

**COMMUNITY CARE FAMILY CARE
PARTNERSHIP PROGRAM (PARTNERSHIP)
DUAL ELIGIBLE SPECIAL NEEDS PLAN (SNP)**

Provider Model of Care Training



Introduction

- Community Care is a nonprofit organization with over 40 years of experience helping elderly adults and adults with disabilities live as independently as possible. Community Care coordinates a full range of supportive services to help members live safely, confidently and with dignity.
- This course was created to meet the Model of Care training requirements established by of the Center for Medicare and Medicaid Services (CMS) for the Community Care Special Needs Plan (SNP).
- This course will also help employees and providers who work with Community Care's Special Needs Plan understand the Model of Care which is the essential framework for the program.

What is a Special Needs Plan?

Congress created special needs plans in 2003 as part of the Medicare Modernization Act (MMA).

SNPs are a type of Medicare Advantage plan serving specific groups of vulnerable Medicare beneficiaries.

The Partnership Program

Community Care offers a dual-eligible SNP for individuals who are enrolled in Medicare and eligible for Wisconsin Medicaid. Partnership integrates Medicare Parts A, B and D, and Medicaid long-term care services, sometimes called home and community based waiver services, through contracts with the Wisconsin Department of Health Services (DHS) and the Centers for Medicare and Medicaid Services (CMS).

Through this model of care, Community Care offers a broad range of comprehensive services across the entire continuum of care. Funding is provided through capitated payments from Medicare and Medicaid. Partnership is considered a fully integrated dual-eligible SNP because members receive all medical care, long-term care and prescription drugs from a single source and have no premiums or copays.

Who is Eligible for Partnership?

- Members must live in the Community Care service area which includes Milwaukee, Racine, Kenosha, Waukesha, Washington, Ozaukee, Calumet, Outagamie and Waupaca Counties in the State of Wisconsin.
- Members must be 18 years or older.
- Members must meet a state target group of frail elder, intellectual/developmental disability or physical disability.

Who is Eligible for Partnership? (continued)

- Members must meet a nursing home level of care.
- Members must be eligible for Wisconsin Medical Assistance (Medicaid).
- Members must be enrolled in Medicare Parts A, B and D, If eligible.

Medicare eligible members are enrolled in the Dual-Eligible SNP.

Although most Partnership members have Medicare and are enrolled in the SNP, a small number are only eligible for Medicaid.

Model of Care Requirements

As a dual-eligible SNP, Community Care is required to develop a written Model of Care (MOC) which is reviewed and approved by CMS on a regular basis.

CMS also requires employees and providers to receive training about the MOC to improve their understanding of the program and serve members more effectively.

Model of Care Elements

The Partnership Model of Care covers four main areas:

- Description of the SNP population
- Care Coordination
- Provider Network
- Quality Measurement and Performance Improvement

MOC 1: The SNP Population

Factors Associated with the Plan's Population

SNP Target Population Demographics

- 74% dual-eligible and 26 % Medicaid only
- 43% frail elders
- 23% adults with physical disabilities
- 34% adults with Intellectual/ developmental disabilities
- 77% between the ages of 55 and 101
- 4% are 90 or older
- 58% female and 42% male

MOC 1: The SNP Population

Factors Associated with the Plan's Population Health Conditions Impacting the Plan's Members

Based on data from the electronic medical record, the most prevalent health conditions in the Partnership population are:

- High cholesterol and other lipid disorders
- Falls
- Hypertension
- Diabetes
- Obesity
- Arthritis
- Incontinence
- Depression
- Coronary artery disease

MOC 1: The SNP Population

Factors Associated with the Plan's Population

Unique characteristics of the D-SNP population served - Most Vulnerable Members

- All members must meet a nursing home level of care and be financially eligible for Medicaid, but some members are more vulnerable and at risk than others.
- Community Care identifies vulnerable/high risk members through their assessments. Appropriate actions to mitigate risk for the most vulnerable members are documented in the member's care plan.
- Nurse Practitioners (NP) manage members with complex medical issues, serious mental health and substance abuse issues, multiple referrals and new diagnoses requiring increased oversight (i.e. cancer). Hospitalizations and repeat ER visits may also result in priority care from an NP.

MOC 2: Care Coordination

SNP Staff Structure

The staff structure section of the Model of Care describes the roles and responsibilities of employed staff having clinical and administrative responsibilities and performing oversight.

Community Care staff includes care managers who perform health risk assessments, develop a unique care plan for each member and assist members as they transition to Community Care providers.

Other staff essential to the implementation of the model of care include provider management, quality improvement and operational staff. Additional administrators provide oversight.

MOC 2: Care Coordination

Care Coordination:

Health Risk Assessment (HRA) and Health Risk Assessment Tool (HRAT)

The Health Risk Assessment (HRA) is the foundation of each member's individualized care plan.

Each member of the Partnership interdisciplinary care team (IDT) completes an assessment covering their professional discipline. They obtain medical information and learn about the member's social needs as well as considering the member's own goals and preferences.

