H5826 Community Health Plan of Washington
Dual Eligible (Full Benefit Dual) Special Needs Plan

Model of Care Score: 88.33%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The Community Health Plan of Washington (CHPW) SNP provides service to dual-eligible Medicare and Medicaid members in Washington State. About 41 percent of members reside in King, Yakima and Spokane counties, with the remaining members residing in outlying Washington State counties. Members are older, disabled, with multiple co-morbidities, including cancer, congestive heart failure, stroke, obesity, dementia and diabetes. Some members require transplant services, skilled nursing (SN) and long term care (LTC) to maintain or survive, while others need hospice and end of life care. The top three conditions include diabetes, chronic obstructive pulmonary disease (COPD) and depressive disorders.

Almost half of members speak Spanish as their primary language, 40 percent of members speak English and four percent speak Chinese or Russian. About 62 percent of members are female, and the average age is 61 years. Most members have a high school education and about three percent of members are illiterate. Over 73 percent of members live independently, and more than one-third use the Community Options Program Entry System (COPES). COPES is a Washington State program that enables individuals who require nursing home level care to receive care in their current living environment. About 63 percent of members are White, 23 percent are Hispanic or Spanish and seven percent are Black or African American.

Provider Network

CHPW's network includes 2,000 primary care providers (PCP) who practice at nearly 425 clinic sites, 13,000 contracted (in-network) specialists and over 100 contracted Washington State Hospitals. To address the top three co-morbidities of this population, type II diabetes, benign hypertension and hyperlipidemia, CHPW contracts with providers such as endocrinologists, ophthalmologists, pulmonologists and oncologists. Members also have access to non-prescribing behavioral health practitioners, cardiologists, internal medicine providers, OB/GYNs, ophthalmologists, otolaryngologists, orthopedic providers and pulmonary disease providers. Most SNP members have desired access to a prescribing behavioral health practitioner and 70 percent have access to an endocrinologist.

CHPW supplies members with home health care, personal care services, self-directed care, adult day services, environmental modifications, personal emergency response systems and home delivered meals. CHPW is contracted with area agencies on aging who have expertise in the delivery of long-term supports and services (LTSS). CHPW has operational agreements with a variety of agencies, facilities and programs, including: private and community physical and behavioral health inpatient facilities (hospitals), hospital emergency departments, regional support networks, LTC facilities and inpatient and outpatient drug and alcohol treatment programs.

Care Management and Coordination

The health risk assessment (HRA) evaluates members' medical, behavioral, psychosocial, cognitive and functional needs to determine the level of frailty level and current health risk. An initial HRA is conducted within 90 days of enrollment and annually for all members. A new HRA may be conducted sooner based on changes in health status or health risk. HRA responses are scored and categorized in order to draft an individualized care plan (ICP) within the care management system. The care manager (CM), a licensed clinical professional, is responsible for providing care coordination and/or case management services to members. The CM also reviews the HRA and conducts further assessments with the member and this information is also saved in the care management system. The ICP is a continual processes, based on member specific needs, health conditions, family situations and the physician's plan of treatment.

Annually, upon completion of the HRA, the assigned CM works with the interdisciplinary care team (ICT) to review the findings and recommend updates to the ICP. Meetings occur weekly for review and discussion of ICPs, and the assigned CM is responsible for representing the input that has been provided by the member and PC. The ICT includes PCPs, geriatric specialists, clinical pharmacists, case managers and care coordinators, social workers and mental health care providers. Nutritionists, exercise physiologists and certified diabetes educators may also be included. ICTs analyze and incorporate the results of the initial and annual HRA into the ICP, collaborate to develop and update ICPs for each member and manage the medical, cognitive, psychosocial and functional needs of members.

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: http://www.chpw.org/