NaviCare® Model of Care

How we take care of your patients

When your patients join Fallon Health's NaviCare® HMO SNP, they're assigned a Care Team to coordinate their care and help them meet their health goals. You're welcome to provide input to your patient's care plan at any time. Here's a snapshot of the Care Team—who they are and what they do.

Navigator

- Provides information to your patient about benefits and services.
- Assists with care plan development, reviews and obtains consent for care plans.
- Assists patient with provider access and service coordination.
- Provides care coordination around patient care transitions.

Nurse Case Manager or Advanced Practitioner

- Assesses clinical and daily functional needs.
- Supports patient in accessing the care they need when transitioning between or out of facility settings.
- Provides education about chronic disease and medication management.

Primary Care Provider

- Provides overall clinical direction.
- Provides primary medical services including acute and preventive care.
- Orders prescriptions, supplies, equipment, and home-based services and supports.
- Documents and complies with advance directives in alignment with the patient's wishes for future treatment and health care decisions.
- Provides input into patient's care plan and receives periodic care plans for review and involvement.

Geriatric Support Services Coordinator (as needed)

(Employed by local ASAPs for community-based patients)

- Evaluates need for services to help patient remain at home and coordinates those services.
- Helps patient with completion and submission of MassHealth, Medicare, or other financial documents.
- Connects patient with community resources.

Behavioral Health Case Manager (as needed)

- Identifies and coordinates services to support patient's emotional health and well-being.
- Supports patient through transition phases of older adulthood.
- Helps connect patient with their Care Team, mental-health providers, and substance-use counselors, if needed.
- Supports patient through life transitions such as offering resources related to grief and loss, Alzheimer's/dementia resources, and family caregiver support.

Clinical pharmacist (as needed)

- Visits patients after care transitions to perform a medication reconciliation and teach them proper medication use.
- Participates in case conferences for patients with complex medication profiles.
- Supports patients after care transitions, may complete medication reconciliations via telehealth, provides additional education and resources around medication management.
- Collaborates with providers to ensure a safe, effective medication regimen is in place. The goal is to prevent medication errors, complications, or adverse outcomes when possible.

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