Model of Care
(MOC)

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

Model of Care Annual Training Requirement

As a Medicare-Medicaid Plan, First Choice VIP Care Plus, is required to training its providers on how we integrate and coordinate care and services for our members. This is done through our Model of Care.

Providers may receive training on the Model of Care in the following ways:

- Access an online interactive Model of Care training module on our website, www.firstchoicevipcareplus.com, under the Provider Training and Education link – also available in PDF format.
- Review printed Model of Care training materials received from the plan.
- In person from a training seminar or a Network Management Account Executive.

Model of Care — Why First Choice VIP Care PLUS Was Created

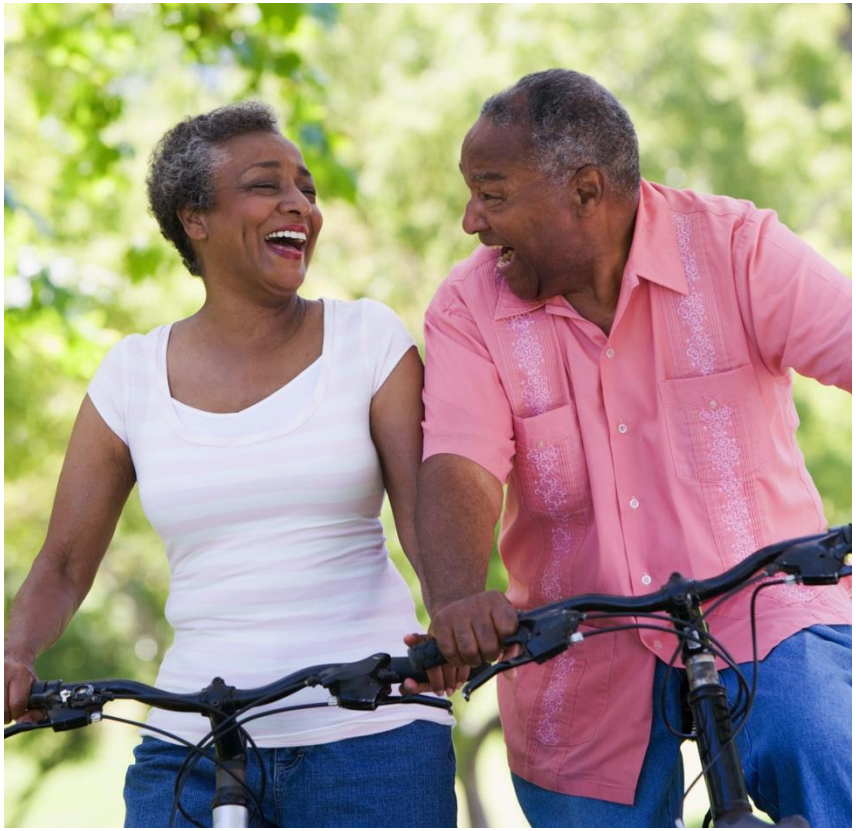
The First Choice VIP Care Plus plan was created to offer Medicare and Healthy Connections Medicaid eligible beneficiaries the opportunity to receive coordinated benefits and efficiently and effectively manage their care.

The goals of creating this plan are to:

- Improve health outcomes.
- Keep beneficiaries in the community.
- Simplify the delivery system and align payments for the provider.

How is this accomplished?

Through the Model of Care.



What Is the Model of Care?

The Model of Care is:

- A high quality, patient centric medical care delivery system for dual eligible Medicare-Medicaid members.
- An approach of bringing multiple disciplines together as a team to provide input and expertise for a member's individualized care plan.
- Part of a plan designed to maintain the member's health and encourage members' involvement in their health care.

What Is the Model of Care? – Simplified

The Model of Care is First Choice VIP Care Plus's

Model of how we **Care** for our Dual Eligible members.

