Special Needs Plan Model of Care (SNP - MOC)

2020 Model of Care Training for Providers

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SPECIAL NEEDS PLAN MODEL OF CARE PROVIDER TRAINING REGULATION

- Chapter 42 of the Code of Federal Regulations, Part 422 (42 CFR 422.101 (f)(2)(ii)) mandates that Special Needs Plans (SNPs) conduct SNP Model of Care (MOC) training for all employed and contracted providers.

- The SNP MOC is the evidence-based process by which CCHP integrates benefits and coordinates care for members enrolled in CCHP's SNP.

PROVIDER TRAINING STANDARDS

All CCHP participating providers must receive training on the MOC initially and annually thereafter.

- Initial training must be completed within 90 days from contract execution date and annually thereafter.
- Annual training is provided via live webinar and attestation statement must be completed within 90 days from the live webinar.

Learning Objectives

- To gain an understanding and comprehension of CCHP's Special Needs Plans (SNPs)
- To gain an understanding and comprehension of the Elements of the SNP Model of Care.
- At the end of this training, you will be able to:
  - ❖ Describe the best practices for the SNP Model of Care.
  - ❖ Describe how you can help improving our members health outcomes.

What is SNP Model of Care?

- Special Needs Plans are specialized Medicare Advantage plans for beneficiary with special circumstances. A SNP can be one of 3 types:
  - Chronic SNP (C-SNP) for members with severe or disabling chronic conditions.
  - Institutional SNP (I-SNP) for members requiring an institutional level of care or equivalent living in the community.
  - Dual-Eligible SNP (D-SNP) for members eligible for Medicare and Medicaid.

- Model of Care is CCHP's comprehensive plan for delivering our integrated care management program for our special needs member.
  - It is the architecture for promoting quality, care management policy and procedures, and operational systems.

CCHP offers a Dual Eligible SNP (D-SNP)

- CCHP offers a D-SNP named "CCHP *Senior Select Program (HMO SNP)"*

  - Enrollees must have Medicare and Medicaid benefits
  - Offered in San Francisco
  - Current membership is 3,004 members
  - Enrollees in this D-SNP are responsible for $0 for covered medical services

SNP MOC: 4 Domains, 15 Elements

MOC 1: Description of the SNP Population

Element A. Description of Overall SNP Population

Element B. Sub-Population: Most Vulnerable Beneficiaries

MOC 2: Care Coordination

Element A. SNP Staff Structure

Element B. Health Risk Assessment Tool

Element C. Individualized Care Plan (ICP)

Element D. Interdisciplinary Care Team (ICT)

Element E. Care Transitions Protocols

SNP MOC: 4 Domains, 15 Elements (cont.)

MOC 3: SNP Provider Network

Element A. Specialized Expertise

Element B. Use of Clinical Practice Guidelines and Care Transition Protocols

Element C. MOC Training for the Provider Network

Element 4: Quality Measurement and Performance Improvement

Element A. MOC Quality Performance Improvement Plan

Element B. Measurable Goals and Health Outcomes for the MOC

Element C. Measuring Patience Experience of Care (Satisfaction)

Element D. Ongoing Performance Improvement Evaluation of the MOC

Element E. Dissemination of SNP Quality Performance Related to the MOC

Description of the SNP Population

CCHP currently has 3,004 SNP beneficiaries in San Francisco.

- 30-106 years old is the age range of this population; the average age is 79 years old
- 80% of beneficiaries are between the ages of 68-89 years old
- 56.4% beneficiaries are women, 43.6% are men

SNP MOC responds to our mission

Provide high-quality, affordable healthcare through culturally competent and linguistically appropriate services

- CCHP provides services to:
  - Frail elderly
  - High health risk individuals
  - Low-income and low socioeconomic population
  - Individuals with multiple chronic and acute health problems
  - Individuals with or at risk of medication and treatment plan non compliance
  - Individuals that lack family support
  - Limited English literacy individuals
  - Individuals with barriers to access community resources and support
  - Strive for quality outcomes
  - Support PCPs plan of care
  - Educate, guide, and support individuals to health and community resources

Care Coordination Activities and Programs

- Care Coordination staff include registered nurses and social workers
- Performs an assessment to identify individual health needs
- Develops a comprehensive ICP
- Identifies barriers to goals and strategies to address
- Provides personalized education for optimal wellness
- Encourages preventive care
- Post Discharge planning
- Reviews and educates on medication regimen
- Assists member to access community resources
- Assists caregiver when member is unable to participate
- Provides a single point of contact during care transition

Health Risk Assessment

Self-reported survey includes questions on medical, psychosocial, cognitive, functional and mental health.

- Initial HRA must be completed within 90 days of effective enrollment.
- Annual reassessment must be completed within 365 days of last HRA.
- Telephonic outreach is conducted if no HRA is returned within 1 month of mailing date.
- Used to stratify member into risk categories for care coordination.
- HRA provides the basis for the development of the plan of care.

HRA Sample

健華人計劃保 CCHP Health Plan
445 Grant Avenue, Suite 700 | San Francisco, CA 94108
T 1-415-955-8800 | F 1-415-955-8818 | www.CCHPHealthPlan.com

MEMBER HEALTH SURVEY
華人保健計劃會員健康評估

Member Name:
CCHP ID #:

1 What is your preferred language? 您的首選語言是什麼?

- ☐ English 英語
- ☐ Cantonese 廣東話
- ☐ Mandarin 普通話
- ☐ Spanish 西班牙語
- ☐ Other, please specify 其他，請註明: _____

2 What is your ethnicity? 您的種族是:

- ☐ African American 非裔美國人
- ☐ Caucasian 白人
- ☐ Chinese 華人
- ☐ Filipino 菲律賓人
- ☐ Hispanic or Latino 西班牙裔或拉丁裔
- ☐ Korean 韓國人
- ☐ Native American or American Indian 美洲原住民或美國印第安人
- ☐ Vietnamese 越南
- ☐ Other, please specify 其他，請註明: _____

3 In general, you would say your health is: 一般而言，您會如何形容您目前的健康狀態?

- ☐ Excellent 非常好
- ☐ Good 好
- ☐ Fair 還可以
- ☐ Poor 差

4 When was the last time you saw your primary care doctor? 您上次約見醫生是在什麼時候?

- ☐ Less than 6 months ago 六個月內
- ☐ 6-12 months ago 六至十二個月前
- ☐ More than 1 year ago 超過一年前

5 What health conditions do you have or have you had in the past?
(Please check all that apply)
您曾否被診斷過患有下列任何一種疾病?（請註明所有適用的項目）

- ☐ Chronic obstructive pulmonary disease 慢性肺病
- ☐ Chronic pain 長期嚴重痛症
- ☐ Congestive heart failure 心臟衰竭
- ☐ Dementia 癡呆
- ☐ Depression 抑鬱症
- ☐ Diabetes 糖尿病
- ☐ Heart disease 心臟病
- ☐ Hepatitis 肝炎
- ☐ High blood pressure 高血壓
- ☐ High cholesterol 高膽固醇
- ☐ HIV/AIDS 愛滋病
- ☐ Kidney dialysis 腎透析（洗腎）
- ☐ Obesity 肥胖症
- ☐ Parkinson's disease 帕金森病
- ☐ Stroke 腦中風
- ☐ None 沒有

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6 Do you take your medications as ordered by your doctor? 您是否遵從醫生指示服用藥物?

- ☐ Yes 有
- ☐ No 沒有
- ☐ I do not have to take medicine 我不需要服藥

7 Have you been hospitalized 2 or more times in the past 12 months?
在過去 12 個月內，您是否曾經住院兩次或以上?

- ☐ Yes 有
- ☐ No 沒有

8 Have you had 3 or more emergency (ER) visits in the past 12 months?
在過去 12 個月內，您是否曾經使用急診室三次或以上?

- ☐ Yes 有
- ☐ No 沒有

9 Have you fallen 2 or more times in the past 12 months?
在過去 12 個月內，您是否曾經跌倒過兩次或以上?

- ☐ Yes 有
- ☐ No 沒有

10 Do you need help to get around inside or outside the home?
您在家或外出行動需要人幫忙嗎?

- ☐ Yes 需要
- ☐ No 不需要

11 Do you use a cane, wheelchair, or walker? 您使用拐杖，輪椅，或助行車嗎?

- ☐ Yes 有
- ☐ No 沒有

12 Do you live alone? 您是否獨居?

- ☐ Yes 是
- ☐ No 不是

13 Do you have help at home? 您在家裡是否得到所需的幫助?

- ☐ Yes 有
- ☐ No 沒有
- ☐ I do not need help 我不需要幫助

14 Do you currently smoke cigarettes or use tobacco on a daily basis?
您是否每日抽煙或使用任何煙草製品?

- ☐ Yes 有
- ☐ No 沒有
- ☐ I do not smoke cigarettes or use tobacco 我不抽煙或使用任何煙草製品

15 In the past four weeks, have you been feeling down, hopeless, or have little interest in doing things? 在過去的四個星期裡，您是否感到沮喪，絕望，或對做任何事情都沒興趣?

