COMMUNITY HEALTH CHOICE

MODEL OF CARE TRAINING

PLEASE REVIEW THE FOLLOWING INFORMATION AND COMPLETE THE ATTESTATION BELOW

Community Health Choice's Medicare Dual Special Needs Plan (HMO D-SNP) is a CMS authorized program for people eligible for both Medicare and Medicaid. The HMO D-SNP provides Medicare benefits through a managed Model of Care that employs member assessment, stratification, individualized care planning, and protocols for Care Transitions. An Interdisciplinary Care Team (ICT) is core to the program's purpose of achieving integrated care and quality outcomes.

HMO D-SNP eligible members have a higher disease burden, more behavioral health comorbidities, and more social factors with adverse effect on health than the general population.

Community Health Choice will use Interdisciplinary Care Teams (ICTs) to develop each member's individualized care plan. An ICT is composed of knowledgeable, licensed, and (as appropriate) credentialed individuals involved with the care of the member, based on the needs of the member.

The Community Health Choice Case Manager leads the ICT, and is responsible for organizing the ICT in response to:

- Member or provider requests
- Utilization or changes in member's clinical condition or social situation, or medical, nursing facility and Behavioral Health assessments

The PCP is always a member of the ICT. The member, the center of the care planning process, may choose to include family or caregivers and other clinical or non-clinical people who assist with decision-making or complying with treatment plans.

The D-SNP population has significant healthcare challenges, but a segment of the population is deemed **Most Vulnerable Members:**

- Homeless
- Super elderly (> 80 years of age) isolated, mobility issues, and/or dementia
- Serious mental illness (based on diagnostic codes)
  - Multiple hospitalizations (acute care or mental health facility) – 3 hospitalizations in 3 months or a readmission within 7 days
  - Multiple ED visits (>3 ED visits/rolling 3 months)
  - Any encounter with law enforcement
- Living in a rural area with serious co-morbidities
  - Missing 2 out of 3 medical appointments in 3 months or know to not have a relationship with a PCP
  - Known lack of transportation
  - Has 3 or more chronic medical diseases with known morbidity and mortality
- Significant medical issues such as late stage III-IV cancer, spinal cord and brain injuries who have limited social support

Possible ICT members in addition to PCP and Community Health Choice Case Manager include the following:

- Member/Caregiver/Authorized Representative/Conservator
- Specialist, Behavioral Health provider
- County Social Worker
- Home health provider
- Member's neighbor, friend, advocate, or clergy with approval from member

The ICT meets at least annually in a location convenient for the ICT members, frequently by phone.

Community Health Choice RNs conduct a Health Risk Assessment (HRA) with each member within 90 days of enrollment and at least annually. The HRA assesses the member's medical, behavioral, social, cognitive, and functional status. Members may request an HRA at any time.

The HRA is the basis for an Individualized Care Plan (ICP) which has essential components:

- The member's self-management goals and objectives.
- The member's personal healthcare preferences.
- Identification of goals (met or not met).
- Barriers to meeting goals.
- If the member's goals are not met, the process for reassessing the current ICP and determining the appropriate alternative actions.
- Description of the role of the member's caregiver.

Clinical Practice Guidelines (CPGs)
Community Health Choice develops or adopts medical and behavioral health CPGs that are relevant to the HMO D-SNP population, and promotes the CPGs to the network. CPGs are posted on the Community Health Choice provider portal. The use of clinical practice guidelines and nationally recognized protocols may need to be modified or are not appropriate for some vulnerable HMO D-SNP members due to multiple chronic conditions or other complicating factors.

Care Transitions

Community Health Choice uses care transition protocols to maintain continuity of care for HMO D-SNP members. A care transition is the movement of a member from one care setting to another as the member's health status changes. Care settings are a private home, home with home health care, acute care or Long Term Acute Care (LTAC) Hospital, Skilled Nursing Facility, or other facility settings such as Nursing Home or Board & Care.

The Community Health Choice Case Manager is the member's single point-of-contact through transitions who has ongoing contact with the member and/or caregiver to ensure that any questions or concerns about the transition process are addressed timely and thoroughly. The case manager, with the ICT, ensures information regarding the member's care plan and treatment protocols are shared with treating providers. Records and care plan are properly updated. The Case Manager facilitates communication and referrals to support changes in treatment and follow up on scheduled services as required for successful care transitions.

The HMO D-SNP Provider Network

Community Health Choice's network is designed to meet the needs of D-SNP members including primary care, medical specialists, behavioral health clinicians, and facilities. Out of Network providers are approved through the UM process when the member's needs cannot be met through contracted providers. A pharmacy benefits manager and pharmacy network are contracted.

HMO D-SNP network Providers and Vendors are required to complete Model of Care training when joining the network and annually thereafter.

Providers must notify Community Health Choice of practice changes in a timely manner to ensure an accurate provider directory.

Quality Program and Performance Improvement

Community Health Choice maintains a robust quality program to monitor key aspects of member outcomes and experience, and to continuously evaluate and improve the Model of Care.

By completing the information requested below, I am attesting that I have read the Model of Care Training on behalf of the practice that I represent.

To attest to the completion of the Model of Care Training, please click here