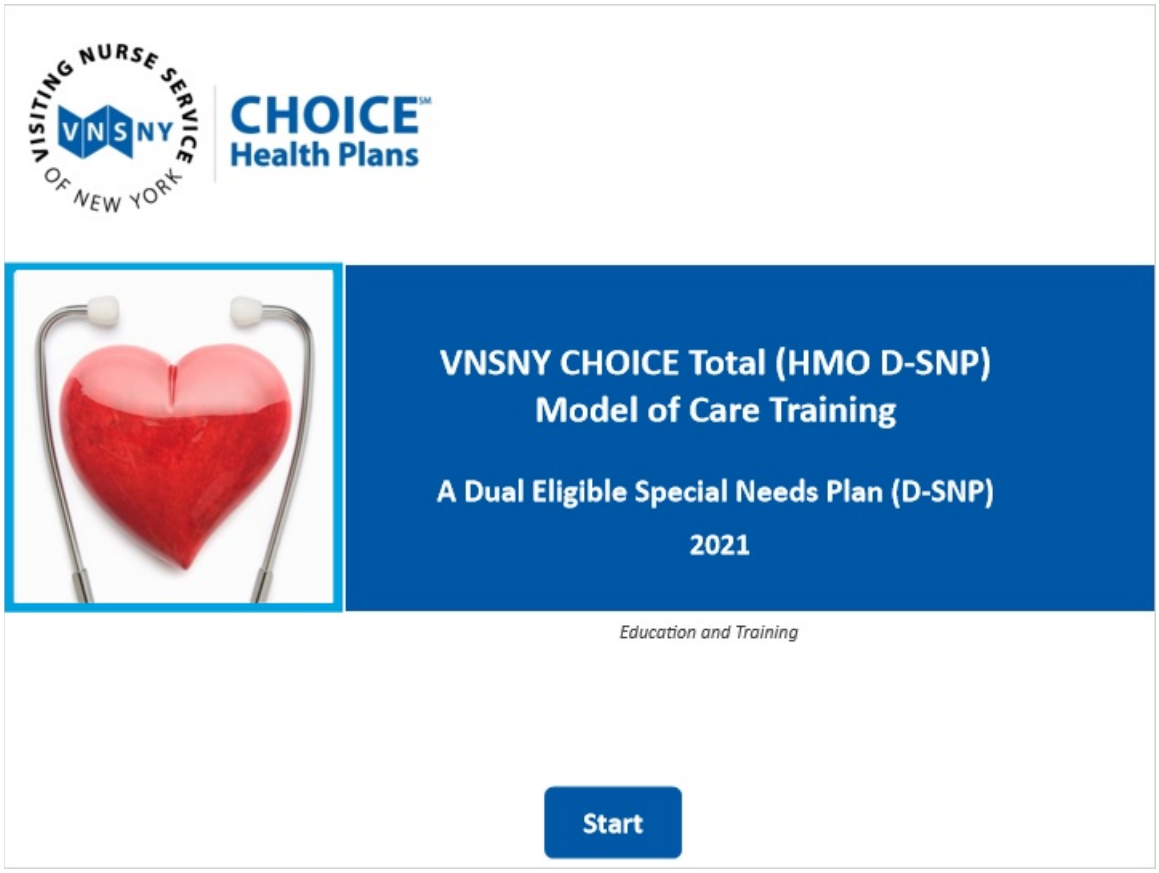
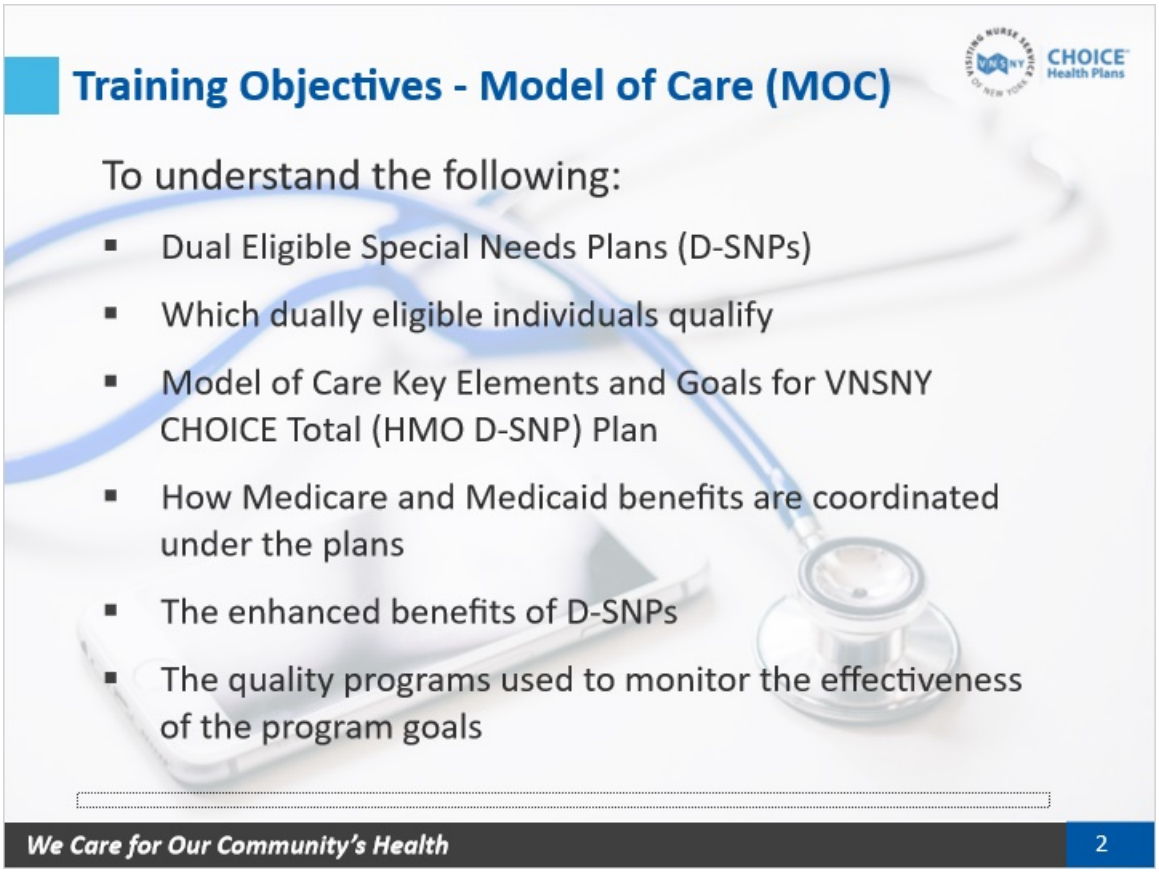
2021 MA Model of Care - Dec. 2020



Notes:

Welcome to this training on the VNSNY CHOICE Total Model of Care.

1.2 Training Objectives—Model of Care (MOC)



Notes:

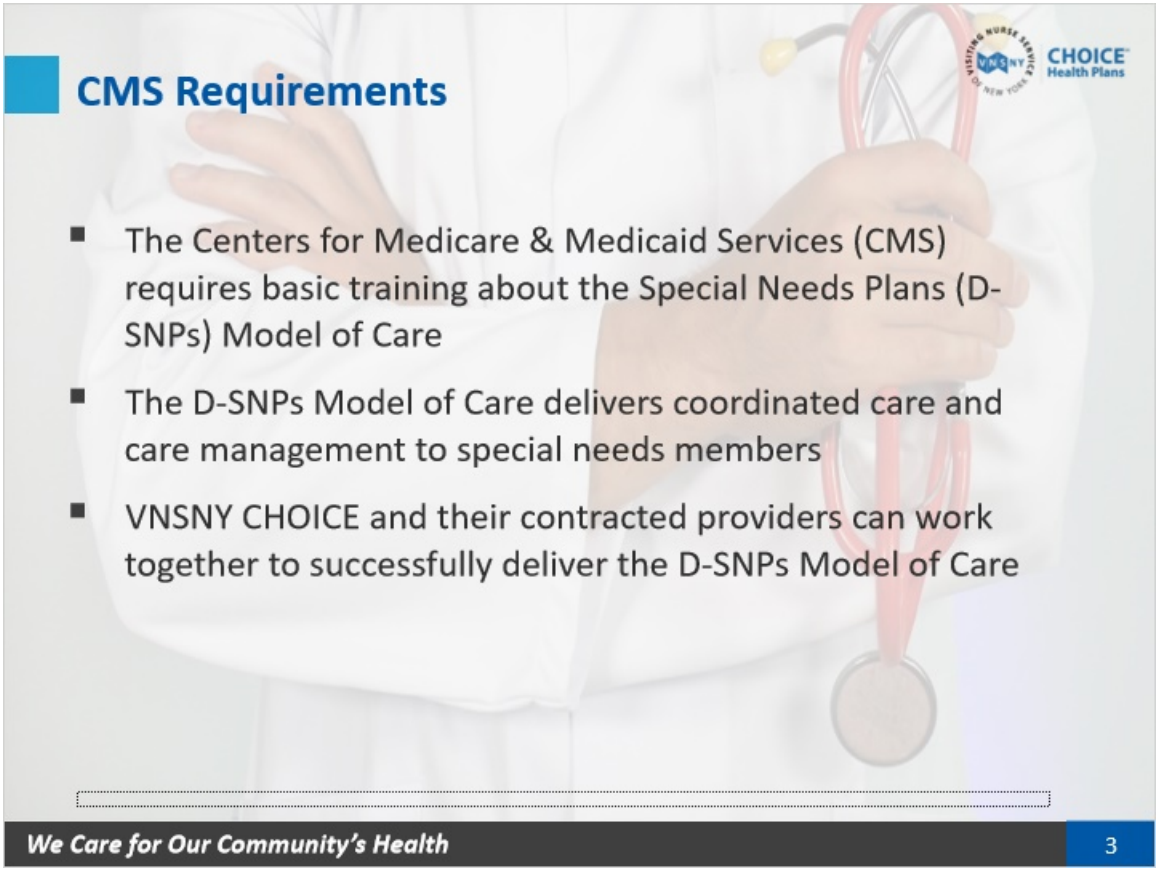
This presentation will outline the different components of our VNSNY CHOICE Total Health Plan Model of Care and is intended to provide a broad overview of how VNSNY CHOICE Total addresses the member's needs and achieves positive outcomes. By the end of this training module you will be able to:

- Explain Dual Eligible Special Needs Plans (D-SNPs)
- Describe which dually eligible individuals qualify for these plans
- Describe the Model of Care key elements and goals for VNSNY CHOICE's Total HMO SNP Plan
- Describe how Medicare and Medicaid benefits are coordinated under the plans
- Describe the enhanced benefits of D-SNPs

And Describe the quality programs used to monitor the effectiveness of the program goals.

Please note: Model of Care will be abbreviated as M O C throughout this presentation.

1.3 CMS Requirements



Notes:

CMS Requirements
The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff receive basic training about the Special Needs Plans Model of Care.
The SNP's Model of Care is the plan for delivering coordinated care and care management to special needs members.
This course will describe how VNSNY CHOICE and their contracted providers can work together to successfully deliver the SNP's Model of Care.

1.4 VNSNY CHOICE Total

Notes:

VNSNY CHOICE Total

The VNSNY CHOICE DSNP plan currently operates throughout New York City in the Bronx, Kings, New York, Queens and Richmond Counties), as well as Westchester and Long Island's Nassau & Suffolk Counties.

