CHILDREN'S MERCY PEDIATRIC CARE NETWORK
CASE MANAGEMENT PROGRAM DESCRIPTION

Effective Date: 01/01/2012
Revision Date(s): 07/11/2012; 12/28/2012; 03/25/2013; 08/01/2013; 10/23/13; 01/06/14; 05/20/14
Approval Date(s): 02/07/2012; 7/31/2012; 01/02/2013; 04/16/2013; 08/06/13; 10/23/13; 01/14/14; 05/27/2014; **11/7/14**
Annotated to meet 2014 NCQA Health Plan Standards, Guidelines and Procedures
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I. INTRODUCTION:

A. PROGRAM DESCRIPTION

Children’s Mercy Pediatric Care Network (CMPCN) offers case management (CM) to eligible members. Case management is a system that focuses on 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, CMPCN continually assesses the characteristics and needs of the population and sub-populations being managed to identify opportunities to enhance and/or modify its case management program. This includes children with special needs, disabilities, and other complex health issues. CMPCN assesses program interventions and resources to determine if changes are needed to better meet the needs of the population.

B. PROGRAM GOALS

The goal of case management is to help members regain optimum health or improved functional capacity, in the right setting and in a cost effective manner. It involves comprehensive assessment of the member’s condition, determination of available benefits and resources, and development and implementation of a case management plan with goals, monitoring and follow-up.

C. PROGRAM OBJECTIVES

The objectives of the case management program are to:
- Assist the member in achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- 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 the member in self-advocacy and self- management
- Achieve cost efficiency in the provision of health services while maximizing health care quality
- Mobilize community resources to meet needs of members

II. LEVELS OF CASE MANAGEMENT:

CMPCN utilizes claims or encounter data, hospital discharge data, and data collected through the utilization management process to identify members eligible for case management services. The CMPCN Case Management Program is stratified into three (3) levels of case management:
- Complex Case Management (CCM)
- Case Management (CM)
- Care Coordination (CC)

A. COMPLEX CASE MANAGEMENT

In order for members to be eligible for the complex case management program, they must meet one (1) or more of the following criteria:
- 3 or more inpatient hospitalizations in the past 6 months (excluding chemo/cancer related admissions)

Comment [C1]: QI 7. A. 1,2,3,5 and 6
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- 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 OB 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)

CCM exclusions include:
- Members who are pregnant – except the High Risk OB indicator
- Members who meet the high risk indicator, but are at or above 35 weeks gestation at time of referral
- Members in hospice or long term care facilities (includes SNF or LTAC) without anticipated discharge to home
- Members with significant behavioral health diagnosis (schizophrenia)
- Members who have another insurance primary

B. CASE MANAGEMENT OR CARE COORDINATION

Members who are identified as needing case management services but who are assigned to a state-designated Health Home are opened in a Care Coordination level of case management in order to coordinate services with the member’s designated Health Home.

All other cases are designated as either Case Management or Care Coordination following a comprehensive assessment by the Case Manager, which includes addressing the following questions:

- Has member established care with a PCP and/ or Specialist who is actively directing member’s care?
  - Determined by either claims review or call to PCP/Specialist office
- Is a plan of care established?
  - Determined by member articulating plan of care to the Case Manager or confirmed with PCP or specialist office
- Is the member following the plan of care?
  - Determined by member articulating plan of care AND confirmation with PCP or specialist office
- Is the member adherent to medications as prescribed?
  - Determined by member articulating current medications AND by review of pharmacy claims history
- Does the member have a social support system in place?
  - Determined by member articulating support systems via assessment process

If the Case Manager is able to answer “yes” to all 5 questions, the case status may be considered a Care Coordination case. At the Case Manager’s discretion, a case may be placed at any time in a Case Management status (higher level of services) but may only be considered Care Coordination (lower level of services) if all 5 questions are answered with a “yes”.

