



# SPECIAL NEEDS PLAN (SNP) MODEL OF CARE TRAINING

February 2016





## *Learning Objectives*

- ➔ To gain understanding and comprehension of EmblemHealth's Special Needs Plans (SNPs)
- ➔ To describe the product offerings provided to EmblemHealth SNP members
- ➔ To gain 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

# AGENDA

- ✚ Description of the SNP population
- ✚ Care Coordination
- ✚ SNP Provider Network
- ✚ Quality Measurement and Performance Improvement

# THE HISTORY OF SPECIAL NEEDS PLANS AT EMBLEMHEALTH

## Past

- Chronic Care (diabetes) SNP – no longer offered
- Several dual eligible SNPs
- Managed Long Term Care (MLTC) Plan [Medicaid Advantage Plus (MAP)] no longer offered
- Fully Integrated Dual Advantage (FIDA) no longer offered

## Present

- EmblemHealth Dual Eligible HMO SNP EmblemHealth Dual Eligible PPO SNP



# MEMBERS ELIGIBLE FOR MEDICAID

EmblemHealth has **two Special Needs Plans** in which enrollment is limited to beneficiaries who are eligible for Medicare and any level of Medicaid. These plans are:

- EmblemHealth HMO SNP (also known as the **HIP SNP**)
- EmblemHealth PPO SNP (also known as the **GHI SNP**)

## Member Benefits:

- These SNPs offer all of the required Medicare benefits and include reduced member costs for medical care and prescription drugs.
- Medicaid fee for service may provide additional benefits if the member is eligible.

# EMBLEMHEALTH SNP PLAN OFFERINGS

## HMO SNP

- Dual Plan

## PPO SNP

- Dual Plan



# GOALS FOR OUR MEMBERS

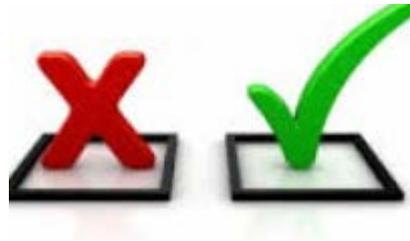
## Improve and Assure the Members' Receipt Of the Following:

1. Access to affordable care and medical, mental health, social and preventive health services
2. Coordinated care through an identified point of contact
3. Transition of care across health care settings and practitioners
4. Appropriate services
5. Cost-effective services
6. Beneficiary health outcomes



# SPECIAL NEEDS PLAN MODEL OF CARE OVERSIGHT CRITERIA

- ✦ The Centers for Medicare & Medicaid Services (CMS) regulates all of the EmblemHealth SNPs.
- ✦ The SNP Model of Care review and approval process occurs initially and then periodically.
- ✦ SNP Plan Models of Care are scored using a CMS-approved Reviewer Guide that identifies the types of evidence required for each Element.



# SPECIAL NEEDS PLAN MODEL OF CARE ELEMENTS

## Element 1: Description of the SNP Population

- A. Overall SNP Population
- B. Sub-Population: Most Vulnerable Beneficiaries

## Element 2: Care Coordination

- A. SNP Staff Structure
- B. Health Risk Assessment Tool
- C. Individualized Care Plan (ICP)
- D. Interdisciplinary Care Team (ICT)
- E. Care Transitions Protocol



# SPECIAL NEEDS PLAN MODEL OF CARE ELEMENTS CONTINUED

## Element 3: SNP Provider Network

- A. Specialized Expertise
- B. Use of Clinical Practice Guidelines and Transition Protocols
- C. MOC Training for the Provider Network

## Element 4: Quality Measurement and Performance Improvement

- A. MOC Quality Performance Improvement Plan
- B. Measurable Goals and Health Outcomes
- C. Measuring Patient Experience of Care (SNP member satisfaction)
- D. Ongoing Performance Improvement Evaluation
- E. Dissemination of SNP Quality Performance



