

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

Model of Care Score: 100.00%

3-Year Approval

January 1, 2015 – December 31, 2017

Target Population

The CareMore Health Plan (CHP) serves individuals who have Medicare and end-stage renal disease (ESRD). 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 spoken by CHP plans with Spanish being the next most prominent language spoken.

The SNP population includes 1,858 members with males outnumbering females (1,172 vs. 686) and the average age of members is 64 years. Among the SNP population, the following co-morbidities exist: 80 percent have ischemic heart disease or peripheral vascular disease, 20 percent have risk factors for amputations, 30 percent have clinical depression, 95 percent have poor social support structure and 5-10 percent have substance abuse problems with narcotic or benzodiazepine habituation and alcoholism. Those with multiple chronic conditions, including behavioral conditions, need chronic condition management, training on self-management technique and may also need integration of behavioral health coordination of services. A large number of members do not have formal education on how to manage and treat their chronic illness; do not see their nephrologists or PCP on a regular basis; are not aware of the progression of their disease and have unrealistic expectations; and finally, are not engaged in end of life planning.

Provider Network

The facilities included 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, vascular surgeon, nephrology, psychiatry, geriatric specialists, immunologists, speech pathologists, laboratory specialists, radiologists and podiatrists). The PCP has the primary responsibility to coordinate the member'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 in the member's home, assisted living center, board and care facility or telephonically. The collected data is integrated into the electronic health records system. At a minimum, the HRA is updated 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 with the member's vitals, labs, medical history and physical exam. In conjunction with the member, the NP documents the specific needs and goals 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 members with their input and that of the PCP, intensivists, case managers, fitness trainers, social workers, behavioral health, endocrinologists, nephrologists, podiatrists, ophthalmologists, vascular surgeons, dialysis centers and nurses, 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 condition 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>