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MyCare Model of Care Annual Training

Learning Objectives

Participants will be able to:

- Describe My Care populations
- Identify 3 benefits available to meet the unique needs of the population
- Understand the important components of the Trans-disciplinary Care team and Individualized Care Plan to improve the care coordination of My Care members
- Name 2 principles of the Transitions program
- Identify 3 outcomes measured by the Model of Care evaluation

Model of Care overview

- The goals of Model of care include
  - Improving access to physical and behavioral health care
  - Access to preventative care
  - Provider network access
  - Care Coordination through identified point of contact including Health risk assessment, care plan and TDCT- Trans-disciplinary care team
  - Improving transitions across the health care continuum
  - Appropriate utilization of services
  - Improving the member outcomes

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What is MyCare?

- Ohio's Integrated Care Delivery System
- MyCare Ohio is a demonstration project that **integrates Medicare and Medicaid services** into one program, operated by a Managed Care Plan.
- A coordinated approach to providing health care and long-term services and supports
- Requirements are based on 3 way agreement between CMS, ODM and CareSource and the provider agreement defined by ODM

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Advantages to MyCare

- Single point of contact for care
- Care Management Support 24/7
- A team of professionals to coordinate care
- One ID card(for Opt-In members)
- Focus on prevention and wellness
- Nurse Advice Line
- Better coordination= Better health outcomes
- Health Partners submit claims to only 1 place (*for Opt-In members)*
- *Enhanced benefit package for Opt-in members*

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MyCare Target Populations

- Eligible for Medicare (Parts A, B and D) and FULLY eligible for Medicaid;
- Over the age of 18
- Living in one of the demonstration counties.
- Home & Community Based Services, (HCBS)Waiver members, Long term Care (LTC) Residents, and Community Well Members

Low Income Elderly

Under 65 Disabled

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Waiver Service Coordination or Home & Community Based Services

- CareSource works with Area Agencies on Aging to provide are management to our waiver members
- Services & supports provided in the home and community include:
  - Personal Care Services
  - Home Delivered Meals
  - Home Making Services
  - Adult Day Care
  - Emergency Response System (ERS)
  - Non emergency transportation
  - Home modifications

Goals of MyCare

- Improve member access to Medical, Behavioral Health, LTSS and Social Services
- Improve member access to affordable care-single point of contact
- Seamless transitions across Health Care settings
- Medication Therapy Management
- Ensure appropriate utilization of services
- Improve member's health outcomes with Member-Centered Care

Care Management Visit Schedule

- All members must have a face to face visits.

- Assessment and visit requirements
  - Intensive 15 days / monthly visit for life of demo
  - High 30 days / monthly visit for 6 months
  - Medium 60 days / visit 1st 2 months, then quarterly
  - Low 75 days / visit 1st 4 months, then biannually
  - Monitor 75 days / visit 1st 6 months, then annually

- Initial and ongoing (event based) assessments, as well as annual reassessment.

- Reassessment must occur within 365 days of last assessment.

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MyCare Model of Care

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.

Stratify Enrollee

Assess needs & Personal Goals

Confirm Strat/ Acuity

Develop Member Centered Care Plan & Service Plan

Implement new plan with member

Monitor & reassess Care Plan

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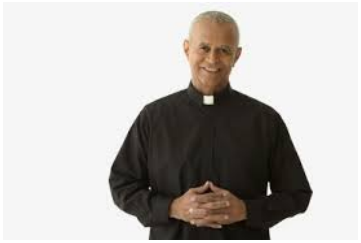
Trans-Disciplinary Care Team



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Transitions of Care & Post Discharge Coordination

Goals

- ↓ ER visits
- ↓ Hospital admits/ readmits
- ↑ Compliance w/ MD d/c plan
- ↑ Use of appropriate med choices/combos
- ↑ Use of appropriate Community Referrals
- ↑ Member Satisfaction & Health Outcomes

Transition Coordinator Role

- LOC requests for NF & Waiver will be sent to TC
- LOC for Waiver will be sent to the local AAA by the TC
- CareSource TC will determine LOC for LTC members

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Care Treatment Plan

- Individualized & Personalized
- Prioritized
- Actions with timeframes for completion
- Developed on assessment findings, member preferences & input from the TDCT
- PCP involvement is necessary

Other Care Management Interventions

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

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CMSA Standards of Practice for Case Management

- Appropriate member identification and selection
- Assessment & problem identification
- Development of case management plan & goal establishment
- Implementation & coordination of care activities
- Evaluation of case management plan & follow up

Member and TDCT Available Resources

- Provider Portal
- Member Portal
- CareSource Website
- CareSource Call Center
- Secure Email
- Employee Connectivity- Laptops, iPhones, iPads
- 24 hour Nurse Advise Line
- 24 hour Behavioral Health Line

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Consumer Advisory Councils

- Occur quarterly by Region (Cleveland, Youngstown & Akron)
- Forum for members to come and discuss MyCare Ohio successes, suggestions, and struggles with CareSource
- CareSource staff present- Consumer Experience, Care Management Leadership
- Member Advocates invited (i.e. Ombudsman)

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Model of Care Evaluation

- Monitor and analyze Utilization Management data, Waiver service utilization, HEDIS (encounters & claims), Part D Pharmacy utilization, and other financial data.
- CMS and state reports
- Effectiveness of Case management model including, HRA, Care Plans, TDCT and transitions
- Member health and outcomes

Model of Care Evaluation

- Updates to MOC throughout the year as needed
- Review of the MOC effectiveness
- Reviewed annually by:
  - Executive Council
  - Quality Enterprise Committee
  - Care Management Quality Improvement Committee
  - Market Quality Improvement Committee

Health Partner Network

- Comprehensive network of primary care providers, specialists, such as cardiologist, neurologist, and behavioral health specialists to meet the complex health needs of the My Care and Medicare Advantage population
- My Care has specialized Long Term Services and Support provider that specialize in services for complex Nursing Facility and Waiver members

Quality Improvement

- CareSource has a Quality Improvement program that monitors the health outcomes and implementation of the My Care Model of Care (MOC) by:
  - Identifying and defining measurable MOC goals
  - Collecting HEDIS, STARS and quality with hold measures
  - Conducting a Quality Improvement Project (QIP) annually that is relevant to improving Long term care rebalancing to the My Care.
  - 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

Questions?


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