Optimum Healthcare, H5594
Chronic or Disabling Condition (Chronic Lung Disorders)
Special Needs Plan

Model of Care Score: 100%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Optimum Healthcare's target population is members with Chronic Lung Disorder (CLD), which would require a diagnosis of asthma, chronic bronchitis, emphysema, pulmonary fibrosis or pulmonary hypertension. CLD is prevalent in the Medicare-age U.S. population and among Optimum Healthcare Medicare members. The prevalence of chronic obstructive pulmonary disease (COPD) among the current Optimum Healthcare Medicare population is approximately 21% (as based on claims and encounter data), and was greater than 14% among the national Medicare FFS population in 2008.

Provider Network

The plan has a network of providers and board- certified specialists with clinical expertise including primary care providers (PCPs), pulmonologists, nursing professionals, rehabilitation and restorative therapy specialists, social workers, mental health specialists, medical specialists, pharmacists, oral health specialists and mid-level practitioners. The plan also maintains a network of facilities that have specialized clinical expertise pertinent to the SNP population which includes acute care hospitals, tertiary medical centers, acute care rehabilitation facilities, skilled nursing facilities and extensive pharmacy locations among others.

The PCP, as the main coordinator of the interdisciplinary care team (ICT), is responsible for communicating with the ICT about the services provided to the member. The PCP is responsible for ensuring that all specialty services are performed and communicated in a timely fashion in order to provide quality care to the member, and is responsible for ensuring that any required follow-up is scheduled and performed. Additionally, Utilization, Case and Disease Management staff that facilitate member care occasionally identify clinical gaps.

Care Management and Coordination

Optimum conducts an initial comprehensive health risk assessment (HRA) within 90 days of the member's enrollment which addresses health status, clinical history, mental health status, life-planning activities, cultural and linguistic needs, visual and hearing needs and caregiver resources. Clinical staff (composed of physicians, nurses and social workers) develop triggers that are used to electronically triage member needs by risk stratification, and a comprehensive health risk analysis is conducted by credentialed health care professionals. The plan conducts

reassessment annually after the initial assessment and maintains information from all assessments in the Plan's documentation system.

Member's and/or caregivers participate in care planning when feasible by telephone communication or written correspondence with the disease case manager or PCP. The member's plan of care includes short and long term goals, preferences of care, member benefits, community services, barriers to meeting health goals and caregiver resources. The primary owner of the care plan manages, reviews and revises the care plan as needed. The plan determines the primary owners based on the member risk stratification tier, however, the PCP is one of the primary owners regardless of the designated tier. The PCP updates the care plan at least annually in the plan's documentation system, where stakeholders, members, providers and ICT members can access it electronically.

Members and representatives, in collaboration with the members' PCPs, are a core requirement for the ICT. This core ICT composition uses the initial review of health and service needs based on the HRA to identify additional ICT members, taking into account recommendations from core SNP clinical and administrative staff, the chief medical officer and the chief executive officer. The ICT responsibilities include review and approval of care plan models and care management policies, as well as periodic review and update of clinical guidelines. The ICT includes the member and/or the member's representative if needed, as well as the PCP, nurse practitioner, restorative health specialist, social services, mental health provider, case manager, board certified physician, clinical pharmacist, disease management specialist, nurse educator and caregiver/family member when feasible. The ICT convenes bi-annually as an oversight committee, and quarterly as a multi-disciplinary care team to review cases.

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: https://www.youroptimumhealthcare.com/medicare/special_needs_plan_info_members.