

**PEDIATRIC CARE NETWORK
CARE INTEGRATION PROGRAM DESCRIPTION**



**CARE INTEGRATION
PROGRAM FOR CARE
COORDINATION AND DISEASE
MANAGEMENT IN MISSOURI**

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Annotated against 2017 NCQA Health Plan Standards, Guidelines and Procedures

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I. INTRODUCTION

A. PROGRAM DESCRIPTION

The Pediatric Care Network (PCN) offers a comprehensive care integration program, consisting of care management/coordination (CM/CC) and disease management (DM) to eligible members. The care integration program focuses on preventive health while enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring and coordinating services and resources needed by members and families ; facilitating care transitions across care settings; ensuring and facilitating the achievement of quality, clinical and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality or cost impact and creating opportunities and systems to enhance outcomes. Through data analysis and identification of high cost or high risk trends, PCN continually assesses the characteristics and needs of the population and sub-populations being managed to identify opportunities to enhance and/or modify its care integration program. This includes children with special needs, disabilities, and other complex health issues. Disease management interventions focus on two chronic conditions that are relevant to the pediatric population; asthma and diabetes. PCN assesses all program interventions and resources to determine if changes are needed to better meet the needs of the population and ensure the patients receive well-coordinated care along the health care continuum while promoting quality care through appropriate, cost effective interventions.

B. PROGRAM GOALS

The goal of the care integration program is to help members sustain or regain optimal health in the right setting and in a cost effective manner. This is achieved through the well-coordinated efforts between the program staff and patient centered medical home practices utilizing multiple disciplines, including PCP aligned care teams. Including the primary care providers (PCP) in this integration assures continuity of care and alignment for improving health outcomes. The Care Integration staff work closely with the PCP's to assess the population's needs, determine available benefits and resources, and develop and implement specific interventions to meet the population needs. (See Local Community Care Coordination Program; LCCCP guide)

C. PROGRAM OBJECTIVES

The objectives of the Care Integration program are to:

- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- Promoting strong member/Primary Care Provider relationships for coordination and continuity of care, using Patient Centered Medical Home concepts
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services
- Promote clinical care that is consistent with scientific evidence and member preferences
- Ensure the integration of medical and behavioral health services
- Educate members in self-advocacy and self- management
- Minimize gaps in care and encourage use of preventive health services
- Achieve cost efficiency in the provision of health services while maximizing health care quality
- Mobilize community resources to meet needs of members

D. CLINICAL PRACTICE GUIDELINES/EVIDENCE-BASED PRACTICE

When conducting education, member assessments, activities and interventions, PCN utilizes evidence-based guidelines as a foundation, including Milliman Care Guidelines (MCG), guidelines adopted from various national resources, such as the American Academy of Pediatrics, the Case Management Society of America's (CMSA's) standards of practice along with standardized nursing protocol for assessment,

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planning, intervention, and evaluation, etc. PCN updates its guidelines to reflect modifications made to the guidelines based on the availability of newly developed guidelines or modifications to existing guidelines. The PCN also distributes evidence-based guidelines for practice to providers through its website and educates the providers about the availability of those guidelines through regular newsletters. The evidence-based guidelines adopted by the PCN are reviewed and approved by the Clinical Quality Committee (CQC) at least annually

E. CULTURAL COMPETENCY

PCN ensures that its programs and services are accessible to the diverse membership we serve. All Care Integration staff is trained for cultural competency at least annually to ensure ongoing education about cultural needs of the population served and how practices and beliefs affect healthcare outcomes. In addition, interpreter services and resources are available to staff, members and their families when communicating via phone or in person, as needed.

