Fallon Community Health Plan - NaviCare, H9001,
Dual-Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 96.88%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Fallon Community Health Plan (FCHP) – NaviCare is a dual-eligible SNP serving the following Massachusetts counties, Worcester, Hampden and parts of Franklin, Hampshire, Middlesex and Norfolk. Current and prospective members may live in the community or in a long-term care facility. FCHP membership in this service area have been diagnosed with the following conditions, 32.1% are diagnosed with diabetes, 24.81% are diagnosed with COPD, 22.2% are diagnosed with congestive heart failure, 37.16% are diagnosed with depression and 15.53% are diagnosed with dementia.

Provider Network

NaviCare's network includes inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, radiology/imaging, medical specialists, behavioral and mental health specialists and others including ancillary providers such as pharmacists, therapists, skilled home health care agencies and durable equipment suppliers. The primary care team (PCT) connects the member to the appropriate service provider when determining which services the member will receive and is led by the primary care physician (PCP). FCHP's credentialing committee determines whether network facilities and providers are actively licensed and competent.

Care Management and Coordination

NaviCare's health risk assessment (HRA) tool includes sections on medical, psychosocial, functional, cognitive, medical and mental health history and is completed for each new member within 30 days of enrollment and then annually thereafter. Each member has a PCT who review, analyze and stratify the member's health needs using the findings of the HRA. The PCT often meet in-person at the PCP's office and save their meeting summaries to a secure electronic centralized enrollee record (CER).

The PCT, led by the PCP and supported by a patient navigator, is responsible for developing an individualized care plan (ICP) for each enrollee. The navigator serves as an advocate for the patient, acts as a care coordinator and assists the PCT with completing and/or documenting tasks in the CER. The member is a part of the PCT and has a voice in the initial development of the ICP and can suggest modifications to the ICP. The ICP includes treatment goals (medical, functional, and social – both long and short term) and measures progress and success in meeting those goals. The results of the HRA, goals/objectives, specific services and benefits and outcome measures are included in the ICP, which is specifically written in 'member-friendly' language. The PCT updates the ICP at least once every six months or, for members who are in a long term

care dwelling, at least quarterly. The navigator documents updates to the ICP in the CER, and also uses the CER system to send 'tasks' to the PCT members, who have access to the CER and are notified of revisions in this way.

The composition of the PCT for all community dwelling members includes the PCP, the member, a registered nurse case manager, the navigator, the geriatric support services coordinator and an assisted living facility liaison. Members in a long term care dwelling replace the latter two with a long term care dwelling liaison. In both instances, the PCT may also include a nurse practitioner, physician's assistant or other professionals. The navigator is responsible for scheduling the meetings, notifying all members of the PCT about the meetings, ensuring established protocols are followed, documenting PCT and care planning activity and incorporating in the results of the PCT into the member's CER. The PCT communicates in-person, over conference call, or through electronic dissemination by the navigator. PCT meetings occur every 90 days for community-dwelling members and long-term care dwelling members, or more frequently based on the member's clinical status and need.

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: www.navicare.org