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Annual Special Needs Plan (SNP) Model of Care Training

Ambulatory Care Management

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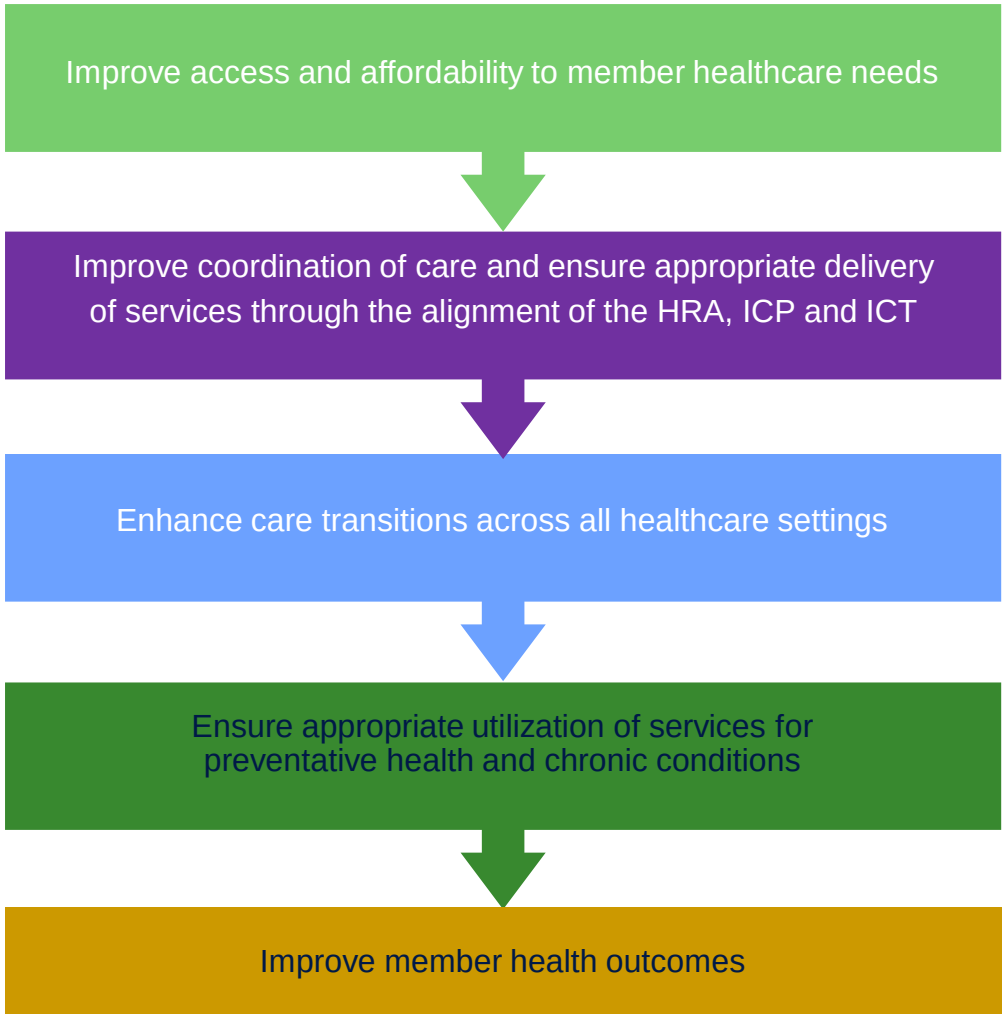
Special Needs Plan: Goals



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Special Needs Plan: MOC

- Model of Care (MOC): CMS requires SNP Plans to develop a MOC that describes their approach to caring for their target population. The SNP MOC is a working framework on how the SNP proposes to coordinate the care of the SNP enrollees.
- Required Training: CMS requires all employed and contracted staff, who provide direct and indirect care coordination services to SNP members, to complete initial SNP MOC training and annually thereafter. Delegated Health plans require each medical group to provide initial and annual training for all employed and contracted staff and maintain the documentation of that training.

