H2224 Senior Whole Health, LLC.
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 85.00 %

3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Senior Whole Health (SWH) serves dual eligible members age 65 years and older in Massachusetts. Members in SWH are poor, aged, frail, disabled, and chronically ill or near end of life, and are culturally and linguistically diverse. Social, cognitive and environmental factors also play a role in the health status and health outcomes of the member population. The average composition of a SWH member is that of females who are 76 year old with two to three chronic conditions, on at least seven medications and with low literacy (13 percent). As a result of economic and social burdens of this population, member's functional status declines and any associated physical and mental changes of age are often accelerated.

Provider Network

The SWH Provider Network is comprised of a combination of clinical professionals with expertise in dealing with older populations as well as facilities (in addition to hospitals) that care for this high risk population. Practitioner Network specialties include, but are not limited to: internal medicine (IM) and family medicine (FM), primary care physicians (PCP), geriatric specialist such as nurse practitioners, geriatricians (IM and FM), and cardiologists and other IM specialists, allied and ancillary providers, and behavioral health. In addition to the professional practitioners there are a number of specialized facilities including: hospital inpatient and outpatient units, skilled nursing facilities and long term care facilities, senior day care/adult day health facilities.

Care Management and Coordination

The health risk assessment tool (HRAT) collects data related to medical needs, functional status, cognitive status, psychosocial status and the mental health needs of the members and is carried out for each member prior to or upon enrollment. Ongoing re-assessments are conducted at least every six months, annually and more frequently depending on changes in the condition of the member. Standard assessments are conducted for all members, with more detailed assessments undertaken depending upon the complexity of individual's care requirements. Results of the HRAT are then stratified into two categories and discussed with the interdisciplinary care team (ICT).

The ICT is person-centered, built on the member's specific preferences and needs, delivers services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. The ICT is compromised of the member/caregiver, PCP, nurse case manager, member support coordinators (MSC), geriatric support services coordinators (GSSC) and pharmacists. The member's participation is facilitated by the ICT through home visits, face-

to-face meetings, or telephonic communication in the members preferred language. The care planning process integrates the member's goals with the recommendations and insights of all necessary practitioners.

The individualized care plan (ICP) integrates the member's goals, values, and preferences with the recommendations and insights of all relevant practitioners and community service providers. The member's participation is facilitated by the ICT members through home visits, face-to-face meetings, telephonic or alternative formats in the members preferred language when possible. ICP uses the information from the SWH health risk assessment and other tools, member goals, medical, behavioral health and social service needs of the individual. Assessments of the member's health status, activities of daily living, instrumental activities of daily living, mental/emotional functioning, safety/environmental status, home situation, and formal and informal support systems all contribute to SWH's understanding of the member and the elements needed for a complete care plan. The ICP is implemented by the ICT which integrates medical, behavioral health, community long term and social supports and other support services toward meeting the needs of each member.

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.seniorwholehealth.com