

H9104 Scan Health Plan, Institutional (Equivalent) Special Needs Plan

Model of Care Score: 95.00%

3-Year Approval

January 1, 2015 – December 31, 2017

Target Population

SCAN Health Plan (SCAN) Institutional-Equivalent Special Needs Plan (I-SNP) serves members who are institutional equivalent, living in the community but requiring an institutional level of care. This I-SNP enrolls members that meet a nursing facility level of care (NFLOC) criteria and reside in Los Angeles, Orange, San Bernardino, and Riverside counties. Due to their frailty, need of assistance in managing their chronic conditions and the complexity of their conditions, these members may have difficulties accessing care, managing their medications and using appropriate levels of care.

Medical conditions and co-morbid conditions associated with this I-SNP population may include: a wide-range of chronic conditions, including but not limited to: diabetes, congestive heart failure, cardiovascular disorders, chronic obstructive pulmonary disease, chronic kidney disease, decreased functional status, depression, dementia and obesity. Other health conditions affecting I-SNP members that may complicate care include: heart attack, stroke, chronic pain, pressure ulcers, arthritis, malnutrition and mental health diagnoses. Limited functional status, pain and depression can contribute to social issues such as isolation and increased caregiver burden. Low-income also adversely affect medication adherence and nutrition.

Provider Network

The network is composed of services essential to the care of members with chronic conditions, such as primary care physicians (PCP), specialists with expertise in endocrinology, ophthalmology and cardiology; diagnostic services, home health services, hospice or palliative care and outpatient rehabilitation. Contracted facilities include: hospitals, intermediate care centers, after hours clinics, acute and long-term care, tertiary care, ambulatory clinics, skilled nursing facilities and specialty outpatient clinics. Specialty services are contracted or available as needed on a case-by-case basis.

Care Coordination and Management

Prior to enrollment, an RN employed by a third-party contracted vendor assesses the member in the home to determine if Nursing Facility Level of Care criteria is met. Within 90 days of enrollment and annually thereafter, a Care Manager (CM) contacts the member via phone to complete an initial health risk assessment (HRA) and documents their responses in SCAN's care management system. The HRA assesses members' risk in four broad domains: medical, psychosocial, cognitive and functional needs.

Based on the HRA results, utilization data, referrals data and medical documentation, the member may be further assessed to determine the appropriate level of care management, interventions and services. Every member has an individualized care plan (ICP) that defines their needs for care coordination services, such as information about benefits and services, health education to manage chronic conditions, referrals for community-based services, and may outline complex care or disease management clinical interventions. During the care planning process, CMs may also discuss advance directives and end-of-life care. The CM mails the finalized ICP to the member and includes information about who to call if they need assistance in managing their conditions or if their health status changes. An additional copy of the ICP is faxed to PCP with a request to review, comment, sign and return by fax. PCPs retain the ICP in the member's medical record. High-risk members are referred to the interdisciplinary care team (ICT) for review. All ICT members have access to the HRA, ICP and ICT notes in the electronic care management system.

The ICT is composed of highly-skilled clinical staff at both the health plan and the provider organization caring for the member. Team members include staff from the plan such as a geriatrician, medical directors, case managers, clinical pharmacists, behavioral health specialists and nutritionist as well as staff from the provider organization: PCP, specialists, nurse practitioners and physician assistants. The ICT meets in-person on a weekly basis to communicate and discuss the member's care. Professionals from the disciplines mentioned above attend and PCPs/care managers from provider organizations are encouraged to call in or attend in-person.

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.scanhealthplan.com.