Our mission is to improve the health and quality of life of our members.
Complex Case Management Program Description

I. Purpose
To improve the health status and quality of life of members with multiple complex medical conditions, while decreasing unnecessary hospitalizations and emergency room (ER) visits, by improving member self-management skills, and by increasing adherence of both members and providers with Passport Health Plan’s (PHP) Clinical Practice Guidelines, which are based on current scientific data. To proactively provide coordination of care and services to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need assistance navigating the health care system.

The purpose of the Embedded Case Manager is to engage more members into care coordination activities to reduce care gaps, evaluate for and work to eliminate barriers to care, promote the most cost effective healthcare delivery by coordinating with all care providers, work to reduce inappropriate utilization of the ER, and partner in the member’s treatment plan to promote improved compliance.

II. Mission and Values
The Complex Case Management (CM) Program is designed to support the PHP mission to improve the health and quality of life of our members. It is also designed to support the values, which are as follows:

- **Integrity**: The virtue that requires our adherence to moral and ethical principles, and soundness of moral character.
- **Collaboration**: The principal that directs us to recognize the inherent worth of each associate and to mine individual talent, skills and competencies to create value for our members, providers, and the Commonwealth.
- **Community**: The commitment to an environment that focuses on serving our community of associates, members, providers and citizens that values understanding, acceptance, and respect of individuals and their multicultural richness.
- **Stewardship**: The wise and responsible use of all resources; human, financial, and material, for the greater good.

Scope
PHP Complex CM Program is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services needed to meet the member's health and human service needs and is characterized by advocacy, communication, and resource management.

PHP Complex CM Program has adopted the Commission for CM Certification (CCMC) definition of CM "CM is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."1

---

The CM Department serves the PHP eligible members for Jefferson County and fifteen (15) surrounding counties. PHP Complex Case Managers complete a comprehensive assessment, identify available benefits and resources, and work with practitioners, including the primary care provider (PCP) and specialists, to develop and implement the CM treatment plan. This plan includes establishing both long and short term performance goals, identification of barriers to meeting goals, monitoring for compliance, and follow-up. Periodic assessments of progress against plans and goals are conducted and modifications to the plan are made as needed.

III. Population Identification
Members are identified for Complex CM through the following sources:

- Member or caregiver referral
- Practitioner referral
- Internal PHP departments such as Members Services or Disease Management
- Referral from hospital discharge planners and PHP on-site care managers
- Community agencies
- Nurse 24/7 triage line encounter forms
- Daily hospital census report, which includes information regarding discharges
- Health Risk Assessment Forms (HRA). These are health risk assessments which are mailed to all new health plan members and are completed and returned by the member or may be completed telephonically by outreach staff.
- Predictive modeling software. New members are identified monthly by claims and pharmacy data and on a systematic basis by review of Utilization Management (UM) data.
- Scripted screening completed by the Rapid Response Outreach Team (RROT) Case Manager Technician (CMT).
- A trigger list for members who may be appropriate for Complex CM.
- A trigger list for members who may appropriate for Behavioral Health CM.
- Embedded Case Managers in high volume provider offices

The trigger lists includes but is not limited to:

**Individuals with Special Health Care Needs:**
- Children in or receiving foster care or adoption assistance
- Blind/Disabled children <19 and related populations eligible for SSI
- Adults over the age of 65
- Individuals with chronic physical health illnesses
- Individuals with chronic behavioral health illnesses
- Homeless (upon identification)

**Individuals with Behavioral Health Needs:**
- Member has a prior history of acute psychiatric or substance use disorder. Admissions authorized by BHS; with a re-admission within a 60-day period.
- First inpatient hospitalization following lethal suicide attempt, or treatment for first psychotic episode
- Member has combination of severe, persistent psychiatric clinical symptoms, and lack of family, or social support along with an inadequate outpatient treatment relationship which
places the member at risk of requiring acute behavioral health services.