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

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SNP Types & Eligibility

Chronic Special Needs Plan (C-SNP)

- Eligibility verified 30 days post enrollment
- Designed for members who have been diagnosed with cardiovascular disorders, chronic heart failure, and/or diabetes

Fully Integrated Dual Eligible Special Needs Plan (DSNP)

- Eligibility verified monthly
- Designed for members who have both Medicare Part A and Part B, Full Medicaid benefits (HealthNet Sr offers Part D)

Institutional Special Needs Plan (ISNP)

- Eligibility verified outside vendor
- Meet state criteria for Nursing Facility Level of Care (NFLOC)
- Healthy at Home Plan – Must reside in the community and not a facility (I-SNP is Institutional Equivalent)

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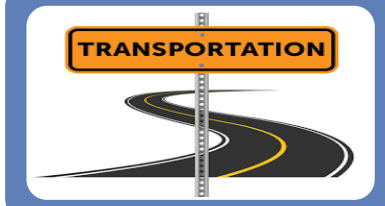
SNP Member Benefits

Health Risk Assessment (HRA)-Health Plan performs an initial HRA

Medication Therapy Management–a pharmacist reviews medication profile quarterly and communicates with member and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues (Health Net ONLY)



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 and region

In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation. T**hese benefits vary by region and type of SNP

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MOC – Language Needs

SNP 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

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The 4 Elements of SNP Model of Care

Special Needs Plans:
- Chronic SNP (**C-SNP**)
- Fully Integrated Dual Eligible SNP (**FIDE –SNP)**
- Institutional SNP (**I-SNP**)

Staff/providers deliver care to SNP members must complete SNP MOC training annually

SNP Population → **Care Coordination** → **Provider Network** → **Quality Measurement & Performance**

Care Coordination:
- Health Risk Assessment (**HRA**)
- Individualized Care Plan (**ICP**)
- Interdisciplinary Care Team (**ICT**)
- Care Transitions (**CT**)

- Measures are evaluated on an annual basis
- SNP model of care program evaluation process
- Quality Improvement Plan

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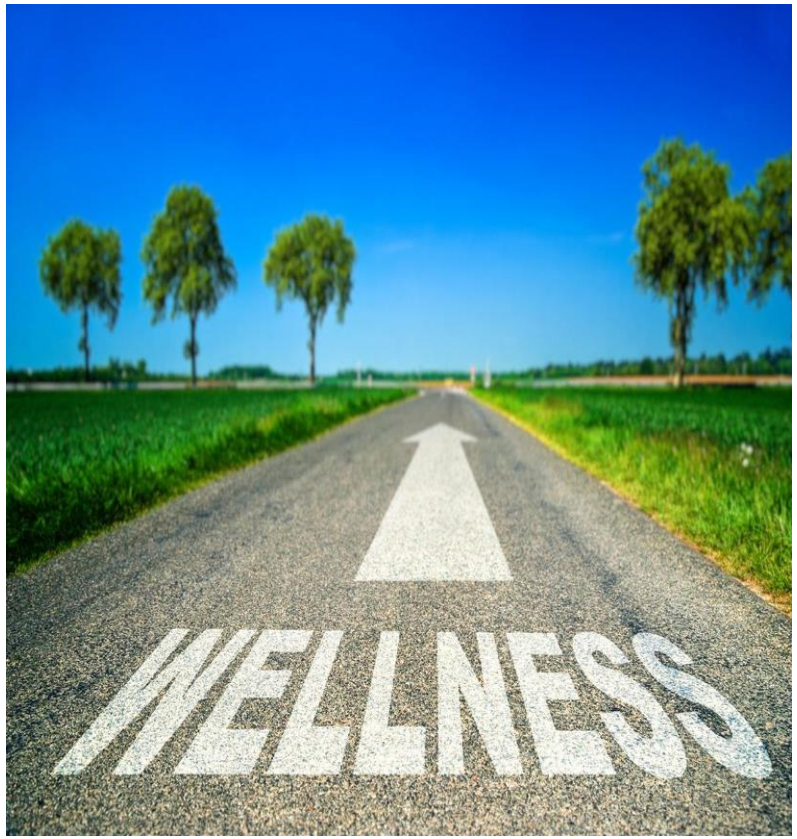
Health Risk Assessment (HRA) Triggers

