Special Needs Plan (SNP) Model of Care Training

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Agenda and Presenters

Section	Presenter	Presenter Email
Introduction	**Debbie Ong**, HCS Project Principal	debong@scanhealthplan.com
SCAN Mission	**Eve Gelb**, Senior VP Member and Community Health	EGelb@scanhealthplan.com
SNP Basics and Member Journey	**Lisa Roth**, VP Care Management and Social Support	LRoth@scanhealthplan.com
HRAs (Health Risk Assessments), Care Plans and Triggers	**Lisa Desai,** Manager Care Coordination	LDesai@scanhealthplan.com
Individualized Care Plan (ICP)	**Robi Hellman**, Director of Education & Training **Ellen Sloan**, RN, CCM Manager, Senior/Commercial Case Management Monarch	JDespal@scanhealthplan.com
Interdisciplinary Care Team (ICT)	**Maricris Tengco RN**, Director Care Coordination	mtengco@scanhealthplan.com
Care Transitions	**Robi Hellman**, Director of Education & Training	JDespal@scanhealthplan.com
Audit and Oversight	**Adalinda Gutierrez,** Manager, Clinical Network Compliance and Delegation Oversight Quality	AGutierrez@scanhealthplan.com
For Groups with Connections and Connections at Home Members (DSNP) only: DHCS Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)	**Jill McGougan**, Medi-Cal Operations Manager	JMcgougan@scanhealthplan.com

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Important Note

First 60-70 min of the presentation :

- **SCAN's Special Needs Plan (SNP) Model of Care (MOC)Training**
  - This applies to all Medical Groups delegated to provide care for below SNP types:
    - Chronic Special Needs Plan (C-SNP) – Balance, Heart First, VillageHealth
    - Dual Special Needs Plans (D-SNP) - Connections, Connections at Home
    - Institutional Special Needs Plan (I-SNP) – Healthy at Home

Second 20-30 min of the presentation :

- **SCAN's Initial Health Assessment (IHA)/ Staying Healthy Assessment (SHA) Training**
  - This applies to all Medical Groups delegated to provide care for:
    - D-SNP – Connections, Connections at Home

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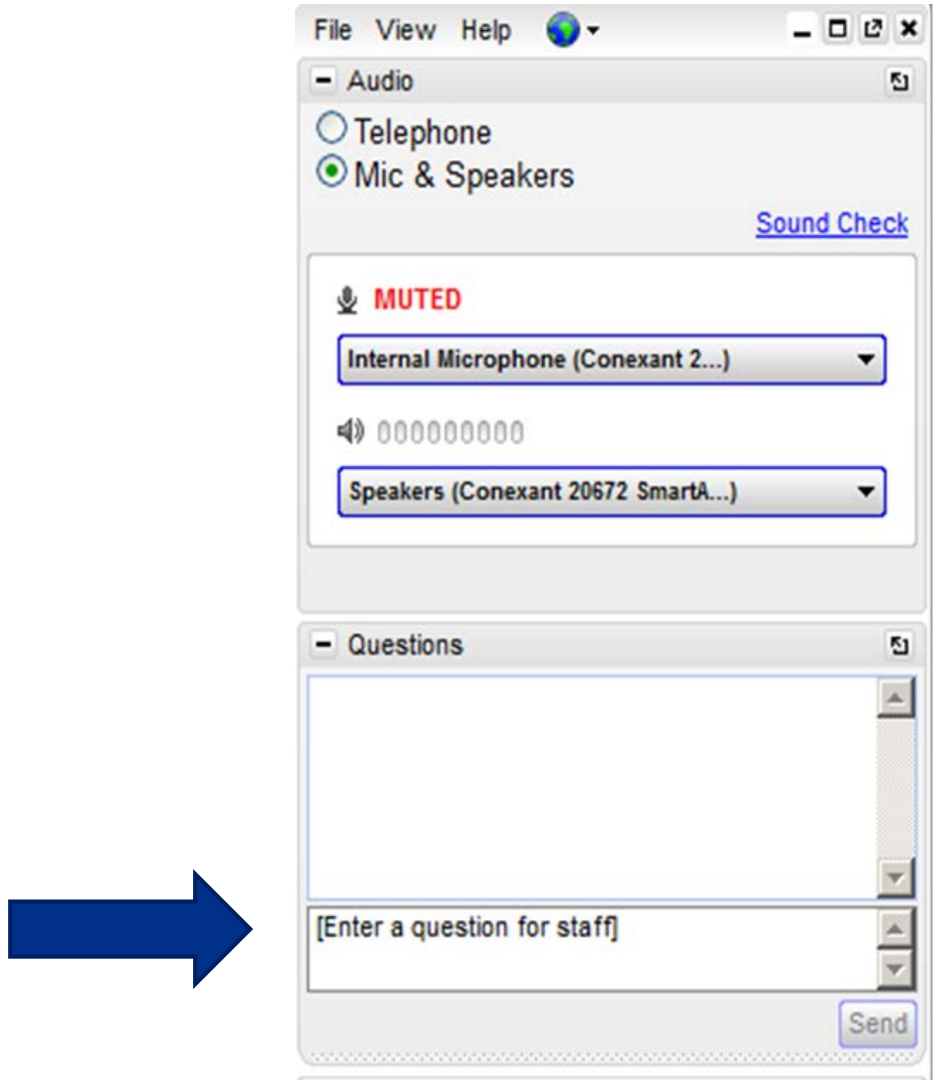
Questions from the Audience



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SNP and SCAN's Mission

Eve Gelb

Senior VP Member and Community Health

Learning Objectives

Describe SNP Basics and the SNP Member Journey

Explain Your Requirements as a SNP Provider

Describe SNP Audit Requirements

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SNP Basics and Member Journey

Lisa Desai

Manager, Care Coordination

The 4 elements of the SNP Model of Care

SNP Population

- Chronic SNP (**C-SNP**)
- Fully Integrated Dual Eligible SNP (**FIDE –SNP)**
- Institutional SNP (**I-SNP**)

Care Coordination

- Health Risk Assessment (**HRA**)
- Individualized Care Plan (**ICP**)
- Interdisciplinary Care Team (**ICT**)
- Care Transitions (**CT**)

Provider Network

- Staff/providers deliver care to SNP members must complete SNP MOC training annually

Quality Measurement & Performance

- Measures are evaluated on an annual basis
- SNP model of care program evaluation process
- Quality Improvement Plan

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Journey of a Special Needs Plan Member (SCAN)

Step 1

Member becomes a SNP member

Step 2

SCAN Verifies Enrollment Eligibility

- Duals – confirm eligibility in Medicare and Medi-Cal
- CSNP – confirm diagnosis

Step 3

SCAN Conducts the HRA and creates initial ICP and ICT

- HRA - Health Risk Assessment
- ICP – Individualized Care Plan

Step 4

Documents placed on SNP sftp/mft

- Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)
- Trigger Report with identified triggers from HRA responses

