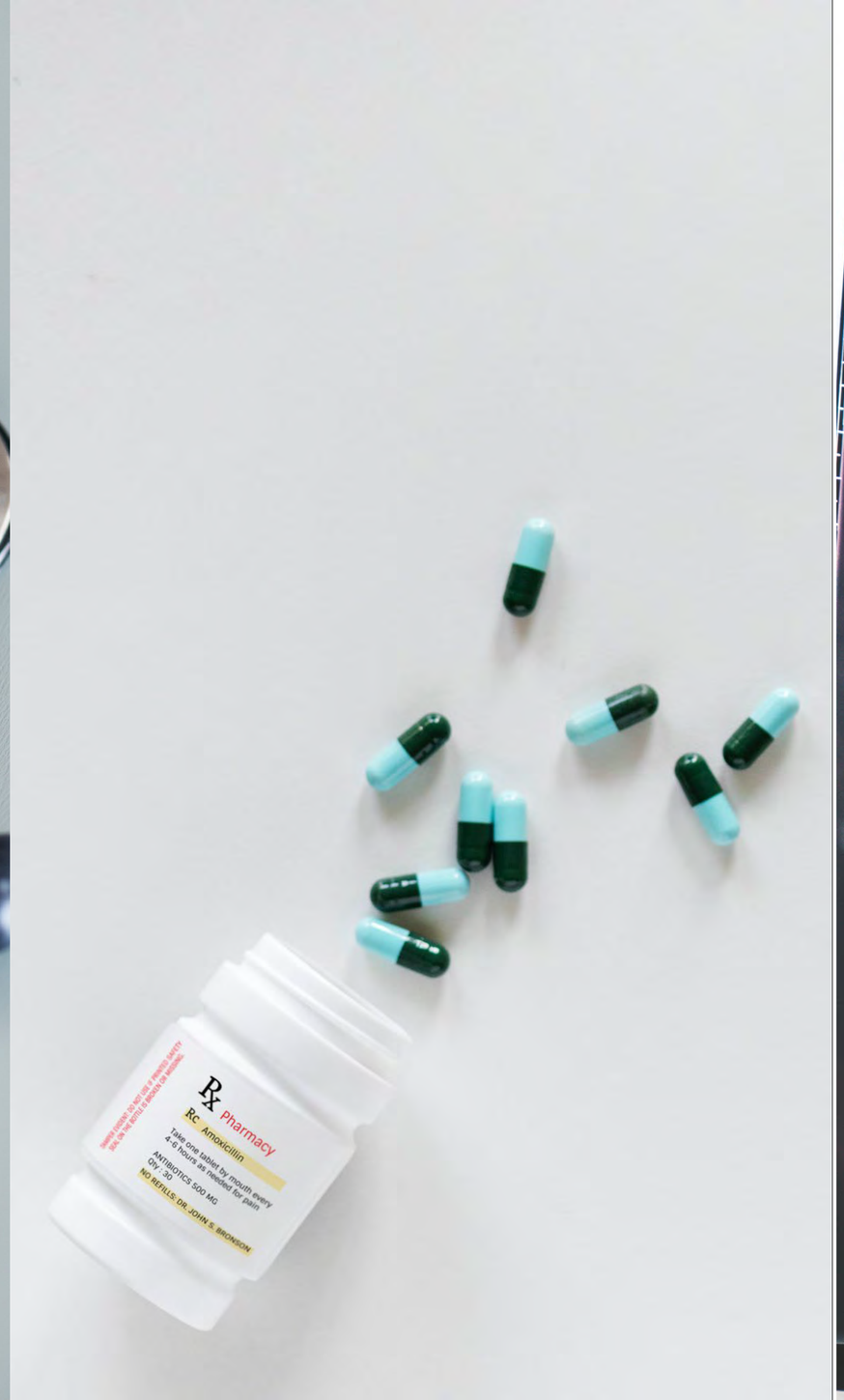
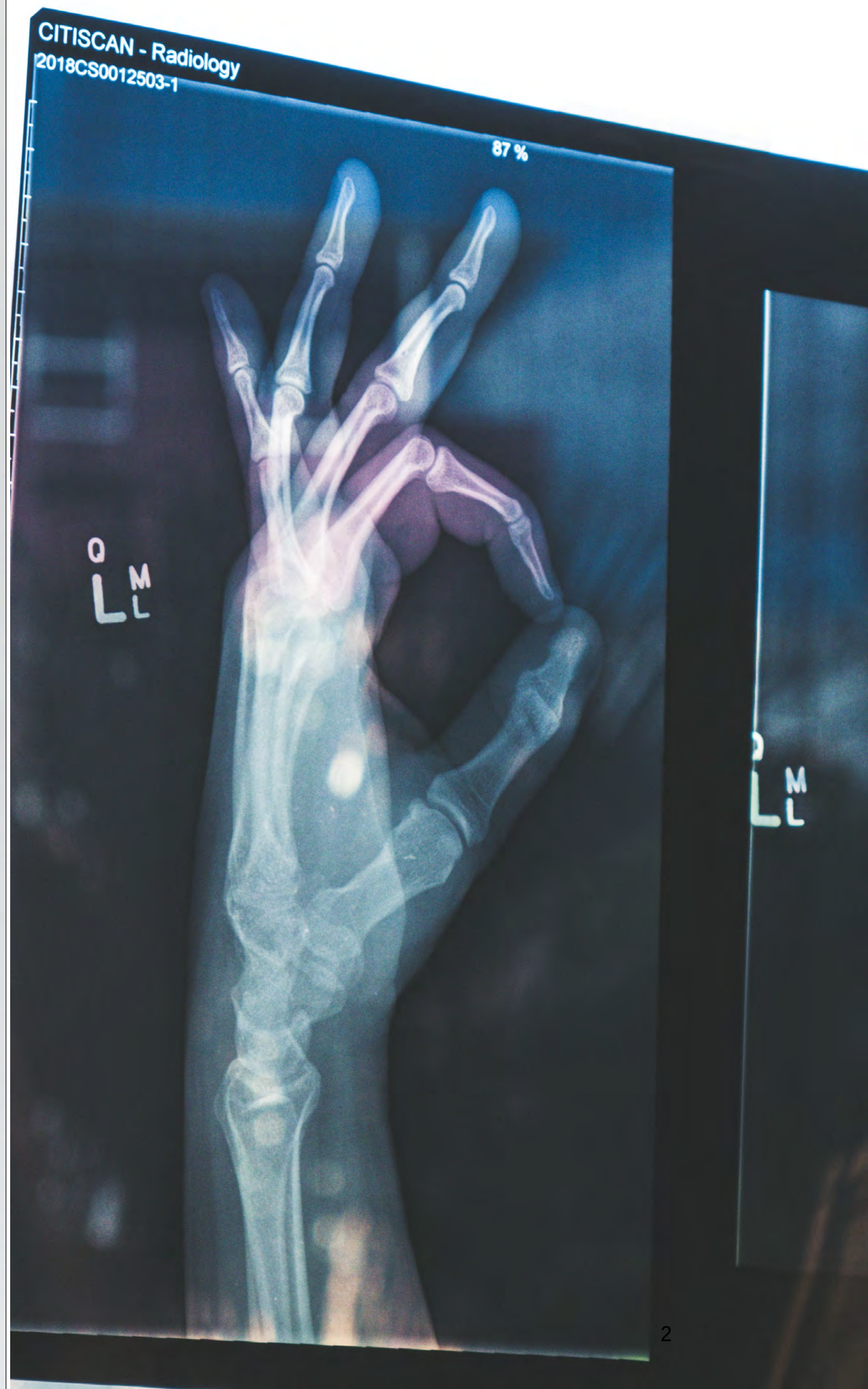
Sonder Health
A Medicare Advantage Company

