Kaiser Foundation Health Plan of Georgia, H1170
Dual-Eligible (All Duals) Special Needs Plan

Model of Care Score: 88.13%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Kaiser Foundation Health Plan of Georgia, Inc. (KFHPGA) offers a special needs plan for members who are dually eligible for Medicare and Medicaid. KFHPGA provides services through a contract with The Southeast Permanente Medical Group, Inc. (TSPMG). Kaiser Permanente Georgia's target population are those Medicare members who are dually eligible for Medicare Parts A and B, and Medicaid, and has over 800 SNP members. Approximately 86% of these members are over age 65 and 57% have at least one of four chronic diseases: congestive heart failure, coronary artery disease, diabetes mellitus or chronic obstructive pulmonary disease. As a result, members have higher risk scores and require more care coordination.

Provider Network

The plan has service agreements in place with providers and specialists including TSPMG to provide direct care services to all members. Additionally, KFHPGA contracts with hospitals, dialysis facilities and specialists. Specialist services are also provided by TSPMG and affiliated community providers and include but are not limited to: behavioral health, cardiology, pain management, urology, neurology, otolaryngology, nephrology, gastroenterology, ophthalmology, orthopedics, general surgery, rheumatology, pulmonology and endocrinology. Physicians with expertise and certification in medical subspecialties such as geriatric medicine and palliative care are available within TSPMG as part of the Kaiser Permanente network to care for elderly, frail members at end of life and those with chronic conditions.

Care Management and Coordination

KFHPGA utilizes the health status questionnaire (HSQ) to identify member needs. The HSQ acts as the health risk assessment (HRA) and includes questions related to functional status, chronic health conditions, and utilization to predict risk scores. Registered Nurse (RN) care managers review the completed HSQs and contact members to conduct further assessment of health status and health care goals. Based on these assessments, KFPHPGA develops an individual care plan (ICP) for all members at least annually. The plan contacts the member after review of his/her HSQ, or after a transition of care occurs, to assess health and functional status as well as member care goals. The ICP includes at least one to three specific and measurable goals. These goals are developed collaboratively with the member (when available) and based on the member's top health concerns identified during the assessment. Elements included in the ICP include the member's goals for his/her own health, assessment of functional status, pain,

caregiver availability and support, disease specific assessment (including attention to medication issues) and advance care planning.

KFPHPGA reviews the ICP and an interdisciplinary care team (ICT) revises it annually, or whenever a major change in health status or care transition occurs. Due to the prevalence of depression, dementia and other mental health illnesses, a geriatric psychiatrist acts as a part of the ICT. The plan also adds clinical pharmacists to the team in order to identify medication needs. KFPHPGA uses a social worker to coordinate community and internal resources for social service needs. Finally, RN care managers are in place to assist with coordination of care and to development and implement the ICP.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.kp.org/medicare