AHF AIDS HEALTHCARE FOUNDATION

Medicare Advantage Special Needs Plan

Chronic Care Program

Model of Care Training

2012 - 2013

POSITIVE HEALTHCARE

Course Overview

This course will describe:

- PHP's Model of Care – Chronic Care Program
- Health Homes
- Interdisciplinary Care Teams
- Health Risk Assessments
- Individual Care Plans
- How PHP and its contracted providers can work together to successfully deliver the SNP Model of Care to PHP Plan Members.

Course Objectives

After the training, attendees will be able to:

- ✓ Describe the PHP Model of Care – Chronic Care Program (CCP)
- ✓ Define the core team of case management
- ✓ Explain the benefits of partnership with the PHP member
- ✓ Describe the essential role of contracted providers in delivering the PHP Model of Care CCP

Special Needs Plan Background

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- The Centers for Medicare and Medicaid Services (CMS) requires health plans designated as Special Needs Plans (SNPs) to provide initial and annual Model of Care (MOC) training to all staff and contracted medical providers.

- The SNP Model of Care involves building a relationship with providers, members, and the community to facilitate member self management of their healthcare.

- SNPs were created in 2003 as part of the Medicare Modernization Act

Care Management through SNPs

As of 1/1/2010, all SNP enrollees must qualify as:

- **Dually eligible** for Medicare and Medicaid benefits and services

OR

- **Institutionalized or institutional equivalent** residing in the community

OR

- Having certain **CMS-approved severe or disabling chronic conditions**

Purposes of SNP

The purposes of the Special Needs Plan are to:

- Increase plan & beneficiary participation in managed health care
- Encourage access of “special needs” populations
- Provide better coordination of care between primary, specialty, acute, and long term care providers
- Reduce fragmentation
- Improve quality outcomes

SNP Model of Care

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The SNP Model of Care is the ***architecture*** for care management policy, procedures, and operational systems.

Model of Care Elements

1) Measurable Goals

2) Staff Structure & Care Management Roles

3) Interdisciplinary Care Team

4) Provider Network with Specialty Expertise and

5) Evidence based practice utilizing Clinical Practice Guidelines

Model of Care Elements

6) Model of Care Training

7) Health Risk Assessment

8) Individualized Care Plan

9) Communication Network

10) Performance & Health Outcome Measurement

PHP MOC Description

Our MOC - Chronic Care Program (CCP) is a relationship between PHP contracted providers, members, their caregivers and the community. Our members are encouraged to be active in care self-management in order to achieve their health & psychosocial goals.

CCP Characteristics

- The program strengthens the centralized role of the nurse in care coordination by designating registered nurse case managers as care team managers.
- The program is grounded in the principles of case management to address the continuing care needs of members in the different AHF programs.

CCP Characteristics (cont.)

- The case management model is also aimed at more efficient utilization of existing resources for members, providers and staff.

- Our goal is to help members successfully navigate through the complex system in order to provide seamless coordination and transition from one level of care to another.

Health Homes

Health Homes are the foundations where the Primary Care Provider, Case Management Nurse, Member and their care givers are in a care partnership.

This partnership impacts the ‘Quality of Care’ for members by:

•providing a team approach to care

•incorporating evidence based practice into interventions and

•Utilizing Community Resources appropriately

Health Homes (cont.)

Our Health Home Primary Care Providers are board-certified HIV disease specialists who serve as gate-keepers for specialty referrals.

PHP looks to all providers to collaborate on the ICP with care managers, members and their caregivers to manage HIV/AIDS & co-mobidities