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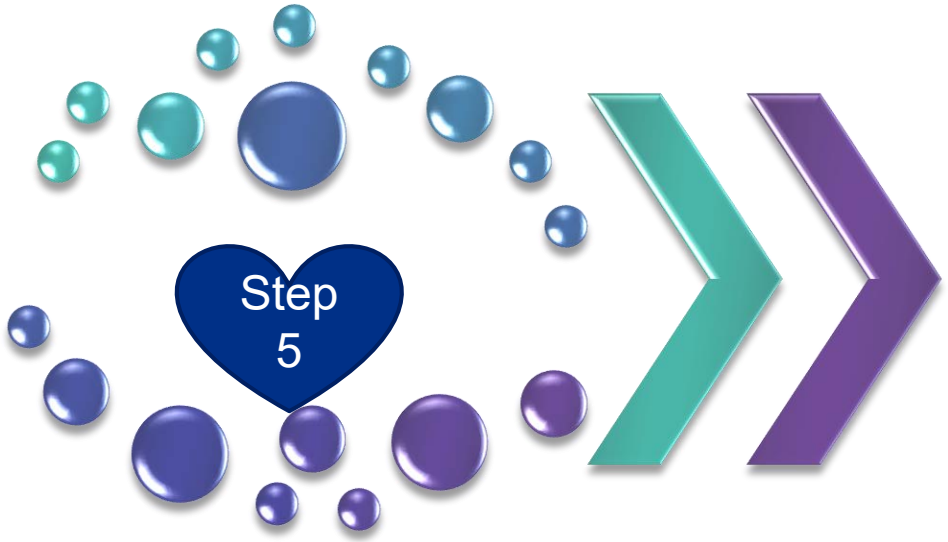
Journey Continues…. SNP Care Management (Medical Group)



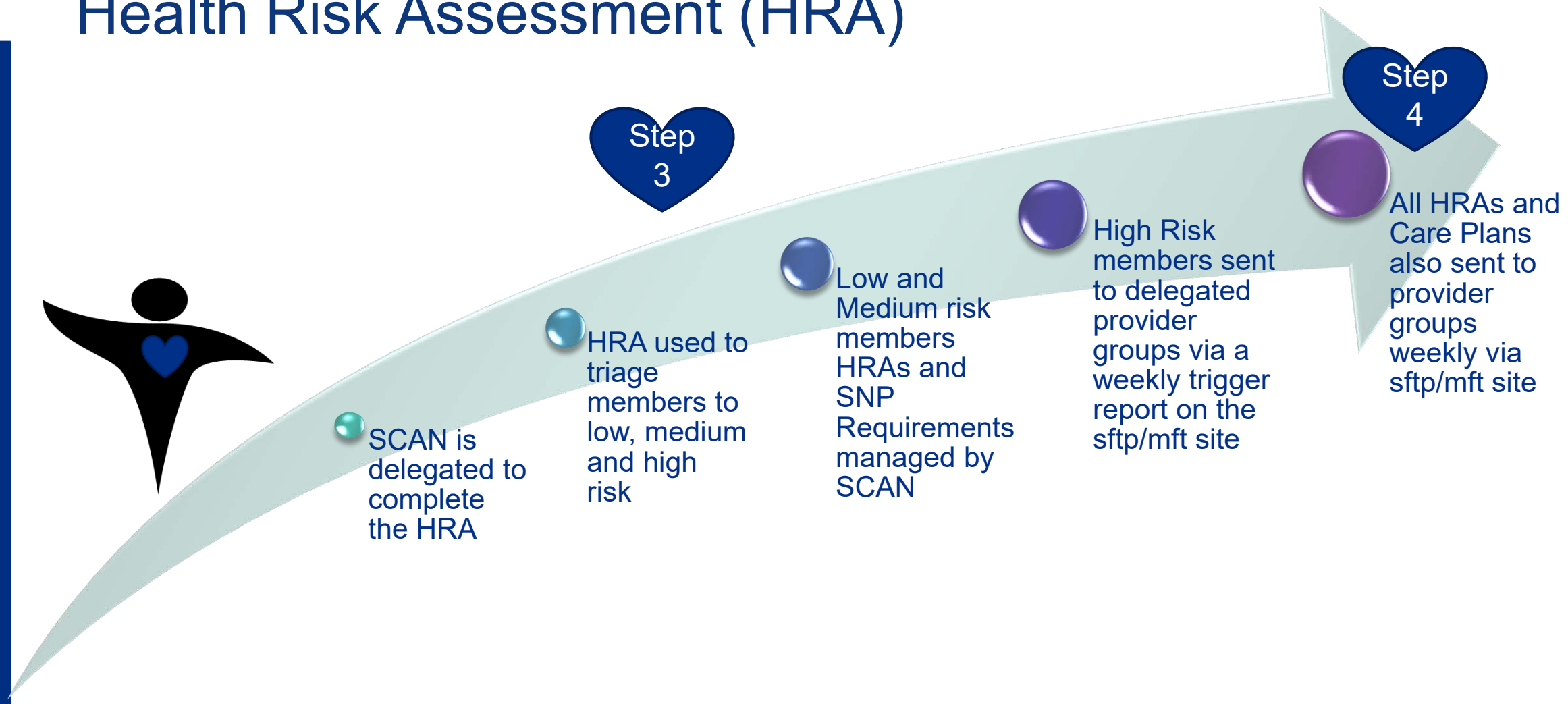
Pick up documents from SNP sftp/mft

- **Case Manager Assignment**
- **Review assessment, care plan and conduct clinical review**
- **Case Manager conduct member outreach**
- **Case Manager work with the member to decide on care management program goals**
- **Care Plan Implementation and Coordination of ICT**
- **Send revised care plan and any education material to member**
- **Re-evaluation of Care Plan and ongoing Follow-up**

HRAs, Care Plans and Trigger Reports

Lisa Desai
Manager, Care Coordination

Health Risk Assessment (HRA)



Provider Group Requirements

Step 5

Pick up weekly trigger reports, HRAs and Care Plans within 7 days of posting on SCAN sftp site

Document in member chart date of trigger report and triggered concerns identified

Complete a clinical review of all available member records, including SCAN HRA and Care Plan

Outreach to member, documenting attempts and outcome (i.e. enrolled in CM, declined, failed contact, etc)

Complete and Document ICT (Interdisciplinary Care Team)

Step 6

Update Care Plan

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HRAs, Care Plans and Trigger Reports

Individualized Care Plan (ICP)

Jeanette Despal, Clinical Trainer

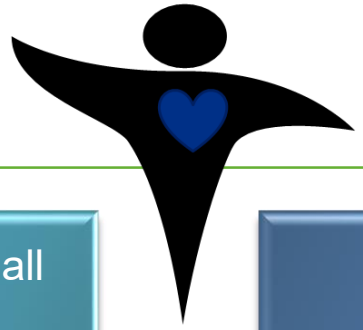
Learning Objectives

Provider expectations for creating a SNP care plan

When to update the Care Plan

Communicating the SNP Care Plan

Creating the SNP Care Plan



Upon receipt of SCAN documents:

Complete a clinical review of all available member records, Prioritize the 3-6 main problems with specific, measureable and time-bound goals and send updated care plan per protocol SCAN HRA and Care Plan and document findings

Outreach to member, documenting attempts and outcome within 30 days of receipt of trigger report

Review triggers with the member on your outreach and assess for any other concerns, determine acuity level and need for case management.

