



# PPHP Model of Care (MOC) Facility Training

2021

# Overview – Regulatory Requirements

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to enrollees **§ 422.101 (f)**
- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers and staff **§ 422.101 (f)**

# Goals of Training

Describe what an Institutional Special Needs Plan (I-SNP) is and the purpose of the MOC

Show how PPHP's MOC can help you as facility staff

Help you understand your role in the MOC

# What is an I-SNP?

I-SNPs restrict enrollment to Medicare Advantage (MA) eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a:

- Skilled nursing facility (SNF)
- LTC nursing facility (NF)
- Intermediate care facility for the mentally retarded (ICF/MR)
- Inpatient psychiatric facility

# To be eligible for PPHP enrollment, nursing facility residents must:



Reside in a PPHP contracted long term care facility for at least 90 days



Be enrolled in Medicare Part A and Part B

# What is the MOC?

**The MOC is PPHP's detailed, written commitment to CMS on how we will provide specialized care to enrolled I-SNP members.**

*\*CMS will audit PPHP against the processes and commitments described in the MOC*

The MOC contains the following required components:

- Description of the Plan Population
- Care Coordination
  - Health Risk Assessment, Individualized Care Plan & Interdisciplinary Care Team
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice Guidelines and Protocols
  - MOC Training for Providers and Facilities
- Quality Improvement and Performance Monitoring

# Goals of PPHP's MOC

## The MOC is designed to:

- Reduce non-essential hospital admissions when care can safely be provided in the nursing facility
- Maintain the residents at an optimal level of function
- Increase compliance with appropriate screenings/testing
- Increase compliance with clinical practice guidelines
- Enhance identification and address problems earlier to optimize member function
- Improve communication related to member's care

# Advantages for Nursing Facilities

PPHP's MOC offers many advantages for nursing facilities, including:

- A local and dedicated provider clinical team that provides additional on-site primary care, case management and care coordination
- Better quality of care and health outcomes for patients as measured by HEDIS<sup>®</sup> scores and hospital use rates



In the following slides, look for the “star” symbol for quick tips and summaries of what facilities can expect from the Plan





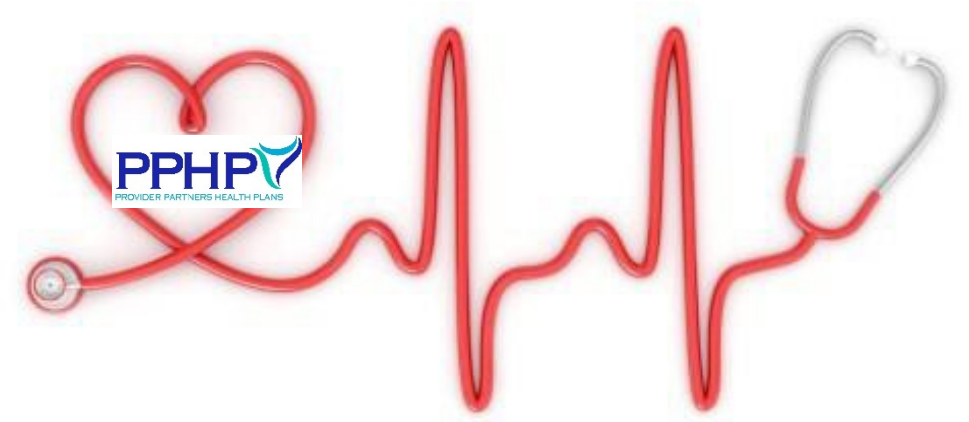
# Key SNP Staff

- Nurse Practitioner (NP)
  - Assigned to each nursing facility and all members in residence
  - Dedicated point of contact for providers, members and families/caregivers
  - Promotes continuity of care, coordinates care plan communications and implementation
  - Provides on-site primary care support
  - Visits/assesses each member at least monthly - and as often as daily, based on member condition and risk level



The NP will work closely with you to manage members' care and will keep you informed on their progress and changes in condition

# Key SNP Staff continued...



- RN Care Coordinator (RNCC)
  - Assigned to each nursing facility and dedicated to all members in residence
  - Liaison between the NP and facility staff
  - Rounds on each member and alerts NP to changes in member risk level or transitions
  - Partners with the NP to coordinate care and follow up for the member.



The RNCC will be in the facility on weekdays. Contact the RNCC or the NP if you have any concerns with a PPHP member.

# Key SNP Staff continued...



- Partner Development Representatives
  - Conduct account management, member and facility relations activities in the facilities.
  - Knowledgeable about covered benefits under Medicare, Coordination of Benefits (COB) issues, MOC and administrative processes
  - Support members and care plan implementation by focusing on member experience and promoting positive facility and provider relationships.

