Providence

Annual Special Needs Plan (SNP) Model of Care Training

Ambulatory Care Management

2023

CME Accreditation

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CME Accreditation Information
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Swedish Medical Center and Providence St. Joseph Health. Swedish Medical Center is accredited by the ACCME to provide continuing medical education for physicians.

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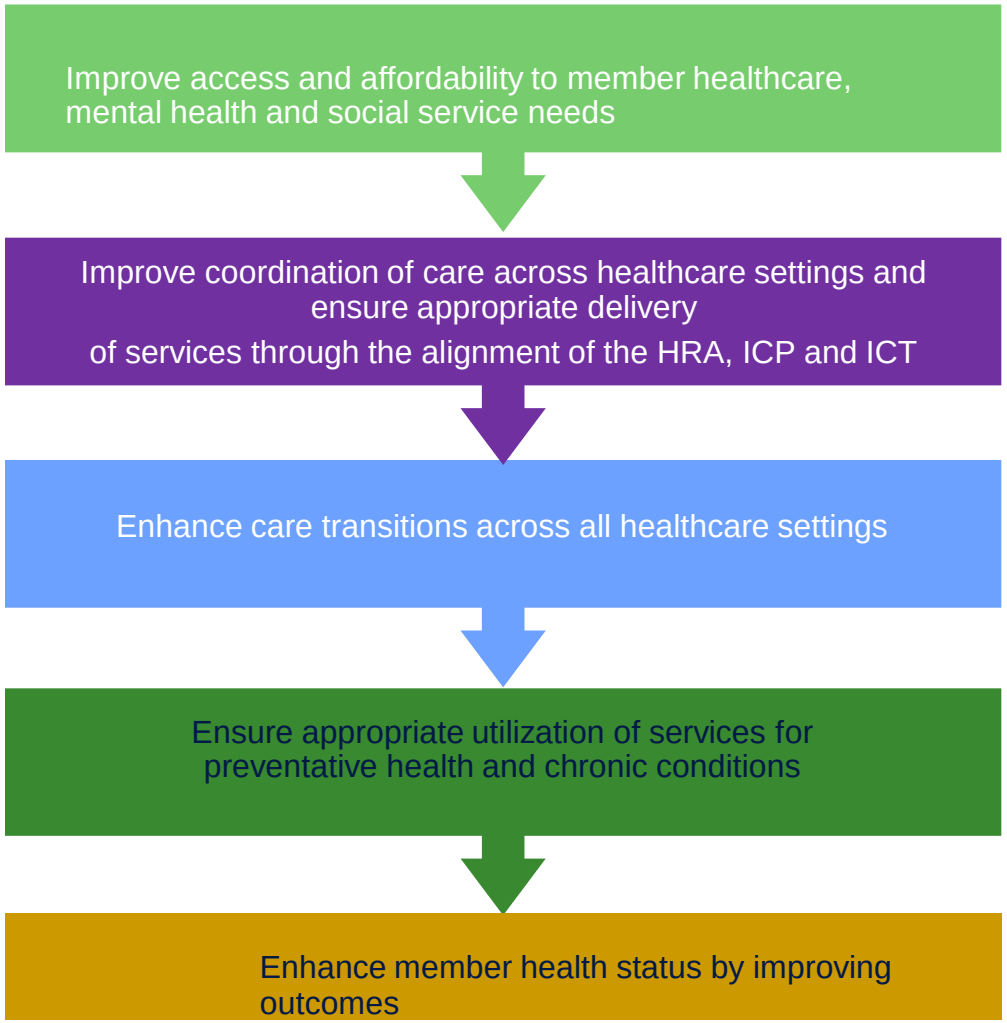
Special Needs Plan: Goals



Special Needs Plan: MOC

- Model of Care (MOC): CMS requires SNP Plans to develop a MOC that describes their approach to caring for their target population. The SNP MOC is a working framework on how the SNP proposes to coordinate the care of the SNP enrollees.
- Required Training: CMS requires all employed and contracted staff, who provide direct and indirect care coordination services to SNP members, to complete initial SNP MOC training and annually thereafter. Delegates this requirement to each medical group to provide initial and annual training for all employed and contracted staff and maintain the documentation of that training.

