SecurityHealth Plan℠

Security Health Plan of Wisconsin
D-SNP Model of Care
2023

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MOC 1: Description of the SNP Population

Through the D-SNP Model of Care (MOC), Security Health Plan will enroll and engage a complex population requiring multiple services, including primary medical care, long-term care services, medication therapy, preventive care, and other services designed to help the member live a healthy life.

The Security Health Plan (SHP) D-SNP Model of Care is the plan for delivering coordinated care and care management to the Medicare-Medicaid dual eligible population. The SHP D-SNP Model of Care provides the basic framework under which the D-SNP care management team will meet the needs of each of its enrolled members. The SHP D-SNP program model of care supports Security Health Plan's mission, vision and values: member centric care; trust through honesty, integrity and compassion for our members; teamwork; excellence through education and best practices delivering exceptional quality; and affordability to hold ourselves accountable as we manage resources and deliver value-based care.

The following are the fundamental values of Security Health Plan when serving D-SNP population:

- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across healthcare settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes

MOC 1: Element A: Description of Overall SNP Population

MOC 1: Element A: Factor 1: Describe how the health plan staff will determine, verify and track eligibility of SNP enrollees.

Enrollment verification and tracking:
Security Health Plan markets the D-SNP plan to full-dual eligible Medicaid and Medicare members currently enrolled in SHP Medicare Advantage plans. Security Health Plan also markets to full-dual eligible members utilizing its provider partners, the Aging and Disability Resource Centers and agent/broker. Any beneficiary who meets the eligibility requirements may enroll in SHP's D-SNP plan. (Attachment: Medicare Advantage – Eligibility and Applications Requirements)

Eligibility information:

- Entitled to Medicare benefits under Part A
- Enrolled in Medicare Part B
- Entitled to Full Medicaid Benefits from the State of Wisconsin
- And reside in the SHP service

area

Service Area:

- Barron, Chippewa, Clark, Eau Claire, Lincoln, Marathon, Oneida, Portage, Price, Rusk, Taylor, Wood counties in Central Wisconsin. (Attachment: D-SNP Map)

Upon application, Security Health Plan Enrollment Services verifies Medicaid eligibility using the state's online eligibility portal. Once Medicaid eligibility has been verified, Security Health Plan Enrollment Services continue processing the application following its normal Medicare enrollment procedures including:

- Service area verification validating county of residence for the SHP Service Area counties.
- Medicare eligibility verification using the Batch Eligibility Query (BEQ) into the MARx system.
- As of 01/01/2019, CMS changed the election period for Medicaid eligible beneficiaries. Beneficiaries no longer have a year-round special election period. These members have a Special Election period around the date they have a change in Medicaid benefits. If the member has no change to their Medicaid benefits, these members only have a once per quarter election period to make a change. Quarters available: January-March, April-June, July-September. Along with confirming the member's Medicaid eligibility, the availability of an election period for the member will also be validated. Submission is to CMS via MARx. MARx is the Medicare system that Enrollment uses to verify Medicare/plan information. Submission to CMS occurs via an electronic transmission file sent daily during the week.
- A monthly enrollment verification list is run by SHP Enrollment Services identifying Medicaid renewals. A review is completed by the D-SNP care management team to determine follow up needs with the member identified and/or member representative. (Attachment: DSNP Monthly Medicaid Reverification Process)

D-SNP Care Management team assists with the following:

- Member outreach is completed to assist with further enrollment needs and follow up. All outreaches are documented in the SHP electronic documentation system
- An alert is place in the SHP electronic documentation system to assist the D-SNP care management team in the identification of enrollment dates. Enrollment dates are updated as needed.
- If a member is on the Loss of Eligibility report, a letter is mailed from Enrollment Services stating that they may lose coverage in D-SNP/Ally Rx if renewal is not completed. The member has a two month grace period.
- During the two-month grace period, the D-SNP care management team continue outreach with the D-SNP member and/or representative to assist with their Medicaid renewal needs.
- Members have 60 days past the Medicaid Renewal Due date to complete the Medicaid Renewal and maintain Ally RX coverage. If the member is identified as not being eligible, the D-SNP care management team outreaches the SHP Sales department for continued outreach to the member to assist with selection of a different plan.

- The D-SNP Social Worker, RN Team Lead, D-SNP Manager have access to the Medicaid portal and track each D-SNP member's eligibility renewal date throughout their enrollment in the D-SNP program.
- The D-SNP care management team utilizes the SHP Enrollment Services Team Leader as a resource for member enrollment questions, MA renewal questions and eligibility as needed. SHP Customer Service assists with calls from members regarding enrollment and facilitates in referral calls to the D-SNP team to follow up with the member.

MOC 1: Element A: Factor 2: Describe the medical, social, cognitive and environmental factors, living conditions and comorbidities associated with the SNP population.

Security Health Plan Dual Special Needs Plan (D-SNP) enrolls members who are enrolled in both Medicare and full Medicaid benefits and reside within the SHP D-SNP county service area. SHP D-SNP serves diverse populations with complex cultural, medical, psych-social, cognitive, and socio-economic needs.
Security Health Plan (SHP) works to establish preventive assistance and improve overall population health status. Knowing the dual eligible population has a higher incidence of frailty and complex chronic conditions, Security Health Plan's program addresses not only specific medical conditions; it also looks at the impact of issues of social determinants of health (SDOH) such as isolation and lack of access to adequate nutrition, and barriers to care such as lack of transportation. SHP places a focus on populations with special health needs such as chronic conditions or severe and acute episodes of illness along with mental health needs that may be identified during interactions with the D-SNP member and/or representative during assessments and ongoing follow up.

The D-SNP program assists in the improvement of the health of our SHP members and enhance the quality of care while reducing costs. The D-SNP program has developed a comprehensive care model that incorporates the member's social, behavioral health and medical needs across the continuum of care. The SHP D-SNP program is a team based care management program including a registered nurse, social worker, and a community support specialist, with access to medical directors, pharmacist, primary care providers, health/wellness coaches and nurse navigators.

The D-SNP case management program assists with coordination of care and integration of the member's health care needs. Members are stratified according to their needs to assist the D-SNP team in communication, coordination of care, and creating an individualized care plan with the member to assist with their needs and quality of care. Stratification is assessed initially and ongoing while the member is engaged in the SHP D-SNP program. Coordination of care with changes in stratification identified are discussed with the specific D-SNP care management team (including providers, RN, Social Worker, Medical Directors, Pharmacist) to address changes, increased coordination and service needs. The D-SNP member plan of care is updated on an ongoing basis to identify barriers, increased needs, interventions, goals met, and changes.

D-SNP members identified during assessments and ongoing follow up with chronic conditions such as Heart Failure and COPD are referred to related programs for ongoing assistance with the

management of their chronic conditions. Gaps in Care (diabetic management, vaccinations, yearly exams) are assessed initially, annually and ongoing. Member gaps in care are identified and addressed with education and referrals for further management.

Security Health Plans membership is primarily Caucasian with the preferred spoken language of English. Some of the state of Wisconsin demographic, social, and environmental factors for this population include the following:

- State population 2022 is 5,867,518
- Medicare beneficiaries in Wisconsin is 1,130,066
- Medicaid beneficiaries in Wisconsin is 1,269,139
- 12.8% to 19.5% Medicaid population is dual-eligible in Wisconsin
- 17.5% of the Wisconsin population is >65 years of age
- 50.2% of the population are female
- 87% of the population are Caucasian
- 11.3% in poverty (591,486 in poverty)
- 10.1% with hunger and food insecurity (2019)
- 2.6% of the population has a less than 9th grade education
- 91.26% of the population speak only English

Reference: United States Census Bureau Quick Facts:
https://worldpopulationreview.com/states/wisconsin-population
https://www.medicaid.gov/state-overviews/scorecard/dual-eligible-enrollment/index.html
https://talkpoverty.org/state-year-report/wisconsin-2020-report/

The significance of these factors cannot be underestimated. Dual eligible account for a significant total of the total Medicaid and Medicare expenditure. Medicare costs in Wisconsin per enrollee in 2019 was $9,156.00. In 2019 Medicaid costs in Wisconsin was $8,436.00. Multiple factors drive spending and put the dual eligible population at risk. The lack of financial resources is complex. Poverty can affect and individual's ability to access adequate housing, nutritious food and transportation. Some of the factors include:

- Characteristics and health status
- Scope of benefits covered
- Mix of delivery systems, such as managed care and fee for service
- Local health care costs and market features
- Rural locations – transportation, medical facilities, housing, in-home assistance are all affected (D-SNP county percent of population below the poverty level-2019; SHP Population count 1/1/2020-12/31/21):

County	Poverty %	SHP D-SNP Member Population
Barron County	10.7%	28
Chippewa County	10.3%	95
Clark County	12.1%	102
Eau Claire County	13.8%	118
Lincoln County	9.0%	98
Marathon County	9.2%	306
Oneida County	7.9%	14
Portage County	12.1%	52
Price County	13.1%	56
Rusk County	12.1%	61
Taylor County	9.9%	63
Wood County	10.3%	251

Security Health Plan (SHP) – State of Wisconsin County Population Table

County	Population	Designation
Barron County	46,711	Noncore
Chippewa County	66,297	Small Metro
Clark County	34,659	Noncore
Eau Claire County	105,710	Small Metro
Lincoln County	28,415	Micropolitan
Marathon County	138,013	Small Metro
Oneida County	37,845	Noncore
Portage County	70,377	Micropolitan
Price County	14,054	Noncore
Rusk County	14,188	Noncore
Taylor County	19,913	Noncore
Wood County	74,207	Micropolitan

Sources: 2020
https://www.wisconsin-demographics.com/counties_by_population
https://www.kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html
https://fred.stlouisfed.org/release/tables?rid=416&eid=342620
https://worldpopulationreview.com/states/wisconsin-population

Clearly, there are many factors that affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. Factors such as demographics (race, age, gender), the circumstances of one's environment, income and

education level, access to health care services, and social supports all have considerable impacts on the status of an individual's physical and mental health.

The D-SNP service areas are rural in nature, with populations per square mile under the State of Wisconsin average. This, along with lack of public transportation outside of several urban areas such as Eau Claire and Wausau, suggest that transportation is an issue for this population.

For the most part, beneficiaries in the State of Wisconsin's Medicare and Medicaid health plans live in their own homes. Based on the geography of our D-SNP service area, there is a lack of public transportation. There are forty-five Aging and Disability Resource Centers (ADRC) and eleven Tribal Aging and Disability Resource Centers that serve all of Wisconsin's 72 counties. By proactively identifying the specific needs and characteristics of this D-SNP population, the program actively determines and addresses resource needs.

The D-SNP care management team outreaches the ADRC and community resources as identified to assist the member with transportation, housing, financial needs etc. Collaboration with community resources is essential in assisting the member in meeting their identified goals of care. Coordination of care takes place with D-SNP members identified as participating in any state funded programs (Family Care, IRIS), Home Health or Hospice. The Family Care Organizations are notified via email or fax of all members enrolled in the SHP D-SNP program on admission to the D-SNP program and with any transition of care on members that are participating in the Family Care programs.

https://www.dhs.wisconsin.gov/mh/county-services-dashboard.htm

Below is a listing of some of the Aging and Disability Resource Center services utilized by SHP enrollees: (Attachment: ADRC map)

Service	Description
Benefit Specialists	Help older adults with disabilities with questions and problems related to benefits such as Medicare, Medicaid, Social Security, Food Share and health
Tribal Aging and Disability Resources	Liaison between the tribe and member with aging and disability resources.
Dementia Care Specialists	Support individuals with dementia and their families to assist them to remain active and in their homes longer.
Pre-Admission Consultation	Counseling for decision support process for long-term care options.

Adult Long Term Functional Screening	Provide screening for functional status, health and need for assistance for various programs that serve the frail elderly with intellectual/developmental or physical disabilities.
Information and Assistance	Assist with determination of individual needs and consider what services and programs are available to meet the specific needs.
Community Based Classes	Health Educators providing classes on a variety of aging topics.
Elderly Nutrition Program	Senior Dining for individuals age 60 or older have provides access to community dining centers, meals.
Source: https://www.dhs.wisconsin.gov/aps/pros-shadow.htm	

Care coordination connects members to health and service programs. Social factors can be barriers to care and lead to compliance with gaps in care, medication compliance and their overall health care needs of the D-SNP member. Social factor obstacles identified with the D-SNP member may include getting out of the house, doing errands/shopping, going to church, family and friend visits. The D-SNP care management team identifies and assists with referrals to community activities, follow up on needs and communication with the member to address their needs, listening to their concerns and having consistent follow up to address these needs if an important factor in engaging with the D-SNP members along with assisting with their social needs. The D-SNP care management team utilizes a team approach to identify interventions to facilitate communication and coordination of care support to the D-SNP member and their families, wherever they are (at home or facilities).

The D-SNP care management team coordinates access to a range of health care services and providers, good communications and effective care plan transitions between providers, and a focus on total health care needs of the SHP D-SNP member with a clear and simple information that members can understand.

Members who live in skilled nursing facilities (SNF) generally require assistance with their care on a continuous basis. This care may include help with basic services including bathing, medication adherence, and other physician services. Members may also require ancillary services such as physical therapy, occupational therapy and speech therapy. SHP D-SNP care management team coordinates cares with SNF vendor partners for care coordination while D-SNP members are admitted to a SNF for short-term therapy needs and or medical needs.

Members in skilled nursing facilities generally have a greater sense of community with

shared dining services, fellowship and other activities to help the enrollee live a more social life, be more active in a safe environment and be more involved in their care. The D-SNP care management team coordinates and collaborates with the skilled nursing facility to assist in the management of the D-SNP member's care.

D-SNP care coordination also identifies members with cognitive impairments. Ongoing support and education of regular physical activity, a healthy diet, social activity and intellectual stimulation is provided to all D-SNP members that show cognitive decline. Referrals to local support groups for the member and/or family is important, especially for a caregiver to support and learn how to best assist the member with cognition concerns.

Support to the family, collaboration with a SNF facility on member cares, family involvement, and care conferences are facilitated by the D-SNP care management team. Member's cognitive needs are identified during initial/annual assessments and ongoing communication with the family and /or facility the member resides in. Appropriateness of where the member lives, quality of care, safety of the member are addressed also during the assessments and ongoing care. Members with increased transitions, hospitalizations, ED visits, and increased calls to providers all are indicators identified and assessed to recognize cognitive impairments with the member.

Collaboration includes attending care conferences with the skilled nursing facility, member and outside community resources and being an outside resource for family and member representatives. Management of the skilled nursing population is essential in identifying long-term care needs, transitions to and from the facilities, along with assisting with change, coping and coordination of care for the member.

MOC 1: Element A: Factor 3: Identify and describe medical and other health conditions impacting SNP enrollees.

In the United States, the diseases and conditions that currently take the largest toll in death, illness and disability are chronic diseases—such as cancer, heart disease and stroke, and diabetes. People with chronic conditions are the most frequent users of health care in the United States. Six in ten Americans live with at least one chronic disease. Chronic diseases also are costly to states, yet they are among the most preventable of health problems. Chronic diseases can be disabling and reduce a person's quality of life, especially if left undiagnosed or untreated. 90% of the nation's $3.8 trillion in annual health care expenditures are for people with chronic and mental health conditions.
Source:
https://www.cdc.gov/chronicdisease/about/costs/index.htm)

- Over 517,000 Wisconsin residents suffer from Diabetes. An estimated 9% of Wisconsin adults have diagnosed diabetes. Additionally, 34% have prediabetes, but the majority remain undiagnosed and unaware of their condition (National Diabetes Statistics Report, 2020).
- 15.5% of adults in Wisconsin smoke (https://www.tobaccofreekids.org/problem/toll-us/wisconsin)

- Annual health care costs in Wisconsin directly caused by smoking is $2.66 billion.
- An estimated 31% of Wisconsin adults have diagnosed hypertension. (Centers for Disease Control and Prevention)
- Estimated numbers of new cancer cases and deaths in 2021 (In 2021, there will be an estimated 1.9 million new cancer cases diagnosed and 608,570 cancer deaths in the United States.
- Leading causes of death in Wisconsin:
    1. Heart Disease
    2. Cancer
    3. Accidents
    4. Chronic Lower Respiratory Diseases
    5. Stroke
    6. Alzheimer's disease
    7. Diabetes
    8. Kidney Disease
    9. Suicide
    10. Influenza/Pneumonia

Overall - Population Chronic Conditions

Condition	United States (Population)	Wisconsin (Population)
Invasive Cancer	1.9 million	37,320
Asthma Prevalence	25 million	460,075
Serious Mental Illness in adults >18 years of age	14.2 million	200,00
Diabetes Prevalence	34.2 million	392,965
COPD Prevalence	16 million	251,000

https://www.rtor.org/directory/mental-health-wisconsin/
https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/WI

Security Health Plan's D-SNP care management processes are enhanced to ensure those members are aware of the community resources and programs that are available to reflect the current SHP member demographics. D-SNP member education, staff education on specific disease related resources, and gaps in care are identified to assist the D-SNP population in the management of their medical and other health conditions. Education materials are available for D-SNP members for specific chronic conditions identified, such as diabetes, COPD, and hypertension. Telemonitoring services are also available to D-SNP members to provide increased assistance with in-home management of their chronic conditions.
D-SNP members are also educated on utilizing the 24-hour nurse-line for healthcare questions and concerns. Tobacco cessation is assessed and discussed with D-SNP members. Wellness coaching is available to all D-SNP members, as well as nutrition and stress coaching.

D-SNP members actively case managed are identified daily as hospitalizations and skilled nursing facility admissions and discharges occur. Emergency room visits are identified per claims. The assigned D-SNP care management team reviews and discusses the identified areas of care, health concern, and gaps in care and update the individualized plan of care (ICP) as needed and as changes occur.

SHP D-SNP Population

Age/Gender

	Gender Code	
Age Range	F	M
21-25	2	
26-30		6
31-35	2	6
36-40	7	11
41-50	25	27
51-60	60	52
61-70	180	129
71-80	194	89
81-90	197	101
91+	161	37

Race Description

Race Desc	
WHITE	1,207
ASIAN	8
NO ETHNICITY	6
AMERICAN INDIAN	4
BLACK OR AFRICAN AMERICAN	4
OTHER	4
UNKNOWN	2
ASIAN INDIAN	1
MULTI-RACIAL	1

A potential barrier to a D-SNP member with an average age of 81-90 years of age is understanding benefits, enrollment/engagement in the program, services available and/or covered and recent changes in the overall healthcare crisis related to the COVID pandemic. The D-SNP care management team is available to assist with benefit and claim questions. The SHP claims and enrollment departments assist with clarifications to questions and concerns the D-SNP members have. The D-SNP team is able to utilize the other departments within SHP to assist the members and address their questions and concerns. Members have the option to utilize the D-SNP opt out line to contact the D-SNP care management team also, as a direct contact to their team.

Security Health Plan Population by Disabilities

Members with hearing or vision disabilities are at increased risk for poor health outcomes. In order to determine the prevalence of these disabilities in our population, an internal business report was reviewed to identify those members whose demographics data indicated they have a hearing and/or vision disability. The findings are shown below:

Disability	Number of Members	SHP Medicare %
Hearing Impairment – H91.90	5,325	73%
Deaf – H91.3	4.936	79%
Blindness & Low Vision – H54	2,063	78%
Vision – H54 & Hearing – H91	7,241	75%

Security Health Plan accommodates these members' vision/hearing needs upon request via TTY interaction and large print or braille documents.

SHP D-SNP population Chronic Disease prevalence

	Chronic Disease	Population	Prevalence
1	I10 Essential (primary) hypertension	662	73.0%
2	E78 Disorders of lipoprotein metabolism and other lipidemias	645	71.1%
3	K21 Gastro-esophageal reflux disease	426	47.0%
4	G89 Pain, not elsewhere classified	380	41.9%
5	F41 Other anxiety disorders	354	39.0%
6	E11 Type 2 diabetes mellitus	349	38.5%
7	E66 Overweight and obesity	342	37.7%
8	F32 Major depressive disorder, single episode	330	36.4%
9	M19 Other and unspecified osteoarthritis	322	35.5%
10	I25 Chronic ischemic heart disease	283	31.2%
11	G47 Sleep disorders	272	30.0%
12	H25 Age-related cataract	259	28.6%
13	N18 Chronic kidney disease (CKD)	251	27.7%
14	I50 Heart failure	246	27.1%
15	E03 Other hypothyroidism	240	26.5%
16	J44 Other chronic obstructive pulmonary disease	231	25.5%
17	M81 Osteoporosis without current pathological fracture	207	22.8%
18	R32 Unspecified urinary incontinence	190	20.9%

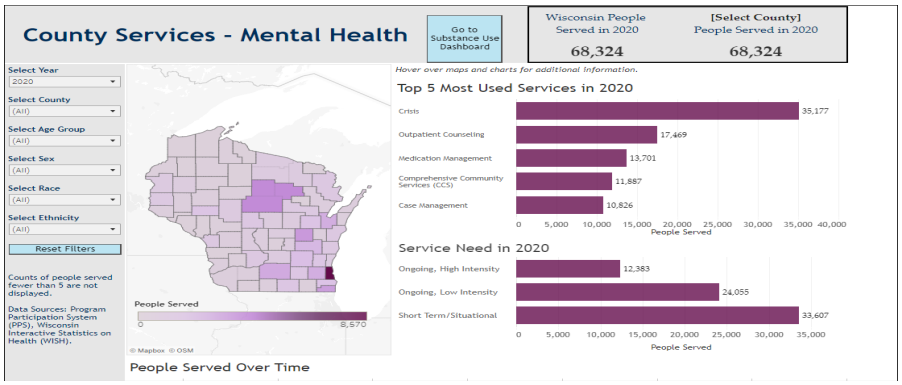
Effective care coordination for D-SNP members focuses on patient centered care and a patient centered process. D-SNP members and families that are knowledgeable about their care and have the needed resources available to make healthcare decisions will have improved health and wellness outcomes. This includes identifying D-SNP members with chronic conditions, specific disease condition education needs, medication management and compliance needs. Health education materials are available to the D-SNP members, along with targeted outreach

to the members for f/u. The D-SNP team utilizes Healthwise education materials for ongoing member education and to support member's better management of their chronic conditions. Care collections within the Healthwise system assist the D-SNP care management team in creating a specialized education packet for the D-SNP member. Identification of barriers, areas of health needs can be identified during assessments and education packets can be created to assist the member in management of these needs. For example, a member with hypertension may receive education materials including Recognizing signs/symptoms, Medication treatment, and Exercise and diet. (Attachment: Healthwise Hypertension)

Per claims data, the average length of stay for an inpatient stay for a D-SNP member is 5.6 days. Readmission rate for the SHP D-SNP population is 15.2%. ER utilization, hospitalization and SNF admissions are monitored daily by the D-SNP care management team. D-SNP members receive education on preventive care and recommended follow-up for diagnosed chronic conditions, identified barriers to understanding their role in the treatment of their conditions including poor health literacy and poor memory. Challenges encountered regarding addressing health needs within the SHP population vary between counties within the service area. Transportation and community resources related to the rural population are a barrier.
(Attachment: DSNP Readmissions)

Security Health Plan staff have access to a language line for interpreters in a comprehensive list of languages, along with the ability to print educational materials in requested languages. Annual training is provided to staff informing them how to access these services. Additional training is also completed within Security Health Plans case management team regarding health literacy.
Racial and cultural beliefs influencing health care, preferred language, English proficiency, and health literacy are assessed as part of the general assessment when members engage in case management services.

For those with chronic disease, the impact has been particularly profound. Heart disease, diabetes, cancer; chronic obstructive pulmonary disease, chronic kidney disease, and obesity are all conditions that increase the risk for severe illness from COVID-19. Other factors, including smoking and pregnancy, also increase the risk. In addition to COVID-19–related deaths since February 1, 2020, an increase in deaths has been observed among people with dementia, circulatory diseases, and diabetes among other causes.
(https://www.cdc.gov/pcd/issues/2021/21_0086.htm)



Source: Wisconsin Behavioral Risk Factor Survey, 2019

To best assist D-SNP members who may be struggling with behavioral health challenges, the D-SNP care management team monitors member identified needs, provides support and advocacy for the members who are in need of behavioral health treatment. The D-SNP care management team works with the behavioral health providers for assistance with member appointments and outpatient counselling needs. Long wait times to see behavioral health providers for follow-up and treatment can be a challenge. Provider access and availability issues are discussed during meetings and the stakeholders work on a plan to address the needs identified. The D-SNP care management team maintains communication with the behavioral health providers, discuss potential barriers to services, and review barriers during interdisciplinary team meetings for plans to assist the member. SHP Network Management is updated on barriers to provider access. The D-SNP care management team also works with provider integrated care coordination teams for specific identified behavioral health follow up, such as for depression.

Being a very rural state, the connection to local resources and medical providers can be difficult. Security Health Plan has built a care management system to serve the D-SNP population. Our D-SNP provides full integration of Medicare Part A, B, and D benefits, which provides members with significant benefits, such as:

- Seamless administration and coordination of all covered services, including prescription drug coverage
- Seamless care coordination of all covered services
- Integrated materials that describe benefits, services, and processes
- Seamless claims processing
- Collaboration of home and community based services
- Collaboration of local resources

Our Model of Care connects the full spectrum of services through a network of quality health providers, use of Nurse Navigators, D-SNP care management team and coordination of plan and community based services to deliver the most appropriate care in the least restrictive setting for each individual in a cost effective manner.

MOC 1: Element A: Factor 4: Define unique characteristics of the SNP population served.

SHP D-SNP carefully considers the social, psychological, and environmental needs of its D-SNP members as part of its evaluation of its population. Evaluation of care management needs encompasses the entire scope of its members' needs. The description below includes limitations and barriers that pose potential challenges for SHP D-SNP members, all of whom are dually eligible for Medicare and full Medicaid, and most of whom have conditions that require long-term care services.

SHP D-SNP's population tends to have challenges that include the following: lack of financial resources, lack of caregiver/family support, knowledge deficit related to navigating the health care system, unstable home environments, access to care issues because of lack of transportation, variations in education and literacy levels, multiple medical conditions and issues with activities of daily living. SHP D-SNP program ensures its MOC takes these obstacles into account when coordinating and managing care for its members.

Our Model of Care covers the full spectrum of services through a robust network of primary, specialty care, behavioral health, along with Care Managers who have prior work experience with both the community enrollees as well as institutionalized enrollees. The individualized care team develops an individualized care plan, which targets the enrollee's specific strengths and opportunities, as well as goals, problems and interventions developed to develop care in the least restrictive setting possible for the enrollees.

Living Environment

From its experience, SHP D-SNP understands how its members' living environment can act as a barrier to care and therefore the home environment must be understood in order to fully gauge members' needs, particularly within the rural counties within Wisconsin. For example, if SHP D-SNP program learns of a member being discharged from the hospital following a leg fracture and understands that member resides on the third floor of a walk-up apartment, it can provide support to assist the member with learning how to climb stairs with crutches or a cast or authorize additional home care services and/or additional resources for in home assistance.

Socioeconomics/ Health literacy (Language/Education)

Members are likely to live in poverty and otherwise lack resources to assist them in navigating the health care system. This may be a point of confusion for members in the event they do not understand how to navigate Medicare and Medicaid. Additionally, although members may be eligible for covered benefits under our plan, they may not understand these benefits are available or may misunderstand their coverage, creating a barrier. Reduced education and literacy rates among SHP's population create an additional barrier, leaving beneficiaries potentially vulnerable. SHP D-SNP care

management team considers these factors during the care management process, explaining benefits in the spoken language or in terms, members can understand, in order to improve access to care and improve health outcomes (described further in MOC 2).

The SHP population data demonstrates that the D-SNP population is anticipated to be primarily:

- Female
- > 65 years of age
- Primary language is English
- Race - Caucasian
- Live in a rural community
- Lower level of poverty
- The likely primary medical diagnoses for the D-SNP population are:
  1. Hypertension
  2. Hyperlipidemia
  3. Diabetes
  4. Anxiety/Depression
  5. Pain

In addition to multiple co-morbidities, members are faced with challenges resulting from socioeconomic and environmental factors. Additional conditions such as multiple co-morbidities, mental health issues, lack of financial resources, cultural factors, health literacy challenges and poor family/social support affect the ability of these members to successfully self-manage their chronic conditions. The goal of the D-SNP care management program is to support the member through coordination of care, teaching of self-management techniques, mitigating barriers to accessing care and community resource referrals. End-of-life issues are addressed through discussions with Care Managers regarding Advance Directives. Members requiring end-of-life care may be referred to a community-based Palliative Care program or hospice agency of the member's choosing.

The Program and Partnerships developed throughout the care of the enrollees are aimed at developing a system which is:

- **Person driven** – designed to give enrollees the opportunity to decide where and with whom they want to live and have some control of the services which are being delivered and by whom. Enrollees enrolled have the right to volunteer or work to earn money to gain a sense of self-worth all while including friends and family who can help them be integrated into the community.
- **Inclusive** – the D-SNP care management team works with the enrollee to create an environment, which encourages and supports enrollees to live where they want with access to a full array of quality services and supports in the community. This includes working with community resources and state run community programs.
- **Effective and Accountable** – Security Health Plan spends considerable time to ensure that services are of high quality, that are aimed at improving the quality of life of the enrollee. It is essential to ensure that there is a sense of accountability and

responsibility between Security Health Plan and public and private local resources to ensure that enrollees are part of the planning process for their care long term.

- **Sustainable and efficient** – the coordination of services that are funded contracted correctly and fairly is critical to the success of a program designed to meet the needs of the enrollee in a cost effective manner.
- **Coordinated and Transparent** – Security Health Plan strives to provide a seamless package of care coordination, taking into account the use of health information technology to provide transparent information to enrollees, providers and the payer sources.
- **Culturally Competent** – Security Health Plan takes cultural competency considerations in the highest regard ensuring that enrollee's cultural and linguistic needs are met.

The ability to develop a robust base of home and community based service, while promoting community inclusion and ensuring quality and efficiency is all part of Security Health Plan's approach to providing comprehensive, holistic and person centered care which allows the network of providers, supportive services to be flexible and individualized to meet the specific needs of the enrollee—regardless of living placement.
(Attachment: Services available per county)

- **Prescription drugs:** pharmacy benefits, medication therapy management (MTM) –SHP provides services to all eligible members in the specific counties, MTM services are contracted with pharmacies in all counties to provide medication reconciliation
- **Home Health**
- **Hospice Care**
- **Care Management** – Care Management is provided to all members eligible in the counties listed. Marshfield Clinic providers, Aspirus providers have care management services available to enrollees also.
- **Transportation:** The following are covered services provided by Medicaid. The State of Wisconsin's non-emergency medical transportation manager is Veyo, Inc. This company arranges for eligible Medicaid members throughout the state to their covered preventative and life sustaining medical appointments. Veyo provides:

    1. *Purpose.* Transportation by ambulance, specialized medical vehicle (SMV) or county-approved or tribe-approved common carrier as defined under par, is a covered service when provided to a recipient in accordance with this section.
    2. *Transport by ambulance.* Ambulance transportation shall be a covered service if the recipient is suffering from an illness or injury that contraindicates transportation by other means, but only when provided:
        a. For emergency care, when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition:
            i. From the recipient's residence or the site of an illness or accident to a hospital, physician's office, or emergency care center;
            ii. From a nursing home to a hospital;
            iii. From a hospital to another hospital; and
        b. For non-emergency care when authorized by a physician, physician assistant, nurse midwife or nurse practitioner by written documentation which states the

specific medical problem requiring the non-emergency ambulance transport:

i. From a hospital or nursing home to the recipient's residence;
ii. From a hospital to a nursing home;
iii. From a nursing home to another nursing home, a hospital, a hospice care facility, or a dialysis center; or
iv. From a recipient's residence or nursing home to a hospital or a physician's or dentist's office, if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnosis or treatment that cannot be obtained in the nursing home or recipient's residence.

- **Rehab services:** provided by affiliated providers within the SHP network
- **Psychiatric services**
- **Therapy (OT, PT, SLP):** provided by affiliated providers within the SHP network
- **Pharmacy services:** provided by affiliated providers within the SHP network
- **Community Wellness:** ADRC in specific counties
- **Palliative Care**
- **Community Resources**
- **Advance Care Planning**
- **Behavioral Health Care Management**: provided to all eligible members

The D-SNP member population has higher utilizations costs, higher hospital admissions, more complex health care needs and socioeconomic need. These members are in need of long-term care support, activities of daily living management, chronic condition management, housing, transportation, nutrition and self-care. These characteristics describe the challenges encountered.

The D-SNP care management team outreach community providers and resources to coordinate benefits and services, along with engaging community partners and providers in the development of plans of care to ensure the member's entire care team is working with the D-SNP member on similar goals.