# SNP MODEL OF CARE

## ELEMENT 1 – SNP TARGET POPULATION

- ❑ Often because of educational and economic factors, this population does not successfully navigate the healthcare delivery system and seeks care in emergency rooms rather than having regularly scheduled preventive care visits
- ❑ Due to financial considerations, eligible members often do not have cell phones or home telephones, which can make it difficult to reach them to coordinate care and help them to manage their benefits
- ❑ Based on income and education, these members may have poor nutritional status and have issues with obesity and high blood pressure, which can set the stage for diabetes, heart disease and stroke
- ❑ In addition, cultural considerations, such as prevalence of smoking in certain populations, are also a factor

population



# SNP MODEL OF CARE

## ELEMENT 2 – CARE COORDINATION

- ✚ SNP Staff Structure
- ✚ Health Risk Assessment Tool
- ✚ Individualized Care Plan (ICP)
- ✚ Interdisciplinary Care Team (ICT)
- ✚ Care Transitions Protocol



## ELEMENT 2 – STAFF STRUCTURE AND CARE MANAGEMENT ROLES

The Staff Structure and Care Management Roles Section overviews the roles and responsibilities of specific employed or contracted staff who perform clinical, administrative and oversight functions. Some of the clearly **defined roles** include:



- Pharmacists to review for medication trends
- Utilization management support staff complete the necessary documentation as member's transition from one treatment setting to another
- Case management clinical staff (Nurses and Social Workers) provide outreach to members to facilitate discharge and other resources as needed

## ELEMENT 2 - HEALTH RISK ASSESSMENT (HRA)

- ✦ The HRAs are issued to all new SNP members within 90 days of their enrollment and then issued to all SNP members on an annual basis going forward
- ✦ There are several outreach attempts made to obtain the member's responses
- ✦ They may be sent postcards, an additional survey or be part of a call campaign
- ✦ Once the responses have been received, the answers are reviewed using an internally developed stratification guide
- ✦ The stratification guide assists in determining where the member should be referred internally for further outreach, evaluation and development of an individualized care plan or if they need the additional assistance of one of EmblemHealth's delegated entities
- ✦ Reporting is designed to identify members "at risk," members with selected conditions, diseases or services, and members needing or requesting condition specific services that EmblemHealth offer



## ELEMENT 2 - HEALTH RISK ASSESSMENT

- HRA mailings and response reporting is completed monthly and responses are referred electronically to internal and external departments and programs to launch outreach efforts.

### Departments and Programs Such As:

- Utilization Management
  - Case Management
  - Disease Management
  - Behavioral Health
  - Customer Service
  - Smoking Cessation Programs
- These programs are multidisciplinary, continuum-based approach to health care delivery that proactively identifies members with, or at risk for chronic medical condition.
  - It also supports the doctor-member relationship and plan of care, emphasizes the prevention and exacerbation and complications using cost effective, evidence based practice clinical guidelines and member empowerment strategies such as self-management.



## ELEMENT 2 - HEALTH RISK ASSESSMENT

- Completed HRAs provide a method for the Plan to evaluate clinical, humanistic and economic outcomes with the goal of improving the overall health of our member
- Through education support and telephonic health coaching, the SNP member is expected to show an improvement in treatment adherence and the subsequent reduction in inappropriate and/or unnecessary medical utilization, or an increase in necessary medical utilization
- HRA program referrals result in an improved quality of life, periods of improved willingness for members living with chronic diseases, conditions, while addressing quality of life issues



## ELEMENT 2 – INDIVIDUALIZED CARE PLANS

- ✦ The Individualized Care Plan (ICP) is the comprehensive care planning document which is customized to speak to the needs of the member
- ✦ A plan of care is the written documentation of the case management process used to solve one or more of a member's problems
- ✦ The ICP development begins when problems are identified
- ✦ This problem identification can begin during the administration of the HRA, during interactions with the members and /or during the telephonic assessment of the member
- ✦ Additionally, problems can be noted from indirect sources when viewing the patient profiler, reviewing member's claims for their utilization patterns, evaluating the member's lab results or speaking with the primary care provider
- ✦ The patient profiler is a system which pulls together a members health data (such as lab, claims and pharmacy information), so that the case manager can get a current snapshot of the members health situation



