AmeriHealth Caritas VIP Care Plus

Model of Care (MOC)

AmeriHealth Caritas
VIP Care Plus

Model of Care Annual Training Requirement

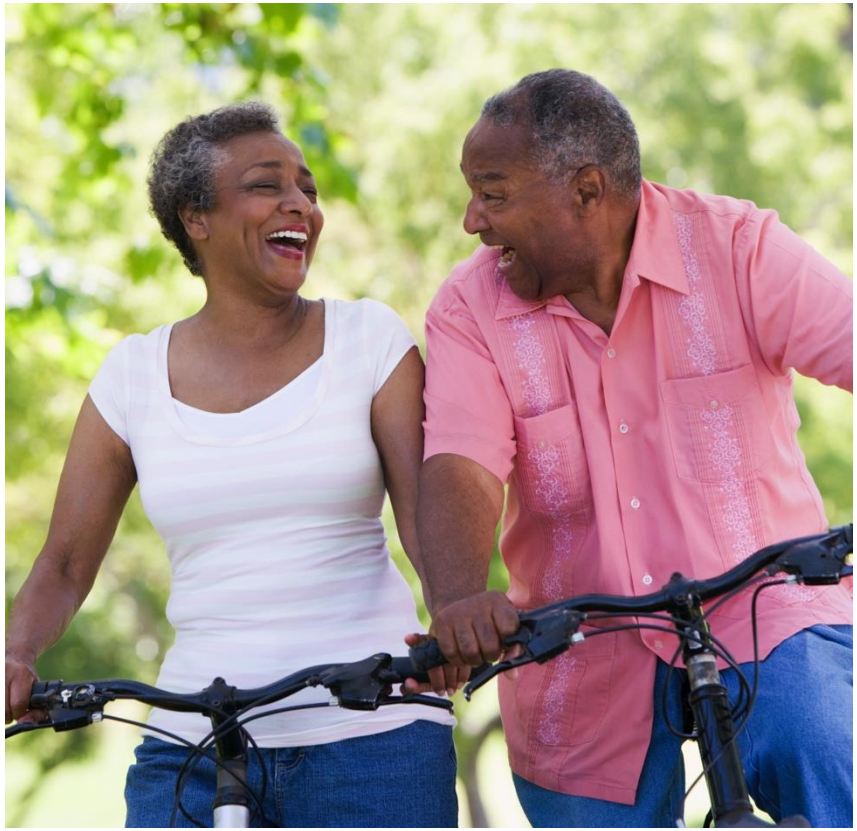
As a Medicare-Medicaid Plan, AmeriHealth Caritas VIP Care Plus, is required to training its providers on how we integrate and coordinate care and services for our members. This is done through our Model of Care.

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.amerihealthcaritasvipcareplus.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.

Why was AmeriHealth Caritas VIP Care Plus Was Created?

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



The goals of creating this plan are:

- Improve health outcomes, while reducing health care expenditures.
- Keep beneficiaries in the community.
- Simplify the delivery system and align payment 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 AmeriHealth Caritas VIP Care Plus's **Model of** how we **Care** for our Dual Eligible members.

Why is the Model of Care Necessary?

Due to their greater health needs and utilization of services, dual eligibles are a high-cost population:

- 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

How are Medicare-Medicaid (Dual Eligibles) Different from General Medicare Population?

They are:

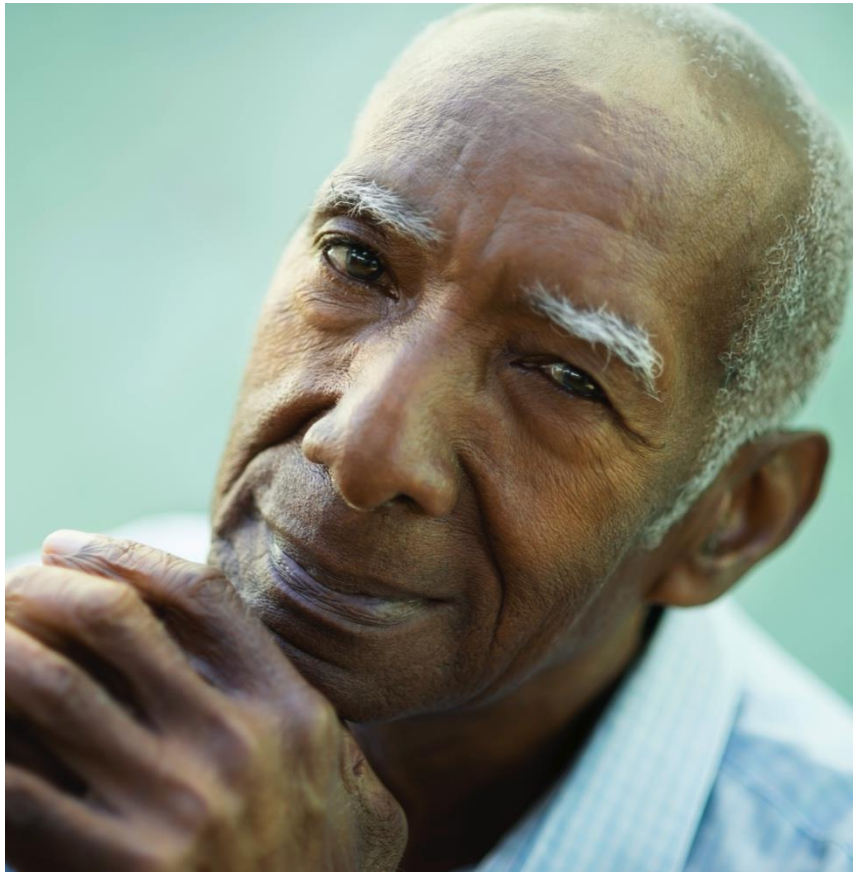
- Three times more likely to live with a disabling condition.
- More likely to have greater limitations in activities of daily living (ADLs), such as bathing and dressing.
- More likely to suffer from cognitive impairment and mental disorders.
- Indicated to have higher rates of pulmonary disease, diabetes, 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

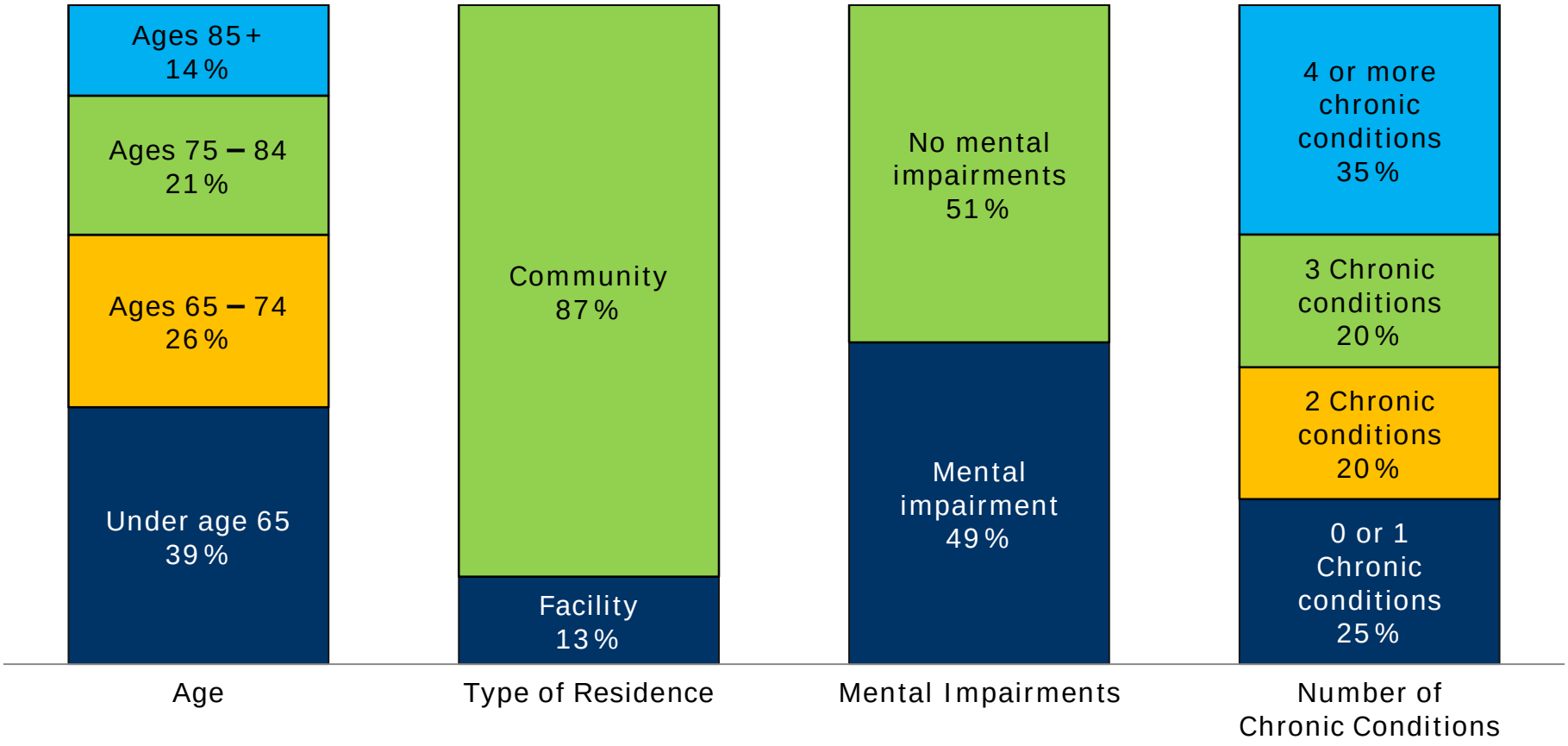
Issues in the dual-eligible population that increase costs include:

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



The AmeriHealth Caritas VIP Care Plus Model of Care aims to reduce healthcare expenditures and over utilization by providing coordinated care management for each AmeriHealth Caritas VIP Care Plus member.

Why Are Dual Eligibles Special-Needs Members?



Note: **Mental impairments were defined as Alzheimer's disease, dementia,** depression, bipolar, schizophrenia or mental retardation.
Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, 2008.

Building the Model of Care Integrated Care Team (ITC)

An integral part of the MOC is building a ITC. This begins with the development of a AmeriHealth Caritas 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 AmeriHealth Caritas VIP Care Plus Care Team includes:

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

AmeriHealth Caritas VIP Care Plus Care Team Roles & Responsibilities

Personal Care Connectors I

All Customer Service Functions

Welcome Calls

Provider Lookup / PCP Assignments

Quoting Benefits

Initial Health Screening

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 does the Care Team Help Members?

AmeriHealth Caritas VIP Care Plus 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 to 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 Model of Care Integrated Care Team (ITC)

The Care Team alone cannot help the member reach their goals of the person-centered planning approach. The ITC is crafted to serve the individual goals/needs of each member and is completed by including the AmeriHealth Caritas VIP Care Plus Care Team along with the following, if applicable:

- The member.
- The primary care provider or medical home.
- Health plan nurses, medical directors and pharmacists.
- LTSS and PIHP Supports Coordinator.
- Physical and behavioral health specialists.
- Home health and personal care providers.
- Social workers.
- Nursing facility representative.
- Physical, speech and occupational therapy providers.
- Others who play an important role in their care - family members, friends, pastor, etc.

What is the Primary Care Provider/Medical Home's Role?

The primary care provider/medical home is the main provider responsible for overseeing the overall care of the member. The key responsibilities of this role include:

- Helping members determine which services they need.
- Connecting members to the appropriate services.
- Serving as a central communication point for the member's care.
- Reviewing the plan of care sent by AmeriHealth Caritas VIP Care Plus.
- Providing feedback to AmeriHealth Caritas VIP Care Plus.

How will the Integrated Care Team work together?

