Quality Health Plans of New York, H2773
Chronic or Disabling Condition Special Needs Plan
(Cardiovascular Disorders, Chronic Heart Failure, Diabetes)

Model of Care Score: 92.5%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The target population of the Quality Health Plans of New York Chronic Care Special Needs Plan (C-SNP) is members who have been diagnosed with at least one of the following conditions: chronic heart failure, cardiovascular disorder and diabetes. Prospective members complete a pre-enrollment qualification assessment to determine if they meet the basic criteria for enrollment. Nearly half the Plan's members (45 percent) have some form of cardiovascular disorder. Those with diabetes also typically have at least one additional chronic condition, including cardiovascular conditions. Members with cardiovascular conditions are automatically enrolled in the Plan's Health Disease Management/Member Outreach Program.

Provider Network

The provider network consists of providers and facilities pertinent to the care of the chronic condition SNP members. These include, but are not limited to institutional facilities (acute and skilled nursing and psychiatric facilities), primary care providers, specialty providers such as cardiologists, endocrinologists, nephrologists, behavioral and mental health specialists, nurses, laboratory centers, radiology centers, ambulatory care centers physical, occupational and speech therapists. Medical directors review medical records to assure that providers utilize appropriate evidence based clinical practice guidelines and nationally recognized protocols such as those for diabetes by the American Diabetes Association and heart disease by the American Heart Association. The Plan has also devised its own proprietary specialty standards program and uses medical record review, reports, pharmacy records and peer review meetings to review and assess overall provider performance.

Care coordination and care management

Every new member is contacted by phone and receives an initial health risk assessment (HRA), level of care assessment and identification for case management. The HRA can also be completed by the member's primary care physician (PCP). The purpose of the HRA is to assess the needs of each member using the following: health status, clinical history, activities of daily living, mental health status, life planning, cultural and linguistic needs, preferences or limitations, caregiver resources, benefits, case management plans and goals, barriers, follow up schedule, and self-management plan.

Each member receives an individualized care plan (ICP) which is based on the results of the HRA. The ICP is developed by the nurse coordinator and medical director. The level of interventions and ongoing assessment are determined by the level of need of each member by the medical director. The nurse coordinator and medical director work with the member's PCP to present the plan to the member so they understand the plan and care goals. The member is involved in the development of the ICP and participates in a number of ways, which may include phone, in writing, Web-based electronic interface or virtual correspondence. The ICP includes a clinical history, social history, advance directives, power of attorney declaration and care giver information.

Member management is designed specifically for medical, behavioral and psychosocial issues. These assessments will drive the identification of specific problems or challenges, the setting of goals and creation of appropriate interventions. Members are placed into one of three categories (low intensity, which receives care coordination; moderate intensity, which receives care coordination and integrated chronic management; and high intensity, which receives integrated complex case management).

The interdisciplinary care team (ICT) will be coordinated by a nurse and chaired by a medical director of the Plan. Each member will be assigned to an ICT. The core composition of the ICT will include a nurse coordinator, pharmacy director, medical director, member's primary care physician (PCP), mental health services specialist and social services specialist. Additional providers will be invited on a case-by-case basis and may include medical specialists, dieticians/nutritionists, home health nurses, physical therapists, caregiver/family member (whenever feasible).

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.qualityhealthplansny.com