I-SNP Model of Care Training

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Objectives

- Medicare/Medicare Advantage 101
- Basic Concepts of Special Needs Plans
- Requirements for Success
- Purpose and Key Components of the Model of Care
  - Health Risk Assessments (HRA)
  - Individualized Care Plans (ICP)
  - Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocols

Medicare/Medicare Advantage 101

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Medicare/Medicare Advantage 101

Medicare

- A federal system of health insurance for people 65+ years of age and for qualifying individuals younger than 65 years of age with disabilities
- **Part A (Hospital Insurance)**
  - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
- **Part B (Medical Insurance)**
  - Part B covers certain doctors' services, outpatient care, medical supplies and preventive services.
- **Part D (Prescription Drugs)**

Medicare/Medicare Advantage 101

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All-in-one alternative to Original Medicare. These bundled plans include Part A, Part B and usually Part D.

- **Health Plan Options**
  - Approved by Medicare
  - Run by Private Companies
  - Available across the United States
- **Enrolled Members Receive Services Through the Plan**
  - All Part A and Part B Covered Services (A+B=C)
  - Some plans may provide additional benefits
- **Members are still in the Medicare Program**
  - Medicare pays the plan every month for the member's care
  - Members have Medicare rights and protection

Basic Concepts of Special Needs Plans

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Institutional Special Needs Plan (I-SNP)

A special needs plan (SNP) is a Medicare Advantage (MA) plan specifically designed to provide targeted care to special needs individuals.

- Who can join an I-SNP?
  - Enrolled in Medicare Part A (Hospital) and Part B (Medical)
  - Live in the Plan‘s service area (specific counties)
  - Reside (or expected to reside) in a participating I-SNP nursing facility for greater than 90 days at time of enrollment

Institutional Equivalent Special Needs Plan (IE-SNP)

For MA eligible individuals living in the community, but requiring an institutional level of care (ex: Assisted Living Facility or Basic Care), the following conditions must be met:

- Enrolled in Medicare Part A (Hospital) and Part B (Medical)
- Live in the Plan's service area (specific counties)
- May reside at home or in a participating Assisted Living or Basic Care Facility but require an equivalent level of care as a Skilled Nursing Facility.
- A determination that the individual has institutional Level of Care (LOC) needs that are based on the use of a state assessment tool.
- The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity that performs the LOC assessment.

Requirements for Success

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A New Way of Delivering Care

- Employs Physician/Nurse Practitioner and/or Physician Assistants to provide additional services over & above traditional Medicare.
- The model focuses on routine visits and preventative care which has shown **improved clinical outcomes.**
- Allows for significant **reinvestment** into facilities and staff.

Model of Care

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Model of Care Overview

- The Model of Care submitted by the Plan is scored by the National Committee for Quality Assurance (NCQA).
  - The score determines if a 1, 2 or 3 year approval timeline is achieved.
- The Model of Care must be monitored, process documented and changes updated.
- Must be approved by CMS

What Creates Success?

- **Membership**
- **Medical Management**
  - Focus on Prevention:
    - Routine Visits
    - Care Protocols
    - Skill in Place
  - Goals to Avoid or Reduce:
    - Unnecessary Hospitalizations and Readmissions
    - ER Visits
    - SNF (post-acute part A services)
    - Nonessential Specialist Visits

As the Payer (instead of Traditional FFS Medicare), the Plan can pay for the visits, activities and work that directly contributes to better care.

- **Quality**

What is the **Model of Care**?

The Model of Care (MoC) is the **contract** that the Plan submits to CMS clearly outlining who our members are, how we take care of them and how we manage the quality of that care.

CMS requires all Medicare Advantage Special Needs Plans (SNPs) to have a **Model of Care**.

Below are the four Model of Care Elements:

- MoC 1: Description of the SNP Population
- MoC 2: Care Coordination (clinical team's focus)
  - Health Risk Assessment (HRA)
  - Individualized Care Plan (ICP)
  - Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocols
- MoC 3: Provider Network
- MoC 4: Quality Measurement and Performance Improvement

MoC 1: **Description of the I-SNP Population**

- Resides in a long-term care facility, assisted living or independent living
- Has multiple chronic conditions requiring close monitoring
- Likely prescribed high-risk medications
- Requires more care coordination than the general population

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MoC 2: **Care Coordination**

- Health Risk Assessments (HRA)
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

To receive credit for the Model of Care activities completed, EPIC documentation of the above care coordination is evaluated by the Plan. This is how the Plan ensures member quality of care.

