



## **CARE MODEL**

### **Overview**

Senior Whole Health (SWH) has advantages both for the member and the provider over standard managed care programs. Senior Whole Health uses a needs-based approach to coordinating care that includes the individual and his/her caregivers in decision-making. Senior Whole Health covers an array of supportive and interventional services based on the member's medical, behavioral, long term care, spiritual and social needs. Care is coordinated across all locations and levels of care and promotes the member's optimal functioning, autonomy and ability to stay in the community.

SWH facilitates coordinated, integrated care planning for each member that includes Primary Care Physicians (PCP), SWH Nurse Care Managers (SWH NCM), Community Agencies as well as behavioral health and pharmaceutical experts and any other type of provider recommended by the member's care team.

Five salient features of the SWH Care Model are:

- Early Assessment
- Interdisciplinary care teams
- Individualized care plans (ICP)
- Coordinated, integrated care
- Continuous reassessment

Individuals who make the coordinated approach work are:

- Community-based Primary Care Physicians
- A SWH Nurse Care Manager for each member (SWH NCM)
- Community Service Agencies
- A SWH Community Resource Coordinator (CRC)
- The Member

Each SWH member selects a community-based Primary Care Physician (PCP) from the SWH network. The PCP is responsible for overall clinical direction and is the locus for care integration and coordination. Each member is assigned a SWH Nurse Care Manager. The SWH Nurse Care Manager provides a single contact point for members and providers, facilitating care coordination and fostering familiarity with the member's needs. Ongoing communication and collaboration between the PCP and the SWH Nurse Care Manager is essential for care plan development and implementation. The CRC

helps members and PCPs navigate the network of support and information services available to seniors, and integrate non-medical support services into care plans.

## **Program Features**

### **1. Medicare and Medicaid reimbursement combined into a single insurance product:**

No secondary billing

### **2. Primary Care Physician:**

In the Senior Whole Health model each member has a Primary Care Physician (PCP) who:

- Is aware of all services provided to Member
- Understand all Member needs, not just clinical needs
- Is involved with social and support services (not filling these needs but making sure someone does)
- Notifies SWH of any change in status for a primary care panel member
- Alerts SWH of any deficiencies in services
- Participates as the clinical leader of the Patient Care Team (PCT) for any member with a complex care need
- Notifies SWH of needs for additional contributors to the PCT
- Collaborate with the PCT on development of the ICP
- Ensures buy-in from Member or Member caregiver for ICP (logistics can be handled by the SWH Nurse Care Manager)
- Provides required information to populate the Central Enrollee Record.

### **3. Multidisciplinary Primary Care Teams (PCT) responsible for individual care plans:**

SWH members have a PCP to direct their care. The PCP invites other professionals and persons critical to meeting the care needs of the member to participate in evaluating and planning services. The member, or his/her designated representative, is an active participant in care plan decisions.

SWH Nurse Care Managers, the CRCs and community PCPs are always part of the PCT and are essential in care planning and identifying supportive services. The SWH Nurse Care Manager will communicate with the member and implement and manage the care plan established by the PCT.

### **4. Qualified SWH Nurse Care Manager to facilitate care coordination:**

Each SWH member is assigned a SWH Nurse Care Manager. A SWH Care Nurse Manager is available 24/7 through a toll free line. The SWH Nurse Care Manager is the liaison between the member and his/her caregiver(s), the Primary Care Physician (PCP), and all involved providers. These professionals facilitate, integrate and monitor all facets of the care plan, regardless of the care setting. The SWH Nurse Care Manager is the “glue that holds the pieces together” to ensure that all aspects of the care plan are in place and that the member’s questions and preferences are addressed. This role provides the coordination component that supports the provider and that is traditionally not reimbursed by insurers.

## **5. Innovative electronic information management systems:**

The Central Enrollee Record (CER) is a customized, accessible electronic information and data systems designed specifically for the senior population are available through Senior Whole Health. This data system permits authorized providers to access and enter pertinent member information that is critical in managing care in a coordinated, integrated fashion. This system, unique to SWH, has individual care plans, emergency plans, assessment tools, member preferences, and tracking systems that facilitate monitoring multiple providers and trigger needed interventions.

### **Care Management Process**

Senior Whole Health believes that promoting health and preventing unnecessary illness contributes to a healthy and productive life. To achieve this end, health care providers must address all facets of an individual's life—physical, mental, spiritual, community. Preventing acute episodes of illness lead to healthy independent individuals.