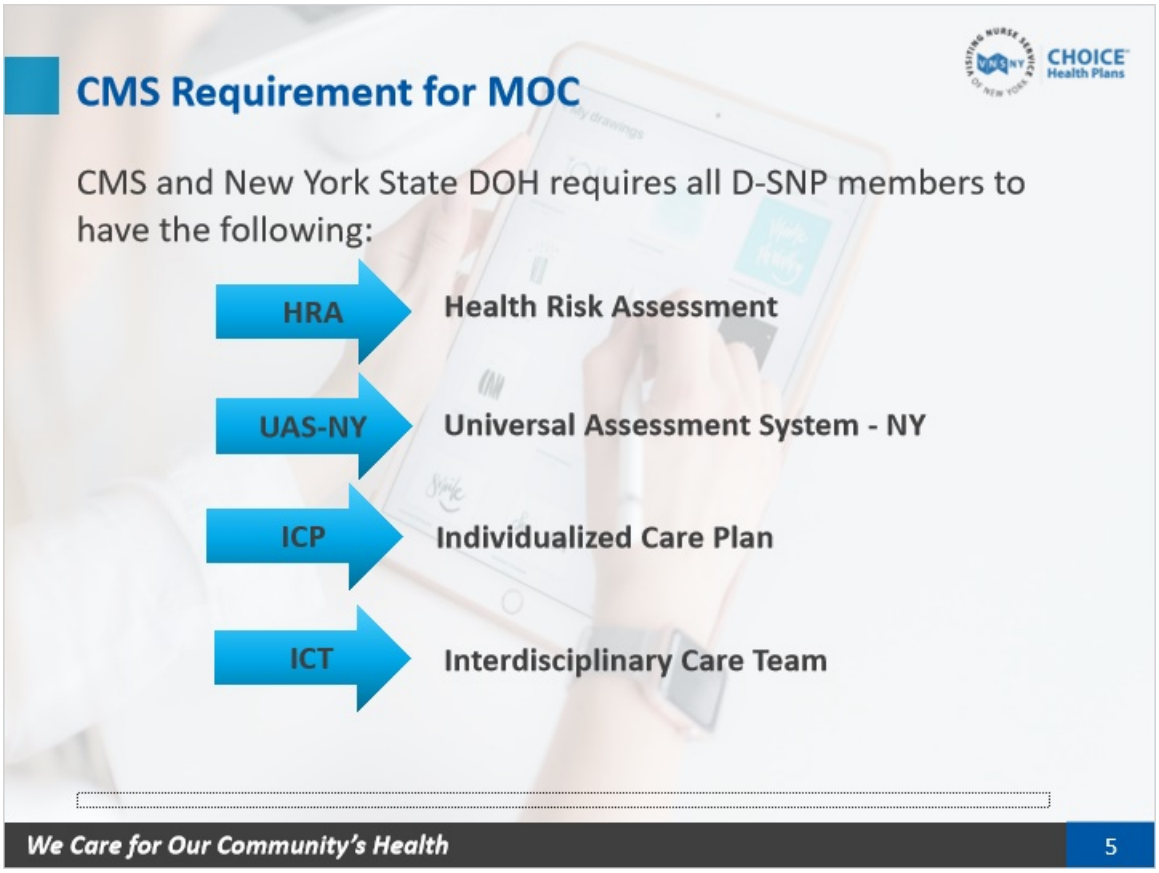
VNSNY CHOICE DSNP draws its membership from individuals residing in the greater New York City area community.

A significant proportion of these individuals have medical co-morbidities.

Dual eligible Medicare beneficiaries are generally poorer and have worse health status' than other Medicare beneficiaries. On average, they have 25 percent more chronic conditions than other Medicare beneficiaries.

Applicants must have Medicare and Medicaid and need to be clinically eligible based on a comprehensive assessment using the Uniform Assessment System UAS New York tool. Enrollment into the DSNP program requires approval from both CMS and DOH.

1.5 CMS Requirement for MOC

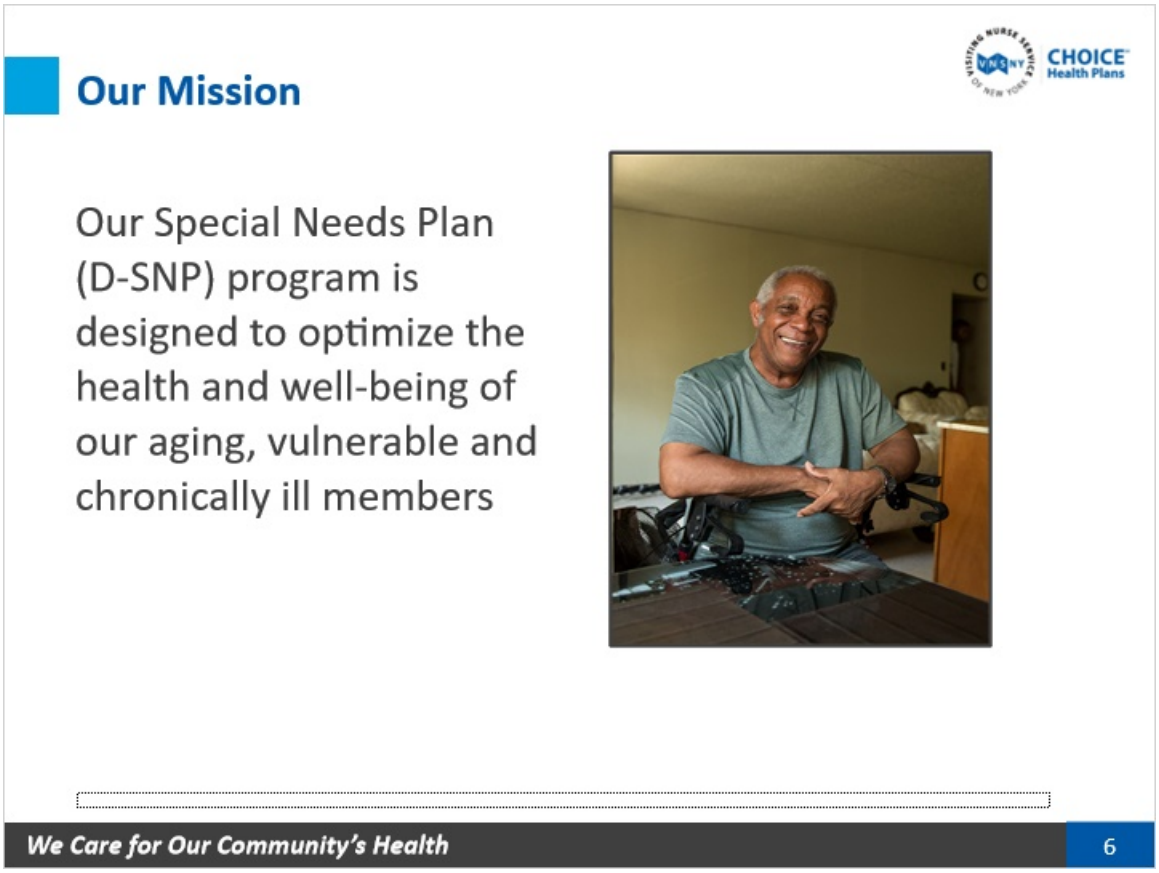


Notes:

CMS requires all DSNP members have the following:

- A health risk assessment
- A universal assessment done via UAS NY
- An individualized care plan
- And a interdisciplinary care team

1.6 Our Mission



Notes:

Our Special Needs Plan program is designed to optimize the health and well-being of our aging, vulnerable and chronically ill members.

1.7 MOC Goals

Notes:

Model of Care Goals
The Model of Care is a plan for delivering care management and care coordination to improve quality, Improve access, Create affordability, Integrate and coordinate care across specialties, Provide seamless transitions of care, Improve use of preventive health services, Encourage appropriate utilization and cost effectiveness, And improve the member's health and experience.

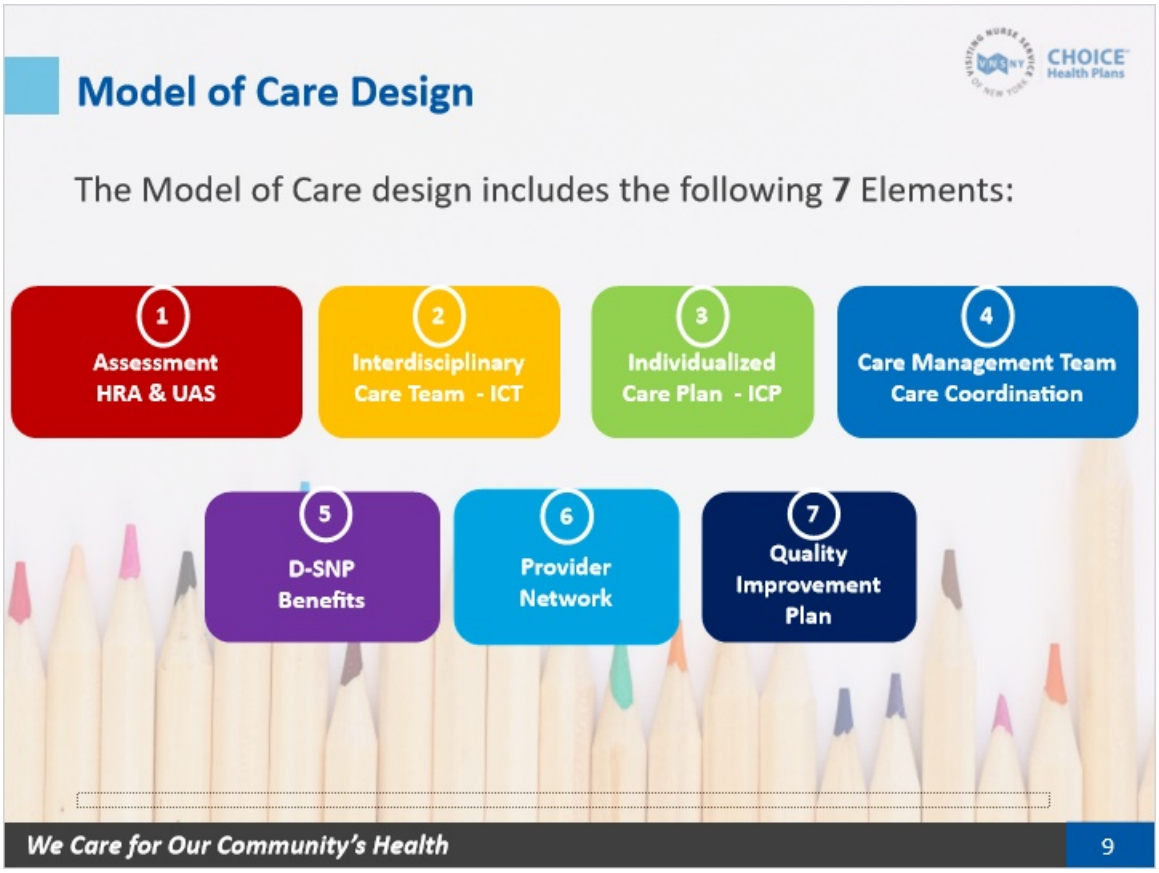
1.8 MOC Goals (Cont'd)

Notes:

The goal of our DSNP plan is to improve quality, reduce costs and improve the member experience.

This can be accomplished by improving access to care and improving coordination of care, as members navigate the health continuum to improve their health outcomes and quality of life.

1.9 MOC Design



Notes:

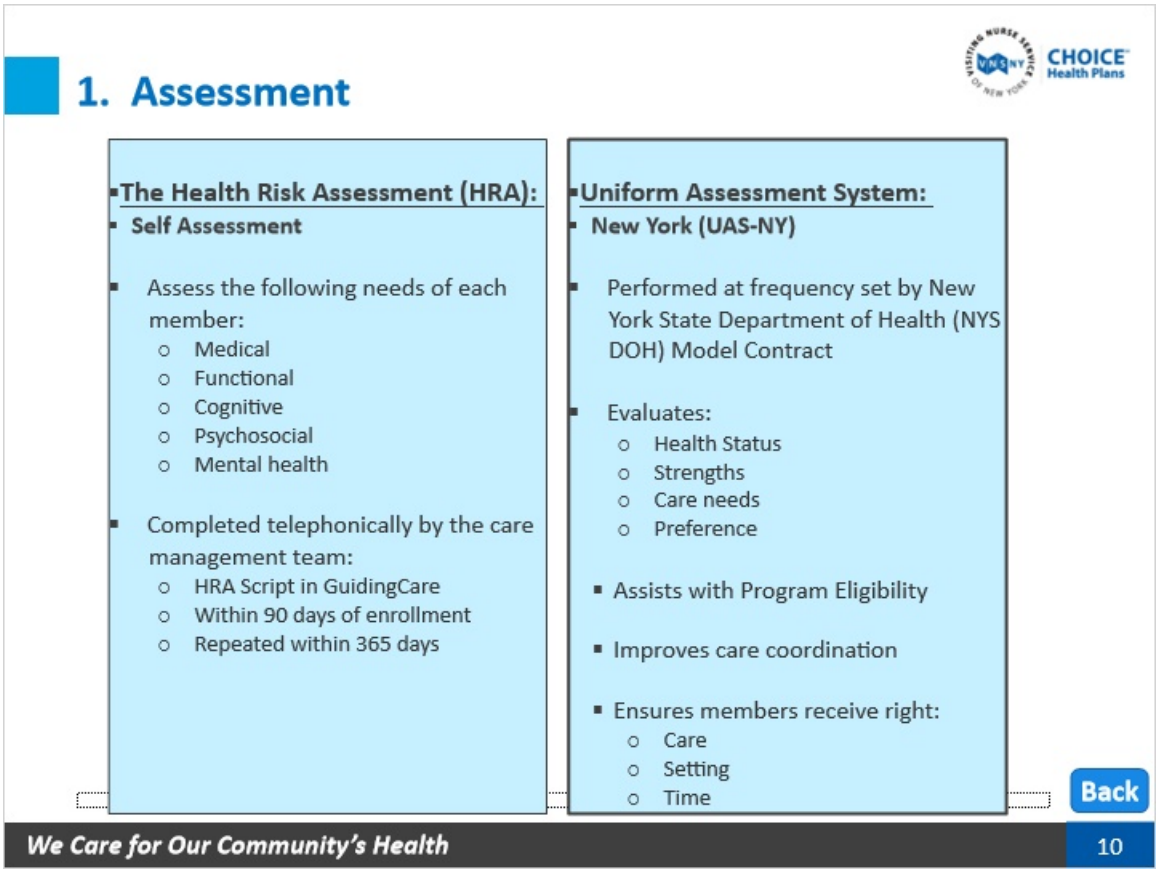
The Model of Care design includes the following 7 elements:

- An Assessment; like the Health Risk Assessment (HRA) And Uniform Assessment System - New York (UAS-NY),
- An Interdisciplinary care team (ICT),
- An Individualized care plan (ICP),
- Care Management Team, Care Coordination,
- DSNP benefits
- A Provider Network

And a Quality Improvement Plan (QIP)

We will review each one of these elements in the model of care design.

