El Paso Health+
Advantage Dual SNP

Dual Eligible Special Needs Plans (DSNP) Model of Care Training- Providers

Mission & Vision

Our **Mission**

To **build relationships** with our Members, Providers, and Partners that strengthen the delivery of healthcare in our community and **promotes access to quality healthcare** for children, families, and individuals.

Our **Vision**

We will be the region's **trusted** community health plan.

Introduction

- The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and member facing staff receive basic training about the Dual Special Needs Plans (DSNPs) Model of Care (MOC).

- The DSNPs Model of Care is the plan for delivering coordinated care and care management to special needs members.

- This course will describe how El Paso Health and our contracted providers can work together to successfully deliver the DSNPs Model of Care.

Training Plan Content
D-SNP Model of Care

Learning Objectives

- EPH employed and contracted staff who directly or indirectly affect Care Coordination services for DSNP Members are required to complete DSNP MOC training initially - within 30 days of start date or execution of contract

- Program participants will be able to:
  - List the three overall goals of the D-SNP Model of Care
  - Describe the three vulnerable subpopulations
  - Understand the purpose of the Health Risk Assessment
  - Understand the key components of the Individualized Care Plan and how it impacts Care Coordination
  - Understand the purpose of the Interdisciplinary Care Team and how it impacts Care Coordination
  - Name two principles important to improve transitions of care
  - Identify three Performance indicators being measured to evaluate the Model of Care

MOC 1
Description of Overall SNP Population

MOC 1: Description of Overall SNP Population

Dual Special Needs Plans Eligibility & Features

Eligible members:

- Reside within the program's service area
  El Paso and Hudspeth Counties
- Meet dual eligibility status requirements
  QMB and QMB+
- Benefit plans are **custom designed** to meet the needs of the target population

Primary coverage for dual eligible members:

- Medicare is always primary
- Medicaid is the payer of last resort and supplements Medicare coverage
- Members are eligible for special election period to change health plans quarterly throughout the year

MOC 1: Description of Overall SNP Population

Goals of Special Needs Plans

Goal One	Goal Two	Goal Three
Improve Access	Provide Seamless Care Coordination	Improve Outcomes
• To safer, higher quality, equitable, and affordable healthcare	• ensure that the patient's need and preferences for health services and information sharing across people, functions, and sites are met over time	• Social, Behavioral and Medical outcomes for vulnerable populations • HEDIS measures
(CMAG 2012)	*(NQF 2006)*	

MOC 1: Description of Overall SNP Population

Vulnerable Subpopulations

- **Diagnosis of Diabetes**
- **Diagnosis of Alzheimer's Disease or other dementia; Indication of forgetfulness**
- **And age of 80 years or older who live in the community and have three or more chronic illnesses (Frail Individuals)**

MOC 1: Description of Overall SNP Population

Language and Communication Resources

- In 2015, EPH adopted National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care standards to ensure that all Members entering the health care system receive equitable and effective treatment.
  - Identifies resources to assist Members with language and communication needs
- Language and Cultural
  - EPH Member Services Representatives, Outreach Associates, and Case Managers and after hours Nurse line are bilingual in English and Spanish or arrange Interpretation Services for other languages. EPH staff participate in cultural competency training as well as live locally, among DSNP members
- Literacy and Impairment (hearing, vision, self-care, and independent living difficulties)
  - Materials provided in preferred language and form (e.g., larger print, Braille, and versions in other languages)
  - Sign language interpretation, or Telecommunications Device for the Deaf (TDD) access.

MOC 2
Care Coordination

MOC 2: Care Coordination

Case Management

Description of how Care Coordination takes place and the roles of the Case Manager

- **Member centric, evidence based Care Coordination** is provided through an integrated staff structure in which the Dual Special Needs Plan (DSNP) **Members' health care needs are met and health services are delivered in the preferred setting.**
- EPH administrative and clinical staff roles support Care Coordination to **maximize the use of effective, efficient, safe and high-quality Member services** provided by network Providers as well as Community Partners.
- Case Managers core functions **promote the highest level of physical, psychological, and social functioning possible** for Members and their families.

MOC 2: Care Coordination

Health Risk Assessment

The Health Risk Assessment (HRA) is a series of questions designed to best identify a Member's state of health, risk for exacerbation of acute or chronic conditions, functional decline, and social issues likely to impact the Member's ability to achieve personal health and well-being goals.

Purpose:

- Assess the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary.
- Contributes to development of the Individualized Care Plan (ICP)
- Supports Interdisciplinary Care Team (ICT) composition and activities

MOC 2: Care Coordination

Health Risk Assessment

Process:

- EPH employs a collaborative team approach to ensure completion of the HRA. Health Services work to perform outreach, generate mailings, and coordinate with Providers to facilitate Member engagement.
- HRA mailing
- Member Services Outreach
- Case Manager Outreach

Each DSNP Member will have an HRA and ICP completed initially within 90 days of enrollment effective date and within 365 days of the last HRA. Reassessment is not limited to once per year. Additional reassessments can be conducted more frequently if there is a change in social, environment, medical or behavioral health status, which may include emergency department visits, inpatient admission, or change in risk analysis.

MOC 2: Care Coordination

Individualized Care Plan

Each D-SNP Member will have an Individualized Care Plan completed initially and updated at least annually, or with a change in health care needs, per CMS regulations.

Purpose:

- Identify gaps in care, at risk areas, knowledge deficits, and self-management issues.
- Develop individualized, member centric opportunities and associated goal with correlating health care professional interventions

Process:

- Identify opportunities based on HRA
- Member prioritizes individualized goals
- Linguistic and cultural preferences are included
- Updated as changes occur

MOC 2: Care Coordination

Individualized Care Plan Continued

The ICP will be individualized based on the initial HRA results, the Case Manager assessment, the Member's medical history, health care, cultural and linguistic preferences, pharmacy utilization, and input from all active Members of the ICT.

MOC requirements:

- Each D-SNP Member will receive an Individualized Care Plan within 30 days of completion of the HRA. The ICP is shared in the manner that the Member has requested.
- Should the D-SNP Member not complete an HRA with three (3) telephonic attempts, known providers are engaged to find alternate contact numbers. If all efforts are unsuccessful, an Unable To Reach letter is mailed encouraging the Member to contact EPH to complete the HRA and provide input into an ICP if needed. If repeated attempts to contact member fail, a HRA reassessment attempt will be scheduled for the following 12 months.

MOC 2: Care Coordination

Interdisciplinary Care Team

Team Member selection, role, and how information is shared

Purpose: The Interdisciplinary Care Team (ICT) is a group of health care professionals from diverse fields who work together consistently toward a common goal for the Member, to improve care.

Composition of the Interdisciplinary Care Team:

- Core team: Member or representative, Primary Care Provider (PCP) or designee, and Case Manager.
- Expanded ICT: Core team and others to address specific needs at a point in time.
  - Caregiver, Member Services Representative, Medical Director, Specialists, Clinical Supervisor, Pharmacy Technician, Pharmacist, Utilization Review Nurse Coordinator, and partners such as a Case Manager with the Local Mental Health Authority.
  - Any person/Provider who has an impact on the health and wellbeing of the Member.

MOC 2: Care Coordination

Interdisciplinary Care Team Continued

Roles:

- Member and/or caregiver: identify and prioritize goals, indicates cultural, linguistic and other preferences
- Case Manager: primary contact for ICT members, schedules, leads and documents findings of ICT case conference, shares updates to ICP
- PCP: provides insight on primary care and treatment, makes recommendations
- Expanded ICT members: provide insight on specialty care and treatment, make recommendations

Communication Plan:

- The Case Manager acts as the single point of contact for members of the ICT
- A meeting summary of each case review by the ICT is documented in the Member's record
- The updated ICP is shared with members of the ICT

MOC 2: Care Coordination

Interdisciplinary Care Team Continued

MOC requirements:

- All DSNP members are assigned an ICT
- Special accommodations will be made for Members with hearing or visual impairments, language and literacy barriers, and cognitive deficiencies.
- Case review meetings will occur weekly
- Criteria for review includes
  - unplanned hospitalized for anticipated length of stay of 7-10 days
  - all cause readmission
  - Risk of admission
  - Pharmacotherapy non-adherence
  - Inadequate progress toward goals
  - Member, Caregiver or ICT Member Request
  - Any other as approved by Director of Health Services

MOC 2: Care Coordination

Face to Face Encounters

- EPH outreach staff will conduct face-to face encounters using various methods that may include, but not limited to, home visits, member advisory encounters, or EPH site visits from member
- EPH has a mechanism in place to track face-to-face encounters by using an activity within the OICS System that will identify a Member that had a face-to-face encounter.
- During face-to-face encounters, barriers to treatment, health concerns, and/or active or potential issues will be addressed with Member or caregiver. If a barrier to treatment, health concern or active or potential issue is identified, the EPH staff will address this immediately with the Member and/or caregiver and make every effort to expeditiously resolve.
- Frequency of contact is contingent upon Members' severity level, level of need, change in condition, but will be conducted at least annually or more often if needed.

MOC 2: Care Coordination

Detail the essential components of the ICP

The ICP includes the following essential elements:

- HRA results;
- Identification of the Member's support system (i.e., caregiver)Opportunities which are defined as a need to improve health outcomes;
- Identification of goals, met and not met,, including self-management goals;
- Interventions, including a description of services tailored to meet the Member's needs and preferences
- Actions;
- Progress toward goals, interventions, and actions allowing Case Management team to reassess progress to meeting goals, determining alternative actions, and updating ICP if needed.

