



# HAP Empowered Duals (HMO SNP) Model of Care Training - 2019



# Objectives of this Learning Module

- Overview of HAP products and care management philosophy
- Review Model of Care goals and elements for HAP Empowered Duals (HMO SNP) plan:
  - General description needs of HAP Empowered Duals (HMO SNP) members
  - Overview of care coordination
  - Provider network
  - Quality measurement and performance improvement
- Summary and post test

# Overview of products and care management philosophy

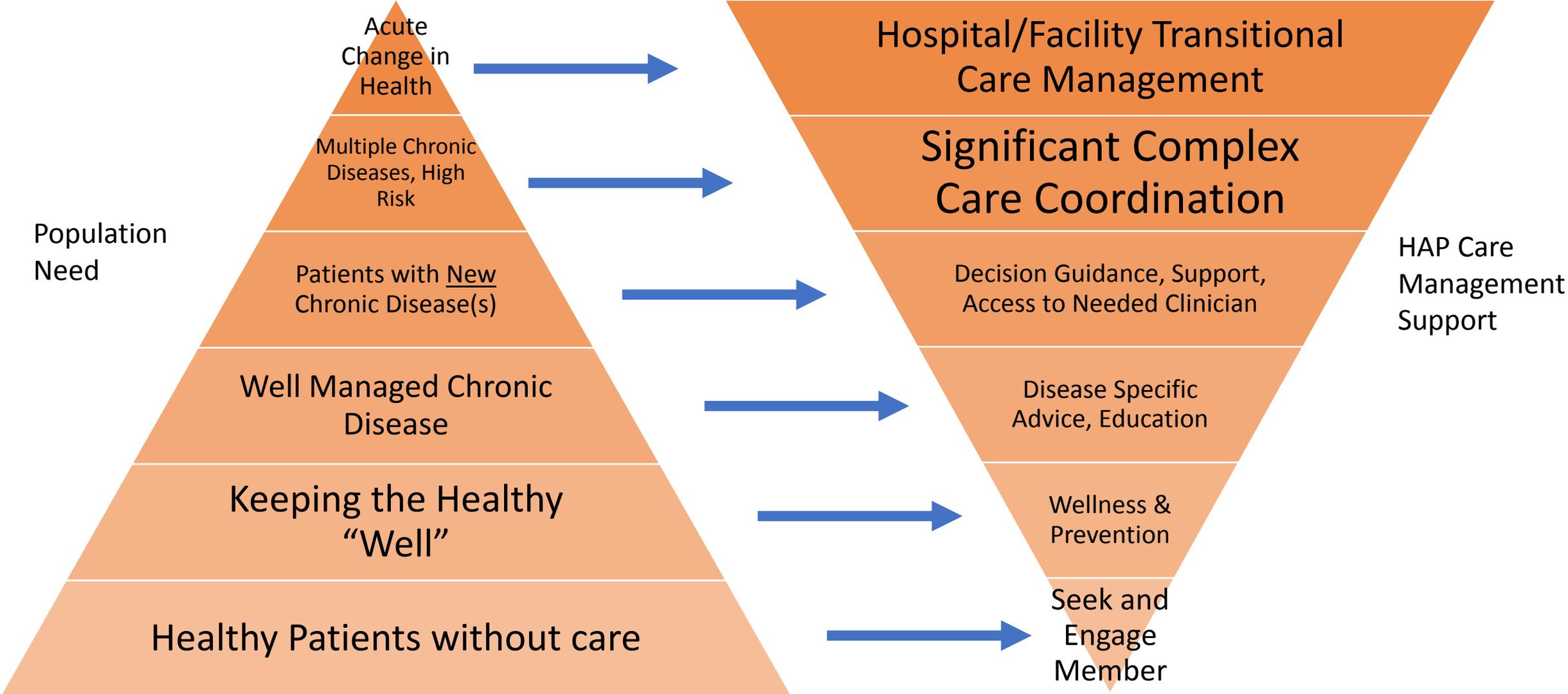
# HAP offers a variety of commercial and government plans with a broad model of care

- **HAP Commercial and Self-Funded Plans** – Mid/Southeast MI
- **HAP Medicare Advantage** for Seniors - Mid/Southeast MI
- **HAP Empowered Duals (HMO SNP)** – January 2019 (Genesee County)
- **HAP Empowered Medicaid** – Region 6 (Shiawassee, Genesee, Tuscola, Sanilac, Lapeer, Huron and St. Clair Counties)
- **HAP Empowered MI Health Link** – (Wayne and Macomb Counties)

# Health Care Management – Member Centric



# Care Management – Managing Population



# HAP Care Management Mission/Vision

- **Mission:** The HAP Care Management Team assists members and their support systems in managing complex medical conditions more effectively to:
  - improve functional health status
  - enhance coordination of care and member experience
  - eliminate duplication of services
  - reduce the need for low-value medical services
  - increase member engagement in self care
- **Vision:** HAP Care Management will be recognized experts and vital participants in the care coordination team who meet members where they are and empower people to understand and access quality, appropriate health care.

