2021 Dual Special Needs Plan Model of Care Evaluation
Summary of Findings

What is a Dual Special Needs Plan Model of Care?

A Dual Special Needs Plan Model of Care (D-SNP MOC) describes how we provide healthcare services to our members who have special needs. Our purpose is to provide them with access to care that is reliable, convenient, and accessible. Annually, we check the quality of the care and service we make available to these members. We set goals and follow steps and actions to correct our process if we do not meet those goals. This process is called a Corrective Action Plan (CAP).

Here are some checkpoints we used to evaluate the quality of the services we made available to our senior members who qualify as D-SNP plan members:

- Member Satisfaction Survey
- Availability and location of primary care doctors and specialists near the members' home
- Grievances (complaints) related to access to care
- Care coordination
- Transitions of care
- Health effectiveness data and information set (HEDIS) measures
- Provider and staff training

What if we do not meet our goals outlined in a Corrective Action Plan (CAP)?

We continue to evaluate and look for the best possible means of meeting our goals.

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How did we do in 2021?

1. Member Satisfaction Survey
   Our goal is to ensure members are satisfied with the care they receive from their doctors and their health plan, improving year over year.

   The satisfaction rating met our goals for Care Coordination and Health Plan Customer Service.

   We did not meet our satisfaction goals for Rating of Health Plan, Rating of Health Care, Getting Care Quickly, and Getting Needed Care.

   We know these services are important to our members. We will focus on ways to improve services and make members' experience a positive one.

   We want to be a trusted health plan and listen to what members tell us on member satisfaction surveys. This is an important way of making positive changes for our members. Our CAP is intended to foster a team solely dedicated to member experience with the goal of helping to drive our strategy for improving the member's experience.

2. Availability and Location of Primary Care Doctors and Specialists Near Members' Homes
   Our goal is to ensure members have access to primary care and specialty care doctors near their homes.

   We met our goals of ensuring that primary care doctors are located within 10 miles of 90% of our membership's homes.

   We also met our goals for ratio of specialty care doctors to members for 90% of our membership.

   If a doctor is not available in a member's area, we offer free transportation services from the member's home to the doctor.

3. Grievances (Complaints) Related to Access to Care
   Our goal is to identify whether there are patterns of complaints related to access and availability of providers.

   We met both goals in 2021 of ensuring that 98% of transportation requests are fulfilled by the transportation vendor and that fewer than 1% of complaints are related to transportation services.

   Despite having a 65% increase in D-SNP membership with only a 31% rise in grievances per 1000 members, the Access to Care goal was not met. We will continue to watch for patterns and work to improve our ways of identifying all types of complaints so that we can quickly correct them.

4. Coordination of Care

   All members are contacted for completion of a Health Risk Assessment (HRA), which is a questionnaire to identify health care needs, and an Individualized Care Plan (ICP), which is a plan of action on how to meet health care needs. Members are also invited to participate in a meeting with their care team to discuss goals and interventions for their health.

   We did not meet HRA, ICP, and care team goals. We strive to conduct outreach to 100% of members for an HRA, create an ICP, and hold a care team meeting for every member, regardless of the member's active participation. We have implemented a work plan with various strategies to support meeting goals in 2022.

5. Transitions of Care

   Our goal is to improve transition of members' care across all healthcare settings.

   We work with hospitals and skilled nursing facilities (SNFs) to make sure our health plan provides timely and efficient care for all members. We track the following measures:

   - Care manager updates member's ICP within 30 days of transition of care episodes.
   - ICP is shared with member and his or her primary care doctor within 5 business days of the update.
   - Care manager contacts member within 2 business days of discharge to home to help with transitional care needs.

   We did not meet goals for these measures. A daily report was created to track transition members and better meet timelines.

6. Health Effectiveness Data and Information Set (HEDIS®) Measures

   Our goal is to improve member health outcomes with access to preventive health services.

   Health plans use data to see how well they are doing with their care for members. We met goals for Antidepressant Medication Management, ensuring members who need an antidepressant start and stay on the medication. The goals for the following topics were not met:

   - Colorectal Cancer Screening: Ensuring members receive a colorectal cancer screening
   - Breast Cancer Screening: Ensuring members receive a breast cancer screening within the recommended timeframe
   - Medication Reconciliation Post Discharge: Ensuring members have their medications reviewed after a hospital stay
   - Diabetes Care: Ensuring members get an eye exam to check for potential damage from diabetes
   - Diabetes Care: Ensuring members get their blood sugar checked as directed by clinicians because they are diabetic

Our CAP to meet goals on these measures is intended to educate and conduct outreach to our doctors to get members the help and services they need to prevent chronic health problems. Our goal is to ensure that members stay as healthy as possible all year long.

7. Provider and Staff Training

   Our goal is to ensure all providers and staff members are trained initially and annually on the Model of Care.

   All new providers are notified of the training process and their obligation to complete the training upon acceptance to the network and then annually thereafter. New staff members are required to complete the training within 90 days of onboarding. Modes used to contact or remind providers and/or staff members of the training consist of fax and e-mail with instructions on how to access the web-based training module.

   For provider training, we did not meet our performance goal of 80% for initial training (55%) and annual training (45%). We will make operational changes to address the low compliance rates.

   For staff training, we met our performance goal of 100% for initial training and annual training. The team will continue to use its system of reminders to ensure compliance.

The above summary is an excerpt from the full evaluation. A full version of the evaluation is available upon request.

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