American Health Inc. H5774
Dual Eligible (Full Duals) Special Needs Plan

Model of Care Score: 84.38%
2-Year Approval **January 1, 2012 to December 31, 2013**

Target Population

Almost 70% of American Health Inc.'s population is dual eligible and nearly 52% of these members have diabetes. In addition, 25% of the population is disabled and less than 65 years of age. Based on the SNP's analysis of data and pharmacy utilization experience, this population frequently utilizes medications to control pain (narcotics, pain killers, opioids).

Provider Network

The SNP's provider network includes: 1,544 specialists, 54 hospitals, three rehab facilities, three skilled nursing facilities, 419 laboratories, 46 radiology and imaging centers, 12 home health agencies, 118 physical and occupational therapists and 16 nutritionists. It also encompasses the following behavioral health providers: 139 clinical psychologists, 133 psychiatrists, six inpatient facilities, 14 partial hospitalization centers and 15 outpatient clinics.

Care Management and Coordination

American Health Inc. (AHM) conducts a health risk screening process with new members by phone or in writing to obtain a basic health history, a history of chronic conditions and evaluate continuity of care needs. It refers and assigns all members (high risk, complex cases, and frail elderly, among others) to a case manager. The assigned case manager contacts the member and intervenes according to the findings from the screening. This screening, along with a data analysis will provide the risk to be addressed in established phases of intervention.

Case managers contact members identified as potential complex cases to complete a health risk assessment (HRA). Elements of the assessment interview include but are not limited to: health status, the course of present illness including symptoms, current management of illness, a review of medications, past medical history including family's medical history, social history, and the perception of illness.

The primary care physician (PCP) evaluates the member's health status, preventive needs, medication and case management needs during a physical examination. The PCP and the case manager contact members and obtain a complete clinical history and assess their medication use.

The PCP or case manager also evaluates the member's functional status and the activities of daily living; they consider living conditions, caregiver support, the social environment, education and training regarding the patient's condition, the availability and accessibility of needed services, general safety of the member and long term care requirements.

Annually, the PCP performs a quality health risk evaluation (QHRE). This is a comprehensive assessment of the member that includes a complete a review of systems, chief complaints, physical exam, and an assessment and treatment plan. The QHRE also encompasses quality measures such as breast cancer screening, colon cancer screening, osteoporosis screening, glaucoma, hemoglobin A1C for diabetic members, cervical cancer screening and prostate cancer screening.

After a member identified for case management agrees to participate in the program, the case manager (certified and licensed RN) develops an individualized care plan (ICP) based on the HRA findings. The ICP promotes early and intensive treatment interventions and includes: short and long-term goals, follow-up and educational interventions, self-management plans, progress assessment, coordination of medically necessary, cost-effective services, multidisciplinary clinical, rehabilitative, and support services selected from a broad spectrum of resources and the use of non-participating providers in cases where the network does not meet the needs of the patient. As the member's healthcare needs change, the manager and the director review and revise the care plan. The medical director also reviews special plans on a weekly basis.

A multidisciplinary approach to case/disease management enables the case manager to develop a treatment plan that includes monitoring of comorbidities frequently associated with chronic medical conditions. The team is composed of the Alianza medical director (who is the direct liaison with the primary care and specialty physicians), AHM medical director, case managers and the director of pharmacy. For special complex cases, the team may include mental health case managers who coordinate mental and behavioral health services, social workers, gerontologists, the health educator and nutritionist. Members will have access to the ICT through their case managers.

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: http://www.americanhealthgroup.com/