

## **The Health Care Oversight and Coordination Plan**

The Resource Development Unit has prepared a plan *The Health Care Oversight and Coordination Plan* to strengthen activities to improve the health care and oversight of children and youth in foster care for the next five years.

The requirements that are listed below are requirements agreed upon in the Modified Settlement Agreement to help ensure the wellbeing of each child upon entering and while in the foster care system. When a child is placed in the custody of Division of Family and Children Services (DFCS), DFCS must provide access for the child to the physical, dental, and mental health care services requirements included below.

**The GOAL is to increase the services available to foster children throughout the state.**

### **Requirements**

1. *Physical and Mental Health Care*
  - a. *Every child entering foster shall receive a health screening evaluation from a qualified medical practitioner within 72 hours after placement that is in accordance with the health screening recommended by the American Academy of Pediatrics.*
  - b. *Every child entering foster care shall receive a comprehensive health assessment within 30 days of the placement. The assessment shall be in accordance with the recommendations of the American Academy of Pediatrics, except that dental exams shall be governed by Section II.B.3.e of the Modified Settlement Agreement*
  - c. *Nothing in the above paragraphs shall prohibit the initial health screening evaluation and the comprehensive health assessment from being conducted in one clinical visit. However, in such instances, this combined visit shall be conducted within 72 hours of placement.*
  - d. *All children shall receive periodic medical examinations and all medically necessary follow-up services and treatment throughout the time they are in state custody, in accordance with the time periods recommended by the American Academy of Pediatrics.*
  - e. *Every child three years old and older shall receive a dental examination within 90 calendar days of foster care placement and every six months thereafter. Every foster child who reaches the age of three in care shall be provided with a dental examination within 90 calendar days of his/her third birthday and every six months thereafter. Every foster child shall receive all medically necessary dental services.*

*f. Every child four years old and older shall receive a mental health assessment by a qualified professional within 30 calendar days of foster care placement. Every foster child who reaches the age of four in care shall receive a mental health assessment within 30 calendar days of his/her fourth birthday. Every foster child shall receive recommended mental health services pursuant to his/her assessment.*

*g. Every foster child ages birth through three shall receive a developmental assessment by a qualified professional within 30 days of foster care placement and each child older than three shall be provided with a developmental assessment if there are documented factors that indicate such an assessment is warranted. All foster children shall be provided with needed follow-up developmental services*

*h. Nothing in the above paragraphs shall prohibit the developmental and the comprehensive health assessment from being conducted in one clinical visit.*

### **Objectives**

*i. By the end of Implementation Period Three:*

- 1) At least 50% of children entering custody during the Period shall receive a health screening evaluation from qualified medical practitioner within 72 hours after placement that is in accordance with the health screening recommended by the American Academy of Pediatrics.*
- 2) At least 50% of children entering custody during the Period shall receive a comprehensive health assessment consistent with Modified Settlement Agreement requirements within 30 calendar days of entering care.*
- 3) At least 75% of children in custody during the Period shall receive periodic medical examinations and all medically necessary follow-up services and treatment consistent with Modified Settlement Agreement requirements.*
- 4) At least 60% of children three years old and older entering custody during the Period or in care and turning three years old during the Period shall receive a dental examination within 90 calendar days of foster care placement of their third birthday, respectively.*
- 5) At least 60% of children in custody during the Period shall receive a dental examination every six months consistent with Modified Settlement Agreement requirements and all medically necessary dental services.*
- 6) At least 50% of children four years old and older entering custody during the Period or in care and turning four years old during the Period shall receive a mental health assessment by a qualified*

*professional within 30 calendar days of foster care placement or their fourth birthday, respectively.*

- 7) *At least 70% of children who received a mental health assessment during the Period shall receive all recommended mental health services pursuant to their assessment.*
- 8) *At least 30% of children in custody ages birth through three during the Period, and older children if factors indicate it is warranted, shall received a developmental assessment by a qualified professional within 30 calendar days of foster care placement and all needed developmental services. (Modified Mississippi Settlement Agreement and Reform Plan, Civil Action No. 3:04CV25ILN, Section II, B, 3, i.)*

### **Strategies for Increasing the Array of Services to Foster Children:**

In striving to attain our objectives as stated above the following ten (10) items are the foundational information needed for children entering foster care to receive appropriate services. Each step includes guidelines to obtain information pertinent for the child to better determine what type of services are needed to serve the child's wellbeing.

1. **Obtain Medical Information on foster children.** Immediately upon placement into custody –
  - Social worker shall obtain a medical history on the foster child from the birth parents as part of the CFA process.
  - Review all available data and medical history on the child.
  - Identify any developmental/mental health/health conditions requiring immediate attention.
  - Collect all medications the child is currently taking and assure they are provided to the current caretaker.
  - The role of the worker is to consult with the medical provider about current medications to make sure they are all appropriate and are being administered as prescribed. Birth, resource parents and age-appropriate youth should be part of this discussion whenever possible.
  - Key medical information obtained from the screenings/assessments should be shared with the birth parent and resource parent and age appropriate youth.
  - Assure that as part of the youth's participation in independent living services he/she obtains information on health insurance, Medicaid and medical care services.
2. **Initial Health Screening.** Within 72 hours of placement -
  - Every child shall receive a health screening evaluation from a qualified medical practitioner within 72 hours of placement to identify health conditions that should be considered in making placement decision.

- Guidelines for this assessment can be viewed on the DFCS Connections Website document “Fostering Health-Health Care for children and Adolescents in Foster Care, 2<sup>nd</sup> Edition, American Academy of Pediatrics,” Chapter 2, pages 16, 17 and 18. The purpose of this screen is to identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases, signs of abuse or neglect, signs of infection or communicable diseases, hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances.
- Birth parents/resource parents should be involved in all assessments/screenings. Participation in these appointments provides a good opportunity for shared parenting allowing the birth parent to remain involved in the regular care of their child assuming there are not safety concerns.

