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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Model of Care

Learning Objectives

- After completing this module, you will:

  ➢ Understand member-centered planning processes.

  ➢ Know the goals of the OneCare Connect Model of Care.

  ➢ Understand the key components.

  ➢ Understand the roles of key OneCare Connect staff at CalOptima and at the health networks.

  ➢ Explain how the components of the program interact to meet member needs.

  ➢ Understand the value of coordination of benefits and services for the member.

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Course Content

- OneCare Connect (OCC) Program
- Model of Care (MOC)
  - Definition and Goals
  - Person-Centered Planning
- Model of Care Elements
  - Staff Structure
    - Personal Care Coordinator (PCC)
  - Health Risk Assessment (HRA)
  - Interdisciplinary Care Team (ICT)
  - Individual Care Plan (ICP)

Note: Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

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Course Content (cont.)

- MOC Elements (cont.)
  - Coordination of Care
  - Transitions of Care
  - Continuity of Care
  - Specialized Network Services
  - Clinical Practice Guidelines

- Model of Care Member Services
  - Member Rights
  - Long-Term Services and Supports (LTSS)
  - Abuse and Neglect Reporting
  - Communications

- Performance Measures

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OneCare Connect Program

- California's Cal MediConnect program:
    - ➢ Combines Medicare and Medi-Cal benefits.
    - ➢ Coordinates all care, supports and services via one plan — CalOptima OneCare Connect .
    - ➢ Integrates behavioral health benefits with physical health benefits.
    - ➢ Offers improved access to Long-Term Services and Supports (LTSS), including nursing facilities, Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP).
- Coordination of care through OneCare Connect enables the member to receive quality services to achieve optimal outcomes, independence, health and quality of life.

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Added Benefits

- In addition to Medicare and Medi-Cal covered services, OneCare Connect members receive:
  - ➢ Coordination of benefits via an Interdisciplinary Care Team (ICT) and an Individual Care Plan (ICP).
  - ➢ Support from a Personal Care Coordinator (PCC) to help navigate the health care system.

Eligible Members

- OneCare Connect members must meet all criteria to be eligible for benefits.
- Must be:
  - Age 21 and older
  - Residing in Orange County
  - Enrolled in Medicare Parts A, B, D
  - Receiving full Medi-Cal benefits ($0 Share of Cost)
    - Share of Cost exception: Members who reside in a nursing home, are enrolled in Multipurpose Senior Services Program (MSSP) or have In-Home Supportive Services (IHSS).

Excluded are people under 21, with other health insurance, with other share of cost, in certain waiver programs, receiving services through state or regional developmental centers or intermediate care facilities, confined to correctional facilities or living in a veteran's home.

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What is the "Model of Care?"

- An integrated delivery system that supports:
  - ➢ Care Management Policy
  - ➢ Procedures
  - ➢ Operational Systems
- A member-centric program to support members health and health care decisions.
- Benefits managed via care coordination, health management and planning.
- Component of CalOptima Quality Improvement Program (QIP).

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CalOptima Model of Care
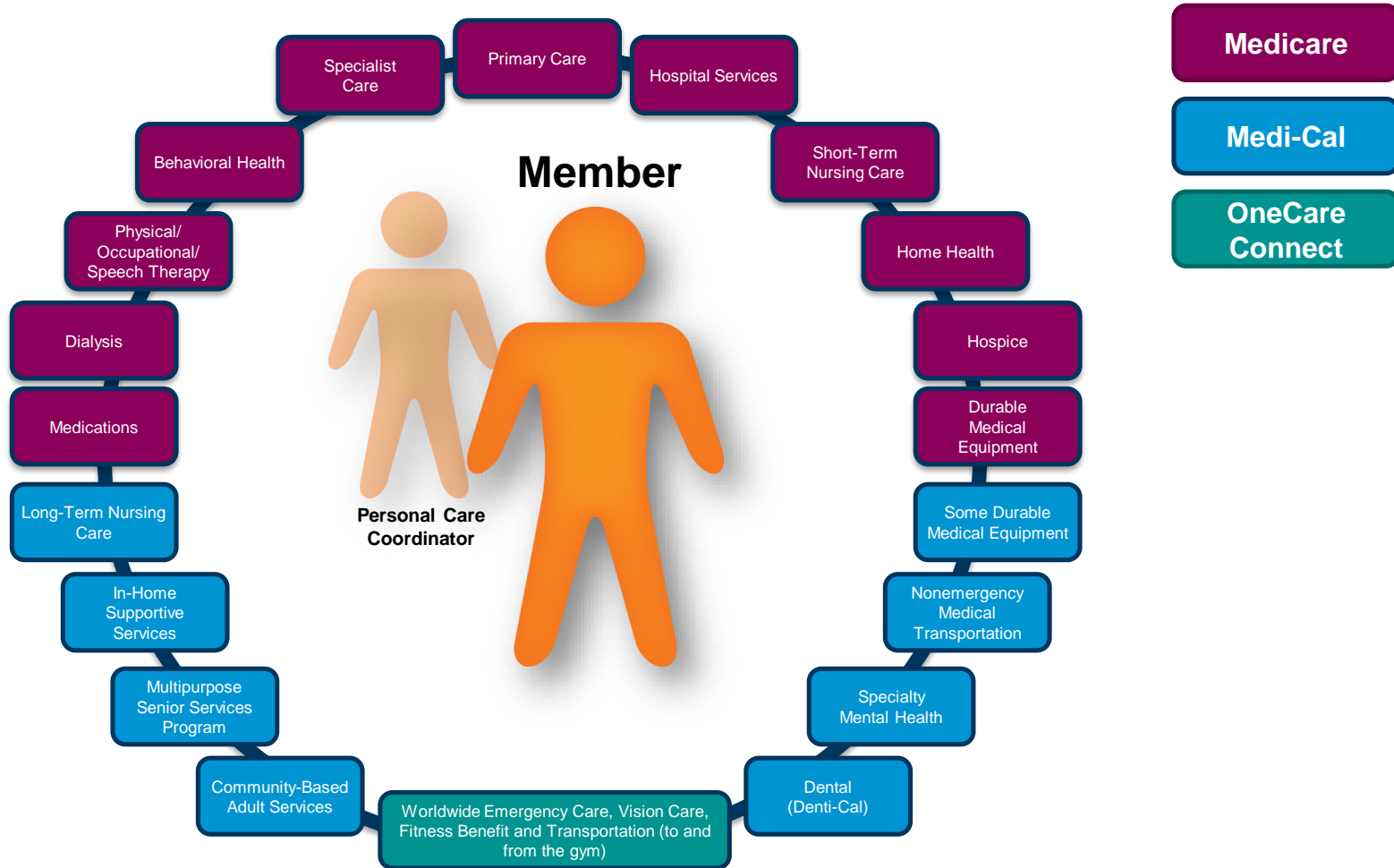
Model of Care: Goals