## ELEMENT 2 – INDIVIDUALIZED CARE PLANS

- The Individualized Care Plan (ICP) is a plan of care which flows from each member's unique list of diagnoses and is organized by the individual's specific needs and includes the member's self-management goals and objectives.
- It should include both long and short term goals, which should be prioritized based on the member's input
- The documentation should also identify any barriers to the member being able to meet the goals and the ICP should be based upon identifiable physical, functional, psychosocial, behavioral, environmental, residential, family dynamics and support, spiritual, and cultural problems
- It focuses on actions which are designed to solve or minimize the existing problem and incorporates the member's healthcare preferences
- It is a product of a deliberate systematic process which includes a description of services specifically tailored to the members needs which relates to the future and produces a desired outcome or change in the client's condition
- In order to get the member to a state of resolution of the identified problems, the goals and objectives are reviewed and evaluated periodically to see if they are met or not met, or if the member wishes to continue to work on that goal
- If the ICP goals are not met, the nurse case manager reviews the goals with the member, caregiver, the member's health care provider to determine likely barriers, and develops appropriate alternative actions
- The ICP should be discussed with the member during each outreach, and a written copy should be sent to the member and provider each time it is adjusted

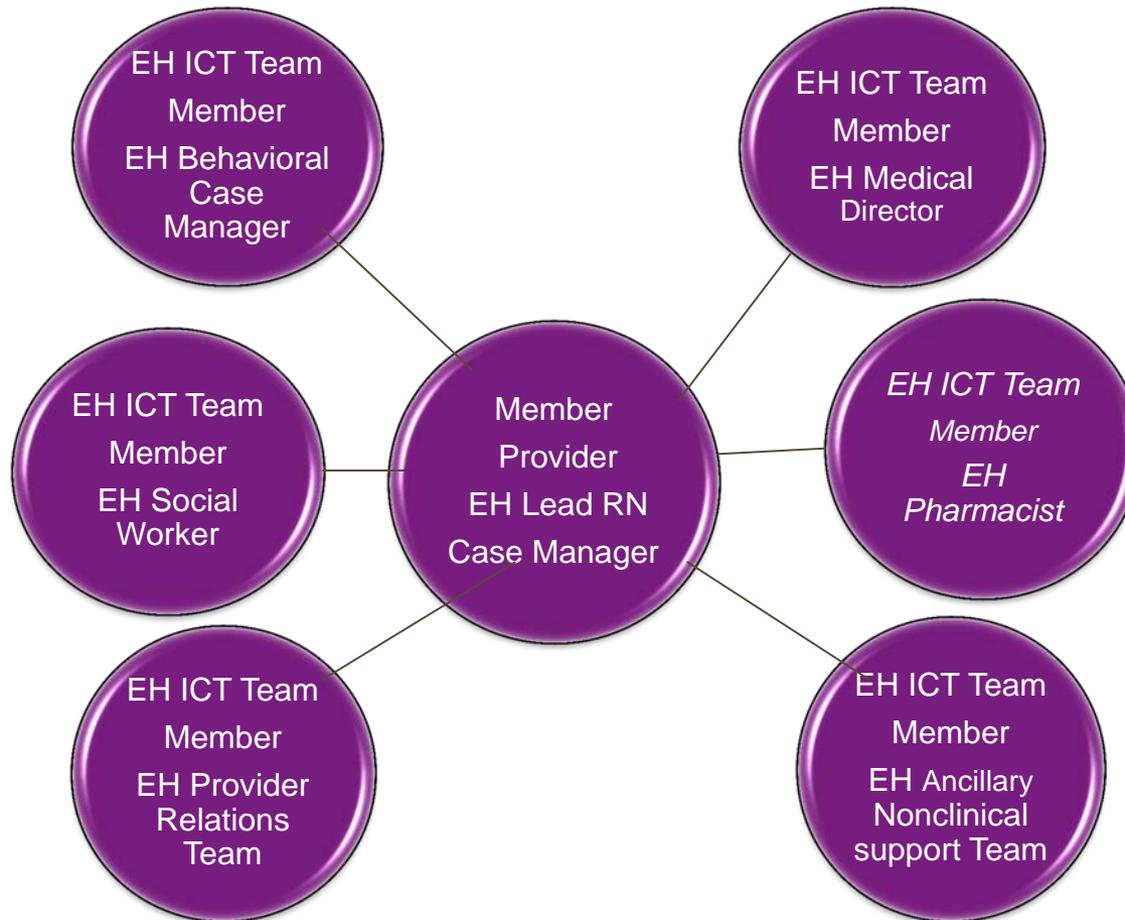


## ELEMENT 2 – INTERDISCIPLINARY CARE TEAM

- The Interdisciplinary Care Team (ICT) is a multidisciplinary team (plan medical director, nurses, social workers, pharmacist, nutritionist etc.) designed to ensure appropriate oversight along with front-line management of the processes and staff who care for SNP members
- This team approach is member-centric and provides access to care
- The member's electronic medical record (EMR) should include written documentation of the who is part of their ICT, inclusive of their roles and responsibilities
- The ICT should also include the members Primary Care Physician (PCP), any specialists, and the member or their representative



# INTERDISCIPLINARY CARE TEAM



## ELEMENT 2 – CARE TRANSITIONS PROTOCOL

- ❑ The organization follows Coleman's model that defines transitional care as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location
- ❑ Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities
- ❑ Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status
- ❑ It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition
- ❑ Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs



## ELEMENT 2 – CARE TRANSITIONS PROTOCOL

- ❑ For planned transitions from the member's usual care setting to the hospital and transitions from the hospital to the next care setting, EH identifies, via reporting mechanisms, that these planned transitions are going to occur
- ❑ The Care Manager outreaches to the member to determine if changes to the ICP are required based on the member's needs after the transition
- ❑ For planned and unplanned transitions from the member's usual care setting to the hospital and transitions from the hospital to the next setting, EH facilitates sharing of the sending setting's plan of care with the receiving setting within one business day of notification of the transition
- ❑ When a member experiences a planned or unplanned transition from any setting to any other setting the member's usual practitioner is notified of the transition within 7 business days from the time of notification of the transition



## ELEMENT 2 – CARE TRANSITIONS PROTOCOL

- ❑ Case Management care transitions protocol for Special Needs Programs (SNP) is administered in alignment with EmblemHealth's SNP Model of Care (SNP MOC)
- ❑ Special effort is made to coordinate care when SNP members move from one setting to another, such as when they are discharged from a hospital, to reduce risk of poor quality care, risks to patient safety and to maximize health outcomes
- ❑ Utilizing a multidisciplinary team approach to support SNP member's medical, behavioral health, pharmacy, social and financial needs, case managers work with the member, provider, and community delivery systems to coordinate care and services
- ❑ Outreach is performed to members newly discharged from the hospital to ensure they understand their discharge plan, to arrange for needed post discharge services (such as homecare, durable medical equipment, transportation, etc.) and to educate beneficiaries on self-management techniques
- ❑ Individualized care plans (ICP) are formulated with the SNP member's input following an assessment and contains, but is not limited to the following components: Member self-management goals and objectives; the member's personal healthcare preferences; services specifically tailored to the beneficiary's needs; and identification of goals met/not met

## ELEMENT 3 – SNP PROVIDER NETWORK

- ✦ Specialized Expertise
- ✦ Use of clinical practice guidelines and transition protocols
- ✦ MOC training for the provider network