**3. Comprehensive Health Assessment.** Within 30 days of placement-

- Every child entering foster care shall receive a comprehensive health assessment within 30 days of placement and yearly thereafter.
- The assessment must be done by a qualified pediatrician, nurse practitioner or other qualified health professional.
- Guidelines for this comprehensive assessment may be found in the “Standards for Healthcare for Children and Adolescents in Foster Care” Chapter 1, page 4 of the “Fostering Health-Health Care for Children and Adolescents in Foster Care, 2<sup>nd</sup> Edition, American Academy of Pediatrics,” shown on the DFCS Connection Website. Components of this assessment can be viewed in Chapter 2, pages 22-26. The purpose of this assessment is to review all available medical data and medical history about the child/adolescent; to identify medical conditions, to identify developmental and mental health conditions requiring immediate attention and to develop an individual treatment plan.
- The initial health screening evaluation and the comprehensive health assessment could be conducted in one clinical visit. However, in such instances, this combined visit must be conducted within 72 hours of placement.

**4. Initial Mental Health Intake Assessment.** Within 30 days of placement-

- Every child 4 years old and older shall receive a mental health assessment by a qualified professional with expertise in the developmental, educational and mental health conditions of children and adolescents within 30 calendar days of foster care placement. Every foster child who reaches age 4 in care shall receive a mental health assessment within 30 calendar days of his/her 4<sup>th</sup> birthday. Every foster child shall receive any mental health services that are recommended/referred in the assessment including, but not limited to, individual counseling, family counseling, group counseling, and medical treatment.
- Psychologicals are not indicated initially unless ordered by the court and do not replace the 30 day mental health intake assessment.

- 5. Initial Assessment.** Within 90 days of placement-
- Every child three years old and older shall receive a dental examination within 90 calendar days of foster care placement. Every foster child who reaches the age of three in care shall be provided with a dental examination within 90 calendar days of his/her third birthday.
  - Children shall receive follow up dental services every six months after the initial dental examination as well as all medically necessary dental services.
- 6. Periodic Ongoing Medical Examinations.** In accordance with the guidelines of the AAP-
- More frequent preventive pediatric visits are recommended for the child/youth in foster care because of the multiple environmental and social issues that can adversely impact their health and development.
  - All children shall receive periodic medical examinations and all medically necessary follow up services and treatment throughout the time they are in state custody, in accordance with the time periods recommended by the American Academy of Pediatrics including monthly visits for infants up to 6 months and semi-annual visits beyond years of age through adolescence. Preventive pediatric visits are recommended for the child and adolescent in foster care because of the multiple environmental and social issues that can adversely impact their health and development.
  - Components of the periodic preventative health care can be viewed on the DFCS Connections Website document “Fostering Health-Health Care for Children and Adolescents in Foster Care, 2<sup>nd</sup> Edition, American Academy of Pediatrics,” chapter 2, pages 30-32. The purpose of these examinations is to promote overall wellness by fostering healthy growth and development, to identify significant medical, behavioral, emotional, developmental and school problems through periodic history, physical examination and screenings, to regularly assess for success of foster care placement, to regularly monitor for signs or symptoms of abuse or neglect and to provide age-appropriate anticipatory guidance on a regular basis to children and adolescents in foster care and birth and resource parents.
- 7. Therapeutic Services.** As needed-
- Necessary therapeutic and rehabilitative services because of a diagnosis of significant medical, developmental, emotional or behavioral problems shall be provided to children in foster care.
  - These service needs should be identified as part of the comprehensive family assessment process, incorporated into the Family Service Plan and monitored as part of the case planning process.
- 8. Information gathered from specialized screenings/Assessment.** Prior to developing case and when assessments and case plans are updated-

- Use information from medical, dental, and mental health screenings, assessment, and case file information to identify need for more in-depth evaluations.
- Discuss needs for specialized screenings/evaluations with parents and relevant family members; determine provider/locations that can best serve them.
- Assess individual health, dental, developmental, and mental health needs of children and families.
- Make prompt referrals for additional evaluations and needed services as soon as the need is identified. Involve family in decisions about where to obtain the services.
- Clarify with providers the precise needs for screening/evaluation or services and ensure provider has the information needed to proceed.
- Identify and provide assistance that the family may need in participating in evaluations.
- Obtain copies from service providers of the results of the evaluations, file in the case record, and include in the child's medical passport.
- Discuss assessment findings and recommendation with the family and seek their views and perspectives about the information and any conclusions that are drawn.
- Provide copies of medical, dental, and mental health information on children in care to their resource parents/caretakers and birth parents as appropriate.

**9. Update assessments on a regular basis.** As needed-

- In visits with family members, ask about changes in strength/needs with regard to medical, dental and mental health issues of the child/youth and identify any related emerging issues that need assessing.
- Track and make referrals for ongoing periodic screenings and assessments, e.g. EPSDT, and follow up assessment activities for other screenings/evaluation, e.g., re-evaluation of mental health issues.
- Make prompt and clearly defined referrals for additional or updated specialized evaluations needed as circumstances change or new needs emerge.
- Obtain copies of new/updated screenings/evaluations and use in revising plans, file in the child's medical passport, and provide to foster care providers.
- Make direct contact with providers of assessments/evaluations (with family's consent) to evaluate progress, identify needs, etc.
- Discuss progress needs with relevant family members and resource parents/caretakers.

**10. Ongoing medical care.** Exit from custody-

- Review child's health conditions with birth parents and/or whoever is assuming responsibility for the child as identified during the child's stay in foster care.
- Be certain to include the older youth in all discussions regarding their medical/dental/mental health care.
- Identify ongoing conditions that will require intervention.
- Convey summary of child's health history to appropriate caregivers and primary physicians.
- Obtain needed supports and make referrals for services that can ensure any medical/dental/mental health issues the child/youth may have are addressed when the case is closed.
- Provide documents to the age appropriate youth and/or caregiver.
- The worker shall provide each youth transitioning to independence with at least six months' advance notice of cessation of any health benefits.
- The worker shall inform all youth transitioning to independence that he/she is eligible for Medicaid through age twenty-one. It shall be the workers responsibility to assist the youth with completing the necessary documents to continue Medicaid services and to ensure he/she has received his/her Medicaid care prior to transitioning out of care.

