MOC 1 Description of the SNP-specific Target Population (General Population)

Element A

The Medicare-Medicaid Coordinated (MMC) population is comprised of a subset of fully dual eligible Medicare beneficiaries who qualify for a Managed Long Term Care Plan in New York State. The membership will consist of beneficiaries who receive both Medicare and full Medicaid and require long term care services. Members will be 18 years or older and live in the approved service area. Members must be eligible for nursing home level of care as determined by the New York State Assessment tool, which is the UAS-NY, and are capable, at the time of enrollment, of returning to or remaining in their home and community without jeopardy to their health and safety. The goal of the plan is to help nursing home eligible individuals remain living safely in their homes and community by meeting each member’s needs for coordinated care across the continuum.

Factor 1: Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.

In order to enroll in GuildNet Gold, members must have full Medicare, full Medicaid and qualify for long term care services. Upon expressing interest in enrollment and completing a scope of appoint form or call, the Plan sends a licensed marketing representative to explain the program to beneficiaries. At that time, GuildNet verifies that the member has Medicare Part A and Part B through a review of the MARx system. If a beneficiary is interested in joining the plan, a Registered Nurse visits the beneficiary in their home, hospital or nursing facility if the beneficiary is scheduled to return home. GuildNet also checks Medicaid eligibility on the NYS eligibility system, ePACES. If a beneficiary does not have Medicaid but seems to meet the requirements, the GuildNet Eligibility Team assists with the Medicaid application.

When it is confirmed that the beneficiary has or is entitled to Medicare and qualifies for Medicaid, the beneficiary receives and actively participates in a timely comprehensive assessment completed by a Registered Nurse and used by the Interdisciplinary Care Team (IDT) to develop the Plan of Care (POC). Assessment domains of the New York State approved Health Risk Assessment tool (UAS-NY) includes the following domains:

a. Social;
b. Functional;
c. Medical;
d. Behavioral;
e. Community-based or facility-based or facility-based long-term services and supports (LTSS) needs;
f. Wellness and prevention;
g. Caregiver status and capabilities; and
h. The Members’ goals.
Members must also require care management and be expected to need at least one of the following services for at least 120 days from the effective date of enrollment:

- nursing services in the home;
- therapies in the home;
- home health aide services;
- personal care services in the home; or
- adult day health care

On an ongoing basis, GuildNet monitors the TRR on a daily basis to ensure there is no change to Medicare eligibility. GuildNet also receives rosters twice a month that list members enrolled with NYS in GuildNet and indicate if a member has lost Medicaid eligibility. The NYS enrollment agent sends disenrollment reports to the plan which are entered in our electronic membership system. GuildNet tracks Medicaid recertification dates, and has a process to identify members 3 months prior to their recertification date for Medicaid and to assist them with the process.

The UAS-NY is recorded electronically and is submitted to NYSDOH. The tool includes a scoring component that determines whether the beneficiary requires the appropriate level of services to qualify for the program. Given the frailty of the GuildNet Gold population, all members have a Care Manager and an Interdisciplinary Care Team. Members are contacted minimally on a monthly basis to monitor their health status, review their POC and review the services they require.

Factor 2: Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population.

100% of the population qualifies as receiving home and community based service
100% of the population is nursing home equivalents living in the community
100% of the population is fully Dual Eligible.

NYSDOH produced reports based on the state mandated risk assessment tool. The last full report of our membership was based on the former comprehensive assessment tool, the Semi Annual Assessment of Members (SAAM). The state sends reports back to the plans that provide demographic information about the current membership.

The last analysis of the SAAM data on our members in MAP:
Average member age is 77.8 years. 34% are older than 85
71% are female
96.7% of our current membership requires caregiver assistance
47.6 % live alone.
28.1 % require assistance with ADLs
64.1% require assistance with IADLs
98.9% require psychosocial assistance
33.2% require financial assistance
53.1% have some decrease in cognitive function.
52.9% have some level of confusion
52% have some impaired decision making
13.6% have severe vision loss
86% require assistance with medication management

The current GuildNet population is very diverse, with:
42.7% English speaking
46.1% Spanish speaking
5.2% Chinese speaking and
1.4% Russian speaking

In terms of ethnicity:
16.3% are White
23.1% are Black and
49.9% are Hispanic.
10.3% are other

Since all members receive full Medicaid, all are economically disadvantaged. GuildNet has access to the NYS Medicaid data base to check on the Medicaid eligibility of members as well as checking eligibility in the MARx system. The state requires reassessment of members every 6 months so that there is confirmation of long term care status on a regular basis. In addition, the Interdisciplinary Care Team has contact with members every month and they record and track the members’ current health status.

Factor 3: Identify and describe the medical and health conditions impacting the SNP beneficiaries

Top diagnoses included from the health assessment:
Osteoarthritis 21.3%
Senility or mental disorder 9.7%
Blindness 9.7% (state average 1%)
Joint disorder 4.8%
Diabetes without complications 3.8%
Paralysis 3.2%
Acute Cerebral Vascular Disease 3.0%
Late effect CVD 2.2%
Congestive Heart Failure 2.2%
Rheumatoid Arthritis 2.2%

Overall prognosis for members is reported as:
70.6% poor
27.4% fair
2.0% good

The major reasons for hospitalization were
- Respiratory problems
- Cardiac problems
- Diabetes
• GI bleed

In addition:
• 17.5% of members fell in the last 6 months
• Over 50% showed a decrease in cognitive function.
• 16.7% were depressed
• 82% reported anxiety

In terms of cost; for 2012 and 2013, the top diagnoses were:
• Streptococcal septicemia
• Congestive heart failure, unspecified
• Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
• Closed fracture of unspecified intracapsular section of neck of femur
• Alteration of consciousness
• Unspecified respiratory abnormality
• Atherosclerosis of aorta
• Chronic kidney disease (CKD)
• Urinary tract infection, site not specified
• Generalized osteoarthrosis, unspecified site

Many members have heart disease and diabetes. There is a higher than normal percent of members who have severe visual impairment. Many members have multiple co morbidities, polypharmacy and many have a decrease in cognitive function. The vast majority require assistance to maintain living at home.

The new state assessment tool that was performed on approximately 700 members indicated individual diagnoses that do not reflect the actual number of members with that diagnosis (one member can have multiple related diagnoses). For 2014, with there were,
• 216 diagnoses of diabetes
• 247 diagnoses of elevated cholesterol
• 123 diagnoses of dementia
• 258 diagnoses of psychiatric illness
• 288 diagnoses of vision problems
• 393 diagnoses of hypertension
• 220 diagnoses of heart disease including CHF
• 301 diagnoses of various types of osteoarthritis/ostearthrosis
• 112 diagnoses of osteoporosis
Factor 4: Describe the unique characteristics of the SNP population served.

GuildNet members all have Medicare, full Medicaid and require home and community based services. The population is poor, frail and multicultural. Almost all members require some kind of assistance to remain in the community. GuildNet provides support to the members by providing personal care workers when necessary and assisting with all aspects of care. This includes assisting with appointments and transportation to get to the medical appointments. GuildNet also contracts with a pharmacy that can deliver medications to the home in blister packs to improve compliance. GuildNet works with informal care givers and families to provide a safe environment for members. The care plan is designed to encourage members to set their own goals in a culturally sensitive manner and the plan educates members and caregivers about self management options when the members or family are receptive. GuildNet is sensitive to the cognitive limitations of some of our members and works to include the member and the family in the care process as much as possible.
MOC 1 Description of the SNP Population

Element B: Subpopulation- Most Vulnerable Beneficiaries

Factor 1: Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specialty tailored services for such beneficiaries.

The GuildNet Gold population by definition is a vulnerable population requiring coordinated medical, psychosocial and long term care supports and services. GuildNet has defined its “most vulnerable population” as the following:

- Members who have 3 or more hospitalizations within a 6 month period;
- Any Member who has a hospital admission for a mental health diagnosis;
- Members in need of palliative /hospice care, confirmed by the treating MD; or
- Members newly diagnosed with a severe /profound or total vision loss.

GuildNet Gold will use a variety of methods to identify such members including claims data, hospital and other service utilization reports, pharmacy claims, provider reports, diagnostic data, and the Interdisciplinary Care Team (IDT) communication/identification

GuildNet delegates Utilization Management for Medicare services to EmblemHealth. The IDT receives a Daily Hospital Report from the EmblemHealth Utilization Management (UM) department. This report provides information on the admitting facility, admitting diagnosis and admission date, as well as the number of continued days of stay. Information in this report is entered in the GuildNet Gold electronic health record disposition screen and serves as the basis for an adhoc report that informs the IDT of any members who have been hospitalized. This report provides timely identification of members where intervention is needed to prevent further hospitalization. In addition to the above hospital report, a report from the GuildNet data warehouse from claims data confirms this information. Staff may use their Journal functionality in the electronic health record to monitor the frequency of their member’s hospitalization utilization.

GuildNet Gold members’ self-reported diagnostic data and current medications are reviewed using the health risk assessment at enrollment. The presence of a psychiatric diagnosis and/or the use psychotherapeutic medications will trigger referral by the IDT to a Mental Health Liaison (MHL) for evaluation and to assure that the Member has access to behavioral health services. These members are monitored by the IDT for hospitalization related to their psychiatric diagnosis utilizing the Daily Hospital Report described above, as well as hospital claims data received via the data warehouse. The MHL recommends and makes appropriate linkages to community mental health treatment providers with the intent to prevent further need for hospitalization.

Frequently the IDT is informed of member hospitalizations by the home care providers responsible for providing personal care services. Most often this is the earliest notification the ICDT receives because the aide is either present when hospitalization is required or they are
informed by the Member or informal caregiver to place services on hold because of the hospitalization.

The identification of members in need of hospice or palliative care will occur through several mechanisms. Identification of diagnoses and medications through the enrollment health risk assessment as well as any changes identified through the reassessment conducted every 6 months will trigger further investigation with the physician/providers as to member needs. These changes are entered into the electronic health record. In addition to the health risk assessment, the CM has contact with members at a minimum of monthly. The team is able to identify when a member is near end of life or is eligible for hospice care. The IDT is also in contact with the PCP and can identify terminally ill members during those care planning discussions. Every encounter with the Member and their providers is an opportunity to gather information about changes in the Member’s status that might warrant referral for hospice and/or palliative care. Monthly pharmacy claims data will trigger further investigation of new claims of narcotics, immunotherapy or chemotherapy agents to explore with physicians as to the Member’s medical status/prognosis. The Utilization Committee, led by the GuildNet Medical Director is also responsible for reviewing pharmacy claims and specific reports will be created through the data warehouse that highlight specific medication categories which will be shared with the IDT and will trigger further exploration of the Member’s status.

Members with diagnoses of specific vision impairments such as macular degeneration, glaucoma and cancer of the eye, will be identified through reports utilizing select ICD10 codes that will be made available to the IDT for further investigation of the individual Member’s prognosis and status related to their vision. The diagnosis reports are generated by both claims data and self reported information during every 6 month assessments as well as intermittent telephonic discussions with the Member and providers. Additionally, there are vision specific questions included in the enrollment and every six month re-assessment which explore any decline in functional status that may be attributed to changes in vision. CMs will also be alerted if there are requests for vision related services or DME. Additionally, the IDT will monitor incidents and falls data as a potential source of information regarding member’s vision status. All falls/injuries are expected to be reported to the CM by home health providers and are logged in the GuildNet computer system which generates a monthly report that is reviewed by the Quality Assurance Performance Improvement (QAPI) department. The QAPI department monitors the falls with major injury report for members with repeat falls and notifies the CM/IDT of the member. The IDT will initiate the falls protocol which includes an investigation as to the potential cause(s) of the repeat falls. In some instances this investigation will identify the need for further evaluation of the Member’s vision status.

**Factor 2 & 3 Correlation between demographic characteristics and clinical requirements**

All GuildNet Gold members are assessed at time of enrollment and at 6 month intervals using the NYS assessment tool (UAS-NY) which is electronically recorded and available to the plan via a secure website. The UAS-NY content forms the basis for the development of the Care Plan and helps identify the most vulnerable among the membership.
To address special needs, the GuildNet Gold IDT:

- Reviews the results of the UAS-NY once scanned or uploaded into the GuildNet Gold electronic health record. The CM will review the UAS-NY for accuracy, comprehensiveness and to determine Member needs. Triggers within the GuildNet electronic health record notifies the CM and the CM supervisor of a received UAS-NY. The CM reviews the assessment for accuracy no later than 10 days from receipt.
- Develops an individualized Plan of Care to address the member’s identified needs.

Information about services available for GuildNet Gold’s most vulnerable population and how to obtain those services will be shared with members and providers via the plan’s website, newsletters and care coordination activities.

In addition to the standard Medicaid and Medicare covered benefits offered by GuildNet Gold, the most vulnerable members as defined by GuildNet Gold will be in need of additional services.

The entire GuildNet population is frail and economically disadvantaged. Most of the population requires home and community based services to stay in the community. There is a high level of health illiteracy compounded by confusion and memory loss. The level of education of the membership is low and the population is multicultural which can include culturally specific interpretations of health care diagnoses and treatment. All of these factors can compound the challenges facing those members who are most vulnerable.

The following describe the special services developed for GuildNet Gold’s most vulnerable population:

**Disease management** interventions for people who have been hospitalized 3 or more times with select cardiovascular, cardiopulmonary diseases and those with a new and profound vision loss will be implemented with the intent of improving member self management and thereby reducing ER visits and unplanned hospitalizations. This may include additional support post hospitalization to ensure the member and the situation are stabilized. Other disease management programs available include a Diabetes Disease Management Team (DDMT).

**Avanti Pharmacy Home Delivery and Management**- This home delivery program provides pre-poured medications along with a pharmacist conducting medication reconciliation and oversight and education through Avanti pharmacy services. The use of this value-added service is encouraged for members who have readmissions to hospitals and/or frequent Emergency Room visits with the expectation that the added attention of the pharmacist oversight will lead to early identification of medication non-adherence or ineffectiveness and thereby potentially reduce unnecessary admissions.

**Mental Health Liaison (MHL)**–This position is filled with Social Workers who have an expertise in assessment for behavioral health needs. These positions may be ad hoc members of
the IDT and are clinically supervised by licensed social workers and therapists from the Mental Health division Lighthouse Guild. The MH Liaisons will conduct basic behavioral health screening tests upon request of the IDT and for members with a history of mental illness and/or substance abuse. Test results will inform the Plan of Care and help facilitate referrals to Beacon Health Options (delegated for behavioral health network and UM).

**Palliative care team/consultants**- GuildNet has a specialty palliative care case management team that employs a certified palliative care nurse as well as a Masters prepared social worker with palliative care experience. This team will provide care management of members in need of palliative care or consultation to the IDT as appropriate for members at the end of life. Consultation may take the form of recommendations for physicians with expertise in palliative/pain medicine, hospice or palliative care providers in the community and/or skilled nursing facilities with palliative care capacity.

**Vision rehabilitation** is a service offered by Lighthouse Guild, the parent company of GuildNet Gold. This service provides evaluation and training for individuals who are legally blind or experiencing new vision loss. The goal of vision rehabilitation services is to assist the individual in maximizing their usable vision and maintaining independence to the extent possible. The vision rehabilitation clinicians will be available to consult with the IDT in how best to meet the needs of the member with newly diagnosed and profound vision loss. If the member is diagnosed as legally blind they may qualify for rehabilitation services through the New York State Commission for the Blind and Visually Handicapped (CBVH). Additionally, the Vision Rehabilitation department is available to assist with the identification of adaptive equipment that will assist the visually impaired Member with activities of daily living which will then be authorized by the IDT as appropriate.

**Certified Occupational Therapy Assistants (COTAs):** GuildNet employs Certified Occupational Therapy Assistants (COTAs) who are responsible for making home visits to assess the environment for safety and adaptive equipment needs related to vision impairment.

**Recreational therapist**- GuildNet employs a certified recreational therapist as a Case Aide who conducts telephonic assessments of GuildNet Gold members at the request of the IDT. The recreational therapist is knowledgeable about community resources that may be beneficial to plan members. This add on service is especially valuable for members who may be experiencing social isolation or depression due to vision impairment or mental illness.

**Factor 4 Establishing Relationships with Community Partners**

GuildNet Gold has established relationships with the EmblemHealth provider network to ensure that high quality services are available to its’ most vulnerable members. The IDT reaches out to the members’ providers both in the medical and social service communities to inform them of the benefits available through the plan and to collaborate to make the appropriate linkages to community based supports. Often these community providers have knowledge of the members’ cultural, language, and spiritual preferences, as well as the ability to meet the need for special accommodations related to functional, mental, and learning disabilities.
Using both the EmblemHealth and GuildNet provider directories, the IDT provides information and linkage to providers identified as ADA compliant for members with special needs that require reasonable accommodations. Linkages to peer advocates in the disability community are also made to assist members and their significant others to understand and access community resources that can help them maximize their independence and reach their goals.

The GuildNet Social Work staff maintains a directory of community agencies in the service area and has relationships with agencies or programs that provide non-covered services. The Social Work staff can assist in identification of and referrals to community partners who can provide additional services to our members such as home visitation or peer support for vision loss. All services are entered into the Plan of Care and are followed by the IDT.
**MOC 2: Care Coordination**

GuildNet Gold (GNG) care coordination helps ensure that SNP beneficiaries’ health care needs, preferences for health services and information sharing across providers and facilities are met over time. Care coordination maximizes the use of effective, efficient, safe, high quality care and services including services furnished outside the provider network, that ultimately lead to improved health outcomes.

Please See Attachment A for the Table of Organization

**Element A: SNP Staff Structure**

**Factor 1: Administrative Staff Roles and Responsibilities, including oversight functions for personnel that directly or indirectly affect the care coordination of SNP beneficiaries.**

**Enrollment and Eligibility**

**Marketing**

*Licensed Marketing Representatives* visit beneficiaries who express an interest in joining GuildNet Gold. After a signed Scope of Appointment is received or recorded, the Marketing Representatives visit the beneficiary to explain the program and verify Medicare and Medicaid beneficiary numbers. After the Intake Nurse Manager determines that the beneficiary qualifies for the program and obtains the Medicaid application, the Marketing Representative visits the beneficiary again to review the program and get a signed Medicare application.

**Intake**

*Intake Nurse Manager* conducts an assessment in the beneficiary’s home or skilled nursing facility, if the beneficiary is about to return to the community, using the state mandated health risk assessment tool (UAS-NY). This assessment determines the member’s clinical eligibility for the program (nursing home level of care) and determines whether the beneficiary will need home and community based services for the next 120 days.

*Intake Member Service Representatives* (MSRs) check the beneficiaries’ eligibility on ePACES, the NYS Medicaid eligibility system. When the Medicaid eligibility is confirmed and the Medicaid application is signed, the MSR submits the application to NYS through Maximus.

**Medicare Enrollment Submission – delegated to Emblem Health**

*Enrollment Representatives* submit batch enquiries to CMS to confirm eligibility for Medicare and submit the enrollment file to CMS through Infocrossing. The TRRs are received and processed through the Emblem Health enrollment system and required letters are generated.
Reconciliation

**Medicare Enrollment Coordinator** reconciles the files from NYS Maximus and CMS and works with the state and CMS to resolve any discrepancies in the enrollment files to ensure that members are appropriately enrolled in both programs. GuildNet receives Daily TRRs and twice monthly rosters of enrolled members from NYS which is also reconciled against Medicare membership.

Claims Processing

GuildNet Gold pays for Medicare, Medicaid and home and community based services.

**Delegated:** EmblemHealth processes Medicare claims for GuildNet Gold. Emblem accepts paper and electronic claims in HIPAA compliant formats. The Claims department checks for member eligibility at the time of the service, whether the service is covered and whether appropriate authorizations are in place. EmblemHealth follows all regulatory requirements when processing claims and follows prompt pay regulations. Emblem issues approved denial letters for services that do not meet the criteria for payment. GuildNet receives reports of all paid and denied claims through a secure file transfer protocol (FTP) site.

EmblemHealth contracts with Express Scripts, a pharmacy benefits manager (PBM) which pays all pharmacy claims. Claims reports and PDE data are sent to GuildNet for evaluation.

EmblemHealth employs approximately 145 staff in the claims department which processes claims for all Emblem lines of business, including GuildNet. Job titles include: Emblem Manager ASO Billing and Reporting, Emblem Manager Claims, Emblem Sr. Approver, Medical Claims, Emblem Director Claim Operations: Hospital, Dental and Employee Claims, Emblem Senior Director, Claims Processing, Emblem Director, Medical Claims, Emblem Director, and Claims Reporting and Data Analytics.

**Delegated:** RelayHealth processes claims for Medicaid services including home and community based services. RelayHealth was created by McKesson Corporation in 2006 and provides a HIPAA-compliant gateway and a flexible platform for managing claims transactions. It supports all claim data formats, provides claims editing and validation, Web reporting, and real-time eligibility and claims status hosting. The system processes and cleans electronic medical claims more efficiently, streamlines transaction management for tighter edits, reduces medical claim denials, reduces phone calls and confirming data, and expedites payments for providers and hospitals.

Based on authorization for Medicaid claims, RelayHealth processes payments and denials for Medicaid services. They also provide providers information regarding member eligibility and claim status. They are capable of generating multiple financial reports for GuildNet Gold. RelayHealth designates appropriate staff members who are available to service GuildNet Gold Medicaid claims.
Coordination of Benefits (delegated to Emblem Health)

The Medicare application includes a question about other types of insurance, and if the question is answered affirmatively, the information verified and is entered into the membership system. A letter is sent to these members to confirm that the other form of insurance is active and to get information about the other insurer. MSP information is sent to GuildNet on an MSP report. The information is stored in the claims system. The COB department also evaluates CMS reports of other insurance and follows up with members to confirm the insurance.

Benefits are also coordinated for Part D benefits. Information and change in status is communicated to CMS through the ECRS system.

GuildNet has access to the NYS Medicaid system (EPACES) that also indicates other forms of health insurance.

There are approximately 11 staff members at Emblem who are responsible for COB for all lines of business.

- Emblem Supervisor, COB
- Emblem Manager COB CWF
- Emblem COB Analyst

Administrative Oversight

Administrative Oversight is the responsibility of senior staff. Delegated entities monitor staff performance on a daily basis. GNG staff examines the performance on internal and external measures to insure regulatory compliance and high quality care. Enrollment and eligibility verification is determined and processed by Intake department staff. Claims processing is managed by Provider Relations department. Administrative oversight of all operations is clearly delineated among the management staff. A Delegated Oversight Committee has a formal process to monitor the performance of all delegated entities.

President – GuildNet Gold

- Responsible to oversee all GNG planning, development and operations
- Responsible for compliance with Federal and State contracts
- Responsible to monitor, analyze and evaluate staffing and budgeting to assure appropriate health care services are delivered to members

Chief Operations Officer – GuildNet

- Responsible for ensuring appropriate utilization of program resources to GuildNet members while assuring the highest quality standards;
- Accountable for successful and timely execution of activities to achieve efficient functioning of all departments toward goal achievement;
- Responsible for strategic planning and new program development;
- Creates models of performance excellence by identifying best practices, effective measurement systems and improving health services and operations;
Initiates and participates in other program activities as indicated in promoting program growth and stability
Ensures compliance of all service departments with regulatory and programmatic standards and requirements;

**VP of Business Development**
**Director, Provider Relations**

- Oversees the credentialing process for all new providers in the Medicaid network
- Collects credentialing information for all new Medicaid providers in the network.
- Reviews access and availability information
- Checks federal and state data bases to ensure providers are qualified for and participate in government programs.
- Coordinates recredentialing of providers on a regular basis
- Keep records of provider specific complaints and grievances and consider them while recredentialing.
- Negotiates new Medicaid network provider contracts
- Liaison with RelayHealth, vendor for authorization/claims payment system
- Leads the Delegated Oversight Committee which monitors the performance of all delegated entities.

**Provider Relations Department – EmblemHealth (delegated entity)**

**Director, Credentialing**

- Oversees the credentialing process for all new providers in the network
- Collects credentialing information for all new providers in the network.
- Reviews access and availability information
- Checks federal and state data bases to ensure providers are qualified for and participate in government programs.
- Coordinates recredentialing of providers on a regular basis
- Keep records of provider specific complaints and grievances and consider them while recredentialing.

**Senior Director, Provider Network Management**

- Oversees operation of Provider Network for all types of providers
- Leads provider satisfaction and reimbursement committees
- Assures network compliance with all regulatory agencies and accreditation agencies
- Oversees provider communication

**Vice President Hospital and Contract Management**

- Oversees quality outcomes at facilities
- Assures adequate consumer access to facilities

**Vice President Network Development**

- Coordinate all activities relating to plan service for the EmblemHealth Provider community
Medicare Services – GuildNet

Assistant Vice President, Medicare Services
- Reviews Enrollment reports for timeliness and accuracy of enrollment submissions
- Reviews member services reports of answering times, hold times and abandoned calls for internal and delegated entities
- Monitors accuracy of information given on the Member Services line
- Reviews utilization data for medical and pharmacy claims
- Liaison to NYS and Federal regulatory agencies
- Manages oversight process for delegated entities
- Oversees and monitors regulatory compliance related to Medicare plans

Quality Department - GuildNet

Senior Vice President, Quality Assurance Performance Improvement (QAPI) oversees all quality programs for all programs at GuildNet, is responsible for strategic planning and new program development, assures compliance with all regulatory requirements, develops and oversees targeted studies related to QAPI activities and analyzes quality and operational key indicators and trends as well as the effectiveness of the Models of Care. Responsible for the Staff Development and the Reassessment departments.