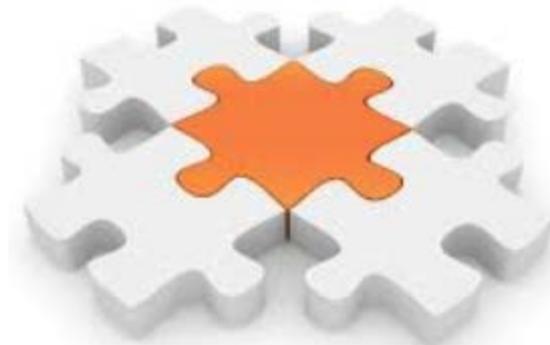
## ELEMENT 3 – SPECIALIZED EXPERTISE

- ❑ Demonstrate the specialized expertise in the SNP's provider network
- ❑ Show how the SNP determined that its network facilities and providers were actively licensed and competent
- ❑ Specify who determines which services beneficiaries will receive
- ❑ Show how the provider network coordinates with the ICT and the beneficiary
- ❑ Demonstrate how the SNP assures that providers use evidence-based clinical practice guidelines and protocols



## ELEMENT 3 – USE OF CLINICAL PRACTICE GUIDELINES AND TRANSITION PROTOCOLS

- Providers are able to review and utilize all Emblem Health Medical Policies on the plan's website
- The EmblemHealth Medical Policies are available in the Clinical Corner Section of the EmblemHealth website under the Provider tab
- Clinical Corner is a resource for practice guidance related to the treatment of acute, chronic and behavioral health issues, as well, as the medical appropriateness of specific interventions
- In addition, EmblemHealth utilizes the McKesson CERME criteria for Inpatient admissions to Acute Hospitals, Acute Rehab, Skilled Nursing Facilities, review of Procedures, Durable Medical Equipment (DME) and Home Care services



## ELEMENT 3 – USE OF CLINICAL PRACTICE GUIDELINES AND TRANSITION PROTOCOLS

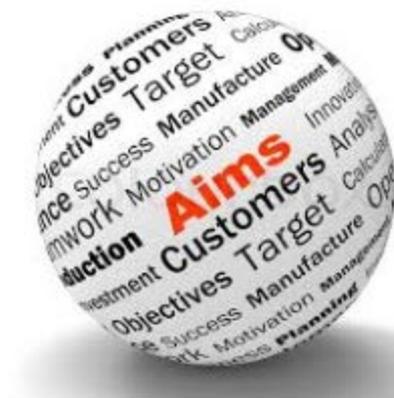
- SNP Case Management is a voluntary and free value-added program for the majority of our members based on benefit package
- National evidence-based criteria, national evidence-based clinical practice guidelines, and Milliman Chronic Care guidelines are utilized in the development of the program
- They are utilized to assist in decision-making regarding appropriate health care for specific clinical circumstances and to improve health outcomes.
- EmblemHealth bases its transition protocols on the Coleman Model of Care Transitions<sup>®</sup>.
- The term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness



# ELEMENT 3 – USE OF CLINICAL PRACTICE GUIDELINES AND TRANSITION PROTOCOLS

The **Coleman Model** of the SNP Care Transitions Program aims to:

- ✚ Support patients and families
- ✚ Increase skills among healthcare providers
- ✚ Enhance the ability of health information technology to promote health information exchange across care settings
- ✚ Implement system level interventions to improve quality and safety
- ✚ Develop performance measures and public reporting mechanisms
- ✚ Influence health policy at the national level