### **Increasing and Improving the Service Array Through Collaboration with Magnolia Health Plan**

Mississippi Department of Human Services/Division of Family and Children Services (MDHS/DFCS) began a partnership with Magnolia Health (Magnolia) Plan January 1, 2013 to provide services for the foster children of Mississippi. The Mississippi Division of Medicaid contracted with Magnolia to provide services for foster children age birth to 19 years of age. Children over 19 will receive Medicaid direct services.

Children aging out of the foster care system will have a copy of their electronic health record that has captured their physical, dental and mental health history.

Magnolia is a subsidiary of Centene Corporation. While Centene is a national company with corporate offices in St. Louis, Missouri, its local approach to managing health plans enables it to provide accessible, high quality, culturally sensitive healthcare services to its members. This local approach allows Medicaid recipients, providers and state regulators direct access to the local health plan where its officers and staff are available and accountable.

For optimum organization and efficiency, Centene combines its local approach with centralized finance, information systems, claims processing and medical management support functions. Currently Centene provides foster care services for the states of Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Missouri, New Hampshire, Ohio, South Carolina, Texas, Washington, Kentucky, Louisiana, Wisconsin and Mississippi.

Centene is a multi-line health care enterprise operating primarily in two segments: Medicaid managed care and specialty services. The government services Medicaid managed care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (SCHIP) and Supplemental Security Income (SSI).

The U.S. Children's Bureau estimates around 800,000 children are served in the foster care system each year. The Urban Institute found that States disburse approximately \$10 billion annually in federal and state funds to meet the needs of children placed in foster care. Much of the foster care population has special behavioral and medical needs.

One study by the Urban Institute suggests that as many as 80 percent of children involved with child welfare agencies have conditions which require mental health services. Coordinating services and health information for this population has unique challenges. Keeping track of medical history including medical conditions, doctor visits, immunization, and prescription drug history is complicated by the temporary nature of care situations. Many states are turning to Medicaid managed care solutions to help coordinate the unique medical, behavioral and social services for these children.

On April 1, 2008, Centene began providing statewide managed care services to foster care children in the state of Texas under its subsidiary, Superior Health Plan. With commencement of operations, Centene became the first organization in the country to serve as a state's exclusive managed care company for the foster care population.

Magnolia Health Plan is a managed care organization providing MDHS/DFCS foster children under Mississippi Coordinated (MSCAN). They assist our case workers in locating medical, dental and mental health services. A provider list of Magnolia Providers can be seen at **Attachment 1**. This attachment has two lists – one is broken down into counties with number of providers. The other list is a breakdown by town and physician, dentist or mental health provider as well as pharmacy services. Magnolia has approximately 15,000 providers in Mississippi and the surrounding states that are available to provide physical, mental health and dental services. Magnolia has providers in all 84 counties in Mississippi. This is a vast improvement in services for our foster care children. Where there were gaps in the state, mainly in the northern part of the state, gaps have closed.

Being a part of the Magnolia Health Plan has greatly enhanced our service array for foster children. They are afforded continuity of having a medical home, opportunities for more specialized services, case management services and follow up care. Because of the number of Magnolia providers our children will be able to be serviced within their communities. The foster children will have access to specialized services not only in Mississippi but out of state to provide the best services possible to meet their particular needs. Medical providers for Magnolia Health Plan are supplied with and required to use the American Academy of Pediatrics Healthy Foster Care America form which includes a brief medical history as well as the initial health screening (within 72 hours of placement) and the comprehensive admission health assessment (within 30 days of placement).

**Attachment 2.** A Provider Reference Card (**Attachment 3**) is provided for the DFCS caseworkers, foster parents, parents or other caregivers and the general public listing most used services and how they can be accessed. Magnolia Health Plan has a dedicated Foster Care Case Management phone number (1-888-869-7747) for the convenience of MDHS/DFCS workers and foster parents and/or other caregivers for foster children to answer questions and to assist in scheduling appointments or any other related needs.

Magnolia Health Plan provides a CentAccount Card for foster children that meet certain healthy behaviors. The card is given to the foster parent for the child. The CentAccount rewards program lets you earn money onto your own CentAccount card simply by doing things that help you stay healthy. The card is accepted at most local pharmacies and stores. It can be used at stores and pharmacies that accept credit cards for health related items only. The card can also be used to help pay for utilities such as gas and electricity. At **Attachment 5** is a chart that explains the amount that will be put into the account for each behavior you complete.

The following information will explain the Case Management Program that Magnolia provides. Magnolia has a specialized team of 6 Foster Care Case Managers and 4 additional staff for backup. These staff include registered nurses and licensed clinical social workers.

The purpose of the Case Management Program is to define the goals and objectives of the program, the target Case Management population, and the methods and processes of identifying and assessing members, managing member care, and measuring the impact of interventions. Magnolia provides foster children under their Foster Care Case Management Program specific plans of care that focus on organizing, securing, integrating, and modifying the resources necessary to maximize and support the wellness and autonomy of each child.

Centene and Magnolia Health Plan (Magnolia) adhere to the Case Management Society of America's (CMSA) definition of case management: "a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a foster child's health needs through communication and available resources to promote quality cost-effective outcomes". Centene and Magnolia provide both episodic and complex case management, based on member needs and the intensity of service required. Magnolia refers to its case management program as Case Management. Magnolia Case Management Program coordinates and monitors the care for members with special needs. Magnolia Case Management Program is designed to ensure the intensity of interventions provided corresponds to the member's level of need.