Director, Quality Assurance Performance Improvement (QAPI) oversees the direction of QAPI activities, develops and implements studies such as the Chronic Care Improvement Program (CCIP) the Quality Improvement Program (QIP) and state required studies, oversees and manages the appeals and grievance processes, aggregates and analyzes data from internal audits, satisfaction surveys, grievances and appeals, reviews care delivery, member satisfaction and provider satisfaction to evaluate the quality of care delivered, coordinates evaluation of the Model of Care and develops and implements member health initiatives

Compliance

Chief Compliance Officer – Lighthouse Guild establishes and implements an effective compliance program for the Lighthouse Guild and its subsidiaries, acts as HIPAA compliance officer oversees ongoing activities related to the development, implementation, maintenance of and adherence to policies and procedures federal and state privacy practices and reviews instances of possible Fraud, Waste and Abuse

Assistant Director of Program Integrity – GuildNet reviews all plan material prior to submitting them to CMS to insure regulatory compliance, reviews all CMS and NYS DOH memos that affect plan regulations, administers compliance plan and audits,
reviews data for Fraud, Waste and Abuse and reviews appeals and grievances for regulatory compliance

**Factor 2: Clinical Staff Roles and Responsibilities including oversight functions.**

GuildNet Gold (GNG) utilizes employed staff who perform clinical functions including coordination of care, provision of clinical care, education and care management. Employed staff perform key care management and clinical functions. Some supplemental functions may be performed by contracted network providers such as certified home health agencies which may conduct interim assessments on behalf of the Interdisciplinary Care Team (IDT). Clinical management of the GN Gold member begins at the time of the enrollment assessment visit.

**Direct beneficiary care and education on self management techniques**

**RN Care Managers** (RNCMs) evaluate members in person and perform comprehensive health assessments... Intake RNCMs do initial evaluations and create initial care plans. Reassessment RNCMs conduct semi-annual assessments and interim assessment if there is a significant change in condition. Assessments are done in the member’s home, hospital or SNF if the discharge is planned.

RNCMs provide member education on self management techniques includes disease/medication management and health and wellness issues, such as flu prevention or home safety. Educational programs are developed using evidence based medicine and member specific education is based on the individual’s disease, co-morbidities and psycho-social factors. Educational goals are part of the Plan of Care (POC).

**SW Care Managers** (SWCMs) and **Mental Health Liaisons** (MHLs) provide education and assistance with behavioral health issues and social issues. SWCMs also assist members in accessing community based services to increase self management.

**Member Service Representatives** (MSRs) assist the Interdisciplinary Care Team (IDT). They are non-clinical staff members who assist with educational campaigns based on a population focused approach. When education efforts are conducted by an MSR, such as reminders about flu vaccines, it is under the guidance of an RN.

**Care Coordination**

**RN or SW Care Managers** are the primary Care Manager responsible for care coordination within the IDT and with external providers. This is accomplished by reviewing all provider reports, reassessment documentation and sharing information as necessary with other core IDT members. The Care Manager creates the initial Plan of Care (POC) and has the responsibility of sharing the POC with other IDT members. The CM also updates the POC after regular assessments and if there is a significant change in condition. Additionally, the primary Care Manager is responsible for assuring that appropriate documentation is complete and timely and is shared appropriately with other team members and appropriate providers.
**Pharmacy Consultation**

EmblemHealth has a contract with Express Scripts (ESI) who contract with an extensive network that meets all regulatory requirements. The pharmacy network offers many options to GuildNet members. The retail network consists of chain and independent pharmacies in the service area as well as pharmacies throughout the country. Pharmacies are located in areas accessible to the GuildNet Gold membership. There is also a mail order pharmacy option and a contracted pharmacy (Avanti) that will deliver medication packaged in daily doses to members’ homes if they so choose or if it is necessary to help assure proper medication adherence. Pharmacists review medications for all members qualifying for the medication therapy management program (MTMP).

**Pharmacists** are employed by ESI and by EmblemHealth in their Pharmacy department. EmblemHealth pharmacists run the MTMP program. GuildNet also contract with a pharmacist on a consulting basis to provide medication reviews on an individual and a plan-wide basis.

**Behavioral Health Counseling**

**Mental Health Liaisons (MHSs)** are employed by GuildNet to assist with mental health assessments and referrals to appropriate member health providers. MHLs are utilized during the initial assessments to evaluate behavioral health issues, they are used on reassessments when there is a known behavioral health issues, and they can assist the IDT when new issues arise.

GuildNet utilizes Beacon Health Options as our behavioral health vendor. Beacon Health Options has contracts with behavioral health and mental health specialists, clinical psychologists, drug and alcohol counselors. When members have significant behavioral health issues, these staff members are included in the IDT team.

**Clinical Oversight- license and competency verification**

Manager of Human Resources
- Verifies credentials prior to hiring staff including education and licensure
- Verifies that staff is not on the NYS or Federal exclusion lists for not participating in government programs.
- Checks references on potential employees
- Maintains updated files on licensure and required recertifications.
- Monthly checks of excluded provider list against staff

**Competency verification that relates to the population being served.**

All employees serving GuildNet Gold members participate in a formal orientation program conducted by the Staff Development Department. Orientation content is based on the staff role within the Medicare program line. The basic orientation for all assigned staff may be supplemented with additional training and/or provision of relevant clinical references and materials to support care management for beneficiaries with particular needs. The Staff Development Manager or designee is responsible for tracking all training and assuring that staff has completed appropriate training modules as well as communicating compliance status to the
respective department heads. Training modules cover program specific information including the IDT and the Plan of Care, but also includes clinical modules that address elements of aging as well as specific diseases that are common in the population. Modules are followed by a test to ensure that the staff is exhibits competency in the areas that were taught.

The purpose of training is to ensure that staff receive a strong foundation for care management and support of the member in the GuildNet Gold Plan.

Clinical Practice Oversight

**Care Management Supervisors** review a sampling of member records every month using a tool that checks elements for timely information exchange, contact with PCPs and families, medications reconciliation and follow up after transitions of care.

**Quality Specialists** perform routine audits reviewing charts for completeness and timeliness as well as reviewing adherence to transition of care protocols.

Utilization Management

**Medical Director - GuildNet**
- Reviews requests for Medicaid services to ensure those that do not meet standard criteria are medically necessary and appropriate.
- Reviews care to determine if it is consistent with evidence-based clinical practice guidelines or there are documented reasons why the guidelines might not apply in specific cases.
- Reviews complaints about quality of medical care.
- Reviews utilization data and looks for patterns of under and over utilization.
- Reviews pharmacy claims and utilization data for appropriateness.
- Represents GuildNet on EmblemHealth Health Status Improvement Committee.

**Medical Director - EmblemHealth**
- Reviews requests for Medicare service to ensure those that do not meet standard medical criteria are medically necessary and appropriate although they do not meet the standard criteria. For example, there may be extenuating family circumstances that require an outpatient procedure to be performed in an inpatient setting.
- Reviews complaints about quality of medical care.
- Reviews utilization data and looks for patterns of under and over utilization.
- Reviews pharmacy claims and utilization data for appropriateness.
- Reviews care to determine if it is consistent with evidence-based clinical practice guidelines or there are documented reasons why the guidelines might not apply in specific cases.
- Contacts providers to discuss utilization issues and/or evidence-based clinical practice issues.
- Reviews denials of service request and determines if medically appropriate or if the service should be denied.
- Oversees process of coordinating Medicare and Medicaid benefits.
Gives final decision for credentialing and recredentialing of providers and Chairs the Credentialing committee.

Utilization Management Medicare Services– EmblemHealth
GuildNet has a contract with EmblemHealth to provide utilization management and claims payment for Medicare services. There is constant communication between the GuildNet Care Management team and the EmblemHealth Utilization Management team. Nurses evaluate selected services to see if they meet standard medical necessity criteria and they are offered in the least restrictive environment possible. Utilization Management (UM) staff RNs are responsible for traditional medical management functions including, but not limited to:

- Reviewing and acting on requests for services that require prior authorization, including facilitating the fulfillment of documentation requirements to act on such requests. For example, UM staff gets the clinical information to support skilled nursing services and monitors progress toward home care goals;
- Tracking members who are admitted to the inpatient hospital setting and requesting regular clinical updates;
- Assisting in hospital discharge planning including coordinating post discharge care plan; and
- Providing expertise on covered benefits and coordinating care across settings (e.g. inpatient setting or skilled nursing facility)

Director, Clinical Review directs administrative and operational functions related to the interdisciplinary, retrospective review of clinical records, ensures reviews meet regulatory and departmental timeframes and analyzes trends and prepare corrective actions if required.

Senior Director, Utilization Management Services oversees operations of pre-certification, concurrent and discharge planning reviews, monitors clinical effectiveness of UM functions and assures processes meet regulatory standards

Vice President, Clinical Utilization provides oversight for the Utilization Management function, analyzes data and information in the department, and oversees medical appropriateness decisions through retrospective reviews

Director, Clinical Pharmacy Program directs the administrative and operations functions related to the provision of clinical pharmacy services, plan and conducts education programs related to disease states, coordinates the Pharmacy and Therapeutics committee and conducts research to maintain the drug formulary

Senior Data Analyst - GuildNet
- Analyzes utilization data based on claims for medical, long term care and pharmacy services.
- Analyzes specific indicators for use of evidence-based guidelines.
- Reports to the Utilization Committee, which includes the Medical Director, COO, Vice President of Care Management, AVP for Medicare Services which, reviews reports on claims and encounter data.

**Factor 3: Coordination of responsibilities and job title**

GuildNet operates a Dual SNP that is a Medicaid Advantage Plus Plan. The benefit plan includes Medicare, Medicaid and the long term care services that are offered in a Managed Long Term Care plan (MLTC). GuildNet only offers Special Needs Plans and all job positions and titles have been developed specifically for the SNP. GuildNet also has an MLTC plan that does not cover Medicare services. Many of the job titles and responsibilities for the Medicaid portion of the plan mirror those in place for the MLTC.

**Vice President of Care Management** develops implements and oversees strategic and operational processes for clinical operations, oversees provision of quality care management/clinical services and ensures adequate staffing and system support to provide optimal member services.

**Assistant Vice President, Care Management** ensures optimal operational efficiency of the care management department, monitors trends in utilization and optimal quality of services and implements corrective action as warranted and ensures regulatory compliance. Ensures adherence to clinical practice guidelines and transitions protocols. Documents outcome of compliance reviews for key indicators including, but not limited to continuity of care and care transitions.

**Director, Care Management Services** directs care management teams and oversees the clinical operations of the IDT’s, assures compliance of care management staff with GuildNet policies, protocols, regulatory requirements and clinical standards of practice and ensures appropriate utilization and quality of service to members.

**Intake**

**Intake Nurse Manager** conducts an assessment in the potential member’s home or skilled nursing facility, if appropriate, using the state mandated health risk assessment tool (UAS-NY). This assessment determines the member’s clinical eligibility for the program (nursing home level of care) and is the foundation for the development of the preliminary care plan, taking into account the members’ medical, functional and psychosocial needs as well as their (and/or their informal caregivers’) goals into the development of this care plan. The Intake Nurse is responsible for developing the preliminary care plan based on the assessment.

**Intake Supervisor** is responsible for review of the assessment/documentation obtained by the Intake Nurse. This position is also responsible to assure compliance with standards of practice, GNG policy and regulatory requirements as it relates to the Intake process. The Intake Supervisor directs intake staff in the development of the preliminary care plan.
Transition Team

The transition team is responsible for effectuating the transition of the applicant into an enrolled member and implementing the services of the preliminary care plan that are required on day one of enrollment and before the IDT can complete their multidisciplinary assessments. The transition team also participates in resolving issues that may be newly identified between the time of assessment and enrollment. The transition team is composed of a Care Manager Supervisor, Nurse Care Manager, Social Worker and Member Service Representative.

**Transition Team Supervisor** manages the review of all new enrollees assuring appropriate services, CM assignment and smooth transition that reflects cultural sensitivity and reasonable accommodation of enrollee needs.

**Nurse Care Manager** assigned to the Transition Team is primarily responsible for review of each new member’s health risk assessment and implementation and coordination of the preliminary care plan services.

**Social Worker** assigned to the Transition Team is primarily responsible for coordinating discharges for members in hospitals /nursing facilities at the time of enrollment who will be returning to community.

**Member Services Representative** assigned to the Transition Team is primarily responsible for processing authorizations for required services.

Care Management/Interdisciplinary Care Team

Once enrolled, the coordination of care management activities is the responsibility of the Interdisciplinary Care Team (IDT) which is led by a primary Care Manager who is assigned to each member. The determination of the primary Care Manager is dependent on the dominant needs of the Member and may either be a Social Work CM or RN CM. This determination is made by the Transition Team Supervisor and/or the Care Management Supervisor, however all members have access to a Nurse Care Manager for clinical issues. The primary Care Manager is responsible for the creation and maintenance of the POC with the IDT and care coordination within the IDT and with external providers. This is accomplished by reviewing all provider reports, reassessment documentation and sharing information as necessary with other core IDT members. Additionally the primary Care Manager is responsible for assuring that appropriate documentation is complete and timely and is shared appropriately with other team members and appropriate providers. Member education on self management techniques includes disease/medication management and health and wellness issues, such as flu prevention or home safety is also the responsibility of the IDT and often is the responsibility of the RNCM on the team even if not the primary CM.

The core clinical members of the IDT in addition to the member and desired informal caregivers for all members include the CM, Social Worker as needed, and Primary Care Physician. Additional clinical members of the IDT may include, depending on member’s needs/goals, the following: case aides, mental health liaisons and/or mental health providers, medical specialists,
palliative care consultants, certified diabetic educators, rehabilitation professionals, GuildNet Medical Director or physician reviewers. Roles are described below:

**Nurse Care Manager** is responsible for directing the Interdisciplinary Care Team for the purpose of planning, coordinating and authorizing care and developing and maintaining the POC. The Nurse Care Manager performs on going assessments of member health and creates a plan of care with the IDT. The CM evaluates progress towards goals and timeliness and the quality of care the member receives. The CM ensures communication between IDT members and educates the member or caregiver on self management techniques.

**Care Manager Supervisor:** Responsible for clinical oversight of care management activities for dedicated Nurse Care Managers and the IDT assuring high quality care and optimum outcomes. Performs regular review of records to make sure services are received timely.

**Social Worker:** Provides comprehensive psychosocial assessment to supplement the nursing/medical assessments that guide the development of the care plan. Assesses and identifies the clinical, psychosocial and financial needs of the patient/family/caregivers and establishes mutually agreed upon goals. Discusses and develops a comprehensive Plan of Care in collaboration with other members of the IDT

**Social Work Supervisor** is responsible for the performance of the Social Work Care Managers, the recreational therapy staff and the general Social Workers. She evaluates the effectiveness of the social work services in terms of quality and ensures complete record documentation.

**Mental Health Liaison** is a social worker with a minimum of a Bachelor’s degree with demonstrated experience in behavioral health assessment and entitlements processing. This position is a possible addition to the IDT when the member has history of or is newly diagnosed with a mental illness.

**Member Services Representative** is a non-clinical staff member who provides to support to the IDT by assisting members to access services as needed in conjunction with the Care Plan. Responds to telephone inquiries and participates in the resolution of complaints. May contact members to remind them of preventive health services

**Palliative Care Nurse Specialist** is a GuildNet NCM with expertise in palliative care and end of life issues, who is available to offer assessment, consultation, and coordination to the IDT in meeting member’s symptom and support needs when faced with advanced disease.

**Palliative Care Social Worker** offers assessment, consultation and coordination to the IDT. She develops maintains and updates a community-based resource network of palliative care providers.
Coordinator Diabetes Disease Management Team supervises the diabetes disease management team including nutritionists and certified diabetic educators. The team provides assessment and teaching to plan members and evaluates the effectiveness of service delivery.

Certified Diabetic Educators/ Nutritionists provide individualized and group nutrition assessments, planning and counseling for diabetic management. They work with CMs as part of the IDT when they are providing services.

Case Aide identifies, coordinates, and evaluates needed health care services for assigned members. She initiate and monitors service authorizations to indicated vendors and providers in and out of network. The Case Aide, a member of the IDT, works under the direction of an RN Care Manager, or Nurse Care Manager Supervisor or Social Work Supervisor.

Certified Occupational Therapy Assistant (COTA) provides an array of services to visually impaired members and makes recommendations and referrals for rehabilitation services to assist blind and visually impaired members remain safe and independent in their homes.

Medical Director/Physician Reviewers are responsible for determinations of medical necessity. Additionally the Medical Director is responsible for oversight of the QAPI committee and to assure compliance with evidence based guidelines and standards of practice.

Primary Care Physicians (PCPs) are responsible for ensuring that the member’s needs are met in the most life-enhancing, least intensive setting possible, seeing the patient at appropriate time intervals and providing or ordering services as needed, working with GuildNet Gold and EmblemHealth to obtain authorization for services, reviewing and authorizing the Care Plan, and communicating changes to the Care Plan or home care orders as a result of members’ changing health care needs.

Other Medical Specialties such as endocrinologists, nephrologists, orthopedists or psychiatrists could be considered part of the IDT when involved in the member’s care. Other disciplines such as the vision or physical therapist are also likely participants in the clinical management of the member given GuildNet Gold target population.

Reassessment Process:

GuildNet Gold employs reassessment RN’s to conduct a state mandated health risk assessment (UAS-NY) every 6 months. Contracted RN’s from Certified Home Health Agencies may also provide assessments during episodes of skilled nursing care. Interim assessments may be conducted for significant changes in condition or at the request of the IDT.

Reassessment Nurse conducts in home/facility assessments utilizing the NYS mandated tool (UAS-NY). They collaborate with the CM/IDT to assure an accurate assessment is
obtained and that all issues requiring immediate follow up are addressed by the IDT prior to receiving formal assessment.

**Senior Reassessment Specialist and Reassessment Specialist** are responsible for supervision and oversight of all reassessment activity and accuracy and analysis of assessment data.

**Data Entry Supervisor** is responsible for ensuring that reassessments are scheduled and submitted in a timely manner.

**Factor 4: Describe Contingency Plans used to address ongoing continuity of critical staff functions.**

An established plan for daily coverage of absent members of the care management staff is part of daily operations. Directors and Care Management Supervisors are responsible for ensuring close oversight of daily coverage assignments. Directors are expected to provide guidance to Supervisors regarding adherence to the protocol. Through this process we seek to establish an equitable rotation for daily coverage assignments; ensure accurate documentation of available staff and coverage assignments each day and promote accountability for meeting the needs of members when primary Care Managers are absent. The staff is organized into teams which report into a Supervisor. Team members cover for each other. Each Director covers a number of Supervisors and can pull from that group for coverage. The electronic health record allows a staff member’s “to-do” list to be transferred to another staff member to ensure all the tasks are covered. In case of an emergency where staff cannot get into the office, some staff members have the ability to work from home. Staff working from home, with full computer access, can address time sensitive issues without a break in continuity.

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

All employees assigned to GuildNet Gold will participate in a formal orientation program conducted by the Staff Development Department. Assigned staff will participate in a formal orientation program with the content based on their role within the Medicare program line. The basic orientation for all assigned staff will include a module on the Overview of the GuildNet Gold Plan. Additionally, they will receive an annual training session on updates to the Plan at the team meeting level. The Staff Development Manager or designee is responsible for tracking all training and assuring that staff has completed appropriate training modules as well as communicating compliance status to the respective department heads.

The purpose of training is to provide instruction and guidance; understanding of the organization’s values and culture, and; to ensure that staff receive a strong foundation for participation in case management or support of the member in the GuildNet Gold Plan. Integral to the orientation is training on the established Model of Care (MOC) and the goals of the MOC.

Intensive training on the GuildNet Gold MOC is provided to staff members of: Administration, Care Management, Staff Development, Quality Assurance and Performance Improvement
Staff will be trained on the MOC in-person face-to-face for the initial training, before managing GNG cases. Thereafter, the annual MOC training is completed by a self learning module. All MOC training is developed by GuildNet’s Staff Development Department which reports to the Senior Vice President (SVP) of QAPI. This training will occur upon orientation to the GNG program and staff will be required to take a post-test to demonstrate their understanding of each module. The MOC training describes the regulatory requirements, the role of the Care Manager (CM) who is a Nurse Care Manager (NCM) or Social Work Care Manager (SWCM); the Interdisciplinary Care Team (IDT); use of the health risk assessment tool (HRA); and the model’s current goals and measurements. Sign-in sheets and the results of testing will be tracked and kept on file by Staff Development for the initial training. For annual self learning, a web-based self learning program is utilized and staff compliance is tracked in an automated data base. If training is not completed by a staff member or if test results indicate a lack of understanding, Staff Development will notify the staff member’s supervisor who works with Staff Development to ensure training is completed. Staff will not be assigned cases for the GuildNet Gold plan until their training has been satisfactorily completed. Reports on the status of training will be made to the Compliance Committee by the SVP of QAPI. Updates to the MOC are shared via email and posted on the web site.

The following modules will constitute the basic components of orientation: Beneficiary Protections, GuildNet Gold Care Management, MOC, Scripts and Benefit Grid Training, Enrollment and Disenrollment Training, and Annual Updates. Administration, Care Management, Staff Development, QAPI, Medicare Services, Provider Relations, Mental Health Liaisons, and Consultants will be required to attend the basic orientation. The Annual Program Update and MOC modules will be mandatory training for all required staff. The MOC training module is developed to incorporate all of the required eleven elements, both clinical and non-clinical elements of the MOC for the GuildNet Gold Plan. Orientation will occur monthly or when training new staff is required.

GuildNet’s Staff Development Department, which is responsible for most organizational trainings, develops the content of MOC training, with input from clinical staff and management. Medicare Services has oversight for ensuring that the training reflects current regulatory requirements.

Initial MOC training will be conducted by a Staff Development Specialist in a classroom setting in a face-to-face session. The Staff Development Specialist is the lead trainer and developer of the content. The training will consist of a PowerPoint presentation with: handouts of the presentation, the current MOC tracking grid, and a summary of the eleven (11) elements of the MOC. The group must sign the attendance sheet when they attend and will be required to take a pre-test and post-test of the module. Annually staff will be required to take a self learning module for updates to the plan’s Model of Care. For annual MOC training the self learning module includes a post test which the staff member must pass in order to meet the requirement
that the module was taken. A passing grade of 70% has been internally established. Those not achieving a passing grade will be required to attend remediation and will not be permitted to participate in the Plan until a passing grade is attained. When remediation is needed, the Staff Development Specialist will re-train the Care Management staff member on the twelve elements of the MOC. Screen shots of select slides developed and a sample question from the MOC exam are included as examples of content. The current MOC PowerPoint presentation (used for MA-SNP), and Post-test are included in as Attachment B.

What is the “Model of Care”?

- All special needs plans are required to have a Model of Care (MOC)
  - Framework within which plan operates
  - Broadly defines plan’s structure, processes and goals
  - States how plan will:
    - Assess members’ individual needs
    - Deliver services to meet those needs
    - Measure progress toward achieving goals

10. MOC Oversight and Evaluation

- MOC Oversight Committee
  - Meets quarterly to review progress made toward meeting goals
  - Establishes measurable performance indicators for each goal annually
  - Monitors performance indicators for each goal and creates improvement plan for non-performance
  - Formally reviews MOC annually
  - Reports findings to Quality Assurance Performance Improvement Committee and GuildNet Board of Directors
Summary

- The Model of Care (MOC) is a framework that defines a plan’s structure, processes and goals.
- The MOC defines eleven key elements of each plan.
- The MOC describes how the plan will assess members’ needs, meet those needs, and measure outcomes.
- MOC training is provided annually to all SNP staff.

MOC – Sample Post-test question

Choose the best answer:
1. Which is NOT a MOC goal of GuildNet Gold?
   a. Improve access to affordable care
   b. Improve coordination of care
   c. Improve health outcomes
   d. Improve care of the chronically ill through increased nursing home placement
   e. Achieve effective transitions of care between health care settings

Annual Training

Following the annual evaluation of the MOC goals, annual training will be conducted to review the prior year’s goal progress and to provide instruction in changes to the current year’s MOC goals. The annual training is completed as a self learning module with a post-test which the staff member must achieve a 70% to pass the module.

The Staff Development Department will be responsible for coordination of annual mandatory training of staff and tracking participation in educational programs. Staff Development will maintain an evaluation of each program, sign-in sheets, test materials and certificates of completion, as appropriate. Supervisors will be notified of staff requiring attendance at scheduled trainings and make up sessions as needed. Supervisors will be responsible for corrective action for staff that does not attend mandatory sessions.

EmblemHealth Training - Staff

EmblemHealth provides numerous services for GuildNet members, particularly in regard to Utilization Management, Appeals and Grievances and Member Services. The Medicare Services Department will furnish EmblemHealth with the GuildNet Gold MOC Training Module which will be distributed to the manager of those areas of EmblemHealth that interact with GuildNet members and/or the IDT. Each department manager will complete an attestation stating that the staff has reviewed the MOC. GuildNet Medicare Services department will be available to answer any questions related to the MOC.
Factor 6: Describe how the organization documents and maintains training records as evidence that employees and contracted staff complete MOC training.

The Staff Development Department has the ultimate responsibility for ensuring that all staff members are trained on the MOC. The Staff Development Department keeps a spreadsheet of all staff that is provided training. This list is further broken down by role responsibility and the required training for each role within the Plan. The spreadsheet documents the date of training completion and the scores for required testing. The dates enable the Staff Development Department to track when to schedule annual training and compliance with completing mandatory training.

Example: Sign in Sheet (September MA SNP Model of Care training)
The SVP of QAPI oversees the MOC training process and ensures that the presentations are updated as appropriate with the assistance of the AVP of Medicare Services and Director of QAPI. The Staff Development Manager is responsible for ensuring that the sign in sheets and test results are maintained and that the training spreadsheet is updated. The spreadsheet is also used to identify staff requiring further remediation, based on test results, and to identify when to schedule annual training. When remediation is needed, the Staff Development Specialist will retrain the Care Management staff and retest the staff on the eleven elements of the MOC. A passing grade of 70% is required of Care Management staff on all required modules.
Factor 7: Describe actions the organization takes if staff do not complete the required MOC training.

All GuildNet Gold staff will be provided face-to-face initial training on the MOC. All GuildNet staff who are involved in the implementation of the MOC are required to take the annual training. Staff Development tracks completion of the module and if the staff member has not succeeded in getting a passing grade and will inform them that they must retake the module and pass the post test. Staff receives email notification of required training sessions and if need be the makeup sessions. The Department Supervisor is responsible to ensure that their staff takes the self learning module. A list of staff requiring make-up of the self learning module is sent to the respective Supervisor.

Staff is expected to attend the trainings and/or complete self learning modules when scheduled but a challenge of training presents when a staff member is on vacation or LOA. Staff development is responsible to see that staff are given a make up session of the scheduled training or catch up of trainings for LOA.

If the staff member does not attend mandatory training they are counseled and a note is made to their employment file. Staff who have not successfully attended and completed annual training will not be assigned cases until they have achieved compliance.

