Optum

2024 Model of Care Training

California Health Plans

Delegation Oversight & Education

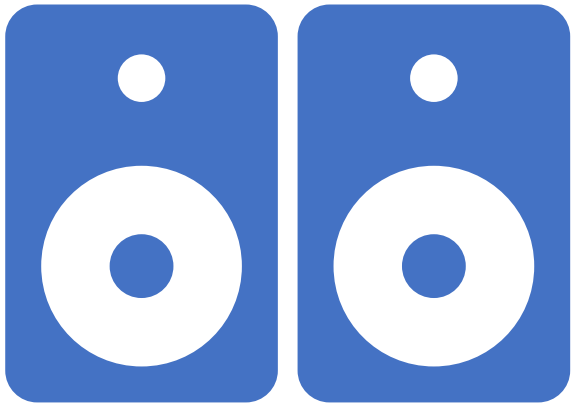
April 2024

Welcome to this training session.
A few important announcements

The session is pre-recorded

Reach out to your Manager if you have questions

Thank you for completing the session



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Model of Care (MOC) Training Goals

- This course provides an overview of Optum's Model of Care (MOC) for delivering coordinated care and case management to Special Needs/Dual Eligible patients with both Medicare and Medicaid.

- CMS, through our contracted health care plans, requires that all Optum providers, teammates and affiliated partners receive basic training on Optum MOC. This course describes how all providers, teammates and affiliated partners can work together to successfully deliver Optum MOC.

Agenda

- Special Needs Plans
- Model of Care
- Key Elements of Care Coordination
- Specialized Provider Network
- Quality Management & Performance
- Recognizing MOC is patient-centered

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MOC Special Needs Plan-DSNP

Background:

- SNPs were created as part of the Medicare Modernization Act of 2003 (MMA)
- A Medicare Advantage coordinated care plan was specifically designed to provide targeted care to individuals with special needs

Requirements:

- Medicare Advantage plans must design special benefit packages for special needs individuals

Benefits:

- Improve care and decrease healthcare costs
- Through improved coordination and continuity of care (COC)

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MOC Special Needs Types

Dual Eligible (D-SNP):

- Eligible for both Medicare and Medicaid

Chronic Disease (C-SNP):

- With specific severe or disabling chronic condition

Institutional (I-SNP):

- Requiring institutional level of long-term care or equivalent living in community

MOC Special Needs Plan Goals

Improve access:

- To medical, mental health and social services
- To affordable care and preventive health services

Improve coordination:

- By coordinating care through an identified point of contact
- Through transitions of care across health care settings, providers and services

Improve outcomes:

- Patient health outcomes
- Identify how various demographic factors combine to adversely affect health status

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Model of Care (MOC)

Description:

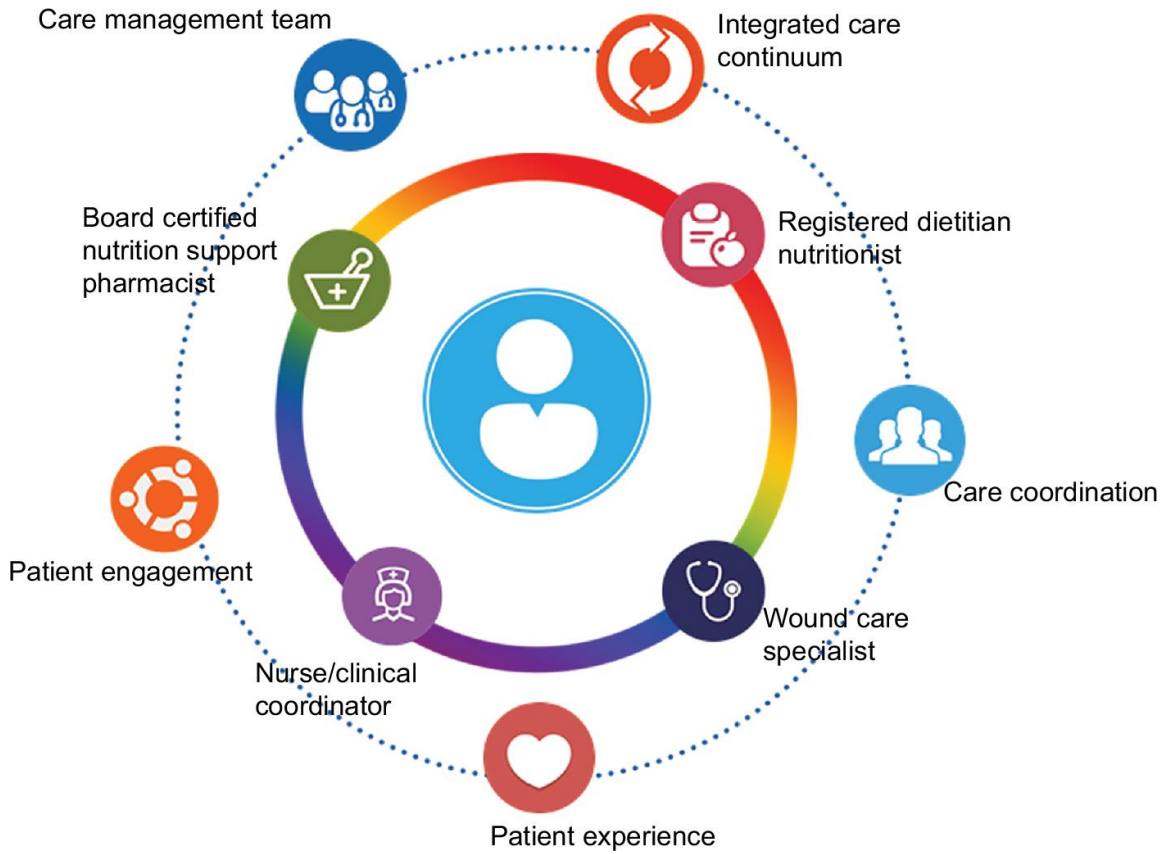
- MOC is considered a vital quality improvement approach for ensuring that the unique needs of each patient enrolled in a SNP are identified and addressed

