Chapter 10

Model of Care

The South Country Health Alliance Model of Care is our plan to address the unique needs of each member in AbilityCare (SNBC) and SeniorCare Complete (MSHO), our two fully integrated Medicare Advantage Special Needs Plans for individuals eligible for both Medicare and Medicaid.

About Our AbilityCare Members

AbilityCare members are eligible to voluntarily enroll with South Country if they are Medicare beneficiaries who are:

- Between the age eighteen (18) through age sixty-four (64);
- Eligible for Medicaid;
- Eligible for Medicare Part A and Part B;
- Residing within the South Country's Service Area (Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha, and Waseca Counties); *and*,
- Either be certified disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT) or a person with Developmental Disability (DD) or related conditions for the purpose of the DD waiver, as determined by the Local Agency.

The average age of our AbilityCare members is 50 years. Around 79% of our members enrolled in AbilityCare are between age 40-64. Approximately 59% of AbilityCare members reside in the community. On average members have:

- Four (4) chronic conditions
- Nine (9) primary care visits within a given year.
- Twenty-nine percent (29%) of the members were hospitalized within a given year.
- The top five (5) diagnosis for disease prevalence based on 2019 claims data are depression, anxiety disorder, hypertension, fibromyalgia, chronic pain and fatigue and hyperlipidemia.

About Our SeniorCare Complete Members

SeniorCare Complete members are eligible to voluntarily enroll with South Country if they are Medicare beneficiaries who are:

- Sixty-five (65) years of age or older; or
- Turning sixty-five (65) years of age within the month they are requesting SeniorCare Complete enrollment; and
- Eligibility for Medicaid and Medicare Parts A and B; *and*
- Reside within South Country's service area (Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha, and Waseca Counties)

Our SeniorCare Complete population is older when compared to the national averages based on the 2018 Cohort 21 Baseline Demographics for HOS. South Country has 44.6% of our membership ages 80+ compare to the national average of 23.9% being 80+. There are more

females enrolled in SeniorCare Complete compared to males with females making up around 70% of the membership. Approximately 59% of SeniorCare Complete members reside in the community. On average members have:

- Five (5) chronic conditions
- Six (6) primary care visits within a given year
- Thirty-eight percent (38%) of the members were hospitalized within a given year.

The top five (5) diagnosis for disease prevalence based on 2019 claims data are hypertension, arthritis (osteoarthritis and rheumatoid), depression, hyperlipidemia, and chronic kidney disease.

Care Coordination

Care Coordinators live and work in our members' communities and are experts in identifying and working with local providers and resources. This relationship significantly improves the member experience, streamlining the process of meeting the member's needs while emphasizing preventive care and reducing unnecessary use of health care resources.

Each member on SeniorCare Complete is assigned a county-based Care Coordinator. Some members enrolled and living in Freeborn, Dodge, Steele or Waseca have an internal Care Coordinator at South Country. Care Coordinators tasks include, but are not limited to:

- Conducting initial, annual, and periodic health assessments using an approved tool to learn about member's support and service needs.
    - It is expected that the face-to-face health risk assessment will be completed within thirty (30) days of enrollment and no more than 365 days after the previous health risk assessment for those who are continuously enrolled. The Health Risk Assessment tool is a guide to facilitate discussion with the member and the member's Interdisciplinary Care Team (their level of involvement is by member choice) about the member's strengths, goals, wishes, needs, health concerns, and choices about their life, housing, and services and supports needed to remain in and integrate into the community where they reside.
- Facilitating member access to specialists and therapies;
- Triaging member's care needs and wants with South Country staff, providers, primary care provider, and other participants on the member's the Interdisciplinary Care Team as needed;
- Advocating, informing, educating members, and creating a path for members to access South Country's services and benefits;
- Educating members on self-management techniques including good health care practices and behaviors which prevent putting the member's health at risk and working to keep members engaged in their own care;
- Facilitating the development, implementation, monitoring, and updating of the Individualized Care Plan built from information obtained in the health risk assessment, and distribution of the Individualized Care Plan for each member;
    - It is the expectation that the Care Coordinator utilizes that information learned through the health risk assessment process and during the health risk assessment visit/discussion to develop with the member an Individualized Care Plan that is person-centered and driven by what the member and/or authorized representative has voiced as goals, areas they want to work on, and what they want and need from formal and/or informal services and supports. It is expected that the Care Coordinator will include the member in the development of the