The Staff Development Department has the ultimate responsibility for ensuring that all staff members are trained on the MOC.
MOC 2: Care Coordination

Element B - Health Risk Assessment Tool (HRAT)

The organization’s MOC includes a clear and detailed description of the policies and procedures for completing the HRAT that addresses:

Factor 1: How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) or Plan of Care (POC) for each beneficiary (Element 2D).

As part of the Medicaid Redesign effort in New York State, the Office of Long Term Care created a system to facilitate uniform assessments for home and community-based programs in New York State. The electronic system, UAS-NY (Uniform Assessment System for New York), is based on a uniform data set and will standardize and automate needs assessments for home and community based programs in New York.

The Department of Health has selected the interRAI Suite of assessment instruments to be the basis of the tool. InterRAI, a collaborative network of researchers in over 30 countries is committed to improving health care for persons who are elderly, frail, or disabled. Their goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data. The interRAI organization and its assessment tools are used in many states as well as Canada and other countries. New York State Department of Health has adopted and modified the interRAI as the mandatory Health Risk Assessment tool, named the Universal Assessment System-New York (UAS-NY) which became the official HRAT effective in October 2013.

The UAS-NY health risk assessment tool is comprised of a multi-part assessment tool that consists of a Community Assessment and two supplemental tools for Functional Assessment and Mental Health Assessment. The Community Assessment tool assesses multiple domains of function, health, social support, and service utilization. The Functional Supplement tool is used to collect additional data related to health, function, and social support. The Mental Health Supplement tool will capture additional information related to mental health service history, mental state, and social relations. Based on responses to the Community Assessment, the Functional Supplement and the Mental Health Supplement may be triggered for completion.

GuildNet Gold has incorporated additional elements such as: member goals, community resources utilized, and additional safety evaluations into the UAS-NY tools to assist the care managers in developing a comprehensive care plan for the members. The items in the Community Assessment and the two supplements measure a person’s objective performance and capacity in a variety of areas, and evaluate multiple domains including clinical, mental health, psychosocial, and physical function. Information obtained through the assessment is used to develop the individualized care plan and to provide or arrange for appropriate services.

The Community Assessment will enable the plan to determine whether an individual is clinically eligible for GuildNet Gold.
As with any assessment, the underlying goal is to ensure a consistent interpretation and approach for conducting the assessment. This consistency is critical for the member being assessed and for assessors. Assessment staff are trained on performing the UAS-NY assessment via the New York State training modules and staff will receive certification upon completion of the training program. GuildNet Gold staff will receive periodic training to insure that they are performing the assessments per the regulatory guideline and an inter-rater reliability scenario will be developed to evaluate the assessment staff.

To support a standardized and uniform approach to member assessment, the UAS-NY training platform has been provided to insure consistency in evaluation for items included in the Community Assessment and the two supplements. The training includes items such as: Intent Reason(s) for including the item (or set of items) in the UAS-NY Community Assessment, including discussions of how the information will be used by clinical staff to identify problems and develop a plan of care, definitions or explanations of key terms, process for identifying sources of information and methods for determining the correct response for an item. Sources of health risk assessment information may include:

- interview and observation of the person;
- discussion with the person’s family, other caregivers, and the person’s physician;
- review of any clinical records or other administrative documentation.

The assessment process requires communication with the member and primary caregiver/family member, if available, observation of the member in the home environment, and review of supplemental documents when available. Whenever possible, the member is the primary source of the assessment information. Staff will also receive instruction on the most accurate method of recording the response for each item, with descriptive explanations of the individual response options.

Sometimes the assessor will need to reconcile information received from multiple sources to complete the assessment. For example, the person being assessed may report something that is very different from the response of the member’s family. In this case, the assessor must use his or her clinical judgment to determine the most appropriate response for the particular item(s).

The initial UAS-NY Community Assessment is completed when the person is first referred for service by an agency. Subsequent assessments will be completed according to New York State guidelines, currently biannually and may also be updated when there is a significant change in a member’s conditions such as following a hospitalization. Some sample questions from the proposed UAS-NY tool are included below.

**Note: A copy of the UAS-NY and Community Assessment are included as Attachment C**
Factor 2: How the organization disseminates the HRAT information to the Interdisciplinary Care Team (IDT) and how the IDT uses the information (Element 2D).

The GuildNet CM and GuildNet members of the IDT will have access to all the documentation and clinical findings relevant to the care management of the member in the electronic health record (EHR). The internal interdisciplinary care team will communicate via secure conference line or via secure electronic mail, or in-person whenever possible. All internal core members of the interdisciplinary care team will be included when secure electronic mail is used. IDT meetings, telephonic or in-person, that include the member, PCP, or specialty providers included in the IDT will be entered in the electronic health record (EHR) by the IDT CM or SW, the format for the minutes/member notes will be problem/issue, assessment/findings, plan, evaluation/goals (PAPE). The internal interdisciplinary care team will have access to the electronic health record (EHR) and be responsible for entering their individual findings including the recommended plan.

All enrollee’s will receive a comprehensive Health Risk Assessment (HRA) using the Universal Assessment System New York (UAS-NY) prior to enrollment and at 6 month intervals from the date of enrollment, or with a significant change in the member’s cognitive and functional assessment. The Health Risk Assessment data is available to all members of the IDT that have been authorized through the UAS-NY system. The Care Manager, who is the lead professional member of the IDT, is responsible for communicating the findings with other team members through the electronic health record. Within the first 30 days of enrollment additional telephonic assessments are completed with the member and shared with the IDT. The CM completes a New Enrollee Assessment (described above), SW completes a psycho-social assessment, and the MHL may complete a mental health assessment on those members with a psychiatric diagnoses or medications. The SW and MHL perform a telephonic assessment of the member, documents their findings in the electronic health record, and share their findings with the interdisciplinary care team via secure electronic mail, in-person, or via secure conference call with the team. Assessments are repeated based on the status of the member. The Plan of Care is mailed to the member or designated representative and the member at enrollment, every 6 months thereafter, and upon significant changes.

- The Care Manager (CM), who can be either a Registered Nurse or a Social Worker, will review cases prior to the reassessment visit and identify specific issues, potential needs/ changes to Plan of Care and if necessary may initiate a discussion with the scheduled Reassessment Nurse prior to a scheduled home visit.

- Situations requiring immediate clarification/changes will be reported to the CM at the time of the home visit. If the CM is not available, then the Supervisor or Director of Care Management is to be contacted.

- Documentation from the Reassessment Nurse conducting the reassessment will include the HRA and if applicable, an addendum progress note describing issues not addressed on the HRA and any other required supplemental forms; i.e., Fall Risk
Assessment Tool (FRAT) (Attachment D), Emergency Room visits, change in caregiver status, demographic changes.

- CM receives an Activity notification once the results of the HRA/UAS-NY is uploaded or entered to GuildNet Gold electronic health record. The CM will review the HRA for accuracy and will approve the assessment in the electronic health record. Every member receives a standardized score and Fall Risk Assessment score based on the results of the clinical, functional and cognitive results of HRA/UAS-NY. The Activity is a specially designed system within GuildNet Gold electronic health records which notifies the CM and the CM supervisor of a received HRA/UAS-NY. The CM will review the assessment for accuracy no later than 10 days from receipt.

- If the member has Personal Care Hours, the Personal Care Assistance Tool, (PCAT) or “tasking tool” is to be done by the CM only upon receipt of the HRA. The nurse conducting the reassessment is not to discuss or offer an opinion to the member, caregiver or family on the provision of hours or services, but to complete the assessment and refer any questions to the CM responsible for the member’s reassessment.

- CM will contact providers of network and non-network services, including the PCP, to obtain information about member’s status, care needs and response to provided services. CM will also discuss potential POC for member for the next 180 days with each provider. CM will contact member and/or significant other to discuss the POC.

- CM will document reassessment findings and indicate any changes to POC.

- Revisions to the Plan of Care will be updated in the EHR and mailed to the PCP.

- Authorization of all needed services will be completed and documented in the EHR.

- All pending reassessments assigned to an RN will be tracked by department clerical staff and monitored at a minimum monthly for return of completed reassessments. Notification to supervisor of incomplete assignments will be done. Supervisor/designee will call the appropriate party and discuss resolution.

- The core internal Interdisciplinary Team for GuildNet Gold, includes at least the member, the member’s family or informal caregivers desired by Member or required as result of member’s cognitive status, the PCP (if available), a Social Worker(who may serve as primary care manager) as needed and a Nurse Care Manager. Other providers, such as a Mental Health Liaison, medical specialists, rehabilitation therapists and the member’s Home Health Aide or Personal Care Aide may be included on the IDT as necessary to meet the member’s clinical needs. Most IDT meetings are informal, and are conducted through electronic or verbal communication facilitated by the CM. The CM communicates and collects clinical and psychosocial information from IDT members through the electronic health record, by phone, fax, or by email. Information collected from IDT members is documented by the CM in
the electronic health record. (Note: All records are maintained in accordance with HIPAA and Medicare record retention requirements.) As appropriate, the CM will share information collected from providers with IDT members via the same mechanisms. Collection and sharing of the information among IDT members happens at a minimum of every six (6) months, following the six (6) month re-evaluation of the member’s health risk assessment. It may also take place upon changes in the member’s condition including discharge from the hospital or skilled nursing facility. When it is necessary, the CM may convene an in-person meeting with the member, their family and caregivers, and other members of the IDT.

Factor 3: How the organization conducts the initial HRAT and annual reassessment for each beneficiary.

Currently the Health Risk Assessment (HRA) (UAS-NY), which is used to determine eligibility, is administered in person by an RN during the enrollment process within 30 days of enrollment and every six (6) months thereafter. The HRA may be re-administered more frequently if there are significant changes in the member’s condition. If a member experiences a significant change to his/her condition that warrants a reassessment outside of the HRA’s required semiannual assessment window, or the plan chooses to reassess the member more frequently than every six months, the HRA may be completed as part of the comprehensive reassessment, but the HRA may not be required in these circumstances.

The Semi-Annual Health Risk Assessment may be deferred per current regulation:
- If the member is in the hospital when the semiannual reassessment HRA is due, the reassessment may be deferred until the member is discharged from the hospital.
- If the member is out of the area when the semiannual reassessment HRA is due, the reassessment may be deferred until the member's return.

The deferred reassessment resets the reassessment cycle to the next six-month date.

Initial Assessment: Start of Enrollment (SOE)

The SOE HRA is an integral component of the comprehensive assessment of the plan eligibility as it establishes a baseline for the member’s health and functional status. The member is evaluated in person by an Intake Nurse in their community residence using the health risk assessment tool(s) described above along with additional home and environmental safety assessment tools. The in home assessment also includes verification of the Medicaid and Medicare card documents and provides members information on Advance Care planning.

Initial Evaluation

- A prospective enrollee requests information on the GuildNet Gold plan.
- The first, or SOE, HRA data set is collected as close to enrollment as possible as mandated by the government.
The Intake Nurse Care Manager:

- Visits the applicant in person and collects and evaluates social, clinical and environmental information, including the NYS DOH-mandated assessment tool to determine eligibility, the applicant’s ability to be managed safely at home and the applicant’s need for plan services.
- Assessments can be completed in one or more visits, depending upon patient tolerance, questions, need for family member input, etc. At least one visit will be done at home.
- The Advance Directives form is given to applicant and a copy is obtained if the potential enrollee is willing to complete or provide one.
- An assessment of ability to remain safely at home is done based on information obtained from patient, referring party and home assessment information.
- Explains to the enrollee that a physician must collaborate with GuildNet in the development of the plan of care or the enrollee may choose another physician;
- Contacts the individual’s personal physician to inform him/her of the individuals’ interest in GuildNet and to ascertain if he/she would be willing to collaborate with GuildNet in planning the person’s care;
- If the physician is unwilling to collaborate with GuildNet and the individual still wishes to enroll, GuildNet can assist the potential enrollee in choosing another physician.
- Develops a transitional Plan of Care with the applicant and involved family/informal caregivers, and advises the applicant s/he can get a written copy of the Plan of Care upon request.
- Involves applicant, significant others and physician in development of plan of care through review of services and member needs.

The Case Manager:

- Plan of Care is reviewed and adjusted according to the members’ needs.
- Member and PCP are notified of changes in the POC.

Reassessment Protocol:

- Reassessment dates will be monitored utilizing the Electronic Health Record System reassessment tickler file. Reassessment dates are scheduled every 6 months based on the date of the last UAS-NY completed.
### Reassessment dates

Currently all MLTC and MA SNP plans are required by contract to reassess enrollees for continued eligibility semiannually using the NYS DOH approved HRA tool. Each time a semiannual reassessment is due, the HRA must be completed within the 30 day time frame to complete the assessment.

The Reassessment Nurse performs the HRA as a face-to-face interview in the member’s community residence, which can be either their home or a SNF. Permitted deferred reassessments for out of Area or during hospitalizations were defined above.

Visits will be assigned by the data entry staff to the Reassessment Nurse approximately 2 weeks prior to the next Plan scheduled reassessment month.

A member's Enrollment Date is April 1, 2014. The plan is required to complete six-month reassessments on October 1, 2015. Therefore, the plan conducts the first in-home face-to-face Semi-annual Health Risk Assessment visit any time between October 1, 2015 and October 31, 2015.

#### Interim Assessments:

Interim Reassessments will be performed when there is a request from the care manager to assess for a significant change in a member’s condition. These requests for an interim reassessment may include a change in a member’s support system, change in mental or physical condition or following a transition of care. Interim assessments reset the next UAS-NY due date.

To obtain objective assessment data for members who require nursing home placement and/or interim reassessment evaluations. Interim assessments (for changes in clinical condition and requests for changes in PCA hours) or PRI (Patient Review Instrument for nursing home placement) are different types of evaluative tools that assist the care manager in making sound care management interventions based upon objective data collected. The Reassessment Nurse...
will attempt to schedule a face-to-face in home evaluation of the member within five (5) business days of the request.

Factor 4: The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

The Intake Nurse Care Manager/Reassessment Nurse reviews the Member information upon receiving their assignments. They complete documentation in the electronic health record (EHR) including, but not limited to, review and updating of the HRA tool that will populate the Plan of Care (POC) for members, progress notes and any requested supplemental documents.

The Intake Nurse Care Manager/Reassessment Nurse reviews all data collected for accuracy and completeness prior to submission. The submitted HRAT will be complete and accurate, processed as per protocol by the data entry clerk and reviewed for accuracy by the Nurse Care Manager (NCM) or designee.

The Director of Intake or designee evaluates reassessment packets for quality, completeness and consistency, performs clinical review of work submitted and resolves clinical documentation issues.

The Transition Team Nurse Supervisor reviews all new enrollee information and assigns a Care Manager to the member. Every member is assigned a Care Manager upon enrollment and the members are not stratified. The Case Manager is the Lead of the Interdisciplinary Care Team (IDT) and is responsible for the member’s Plan of Care (POC).

The Intake Nurse Care Manager/Reassessment Nurse reviews cases with the assigned CM for any potential needs or changes to POC prior to scheduled home visit, as needed. The Intake/Reassessment Nurse reports any changes in POC that require immediate attention to CM at the time of visit. Examples include but are not limited to, new diagnoses, new medications or any changes in member status such as skin impairments. The Reassessment Nurse is expected to notify/communicate any significant changes to the CM via phone or email in addition to documenting the assessed needs in a progress note.

The Senior Reassessment Specialist evaluates reassessment packets for quality, completeness and consistency, performs clinical review of work submitted and resolves clinical documentation issues.

The Senior Reassessment Specialist and Reassessment Specialist also perform field evaluation of Reassessment staff following orientation and annually thereafter to assess competence and identifies and works with staff who have been identified for remediation, and is involved in the retraining and remediation process and documentation of progress or recommendations for continued employment.

The Care Managers (CM) will review the HRA and utilize any supplemental assessment tools for accuracy and will approve the assessment in the EHR. The CM will contact providers of network and non-network services, including the PCP, to obtain information about member’s status, care
needs and response to provided services. The CM will also discuss the potential POC for the member for the next 180 days with each provider. The CM will contact member and/or significant other to discuss the POC. The CM will document the reassessment findings and indicate any changes to the POC. Revisions to the Plan of Care will be updated in the EHR system and mailed to the PCP.
MOC 2: Care Coordination

Element C: Individualized Care Plan (ICP) will be referenced in this model of Care as the Plan of Care (POC).

The description of the organization’s POC must include:

Factor 1: The essential components of the POC
Care Planning is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The plan of care is based in assessment of the member’s health care needs and developed in consultation with the member and his/her informal supports. Effectiveness of the plan of care is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan of care and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the plan of care or elsewhere in the care management record.

Guild Net Gold, committed to Person-Centered Care, recognizes that the key component of the interdisciplinary care team is the Member who will be included in all phases of care planning and care coordination of services. Self management goals and objectives are established as part of the plan individualized care plan. Interventions include the provision of care and services tailored to the needs of the member in an effort to meet the identified goals. Through ongoing contacts with the member, caregivers and formal assessments, the IDT evaluates progress toward goals. When goals are not met, the team collaborates with the member to consider mutually agreed upon options for achieving goals.

Each Member shall receive, and be an active participant in the completion of, a timely Comprehensive Assessment of medical, behavioral health, community-based or facility-based long-term services and supports (LTSS), and social needs. The New York State approved Universal Assessment (UAS-NY) is the assessment used for Guild Net Gold and is completed by an RN who is on staff or under contract with the Plan.

The POC is based on the UAS-NY assessment tool as well as the New Enrollee Summary. The New Enrollee Summary, completed by the Care Manager, includes the Community Assessment and explores the preferences, strengths and accommodations needed by the Member to facilitate active participation not only in the care planning process but in obtaining and utilizing services of the Plan. The UAS-NY assessment and new enrollee summary provides the basis for the POC which is developed and agreed to by the Member. A review of the POC follows every assessment and /or change in Member status to assure that the plan remains current and appropriate to Member needs. Following the initial assessment conducted at enrollment, The UAS-NY is conducted at a minimum of six month intervals and may also be triggered by one of the following events:
- Hospital admission
- Care setting transitions
• Signiﬁcant change in health status such as change in functional/cognitive condition or
development of a new diagnosis
• Loss of informal Caregiver
• Upon request of a Member of the IDT

Assessment domains will include, but not be limited to, the following: social, functional,
medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well
as the Member’s preferences, strengths, and goals. Relevant and comprehensive data sources,
including the Member, providers, and family/caregivers, shall be used by the Assessment RNs in
completing the Assessment. Results of the Assessment will be used to conﬁrm the appropriate
acuity or risk stratification level for the member and as the basis for developing the integrated,
Plan of Care. The Assessment RN must be accessible to each Member’s IDT for any follow-up
or clarifying questions the IDT may have regarding the information contained in the Assessment.

The POC must specify the care and services needed to meet the Member’s known and
anticipated medical, functional, social, and cognitive needs identiﬁed in the initial
comprehensive Assessment.

The POC will specify the following components:
• All active chronic problems, current non-chronic problems, and problems that were
previously controlled and or classiﬁed as maintenance care but have been exacerbated
by disease progression and/or other intervening conditions;
• For each need identiﬁed, the POC must state the problem, interventions to resolve or
mitigate the problem, the measurable outcomes to be achieved by the interventions,
the anticipated time lines in which to achieve the desired outcomes, and the staff
responsible for conducting the interventions and monitoring the outcomes;
• Reasonable long-term and short-term goals for all problems identiﬁed;
• All services authorized and the scope and duration of the services authorized;
• Member’s goals and preferences and how they will be addressed;
• Method and frequency of evaluating progress towards goals and documentation of
progress toward the goals including success, barriers, or obstacles;
• When goals are not met as anticipated, the IDT must evaluate and address barriers to
attainment. Goals may require longer time frames for achievement or may remain
ongoing.
• How frequently speciﬁc services will be provided;
• Member choice of service providers;
• Individualized back-up plans.
• The person(s)/providers responsible for speciﬁc interventions/services;
• Member’s informal support network and services;
• Member’s need for and plan to access community resources and non-covered
services, including any reasonable accommodations; and anything else appropriate for
the needs of the Member.
Factor 2: The process to develop the POC, including how often the POC is modified as beneficiaries’ health Care needs change.

The foundation of the POC is the assessment tools and the individual answers that will generate particular issues /problems that should be addressed in the POC. The POC will propose short/long term goals and interventions based on the Member’s individual assessment responses, while also allowing for ad hoc goals and interventions to be incorporated. Additionally, staff will complete a Fall Risk Assessment Tool (FRAT) and Personal Care Assessment Tool (PCAT). The FRAT score and the FRAT guidelines assess Member risk and are used in conjunction with a Falls protocol to identify a plan for rehabilitation or steps to ensure safety. The PCAT is a care planning tool available to the IDT to help determine the amount and level of personal Care assistance needed by the Member. Needed services and preference for care are discussed with the Member or their designated representative and their PCP at enrollment, upon significant changes in Member status, and every 6 months following enrollment.

In addition to the findings of the UAS-NY, other contributors to the Member’s POC are the findings and reports of providers involved in the Member’s Care such as, but not limited to the PCP, physical therapy, social day care, skilled nursing, the personal care attendant and the medical specialties that may be involved. The input of these providers is critical to the evaluation of the Member’s response to care, possible modification of the Members goals of care and potential interventions going forward. Additionally, the telephonic assessments and interactions that internal Members of the IDT have with the Member between formal assessments contribute valuable information on the Members’ status and insight into needed modifications to the POC.

The CM prioritizes the needs and concerns of the Member, identifies attainable goals and measurable outcomes, needed interventions and services to be implemented, and the person(s)/providers responsible for the specific interventions or services. The CM will evaluate the effectiveness or the POC through regular contacts with the Member and/or their representative and review of assessments from rehabilitation staff, reassessment nurse, family and community based medical providers included in the IDT.

The information and diagnoses gathered from the UAS-NY, Community Assessment as well as provider reports and telephonic IDT assessments are utilized to develop the Member’s individualized POC. The GuildNet Gold POC is designed so that identified issues or problems, short and long term goals and interventions are generated based on the Member’s responses to the UAS-NY, New Enrollee Summary, FRAT or PCAT. These aspects of the POC are modified as the Member’s health care needs change. The following is a description of how the POC is developed:

The IDT Care Manager selects potential Member issues based on the responses to the questions on the UAS-NY which assesses the Members individual medical issues such as incontinence, shortness of breath with exertions; current diagnoses and medications; functional status such as “requires human assist with transfers or supervision with ambulation”; or cognition such as “unable to recall events of the past 24 hours.”
The Care Manager reviews the list of potential Member issues and chooses the ones most appropriate to the individual Member. For example, the Care Manager may not choose incontinence as an issue if the Member has occasional stress incontinence and is able to toilet/change self independently. The Care Manager would choose incontinence as an issue if the Member is dependent with toileting and incontinent of urine.

The Care Manager is develops a list of potential goals based on the Member specific issues identified by the UAS-NY and is reviewed by the member. An example of a goal might be “prevent daytime incontinence” for a Member who is ambulatory but may not be appropriate for a bedbound Member with dementia whose goal may be to “maintain skin integrity”.

A list of potential interventions are provided based on the Member specific goals identified by the UAS-NY and the Care Manager such as the intervention associated with urinary incontinence for an ambulatory Member may be “scheduled voiding during the day” versus the interventions needed for a bed bound Member with dementia which would include incontinence supplies, barrier creams, and home health aide service for frequent changing and repositioning. The intervention section of the POC includes covered Medicaid and Medicare services as well as non-covered services that are needed by the Member. Possible interventions include but are not limited to, hospitalization, personal care services, pharmacy, telephone reassurance and books on tape to name a few.

The Care Manager identifies/assigns the members of the team that are responsible for each intervention, including the Member and /or informal Caregivers. Some examples of role responsibilities are: the authorization team is responsible for authorizing needed incontinence supplies; the HHA is responsible for toileting or changing a Member’s diapers and inspecting the Member’s skin for evidence of breakdown; the SW for assisting the family in completing an application to the Alzheimer’s Association for a Safe Return bracelet.

**Factor 3: The personnel responsible for development of the POC, including how beneficiaries and/or Caregivers are involved.**

The POC is developed by the Care Manager with member participation and addresses issues, medical diagnoses, goals and interventions generated from the responses to the UAS-NY.

As stated earlier, GuildNet Gold (the Plan) provides person-centered, comprehensive and interdisciplinary Care management to its members. Care Management is a process that assists members in meeting health, safety, functional and quality of life goals by authorizing, accessing and coordinating health, long-term support services, and other related services. Care Management includes the coordination of covered services with non-covered services. The Plan is committed to maximizing the Member’s strengths in the development of the Person Centered Plan of Care (POC) as well as considering and making reasonable accommodations for their preferences, language and cultural needs and the ability to actively participate in the IDT and development of the POC. It is the Plan’s intent to foster, to the full extent possible, the Member’s independence and self-direction in the least restrictive setting while assuring their health and safety.
Members are encouraged to be fully engaged members of the IDT and as such the Plan will inform the Member and their desired informal supports how they can be involved in the care planning process and make reasonable accommodations to facilitate this. Additionally the IDT will be responsible for keeping the Member informed about opportunities and activities they may be interested in including but not limited to consumer directed services, educational, recreational and/or vocational services that may be available to them through the plan or in the community. Such services would be included in the POC, as would goals and services related to their health conditions and functional status and the service and interventions related to such conditions.

The Interdisciplinary Care team (IDT) for all Members will be comprised of an internal core group that will include a Registered Nurse (RN) or Social Work(SW) Care Manager(CM), and a generalist SW as needed if (the Member is assigned to a NCM). The Care Manager will be the team leader and primary point of contact for the Member. The individuals responsible for development of the individualized plan of care include the Care Manager (CM), Social Worker as needed, Member, and/or the Member’s designee, and the Member’s primary Care provider (PCP). Depending on the Member’s needs and preferences, the IDT may include others involved in the Member’s Care such as, such as Certified Occupational Therapy Assistants (COTA’s), Physical Therapists (PT), Reassessment Nurses completing the UAS-NY the MSR and Mental Health Liaison (MHL).

The Care Manager will complete a comprehensive telephonic assessment with the Member and/or informal Caregiver to determine the current status of the Member. The Care Manager will assess the individual needs of the Member, their preferences, strengths, capacity to understand and current knowledge of their individual diagnoses and medications. The assessment will also determine if there are informal or formals supports in place for member.

