Model of Care Training

CareSource 2025

DUAL SPECIAL NEEDS PLAN (D-SNP)
& OHIO MYCARE

CareSource™

Our Duals

CareSource®

CareSource Dual Advantage serves people who are dually-eligible for Medicare and Medicaid.

Our person-centered, integrated care model provides care coordination to a population with complicated health care needs.

Redefining independence

CMS REQUIREMENTS

The **Centers for Medicare & Medicaid Services (CMS)** requires all contracted medical providers and staff receive basic training about the D-SNP Model of Care and to annually complete a refresher training.

The Model of Care for D-SNP is the framework for delivering coordinated care and care management to dual-eligible, special needs members.

This training guide will outline the D-SNP model of care and how that is delivered through our care management staff in partnership with our network of contracted providers.

TRAINING OBJECTIVES & ATTESTATION

Training Objectives:

- Provide understanding of D-SNP
- Describe the annual model of care training requirement
- Describe the model of care
  - **Elements:** Health Risk Assessment (HRA), Face-to-Face Encounter, Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), Transitions of Care
- Web-Based Access

Attestation:

To ensure you receive credit, **make sure you attest to completing this training**. You can attest by:

1

Following the link at the end of this presentation

OR

2

Visiting our website:
CareSource.com > Providers Scroll to bottom of page, under Tools & Resources, and select Forms

D-SNP MODEL OF CARE ELEMENTS

The Model of Care relies on a collaborative relationship between the **provider role** and **staff role** to deliver on each element. Care Management staff will ensure active implementation of each of these elements with the support of providers.

- Element 1 Health Risk Assessment (HRA)
- Element 2 Face-to-Face Encounter
- Element 3 Individualized Care Plan (ICP)
- Element 4 Interdisciplinary Care Team (ICT)
- Element 5 Care Transition Protocols
- Element 6 Clinical Practice Guidelines
- Element 7 Quality Measurement & Evaluation

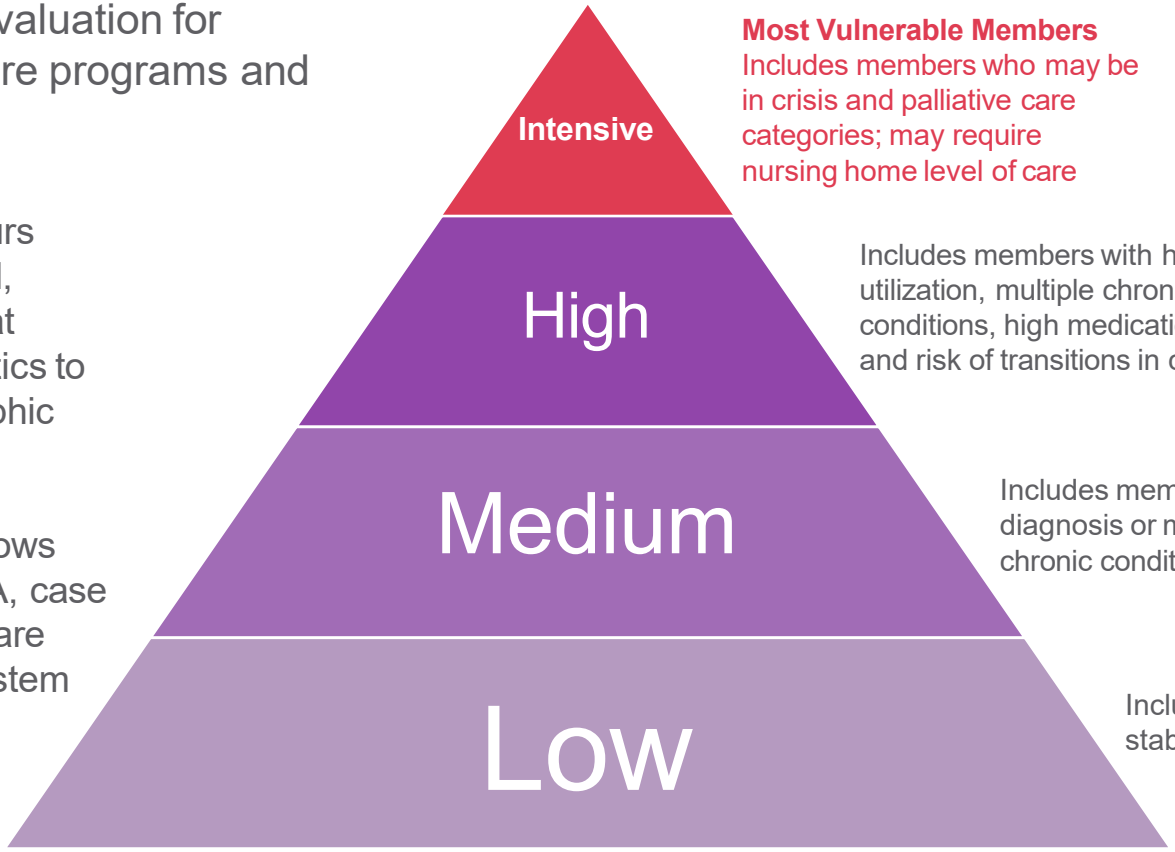
HRA TOOL:

- **Identifies members** with the most urgent needs
- Drives **the level of care coordination** the member requires
- Engages the member by including active **needs review** and **goal setting**
- Creates the member's **Individualized Care Plan**
- **Comprehensively assesses** the medical, functional, cognitive, psychosocial, and mental health needs of the member
- Must be completed **within 90 days of enrollment**
  - The assessment is then repeated on annual basis (365 days), or if a significant change event occurs in the member's health, such as sudden illness

Care Management

Member data undergoes risk stratification, acuity assignment and evaluation for assessment of proper care programs and clinical treatment.

- **Risk stratification** occurs through a system-based, automated approach that applies predictive analytics to the member's demographic data
- **Acuity assignment** follows once the member's HRA, case manager, and ICT data are incorporated into the system



Members are **stratified based on their medical, behavioral and social needs** and placed into appropriate clinical programs to improve their health and well-being.

ELEMENT 2 | FACE-TO-FACE ENCOUNTERS

Face-to-Face Encounter:

- All members are offered the opportunity for a face-to-face encounter for the delivery of health care, care management, or care coordination.
- Face-to-face encounters must occur with the member's consent annually beginning within the first 12 months of enrollment.
- Must be between the member and a participant of the member's ICT.
- Must be in-person, or through a visual, real-time or interactive virtual encounter.

INDIVIDUALIZED CARE PLAN (ICP):

- Serves as the **primary tool for continuous monitoring** of the member's current health status. It is the ongoing action plan to address the member's care needs in conjunction with the ICT and member.
- Utilized as a **common data source across the ICT** members to understand the member's services, needs and goals.
- Contains **member-specific issues, goals, and interventions** that address issues found during the HRA tool and any team interactions.
- **Leverages data** such as: health risk assessment results, laboratory results, pharmacy data, emergency department and hospital claims data, case manager observations, ICT input, member preferences and goals.
- Exists as an **evolutionary document** that changes as the member's needs and goals change.

Support Tools

Provider Portal

The provider portal is the tool used to share the member's profile with the provider and chosen ICT. The portal comprises the HRA tool, ICP and member health records and is always available to the PCP. The portal:

- Summarizes the ICP
- Captures HEDIS gaps in care
- Contains medication review notes
- Includes diagnoses from claims data, lab results, and a list of current medications filled by the member

Member Portal

The member portal is the communication tool used with the member and caregiver to share the member's profile. In addition to providing information about the plan, the Member Portal:

- Summarizes the ICP for the member
- Documents service and treatment utilization
- Displays current medications
- Provides necessary contact information