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Types & Eligibility

Chronic Special Needs Plan (C-SNP)	• **Eligibility verified 30 days post enrollment** • Balance Plan: Diabetes • Heart First Plan: CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder • VillageHealth Plan: ESRD
Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP/D-SNP)	• **Eligibility verified monthly** • Designed for members who have both Medicare Part A and Part B, Full Medicaid benefits and FIDE SNP • Connections and Connections at Home Plan
Institutional Special Needs Plan (I-SNP)	• **Eligibility verified by outside vendor** • Meet state criteria for Nursing Facility Level of Care (NFLOC) • Healthy at Home Plan - Must reside in the community and not a facility (I-SNP is Institutional-Equivalent)

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Member Benefits

Health Risk Assessment (HRA)-Health Plan performs an initial HRA

Transportation–the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region

In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation.** These benefits vary by region and type of SNP.

The 4 Elements of Model of Care

Special Needs Plan
-Chronic SNP **(C-SNP)**
-Fully Integrated Dual Eligible SNP **(FIDE-SNP)**
-Institutional SNP **(I-SNP)**

Staff/Providers deliver care to SNP members must complete annual MOC training

Population → Care Coordination → Provider Network → Quality Measurement and Performance

Care Coordination

-Health Risk Assessment **(HRA)**
-Individual Care Plan **(ICP)**
-Interdisciplinary Care Team **(ICT)**
-Care Transition **(CT)**

-Measures are evaluated on an annual basis
-SNP model of care program evaluation process
-Quality Improvement Plan

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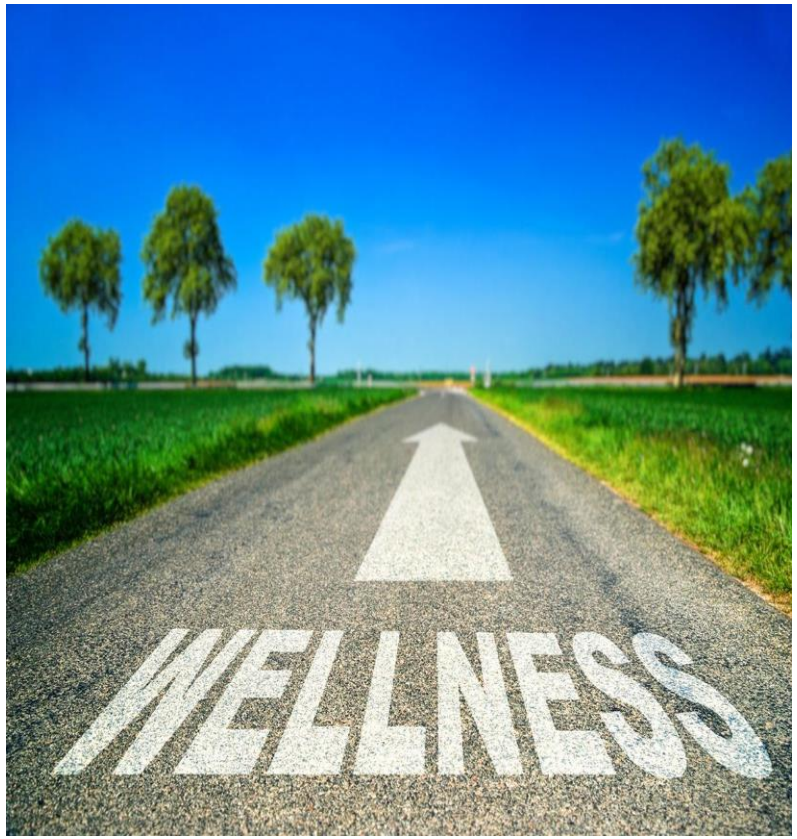
Health Risk Assessment (HRA) Triggers

- "Poor" self-rated health
- 8 or more medications
- Moderate to Severe Depression (PHQ-2)
- Difficulty with ADLs – (Bathing, Eating & Toileting)
- 3 + Falls in the last year
- 3+ SNF admissions in the last year
- 3 + ER visits in the last year
- Report difficulty managing health condition
- 3 + hospital admissions in the last year
- Requests a Case Manager/RN

Individualized Care Plan (ICP)



- Must be completed within 30 days of notification by Health Plan of a new SNP patient per CMS/Health Plan requirement
- Developed based on the patient's assessment and identified problems
- Includes patient's self-management plans and goals
- Includes barriers and progress towards goals
- Shared with patient/caregiver, PCP, and any settings where the patient has a transition of care: Hospital, Skilled Nursing Facility
- Updated with changes to health such as new diagnosis, hospitalization, or at least annually and communicated to ICT and patient