Review all findings in your Interdisciplinary Rounds

Send the revised care plan to PCP and member

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When to Update the Care Plan:

Clinical review identifies a change of health status not reflected on the SCAN care plan

A change of health status occurs at any point during the member journey

During outreach to the member a new concern is identified

As a result of Interdisciplinary review

During outreach a member denies any identified concern or your records indicate it is been addressed

Send the revised care plan to the member and PCP

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Interdisciplinary Care Plan (ICP)

Step 6

Monarch Health

Individualized Care Plan Best Practices

Care Plan Best Practices

ELLEN SLOAN RN CCM

MANAGER SENIOR/COMMERCIAL CASE MANAGEMENT

MONARCH HEALTHCARE

What has helped us to meet MOC requirements

- Good relationship and collaboration with SCAN
- Receiving HRA on members
- Developing assessments to meet requirements
- Creating assessments that follow SCAN's audit tool
- Our clinical charting system (Essette)that allows us to customize assessments
- We update the assessments every year post MOC training and also request updated audit tool annually.

Referral Information

1) Date CM offered and accepted or date of assessment/care plan if member declined or UTC.

2) Participation status

- ○ Accepted CM
- ○ Declined CM
- ○ Unable to contact

3) Introduction of SNP CM Program

- ☐ Informed of right to decline or disenroll from CM program at any time
- ☐ SNP CM program and services offered
- ☐ Personnel responsible for CM and supporting them through transitions
- ☐ Informed of right to request ICT meeting
- ☐ Reviewed available benefits with member

4) Trigger report and HRA status

-- Select One --

Initial Assessment

Referral Information

1) Date CM offered and accepted or date of assessment/care plan if member declined or UTC.

2) Participation status

- ○ Accepted CM
- ○ Declined CM
- ○ Unable to contact

3) Introduction of SNP CM Program

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- ☐ Reviewed available benefits with member

4) Trigger report and HRA status

-- Select One --

Social Determinants of Health

5) What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future.
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

6) Within the past 12 months, you worried that your food would run out before you got money to buy more

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

7) In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes
- ☐ No

8) How hard is it for you to pay for the very basics like food, housing, medical care and heating?

- [ ] Very hard
- [ ] Somewhat hard
- [ ] Not hard at all

9) How often do you feel lonely or isolated from those around you?

- [ ] Never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Always

10) How many times in the past year have you used illegal drugs or prescription drugs for non-medical reasons?

- [ ] Never
- [ ] Once or twice
- [ ] Monthly
- [ ] Weekly
- [ ] Daily or almost daily

11) Feeling down, depressed or hopeless?

- [ ] Not at all
- [ ] Several days
- [ ] More than half the days
- [ ] Nearly every day

SNP Assessment

12) Self-reported health status

- ◯ Good
- ◯ Fair
- ◯ Poor

13) Identify and describe member's health conditions

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14) Describe member's behavioral health status

- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Schizophrenia
- ☐ Substance abuse
- ☐ Other
- ☐ No behavioral health conditions
- ☐ Unable to assess

15) Cognitive status

- ◯ Alert/oriented, able to focus and shift attention, comprehend and recall direction independently
- ◯ Requires prompting only under stressful situations or unfamiliar conditions
- ◯ Requires assistance and some direction in specific situations or consistently requires low stimulus environment due to distractibility
- ◯ Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ◯ Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.
- ◯ Unable to assess

16) Member's preferred language

- ◯ English
- ◯ Spanish
- ◯ Vietnamese
- ◯ Farsi
- ◯ Korean
- ◯ Chinese
- ◯ Other
- ◯ Unknown

17) Limitations and barriers that pose potential challenges

- ☐ Barriers with language or literacy
- ☐ Cultural or spiritual beliefs
- ☐ Financial or insurance issues
- ☐ Lack of caregiver support and/or psychological impairment
- ☐ Lack of reliable transportation
- ☐ Lack of understanding of medical conditions
- ☐ Lack of motivation
- ☐ Visual or hearing impairment
- ☐ None
- ☐ Other
- ☐ Unable to assess

18) Caregiver status

- ☐ Caregiver assists with ADL's
- ☐ Caregiver assists with finances
- ☐ Caregiver assists with medications
- ☐ Caregiver is involved in decision making
- ☐ No caregiver involvement
- ☐ Potential caregiver issues, such as neglect or abuse
- ☐ Lives in Assisted Living where assistance is available PRN

19) Name and relationship of caregiver(s)

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20) Fall risk screening

- [ ] Walking or balance problems
- [ ] Falls during the past year?
- [ ] No history of falls

21) Recommended preventive care

- [ ] Annual flu shot
- [ ] Pneumonia vaccine
- [ ] Colorectal cancer screening
- [ ] Breast cancer screening
- [ ] A1C
- [ ] LDL
- [ ] Glaucoma
- [ ] Retinal eye exam
- [ ] Other
- [ ] None due at this time

22) ADL status

-- Select One --

23) Hearing status

- [ ] Adequate hearing
- [ ] Inadequate hearing

24) Vision status

- [ ] Adequate vision
- [ ] Inadequate vision

25) Over the past 6 months, how would you rate your pain on a scale of 0-10, 10 being the worst? N/A if unable to assess

SNP ICT

1) Trigger report received

2) ICT date

3) ICT type

- ◯ Post trigger report
- ◯ Change in health status
- ◯ Opened to Case Management
- ◯ Referral to Case Management

4) Care Management Level

- ◯ Basic Care Management
- ◯ Care Coordination
- ◯ Complex
- ◯ HRA received
- ◯ HRA failed or declined

PCP or Urgent Care/Hospitalizations

5) Has member completed an annual wellness visit with the PCP this year?

- (•) Yes
  - Date
    - [ ] 
- ( ) No

6) Has member been in ER or Urgent Care or been hospitalized this year?

