2016
Complex Case Management
Program Description

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 members and clinicians adherence with national guidelines. 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.

II. Mission and Values
The Complex Case Management (CM) Program is designed to support Passport Health Plan’s (Passport) 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, clinicians, and the Commonwealth.

- **Community**: The commitment to an environment that focuses on serving our community of associates, members, clinicians 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.

III. Program Goals
- Increase the rate of members who either improved or reached their optimal level of health at discharge from the Complex CM Program.

- Meet or exceed a rate of 90% of goals partially or completely met for members enrolled in the Complex CM Program.

- Maintain a rate of 90% or above in member satisfaction with all areas of CM services.

- Meet or exceed a rate of 75% or above in member’s perception of improved overall health status and quality of life.
IV. Scope
Passport’s Complex CM Program has adopted the Commission for CM Certification (CCMC) definition of CM "CM is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client’s health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.”

The CM Department serves the Passport eligible members throughout the state of Kentucky. Passport’s Complex Case Managers complete a comprehensive assessment, identify available benefits and resources, and work with clinicians, including the primary care provider (PCP) and specialists, to develop and implement the CM treatment plan. This plan includes establishing prioritized 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.

Complex Case Managers 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. To improve the health status and quality of life of members with multiple complex medical conditions, while decreasing unnecessary hospitalizations and ER visits, by improving member self-management skills.

Department of Health (DOH) School Board Manager identifies, assesses, plans, coordinates and implements appropriate cost-effective health care services for individuals identified with special health care needs and medically fragile children. The manager works onsite at health departments and schools throughout the state in order to monitor the continuity and coordination of care and prevention of duplication for these children as part of the continuous quality improvement program.

V. Population Identification
Members are identified for Complex CM through the following sources:
- Referrals by:
  - Member or caregiver referral.
  - Clinician referral.
  - Internal Passport departments such as Members Services or Disease Management.
  - Referral from hospital discharge planners and Passport 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 a Care Connector outreach representative.
- 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 Care Connector outreach representative.

Embedded Case Managers in high volume clinician offices.
A trigger list for members who may be appropriate for Complex CM.

The trigger list 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 the Behavioral Health (BH) Program; 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 postpartum 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, clinician 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 Intensive CM team determines the benefit of inclusion beyond standard criteria.

In addition to the above methods of member identification, Passport at least annually, assesses the characteristics of its entire enrolled population to determine its relevant needs in order to update processes, resources, and special programs as needed.

Passport Complex CM Department utilizes BH Program for BH referrals when identified. A referral form is utilized to notify BH Program’s CM Department. Co-management of Passport CM services and BH Program CM services for Passport members can occur if member has both complex physical and behavioral health needs.

Multidisciplinary team meetings occur every two weeks between Passport and BH Program staff to discuss complex cases to evaluate and optimize resource assistance and availability. The team collaborates to identify issues and to discuss options to meet team/member goals, and utilize resources to achieve optimal results for members and their families.
VI. Complex CM Information Technology System Support
Passport 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 Complex Case Manager’s identifier code. Within JIVA, there is an automated queue routing system enabling the Complex Case Manager to schedule follow-up calls and/or route the case to another department, or individual, within Passport, as needed. The basic Adult and Pediatric Assessments or Maternity Assessment are algorithmic and drive the Complex Case Manager to specific interventions based on member responses to specific questions.

Passport Complex Case Managers use algorithms integrated into JIVA and the national guidelines, key components of which are also integrated into JIVA, to conduct assessments and case manage members. These tools are utilized to guide the Complex 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 national guidelines are distributed to all participating clinicians as part of the Provider Manual and are available on the Passport website. Guidelines are reviewed, updated, and posted on the Passport website www.passporthealthplan.com at least every two years, and anytime new scientific evidence or national standards are published.

VII. 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 and review:
  - All the documentation that has been entered as it relates to the member.
  - Any correspondence that the member has sent to Passport or that Passport has sent to the member.
  - The member’s established care coordination assessment and plan of care.
  - Claims, both pharmacy and medical, related to the member.
  - Results of labs/screenings, as available.
  - Care gaps, as available.
A clinical summary, of the last six months history, of the member regarding tests and services, medical conditions, medications, ER visits, inpatient admissions, office visits, etc.