Interdisciplinary Care Team (ICT)

- All SNP members require interdisciplinary care
- **Interdisciplinary care can be formal or informal**
- **Our *formal* ICT team meets weekly** and consists of Medical Director, Social Worker and SNP Care Management nurse
  - Patients/caregivers are invited to ICT during the initial assessment and care plan sign-off. They have the right to opt in or out of participation.
  - The PCP is invited to join the weekly ICTs
- ***Informal*** ICT can occur in person, over the phone or electronically between any two members of the patient's care team

Transition of care (TOC)

- Patients are at risk of adverse outcomes when there is a transition between settings
- Patients experiencing an inpatient transition are identified
- The patient's care plan is shared between care settings upon admission
- PCP is notified of patient's discharge

Discharge follow up call is made to patient; Care Manager to review the following:

- ❑ Discharge instructions and verify understanding
- ❑ Medications and ensure new prescriptions have been filled and picked up
- ❑ Follow-up appointments in place
- ❑ Home Health start date and confirm they have been in touch with the patient (if applicable)
- ❑ Durable medical equipment has been delivered (if applicable)
- ❑ Additional education around diagnosis, symptoms, when to call the doctor
- ❑ Nurse Advice Line and Urgent Care Center information provided
- ❑ Questions the patient/family/caregiver may have

Role of SNP Care Manager

- ❑Reviews Health Risk Assessment (HRA) from Health Plan
- ❑Performs an assessment of medical, psychosocial, cognitive and functional status
- ❑Develops a comprehensive individualized care plan with member input
- ❑Identifies barriers to goals and strategies to address
- ❑Discusses member care at Interdisciplinary Care Team (ICT) meetings
- ❑Facilitates transitions of care calls after an ED visit or acute hospitalization
- ❑Provides personalized education for optimal wellness
- ❑Encourages preventive care such as flu vaccines and mammograms
- ❑Reviews and educates on medication regimen
- ❑Promotes appropriate utilization of benefits
- ❑Assists member to access community resources
- ❑Assesses cultural and linguistic needs and preference

Your Role as the Physician

- ✓ Review comprehensive and individualized care plans created for each patient
- ✓ Encourage your patients to engage with their assigned SNP Care Managers and take advantage of the benefits.
- ✓ Participate in ICT meetings for your patient if necessitated
- ✓ Collaborate with patient care during Transitions to reduce gaps in care and readmission risk
- ✓ Provide medical documentation necessary to the SNP Care Manager for the assessment and care planning process

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Disability Awareness

2023

Objectives

- Explain the prevalence and types of disabilities within Providence’s population
- Identify and explain the legal requirements related to access for person with disabilities
- Define the basic rights of persons with disabilities
- Identify the physical accessibility components at a provider's office that are assessed and reported.
- Define your responsibilities in interacting with members, visitors, patients & their companions with disabilities.
- Use appropriate terminology and proper etiquette when interacting with people with disabilities
- Identify available resources and community resources.

Definitions: Impairment vs disability

Functional Limitations

- Difficulty completing basic or complex activities because of a physical, mental, or emotional restriction.
- May be due to behavioral and/or chronic health conditions.

Functional Capabilities

- Strengths of a person with a disability to perform certain activities, with or without accommodations.

Impairment

- Alteration of a person's health status as assessed by medical means
- Typically identified with an organ or body part
- Ranges from mild (pinky amputation) to severe (tertraplegia)
- Does not include impact on person's ability to function in society