1.10 1. Assessment

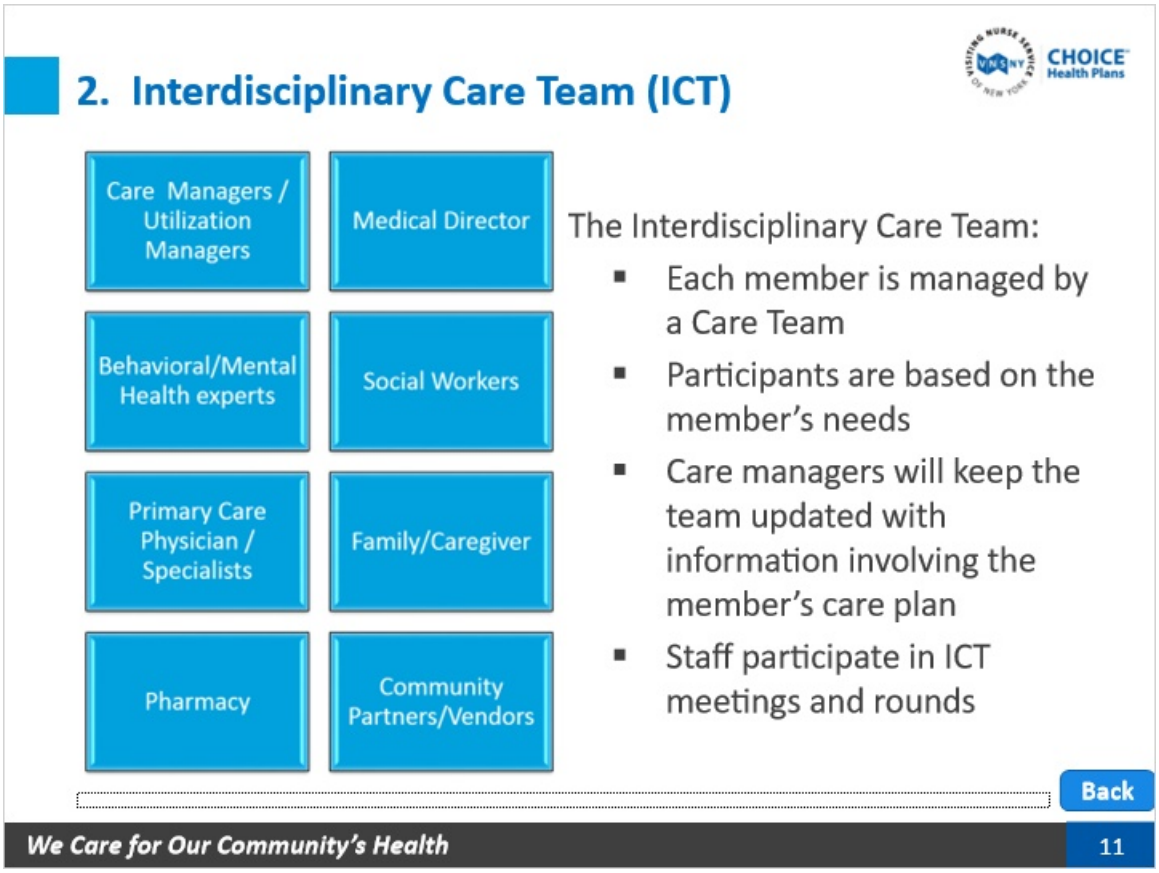


Notes:

The Health Risk Assessment (HRA) and Self Assessment help assess the following needs of each member: Medical, Functional, Cognitive, Psychosocial, And Mental health

This assessment is completed telephonically by the care management team via an HRA script in Guiding Care within 90 days of enrollment and repeated within 365 days.

1.11 2. Interdisciplinary Care Team (ICT)



Notes:

Number 2: The interdisciplinary Care Team (ICT)

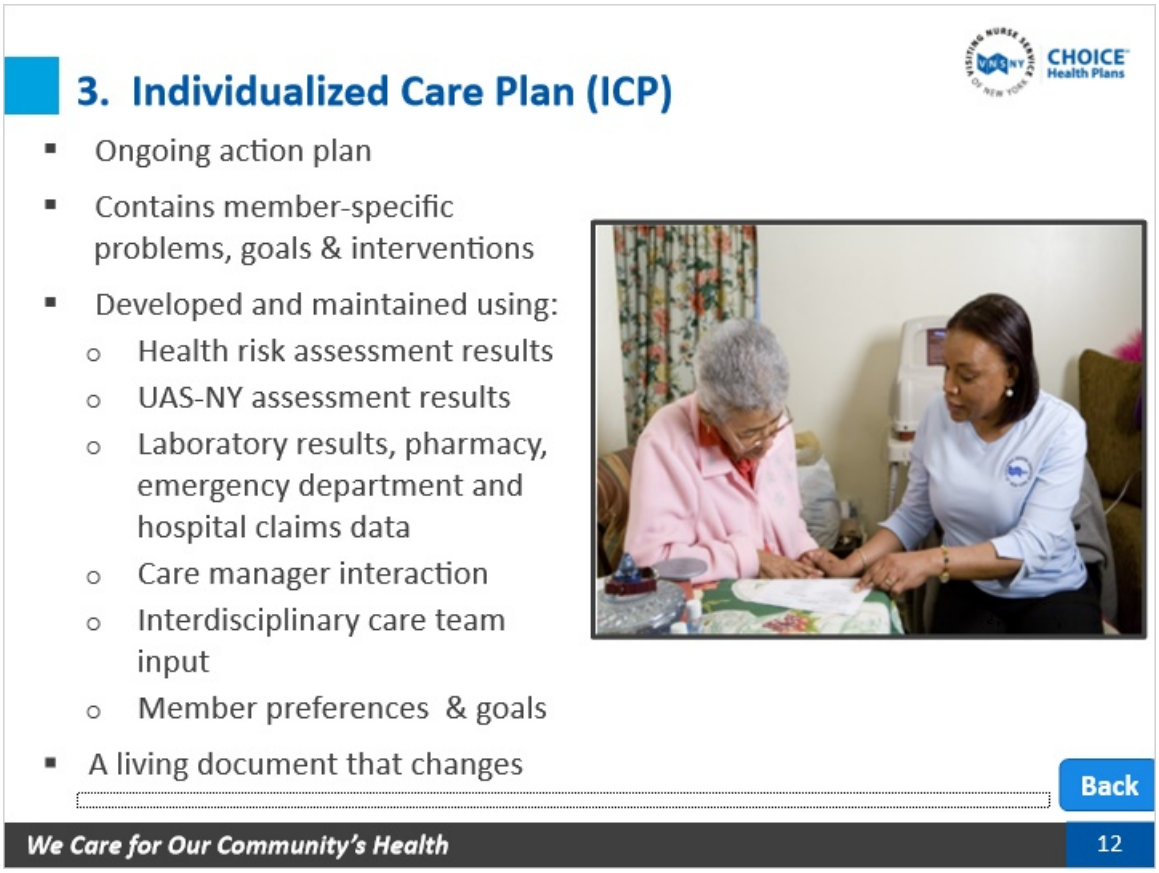
The ICT is part of the Individualized Comprehensive care Planning process.

Staff participate in ICT meetings and rounds. These meetings ensure the integration into the Individual Care Plan of the Beneficiary's medical, psychosocial, cognitive and functional and specific needs.

They review encounter information on referrals, hospital stays, and other data to identify possible areas of under or over utilization.

The ICT is dedicated to quality and accountability in ensuring services are consistent with evidence-based practice, CMS guidelines and the VNSNY CHOICE mission.

1.12 3. Individualized Care Plan (ICP)



Notes:

Number 3: An Individualized Care Plan or ICP; is the mechanism for evaluating the member's current health status. The ICP is used to manage and monitor the member. Individualized care plans are developed and updated by the Care Manager. They include, but are not limited to the following:

Establishing member prioritized goals: what is important, **TO** the member and, **FOR** the member
Identifying resources that might benefit the member, including recommendations for the appropriate level of care,
Planning for continuity of care, including assisting the member in making the transition from one care setting to another

Collaborative approaches to health and care management which can include the PCP, family or member representative,

And Establishing time frames for on-going evaluation of the member's goals.

1.13 4. Care Management Team / Care Coordination

Notes:

Number 4: Care Management Team Care Coordination

Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the member and their caregiver's comprehensive health needs through communication and available resources.

This collaborative process promotes member safety, quality of care and cost-effective outcomes.

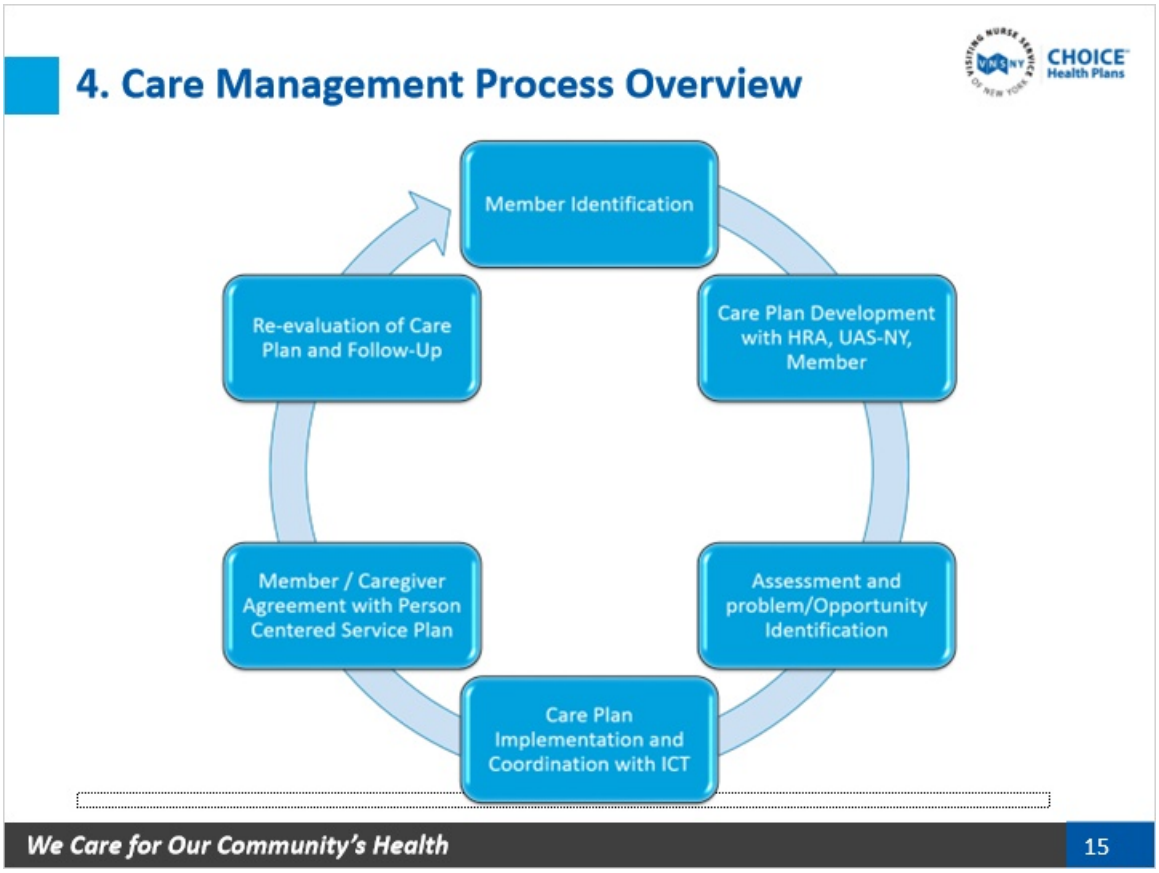
1.14 Care Management (Cont'd)—Care Manager

Notes:

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the member navigate the healthcare system.

They collaborate with providers, their social support system, their community and other professionals associated with the member's care.

1.15 Care Management Process Overview



Notes:

Here is the Care management Process overview. The process consists of:

Member identification,

Care plan development,

Assessment, problem or opportunity identification,

Care plan implementation and coordination with the ICT,

Member caregiver agreement with the person centered plan,

And re-evaluation of the care plan along with follow up.

1.16 Care Coordination

Notes:

Care coordination integrates and coordinates care across specialties, it improves coordination of care and seamlessly transitions members between care settings. It does all this through a central point of contact, the care manager. Firstly, the PCP is the gatekeeper responsible for identifying the beneficiary needs. The care manager then coordinates the care with member, the PCP and other participants of the member's ICT - All snp members have a PCP and CM. When transitioning between care settings, the care manager notifies the member's pcp of the transition, shares the members ICP with the PCP, hospitalist, the facility and or the member or caregiver where applicable. It also entails contacting the member prior to a planned transition and providing educational materials as well as answering any questions related to the upcoming transition.

1.17 Care Management and Transitions

Notes:

Care management and Transitions

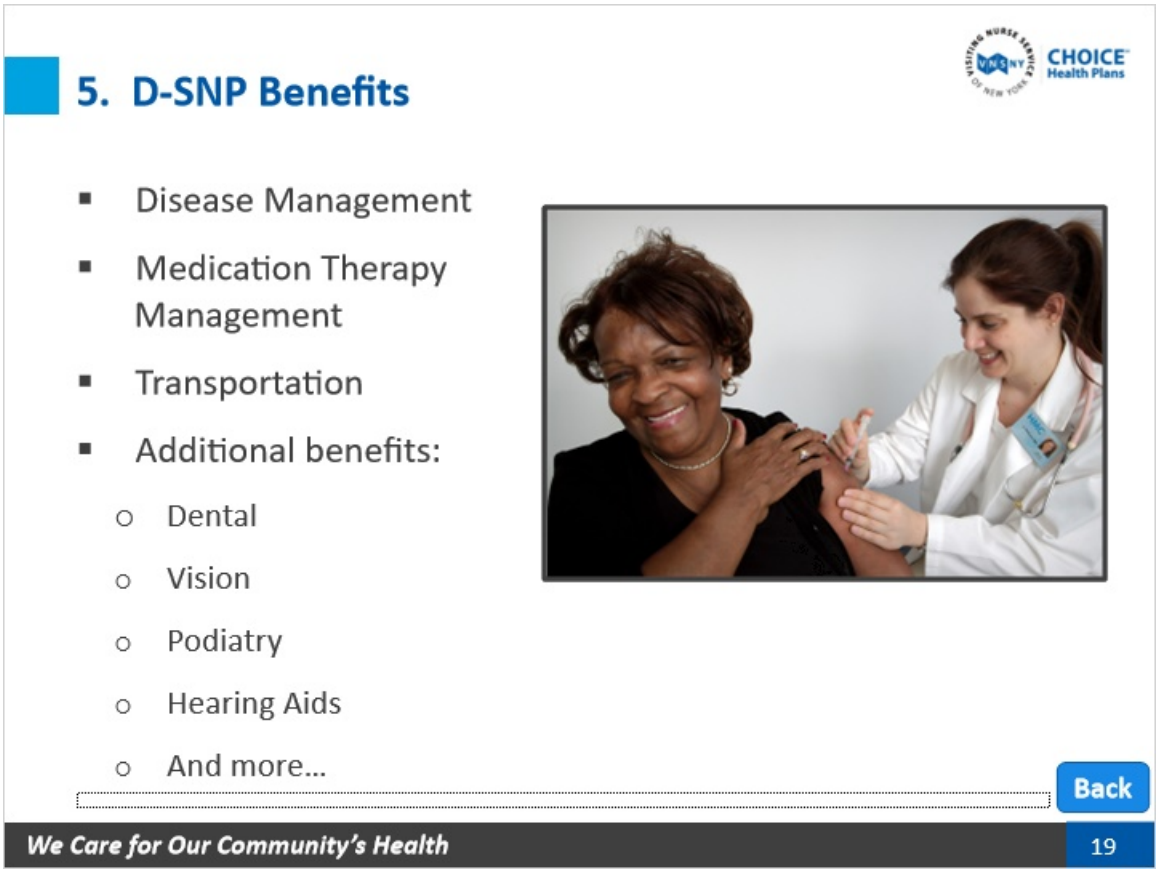
Members are at risk of adverse outcomes when transitioning between settings so it is important to identify and manage members experiencing inpatient transitions thru pre-authorization, facility notification, and inpatient census. Important elements such as diagnoses, medication reconciliation, treatments, providers and contacts of the care plan must be transferred between care settings before, during and after a transition.
Members are able to communicate their health information to healthcare providers in different settings And Members are educated on health status and self-management skills such as discharge needs, meds, follow-up care, and how to recognize and respond to issues that may arise.

1.18 Care Coordination (Cont'd)

Notes:

Additional Care Coordination also includes Post-Hospitalization Transitions of Care. During these calls, the Care Manager helps the member understand discharge diagnosis and instructions. They also facilitate follow-up appointments, Assist with needed home health and equipment, Resolve barriers to obtaining medications, And Educate the member on new or continuing medical conditions.

1.19 5. D-SNP Benefits



Notes:

Number 5: DSNP benefits

DSNP benefits include:

Disease management – a whole person approach to wellness with comprehensive online and written educational and interactive health materials,

Medication Therapy Management – where a pharmacist reviews the member's medication profile quarterly and communicates with the member and the doctor regarding issues such as duplications, interactions, gaps in treatment and adherence issues,

And Transportation - medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP MMP and region.

1.20 6. Working with our Providers

Notes:

Number 6: Provider Network

VNSNY CHOICE Medicare Total Program has a large network of providers including primary care physicians, specialists, nurses and health care professionals such as Audiologists, Podiatrists and Optometrists.

Our extensive pharmacy network includes independent neighborhood stores as well as national chains.

And Providers in our plan include clinics, hospitals, and nursing home facilities.

Members can see any specialist or other providers in the network without a referral.

1.21 7. Quality Improvement Plan (QIP)

Notes:

And the last element in the model of care is Number 7 – the Quality Improvement Plan (QIP)

Our Quality Improvement Program monitors health outcomes by monitoring the implementation of our Model of Care.

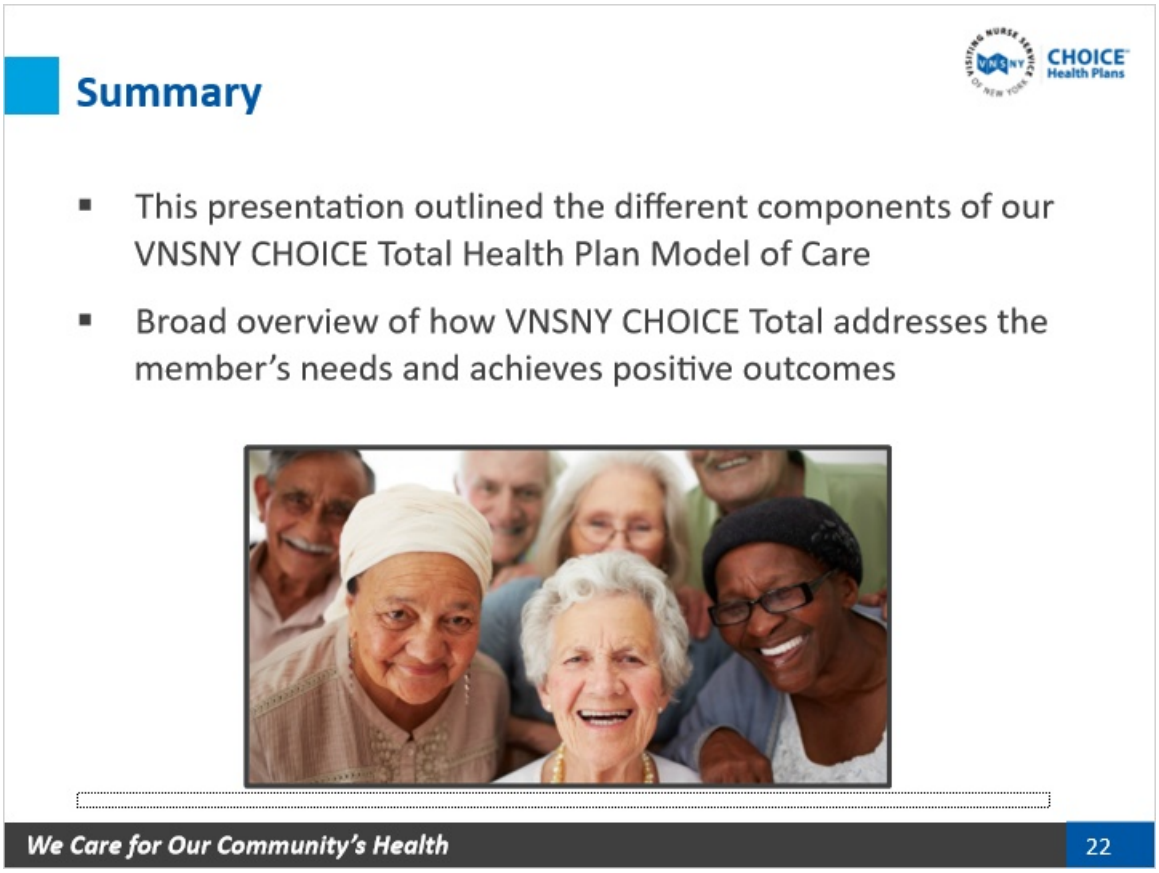
We monitor these health outcomes by:

Collecting HEDIS measures data,

By an Annual Quality Improvement Project that focuses on a clinical or service aspect relevant to our Members,

And by Providing an Advanced Illness Management Program.

1.22 Summary

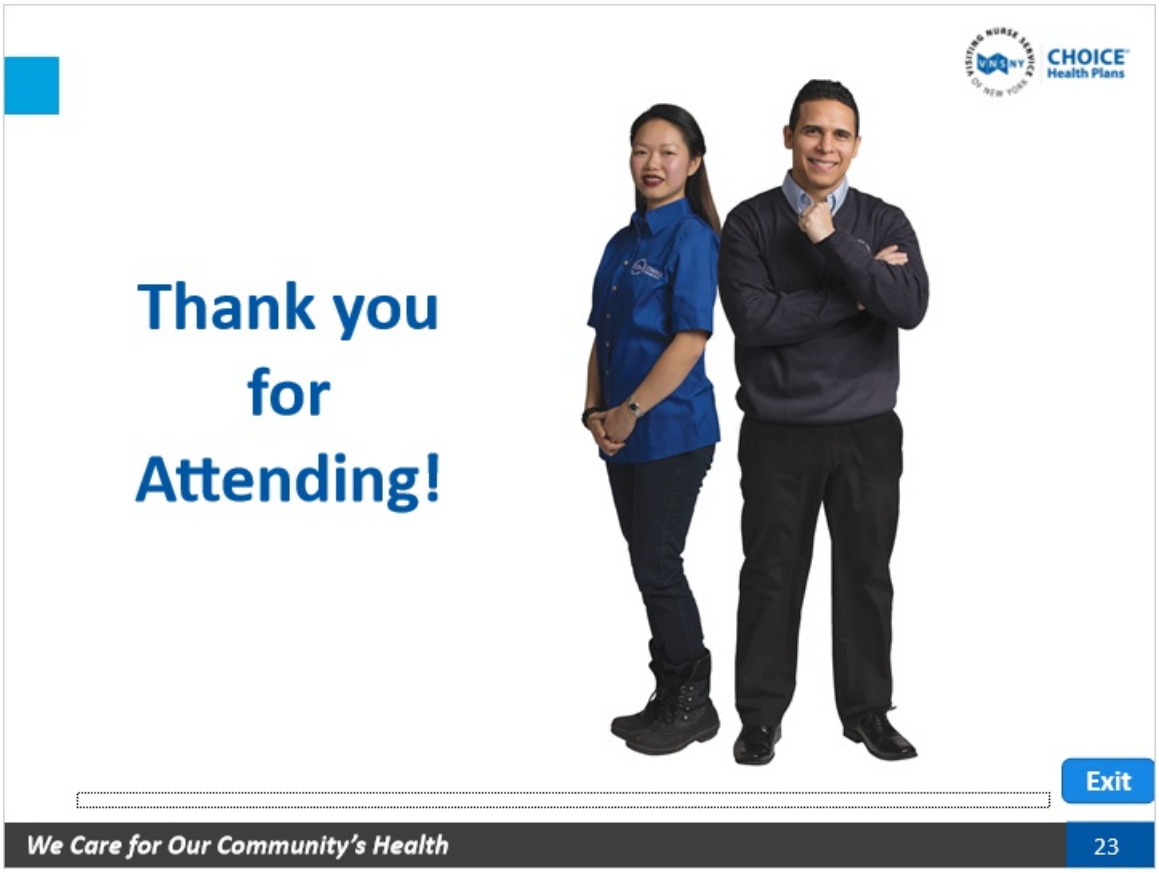


Notes:

In Conclusion

Understanding the model of care key elements and goals for the VNSNY CHOICE Total Plan helps us address the member's needs and achieves positive outcomes.

