Elderplan, Inc., H3347
Institutional (Facility) Special Needs Plan

Model of Care Score: 75.63%
2-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

The Elderplan Medicare Institutional Special Needs Plans are designed to healthcare to those beneficiaries permanently residing in contracted nursing facilities for greater than 90 days at time of enrollment, who are eligible to receive services under Medicare Parts A and B and who do not have End Stage Renal Disease (ESRD). These members reside in the counties of Richmond, Bronx, Queens, Kings, New York & Westchester (Partial).

Provider Network

Elderplan conducts evaluations twice a year and analyzes claim and encounter data to ensure that a sufficient number of board certified practitioners in In addition to the Primary Care Physicians, the NPO Department ensures that a sufficient number with expertise in such key areas as geriatrics, cardiology, neurology, nephrology, pulmonology, endocrinology, orthopedics, behavioral health, nurse practitioners, physical therapist, occupational therapist, respiratory therapist along with inpatient acute hospitals and rehabilitation and psychiatric facilities are participating in the network.

It ensures that qualified physicians and nurse practitioners are available to make home visits when the need arises. The plan also ensures the availability of that there are a sufficient number of these specialist physicians who will be available and willing to provide services directly on the premises of the long term care facility. It reviews an inventory of non-participating providers that have performed clinical services in the past to fill any identified or anticipated gaps.

All members must select a participating primary care physician (PCP) who works closely with the member and ICT to assure the member has access to all necessary primary, secondary and tertiary services. The care manager acts as liaison between the PCP and the interdisciplinary care team (ICT) and will encourage and support the member in conversations with his/her PCP.

Care Management and Coordination

Elderplan requires that Nurse Practitioner (NP) uses the Health Status Form (HSF) to complete a comprehensive medical, psychosocial, functional assessment by the designated Nurse Practitioner within the first 30 days of enrollment.

The NP also administers the Naylor Risk of Acute Hospitalization (NRAH) tool to members upon enrollment and annually thereafter to identify medical, psychosocial, functional and cognitive needs. A numeric score is inserted. Using the score of the risk assessment, early stratification of the members' needs forms the basis for beginning the care plan development with collaboration of the primary care physician and the ICT. In addition to these risk assessments, as part of the collaboration with the long term care facilities, the Plan receives a copy of the quarterly and annual MDS (Minimum Data Set) assessment tool. The MDS is completed by registered professional nurse at the facility who is responsible for administering MDS to all residents of the long term care facility.

An enrollment registered nurse develops the initial care plan with member, caregiver and physician support. Subsequently, the ICT team supervisor reviews this information and assigns a care manager, who has access to a variety of clinical guidelines and criteria embedded in the organization's system. The care manager works to develop goals and identify the appropriate interventions, which may include services such as home visits by physicians, telehealth monitoring or palliative care. The care manager elicits member participation in areas such as advance care planning. When the care manager identifies clinical concerns, PCP participation is solicited.

Elderplan evaluates and updates the care plan on a quarterly basis or when the ICT identifies a significant change in condition or health status. The PCP receives a copy via mail or fax. The individualized plan of care (ICP) is accessible and any member of the ICT can update it.

Each ICT consists of designated nurse care managers, social work care managers and managed care coordinators. Elderplan's registered pharmacists, chief medical officer and physician advisors also consult and contribute to ICT teams. Managed care coordinators provide administrative support. In addition to these employed staff, the plan considers the PCP and other professional providers of care part of the ICT. Elderplan also adds behavioral and/or mental health specialists to the ICT as necessary to meet needs of member.

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: http://elderplan.org/