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

Model of Care Score: 85.00%
1-Year Approval[1] **January 1, 2015 – December 31, 2015**

Target Population

Trillium's institutional special needs plan (I-SNP) operates in Lane County, Oregon. The plan serves members who live and receive care in a community based setting. This plan is designed for members who desire to receive their care where they live and have barriers to seeking out care in the community. This population has difficulty with expressing their needs due to physical and cognitive disabilities, appointment management issues, and transportation limitations. Members rely on caregivers to provide them with assistance of daily living activities.

Demographically, 70 percent of members are over the age of 65 years old. Many of these members have multiple, chronic or disabling conditions. For members that are over 65 years or age, the ratio of women (67 percent) is much higher than men (33 percent). The majority of members speak English while less than 5 percent speak Spanish. There are also members who only speak Russian, Vietnamese or Chinese.

Trillium I-SNP members considered "most vulnerable" are proactively identified and stratified as high risk. In terms of the most vulnerable subpopulations, 13.9 percent of the membership has been diagnosed with COPD, 9.3 percent with chronic heart failure and 8.3 percent have cancer. The plan also identifies that over 80 percent of the membership has health literacy barriers.

Provider Network

Trillium provides access to preventive and primary care through a specialized provider network that understands the specific needs of the I-SNP membership. Providers also receive training to provide care for members who are frail, disabled or require end of life care. The network includes services such as, facilities, laboratory, skilled nursing, pharmacy, practitioners, specialists, allied health professionals and behavioral/mental health.

Trillium collaborates with its provider network in establishing best practices and defining effective performance measures. The plan assures that providers use evidenced based clinical practice guidelines and nationally recognized protocols by semiannual analysis of claims data, pharmacy record, lab data, and member electronic health records. Medical records reviews assure that providers use appropriate clinical guidelines.

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[1] Per CMS guidance, plans that use the cure process receive a one-year approval, regardless of their final score.

Care Coordination

The care coordination process begins with a health risk assessment (HRA) when a member enrolls into Trillium Health Plan. The HRA assess health status, estimates the level of health risk and provides feedback to members and staff about Medicare benefits, community resources and the member's relationship with their primary care provider (PCP). HRA's are offered to all members within 90 days of initial enrollment, and are repeated either annually or whenever there is a significant change in a member's health status. The member's prior authorization, claims data, and HRA responses are used to screen the needs/risks of the member and to develop an individual care plan (ICP).

The ICP remains at the member's facility, where the nursing staff updates and maintains the care plan. The plan also solicits input from the member in development of the care plan whenever possible. Trillium makes the care plan available to all staff involved with care of the member. Depending upon findings of the triggered areas on Trillium's HRA, the components of the care plan can include but are not limited to, impairments, treatments/procedures, barriers, preferences and limitations.

Based on the members ICP, the plan assembles an interdisciplinary care team (ICT) for all members which reflects specific components of the care plan. All participants on the ICT, including the member, work together to reach goals and maintain treatment procedures reflected in the care plan. The primary composition of the ICT includes, nurse care managers, dietary services, social services, primary care providers and plan staff.

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