HealthKeepers, INC (AmeriGroup) H3447, H8991
Institutional (Facility and Institutional Equivalent) Special Needs Plan

Model of Care Score: 87.50%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The plan targets patients that live in the community (i.e., assisted living, board and care, or group home setting) with an institutional level of care as well as those living in contracted or qualified institutional facilities. Those patients living in the community tend to have an increasing need for full-time assistance and monitoring for things such as medication management, safety and fall prevention and other activities of daily living. For this population, the plan includes delivery of many primary care services within their care setting. For those patients living in nursing homes, who typically have conditions such as Alzheimer's or other forms of Dementia, clinical depression and multiple co-morbidities resulting in frailty and decreased function, the plan works with the nursing homes to assist in the model of care delivery. It includes weekly nurse practitioner (NP) visits and additional benefits and services designed to address their needs.

Provider Network

The plan contracts with a network of providers including primary care physicians (PCPs) and specialists in all specialty fields. They also employ clinicians with specialized expertise with institutionalized populations, particularly nurse practitioners (NPs), who work directly with members, their family, their facility and coordinate with other providers to deliver all needed services; and are specially trained to manage chronic conditions such as Dementia, Diabetes, Cardiovascular disease, COPD and treatment of complex wounds. The majority of patient care is provided at the member's homes or facility, including medical and clinical services, preventive and health education and wellness services. NPs visit members at least weekly. The plan uses hospitalists/extensivists (Geriatric specialists and Board Certified in Internal Medicine) to treat and coordinate care transitions for members that are hospitalized. The plan has a behavioral health program that uses a multidisciplinary team of employed and contracted psychiatrists, clinical psychologists and NPs to provide services in facilities and outpatient settings. The plan also employs pharmacists and social workers to help manage the pharmacy and care management programs.

Healthkeepers, INC contracts with other allied health professionals such as physical, occupational and speech therapists and dieticians. They contract with facilities including acute care hospitals, skilled nursing facilities, home health care agencies, hospice, dialysis facilities, laboratory and radiology. All members have a PCP who monitors and manages their care. The NP acts as a gate keeper for members.

Care Management and Care Coordination

Each member is assessed, usually within 30 days of enrollment, to determine their level of need and appropriate interventions. All institutionalized members are automatically considered frail, and followed closely for monitoring, coordination and intervention. The plan uses a standardized health risk assessment (HRA) to conduct the assessments, which include screens for chronic conditions, medical, functional, cognitive and psychosocial needs. Assessments are done in person by a NP in the members' place of care.

After the HRA is complete, the member and their NP review the results and develop an individualized care plan (ICP). The ICP addresses member-specific barriers, preferences and limitations, care giver resources available, clinical goals and other specific needs of the member. The ICP is revised and updated based on the assessment of the NP with each visit. The NP uses the assessment and ICP information to determine the composition of the interdisciplinary care team (ICT) and involves them as needed. The ICT consists of NPs, PCPs, care managers, hospitalists and other specialists as needed (e.g., behavioral health, podiatry, social worker). The ICT meets monthly to monitor the status of the member ICPs and address instances where members are not progressing toward their care goals. When possible, the ICT meets in person with the member at the member's home care setting, to review the ICP and assess the member's needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.wellpoint.com/.