Model of Care

MSHO, Connect + Medicare & I-SNP

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UCare Model of Care (MOC)

The purpose of this training is to:

- Provide information about the Model of Care and the annual training requirement for UCare's Special Needs Plans (SNP)
- Outline the importance of your role as a provider – Primary Care or Specialist, on the Interdisciplinary Care Team (ICT)
- Explain how to interface with the care coordination team in the provision of care

Powering the Way

We have clear priorities focused on:

- Increasing access to affordable, cost-effective health care like Primary and Specialty Care
- Improving the coordination of care
- Supporting improvements in health outcomes and quality of life for our members
- Ensuring seamless transition of care
- Managing costs

We'll achieve these priorities by:

Sharing our Model of Care with you!

Quality Measurement & Performance Management

Data & Reports

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:

- Set goals and create health outcome objectives
- Evaluate the Model of Care annually
- Identify improvements

Who We Serve

MSHO, Connect + Medicare and I-SNP

UCare’s Special Needs Plans

Minnesota Senior Health Options (MSHO) and Connect + Medicare (D - SNP)

- 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

Institutional Special Needs Plan (I – SNP)

- Parts A, B, and D (pharmacy)
- Members have one ID Card
- One phone number for health plan questions
    - 612-676-6800

Who We Serve

	Serving Members	Age Range	Identified Gender	Living Arrangements	Race/Ethnicity
Connect + Medicare	that have a certified disability who are dually eligible for Medicare and Medical Assistance	18 to 64 years	Female: 55% Male: 45%	Community: 98% Facility: 2%	Asian: 7% Black or African American: 14% Hispanic: 3% Native American: 3% White: 73%
Vulnerabilities: Disabled adults, diagnosed with a physical, developmental, mental illness, or brain injury. Most of the population is diagnosed with serious and persistent mental illness. Most of the population has multiple complex, chronic conditions.					
MSHO	elderly who are dually eligible for Medicare and Medical Assistance	65 to 85+ years	Female: 64% Male: 36%	Community: 41% Facility: 13%	Asian: 16% Black or African American: 20% Hispanic: 3% Native American: 1% White: 60%
Vulnerabilities: Older adults, often frail, are at risk for readmission to the hospital, at risk of multiple chronic conditions and polypharmacy.					
I-SNP	18 and older who are Medicare 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) or an Assisted Living (AL)	65 to 85+ years	Female: 67% Male: 33%	Facility: 100%	Asian: 2% Black or African American: 4% Hispanic: 1% Native American: 1% White: 91%
Vulnerabilities: 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					

Provider Network

UCare’s provider network meets a wide range of needs

Members may receive care from any contracted provider within 30 miles (primary care) or 60 miles (specialty care) from the member’s primary residence without a referral.

The network includes but is not limited to:

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

Enrolling in SNP

MSHO

Member’s county financial worker or Senior Linkage Line 800-333-2433

MSHO and Connect + Medicare

UCare’s Enrollment: 612-676-3554 or 800-707-1711

I-SNP

UCare’s Sales ISNP team: 612-676-6821 or 877-671-1054

Care Coordination

Connecting members with providers

Care Coordinator (CC)

The CC serves as a primary point of contact for all members of the Interdisciplinary Care Team (ICT)

Care Coordinator qualifications:

- Minnesota Licensure:
  - Nurse Practitioner
  - Independently Licensed Mental Health Professionals (LP, LPCC, LMFT, LICSW) (CT+MED)
  - Public Health Nurse
  - Physician Assistant
  - Physician
  - Registered Nurse
  - Social Worker/County Social Worker

Care Coordination

The Care Coordinator (CC) Supports members by:

- Conducting Health Risk Assessments
- Closing Gaps in Care
- Supporting member's goals and needs
- Communicating with the ICT
- Individual Support Planning
- Improving Quality of Life
- Facilitating Transitions of Care

Health Risk Assessment

The annual health risk assessment completed by the care coordinator provides direction and insights into:

1. Determining member needs
2. Understanding how members manage their health
3. Needed supports to manage overall health
4. What’s important to and for the member

Empowering our People

Individualized Support Plan

The person-centered information contained in the support plan is used to monitor gaps in the member's medical, psychosocial, cognitive, functional and mental health needs. The focus is on preventative and health care services, disease-specific interventions and service coordination.

The support plan addresses needs identified in the HRA by:

- Prioritizing goals
- Identifying barriers and interventions
- Identifying and coordinating service needs
- Identifying members of the Interdisciplinary Care Team
- Planning for care continuity, transition and/or transfers
- Updating progress made toward goals/plan
- Managing ongoing communication between teams

Transition of Care Protocols

CC role

- Coordinating services and equipment needs to promote health and safety
- Supporting family and caregivers with education and resources throughout transitions
- Ensuring communication between the Interdisciplinary Care Team members
- Sharing the member's support plan updates with the Interdisciplinary Care Team
- Supporting members with arranging transportation to scheduled appointments

CCs support the member's understanding of:

- Any health status changes
- Discharge instructions
- Changes to medication(s)
- Follow-up appointments scheduled

Transition of Care

The key to successful Transition of Care

Transition of care protocols are in place to improve coordination and communication with providers and to improve member outcomes by reducing fragmented care and avoiding re-hospitalizations.