Patient-Centered Approach:

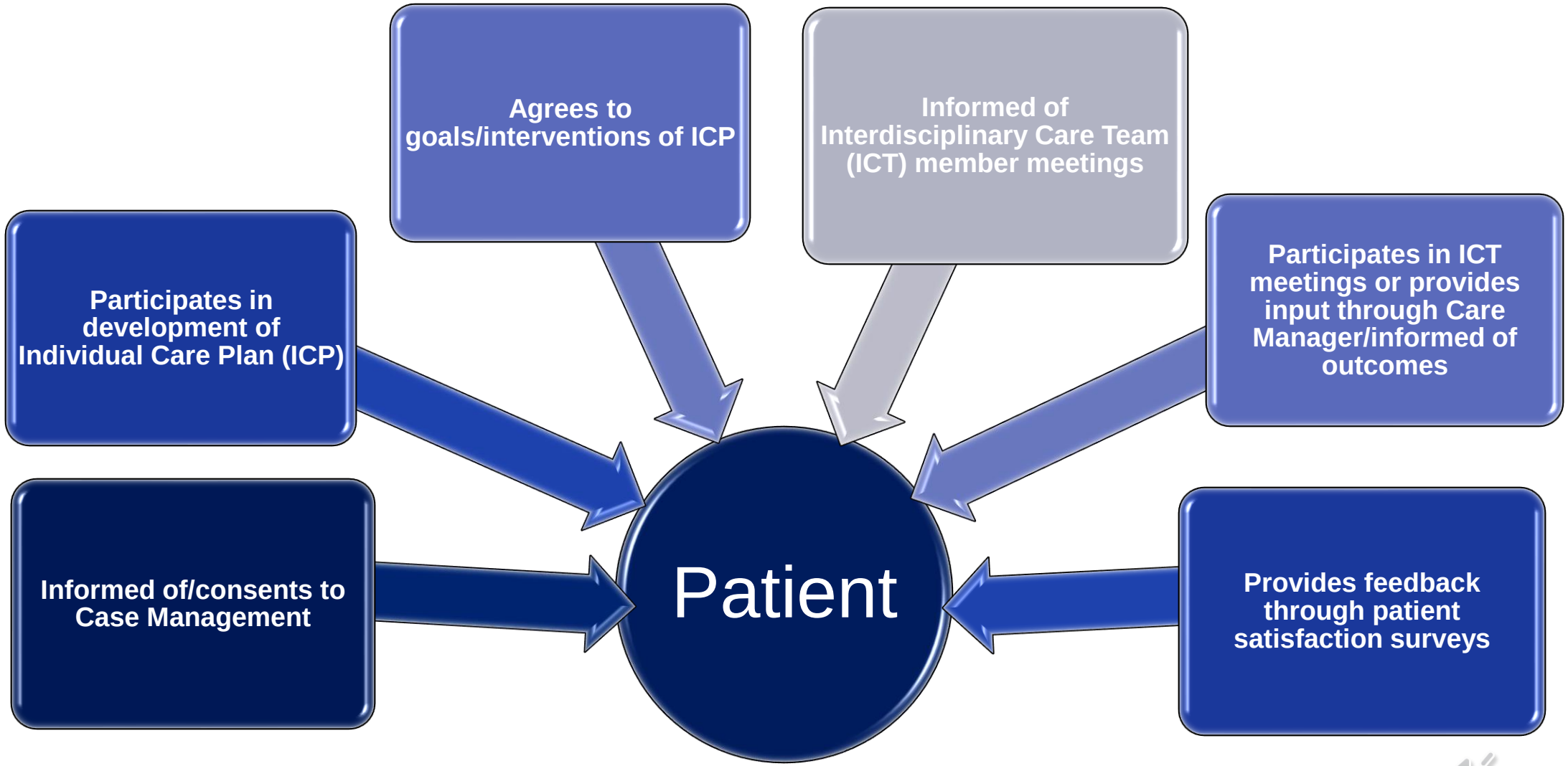
- The MOC provides a patient-centered approach that emphasizes coordination of benefits and services to improve quality of care and healthcare outcomes

