H5594 Optimum Healthcare
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

Optimum Healthcare, Inc.'s (Optimum) Chronic Special Needs Plan (C-SNP) targets Medicare members with cardiovascular disorders (CVD - limited to cardiac arrhythmias, peripheral vascular disease or chronic venous thromboembolic disorder); congestive heart failure (CHF); or diabetes mellitus (DM). These diseases are specifically grouped together in this C-SNP due to the prevalence and incidence rate in the Medicare-age population as well as the strong correlation between CVD and DM. Furthermore, CHF, CVD and DM are all associated with early mortality and reduced quality of life.

Men comprise 58 of the C-SNP's population and women 42 percent. The majority (52 percent) of members are in the 65-74 age group with approximately 36 percent in the 75 and older age bracket. Members generally experience comorbidities, most commonly: renal failure (10.9 percent), vascular disease (9.5 percent), diabetes with renal or peripheral circulatory manifestation (9.2 percent), polyneuropathy (8.7 percent), angina pectoris/old myocardial infarction (7.0 percent) and chronic obstructive pulmonary disease (6.7 percent).

Provider Network

Optimum has a network of providers and board-certified specialists with clinical expertise that includes: internists, cardiologists, general and cardiovascular surgeons, neurologists, endocrinologists, optometrists, ophthalmologists, podiatrists, neurologists, nephrologists, orthopedic surgeons, pulmonologists, wound care specialists, acute and outpatient rehabilitation services, home health services, durable medical equipment services, social workers, mental health specialists, pharmacists and/or clinical pharmacists. In addition to these specialists, Optimum has a vast primary care network including providers specializing in internal medicine, geriatric medicine and family practice. Its network also consists of: acute care hospitals, tertiary medical centers, acute care rehabilitation facilities, laboratory providers, skilled nursing facilities, pharmacies, free-standing radiology facilities, outpatient diabetes management education, cardiac rehabilitation centers and wound care centers.

Care Coordination and Management

Within 90 days of enrollment and annually thereafter, each member completes an initial comprehensive health risk assessment (HRA). In addition to the HRA, members undergo a separate disease-specific (CHF, CVD or DM) assessment. The responses reflect the member's perception of his or her medical, psychosocial, cognitive and functional status to identify potential care gaps. Information from all of the assessments is documented in the plan's electronic system.

Based on a review and analysis of the member's responses and depending on his or her risk stratification level (Tier 1, 2 or 3), either the nurse/social worker (NCM/SW) or primary care physician (PCP) develops the individualized care plan (ICP). The essential elements of the ICP are problems, goals and interventions. In the ICP, the interdisciplinary care team (ICT) prioritizes goals for a member's health status, establishes timeframes for reevaluation, identifies resources to benefit the member (recommendations to appropriate level of care) and outlines a plan for continuity of care (including transitions).

As care management conversations occur between nurse case managers, PCPs, members, and other key member ICT participants, case notes are documented in the health plan's case management system and updates are made to the ICP and communicated to the care team. The PCP always gets a faxed copy of the updated care plan, which supplements verbal notification through telephone contact. The PCP as the "medical home" is on point to disseminate the information to other key stakeholders including specialists, facilities etc. It is also the PCP's responsibility to ensure that the revised ICP is acted upon and implemented to assure quality outcomes. Member cases are also presented and discussed at the formal, quarterly ICT meeting attended by administrative and clinical personnel, pharmacy and physician committee members.

The composition of the ICT is based on the problems, interventions and goals established during the care planning process. Core members of the ICT include: the PCP, the NCM/SW, specialists and other care professionals and the member/caregiver. Depending on the member's condition and unique needs, additional expertise may be added 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: https://www.youroptimumhealthcare.com/medicare/special_needs_plan_info_members