Health Net Health Plan of Oregon H6815
Chronic or Disabling Condition
(Cardiovascular Disorders, Chronic Heart Failure, and Diabetes) Special Needs Plan

Model of Care Score: 93.13 percent
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The populations targeted for Health Net's Special Needs Plan (SNP) Model of Care are Medicare members with the disabling chronic diseases of diabetes, chronic heart failure and cardiovascular disorders residing in Clackamas, Multnomah, Washington, Marion, Polk, Benton, Lane, Linn and Yamhill counties. According to the 2011 Health Outcomes Survey (HOS), about 20 percent of Medicare adults reported they had Diabetes, 13 percent Coronary Artery Disease, 10 percent Myocardial Infarction, 8 percent Congestive Heart Failure, 56 percent Hypertension and 25 percent reported other heart conditions. Due to high risk factors in these members, Health Net's Chronic Care Improvement Program helps to monitor clinical trends, and design services and quality improvement interventions.

Provider Network

Health Net maintains a comprehensive network of Primary Care Providers (PCP), facilities, specialists and ancillary services to meet the needs of SNP members with chronic disease such as diabetes, cardiac, respiratory, musculoskeletal and neurological disease and behavioral health disorders. It contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, outpatient pharmacies, and hospices allow SNP members to obtain the services they need.

Care Management and Coordination

Health Net attempts to complete an initial health assessment (HRA) within 90 days of enrollment and an annual reassessment of each SNP member's medical and mental health history, psychosocial, functional and cognitive needs. The results are evaluated by the interdisciplinary care team (ICT) to develop or update the member's individualized care plan (ICP). The assessment is primarily conducted by telephone or mail when unable to reach the member and is available in English or Spanish. Case managers may revise the member's stratification during assessment or reassessment.

At minimum, interdisciplinary care team (ICT) members include a medical expert (e.g., PCP, specialist, or nurse case manager), social services expert (e.g., social worker, or community resource specialist) and behavioral and/or mental health specialist (e.g., psychiatrist, psychologist, or drug or alcohol therapist) when indicated. Other members may include pharmacists, restorative health specialists (e.g., physical/occupation therapist), nutrition specialists (e.g., dietician), disease management specialists, caregiver/family member, and also pastoral specialists. The member's PCP and the case manager assigned to the member are always included on the team, the medical director and specialists may be included when needed for specific disease management. The role of the ICT is to analyze and incorporate the results of the initial and annual HRA into the care plan, collaborate to develop and annually update an individualized care plan (ICP) for each SNP member, manage the medical, cognitive, psychosocial, and functional needs of the members, and communicate with team members and providers of care to coordinate the member care plan.

The case manager works collaboratively with the ICT, member/caregiver and the member's provider(s) to develop an individual documented ICP incorporating information from the HRA, member assessment and other sources. Each problem is documented with a problem statement in the medical management system and has at least one goal and one intervention. Higher priority goals address acute and immediate clinical, psychosocial and financial needs. Long-term goals delineate activities to sustain health improvements and optimal health status, or provide optimal support at the end of life.

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.healthnet.com/portal/shopping/content/iwc/shopping/medicare/introduction.action