THE SWH CARE MODEL

Since enrolling its first member in Massachusetts in 2004, Senior Whole Health (SWH) has led the way as an affordable and innovative health care plan for "dual-eligibles" — people who qualify for both Medicare and MassHealth.

Senior Whole Health is an approved Medicare Advantage Special Needs Plan (SNP), a Medicare Part D Plan and has a contract with MassHealth to serve elders age 65 who qualify for MassHealth Standard.

Senior Whole Health's way of delivering health services has advantages to both our members and our providers. Our mission is to maximize our members' quality of life, health, security and independence. Our unique business model covers an array of supportive, acute, behavioral, social, preventive, and long-term care services based on each member's individual needs.

What makes SWH different from other traditional Medicare and Medicaid?

Senior Whole Health facilitates coordinated, integrated care planning for each member that includes:

- **Your Primary Care Doctor** — SWH has many doctors in its network and we want you to remain with your primary care physician whenever possible. Your doctor provides the clinical direction for your team.

- **SWH Nurse Care Managers** — Each member is assigned a SWH Nurse Care Manager who develops your care plan with you, your family/caregiver and doctor. She/he will visit you as needed.

- **ASAP Geriatric Service Coordinators** — Our members also receive regular visits from a Geriatric Service Coordinator who works for your local elder agency. Their role is to review the services you receive, assess your ability to live at home and determine other needs you might have. They also help SWH put in home-based services when needed.

- **SWH Community Support Coordinators** — SWH staff is multi-lingual and works closely with our nurses and Geriatric Services Coordinators. Together they assist in navigating the network of support and information services available to you and stay in touch to make sure things are running smoothly.

- **SWH Pharmacists —** SWH has pharmacy consultants who work with your local pharmacy and doctor to ensure you're receiving the necessary medications.

- **SWH Behavioral Health Experts —** We also employ behavioral health consultants to help your care team find the services you might need.

- **Caregivers** — You and your caregiver(s) are an integral part of your care team. Be sure to tell us what you need — and what will work for you — and, together, we will come up with an appropriate plan of care.

- **Other Health Care Providers** — Sometimes other providers are involved in caring for you such as a homemaker, a physical therapist, or podiatrist. Our team will work closely with them to make sure their services match your needs.

Five important features of the SWH Care Model:

1. **Early Assessment** — Every member receives a house call from their local elder agency's Geriatric Service Coordinator. This visit helps us learn more about you and your health care needs. It also lets us know when your health changes and you're in need of further help.

   Some members will also have their Nurse Care Manager visit them to make sure we can plan for other services that are right for you and your family.

   If you live in a nursing facility, your Nurse Care Manager will stop by and meet with staff to determine your needs and care plan.

   You will receive a welcome call from our Member Services Coordinators and/or our SWH Community Support Coordinators to make sure you understand the program. At that time, they will also let you know how to reach us, make sure your services are working properly, and answer any questions.

2. **Interdisciplinary Teams** — You, your physician, health care provider, family members, other caregivers and SWH staff form an important team. By working together as a unit, they can create a plan of care that's right for you based on your current health. Your doctor, SWH Nurse and the local Geriatric Service Coordinator will also make sure you're receiving the services

you need and that they are working effectively.

3. **Individual Care Plan —** We recognize that every person is different. That is why we individually tailor each person's health care. Once a care plan has been developed, you or your authorized representative will have an opportunity to review and approve it.

4. **Coordinated, Integrated Care —** SWH pays for all your services that we agree upon in your care plan whether they are at home, in the hospital or in a skilled nursing facility. If you happen to be admitted to the hospital, we are immediately notified, enabling us to seemlessly coordinate services to care for you upon your discharge.

5. **Continuous Assessment —** Everyone's health changes with time. SWH will be in touch with you and your caregivers so that we can help you with those changes and make sure you have the right services.

THE SWH CARE MODEL IS:

Simple — Our voluntary plan is easy to understand. We provide one card that seemlessly integrates all Medicare, Medicaid and Medicare Part D Pharmacy benefits into one comprehensive plan:

- Members are given one health plan card for everything instead of three (i.e. Medicare, MassHealth and Part D)

- Providers bill only SWH rather than the three different plans.

- Members' hospital care, doctor visits, home services, nursing home stays, exercise programs and more are paid for by SWH.

- Members and providers call one toll-free number for questions, problems and services. Our toll-free number is available seven-days-a-week, 24-hours-a-day to assist members.

- SWH has an electronic member record that helps facilitate communication among all providers. It includes assessments, medication information, contacts, health problems and your services. This lets your Nurse Care Manager and others know what health services you are receiving and what you need.

- The program is voluntary. Members can leave the program at the end of any month of the year and join any month of the year.

Secure — At any time of the day or night, your can call us and be connected with your Nurse Care Manager. Our multi-lingual staff can also help connect you over the phone, when needed, with your doctor and Geriatric Service Coordinator.

- SWH believes you should not have to change your primary doctor if you don’t want to. That’s why we contract with doctors throughout Massachusetts. Our extensive network is your key to continued health, allowing your trusted physician to remain your primary health care provider.

- SWH Nurse Care Managers are assigned to every primary care doctor in our network. If you are in need of services, your Nurse Care Manager will visit you at home. She/he will then communicate with you, your family and your doctor about your care. Your Nurse Care Manager is on call day and night to assist with any problems or concerns that arise.