- ☐ Yes 有
- ☐ No 沒有

Thank you very much for completing this survey. Please return the completed survey in the enclosed self-addressed stamped envelope.
謝謝您的寶貴時間, 請使用預付回郵信封寄回.

Development of Individualized Care Plans (ICP)

- HRA responses used to develop/update the ICP
- Data such as claims and pharmacy is used to develop the member's ICP when no HRA response is received
- ICP is maintained and stored to assure access by all care providers and meet HIPAA and professional standards
- ICP includes:
  - Member's health care preferences
  - Goals and objectives and targets with detailed tasks and self-management plans
  - Interventions and services tailored to member's unique and individual needs
  - Documentation if time-bound goals met or not met
- Utilize evidence-based guidelines such as InterQual Care Guidelines

Individualized Care Plan Goals Model

ICP goals based on the SMART Measurable Goal Model:

1. **Specific** – Exactly what is to be learned/accomplished by the member.
2. **Measurable** – A quantifiable goal and specific result that can be captured reported and documented in the ICP.
3. **Attainable** – Goal is achievable by the member.
4. **Relevant** – Goal is clearly linked to health status.
5. **Time-Bound** – The deadline or time period to motivate and evaluate is specific in terms of specific date, number of days/weeks/months or calendar year.

Individualized Care Plan…*cont*.

- ICP addresses HRA responses and member preventive care gaps
- Members that do not respond to the HRA will receive an ICP based in part of claims or encounter data
- ICP is documented in the care management tool and updated when a member's health status changes or at minimum annually.
- ICP updates and changes are communicated to the member, caregiver(s) and primary care provider (PCP).

ICP Sample

CCHP 華人健保計劃 Health Plan

Care Plan

您報告稱您患有糖尿病。

甚麼是糖尿病？
糖尿病通常是一種慢性和終身疾病。糖尿病是因為身體沒有足夠的胰島素。胰島素是由胰臟分泌出來的。食物經消化後會分解成葡萄糖（Glucose）. 胰島素將葡萄糖和澱粉分解成所需的能量。如果沒有足夠的胰島素，葡萄糖會累積在血液裡。當血液裡的葡萄糖過高時，就會在尿液裡排出。糖尿病能引發嚴重的健康問題，例如心臟，腎，眼睛，和神經系統。

我應該怎麼做？

- 遵從您每日的護理計劃
- 處理其它健康問題，比如心臟病或腎病
- 按照醫生指示服用您的藥物
- 知道您的血糖血紅素HbA1c度數目標及血糖讀數
- 遠離那些讓您感覺更壞的事物
- 與您所有的醫生跟進聯絡
- 緩解您的症狀以幫助防止疾病惡化
- 改善生活方式

以下是您的建議目標，除非您的醫生已經給予您不同的目標：

- 在未來的一年內，我將保持我的日常血糖在目標範圍內，以保持我的血糖血紅素HbA1c在7%以下或在我醫生為我設定的目標範圍內，並避免低血糖
- 在未來的一年內，我會繼續遵守指示服用糖尿病藥
- 在未來的一年內，我會保持腳部健康，預防感染
- 在未來的一年內,我會去做眼睛檢查和保持我的眼睛健康
- 在未來的一年內，我目前的腎臟功能將會改善或者維持現狀
- 在未來的一年內，我目前的膽固醇指標將會改善或者維持現狀
- 在未來的一年內，每次的醫生看診，我的血壓將會保持在140 / 90 mmHg以下
- 在未來的一年內，如果我的醫生給我配了降膽固醇藥物以預防或治療心臟病，我將會遵守指示服藥

You reported that you have Diabetes.

What is Diabetes?
Diabetes is usually a chronic and lifelong disease. Diabetes happens when there is not enough insulin in your body. Insulin is made by the pancreas. Food is broken down into sugar (glucose) during digestion. Insulin changes sugar and starches into energy that you need throughout the day. Without enough insulin, glucose builds up in your blood. When the level of glucose becomes too high, it spills into the urine. Diabetes can cause serious health problems, such as heart, kidney, eye, or nerve damage.

What should I do?

