CareMore Operational Guidelines Amerigroup-TN December 10, 2014

CareMore Operational Guidelines- Amerigroup TN

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Welcome to the CareMore Model of Care. Our goal is to assist you in providing quality care to your patients while achieving better patient outcomes, better practice economics and streamlined care coordination. By furnishing the means to accomplish these ends and helping you and your patients access them, we are confident you will experience a sense of pride as a result of having coordinated with our Care Centers.

The CareMore model of care achieves improvement in health care delivery by the thoughtful implementation of added CareMore Care Center services such as our Diabetes Management Program, Asthma/COPD Program and Congestive Heart Failure Program, to name a few. These patient programs serve as tools that enable your patients to access high quality patient care. These services are highlighted in Section 1.6 of this Operational Guidelines Document. Take the time to review them and you will see how the integration of these services has the effect of alleviating certain demands on your practice while improving your patients' outcomes.

Our interdisciplinary team at CareMore looks forward to collaborating with you and your patients. Together we can improve the health and wellness of your patients. If you have any questions, please contact me at 901-425-1880, Monday through Friday, from 8am – 5pm (CST).

Respectfully,

George M. Mangle, DO

George Mangle, M.D.
CareMore Regional Medical Officer, Memphis, TN

1.1 CareMore History

- CareMore started as medical group with the philosophy of "putting our patients first", success allowed the medical group to start a health plan focused on comprehensive care under clinical modeling that embraced outcomes
- CareMore has extensive experience providing comprehensive benefits to over 80,000 complex patients from diverse cultural backgrounds, many of them dually eligible for Medicare and Medicaid
- Timeline:

    - *1993: Founded by doctors as a Medical Group*
    - *2003: Became a Health Plan*
    - *2007: Introduced Special Needs Plans*
    - *2008: Started expansion outside of Los Angeles County*
    - *2011: Acquired by WellPoint*
    - *2013: Expanded East-Ohio & Virginia*
    - *2014: Implemented Duals Demonstration*

1.2 CareMore Philosophy of Health Care

- Provide overtly coordinated care with a care path that takes into account patients' multiple conditions and treats them simultaneously
- A physical and human locus of care is required to create care coordination and a setting where care habits of patients can be sustained
- A complete care continuum requires equal attention to medical, social, psychological and pharmacological needs of the patient
- Clinicians in key roles must be confident generalists, persistent and deliberate, with competence as clinical decision makers, communicators and team players
- All providers of service have a buy-in for the system of care, not just their individual capabilities
- An obsessive attention to detail in both micro matters (individual care) and macro matters (care programs) permits optimal outcomes
- An explicit approach to care is required for each chronic condition, for high-frequency acute episodes, and for end-of-life
- A willingness to thoughtfully challenge the status quo provides windows of insight into clinical innovation and care pattern redesign which can optimize patient health and comfort, and conserve financial resources

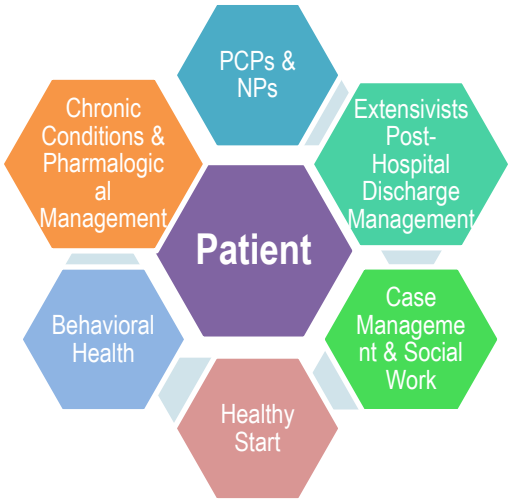
1.3 CareMore Patient Experience

- **CareMore Care Centers provide direct services, ensure access to care, and create security and customer loyalty**

- **Social Environment**
  - "Community link" for the patients and their family, including caregivers to community-based resources, services, and educators
  - Host classes and activities to promote patient and family engagement
  - Develop close patient and family relationships to help make informed decisions

- **Clinical Support**
  - Primary Care Services
  - Extended hours / days
  - Integrated Care Coordination
  - Care Management- Consistent monitoring of patients and intervention focusing on avoidable admissions and treating conditions

1.4 CareMore Model of Care



- There are three CareMore Care Centers across the greater Memphis metropolitan area to service Amerigroup members

Midtown area	**Hickory Hill area**	**Raleigh area**
1169 Jefferson Avenue Memphis, TN 38104 Phone #: 901-425-1880 FAX #: 901-725-5768 Hours of Operation: 7:30am-7pm CST, Monday-Saturday	6544 Quince Road Memphis, TN 38119 Phone #: 901-425-0190 FAX #: 901-624-6234 Hours of Operation: 7:30am-7pm CST, Monday-Saturday	2922 Covington Pike Memphis, TN 38128 Phone #: 901-425-0200 FAX #: 901-213-9868 Hours of Operation: 7:30am-7pm CST, Monday-Saturday

- A revolutionary approach to primary care delivery and access
- Care coordination for high-risk patients with chronic conditions
- Clinical leaders who are directly involved in care
- Collaborative communication with non-CareMore primary care providers (PCPs) regarding patients being treated in the care center to maintain medical home
- Multidisciplinary teams that deliver high-touch care and support
- Proven processes to deploy a rapid clinical response
- A broad scope of patient-centric programs
- Clinical interventions backed by evidence-based medicine; sourced from recognized organizations such as the U.S. Preventive Services Task Force (USPSTF) and the Agency for Healthcare Research and Quality (AHRQ), approved by the CareMore Quality Management Committee
- CareMore will follow TennCare guidelines and requirements as applicable

- Expect model to evolve as CareMore becomes integrated in the communities

1.5 CareMore Clinical Team

The Extensivist: Sometimes referred to as a "Hospitalist", these physicians act as the patient's attending physician of record while hospitalized in select facilities. The Extensivist services include:

- **Hospital Admissions:**
  - Manage patient hospitalization decision, take control of entire inpatient stay, including specialist consultation, diagnostics, PCP communication, family communication
  - Create and manage discharge plan by coordinating with CareMore case managers to review hospitalized patients and discuss and develop Hospital discharge plans
  - Admit the patients visiting Hospital Emergency Rooms to Hospital as medically necessary
  - **Communication with the Patient's PCP including the following:**
    - Upon Admission**:**
      - Extensivist call to PCP to notify of admission, status, and gather any additional pertinent medical information
    - Upon Discharge**:**
      - Phone call from Extensivist to PCP with discharge status and post discharge instructions
  - Additionally, Extensivist supporting the Case Manager will ensure that the History and Physical (H&P) and Discharge (DC) Summary is provided to PCP

- **Skilled Nursing Facilities (SNFs)**
  - Retain lead physician role during SNF stay
  - See the CareMore patients in the SNFs at least once a week until patients maintain a certain "skilled" level, which is normally from 1 to 2 weeks
  - **Communication with the Patient's PCP including the following:**
    - Upon Admission:
      - Extensivist call to PCP to notify of admission, status, and discharge plan
    - Upon Discharge:
      - Phone call from Extensivist to PCP with Discharge status and post discharge instructions
  - Additionally, Extensivist supporting the Case Manager will ensure that the H&P and DC summary is provided to PCP

- **CareMore Care Centers (Outpatient)**
  - Post Stabilization:
    - Patients will be followed in the clinic post discharge on an out-patient (OP) basis until acute episode or frailty resolves
    - Palliative Care - Guide and support transition to palliative care and end-of-life as appropriate
  - **Communication with the Patient's PCP including the following:**
    - OP Visit Notes from Extensivist for each patient visit – e.g. post discharge follow-up, patient status, treatment/care plan, referrals to other services or community resources

The Nurse Practitioner, A certified Nurse Practitioner (NP) is a registered nurse who is certified by the Board of Nursing and has been issued a certificate of fitness by the Board of Nursing. The NP delivers care within his/her scope of practice under the supervision of a physician who has expertise in the same area of medicine as the NP. The Nurse Practitioner services include:

- **Comprehensive Care**
  - Perform a comprehensive health assessment and identify preventive health measures to assess, evaluate and develop a plan of care with the patient to promote self-management skills to function to the best of their ability
  - Identify patients' health care needs, develop and provide a treatment plan in collaboration with members of the health care team
  - Identify psychosocial issues and modify interventions to support adherence to health care management
- **Chronic Care (*refer to CareMore Care Center Clinical Specialized Programs below*)**
  - Promote access to care to prevent acute episodes and limit adverse outcomes
  - Promote routine follow up to support the provision of optimal medical care
  - Manage chronic conditions and lead interdisciplinary teams specific to a patient's needs
  - Staff home wireless monitoring systems for specialty program management
  - Available for 24/7 telephonic patient consultation

- **Communication with the Patient's PCP including the following:**
  - OP Visit Notes from the NP to PCP for each visit, includes treatment plan, care plan, referrals to other services and community resources as needed, chronic condition program visits- e.g. Diabetes, Asthma