ICT ROLES & RESPONSIBILITIES

- Determining each member's needs and goals
- Coordinating member's care
- Identifying programs and anticipating crises
- Educating the member about conditions and medications
- Coaching the member to use the individualized care plan as a tool to maintain and improve his or her health
- Referring the member to community resources based on their needs
- Managing transitions of care, including proactively identifying problems causing the need for a transition and preventing unplanned transitions
- Coordinating Medicare and Medicaid benefits for the member
- Helping members access resources to resolve eligibility issues

ICT ROLES & RESPONSIBILITIES

Face-to-Face Encounter

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- Must be between the member and the participant of the member's ICT.
- Must be in-person, or through a visual, real-time or interactive virtual encounter.

Provider Roles & Responsibilities

- **Communicating** with case managers, ICT participants, members/caregivers about the ICP, course of treatment, and medical education.
- **Collaborating** with CareSource to create the member's ICP.
- **Reviewing and responding** to member-specific information and notifications via the provider portal.
- **Maintaining the ICP** in the member's medical record.
- **Participating in the ICT**, providing input and insight.
- **Educating the member** on the importance of completing the HRA tool to inform his or her individualized plan of care.
- **Encouraging the member** to work with the Care Management team.
- **Completing this model of care training** upon onboarding and annually.

CareSource Staff Roles & Responsibilities

- **Educating the member** on the importance of completing the HRA tool to inform his or her individualized plan of care.
- **Encouraging the member** to work with their Care Management team.
- **Encouraging PCPs** and specialty providers to participate with the member's ICT.
- **Informing PCPs** of changes to the members' ICPs based on needs and preferences.
- **Notifying providers** of potential gaps in care.
- **Reminding providers** and staff to perform their MOC training annually.

CLINICAL PRACTICE GUIDELINES

- CareSource uses evidence-based, nationally recognized CPGs.
- CPGs are posted on the provider portal for easy access.
- CPGs are intended to serve as a resource for providers and may be used as a guide for managing or treating a clinical condition.
- Information contained in the CPGs is not a substitute for a provider's clinical judgment.
- Certain CPGs may not always be appropriate for some members with complex health care needs.
- In the event a service requested, or member need arises, that does not clearly meet CPG requirements, the Case Manager will work with the ICT and the Utilization Management team to review the member's needs and services may be approved.

TRANSITIONS OF CARE

- CareSource case managers will coordinate the **Transition of Care Process** with specific discharge protocols to help members back into their homes and communities.

- Through **regularly-scheduled follow-up calls** post-discharge, case managers will work closely with the member to:

  - Help the member understand discharge diagnoses and instructions
  - Facilitate and schedule follow-up appointments
  - Assist with home health needs or ordering equipment
  - Help remove barriers to prescriptions
  - Coordinate resources for social determinant needs
  - Provide education on new or continuing medical conditions

CONTINUITY OF CARE

- CareSource ensures that the member's care is not disrupted or interrupted for new enrollees.
- Continuity of Care occurs when a newly enrolled member requests continuation of care from the provider who was treating them prior to their enrollment.
- CareSource honors previous prior authorizations from Medicare or Medicaid providers to promote safe and coordinated transitions.

Measurement

Performance, quality and health outcome measurements are collected, analyzed and reported to **evaluate the effectiveness** of the model of care.

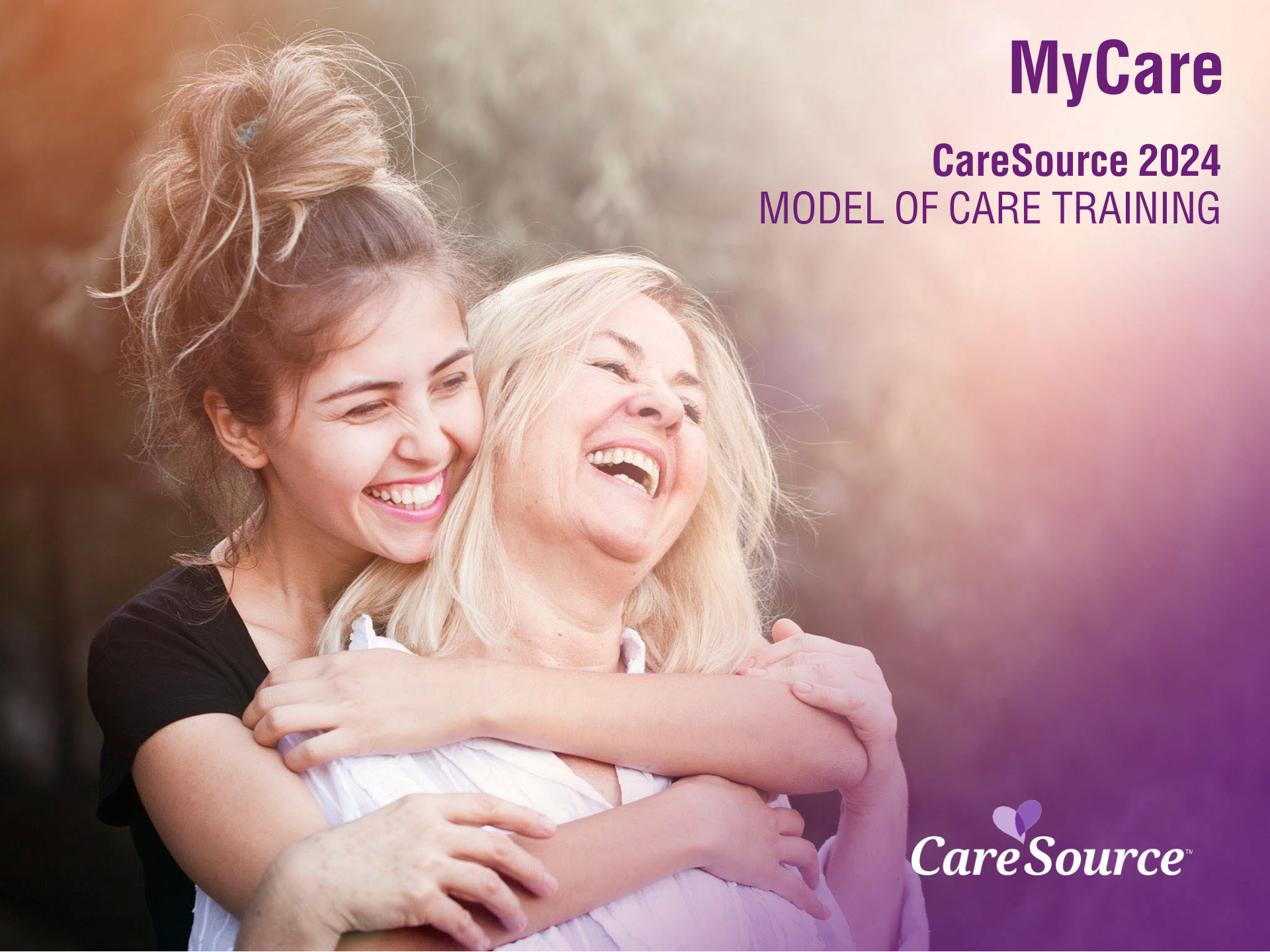
Our Quality department reviews the following measures:

- Healthcare Effectiveness Data and Information Set (HEDIS): used to measure performance on dimensions of care and service
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
- Other health outcomes surveys
- CMS reporting elements
- Clinical service quality improvement projects

Performance Evaluation

Once performance data is collected, the Model of Care must be held to **program standards and outcome goals**, including evaluation of the following areas:

- Improving access and affordability of health care needs
- Improving coordination of care and delivery of services
- Improving transitions of care across health care settings
- Ensuring appropriate utilization of services for preventive health and chronic conditions



MyCare

CareSource 2024
MODEL OF CARE TRAINING

CareSource™

MyCare MODEL OF CARE ELEMENTS

The MyCare Model of Care relies on a collaborative relationship between the provider and the CareSource staff to deliver on each element.