- Access to medical, mental health and social services
- Affordable care
- Coordination via identified point of contact
- Smooth transitions
- Preventive health services
- Appropriate utilization
- Cost-effective delivery

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Model of Care: Goals (cont.)

- Improved outcomes for:
  - ➢ Reduction in hospitalization, emergency room visits and nursing facility placement
  - ➢ Self-management and independence
  - ➢ Mobility and functional status
  - ➢ Pain management
  - ➢ Quality of life as self-reported
  - ➢ Member satisfaction

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Person-Centered Planning: A Core Requirement

Definition:

"**Person-centered planning** is a process…to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual…[it] enables and assists the individual to identify and access a personalized mix…services and supports that will assist… personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those…the individual identified, including medical and professional staff. The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services…become part of the plan of care."

Source: Centers for Medicare and Medicaid Services

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Knowledge Check

1. OneCare Connect is a:
   a) Pilot program to integrate medical care, long-term care, behavioral health care and social services for people eligible for both Medicare and Medi-Cal
   b) Pilot product created by U.S. Dept. of Health and Human Services
   c) A statewide health system
   d) All of the above

2. While meeting member health and functional needs, the OneCare Connect Model of Care is expected to accomplish:
   a) Reduced costs
   b) Improved care
   c) Reduced health disparities
   d) All of the above

Knowledge Check Answers

1. a) Pilot program to integrate medical care, long-term care, behavioral health care and social services for people eligible for both Medicare and Medi-Cal

2. d) All of the above

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Model of Care: Elements

- Key program components:
  - ➤ **Personal Care Coordinator (PCC)**
    - ▪ Specialized staff assigned to assist with completion of HRAs and serve as point of contact for members
  - ➤ **Health Risk Assessment (HRA**)
    - ▪ Member's health status information used to improve the care process and offer providers actionable information
  - ➤ **Care Management Levels (CML)**
    - ▪ Identified from the HRA; HRA analysis leads to initial recommendations, including identification of Basic, Care Coordination or Complex care management levels and ICT participants
  - ➤ **Interdisciplinary Care Team (ICT)**
    - ▪ Team in which all participants coordinate their effort to benefit the member
  - ➤ **Individual Care Plan (ICP)**
    - ▪ An actionable plan of care developed by the ICT and delivered to the member with a focus on cultural differences, language, alternative formats and health literacy

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Model of Care: Elements (cont.)

Components include:

Structure	Member Support
Personal Care Coordinator (PCC)	Member and Provider Communications
Health Risk Assessment (HRA)	Member Rights
Case Management	Self-direction, Recovery Model, Independent Living
Interdisciplinary Care Team (ICT)	Individual Care Plan (ICP)
Provider Network and Specialized Services	Care Coordination
Long-Term Services and Supports (LTSS)	Clinical Practice Guidelines
Continuity of Care	Community Resources

Model of Care: Training

- CalOptima ensures the following receive training on the OneCare Connect Model of Care:
  - ➢ Newly contracted physicians and staff with direct responsibility for Model of Care, ICT and ICP planning or interaction with member for ICT and ICP
  - ➢ CalOptima employees with OneCare Connect member contact during new hire orientation
  - ➢ On a continuing basis due to procedural, benefits or regulatory changes that affect Model of Care activities or when deemed necessary by CalOptima, CMS or DHCS (Department of Health Care Services)
  - ➢ Annually

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Model of Care: Staff Structure

Staff functions supporting Model of Care include:

