Children's Mercy
PEDIATRIC CARE NETWORK

CARE INTEGRATION PROGRAM FOR DELEGATED CARE MANAGEMENT AND DISEASE MANAGEMENT

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Annotated against 2016 NCQA Health Plan Standards, Guidelines and Procedures

PEDIATRIC CARE NETWORK
CARE INTEGRATION PROGRAM DESCRIPTION

I. INTRODUCTION

A. PROGRAM DESCRIPTION

The Pediatric Care Network (PCN) offers a comprehensive care integration program, consisting of case management (CM) and disease management (DM) to eligible members. The care integration program focuses on preventive health and 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 with complex issues; 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.

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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. 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.

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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, 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.

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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 nurses, and social workers, and Medical Directors, as well as administrative/non-clinical staff to support program initiatives. The primary roles within the Care Integration team working directly with patients, caregivers, and community providers are detailed below. These roles form interdisciplinary care teams (exhibit A).

Care Facilitation Coordinators:
Care Facilitation Coordinators are trained administrative staff who works 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 clinical staff with other duties to support functions within the department.

Care Facilitation Nurses:
Care Facilitation Nurses are Registered Nurses who are responsible for prior authorization functions for inpatient an outpatient services, using evidence-based clinical criteria. The Care Facilitation Nurse will work in collaboration with the provider offices by providing education on the prior authorization process, facilitating referrals to network providers, providing member outreach to identify and screen members with complex needs for enrollment into Care Integration programs, and sharing of pertinent patient information with care teams to enhance coordination of care.

Care Navigators:
Care Navigators are Registered Nurses or Licensed Social Workers who are responsible for identifying, planning, implementing, and managing health care alternatives for complex patients and assisting the primary care provider practices in managing and improving quality measures for its patient population. The Care Navigator works with primary care providers to ensure their patients receive well-coordinated care along the health care continuum, promoting quality care through appropriate, cost-effective interventions.

Care Navigators support the patients, caregivers and providers through a process of assessment, development and monitoring of ongoing care plans, including identified barriers, interventions and goals established as part of the assessment and care management process. In addition, Care Navigators interact on a case-by-case basis with providers telephonically, electronically through the provider portal, and in person through attendance at patient appointments to reinforce the provider's plan of care.

Through integration of evidence-based clinical guidelines, preventive guidelines, protocols, and other metrics, they support development of treatment plans that are patient-centric. Care Navigators promote quality and efficiency in the delivery of healthcare. This involves ongoing contact with patients, families, providers, community agencies, and payers.

Community Resource Specialists:
Community Resource Specialists are non-licensed staff who work as members of the care team to support population health initiatives and care coordination. 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 to link members to community resources in an effort to minimize barriers to care.

Practice Facilitation Specialists:
Practice Facilitation Specialists work 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.

Provider Relations Representatives:
The Provider Relations Representatives work as part of the care team to keep provider offices informed and functioning at the highest level possible with all population management tools and resources. They assist practices with understanding the Medicaid contracts and provide a streamlined communication with the Managed Care Organization (MCO) on behalf of the PCN providers.

II. CARE INTEGRATION PROGRAM LEVELS:

PCN utilizes claims or encounter data, disease management stratification, gaps in care reports, hospital discharge data, and data collected through the utilization management process to identify members eligible for case management services.

A Care Navigator completes a Screening and Assessment on every member identified in an at-risk population. Members open for care management have highly complex medical needs and/or psycho-social needs requiring interventions from a Care Navigator.

Examples of cases opened for care management include the following:

- 3 or more inpatient hospitalizations in the past 6 months
- Greater than 21 day inpatient hospitalization with discharge to home (includes NICU if plans for home services beyond the 4 standard home visits)
- High Risk pregnancy with history of preterm labor (at or before 35 weeks gestation), previous low birth weight baby (at or below 2,500 gms at birth), current multiple birth pregnancy, diabetes, and/or hypertension (any one of these or more)
- Identified as high risk on disease management stratification report for asthma or diabetes
- High risk score based on predictive modeling program
- Extensive in-home services, required, such as ventilators, private duty nursing services, etc.
- New or complex medical diagnoses
- Members with complex medical and psychosocial issues requiring co-case management between medical and behavioral care management
- Elevated lead level with no other primary medical diagnosis
- Autism
- Unstable or inconsistent home environment
- End of life support
- Stable medical condition but requiring assistance with appointments and/or accessing needed resources

Examples of cases excluded from care management include:

- Members who have another insurance as primary with active care management in place
- Members who chose to opt out of the care management program

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III. IDENTIFYING MEMBERS FOR CARE INTEGRATION PROGRAMS:

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. For members identified for case management, if the staff member is unable to get in contact with the member/caregiver(s), a new referral may be sent every 90 days for a repeat contact attempt.