F. PROGRAM STAFF AND RESPONSIBILITIES

The PCN's Care Integration staff consists of multiple disciplines including nurses, social workers, respiratory therapists, certified asthma and diabetes educators, physicians and non-clinical staff. The primary roles within the Care Integration team working directly with patients, caregivers, and community providers are detailed below. (See LCCCP program guide for scope of practice)

Care Facilitation Coordinators:

Care Facilitation Coordinators are trained administrative staff who serve as the front lines in answering provider calls and faxes into the Care Integration department. They assist with entering prior authorization information, screening pregnancy notification forms, facilitating referrals to home care agencies, and assisting the PCP aligned care teams with other duties to support functions within the department.

Care Navigators:

Care Navigators are licensed Registered Nurses or Social Workers whose primary role is to provide care coordination for identified at-risk members, addressing barriers to care for an assigned population of patients and primary care practice(s). The Care Navigator provides care coordination services in order to make sure that patients receive well-coordinated care along the health care continuum and promotes quality care through appropriate, cost effective interventions.

Care Navigators follow a process of assessment, barrier identification, care planning, and ongoing re-evaluation of progress to ensure medical, social, and behavioral needs of the patients are met. This process centers on facilitating the development of patient-centric goals, communicated with the entire care team, to help drive care team interventions and activities toward attaining optimal patient outcomes. The Care Navigator assists not only patients and families with navigation of the healthcare system, but also supports Primary Care Providers and their staff in navigating complex medical systems and facilitating access to community resources for patients and families.

Practice Facilitation Specialists:

Practice Facilitation Specialists are licensed Registered Nurses or Respiratory Therapists who work closely with Primary Care Provider practices to facilitate practice transformation and support practice management processes aimed toward improving patient outcomes. Practice Facilitation Specialists use evidence-based guidelines and best practices as a basis for teaching chronic disease management, wellness promotion, and patient-centered medical home (PCMH) concepts. Their role includes promoting a culture of learning and quality improvement (QI) within practices and providing coaching to support transformation and sustained change within the PCP practice as well as the PCP aligned care team.

Community Resource Specialists:

Community Resource Specialists work as members of the care team to support population health initiatives and care coordination while supporting the care team with delegated utilization management functions..

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This position works closely with all areas of the PCN and its stakeholders, including providers, patients and families, community agencies, and other health care professionals.

II. IDENTIFYING MEMBERS FOR CARE INTEGRATION PROGRAMS:

Comment [C1]: QI 6.H.1-4

PCN uses internal and external referrals to identify potential members needing care integration services. Identification can occur at any time during the member's eligibility with the PCN. Upon referral, care integration staff assess the member's eligibility for participation in one of the care integration programs and conduct follow-up outreach to the member/caregiver(s) and his/her referring provider as applicable. Health plan referrals will be addressed within 1 business day by a care team member.

Referrals may come from but are not limited to:

- Health Risk Assessment from Health Plan enrollment process
- Predictive modeling report
- Disease management registry
- Any PCN staff (i.e., Care Integration staff, Provider Relations, etc.)
- The member's Health Plan staff (i.e. Quality Management, Customer Service, Health Appraisals, etc.)
- Review of daily census reports and chart review at hospitals
- Providers – educated through Health Plan provider newsletters, the PCN or Health Plan websites and the PCN provider educational materials
- Community Agencies – educated through the PCN and Health Plan websites, outreach events, and targeted education events
- Local Health Departments – educated through the PCN and Health Plan websites, outreach events, and targeted education events
- Internal encounter/claims/pharmacy/lab data – through the use of automated trigger reports generated monthly and EHR data, when available
- Nurse Advice Line
- Member self-referral – educated through Health Plan Member Newsletters, the PCN and Health Plan websites, and the Health Plan Member Handbook
- Transition of care from another Health Plan or FFS program

Comment [ML2]: QI 6.B.5

Comment [C3]: QI 6.B.3

Comment [C4]: QI 6.B.8

Comment [ML5]: QI 6.B.1 and 2 and QI 6.B.4 and 7

Comment [C6]: QI 6.B.8

PCN uses proactive approaches to screen for population health opportunities. Using encounter data, reports are generated on a routine basis either daily, weekly, monthly or quarterly depending on the type of report. Members are contacted either by mail or phone identifying them as a possible candidate for care integration services.

