Central Health Medicare Plan

ANNUAL SNP MODEL OF CARE TRAINING ACKNOWLEDGEMENT 2016-2017

Medical Group(s)/Provider:

_____

(Please write in your Medical Group or Individual Provider Name on the above line)

I acknowledge that I have completed the 2016 annual SNP Model of Care Training.

_____

Signature

_____

Print Name

_____

License(s)

_____

NPI/Tax Id

_____

County

_____

Date

You may fax or e-mail this signed form to MedPOINT Management Compliance Department:

Fax number: 818-702-1743

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MODEL OF CARE TRAINING 2016-2017

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 3 SNPs in 2016
- Dual eligible SNP(D-SNP)
- Chronic SNP (C-SNP)
- Institutional SNP(I-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 2 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
- Available in the area of Los Angeles, San Bernardino and Ventura

C- SNP

- Members with chronic conditions
- Available in Los Angeles, San Bernardino and Orange County
- Chronic conditions need to be verified in order for patients to be continually enrolled.
- C-SNP includes:

  1. Diabetes
  2. Chronic heart failure
  3. Cardiovascular disorders (cardiac arrhythmia's, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder)

I-SNP

- Members who require or expected to need level of services provided in institutionalized setting for >90 days.
- Available in the Los Angeles area

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(CHF), medical alert system.
- Wellness center- centrally located clinics run by NP/PA as a one stop shop for most preventive care

SNP benefits (Cont.)

- Partnership with patient's IPA - to engage patients in educational activities
- Medication Therapy Management
- Education Materials- nurses are involved in 1:1 disease management. SNP members receive disease specific materials.
- 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 of Quality Management- works 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. 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 HRA questions will trigger a corresponding care plan.
- The entire HRA, once completed, is risk assigned based on clinical criteria into low, medium or high risk.
- Low and medium risk members are case managed telephonically
- High risk members will receive in home assessment by Nurse Practitioner and Social Worker.

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.

INDIVIDUALIZED CARE PLAN

INDIVIDUALIZED CARE PLAN

- CHMP unique software combines information from HRA, claims, encounter data and HCC categories
- A unique, individualized care plan is therefore developed, specific to each member's health conditions.
- Care plan is created for every SNP member, regardless of risk.
- The individualized care plan includes:
  - Measurable goal, both short and long term
  - Specific interventions tailored to member's need and self management plans
  - Timeline for these goals
  - Members are involved in care plan creation
  - Care plans are communicated to patients/caregiver and providers

Individualized Care Plan(cont)

- Care plans are reviewed at least annually.
- Care plans are also reviewed when the timeline stated in the goals triggers a follow up. At each follow up intervals, barriers to achieving goals are explored.
- Care plans are also reviewed when there is a change of condition, such as an inpatient admission, change of hospice status etc.

INTERDISCIPLINARY TEAM(ICT)

ICT

- As mentioned in previous slides, each SNP members receive a HRA. Care plans are then created with the input from the members.
- The preliminary care plans are then presented to the ICT meeting on a weekly basis.
- Members and their PCPs and /or specialists are invited to this meeting.
- ICT team is made up of clinical staff including MD, NP, RN, LVN, Social worker, coordinator, PT/OT, pharmacy, PCP, specialists.
- ICT team discusses the care plans for each member. ICT team can approve care plans as written or make recommendations to the care plans.
- ICT team keeps formal meeting minutes that are stored in centralized system.
- A final Individualized Care Plan(ICP) is developed for each member at the end of ICT meeting
- The Individualized Care Plan (ICP) is now ready to be sent to members/caregiver and their PCPs.

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
- Post- discharge, members will receive follow up phone calls by inpatient CM at 72 hours and 14-21 days.
- The purpose of this call to ensure patient understand their disease process, has post-discharge follow up, address any additional issues, contingency plan and med reconciliation
- All SNP discharges are communicated to the SNP team in email
- If there are any new issues or unresolved issues, SNP clinical team will create a new care plan and discuss this in the ICT meeting, with input from members.

PROVIDER NETWORK

Specialized Provider Network

- CHMP has comprehensive network of PCP, specialist, mental health provider, and ancillary services the specifically meet the needs of our various SNP population.
- All network providers are required to be trained on CHMP model of care
- Delegation oversight team and Credentialing team at CHMP ensure compliance of delegated entities and providers with all elements within the model of care.

PERFORMANCE AND HEALTH OUTCOMES

PERFORMANCE AND HEALTH OUTCOMES

- 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
- All outcomes are communicated to stakeholders via member and provider newsletter.
- Outcomes are also reported internally in QM committee meeting and ultimately to the Board of Directors.
- Corrective action plans are issued if goals are not met, including but not limited to changing policy & procedure, staffing, network expansion etc.

Examples of Data collected

- Inpatient bed days and readmission rate
- SNP member satisfaction survey
- HRA completion rate
- Care plan compliance rate
- HbA1c control in diabetic population
- SNP access to care
- SNP quality of care

RESOURCES

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