HMO C-SNP)

2025 SNP Model of Care Training


Rx Pharmacy
Rx: Amoxicillin
Take one tablet by mouth every 4-6 hours as needed for pain
ANTIBIOTICS 500 MG
QTY: 30
NO REFILLS DR. JOHN S. BROKSON


CITISCAN - Radiology
2018CS0012503-1
87 %

Objectives

- ☑ An understanding of the MOC training requirements
- ☑ A comprehensive review of Special Needs Plans (SNPs)
- ☑ Describe the available SHP SNPs and how members enroll
- ☑ Define the goals of the SHP SNP Model of Care
- ☑ Describe the components of the SHP SNP Model of Care
- ☑ Expand on the benefits available to SHP SNP Model of Care members
- ☑ Provide contact information if questions about Sonder Health Plan’s SNP or need more information

Training Requirement

Who must participate in SNP MOC training?

Training is required for all network providers and out-of-network providers who have seen or will see beneficiaries on a routine basis (42 CFR 422.101 (f)(2)(ii)), as well as for provider staff and internal contractors. We require all Sonder and contracted staff to complete MOC training as well. Knowledge of the MOC is vital to those who participate in administering the Special Needs plan Model of Care.

Frequency of training?

Initial and annual SNP MOC training is required by Medicare

How is training conducted?

Training may be conducted in-person or through self-study

Evidence of training?

At the conclusion of training, participants will complete an attestation (including name, NPI, and date of training) and may be requested to complete a training evaluation

What is a Special Needs Plan? (SNP)

What is a SNP?

Medicare SNPs are a type of Medicare Advantage Plan

Who is eligible to enroll in a SNP?

Medicare SNPs limit membership to people with specific diseases or characteristics, and members must specifically sign up for a SNP when selecting a health plan

Types of SNPs

(1) institutional SNP (I-SNP): for people who live in certain institutions (like a nursing home) or who require nursing care at home

(2) chronic SNP (C-SNP): people who have specific chronic or disabling conditions

(3) dual SNP (D-SNP): people who are eligible for both Medicare and Medicaid

SNP model of care

Each SNP has its own “Model of Care” that is defined to meet the needs of the specific SNP population, and outlines the SNP structure, processes, resources, and requirements to meet those needs

Interdisciplinary care team

All SNP members have an interdisciplinary care team comprised of doctors, care managers, caregivers, and the patient themselves, that is responsible for developing, updating, and maintaining a care plan

Additional benefits and services

SNP members are offered supplemental services and benefits to help better manager their condition, if applicable, and improve or maintain their health

SHP Available SNPs

Diabetic Wellness	ESRD	Heart Healthy	Dementia	DSNP	Chronic Lung Conditions
Designed for Medicare members who reside in the Sonder service area and have a diagnosis of Diabetes mellitus (C-SNP)	Designed for Medicare members who reside in the Sonder service area and have a diagnosis of End-stage renal disease (ESRD) requiring dialysis (C-SNP)	Designed for Medicare members who reside in the Sonder service area and have a diagnosis of either a cardiovascular disorder, including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, or chronic venous thromboembolic disorder; or chronic heart failure (C-SNP)	Designed for Medicare members who reside in the Sonder service area and have a diagnosis of Dementia (C-SNP)	Designed for Medicare members who reside in the Sonder service area and are also entitled to medical assistance from a state plan under Title XIX (Medicaid) (D-SNP)	Designed for Medicare members who reside in the Sonder service area and have been diagnosed with one of the following chronic lung conditions: chronic obstructive pulmonary disease (COPD)- also called emphysema, chronic bronchitis, asthma, pulmonary fibrosis, or pulmonary hypertension (C-SNP)

Enrollment

Qualifying diagnosis or Medicaid-eligibility

All members enrolled in the SNP must have either a qualifying diagnosis (for either the Diabetes or Cardiac C-SNP) or also be eligible for Medicaid, which is also called “dual eligibility” (for the D-SNP)

Verification

The member’s chronic condition must be verified with the member’s primary care practitioner (for C-SNPs) or their Medicaid eligibility must be verified with the state (for D-SNPs) upon enrollment

Model of Care Goals

1

Quality

Improve the quality of care and services received by members

Documenting SNP specific Hedis measures, quality studies

2

Access

Improve access to essential services, including medical, mental health, and social services