- Every community in Massachusetts has a local elder services agency called an Aging Services Access Point (ASAP). SWH contracts with all ASAPs in our service area to make sure we work with people in your community who know you and the local resources available. Every new member who is not in a nursing home receives a home visit from a Geriatric Service Coordinator from his/her local ASAP. They will review how well you can manage at home, any services you currently have and other additional needs you might need to remain living at home. They will also discuss wellness and exercise programs available to you.

- SWH has Member Service Coordinators and Community Support Coordinators who are multi-lingual and available by phone to help answer questions and resolve problems. They work closely with Nurse Care Managers and Geriatric Service Coordinators. Member Services Coordinators help educate you about SWH and the services that are available to you, while our Community Support Coordinators make sure your home services are working as they should.

- In addition to our multi-lingual staff, we also contract with interpreters, Language Line Services, as well as Massachusetts Relay — the service for those who prefer using text-based devices for phone conversations. SWH wants to make sure we understand what you need and that you understand what your providers are saying.

Independent — Our goal is to keep you healthy and living in the comfort of your own home. That's why we provide access to home- and community-based services, as well as prevention and stay-healthy programs. We also offer you — and those involved in your caregiving — as much support as needed:

- We contract with homemakers, personal care providers, Meals-on-Wheels and many others who can help support you in your home. Your Nurse Care Manager and Geriatric Service Coordinator will determine your need for these services and make any necessary arrangements.

- SWH believes it's important to stay as healthy as possible. That's why we offer a gym benefit, as well as education and support programs about specific chronic conditions you might have. All members are encouraged to take advantage of our full-time health educator.

- Your caregivers work hard to help you stay at home. From time to time they need a break or to talk to other caregivers and support groups. Our Caregiver Advocate is there for them to call to find out about respite and other resources. We also have a regular Caregiver newsletter that contains a wealth of information to assist them in their important role.

- Members and their caregivers are involved in decisions regarding their health care. Access to an array of home- and community-based services help support our members in the residence of their choice whether it is at home, in assisted living, a nursing home, or other location.

At SWH, we measure our success by the quality of life we are able to provide our members.

THE SWH Care Management Process

1. Member Intake

After you join SWH, a Member Service Coordinator will call and welcome you to the plan. She/he will also confirm your choice of primary care physician and educate you about our program and how to best to reach us. Our Member Service Coordinators are a vital part of your health care team. They provide personalized services by assisting with referrals to information and community resources, as well as answering questions about the health plan and its numerous benefits. Communication with our Nurse Care Managers, who are predominantly bi-lingual, and local Geriatric Service Coordinators are ongoing and actively supported through direct discussion of your questions and needs and through our electronic member record.

2. Initial Assessment

Assessments of your health status, home situation and support systems help us determine a complete plan of care for you. This includes identifying programs, support services, and other key information vital for your well-being.

As a new member, you will receive an initial visit from your local Geriatric Service Coordinator. Their job is to conduct functional and cognitive assessments at your home in order to identify your long-term care service needs. They will also discuss your health care preferences and determine the availability of informal support.

If you already have a health issue or are receiving services, you'll receive a visit from your Nurse Care Manager. For those coping with functional deficits or behavioral health problems or dementia, they will also perform an MDS-HC Assessment.

Likewise, if you live in a nursing home, your Nurse Care Manager will visit you and work with nursing home staff and your physician to ensure your needs are being met.

If you haven't seen your primary care physician recently, please make an appointment soon so that they can also make a new assessment. This

includes examining your medical history, evaluating your urgent and preventive care needs, and outlining a plan for ongoing medical services.

3. Individual Care Plans (ICP)

Each SWH member has an Individual Care Plan (ICP). ICPs integrate your total health needs, wishes, and what is feasible given the availability of a support network and caregivers. Using the assessments and service recommendations outlined by your doctor and the Geriatric Service Coordinator, your SWH Nurse Care Manager will draft a care plan for final review by your primary care physician. If you have Complex Care Needs (including nursing home residents, community-based nursing home eligible members and other members with health risks), your doctor and Nurse Care Manager will determine whether additional professional input is needed for further evaluation and care planning. Your input and final signoff by either you, or your authorized representative, is a necessary component of the care planning process.

4. Reassessment and Ongoing Monitoring

Your Nurse Care Manager and Geriatric Service Coordinator will monitor your care to make sure that you're receiving the right services and are happy with them. They'll also follow-up with you regularly to identify potential problems that can be referred to your doctor, who can involve other providers as necessary. Your health and social status will also be reassessed at scheduled intervals, and when there is a significant change in your health status or support system.

Your Community Support Coordinator will also keep in contact with you regularly to make sure your health has not changed and that you remain satisfied with the program. These community support staff stay in touch with your Nurse Care Manager and Geriatric Service Coordinator to ensure you are receiving the services you need. They also make sure your services are doing what you need them to do.

5. Continuum of Care

Contractual relationships support ongoing delivery of services to members across a variety of care settings. Determining which care setting is the most appropriate for you (i.e. home, hospital, office, rehabilitation, behavioral health facilities and nursing home) is a vitally important part of the overall planning process. Whether you stay at home or are more comfortable in another environment, our state-of-the-art data systems enable each of our staff members to constantly monitor your well-being.