Longevity Health's Model of Care provides residents living in long-term care facilities with a patient-centered experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, our Model of Care is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits provide additional services and support for Longevity Health's special Member population.

The Model of Care includes 4 sections:

- **MOC 1**: Description of the Overall SNP Population
- **MOC 2**: Care Coordination
    - SNP Staff Structure
    - Health Risk Assessment (HRA)
    - Face-to-Face Encounter
    - Individualized Care Plan (ICP)
    - Interdisciplinary Care Team (ICT)
    - Care Transition Protocols
- **MOC 3:** Provider Network
- **MOC 4:** MOC Quality Measurement and Performance Improvement

MOC 1 Description of the Overall SNP Population

Likely characteristics of Longevity Health members:

- High utilization of medical and pharmacy services
- Have multiple chronic conditions such as heart disease, diabetes, COPD, depression
- High risk for falls

- May be confined to bed or wheelchair and require assistance with activities of daily living
- Often have moderate to severe cognitive impairment and overall low health literacy

Characteristics of the most vulnerable Members may include:

- **Utilization history**: High utilization of medical services results when chronic conditions are not stabilized and well-controlled
- **Current clinical status:** Receiving Part A skilled services in the nursing facility
- **Medication status:** Over-medication can pose health threats to members. High-risk medications like anticholinergics, CNS drugs, and antipsychotics increase risk for falls, behavior changes, and other dangerous side effects.
- **Chronic conditions:** Members with multiple chronic conditions require additional monitoring, treatment titration, and stabilization efforts to minimize risk for adverse outcomes

MOC 2 Care Coordination

SNP Staff Structure

The SNP Clinical team is comprised of Advanced Practice Registered Nurses or Physician Assistants, Registered Nurses, Social Workers, Primary Care Physicians, and Pharmacists.

Health Risk Assessment (HRA)

The HRA is used to initiate the development of the Individualized Care Plan (ICP), collect information about the health status of Longevity Health members, help to stratify members by risk level, and monitor changes in health status on an annual basis.

All new members receive an HRA upon initial enrollment, with a significant change in condition such as a hospital stay, and within 364 days of the last HRA.

Face-to-Face Encounter

The annual face-to-face encounter is required by Medicare for all SNP members. The goal of the face-to-face encounter is to improve health outcomes, identify needs and risks, reduce gaps, and increase collaboration between the member's ICT and the care management team.

Individualized Care Plan (ICP)

Needs identified in the HRA are addressed in the ICP. The ICP focuses on member self-management goals and preferences. All members have an ICP that is updated with significant changes in health status and is available to the member and the Care Team.

Individualized care team (ICT)

The ICT revolves around the member and is focused on the member's goals and preferences. The exact composition of the ICT varies and is dependent on each member's unique needs. ICT participants are selected based on their functional roles, knowledge, and/or established relationship with the member. The ICT reviews progress towards goals and updates the ICP as needed.

Care Transitions

The Model of Care utilizes care transition protocols to safely transition members between levels of care and across care settings using evidence-based clinical practices. Care transition protocols ensure that every member has a centralized point of contact for care transitions and facilitate information-sharing with external providers/facilities to ensure coordinated care across settings.

MOC 3 Provider Network

Longevity Health members have access to a comprehensive contracted network of providers, facilities, ancillary services, specialist physicians, and acute care facilities with the specialized clinical expertise to care for I-SNP members. Primary care services and supportive ancillary services such as therapy, diagnostic radiology, and labs are provided within the facility as appropriate. Longevity Health clinicians also coordinate services outside of the facility including specialist visits and diagnostic testing not available on campus. Both contracted providers and out-of-network providers seen by members on a routine basis receive initial and annual training on the Model of Care.

MOC 4 Quality Measurement and Performance Improvement

The purpose of the Quality Improvement Program (QI Program) is to take a proactive approach to improve quality of care for Longevity Health members. The QI Program supports and promotes this vision through continuous improvement and monitoring of medical care, patient safety, and behavioral health services.

The QI Program is assessed annually to evaluate the overall effectiveness of the program. Enhancements are made to the QI Program based on the annual evaluation. The QI Program provides the overall structure, framework, and governance to improve quality of care for members. The QI Program includes both performance (process) measures and member outcome measures.

Key quality initiatives focus on:

- Fall prevention, medication adherence, and deprescribing based on clinical guidelines
- Reducing unnecessary hospital readmissions
- Improving member experience

Longevity Health Plan Inc. is an HMO I-SNP with a Medicare contract. Longevity Health Plan of New Jersey Inc. is a PPO I-SNP with a Medicare contract. Enrollment in Longevity Health Plan depends on contract renewal. Longevity Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.