Texas Independence Health Plan

TIHP Model of Care (MOC) Facility Training 2024

Goals of Training

- Describe what an Institutional Special Needs Plan (I-SNP) is and the purpose of the MOC
- Show how TIHP's MOC can help facility staff and patients
- Help you understand your role in the I-SNP MOC

Overview

- The Medicare Modernization Act of 2003 (MMA) established an MA Coordinated Care Plans (CCP) specifically designed to provide targeted care to individuals with special needs.
- In the MMA, Congress identified “special needs individuals” as:
    1) Institutionalized Individuals (I-SNP)
    2) Dual eligibles (D-SNP)
    3)Individuals with severe or disabling chronic conditions (C-SNP)
        - *As specified by CMS.*
- MA CCPs established to provide services to these special needs individuals are called “Specialized MA plans for Special Needs Individuals,” or SNPs.
- SNPs were first offered in 2006.
- The MMA gave the SNP program the authority to operate until December 31, 2008.

Regulatory Requirements

- The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to design and implement a Model of Care (MOC) that details how the Plan will provide specialized care to enrollees **§ 422.101 (f)**

- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers and staff **§ 422.101 (f)**

Background and Purpose of MOC

- The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.
- The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.
- TIHP MOC ISNP Plan was initiated in January 2020 in 35 Regency facilities for the Institutionalized residents with long term advanced illness or disabilities.
- In January of 2022, a Service Area Expansion added 18 additional Regency facilities.
- The TIHP MOC was created to provide NP and RNCC services in Regency managed facilities.
- The ISNP MOC is managed by Nurse Practitioner Services of Texas (NPST).

What is the MOC Plan?

The MOC Plan is TIHP's detailed, written commitment to CMS on how we will provide specialized care to enrolled I-SNP members.

The MOC contains the following required components:

- Description of the Plan Population
- Care Coordination Process
  - Health Risk Assessment with Individualized Care Plan & Interdisciplinary Care Team
  - Care Transitions Protocols
- Specialized Provider Network and Use of Clinical Practice
  Guidelines and Protocols
  - MOC Training for Staff, Providers and Facilities
- Quality Improvement and Performance Monitoring

Institutional Special Needs Plan (I-SNP)

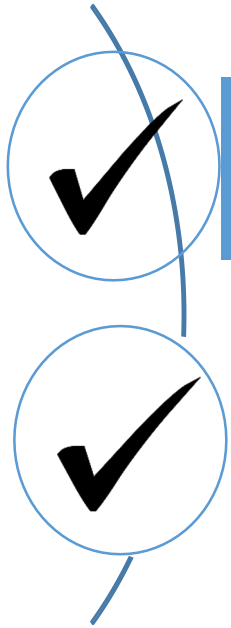
TEXAS INDEPENDENCE HEALTH PLAN

I-SNP : A Medicare Advantage (MA) coordinated care plan specifically designed to provide targeted care to special needs individuals who reside in a long-term facility.

Enrollment is restricted to:

- Individuals with Medicare Part A and Part B
- Live in LTC for 90 days or longer or can enroll if the patient was admitted for LTC and there is no plan for discharge
- Have had or are expected to need the level of services provided in a LTC Nursing Facility

Eligibility for TIHP Enrollment



- Reside in a TIHP contracted long term care facility for at least 90 days or if admitted for LTC and there is no plan for discharge
- Be enrolled in Medicare Part A and Part B

Goals of TIHP's I-SNP Plan

Texas Independence Health Plan

The I-SNP Plan is designed to:

- Reduce non-essential hospital admissions when care can safely be provided in the nursing facility
- Maintain the residents at an optimal level of function
- Increase compliance with appropriate screenings/testing
- Increase compliance with clinical practice guidelines
- Enhance identification and address problems earlier to optimize member function
- Improve communication related to member's care

