

**H2593 CareMore Health Plan of Arizona, Inc.
Institutional (Facility) and Institutional Equivalent (Living in the Community)
Special Needs Plan**

Model of Care Score: 100.00%

3-Year Approval

January 1, 2015 – December 31, 2017

Target Population

CareMore Health Plan of Arizona, Inc. (CareMore Touch) Institutional and Institutional Equivalent SNP (I-SNP) targets members who require an institutional level of care and reside in assisted living facilities (66 percent), a board and care or group home (23 percent) in one of the plan's service areas in Arizona. Members also reside in contracted and qualified institutional facilities such as nursing homes (11 percent). The entire CareMore Health Plan (CHP) includes the following ethnicities: Hispanic (31 percent), Non-Hispanic Caucasian (27 percent), Asian (21 percent) and African American (11 percent). English is the primary language spoken among all CHP plans with Spanish being the next most prominent.

CareMore Touch's I-SNP population includes 2,530 members of which 69 percent are female and the average age of members is 83 years old. Members have the following conditions: dementia (52 percent), diabetes (27 percent), asthma (7 percent), congestive heart failure (6 percent), coronary artery disease (5 percent), chronic obstructive pulmonary disease (4 percent) and severe mental illness (3 percent). Members have significant physical and cognitive decline, complex medical management needs, an increased need for assistance with multiple activities of daily living and an inability to thrive independently.

Provider Network

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

In addition to a full contracted network of primary care providers (PCP), specialists and nursing professionals, CareMore Touch employs mid-level providers who are specially trained in: adult and geriatric care, how to care for members in an institutional and skilled nursing facility setting and wound care management. Other clinicians include a behavioral health team and medical directors with expertise in hospice and palliative medicine. Additionally, CareMore Touch contracts with the following providers who work closely with the interdisciplinary care team

(ICT): podiatrists, who provide services at the bedside, mobile laboratory services, imaging vendors, home health agencies and durable medical equipment providers.

Care Coordination and Management

Within 30 days of enrollment, a mid-level provider staff (MLP), typically a nurse practitioner or physician assistant, performs an initial face-to-face assessment (HRA) and comprehensive physical exam with the member at their place of residence to assess their medical, social, cognitive, psychosocial comorbidities, socioeconomic status and other health conditions. The MLP also conducts other screenings including the PHQ-9 Depression screening, miniCog, Community Assessment Risk Screen, fall risk screen, onsite lab testing, pain assessment scale and Barthel Index of Activities of Daily Living. The MLP enters the collected data into an electronic health records system. At a minimum, an HRA occurs annually and whenever there is a significant change in health status or after transitions of care.

Within 90 days of enrollment and after the initial assessments are completed, the MLP and the medical director develop an individualized care plan (ICP) to meet the specific needs of the member which also reflects their specific barriers, preferences, limitations and available caregiver resources. The ICP includes diagnostic test results, preventive screenings, medications, immunization history and needs, nutrition and health management guidelines, referrals, sickness plan and other recommendations. The member receives a copy of the updated ICP after each 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 medical director, the ICT includes: MLPs, family practice physicians, care managers, hospitalists and other specialties (e.g. mental health, podiatrists and end-of-life care providers). The majority of a member's interaction with the ICT occurs face-to-face through the MLP's weekly home visits, but may also occur via telephone. The ICT meets monthly to evaluate and review members and oversee the performance of the program.

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>