Model of Care Training

2023 VNS Health Medicare

VNS Health Total (HMO D-SNP), VNS Health EasyCare Plus (HMO D-SNP) and VNS Health EasyCare (HMO)

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Education and Development

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Training Objectives

At the end of this module you will be able to:

- Explain all (3) Medicare Plans:
  - VNS Health Total (HMO D-SNP)
  - VNS Health EasyCare Plus (HMO D-SNP)
  - VNS Health EasyCare (HMO)
- Describe which individuals qualify for these plans
- Describe the Model of Care key elements and goals
- Describe how Medicare and Medicaid benefits are coordinated under the plans
- Describe the covered benefits
- Describe the quality programs used to monitor the effectiveness of the program goals

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CMS Requirements

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 VNS Health Health Plans and their contracted providers can work together to successfully deliver the Model of Care.

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CMS Requirement for Model of Care

CMS and New York State DOH requires all D-SNP members to have the following:

- **HRA** — Health Risk Assessment
- **ICP** — Individualized Care Plan
- **ICT** — Interdisciplinary Care Team
- **UAS-NY** — Universal Assessment System – NY (VNS HealthTotal)

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VNS Health Total

A Dual Eligible Special Needs Plan (D-SNP) whose features include:

- Enrollment limited to beneficiaries within the **target SNP population**
  - Residing within the program's service area
  - Eligible for both Medicare and Medicaid
  - Eligible for long-term services and supports (LTSS)
  - Require community-based long-term care (CBLTC) services for more than 120 days
  - Eligible for Nursing Home Transition and Diversion waiver
- Benefit plans are **custom designed** to meet the needs of the target population
- Requires enrollment approval from CMS and DOH

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VNS Health EasyCare Plus

HMO Special Needs Plan (D-SNP) designed to offer focused care management to individuals that have both Medicare & Medicaid.

- Enrollment limited to beneficiaries within the target SNP population
  - Residing within the program's service area
  - Eligible for both Medicare and Medicaid
  - No Long-term Support Services
- Benefit plans are custom designed to meet the needs of the target population who don't need long-term support services
- Requires enrollment approval from CMS and DOH

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VNS Health EasyCare

- HMO Medicare Advantage Prescription Drug (MAPD) plan designed to make medical care more affordable
- Enrollment limited to beneficiaries within the **target population**
  - **Enrollees with Medicare only**
  - Residing within the program's service area
  - Eligible for both Part A & Part B coverage
- Benefit plans are **custom designed** to meet the needs of the target population
- Requires enrollment approval from CMS and DOH

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Our Mission

Our programs are designed to optimize the health and well-being of our aging, vulnerable and chronically ill **enrollees.**

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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
- Improve enrollee health and experience

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Model Of Care Goals

- **Improve Access**
  - Improving access to medical, mental health, and social services
  - Improving access to affordable care, long-term supports and services (LTSS), and preventive health services
- **Improve Coordination**
  - Improving coordination of care through an identified point of contact
  - Improving transitions of care across health care settings, providers, and health services
  - Assuring appropriate and cost-effective utilization of services
- **Improve Health Status**
  - Improving enrollee health outcomes
  - Assuring enrollee satisfaction

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Model Of Care Design

The Model of Care design includes the following:

1. Assessment
   - Health Risk Assessment (HRA)
   - Uniform Assessment System - New York (UAS-NY) – VNS HealthTotal only
2. Interdisciplinary care team (ICT)
3. Individualized care plan (ICP)
4. Care Management Team / Care Coordination
5. Benefits
6. Provider Network
7. Quality Improvement Plan (QIP)

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Model Of Care
Assessment

1. Assessment

- The Health Risk Assessment (HRA):
  - Self assessment
  - Assess the following needs of each enrollee:
    - Medical
    - Functional
    - Cognitive
    - Psychosocial
    - Mental health
  - Are completed telephonically by the care management team:
    - HRA Script in GuidingCare
    - Within 90 days of enrollment
    - Repeated within 365 days

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Model Of Care
Assessment

Uniform Assessment System – New York (UAS-NY): **VNS Health Total Only**

- **CHA-NY** assessment is performed at the frequency set forth by the New York State Department of Health (NYS DOH) Model Contract
- Evaluates the following needs of each enrollee:
  - Health status
  - Strengths
  - Care needs
  - Preferences
- Assists with program eligibility
- Improves care coordination and facilitated service delivery
- Ensures **enrollees** with long term care needs receive the right care, within the right setting and at the right time

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Model Of Care
Interdisciplinary Care Team

Care Managers / Utilization Managers	Medical Director
Behavioral/Mental Health experts	Social Workers
Primary Care Physician / Specialists	Family/Caregiver
Pharmacy	Community Partners/Vendors

The Interdisciplinary Care Team:

- Each enrollee is managed by a Care Team
- Participants are based on the member's needs
- Care managers will keep the team updated with information involving the member's care plan
- Staff participate in ICT meetings and rounds.

