CareMore Health Plan, H0544
Chronic or Disabling Condition (Cardiovascular Disorders and Chronic Heart Failure)
Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

The CareMore Health Plan (CHP) serves Medicare members who have cardiovascular disorders and/or chronic heart failure disorders (CAD/CHF) and live in one of CHP's service areas.

Among the CAD/CHF SNP population, the following co-morbidities exist: diabetes (60 percent), high cholesterol (80 percent), high blood pressure (80 percent), chronic kidney disease (60 percent), clinical depression (50 percent) and poor nutritional status and/or obesity (80 percent). Additionally a large population of these patients has no formal education on how to manage and treat their cardiovascular condition.

Provider Network

In addition to a full contracted network of providers that includes primary care physicians (PCP) and specialists, CHP employs clinicians with specialized expertise to provide additional services to the CAD/CHF population: nurse practitioners (NP) who specially trained in cardiology care, a cardiologist who acts as the medical director of CHP's CAD/CHF management program, dieticians, a medical officer and extensivists who work in CHP contracted hospitals. Additionally CHP contracts with providers who work closely with the interdisciplinary care team (ICT): employed and contracted cardiologists, preferred specialists for cardiovascular surgery and fitness instructors. The PCP has the primary responsibility to coordinate the member's health care needs and services.

Care Management and Coordination

Within 30 days – and more than 90 days – of initial enrollment, the NP schedules a health risk assessment (HRA) with each member to assess their chronic conditions identify risk level and determine appropriate interventions. The HRA includes questions about the member's medical, functional, cognitive and psychosocial needs. In addition to the HRA, the member may complete a number of other screenings such as, but not limited to: PHQ-9 Depression screening, miniCog, mini-mental state examination, community assessment risk screen, fall risk screen, onsite lab testing, pain assessment scale and Barthel Index of Activities of Daily Living. The NP

completes the assessments at the member's home or telephonically. At a minimum, the HRA is annually, whenever there is a significant change in health status, or after transitions of care.

After the HRA is completed, along with the member's vitals, labs, and medical history and physical exam, the NP develops the individualized care plan (ICP). In conjunction with the member, the NP documents the specific needs and goals of the beneficiary, considering their specific barriers, preferences and limitations and caregiver resources. A copy of the initial ICP and all of its revisions are documented and retained in CHP electronic medical record system, which is available to members of the ICT. The NP distributes a copy of the revised ICP to the member at each their appointments. At a minimum, the ICP is updated annually. Additional ICP revisions occur when patients are discharged from hospitals and skilled nursing facilities to manage their transition of care until they stabilize.

Led by the NP, the ICT coordinates the special needs of the beneficiaries with interdisciplinary and multidisciplinary input from nurse practitioners, internists, case managers, fitness trainers, cardiologists, social workers, registered dietician and mental health professionals. Additionally, CHP has supplemental ICTs, CareMore Intervention Team and Neighborhood ICT, that meet at a minimum of weekly to manage and assess the complex needs of these vulnerable populations. The former ICT is dedicated to patients with severe psychosocial issues and end of life needs and patients who are hospitalized and skilled level and the latter ICT assesses the needs of frail patients in their neighborhoods. These teams may include additional providers: medical supervisors, specialists, if applicable, and extensivists who are board certified in internal medicine, regional medical directors and office managers.

The ICT works virtually using a variety of electronic systems to communicate the patient's medical conditions and treatment needs, along with information on assessments and treatment plans, medication refills and lapses in refills, lab results services being provided by all of CHP's providers (within and outside of the ICT). During formal CVD/CHF ICT meetings, the team monitors completion of ICP and reviews the details of ICPs for members who are not meeting clinical goals.

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: