Constellation Health LLC, H3054
Chronic or Disabling Condition (Cardiovascular Disorders, Chronic Heart Failure, and Diabetes)
Special Needs Plan

Model of Care Score: 82.50%
3-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

Constellation Health is structured to provide a coordinated framework for ensuring access to and supporting the care coordination of quality, cost effective, and efficient health care services to Chronic Special Needs Plan (C-SNP) members in Puerto Rico using evidence based medicine. The C-SNP targets Group 4 conditions: Diabetes Mellitus, Chronic Heart Failure, and Cardiovascular Disorders.

Data from the Centers of Disease Control and Prevention regarding the prevalence of chronic conditions in the island confirms that Puerto Rico has a higher incidence of diabetes, when compared to the US mainland. Additionally, cardiovascular diseases are the leading cause of death for people 60 years and older in Puerto Rico and the older the population the greater the percentage of people dying from this cause. The prevalence and incidence of heart and vascular diseases including hypertension, cardiovascular and peripherovascular disease increases, particularly after 45 years of age. Hypertension occurs in 50% of the population aged 60 years and 66.6% of those aged 70 years and older which often leads to more complex conditions such as: cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorders, and Congestive Heart Hailure (CHF).

Provider Network

Constellation Health has an extensive provider network that includes: 17 hospitals, two skilled nursing facilities in the counties of the San Juan Metropolitan Area and North East Coast of Puerto Rico and home care services through three licensed agencies**.** Constellation Health contracts with clinical reference laboratories, dialysis facilities, radiology and imaging centers and members have access to over 250 practitioners with specialties in cardiology, nephrology, pulmonology, geriatric specialists, immunology, psychiatry, clinical psychology and other sub specialties. The network includes wound care specialists, dental and vision practitioners, podiatrists, behavioral and mental health specialists, physical therapists, occupational specialists, speech therapists, home care specialists, laboratory specialists, radiology specialists, pharmacists, nutritionists, registered nurses, nurse practitioners, nurse managers and nurse educators. It also provides 24 hour access to a nurse case manager (NCM) responsible to ensure that the member receives appropriate care after hours.

The primary care physician (PCP) is an important link and gatekeeper that coordinates with the Constellation Health's interdisciplinary care team (ICT) to ensure that services requiring prior authorization and transition of care events are appropriately documented in the care management

system. Each member is assigned to a NCM who coordinates, manages and authorizes the delivery of services specific to the unique needs of the member.

Care Management and Coordination

Constellation Health will use a health risk assessment (HRA) to assess clinical, social and behavioral status of its members. The HRA consists of a health history questionnaire and a physical examination that serves as the primary source of information for member stratification, development of the individual care plan (ICP) and assignment to an ICT. The PCP administers the HRA face-to-face within 90 days of member enrollment. Reassessment also occurs face-to-face annually within one year of the last assessment. Constellation Health enters this information into an electronic tool for stratification according to an algorithm based on disease status, functional status and cognitive status.

The ICP is the main tool to direct a member's care interventions based on his or her risk level. The ICT will develop disease-specific care plans based on current clinical practice guidelines, such as screening tests and lifestyle modifications, along with the gender and age-based preventive care interventions. The ICP will also include educational material on disease-specific self-care.

The NCM develops and maintains the ICP and communicates expectations to the member regarding education and outreach efforts, communication processes, resources, involvement, and ongoing access to the ICT. The NCM works collaboratively with the member, caregiver, PCP, social worker and the ICT to ensure all are involved with short and long term goal setting, prescribed interventions, identification of barriers for each of the identified problem areas, and the provision of safe transitions between care settings. The NCM coordinates, manages and authorizes all aspects of the delivery of care and services to the member. The member has ongoing access to the ICT through the NCM and the member can contact him or her to request additional services or request changes to the ICP.

The ICT includes clinical professionals from different disciplines who engage in complementary tasks to support the member's care management needs. The clinical and social complexities of each dual eligible member may require the addition of other disciplines or resources to the ICT.

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.constellationhealth.pr.com