Geisinger Health Plan, H3954
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Geisinger Health Plan (GHP) manages a Chronic Care SNP in New Jersey for members that have diabetes, a medically complex chronic condition that has a high risk of hospitalization, complications and the development of additional co-morbid conditions. Data compiled by the Department of Health and Senior Services in New Jersey show an estimated 7% of the adult population has diabetes. This chronic condition is even more prevalent in persons 65 years old and over, with an almost 17% incident rate.

Provider Network

GHP maintains a comprehensive provider network for its SNP population that consists of numerous facilities, medical specialty physicians, nursing professionals, behavioral and mental health specialties as well as allied health professionals including but not limited to pharmacy, physical, speech and occupational therapy. The network also includes providers who specialize in areas of importance to individuals with diabetes and/or heart failure such as cardiovascular disease, durable medical equipment, endocrinology and metabolism, nephrology, ophthalmology, optometry, and prosthetics and orthotics.

Care Management and Coordination

GHP uses a predictive modeling software application that takes medical and pharmacy claims data, as well as laboratory results, where available, to calculate acute or chronic risk scores. The acute risk score predicts the likelihood of the need for an inpatient event. The chronic risk score signifies that the member is lacking some or all of the preventive health or chronic care services. A health risk assessment (HRA) is completed within 90 days of the member's enrollment date. The assessment can be completed by phone or face to face at their provider's office to collect information such as activities of daily living, safety issues, current therapies, medication reconciliation, nutrition, pain analysis, depression screening, behavioral health needs, life planning, environment and caregiver support.

The members' case manager and primary care provider (PCP), collaborate with the interdisciplinary care team (ICT) to determine the member's health care needs and to formulate an individualized care plan (ICP). The ICP is often developed with the member and family present in the primary care site with all team members working collaboratively. The ICP is built around the patient's goals and engagement. The self-management action plan and ICP are revised with changes in health status, e.g., post-hospitalization, emergency room (ER) visit, exacerbation, change in a current condition or a new diagnosis.

The member's PCP has the ultimate responsibility as the gatekeeper for all the necessary services and treatments that a SNP member may need. Additional clinical providers and community service representatives on the team are determined based the member's responses on their HRA and the most current ICP available. Appropriate Plan staff, specialty or ancillary providers and/or community providers are included in order to develop a member-centric ICT to assess, revise and communicate a well-rounded plan of care. When any significant clinical events occur (e.g., acute care admission, frequent emergency room visits), the PCP or case manager can recommend the re-evaluation of the ICP for a member and suggest the appropriate changes for discussion at the next available ICT meeting.

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.thehealthplan.com/.