H2593 CareMore Health Plan of Arizona 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 (CHP) serves individuals with Medicare who have diabetes mellitus (DM). 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 members with Spanish the next most prevalent language spoken.

There are 27,262 DM SNP members, with more female members compared to male members (14,061 vs. 13,201). The average age of members is 72 years. Members have the following co-morbidities: high blood pressure (50 percent), high cholesterol (80 percent), chronic kidney disease (60 percent) and heart disease (60 percent). Other chronic complications specific to members are blindness, nerve damage, stroke, heart attack and loss of circulation in arms and legs. The majority of members have poor nutritional status which can impact HbA1c levels and lead to neuropathic limbs that result in ulcers and amputations.

CHP recognizes members with DM need nutritional counseling, diabetic supplies, wound care and routine medical and podiatry care. Those with multiple chronic conditions including behavioral health conditions need chronic condition management and self-management education; and may need integrated of behavioral health care services. Many members do not know how to manage and treat their diabetes or understand how to manage their diet.

Provider Network

CHP's network includes 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.

The network also includes primary care physicians (PCP) and specialists such as pain management, behavioral health, cardiology, pulmonology, vascular surgeons, nephrology, psychiatry, geriatric specialists, immunologists, speech pathologists, laboratory specialists, radiology specialists and podiatry. The PCP has primary responsibility for coordinating members' 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) to assess members' medical, functional, cognitive and psychosocial needs. A number of other screenings as also conducted which include, but are not limited to depression, cognitive, community, fall risk, onsite lab testing, pain assessment scale and activities of daily living (ADL). The HRA is completed at a CHP care center, in the member's 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 a care transition.

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 needs and goals, considering the member's 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 a care transition.

Led by the NP, the interdisciplinary care team (ICT) coordinates the special needs of members with their input, and that of the PCP, extensivists who are board certified in internal medicine, case managers, fitness trainers, social workers, behavioral health, cardiologists, cardiology physician assistants 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