

Overview

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, *Case Management* is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs.

Case Management ensures continuity of care for the members through coordination of care among physicians and other providers. Case managers work side by side in an integrated manner with social workers/behavioral health staff and pharmacy staff to supply members with essential additional benefits and a comprehensive approach to provision of member needs and services.

- Primary Care Physicians (PCP's) serve as principal case managers and coordinators of care. The Plan's Case Management team serves in a support capacity to the PCP and assists in coordinating care among multiple physicians and providers.
- The Case Management team is comprised of specially qualified nurses who assist the physician in achieving member wellness and autonomy through advocacy, communication, education and service facilitation.
- The Plan has incorporated Case and Disease Management programs that manage members with specific health care needs such as: Transplant, High-Risk OB/Prenatal, EIP/Special Needs for Children, Asthma, Congestive Heart Failure, Diabetes, HIV/AIDS, Hypertension, Elevated Lead Levels, catastrophic diseases (adult and children) and Smoking Cessation.

Transplant Case Management

WellCare offers a transplant case management program with dedicated transplant case managers to ensure information is available to providers and to facilitate all aspects of the transplant process.

A transplant case manager will be assigned to assist providers in the multiple needs of the member as a transplant candidate.

The transplant case management team will:

- Evaluate the member for eligibility and covered transplant benefit;
- Assist providers in initiating transplant protocol;
- Provide a list of potential facilities for transplantation based on:
 - Medicare/Medicaid Centers of Excellence
 - Geographical proximity to the patient
 - Authorizations for services through all the transplant phases
 - Testing and preparation for transplant;
- Act as the member's advocate, emotional support and Plan liaison;
- Request medical documentation and records from the office; and
- Facilitate approval of transplant benefits.

Obstetrical Care

In support of obstetrical care, the Plan has adopted Guidelines of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). These clinical practice guidelines are based on valid and reliable clinical evidence.

The Plan contracts with participating providers for OB care that includes OB services as well as midwife services. The OB or midwife ~~must~~ will complete the Prenatal Notification form/Risk Assessment Form (DH3134) (found in the **Forms** section of this manual) at the first prenatal visit. The providers will retain a copy of the Prenatal Risk Screening Notification Form

in the medical record and forward a copy within ten (10) business days, to the county health department where the screening was performed. A copy of the Prenatal Risk Screening form (DH3134) will also be provided to the member. Then, fax the completed form to Plan's OB department. Upon receipt, the Plan will give comprehensive authorization for prenatal, delivery and postpartum care. Additionally, the member will be enrolled in the Prenatal Program and evaluated for enrollment in the High-Risk OB Case Management Program. If a pregnant member is receiving care from a non-participating provider, the Plan will make special arrangements to reimburse the provider for the member's care though the postpartum period.

The provider is required to provide the most appropriate and highest level of quality care for pregnant women.

The Prenatal Program

The Prenatal Program promotes a healthy pregnancy and delivery for the member and baby. The member receives educational material, trimester and postpartum letters and a Prenatal Reward form (see the **Forms** section of this manual).

The member will present the Prenatal Reward Form to the physician for signature at the end of each trimester and at the postpartum visit. The physician completes the form, signs the form at the bottom and faxes it back to the Plan. The member will receive a stroller for keeping at least six prenatal visits and a postpartum visit (between the third and seventh weeks) with their OB.

High-Risk OB Case Management

The focused High-Risk OB Case Management Program provides assistance to members that are identified as potential high-risk pregnancies. If the physician notifies the Plan of a member's non-compliance, the high-risk OB case manager can support the physician with necessary interventions to

encourage compliance.

The High-Risk Case Management Program:

- Educates members on their medical condition;
- Coordinates care through the continuum; and
- Assists the member in being an active participant in his/her own health care.

CMS & Early Intervention Programs

The Plan partners with Children's Medical Services (CMS) to provide additional benefits to members and referrals for diagnosis specific resources. The case managers provide parents/guardians/caregivers with valuable information to increase awareness and enhance understanding of available benefits and resources.

An example is the CMS Early Steps Program. When a child is identified as a potential Early Steps candidate, the case manager works collaboratively with CMS to determine eligibility to ensure a seamless transition if the child is accepted to the CMS program.

Lead-Level Screening Program

The Plan provides Case Management services to all eligible children with blood lead levels (BLL) greater than or equal to 10 mcg/dl.

Services include:

- Family education about lead poisoning;
- Assistance in obtaining lead abatement;
- Coordination of testing of siblings;
- Scheduling of appointments; and
- Coordination of transportation, when needed.

Those members with elevated blood lead levels will be identified through a monthly lead level report from contracted laboratories and from the Plan's Child Health Check Up Plan.

Disease Management Programs

The Disease Management Program proactively identifies members with certain diseases and provides education for these members and/or their caregivers. The Disease Management Program empowers members to make behavior changes to help improve their health and reduce the complications of their disease(s).

In addition, the program educates members and their caregivers about the standards of care for their disease states and what triggers to avoid. The program also reviews the medication(s) the member is receiving to verify they are appropriate for the member's specific condition(s).

The program also focuses on educating the provider with regards to the standards of care and current treatment recommendations for the individual disease management conditions. Intervention and education will help improve the quality of life of members, help improve health outcomes and help decrease medical costs.

The Disease Management Program is comprised of 13 disease states: (Note: The **bolded** conditions are Florida specific state requirements.)

- **Asthma**
- Chronic Obstructive Pulmonary Disease (COPD)
- **Diabetes**
- **Congestive Heart Failure (CHF)**
- Coronary Artery Disease (CAD)
- Obesity
- **Hypertension (HTN)**
- **HIV/AIDS**
- Major Depression*
- **Bi-Polar/Mental Illness (Behavioral Health)***
- **Substance Abuse (Behavioral Health)***
- **Smoking Cessation**

* WellCare's case and disease management program screens for these

diseases, and then they are referred to the behavioral health vendor's intensive case management programs.

- Members are stratified according to the severity of their disease.
- All members receive educational mailings and have the opportunity to request additional educational materials specific to their condition or needs.
- Members who are stratified in the most high-risk categories receive telephonic intervention by a disease management nurse. The nurse conducts a telephonic disease-specific health risk assessment and provides education regarding the disease process.
- All members receive periodicity letters to remind them of the preventive health care they need.
- Members receive flu and pneumonia reminders.
- Members receive newsletters that feature articles related to specific disease states to provide further education and awareness.
- Providers receive Clinical Practice Guidelines based on nationally-recognized evidence-based guidelines.
- Providers receive newsletters that feature articles regarding the latest treatment guidelines.