The Care Manager is responsible for evaluating the effectiveness of the POC and to assess progress toward goals, and together with the other Members of the IDT modify the goals and interventions if warranted. The POC contains a section on monitoring outcomes so that the Plan of Care can always be current. POC outcomes or effectiveness of the POC are evaluated by the Care Manager through regular contact with the Member and or their representative, as well as informal and formal caregivers involved in the Members care. Comprehensive review of the Plan of Care is completed every 6 months after enrollment and with a new UAS-NY.

Throughout the care planning process the Member’s preferences for care are always considered. For all covered services, Members are able to choose from a network of providers. GNG Care Manager will also try to accommodate the care setting in which the Member wishes to receive services (for example in a facility or in the community) to the extent that it is offered and appropriate.

The IDT licensed Social Worker (SW), if needed, is responsible for assessing the Member’s need for SW assistance with eligibility for “entitlements social and community services, housing, psychosocial and mental health issues. SW evaluates the Member and participates in the development of the POC upon enrollment, upon reassessment every 6 months and as needed.
upon change. The POC is mailed to the Member, PCP, and specialty providers upon request on enrollment, upon reassessment at least every 6 months, and upon request. The POC is available via mail, fax or encrypted electronic mail.

The Mental Health Liaison is a licensed Clinical Social Worker who completes a telephonic mental health assessment with the Member at enrollment on Members with a psychiatric diagnoses or medication, share their findings with the IDT, and assist Member with linkage to mental health services.

Together, these assessments will assist the Care Manager in coordinating the care for member. For external Members of the IDT, the Care Manager will share the findings of the assessments and discuss their input into the Plan of Care. Following the completion of the assessment and obtaining input of other IDT Members, the Care Manager, the Member and/or designee will identify problems/issues, outline a plan, and begin to develop measurable goals for the next 6 months. The Member’s clinical, psychosocial and functional status will continue to be assessed and the Plan of Care revised and updated by the Care Manager, with input from the IDT which includes the Member and or representative every 6 months thereafter and upon significant changes in Member status.

The opportunity for Member input into the development and modification of the POC occurs at any time after enrollment. The member is encouraged to be an active participant in the care planning activities.

The Care Manager is responsible for coordinating the activities of the IDT and ensuring communication with all Members of the IDT. The Care Manager will develop and document the Member’s written POC in collaboration with the other IDT Members, arrange for delivery of plan services and coordinate with non-plan service providers.

The Care Manager/IDT ensures that all medically necessary covered benefits are provided to Members in a manner that supports:

- Self-direction;
- Is sensitive to the Member’s functional and cognitive needs, language, religious, culture, and basic Member rights;
- Allows for involvement of the Member and Caregivers;
- Is in a care setting appropriate to the Member’s needs, in the least restrictive community setting with a preference for the home and the community; and
- Provided in accordance with the Member’s wishes.

**Factor 4: How the POC is documented, updated and where it is maintained.**

The Care Manager, along with the Member and the IDT, will be responsible for the creation, revision and maintenance of a Member’s individualized plan of care.

GuildNet Gold will utilize a secure electronic health record accessible to all internal members of the IDT. Lighthouse Guild, the parent organization of GuildNet, established policies and
procedures to address the required HIPAA Security regulations to assure privacy, security, and safety of records in accordance with industry standards.

One of the many features of the electronic health record is a specially developed POC that is individualized to the needs of the GuildNet Gold Member. The POC is one aspect of the EHR which contains the following sections:

- issues or problems identified by the IDT (including the Member),
- short and long term goals of care,
- proposed interventions
- the role of the individual responsible for the intervention
- outcomes of care

All internal core Members of the IDT including Care Manager, and the SW as needed, will have access to this system. Other internal IDT Members that have access depending on the individual needs of the Member and their participation in the IDT include the Mental Health Liaison (MHL), Palliative Care Team, Diabetes Disease Management Team, and Certified Occupational Therapy Assistants (COTA). Additionally, management and administrative staff with varying levels of oversight responsibility, including the Quality Assurance Performance Improvement (QAPI) department staff will have access to the POC. Each internal IDT Member has a secure password and all changes made to the Member’s electronic health record are time stamped with the IDT Member’s name.

External Members of the IDT will have access to the POC upon request and at scheduled intervals such as the every 6 month post assessment review and whenever there are substantial changes in Member status requiring modifications to the POC. These external Members although not having access directly to the GuildNet computer system will receive the Plan of Care via mail, secure e-mail or fax.

Issues identified by the PCP or specialty providers involved in the development of the POC will be added by the Care Manager and faxed to the PCP or specialty provider once the Plan of Care is finalized.

**Factor 5: How updates and modifications to the POC are communicated to the beneficiary and other stakeholders.**

The IDT Care Manager is responsible for sharing information, planning care, and coordinating services with the Member and/or their designated representative. The Care Manager will contact the Member, representative, and informal Caregiver within 24 hours of unplanned transitions and within 72 hours of planned transitions. Ongoing communication with the Member, Caregivers, family, and providers will be imperative in securing an appropriate plan of Care for the Member throughout the transition process and beyond the transition. The Care Manager will develop and document the Member’s written POC in collaboration with the other IDT Members, arrange for delivery of plan services and coordinate with non-plan service providers.

The Care Manager/IDT, along with the Member Services staff, are responsible for effectively communicating with all providers, in order to prevent duplication of services, ensure appropriate
reimbursement sources for services, increase continuity of care, and promote optimal scheduling of services to meet the Member’s goals. A copy of the POC is sent via mail, fax or via encrypted e-mail to the Member and PCP upon enrollment, upon completion of the assessment/POC review every 6 months, whenever there are substantive changes to the POC and upon request. Internal IDT Members can access the POC through the electronic health record. Upon request and with Member approval, the POC will be available via mail or fax to external IDT Members and specialty providers involved in the Member’s care.

The Care Manager is responsible for notifying the applicable IDT member when the telephonic assessments are complete and obtain their input for development of the POC. For external members of the IDT, contingent on the Member’s agreement, the Care Manager shares the findings of the assessments and discusses their input into the POC.

The Care Manager is responsible for coordinating the activities of the IDT and ensuring communication with all Members of the IDT. The Care Manager will develop and document the Member’s written POC in collaboration with the other IDT Members, arrange for delivery of plan services and coordinate with non-plan service provider.

All interactions with the Member, providers and IDT Members are recorded in the electronic health record. The Care Manager is responsible for reviewing the documentation and communicating relevant information to IDT Members. Any substantive changes in Member status that warrant modifications to the POC are discussed with the IDT Members, including the Member and/or their designated representative and recorded in the electronic health record. The Care Manager will also contact the PCP with significant changes in Member status requiring modification to the Plan of Care and at a minimum every 6 months to discuss the Member’s semi-annual assessment findings and goals of care and/or proposed modifications to the POC. The Plan of Care will be sent to the PCP at enrollment and every 6 months thereafter. The Care Manager is responsible for assuring that the POC is updated accordingly and that interventions are authorized and implemented. A copy of the POC will be sent via mail, fax or via encrypted e-mail to the Member and PCP upon enrollment, upon completion of the UAS-NY/Plan of Care review every 6 months, whenever there are substantive changes to the POC and upon request. Internal IDT Members can access the POC through the electronic health record. Upon request, the Plan of Care will be available via mail or fax to specialty providers involved in the Members Care.

Additionally, the CM will fax the POC which includes diagnoses, medications, current services, and baseline functional status when a Member is admitted to the hospital for planned or unplanned transitions. The information will be sent to the hospital SW, the primary care provider (PCP) and Emblem Health UM. The Care Manager will also include barriers to a safe transition or any other pertinent issues, and Advance Directives.
MOC 2: Care Coordination

Element D: Interdisciplinary Care Team (IDT)

The organization’s MOC must describe the critical components of the IDT, including:

Factor 1: How the organization determines the composition of IDT Membership.

The term “Interdisciplinary Care Team” (IDT) can be used synonymously with “Interdisciplinary Team” (IDT) and for the purposes of this MOC the term IDT will be used.

GuildNet Gold provides person-centered, comprehensive and interdisciplinary Care Management to its Members. Care Management is a process that assists Members in meeting health, safety, functional and quality of life goals by authorizing, accessing and coordinating health, long-term Care, and related services. Care Management includes the coordination of covered services with non-covered services. GuildNet Gold is committed to maximizing the Members’ strengths in the development of the Plan of care (POC) as well as considering and making reasonable accommodations for their preferences, language and cultural needs while fostering, to the full extent possible, member independence, dignity, and self-direction in the least restrictive setting. Every Member will be offered an Interdisciplinary Care Team (IDT) to help coordinate their services, led by a Care Manager.

GuildNet Gold uses an Interdisciplinary Team (IDT) approach to providing each member with an individualized comprehensive care planning process in order to maximize and maintain every member’s functional potential and quality of life. For each member, an individually tailored IDT, led by a dedicated Care Manager, will ensure the integration of the member’s medical, behavioral health, community-based or facility-based LTSS, and social needs.

GuildNet Gold will identify the individuals who will be on the member’s IDT and contact them to establish the member’s IDT as soon as possible.

The philosophy governing the composition of the IDT is that as a person-centered model the member is an active member in the discussions and planning of their own Plan of Care and as such, the assignment of the Care Manager/IDT will, to the extent possible, be culturally and linguistically appropriate.

GuildNet will use best efforts to match Members cultural preferences and special needs with a Care Manager/IDT which can best serve their needs. GuildNet is committed to providing service to its Members in a culturally sensitive and appropriate manner. GuildNet’s management is committed to promoting multi-cultural knowledge in its employees to afford optimal service to its membership. Members’ special needs may include language and cultural concerns and preferences and may also include: challenging behavioral health concerns, complex care management issues, communication limitations and/or other complex clinical and social service situations.
The interdisciplinary Care team (IDT) for all Members will be comprised of an internal core
group that will include a Registered Nurse (RN) or Social Work (SW) Care Manager (CM), and
a generalist SW as needed if the Member is assigned to a RN Care Manager. The Care Manager
will be the team leader and primary point of contact for the Member. The individuals responsible
for development of the individualized Person-Centered Plan of care (POC) include the Care
Manager (CM), Social Worker, Member, and/or the Member’s designee, and the Member’s
Primary Care Provider (PCP). Depending on the Member’s needs and preferences, the IDT may
include others involved in the Member’s Care such as, such as Certified Occupational Therapy
Assistants (COTA’s), Physical Therapists (PT), Reassessment Nurses completing the UAS-NY,
the MSR, Mental Health Liaison (MHL) specialty medical providers, and community based
providers.

During the Intake assessment process the IDT model is discussed with the potential Member.
The Intake staff will make note of any preferences for specific Care Managers or specific
accommodations needed or preferred by the Member or their Designee, such as language,
dominant behavioral health needs, Member acuity, etc.

Assignments of the Care Manager (Care Manager) are based on but not limited to the following:

- If the Member has a special need(s), the Supervisor of the Transition Team or designee
  assigns the Member to the GuildNet Gold Care Manager (CM) who is best suited to
  meeting the Member’s needs such as a Care Manager with clinical experience in
  palliative care or behavioral health for example.

- If the Member does not have a special need(s) or specific Care Manager request, the
  member will be assigned to a Care Manager based on geography or caseload availability.

- If the Member requests a particular Care Manager/IDT or change in Care Manager,
  GuildNet Gold will use best efforts to accommodate the Member and make the requested
  assignment.

A Member’s IDT must be comprised of the following individuals:

1. Member;
2. Member’s designee(s), if desired by the Member;
3. Primary Care Provider (PCP) or a designee with clinical experience from the PCP’s
   practice who has knowledge of the needs of the Member, if available;
4. GuildNet Gold Plan Care Manager

Based on information discovered in the HRA and the problems defined in the Plan of care, the
IDT may also include the following if approved by the member:

1) Behavioral Health Professional, if there is one, or a designee with clinical experience
   from the Behavioral Health Professional’s practice who has knowledge of the needs of
   the Member;
2) Member’s nursing facility representative who is a clinical professional, if receiving
   nursing facility care; and
3) Additional individuals including:
a. Other providers either as requested by the Member or his/her designee; or as recommended by the IDT members as necessary for adequate care planning and approved by the Member and/or his/her designee; or
b. The RN who completed the Member’s Assessment, if approved by the Member and/or his/her designee.

If the Member or their representative requests a change in Care Manager, GuildNet Gold Management will use best efforts to resolve conflicts and accommodate requests to change the Care Manager.

The IDT will make every effort to accommodate meetings to meet the Members’ needs. This would include scheduling meetings at a time when the Member and/or Designee were available, or using the language line or the TTY phone if the Care Manager could not communicate without such assistance.

Self management goals and objectives are established as part of the individualized plan of care. Interventions include the provision of care and services tailored to the needs of the member in an effort to meet the identified goals. Progress towards goal achievement is evaluated during semi-annual reassessments and upon significant change in status. The IDT Care Manager will evaluate why a goal or health care outcome has not been met. The IDT Care Manager evaluates processes to determine if there are barriers to goal achievement and collaborates with member to discuss if goal is attainable, consider modifying goal, extending timeline for goal completion or accept that goal is not achievable due to valid barriers and obstacles.

**Factor 2: How the roles and responsibilities of the IDT Members (including beneficiaries and/or Caregivers) contribute to the development and implementation of an effective interdisciplinary Care process.**

GuildNet Gold (the Plan) provides person-centered, comprehensive and interdisciplinary Care management to its Members. Care Management is a process that assists Members in meeting health, safety, functional and quality of life goals by authorizing, accessing and coordinating health, long-term Care, and related services. Care Management includes the coordination of covered services with non-covered services. The Plan is committed to maximizing the Members’ strengths in the development of the Plan of care (POC) as well as considering and making reasonable accommodations for their preferences, language and cultural needs while fostering, to the extent possible, Member independence, dignity, and self-direction in the least restrictive setting. Every Member will be offered an Interdisciplinary Care Team (IDT) to help coordinate their services, led by a Care Manager. The IDT is person-centered, built on the Member’s specific preferences and needs and delivers services with transparency, individualization, accessibility, linguistic and cultural competence, and dignity.

To the extent they are able, Members should participate in care planning. Members must be asked to express their preferences about care, and these must be respected and incorporated into care decisions, as appropriate. The interdisciplinary team and the Member work together to make clinically sound care decisions.
The Member collaborates in person, telephonically, by fax, or in limited circumstances, by encrypted e-mail with the IDT upon enrollment, every 6 months and as necessary upon any significant change in their condition or circumstances, to establish short and long term goals that are individualized, realistic, and measurable. The IDT will conduct outreach calls to the Member monthly between 6 month assessments and Plan of Care reviews. The purpose of the outreach call is to assure that arranged services continue to meet Member’s needs and to determine any changes in status between assessments, such as transitions of care, wounds, or falls may necessitate Plan of care review. During these calls the IDT conducts education on wellness initiatives, disease management, determines adherence with medication and treatment regimens, and determines progress toward goals. The IDT Member will inquire about upcoming medical appointments so that they can assist the Member with preparation, transportation arrangements or alert provider in advance of any particular concerns the IDT may have regarding the Member as well as answering any questions related to plan services or Member status. A copy of the plan of care is mailed, faxed or emailed to the PCP and the Member or their designated representative every 6 months or on request. All IDT activities will be documented in the Members GuildNet Gold electronic health record (EHR).

The primary roles/functions of the key IDT Members and support staff may include but are not limited to:

**Member Service Representative:**
- Orient the New Member to Plan operations and serves as liaison amongst IDT Members;
- Enters authorizations at the direction of the Care Manager and confirms provider receipt of authorization;
- Assists Member in accessing services by assisting in scheduling appointments and arranging transportation if required;
- Confirms receipt of services/items authorized;
- Shares Plan of Care with facilities and providers approved by Member;
- Tracks receipt of written reports from providers and assures dissemination to IDT Members; and
- Assures that completed notices and written communication such as the Plan of Care is shared with IDT Members including Member and PCP.

**Case Aide: non-clinician care coordinator:**
- Conducts routine telephonic assessment of the Member between in-person assessments under the supervision of the care manager;
- Monitors and documents progress toward goals by communicating with providers and shares with Care Manager;
- Tracks transitions of Care and assures that notifications occur as required and obtains necessary contact info for facility;
- Conducts routine wellness initiatives with Member,
- Participates in obtaining necessary clinical information needed for coverage determinations.
**Care Manager:**
Care Managers are trained on physical health, aging, appropriate support services in the community (e.g., community-based and facility-based LTSS), frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer’s disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate.

The Care Manager directs the activities of the IDT and identifies the initial members of the team (which include the PCP, Member and relevant specialists and family members if available and appropriate). After the initial assessments are completed, the Care Manager will contact IDT members via telephone. Information will be conveyed through faxed, mailed or electronic copies of the Plan of Care. Providers will be informed that the POC is available on the provider portal. The Care Manager incorporates all the problems, goals and interventions into the Plan of Care and will adjust the Plan of Care as necessary as a result of the collaboration. When the Plan of Care is completed, the CM sends a copy, via mail, fax, or email to all members of the team. The Care Manager is the center of the IDT communication process. The IDT will assist Members in making appointments and arranging transportation for visits. The IDT will follow up on consultations to ensure the Member made it to the appointment and that the consultant has sent a report of her findings. The CM will make changes to the Plan of Care based on new input from providers.

Responsibilities of the CM include but are not limited to the following:

- Assumes the role of primary Care Manager for Members and assess the clinical risks and needs of each Member;
- Facilitates the development of the Plan of Care or review and approval by the Member;
- Facilitates IDT meetings periodically as appropriate;
- Conducts medication reviews and reconciliations as appropriate (RN);
- Makes requests for medication adjustments to the PCP or other prescribers as needed;
- Identifies the Member’s strengths, preferences, as well as family and community supports that can assist the Member in addressing clinical risks; and
- Follows-up within three business days of a Member’s planned admission to an acute hospital, and coordinates with the Member and the hospital staff to facilitate hospital discharge. Follows-up within one business day of a Member’s unplanned admission to an acute hospital; and
- Provides the Member and/or their Designee with information about how to contact the Plan with any issues or concerns.

**Intake and Reassessment RN:**
- Conducts the assessment face-to-face, in the Member’s place of residence, or in some other location that is preferred by the Member;
- Administers the comprehensive assessment and supplemental assessment and other specialty assessment instruments, as needed and as determined by the Member’s health care conditions and functional status;
• Participates in the formulation of the Member’s individualized plan of care, as requested by Member;
• Conducts re-evaluations of Members every 6 months or as requested by the IDT.
• Informs members and/or his/her representative of the option to use Consumer Directed Personal Assistance Services (CDPAS).

Factor 3: How IDT Members contribute to improving the health status of SNP beneficiaries.

GuildNet Gold’ target population is comprised of individuals with severe, disabling, chronic conditions who have co-morbid and medically complex diagnoses which are either disabling or life threatening. This population has a high risk of hospitalization or other significant adverse health outcomes and may also require specialized care across care transitions. Because of the complexity of this population, GuildNet Gold will utilize a standard team construct for the Interdisciplinary Care Team (IDT) with the ability to supplement with additional internal and external team Members as warranted by the needs of the Member. As part of the enrollment process all enrollee’s will receive a comprehensive Health Risk Assessment (HRA) utilizing the NYS mandated assessment tool, the Universal Assessment System New York (UAS-NY). The information obtained through this assessment and the primary language needs of the Member will help determine the assignment of the primary contact of the IDT for the Member. The core internal Members of the Interdisciplinary Care Team (IDT) will consist of a Registered Nurse Care Manager (RNCM) or a Social Worker (SW) as needed, if assigned to a RNCM. All Members will have access to a Nurse Care Manager. Other GuildNet Gold internal IDT Members may include staff from the Diabetes Disease Management Team (DDMT), Palliative Care Team, as well as Care Aides, and Certified Occupational Therapy Assistants (COTA), depending on the needs of the Member. Mental Health Liaison staff will assess those Members that present with psychiatric diagnoses or are using psychotropic medications. GuildNet’s Medical Director and/or physician reviewers are available for consultation to the IDT as needed. The Member and/or their designated representative as well as the primary medical provider or PCP may be Members of the IDT. EmblemHealth Utilization Management staff, Medical specialists, providers of community-based or institutionally-based health services, and providers of community-based non-medical services are included in the IDT as needed depending on the Member needs.

The IDT Care Manager in collaboration with other IDT members:
• Develops the POC and goals
• Implements the POC
• Monitors POC
• Updates the POC base on changes in the Member’s condition or on progress toward meeting goals

The Care Manager is responsible for coordinating the activities of the IDT and ensuring communication with all Members of the IDT. The CM will develop and document the Member’s written Plan of Care in collaboration with the other IDT Members, arrange for the
delivery of plan services and coordinate with non-plan service providers, and evaluate the Member’s progress towards the goals identified in the Plan of care.

The IDT Care Manager contributes to improving the health status and outcomes of GuildNet Gold members by:

- Collaborating in person, telephonically or by fax with other IDT Members upon enrollment, every 6 months, and as necessary upon any significant change in the Member’s condition or circumstances, to establish short and long term goals with/for the Member that are individualized, realistic, and measurable;

- Educating the Member about their health risks and care as appropriate, or referring the Member to Plan services for education about health risks and care, providing information to the Member, the Member’s family or informal caregiver and the member’s PCP about available Plan services and how to use them effectively;

- Suggesting goals in the plan of care that encourage self management of disease, foster healthy changes in behavior and emphasize wellness;

- Selecting Plan and non-Plan services with the IDT to assist the Member in reaching their goals in the least restrictive setting possible and in the most cost-effective way possible;

- Ensuring authorization of Plan services that require authorization, ensuring coordination with Plan services that the Member is permitted to self-select and coordinating both with non-Plan services;

- Communicating the Member’s needs and the Plan of care to providers outside the IDT as needed, particularly at times of transition from setting to setting and between providers;

- Monitoring the Member’s response to the Plan of care and progress toward achieving the goals identified by the Member and other IDT Members, and revising the Plan of care every 6 months and as needed with the IDT, ensuring the inclusion of the Member at all times.

- Identifying and addressing barriers to care;

- Ensuring that a hard copy of the Plan of care is mailed every 6 months to the Member and the Member’s PCP as requested; and

- Receiving, resolving and documenting all same-day resolution grievances, and document all Care management activities in the Member’s record.

The Social Worker (SW) is responsible for assessing the Member’s need for SW assistance with eligibility for “entitlements”, social and community services, housing, psychosocial and mental health issues. The SW also participates in the development of the Plan of Care as needed.

The SW contributes to improving the health status and outcomes of GuildNet Gold members by:
• Assessing the Member’s financial resources and need for concrete services upon enrollment, upon reassessment and as needed upon change in Member status;
• Assessing the Member’s cognitive and psychosocial status when in-depth assessment and intervention is needed;
• Assessing Caregiver availability, ability and need for support as needed. Collaborate in the development of the Member’s Plan of care, particularly when psychosocial issues are identified and/or need for community resources; and
• Providing support to the Member and the family/informal Caregiver in coping with chronic illness and/or care giving, and provide concrete services and assistance with State and Federal social programs.

The IDT Mental Health Liaison contributes to improving the health status and outcomes of GuildNet Gold members by:

• Assessing each Member’s mental health needs upon enrollment when a psychiatric diagnosis or use of psychotropic medications is identified by the IDT upon enrollment;
• Conducting depression screening and using other behavioral health screening tools upon referral from IDT; and
• Assisting the Member/informal Caregiver in development of adaptive/coping techniques related to the Member’s health condition.

The Member Service Representative team contributes to improving the health status and outcomes of GuildNet Gold members by:

• Responding to Member’s requests for information and/or services;
• Information gathering and documentation;
• Assisting the Member with the selection of providers;
• Coordinating service delivery dates and locations between the Member and providers, and assuring receipt of services as authorized;

Supplemental Members of the IDT:

The Case Aide, working in conjunction with the Care Manager is responsible for coordinating services for the GuildNet Gold members and may be discipline specific such as with recreational therapy or more generalized such as assuring implementation of the Plan of Care and problem solving to assure Member’s needs are met. Care Aides with recreational therapy experience is available to the team to assist with options for socially isolated Members or visually impaired Members who would benefit from books on tape or other diversionary services.

The Palliative Care Team is a specialized care management team comprised of an RN with hospice and palliative care certification and a Master’s prepared Social Worker with experience in caring for people with advanced disease.
The **Diabetes Disease Management Team** Nutritionists who are certified diabetes educators and will provide specialized disease management education and monitoring.

The **GuildNet Medical Director** and other contracted GuildNet Physician reviewers are available to consult with the IDT to assist in the management of the Member.

**Factor 4: How the SNP’s communication plan to exchange beneficiary information occurs regularly within the IDT, including evidence of ongoing information exchange.**

All Care coordination is documented in the electronic health record (EHR); the internal Members of the IDT have access to the EHR.

The Care Manager/IDT, along with the Member Services staff, are responsible for effectively communicating with all providers, in order to prevent duplication of services, ensure appropriate reimbursement sources for services, increase continuity of care, and promote optimal scheduling of services to meet the Member’s goals. A copy of the Plan of Care is sent via mail, fax or via encrypted e-mail to the Member and PCP upon enrollment, upon completion of the assessment/Plan of Care review every 6 months, whenever there are substantive changes to the Plan of Care and upon request. Internal IDT Members can access the Plan of Care through the electronic health record. Upon request and with Member approval, the Plan of Care will be available via mail or fax to external IDT Members and specialty providers involved in the Members Care.

The internal interdisciplinary care team will communicate via secure conference line or via secure electronic e-mail, fax, or in-person whenever possible. IDT meetings, telephonic or in-person, that include the Member, PCP, and/or specialty and community providers included in the IDT will be documented in the electronic health record by the IDT Care Manager or SW. The internal interdisciplinary care team will have access to the electronic health record (EHR) and are responsible for entering their individual findings including the recommended plan. These findings are reviewed as a team during care planning at enrollment, upon changes, and every 6 months after enrollment.

The GuildNet Gold electronic health record is comprised of a several programs including an authorization; a care management documentation system which includes assessments, contact/progress notes, the Plan of Care as well as demographic information. Provider reports and Member correspondence are added to the EHR through a document management system. Records are maintained according to regulatory requirements. Additionally, claims data and clinical reports for authorization purposes managed by EmblemHealth are accessible to GuildNet IDT Members via a secure portal to the EmblemHealth system.

