Children's Mercy
PEDIATRIC CARE NETWORK

CARE INTEGRATION PROGRAM FOR DELEGATED CASE MANAGEMENT AND DISEASE MANAGEMENT

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Annotated against 2025 NCQA Health Plan Standards, Guidelines and Procedures

I. INTRODUCTION

A. PROGRAM DESCRIPTION (PHM 2.B, PMH 2.C)

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 (keeping members healthy) and enhancing and coordinating a member's care across an episode or continuum of care (patient safety or outcomes across care settings); negotiating, procuring and coordinating services and resources needed by members and families with complex issues (managing members with emerging risks); facilitating care transitions across care settings (patient safety or outcomes 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 to identify opportunities to enhance or modify the care integration program. This includes children with special needs, disabilities, limited English proficiency, racial/ethnic minorities, and/or other complex health issues (managing multiple chronic illnesses). Disease management interventions focus on three chronic conditions relevant to the pediatric population: asthma, diabetes, and obesity. When delegated for behavioral health, PCN also provides disease management interventions focused on depression. At least annually, PCN assesses all program interventions and resources to determine if changes are needed to better meet the needs of the population. This assessment includes review of community resources available to address member needs and healthcare disparities

B. PROGRAM GOALS (PHM 1.A.1)

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 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 PCPs to assess the population's needs, determine available benefits and resources, and develop and implement specific interventions to meet the population's needs. Additionally, the Care Integration Staff coordinate with PCPs to ensure provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

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 and 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 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 (PHM 5.B.1)

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) and American Case Management Association (ACMA) standards of practice along with standardized nursing protocol for assessment, planning, intervention, and evaluation, etc. PCN updates these 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 to providers through its website and educates providers about the availability

of the guidelines through regular newsletters. The evidence-based guidelines adopted by the PCN are reviewed and approved by the Clinical Quality & Operations Committee (CQOC) at least annually.

E. CULTURAL COMPETENCY

PCN programs and services are accessible to the diverse membership we serve. All Care Integration staff receive cultural competency training 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 are available to staff, members when communicating via phone or in person, as needed. PCN supports population health management initiatives of contracted health plans that ensure culturally competent interventions for members with limited English proficiency and/or members of minority racial and ethnic groups. Through regular review of policy, practice, and tools PCN utilizes education, in conjunction with principals of trauma informed care (TIC) and health plan aligned programming, to promote health equity in the population served (PHM 1.A.6, PHM 2.B.5-6, PHM 2.C.3).

F. PROGRAM STAFF AND RESPONSIBILITIES

Care Integration staff consists of nurses, social workers, mental health professionals and medical directors, as well as administrative/non-clinical staff who support program initiatives. Active case management caseloads (aggregate across all plans) are monitored via daily report for both case number and case complexity. The primary roles within the Care Integration team working directly with members, caregivers, and community providers are detailed below. These roles form an interdisciplinary care team (exhibit A).

Behavioral Health Care Navigator:
Behavioral Health Care Navigators are Registered Nurses or Licensed, master's prepared mental health professionals responsible for prior authorization and outreach for inpatient and outpatient behavioral health services. The Behavioral Health Care Navigator works in collaboration with care providers through education on the prior authorization process, facilitation of referrals to network providers and services. The Behavioral Health Care Navigator supports members, caregivers, and providers through a process of assessment, development, and monitoring care plans, including identified barriers, interventions and goals established as part of the assessment and case management process. This position works closely with all areas of the Care Integration department, providers, community organizations, other health care professionals, and members/caregivers.

Care Facilitation Coordinators:
Care Facilitation Coordinators are trained administrative staff who work as the front line in answering provider calls and faxes to the Care Integration department. They assist with entering prior authorization information, screening pregnancy notification forms, facilitating referrals to home care agencies, and assisting 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 and outpatient services, using evidence-based clinical criteria. The Care Facilitation Nurse works in collaboration with 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 pertinent member 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 members and assisting primary care provider practices in managing and improving quality measures for its member population. The Care Navigator works with primary care providers to ensure their members receive well-coordinated care along the health care continuum, promoting quality care through appropriate, cost-effective interventions.

