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

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

The Preferred Care Partners Inc. (PCPI) Chronic Special Needs Plan (C-SNP) operates in Miami-Dade and Broward counties of Florida. To be eligible, members must be 18 years of age or older, entitled to Part A and enrolled in Part B of Medicare, reside in one of the service areas and have a physician confirmed diagnosis for cardiovascular disease (CVD), chronic heart failure (CHF) and/or diabetes (DM).

The C-SNP consists of approximately 3,519 members of which 47 percent are female and 89 percent of this group is over the age of 65. The remaining 53 percent of members are male and 86 percent of them over the age of 65. A large portion of the population is Hispanic (41 percent) while White and Black members comprise 21 and 7 percent respectively.

A diagnosis of CVD, CHF or DM is required for C-SNP enrollment; currently 56 percent of the membership have a DM diagnosis, 34 percent have a CVD diagnosis and 9 percent have been diagnosed with CHF. In addition, the most common co-morbid conditions within the population are: hypertension, hyperlipidemia and chronic kidney disease. Cognitive impairment is also a concern for the plan's members.

PCPI recognizes that several social and environmental factors and can also have an impact on members' living needs and health. Among them, 18% of the population lives alone and a number of members (27.5 percent in Miami-Dade and 17.5 in Broward Counties) have incomes below 125 percent of the federal poverty guideline.

Provider Network

PCPI's network includes primary care physicians and specialists, such as endocrinologists, cardiologists, pulmonologists, oncologists and mental health providers. The C-SNP has an extensive hospital network with expertise in: trauma, burns, emergency, surgery, heart, digestive and cancer care. In addition, the plan contracts with facilities that provide diagnostic and treatment services to meet their members' specialized needs. These facilities include, but are not limited to: outpatient facilities, rehabilitative and long-term care facilities, skilled nursing facilities, behavioral/mental health facilities, laboratories, home health agencies and pharmacies.

Care Coordination and Management

Within 90 days of enrollment, the nurse case manager (NCM) administers a comprehensive health risk assessment (CHRA) tool to each member that evaluates his or her medical and mental history and functional, cognitive and psychosocial status. The NCM conducts reassessment annually, or sooner, if there is a change in the member's condition.

After completion of the initial CHRA, PCPI distributes the results and acuity stratification to the interdisciplinary care team (ICT). The ICT uses this information to develop an individualized care plan (ICP) within 30 days of CHRA completion. The ICP includes the following elements: member-focused interventions, short and long-term goals and corresponding time frames for completion, potential barriers to goal completion, cultural/language preferences, healthcare preferences, visual and hearing needs/limitations, educational needs, assessment of activities of daily living, family involvement and services needed. The NCM reviews the ICP during each member interaction to monitor appropriateness and make changes as necessary. Following the initial meeting, the ICT meets annually to review the ICP, or sooner, based upon any significant health status changes that may require more frequent communications and ICP updates.

PCPI determines the composition of the ICT based on the member's CHRA results, acuity stratification and specific needs. At a minimum, the ICT includes: the NCM, the primary care physician, social worker, member and/or caregiver. Ad hoc members include the plan's medical director and/or delegated physician, clinical pharmacist and the behavioral health vendor.

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.mypreferredcare.com/en/members/main.aspx