- Follow your daily care plan
- Take care of other health problems such as heart or kidney disease
- Take your medicines as your doctor told you
- Know your goal for hemoglobin A1c (HbA1c) and blood sugar readings
- Stay away from things that make you feel worse
- Follow up with all your doctors
- Manage your symptoms to help keep the disease from getting worse
- Make lifestyle changes

The following are your recommended goals, unless different goals have been given to you by your doctor:

- My daily blood sugars will be within my target range in order to keep my HbA1c test under 7% or a personalized goal my doctor set for me and avoid low blood sugar over the next year
- I will continue to take diabetic medications as prescribed over the next year
- My feet will be healthy and free from infections over the next year
- My eyes will stay healthy as possible as demonstrated during my eye exam over the next year
- My current kidney function will improve or stay the same over the next year
- My current cholesterol levels will improve or stay the same over the next year
- My blood pressure will be under 140/90 mmHg at every doctor's visit
- I will take a cholesterol-lowering drug if prescribed over the next year to prevent or treat heart disease

10/31/2017

CCHP 華人健保計劃 Health Plan

Care Plan

以下行動可能幫助您或您的醫生制定一個計劃，以預防或減少您患重病的機率：

- 我會定期約見醫生(上次見醫生日期: 08/10/2017)
- 如果家庭醫生推薦，我會看內分泌科醫生（上次見醫生日期：沒有資料）
- 我會在家做血糖測試和記錄結果
- 在下一次看完醫生後，我會知道我的血糖目標是什麼
- 我會確保我接受常規的血糖血紅素HbA1c 血液測試（上次做測試日期：07/26/2017）
- 我會確保我接受膽固醇血液檢測（上次做測試日期：07/26/2017）
- 我會確保我接受常規的血液檢查來監測我的腎功能（上次做測試日期：08/10/2017）
- 每次醫生檢查我都會和醫生討論我的藥物
- 我會遵守醫生提供的飲食建議
- 在下一次看完醫生後，我會知道我的體重目標是什麼
- 我會每天進行自我腳部檢查

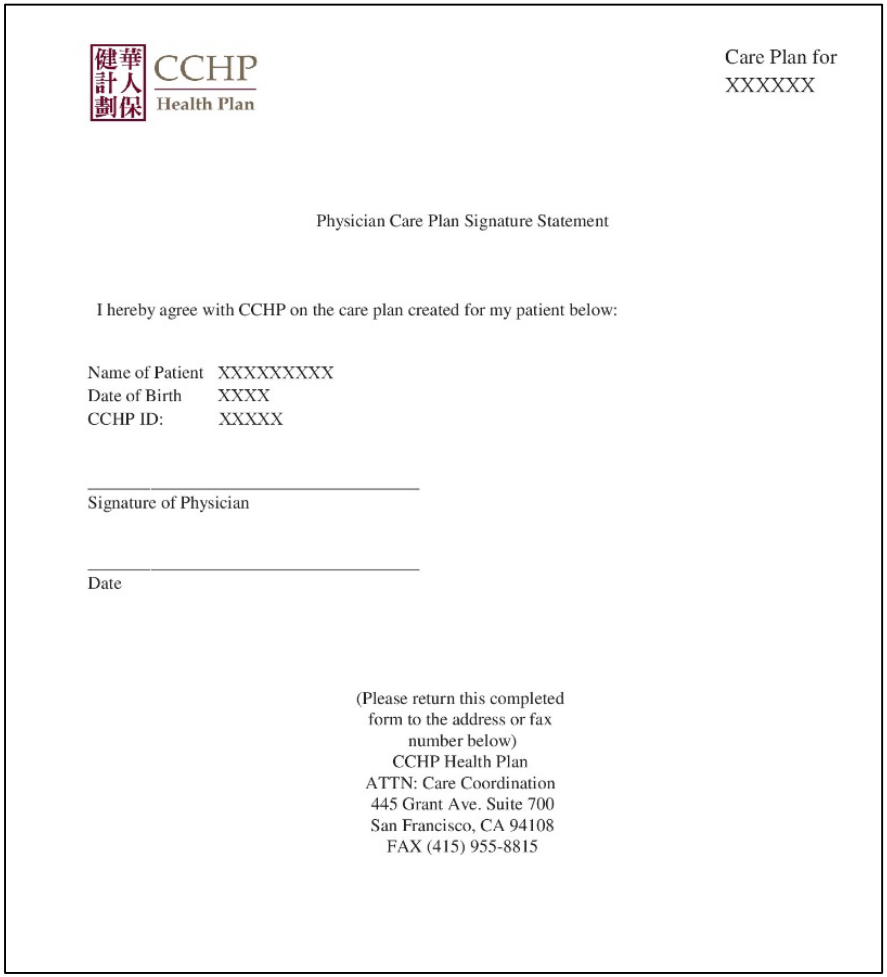
The following actions will help you and your doctor develop a plan to prevent or reduce your chances of serious health problems:

- I will make sure I see my doctor regularly (Last Visit: 08/10/2017)
- I will see an endocrinologist if recommended by my doctor (Last Visit: Data Not Available)
- I will do home blood sugar monitoring and keep records
- I will know what my blood sugar goal is after my next doctor's appointment
- I will make sure I have an HbA1c test regularly (Last Test: 07/26/2017)
- I will make sure I have a blood test to monitor my cholesterol levels (Last Test: 07/26/2017)
- I will make sure I have a blood test to monitor my kidney function (Last Test: 08/10/2017)
- I will review my medications with my doctor at each visit
- I will follow the dietary recommendations if given by my doctor
- I will know what my healthy weight goal is after my next doctor's appointment
- I will check and examine my feet daily

10/31/2017

ICP Provider Statement

- Providers are asked to sign and return the Physician Care Plan Signature page to Care Coordination department if they agree with the care plan.
- If the provider does not sign and return the signature page in two (2) weeks the care plan is considered accepted.



華人保健計劃 CCHP Health Plan

Care Plan for
XXXXXX

Physician Care Plan Signature Statement

I hereby agree with CCHP on the care plan created for my patient below:

Name of Patient XXXXXXXXX
Date of Birth XXXX
CCHP ID: XXXXX

_____
Signature of Physician

_____
Date

(Please return this completed form to the address or fax number below)
CCHP Health Plan
ATTN: Care Coordination
445 Grant Ave. Suite 700
San Francisco, CA 94108
FAX (415) 955-8815

Interdisciplinary Care Team (ICT) and Staffing

- CCHP participants of the ICT include, but not limited to:
  - **Medical Director.** Responsible for administrative performance compliance and care delivery services to ensure high quality of care for all beneficiaries
  - **UM Manager and Director of Clinical Services.** Ensure implementation and communication of the SNP MOC.
  - **Care Coordination Nurses**. Contact communicate and coordinate care; post-discharge, disease and case management and health education.
  - **Medical Social Workers.** Address psychosocial issues access to low or no cost community resources, housing programs, appointments with network and out of network social workers, psychologists, psychiatrists and other mental health services.
  - **MTM Pharmacist.** Address medication issues or concerns and refer to MTM program for medication review if deemed eligible.

Interdisciplinary Care Team (ICT)

- ICT meeting is held on a weekly basis; ad hoc meetings may be held in between weekly ICT meetings when needed
- ICT meetings discuss and evaluate member's plan of care
- Provider and member participation in the ICT meetings can better help address member needs and achieve the plan of care

Transition of Care

Care transitions occur when a member moves from one health care provider or setting to another; for example, member was admitted to hospital and discharge to home, acute rehab, or skilled nursing facility.

- The member's plan of care is updated in the event of a health status changes or care transition.
- Primary care providers are notified when their patient has a transition of care.
- Our clinical staff will assist members to ensure appropriate follow up care is arranged after a transition of care.

Network Providers

- Incorporate relevant clinical information in the member's plan of care
- Follow transition of care protocols
- Utilize evidence-based care guidelines
- Annually review delegated group utilization decisions and member appeals process
- Review patient medication profiles in a Medication Therapy Management (MTM) Program
- Contribute to improve the STAR and HEDIS outcomes reporting
- Help improve member experience through CAHPS and HOS data collection
- Take part in the Quality Improvement (QI) committee quarterly meeting to monitor and evaluate MOC quality performance process

Role of the PCP

- Plays an integral part of the care team
- Take calls from the member's Care Coordinator
- Collaborate with the member's Care Coordinator to address needs
- Review the member's plan of care and send back the care plan attestation
- Participate in the ICT meeting when possible
- Participate in the annual MOC training live webinar

Summary

- CCHP SNP MOC needs to be YOUR model on managing care for your patients
- The model supports the mission of CCHP and its business objectives
- You are key to improving our members health outcomes

References

- Chapter 5 of the Medicare Managed Care Manual
- Title 42, Part 422, Subpart D, 422.152
- https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans
- Model of Care Scoring Guidelines CY 2019 (2/2/2018)
- Chapter 16B Special Needs Plans of the Medicare Managed
- CCHP Policies and Procedures

Training Attestation

After you have completed the training module, please print this page. Read and sign this Attestation Statement and return to CCHP Provider Network Management via fax at 415-955-8815.

I acknowledge that I have completed the **2020 SNP MOC Provider Training**.

_____

Print Name

_____ _____

Signature Date Completed

Contacts and information

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- Kienn.Chow@cchphealthplan.com
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THANK YOU

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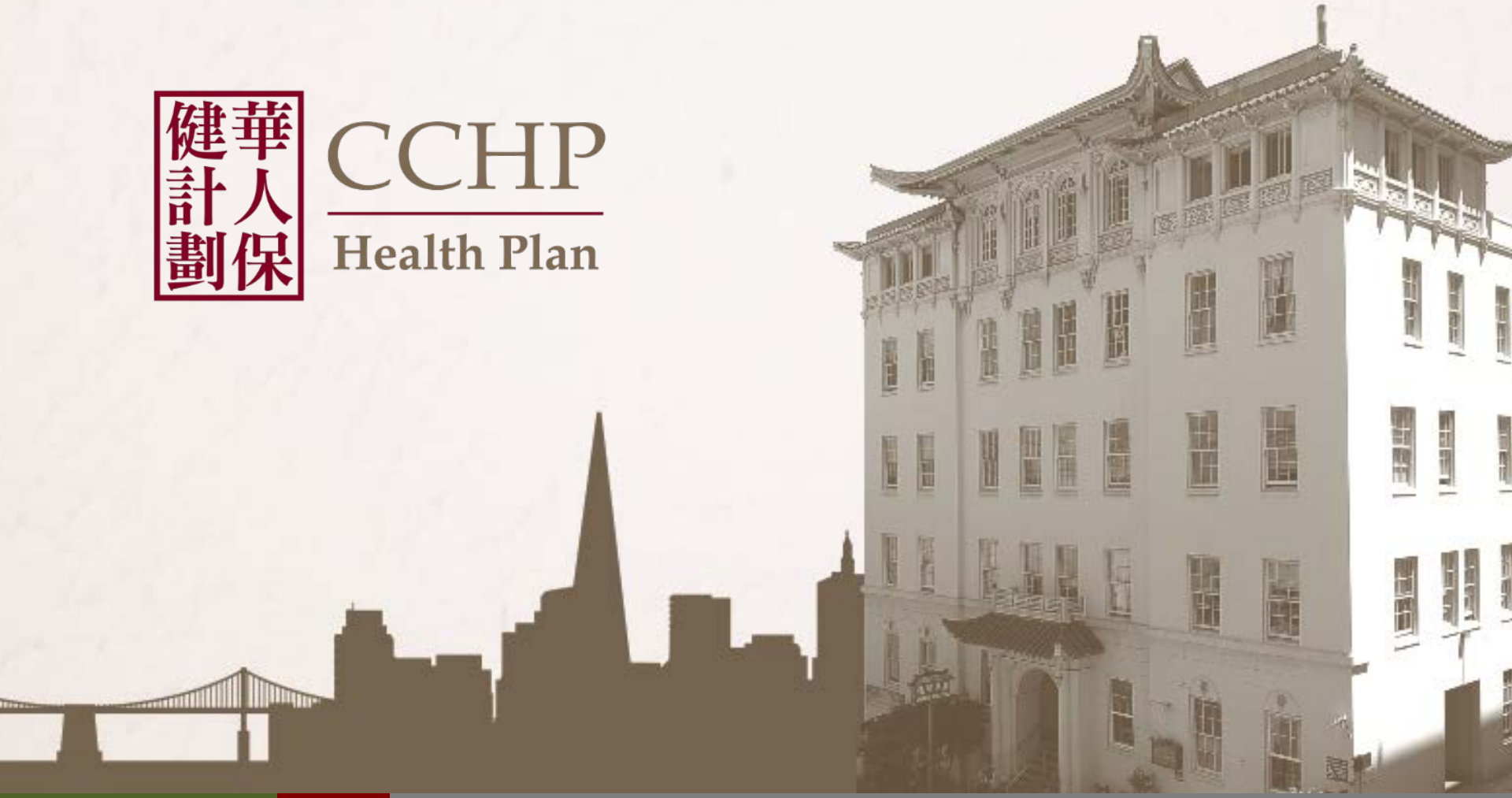
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