VNSNY CHOICE

VNSNY CHOICE- Care Management

9.1- Overview for all VNSNY CHOICE Members

Care Management- Medicare Advantage Program

The purpose of the Care Management Program is to:

1. Increase disease prevention and reduce disease progression
2. Promote early detection of serious medical problems
3. Promote member outreach and education to assist members in achieving independence through self-care
4. Establish a collaborative relationship between VNSNY CHOICE and the providers caring for the member through information sharing.

VNSNY CHOICE Medical Management staff clinically and administratively identify, coordinate, and evaluate the services delivered to members with complex, acute and chronic needs on a case-by-case basis. The Care Management program is designed to coordinate the delivery of both short and long-term health services for those members identified with special needs because of their medical or mental status. The coordination occurs regardless of the care setting, responds to the total health needs of the member, and attempts to assure the highest quality of care is being delivered to the member in the most appropriate setting for the member’s medical condition. All Care Management activity includes collaboration with the PCP and other attending providers.

For VNSNY CHOICE Medicare Advantage plan members, care management is inclusive of utilization management where authorization of inpatient hospital admissions, acute and sub acute rehabilitation requests as well as outpatient services are reviewed using MCG® (formerly known as Milliman Care Guidelines), a nationally recognized set of evidence based guidelines.

Identifying Members with Significant Potential for Health Improvement

As part of the Care Management Program, VNSNY CHOICE conducts a health risk assessment for all members within 90 days of enrollment to initially identify members with chronic diseases and special health care needs and stratifies them according to severity levels. This includes identifying members with significant potential for improvement; members with a catastrophic illness, chronic diseases, traumatic injury, special care needs involving difficult circumstances, or the need for multiple services requiring assistance.

This allows our Medical Management staff to tailor education and related assistance including disease management and care management programs, when appropriate, based on the member’s specific needs.
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9.1- Overview for all VNSNY CHOICE Members

Care Management- Medicare Advantage Program (cont.)

A member may self-refer, or be referred by the member’s family, provider, or VNSNY CHOICE staff to any of our Care or Disease Management Programs. In addition, regular analysis of health care, quality and utilization data is performed to identify members with special medical needs, including but not limited to:

- Sentinel diagnoses
- Recurrent inpatient episodes of care
- Members with health care costs above a predetermined level
- Pharmacy data analysis
- Medical record and laboratory data analysis identifying members with poorly controlled medical conditions
- Medical coordination for those members receiving behavioral health care who are identified as having significant unmet or unstable medical problems.

Physician Collaboration

The cornerstone of the VNSNY CHOICE Care Management program is effective collaboration with participating primary physicians. These collaborative relationships will include:

1. Identification of individuals appropriate for disease management, working with participating physicians and office staff.
2. Development and implementation of member-specific care plans, using evidence-based treatment regimens that will be coordinated by the physician and care manager.
3. Patient education, focused on supporting self-care management and monitoring.
4. Care manager feedback to physicians regarding patient status and clinical needs.
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9.1- Overview for all VNSNY CHOICE Members

**Care Management- Managed Long Term Care**

A VNSNY CHOICE Care Coordinator is assigned to each member based on a member’s geographic location or care needs and is responsible for care across all settings, i.e. community, hospital, or nursing home. Upon enrollment and if there is a change, members are given the contact number for their Care Coordinator.

The Care Manager assigned to the member is responsible for initial assessment, ongoing monitoring and reassessment, coordination and authorization of services. This will be done in collaboration with the member’s physician, team members and other disciplines within VNSNY CHOICE, its network, and the community. Care Managers are responsible for coordinating covered and non-covered services.

Care planning is further supported through VNSNY CHOICE’s cooperative agreement with VNSNY Home Care’s Clinical Triage Unit, which provides 24 hour/365 days nursing telephone consultation (live voice) and, when necessary, nursing or home health aide services in the home.

Care management is also supported by contracts with network providers specifying responsibility for timely initiation of services, adherence to VNSNY CHOICE standards of care and participation in joint planning and written and verbal communication.

The Care Coordinator also utilizes formal and informal linkages with community services in planning care. This includes community resources, reflecting programs and services available in the neighborhoods served by each team. In addition, Social Workers, participate in clinical conferences and interdisciplinary rounds. These meetings, focused on developing care management strategies may also include medical directors, clinical pharmacist, rehabilitation consultants, behavioral health specialists and nurse practitioners who are available to staff for consultation on members who present with multiple comorbid conditions and complex psychosocial problems.

The Care Coordinator, through ongoing assessment of members in hospitals and nursing homes, will regularly consult with facility staff to ensure an appropriate and effective inpatient plan of care that seeks to improve and stabilize the member’s health status and aid in the return of the client to the community, where possible.