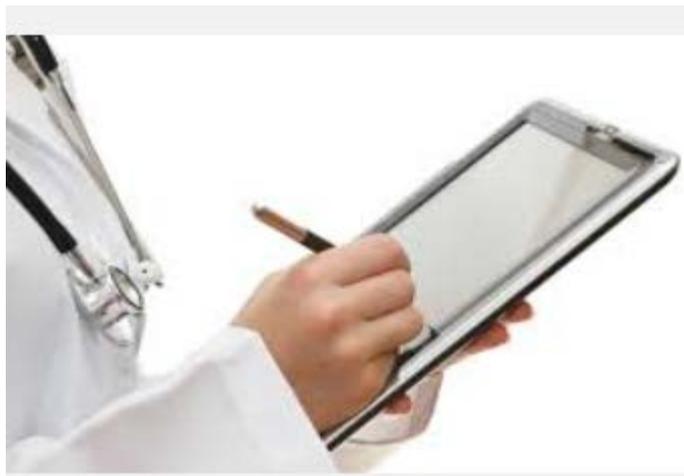
## ELEMENT 3 – USE OF CLINICAL PRACTICE GUIDELINES AND TRANSITION PROTOCOLS

- ❑ EmblemHealth encourages the use of Clinical Practice Guidelines (CPG) by adopting and disseminating practice guidelines for the provision of acute, chronic and behavioral health services that are relevant to the enrolled membership
- ❑ The Plan uses preventive and condition specific clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances
- ❑ EmblemHealth established a clinical basis for its guidelines by identifying and adopting evidence-based clinical practice guidelines that employ nationally recognized protocols for assessment, care and maintenance of health
- ❑ The guidelines are reviewed by clinicians and approved for use by the Plan's Health Status Improvement Committee (HSIC) and all Clinical Practice Guidelines are reviewed at least every two years and updated as needed, with the exception of the HIV/AIDS Clinical Practice Guidelines, which are reviewed and updated annually
- ❑ Clinical Practice Guidelines are available on the plan's Provider Portal, in the Provider Manual and paper copies are made available upon request from the provider
- ❑ Updates are posted to the Provider Portal as needed and made available in the Provider Newsletter

## ELEMENT 3 – MODEL OF CARE TRAINING FOR PERSONNEL AND PROVIDER NETWORK

### The SNP Must:

- Describe how the SNP conducted initial and annual model of care training
- Demonstrate how the SNP assures and documents completion of training
- Specify who the SNP identified as responsible for oversight of the model of care training
- Show what actions the SNP will take when the required model of care training has not been completed



## ELEMENT 4 – SNP MODEL OF CARE

- ✦ MOC Quality Performance Improvement Plan
- ✦ Measurable Goals and Health Outcomes
- ✦ Measuring Patient Experience of Care (SNP measurement of satisfaction)
- ✦ Ongoing Performance Improvement Evaluation
- ✦ Dissemination of SNP Quality Performance



# ELEMENT 4 – SNP MODEL OF CARE

## QUALITY PERFORMANCE IMPROVEMENT PLAN

- The **Quality Performance Improvement Plan** is designed to monitor and evaluate the MOC's structure to ensure that it effectively accommodates members' unique healthcare needs.
- The MOC structure provides coordinated and appropriate care for our special needs members

### Key Objectives Of the Quality Improvement Plan Are To:

- Evaluate and improve members' access to clinical and administrative services.
- Monitor continuity and coordination of health care
- Monitor and evaluate the current status of the Plan's care and service against regional and national requirements and benchmarks
- Ensure members' access to safe medical and behavioral health care



# ELEMENT 4 – SNP MODEL OF CARE

## QUALITY PERFORMANCE IMPROVEMENT PLAN

- The **Individualized Care Plan (ICP)** is the initial and ongoing mechanism used for formulating an action plan based on the member's current health condition and medical history
- The Plan regularly collects data from internal and external sources to evaluate MOC quality performance against measurable goals

### Stakeholders involved in the Quality Performance Improvement Process include:

- A multi-disciplinary team from Care and Case Management including nurses, physicians, social workers, dieticians, rehabilitation specialists, pharmacists and behavioral health clinicians
- A multi-disciplinary team from Quality Management including nurses, pharmacists, social workers, health educators and healthcare analysts

# ELEMENT 4 – SNP MODEL OF CARE QUALITY PERFORMANCE IMPROVEMENT PLAN

**All Quality Improvement activities that impact the SNP population are monitored through the Quality Improvement Program Work Plan.**