Individualized Care Plan and will finish and send it to the member to review and sign (if in agreement) within thirty (30) days of the health risk assessment. It is expected that the Care Coordinator will make updates to the Individualized Care Plan in a timely manner and send it out for review by the member any time there is a significant change to the member's health status or a change to the member's chosen services or provider.

- Communicating effectively and sharing the member's Individualized Care Plan (e.g., goals/services/wishes) with the member and the member's chosen Interdisciplinary Care Team;
- For SeniorCare Complete arranging and/or coordinating the provisions of managed long-term services and supports identified in the Individualized Care Plan including knowledgeable and skilled specialty services and prevention, early intervention, social supports, and all medically necessary services;
- Retrieving consultation and diagnostic reports from contracted specialists;
- Facilitating translation services for members through the South Country's contracted telephonic interpreter line or accessing contracted in-person interpreters as needed;
- Assisting the member or member's authorized representative, if applicable, to navigate the health care system, maximize informed choice of services and provides, and preserve member control over services and supports;
- Facilitating and coordinating all transitions of care as needed for each member including ensuring that the member has the right service, at the right time and from the correct provider; and that member choice is reflected regarding all changes in care setting;
- Following-up with member on Utilization Management activities such as hospitalization or Emergency Department used by member;
- Assisting with scheduling appointments for primary and preventive medical and dental care and follow-up services for each member; and
- Assisting the member as needed with transportation services to ensure members have timely and appropriate travel to and from appointments. who assists the member in selecting a primary care clinic or practitioner.

Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team in each member case acts as an important part of the Model of Care. The ICT is a collaborative group that may consist of South Country Health Alliance staff, Care Coordinators, Community Care Connector, authorized representatives, and providers. Some of the goals of the ICT include the following:

- Share member clinical information to ensure members receive appropriate and timely care.
- Share completed member care plans directly with providers to improve understanding of member preferences.
- Monitor transitions in care (e.g., emergency room visits, hospitalizations) to improve discharge planning, decrease length of stays, decrease readmissions, and improve the members' overall care.

At minimum the Care Coordinator communicates annually with the members primary care provider identified by the member.

Care Transition Protocols

Transition of care services are provided by the member's Care Coordinator when they move from one care setting to another due to a change in health status. Examples of care transition settings include: moving to/from home, acute care, skilled nursing facility, custodial nursing facility, regional treatment center, outpatient surgery, or rehabilitation facility. Any movement between settings of care is a separate transition including the member's transition back to their usual care setting. Proactive care coordination is provided to prevent transitions including unnecessary emergency room visits and hospitalizations and coordinating services for members at high risk of having a transition (e.g., falls, lack of preventive care, or poor chronic disease management).

The Care Coordinator is responsible for completing outreach to the most appropriate individual to assist the member through the transition this could include but not limited to: the member and/or the member's authorized representative, nursing home or residential service staff within one (1) business day of notification from South Country Health Alliance. South Country requires hospitals to notify South Country of an admission within one (1) business day. The protocol is South Country notifies the Community Care Connector (as South Country's liaison) located in the member's county of residence about a member hospitalization (admission and/or discharge). South Country sends this communication to the Community Care Connector through TruCare, our electronic care coordination documentation system. The Community Care Connector then forwards the transition information to the Care Coordinator working with that member.

The Care Coordinator is responsible for managing the member's transition as the member moves from care setting to care setting. As part of the care transition process, the Care Coordinator must communicate with the member's Primary Care Provider (for example, physician) to ensure that the Primary Care Provider is aware of the member's hospitalization and to discuss possible long-term change in health status and potential needed services or supports upon discharge including a possible change in medications.

The Care Coordinator must document all the tasks involved in the member's care transition process on the Transitions of Care (TOC) Log. The log helps guide the Care Coordinator to ensure that all care transition tasks are completed as directed by South Country and that Care Coordinators work directly with all applicable providers involved in the transition. The log is designed to ensure that when followed the member has optimal receipt of continuity of care and support throughout changes in care settings.

Provider Network

South Country has a comprehensive and geographically dispersed provider network created to meet the health and well-being needs of our members throughout our nine (9) participating counties. Our provider network consists of local community-based providers and state-wide health systems that include primary care, hospitals, behavioral health (including mental health and chemical dependency), specialty care, home care agencies, medical equipment and supplies, pharmacies, dentists, and non-emergency transportation.

Measurable Goals & Health Outcomes

Goal 1

Improve the ease of navigating the clinical and social system for the member and assure that the member has access to the right services at the right time from the right provider and that is affordable.

- Desired Outcome: To provide integrated care coordination and promote services accessibility including preventive health services and provide comprehensive

coordination of all services to meet the needs and wants of the member across the continuum: social services, public health, medical and other community services.

- Process: A health risk assessment will be completed, and an individual care plan will be developed collaboratively by the Care Coordinator and the member, if the member is willing, with the input from the members interdisciplinary care team.
- Measure 1: Percentage of members who have a completed initial health risk assessment within thirty (30) days of enrollment.
- Measure 2: Percentage of members who have an annual health risk assessment completed no more than 365 days from the previous health risk assessment
- Measure 3: Percentage of members who actively refused to participate in an initial health risk assessment within thirty (30) days of enrollment.
- Measure 4: Percentage of members who actively refused to participate in an annual health risk assessment no more than 365 days from the previous health risk assessment or no more than 365 days for the member's enrollment month.
- Measure 5: Percentage of members who are unable to be reached to participate in an initial health risk assessment within thirty (30) days of enrollment.
- Measure 6: Percentage of members who are unable to be reached to participate in an annual health risk assessment no more than 365 days from the previous health risk assessment or no more than 365 days for the member's enrollment month.
- Measure 7: Percentage of members who have developed, with the assistance of their Care Coordinator, an individual care plan within thirty (30) days of the completed health risk assessment.

Goal 2

Assure that members receive care and services from a system that is seamless for members across healthcare settings, providers, and health and social services.

- Desired Outcome: Members will experience seamless transitions of care across health care settings, providers, and health/social services
- Process: Care Coordinators will be notified regarding a health care event (i.e. hospitalization or nursing facility placement) for follow-up with the member or most appropriate individual to assist with the member through the transition.
- Measure 1: Percentage of members or appropriate individual to assist the member contacted within one (1) business day for follow-up by a Care Coordinator for a health care event when notified fourteen (14) days or less after the event.
- Measure 2: Percentage of members who discharge from a hospital and have a completed medication reconciliation within 30 days of discharge following HEDIS specifications for Mediation Reconciliation Post Discharge.
- Measure 3: (SeniorCare Complete Only) Percentage of members with an acute inpatient stay and observation stay followed by and unplanned acute readmission for any diagnosis within 30 days based on HEDIS specifications for Plan All Cause Readmissions.

Evaluation

To make sure that our Model of Care is a successful framework for the delivery of our integrated Medicare and Medical Assistance products, our model is evaluated through a Plan-Do-Act-

Check cycle. Results are documented and preserved as evidence of the effectiveness of the Model of Care and reviewed for opportunities to improve processes and strategy where needed.

Questions

If you have further questions, please contact South Country Health Alliance at 1-507-444-7770.