Section IX

Special Needs & Case Management

Intensive Case Management (Health Education and Management)

Keystone Mercy has a comprehensive Member health education and management program. This proactive medical care coordination program focuses on Members with specific health risks. Based upon the illness and the severity of illness of Members, Network Providers may be contacted to refer Keystone Mercy patients for participation in one or more of these programs. These programs are intended to be a collaborative arrangement between Keystone Mercy Case Managers and a Network Provider's existing treatment plans for the involved Members and will in no way impede the Network Provider's autonomy to provide care to Members enrolled in the following programs:

Special Needs/Case Management

Keystone Mercy's Special Needs/Case Management Department, located within the Medical Affairs Department, provides intensive Case Management Services designed to meet the medical and social needs of Members identified as having case management and/or Special Needs. This Department is intended to provide dedicated, intensive Case Management Services and other necessary assistance for:

- Members identified as having an ongoing complex medical condition whose care must be coordinated across various Health Care Providers
- Members with limitations that hinder their ability to access and/or receive necessary medical care and other necessary services

While these two categories frequently overlap, some examples of Members assigned to Case Managers include, but are not limited to:

- A Member with HIV/AIDS who requires ongoing coordination of medical care across different Health Care Providers but who has intact social support structures
- A technology dependent child whose parents require the services of various social support agencies and special education in caring for their child
- A Member who is residing in a foster care home or an ICF/MR
- A child who has been identified as potentially developmentally delayed
- A teenager with a substance abuse problem or a pregnant Member who is an IV drug user
- A young Member with a serious emotional disturbance and/or behavioral disorder
- A homeless Member with substance abuse problems and/or tuberculosis

The Case Managers act as liaisons with various government offices, Health Care Providers and public entities to deal with issues relating to Members with Special Needs, and to assist individuals with disabilities who are having difficulties accessing services through Keystone Mercy. The Special Needs/Case Management Department can be reached by calling **1-800-521-6007**.

WeeCare Program for Pregnant Members

Keystone Mercy has developed a comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population, which were evidenced by the following:

- High neonatal intensive care days
- Excessive infant readmission rates

- Rising preterm births
- Increased incidents of maternal complication requiring extended hospitalizations

The program is a complimentary extension of Keystone Mercy's existing core obstetrical program. The goals of the WeeCare Program are:

- Early identification of pregnant Members
- Early and continual intervention throughout pregnancy
- Provision of programs designed to encourage Members to seek care and follow prenatal protocol

Keystone Mercy utilizes several means to identify Members as early in their pregnancy as possible. These include but are not limited to Claims investigation, information from the initial health assessment, the coordination of internal Keystone Mercy Departments, the use of Member newsletters and referral networks, and physician referrals. Members who agree to participate in the WeeCare Program are paired with a Keystone Mercy WeeCare Case Manager. The WeeCare Case Manager works closely with the Member, assuring that she has the means necessary to receive prenatal instruction and respond to various social and medical needs. WeeCare Case Managers offer the following types of special services to our WeeCare Members:

- Counseling
- Home Visits (as needed)
- Health Education
- Various social support services

Members may refer themselves to the participating OB/GYN specialist of choice for maternity care services, including the initial visit.

WeeCare separates pregnant Members into low and high intensity risk categories with the following goals:

- Low Risk Pregnancy Management - Members will receive pregnancy-related educational materials encouraging good prenatal care
- High Risk Pregnancy Management - Pregnant Members identified at risk for preterm labor and/or other pregnancy complications will be assigned a Nurse Case Manager to provide ongoing supervision and education concerning pregnancy. A letter will be sent to the Member's physician to notify him/her of the Member's enrollment in the program with a summary of the initial assessment

All pregnant Members have access to a 24-hour toll free registered nurse call line at **1-866-431-1514**.

For more information or to refer Members to the WeeCare Program call **1-800-521-6007**:

- To request Case Management Services for pregnant Members
- For questions on WeeCare Program specific policies and procedures
- To request out patient home care services for pregnant Members

Postpartum Home Visit Program

Purpose

The Postpartum Home Visit is offered to all Members who deliver a baby and will provide all newborns with a clinical nursing visit within one (1) week of discharge from the hospital. All detained babies are also offered a home visit within one (1) week of their hospital discharge. 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 deliveries (vaginal or caesarian) 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.