Goals and care plans are developed with the member and/representative to focus on maintaining or improving current health status. Goals for independent living without support are developed. The D-SNP program is reviewed annually to identify opportunities for improvements and recommendations for the current program.

MOC 1: Element B: Subpopulation – Most Vulnerable Beneficiaries

MOC 1: Element B: Factor 1: Define and identify the most vulnerable enrollees within the SNP population, detailing the process for identification.

SHP D-SNP program targets solutions to the physical, mental, long-term, and psychosocial needs of those members defined as the most vulnerable subpopulation. The most vulnerable members are those whose needs exceed those of the general D-SNP membership, and for whom intense

care coordination and care management activities are most likely to have the most benefit.

The sources used to identify the most vulnerable population include but are not limited to: health risk assessment, claims, and referral information from internal resources, enrollment data indicators of eligibility due to disability, other assessment tools, predictive modeling outputs (HBI), pharmacy utilization data, hospital/ER/SNF census reports, and risk stratification reports. In addition to the data sources above, members in each of the most vulnerable categories may also be identified utilizing community partners/agencies and the provider network. Since these members are SHP D-SNP program enrollees, other clinical assessments provide a more holistic view of the member allowing for a comprehensive care management approach.

Claims data is presumed to underreport the prevalence of Social Determinants of Health (SDOH) needs because providers may not ask members about or members may not admit to or volunteer SDOH needs or, if needs are identified, the claims submitted may not include the needed coding for SDOH identification. Therefore, Security Health Plan works closely with its provider partners, encouraging them to refer patients to Security Health Plan case management should they identify SDOH concerns in our member population. Case management staff screen for social determinant of health needs as part of the initial and annual assessments. Past experience has shown that some members with SDOH needs are difficult to contact or keep in contact with because they lack a permanent address or have changed phone numbers or lack of phone numbers for outreach.

Current and new system and community resources for addressing SDOH needs are regularly reviewed, discussed, and shared among case management staff as service providers and availability are always changing. Security Health Plan has recently partnered with NowPow, a community referral platform designed to connect people to the right community resources, offering the case management team additional access to resources for addressing SDOH needs.

Older adults moving between healthcare settings are vulnerable to receiving fragmented and unsafe care when transitions occur. The D-SNP care management team receives notification daily of admissions and discharges from hospitalizations, outpatient surgeries and observation stays. Emergency Room visits are identified via claim review and daily reports that go directly to the D-SNP care management team working with the member. SHP D-SNP case managers work closely with our SNF partner for members admitted with short-term health care needs resulting in a SNF stay. Our SNF partner identifies members with high risk for readmission after SNF discharge, need for continued complex case management needs post SNF discharge, D-SNP members not meeting criteria for SNF admit and discharging home and members leaving AMA. Members identified with the following diagnosis discharging from a SNF have been identified as high risk for readmission to SNF and/or the hospital:

- UTI/Sepsis
- Heart Failure
- MI
- Diabetes
- Falls/prior fractures

The SNF information is sent via a continuity of care form to the D-SNP care management team. The D-SNP care management team follows up with the D-SNP member for further assessment, resources, PCP follow up and identified health care concerns after SNF discharge. The coordination of care with outside resources assists in the overall prevention of potentially readmission to the hospital, continuity of care and preventing unmet health care needs upon discharge. (Attachment: SNF Continuity of Care form)

The most vulnerable members are those that meet the D-SNP criteria and, based on the criteria below, will most likely need additional resources. The most vulnerable members are identified via the results of a health risk assessment tool (HRAT), discharge planning assessment, transitions assessment, and ongoing outreach. The HRAT assesses members on a number of factors including but not limited to SDOH, mental, physical, functional, cognitive status.

A member is stratified as High, Medium or Low risk. A member is stratified as high risk based on:

- Multiple high risk or co-morbidity chronic conditions
- Limited or no social support and resources
- High risk nutrition issues
- Need for medication management for multiple medications/non-compliance
- Environment with high risk safety or accessibility issues
- Social determinants of health

Members in each of the most vulnerable categories are identified as follows:

- Risk for potential high cost – diagnosis
- Risk for high utilization/hospitalization/ER – readmission
    1. HBI Solutions is a predictive risk model which calculate patient risk based on selected data features from machine learning. The risk scores are viewed in dashboards and patient lists that enable the population to be filtered based on risk and/or specific attributes such as acute and chronic conditions. The tool identifies chronic disease count, top 10 chronic diseases, and top 10 primary diagnosis. Other factors included are SDOH and other factors influencing health of the members.
- There are a few dashboard tiles specific to Acute and Chronic Conditions. This section defines those tiles.
    2. **Condition Risk**
        a. This tile on the Population Risk Management dashboard provides an aggregate view of risk distribution for the selected population from Low to Present. The definition of “Present” for each risk model is provided below. Members of the population with Low – Very High risk for the condition, by default do not have the condition as evidenced by the lack of the defined diagnosis codes within their clinical data set.
    3. **Chronic Disease Count**
        a. This tile on the Population Risk Management dashboard provides the aggregate distribution of members with documented chronic conditions – No Chronic Condition, Single Chronic Condition, or Multiple Chronic Conditions. This is not limited to Primary diagnoses but include all chronic

conditions. Conditions are classified as chronic if the AHRQ chronic disease indicator.

4. **Chronic Disease (Top 10)**
    a. This Population Risk Management dashboard tile provides the Top 10, Top 20, Top 50, or All Chronic Diseases for the selected population. These are chronic diseases documented for any encounter type, and again is not limited only to primary diagnoses and is included as chronic when the AHRQ Chronic Disease Indicator=1.
5. **Primary Diagnosis Group (Top 10)**
    a. This Transition Risk Management dashboard tile provides the Top 10, Top 20, or Top 50 primary diagnoses associated with the discharges of the selected population. This tile is only available when the Encounter Status is Discharged. These may be acute or chronic conditions.
    b. Individual Profile
    c. Clinical Summary
    d. Chronic Disease Conditions
    e. Chronic disease conditions coded as an ICD10 within the last 24 months where the AHRQ chronic condition indicator=1 within the ICD-10 code ranges defined below.

6. **Acute Disease Conditions**

    a. Acute disease conditions coded as an ICD10 within the last 12 months where the AHRQ chronic condition indicator+0 with the ICD10 code ranges.

7. **Encounter History**
    a. The encounter history includes the primary diagnosis and primary procedure when available. (Attachment: Member Risk Dashboard-example)

Using available data sources, SHP has identified its most vulnerable populations as those members who have:

- High risk for readmission within 30 days of discharge from a facility
- Potential for high cost related to high cost
- Potential for high risk related to utilization, hospitalization and emergency room

Re-hospitalizations are costly, potentially harmful, and often avoidable. Evidence suggests that the rate of avoidable re-hospitalizations can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management. Studies have consistently demonstrated that specific characteristics correlate to high predictive risk of readmission in the Medicare population.

SHP's D-SNP robust program targets its members at greatest risk of readmission, includes the following elements:

- Using inpatient utilization data, ED utilization data, HBI predictive modeling designed to predict readmission risk using a scoring algorithm that assesses the likelihood of readmission based on length of stay of the current admission, the acuity of that admission, comorbid conditions, and the number of ED visits.

- A Post-Discharge Assessment of readmission risk conducted within two – five days of notification of discharge: A Care Manager reviews history, claims, medications, etc. and then outreaches the member to conduct a comprehensive, care transition assessment. The assessment includes topics related to scheduling of and need for transportation to follow up appointments, review of medication changes and an assessment of adherence, the member's general perception of health and their ability to manage ADLs, including meal preparation, follow up on services required upon discharge, including DME, rehabilitative therapies and wound care, and the PHQ-2 depression screening as needed.
- Care planning: Responses to the comprehensive care transitions assessment are used to create/update the care plan with opportunities goals, and interventions, which may include referrals to health care providers or community partners/agencies and/or deployment of in-home care transitions services to the member's home.

As the Care Management process is unique for every member and changes with a member's needs, we have included a case study to walk through an example of how we would approach a vulnerable member. (Attachment: Member Case Example)

Interventions:

- SHP's utilization review care management and care management staff actively collaborate with the hospital discharge planning staff to affect a safe and comprehensive discharge plan. This includes authorizing necessary services or equipment, so they are available at the time of discharge. The staff coordinates with the Care Managers that are responsible for care transition care delivery. Updates are given to the discharge planners and/or care managers of member needs identified at home, potential barriers identified upon discharge and potential discharge needs. Members enrolled with a Medicaid MCO are notified of the member hospitalization with 5 days of the D-SNP care management notification of the hospitalization. Coordination between the MCO and D-SNP takes place to assist in a safe discharge plan for the D-SNP member.
- SHP D-SNP care management team utilizes a discharge planning assessment to assist with identifying discharge needs while the D-SNP member is in the hospital. Following discharge, a transition assessment is completed with the member and/or representative to target member needs and interventions. The transition assessment focuses on improving care; safety in the home; PCP follow up and ongoing outreach; medication adherence; condition management; reduced hospitalizations and ongoing self-management
- Care Manager works with each member and their family caregivers to monitor and respond quickly to worsening symptoms. To further assist patients and family caregivers to understand early symptom recognition, providers consistently ask them to identify factors that contribute to exacerbations of chronic conditions. Guided by individual patient goals and unique learning styles and preferences, the Care Managers utilize multiple teaching strategies and tools, including coaching, modeling, and the use of teach-back.
- The Care Manager encourages consensus about plans of care among older adults, family caregivers, and members of the care team. Outreach to all involved physicians (e.g., primary care, specialists, hospitalists) and other team members in various settings (e.g., nurses, social workers, pharmacists, physical therapists, staff in skilled nursing facilities

and community-based organizations) is important to achieve shared understanding of patient goals and care plans. This multidisciplinary approach streamlines plans of care, decreases burden on patients and family caregivers to coordinate care and contributes to enhanced outcomes.

- Enhanced communication occurs along the care continuum, including retrospective case reviews for root cause analysis, when readmission occurs.
- Transition care may also include transition from hospital to home; home to an assisted living facility. Coordination with the facilities, med management, safety, physical needs are identified with the transition. The D-SNP care management team coordinates with the facility for ongoing outreach and management needs of the member. D-SNP social worker care manager may assist with the coping and stress of the change and family support during the transition. PHQ9 is assessed as identified needs arise.

The D-SNP care management team identifies the D-SNP population at risk. Monthly reports are run within SHP's care management system that identifies D-SNP members that are high risk/potential risk based on age, diagnosis, ER/hospital utilization. The D-SNP care management team are alerted, review and follow up with the identified members to discuss next steps in assisting in their healthcare management. A member dashboard is utilized in the ongoing care management of the member that identifies medical costs, outpatient visits, ER visits, inpatient visits and risk. (Attachment: Member dashboard).

The goal is to improve the care and quality of life for those living with chronic conditions. Using the member dashboard, the D-SNP care management team is able to identify risk for readmission based on outpatient visits, medications, ER visits, claims. The care management team is able to formulate a plan with the member, provider for ongoing support and education to decrease the risk, identify need for education in the home (home health referral). The D-SNP care management team provides education and coaching for members to improve their understanding of their condition and possible actions/steps to achieve better outcomes.

The D-SNP care management team supports members to seek medical care. Members are supported throughout the entire spectrum of care, including Wellness, Behavioral Health, Transition Care and Complex case management. The prevalence of identified barriers such as chronic condition, poverty status, education, cognition and place of residence are reviewed and identified in the plan of care to assist the member in achieving the best quality outcomes.

To ensure continuity of care for the D-SNP members, the D-SNP care management team may attend care conferences, provider appointments and assessments performed in the member home or facility. Visits may assist in the determination of increased assistance needed in the home, eligibility for long-term care support and education/reinforcement of changes identified during provider appointments. When outside community resources are also involved in the care coordination of the D-SNP member, the D-SNP care management team may defer to the other agency/provider to direct services. For example, to support a member who is on hospice, the D-SNP care management team will defer to the hospice team to initiate the care planning. The D-SNP care management team will remain involved as a resource to the member/member's family to assist with coordination.

The D-SNP care management team collaborates with the social work care manager and with the state or local human service agency when the Enrollee requires any of the following

services: Pre-petition Screening, OBRA Level II Screening, Spousal Impoverishment Assessments, Adult Foster Care, Group Residential Housing or Extended Care or Halfway House Services, Mental Health Case Management, and Adult Protection. The D-SNP care management team has ongoing collaboration on member enrollment status and assist with changes identified, eligibility and follow up to assist the D-SNP member in having adequate health care coverage as needed.

MOC 1: Element B: Factor 2: Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable enrollees.

The demographics associated with SHP's most vulnerable D-SNP members are most commonly age, socioeconomics, rural communities with limited resources, health literacy and the presence of significant co-morbid conditions. These characteristics can affect cognition, lead to depression, and limit the member's ability to self-manage and be compliant with their health care needs and conditions.

People with multiple chronic conditions are at greater risk for a variety of adverse health events resulting from poor care coordination, receiving conflicting advice from health care providers, and the substantial and unaffordable out-of-pocket costs of their care. The financial considerations, including the challenges of managing coordination of benefits between Medicare and Medicaid are frequently overwhelming and may impose real or perceived barriers to a member-seeking healthcare. SHP D-SNP care management comprehensive individualized care planning, care coordination services and targeted program for providing more intensive services, mitigates the risks for individuals who are managing multiple chronic conditions.

All D-SNP members are presumed to face financial challenges to accessing care due to the fact that they meet the financial eligibility criteria for Medicaid. In addition to the benefits of the care management and care coordination services outlined in the examples above, SHP's D-SNP product may include services to address potential cost barriers to care, including services that cannot be accessed through Medicare or Medicaid alone. Extra benefits might include transportation to medical appointments, an over-the-counter prescription drug benefit, hearing aids, one pair of eyeglasses with frames, heart healthy meals post hospitalization, targeted disease specific online care management opportunities, and wellness benefits, such as tobacco cessation, stress and weight management. SHP reevaluates the benefit design on an annual basis and analyze the services used by all SNP members. SHP further analyzes the vulnerable population to ensure the benefit offering meets the needs of that population. This analysis is performed with the intention of identifying additional benefits needed to support this population in the next year's bid process. SHP considers the unique medical, social, environmental, and long-term care needs of its vulnerable population when working to

identify any additional services needed.

Non-compliance is also a significant concern in the most vulnerable beneficiaries given their unstable social, environmental, and financial concerns. Noncompliance can be identified by failure to keep follow up appointments, failure to complete recommended testing and labs, failure to follow medication instructions and regimens and failure to make behavioral and lifestyle changes (diet, exercise, smoking). Members of the ICT recognize the importance of understanding the reasons behind the member's non-compliance and work to resolve these issues on an individual basis. SHP utilizes licensed social workers to address any problems the member may be experiencing with housing, food, transportation, or other needs.

MOC 1: Element B: Factor 3: Illustrates a correlation between the demographic characteristics of the most vulnerable enrollees and their unique clinical requirements.

SHP's rural population, high-risk co-morbidities, along with the identified average age of the D-SNP population, >81 years of age, is a direct correlation to the D-SNP most vulnerable population. Accessing health care with several co-morbidities is also very demanding on this vulnerable D-SNP population. The higher need for more frequent provider follow up, limited transportation, increased distance to obtain healthcare close to their homes puts the D-SNP members at high risk. Risk includes non-compliance with annual wellness visits, completion of preventive exams and follow up, decreased cognitive abilities due to age, increased hospitalizations related to non-compliance with routine follow up, and limited caregiver resources. Overall, the ability to access healthcare, including availability, convenience to obtain healthcare (travel), and limited resources affects the D-SNP population and their health care utilization.

MOC 1: Element B: Factor 4: Identify and describe established relationships with partners in the community to provide needed resources and provide a complete description of the process for supporting continuity of community partnerships and facilitating access to these specially tailored community services by the most vulnerable enrollees and/or their caregiver(s).

Our goal is to continue to build the necessary relationships to operate an expanded service health plan that services members with special needs. SHP recognizes that the needs of its most vulnerable population may not all be met through direct outreach from the D-SNP care management program. For this reason, SHP refers to a host of community agencies and providers to assure access to community services by the most vulnerable members and/or their caregivers. SHP employs licensed social workers who are adept and skilled at identifying community resources that might benefit its membership and serve as the liaison to the community to foster these mutually beneficial relationships.

To support the D-SNP care management team in ongoing knowledge and education on

community resources and partners available to assist the D-SNP population, joint conferences/team meetings are held with community partners. Introduction of the programs and services available, promote collaborations and assist in the coordination of care needs identified for the vulnerable D-SNP population.

For example, all new D-SNP enrollees identified as having a MCO organization, are notified of SHP D-SNP care management program involvement with the member, how to contact the D-SNP care management team and who the D-SNP care management team is. Specific steps have been coordinated with the MCO's on how to communicate effectively with them (email, fax, messaging etc.)

Stakeholder engagement and meaningful partnerships are embedded in the culture and core functions of Security Health Plan. We will concentrate effort in the following areas:

- Our Care Coordination Partnerships – Communicating the value of our engagement with Community Partnerships
- Stakeholder Identification, Engagement and Input Solicitation
- Provider Engagement, Input, Training, Support and Payment

Our goals articulate how we will ensure that we deliver on our vision for our members. Our goals express the four major themes for business activities. Our D-SNP care management team is organized around and is accountable for these four key goals:

- Care Coordination - Providing for an improved system that connects services and systems – Maximize our communication and education opportunities with Community Partnerships and community resources.
- Locally Focused and Integrated Planning - To provide our stakeholders an opportunity with a state, regionally and local targeted approach to receive information and have input into health care planning, identifying current and future needs or concerns.
- Patient-Centered Health Care Provider Networks - To provide education and opportunity for health service providers to understand and engage in our Model of Care
- Effective Home and Community Based Services – Educate providers and provide an opportunity for input. Communicating our commitment along with our expectation of accountable, and effective management

Care coordination with the interdisciplinary care team helps to ensure that the member's healthcare needs, health care services and information sharing across the healthcare system/staff and facilities will be met while engaged in the D-SNP program. Care coordination will include:

- Maximizing the effectiveness of member services in the healthcare system
- Ensuring safe, efficient and high quality care for the member
- Identifying healthcare outcomes for the member and setting up follow-up as needed
- Providing services through the provider network for services needed
- Assisting with referrals to Home Health, appointments, meals, transportation and other services as needed that are identified through the assessment process and ongoing care management

- Update providers and services as needed to coordinate care
- Continue to collaborate with community to identify needed resources as they become available
- Enhance partnership within the community resources with continued collaboration and education with the D-SNP program and D-SNP care management team

Stakeholder groups identified

- Department of Health Services (DHS)
- Veteran's Administration
- ADRC of Central Wisconsin – classes for members on falls, safety in the home, chronic condition classes – example: Diabetes
- Mobile Crisis Service Center: services for people experiencing risks or a psychological crisis who requires mental health intervention, information and referrals, linkage to appropriate treatment
- Family Health Center of Wisconsin – updates on D-SNP program, member identification, care coordination and referral resources
- Nursing Homes within D-SNP service area – updates to SNF's on collaboration with the SNF for the D-SNP member, program information, coordination with families and outreach to the D-SNP team
- Home Health/Hospice Agencies within the D-SNP service area – Nurse on Call program – members identified as not meeting Home Health criteria, needing a one-time visit to assess safety, med compliance, home environment – one time Home Health visit to assess members needs/educate – may assist in identifying other home care needs
- Community Resources – at local county levels – food backs, local transportation, loan closets, food shares
- Cell Phone Program: Free or discounted cellular service for income eligible consumers
- Family Care Organizations (Inclusa, My Choice, Lakeland)
- Advance Care Planning – No ACP identified, community ACP meetings are available, online appts can be coordinated with an ACP facilitator by the D-SNP care management team
- Integrated Care Coordination (Behavioral Health) – D-SNP members identified with depression/anxiety diagnosis or needs; D-SNP care management team outreaches PCP for identification, referral; coordination with the ICC coordinator for member f/u needs

Other partnership development strategies

The D-SNP care management team has a unique opportunity to work with local partners to establish a base of local resources aimed at meeting the needs of members while they age in place. These roles assist in establishing partners in the community, care coordination and assisting with increased member outcomes.

The D-SNP care management team collaborates with the state or local human service agency as needed for barriers in care or special needs that are identified for the member. Other areas of assistance that can be provided to members include:

- Help to understand an illness or condition. How does it affect me and the people who care for me?
- Help to identify needs or resources to manage their health. What are the informal

and formal supports that are available in the communities? Where does the member live?

Examples for information supports include:

1. Families
2. Friends
3. Neighbors
4. Faith Communities
5. Volunteers
6. Community Support Specialist (in conjunction with the RN care manager and Social Work care manager)
    a. Emotional support
    b. Explanation of a doctor's recommendations
    c. Help to recognize early changes in a medical condition that need medical attention (help to get to the doctor sooner)
    d. Help with finding a health care provider, community resources or, relevant web sites
    e. Help to make the most of their health plan benefits
    f. Information on diet and nutrition
    g. Information on managing medications
    h. Help to prepare for doctor visits, what questions I need to ask, what my medications are, how will I get there and back?
    i. Housing
    j. Local resources
        i. Food pantries
        ii. Social activities
        iii. Senior Centers
        iv. Church groups
    k. Assistance with legal matters, including Medicaid and Social Security
    l. Transportation
    m. Applications for benefits or services
    n. Affordable, culturally-appropriate mental health counseling

MOC 2: Care Coordination

Security Health Plan works collaboratively to support care coordination for the member population. Care coordination maximizes the use of effective, efficient, safe and high quality patient services that ultimately lead to improved healthcare outcomes. Care management services assist members in navigating the care system and in obtaining services in an optimal setting. Care Coordination includes:

- Monitoring health status of a targeted population
- Identifying their needs
- Improving access to quality healthcare services and benefits
- Managing chronic diseases
- Avoiding inappropriate hospitalizations and emergency room visits
- Decreasing the members' medical, mental and social risks.

MOC 2: Element A: SNP Staff Structure

MOC 2: Element A Factor 1: Describe the roles and responsibilities of employed or contracted staff who perform administrative plan functions, including oversight functions that directly or indirectly affect care of enrollees in the SNP.

Security Health Plan is staffed and organized as a comprehensive managed care organization with a full complement of administrative departments and clearly defined roles necessary to support its model of care. The table below illustrates:

- The executive-level accountability for functional oversight of administrative activities.
- The leadership-level accountability, detailing responsibility for the provision of administrative support to the model of care (e.g., enrollment and eligibility, member services, process claims, etc.).
- The specific departmental positions that directly perform these functions.

Administrative functions, such as processing of enrollments, verifying eligibility, and claims processing are performed by a Security Health Plan staff-Claims department, Enrollment Services and Provider Network. The Security Health Plan Enrollment department processes all enrollments.

Department	Position	Department Position Hierarchy and Role/Responsibility
Administration	Chief Operating Officer	Reports to the CEO. Accountable for, and oversees all performance within the Operations area of the organization such as Enrollment, Claims, Customer Service, and Training, to name a few.
	Chief Legal & Compliance Officer	Reports to the CEO, Responsible for leading corporate strategic and tactical legal and compliance initiatives. Implements and oversees the Medicare Compliance Program while ensuring overall compliance; oversees all performances with in the Legal and Compliance areas of the organization, such as Legal, Compliance and Privacy, and Subrogation
	Chief Medical Officer	Reports to the CEO, providing guidance and direction of the organization's value-based care and population health strategy; accountable for strategic and operational success of the population health management, quality and pharmacy functions of the health plan and manages the SHP Medical Director's and departmental directors to provide leadership for all activities within those departments.

Department	Position	Department Position Hierarchy and Role/Responsibility
		Direct oversight of Pharmacy, Population Health, Quality and Medical Directors.
	Chief Financial Officer	Reports to the CEO, accountable senior executive for actuarial services and financial leadership; direct oversight of insurance risk evaluation, premium rate setting, trend development and strategic positioning of SHP products and services; responsible, in collaboration with the VP Finance, Shared Services and Marshfield Clinic Health System (MCHS) Chief Investment Officer, for the development and implementation of financial policy, planning and analysis to guide decisions that preserve and improve the financial performance; oversees the director of finance and accounting and director of actuarial and risk adjustment
	Chief Growth Officer	Reports to the CEO, provides the vision, leadership and management for development and implementation of strategies that foster the achievement of annual and long-term growth; direct oversight of the Product Development, Retention, Marketing, Communications, Sales, and Government Programs Departments at Security Health Plan; member of the executive leadership team at the Health Plan and reports to the Chief Executive Officer. In addition, the CGO works closely with the Chief Operations Officer, Chief Financial Officer, Chief Actuary and Chief Medical Officer to develop strategy and set direction for the Health Plan.
	Director of Provider Relations/Contracting	Reports to the CEO; responsible for contracting and maintaining relationships; closely collaborate with the MCHS Chief Financial Officer, MCHS Chief Clinical Strategy Officer, SHP Chief Executive Officer, Marshfield Clinic Chief Medical Officer, and other system leadership in developing and implementing payer and network strategies to achieve MCHS strategic goals. Oversees contract managers
	VP Community Health and Wellness	Reports to CEO; provides executive oversight, leadership, and vision necessary to develop and implement effective and efficient strategies focused on community health improvement,

Department	Position	Department Position Hierarchy and Role/Responsibility
		wellness and health promotion, and health equity, diversity and inclusivity; accountable for developing, executing and maintaining the means to measure and report the comparative value of community health improvement, wellness and health promotion, and HEDI investments; Oversees Wellness and Health Manager, Health Coaches and Educators
Business Development	Director of Health Plan Products	Reports to the Chief Growth Officer; responsible for driving the growth of Security Health Plan's product portfolio and strategy as well as provide support for government relations activities. This role will work collaboratively with professionals across the System (Security Health Plan, Clinic, care delivery and other MCHS business units) to foster innovation and growth. Oversees and works with Risk Adjustment, coding and auditing; product and implementation managers and specialists
	Director of Marketing & Communications	Reports to the Chief Growth Officer; assesses market trends and sets strategic direction for communication and marketing efforts of Security Health Plan (SHP) of Wisconsin, Inc. ; Collaborates with executive leadership at SHP and Marshfield Clinic Health System (MCHS), as well as other SHP and System leaders to assess marketing and communication needs, track industry trends, establish position statement; develops, oversees and manages SHP's brand, marketing, digital marketing, communications, community relations, events and sponsorship/community contributions functions and staff. Responsible for marketing specialists, marketing assistant; manager of marketing and communications
	Director of Sales	Reports to the Chief Growth Officer; directs, manages and executes sales strategies and processes to effectively sell and support Security Health Plan products and demonstrates results to achieve designated sales and earning goals. This individual directly oversees the Business Sales Team and related support personnel for Security Health Plan and

Department	Position	Department Position Hierarchy and Role/Responsibility
		assures external and internal sales staff and processes are fully compliant with internal and external requirements; provide guidance and assistance to the Consumer Sales Manager and Consumer Sales Team to create a coordinated effort and cross-functional approach to attracting and retaining all members in a Security Health Plan product.
Operations	Director of Population Health	Reports to the CMO; provides operational strategic and operational leadership of the Health Services (UM – Utilization Management, CCM – Complex Case Management and Chronic Condition Management, Wellness) and Quality departments for Security Health Plan (SHP). The individual will identify opportunities for alignment and improvement in the Health Services and Quality departments including development of innovative strategies to provide effective and efficient programs and service to SHP members and provider networks. The Director of Population Health will collaborate with the Chief Clinical Officer (CCO) to lead a team supporting the strategic initiatives of the department and organization supporting the delivery of affordable, high-quality care and insurance products.
	Director of Pharmacy	Reports to the CMO; provides strategic and operational leadership of the Security Health Plan (SHP) pharmacy and prescription benefit programs; collaborate with the Chief Clinical Officer (CCO) to lead a team supporting the strategic initiatives of the department and organization supporting delivery of affordable, high-quality care and insurance products;
	Director Health Plan Quality	Reports to the CMO; accountable for successful achievement of quality accreditation for the business lines, measured by various external stakeholders such as the Centers for Medicare & Medicaid Services (CMS) star ratings and the National Committee for Quality Assurance (NCQA). This position manages staff and provides initiatives supporting the strategic and operational goals of the organization and manages the appeals and grievance functions;

Department	Position	Department Position Hierarchy and Role/Responsibility
		responsible for program coordinators, member advocates, member experience representative, QI RN's
	Director of Member Experience	Reports to COO; responsible for designing, directing, implementing and maintaining a member contact center strategy and integration program for Security Health Plan call centers. This individual will work closely with SHP's management team to develop and foster a culture passionate about member experience and will provide horizontal oversight of member experience within SHP service lines. manages the overall operations of the Contact Center, providing strong leadership, direction and motivation for the staff and ensuring cost, productivity, quality and service objections are met; responsible for CS agents, benefit specialist agents, training agents
	Health Services Clinical Manager	Reports to Population Health Director: functions as an integral team member of Security Health Plan's (SHP) Health Services Department providing strategic program oversight to a spectrum of utilization and population health management programs. This manager is accountable and has the overall responsibility for the day to day operations of the care management and care coordination program operations. This professional works closely with SHP Medical Directors to oversee health care services and ensure the promotion of quality, cost-effective care to SHP members. This professional serves as a liaison between SHP's Health Services Department and other SHP departments and provider care delivery operations. Oversees RN care managers, Social Worker care managers, Community Support Specialists, Engagement Associates and Specialists, nurse navigators, UR specialists, CS agents
	Wellness and Health Promotion Manager	Reports to VP Community Health and Wellness; responsible for the overall management of wellness and health promotion programs, services, resources, staff, and initiatives that contribute to improving the health, lifestyles

Department	Position	Department Position Hierarchy and Role/Responsibility
		and overall wellbeing of plan members. The Manager-Wellness and Health Promotion is accountable for communication to internal and external stakeholders, reporting on program performance, and participating in various process design and improvement initiatives to achieve identified business objectives. Oversees Health Coaches and Educators.
	Pharmacy Manager	Reports to Pharmacy Director; responsible for managing a staff responsible for the coordination and facilitation of the prescription drug benefits for Security Health Plan (SHP) and for managing the day-to-day operational activities for the department. Oversees pharmacists; pharmacy specialists

MOC 2: Element A Factor 2: Describe the clinical staff's roles and responsibilities, including oversight functions noted in Factor 1.

Security Health Plan is staffed and organized as a comprehensive organization with a full complement of clinical departments and positions necessary to support its model of care. The table below illustrates:

- The executive-level accountability for functional oversight of clinical activities.
- The leadership-level accountability, detailing responsibility for the provision of clinical support to the model of care (e.g., promote access to appropriate and timely medical and mental health care, conduct clinical review, perform care management/coordination activities, provide self- management education, provide pharmacy consultation, etc.).
- The specific departmental positions that directly perform these functions.

