H9915 MedStar Family Choice Inc.
Chronic or Disabling Condition (Chronic Heart Failure and/or Diabetes)
Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

MedStar Family Choice Chronic Condition SNP (MedStar C-SNP) intends to offer a C-SNP for individuals who are diagnosed with diabetes or chronic heart failure (CHF). MedStar's service area will be Washington, DC and specific counties in Maryland. In addition to the diabetes and CHF diagnoses, MedStar C-SNP expects members will have co-existing chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), depression and serious mental illness. Members may also experience psycho-social issues including poverty, homelessness, family dysfunction, addiction and lack of resources.

Provider Network

Participating network providers include: acute care hospitals and medical centers offering in-patient care services; hospital-based emergency departments and urgent care centers; skilled nursing facilities (SNF); rehabilitation centers and rehabilitation or restorative therapy specialists; long term care centers; home care agencies offering home health services (clinical assessments and treatment, wound management, home safety assessments, and home-based end-of-life care); durable medical equipment (DME) providers; pharmacies and clinical pharmacists; outpatient centers including dialysis facilities; radiology and diagnostic facilities. The network also includes ancillary providers, primary care practitioners (PCP), mid-level practitioners; behavioral health specialists and medical specialists pertinent to targeted chronic conditions including oral health. Telemonitoring and telemedicine services will be offered for unique patient populations through a few of the larger hospitals within the network.

More specifically, the MedStar C-SNP network includes internists, family practitioners and geriatricians. The contracted specialists will also include sub-specialists. Contracted specialists include: allergists, cardiologists (general and interventionists), chiropractors, emergency medicine physicians, endocrinologists, dermatologists, gastroenterologists, gynecologists, hospitalists, pulmonologists, obstetricians, oncologists, ophthalmologists, orthopedists, nephrologists, neurologists, neurosurgeons, general surgeons, thoracic surgeons, transplant specialists and urologists.

Care Management and Coordination

MedStar C-SNP uses an internally developed health risk assessment (HRA) tool to collect information on members' use of services, access barriers, caregiver supports, assistance with daily activities, medical and behavioral health conditions and lifestyle risk factors. The responses are used to develop each member's individualized care plan (ICP) and are designed to mitigate health risks. The HRA will be sent to members annually, and results from re-assessments are compared to the initial and subsequent re-assessments to identify changes in the member's health status.

The HRA results will be reviewed, analyzed, and stratified by care managers and lifestyle health coaches. For new members this may be the only data available to begin the ICP. The responses to the annual HRA will be used in the monthly health management program stratification process. The development of the individual plan of care begins with the PCP, member input, in collaboration with applicable caregivers, other providers and the care manager (CM) as appropriate. The CM holds primary responsibility for coordinating a member's ICP, communicating with the member, caregivers, PCP, providers who treat the member and the interdisciplinary care team (ICT). The PCP and the CM, work with the member in establishing patient centered goals based on identified issues.

The assigned CM, under the guidance of the PCP will involve any member of the ICT as needed. ICT staff include but are not limited to nurses with specialized training, social workers, transition coordinators, pharmacists, lifestyle health coaches, medical director, specialists, home care and other ancillary providers. The ICT facilitates communication and coordinates services between PCPs, specialists, behavioral health providers, ancillary services, home care agencies, hospitals, SNFs and community services. Weekly ICT meetings promote the interdisciplinary communication process review members' needs, make sure they have timely access to care, help improve health outcomes and appropriate utilization of services and settings.

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://medstarmedicarechoice.org.