Care Navigators support members, caregivers, and providers through a process of assessment, development, and monitoring care plans, including identified barriers, interventions and goals established as part of the assessment and case management process. In addition, Care Navigators interact on a case-by-case basis with providers telephonically or

electronically through the provider portal, and in person through attendance at member 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 member-centered. Care Navigators promote quality and efficiency in the delivery of healthcare. This involves ongoing contact with members, 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 PCN and its stakeholders, including providers, members and families, community agencies, and other health care professionals to link members to community resources to minimize barriers to care. As part of their incentive model, PCN practices screen members for social determinant of health (SDOH) needs to better understand risk factors that contribute to a member's health and well-being. Practices can refer members with complex SDOH needs to care teams for Care Coordination. Addressing SDOH issues is an evidence-based practice shown to reduce health care costs, increase member satisfaction, and positively impact member's health outcomes.

Population Health Network Representatives
The Population Health Management Network representatives (Network Reps) work with the Primary Care Practices to help facilitate practice transformation, which includes patient-centered medical home concepts as well as population health for the practice. Each representative is assigned to a Pediatric Care Network (PCN) Primary Care Provider (PCP) practice in Missouri and Kansas. They assist each practice in understanding the Medicaid contracts and provide a streamlined communication process with the contracted Managed Care Organizations (MCO) for issues such as coverage, claim issues and eligibility issues. In addition, they support practice management processes of each PCN practice with the goal of improving member quality outcomes. Part of this support includes population stratification via tri-annual performance review. As part of the triannual performance review an executive summary is formed, part of which is recommended targeted interventions based on population stratification. Algorithms utilized in this stratification are evaluated to ensure they avoid racial biases (including, but not limited to, ensuring algorithms consider measures other than cost-based considerations). (PHM 2.D).

II. 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 contact the member/caregiver(s), a new referral may be sent every 90 days for repeat contact attempt.

Referrals (PHM 2.A, PHM 5.A):
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 – using 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:
PCN will offer care management and complete a screening/assessment within fourteen (14) business days of notification of pregnancy. With first attempt completed within 10 business days of referral. Pregnancy notifications sent to PCN by providers are screened by a Care Facilitation Coordinator. High-risk pregnancies, , are referred through the online documentation system to a Care Navigator for assessment and enrollment in case management. Pregnant members with no high-risk identifiers, as defined below, are referred through the online documentation system to a Care Facilitation Nurse for assessment and if further needs are identified following the assessment, referred to a Care Navigator for enrollment in case management. A letter, including prenatal education literature, is sent to all pregnant members offering case management services. Aside from more stringent timeframes, pregnancy outreach attempts will be made by PCN per Section IV of this policy. Additionally, if unable to reach the member through other methods, PCN will speak with OB provider office to request they alert member to contact PCN at next appointment or send a "Provider Pregnancy" letter to provider of OB Care (from PNF) and/or PCP requesting member contact PCN Care Navigator with next visit.

High Risk OB Indicators used to refer members to case management, and additional engagements, include:

Missouri
PCN shall offer CM services based upon MHD's Notification of Pregnancy (NOP) risk stratification scoring of physical, mental, and SDOH needs of the member. If PCN has not received NOP information for the pregnant member, but the pregnant member is deemed newly eligible for CM services through another information source, three (3) outreach attempts will occur within fourteen (14) business days of the member becoming active within the health plan. If the NOP is subsequently received, the fourteen (14) business day requirement still applies.

If an NOP is received outreach attempts will follow the state outlined timeframes as follows:

1. Members deemed high (risk score between 35 and 49) and very high (risk score above 50) should receive initial outreach within three (3) business days of the health plan receiving the NOP data, excluding the day on which the NOP data was received, and three (3) outreach attempts should be made within five (5) business days.

