

CASE AND DISEASE MANAGEMENT

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Case Management Program Overview

The Centers for Medicare and Medicaid Services and the state of Missouri are contracted with WellCare Health Plans, Inc. to provide comprehensive, cost-effective managed care health services to enrolled members.

The purpose of the Harmony Health Plan of Missouri (Harmony) Case Management Program is to decrease fragmentation of healthcare service delivery, facilitate appropriate utilization of available resources and optimize member outcomes through education, care coordination and advocacy services.

The Case Management team is comprised of experienced registered nurses who conduct a comprehensive assessment of the member's medical, psychosocial and resource needs, develop an individualized treatment plan, establish treatment goals, monitor outcomes and update the treatment plan as needed.

Harmony currently offers complex, OB and lead screening case management programs. Providers may refer Plan members to any of these programs by calling **(866) 635-7045**. These programs are voluntary and members can opt-out at any time.

Complex Case Management

Complex Case Management is the coordination of care and services for members who have either experienced a critical event or have a chronic illness(s) that requires extensive resources. The case manager navigates the health care system facilitating the appropriate delivery of care and services with an ultimate goal for the member to regain optimum health or improved functional capability, in the right setting and in a cost effective manner. Complex case management includes a comprehensive assessment of the member's clinical condition and psychosocial needs; determination of available benefits and resources; development and implementation of a case management plan with performance goals; and, ongoing monitoring with follow up as needed.

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Distinguishing characteristics of the typical candidate for complex case management include:

- Complex and or severe illness(es)/condition(s)
- Intensive level of management needed
- Extensive utilization of resources needed to regain optimal health or improved functionality

Lead Case Management

The Centers for Medicare and Medicaid services (CMS) guidelines recommend annual lead assessments beginning at age 6 months and continuing through 72 months of age. WellCare provides lead case management services to members (ages 0 to 6 years of age) with elevated venous blood lead levels of 10 mcg/dL or greater.

Lead Case management services include:

- Collaboration with the PCP for screening tests and interventions;
- Initial face-to-face in-home site visit for member/family assessment, lead poisoning education, engagement of family in care plan development and identification of the care manager and phone number;
- Coordinating a home environment assessment by the Public Health Department, as needed;
- Follow-up with member/caregiver and collaboration with PCP until the lead level is below 10 mcg/dL;
- Three month follow-up in-home assessment to evaluate member's progress, parental compliance with recommended interventions, continued lead poisoning education and reinforce medical regime; and
- Discharge face-to-face in-home visit to counsel regarding blood lead level status, ongoing nutrition, hygiene and environmental maintenance.

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OB Case Management

Within 15 days of confirmation of pregnancy, Harmony offers case management services to eligible members.

Program features include:

- Referrals for prenatal care within two weeks of enrollment in case management;
- Tracking all prenatal and post-partum medical appointments. Follow-up on broken appointments made within one week of the appointment;
- Verifying EPSDT/HCY screens are current if the member is under age 21;
- Referrals to WIC within two weeks of enrollment in case management;
- Assistance in making delivery arrangements by the 24th week of gestation;
- Assistance with arranging transportation 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 enrolling the newborn in ongoing primary care (EPSDT/HCY services) including referral/assistance with MO HealthNet application for child if needed;
- Identification of feeding method for the infant;
- Notifications to current health care providers if case management services are discontinued;
- Referrals for family planning services if requested; and
- Directions to take Folic Acid vitamins before next pregnancy.

Candidates for Case Management

Members appropriate to consider or refer for Harmony's Case Management Programs include:

- **All pregnant members**
- Catastrophic – head injury, near drowning, burns, etc.

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- Complex – multiple co-morbidities or multiple intricate barriers to quality health care, i.e., HIV/AIDS.
- Lead blood lead levels equal to or greater than 10 mcg/dL.
- High-Risk Obstetrics Program – teen pregnancy, past history of low birth weight, history of pre-term birth, etc.
- Transplantation – solid organ or tissue transplants from evaluation to one year post-transplant
- Special-needs population – developmentally delayed, autism, failure to thrive, etc.
- Long-Term care – medically-frail elderly
- Chronic pain
- Cancer
- Hepatitis
- Sickle cell anemia
- Anxiety disorders
- Cardiac disease
- Pervasive developmental disorder

Disease Management Program

Disease management is a population-based strategy that involves consistent care across the continuum for members with or at risk for certain disease states. Elements of the program include education of the member about the particular disease and self-management techniques, monitoring of the member for adherence to the treatment plan and the consistent use of validated, industry recognized evidence-based clinical practice guidelines by the treatment team as well as the disease manager.

The disease manager serves as an important link between the member, the health care team, the payer and the community. Disease management occurs across a continuum of care, and while population based, is member-centric focusing on the individual.

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The Harmony Disease Management Program targets the following conditions:

- Major depression
- Asthma- adult and pediatric
- Childhood obesity
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Chronic kidney disease
- Diabetes- adult and pediatric
- HIV/AIDS
- Hypertension

Candidates for Disease Management

While Harmony encourages referrals from providers, members, hospital discharge planners, and others in the healthcare community, steps are taken within the organization to proactively identify members with or at the highest risk for suboptimal outcomes and increased utilization of services.

Harmony routinely utilizes a proprietary algorithm to conduct data mining of claims, encounter, pharmacy, lab and utilization data. The algorithm considers factors related to the severity of illness, service utilization and service costs.

Interventions for members identified through data mining vary depending on their level of need and stratification score. Interventions are based on industry recognized clinical practice guidelines. At a minimum, members receive educational mailings and the opportunity to request additional educational material specific to their condition(s) or needs as well as a resource contact number for additional information. Higher stratification levels receive disease specific educational materials, a comprehensive assessment by a disease management nurse, identification of a care plan and goals and follow-up assessments to monitor adherence to the Plan and attain goals.

Disease-specific Clinical Practice Guidelines adopted by Harmony Health Plan are posted on the provider

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Web site and may be accessed through the following link: : <http://www.harmonyhpm.com/Provider/PEMs>.

Access to Case and Disease Management

If you would like to refer a potential candidate to the Disease or Case Management programs or would like more information about one of the programs please call the Care Management Referral Line at **(866) 635-7045** or complete the Care Management Referral Form found on the Web site and fax to the Plan.