III. IDENTIFYING MEMBERS FOR CASE MANAGEMENT:

CMPCN uses internal and external referrals to identify potential members needing case management services. Identification can occur at any time during the member’s eligibility with the CMPCN. Upon referral, case management staff assess the member’s eligibility for participation in one of the case management programs and conduct follow-up outreach to the member/caregiver(s) and his/her referring provider as applicable. In those instances where the Case Manager 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 by the Case Manager.
Referrals may come from but are not limited to:

- Any CMPCN staff (i.e., Disease Management, Utilization Management, Provider Relations, etc.)
- The member’s Health Plan staff (i.e. Quality Management, Customer Service, etc)
- Transition Nurses – through review of daily census reports and chart review at onsite hospitals
- Providers – educated through Health Plan provider newsletters, the CMPCN or Health Plan websites and the CMPCN provider educational materials
- Community Agencies – educated through the CMPCN and Health Plan websites, outreach events, and targeted education events
- Local Health Departments – educated through the CMPCN and Health Plan websites, outreach events, and targeted education events
- Internal encounter/claims/pharmacy data – through the use of automated trigger reports generated monthly
- Nurse Advice Line
- Member self-referral – educated through Health Plan Member Newsletters, the CMPCN and Health Plan websites, and the Health Plan Member Handbook
- New member already established in case management through another program (i.e. state FFS program or another Health Plan)

CMPCN uses proactive approaches to screen for case management 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 case management services.

A. ER REPORTS - Reports are generated monthly for those members who have had 3 or more Emergency Room (ER) visits in a quarter.

B. DIAGNOSIS TRIGGER REPORTS – Reports are generated monthly for existing members who have received a new diagnosis for any one (1) of the following:

- Cancer
- Cardiac Disease
- Chronic Pain
- Hepatitis C
- HIV/Aids
- Autism
- Sickle Cell Anemia
- Pervasive Development Disorder
- Anxiety

These members are sent a letter which outlines an opportunity to be screened for case management services. Letters are sent no more frequently than once every 6 months to the same member.

C. HIGH RISK OB SCREENING – Within 15 days of receipt of a Pregnancy Notification Form confirming a CMPCN member is pregnant, a letter is sent offering case management services. Reports are generated each week and sent to an outside vendor for mailing.

In addition, the Pregnancy Notification forms are screened by a Resource Specialist and high risk pregnancies, as defined by CMPCN, are referred through the CARE system to a Case Manager for assessment and enrollment in the Case Management program.

High Risk OB Indicators used to refer members to case management include:

a) Age 16 and under
b) Fetal anomalies (current)
c) Placenta previa (current; do not refer for low lying placenta)
d) History of PIH, HELLP or fatty liver of pregnancy

e) Chronic medical conditions that are being aggressively treated

f) Multiple birth pregnancy (current)

g) Hyperemesis gravidarum

h) History of previous stillbirth or fetal/infant death

i) Grand multiparity of 9 or more pregnancies

j) Hemoglobinopathy (i.e.: sickle cell anemia (not trait), thalassemia major)

k) Incompetent cervix (history/current)

l) Current or history behavioral health diagnosis (i.e.: depression, bipolar, anxiety, OCD, schizophrenia) and/or substance (includes Alcohol) use (i.e.: illicit drugs-including marijuana, cocaine, meth, etc.)

If only risk factor is behavioral health and/or substance (includes Alcohol) use-

Resource Specialist will refer to the Behavioral Health/Substance Abuse vendor via fax and document referral in outreach notes.

If member has behavioral health and/or substance abuse use AND another risk factor, Resource Specialist will refer to Case Manager. CM sends referral, if appropriate, to the appropriate Behavioral Health/Substance Abuse vendor.

m) Current STD (syphilis, gonorrhea, chlamydia, herpes (HSV), HPV, and trich) along with any other risk factor (if STD is the only risk factor, the case is not referred)

n) HIV

o) History of preterm labor

p) Domestic violence (current)

q) Current or history diabetes

r) Hypertension (history/current)

s) Asthma

If member’s only risk factor is asthma, Resource Specialist will refer to Asthma Disease Management Specialist only.

t) Any provider request for Case Management or an outreach call to member

D. 3 OR MORE INPATIENT STAYS IN 6 MONTHS REPORT – A report is generated monthly to identify members who have had 3 or more inpatient hospitalizations in a 6 month period. These members are referred by the Resource Specialist team to complex case management for assessment and ongoing coordination of care. Members appear on this report only once every 6 months.