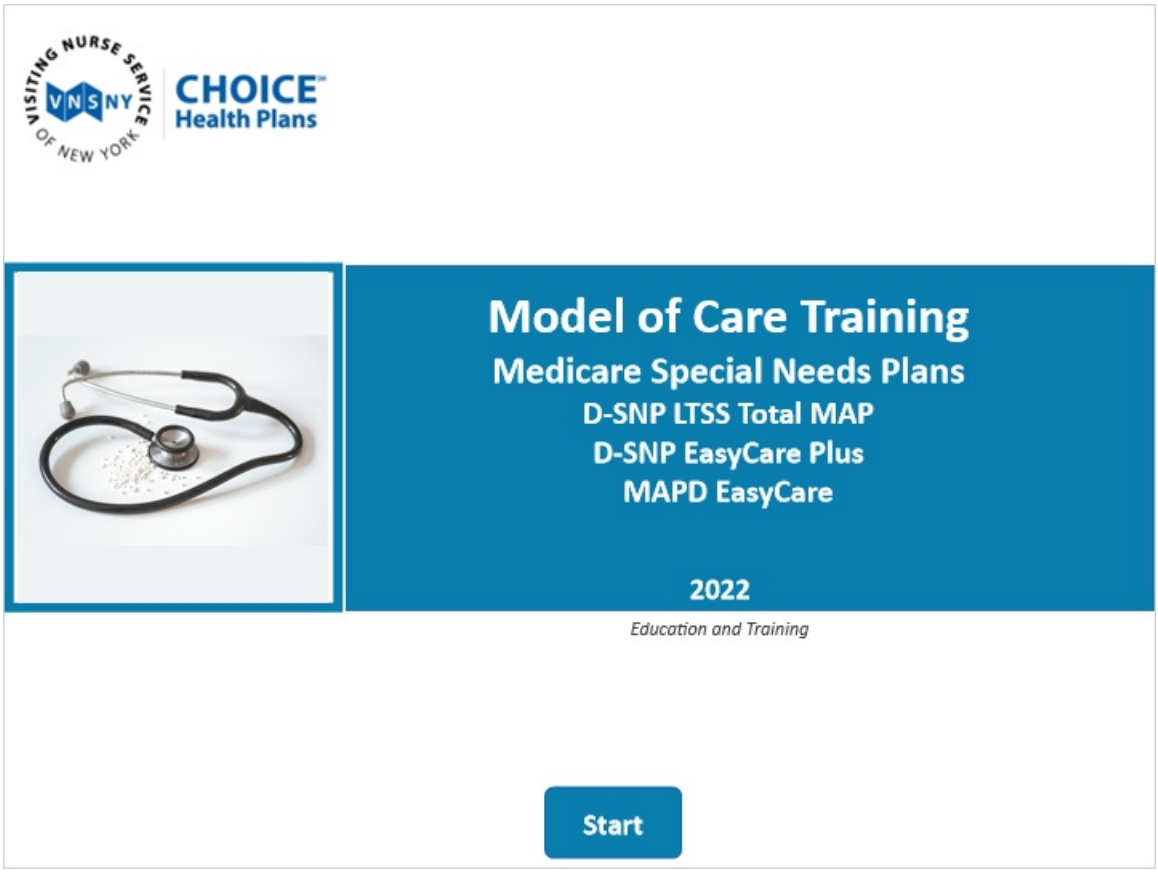
1.23 Thank you for Attending!



Notes:

Thank you for attending the VNSNY CHOICE Total Model of Care Training.

1.1 VNSNY CHOICE Total (HMO D-SNP)



Notes:

Welcome to this training on the VNSNY CHOICE Model of Care.

1.2 Default bullets

Notes:

At the end of this course you will be able to understand the following:

- All three Medicare Plans
- Which individuals qualify for the plans
  The Model of Care key elements and goals
  How Medicare and Medicaid benefits are coordinated under the plans
- the Covered benefits
- and The quality programs used to monitor the effectiveness of the program goals

1.3 Content-2

Notes:

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff receive basic training about the Model of Care.
The Model of Care is the plan for delivering coordinated care and care management.
This course will describe how VNSNY CHOICE and their contracted providers can work together to successfully deliver the Model of Care.

1.4 Content-1

Notes:

The first of the three Medicare plans is MAP Total.

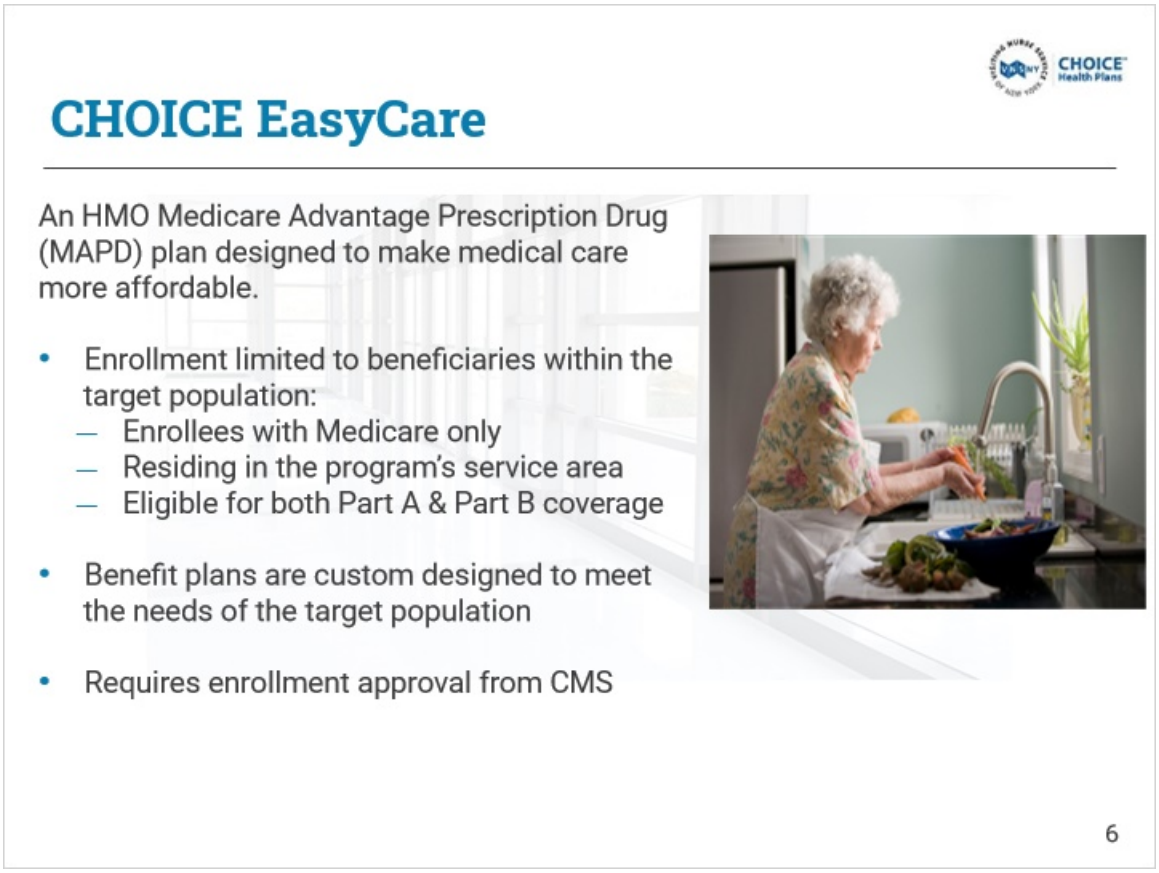
An HMO dual special needs plan that currently operates throughout New York City, Long Island and Westchester.
Map Total draws its membership from individuals residing in the greater New York city area community. A significant proportion of these individuals have medical co-morbidities, are generally poorer and have worse health status' than other Medicare beneficiaries. On average, they have 25 percent more chronic conditions than other Medicare beneficiaries. To enroll in the plan, all applicants must have Medicare and Medicaid, be eligible for long term services and support (LTSS), and be clinically eligible based on a comprehensive assessment using the Uniform Assessment System. Enrollment into a dual special needs program requires approval from both CMS and D O H.

1.5 Content-1

Notes:

The second of our three Medicare plans is EasyCare Plus. An HMO Special Needs Plan designed to offer focused care management to individuals who are dual eligible. Enrollment is limited to beneficiaries within the target Special needs population who reside within the program's service area are eligible for both Medicare and Medicaid, And do not require long-term support services. Benefit plans are custom designed to meet the needs of the target population and requires enrollment approval from CMS and D O H.

1.6 Content-1



Notes:

The third Medicare plan is Easy Care.
An HMO Medicare Advantage Prescription Drug plan (MAPD) designed to make medical care more affordable.

Enrollment is limited to beneficiaries with Medicare only, who reside in the program's service area
and are Eligible for both Part A & Part B coverage

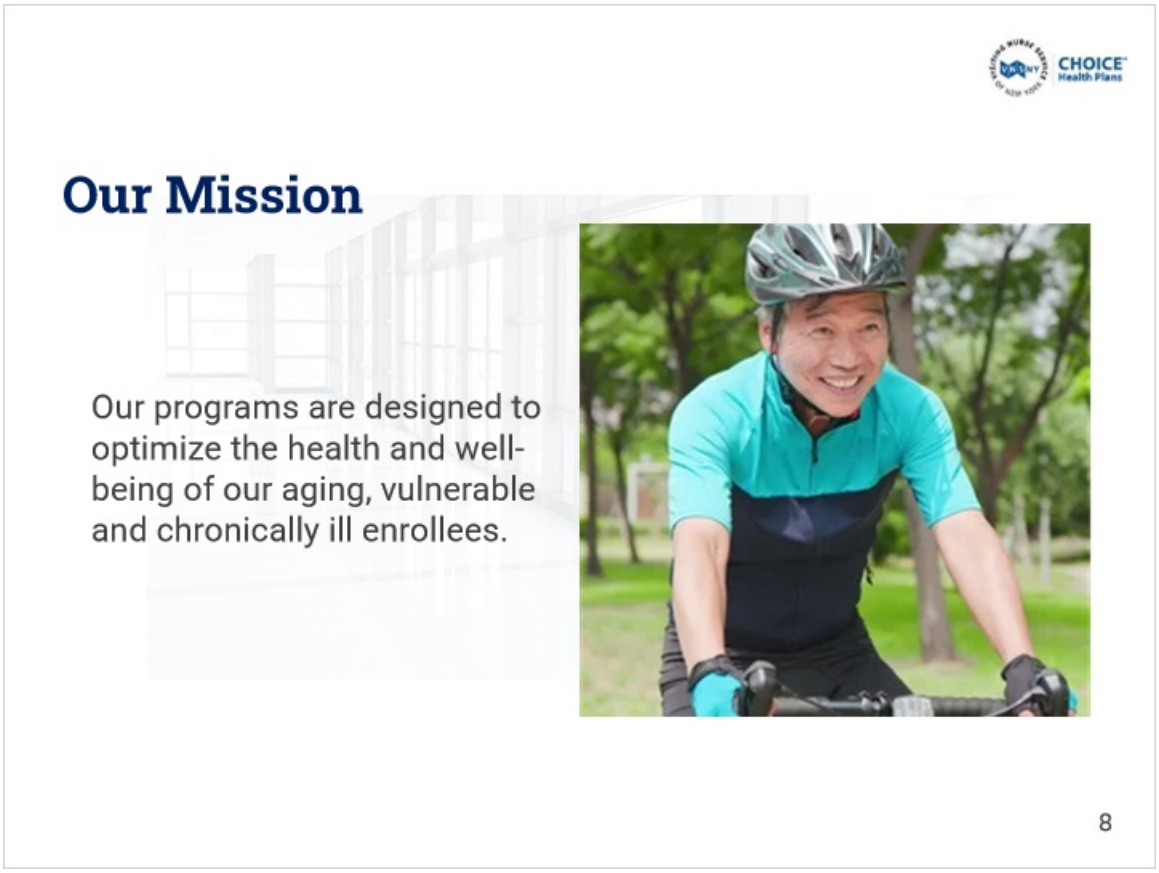
Benefit plans are custom designed to meet the needs of the target population and requires enrollment approval from CMS.

1.7 Content-1

Notes:

CMS requires all d snip members have the following:
A health risk assessment
An individualized care plan
An interdisciplinary care team
And for MAP Total; A universal assessment done by a UAS nurse.

1.8 Content-1



Notes:

The mission of Our program design is to optimize the health and well-being of our aging, vulnerable and chronically ill enrollees.