A. PREDICTIVE MODELING REPORTS

- a. **ER report** – High ER utilizers are identified monthly on a predictive modeling report and outreach is made to members who have had 3 or more Emergency Room (ER) visits in a quarter.
- b. **High Cost report** - A monthly report that identifies medically complex members with significant utilization.

B. HOSPITAL CENSUS REPORT

A report is generated each day detailing the inpatient hospital census. The report is reviewed daily by the care team to assess for hospital stays in excess of 14 inpatient days and re-admissions within 30 days. Cases identified are followed by a Care Navigator for further interventions.

C. TRANSITIONAL CARE PROGRAM

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Based on established criteria including :1) re-admission to the hospital within 30 days with same or similar diagnosis, 2) inpatient stays greater than 14 days, and 3) all medically complex children, cases are reviewed for transitional care coordination by the aligned PCP care team. Within 1-3 days of discharge from an inpatient facility, members meeting the criteria receive a post-discharge screening and education call. If barriers are identified on the initial call which could impact a member’s ability to be successful in their transition to home, the member is referred for subsequent follow-up at 10-14 days post-discharge and may be followed by the PCP aligned care team. The goal of the Transitional Care program is to reduce post-discharge ER visits and readmissions for same/similar diagnoses and to assist members and their caregivers in being successful with their transition to home and follow up care.

D. DISEASE MANAGEMENT REGISTRY

A monthly registry is produced identifying and stratifying members with asthma and diabetes as low, medium or high risk based on medical and pharmacy claims. A report is generated from the registry each month identifying new members or those that have had a change in risk level (low to medium risk or medium to high risk). All members on this report are automatically referred to the aligned PCP care team for further assessment.

Comment [ML7]: QI 6.B

ASTHMA RISK STRATIFICATION		
Activities Previous 12 Months	Points Per Activity	Initial Risk Category
Emergency Department Visit in Past 12 Months	1 point/asthma visit	Low: 0-3 total points
Hospitalization in Past 12 Months	2 points/asthma visit	Medium: 4-6 total points
Any Oral Corticosteroids in Past 12 Months	1 point	High: ≥ 7 total points
≥ 8 Short acting Beta 2 Agonist Canisters in Past 12 Months	1 point	

DIABETES RISK STRATIFICATION		
Activities Previous 12 Months	Points Per Activity	Initial Risk Category
One ED visit within the previous 12 months	1 point/diabetes visit	Low: 1 total points
Member on insulin/hyperglycemic	1 point	Medium: 2-3 total points
Hospitalizations in the previous 12 months	2 points/diabetes visit	High: ≥ 4 total points

E. PREGNANCY SCREENING

Pregnancy Notification Forms, sent to the PCN by providers, are screened by the care teams. High risk pregnancies, as defined by PCN, are referred through the online documentation system (CARE Web) to a

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care team. A letter, including prenatal education literature, is sent to all pregnant members offering care coordination.

High Risk OB Indicators used to refer members to care teams include:

- a) Age 16 and under
- b) Fetal anomalies (current)
- c) Placenta previa (current; do not refer for low lying placenta)
- d) History of PIH, HELLP or fatty liver of pregnancy
- e) Chronic medical conditions that are being aggressively treated
- f) Multiple birth pregnancy (current)
- g) Hyperemesis gravidarum
- h) History of previous stillbirth or fetal/infant death
- i) Grand multiparity of 9 or more pregnancies
- j) Hemoglobinopathy (i.e.: sickle cell anemia (not trait), thalassemia major)
- k) Incompetent cervix (history/current)
- l) Current or history behavioral health diagnosis (i.e.: depression, bipolar, anxiety, OCD, schizophrenia) and/or substance use (i.e.: illicit drugs-including marijuana, cocaine, meth, etc. and alcohol)
- m) Current STD (syphilis, gonorrhea, chlamydia, herpes (HSV), HPV, and trichomonas) along with any other risk factor (if STD is the only risk factor, the case is not referred)
- n) HIV
- o) History of preterm labor
- p) Domestic violence (current)
- q) Current or history of diabetes
- r) Hypertension (history/current)
- s) Asthma
- t) Any provider request for care coordination or an outreach call to member

