



A Public Agency

OneCare (HMO SNP)
CalOptima
Better. Together.

OneCare Model of Care

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.

Learning Objectives

After completing the module, you will be able to:

- Define OneCare and Model of Care (MOC).
- Identify the four core elements of the OneCare MOC.
- Describe eligibility for OneCare participation and identify specialized services for most vulnerable OneCare members.
- Define Care Coordination, Health Risk Assessment (HRA), Individual Care Plan (ICP) and Interdisciplinary Care Team (ICT).

Learning Objectives (cont.)

- Understand the essential role of the contracted network of providers, adherence to care standards and oversight.
- Describe the Quality Measurement and Performance Improvement outcomes of the MOC.
- Define how MOC effectiveness is measured.

Course Content

- OneCare Model of Care Overview
- OneCare Population
- Care Coordination
- Care Staff Roles and Responsibilities
- Key Components
 - Health Risk Assessment
 - Individual Care Plan
 - Interdisciplinary Care Team
- Specialty Programs
- Evaluating the Model of Care
- Communication Processes and Methods

Overview

- The Centers for Medicare and Medicaid Services (CMS) require:
 - All Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC).
 - All employed and contracted personnel and providers of the MA-SNP are to be trained on the MOC.
- The OneCare MOC is CalOptima’s “road map” for care management policies, procedures, and operational systems.
- This course describes the OneCare MOC and how CalOptima and the network of contracted providers work together to ensure the success of the MOC and enhance the coordination of care for the members.

What is OneCare?

OneCare is:

- CalOptima's Medicare Advantage Special Needs Plan
 - Also known as:
 - HMO-SNP
 - SNP-plan
 - D-SNP
- Serves people:
 - Eligible for both Medicare and Medi-Cal (Medicaid) benefits
 - Residing in Orange County
 - Not qualified for the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Model of Care

- A document required by Centers for Medicare and Medicaid Services (CMS) for a D-SNP
 - Defines the care management policies, procedures and operational systems for OneCare
 - Is “member-centric” with the ongoing focus on the member and the member’s family/caregiver
- Four core elements are:
 - Population description of SNP
 - Care coordination
 - Provider network
 - Quality measurement and performance improvement

OneCare Population

- OneCare population description includes:
 - Eligibility to participate
 - Social, cognitive and environmental factors; living conditions; and co-morbid conditions of members
 - Medical and health conditions impacting members
 - Unique characteristics of the population
 - Identification of the most vulnerable members of OneCare with specialized services listed for these members

OneCare Population (cont.)

- OneCare's most vulnerable members are the following special populations:
 - Frail and/or disabled
 - In need of disease management
 - Diabetes Mellitus (DM)
 - Congestive Heart Failure (CHF)
 - With behavioral health needs
 - Institutionalized
 - At end of life

Knowledge Check

1. What does the acronym OC MOC mean?
 - a. Orange Coast Care Model of Orange County
 - b. Open Care Coordinator Model of Orange County
 - c. OneCare Model of Care
 - d. OneCare Medicare Order for Care
2. Care coordination is one of the four core elements of the MOC
 - a. True
 - b. False
3. OneCare vulnerable members include those who are:
 - a. Frail and/or disabled
 - b. Have behavioral health needs
 - c. Institutionalized
 - d. All of the above

Knowledge Check - Answers

1. c. OneCare Model of Care
2. a. True
3. d. All of the above

Care Coordination

- Care coordination includes:
 - Organization of member care activities
 - Sharing information among all of the health care participants involved with a member's care
 - Achieving safer and more effective care
- Main goal of care coordination is:
 - To meet members' needs and preferences in the delivery of high-quality, high-value health care

Care Coordination (cont.)

- Care coordination components include:
 - Staff structure
 - Administrative, clinical, and oversight roles specific to OneCare including a Personal Care Coordinator (PCC)
 - Health Risk Assessment (HRA)
 - Assessment of the OneCare members' health needs
 - Interdisciplinary Care Team (ICT)
 - A team of medical, behavioral, and ancillary providers, plus the OneCare member and an authorized representative who convenes to manage the member's care and assure care coordination
 - Individual Care Plan (ICP)
 - A plan of care for the OneCare member based on information from the HRA
 - Care transition protocols
 - Guidelines on how to manage the OneCare member across the care continuum

Staff Structure and Roles

- Organized to align with essential care management roles:
 - Administrative
 - Personal Care Coordinator (PCC)
 - At CalOptima
 - At contracted health networks
 - Clinical
 - Oversight

Administrative

- Manage:
 - Enrollment
 - Eligibility
 - Claims
 - Grievances and provider complaints
 - Information communication
 - Collection, analysis, and reporting of performance and health outcomes data

Personal Care Coordinator

- At CalOptima
 - Administer the HRA for each member
 - Initial and annual
 - May be face-to-face, telephonic, or paper-based
 - Enters HRA responses into data platform for RN review
 - Note — HRA collection not delegated to the health networks
 - Communicate key event triggers to the health network
 - For example, significant changes in a member's medical condition
 - Conduct warm transfer calls of the member to the health network

PCC (cont.)

