H2419 South Country Health Alliance
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 90.00 %

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

Target Population

South Country Health Alliance is a county-based health plan providing services in twelve rural Minnesota counties. SeniorCare Complete is the Dual Eligible special needs plan (SNP) as a part of South Country Health Alliance. The average age of members enrolled in SeniorCare Complete is 85 years old (45 percent) and the majority are females (74 percent) who outnumber the males (26 percent). Approximately 75% of the population is nursing home certifiable and has limitations in their activities of daily living (ADLs) such as bathing, grooming, dressing and toileting. Ninety-seven percent of members are Caucasian, with 99 percent of members speaking English. Members who are enrolled in SeniorCare Complete have mental health disorders, pulmonary disease, diabetes, cardiovascular disease, and Alzheimer's disease so many need in-home care providers either for personal care or home management plus a range of medical and community services.

Provider Network

South Country's provider network includes over 85 community and referral/tertiary hospitals, 7,800 licensed physicians of which 1,550 are primary care physicians (PCP), 47 skilled nursing facilities, 115+ home health care locations, 100 durable and specialty equipment providers, 450+ mental health and chemical dependency providers and facilities, state-wide pharmacy network, dental network with over 1,500 practice locations. While the South Country provider network was created to meet the complete spectrum of medical and social needs of our members, it also includes subsets of specialized providers who are focused on the unique needs of our elderly and disabled populations.

Care Management and Coordination

The health risk assessment tool (HRAT) used by South Country is called the Long-Term Care Consultation (LTCC) developed by the state of Minnesota. South Country will be transitioning throughout 2015 to a new state tool called MNChoices which is web-based. South Country also utilizes a shortened HRA in addition to the state's tools. The HRAT includes the member's health status including diagnosis and condition specific issues, hearing, visual and communication needs, preferences or limitations, supports and services based on the member's strengths, needs, choices and references in life domain areas, cultural and linguistic needs, preferences, or limitations, caregiver resources and involvement, documentation of clinical history and medications, ADLs and instrumental ADLs (IADLs), mental health/ cognitive functioning, nutritional health, self-preservation and safety and life planning activities. The assessments are completed within 30 days of enrollment and annually, thereafter. Re-assessments may be performed in between when a member has a change in health status.

The Interdisciplinary Care Team (ICT) membership is based upon identification of the member's needs through the ICP and through member's preferences. However, the core members of the ICT are the care coordinator, member's primary care provider (PCP), South Country health services department team, community care connector, member's responsible party (if applicable), residential providers, and case manager. Care coordinators develop and lead the ICT at the county or agency level to ensure that members have access to both a registered nurse and a social worker. The participation of the member is encouraged and meetings are held quarterly by phone or face-to-face.

South Country's Comprehensive Individualized Care Plan (ICP) includes the following elements: identification of health and safety concerns and the development of long and short term goals along with barriers for achieving the goals; follow-up and ongoing communication with the member; member's personal goals and any community relationships and support; discussing with the member alternative actions when goals are not met; specifically tailored services and prevention and early intervention services; accommodate the specific cultural and linguistic needs of the member; member plans including emergency preparedness plan, community-wide disaster plan, essential services back-up plan, self-management plan, and personal risk management plan; and advance directive planning assistance. The ICP is developed within 30 days of the HRAT and reviewed and updated quarterly by phone or face-to-face meetings or when there is a change in health status. The ICP is shared with the ICT.

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.mnscha.org