Health Risks Assessments are completed as follows:

- Initial assessment
- Semi-annual assessment
- Annual assessment
- Change in condition assessment

MOC 2: Care Coordination

Care Coordination:

Health Risk Assessment (HRA) and Health Risk Assessment Tool (HRAT)

The **initial assessment** is completed by the nurse practitioner (NP), registered nurse (RN) and care manager (CM)(social worker). The initial HRA begins within 10 days of enrollment and must be completed within 30 days of enrollment.

The **semi-annual assessment** occurs six months from the member's enrollment date and is completed by the RN and CM. A targeted assessment by the NP is also completed if the member is determined to be high risk.

The **annual assessment** occurs 12 months from the member's enrollment date and is completed by the NP, RN and CM.

A **change of condition assessment** occurs when the interdisciplinary care team (IDT) identifies a need based upon a significant change in a member's health status.

MOC 2: Care Coordination

Care Coordination:

Health Risk Assessment (HRA) and Health Risk Assessment Tool (HRAT) (

The HRA typically takes place in person in the member's residence and is documented in the member's electronic medical record.

Community Care's HRAT is comprised of the assessments completed by each discipline, NP, RN and CM. Each discipline-specific assessment tool includes a series of electronic screens completed by staff and documented in the member's electronic medical record (EMR).

Staff is also required to make telephonic contact with each member in any month where a face-to-face meeting does not take place.

MOC 2: Care Coordination

Care Coordination Individualized Care Plan

A complete, unique Member-Centered Plan (MCP) for each member is completed within 60 days of enrollment.

The interdisciplinary care team (IDT) develops the MCP in person with the member, member's legal representative and anyone else chosen by the member. The member's participation is essential to the development of the MCP.

The MCP identifies all long-term care outcomes, services and supports based on information obtained during the comprehensive assessment which is:

- Sufficient to assure the member's health, safety and well-being;
- Consistent with the nature and severity of the member's disability or frailty; and
- Satisfactory to the member in supporting the member's outcomes.

The MCP is collaboratively developed following initial enrollment and reviewed/revised at least every six months and with any change in condition.

MOC 2: Care Coordination

Care Coordination

Care Plan Review

The MCP is shared with the member and/or legal representative and discussed to assure understanding and agreement with the plan. The member is asked to sign the MCP and is given a copy.

The care plan is shared with providers caring for the member including residential providers, supportive home care agencies and medical providers.

MOC 2: Care Coordination

Care Coordination Interdisciplinary Care Team (IDT)

Every member is assigned to an IDT which includes a nurse practitioner, registered nurse and care manager. The member, family members, member's legal decision maker and anyone else the member designates are also part of the team.

The primary care physician and other health care professionals may be part of the IDT depending on the member's needs.

Members also have access to other Community Care resources including a financial eligibility specialist, behavioral health specialist, rehabilitation specialist and the advanced disease support team which includes a palliative care NP and a chaplain.

MOC 2: Care Coordination

Care Coordination Interdisciplinary Care Team (IDT)

The IDT is responsible for ongoing assessments and care planning to be sure medical and long-term care needs are met.

Community Care seeks staff who are experienced in caring for elderly and disabled individuals.

All IDT staff receive initial training through a comprehensive onboarding program and are required to complete annual training to increase understanding of the program and the Model of Care and reinforce knowledge of the populations served and Community Care policies.

MOC 2: Care Coordination

Care Coordination Care Transitions

Community Care understands that care transitions can be a difficult time for members and takes steps to minimize the risk.

Community Care works to enhance continuity of care as changes occur:

- Within the practice setting;
- Between Community Care teams;
- Across the continuum of care; or
- Between both long-term and acute/primary care providers.

Face to face hand offs are conducted whenever a member's care is transitioned to a new Community Care team.

MOC 2: Care Coordination

Care Coordination Care Transitions

When members are unexpectedly admitted to a hospital:

- The care manager contacts the hospital discharge planning department.
- The NP contacts the hospital and maintains contact with the admitting physician throughout the hospital stay.
- The RN visits the member within one day of discharge to complete an assessment.
- Any member discharged from the hospital is followed by the NP for careful monitoring and follow-up contacts.

Community Care works closely with hospital staff to reduce readmissions.

Planned residential transitions involve the member, member's family and IDT staff to be sure placement is appropriate. The IDT makes regular visits to monitor care and determine if the member's outcomes are being met.

MOC 2: Care Coordination

Care Coordination Care Transitions

When a member's health status significantly changes:

- The IDT completes a reassessment and updates the member's care plan;
- A change of condition care plan is created; and
- The advanced disease support team may also be available to the member.

Care coordination required by transitions is best provided by the Interdisciplinary Care Team.

MOC 2: Care Coordination

Care Coordination Care Transitions

Staff members work together to develop goals and a common treatment plan but maintain professional responsibilities and individual assignments.

