CarePoint Insurance Company, H5141
Institutional (Facility) and Institutional Equivalent (Living in the Community)
Special Needs Plan

Model of Care Score: 98.13%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

The target population for the CarePoint Advantage Institutional SNP (CarePoint I-SNP) includes enrollees in Hudson County, New Jersey, who are over 21 years of age, and 1) currently reside in skilled nursing facilities and require nursing services on a daily basis to manage their chronic conditions and support activities of daily living (ADL), or 2) currently reside in the community and qualify by virtue of their health and/or mental health status and ADL functioning for skilled nursing home placement, and 3) are predominantly frail, disabled or nearing end-of-life.

The population of Hudson County is nearly 40% Hispanic with Spanish as their primary language. This population is characterized by the prevalence of conditions including hypertension (77%), chest pain (54%), coronary artery disease (52%), congestive heart failure (33%), cancer (44%), osteoarthritis (38%), and diabetes mellitus (37%); is more likely than their age cohorts to exhibit two or more ADL dysfunctions, and have the compounding factor of multiple chronic morbidities. Many enrollees experience multiple diagnoses, often with complications including wounds, nutritional compromise, depression or dementia.

Provider Network

The CarePoint network includes acute hospitals, sub-acute, skilled, rehabilitative, long term care and behavioral health facilities, home health care agencies, laboratory, and radiology services. The network of providers includes but is not limited to the full range of primary care and medical specialists, including gerontology, cardiology, nephrology, neurology, and pulmonology. The long term care facilities and home health care agencies have social workers, registered nurses, nurse practitioners, behavioral and mental health specialists, allied health professionals such as physiatrists, physical therapists, occupational therapists, and speech therapists.

Care Management and Coordination

CarePoint Advantage conducts health risk assessments (HRA) for all new enrollees within 90 days as a mechanism for screening for potential I-SNP eligibility. The assessment evaluates multiple issues related to medical, psychosocial, functional, cognitive, medical and mental health, assesses personal resources and strengths, determines service needs, and identifies interventions corresponding to the determined problems.

The interdisciplinary care team (ICT) is comprised of a core group of clinical and support staff, and team selection is based on the results of the HRA and identified needs of the member, or request of the member/caregiver such as request for a chaplain or spiritual advisor. The member

is the center point of all participants of the ICT, and each participant is connected to the member. The ICT is coordinated by the nurse practitioner or care manager who is responsible for coordination, facilitation, and ensuring appropriate clinicians participate in the ICT. Team members may vary and stagger their participation depending on the member's needs and identified short/long term goals. As members develop new conditions such as a hospitalization or a change in condition, new clinicians such as a wound therapist may be engaged. Other specialists and ancillary providers are consulted as needed. CarePoint's core ICT membership will conduct care plan reviews quarterly with a full ICT review at least annually.

The ICT consults with the member to the greatest degree possible in an effort to develop a comprehensive individualized care plan (ICP) that addresses the member's specific needs. The nurse practitioner oversees the development and revision to the ICP as needed depending on changes in the member's condition. The initial ICP is developed at the first ICT care conference, and, in the event that the PCP is not in attendance, is presented to the PCP by the nurse practitioner for review. In the event that the member/family was not in attendance at the ICT care conference, the nurse practitioner then discusses the ICP with the member/family and gains their input. Once all are in agreement, the ICP is distributed to the ICT and a copy is provided to the PCP, member/family and any other relevant network provider involved in the ICP. A follow up care conference is scheduled in approximately 90 days.

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.carepointadvantage.org/