Health Risk Assessment (HRA)

Purpose of Health Risk Assessment:

1) Starts the **new member assessment**
   - Collects member self-reported health status
2) Starts the care planning process
   - **Identified needs are documented in the care plan** (medical, functional, cognitive, psychosocial and mental health, etc.)
   - **This is a CMS requirement (for initial HRAs and Annuals)*
3) Provides an **annual checkpoint** of key geriatric health metrics and monitors for changes in self-reported health status.

Health Risk Assessment (HRA)

Requirements:

- New Plan members must receive an HRA within 90 days of enrollment.
- Existing members must have an HRA annually (within 364 days of their prior assessment).

Health Risk Assessment (cont.)

HRA Outcomes:

- Contribute to the member's Individualized Care Plan (ICP):
- Contribute to a risk score which determines the frequency of APP (Advanced Plan Practitioner) visits

HRA Risk Score	Risk Stratification Level	Frequency of visits
8 - 15	High	Once a week
5 - 7	Medium	Twice a month
0 - 4	Low	Once a month

Post–HRA Visit & Rounding

- The APP will complete a post-HRA visit according to the stratification level guidelines.
- Visit will include:
  - HRA review *(Provider visit notes should include documentation of HRA results/outcomes)*
  - Review of available historical hospital, specialist and diagnostic information
  - A comprehensive exam (new members only) including an History and Physical (H&P)
- Outcomes of the post-HRA visit (i.e., medication changes, therapy referrals, diagnostic tests, scheduling of next visit, etc.), will be included in the facilities Electronic Medical Record (EMR) and incorporated into the **Individualized Care Plan**.
- After the post-HRA visit (initial or annual), the APP should round based on the HRA stratification level.

Individualized Care Plan (ICP)

Documentation Requirements:

- **Address the needs** identified in the HRA (initial and annually)
- **Address the changes** in health status/change in level of care
- **Identification of self-management goals**, met or unmet and barriers
- **Services specifically tailored** to the member's medical, psychosocial, functional and cognitive needs
- **Roles/responsibilities** of the member's caregiver(s).
- **Quarterly Updates**

SMART Goals

S	M	A	R	T
Specific (direct, detailed and meaningful)	**Measurable** (quantifiable to track progress or success)	**Attainable Achievable** (realistic)	**Relevant** (aligns with the member and/or ICT's goals)	**Time-Based** (deadline)

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SMART Goal Example

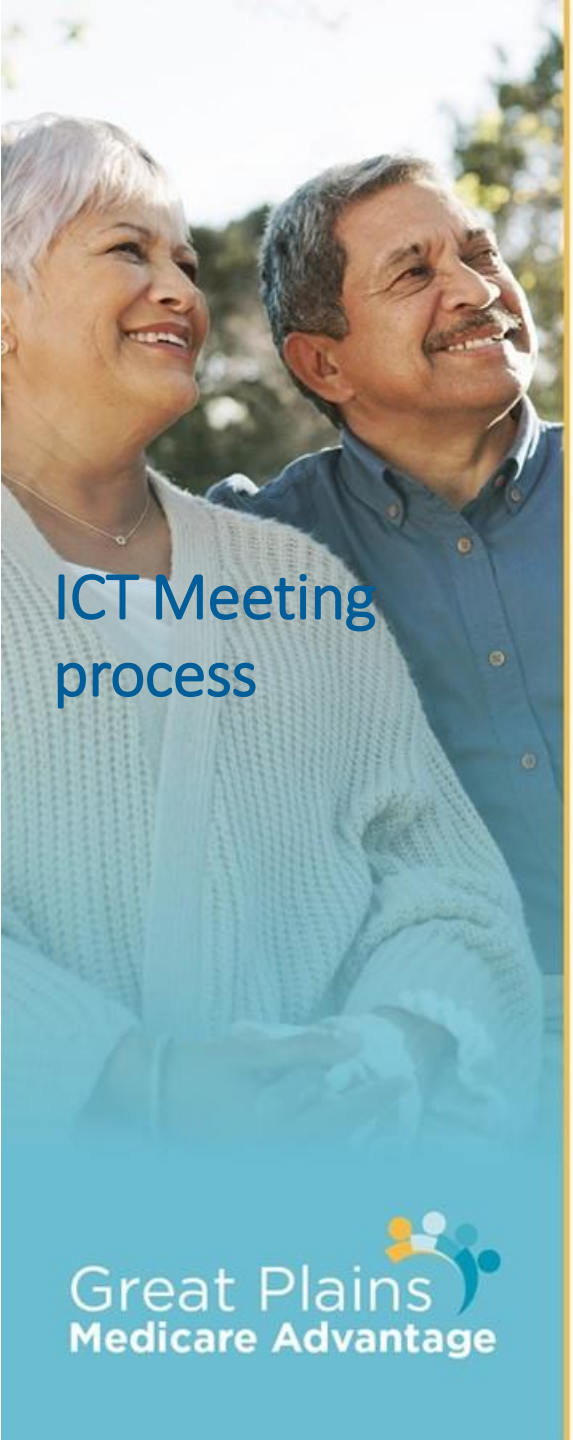
Problem	Goal	Interventions
Fall Risk	Measurable timeline & measurable outcome	Advanced Plan Practitioner will educate member, caregiver and facility staff on increased risk of falls associated with medications (i.e., antihypertensive agents, diuretics, opiates, etc.).
	Member will remain free from falls for next 3 months. Date Initiated: xx/xx/xxxx Target Date: xx/xx/xxxx	• Facility staff will utilize assistive mobile devices (i.e., walker) while member ambulates. • Facility staff, member and caregivers will be educated on appropriate non-skid socks/shoes, appropriate fitting clothing (i.e., long pants, loose shoes, etc.) to prevent falls. • Facility staff will toilet member prior to naps and bedtime. • Facility staff will ensure bed alarm is activated when member is not under direct supervision. • Facility staff will verify member has call bell within reach at each shift. • Facility staff to relocate member to room close to nursing station for easier access to nursing staff.