Within the first 30 days of enrollment the following telephonic assessments are completed with the Member and shared with the IDT: the Care Manager completes a New Enrollee Summary, the SW completes a psycho-social assessment, the MHL completes a mental health assessment on those members with a psychiatric diagnosis or who are using psychotherapeutic medications. The SW assessment will be reviewed and updated upon identification of significant changes. The
SW and MHL perform a telephonic assessment of the Member, documents their findings in the electronic health record, and share their findings with the interdisciplinary Care team via secure electronic mail, in-person, or via secure conference call with the team. The Plan of care is sent to the Member and/or designated representative and the PCP at enrollment, every 6 months thereafter, and upon significant changes or on request.

Additional interdisciplinary care team Members may include the EmblemHealth Utilization Management (UM) staff. The GuildNet Gold Care management staff will meet with the utilization management staff every two weeks via secure conference line to discuss all Members with the following: hospitalization, acute medical rehabilitation, sub-acute rehabilitation, and certified home health agency (CHHA) services. A daily in-patient census report will be received from the utilization management department to identify which members require review. These reports will be shared with the internal IDT. The purpose of the meetings will be to assess clinical progress, need for continued admission, and discharge planning including coordination of authorized services. Care conference notes of those Members discussed will be entered in the Member’s clinical record by the GuildNet Gold Care Manager and will serve as the meeting minutes. Clinical reports received by GuildNet from medical providers will be added to the Member’s electronic health record and faxed to the primary Care provider. These reports are viewable by the other internal interdisciplinary Care team. The EmblemHealth UM department will enter utilization management notes in their electronic health record. The GuildNet Care Manager will have access to all the documentation entered in the Member’s Emblem EHR. Clinical findings relevant to the Care management and coordination of Member services will be documented in GuildNet’s EHR and shared with the internal interdisciplinary care team.
MOC 2: Care Coordination

Element E: Care Transitions Protocols

Factor 1: How the organization uses transition protocols to maintain continuity of care for SNP beneficiaries.

Transitional care comprises a variety of time-limited services that are designed to ensure continuity of effective health care and avoid less than optimal outcomes among at-risk populations as they move among multiple providers and across a variety of health care settings. Frail, elderly and disabled adults are particularly vulnerable to receiving fragmented and unsafe care when moving between various health care settings. This is often related to the lack of information on the part of new providers and lack of adequate assessment and planning for new needs/settings. Transitions may be planned such as elective admission for short term rehabilitation or unplanned such as hospital admission following an emergency room visit. Each type of transition can lead to anxiety for the member and his/her caregivers as well as potentially leading to adverse outcomes for lack of coordinated assessment, information sharing and planning of care.

GuildNet Gold is committed to assuring that members transitioning between various settings over the continuum of care are in a position to receive optimal services in the least restrictive care setting that is clinically appropriate to manage the member’s condition. The primary care manager remains actively involved with the member during transitions to ensure exchange of essential information and to facilitate return to the community with a resumption of services. This is accomplished through adherence to established protocols that delineate coordinated efforts including but not limited to:

- Communication and information sharing and care planning;
- Beginning the process of discharge planning immediately after a planned or unplanned transition;
- Managing expectations of members and their caregivers;
- Assuring them that Plan staff will be available to assist them through these processes; and
- Identifying members at high risk of unplanned transitions and collaborating with the Member, caregivers and providers to minimize the risk or an unwarranted transition.

During the discharge planning process, members are connected to the providers who will be critical to their post admission care. This includes:

- The PCP who is kept informed of the member’s progress during the admission;
- The family and/or informal care giver who will be involved in post admission care;
- The home care agency which will be authorized to provide skilled and/or custodial services post discharge;
- Any specialty provider (i.e. medical, psychiatric, rehabilitation) who will need to follow the member post discharge.
The Care Manager/Interdisciplinary Team (CM/IDT) identifies and assesses Member needs in order to provide continuity of care and a safe environment upon transition from one level of care to another. Identification of members at risk for transitions of care can be accomplished through, but is not limited to, the following:

- Telephonic assessment, including determination of skilled and custodial care service needs
- Review of utilization and claims data
- In-home assessment (semi-annual and/or interim-significant change in status)
- Fall Risk Assessment
- Provider reports/concerns
- Review of complaints/incidents
- Review of hospital admission reports
- Frequency of Emergency Room visits
- Review of long term/skilled nursing care facility admission reports
- Authorization of necessary services

Transitions should be managed across the following care settings:

- Home including the need for home health care
- Hospitalizations
- Skilled nursing facilities for long term care or short term rehabilitation
- Outpatient/Ambulatory Care/Surgery Centers
- Adult Day Health Care Program
- Out of Area services (if necessary)
- Dialysis
- Respite
- Behavioral Health admissions
- Other community based service providers

**Factor 2: The personnel responsible for coordination the care transition process.**

Care Managers are responsible for coordinating the care transition process. The Plan monitors transfers to minimize unnecessary complications during care setting transitions and hospital readmissions. Additional interventions include follow-up appointments with PCP and other providers to determine need for changes in care, treatment and services.

The CM has developed the care plan with the IDT and has regular contact with the member. The CM may receive notification of transitions/admission to a facility in a variety of ways. Planned admissions received through prior authorization reports or are reported by family member/caregiver or the Member during the routine telephone assessment or a telephone call specifically for that purpose. Notifications of unplanned transitions are received through daily admission reports and may also be made telephonically by the family/caregiver or by the paraprofessional/nursing provider on the case. Members are encouraged to inform the Plan in advance of any planned transitions and are asked specifically in the routine telephonic assessment. The CM initiates the process of discharge planning as soon as a transition occurs.
The CM contacts the receiving facility and speaks to the discharge planning staff to ensure all services are in place prior to discharge.

The Member Service Representative (MSR) will send the receiving facility an abbreviated copy of the plan of care that includes diagnoses, medications and baseline functional status. This sharing of information facilitates oversight, coordination of care and avoidance of preventable injuries complications. The MSR will also assist the member in scheduling follow-up appointments and contacting the member to ensure the appointments have been kept.

The Utilization Management (UM) department notifies the CM/IDT of inpatient admissions of members via a shared electronic portal within one business day of notification of member admission or pre-authorization for planned admission. Additionally, The UM department forwards an electronic report on a daily basis (Monday-Friday) of all admissions including pre-authorized hospital and SNF admissions received from in-network and out-of-network providers. The UM department evaluates admissions and services using standard criteria and assists in the discharge planning process and authorization of services post discharge.

The CM contacts the following as appropriate to confirm the transition, evaluate potential changes in health status and determine the anticipated plan:

- Member/caregiver/family-no later than 3 days prior to transition if the Plan is made aware in advance and within 1 business day of notification if the Plan informed after transition has taken place;
- Primary Care Provider-within 1 business day of notification.

Factor 3: How the organization transfers elements of the beneficiary’s Care Plan between health care settings when the beneficiary experiences an applicable transition in care.

The CM documents all communication related to the transition among interdisciplinary team members, including member, caregiver, family, providers and facilities. This coordination and interfacing with and among clinical service and community based long term services and support providers ensures that all are knowledgeable and prepared to support the Member.

Protocols and documentation templates have been developed to guide interventions and documentation for specific transitions of care. All members have a current care plan in their electronic health record. When a planned transition of care is scheduled, the CM sends a care plan summary to the receiving facility prior to the admission.

The CM/IDT communicates with receiving facility/provider to:

- Explain the Plan, the role of CM and contact information for the CM;
- Determine what information the provider/facility currently has and what may be needed from the Plan record;
- Identify responsible contact person/liaison at facility/provider with whom CM/IDT must communicate;
- Determine current plan of care and anticipated discharge plans if known; and
- Forward copies of an abbreviated care plan via secure fax/e-mail, containing a summary of current diagnoses, the most recent functional assessment, medications and services in
place prior to transition, as well as Advance Directives, if on file, to facility/provider within 1 business day of notification of the transition.

During the admission, the UM department is in touch with the facility to evaluate the level of services and authorize care. The CM is in contact with the discharge planning unit of the facility to determine the discharge plan. There is regular communication between the CM and the UM staff through an electronic portal, faxed reports and/or telephonic meetings.

The CM receives a discharge summary from the facility and reviews/revises the current POC based on changes that occurred during the admission. In order to assure an effective and safe plan of care, the CM/IDT must consider the following:

- Level of mental and functional status;
- New diagnoses, treatments, and/or medications;
- Exacerbations of existing diagnoses;
- Impact of new treatments/medications on existing regimen;
- Need for equipment/supplies;
- Social and environmental considerations, if any; and
- Anticipated services

Once a member returns home or is sent to another facility such as a nursing home, the POC is updated based on the discharge summary of the sending facility and a new evaluation when appropriate. The new POC is sent to the Member and the PCP.

**Factor 4: How beneficiaries have access to personal health information to facilitate communication with providers in other health care settings.**

A copy of the Plan of Care (POC) is sent via mail, fax or via encrypted e-mail to the Member and PCP upon enrollment, upon completion of the assessment/POC review every 6 months, whenever there are substantive changes to the POC and upon request. Internal IDT members can access the POC through the electronic health record. Upon request and with Member approval, the POC will be available via mail or fax to external IDT members and specialty providers involved in the Members’ care.

The POC will contain the following information:

- Prioritized list of Member’s concerns, needs, and strengths;
- Attainable and measurable goals;
- Reasonable target dates for meeting the goals and outcome measures selected by the Member and/or caregiver;
- Interventions and services to be implemented and the individual/provider responsible for the intervention;
- Amount and frequency of intervention or service, including beginning/end date;
- Progress towards meeting goals including and barriers toward attainment of goals;
- Member’s informal support network and services;
- Member’s need for and plan to access community resources and non-covered services;
• Member choice of services (including self-direction);
• Member choice of service providers;
• IDT service planning, coverage determinations, care coordination and care management are delineated; and
• Individualized back-up plans.

The Member Handbook also documents member rights and responsibilities including the right to receive a copy of their medical records and ask that the records be amended or corrected. Members at a minimum are informed of their rights during the enrollment process and annually through the Member Handbook /Evidence of Coverage.

**Factor 5: How beneficiaries and/or caregivers will be educated about the beneficiary’s health status to foster appropriate self-management activities**

During the development of the Plan of Care (POC), the Care Manager (CM) and the Member establish goals based on identified problems. These goals will include areas where the Member and/or care giver can learn to manage health problems independently. It can include areas such as recording daily weights to identify early signs of CHF or keeping the floor clear of clutter and keeping lights on to prevent falls. The CM/IDT will review progress toward these goals minimally on a monthly basis.

**Preventing Unplanned Transitions of Care**

1. CM/IDT is responsible for identifying those members who are at high-risk of unplanned transitions.
2. Identification of at risk members can be accomplished through but not limited to the following:
   a. Telephone assessments
   b. Provider or caregiver reports /concerns
   c. Increase in number of complaints /incidents/personnel changes
   d. In-home assessment (interim or Semi-Annual)
   e. Utilization/claims reports
3. The following factors may be indicators for risk of unplanned transitions of care:
   a. Frequent ER visits
   b. Recurring hospitalizations
   c. Increase in MD visits
   d. Caregiver stress/inconsistency of care
   e. Recurring falls
   f. Increasing signs of confusion /cognitive impairment
   g. Member/Caregiver confusion regarding Member medication regimen;
   h. Incomplete knowledge of signs and symptoms to report and how to respond to such changes; and/or
   i. Noncompliance with treatment regimen
4. Upon identification of potential risk of unplanned transition the CM/IDT will:
a. Arrange for in home assessment of the member and the environment by the following as appropriate:
   i. The Plan Assessment RN
   ii. The Plan Certified Occupational Therapy Assistant (COTA)
   iii. Certified Home Health Agency (CHHA)
   iv. Rehabilitation therapist
   v. Social Worker
b. Use the assessments to develop self management goals that are incorporated into the POC and are followed during monthly contacts.
c. Notify PCP/MD of CM/IDT assessment/concerns and discuss adjustments to POC
d. Arrange for further evaluation by medical professionals as appropriate;
e. Discuss concerns and action plan with Member/Caregiver for preventing unplanned transitions and implications of such;
f. Identify educational needs of Member/Caregiver and implement training as appropriate; (include goal setting and problem solving strategies and support to reduce likelihood of a crisis and improve health outcomes).
g. Implement necessary services /adjustments to POC; and
h. Evaluate effectiveness of the POC in minimizing risk of unplanned transition.

Factor 6: Notification of Point of Contact: How the beneficiaries and/or caregivers are informed about the point of contact throughout the transition process.

Every member of GNG has a CM and an IDT. The member and caregivers are informed at the time of enrollment about the Plan, the IDT, the role of CM and contact information for the CM. Through ongoing contacts, the member/caregiver is reminded of their care team members and how to access anyone on the team. Throughout the transition of care, the CM remains the point of contact and ensures effective communication with facility personnel and member/caregiver.
MOC 3 Element A Network with Specialized Expertise

The organization must establish a provider network with specialized expertise that describes the following components of the network:

Factor 1: Specialized network: How providers with specialized expertise correspond to the target population identified in MOC1.

GuildNet Gold is a managed care plan created especially for beneficiaries who are elderly or disabled, indigent and who qualify as nursing home eligible but are living in the community. The group is ethnically diverse and members speak Spanish, Russian, Mandarin, Cantonese, and Creole among other languages. GuildNet Gold members will receive Medicaid and home and community based services. PCPs and specialists who are recruited into the network are educated about the population that GuildNet Gold serves. PCPs also receive a call from GuildNet Gold when they are chosen as a PCP by one of our members. GuildNet Gold sends providers a summary of the Model of Care when they start following one of our members. GuildNet Gold hires Care Managers who have experience with a geriatric and/or disabled population and are familiar with home and community-based services. The Care Managers understand the challenges of working with members with multiple chronic conditions without adequate financial resources and receiving home and community based services to allow them to stay at home safely.

GuildNet Gold, through its contract with EmblemHealth, contracts with facilities necessary for the care of our members including inpatient facilities, outpatient facilities, psychiatric and rehabilitation hospitals, skilled nursing facilities, dialysis facilities, laboratories and radiology/imaging facilities and also contracts with PCPs and medical specialists that are specific to the needs of our population. Specifically, there is an extensive network of geriatricians, internal medicine providers and family practice doctors. There are also providers that have expertise in treating the HIV population. Specialty services include: allergy and immunology, ambulatory surgery, cardiology, chiropractor, dermatology, dentistry, ENT, endocrinology, gastroenterology, general surgery, gynecology, hematology, infectious disease, nephrology, neurology, oncology, ophthalmology, orthopedics, pain management, physical medicine and rehabilitation, podiatry, pulmonology, radiation oncology, rheumatology, and vascular surgery. EmblemHealth contracts with behavioral health and mental health specialists and clinical psychologists through Beacon Health Options and these providers serve GuildNet members. There are also contracts with drug and alcohol counselors and various physicians who specialize in diabetes who employ nurse educators. Other specialties include physical therapists, occupational therapists, speech pathologists, podiatrists, certified home care agencies, radiologists, laboratory specialists, and pharmacists.

EmblemHealth has a contract with Express Scripts (ESI) who contract with an extensive network that meets all regulatory requirements. The pharmacy network offers many options to GuildNet members. The retail network consists of chain and independent pharmacies in the service area as well as pharmacies throughout the country. Pharmacies are located in areas accessible to the GuildNet Gold membership. There is also a mail order pharmacy option and a contracted...
pharmacy (Avanti) that will deliver medication packaged in daily doses to members’ homes if they so choose or if it is necessary to help assure proper medication adherence. Pharmacists review medications for all members qualifying for the medication therapy management program (MTMP).

All physicians are in contact with the Care Managers and physician claims data is examined when GuildNet Gold is looking at care delivery in terms of quality measures. Members must change to an in-network provider and Member Services Representatives will assist in finding an appropriate alternative provider for the member.

GuildNet Gold has an extensive network for Medicaid covered services: including Licensed Home Care, Outpatient and in-home Physical, Occupational and Speech therapy, Adult Day Health Care durable medical equipment suppliers, dental and vision care providers for Medicaid-covered as well as transportation vendors for non-emergency medical transportation,

Our Provider Relations Department is responsible for developing and maintaining the network of providers and assuring the network includes providers for all covered Medicaid Services. The department monitors the performance of providers through audits and feedback from members.

**Factor 2: Licensure and certification: How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.**

There is a rigorous credentialing process that assures that all contracted providers meet the organization’s standards and are able to participate in Medicare programs. GuildNet has delegated credentialing of Medicare providers to EmblemHealth for their GHI network of medical providers. GuildNet Gold has a Credentialing Committee that has responsibility and authority to review the credentials of providers of Medicaid services.

GuildNet credentials Medicaid providers including but not limited to: licensed home care agencies, skilled nursing facilities for long term Medicaid stays, dentists (through HealthPlex) non-emergency medical transportation, nutrition services including meals on wheels, Adult Day Health Care, Social Day Care, Social and Environmental Supports and Personal Emergency Response Systems (PERS). GuildNet has a credentialing process for Medicaid providers that reviews and validates education, licensure, competence and exclusions as listed below

First tier and second tier entities credential providers in their particular networks. First tier entities include EmblemHealth for medical services and facility contracts, and HealthPlex for dental services.

Second tier entities include Beacon Health Options, which credentials psychiatric and substance abuse providers, Express Scripts, which credentials pharmacy providers and Davis Vision, which credentials optometrists and opticians. EmblemHealth monitors the performance of second tier entities although reports on delegated oversight are evaluated by the GuildNet Delegated Oversight Committee.
Medicaid providers are credentialed by GuildNet or by a delegated entity that is monitored by the GuildNet Delegated Oversight Committee. Credentialing occurs upon initial application to the program and providers are re-credentialed every 3 years thereafter. All providers are held to the same credentialing standards. Providers are considered without regard to race, creed, color, gender, age, sexual orientation, national origin or handicap, unless the latter affects the ability of the practitioner to provide quality healthcare.

Providers are required to provide evidence of education, licensure, and insurance and are checked against the exclusion list upon initial credentialing and monthly thereafter.

EmblemHealth has an extensive credentialing and re-credentialing program for providers and facilities, which examine licensing, education, continuing education, board certification, insurance, exclusions, work history and admitting privileges as required.

**Factor 3: Licensure and Certification: How the SNP document, updates and maintains accurate provider information.**

GuildNet maintains the most up-to-date information on its contracted and delegated Providers to ensure accurate reporting and on-line search results. GuildNet has a data base of all providers. Providers are advised that they have to contact GuildNet if any of their information or demographics change. GuildNet publishes a directory of all providers, but a more up-to-date version is available on line.

Each new practitioner, facility and ancillary provider is required to complete an application which asks for demographic information. The data from this application is used to enter information into the plan’s databases.

On a quarterly basis, EmblemHealth sends out the current information in its files, to each of the facility and ancillary vendors for their review. All responses are used to update the plan’s databases.

Every three years, practitioners, facility and ancillary providers are subject to recredentialing. As part of this process they are required to complete a recredentialing application which captures demographic information and ADA requirements which is used to update the plan’s databases.

The Vendor database is updated on a daily basis. Updates may be due to changes to existing Provider information after receipt of a fax, email or mailed correspondence and/or to add new Participating Provider information.

Periodically, the Plan will conduct a survey and will request that demographic and accessibility requirement information be verified as part of the process. All responses are used to update the plan’s database.

**Factor 4: Collaboration with the IDT: How providers collaborate with the IDT and contribute to a beneficiary’s POC to provide necessary specialized services.**
The IDT is the basis of the Model of Care. All providers are informed about the Model of Care. Providers are also educated about communication between providers in the Provider Manual. The Provider Manual includes information about physician collaboration. These collaborative relationships include:

- Development and implementation of member-specific care plans, using evidence-based treatment regimens that will be coordinated by the physician and Care Manager;
- Communication between PCPs and specialists regarding diagnosis, further treatment, testing and follow-up;
- Patient and caregiver education, focused on supporting self management and monitoring; and
- Care Manager feedback to physicians regarding patient status and clinical needs.

The Care Manager directs the activities of the IDT. The CM identifies the initial members of the team (which may include the PCP, member and relevant specialists and informal caregivers if appropriate). After the initial assessments are completed, the Care Manager will contact IDT members via telephone. Information will be conveyed through faxed, mailed or electronic copies of the Plan of Care (POC). The CM incorporates all the problems, goals and interventions into the POC and will adjust the POC as necessary as a result of the collaboration. When the POC is completed, the CM or designee sends a copy, via mail, fax, or email to all members of the team. The Care Manager is the center of the IDT communication process. With the help of internal members of the IDT, the CM will assist members in making appointments and arranging transportation for visits. The CM/IDT will follow up on consultations to ensure the member made it to the appointment and that the consultant has sent a report of her findings. The CM will make changes to the POC based on new input from providers.

The Provider Manual states that specialists need to submit consultation reports to the PCP after seeing a GuildNet Gold member. The IDT will assist members in making appointments with a provider with the appropriate expertise who is accessible to the member. When a service is requested that requires authorization, the request is reviewed for medical necessity based on standard utilization management protocols. Depending on the nature of the request (Medicare or Medicaid) the UM department at EmblemHealth or GuildNet Gold use CMS guidelines, Interqual guidelines, national clinical standard of care guidelines, or New York State Department of Health approved guidelines for Medicaid services to evaluate the request. If the service does not meet the criteria, the request is referred to the Medical Director for review. The GuildNet Gold Medical Director or designee will review denials, and has the opportunity to consult with the provider to decide if the service is necessary and will benefit the member. For example, GuildNet Gold may provide additional services such as physical therapy to assist in falls prevention.

GuildNet Gold uses an electronic care plan, part of the electronic health record, for each member. All services and referrals are recorded in the electronic health record. The Care Manager contacts the physician if there is a change in condition as well as noting the service in the chart. The Care Manager/IDT creates a reminder in the system for follow-up on a given issue. The IDT follows up on service delivery to assure that it is scheduled promptly and makes sure that the service was delivered as expeditiously as required by the member’s health status. The Care Manager/IDT contacts the member and/or specialist after specialty service delivery to
determine what follow up is needed and will make sure that the follow up occurs promptly. Reports that are received from providers, facilities or home care agencies are saved in the electronic health record and are used to evaluate and update the POC.

The Care Manager will work with the Utilization Management (UM) Nurse who is doing prior authorization or concurrent review for members in another setting such as a hospital or a nursing home. The Care Manager will keep the IDT apprised of the member’s progress. When the member is being discharged home, the Care Manager will participate in the discharge planning and ensure the member receives appropriate follow-up.
MOC 3: Provider Network
Element B: Use of Clinical Practice Guidelines and Care Transition Protocols

The organization must oversee how network providers use evidence-based medicine, when appropriate, by;

Factor 1: Utilization of guidelines and protocols. Explaining the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to each SNP’s target population.

GuildNet Gold uses the EmblemHealth GHI network as its provider network. Emblem participating providers must comply with all applicable laws and licensing requirements. In addition, participating providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating providers must also comply with GuildNet Gold’s standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity);
- Guidelines by professional organizations such as the American Diabetes Association and the American Heart Association;
- All federal, state, and local laws regarding the conduct of their profession.

Providers are informed of the guidelines in the provider manual which has links to the guidelines as listed above.

GuildNet Gold monitors network provider utilization of clinical practice guidelines relating to its target population through clinical quality initiatives and HEDIS measures. GuildNet Gold reviews a sample of records on a scheduled basis to ensure that providers are using evidence based protocols to treat their patients. Reports are evaluated for some measures, such as dilated eye exams for diabetic members, annually and others, hgbA1c tests, biannually. Other reports, such as physician follow-up visits post-hospitalization and use of ACE and ARBs in members with diabetes and hypertension, are examined quarterly. GuildNet Gold examines the overall results for network and Point-of-Service providers separately. If there is any difference in the rates of compliance with clinical practice guidelines, GuildNet Gold analysts drill down to the provider level and the Provider Relations Department and/or the Medical Director contacts the provider to review the guidelines/protocols with the provider.

An EmblemHealth Quality Committee includes the GuildNet Gold Medical Director and reviews quality measures and HEDIS rates that indicate whether providers are following clinical practice guidelines. This Committee interacts with providers and discusses medical practice expectations when outliers are identified.

Case Managers and the ICT will use national evidence based guidelines when they are creating the Care Plan. As part of the routine monitoring provided by the ICT, markers of nationally accepted guidelines will be monitored such as routine preventive tests and drug
compliance. The ICT will arrange for appointments and transportation for podiatric visits for diabetics for example and will share results of the visit with the ICT.

Factor 2: Exceptions to guidelines. Identifying challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries.

GuildNet Gold has mechanisms in place to identify challenges where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries with complex health care needs.

Providers communicate with the IDT, EmblemHealth, the Quality Assurance and Performance Improvement (QAPI) and the Utilization Management (UM) departments at GuildNet Gold when they identify situations where current clinical practice guidelines and nationally recognized protocols fail to apply to, or meet the needs of, the Plans’ vulnerable beneficiaries. The providers’ concerns are addressed promptly by the appropriate department/(s) (Provider Relations, QAPI, UM, and/or EmblemHealth) on an individual basis and then the Plan determines if global changes to practice guidelines and protocols are required through GuildNet Gold’s Clinical Operations committee and EmblemHealth’s Health Status Improvement Committee.

GuildNet Gold’s Utilization Management (UM) department reviews provider and beneficiary requests for items and services. During these reviews, the UM department identifies challenges where the unique needs of the Plan’s medically complex beneficiaries cannot be sufficiently be met by current clinical practice guidelines and protocols. The UM staff can respond immediately to an individual member’s situation and make exceptions to provide the appropriate services. The UM department then communicates these challenges to the Clinical Operation committee. The clinicians on this committee address these challenges and are authorized to make permanent modification to guidelines and protocols.

GuildNet Gold’s Quality Assurance and Performance Improvement (QAPI) department logs beneficiary complaints and grievances. As these logs are analyzed, individual cases and/or trends are identified that demonstrate a need for clinical practice guidelines and/or nationally recognized protocols to be modified because the guidelines/protocols do not adequately address the complex medical needs of the SNP beneficiaries. The QAPI department conveys this information to the Medicare Inter-departmental committee and Clinical Operation committee at GuildNet Gold and the Health Status Improvement Committee at EmblemHealth for these committees to amend the clinical practice guidelines and protocols as necessary.
Factor 3: Exceptions to guidelines: Providing details regarding how decision to modify clinical practice guidelines or nationally recognized protocols are made, incorporated in the POC, communicated to the IDT and acted upon by the IDT.

