SPECIAL NEEDS PLAN (SNP) MODEL OF CARE (MOC) PROVIDER TRAINING

AlohaCare Advantage Plus (HMO SNP)
HISTORY

• AlohaCare was formed by a network of Hawaii community health centers in 1994.

• We are a non-profit health plan governed by a community Board of Directors that includes representatives from many of Hawaii’s community health centers.

• We are committed to improving the health of Hawaii’s communities.

• We offer our Medicare Special Needs Plan, AlohaCare Advantage Plus, and our Medicaid QUEST Integration program to eligible individuals living on Oahu and the neighbor islands (Kauai, Molokai, Lanai, Maui and Hawaii).
MISSION

Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating access to quality health care for all. This is accomplished with emphasis on prevention and primary care through community health centers that founded us and continue to guide us as well as with others that share our commitment.
LEARNING OBJECTIVES

After this training, you will be able to:

- Recognize the AlohaCare Advantage Plus plan as a dual-eligible Special Needs Plan (SNP)
- Describe the 4 elements of the SNP Model of Care (MOC)
- Describe the provider role in relation to the corresponding elements of the Model of Care
- Describe the provider role in care management and care transition process under the AlohaCare Care Management Program
SNP BACKGROUND

• The Medicare Act of 2003 established a Medicare Advantage coordinated care plan that is designed to provide coordinated care and case management to individuals with special needs.

• CMS requires all AlohaCare providers to receive basic training about Special Needs Plan Model of Care (SNP MOC).

• AlohaCare’s Advantage Plus plan covers Dual Eligible members. To be eligible for AlohaCare Advantage Plus, members must be eligible for both Medicare and Medicaid (QUEST Integration).
WHAT IS THE SPECIAL NEEDS PLAN MODEL OF CARE (MOC)?

• The Special Needs Plan Model of Care is a mandated service by CMS and it contains the following four (4) elements:

  - Description of the SNP Population
  - Care Coordination
  - SNP Provider Network
  - Quality Measurement & Performance Improvement
MODEL OF CARE 1

- SNP Population
AlohaCare Advantage Plus

A Special Needs Plan available to people who have Medicaid (QUEST Integration) and Medicare
DESCRIPTION OF THE SNP POPULATION

• The identification and comprehensive description of the SNP population is an integral component of the MOC.

• A thorough understanding of the SNP population ensures that appropriate staff, processes, programs, providers, and community resources must be in place in order to address the full continuum of care and needs that are exhibited by and prevalent in the members currently being served, as well as potential SNP beneficiaries.
AlohaCare has an estimated 1570 dual eligible members; about 85% have AlohaCare for both their Medicare and QUEST Integration plan. Average member age: 68.5 years. Females comprise 59.5% of the SNP population. Culturally and ethnically diverse population. Prevalent Conditions: Chronic kidney disease, diabetes, cardiovascular disease (e.g., CAD, CHF, hypertension, hyperlipidemia, MI, etc.)
MODEL OF CARE 2

- Care Management
CARE MANAGEMENT

• Care Management helps ensure that SNP beneficiaries’ healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time.

• Care Management maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP’s provider network.
CARE MANAGEMENT

All AlohaCare SNP members:

✓ Receive care management services

✓ Are assigned to an AlohaCare Care Manager (Care Navigator, Care Coordinator or Service Coordinator) who is the member’s primary contact

✓ Are supported by a member-specific Interdisciplinary Care Team (ICT), which includes the Member, family members/ caregivers, PCP, other providers and appropriate AlohaCare staff who provide input into the development of the best care plan for the Member
SNP NEIGHBORHOOD MODEL

• The Care Managers are located in the member’s community for our members with complex medical needs.

• The Care Manager meets with the member in their home to assess their individual needs.

• The Care Managers work with the community resource providers and service providers in the member’s community.
COMPONENTS OF CARE MANAGEMENT

• Completing an initial **Health Risk Assessment (HRA)** and annual reassessments with the member

• Developing the **Individualized Care Plan (ICP)** with the member, PCP and an Interdisciplinary Care Team (ICT)

• Ensuring that the member’s healthcare needs and information is shared across appropriate healthcare staff and facilities, as needed

• Coordinating delivery of services and specialized benefits that meet the member’s needs

• Assisting members with care transitions
HEALTH RISK ASSESSMENT (HRA)

• **CMS Requirement**: AlohaCare must conduct an initial member HRA within 90 days of the Member’s enrollment date in the plan, and annually thereafter (within 365 days of last assessment), or when the member’s health status changes.
COMPONENTS OF HRA

The Health Risk Assessment (HRA) is a member questionnaire that includes medical (including preventive), psychosocial, cognitive, cultural and functional questions.

It identifies and guides care management options based on opportunities, available interventions, and the member’s goals, priorities and preferences.

Provider Role:

- Review and discuss the HRA with member
- Identify immediate health risks
- Take necessary interventions
HOW THE SNP USES THE STRATIFIED RESULTS TO IMPROVE THE CARE MANAGEMENT PROCESS
INDIVIDUAL CARE PLAN (ICP)

- Using the HRA, an ICP is developed for each SNP member by the assigned Care Manager, with input from the Interdisciplinary Care Team (ICT).

- The ICP ensures that the member’s needs and preferences are addressed.

- The ICP is updated/revised at minimum, annually or when the member’s health status changes through ongoing member evaluation and coordination of services and benefits.