- At a health network:
 - Member's point of contact and liaison between the member, provider, health network and CalOptima
- Role:
 - Guide member in understanding and accessing their benefits
 - Schedule and participate in ICT meetings, as appropriate
 - Assist member with scheduling appointments, facilitate referrals
 - Assist with coordination of member's health care needs
 - Notify member's care team of key events
 - Facilitate communication of ICP to Primary Care Provider (PCP) and other care team members, including member

Clinical Staff

- Examples of clinical staff may include:
 - PCP
 - Registered Nurse (RN) Case Manager
 - Licensed Clinical Social Worker (LCSW)
- Roles:
 - Advocate for, inform and educate members
 - Coordinate care
 - Identify and facilitate access to community resources
 - Educate members on health risks and management of illnesses
 - Empower members to be advocates of their health care
 - Maintain and share records and reports
 - Assure HIPAA (Health Insurance Portability and Accountability Act) compliance

Oversight

- CalOptima and the health networks collaborate to support the MOC.
- Role:
 - Monitor MOC implementation
 - Evaluate effectiveness of the MOC
 - Assure licensure and competency
 - Assure statutory and regulatory compliance
 - Monitor contractual and delegated services
 - Monitor interdisciplinary care teams
 - Assure timely and appropriate delivery of services
 - Assure providers use evidence-based clinical practice guidelines
 - Assure seamless transitions and timely follow-up

Health Risk Assessment

- Process:
 - CalOptima PCC:
 - Administers initial HRA and annual HRA for each member
 - Uses a standardized HRA tool
 - Note — HRA completion is **not** delegated to health network
 - May be completed face-to-face, telephonic, or paper-based
 - Identified care needs are categorized into Care Domains:
 - Access, coordination of services, health monitoring, medical-acute, medical-chronic, behavioral health, long-term care and Long-Term Services & Supports (LTSS)
 - Used by clinical staff to evaluate the medical, psychosocial, cognitive, and functional needs with medical and behavioral health history
 - Used to develop a member's individual care plan (ICP)

Interdisciplinary Care Team

- Role and process:
 - Includes the member's medical, behavioral, and ancillary providers, plus the OneCare member and an authorized representative, if desired
 - Convenes to manage the member's care and assure care coordination
 - Analyzes and incorporates the results of the initial or annual HRA into the ICP, utilizing evidence-based guidelines
 - Collaborates to develop and annually, or as needed, update the member's ICP
 - Manages the medical, cognitive, psychosocial, and functional needs of each member
 - Communicates the ICP to all caregivers for care coordination
 - Provides a copy of the ICP to the member in the member's preferred language, font and print size

Composition of the ICT

ICT composition determined by member's needs

Core Participants:

- Member and/or designated representative
- PCP assigned to member

Additional Participants:

- Behavioral health specialist
- Pharmacist
- Case manager
- Health network PCC
- Therapist (speech and/or physical)
- Nutritionist
- Appropriate specialist
- Health educator
- Disease management specialist
- Social worker

Individual Care Plan

- Process:
 - Developed by ICT for each OneCare member
 - Includes the member's personalized goals and objectives, specific services and benefits and measureable outcomes
 - Goals and objectives prioritized by the member's preference
 - Written ICP communicated to member, caregivers and providers
 - Members and/or caregivers (at member request) given a copy of the ICP and asked to sign off
 - Written ICP reviewed and revised annually by PCP or ICT or when health status changes
 - Accessible to all care providers
 - Records maintained per HIPAA and professional standards

ICP Distribution

- The ICP will be signed by the member's PCP.
- The ICP **must** be shared with appropriate specialty providers and ICT participants.

Knowledge Check

1. Who administers the initial HRA?
 - a. Member's doctor
 - b. Member's care giver
 - c. CalOptima PCC
 - d. Member's care coordinator
2. Who develops the member's ICP?
 - a. Member's care coordinator
 - b. ICT
 - c. Health network PCC
 - d. Member's care giver
3. The purpose of care coordination is to organize and coordinate the member's care activities.
 - a. True
 - b. False

Knowledge Check - Answers

1. c. CalOptima PCC
2. b. ICT
3. a. True

OneCare Provider Network

- CalOptima:
 - Contracts with board-certified providers
 - Monitors network providers to assure they use nationally recognized clinical practice guidelines
 - Assures that network providers are licensed and competent through a formal credentialing review
 - Maintains a broad network of specialists that include palliative care, pain management, chiropractors and psychiatrists
 - Monitors network adequacy to ensure access to care
 - Provides training on OneCare MOC for the providers and those who routinely interact with OneCare members:
 - Assures provision and attestation of initial and annual MOC training

OneCare Provider Network (cont.)

