

HealthKeepers, INC (WellPoint), H3447
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 91.88%

3-Year Approval

January 1, 2014 – December 31, 2016

Target Population

HealthKeepers, which is offered by WellPoint (WP), targets members with diabetes. The members generally have the following co-morbidities: 50% with high blood pressure, 80% with high cholesterol, 60% with chronic kidney disease, and 60% with heart disease. WP's mean age of its diabetes SNP population is between 70 and 72 depending on the market. These members have some of the frailties and risk factors associated with the elderly, such as cognitive impairment, functional impairment (e.g., vision, fine motor skills, arthritic deformities) and varying ability in social and care giver support. Additionally a large population of these members have no formal education on how to manage and treat their diabetes.

Provider Network

WP coordinates with health care providers to deliver its clinical model and has strategies to ensure there is targeted clinical expertise for each setting. In addition to a full contracted network of providers (e.g, PCPs, specialists), WP employs clinicians with specialized expertise to provide additional services to the diabetes population. These clinicians are nurse practitioners who are specially trained in diabetes and wound care management. An endocrinologist acts as the medical director of WP's diabetes management program and dieticians. WP also contracts with providers who work closely with the interdisciplinary care team (ICT) such as podiatrists who work out of WP's Care Centers, preferred specialists for ophthalmology, vascular surgery, and orthopedic surgery and fitness instructors.

WP's approach to providing beneficiaries with access to services is tailored to their needs. All beneficiaries have a primary care provider (PCP) who acts as a gate keeper for the member. All beneficiaries are also provided with immediate access to services and benefits by WP clinicians during their annual Healthy Start and Healthy Journey Assessments. Beneficiaries who are frail or with uncontrolled chronic conditions are managed by a WP clinician;

Care Management and Care Coordination

WP utilizes a standardized health risk assessment (HRA). Questions, screening tools, guidelines and protocols are used to identify members and determine appropriate interventions in order to assess members for all chronic conditions a member may have. This allows members to get the

care needed for other conditions, along with their diabetes care. The HRA includes questions regarding physical, mental, functional, cognitive and psychosocial health and status. Members receive the HRA upon enrollment and annually thereafter. This may be performed at the member's home or by telephone. Results are reviewed by a nurse practitioner who will indicate the treatment process for each chronic condition using Healthy Start and Healthy Journey guidelines to determine which clinical programs a member should be triaged.

After the HRA has been completed, the member's individualized care plans (ICP) are developed during Healthy Start and Healthy Journey appointments. Along with the nurse practitioner, the member reviews the results of the HRA and develops the ICP to meet the specific needs of the member. Specific barriers, preferences and limitations (e.g., cultural) and care giver resources availability are also discussed. WP's nurse practitioners and other members of the ICT review and revise the ICP every time they see a patient. Clinical managers and medical directors conduct periodic reviews of the dictations and charts resulting from Healthy Start and Healthy Journey assessments to ensure members have a complete and appropriate care plan.

The interdisciplinary care team (ICT) is a multi-member team that is led by the nurse practitioner, internist/extensivist, endocrinologist, case managers, fitness trainers, ophthalmologists, social workers, registered dietician, podiatrist, vascular surgeon, orthopedic surgeon and behavioral health specialists. Additionally WP has another ICT, CareMore Advanced Care Team (ACT), dedicated to members with severe psychosocial issues and end of life needs and members who are hospitalized or need a skilled nursing facility level of care. These teams meet at a minimum of weekly to manage and assess the complex needs of these vulnerable populations. These teams are comprised of: medical supervisors, nurse practitioners, specialists (if applicable), extensivists (board certified in Internal Medicine), case managers, behavioral health professionals, social workers, and other professionals as needed (e.g. Dieticians, Clergy).

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://www.wellpoint.com/>.