Total Health Care, INC. H1444
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 95.00%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

In Michigan, there are over 220,000 dual eligible individuals representing individuals who possess some of the most complex health care needs. Over 1% are in hospice care, more than 3% are participating in habilitation support waiver programs, approximately 4% are in the MI Choice Program, 15% are in nursing homes and 77% are served by standard fee for service programs in Medicare and Medicaid. A large percentage of Michigan's over age 65 population are female. Total Health Care (THC) has an ethnically diverse population, 19.44% Caucasian, 46.84% African American, and approximately 1.23% Hispanic, 0.01% Asian or Pacific Islander and 0.04% American Indian or Alaskan native. The top chronic conditions include: ischemic heart disease, diabetes, depression, chronic heart failure, arthritis, behavioral health, Alzheimer's-related disease, COPD and chronic kidney disease. Many of the dual eligible have multiple chronic conditions with 10% of enrollees with 4 chronic conditions, 8% with 5 chronic conditions and 14% with 6 chronic conditions.

Provider Network

THC maintains a comprehensive network of practitioners and providers to care for all SNP members, whether it is for medical (internal medicine, family practice and nurse practitioners), behavioral health (psychiatrists and inpatient facilities), specialty (cardiology, nephrology, geriatrics and pulmonology), home and community care and acute hospitalizations, skilled nursing facilities, radiology, DME vendors and home care agencies to name a few. THC also looks to the availability and types of community agencies that may be of assistance to the member such as Meals on Wheels, Catholic Charities, senior centers and faith based programs.

Care Management and Coordination

The health risk assessment (HRA) evaluates members' medical, behavioral, psychosocial, cognitive and functional needs. The HRA is designed to determine the frailty level of the member and level of current health risk. The HRA is conducted within 90 days of enrollment into the SNP dual-eligible plan. HRAs are distributed via mail to members. THC attempts to execute the annual HRA for all members within twelve months of the initial HRA completion date. A new HRA may be conducted earlier than the annual reassessment period should clinical information from claims, pharmacy or other data used to monitor member health status identify member health risks that would lead to re-stratification.

The individualized plan of care (POC) is developed with the input of the entire interdisciplinary care team (ICT). THC has integrated internal and external resources to create an ICT to manage and oversee the members care. Care plan updates that occur as a result of the ICT review will be

sent to the member and the member is encouraged to provide feedback again at that time. After initial POC development, the care coordinator is the lead for the member's POC review with the ICT, gaining input from all involved professionals, updating the plan based on that input and communicating the plan to all involved parties. The POC includes evaluating the member's health condition (using an HRA), assessing the family situation, and incorporating the physician's plan of treatment and is developed using evidence based clinical practice guidelines. The POC involves a continual process of assessing needs, planning, implementing, coordinating, monitoring, and evaluating outcomes.

The core internal interdisciplinary care team (ICT) includes a care coordinator (LPN) or case manager (LCSW/RN), consulting physicians (medical and behavioral), the program manager/supervisor (RN) and a behavioral health ICT member (Psychologist, LSW or LCSW) if not already represented by others in the ICT with a behavioral health specialty. The External ICT includes the member's primary care physician (PCP) and any specialists actively involved in the care of the member. The member is central to the team and they are encouraged to be involved in the process of their own care planning. Input from other ancillary healthcare providers, such as pharmacists, dieticians, or nurse educators, is obtained when the clinical need for such disciplines is identified.

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.TotalMedicarePlus.com