2. Members deemed moderate risk (risk score between 15 and 34) should receive initial outreach within five (5) business days of the health plan receiving the NOP data, excluding the day on which the NOP data was received, and three (3) outreach attempts should be made within ten (10) business days.

3. Members deemed low risk (risk score below 15) should receive initial outreach within five (5) business days of the health plan receiving the NOP data, excluding the day on which the NOP data was received, and three (3) outreach attempts should be made within fifteen (15) business days.

Kansas

In addition to standard efforts, KS Referrals with any of the below high risk indicates noted in referral or claims within 6 months who are unable to be reached will require a drive-by.

- Hypertension
- Diabetes
- Sickle Cell
- Serious BH condition/mood disorder (depression, bipolar)
- Current substance use
- Late to care post first trimester

- History of pre-term delivery between 20-32 weeks
- Or per Clinical Judgement

The Pregnancy Notification Report is another method used to capture pregnant members. This daily report identifies newly pregnant members by ME code or pregnancy related claims. Tasks are generated from this report to a Care Facilitation Nurse or Care Navigator for outreach to the member.

Within 14 business days from the PCN being notified of the pregnant member, the Care Facilitation Nurse or Care Navigator 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) to complete an assessment with the member. After these efforts have been exhausted and if the Care Navigator is still unable to reach the member, outreach efforts may cease.

Health Screening Referrals (Kansas program):
Kansas health plans are required to conduct health screenings (HST/HSA) on all members at enrollment and annually. Members identified for a health risk assessment (HRA) during the screening are referred for case management follow up. When members are PCN aligned, this referral is sent by the Kansas healthplan to the PCN. The PCN reaches out to the member to provide education on case management services and offer a face-to-face visit as appropriate to complete PCN screening and assessment. The PCN makes every reasonable effort (3 phone calls and one letter) to contact the member.

Proactive outreach:
PCN uses proactive approaches to screen the population to identify members who could benefit from PCN services. 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 case management 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. (Case Assessment and Referral Evaluation) Web is the web-based documentation system used by the care teams. This system includes platforms to enter authorizations, view claims, complete case management screenings, assessments and care plans, routing of cases, and to send tasks to other care team members. The care team can filter their population to identify high ER utilizers, members with multiple gaps in care and members with high-risk scores.

C. HOSPITAL CENSUS REPORT (PHM 2.A.6, PHM 5.A.1-2)

A report is generated each day detailing the inpatient hospital census. The report is reviewed daily by the care team to assess hospital stays in excess of 14 inpatient days and re-admissions within 30 days. Cases identified are referred to a Care Navigator or Behavioral Health Care Navigator for further assessment and potential collaboration with facility discharge planners.

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 for an additional screening. Within 48 hours of notification to PCN 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 or Behavioral Health Care Navigator. If clinical assessment warrants additional interventions, the Care Navigator or Behavioral Health Care Navigator can complete a face-to-face visit with the member or utilize a home health agency to meet with the member 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 or 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 the listed diagnoses 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 who had a change in risk level (low to medium risk or medium to high risk). All members on this report are offered intervention from PCN for further assessment.

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

OBESITY RISK STRATIFICATION	
Activities Previous 6 Months	**Initial Risk Category**
At least one encounter within the past 6 months with a BMI greater than 95% and 0 comorbidities*	**Low**
At least one encounter within the past 6 months with a BMI greater than 95% and 1 comorbidities*	**Medium**
At least one encounter within the past 6 months with a BMI greater than 95% and ≥ 2 comorbidities*	**High**

***Comorbid condition diagnoses are defined in conjunction with network specialists**

DEPRESSION RISK STRATIFICATION*	
Activities Previous 6 Months	**Initial Risk Category**
No depression hospitalization AND ≤ 1 depression ED visits within the previous 6 months	**Low**
One depression hospitalization OR ≥ 2 depression ED visits within the previous 6 months	**Medium**

≥ 2 depression hospitalizations or ≥ 1 depression hospitalization that included suicidal ideation/attempt	**High**

***Depression program specific to plans where PCN is delegated for Behavioral Health**

III. 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 PCN care team member completes a screening and assessment on every member identified and successfully engaged. Members open for case management have medical needs and/or psychosocial needs requiring interventions from a Care Integration staff member. Members can be excluded from case management if they have case management through another primary insurance, or the member has opted out of the case management program.

