
ucare®

UCare Model of Care

- Minnesota Senior Health Options (MSHO)
- Connect + Medicare
- Institutional Special Need Plan (ISNP)

Training Purpose

- Provides information about Model of Care requirements for UCare's Special Needs Plans (SNP)
- Outlines the importance of your role as a provider – Primary Care or Specialist, on the Interdisciplinary Care Team
- Explains how to interface with the care coordination team in the provision of care
- Training required for new providers and annually thereafter

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

Why does UCare have an MOC?

It employs interventions to drive improvements in health outcomes and quality of life, which enhances:

- Access to Primary & Specialty Care Providers
- Improved coordination of care
- Seamless transitions of care
- Cost management

UCare's Special Needs Plans (SNP)

These plans serve members residing within UCare's service area:

- **Minnesota Senior Health Options Program (MSHO)** serves elderly members who are dually eligible for Medicare and Medical Assistance, and 65 or older
- **UCare Connect + Medicare Program** serves members with disabilities between the ages of 18-64 who are dually eligible for Medicare and Medical Assistance
- **Institutional Special Needs Plan (ISNP)** serves members 18 and older who are Medical Assistance eligible members who for 90 days or longer have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), or an Assisted Living (AL)

UCare's Dual Special Needs Plans (D-SNP)

Integrated products combining Medicaid and Medicare:

- Parts A, B, and D (pharmacy) plus Medicaid benefits
- Members have one ID card
- One phone number for health plan questions
  - 612-676-6830 or 1-855-260-9707

Enrolling in SNP

Enrollment is voluntary, with several ways to enroll:

- Member's county financial worker (MSHO)
- Senior Linkage Line: 800-333-2433 (MSHO)
- UCare's Enrollment: 612-676-3554 or 800-707-1711 (MSHO and Connect+)
- UCare's Sales ISNP team: 612-676-6821 or 877-671-1054 (ISNP)

Connect+ Medicare Member Demographics

Age Range: 18 to 64 years

- Female: 55%
- Male: 45%

Living Arrangements:

- Community: 98%
- Institutional: 2%

Race:

- Asian: 7%
- Black or African American: 14%
- Hispanic: 3%
- Native American: 3%
- White: 73%

ISNP Member Demographics

Age Range: 65-85+ years

- Female: 67%
- Male: 33%

Living Arrangements:

- Institutional: 100%

Race:

- Asian: 2%
- Black or African American: 4%
- Hispanic: 1%
- Native American: 1%
- White: 91%

MSHO Member Demographics

Age Range: 65-85+ years

- Female: 64%
- Male: 36%

Living Arrangements:

- Community: 41%
- Institutional: 13%
- Waiver: 46%

Race:

- Asian: 16%
- Black or African American: 20%
- Hispanic: 3%
- Native American: 1%
- White: 60%

Vulnerable Populations

Connect + Medicare

- Disabled adults, diagnosed with a physical, developmental, mental illness, or brain injury
- The majority of the population is diagnosed with serious and persistent mental illness
- Most of the population have multiple complex, chronic conditions

MSHO

- Older adults, often frail
- At risk for readmission to hospital
- At risk for multiple chronic conditions and polypharmacy

ISNP

- Older adults that have diseases of aging that are chronic, progressive, or degenerative
- Dealing with mobility issues or limitations in ability to function independently that are compounded by the existence of multiple co-morbidities and frailty
- 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 some degree of cognitive impairment

Care Coordinators

Care Coordinator qualifications:

- County Social Worker
- Minnesota Licensure:
  - Nurse Practitioner
  - Public Health Nurse
  - Physician Assistant
  - Physician
  - Registered Nurse
  - Social Worker
  - Mental Health Professionals (Connect +)

Care Coordination

The Care Coordinator (CC) coordinates care and services for the member, including:

- Annual health risk assessment (HRA) to evaluate members' medical, psychosocial, cognitive, functional, and mental health needs
- Creating an individualized, person-centered care/support plan (ICP) addressing needs identified by the HRA
- Closing gaps in care, improving quality of life, and meeting the member's individual needs
- Communicating with the Interdisciplinary Care Team (ICT), the team providing health care services for members
- Facilitating care transition protocols

Health Risk Assessment (HRA)

The HRA provides the Care Coordinator with pertinent information related to all members' **medical, functional, cognitive, psychosocial and mental health needs**.

The HRA provides insight into:

- Determining member needs
- How member manages their health
- Needed supports to manage overall health
- Identifying member concerns

Individualized Care/Support Plan (ICP)

The person-centered information contained in the ICP is used to monitor gaps in the member's **medical, psychosocial, cognitive, functional and mental health needs**.

