H1961 Peoples Health, Inc.
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Peoples Health Inc. (PH) provides specialized care for members that have Medicare and are also entitled to medical assistance under any of the Medicaid categories. PH currently serves 4 regions in Louisiana, which include Greater New Orleans, the Capital Area, South Central Louisiana, and the Northshore Area.

Forty percent of members are between 65-75 years old, approximately 52 percent of members are African-American, 44 percent are White and 66 percent are female. Nearly four percent of members are institutionalized. Current members have an average number of 2 co-morbidities and over a third of members experience back problems and/or diabetes without complication. The top diseases are hypertension, diabetes, chronic obstructive pulmonary disease, and congestive heart failure.

This population tends to have limitations and barriers that pose potential challenges for members; examples include: poor health literacy, lack of access to transportation for their non-medical needs, prevalence of mental health disorders affecting their ability and desire to manage their health, lack of funds to afford basic care not covered by the plan, social isolation, lack of caregivers and high "unable to reach" rates due to disconnected phones.

Provider Network

The plan contracts with primary care physicians (PCP) and specialists with expertise in chronic and co-morbid conditions. Specialists include rehabilitation/restorative specialists, mental health and substance abuse specialists, wound care and oral health specialists. The contracted providers with the most highly utilized disciplines are internal medicine (including geriatric specialists), allergists/immunologist, cardiologists, endocrinologists, nephrologists, oncologist, ophthalmologists, pulmonologists and urologists. PH contracts home health providers and outpatient surgical centers as well as acute, urgent and long-term care facilities.

Care Coordination and Management

The health risk assessment tool (HRAT) addresses the medical, psychosocial, cognitive and functional needs of the member. Care coordinators (CC) contact the member by phone to complete the HRAT within the first 90 days of enrollment into the plan, and at least annually thereafter as part of the individualized care plan (ICP) update. The assessment is also completed whenever the member has a health status change. HRAT and HRA results identify areas that

need to be addressed, such as health risks, medical conditions, medication issues, needed testing and preventative screenings; they also determine whether referrals to a care management program are needed.

Within 30 days of its completion, the CC disseminates the HRAT/HRA results to the interdisciplinary care team (ICT) to initiate the ICP development. The ICP contains a listing of member-specific medical and health related problems, personal healthcare preferences, short and long term goals and interventions needed to meet the goals. The CC reviews the ICP with the member/and or caregiver face-to-face or by phone and then may update the ICP based on the member's or caregiver's feedback and healthcare preferences. Together, the CC and the member create a timeframe for reevaluation of their goals if necessary; otherwise, the CC will reevaluate the ICP annually. The ICP is available to the ICT through the PH's care management documentation and authorization system and the plan's secured, web-based, comprehensive portal, where the ICT is stored.

Members/contributors to the ICT include the CC, PCP, member and member's caregiver; they may also include case managers, nurses, social workers, pharmacists, nutritionists, preventative health specialists, chronic care specialists, mental health experts and the medical director. The CC communicates both the ICT's decisions and revisions of the ICP to the member and their caregiver through face-to-face consultation or by phone.

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.peopleshealth.com.