UnitedHealthcare (Erickson), H5652
Chronic or Disabling Condition
(Cardiovascular Disorders, Chronic Heart Failure, and Diabetes)
Special Needs Plan

Model of Care Score: 89%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Erickson Advantage (EA) enrolls eligible members who reside in or are expected to reside in a long term care or skilled nursing facility continuously for 90 days or longer. EA assesses members who enrolled in the health plan prior to the 90 day eligibility requirement to determine whether their condition will require institutionalization for at least 90 days. The plan targets members that live in the long term care section of the continuing care retirement community and skilled nursing facilities. These members typically are more than 80 years old, have approximately six chronic diseases and show a high prevalence of dementia and mobility problems.

Provider Network

EA's primary care providers are geriatricians who practice on campus in a full time medical center. Erickson communities offer medical centers where members schedule appointments with their primary care providers, podiatrists, mental health practitioners and preferred specialty providers. Core specialty providers who have campus medical center privileges are those that provide a geriatric focus of care. EA contracts with outpatient facilities and tertiary facilities and provides transportation to off-campus providers and facilities for medical care. The continuing care retirement communities provide skilled nursing, long term care facilities and pharmacies on campus. EA performs initial credentialing for each network facility and physician to ensure these providers have current licenses and that physicians are board certified in their designated specialties. Providers are re-credentialed every three years. Members have open access to services that do not require authorization. For services requiring authorization, the care coordinator works with the member's provider(s) to determine if the service meets medical criteria based on Milliman guidelines and Medicare coverage guidelines.

Care Management and Coordination

EA conducts health risk assessments (HRA) via direct mailing within 90 days of enrollment and quarterly thereafter to determine if there are mitigating risk factors requiring intervention. EA directors of clinical and quality operations and the EA medical director review results of the HRA scores and refer the highest risk members to the care coordinator to evaluate needs for complex case or disease management. EA care coordinators communicate the plan of care electronically with the providers. The HRA contents are designed to identify members at risk in specific domains including chronic diseases, high utilization of medications, physical disabilities

impacting activities of daily living, the need for additional assistance in their current living situation, depression, decreased cognitive functioning and high hospital admission utilization.

Members have care plans that are accessible to the EA care coordinator (EACC) for review and collaboration at any time. EA Care Coordinators develop the plan of care in conjunction with the member/caregiver and primary care provider. Consultations with the health plan clinical directors provide further assistance in the care planning process. The plan of care (POC) is developed based on the results of a comprehensive, multiple domain, in-home assessment conducted by the care coordinator, the review of data retrieved by electronic medical record, member and/or family interviews and other relevant resources. The POC is documented in the secure clinical software system by the care coordinator, who makes changes to the plan of care, communicates with the member and forwards an updated POC to the electronic medical record and primary care physician (PCP).

The Interdisciplinary Care Team (ICT) includes the PCP, nurse practitioner, social worker and nursing. The EACC coordinates care and participates in the implementation of the POC. Ancillary services and specialty providers are all contributors to the team as required. EA's campus ICT model operates through a network of software communication tools, face to face consultation and team meetings. The venue is determined based on the location and needs of the member at any given time. The ICT is naturally integrated across each campus and meetings are generally ad hoc, in person, or electronic. Regular team meetings are conducted when members receive skilled care in an institutional setting. Members are the central core of the care team; they define their healthcare goals with the care coordinator and the team, centered on their desired focus of care: longevity, comfort, or function.

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: http://www.ericksonadvantage.com/2014/default.asp