Providers will ensure active implementation of each of these elements with the support of Care Management.

- Element 1 Health Risk Assessment (HRA)
- Element 2 Interdisciplinary Care Team (ICT)
- Element 3 Individualized Care Plan (ICP)
- Element 4 Care Management & Coordination
- Element 5 Quality Measurement & Evaluation

Health Risk Assessment

- MyCare Care Manager completes a comprehensive assessment with member and/or caregiver based on level of risk.
- An Individualized care plan is developed based on the results of the assessment.
- Person-Centered Service Plans are developed to meet the needs of waiver members.

ICT RESOURCES INCLUDE:

- Members have assigned **Care Managers** who are the point of contact for member needs.
- **Provider portal** is the tool used to communicate the member's profile with the provider and chosen ICT.
- **Member portal** is the tool used to communicate all member activities within a central location.
- CareSource **website** for general plan information
- CareSource **Call Center**
- 24-hour **Nurse Advice Line**
- 24-hour **Behavioral Health Line**

ELEMENT 3 | INDIVIDUALIZED CARE PLAN (ICP)

OUR CARE TREATMENT PLAN IS FOCUSED ON:

- Creating **individualized & person-centered** member treatment plans
- **Actions and goals** with time frames for completion
- Developed on **assessment findings**, member preferences and input from the Trans-Disciplinary Care Team (TDCT)
- **PCP outreach and engagement**

Care Management Visit Schedule

Our tailored approach to care coordination enables our staff to build an **individualized, comprehensive plan of care** that can adapt based on a member's developing needs and personal goals.

Face-to-Face Visits

- All members **must** have face-to-face visits
- Assessment and visit requirements

Risk Stratification	Recommended Frequency	Required Frequency
Intensive	30 days/every 2 months	No more than 60 days between visits
High	30 days/every 3 months	No more than 90 days between visits
Medium	30 days/every 6 months	No more than 120 days between visits
Low	75 days/contact may be in person or by phone but must occur every 6 months at minimum.	No more than 180 days between contacts. Waiver and Institutional Members must be in person.
Monitor	75 days/contact may be in person or by phone but must occur every 6 months at minimum.	No more than 180 days between contacts. Waiver and Institutional Members must be in person.

- Initial and ongoing (event based) assessments, as well as annual reassessment.
- Reassessment must occur within 365 days of last assessment.

Care Coordination

Care Coordination *including Waiver Service Coordination (as appropriate)* ensures:

- Clinical quality access
- Availability of health care and services
- Coordination of care across all service settings
- Healthy transitions in care

Specialized Intervention Programs

- Medication Reviews
- Treatment Plan Support
- Care Transitions
- Post-Discharge Support
- Self-Care Management
- Independence at Home
- Interpersonal & Social Relationships
- Care Coordination
- Decision Coaching
- Connections to Community Resources
- Preventive & Screening Services
- Health Education
- Knowledge of when to call a physician

ELEMENT 5 | QUALITY IMPROVEMENT

CareSource has a Quality Improvement program that monitors the health outcomes and implementation of the MyCare MOC by:

- Identifying and defining measurable MOC goals.
- Collecting HEDIS, STARS and quality withhold measures.
- Conducting a Quality Improvement Project (QIP) annually that is relevant to improving long-term care rebalancing to the MyCare.
- Chronic Care Improvement Program (CCIP) that identifies eligible members and intervenes to improve disease management and evaluates program effectiveness (Cardiac Medications).
- Communicating goal outcomes to stake holders.

THANK YOU!

CareSource offers benefits that cover the full spectrum of our members' journeys. Regardless of their age, we offer a lifetime of care and an unwavering promise of *health care with heart*.

MISSION-DRIVEN CULTURE

INNOVATIVE CONSUMER-DRIVEN BENEFITS

COMMUNITY-BASED PARTNERSHIPS

CareSource

Click HERE to Complete Attestation Statement