Levels of Case Management include:

- All members of Magnolia Health Plan are in Care Management Program.

- Low Level Case Management – appropriate for members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Low Level Case Management typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor medical or behavioral health concerns arise.
- Disease Management/medium risk – appropriate for members needing a higher level of service, with clinical needs. Members in Case Management may have a complex condition or multiple co-morbidities that are generally well managed. Members in Case Management typically have adequate family or other care giver support and are in need of moderate to minimal assistance from a Case Manager. In addition, this level of care may include members who have diseases that may not be impactable from a financial perspective but still require significant intervention such as those children that are frail, or at the end of life, or who have chronic diseases such as cancer or end stage renal disease.
- Complex Case Management/high risk – a high level of Case Management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs. Complex Case Management/high risk is performed by Magnolia Case Management staff for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Members are generally categorized into complex Case Management/high risk based on Magnolia ability to have the greatest impact on health outcomes and cost.

The goals of Magnolia Case Management Program are to:

- Assist members in achieving optimum health outcomes, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals and improving their ability to self-manage their disease or condition.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

Case Management functions include:

- Early identification of members who have special needs.
- Assessment of member's risk factors.
- Development of an individualized care treatment plan in collaboration with the member and/or member's family, Primary Care Provider (PCP), and managing providers.
- Identification of barriers to meeting goals included in the care treatment plan.

- Referrals and assistance to ensure timely access to providers.
- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the care treatment plan as required by the member’s changing condition.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/Case Management activities.
- Addressing the member’s right to decline participation in the Case Management program or disenroll at any time. (MDHS/DFCS has the right to disenroll any child at any time)
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all Case Management procedures in compliance with HIPAA and state law.

Centene and Magnolia have defined a set of Case Management population criteria for use with all product lines (e.g. Aged, Blind and Disabled/ABD; Covered Families and Children/CFC; , In patient utilization , Temporary Assistance for Needy Families (TANF),Children with Special Health Care Needs, etc.). This creates efficiencies such as a consistent Case Management Program Description and a consistent measurement process of Case Management program effectiveness across all Magnolia product lines. The criteria below is not all inclusive; clinical judgment should be used to determine a member’s appropriateness for each level of Case Management, considering such factors as stability of the condition(s), available support system, current place of residence, etc.

<b>High Risk, Complex Case Management Criteria</b>
<p>High Risk, Complex Case Management Target will include 1% of the highest utilizing, most impactable members:</p> <ul style="list-style-type: none"> <li>• Magnolia will use the Impact Pro predictive modeling program including inpatient stay probability as the primary risk score considered for member identification and targeting.</li> <li>• Will filter for members with clinical conditions that meet the State’s list of case manageable conditions and then stratify them according to the probability of an inpatient stay in the next 12 months.</li> </ul> <p>Data includes:</p> <ul style="list-style-type: none"> <li>• Comprehensive member profile, including all claims (FFS and Plan) for the prior 12 months, summary of episodes in the 12 month period, risk identifiers, clinical indicators, gaps in care, care team and “case definitions” (complex criteria used to</li> </ul>

identify and stratify members for Case Management).

- Will identify members based on clinical criteria in conjunction with future risk of inpatient stay; the initial threshold for this risk score will be a 30% probability of the member having an inpatient stay in the next 12 months.

**Medium Risk Criteria**

- One inpatient hospital readmission within 90 days for same or similar diagnosis (within a rolling 12 month period)
- Three or more acute inpatient hospitalizations (within a rolling 12 month period) for non-manageable conditions
- Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual or where there is minimal expectation that utilization will decrease. Diagnoses include, but are not limited to:
  - HIV/AIDS
  - Cancer
  - High risk maternity members
  - Neonates up to six months of age
  - Kidney failure members on dialysis
  - Members receiving home care services
  - Sickle cell members who are not high utilizers
  - End of life care
- Children with special health care needs

**Low Risk/Care Coordination Criteria**

- Primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources
- Need for assistance with accessing health care services
- Members with avoidable, preventable, PCP-treatable ED visits
- History of a health condition, chronic or pre-existing that places the member at risk for potential problems or complications. This includes the following diagnoses and at the discretion of the Case Manager: Asthma, Coronary Artery Disease, Congestive Heart Failure, Diabetes, Non-Mild Hypertension, Chronic Obstructive Pulmonary Disease, Severe Mental Disorder, Substance Abuse, HIV/ Aids, Sickle Cell Anemia, Hemophilia, Chronic Renal Failure, Multiple Sclerosis, or issues related to Transplant or Cancer.

The Vice President of Medical Management (VPMM), and/or any designee as assigned by Magnolia President and CEO are the senior executives responsible for implementing the Case Management Program in collaboration with the Chief Medical Director (CMD), including quality improvement, cost containment, medical review activities, outcomes tracking, and reporting relevant to Case Management. The Chief Medical Director is

involved in the implementation, monitoring, and directing of behavioral health aspects of the Case Management Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. .

The CMD's responsibilities include, but are not limited to, collaboration with the VPMM of the following activities:

- Assists in the development and revision of Case Management policies and procedures as necessary to meet state statutes and regulations.
- Monitors compliance with the Case Management Program.
- Provides clinical support to the Case Management staff in the performance of their Case Management responsibilities.
- Provides a point of contact for practitioners with questions about the Case Management process.
- Communicates with practitioners as necessary to discuss Case Management issues.
- Assures there is appropriate integration of physical and behavioral health services for all members in Case Management as needed.
- Educates practitioners regarding Case Management issues, activities, reports, requirements, etc.
- Reports Case Management activities to the Quality Improvement Committee and other relevant committees.

The VPMM is a Registered Nurse with experience in Utilization Management and Case Management activities. The VPMM is responsible for overseeing the day-to-day operational activities of the Magnolia Case Management Program. The VPMM reports to the Magnolia President and CEO. The VPMM, in collaboration with the CMD, assists with the development of the Case Management Program strategic vision in alignment with corporate and Magnolia objectives, policies, and procedures.