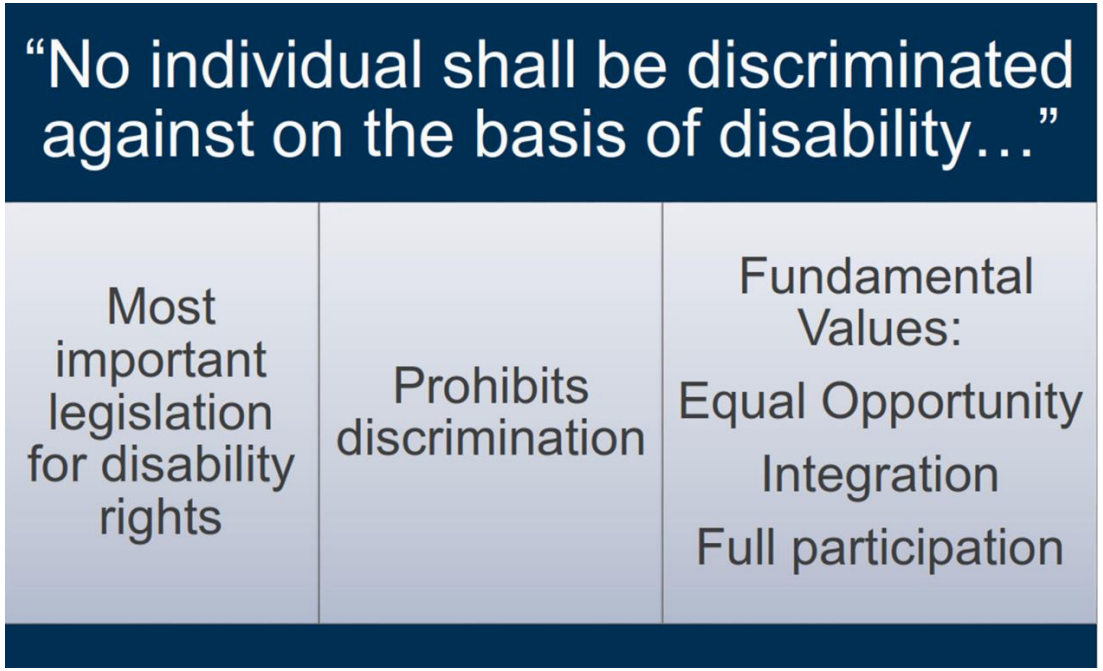
Disability

- A physical or mental impairment that substantially limits one or more of the major life activities (mobility, cognitive, vision, speech, or hearing)
- Birth (congenital) to acquired over lifetime
- Visible or hidden

Americans with disabilities act

The ADA requires:

- Medical care providers make their services available in an accessible manner.
- Policies, procedures and guidelines be in place regarding non-discrimination based on disability.
- Providence is committed to providing equal access for members and their companions with disabilities.



The Rehabilitation act of 1973

Section 504- Prohibits discrimination due to disabilities in programs that receive federal funding

"No qualified individual with a disability …shall be excluded from, denied the benefits of, or be subjected to discrimination under" any program activity.

Program accessibility

Effective communication

Accessible construction and alterations

Section 508- Requires electronic and information technology to be accessible to people with disabilities including employees and members of the public

Visual and audio outputs, optical aids

Accessibility- related software: Jaws (job access with speech)

The Olmstead decision

- Olmstead, or Olmstead v. LC, is the name of the most important civil rights decision for people with disabilities in our country's history. This 1999 United States Supreme Court decision was based on the Americans with Disabilities Act. The Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when the following three-part test is met:

- The person's treatment professionals determine that community supports are appropriate;

- The person does not object to living in the community; and

- The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

Most integrated setting

Integrated setting

- Refers to a setting that, “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible”
- Term means services and benefits to persons with disabilities should not be separate or different from a person without disabilities unless the separate programs are necessary to ensure that benefits services are equally effective

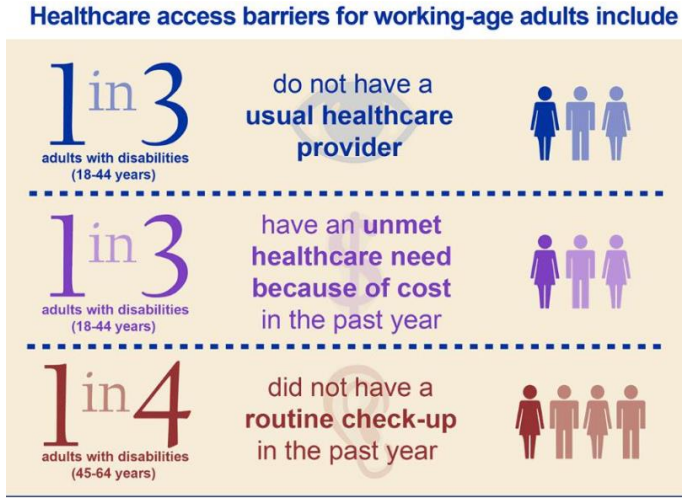
Least restrictive

- Least restrictive environment is terminology for educations settings
- All other settings use the term “integrated setting”
- A “least restrictive environment/setting possible” means members are treated in an environment and manner that respects individual worth, dignity, privacy and enhances their personal autonomy.

