H5989 Centerlight Healthcare Inc.
Institutional (Facility and Institutional Equivalent: Living in the Community)
Special Needs Plan

Model of Care Score: 96.67%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The plan-specific target population is dual eligible individuals who require long-term institutional level of care and support in a residential skilled nursing facility (SNF) or in the community for more than 90 days. Members must be covered by Medicare parts A, B and D and live in the New York counties of Bronx, Kings, Manhattan, Queens, Richmond, Nassau, Rockland, Suffolk and Westchester. Excluded from the target population are residents of a New York State office of mental health facility and individuals receiving services from the New York State office for people with developmental disabilities.

Almost two thirds of members are female, 89 percent are between the ages of 65 and 100 years old. Just over half of members are Black, 36 percent are white and nine percent are Hispanic. English is the primary language spoken by 95 percent of members. Members are medically complex, costly, elderly and disabled individuals with multiple chronic, debilitating conditions; functional disabilities; psychosocial issues; behavioral disorders and are at a high risk for hospital admissions. They also experience cognitive deficits, difficulties with ambulation, low socioeconomic status, low health literacy, language/cultural barriers and social isolation. Falls and fractures are common, as well as feeding difficulties and poor nutrition. Many are depressed due to overall failing health, as they approach the end of life.

Common conditions found in the I-SNP population include but are not limited to dementia, diabetes, hypertension, stroke with residual disability, coronary artery disease and depression**.** Thirty-four percent of current CenterLight I-SNP members have four or more chronic conditions which require numerous maintenance medications.

Provider Network

CenterLight contracts with providers experienced in caring for the frail elderly who meet members' language and cultural needs. The network includes primary care services, medical specialty services, home-based and community-based services, allied professional services, and facility-based care. For I-SNP members, CenterLight has a network of four owned and operated SNFs and eight contracts with facilities across the CenterLight service area. Through training and experience, primary care physicians (PCP) and specialists in the CenterLight network have

expertise in care planning through the acute and post-acute continuum of services. CenterLight has 10,000 contracted providers covering the Greater New York Area. Medical specialty services include but are not limited to allergy and immunology, cardiology, chiropractic medicine, dermatology, endocrinology, gastroenterology, general surgery and geriatric medicine.

Care Management and Coordination

CenterLight uses a suite of health risk assessment (HRA) tools to evaluate the medical, functional, psychosocial and cognitive history and needs of its members. These tools are used to specifically define the problems addressed by the interdisciplinary care team (ICT) during the development of an individual care plan (ICP). These tools have been thoroughly vetted as clinically effective for the CenterLight Health I-SNP population. Key information to complete the HRA is provided by the member, family and any other appropriate or significant source.

Within the first 30 days of enrollment, the nurse practitioner (NP) performs a complete physical examination and uses a comprehensive screening tool developed by CenterLight to obtain the following health information: the patient's medical history, list of medications, advanced directives, review of all systems, vaccinations, blood screenings, physician coordination information and designated family health care proxy, if appropriate.

The SNF is required to complete other assessments including the minimum data set (MDS). The initial MDS results provide a foundation for the development of an ICP. The MDS is completed by the facility's ICT, which includes but is not limited to the nursing staff, PCP, social worker, rehabilitation (physical, speech, occupational) therapists and a dietitian. This expertise contributes to an understanding of the strengths, needs and preferences of the member. The NP is a member of the ICT and works with SNF staff to ensure there is agreement on the ICP.

The HRA is an ongoing reassessment of member health status, after the initial HRA, follow-up clinical assessments are conducted monthly. If there is a change in a member's health status, it will be documented and the ICP will be revised and communicated between PCP and member/ health care proxy and other members of 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 beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.CenterLightHealthcare.org