UCare Model of Care

- Minnesota Senior Health Options
- Connect + Medicare
- Institutional Special Needs Plan

Training Purpose

Provides information about Model of Care requirements for UCare's Special Needs Plans:

- Minnesota Senior Health Options (MSHO)
- Connect + Medicare
- Institutional Special Needs Plan (I-SNP)

Outlines the importance of your role as a provider or care coordinator on the interdisciplinary care team.

Explains how to interface with the care coordination team in the provision of care.

Delivering coordinated, appropriate care

- The Model of Care (MOC) is UCare's care delivery model approved by the Center for Medicare and Medicaid Services (CMS).
- This course meets the CMS MOC provider training requirement for UCare's MSHO, Connect + Medicare, and ISNP products.
- This training will identify how you, as the provider of care, will support UCare's Model of Care and understand the CMS requirements for serving these members.

UCare's Model of Care (MOC)

The MOC's overall goal is to drive improvements in health outcomes and quality of life for members.

UCare's MOC is designed to:

- Increase access to affordable, cost-effective health care
- Improve coordination of care
- Ensure seamless transitions of care
- Manage costs

Why does UCare have an MOC?

Required by CMS and has four components:

- Population description and characteristics
- Care coordination details
- Provider network that ensures adequate access
- Quality measures and process improvement goals

It helps provide:

- Access to high-quality health services
- Coordination of all services needed
- Opportunities for involvement in the development of individualized care plans
- Care-transitions support to members and families
- Treatment in-place, in the most feasible, comfortable setting

UCare's Special Needs Plans

Integrated products combining Medicaid and Medicare:

- Parts A, B, and D (pharmacy) plus Medicaid benefits
  - MSHO and Connect + Medicare require Medicaid benefits
- Members have one ID card
- One phone number for health plan questions:
  - 612/676-6830 or 855/260-9707

UCare’s Special Needs Plans (SNP)

These plans serve members residing within UCare’s service area:

- **Minnesota Senior Health Options Program** serves elderly members who are dually eligible for Medicare and Medical Assistance, and 65 or older.
- **UCare Connect + Medicare Program** serves members with disabilities between the ages of 18-64 who are dually eligible for Medicare and Medical Assistance.
- **ISNP** serves MA-eligible members 65 or older who for 90 days or longer have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), or an Assisted Living (AL).

How do Members enroll?

Enrollment is voluntary, with several ways to enroll:

- Member’s county financial worker (MSHO or Connect + Medicare)
- Senior Linkage Line: 800-333-2433 (MSHO)
- UCare’s Enrollment: 612-676-3554 or 800-707-1711

MSHO Member Demographics

Age Range: 65-85+ years

- Female: 63.26%
- Male: 36.47%

Living arrangements:

- Community: 42.01%
- Institutional: 14.58%
- Waiver: 43.41%

Race:

- Asian: 17.60%
- Black: 22.56%
- Native American: 1.31%
- White: 55.20%

Connect + Medicare Member Demographics

Age Range: 18-64 years

- Female: 55%
- Male: 45%

Living arrangements:

- 98% community
- 2% institutional

Race:

- White: 72%
- Black or African American: 14%
- Asian: 3%
- Native American: 3%

ISNP Member Demographics

Age Range: 65-85+ years

- Female: 65.58%
- Male: 34.42%

Living arrangements:

- 100% community residing in an Assisted Living or Long-Term Care Facility.

Race:

- Asian: 1.44%
- Black: 5.33%
- Hispanic: .88%
- Native American: 1.21%
- White: 90.19%

Vulnerable Populations

The Connect + Medicare population is comprised of disabled adults:

- Diagnosed with a physical, developmental, mental illness, or brain injury
  - The majority of the population is diagnosed with serious and persistent mental illness
  - Most of the population have multiple complex, chronic conditions

The I-SNP population is comprised of older adults:

- With diseases of aging that are chronic, progressive, or degenerative
- Dealing with mobility issues or limitations in ability to function independently that are compounded by the existence of multiple co-morbidities and frailty
- Residing in an institutional setting (long-term care) or at a nursing home level of care (assisted living) and have been receiving or are expected to receive a nursing home level of care for 90 days or more
- Experiencing some degree of cognitive impairment

The MSHO Population is comprised of older adults:

- Diagnosed with cardiovascular conditions, dementia, respiratory failure, renal failure, or fractures
- Overall physical frailty; difficulty walking, falls, weight loss, weakness
- Require nursing home level of care and reside in the community or in a nursing facility

Care Coordinators

Qualified professionals:

- Licensed Social Worker
- County Social Worker
- Independently Licensed Mental Health Professional:
  - Psychologist
  - Professional Clinical Counselor
  - Independent Clinical Social Worker
  - Marriage and Family Therapist
- Minnesota licensure:
  - Registered Nurse
  - Nurse Practitioner
  - Public Health Nurse
  - Physician Assistant
  - Physician

The Care Coordinator's Role

Every member is assigned a care coordinator

- The care coordinator partners with the member and their Interdisciplinary Care Team (ICT)
  - All Primary Care Physicians are considered an integral part of the member's ICT
- The care coordinator is the primary point of contact ensuring ongoing communication between members of the Interdisciplinary Care Team

To find out who the member's care coordinator is, call UCare's Customer Service:

- **MSHO:** 612/676-6868 or 866/280-7202
- **Connect + Medicare:** 612/676-6830 or 855/260-9707
- **ISNP:** 612/676-6821 or 877/671-1054

Care Coordination

The Care Coordinator (CC) coordinates care and services for the member, including:	Annual health risk assessment (HRA) to evaluate members' medical, psychosocial, cognitive, functional, and mental health needs.
	Creating an individualized, person-centered care plan (ICP) addressing needs identified by the HRA.
	Closing gaps in care, improving quality of life, and meeting the member's individual needs.
	Communicating with the Interdisciplinary Care Team (ICT), a professional team providing health care services for members.
	Facilitating care transition protocols.

Care Coordination Requirements

Care coordination services consist of a comprehensive assessment of the member's condition, the determination of available benefits and resources, the development and implementation of an individualized support plan with performance goals, monitoring, and follow-up.

Care Coordinator Requirements and associated forms used for members can be found:

- MSHO Care Coordination
- UCare® - Care Coordination UCare Connect Plus Medicare
- I-SNP Care Coordination

Additional UCare Care Coordination and Case Management resources can be found here:

- UCare® - Care Management Manual

Health Risk Assessment (HRA)

An HRA provides the Care Coordinator with pertinent information related to member's **medical, functional, cognitive, psychosocial, and mental health needs**.

The HRA provides insight into:

- Determining member needs
- How member manages their health
- Needed supports to manage overall health
- Identifying member concerns

Individualized Care Plan (ICP)

The person-centered information contained in the ICP is used to monitor gaps in the member's **medical, psychosocial, cognitive, functional and mental health needs**.

The focus is on preventive and maintenance health care services, disease-specific interventions, and health care service coordination. The ICP addresses needs identified in the HRA by:

- Prioritizing goals
- Identifying barriers and interventions
- Identifying and coordinating service needs
- Identifying ICT members
- Planning for care continuity, transitions, and/or transfers
- Updating progress made toward goals/plan
- Managing ongoing communication between teams

Interdisciplinary Team

The Interdisciplinary Team consists of:

- Member and/or appropriate family/caregiver
- MSHO or Connect + Medicare care coordinator
- Primary Care Provider
- Other providers appropriate to specific health needs (Specialists, Mental Health Providers, Palliative Care Team, Pharmacist, etc.).
- Others included as identified by the member and others on the team.

Care Transition Protocols

The overall goal is to improve transitions in order to reduce fragmented care and avoid re-hospitalizations. Care coordinators:

- Coordinate care, improve communication, and share / update the member's ICP
- Assist members, families, facilities, providers, or others with planned and unplanned transitions from one care setting to another
  - Examples include transition from hospital to home, or skilled nursing facility to home
- Follow-up to ensure that the member understands:
  - Any health status changes, discharge instructions, and changes to medication(s)
  - That follow-up appointments are scheduled, including any transportation needs

Provider Network

UCare's provider network meets a wide range of needs:

- Members may have care from any contracted provider without referral
- The network includes but is not limited to:
  - Primary Care Providers
  - Specialists and Specialty Care Clinics
  - Dental Providers

Quality Measurement & Performance Management

UCare collects and analyzes data and reports from a variety of sources to measure plan performance which include:	Claims, utilization, pharmacy, demographic information	HEDIS, CAHPS, Stars, predictive modeling, and evidence based analytic tools
This information helps UCare to:	Annually evaluate the Model of Care	Identify improvements to be made for our members

Outcomes

The overall goal of UCare's Model of Care is to employ interventions to drive improvements in health outcomes and quality of life for our SNP members.

UCare's Model of Care is designed to improve:

- Access to affordable, cost-effective health care, including medical, mental health, preventive, and social services.
- Care coordination through alignment of HRA, ICP, and ICT.
- Seamless transitions of care across healthcare settings, providers, and health services.
- Costs while assuring appropriate utilization of services for preventive health and chronic conditions.

UCare sets specific goals and health outcome objectives, that are measured at least annually. Our goals include preventive goal HEDIS measures, member satisfaction with the plan, improved access, seamless transitions, and improving coordination of care via HRA, ICP, and ICT.

Clinical Practice Guidelines (CPGs)

UCare has clinical practice guidelines to support good decision-making by patients and clinicians, and to improve health care outcomes.

Medical CPGs:

- Asthma Diagnosis and Management
- Care of Older Adult
- Diabetes: Type 2 Diagnosis and Management
- Management of Heart Failure in Adults
- Obesity for Adults: Prevention and Management
- Prenatal Care
- Preventive Services for Adults
- Preventive Services for Children and Adolescents

Mental Health and Substance Use CPGs:

- Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder
- Assessment and Treatment of Children and Adolescents with Depressive Disorder
- Treatment of Patients with Major Depressive Disorder
- Treatment of Patients with Schizophrenia
- Treatment of Patients with Substance Use Disorders

Summary

- Care coordination is only one component of UCare's care model.
- The UCare Model of Care applies to MSHO, Connect + Medicare, and ISNP which currently serves around 21,000 members.
- Care coordinators work with members, families, and providers on transitions of care with a goal of reducing re-admissions.
- UCare uses data and reports to evaluate the Model of Care annually.
- Providers play an important role as a member of the Interdisciplinary Care Team.

Next Steps

Complete

Please complete the attestation on UCare's website and return to the MOCAttestation@ucare.org for proof of completion.

Reach out

- If you have any questions, please reach out to:
  - ISNP – ISNPprogramcoordinator@ucare.org
  - MSHO – MSC_MSHO_Clinicalliaison@ucare.org
  - Connect + Medicare – SNBCclinicalliaison@ucare.org