Administrative	Clinical	Oversight
Enrollment Processing	Primary Medical Care	Professional Staff Credentialing
Customer Service	Behavioral Health	Pharmacy Management
Network Management	Case Management	Audit and Oversight
Claims Adjudication	Utilization Management	Regulatory Compliance
Grievances and Appeals	Disease Management	Quality Improvement
Personal Care Coordinator	Long-Term Services and Supports	

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Knowledge Check

1. OneCare Connect's Model of Care includes:
   a) The member, family and caregivers
   b) An Interdisciplinary Care Team (ICT)
   c) Enhanced care management and services
   d) All of the above

2. The purpose of the person-centered planning process is to identify the strengths, capacities, preferences, needs and desired outcomes of the individual:
   a) True
   b) False

3. The Model of Care has four key elements. They are:
   a) ADA, ICP, LTC, MOC
   b) HRA, OCC, PMG, CML
   c) ICT, PCC, HRA, ICP
   d) PCC, LTSS, MTM, IHSS

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Knowledge Check Answers

1. d) All of the above

2. a) True

3. c) ICT, PCC, HRA, ICP

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Personal Care Coordinator

- All OneCare Connect members have an assigned PCC
  - ➢ Primary point of contact at the health network level and with the CalOptima Community Network providers.
  - ➢ Acts as a liaison between member, providers, health network and CalOptima.
  - ➢ Helps member navigate the health care delivery system and facilitates access to care and services.
  - ➢ Experienced in working with seniors or people with disabilities.
  - ➢ Knowledgeable about health care service delivery, managed care and community resources.
  - ➢ Communicates effectively, both verbally and in writing, with individuals from varying cultural and ethnic backgrounds.
  - ➢ Licensure is not required.

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Personal Care Coordinator (cont.)

- Employed both at the health network and at CalOptima
  - CalOptima PCCs:
    - Assist the member with telephonic and in-person completion of the HRA
    - Notify the member's health network of key events
    - Collaborate with health network PCCs and CalOptima Customer Service on behalf of the member
  - Health network PCCs and CalOptima Community Network PCCs:
    - Function as the member's primary point of contact at the health network
    - Support the member in accessing and using the health care system
    - Assist with scheduling appointments
    - Notify the health team regarding triggers or key events to ensure real time response
    - Work with case management to resolve access, medical and psychosocial issues
- CalOptima provides PCC training and oversight.

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Personal Care Coordinator (cont.)

- Health network requirements:
  - Staffing:
    - Maintain ratio of PCC to members
    - Supervised by licensed nurse
    - Must complete mandatory training
  - Reporting:
    - Submit staffing ratio data on monthly file
    - Report changes in health network PCC staffing levels or personnel assignments
  - Oversight:
    - Ensure PCCs complete all defined responsibilities, including documentation

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Health Risk Assessment

- Questionnaire completed by the member
- An adjunct to the primary care provider's (PCP) history and physical
- Purpose:
  - ➢ Uncover problems
  - ➢ Detect barriers to progress or completion of goals
  - ➢ Offer providers actionable information
  - ➢ Facilitate the planning process:
    - ▪ Development of an **initial** Care Plan (**iCP**) using HRA findings
    - ▪ Identification of potential Interdisciplinary Care Team (ICT) members
    - ▪ Development of a finalized Individual Care Plan (ICP)

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Health Risk Assessment (cont.)

- Purpose (cont.)
  - Identify key member accommodation needs:
    - Physical
    - Cultural differences
    - Language
    - Alternative formats
    - Health literacy
  - Identify a member's care management level:
    - Basic
    - Care coordination
    - Complex

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Health Risk Assessment (cont.)

- Purpose (cont.)
  - Categorize member's needs:
    - Medical (acute and chronic)
    - Behavioral health
    - LTSS
    - Access
    - Coordination of services
    - Health monitoring
  - Facilitates creation of an iCP and makes recommendations for referrals
  - Identifies areas for further assessment (e.g., memory assessment, wound care and home safety evaluation)

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What HRA Includes

Questions to assess the member's health status:

Activities of daily living (ADLs)	Dialysis	Medications
Alcohol and other substance use	Durable medical equipment (DME) and medical supplies	Pain level
Behavioral health conditions	Functional status	Perception of health status
Chronic and severe conditions	Health and social risks	Pregnancy
Depression screening	Hospital and emergency room utilization	Use of LTSS services
Developmental disability	Living arrangements, caregiver involvement	Use of social services

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What HRA Reveals

- The HRA can reveal these needs and opportunities:
  - ➢ Improved coordination of member's medical and/or behavioral health acute or chronic conditions
  - ➢ Referral for behavioral health or follow-up assessment
  - ➢ Referral to substance use programs
  - ➢ Referral for LTSS or home and community-based services
  - ➢ Referral to disease management, health education and/or pharmacy services
  - ➢ An increased risk of adverse events based on medical, functional, social, behavioral needs
  - ➢ Evaluates for:
    - ▪ Advance directive information and assistance
    - ▪ Nutrition, exercise and limitations to productivity
    - ▪ Preventive care and early disease detection
    - ▪ Community resources

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What HRA Reveals (cont.)

