SNP Alliance
Best Practices

October 2013

SCAN: Best Practices in Care for Nursing Home Certifiable Beneficiaries at Home

Background

SCAN Health Plan (SCAN) is the nation's fourth largest not-for-profit Medicare Advantage (MA) plan, serving nearly 145,000 members in California and Arizona. SCAN's mission is to find innovative ways to enhance seniors' health and independence and SCAN is dedicated to providing comprehensive medical coverage, prescription benefits, and support services specifically designed to meet the unique needs of seniors.

Since its founding in 1977, SCAN has provided the care needed to keep more than 50,000 seniors out of nursing homes, despite the vulnerability and frailty of its members. SCAN has demonstrated experience with the aging and long-term care populations under both the Medicare and Medicaid programs.

SCAN's I-SNP

SCAN's Institutional Special Needs Plan (I-SNP) serves members who are "institutional equivalent" — who live in the community but require an institutional level of care. Many of these members were initially part of CMS' Social HMO demonstration. When the Social HMO ended, this Plan Benefit Package (PBP) closed to any new enrollments in 2009 and 2010 and transitioned to an Institutional-Equivalent SNP. In 2011, enrollment was reopened for those meeting nursing facility level of care (NFLOC) and residing in their own home.

Currently, SCAN's I-SNP enrolls 5,068 members in Los Angeles, Orange, San Bernardino, and Riverside counties in Southern California. These members meet the state's NFLOC criteria of two or more Activities of Daily Living (ADL) impairments, are typically frail, and generally require caregiver support and assistance in managing their chronic conditions. Because of their complex health status, many members have difficulty accessing and utilizing appropriate levels of care and managing their medications.

A Member-Centric Model of Care

SCAN's I-SNP employs an integrated medical/social approach to managing vulnerable individuals. In addition to the CMS Model of Care requirements, SCAN has a suite of care management programs addressing an individual's needs at each stage of the health care continuum. SCAN's care management programs incorporate member education and coaching to enhance self-management skills, medication reconciliation across care settings, behavioral health care coordination, and referrals to community-based resources.

All I-SNP members are enrolled in a care management program, ranging in intensity from complex care management and disease management to care coordination and monthly monitoring. Care management and coordination at SCAN consists of several different programs working concomitantly in addressing needs for the frail elderly population:

- Complex Care Management (CCM) reduces acute care by emphasizing prevention, self-care, access to care, and the coordination of medical care and community services. Interventions are tailored to the member's clinical, functional, and social needs.
- Disease Management (DM) for Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).
- Care Coordination: SCAN has a variety of services and programs to help coordinate care for this population. Through targeted outreach calls, the SCAN Buddy Program helps remove barriers to accessing preventive health services, remind members to make doctors' appointments, and prompt effective doctor/patient communication.

  Some I-SNP members are also dually-eligible. Given the complexity of Medicaid eligibility, benefits, and services, SCAN developed a Personal Assistance Line (PAL) program to provide culturally sensitive and specialized expertise to access benefits from both programs.
- The SCAN Memory Program is designed for members with dementia and their caregivers, and is based on a proactive model that assesses member status and anticipates and prepares for care management issues that may arise.

Additional benefits for this SNP include:

- Transportation to medical appointments
- In-home meal delivery after hospitalizations
- Emergency-Response Systems for members at risk for falls

Successes

A primary contributor to older adults' quality of life is their ability to remain independent and at home. SCAN's entire care management team is focused on helping members with functional limitations achieve their goal of independence, remaining at home and in improved health. Data show that SCAN has achieved a high level of success. In 2012, 91% of members indicated that SCAN helped them manage their health more effectively, and 84% indicated that SCAN helped them improve their ability to live independently. In 2012, approximately 92% of SCAN I-SNP members were able to remain in their own home and avoid long-term care in a facility. In addition, SCAN's All-Cause Readmission Rate for the I-SNP is 9.83%, well below the Medicare national average of 14%[1].

[1] NCQA (2012) – www.ncqa.org/portals/0/Publications/2012%20BI_NCQA%20ReAdMi%20_Pub.pdf

Success Story

While conducting a member's annual I-SNP assessment, SCAN's care manager discovered that the member's authorization for oxygen had expired and her son had been paying privately for the equipment. To complicate matters, the member had changed PCPs since the original authorization and was unable to visit her new PCP without a portable O2 concentrator in order to obtain a needed medical evaluation to reauthorize the oxygen. The care manager diligently worked with the PCP's staff to expedite an urgent referral for a home health assessment. As a result of these efforts, the member was assessed in her home and her oxygen was delivered the very next day. The member was also referred to the physician groups' House Calls program.

During the course of the I-SNP assessment, the care manager also learned that the member's sister (who wasn't yet due for her annual reassessment) was extremely frail, at a dangerously low weight, and had not been seen by her PCP since 2011. The care manager was able to coordinate an expedited referral so that this member was assessed by the home health nurse in conjunction with her sister's visit. As a result, the member was also referred to the House Calls program.

This story demonstrates true compassion and care of members, working diligently to keep members independent and in their own homes, and demonstrates the importance of the efficiency of care coordination efforts.

Challenges

Despite these successes, membership in the ISNP is declining — this is due to death, difficulty identifying new members in the community, challenges differentiating benefits (such as no in-home support), and stricter eligibility criteria (revised state NFLOC interpretation).