Referrals:
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

Pregnancy Notification:
Pregnancy notification sent to the PCN by providers, are screened by a Care Facilitation Coordinator. High risk pregnancies, as defined by PCN, are referred through the online documentation system to a Care Navigator for assessment and enrollment in care management. A letter, including prenatal education literature, is sent to all pregnant members offering care management services. High Risk OB Indicators used to refer members to care management include:

- Mother's age ≤ 17 or ≥35 at time of conception
- Preterm Labor
- Pre-pregnant weight < 100 lbs or >200 lbs
- Previous C-section
- Previous Fetal Death/Stillborn (20 wks or >)
- Diabetes
- Previous Infant Death
- STI (Vaginosis, Syphilis, Gonorrhea, Chlamydia)
- Prior Low Birthweight infant (<2500 gms)
- Smoking -
- Domestic Violence
- Hepatitis B, Hepatitis C, and/or HIV
- Alcohol use
- Drug use

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- Hypertension, Hx of 140/90 or >
- Mental Illness
- Pregnancy Induced Hypertension
- Mother's education is < 8 years
- Incompetent cervix or cerclage
- Homeless
- Interconceptual Spacing < 1 year
- Living alone or single parent living alone
- Multiple gestation
- Considering relinquishment of infant
- Late entry into care (after 4th month or 18 weeks gestation)
- Unfavorable environmental conditions
- Elevated blood lead level 15/19μg/dL or greater
- Neglect of children in the home
- Gravida ≥ 7
- Partner with history of violence
- Any provider request for case management or an outreach call to member

Proactive outreach:
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

Care teams utilize analytical software for predictive modeling reports. A high cost report generates monthly for the care teams to identify medically complex members with significant utilization.

B. C.A.R.E. WEB

C.A.R.E. Web is the web-based documentation system used by the care teams. This system includes platforms to enter authorizations, view claims, complete care management screenings, assessments and care plans, routing of cases, and to send tasks to other care team members. Each care team also has ability to filter their population to identify high ER utilizers, members with multiple gaps in care and by risk score.

C. HOSPITAL CENSUS REPORT

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

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D. TRANSITIONAL CARE PROGRAM

Based on established criteria, members at high risk for re-admission to the hospital and/or post discharge ER visits are referred to the PCN's transitional care program. 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. If the concerns about barriers to care continue to exist or a member is identified as needing more intensive,

ongoing monitoring, the member is referred to the appropriate Care Navigator for further interventions. If clinical assessment warrants additional interventions, the Care Navigator can complete a face-to-face visit with the member or utilize a home health agency to meet with the patient in the home to address barriers to care. 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.

E. 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 referred to a Care Navigator for further assessment.

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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

IV. CASE MANAGEMENT PROCESS:

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Members identified for care coordination are screened by a Care Navigator. The first step in the screening process is a review of the member's clinical history utilizing the EMR, claims (medical, pharmacy and behavioral health) and authorizations. This information prepares the Care Navigator with information to address with the member during the assessment and care planning.

The remainder of the screening addresses adherence with primary care visits, chronic medical and behavioral health conditions, psychosocial concerns and social determinants of health. An in depth

assessment is completed during the screening if the member responds positively to any of the screening questions.

At the time of initial assessment, members are educated about the program detailing how they were identified, how to utilize the services, and how to contact the Care Navigator. As part of the introduction, Care Navigators are also required to inform members about the following:

- Name and contact information for the Care Navigator
- The nature of the care management relationship and expected contact intervals –including telephonic and face to face contact as needed
- Circumstances under which information will be disclosed to third parties
- The availability of a complaint process; and
- The right to "opt out" of the program

Members have the right to "opt out" from the care management program at any time by requesting to be dis-enrolled from the program.

Care Navigators are required to make at least three (3) phone attempts within a three (3) week time frame on different days and at different times using different phone numbers, when possible to try to reach the member for initial contact. After the first failed attempt to reach the member, a letter is sent to the member requesting a return call. If no response is received from the member after the three phone attempts and sent letter, the case is closed from the care management program one week after the last phone attempt.