E.D. HOSPITAL CENSUS REPORT- A report is generated each day detailing the inpatient hospital census. The report is reviewed daily by the Transition Nurses to assess for hospital stays in excess of 21 inpatient days and re-admissions within 30 days. Cases identified are referred to the Case Manager via the CARE system.

IV. CASE MANAGEMENT PROCESS:

At the time of initial assessment, members are asked if they are willing to participate in the program. As part of the introduction, Case Managers are also required to inform members selected for case management and document the following:

- Name and contact information for the Case Manager
- The nature of the case management relationship and expected contact intervals – Case Managers attempt to meet all high risk members face to face and attend clinic and home visits as needed
- Circumstances under which information will be disclosed to third parties
- The availability of a complaint process; and
- The reason why they were selected for case management
- The right to “opt out” of case management
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Members have the right to decline participation in, or “opt out” from the case management program at any time by requesting to be dis-enrolled from the program.

In instances where the Case Manager is unable to reach the member at the time of initial contact attempt, the Case Manager will place the case in an Outreach status while attempting to contact the member. Case Managers 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 case management program one week after the last phone attempt.

For open cases that have already been established and contact is lost, the Case Manager 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. CASE MANAGEMENT SYSTEMS

When conducting case management assessments, activities and interventions, CMPCN Case Managers utilize the Case Management Society of America’s standards of practice along with standardized nursing protocol for assessment, planning, intervention and evaluation. CMPCN’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 real-time through a weekly round table discussion with a CMPCN Medical Director and Director of Clinical Services, Transitional & Complex Care.

The CARE system has the following automated features:
- Date, time, and user stamp for each entry
- Reminders – a message that the Case Manager uses to remind him/her of a specific task
- Tickler List – a list of all follow-ups upcoming, due, or overdue
- Member Goals
- Member Care Plan
- Message Alerts

B. EVIDENCE-BASED GUIDELINES FOR ASSESSMENT

When conducting complex case management assessment, activities and interventions, CMPCN utilizes the Case Management Society of America’s (CMSA’s) standards of practice along with standardized nursing protocol for assessment, planning, intervention and evaluation. The complex case management assessment tools programmed into CMPCN’s CARE documentation system rely on evidence-based guidelines that are used in full or modified as necessary to accommodate CMPCN’s population. Complex case management assessment tools are reviewed and approved by the CMPCN Clinical and Quality Management Committee (CQMC) at least annually. CMPCN updates its complex case management software to reflect modifications made to the assessment criteria based on the availability of newly developed criteria or modifications to existing criteria.

C. INITIAL ASSESSMENT

For each member enrolled in CMPCN’s case 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. Case Managers conduct an initial review of the case within five (5) business days of receipt of the referral to determine complexity level and status. Cases requiring immediate attention are handled with urgency and an attempt to initiate an assessment is made within one (1) business day. Cases with no emergent needs must be contacted within ten (10) business days. In all cases, a completed assessment must be done within 30 calendar days of identifying the case for case management and/or receiving a referral. Inpatient cases
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identified as needing case management services are shadowed by the Case Manager until discharge. At the
time of discharge from the hospital, the member is identified for referral to case management and a referral
is made by the Transition Nurse to the Case Manager as part of the discharge planning process.

Case management staff conducts an initial assessment and ongoing evaluation of:

- Health status including condition-specific issues
- Clinical history, including 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 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 case manager is
    prompted to proceed with the remaining seven questions on the PHQ 9 screening. The case
    manager’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 service and reporting the screening outcome to the PCP for ongoing
    monitoring. The case manager develops goals and a self-management plan activities to monitor
    the member’s progress in this area. The case manager 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 Case Manager 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 Case
    Manager determines if such a discussion is appropriate during the first contact based on the member’s
    circumstances. The case management welcome letter directs members to the health plan handbook for
    additional information on advance directives.
- 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.
- Available benefits – Community Resources
  - Assessment of the member’s eligibility for health benefits and other pertinent financial information
    regarding benefits, 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.

