SCAN HEALTH PLAN OF ARIZONA, H9385, H5425
Chronic or Disabling Condition (Cardiovascular Disorders and Chronic Heart Failure)
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 Special Needs Plan (SNP) will serve members that have a confirmed diagnosis of Chronic Heart Failure (CHF) or other cardiovascular disorders (e.g., Cardiac Arrhythmias, Coronary Heart Disease, Peripheral Vascular Disease, and Chronic Venous Thromboembolic Disorders).

Provider Network

Contracted provider organizations (POs) are specifically selected to participate in this C-SNP based on their special expertise and wide range of facilities that meet the anticipated needs of the C-SNP-CHF and Cardiovascular Disorder population. The network is composed of services essential to the care of members with CHF and Cardiovascular Disorders such as cardiology, home health, hospice or palliative care, and outpatient rehabilitation. Contracted facilities include: hospitals, intermediate care centers, after-hours clinics, acute and long-term care, tertiary care, imaging, lab, rehab, skilled nursing facilities (SNF) and specialty outpatient clinics. Specialty services are contracted or available on a case-by-case basis.

Care Management and Coordination

Each month, SCAN uses an enrollment report to identify all new C-SNP members in the plan. Care coordination management distributes the work list to care navigators, who contact members via telephone for their initial health risk assessment (HRA). The care coordination managers also monitor the reports to ensure that the initial assessment is completed within 90 days of the member's effective date. If care navigators have three (3) unsuccessful attempts reaching the member for the HRA, a reminder postcard is mailed, asking the member to call SCAN's care coordination management team.

The case manager reviews and revises the care plan at least annually and more often based on risk stratification results, member call-in, or referral from the member's primary care physician (PCP) or internal SCAN departments. For those in case management, care plans are reviewed during the interdisciplinary care team (ICT) meetings, which range from weekly to quarterly, or when a member's health status changes. Revisions are made at any time, in collaboration with the

PCP, member and caregiver and any other treating personnel. For members who are not in case management, care plans are reviewed at least annually and completed in conjunction with the annual HRA.

The ICT is composed of highly-skilled clinical staff at both the health plan and the PO level caring for the member. Member cases are established prior to the meeting and the PO representatives (physician and case manager) are notified. The meeting is facilitated by the case management manager and the outcomes, such as decisions and referral requests, are documented in the member's case notes and maintained in the case management system. This includes updated care plans completed with the member and care manager which are subsequently sent to the member and physician.

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/