We are committed to empowering our members and their families in the participation of short and long term planning that includes remaining in their community for as long as possible. These fundamental principles of the Senior Whole Health care process drive the teams' holistic approach.

The health status and care needs of individuals are fluid. Everyone's health, support systems and personal lives change regardless of age. SWH incorporates systems to ensure ongoing reevaluation and restructuring of care services respond to these changing needs. The unique electronic data system as well as the personal assignment of a SWH Nurse Care Manager and a PCP to each member promotes timely and necessary adjustments.

#### **1. Member Intake:**

The SWH Community Resource Coordinator (CRC) conducts the welcome call, confirms the PCP selection, and administers a health risk assessment survey, which may prompt a PCP visit or a care manager assessment. SWH members can contact SWH Client Services staff through a toll free number. SWH CRCs are important participants on each member's health care team. SWH CRCs provide personalized services to SWH members by assisting with referrals to information and community resources, as well as answering questions about the health plan and benefits. Communication with the SWH Nurse Care Managers is ongoing and actively supported through direct discussion of the member's questions and needs and through SWH's Call Tracking System that records all telephonic encounters with members.

#### **2. Initial Assessment:**

Assessments of the members' health status, home situation and support systems contribute to SWH's understanding of the member and the elements needed for a complete care plan. All new members are assessed to determine their health care needs and interests, and to help SWH identify programs, support services, and information that are important for each member. Initial assessments are conducted by the member's PCP and RN or social worker. A medical

assessment by the PCP includes a medical history, evaluation of urgent and preventive care needs, and a plan for ongoing medical services.

A functional and cognitive assessments at the member's residence that identify long term care service needs, and identifies members' preferences and the availability of informal support an identify members who may have functional deficits or behavioral health problems or dementia.

**3. Individual Care Plans (ICP):**

Each SWH member has an Individual Care Plan (ICP). ICPs integrate the member's total health needs, his/her wishes, and what is feasible given the availability of a support network and caregivers. Using the assessments and service recommendations outlined by the PCP and community case workers/service providers, the SWH Nurse Care Manager drafts a care plan for final review by the PCP. For members with Complex Care Needs (including nursing home residents, community-based nursing home eligible members and at risk community-based members), the PCP, with the SWH Nurse Care Manager determine if additional professional input is needed for further evaluation and care planning. The PCT reviews the assessments, completes a full evaluation, and finalizes the ICP. Input and final agreement by the member is a necessary component of care planning.

**4. Reassessment and Ongoing Monitoring:**

The assigned Care Manager monitors care to assure that the member is receiving the services and is satisfied with them. Ongoing follow-up with the member promotes early identification of potential problems that can be referred to the PCP, who can involve other providers as necessary. Reassessments to evaluate a member's health and social status are conducted at scheduled intervals, and when there is a significant change in a member's health status or support systems.

**5. Continuum of Care:**

Contractual relationships support ongoing delivery of services to Members across a variety of care settings, including the home, hospital, office, rehabilitation, behavioral health facilities and nursing homes. The setting for care that is most appropriate for the member is part of the care planning process. SWH data systems enable staff to monitor care across care settings.

**6. Centralized Member Record (CER):**

The SWH Centralized Member Record promotes communication among all providers as well as with the Member. The CER includes assessment tools, long term care planning modules, scheduling, and pharmacy and member contact information to support the PCT and to facilitate timely communication among all parties.

**7. SWH Client Services Department:**

SWH Community Resource Coordinators (CRC) are available to respond quickly to member questions and concerns. The CRC educates members upon enrollment and unlike the typical member services function, can meet with members in their homes to provide a face-to-face member orientation. The CRC also maintains a roster of members who are called on a regular

basis as a “check in” to verify that all is well or that care needs are changing. The CRC is able to coordinate community services for the members and works with the local agencies/service providers and SWH Nurse Care Managers to ensure that clinical and community resources are linked effectively.

**8. Emergency Care Plans:**

An Emergency Care Plan is part of every SWH Member’s Centralized Enrollee Record. Pertinent information such as medications, services, and contacts are available. Each member/caregiver receives a copy of the Emergency Care Plan. The toll-free number is reviewed with the SWH Community Resource Coordinator during the welcome call and is included in member materials. Emergency plans are reviewed with Complex Care Needs Members/caregivers by the SWH Nurse Care Manager.