Clinical practice guidelines and nationally recognized protocols are reviewed on a standing basis as well as whenever necessary. (See above for examples of when the Plan is made aware that decisions to amend/ignore clinical practice guidelines/protocols arises) GuildNet Gold participates in EmblemHealth’s review of clinical practice guidelines every two (2) years with the exception of HIV/AIDS Clinical Guidelines which are updated annually. As noted above, ad hoc decisions to modify clinical practice guidelines/protocols arise based on beneficiary needs and can be addressed promptly by the Plan. Plan clinicians base the decision to modify guidelines/protocols on the needs of the beneficiary, determinations of medical necessity, an assessment of the current state of medical literature, and their clinical judgment and experience.

Changes to clinical practice guidelines and nationally recognized protocols are incorporated into the patient’s POC and communicated with the IDT and acted on by the patient’s IDT or by other providers whenever;

- The change relates to the current care/service/item they are receiving
- During the semi-annual Care Plan review

This communication can be verbal or written. If verbal notification is given, a written copy is also provided. Clinical practice guidelines, and their updates/modifications, are distributed to providers via the Provider Manual, the EmblemHealth website, the GuildNet website and notices in the provider newsletter. Once new guidelines/protocols are approved, Provider Relations is informed and the information is retained for inclusion in future editions of the Provider Manual. These updates are also posted on the website. GuildNet Gold’s QAPI department is able to perform focused audits to ensure that the changes made to clinical practice guidelines/protocols have been implemented and the beneficiary’s health care needs are being adequately met.

Factor 4: Care Transition Protocols: describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.

The Case Manager is the communication hub for the IDT and in that role ensures that SNP providers are using transition of care protocols to manage members.

Network providers are required to adhere to the terms and conditions of contracts with GNG and EmblemHealth. Providers agree to abide by the Quality Improvement, Utilization Management, Claims Submission and other applicable rules, policies and procedures including those related to Transitions of Care.

GuildNet Gold uses the EmblemHealth GHI HMO network as its provider network for Medicare services. EmblemHealth participating providers must comply with all applicable laws and licensing requirements. GuildNet Gold holds contracts directly with
Medicaid providers. All providers are educated about the GuildNet Gold Plan as well as the Model of Care.

Participating providers must comply with GuildNet Gold policies and procedures regarding the following:
- Model of Care requirements;
- Pre-authorization and notification requirements and timeframes;
- Participating provider credentialing requirements;
- Case Management process and participation on the Interdisciplinary Care Team;
- Appropriate release of inpatient and outpatient utilization and outcomes information;
- Accessibility of member medical record information to fulfill the business and clinical needs of GuildNet Gold;
- Cooperating with efforts to assure appropriate levels of care;
- Maintaining a collegial and professional relationship with GuildNet Gold personnel and fellow participating providers;
- Providing equal access and treatment to all GuildNet Gold members; and
- Using evidence based medicine to develop in-office protocols and treatment plans for common diagnoses.

GuildNet Gold Case Managers (CMs) follow the Member through the transitions process to ensure smooth transition for the particular any service including but not limited to transfers to facilities, home, homecare, ADHC and Social daycare. For example, the CM is in touch with the receiving facility during an admission and starts the discharge planning process at the time of admission. The Plan sends information about the Member to the receiving facility to assist in the coordination of care. Once a member leaves a facility to return home or be admitted to a SNF, the CM reassesses the member and works with the PCP and other members of the IDT to update the POC. The CMs send a copy of the updated POC to the PCP the Member. The CM ensures that all necessary services are authorized for the Member prior to the return home or to another facility.

The IDT also assists the Member in making follow-up appointments ensuring the Member has transportation to the appointment and then contacting the Member to verify that the appointment was kept.
MOC 3: Provider Network

Element C MOC Training for the Provider Network

The organization’s description of oversight of provider network training on the MOC must include:

1. Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.

All contracted and delegated providers receive annual training Model of Care training through multiple modalities (including but not limited to web-based, self-study, phone and office/trainer led).

- Newly contracted providers receive Model of Care training during the initial orientation.

On an annual basis, contracted and delegated providers receive a web-blast notifying them of training.

Medicaid Provider Training

GuildNet requires that all providers receive Model of Care (MOC) training. GuildNet’s Provider Relations Department will include MOC Training in their credentialing process and will track and insure that Vendors receive the MOC information and access to the GuildNet MOC training and annual training updates on the GuildNet website. The Provider Relations Department shall maintain a tracking tool and provide an annual report to the SVP of QAPI of the training compliance of the contracted Vendors.

Providers will be trained on the elements of the MOC, how the MOC works and how to access services from GuildNet. Providers will be instructed that the MOC training for providers is posted on the GuildNet website and that information is updated annually. An annual update of the changes in the MOC will be posted on the GuildNet website and the Vendor will be responsible for checking this information annually. An email blast to all Vendors will be sent when the MOC training is updated on the website, generally in the fall of each year.

Medicare Provider Training

The provider training describes the regulatory requirements and the specifics of GuildNet Gold’s MOC. There is a link on the GuildNet website as well as on the EmblemHealth website that links to the training. An outreach call is placed to our member’s PCP that provides information about the program and the MOC. The PCP also receives a letter upon their member’s enrollment explaining their role and responsibilities to the member and also a brief description of the GuildNet MOC with a link to our website for their convenience. The web site contains the complete training materials and a copy of the MOC. Annually, GuildNet Gold will direct providers to the web site where the full MOC will be posted. When a new provider begins seeing
a member regularly, the CM will inform the provider relations team who will contact that provider with the training information.

2. Documenting evidence that the organization makes available and offers training on the MOC to network providers.

Ongoing compliance with GuildNet Gold Model of Care training is monitored and tracked.

- Delegated providers are required to monitor and provide a tracking tool that will be reviewed quarterly by GuildNet’s Delegated Oversight Committee.
- Provider Relations shall maintain a tracking tool and provide an annual report to the Senior Vice President of Quality Assurance and Performance Improvement of the training compliance of the contracted Vendors.

The VP of Business Development presents a report of contracted Vendors compliance with the MOC training based on filed attestations. The SVP of QAPI reviews this report with the VP of Business Development. The Provider Relations department tracks attestations that training has been completed by paper, on line and verbally. If a provider has not attested to training, the Provider Relations department will follow up by mail.

The Medicare Services Department tracks that medical providers have been contacted and received a summary of the Plan as well as the summary MOC document. Providers will be directed to the GuildNet web site to view the complete MOC and MOC training. The department will review the tracking spreadsheet and follow up with any providers who have not been contacted.

3. Explaining challenges associated with the completion of MOC training for providers.

Some providers only see one or two GuildNet Gold members and do not want to take the time to review the complete training. Other providers work with numerous SNPs and find the training repetitious. Providers in clinics and busy practices can be difficult to reach. As a result, GuildNet has developed a process that is flexible to try to meet the providers’ needs. GuildNet reaches out to each office individually for every member. If the provider is not available, the office staff is given the information about training. Training can be accomplished on-line, in person, by telephone or on paper depending on the preference of the provider. GuildNet requests an attestation on paper, on-line or verbally to indicate that the training was done. PCPs have regular contact with the CMs and learn about the MOC through direct participation in the care planning process.

4. Taking action when the required MOC training is deficient or has not been completed.

Providers that are not in compliance with training will be mailed a copy of the MOC presentation and a cover letter requesting that they complete the training within one (1) month and return the signed training attestation. The Provider can also request a face-to-face training
session. Vendor agencies that do not complete the training within the extension provided will be sanctioned, and may be removed from the network, and members can be reassigned to another vendor.

GuildNet will make every effort to have providers complete the training. If a provider refuses to complete the training and cooperate with the program of care coordination, the Plan will discuss the situation with the Member and see if the Member will change to another provider.
MOC 4: MOC Quality Measurement and Performance Improvement

Element A: MOC Quality Performance Plan

The organization must develop a MOC quality performance improvement plan that:

1. **Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs.**

The goal of the performance improvement and quality measurement plan is to improve GuildNet Gold’s ability to deliver high-quality health services and benefits to its dual eligible SNP beneficiaries. GuildNet will evaluate the effectiveness of the GuildNet Gold Model of Care through the use of clinical indicators and outcome measures targeted to the unique needs of our population and vulnerable membership. The most vulnerable population is defined as the following: members who have 3 or more hospitalizations within a 6 month period; any member who has a hospital admission for a mental health diagnosis; members in need of palliative/hospice care, confirmed by the treating MD; or members newly diagnosed with a severe/profound or total vision loss.

Data for these indicators and measures will come from the Quality Assurance Performance Improvement (QAPI) Program, including but not limited to, targeted studies, utilization data, claims data, surveys, complaints and grievances, network performance analysis, and other data collection mechanisms, such as, CMS and NYS DOH reports. Indicators and measures will be evaluated and revised as needed and new indicators and measures may be identified that enhance evaluation of the effectiveness of the Model of Care. The outcome of the analyses of indicators and measures may be used to realign GuildNet Gold’s Case Management activities, implement processes to improve clinical outcomes, and realign business processes found to negatively impact quality or access to care. Corrective Action Plans (CAP) will be implemented when indicated.

GuildNet will review the progress that has been made toward meeting the goals of the GuildNet Gold Model of Care and will review issues related to the Model of Care structure, provider network, and communications mechanisms. This will be completed via the Medicare Interdepartmental Committee (Committee), at least quarterly. The Committee will review each goal of the Model of Care and monitor the corresponding performance measures which will be compiled by the Quality Assurance and Performance Improvement (QAPI) department in conjunction with the Medicare Services department. The Committee will also make recommendations for improvement and implement CAPs as needed.

An Annual Evaluation will be performed to assess whether Model of Care goals, objectives and outcomes remain effective and meaningful; to recognize the accomplishments of the previous year; and to make recommendations for the coming years’ Model of Care goals and oversight activities.
2. Describes specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance.

Data Management
Through knowledge gained on current levels of performance, GuildNet Gold will be able to convert raw data into useful information that facilitates decisions about the need to redesign activities or processes, the degree of variance of current processes, the effects of previous improvement activities, and the identification of opportunities for improvement.

The Information Technology Systems Department of Lighthouse Guild will partner with GuildNet Gold to ensure data driven decision-making is integrated throughout GuildNet QAPI processes. The ability to extract and analyze data is integral to the QAPI Program and oversight of the Model of Care.

A systematic process for comparing significant data related to the care and/or service processes and outcomes and personnel will be employed. Appropriate staff of GuildNet Gold, i.e., will meet regularly with the Information Technology Systems Department to identify quality indicators and create system reports as follows:

- Statistical data
- Demographic data
- Financial data
- Event data
- Tracking for reassessment
- Tracking recertification
- Member hospital days

All GuildNet Gold Protected Health Information (PHI) will be protected in compliance with current HIPAA regulations and with the policies of Lighthouse Guild to:

- Promote data validity
- Data confidentiality
- Data security
- Data availability

Sources of data for each indicator used by the QAPI Committee will include but not be limited to:

- Member satisfaction surveys
- Grievances and Appeals
- Clinical record reviews
- Clinical, health and social data
- Assessment data
- Claims and Encounter data
- Enrollment and Disenrollment data
All GuildNet Gold member assessment data will be maintained in a computer database that is accessible to approved personnel for data assessment/performance improvement purposes. The specific data will indicate performance, including but not limited to, the following functions:

- timeliness of care plan implementation,
- adherence to care plan and frequency of updates,
- adherence to screening and assessment criteria,
- provider accessibility and environmental standards,
- tracking, investigating, reporting and recommendations regarding adverse patient care outcomes in all covered services,
- timeliness, appropriateness, and quality of services provided,
- member satisfaction,
- hospital admissions and re-admissions, emergency room utilization, and
- nursing home admissions.

**Internal Quality Improvement Activities**

To ensure oversight of the Model of Care and continuous quality improvement of services, care, and operations, ongoing quality improvement activities will be in place for GuildNet Gold. QAPI will maintain several data dashboards that will contain data from all QAPI activities related to the oversight of health outcomes and the Model of Care. The dashboards will be updated monthly, quarterly and annually. Below, is a description of these QAPI activities.

**Health Outcomes and Quality Measures**

QAPI staff will conduct audits, collect data and monitor health outcome and quality measures on a day to day basis, at a member specific level, using information maintained in the electronic health record and other sources. QAPI staff will review all grievances, serious injury as a result of a fall, and hospitalizations and evaluate the impact on the member. QAPI staff will work with Case Management staff to develop and implement the appropriate intervention for the member, and monitor the implementation and outcome, modifying interventions as necessary. Interventions will be designed to continuously improve health outcomes. These dashboards will be available for review by CMS and other regulators.

**Access to Care and Services**

The adequacy of the provider network will be evaluated on an ongoing basis to ensure that members have access to the care they need. Annually, a geoaccess evaluation based on specialty will be completed and presented to the QIC for consideration. To evaluate adequacy of the provider network, QAPI staff will conduct a monthly analysis of complaints filed by members and/or their representatives to identify deficiencies in the provider network. This analysis will be reviewed by the Quality Improvement Committee (QIC). If the analysis indicates issues with accessing specific providers or services, QAPI staff will work with Provider Relations and Medicare Services to develop and implement a CAP. This may include adding providers to the network, or working with individual providers to improve their performance. Data reported to Provider Relations will be considered during the re-credentialing process. These data will be documented in the Health Outcomes and Quality Measures dashboard and be available for review by CMS and other regulators.
Member Satisfaction
The QAPI department or designated vendor will conduct an annual member satisfaction survey. The purpose of the survey will be to measure satisfaction with the health plan and to identify opportunities for improvement. The topics covered by the survey may include satisfaction with Plan Services, Utilization Management, Customer Service, Case Managers, Vendor Services and Provider Relations. Appropriate sampling methodology will be used.

The plan will target a satisfaction rate of 80% in all categories surveyed. If the satisfaction rate for any area is below 80%, the plan, the QAPI Committee and/or QIC will develop strategies to improve satisfaction. Member satisfaction surveys will be maintained by the plan and be available for review by CMS and other regulators.

Process Improvements
GuildNet Gold is committed to improving the quality of the services delivered to both internal and external customers. To this end, the organization will continuously pursue process improvements that affect the plan’s ability to have productive and satisfying interactions with members and providers. Each year the plan will select one or more business process as its focus for improvement. The QAPI Committee will identify these activities through analysis of complaints and appeals, member satisfaction surveys, provider satisfaction surveys and key business indicators.

Complaints/Grievances
All complaints/grievances, including quality of care complaints, will be recorded in a database, monitored, tracked and analyzed. Summary by complaint type will be reported to the QAPI Committee. Where issues are identified, the QAPI Committee and the QIC will develop strategies to improve performance in the area(s) with a high complaint rate. This may include the formulation of workgroups to look at specific issues, modifications to the provider network, and changes to business practices. These data will be documented in the Health Outcomes and Quality Measures dashboard and be reported quarterly to the NYSDOH. This information will be available for review by CMS and other regulators.

Ensuring Appropriateness of Care
GuildNet Gold will perform various quality improvement activities to evaluate the quality and appropriateness of care.

- The QAPI department will conduct audits of the clinical information maintained in the member’s electronic health record to ensure that the plan documents, provides and/or arranges for the appropriate interventions to address identified health risks. The results of these audits will be shared with Case Management staff. Where deficiencies are noted, QAPI staff in conjunction with Case Management will develop strategies to improve performance. This may include re-educating/training staff. Results of audits will be documented, maintained by the Director, Quality Assurance and Performance Improvement and presented to the QI Committee and QAPI Committee. Documentation will be available for review by CMS.
EmblemHealth on behalf of GuildNet Gold will evaluate services delivered by GHI network providers through review of provider performance data. This information will be aggregated and considered during the re-credentialing process. Provider office site and medical record keeping reviews will be conducted at the time of the initial application for all Primary Care Physicians (PCPs) and high volume practitioners to evaluate the office site and medical record keeping practices. EmblemHealth maintains documentation of site visits and their evaluation of providers. This information is reviewed by the Delegated Oversight Committee at GuildNet. This information will be available for review by CMS.

**Patient Safety**

Patient safety activities are conducted through the QAPI department and are reported at the GuildNet QAPI Committee meeting. Some of these activities include identifying, addressing, then tracking and trending of clinical and service complaints to determine rates of patient safety complaints, and participating in the vendor oversight activities. 100% of Clinical Quality grievances are reviewed and appropriate action taken to ensure member safety.

**Quality Improvement Projects/Studies**

Quality Improvement Studies, either clinical or service, will be used to evaluate the current state of the model of care and to improve any areas of opportunity through specific and targeted interventions. These areas of opportunity may be identified within GuildNet or by outside entities such as auditors from City, State and/or Federal agencies.

The following outlines the process by which a clinical or service study will be conducted in order to assure that the study is performed in a standardized and methodical manner. Through the utilization of the quality improvement process, meaningful data will be obtained which in turn will be used to identify areas of opportunity, interventions and problem resolution.

- An area of concern is identified through data analysis. This may be either of clinical or service origin and should be relevant and of importance to the quality of care or utilization of services provided to members of all GuildNet Gold.

- The topic identified will be reviewed with the appropriate department head and the Medical Director. If consensus is obtained, the study is outlined and the proposed study is presented to the QIC and/or the Clinical Operations Committee (COC) for review, comment and approval. The study outline will:
  - identify the rationale for the study
  - identify the area of opportunity
  - identify the affected population
  - define the sample size and methodology
  - identify the performance indicator(s) that will be addressed by the study
  - identify the performance goals and benchmarks when available
  - specify the data collection type and process
  - detail the timeframe for data collection, intervention, analysis and re-measurement
include appropriate barrier analysis and/or limitations of the study
include quantitative and/or statistical analysis

- The study will have parameters regarding all of the elements noted above and will be expanded into a recognized standardized study format as recommended by State, Federal or accrediting entities. The initial data will be analyzed and appropriate interventions will be developed by a multidisciplinary team. Interventions may be either targeted or population-based. Interventions will then be approved and implemented by the appropriate department or area.

- After sufficient time has passed to allow the interventions to be implemented, the effectiveness of these interventions will be assessed through re-measurement of the data using the same methodology as in the initial data collection. The results will then be compared to the performance goals and benchmarks, and the goals revised if necessary. If the expected improvement is not noted upon re-measurement, the multidisciplinary team will meet again to discuss possible barriers to improvement. At this time, it may be decided to continue with the original interventions, revise these interventions or develop new interventions. Re-measurements will take place per the continuous quality improvement cycle until either the performance goal is reached or the decision is made by senior management and the QIC or COC that the study is no longer appropriate.

- Final Quality Improvement Study results will be documented and presented to the GuildNet QAPI Committee. Results will be subsequently reported by the Sr. Vice President of Quality Assurance up to the GuildNet Board of Directors through the Regulatory and Compliance Committee, which is a subcommittee of the GuildNet Board of Directors.

3. Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.

The Performance Improvement Plan adopted by the GuildNet Board of Directors will be implemented on an organization wide basis led by the Medical Director. The QAPI Committee (Internal and External) led by the Medical Director will identify, and prioritize performance improvement activities with consideration of:

- developing opportunities to improve the important functions of the GuildNet Gold Model of Care
- the needs and expectations of the members, staff, providers, and other interested parties
- areas selected as high volume, high risk, or problem prone
- areas of quality control
- resources required for improvement
- GuildNet's mission.

Performance Improvement Activities may be identified by the External QAPI Committee or Internal QAPI Subcommittees. Internal QAPI subcommittees will be comprised of GuildNet Gold Staff and consultants with direct access to PHI (Personal Healthcare Information). The Quarterly QAPI Committee will be comprised of both, GuildNet and non-GuildNet staff, and community
representatives. Note: Information and data will be aggregated will not be presented by member or by vendor. Performance improvement activities for the Model of Care defined by the Committee will describe:

- expected impact of the activity on a relevant dimension of care
- performance expectations of the activity
- performance measure for the activity
- input of staff who are close to the area affected
- assignment of responsibility at the appropriate staff level or with the appropriate person to implement the recommendation(s)
- assignment of appropriate subcontractor to implement performance improvement recommendations.

Activities completed by the Performance Improvement process may result in:

- changes in orientation or in-service training programs
- changes in policies and procedures
- modifications in the way services are delivered
- increase/decrease in the services provided
- personnel changes
- provider/subcontractor changes.

All performance improvement activities will be monitored for effectiveness in meeting the predetermined expectations. If an activity fails to meet the defined expectation, a new activity will be developed.

The Board:
GuildNet is a subsidiary of Lighthouse Guild. Lighthouse Guild’s Board of Directors (Board), maintains ultimate accountability for oversight of the QAPI program and the GuildNet Gold Model of Care which will be reviewed and approved at least annually. The Board will receive reports on QAPI and Model of Care activities through the Regulatory Oversight and Quality Assurance Committee, which is a subcommittee of the Board.

Medical Director
The Medical Director is the person responsible for administration of the QAPI program. The Medical Director, in conjunction with the Director, Quality Assurance and Performance Improvement, provides day-to-day oversight of the QAPI Program and its implementation, including ensuring that recommendations of the QAPI Committee are implemented.

Senior Vice President, Quality Assurance and Performance Improvement
The Senior Vice President of Quality Assurance and Performance Improvement will be responsible for development, implementation, integration and management of all quality assurance
performance improvement, reassessment and staff development activities within the GuildNet Gold Plan. Also functions as the Compliance Representative of the Managed Long Term Care.

The Senior Vice President of Quality Assurance and Performance Improvement will prepare and submit an Annual Report approved by the Medical Director to the GuildNet Board of Trustees. A written summary of performance improvement activities will be incorporated into the GuildNet annual report. The Annual Report will include but is not limited to the following:

- Aggregate Service Data for all care settings and service provided.
- Aggregate overview of grievances, incidents, surveys, and record reviews.
- Descriptions of:
  - overall GuildNet performance,
  - priorities established,
  - performance indicators,
  - performance improvement activities implemented,
  - staff Education completed, planned or needed,
  - communication systems, and
  - changes to the QA systems/processes made or needed.

**Director, Quality Assurance and Performance Improvement**

The Director, Quality Assurance and Performance Improvement, who reports to the Senior Vice President of Quality Improvement, supervises the staff that conducts quality audits and studies, and oversees QIPs and CCIPs. In addition, the Director, Quality Assurance and Performance Improvement will be responsible for:

- Communicating the decisions of the QAPI Committee to the appropriate personnel in the GuildNet organization;
- Overseeing the implementation of the performance improvement activities approved by the QAPI Committee;
- Collection of data necessary to determine the effectiveness of the performance improvement activity;
- Providing the QAPI Committee with information and analyses to assess the effectiveness of the implemented performance improvement activity;
- Reviewing performance and quality indicators, and the results of studies and audits, with the Medical Director; and
- Overseeing the QIC.

**Medicare Quality Assurance and Performance Improvement Specialist**

The Medicare Quality Assurance and Performance Improvement Specialist will be responsible for the collection, aggregation, analysis, and reporting of relevant clinical and utilization data related to the GuildNet Gold Plan. The data will be used to support program development, utilization of clinical resources, staff performance and clinical improvement activities. Additionally this position contributes to compliance with NYSDOH, Medicaid /Medicare regulations, as well as satisfying
requirements of accrediting organizations, and supports clinical improvement activities related to
the development, implementation, and monitoring of clinical guidelines and protocols.

**Senior Medicare Data Analyst**

The Senior Medicare Data Analyst will be responsible for the collection, aggregation, analysis and
reporting on data related to operational issues, utilization, finance and compliance with regulatory
requirements. The data will be used improve internal processes. The Medicare Data Analyst will
also compile data on internal audits and data received as part of delegated oversight.

On a quarterly basis, the staffs of the Medicare Services and QAPI Departments will compile data
used to evaluate the specific performance measures defined by the GuildNet Gold Model of Care. Data will be presented to the Medicare Interdepartmental Committee (Committee), which will be made up of Nurse Case Managers, Nurse Case Manager Supervisors and Directors, Assistant Vice Presidents of Case Management, Vice President of Case Management, the Chief Operations Officer of GuildNet, the Senior Vice President of Quality Improvement, the President of GuildNet, the Vice President of Business Development, and the staff of the Medicare Services department for evaluation of GuildNet Gold' progress toward meeting the established Model of Care goals. If an area of non-performance is identified, the Committee may assign a multi-disciplinary work group to look at the issue or may suggest changes to current processes. Recommendations made by the Committee will be implemented by the responsible departments and the effectiveness of the changes will be monitored as part of the quarterly review.

Annually, a subset of the Committee members, which will include at a minimum, senior leadership
of the Case Management, Medicare Services, Provider Relations and QAPI departments as well as the Medical Director and President of GuildNet, will perform a formal review of Model of Care goals and will evaluate their effectiveness by analyzing the plan’s performance against the measures established for each goal.

Based on the annual analysis and review, the Committee may decide the following with regard to
meeting one or more of the GuildNet Gold Model of Care goals:

- undertake quality initiatives/studies to improve performance;
- revise performance measures;
- revise operations/business practices or care management practices; and/or
- make changes to the provider network.

The results of the quarterly and annual reviews will be documented and presented to the GuildNet Quality Assurance Performance Improvement Committee. Results are subsequently reported by the Sr. Vice President of Quality Assurance Performance Improvement up to the GuildNet Board of Directors through the Regulatory and Compliance Committee, which is a subcommittee of the GuildNet Board of Directors.

**The Regulatory Oversight and Quality Assurance Committee:**

The Regulatory Oversight and Quality Assurance Committee will be a sub-committee of the Board
that reviews audits that are conducted by regulatory bodies or internal Quality Assurance
Departments. This Committee will meet semi-annually or as needed. The Senior Vice President of Quality Improvement will make regular reports to the Regulatory Oversight and Quality Assurance Committee on the status of the QAPI program and activities.

**The QAPI Committee:**
The Board will appoint a QAPI Committee (Committee) that will be responsible for developing the QAPI program. The program will be evaluated and revised at least annually by the Committee. The Committee, will be made up of staff from the QAPI department, key operations areas, and will be led by the Medical Director, in coordination with the President and the Senior Vice President of Quality Improvement. Providers will participate on the Committee, as well as a member representative. Meetings will be held quarterly, and minutes of these meeting are documented and shared with the Regulatory Oversight and Quality Assurance Committee, and with the Board itself. QAPI meeting minutes will include: discussions by participating providers, committee decisions, actions, review of QAPI activities, barriers to achieving goals. Attendance sheets for each Quality Assurance Performance Improvement Committee meeting will also be maintained.