MOC 3
Provider Network

MOC 3: Provider Network

- El Paso Health maintains a specialized provider network that is designed to provide access to medical, behavioral and psycho-social services for the dual population.
- EPH operates an effective and efficient credentialing and re-credentialing process to validate Provider qualifications as outlined in our quality management program.
- Our average approval time for a credentialing or re-credentialing application is 30 days, and EPH makes determinations on all applications within 60 days of receiving a complete application, which exceeds the state of Texas 90-day requirement.
- The EPH's credentialing and re-credentialing program conforms to all state and federal antidiscrimination regulations and facilitates the health plan's ability to ensure Providers and facilities are competent and have active licenses.

MOC 3: Provider Network

El Paso Health provider partners are an invaluable part of the interdisciplinary care team. Our D-SNP Model of Care offers an opportunity for us to work together for the benefit of our members by enhancing communication, focusing on each individual member's special needs and delivering care management programs to assist with the patient's medical and non-medical needs.

The provider role

- Communicate with D-SNP care managers, ICT members and caregivers
- Collaborate with our organization on the ICP
- Participate in the ICT
- Complete MOC training upon onboarding and at MOC renewal
- Submit changes in contact and other information pertinent to his or her practice to El Paso Health

MOC 3: Provider Network

- EPH monitors network Providers to ensure the use of our Clinical Practice Guidelines (CPGs) when appropriate.
- Every year as part of our HEDIS hybrid review, medical records are requested for a sample of our Members and are reviewed by our Quality Improvement nurses.
    - As part of this review, the medical record documentation is assessed for adherence to our CPGs, for applicable HEDIS measures.
- In addition, Providers are monitored for compliance with CPGs through Member and Provider complaints, UM services, adverse events, potential quality of care concerns, access and availability surveys, and internal service metrics.
- Results of CPG adherence are examined by the Quality Improvement department through select guideline quality measures. Results of these measures are shared with Providers at least annually through Provider profiling and can occur more often if necessary. In addition, overall compliance with CPG measures are presented and reviewed annually by Quality Improvement Committee (QIC).

MOC 4
Quality Improvement

MOC 4: Quality Measurement and Performance Improvement

- Measureable Goals: Identifies D-SNP goals, how performance is evaluated, and communicated to stakeholders
  - EPH utilizes a wide array of data sources, performance and outcome measures to analyze, evaluate, and report on MOC implementation and effectiveness
    - medical and pharmacy utilization reports
    - call center utilization reports
    - complaints and appeal reports
    - network adequacy reports
    - quality of life indicators
    - clinical health outcome metrics (HEDIS)
    - Member satisfaction survey results
    - internal MOC implementation audit tool
    - CAHPS survey

MOC 4: Quality Improvement

Goals Continued

EPH D-SNP Goals and impact on vulnerable subpopulations

- Health outcome measures specific to the identified vulnerable populations will be monitored regularly and assessed annually
- All Vulnerable D-SNP Populations
  - Admissions, ED Visits and Re-admissions, provider access and availability
- Diabetes Population
  - Comprehensive Diabetes Control

MOC 4: Quality Improvement

Goals Continued

- Alzheimer's Disease and other Dementias Population
  - Inappropriate use of antipsychotic medications for Members with Alzheimer's and other dementia-related conditions (Potentially Harmful Drug-Disease Interactions in the Elderly)
  - Hospitalization following discharge from a skilled nursing facility
  - Rate of individuals who move to a long term facility
- Frail Population - 80 years or older who live in the community and have three or more chronic illnesses
  - Flu Shot Rate
  - Incidence of Osteoporosis
  - Pneumonia Vaccine
  - Hospitalization following discharge from a skilled nursing facility
  - Rate of individuals who move to a long term facility

MOC 4: Quality Improvement

Evaluation of Performance and Communication of Results

Performance indicators tracked quarterly through the MOC audit tool:

- Percent of associates who directly or indirectly affect care coordination services who receive DNSP Model of Care training annually
- Percent of network providers who receive initial DNSP MOC training within 30 days of inclusion in EPH Network
- Percent of network providers who receive DNSP MOC training annually
- Percent of DNSP members who complete initial HRAT within 90 days of enrollment
- Percent of DNSP members who complete HRAT annually
- Percent of DNSP members who receive an ICP within 30 days of completing HRAT
- Percent of admissions or discharges that are communicated to the ICT within 1 business day of notification
- Percent of transitions of care where Member's ICP is shared with provider or facility within 5 business days of notification

Communication of results: If goals are not met the PDSA method is applied to determine the root cause of the deficiency. The Medical Director, Director of Health Services, and/or Providers are notified about deficiencies. Interventions are put in place. The results are reported to the OIC, QIC and applicable departments and the BOD in quarterly and/or ad hoc reports.

DSNP Model of Care Provider Attestation

All providers must complete training and submit attestation at the time of MOC renewal.

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