- Quarterly updates are presented to and approved by the Health Status Improvement Committee (HSIC)
- Executive oversight is provided by the Quality Improvement Committee (QIC) and the Quality Committee of the Board

**The Plan integrates SNP-specific measureable goals and health outcomes objectives into the overall performance improvement plan.**

- The Plan systematically selects and prioritizes SNP quality improvement projects in an effort to achieve the greatest benefit to members
- Topics are relevant to and affect a significant portion of SNP members, and have a potentially significant impact on member health status and/or satisfaction



# ELEMENT 4 – SNP MODEL OF CARE

## MEASURABLE GOALS AND HEALTH OUTCOMES

### Measurable Goals

- ✦ To improve access to essential services such as medical, mental health and social services
- ✦ To improve access to affordable care and preventive health services
- ✦ To improve coordinated care through an identified point of contact (e.g., gatekeeper)
- ✦ To improve seamless transition of care across health care settings, practitioners and health services
- ✦ To assure appropriate utilization of services and cost-effective service and to improve beneficiary health outcomes



- The individualized care plan is the initial and ongoing mechanism used for formulating an action plan to address areas of concern by evaluating the member's current health condition and medical history
- Since members can have varying levels of health needs, the individualized care plan provides a structure to organize outreaches for the interdisciplinary care team and to document results
- The individualized care plan is re-evaluated on a regular basis or if the member's health status undergoes a substantial change

# ELEMENT 4 – SNP MODEL OF CARE

## MEASURABLE GOALS AND HEALTH OUTCOMES

- ✦ The Plan's method for conducting and evaluating quality improvement includes the gathering of claims / encounter data, pharmacy data, lab, vendor, supplemental data sources, medical records, survey data, and/or utilization management data for baseline measurement, root cause analysis and re-measurement including statistical analysis
- ✦ This information is used to develop and implement appropriate quality improvement initiatives and determine the impact of prior quality improvement initiatives
- ✦ Quarterly the Plan reviews statistical trends of Plan performance in HEDIS/QARR and Star measures to determine the impact of prior quality improvement initiatives and/or the need for future quality improvement initiatives
- ✦ Plan performance is also compared to benchmarks that include the NCQA 90th percentile for Medicare plans and CMS 5 Star Ratings.
- ✦ CAHPS and HOS results are measured and trended annually



# ELEMENT 4 – MEASURING PATIENT EXPERIENCE OF CARE (SNP MEASUREMENT OF SATISFACTION)

- ✦ Through the Plan's Quality Committee Customer Experience Service Improvement Committee (CESIC) Members' satisfaction with care and services, as evidenced by the CAHPS results, are compared to the Plan and CMS national benchmarks
- ✦ Measures that fall below the goals are analyzed for root causes. Opportunities are ranked, quality improvement initiatives are recommended, developed, and implemented to address measures that fall below goals
- ✦ CESIC includes Plan leaders and clinical staff who work with the SNP population



# ELEMENT 4 – DISSEMINATION OF SNP QUALITY PERFORMANCE

## Improving Beneficiary Health Outcomes

- This measurement will capture the results of the SF12 overtime for SNP members receiving case management services
- The SF12 (the short form twelve) assesses how members feel about their quality of life in relation to their health
- This assessment is based upon self-reported data provided by the member
- The SF12 will be administered at the time the member is enrolled into the case management program, every six months after initial enrollment into the case



# ELEMENT 4 – ONGOING PERFORMANCE IMPROVEMENT EVALUATION

The **Plan's Quality Management Department (QM)** conducts an annual review of HEDIS and New York State (NYS) Quality Assurance Reporting Requirements (QARR) measures from the NCQA measurement domains and NYS specific measures listed below to determine which measures will be available for reporting for the next calendar year:

- ✚ Effectiveness of Care
- ✚ Measures Collected Through Medicare Health Outcomes (HOS) Survey
- ✚ Measures Collected Through CAHPS® Health Plan Survey
- ✚ Access/Availability of Care
- ✚ Use of Services
- ✚ NYS Specific Measures



# ELEMENT 4 – ONGOING PERFORMANCE IMPROVEMENT EVALUATION

The list is generated according to NCQA, HEDIS and NYS QARR Technical Specifications and their program updates throughout a calendar year.