Historical data or “closed” cases.

All of this data allows everyone interacting with the member to have to 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.

VIII. 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 “opt out” at any time. Members are educated on CM services and advised at the time of the initial Complex Case Manager’s 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 Care Connector’s 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.

IX. 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 Passport member website (www.passporthealthplan.com).

X. Complex CM Process
The Passport 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, Passport Complex CM procedures address the following:
- Members’ right to decline participation or “opt out” 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 functions.
- 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 CM 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.
• A 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.

XI. 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. Clinician Notification and Involvement
Participating clinicians with Passport are notified of the Complex CM Program by the following:
• Welcome packet to new participating clinicians with information regarding how the Complex Case Managers work with members and instructions on how to access the Program.
• The Passport Provider Manual
• The Passport Provider Website @ www.passporthealthplan.com
• Quick Reference Guide
• Provider Orientation Kit
• eNews

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

XIII. Member Satisfaction with Complex CM Program
Passport’s Complex CM Program has a systematic method of evaluating member satisfaction with all areas of CM services (Appendix D). The CM Member Satisfaction Survey (Appendix E) measures the frequency of contact and satisfaction with the Complex 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 Complex 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 clinician inquiries and complaints allowing for real-time on-line communication between departments.

Complaints or inquiries through the CM Department are resolved in the CM Department and then forwarded to Member Services for documentation in EXP. Additionally, all member complaints regarding CM services are forwarded to the Manager of Care Coordination or his/her designee, for follow-up.

The Manager of Care Coordination or his/her designee, 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.

XIV. Annual Evaluation
The annual evaluation of the Complex CM Program is conducted by the Manager of Care Coordination, the Director of Medical Management Care Coordination, the Director of Quality, the Chief Medical Officer, or designee.

Objectives, activities, and outcomes are evaluated at a minimum of annually in order to:
- 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 Complex CM Program and set the program goals for the following year. Any identified changes will be submitted to the Department of Medicaid Services (DMS) for review and approval. Passport shall have approval from DMS for any changes prior to implementation.

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
- May 6, 2014
- May 12, 2015
- June 14, 2016
Appendices

A. Acuity Level Grid
B. Clinician Notification: Member Admission Cover Letter
C. Clinician Notification: Member Goals Letter
D. Clinician Notification: Member Discharge from CM Letter
E. CM Member Satisfaction Survey
The Acuity (Quadrant Level) is determined by the CM based on the member’s identified risk level for their Physical Health (PH) and Behavioral Health (BH) conditions.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>PH Risk Level</th>
<th>BH Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Undecided-member not engaged</td>
<td>Undecided-member not engaged</td>
</tr>
<tr>
<td>1</td>
<td>Low PH needs</td>
<td>Low BH needs</td>
</tr>
<tr>
<td>2</td>
<td>Low PH needs</td>
<td>High BH needs</td>
</tr>
<tr>
<td>3</td>
<td>High PH needs</td>
<td>Low BH needs</td>
</tr>
<tr>
<td>4</td>
<td>High PH needs</td>
<td>High BH needs</td>
</tr>
</tbody>
</table>
<<Date; Month name/day, year; i.e.; May 27, 2015 >>

<<PCP NAME>>
<<PCP ADDRESS>>
<<CITY, STATE  ZIP CODE>>

MEMBER NAME:  <<LAST, FIRST>>
MEMBER PHP ID#: << 00000000>>
MEMBER DATE OF BIRTH: << 00/00/0000>>

Dear <<Dr. PCP Last Name>>;

Hello, my name is <<CM Name>> and I want to make sure you know that << Member’s Name>> is participating in Passport Health Plan’s Case Management Program. I am providing you, for your records, with a copy of << Member’s Name>>’s Case Management treatment plan goals, which were agreed upon during our discussion of Passport’s Case Management Program. These are the items I will be focusing on with him/her.

If there are additional areas of concern that you would like for me to address with << Member’s Name>>, please let me know and I will work with << Member’s Name>> on those concerns as well. I can be reached at 1-877-903-0082; ext. <<0000>>. Also, if you have any information that would assist me in working with this member, please let me know so that I can incorporate it into his/her treatment plan. I will send you periodic updates on of << Member’s First Name>>’s progress.

