Welcome !

Dear Provider:

The Centers for Medicare and Medicaid Services (CMS) require Medicare organizations to provide annual Model of Care Annual Training to all participating practitioners in Medicare plans. Trillium Community Health Plan is committed to working with you to fulfill this CMS requirement.

Once the training is completed, please complete and submit the attestation form located at the end of the presentation. Attestation forms, to document your completion of the training, can be submitted via fax (541-434-1291) or email: TrilliumMoc@trilliumchp.com. Please remember to include all tax identification numbers (TINs) that you are representing when completing the attestation form.

Thank you for your participation. We look forward to a long and positive partnership in providing quality health care services and coverage. If you need additional information, please contact Patty Lane at 541-799-3364, or Alex McKenzie at 541-799-3291.

Thank you.

Medicare:

2016 Model of Care Training

January 2016

Model of Care Training

- This course is offered to meet the CMS regulatory requirements for Model of Care Training for our Special Needs Plans.
- It also ensures all employees and providers who work with our Special Needs Plan members have the specialized training this unique population requires.

Model of Care Training

- The Model of Care (MOC) is Trillium's documentation of the CMS directed plan for delivering coordinated care and case management to members with both Medicare and Medicaid.
- The Centers for Medicare and Medicaid (CMS) require all Trillium staff and contracted medical providers to receive basic training about the Trillium duals program Model of Care (MOC).
- This course will describe how Trillium and its contracted providers work together to successfully deliver the duals MOC program.

Model of Care Training

Trillium provides two programs for dual eligible members:

Dual Special Needs Plan (DSNP)

- Trillium Advantage Dual

Institutional Special Needs Plans (ISNP)

- Trillium Advantage TLC
- Trillium Advantage TLC Community

Training Objectives

Trillium Community Health Plan

After the training, attendees will be able to:

- Describe the basic components of the Trillium Model of Care (MOC)
- Explain how Trillium medical management staff coordinates care for dual eligible members
- Describe the essential role of providers in the implementation of the MOC program
- Explain the critical role of the provider as part of the MOC required Interdisciplinary Care Team (ICT)

SNP

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. CMS has defined three types of SNPs that serve the following types of members:

- Dually eligible members (D-SNP)
- Individuals with chronic conditions (C-SNP)
- Individuals who are institutionalized or eligible for nursing home care (I-SNP)

Health plans may contract with CMS for one or more programs.

SNP

- For D-SNP members, Medicare is always the primary payer and Medicaid is secondary payer.
- D-SNP members may have both Trillium Medicare and Trillium Medicaid but not always so it is important to verify coverage prior to servicing the member.

SNP

ISNP members must:

- Have Trillium Medicare but are not required to have a Medicaid plan.
- Be assessed as long term care eligible by state assessment with a service priority level of <13.
- Live within a contracted long term care facility for ISNP or in a community based care setting for ISNP/E.
- Agree to routine cadence of visitations by ISNP nurses and/or mid level practitioners.

What is the Model of Care?

Trillium Community Health Plan®

The Model of Care is Trillium's plan for delivering our integrated care management program for members with special needs. It is the architecture for care management policy, procedures, and operational systems.

Model of Care Goals

The goals of the MOC are to:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes

Model of Care

CMS re-organized the 11 MOC elements to 4 in 2014 to accomplish the following:

- Integrate the related elements
- Promote clarity and enhance the focus on care needs and activities
- Highlight the importance of care coordination
- Address care transitions as well as other aspects of care coordination, which were not explicitly captured in the 11 elements

Model of Care

The revised Model of Care elements are:

- Description of the SNP Population
- Care Coordination
- SNP Provider Network
- Quality Measurements & Performance Improvement

Model of Care Process

- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the members' medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Trillium case management program for follow up.

Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is developed with input from all parties involved in the member's care.

The Individualized Care plan includes:

- Goals and Objectives
- Specific services and benefits to be provided
- Measureable Outcomes

Individualized Care Plan (ICP)

- Members receive monitoring, service referrals, and condition specific education.
- Case Managers and PCPs work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP).

Trillium disseminates evidence-based clinical guidelines and conducts studies to:

  - Measure member outcomes
  - Monitor quality of care
  - Evaluate the effectiveness of the Model of Care (MOC)

Interdisciplinary Care Team (ICT)

- Trillium Case Managers coordinate the member's care with the Interdisciplinary Care Team (ICT) which includes appropriately involved Trillium staff, the member and their family/caregiver, external practitioners and vendors involved in the member's care based on the **member's preference** of who they wish to attend.
- Trillium Case Managers work with the member to encourage self-management of their condition as well as communicate the member's progress toward these goals to the other members of the ICT.

ICT and Inpatient Care

Trillium Community Health Plan

Trillium's Case Managers:

- Coordinate with facilities to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level
- Work with the facility and the member or the member's representative to develop a discharge plan
- Proactively identify members with potential for readmission and enroll them in case management

ICT and Inpatient Care

- Notify the PCP of the transition of care and anticipated discharge date and discharge plan of care
- Trillium staff manage transitions of care to ensure that members have appropriate follow-up care after a hospitalization or change in level of care to prevent re-admissions
- During an episode of illness, members may receive care in multiple settings often resulting in fragmented and poorly executed transitions

ICT and Transition of Care

Managing Transitions of Care interventions for all discharged members may include but not limited to:

- Face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan

ICT and Transition of Care

In-home visits or phone call within 1-2 days post discharge to evaluate member's:

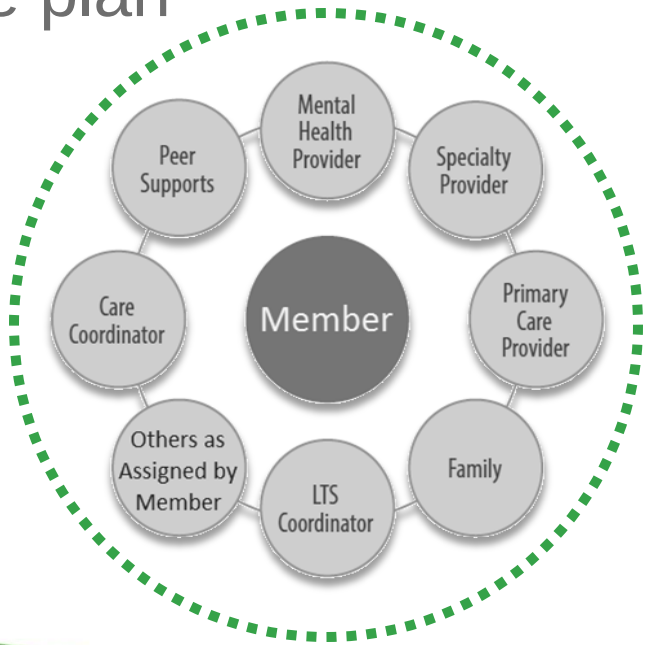
1. Understanding of their discharge plan
2. Understanding of their medication plan
3. Ensure follow up appointments have been made
4. Home situation supports the discharge plan

- Enrollment into the Case Management program
- Ongoing education of members to include preventive health strategies in order to maintain care in the least restrictive setting possible for their health care needs

ICT

Trillium's program is member centric with the PCP being the primary ICT point of contact.

- Trillium staff work with all members of the ICT in coordinating the plan of care for the member.



ICT Member Responsibilities

Trillium works with each member to:

1. Develop their personal goals and interventions for improving their health outcomes
2. Monitor implementation and barriers to compliance with the physician's plan of care
3. Identify/anticipate problems and act as the liaison between the member and their PCP
4. Identify Long Term Services and Supports (LTSS) needs and coordinate services as applicable

ICT Member Responsibilities

5. Coordinate care and services between the member's Medicare and Medicaid benefit
6. Educate members about their health conditions and medications and empower them to make good healthcare decisions
7. Prepare members/caregivers for their provider visits-utilize personal health record
8. Refer members to community resources as identified
9. Notify the member's physician of planned/unplanned transitions

Provider ICT Responsibilities

Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with:
- Trillium Case Managers
- Members of the Interdisciplinary Care Team (ICT)
- Members and caregivers

CMS Expectations for the ICT

CMS expects the following related to the ICT:

- All care is per member preference
- Family members and caregivers are included in health care decisions as the member desires
- There is continual communication between all members of the ICT regarding the member's plan of care
- All team meetings/communications are documented and stored

Provider Network

Trillium is responsible for maintaining a specialized provider network that corresponds to the needs of our members.

Trillium coordinates care and ensures that providers:

- Collaborate with the Interdisciplinary Care Team
- Provide clinical consultation
- Assist with developing and updating care plans
- Provide pharmacotherapy consultation

Provider Network

CMS expects Trillium to:

- Prioritize contracting with board-certified providers
- Monitor network providers to assure they use nationally recognized clinical practice guidelines when available
- Assure that network providers are licensed and competent through a formal credentialing process
- Document the process for linking members to services
- Coordinate the maintenance and sharing of member's health care information among providers and the ICT

CMS Expectations

- All team members are involved and informed in the coordination of care for the member
- All team members must be advised on the ICT program metrics and outcomes
- All internal and external ICT members are trained annually on the current Model of Care

Summary

Trillium values our partnership with our physicians and providers

The Model of Care requires all of us to work together to benefit our members by:

- Enhanced communication between members, physicians, providers and Trillium
- Interdisciplinary approach to the member's special needs
- Comprehensive coordination with all care partners
- Support for the member's preferences in the plan of care
- Reinforcement of the member's connection with their medical home

Attestation

Upon completion of the annual Model of Care training, please complete the attestation form.

I attest to completing the 2017 Model of Care training course.

Completion date: _____

Your name: _____

Your signature: _____

Your phone number: _____

Your email: _____

TIN(s): _____

Organization name: _____

Please remember to include all tax identification numbers (TINs) that you are representing when completing the attestation form.

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