HealthCare Partners of Nevada (Humana Health Plan) H2949,
Chronic or Disabling Condition (Chronic Lung Disorders) Special Needs Plans

Model of Care Score: 85.63%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

The target population of HealthCare Partners of Nevada (HCPNV) includes members with Chronic Lung diseases. Chronic Lung diseases have a high potential for complex medical and medication management. Approximately 5% of deaths in the United States had chronic obstructive pulmonary disease (COPD) as the underlying cause, and smoking is estimated to be responsible for at least 75% of COPD deaths. The CDC estimates that approximately 48.6% of adults in Nevada either currently smoke or have a past history of smoking. Individuals with Chronic Lung disease are more likely to require coordination among a wide range of providers, including primary, specialty, allied health, home health, rehabilitative services and palliative care specialists in both inpatient and outpatient settings.

Provider Network

HCPNV offers a comprehensive network of care centered on primary care, with medical and surgical specialists available to augment and support the primary care provider (PCP). This network includes but is not limited to acute care facilities, primary care outpatient facilities, specialty care outpatient facilities, long term care facilities, skilled nursing facilities, and inpatient and outpatient laboratories. The Registered Nurse Care Coordinator (RNCC) is responsible for the coordination of services and communicates with stakeholders through face to face, online or telephonic outreach.

Care Management and Coordination

HCPNV, in collaboration with Humana, utilizes a health risk assessment (HRA) tool that identifies the specialized needs of members including medical, psychosocial, functional, environmental and cognitive needs. The plan assesses all members against the HRA within 90 days of active enrollment and reassesses members annually. The health care professionals on the interdisciplinary care team (ICT), such as the PCP, RNCC and medical social workers integrate information from the HRA and the predictive model to determine the appropriate risk-group level for each member. RNCCs coordinate communication regarding the risk-group results to the appropriate ICT members as well as applicable network providers. Communication to the ICT team may be through written notification, electronic notification, face-to-face interactions, by phone or a combination thereof, and is documented in the members' medical record.

The ICT develops and implements individualized plans of care (ICP) in conjunction with members and caregivers. When feasible, members participate in developing goals and actions they feel will help them meet targeted goals. If possible, members meet with RNCCs while in

their PCP's office; otherwise they work with RNCCs via telephone conferences. The ICP addresses short term and long term goals and incorporates information from the HRA, preferences of care, desired health outcomes and specific needed services, such as those for members near the end of life, and members with multiple and complex co-morbidities. HCPNV reviews and revises the ICP annually and on an ad hoc basis as members' statuses change. The plan documents and maintains the ICP in HCPNV's proprietary care management program, where it can be provided to applicable parties as changes occur. RNCCs are responsible for keeping all pertinent team members informed about care plans and any changes when they occur.

The ICT at a minimum includes the member and/or caregiver, the PCP, the primary RNCC and the medical social worker. The ICT may include additional members based on the needs outlined in the ICP, such as HCPNV's medical director, restorative health specialists, dieticians, pharmacists, disease management specialists, end of life specialists, home health specialists, external social services specialists or surgical specialists. Members and/or caregivers have direct access to the ICT. RNCCs schedule and facilitate team meetings and interactions, and document care plans in the medical health records and care management database, to which all members of the ICT have access.

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 websites at:

http://www.humana.com/SNP

http://www.hcpnv.com/casemanagement