CCP Partnership Model

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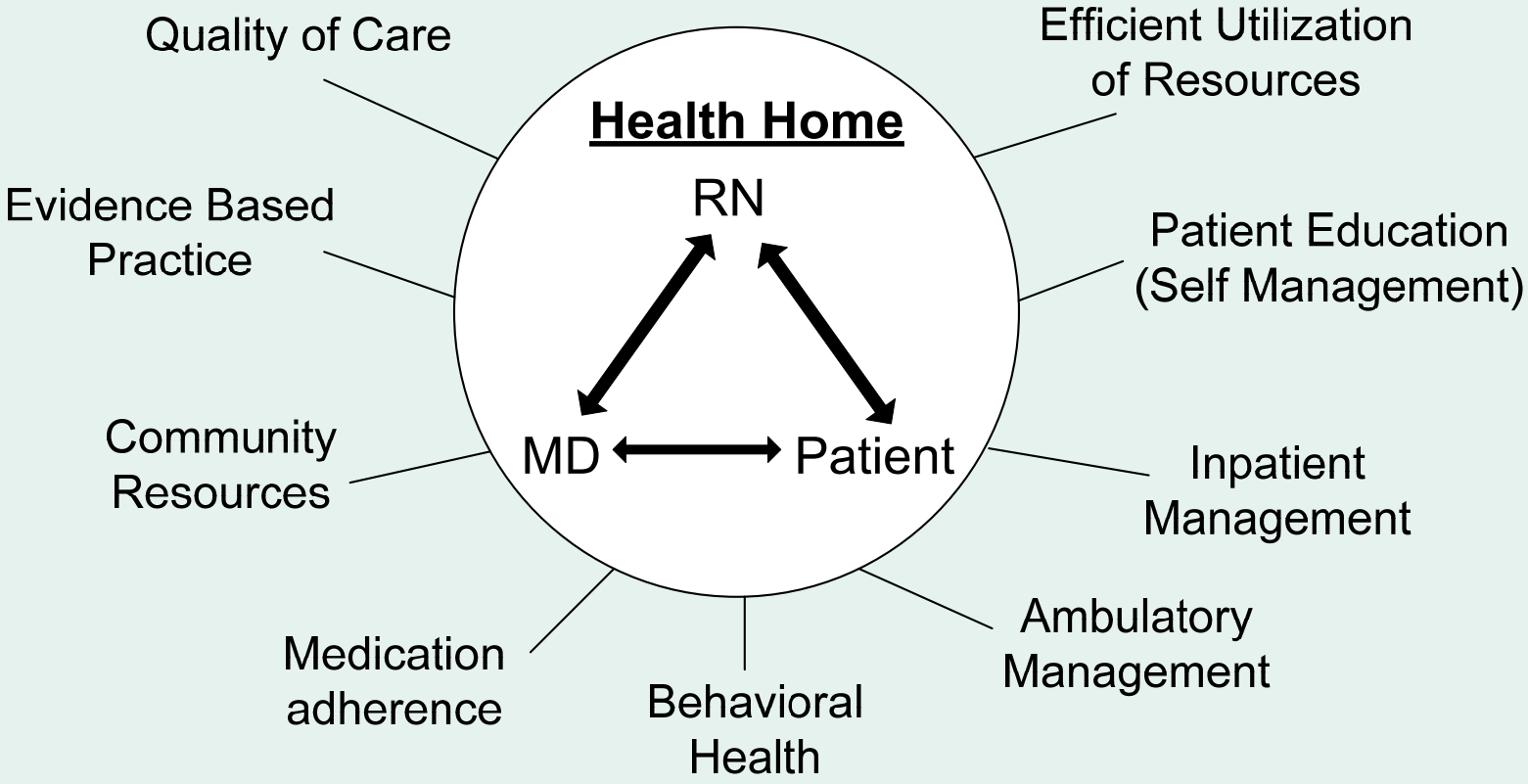
‘Health Home’ with the Primary Care Provider, nurse and member in a care partnership



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CCP Partnership Model (cont.)

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- This model fosters efficient utilization of resources by involving the team in care review, encouraging medication adherence, supporting member self management and compliance with the plan of care

- The case management program also builds a partnership with the physicians through team conferences

CCP Partnership Model (cont.)

- Provides ‘Ambulatory Management’ when the Core Team follows up on services in the outpatient setting

- Provides ‘Inpatient Management’ when the Core Team contacts the member, coordinates discharge plans with the Utilization Management nurse and assesses member self management skills for appropriate services

CCP Partnership Model (cont.)

The Core Team's partnership under the direction of the RN Care Team Manager:

- Facilitates the development of Individualized Care Plans (ICPs) for each PHP member.
- Provides information on the member's home environment & the psychosocial aspects of care.
- Focuses on the total individual and supports self-care when possible.
- Increases the member's involvement in decision making.