Case management staff work with members enrolled in CMPCN’s case management program to develop
an individualized case management plan and a member self-management plan. The plans are
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communicated and agreed upon by the member/caregiver. The prioritized goals in the case management plan are intended to contribute to improved health outcomes. Case Managers 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 CARE 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 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. All goals should be specific, measurable and within the control of the Case Manager, including documenting member’s progress toward the goals and/or revising the goals, as appropriate.

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 and goals that they have agreed to with the Case Manager, as well as their Case Manager’s name and contact information. The member’s Primary Care Provider is also notified by letter when a member is enrolled in the program. The Case Manager sends each member’s Primary Care Provider a copy of the member’s identified barriers, case management plan, goals and member self-management plan upon opening a case and at least every three months while a case is active or more often if significant changes are made to the member’s plan. The case management plan is also available to Primary Care Providers in real time on the CMPCN Provider Portal.

D. ONGOING MONITORING AND EVALUATION

The Case Manager employs a process of ongoing assessment and documentation to monitor the quality of care and services provided to the member. The Case Manager 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. 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 case manager. Case Managers 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.

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 the CARE system with a specific date listed for follow-up and a note as to the expected content of the next follow-up contact.

E. COLLABORATING OUTSIDE THE CASE MANAGEMENT PROGRAM

1. Coordination with Disease Management:
CMPCN has disease management (DM) programs for asthma and diabetes. In cases where asthma or diabetes is the member’s primary condition causing barriers to optimal health outcomes, the case is managed by the Case Manager, and may be referred to the DM Specialist Population Health Specialist for short-term education. In cases where co-morbidities exist, the case is discussed between the Case Manager and the Disease Management Population Health Specialist to determine the best program care plan to meet the member’s needs.
2. **Coordination with Behavioral Health:**
CMPCN staff work collaboratively with the Health Plan behavioral health vendor 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 CMPCN to the behavioral health vendor or from the behavioral health vendor to CMPCN for co-case management, a referral form is used to facilitate case communication and an indicator is added to the CARE documentation system that the case is being co-case managed.

3. **Coordination with Utilization Management/Care Transitions Program:**
CMPCN Transition Nurses document in the CARE system pertinent clinical information related to inpatient episodes of care for members in case management. Documentation includes inpatient testing, transfers, aftercare and discharge planning. In addition all inpatient admissions are screened for case management. This facilitates communication and coordination of care between the Case Manager and Transition Nurse to ensure all the member’s needs are met following inpatient discharge. For members already in case management at the time of an inpatient stay, the initial 1 to 3 day post discharge follow-up call will be made by the Case Manager assigned to the member and the transitional care tab will be completed for that call. All future interventions will continue to be documented in the case management record. For members identified as needing case management services during their inpatient stay, the initial 1 to 3 day post discharge follow-up call will be made by the Transition Nurse, then the case is referred to the Case Manager for further post-discharge interventions. See the Transitional Care Program criteria for more details on this program.

4. **Coordination with Health Homes (Missouri only)**
On a monthly basis, the state of Missouri sends a file of members receiving Health Home services to the Health Plan. The Health Plan contact forwards the file of PCN members to the Manager of Transitional and Complex Care at CMPCN. All identified CMPCN members are flagged in the CARE system to identify members assigned to a Health Home. The Case Managers identify a Health Home member through the flag in CARE on the main demographic screen. When coordinating services for a Health Home member, the Case Manager notifies the designated Health Home contact that the member is in case management with CMPCN and provides their contact information. The Case Manager 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.

On a weekly basis, ER claims are reviewed for identified Health Home members and sent to the Manager of Transitional and Complex Care. If a Health Home member has been to the ER based on the weekly report and is in case management, the Case Manager is notified and sends the information to the designated Health Home contact. For members not in case management, the Manager of Transitional and Complex Care sends the information directly to the Health Home contact.