- (•) Yes
  - Date of most current visit
    - [ ] 
- ( ) No

Medical Status

7) Medical conditions

- ☐ Asthma
- ☐ CHF
- ☐ Cholesterol
- ☐ Chronic pain
- ☐ COPD
- ☐ Diabetes
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Osteoarthritis
- ☐ Mental health condition
- ☐ Rheumatoid arthritis
- ☐ Substance abuse
- ☐ Other

Psychosocial Status

8) Psychosocial status

- ☐ Lives alone
- ☐ Lives with caregiver
- ☐ Adequate housing
- ☐ Inadequate housing
- ☐ Cognitive problems
- ☐ Problems with finances
- ☐ Problems with adherence
- ☐ Other

ICT

9) ICT Participants ***All Monarch Healthcare attendees have attended MOC training

- ☐ PCP
- ☐ Member/DPOA
- ☐ Bahareh Khavarian MD
- ☐ Melissa Lehrich LCSW
- ☐ Janice Asuncion RN
- ☐ Betsy Williams RN
- ☐ Charo Villareal RN
- ☐ Evelyn Miramontes, CMA/Coordinator
- ☐ Other Attendees:

10) Discussion notes

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Thanks for Listening :)
Blingee

Interdisciplinary Care Team (ICT)

Maricris Tengco

Director of Care Coordination

ICT Objectives

Define SNP ICT requirements

Define the roles and composition of ICT

Understand different format of ICT

Provide clear description of the communication plan between ICT members and clear documentation of the ICT

SNP ICT Requirements

	1	2	3
Requirements	**All SNP members received from HRA trigger report and via referral process**	**Composition of ICT (at minimum):** • **CM assigned** • **Care Coordinator** • **Medical Expert (e.g. PCP, Specialist, Nurse Practitioner, Medical Director)** • **Member/Representative (if available)**	**ICT Format:** • **In- person** • **Telephonically** • **Electronically** 
Operations and Documentation	1. Complete within 30 days of receipt 2. Includes failed contact and declined	1. All ICT participants are required to complete MOC training (attestation is needed) 2. ICT recommendations and decisions are documented in the member's record (electronic or paper chart) 3. Evidence that copy of care plan was provided to/available to ICT participants and members	1. Date member trigger report/referral received 2. Member's acuity level 3. Date of ICT 4. ICT Participants 5. If member has seen their PCP or had any ER visits/ hospitalizations in the last year 6. Summary of case discussion and recommendations

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Interdisciplinary Care Team (ICT)

Care Transitions

Jeanette Despal, Clinical Trainer

Care Transitions Objectives

CT Overview

Provider Expectations

CT logs

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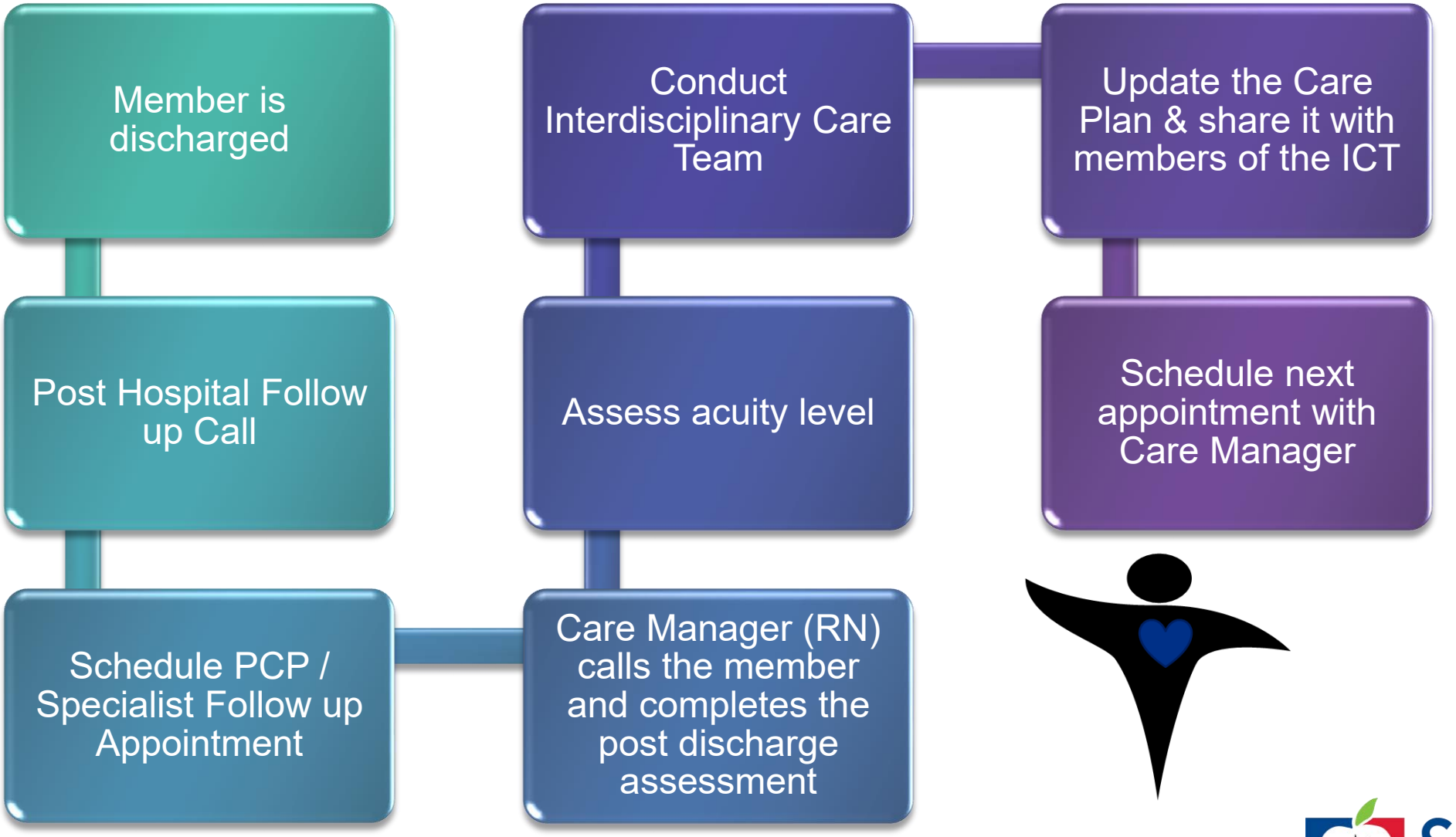
Journey Continues…. SNP Care Transitions



Care Transitions (CT)

Delegated Medical Group Expectation

Care Transitions documentation must include:

- Members contacted (or attempts made) within five business days of discharge notification from one setting to another
- Notification to PCP within five business days of discharge
- Ensure follow-up services and appointments are scheduled within 5 business days of transition
- Care is provided by appropriate persons
- Care plan transferred between settings before, during, after transition of care
- Member coaching occurred
- Members of the ICT and members/caregivers have access to the plan of care

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2020 SCAN CT Log Due Dates

SCAN provides oversight to ensure regulatory and compliance requirements are met

CT logs are to be submitted on a quarterly basis:

- May 15 (Q1)
- August 15 (Q2)
- November 15 (Q3)
- Feb15 (Q4)

