

# Model of Care

Provider Training



January 2021

# **WELCOME! THANKS FOR BEING A PART OF BRANDMAN HEALTH PLAN!**

EACH CMS C-SNP HEALTH PLAN HAS ITS OWN  
*MODEL OF CARE (MOC) TRAINING;*  
UNFORTUNATELY, COMPLETING TRAINING FOR ONE  
PLAN DOES NOT MEET COMPLIANCE FOR ANOTHER.

Frequency of Required Training: Initial then Annual



# Overview

- Why Brandman Health Plan (BHP)
- Goals & Objectives of BHP
- Chronic Condition Special Needs Plan (C-SNP)
- Model of Care (MOC)
  - Structure of Care
  - Interdisciplinary Care Team
  - Delivery of Coordinated Care



# Mission & Core Values

- To be a leader in advancing knowledge of senior wellness and health, and applying that knowledge to our members through the care, benefits and services we offer.
- Core Values:
  - Compassion
  - Integrity
  - Excellence
  - Collaboration
  - Service with a Sense of Urgency
  - Respect



# A Different Brand of Health Care

Enhanced benefits. Care with dignity.  
A trusted legacy.

That's the Brandman difference.



# Our Difference

- **Inclusive Care Approach:** We focus on helping to build better physical, mental, and emotional health for a happier, healthier member.
- **Inclusive Plan Options:** Our plan options include coverage under Medicare, Medi-Cal, and CSNP programs, *plus* additional benefits to help members find the right fit for their unique needs.
- **Inclusive Service and Support:** We provide multicultural and multi-lingual support, serving people from all walks of life with dignity and empathy.
- **Inclusive Network Coverage:** With a network of nearly 4,000 providers, it's convenient to find quality, compassionate care in the neighborhood



BHP provides Benefit Plans and Targeted Care Programs to Medicare-eligible individuals over 65 with one or more of these conditions:



### Brandman Aspire

Aspire is our plan formulated specifically to help those who suffer from dementia or other cognitive disorders.



### Brandman Arise

Arise encompasses care programs focused on helping those with diabetes, CHF, or cardiovascular disorders.



# Medicare with More

- Brandman offers our members many benefits in addition to those provided by Original Medicare—without extra premiums or out-of-pocket costs
- Our coordinated care programs help guide members with chronic conditions to the right care in the right order
- By bringing all of this together, we help our members get the most from their health coverage while enjoying a better care experience and improved outcomes and quality of life



# Supplemental Benefits

- Chiropractic Services
- Gym & Fitness Center Benefit
- Routine Transportation
- Acupuncture
- Meal Benefit
- Dental - Preventive & Comprehensive
- Hearing Exams/Hearing Aids
- Vision
- OTC Drug Program
- In-Home Safety Assessment
- Health Education and Wellness Classes
- 24/7 Nurse Advice Line
- Telehealth



# Example of Integration of Benefits

- Post-discharge from hospital, members can receive 5 days of meals three times a day
- Members with elevated BMI have access to membership at multiple fitness centers; for those that don't feel comfortable going to a gym, home fitness kits are available
- Undergoing hip/knee replacement surgery with concerns about safety and recovery with the new appliance; members can request for in-home safety assessment



# Network

- BHP will cover all of Los Angeles County
- IPAs
- Provider Directory
  - Over 4,000 providers will accept BHP
  - Additional providers for direct contracting
- Hospital contracts
- Ancillary contracts
  - VSP, Liberty Dental, Hearing Care Solutions



# Goals & Objectives

- Goal: Engage members with chronic conditions to take control of their health by participating in self-care management
  - BHP provides guidance and resources
- Improve access to affordable and preventable medical/mental health care, and social services
  - Improve member's self-management, independence, mobility and functional status



# Goals & Objectives – con't

- Promote coordinated care for members with special needs to improve health outcomes
  - Reduce hospitalizations and SNF placements
  - Improve pain management, quality of life as self-reported, satisfaction with health status and health services SNP
- Maximize transition and care across healthcare settings and providers
- Assure appropriate utilization of services and cost-effective service delivery



# Chronic Special Needs Plan (C-SNP)



- Arise: Diabetes, CHF, or Cardiovascular Disorders



- Aspire: Dementia or other Cognitive Disorders

# Model of Care (MOC)

- Per CMS, a MOC provides the basic framework under which the SNP will meet the unique needs of each of its enrollees through the plan's care management practices
- MOC is the foundation for promoting Continuity of Care through SNP quality, care management, and care coordination processes
- Delivery of Coordinated Care
  - Structure of Care Management and Systems
  - Specialized Benefits: Community Partnerships



# Structure of Care

- Interdisciplinary Care Team (ICT) – collaborative approach to care
  - Member/Member's Caregiver/ Family
  - PCP/Specialists (need based on member's specific disease and conditions)
  - Case Managers/Care Transition Nurse
  - Other designated providers/team members as needed (such as Social Worker, Pharmacist, Dietitian, Community Liaison, Community Based Providers, BHP's Medical Director, Home Health Nurse)



# Role of Member

- Members (and their caretaker/family members) are the center of the ICT
- In order manage chronic conditions, members must take control of their health by participating in self-care management
- Set and prioritize goals of care by participating in:
  - Health Risk Assessment (HRA)
  - Individualized Care Plans (ICP)
- Communicate with team when changes occur



