H1170 Kaiser Foundation Health Plan of Georgia Inc.
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 91.67%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The target population of the Kaiser Foundation Health Plan of Georgia (KPGA) is Medicare members who are dually eligible for Medicare Part A, Part B and Medicaid. Members are geographically located throughout Georgia. The KPGA SNP plan covers 12 counties in the metro Atlanta area, which is a sprawling metropolitan region of approximately 6 million people.

Nine percent of members are cared for by spouses or partners who may also be elderly, frail or in poor health. The most frequent type of assistance requested by members is for help with activities of daily living (ADLs and/or instrumental ADLS), general supervision for safety reasons and respite care.

As of December 1, 2013, KPGA had 944 members. Three-fourths of members are female and the average age is 73, with 82 percent of members age 65 and older. Half of the members are African-American and most members speak English as their primary language. Eighty percent have at least one or more of the following conditions: arthritis, asthma, cancer, chronic kidney disease, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, end stage renal disease (ESRD), neurological disease or self-reported poor health. Just over half of members have two or more of these conditions. In addition to physical health disorders, 25 percent have been diagnosed with anxiety, depression, drug and alcohol abuse or schizophrenia.

Provider Network

Kaiser Permanente operates an integrated delivery network that links care delivery and health plan operations. It has service agreements in place with providers and specialists, including Kaiser Foundation Hospitals and The Southeast Permanente Medical Group (TSPMG) to provide direct care services to members. The KPGA contracts with hospitals, dialysis facilities and specialists. Specialists include but are not limited to internal medicine, behavioral health, cardiology, pain management, urology, neurology, otolaryngology, hematology, oncology, nephrology, gastroenterology, ophthalmology, optometry, orthopedics, general surgery, rheumatology, pulmonology and endocrinology. Physicians with expertise and certification in medical subspecialties such as geriatric medicine and palliative care are also available to care for members who are elderly, frail, members at end of life and those with chronic conditions.

Care Management and Coordination

SNP registered nurse (RN) care managers hold primary responsibility for member care coordination. Other KPGA departments provide clinical support such as disease-based case management, health coaching or pharmacy consultation and counseling. SNP RN program managers are RNs certified as chronic care professionals who provide coordination of care, manage SNP transitions and serve as points of contact for members and caregivers.

KPGA conducts initial and annual health risk assessments (HRA) to evaluate frailty, hospital readmission and advanced illness. HRA results are communicated by the SNP RN care managers to the interdisciplinary care team (ICT) and subsequently the primary care physician (PCP), weekly. ICT members include but are not limited to a physician lead trained in chronic condition management and certified in geriatric medicine; RN certified case and care managers; clinical pharmacy specialist; geriatric psychiatrist; licensed master's prepared social worker; nurse practitioner and a licensed practical nurse.

Interventions are developed and recommended by the ICT based on the member's risk score and factors such as emergency room (ER) or hospital utilization, changes in functional or cognitive status, polypharmacy and caregiver availability or capability. This information is used to create an individualized care plan (ICP). The member's personal health preferences are assessed and used to prioritize the goals and interventions for the ICP. Components of the ICP include: self-management plans and activities; medical and care management interventions and recommendations to help achieve the goals; medication changes; lab or radiology tests; immunizations; referrals to appropriate providers; advance care planning; identification of barriers; schedule for re-assessment and communication and a plan to assess progress.

Members with higher risk scores are prioritized for outreach by the RN care manager. Members who experience a transition or change in health status receive a reassessment which results in an updated ICP. Other criteria for outreach include ER visits, acute mental status changes, falls or gait instability, medication errors or notifications of changes to member's status by their PCP or other practitioner.

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://healthy.kaiserpermanente.org/health/care/consumer/shop-health-plans/medicare