- Needs to be addressed:
  - Optimization of medical treatment
  - Education in self care deficits
  - Integration of care fragmented by transitions of care, psychosocial settings or multiple providers
  - Disease management built on evidence-based clinical guidelines for monitoring progress and early detection of exacerbations or complications
  - Arrangement for community-based resources, DME, illness-specific support and social services
  - Identification of participants for the ICT to develop a comprehensive assessment and final ICP

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What HRA Reveals (cont.)

- Analysis of the HRA categorizes the responses into "domains."

- HRA domains provide a framework in the development of the initial care plan (iCP):

  ➢ Acute medical

  ➢ Chronic medical

  ➢ LTSS

  ➢ Behavioral health (BH)

  ➢ Access

  ➢ Coordination of
    services

  ➢ Health monitoring

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HRA Identifies Members at Risk

- Most vulnerable members:
  - At risk for poor health outcomes
  - Have demonstrated increased resource utilization
  - At risk for unplanned transitions of care

- Purpose of care management levels:
  - Identify members with multiple needs
  - Classify members by level of needed care
  - Tailor interventions to improve outcomes to individual risk

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HRA Identifies Members at Risk (cont.)

An algorithm is used to analyze the following data sources to identify a member's risk:

- ➢ Claims or encounter data;
- ➢ Hospital discharge data;
- ➢ Pharmacy data;
- ➢ Laboratory results, as available;
- ➢ Data from the UM process; and
- ➢ Health risk assessment data
- Care management levels are:
  - ➢ Complex (high)
  - ➢ Care coordination (moderate)
  - ➢ Basic (low)

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Member Interventions

- The Model of Care processes support the identification of:
  - ➢ Care needs and interventions tailored to members' unique needs and preferences
  - ➢ Interventions focused on coordination of medical, behavioral health and LTSS services:
    - ▪ Coordination with community resources ensures appropriate services are received by the member for services not covered by OneCare Connect benefits.

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Member Interventions (cont.)

- CalOptima LTSS team:
  - Manages vulnerable members living in the community or long-term care (LTC) facilities
  - Aim is to keep them in least restrictive care setting or assist in transitions to or from long-term care facilities

- Behavioral Health specialists:
  - Assess and provide consultation to ensure coordination of behavioral health and physical health services for members

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Model of Care Process: HRA

- Members can complete HRA in person, by mail or by telephone

- CalOptima PCC will outreach to encourage HRA completion

- Completed by the member initially when joining the plan and annually

Model of Care Process: HRA (cont.)

- The steps in the HRA process include:
  - Member's HRA responses are entered into medical management system
  - Data is automatically scored by the clinical system and a summary initial care plan (iCP) report produced
  - iCP is reviewed and analyzed by a registered nurse (RN)
  - HRA responses suggest a care management level, which is evaluated by the RN:
    - Complex (high)
    - Care Coordination (moderate)
    - Basic (low)

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Model of Care Process: HRA (cont.)

- Member iCP files

  - Sent daily to assigned health networks via secure file transfer. Includes:
    - HRA questions and responses
    - List of suggested interventions and ICT participants
    - Medication list, when indicated
  - Health network PCC retrieves the member's iCP file.

- Alerts in the iCP notify the health network of HRA-identified issues potentially requiring immediate attention.

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Model of Care Process: HRA (cont.)

- OneCare Connect population health data:
  - ➢ Evaluated annually
  - ➢ Population characteristics tracked and trended
  - ➢ Used to develop specialized programs
  - ➢ Used to determine additional benefits
  - ➢ Used to modify HRA as needed

Model of Care Process: Clinical Team

- Health network clinical team responsibilities:
  - Review iCP file and identify care management level.
  - Follow protocols to ensure appropriate follow-up for members:
    - With a positive response to a sentinel behavioral health question, referred to the contracted behavioral health specialist
    - With DME or supplies in the home, trigger an intervention by case management for coordination of services
    - Meeting screening criteria for coordination of care, care transition or chronic condition management, referred to the appropriate program
    - Needing LTSS, reviewed by case management
    - With indicated social support needs, reviewed by case management

- Ensure appropriate licensed personnel review the HRA and iCP provided by CalOptima.

- The PCP is expected to review the HRA results with the member during the initial and annual assessment.

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Model of Care Process: ICT

- All members with a care management level of complex or care coordination will have an ICT.

- High-risk members will have the most complex ICTs, which may include a broader range of participants.

- Any member may request and participate in an ICT if desired.

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Model of Care Process: ICT (cont.)

- PCP responsibilities:
  - ➢ Review the HRA results with the member during initial or annual assessment.
  - ➢ Act as the leader and direct the ICT for members with basic care management level.

- Health network responsibilities:
  - ➢ Coordinate the ICT meeting for members with care coordination and complex care management levels and finalize the ICP.
    - ▪ Member and/or authorized representative must be invited and encouraged to participate.
    - ▪ Other health care professionals, as appropriate, are invited to participate.
    - ▪ Must document all attendees and refusals to participate in ICT.

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Model of Care Process: ICT (cont.)

- ICT composition determined by member needs (iCP and CML)
  - ➢ Appropriate accommodations for cultural, linguistic needs and/or disabilities of the member must be made

Core Participants	Possible Additional Participants	
Member/Authorized Rep	Medical Director	Disease Management Coach
PCP	Pharmacist	LTSS Coordinator
PCC	Behavioral Health Specialist	Facility Discharge Planner
Specialist, as indicated	Social Worker	Therapist
Case Manager	Dietitian	Community-Based Organization(s)

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Model of Care Process: ICT (cont.)