Interdisciplinary Care Team (ICT)

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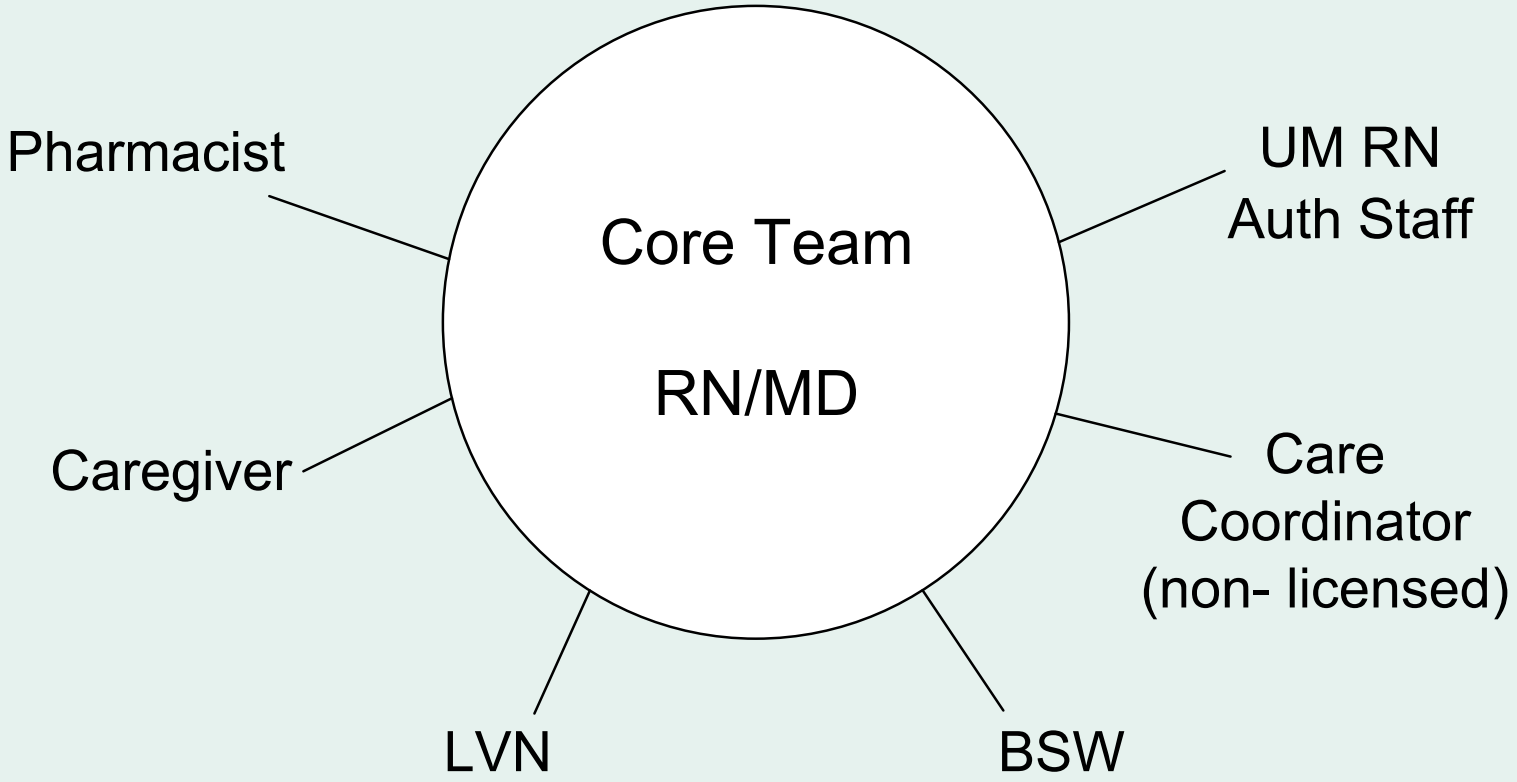
- Each member is assigned to a Health Home with an Interdisciplinary Care Team (ICT)

- ICT members each have clearly defined roles.

- The ICT provides the infrastructure needed to review and coordinates the Individualized Care Plans (ICPs) for our members

- Its functions include:
  - monitoring ICPs; and
  - sharing information with the member, their providers, caregivers, and community-based services.

Interdisciplinary Care Team (cont.)



Care Team Roles

Primary Care Provider

- Initiates a Plan of Care with the member and signs off on the Individualized Care Plan created with the RN Care Team Manager
- Participates in member conferences
- Completes initial & annual PHP MOC training
- Adheres to evidence based interventions
- Provides or arranges for the delivery of routine comprehensive preventative services & medically necessary primary care and urgent care services

Care Team Roles (cont.)