# HAP Care Management Values

- **Empathize** with members who may be struggling with their clinical condition, as well as social or economic barriers in accessing services.
- **Engage** members in understanding their condition and what they need to do to improve their health status.
- **Empower** members to take more control of their own care and collaborate with their primary care team.

# Review Model of Care Goals and Elements for HAP Medicare DSNP Program:

General Description Needs of DSNP Population

Overview of Care Coordination

Provider Network

Quality Measurement and Performance Improvement

# What is the Model of Care?

- The MOC is HAP's plan for delivering our integrated care management program for members with special needs.
- **It's the foundation for care management policy, procedures and operational systems.**
- It ensures all employees and providers who may work with HAP Empowered Duals (HMO SNP) members have the specialized training this unique population requires.

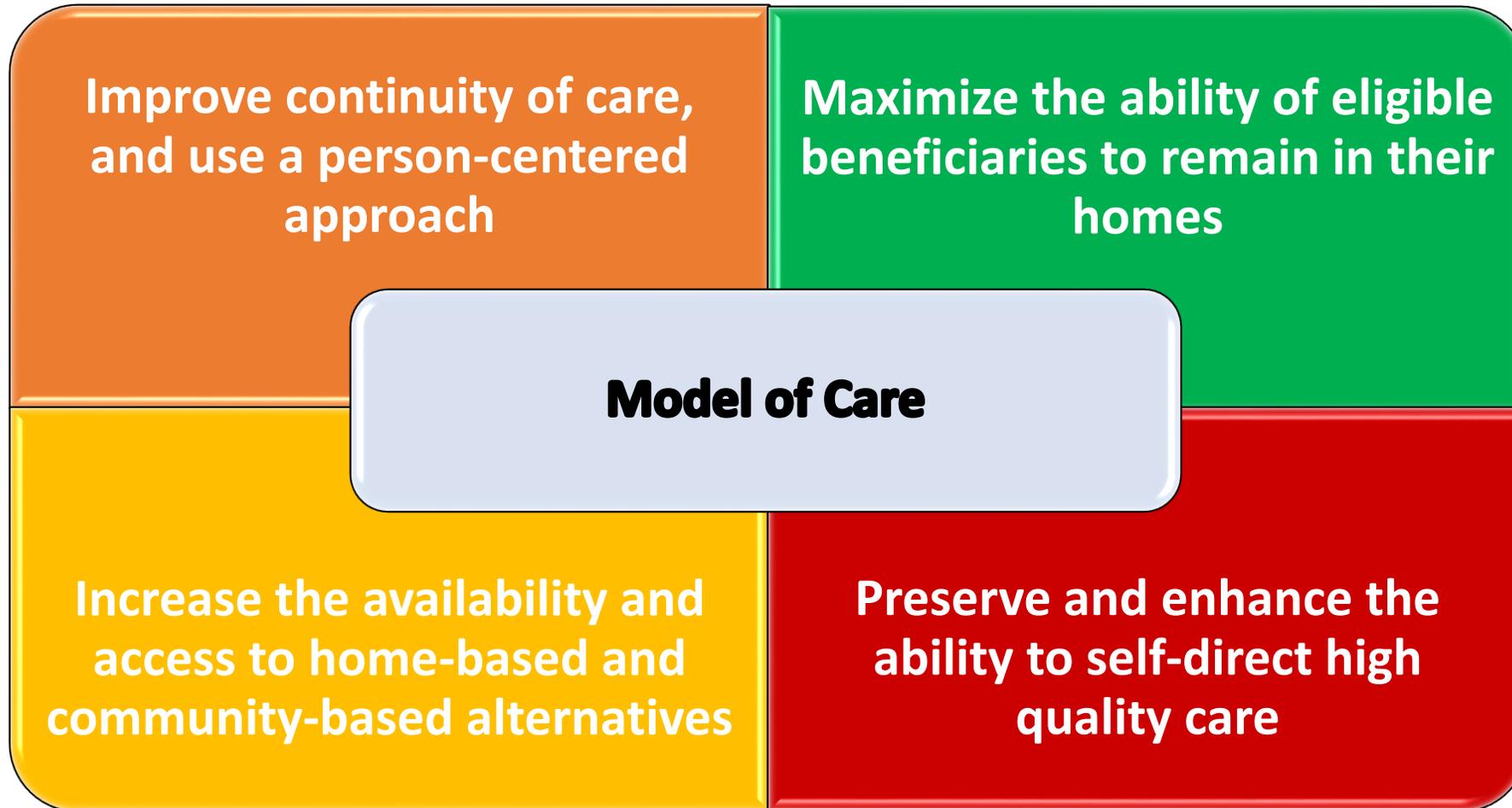


# Model of Care Goals

The goals of the MOC are to:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care
- Improve transitions of care across healthcare settings and providers
- Improve access to preventative health care services
- Ensure appropriate utilization of services
- Ensure cost-effective service delivery
- Improve member health outcomes