The Pregnancy Notification Report is another method used to capture pregnant members. This daily report identifies newly pregnant members by an ME code or Pregnancy Notification Form (PNF). The care team monitors this report and creates a task on the members that have not been screened. Within 15 days from the PCN being notified of the pregnant member, the care team makes at least three (3) phone call attempts, followed by a letter and attempts to obtain contact information from the member's provider (OB, PCP or ancillary providers) in an effort to complete a pregnancy risk screening. After these efforts have been exhausted and if the care team is still unable to reach the member, outreach efforts may cease.

III. CARE COORDINATION PROCESS

A. CARE INTEGRATION DOCUMENTATION SYSTEM (CARE WEB)

PCN's care integration program has defined practices and standards for member care planning, identification of prioritized goals and documentation criteria. The care planning process is supported real-time through regular round table discussions with the PCN Care Integration management team and Medical Director(s).

The CARE Web system has the following automated features:

- Date, time, and user stamp for each entry
- Tasks – a message that the care team uses to remind him/her of a specific task
- Outreach task lists and routing of cases between Care Integration staff members
- Care Plans
 - Barriers, Interventions & Prioritized Goals
 - Member Self-Management Plans
- Message Alerts

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B. ONGOING MONITORING AND EVALUATION

Comment [CR8]: QI 6.A.7

Care Integration Program	Interventions
Care Coordination and Disease Management	<ul style="list-style-type: none"> Review of data and information about the member's current medical status, including medical record review, psychosocial history, prescription usage and authorization/claim history Outreach/Screening Identification of barriers to care Gaps in care education Formulation of the care plan including prioritized, patient-centered goals and member self-management plans Situation ,background assessment/response (SBAR) notes/plans including barriers, interventions, goals and self-management plans Chronic condition monitoring Individualized member education and coaching to self-manage their condition and access community resources Referrals to community resources (using the web based application resource) Face to face encounter with the member Coordination of services with the member and the multidisciplinary team Encourage & Facilitate well-child visits, annual screenings and immunizations Post-discharge follow-up calls Case discussion during care team huddles PCN health literature mailed and reviewed with the member

Comment [SW9]: QI 6.A. 2 and 3

Comment [SW10]: QI 6.A.1

Comment [SW11]: QI 6.A.4

Comment [SW12]: QI 6.A.9

Comment [SW13]: QI 6.A.7

Care Integration Program	Interventions
Asthma Disease Management	<p>Low Risk (0-3 points)-Targets those with intermittent asthma and well controlled asthma.</p> <ul style="list-style-type: none"> Initial disease-specific and program information mailed to member and provider – encouraging members to communicate with their provider(s), explaining how to access and utilize the program resources, how the member was identified for the program, and how to opt out of the program Maintain members in disease management registry Monitor for risk level changes
	<p>Medium Risk (4-6 points)-Targets those with not well controlled asthma.</p> <ul style="list-style-type: none"> Initial disease-specific and program information mailed to member and provider – encouraging members to communicate with their provider(s), explaining how to access and utilize the program resources, how the member was identified for the program, and how to opt out of the program Spring/Fall outreach mailings to facilitate scheduling of provider appointments and medication adherence Disease and age specific health literature: <ul style="list-style-type: none"> Early Warning Signs of Asthma Kids early warning signs of asthma