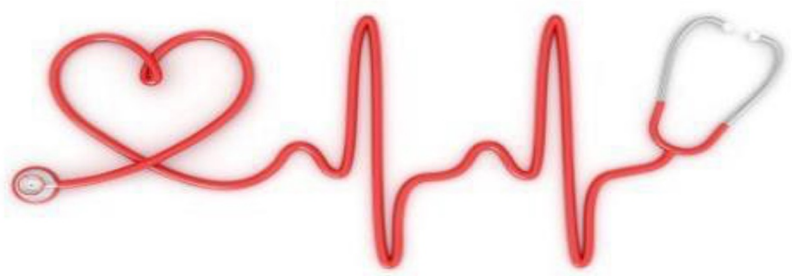
Advantages for Nursing Facilities

TIHP's I-SNP offers many advantages for nursing facilities, including:

- A local and dedicated clinical team that provides additional on-site primary care, case management and care coordination
- Emphasis is on proactive and preemptive care, population health management
- Increased availability of an on-site clinician for the Members
- Increased communication and collaboration among care team
- Encourage appropriate therapy and increased clinical knowledge for facility nursing staff.
- Improved quality of care and health outcomes for patients as measured by HEDIS® scores and hospital use rates

Key I-SNP Staff – NP

Nurse Practitioner



- Assigned to each nursing facility and all TIHP members in residence
- Communicates and collaborates with Health Care team
- Enhance family/caregivers' communication
- Promotes continuity of care,
- Coordinates care plan communications and implementation and clarification of goals
- Provides on-site primary urgent/acute care
- Support treatment in place to avoid unnecessary hospital transfers
- Visits/assesses each member at least monthly - and as often as daily, based on member's condition

The NP will work closely with facility staff to manage members' care and will keep everyone informed on their progress

Key SNP Staff- RNCC

RN Care Coordinator

- Assigned to each nursing facility and dedicated to all TIHP members in residence
- Liaison between the NP and facility staff
- Rounds on each TIHP member and alerts NP to changes in member condition or transitions
- Partners with the NP to coordinate care and follow up for the TIHP member

The NP/RNCC will be in the facility on weekdays as scheduled . Contact the NP or RNCC if you have any concerns with a TIHP member.

Individualized Care Plan (ICP)

Each TIHP member has an ICP:

- An ICP helps keep track of what the members and the healthcare team have planned or are working on for the next 12 months to improve the member's health and wellbeing.
- Tailored to the needs and preferences of the member as identified through the HRA
- Shared with member/responsible party, facility staff, the PCP
- Reviewed/updated by the NP on as needed in accordance with TIHP member's condition

The NP will contact you to discuss the ICP initially and with any modifications.

Interdisciplinary Care Team (ICT)

- Every member has an ICT tailored to the needs identified on the HRA and ICP
- The ICT oversees and coordinates the member's care plan
- Composition varies but, at a minimum, the ICT includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP.
- NP coordinates communications among ICT members and may request a formal meeting.

Please participate in ICT planning meetings if requested and contact the NP to discuss changes to the member's care plan.

