Model of Care Training for Simply Healthcare SNP Providers
BACKGROUND OF SNP

- SNP = Special Needs Plan
- It is a different type of Medicare Advantage Plan that focuses on beneficiaries that have special needs and would benefit from focused coordination of care

At the core of the SNP is to provide:
  - Improved Access
  - Coordination
  - Continuity of Care

Focus of the SNPs:
  - Monitor health status
  - Identification of the members’ needs
  - Improving Access to Quality Healthcare & Benefits
  - Chronic Disease Management
  - Prevent avoidable hospitalizations
  - Decrease medical, mental and social risks
SNP TARGET POPULATIONS

Simply Healthcare has 5 distinct SNP products for Individuals who have Medicare Part A, Part B, and Part D

A Dual Eligible Special Needs Plan (D-SNP) – for individuals who have both Medicare and Medicaid
SNP TARGET POPULATIONS

**An Institutional Equivalent Special Needs Plan (IE-SNP)** – for individuals who reside at home or an ALF but require an equivalent level of care of a long term facility [skilled nursing facility (SNF)/NF, Intermediate Care Facility (ICF) or Inpatient Care Facility].

**An Institutional Special Needs Plan (I-SNP)** – for individuals who reside or are expected to reside for 90 days or longer in a long term care facility (skilled nursing facility (SNF)/NF, Intermediate Care Facility (ICF) or Inpatient Care Facility).
A Chronic Special Needs Plan (C–SNP) for people living with HIV/AIDS

A Chronic Special Needs Plan (C–SNP) for persons living with Diabetes
**WHAT IS THE DIFFERENCE?**

**ELIGIBILITY**
- Simply Care is for individuals who reside or are expected to reside for 90 days or longer in a long term facility (SNF/NF), Intermediate Care Facility (ICF) or Inpatient Care Facility

**CASE MANAGEMENT**
- Members are automatically enrolled in the Case Management Program unless actively choosing to “Opt-Out” of this service
- Medical case management is provided to the member face-to-face and/or telephonically by an assigned Nurse Practitioner (NP) or nurse case manager

**HEALTH RISK ASSESSMENT(HRA)**
- HRA Assessment and Care Plan are done within 30 days of enrollment

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**ELIGIBILITY**
- Simply Comfort is for individuals that are either in Assisted Living Facilities or at home but they meet Nursing Home Criteria Level of Care (LOC) criteria

**CASE MANAGEMENT**
- Members are automatically enrolled in the Case Management Program unless actively choosing to “Opt-Out” of this service
- Medical case management is provided to the member face-to-face and/or telephonically by an assigned Nurse Practitioner (NP) or nurse case manager

**HEALTH RISK ASSESSMENT(HRA)**
- HRA Assessment and Care Plan are done within 30 days of enrollment

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**ELIGIBILITY**
- Simply Complete is for individuals that have both Medicare and Medicaid with special needs but do not meet criteria for nursing home.

**CASE MANAGEMENT**
- Member must actively decide to “Opt-In” to the Case Management Program
- Telephonic Contact with a Clinical Care Manager (RN/LPN/MSW)

**HEALTH RISK ASSESSMENT(HRA)**
- HRA Assessment and Care Plan are done within 90 days of enrollment
WHAT IS THE DIFFERENCE?

**ELIGIBILITY**
- Simply Clear is for individuals that have a confirmed diagnosis of HIV/AIDS

**CASE MANAGEMENT**
- Members are automatically enrolled in the Case Management Program unless actively choosing to “Opt-Out” of this service
- Case management is provided telephonically a Clinical Case Manager (RN/LPN/MSW) who has specialized training or experience in working with this population

**HEALTH RISK ASSESSMENT (HRA)**
- HRA Assessment and Care Plan are done within 90 days of enrollment

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**ELIGIBILITY**
- Simply Level is for individuals that have a confirmed diagnosis of Diabetes

**CASE MANAGEMENT**
- Member must actively choose to “Opt-In” (participate) to the Case Management Program
- Case management is provided telephonically a Clinical Case Manager (RN/LPN/MSW) who has specialized training or experience in working with this population

**HEALTH RISK ASSESSMENT (HRA)**
- HRA Assessment and Care Plan are done within 90 days of enrollment
A Nurse Practitioner (at no cost to facility) who provides individualized services and/or a case manager who closely monitors and coordinates care for your residents.