Collaboration between the care team care coordinator, the member, and the rest of Integrated Care 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

AmeriHealth Caritas VIP Care Plus | MI HEALTH LINK Linking Medicare & Medicaid for you

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

Model of Care — Plan Implementation Overview

1. Each member enrolls with a primary care provider/medical home.
2. An Initial Health Screen is completed upon enrollment.
3. A Comprehensive Assessment will be completed within 60 days of enrollment for all members. A Level One and Level Two Assessment are used to collect member information regarding:

    - Physical and behavioral health history.
    - Preventive care.
    - Level of activity.
    - Medication use.

4. Care Team coordinates and arranges care for the member as needed.
5. An Individualized Care Plan is developed which includes care and support from health care providers, community agencies and service organizations.

Integrated Care Bridge overview

What is the Integrated Care Bridge (ICB)?

- A web-based care coordination platform that is accessible for members and providers that allows secure access to the member's care plan.
- Allows all members and participants of the Integrated Care Team (ICT) to access and update information when appropriate .
- Providers can access the ICB through the NaviNet portal and members may access the ICB through the Member portal both which are accessible on the AmeriHealth Caritas VIP Plus website.

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 Facility Transition Services

Member was hospitalized and admitted to inpatient Rehab for muscle weakness and pain. The member's discharge plan was to return home to live with her family again. During her time at the Nursing Facility, her mobility decreased, she was not ambulatory and required a 2 person Hoyer lift for transfers.

The Care Coordinator and the member made arrangements for a member centered planning meetings with the nursing facility staff, the member and her interested parties, the ICO Manager as well as the ICO Medical Director to discuss the member's desires and wishes for discharge and what needed to be in place to meet those discharge goals.

Through that meeting, her fiancé agreed to provide informal support, the granddaughter agreed to be a formal support, and 1 additional formal support from a vendor would provide additional supports for transfers. Through these 3 supports, the member would receive 3+ intervals of care and support each day. Additional services provided include Skilled Care (Nursing, PT and OT), DME (bed pan, bedside table, gel mattress pad, incontinence supplies, bedside commode, walker, bariatric hospital bed and lift chair). Member was also approved for wavier services and connected with a visiting physician. The Member was discharged home to her family and reports that she was thrilled to be home for the summer.

Success Story – Finding a Hard to Reach Member

A 69 year-old male member who was effective with our plan on 9/1/15, was determined to be “Unable to locate”. On 10/5/15 the member was found unresponsive covered in feces and urine, by EMS and was admitted to the hospital. His family indicated he had been missing since June of 2015. The member has a history of Schizophrenia and Methadone use. Member also had diagnoses of decubitus ulcer, arthritis, liver disease, hypertension, kidney failure, sepsis, and asthma. Member was transitioned to a nursing facility for rehabilitative services.

During this time our Care Coordinator (CC) worked with the member and the social worker at the nursing facility to make sure his needs were met. The member expressed interest in returning to the community to live, but the boarding house he lived in for 10 years had closed up and he knew he had a long road to recovery before he could live on his own again. After several years of recovery and with the assistance of the CC in finding him housing and some personal care services the member was able to move into an apartment on 2/15/18 to live independently again.

Success Story – Finding Extra Help for Members

- Member is an 80 year old Polish woman that does not speak English. Member is receiving personal care services, non-emergency transportation, and Personal Emergency Response System (PERS). The member's daughter said that the services have been invaluable to their family because they have improved her mother's quality of life and independence. She said that her mom has a Polish speaking caregiver that was assigned by the AAA. They are pleased with the AAA's vendor selection and ability to accommodate her mother's needs, especially her language. Family relationships have improved as the daughter can now be a daughter and not always a caregiver.

- Member was discussed in Interdisciplinary Care Team meeting, which included a representative from the local AAA, since she was to be discharged from a SNF. A CC and the AAA representative went to member's home on the day of discharge to complete a Level 2 assessment along with a transition of care assessment. The services that were recommended were PERS and Personal care services. The member had to be readmitted to the hospital because when she was reaching for her walker in the bathroom she fell and hit her head. She was able to press the PERS button to receive assistance. Her son says that if she did not have that PERS, she would have been lying there alone for a very long time. He is very grateful for assistance and the service.