Why the Model of Care is Necessary

- There are approximately 9 million dual eligibles in the United States.
- They are more sick and frail than the general Medicare population.
- 21% of Medicare population =

  31% of Medicare costs
- 15% of Medicaid population =

  39% of Medicaid costs

Reference: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8353.pdf

Model of Care - How Medicare-Medicaid (Dual) Eligibles Are Different from the General Medicare Population

They are:

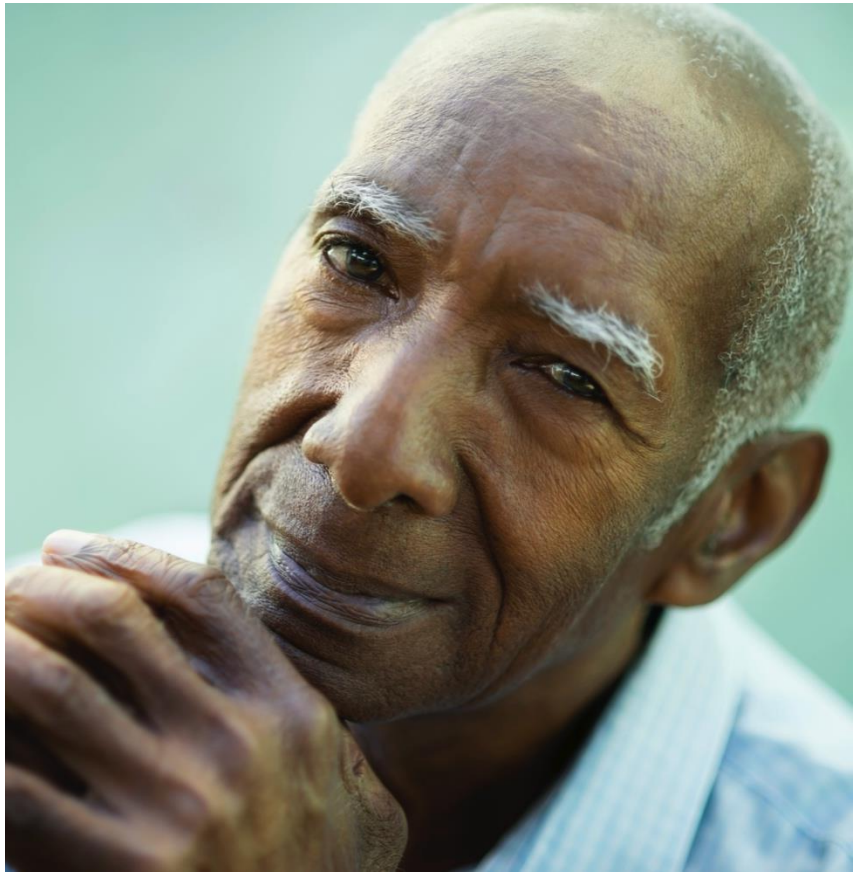
- Three times more likely to live with a disabling condition.
- More likely to have greater limitations in activities of daily living (ADLs), such as bathing and dressing.
- More likely to suffer from cognitive impairment and mental disorders.
- Indicated to have higher rates of pulmonary disease, diabetes, stroke and Alzheimer's disease.
- More likely to be in need of in-home care providers, plus a range of doctors and other health and social services, due to these high health needs.

Medicare Payment Advisory Commission (MedPAC). *Report to Congress: New Approaches in Medicare,* Chapter 3: Dual Eligible Beneficiaries, an Overview, June 2011.