5. **Referral Management Only**
In some instances, a case will be opened by the Case Manager for complex referral tracking only. Cases meeting criteria for Referral Management type are those that do not meet complex case management criteria and may be cases where the member or member’s family refuse case management services, have met all goals, and/or are unable to be reached for case management interventions. Referral Management only cases are opened at the discretion of the Case Manager and may be a referral from the prior authorization area due to complex referral needs and the need for one person to manage the authorization of services. An assessment and planning process is not required for these cases. They are tracked for purposes of reporting only and monitored during audits to ensure the case type chosen was appropriate for the situation.
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6. Coordination with Primary Care Providers and Medical Home
In addition to carrying a caseload of active cases, Case Managers are assigned as primary liaisons to contracted Primary Care Providers (PCP’s) with the PCN. In their role as a Case Manager Liaison for a PCP office, they provide education about case management services, in conjunction with the Medical Home team. All Case Managers complete a Case Management Summary report for the member’s assigned PCP and any specialists actively involved in the member’s care within 15 days of completing the opening case assessment, care plan, member self-management plan and goals. The initial report is then mailed or faxed to the member’s assigned PCP/Specialist by the Case Manager. On a quarterly basis, each Case Manager is required to update the Case Management Summary reports on their existing cases and send updated reports to the member’s assigned PCP, as well as any specialists actively involved in the member’s care. The Case Management Summaries are saved in the attachment section of CARE and they are available in real time on the CMPCN Provider Portal.

F. CASE CLOSURE
Criteria must be met on all cases in order for case management services to be terminated. Prenatal cases are reviewed for closure no sooner than sixty (60) days from delivery. Termination of a case can be requested by either the Case Manager, 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 health plan
- Member is dis-enrolled from the CMPCN (i.e. changes PCP assignment)
- Death
- Provider, Member, or Authorized Representative of Member Requests
- Lack of contact or compliance with the Case Manager 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 may 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, Women, Infants and Children (WIC) and other providers and programs for member contact information

The Case Manager notifies the member verbally and by letter of discontinuation of case management services and documents the reason for case closure and discussions with the member. The member’s primary care physician must be notified in writing of all instances of children discharged from case management, and the reason for discharge. In addition, the notification must include a history of the child’s condition.

Transition of care forms should be completed by the Case Manager and faxed to the accepting Health Plan or state agency on all members who will be transferring to another Health Plan or the fee-for-service program, when known. Every attempt to coordinate care should be made with the accepting entity to ensure the best possible outcome for the member.

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

- The initial case management/admission encounter is required to be face-to-face and include assessment of member's needs. This is offered to all newly pregnant women in the prenatal packet, which is sent when the Pregnancy Notification Form is received.
- The pregnancy risk appraisal form is attached as a permanent part of the member’s CARE record.
- Intermediate referrals to substance-related treatment services if member is identified as substance abuser. IF member is referred to C-STAR, care coordination should occur in accordance with the Substance Abuse Treatment Referral Protocol for Pregnant Women under MO HealthNet Managed Care.
- 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 in OB case management. 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 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 (EPSDT/HCY services).
- Identification of feeding method for the child.
- Referrals for family planning if requested.
- Directions to start taking folic acid vitamin before the next pregnancy.

H. LEAD CASE MANAGEMENT (Missouri only)

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

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

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

- Ensure confirmation of capillary tests using venous blood according to the timeframe listed below:
  - 10-19 ug/dL - Within 2 months
  - 20-44 ug/dL - Within 2 weeks
  - 45-69 ug/dL - Within 2 days
  - 70 ug/dL – Immediately

- Ensure that the childhood blood lead testing and follow up guidelines are followed as required:
  - 10-19 ug/dL - 2-3 month intervals
  - 20-70+ ug/dL - 1-2 month intervals, or depending upon the degree of the elevated lead level, by physician discretion until the following three conditions are met:
    - BLL remains less than 15 ug/dL for at least 6 months
    - Lead hazards have been removed
    - There are no new exposures
- When the above conditions have been met, proceed with the retest intervals and follow-ups for BLL's ranging from 10-19 ug/dL.
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A minimum of 3 member/family encounters are made, all face-to-face:

- 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 case manager'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 or 3rd encounter is required to be performed prior to discharge between the 6th and 7th months after the initial encounter unless there is a medically necessary need for further follow-up. If the child meets the criteria for discharge, this encounter must include, but is not limited to, discharge counseling regarding current blood lead level status, review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance.