The Committee will develop and oversee the implementation of the QAPI program. It will approve the quality goals for the year, and determine which studies and audits will be conducted. The Committee will review quality and performance indicators, oversee clinical policy and procedure development, review the results of quality studies and audits, and make recommendations to improve quality of services and operations based on the information it reviews. This may include revisions to policy or procedures, changes in service delivery, or the formulation of workgroups to look at issues in more depth.

The results of studies and audits, and quality/performance indicators will be presented to the Committee by the Director, Quality Assurance and Performance Improvement/designee. Other GuildNet staff, including Case Management, Provider Relations, and Medicare Services will make reports to the Committee on quality related issues identified as the result of day-to-day operations. Workgroups assigned to study quality related issues will also make reports to the Committee, as do representatives of member focus groups which will be formulated to address improved services to members.

**Other Quality Improvement Sub-Committees**

**Quality Improvement Committee (QIC)**
Led by the Director, Quality Assurance Performance Improvement, the QIC will be a working committee responsible for collecting, analyzing, and integrating data reported to the QAPI Committee. The membership will include but not be limited to Quality Improvement department staff and other GuildNet Departments staff, as needed. Reports from the Delegation Oversight Committee are presented at the QIC meetings. The QIC will meet a minimum of eight times per year and ad hoc as needed. Meeting minutes will be taken and maintained.
As applicable to the product line, the Committee will:

- identify areas of needed quality improvement through analysis of quality indicators, results of quality studies and audits;
- develop, analyze, trend, and monitor quality indicators;
- analyze the results of Satisfaction Surveys and clinical quality improvement programs/studies/audits, disenrollment trends, and quality indicators;
- target interventions, monitor process improvements, and establish tracking mechanisms;
- evaluate the effectiveness of communication to providers and Members;
- evaluate complaints and appeal data;
- provide in-depth analyses together with plans of action to affect improvement;
- be responsible for the submission of HEDIS, Chronic Care Improvement Project (CCIP), Quality Improvement Performance(s) (QIP); and
- report findings of all activities to the QAPI Committee through the Director, Quality Assurance and Performance Improvement.

**GuildNet Clinical Operations Committee (COC)**

The COC will be made up of senior GuildNet management staff including the Chief Operations Officer of GuildNet, the Senior Vice President of Quality Improvement, the Director, Quality Assurance and Performance Improvement, the Vice President of Case Management, the Assistant Vice President of Medicare Services, the Vice President of Business Development, the Senior Vice President of Intake, the Medical Director, and case management staff. Case Management participants will represent the Interdisciplinary Care Team members and GuildNet members. The COC will review the data and analyses conducted by the QIC and evaluate the QAPI program and Model of Care effectiveness. The COC will make recommendation to improve quality and develop the performance improvement projects and priorities for the year.

**GuildNet Compliance Committee:**

The Compliance Committee will consist of senior and executive level GuildNet staff, the Lighthouse Guild Compliance Officer, Vice President of Finance, and Director of IT. GuildNet Compliance Committee will have a delegation oversight program in place, and through this program quality related issues may be identified. These issues will be brought back to the Committee by the Senior Vice President of Quality Improvement who is a member of the Compliance Committee. The Compliance Committee will meet quarterly and minutes will be recorded and maintained.

**GuildNet MOC Oversight Committee (Medicare Interdepartmental Committee):**

The Model of Care Oversight Committee (Committee) will be made up of Nurse Case Managers, Nurse Case Manager Supervisors and Directors, Vice Presidents of Case Management, the Chief Operation Officer of GuildNet, the Senior Vice President of Quality Improvement, President of GuildNet, Vice President of Business Development, Director, Quality Assurance and Performance Improvement and staff of the Medicare Services department. The Committee will review each goal of the Model of Care and monitor the corresponding performance measures, which will be compiled by the Medicare Services department with the assistance of the QAPI department. On
an annual basis, the Committee will formally review the GuildNet Gold Model of Care and evaluate effectiveness. Based on the analysis and review of Model of Care indicators will be established for each goal. The Committee will undertake, as appropriate, quality initiatives to improve performance with regard to meeting one or more of its goals, revise its measures, operations/business practices or care management practices, and/or make changes to the provider network, to meet the Model of Care goals. The results of this meeting will be documented and presented to the GuildNet Quality Assurance and Performance Improvement Committee, which includes providers, by the Senior Vice President of Quality Improvement.

**Delegation Oversight Committee (DOC)**
The Plan's internal committee responsible for reviewing, the quality and care and service provided to the Plan by delegate/vendor organizations through continuous oversight of performance, regular reports and corrective actions as applicable. The DOC makes recommendations to approve/disapprove the delegate’s performance, and monitors the delegated activities. The DOC can initiate improvement action plans, monitor, corrective action plans and recommend cancelation of an agreement that is consistently non compliant. The committee is a sub-committee of the Plan's Quality Improvement Committee which reviews and approves/disapproves the DOC's recommendations.

**Corrective Action Plans:**
In an effort to correct actual or potential performance issues, reduce risk of recurrence and promote a culture of continuous quality improvement, GuildNet Gold will utilize various methods to evaluate performance at all levels of the organization and monitor compliance with applicable laws, regulations and company policies.

Detection of actual or potential quality or performance issues will result in the initiation of appropriate corrective action(s) which will be designed to identify and address the root cause(s) of the issue(s), so that risk of recurrence will be reduced while remediating the immediate situation. Corrective actions will effectively address the nature, severity and degree of risk associated with the issue(s) identified. In order to be considered sufficient a corrective action plan will: clearly define the issue targeted for correction; identify and address the root cause(s) of the issue; define the action(s) to be implemented; provide for adequate training and education to effect the correction; contain specific, measurable criteria for evaluating effectiveness; specify a timeframe for improvement, evaluation and completion; and define the consequences of non-satisfactory implementation. Thorough records of all deficiencies and corrective actions taken will be maintained by the QAPI Department or Compliance Department.

4. Describe how SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B.

The Model of Care will be evaluated on an annual basis. Using data maintained in the electronic health record, as well as from claims, the QAPI staff will prepare the monthly Health Outcomes and Quality Measures dashboard. These data will be reviewed and analyzed by the QIC which identifies trends, issues, and areas for improvement.
On a quarterly basis trends, issues, and areas for improvement will be presented to the Medicare Interdepartmental Committee, along with status reports made on the Model of Care Goals. Based on the information presented, the Medicare Interdepartmental Committee will strategize to improve performance. These strategies will be implemented by Case Management and operations staff as required, with QAPI staff providing oversight. On an annual basis, the Medicare Interdepartmental Committee will review quality performance for the year, and recommend changes to the Model of Care Goals based on performance indicators and the outcome measures and other studies. The Senior Vice President of Quality Improvement presents the recommendations to the QAPI Committee. If accepted by the QAPI Committee, the Model of Care Goals will be formally revised. The revised Model of Care Goals will be submitted to the Regulatory Oversight and Quality Assurance Committee, and the Board for approval. The approved Model of Care Goals will be available for CMS review at onsite audits.

On an annual basis, the Senior Vice President of QAPI will provide the Board with a formal evaluation of the QAPI program and associated activities, including the Model of Care Goals. The report will provide the Board with detailed information on QIP, CCIP, other studies, and internal quality improvement activities, and will advise the Board how GuildNet Gold performed against quality measures. The evaluation will be available for CMS review at onsite audits.

As an ongoing process, when opportunities for improvement are identified, the Director, Quality Assurance and Performance Improvement/designee will work with the QAPI department to conduct root cause analysis and identify barriers to care or service. GuildNet’s process for conducting Quality Improvement initiatives will be to implement PDSA (Plan, Do, Study, Act) cycles and analyze results until the opportunity for improvement is addressed.

All GuildNet Gold Committees that review the Model of Care Goals monthly, quarterly and annually, including the Regulatory Oversight and Quality Assurance Committee, the QAPI Committee and the Medicare Interdepartmental Committee, will maintain both electronic and hard copies of all agendas, presentations and reports. Discussions and recommendations will be reflected in the approved, written committee meeting minutes which will be available for CMS review at onsite audits.
MOC 4: Quality Measurement & Performance Improvement:

Element B: Measureable Goals & Health Outcomes for the MOC

GuildNet Gold (GNG) members are fully dual eligible Medicare beneficiaries, receiving both Medicare and full Medicaid, and require long term care services. Members are 18 years of age or older and eligible for nursing home level of care. The membership consists of frail elderly and disabled individuals who are culturally diverse and economically disadvantaged. As described in MOC 1, GNG members present with a variety of medical, physical, behavioral, economic and social problems and have complex medical and social conditions that require a high level of coordination. To ensure that GuildNet Gold meets the needs of this vulnerable population, specific, measurable goals have been set for the Model of Care.

Factor 1: Identify and define the measurable goals and health outcomes used to improve the health care of SNP beneficiaries.

Factor 1: Identify goals

GuildNet has identified 7 areas of focus for the Model of Care. Each goal has a specific metric monitored by the Quality Assurance Performance Improvement Team (QAPI) and reviewed and reported as detailed in MOC 4 Elements D and E.

Goal 1: Improving access to essential services such as medical, mental health, and social services

Percent compliance of GuildNet Gold providers with access standards
Percent compliance of GuildNet Gold providers with availability standards

To ensure network composition and service accessibility meets the needs of GuildNet Gold members, provider network adequacy and provider access and appointment availability is analyzed annually. GuildNet Gold members are at high risk for multiple chronic conditions. An adequate provider network within the defined geographic area remains essential to GuildNet Gold’s ability to effectively coordinate care and services.

GuildNet Gold monitors the percent of GuildNet Gold providers (including delegated partners’ providers) that are in compliance with established access and availability standards which include, but are not limited to:

- Routine Care (Established or New) 30 days
- Sick visits (non-urgent) 48-72 hours
- Mental Health (urgent) 48 hours
- After Hours Access 24 hours per day, 7 days per week

GuildNet Gold monitors the composition of the GuildNet Gold networks (including contracted partners’ networks) annually. This review evaluates whether the networks are compliant with predetermined standards to ensure sufficient choice of primary and specialty care providers. In
addition, the geo access analysis evaluates adequate service provision in each geographic area. 
Network requirements also include guidelines for time/travel distance.

On a monthly basis staff conducts an analysis of complaints filed by participants and/or their 
representatives to identify deficiencies in the provider network. This analysis is reviewed by the 
QIC. If the analysis indicates issues with accessing specific providers or services, QAPI staff 
works with Provider Relations and Medicare Services to develop and implement a corrective 
action plan (CAP). This may include adding providers to the network, or working with individual 
providers to improve their performance. Data reported to Provider Relations are considered 
during the re-credentialing process. These data are documented in the Health Outcomes and 
Quality Measures dashboard and is available for review by CMS and other regulators.

The adequacy of the provider network will be evaluated on an ongoing basis to ensure that 
members have access to the care they need. To evaluate adequacy of the provider network, 
QAPI staff will conduct a monthly analysis of complaints filed by members and/or their 
representatives to identify deficiencies in the provider network. This analysis will be reviewed 
by the Quality Improvement Committee (QIC). If the analysis indicates issues with accessing 
specific providers or services, QAPI staff will work with Provider Relations and Medicare 
Services to develop and implement a CAP. This may include adding providers to the network, or 
working with individual providers to improve their performance. Data reported to Provider 
Relations will be considered during the re-credentialing process. These data will be documented 
in the Health Outcomes and Quality Measures dashboard and be available for review by CMS 
and other regulators.

Goal 2: Improving access to affordable care

Rate of Disenrollments due to loss of Medicaid

GuildNet Gold monitors member eligibility for Medicaid and has staff available to assist members 
with recertification. The GuildNet Gold population is composed of frail and culturally diverse 
elderly and disabled members who need assistance with maintaining their Medicaid eligibility and 
benefits. Medicaid recertification assistance is available from Medicaid Eligibility specialists and 
in-home Social Work services. Members can speak with their Care Managers about any issues and 
the appropriate referrals for assistance will be made.

Goal 3: Improving coordination of care through an identified point of contact (e.g., 
gatekeeper)

Percent compliance of Case Management staff adherence to standards for care coordination as 
determined by record reviews.

The Quality Assurance and Performance Improvement (QAPI) department conducts regular 
chart audits to ensure that member services are meeting the standards for care coordination.

Each member has a Care Manager (CM) who serves as the member’s primary point of contact 
with the plan. The Care Manager facilitates the Interdisciplinary Care Team (IDT). The IDT
will include the CM, the member, the member’s family or informal caregiver as required, and the PCP, if available. Specialists, other providers, and staff, will be involved in the IDT based on the member’s health condition(s) and the results of the health risk assessments using the NYS approved UAS-NY HRAT. Through this patient centric approach to care, the team provides coordination of services.

The CM is responsible for ongoing evaluation of member’s health risks through telephone contact with the member and through monitoring the results of the Health Risk Assessment (HRA), which is administered by a Reassessment Nurse in person, at the member’s home, every six (6) months and for any significant change in the member’s status. The CM shares health risk information with members of the IDT through the electronic health record when members of the IDT are part of the organization or parent organization. In all other cases, the CM shares information with the IDT verbally or in writing. IDT members also provide information back to the CM regarding services and interventions that should be put in place to meet the member’s needs. With input from the IDT, the CM documents the Plan of Care (POC). The CM arranges the delivery of covered benefits identified in the plan of care and also coordinates non-plan services required by the member.

The member’s PCP works closely with the CM in identifying the member’s acute and chronic needs, and the services necessary to support those needs. Communication between the PCP and the CM occurs as changes in condition take place or whenever needs are identified, and when the plan of care is evaluated.

**Goal 4: Improving seamless transitions of care across healthcare settings, providers, and health services**

*Percent compliance of Case Management staff adherence to the care transitions protocol as determined by record reviews.*

The QAPI department conducts regular chart audits to ensure that standards for care coordination are met.

Transitional care comprises a variety of time-limited services to ensure continuity of effective health care and avoid less than optimal outcomes among at–risk populations as they move among multiple providers and across a variety of health care settings. To avoid potential fragmented care during transitions, Care Managers increase communication with the transitional facility, the member, his caregiver and the member’s PCP.

GuildNet Gold is committed to assuring that members transitioning between various settings over the continuum of care receive optimal services in the least restrictive care setting that is clinically appropriate. During planned transitions, GuildNet assists members and informal caregivers in managing expectations and provides support throughout the process.

**Goal 5: Improving access to preventive health services**

*Increase the rate of members receiving colorectal cancer screening (HEDIS).*
Increase the rate of members with hypertension who have a blood pressure below 140/90 (HEDIS: Controlling High Blood Pressure).

GuildNet Gold develops targeted wellness initiatives to improve member compliance with preventive health services. Care Managers (CM) and the Interdisciplinary Care Team (IDT) utilize a centralized Electronic Health Record (EHR) to document demographic and health information for members. The EHR has functionality to assist the CM/IDT with reminding members about age-specific, recommended preventive care. The EHR also retains historical information and allow for continuity of care and coordination of services among team members.

Goal 6: Assuring appropriate utilization of services

Increase the rate of members with a diagnosis of diabetes who receive a dilated eye exam. Increase the rate of members who have an annual PCP visit. Increase the number of members who receive annual dental and vision exams. Increase the number of members who receive a hearing exam every two years.

GuildNet monitors several measures to ensure appropriate utilization of services. Preventing hospitalizations and readmissions is a primary focus of the GuildNet Gold Model of Care.

As discussed in MOC 1, GuildNet identifies members with vision impairments as one of GuildNet’s most vulnerable populations. Care Managers emphasize vision screening that will help maintain optimal vision and eye health.

GuildNet works to ensure that members receive appropriate services and wellness screenings. To this end GNG has set goals for increasing the rate of annual PCP visits for all members and increasing the rate of dilated eye exams for diabetic members. Each GNG member works with his Care Manager to schedule preventive health screenings and annual PCP wellness visits.

Goal 7: Improving beneficiary health outcomes

Decrease hospital days measured per 1000 members per month. Decrease the Average Length of Stay (ALOS) for hospitalized members. Decrease the rate of unplanned hospital readmissions within 30 days. Decrease in the rate of member falls with major injury.

GuildNet monitors several measures to ensure improved member health outcomes. The GuildNet Gold Model of Care focuses on preventing hospitalizations and decreasing the ALOS. The MOC also aims to decrease the rate of unplanned hospital readmissions within 30 days of discharge as well as preventing falls and falls with injury.

Factor 2: Identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes at the plan level.

GuildNet uses a variety of data sources to evaluate the health outcome measures. Data sources include:
• Electronic Health Record,
• Claims data,
• Self reported data elicited through communication with Care Managers and the IDT
• Survey data
• Physician offices (including lab reports and clinical information)
• Hospital reports
• Ancillary personnel reports (HHA, CHHA, PT OT etc)

Specific measures and timeframes for each of the seven areas are:

**Goal 1: Improving access to essential services such as medical, mental health, and social services**

85% compliance for GuildNet Gold providers with access standards, annually  
85% compliance for GuildNet Gold providers with availability standards, annually

**Goal 2: Improving access to affordable care**

Maintain the rate of Disenrollments due to loss of Medicaid at or below 5% (<= 5%), annually (measured quarterly).

GuildNet Gold will monitor and maintain the disenrollment rate related to failure to maintain Medicaid eligibility at or below five percent (5%) of disenrollments.

**Goal 3: Improving coordination of care through an identified point of contact (e.g., gatekeeper)**

85% of record reviews showing case management staff adherence to standards for care coordination, semi-annually.

**Goal 4: Improving seamless transitions of care across healthcare settings, providers, and health services**

85% of record reviews showing case management staff adherence to the care transitions protocol, semi-annually.

**Goal 5: Improving access to preventive health services**

Increase by 5%, the rate of members receiving colorectal cancer screening (HEDIS), annually. 
Increase by 5%, the rate of members with hypertension who have a blood pressure below 140/90 (HEDIS: Controlling High Blood Pressure), annually.

**Goal 6: Assuring appropriate utilization of services**

Increase by 10% annually, the rate of members with a diagnosis of diabetes who have received a dilated eye exam.
Increase to 85%, the rate of members who have an annual PCP visit (measured annually). 
Increase the number of members who receive annual dental and vision exams.
Increase the number of members who receive a hearing exam every two years

Goal 7: Improving beneficiary health outcomes

Decrease by 5% annually, hospital days measured per 1000 members per month (measured quarterly).
Decrease by 5% annually, the Average Length of Stay (ALOS) for hospitalized members (measured quarterly).
Decrease by 5% annually, the rate of unplanned hospital readmissions within 30 days (measured quarterly).
Decrease by 5% annually, member falls with major injury measured per 1000 members per month (measured quarterly).

Factor 3: Describe how the SNP establishes methods to assess and track the MOC’s impact on SNP beneficiaries’ health outcomes.
Factor 4: Describe the processes and procedures the SNP will use to determine if health outcome goals are met.

Factors 3&4: Track and assess goals

The following format is used to collect and analyze the MOC data. The Quality team looks for any trends on a quarterly basis as well as the year to date data to assess progress towards the goal. The team compares the current year’s data against the previous year results.

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<th>Benchmark</th>
<th>2015 Results</th>
<th>Change</th>
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<td>3 COORDINATION OF CARE</td>
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<td>Q1 2015</td>
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<td>Q3 2015</td>
<td>Q4 2015</td>
<td>Change</td>
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<td><strong>Rate of compliance with</strong></td>
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<td><strong>documentation where Case</strong></td>
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<td><strong>Manager effectively</strong></td>
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<td><strong>coordinated care</strong></td>
<td>85%</td>
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<td><strong>Rate of compliance by Case</strong></td>
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<td><strong>Management with the</strong></td>
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<td><strong>Transition of Care Protocol</strong></td>
<td>85%</td>
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<tr>
<td><strong>ACCESS to PREVENTIVE</strong></td>
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<td><strong>HEALTH SERVICES</strong></td>
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<td><strong>Rate of Colorectal Cancer</strong></td>
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<tr>
<td><strong>Screening (HEDIS) (annual)</strong></td>
<td>5%</td>
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<td>Increase</td>
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<td><strong>Rate of Controlling High</strong></td>
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<tr>
<td><strong>Blood Pressure (HEDIS)</strong></td>
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<tr>
<td><strong>(annual)</strong></td>
<td>5%</td>
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<td>Increase</td>
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<tr>
<td><strong>APPROPRIATE and COST</strong></td>
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<td><strong>EFFECTIVE</strong></td>
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<tr>
<td><strong>UTILIZATION OF SERVICES</strong></td>
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<td><strong>Rate of Dilated Eye exam</strong></td>
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<tr>
<td><strong>completion for diabetic</strong></td>
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<td></td>
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<tr>
<td><strong>members (HEDIS) (annual)</strong></td>
<td>10%</td>
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<td>Increase</td>
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<tr>
<td><strong>Rate of MD/PCP visit within</strong></td>
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<tr>
<td><strong>30 days of hospital discharge</strong></td>
<td>5%</td>
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<td>Increase</td>
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<tr>
<td><strong>Rate of Annual PCP Visit for</strong></td>
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<tr>
<td><strong>all members (HEDIS)</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td><strong>(annual)</strong></td>
<td>10%</td>
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<td>Increase</td>
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<tr>
<td><strong>Rate of Annual Dental Visit</strong></td>
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<td><strong>for all members (annual).</strong></td>
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<tr>
<td><strong>Rate of Annual Eye Exam for</strong></td>
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<td><strong>all members (annual).</strong></td>
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<tr>
<td><strong>Rate of Biannual Hearing</strong></td>
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<td><strong>exam for all members</strong></td>
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<td><strong>(biannually).</strong></td>
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<tr>
<td><strong>NUMERICAL HEALTH OUTCOMES</strong></td>
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<td><strong>Number of hospital days</strong></td>
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<tr>
<td><strong>PTMPM</strong></td>
<td>5%</td>
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<td>Decrease</td>
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<tr>
<td><strong>Average Length of Stay</strong></td>
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<tr>
<td><strong>(ALOS) PTMPM</strong></td>
<td>5%</td>
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<td>Decrease</td>
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<tr>
<td><strong>Hospital Readmissions within</strong></td>
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<tr>
<td><strong>30 days</strong></td>
<td>5%</td>
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<td></td>
<td>Decrease</td>
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<tr>
<td><strong>Number of Long Term SNF</strong></td>
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<tr>
<td><strong>Admissions (PTMPM)</strong></td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td>Decrease</td>
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<tr>
<td><strong>Falls</strong></td>
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1 Robert Wood Johnson Foundation www.rwif.org, NY State Average
In order to effectively monitor the Model of Care Goals, the Quality Assurance and Performance Improvement (QAPI) department maintains a dashboard that includes all relevant measures. The Dashboard:

- defines the measures used to monitor the Model of Care Goals;
- defines performance goals for each measure;
- contains external benchmarks for measures, if available;
- defines the timeframe for measurement, i.e., quarterly, semi-annually or annually; and
- includes results for each measure.

The Medicare QAPI Specialist collects the data for all MOC Goals and updates the MOC dashboard quarterly and as needed. The Specialist conducts a quarterly analysis of all data and prepares the dashboard and a report of findings for the Medicare Interdepartmental Committee’s review of the MOC goals. The data and presentation are reviewed by the QAPI Director and the Medical Director prior to the meeting.

The Medicare Interdepartmental Team discusses correction actions, training or other performance improvement plans based on the results. Quarterly, the MOC results and proposed actions for the Medicare Interdepartmental Team are presented to the Quality Improvement Committee and the GuildNet Board for review.

**Factor 5: Describe the steps the SNP will take if goals are not met in the expected time frame.**

GuildNet reviews the progress that has been made toward meeting the goals of its Medicare Advantage Dual Special Needs Plans’ Models of Care and reviews issues related to the Models of Care structure, provider network, and communications mechanisms. This is completed via the Medicare Interdepartmental Committee (Committee), at least quarterly.

The Committee reviews each goal of the Models of Care and monitors the corresponding performance measures, which are compiled by the Quality Assurance and Performance Improvement (QAPI) department in conjunction with the Medicare Services department.

If an area of non-performance is identified, the Committee may assign a multi-disciplinary work group to look at the issue or may suggest changes to current processes. Recommendations made by the Committee are implemented by the responsible departments and the effectiveness of the changes is monitored as part of the quarterly review.

Annually, a subset of the Committee members, which includes at a minimum, senior leadership of the Case Management, Medicare Services, Provider Relations and QAPI departments as well as
the Medical Director and President of GuildNet, performs a formal review of Models of Care and evaluates their effectiveness by analyzing the plans’ performance against the measures established for each goal.

Based on the annual analysis and review, the Committee may decide the following with regard to meeting one or more of the Models of Care goals:

- undertake quality initiatives/studies to improve performance;
- revise performance measures;
- revise operations/business practices or care management practices; and/or
- make changes to the provider network.

The results of the quarterly and annual reviews are documented and presented to the GuildNet Quality Assurance and Performance Improvement Committee. Results are subsequently reported by the Sr. Vice President of Quality Assurance up to the GuildNet Board of Directors through the Regulatory and Compliance Committee, which is a subcommittee of the GuildNet Board of Directors.

**Goal 1: Improving access to essential services such as medical, mental health, and social services**

GuildNet Gold expects that GuildNet Gold provider networks will achieve compliance of 85% or more with standards for access and availability.

**Goal 2: Improving access to affordable care**

GuildNet will monitor and maintain the disenrollment rate related to failure to maintain Medicaid eligibility at or below five percent (5%) of disenrollments from GNG.

**Goal 3: Improving coordination of care through an identified point of contact (e.g., gatekeeper)**

GuildNet Gold will conduct medical record reviews semi-annually to determine if case management staff adheres to standards for care coordination.

**Goal 4: Improving seamless transitions of care across healthcare settings, providers, and health services**

GuildNet Gold will conduct medical record reviews semi-annually to determine if case management staff effectively follows the transitions of care protocol.