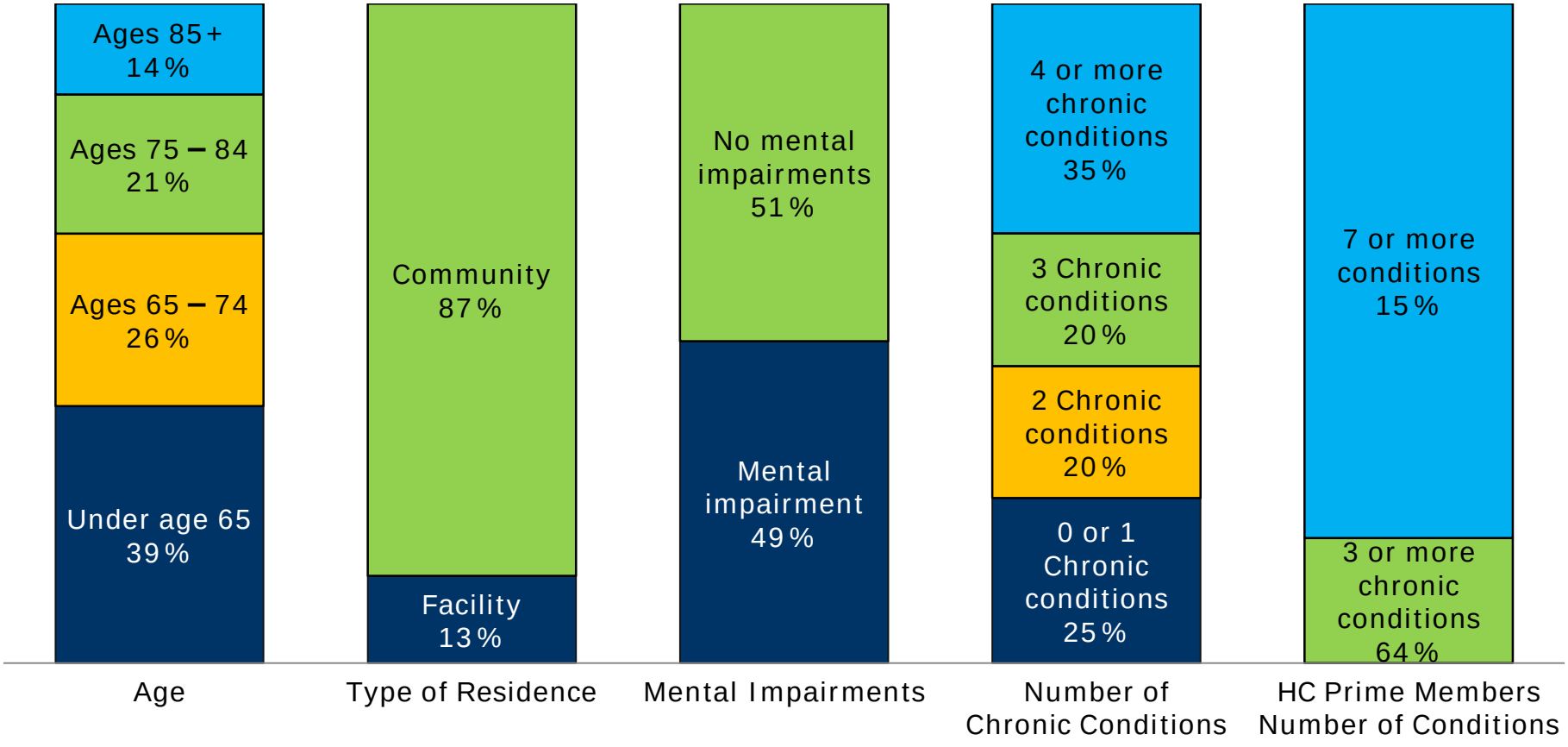
Model of Care — Outlining the High Volume = High-Cost Issue in the Dual-Eligible Population

Issues in the dual-eligible population that increase costs include:

- Frequent emergency room (ER) visits.
- Readmissions to hospital.
- Long-term skilled nursing facility stays.
- Poor medication adherence.