At the completion of the screening and assessment, the PCN staff member assigns a case management level to the member. This level is determined by the needs of the member and determines the recommended frequency of contact by the Care Integration staff member. Intervention/follow up planning across all program levels are individualized and determined with member input at the time of enrollment and may vary based on individual need/preference of member. Members identified with needs related to Asthma, Diabetes, Lead Poisoning, Pregnancy, Autism, Obesity, Behavioral Health Concerns, and/or other chronic medical conditions and needing intervention for at least 60 days are part of the complex case management program.

Program Levels:

Level I – Outreach Monitoring: This level is appropriate for members with basic education, resource, and care coordination needs. This could include basic health education, monitoring of PCP visits and addressing gaps in care. The Care Integration member works with the member and/or providers to ensure the member is adhering to wellness visits. Recommended contact frequency includes attempted contact with the member by mail or telephone at a minimum of every 3 months, or per member's requested cadence, and offer of a face-to-face visit annually. The member attending a well visit annually meets the face-to-face requirement for this level.
Examples:

- 3 or more emergency department visits in the past 3 months
- Elevated lead level with no other primary medical diagnosis (see section IV.E. for face-to-face visits requirements)
- Autism
- Members with social determinants of health issues impacting home environment
- Members receiving adoption subsidy or who have aged out of the foster care system (Kansas Specific)
- Non-High-Risk Pregnancy
- Foster Care members without complex needs (Kansas Specific)

Level II – Transitional Care Coordination: This level is appropriate for members needing short-term case management services to ensure a smooth transition home after a hospitalization or other inpatient/residential placement. The Care Integration staff member offers at least one face-to-face visit with the member after discharge and continues to work with the member through attempted monthly telephonic contact, or per member's requested cadence. This level of care is reassessed for members warranting intervention beyond 2 months post discharge.
Examples:

- Members identified through the Transition of Care program
- Members discharged from the NICU with no need for additional home services beyond the 4 standard visits
- Members discharged from inpatient psychiatric services needing short-term community or home services post discharge
- Members with newly started Private Duty Nursing or Personal Care Assistant services

Level III – Care Management: This level is appropriate for members with chronic conditions or high-risk conditions. The Care Integration staff member primarily works with the member telephonically attempting a minimum of monthly, or per member's requested cadence, telephonic contact. The Care integration staff member offers a face to face visit every 3 months.
Examples:

- High Risk pregnancy with history of preterm labor (at or before 35 weeks gestation), previous low birth weight baby (at or below 2,500 grams 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
- High risk score based on predictive modeling program
- New or complex medical diagnoses
- Members discharged from inpatient psychiatric services needing long-term community or home support services
- Members with complex medical and psychosocial issues requiring co-case management between medical and behavioral case management
- Members in foster care with moderate needs (Kansas Specific)

Level IV – Intensive Care Management: This level is appropriate for members requiring intensive case management services. This includes members with multiple complex co-morbidities, chronic conditions poorly managed, and members with frequent hospitalizations. The Care Integration Staff Member attempts a minimum of monthly, or per member's requested cadence, telephonic contact with the member. The Care integration staff member offers a face to face visit every other month.
Examples:

- 3 or more inpatient hospitalization in the past 6 months
- Greater than 21-day inpatient hospitalization (includes NICU if plans for home services beyond the 4 standard home visits)
- Members enrolled in Hospice Services
- Members identified on the KDHE Unified Log (Kansas Specific)
- Members in foster care with complex/high needs (Kansas Specific)