- Presence of a co-morbid medical condition that when combined with psychiatric and/or substance use disorder could result in exacerbation of fragile medical status
- Adolescent or adult that is currently pregnant, or within a 90 day post partum period that is actively using substances, or requires acute behavioral health treatment services
- A child living with significant family dysfunction and continued instability following discharge from inpatient or intensive outpatient family services that requires support to link family, providers and state agencies which places the member at risk of requiring acute* behavioral health services.
- Multiple family members that are receiving acute behavioral health and/or substance use treatment services at the same time
- Other, complex, extenuating circumstances where the ICM team determines the benefit of inclusion beyond standard criteria

PHP Complex Case Management Department utilizes Beacon Health Strategies for behavioral health referrals when identified. A referral form process is utilized to notify Beacon’s CM department. Co-management of PHP CM services and Beacon CM services for PHP members can occur if member has both complex physical and behavioral health needs.

V. Complex CM Information Technology System Support

PHP Complex Case Managers document all direct interactions with members and/or caregivers in the CM notes section of JIVA, a care coordination software tool. All interactions, or attempted interactions, with a member or on a member’s behalf are documented in the CM notes. All CM notes are automatically stamped with the time, date, and the case manager’s identifier code. Within JIVA, there is an automated queue routing system enabling the case manager to schedule follow-up calls and/or route the case to another department, or individual, within PHP, as needed. The basic Adult and Pediatric Assessments are algorithmic and drive the case manager to specific interventions based on member responses to specific questions.

PHP Complex Case Managers use algorithms integrated into JIVA and the Plan’s Clinical Practice Guidelines, key components of which are also integrated into JIVA, to conduct assessments and case manage members. These tools are utilized to guide the case managers to direct members to the appropriate preventive services for the member’s age and sex as well as the expected treatment for specific medical conditions.

The Plan's Clinical Practice Guidelines are distributed to all participating practitioners as part of the Provider Manual and are available on the PHP website. Guidelines are reviewed, updated, and posted on the health plan’s website www.passporthealthplan.com at least every two years, and anytime new scientific evidence or national standards are published.

VI. Integrating Member Information

Passport utilizes an integrated documentation system, JIVA, in order to allow all health plan staff access to member information. In JIVA’s Member Centric view all users are able to view information that is specific to the member such as demographics, eligibility, member’s PCP, spoken language, and preferences on receiving educational materials or phone contact. Users also have the ability to enter additional addresses, or phone numbers, which the member may give as an alternative way to reach him/her that is not associated with the state
file download that populates the basic demographic fields in JIVA. The Member Centric view may also be utilized to denote a caregiver name and phone number, as needed. In addition, JIVA utilizes widgets to provide quick reference to “open” authorizations, care coordination activities, and appeals. Users can view detail of each “open” item, or view a summary of each, depending on what information is needed. JIVA also has multiple quick-access tabs across the top of the Member Centric view to allow a user the ability to:

- Edit demographic information and preferences, as needed.
- Add an episode or “open” cases.
- Upload documents related to the member and/or the member’s care that need to be visible to all users in order to facilitate seamless care coordination.
- View all the documentation that has been entered as it relates to the member.
- View any correspondence that the member has sent to the Plan, or that the Plan has sent to the member.
- View the member’s established care coordination assessment and plan of care.
- View claims, both pharmacy and medical, related to the member.
- View results of labs/screenings, as available.
- Review care gaps, as available.
- View a clinical summary, of the last 6 months history, of the member regarding tests and services, medical conditions, medications, ER visits, inpatient admissions, office visits, etc.
- View historical data or “closed” cases.

All of this data allows everyone interacting with the member to have the most current and available data in order to make every contact count to its fullest potential and improve coordination of care by all users having the same information.

VII. Member Participation and Opting Out of the Program
Participation in Complex CM Program is voluntary and the member has the right to decline participation. If the member initially accepts CM services he/she may choose to unenroll at any time. Members are educated on Complex CM services and advised at the time of the initial case manager contact that participation is voluntary. If the member agrees to participate, the initial assessment begins. If the member declines participation at the initial contact they are provided CM and RROT contact information and advised that if they wish to access the services in the future they can call or write. Members are also advised that they may request verbally or in writing to discontinue CM services at any time.

VIII. Member Contact
Contacts with those members who agree to participate in Complex CM Program may be by phone, mail, or face-to-face based upon their individually identified level of need. Members receive information about CM and how to contact the CM Department via the member handbook, articles in member newsletters, informational handout, and through the PHP member website (www.passporthealthplan.com).
IX. **Complex CM Process**

The PHP Complex CM Program includes procedures for improvement in delivery and management of health care services promoting quality, cost-effective outcomes.