Disabilities and healthcare access

- Persons with disabilities and functional limitations may encounter environmental barriers to care.
- Most difficult barriers to overcome are attitudes.
- Focus on individual's ability rather than on disability.

Physical Access	Communication Access	Program Access
Ability to get: • To • Into • Through • Onto	**Ability to::** • Understand what is being asked • Use the information given • Result in effective communication	**Participate in:** • Health education • Prevention & treatment • Community-based programs



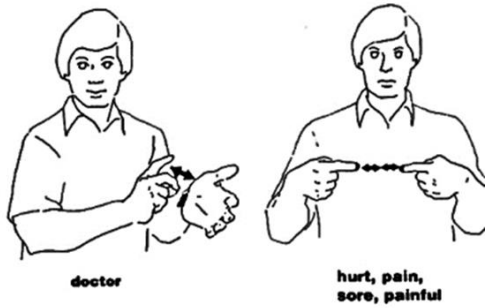
Accessibility requirements for providers

- **<u>Intended to meet the needs of any patient to improve program access and health outcomes</u>**

- Department of Health Care Services (DHCS) requirement MMCD PL 12-006 requires California plans “ to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve high volume of seniors and persons with disabilities.”
- Required for all Medi-Cal contracted providers

Physical access

Effective communication



Reasons for accommodations

Functional limitations may create a need for accommodations such as:

- Physical accessibility.
- Changes to provider office policies.
- Accessible exam or medical equipment.
- Effective communication.
- Member and health education materials in alternate formats.
- Physical disabilities may be more obvious, but unseen mobility issues are more common.
- For example, a member may experience an issue with physical ability to move around or walk a distance due to hip or knee problems, breathing issues, weakness, etc.

Never assume to know the member's disability

Types of physical accommodations

- Put yourself in the position of a person who is sight impaired, uses a wheelchair or is hard of hearing. Then think about what you would need to access information or simply enter an office
- Can you think of additional common types of physical accommodations? There are many barriers to access that are often overlooked by people who don't need them.
- These are everyday things we use, including: elevator, doors, doorways, hallways, restrooms, parking lots, telephones, forms and documents

Speech Disabilities

Members with speech disabilities may use:

- Their own voice
- Letter board
- Pen and paper
- Augmentative and alternative communication devices
- Speech generating devices (SGDs) “talk” when certain letters, words, pictures, or symbols are selected
- Speech-to-speech relay services (STS)
- A call that uses a specially-trained communications assistant

Speech disabilities can be:

- Developmental
- Result of illness or injury
- No speech
- Difficult to understand

Communication tips

If you have trouble communicating:	
Ask the member how he or she wants to communicate	Speak slowly, clearly and patiently, and give time to respond

Don't:
Assume — which also includes not assuming someone from another culture understands American Sign Language.
Rush or ask the member to hurry.

Use People-First Language			
Person with a disability	Person who is deaf	Person who uses a wheelchair	Person with an intellectual disability

Avoid Negative Language:
Handicapped person, blind person, wheelchair-bound or mentally retarded

- When talking about a disability or with a person with disabilities, focus on the person, not the disability, avoid negative language and use people-first language

Communication tips

Members with mental health and/or substance abuse conditions may need consideration:

Know how to get help in the event of a crisis, remain calm and offer support

Keep stress levels to a minimum

Change words you use

Ask what environment they are most comfortable in

DON'T:

- Finish their sentences or cut them off
- Mimic or mock their speech
- Assume you know what they are saying
- Be patronizing

Resources and Authorities

- Contact the member's assigned health plan for interpreting services
- Centers for Disease Control and Prevention, Disability and Heath www.cdc.gov/disabilities
- Deaf and disabled telecommunications program (DDTP)1-800-806-1191 http://ddtp.cpuc.ca.gov
- California telephone access program https://www.youtube.com/watch?v=9j3lwGUvS0c
- California relay services (CRS) http://ddtp.cpuc.ca.gov/default1.aspx?id=1482
- Title 29, The United States Code, Section 794 (section 504 of The Rehabilitation Act of 1973)
- Americans with Disabilities Act of 1990
- DHCS Facility Site Review (FSR), Physical Accessibility Review Survey (Attachment C- "29 elements")
- Department of Health Care Services (DHCS)

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Cultural Competency and Patient Engagement