- Convenes and reviews information supplied by the health network, including HRA and iCP components
  - ➢ Problem list
  - ➢ Medications list
  - ➢ Hospitalizations
  - ➢ Emergency room visits
  - ➢ Vaccinations
  - ➢ Advance directive
  - ➢ Social situation
  - ➢ Behavioral health reports
  - ➢ Medication Therapy Management
  - ➢ LTSS
  - ➢ Change in health status

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Model of Care Process: ICT (cont.)

- Comprehensive initial assessment by PCP and care manager:
  - HRA results and past medical history/co-morbidities
  - Medication reconciliation and compliance
  - Member/caregiver support systems, resources, involvement
  - Mental health, cognitive functions, cultural and linguistic needs
  - Motivational status or readiness to learn
  - Visual/hearing needs, preferences or limitations
  - Life-planning activities
  - Functional status — ADL (activities of daily living) and IADL (instrumental activities of daily living)
  - Current status and treatment plan

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Model of Care Process: ICT (cont.)

- Comprehensive initial assessment by PCP and care manager (cont.)
  - ➢ Barriers to quality, cost-effective care and treatment plan
  - ➢ Implications of resources, and coverage availability and limitations
  - ➢ Current living arrangements and resources utilized
  - ➢ Need for referrals to LTSS and/or community resources
  - ➢ Palliative/hospice services and alternate care settings

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Model of Care Process: ICT (cont.)

- Results in a finalized ICP that includes the member's prioritized goals and potential barriers.

  - Dynamic and person-centered plan of care for all members:

    - Includes comprehensive input from the member, member's caregiver, PCP, specialists and other providers

    - Identifies member strengths, capacities and preferences

    - Provides additional care options, including transitions of care settings

    - Identifies long-term care needs and the resources available

- Members or caregivers are encouraged to contribute to the initial and re-assessment care plans.

- Written ICT recommendations and the ICP are provided to the member (in a member-friendly format), the PCP and other members of the ICT.

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Model of Care Process: ICP

- Based on review of member's information, ICP key elements include:
  - Member-centric prioritized goals that take into account:
    - Member/caregiver's needs and preferences
    - Member/caregiver's desired level of involvement in case management plan
  - Barriers to meeting goals and complying with plan
  - Self-management plan
  - Resources to be utilized, including appropriate level of care
  - Planning for continuity of care, including transitions/transfers
  - Scheduled time frame for re-evaluation
  - Assessment of progress towards goal, with modifications as needed
  - Collaborative approaches, including family participation

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Model of Care Process: ICP (cont.)

- Completion time for ICP:
  - ➢ Complex Care Management (High) — ICT/ICP completed within **10 business days** of HRA collection and health network submits documentation within **60 days**
  - ➢ Care Coordination (Moderate) — ICT/ICP completed within **30 business days** of HRA collection and health network submits documentation within **60 days**
  - ➢ Basic Care Management (Low) — PCP completes in **30 business days** of HRA collection and health network PCC obtains and submits documentation within **145 days**

- ICP must be developed by appropriately licensed professionals.

- Use of evidence-based clinical guidelines to develop ICP goals is documented.

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Model of Care Process: ICP (cont.)

- Health Network PCC:
  - ➤ Distributes ICP to member, caregiver or authorized representative at literacy-appropriate level, meeting language requirements
  - ➤ Delivers professional-level ICP to PCP, ICT participants and health care team (specialists and other disciplines) in addition to keeping a copy at health network
  - ➤ Forwards ICP and ICT copy to CalOptima in established care management level turnaround times
- PCP ensures that ICP interventions are implemented and goals are achieved with assistance from the health network PCC or care manager.

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Model of Care Process: ICP (cont.)

- Health network reassesses member with health status changes or key events:
  - ➤ Changes in care settings:
    - ▪ Hospitalization (observation or inpatient)
    - ▪ Outpatient surgery
    - ▪ Skilled nursing facility (SNF) admission
    - ▪ Emergency room visits
    - ▪ Changes to LTSS care level
  - ➤ New behavioral health referral or admission
  - ➤ Reported alteration in mental/functional status
  - ➤ Multiple falls
  - ➤ Unsafe home environment
  - ➤ Pharmacy referral, drug interactions or new member transition

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Model of Care Process: ICP (cont.)

- Health network reassesses member with health status changes or key events (cont.)
  - Request for medication review
  - Authorization for out-of-area provider
  - Care management level change
- Based on assessment for change of health status, PCP may intervene:
  - Convene an ICT
  - Change the composition or add participants to ICT
  - Develop or update member's ICP
  - Link member to community resources and services as appropriate

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Model of Care Process: Summary

- At every step, interventions are monitored and facilitated by the PCC with a view to comply with due dates, achieve member satisfaction and assist with ICT tasks.

- Member outreach from the PCC increases HRA response rates and provider and member collaboration.

- All members will have an ICP completed by the health network in collaboration with the PCP.

- The Model of Care process provides an efficient pathway toward improving member participation and outcomes.