For open cases that have already been established and contact is lost, the Care Navigator will make three (3) separate attempts on different days and at different times with documentation of attempts to locate alternative contact numbers, send a letter on the final attempt and if no response, the case will be closed.

A. CARE INTEGRATION DOCUMENTATION SYSTEM

When conducting member assessments, activities and interventions, PCN Care Navigators utilize the Case Management Society of America's standards of practice along with standardized nursing protocol for assessment, planning, intervention and evaluation. PCN's care management program has defined practices and standards for member care planning, identification of prioritized goals, documentation and case closure 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 C.A.R.E. Web system has the following automated features:

- Date, time, and user stamp for each entry
- Reminders – a message that the Care Navigators uses to remind him/her of a specific task
- Task List – a list of all follow-ups upcoming, due, or overdue
- Routing of cases between Care Integration staff members
- Care Management Plans including barriers, interventions, prioritized goals and member self-management plans
- Message Alerts

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B. INITIAL ASSESSMENT

For each member enrolled in PCN's care management program, the care planning process begins with a thorough review of data and information about the member's current medical status, which may include medical record review, psychosocial history, prescription usage and authorization/claim history. A Care Navigator completes a Screening and Assessment on all referred or identified high risk members. In all cases, a completed assessment must be done within 30 calendar days of identifying the case for care management and/or receiving a referral. Inpatient cases identified as needing care management services are shadowed by the Care Team until discharge. At the time of discharge from the hospital, the member is identified for referral to care management and a referral is made to the Care Navigator as part of the discharge planning process.

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For cases in Care Coordination the Care Navigator conducts an initial assessment and ongoing evaluation of:

- *Health status including condition-specific issues*

Evaluation of the member's health status specific to identified health conditions, self-monitoring, adherence to treatment plans, and likely co-morbidities

- *Clinical history, including medications*

Documentation of clinical history, including disease onset, key events, inpatient stays, treatment history and current/past medications

- *Activities of daily living*

Evaluation of the member's functional status related to activities of daily living such as eating, bathing, mobility, hearing and vision

- *Behavioral health status including cognitive functions*

Evaluation of the member's behavioral health status, including psychosocial factors and cognitive functions such as the ability to communicate, understand instructions and process information about their illness make independent decisions about care and self- management plan. Every member ≥12 years and older is screened for depression using the Patient Health Questionnaire (PHQ). If the member responds "yes" to either of the first two questions on the questionnaire, the Care Navigator is prompted to proceed with the remaining seven questions on the PHQ 9 screening. The Care Navigator's interventions are dependent upon the severity of the depression score. Interventions may include education with the member/caregiver on the available behavioral health benefit, referral for behavioral health services and reporting the screening outcome to the PCP for ongoing monitoring. The Care Navigator develops goals and self-management plan activities to monitor the member's progress in this area. The Care Navigator will also re-assess the member using the PHQ 9 during the next contact for a member with severe depression, in three months for moderate depression and in six months for mild depression.

- *Life planning activities*

Assessment of life planning activities such as wills, living wills or advance directives and health care powers of attorney. The Care Navigator will make every effort to assess the status of life-planning activities completed by a member and provisions for care of sick children in the event the care taker is no longer able to care for the child. If expressed life-planning instructions are not on record, the Care Navigator determines if such a discussion is appropriate during the first contact based on the member's circumstances.

- *Cultural and linguistic needs, preferences or limitations*

Evaluation of the member's cultural and linguistic needs, preferences, or limitations, including providing information in the member's primary language, identifying providers who are qualified to meet the member's needs, and any healthcare-related impact that the member's cultural practices may have on the plan of care.

- *Caregiver resources*

Evaluation of caregiver resources such as family involvement in and decision making about the care plan, location of care givers, and their availability for routine and emergent situations. Evaluate the sufficiency of the resources and support based on the member's needs.

- *Available benefits – Community Resources*

Assessment of the member's eligibility for health benefits and other pertinent financial and support information. Assessment of community services available for members, such as respite care, support groups for care givers, etc.

- *Barriers to meeting goals or complying with the plan*

Address any issue that may be an obstacle to the member receiving or participating in the case management plan.

Care Integration staff work with members enrolled in PCN's care management program to develop an individualized case management plan, prioritized goals, and a self-management plan. The plans are communicated and agreed upon by the member/caregiver and are intended to address the member/caregiver's goals, preferences, and desired level of involvement. Care Navigators develop a schedule for follow-up and communication with each member, implement the schedule and revise it as necessary.

