Quality Insider

Senior Whole Health of New York NHC Model of Care

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A central aspect of how SWH of NY NHC cares for members is defined by our Model of Care. The Model of Care document approved by the Centers for Medicare and Medicaid Services (CMS), describes in detail how we provide care management to our members, including the regular assessment of their needs and development of a care plan to guide the services we provide to them. CMS requires SWH of NY NHC to provide training to our providers based on our Model of Care. This edition of Quality Insider, along with training presentations available at www.seniorwholehealthny.com, will provide you with the information you need to gain a better understanding of our Model of Care. If you have additional questions, please call your provider relations manager.

About Senior Whole Health of New York NHC

Our mission: To maximize the quality of life, health, security, and independence of our members.

Our members: SWH of NY NHC's members are a vulnerable population that is often poor, frail, disabled, chronically ill or near the end of life:

- Enrollment age is 18+ but most members are over 65
- Members will likely have chronic care conditions and/or disabilities
- Many members will not speak English
- Many members will be prescribed five or more medications
- Many members will have limited reading ability

Model of Care

Senior Whole Health of New York NHC manages the complex needs of our members using a carefully designed Model of Care that works to facilitate the appropriate care in the appropriate place at the appropriate time.

Key elements are:

- Initial Assessment — identifies the care needs of the member
- Individualized Care Plan (ICP) — documents our approach to meeting the member's identified needs
- Interdisciplinary Care Team (ICT) — team members who are chosen by the member are responsible for implementing and monitoring ICP
- Reassessment and Care Plan update — as the member achieves identified goals, member is reassessed, new goals are identified and the care plan is updated

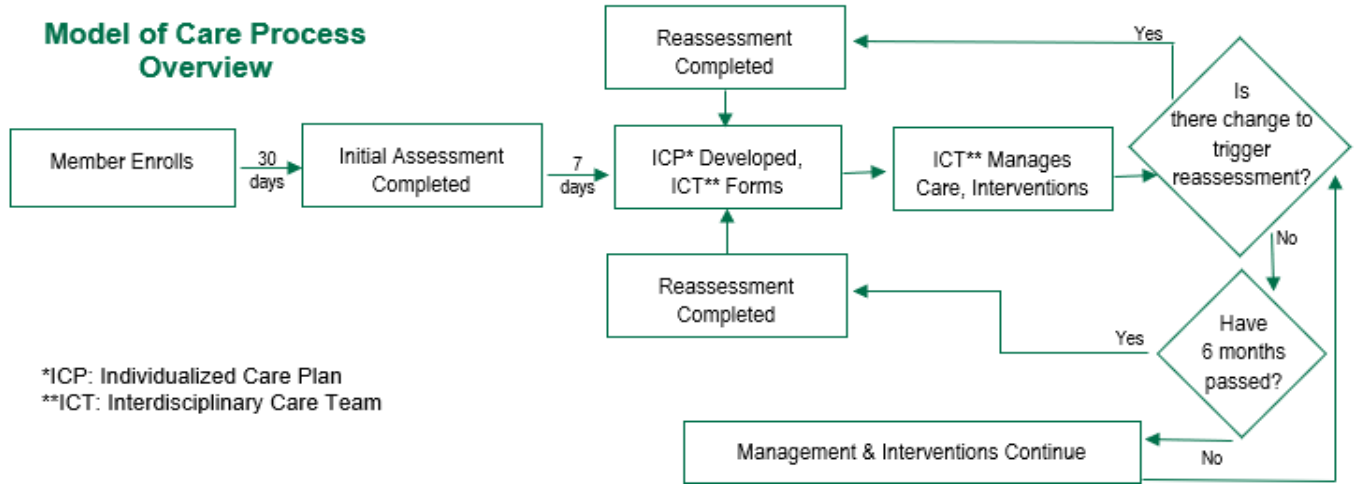
Assessment Details

Types:	Initial assessment, Geriatric Service Support Coordinator (GSSC) assessment, Nurse Care Manager (NCM assessment)
Timeline:	Initial assessment is completed within 30 days of enrollment
Components:	Clinical, Functional, Behavioral and Advance Care Planning
Output:	Identified opportunities to help members improve care; identified potential barriers to improved care; opportunities to improve care prioritized and populated in ICP

Individualized Care Plan (ICP) Details

Developed jointly by the NCM and member using the opportunities identified in the initial assessment. Steps include:

- Prioritize opportunities
- Identify barriers
- Develop goals
- Propose interventions
- Member reviews and agrees to approach
- ICT manages care plan



Reassessment and Care Plan Update

Reassessment can be triggered by:

1. Events such as hospitalization, increased ER utilization, a decline in physical or mental status or loss of a support system.
2. Changes from the baseline assessment.
3. The ICT team if it's determined there's a need to modify or update the ICP. Reasons include:
    a. Unsafe home environment
    b. Member or caregiver concerns
    c. Medication non-adherence
    d. Lack of PCP engagement
4. Reassessment also applied every six months:
    a. Member is reassessed, any changes are identified, care plan is modified
    b. If no changes are identified, initial ICP, goals and interventions are continued

Provider Network Overview

- The ICT is supported by a comprehensive provider network that includes PCPs, specialists and facilities (including hospitals and ancillary providers).
- The network size and composition are monitored annually and adjusted as needed.
- Member access to providers is monitored annually and issues addressed as needed.
- Members' cultural and linguistic needs are considered as the network is developed and managed, i.e. nurses, care representatives, geriatric coordinators and providers are assessed for language capabilities. Translators are always available to our members.

Model of Care Conclusion:

- Member is regularly assessed.
- Care plan is adapted to meet the member's evolving needs.
- Different care providers are involved to meet member's unique needs.
- Network is in place to support the clinical and behavioral care needs.
- Process is dynamic on both the individual and macro levels:
    - Regular effort to identify and implement enhancements to address member needs.
    - Interventions designed to support member's care needs and improve the program as a whole.
- As the process continues, both the member and the Model of Care get better.

Encourage members to contact SWH of NY NHC Member Services at 1-877-353-0185 with questions about the Model of Care.