- "Poor" self-rated health
- 8 or more medications
- Moderate to Severe Depression (PHQ-2)
- Difficulty with ADLs – (Bathing, Eating & Toileting)
- 3 + Falls in the last year
- 3+ SNF admissions in the last year
- 3 + ER visits in the last year
- Report difficulty managing health condition
- 3 + hospital admissions in the last year
- Requests a Case Manager/RN

Individualized Care Plan (ICP)



- Must be completed within 30 days of notification by Health Plan of a new SNP patient per CMS/Health Plan requirement
- Developed based on the patient's assessment and identified problems
- Includes patient's self-management plans and goals
- Includes barriers and progress towards goals
- Shared with patient/caregiver, PCP, and any settings where the patient has a transition of care: Hospital, Skilled Nursing Facility
- Updated with changes to health such as new diagnosis, hospitalization, or at least annually and communicated to ICT and patient

Interdisciplinary Care Team (ICT)

- All SNP members require interdisciplinary care
- **Interdisciplinary care can be formal or informal**
- **Our *formal* ICT team meets weekly** and consists of Medical Director, Social Worker and SNP Care Management nurse
  - Patients/caregivers are invited to ICT during the initial assessment and care plan sign-off. They have the right to opt in or out of participation.
  - The PCP is invited to join the weekly ICTs
- ***Informal*** ICT can occur in person, over the phone or electronically between any two members of the patient's care team

Transition of care (TOC)

- Patients are at risk of adverse outcomes when there is a transition between settings
- Patients experiencing an inpatient transition are identified
- The patient's care plan is shared between care settings upon admission
- PCP is notified of patient's discharge

Discharge follow up call is made to patient; Care Manager to review the following:

- ❑ Discharge instructions and verify understanding
- ❑ Medications and ensure new prescriptions have been filled and picked up
- ❑ Follow-up appointments in place
- ❑ Home Health start date and confirm they have been in touch with the patient (if applicable)
- ❑ Durable medical equipment has been delivered (if applicable)
- ❑ Additional education around diagnosis, symptoms, when to call the doctor
- ❑ Nurse Advice Line and Urgent Care Center information provided
- ❑ Questions the patient/family/caregiver may have

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Role of SNP Care Manager

- ❑Reviews Health Risk Assessment (HRA) from Health Plan
- ❑Performs an assessment of medical, psychosocial, cognitive and functional status
- ❑Develops a comprehensive individualized care plan with member input
- ❑Identifies barriers to goals and strategies to address
- ❑Discusses member care at Interdisciplinary Care Team (ICT) meetings
- ❑Facilitates transitions of care calls after an ED visit or acute hospitalization
- ❑Provides personalized education for optimal wellness
- ❑Encourages preventive care such as flu vaccines and mammograms
- ❑Reviews and educates on medication regimen
- ❑Promotes appropriate utilization of benefits
- ❑Assists member to access community resources
- ❑Assesses cultural and linguistic needs and preference

Your Role as the Physician

- ✓ Review comprehensive and individualized care plans created for each patient
- ✓ Encourage your patients to engage with their assigned SNP Care Managers and take advantage of the benefits.
- ✓ Participate in ICT meetings for your patient if necessitated
- ✓ Collaborate with patient care during Transitions to reduce gaps in care and readmission risk
- ✓ Provide medical documentation necessary to the SNP Care Manager for the assessment and care planning process