SCAN HEALTH PLAN OF ARIZONA (VillageHealth), H5943
Chronic or Disabling Condition (End Stage Renal Disease) Special Needs Plan

Model of Care Score: 96.25%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Scan Health Plan's 2014 Chronic Condition Special Needs Plan (C-SNP) for End Stage Renal Disease (ESRD) will serve members that are diagnosed with ESRD. These members may also be frail, disabled, low income and suffer from other complex conditions.

Provider Network

VillageHealth's provider network was selected to participate in this C-SNP due to their expertise and range of facilities that meet the anticipated needs of the ESRD population. The network includes services essential to the care of members with ESRD, such as nephrology, dialysis centers, home health and hospice. Contracted facilities include, hospitals, intermediate care centers, after-hours clinics, acute and long-term care, tertiary care (kidney transplant facilities), imaging, lab, rehabilitation, skilled nursing facilities (SNF) and specialty outpatient clinics. Specialty services are contracted or available when needed, on a case-by-case basis.

Care Management and Coordination

A VillageHealth nurse is assigned to each member at enrollment. Within 10 days of enrollment a set of minimum requirements are collected from the member which include, the number of hospitalizations, medications and allergies. Within 30 days of enrollment, a comprehensive in-person or telephone assessment is completed with the member. The nurse captures member goals and works with the member and/or caregiver to develop a member-centered care plan. VillageHealth utilizes an initial health risk assessment (IHRA) as a guide for the nurse to develop rapport and learn more about a member's history, needs and goals. Reassessing member needs is an on-going process and occurs with each member encounter as well as when there are changes in member health status. Members are reassessed at least once annually.

The VillageHealth nurse develops and manages the care plan, while other team members help with and contribute to the plan of care. VillageHealth requests and forwards consult notes, hospital discharge summaries and care management reports for inclusion in the member's chart or medical record. The care plan is then reviewed and revised, at least annually, by the VillageHealth nurse, who also documents this in the member's record.

The interdisciplinary care team (ICT) is composed of all providers who care for the member during a particular episode of care, such as a hospitalization, or provide ongoing care through a course of treatment. The VillageHealth nurse, nephrologist, primary physician and other members of the ICT, which include a social worker, dietitian, dialysis center nurse and clinical pharmacist as needed, meet in order to address the specific needs of the member. The composition of the ICT can change based

on transitions from one care setting or service to another, and also because of a change in the member's needs.

The ICT meetings incorporate the results of the initial and annual HRA, as well as ongoing assessments into the care plan. The team manages member care and unmet needs and continually updates the individual's care plan. The outcomes of each ICT meeting (decisions, referrals, and changes to care plan) are documented in the VillageHealth electronic care management system.

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: https://www.scanhealthplan.com/