While care for each member in Complex CM is individualized, PHP Complex CM procedures address the following:

- Members’ right to decline participation or unenroll from Care Coordination programs and services offered by the organization.
- Initial assessment of members’ health status, including condition-specific issues.
- Documentation of clinical history, including medications.
- Initial assessment of activities of daily living.
- Initial assessment of mental health status, including cognitive functioning.
- Initial assessment of life planning activities.
- Evaluation of cultural and linguistic needs, preferences or limitations.
- Evaluation of caregiver resources and involvement.
- Education/evaluation of available benefits within the organization and from community resources.
- Evaluation of visual and hearing needs, preferences, or limitations.
- Development of an individualized CM plan, including prioritized goals, that considers the members’ and caregiver’s goals, preferences, and desired level of involvement in the CM plan.
- Identification of barriers to meeting goals or complying with the plan.
- Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.
- Development of a schedule for follow-up and communication with the member.
- Development and communication of member self-management plans.
- Process to assess progress against the CM plans for members.

The above steps are repeated throughout the course of active CM, as dictated by the member’s individual medical and psychosocial condition, and progress towards goals.

X. **Complex CM Acuity Levels**

Once members are identified for CM, the members are stratified using an acuity scale. The acuity level scale defines the parameters of each acuity level (*Appendix A*).

Interventions are based on Acuity Levels, Medical Treatment Care Plan, CM Goals, Member Knowledge Level and Member Support System and Involvement.

XII. **Foster Care/Adoption/Guardianship Liaison**

The Foster Care/Adoption/Guardianship Liaison is a case manager that identifies, assesses, plans, coordinates, and implements appropriate cost-effective healthcare services for individuals identified as residing in Out of Home Placement. The Liaison works in collaboration with the Department for Community Based Services (DCBS) to identify DCBS clients for Care Coordination Services and is responsible for identifying and correcting problems with special populations including Foster Care, Guardianship, Department of Juvenile Justice, Kinship, Adoptive Assistance, and Residents of Psychiatric Treatment Facilities and Group Homes.
XIII. Practitioner Notification and Involvement

Practitioners in the Plan are notified of the program by the following:

- Welcome packet to new participating providers with information regarding how the Complex Case Managers work with members and instructions on how to access the program
- The PHP Provider Manual
- The PHP Provider Website @ www.passporthealthplan.com
- New Provider Toolkit
- Medical Office Notes
- Articles in the provider newsletter

PCP will receive written notification regarding their patients' participation in CM and a copy of the member's goals letter. Contact with the member's PCP and/or specialist continues, as needed, throughout the time the member remains in CM. An additional notification letter is sent to the PCP at the time the member is discharged from CM (Appendices B and C).

XIV. Member Satisfaction with Complex CM Program

PHP CM has a systematic method of evaluating member satisfaction with all areas of CM services (Appendix D). The CM Member Satisfaction Survey measures the frequency of contact and satisfaction with the case manager, the member's perceived improvement of overall quality of life, the member's perceived improvement in pain control or management, if applicable, and the member's perceived improvement in their overall health status.

The survey results are tracked and analyzed to identify opportunities to improve satisfaction with the Complex CM Program. Results are reported quarterly by the Manager of CM or his/her designee, with the goal of 90% or above in member satisfaction with all areas of CM services and 75% or above in the member's perception of improved overall health status and quality of life. Changes to the CM Program are made as needed.

Complaints and/or inquiries regarding CM services can be received by member services or through the CM department. Complaints and inquiries through member services are documented in EXP, a customer-service software package that records, tracks, and reports on all member and provider inquiries and complaints allowing for real-time on-line communication between departments. Complaints or inquiries through the CM department are resolved in the department and then forwarded to member services for documentation in EXP. Additionally, all member complaints regarding CM services are forwarded to the Director of Medical Management Care Coordination for follow-up.

The Director of Medical Management Care Coordination conducts a quantitative and qualitative analysis of complaints and inquiries regarding CM services, annually. This analysis is used to identify patterns of member complaints and opportunities to improve satisfaction with the Complex CM Program. Changes to the Complex CM Program are made as needed.

