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

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

The CareMore Health Plan (CHP) serves individuals who have Medicare and have cardiovascular disorders and/or chronic heart failure disorders (CVD/CHF). Among the overall CHP population, the ethnic breakdown is: Hispanic (31 percent), Non-Hispanic Caucasian (27 percent), Asian (21 percent) and African American (11 percent). English is the primary language in all of the CHP plans with Spanish being the next most predominant.

The CVD/CHF SNP population includes 6,644 members with males slightly outnumbering females (3,347 vs. 3,297) and the average age of members is 77. Among the CVD/CHF SNP population, the following co-morbidities exist: 60 percent have diabetes, 80 percent have high cholesterol, 80 percent have high blood pressure, 60 percent have chronic kidney disease, 50 percent have clinical depression, and 80 percent have poor nutritional status and/or obesity. Other chronic complications of CVD/CHF causing serious long-term problems include failure to renew prescriptions, experience change in dietary sodium intake, cardiopulmonary disease, and systemic conditions such as anemia, infection, thyrotoxicosis, renal failure.

CHP recognizes members with CVD/CHF disorders experience multiple chronic conditions including behavioral health; need chronic condition management and self-management education; and may need integration of behavioral health coordination of services. A large number of this population do not have formal education on how to manage and treat their cardiovascular condition.

Provider Network

The facilities included in CHP's network include: skilled nursing, long-term acute psychiatric, board and care/assisted living facilities, short-term placements, shelters, psychiatric partial hospitalization, rehabilitation and dialysis units. CHP's ancillary services include: transportation, home health, durable medical equipment, hospice, dental, vision, physical, occupational, and speech therapy and exercise and strength training centers.

In addition to primary care physicians (PCP) and specialists (e.g. pain management, behavioral health, vascular surgeon, nephrology, psychiatry, geriatric specialists, immunologists, speech pathologists, laboratory specialists, radiologists and podiatrists), CHP employs clinicians with

specialized expertise to provide additional services to the CHF population: nurse practitioners are specially trained in cardiology care, a cardiologist who serves as the medical director of CHP's CVD/CHF management program, a medical officer who is board certified in internal medicine and registered dieticians. The PCP has the primary responsibility to coordinate the member's health care needs and services.

Care Management and Coordination

Within 90 days of initial enrollment, the nurse practitioner (NP) schedules a health risk assessment (HRA) with the member to assess their medical, functional, cognitive and psychosocial needs and to conduct a number of other screenings such as, but not limited to: PHQ-9 Depression screening, miniCog, Community Assessment Risk Screen (CARS), fall risk screen, onsite lab testing, pain assessment scale and Barthel Index of Activities of Daily Living. The HRA is completed at a CHP care center or (if the beneficiary is unable to come into the care center) in their home, assisted living, board and care facility or telephonically. The collected data is integrated into the electronic health records system. At a minimum, the HRA is conducted annually, whenever there is a significant change in health status, or after transitions of care.

The NP develops the individualized care plan (ICP) after the HRA is completed, along with the member's vitals, labs, medical history and physical exam. 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. The member receives a copy of the updated ICP after every revision. At a minimum, the ICP is updated annually, whenever there is a significant change in health status, or after transitions of care.

Led by the NP, the ICT coordinates the special needs of the beneficiaries with input from the member, PCP, extensivists who are board certified in internal medicine, case managers, fitness trainers, social workers, behavioral health, cardiologists, cardiology physician assistants and registered dieticians. Through the use of electronic web-based systems, face-to-face meetings, web-based technology, video conferencing and audio conferencing technology, the ICT communicates the member's medical conditions and treatment needs, along with information on services being provided by all of CHP's providers.

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: http://www.caremore.com