UNIVERSITY of MARYLAND
HEALTH ADVANTAGE

2020 Model of Care Training

Model of Care Training

- This course is offered to meet CMS regulatory requirements for Model of Care Training with our Special Needs Plans.

- It also ensures all employees and providers who work with our Special Needs Plan members have the specialized training this unique population requires.

Model of Care Training

- The Model of Care (MOC) is University of Maryland Health Advantage's (UMHA) documentation of the CMS directed plan for delivering coordinated care and case management to members within a Dual Special Needs Plan (DSNP).
- The Centers for Medicare and Medicaid (CMS) require all UMHA staff and contracted medical providers to receive basic training about the UMHA duals program Model of Care (MOC).
- This course will describe how UMHA and its contracted providers work together to successfully deliver the duals MOC program.

Training Objectives

After the training, attendees will be able to:

- Describe the basic components of the UMHA Model of Care (MOC).
- Explain how UMHA medical management staff coordinates care for dual eligible members.
- Describe the essential role of providers in the implementation of the MOC program.
- Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT).

DSNP

- Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:
  - Dually eligible members (D-SNP)
  - Individuals with chronic conditions (C-SNP)
  - Individuals who are institutionalized or eligible for nursing home care (I-SNP)
- Health plans may contract with CMS for one or more programs.

  UMHA currently contracts for D-SNP only
- For D-SNP members, Medicare is always the primary payer and Medicaid is secondary payer.

What is the SNP Model of Care (MOC)?

- The SNP MOC is the plan for delivering case management and services for UMHA members with special needs. It sets guidelines for:
  - Staff structure and Care Management roles
  - The interdisciplinary care team
  - Provider network having special expertise and use of Clinical Practice Guidelines
  - A member health risk assessment (HRA)
  - Assessment and case management of members
  - Communication among members, caregivers, and providers
  - Integration of the primary care physician (PCP)
  - Model of Care training
  - Measurable program goals

What are the SNP MOC Goals for our UMHA members?

The SNP MOC Goals for our members fall into six categories:

1. Improve Access to medical, mental health, social services, affordable care and preventative health services
2. Improved Coordination of Care through an identified point of contact
3. Improved Transitions of Care across health care settings and practitioners
4. Assure Appropriate Utilization of services
5. Assure Cost-Effective service delivery
6. Improve Beneficiary Health Outcomes

Interdisciplinary Care Team Goals

The goals of the MOC are achieved by the coordinated efforts of the Interdisciplinary Care Team (ICT).

- The ICT, together with input from the member, collaborate to develop and update their individualized care plan.
- The team manages the medical, cognitive, psychosocial and functional needs of the member.
- The team communicates on the coordination of the care plans.
- Through the team, problems/opportunities can be identified and possible resolutions can be presented to assist the member achieve solutions to health or care issues.

ICT Functions

- Inpatient and complex case and disease management, care coordination
- Primary medical care management to members in long term, transitional care and assisted living facilities
- Assessment of emotional, behavioral and cognitive problems, behavioral health case management
- Data collection and analysis of program goals
- ICT members include: The member/primary care giver, nurses, physicians, pharmacists, licensed clinical social workers and care coordination technicians. Additional health care disciplines may be included as appropriate.
- If providers of care are needed at one of these meetings, we make every effort to accommodate their schedule.

ICT Functions (cont.)

- Regular care coordination and case roundtable meetings to discuss healthcare needs of frail members requiring care coordination.
- ICT members include: The member/primary care giver, nurses, physicians, pharmacists, licensed clinical social workers, care coordination technicians. Additional health care disciplines may be included as appropriate.
- If providers of care are needed at one of these meetings, we make every effort to accommodate their schedule.

The goal of the UMHA is to support and work with our providers and members with the goal of moving our members toward their optimal health status.

How does our SNP MOC operate?

- Every SNP member is evaluated annually with a Health Risk Assessment (HRA)
- A UMHA case manager develops an individualized care plan (ICP) with input from the member, the member's interdisciplinary care team (ICT) and the member's caregiver/family
- Case managers and the PCPs work closely together to monitor the ICP

Role of the Provider in the ICT Team

Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with:

  -UMHA Case Managers

  -Members of the Interdisciplinary Care Team (ICT)

  -Members and caregivers

CMS Expectations for ICT

CMS expects the following related to the ICT:

- All care is per member preference
- Family members and caregivers are included in health care decisions as the member desires
- There is continual communication between all members of the ICT regarding the member's plan of care
- All team meetings/communications are documented and stored
- All team members are involved and informed in the coordination of care for the member
- All team members must be advised on the ICT program metrics and outcomes

All internal and external ICT members are trained annually on the current Model of Care

Provider Network

UMHA is responsible for maintaining a specialized provider network that corresponds to the needs of our members.

UMHA coordinates care and ensures that providers:

- Collaborate with the Interdisciplinary Care Team
- Provide clinical consultation
- Assist with developing and updating care plans
- Provide pharmacotherapy consultation

University of Maryland Health Advantage Case Management Programs

Identification for Care Management

- Inpatient Status
- HRA
- Monthly Risk Stratification
- Community Referrals
- Physician/Specialist Referrals

Identification of Member Needs

- Comprehensive Health Assessment
- Individualized Care Plan

Case Management Programs

- Integrated Case Management/Point of Contact Assessments/Care Planning
- Care Transitions
- Post Acute care Follow Up
- Pharmacy Medication Therapy Management
- SNF/LTC Care Management

Individualized Care Plan (ICP)

- The individualized care plan is the initial and ongoing mechanism of evaluating the member's current health status and formulating an action plan to address care needs and gaps in care in conjunction with the ICT and member.