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The results of the assessment for each factor must be clearly documented in the online documentation system, even if the factor is not applicable to the member. The assessment must be completed within 30 days of identification and/or referral for care management. Assessments may be completed in multiple visits and may be completed by other members of the care team and with the assistance of the member's family member or caregiver. All goals should be patient-centered, specific, measurable and within the control of the Care Navigator and/or the member or caregiver. The Care Navigator is responsible for documenting the member's progress toward the goals and/or revising the goals, as appropriate.

In cases where a member was previously enrolled in care management, closed, and is now re-enrolled in care management, a new assessment is required if the case has been closed for longer than 30 days.

All members enrolled in a care management program receive a welcome letter outlining how the program works, the self-management plan that they have agreed to with the Care Manager, as well as their Care Navigator's name and contact information. The member's Primary Care Provider is notified via the Provider Portal when a member is enrolled in the program. The Primary Care Provider is able to view the Care Navigator's notes, care plan, including identified barriers, goals and member self-management plan. The Primary Care Provider is sent notification via the Portal when changes are made to the member's care plan. Providers are expected to review the care plan, provide input and approval of the revisions to the plan.

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C. ONGOING MONITORING AND EVALUATION

Care Integration Program	**Interventions**
Care Management	• Outreach/Screening • Enrollment • Notification of care coordination activities to the Primary Care Provider via the Provider Portal • Comprehensive condition specific bio-psychosocial assessment • Identification of barriers to care • Gaps in care education • Formulation of the care management plan including prioritized goals and member self-management plans • Communication with the Primary Care Provider and Specialist regarding the care plan • Chronic condition monitoring • Individualized member education and coaching to self-manage their condition and access community resources • Referrals to community resources • Member contact attempts every 1-3 months (minimum) • 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 discussions during Clinical Rounds • PCN health literature mailed and reviewed with the member

Care Integration Program	**Interventions**

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Asthma Disease Management	Low Risk (0-3 points)-Targets those with intermittent asthma and well controlled asthma. • 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
	Medium Risk (4-6 points)-Targets those with not well-controlled asthma. • 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: o Early Warning Signs of Asthma o Kids early warning signs of asthma o Asthma Medications o Asthma Action Plan • Depression screening by the Care Navigator and behavioral health referral if indicated. • If the member had a change in risk level from low to medium, a referral is generated to care management.
	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. • 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 for care management interventions • Individualized treatment plan is developed by the Care Navigator and member • Collaboration with the PCP to increase member engagement with the PCP • Depression screening by the Care Navigator and behavioral health referral if indicated. • If the Care Navigator cannot reach the member, a referral is sent to a home visiting agency for telephone and drive-by attempts to engage with the member.
Diabetes Disease Management	Low Risk (1 point)-Targets those with a diabetes diagnosis. • 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
	Medium Risk (2-3 points)-Targets those with not well-controlled diabetes.

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	• 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:
	  o Type 1 Diabetes Mellitus
	  ▪ What is Type 1 diabetes
	  ▪ DKA Prevention
	  ▪ Carb Counting
	  o Type 2 Diabetes Mellitus
	  ▪ 7 Healthy Tips
	  ▪ Physical Activity
	  ▪ Type 2 Diabetes in Preteens and Teens
	• Depression screening by the Care Navigator and behavioral health referral if indicated.
	• If the member had a change in risk level from low to medium, a referral is generated to care management.

	High Risk (≥ 4 points)-Targets those with poorly controlled diabetes. In addition to the interventions listed for medium risk, the following interventions are also applied to this risk group. • 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 for care management • 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 Navigator and behavioral health referral if indicated. • If the Care Navigator cannot reach the member, a referral is sent to a home visiting agency for telephone and drive-by attempts to engage with the member.

The Care Navigator employs a process of ongoing assessment and documentation to monitor the quality of care and services provided to the member. The Care Navigator 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. 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 referrals. At a minimum, the member's care plan, including self-management plan, are updated according to the priority level of the goals: low priority goals are updated at a minimum of every 90 (ninety) days, medium priority goals are updated at a minimum of every 60 (sixty) days, and high priority goals are updated at a minimum of every 30 (thirty) days. The member self-management plan is updated at the same frequency as the follow-up plan schedule as agreed upon by the member and the Care Manager.