Thank you for your continued support of Passport Health Plan’s Care Coordination Department and our overall mission to improve the health and quality of life of our members.

Sincerely,

<<Case Manager Name & Credentials>>
Care Coordination Department
Passport Health Plan
1-877-903-0082; ext. <<0000>>
Or local: <<000-0000>>

Enclosure

(Adult Admission Letter)
<<Date; Month name/day, year; i.e.; May 27, 2015 >>

<<PCP NAME>>
<<PCP ADDRESS>>
<<CITY, STATE  ZIP CODE>>

MEMBER NAME:  <<LAST, FIRST>>
MEMBER PHP ID#: << 00000000>>
MEMBER DATE OF BIRTH: << 00/00/0000>>

Dear <<Dr. PCP Last Name>>;

<<Insert minor member’s caregiver/parent name here and relationship to minor member along with minor member’s name >> has agreed for <<Minor Member’s name>> to participate in Passport Health Plan’s Case Management Program. Attached you will find a copy of the member’s treatment plan goals, which were agreed upon with the member’s <<Parent/caregiver and their name>>. These are the areas I will be focusing on.

If there are concerns that you would like for me to address with this member, please call me at 1-877-903-0082; ext. <<0000>>.

If you have any information that would assist me in working with this member, it would be greatly appreciated. I will follow up with you periodically to provide updates on this member’s progress.

Sincerely,

<<Case Manager Name & Credentials>>
Care Coordination Department
Passport Health Plan
1-877-903-0082; ext. <<0000>>
Or local: <<000-0000>>

Enclosure

(Pediatric Admission Letter)
[Date]

Dear <Member’s Name>,

As your Case Manager at Passport Health Plan, I’ll be helping you get the care you need to stay healthy.

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

1. I will support you and give you information on community resources that can help you. I will also help you set up any health care services you need.
2. Along with this letter, I have included a community resource guide. This guide has the phone numbers to any agencies or groups who can offer you free resources.
3. You will talk to your doctor(s) about any issues or worries you have about your treatment plan.
4. <fill-in as needed>

If you have any questions, please call me at 1-877-903-0082, press 0, then press <XXXX>. TTY/TDD users may call 1-800-691-5566. I am here Monday through Friday from 8 a.m. to 6 p.m. Eastern Time. If I do not answer, please leave a message with your name and phone number.

You can also call our Care for You Nurse Advice Line at 1-800-606-9880. Registered nurses are here to answer your questions 24 hours a day, 7 days a week. If you do not want to be part of our program, please call me at 1-877-903-0082, press 0, then press <XXXX>.

Sincerely,

<Name>, <Title>
Passport Health Plan

CC: <PCP NAME>
   <PCP ADDRESS>
   <CITY, STATE ZIP CODE>

(Adult Member Goal Letter)
[Date]

Dear <Member’s Caregiver/Parent(s) Name>,

As <member’s name> Case Manager at Passport Health Plan, I’ll be helping <him/her> get the care <he/she> needs to stay healthy.

You and I have talked about <member’s name> needs and we have decided on these goals:

1. I will support <member’s name> and give you information on community resources that can help <him/her>. I will also help you set up any health care services <member’s name> needs.
2. Along with this letter, I have included a community resource guide. This guide has the phone numbers to any agencies or groups who can offer you free resources.
3. You will talk to <member’s name> doctor(s) about any issues or worries you have about <his/her> treatment plan.
4. <fill-in as needed>

If you have any questions, please call me at 1-877-903-0082, press 0, then press <XXXX>. TTY/TDD users may call 1-800-691-5566. I am here Monday through Friday from 8 a.m. to 6 p.m. Eastern Time. If I do not answer, please leave a message with your name and phone number.

You can also call our Care for You Nurse Advice Line at 1-800-606-9880. Registered nurses are here to answer your questions 24 hours a day, 7 days a week. If you do not want to be part of our program, please call me at 1-877-903-0082, press 0, then press <XXXX>.

