

# Section IX

## Special Needs & Case Management



### **Integrated Health Care Management (IHCM)**

The Integrated Health Care Management (IHCM) program is a population-based health management program that utilizes a blended model that provides comprehensive case management and disease management services to the highest risk health plan Members. The primary focus is on coordination of resources for those Members expected to experience adverse events in the future. The IHCM Program provides specialized services, which support and assist Members with medical, behavioral and/or social issues that impact their quality of life and health outcomes. Identified issues/diagnoses that would result in a referral to the IHCM Program include, but are not limited to:

- Multiple diagnoses (3 or more major diagnoses)
- Pregnancy
- Pediatric Members requiring assistance with EPSDT services
- Pediatric Members requiring in-home nursing services
- Members with dual medical and behavioral health needs
- Members with behavioral health diagnoses needing assistance with referral to a Behavioral Health Managed Care Organization (BH-MCO) or special help with access to medical care
- Members with Intellectual Disability
- Members with a Special Need
- Members with Chronic Diseases including:
  - Heart Failure
  - Diabetes
  - Asthma
  - COPD
  - Coronary Artery Disease
  - Sickle Cell
  - HIV
  - Hemophilia

The primary method of service for the IHCM Program is telephonic outreach, assessment, and intervention. The IHCM staff makes outreach calls to the Member, and/or Member representative, as indicated, and collaborates with the PCP and Specialist to develop a treatment plan.

### **Complex Care Management (CCM)**

The Complex Care Management (CCM) program is a blended model that provides comprehensive case management and disease management services to the most complex adult and pediatric members with several co-morbidities. These members may also need disease management education for Cardiovascular Disease, Diabetes, Asthma or COPD. Members are identified for CCM through many sources, including referrals from internal and external sources.

**For more information and/ or to refer Members to the Complex Care Management program call: 1-800-573-4100.**

### **Pediatric Shift Care**

Pediatric Shift Care Management is provided to members less than 21 years of age who are medically fragile and have chronic health care needs and receive skilled nursing and/or home health aide services.

**For more information and/ or to refer Members to the Pediatric Shift Care Management program call: 1-800-573-4100.**

**Disease State Management (DSM)**

Members identified as high-risk receive targeted education and fact sheets on their disease as well as engagement into our Complex Case Management program. Care managers address goals, and develop a plan of care with input from the member and the physician(s). Members assessed to be low-risk receive information via mailings with access to a case manager as necessary.

**For more information and/ or to refer Members for Disease State Management call: 1-800-573-4100.**

**Episodic Case Management/Special Needs Unit**

The Episodic Case Management/Special Needs Unit provides coordination of services to new adult and pediatric Members to the plan and existing Members with short-term and/or intermittent needs who have single problem issues and/or multiple co-morbidities. The case managers in this unit support Members in resolution of pharmacy, DME and/or dental access issues, assistance with transportation, identification of and access to Specialists, or referral and coordination with behavioral health providers or other community resources. There is also a dedicated case manager who acts as the point person/liaison to coordinate and collaborate with Behavioral Health MCOs for members with both physical and behavioral/mental health issues, as well as various government offices, Health Care Providers, and public entities to deal with issues relating to members with Special Needs.

**For more information and/ or to refer Members to the Special Needs Unit call: 1-800-573-4100.**

**Urgent Response Team**

The Urgent Response Care Management team provides coordination of services to Pediatric and Adult members who have an “urgent” need. The members may have a single issue or a variety of issues that need to be addressed **urgently/immediately**. The care managers in this unit support Members in resolution of pharmacy, DME, dental access issues, and coordination of behavioral health and community resources that need to be addressed urgently/immediately.

**For more information and/or refer Members to the Urgent Response Team call: 1-800-573-4100**

**The Bright Start Maternity Program® for Pregnant members**

The Bright Start Maternity Program is a focused collaboration designed to improve prenatal care for pregnant Members. The Bright Start Maternity Program assesses, plans, implements, teaches, coordinates, monitors and evaluates options and services required to meet the individual’s health needs using communication and available resources to promote quality and cost effective outcomes. The design of the Bright Start Maternity Program allows for collaboration between the Care Manager, the Member, the Obstetrician, and the BHMCO for assessment and interventions to support management of behavioral/social health issues.

The Bright Start Maternity Program is designed to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program provides focused, collaborative services designed to improve prenatal care for pregnant members. Keystone First developed this comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population.

