H2593 CareMore Health Plan of Arizona Inc.
Chronic or Disabling Condition (Chronic Lung Disorders) Special Needs Plan

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

Target Population

The CareMore Health Plan of Arizona, Inc. (CHP) serves individuals with Medicare, who have chronic obstructive pulmonary disorder (COPD). About 31 percent of CHP members are Hispanic, 27 percent are Non-Hispanic Caucasian, 21 percent are Asian and 11 percent are African American. English is the language spoken by most CHP members, followed by Spanish.

There are 12,558 COPD SNP members. There are more females in the plan compared to males (6,986 vs. 5,572) and the average age of members is 75 years. Members have the following co-morbidities: clinical depression (50 percent), poor nutritional status (75 percent), poor quality of life due to an inability to perform their basic activities of daily living (60 percent) and 60 percent have frequent flare ups resulting in hospitalization. Other significant comorbid conditions include: hemoptysis, asthma, pulmonary tuberculosis, pneumonia, and pulmonary fibrosis and lung nodules. Members are not properly educated on the different types of nebulizers or oxygen and how to use them, they lack knowledge on how to get supplies and durable medical equipment (DME), they are not properly trained on how to take their medicine, they are non-compliant due to a lack of understanding the seriousness of the disease, they ignore the need for influenza and pneumococcal vaccinations which can lead to severe or frequent COPD exacerbations.

CHP recognizes members with COPD disorders experience multiple chronic conditions including behavioral health conditions and may require chronic condition management and self-management education as well as integrated behavioral health care services.

Provider Network

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

In addition to primary care physicians (PCP), CHP's provider network includes specialists in the following fields: pain management, behavioral health, pulmonologists, vascular surgeons, nephrology, psychiatry, geriatric specialists, immunologists, speech pathologists, laboratory

specialists, radiologists and podiatrists. The PCP has primary responsibility for coordinating 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 medical, functional, cognitive and psychosocial needs. A number of other screenings as also conducted which include, but are not limited to depression, cognitive, community, fall risk, onsite lab testing, pain assessment scale and activities of daily living (ADL). The HRA is completed at a CHP care center or in the member's 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, or whenever there is a significant change in health status, or after a care transition.

The NP develops the individualized care plan (ICP) after the HRA is completed, along with the member's vitals, labs, and medical history and physical exam. In conjunction with the member, the NP documents the member's needs and goals, considering 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 a care transition.

Led by the NP, the interdisciplinary care team (ICT) coordinates member needs with input from the member, PCP, extensivists who are board certified in internal medicine, case managers, fitness trainers, social workers, behavioral health, pulmonologists, respiratory therapists 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