The care management plan is specific to the member's needs and identifies the following:

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- Barriers/problems that may be preventing the member from optimal health outcomes
- Prioritized goals, which are mutually established with the member, specific and measurable
- Care Management interventions/Care Plan
- Member self-management Plan

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All documentation related to the case is entered in C.A.R.E. Web with a specific date listed for follow-up and a note as to the expected content of the next follow-up contact.

D. OB CASE MANAGEMENT

In addition to the above items, the following are included in care plans of pregnant women:

- The initial case management/admission encounter is required through a face-to-face or a phone assessment of member's needs. This is offered to all newly pregnant women in the prenatal packet, which is sent when the PCN is notified of a pregnant member. The pregnancy risk appraisal form is attached as a permanent part of the member's record in C.A.R.E. Web.
- Intermediate referrals to substance-related treatment services if member is identified as substance abuser. Care Navigators will coordinate care with the treatment facility and appropriate state agencies
- Referral to prenatal care (if not already enrolled) is made within 2 weeks of enrollment in care management.
- Tracking of all prenatal and post-partum medical appointments is offered to members Follow-up on broken appointments is made within 1 week of the appointment.
- Verification that EPSDT/HCY screens are current.
- Referrals to WIC (if not already enrolled) within 2 weeks of enrollment in care management.
- Assistance in making delivery arrangements by the 24th week of gestation.
- Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care.
- Referrals to prenatal or childbirth education where available.
- Assistance in planning for alternative living arrangements which are accessible within 24 hours for those who are subject to abuse or abandonment.
- Assistance to the mother in enrolling the newborn in ongoing primary care
- Assistance in identifying and selecting a medical care provider for both the mother and child.
- Identification of feeding method for the child.
- Referrals for family planning if requested.
- Directions to start taking folic acid vitamin before the next pregnancy.
- Post-partum home visit to assess mom/baby needs

E. LEAD CASE MANAGEMENT (Missouri program)

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

- 10-19 µg/dL within 1-3 days
- 20 to 44 µg/dL within 1-2 days
- 45 to 69 µg/dL within 24 hours
- 70 µg/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 µg/dL - Within 2 months
  - 20-44 µg/dL - Within 2 weeks
  - 45-69 µg/dL - Within 2 days
  - 70 µg/dL – Immediately
- Ensure that the childhood blood lead testing and follow up guidelines are followed as required:
  - 10-19 µg/dL - 2-3 month intervals

  - 20-70+ µg/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 µg/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 µg/dL.

A minimum of two member/family encounters are made, all face-to-face, by members of the PCN care team.

- Initial visit is performed within 2 weeks of receiving a confirmatory blood lead level that met the lead care 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 Care Navigator's name and telephone number
- 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 evaluation is completed prior to discharge from the program. Discharge may occur when the member's lead level has normalized (less than 10 µg/dL), eligibility has termed or the member has transitioned to a new health plan. If the child meets the criteria for discharge, this encounter must include, but is not limited to, rationale for program discharge and transition plan if appropriate, discharge counseling regarding current blood lead level status, review of ongoing techniques for prevention of re-exposure to lead hazards, as well as education on nutrition, hygiene, and environmental maintenance. This contact will occur via telephone or in person by Care Integration staff.

Documentation in the member record includes:

- Initial visit: Admission progress 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 care management activities. DHSS childhood Lead Poisoning Prevention Program Nurse Lead Case Management Questionnaire & Nutritional Assessment to assist in capturing all required care 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 care management, contacts with child's primary care provider, and progress made to meet plan of care goals.
- Exit /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 care management, and continued care coordination plan.

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

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

F. COLLABORATING OUTSIDE THE CARE INTEGRATION PROGRAM

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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 case communication and an indicator is added in C.A.R.E. Web. This alerts the care team to coordinate care with the health plan representative.

2. Coordination with Health Homes (Missouri program)

On a monthly basis, the state of Missouri sends a file of members receiving Health Home services to the Health Plan. This information is integrated into C.A.R.E. Web and all identified PCN Health Home members are flagged. . When Care Integration staff identifies a Health Home member through the flag in C.A.R.E. Web, the staff member 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 Navigator will reach out to community agencies to report the current plan of care and/or to elicit additional resources for the member. The Community Resource Specialist will work with identified members to explore connections/coordination with additional community agencies. The care team often coordinate services with the local Regional Developmental Disabilities Office, Community Mental Health Centers, Family Support Division, First Steps/Infant-Toddler Services, WIC, Public Health Departments, and various other advocacy/support groups.