### Program Goals:

- Early identification of pregnant Members (utilizing laboratory and pharmacy data) and accurate contact information
- Improve health outcomes for neonates
- Facilitate access to needed services and resources
  - Dental Screenings
  - Behavioral Health Screenings
- Build collaborative relationships with community-based agencies that specialize in services for maternal-child health
- Encourage early prenatal care and continuum of care through post-partum period by increasing awareness through member newsletters, media engagements, provider education and community alliances
- Assess and address healthcare disparities in pregnant women

Members enrolled in the Bright Start Maternity Program receive a variety of interventions depending upon the assessed risk of their pregnancy. Case Managers play a hands-on role, as necessary, in coordinating and facilitating care with the members' physicians and home health care agencies. They also outreach to ensure member follow-up with medical appointments, identify potential barriers to getting care, and encourage appropriate prenatal behavior.

Members are triaged using informatics reports and assessment information provided by the obstetrics practitioner into low-risk and high-risk populations.

- Low risk Members receive educational material about pregnancy, preparing for delivery, and how to access a Plan Case Manager for any questions/issues.
- Low risk Members also receive an outreach call after delivery to complete a post-partum survey.
- Members that are triaged as high-risk receive "high touch" case management interventions by a case manager.

### Bright Start Maternity programs designed to positively impact birth outcomes:

- Moms 2B program
- Text4 Baby program
- Breast Pump program
- Postpartum visit coordination
- Postpartum care rewards program
- Keys to Your Care rewards program

**For more information and program details visit the dedicated Bright Start Maternity page on the Provider Center at [www.keystonefirstpa.com](http://www.keystonefirstpa.com) To refer Members to the Bright Start Maternity Program call 1-800-521-6867.**

## ***Postpartum Home Visit Program***

### **Purpose**

The Postpartum Home Visit is offered to all Members who deliver a baby. The purpose of the program is to ensure the Member receives the appropriate clinical assessment, education and support for a healthy transition from the hospital to home.

All Members and newborns are eligible to receive a clinical nursing visit within one (1) week of discharge from the hospital.

- All deliveries (vaginal or cesarean) are eligible for up to two (2) home visits.
- If complications are identified during the home visit, it is the responsibility of the Home Visit Provider to request the authorization of additional home visits or other services
- When a detained baby is discharged more than one (1) week from birth, an authorization is required to receive a home visit.

### **Home Nursing Visit**

The Postpartum Home Visit includes a physical, psychosocial and environmental assessment with individualized education, counseling and support.

### **Requesting a Postpartum Home Visit**

Network Providers should contact their facility's Discharge Planner to request a Postpartum Home Visit for their patient.

## ***Pediatric Preventive Health Care Program – Known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT)***

The goal of the Pediatric Preventive Health Care (PPHC) Program is to improve the health of Members under age 21 by increasing adherence to the Pennsylvania Children's Checkup Program and National Immunization Program guidelines. The PPHC program focuses on identification and coordination of preventive services for Members under age 21.

The program is structured to provide assessment of the Member's condition and monitoring of adherence to pediatric preventive guidelines, along with consideration of the Member's other health conditions and lifestyle issues. The PPHC Program provides a mechanism to ensure that Members under age 21 receive screening, preventive care and related medical services required by the EPSDT program. By state and federal mandate, EPSDT requirements include: well child visits, immunizations, lead screening, dental services, vision screening, hearing screening, anemia screening, urinalysis, Sickle Cell Disease screening and screening for Sexually Transmitted Diseases (STDs). Members are considered enrolled upon identification, unless the Member or parent/guardian notifies Keystone First to remove the Member from the program. Upon enrollment, eligible Members receive program materials explaining how to use the

program, available services, how Members are selected to participate and how to opt-out of the program.

Detailed information about Keystone First's EPSDT requirements for physicians can be found in Section II Referral and Authorization Requirements and Policies.

### **Outreach & Health Education Programs**

Keystone First develops innovative programming in an effort to increase member health screening compliance in the community setting while also providing disease management/prevention education. The goal of Keystone First's Community Health Education Programs is to increase members' knowledge of self-management skills for selected disease conditions. The health education programs focus on prevention in order to help members improve their quality of life. The Public Affairs and Marketing team targets Keystone First members who are non-compliant for HEDIS measures, in an effort to facilitate health screenings, provide education, close care gaps, and re-connect them with their PCP's. The Keystone First Public Affairs & Marketing team works in collaboration with the Rapid Response Outreach Team and Case Management units to achieve these desired outcomes.

