2019 MeridianCare Model of Care Provider Training
Training Requirement

All providers that are contracted with MeridianCare Extra must complete the Model of Care (MOC) training annually. This training also includes out-of-network providers who provide care for MeridianCare Extra members.
Objectives

- To provide guidance and information related to the MOC, how to meet the special needs of our unique membership, and the importance of your role as their healthcare provider

- Identify the importance of member assessments and the creation of an individualized care plan (ICP) for each member

- Provide education on available resources that make our members’ lives healthier
Hi, my name is Dr. Meridian and I will be guiding you through this training today. Get ready to learn all about the Model of Care!

The MOC is a quality tool that ensures the unique needs of each member are met. This is accomplished by embracing the core elements of the MOC, which we will cover in this training.

MeridianCare’s MOC encompasses members in the Michigan and Ohio Dual-Eligible Special Needs Plan (D-SNP) populations.
MeridianCare's Quality Improvement program establishes goals to address social determinants of health, medical conditions, and environmental barriers that members face on a daily basis. The MOC's success is measured by tracking specific goals that relate to these factors to determine if the member's health outcomes are improving.

As a network provider, your role in the MOC is the most significant in ensuring the members get their necessary preventive visits completed each year, creating a comprehensive plan of care, and positively impacting their health outcomes. MeridianCare's MOC is designed to support you in providing quality care to our members.
Model of Care: MI/OH DSNP Goals

Hover over each box to learn more!

- **HEDIS®**
- **CAHPS®**
- **Access & Availability Standards**
- **HRA**
- **Medication Adherence**
- **Reducing Hospitalizations**
- **CCIP**

- An initial Health Risk Assessment (HRA) is completed up to 90 days before and up to 90 days after a member joins the plan.
- MeridianCare will make every attempt to contact a new member within 90 days to complete the HRA. A total of five attempts will be made before a member is placed into an “unable to contact status.”
- A re-assessment HRA must be completed, at a minimum, at least annually.
Model of Care Elements

Hover over the boxes below to learn more...

- Description of the dual-eligible population
- Care Coordination
- Provider Network
- MOC Quality Measurement and Performance Improvement

This includes MeridianCare having a performance improvement plan in place and setting measurable goals and health outcomes for the MOC.
NCQA Scoring

- **85% and up** = Three year approval
- **75%-84%** = Two year approval
- **70%-74%** = One year approval
- **70%** = Minimum score for passing

Plans scoring below a 70% are allowed one resubmission to correct deficiencies. Regardless of the score following the cure opportunity, the SNP will only receive a one-year approval.

MeridianCare scored a 100% on the 2018 MOC and was granted a three-year approval by the National Committee for Quality Assurance (NCQA).
An ICP is created after a member’s stratification level has been determined. The ICP is created by the member, their care manager, interdisciplinary care team (ICT), provider(s), and whomever else the member might like to include in his or her health care decisions (e.g., caregivers or family members).

This document outlines the plan for a member’s treatment and personal health goals, the results of which are continuously documented and monitored for progress.
The ICP must include the following elements:

- Prioritized, person-centered goals that include interventions and progress to reach those goals
- Timeframe(s) for re-evaluation
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfers
- Member readiness to change and strengths to support each goal
- Member’s needs as they relate to medical, behavioral health, long-term supports and services, social, and functional domains

It’s important to remember that we must always protect the member’s protected health information (PHI) when discussing the ICP!
After the ICP has been created, it is presented at an ICT meeting. The goal of this meeting is to provide tools, resources, and education for each member and to encourage the member to self-manage his or her own care successfully.

A member’s risk level will determine how and when the initial ICT meeting is held, as well as the frequency of ongoing ICT meetings. Roll-over each risk level below to learn more.

- High Risk
- Medium Risk
- Low Risk
The core members of an ICT include the following:

 MEMBER | MEMBER’S CAREGIVER | MEMBER’S CARE MANAGER | MEMBER’S TREATING PROVIDER(S)

The Care Manager encourages the member to play an active role in developing their individualized care plan.
In addition to the core group of ICT members, an ICT may be expanded to include additional resources, as indicated by the needs and responses from the HRA. Examples include:

**Member’s Social Worker(s)**

**Member’s Pharmacist**

**Member’s Nutritionist**

**Member’s Palliative Care Specialist**

Based on the member’s individual needs, each ICT composition will slightly vary.
Following the ICT review, an updated copy of the care plan will be made available to all ICT participants within 10 days of the ICT review via the population health portal.
Transition of Care (TOC)

TOC process can be defined as any transition from one type of care setting to another and can include the transition of a new member onto a MeridianCare plan. The TOC process is designed to accomplish the following:

- Reduce all-cause readmissions
- Reduce ambulatory sensitive condition admissions
- Improve the patient experience by reducing the number of care transitions required to return the member to an ambulatory environment
- Provide member with tools and support that promote knowledge and self-management of their condition(s)
- Improve health outcomes for members

Members going through the TOC process due to a medical facility transition are managed by a Clinical Care Coordinator.
Once the care manager is notified of the impending or occurring transition, the case is reassigned to the appropriate clinician to assume care of the member during the transition. The clinician is responsible for coordinating the care transition process and for ensuring that follow-up services and appointments are scheduled and performed.
MeridianCare’s provider network is developed to address the unique needs of the D-SNP population.

Clinical Practice Guidelines

CPGs are posted to the provider website to support providers in the delivery of consistent and high quality care.

MeridianCare recognizes that there will be situations in which members will need healthcare services outside of CPGs as well as nationally recognized protocols based on the unique circumstances of each member.
MeridianCare encourages the use of evidence-based CPGs by our providers.

The following CPGs should be used by all MeridianCare Extra providers in Michigan and Ohio:

MeridianCare Extra (MI/OH DSNP)

(Click the hyperlink above to view MeridanCare Extra CPGs)
Internal auditing and data analysis is completed throughout the year to ensure that MeridianCare is meeting the goals set forth in the MOC. Hover over the shapes below to learn more.

HEDIS® Data  CAHPS® Data  HOS Data  MCS Data
Utilization Management Data  Access & Availability Data  CLAS Data  Acumen Data

Annual analysis includes a review of timeliness of preventive care, routine care, and primary care appointments, along with ability to obtain urgent care, emergency care, and after hours care for the D-SNP population.
MeridianCare's Quality Improvement Program Plan (QIPP) is a dynamic program that is responsive to the changing needs of MeridianCare members.

It was implemented to continuously improve the quality of care in a low resource environment in order to make high quality health care easier to give and receive in clinical and non-clinical areas for the D-SNP population.

The objectives of the QIPP are based on clinical knowledge and health care services research.
Here are a few of the core objectives of MeridianCare’s QIPP. Hover over each box to learn more.

- Provide Quality Care
- Administer Special Programs
- Meet Cultural and Linguistic Needs
- Administer Surveys
- Reduce Costs
- Develop and Administer Training

MeridianCare administers surveys, such as CAHPS® and HOS, to assess and monitor member satisfaction, functional status, and health outcomes.
Thank you for reviewing the 2019 Model of Care training!