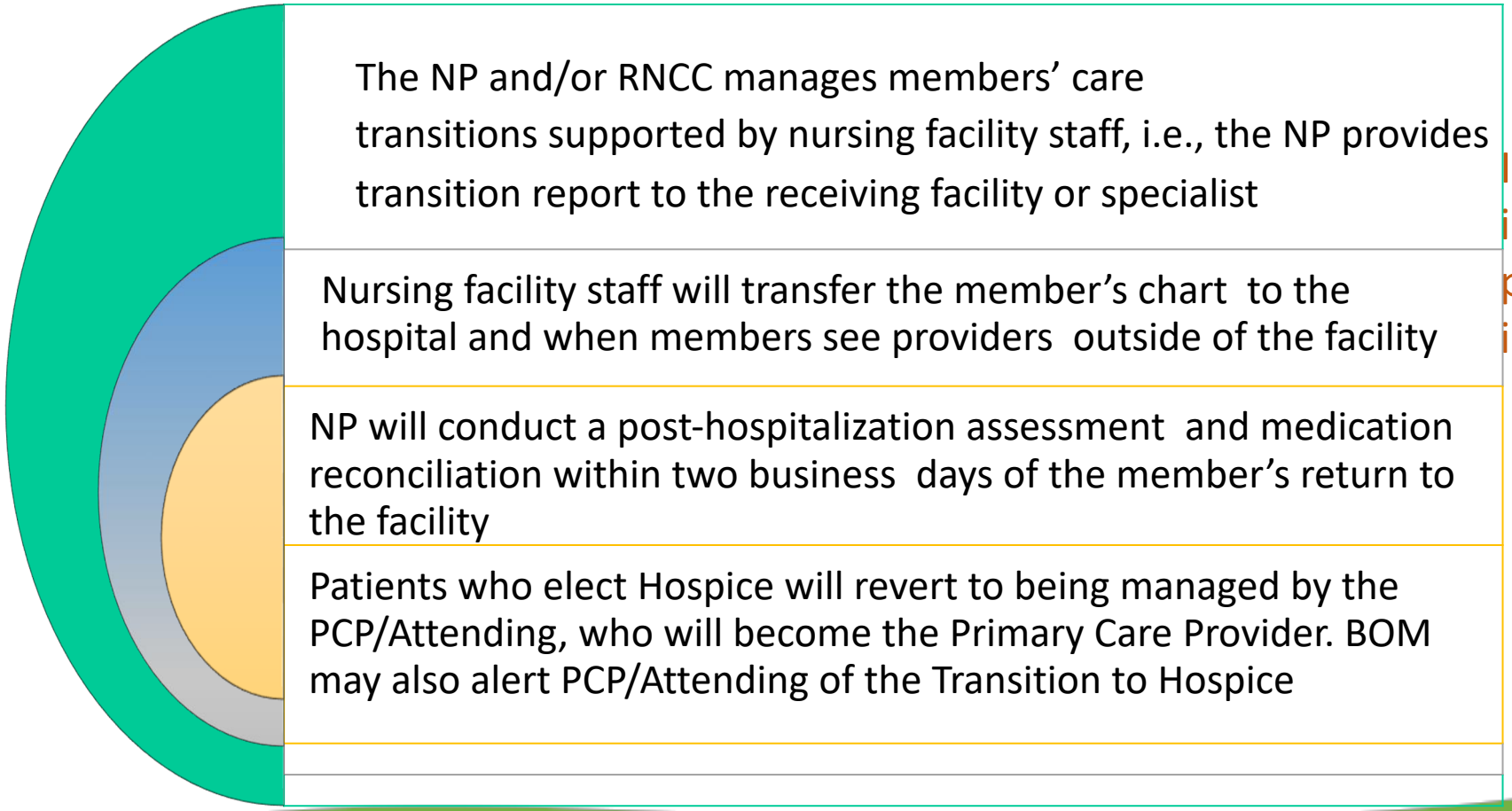
How the I-SNP program works in your SNF

Interdisciplinary Care Team (ICT) is designed to help everyone involved in TIHP Member's Health to Know:

- What is important to the member/responsible party
- The member's goal for the next 12 months
- About the member's health conditions
- The healthcare and support the member needs
- NP coordinates communications among ICT members and may request a formal meeting.
- At a minimum, the Interdisciplinary Care Team (ICT) includes the NP, RNCC, facility staff and the PCP. Additional participants may be added by the NP.

Please participate in ICT with the NP to discuss changes to the member's care plan.

