# Group Health Incorporated (Emblem Health), H5528
# Dual Eligible (Dual-Eligible Subset)
# Special Needs Plan

**Model of Care Score: 96.88%**
**3-Year Approval** **January 1, 2013 – December 31, 2015**

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## Target Population

The target population for EmblemHealth Dual Eligible (PPO SNP)are individuals who are eligible for Medicare Part A and Part B, and are eligible for Medicaid through the New York State Department of Health. EmblemHealth is the parent company for the HIP Health Plan of New York (HIP) and Group Health Incorporated (GHI). The EmblemHealth Dual Eligible (PPO SNP) service area is the five boroughs of New York City, Nassau, Suffok, Westchester and Rockland counties. The membership contains significantly more woman than men and the age of the members enrolled in the SNP plans for GHI mostly span from 65 to 79 years old.

## Provider Network

The GHI provider network offers a comprehensive medical and ancillary delivery system across the New York tri-state area. Specifically, EmblemHealth contracts with medical specialists (cardiology, nephrology, psychiatry, geriatric specialists, pulmonologists, immunologists); behavioral and mental health specialists (drug counselors, clinical psychologists, social workers) and nursing professionals (nurse anesthetists, nurse practitioners). GHI also contracts with allied health professionals (physical therapists, occupational specialists, speech pathologists, radiology specialists) and facilities pertinent to the care of special needs members (e.g., inpatient, outpatient, rehabilitative, long-term care, psychiatric, laboratory, radiology/imaging).

## Care Management and Coordination

Health risk surveys (HRS) are used to identify a member's baseline health status and to proactively identify members "at risk" for gaps in care. The surveys are mailed or conducted by phone. Re-enrolled SNP members receive an HRS annually. Frontline case and disease management staff, who are nurses, licensed social workers, mental health professionals and registered dieticians, review, analyze and stratify the health care needs identified in the HRS results. All team members utilize this information to determine where the member should be referred for further outreach and evaluation based upon individual needs.

The individualized care plan (ICP) is developed by the registered nurse (RN) case managers on the team. When a member is accepted into the case management program, an assessment is administered by one of the nurses on the clinical team to either the member or a person that they designate. The survey addresses all aspects of the member's current state including health history, support system, knowledge regarding the conditions, compliance with the prescribed treatment plan, benefits available under the plan and current health care needs. The areas of focus include but are not limited to medical, behavioral health, psychosocial and

pharmacologic needs with interventions created for the focus areas. The case manager outreaches to the member based upon the care plan problems, goals and interventions and is updated by the nurse with member input each time the member and nurse review the progress toward the goals. These discussions happen at a minimum of once a month depending upon the severity of the member needs. Triggers for care plan updates include transition of care for the member such as admission/readmission into an acute care or skilled facility.

The interdisciplinary care team (ICT) is comprised of a multidisciplinary team which includes but is not limited to, a medical director, the senior director of care and case management, the director of utilization management, and the manager of complex case management, as well as frontline staff within the respective departments. The frontline staff includes the following: licensed social workers, nurses, case managers, utilization management agents, mental health staff, registered dieticians and ancillary support staff. The team has a member-centric approach that manages the member's health care needs across the health care continuum. The participation of the member is facilitated whenever possible, by identifying which providers the member would prefer to see and to maximize involvement in decision-making regarding care and preferences, as much as possible. Members are able to request a case review with the GHI multidisciplinary team managing their care needs. The ICT meets either in person or by phone several times a week for rounds to discuss complex cases or cases that need referrals for services or programs.

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.emblemhealth.com/our-plans/medicare