



SCAN 2010 Special Needs Plan (SNP) Model of Care Training

SCAN Health Plan

Course Overview

- The Centers for Medicare and Medicaid (CMS) require all contracted medical providers to receive basic training about the Special Needs Plans (SNP) Model of Care.
- The SNP Model of Care is the plan for delivering coordinated care and case management to special needs members.
- This course will describe how SCAN Health Plan and its contracted providers can work together to successfully deliver the SNP Model of Care.

Learning Objectives

After the training, attendees will be able to:

- Describe the basic components of the SCAN Health Plan SNP Model of Care.
- Explain how SCAN case management programs work and how contracted providers will work with the programs.
- Describe the essential role of contracted providers in delivering the SNP Model of Care.

What are Special Needs Plans?

- Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs.
- There are three types of SNPs that serve the following types of members:
 - Dually eligible members
 - Individuals with chronic conditions
 - Individuals who are institutionalized or eligible for nursing home care

What is the SNP Model of Care?

- The SNP Model of Care is the plan for delivering case management and services for Medicare Advantage members with special needs. It sets guidelines for:
 - Assessment and case management of members
 - Communication among members, caregivers, and providers
 - Use of an Interdisciplinary Team (IDT) of health professionals
 - Integration of the primary care physician (PCP)
 - Measurement of individual and program outcomes

SCAN SNP Model of Care

- Every SNP member is evaluated annually with a Health Risk Assessment
- An Interdisciplinary Team develops an Individualized Care Plan (ICP) with input from members and their caregivers/families
- Members are then triaged to the appropriate SCAN case management program