Success Story – Finding Extra Help for Members

A member called into Member Services at 5:29 pm on a Friday stating that they were out of colostomy bags and would have nothing to carry them over the weekend. The DME provider was awaiting chart notes from the PCP's office (who was closed for the day). The Personal Care Connector (PCC) realized how urgent this situation was and instead of leaving the traditional message for the office to follow up with member on Monday or putting the work off on another department she consulted her lead and they sprang into action.

The lead agent called her manager's cell phone and the other PCC had the DME provider on another phone. Together they were all were able to come up with a temporary solution for the member. The manager gave authorization for the DME provider to supply one emergency bag with the promise that a Community Health Navigator (CHN) would go and personally have the records faxed to the DME provider on Monday. The member was able to secure supplies same day. Although the PCCs were scheduled to leave at 5:30 they stayed until the job was complete. The member was so very grateful for the two PCCs not just "pushing them to the side“.

Monday morning a CHN was assigned to work with member and the DME provider on a non-temporary solution. The CHN did fax records to the DME provider on Monday and made sure they received it. The CHN also ensured that the member obtain the needed supplies. The member was very relieved to have the supplies needed and pleased with timeliness of our response.

Success Story – Behavioral Health / Community Resources

Words from a member's mother:

As I sit thinking of the past 7 months, I must share our success story. My son (our member) was born with something called Symbrachydactly (Missing joints in his fingers and toes). Since birth, I advocated for services at school and home. Many times unsuccessfully. Most professionals viewed my son as lazy, not understand his condition. He has been involved many State programs and provided a social worker who was nice and friendly but, he still fell in-between the cracks.

However, when we received the card in the mail indicating we were selected for this Pilot Program my son was nervous, a he isn't comfortable with change. After many discussions and going back and forth with the previous State program I convinced him to give it a chance.

For years, my son and I have been frustrated with the lack of assistance we received to help him adjust and maintain a normal life. At one point he tried to commit suicide. He stopped bathing, taking his meds which caused him to be hospitalized monthly. He just gave up on life. In my opinion, most of it had to do with his sister and I suffering from an auto accident. Her back fractured. Both my legs broken, two piece in my spine, and my left foot shattered in more than 100 pieces. His words were "what would happen to me if you died". So, he sent a text message to his sister, myself and his favorite cousin saying "I'm sorry for being a burden, I love you and goodbye". Thank heavens whatever he tired was unsuccessful. So, he pushed through but my concern is, what would happen to my son if something happened to me?

Success Story – Behavioral Health / Community Resources cont.

In September 2016, we had the initial evaluation with the Care Team. My son was still uncertain. However, the Care Team seemed to understand his needs, listened to his concerns, and cared about his overall wellbeing. My son believes he isn't considered a number on a caseload. After every phone call and visit, we step away feeling respected and treated with dignity. My son stated as a disable person he doesn't want folks to look at him with pity.

Since his enrollment into the Program, his seizures and hair loss have decreased. He hasn't had issues with filling his medicine. He has a girlfriend who is actually his best friend. This was an issue in the past because no one would take the chance on dating him due to his health issues. He will start school in the fall of 2017 to start his GED classes. Last year his doctor shared news with us if my son does have brain surgery he could die. After soaking in those words, my son stated he would start living life to the fullest.

I can't express how much this program not only saved his life but mine as well. With my own health issues and having 12 surgeries I suffered from depression. Trying to meet his needs along with mine has been hard. I couldn't leave the house without him because at any moment he could have a seizure. I transport him to every appointment, sport practice, social event, clothing shopping, etc. My social life suffered due to his many health issues. He was issued a GPS monitor, equipment to assist with bathing and more supplies are being ordered. My son is smiling again. He cares about his health. He takes his meds as prescribed. His eating is poor but we're working with him to eating more veggies. **I'm forever grateful to this program and all the workers involved. This program saved our lives. Thank you the bottom of our hearts to the many people who work towards helping families and giving me my son back.**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