# What is core to HAP's Model of Care (MOC)?



# Health Challenges of Genesee County

- Currently, HAP has about 1,000 Medicare Advantage members in Genesee County. In addition, HAP has an active Medicaid program with over 1,600 members in Genesee County. As part of its already existing Medicare Advantage and Medicaid Programs, HAP performs annual community assessments of Genesee County to determine the unique needs of local residents.
- HAP identifies beneficiaries in the categories below to be the most vulnerable and have established specific processes and/or services to address their special needs.
  - Frail
  - Disabled
  - Chronic Kidney Disease
  - Ethnic minorities
  - Poor (low socioeconomic status)
  - Other social determinants (food scarcity, housing instability)
  - Members with multiple and complex medical and/or behavioral health conditions
  - Members with multiple emergency room visits and/or hospital admissions within a 3-month period
  - Members near the end of life

# Health Challenges of Genesee County

Sources which assist in identification of vulnerable beneficiaries are:

- Physician referrals for case management
- Hospital discharge planners
- Precertification and utilization review programs
- Beneficiary or family of the beneficiary
- Claims, pharmacy or laboratory data
- Disease management programs
- Review of over/under utilization of health care services
- HAP Customer Service
- Health Risk Assessment tool
- Medical, psychosocial, cognitive or functional challenges

# Health Challenges of Genesee County

- According to State of Michigan statistics, Genesee County ranks in the bottom 10% out of the 83 counties in Michigan for the incidence of health outcomes including premature death and poor health behaviors, such as smoking, obesity, excessive drinking.
- It also ranks low for clinical care with a ratio of patients with every mental health provider (470).
- Heart disease is the leading cause of death followed by cancer and stroke.
- The leading diseases prevalent in Genesee County hospitalizations include:
  - Heart disease
  - Injury/poisoning
  - Septicemia
  - Psychoses
  - Osteoarthritis
  - Cancer and malignant neoplasms

# Person Centered Health Delivery Model of Care

## **Integrated Care Coordination - one stop shop**

- Primary care - physical, medical care
- Behavioral health - mental health and substance use care
- Psychosocial - in home or facility based supportive services
- Environmental - in home or facility based supportive services
- Long Term Services and Supports - in home or facility based supportive services
- Transitions of care - members who have admissions from setting to setting; setting to home

# Model of Care Process – Assessment/Referral

- A Health Risk Assessment (HRA) is used to obtain information about the member. An initial assessment is completed for all new beneficiaries within 90 days of enrollment. It's used to identify a member's needs and goals to develop an individualized plan of care (ICP) in collaboration with the member.
- An annual reassessment is done to identify changes in the beneficiary's condition and needs and update the plan of care according to changes in the member's needs and goals.
- The assessment collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.
- Members are assessed by the Care Coordinator for care services accordingly and referred appropriately.

# Model of Care Process – Care Plan Development

- The HAP case manager uses the completed assessment to develop case management initiatives and an ICP with input from the beneficiary.
- It's also shared with the interdisciplinary care team (ICT) to develop an ICP in collaboration with the beneficiary.
- The annual HRA is used to update the beneficiary's ICP that was developed at the time of the initial HRA or the previous annual HRA.
- The update of the annual ICP is also done in collaboration with the member, providers and the ICT.

# Model of Care Process – The Individualized Plan of Care

- The ICP is developed in collaboration with the member and includes essential components to ensure it meets individual needs and is specific to each member. The ICP addresses the following components:
  - The identified problems, interventions and goals based on priority of health care and behavioral health needs and preferences
  - Health, behavioral, community and other services/resources specific to meet member needs
  - Member goals and objectives that are “person-centered” and related to self-management and/or disease management
  - Specified time frames for accomplishment of goals
  - Follow-up with the member to identify status of goals with notation when goals are met
  - Identification of new goals when other goals are met and/or;
  - Identification of adjusted/revised goals when barriers occur

# Model of Care Process – The Individualized Plan of Care

- An ICP is developed with input from the ICT.
- The ICP includes 3 general components:
  - Goals and Interventions
  - Specific services and benefits to be provided
  - Measurable Outcomes

# Model of Care Process – The Interdisciplinary Care Team

- The HAP Case Manager provides the beneficiary with information on the ICT during the ICP development and works with the beneficiary to determine who should be involved in the ICT.
- The participants of the ICT are based on the beneficiary's specific identified needs, interventions and goals.
- The ICT can consist of multiple persons or only one or two persons based on the care coordination needs of the member and the persons and professionals required to establish and coordinate an ICP. This can include the primary care physician or staff.