The CM Manager is a registered nurse or other appropriately licensed healthcare professional with Case Management experience. The CM Manager directs and coordinates the activities of the department including supervision of Case Managers, Program Specialists, Program Coordinators, and Connections Representatives. The CM Manager reports to the Regional CM Directors. The CM Supervisor works in conjunction with the CM Directors/Managers and Utilization Management staff to execute the strategic vision in conjunction with Centene Corporate and Magnolia objectives and attendant policies and procedures and state contractual responsibilities. The CM Manager/Supervisor is responsible for ensuring that the CM staff is operating within their scope of practice.

Care Coordination/Case Management (CC/CM) Teams are generally comprised of multidisciplinary clinical and non-clinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Case Managers work closely with the concurrent review staff to coordinate care when members are hospitalized and assist with

discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Case Manager's average care load would be 80 – 100 cases. ICT roles include:

***Medical Director***

- Physician who holds an unrestricted license to practice medicine in Mississippi and is Board Certified with experience in direct patient care.
- Serves as a clinical resource for Case Managers and members' treating providers.
- Facilitates multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases.
- Provides a point of contact for providers with questions about the Case Management process.
- Communicates with practitioners as necessary to discuss Case Management issues.
- Can provide face to face member interaction as necessary based on member's specific needs.

***Case Manager II (CM)***

- Licensed Nurse (CCM credential preferred)
- Accountable point of contact for all members in complex care/high risk Case Management. Responsible for oversight of non-clinical members of the integrated CC/CM team. Ensures staff is operating within their scope of practice.
- Responsible for working with the member and their physician to identify needs and create a care treatment plan to help the members achieve their goals.
- Participates in inpatient rounds with concurrent review nurses and other multidisciplinary Case Management team members to assist with discharge planning and coordination with the member's treating providers.
- Coordinates with the behavioral health Case Manager and providers as needed for members receiving services through the behavioral health delegate.
- Communicates and coordinates with the member and their caregivers, physicians, behavioral health providers, Disease Management health coaches, and other members of the Case Management multi-disciplinary team to ensure that member's needs are addressed.
- Provides face to face member interaction at point of service as determined by member's specific needs and goals of care treatment plan.

***Program (or Social Service) Specialists***

- Program Specialists are licensed social workers or college graduates with a background in social services or other applicable health related field who may or may not be licensed.
- Works under direction of Case Manager II, performing member outreach and care coordination.

- Licensed program specialists can provide face to face member interaction as directed by the CMII.

### ***Program Coordinator (PC) I***

- Non-clinical staff person working under the direction and oversight of a CM II.
- Provides administrative support to CC/CM team.
- Collects data for Health Risk Screening/Assessment.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Case Manager II.

### ***MemberConnections Representative/Community Health Worker (MCR/CHW)***

- MemberConnections Representatives/Community health are workers typically hired from within the communities served to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.
- Works both in the office and in the community with face to face member interaction at point of service.
- Performs member outreach, education, and home safety assessments.
- Assists with community outreach events such as: Health Check Days, Healthy Lifestyle events, Baby Showers, Diaper Days, Library/Reading Events, etc.
- Assists with Connections Plus cell phone program, pod cast programs, etc.
- Licensed Community Health Workers can provide face to face member interaction as directed by the CMII

### ***Other licensed/certified staff that may be included in the Integrated Care Teams***

- Registered Social Worker Assistants (RSWA)
- Pharmacists, etc.
- Any licensed/certified staff utilized for face to face member interaction, will be fulfilling care treatment plan goals or actions within their respective scope of practice, and will do so at the direction of the CMII.

### ***Information Systems***

Assessments, care plans, and all Case Management activities are documented in a central clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the Case Management team to generate reminder/task prompts for follow-up according to the timelines established in the Case Management care plan. Reminders/tasks can be sent to any team member, e.g. allowing Case Managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g. inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation

system enables the Case Manager to add all providers and facilities associated with the member's care to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the Case Management team to easily access all clinical information associated to a member's care in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of Case Management interventions.

### **MEMBER IDENTIFICATION AND ACCESS TO CASE MANAGEMENT**

A key objective of Magnolia Case Management Program is early identification of members who have the greatest need for care coordination and Case Management services. This includes, but is not limited to, those classified as children with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are disabled, or at the end of life.

#### ***Data sources***

Members are identified as potential candidates for Case Management through several data sources, including, but not limited to:

- Predictive modeling software (Impact Pro™)
- Administrative data: claims or encounters
- Hospital discharge data
- Pharmacy data
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- ED Utilization reports
- Laboratory data
- Readmission reports
- State/CMS Enrollment Process and other State/CMS supplied data
- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD)
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments
- Information provided by practitioners, such as Notification of Pregnancy (NOP)

Reports identifying members for Case Management are reviewed by management staff at least on a monthly basis and forwarded to the Case Management team for outreach and further review for Case Management.

#### ***Referral sources***

Additionally, direct referrals for Case Management may come from resources such as:

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Case Management Program and referral process

through the Provider Handbook, the Magnolia website, Provider Newsletters, and by Provider Services staff.

