SCAN Health Plan, H9104
Institutional (Institutional Equivalent-Living in the Community) Special Needs Plan

Model of Care Score: 86.25%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

SCAN Health Plan's Institutional Special Needs Plan (I-SNP) serves members who are institutional equivalent, living in the community but requiring an institutional level of care. The I-SNP enrolls members that meet nursing facility level of care (NFLOC) in Los Angeles, Orange, San Bernardino, and Riverside counties, California. These members meet NFLOC criteria of 2 or more activities of daily living (ADL) impairments, are typically frail, require caregiver support and help managing their chronic conditions. Due to the complexity of their conditions, these members may have difficulties accessing care, managing their medications, and using appropriate levels of care.

Provider Network

The provider network is designed to provide adequate access to covered services to meet the needs of the targeted I-SNP population. These networks include, but are not limited to: primary care physicians (PCP), specialists, acute care facilities, long term care facilities, diagnostic and rehabilitation services, home health agencies, ambulatory clinics and ancillary providers. The PCP's office is the central point for determining, organizing and coordinating care, based on individual member needs and priorities. The PCP manages the medical, cognitive, psychosocial and functional needs of the member. The PCP helps each person access specialists and other health care providers and services, such as care management, social services, behavioral health, health education and other special programs as needed.

Care Management and Coordination

SCAN utilizes the NFLOC's tool to identify member risks and needs. The purpose is to assess unmet social and medical needs that put the member at risk for institutionalization. This comprehensive tool assesses the four key domains of medical, social/psychological, cognitive and function. The tool qualifies the member as NFLOC, generates data for the individualized care plan (ICP), and triggers a referral to case management if needed. Initial assessments are generally scheduled within 30 days of enrollment and are conducted face-to-face by a registered nurse (RN). Once the assessment is completed, the contracted RN faxes the assessment results and documentation to SCAN and schedules a conference call with the SCAN SNP Specialist. Annual assessments are performed thereafter.

The ICP defines member needs for care coordination services, such as information about benefits and services, health education to manage chronic conditions, referrals for community-based services, or referral for more intensive case management by geriatric health management & monitoring or disease management. The ICP is based off of the needs identified in the health

risk assessment (HRA), which a key component of the care planning process is the member's/caregiver's participation. Once the ICP is developed, it is reviewed and finalized with the member. The member is encouraged to review their care plan with their treating physician. Finalized ICPs are documented in SCAN's software platform. The member receives a copy of the ICP. An additional copy of the ICP is faxed to the PCP with a request to review, comment, sign and fax back. PCPs are requested to retain the care plan in the member's medical record.

The interdisciplinary care team (ICT) is composed of highly-skilled clinical staff at both the health plan and the provider organization caring for the member. Team members include members from the health plan such as medical directors, geriatricians, case managers; and from the provider organization: PCP, specialists, nurse practitioners and physician assistants. The team's role is to analyze findings from the HRA and comprehensive geriatric assessment and build or review an ICP for each SNP member, and include the member in the care planning process whenever feasible. The ICT communicates primarily through shared communication between PCP and SCAN case managers, the member/caregiver, and other relevant medical personnel.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.scanhealthplan.com/