# Interdisciplinary Care Team

- HAP's program is member centric with the PCP being the primary ICT point of contact.
- HAP's care management team works with all members of the ICT in coordinating the plan of care for the member.



# CMS Expectations for the ICT

CMS expects the following related to the ICT:

- All care provided is according to the member preference.
- Family members and representatives are included in the health care decisions as the member desires.
- Continual communication with all members of the ICT regarding the member's plan of care.
- All team meetings and communications are documented and stored.

# Model of Care Process – The ICT

- PCPs who participate in the ICT:
  - Provide input to assist in the development and update of the ICP with the beneficiary and ICT
  - Assist the ICT and beneficiary to establish goals
  - Ensure primary care and specialty care needs are identified in the ICP
  - Provide access for the beneficiary to receive primary care and provide referrals for specialty care as indicated
  - Ensure timely and appropriate delivery of services
  - Collaborate with the ICT as beneficiary's needs change
  - Provide clinical consultation with developing and updating care plans
  - **Maintain copies of the ICP and ICT worksheets and transitions of care notifications in member's medical records when received.**

# ICT and Transition of Care



Managing transition of care interventions for all discharged members may include but not limited to:

- Face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.
- Ongoing education of members includes preventative health strategies in order to maintain in the least restrictive setting possible for their health care needs.

# Provider Network

- HAP is responsible for maintaining a specialized provider network that corresponds to the needs of our members.
- HAP coordinates care and ensures providers can:
  - Collaborate with the ICT
  - Provide clinical consultation
  - Assist with developing and updating care plans
  - Provide pharmacotherapy consultation

# Provider Network

CMS expects HAP to:

- Prioritize contracting with board-certified providers.
- Monitor network providers to ensure they use nationally recognized clinical practice guidelines when available.
- Ensure network providers are licensed and competent through a formal credentialing process.
- Document the process for linking members to services.
- Coordinate the maintenance of sharing member's healthcare information among providers and the ICT.

# HAP Provider Collaboration

- HAP values our partnerships with our physicians and providers.
- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers and HAP
  - Interdisciplinary approach to the member's special needs
  - Comprehensive coordination with all care associates
  - Support for the member's preference in the plan of care
  - Reinforcement of the member's connection with their medical team

# Quality Measurement and Performance Improvement

- The goal of quality measurement and performance improvement for HAP is to ensure the HAP Empowered Duals (HMO SNP) members receive high-quality health care services and benefits.
- The goal of HAP's Quality Improvement Program is to increase HAP's effectiveness and efficiency and integrate quality measurement and performance improvement concepts that drive change.
- The quality performance improvement plan is designed to determine whether the overall Model of Care structure effectively accommodates beneficiaries' unique health care needs.

# Time to Test Your Knowledge!



## See if You Can Answer Without Clicking to The Next Slide

1. What county is HAP Empowered Duals (HMO SNP) plan offered?
2. What are the four elements of the Model of Care?
3. What are the three components of a member's Individual Care Plan (ICP)?
4. Who is included in the Interdisciplinary Care Team (ICT) for the member?
5. Who is the primary contact for the ICT?
6. True or False? One of the provider responsibilities in the ICT is to maintain copies of the ICP and ICT worksheets and transitions of care notifications in member's medical records when received.

# How Did You Do?

1. What county is HAP Empowered Duals (HMO SNP) plan offered?

Genesee County

2. What are the Four Elements of the Model of Care?

1. General description needs of HAP Empowered Duals (HMO SNP) members

2. Overview of Care Coordination

3. Provider Network

4. Quality Measurement and Performance Improvement

3. What are the three components of a member's Individual Care Plan (ICP)?

1. Goals and Interventions

2. Specific services and benefits to be provided

3. Measurable outcomes

4. Who is included in the Interdisciplinary Care Team (ICT) for the member?

HAP staff, the member, the member's family representative, external practitioners including PCPs and vendors involved in the member's care based on the member's preference.

5. Who is the primary contact for the ICT?

The member's PCP is the primary contact.

6. True or False? One of the Provider Responsibilities in the ICT is to maintain copies of the ICP and ICT worksheets and transitions of care notifications in member's medical records when received.

True.

Thank you for completing the HAP Empowered Duals (HMO SNP)  
Model of Care training.

Please return to the attestation page.