Department/Position	Department Position Hierarchy and Role Responsibility
Chief Medical Officer	Reports to the CEO, providing guidance and direction of the organization's value-based care and population health strategy; accountable for strategic and operational success of the population health management, quality and pharmacy functions of the health plan and manages the SHP Medical Director's and departmental directors to provide leadership for all activities within those departments. Direct oversight of Pharmacy, Population Health, Quality and Medical Directors; Minimum Required: Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.); Minimum Required: Five or more years' of executive level, or ten or more years' of management level experience in managed care organization or health plan, preferably in an integrated health system. Demonstrated understanding of

Department/Position	Department Position Hierarchy and Role Responsibility
	healthcare and medical economics in managed healthcare; and evidence of applying this knowledge in day-to-day activities. Demonstrated success with program design, development and implementation in prior leadership roles.
Director of Population Health	Reports to the CMO; provides operational strategic and operational leadership of the Health Services (UM – Utilization Management, CCM – Complex Case Management and Chronic Condition Management, Wellness) and Quality departments for Security Health Plan (SHP). The individual will identify opportunities for alignment and improvement in the Health Services and Quality departments including development of innovative strategies to provide effective and efficient programs and service to SHP members and provider networks. The Director of Population Health will collaborate with the Chief Clinical Officer (CCO) to lead a team supporting the strategic initiatives of the department and organization supporting the delivery of affordable, high-quality care and insurance products. Minimum Required: Bachelor's degree in nursing, public health, health care administration, business administration or related field. Minimum Required: Five years of management experience in a health plan or integrated care delivery organization. Demonstrated knowledge of value-based care, care management or population health principles. Demonstrated proficiency with using data and synthesizing data to drive execution and performance in clinical and quality programs. Demonstrated high-level proficiency with verbal, non-verbal and written communications skills, presentations and with the Microsoft Office Suite.
RN Manager- Clinical Care Management (includes case management and utilization management)	Reports to Population Health Director: functions as an integral team member of Security Health Plan's (SHP) Health Services Department providing strategic program oversight to a spectrum of utilization and population health management programs. This manager is accountable and has the overall responsibility for the day to day operations of the care management and care coordination program operations. This professional works closely with SHP Medical Directors to oversee health care services and ensure the promotion of quality, cost-effective care to SHP members. This professional serves as a liaison between SHP's Health Services Department and other SHP departments and provider care delivery operations. Oversees RN care managers, Social Worker care managers, Community Support Specialists, Engagement Associates and Specialists, nurse navigators, UR specialists, CS agents; Minimum Required: • Current State of Wisconsin Registered Nurse License or Nurse Compact License. Minimum Required: Five years of experience in public health nursing, health education, managed care, utilization management or case management. Three years of supervisory experience. Knowledge of BC/MA and Medicare recipients and their special

Department/Position	Department Position Hierarchy and Role Responsibility
	needs is also required. Knowledge of case management processes, programming and utilization processes. Individuals hired are expected to serve patients of different ages, backgrounds, etc. When performing the essential functions of the role, the individual must identify the patient age group to be served and apply the appropriate care based on the patient's age and background. The hiring manager is responsible for communicating the patient population generally encountered in the role and is responsible for ensuring the appropriate cultural, age and related training needed to serve the patient populations
RN Care Management Team Lead	Reports to D-SNP RN Clinical Manager; The Registered Nurse Team Leader performs all of the job duties and responsibilities of the Registered Nurse and assists with the day-to-day supervisory duties and overall operations of his/her section acting as a resource and role model for the staff. This individual demonstrates excellent clinical, problem-solving, interpersonal, and leadership skills, and makes decisions consistent with Marshfield Clinic Health System (MCHS) policies, department protocols/guidelines, and the Wisconsin Nurse Practice Act; Minimum Required: Two years' nursing experience in area of training. Demonstrated leadership skills with the ability to prioritize multiple tasks; strong communication, customer service, and interpersonal skills; Minimum Required: Current State of Wisconsin Registered Nurse License Compact License. Basic Life Support (BLS) certification awarded by the American Heart Association (AHA) within three months of hire. Individuals hired are expected to serve patients of different ages, backgrounds, etc. When performing the essential functions of the role, the individual must identify the patient age group to be served and apply the appropriate care based on the patient's age and background. The hiring manager is responsible for communicating the patient population generally encountered in the role and is responsible for ensuring the appropriate cultural, age and related training needed to serve the patient populations
RN Care Manager	Reports to the D-SNP RN Clinical Care Management Manager; The RN is responsible for the assessment, coordination, planning, and implementation of case management services. S/he is also responsible for carrying out the management of specific, individual medical episodes identified through utilization review, disease management, and quality assurance functions. This individual ensures that case management program objectives are met by evaluating the effectiveness of alternative care services and that cost effective, quality care is maintained. Minimum Required: Five years' clinical experience in home health, nursing home, hospital, community outreach care, case management, utilization management, and/or discharge planning. Experience with keyboard, computer, and general office equipment.

Department/Position	Department Position Hierarchy and Role Responsibility
	Minimum Required: Current State of Wisconsin Registered Nurse License or Nurse Compact License. Basic Life Support (BLS) certification awarded by the American Heart Association (AHA) within three months of hire. Valid driver's license required with an acceptable record. Individuals hired are expected to serve members of different ages, backgrounds, etc. When performing the essential functions of the role, the individual must identify the member age group to be served and apply the appropriate care based on the member's age and background. The hiring manager is responsible for communicating the member population generally encountered in the role and is responsible for ensuring the appropriate cultural, age and related training needed to serve the member populations.
Social Worker Care Manger	Reports to the D-SNP RN Clinical Care Management Manager; The Social Worker is responsible for the assessment, coordination, planning, and implementation of case management services. S/he is also responsible for carrying out the management of specific, individual medical episodes identified through utilization review, disease management, and quality assurance functions. This individual ensures that case management program objectives are met by evaluating the effectiveness of alternative care services and that cost effective, quality care is maintained. Minimum Required**:** Bachelor's degree in Human Services-related field. Minimum Required**:** Five years' social work experience in psychiatric setting, human service agency, community outreach care, skilled nursing facility, case management, and or discharge planning; Individuals hired are expected to serve patients of different ages, backgrounds, etc. When performing the essential functions of the role, the individual must identify the patient age group to be served and apply the appropriate care based on the patient's age and background. The hiring manager is responsible for communicating the patient population generally encountered in the role and is responsible for ensuring the appropriate cultural, age and related training needed to serve the patient populations
Community Support Specialist	Reports to the D-SNP RN Clinical Care Management Manager; The Community Support Specialist is a point of contact for member's engaging in case management services offered by Security Health Plan (SHP). Through outreach and collaboration, the individual determines the member's needs and how to best address them, in collaboration with the Care Management team. The Community Support Specialist works as part of the Care Management interdisciplinary team assisting members in successfully managing within the community. The Community Support Specialist educates members on benefits of the program, assists with assessment of the member for their healthcare needs and assists the team with day to day management of member needs identified on an ongoing basis; Minimum Required: High

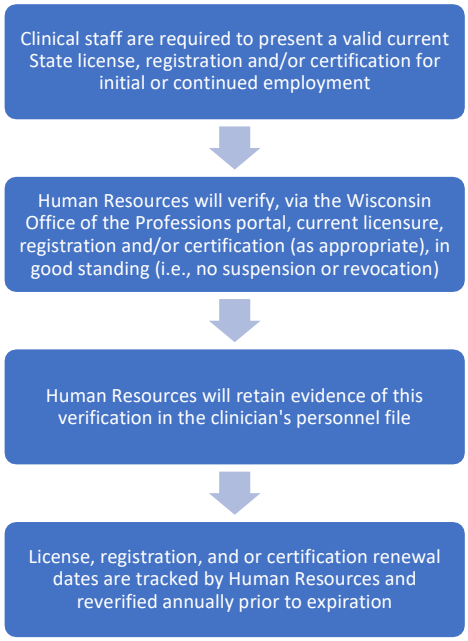
Department/Position	Department Position Hierarchy and Role Responsibility
	school diploma or equivalent. Successful completion of Mental Health First Aide training within one year of hire. Preferred/Optional: Associates degree in sociology or human services education. Minimum Required: State of Wisconsin driver's license and acceptable driving record. Basic Life Support (BLS) certification awarded by the American Heart Association (AHA) within three months of hire; Minimum Required: State of Wisconsin driver's license and acceptable driving record. Basic Life Support (BLS) certification awarded by the American Heart Association (AHA) within three months of hire
Utilization Management Specialists/Reviewers	Reports to the UM Clinical Manager; The Utilization Review Specialist performs prospective, concurrent and retrospective reviews for inpatient acute medical and rehabilitation care. Responsible for authorizing payment of inpatient hospitalizations. Responsible for authorizing pre-admission certifications, continued stay assessments, and discharge planning by assessing medical necessity and choice of setting. This position works closely with SHP Case Management/Utilization Review Nurses and Security Health Plan (SHP) Medical Directors in all managed care activities. The Utilization Review Specialist works closely with physician providers and hospital facility staff to facilitate the continuum of care in the most cost effective manner; Minimum Required: Five years' experience in a patient care or health insurance's utilization management department. Individuals hired are expected to serve patients of different ages, backgrounds, etc. When performing the essential functions of the role, the individual must identify the patient age group to be served and apply the appropriate care based on the patient's age and background. The hiring manager is responsible for communicating the patient population generally encountered in the role and is responsible for ensuring the appropriate cultural, age and related training needed to serve the patient populations.
Director of Pharmacy	Reports to the CMO; provides strategic and operational leadership of the Security Health Plan (SHP) pharmacy and prescription benefit programs; collaborate with the Chief Clinical Officer (CCO) to lead a team supporting the strategic initiatives of the department and organization supporting delivery of affordable, high-quality care and insurance products; Minimum Required: Five years' of management experience in a health plan or integrated care delivery network as a pharmacist with formulary management and medication utilization evaluation background. Demonstrated knowledge of value-based care principles and managing strategic vendor partners (PBM). Demonstrated proficiency with using data and synthesizing data to drive execution and performance in pharmacy program and formulary management. Demonstrated high-level proficiency with verbal, non-verbal and written communications skills,

Department/Position	Department Position Hierarchy and Role Responsibility
	presentations and with the Microsoft Office Suite; Minimum Required: Must be currently licensed as a pharmacist in the State of Wisconsin (or be eligible to be licensed as a pharmacist by reciprocation or examination within six months). License must be without restriction.
Clinical Pharmacy Manager	Reports to the Director of Pharmacy; Reports to Pharmacy Director; responsible for managing a staff responsible for the coordination and facilitation of the prescription drug benefits for Security Health Plan (SHP) and for managing the day-to-day operational activities for the department. Oversees pharmacists; pharmacy specialists; Minimum Required: Bachelor's degree in Pharmacy; Minimum Required: State of Wisconsin Pharmacist license or eligibility for WI Pharmacist Licensure and licensure must be obtained within three months of hire.
Pharmacist	Reports to the Pharmacy Manager; The Pharmacist – Lead is an important information resource to patients, providers, and staff and interacts in a courteous, professional manner at all times. The individual maintains appropriate documentation and meets all state and federal standards. The Pharmacist – Lead assists management with maintaining an effective, knowledgeable team by acting as a resource and role model to other Pharmacists and by demonstrating excellent problem-solving, interpersonal and leadership skills. Minimum Required: Two years' experience as a pharmacist. Demonstrated leadership ability. Minimum Required: Pharmacist license awarded by the State of Wisconsin or eligibility for WI pharmacist licensure that must be obtained within three months of hire
Pharmacist Specialists	Reports to the Pharmacy Manager; The Security Health Plan (SHP) Pharmacy Benefit Specialist is responsible for the daily administration of the SHP pharmacy benefits. This individual works closely with the Pharmacy Director, Clinical Pharmacy Specialist, and Operations Manager to provide consistent and accurate pharmacy benefit administration for SHP customers. The SHP Pharmacy Benefit Specialist recognizes and analyzes aberrations in the functioning of benefits to monitor the services and performance of SHP's pharmacy benefits, and to communicate those issues to the appropriate areas. Minimum Required: Five years' of experience working as a pharmacy technician with knowledge of electronic pharmacy claims processing. Demonstrated proficiency with customer service skills. Minimum Required: Certified Pharmacy Technician (CPhT) awarded by the Pharmacy Technician Certification Board required or must attain certification within 6 months of hire date.
Director of Quality	Reports to the CMO; accountable for successful achievement of quality accreditation for the business lines, measured by various external stakeholders such as the Centers for Medicare &

Department/Position	Department Position Hierarchy and Role Responsibility
	Medicaid Services (CMS) star ratings and the National Committee for Quality Assurance (NCQA). This position manages staff and provides initiatives supporting the strategic and operational goals of the organization and manages the appeals and grievance functions; responsible for program coordinators, member advocates, member experience representative, QI RN's; Minimum Required: Bachelor's Degree in public health, wellness, nursing, healthcare administration, management or related field. EXPERIENCE Minimum Required: Seven years' experience with healthcare operations. Knowledge of quality initiatives, business metric development and measurement processes. Three years of management experience.
Quality Improvement RN	Reports to the Director of Quality; The Quality Improvement Nurse - SHP is part of an interdisciplinary team working to develop, implement and monitor strategies to improve clinical and service outcomes for Security Health Plan (SHP) members. This individual assists in preparing documentation for accreditation purposes and assists in maintaining regulatory compliance. Minimum Required: Diploma or associate degree in nursing. Minimum Required: Five years' experience in healthcare delivery Demonstrated leadership ability
Member Advocate	Reports to the Director of Quality; The Member Advocate and Experience Liaison provides a channel between the member and the organization through which members, providers, and staff may seek potential solutions to problems and concerns related incoming expressions of dissatisfaction. The Member Advocate and Experience Liaison acts as a neutral party in sensitive care concerns and patient experiences by actively listening, instilling trust and confidence, and conveying professionalism to the patient(s), provider(s), or staff member(s) involved. The individual communicates and demonstrates to the member, member's authorized representative, and/or provider the concern and responsiveness of the organization in serving the unique health care needs of the individual. The Member Advocate and Experience Liaison provides member and provider experience support Health Plan wide. Minimum Required: Bachelor's degree in nursing, social work, healthcare administration or related field. EXPERIENCE Minimum Required: Five years' of direct patient or member care or healthcare operations experience to include member interaction on the telephone. Working knowledge of medical terminology and anatomy and physiology.
VP of Community Health and Wellness	Reports to CEO; provides executive oversight, leadership, and vision necessary to develop and implement effective and efficient strategies focused on community health improvement, wellness and health promotion, and health equity, diversity and inclusivity; accountable for developing, executing and maintaining the means to measure and report the comparative value of community health

Department/Position	Department Position Hierarchy and Role Responsibility
	improvement, wellness and health promotion, and HEDI investments; Oversees Wellness and Health Manager, Health Coaches and Educators
Wellness and Health Promotion Manager	Reports to the VP of Community Health and Wellness; Reports to VP Community Health and Wellness; responsible for the overall management of wellness and health promotion programs, services, resources, staff, and initiatives that contribute to improving the health, lifestyles and overall wellbeing of plan members. The Manager-Wellness and Health Promotion is accountable for communication to internal and external stakeholders, reporting on program performance, and participating in various process design and improvement initiatives to achieve identified business objectives. Oversees Health Coaches and Educators. Oversees Health Coaches and Educators. Minimum Required: Bachelor's degree in community health, health education, wellness, health promotion or related field. EXPERIENCE Minimum Required: Three years' experience with health education. Three years management experience.
Health Coaches and Educators	Reports to the Wellness Manager; The Health Educator is responsible for promoting, maintaining, and improving individual and/or community health by assisting individuals and communities to adopt healthy behaviors that promote healthy living and prevent disease. This includes collecting and analyzing data to identify health needs, planning, implementing, monitoring, and evaluating health education designed to encourage healthy lifestyles, policies and environments. Minimum Required: Bachelor's Degree Community Health, Health Education, Wellness, Health Promotion, or a related field. EXPERIENCE Minimum Required: Two years' of health education experience. Experience with Microsoft Office products. Strong written and verbal skills.

As applicable to the role/responsibility, license and competency verification is validated through the following process:



MOC 2: Element A: Factor 3: Describe how staff responsibilities coordinate with the job title (provide organization chart).

Staff oversight responsibilities include any license and competency verification that relates to the specific population being served by Security Health Plan. All professional clinical staff holds current and up to date licensures for their job title. The above descriptions describe staff responsibilities with job title. Below is the organizational chart demonstrating levels of accountability. The D-SNP program manager reports up through health management to the CMO for regulatory, compliance and clinical oversight. The CMO has oversight of the departments responsible for utilization management programs, quality improvement and care management programs. The structure allows for oversight of the full continuum of care for all members ensuring there are adequate provider networks. Regular collaboration with other operational areas occurs as part of development and implementation of the D-SNP program, such as Utilization Management, Claims, Sales, and Enrollment services.

The core D-SNP care management team consists of a Registered Nurse, Social Worker and Community Support Specialist. This core team provides personalized service to each member enrolled in the SHP D-SNP program.

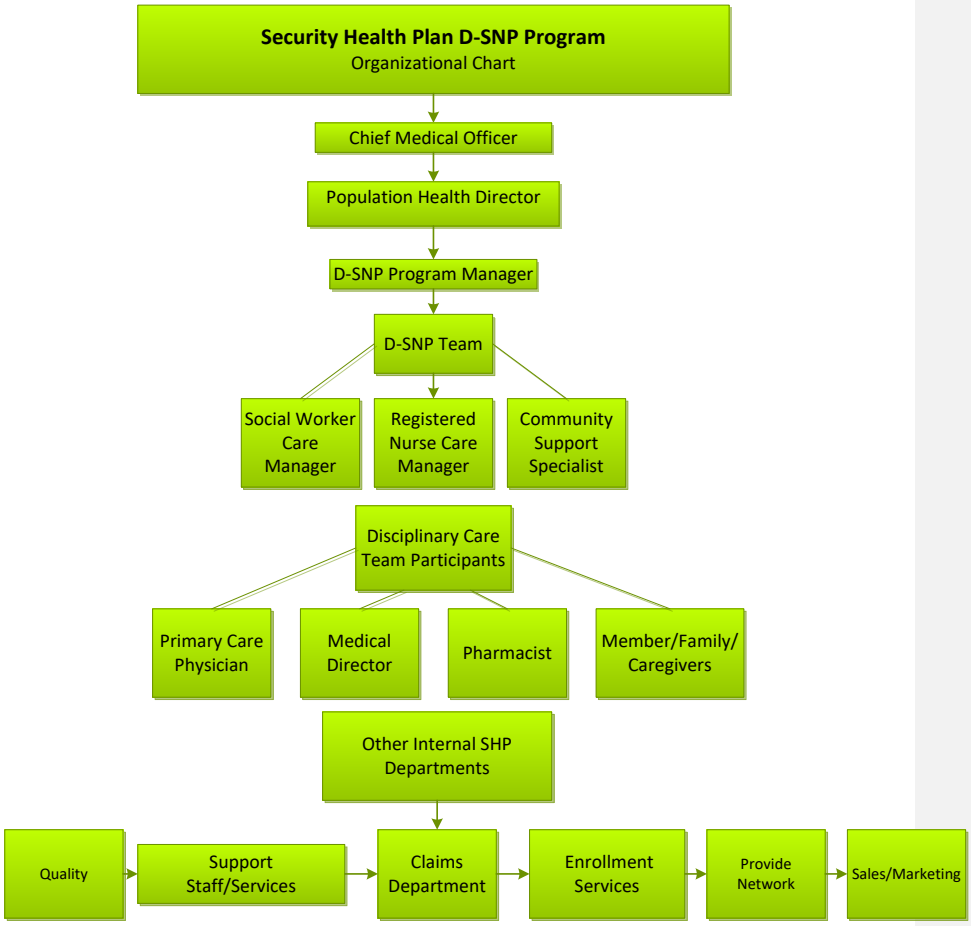
Ongoing review of work responsibilities and work processes is done to ensure the D-SNP care management team is able to meet the regulatory and clinical needs of the SHP D-SNP program

membership. The D-SNP care management team serves as advocates in identifying, facilitating and coordinating member care, resources and services.

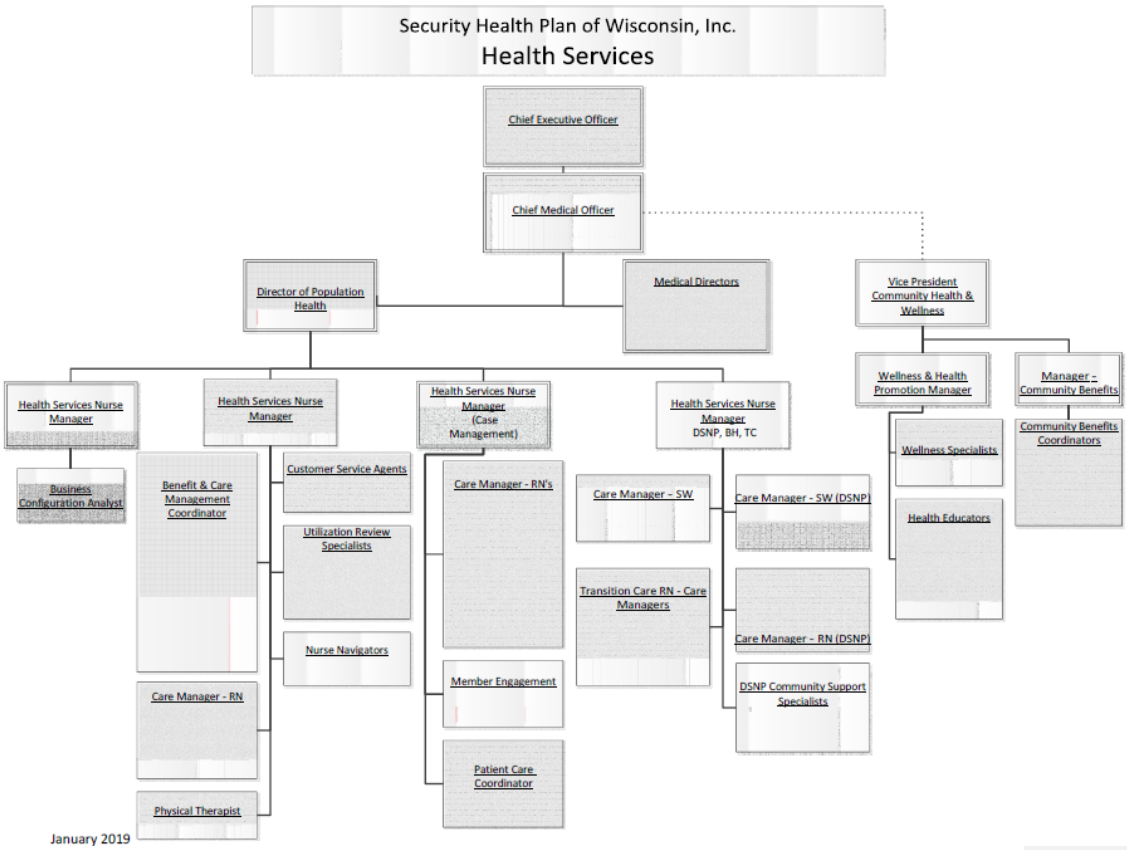
Below is the D-SNP program organizational chart demonstrating levels of accountability. If there is an instance that requires a change to staff title/position, the level of accountability escalates to be responsible until resource plans are made to accommodate any operational changes in the D-SNP program.

The SHP organizational structure is arranged for both operational and clinical oversight of Security Health Plan. The Director and Manager of the D-SNP program reports up through health management to the CMO for regulatory, compliance and clinical oversight. The structure allows for oversight of the full continuum of care for all SHP members. This also allows ensuring there is adequate and accessible provider network, condition management programs, aligning the quality improvement programs and maintaining NCQA and CMS clinical requirements for optimum care of the SHP member ship.

D-SNP organizational chart



SHP Organizational Chart



MOC 2: Element A Factor 4: Describe contingency plans used to address ongoing continuity of critical staff functions.

Security Health Plan's goal is to maintain appropriate and adequate staffing to meet member needs while also meeting regulatory and clinical plan requirements. A SHP Business Continuity Plan is in place for the organization to assist in such instances as a natural disaster to identify points in time when a disruption of care could potentially impact the SHP member. Staffing needs and resource needs and a plan of action are identified to be taken in such instances.

Internal process support for health plan operations: Frequently a health plan experiences changes in staffing level needs - example: Program open enrollment needing additional customer service or membership staff. We have become accustomed to vendor outsourcing when staffing needs change or when temporary staffing is required while vacancies are filled. The health plan has a strong effective program that encompasses everything from vendor selection and procurement processes, closure of contracts and vendor performance evaluations to meeting compliance obligations, if needed.

A contingency plan (or plans) is in place to avoid a disruption in care and services when existing staff can no longer perform their roles and meet their responsibilities. The organization identifies staff functions and schedules and ensures day-to-day scheduling, backup of staff to ensure ongoing continuity of staff functions. Security Health Plan's Attendance/Absenteeism/Tardiness policy provides direction for continuity staff coverage. SHP D-SNP care management team provides care management coverage when a team member is out of the office or when staffing changes occur.

Schedules are updated and recorded in the Security Health Plan documentation system and are available to all members of the D-SNP care management team and leadership. Staff that conduct visits to members have laptops and cell phones to enable communication with other members of the D-SNP care management team and support staff. Community Support Specialists, RN care manager, and the Social Work care manager are available and assessable to the team if assisting the member at a home visit. The Community Support Specialist has day to day direct contact via the phone with the D-SNP member as needed. Virtual telephonic visits are available for the D-SNP team to utilize for member contact. A challenge is member internet availability in the rural communities.

The RN care manager or the Social Worker care manager have direct contact with the member as needs are identified and as, care transition changes occur. In the event a D-SNP care management team member terminates employment with SHP or is out unexpectedly, the D-SNP members are reassigned to another care manager within the D-SNP care management team. Phone coverage for member calls is managed by utilizing a D-SNP opt out line rotation. A D-SNP shared email is also available internally at SHP for messages to be sent to the D-SNP team from other departments regarding member calls to SHP. The contingency plan also utilizes other RN care managers, engagement specialists, and patient care coordinators within the SHP care management programs to assist as needed as part of the D-SNP contingency plan.

Contingency plan:

At the member level – each member has an individualized care plan. The RN care manager,

Social Work care manager and/or the Community Support Specialist discusses contingency plans and emergency back up plans in case caregivers or service providers do not show up to provide needed care or there is a disruption in service provision. The D-SNP care management team discusses with the member and/or representative a plan of what to do and numbers to call if a contingency plan is needed. The member will have the number of their service provider, health plan customer service, Community Support Specialist, RN Care Manager, Social Worker care manager, clinic and 24 hour nurseline. The contingency plan may also be a part of the member's care plan.

Reports are run from Jaspersoft (SHP care management documentation system) monthly to identify D-SNP care management team caseloads. The reports assist with identify the number of cases per RN care manager, social worker and community support specialist. This assists in the ongoing tracking and needs to assist with a contingency plan with staff terminations, absences and the need for new hires.

At the service level:
The health plan will provide training for in-home providers on the importance of reliable staffing and the need to have back up contingency plans for members receiving home and community based services. The health plan also has a Business Recovery Plan that is updated annually that identifies that steps needed to be taken in the instances where there is a disaster that may affect health plan operations. In the event of a disaster, the SHP leadership team is alerted and works with the Recovery team to:

- Identify specific vulnerabilities
- Identify the level of absenteeism that will require backup resources to be utilized
- Identify internal/external resource options available for alternative support
- Determine any arrangements needed to assist team
- Identify any special tools required for team members working from home

MOC 2: Element A Factor 5: Describe how the organization conducts initial and annual MOC training for its employed and contracted staff.

Security Health Plan believes that in order to effectively and efficiently meets our members' needs, providers involved in the members' care need to have an understanding of our D-SNP Model of Care and program. Upon hire and annually, all employed staff who work with the D-SNP program are required to have updates and training on the D-SNP MOC. Upon hire to SHP, all new employees are required to complete an initial D-SNP CBT (computer-based training). The following departments will complete an annual D-SNP CBT:

- Health Services – including Wellness, Utilization Management, Complex Care Management
- Customer Service
- Pharmacy
- Quality
- Sales – Consumer Enrichment Team

The D-SNP care management team has scheduled monthly training and education on MOC policies and processes. Additional training includes: advance care planning, motivational

interviewing, compliance reviews, pharmacy updates and other education programs (example: time management, stress reduction, community resources and programs, disease specific conditions, SDOH, outside contracted vendors).

Model of Care Training
Security Health Plan conducts initial and ongoing training for all pertinent care management staff, practitioners, providers, case managers, facilities, appropriate committees, Security Health Plan administrative staff, and any other associated care providers and/or vendors as identified. (Attachment: MOC SHP Internal Staff Training) (Attachment: MOC Provider Training)

Security Health Plan provides initial and ongoing training for providers on the Model of Care through the following venues:

- Webinars
- Face-to-face training/meetings
- Teleconferencing
- Video conferencing
- Newsletters and brochures
- On-line
- Other printed materials
- Health plan website

Security Health Plan's Model of Care related documents are posted on the Security Health Plan website and provider portal.

Initial Model of Care Training

- Newly credentialed providers that provide care the D-SNP members receive a summary document of the Model of Care (CBT). Ongoing education is provided to the providers thru an annual CBT. Providers, upon request, may receive a complete document of the Model of Care from Security Health Plan. The MOC is also available to providers on the SHP Provider portal.
- New RN D-SNP Care Managers, Social Workers and Community Support Specialists receive individual instruction on the Model of Care and its components from an experienced Security Health Plan staff. They also receive Security Health Plan policies and procedures that include Model of Care components, information on accessing Security Health Plan Care Management or Wellness services, forms, and other related materials.
- New Security Health Plan care management staff, Medicare operations staff, customer service, contracted staff, vendors, Security Health Plan administrative staff; receive the Model of Care along with training that is appropriate for implementation and application of the Model of Care within the scope of their job duties or committee participation.
- All internal SHP staff initial and annual training is recorded in the SHP Training site-Learning Connections. All trainings for newly hired SHP staff is part of staff training and recorded by SHP Training and Development. Annual trainings are recorded by SHP training and Development. All employees have a recorded transcript of CBT completed.

Training methods available

- Face to Face – onsite training and classroom instruction-available on as needed basis
- Computer Based Training (CBT) – online training modules developed on the MOC
- Webinars – available on an as needed basis through the SHP website and SHP training staff
- SHP Website

Annual Model of Care Training

Ongoing Model of Care training takes place throughout the year and on an ad hoc basis.
Initial and Annual Model of Care CBT training objectives:

- Basic components of the SHP Model of Care
- Explains how SHP D-SNP care management team coordinates care for dual eligible members
- Describes the essential role of providers in the implementation of the Model of Care.
- Explains the critical role of the provider as part of the Model of care and the interdisciplinary care team

D-SNP Team Training and Education

Trainings are held on a regular schedule and changes or updates to the Model of Care are provided. All D-SNP staff is required to complete specific Health Plan and system wide Computer Based Training (CBT) competencies annually. Example of competencies completed includes:

- Privacy and Compliance
- Ethics
- Appeals and Grievance
- Fraud, Waste and Abuse
- Limited English Proficiency
- Fire Safety
- Cultural Awareness
- Social Determinants of Health
- Advance Care Planning

Initial Staff onboarding training includes:

- Overview of SHP care management programs (CM, DSNP, Transition Care, Wellness, QI, Behavioral Health, Pharmacy)
- Overview of SHP products (Medicare Advantage, Medicaid, Commercial)
- General overview of SHP (Customer Service, Sales, Claims)
- Policies and procedures
- Resources
- Roles and responsibilities
- Specific job duties and process (SHP care management documentation system and processes)

Initial and Ongoing MOC training includes:

- Individualized Care Plans - reviews, updates, assessments and ongoing documentation
- Interdisciplinary Care Team – review, assessments and ongoing documentation
- Assessments: engagement with D-SNP members, process for outreach and documentation
- HRAT assessment: identifying member needs

- Transition Care – assessment, follow up on transitions
- Community Partners – Family Care Organization involvement, care coordination and outreach
- Medication Reviews – pharmacy
- Utilization Management- authorizations, service requests (Home Health)

Instructors:
Training not directly provided by the staff in each area may be provided by contractors. An example would be if it is determined a change is made which impacts all Care Managers and Clinical Guidelines. Security Health Plan would take the lead and provide the initial training with the expectation the employees' supervisor and contracted staff's supervisor would be responsible for going forward with the ongoing training. SHP also utilizes corporate educators within the system to assist with ongoing training on topics such time management, working efficiently as a team, and phone etiquette.

MOC 2: Element A: Factor 6: Describe how the organization documents and maintains training records as evidence that employees and contracted staff completes MOC training.

Security Health Plan assures that all contracted and employed care management staff has completed training on the Security Health Plan Model of Care. Education and training sessions have agendas, attendance, handouts, mailing lists (if appropriate), and minutes and/or presentation documents are recorded. SHP electronic training distributes and documents participation in computer based trainings. Staff training completion is electronically documented based on the individual's successful completion of the training. Reports are available to management with names of individuals required to take the training and those who have not completed the training. For all SHP DSNP care management team members' face-to-face trainings, Security Health Plan maintains a record of attendees and minutes of the training curriculum.

- For all D-SNP care coordination/MOC sponsored training, SHP maintains a record of attendees and minutes of training curriculum.
- For provider training – webinar, mail out, website, and teleconference trainings, Security Health Plan requires that all attendees send an email of attendance, and a Certificate of Attendance is sent to each attendee upon completion per request of the provider organization.
- All new hires are given a CBT checklist and calendar with CBT's required and timeline to finish upon hire. Annually CBT checklist is given to all SHP staff with required CBT's and timeline for completion.
- Security Health Plan training department retains documentation of all required trainings, training curriculum and attendance for CBT training.
- Training reports are analyzed at least annually and more frequently if needed to assure that all contracted providers and pertinent care management staff has been trained and to assess for changes/updates as needed.
- Incomplete training will be managed by internal SHP disciplinary process and policy.
- If the required training is not completed according to the training plan, SHP will

determine the cause(s) of the issue and develop a plan with the providers, staff, etc. to ensure that the training is completed.

- Initial and Ongoing MOC training to providers in documented via internal tracking of completed computer based training and via 360 Compliance review and attestation of completion of MOC review.

