Chinese Community Health Plan H0571
All Dual Special Needs Plan

Model of Care Score: 88.75%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

This SNPs target population consists of 95 percent Medicare members that are of Chinese ethnicity who were born in China and primarily speak Cantonese. The program is called the Chinese Community Health Plan (CCHP) dual eligibility program and eligibility is provided to those members who also have Medi-Cal coverage. CCHP is a subsidiary of the Chinese Hospital of San Francisco, a not-for-profit hospital. CCHP operates in a small geographic area of 2 adjacent counties; San Francisco and San Mateo Counties with all of the membership residing in urban and suburban areas respectively. The most vulnerable segment of the CCHP population (the low-income, frail elderly) have chronic and acute health problems, often complicated by language access, poor diet, noncompliance with medications, infrequent medical attention, and faulty or absent medical equipment.

Provider Network

The provider network for CCHP consists of Chinese Hospital, plus several other hospitals located in San Francisco, including two major tertiary facilities. A majority of routine inpatient and outpatient care is provided at Chinese Hospital, which is a 54-bed general acute care not-for-profit hospital primarily serving the Chinese community. A wide range of special bilingual services, such as intensive care, coronary care, same day surgery, outpatient services, nursing services, health education, and Chinese dietary services are available. In addition, most of the 199 physicians in the Chinese Community Health Care Association (CCHCA) are on the medical staff of Chinese Hospital. For members who need long term care, there are several in-network contracted facilities. The primary care provider (PCP) determines which medical services the beneficiaries will receive.

Care Management and Coordination

Upon enrollment, each CCHP member completes a health risk assessment (HRA) questionnaire. This questionnaire encompasses demographic information, durable medical equipment use, medication use, need for personal assistance, need for medical assistance and frequency of health care use. The coordinators are notified through a monthly enrollment list generated by the Marketing and Membership departments. Each new member is sent a welcome letter, the coordinator's business card and an additional needs assessment questionnaire. The additional dual eligibility questionnaire was developed by the dual eligibility program to probe for more in-

depth information regarding the member's health and social needs. For this specific target population, these additional assessments are needed as the use of herbal medicine is high and potential risks need to be identified. The Medical Director, disease management case managers, inpatient case managers, outpatient case managers and PCP are all involved in the review of the questionnaires.

The interdisciplinary care team, (ICT) consists of the member's PCP and five staff members - three case managers and two care coordinators, who speak English and at least one locally used Chinese dialect.

A questionnaire is sent out the same day the physician is notified of member enrollment and upon return of the questionnaire, the coordinator will call the member to discuss their needs. SNP coordinators maintain a daily log of activities with the participants. Information from the questionnaire is maintained in a database in order to build a complete profile of the member. The initial survey and subsequent assessments are combined to form a complete picture of the member and are accessible in both electronic and hardcopy to ICT members.

The disease management case manager develops the individualized plan of care (ICP) gathering input from the PCP whenever applicable. The ICP is communicated to the member, member's PCP and other ICT members as appropriate (via phone or mail). The ICP and any revisions are communicated to the beneficiary, ICT and pertinent network provider via committee meetings, memorandums, newsletters, telephone, fax and e-mail.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: https://www.cchphmo.com/