### ***Rapid Response and Outreach Team (RROT)***

The Rapid Response Team was created to address the urgent non-clinical needs of our Members. The RROT is trained to assist in the rapid triage of the Member's needs. Their goal is to reduce both unnecessary emergency room visits and in-patient stays as well as assist in removing barriers to needed health care services.

The team consists of registered nurses, social workers and care connectors (non-clinical) who are trained to triage and assist members in overcoming barriers in achieving their health care goals.

The RROT can assist members:

- Schedule doctor appointments.
- Help with transportation concerns.
- Help members understand health conditions.
- Help remove barriers to health care services.
- Answer questions about how to get medicine, supplies and medical equipment.
- Find resources in the community (dental, vision, behavioral health, housing, food and clothing).
- Call members after a stay in the hospital to make sure the services they need (such as therapy and home health care) have been set up.

There are four key service functions performed:

1. **Inbound Call Service.** Members and Keystone First providers may request RROT support via a direct, toll-free Care Coordination line. Referrals to RROT are also received through many sources, such as the Special Needs Call Line, Member Services,

Pharmacy, Utilization Review, Retention Unit and Provider Relations. The RROT toll-free number is provided as a contact point for all member mailings and automated messaging – encouraging members who need additional support or information to call.

2. **Outreach Service.** Outreach activities include telephonic survey or assessment completion and support of special projects or Quality initiatives. RROT associates also place outreach follow-up calls to those members who have called the 24 hour Nurse Line and require further assistance from Care Management staff.
3. **Clinical and Non-Clinical Case Management Support.** Care Coordinators support Care Managers in Care Coordination by providing administrative support to members. These include appointment scheduling and reminders, transportation support, member educational mailings, and other administrative tasks assigned by Care Managers.
4. **Support EPSDT (Early Periodic Screening Diagnostic and Treatment) services.** EPSDT services are mandated by Federal and State contracts to ensure that children who are enrolled in Medicaid, receive preventive health services before a condition becomes serious to impair their growth and development. Care Connectors are trained to assist parents/guardians in getting access to routine check-ups, mandatory periodic examinations and evaluations which are helpful to assess, control, correct or reduce health problems identified.

### **Let Us Know Program**

The Let Us Know program is administered through RROT and is a partnership between Keystone First and the provider community. This program was designed to assist providers in the engagement and management of chronically ill members. The program supports providers in the identification, outreach and education of members for such issues as inappropriate use of emergency room, not showing up for appointments, non-compliance with prescribed medications, and much more.

There are three ways to alert the Let Us Know Program:

1. Contact the Rapid Response and Outreach Team: Call 1-800-573-4100 from 8:00 a.m. until 6:30 p.m. or fax a member intervention request form to 1-800-647-5627. The form can be found on the Let Us Know section of the Provider Center at [www.keystonefirstpa.com](http://www.keystonefirstpa.com)
2. Use the NaviNet Care Gap Worksheet found on Navinet.
3. Refer a patient to Complex Care Management at 1-800-573-4100.

### **Tobacco Cessation**

The tobacco cessation program offers Members a series of educational classes easily accessible within their communities. The program offers targeted outreach to Members who are pregnant or who have chronic conditions such as asthma, diabetes, cardiovascular disease or other serious medical conditions, encouraging these Members to enroll in tobacco cessation classes. For more information go to the Department of Health website: <http://tinyurl.com/PA-Tobacco>

## **Breast Cancer Screening and Outreach Program (BCSOP)**

BCSOP is an outreach program developed to increase Members' awareness of the importance of a mammography screening and to encourage female Members age 50 and older to have regularly scheduled mammograms. Keystone First establishes partnerships with community organizations. Designated outreach staff contacts Members by phone or mail, to schedule mammography screenings, remind Keystone First Members of appointments, and reschedule appointments if necessary. At the time of the screening, Members are educated about breast self-exam and instructed to contact their doctor for the results of the screening. All results are sent to the PCP for follow-up.

## **Domestic Violence Intervention**

Keystone First is participating in a collaborative domestic violence education program with the Department of Human Services (DHS) and other HealthChoices Managed Care Organizations. There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health Care Providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables Health Care Providers to assist their patients, and family members who are victims.

The clinical model known as RADAR was developed by the Massachusetts Medical Society to assist clinicians in addressing domestic violence and is an excellent tool for assisting Health Care Providers in the identification of and intervention with possible domestic violence victims.