3

Coordination of care

Improve coordination of care

Access to staff with knowledge of programs and community resources

4

Outcomes

Improve member health outcomes

Reduced hospitalizations, increase preventative services

5

Transitions

Improve transitions of care across health care settings and providers

6

Preventive services

Improve access to preventive services

7

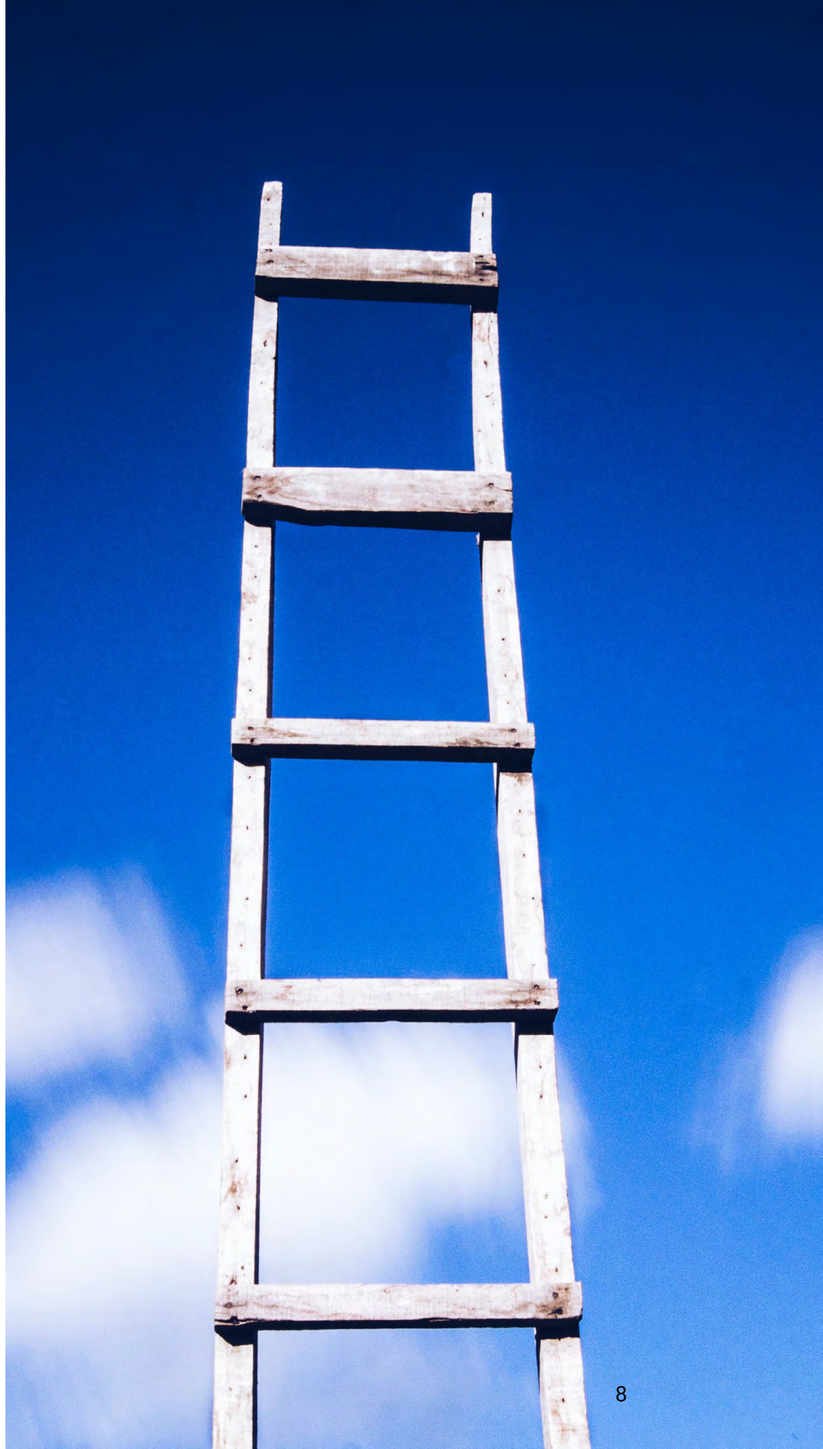
Appropriate utilization

Facilitate appropriate utilization of services

8

Affordability

Improve access to affordable care



Sonder Health Plans, Inc

Components of SNP Model of Care

Health Risk Assessments

- All Sonder Health Plan members are asked to complete an initial health risk assessment (HRA) within 90 days of enrollment, and annually thereafter
- The HRA gathers information to identify the specialized medical, psychosocial, functional, mental health, and cognitive needs of the member
- Information gathered through the HRA is used to:
    - initiate the care management process and to stratify the member by risk
    - identify the most vulnerable members of the SNP that could benefit from additional services
    - to create the SNP member’s Individualized Care Plan (ICP)
    - to support ongoing care coordination efforts
    - to identify any changes in the members health or functioning

Case and Disease Management

- Coordinates care and services
- Helps member manage chronic conditions or episodic care needs

Components of SNP Model of Care

Quality Improvement Program

- Goal of program is to improve the delivery of HEDIS high-quality services and benefits
- Measures effectiveness of the overall program and implemented quality improvement interventions
- Utilizes selected quality measures to measure, track, and trend quality

Specialized Network

- Sonder Health Plans maintains a provider network with specialized expertise to address the needs of the SNP’s target population
- The network may include, but is not limited to, internal medicine, endocrinologists, cardiologists, oncologists, mental health specialists and other specialists

Components of SNP Model of Care

Clinical practice guidelines

- Sonder Health Plans adopts and follows evidence-based clinical guidelines in order to provide the right care at the right time.
- Clinical practice guidelines are made available to provider via the provider portal or upon request.
- The guidelines allow Sonder to maintain consistency in the application of the clinic practice guidelines to utilization decisions, member education, covered services.

Care transition protocols