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 Mercy 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 Mercy's EPSDT requirements for physicians can be found in Section II Referral and Authorization Requirements and Policies.

Disease Management Program

Another facet of the Intensive Case Management Program is a voluntary program for Members focused on prevention, education, lifestyle choices and adherence to a treatment plan. The Intensive Case Management program is designed to support a Network Provider's plan of care for patients with the following diseases:

- Asthma
- Heart Failure
- COPD
- CAD
- Diabetes

Members will receive educational materials and if identified as high risk will be assigned to a Case Manager for one-on-one education and follow-up. **For more information or to refer a patient, call 1-800-521-6007**.

Keystone Mercy also provides Disease Management services to Members with the following diagnosis:

- HIV
- Sickle Cell
- Hemophilia
- Pregnancy

Members in this program are assigned to a Disease Management Nurse who provides education and assistance with obtaining medications and specialty referrals. **For more information or to refer a Member to the HIV, Sickle Cell or Hemophilia program, call 1-800-521-6007**.

Outreach & Health Education Programs

The goal of Keystone Mercy's 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 Keystone Mercy Health Education Department works in collaboration with Outreach and Case Management units to achieve desired outcomes.

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://webserver.health.state.pa.us/health/custom/tobaccocessationmap.asp

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 Mercy establishes partnerships with community

organizations. Designated outreach staff contacts Members by phone or mail, to schedule mammography screenings, remind Keystone Mercy 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

Keystone Mercy is participating in a collaborative domestic violence education program with the Department of Public Welfare (DPW) 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.

Use "RADAR" - Recognizing and Treating Partner Violence
The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

Remember to ask routinely about partner violence.

Ask 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.

Document information about "suspected domestic violence" or "partner violence" in the patient's chart.

Assess 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.

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

For more information on "RADAR" visit the Provider Center at www.keystonemercy.com or visit the Pennsylvania Medical Society at http://www.pamedsoc.org/. For a list of where to get help for a patient, please see Appendix IX.

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 in Pennsylvania is a collection of services and supports that help families to enhance their skills in raising a child with disabilities. DPW's Office of Developmental Programs funds the Commonwealth's Early Intervention system for eligible infants and toddlers, from birth to age three. When a child turns three years of age, the responsibility for funding Early Intervention services changes from DPW to the Department of Education. Children may remain eligible for Early Intervention services through the minimum age at which a child can attend first grade in his/her own school district.

An infant or toddler (birth to three years of age) is eligible for Early Intervention Services if he/she:

- Shows a significant delay in one or more areas of child development
- Has a physical disability, a hearing or vision loss
- Receives a specialist's determination that a delay exists even though it is not evident on evaluations (called informed clinical opinion)
- Has a known physical or mental condition with a high probability for developmental delay (Down Syndrome is one example)

If an infant or toddler is found not to be eligible for Early Intervention, he/she may still be eligible for follow-up tracking in the event the needs of the child and family change.

Children eligible for tracking are:

- Born weighing less than 3 ½ pounds
- Cared for in a neonatal intensive care unit
- Born to mothers who are chemically addicted
- Found to have blood lead levels at 15 micrograms per deciliter and above

The services provided to eligible children and their families are individualized in accordance with the developmental needs of each child. Early Intervention supports may include a range of informal and formal opportunities, experiences and resources found in each family's community. Services may be provided in the child's home, childcare center, nursery school, playgroup, or other community settings where the child would be found if he or she did not have a disability.

Families with concerns about their child's development should consult their family Network Provider. If parents have continuing concerns, or want additional information, they may call the CONNECT Information and Referral line at **1-800-692-7288** (TTY accessible).

Referrals to Early Intervention are directed to the local Early Intervention service coordination unit. Initial contact with the referred family occurs locally at a time and place convenient to the family. A screening at no-cost to the family will be offered to determine if the child shows any areas of delay. Further evaluations may determine eligibility for Early Intervention services or follow-up tracking.

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 Mercy 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 Mercy 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 Mercy'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 Mercy's Provider Network Management Department will negotiate a contract with specialists who meet Keystone Mercy's Credentialing criteria, and who 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.