- NurseWise/Nurse Advice Line staff – NurseWise, the nurse advice/medical triage phone service for Magnolia, has policies and procedures in place for referring members to e Magnolia for Case Management screening. This may be accomplished via a “triage summary report” that is sent to Magnolia electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at Magnolia.
- Disease Management (DM) Health Coaches – Nurtur, the DM vendor for Magnolia, works closely with the Magnolia Medical Management department and Case Management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as Case Management rounds, are held between the Case Management team and DM staff.
- Hospital staff, e.g. hospital discharge planning and Emergency Department staff - facility staff is notified of the Magnolia Case Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform Magnolia UM staff if they feel a member may benefit from Case Management services; UM staff then facilitate the referral.
- Magnolia Staff - UM staff work closely with Case Management staff on a daily basis and can initiate a referral for Case Management verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
  - Magnolia MemberConnections/Community Health Worker Program- MemberConnections Representatives/Community Health Workers (MCRs/CHWs) are trained on all departments within Magnolia and have a full understanding of all staff functions. MCR/CHWs work closely with the Case Management team, referring members who may benefit from Case Management services.
  - Magnolia Member Services - Member Services staff is also trained on all departments within Magnolia and have a full understanding of all staff functions, including the role and function of the Case Management team.
  - Other intradepartmental referrals e.g., Provider Specialists and QI Department.
- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consentor - members are educated about Case Management services in the Member Handbook, received upon enrollment and available on the Magnolia website, and through contact with Member Services and/or other Magnolia staff.
- Community/social service agencies – community agency staff are informed of the Case Management Program during interactions with the Magnolia Case Management team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential Case Management needs to Magnolia staff.

- Delegated entity staff (e.g. behavioral health, vision, dental, DME/home health, etc.) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for Case Management. Magnolia CM staff also regularly communicates with delegates through oversight meetings, Case Management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- Managed Care Enrollment Center.

The specific means which a member was identified as a potential candidate for Case Management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to Case Management. Multiple referral avenues help to minimize the time between need for and initiation of Case Management services. Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

### **SCREENING AND ASSESSMENT**

As soon as a foster child enters foster care DFCS social workers call Magnolia to alert them and to provide information on the child so that the case management process can begin.

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification as potential candidates for complex Case Management. Case Management team staff obtain consent to complete the Case Management screening and/or initial assessment for Complex Case Management once member contact is made. Case Management staff also explains the Case Manager role and explains the function, value and benefits of the Case Management Program to the member and/or their authorized representative or guardian. Members identified as low and medium risk must have the assessment and care treatment plan developed no later than within 60 days of enrollment or identification of the member's health condition, and may have outreach initiated in writing.

General standardized assessments have been developed internally to address the specific issues of Magnolia unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for Case Management. All assessments are documented in the central clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity.

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Case Management Program, and are informed they are entitled to decline participation in, or disenroll (opt out) from Case Management at any time.. The member/guardian is notified of the potential need for the Case Management team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always

obtained prior to any contact. Documentation of verbal member consent to participate in the Complex Case Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented. Medium or low risk members are understood to be in the Case Management program unless the member opts out by contacting their Case Manager.

Members unable to be contacted via telephone are mailed a letter requesting that the member call the Case Management team. MCR/CHWs may also be utilized when necessary, to assist in outreach for members who are difficult to contact. MCR/CHWs go to the member's physical address and attempt to initiate contact. They may also outreach to local community agencies and provider offices in an effort to locate a member. If a MCR/CHW is successful in locating the member, they may perform a general screening in person, including observation of the member in their home surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc.

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily psychosocial needs are designated as low priority/low frequency of contact (minimum of once/year) and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly stable and the member has adequate care giver support are identified as a medium priority with a moderate frequency of contact (minimum of twice/year). Member designated as moderate/medium priority are assigned to a Case Management team who confirm the findings of the screening assessment and may complete a more thorough assessment with the member. A Case Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Case Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Case Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history. Stratification as low, medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management may be revised at this time, or following further assessment.

The Case Manager then attempts outreach to the member and/or authorized representative or guardian telephonically within one week for members identified as high priority and thus appropriate for complex/high risk Case Management, to perform an in-depth assessment to more closely identify and prioritize the member's individual needs. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about a member's condition(s). These condition-specific assessments, such as the Diabetes and Asthma assessment, are derived from evidence-based clinical guidelines. During the in-depth Case Management assessment, the Case Manager evaluates the full scope of the member's situation, including:

- The member's health status, including condition-specific issues and likely co-morbidities.
- Documentation of the member's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring.
- Assessment of activities and instrumental activities of daily living.
- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.
- Assessment of mental health status (e.g. presence of depression and/or anxiety) and cognitive functioning.
- Assessment of psychosocial issues such as alcohol or drug dependency, smoking, significant life stressors, etc.
- Assessment of visual or hearing impairments.
- Assessment of life planning activities such as living wills, advance directives, etc.
- Evaluation of cultural and linguistic needs, preferences or limitations.
- Evaluation of caregiver resources and level of caregiver involvement in care plan implementation.
- Assessment of personal resources and limitations.
- Evaluation of available benefits and other financial resources; referrals to community resources.
- Assessment of educational and vocational factors.

Case Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital Case Managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. The role and function of the Case Manager is also explained to the member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The Case Management team reviews the gathered information and begins to build a care treatment plan. The initial assessment and care treatment plan are completed no later than 30 days after a member is identified as appropriate for complex Case Management, but in most cases is completed earlier. Case Management teams may include Case Managers, Program Coordinators, Social Workers/Program Specialists, Behavioral Health Specialists, and Member Connection Representatives/Community Health Workers. Each contributes different skills and functions to the management of the member's care. Each must work within their scope of practice and are monitored by the Case Manager and human resources department to ensure that this occurs. Other key participants in the development of the care plan may include:

- Member
- Member authorized representative or guardian
- PCP and specialty providers
- Magnolia Medical Directors
- Hospital discharge planners

- Ancillary providers (e.g., home health, physical therapy, occupational therapy)
- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g. United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation; companionship, etc.)
- Other non-health care entities (e.g. Meals on Wheels, home construction companies, etc.)

***Continuity and Coordination of Care between Medical and Behavioral Health Care***

When Magnolia staff identifies a member with coexisting medical and behavioral health disorders, and the member’s primary diagnosis is a behavioral health condition, the case is referred to our Severe Mental Illness (SMI) team who serves as the lead Case Manager, working in tandem with the medical Case Management team. Whether the member’s primary diagnosis is physical or behavioral determines whether a medical or behavioral health Case Manager will serve as the lead Case Manager.