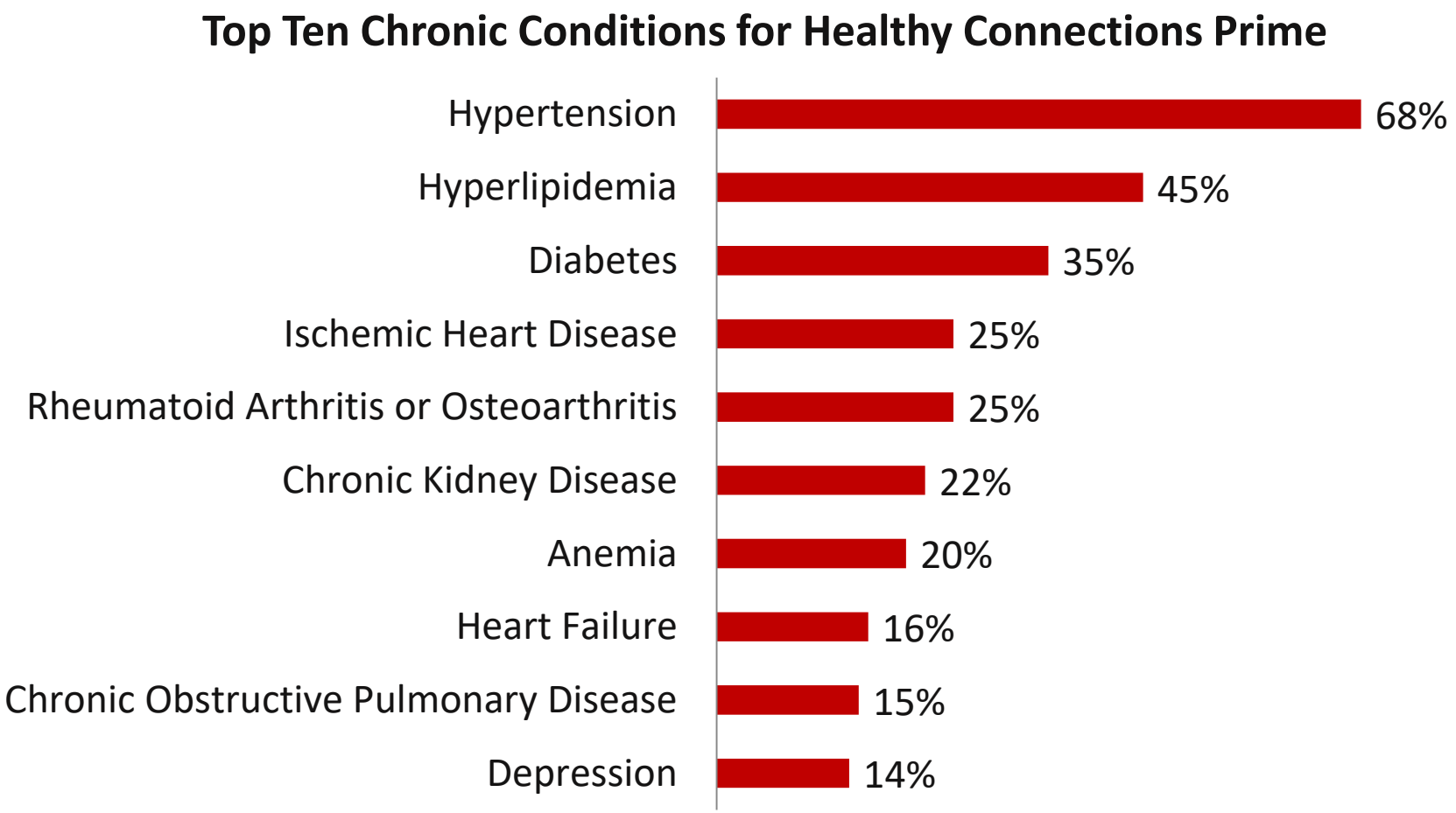
Model of Care — Why Dual Eligibles Are Special-Needs Members



Note: **Mental impairments were defined as Alzheimer's disease, dementia,** depression, bipolar disorder, schizophrenia or intellectual disabilities .

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, 2008.

