

H5992 Senior Whole Health of NY, Inc.
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 90.00 %

3-Year Approval

January 1, 2015 – December 31, 2017

Target Population

Senior Whole Health (SWH) of New York (NY) serves dual eligible members of age 65 years and older. Most members are Managed Long Term Care (MLTC) who are not only dual eligible, but may be nursing home certifiable already, having many activity of daily living (ADL) or instrumental ADL deficits and requiring significant personal care assistants (PCA) support. Members in SWH are poor, aged, frail, disabled, and chronically ill or near end of life, and are culturally and linguistically diverse. Social, cognitive and environmental factors also play a role in the health status and health outcomes of the member population. The average composition of a SWH member is that of females who are 76 year old with five chronic conditions, on at least seven medications and with low literacy. Because of economic and social burdens of this population, member's functional status declines and any associated physical and mental changes of age are often accelerated.

Provider Network

The SWH Provider Network is comprised of a combination of clinical professionals with expertise in dealing with special populations, facilities, and services that care for the NY dual eligible population. Other specialist may include nurse practitioners, family medicine, geriatricians, nurse midwives, and gynecologists, medical and surgical specialists. Specialized facilities and services may include academic, community based hospitals, behavioral health, home health, social and medical day care, skilled nursing facilities, vision care, speech and hearing services, pharmacy, durable medical equipment, lab and radiology.

Care Management and Coordination

The health risk assessment tool (HRA) is carried out for each member prior to or upon enrollment. Ongoing re-assessments are conducted at least every six months, annually and more frequently depending on changes in the condition of the member. This assessment is a combination of a comprehensive initial assessment which includes a uniform assessment system for NY, risk stratification assessment, and primary care physician (PCP)/ behavioral health (BH) clinician assessment. Results of the HRA are then stratified to determine the frequency and intensity of the care management. Demographic information, health status assessment, review of medical, behavioral health, current treatments and therapies, allergies and immunizations, and

current medications, medical/social resources/health summary, cognitive and functional patterns, sensory and communications assessment, social, functional status, and several other factors are considered.

The interdisciplinary care team (ICT) is person-centered, built on the member's specific preferences and needs, delivers services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. The ICT is comprised of the member/caregiver, PCP, BH professional, nurse case manager, member's PCA, member's nursing facility and its clinical professional. Other participants that are sometimes requested to attend may include a physical therapist or pharmacist. The member's participation is facilitated by the ICT through home visits, face-to-face meetings, or telephonic communication in the members preferred language.

The individualized care plan (ICP) integrates the member's goals, values, and preferences with the recommendations and insights of all relevant practitioners and community service providers. The member's participation is facilitated by the ICT members through home visits, face-to-face meetings, telephonic or alternative formats in the members preferred language when possible. The essential elements incorporated in the ICP include the member goals and preferences for care, results of the UAS and health risk stratification assessments, needs for medical, behavioral health, pharmacological and add-on benefits and services, a review of member's social support system (community or within the home), special equipment needs, mental-health status, tobacco and other substance use, and the need of long term care services.

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 member needs.

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