The focus is on preventive and maintenance health care services, disease-specific interventions, and health care service coordination. The ICP addresses needs identified in the HRA by:

- Prioritizing goals
- Identifying barriers and interventions
- Identifying and coordinating service needs
- Identifying ICT members
- Planning for care continuity, transitions, and/or transfers
- Updating progress made toward goals/plan
- Managing ongoing communication between teams

Interdisciplinary Team

This team consists of:

- Member and/or appropriate family/caregiver
- Care Coordinator
- Primary Care Provider
- Other providers appropriate to specific health needs (specialists, mental health providers, etc.)
- Others as identified by member or team

Provider Role on the ICT

Expectations:

- Providing appropriate care to the member
- Collaboration with the Care Coordinator and Specialists
- Reading through and providing input to the care plan
- Working with the member to identify meaningful goals
- Work with the Care Coordinator to identify the most appropriate level of care for members experiencing a transition
- Supporting members with improving quality of life

Care Coordinator's Role

Every member is assigned a Care Coordinator

- The Care Coordinator partners with the member and their ICT
- All Primary Care Physicians are considered an integral part of the member's ICT
- The Care Coordinator is the primary point of contact for ICT members, ensuring ongoing communication and coordination

To find out who the member's Care Coordinator is, call UCare Customer Service:

- **MSHO:** 612-676-6868 or 1-866-280-7202
- **Connect + Medicare:** 612-676-6830 or 1-855-260-9707
- **ISNP:** 612-676-6821 or 1-877-671-1054

Care Transition Protocols

Care transition protocols are in place to improve transitions by reducing fragmented care and avoiding re-hospitalizations.

Care coordinators:

- Coordinate care, improve communication, and share / update the member's ICP
- Assist members, families, facilities, providers, or others with planned and unplanned transitions from one care setting to another
  - Examples include transition from hospital to home, or skilled nursing facility to home
- Follow-up to ensure that the member understands:
  - Any health status changes, discharge instructions, and changes to medication(s)
  - That follow-up appointments are scheduled, including any transportation needs

Care Transitions Protocols

The goal in coordinating care with providers is to improve coordination and communication, reduce fragmented care and avoid re-hospitalizations.

- Providers work with the Care Coordinator before, during and after transition to ensure continuity and coordinated care
- Care Coordinators can be available for questions related to transitions of care guidelines
- Providers adhere to transition protocol guidelines and work with Care Coordinators to reduce readmissions and improve outcomes
- Identify if member has new or changing needs as a result of the transition

Provider Network

UCare's provider network meets a wide range of needs

- Members may have care from any contracted provider without referral

The network includes but is not limited to:

- Primary Care Providers
- Specialists and Specialty Care Clinics
- Dental Providers

Quality Measurement & Performance Management

UCare collects and analyzes data and reports from a variety of sources to measure plan performance including but not limited to:

- Claims, utilization, pharmacy, and demographic information
- HEDIS, CAHPS, Stars, predictive modeling, and evidence-based analytic tools

This information helps UCare to:

- Evaluate the Model of Care annually
- Identify improvements

Outcomes

The overall goal of UCare's Model of Care is to employ interventions to drive improvements in health outcomes and quality of life for our members. UCare's Model of Care is designed to improve:

- Access to affordable, cost-effective health care, including medical, mental health, preventive, and social services
- Care coordination through alignment of HRA, ICP, and ICT
- Seamless care transitions across healthcare settings, providers, and health services
- Costs while assuring appropriate utilization of services for preventive health and chronic conditions

UCare sets specific goals and health outcome objectives, that are measured at least annually. Our goals include preventive goal HEDIS measures, member satisfaction with the plan, improved access, seamless transitions, and improving coordination of care via HRA, ICP, and ICT.

Clinical Practice Guidelines (CPGs)

UCare has clinical practice guidelines for providers to support good decision-making and to improve health care outcomes.

Medical CPGs:

- Asthma Diagnosis and Management
- Care of Older Adult
- Diabetes: Type 2 Diagnosis and Management
- Management of Heart Failure in Adults
- Obesity for Adults: Prevention and Management
- Prenatal Care
- Preventive Services for Adults
- Preventative Services for Children and Adults

Mental Health and Substance Use CPGs:

- Assessment and Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder
- Assessment and Treatment of Children and Adolescents with Depressive Disorders
- Management of Posttraumatic Stress Disorder and Acute Stress Disorder
- Treatment of Opioid Use Disorder
- Treatment of Patients with Major Depressive Disorder
- Treatment of Patients with Schizophrenia
- Treatment of Patients with Substance Use Disorders

Summary

- The MOC is designed to meet the needs of our member population
- Providers play an important role as members of the Interdisciplinary Care Team
- Providers and Care Coordinators work together to improve outcomes and the quality of life for members
- UCare annually evaluates the Model of Care, using data and reports

Next Steps

- Please complete the electronic attestation on UCare's website for proof of completion.

- If you have any questions, please reach out to:
  - ISNP – ISNPprogramcoordinator@ucare.org
  - MSHO – msc_msho_clinicalliaison@ucare.org
  - Connect + Medicare – SNBCclinicalliaison@ucare.org