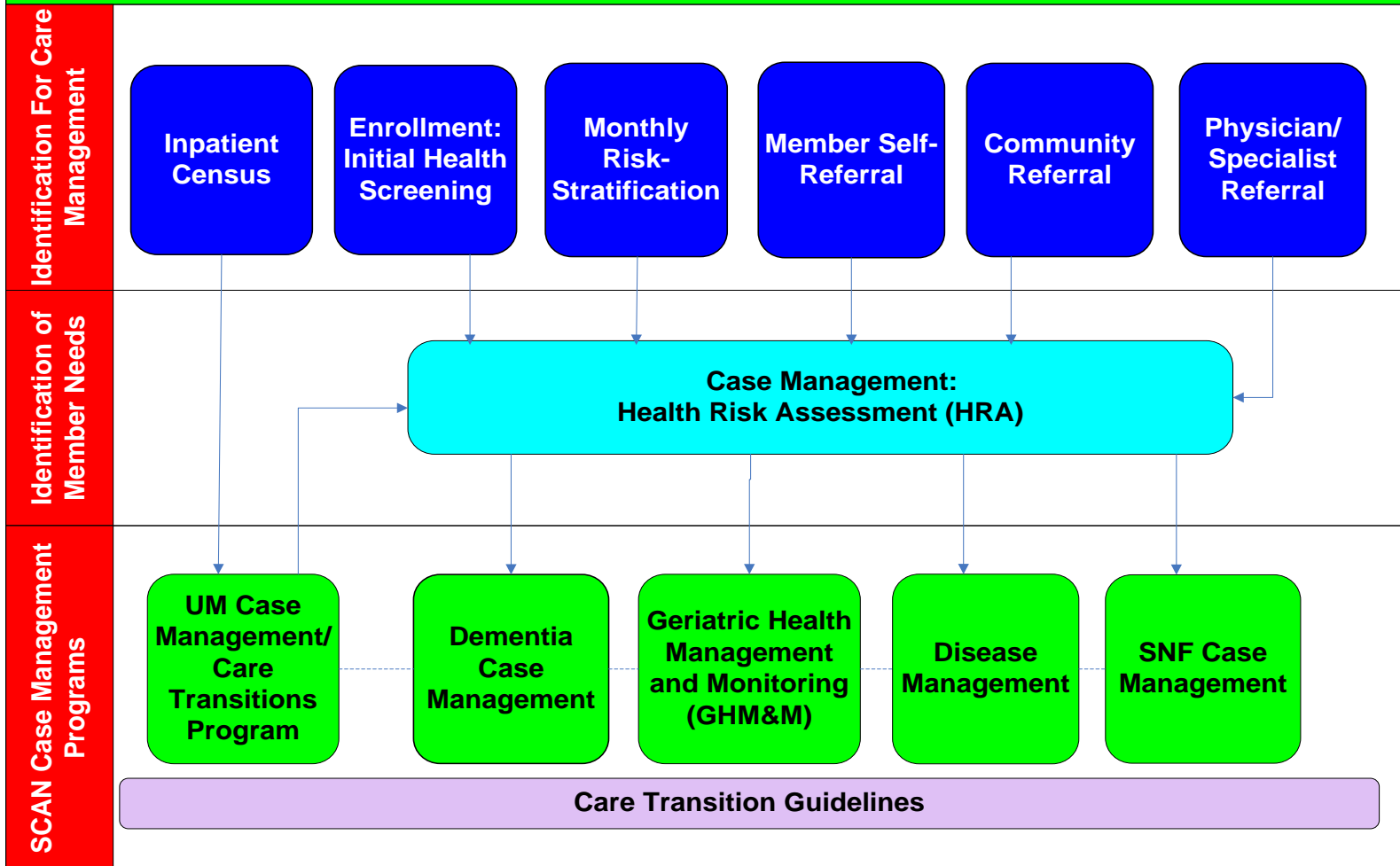


SCAN SNP Model of Care (cont'd)

- Member receives follow up, referral, education
- Member is re-assessed every year
- Case managers and PCPs work closely together to monitor the Individualized Care Plan
- SCAN Health Plan will disseminate evidence-based clinical guidelines and will conduct studies:
 - to measure benefits to member and SCAN
 - to monitor quality of care
 - to evaluate the Model of Care

SCAN Case Management Programs

SCAN Case Management



SCAN Case Management Programs: Inpatient Case Management and Care Transitions

- Inpatient Case Management
 - Coordinates with medical groups to assist members in the hospital or in a skilled nursing facility to access care at the appropriate level
- Care Transitions
 - Ensures members have appropriate follow-up care after a hospitalization
 - The goal is to prevent hospital re-admissions



SCAN Case Management Programs: Geriatric Health Management and Monitoring

- Geriatric Health Management and Monitoring (GHM&M)
 - Assists members living in the community (ambulatory case management)
 - Helps members manage their chronic conditions and medications, and to navigate the health care system



SCAN Case Management Programs: Disease Management

- Disease Management
 - Helps members with Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD)
 - Provides education to members about their disease, self-management/self-care, medication and nutrition

What SCAN Case Managers can do to help Providers

- Determine member's personal goals and needs
- Coordinate care
- Identify problems/anticipate crises
- Educate members about their health conditions and medications
- Coach members to manage according to the provider's plan of care
- Prepare members/caregivers for their provider visits
- Refer members to community resources

Working With Our Providers

- We value our provider partners
- SCAN SNP Model of Care offers the opportunity for us to work together for the benefit of our member, your patient
 - Enhance communication
 - Focus on special needs
 - Deliver case management programs to assist you with patient's non-medical needs
 - Support your plan of care

Your Role as the Provider

- Communicate with SCAN case managers, members of the Interdisciplinary Team (IDT), members and caregivers
- Collaborate with SCAN on the Individualized Care Plan (ICP)
- Review and respond to patient–specific communication
- Maintain ICP in member’s medical record
- Participate in IDT

Model of Care Key Elements

Table of Responsibility

Element	SCAN	SCAN and PO
Implementation of Health Risk Assessment	X	
Development of Individualized Care Plan		X
Case Management		X
Coordination of Behavioral Health Services		X
Use of Interdisciplinary Team		X
Integration of Communication between Members, Plan and Providers		X
Implementation of Annual Provider Training		X
Use of Evidence-Based Guidelines		X
Analysis and Reporting of Outcomes Measures		X
Development of Quality Studies	X	

SCAN Contacts for SNP Model of Care

For Questions About:	Please Contact:	Contact Information:
Outpatient Case Management	Lisa Roth, Director, Geriatric Health Management & Monitoring (GHM&M) and Independent Living Power (ILP)	lroth@scanhealthplan.com 562-637- 7310
Disease Management	Jan Wyrick, Manager, Disease Management	jwyrick@scanhealthplan.com 562-997-1543
Inpatient Case Management	Sharon Fetterman, Director, Utilization Management	sfetterman@scanhealthplan.com 562-989-4433
Care Transitions	Sharon Fetterman, Director, Utilization Management Pat Hegeman, Manager, Complex Care Management	sfetterman@scanhealthplan.com 562-989-4433 phegeman@scanhealthplan.com 562-997-1589
Quality Management	Valli Coakley, Director, Quality Management	vcoakley@scanhealthplan.com 562-989-5127
Provider Services	Karen Sugano, Vice President, Provider Services	ksugano@scanhealthplan.com 562-308-2812