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Knowledge Check

1. A member may choose to include and exclude participants of his/her ICT:
   a) True
   b) False

2. Who will have a formal ICT?
   a) Only high-risk members, members who request an ICT, and members whose provider requests an ICT on their behalf
   b) Member in MSSP and not severely impaired
   c) Only institutionalized members in long-term care settings for more than 90 days
   d) Members with CML of complex or care coordination
   e) All members

3. When members enroll in OneCare Connect they:
   a) Have an assigned PCC
   b) Will have a care team
   c) Must participate in an ICT meeting
   d) a and b
   e) a, b and c

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Knowledge Check (cont.)

4. Who gets an HRA?
   a) Only high-risk members
   b) Only high-risk members and institutionalized members
   c) Only high-risk members, institutionalized members and members with a history of substance abuse
   d) Every enrollee

5. The Individual Care Plan (ICP) is developed by:
   a) The PCC
   b) A collaborative team that may include the member, member's caregiver, PCP, specialist and others involved in the member's care
   c) CalOptima clinical staff

6. Goals — specific, measurable, achievable, relevant, and time-dimensioned — are part of an ICP.
   a) True
   b) False

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Knowledge Check Answers

1. a) True
2. d) Members with CML of complex or care coordination
3. d) a and b
4. d) Every enrollee
5. b) A collaborative team that may include the member, member's caregiver, PCP, specialist and others involved in the member's care
6. a) True

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What Is Coordination of Care?

- Definition:
  - An approach to health care in which all of a member's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the member and the member's caregivers and works with the member to make sure that the member gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated.

- Goal:
  - Help member regain optimum health or improve functional capability, in the right setting and in a cost-effective manner.

- Supports individual choice:
  - Live in least restrictive environment
  - Maintain independence
  - Prevent functional decline

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Coordination of Care: Process

- PCC and/or care manager facilitates coordination of care for a member with the PCP and other providers, e.g., behavioral health, durable medical equipment (DME) or LTSS:
  - ➢ Share pertinent member information.
  - ➢ Ensure ICT team follows up on member referrals to appropriate services or providers.
  - ➢ Share identified services and member health care outcomes with ICT and PCP during ICT planning.
  - ➢ Communicate ICP changes to ICT/PCP in writing or via phone.
  - ➢ Inform members and encourage discussion with PCP.
  - ➢ Incorporate outcomes of the intervention into the ICP.
- Care management sensitive to individual health needs and goals

Coordination of Care: Process (cont.)

- Activities include:
  - Targeted assessment of identified member needs
  - Creation of individual care plan
  - Facilitation of identified referrals
  - Facilitation of continuity of care with non-contracted providers
  - Development of prioritized term goals
  - Follow up communications
  - Discussion of ICP with ICT
- Focus on members with increased service needs:
  - Episodic
  - Increased resources
  - Multiple services along the continuum
- Goal is seamless delivery of health care services.

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Coordination of Care: Standards

Five elements of a member-centered approach:

1. Individual service planning and delivery

2. Member and any designated caregiver, family member or others chosen by member who participates in service planning and delivery

3. Consideration of member values, culture, traditions, experiences and preferences in definition of quality

4. Recognition and support of member's self-care abilities

5. Integration of formal and informal supports

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Coordination of Care: Specialized Providers

- Coordination includes working with the specialized provider and networks:
  - Behavioral health programs — coordinated by CalOptima
  - Specialty services — dialysis, transportation, DME, home health and specialty pharmacies
  - Psychosocial programs — homeless and recuperative programs
  - Centers of Excellence — transplants
  - Chronic condition program — asthma, diabetes, cardiovascular conditions
  - Home and community-based providers — CBAS, MSSP
  - Community-based support programs — Aging and Disability Resource Connection of Orange County (ADRCOC)
  - Long-term care facilities
  - Rehabilitative facilities

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Transitions of Care

- Definition:
  - Coordination of services and care from one care setting to another
- Goal:
  - Assisting the member to remain in least restrictive setting
- Process:
  - PCC and/or care manager coordinates care:
    - Assists with the transfer of clinical records
    - Assists with identification of needed providers or facilities
    - Facilitates reconvening of ICT
    - Facilitates updates to ICP to reflect new provider, facility, or services and care needs
    - Communicates ICP between the sending and receiving settings, ICT and member, caregiver and/or authorized representation within one business day of notification that transition occurred
    - Sends ICP by faxing, mailing or electronic medical record transfer or face-to-face hand-off to member

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Continuity of Care

- Definition:
  - Continuity of care for services and medicines means that the member can continue receiving any current **medically necessary services or prescriptions*** after enrolling in OneCare Connect for a specific period of time if certain criteria are met.

- New members informed of right to continue Medicare or Medi-Cal services:
  - Medical
  - Mental and behavioral
  - Long-term services and supports (LTSS)
  - Pharmacy

*Continuity of care for prescriptions only applies to prescriptions covered by Medi-Cal.

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Continuity of Care (cont.)