- Sonder also utilizes care transition protocols for continuity of care, and works with providers to ensure that they also follow these protocols.
- During a care transition, the Care Manager reviews the member’s Individualized Care Plan, coordinates any additional services needed, and documents the information in the member’s ICP.

Components of SNP Model of Care

Interdisciplinary Care Team (ICT)

- The composition of the Interdisciplinary Care Team is based on the needs of the SNP member, and can include: the medical director, a case/ disease manager, a behavioral health specialist, a pharmacist, dietician, social worker, and network practitioners that provide care to the member.
- The ICT establishes short and long-term goals during each ICP review and determines whether additional services are needed.
- The ICT is responsible for reviewing and updating the Individualized Care Plan.

Individualized Care Plan (ICP)

- The individualized care plan includes the Health Risk Assessment, goals and objectives, personal preferences, recommended services, measurable outcomes, and barriers to care.
- The ICP is updated by the SNP Care Manager and the ICT as needed, and as the member’s circumstances and/ or health changes.
- The ICP is made available to all members of the ICT.

Components of SNP Model of Care

Member Satisfaction

- Sonder Health Plan’s goal is to improve member satisfaction both with their healthcare services as well as their satisfaction with their overall health. Case Management Satisfaction and other surveys are conducted annually to assess member satisfaction

Face to Face Encounters

- Within the first 12 months of enrollment, as feasible and with the member’s consent, the organization conducts face-to-face encounters to deliver health care, care management, or care coordination services.
- Face-to-face encounters must be either in person or through a visual, real-time interactive telehealth encounter. The encounter must be between the member and a representative from any of the following:
  - A member of the Integrated Care Team (ICT)
  - The organization’s care management or coordination staff
  - A healthcare provider contracted with the health plan.

Provider Role in SNP Model of Care

- The PCP is a member of the SNP member's Interdisciplinary Care Team (ICT) and has input into the development and changes to the member's Individualized Care Plan (ICP).
- The PCP may also initiate an ICT meeting for a member.
- Other providers caring for the member may also be asked to participate in the ICP.
- The PCP is the focal point for coordination of care and responsible for implementing the SNP plan of care.