Comment [ML14]: QI 6.A.8 and D.1-3 and G.1-2

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	<ul style="list-style-type: none"> ○ Asthma Medications ○ Asthma Action Plan • Depression screening by a care team member and behavioral health referral if indicated. • If the member had a change in risk level from low to medium, a task is generated to the appropriate care team. <p>High Risk (≥ 7 points)-Targets not well controlled asthma and poorly controlled asthma. In addition to the interventions listed for medium risk, the following interventions are also applied to this risk group.</p> <ul style="list-style-type: none"> • Initial disease-specific and program information mailed to member and provider– encouraging members to communicate with their provider(s), explaining how to access and utilize the program resources, how the member was identified for the program, and how to opt out of the program • All members are referred to the assigned care team care coordination interventions • Individualized treatment plan is developed by Care Navigator and member • Collaboration with the PCP to increase member engagement with the PCP • Depression screening by a care team member and behavioral health referral if indicated. • If the care team cannot reach the member, a referral is sent to a home visiting agency for telephone and drive-by attempts to engage with the member.
<p>Diabetes Disease Management</p>	<p>Low Risk (1 point)-Targets those with a diabetes diagnosis.</p> <ul style="list-style-type: none"> • Initial disease-specific and program information mailed to member and provider– encouraging members to communicate with their provider(s), explaining how to access and utilize the program resources, how the member was identified for the program, and how to opt out of the program • Maintain members in disease management registry • Monitor for risk level changes
	<p>Medium Risk (2-3 points)-Targets those with not well controlled diabetes.</p> <ul style="list-style-type: none"> • Initial disease-specific and program information mailed to member and provider– encouraging members to communicate with their provider(s), explaining how to access and utilize the program resources, how the member was identified for the program, and how to opt out of the program • Disease and age specific health literature: <ul style="list-style-type: none"> ○ Type 1 Diabetes Mellitus <ul style="list-style-type: none"> ▪ What is Type 1 diabetes ▪ DKA Prevention ▪ Carb Counting ○ Type 2 Diabetes Mellitus <ul style="list-style-type: none"> ▪ 7 Healthy Tips ▪ Physical Activity ▪ Type 2 Diabetes in Preteens and Teens • Depression screening by a care team member and behavioral health referral if indicated. • If the member had a change in risk level from low to medium, a task is generated to the appropriate care team.
	<p>High Risk (≥ 4 points)-Targets those with poorly controlled diabetes. In</p>

Comment [ML15]: QI 6.A.5 and 6

Comment [ML16]: QI 6.A.5 and 6

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	<p>addition to the interventions listed for medium risk, the following interventions are also applied to this risk group.</p> <ul style="list-style-type: none"> • Initial disease-specific and program information mailed to member and provider– encouraging members to communicate with their provider(s), explaining how to access and utilize the program resources, how the member was identified for the program, and how to opt out of the program • All members are referred to the appropriate care team for care coordination • Individualized treatment plan is developed by the Care Navigator and member • Targeted mailing of additional resources • Referral to community-diabetes education program if available • Collaboration with the PCP to increase member engagement with the PCP and decrease utilization • Depression screening by the care team and behavioral health referral if indicated. • If the care team cannot reach the member, a referral is sent to a home visiting agency for telephone and drive-by attempts to engage with the member.
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Comment [SW17]: QI 6.A.5 and 6

The care team employs a process of ongoing assessment and documentation to monitor the quality of care and services provided to the member. The care team is responsible for evaluating the information obtained during each telephonic or face-to-face interaction with members and assessing the member’s status, his/her progress toward overcoming barriers and reaching goals and identifying the gaps and/or continued problem areas. The Care Navigators review and update care plans as needed based on the member’s condition, as well as identify and facilitate access to community resources and follow-up to ensure member compliance with the plan of care. All information related to the member is entered in the online documentation system (CARE Web) using Situation, Barriers, Assessment, and Recommendation (SBAR) documentation format.