Patient-Centered Care:

- Focuses attention on individual patients' needs and concerns.



MOC Patient-Centered Approach



MOC Care Coordination

SNP members are required to have the following elements completed:

Model of Care Staff

Administrative

Claims, Contracting, Referral Management

Clinical

Providers, Specialists, Behavioral Health, Pharmacists, Case Managers

Care Coordination

Patient Care Coordinators, Social Workers, Health Advocates

Oversight

Quality and Delegation Oversight

MOC Health Risk Assessment (HRA)

HRA assesses the medical, cognitive, functional, psychosocial and mental health of each beneficiary

The HRA may be completed face-to-face, telephonic, or paper-based by mail

Initial HRA is completed within 90 calendar days of enrollment and at least annually thereafter or after a health status change

- Results are used to develop patient's ICP
- Not all health plans delegate accountability to Optum
- Optum uses health plan's standardized HRA tool, if delegated

MOC Individualized Care Plan (ICP)

- The ICP is developed as a result of the patient's HRA and Comprehensive Assessment
- The ICP interventions and barriers are personalized to guide the patient towards meeting the goals established.
- Evidence-based
- Collaborative process
- Facilitate individual’s and family’s comprehensive needs
- Promote quality and cost-effective outcomes

MOC Individualized Care Plan (ICP)

- The Care Manager is the key individual responsible for developing and implementing the ICP. The Care Manager also acts as the Dementia Care Specialist

- The Care Manager develops the ICP using available resources; including the HRA, medical records, utilization patterns, pharmacy records, health plan care plan (when provided) and appointment history. This information is incorporated into the goals of care for the ICP. Coordination of care activities such as a transition of care or change in condition are incorporated into the ICP and goals of care

MOC Individualized Care Plan (ICP)

- The patient is invited and encouraged to participate in the development of the care plan and the ICT
- The care plan is reviewed and revised annually or when health status changes
- Includes personalized goals and objectives, specific services and benefits, and measurable outcomes
- Goals and objectives are prioritized by patient preferences.

MOC Individualized Care Plan (ICP)

- Patients are notified of the CM single point of contact by letter or phone call
- Patients may opt out of active CM; however, CM must continue to attempt contact annually, or whenever there is a change in status
- Patients are stratified according to risk profile, to focus resources on our most vulnerable patients (that is, those who are frail, disabled, and or those with chronic diseases)

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MOC Individualized Care Plan Components

Define Care Opportunities	SMART Goals	Address care gaps in goals or problems	Barriers	Patient centered
Define Care Goals including prioritization of identified goals based on patient preference if engaged, or if not engaged, then based on risk	• Specific • Measurable • Achievable • Realistic • Time Bound	Problems should be personalized to patient based on record or patient interview	Identify and document barriers that may hinder goal achievements. Barriers may be: • Medical/Health • Psychosocial • Functional/ADL • Cognitive • Additional concerns	Confirm that the patient agrees with the goals and interventions. Interventions should be achievable which will lead to goal success and improved patient outcomes

MOC Interdisciplinary Care Team (ICT)

