MODEL OF CARE TRAINING 2018

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 will be offering up to 2 SNPs in 2018
- 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 to have Model of care (MOC) be approved by NCQA effective beginning January 1, 2012.
- MOC are scored based on content. Depending on the integrity of the MOC, a SNP can be approved from 1 to 3 years.
- CHMP currently has SNPs that are approved for 3 years.

MODEL OF CARE GOALS

- Improve 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
- Improve beneficiary health outcomes

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
- Available in the area of Los Angeles, San Bernardino and Ventura(009)

C- SNP

- Members with chronic conditions
- Also known as PBP 006
- Available in Los Angeles, San Bernardino and Orange County
- Chronic conditions need to be verified in order for patients to be continually enrolled.
- In 2015, CHMP's C-SNP targets diabetes ONLY
- Since 2016, C-SNP expanded to include:

  1. Diabetes

  2. Chronic heart failure

  3. Cardiovascular disorders (cardiac arrhythmia's, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder)

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 across all different healthcare settings. Nurses are available 24/7
- GRACE Program- Nurse practitioner and social work 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 sugar testing for diabetic patients, scales, medical alert systems
- Wellness center- centrally located clinics run by NP/PA as a one stop shop for most preventive care

Cont. SNP benefits

- Partnership with patient's IPA - to engage patients in educational activities
- Medication Therapy Management
- Education Materials- all SNP members receive disease specific materials. Materials are available in multiple languages
- Opportunity to participate in interdisciplinary meeting so that patients are actively participating in their care plans
- Other benefit including but not limited to: transportation, dental benefits, vision benefit, gym membership, acupuncture, zero dollar copay in diabetic supplies and 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 Care Coordination- work concurrently with medical director as above
- Director of Quality Management- work on QM projects
- Director of Pharmacy- involve in ICT meeting when medication question arises
- GRACE Team- NPs and SWs who visit high risk patients at home
- Diabetes Educator- education classes to DM members
- Social Worker- assist NP to manage psycho-social issues
- Nurse Practitioner/Physician Assistant: direct patient contact and liaison between patient and providers
- Case Manager- day to day implementation of care plans
- 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 questions are scored
- Different scores will trigger different level of severity called tiering
- Tier 1 patients are low risk patients
- Tier 2 patients will require telephonic case management on a case by case basis
- Tier 3 patients are considered high risk and will receive in home assessment by GRACE team.

HEALTH RISK ASSESSMENTS

- MIPPA of 2008 mandated that MAOs conduct initial and annual health risk assessments for EACH beneficiary.
- To be done within 90 days of enrollment and then annually
- HRA are both done telephonically, face to face and/or by mail. 3 attempts are made to contact member
- Use the results 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 develops preliminary care plans for each unique patients based on HRA.
- High risk patients will have nurse practitioner/SW visit prior to ICT meeting to address their unique needs
- ICT team analyze and incorporate the results of the initial and annual health risk assessment, and any additional NP/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 weekly basis. All SNP members are discussed at least once during the year, depending on their health care needs.
- Patients are invited to attend ICT meetings. This is completely voluntary. CHMP encourage members to participate in the development of their care plan
- 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 to all stakeholders via newsletters.

INDIVIDUALIZED CARE PLAN

- Developed for each beneficiary by the respective interdisciplinary care team
- Input from HRA, case management, NP/SW, PCP and members/caregiver
- Reviewed and revised annually or when health status changes
- The individualized care plan includes:
  - Goal and objectives
  - Specific services and benefits to be provided that is tailored to patients need, 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
  - Communicated to patients/caregiver and providers

Individualized Care Plan

- C-SNP members also received disease specific intervention and education classes
- Education classes and wellness visits by nurse practitioners are sometimes done in collaboration with delegated entities
- Education classes are usually conducted by various combination of NP/RN, dietician, podiatrist, physical therapist/trainer or ophthalmologist.
- NPs 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 GRACE team
- Routine risk patients will receive follow up phone calls by inpatient CM at 1-7 days and again at 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 med reconciliation
- If patient is stable after 14-21 days, patient will be educated about self management
- If patient still unstable after 14-21 days, they will be referred to GRACE team

GRACE

- Geriatric resources for Assessment and Care of the Elders
- High risk case management with additional focus on geriatric syndrome.
- Team of nurse practitioners, RN/LVN and social worker
- Visits patients at home to provide assessment of medical and psychosocial needs
- Discuss patient in ICT in collaboration with ICT team members, PCP and patients, in order to create individualized care plans
- Visits patients 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 team and UM team at CHMP ensure compliance of delegated entities with all elements within the model of care.

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 to 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. Eg. changing policy & 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 settings and providers
- Improved access to preventive health services

RESOURCES

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