Upload to the sftp site into the 'SNP' folder

A sweep will then pick up the data and generate the compliance report

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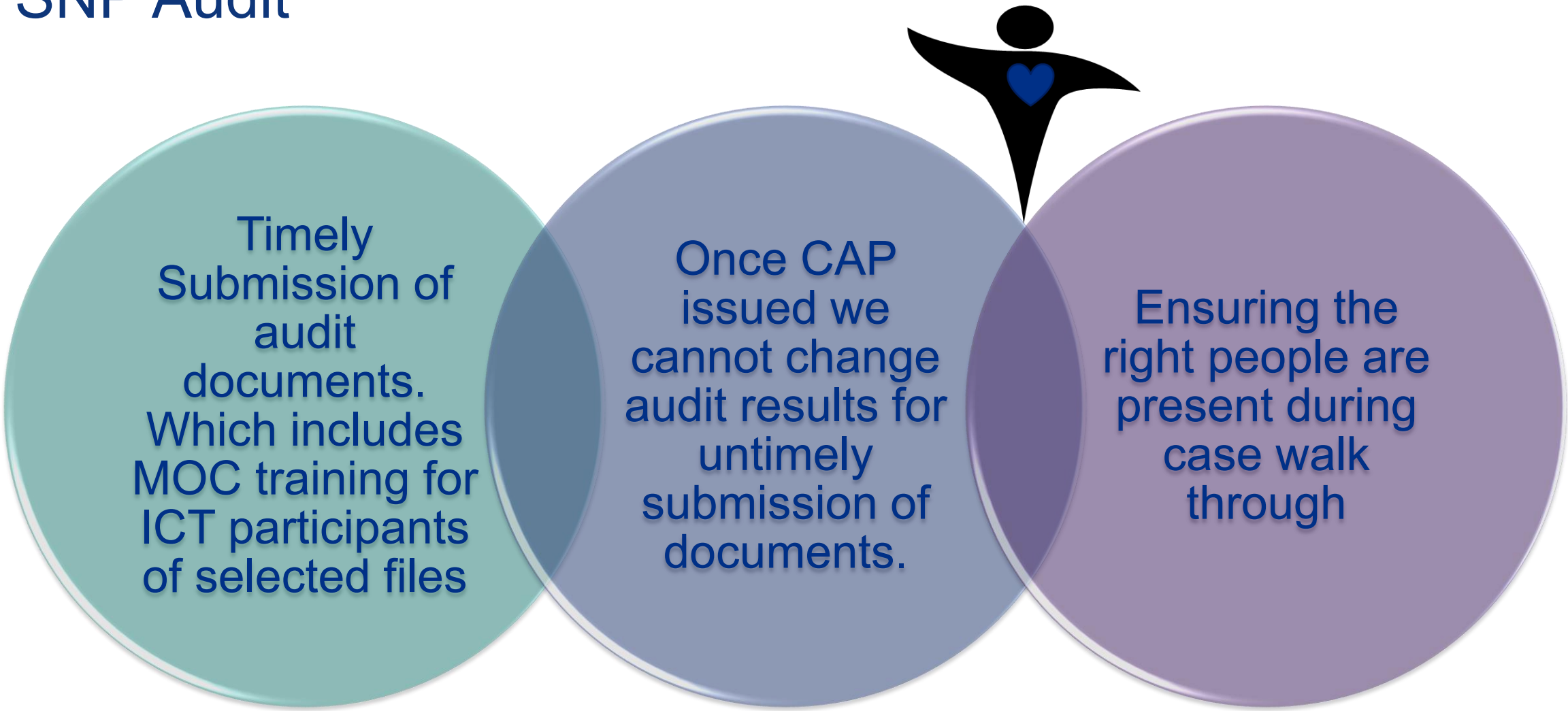
Care Transitions

Audit and Oversight

Adalinda Gutierrez

Manager, Clinical Network Compliance & Delegation Oversight Quality

SNP Audit



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Corrective Action Plan

Corrective Action Plans

- Root Cause Analysis- the “why” deficiency occurred.
- Corrective Action Plan- Group plan for correcting deficiency
- Implementation Date
- Responsible Individual- Must be a person not a department

Repeat Deficiencies

- Cannot accept same root cause or corrective action plan from previous submitted CAP

File Review Deficiencies (Case walk through)

- Corrective Action Plan. Cannot site that they will update a policy only.

Questions?

Initial Health Assessment /Staying Healthy Assessment Annual Provider Training

Jill McGougan

Benefits of Comprehensive Assessments

Who's Responsible for What- The Delegated Agreement

Provider Group Expectations

Benefits of Comprehensive Assessments

- Americans can avoid 100,000 deaths annually, if 90% of adults receive annual wellness visit/age-appropriate screenings- Mark Ryan, M.D., Doctors Articles, Primary Care
- Increases the member's likelihood of obtaining timely age-specific preventive services
- Establishes a baseline, especially for older or more chronically ill patients whose function can change drastically from year to year
- Helps to improve preventative and care coordination metrics, and identifies detrimental social determinants of health
- Encourages trust and mutual respect in the patient-PCP relationship

Regulatory Requirements

Medicare

- Initial Medical Appointment/Assessment within 90 days of enrollment (Welcome to Medicare)
- Annual Appointment (Annual Wellness Visit or AWV) – once per year

Medi-Cal

- Initial Health Assessment (IHA) within 120 days of enrollment
- Must use Staying Healthy Assessment (SHA) Form (DHCS approved form)
- Annual Assessment – within 365 days of previous assessment

*** SCAN Policy is for IHA/SHA to be completed within 90 days of enrollment.**

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Regulatory Requirements for Medi-Medi Members

Initial Health Assessment (IHA)/Staying Healthy Assessment (SHA) within 90 days of enrollment and annually*

Initial Health Assessment (IHA)

- Comprehensive Exam with PCP
- Documentation of all areas assessed
- Please note outreach attempts in Member's Medical Record

Staying Healthy Assessment (SHA)

- DHCS Approved Form
- Included as part of Member's Medical Record
- Please note if member declines to complete

Initial or Annual or Preventative Visit Code

- Appropriate coding for initial and annual visits
- Code list included with IHA ASAP report

*DHCS Requirement: Title 22, CCR, Section 53851 (b) (1)

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Who's Responsible for What – The Delegated Agreement

SCAN

- Educate medical groups on IHA/SHA requirements
- Ensure providers are conducting IHA/SHA and AWV
- Monitor/audit

Provider Organizations

- Train employed and contracted providers on IHA/SHA/AWV requirements
- Monitor IHA/SHA/AWV and support providers to complete

Contracted Providers/IPAs

- Track patients and outreach to those due/past due for initial and annual wellness visits
- Ask patients to complete the SHA form, develop plan with patient and review annually, must be filed/documented in patient chart/medical record

Provider Group Expectations

Policies and Procedures around IHA/SHA and AWV expectations for employed and contracted Providers

- Delineate Provider Group role in monitoring, training and supporting the completion of the IHA/SHA and AWV
- Initial and Annual Provider Training

Monthly monitoring of completion of IHA/SHA and AWV

- Track using SCAN Provider Portal Report – IHA_ASAP Report (must access by the 15th of every month)
- Outreach to Providers
- Outreach to Patients