Components of SNP Model of Care

Additional benefits

- Sonder Health Plans offers additional benefits and services to SNP members to address the health care needs. Other additional benefits and services offered address the member's social needs, which can also affect member health.
- Additional benefits are designed to take into account the specific needs of the target population.

Community partners

- Sonder partners with providers within the community in order to deliver needed services to its most vulnerable members, and works with these partners to facilitate member or caregiver access and maintain continuity of services.
- Community partners also play a critical role in assisting the member with financial needs, utility assistance, meals and healthy food, home safety solutions, and health education programs.

Services and Additional Benefits

- Sonder Health Plan provides care management services to coordinate health care for all members.
- SNP members who are at increased health risk are targeted for more frequent contact by SNP Care Managers.
- Members are stratified into tiers in care management, which determines the level of care management services they will receive, including the frequency of contact and follow up by SNP Care Managers.

care management

preventive health

discharge planning

Services and Additional Benefits

- Members are monitored for compliance with recommended preventive services and screenings.
- Sonder Health Plans may initiate member outreach projects and work with physicians by identifying patients with care gaps.
- Preventive services and screenings include but are not limited to: Welcome to Medicare and Annual Wellness Exams; flu, hepatitis, and pneumococcal shots; bone density testing; and screenings for breast cancer, colorectal cancer, lung cancer, prostate cancer, and cervical cancer.

care management

preventive health

discharge planning

Services and Additional Benefits

- SNP Care Managers coordinate with the SNP care team, hospital discharge personnel and ancillary services after a member's hospital discharge.
- Discharge planning includes developing a comprehensive discharge plan, sharing discharge information with the member's care team, conducting post-discharge member contact, and providing the member's primary care provider with a copy of the care plan that includes information about follow-up appointments, new medications prescribed, and any changes in the member's health care needs.

care management

preventive health

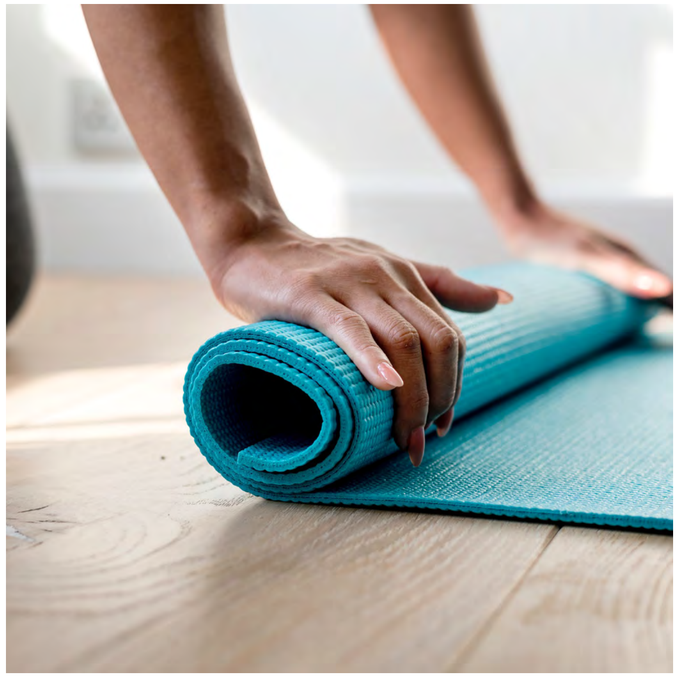
discharge planning

Services and Additional Benefits

- The Medication Therapy Management Program is designed to improve medication management, evaluate medication usage for medication dependence or poly-pharmacy, and alert the SNP care team to medication abuse or contraindications.
- The program also monitors tracks members using high-risk medications according to The Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, or Beers List.

