Humana, H1036
Institutional (Facility) and Institutional Equivalent (Living in the Community)
Special Needs Plan

Model of Care Score: 85.63%
3-Year Approval **January 1, 2013 – January 1, 2016**

Target Population

Humana's specific target population is the institutional population, which includes both individuals residing in a long term care facility under contract with the organization as well as individuals who are institutional equivalents residing in the community. The targeted SNP populations includes members characterized as frail, i.e., are unable to perform activities of daily living and instrumental activities of daily living without assistance and are at risk for institutional placement or are already institutionalized. These members may have complex medical needs and increased psychosocial needs that impact compliance with care plans and health outcomes.

Provider Network

Humana has a selected network of primary care physicians (PCPs) and a network of specialists, acute facilities, sub-acute facilities and home health care providers to address the needs of institutionalized and institutional equivalent members such as hospitalists, geriatric specialists, nurse practitioners and community based/home visit physicians. When and if the interdisciplinary care team (ICT) determines that the member should receive services from the provider network, the clinical care managers (CCM) will reach out, assist and collaborate with the provider network.

Care Management and Coordination

The health risk assessment (HRA) tool not only provides an evaluation of the members' eligibility for institutional services, but also provides a comprehensive evaluation of member risk related to memory, general health, sensory and communication impairment, health conditions and therapies, social resources, mental health, nutrition, residential living environment, medications, substance abuse and caregiver resources. Humana conducts assessments within 90 days of member enrollment and reassessment occurs annually thereafter, however care management allows for monthly evaluation to identify changes in health or level of care. The CCM has the ability to make adjustments to the member's risk-group level based on additional inputs from the member, caregiver or family and collaboration with the PCP. Humana translates the results of the HRA tool data into multiple formats to facilitate communication across many audiences.

The CCM in collaboration with the member, caregiver and/or family initiates the individualized care plan (ICP) and works with the ICT to develop an ongoing care plan. Each member's ICP identifies overall goals that reflect their unique needs, are realistic and measurable, include a

time frame for achievement as appropriate, identifies services and care to meet members' care goals and connects the member/caregiver with add-on benefits and services. The CCM conducts both the initial and ongoing (at a minimum monthly) face-to-face or telephone visits with the member to evaluate any changes in the member's condition or health status and reviews and revises the care plan as necessary. The CCM makes updated care plans available to the PCP and other providers in an electronic format through the care management application.

The ICT is generally composed of CCMs, PCP(s) (or usual practitioner), specialists, home care representatives, social services, behavioral health care providers, pharmacists, caregivers and most importantly the member. The CCM drives the composition of the ICT. The membership of the ICT is based on the unique special needs of the member and or requests for additional specialists by the ICT. The Member is integrated in the ICT via verbal updates and ongoing planning with the case manager and face-to-face visits with the usual practitioner and/or specialists during office visits. As necessary, the CCM facilitates all of the ICT operations and communications and is the single point of contact for the ICT, responsible for all communication to all the members of the ICT including updating any changes in member health status via the care plan. The Care Coordinator assists in this process as needed.

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.humana.com/SNP