The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

**R**outinely screen about partner violence.

**A**sk directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview the patient in private at all times.

**D**ocument information about "suspected domestic violence" or "partner violence" in the patient's chart.

**A**ssess the patient's safety. Is it safe for her to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

**R**eview options with the patient. Know about the types of referral options (e.g., shelters, support groups, legal advocates).

You can help your patients by referring them to [www.ndvh.org](http://www.ndvh.org) or have them contact the National Domestic Violence Hotline, where all calls are free and confidential.

### **National Domestic Violence Hotline**

1-800-799-7233 (SAFE)

1-800-787-3224 (TTY for the Deaf)

*Help is available in English, Spanish and many other languages.*

For a list of where to get help for a patient, please see the Appendix.



## **The Provider's Role**

Network Providers can help to identify and refer Members who are at high risk for particular diseases and disorders to the appropriate program.

### **Call the Outreach & Health Education Program Staff at 1-800-521-6007:**

- With questions about any of the health education programs
- With requests for outreach services

## ***Pennsylvania's Early Intervention System***

### ***Early Intervention Services\****

While all children grow and develop in unique ways, some children experience delays in their development. Children in Pennsylvania with developmental delays benefit from a state supported collaboration among parents, service practitioners and others who work with young children needing special services. The Pennsylvania Early Intervention program provides support and services to families with children birth to age 5 with developmental delays. Early Intervention builds upon the natural learning opportunities that occur within the daily routines of a child and their family.

Early Intervention promotes a philosophy that supports:

- Services and resources for children that enhance daily opportunities for learning provided in settings where a child would be if he/she did not have a disability.
- Families' independence and competencies.
- Respect of families' strengths, values and diversity.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

\*Source – <http://www.dhs.pa.gov/citizens/earlyinterventionservices/>

### ***What Children Are Eligible?***

Children from birth to age 5 who have special needs due to developmental delays or disabilities are eligible to receive Early Intervention services.

Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through CONNECT Helpline at 1-800-692-7288 and document the referral in the child's medical record.

### ***What Services are Provided to Meet the Developmental Needs of a Child?***

The services provided to children and their families differ based upon the individual needs and strengths of each child and the child's family. Services such as parent education, support services, developmental therapies and other family-centered services that assist in child development and may be included in a family's Early Intervention program.

Early Intervention promotes collaboration among parents, service providers and other important people in the child's life to enhance the child's development and support the needs of the family.

### ***Where do Children and Their Families Receive Services?***

Services may be provided in the child's home, child care center, nursery school, play group, Head Start program, early childhood special education classroom or other settings familiar to the family. Early Intervention provides supports and services in a variety of settings at no cost to the family. Early Intervention supports and services are embedded in typical routines and activities, within the family, community and/or early care and education settings. This approach provides frequent, meaningful practice and skill building opportunities.

Parents who have questions about their child's development may contact the **CONNECT Helpline at 1-800-692-7288**. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children ages birth to age 5. In addition, CONNECT can assist parents by making a direct link to their local Early Intervention program or local preschool Early Intervention program.

Referrals to Early Intervention are directed to the local Early Intervention service coordination unit. Initial contact with the referred family occurs locally and at a time and place convenient to the family.

### ***Specialists as PCPs for Special Needs Members***

Specialists may be able to serve as PCPs for Special Needs Members, including Members that have a disease or condition that is life threatening, degenerative, or disabling. Keystone First Members may contact the Special Needs Unit to request designation as a "Special Needs Member" and request approval to utilize a specialist as PCP. Case Managers will work with the Member and Keystone First staff to identify an appropriate Specialist. The Specialist must have expertise in the treatment of the medical condition of the Member.

To accommodate these Members, Keystone First's Special Needs Unit will contact the requested Specialist and obtain their verbal agreement to provide specialty care services, as well as, primary care services. The Specialist will be informed that the final approval is subject to meeting credentialing requirements and office accessibility standards (including EPSDT). Upon approval, this information will be forwarded to the Provider Network Management and Member Services Departments. Keystone First's Provider Network Management Department will negotiate a contract with specialists who meet Keystone First's Credentialing criteria, and who

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wish to function as a PCP for a Member(s) with Special Needs. The specialist will be set-up in our Provider Network database as a "Specialist as PCP". The Member will then be assigned to the "Specialist as PCP" panel.