H4922 AgeWell New York LLC.
Institutional (Facility) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

AgeWell New York's (AgeWell) Institutional SNP (I-SNP) target population requires institutional skilled nursing facility (SNF), nursing facility (NF), SNF/NF, intermediate care facility for the mentally retarded (ICF/MR) or inpatient psychiatric facility level-of-care, and needs an institutional level-of-care for 90 days or longer. Members have Medicare Part A and B and reside in AgeWell's geographic service area of Nassau, Queens, Brooklyn, Suffolk, Bronx, Manhattan and Westchester. AgeWell covers primary, specialty and acute medical services and Medicaid-covered long term care services. Thirty-nine percent of members are between 75 and 85 years and 24 percent are older than 85 years. The top diagnoses are hypertension (77 percent), osteoarthritis (55 percent), lipid metabolism disorder (46 percent) and diabetes (40 percent). Thirty-five percent of members are White, 20 percent are Black, 20 percent are Asian or Indian and 15 percent are Hispanic. English is the primary language spoken by 30 percent of members, 25 percent speak Russian, 20 percent speak Chinese and Korean and 15 percent speak Spanish. The majority of members have expressed difficulty walking (94 percent).

Provider Network

The AgeWell provider network includes inpatient, outpatient, rehabilitative, dialysis, long-term care, psychiatric, laboratory and radiology/imaging. Medical specialists include but are not limited to primary care, internists, cardiology, nephrology, psychiatry, geriatric specialists, oncologists, pulmonologists, neurology, gynecology, immunologists, dermatologists and gastroenterologists. Network behavioral and mental health specialists include psychiatrists, drug counselors and clinical psychologists. Nursing professionals include registered nurses (RN), nurse practitioners (NP), nurse managers and nurse educators. Allied health professionals include pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists and radiology specialists. The network also provides members with 24 hour access to a nurse care manager.

Care Management and Coordination

Each member is assigned an interdisciplinary care team (ICT) led by an AgeWell New York NP. In addition, the NP collaborates with the in-house plan care manager (CM) to assist in the dissemination of information to ICT members. A health risk assessment (HRA) is completed by

a RN within 30 days, but not to exceed 90 days after the member's enrollment and a semi-annual reassessment is performed. The individualized care plan (ICP) is developed by the CM and is based on the member's HRA. The CM also uses other quarterly and annual assessments, provided by the nursing home, to aid in the care planning process. Members are assigned a risk level, which is based on functional deficits, level of independence with activities of daily living (ADLs), disease process and complexity, fall risk, risk for new falls and history of falls, medication management and medication regimen, cognitive function, mental health and psychosocial needs, environmental needs and living arrangements, support systems, transportation needs and lack of primary care physician (PCP) or need for a specialist.

The ICP is composed of several key elements that allow the CM to focus goals and interventions on the member's identified problems. The ICP is developed in collaboration with the member and is meant to be a "living" document in that it is updated and revised according to the changing needs of the member. AgeWell New York's ICP includes, but is not limited to: the member's self-management goals and objectives; personal health care preferences; a description of services specifically tailored to the member's needs and whether the goals have been met. The CM, with the involvement of the NP assigned to the nursing home, works with the member's PCP as well as auxiliary care providers to identify and prioritize problems, implement interventions and deliver services and a comprehensive treatment plan.

Members of the ICT are determined by analysis of the member's initial HRA and subsequent assessments. In addition to the member and family/caregivers, the ICT includes the medical director, PCP, specialist(s) as warranted, CM, NP, home and community-based service providers. Additional members can include health educators, health coaches, pharmacists, behavioral health specialists and social workers. The primary purpose of the ICT is to coordinate the delivery of services and benefits that address the member's specific needs in a cost-effective manner. The ICT also communicates with the member, additional providers and caregivers.

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.agewellnewyork.com