- What will NP or RN case manager do?
  - HRA (initial and annual)
  - COA (Care for Older Adults) evaluation
  - Periodic Visits to member
  - Prescribe medication as discussed with the PCP (NP only under protocol with member’s PCP)
  - Order diagnostic testing
  - Coordinate with the PCP
  - Plan of Care
  - Medication Reconciliation
  - Post Hospitalization Visits
  - Communicate with Family Members and Caregivers
INTERDISCIPLINARY CARE TEAM (ICT)

- Comprised of the member/family/caregiver (as appropriate) and those involved in the member’s care (PCP, specialist(s), case manager, and others as needed) to provide a member-centered approach to care and collaborate in care planning. This includes discussions concerning the individual’s health status, current/possible interventions, and goals for the member.

- Internal Health Services ICT Meetings– The team is led by the Medical Director and includes, as needed/available, members of the health services department who are identified as part of the members ICT team (e.g., NP, Care Manager, PCP, clinical pharmacist, social worker and caregiver). The health services department maintains regularly scheduled ICT team meetings to review clinical progress of Moderate/High Risk cases.

- Member-Centered ICT Meetings– The team meets regularly and includes, as needed/available, the care manager or NP, providers, PCP, member or legal representative(s), and others involved in the member’s care.

- RECAP: The ICT is comprised of:
  - The Member
  - The member’s caregiver/relative/legal representative(s)
  - Our Nurse Practitioner or Case Manager
  - PCP
  - Specialist MD
  - Ancillary healthcare providers
  - Medical Director
  - Chief Medical Officer
  - Clinical Pharmacist
WHY IS THE ICT SO IMPORTANT?

- Cornerstone to our Model of Care
- This team will assure the continuity of care for our member
- PCP participation is required
- It helps us address any pressing issues with the member’s current health status
- It helps to assure that there is no overlap in medications, and/or services
PROVIDER ROLES AND OBLIGATIONS

- Plan of Care feedback and consensus
- Clinical coordination for the member
- Participation in ICT
- Responsive and cooperative with Simply Nurse Practitioners and Case Managers
- Referring member to medically necessary services
- Communication with the member’s family or legal representative
- Timely submission of documentation
- Obtaining informed consent from member or legal representative
- Access and use of our evidence-based Clinical Practice Guidelines
SIMPLY CARE, COMFORT, AND CLEAR “Opt–Out” MODELS OF CARE

Member

- Facility (NH/ALF)
- Family
- Specialists
- PCP

MANDATORY Simply CM (NP/PA/RN)–Face-to-Face and/or Telephonic Contact
SIMPLY COMPLETE AND LEVEL MODELS OF CARE

Member

Family

Specialists

PCP

OPTIONAL
Simply Clinical Case Manager - Telephonic Contact
ALL SNPs: CLINICAL CASE MANAGERS

They are NPs/RNs/LPNs/MSWs who perform:

- Health Risk Assessments
- Plans of Care
- Coordination of Services
- Communication with par and non-par PCPs/specialists and Interdisciplinary Care Team (ICT)
Training for the provider Network will be available on the company website. Providers will be informed of updates via fax blasts, newsletters or in-person. Trainings may include:

- Model of Care
- HRA
- Plan of Care
- Care and Disease Management
- Emphasis on ICT
- Community Resources
- Evidence-based, nationally recognized guidelines
- Member Benefits
- Provider Network
- Eligible Population
- Obligations and Role
The Care Plan is developed by the Nurse Practitioner or Case Manager to address issues the member may be facing within these areas:
- Medical
- Psychosocial
- Behavioral
- Cognitive
- Functional
- Pharmaceutical

The Care Plan is formulated based on
- HRA Assessment
- MD Feedback
- Clinical Assessment
- Social Evaluation
- Any additional findings or needs that may be reported by the member.

The Care Plan is reviewed and approved by the PCP and shared with the member and/or legal representative.
COMMUNICATION WITH PAR and NON–PAR PROVIDERS

- Provider Handbook
- Provider Newsletters
- Simply’s website
- Educational Materials
- Fax Notifications
- Telephonic
- Regular Mail
- In–Service Trainings at the time of contracting and updates
Questions? Comments?

We are happy to help you!