- OneCare provider network includes:
 - Primary care providers
 - Specialized expertise:
 - Specialists, hospitalists, pharmacists, crisis teams
 - Skilled nursing facility (SNF)
 - Behavioral health providers
 - Allied health providers, ancillary services
 - Substance abuse detoxification and rehabilitation services
 - Use of evidence-based clinical guidelines and care transition protocols:
 - Formalize oversight of provider network adherence to nationally recognized care standards.

OneCare Programs and Services

- OneCare specialty programs and services include:
 - Behavioral health
 - Specialty services:
 - Dialysis
 - Transportation
 - Durable Medical Equipment (DME)
 - Home health
 - Psychosocial programs such as drug and alcohol treatment
 - Referrals to:
 - Community-Based Adult Services (CBAS)
 - In-Home Supportive Services (IHSS)
 - Housing assistance
 - Meals on Wheels
 - Personal finance counseling

OneCare Programs and Services (cont.)

- Disease management and health education programs
- Community-based resources, such as:
 - Aging & Disability Resource Connection of Orange County (ADRCOC)
 - Multi-Purpose Senior Services Program (MSSP)
 - Office on Aging (OOA)
 - Dayle McIntosh Center (independent living)

Evaluating the Model of Care

- CMS defines processes and tools to measure health care outcomes.
 - Purpose is to ascertain that health plans provide high-quality health care for their members.
- Processes include:
 - Quality measurement (QM)
 - Performance improvement (PI)
- Methods include:
 - MOC Quality PI Plan
 - Measureable goals and health outcomes measurements
 - Measuring patient experience of care
 - Ongoing performance improvement evaluation
 - Dissemination of SNP quality performance related to the MOC

Performance Measurement

- Uses standardized quality improvement measures to measure performance and health outcomes such as:
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Disease management measures
 - Utilization management measures
 - Member satisfaction (surveys)
 - Provider satisfaction (surveys)
 - Ongoing monitoring of complaints and grievance summaries
 - Tracking and assessing completion of MOC training

Measurable Goals

- Evaluates measurable goals that:
 - Improve access to medical, behavioral, and social services
 - Improve access to affordable care
 - Improve coordination of care through an identified point of contact
 - Improve transitions of care across health care settings and providers
 - Improve access to preventive health services
 - Assure appropriate utilization of services
 - Assure cost-effective service delivery
 - Improve member health outcomes

Measurement of Effectiveness

- Evaluates measures of effectiveness by collecting and reporting data on:
 - Improvement in access to care
 - Improvement in member health status
 - Staff implementation of MOC
 - Comprehensive HRA
 - Implementation of ICP
 - Provider network of specialized expertise
 - Application of evidence-based practice
 - Improvement of member satisfaction and retention

OneCare Clinical Guidelines

- Supports the physician management of chronic conditions
 - Disseminates best practices, evidence-based guidelines
 - Shares provider tool kits to promote education and adherence

Communication Processes and Methods

- Utilizes an integrated system of communication for members and providers
 - Both scheduled and as needed
- Methods include:
 - Member newsletters
 - CalOptima website
 - Networking and focus group sessions
 - Conferences: face-to-face, telephonic, electronic
 - Committees:
 - Utilization Management Committee (UMC)
 - Quality Assurance Committee (QAC)
 - Member Advisory Committee (MAC)
 - Provider Advisory Committee (PAC)

Knowledge Check

1. CalOptima monitors network adequacy to ensure members have access to care.
 - a. True
 - b. False
2. Specialty programs for OneCare members include:
 - a. Behavioral health
 - b. Health education
 - c. Durable Medical Equipment (DME)
 - d. All of the above
3. OneCare develops their own quality improvement measures to measure performance and health outcomes.
 - a. True
 - b. False

Knowledge Check - Answers

1. a. True
2. d. All of the above
3. b. False

Summary

- OneCare's Model of Care:
 - Defines and creates a comprehensive strategy and infrastructure for care of our members
 - Meets the unique needs of the dual-eligible population by:
 - Setting agency-wide strategic goals
 - Contracting with expert practitioners
 - Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

Acronyms List

- CBAS = Community-Based Adult Services (formerly Adult Day Care)
- CMS = Centers for Medicare and Medicaid Services
- QAC = Quality Assurance Committee
- HEDIS = Health Care Effectiveness Data and Information Set
- HIPAA = Health Insurance Portability and Accountability Act
- HN = Health Network
- HRA = Health Risk Assessment
- ICP = Individual Care Plan

Acronyms List (Cont.)

- ICT = Interdisciplinary Care Team
- LTSS = Long-Term Services and Supports
- MAC = Member Advisory Committee
- MOC = Model of Care
- PAC = Provider Advisory Committee
- PCC = Personal Care Coordinator
- PCP = Primary Care Physician
- SNP = Special Needs Plan
- UMC = Utilization Management Committee

Authorities

- H5433_2021_DSNP MOC final

References

- CalOptima Policy GG.1204: Clinical Practice Guideline
- CalOptima Policy EE1103: Provider Education and Training
- CalOptima Policy MA.6032: Model of Care