PRTF Level: This level is appropriate for members that require residential treatment level of care for severe mental health needs that have exhausted community resources. The care integration staff member makes telephonic attempts, and offers F2F contact, every two weeks. Additionally, the care integration staff member attends all applicable community partner meetings (e.g.- KDADs/POC or TP calls/CBST calls/Treatment Stability Meetings)

- Members approved for PRTF (Psychiatric Residential Treatment Facility) level of treatment

IV. CASE MANAGEMENT PROCESS (PHM 1.A.2, PHM 1.B):

Members identified for care coordination are screened by a Care Integration staff member. The first step in the screening process is a review of the member's clinical history utilizing the EHR, claims (medical, pharmacy and behavioral health) and authorizations. This data prepares the Care Integration staff member with information to address 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 Integration staff member. As part of the introduction, Care Integration staff members are also required to inform members about the following:

- Name and contact information for the Care Integration staff member
- The nature of the case management relationship and expected contact intervals, including telephonic and face to face contact as needed

- Available services
- 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

Member's enrollment into and eligibility with the health plan serves as consent for case management services. Members have the right to "opt out" from the case management program at any time by requesting to be dis-enrolled from the program.

Care Integration staff members are required to make at least three (3) phone attempts within a four (4) week time frame on different days, at different times, using different phone numbers, when possible, to try to reach the member for initial contact. After a 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 letter, the case is closed from the case management program. Care Integration staff remain available to the member pending response to outreach attempts and/or notification of further needs.

For open cases that have already been established and contact is lost, the Care Integration staff member 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, Care Integration staff members utilize the Case Management Society of America's standards of practice, along with standardized nursing protocol, for assessment, planning, intervention, and evaluation. PCN's case 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 in real-time through regular discussions with the PCN Care Integration management team and/or Medical Director(s). These discussion opportunities include but are not limited to daily huddles (team specific followed by all teams), monthly medical director rounds, bimonthly Care Integration Meetings and All Staff Huddles, Bi-annual All Care Team Meetings, and PRN case/topic specific staffing.

The C.A.R.E. Web system has the following automated features (PHM 5.B.2-3):

- Date, time, and user stamp for each entry
- Reminders – a message that the Care Integration staff member uses to remind him/herself 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

B. INITIAL ASSESSMENT (PHM 5.C)

For each member enrolled in PCN's case management program, the care planning process begins with a thorough review of data and information about the member's current status, which may include medical and behavioral record review, psychosocial history, prescription usage and authorization/claim history. A Care Integration staff member completes a screening and assessment on all referred or identified high-risk members. A completed assessment must be done within 30 calendar days of identifying the case for case management and/or receiving a referral, unless otherwise specified in this document. Inpatient cases identified as needing case management services are monitored by the Care Team until discharge. As needed, the Care Team coordinates with the hospital discharge planner to address post hospital need preparation. At the time of discharge from the hospital, the member is identified for referral to case management and a referral is made to the Care Integration staff member as part of the discharge planning process.

For cases in Care Coordination, the Care Integration staff member 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, toileting, hygiene, and dressing.

- *Vision and hearing needs*

Evaluation of the member's vision and hearing. Including specific needs to consider and potential barriers to care.

- *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 Integration staff member is prompted to proceed with the remaining seven questions on the PHQ 9 screening. The Care Integration staff member'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 Integration staff and member develop goals and self-management activities to monitor the members' progress. The Care Integration staff member will also reassess 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 Integration staff member 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 caregiver is no longer able to care for the child. If life-planning instructions are not on record, the Care Integration staff member determines if 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 caregivers, and their availability for routine and emergent situations. Evaluate the sufficiency of the resources and support based on the member's needs.

- *Social Determinants of Health*

Assessment of the member's social and/or economic conditions that affect health, functioning, and quality of life outcomes. Including specific needs to consider and potential barriers to care

- *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, that supplement those for which the MCO has been contracted to provide. At a minimum, Care Integration staff will assess the member's eligibility to access community mental health, transportation (outside of NEMT benefits), wellness programs, palliative care programs, and nutritional supports. Based on SDOH screening, additional program eligibility will also be explored.

