Trillium Community Health Plan, H2174
Institutional (Institutional Equivalent-Living in the Community) Special Needs Plan

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

Target Population

Trillium Institutional Special Needs Plan target population are Institutional Equivalent (ISNP-E) members who live in a community based care setting, such as Assisted Living, Residential Care, Adult Foster Home, and Group Homes. This population is often dual eligible and must be deemed long term care eligible by state assessment. This population also desires to remain out of long term care as long as possible. Aging in place is supported and encouraged. Characteristics of this population include but are not limited to: significant disability from physical, developmental, or injury related issues, frailty due to lack of health reserve secondary to age or chronic illnesses, illness progression such as end stages of complex conditions - chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and cancer, multiple co-morbid disease states whose interdependence complicates care, and cognitive impairments and mental illness.

Provider Network

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

Care Management and Coordination

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 primary care provider. The risk assessment self-scores based on the particular risk areas. The scoring will determine if the member requires weekly, bi weekly or monthly visits by contracted nurse practitioners. A comprehensive risk assessment is done, 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) or service plan as it is called in the residential facilities, is developed by the member, facility licensed nurse, facility administrator and the contracted nurse practitioner. The ICP reflects the residents capabilities, choices and if applicable, measurable goals and managed risk issues. The ICP must reflect the resident's needs as identified in the evaluation and include resident preferences that support the principles of dignity, privacy,

choice, individuality and independence. The ICP must be completed: prior to resident move-in, with updates and changes as appropriate within the first 30-days; and following quarterly evaluations. When the resident experiences a significant change of condition the service plan must be reviewed and updated as needed. Involved family members and case managers must be notified in advance of the service-planning meeting.

Interdisciplinary care team (ICT) composition is determined by Oregon Administrative Rules for Assisted Living Facilities and Residential Care Facilities. As applicable, the service planning Team must also include: (A) case managers and family members, as available; (B) a licensed nurse if the resident will be, or is, receiving nursing services or experiences a significant change of condition; and (C) the resident's physician or other health practitioner. Other ad-hoc ICT members may include pastoral care, ombudsman, restorative therapies, specialists, or mental health practitioners. The ICT operates on a required assessment schedule based on initial, quarterly and annual meetings as well as based on change of condition. Changes of condition are identified during assessment or in between assessment periods. They are determined by the resident care manager. On occasion a significant change of condition is triggered and communicated by the care facility staff. The contracted nurse practitioner takes this as a trigger to also complete an updated HRA.

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/isnp-2014.php