medication management

fitness benefit



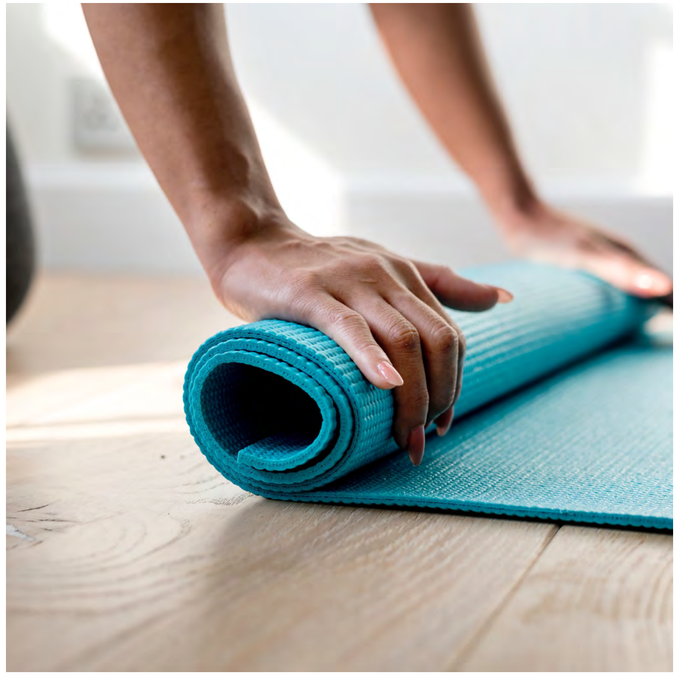
nursing hotline

Services and Additional Benefits

- Members may join the fitness program “Silver & Fit” which provides gym access and flexible fitness classes outside the gym in order to help members improve or maintain good health.
- The fitness benefit includes an orientation for each enrollee to the facility and the equipment. The benefit also may include development of a personalized exercise plan and a limited number of sessions with a certified trainer.

medication management

fitness benefit



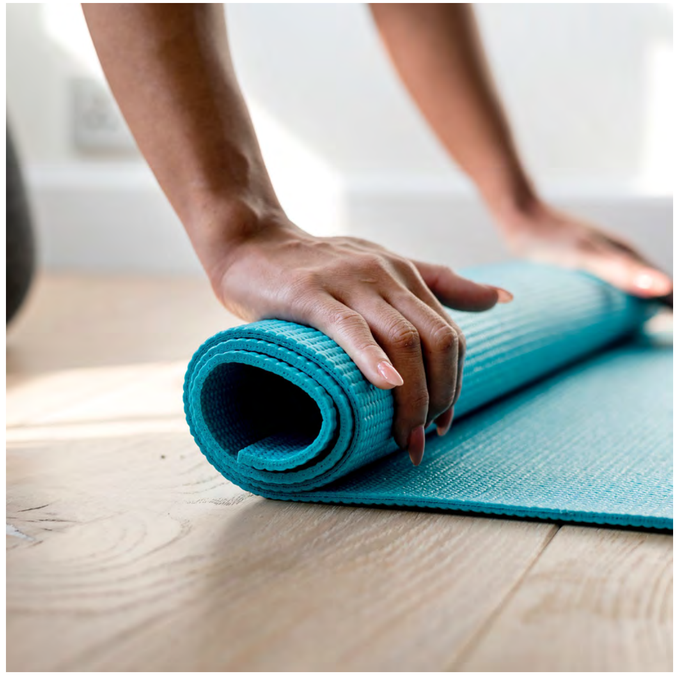
nursing hotline

Services and Additional Benefits

- Sonder Health Plans contracts with a nurse hotline, which is made available to members 24 hours a day, 7 days a week, and 365 days a year, to provide advice about basic health concerns including symptom; understanding medication, including side effects and how to take medication safely; and when it is appropriate to go to the doctor, urgent care, or emergency room.

medication management

fitness benefit



nursing hotline

Services and Additional Benefits

- Recently discharged members who are identified as having balance issues or mobility challenges, poor eyesight, or a history of falls, may be referred to receive an in-home assessment to determine whether there are any safety issues that could result in a fall or other injury.
- The assessment may include identification of any modifications needed to reduce risk of injury.