- *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 case management program to develop an individualized case management plan, prioritize goals, and creating 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 Integration staff members develop a schedule for follow-up and communication with each member, implement the schedule and revise it, as necessary.

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. At the completion of the initial assessment, the staff members will summarize the member's situation & any implications from the data and answers from questions for use in their Care management plan. The assessment must be completed within 30 days of identification and/or referral for case 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. In the instance staff are unable to complete the assessment within 30 days of identification and/or referral for care management, they will clearly document efforts made and PCN will remain available pending responses from member/family to outreach or notification of further needs. Reasons for inability to complete the assessment within this timeframe might include:

- Member hospitalized during the initial assessment timeframe, thus assessment/enrollment held until transitional support.
- Member cannot be contacted after due diligence efforts
- Natural disaster, thus assessment/enrollment held until standard operation processes resume
- Member deceased, thus member no longer requires services

All goals should be member-centered, specific, measurable and within the control of the Care Integration staff member and/or the member or caregiver. The Care Integration staff member is responsible for documenting the member's progress toward the goals and/or revising the goals, as appropriate. Goals will be formulated into a care plan and/or plan of service that meets all applicable state requirements including, but not limited to, those outlined in the following RFP references:

- EVT0009267 (7.4.4.1. Plans of Service)
- RFPS30034902200777 (2.12.1 Member Care Management)

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

All members enrolled in a case management program receive a welcome letter outlining how the program works, the self-management plan that they have agreed to and their Care Integration staff member's name and contact information. The member's Primary Care Provider and any known involved specialists receive a copy of the welcome letter. Additionally, the member's Primary Care Provider is notified via the Provider Portal when a member is enrolled in the program. The Primary Care Provider can view the notes, care plan, including identified barriers, goals, and member self-management plan. The Primary Care Provider is notified 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 revisions to the plan.

A reassessment of the member's needs shall take place within three (3) Calendar Days of discovery or notice of Significant Change in Condition or needs. Actions taken (e.g., referrals to community agencies, authorizations of new services) that were a result of a Significant Change in Condition will be communicated to the Member and documented in the Member's record within four (4) Business Days of the Significant Change in Condition event to ensure appropriate communication of the event. Additionally, a reassessment of the member's needs shall occur if the member is receiving long-term case management services (reassessment every 365 days).

C. ONGOING MONITORING AND EVALUATION (PHM 5.E)

Care Integration Program	**Interventions**
Case 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 case 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**
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 • If the member had a change in risk level from low to medium, member receives IVR outreach offering enrollment into case 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. • All members are referred for case management interventions • Individualized treatment plan is developed by the Care Navigator and member • Collaboration with the PCP to increase member engagement with the PCP •
	Low Risk (1 point)-Targets those with a diabetes diagnosis.

Diabetes Disease Management	• 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. • 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 • If the member had a change in risk level from low to medium, member receives IVR outreach offering enrollment into case 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. • All members are referred for case 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 •
Obesity Disease Management	Low Risk- Targets those with a BMI greater than 95% • 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- Targets those with a BMI greater than 95% and 1 comorbid condition • 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 • Provider mailing of available resources to share with patient.

	• If the member had a change in risk level from low to medium, member receives IVR outreach offering enrollment into case management.
	High Risk-Targets those with a BMI greater than 95% and ≥2 comorbid conditions. In addition to the interventions listed for medium risk, the following interventions are also applied to this risk group. • All members are referred for case management • Individualized treatment plan is developed by the Care Navigator and member • Targeted mailing of additional resources • Referral to community-weight management education program if available • Collaboration with the PCP to increase member engagement with the PCP and decrease utilization
Depression Disease Management (if delegated)	Low Risk- Targets those with depression • 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- Targets those with depression and frequent ED utilization • 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 • If the member had a change in risk level from low to medium, member receives IVR outreach offering enrollment into case management.
	High Risk- Targets those with depression resulting in frequent hospitalization or high risk hospitalization. In addition to the interventions listed for medium risk, the following interventions are also applied to this risk group. • All members are referred for case management • Individualized treatment plan is developed by the Care Navigator and member • Targeted mailing of additional resources • Referral to community-depression education program if available • Collaboration with the PCP to increase member engagement with the PCP and decrease utilization