Oversight of Model of Care training

Security Health Plan D-SNP Program Director and/or Manager is responsible for assuring that quality and timely Model of Care training has occurred for employed and contracted personnel. Oversight is monitored through documentation and the review of all new and existing training curriculum and attendance sheets. SHP Training and Development department assists with CBT creation; email reminders sent to providers for timely completion of CBT. SHP Provider Network Contract Managers assist with provider contacts to assist in timely completion of specific facility/network MOC training. Training documentation will be maintained at Security Health Plan. The D-SNP manager is responsible for monitoring completion of training of his/her direct reports. Staffs who continue to be non-compliant with completing trainings are addressed through their manager with potential remedial action, as needed.

MOC 2: Element A: Factor 7: Describe actions the organization takes if staff do not complete the required MOC training

To ensure all SHP employees receive initial and annual Model of Care training, SHP Training and Development has incorporated this requirement in the Human Resources policies and procedures related to employee and contracted personnel job performance descriptions and ongoing yearly performance reviews. SHP's Learning Connection Software System allows the D-SNP manager to complete a "my team" report of CBT completion. Staff are also able to track their completion of CBT's on their personal transcript in Learning Connections.

Several actions will be taken when employees and/or contract personnel do not complete the Model of Care training. This includes, but is not limited to, disciplinary action for plan employees & contracted staff and possibly termination.

When a SHP employee fails to complete the Model of Care (MOC) training as outlined in the new employee orientation description, or in organizational policy and procedures, their immediate manager will discuss the non-compliance with the employee and work to resolve the issue. Since scheduling problems for the face-to-face session can be overcome by the convenience of an online module, staff are reminded of this and provided a due date for completion. MOC training is reviewed with each D-SNP staff yearly performance review.

Failure to comply after this reminder will be brought to the attention of the employee's manager/director, then to Humans Resources. Employees who still fail to complete the Model of Care training despite reminders and discussions, will be deemed insubordinate and considered for disciplinary action.

Actions for ensuring that relevant training is completed and/or dealing with non-compliance are developed through coordinated efforts of employees and providers to ensure that the Model of Care training requirements are met. Possible actions could include, but are not limited to, the following:

- System of notification for reminders of non-completion of training
- Education on training, training schedules and purpose of MOC training
- Individual disciplinary action plan for non-completion of MOC training
- Following applicable internal policies and procedures and contractual requirements, Security Health Plan may terminate an employee, provider, and/or facility that does not comply or adhere to the MOC training process and schedule.

Provider CBT completion is tracked through Learning Connections and/or 360 Compliance tool. Providers outside of the SHP computer system are alerted with an email of the training needed and deadlines through the 360 Compliance tool. An email is sent to specific provider contacts for network providers. 360 Compliance tool sends the provider MOC training and an attestation to be completed. The attestation is to be returned in 30 days attesting to completion of the MOC training. If after 30 days the attestation is not returned, outreach is made to the specific contacts. Provider Network is notified of the non-compliance with the training. Providers are offered individual training (online and/or in person), and MOC training available on the SHP website (attestation included on the provider portal). Continued failure to comply with the MOC training is reviewed with SHP Provider Network and potential disciplinary and failure to follow contracts is discussed.

At any time, facilities(SNF, Home Health), vendors (naviHealth, pharmacies, dental), community resources (ADRC, Family Care Organizations) and providers can be identified by internal SHP staff, external contacts, members and/or family representatives as needing more education and ongoing information on the DSNP Model of Care and program. Targeted mailings with MOC training and/or online webinars maybe provided for ongoing compliance with training and learning.

Challenges arise when requiring training to providers. All of these factors are reviewed with the Quality Improvement Committee for feedback from providers on how to address and improve the completion of the MOC training. Factors that arise are:

- Provider engagement – scheduling, time to complete, provider schedules, multiple duties and documentation needs that providers perform, healthcare crisis
- Multiple MOC trainings to one provider – in competing D-SNP communities, several D-SNP programs may be available to enrollees; providers need to complete for each D-SNP program
- Information overload – duplication of the same MOC information from different D-SNP programs
- Method of training – depending on the facility, internal CBT's utilized or attestation for external providers
- Understanding the usefulness of the MOC training and why they should complete the training

MOC 2: Element B: Health Risk Assessment Tool (HRAT)

Members who are dual-eligible for both Medicare and Medicaid are often frail and chronically impaired and may access a wide range of services from acute care to social services, home care, or sub-acute care. The complexity of the medical needs of these members requires early identification of current health status and risks to facilitate a

timely and comprehensive approach to health care delivery, as is captured in the unique member plan of care. SHP D-SNP program utilizes a comprehensive health risk assessment tool (HRAT) to initially identify the specialized medical, functional, cognitive, psychosocial, mental, and cognitive health needs of its D-SNP population. The response data from the HRAT is used to develop the Individualized Care Plan (ICP).

MOC 2: Element B: Factor 1: Describe the process (policies and procedures [P&Ps]) for completing the HRAT and how the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each enrollee (Element 2D).

SHP's HRAT (Attachment: HRAT assessment) is a screening/assessment that is used primarily to assess the health needs of the D-SNP members at high risk for heavy use of health-related resources in the future. The HRAT contains specific questions regarding medical, functional, psychosocial, mental, and cognitive issues. The HRAT also assesses the member's ability to perform Activities of Daily Living (ADL), financial needs and home environment/safety, and SDOH. All enrolled members will receive the HRAT per regulations at 42 CFR §422.101(f)(i) and 42 CFR §422.152.(g)(2)(iv).

SHP's trained D-SNP care management team completes the HRAT screening/ assessment via visit to the member's home, telephonically, video conference, mail based on the member's preference with the member/designated representative, within the first 90 days of enrollment. The D-SNP care management team is trained in the use of open-ended questioning (motivational interviewing) and probing to maximize the information obtained from the members. The HRAT is also used as the tool to reassess the member, at least annually thereafter, and any time the member has a change in health status (e.g., hospitalizations that result in a functional or medical or mental change to the ICP, change in finances or living arrangements, etc.).

(Attachment: DSNP Initial Checklist) (Attachment: DSNP Annual Check list)

(Attachment: DSNP Annual Assessment)

The basic process for the development of the member's individualized care plan (ICP), utilizing the HRAT assessment data and information, includes the following steps:

- **Initial Screening**
  1. Upon notification of member enrollment and eligibility in the D-SNP program, a D-SNP case and program is opened in the SHP documentation system.
  2. Initial screening is initiated within 90 days of enrollment
  3. D-SNP Community Support Specialist (CSS) opens, assigns and completes the PHM (Population Health Management) screening assessment
  4. PHM screening assessment is started/completed after the member eligibility date
     a. D-SNP Care Management team is notified of member enrollment

b. PHM screening includes:
    i. Verifying member eligibility and benefits
    ii. Updating alerts
    iii. Verifying PHI and advance directives

- **Member initial screening outreach**
    1. 3 outreach attempts are made to start initial engagement with the D-SNP member and/or representative
    2. Outreach attempts are documented in the SHP documentation system. Documentation includes:
        a. Date of outreach
        b. Outreach attempts – 1,2,3
        c. Outcome of attempt
        d. Note
    3. No response after three outreach attempts – unable to reach letter sent. Unable to Reach process followed. Outreach annually and/or transition in care identified.
    4. Member declines D-SNP care management team follow up – Decline process followed. Outreach annually and/or transition in care identified.
    5. Outreach successful – initial HRAT comprehensive assessment scheduled with member and RN and/or SW
        a. Initial screening gathers information to start the process for care management follow up and identification of needed services, barriers, and member medical history.
        b. The Initial Screening will identify follow up needs for the comprehensive initial assessment

- **Initial HRAT Comprehensive assessment**
    1. Initial HRAT comprehensive assessment is completed within 90 days of the member enrollment in the D-SNP program. The assessment assesses the medical, dental, functional, cognitive, psychosocial and mental health needs of the member. The assessment includes the following:
        a. Assessment Outreach/Timeframe
        b. Screening
        c. Medical and Behavioral Health conditions/Surgeries/Allergies
        d. Medications
        e. Symptoms
        f. Nutrition
        g. Cognition
        h. ADLs/IADLs
        i. Home Environment/Safety
        j. Substance Use
        k. Cultural and Spiritual beliefs
        l. PHQ 2 and 9(assessment of symptoms within the last 2 weeks)
        m. Planning for the future
        n. Finances/Employment

o. Services and Supports
p. Care Plan (includes member strengths, goals, goal achievement)
q. Stratification
r. Summary

2. The initial HRAT comprehensive assessment can be completed face to face, virtual and or telephonic.
3. The assessment can be completed by the member, power of attorney of healthcare/guardian and/or the family per the member request.
4. The HRAT assessment is used to identify the member's needs and to assist in the development of the service plan that outlines problems, interventions, goals and barriers in coordination with the member.
5. At the completion of the assessment, overall review is discussed with the member. Discussion includes:
   a. Members strengths
   b. Member goals
   c. Discussion on how member feels they can achieve their goals (interventions)
   d. Who the member wished to have participate in the ICT and care planning process or execution of the care plan
   e. Level of ICT participation (including the role of each person) will play as well as how they will receive the care plan.
6. If the member is unable to reach, the assessment cannot be completed. The unable to reach letter informs members of how to contact and outreach the D-SNP care management team as needed. The D-SNP team will attempt outreach again annually and if a transition of care is identified.
7. If the member declines to complete the assessment, clear documentation will be in the SHP care management documentation system. Information is given to the member and/or representative with a declination of the assessment.
   a. D-SNP care management will attempt outreach again in another 365 days and/or if there is a transition of care identified

- **Stratification**

  Member stratification includes identifying members as High, Medium or Low risk. The stratification process provides a framework for the D-SNP care management team to target and develop interventions and goals for the ICP, improve care coordination, identify resources and to prioritize the member's needs during the initial and ongoing assessments.

  1. Needs stratification is done with initial, annual and transition assessments
  2. Member needs stratification is an ongoing process of assigning members a particular risk status. (Attachment: Stratification/Acuity)
  3. The risk status is based on data reflecting vital health indicators, lifestyle and medical history obtained during the Initial, Annual HRAT comprehensive assessment. Stratification includes:
     a. High – intensive needs/high risk – proactive case management
     b. Medium – rising risk
     c. Low – stable – minimal risk

High Risk: High risk members have at least one complex illness, multiple comorbidities and psychosocial problems. Changes in risk level or member needs identified will be communicated with the D-SNP care management team and documented on a regular basis. Updates to the care plan will be identified by the D-SNP care management team and updated on the care plan as needed. Risk reassessment will be made with the member and/or representative for ongoing identification of needs and changes. All member contact is documented and providers are updated on an as needed basis. High risk members are contacted, depending on the need identified face to face or telephonically by the RN, Social Worker and/or the Community Support Specialist. High Risk reassessment includes assessment of:

- Overall health changes –medical/behavioral health
- Emergency Room visit and/or hospitalizations
- Signs and symptoms –physical, mental or other related changes
- Medications – changes, new, or discontinued
- Safety – falls, s/s depression (PHQ2), home concerns (caregiver, nutrition, transportation)
- Provider follow-up and/or appointments
- Advance Care Planning
- SDOH

Medium Risk: Medium risk members have multiple risk factors that could push them into the high risk category if left unaddressed. An example of medium risk would be a diabetic member who is obese and smokes. Changes in risk level or member needs identified will be communicated with the D-SNP care management team and documented on a regular basis. Updates to the care plan will be identified by the D-SNP care management team and updated on the care plan as needed. Risk reassessment will be made with the member and/or representative for ongoing identification of needs and changes. All member contact is documented and providers are updated on an as needed basis. Medium risk members are contacted, depending on the need identified face to face or telephonically by the RN, Social Worker and/or the Community Support Specialist.. Medium Risk reassessment includes assessment of:

- Overall health changes –medical/behavioral health
- Emergency Room visit and/or hospitalizations
- Signs and symptoms –physical, mental or other related changes
- Medications – changes, new, or discontinued
- Safety – falls, s/s depression (PHQ2), home concerns (caregiver, nutrition, transportation)
- Provider follow-up and/or appointments
- Advance Care Planning
- SDOH

Low Risk: Low risk members are healthy or have well managed conditions. Low risk members are contacted, depending on the need identified face to face or telephonically by the RN, Social Worker and/or the Community Support Specialist.

Minimal risk reassessment will be made with the member and/or representative for ongoing identification of needs and changes. All member contact is documented and providers are updated on an as needed basis. Low risk members are contacted, depending on the need identified face to face or telephonically by the RN, Social Worker and/or the Community Support Specialist. Low Risk reassessment includes assessment of:

- Overall health changes – medical/behavioral
- Emergency Room visit and/or hospitalizations
- Signs and symptoms –physical, mental or other related changes
- Medications – changes, new, or discontinued
- Safety – falls, s/s depression (PHQ2), home concerns (caregiver, nutrition, transportation)
- Provider follow-up and/or appointments
- Advance Care Planning
- SDOH
- The member stratification can changes during the course of engagement in the D-SNP program. Changes are identified and the service plan is updated/changed to reflect the stratification changes and member needs.
- Members identified as High Risk stratification are referred to the ICT team for intensive care management follow up for the needs identified.
- Ongoing needs stratification reassessment includes assessment of:
    1. Overall health changes
    2. Emergency Room visit and/or hospitalizations
    3. Signs and symptoms –physical, mental or other related changes
    4. Medications – changes, new, or discontinued
    5. Safety – falls, s/s depression (PHQ2), home concerns (caregiver, nutrition, transportation)
    6. Provider follow-up and/or appointments
    7. Advance Care Planning
    8. SDOH

When completing the Initial and Annual HRAT the following is assessed and reviewed with the member. If applicable and per agreement of the member, added within the care plan:

a. Health literacy
b. All formal and informal supports (include names or positions)
c. Medical and nonmedical needs
    I. Acute and chronic medical conditions
    II. Mental and behavioral health conditions
        - Medical and behavioral health needs identified are discussed during the assessment; added to the care plan per agreement of the member; ongoing follow up continues with the member per the care plan goals/interventions created; provider f/u needs are identified and referrals are made as identified. Ongoing documentation and follow up of medical and behavioral

health needs are documented in the plan of care within the SHP documentation system.

i. Dental care
ii. Medications and compliance
iii. Supports in the home
iv. Social determinants of health (SDOH)
    - SDOH are identified in the initial screening and comprehensive assessment; needs identified are discussed during the assessment; added to the care plan per agreement of the member; ongoing follow up continues with the member per the care plan goals/interventions created; provider f/u needs are identified and referrals are made as identified. Coordination of benefits are reviewed and discussed on an ongoing basis. Ongoing documentation and follow up of SDOH needs are documented in the plan of care within the SHP documentation system

i. Gaps in care

d. Follow up is identified and agreed upon by the member.
e. Barriers identified with the initial HRAT assessment, members that are unable to reach; members that decline engagement and interaction with the SSI care management team are reviewed. Opportunities to reconcile the barrier or to improve process are included in training and ongoing development and management of the D-SNP program.

The Care Manager will review the initial stratification of the member and will adjust the stratification based on the developing care plan and the member's care management needs and preferences.

i. The Care Manager further augments the developing plan of care as appropriate, based on member-provided information, and available past medical history. Components of the plan of care include, but are not limited to:
    - Opportunity statements
    - Short and long-term goals that consider the member's specific conditions, limitations, and preferences
    - Planned interventions
    - Time frames for goal achievement, and identification of "goals met" or "goals not met"
    - Barriers and challenges to meeting goals as communicated by member/designated representative

The Care Manager generates an initial individualized care plan (ICP) from SHP's care management documentation system, customizing it as necessary to meet the member's specific needs. The D-SNP care manger convenes the ICT to review the plan of care as developed to this stage, and all data and information collected (including the priorities identified by the results of HRAT assessment), are reviewed and utilized by the team to finalize the care plan in collaboration with the member and his/her primary care provider.

- The HRAT assessment results drive identification of member health status

improvement opportunities that become the basis for intervention via the plan of care.

The Care Manager monitors and reevaluates the care plan at frequencies dictated by the member's unique health status based on member's reassessments to confirm that the planned interventions remain appropriate for the member's condition and projected/desired outcomes.

- The identification of care transitions would trigger more frequent reassessment until resolution. These events may include but are not limited to unplanned hospital admission or ER visit, loss of a spouse/significant other/child, change in finances, altered living arrangements, etc.

1. The Care Manager will convene the ICT as needed should the need for care plan modification be identified, which may include revision to interventions and/or ICT membership.
2. Members are reassessed annually, at minimum, using the HRAT. The Care Manager convenes the ICT to:
   - Discuss the various risks revealed by the HRAT and any other assessments that may have been completed.
   - Confirm the appropriateness of resulting opportunity statements, goals, interventions, and frequency of interventions.
   - Promote ICT decision-making to arrive at a final plan of care.
   - Receive confirmation of ICT member involvement in implementing the plan of care, as applicable.

MOC 2: Element B: Factor 2: Provide a detailed description of how the organization conducts the initial HRAT and annual reassessment for each enrollee.

The D-SNP care management team is notified of the D-SNP member enrollment to the program. The D-SNP care management team is identified for the member (Community Support Specialist, RN and Social Work care manager). Outreach is initiated to the member for engagement and assessment by the D-SNP care management team. No assessments are completed before the actual enrollment date of the identified D-SNP member. All outreach attempts are documented within the SHP documentation system.

Methods used to complete the initial HRAT:

- Face to Face (preferred method of completing the HRAT) with the D-SNP care management team (RN, SW and/ or Community Support Specialist)
- Phone call
- Virtual
- Mail

The information from the HRAT is utilized to assist with appropriately stratifying the member according to their individual needs. Documentation of the HRAT is completed within the Security Health Plan's computer system and/or paper and is a permanent electronic record, which is available for all team members to access and review after the HRAT completion. The HRAT identifies specific triggers including medical, behavioral, cognitive, psychosocial and

functional risks. The HRAT assessment information and triggers are then stratified according to the member's needs.

The HRAT is shared with providers as appropriate. The D-SNP care management team updates and reviews the initial and annual HRAT findings with the ICT which includes a review and summary of the HRAT, barriers and action plan of care for the member by the D-SNP care management team. Permission will be obtained from the member to share all information that is needed to coordinate and collaborate with their providers and others involved in their healthcare as needed. The individualized care plan is sent to the PCP, member and /or representative. The individualized care plan is documented in the SHP documentation system.

If the member is unreachable, after 3 attempts to reach the Member or their representative the Care Manager initiates the steps outlined in the "Unable to Reach/Refused Checklist." (Attachment: Unable to Reach/Declined checklist) The workflow requires the Care Manager to make multiple attempts (at a minimum 3 documented phone calls and a follow up letter), via various methods, days, and times, to reach the member, including checking Salesforce and EMR records to confirm current phone number, reviewing authorizations for member admissions, vendor contacts (i.e., personal care worker or social day care), if applicable, PCP outreach, and member letters. Member refusals to complete the HRA are documented and tracked the SHP care management documentation system. At a minimum, an HRAT reassessment occurs within 365 days of the previous assessment. Members are also reassessed as warranted upon the occurrence of a health status change when a care transition occurs. (e.g., admission to the hospital, ER visit, death of a spouse/significant other/child, change in finances or living arrangements, etc.). These situations require the Care Manager to assess, at a minimum, for:

- change in diagnosis
- change in medications
- need for outpatient testing or specialty consultations
- confirmation regarding the appropriate level of care, and
- new opportunities that will need to be addressed in the care plan.

The Care Manager will, in collaboration with the member's PCP, the member/designated representative, and other members of the ICT as indicated, revise the plan of care to appropriately address healthcare and/or social needs identified as a result of the health status change, care transition or other significant changes.

Barriers and strengths will be identified in completing the HRAT assessment, members that are hard to reach; members that refuse engagement and interaction with the D-SNP care management team are reviewed. Opportunities to reconcile the barrier or to improve process are included in training and ongoing development and management of the D-SNP program. Member care plans created encourage outreach to the D-SNP care management team with hard to reach and members that have refused participation.

1. The comprehensive Care Plan is developed to ensure that appropriate care is delivered to the member by following an evidence-based, member-centric treatment plan that addresses his or her unique needs.
2. The plan of care is developed by the D-SNP care management team and the member,

incorporating the elements identified in the screening, comprehensive assessments and the needs- stratification processes. The Care Plan includes the following:

a. The care plan is formulated using the initial and annual HRAT assessment. The HRAT assessment identifies problems, barriers, strengths of the member.
    i. At the completion of the Initial Assessment, discussion takes place with the member, is documented in the assessment, member verbal agreement to the discussed plan of care and follow up plan is completed and the care plan is created.
    ii. The care plan is sent to the member for their records.
    iii. The care plan is sent to the primary care provider for signature and return to SHP D-SNP care manager.
b. Reflects member understanding of the D-SNP program, care management team and ICT team
c. Developed and discussed in coordination with the member face to face, virtual and/or telephonically during the initial and annual assessment.
    i. Care plan is sent to member after assessment completion for review of care plan
    ii. Member acknowledgement of care plan and review is documented during assessment
d. Prioritizes interventions based on the member's medical, mental, behavioral, dental health and other social needs.
~~d.~~e. The HRAT assessment, claims data, medical records, member input, assist in the development of the care plan with the member.
f. The care plan is a permanent part of the documentation within the member's case and chart. The plan of care is assessable to case managers, medical directors, health coaches and ancillary personnel involved in the member's care.
~~e.~~g. Member centric with short and long-term health and wellbeing goals are identified.
~~f.~~h. Health literacy and cultural competency are identified based on the member's needs.
~~g.~~i. Identify formal and informal supports, by name or position, that are instrumental to the member's care plan goals, including their role in assisting in the outcome of the plan of care.
~~h.~~j. Identify current medical and nonmedical needs that will be addressed by the care management team. Included are:
    i. Chronic conditions and acute illness
    ii. Mental and behavioral health conditions and history
    iii. Dental care needs
    iv. Medications and compliance
    v. Supports in the home (ADL/IADL)
    vi. Social determinants of health
    vii. Other factors that will impact the member's ability to achieve their goals
    viii. Gaps in care
~~i.~~k. Evaluates the member's readiness to self-manage their care and willingness to adopt healthy behaviors

j.l. A description of the interventions that will be implemented to address the member's needs

MOC 2: Element B: Factor 3: Explain how the organization then disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and subsequently how the ICT uses that information (Element 2E).

Upon completion of the HRAT and the comprehensive assessment, the DSNP team meets to review the information learned, both from the conversation with the member and all other sources used to gather the information for the assessments. The PGI meeting (Problems, Goals and Interventions) are scheduled upon submission of the initial HRAT, the Annual HRAT and any transition assessments that occur. While any member of the DSNP care management team can schedule the meetings, the ultimate responsibility falls to either the RN or SW care manager that is the primary staff member of the care management team. The PGI meetings involve at least once licensed staff (RN or SW) and the Community Support Specialist, though the team may also include both licensed staff (RN and SW) and/or the member, depending upon the specific member circumstances and/or preferences. The Care management team works together to formulate the care plan based upon the information learned in the HRAT and comprehensive assessment as well as to stratify the member's risk level.

The PGI meetings also serve as the ICT meetings for members that are less medically and socially complex and those that are lower risk. Also included in this category is members that cannot be reached or do not wish to engage with the care management team. Based upon the results of the assessments, the PGI meeting and the stratification of the member, the DSNP Care management team may choose to also discuss a member's health and/or social complexity and higher level of risk (medium and/or high risk) with a larger group of the Interdisciplinary Team Members (ICT) as needed to assist in developing an effective plan of care that will meet the members needs and help improve health and social outcomes. These meetings are scheduled by the care management team, with the primary licensed staff having the ultimate responsibility to ensure the meeting is scheduled and completed, when warranted. Potential ICT members, in addition to the CSS, RN Care manager and SW Care manager, may include, but is not limited to the following:

- Member or Legal Representative
- Primary Care Provider
- Pharmacist
- Medical Director
- Behavioral Health Medical Director
- Wellness Staff
- DSNP Manager

The PGI and ICT meetings are completed via phone, through video technology or face to face and at least one ICT is required annually, upon completion of the Initial and annual assessments, as well as after any transition occurs.

MOC 2: Element B: Factor 4: Describe the detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results, including how the results are communicated back to the ICT, PCP and other applicable providers.

The plan of care and follow up begins with the HRAT and care plan development. Once the initial HRAT is completed, the member will be stratified based on their needs and be placed in a risk category of high, medium, or low. Interventions and touch points will be based on this stratification. With stratification, the D-SNP care management team will complete the following:

- Use the results of the HRAT assessment to modify the member outreach and follow up needs
- Communicate the risk level to the ICT team
- Continuously evaluate and adjust the member's risk stratification level according to changes in the member's needs
- Changes and progress in the care plan goals
- A HRAT reassessment will be completed with every member to identify changes in member care and in risk level stratification. The HRAT reassessment is documented and the D-SNP care management team is notified of changes and member needs identified.
- The risk score is based on a combination of HRAT responses, prior utilization or primary care, emergency department and/or inpatient hospital admissions, mental health or chemical dependency services, pharmacy utilization and presence of conditions such as but not limited to congestive heart failure, mental health conditions, Parkinson's and Huntington's Diseases, diabetes, and substance abuse disorders.
- The D-SNP Care Manager reviews the data and assigns the initial stratification of the member in the SHP documentation system. The Care Manager will adjust the stratification based on the developing care plan and the member's care management needs and preferences. The Care Manager will utilize the member's stratification in the development of the member's plan of care, that will be presented to the ICT for review, approval, and implementation.
- Through this stratification process, the D-SNP care management team can identify and categorize the risk level of each member and better deliver the appropriate type and intensity of care management interventions to drive positive clinical outcomes. The risk level and needs of the Member will determine the method, mechanisms, and frequency of care management engagement. The risk level is housed in the ICP and with in the member dashboard in the SHP documentation system. This is readily available to the D-SNP care management team and anyone reviewing the member case. When the ICP is discussed with other providers, the risk level is also shared. Members identified as high risk receive proactive care management. Those members who are not considered high risk will receive the level of care management engagement, based on their specific. This allows SHP D-SNP to ensure the focus and support is targeted towards the highest risk members.
- Example of stratification changes: Member initial stratification 1 – low risk; changes identified -member living alone, two emergency room visits within 2 weeks, hospitalized with exacerbation of disease, falls reported from emergency room visit, weight loss of 10 pounds in last month. HRAT completed after hospital discharge, stratified as 3 – High

Risk related to falls, medication changes, lives alone, need for increased support in home, increased nutrition needs, home health needs.

MOC 2: Element C: Face-to-Face Encounter

MOC 2: Element C: Factor 1: Describe in detail the process, including policies, procedures, purpose and intended outcomes of the face-to-face encounter.

Security Health Plan will provide a face-to-face encounter for the delivery of the D-SNP member health care, care management and/or care coordination on an annual basis, beginning within the first 12 months of the enrollee's enrollment in the D-SNP program. Members currently enrolled in the D-SNP program will have a face-to-face encounter within 12 months of last annual HRAT assessment. This includes members identified as unable to reach and declined also. Tasks/reminders are created within the D-SNP member's case within the SHP care management system. An alert will also be created with the next due date of the face-to-face visit.

Consent will be obtained before the face-to-face encounter with the member and/or representative via outreach with the member and/or representative. Consent will be completed via telephonic outreach to the member and/or their representative. The face-to-face encounter will be either in-person or through a visual, real-time, interactive telehealth encounter. The face-to-face encounter is part of the overall care management strategy in the overall care and follow up of the enrollee. The encounter may include the member and/or representative, an ICT member and or contracted plan healthcare providers. All outreach attempts for face-to-face encounters will be documented in the SHP care management documentation system. (Attachment: face-to-face visits); (Attachment: face-to-face encounter process)

The D-SNP care management unable to reach process will be followed for face-to-face visits with the D-SNP member. Three outreaches will be attempted, an unable to reach letter sent and documented within the SHP care management system. The D-SNP care management team will be updated of unable to reach.

D-SNP members may decline a home visit. Attempts to engage the member and/or representative to complete a face-to-face visit with the D-SNP care manger will be completed using motivational interviewing techniques. Declined home visits will be documented.

The purpose of the face-to-face encounter:

- Collaborative goal setting with the D-SNP member
- Engagement with the member and/or representative to assess current concerns and health issues
- Assessing, evaluating and addressing potential physical, behavioral, functional and cognitive need the member may be experiencing
- Assist with referrals, resources needed and identified during the face-to-face encounter
- Complete an initial, annual or transition assessment (will depend on timeframe)

The overall outcomes identified for the face-to-face encounters:

- Understanding of the benefits of the personalized care management team that can assist with their health care needs, barriers and questions
- Identification, review, understanding and compliance with their D-SNP care plan
- Improvement in well-being and/or coping skills
- Maintenance of/improvement in physical or cognitive function
- Engagement with the member and/or representative
- Knowledge of and understanding of medical conditions and symptoms
- Maintenance of/increase in independence
- Maintenance of/increase in quality of life

Potential challenges identified for the face-to-face encounters:

- Older population that have autonomy in their homes, including compliance and non-compliance with their healthcare and don't want someone coming in and potentially making changes
- Prior negative experiences with face-to-face in person encounters
- Decline or unable to reach on prior outreach attempts to complete assessments
- Staff safety during encounters

MOC 2: Element C: Factor 2: For instances in which the SNP is providing the encounter, include staff (employed and/or contracted) who may conduct the face-to-face encounter.

All face-to-face encounters will be conducted by the SHP D-SNP RN care manager and/or the SHP D-SNP Social Worker care manager. Consent for the face-to-face encounters may be obtained and encounter may be scheduled by the SHP Community Support Specialist, D-SNP RN or Social Worker care manager. Three outreach attempts will be made to schedule the face-to-face encounter and an unable to reach letter will be mailed. Outreaches, dates and date the letter sent will be documented in the SHP care management documentation system. Unable to reach and declined face-to-face encounters will also be documented.

MOC 2: Element C: Factor 3: Describe how the SNP will verify through data collection that the enrollee has participated in a qualifying face-to-face encounter.

Face-to-face encounters are documented in the initial HRAT assessment, annual HRAT assessment, transition assessment and or the ongoing outreach note within the SHP care management documentation system. (Attachment: DSNP Ongoing Outreach Note)
Tasks will be created within the documentation system for a reminder of next annual due date for face-to-face encounter. An alert will also be created within the system identifying date of last face-to-face encounter. Reports will be created and reviewed monthly on every D-SNP member enrolled in the program. The report will include:

- Member Name

- Date of Face-to-Face encounter
- Date of last annual visit (unable to reach and declined included)

Reports will be managed by the D-SNP clinical manager and RN Team Lead, reviewed with the D-SNP team during monthly education days. Data will be analyzed and reviewed within the SHP QIC committee for feedback and or changes identified with face-to-face encounter data.

MOC 2: Element C: Factor 4: Explain what types of clinical functions, assessments, and/or services may be conducted during the face-to-face encounter.

The D-SNP HRAT initial, annual, and/or transition assessments and the ongoing outreach note can be utilized and completed during the face-to-face encounter. The HRAT assessments assess and evaluate the members functional, medical, physical, cognitive, psychosocial and mental health needs potentially encountered during the face-to-face encounter. No hands on care is completed with the face-to-face encounters.

MOC 2: Element C: Factor 5: Provide a detailed description of how health concerns and/or active or potential health issues will be addressed during the face-to-face encounter.

Needs, health concerns and issues identified during the face-to-face encounter will be discussed with the member during the encounter. Referrals, resources, updates to providers, education will be provided during the encounter. Ongoing follow up with the member will be determined at the face-to-face encounter with the member agreement. Care plan will be reviewed, changes discussed and updated as needed, identified and agreed upon with the member. ICT team will be updated on changes, and needs identified. PCP, specialists, caregivers, facility coordinators will be notified and involved in concerns identified. Needs identified during a visit to a member in a SNF, will be addressed with RN at SNF and/or social worker. For example, medication questions, falls, symptom management. With member consent, caregivers, family members will be updated on concerns/issues identified during face-to-face encounter. Example: member reporting falls in the home when home alone, not able to get out and get food supplies. Caregivers and family updated on needs, referral to Family Care Organization and/or Home Health for evaluation for increased caregiver resources and in-home cares. PCP to be updated on falls, appointment set up for follow up as needed.

MOC 2: Element C: Factor 6: Describe how the SNP will conduct care coordination activities through appropriate follow-up, referrals and scheduling as necessary.

Care concerns and issues identified will be discussed with the member and/or representative during the face to face encounter. Follow up will be made directly to resources needed and/or identified. Example, member with recent falls identified during the face to face encounter.

Therapy, Home Health for in-home visits, fall safety, safety in the home, caregiver resources needed for safety in the home will be discussed with the member. Member agreeable to Home Health for f/u safety and home exercise program. D-SNP RN care manager will f/u with the provider for Home Health referral. Ongoing outreach will continue with the member to identify progress/changes during Home Health f/u. A referral may need to be made to Home Health and/or Family Care Organization to assess member for increased in-home assist. Home safety, SDOH concerns will be addressed and resources will be made to the appropriate areas to assist. 911 will be utilized with members identified in immediate danger, needing crisis intervention and/or having immediate health concerns. Members needing authorizations for procedures, will be assisted with the PCP follow up and appointment scheduling.

MOC 2: Element D: Individualized Care Plan (ICP)

Security Health Plan follows regulatory and best practice standards regarding members ICP by following the SHP ICP process. The D-SNP care management team develops an ICP for all members.
The D-SNP care management team and ICT work in partnership with the member, their authorized family/representative, primary care provider, and other collateral sources to assure that the member is involved in the care plan process and making choices based on the needs assessment. The member's choice and input will be documented.

MOC 2: Element D: Factor 1: Detail the essential components of the ICP.

The ICP includes, but is not limited to:

- Completion of the ICP according to the MOC and ICP process
- Include interventions designed to meet the needs identified in the HRAT assessments
- Include measurable outcomes
- Review and revise the ICP in accordance with the MOC and policies and based on the member condition and changes
- Document follow up with member regarding care plan interventions, goals met and services provided
- Engage the member and/or representative participation when developing the ICP
- Ensure communication of the ICP takes place among the D-SNP care management team, providers, and members as needed and per policy
- Member self-management goals and interventions. This may include member centered goals, ongoing monitoring of the goals, barriers/strengths that may exist, readiness to change and specific interventions.
- Description of services specifically tailored to the member needs.
- Identification of goals (met or not met). If the member's goals are not met, the ICT will work with the member to identify barriers or issues that exist and work on the remedies/solutions.
- Prevention focused interventions and goals in addressing the encouragement of the member to seek annual physicals, ongoing dental care, immunizations, and eye and hearing exams and identified therapies.
- Identification of Advance Care planning needs and follow up – Advance Care Planning is an essential component of the member's plan of care. The comprehensive assessment

and the psychosocial assessment will assist in the direction of further needs identified for continued advance care planning. The D-SNP care management team will facilitate discussion and continued direction and planning that includes the discussion of Advance Directive planning and choices.

- Risks to health and safety – a plan for addressing these risks is included in the care plan. This includes providing choices to the member to help them manage their own risks and implement contingency plans for emergency situations
- Declined and Unable to Reach – a plan of care is developed for members that decline to participate in the D-SNP program or are unable to reach after enrollment to the program. Members are encouraged to participate and are outreached per the unable to reach process. The care plan is sent to the member and/or representative for future outreach. The decline or unable to reach assessment is documented and shared with the D-SNP care management team and the ICT team. The SHP Medical Director assists in the review and signing of the Unable to Reach and/or Declined ICP. (Attachment: Care Plan example)

The essential components of the individualized care plan (ICP) are:
Member self-management goals and interventions
Member health care preferences
Description of services specifically tailored to the member needs
Identification of goals (met or not met)
Member goals are identified during initial, annual, transition and ongoing assessments. If the member is unable to reach or declined to participate in case management, the developed goals are based on how to contact the D-SNP care management team, advance care planning, reporting any updates and changes and access to the D-SNP care management team.

The individual care plan incorporates the essentials elements to meet the member's assessed needs identified by the health risk assessment in the areas of medical, SDOH, psychosocial, functional, and cognitive needs, and mental and medical health history. The care plan includes specific goals and objectives, interventions, and outcomes as well as specific services and benefits to be provided. Methods for monitoring the outcomes/goals and treatment follow-up are incorporated. The care plan is designed to incorporate the disability, cultural/religious and linguistic needs, and type of services, and benefits to be provided. It addresses the amount, frequency, and duration of each service and the type of provider furnishing the services.

Identification of any risks to health and safety and a plan for addressing these risks must be included in the care plan. This includes providing choices to members to help them manage their own risks and implement contingency plans for emergency situations.

Prevention goals and interventions are included addressing the encouragement for the member to seek annual physicals, ongoing dental care, immunizations, eye and hearing exams, and identified therapies. The individualized care plan will also include the discussion of Advance Care Planning and Advance Directive completion.

The ICP is updated at least annually using information gathered during the annual reassessment. The ICP is also updated or revised if a member's need change as a result of a transition, hospitalization or significant change in chronic condition requiring end of life care and potential enrollment in Hospice services.

MOC 2: Element D: Factor 2: Describe the process to develop the ICP, including applicable staff involved, how often the ICP is modified as enrollees' health care needs change

The D-SNP member is contacted to complete the HRAT as described in MOC 2, Element B. During each assessment, the member is invited to actively participate in the development of their ICP. Assurance is given that involvement can be at the level desired by the member, and that all go-forward interactions and planned goals/interventions will consider member preferences. Additional topics discussed during an interaction include, but is not limited to the following items:

- Providing information regarding how the ICP is developed, the member's role in its development, and how it will support the member in reaching his or her own health care goals and improve their health care experience.
- Encouraging member or member representative's participation in the care planning process and further encouraging the member/designated representative to include other caregiver or informal designated representative involved in the member's care.
- Conveying that the member can decline participation in care planning, should the member prefer to do so.
- Explaining that the member may request a change in their ICP at any point by contacting the Care Manager
- Assessing the impact of social determinants of health (SDOH), and the extent of cultural/linguistic and/or vision/hearing needs, preferences, or limitations.
- Evaluating the extent of the member's ability and/or willingness to perform self-care activities, and the level of caregiver support.
- Identifying any barriers that may preclude goal achievement.
- The ICP is developed by the RN and/or the Social Worker care manager in conjunction with the assessment completed.
- The care plan will be reviewed, at a minimum, annually with the member reassessment. The RN and/or Social Work care manager is responsible for updating the care plan at the annual assessment as needed. Care plans will also be reviewed if there are significant changes to the member's health status and/or living arrangement (transition).
- The care plan is a living document that is reviewed, with the member and ICT, as agreed and/ or as is dictated by changing circumstance and new medical input. The RN care manager and/or the Social Work care manager has responsibility to assure the plan is moved forward, milestones kept up to date, goals and objectives updated, and outcomes documented.
- For members receiving LTC support, residing in facilities, receiving Hospice interventions, the RN and/or SW case manager works with the member and their team to develop and maintain the ICP. These members generally have community resources to coordinate and assist them. The goal of the ICP is to align member services, goals, outcomes and self-management.

Each care plan includes:

a. Development of a case management plan, including long- term and short- term goals that take into account the member's or responsible parties' goals and preferences.
b. Identification of barriers to meeting their goals or complying with the plan.
c. Development of a schedule for follow-up and communication. Member stratification is identified and incorporated into the planning of the ICP and ongoing follow up needs.
d. Development and communication of their self- management plans
e. A process to assess their progress against case management plans.
f. At the end of each care plan there is a section for measuring outcomes.

MOC 2: Element D: Factor 3: Identify the personnel responsible for development of the ICP, including how enrollees and/or caregivers are involved.

The D-SNP RN and/or SW case manager are responsible for the development of the ICP. (See roles and responsibilities of the D-SNP RN case manager and D-SNP Social Worker in MOC 2: Element A Factor 2: Describe the clinical staff's roles and responsibilities, including oversight functions noted in Factor 1)

The ICT team recognizes the importance of family and/or caregiver involvement in the formation and development of the ICP and review. All efforts will be made to include the family and/or caregivers in the creation, updating, and ongoing review of the ICP. If family and/or caregivers are unable to participate face to face, telephonically or virtually with D-SNP care management team, the ICP will be mailed to them for review. Members are offered a copy of the ICP and are encouraged to share it with their community partners and PCP. The D-SNP care management team may contact the community care partner to participate in the ICP review to discuss the interventions, goals and potential barriers. All attempts for review and follow-up will be documented in SHP documentation system. If continued difficulty is documented for review of the plan of care with the member's family and/or caregivers, the ICT will meet to develop a strategy for contact, review and compliance of the ICP. The ICP review is documented in the SHP care management system along with a copy of the updated care plan. Members may refuse to meet face to face or telephonically to review the care plan. Refusal to review is documented and the care plan is sent to the member and/or representative for review at their discretion.

The D-SNP RN and/or Social Worker Care Manager will:

- Establish a task/reminder for care planning to be completed within 30 days of HRAT completion.
- Initiate care plan development in the SHP documentation system based on health risk assessment findings.
- Contact the member to discuss the process to improve the member's health status, promote member involvement in development of the plan of care and record any additional pertinent information received.
- Continue initial care plan development, which includes consideration of risks identified from the assessment, such as the status of Advance Directives, level of personal care

assistance required, sensory deficits (vision, hearing and/or speech), reported feelings of depression, and high-risk factors, such as weight status and alcohol/chemical dependency.

- Review the problems/opportunities, goals, and interventions. .
- Provide the ICP to the member's PCP and member/designated representative in the method desired
- Convene the ICT and
  1. Discuss member risk based on results of HRAT, member stratification and any other information available, such as utilization data, claims, pharmacy, etc.
  2. Confirm completeness of resulting opportunity statements, goals, and interventions/frequencies.
  3. Promote ICT decision-making to arrive at a final plan of care.
  4. Receive confirmation of ICT member involvement in implementing the plan of care, as applicable.
- Modify the plan of care in the SHP care management documentation system , as necessary, based on ICT feedback.
- If ICP is modified, provide a copy to the member's PCP and the member/designated representative in the method desired.
- Tasks/Reminders are created to track the required follow-up assessments and reviews based on member stratification and acuity/risk designations.
- Keep the PCP, member, ICT participants and other D-SNP personnel involved in the member's care informed of any changes in the member's health status identified via reassessment, which may warrant a change in the plan of care. Convene the ICT and be prepared to modify the plan of care as needed when member health or other significant status changes warrant.
- Participate in the annual review of risk reassessment findings, to identify opportunities to improve the care coordination process.

MOC 2: Element D: Factor 4: Detail how the ICP is documented and updated, and where it is maintained.

The care plan is documented in the SHP care management documentation system. An ICP assessment is completed which documents the following: (Attachment: ICP)

- ICP care conference (initial, annual, transition, update)
- ICP care conference Declined/Unable to Reach
- ICP completed (method of completion)
- ICP completed with
- ICP participants
- ICP progress: problems/interventions/goals – review/updated/agreed upon
- ICP sent to

The ICP is updated and maintained as a permanent part of the documentation within the member's case and chart in the SHP documentation system. The care plan will be reviewed, at a minimum, annually with the reassessment. The RN and/or the Social Worker care manager are responsible for updating the care plan at the annual assessment. Care plans will also be reviewed and revised if there are significant changes in the member's health status and/or living arrangement. Care plans are also reviewed and revised to support a proactive and preventive approach. The care plan is maintained by the RN care manager and/or the Social Work care

manager and entered into the case management system. The transition process ensures timely updates to the ICP according to policy. This may include, but not limited to, review of medications, changes in condition and changes in needs, and may trigger revision of the care plan based on changes in needs, services, and goals.
The member's individualized care plan is accessible to the Care Managers, medical directors, acute and complex care case managers, behavioral health case managers, Disease Management, Health Coaches, Health Educators and ancillary personnel involved with the member's care.
The care plan is a living document that is continually reviewed, with the member and D-SNP care management team, as agreed and/ or as is dictated by changing circumstance and new medical input. The D-SNP RN and/or Social Worker Care Managers are responsible to assure the plan is moved forward, milestones kept up to date, goals and objectives updated, and outcomes documented.

MOC 2: Element D: Factor 5: Describe how updates and modifications to the ICP are communicated to the enrollee and other stakeholders.

The member, ICT, and pertinent network providers receive communication regarding the initial individualized care plan and any care plan revisions in a timely manner. A copy of the care plan and/or summary is provided to the member and his/her legal representative, primary care provider, and other appropriate specialized pertinent providers. Members who decline engagement in the D-SNP program or who do not respond to care management outreach will be contacted for when there is a change in the member condition. Ongoing attempts to engage members who opt out will be made based on needs identified, care transitions per policy.

The PCP and/or specialist are notified of the member's enrollment in the D- SNP program, engagement in program and ICP with an initial care plan letter and attached care plan. The provider will be instructed to sign and return one of the care plan copies and keep the other copy for their records. Ongoing communication will take place with the provider from the D-SNP care management team. The provider is notified as changes occur in the care transitions for the member, medication or care treatment changes needed or care needs that are identified on a day to day basis as needed. All communication with the providers and the ICT is documented in the SHP documentation system. All team members are able to view documentation as needed. The initial care plan letter includes:

- Member involved in the SNP program
- D-SNP care management team contact information
- Discussion and education given to member including:
  1. Understanding and managing medications
  2. Identifying choices and resources for health care needs
  3. Assessing and coordinating necessary health care services
  4. Improving the understanding and self-management for specific health conditions
- ICP – including short term and long term goals, interventions and outcomes

1. Care plans are continually updated as we work with the D-SNP members. Some or all PGI should be reviewed during our ongoing calls with members and we also update care plans during transitions and future annual reviews. During ongoing

follow up call with members, the problem last reviewed dates should be updated when the PGI is discussed with the member.

2. If a PGI is noted to be completed during an ongoing call, it can be closed. An example of this may be if the member had a PGI related to immunizations. During an ongoing call you are made aware that the member received the needed immunization and is again current.
3. Add Hospitalization PGI and any other pertinent PGI related to the hospitalization. During the transition assessment call with the member, the PGI, current and those planned to be added, should be discussed with the member.
4. No PGI changes are required, but any concerns noted during the transition assessment should be addressed on the care plan. For example, if member was previously independent with ADLs, but now requires some assistance, it may be appropriate to add a PGI related to Caregivers to the care plan. Or if member has had a progression of Dementia and is now a wandering risk, it may be appropriate to add the personal safety PGI to the care plan.
5. Upon notification of enrollment in Hospice, the care plan should be reviewed with the member and a Hospice PGI added. The Start date of the PGI should be the date of enrollment.

MOC 2: Element E: Interdisciplinary Care Team (ICT)

ICT Overview

The member's unique needs identified by a member, family, caregiver, care manager or provider drive the composition of the ICT. In addition to input from the member, the D-SNP care management team will use all available data in assessing for team membership included but not limited to; the initial health risk assessment, the ongoing assessments and the individualized care plan.

MOC 2: Element E: Factor 1: Provide a comprehensive description of how the organization determines the composition of ICT membership, including addition of team members to address unique needs of enrollees.

Depending on the unique needs of the member, the member's ICT may be comprised of the following:

- Member
- Designated Representative/Caregivers
- RN Care Manager
- RN Team Lead Care Manager
- Social worker Care Manager
- RN Clinical Manager
- Member's Primary Care Provider
- Pharmacist
- Medical Director

The D-SNP RN and/or Social Worker Care Manager, in conjunction with the member and/or their caregiver, determines the composition of the ICT based on the member's health risk assessments, risk stratification, care goals, and any needs identified. If a specialist is leading the member's clinical services, that specialist may take the place of the PCP on the ICT. The decision to designate a specialist in place of a PCP is made in collaboration with the member, based on his/her primary healthcare needs.

Depending on the unique needs of the member, as defined in the ICP, the ICT may include additional clinicians, community workers, and others such as mental health professionals, peer support workers, and external agency case and Care Managers (e.g., long-term support services Care Managers, contracted nursing facility Care Managers, physician specialists, nutritionists, physical/occupational/speech therapists, etc.). Similarly, the ICT may include SHP staff representing specialized programs (Wellness coach, nurse navigator). In all cases, the member has ultimate authority over the composition of the team, to include adding or removing participants. Subject matter experts may participate as full members of or as ad hoc members of the ICT.

The D-SNP RN and/or Social Worker Care Manager will coordinate the selection of these permanent and ad hoc ICT participants. Once a list of ICT members has been identified, the Care Manager documents this information in the SHP documentation system . The composition of the ICT is updated as required by changes to the member's health status or psychosocial needs. However, the core ICT membership, including the member, the RN Care Manager and the member's PCP, will remain intact to ensure consistent member support over time.

Upon review of the member's ICP, the ICT addresses barriers/delays to goal attainment and recommends changes to the ICP to help remove barriers and achieve outcomes. If there is a significant change in condition, the D-SNP RN Care Manager works with the member or designated representative to evaluate the status of the ICP and, if necessary, convenes an ICT meeting to discuss necessary changes.

MOC 2: Element E: Factor 2: Describe the roles and responsibilities of the ICT members (including enrollees and/or caregivers) and how each contributes to the development and implementation of an effective interdisciplinary process.

The ICT is unique for each member based on their need. The ICT role is to:

- Analyze and incorporate the results of the initial and ongoing assessments.
- Collaborate to develop and annually update an individualized care plan for each member.
- Manage the medical, cognitive, psychosocial and functional needs of the member through collaboration and the development of a comprehensive care plan
- Coordinate with the provider network and the member to deliver specialized services in a timely and quality way
- Always respect the wishes of the member and/or representative
- Be cognizant of any special communication needs of persons with disabilities

- Performing routine activities related to the management of the member identified through the ICT review with face to face intervention and/or telephonic outreach
- Ensure members with language, hearing or cognitive impairments receive appropriate translation services
- Discharge planning and care management

Member and/or designated representative engagement in the ICT is the dominant factor, and every effort is made to facilitate participation and involvement. Members challenged with medical and behavioral conditions, access to care services, as well as chronic illnesses and disabilities require a multidisciplinary care approach to regain health and function.

The ICT involves the member in the care planning process in the following ways, driven by the D-SNP RN and/or Social Worker Care Manager, with assistance from social worker and community support specialist.

- Working with the member to identify interventions that will help them to maintain their independence and safety.
- Continually evaluating health outcomes and discussing revisions to goals with the member.
- Reviewing the completed ICP with the member to assure agreement and understanding.
- Reinforcing the availability of the D-SNP RN and/or Social Worker Care Manager to discuss any questions or concerns that may arise during the course of implementing the ICP and/or ICT activity.

Responsibilities of care coordination include supporting the member's needs across the continuum of care via in–person (or telephonically) engagement by leveraging member involvement, case management, and program referral processes. The D-SNP care management team partners with the member, the health plan, the PCP and Network Providers. The D-SNP care management team ensures development of an individualized holistic plan of care that is member centric. ICT members contribute to improving the health status of the D-SNP members by utilizing their individual expertise and team collaboration.

The D-SNP care management team will ensure access to an adequate range of choices for members by helping the member identify formal and informal supports and services, ensuring that the services are culturally sensitive and arrange for interpreter services if applicable. The D-SNP care management team will work with Social Service Agencies and Veteran's Administration to coordinate services and support for member's needs. (I.e. Social Service Agencies, Housing, Employment, Primary Care Clinics and Specialists, Community based resources, DM/CM program, Transportation and Veteran's Administration).

MOC 2: Element E: Factor 3: Detail how ICT members use the outcomes to evaluate, contribute and continually manage and improve the health status of SNP enrollees.

The ICT reviews objective data, including member-specific claims and utilization history to

determine the effectiveness of interventions. For example, an analysis might be conducted to evaluate the effectiveness of a care coordination plan for a member who was deemed high risk because of the number of opioids in a given period. In this case, the ICP goal may have been to enhance the coordination of care between and amongst providers to ensure adequate pain management. If the goal was attained, then the intervention would be deemed effective, and the member's goal met.

The information obtained in by the ICT is used to monitor gaps in medical, behavioral, and psychosocial services. The focus is on preventive and maintenance health care services, disease specific intervention and increased coordination between social service and health care providers. Care coordination is provided with ongoing monitoring and assessment of each member based on their identified needs and goals. This also ensures that care is consistent with best practices, collaborating with other participants in efforts to improve care, outcomes, and satisfaction and supporting and facilitating connections with local community care and service providers.

The ICT members contribute to improving the health status of the D-SNP members by drawing upon their individual expertise and team collaboration. This includes the member barriers identified with the team to develop goals and work together to resolve their healthcare concerns.

As described, the ICT includes a variety of clinicians, as well as non-clinical resources, each with a unique perspective and expertise in developing, and modifying the ICP, and contributing to an effective ICT. SHP may also engage others (e.g., pharmacists and member care representatives) in the ICP and ICT processes to assure that a holistic person-centered plan of care is developed and maintained. For example, the Primary Care Provider or Medical Director may recommend to the team that the member's risk stratification be updated to reflect, more accurately, the member's need for more or less intensive care coordination or care management. Community based resources participating in the ICT offer insights into what services the member is receiving, and what is available, that might optimize the member's independence or their ability to remain safely in the home. Participants of the ICT provide expertise and recommendations for customized, measurable, member centered goals and interventions. Updates to the ICP occur at least annually, or upon a triggering event, as described earlier in this document. The ICT meets in person, or via phone conference, to discuss and review the member's status, existing ICP, results of the HRAT, and any other documentation available, such as lab results, claims, pharmacy reports, etc. to finalize the ICP.

MOC 2: Element E: Factor 4: Describe how the SNP's communication plan to exchange enrollee information occurs regularly within the ICT, including, evidence of ongoing information exchange:

All D-SNP member assessments, ICP's, care transitions, claims, and pharmacy data are maintained in SHP's care management documentation system. The D-SNR RN Care Manager has primary accountability to coordinate all communication regarding implementation of the ICP, including the involvement of the ICT. Ongoing communication with ICT members can occur via multiple methods, depending on member preference, including telephonically, by mail, or secure email, etc.

Communication with members possessing vision/hearing impairments and/or language barriers can be accomplished via various methods, such as printed translation (Braille or preferred language, upon request), telephone and face-to-face translators, large print, and TTY. Mental health professionals may be consulted regarding appropriate communication strategies for members with cognitive or mental health issues influencing that may influence their ability to communicate.

Physician communication typically occurs in the manner desired by the physician. Should electronic transfer of information be requested, staff adheres to SHP's protocols to ensure that the parameters of the HIPAA security and privacy rules are followed.

ICT meetings occur at least annually or at the frequency dictated by a change in the member's health care status. Documentation of the ICT meetings are maintained in the member's record, including the list of attendees, and any follow-up action items. These meetings may occur face-to-face, via phone conferencing, and/or virtual means (e.g., WebEx).

The D-SNP RN and/or Social Worker Care Manager documents the outcome of discussions, when applicable, updates are recorded in the member's ICP, as well as housed in the SHP care management documentation system. Over the course of monitoring the progress of the ICP, should significant changes be identified in member condition, care needs, social, financial, or environmental status, additional ICT members will be engaged to meet the unique need. if there is not already a capability within the team.

In addition to ICT meetings, the D-SNP care management staff participates in periodic staff meetings, where changes to policies and procedures, and updates to state and federal regulatory requirements are reviewed. In-services on topics relevant to D-SNP enrollees are also provided.

MOC 2: Element F: Care Transition Protocols

MOC 2: Element F: Factor 1: Describe how the organization uses care transition protocols to maintain continuity of care for SNP enrollees.

Protocols used for member's transition between care settings provides for the member's continuity of care. Older and disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly controlled. The members care plan is shared with providers and the member with these transitions which may contain updates and required care coordination activities as identified. The role of the D-SNP care manager, along with the community support specialist and social worker is to provide seamless support and coordination of services during care transitions across healthcare settings.

Care transition process is used with both planned and unplanned transitions. Planned transitions include things such as a scheduled elective procedure, including outpatient

procedures performed in a hospital or outpatient/ambulatory care facility, decisions to enter a long-term care or rehabilitation facility, or a return to the enrollee's home (usual care setting) after an unplanned transition. Unplanned transitions include things such as an emergency hospitalization. Members and/or representatives are educated on the care transitions process used by the D-SNP care management team so they are aware of the contact and follow up that will be made by the D-SNP care management team.

Care transitions with the D-SNP program are for supporting the member before, during and after transitions to coordinate the members care. Often, the medical providers and community care providers are not aware of the member's transition. The D-SNP care management team is able to provide a complete picture of the member's needs/changes which in turn assists in assisting with an appropriate discharge and follow up plan.

Movement between sites of care require a transition plan including the member's transition back to his/her usual care setting, which is noted in the Member's Care Plan. Typical care transitions are (not all inclusive):

- Hospital - Home
- Hospital - SNF
- Hospital – Hospital (transfer)
- Hospital – Assisted Living
- SNF – Assisted Living
- SNF – SNF (transfer)
- SNF - Home
- SNF - Hospital
- Other Institution Setting - Hospital
- Other Institution Setting – Community

During the time of a member's transition in a care setting, the D-SNP RN and/or Social Worker care manager and/or other members of the ICT, ensure that that the member has a safe, well-coordinated transition from one level of care to another. This collaborative team process strives to achieve improved member outcomes during transitions in care. SHP D-SNP care management team aims to facilitate a safe transition for all eligible members. The goals are to address any knowledge deficits or educational needs the member has regarding the transition, their diagnosis(es), and treatment, improve the member's access to follow-up services needed post-discharge, ensure the member is able to fill new prescriptions and understands the instructions for medication administration, has a follow-up appointment scheduled with his/her PCP, as well as any appropriate specialists that may be required, based on the member's discharge diagnosis(es)and knows how to contact the D-SNP care management team for any other post-discharge needs. The following measures are implemented to achieve these goals:

- Analyze the member's needs at the time of admission and discharge, to identify if any specialist providers are needed. This includes assessment of any barriers (financial, social, etc.) that may result in readmission. This also includes of available hospitalization records, discussion with the facility/discharge planners.
- Communication, written or verbal, with the PCP of the member's progress during the transition. Coordination with specialists (i.e., medical, geriatric, psychiatric,

rehabilitation) post-discharge

- Communication with the member/designated representative about the care transition process and the need to notify the SHP D-SNP care management team if there are any changes in the member's health status. This includes review of any clinical information, any medication changes/reconciliation, and assessment if there is a significant change in condition warranting a new HRAT.
- Assists the member with finding the appropriate specialists and with making appointments, as necessary.

Upon transfer back to the usual care setting, the D-SNP care management team uses the following steps to lessen readmission:

- Timely notification of the transition to D-SNP care management team
- Timely follow up with member/family
- Timely follow up visit to primary care or specialists (within 7-14 days as needed and able)
- Discussions with living arrangement providers as part of the member's ICT updates for care transitions e.g. SNF or Assisted Living
- Medication self-management which requires accurate medication review (member/family/facility must understand changes)
- Knowledge of red flags/triggers (knowledge of the warning signs that indicate the condition is worsening and how to respond)
- Updating the care plan with changes identified
- Utilization of nurse line for questions
- D-SNP care management team follow up to assess member's changes, progress and increased needs identified.

Authorization data on SNF admission, hospital admissions and discharges is available within the SHP care management documentation system. Task/Reminders are sent to the D-SNP RN care manager with notification on a hospitalization, emergency visits and SNP admissions. Upon notification of the transition, the D-SNP RN and/or Social Worker Care Manager reviews and updates the D-SNP care management team., contacts the admitting facility (as needed) for updates and discharge plans and continues to monitor until the member is discharged home or to another place for cares. Members with enrollment in a MCO, are also alerted on member admission to the hospital to continue the coordination of care for the member. Ongoing communication with the member, member representative and facility continues as needed during the transition time period.

Data on Care Transition activity is collected on an ongoing basis with the evaluation of

- Timely delivery of care – post discharge follow up
- Member/designated representative engagement
- Readmission rates

MOC 2: Element F: Factor 2: Describe the personnel responsible for coordinating the care transition process.

The D-SNP care management teams are essential to supporting the member's needs across the continuum of care. Regular engagement and contact with the member and their providers informs the D-SNP care management team of health care service needs and supports, thus allowing active management of planned and unplanned transitions. The goal of this process is to reduce incidents related to fragmented or unsafe care and to reduce readmissions. Transitions of care engagement and follow up takes place regardless of how or when the D-SNP care management team learns of the transition.

The D-SNP care management team makes special efforts to coordinate care when members move from one setting to another. The team works on providing seamless coordination and transition of medical care across the health care settings, including providers and other health care services. The D-SNP care management team supports the member before, during and after transitions and coordinating the care transition process. The D-SNP care management team outreaches the member, member representative or facility the member was transitioned to. The D-SNP care management team assists with facilitating and discussing any changes in the member's condition and changes in needs related to the transition to assist with care planning.

The D-SNP care management team is responsible for coordinating the care transition process and supporting the team to assist in ensuring follow up services and appointments are scheduled and completed. This may be the nurse care manager, social worker, or coordinator to facilitate discharge planning based on available information. They can coordinate with the facility, PCP, member and/or family or caregiver. The RN Care Manager and/or the Social Worker Care Manager assumes primary responsibility for the care transition process. These individuals are responsible for safe, effective care transitions from one setting to another, including, but not limited to, hospital to hospital, hospital or SNF to home. They become involved when the need for transition is identified and follow the member throughout the post-transition period to successfully manage all needed aspects of care, which includes ensuring that follow-up services and appointments are scheduled and performed. The D-SNP RN care manager involves other ICT members as appropriate. The member needs identified during the transition may include safety in the home, medication reconciliation and management, symptom recognition and follow up and ongoing management and education related to the transition. (Attachment: Transition Assessment) (Attachment: Discharge Planning Assessment)

MOC 2: Element F: Factor 3: Describe how the organization transfers elements of the enrollee's ICP between healthcare settings when the enrollee experiences an applicable transition in care.

D-SNP care management team documents transition in the member's record within the SHP documentation system. A new note is completed for each transition and is kept in the member's file along with additional case notes documentation as appropriate. (This documentation is an extension of the members care plan specific to transitions)

During the time of a member's transition in care, the D-SNP RN and/or Social Worker care manager, in collaboration with the ICT members, ensures that that the member has a safe, well-coordinated transition from one level of care to another. This collaborative team process strives to achieve improved outcomes during transitions in care. Several measures have been implemented to achieve these goals:

- For identified planned transitions, the care management team will outreach the member and/or family/caregiver to educate and coordinate care services such as transportation to the facility or follow-up physician appointments.
- For unplanned transitions, the D-SNP care management team will communicate with the facility/provider/physicians and/or member/designated representative, to share pertinent information such as the ICP, medical history, diagnoses, and medications.
- Upon notification of admission, member admission records/notes, authorizations and any other admissions information is reviewed. A discharge planning assessment is completed while the D-SNP member is still in the hospital. The assessments assists in identifying
- Provide educational materials to promote the member's self-management skills.
- Collaborates with the members of the ICT as appropriate, to provide information on the transition process, discuss changes to the member's health status, and coordinate any post discharge services or long-term community support services. Assists in the coordination of any post discharge services or long-term community support services. This may include coordination of services such as home care, personal care services, rehabilitation, transportation, medication, meal delivery, and/or follow-up medical appointments; as well as referring the member to programs, such as smoking cessation/fitness, alcohol/substance abuse, Federal food stamps/ low-income energy or subsidized transportation, when the need is identified.

The primary Care Manager communicates to the ICT that the member has transitioned to their previous or the planned level of care and can continue to be monitored through SHP's care management process. The D-SNP care manager documents all member, facility, and practitioner communications., utilizing specific note types that reflect transition activity.

The D-SNP care management team documents care transition contacts with the following guidelines:

- Before transitions, members have an ICP with goals, interventions and self-management tools to assist in avoiding transitions. Members active in case management are utilizing services and working with the D-SNP care management team. The ICT has a role to identify if the member is at risk or risk is changing and need to engage more frequently or add on services before a transition occurs. The D-SNP care management team assists in ensuring appropriate services are in place to prevent a transition.
- During and after a transition, providers are required to submit authorization for services, such as hospital admission and SNF admissions (if not for long term care). The D-SNP care management team follows process/policy for member follow and following for discharge and transfer from the specific facility.
- After the transition, the D-SNP care management team continues to monitor the process and evaluate for any further needs or changes in the status resulting in a change

of the ICP. The member is followed after the transition to support any care needs and update the ICP and the ICT of the transition and resulting changes. The D-SNP care management team is updated and needs are followed up by the appropriated D-SNP care management team member.

- A transition assessment is completed with the member and/or the representative after the transition to identify changes, additional services needed, change in providers, living arrangements, safety, medication changes. The ICT reviews the transition and identifies any additional services or changes needed with the member plan of care.
- Care partners involved are updated on member transitions, ICT reviews needed or collaboration with the member following the transition.

MOC 2: Element F: Factor 4: Describe the process for enrollees to access their personal health information to facilitate communication with providers in other healthcare settings or specialists.

The member and/or representative has a copy of their care plan when completed by the D-SNP care management team that describes the member's goals and interventions, services utilized and provider information. The member can request copy given to family. The member care plan can be mailed or emailed to family upon request. The member provider is sent a copy of the updated plan of care resulting from a transition. The updated plan of care is recorded and available for the ICT core team review in the SHP care management documentation system.

