Institutional Special Needs Plan Model of Care (HMO I-SNP)

Engaging together to deliver care to a complex population

ucare®

Training Overview

This training will provide an overview of the Institutional Special Needs Plan (I-SNP) and characteristics of the population, and as a result you will understand:

- The primary goals of the MOC
- Characteristics of the targeted population
- The services offered to treat and manage complex, chronic illness by an interdisciplinary team approach
- Your responsibilities and role as a provider or care coordinator, who is part of an interdisciplinary team delivering goal-oriented care

Delivering coordinated and appropriate care

The Model of Care (MOC) is UCare's care delivery model approved by the Center for Medicare and Medicaid Services (CMS)

This course meets the CMS requirements for provider training on UCare's Institutional Special Needs Plan (I-SNP)-MOC

This course describes the role of providers, engaging with UCare to successfully deliver the MOC program to a highly specialized population

Why does UCare have a MOC?

Required by CMS and has four components:

- Population description and characteristics
- Care coordination details
- Provider network that ensures adequate access
- Quality measures and process improvement goals

It helps provide:

- Access to high-quality health services
- Coordination of all services needed
- Opportunities for involvement in the development of individualized care plans
- Care-transitions support to members and families
- Treatment in-place, in the most feasible, comfortable setting

UCare's Model of Care (MOC)

The MOC's overall goal is to drive improvements in health outcomes and quality of life for members.

UCare's MOC is designed to:

- Increase access to affordable, cost-effective health care
- Improve coordination of care
- Ensure seamless transitions of care
- Manage costs

Qualifying criteria & enrollment

- Qualifying criteria:
  - Must have Medicare Part A & B
  - Meet the standard for needing a nursing home level of care
  - Live in the plan service area in a participating long-term care or assisted living facility
- Enrollment:
  - To learn more about enrollment, please call UCare Sales ISNP team at:
    - 612-676-6821 or 877-671-1054
    - SNPSales@ucare.org

I-SNP Model of Care components

Model of Care: the components

A population of the most vulnerable

The I-SNP population comprises older adults who are:

- Receiving Medicare with multiple, complex, chronic conditions
- Dealing with mobility issues or limitations in ability to function independently
- Residing in an institutional setting (long-term care) or at a nursing home level of care (assisted living) and have been receiving or are expected to receive a nursing home level of care for 90 days or more
- Experiencing with some degree of cognitive impairment
- Living within the Health Plan service area

I-SNP Demographics

Age Range

- 85 and Older: 43.37%
- 75-84: 30.71%
- 65-74: 25.91%

Sex

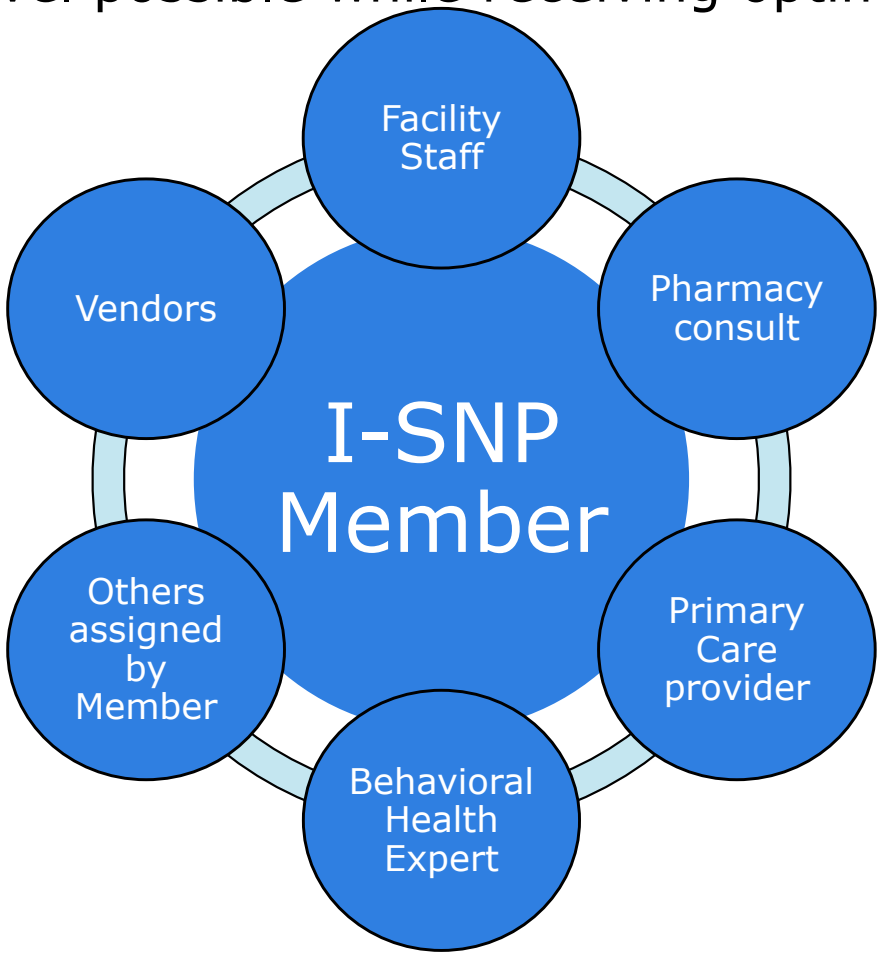
- Female: 65.58%
- Male: 34.42%

Race

- Asian: 1.44%
- Black: 5.33%
- Hispanic: .88%
- Native American: 1.21%
- White 90.19%

Staffing Structure

UCare's MOC is designed to ensure members are enabled to function at the highest level possible while receiving optimal delivery of care in the facility.



Model of Care : the components

Care Coordination: working together

- Care coordination is about working together to care for the I-SNP population. Your role is to identify and then focus on the special needs of this population while minimizing transitions of care
- The four elements of care coordination are:

Health Risk Assessment (HRA)

Interdisciplinary Care Team (ICT)

Individualized Plan of Care (IPOC)

Care Transition Protocols

Care Coordination: the elements

Health Risk Assessment (HRA)

- All members receive an assessment upon enrollment and then again at any change in condition
- Determines outreach timing, evaluates current health status and is a foundation to the IPOC
- Identifies those “at risk” needing condition-specific services to assist in their stabilization

Care Coordination: the elements

Interdisciplinary Care Team (ICT)

The ICT includes the member or designated family/caregiver as well as clinicians representing a wide variety of disciplines.

The ICT performs the following functions:

- Determines and addresses the member’s specific needs
- Assists in members' care plan creation and implementation
- Makes recommendations for additional services

Care Coordination: the elements

Individualized Plan of Care (IPOC)

- All Members must have an IPOC
- Members are actively involved in the development and reviews and have significant input
- Addresses existing problems and care preferences and details the actions/services needed to respond
- Revised with changing needs and feedback from providers, member or their family

Care Coordination: the elements

Care transition protocols

- Details the process for coordinating care across care settings/providers
- Highlights the efforts that will maximize health outcomes utilizing a multidisciplinary approach
- Includes logistical arrangements, education need, and identifies the process for coordination among all involved providers
- Ensures the development of a personal health record including questions for providers who will perform follow-up and identifies self care management opportunities
- Identifies care preferences that can be shared across settings and providers

Model of Care: the components

Provider network includes:

- A wide array of those with expertise pertinent to the care and treatment of the member and all who are delivering health care daily to the member
- All who are routinely involved with the member are expected to have active involvement, to collaborate and follow clinical practice guidelines
- The long-term care, memory care and assisted-living facilities that have agreed to the MOC, and their staff
- Those receiving initial and annual training as required and offered through multiple distribution vehicles

Model of Care: the components

Quality measurement & improvement includes:

- A Health Plan process for developing and monitoring a performance and improvement plan
- Monitoring the use of specific measures and health outcome goals specific to the I-SNP membership
- Measuring the patient experience and determining satisfaction
- Sharing of quality performance to providers for consideration of strategies to continually improve

Takeaways

You help ensure that I-SNP members achieve the healthcare they desire and deserve, including:

- Essential medical, mental health, and social services demonstrating expertise in the management of chronic disease and the aging process
- Coordinated care through alignment with the Interdisciplinary Care Team and the established IPOC
- Seamless transitions of care across health care settings, providers, and health services
- Appropriate utilization of services, achievement of desired health outcomes, and the benefits of best practices

Next steps

Complete your attestation to validate the completion of this training and keep a copy for your records.

- Provider/Provider Groups (those who are delivering routine care or services to the I-SNP member) are responsible for ensuring that ALL appropriate staff members complete initial training upon hire and the annual refresher
  - An attestation form for a group may be accepted; however, it is the provider/leader's responsibility to comply with the training requirement and ensure that all staff are properly trained.
  - In addition, the provider/leader must list all staff members who have been trained

Have questions? We have answers!

Call us

Speak to the ISNP Program Coordinator today.
Call 612-676-6746

Email

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