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Model Of Care
Individualized Care Plan

- The Care Plan is the ongoing action plan to address the participant's care needs in conjunction with the ICT and enrollee.
- Care Plans contain member-specific problems, goals and interventions, addressing issues found during the case management process
- An ICP is developed and maintained using:
  - Health risk assessment results
  - **CHA**-NY assessment results
  - Laboratory results, pharmacy, emergency department and hospital claims data
  - Care manager interaction
  - Interdisciplinary care team input
  - enrollee preferences and personal goals
- This is a living document that changes as the enrollee changes.

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Model Of Care
Care Management

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 to promote enrollee safety, quality of care and cost-effective outcomes.

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Model Of Care
Care Manager

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the enrollee to navigate the healthcare system and collaborating with providers, their social support system, their community and other professionals associated with their care.

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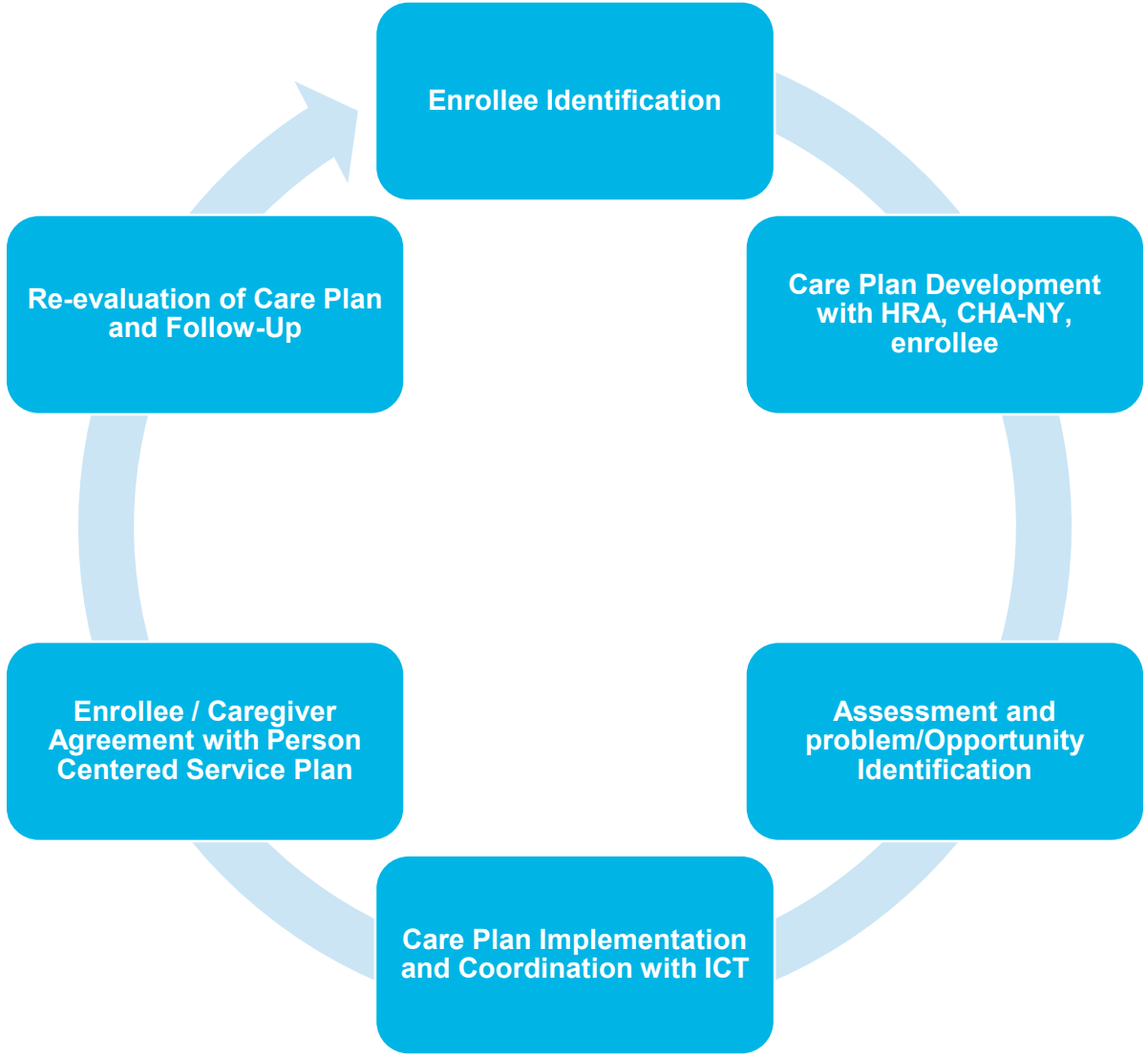
Care Management Process Overview



