Preferred Care Partners, H1045
Chronic or Disabling Condition (Cardiovascular Disorders, Chronic Heart Failure and Diabetes) Special Needs Plan

Model of Care Score: 85.63%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Preferred Care Partners operates a C-SNP for members with a primary diagnosis of diabetes, chronic heart failure and cardiovascular disorders. These members must reside in the plan's service area, have a physician confirmed diagnosis of diabetes, have chronic heart failure and/or cardiovascular disease, receive services under Medicare parts A and B, and be eligible or receive assistance from the state. The SNP's service area consists of: Miami-Dade, Broward, Hillsborough, Lake, Manatee, Marion, Pinellas, Sumter, Hernando, Pasco, Osceola, Seminole, Orange, Polk and Volusia counties in Florida.

The plan selected diabetes, chronic heart failure and cardiovascular disorders as target diagnoses due to the prevalence of these conditions in its member population. It identifies members in the target population through reporting criteria obtained from eligibility files and claims or encounter information processed monthly. These members have complex social/medical needs that often place them at risk of hospitalizations, lack of compliance with care and unfavorable health outcomes.

Provider Network

Preferred Care Partners has a network of providers and facilities that spans an eight county service area. Its practitioners include: physicians, specialty care providers and mental health providers who have expertise treating chronic conditions, addressing issues related to the frail or disabled and those members near the end-of-life. The plan's network also includes: inpatient/outpatient facilities, emergency rooms, skilled nursing facilities, rehab centers, behavioral health facilities, laboratories, home health agencies, pharmacies and other facilities.

The SNP's network has services beyond the scope of the interdisciplinary care team (ICT) to target any area of care needed by the membership. All members receive a copy of the provider directory upon enrollment. Existing members receive the directory on an annual basis or upon request.

Care Management and Coordination

Preferred Care Partners' case management team develops an individual plan of care (ICP) as a result of: data collected through a comprehensive health risk assessment (HRA), an interview with the primary care physician and the involvement of the member or caregiver and the ICT.

The ICP includes the following elements: member-focused goals and objectives, diet/nutrition, preventive health, activities of daily living, a medication reconciliation, medical history, family involvement, specific services needed by the member, the member's preferences for care based on cultural and linguistic needs, pharmacy data, a history of hospitalizations, identified factors placing members at increased risk and benefits. ICPs are designed to address the specific care needs of the member in order to optimize outcomes and quality of life including those of the vulnerable subpopulations.

Preferred Care Partners' ICTs consist of the family/caregiver and professionals who are engaged in supporting the member's care. The member or caregivers have direct access to case managers. Case managers encourage the participation of the member or family/caregiver in the development and implementation of the ICP. The ICT is composed of diverse groups of health care professionals working together to meet the physiological, social, spiritual and economic needs of members.

The ICT interacts and relies on one another to accomplish goals and engage the member as a partner in his/her care and disease through teaching. The SNP determines the exact composition of the ICT based on the member's needs, disease and disabling conditions. ICT meetings are scheduled and conducted in a manner that facilitates the active participation of all members. Prior to the meeting, each participant of the ICT receives pertinent documentation from the member's ICP and any other information required.

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: http://www.mypreferredcare.com/en/home.aspx