# CMS Care Coordination Requirements and PPHP's Approach

CMS MOC Regulatory Requirement		PPHP MOC Process
Health Risk Assessment (HRA) §42 CFR (f)(1)(i)	1) <u>All</u> SNP members must have an initial HRA within 90 days of enrollment and at least annually thereafter within 364 days of the previous HRA	<ul style="list-style-type: none"> <li>PPHP NP conducts a comprehensive HRA within 30 days of enrollment and at least annually thereafter.</li> <li>NP conducts interim assessments at least monthly.</li> <li>Member risk level assigned with each assessment and determines NP or RNCC visit frequency.</li> </ul>
Individualized Care Plan (ICP) §42 CFR (f)(1)(ii)	2) <u>All</u> SNP members must have an ICP based on the needs identified in the HRA	<ul style="list-style-type: none"> <li>NP develops member's ICP after completing the HRA and in the same member visit.</li> <li>ICPs reviewed/revised with each assessment</li> </ul>
Interdisciplinary Care Team (ICT) §42 CFR (f)(1)(iii)	3) <u>All</u> SNP members must have an ICT that collaborates in care plan development and implementation	<ul style="list-style-type: none"> <li>NP is the "hub" of each member's ICT and coordinates communications with other participants.</li> <li>The NP will talk to you about the member's HRA results and care plan along with revisions and updates.</li> </ul>



All of these activities are documented centrally in the member's chart at the facility as well as in PPHP's electronic medical record.



# Health Risk Assessment (HRA)

- Conducted by the NP, the HRA identifies the medical, psychosocial, cognitive, functional and mental health needs and risk level of each member
- Risk level dictates the member's visit schedule by the NP or RNCC
  - High risk: members are seen **at least every 14 days or bimonthly**
  - Low risk: members are seen **at least monthly**
- The member is reassessed if there is a change in health condition or care transition
- HRA findings are used to develop/update the member's care plan



NP may contact you for assistance with the assessment especially if the member is cognitively impaired

# Individualized Care Plan (ICP)

- Tailored to the needs and preferences of the member as identified by the HRA
- Shared with member/responsible party, facility staff, the PCP and key specialists, as needed
- Clinical practice guidelines applied
- Reviewed/updated by the NP on a routine basis and at least monthly in accordance with member risk level



The NP will contact you to discuss the ICP and the best ways to care for the member.





# Individualized Care Plan (ICP) Goals



## ICP goals must be based on the **SMART** Measurable Goal Model

- **S**pecific – Exactly what is to be learned/accomplished by the member
- **M**easurable – A quantifiable goal and specific result that can be captured, reported and documented in the ICP.
- **A**ttainable – Goal is achievable by the member.
- **R**elevant – Goal is clearly linked to health status.
- **T**ime-Bound – The deadline or time period to motivate and evaluate is specific in terms of specific date, number of days/weeks/months or calendar year.



