Bravo Health, H2108, H3949, H4528
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 95.63%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Bravo Health established the chronic condition special needs plan (C-SNP) to serve members who are living with diabetes mellitus. It recognizes that this population has significant health care considerations that are different from the regular Medicare population. In addition to diabetes, the top health conditions experienced by this population are congestive heart failure, renal failure, coronary artery disease and other cardiac conditions. Almost all members in this program have more than one health condition and average 40 prescription fills per year, as well as a higher incidence of hospital admissions.

Provider Network

Bravo Health offers members access to a network of contracted facilities, primary care and specialty care physicians, behavioral health, mental health and alcohol and substance abuse specialists, as well as a complete ancillary care network. Specifically, Bravo Health has made efforts to provide more than the minimum required providers for the following specialty types: Board-certified cardiology, endocrinology, nephrology, ophthalmology and pulmonology specialists. In addition to these specialists, Bravo Health ensures that its network includes additional podiatrists, orthopedic surgeons and vascular surgeons to provide quality of care to diabetic members. Bravo Health also operates a series of Advanced Care Centers, staffed with physicians and other clinical staff members, who are able to provide a large array of services for both walk-in and scheduled appointment needs. Bravo Health requires that members receive a referral for specialist care from their primary care physician (PCP). They also encourage members to first see their PCP for routine health needs or care that is not an emergency.

Care Coordination

The health risk assessment (HRA) is a comprehensive assessment of the medical, psychosocial, cognitive and functional needs of the member and includes medical and mental health history as well as environmental influences. The tool is intended to identify the care needs of the member upon enrollment and on an annual basis for all enrolled members. The initial assessment is sent to each member in the Welcome Packet and the HRA is incorporated into the member newsletter that is sent out to all renewing SNP members at the beginning of each year. HRAs may be completed by mail, telephone or in person by a healthcare professional. In addition to a physical HRA, Bravo Health staff use the SF-8 survey tool to conduct risk assessments via phone. These assessments help identify whether a member requires care management or home and community-based services.

The individualized care plan (ICP) is a collaboration between Bravo Health, the member and his or her health care providers and representatives. The responses to the HRA and additional data tools, such as administrative assessments, mail and phone surveys and clinician-delivered assessments are used to formulate a plan of care. The ICP is developed and also updated/refined by the case manager with each member contact. The essential elements of the ICP are the risk stratification level that provides information on the relative priority of the case, member-specific care gaps that focus on specific member education issues, clinical and drug compliance problems and important non-clinical barriers that may complicate member care and case manager notes. The ICP is updated on an ongoing basis and the member may be reassessed when they have a significant change to their health status, environment or utilization patterns.

Bravo Health's interdisciplinary care team (ICT) was developed to ensure efficient coordination of care, especially for any care transitions. The core team consists of a medical director, case manager, licensed social worker, behavioral health case manager, inpatient nurse reviewer, precertification nurse and managerial staff. Team members are selected based on their functional roles and knowledge of the member population. The core team is supplemented on a case-by-case basis by network providers with skills matched to the unique needs of the member, office based Bravo Health practice coordinators, behavioral health and substance abuse specialists, clinical pharmacists, member services representatives, family member and caregivers. ICT clinical rounds are conducted four times per week to discuss specific member needs.

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: