testing for COPD Pharmacotherapy
- Management of COPD Exacerbations
- Controlling High Blood Pressure
- Persistence of Beta-Blockers after Heart Attack
- Osteoporosis Management Older Women with Fracture
- Medication Reconciliation Post-Discharge
- Implement Care Plan
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental illness
- Potentially Harmful Drug Disease Interactions
- Use of High Risk Medications in the Elderly
- Care for Older Adults
- Board Certification



Training Requirements and Frequently Asked Questions

Staff Training

- Requirements are based on the CMC Model of Care guidelines
- All employees MUST be trained on the Model of Care upon hire and annually thereafter (MOC Element C, 42 CFR 422.101)
- All training MUST be documented

HRA/ICP/ICT Frequently Asked Questions

- 1. What if the HRA is not received timely?**
 - Initiate the ICP. Document that there was no HRA at time of completion of ICP.
- 2. What if HRA arrives after I have completed the initial assessment?**
 - Review HRA and update ICP with any additional or clarified information.
- 3. Do I need to monitor ICP once completed?**
 - Yes. All ICPs should be updated and monitored based on the patient's current status and changes.
- 4. When should I initiate an ICT?**
 - Documentation and implementation of the ICT should start along with the ICP.
- 5. What are requirements if a patient chooses to opt-out?**
 - The ICP and ICT must still be completed per MOC requirements. Best practice is to reach out to member at least annually and/or when there is a change or transition to offer case management services.