4. Coordination with Primary Care Providers and Medical Home

PCN primary care providers have access to the C.A.R.E. Web system via the Provider Portal for their assigned patients. In real time, Providers receive notifications in the Provider Portal to alert them of care coordination actives on assigned patients. The Primary Care Provider is able to view the Care Navigator's notes, care plan, including identified barriers, goals and member self-management plan. The Primary Care Provider is also sent notification via the Portal when changes are made to the care plan. Providers are expected to review the care plan, provide input and approval of the revisions.

G. CASE CLOSURE

Criteria must be met on all cases in order for care management services to be terminated. Termination of a case can be requested by either the Care Navigator, provider or member. In order for a case to be closed, at least one (1) of the following must be met:

- Achievement of goals stated in the member care plan, including stabilization of the member's condition, successful links to community support and education and improved member health
- Member is dis-enrolled from the PCN

- Death
- Provider, Member, or Authorized Representative of Member Requests
- Lack of contact or compliance with the Care Navigator with written documentation in the care plan of attempts to locate and engage the member. At least three (3) phone attempts and one (1) letter attempt must be made to contact the member and/or caregiver prior to closure. Examples of actions to attempt contact include:
  - Making phone call attempts before, during and after regular working hours
  - Visiting the member's home
  - Sending letters with an address correction request
  - Checking with the Primary Care Provider, transportation vendor, Women, Infants and Children (WIC) and other providers and programs for member contact information

The Care Navigator notifies the member verbally of discontinuation of care management services and documents the reason for case closure and discussions with the member. The member's primary care physician is notified via the Provider Portal when a member is discharged from care management. The provider can view the reason for discharge, assessment including the child's clinical history, care plans and interventions that occurred during the member's engagement in the care management services.

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.

V. PROGRAM ACCOUNTABILITY AND EFFECTIVENESS:

A. FEEDBACK FROM MEMBERS

PCN performs annual care management and disease management member satisfaction surveys. The surveys are designed to measure the satisfaction and program experience with the care 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 Navigator and overall program services. The surveys are administered telephonically and are comprised of a sample size of members who have received or are receiving care management or 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 care management or disease management program aspects. These complaints are also reviewed for opportunities to improve program services on at least an annual basis.

Commented [ML39]: QI 5.I.1 and 2

B. FEEDBACK FROM PROVIDERS

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

C. AUDITS/ACCOUNTABILITY

Staff audits are conducted each quarter. Records are randomly selected for each staff member and audited by both peers and leadership. New employees must have a 90% or higher threshold during the first year of employment and 95% or higher thereafter. Individual and group education is provided to address issues identified during the audit process. For staff who do not achieve the benchmark, an individual improvement plan is developed with the manager and a re-audit is conducted to ensure compliance with standards. Audit reports are prepared quarterly and reported to the appropriate oversight committee.

PEDIATRIC CARE NETWORK
CARE INTEGRATION PROGRAM DESCRIPTION

D. PROGRAM EFFECTIVENESS:

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

A. Member Satisfaction with Care Management and Disease Management (Member survey and analysis of complaints/grievances from members related to the programs)
B. 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)
C. Re-admission rates within 30 Days of Inpatient Hospitalization
D. ER Visits within 30 Days post Discharge from Inpatient Hospitalization
E. Rate of Hospitalizations (pre and post care management intervention)
F. Rate of ER Visits (pre and post care management intervention)
G. Per member per month cost of medical care (pre and post care management intervention)

Commented [C40]: QI 5.J.1-6; K 1-4 and QI 6.J.1-5

Commented [ML41]: QI 6.I.1 and 2

REFERENCES:
RFPS30034901600685 MO HealthNet Managed Care contract – eff. May 2017
EVT0001028 KanCare Managed Care contract-eff. January 2013

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REVIEW AND APPROVAL:

Committee: Date:

Internal PCN Management: February 7, 2012; July 31, 2012; January 2, 2013; April 16, 2013; August 6, 2013; May 27, 2014; November 18, 2014; February 2, 2016; February 13, 2018

Clinical Quality Committee: March 2012; January 2013; July 2013; May 2014; November 2014; May 2015; February 2016

Utilization Management Committee:

APPROVED:

_____ _____

VP, Executive Director Date

PEDIATRIC CARE NETWORK
CARE INTEGRATION PROGRAM DESCRIPTION

EXHIBT A