2023

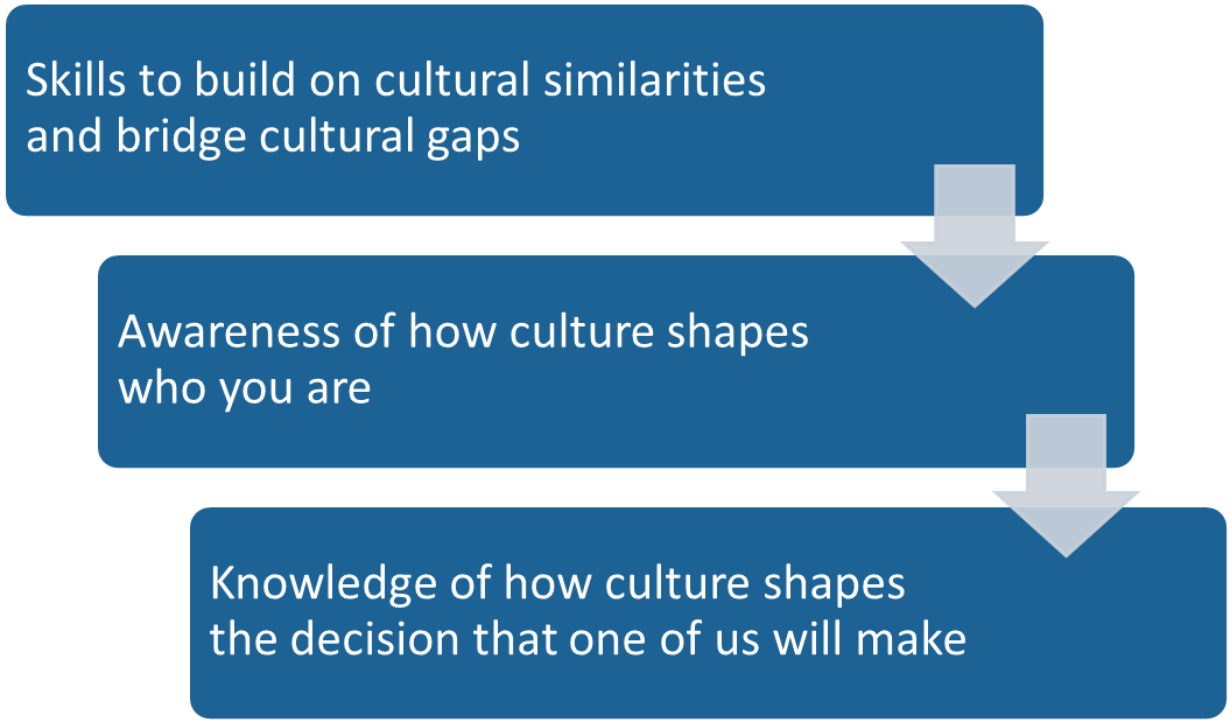
What is Culture?

- Culture refers to integrated patterns of human behavior that includes language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.
- We use it to create standards for how we act and behave socially.

- [1]Source from http://minorityhealth.hhs.gov and The Cross Cultural Health Care Program

Building Cultural engagement

Culture is not only learned but it is shared, adaptive, and is constantly changing.



Individual Culture

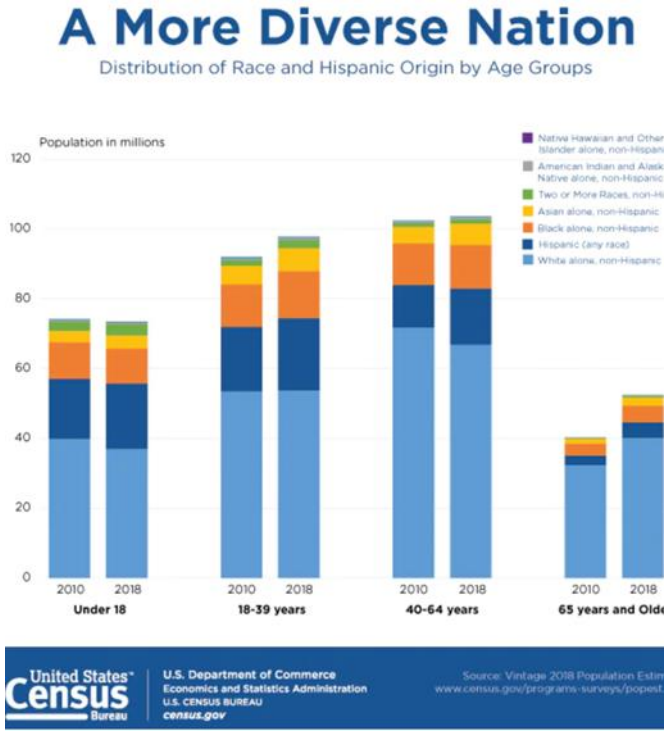
- Our view of illness and what causes it.
- Our attitudes toward doctors, dentists, and other health care providers.
- When we decide to seek our health care provider.
- Our attitudes about seniors and persons with disabilities.
- The role of caregivers in our society.
- Culture is a unique representation of the variation that exists within our society.