Top Ten Chronic Conditions for Healthy Connections Prime



Building the Model of Care Multidisciplinary Team (MT)

An integral part of the MOC is building a MT. This begins with the development of a First Choice VIP Care Plus Care Team. Both the providers and members have access to this team which helps members modify their behavior and how they access health care.

The First Choice VIP Care Plus Care Team includes:

- ✓ Personal Care Connectors
- ✓ Community Health Navigators
- ✓ Care Coordinators

First Choice VIP Care PLUS Care Team Roles & Responsibilities

Personal Care Connectors

All Customer Service Functions

Welcome Calls

Provider Lookup / PCP Assignments

Quoting Benefits

Screening Questions
General Appointment Assistance

Medicaid Re-Certification

Triage to Model of Care

Non-Clinical Call Campaigns

Gaps in care reminders

Community Health Navigator

In-person engagement

Links member to health and social service system

Assists with basic navigation such as shopping and transportation

Accompanies member to key appointments

Coaches for behavior change and condition management

Care Coordinator

In-Home Assessments

Develops plan of care

Member Care Team Leader

Local PCP Outreach

Transition Coordinator

Work together to support the member

How the Care Team Help Members

The Care Team understands the most common diagnosis is poverty.

- Help address limited resources in all aspects of a member's life that will impact medical care and costs.
- Build trusted relationships.
- Monitor changes in condition.
- Advocate for the member.
- Overcome barriers to better adherence to medication and self-care regimes.

The Care Team knows that transitions of care are major events.

- The Care Team is involved in assisting the member and the provider with managing the details across settings to prevent readmissions.

The Care Team knows that caregiver involvement is critical.

- The Care Team helps identify capable resources (such as friends, family and agencies) who can provide members with better care and the Care Team with a more objective perspective.

Person-Centered Planning Approach

- ✓ The Care Team takes a Person-Centered planning approach with our members.
- ✓ Person-centered care begins with the individual's goals and respects and addresses their preferences and needs.
- ✓ While person-centered care planning places the individual at the center of WHAT care is to be provided, by WHOM and WHEN, the care manager is often at the center of HOW that care is coordinated.

Person-Centered Planning Approach

Health and medical goals are highly individual and people's engagement in setting goals has been demonstrated to affect not only their participation in and adherence to treatment, but their health outcomes and quality of life. Care coordinators work with members to:

- **Step 1: Elicit Goals** – Identify what is important.
- **Step 2: Negotiate Goals** – Break goals down to smaller attainable goals, facilitate conversations.
- **Step 3: Support Goal Attainment** – Recognizing and addressing barriers, Motivational Interviewing.
- **Step 4: Monitor Goal Attainment** – Assessments and care plan updates.

Continuing to Build the Multidisciplinary Team (MT)

The Care Team alone cannot help the member reach their goals of the person-centered planning approach. The MT is crafted to help support the individual goals/needs of each member and is completed by including the following, if applicable:

- The member.
- The primary care provider or medical home.
- Health plan nurses, medical directors and pharmacists.
- Physical and behavioral health specialists.
- Long Term Services and Supports (LTSS) providers.
- Social workers.
- Community mental health workers.
- Physical, speech and occupational therapy providers.
- Others who play an important role in their care - family members, friends, pastor, etc.

Working Together

Collaboration between all members of the multidisciplinary team, yields a ***Member Individual Care Plan*** that is specifically designed to meet the member's health and personal needs.

The team will be in charge of coordinating the needed services. For example:

- The care team will make sure the doctors know about all medicines a member takes so they can reduce any side effects.
- The care team will make sure a member's test results are shared with all of the member's doctors and other providers.
- Primary Care Physicians will be responsible for directing the member's care.
- The development and any updates needed to the Individual Care Plan (ICP).
- Manages medical, cognitive and psychosocial needs of member.
- Works together as a "team" to ensure best outcomes for the member.