- Benefits can continue for a limited time, provided all criteria are met:
  - ➢ Primary and specialty Medicare and Medi-Cal services
  - ➢ Special rules for pharmacy
  - ➢ Special rules for overlapping benefits
  - ➢ Special rules for members residing in a nursing facility
- General criteria:
  - ➢ Evidence of an existing relationship with provider
  - ➢ Provider must accept the plan reimbursement
  - ➢ Provider without quality or credentialing issues

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Wellness

- Wellness programs help members live optimally
  - Decrease/cessation of tobacco use
  - Reward those who achieve certain targets or take certain required actions
- CalOptima helps members to find individual balance of information and support to achieve optimal health status
  - Health education and disease management services available to members

Provider Network and Specialized Services

- Comprehensive network for OneCare Connect members:
  - Facilities
  - Medical specialists
  - Behavioral and mental health
  - Nursing professionals
  - Allied health professionals
  - Ancillary providers
  - Home and community-based service providers
  - Long-term care providers
- Providers credentialed according to NCQA guidelines and re-credentialed every three years

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Clinical Practice Guidelines

- OneCare Connect providers utilize evidence-based clinical practice guidelines from recognized sources for non-preventive health, acute and chronic medical conditions, behavioral health services

  ➢ Reviewed and approved by the Quality Assurance Committee (QAC) annually and updated when necessary.

- Guidelines disseminated to practitioners via CalOptima website, quality review visits, newsletters

- Compliance measured by Quality Assurance Committee (QAC) annually

- Performance measured by NCQA Health Effectiveness Data and Information Set (HEDIS®) rates and Star measures and annual medical record review

Model of Care: The Member

- Concepts supporting the member include:
  - Member rights
  - Recovery model
  - Most integrated/least restrictive setting
  - Independent living
  - Eliminating barriers
  - Identifying and reporting abuse and neglect
  - Communications

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Member Rights

- Member enrollment in OneCare Connect is optional.
- Potential members are informed of enrollment rights and options, plan benefits and rules, and care planning process in accessible format.
- Members may choose their current doctors or clinics, if they are in the OneCare Connect network.
- Members may change their health network or PCP monthly

Member Rights (cont.)

- Multiple methods and modalities are used to meet cultural, linguistic and disability needs.

- Members are ensured they will not be balance billed.

- **OneCare Connect supports members' right to decide how to receive care in home and community-based settings to maintain independence and quality of life.**

For more information about the member's rights, see the OneCare Connect module on Member Rights or refer to the Member Handbook.

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Member Care Concepts

The three key concepts to planning and coordinating member care:

- Recovery Model: "Recovery is an individual's journey of healing and transformation to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential." (USDHHS)

- Most Integrated/Least Restrictive Setting: All consumers of public mental health services are treated in an environment that is the minimum necessary to enable effective treatment and in a manner that respects individual worth, dignity, privacy and enhances autonomy.

- Independent Living: Allows for member choice, member autonomy and member control.

For more information see the OneCare Connect module on Behavioral Health Services

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Member Care Concepts (cont.)

- Members with disabilities have the right to:
  - ➢ Live in their own homes with dignity and appropriate support
  - ➢ Participate fully in their communities
  - ➢ Make decisions that concern their livelihood

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Members with Disabilities

- Legislation
  - Americans with Disabilities Act (ADA) of 1990
  - Supreme Court Olmstead Decision in 1999

- Requirements
  - ADA requires states to place qualified individuals with mental disabilities in community settings, rather than in institutions.
  - Care professionals determine what placement is appropriate.
  - Individuals do not oppose such placement.
  - States must be able to reasonably accommodate the placement, taking into account resources available and the needs of others with disabilities.
  - Public entities must administer their services, programs and activities in most integrated setting appropriate.

For more information see the CalOptima module on Disability Awareness

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Eliminating Barriers

- CalOptima works to eliminate barriers to independent living via community services and Long-Term Services and Supports (LTSS).

- LTSS goals:
  - Provide an alternative to institutional placement
  - Seamless service delivery
  - Physical and programmatic accessibility
  - Member-centered care coordination
  - Integration of LTSS with medical and behavioral health
  - Referrals to other agencies or community-based organization for needs not covered by OneCare Connect benefits

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Integrated Long-Term Services and Supports

- CalOptima administers:
  - Long-Term Care (LTC) as a Medi-Cal managed care plan benefit
  - Community-Based Adult Services (CBAS) as a Medi-Cal managed care benefit
  - Multipurpose Senior Services Program (MSSP) as a Medi-Cal plan benefit
- CalOptima coordinates with the Orange County Social Services Agency (SSA) and Orange County IHSS Public Authority for In-Home Supportive Services (IHSS).
  - NOTE: as of **January 1, 2018** IHSS is no longer a OneCare Connect plan benefit but remains available to eligible Medi-Cal beneficiaries as a fee-for-service benefit.
- OneCare Connect members have access to coordinated Long-Term Services and Supports (LTSS).

For more information see the OneCare Connect module on Long-Term Services and Supports (LTSS)

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Abuse and Neglect

- OneCare Connect members may be vulnerable to abuse or neglect due to:
  - Medical or mental health condition or disability
  - Age and frailty
  - Social isolation
  - Poverty
- All providers and staff are required to watch for and report incidents of abuse or neglect.

Abuse and Neglect (cont.)