D-SNP members are encouraged and reminded to use a personal health record that documents their medical history, medications, vaccinations, exams, tests, surgeries and concerns to discus with their provider. The personal health history record is given to the D-SNP member upon enrollment in the program. The D-SNP care management team also assists in providing information to those involved in the member care in order to coordinate care as needed. D-SNP members are encouraged to participate in self-management of their own care to be as independent and knowledgeable in their health care decisions.

MOC 2: Element F: Factor 5: Explain how the enrollees and/or caregiver(s) will be educated about the enrollee's health status to foster appropriate self- management activities and the expectation for demonstrating understanding of appropriate self-management.

The D-SNP RN and/or Social Work care manager outreach the member and/or after the return to their usual setting of care to assess the member's needs. The Transition assessment will be completed with the member and/or representative to identify changes and updates needed for continued case management and support to the member. Upon completion of the transition assessment, an ICT review is completed, the member care plan is updated and follow up needs are addressed by the D-SNP care management team. Transition changes reviewed are: medication changes/new prescriptions, DME/supply needs, scheduling of follow-up appointments, transportation needs, changes in functional needs (bathing, eating, dressing, transfers, etc.), and the member's understanding of what to do if their condition worsens. Transition follow up stresses the importance of follow up appointments and scheduling of follow up appointments.

Education will be provided to the member and/or representatives related to the prevention of unplanned transitions and/or how to maintain their health and remain in the least restrictive setting. This education is tailored to the member's specific health needs, diagnoses, and health issues. This education is in a format the best works for the enrollee based on their abilities.

Members can still benefit from ongoing education discussions about their conditions, appropriate care, gaps in care and treatment options. The goal is educational and can help build the relationship with the D-SNP care management team.
Educational examples include (but are not limited to):

- Use of written materials related to an enrollee's medical condition.
- A referral to Disease Management
- A referral to Wellness
- A referral to Behavioral Health Case Management
- A referral to Medication Therapy Management
- Falls risk education
- Safety in the home
- Caregiver support/training
- Discussion with enrollee or family/caregiver during a nursing facility care conference
- Ongoing updates to advance directives, advance care planning and backup plans for care

For the transition back to the usual care setting it is especially important to address the following:

- Timely follow up appointment: the importance of the appointment, scheduling of the appointment if they need help getting to the appointment.
- Medication Self-Management: understanding of their current medications regime and should discuss whether there were any changes to the regime, do they have the medications, do they remember to take them, do they need help setting them up, do they have any questions or concerns. Also included is facility management of meds and changes if applicable.
- Knowledge of red flags and triggers: discussion of symptoms that indicate problems with healing or recovery such as warning signs and symptoms, what action should be taken if the symptoms appear, who and when to call with questions/concerns, and are those phone numbers available?
- Safety in the home : members are assessed for safety in the home with falls, ambulation, medications that may inhibit safety
- Prevention of readmissions: members are educated on early detection of signs and symptoms, updating the D-SNP care management team with changes, utilizing the nurseline and follow up with providers and specialists

MOC 2: Element F: Factor 6: Detail how and when the enrollee and/or caregiver(s) are informed about the point of contact throughout the transition process.

All D-SNP members enrolled in the program are assigned to a D-SNP care management team, which includes a RN care manager, Social Work care manager and a Community Support

Specialist. Upon engagement with the D-SNP care management team, the team is discussed with the member and/or representative, how to communicate with the team and follow up services to be provided to the member by the team. The role of the D-SNP care management team is explained upon engagement with the team. If a member is unable to reach or declines follow up in the program, D-SNP care management team contact information is on the care plan for the member to access and utilize when needed. Members are educated on ongoing follow up and care transitions.

Upon enrollment to the D-SNP program, an enrollment folder is sent or given to the member and/or representative. The enrollment folder includes member benefit information, medical and pharmacy benefit information, supplemental benefits, advance directive information and care management services. Members are given a D-SNP folder upon engagement with the D-SNP care management team. The folder includes:

- D-SNP team and contact information
- D-SNP opt out line information
- Nurseline information
- Personal Health Record

D-SNP members are outreached by the D-SNP care management team introducing him or herself and describing the role and activities of the D-SNP program, team and upcoming meetings and follow up. Upon meeting with the member and/or representative face to face or telephonically, education is provided on the initial, annual, transition and ongoing assessments, the ICT/ICP reviews, and coordination and collaboration with the member and/or representative on a continual basis to address needs and health care concerns and they arise.

The SHP D-SNP care manager maintains continuous communication with the member/designated representative/facility/provider throughout the transition process. The Care Manager ensures continuous communication by:

- Conducting initial outreach to discuss the care transition process
- Providing a direct phone number to the member/member representative to reach the Care Manager should any change to the member's health status or ICP occur.
- Communicating to the member/designated representative, upon conclusion of the care transition process, the resumption the prior level or the appropriate level of care management intensity and services.

The SHP D-SN care management team is composed of dedicated staff members who serve as a liaison between the member/designated representative and providers. An important role of the D-SNP care management team is early identification of post discharge needs. The discharge plan includes the initiation of a variety of services or benefits to be utilized by the member upon discharge from an inpatient setting or outpatient service. The needs and desires of the member and input from their healthcare providers are essential for a successful transition. The goals of discharge planning are:

- Prevention of readmission
- Delivery of care in the appropriate setting

- Continuity of Care
- Coordination of levels of care
- Identification of members for referral to social services and community support agencies
- Improved patient safety
- Improved medication management and adherence

The Care Manager (RN or Social Worker) serves as support for the member during transitions between any points in the healthcare system, such as outpatient services, office visits, home health or a change in home settings. The D-SNP care manager addresses any fragmented or unsafe care during transitions.

Another important element of the transition process is the reduction in care transitions. This is accomplished through early detection of members at risk for transition, identifying gaps in care, members at high risk for readmission. The Care Manager maintains ongoing scheduled contact with members, enabling early detection of high-risk members and timely interventions. All education of the member/caregiver on the member's condition(s) including early detection of the exacerbation of symptoms and problem prevention is documented in the SHP care management documentation system.

The D-SNP RN care manager notifies the member's physicians of all abnormal clinical data and any medication reconciliation issues and proactively coordinates interventions. Various reports are analyzed regularly, including readmission reports, emergency room utilization, and post-acute hospital census.

MOC 3: Provider Network

The D-SNP Provider Network is a network of healthcare providers who are contracted to provide health care services to D-SNP members. Each D-SNP program is responsible for ensuring their MOC identifies, describes, and implements the following for its D-SNP Provider Network. SHP provider network has the expertise to meet the health care needs as well as the unique health care needs of the population.

MOC 3: Element A: Specialized Expertise

MOC 3: Element A: Factor 1: Provide a complete and detailed description of the specialized expertise that corresponds to the target population identified in MOC 1.

Security Health Plan offers it member's access to a network of contracted facilities, primary and specialty care physicians, behavioral/mental health specialists and alcohol/substance abuse specialists, as well as a complete ancillary care network. SHP has more than 10,000 physicians and health care specialists in Wisconsin, Minnesota, Illinois and Upper Michigan who provide

high-quality care to our enrollees. According to the needs to the members, Security Health Plan concentrates its efforts of meeting or exceeding the minimum network adequacy guidelines for the following specialties: cardiology, cardiac surgery, endocrinology, psychiatry and pulmonology. The plan's network includes facilities pertinent to the needs of the D-SNP members such as inpatient, outpatient, rehabilitative, psychiatric, laboratory and radiology/imaging. The network also includes allied health professionals such as physical therapists, occupational therapists, speech pathologists and radiology specialists.

This network includes primary care physicians who are the anchor of the team, but additional team members/providers will be added as needed in order to effectively coordinate and provide the full range of Medicare services through a multidisciplinary approach. The member has a choice of a PCP and may see specialists within the network of contracted specialists; some services may need prior authorization. Security Health Plan also has procedures in place to authorize out of network services when the contracted network does not meet a member's needs as determined by the member's care plan. Security Health Plan regularly tracks and trends out–of–network referrals for potential network expansion follow–up.

The broader provider team can grow to include a pharmacist, advocate, family member, mental health providers, or other SHP providers. The D-SNP care management team's approach means that it will coordinate care with all providers and facilities, assist with discharge planning, manage care for those with complex medical needs, and facilitate transitions between providers and between institutional and community settings. The team will emphasize preventive care, and it will help ensure that principles of person-centered care and evidence-based practices are followed as a matter of standard practice.

Security Health Plan ensures that the number and type of providers are sufficient to meet the needs of the projected enrollment and cover all of the benefits of the plan through a variety of means, including, but not limited to:

- Network availability and accessibility report
- Utilization management department reports
- Quality improvement reports
- Customer Service reports
- Member comments and requests
- Applicable appeals and grievances follow–up
- Member Satisfaction surveys

(Attachment: Network Availability)

Marshfield Clinic Health System Credential Committee oversees and completes the network plan providers competency and active licensure requirements. Marshfield Clinic Health System has established credentialing criteria for network participation that is used to evaluate a provider's credentials. The credentialing criteria serve as a foundation for determining a provider's eligibility and continued eligibility in the Security Health Plan network. Providers are expected to remain in compliance with credentialing criteria at all times. Compliance is

monitored and status changes are reported to Payer Strategy and Network Contracting Account managers and the credentialing staff. The goal of credentialing is to implements systematic processes that help obtaining and maintaining a high quality network of providers. Verification of credentials from the primary source and nationally recognized methods is performed.

Security Health Plan's provider, facility, and long term facility networks include a wide variety of services in inpatient, outpatient and community setting. Security Health Plan Payer Strategy and network Contracting Account Managers provides oversight for ongoing training and communication with the network providers. Provider updates and newsletters are regularly distributed. Clinical oversight and communication is provided by Security Health Plan team of Medical Directors.

The D-SNP care management team is responsible to facilitate access to care, while providing the member with choices in care providers who will care for the member in culturally competent, person centered manor. The D-SNP care management team works with the facilities, Security Health Plan Customer Service and SHP Nurse Navigators if assistance is needed to identify a medical or specialized service provider. The D-SNP care management team is responsible to assure follow-up is scheduled and performed. Security Health Plan includes a statewide provider network including primary care, specialist care, social workers, registered nurses, nurse managers, health coaches, pharmacists, physical therapists, occupational therapists, speech therapists, mental health specialists, drug counselors, clinical psychologists, audiologists and other allied health professionals. The services include inpatient, outpatient, rehabilitative, surgery centers, infusion centers, dialysis, audiology, home health care, skilled-nursing care, psychiatric, laboratory, radiology and imaging centers. In addition to the selected primary care provider, the specialized expertise of the other providers will be solicited as guest or permanent ICT members as identified and as needed. The involvement of those with specialized expertise will be based upon each member's situation.

To meet the more diverse and complex need of the members, Security Health Plan has contracted with additional providers and vendors. All providers become potential members of the interdisciplinary care team created to meet the needs of individual members. These contracts include:

- Contracting home health agencies- RN's, MSW's Physical therapists, Occupational therapists and speech therapists working in conjunction with Security Health Plan Case Managers ensuring that member's functional, physical and emotional needs are met.

To further meet the special needs of the program's members, and to broaden the interdisciplinary care team network, Security Health Plan has agreements with:

- Palliative Care Consultation- Consulting with physician who is a palliative care specialist with a goal to prevent, relieve, reduce or soothe the symptoms of disease or disorder without affecting a cure.
- Hospice- A team oriented approach in expert medical care, pain and symptom management, emotional and spiritual support tailored to a members needs and wished at end of life

Summary of currently contracted skilled nursing facilities in the provider network, by county

County	Contracted Skilled Nursing Facilities
Barron	1
Clark	4
Chippewa	5
Eau Claire	6
Lincoln	3
Marathon	6
Oneida	6
Portage	2
Price	2
Rusk	0
Taylor	2
Wood	5

MOC 3: Element A: Factor 2: Explain how the SNP oversees its provider network facilities and oversees that its providers are actively licensed and competent (e.g. confirmation of applicable boar certification) to provide specialized healthcare services to SNP enrollees.

Marshfield Clinic Health System Credentialing Committee oversees and completes the network plan providers competency and active licensure requirements. Marshfield Clinic Health System has established credentialing criteria for network participation that is used to evaluate a provider's credentials. The credentialing criteria serve as a foundation for determining a provider's eligibility and continued eligibility in the Security Health Plan network. Providers are expected to remain in compliance with credentialing criteria at all times. Compliance is monitored and status changes are reported to Payer Strategy and Network Contracting Account managers and the credentialing staff. The goal of credentialing is to implements systematic processes that help obtaining and maintaining a high quality network of providers. Verification of credentials from the primary source and nationally recognized methods is performed.

The objectives of the program are to:

- Ensure high-quality health care practitioners and/or long term care providers for members
- Provide an optimal number of practitioners and/or providers appropriate for the member population
- Minimize risks to the health and safety of members

Applications the credentialing process enables Security Health Plan to appropriately affiliate quality Physician and non-physician providers. The process ensures that providers are properly trained and qualified.

- Are sent out electronically thru App Central within Cactus the credentialing software. If applications are submitted without required information, the application is returned. The provider is unable to submit the application back without all of the disclosure questions answered or signing and dating the attestation
- When the application is accepted, information is auto loaded into Cactus (SHP documentation system). The credentialing staff verifies all information appears correct in Cactus and primary source verifies all applicable information following NCQA and Security Health Plan standards.

Initial Credentialing and Re-credentialing for a Practitioner

- Every practitioner submits an application which includes information on the following items:

1. State license
2. Current primary admitting facility privileges, as applicable
3. Drug Enforcement Agency (DEA) certification, as applicable
4. Board certification/education and specialty, as applicable
5. Work history (most current last five years)
6. Professional Liability insurance
7. Answers to standard questions
8. Signed attestation/release by practitioner

All required criteria are reviewed and applicable notes are added to the credentialing worksheet. If the credentialing file is considered "clean" the Marshfield Clinic Health System Medical Director (or his/her designee) will review the worksheet with any other applicable documentation attached. They will then sign and date the worksheet indicating the file has been approved. If the file does not meet the "clean" file definition the file will be presented at the next Marshfield Clinic Health System Credentialing Committee with a summary and all applicable documentation. The Marshfield Clinic Health System Credentialing Committee with either approves the file, request additional information, or not approve credentialing. (For a clean file definition, refer to "Clean File Definition for Credentialing & Re-credentialing Files" policy. A "clean" file also refers to a credentialing file that has met NCQA and SHP standards.

Initial & Re-credentialing for a Facility

When a new facility is being contracted or an existing contracted facility is up for re-credentialing, Marshfield Clinic Health System SHP entity has established policies and procedures for the initial approval and re-approval of facilities and organizations contracted to provide services to SHP members. The scope of facilities approved include hospitals, skilled

nursing facilities (SNFs), rehabilitation centers (RCs), home health agencies (HHAs) , ambulatory surgical centers (ASCs) , Residential, Inpatient and Ambulatory Mental Health Facilities, and CORF's, End Stage Renal, Portable Imaging suppliers, RHC's, Clinical Laboratories, and FQHC's. All facilities are approved before services are provided to SHP members, and are re-approved at least every three years. Each facility type houses the credentialing/re-credentialing, Joint Commission accredited/not Joint Commission accredited letters and worksheets in Cactus.

MOC 3: Element A: Factor 3: Describe how the SNP documents, updates and maintains accurate provider information.

Credentialing is completed through the Marshfield Clinic Health System credentialing committee to verify the provider's competency and active licensure. Credentialing information for providers and facilities is contained within a database solely dedicated to credentialing activities. Security Health Plan receives provider requests to update names, addresses, and phone numbers. Security Health Plan Payor Strategy and Network Contracting Account Managers reviews the information received routinely. Payor Strategy and Network Contracting Account Managers works with the providers to validate the provider affiliations for our contracted systems. (Attachment: Provider Quality) (Attachment: Network Adequacy)

An online provider directory is available for the D-SNP care management team to utilize in assisting members in finding providers to meet their healthcare needs.
(Attachment: Provider Directory Accuracy)

MOC 3: Element A: Factor 4: Describe how providers collaborate with the ICT and contribute to an enrollee's ICP to provide necessary specialized services.

The D-SNP care management team is the central point of contact for ensuring that the member and ICT members communicate and coordinate a member's care. The D-SNP care management team schedules regular meetings for the member/family/caregivers, the social worker care manager, and other ICT providers as appropriate.

The member's PCP is responsible for directing, communicating and coordinating routine and specialty care. Members are encouraged to select a PCP upon enrollment and to have a PCP coordinate care with specialists and ancillary services as needed. SHP Pharmacists are available to assist the D-SNP care management team for medication consultation. The pharmacist is a resource to the D-SNP care management team for concerns regarding polypharmacy, contraindications, and may provide guidance to the D-SNP care management team to discuss options with providers and or members to reduce the number of medications prescribed or alert providers of potential interactions. The pharmacist completes a medication therapy management review on all D-SNP enrolled members on initial engagement with the team and thereafter annually with the member's annual reassessment.

Upon identification of involvement of a community partner such as an Inclusa, My Choice or Lakeland care manager, LTC support person, an assigned county care manager/support, the D-

SNP care management team will make attempts to connect, collaborate and discuss current and future care planning for the member. The D-SNP care management team sends a fax and or email to the Inclusa, My Choice and or Lakeland identifying the D-SNP member was enrolled in the SHP D-SNP care management program. Permission is received by the member and/or representative to coordinate and share information with the other community partners. Together they will develop a communication plan and discuss ICP related to goals and treatment plans. As appropriate, the D-SNP care management team will coordinate home visits and care conferences with the member and/or representative and the community partner to participate in assessments and care planning to ensure the needs of the member are being met.

In addition, when a member is identified through our disease management and wellness program, the member's D-SNP care management team is notified to discuss participation in the program our purpose is to support the member/provider relationship through evidenced based intervention and community recognized clinical practice guidelines to achieve optimal member health. Members are encouraged to discuss the information they receive through the program with their physician or other health care professional.

Physicians may be notified of health or safety issues in subsequent written notices, at the discretion of the clinician working with the member. Providers are updated regularly on changes and needs identified and as needed on members care plan by the RN and/or SW care manager. Providers are able to outreach the D-SNP care management team directly via phone, D-SNP opt out line or via D-SNP secure shared email.

- PCPs receive individualized invitations to attend all ICT meetings for their attributed members. The plan accommodates any special PCP requests for participation such as onsite meetings or participation via teleconference.
- Specialists or other ancillary providers are invited to the ICT, when indicated
- Each ICP, approved by the ICT, includes the physician's problems, goals, and interventions for each member.
- A copy of the care plan is sent to the PCP after every update.
- The D-SNP RN care manager collaborates with the PCP and Specialists regarding any issues with implementation of the care plan
- The D-SNP RN care manager regularly communicates with physicians and community providersto coordinate services and identify any unmet needs

MOC 3: Element B: Use of Clinical Practice Guidelines and Care Transition Protocols

MOC 3: Element B: Factor 1: Explain the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP's target population.

Our provider contracting agreements and Provider Manuals require that contracted providers must follow evidence-based clinical practice guidelines. The Provider Manual is incorporated

into, and an extension of, the provider contracts. The Provider Manual lists the evidence-based clinical practice guidelines that Security Health Plan endorses and explains how providers will be reimbursed for services provided in accordance with the guidelines.

Security Health Plan network practitioners utilize evidence-based clinical guidelines to various degrees in the treatment of their patients to promote the use of nationally recognized and accepted practices for providing the right care at the right time. The opportunities for improvement which exist within specific groups and regional areas were appropriately communicated and monitored. (Attachment: Clinical Practice Guidelines)

Security Health Plan collects and reports annual Healthcare Effectiveness and Data Information Set (HEDIS) data. The outcomes of the HEDIS measures are benchmarked to NCQA Audit Means, Percentiles, and Ratios, NCQA's Quality Compass and CMS benchmarks. The success of the HEDIS measure results is a reflection of a practitioner's compliance with the use of clinical practice guidelines and protocols. Annual results of HEDIS are reported in the Quality Improvement Committee.

Quality Improvement Projects selected by Security Health Plan may be based on the outcome of the annual HEDIS measures. As a method of improvement, active member and practitioner interventions would incorporate education about the use of and compliance to clinical practice guidelines and protocols.

The Centers for Medicare and Medicaid services (CMS) rates Medicare Advantage plans, such as Security Health Plan, on a scale of one to five STARs, with five STARs representing the highest quality.

The current STAR rating strategy defined by CMS is consistent with its three-part aim which includes better care, healthier people and communities, and lower-cost care through quality improvement. Each year, Security Health Plan evaluates the plan's effectiveness in improving the quality and safety of care and service to our members. Interventions are conducted to improve member compliance while focusing on physician engagement. Security Health Plan continues to work with physician groups to offer measurable and actionable data. We understand the positive influence physicians have on member's behavior in relation to maintaining and improving their health.

MOC 3: Element B: Factor 2: Identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP enrollees.

There are circumstances where guidelines must be modified to adjust for advanced age, disability, or complicating factors of co-morbidities. Examples of this are the recommendations made for high-risk diabetic members. When reviewing each member's case, the team considers the member's medical history, multiple chronic conditions, age, frailty, diet, current medication profile, as well as other cognitive, functional, and socio-economic factors affecting the member's ability to manage their disease. Depending on these factors, the team may choose to deviate from the standard CPGs adopted by the plan.

A challenge often encountered with a special needs population, especially members with a behavior health diagnosis, is noncompliance. Often recommendations for following pharmacy or treatment regimens including dietary changes are not adhered to. An example: A Security Health Plan D-SNP member goes to their physician because they are in pain or some other discomfort and wants to be comfortable again; they are not necessarily in pursuit of the ideal health outcome. The physician sees, by the member's chart, that the member has liver disease, diabetes and hypertension and tests have indicated high cholesterol. Clinical guidelines that govern disease paths are not always in harmony with members that have multiple co-morbidities. These multiple co-morbidities may prevent them from following the guidelines. In this situation, the member should be on Statins, but the member also has liver disease. Statins are contraindicated, so the physician should not follow the guidelines, and prescribes fish oil and a significant diet change to replace the statins to lower the member's cholesterol.

Certain clinical practice guidelines and protocols may not always be appropriate for some patients with complex health care needs also. In these cases, the organization must identify challenges to using clinical practice guidelines and nationally recognized protocols for certain beneficiaries with complex health care needs and detail how the decision to modify or ignore such guidelines is made, incorporated into the patient's ICP, communicated with the ICT and acted on by the member's ICT or by other providers.

For example: Colorectal screening: Colon cancer screening is recommended for average risk persons beginning at 50 years of age. However, the effect of co-morbidities and the potential increased risk of procedures performed on older adults are important concerns. The ability to tolerate colonoscopy and sedation for diagnosis, if screening with occult blood is positive, also must be considered in this frail population

SHP follows its policies for medical services and technology assessment as indicated to evaluate requests outside of established and approved medical guidelines. Selected HEDIS measures and goals used to measure compliance of network providers are updated on regular basis. Care managers review red flags with members based on their current condition and advise members when to seek ED care versus calling the provider to schedule an office visit. Medication review is completed with members and facilities upon admission and discharge and the care managers seek pharmacist assistance and input as needed.

MOC3: Element B: Factor 3: Provide details regarding how decisions modify clinical practice guidelines or nationally recognized protocols are made for clinically complex members, incorporated into the ICP, communicated to the ICT and acted upon by the ICT.

There are times when the clinical care guidelines typically used do not apply or is a challenge, only pieces of the guideline may apply or there is not standard clinical guideline established. For example, based on members' co-morbidities the member has, clinical care guidelines for each condition may be in conflict with each other. The D-SNP care management team will seek guidance from the treating provider to determine which guidelines should be followed.

Some members may not perceive their medical condition as a primary concern and may be more focused on the socioeconomic issues. In this situation, there may be no clinical care guidelines specific to the member concerns, but there may be some clinical care guidelines that can have an impact on those issues addressed by the member. With behavioral health conditions, the clinical care guidelines may need to be adapted based on the member's current behavioral health issues. The member may also deny having a behavioral health diagnosis, in which case providing behavioral health guidelines would be ineffective.

The D-SNP care management team has several options: they will prioritize the issues to discuss with the member, and strategize the effective ways to approach the member---knowing that continuing to build a trusted relationship is the only way to impact long term behavior changes. After ICT review and D-SNP care management team collaboration, the team puts forward a plan and contacts the member for discussion and education:

- Discussion with member re; their health issues. Solutions to solve- are there other medical issues not being addressed.
- Potential to refer the member to the Medication Management Program, Wellness, and /or Disease Management programs. The member e may also be a candidate for the program that limits the member to one prescriber and one pharmacy.
- Recommendations will be made for follow-up with the member's mental health worker, counselor or provider, enrollment to the Integrated Care Coordination program.
- Interaction with the member, member representative, facility, and/or provider documented, along with any changes that will be made to the member's care plan and goals.
- ICT review and further recommendations to assist the member with their concerns

In an example of a member with multiple co-morbidities and pain, is two challenges can arise, noncompliance and potential opioid overuse. This scenario is an example of how clinical guidelines may conflict with multiple chronic conditions. The key to working with this member's circumstances is the appropriate coordination and navigation of health care services. Collaboration with the provider, pharmacy input and coordination with the D-SNP care management team is important for the member to receive coordinated care to achieve the best outcome for the member.

Security Health Plan's internal medical and pharmacy policies are reviewed on an annual basis by Utilization Management staff, the Policy and Procedure workgroup, and the Security Health Plan medical directors. The Policy & Procedure workgroup ensures all information is current and correct. The Policy and Procedure workgroup review the policies for benefit language information, claims coding, and medical necessity appropriateness. The Policy & Procedure also have staff outreaching to other payers for how they manage benefits in a like or similar fashion. The committee meets monthly as needed.

MOC 3: Element B: Factor 4: Describe how SNP providers ensure continuity of care using the care transition protocols outlined in MOC Element 2F in and outside of the network.

SHP makes every effort to coordinate care when members move from one setting to another. An example is when a member is discharged from a hospital or skilled nursing facility to their

home in the community. With every transition, the ICT coordinates care to ensure a safe transition home.

For transitions to a hospital, per provider contract stipulation, SHP 's providers are required to notify SHP's utilization management department of all admissions within 24 hours or the next business day. Also, per contract, the provider is required to supervise and coordinate the member's care. When a care transition is necessary, the sending and receiving providers are required to exchange information to facilitate the ongoing care of the enrollee and are required to submit clinical information including diagnosis information and a treatment plan to SHP.

Our providers are expected to follow the Security Health Plan Provider Manual which details the clinical practice guidelines. The D-SNP care management team is in active communication with members and providers during a transition. The D-SNP care management team works with the providers to ensure that care transition protocols are followed when the member is being transitioned between their home and the hospital or nursing facility, whether planned or unplanned. If the member transitions between any members of the D-SNP care management team, due to relocation to another county / region, the D-SNP care management team works with the new Care Manager to ensure ongoing continuity of care during this transition.

Various reports are analyzed regularly, including readmission reports, emergency room utilization, hospital, and post-acute hospital census, and population analysis are discussed at the Utilization Committee. Additionally, provider medication reconciliation rates and care transition support are reviewed and reported to the Quality Assurance/Continuous Quality Improvement Committee.

MOC 3: Element C: MOC Training for the Provider Network

MOC 3: Element C: Factor 1: Detail initial and annual training for network providers and out-of-network providers seen by enrollees on a routine basis.

Security Health Plan conducts initial and annual training for all pertinent care management staff, practitioners, providers, case managers, facilities, appropriate committees, Security Health Plan administrative staff, and any other associated care providers and/or vendors. For new D-SNP providers joining the network, the D-SNP MOC is available on the provider portal and on the SHP external website. An attestation of review/completion is available for any provider review the MOC and sign an attestation of understanding and view. Upon request, providers may receive the complete document of the Model of Care from Security Health Plan.

The Model of Care training for network providers and out of network providers will encourage and support better collaboration and communication in the care for the D-SNP member. Notification to new providers explains the importance of the training and the measure of participation. (Attachment: MOC provider training) (Attachment: Internal/External Training Guide) (Attachment: Staff Education/Training Calendar)

Yearly, D-SNP providers receive invitation to participate in the MOC/D-SNP training

education. The providers are notified of where to locate the D-SNP program summary and PowerPoint presentation on the SHP website and provider portal. Training for all providers, contracted or non-contracted, is also available on the plan's website. Because the trainings are electronic, they may be accessed at any time, making it easy for busy providers to complete as their schedule permits.

Security Health Plan provides initial and ongoing training for all providers on the Model of Care through the following resources:

- Web based training modules
- Face to face training –per request
- Teleconferencing
- Provider Updates and Newsletters
- Other printed material
- Provider Portal

Security Health Plan Model of Care related documents are posted on the Security Health Plan website. Providers are encouraged to contact the D-SNP manager with any questions or concerns related to the training or the D-SNP program.

Provider MOC training content is updated annually, or as necessary, by SHP Clinical Manager Director, QI Director and Training and Development. The MOC is presented annual at SHP QIC meeting for provider feedback and suggestions on changes, engagement of providers and the importance of coordination with the D-SNP team.

The Provider MOC Training content reviews the four key Elements of the Model of Care:

- Description of the SNP Population
- Care Coordination
- Provider Network
- MOC Quality Measurement and Performance Improvement

MOC 3: Element C: Factor 2: Describe how the organization documents evidence of training (maintains records) on the MOC training.

As part of the Model of Care training; employees, providers and contractors receive information on the Model of Care. All trainees will have the ability to receive training in one of the following venues:

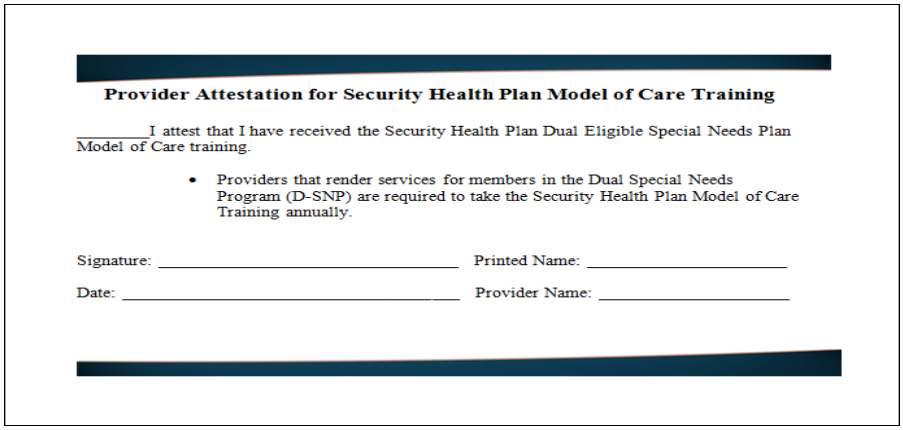
- Web based training modules
- Face-to-face training
- Video conferencing
- Provider portal

Documentation of employees, community partners and contracting agencies participating in the D-SNP training/education is maintained by meeting minutes/agendas, training calendar and presentation slides. (Attachment: Staff Education/Training Calendar)

Provider training is documented in the Marshfield Clinic Health System (MCHS) Learning

Connection for provider's affiliated with the MCHS system. A record of completion of the D-SNP initial and annual training is documented and recorded in Learning Connection. A report is available for completion and non-completion of the required CBT training.

Non-affiliated MCHS provider training is documented and recorded in the SHP 360 Compliance system. A representative is assigned to attest that the providers they are responsible for have reviewed and understand the D-SNP initial and annual MOC training/education. The following is an example of the attestation:



Provider Attestation for Security Health Plan Model of Care Training

_____I attest that I have received the Security Health Plan Dual Eligible Special Needs Plan Model of Care training.

- Providers that render services for members in the Dual Special Needs Program (D-SNP) are required to take the Security Health Plan Model of Care Training annually.

Signature: _____ Printed Name: _____

Date: _____ Provider Name: _____

Providers are notified of the requirement to complete the MOC training through provider newsletters, letter and/or email and targeted mailings. SHP staff is are required to review the D-SNP MOC training upon hire. Annually specific departments with direct engagement and/or involvement with the D-SNP team and MOC are required to review and complete the MOC CBT. The following SHP departments will complete the MOC CBT annually (other departments may be added as identified by need):

- Health Services – including complex care management and utilization review
- Quality
- Sales – Consumer Enrichment Team
- Customer Service
- Wellness
- Enrollment

MOC 3: Element C: Factor 3: Explain any challenges associated with the completion of MOC training for network providers.

The manager of the D-SNP program encourages network providers to participate in the D-SNP MOC training and education. Challenges include staff turnover, large number of providers needing the training, timeliness of training. Recent changes with the pandemic measures has hindered availability of providers. With the severity of current patients in the hospital, any outside or extra activities are viewed as not important, not efficient time for them to complete the training. Providers are asked to participate in other SNP trainings, along with other

regulatory requirements, making engagement and participation with the MOC training difficult. SHP continues to routinely provide information regarding benefits and services the members receive through SHP.

