

Universal Care, INC., H0838
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 80.63%

2-Year Approval

January 1, 2014 – December 31, 2015

Target Population

Brand New Day (BND) is a Chronic Care Special Needs Plan (C-SNP) for individuals with a diabetic condition. To qualify for the C-SNP, potential members need to have a diagnosis of type 2 diabetes from a qualified medical professional. BND focuses on care for adults over the age of 65 who reside in California. Estimations by the plan show that over 13.5% of the California adult population over 65 has diabetes.

Type 2 diabetes accounts for 90-95 percent of all California diabetes cases. Risk increases with age, obesity and a sedentary lifestyle. Diabetes also causes health complications, such as heart attacks, stroke, blindness, kidney failure and peripheral neuropathy. The most common comorbid conditions/diseases for diabetics at Brand New Day are: congestive heart failure, cerebrovascular disease, chronic obstructive pulmonary disorder, renal failure, hypertension and hyperlipidemia.

Provider Network

Brand New Day has a special network of providers with expertise in diabetes care. The plan assigns a designated primary care provider (PCP) to all members who enroll with the plan. BND requires each PCP to have documented experience in treating diabetic patients and each provider must agree to comply with: the BND Diabetic Model of Care, the BND American Diabetes Association (ADA) treatment guidelines and the BND Diabetes Care Management Matrix. Additional support for members who require it comes from other specialties within the provider network. The network consists of: nurse complex case managers, health coaches (assigned to all members within 30 days of enrollment on the plan), hospitals and skilled nursing facilities.

The plan's matrix of providers includes practitioners and providers in other specialties that treat members with complex conditions who require additional medical services. Other providers utilized consist of: nutritionists, exercise counselors, community support groups, behavioral health providers, palliative care physicians, durable medical equipment (DME) and pharmacies. In addition, BND contracts with other specialists on an as needed basis for members who require further assistance.

Care Management and Coordination

BND assigns a registered nurse complex case manager (RN CCM) to each member upon enrollment. Enrollment staff schedules a first appointment for the member with the RN CCM. During the first (telephone) meeting, the RN CCM conducts the intake, which includes completing the health risk assessment (HRA). The RN CCM and member complete the initial HRA together and jointly develop the first individual care plan (ICP) during the telephone intake meeting. The member's intake includes an assessment of his/her support system and living situation.

The RN CCM acts as facilitator for the interdisciplinary care team (ICT) and accepts responsibility for sharing and coordinating with the ICT members. The RN CCM ensures input from ICT members gets incorporated into the ICP in a timely manner. The composition of the ICT takes into account the medical condition of each member and consists of a core team that includes: the RN CCM, health coaches, social services experts, pharmacists, field intervention nurses and the member. Other specialties are added to the ICT on an as needed basis, in accordance with the member's unique needs.

The member is the key stakeholder in the ICT (or caregiver/health coach representing the member if he/she does not or cannot participate). The assigned health coach strives to involve the member in the ICT meetings by telephone. The case manager contacts the member regularly to discuss the care plan and consider the member's individual needs based on his/her condition. The case manager and member discuss plans for meeting care goals. A member actively participates in the development of the ICP based on his/her physical and/or psychosocial capabilities and indicates whether he/she agrees with the care plan.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.brandnewdayhmo.com