

10: Case Management Services

10.1 Background

Unison strongly believes in the utilization of case management services to promote comprehensive coordinated care for identified populations.

Our Case Management program serves as an individualized service delivery based on comprehensive assessment tools that are used to develop a care plan. The care plan is developed in collaboration with the member, family (if applicable), and the treating physician. The goal is to empower the member and involve them in all aspects of the planning and service arrangements.

The Unison philosophy expands on this premise as we believe that psychosocial issues, especially in the Medicaid population, directly impact upon the members' ability to manage their disease or condition. To this end, our case management team employs a multidisciplinary approach where the clinical case management (RN) activities are complimented or assisted by social work-based case managers through our Special Needs Unit (SNU).

10.2 Physician Involvement

Physicians can be actively involved in the case management programs in several ways. The plan recognizes the importance of not only including the treating physician on a member by member basis but also to use the expertise of practicing physicians in the ongoing refinement of the case management program.

The various processes for physician involvement are described below:

- Each treating physician is notified in writing and by telephone at the time of their patient's enrollment in the case management program and is invited at that time to participate in the initial and ongoing development of the care plan. The case manager may contact the primary treating physician in order to design specific interventions in conjunction with the practitioner's treatment plan. This is also considered as an opportunity by the case manager to develop a relationship with the treating physician and his office staff
- The case managers contact the treating physician with any serious changes in member's condition to update/redirect the plan
- Physicians receive a quarterly roster of their members accompanied by a patient profile or "Report Card" (for certain programs) that provides relevant member-specific medical information such as condition monitoring, adherence to treatment plans and identification of co-morbid conditions for several of the case management programs. Physicians who score high results on the report cards are highlighted in provider newsletters as "best practices."
- Annually, physicians receive Health Management Program Description outlining key activities that illustrate program services including case management services and identifies how the plan works with both the physician and the member
- Physicians are strongly encouraged to refer patients to case management on an as needed basis

Physicians can refer their patients for case management by any one of the following methods:

Unison Health Plan Provider Services Department
www.unisonhealthplan.com
800.600.9007

- FAX the Health Management Program Form to 412.457.1355
- Call Case Management at 877.844.8844 to identify the member
- Mail the Health Management Referral Form to:

Unison Administrative Services
Attn: Case Management
300 Oxford Drive
Monroeville, PA 15146

10.3 Health Management Programs

The **Adult Case Management** portion of the program identifies and risk-stratifies the adult medically complex population with consideration to co-morbid conditions and social environment. Activities are designed to address members within the continuum of their disease, including educational outreach, ongoing-targeted short and long term case management, as well as collaboration with the member's physician and other health care team members to effectively educate and develop an optimal treatment plan to help the member manage their disease.

The **Pediatric Case Management** portion of the program was intentionally designed to have a very broad diagnoses base to allow referrals for reasons other than catastrophic type illnesses or conditions. Children with Special Health Care Needs (CSHCN) require case management inclusive of targeted and focused care plans that often include a strong social work component resulting in a collaboration of clinical case management with social services.

CSHCN are defined as follows:

- Members age 17 and under and pregnant

Member under age 21 who are also have:

- Asthma
- A chronic physical, emotional, or mental condition for which they need or are receiving treatment or counseling
- Supplemental Security Income (SSI) for a health related condition
- A current letter of approval from the Bureau of Children with Medical handicaps (BCMh)

The following case management programs are offered through Unison:

10.3.1 Asthma Case Management

The Asthma program focuses on children and adults with moderate to severe asthma and has a heavy emphasis on improving the quality of life, patient education and the increased usage of long-term control medications. Each patient is assessed, stratified and the care plan intensity can range from basic educational mailings for those members who require limited assistance to comprehensive care plans with frequent outreach to both the patient and the treating physician. All children under 21 years of age with a diagnosis of asthma, regardless of severity, should be referred to case management services for screening/assessment.

10.3.2 High Risk Pregnancy Case Management

The high risk pregnancy program is partnered with the Miracles program which offers a “buddy” system for all pregnant members to encourage pre-natal care. Members are identified as high-risk, primarily through the OB/GYN physician’s submission of the OB Needs Assessment Form that is completed during the first prenatal visit. The assessment form is designed to clearly identify member that are at risk of pre-term labor or a poor outcome of the pregnancy.

