Satellite Health Plan, H5765 Chronic or Disabling Condition Special Needs Plan (End-Stage Renal Disease Requiring Dialysis-Any Mode of Dialysis)

Model of Care Score: 100%

3-Year Approval January 1, 2014 – December 31, 2016

Target Population

Satellite Health Plan, Inc. (SHP) has created an evidence-based Chronic Condition Special Needs Plan to address the needs of members with End Stage Renal Disease (ESRD) living in Santa Clara County, California. Compared to national rates, California ESRD prevalence and incidence rates are much higher. There are substantial racial and ethnic differences in those who experience ESRD. According to the USRDS report, incident rates in the African American and Native American populations are 3.5 and 1.9 times greater, respectively, than the rate among whites and the rate in the Hispanic population is 1.5 times higher than that of non-Hispanics.

Provider Network

The network includes practitioners and organizational providers needed in each care setting and level of care, with an emphasis on nephrologists, home and in-center dialysis units, dialysis access care professionals and other providers of care related to the membership's common comorbidities including diabetes and cardiovascular disease. The SHP credentialing program utilizes a designated credentialing committee that includes contracted network practitioners who consult in the development and modification of SHP credentialing policies and procedures and in the selection and evaluation of network providers. The interdisciplinary care team (ICT) coordinates the delivery of specialized services by leveraging the role of the principal care nephrologist (PCN) and a SHP nurse care manager, and pharmacist led Medication Therapy Management (MTM).

Care Management and Coordination

SHP has developed a comprehensive health risk assessment (HRA) tool that it uses to evaluate the member's medical, psychosocial, functional and cognitive needs. The tool also captures medical and mental health history. The HRA tool includes assessments of general health, functional status, ESRD care, vulnerability and multiple condition-specific assessments. Within 30 days of notification that the member has enrolled, the care manager schedules the HRA followed by a Comprehensive Medication Review with the pharmacy MTM team. A member's change in health status or care setting may trigger the completion of a comprehensive interim HRA and an MTM Targeted Medication Review, while reassessment occurs annually. The

review, analysis and stratification of the member's healthcare needs are team efforts, with the care manager facilitating the processes.

The ICT develops the individualized care plans (ICP) during the first ICT meeting for the member's case. The member's ICP contains information on problems to be addressed, which may include, but are not limited to, medical, treatment support, areas of risk and uncontrolled chronic conditions. The care manager is responsible for monitoring and managing the member's care plan on an ongoing basis.

The ICT membership includes representation from SHP's health services department, the provider network and the member and caregiver. This allows the ICT to ensure it considers medical, nursing, social work, nutrition, pharmacy and member perspectives in the development and management of each member's care plan. SHP makes every effort to include the member in the ICT. During the initial face-to-face HRA, the care manager determines if the member has an identified caregiver or family member that he/she would like to have involved in the ICT meeting. If so, the care manager reaches out to that individual to educate him/her about the ICT. The ICT arranges operations and communications around the member's primary point of care, usually the dialysis center. The care manager visits the dialysis center on a regular basis and serves as the liaison among the ICT members, ensuring communication of critical information and coordination of services.

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.satellitehealthplan.com/