Care management is an ongoing process. Through home visits, telephone contacts with members, caregivers, and communication with physicians, hospitals, disciplines and programs, the Care Manager is in touch with the member and their families about his/her condition and progress. As part of this process, the Care Manager is able to identify the need for further intervention, including the need for urgent or emergency services.
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9.1- Overview for all VNSNY CHOICE Members

Care Management- SelectHealth
The purpose of VNSNY CHOICE’s Care Coordination Program is to provide a process in collaboration with the member, family, caregiver, physician(s) and other health care providers that focus on member education, advocacy and empowerment. The Care Coordination Program strives to enhance the member’s quality of life by creating continuity of care, facilitating provision of services in the appropriate setting, and managing resource allocation to promote high quality, cost-effective outcomes.

Clinical Care Coordination
VNSNY CHOICE’s Clinical Care Coordination program ensures that the member’s medical, behavioral, psycho-social support, and community-based intensive care management service needs are coordinated by all providers involved in the member’s care, including the PCP and the medical case manager. The CEM ensures that a Patient Centered Service Plan (PCSP) addresses identified member needs and that medically appropriate service utilization addresses the opportunities, goals and interventions of the PCSP.

The objectives of VNSNY CHOICE’s Clinical Care Coordination Program are as follows:

• To plan, implement, monitor and evaluate services to meet an individual’s health needs in order to promote high quality, cost-effective outcomes.

• To identify members with complex health care needs who would benefit from medical care coordination intervention.

• To monitor and document the member’s on-going care needs.

• To coordinate member care in collaboration with physicians, the member, care providers and family.

• To identify and recommend alternative care options and prevent hospitalization when feasible.

• To develop and implement disease management for appropriate members in accordance with the standards of care of New York State Department of Health, the AIDS Institute, and other professional specialty groups.

• To evaluate clinical services through close contact with physicians, ancillary service providers, behavioral health specialist and members of the interdisciplinary team, engaging in continuous quality improvement.
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9.1- Overview for all VNSNY CHOICE Members

Clinical Care Coordination Process

- All VNSNY CHOICE members, if new to a care site and/or provider, will be assessed by a PCP within 30 days of the effective date of enrollment.

- The CEM monitors clinical services through close contact with physicians, ancillary service providers, community and faith based resources and members of the interdisciplinary team, as deemed appropriate, to help ensure the provision of high quality care. If the member is hospitalized, the VNSNY CHOICE CEM will remain in close contact with the member’s Case Manager, the hospital social worker, and UR department, as applicable, in order to facilitate an evaluation of the patient’s and family’s ability to comply with an agreed-upon treatment plan and facilitate an appropriate discharge plan.

- If medically appropriate, the CEM discusses alternative care options with the member and his/her PCP. Alternative care providers include, but are not limited to:
  - Home Health Services
  - Rehabilitation Facilities
  - Hospice (in or outpatient)
  - Skilled Nursing Facilities
  - Transitional Care Units
  - Sub-Acute Facilities
  - Long Term Care Facilities
  - Referred Community Resources
  - Behavioral Health Providers

Clinical Care Coordination is an important component of VNSNY CHOICE’s overall Quality Improvement Program. Specifically, the CEM helps set and monitor performance standards and measurable clinical outcomes.

Health Home Community-Based Intensive Case Management is defined as comprehensive family-centered case management with frequent contact by a team of case managers, case management technicians, and community follow-up workers. Intensive case management is designed for patients with multiple complex needs who require home visits, active community follow-up and frequent contacts. HIV COBRA intensive case management may be carried out only by an entity designated by the New York State Department of Health AIDS Institute.

VNSNY CHOICE has service agreements with community-based organizations, referrals to participating psychosocial support service providers, (e.g. housing, nutritional service agencies), and communicates the support plan with the member’s PCP. The provision of psychosocial case management services is monitored through the Psychosocial Committee of VNSNY CHOICE’s Quality Improvement Program.
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9.1- Overview for all VNSNY CHOICE Members

Care Management- FIDA Complete

The purpose of the Care Management Program is to:

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For VNSNY CHOICE FIDA plan members, care management is inclusive of utilization management where authorization of inpatient hospital admissions, acute and sub acute rehabilitation requests as well as outpatient services are reviewed using MCG ® (formerly known as Milliman Care Guidelines), a nationally recognized set of evidence based guidelines.
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A member may self-refer, or be referred by the member’s family, provider, or VNSNY CHOICE staff to any of our Care or Disease Management Programs. In addition, regular analysis of health care, quality and utilization data is performed to identify members with special medical needs, including but not limited to:

- Sentinel diagnoses
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1. Identification of individuals appropriate for disease management, working with participating physicians and office staff.
2. Development and implementation of member-specific care plans, using evidence-based treatment regimens that will be coordinated by the physician and coordinated care manager.
3. Patient education, focused on supporting self-care management and monitoring
4. Coordinated care manager feedback to physicians regarding patient status and clinical needs
VNSNY CHOICE

9.2- Models of Care for all VNSNY CHOICE Medicare and FIDA Members

Medicare Model of Care

The VNSNY CHOICE Medicare Advantage Special Needs Plan model of care is a structural framework guiding care management policies and operational systems for Medicare and Medicaid beneficiaries. Our model complies with requirements of the Center for Medicare and Medicaid Services (CMS) and MIPPA (Medicare Improvements for Patients and Providers Act).