Interdisciplinary Care Team (ICT) Meetings

Requirements:

- **Quarterly (ICT) meetings**, led by APP. Additional ICT meetings if updates are needed to the Individualized Care Plan (due to HRAs, level of care transitions)

- **Best practice is to attend in person**. If unable, the APP can discuss needs individually with care team (DON, therapy, dietary, etc.)



ICT Meeting Process

- **ICT meetings** ensure **effective coordination** of care and improved health outcomes.
- **Quarterly ICT meetings** allow the APP to re-evaluate and update the ICP based on feedback from the ICT members.
- Ad hoc **meetings are scheduled as needed** with ICT members and the APP to address **urgent issues** and support gaps in care.
- The **composition of the ICT varies** depending on each members' circumstances, risk-level and individual needs and preferences.
- The APP and the ICT review **progress toward goals** during clinical visits and ICT team meetings for improved management and member satisfaction.

Interdisciplinary Care Team (ICT) Members

1. Member/Legal Representative/Guardian
2. Advanced Plan Practitioner (APP)
   - Physician / PCP
   - Nurse Practitioner
   - Physician Assistant
3. Facility Staff
   - Nursing
   - Pharmacy
   - Dietary
   - Activity Director
   - Therapy

Role: Advanced Plan Practitioner

- Communicates and coordinates with member/family upon HRA completion and quarterly during ICT meetings. Educates member/family.
- Participates in development of Care Plan; Ensures needs/gaps identified in the HRA or subsequent visits are addressed in the Care Plan.
- Attends Quarterly Interdisciplinary Care Team (ICT) Meetings.
  - Best practice is to attend in person. If unable, the APP can discuss needs individually with appropriate care team members (Social Worker(SW), Director of Nursing(DON), therapy, dietary, etc.).
- Conducts oversight for all transitions of care events.

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Role: Facility Staff

- Includes various staff members (nurse, social worker, nutritionist, pharmacist, therapist, activity director, etc.)
- Communicates with all ICT members regarding changes in treatment
- Contributes to the ICT for the ICP development
- Documents and implements the care plan
- Ensures transition of care protocols are followed, **notifies APP of ALL** unplanned **transfers** and **changes in conditions**

Care Transition Protocols (Triggering Events)

Transition definition: a change in level of care

Care Transition Protocols provide a collaborative, proactive approach to safely transition members between levels of care and across care settings using targeted strategies:

- **APPs serve as a centralized point of care coordination** for members and families/caregivers for all care, including transitions.
- **APPs provide preventive and primary care services** delivered in the facility.
- **APPs minimize the need for transitions outside of the facility** through delivery of wellness, preventive and monitoring services delivered in coordination with the ICT members.

Transition Follow-up Timeline
Triggering Events

Member LEAVES a facility (IP, ER, OBS, LTAC)

Within two business days:
The APP coordinates an in-person HRA within two business days of the member's RETURN to the facility.

Within seven days:
The APP completes a face-to-face visit with the member within seven days of the member's RETURN to the facility and coordinates an updated ICP with the ICT.