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Primary Care Provider (cont.)

- Coordinates or seeks referrals to PHP providers having special expertise in treating PLWHA, including:
  - Specialty physician services
  - Hospital inpatient and outpatient services
  - Ancillary services (lab, radiology, orthotics / prosthetics & DME)

Care Team Roles (cont.)

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RN Care Team Manager

- Working from their Health Home base, collaborates with and plays a lead role with Health Home and external network PCPs, the Care Team and other practitioners to ensure members are well supported and managed within the Health Home

- Completes assessments for all new members and assigns them a severity level. Members with Severity Level II are assigned to LVN Care Partners and Severity Level I members are assigned to Care Coordinators

Care Team Roles (cont.)

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LVN/LPN Care Partner

Under the direction of the RN Care Team Manager the LVN/LPN Care Partner coordinates all related activities of the Severity Level 2 members by:

- **Implementing, evaluating, and revising the care plan for their assigned members**
- **Completing reassessments every 8 weeks**

Care Team Roles (cont.)

Care Coordinator

Under the direction of the RN Care Team Manager the Care Coordinator:

- Implements the care plan for Severity Level I members by coordinating and scheduling services
- Implements required member mailings
- Schedules member assessments, re-assessments and home visits
- Ensures that all members are administered the 17 Question Knowledge Survey and the SF-12 survey that identifies the impact of illness on the member
- Reviews claims for red flag events such as: ER visits, hospitalizations and readmissions

Care Team Roles (cont.)

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Medical Social Worker

Under the direction of the RN Care Team Manager the Medical Social Worker:

- Provides additional assessment for the Care Teams and suggests referral for additional support when appropriate
- Receives referrals from the team members for Plan members needing behavioral health providers
- Works with the Benefit Coordinator to provide referral and access to community services
- Develops and maintains a current repository of community services for use by the Care Teams

Care Team Roles (cont.)

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Utilization Management Nurse

- Informs the RN Care Team Manager of member admissions to hospitals, SNFs, home healthcare services, rehabilitation or detoxification centers and long term acute placements

- Coordinates the discharge of members with respective Care Team members and starts the transition process

Care Team Roles (cont.)

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Pharmacist

- *Participates in Interdisciplinary Care Team conferences with any additional pharmacology information and member related assessments*

- *Provides medication information directly to members in the clinic and shares any strategies useful for adherence to medication regimen*

Care Team Roles (cont.)

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Authorization Coordinator

Under the Supervision of the Director of Utilization and Case Management

- Facilitates authorization for ambulatory care and services
- Communicates authorization information to appropriate Care Team members
- Supports referral process where necessary

Health Risk Assessment (HRA)

- The RN Care Team MAnager conducts initial and annual HRAs for EACH plan member to assess the member's medical, psychosocial, cognitive, and functional needs.

- Health risk assessment tool addresses the needs of PLWHA to determine acuity level for each member.

- The results of the HRA are used to develop and update an Individualized Care Plan (ICP) for the member.

- The HRA may be face-to-face or telephonic.

Individual Care Plan (ICP)

- The Care Team develops an ICP for each member using a problem/intervention framework.
- Follow-up on the care plan interventions occurs at least quarterly and is determined by the SL stratification
- Updated by the Care Team at least annually or when member's health status changes.
- .Communicated to all caregivers for care coordination.
- Members and/or their caregivers must sign off on or acknowledge the ICP.
- Includes goals and objectives, specific services, benefits and measures outcomes.

Summary

Positive Healthcare values the partnerships we have developed with our providers. Our Chronic Care Program provides us the opportunity to work together for the benefit of our members through:

- Enhanced communication between PHP, our providers, our members and other care partners;
- Individualized focus on each member's special needs;
- Comprehensive coordination with all care partners;
- Support for the member's Individual Care Plan; &
- Connecting the member to their medical home.

MOC Annual Training Attestation

Congratulations on completing the required SNP MOC Training!
In order to validate your completion of this training, please sign and date the enclosed MOC Annual Training Attestation Form and return it to Positive Healthcare Provider Relations either by mail or fax as indicated below:

CALIFORNIA:

PHP Provider Relations

Fax: 323-436-5032

FLORIDA:

PHP Provider Relations
110 SE 6th Street, Ste. 1960
Ft. Lauderdale, FL 33301

Fax: 954-522-3260