Sincerely,

<Name>, <Title>
Passport Health Plan

CC: <PCP NAME>
    <PCP ADDRESS>
    <CITY, STATE ZIP CODE>
<<Date; Month name/day, year; i.e.; May 27, 2015 >>

<<PCP NAME>>
<<PCP ADDRESS>>
<<CITY, STATE ZIP CODE>>

MEMBER NAME: <<LAST, FIRST>>
MEMBER PHP ID#: << 00000000>>
MEMBER DATE OF BIRTH: << 00/00/0000>>

Dear <<Dr. PCP Last Name>>;

Your patient, <<Insert Member’s Name>> is being discharged from Passport Health Plan’s care coordination services effective <<date: 00/00/0000 format>>. This is not a disenrollment from Passport. However, it does mean that a case manager will no longer be making active outreach calls to the member due to the following reason(s):

- <<Reasons for discharge: i.e.; Member’s care plan goals met. ; Member disenrolled from plan. Member has been unable to contact. >>

If you have questions about this decision, or if you feel care coordination services would be helpful for another Passport member, please call 1-877-903-0082; ext. <<0000>> to make a referral.

Sincerely,

<<Case Manager Name & Credentials>>
Care Coordination Department
Passport Health Plan
1-877-903-0082; ext. <<0000>>
Or local: <<000-0000>>
CRITERIA FOR DISCHARGE FROM CARE COORDINATION

Criteria for members to be discharged from Care Coordination include, but are not limited to, the following:

GENERAL GUIDELINES

- Unable to contact after a minimum of 2-3 attempts (two attempts if member has no valid phone number, three attempts if member has a valid phone number) within a 30-day period
- Member is admitted to a facility and the stay is longer than 30 calendar days
- Member deceased
- Member disenrolled from the plan, on Community Based Waiver Program, in a Skilled Nursing Facility, or long-term incarceration
- All achievable goals met or unable to further impact care
- At member request
- Abusive or threatening behavior by the member toward the Care Coordinator
- "Special" external customer referrals must be discussed with the department Manager prior to discharge

PSYCHOSOCIAL REFERRALS

- Adequate support system in place or available for member when they are ready
- Member/Caregiver is linked to behavioral health services, if needed

MEDICAL REFERRALS

- Medical conditions are stable, needs are currently being met and exacerbations can be handled by current plan of care (POC)
- Optimal medical improvement has been reached

COMPLIANCE/ADHERENCE REFERRALS

- Unable to impact after involvement with member, Primary Care Provider (PCP)/Specialist and all appropriate agencies
- Compliant with PCP/Specialists’ appointments, in good standing with Child Protective Service (CPS)/Adult Protective Service (APS) and with no new areas of concern for at least 3-months
Case Management Satisfaction Survey

Our records show that ______________________, your case manager, recently worked with you or someone in your family with some concerns about your health care.

Your Opinions Matter to Us! Please take a moment to answer the questions below. Your answers will tell us what we’re doing right and how we can improve.

Please check the best answer.

How would you rate the following:

1. How well the program helped you understand your health problems:
   □ Excellent (4)    □ Fair (2)
   □ Good (3)        □ Poor (1)

2. The professional and courteous manner of your case manager:
   □ Excellent (4)    □ Fair (2)
   □ Good (3)        □ Poor (1)

3. The way your case manager helped you with your care:
   □ Excellent (4)    □ Fair (2)
   □ Good (3)        □ Poor (1)

4. The written materials mailed to you (brochures, letters, newsletters):
   □ Excellent (4)    □ Fair (2)
   □ Good (3)        □ Poor (1)

Please answer the following questions:

5. Did your case manager give you information to help you make decisions about your care? □ Yes □ No

6. Do you feel your overall quality of life has improved? □ Yes □ No

7. Do you feel your overall health has improved? □ Yes □ No

8. Do you want us to call you about your survey answers? If so, please provide your name and phone number: (Please print)
   NAME: ____________________________
   PHONE #: __________________________
   This is optional if you don’t want to be contacted

9. Are there ways the program could have been more helpful to you? If so, please explain: (Please print)
   ___________________________________
   ___________________________________

Please return this survey. The postage has been paid for you. Thank you again for your time!

Please moisten here and fold this paper in half.