Care Transitions Protocols



The NP and/or RNCC manages members' care transitions supported by nursing facility staff, i.e., the NP provides transition report to the receiving facility or specialist

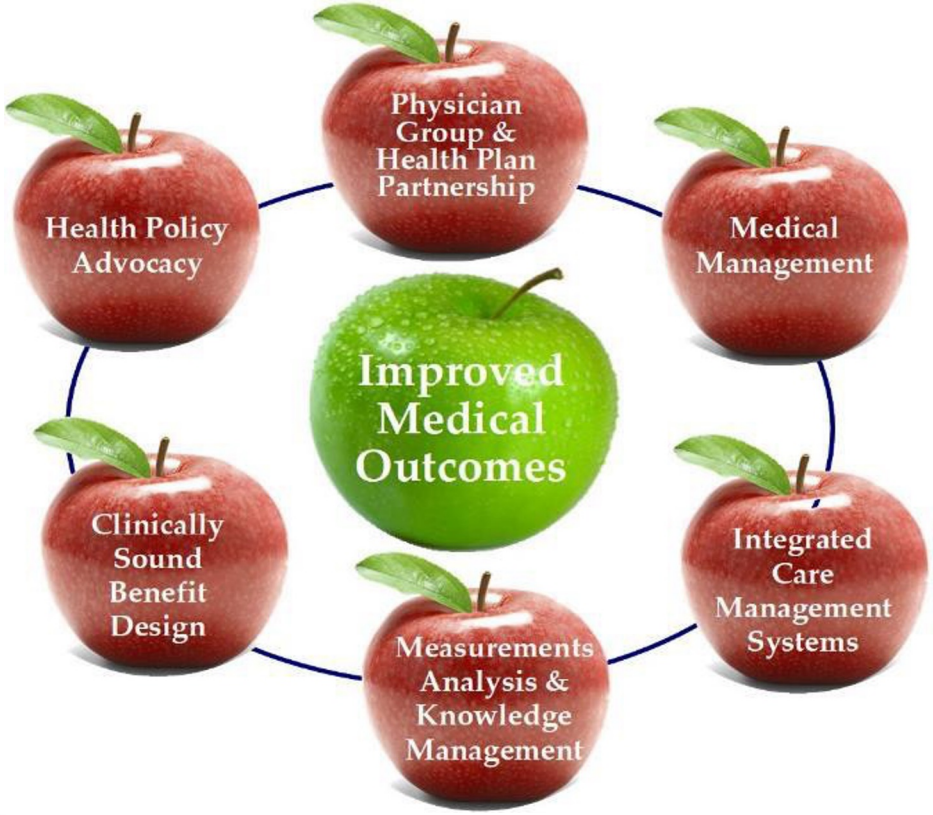
Nursing facility staff will transfer the member's chart to the hospital and when members see providers outside of the facility

NP will conduct a post-hospitalization assessment and medication reconciliation within two business days of the member's return to the facility

Patients who elect Hospice will revert to being managed by the PCP/Attending, who will become the Primary Care Provider. BOM may also alert PCP/Attending of the Transition to Hospice

If you see that a TIHP member is at risk for a hospitalization, please contact the NP or RNCC immediately!

TIHP and Facility Staff Partnership For Care



Specialized Provider Network

- TIHP maintains a comprehensive network of primary care providers and specialists
  - Includes providers with specialized expertise in the long-term care population and who routinely care for members in network nursing facilities

- All contracted providers are credentialed
- A network adequacy report is completed annually to ensure that members have access to services

Expectations for Nursing Facilities

- Get to know the NP and RNCC teams assigned to TIHP members. We are here to help you!
- Communicate ALL changes in condition no matter how small!!
- Early identification of changes in condition and report directly to the ISNP NP/RNCC.
- Report any changes, no matter how small, they may be clues to patients impending change in condition which needs to be addressed before becoming decompensated and unmanageable.
- Discuss the member's care plan and participate in ICT conferences and activities
- Call the NP or RNCC if a TIHP member is at risk for a transition/transfer to ER.
- Notify the NP or RNCC as soon as the member returns from a hospital stay
- Deliver care in accordance with appropriate evidence- based guidelines

Facility Staff Attestation

I attest that I have received the 2024 Model of Care Training for TIHP:

_____ _____

Printed Name Organization Name (if applicable)

_____ _____

Signature Title

_____

Date