C. LEAD CASE MANAGEMENT

Lead case management is offered to all children when knowledge of elevated blood levels is present:

- 10-19 ug/dL within 1-3 days
- 20 to 44 ug/dL within 1-2 days
- 45 to 69 ug/dL within 24 hours
- 70 ug/dL or greater immediately

The following services are included in the care plans for children with elevated blood levels:

- Ensure confirmation of capillary tests using venous blood according to the timeframe listed below:
 - 10-19 ug/dL - Within 2 months
 - 20-44 ug/dL - Within 2 weeks
 - 45-69 ug/dL - Within 2 days
 - 70 ug/dL – Immediately
- Ensure that the childhood blood lead testing and follow up guidelines are followed as required:
 - 10-19 ug/dL - 2-3 month intervals
 - 20-70+ ug/dL - 1-2 month intervals, or depending upon the degree of the elevated lead level, by physician discretion until the following three conditions are met:
 - BLL remains less than 15 ug/dL for at least 6 months
 - Lead hazards have been removed
 - There are no new exposures
- When the above conditions have been met, proceed with the retest intervals and follow-ups for BLL's ranging from 10-19 ug/dL.

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A minimum of 3 member/family encounters are made, all face-to-face, by a contracted home health agency. The agency submits the state approved forms to the PCN for further coordination of care.

- Initial visit is performed within 2 weeks of receiving a confirmatory blood lead level that met the lead case management requirements. This visit includes the following:
 - A member/family assessment
 - Provision of lead poisoning education offered by health care provider
 - Engagement of member/family in the development of the care plan
 - Delivery of the assigned care team's contact information
- Follow-up visit or 2nd encounter is made within 3 months following the initial encounter. This includes an assessment and review of the child's progress, parental compliance with recommended interventions, reinforcement of lead poisoning education, member education, and the medical regime should be performed at that time.
- An exit or 3rd encounter is required to be performed prior to discharge between the 6th and 7th months after the initial encounter unless there is a medically necessary need for further follow-up. If the child meets the criteria for discharge, this encounter must include, but is not limited to, discharge counseling regarding current blood lead level status, review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance.

Documentation in the member record includes:

- Initial visit: documents contact with the child's primary care provider and any planned interventions by the health plan or subcontracted case management. Notes also include the plan of care, blood lead levels, assessment of member/family including resulting recommendations, and lead poisoning education including acknowledgement of parental understanding of this education.
- MOHSAIC Lead Application must be used to document lead case management activities. DHSS childhood Lead Poisoning Prevention Program Nurse Lead Case Management Questionnaire & Nutritional Assessment to assist in capturing all required case management elements for documentation. Forms are found: Lead Poisoning Prevention manual @ <http://health.mo.gov>.
- Follow-up visit documentation includes the most recent lab results, member status, any intervention by case management, contacts with child's primary care provider, and progress made to meet plan of care goals.
- Exit visit/discharge documentation must include date of discharge, reason for discharge, lab results, member status, and exit counseling. Exit counseling documentation must include telephone number for member questions/assistance, status of plan of care goal completion, member/family and primary care provider notification of discharge from case management, and continued care coordination plan.

Children receiving case management due to elevated blood levels will have cases reviewed for closure using the following occurrences:

- Current blood lead level is less than 10ug/DL.
- If child is dis-enrolled, referral to new health plan, local public health agency, or health care provider has been complete.

D. COLLABORATING OUTSIDE THE CARE INTEGRATION PROGRAM

1. Coordination with Behavioral Health:

PCN staff work collaboratively with the Health Plan behavioral health staff to coordinate and manage the medical and behavioral health needs of enrolled children. Creating links between these systems assists in coordinating care and support to ensure that care is appropriate and delivered at the proper time. Integrating information also allows the opportunity to offer interventions that match the severity of the condition. When cases are referred from either PCN to the behavioral health vendor or from the behavioral health vendor to PCN for co-case management, a referral form is used to facilitate care coordination and an indicator is added to the online documentation system that the case is being co-case managed.