**Brandman**  
**HEALTH PLAN**

# Role of Provider

- All practitioners must complete and maintain credentialing per Federal and State requirements
  - Specialists will be added to ICT per member's specific disease and conditions
- Collaborate and provide input to member's care with the ICT
  - Ensure timely preventative care is provided
  - Provide clinical and pharmacotherapy consultation
  - Attend ICT meetings



# Role of Provider – con't

- Assist with developing and updating ICP
  - Comprehensive approach to the management of the member's illness
  - Help member/caregiver make health care decisions that are in their best interest and is evidence-based
- Maintain BHP policy/procedures
  - MOC training annually after initial training
  - Transition of care protocols
  - Participate in Quality Improvement Initiatives



# Role of Case Management

- Case Managers (CM)
  - Lead point of contact
  - Coordinates/reassess care and resources to ensure alignment of member goals
  - Optimize member care in ambulatory setting
- Care Transition Nurse (CTN)
  - Manages movement of member from one care setting to another due to health status changes (planned or unplanned) to maximize recovery and avoid preventable transitions



# Health Risk Assessment (HRA)

- A health questionnaire that provides an overview of member's health risks and quality of life
  - Demographics
  - Medical/ behavioral health and psycho-social history
  - Environmental, Cognitive, and Functional status/ needs
- Ideally, HRA is to be completed within 30 days of initial enrollment, but no more than 90 days of enrollment. HRA is reassessed annually, or when there is a change in the member's condition
- Clinical review and stratification category of the HRA will be completed by a licensed staff member
- Results of the HRA are communicated to the member's provider



# Individualized Care Plan (ICP)

- Patient-Centered Approach
  - Establishing member prioritized goals
    - What is important **TO** the member and **FOR** the member
    - What does the member hope to achieve regarding their life and health; what are they worried about
- Collaborative approaches to health and care management which includes the PCP, family or member representative
- Identifying resources that might benefit the member, including recommendations for the appropriate level of care
- Established timeframes for ongoing evaluation of member's goals
- Planning for continuity of care, including assisting the member in making the transition from one care setting to another



# ICP – Potential Barriers/ Opportunities

- Medical conditions not being well managed
- Ineffective pain management
- Cognitive deficits (dementia, brain injury)
- Unable to meet financial obligations (rent, utilities, food)
- Unsafe housing, lack of social support
- Lack of knowledge to self-manage health; barriers to understanding the validity of the recommendation
- Lack of caregiver or family support
- Communication needs: language or sensory deficits
- Cultural or other beliefs interfere with prescribed treatment (herbs which interfere with medication efficacy)
- Member's age, frailty factor and poor quality of life (desire or lack of desire) for aggressive treatments



# Summary of Care

- Enroll member to BHP; Complete HRA
- Develop preliminary ICP based off HRA
- Assess for opportunities; refine ICP with ICT input
- Member Agreement with Care Plan
- Implementation of ICP
- Re-evaluation of ICP & Follow up

# Quality Improvement Program (QIP)

- Multi-disciplinary committee
- Measurable Goals/Metrics
- Data Collection
  - Includes grievances
- Analysis
- Evaluation
- Revise Goals, if applicable

~ More details on QIP to follow ~



# Chronic Care Improvement Program (CCIP)

- Beyond care coordination and overall management
- Designed to address limitations and barriers and respond to the complex health care needs of at-risk members
- Promotes effective chronic disease management and the improvement of care and health outcomes for enrollees
- Goals include:
  - Slowing disease progression
  - Preventing complications and development of comorbidities
  - Improving quality of life
  - Reducing preventable emergency room encounters and inpatient stays



# Chronic Care Improvement Program (CCIP)

- Metrics include, not limited to:
  - Diabetes: >80% of members will have A1C levels checked twice a year
  - CHF: >50% of members will participate in weekly weight measurement
  - HTN: >50% of members will monitor their blood pressure (BP) through weekly measurement
  - Dementia: 90% of members will be evaluated for fall risk, advanced life planning, high risk medication review annually



# Provider Attestation

## **Chronic Special Needs Plans (C-SNP) Model of Care Training Attestation**

I, \_\_\_\_\_, hereby attest that I have completed the Chronic Special Needs Plan (C-SNP) Model of Care Training.

I understand the Model of Care and the role in improving health outcomes for the vulnerable population. It is understood that the annual training is mandatory for all providers that care for C-SNP members and is required by the Centers for Medicare and Medicaid Services (CMS).

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

Physician Name \_\_\_\_\_ NPI \_\_\_\_\_

IPA Affiliation: \_\_\_\_\_

Please return completed attestation and provider signature list to:

Brandman Health Plan Provider Services Department

Email to [providerservices@brandmanhealthplan.com](mailto:providerservices@brandmanhealthplan.com)

or send via fax 818-609-2704



Questions/Comments/Input can be provided by  
emailing:

**[providerservices@brandmanhealthplan.com](mailto:providerservices@brandmanhealthplan.com)**

Thank you for successfully completing BHP's MOC training.  
Please submit your attestation to the email above.