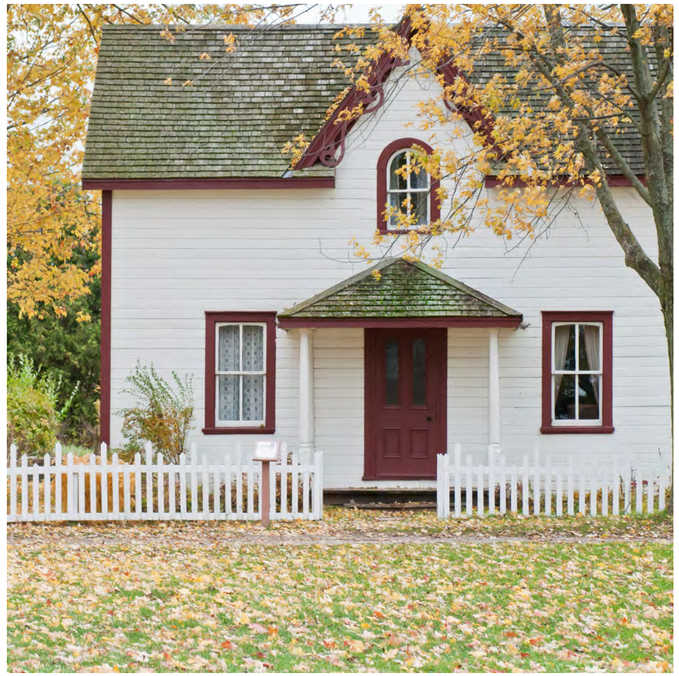
in-home assessment

meal delivery

Services and Additional Benefits

- A temporary meal delivery service is available to members either immediately following surgery or an inpatient hospital stay or as part of a supervised program that includes supervised lifestyle modification related to a chronic condition.
- This service is in addition to meal services that may be available to members through community partners (Atlanta Community Food Bank), and members may be referred to community partners for additional meal delivery or meal services, if needed.

in-home assessment



meal delivery

Sonder Health Plans, Inc

Services and Additional Benefits

- Immediately following a discharge, Sonder Health Plan may arrange for the services of a qualified health care provider to perform a medication reconciliation.
- This provider confirms that the member has obtained the medications prescribed upon discharge, and ensures that medications that may cause potential interactions are discontinued. This provider also educated the member about how to take the medication and also potentially harmful side effects.

medication reconciliation

transportation

health education

Services and Additional Benefits

- Sonder Health Plan makes available pre-arranged transportation for members as needed to assist the member in obtaining non-emergent, covered Part A and B services, including doctor visits, other health care appointments, or to obtain medication.

medication reconciliation

transportation

health education

Services and Additional Benefits

- Members are offered condition-specific health education that teaches members how to manage their condition using written materials made available either by website or mail, and interaction with a certified health educator or other qualified health professional.

medication reconciliation

transportation

health education

Community Partners

- As part of the SNP Care Plan development, Care Managers assess whether there are additional community-based services from which a SNP members could benefit.
- Care Managers will either provide the member with the community partner’s contact information, or will perform a warm handoff.

Empowerline

- The Atlanta Regional Commission Aging Division, a regional office of the Georgia Department of Human services, serves the counties that comprise the Sonder service area. Metro Atlanta seniors, individuals with disabilities, and their caregivers are connected to the services provided by this office via “Empowerline”
- The use of Empower line is free, and services coordinated through Empowerline may be offered at no cost for eligible low-income individuals, at reduced cost, or at full cost, as determined by an Empowerline case manager.
- Services include transportation, self-management programs, assistance with food, help with health care costs, assistance with utilities or emergency financial assistance, home modifications and repairs, and caregiver resources.

Other community partners

- Care Managers may refer members to mail order pharmacies, particularly those who lack transportation or have disabilities and therefore may be less able to obtain prescriptions from a brick-and-mortar pharmacy.
- Care Managers may also assist members with obtaining advance care directives through the Georgia Division of Aging.

Questions?

contact information

To obtain a member’s care plan, refer a patient for additional services, request an interdisciplinary care team meeting for a member, or obtain additional information about the SNP Model of Care, please contact Sonder Health Plans at **(800) 331-2928. Ext. 1110**

Sonder Health
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