1.9 Content-1

Notes:

The Model of Care, is a plan for delivering care management and care coordination to

Improve quality
Improve access
Create affordability
Integrate and coordinate care across specialties
Provide seamless transitions of care
Improve the use of preventive health services
Encourage appropriate utilization and cost effectiveness
And improve the enrollee's health and experience

1.10 Content-1

Notes:

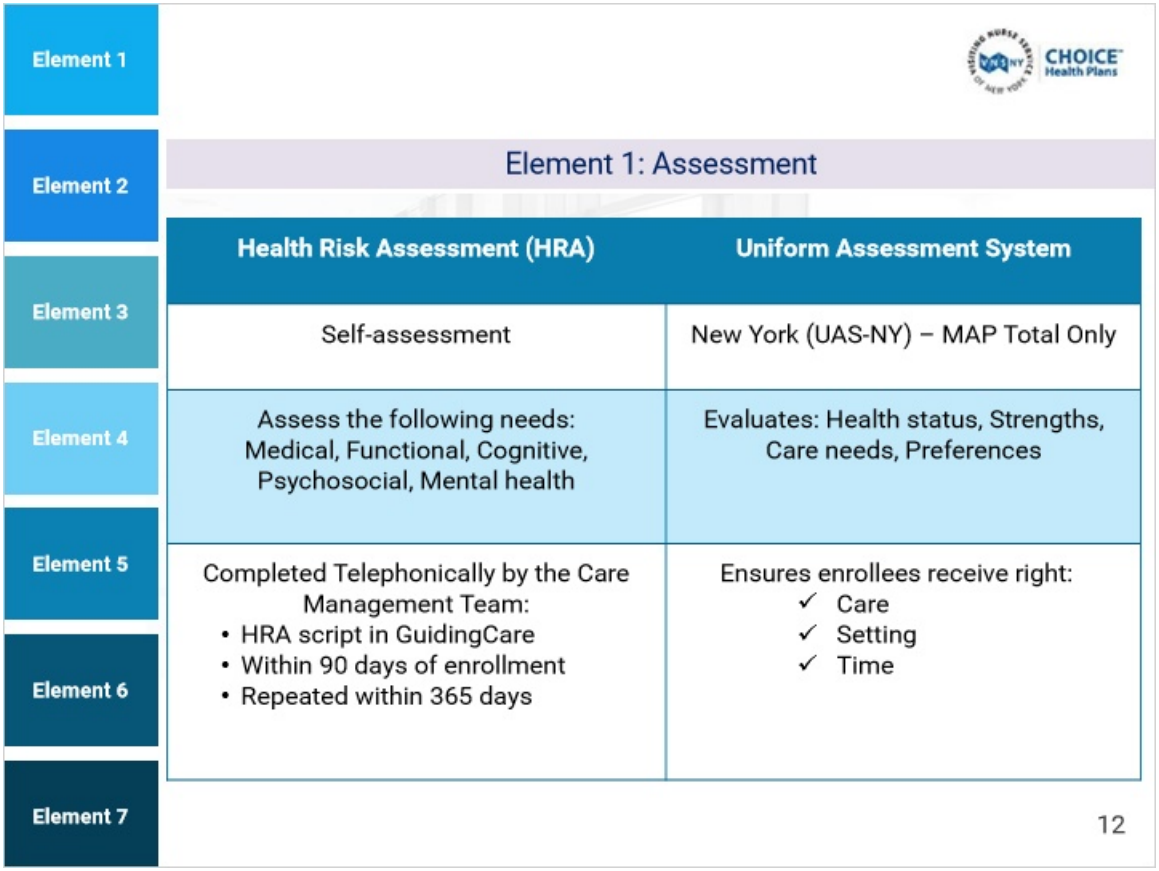
The goal of our Dual special needs plan is to improve quality, reduce costs, and improve the enrollee experience.
This can be accomplished by improving access to care, and improving coordination of care, as enrollees navigate the health continuum, in order to improve their health outcomes and quality of life.

1.11 MOC Design Button Tabs

Notes:

The model of Care design consists of 7 elements.

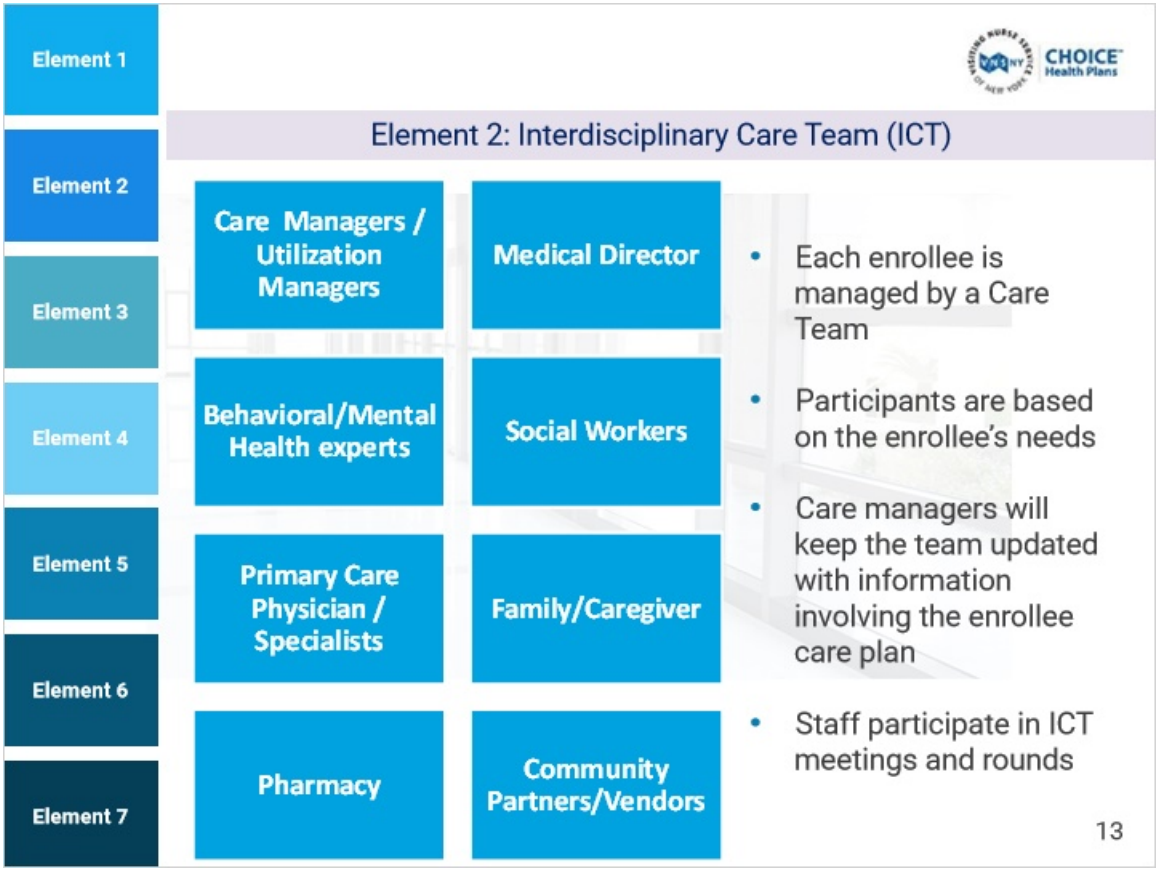
Element 1: Assessment



Notes:

Element number 1 in the model of care is the Assessment. The Health Risk Assessment (HRA) and Self-assessment help assess the following needs of each enrollee: Medical, Functional, Cognitive, Psychosocial, And Mental health. This assessment is completed telephonically by the care management team thru an HRA script in Guiding Care within 90 days of enrollment and is repeated every 365 days. The Uniform Assessment system is an In-home assessment performed at the frequency set forth by the New York State Department of Health model contract. A community health assessment is performed only for the MAP Total plan whose enrollees need long term services and support (LTSS). It Evaluates the following needs of each enrollee: Health status, Strengths, Care needs and Preferences. It Assists with program eligibility, it improves care coordination and facilitated service delivery, and ensures enrollees with long term care needs receive the right care within the right setting and at the right time.

Element 2: ICT Team



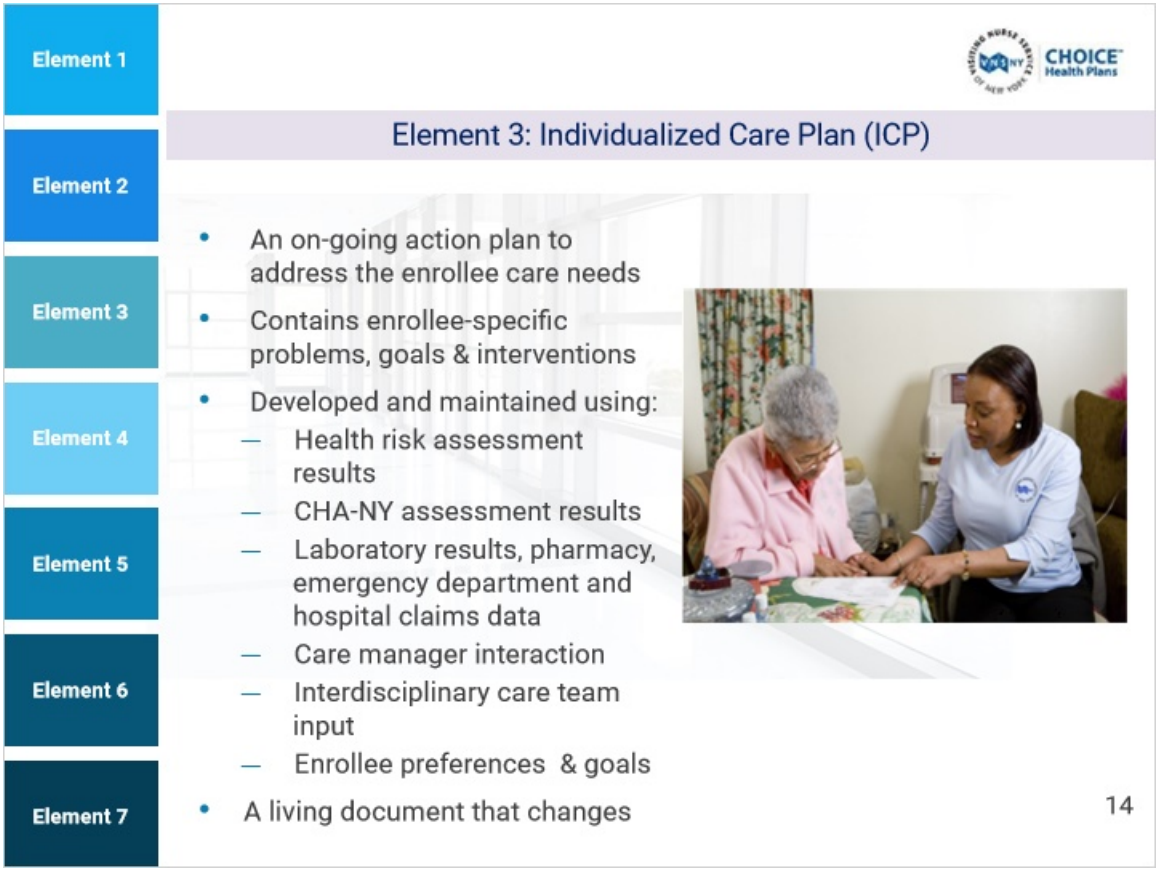
Notes:

Element number 2 in the model of care is the interdisciplinary Care Team.

The Interdisciplinary care team is part of the Individualized Comprehensive care Planning process. Staff participate in interdisciplinary Care Team meetings and rounds. These meetings ensure the integration into the Individual Care Plan of the Beneficiary's medical, psychosocial, cognitive and functional and specific needs. They also review encounter information on, referrals, hospital stays, and other data to identify possible areas of under and over utilization.

The interdisciplinary Care Team is dedicated to quality and accountability in ensuring services are consistent with evidence-based practice, CMS guidelines and the VNSNY CHOICE mission.

Element 3: ICP



Notes:

Element number 3 in the Model of Care is The Individualized Care Plan.

The Care Plan is the mechanism for evaluating the enrollee's current health status.

Individualized care plans are developed and updated by the Care Manager and are used to both monitor and manage the enrollee. They include, but are not limited to the following:

Establishing enrollee prioritized goals, or what is important to the enrollee,

A health risk assessment, including recommendations for the appropriate level of care,

Planning for continuity of care, including assisting the enrollee in making the transition from one care setting to another, Collaborative approaches to health and care management which can include the PCP, family or enrollee representative, And Establishing time frames for on-going evaluation of the enrollee’s goals.

Element 4: Care Management Team

Notes:

Element number 4 in the Model of care is the Care Management Team and Care Coordination

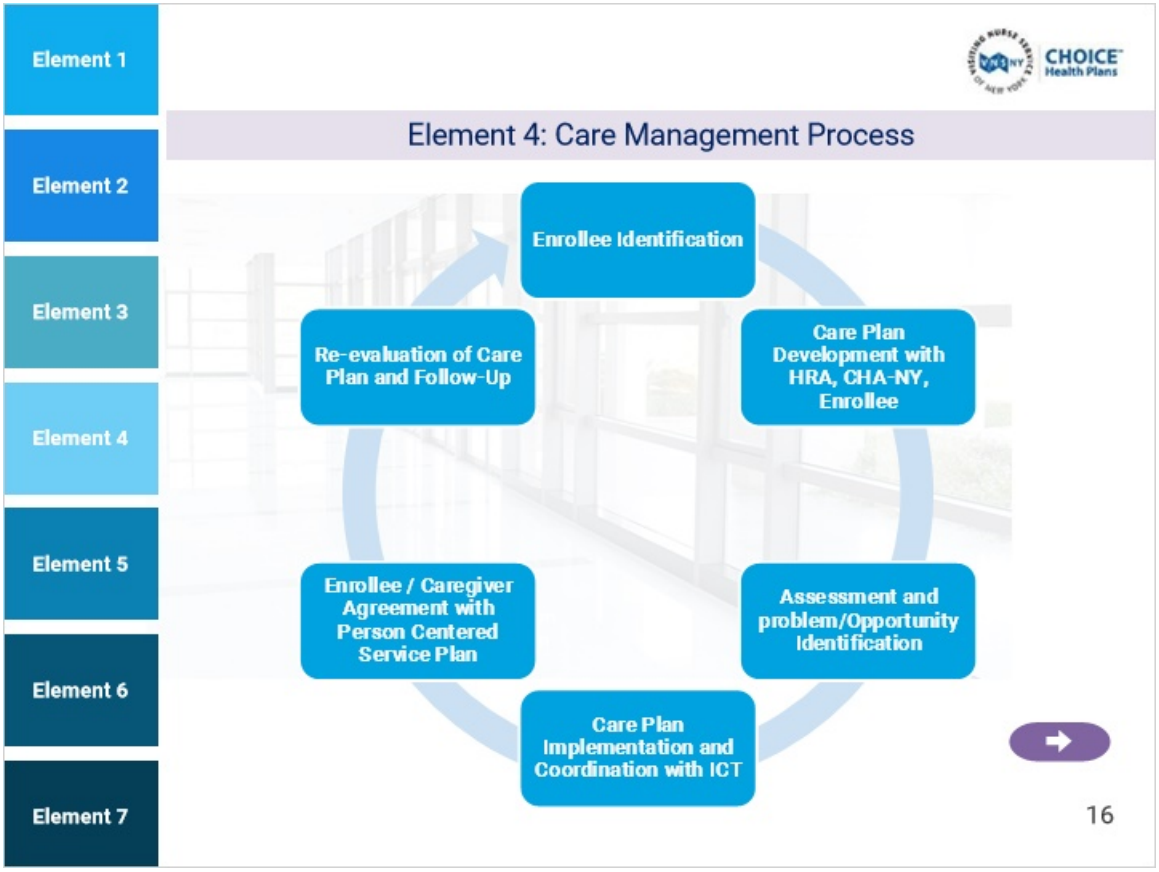
Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the enrollee and their caregiver's comprehensive health needs through communication and available resources.

