1. Learning Objectives For Understanding Model of Care (MOC)

Understanding the Model of Care (MOC) for Special Needs Plan (SNP) Members

Learning Objectives for this Provider Training:

1. Describe the 4 elements of the Special Needs Plan Program

2. Demonstrate an understanding of the Provider and Care Manager role and responsibilities

3. Develop an understanding of the terms frequently referred to during the development of care plans, implementation of a care plan, and the ongoing support of that care plan to meet the members needs

2. The 4 Elements of the SNP Program Model of Care (MOC)

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1. Understanding SNP Population Categories and Qualifications

2. Care Coordination

3. Provider Network

4. Quality and Performance
3. SNP Program MOC – Understanding SNP Population

SNP Program MOC – Understanding SNP Population
Categories and Qualifications

1. Understanding SNP Population Categories and Qualifications
   
   A. Chronic Special Needs Plan (C-SNP)
      - These are members identified to have a serious chronic disease that may impact the
types of resources the member may need to support their care such as diabetes
   
   B. Dual Eligible SNP (D-SNP)
      - Fully integrated plan that is designed for members who have both Medicare Part A and
      Part B as well as Full Medicaid Benefits
   
   C. Institutional SNP (I-SNP)
      - SNPs that restrict enrollment to Medicare Advantage eligible individuals who, for 90 days
      or longer, have had or are expected to need the level of services provided in a long-term
      care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an
      intermediate care facility for individuals with intellectual disabilities (ICF/IFF) or an
      inpatient psychiatric facility

4. SNP Program MOC – Care Coordination

SNP Program MOC – Care Coordination

2. Care Coordination
   
   A. Chronic Special Needs Plan (C-SNP)
      - The following are all required components in the management of a
SNP member and will be covered
later in more detail
      - Health Risk Assessment (HRA) upon
      enrollment and annually
      - Individualized Care Plan (ICP)
      - Interdisciplinary Care Team (ICT)
      - Care Transitions
5. SNP Program MOC – Provider Network

Provider Network

A. Providers who are delivering care to SNP members
B. Training of the Model of Care is required for those managing or caring for a SNP member

6. SNP Program MOC – Quality and Performance

Quality and Performance

A. Quality Improvement plan is developed
B. Quality Metrics are implemented to evaluate the SNP program on an annual basis
7. Goals and Purpose of the Program

Program Goals and Purpose

1. Improve access and affordability to members' healthcare needs
2. Improve coordination of care and ensure appropriate delivery of services through the alignment of the Individualized Care Plan (ICP) and recommendations from a multidisciplinary team called the Interdisciplinary Care Team (ICT)
3. Maximizing efficiency and minimizing disruption to a member's care during their healthcare setting transitions
4. Ensure appropriate utilization of services for preventative health and chronic conditions
5. Improve member health outcomes

8. Care Manager (CM) Role and Responsibilities

Care Manager (CM) Role and Responsibilities

1. Identify a new SNP Enrollee within 90 days. If member is in need of an annual Health Risk Assessment (HRA) update, or a status in condition or care transition event has occurred

2. Conduct Health Risk Assessment (HRA)
   A. Health Plan Case Managers may retain responsibility for the HRA or it may be delegated to a Hoag Clinic Care Manager
   B. HRA is used to triage the priority and risk of the patient to low, medium, or high

3. Once SNP member is assigned to a Hoag Clinic Care Manager:
   A. Gather any clinical records needed for review of case
   B. Conduct member outreach
9. Care Manager (CM) Role and Responsibilities cont.