Duplication of efforts is minimized, and staff is able to leverage their skills.

Taking time to develop a relationship and build trust with the member is emphasized.

The transfer of timely and accurate information across settings is essential to quality care. Member information is transferred to and from providers by means of the plan's transfer form.

MOC 3: Provider Network

Specialized Expertise

Community Care has developed a broad provider network of long-term care and medical providers. They have the specialized expertise needed to care for the dual-eligible population and coordinate the delivery of Medicare and Medicaid services.

Provider expertise covers the full range of primary care and specialty medical providers as well as mental health specialists, residential providers and other specialists experienced in dealing with elderly and disabled populations.

The Provider Management Department has established standards and conducts an annual analysis of the number and geographic distribution of providers and facilities. This information is monitored to ensure the network is adequate and providers address the needs of the members.

MOC 3: Provider Network

Provider Network: Clinical Practice Guidelines

Community Care uses evidence-based and/or expert consensus-driven clinical practice guidelines. Guidelines include, but are not limited to:

- Milliman Care Guidelines
- Center for Disease Control (CDC) Guidelines for Vaccinations and Sexually Transmitted Diseases
- National Guideline Clearing House
- US Preventive Services Task Force (USPSTF)
- High Risk Medications in Older Adults - Beers Criteria
- American Geriatric Society Clinical Practice Recommendations
- Medicare
- Medicaid

MOC 3: Provider Network

Provider Network: Clinical Practice Guidelines

These guidelines are used as a standard for the preventative care and health care services and treatments that are offered to members. They are not intended to replace a clinician's judgment or establish a strict protocol for all members with a particular condition.

Preventive and disease management guidelines are built into the electronic medical record (EMR).

MOC 3: Provider Network

Provider Network Training

During the contracting process, providers receive an information packet from the Provider Management team highlighting key contract expectations and resources. The following information is included in the packet:

- Fraud, Waste and Abuse Prevention
- Provider Communication Requirements
- Member Rights Preservation
- Restrictive Measures Provider Requirements
- Member Grievance and Appeal Information
- Transportation Safety Tips
- Influencing the Exercise of Participant Freedom of Choice
- Comparison of Program Benefits

Providers are asked to visit Community Care's website to review Model of Care training, the Provider Handbook and other updates and information.

Quality Performance Improvement Plan

Community Care has an Annual Quality Plan which is reviewed by executive staff and approved by the Board of Directors.

The Quality Plan is responsive to CMS quality indicators and areas of DHS focus.

Measurable Goals and Health Outcomes for the MOC

Community Care has established several goals within the Model of Care:

- Improve quality of health care and service delivery while containing costs.
- Reduce fragmentation and inefficiency in the existing health care delivery system.
- Increase the ability of people to live in the community and participate in decisions regarding their own health care.

Measurable Goals and Health Outcomes

Community Care's SNP measures the success of the Model of Care through the following:

- Health Effectiveness Data and Information Set (HEDIS)

- Health Outcomes Survey Modified (HOS-M)

- Medicare Advantage Part C and Part D Data Validation

- Annual Quality Review (Conducted by MetaStar)

- Internal File Review to evaluate care management activities and improve member experience.

SNP Member Satisfaction

Member satisfaction is measured through:

Wisconsin Member/Legal Decision Maker Satisfaction Survey

Member Satisfaction Survey –

administered by the Wisconsin Department of Health Services

Health Outcomes Survey Modified (HOS-M)

Internal Member Satisfaction Surveys

Performance Improvement Evaluation

Community Care quality improvement activities include DHS and CMS approved Performance Improvement Projects (PIPs) and a Chronic Care Improvement Program (CCIP).

Community Care sets quality goals and establishes metrics to evaluate progress toward meeting the goals. All staff can access the Quality Scorecard to see how well target goals are met.

The Quality Department completes internal file reviews (IFRs) on a monthly basis and provides feedback to IDTs with immediate remediation for critical concerns.

Dissemination of SNP Quality Performance

Community Care uses many strategies to share operational, financial and program performance status.

Regular communication takes place with several different audiences including:

- Management and staff;
- Board of Directors and board appointed subcommittees;
- Potential members;
- Members and their families and/or legal decision makers;
- Network providers;
- Regulatory agencies and government entities; and
- General public.

Summary

Partnership is a fully-integrated, dual-eligible Special Needs Plan (SNP). Individuals must live in the Community Care service area, be enrolled in Medicare and eligible for Wisconsin Medicaid in order to enroll.

Each member works with an interdisciplinary care team to complete assessments and reassessments and complete a unique, individual care plan.

Community Care's provider network is knowledgeable and able to provide the special care needed by Partnership members.

Summary

Community Care continually monitors the quality of service and care to ensure that members have:

- The medical and long-term care services needed to achieve their health outcomes;
- Coordinated care and transitions through an interdisciplinary team;
- A unique member-centered care plan revised as conditions change;
- Input into the services and supports they receive and the providers they use; and
- The ability to live as independently as possible.

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