**H5425 Scan Health Plan**
**Chronic (Cardiovascular Disorders and/or Chronic Heart Failure) Special Needs Plan**

**Model of Care Score: 95.00%**
**3-Year Approval** **January 1, 2015 – December 31, 2017**

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## Target Population

SCAN Health Plan (SCAN) Chronic Cardiovascular Disorders and/or Chronic Heart Failure Special Needs Plan (C-SNP) serves Medicare members who have a confirmed diagnosis of chronic heart failure (CHF) and/or cardiac arrhythmias, coronary heart disease, peripheral vascular disease (PVD), and chronic venous thromboembolic disorders and live in one of the plan's service areas in California. These C-SNP members represent the full spectrum of newly-diagnosed cardiac conditions to end-stage heart diseases. CHF prevalence in this population is approximately 13 percent and PVD is 21 percent.

Medical conditions associated with uncontrolled CHF and PVD in the C-SNP population include: fluid retention, anemia, anxiety, decreased functional status, chronic coughing, fatigue, weakness, faintness, loss of appetite, frequent urination, heart palpitations, shortness of breath, swollen extremities and sleep problems/sleep apnea. The most common co-morbidities affecting this population include: diabetes, malignant hypertension, lung disease, kidney disease, obesity, thyroid disease and osteoporosis. Other health conditions affecting C-SNP members that may complicate care include: heart attack, stroke, dementia and cancer. Limited functional status, pain, and depression can contribute to social issues such as isolation and increased caregiver burden. Low-income also adversely affects medication adherence and nutrition.

## Provider Network

The network is composed of services essential to the care of members with chronic conditions, such as primary care physicians (PCP), specialists with expertise in endocrinology, ophthalmology and cardiology; diagnostic services, home health services, hospice or palliative care and outpatient rehabilitation. Contracted facilities include: hospitals, intermediate care centers, after hours clinics, acute and long-term care, tertiary care, ambulatory clinics, skilled nursing facilities and specialty outpatient clinics. Specialty services are contracted or available when needed on a case-by-case basis.

## Care Coordination and Management

Within 90 days of enrollment and annually thereafter, a care navigator (CN) contacts the member via phone to complete an initial health risk assessment (HRA) and documents their responses in SCAN's care management system. The HRA assesses members' risk in four broad domains: medical, psychosocial, cognitive and functional needs. Based on the HRA results, utilization data, referrals data and medical documentation, the member may be further assessed to determine the appropriate level of

care management, interventions and services. High risk cases will be reviewed by the interdisciplinary care team (ICT) to help coordinate care and facilitate the best possible healthcare outcomes.

The CN develops an individualized care plan (ICP) for each member either by phone based on their identified needs and input during the HRA. The CN documents the finalized ICPs in SCAN's software platform, mails a copy to members and faxes a copy to the PCP. The CN reviews the ICP annually, at a minimum, or whenever the member experiences a change in condition or status.

The interdisciplinary care team (ICT) is composed of highly-skilled clinical staff at both the health plan and the provider organization caring for the member. Team members include staff from the plan such as medical directors, geriatricians, case managers as well as staff from the provider organization: PCP, specialists, nurse practitioners and physician assistants. The ICT meets in-person on a weekly basis to communicate and discuss the member's care. Professionals from the disciplines mentioned above attend and PCPs/care managers from provider organizations are encouraged to call in or attend in-person. All ICT members have access to the HRA, ICP and ICT notes in the electronic care management system.

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: www.scanhealthplan.com.