The lead Case Manager reviews the member’s clinical information to assure the patient is receiving appropriate behavioral health care. If the patient does not appear to be receiving this care, the Case Manager:

- Contacts the medical provider to ask about a behavioral health consult.
- Assists the member, or coordinates with the behavioral health Case Manager, to make arrangements for the behavioral health consult.
- Follows up to make sure a behavioral health consult was conducted.

When appropriate (including but not limited to when the lead Case Manager is revising the care treatment plan or evaluating a member for discharge from Case Management), the medical and behavioral Case Managers confer with each other to ensure that the necessary expertise is available to monitor and guide member’s care. When serving as the lead Case Manager, the Magnolia Case Manager includes appropriate behavioral health follow-up in Case Management discharge planning.

Outreach may also occur to treating providers and individual practitioners when appropriate. The Case Manager assures proper member consent, specific to information pertaining to behavioral health treatment, is obtained prior to any communication regarding the member.

**ONGOING MANAGEMENT**

***Care Treatment Plan Development***

The initial assessment serves as the foundation for the member’s care treatment plan. The Case Management team identifies issues and needs, and utilizing input from team participants, develops a proposed care treatment plan. The care treatment plan is developed in conjunction with the member; the member’s authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care

treatment plan as needed. Prioritized, short-term and long-term goals are established and barriers to meeting goals or complying with the care treatment plan are identified, as well as possible solutions to the barriers. The proposed care treatment plan is based on medical necessity, appropriateness of the discharge plan as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care treatment plan.

The proposed care treatment plan is discussed with the member and/or member authorized representative or guardian, the PCP/SCP, and the health care team. The member's role is discussed and member/caretaker and provider input is obtained and used to modify the goals according to member's ability and willingness to participate. The Case Manager assures all parties are in agreement with the care treatment plan to ensure successful implementation.

The care treatment plan for members in high risk, complex Case Management includes, at a minimum:

- Prioritized goals and actions with timeframes for completion and member's documented progress towards achieving the goals. Goals are specific, realistic and measurable. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible. There should be at least one short-term and one long-term goal prioritized and individualized to meet member needs.
- Identification of barriers to meeting the goals and recommended solutions for each barrier.
- Resources to be utilized, including the appropriate level of care.
- Interventions to reach those goals, including development of member self-management plans. The Case Manager assures the member has a full understanding of their responsibilities per the self-management plan and is in agreement with it. The Case Manager ensures follow-up on the self-management plan at every subsequent contact.
- Planning for continuity of care and effective and comprehensive transitions of care between settings.
- Collaboration with and involvement of family and significant others, health care providers, etc.
- Documentation in the notes of a schedule for on-going communication with the member and other involved parties, based on individual needs and member preference including anticipated frequency of contacts
- Communication plan with PCP/SCP to ascertain the needs the provider has identified and prioritized including a process to ensure the provider's treatment plan is reflected in the treatment plan developed by Magnolia.
- Identification of providers responsible for delivering services
- Identification of referrals made to specialists or providers and confirmation that the member received these services
- Referrals to community/social/recovery support agencies including assisting members in contacting the agency and validating member received needed service.

- Continuous review and revision of the care treatment plan.
- Provision to report feedback to provider on member compliance with care treatment plan.
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated.

The care plan is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines such as for diabetes and asthma management, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Members assigned to low priority Care Coordination, or members identified as moderate/medium priority assigned to Case Management have an abbreviated care treatment plan.

### ***Monitoring and Evaluation***

Once the care treatment plan is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Revisions to the care treatment plan are made when necessary, e.g. when the member's condition progresses or regresses, when goals are reached, etc. Significant revisions to the care treatment plan are also shared with the PCP or specialist as appropriate. A schedule for continuous review and revision which includes follow-up and monitoring of the member's progress is developed, using as a minimum the intervals defined according to priority level and current needs. The Case Manager may assign tasks to other members of the Case Management team, such as a Program Specialist to manage or assist with psychosocial issues or a Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/task to be created for each case, alerting the Case Management team when follow-up contacts are needed. Follow-up reminders can be set for daily, weekly, monthly, etc. contacts. Intervals for follow-up are based on the goals and time lines in the Case Management care plan.

The Case Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers' or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Member or caretaker agreement to participate in the Case Management Program (agreement may be oral or written; if oral, the Case Manager documents the discussion with the member/caretaker).
- Notes, including a summary of team conferences and all communications with the member/family, health care providers and any other parties pertaining to the member's care.

- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available.
- The Case Management care treatment plan, including:
  - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan, identification of gaps between recommended care and the care that is received by the member and interventions for meeting the member's goals and overcoming barriers.
  - Provision for input to the care treatment plan by the member
  - Provision to share the care treatment plan when requested by the provider
  - Schedule for continuous review and follow-up and communication with the member, member's family, providers, etc.
  - The member's self-management plan.
  - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below.

The Case Manager regularly evaluates the member's progress considering the following factors:

- Change in the member's medical status.
- Change in the member's social stability.
- Change in the member's functional capability and mobility.
- Progress made in reaching the defined goals.
- The member's adherence to the established care treatment plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels, etc.
- Changes in the member or family's satisfaction with the Case Management Program and other services addressed in the care plan.
- The member's quality of life.
- Benefit limits and financial liability.

The Case Manager completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year if the member remains active in Case Management. The plan of care is also updated at these times and shared with the PCP or specialist, as appropriate.

The Case Manager implements necessary changes to the care treatment plan and modifies the goals based on the findings of on-going evaluation. The Case Manager contacts the PCP, or other members of the multi-disciplinary health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The Case Management team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care treatment plan, the Case Manager assures all involved are in agreement with changes to the care treatment plan to ensure ongoing success. The Case Management team also monitors the care on

an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement department.

