UPMC Health Plan, H3907
Institutional (Institutional-Facility and Institutional Equivalent-Living in the Community)
Special Needs Plan

Model of Care Score: 91.25%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

UPMC *for Life* Options is structured to address the unique chronic medical, behavioral health, cognitive and functional status of a population that has been assessed and deemed eligible for nursing facility care along with the barriers and challenges they face. The goal is to continually assess and manage the clinical and functional needs of these members, allowing them to remain at their highest functional level.

The top five clinical diagnoses for the population are: hypertension, hyperlipidemia, osteoporosis, coronary artery disease, and diabetes. On average, the population is 79 years old and three-quarters female. Three-quarters of the population reside in the community.

Provider Network

UPMC contracts and credentials numerous practitioners and providers to ensure that members have access to care. Practitioners assess diagnosis and treat members; they also collaborate with the interdisciplinary care team (ICT) as needed. At a member level, practitioners assist with developing and updating the individual care plan (ICP) and participate in conference calls for interdisciplinary case reviews. Practitioners also assist UPMC Health Plan in the development, implementation and evaluation of clinical programs.

UPMC contracts with facilities that provide diagnostic and treatment services to meet members' needs. These facilities provide services along the continuum of care to UPMC members, including those that are identified as frail, disabled and near end of life. The participating practitioners and providers include: skilled nursing facilities, assisted living facilities, long term care centers, home care agencies, specialists, primary care physicians (PCP), durable medical equipment providers, acute care hospitals and other facilities/providers.

Care Management and Coordination

UPMC has developed methods to obtain information from and about members. The ICT uses this information to develop an ICP for members based on their physical and behavioral health

status, functional and cognitive status, life style risks, types of services needed or receiving, where services are provided, level of understanding of their diseases and management of their conditions, support from caregivers and social needs. The information utilized contains claims data, health risk assessments (HRA) data, assessments completed in facilities and assessments in the electronic health records (EHR) system. UPMC uses the ICP as the basis for establishing the ICT.

The composition of the ICT is determined based on reviews of demographics, prevalence of chronic diseases or conditions, social needs of the members, other clinical/financial reports and from the plan's experience in managing the population. At the core of the ICT is the practitioner who directs the member's care. Depending on the member's location (in an institution or living in the community), this practitioner may be the member's PCP (including mid-level providers such as nurse practitioners or physician's assistants), the medical director at a nursing or assisted living facility, or another practitioner who sees the member while in a facility. Other practitioners, providers or community agencies are added as needed. The ICT includes UPMC staff such as: the medical director, care managers, behavioral providers, health coaches, social workers, pharmacist and lifestyle health coach, along with the member and applicable caregivers.

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 website at: www.upmchealthplan.com/snp