Ensure Provider documentation (patient medical record) includes:

- Staying Healthy Assessment form
- Risks identified are addressed, including appropriate tests/screenings
- Areas of low risk are documented indicating why corresponding tests/screenings are not needed

Requirements also part of the SCAN Provider Operations Manual (POM)

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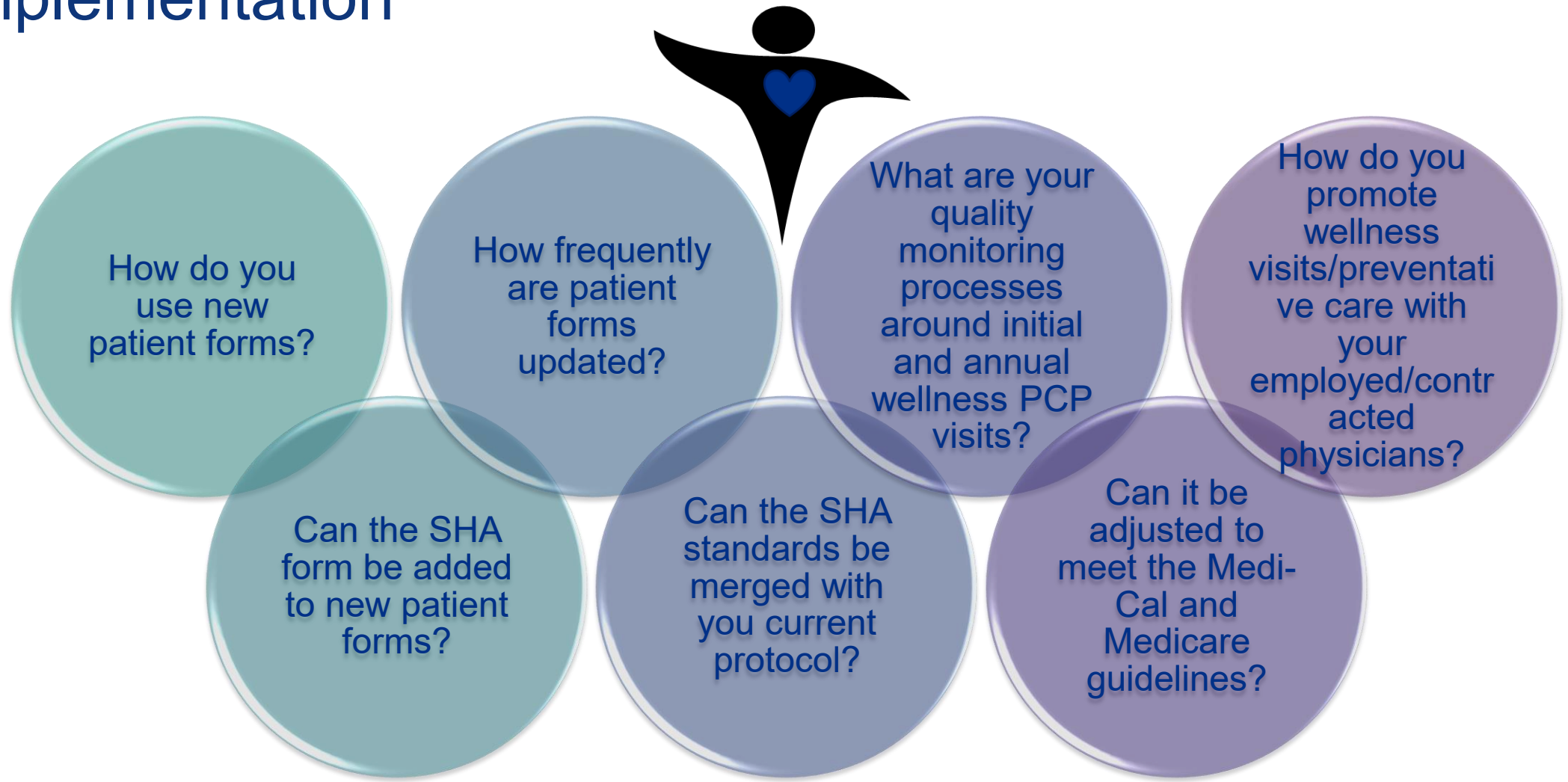
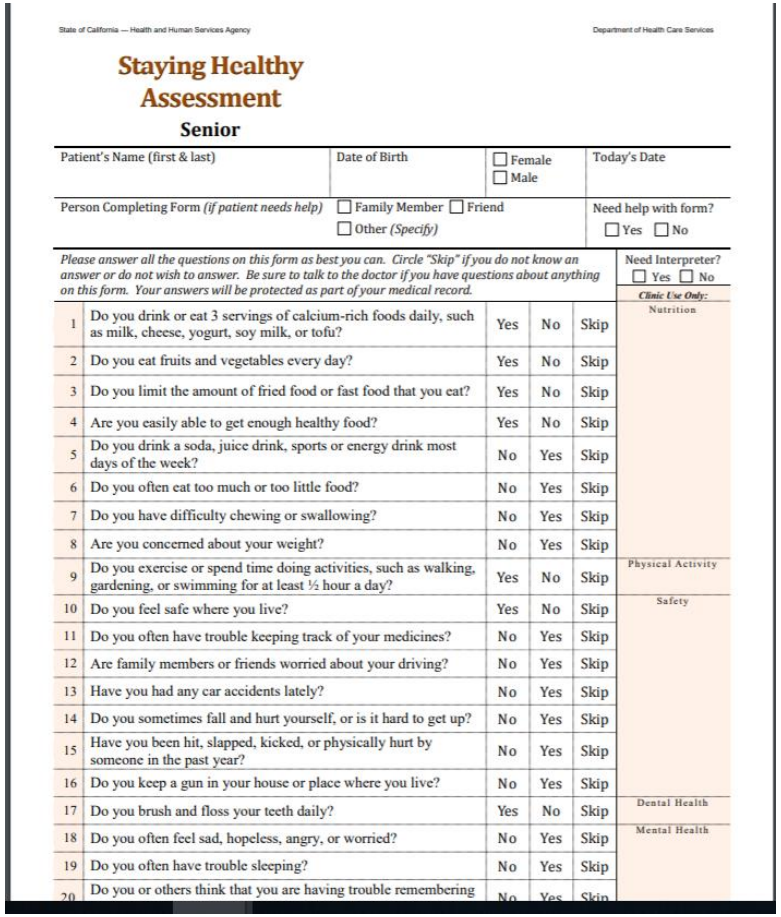
Implementation



DHCS Staying Healthy Assessment Form

Every question needs a response



State of California — Health and Human Services Agency — Department of Health Care Services

