

**H0544 CareMore Health Plan**  
**Chronic or Disabling Condition (End-Stage Renal Disease Requiring Dialysis –**  
**Any Mode of Dialysis) Special Needs Plan**

**Model of Care Score: 91.88%**

**3-Year Approval**

**January 1, 2012 – December 31, 2014**

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**Target Population**

The CareMore Health Plan (CHP) serves Medicare members who have end-stage renal disease (ESRD) and reside in one of CHP's service areas.

Among the ESRD population, the following co-morbidities exist: ischemic heart disease (80 percent), peripheral vascular disease (80 percent) clinical depression (30 percent) and risk factors for amputations (20 percent). Additionally, 95 percent have poor social support structure (e.g. home alone, no family or friends) and five to ten percent have substance abuse problems with narcotic and benzodiazepine habituation and/or alcoholism. A large population of these patients do not see their nephrologists or their primary care physician (PCP) on a regular basis, are not aware of the progression of their disease and are not engaged in 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 ESRD population: nurse practitioners (NP) who are specially trained in ESRD, diabetes and wound care management, nephrologists who act medical directors of CHP's ESRD management program, a CHP medical officer, CHP intensivists who work at CHP contracted hospitals, dietitians and fitness instructors. Additionally, CHP contracts with providers who work closely with the interdisciplinary care team (ICT): podiatrists and preferred specialists for ophthalmology, vascular surgery and orthopedic surgery. 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 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, an internist, nephrologists, vascular surgeons and vascular access providers, dialysis centers, case managers, fitness trainers, ophthalmologists, a social worker, a registered dietician, podiatrists, 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 intensivists 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 provided by all of CHP's providers (within and outside of the ICT). During formal ESRD 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/>