High risk pregnancy indicators are as follows:

- Teen pregnancy – age 17 and under (CSHCN indicator)
- Pre-term labor
- Premature rupture of membranes/cervical dilation
- Uncontrolled insulin dependent diabetes
- Fetal anomalies
- Placental/uterine abnormalities
- Hyper-emesis
- Incompetent cervix
- Uncontrolled asthma
- Uncontrolled or chronic hypertension/pregnancy induced
- Hypertension
- Pre-eclampsia
- Multiple gestation
- History of three or more previous miscarriages after first trimester
- Bleeding after first trimester
- Current drug or alcohol abuse

10.3.3 Pediatric/Neonatal Intensive Care Unit (NICU) Case Management

The Pediatric program includes such diagnoses as but is not limited to the following:

- Multiple Sclerosis/Paralysis/Epilepsy
- HIV/AIDS
- Congenital Anomalies
- Muscular Dystrophy
- Trauma
- CSHCN
- Respiratory & Cardiac Conditions
- Catastrophic type events/conditions
- Obesity
- Sickle cell

The **NICU Case Management** program is designed to assign a case manager as soon as possible after the infant’s birth. The NICU case manager performs all of the Utilization Management (UM) activities for the admission which include continued stay and discharge planning. Contact with the parent(s) is established while the infant is hospitalized so that if the infant is identified, through risk stratification methodology, for case management services post discharge, the critical relationship with the parent(s) has already been established.

If a **High Risk Pregnancy** case manager identifies a patient where premature delivery of a high risk infant is imminent or predicted, the case manager will consult with the NICU case managers and discuss the mother’s clinical and social history allowing a smooth transition of the high risk mother and infant to the NICU case manager.

10.3.4 Adult Case Management

Adult Case Management includes such diagnoses as but is not limited to the following:

- Obesity
- AIDS/HIV
- Anemia/Sickle Cell
- Multiple Sclerosis/Epilepsy/Paralysis
- Trauma
- Circulatory & Respiratory conditions
- Spinal Cord/Head Injuries
- Neoplasm's
- Chronic Pain
- Other Catastrophic conditions

The inpatient utilization management includes a process that requires the UM nurse to screen and refer to case management, patients with pre-identified diseases/conditions for potential short term case management services. Short term case management is defined as a hospital admission that has created a change in the members discharge status that could require additional monitoring and support for a designated period of time.

10.3.5 Diabetes Case Management

Diabetes case management focus is education and improved compliance with the physician's treatment plan. Patients are primarily identified through claims and pharmacy activity but as with all of the programs, members, treating physicians and the plans UM department are also a strong referral source. Each member is assessed, stratified and the care plan is customized to meet each member's needs. Members that require limited assistance will receive educational mailings and members who require a more intense approach, a comprehensive care plan will be developed that includes frequent outreach to both the member and the treating physician.

10.3.6 Wound Care Case Management

Wound Care case management emphasizes activities and treatments that will prevent the complications of chronic or catastrophic wounds, using cost-effective and patient-involvement strategies. Consideration is given to the co-morbid conditions to prospectively provide member outreach. Activities are designed to address members within the continuum of their wound care treatment plan, including educational outreach, ongoing-targeted case management, as well as collaboration with the member's physician and other health team members to effectively educate and develop an optimal treatment plan to help the member manage their wound care treatment.

The wound care program is somewhat unique as it frequently traverses most of the other case management programs due to the co-morbidities associated with chronic diseases. In these instances the member will be dually managed with the acute clinical event determining the lead case manager. The member will always have just one individual accountable point of contact.

10.3.7 Transplant Case Management

The Transplant Case Management program monitors the member from initial evaluation to one (1) year post transplantation. Activities are designed to address members within the continuum of care, provide ongoing-targeted case management, which includes collaboration with the member's physician(s) and the facility transplant team.

The transplant case managers are assigned as the member enters the transplant evaluation process. The case manager performs the UM activities associated with the transplant evaluation, all inpatient admissions and related outpatient services. The case manager develops a relationship with the patient, family and the hospital transplant team which allows the case manager to support the patient and family through a very difficult and stressful time of their lives.

10.3.8 Special Needs Unit (SNU)

The social work based case management of the SNU provides support and assistance to the clinical case management program.