- The following are examples of reportable abuse and neglect
  - Abuse (physical, mental and/or verbal)
  - Neglect
  - Exploitation
  - Disappearance of a member (missing person)
  - Death
  - Serious, life-threatening event requiring immediate emergency evaluation by a medical professional
  - Seclusion and restraints
  - Suicide attempt or self abuse/neglect
- To report suspected abuse or neglect:
  - **Orange County Adult Protective Services 800-451-5155 (24-Hour Hotline)**

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Member Communications

- CalOptima communication systems include but are not limited to:
  - ➢ Member and provider customer service call center
  - ➢ Member and provider website
  - ➢ Face-to-face meetings
  - ➢ Member and provider newsletters
  - ➢ Emails and faxes
  - ➢ Electronic medical records
  - ➢ Care management system
  - ➢ Conference calls

Member Communications (cont.)

- Communication is the responsibility of multiple CalOptima departments:
  - To provider networks and members via policies and procedures, provider portals, provider manuals, member handbooks, newsletters, website, meetings and updates
  - To stakeholders via shared documents — care plans shared electronically with PCP and ICT, and to members and caregivers
- Documents must be maintained on a secured server or via hard copy and in compliance with HIPAA (Health Insurance Portability and Accountability Act) and privacy laws.

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Model of Care: Measurable Goals

- Model of Care goals include:
  - ➤ Improved access:
    - ▪ Medical, mental health, substance use, social services and supports
    - ▪ Affordable care
    - ▪ Preventive health services
  - ➤ Appropriate utilization of services
  - ➤ Coordination of care via identified point of contact
  - ➤ Seamless transitions of care — settings, providers, services
  - ➤ Improved health outcomes determined by:
    - ▪ Prevalence of specified conditions
    - ▪ Quality measures for members in LTC facilities
    - ▪ Inpatient admission rates for specified conditions
    - ▪ Adverse outcomes for inpatient admission rates, ED rates, readmission rates
    - ▪ Transitions out of nursing facilities to home
    - ▪ Appropriate medication management

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Model of Care: Performance

- Quality Assurance Committee (QAC) directs health outcomes improvement program:
  - ➢ Ensures delivery of high quality, cost-effective care to frail and elderly, disabled, chronically ill and end of life population
  - ➢ Structured oversight and coordination
- Data and performance measure results drive improvement.
- Interventions based on data analysis:
  - ➢ Gaps in service area
  - ➢ Possible member benefit needs
  - ➢ Staff and provider training needs
  - ➢ Care transition needs
  - ➢ Improved member outcomes

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How Model of Care Is Measured

- Performance and outcome measures collected and tracked from clinical data warehouse
- Data source for following measures:
  - ➤ Utilization
  - ➤ Case management
  - ➤ Care coordination
  - ➤ Transitions of care
  - ➤ Member health outcomes
  - ➤ Access and availability
  - ➤ Member and provider surveys
  - ➤ Complaints and appeals
  - ➤ Prevalence rates
  - ➤ Quality measures

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Health Outcomes Measurements

- Evaluation sources include but not limited to:
  - Health Outcomes Survey (HOS)
  - Health Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Quality report cards
  - Grievances and appeals
  - Member and provider satisfaction survey results
  - Network access and availability reports
  - Encounter and utilization data
  - Medical records review results
  - Admission/readmission rates
  - Chronic care improvement program

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Model of Care: Maintenance

- Model of Care program description is a stand-alone, written document.

- Presented to QAC, at least annually

- Saved in QAC minutes

- MOC evaluation and QAC minutes maintained electronically in data system

- Data system archived nightly

- Archives copied and stored at off-site location in electronic formats and on data tapes

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Knowledge Check

1. Which of the following has the primary responsibility to ensure that ICP interventions are implemented?
   a) Care manager
   b) PCP
   c) Member
   d) ICT members

2. Enrollment in OneCare Connect is optional.
   a) True
   b) False

3. Coordination of Care is an approach to health care in which only high risk members' needs are coordinated with the assistance of a primary point of contact.
   a) True
   b) False

Knowledge Check Answers

1. b) PCP

2. a) True

3. b) False

Authorities

- DHCS/CMS/CalOptima Cal Medi-Connect 3-way Contract
- H8016-2018 Model of Care, Orange County Health Authority
- CMS/DHCS — California Duals Demonstration Memorandum of Understanding
- CMS National Financial Alignment Initiative
- NCQA Model of Care Review Process
- Agreements/MOU with:
  - Orange County HCA Mental Health Department
- Dual Plan Letter (DPL) 15-001: ICT and ICP Requirements for Medicare –Medicaid Plans
- Dual Plan Letter (DPL) 15-005 HRA
- Dual Plan Letter (DPL) 15-006: Crossover claiming responsibility for Mental Health Services provided to CMC beneficiaries
- Dual Plan Letter (DPL) 16-002: Continuity of Care

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References

- CalOptima Policy CMC.1003: CalOptima OneCare Connect Staff Education and Training
- CalOptima Policy CMC.6021: Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners
- CalOptima Policy CMC.6021a: Continuity of Care for New Members
- CalOptima Policy CMC.6026: Coordination of Care for OneCare Connect
- CalOptima Policy CMC.6031: Health Risk Assessment
- CalOptima Policy EE1103: Provider Education and Training
- CalOptima Policy GG.1204: Clinical Practice Guidelines
- CalOptima Policy GG.1320: Elder or Vulnerable Adult Abuse Reporting

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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