4. Schedule ICT meeting
   A. Identify and invite MSO designated physician, primary care provider and/or additional specialist needed for meeting. Invite member and/or designee, care managers, social workers, therapist as indicated by findings in HRA, and clinical records
   B. Review all findings in the Interdisciplinary Rounds

5. Create Initial Care Plan
   A. Create an initial or an updated care based upon feedback from ICT attendees
   B. Develop care plan goals in collaboration with the member
   C. Prioritize 3-5 main problems with specific, measurable, and time-bound goals

6. Implement and coordinate the care plan

10. Care Manager (CM) Role and Responsibilities cont.

7. Send new and/or any revised SNP member care plans to both the member and you, their provider
   • Including any necessary information, resources, educational materials, or referrals needed for your patient
     – to support them in meeting their goals of the care plan

8. Care Manager will schedule periodic re-evaluation and follow up with the care plan goals with the member
11. Provider Role and Responsibilities

Provider Role and Responsibilities

1. Assist Care Manager (CM) in the development of the member’s care plan
2. Attend ICT meetings to provide your expertise and input for your members’ needs
3. Review Initial Care Plan before the first visit with patient, and when CM communicates new changes to you
4. Anticipate that updated care plans will be provided to you at the time your member has any change in care settings (you may hear the term “transitions of care”) and that the CM or Navigator will assist in arranging for the patient’s follow up care

12. Transitions of Care Result in Care Plan Updates

Transitions of Care Result in Care Plan Updates

Clinical review identifies a change of health status not reflected on the SCAN care plan

A change of health status occurs at any point during the member journey

During outreach a member denies any identified concern or your records indicate it is been addressed

As a result of Interdisciplinary review

During outreach to the member a new concern is identified

Send the revised care plan to the member and PCP
13.1 HRA Trigger Alerts: May Lead to Care Planning Needs

- Self rating of health as “Poor”
- 2 or more drinks per day
- Pain that interferes with daily activities
- 2 or more falls in the last year
- 2 or more ER visits in the last year
- 2 or more unplanned hospital admissions in the last year
- Health concerns that have not been addressed

13.2 HRA Trigger Alerts: May Lead to Care Planning Needs (cont.)

- 8. 12 or more medications
- 9. Difficulty managing and taking medications as prescribed
- 10. Experiencing symptoms or side effects related to medications most or all the time
- 11. Moderate to severe depression (PHQ-2)
- 12. Difficulty with activities of daily living (bathing, eating, etc.)
- 13. Member is afraid of someone hurting them
- 14. Member requests care manager support
14.1 Components of a Comprehensive Assessment

Components of a Comprehensive Assessment

I. Complete History and Physical (includes but not limited to):
   - Present and past illness with hospitalizations, operations, medications
   - Physical exam including review of all organ systems
   - Height, weight, BMI, DP, cholesterol screening
   - Preventative services per USPSTF A and B guidelines for 65-year-old
     (age-appropriate screenings such as TB, Clinical breast exam, mammograms, chlamydia, pap smear, etc.)

II. Social History
   - Current living situations/marital status
   - Work history/education level
   - Sexual history/use of alcohol, tobacco and drugs

14.2 Components of a Comprehensive Assessment (cont.)

Components of a Comprehensive Assessment (cont.)

III. Mental Health and Status Evaluation

IV. Assessment of Risk Factors
   - Staying Healthy Assessment (SHA) required on all dual SNP patients
   - Nutrition
   - Functional status (including Activities of daily living (ADL), IADLs)
   - Physical activity
   - Environmental safety
   - Dental/oral hygiene
   - Falls
   - Language/culture
14.3 Components of a Comprehensive Assessment (cont.)

Components of a Comprehensive Assessment (cont.)

V. Diagnosis and Plan of Care

VI. Use of Clinical based guidelines as best practice in development of a care plan

15. SNP CM Assessment

SNP CM Assessment

1. Introduction of the program
2. Member’s participation status
3. Self reported health status
4. Identify and describe member’s health, behavioral, status
5. Member’s preferred language
6. Assess limitations and barriers, such as risk of falls, culture, financial, hearing, vision, living arrangements, activities of daily living, etc.
7. Caregiver status
16. Components of an Individualized Care Plan (ICP)

Components of an Individualized Care Plan (ICP)

1. Addresses any documented triggers with member
2. 3-6 problems that have specific, measurable, and time-bound goals that address barriers in achieving the desired outcomes
3. Documentation that shows ongoing review and revision of the ICP meetings held due to changes in health status, diagnosis, recent hospitalization, functional status, etc.
4. Evidence of ICP being sent to members and primary care physicians anytime the care plan is updated
5. ICT recommendations are documented in the care plan