H4346 CareMore Health Plan of Nevada
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 who have Medicare and chronic obstructive pulmonary disorder (COPD). The CHP population 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 in all of the CHP plans with Spanish being the second most predominant language spoken.

There are 12,558 members, and females outnumber males (6,986 to 5,572). The average age of members is 75 years. Among the COPD population, the following co-morbidities exist: 50 percent have clinical depression, 75 percent have poor nutritional status, 60 percent have a poor quality of life due to an inability to perform their basic activities of daily living and 60 percent have frequent flare ups resulting in hospitalization. Other significant comorbid conditions include: hemoptysis, asthma, pulmonary tuberculosis, pneumonia, pulmonary fibrosis and lung nodules. Some members are uneducated 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, are not properly trained on how to take their medicine, are non-compliant due to a lack of understanding the seriousness of the disease, ignore the need for influenza and pneumococcal vaccinations which may lead to experiencing severe or frequent COPD exacerbations.

CHP recognizes members with COPD 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.

Provider Network

The facilities in CHP's network include: 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, durable medical equipment, 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 (e.g. pain management, behavioral health, pulmonologists, vascular surgeon, nephrology, psychiatry, geriatric specialists, immunologists, speech pathologists, laboratory specialists, radiologists and

podiatrists). The PCP has the primary responsibility to coordinate the beneficiary'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, and 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 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