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Care Coordination

Integrate and coordinate care across specialties

- The health plan integrates and coordinates care for **enrollees** across the care continuum through a central point of contact. The care manager (CM) functions as this central contact across all settings and providers.

To **improve** coordination of care

- The **Primary Care Physician (PCP) is the gatekeeper** and responsible for identifying the needs of the beneficiary.
- The **Care Management Team coordinates care** with the enrollee, the member's PCP and other participants of the **enrollee's** ICT.
- All **SNP members have a PCP and a CM**.**(Remove this line)**

Through **seamless transitions** between care settings**:**

- **Notifying the member's PCP** of the transition
- **Sharing the enrollee's ICP** with the PCP, the hospitalist, the facility, and/or the enrollee/caregiver (where applicable)
- **Contacting the enrollee** prior to a planned transition to provide educational materials and answer questions related to the upcoming transition

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Care Management and Transitions

Enrollees are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health)

- **Enrollees** experiencing inpatient transition identified/managed (pre-authorization, facility notification, inpatient census)
- Important elements (diagnoses, medication reconciliation, treatments, providers and contacts) of care plan transferred between care settings before, during and after a transition
- **Enrollee** is able to communicate their health information to healthcare providers in different settings
- **Enrollee is** educated on health status and self-management skills: discharge needs, meds, follow-up care, and how to recognize and respond to issues (discharge instructions, post-discharge calls)

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Care Coordination

- **Post Hospitalization Transitions of Care:**
  - The **post-hospitalization** program for **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
  - Facilitates follow-up appointments
  - Assists with needed home health and equipment
  - Resolves barriers to obtaining medications
  - Educates the **enrollees** on new or continuing medical conditions

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Model Of Care
Benefits

- **Disease Management**–whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management**–a pharmacist reviews medication profile quarterly and communicates with enrollee and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** –the number of 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
- Additional benefits include **Dental, Vision, Podiatry, and Hearing Aids**

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Additional Benefits

Additional benefits may include:

- Medication Therapy Management
- Diet and nutritional education
- Behavioral health services
- End-of-life support services
- Social work support
- Home and community-based services partnerships
- Nonemergency transportation
- Meal programs
- Over-the-counter allowance

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Working with our Providers

Provider partners are an **invaluable part** of the interdisciplinary care team. Our Model of Care offers an opportunity to work together for the benefit of **enrollees** by:

- Enhanced **communication**
- Focusing on each individual **enrollee's special needs**
- Delivering **care management** programs to assist with the **enrollees** medical and non-medical needs
- **Supporting** the **enrollee's** plan of care

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Provider Role

- **Communicate** with Care Managers, Interdisciplinary Care Team (ICT) members as well as **enrollees** and Caregivers
- **Collaborate** on the Individual Care Plan (ICP)
- **Review and respond** to enrollee specific communication
- Participate in the Interdisciplinary Care Team (**ICT)**
- Remind enrollee of the importance of the **HRA and/or CHA-NY assessment(s)**, which is essential in the development of the ICP
- **Encourage** the **enrollee** to work with their Care team

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Quality Improvement Plan (QIP)

We implement a Quality Improvement Program to monitor health outcomes monitoring the implementation of our Model of Care:

- Collecting HEDIS measures data
- Annual Quality Improvement Project that focuses on a clinical or service aspect relevant to our **enrollees**.
- Providing an Advanced Illness Management Program

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Summary

This presentation outlined the different components of our VNS Health Health Plans Model of Care.

It is intended to provide a broad overview of how VNS Health Health Plans addresses the **enrollee's** needs and achieves positive outcomes.

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Thank you for attending!