This collaborative process promotes enrollee safety, quality of care and cost-effective outcomes.

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the enrollee navigate the healthcare system.

They collaborate with providers, their social support system, their community and other professionals associated with the enrollee's care.

Care Management Process



Notes:

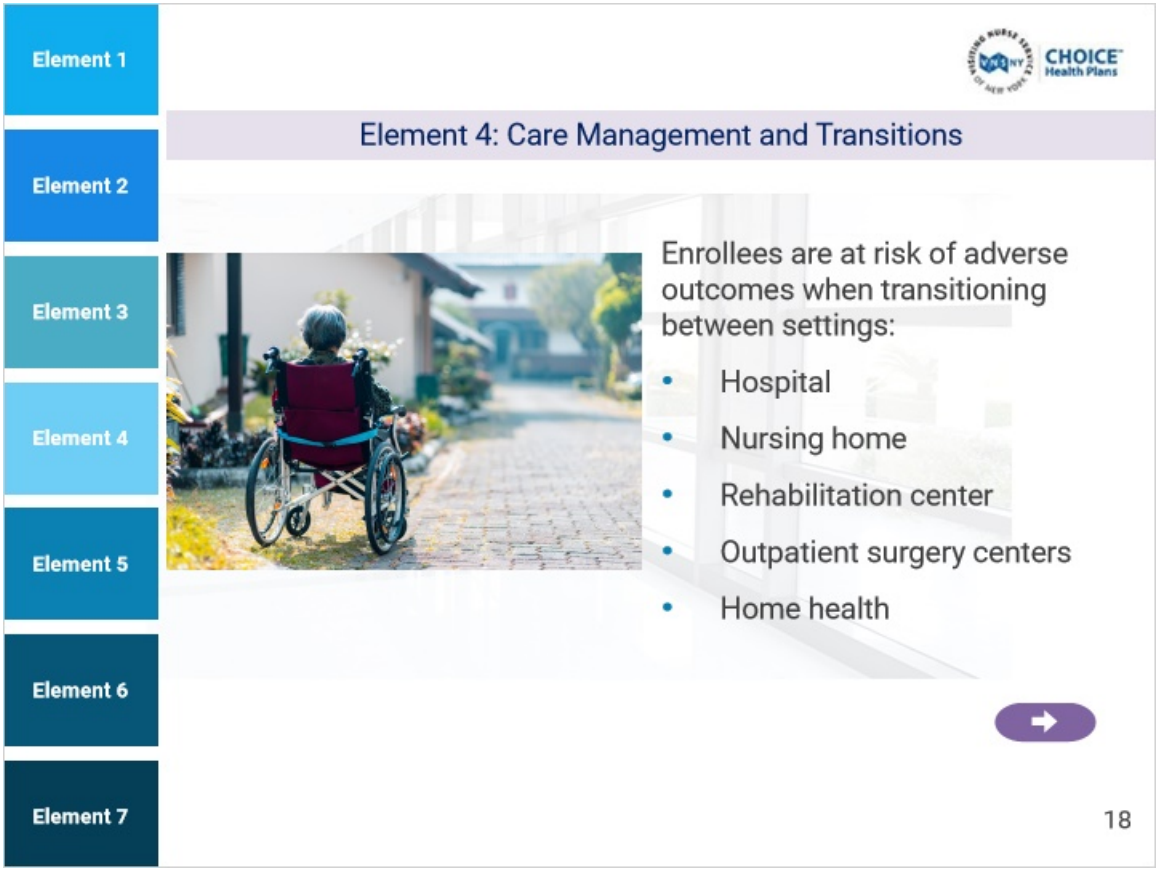
This is an Overview of the Care management Process. Our Care Management Process progresses through 6 different steps. First we follow steps to make sure we are working with the correct enrollee when contacting them. Second, the enrollee's individualized care plan is created with input from the HRA and UAS assessment results. Third, within each enrollee interaction or assessment, a problem or opportunity may be identified. As a result, the patient centered service plan will be created through coordination with the Interdisciplinary Care Team. The patient centered service plan requires the enrollee and caregiver agreement. Finally this Patient Centered Service Plan will require re-evaluation and follow-up during all enrollee interactions. So if any new problems or opportunities are identified the process continues. This overarching process is supported through daily care coordination.

Care Coordination

Notes:

Care coordination integrates and coordinates care across all specialties, it improves coordination of care and seamlessly transitions enrollees between care settings. It does all this through a central point of contact, the care manager. All D-SNP enrollees have a PCP and a Care Manager. The PCP is the gatekeeper responsible for identifying the beneficiary needs. The care manager then coordinates the care with the enrollee, the PCP and other participants of the enrollee's Interdisciplinary Care Team. When transitioning between care settings, the care manager notifies the enrollee's PCP of the transition and then shares the enrollee's Individualized care plan with the PCP, the hospitalist, the facility and the enrollee's caregiver wherever applicable. It also entails contacting the enrollee prior to a planned transition and providing educational materials as well as answering any questions related to the upcoming transition.

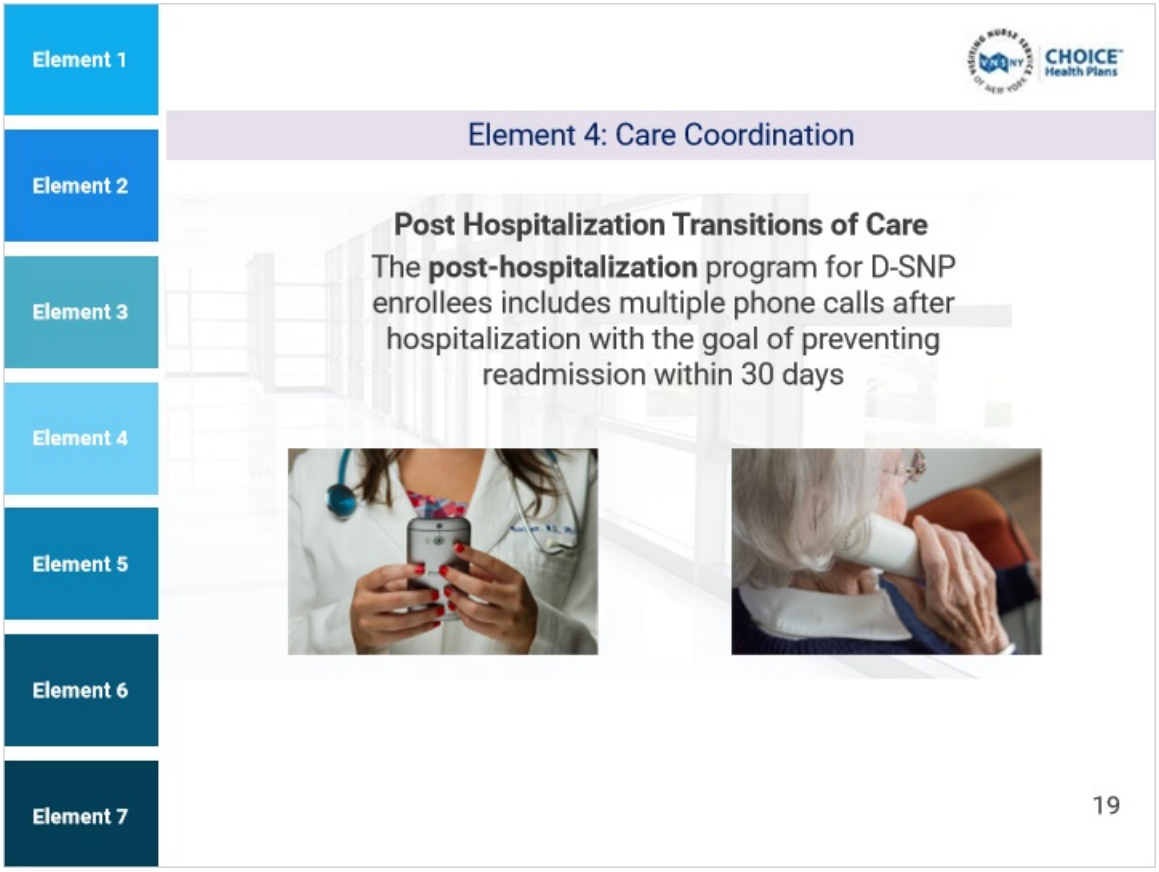
CM and Transitions



Notes:

Enrollees are at risk of adverse outcomes when transitioning between settings, so it is important to identify and manage enrollees experiencing in-patient transitions through pre-authorization, facility notification, and inpatient census. Important elements such as diagnoses, medication reconciliation, treatments, providers and contacts of the care plan, must be transferred between care settings before, during and after a transition. Enrollees are also able to communicate their health information to healthcare providers in different settings, And Enrollees are educated on health status and self-management skills such as; discharge needs, medications, follow-up care, and how to recognize and respond to any issues that may develop.

Post Hospitalizations

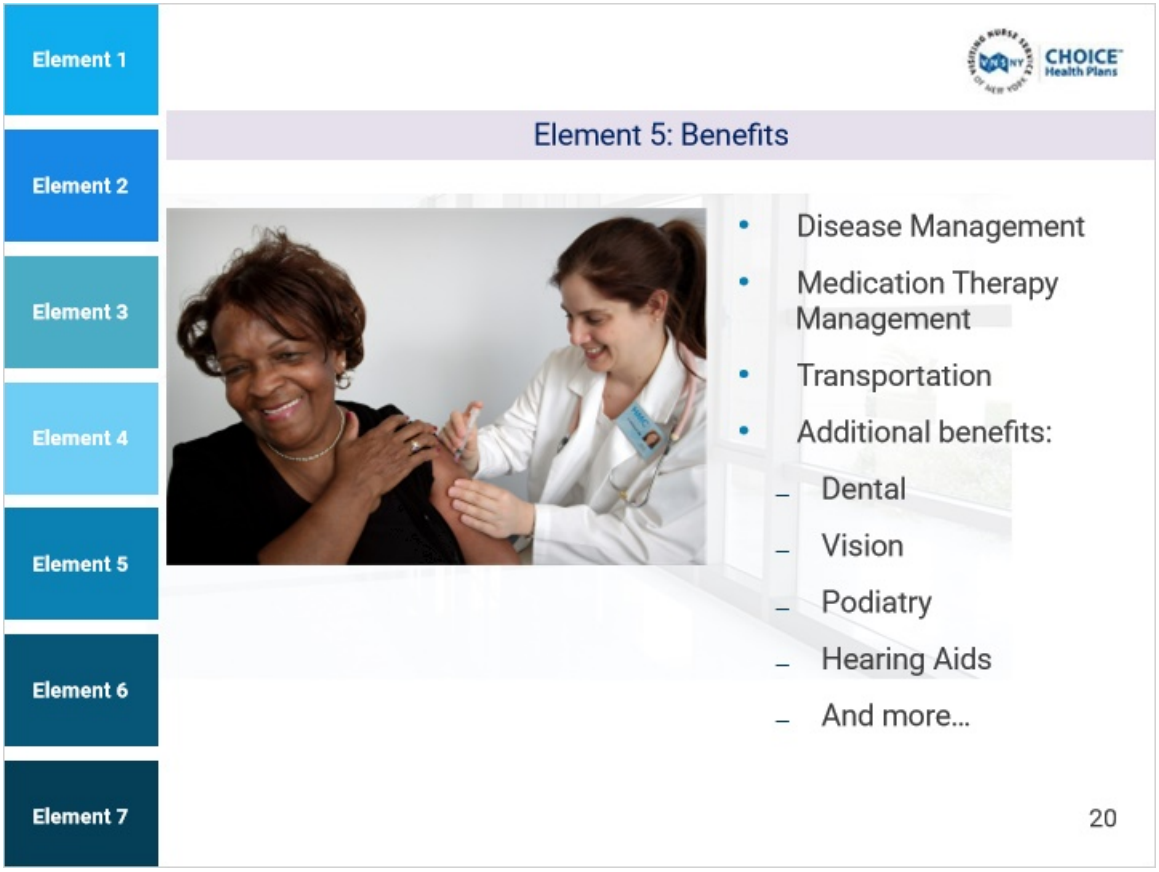


Notes:

Additional Care Coordination also includes Post-Hospitalization Transitions of Care.