- The individual care plan is the primary tool (document) used to communicate with the care team
- ICT members are asked to review and provide feedback on the care plan.
- The primary members of the ICT are the patient/caregiver, Care Manager, and the patient's PCP.
- The Care Manager determines the membership of the ICT based on the individual patient needs (the actual composition of ICT may vary for each patient).
- The Care Manager acts as Dementia Care Specialist
- The responsibilities of the ICT include but are not limited to the management of the medical, cognitive, psychosocial and functional needs of the patient; incorporating health risk assessment finding in the development of the ICP; collaborating with team members in the coordination, development, and review of the ICP; maintaining open lines of communication with Care team for care coordination

Dementia Care Specialist

Care Managers serve as the Dementia Care Specialist

Training Requirements*

Alzheimer's Disease and related Dementias (ADRD)

- Symptoms and progression
- Understanding and managing behaviors and communication
- Caregiver stress and its management
- Community resources for members and caregivers

Training Resources

Community Based Organizations

- Expertise serving people with dementia
- Vitas
- Greater LA Alzheimer's Association

Key Consideration

*All clinical staff will be trained in Dementia Care needs to meet this requirement

MOC Care Transitions

- Care transitions present possible disruptions in patient care. As a patient's care setting, care providers change, there is a need to ensure that care needs are coordinated and communicated

- Care Team:
  - Partners with the PCP to coordinate care with other medical providers
  - Ensures that changes in care, medications, and treatment are communicated to caregivers and physicians
  - Ensures services are scheduled and communicated to patient
  - Provides a point of contact to resolve issues or concerns in a new setting among providers, facility staff, patients and caregivers

MOC Specialized Provider Network Includes

- Hospitalists
- SNF providers
- Behavioral health providers
- Pharmacists
- Crisis teams
- Allied health providers
- Ancillary services
- Substance abuse detoxification and rehabilitation services

MOC Quality Management & Performance Improvement

Standardized quality improvement measures are used to measure performance and health outcomes:

- Tracking and assessing completion of MOC training
- Specific HEDIS measures
- Disease management
- Patient experience surveys
- Provider satisfaction surveys
- Ongoing monitoring of complaints and grievances
- Goal outcomes are communicated to stakeholders

California SNP Health Plans

OneCare is CalOptima's Medicare Advantage Special Needs Plan

Serves people:

- Eligible for both Medicare and Medi-Cal (Medicaid) benefits
- Residing in Orange County
- Age 21 and older

CalOptima is responsible for the completion of the HRA

In the network setting, the PCC is responsible for helping the member understand their benefits, schedule and participate in ICT meetings, assist member with care coordination, notify the member's care team of key events and facilitate communication of the ICP to the PCP and care team members, including member with any updates.

PCP is provided the opportunity to sign the care plan.

Access CalOptima Model of Care Training here

LA Care Dual Special Needs Plan (DSNP) MOC

Medical group is responsible for members identified as low or medium risk on HRA. All members identified as high risk are managed by LA CARE.

ICP development timeline:

- Within 30 days of HRA receipt, or Transition of Care
- Within 90 days of enrollment if no HRA is available

ICT timeline: within 45-60 days of ICP creation date

SCAN Special Needs Plan

Patients are referred via “Trigger” report

- Triggers may be based on the plan HRA, sometimes with the identification of a transition of care event
- ICP is developed based on the trigger report and follows the SMART format
- ICT documentation is due within 30 days of receipt of Trigger report.
- Access SCAN Model of Care Training here.

UnitedHealthcare Special Needs Plan

- Optum is delegated for the C-SNP product
- ICP development timeline:
  - Within 30 days of HRA receipt, or Transition of Care if member is engaged.
  - Within 90 days of enrollment if no HRA is available and member is engaged.
- ICT timeline: within 45-60 days of ICP creation date
- Access United HealthCare's MOC Training here

IEHP DualChoice (HMO D-SNP)

IEHP DualChoice HMO D-SNP serves members

- Eligible for both Medicare and Medi-Cal (Medicaid) benefits
- Residing in Riverside and San Bernardino counties

IEHP is responsible for the completion of the HRA

Every IEHP DualChoice Member is to receive an ICP (individualized care plan) within 30 days of HRA completion or 90 days of enrollment and must be given the opportunity to review and sign the care plan.

Access IEHP Model of Care Training here.

Though Optum California is not delegated for all Health Plans that have SNP membership, evidence of Model of Care training may be required.

Additional Resources Available

For a list of links to the different Health Plans Model of Care trainings, send an email to:

Optum CA Clinical Education

optumcadoclinicaleducation@optum.optumcare.com