Universal Care, H0838
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 86.88%
2-Year Approval **January 1, 2013 – December 31, 2014**

Target Population

Universal offers a special needs plan (SNP) known as Brand New Day (BND) to dual eligible members in five counties in Southern California: Kern, Los Angeles, Orange, San Bernardino, and Riverside. Caucasians comprise the largest percentage of the population in each of these counties followed by Hispanics in all counties but Los Angeles. The populations covered in these counties tend to be lower income than the median. In one county, 27.1% of the membership is at the federal poverty level. The following have been identified as prevalent diseases and health conditions for the members: cardiovascular disease, chronic heart failure, chronic obstructive pulmonary disorder, hypertension, diabetes mellitus, obesity, alcohol or other drug abuse and/or dependence, mental illness and poor dental health.

Provider Network

Along with primary care physicians (PCPs) and the usual specialists, BND ensures adequate numbers of the following are available to meet members' needs: cardiologists, pulmonologists, endocrinologists, nutritionists, psychiatrists, clinical psychologists, marriage and family therapists, certified addiction specialists, clinical pharmacists, registered nurses (for telephonic complex case management), field intervention nurses (LVNs to do routine care in homes under doctor's orders and within an LVN scope of license), home health agencies, skilled nursing facilities and nursing facilities, residential drug/alcohol treatment/rehabilitation, hospitals, psychiatric hospitals, durable medical equipment suppliers and other providers.

BND's life coach helpers (behavioral health case managers) also coordinate services for members through community resources such as: State funded waiver programs, a community assessment service center, the Department of Mental Health, Shelter Plus Care, Salvation Army, Goodwill Industries, missions, churches, synagogues and other entities.

Care Management and Coordination

The PCP administers a health risk assessment (HRA) face-to-face within the first 90 days of a member's enrollment and within 12 months of the previous assessment. A psychiatrist or licensed clinical social worker (LCSW) also completes a psych intake to assess members' social, emotional, financial, behavioral health needs, pain experience, activities of daily living and quality of life within the first 30 days of enrollment. The SNP incorporates this information into its case management database and uses it to determine the member's risk level and potential for hospitalization.

Data and information for the individual care plan (ICP) come from a variety of sources, but primarily from the usual providers who provide input from the member. The ICP takes into account many facets of medical care and incorporates the following data points: the case management database, predictive modeling data, member surveys (such as the health risk assessment), encounter/claims data and utilization information. Members receive input into their care plans from visits with their life coach, PTP and PCP. The ICP furnishes a history of the member's care, medications, treatments, tests results and information on his/her risk level to providers. BND combines all of this information electronically to create an ICP that the interdisciplinary care team (ICT) uses to direct care for members.

BND conducts ICT meetings with the member's usual provider and staff. BND determines the composition of the ICT based on information in the care plan. The core network for the ICT consists of the: PCP, PTP, social workers, life coaches, specialists and facilities (e.g., hospital and skilled nursing facility) BND encourages the member to participate in the ICT. However, due to mental illness and conditions such as paranoia and anxiety, the life coach acts as the member's representative at the care team meetings.

This ICT is also the "crisis team" for the member. Mentally ill members have more crisis episodes than other Medicare members. The BND Quality Council (QC) determined that those who know the member the best are the ones who should participate in the ICT. The QC also adds additional BND staff members to the ICT to help brainstorm and determine how to improve outcomes, reduce avoidable (unplanned hospitalizations) and offer recommendations that may not have been tried.

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