### ***Discharge from Case Management***

The Case Manager may receive input from the PCP, member/family/guardian/caretaker, and other health care providers involved in the member's care treatment plan to determine the appropriateness for closing the case. The following criteria are used on an ongoing basis to determine when discharge from Case Management should occur:

- Member terminates with Magnolia.
- Member requests to disenroll (opt out) from the Case Management Program.
- The member/family refuses to participate in Case Management despite efforts to explain how it can benefit the member.
- The member reaches maximum medical improvement or reaches established goals regarding improvement or medical stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources.
- Insurance benefits are exhausted and community resources are in place.
- Member expires.

If the above criteria indicate a case should be closed, the Case Manager, as appropriate:

- Coordinates care with the new medical entity and community resources as required, allowing for a smooth transition for the member.
- If high risk, complex Case Management has been refused by the member/family, the Case Manager provides the member with contact information for future reference and documents the refusal in the clinical documentation system.
- Contacts the PCP and other providers, when appropriate, regarding impending discharge from Case Management.
- Discusses the impending discharge from Case Management with the member/family.
- Presents community resources and assists in making arrangements with those relevant at the time of discharge.

A letter noting the member is discharged from Case Management is generated and sent to the PCP and the member. The letter documents the reason for discharge and includes, if the member has not terminated with Magnolia, a reminder to contact the Case Management team in the future should medical concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented.

## **PROGRAM ASSESSMENT, DATA COLLECTION AND IMPACT MEASUREMENT**

### ***Population Assessment***

At least annually, Magnolia CMD and VPMM and designates will assess the entire member population and any relevant subpopulations (e.g. ABD, Medicare Dual-eligible Special Needs Plan, etc.) to determine if the Case Management Program meets the needs of all members eligible for Case Management. Data utilized for assessment of the entire

member population includes information provided by CMS and/or the state agency and includes information such as age, gender, ethnicity, race, and/or primary language, and benefit category.

Results of the population assessment are analyzed and subsequent enhancements made to the Case Management Program if opportunities for improvement or gaps in Case Management services are identified. Potential revisions to the Case Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in case loads, etc.
- Revisions to types of Case Management activities assigned to specific members of the Case Management team (e.g. clinical versus non-clinical staff responsibilities).
- Implementation of targeted training, e.g. related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff.
- Improvement in identification of appropriate community resources provided to members and process for assisting members in accessing resources.

The annual population assessment may be a separate document or included as part of an annual Utilization Management Program Evaluation and will be presented to the Magnolia Medical Management Sub-Committee, the Magnolia Quality Improvement Committee, and Magnolia Board of Directors for review and feedback.

### ***Satisfaction***

Member satisfaction with the Case Management Program is assessed no less than annually. Member satisfaction surveys, specific to Case Management services, are completed at least annually for members enrolled in Case Management. Surveys are completed via mail or telephonically for members who have been enrolled in Case Management for  $\geq 60$  days. The results of the surveys are aggregated and evaluated annually both quantitatively and qualitatively and are included in the overall evaluation of the Case Management Program, which is a part of the Utilization Management Program Evaluation as described below.

Member complaints and grievances regarding the Case Management Program are also monitored no less than quarterly. Results of the analysis of member satisfaction surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and determine which opportunities to pursue regarding changes to the Case Management Program, as needed.

### ***Outcomes***

Case Management Program outcomes are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.
- Improved clinical outcomes.
- Member/provider satisfaction.
- Plan specific state requirements/expectations.

Magnolia measures effectiveness of complex Case Management no less than annually using at least three measures that assess the process or outcomes of care for members in complex Case Management. Measures of effectiveness may include indicators such as:

- Readmission rate for members in complex Case Management with specific diagnoses such as CHF or asthma.
- Repeat ED visits for members in complex Case Management.
- Rate of members in complex Case Management who received the annual flu vaccine
- Rate of members at risk of pre-term birth receiving 17-P for members in complex Case Management
- Rate of outpatient care following NICU discharge for members in complex Case Management

Measurement and analysis of the Case Management program is documented as part of the annual Utilization Management Program Evaluation. The Case Management Program is evaluated at least annually and modifications to the program are made as necessary. Magnolia evaluates the impact of the Case Management Program by using:

- Results of the population assessment.
- The results of member satisfaction surveys (i.e. members in Case Management).
- Member complaint, grievance, and inquiry data regarding the Case Management Program.
- Practitioner complaints and practitioner satisfaction surveys regarding the Case Management Program.
- Other relevant data as described above.

The evaluation covers all aspects of the Case Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Medical Management Sub-Committee for review, action and follow-up. The final document is then submitted to the Board of Directors through the Quality Improvement Committee for approval.

### **Condition Specific CM and DM Programs**

Members in condition specific care/disease management programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The Case Management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from Case Management when not specifically addressed in the program. Disease Management has been delegated to Magnolia Disease Management vendor (Nurtur), and Magnolia Case Managers coordinates care and member interaction to prevent duplication of contacts and services.

Magnolia Condition Specific Case Management Programs may include, but are not limited to:

- Emergency Department Diversion Program
- Hemophilia
- Sickle Cell
- HIV/AIDS
- High Risk Pregnancy
- Transplant
- NICU
- Children with Special Health Care Needs

Magnolia Disease Management Programs may include, but are not limited to:

- Asthma
- Diabetes
- Heart Failure
- Coronary Artery Disease
- Hypertension/ Hyperlipidemia

### **Training**

Magnolia Foster Care Case Managers have a team of 4 members (2 social workers and 2 registered nurses) with MDHS/DFCS nurse and 2 members from Division of Medicaid that train DFCS field workers about Magnolia Health Plan and the benefits/services that are available for the foster children in Mississippi under this program. This training is provided on a regional basis covering all MDHS Regions each year. This began in January 2013 and will continue to be ongoing to educate all staff concerning benefits/services available as well as how to access their services.

Currently Magnolia Health Plan provides approximately 4,500 foster care children with medical, dental and mental health services.