Staying Healthy Assessment

Senior

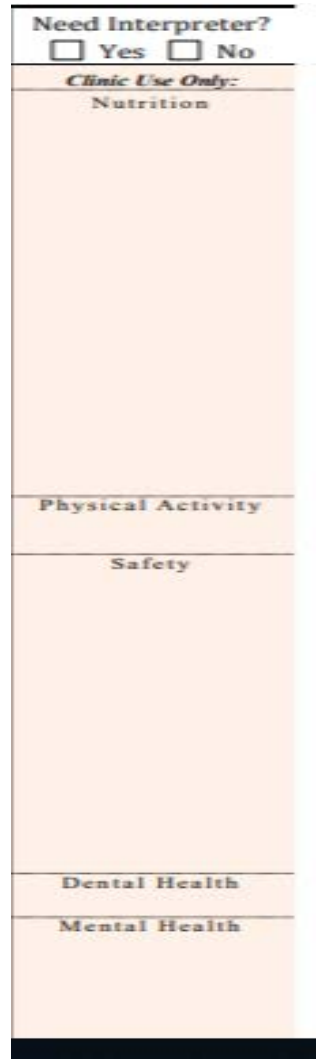
Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)* ☐ Family Member ☐ Friend ☐ Other *(Specify)*			Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering	No	Yes	Skip	



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DHCS Staying Healthy Assessment Form Continued

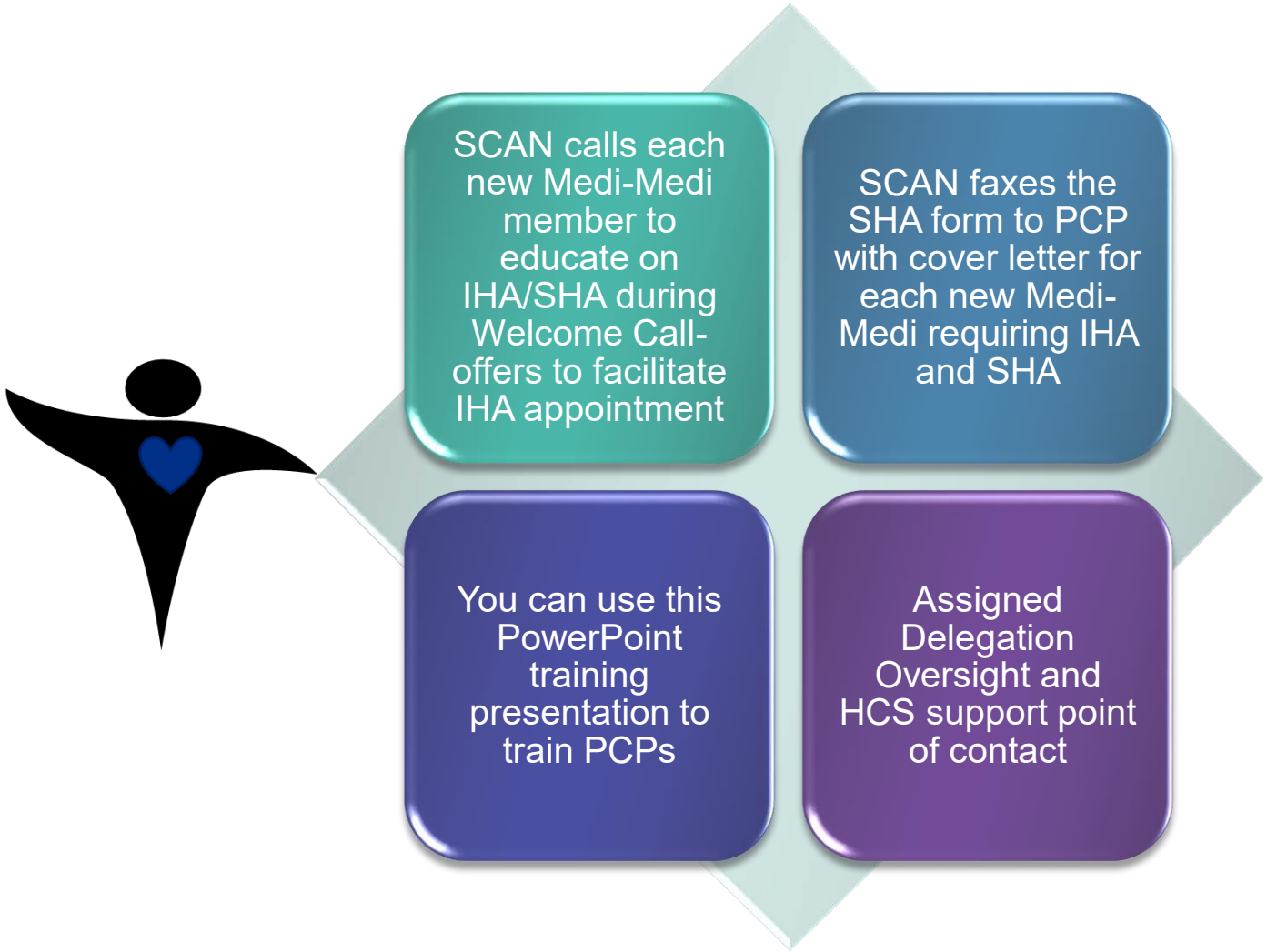
Be sure PCP completes the intervention section and signs the form

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	
☐ Independent Living	☐	☐	☐	☐	☐ Patient Declined the SHA

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

DHCS 7098 I (Rev 12/13) SHA (Senior) Page 2 of 2

Partnering with SCAN



Resources

DHCS fact sheet/FAQ:

http://www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHA_FAQs.pdf

SHA forms:

http://www.dhcs.ca.gov/formsandpubs/forms/pages/staying healthy.aspx

Policy Letter 13-001 (Revised):

http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx

United States Preventative Services Task Force:

https://www.uspreventiveservicestaskforce.org/BrowseRec/Index

All Plan Letter 20-004 (Revised):

https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Questions?

Thank you!

Appendix – SNP MOC

Appendix Table of Contents – SNP MOC

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SCAN's Mission

SCAN Health Plan (SCAN) is one of the nation's largest not-for-profit Medicare Advantage (MA) plan, serving over 200,000 members in California.

SCAN's mission is to keep seniors healthy and independent. We do this is by providing comprehensive medical coverage, prescription benefits, and support services specifically designed to meet the unique needs of Seniors.

