American Health, INC H5774
Chronic or Disabling Care (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 85%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

This plan targets diabetics on the island of Puerto Rico. It applies a chronic care model to this population. Members have a high incidence of diabetes and more than 25 percent are disabled and less than 65 years of age. Members in this plan have higher than average risk scores and 95 percent of the plan's diabetic population has more than one chronic condition, which increases the risk for complications. The model focuses on identifying, stratifying and designing interventions based on members' risk scores and care needs, and acting aggressively to provide interventions to keep members in the least restrictive care setting, preferably at home. Higher risk members receive different interventions including nurse case management. The plan also focuses on reducing the impact of diabetes through an educational program to help members better manage their diabetes.

Provider Network

The plan provides a network that consists of primary care providers (PCPs), specialists, particularly those that focus on diabetes care (e.g., endocrinologists, nephrologists, cardiologists), facilities such as hospitals, skilled nursing, rehabilitation, laboratories and imaging centers, as well as behavioral and mental health specialists.

The PCP is the gatekeeper and coordinates care and services. Members with diabetes and other chronic conditions are able to access specialists without a referral. For members in case management, the PCP and case manager communicate and coordinate services.

Providers are required to comply with health care quality standards, including quality measurement improvement projects (QMIP). Identified deficiencies are addressed through provider education or corrective action plans.

Care management and Coordination

All members are contacted by phone or in writing to conduct a preliminary health risk screening. Members who report a diagnosis of diabetes or other complex needs are referred to a case manager for a more detailed health risk assessment (HRA). The HRA includes an evaluation of the member's health status, clinical history, preventive health needs, health education needs as well as other chronic care and case management interventions. It includes assessing functional

status and activities of daily living and caregiver support, cognitive function and mental health status. The member's PCP will evaluate the member, including a physical examination, review of medications and case management needs. These assessments will be sent to the plan to help develop the member's individualized care plan (ICP).

The case manager (registered nurse) develops the ICP based on the results of the various assessments. The member, the member's family, PCP and all other relevant providers are encouraged to actively participate in the case management plan. The Plan utilizes a multidisciplinary approach, combining clinical, rehabilitative and support services to support members in their care plan objectives. The ICP includes HRA results, goals and objectives, specific services and benefits, outcome measures and preferences for care. Member self-management and education play a central role in the ICP, and are influenced by the member's short and long term goals for care. The ICP is monitored and coordinated by the case manager and PCP and is revised as the members' healthcare needs change.

The interdisciplinary care team (ICT) is comprised of the medical (physician) group Medical Director, who is the direct liaison with the PCP and specialists, the Plan's Medical Director, responsible for evaluating cases and making treatment recommendations, the case manager, responsible for identifying appropriate cases, and the Director of Pharmacy. Other specialists such as mental health case managers, social workers, gerontologists, health educators and nutritionists are part of the team, as determined by the member's needs.

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.ahmpr.com