- The ICP is communicated to the member and/or caregiver and shared with the PCP/providers.
PROVIDER’S ROLE IN ICP

• Collaborate in the development of the Member’s ICP

• Review and discuss the Individualized Care Plan with the member

• Support and encourage the member to continue the treatment established in the care plan

• Contribute, update, input when changes in member’s health occur
INTERDISCIPLINARY CARE TEAM (ICT)

• All SNPs must have an Interdisciplinary Care Team (ICT) to identify care interventions, provide expertise, and coordinate the delivery of services and benefits to members.

• AlohaCare created an ICT Committee composed of the member and provider, at minimum, and as needed a team of health professionals to help address the overall needs of the individual member, as well as the AlohaCare SNP population.
INTERDISCIPLINARY CARE TEAM (ICT)

- Member/Primary Caregiver
- Medical Director
- Care Management Staff
- Community-based Providers
- Additional AC staff if needed (Rx, Service Navigator, DM, etc)
PROVIDER’S ROLE IN ICT

• Participate and provide clinical expertise in the development of the member’s ICP and promote use of clinical practice guidelines

• Collaborate with the Lead Care Manager and other AlohaCare care team members in member goal setting and follow-up

• Engage members in self management and health education

• Coordinate delivery of appropriate quality services and benefits that meet the member’s needs and improves outcomes

• Promote access and integrate other physicians and providers into the member’s health care management, as needed

• Communicate changes in the member’s health status to the ICT
TRANSITION OF CARE

AlohaCare coordinates care when members move from one setting to another (e.g., discharge from a hospital) to assure continuity and quality of care and to minimize risk to member safety.

AlohaCare Care Managers establish communication with the member, authorized representative, PCP, providers, to support safe transitions between care settings by:

- Providing notifications regarding care transitions when known
- Communicating health status changes and sending the corresponding care plans to appropriate providers and parties
TRANSITION OF CARE

To facilitate safe transitions, AlohaCare:

- Notifies Providers when a member experiences a care transition
- Shares the member’s care plan with the receiving setting
- For inpatient discharges, disseminates the hospital discharge instructions to PCP, and appropriate providers
- Coordinates and facilitates post-discharge services
- Conducts post-discharge monitoring services
- Update ICP
PROVIDER’S ROLE IN CARE TRANSITIONS

- Include the admission or discharge notification made by AlohaCare in the member record.
- Evaluate the member as soon as possible after an inpatient discharge (i.e., follow-up office visit, medication reconciliation).
- Review, update and discuss the care plan with the member, particularly any revisions resulting from health status changes.
- Work with the AlohaCare Care Manager to facilitate provision of needed services.
MODEL OF CARE 3

- SNP Provider Network
PROVIDER NETWORK FOCUS

AlohaCare works with network Providers to:

• Ensure member receives timely access to care
• Engage providers with specialized expertise and experience to address the care needs of the D-SNP population
• Promote the use of clinical practice guidelines and protocols when caring for members
• Improve collaboration and active communication with the ICT and care managers
• Enhance participation in developing, reviewing and updating member care plans
• Assure that network providers are licensed through a formal credentialing process
MOC TRAINING FOR PROVIDER NETWORK

• SNP MOC training for Providers Network

When do we train:
• New contract process
• Provider staff onsite visits
• Annually

Training Modalities:
• 1:1 during office onsite visits
• Provider Manual
• Newsletters and Fax Blasts
• AlohaCare Website
SNP MOC TRAINING FOR PERSONNEL AND PROVIDER NETWORK

Provider Role:

- Take the SNP MOC training
- Complete and send the SNP MOC Training Acknowledgement of Receipt Form
- Keep the SNP MOC training as a reference source
MODEL OF CARE 4

➢ Quality Measurement & Performance Improvement
ALOHACARE’S PERFORMANCE AND HEALTH OUTCOME MEASUREMENT PROCESS

How do we know that the Model of Care is working?

AlohaCare uses the PDCA cycle to identify issues and to evaluate trends and patterns.

- The data is analyzed through the PDCA cycle:
  - **Plan** - a roadmap for improvement
  - **Do** - implement changes
  - **Check** - evaluate the effect of changes
  - **Act** - maintain improvements and continue to improve the process
ALOHACARE’S PERFORMANCE AND HEALTH OUTCOME MEASUREMENT PROCESS

AlohaCare:

• Regularly conducts performance and outcomes monitoring of the SNP-MOC program and reports to the internal Quality Improvement Committee.
• Evaluates effectiveness of the SNP-MOC annually and reports to AlohaCare’s quality improvement committee and the Practitioner Advisory Committee.
• Establishes new measures and interventions to continually improve care and health services provided to our members.
• Communicates outcomes to providers.
AlohaCare facilitates information sharing with providers, including performance and quality outcomes, through a variety of communication systems such as:

- Telephone
- Written notification
- Secure emails and fax
- Face to face encounters
PROVIDER’S ROLE IN QUALITY IMPROVEMENT

• Re-assess the member to identify health status changes
• Participate and support AlohaCare’s quality initiatives
• Document and share the proper communication in the member record to support the data collection process (e.g., HEDIS).
• Respond to request of information from AlohaCare
Thank you for partnering with AlohaCare in improving the health of our members and our community. To acknowledge the receipt of this training please sign the attached SNP MOC Provider training acknowledgment form.

For questions or concerns please contact us at:

Provider Services
(808) 973-1650
Toll-free 800-434-1002
MAHALO!