Other challenges in ensuring providers are properly trained on the Model of Care are:

- Contracted providers also contract with a number of other SNP plans. The request to complete multiple trainings can become burdensome and time consuming for busy providers.
- Providers are not always available. Patient care is always the priority,
- Providers may perceive a compensation concern for taking unreimbursed time for training.
- Out of network providers may perceive their involvement with SHP members as time limited and do not see the value in completing the training.
- Pandemic measures

If requested, presentations are arranged with provider groups to educate them on the D-SNP program. If any issues are identified with the provider group such as billing, refusal to see dual eligible members, mediation benefits, they are reported to the contract manager for follow up and additional training and/or corrective action. SHP includes MOC and D-SNP education in provider updated as an encouragement to participate with the D-SNP program. The D-SNP care management teams are encouraged to participate in the education and training of providers that they may have direct contact with in regarding to the D-SNP member building a trust and working relationship between both participants. Actions for ensuring that relevant training is completed for network providers to ensure that the Model of Care training requirements are met will include:

- Face to face education
- Workshops
- Online training and/or webinars
- Refresher documentation and follow up training

MOC 3: Element C: Factor 4: Describe the specific action when the required MOC training is deficient or has not been completed.

Actions for ensuring that relevant training is completed and/or dealing with non-compliance are developed through coordinated efforts of Security Health Plan employees and providers to ensure that the Model of Care training requirements are met. Possible actions could include, but are not limited to, the following:

- System of notification for reminders
- Education
- Individual disciplinary action plan
- Following applicable internal policies and procedures and contractual requirements. Security Health Plan may terminate an employee, provider, and or facility that do not comply.

SHP understands the importance of identifying and addressing these training challenges and has implemented the following in an effort to maximize provider participation:

- Provider Manual and ad hoc communications remind contracted providers there are

variances in MOCs between SNP types and plans.

- Availability of training on SHPs website allows providers to complete the training at a time and place most convenient to their schedules.
- Participation in required training is part of the contractual relationship between the Provider and SHP. This may be leveraged, if necessary. Provider Network is alerted of challenges and non-compliance.
- Care Managers educate providers on applicable elements of the Model of Care, as needed.

When documentation indicates, the Provider has failed to complete the training; Provider Network will continue follow-up efforts until the training is completed.

MOC 4: MOC Quality Measurement and Performance Improvement

MOC 4: Element A: MOC Quality Performance Improvement Plan

MOC 4: Element A: Factor 1: Describe the overall quality improvement plan and how the organization delivers or provides appropriate services to SNP enrollees based on unique needs.

Security Health Plan is committed to continuously improving the quality of care and services provided to our members and promoting effective and efficient utilization of health care resources. These commitments are achieved through our Quality Improvement Program (QI Program). The QI Program is a comprehensive and coordinated program designed to improve the health of members, deliver the best possible health care value, promote objective and systematic program measurements, monitor and evaluate services, and implement quality improvement activities based on these findings. The QI Program facilitates safe, appropriate, and efficient quality care by using evidence-based standards of medical care.
The QI program complies with the Medicare Managed Care Manual Chapter 5 Quality Assessment, Medicare Managed Care Manual 16B: Special Needs Plans, State and Federal regulatory regulations and requirements and the National Committee for Quality Assurance (NCQA) Health Plan accreditation standards.

The QI program objectives are to:

- Implement interventions to improve the quality of health care provided to our members including closing gaps in care
- Implement interventions to improve the service provided to our members
- Execute activities to promote patient safety
- Implement interventions to reduce health care disparities in clinical and non-clinical areas
- Address health literacy and cultural and linguistic needs of our members to deliver health care services that are culturally acceptable and easy to understand
- Implement interventions to coordinate services and improve transitions of care for members with complex medical needs
- Ensure member access and availability to our participating provider network

- Promote and monitor continuity and coordination of care among medical providers, behavioral healthcare providers and facilities participating in member care
- Align the Health Plan QI Program goals with public health initiatives (CMS/HHS, National, State and Local) and goals applicable to Health Plan members.
- Identify, implement, and evaluate opportunities for improvement.

The QI program and D-SNP care management team collaborate to develop a process for data collection, analysis and evaluation of performance based on the MOC. The overall quality improvement work plan includes a dedicated description and work plan on how the organization delivers or provides for appropriate services to D-SNP members based on their unique needs. (Attachment: QI Program description)

Additionally, the annually approved quality program evaluation includes specific goals and metrics in the MOC for evaluation of the MOC and the development of the program work plan. The quality program description includes the following elements.

- Review of the MOC Elements and factors
    1. MOC 1: Description of the SNP Population (General Population)
    2. MOC 2: Care Coordination
    3. MOC 3: Provider Network
    4. MOC 4: MOC Quality Measurement and Performance Improvement
- Review of CMS regulations and protocols
- Current CMS audit protocol SNP MOC
- Description of completed and ongoing quality program activities
- Trending of measures to assess performance in the quality of clinical care quality of service
- Analyzing of whether there have been demonstrated improvements in the quality of care and service to members
- Person(s) responsible for each activity
- Evaluation of the overall effectiveness of the quality program activities.
- Evidence that quality program activities have contributed to meaningful improvement in the quality of clinical care and quality of services provided to members

The quality program work plan targets the MOC improvement initiatives and re-measurement. The work plan is a dynamic document that outlines improvement initiatives and re-measurement. The work plan includes the following elements:

- Program scope and objectives for the year
- Activities planned for the year, including both clinical care and service
- Time frame within which each activity is achieved
- Person(s) responsible for each activity
- Planned evaluation of the MOC

To ensure that SHP delivers appropriate services based on the unique needs of the membership, SHP reviews data to analyze the needs of individual members and the collective membership. On an individual level, data sources include, but are not limited to, member health risk assessments, claims, direct input from the member and their supports, and the Interdisciplinary Care Team (ICT). This data is used to develop an Individualized Care Plan (ICP) with the member,

should they choose to participate in the process. To ensure that the member's ICP addresses the needs identified on the member's Health Risk Assessment Tool (HRAT), the Care Manager reviews each ICP with the ICT, and modifications are made as needed. The Model of Care is continuously evaluated to ensure that SHP D-SNP members receive the highest quality of care, including monitoring a member's access care, improvement in or stabilization of member's health status, the model of care is being implemented, comprehensive annual health risk reassessment is being conducted, and the ICP is implemented. Due to the chronic nature of the D-SNP 's members' health conditions, the plan focuses on compliance with Clinical Practice Guidelines and benchmarks, while noting that individual member compliance with them may not yield positive health improvements.
(Attachment: DSNP MOC QI evaluation)

SHP collects and analyzes data on an aggregate level to better target system interventions to meet the needs of the membership. For D-SNP members, collected data includes, but is not limited to:

- Demographics such as gender and age
- Prevalence of chronic conditions and co-morbidities
- Language and cultural preferences
- Medication adherence
- Utilization data such as emergency room usage for non-emergent care, readmissions, or average length of stay in acute care settings

Examples of interventions based on the analysis of aggregated data include:

- A provider network that includes Primary Care Providers and Specialists to meet the needs of the D-SNP population
- The establishment of a language translation line to ensure that the diverse membership can communicate with the D-SNP staff
- Medication management – programs identifying D-SNP members at risk related to disease and medications – example: Hypertension and meds
- Nutrition – Moms Meals offered to all D-SNP members with hospitalizations with a Heart Failure diagnosis
- Gaps in Care identification and follow up – adequate network providers, telehealth for rural areas, campaigns to assist with gaps (colonoscopy, diabetes)

Security Health Plan follows a consistent process in its approach to quality improvement. Improvement activities involve a cross-functional team approach and are geared towards improving clinical areas of importance and member experience of care and addresses quality of care concerns. SHP uses observational studies and/or the Plan/Do/Study/Act (PDSA) cycle for continuous quality improvement.

SHP's quality improvement process includes:

- Identification of quality indicators relevant to its population, which are monitored on an ongoing basis and evaluated at least annually.
- Monitoring and reporting activities are conducted to:
  1. identify trends or issues requiring evaluation and remediation of procedures or

processes.

2. enable development and implementation of targeted strategies for improvement that are designed to result in systematic enhancements to the delivery and quality of care (e.g., focus audits, surveys, and tracking of complaints).

- A structured and systematic approach to analyze data and identify opportunities for improvement in the effectiveness and efficiency of the health care delivery process.
- Implementation and monitoring of appropriate remedial action for continuous quality improvement.
- Provision of tools for problem solving techniques.
- Supporting the basic quality value of managing by data.
- Increasing credibility and reproducibility of data by determining current performance, identifying benchmarks, establishing goals, and evaluating outcomes.

Interventions are compiled on a Continuous Quality Improvement plan. Interventions may include, but are not limited to:

- System redesign.
- Education for providers and/or members.
- Clinical guideline review, revision, or development.
- Procedure and policy change.
- Form development or revision.

The annual evaluation assesses whether the QIP activities are systematically tracking improvement projects, resulting in improved clinical care and services, and providing appropriate follow-up of corrective actions to monitor their effectiveness. Once a determination is made, the program plan is evaluated to see if certain processes require modification.

Once an improvement plan has been determined to be successful, a regular monitoring schedule is implemented to determine whether the plan remains successful over time. All improvement plans are communicated to stakeholders, including relevant staff, members/patients, groups and agencies via meetings, website, portals, e-mail, memos and/or informal verbal communication when deemed appropriate. All activities are overseen by the Quality Assurance/ Quality Improvement Committee. Updates and discussion are reviewed and recorded quarterly at the SHP QIC meeting. (Attachment: QIC meeting minutes) (Attachment: QIC presentation)

MOC 4: Element A: Factor 2: Describe the process for how the plan collects information, including specific data sources as well as performance and enrollee health measures it uses to continuously analyze, evaluate and report MOC quality performance.

SHP's Quality Improvement process is data driven and utilizes a variety of data sources. Types of data used include but is not limited to demographic, health services, financial, claims, eligibility, provider management, and care coordination records. (Attachment: QI Committee Description)

Security Health Plan has developed policies and procedures to support the collection, analysis, and reporting of the CMS elements. Security Health Plan will utilize the following data sources and performance outcomes measures to continuously analyze, evaluate and report the quality performance.

- Claims
- Admissions and readmissions
- ER visits and observation stays
- Pharmacy data
- Surveys
- Utilization Review data
- Enrollment/disenrollment data
- Gaps in care
- Health Risk Assessment and resources
- Healthcare Effectiveness and Data Information Set (HEDIS) measures
- Member experience surveys
- Appeals, grievances and complaints
- QIP and CCIP programs

Part C Reporting Elements

- The Health plan has developed policies and procedures to support the collection, analysis, and reporting of the following CMS Part C Reporting Elements:
    1. Special Needs Plan (SNP) Care Management

Data for each element is collected using the technical specifications provided by CMS, reviewed for accuracy and submitted according to the reporting schedule specified by CMS. Additionally, these data are audited by an outside independent auditor for accuracy and compliance with CMS data specifications. The data are used in identifying trends and opportunities for improvement.

- **Quality Improvement Projects (QIP) and Chronic Care Improvement Program (CCIP)**
  Security Health Plan's QIP and CCIP projects meet the CMS and the Medicare Managed Care Manual, Chapter 5 – Quality Assessment requirements. Projects are expected to have a favorable effect on health outcomes and member experience and include the following components:
    1. Focus on significant aspects of clinical care and non-clinical services that includes:
        a. Measurement of performance
        b. System interventions, including the establishment or alteration of practice guidelines
        c. Improving performance
        d. Systematic and periodic follow-up on the effect of the interventions
    2. Assessing performance under the plan using quality indicators that are;
        a. Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research

b. Specifically designed to measure outcomes such as changes in health status, functional status, and member satisfaction, or valid proxies of those outcomes

3. Performance assessment on the selected indicators must be based on systematic and ongoing collection and analysis of valid and reliable data
4. Intervention must achieve demonstrable improvement
5. Security Health Plan will report the status and results of each project to CMS as requested
6. A formal quality program evaluation is conducted no less than annually and will include the evaluation of the impact and effectiveness of the quality improvement projects

Security Health Plan implements a Chronic Care Improvement Program (CCIP) for our Medicare Advantage members, including the SNP members. The CCIP includes the following components: established criteria for identifying members with multiple or sufficiently severe chronic conditions for participation in the program and ongoing monitoring.

- **Monitoring of Healthcare Effectiveness and Data Information Set (HEDIS®) Measures**
  Security Health Plan maintains health information systems that collect, analyze and integrate the data necessary to implement quality improvement projects. One source of data is HEDIS® measures that are collected and evaluated annually for Medicare Advantage plans.

  Security Health Plan contracts with an NCQA-certified HEDIS software vendor for HEDIS calculations. Data are submitted to the vendor at least quarterly to provide results for proactive outreach to members with gaps in care. HEDIS results are then calculated annually and submitted to NCQA and CMS to assess plan performance compared against national benchmarks. The results are reported to the Quality Oversight and Governance Counsel and the Quality Improvement Committee for input and suggested action to improve performance. Outcomes may be shared with members and providers through newsletters, website and summary reports.

- **Satisfaction Surveys**
  Member and practitioner satisfaction surveys may be conducted to measure experience and satisfaction with D-SNP program services. Such surveys assist in the identification of concerns, problems and patterns relating to the care and services delivered to Health plan members. Member satisfaction surveys also serve to identify member needs, expectations, and problems relating to access of care and their perception of the quality and safety of the care and services delivered by the participating providers. SHP uses an internally developed survey tool to assess provider satisfaction. Results of surveys are reported to, and reviewed by the Quality Improvement Committee annually for appropriate investigation and follow-up. The data obtained from satisfaction surveys serve as an important source for future quality improvement activities.

  A member survey is sent to enrolled members annually to identify member experience with the D-SNP program. Questions include satisfaction with the D-SNP care management team, receiving information timely, treated with respect, information received useful and easy to understand. Survey will be sent annually to all enrolled D-SNP members including members engaged, unable to reach and declined.

- **Guideline Development and Adoption**
  Security Health Plan adopts clinical practice guidelines from published guidelines from national professional organizations; US Preventive Services Task Force; and government and credible private sources. The QI Committee reviews and approves the use of the preventive and clinical practice guidelines quarterly. The guidelines are embedded within the care management software and assessments utilized by staff. The use of the guidelines is promoted in provider newsletters and available on the Security Health Plan website. Printed guidelines are available to providers upon request.

- **Medication Therapy Management Program**
  The Health plan has established a Medication Therapy Management Program (MTMP) for its Medicare Part D plans that is responsible for:
  1. Ensuring that covered Part D drugs prescribed to targeted beneficiaries are appropriately used to optimize therapeutic outcomes through improved medication use.
  2. Reducing the risk of adverse events, including adverse drug interactions, for targeted beneficiaries.
  3. Including licensed and practicing pharmacists and physicians in decision-making.
  4. Distinguishing between services in ambulatory and institutional settings, as indicated
  5. Coordinating with any care management plan established for a targeted individual in a Chronic Care Improvement Program (CCIP).

The Medication Therapy Management Program criteria for participation include members who have specified multiple chronic diseases, who take multiple specified prescriptions for those diseases. Medication and Pharmacy reviews are reviewed annually.

MOC 4: Element A: Factor 3: Describe how its leadership, management groups, and other SNP personnel and stakeholders are involved with the internal quality performance process.

The Security Health Plan Quality Improvement (QI) Committee oversees the development, implementation and evaluation of QI activities. The committee is comprised of external stakeholders from our two largest provider systems. Physician specialties include primary care practitioners and a clinical psychologist. The committee also includes Security Health Plan's Chief Medical Officer, QI Medical Director, Director of Population Health, Director of Pharmacy Services and Director of Health Plan Quality.

Responsibilities of the QI committee include:

- Develop, measure and assess clinical initiatives that reflect Security Health Plan's demographic and epidemiological population
- Analyze and evaluate results of QI activities
- Review and ensure follow-up on QI/UM activities, recommend interventions and corrective actions
- Review and approve clinical practice and preventive health guidelines

- Recommend initiatives addressing cultural and linguistic diversity
- Review and analyze the effectiveness of behavioral health QI activities, identify opportunities for improvement and recommend interventions
- Review initiatives focused on members with complex medical needs
- Recommend and review policies and procedures affecting internal activities including credentialing, re-credentialing, and suspension/termination of provider contracts
- Review appeals from affiliated providers regarding suspension, limitation or termination of affiliation, or other corrective action taken in response to quality of care issues
- Review reports of member complaints and appeal/grievance activities and provide recommendations as appropriate
- Review the UM criteria used for decision-making
- Review and approve pharmaceutical management activities

The D-SNP program manager presents a report of the D-SNP program to the QI committee at each quarterly meeting. The committee provides direction and identifies priorities. Barriers to meeting metrics and goals are discussed and action items are identified with follow-up at subsequent meetings. Reporting includes D-SNP member engagement, provider engagement with ICT, admissions/readmissions, MTM, barriers to care, gaps in care.

The CMO and/or the Director of Population Health report the D-SNP progress and status of the program, work plan and annual evaluation to the SHP Board of Directors and/or Senior Leadership teams. The D-SNP manager develops and implements policies and procedures and documents for the MOC; develops implements and is responsible for compliance with all quality and care management requirements for the D-SNP program.

On a quarterly basis, metrics are reviewed by the D-SNP care management team and QI teams. Performance metrics are reviewed to identify opportunities for improvement. The D-SNP program manager has oversight responsibility for monitoring and evaluating the model of care effectiveness. Outcomes of the quality performance evaluation may be shared with members and providers through newsletters, bulletins and summary reports.

To ensure high quality, cost effective, seamless care coordination, the plan continuously reviews its goals and benchmarks for high-risk medical, mental, and social needs. This process includes feedback for continuous quality improvement through the D-SNP care management program and the QI program. Through this model, SHP D-SNP program is able to determine whether health plan processes and practices are meeting member needs and expectations. The PDSA methodology is also used to test process changes and to improve products and services from the member and provider viewpoint.
The following elements of the Model of Care are evaluated at least annually:

- Target population-demographics.
- Staff structure and roles of the care management personnel are appropriate with expertise in the population they serve.
- SHP staff and providers are trained on an annual basis and demonstrate knowledge in provision of care for the characteristics of this population.
- The processes to identify and implement a care management program for the Most

Vulnerable Population.

- A Health Risk Assessment that is adequately identifying and stratifying the specialized needs of this complex population.
- Care Management Goals:
- Improving access to essential services such as medical, mental health, and social services.
- Improving access to affordable care.
- Improving coordination of care through an identified point of contact.
- Improving seamless transitions of care across healthcare settings, providers, and health services.
- Improving access to preventive health services.
- Assuring appropriate utilization of services.
- Improving beneficiary health outcomes.
- An Individualized Care Plan that is member-centric and monitored for goal achievement.
- A functional Interdisciplinary Care Team that serves as a vehicle for communication between the Plan, members, and the providers
- A well-developed adequate Network with specialized expertise utilizing evidenced based guidelines for the characteristics of this population.
- A method to evaluate the model of care for performance and health outcome measures.

MOC 4: Element A: Factor 4: Describe how SNP specific measureable goals and health outcome objectives are integrated into the overall performance improvement plan, as described in MOC Element 4B. The process includes how it determines if goals are met (specific benchmarks and time frames).

The overall goal of the Model of Care is to simplify access to healthcare for the member and reduce fragmentation of care delivery. Security Health Plan assures that members have adequate access to qualified health care providers, practitioners and services. Security Health Plan has given additional evaluation and consideration to the types of health care specialists needed to serve our members with special health care needs.

Security Health Plan's Model of Care is based on the following goals:

- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across healthcare settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving beneficiary health outcomes Improving access to essential services such as medical, mental health, and social services

Provider access and availability:

Security Health Plan utilizes a network of affiliated providers. Members are able to access care within the Medicare Advantage network. The network consists of contracted primary care, specialty, and mental health providers sufficient to meet the access regulations of CMS. Each county has availability requirements based on distance and specialty. Annually, Security Health Plan generates a network adequacy report and analyzes the report to identify opportunities for improvement. SHP will improve access to essential available services addressing the unique medical and psych/social needs of the SHP population, including focused interventions on the D-SNP members identified as vulnerable, frail, disabled and having multiple chronic illnesses and/or are near end of life.

Objectives:

- To maintain a PCP network to meet access and availability standards designed to provide and coordinated health services for the SHP population by SHP members having an attributed primary care provider
- To assist SHP members in receiving and verification of an enrollment card within 30 days of enrollment to SHP. It is difficult to access care without an enrollment card.
- To maintain a network of behavioral health services (psychiatrist, psychologist, social workers, therapists) meeting access and availability standards to adequately address the behavioral health needs of the SHP D-SNP population

To maintain relationships with community services (community partner, home health, hospice) necessary to have access and provide services to the SHP D-SNP member, Security Health Plan contracts with current home and community based service providers, provides credentialing and quality standards are met. The Health plan supports continuity of care through current service providers when possible.

Interventions that will be taken if goals are not met in the expected time frames:

- Reassess the data to determine if our measurable outcome is realistic for the special needs population and revise
- Evaluate whether or not in-network services are available within the county
- Provide education to provider on the Health plan access expectations
- analysis review to identify potential gaps in provider network
- Identify and seek contract relationships with high quality providers to fill identified gaps in access
- Revise the goals if appropriate

Improve Access to Affordable Care
SHP will improve member access to affordable care.

Objectives:

- To ensure benefits with low out of pocket costs for covered services
- To provide benefits aimed at meeting the unique needs of the SHP D-SNP population
- To coordinate with community resources to provide non-covered benefits or supplement limited benefits

- To identify and implement mechanisms to improve access to affordable care and assure cost effective health services delivery for the D-SNP members

Improve coordination of care through an identified point of contact

The SHP D-SNP care management team is responsible for direct collaboration and coordination of the member's needs identified through the Health Risk Assessment Tool (HRAT), ongoing assessments and the individualized care plan (ICP). The member is given written information upon engagement into the D- SNP program on is the D-SNP care management team and contact information. If changes occur at any time during the members' participation in the D-SNP program, the written information is updated.

The D-SNP care management team is available by phone during working day hours; with after hour messaging is available. A D-SNP opt outline and shared email are also available for contact from members, customer service and providers for contact with the D-SNP care management team. Member inquiries are answered promptly and/or within a 48 hour time period. The Community Support Specialist has life skills, cultural competencies or experiences that may not necessarily be attached to a license or degree, but such individuals can serve as a support and health service guide to an enrollee in certain situations. Care coordination roles that are more clinical or assessment in nature will be provided in concert with a RN or social worker care manager.

The Model of Care for coordination and collaboration with the member, the D-SNP care management team and the ICT is designed to promote and assure:

- Service accessibility
- Attention to individual needs
- Continuity of care
- Comprehensive and coordinated service delivery
- Culturally appropriate care
- Fiscal and professional accountability
- Maximizing level of self-determination and member's choice of services and living arrangements

Improving seamless transitions of care across health care settings

SHP will improve seamless coordination and transition of medical care across the health care settings, providers and health services.

Objectives:

- To promote centralized coordination of care through selection of a PCP upon enrollment
- Improve coordination of care through an identified point of contact with the D-SNP care management team

Interventions that will be taken if goals are not met in the expected time frames:

Security Health Plan will provide education to providers, enrollees (as appropriate), and the D-SNP care management team regarding management of transitional episodes including, but not limited to:

- Sharing of the care plan
- Collaboration with care delivery team
- Involvement of primary care provider with transitional care episodes and input and development of care plan addressing transitions
- Prevention of avoidable transitions
- Review of Care Coordinator protocols.

Improve Member Health Outcomes
SHP will improve member health outcomes relative to their plan of care throughout the continuum of care

Objectives

- To administer the HRAT to help identify member risks and plan of care goals and outcomes
- To improve members ability to reach their individual goals including self-management, mobility, functional status, pain management, and health care services.
- To reduce acute hospitalizations , ED visits and readmissions
- To prevent unnecessary SNF placement and admissions through care management programs
- To incorporate palliative and hospice care and end of life decision making in the plan of care

Interventions that will be taken if goals are not met in the expected time frames:
Actions will be developed to ensure that the above goal is met. The actions that could take place include, but are not limited to:

- Analyze data for outliers – Hospital level, readmission type
- Target education to hospitals identified
- Collaboration with care delivery team
- Involvement of primary care provider with transitional care episodes and input and development of care plan addressing transitions
- Sharing of the care plan

MOC 4: Element B Measureable Goals and Health Outcomes for the MOC

MOC 4: Element B: Factor 1: Identify and define the measureable goals and health care needs used to improve access and affordability of the SNP population included in MOC 1.

Security Health Plan has developed a comprehensive care management system that assesses current functional status and identifies areas of focus to reduce the member's risk of placement in a more restrictive environment. SHP assesses the members functional status for physical, mental, and social needs at least annually. The D-SNP care management team works via the ICT to help members develop skills and understand community resources to allow the member to remain in the least restrictive environment possible and to manage as much of their care as possible with consideration of their special needs. It is SHP's D-SNP program goal to keep members safe and residing in their own home or home-like setting to the extent possible. SHP's strategic objectives are:

- Improving quality of care provided
- Improving member outcomes
- Reducing cost of care

Security Health Plan will assess quality improvement requirements for the D-SNP program to collect, analyze and report data that measures health outcomes and quality of care management, as well as the effectiveness of the care models. The evaluation of the D-SNP program will include assessment through HEDIS measures and measures that evaluate structure and process requirements through documentation. The measures are used to identify and evaluate appropriate services, ensure shared goals with members, and achieve positive health outcomes. Goals are regularly assessed to evaluate the rate of progression toward goal achievement while identifying and addressing any barriers to meeting those goals.

The 2020-2023 table of identified metrics presents examples of performance and outcome measures that were identified for ongoing monitoring of SHP's Model of Care. The table includes the specific data sources used for measurement, information related to goal achievement and the action plan outcomes.

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2020-2023 Metrics:

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Colorectal Cancer Screening	HEDIS	Assesses adults 50-75 who had appropriate screening for colorectal cancer	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for preventive exams related current COVID related pandemic r/t procedures cancelled, decrease in access to transportation and member concern with leaving their home; D-SNP-created Gap in Care assessment for increased identification of screenings completed. Assessment completed with Initial and Annual Assessments; Member education and provider f/u for gap in care identified.
Care for Older Adults-Advance Care Planning (ACP)	HEDIS	ACP discussion and/or ACP on file; EMR	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education; D-SNP assessed ACP availability with Initial/Annual assessments; Increased member education; D-SNP social worker resource to assist with ACP discussion and assistance; System initiative on ACP documents, correctness of documents and access across facilities to ACP documents; Education quarterly to D-SNP staff on ACP; Annual CBT completed by staff

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Care for Older Adults-Medication Review	HEDIS	Pharmacy Review – MTM-initial review for all new D-SNP members; EMR records - review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.	5 Star	Quarterly/ Annually	Not Met – MTM review completed on every D-SNP member enrolled in program. Barrier –members not engaged (unable to reach/decline) D-SNP care management f/u; – identified potential overall decrease in member f/u for preventive exams related current COVID related pandemic, members not attending PCP visits, PCP visits cancelled. D-SNP education on MTM f/u by pharmacy; Alert created in identifying D-SNP member in need of MTM review; Process established for outreach on member identified, transfer to Pharmacy for f/u Updated medications in SHP care management system for efficiency and accuracy of entry in system
Care for Older Adults – Functional Status Assessment	HEDIS	Functional assessment include in the D-SNP Initial/Annual Assessment; identified ADL/IADL; Cognition, Ambulation Status, Hearing, Vision, Speech and ability to function independently.	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, cancellation of provider f/u; Staff education on Functional Status assessment; updated assessment/ questions; CMS approved use of DSNP HRAT functional assessment; Ongoing staff education on process and purpose, asking questions and f/u with members.

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Care for Older Adults -Pain Assessment	HEDIS	Pain assessment from D-SNP HRAT; Assessing for pain, rating of pain, pain inventory.	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID pandemic r/t member concern with leaving their home, facility closures, cancellation of provider f/u; Staff education on pain assessment; updated assessment/ questions; Pain assessment completed on every D-SNP member; Ongoing staff education on process and purpose, asking questions and f/u with members.
Controlling Blood Pressure	HEDIS	Blood Pressure Control (<140/90)	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education and f/u; Education to DSNP staff on Hypertension, use of Healthwise education materials for f/u and ongoing education with member; Create care collections with Healthwise education specific for members identified with Hypertension; OTC benefit use – staff education od identifying member with gap in care – discuss blood pressure kit and f/u; Gap in Care assessment created – completed initially and annually f/u

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Comprehensive Diabetes Care HgbA1c control	HEDIS	Assesses adults 18-75 yrs. with diabetes. Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). HbA1c control (<7.0%) for a selected population; EMR review	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, Not Met – identified potential overall decrease in member f/u for related current COVID pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education and f/u; Education to DSNP staff on Diabetes, use of Healthwise education materials for f/u and ongoing education with member; Create care collections with Healthwise education specific for members identified with Diabetes; OTC benefit use – staff education od identifying member with gap in care -Gap in Care assessment created – completed initially and annually f/u. Referrals to Diabetic educator, Wellness Coach for nutrition education

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Comprehensive Diabetes Care Kidney Disease Monitoring	HEDIS	Medical attention for nephropathy-microalbumin-urine test.	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, Not Met – identified potential overall decrease in member f/u for related current COVID pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education and f/u; Education to DSNP staff on Diabetes, use of Healthwise education materials for f/u and ongoing education with member; Create care collections with Healthwise education specific for members identified with Diabetes; OTC benefit use – staff education od identifying member with gap in care -Gap in Care assessment created – completed initially and annually f/u. Referrals to Diabetic educator,

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Comprehensive Diabetes Care Eye Exams	HEDIS	Retinol eye exam performed	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, Not Met – identified potential overall decrease in member f/u for related current COVID pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education and f/u; Education to DSNP staff on Diabetes, use of Healthwise education materials for f/u and ongoing education with member; Create care collections with Healthwise education specific for members identified with Diabetes; OTC benefit use – staff education od identifying member with gap in care -Gap in Care assessment created – completed initially and annually f/u. Referrals to Diabetic educator
Antidepressant Medication Management	HEDIS	The percentage of members 18 yrs of age and older who were treated with antidepressant medication, had a dx of major depression and who remained on the antidepressant med tx	Quality Compass 90th percentile	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education; stigma to mental health dx. Ongoing education on Medications, MTM review of meds by pharmacist; Instruction to members on telehealth availability for f/u

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Follow-Up After Hospitalization for Mental Illness	HEDIS	Percentage of discharges for members 6 years of age and older who were hospitalized for tx of selected mental illness dx and who had a f/u visit with a mental health provider within 7 days of discharge	Quality Compass 90th percentile	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education. Increased education to staff and members on telehealth options and follow up. Outreach to facilities while members in facility, set up plan before leaving hospital
Medication Reconciliation Post-Discharge	HEDIS	Percentage of discharges for members 18 yrs and older who had the following Medication Reconciliation Post Discharge. Documentation of med rec on the date of d/c through 30 days after d/c	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education; Ongoing education on Medications, MTM review of meds by pharmacist; Instruction to members on telehealth availability for f/u
Potentially Harmful Drug-Disease Interactions in the Elderly	HEDIS	Percentage of Medicare members 65 yrs of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed a script for a potentially harmful medication, concurrent with or after the dx.	Quality Compass 90th percentile	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education; Ongoing education on Medications, MTM review of meds by pharmacist; Instruction to members on telehealth availability for f/u

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Use of High-Risk Medications in the Elderly	HEDIS	Percentage of Medicare members 66 yrs of age and older who had at least one dispensing event for high risk member	5 Star/ Quality Compass	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education; Ongoing education on Medications, MTM review of meds by pharmacist; Instruction to members on telehealth availability for f/u
Plan All-Cause Readmissions	HEDIS	For members of 18 yrs and older, the number of acute inpt. and observation stays during the measurement yr that were followed by an unplanned acute readmission for any dx within 30 days	5 Star	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education; Increased hospitalizations for severe illness and conditions; Ongoing education of transitions, f/u after hospitalization;
Adults Access to Preventive/Ambulatory Health Services (Total)	HEDIS		97%	Quarterly/ Annually	Not Met – identified potential overall decrease in member f/u for related current COVID related pandemic r/t member concern with leaving their home, facility closures, limited online access to attend online education;
Improving Coordination of Care (D-SNP program)Care Management/HRAT completion/data collection	Care Management System/audits	HRAT completion on every enrolled D-SNP member	100%	Quarterly/ Annually	Met –implemented: increased education on HRAT, questions, engagement with members, using MI for engagement; Required fields on assessment for completion; audits on HRAT completion; 1:1 staff counseling with <100% completion rate;

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
ER visits/1000 members Improve Utilization of Services	HEDIS/Internal reporting	For members 18 yrs and older, the risk adjusted ratio of observed to expected ED visits during the measurement year.	20%	Quarterly/ Annually	Not Met - identified potential overall increase in member f/u in ER related to current COVID pandemic. Increased ER use r/t member concern facility closures, PCP not taking appointments, limited access or education on telehealth visits, and r/t to COVID dx. Staff education on COVID concerns r/t ED visits; coordination of care and communication with PCP for f/u; education of members on telehealth availability
Appeals/1000 members	Appeals Software		<5 appeals/ 1000 member	Quarterly/ Annually	Met – Staff education on appeals process, documentation, coordination with SHP Member Advocate; CBT annually; Review of member authorizations/process, Ongoing staff education
Complaints/1000 members	Customer Management System software		<3 complaints/ 1000 members	Quarterly/ Annually	Met – Staff education on complaint process, documentation, coordination with SHP Member Advocate; Annual CBT, Ongoing staff education

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Care management survey-program evaluation	Care Management System and reports	Annual member survey sent out to all D-SNP members enrolled in the program	75% completion	Annually	Not Met – 104 completed and returned; Updated survey process and question; survey sent annually in one mailing to all current members; Barrier – 1. unable to identify member (name not required) 2. Members living in SNF or assisted living facilities – mailing goes to family members and/or mailing goes to facility and member unable to complete; identified potential overall decrease in member return surveys related current COVID related pandemic – families not having regular contact with family, unable to answer questions.
Improving Coordination of Care Individualized Care Plan (ICP) will be completed timely	SHP data reports /audits	ICP completed on every D-SNP member	100%	Quarterly/ Annually	Met - 100% - increased education to D-SNP staff on ICP reviews, care planning, documentation and f/u; purpose, MOC education; Increased Medical Director and Pharmacy collaboration with ICT team; ICP assessment created for documentation and reporting of completion of ICP.

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Improve members access to essential services medical, mental and social services – evaluation of compliance to network access and CMS standards	SHP data reports	Available access to medical, mental and social services within the D-SNP service areas	95%	Semi-annually	Not Met - 94% - D-SNP educated on Provider Network; resources online to identify provider availability; increased coordination with Provider Network with D-SNP identification of provider areas needed, providers identified for network management to outreach; increased education to members regarding providers and availability; Integrated Care available within system available for mental health, increased use of telehealth for health and f/u with providers; education to members regarding telehealth availability and coordination of resources
Improving Coordination of Care Interdisciplinary Care Team (ICT) will occur according to the MOC and SHP policy	SHP data reports/audits	ICT completed on every member enrolled in D-SNP program	100%	Quarterly/ Annually	Met - 100% - increased education to D-SNP staff on ICT reviews, purpose, MOC education; Increased Medical Director and Pharmacy collaboration with ICT team; Notification to PCP – letter created for notification and f/u; created assessment for documentation and reporting
Improve Seamless Transitions of Care Across Health Care Settings, Providers and Health Services Completed Transitions Assessments according to process/policy	SHP data reports/audits	Transition assessment completed on members enrolled in D-SNP program	73%	Quarterly/ Annually	Met - 87% - Increased education to D-SNP staff on Transition Care and f/u; Created a Transition Care assessment and Discharge Planning assessment for f/u by D-SNP care management team; Task/Reminder created in SHP care management system identifying transitions (hospitalizations/SNF stays); reporting on transition assessments

Metric	Data Source	Description	Goal	Timeframe	Met/Not Met & Action Plan
Improve Advance Care Planning and Advance Directive Planning Advance Directives and Advance Care Planning discussion will be discussed with all DSNP members annually	SHP data reports/audits	ACP discussion with every enrolled D-SNP member	100%	Annually	Not Met - 94% - Education to staff – ACP discussion with D-SNP assessed ACP availability with Initial/Annual assessments; Increased member education; D-SNP social worker resource to assist with ACP discussion and assistance; System initiative on ACP documents, correctness of documents and access across facilities to ACP documents; Education quarterly to D-SNP staff on ACP; Annual CBT completed by staff

The 2023 metric table includes updated metrics and goals for the next D-SNP certification period. These metrics ensure that the unique needs of our SHP D-SNP membership are being met and interventions within the D-SNP program are aligned with the model of care.

The D-SNP QI team will continue to evaluate the metrics and outcomes and develop action plans according to member, member health care needs, barriers, ICT reviews, member satisfaction surveys, claims and complaints and grievances. Goals are regularly assessed to evaluate the rate of progression toward goal achievement while identifying and addressing any barriers to meeting those goals.

2023 Metrics:

	Specific D-SNP Goals			Goals as Measurable Outcomes		
Measure Type	**Goal**	**Description**	**Data Source**	**Benchmark**	**Timeframe**	**How Achievement is Determined**
Care for Older Adults – Functional Status Assessment (Improved Health Status)	5 Star	Functional assessment include in the D-SNP Initial/Annual Assessment; identified ADL/IADL; Cognition, Ambulation Status, Hearing, Vision, Speech and ability to function independently.	HEDIS	88%	Quarterly/ Annually	Functional Status (activities of daily living) assessment to be completed and documented by PCP; D-SNP Initial/Annual HRAT assessment completion of functional status
Care for Older Adults -Pain Assessment (Improved Health Status)	5 Star	Pain assessment from D-SNP HRAT; Assessing for pain, rating of pain, pain inventory.	HEDIS	3 Star (96% percentile)	Quarterly/ Annually	Pain assessment – documentation that the member was assessed for pain, using standardized pain assessment tool; D-SNP Initial/Annual HRAT assessment completion of functional status
Care for Older Adults-Medication Review (Improved Health Status)	5 Star		HEDIS	96.7%	Quarterly/ Annually	Medication list is in the medical record and evidence of medication review by a prescribing provider or pharmacist and the date when it was completed.
Care for Older Adults-Advance Care Planning	5 Star	ACP documented	HEDIS	5 Star (87% percentile)	Quarterly/ Annually	Presence of an ACP in the medical record; documentation of ACP discussion and date; notation that the member previously executed and ACP

	Specific D-SNP Goals			Goals as Measurable Outcomes		
Measure Type	**Goal**	**Description**	**Data Source**	**Benchmark**	**Timeframe**	**How Achievement is Determined**
Controlling Blood Pressure (Health Outcomes)	5 Star	Blood Pressure Control (<140/90)	HEDIS	2 Star (80.56% percentile)	Quarterly/ Annually	Documented EMR recordings of Blood Pressure <140/90
Comprehensive Diabetes Care HgbA1c control (Health Outcomes)	5 Star	Assesses adults 18-75 yrs. with diabetes. Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). HbA1c control (<7.0%) for a selected population; EMR review	HEDIS	3 Star	Quarterly/ Annually	Documented EMR Hemoglobin A1C level of < 8.0%
Performance - Grievances (Access to Care)	Fewer than 20 D-SNP member grievances will be related to provider access per year	Number of grievances filed related to provider access	Member Grievances/ SHP data/reports /audits	9 (2.86%)	Annually	Review of D-SNP member grievances related to provider access
Improving Coordination of Care (D-SNP program)Care Management/Initial HRAT completion/data collection (SNP MOC Performance)	100% completion (within 90 days of enrollment)	Initial HRAT Assessment	Care Management System/audits	100%	Quarterly/Annually	D-SNP outreach for HRAT Initial Assessment completion within 90 days of enrollment in D-SNP program

	Specific D-SNP Goals			Goals as Measurable Outcomes		
Measure Type	**Goal**	**Description**	**Data Source**	**Benchmark**	**Timeframe**	**How Achievement is Determined**
Improving Coordination of Care (D-SNP program) Care Management/Annual HRAT completion/data collection (SNP MOC Performance)	100% (within 364 days of enrollment)	Annual HRAT Assessment	Care Management System/audits	100%	Quarterly/Annually	D-SNP outreach for HRAT Annual Assessment completion within 364 days of last HRA assessment completed
Care management survey-program evaluation (Improved Health Status)	20% completion/ returned surveys	Annual member survey	Care Management System and reports	14%	Annually	D-SNP annual survey sent and returned to all current enrolled D-SNP members
Care management survey – program evaluation – My team helped me understand how to manage my health more effectively (Improved Health Status)	86% strongly agree/agree	Annual member survey	Care Management System and reports	84%	Annually	D-SNP annual survey sent and returned to all current enrolled D-SNP members – strongly agree/agree to improvement in understanding how to manage health more effectively
Improving Coordination of Care Individualized Care Plan (ICP) will be completed timely (SNP MOC Performance)	100%	ICP completed on every D-SNP member	SHP Care Management system reports /audits	100%	Quarterly/Annually	D-SNP Care Management coordination and completion of ICP completion at minimum annually with every enrolled D-SNP member

	Specific D-SNP Goals			Goals as Measurable Outcomes		
Measure Type	**Goal**	**Description**	**Data Source**	**Benchmark**	**Timeframe**	**How Achievement is Determined**
Improving Coordination of Care Interdisciplinary Care Team (ICT) will occur according to the MOC and SHP policy (SNP MOC Performance)	100%	ICT completed on every member enrolled in D-SNP program	SHP Care Management system reports /audits	100%	Quarterly/Annually	D-SNP Care Management coordination and completion of ICT at minimum annually with every enrolled D-SNP member
Improve Seamless Transitions of Care Across Health Care Settings, Providers and Health Services Completed Transitions Assessments according to process/policy (SNP MOC Performance)	80%	Transition assessment completed on members enrolled in D-SNP program	SHP Care Management system reports /audits	73%	Quarterly/Annually	D-SNP Care Management outreach for Care Transition; Transition Assessment completed
Improve Advance Care Planning and Advance Directive Planning Advance Directives and Advance Care Planning discussion will be discussed with all DSNP members annually (End of Life/Quality of Care)	100%	ACP discussion with every enrolled D-SNP member	SHP Care Management system reports /audits	94%	Annually	Identification of ACP discussion and/or ACP on file in EMR or SHP Care Management system; Identified on Initial and/or Annual HRAT Assessment

	Specific D-SNP Goals			Goals as Measurable Outcomes		
Measure Type	**Goal**	**Description**	**Data Source**	**Benchmark**	**Timeframe**	**How Achievement is Determined**
Health Outcome (Access to Care)	85%	D-SNP engagement rate with enrolled members	SHP Care Management system reports /audits	72%	Annually	D-SNP outreach for HRAT Initial and/or Annual Assessment completion

SHP's quality improvement structure enables regular assessment of the overall performance of the MOC to ensure consistency of care for members as well as continued improvement of service. Specific indicators have been identified as key in assessing improvement in health outcomes for D-SNP members. Quality Improvement Committee meets at a minimum quarterly to review the status of attaining the desired goals, identify areas for process improvement, and facilitate appropriate interventions. Goals will be monitored and evaluated through specific indicators as displayed in the table found above.

MOC 4: Element B: Factor 2: Identify specifically enrollee health outcome measures used to measure overall SNP population health outcomes at the plan level.

The annual quality program evaluation will include a comprehensive evaluation of the model of care that describes completed and ongoing activities that address the quality and safety of clinical care and quality of service. Trending of measures will be conducted to assess performance. Analysis and evaluation of the overall model of care effectiveness will be included that describes the major accomplishments, measures trended over time including but not limited to HEDIS, CAHPS and organization-specific data, the issues and barriers that make objectives more difficult to achieve, recommended interventions to overcome those barriers and issues and an assessment of whether or not the model of care objectives were met. The annual quality program evaluation is reviewed and approved in the quality committee meeting structure.

MOC 4: Element B: Factor 3: Describe how the SNP establishes methods to assess and track the MOC's impact on the SNP enrollee's health outcomes.

Tracking impact is an important function of the D-SNP program and as mentioned in MOC 4 Element A is an integral part of the quality program. Quality goals are monitored and measured regularly through member surveys, (CAHPS survey, HOS), program dashboards, KPI's and annual surveys sent to members evaluating their experience with the D-SNP program and care management.

One of the first things a member will experience when they enroll with the D-SNP program is the Heath Risk Assessment Tool (HRAT). Chronic illnesses account for an estimated 83% of total U.S. health spending. Many patients do not receive recommended preventive services and follow-up treatment. To reduce health disparities by completing the health risk

assessment and follow-up interventions will improve the enrollee's health outcomes The HRAT will assist in identifying the health risks and providing follow-up behavior change interventions that can be implemented by the D- SNP care management team. The HRAT will measure the members' health risk at a certain point of time and stratify risks identified. SHP can track and measure from year to year or assessment to assessment changes in the member's scores. Changes may trigger further assessment or exploration of the member needs. We can also track improvement in scores and assess what interventions may have made a difference for the member.

MOC 4: Element B: Factor 4: Describe the processes and procedure the SNP uses to determine if health outcome goals are met.

Specific determinations for how health outcomes are measured are embedded throughout the MOC 4 document. In this section, we will share the determination of member goals with in member's individual health plan.

- The D-SNP care management team completes a curriculum of topics to prepare them for the expectations that accompany care management team functions. Motivational interviewing and writing measurable goals are included. Goals are developed with the member and their families. The D-SNP care management team can suggest goals for members that struggle articulating goals, but they do need to be accepted by the member. Although a goal stating that the member wants to remain at home is a measurable goal, the D-SNP care management team may go deeper and more specific. For example - the member has not seen a doctor for three years; a measurable goal would be to see a doctor within 6 months to establish care and document the date. The D-SNP care management team would check back to see how goals are progressing. Ongoing management by the D-SNP care management team assesses for the writing and monitoring of measurable goals will be included. Based on preventive health and outcome measures with HEDIS measurement and scoring will identify preventive measures and gaps in care are met or not also. If gaps in care are measured, SHP D-SNP care management team will create an action plan based on the gaps in care identified for the member. Specific determinations for how health outcomes are reviewed and measured are throughout the D-SNP Model of Care. With the review of the MOC, the following can be assessed for increased needs, changes and outcome goals:
    1. Interdisciplinary Care Team
    2. Staffing – caseloads,
    3. Members – targeting the right members-member engagement
        a. Tools – what is available? Are the tools appropriate? What changes or additions need to be made?
        b. Dynamics- staffing, member population, assessments etc.
    4. Outreach, engagement, unable to reach, declined members
    5. Community resources –care coordination with other organizations, vendors

MOC 4: Element B: Factor 5 Describe the steps the SNP will take if goals are not met in the expected time frame.

Interventions will be taken if goals are not met in the expected time frame. ICT reviews are

conducted on members including the HRAT assessment, stratification, documentation on collaboration with providers, the enrollee and anyone involved in the enrollee's plan of care. Reviews include:

- Monitor assessment timelines
- Completeness of care plans
- Advance Care Planning and Advance Directive planning
- Gaps in Care
- Action plan follow up

Additional training will be provided depending on deficiencies identified. If goals are not met, corrective action will take place and will be documented. The ICP will also be reviewed and goals revised as needs are identified. The ICT is involved in all corrective action when updates are made and changed. Goals will be reviewed with the member, family and caregivers as designated to identify risks. Collaboration and communication with the PCP will take place to assist the PCP in any changes needed. Readmission and ER visits will be monitored for change needed and better coordination of care and services. Corrective Action Plans, increased education to D-SNP staff, other internal staff, external vendors and providers will be implemented for those initiatives identified not meeting goals within the established time frame.

MOC 4: Element C: Measuring Patient Experience of Care

MOC 4: Element C: Factor 1: Describe specific SNP survey used.

Security Health Plan will evaluate the effectiveness of the Model of Care, Care Coordination activities and the impact it may have on the members.

Member experience survey
A member experience survey will be utilized to measure member satisfaction with the overall D-SNP program, program staff and overall experience with the program. The member experience survey will be completed annually. Each year the survey will be reviewed and compared to the previous year's results for areas of opportunities and improvement.
The survey will include:

- Quality of Care
- Access
- Customer Service
- Satisfaction with the ICT team
- Overall program experience

Sample questions on the survey: (all answers can be strongly agree, agree, disagree, strongly disagree and no opinion)

- Helped me understand how to manage my health more effectively
- Helped me get the care I needed
- Treated me with courtesy and respect
- Answered my questions or concerns in a timely manner
- The information I received related to my health was useful

- The information I received related to my health was easy to understand
- I would recommend care management services to a friend or family

Ongoing Report Monitoring
We generate reports through various departments to measure how trends in complaints or quality of care issues. If, we identify a trend, for example, in grievance and/or appeal types, Security Health Plan staff works to identify the source of the trend and work to identify solutions. Areas we include:

- Appeals, Grievances and complaints

Target Surveys
Members are provided targeted survey at various times, some of which include the closure of a complex case management, disease case management and behavioral health follow-up. Each survey is reviewed on an individual basis and on cumulative basis identifying strengths and weaknesses with the process. Surveys are based on the members' perception of their health status, coordination activities, and quality of life.

Member appeals and grievances are routinely tracked and discussed at the Appeals and Grievances subcommittee. Any trends are evaluated for possible opportunities for improvement. Data and recommendations for quality improvement projects is forwarded to the QIC on a quarterly basis.

MOC 4: Element C: Factor 2: Explain the rationale for the selection of a specific tool.

For the Security Health Plan D-SNP population, Security Health Plan of Wisconsin uses the CAHPS survey to measure the patient experience. The CAHPS survey is a nationally recognized, standard survey administered in a way that delivers statistically valid results.

MOC 4: Element C: Factor 3: Explain how results of patient experience surveys are integrated into the overall MOC performance improvement plan.

Security Health Plan uses a continuous improvement process to assess enrollee experience, identify opportunities for improvement, implement interventions and measure the effectiveness of the interventions.

To develop the performance improvement plan, Security Health Plan has a cross-functional Quality Improvement workgroup to participate in a continuous improvement process. The improvement process uses the following model for measurement, analysis, improvement and control/evaluation as the basis for the process.

Plan: What exactly are we going to do?

- Capitalize learning from process and initiatives to continuously improve and grow the SNP program

Do: When and how did we do it?

- Determine barriers to improvement and design action plans/initiatives

Study: What were the results?

- Review data and trends on top improvement areas and progress
- Monitor progress on action plans/initiatives and measure effectiveness of interventions

Act: What changes are we going to make based on our findings?

- Prioritize improvement opportunities to determine focus areas
- Implement action plans/initiatives

MOC 4: Element C: Factor 4: Detail the steps taken by the SNP to address issues identified in the member survey responses.

Survey responses will be reviewed by the D-SNP care management team and quality program to address issues and concerns identified by developing of a quality improvement plan. Responses will be tracked and trended to identify solutions.

Data Collection and Analysis

Security Health Plan of Wisconsin maintains systems, both electronic and manual, that allow it to collect and analyze data on health outcomes and quality indices. Data collected and analyzed includes, but is not limited to:

- Hospital and SNF admission rates
- Member self-management and independence
- Member mobility and functional status
- Member satisfaction with health status and health services
- Member access to medical, mental health and social services
- Coordination of care through a single point of care management
- Transition of care across settings
- Member access to preventive health services
- Gap in Care

Collection methods for data include standardized data collection using the HEDIS, HOS and CAHPS surveys as well as Security Health Plan administrative data maintained in Security Health Plan databases and transaction processing systems.

The evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care. If areas need improvement an action plan will be put into place to assure continued maintenance and improvement of the model of care. Action plans are presented to and approved by the clinical quality management committee with outcomes reported at the end of the year through the quality evaluation program.

MOC 4: Element D: Ongoing Performance Improvement Evaluation of the MOC

Security Health Plan of Wisconsin currently evaluates and will continue to evaluate the effectiveness of the D-SNP Model of Care and care coordination activities and the impact it has had on members.

MOC 4: Element D: Factor 1: Describe how the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.

In order to respond to a member's health issues and to analyze opportunities for improvement to our Model of Care, reports are developed, collected and analyzed to identify members who may benefit from case management, population health management and to decrease the risk of unplanned transitions.

On an annual basis Security Health Plan generates reports to identify members who may be at risk during transitions of care settings. These members may benefit from continued case management services in order to reduce avoidable transitions, coordinate a member's care, and provide education to proactively address the health issues. These reports are reviewed by the management, the QI committee and the D-SNP care management team

Security Health Plan has identified reports which analyze emergency department visits, inpatient admissions, readmissions and transitions which have occurred, in order to identify areas for improvements by minimizing transitions and maintaining members in the least restrictive setting. These reports are reviewed by management and provided to Security Health Plan Quality Committee in order to identify changes to the current process.

MOC 4: Element D: Factor 2: Detail how the organization will use the results of the quality performance indicator and measures to continually assess and evaluate quality.

Security Health Plan is committed to continuously improving the quality of care and services provided to our members and promoting effective and efficient utilization of health care resources. These commitments are achieved through an organization-wide Quality Improvement Program (QI Program.) The QI Program is designed to improve the health of member's, deliver the best possible health care value, promote objective and systematic program measurements, monitor and evaluate services, and implement quality improvement activities based on these findings. The Health plan QI Program facilitates safe, appropriate, and efficient quality care by using evidence based standards of medical care that meet regulatory requirements.

SHP recognizes the specific clinical characteristics and demographic attributes of members within the D-SNP and on an annual basis evaluates the effectiveness of the model of care within the construct of the QI Evaluation, to ensure that the needs of the population are met. Data collected on performance and health outcome measures are communicated the performance improvement committees and reported at the QIC

The following elements of the model of care are evaluated on an annual basis:

- Target population-demographic and clinical characteristics.
- Staff structure and roles of the care management personnel are appropriate with expertise in the population they serve.
- SHP D-SNP staff and providers are trained on an annual basis and demonstrate knowledge in provision of care for the characteristics of this population.
- A process to identify and implement a care management program for the Most Vulnerable Population.
- A Health Risk Assessment that identifies and stratifies the specialized needs of this complex population.
- Care Management Goals:
    1. Improving access to essential services such as medical, mental health, and social services.
    2. Improving access to affordable care.
    3. Improving coordination of care through an identified point of contact.
    4. Improving seamless transitions of care across healthcare settings, providers, and health services.
    5. Improving access to preventive health services.
    6. Assuring appropriate utilization of services.
    7. Improving beneficiary health outcomes.
- An Individualized Care Plan that is member-centric and monitored for goal achievement
- A functional Interdisciplinary Care Team that serves as a vehicle for communication between the Plan, members, and the providers
- A well-developed adequate Network with specialized expertise utilizing evidenced based guidelines for the characteristics of this population
- A method to evaluate the model of care for performance and health outcome measures

MOC 4: Element D: Factor 3: Detail the organization's ability for timely improvement of mechanisms for interrupting and responding to lessons learned through the MOC performance evaluation.

Security Health Plan's Medicare Advantage staff work closely with Care Coordination acting as liaisons between the workers providing the face to face member interaction and our Medical Management, Medicare Advantage Representatives and Provider Services. Through daily communication, formal training/meetings, and annual audits of Care Coordination, Medical Management, Behavioral Health Management, Quality Management, Medicare Advantage Representatives and Provider Services staff is able to assess current processes related to the Model of Care of Care and work with our internal Integrated Health Management partners to make improvements on an on-going basis. Review will be completed minimally on a quarterly basis or as needed to review lessons learned and observed.

MOC 4: Element D: Factor 4: Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

There are many ways that Security Health Plan communicates to stakeholders. Providers are sent letters or contacted telephonically to communicate changes regarding their patients. Changes to the Model of Care are reflected in the Care Coordination Guidelines, Security Health Plan Provider Manual, and reviewed in face to face as needed. Also, for providers, we utilize provider newsletters for immediate policy and procedure changes. The Provider Manual includes tips on how to submit claims or payment information updates. Updates are provided on the SHP website and provider portal.

The Security Health Plan D-SNP program description is an annual evaluation. It is included in our Quality Improvement Program Evaluation document that is reviewed by the Quality Management Advisory Team and QI Committee. This report is stored electronically and available to CMS upon request.

MOC 4: Element E: Dissemination of SNP Quality Performance related to the MOC

The organization addresses the process for communicating its quality improvement. Ongoing communication of the MOC performance occurs throughout the year via various reports and meetings with various stakeholders.

- Provider Portal/digital outreach and/or Letters are mailed to providers to inform them of QI initiatives mandated by State or Federal regulations
- High volume physicians receive reports on individual performance against expectations and benchmarks with regard to clinical and patient performance and management.

MOC 4: Element E: Factor 1: Describe the performance results and other pertinent information are shared with multiple stakeholders

There are many ways that Security Health Plan communicates to stakeholders. Care coordinators and providers are sent letters or phone calls to communicate changes regarding their patients. Changes to the model of care are reflected in the Care Coordination Guidelines, Security Health Plan Provider Manual, and reviewed in face to face and webinar delegate training. Also, for providers, we utilize provider letters for immediate policy and procedure changes. The Provider Newsletters includes tips on how to submit claims or payment information updates. Providers also utilize the Provider Portal and SHP website for resources such as the provider manuals.

The D-SNP program results and effectiveness report is included in our Quality Improvement Program Evaluation that is reviewed by the appropriate quality committees. This report is stored electronically and available to CMS upon request. The annual QI Program Evaluation is available to practitioners, providers and members upon request.

MOC 4: Element E: Factor 2: State the scheduled frequency of communications with the stakeholders.

Security Health Plan Network Management staff support the providers' needs in the areas of communications, training, education, claim processing, denial questions, contracting requirements, coding requirements and provider appeals.

SHP involves and encourages the participation of its providers, its interdisciplinary care team, and beneficiaries/caregivers in its overall quality improvement program. Through its digital outreach, newsletter, educational materials, website, and member outreach programs, SHP members are provided with an opportunity to contact SHP about issues that they may encounter. Members and their caregiver's input may also be provided via SHPs Appeals and Grievances processes.

Further, participation in SHP provides an avenue for stakeholders to share their ideas and comments about events related to the Plan. Announcements related to quality improvement initiatives are communicated to stakeholders, including members through several methods, including but not limited to:

- Member-centric newsletters and bulletins
- Letters
- Digital outreach
- Telephonic outreach and in-home visits
- Preventive care and screening reminders
- Gap in Care and Disease specific campaigns

In addition, the provider portal, and provider-centric materials such as newsletters, SHP's Provider Manual, letters, and/or digital/telephonic outreach are some of the methods that SHP uses to communicate improvements in care management to providers. For both members/caregivers and providers, the SHP website provides them with easy access to educational and procedural documents.

MOC improvements are communicated to stakeholders at specified interval and on an ad hoc basis. Examples of regular communications and their scheduled frequencies are as follows:

Audience/Stakeholder	How Quality Performance Results Shared	Scheduled Frequency of Communications	Individuals Responsible for Communication
D-SNP Leadership	Quality Improvement	Annually	Director of Quality and Population Health
D-SNP Personnel & Staff	Communication via Staff Meetings	Monthly and Ad Hoc	D-SNP Clinical Manager
	DSNP MOC training	Annually and Ad Hoc	D-SNP Clinical Manager

	Summary of Benefits	Annually and Ad Hoc	Training and Development; D-SNP Clinical Manager
D-SNP Beneficiaries	Preventive Care Communications	Ad Hoc	Director of QI, RN Clinical Manager
	Summary of Benefits	Annual	Marketing and Development Dept.
	Care Manager Communications	Ad Hoc	Care Managers
General Public	Website	Ad Hoc	Director of Marketing, Manager of Marketing
	Marketing Materials	Ad Hoc	Director of Marketing, Manager of Marketing
	Press Releases	Ad Hoc	Director of Marketing, Manager of Marketing
Regulatory Agencies	CCIP and QIP updates	Annual	Director of Quality
	HEDIS	Annual	Director of Quality
	MOC Resubmissions	At least every three years	Director of Quality

MOC 4: Element E: Factor 3: Describe the methods of ad hoc communications with stakeholders.

If specific performance results indicate further evaluation and review an ad hoc meeting will be communicated to the appropriate stakeholders.

Upon recognition of identified outcomes, the SNP will conduct medical record audits, and/or development of ad hoc reports. Education will be provided to members, providers, and the ICT team through the following options (may include, but are not limited to):

- Articles in provider newsletters
- Updates will be made on the website
- Individual letters to members reminding them of the appropriate use of the emergency departments
- Individual education to members on the importance of follow after a hospital discharge
- Continued education with the ICT team on transitions
- Reeducate nursing homes utilization and member management needs

MOC 4: Element E: Factor 4: Identify the individuals responsible for communicating performance updates in a timely manner.

The D-SNP director and clinical manager has oversight responsibility for monitoring and evaluating the effectiveness of communications to providers. Updates will be communicated and/or further evaluations will be completed as appropriate. Reporting will be communicated with the individual providers as needed. Provider manual updates, newsletters, policies and provider alerts are examples of communication techniques to providers.

The Director of Provider Network has oversight responsibility for monitoring and evaluating the effectiveness of communications to providers. He is responsible for content and effectiveness of the on-line provider manual (which includes the provider administrative policies, newsletters, and provider alerts.

The Manager of Customer Service has oversight responsibility for monitoring and evaluating the effectiveness of communications to members, in addition to broker agents. The responsible includes content, readability, alternative language, and contact channels. Contact channels include correspondence, telephone, face-to-face, website, social media and newsletters. Customer service representatives' primary responsibility is to communicate directly with members and agents.

CAHPS is conducted annually and provides beneficiary feedback providing responses to satisfaction, prescription drug usage, health plan satisfaction, and ease in understanding written material, healthcare access, and utilization of healthcare service and physician's ability to communicate. The survey responses are provided as a whole and then by age, nationality, and income. Evaluating the detail provides relevant data and identifies opportunity in improving the delivery of healthcare services.

Marketing is responsible to develop and implement marketing strategies, programs and materials in support of Medicare Advantage (MA) products. This department also coordinates and obtains Center for Medicare and Medicaid Services (CMS) approvals to ensure that all marketing materials and activities are compliant with CMS regulations.

Appendix:

Attachment: Medicare Advantage – Eligibility and Application Requirements



Medicare Advantage-Eligibilit

Attachment: D-SNP Map



D-SNP Service Area.pdf

Attachment: DSNP Monthly Medicaid Reverification Process



DSNP Monthly Medicaid Reverificat

Attachment: ADRC Map



ADRC map.docx

Attachment: Healthwise Hypertension;



Healthwise High Blood Pressure 11-6

Attachment: DSNP Readmissions



DSNP Readmit Stats.docx

Attachment: Services available per county



D-SNP County -Services.docx

Attachment: SNP-Continuity of Care example



Continuity Of Care.docx

Attachment: Member Case example



Member Case.docx

Attachment: Member dashboard



Member Dashboard.docx

Attachment: Member Risk Dashboard



Member Risk Example.docx

Attachment: MOC SHP Internal Staff Training



2022_DSNP_Intro_Slides.pdf

Attachment: MOC Provider Training



2022_DSNP_Provider.pdf

Attachment: HRAT Initial assessment



DSNP Initial HRAT.docx

Attachment: Initial Checklist



Initial Checklist 1-1-2023.docx

Attachment: Annual Checklist



Annual Checklist 1-1-2023.docx

Attachment: HRAT Annual assessment



DSNP Annual HRAT.docx

Attachment: Unable to Reach/Declined checklist



Decline-Unable to Reach Checklist .doc

Attachment: face-to-face visits



Face to Face Encounter.pdf



DSNP Face-to-Face Encounter Guidelin

Attachment: DSNP Ongoing Outreach Note



DSNP Face-to-Face Ongoing Outreach.

Attachment: Care Plan example



DSNP Care Plan.pdf

Attachment: DSNP ICP



DSNP ICP.docx

Attachment: Transition assessment



DSNP Transition Assessment (1).docx

Attachment: Discharge Planning assessment



Discharge Planning Assessment (1).docx

Attachment: Stratification/Acuity



DSNP Stratification Acuity.docx

Attachment: Provider Training Guide



2022_DSNP_Provider.pdf

Attachment: Internal/External Training Guide



2022_DSNP_Intro_Slides.pdf

Attachment: Staff Education/Training Calendar



Staff Education Training Calendar.d

Attachment: QI Committee description



Quality Improvement Comm

Attachment: QI Program description



2021 QI Program Description.doc

Attachment: QIC meeting minutes

QIC 2021 Mtg Minutes.docx

Attachment: QIC presentation

DSNP QIC Update 11-18-21.pptx

Attachment: Provider Directory Accuracy

Provider Accuracy policy.pdf

Attachment: Clinical Practice Guidelines

Clinical Practice Guidelines.pdf

Attachment: DSNP QI Evaluation

DSNP MOC QI evaluation.pdf

Attachment: Provider Quality

Provider Quality.pdf

Attachment: Network Adequacy

Assessment Network Adequacy.p

Attachment: Network Availability

Network Availability.pdf