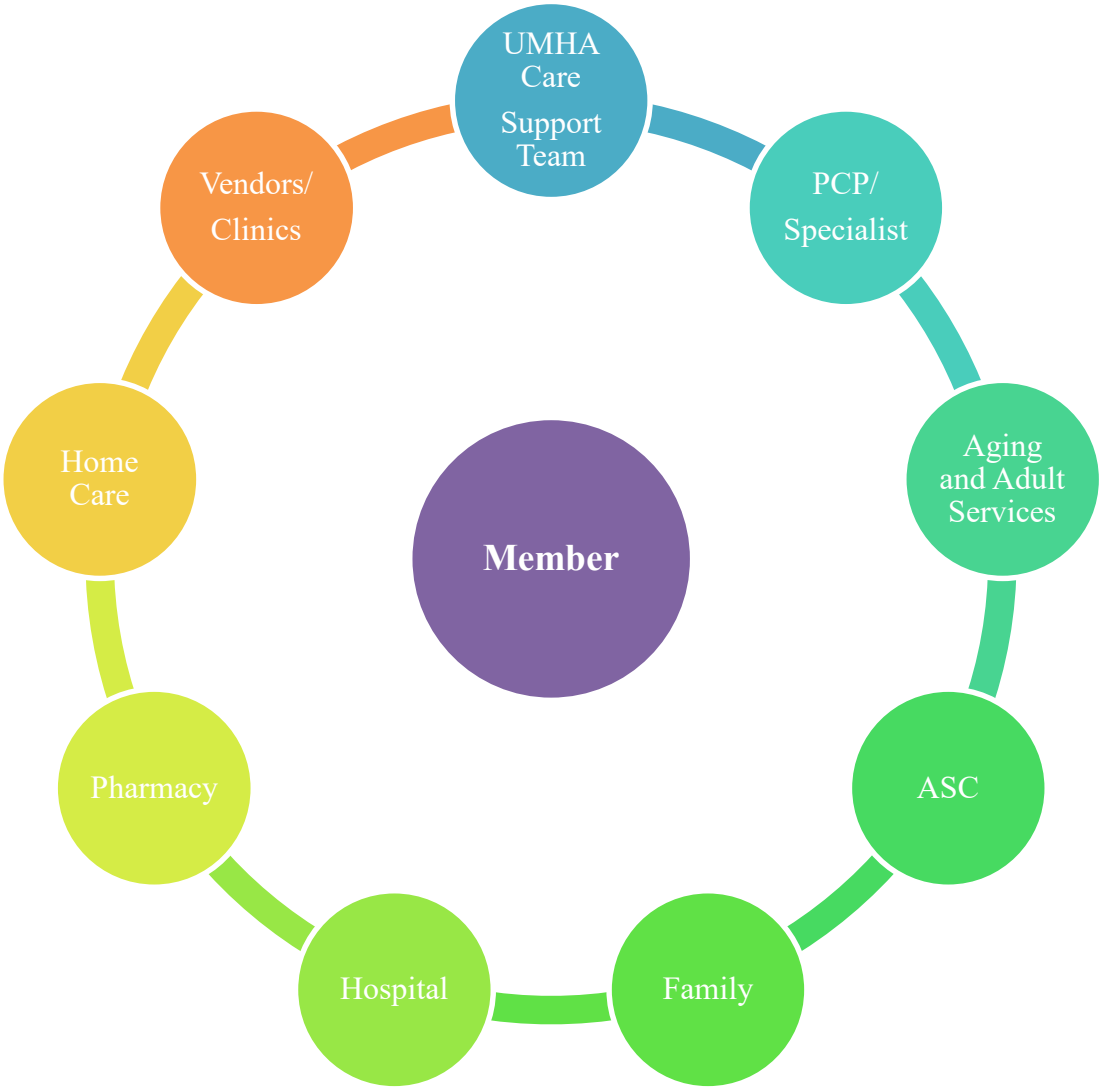
- The individualized care plan is re-evaluated on a regular basis or if the member's health status has a substantial change, such as hospitalization.

Inpatient Case Management

- Our plan Nurse Case Managers coordinate with the hospital interdisciplinary team to ensure a smooth transition through the continuum of care.
  - Identification of discharge planning needs and service coordination
  - Post acute/SNF follow-up by UMHA Transition Care Coordinators
  - Communication continuity with PCP

Keys to Care Coordination

UMHA's program is member centric with the PCP being the primary point of contact.



How do we know if we achieved our goals?

- Monitoring of :
  - Reduction in hospitalizations, ED usage and SNF placements
  - Improvement in self-management and independence
  - Improving quality of life and satisfaction with health services and health status

The mission of the University of Maryland Health Advantage Plan is to improve the health of our members through high quality and preventive care.

We strive daily to make a difference in our community, to turn our vision of better health for everyone into a reality.

Thank you for being a valued provider.

The Provider Relations Team