The post-hospitalization program for Dual special needs enrollees includes multiple phone calls after hospitalization with the goal of preventing readmission within thirty days. During these calls, the Care Team helps the enrollee understand discharge diagnosis and instructions, facilitate follow-up appointments, assist with needed home health and equipment, resolve barriers to obtaining medications, and Educate the enrollees on new or continuing medical conditions.

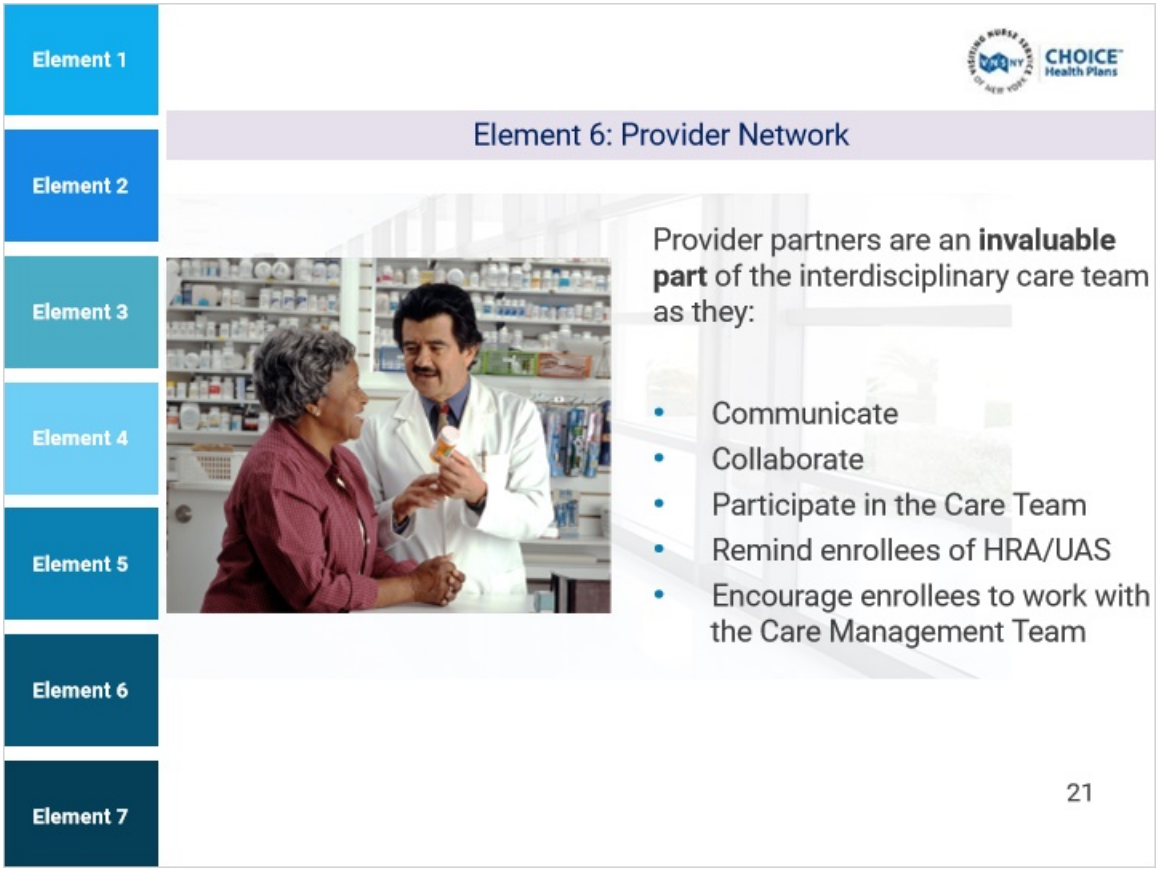
Element 5: Benefits



Notes:

Element number 5 in our Model of Care is Dual special need benefits. These benefits include: Disease management, a whole person approach to wellness with comprehensive online and written educational and interactive materials, Medication Therapy Management – where a pharmacist reviews the enrollee's medication profile quarterly and communicates with the enrollee and the doctor regarding issues such as duplications, interactions, gaps in treatment and adherence issues, Transportation for medically related trips under the health plan or Medicaid benefit that may vary according to the specific SNP MMP region. And Additional benefits that include Dental, Vision, Podiatry, Hearing Aids, Diet and nutritional education Behavioral health services, End-of-life support services, Social work support, Home and community-based services, Meal programs and an Over-the-counter allowance.

Element 6: Provider Network



Notes:

Element number 6 in our model of care is Provider network partners, an invaluable part of the interdisciplinary care team. Our D-SNP Model of Care offers an opportunity to work together for the benefit of enrollees by offering enhanced communication with Care Managers and the Interdisciplinary care team as well as Focusing on each individual enrollee's special needs. They deliver care management programs to assist with the enrollee's medical and non-medical needs and Support the enrollee's plan of care. VNSNY CHOICE Medicare Programs have a large network of providers, including primary care physicians, specialists, nurses, healthcare professional such as Audiologists, Podiatrist or Optometrists. Providers in our plan also include clinics, hospitals, and nursing home facilities. Enrollees can see any specialist or other providers in the network without a referral. And our extensive pharmacy network includes independent neighborhood stores as well as national chains.

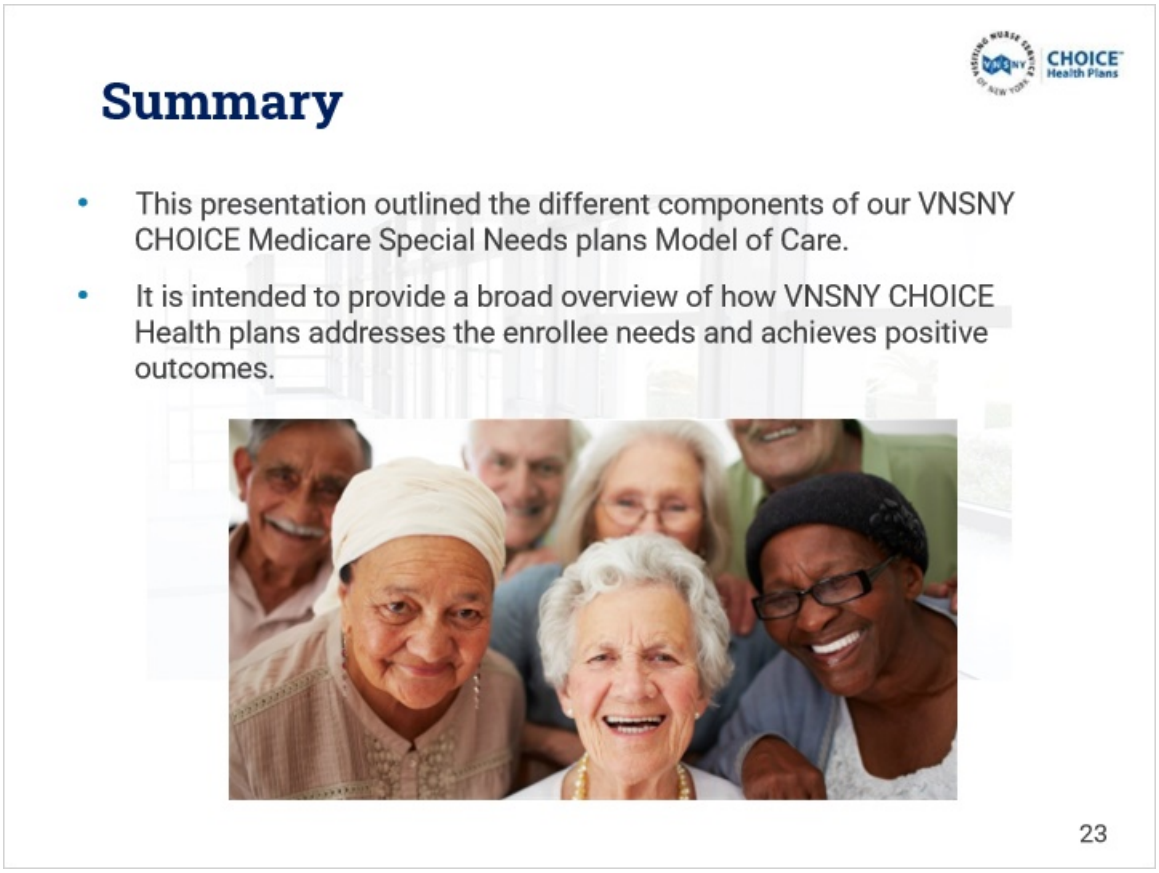
Element 7: QIP

Notes:

Element number 7 in the model of care is the Quality Improvement Plan.

The Quality Improvement Program monitors health outcomes by monitoring the implementation of our Model of Care. We monitor these health outcomes by, collecting Hedis measures data, An Annual Quality Improvement Project that focuses on a clinical or service aspect relevant to our Enrollees, And Providing an Advanced Illness Management Program.

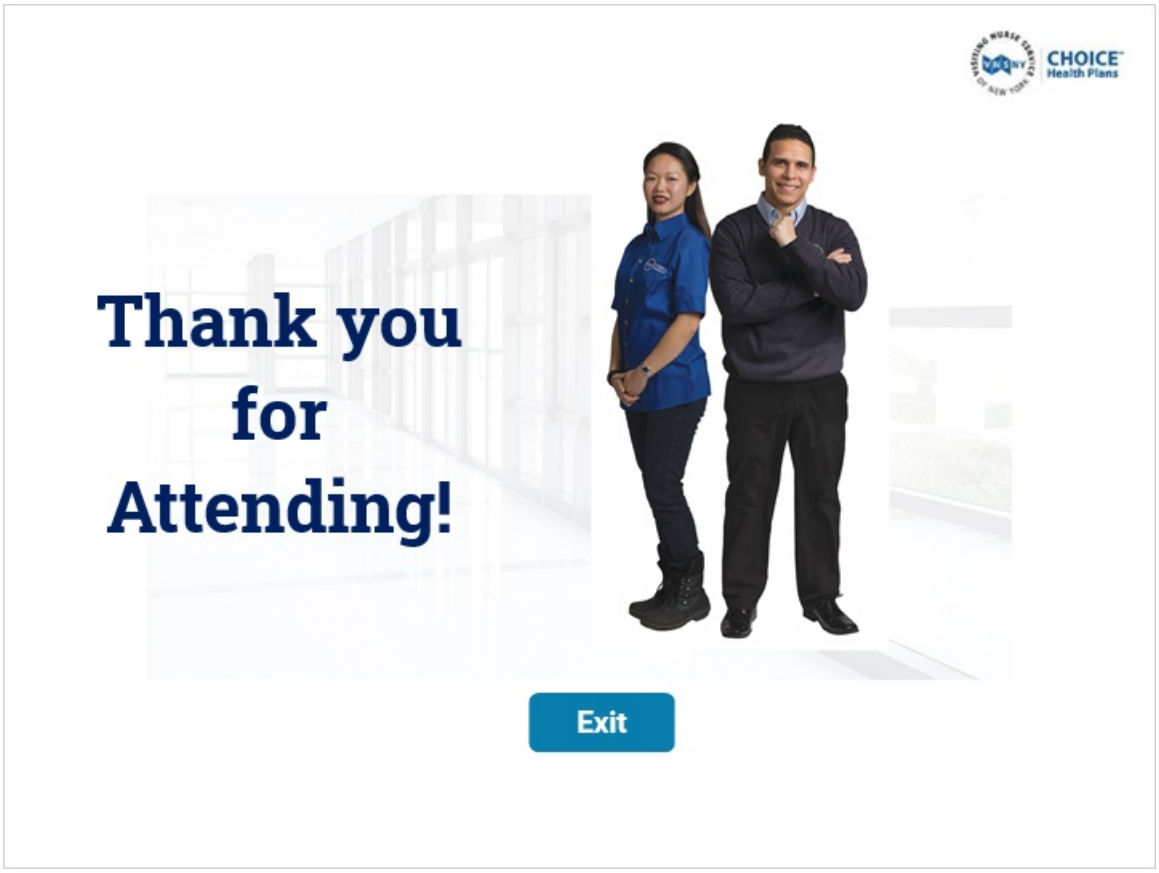
1.12 Content-2



Notes:

In Conclusion
Understanding the model of care key elements and goals for the VNSNY CHOICE Medicare Special needs Plans helps us address the Enrollee's needs and achieves positive outcomes.

1.13 Content-2



Notes:

Thank you for attending this Training on the Medicare Special Needs Plan Model of Care.