Member Care Plan

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Member Care Plan

Member	Scott Calvin	Care Manager	zeuser
Member ID	2836180	Care Manager Phone	
Date of Birth	11/01/2012	Care Manager Email	
Eligibility Start Date	08/01/2014	Plan Last Updated	11/17/2014

Problem	Goal	Intervention and Status	Start/Completed Date
Alteration in Mental status changes r/t seizures	Member/Caregiver will be compliant with medication regime by obtaining, taking medication as prescribed	Assess member/caregiver knowledge on medications, purpose, side effects Assess member medication compliance and educate as needed	12/08/2014 / 01/01/0001
Impaired physical mobility	Member will be able to state his/her physical limitation as it relates to disease process.	Assess for waiver services Assess for knowledge regarding injury and rehabilitation. Arrange for member/caregiver education regarding adaptive devices.	12/08/2014 / 01/01/0001
Ineffective Coping	Demonstrate effective coping mechanisms, setting up realistic goals, and positive adjustments to change in body image.	Assist client in identifying individual strengths	12/08/2014 / 01/01/0001

We have had many member success stories due to the Model of Care process.

We would like to share some of those with you, so you can see the impact we are having.

Success Stories

Success Story - Nursing Home Diversion

When the Care Coordinator (CC) first met the member, he was living with his daughter, wheelchair-bound for over a year, and was alone most of the time. The member had difficultly being transferred from his chair to his wheelchair and fell several times, and after the member's grandson moved out in June 2017, his daughter began to actively and aggressively look for nursing home placement. The member's daughter felt that it was the only possible option for the member since she and her spouse worked long hours. A referral was made to Community Long-Term Care (CLTC) for waiver services, but the daughter kept insisting that she wanted the member to be moved to a nursing home as soon as possible.

The member was hospitalized in October 2017 and then transferred to a skilled nursing facility. The daughter's plan at that time was for him to move to custodial care upon completion of his skilled nursing facility stay. She didn't want the member to return to her home. The member was very sad about all of this and would cry about having to go to a nursing home. The CC worked closely with CLTC and they spoke with the member's adult son. A plan was eventually reached for the member to go and live with the son and his wife. The member is now living with his son and receiving waiver services. Both the CC and Community Health Navigator (CHN) visited the member and they found that the member's son and his wife are taking great care of the member and they observed that the member is extremely happy. It was the first time in over a year that the CC saw the member smile. The member is optimistic and determined to stay out of the hospital. He has started walking daily with the help of his son and received an electric wheelchair so he is able to get outside more.

Success Story – Finding a Hard to Reach Member

A member was hard to reach for 2 years and in June 2018 she was hospitalized. The CC was able to use information in the hospital records to locate the member. The CC made a blind visit, and was eventually able to schedule a visit to conduct the initial assessments. The member was found to be declining in mental status, very forgetful, often confused, refusing to bathe for weeks, hiding her medications and forgetting where they were, or putting all of her pills in one bottle. She was eating very poorly and had lost over 10% of her body weight in the past year. In addition, three adult daughters were not getting along and unable to agree on the care of the member. She was living alone with one daughter next door.

The CC made a referral for CLTC services and contacted the PCP about concerns for the member's safety. One daughter reportedly gave her a large dose of laxatives a few weeks later and she had to go to the ER for treatment for dehydration. After that the CC went by the PCP office to inform him, again, of her concerns because he reportedly had told the family that the member was fine and could live alone. After that, the member was taken to the home of the daughter who has Power of Attorney. The CC requested flexible benefits because the daughter works 7 days/week. As of 11/12/2018, member is receiving care from a Personal Care Assistant 7 hours/day 7days/week. The daughter is administering medications correctly. The member's daughter is also planning to follow up with care gaps for the member.