Documentation in the member record includes:

- Initial visit: 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 case management activities. DHSS childhood Lead Poisoning Prevention Program Nurse Lead Case Management Questionnaire & Nutritional Assessment to assist in capturing all required case management elements for documentation. Forms are found: Lead Poisoning Prevention manual @ [http://health.mo.gov](http://health.mo.gov).

- Follow-up visit documentation includes the most recent lab results, member status, any intervention by case management, contacts with child's primary care provider, and progress made to meet plan of care goals.

- Exit visit/discharge documentation must include date of discharge, reason for discharge, lab results, member status, and exit counseling. Exit counseling documentation must include telephone number for member questions/assistance, status of plan of care goal completion, member/family and primary care provider notification of discharge from case management, and continued care coordination plan.

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

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

### I. AUTISM CASE MANAGEMENT (Missouri only)

CMPCN identifies members with autism several ways. The primary way is through the monthly diagnosis trigger reports based on claims submitted. In addition, the state of Missouri sends the Health Plan a list of members who are on the autism waiver each month. The Health Plan identifies PCN members from that list and forwards any newly identified PCN members to the Director of Clinical Services at CMPCN. All members identified with autism are referred to a Case Manager for coordination of care. If the member doesn’t have co-morbidities and is not on the autism waiver, the case is opened in Care Coordination. If the member has co-morbidities and/or is on the autism waiver, the case is opened in Case Management. Autism case management follows the same procedures as described above for all other case managed cases, including assessment and ongoing management processes. In addition, autism cases are co-case managed.
CHILDREN'S MERCY PEDIATRIC CARE NETWORK
CASE MANAGEMENT PROGRAM DESCRIPTION

with the behavioral health vendor for coordination of care. A case management plan is developed in collaboration with the member, family/caregiver, provider(s), community agencies (if applicable) and the behavioral health case manager to ensure the member’s medical and behavioral needs are met.

V. SATISFACTION WITH CASE MANAGEMENT:

A. FEEDBACK FROM MEMBERS

CMPCN performs an annual complex case management satisfaction survey. The survey is designed to measure the satisfaction and program experience with the complex case management program. The purpose of the survey is to gain information about member perceptions, expectations, experiences and satisfaction with their Case Manager and overall program services. The survey is administered telephonically and is comprised of a sample size of members who have received or are receiving complex case management services. CMPCN analyzes the results and identifies opportunities to improve the satisfaction with the case management program on at least an annual basis.

VI. MEASURING EFFECTIVENESS:

CMPCN monitors the case management program on an ongoing basis with oversight from the Clinical and Quality Management Committee. CMPCN also produces an annual evaluation of the case management program, which includes analysis of all aspects of the program, such as:

- Established program outcomes
- Effectiveness of interventions implemented
- New opportunities for member and provider interventions to improve the program’s effectiveness
- Member satisfaction with case management services
- Analysis of member complaints and inquiries

To evaluate the effectiveness of the case management program, CMPCN assesses established program measures to identify areas of opportunity for improvement. The key measures that CMPCN examines to assess the program include:

A. Satisfaction with Complex Case Management (Member survey and analysis of complaints/grievances from members related to the program)
B. Rate of Hospitalizations (pre and post case management intervention)
C. Rate of ER Visits (pre and post case management intervention)
D. Per member per month cost of medical care (pre and post case management intervention)
D. Re-admission Rates for same/similar diagnosis within 30 days

REFERENCES:
2012 MO HealthNet Managed Care contract, sections 2.10 and 2.11

REVIEW AND APPROVAL:

Committee: Date:
Clinical and Quality Management Committee March 2012; January 2013; July 2013; May 2014