Change in level of care WITHIN the facility (Skill in Place/SNF)

Within two business days:
The APP coordinates an initial updated Care Plan with the facility within two business days of the START of the skilled service.

Within seven days:
The APP completes a face-to-face visit with the Member within seven days of the START of the skilled service and coordinates an updated ICP with the ICT.

Care Transitions Protocols

- Minimizing transitions outside of the facility through the Skill in Place (SIP) program.
  - Goal is to prevent avoidable hospitalizations, when appropriate.
  - Skilled services in the SNF in place of an inpatient hospitalization, by waiving the 3-day hospital stay requirement.
  - SIP requires a **SKILLABLE** need in combination with meeting the SIP criteria.
  - Important Reminder: to meet SIP, the member cannot have been hospitalized in the last 30 days for the SAME or RELATED diagnosis related to the hospitalization.

Care Transitions (cont.)

1. **Member-Centered Care**
   - APP oversees and approves all care transitions.
   - APP educates member/caregiver re: reasons for the transition and prevention of transitions.
   - Transitions align with the member's goals and advance care directives.

2. **Communication**
   - Peer to peer communication is established across sites of care.
     - The expectation is when a member transfers out of the facility (IP, OBS, ER, LTAC, etc.) , the APP has verbal communication with the intake team to give report and to facilitate return to the facility.
     - It is also an expectation that the APP will keep the PCP team informed of member changes in level of care.
     - Information about the member (i.e., medications and care plans) are collected prior, during and post care transition

Care Transitions (cont.)

3. **Safety**
   - Appropriate assessment of the member PRIOR to transition
   - Prompt and consistent medication reconciliation at every transition point
   - Accurate and timely transition of key information (i.e., functional/cognitive status, current problem list, allergies, advance directives, recent labs, consultations, diagnostic testing results, etc.)

Care Transitions

APP Role:

- Coordinates an in-person HRA within 2 business days of the member's RETURN to the facility
- Updates ICT on the member's status and transition plan
- Educates member and/or caregiver on reason(s) for transition and future prevention
- Provides instruction on self-care, recognition of warning signs and who to contact for concerns
- Reviews updated Individualized Care Plan (ICP)
- Coordinates post-hospital follow-up services

Care Transition Personnel

The personnel responsible for coordinating the care transition process include:

- The **Advanced Plan Practitioner** (APP) should be notified by the facility staff of all planned or unplanned care transitions with every effort made to consult with the APP ***before*** a facility sends a member to the hospital.
- The **facility** has the responsibility of notifying the APP ***before*** an unplanned care transition. The facility should also notify the Plan of transfers to hospital so the Utilization Management team can ensure appropriate level of care, and begin care coordination efforts.
- The Plan's **Utilization Management** (UM) team coordinates care when members are admitted to a facility.
- The Plan's **Care Manager** coordinates care for members who discharge from the facility to home.

MoC 3: **Provider Network**

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians and acute care facilities pertinent to the care of long-term senior housing residents.
- Primary care services through the Advanced Plan Practitioner (APP) and supportive ancillary services are coordinated by the APP.
- The APP also coordinates visits and services provided outside of the facility including specialist visits, radiology, lab and other diagnostic testing not available on campus.
- Out of Network referrals may require prior authorization.

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MoC 4: **Quality Measurement and Performance Improvement**

- The Plan's Quality Improvement Program (QI Program) supports and promotes the mission, vision and values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services and the delivery of services to members.
- The Plan's QI Program is assessed annually and reviewed by the Quality Improvement Committee (QIC) to determine the overall effectiveness of the program.
- The goal is to provide accountability for the quality of health care delivery and services.
- Information regarding quality of care is gathered from medical claims data, member complaints, provider complaints and Plan identified situations.
- Patterns of identified substandard care events are monitored and reported as part of the quality improvement program on a quarterly basis.
- The Plan educates its network on key performance measures and changes to the MoC.

Thank you for your participation

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Model of Care (MOC) Provider Training

Attestation Form

The Model of Care (MOC) is a patient-centric medical care delivery system for Institutional Special Needs Plan member's and is designed to maintain the member's health and encourage their involvement in their health care. Great Plains Medicare Advantage is required by the Centers for Medicare and Medicaid Services (CMS) to provide initial and annual training of its Model of Care and as a provider who cares for one of our beneficiaries you are required to complete this training.

I hereby attest that I have reviewed this Model of Care Training to satisfy the CMS requirement.

Provider Name			
Provider NPI			
Clinic/Facility Name			
Provider Signature		Date	

Submit your attestation by Fax to (605) 312-8237 or by email to cindy.held@SanfordHealth.org.