Success Stories – Finding Extra Help for Members

- A CHN was unable to reach a member by phone, so she drove nearly 70 miles to her home and knocked on her door. The member welcomed the CHN into her home, and accepted her offer to help. She had not visited a doctor for four years and didn't have a phone where she lived. The member said her knees hurt and she agreed to go to a doctor. The CHN worked with the member to select a PCP and scheduled an appointment. The CHN attended the appointment with her. During her visit, the CHN discovered the member had more than $1,000 in overdue electric utility bills and her water heater was not functioning properly. The CHN was able to find a resource to have the electricity bill paid, and she got the landlord to install a new water heater.
- During a home visit to perform a reassessment our CC discovered that one of our members who is blind and lives alone, did not have a working smoke detector in her home. Concerned for the member's safety the CC reached out to the CHN for assistance. The CHN reached out to a local Fire Department and was able to obtain a working smoke detector and a bed shaker for the member.

Success Story – Finding Extra Help for Members

- During a home visit the CC noticed that a member's home was in need of some minor repairs and yard clean up. Every Summer the United Way provides home repairs for seniors in the area. The CC made a referral on the member's behalf and the member's name was chosen. With the help of United Way and the Methodist Church the member's entire home was painted, new screens doors were installed and old trees and shrubs left behind by Hurricanes Harvey and Irma were removed.
- Spanish speaking member has been diagnosed with breast cancer. Her provider explained the need chemotherapy, but the member is hesitant and doesn't want to start treatment. The plan's bi-lingual CHN spoke with member to explain the importance of her treatment and to help ease the members concerns. The member expressed interest in going to a cancer support group to get more information that would help the her make a decision about chemotherapy. Due to the fact that the member only speaks Spanish the CHN agreed to accompany the member to the support group class to assist her with translations and to provide support.

Success Story - Resolving Gaps in Care

One of our Community Health Navigators (CHN) was following up on a member and identified it had been several months since the member picked up a prescription for his chronic condition. The CHN called the member and encouraged him to follow up with his PCP to get the prescriptions. After the appointment was scheduled, the CHN met with the member for the appointment. Care gaps were discussed with the doctor. The member received his pneumonia vaccination, planned to get the flu vaccination at the pharmacy, and he picked up his prescriptions at the pharmacy.

The CHN also helped the member to set up transportation services, and enrolled the member with the mail order program, and assisted him in completing the free phone application. Transportation and memory issues are the reasons why the member did not follow up with his PCP appointment and why his prescriptions had not been filled. The member appreciated receiving the assistance and is now better prepared for maintaining and improving his health status.

Success Story - Finding a safe and convenient home

We have a member that really trusts our services and any time he needs help he reaches out to his Care Coordinator and Community Health Navigator (Care Team). In the past the member's care team assisted him with the application process for housing and the member was overjoyed when he was approved for an apartment located on the second floor.

The member was recently diagnosed with lung cancer and now that his health has declined, the member reached out to his care team and advised them that he needed to be moved to a first floor. The member's care team assisted the member with getting a letter from his doctor and they also talked to the Housing Authority to inform them about the member's urgent need to move. Today the member is living at the same facility but now has an apartment on the first floor. With the help of his care team, the member is in a safe and convenient apartment on the first floor that is better suited for his medical condition as he no longer has to walk a flight of stairs to the second floor. The member has also been referred to the waiver program and will begin to receive Flex Benefits via our supplemental program until his waiver application is approved.

SC Healthy Connections Prime Successes

First Choice VIP Care Plus is one of the top 5 Medicare-Medicaid plans in the United States in Member Satisfaction, tying for 1st place with three other plans with a score of 90%.

2016 Assessment and Care Plans Completed within 90-Days of Enrollment		
Metric	South Carolina	Demonstration National Average
Comprehensive Assessments	94.5%	89.5%
Care Plans	83.8%	70.6%

2016 Emergency Room and Hospital Discharge Follow Up		
Metric	South Carolina	Demonstration National Average
Behavioral Health-Related Emergency Room Visits, Annual Visits / 10,000 Member Months	19.8%	38.6%
Percent of Hospital Discharges with an Ambulatory Care Follow-Up Visit Within 30 Days After Hospital Discharge	77.4%	71.1%

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