Goals and objectives are tailored to a member's unique and individual needs

# Individualized Care Team (ICT)

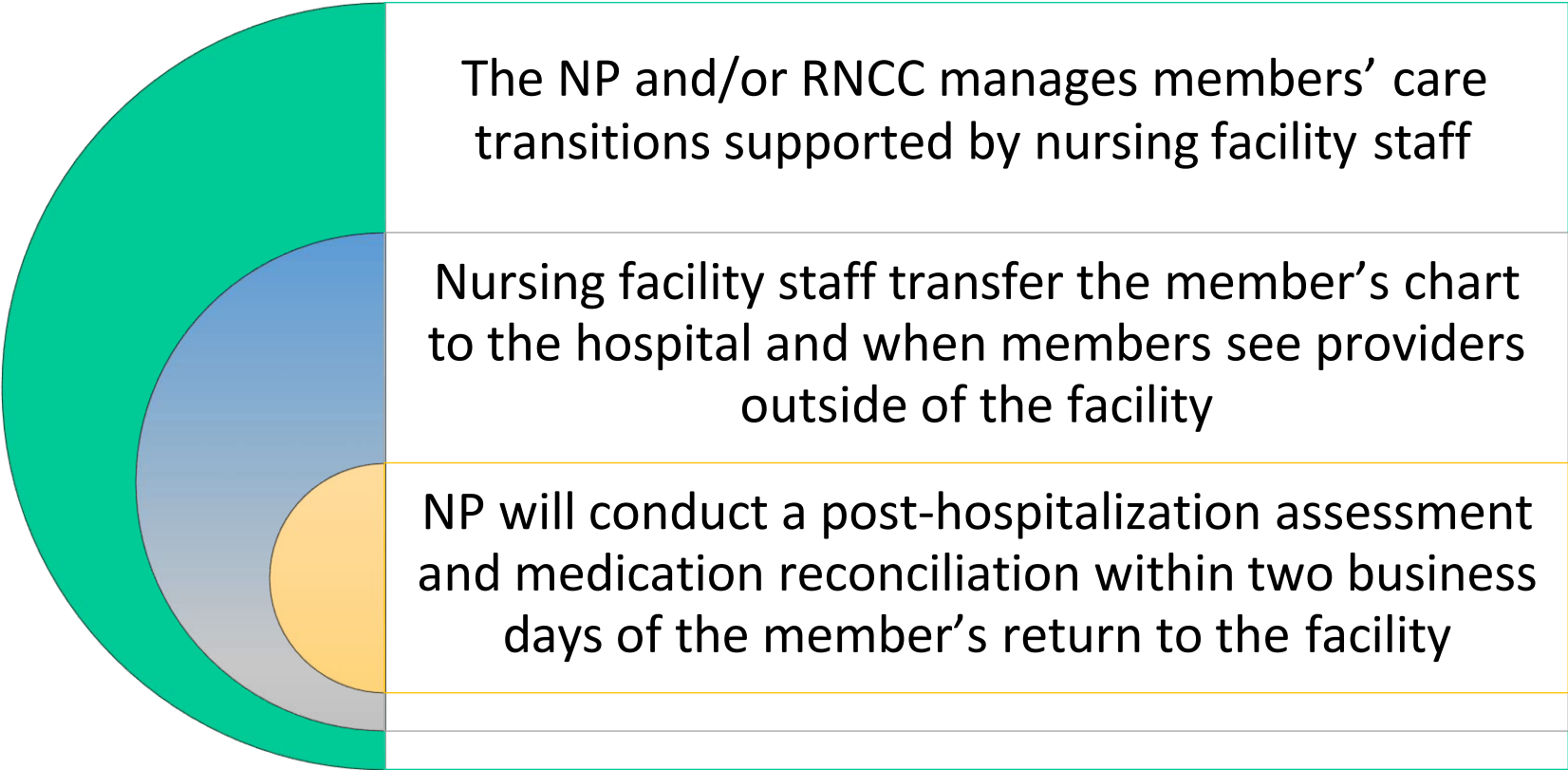
- Every member has an ICT tailored to the needs identified on the HRA and ICP
- The ICT oversees and coordinates the member's care plan
- Composition varies but, at a minimum, the ICT includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP.
- NP coordinates communications among ICT members and may request a formal meeting.



Please participate in ICT care planning meetings if requested and contact the NP to discuss changes to the member's care plan.



# Care Transitions Protocols



If you see that a PPHP member is at risk for a hospitalization, please contact the NP or RNCC immediately!

# A Partnership For Care



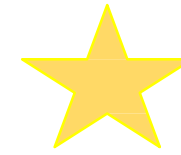
# Specialized Provider Network

- PPHP maintains a comprehensive network of primary care providers and specialists
  - Includes providers with specialized expertise in the long-term care population and who routinely care for members in network nursing facilities
- All contracted providers are credentialed
- A network adequacy report is completed annually to ensure that members have access to services



# Use of Clinical Practice Guidelines

- PPHP has approved and promotes the use of the American Medical Directors Association (AMDA) clinical practice guidelines among internal clinical staff and providers which are tailored to the long-term care population.
- They can be found here: <https://paltc.org/product-store/full-set-clinical-practice-guidelines>



The Plan also measures internal and external provider adherence to evidence-based guidelines via CMS-required HEDIS® reporting



# Expectations for Nursing Facilities

- Get to know the NP and RNCC teams assigned to PPHP members. We are here to help you!
- **Communicate!** Review the member's care plan and participate in ICT meetings and activities
- Call the NP or RNCC if a PPHP member is at risk for a transition
- Notify the NP or RNCC as soon as the member returns from a hospital stay
- Deliver care in accordance with appropriate evidence-based guidelines



Please complete the attestation at the end of this training as PPHP is required to track your completion!

# Model of Care Quality Measures

Measurable  
Goals and  
Health  
Outcomes

HEDIS®

Chronic condition management

Medication adherence

Utilization

Compliance  
with CMS-  
required MOC  
processes

HRA and Care Plan completion rates

Timely member visits

Care transitions management

Staff and Provider MOC Training

Member  
Satisfaction

PPHP-designed survey conducted once per year





# Evaluation of the Model of Care

- Data is collected, analyzed and evaluated on a monthly, quarterly and annual basis from each domain of care to monitor performance and identify areas for improvement and to ensure program goals have been met
- **Annual Evaluation of the MOC**
  - **Formal evaluation of MOC effectiveness led by PPHP's Quality Improvement (QI) department.**



You can request info on PPHP's quality measures and MOC performance data.

# Provider Attestation

**I attest that I have received the 2021 Model of Care Training for PPHP:**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Organization Name (if applicable )

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