The Care Integration staff member employs a process of ongoing assessment and documentation to monitor the quality of care and services provided to the member. The Care Integration staff member is responsible for evaluating the information obtained during each interaction with member 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 Integration staff members 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 Integration staff member.

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

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

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 case 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 case 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 accessible within 24 hours for those 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 mother/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 business days
- 20- 44 µg/dL within 1-2 business days
- 45- 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 - confirm by venous sampling within 2 months
    - 20-44 µg/dL - confirm by venous sampling within 2 weeks
    - 45-69 µg/dL - confirm by venous sampling within 2 days

    - 70+ µg/dL – Immediately confirm by venous sampling as emergency
- Ensure that the childhood blood lead testing and follow up guidelines are followed as required:
    - 10-19 µg/dL - Early follow up testing-Within two to three months. Later follow up testing after BLL declining three to six months;
    - 20-70 µg/dL - Early follow up testing-Within one to two months 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 six months;
        - Lead hazards have been removed; and
        - There are no new exposures.
    - When the above conditions have been met, proceed with retest intervals and follow-up for BLLs 10-19 ug/dL.

At least two member/family encounters are made, all face-to-face (or video conference), unless otherwise directed by current state guidance, by PCN care team members.

- 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 Care Navigator's name and telephone number
- A 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 than10 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.
- The DHSS Databse 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 in the 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 /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 10 µg/dL.
- If a child is dis-enrolled and referral to new health plan, local public health agency, or health care provider has been complete.
- If PCN has documented at least three different types of attempts (home visit, sending letters with an address correction request, checking with the PCP, WIC, and other providers and programs) to contact the member/family to conduct an exit evaluation/case closure, the case will move to quarterly

outreach/interventions. If the family is unreachable after 1 year from last successful contact, a case closure letter will be sent to the member/family with instructions for contacting PCN to resume care management activities.

F. COLLABORATING OUTSIDE THE CARE INTEGRATION PROGRAM (PHM 1.A.3, PHM 2.C.3)

1. Coordination with Behavioral Health:

If delegated, Care Integration staff manage behavioral health needs as outlined in this document. If not delegated, Care Integration staff work collaboratively with the Health Plan behavioral health staff to coordinate and manage the medical and behavioral health needs of children enrolled in other health plans contracted with PCN. Creating links between these systems assists in coordinating care and support to ensure 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. This alerts the care team to coordinate care with the health plan representative. The member's primary diagnosis or condition determines which staff member is the primary lead for case management services. Care Integration staff lead case management services for members with primary medical conditions and behavioral health staff lead case management services for members with primary behavioral health conditions.

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 a Care Integration staff member 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 case conferences, ensuring the Primary Care Provider/Health Home is aware of all services the 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 Community Resource Specialists 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 Integration staff assess members 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 Integration staff member 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 coordinates services with the 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 members. In real time, Providers receive notifications in the Provider Portal to alert them of care coordination actives on assigned members. The Primary Care Provider can view notes, care plans, including identified barriers, goals, and member self-management plans. The Primary Care Provider is also sent notifications 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 for case management services to be terminated and when possible, utilize member/caretaker input to ensure a member centered approach. Staff members with need to discuss cases that appear to be languishing share during monthly medical director meetings or through as needed 1:1 discussion with leadership. Prenatal cases are reviewed for closure no sooner than sixty (60) days after delivery. Termination of a case can be requested by either the Care Integration staff member, Provider, or member/caretaker. 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 Integration staff member 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 Integration staff member notifies the member and the member's PCP when case management services are discontinued. The Care Integration staff member attempts to discuss case management closure with the member including the reason for case closure and how to access case management services in the future. Letters are also sent to the member and PCP to document the case closure. The letter includes a history of the member's condition, reason for disenrollment from case management services and the member's current medical status.

