H4346 CareMore Health Plan of Nevada, Inc.
Chronic or Disabling Condition (Diabetes Mellitus) 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 Nevada, Inc. (CHP) Chronic Diabetes Mellitus Special Needs Plan (C-SNP) serves Medicare members who have a confirmed diagnosis of diabetes mellitus (DM) and live in one of the plan's service areas in Nevada. 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 language spoken.

The DM C-SNP population includes 27,262 members. There are more female members compared to male members (14,061 vs. 13,201) and the average age of members is 72 years. Among the DM SNP population, the following co-morbidities exist: high cholesterol (80 percent), chronic kidney disease (60 percent), heart disease (60 percent) and high blood pressure (50 percent). Other chronic complications specific to this C-SNP population include blindness, nerve damage, stroke, heart attack and loss of circulation in arms in legs. The majority have poor nutritional status which may impact HbA1c levels, neuropathic limps causing ulcers and amputations in 30-40 percent of members.

CHP recognizes that members with DM need nutritional counseling, diabetic supplies, wound care, and routine medical podiatry care. Those with multiple chronic conditions, including behavioral health conditions, need chronic condition management and self-management education, and, may need integration of behavioral health coordination of services. A large population of these members has no formal education on how to manage and treat their diabetes; for example, members do not understand how to manage their diet.

Provider Network

The facilities in CHP'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. CHP's ancillary services include: transportation, home health, durable medical equipment, hospice, dental, vision, physical, occupational, speech therapy and exercise and strength training centers.

In addition to a contracted network of primary care physicians (PCP), specialists and nursing professionals, CHP employs nurse practitioners who are specially trained in diabetes and wound

care management, an endocrinologist who acts as the medical director of CHP's diabetes management program, and registered dieticians. Additionally, CHP contracts with providers who work closely with the interdisciplinary care team (ICT): preferred specialists for ophthalmology, vascular and orthopedic surgery and fitness instructors.

Care Coordination and Management

Within 90 days of enrollment, a nurse practitioner (NP) schedules a health risk assessment (HRA) with the member to assess their medical, functional, cognitive and psychosocial needs. The NP also conducts other screenings such as, but not limited to: 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 HRA is completed at a CHP care center or inside the member's home, assisted living, board and care facility, or telephonically. The NP enters the collected data into an electronic health records (EHR) system. At a minimum, an HRA assessment occurs annually, and whenever there is a significant change in health status or after transitions of care.

After reviewing the member's HRA, vitals, labs, medical history and physical exam results, the NP develops an individualized care plan (ICP). In conjunction with the member, the NP documents the specific needs and goals of the member, considering their specific barriers, preferences, limitations and caregiver resources. 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 NP, the ICT coordinates the care of members with input from the member, PCP, extensivists who is board certified in internal medicine, case managers, fitness trainers, social workers, behavioral health specialists, endocrinologists, podiatrists, ophthalmologists, vascular surgeons, orthopedic surgeons and registered dieticians. The ICT communicates the member's medical conditions and treatment needs through the use of the EHR system, face-to-face meetings, web-based technology, video conferencing and audio conferencing technology.

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