New York State Catholic Health Plan, Inc., H3328
Institutional (Facility) Special Needs Plan

Model of Care Score: 89.38%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Fidelis Care Institutional Special Needs Plan, also known as New York State Catholic Health Plan, serves members who reside or are expected to reside in a long term care facility for 90 days or more. Currently, 72% of this population is age 65 and above. Sixty percent of these members are female and 40% male. They have been admitted to the skilled nursing facility with primary diagnoses of: orthopedic rehabilitation therapy (27%), cardiovascular disorders (9%), respiratory conditions (8%) and behavioral health needs (4%).

Provider Network

Fidelis maintains a network of over 29,000 medical practitioners. It includes geriatricians, cardiologists, surgeons, infectious disease/HIV specialists, mental health specialists, psychologists and substance abuse counselors, orthopedists, rheumatologists, endocrinologists and other medical specialties. Additionally, the plan contracts with: nutritionists, dietitians, podiatrists, dentists, nurse practitioners, eye care/vision specialists, physical, occupational and speech therapists as well as pathologists, laboratory and radiology specialists.

The network also encompasses selected long term care facilities: 54 skilled nursing facilities with 12,874 beds and the following specialty services: rehab/sub-acute beds (54), ventilator dependent (9), Alzheimer unit (50), bariatric beds (22), wound care specialists (34) and HIV/AIDS care (24).

The determination of what care and services the member receives is a collaborative effort between the treating physician, facility medical and nursing staff and the interdisciplinary care team (ICT) coordinated by a registered nurse (RN) case manager in the role of gatekeeper. If the member requires specialized services, the SNP makes arrangements to facilitate the member's timely transfer to a participating long term care facility providing the necessary services and as geographically close to the member's family/support network as possible. If a long term care facility with the required specialty care is not available within a reasonable distance of the member's family, Fidelis may choose an out-of-network facility.

Care Management and Coordination

Fidelis uses a health risk assessment (HRA) to evaluate members' health, psychosocial, functional and cognitive needs including a medical and mental health history that was developed to identify the specific needs of this population including advanced age, multiple co-morbid conditions and deteriorating functional ability.

The RN case manager administers the HRA face-to-face in the facility within 90 days of enrollment. An annual re-assessment is performed within 12 months of the last risk assessment or as often as the health of the member requires. A clinical services case management supervisor reviews the HRA and additional assessments, and determines the member's risk category for the level of care.

RN case managers develop care plans in collaboration with skilled nursing facility clinical personnel, utilizing analysis of the HRA (initial, annual or any intervening HRA performed because of a change in the member's health status) claims, utilization, in-patient and pharmacy data. Individualized care plans (ICP) serve as a guide for care delivery. The RN case manager also reviews and revises the ICP during monthly on-site care planning meetings at the facility, and annually or more frequently as changes in the member's health status warrants. He/she also evaluates the ICP to measure outcomes and determine if the member's needs have been met. The annual review includes a review by the ICT, treating practitioner and facility administrative and nursing personnel.

The ICT coordinates the delivery of services and benefits for members with facility personnel, the treating practitioner and the member/responsible party when feasible. The members of the ICT are selected for their understanding of the institutional population and its special needs as well as their ability to review needs assessments and develop care plans. The ICT is composed of but not limited to: a physician, registered nurse, licensed nursing home administrator, social worker, pharmacist, facility nursing staff and other health care professionals such as physical, occupational or speech therapists.

Recommendations of the ICT are incorporated into the care plan and communicated to clinical staff in the facility, the treating practitioner and member/responsible party.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.fideliscare.org