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2. Coordination with Health Homes

On a monthly basis, the state of Missouri sends a file of members receiving Health Home services to the Health Plan. All identified PCN members are flagged in the online documentation system to identify members assigned to a Health Home. The Care Integration staff identifies a Health Home member through the flag in the online system on the main demographic screen. The care team works in collaboration with the Health Home contact to determine the best way to share information and coordinate care for the member. This may include sharing case notes, arranging for case conferences, ensuring the Primary Care Provider/Health Home is aware of all services member is receiving, etc.

All Health Home members who are admitted for inpatient care are flagged for notification to their assigned Health Home upon admission and discharge. In addition, the Care Facilitation Coordinators review a weekly Health Home ER report. This report identifies Health Home members that have been in the ER in the last two weeks. This information is securely emailed to the appropriate contact at the member's assigned Health Home.

3. Coordination with Community Agencies

Care Navigators assess the member's current support system and other agencies that are providing support to the member. If there are gaps in services or coordination between agencies needs to occur, the Care team member will reach out to community agencies to report the current plan of care and/or to elicit additional resources for the member. The care team often coordinates services with the Kansas City Regional Office, Cornerstones of Care, Community Mental Health Centers, Family Support Division, First Steps, WIC, Public Health Departments, and various other advocacy/support groups.

4. Coordination with Primary Care Providers, Health Plans and Medical Home

For members included in the care integration program, documentation occurs within the CARE Web platform which interfaces with the PCN provider portal. Providers are given access to review care team documentation in real time and provide input into the care plan. Transition of care forms are completed by the Care Navigator and faxed to the accepting Health Plan on all members who will be transferring to another Health Plan from the PCN, when known.

IV. PROGRAM ACCOUNTABILITY AND EFFECTIVENESS:

A. FEEDBACK FROM MEMBERS

PCN performs annual disease management member satisfaction surveys. The surveys are designed to measure the satisfaction and program experience with the complex case management and disease management aspects of the program. The goal of the surveys is to gain information about member perceptions, expectations, experiences and satisfaction with their care team and overall program services. The surveys are administered telephonically and are comprised of a sample size of members who have received or are receiving disease management services. PCN analyzes the results and identifies opportunities to improve the satisfaction with the program on at least an annual basis. In addition, PCN receives information from the contracted Health Plans regarding any member complaints received related to the PCN's disease management program aspects. These complaints are also reviewed for opportunities to improve program services on at least an annual basis.

Comment [ML18]: QI 6.1.1 and 2

B. FEEDBACK FROM PROVIDERS

Annually, the PCN surveys contracted providers to evaluate satisfaction with accessibility to care team staff and the services they provide. This survey is conducted electronically and analyzed to identify opportunities to improve the Care Integration program.

C. PROGRAM EFFECTIVENESS:

Comment [C19]: QI 6.J.1-5

PCN produces an annual evaluation of the care integration program, which includes analysis of all aspects of the program, including:

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- A. Member Satisfaction with care teams and the Disease Management program (Member survey and analysis of complaints/grievances from members related to the programs)
- B. Provider Satisfaction related to Care Integration Program
- C. Select quality of care metrics relevant to the PCN population, as well as specific conditions (i.e. asthma and diabetes HEDIS rates; Childhood Immunization rates; Well Child Visit rates)
- D. Re-admission rates within 30 Days of Inpatient Hospitalization
- E. ER Visits within 30 Days post Discharge from Inpatient Hospitalization
- F. Rate of Hospitalizations (pre and post intervention)
- F. Rate of ER Visits (pre and post intervention)
- G. Per member per month cost of medical care (pre and post intervention)

Comment [ML20]: QI 6.1.1 and 2

REFERENCES:

#S300334901600685 MO HealthNet Managed Care contract – eff. July 2016

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REVIEW AND APPROVAL:

Committee: _____ **Date:** _____

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APPROVED:

VP, Executive Director

Date