Case Management, Case Managers are nurses who collaborate with PCPs and other teams members as needed, to develop individual patient centric care plans that support the overall goals of the patient. Case Managers represent the link between the patient and the multitude of providers by coordinating services. The Case Management services (in collaboration with Amerigroup Case Management) include:

- **Acute Episodes**
  - Take "ownership" of patient at point of admission
  - Prepares patient and family for discharge
  - Stays in close contact with patient and family post discharge to ensure all needs are met
  - Arranges, coordinates and follow-ups on all services necessary to avoid readmission
- **Long term management**
  - Provides on-going evaluation and education in conjunction with patients, their families and/or caregivers
  - Coordinates and follows-up on home-based services as needed
  - Facilitates CareMore Care Center (CCC) and other necessary visits
  - Facilitates transportation and other social services
  - Able to deploy Social Worker resources to support compliance and adherence with care plan
- **Communication with the Patient's PCP including the following:**
  - Case Management will outreach to PCP to request records, as needed
  - History & physical and discharge summary faxed to PCP
  - Discharge notification faxed to PCP
  - Case Management will phone PCP's office to schedule patient's next PCP appointment following discharge

1.6 CareMore Care Center Specialized Program Descriptions

- **Healthy Start Program**
  - Qualifications: Healthy Start assesses patients using a comprehensive evaluation thereby identifying patients' medical history, psychological, psychosocial, and functional needs as well as a comprehensive physical exam.
  - Evaluation of medications, on-site lab results; head-to-toe comprehensive assessment of chronic conditions specific to the patient's needs and directly enroll in other Clinical Programs and other necessary services.
  - Development of patient specific care plans that establish goals and objectives, identify interventions, recommend benefits and services and measures outcomes
  - CareMore's clinical team makes specific recommendations and tailors a plan to meet the patient's individual needs. At the end of the Healthy Start visit, the patient is provided with a personalized care plan that summarizes the patient's overall health status and includes preventive as well as proactive recommendations to be addressed in the patient's follow-up care.
  - **Communication with the Patient's PCP including the following:**
    - A copy of the patient's personalized care plan is forwarded to the patient's PCP so that everyone involved knows exactly what the patient needs along with OP visit note

- **Diabetes Management Program**
  - Qualifications for participation in the program: Difficult to control blood sugar, despite usual treatment plan; usually continued HgBA1C>8.5; Patients requiring initiation of insulin; Patients who would benefit from Diabetes education will receive diabetes & nutrition education only
  - Comprehensive assessment of patient's medical history, medications, dietary, exercise, social history, self-care beliefs, barriers to learning, lifestyle and other factors that may interfere with adherence to treatment plan
  - Development of patient specific care plans that establish goals and objectives, identify interventions, recommend services and benefits, and measure outcomes
  - On-going monitoring and evaluation of patients with high blood sugar levels
  - Comprehensive evaluation of patients having difficulties with insulin levels
  - Monitoring lab values to guidelines: HgBA1c, micro albumin, lipid panel
  - Perform regular foot exams and foot care, including nail trimming
  - Provide information on community resources and support groups

- Education regarding the state and progression of the disease, symptoms, treatment, patient self-management, and extensive dietary counseling
- **Communication with the Patient's PCP including the following:**
  - OP Visit Notes from the NP to PCP for each visit; including treatment/care plan

- **Wound Care**
  - Qualifications for participation in the program: Any active wounds
  - Aggressive management of wounds, which includes frequent and unlimited treatment and evaluation
  - Evaluation including monofilament testing, foot temperatures, ABIs, monitoring of wounds with pictures and measurement
  - Comprehensive assessment of causative factors such as: co-morbid conditions, diet or nutritional habits, psychological issues
  - Development of patient specific care plans for continued wound management
  - Self-management skills to educate patients and care givers on home wound care management, prevention of injury, lifestyle and diet
  - **Communication with the Patient's PCP including the following:**
    - OP Visit Notes from the NP to PCP for each visit; including treatment/care

- **Congestive Heart Failure (CHF) Program**
  - Qualifications for participation in the program: All CHF diagnosis
  - Comprehensive assessment of patient's medical history, stage of congestive heart failure, medications, dietary, exercise, social history, self-care beliefs, barriers to learning, lifestyle and other factors that may interfere with adherence to treatment plan
  - Evaluation and ordering of diagnostic tests, procedures and laboratory findings
  - Development of patient specific care plans for continued monitoring, medication management, weight maintenance and overall health maintenance
  - Patient given a wireless IdealLife scale for use at home for on-going monitoring of patient's weight and symptoms of CHF; alerts are acted upon and interventions coordinated with Cardiologists

- Education regarding the state and progression of the disease, symptoms, treatment, patient self-management, and extensive dietary counseling
- **Communication with patient's PCP including the following:**
  - Wireless Monitoring Communications
    - Notifications
    - Medication Change
    - Enrollment
    - Patient Enrolled but not Participating
    - Patient Refusal
    - Patient Disqualified (e.g. signed on with hospice, atrial fibrillation)
    - Unable to Contact Patient
    - Patient Discharged
  - Reports
    - **Hypertension Monthly Report, includes:**
      - Medication list
      - Blood pressure readings
    - **CHF Monthly Report, includes**:
      - Medication list
      - Summary of alerts
      - Weight readings

- **Asthma / Chronic Obstructive Pulmonary Disease (COPD) Program**
  - Qualifications for participation in the program: All Asthma/COPD diagnosis
  - Comprehensive pulmonary assessment and management of patient's disease state, including monitoring of diagnostic data, and spirometry to determine lung age and disease progression and medication management
  - Self-management skills training to lessen the impact of the disease and improve quality of life; how to deal with complications; coping with asthma and COPD; lifestyle, breathing, and dietary changes; enhanced nutritional training
  - Education regarding asthma and the state and progression of COPD disease
  - Patient provided with pre-printed prescriptions for antibiotics and steroids to catch flare up of COPD early
  - **Communication with the Patient's PCP including the following:**
    - OP Visit Notes from NP to PCP for each visit; includes treatment/care plan

- **Other Misc. Programs**
  - Fall Clinic
    - Qualifications for participation in the program: History of any falls, appears as a fall risk, very unsteady gait
    - Extensivist evaluate patients in the clinic and develop appropriate plan of care
  - Frail Patients (not followed under other CareMore Programs)
    - Qualifications for participation in the program: Patients Post hospitalization and those with continued risk for readmission; High probability of hospital admission in the next 6 months; Significantly more confused; Appropriate for SNF or Assisted Living placement
  - Extensivist evaluate patients in the clinic and develop appropriate plan of care
  - **Communication with the Patient's PCP including the following:**
    - OP Visit Notes from to PCP for each visit; includes treatment/care plan

- **Behavioral Health**
  - Qualifications for participation in the program: Major Depression; Dementia; Alcohol or substance abuse and other psychiatric illnesses (e.g., bipolar, schizophrenia)
  - Provides general psychological / psychiatric care and treatment to patients in the care center
  - Performs mental status examinations, therapy, medication management, and preventive health measures
  - Records physical findings, and formulates a plan and prognosis, based on the patient's condition
  - Discusses case with the Physician and other health professionals to prepare a comprehensive patient care plan
  - Patient Education is an important part of the psychiatric treatment, by utilizing teaching learning theory with the patients and their families to influence outcomes. and also educate their patient on self-management
  - Review medications with patients, including how to use the medications properly; possible side-effects, what the medications are for and what the medications do for them
  - **Communication with the Patient's PCP including the following:**
    - OP Visit Notes to PCP for each visit; includes treatment/care plan

- **Social Worker Support-** Licensed professionals who work in tandem with the case management team and other members of the patient's health care team.
  - Qualifications for participation in the program: Elder abuse, Complex social issues impacting health (e.g., unable to care for self, placement issues, financial issues, care plan non-compliance, alcohol or substance abuse, or suspicion of poor family support/dysfunction, medical and/or physical decline in health status)
  - Coordination of access to medical and behavioral health services, education, financial and social support, and interventions significantly to decrease challenging barriers and the risk of hospitalization
  - Bring community resources into their home to support their activities of daily living such as: meals on wheels, financial benefits, transportation needs
  - Address psychosocial needs, suspicion of issues of poor family support, abuse, or family dysfunction and take appropriate action
  - Assist with placement if patient feeling unsafe living at home
  - Assess for barriers to non-compliance with care plans, frequently missed medications, or frequently missed appointments

1.7 How to Make a Referral to CareMore Clinical Services

Amerigroup Providers can refer their patients to the CareMore Clinics for specialized clinical programs. Phone calls or faxes to the centers are acceptable and must at a minimum, include the following information:

- Patients full name
- Address
- Phone number and alternate number if available
- Date Of Birth (DOB)
- Amerigroup member ID
- Referring providers full name, address & telephone number
- Requested service and diagnosis
- Pertinent clinical information

- Note: CareMore, at its discretion, may require the use of a form made available by CareMore for referral notification

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***Closed Sundays and the following holidays: July 4, Thanksgiving, Christmas and New Year's Day.