Florida Healthcare Plus Inc., H4199
Chronic or Disabling Condition
(Cardiovascular Disorders, Chronic Heart Failure (CHF) and Diabetes)
Special Needs Plan

Model of Care Score: 91.88%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Florida Healthcare Plus (FHP) operates a chronic and disabling condition Special Needs Plan for members with diabetes, CHF and cardiovascular disorders. FHP designed the program to take information from the health risk assessment (HRA) and claims data to identify members with diabetes and/or cardiac diseases. It conducted a further review of all members with these conditions for placement into the SNP Program. Members identified for the chronic SNP are largely Hispanic or African American. Specifically, the program targets diabetics with HbA1c <10, a history of uncontrolled diabetes or a hospitalization within 30 days with a blood sugar <350. Members with cardiac conditions, included in the target population are those with: class 8 CHF or greater, a recent history of MI, two or more cardiac conditions and those with diabetes and any cardiac history.

Provider Network

The plan has a network of qualified practitioners for the target population. FHP contracts with 1,335 primary care physicians, of which 70% are board certified. The specialty network supports the target population with a full complement of specialists, including mental health providers, of which 85% are board certified. Network specialists support primary care and case management resources for complex medical and social issues. Provider resources are available across the continuum of care with coordination of services via communication during the transition of care period. The volume of specialists/facilities with specialized expertise supporting the clinical conditions of all members includes: endocrinologists, cardiologists, nephrologists, pharmacists, dialysis, psychiatrists, social workers and other specialists. Florida Healthcare Plus also contracts with a full complement of acute care hospitals, some with psychiatric units as well as psychiatric hospitals.

Care Management and Coordination

FHP uses an HRA questionnaire to help create care plans for all members. The HRA contains questions that address several areas pertinent to the evaluation of medical, functional, cognitive and psychological problems. The plan stratifies results by risk and places members into varying levels of a tiered complex case management program, as necessary. After the member completes the HRA, case managers and social workers employed by the organization generate individual care plans (ICP). FHP involves the member in short and long term goal setting, interventions and the identification of

barriers for each identified problem area in the ICP. Once developed, all ICPs are communicated to the primary care physician, the member or caregiver and any specialist or practitioner that provides care.

The SNP utilizes ICP to develop an interdisciplinary care team (ICT) based on the unique needs of the member. Once the team has met and addressed the issues/concerns, the care manager will document a summary of the meeting in the care management system. FHP disseminates the written care plans developed and printed from the care management system to the member and the primary care physician. In addition, the care manager also places a follow-up call to the member to discuss the results and outcomes of the ICT meeting. The plan presents the ICP to the ICT at least on a monthly basis.

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:

https://www.floridahealthcareplus.com