The key to successful transition is:

- Providers working with the Care Coordinator before, during and after transition to ensure continuity and coordinated care
- Adhering to transition protocol to reduce readmissions and improve outcomes
- Identifying when a member has new or changing needs because of the transition
- Care Coordinators being available for questions and to assist members with transitions of care needs

Care Coordinator Contacts

MSHO:

612-676-6868 or 1-866-280-7202

Connect + Medicare:

612-676-3310 or 1-855-260-9707

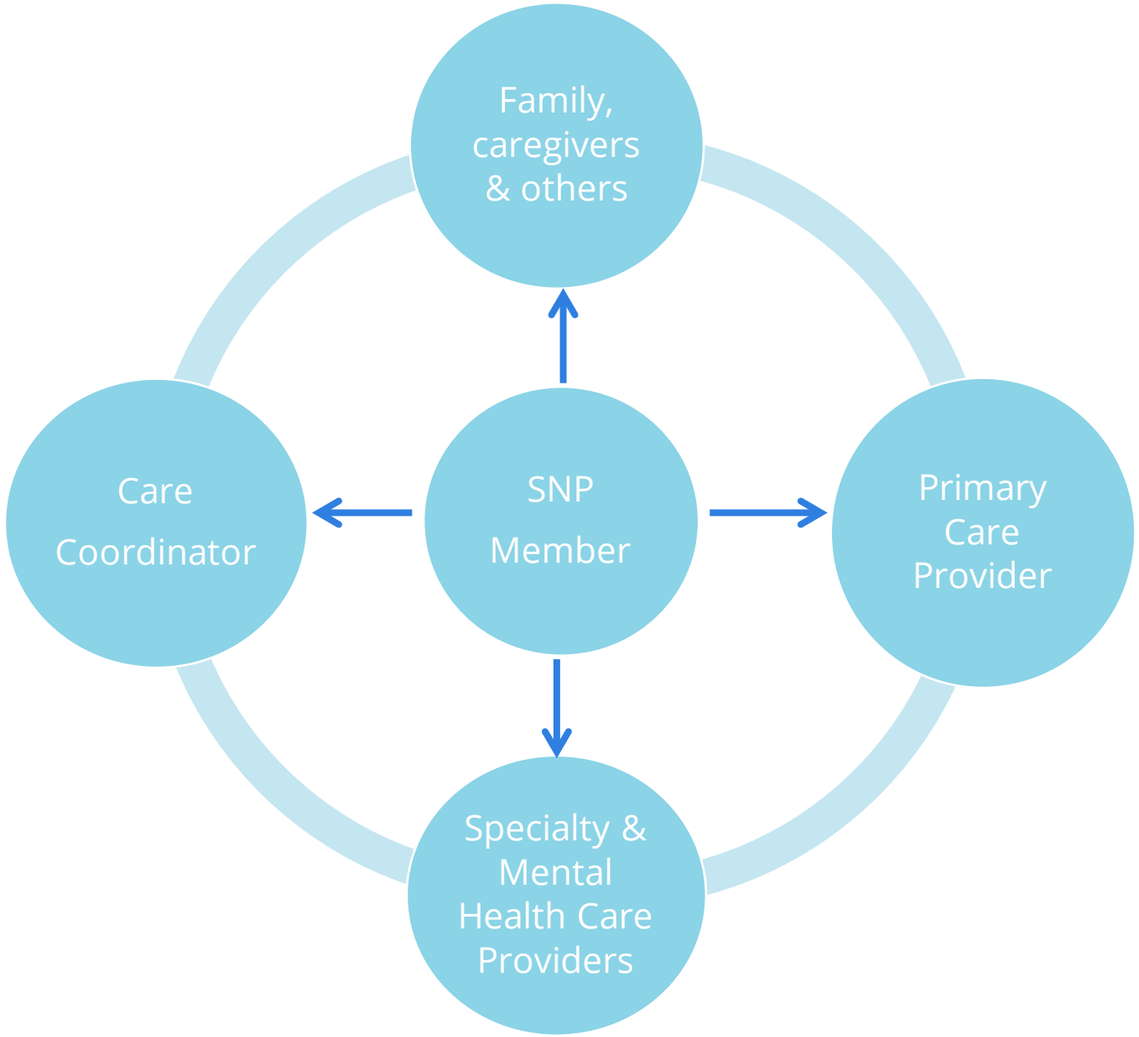
I-SNP:

612-676-3600 or 1-877-523-1515

The Interdisciplinary Care Team

ICT

Interdisciplinary Care Team



Roles on the ICT

Provider Role

- Provide appropriate care
- Review and provide input to the support plan
- Work with members to identify meaningful goals
- Work with the CC to ensure the appropriate level of care for members experiencing transition
- Support members with improving their quality of life

Care Coordinator

- Partner with all members of the ICT
- Serve as the primary point of contact for the ICT
- Facilitate Transition of Care protocols

Providers: Clinical Practice Guidelines

Medical

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

Mental Health and Substance Use

- Assessment and Treatment of Children and Adolescents with ADHD
- Assessment and Treatment of Children and Adolescents with Depressive Disorders
- Management of PTSD 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

Link: UCare Clinical Practice Guidelines

Summary & Attestation

Goals of MOC

Summary

The UCare MOC is designed to meet the needs of our unique 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 uses data and reports to evaluate the Model of Care annually

UCare Goals

Our goals include preventive HEDIS measures, member satisfaction with the plan, improved access to care, seamless transitions, and improved coordination of care via HRA, support plan, and ICT.

Annual Attestation Required

If you have any questions, please reach out to:

MOCAttestation@ucare.org

UCare Attestation

Provider MOC