**Goal 5: Improving access to preventive health services**

GuildNet Gold will monitor and improve the rate of colorectal cancer screenings and blood pressure readings annually.
Goal 6: Assuring appropriate utilization of services

GuildNet Gold will monitor and increase the rate of members with a diagnosis of diabetes who receive a dilated eye exam; an annual eye exam, an annual dental exam, a hearing exam every two years and the rate of members who have an annual PCP visit.

Goal 7: Improving beneficiary health outcomes

- The QAPI department compiles the following hospitalization data for GuildNet Gold members:
  - Hospital days measured per 1000 members per month (PTMPM),
  - Average length of stay (ALOS), and
  - Unplanned hospital readmissions within 30 days.

If the goal is not met or more than a 5% decrease in any of the measures occurs, the COC or MIC will review the findings and make recommendations for improving the results and remeasure. Interventions may include: focused audits of member health records to determine if the hospitalizations and/or readmissions could have been prevented by timely evaluation of the member by his/her physician and providing the member with a medication pre-pour or automated medication dispenser if it is determined that member non-compliance with their medication regimen may have contributed to the admission. These data are monitored and presented to the COC and MIC quarterly. Additional recommendations will be made by the Committee as indicated.

- GuildNet Gold members are projected to be at a higher risk for falls. On an ongoing basis, the QAPI department will collect data on members who have sustained a major injury from a fall. The results will be recorded as per 1000 members per month (PTMPM), entered into the MOC dashboard and presented to the MIC and COC, quarterly. In addition to the quarterly monitoring, the data are evaluated annually and improvement will be reflected by a 5% decrease in the measure of falls with injury. If the goal is not met, the MIC or COC may make recommendations for interventions to address any issues identified.

In addition to the aggregate data on falls, the QAPI department will collect member-specific data on falls. Members who are identified as having a recent fall with injury or members with multiple falls in a 6-month period will be forwarded to the CM for evaluation. The CM will investigate the circumstances surrounding the member’s falls and may make changes to the member’s plan of care.
MOC 4: Element C: Measuring Patient Experience of Care (SNP Member Satisfaction)

The organization’s MOC must address the process of measuring SNP member satisfaction by:

1. Describing the specific SNP survey used.

The CAHPS survey, for collecting standardized information on enrollees experiences, will be utilized beginning in 2015. GuildNet Gold reached the threshold requirements of 600 members in 2014. As prescribed by regulatory bodies, GuildNet Gold will administer the CAHPS survey to all eligible GNG members using a certified MA PDP CAHPS vendor. The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. GuildNet Gold has contracted with an approved MA PDP CAHPS vendor, DSS Research, for the survey administration from a list of the approved survey vendors which is available on www.MA-PDPCAHPS.org. All approved survey vendors will be trained by the CMS CAHPS® Survey Coordination team to conduct the survey. The CAHPS survey evaluates member experience and provides information on the following 6 composite measures:

- Ease of Getting Needed Care and Seeing Specialists
- Getting Appointments and Care Quickly
- Doctors Who Communicate Well
- Coordination of Members' Health Care Services
- Health Plan Provides Information or Help When Members Need it
- Ease of Getting Prescriptions Filled When Using the Plan (MA-PD and PDP)
- Drug Plan Provides Information or Help When Members Need It (MA-PD and PDP)

Results of the CAHPS Health Plan Survey can identify opportunities for improvement and provide benchmarks to track progress towards goals. The survey results will be used to inform and support the improvement process in our GuildNet Gold Model of Care.

The plan will target a satisfaction rate of 80% in all categories surveyed. If the satisfaction rate for any area is below 80%, the plan, the QAPI Committee and/or QIC will develop strategies to improve satisfaction. Member satisfaction surveys will be maintained by the plan and be available for review by CMS and other regulators.

GuildNet Gold will also continue to participate in the HOS survey as the member threshold requirement is met and therefore is mandated by regulatory bodies. GuildNet has voluntarily participated in the HOS Survey prior to enrolling the mandatory threshold membership for the purpose of determining if GuildNet Gold’s (FIDE) membership qualified the plan for the frailty adjustment. The NCQA approved Vendor selected to perform the survey is DSS research (HOS Vendor), who will continue to perform our HOS survey as mandated as long as they continue to be an approved vendor.

The HOS vendor will collect HOS data, according to the NCQA prescribed current year HEDIS® protocol for the Plan’s population. NCQA will select the sample for GuildNet cohort from the Centers for Medicare & Medicaid Services (CMS) data system, and forward it directly to the HOS vendor for processing. All sample processing will be in accordance with the HOS
Vendor current standards and NCQA guidelines detailed in the most current HEDIS® requirements.

The HOS survey tool measures include physical and mental health outcomes results using appropriate risk adjustment techniques. In addition to the physical and mental health outcomes measures, the HOS is also used to collect the Urinary Incontinence in Older Adults, Physical Activity in Older Adults, Fall Risk Management, and Osteoporosis Testing in Older Women HEDIS® measures all of which are indicators of the frailty of our dual eligible vulnerable population. The results of the survey will provide benchmark data to establish our MOC goals to improve our target population’s outcomes.

2. **Explaining the rationale for the selection of a specific tool.**

The GuildNet Gold internal survey tool was selected to provide specific feedback to GuildNet departments to improve internal processes. The internal form allows ongoing benchmark ability to internal processes. Members and/or family will be surveyed/interviewed on a regular basis concerning individual satisfaction with GuildNet Gold’s program and service as a part of the ongoing quality assessment/performance improvement program. All written member surveys are available in English, Spanish, Mandarin and Russian. Future Satisfaction Surveys will be made available in additional languages reflecting the language and culture of the member demographics.

The survey of enrollees is used to measure satisfaction and to target and prioritize areas of improvement is part of the QA/PI Plan. Satisfaction Survey Questions with a Not Satisfied or a Very Unsatisfied response, as well as negative member comments and requests will be forwarded to the member’s Case Manager and/or MSR or Supervisor for resolution. The QAPI department is responsible for aggregating the survey results and to make recommendations and highlight areas for improvement to the appropriate departments, if indicated.

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey tool** provides GuildNet Gold the patient’s perspective of care. The CAHPS survey which will be administered annually, selects a sample of members who are asked to share their perspectives of care provided by GuildNet Gold. The standard survey tool allows meaningful and objective benchmark comparisons between providers on domains that are important to consumers and creates an incentive for providers, such as GuildNet Gold, to improve their quality of care through public reporting of survey results; and enhances public accountability in health care by increasing the transparency of the quality of the care provided.

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services and has become the national standard for measuring and reporting on the experiences of consumers with their health plans, for this reason GuildNet Gold will utilize this survey tool to measure member satisfaction and benchmark program success against like regional, state and national plans.

GuildNet Gold is a dual eligible SNP with members requiring nursing home level of care to be eligible for the plan. Many members also require assistance with activities of daily living and ancillary independent activities of daily living to allow them to remain in the community. The **HOS survey tool** measures include physical and mental health outcomes results using appropriate
risk adjustment techniques. In addition to the physical and mental health outcomes measures, the HOS is also used to collect the Urinary Incontinence in Older Adults, Physical Activity in Older Adults, Fall Risk Management, and Osteoporosis Testing in Older Women HEDIS® measures all of which are indicators of the frailty of our dual eligible vulnerable population. The results of the survey will provide benchmark data to establish our MOC goals to improve our target population’s outcomes.

3. Describing how results of patient experience surveys are integrated into the overall MOC performance improvement plan.

One important use of the various GuildNet Gold Surveys results is to identify strengths and weaknesses in the health plan’s performance and then assess the impact of interventions to improve members’ experiences in specific areas. Survey results are used to identify opportunities for improvement, provide benchmarks and to track progress towards goals. The survey results are reviewed by the QIC and areas identified as opportunities for improvement are brought to the Clinical Operations Department by the Director of Quality. The Clinical Operations Committee discusses interventions to be included in a plan of action to be implemented. The plan of action is then reviewed at the Medicare Interdepartmental Committee meeting for implementation. The Staff Development Department develops any training materials for staff that might be required for internal staff training. The Provider Relations Department addresses issues identified as provider related and develops a plan of action with individual vendors/providers as indicated. Results of the interventions are monitored by the Quality Department or Provider Relations Department and brought to the QIC meeting for inclusion in the quarterly QAPI Committee meeting.

GuildNet Gold is committed to improving the quality of the services delivered to both internal and external customers. To this end, the organization will continuously pursue process improvements that affect the plan’s ability to have productive and satisfying interactions with members and providers.

4. Describing steps taken by the SNP to address issues identified in survey responses.

The QAPI department and designated vendors will conduct an annual member satisfaction survey. The purpose of the survey will be to measure satisfaction with the health plan and to identify opportunities for improvement. The topics covered by the survey will include satisfaction with Plan Services, Utilization Management, Customer Service, Case Managers, and Provider Relations. Appropriate sampling methodology will be used.

Where issues are identified, the QAPI Committee and the QIC will develop strategies to improve performance in the area(s) with a high complaint rate. This may include the formulation of workgroups to look at specific issues, modifications to the provider network, and changes to business practices. These data will be documented in the Health Outcomes and Quality Measures dashboard, trended and tracked quarterly. The trended results will provide an ongoing benchmarking record of improvement and sustained satisfaction or will be able to identify areas that require immediate review, analysis and possible intervention.
The plan will target a satisfaction rate of 80% in all categories surveyed. If the satisfaction rate for any area is below 80%, the plan, the QAPI Committee and/or QIC will develop strategies to improve satisfaction. Member satisfaction surveys will be maintained by the plan and be available for review by CMS and other regulators.
MOC 4: Element D Ongoing Performance Improvement Evaluation of the MOC

1. How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.

Using data maintained in the electronic health record, as well as from claims, the QAPI staff will prepare the monthly Health Outcomes and Quality Measures dashboard. These data will be reviewed and analyzed by the QIC which identifies trends, issues, and areas for improvement.

On a quarterly basis trends, issues, and areas for improvement will be presented to the Medicare Interdepartmental Committee, along with status reports made on the Model of Care Goals. Based on the information presented, the Medicare Interdepartmental Committee will strategize to improve performance. These strategies will be implemented by Case Management and operations staff as required, with QAPI staff providing oversight.

Annually, a subset of the Committee members, which includes at a minimum, senior leadership of the Case Management, Medicare Services, Provider Relations and QAPI departments as well as the Medical Director and President of GuildNet, performs a formal review of Model of Care and evaluates their effectiveness by analyzing the plans’ performance against the measures established for each goal.

2. How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality.

As an ongoing process, when opportunities for improvement are identified, the Director, Quality Assurance and Performance Improvement/designee will work with the QAPI department to conduct root cause analysis and identify barriers to care or service. GuildNet’s process for conducting Quality Improvement initiatives will be to implement PDSA (Plan, Do, Study, Act) cycles and analyze results until the opportunity for improvement is addressed.

3. The organization’s ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

The Medicare Interdepartmental Committee reviews each goal of the Model of Care and monitors the corresponding performance measures, which are compiled by the Quality Assurance and Performance Improvement (QAPI) department in conjunction with the Medicare Services department. These meetings occur minimally quarterly and more often when issues are identified.

If an area of non-performance is identified, the Committee may assign a multi-disciplinary work group to look at the issue or may suggest changes to current processes. Recommendations made by the Committee are implemented by the responsible departments and the effectiveness of the changes is monitored as part of the quarterly review.

Annually, a subset of the Committee members, which includes at a minimum, senior leadership of the Case Management, Medicare Services, Provider Relations and QAPI departments as well
as the Medical Director and President of GuildNet, performs a formal review of Model of Care and evaluates their effectiveness by analyzing the plans’ performance against the measures established for each goal.

Based on the annual analysis and review, the Committee may decide the following with regard to meeting one or more of the Model of Care goals:

- undertake quality initiatives/studies to improve performance;
- revise performance measures;
- revise operations/business practices or care management practices; and/or
- make changes to the provider network.

4. How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

GuildNet Gold will utilize several mechanisms to communicate improvements in the Model of Care to all stakeholders.

GuildNet Gold Members will be advised of improvements in care management and changes to the Model of Care through the member newsletter. Any changes to the Model of Care would also be posted on the GuildNet web site. If there was a change in how to access services, the Interdisciplinary Care Team would review the change with the member during their routine contacts.

GuildNet Gold will communicate to internal stakeholders about the Model of Care and quality initiatives via the Quality Assurance and Performance Improvement Committee which reports up to the GuildNet Gold Board of Directors. Email notifications and employee newsletters may also be used. Annual training of the Model of Care for all GuildNet Gold employees will be conducted. In addition, interim training may also be done if changes to the Model of Care are made.

GuildNet Gold will maintain a website that will include information about the Model of Care. The website will be available to all members, providers, regulatory agencies and the public.

Providers will be notified about the Model of Care and any changes via the Provider Manual and website.

When indicated, GuildNet Gold will also utilize targeted mailings to notify stakeholders, i.e., members and providers, about changes to the Model of Care.

After the Annual Review of the Model of Care is completed, the Provider Manual and GuildNet Gold website are updated to reflect any changes.
MOC 4: Element E: Dissemination of SNP Quality Performance Related to the MOC
The organization must address the process for communicating its quality improvement performance by:

1. Describing how performance results and other pertinent information are shared with multiple stakeholders.

On a quarterly basis, the staff of the Medicare Services and QAPI Departments will compile data used to evaluate the specific performance measures defined by the GuildNet Gold Model of Care. Data will be presented to the Medicare Interdepartmental Committee, which will be made up of Nurse Case Managers, Nurse Case Manager Supervisors and Directors, Assistant Vice Presidents of Case Management, Vice President of Care Management, the COO, the Senior Vice President of Quality Improvement, the President of GuildNet, the Vice President of Business Development, and the staff of the Medicare Services department for evaluation of GuildNet Gold’s progress toward meeting the established Model of Care goals.

Annually, a subset of the Committee members, which will include at a minimum, senior leadership of the Case Management, Medicare Services, Provider Relations and QAPI departments as well as the Medical Director and President of GuildNet, will perform a formal review of Model of Care goals and will evaluate their effectiveness by analyzing the plan’s performance against the measures established for each goal.

The results of the quarterly and annual reviews will be documented and presented to the GuildNet Quality Assurance Performance Improvement Committee. Results are subsequently reported by the Sr. Vice President of Quality Assurance Performance Improvement up to the GuildNet Board of Directors through the Regulatory and Compliance Committee, which is a subcommittee of the GuildNet Board of Directors.

The Regulatory Oversight and Quality Assurance Committee
The Regulatory Oversight and Quality Assurance Committee will be a sub-committee of the Board that reviews audits that are conducted by regulatory bodies or internal Quality Assurance Departments. This Committee will meet semi-annually. The Senior Vice President of Quality Improvement will make regular reports to the Regulatory Oversight and Quality Assurance Committee on the status of the QAPI program and activities.

The QAPI Committee
The Board will appoint a QAPI Committee (Committee) that will be responsible for developing the QAPI program. The program will be evaluated and revised at least annually by the Committee. The Committee, will be made up of staff from the QAPI department, key operations areas, and will be led by the Medical Director, in coordination with the President and the Senior Vice President of Quality Improvement. Network Providers will participate on the Committee, as well as a member representative. Meetings will be held quarterly, and minutes of these meeting are documented and shared with the Regulatory Oversight and Quality Assurance Committee, and with the Board itself. QAPI meeting minutes will include: discussions by participating providers, committee decisions, actions, review of QAPI activities, barriers to
achieving goals. Attendance sheets for each Quality Assurance Performance Improvement Committee meeting will also be maintained.

The results of studies and audits, and quality/performance indicators will be presented to the Committee by the Director, Quality Assurance and Performance Improvement/designee. Other GuildNet staff, including Case Management, Provider Relations, and Medicare Services will make reports to the Committee on quality related issues identified as the result of day-to-day operations.

Other Quality Improvement Sub-Committees

**Quality Improvement Committee (QIC)**
Led by the Director, Quality Assurance Performance Improvement, the QIC will be a working committee responsible for collecting, analyzing, and integrating data reported to the QAPI Committee. The membership will include but not be limited to Quality Improvement department staff and other GuildNet Departments staff, as needed. Reports from the Delegation Oversight Committee are presented at the QIC meetings. The QIC will meet a minimum of eight times per year and ad hoc as needed. Meeting minutes will be taken and maintained.

**GuildNet Clinical Operations Committee (COC)**
The COC will be made up of senior GuildNet management staff including the President of GuildNet, the Senior Vice President of Quality Improvement, the Director, Quality Assurance and Performance Improvement, the Assistant Vice President of Medicare Services, the Vice President of Business Development, the Senior Vice President of Intake, the Medical Director, the Vice President of Care Management and case management staff. Case Management participants will represent the Interdisciplinary Care Team members and GuildNet members. The COC will review the data and analyses conducted by the QIC and evaluate the QAPI program and Model of Care effectiveness. The COC will make recommendation to improve quality and develop the performance improvement projects and priorities for the year.

**GuildNet Compliance Committee:**
The Compliance Committee will consist of senior and executive level GuildNet staff, the Lighthouse Guild Compliance Officer, Vice President of Finance, and Director of IT. GuildNet Compliance Committee will have a delegation oversight program in place, and through this program quality related issues may be identified. These issues will be brought back to the Committee by the Senior Vice President of Quality Improvement who is a member of the Compliance Committee. The Compliance Committee will meet quarterly and minutes will be recorded and maintained.

**GuildNet MOC Oversight Committee (Medicare Interdepartmental Committee):**
The Model of Care Oversight Committee (Committee) will be made up of Nurse Case Managers, Nurse Case Manager Supervisors and Directors, Vice President of Case Management, Assistant Vice Presidents of Case Management, the COO, the Senior Vice President of Quality Improvement, President of GuildNet, Vice President of Business Development, Director, Quality Assurance and Performance Improvement and staff of the Medicare Services department. The Committee will review each goal of the Model of Care and monitor the corresponding
performance measures, which will be compiled by the Quality department with the assistance of the Medicare Services department. On an annual basis, the Committee will formally review the GuildNet Gold Model of Care and evaluate effectiveness. Based on the analysis and review of Model of Care indicators will be established for each goal. The Committee will undertake, as appropriate, quality initiatives to improve performance with regard to meeting one or more of its goals, revise its measures, operations/business practices or care management practices, and/or make changes to the provider network, to meet the Model of Care goals. The results of this meeting will be documented and presented to the GuildNet Quality Assurance and Performance Improvement Committee, which includes providers, by the Senior Vice President of Quality Improvement.

**Delegation Oversight Committee (DOC)**
The Plan's internal committee responsible for reviewing, the quality and care and service provided to the Plan by delegate/vendor organizations through continuous oversight of performance, regular reports and corrective actions as applicable. The DOC makes recommendations to approve/disapprove the delegate’s performance, and monitors the delegated activities. The DOC can initiate improvement action plans, monitor, corrective action plans and recommend cancelation of an agreement that is consistently non compliant. The committee is a sub-committee of the Plan's Quality Improvement Committee which reviews and approves/declines the DOC's recommendations.

**The Participant Advisory Committee/General Public**
GuildNet (GN) is committed to communicating with and getting feedback from members. To accomplish this goal, upon enrollment and annually, all members/participants are informed about GN biannual feedback sessions/town hall meetings. GuildNet will conduct at least two Participant Feedback Sessions annually for the five New York City counties/boroughs. In addition, GuildNet will convene two Participant Feedback Sessions annually in each of the following counties: Nassau, Suffolk, and Westchester.

Committee membership includes at least one Board member liaison and one consumer advocacy or community-based representative, staff liaisons, and provider/vendor representatives.

Members are also invited to participate in our Participant Advisory Committee (PAC), either in-person or remotely. The PAC reflects representation from the diverse range of Participants served, including individuals with disabilities, family members and/or caregivers; providers who offer direct services; and representatives of advocacy or community-based groups serving consumers. The Participant Advisory Committee will: meet quarterly in-person to solicit Participant Feedback. Participant Feedback, however, may be provided at anytime to GuildNet. The Participant Advisory Committee will: provide input to GuildNet Senior Management through meetings, minutes, and staff liaison. Participant and community input and guidance will be invited on program management, quality, service and care issues impacting Participants throughout the GuildNet service area. Minutes of the PAC meetings are presented to the Senior Vice President for Quality and shared with the Plan’s Quality Improvement Committee and Board of Directors. Minutes of the PAC meeting are presented to the Senior Vice President of Quality for inclusion in the quarterly QAPI meeting and shared with the Board of Directors.
Regulatory agencies

Results of quality activities are documented and maintained by the Director of Quality. Quality reports are sent to regulatory entities as scheduled or requested by CMS and NYSDOH. Meeting minutes and reporting documentation is available for review by CMS New York State Department of Health and other regulatory agency upon request.

2. Stating the scheduled frequency of communications with stakeholders.

The QAPI Committee
The Committee, will be made up of staff from the QAPI department, key operations areas, and will be led by the Medical Director, in coordination with the President and the Senior Vice President of Quality Improvement. Network Providers will participate on the Committee, as well as community and member representatives. Meetings will be held quarterly, and minutes of these meeting are documented and shared with the Regulatory Oversight and Quality Assurance Committee, and with the Board itself.

The Regulatory Oversight and Quality Assurance Committee
The Regulatory Oversight and Quality Assurance Committee, a sub-committee of the Board that reviews audits that are conducted by regulatory bodies or internal Quality Assurance Departments, meets at least semi-annually.

Quality Improvement Committee (QIC)
Led by the Director, Quality Assurance Performance Improvement, the QIC will be a working committee responsible for collecting, analyzing, and integrating data reported to the QAPI Committee. The membership will include but not be limited to Quality Improvement department staff and other GuildNet Departments staff, as needed. Reports from the Delegation Oversight Committee, chaired by the Vice President of Provider Relations, are presented at the QIC meetings. The QIC will meet a minimum of eight times per year and ad hoc as needed.

Delegation Oversight Committee (DOC)
The committee is a sub-committee of the Plan's Quality Improvement Committee which reviews and approves/declines the DOC's recommendations. The Delegation Oversight Committee will meet quarterly and ad hoc as needed.

GuildNet Clinical Operations Committee (COC)
The COC will review the data and analyses conducted by the QIC and evaluate the QAPI program and Model of Care effectiveness. The COC will make recommendation to improve quality and develop the performance improvement projects and priorities for the year. The committee will meet quarterly and ad hoc as needed.

GuildNet Compliance Committee:
The Compliance Committee will consist of senior and executive level GuildNet staff, the Lighthouse Guild Compliance Officer, Vice President of Finance, and Director of IT.
Delegation oversight and quality related issues that may have been identified at the DOC committee will be brought to the committee by the Senior Vice President of Performance Improvement who is a member of the Compliance Committee. The Compliance Committee will meet quarterly and minutes will be recorded and maintained.

**GuildNet MOC Oversight Committee (Medicare Interdepartmental Committee):**
The Committee will review each goal of the Model of Care and monitor the corresponding performance measures, which will be compiled by the Medicare Services department with the assistance of the QAPI department. On an annual basis, the Committee will formally review the GuildNet Gold Model of Care and evaluate effectiveness. Based on the analysis and review of Model of Care indicators will be established for each goal. The Model of Care Oversight Committee will meet quarterly and ad hoc as needed.

**The Participant Advisory Committee**
The Participant Advisory Committee will meet quarterly in-person to solicit Participant Feedback. Participant Feedback, however, may be provided at anytime to GuildNet. Participant concerns and issues to GuildNet Board through Board Member liaison or designee, quarterly minutes and annual summary of issues and actions taken to address concerns.

3. **Describing the methods for ad hoc communication with stakeholders.**

GuildNet Gold will utilize several mechanisms to communicate quality improvement performance and improvements in the Model of Care to all stakeholders.

GuildNet Gold Members will be advised of improvements in care management and changes to the Model of Care through the member newsletter. Any changes to the Model of Care would also be posted on the GuildNet web site. If there was a change in how to access services, the Interdisciplinary Care Team would review the change with the member during their routine contacts.

GuildNet Gold will communicate to internal stakeholders about the Model of Care and quality initiatives via the Quality Assurance and Performance Improvement Committee which reports up to the GuildNet Board of Directors. Email notifications and employee newsletters may also be used. Annual training of the Model of Care for all GuildNet Gold employees will be conducted. In addition, interim training occurs if the Model of Care is changed.

GuildNet Gold will maintain a website that will include information about the Model of Care. The website is available to all members, providers, regulatory agencies and the public.

Providers will be notified about the Model of Care and any changes via the Provider Manual and website.

When indicated, GuildNet Gold will also utilize targeted mailings to notify stakeholders, i.e., members and providers, about changes to the Model of Care.
After the Annual Review of the Model of Care is completed, the Provider Manual and GuildNet Gold website are updated to reflect any changes.

4. Identifying the individuals responsible for communicating performance updates in a timely manner.

The Board receives reports on QAPI activities at scheduled Board meetings through the President of GuildNet or Regulatory Oversight and Quality Assurance Committee, which is a sub-committee of the Board. It also reviews and approves this document annually.

The Senior Vice President of Quality Improvement makes reports to the Regulatory Oversight and Quality Assurance Committee on the status of the QAPI program and activities as requested.

The Medical Director is the person responsible for administration of the QAPI program. The Medical Director, in conjunction with the Director of QAPI, provides day-to-day oversight of the QAPI Program and its implementation, including ensuring that recommendations of the QAPI Committee are implemented.

The Director of Quality, who reports to the Senior Vice President of Quality Improvement, supervises the staff that conducts quality audits and studies, and oversees Quality Improvement Projects (QIPs) and Chronic Care Improvement Projects (CCIPs). In addition, the Director of Quality Improvement is responsible for:

- Communicating the decisions of the QAPI Committee to the appropriate personnel in the GuildNet organization;
- Overseeing the implementation of the performance improvement activities approved by the QAPI Committee;
- Collection of data necessary to determine the effectiveness of the performance improvement activity;
- Providing the QAPI Committee with information and analyses to assess the effectiveness of the implemented performance improvement activity;
- Reviewing performance and quality indicators, and the results of studies and audits, with the Medical Director; and
- Overseeing the Quality Improvement Committee.

The Participant Advisory Committee membership includes at least one Board member liaison and one consumer advocacy or community-based representative, staff liaisons, and provider/vendor representatives. The Board member communicates Participant feedback directly to the Board, providing the Participants with a direct link to GuildNet’s governing Board through the Board liaison. Participant Input and Feedback is also provided to GuildNet’s Board and Senior Management through quarterly minutes.