H4346 CareMore Health Plan of Nevada,
Chronic or Disabling Condition (Chronic Lung Disorders) Special Needs Plan

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

Target Population

The CareMore Health Plan of Nevada (CHP) serves Medicare members who have chronic lung disorders (CLD) and reside in one of CHP's service areas in Nevada.

Among the CLD population, the following co-morbidities exist: clinical depression (50 percent), poor nutritional status (75 percent), a poor quality of life due to an inability to perform their basic activities of daily living (60 percent) and frequent flare ups resulting in hospitalization (60 percent). Other factors causing serious long-term problems are: uneducated on different types of nebulizers or oxygen and how to use them, lack knowledge on how to get supplies and durable medical equipment, not properly trained on technique and how to take their medicine, non-compliant due to a lack of education and have very little end of life planning.

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 CLD population: nurse practitioners (NP) who specially trained in pulmonary management, an internal medicine doctor who acts as the medical director of CHP's CLD management program, pulmonologists, dieticians 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 not more than 90 days – of initial enrollment, the NP schedules a health risk assessment (HRA) with each member to assess their chronic conditions to 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 updated annually, and 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 interdisciplinary team (ICT). The NP distributes a copy of the revised ICP to the member at each their appointments. Like the HRA, the ICP is also updated annually, and 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 interdisciplinary and multidisciplinary input from nurse practitioners, internists, case managers, fitness trainers, 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 and services being provided by all of CHP's providers (within and outside of the ICT). During formal CLD 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: http://caremore.com/