XV. Annual Evaluation

The annual evaluation of the Complex CM Program is conducted by the Plan's Manager of CM, the Director of Medical Management Care Coordination, the Vice President of Medical
Management, the Chief Medical Officer, and with input from the Quality Improvement Department.

Objectives, activities, and outcomes are evaluated at a minimum of annually in order to:

- Calculate annual participation rates.
- Determine whether the Complex CM Program has demonstrated improvement in their health status and/or quality of life.
- Evaluate the overall effectiveness of the Complex CM Program.
- Allow for exploration of barriers and limitations of the Complex CM Program.
- Revise areas as needed to improve effectiveness of the Complex CM Program.

Results of this evaluation process are utilized to revise the program and set the program goals for the following year.

**XVI. Program Goals**

- Members who either improved or reached their optimal level of health at discharge from CM.
- Meet or exceed a rate of 90% of goals partially or completely met for members enrolled in CM.
- Maintain a goal of 90% or above in member satisfaction with all areas of CM services.
- Maintain a goal of 75% or above in member’s perception of improved overall health status and quality of life.
- To improve the percentage of opened cases to 50%.

Final approval by the Quality Medical Management Committee:
January 8, 2008
March 3, 2009
March 2, 2010
April 28, 2011
July 20, 2012
July 2, 2013
Appendices

A. Acuity Level Grid
B. Provider Notification: Member Admission Cover Letter
C. Provider Notification: Member Goals Letter
D. Provider Notification: Member Discharge from CM Letter
E. CM Satisfaction Survey
<table>
<thead>
<tr>
<th>Proposals Definitions Status</th>
<th>ICM Definition</th>
<th>Term Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care Management Program (ICM) is a blended model that provides a holistic approach to illness by the CMA.</td>
<td>The member’s level of health needs is evaluated as part of the assessment and management process. The program utilizes a four-quadrant approach in allowing for members to move seamlessly from one quadrant to another based on the member’s needs.</td>
<td>Final Crosswalk for ICM definition, Acuity Level, Complexity Level, Member Class, and Episode Class.</td>
</tr>
</tbody>
</table>
### Complex Case Management Program Description

#### Acuity Level Grid

<table>
<thead>
<tr>
<th>Episode Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Newly assigned case</td>
<td>New member, no outreach needed.</td>
</tr>
<tr>
<td>1 - Minimal 2 months</td>
<td>Member has been engaged in outreach efforts.</td>
</tr>
<tr>
<td>2 - Minimal 3 months</td>
<td>Member has been engaged in outreach efforts.</td>
</tr>
<tr>
<td>3 - Minimal 6 months</td>
<td>Member has been engaged in outreach efforts.</td>
</tr>
<tr>
<td>4 - Annually</td>
<td>Member has been engaged in outreach efforts.</td>
</tr>
<tr>
<td>5 - Pilot program</td>
<td>Member has been engaged in outreach efforts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - Opt Out</td>
<td>Members that have declined ICM services.</td>
</tr>
<tr>
<td>1 - Engaged - New</td>
<td>Member has engaged in outreach efforts.</td>
</tr>
<tr>
<td>2 - Engaged - In process</td>
<td>Member has engaged in outreach efforts.</td>
</tr>
<tr>
<td>3 - Engaged - Episode</td>
<td>Member has engaged in outreach efforts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programs</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex care management</td>
<td>All members that do not fall into the other three categories.</td>
</tr>
<tr>
<td>Rapid Response</td>
<td>Members in RR and in IOB 2000/135 Case Management Program.</td>
</tr>
<tr>
<td>Case Management</td>
<td>Preplan and Possibility members.</td>
</tr>
</tbody>
</table>

Note: Each level represents a different degree of acuity and engagement, with higher levels indicating more intensive case management.
Dear <<Practitioner’s Name>>,

(Member’s Name) has agreed to participate in Passport Health Plan’s Case Management Program. Attached you will find the member’s Case Management treatment plan goals, agreed upon with the member. These are the items I will be focusing on with the member.

If there are areas of concern you have that you would like me to address with this member please let me know. Also, if there is any information you have that would assist me in better working with this member it would be greatly appreciated. From time to time I may send you correspondence to update you on the member’s participation or I may call you if an issue arises where I need your assistance or input.