Transition of care forms are completed by the Care Integration staff member and faxed or securely e-mailed to the accepting Health Plan on all members who will be transferring to another Health Plan from the PCN's contracted Health Plan, when known per PCN policy #5201.

V. PROGRAM ACCOUNTABILITY AND EFFECTIVENESS:

A. FEEDBACK FROM MEMBERS (PHM 6.A)

PCN performs annual case management and disease management member satisfaction surveys. The surveys are designed to measure the satisfaction and program experience with the 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 Integration staff member and overall program services. The surveys are administered via text message and are comprised of a sample size of members who have received or are receiving case management or disease management services and have opted into receiving surveys. PCN analyzes the results and identifies opportunities to improve 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 case management or disease management program aspects. These complaints are also reviewed for opportunities to improve program services on at least an annual basis.

B. FEEDBACK FROM PROVIDERS

Annually, 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 as outlined in Policy 5050. 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.

D. PROGRAM EFFECTIVENESS (PHM 5.F, PHM 6.A, PHM 6.B):

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

A. Member Satisfaction with Case 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; Follow Up After Hospitalization for Mental Illness)
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 case management intervention)
F. Rate of ER Visits (pre and post case management intervention)
G. Per member per month cost of medical care (pre and post case management intervention)

E. NON-DISCRIMINATION AND REASONABLE MODIFICATION

A. PCN complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently because of age, color, culture, ethnicity, gender identity or expression, language, national origin, physical, mental or other disability, race, religion, sex, sexual orientation, socioeconomic status, or other basis protected by law as outlined in CMH "Nondiscrimination of Services and Medical Care Policy"
B. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers as outlined in PCN policy #2401 Multilingual Services and Communication Barriers.
C. Anyone member or caretaker who requires a reasonable modification of policies or procedures to participate in a program, service, or activity of PCN should notify PCN staff. Requested modifications will be discussed in conjunction with PCN leadership and will be honored unless making the modification would fundamentally alter the nature of the service, program or activity or the impairment is objectively transitory (lasting or expected to last 6 months or less) and minor.

REFERENCES:

RFPS30034902200777 MO HealthNet Managed Care contract – eff. July 2022
EVT0009267 KanCare Managed Care contract-eff. January 2025

WRITTEN BY:	REVIEWED BY:
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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, July 24, 2018, January 8, 2019, May 30, 2019; May 12, 2020; May 26, 2021; February 18, 2022; January 3, 2023; June 20, 2023; July 2, 2024; July 11, 2025; October 6, 2025

Clinical Quality Committee/Utilization Management Committee: March 2012; January 2013; July 2013; May 2014; November 2014; May 2015; February 2016; April 2018; April 2019; June 12, 2020 (KS); July 10, 2020 (MO); June 11, 2021(KS); July 7, 2021(MO); October 19, 2022(KS & MO); October 18, 2023 (KS & MO); October 16,2024 (KS & MO); October 16,2025 (KS & MO)

APPROVED:

10/22/2025

SVP, Executive Director Date

EXHIBT A


INTAKE/OUTREACH TEAM
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Community Resource Specialist
Care Facilitation Coordinator
Care Facilitation Coordinator
Care Facilitation Coordinator
Community Resource Specialist
Community Resource Specialist
Care Facilitation Nurse
Longitudinal Case Manager
Care Facilitation Nurse
Community Resource Specialist
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Integrated Care Team Lead
Care Navigator
Community Resource Specialist
Community Resource Specialist
Community Resource Specialist
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Care Navigator
Care Navigator
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Director, Integrated Care
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Manager, Care Integration
Supervisor, Care Integration