Trillium Community Health Plan, H2174
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Dual eligible members represent a population with a high incidence of frailty, mental health and developmental issues, and complex chronic conditions. Trillium dual eligible members often have disability due to mental illness or developmental delay that adversely impacts their ability to access health care and understand important health care issues. Trillium's dual eligible population has an average age of 59 years, Major contributors to the burden of disease in this population include diabetes (5.6% of projected costs), acute and chronic renal failure (5.3% of projected costs), lung disease other than COPD and asthma (4.1% of projected costs), cardiac conditions (3.8% of projected costs) and psychotic/ schizophrenic disorder (3.7% of projected costs).

Provider Network

Trillium's network of providers is comprehensive and structured to meet the needs of our entire population, especially members who are frail and disabled or require end of life care. The network includes, but is not limited to primary care practitioners (PCP), specialists such as cardiologists, oncologists and behavioral and allied health, nursing, rehabilitation, acute care, skilled nursing and hospice facilities.

Care Management and Coordination

The plan's care coordination program addresses not only specific medical conditions, it also looks at the impact of issues such as health literacy, social factors such as isolation and lack of access to adequate nutrition, and barriers to care such as lack of transportation.

The health risk assessment (HRA) is designed to evaluate medical, psychosocial, functional, cognitive, health literacy, and resource needs of members as well as identifying the medical and mental health history, use of alternative medicine and use of the over the counter medications. It also evaluates member use of Medicare benefits, community resources, and their relationship with their PCP. The risk assessment self-scores in multiple component areas to help stratify members based on need. The results of the assessment are conveyed by letter to the PCP and/or the provider whom the member indicates is their usual source of care. Thereafter, information from the assessment is provided to the member or caregiver upon request. Comprehensive risk assessment is done initially, beginning within 90 days of initial enrollment and repeated either annually at the anniversary of enrollment or at the time of any 'trigger' event that indicates a potential change in member health status.

The individual plan of care (ICP) is developed by a registered nurse (RN) care coordinator, who has the first contact with the member after completion of the HRA. Review of all areas of concern identified on the HRA is the basis of core work done to initiate the members' ICP. Active member involvement is integral to the design of Trillium's care coordination program. The ICP includes results of the assessment, goals/objectives developed by the member/caregiver and the RN care coordinator, specific services and benefits needed or used, outcome measures, preferences for care, add-on benefits and services for vulnerable members such as the disabled, those near the end-of-life or those with access to care needs and review of medication use, including pharmacist medication therapy recommendations. Periodic assessments of progress against plans and goals are conducted and modifications to the plan are made as needed.

Interdisciplinary care team (ICT) composition is determined by specific member needs. The core ICT, at a minimum, is comprised of the beneficiary and/or caregiver, the PCP, the involved mental health specialist, any medical specialists regularly involved in the members' care, a licensed clinical social worker, and the Plan pharmacist. Other specialists or allied health service providers will be added to the team based on the members' clinical needs. The registered nurse (RN) care coordinator and the member are invited to participate in the care coordination process and the ICT.

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:
http://trilliumadvantage.com/snp-2014.php