R3444 Care Improvement Plus South Central Insurance Co.
Chronic or Disabling Condition (Chronic Heart Failure and/or Diabetes)
Special Needs Plan

Model of Care Score: 75.00%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

The Care Improvement Plus South Central Insurance Co. (UnitedHealthcare) Chronic Special Needs Plan (C-SNP) targets members with chronic heart failure (CHF) and/or diabetes mellitus (DM) who live in one of its service areas.

Based on data from UnitedHealthcare's total C-SNP population, the average age of the population is 67 years old. Within this population, 49.9 percent are disabled, 41.7 percent live in rural counties, 45.3 percent are African American or Hispanic and 57.7 percent receive a low income subsidy.

C-SNP members often experience high utilization of services rates due to multiple chronic conditions. The four most prevalent disease states within the population are DM (91 percent), cardiovascular disease (62 percent), CHF (52 percent) and chronic obstructive pulmonary disease (COPD) (51 percent). Members must also deal with the challenges of having multiple comorbid conditions and the top three within this population are: DM with COPD (46 percent), CHF with COPD (45 percent) and CHF with COPD (34 percent).

Provider Network

Care Improvement Plus maintains a network of inpatient and outpatient providers designed to provide access to all services that members may need. It consists of primary care physicians (PCP) and specialty providers including but not limited to cardiologists, endocrinologists and pulmonologists. Care Improvement Plus uses an open access model, which enables members to self-refer to contracted providers, which can encompass any participating provider who is willing to bill it. While not part of the provider network, members and providers also have access to pharmacists trained to provide counseling and education through the Care Improvement Plus' Pharmacy Management Program.

Through a partnership with Optum Behavioral Health, UnitedHealthcare offers its members access to inpatient and outpatient mental health services and counseling. The behavioral health network includes psychiatrists, clinical psychologists, clinical social workers, addiction specialists and mental health field workers who work with members in the home setting.

Care Coordination and Management

Within 90 days of enrollment, a HouseCalls practitioner, which can be a network physician or nurse practitioner, administers a face-to-face comprehensive health risk assessment (HRA) to each member in the home and then uploads the responses into the electronic medical record. If the member refuses the HouseCalls visit, he or she completes it telephonically. The HRA assesses the member's medical, functional, psychosocial, cognitive and mental status. A reassessment occurs annually to evaluate the member's progress towards his or her goals. If there is a change in the member's health condition, the reassessment occurs sooner.

The Nurse Case Manager (NCM) uses all available information from the HRA, disease-specific assessments, administrative claims and pharmacy data drive to create an individualized care plan (ICP). The interdisciplinary care team (ICT) reviews and updates the ICP annually, monthly or more frequently based on the member's risk stratification, care coordination and transition needs. After an update, the NCM mails or faxes the ICP to the member and the PCP.

Core members of the ICT include the member, the PCP, the NCM and a clinical pharmacist. Based on the member's needs, the ICT may expand to include: the member's caregiver, a social worker, a behavioral health professional, physician specialists, ancillary health and community-based professionals. In addition, other ICT participants may include: nutritionists, home health professionals, rehabilitation specialists, pain management specialists, palliative care and hospice professionals, transitions care managers, respiratory therapists and utilization management nurses.

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: www.careimprovementplus.com.