Model of Care Goals

• Improve access to affordable care, preventive, medical, mental health and social services

• Improve coordination of care via integrated care planning

• Improve seamless transitions of care

• Assure appropriate utilization of services

• Improve beneficiary health outcomes

All beneficiaries are auto enrolled in care management upon enrollment in the SNP. The Health Risk Assessment (HRA) completed by our staff of clinicians is the evaluation tool to identify aspects of care and specialized needs of members related to medical, functional, psychosocial and cognitive/mental status.

An individualized care plan with opportunities, goals and interventions is developed and updated by the member’s Care Manager. It is used to manage and monitor the member’s care, needs and progress toward goals.

The Interdisciplinary Care Team (ICT) is dedicated to quality and accountability in ensuring appropriate care and services are consistent with best practice, CMS guidelines and the VNSNY CHOICE mission. The ICT collaborates to determine the best course of action to facilitate meeting the medical, psychosocial, cognitive and functional needs of the beneficiary in a timely, cost effective manner.

Participants of the VNSNY CHOICE ICT may include but is not limited to nursing professionals, hospice and palliative care professionals, senior medical management staff, and Quality Management staff. In addition, a clinical pharmacologist, a rehabilitation consultant, behavioral and social services experts, medical directors and other clinicians are also involved as appropriate.

An overview of the VNSNY CHOICE Medicare Advantage model of care is available on our website www.vnsny.org or available by contacting the Provider Relations Department.
Medicare Model of Care (cont.)
Complex Cases Requiring Additional Treatment Planning and Specialty Review
It is the policy of VNSNY CHOICE that each member must be provided quality care throughout the period of illness, facilitating transition between the appropriate levels of care as required, within the appropriate time frames, ensuring continuous and appropriate interventions. Through the Utilization Management process, VNSNY CHOICE will work with its participating providers to identify individuals with complex or serious medical conditions. Once identified, the Medical Management staff will work with the member’s PCP and/or appropriate participating specialists to:

1. Assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis
2. Establish and implement a treatment plan that is appropriate to the Member’s conditions.

FIDA Complete Model of Care
The VNSNY CHOICE FIDA model of care is a structural framework guiding care management policies and operational systems for Medicare and Medicaid beneficiaries. Our model complies with requirements of the Center for Medicare and Medicaid Services (CMS) and MIPPA (Medicare Improvements for Patients and Providers Act).

Model of Care Goals

• Improve access to affordable care, preventive, medical, mental health and social services
• Improve coordination of care via integrated care planning
• Improve seamless transitions of care
• Assure appropriate utilization of services
• Improve beneficiary health outcomes

All beneficiaries are auto enrolled in care management upon enrollment in the SNP. The Health Risk Assessment (HRA) completed by our staff of clinicians is the evaluation tool to identify aspects of care and specialized needs of members related to medical, functional, psychosocial and cognitive/mental status.

An individualized care plan with problems, goals and interventions is developed and updated by the member’s Coordinated Care Manager. It is used to manage and monitor the member’s care, needs and progress toward goals. The Interdisciplinary Care Team (ICT) is dedicated to quality and accountability in ensuring appropriate care and services are consistent with best practice, CMS guidelines and the VNSNY CHOICE mission. The ICT collaborates to determine the best course of action to facilitate meeting the medical, psychosocial, cognitive and functional needs of the beneficiary in a timely, cost effective manner.
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VNSNY CHOICE- Care Management

9.2- Models of Care for all VNSNY CHOICE Medicare and FIDA Members

FIDA Complete Model of Care (cont.)

Participants of the VNSNY CHOICE ICT include nursing professionals, hospice and palliative care professionals, senior medical management staff, and Quality Management staff. In addition, a clinical pharmacologist, a rehabilitation consultant, behavioral and social services experts, medical directors and other clinicians are also involved as appropriate.

An overview of the VNSNY CHOICE FIDA model of care is available on our website www.vnsny.org or available by contacting the Provider Relations Department.

Complex Cases Requiring Additional Treatment Planning and Specialty Review

It is the policy of VNSNY CHOICE that each member must be provided quality care throughout the period of illness, facilitating transition between the appropriate levels of care as required, within the appropriate time frames, ensuring continuous and appropriate interventions.

Through the Utilization Management process, VNSNY CHOICE will work with its participating providers to identify individuals with complex or serious medical conditions. Once identified, the Medical Management staff will work with the member’s PCP and/or appropriate participating specialists to:

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