The Health Care encounter

- Because everyone brings their cultural background with them.
- There are many cultures at work in each health care visit.
- Our personal culture includes what we find meaningful- beliefs, values, perceptions, assumptions and explanatory framework about reality.
- These are present in every communication.

Did you know?

- 1 in 6 people living in the US are Hispanic (almost 57 million)
- By 2035, this could be nearly 1 in 4. (CDC, 2015)
- 20% of people living in the U.S. speak a language other than English at home (CIS, 2014).
- Latino population in the U.S. has grown by 43% between 2000 and 2010 (Census, 2011)
- 17% of the foreign-born population in the U.S. are classified as newly arrived (arriving in 2005 or later). (Census, 2011)



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Barriers vs. Benefits

Barriers to communication	Benefits of clear communication
•Speech patterns, accents or different languages may be used (Linguistic)	• Safety & Adherence
•Many people are getting health care coverage for the first time (Limited Experience)	• Physician & Patient
•Cultural Barriers	• Satisfaction
•Each person brings their own cultural background and frame of reference to the conversation (Cultural)	• Office Process
•Health system have specialized vocabulary and jargon (systemic Barriers)	• Saves Time & Money

Clear communication

Possible patient thoughts…

- I tell you I forgot my glasses because I am ashamed to admit I don't read very well.
- I don't know what to ask and I am hesitant to ask you.
- When I leave your office, I often don't know what I should do next.
- I'm very good at concealing my limited reading skills.

Here's what your team can do…

- Use a variety of instruction methods.
- Encourage open-ended questions
- Use Teach Back Method or "Show Me" method.
- Use symbols, color on large print direction or instructional signs.
- Create a shame free environment by helping with materials.

Clear communication cont.

Possible patient thoughts…

- I put medication into my ear instead of my mouth to treat an ear infection because the instructions said, "For Oral Use Only".
- I am confused about risk and information given in numbers like % or ratios. How do I decide what I should do?

Here's what your team can do…

- Explain how to use the medications that are being prescribed.
- Use specific, clear & plain language on prescriptions.
- Use plain language to describe risks and benefits, avoid using just numbers.

Clear communication cont.

Possible patient thoughts…

- I am more comfortable waiting to make a health care decision until I can talk with my family.
- I am sometimes more comfortable with a doctor of my same gender.
- Its important for me to have a relationship with my doctor.

Here's what your team can do…

- Confirm decision-making preferences
- Office staff should confirm preferences during scheduling

Clear communication: Limited English proficiency

Possible patient thoughts…

- My English is pretty good but at times I need an Interpreter.
- Some days it's harder for me to speak English.
- When I don’t seem to understand, talking louder in English intimidates me.
- If I look surprised, confused or upset I may have misinterpreted your nonverbal cues.

Things the provider team can do :

• Office staff should confirm language preferences during scheduling.
• Consider offering an Interpreter for every visit.
• Consider the volume and speed of the patient’s speech
• Mirror body language, position and eye contact.
• Ask the patient if they're unsure.

Language assistance services

Language assistance is available at no cost

- Interpreter support available.
- Sign language Interpreters.
- Speech to text interpretation for hearing loss in patients who do not sign.
- Member informing materials in alternative formats (i.e., large print, audio, and Braille).

Contact the health plan for assistance with language services

Use professionally trained Interpreters

Hold a brief introductory discussion with the Interpreter and …

- Introduce yourself and give a brief nature of the call/visit.
- Reassure the patient about your confidentiality practices.
- Be prepared to pace your discussion with the patient to allow time for interpretation and avoid interrupting during interpretation.

Alternate formats are required

- Under Title II of the Americans with Disabilities Act and Section504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.

- Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine, as specified.

- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language Interpreters, Tactile Interpreters, captioning and assisted listening devices.

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