- Using proprietary information and methodology, the Plan reviews categories of information and ranks projects accordingly to determine project selection and prioritization for assignment of resources and focus

## Criteria include, but are not limited to, the following:

- Benchmark indicators
- Regulatory and accreditation requirements
- Control of variables and resources
- Project duration and population effected



## ELEMENT 4 – ONGOING PERFORMANCE IMPROVEMENT EVALUATION

- The Plan's method for conducting and evaluating quality improvement includes the gathering of claims / encounter data, pharmacy data, lab, vendor, supplemental data sources, medical records, survey data, and/or utilization management data for baseline measurement, root cause analysis and re-measurement including statistical analysis
- This information is used to develop and implement appropriate quality improvement initiatives and determine the impact of prior quality improvement initiatives
- Quarterly the Plan reviews statistical trends of Plan performance in HEDIS/QARR and Star measures to determine the impact of prior quality improvement initiatives and/or the need for future quality improvement initiatives
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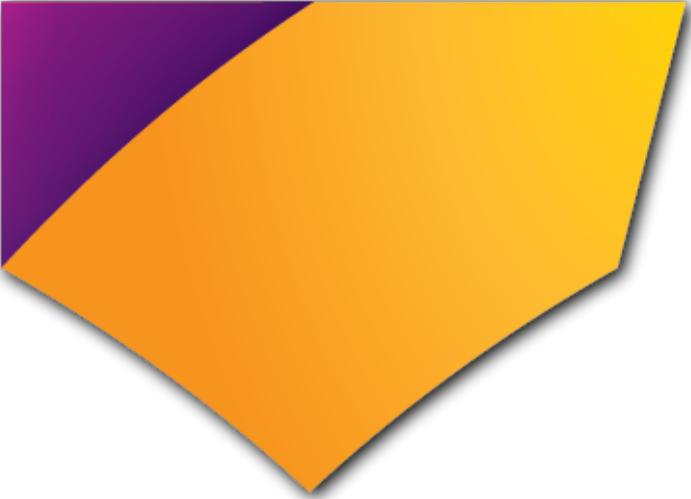
## ELEMENT 4 – DISSEMINATION OF SNP QUALITY PERFORMANCE

- The Plan will communicate its improvements made through the Quality Improvement Program via multiple communication medias in order to reach the greatest number of stakeholders
- Network providers servicing beneficiaries are kept informed of the Plan's progress through newsletters and Web site postings
- Members are sent quarterly newsletters containing information on the Plan's Quality Program and initiatives that are targeted towards the Medicare/SNP population
- The newsletters also inform member's that more information is available on the Plan's Web site
- The Plan will periodically evaluate its method of communication for its program and make adjustments as necessary. In addition to the Plan's formal Quality Improvement Committee structure that supports primary communication of SNP performance within EmblemHealth, results are shared with all employees via the EmblemHealth eNet, the Plan's mechanism to communicate important information to Plan employees

## ELEMENT 4 – DISSEMINATION OF SNP QUALITY PERFORMANCE

- Adhoc communications are developed on an as needed basis
- We communicate HEDIS/QARR measure performance on a quarterly and annual basis to our large provider groups and are available for discussion through established monthly/quarterly meetings
- Specific to CAHPS and HOS, the Plan provides information on an annual basis using the Member and Provider Newsletters and website as its primary communications channels
- Information is shared internally through our comprehensive Quality Committee structure and with Plan colleagues via the eNet





## **SPECIAL NEEDS PLAN MODEL OF CARE TRAINING**