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SNP types and eligibility

Chronic Special Needs Plan (C-SNP)

Eligibility verified 30 days post enrollment

- Balance Plan: Diabetes
- Heart First Plan: CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder
- VillageHealth Plan: ESRD

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP/D-SNP)

Eligibility verified monthly

- Designed for members who have both Medicare Part A and Part B, Full Medicaid benefits and FIDE SNP
- Connections and Connections at Home Plans

Institutional Special Needs Plan (I-SNP)

Eligibility verified by outside vendor

- Meet state criteria for Nursing Facility Level of Care (NFLOC)
- Healthy at Home Plan - Must reside in the community and not a facility (I-SNP is Institutional-Equivalent)

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SNP Goals and Purpose of a SNP

Improve access and affordability to member healthcare needs

Improve coordination of care and ensure appropriate delivery of services through the alignment of the HRA, ICP and ICT

Enhance care transitions across all healthcare settings

Ensure appropriate utilization of services for preventative health and chronic conditions

Improve member health outcomes

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Division of Responsibilities – Plan/Group

SCAN Health Plan

- Diagnosis Verification (C-SNP)
- Health Risk Assessment (HRA) and Care Plan (Initial & Annual)*
- Provide Weekly Trigger Reports
- Provide Tools & Resources

Delegated Medical Group

- Review & Act on Trigger Reports
- Provide CM, Interdisciplinary Care & Care Transitions (CT)*
- Submit Care Transitions (CT) Reports Quarterly*
- For those in Care Management, Update Care Plan*

* Village Health Responsibility for End State Renal Disease (ESRD)

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Health Risk Assessment (HRA)

SCAN

SCAN is responsible for the Health Risk Assessment (HRA)

- Conducted within 90 days of enrollment and annually prior to 365 days from last

Contact attempts to members include telephonic outreach, as well as letters that include paper HRA forms to complete and return by mail

Minimum outreach attempts to member is three, we often make at least five attempts

Other SCAN assessments meet requirement of HRA (NFLOC)

HRA addresses required domains of medical, functional, psychosocial, mental health and cognition

Screens SNP members for care coordination, complex care management (and long-term services and supports for D-SNP)

Health Risk Assessment (HRA)

Delegated Medical Group Expectation

Delegates required to retrieve HRAs, care plans and trigger reports within 7 calendar days of posting on SCAN's SNP sFTP or MFT site (trigger reports are sent the Monday after assessment)

Delegates are required to do (within 30 calendar days of receiving the trigger report) in the members' records:

- Document the date the trigger report was reviewed
- Document clinical review and outreach attempts (min. 3 attempts within 2 weeks)
- Address care management triggers by analyzing findings from HRA and other assessments and inputs and document the following:
- If unable to reach members or members decline to participate, follow organization protocol to complete the activities based on information available in the organization's system and update the documentation
- Document next steps/plan of care going forward (sent letter, etc.)
- If member not enrolled in care management, reason (failed contact, declined)
- ICT documentation for all SNP members that triggers regardless of level of acuity

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HRA triggers

"Poor" self-rated health

2 or more drinks per day

Pain interferes with daily activities every day

2 or more falls in the last year

2 or more ER visits in the last year

2 or more unplanned hospital admissions in the last year

Health concerns that have not been addressed by the PCP or Specialist

12 or more medications

Difficulty managing and taking medications as prescribed

Experiencing symptoms or side effects related to medications most or all of the time

Moderate to severe depression (PHQ-2)

Difficulty with ADLs (bathing, eating, toileting

Member is afraid of someone hurting them

Member requests care manager support

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Individualized Care Plan (ICP)

Delegated Medical Group Expectation

Address all documented triggers and review with member on outreach. Prioritize the 3-6 main problems with specific, measureable and time-bound goals and send updated care plan per protocol. Assess acuity and offer case management.

Measurable goals include the current status, progress to meeting the goal, barriers to achieving the goal and the desired outcome

Documentation shows ongoing review and revision of the ICP that reflect changes in health status(a new diagnosis, recent hospitalization, functional status, etc.)

Evidence of ICP being sent and to members and primary care physicians anytime the care plan is updated

ICT recommendations are documented in the care plan

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Interdisciplinary Care Team (ICT)

Delegated Medical Group Expectation

All triggered SNP members and SNP members received thru referral process need to have an Interdisciplinary Team (ICT) completed regardless of acuity level within 30 days of referral

Minimum ICT composition (collaboration between any of the following):

- CM assigned to member
- Care coordinator (from SCAN)
- Medical expert (primary care physician, specialist, etc.)
- Members/caregivers if available

Interactions and collaborations can occur in person, telephonically or electronically (a formal ICT meeting not necessary for all)

ICT documentation must include evidence of the following:

- Date of ICT collaboration
- List of all ICT participants (including all recommended providers)
- Interventions/recommendations
- Evidence that copy of care plan was provided to/available to ICT participants and members

Documentation that all ICT participants completed SNP MOC training

Care Transitions (CT)

Delegated Medical Group Expectation

Care Transitions documentation must include:

- Members contacted (or attempts made) within five business days post- notification of discharge from one setting to another
- Notification to PCP within five business days of discharge
- Ensure follow-up services and appointments are scheduled within 5 business days of transition
- Care is provided by appropriate persons
- Care plan transferred between settings before, during, after transition of care
- Member coaching occurred
- Members of the ICT and members/caregivers have access to the plan of care

Submission of care transition logs to SCAN SNP sftp on a quarterly basis:

- SCAN provides oversight to ensure regulatory and compliance requirements are met

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SNP sFTP-MFT Operations

SNP Report	Job Schedule	Day of the Week Report is Sent
Completed HRA and Care Plans	Weekly	Saturdays
Trigger Reports	Weekly	Mondays
SNP Census	Monthly	2nd of Month

CMS SNP Resources

CMS Website

- https://www.cms.gov
  - Medicare Managed Care Manual Chapter 5
  - Medicare Managed Care Manual Chapter 16b

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SCAN SNP Resources

- **Debbie Ong**
  SNP Project Principal
  debong@scanhealthplan.com
  562.308.4313

Appendix – IHA/SHA

Appendix Table of Contents – IHA/SHA

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Components of a Comprehensive Assessment

Complete history and physical (includes, but not limited to):

- Present and past illness(es) with hospitalizations, operations, meds
- Physical exam including review of all organ systems
- Height, weight, BMI, BP, cholesterol screening
- Preventative services per USPSTF A and B Guidelines for 65-year old (age appropriate assessments such as TB screening, clinical breast exam, allergy, chlamydia, mammogram, pap smear)

Social history

- Current living situation/marital status
- Work history/education level
- Sexual history/use of alcohol, tobacco and drugs

Components of Comprehensive Assessment

Mental health and status evaluation

Assessment of risk factors- using the Staying Healthy Assessment (SHA)

- REQUIRED for all Dually Enrolled Medi-Cal/Medicare members
- Development of behavioral risk health education – to include assessment of:
  - Nutrition
  - Functional status (including ADL/IADLs)
  - Physical Activity
  - Environmental Safety
  - Dental/Oral Health

Diagnoses and plan of care

Clinical Based guidelines as best practice in development of plan of care

How to identify SCAN members who need IHA/SHA

SCAN provides list of new members on monthly basis

SCAN provides detailed patient-level data through IHA ASAP Report

- To access the report on the SCAN provider portal:
  - Access the SCAN Provider Portal
  - Click on SCAN Documents
  - Click on Network
  - Access the IHA_ASAP folder

Providers are required to make reasonable attempts to contact members and schedule IHA. SCAN recognizes best practice of three good-faith attempts. Documented attempts that demonstrate unsuccessful efforts to contact members to schedule IHA will be considered evidence in meeting requirement.

Preparing for the DHCS Audit