I can be reached at:  Passport Health Plan
5100 Commerce Crossings Drive
Louisville, KY 40229
Phone: <<Case Manager’s phone #>>

If calling long distance: 1-877-903-0082, ext. <<Case Manager’ ext>>

Sincerely,

Case Manager
Dear <<Member Name>>:

Passport Health Plan wants to help you stay healthy. As your Case Manager, I will be helping you get the right care to stay healthy.

You and I have talked about your needs and we have decided on the following goals:

1.
2.
3.
4.

You can reach me at 1-877-903-0082 ext 0000 or TYY/TDD 1-800-691-5566, ext 0000. I am here from 8 AM – 6 PM. You may also leave me a message. Please leave your name and phone number. You can always reach a nurse at our Nurse Line. You can call anytime day or night. To reach a nurse call 1-800-606-9880.

If you do not want to be part of our program, please call me at 1-877-903-0082 ext 0000.

Sincerely,

<<Case Manager Name>>
Care Coordination Department
Passport Health Plan
1-877-903-0082 ext 0000

CC: <<PCP Name>>
<<PCP Address>>
<<City, State  Zip Code>>
<<Date>>

<<PCP Name>>
<<PCP Address>>
<<City, State  Zip>>

Re:  <<Member Name>>
    <<Member ID Number>>
    <<Member DOB>>

Your patient, <<Member Name>> is being closed from care coordination services effective <<date>>. This closure to care coordination services is not a disenrollment from Passport Health Plan. However, it does mean that a case manager will no longer be making active outreach calls to the member as part of a care plan. The member is being closed to care coordination due to the following reason(s):

•  <<Reasons for discharge in # 11B>>

If you disagree with the decision to have your patient discharged from care coordination, please contact me at (502) 585-0000, or at 1-877-903-0082 ext. 0000. I welcome your collaboration. If you feel care coordination services would be helpful for another Passport Health Plan member, please make a referral at 1-877-903-0082.

Sincerely

<<Case Manager>>
Passport Health Plan
Care Coordination
11B – Reasons for Discharge from Case Management

Reasons for approved closure letter to provider:

☐ Member could not be reached despite numerous attempts via telephone or letter
☐ Member achieved all Case Management goals
☐ Caregiver/member refused Case Management Services
☐ Member/caregiver could not be reached despite numerous attempts via telephone or letter for a follow-up after assessment was completed and goals were set. (Note: if this member/caregiver comes to your office, please have them contact me and I will be happy to reinstate the member into the Case Management Program.)
☐ Member has disenrolled
☐ Member has expired
☐ Abusive or threatening behavior by member toward Case Manager
☐ Member at higher level of care
☐ Member has assigned external case manager/care coordinator
☐ Member scheduled to disenroll, transition assistance completed
Case Management Satisfaction Survey
Your Opinion Matters to Us!

___________________, your case manager at Passport Health Plan has recently had a chance to work with you or your family with some concerns about your health care.

In an effort to help others and provide quality service to members, we are asking for your ideas. You can help others by answering the following questions. Please circle the most appropriate answer.

Please circle the best answer.

1. Number of times your case manager contacted you.
   1 time only   2 – 3 times   3-4 times   more than 4 times

2. Professional and courteous manner of your case manager.
   Poor (1)   Fair (2)   Good (3)   Excellent (4)

3. How your case manager helped you with your care.
   Poor (1)   Fair (2)   Good (3)   Excellent (4)

4. The information your case manager gave you to help you make decisions about your care.
   Poor (1)   Fair (2)   Good (3)   Excellent (4)

5. Overall helpfulness of your case manager.
   Poor (1)   Fair (2)   Good (3)   Excellent (4)
Since being in the Case Management program:

Please circle one.

6. Were the goals set by you and your case manager good for you?
   Yes (1) No (2)

7. Do you feel your overall quality of life has improved?
   Yes (1) No (2)

8. Do you feel your overall health has improved?
   Yes (1) No (2)

9. Do you feel you can control your pain better?
   Yes (1) No (2)

10. Additional Comments:

    ______________________________________________________________
    ______________________________________________________________
    ______________________________________________________________

Name (optional): __________________________________________

Please return the survey in the enclosed envelope. If you would like someone to contact you, please include a phone number and time when you can be reached.

Phone Number: ____________ Best Time to Call: ____________

Thank you again for your time!