
Overview

The Harmony Case Management team facilitates collaborative relationships between the members, providers, member's support system and the Plan. The Case Management team advocates for member preferences and the member's unique health service needs. This is accomplished through assessment and planning, anticipating the member's future health care requirements to promote positive outcomes, prevention of complications and eventual recovery. Case Management ensures continuity of care and a smooth transition for the member through the continuum of care, by coordinating care among physicians and other providers.

Case managers coordinate services intended to achieve improved member care and health outcomes, reduction in utilization of emergent services and/or inpatient hospitalizations and increase "community tenure" in terms of the time members spend in productive, rewarding activities. The team also provides member education and seeks to improve the efficiency and value of health care expenditures through efforts to assure access to quality services which ultimately lower overall health related costs.

The Plan categorizes its Case Management programs to best meet the member's specific health care needs:

- Catastrophic, i.e., spinal cord injury, head trauma, etc.
- Transplant
- Complex, i.e., multiple co-morbidities, acute exacerbation of chronic states, end stage renal disease (ESRD), etc.
- Prenatal
 - High Risk Obstetrics
- Special needs
- Lead

Primary Care Physicians (PCP)

PCP's serve as an important partner; critical to the success of the Case Management team. Harmony's program is member-centric - everything revolves around the member's needs, taking into account the member's culture, beliefs and expectations. The Plan's Case Management team makes itself available to support the PCP and assist the PCP in coordinating care among multiple physicians, providers, services, facilities and disciplines.

The Primary Care Physicians:

- Serve as ongoing sources of primary care for the member, including supervising, coordinating and providing all primary care to the members; and
- Are primarily responsible for coordinating other health care services furnished to the members including:
 - Coordinating and initiating referrals to specialty care (both in and out-of-network)
 - Maintaining continuity of care
 - Maintaining the member's medical record.

The Case Management team is comprised of specially-qualified nurses who assist the physician(s) and/ or specialist(s) in achieving member optimum wellness and autonomy through advocacy, communication, education and service facilitation.

The Plan has incorporated Case Management programs that manage members with specific health care needs, including chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, diabetes and multiple inpatient admissions. The physician may call to request Case Management services for any Plan member.

Care Plan Development

A *Care Plan* is developed for every member receiving case management services. Once the member is identified, a mini-assessment is conducted to stratify the member into the appropriate level of case management. Members are stratified based on the complexity of their situations based on diagnosis, psychosocial, financial,

co-morbidities, lack of health education related to their condition, over-utilization, etc. Once the member meets eligibility for case management, the registered nurse case manager conducts the comprehensive assessment.

The Care Plan is developed from the comprehensive assessment and it is shared with the member's support system, PCP and/or specialist. The Care Plan identifies issues unique to the member, barriers to effective care, treatment goals, interventions and expected outcomes. The Care Plan is updated on a regular basis and shared with the PCP/specialist.

Tissue and Organ Transplant Program

The Plan offers a Tissue and Organ Transplant Program with a dedicated Transplant Case Management team to ensure that information is available to providers and to facilitate all aspects of the transplantation process. A member of the Transplant Case Management team will be assigned to assist providers in the multiple needs of the member as a transplant candidate.

All potential candidates for transplantation should be referred to the Transplant Case Management team.

The Transplant Case Management team will:

- Assist providers in initiating transplant protocol;
- Offer providers a list of potential facilities for transplantation based on:
 - Medicare Centers of Excellence
 - Geographical proximity to the patient
 - Specific tissue/organ transplantation team availability
 - Testing and preparation for transplant
- Act as the member's advocate, emotional support and insurance Plan liaison;
- Request medical documentation and records from the office; and
- Facilitate approval of transplant benefits.

Prenatal Program

The HUGS Perinatal Program promotes a healthy pregnancy and delivery for the member and baby. The member receives educational trimester/post-partum letters and a “rewards” form. The member will present the “rewards” form to the physician at the end of each postpartum visit. The physician completes the form, places the office stamp at the bottom and faxes it back to the Plan.

High-Risk OB Case Management

The focused High-Risk OB Case Management Program provides assistance to members who are identified as potential high-risk pregnancies. If the physician notifies the Plan of a member’s non-compliance, potential for the member’s condition to worsen as the pregnancy progresses or other concerns that may threaten the pregnancy, the High-Risk OB Case Management department can support the physician with necessary interventions.

The HUGS Perinatal High-Risk program:

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

Lead Level Screening

Harmony provides case management services to all eligible children with blood lead levels (BLL) equal to or greater than 10mcg/dl. These services include all basic case management services and those services that directly relate to assisting a member who has an elevated lead level, such as education, assistance in obtaining lead abatement, coordination of testing of siblings, scheduling of appointments and coordination of transportation.

The method of identification for members with elevated lead levels is through a monthly report from contracted laboratories and from the Plan’s exam.

Disease Management Programs

The Disease Management Program proactively identifies members with certain chronic diseases and provides superior education for eligible members and/or support systems to empower them to make behavioral changes that will improve their health, reduce complications and the severity of illness. The Disease Management program strives to prevent unnecessary medical complications whenever possible. Early identification, intervention and effective management of complications from chronic conditions/diseases are the “number one” priorities of the Disease Management team.

The program's focus is on educating members and their caregivers regarding the standards of care for chronic diseases, specific triggers to avoid and appropriate medication therapies. The disease manager also educates the member on appropriate action plans, preventing reoccurrences and all measures that will decrease the likelihood of adverse outcomes.

The disease manager educates the member on appropriate action plans, preventing reoccurrences and all measures that will decrease the likelihood of adverse outcomes. The disease manager also assists the member to deal with the stress of chronic illness, understand how to manage his/her emotions in the health care environment and work with his/her physicians and providers in the most effective ways.

The disease manager is sensitive to the emotional and psychological needs of the member, his/her support system and how best to work with that member to maximize his/her adherence to the treatment plan mutually agreed upon with his/her physician.

Additionally, the program also focuses on providing technical support and educational opportunities to ensure the provider is utilizing the most current and nationally recognized standards of care and current treatment recommendations for chronic diseases. Intervention and education will improve the quality of life of members, improve health outcomes and decrease medical costs.

Harmony's Disease Management Program covers the most commonly managed disease states, including:

- Asthma
- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Depression
- HIV/AIDS
- Hypertension

In the Disease Management Programs:

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

- Providers also receive fax alerts that are designed to alert them to abnormal lab values and inappropriate medication usage, in addition to hospitalizations and ER utilization data.
- Providers receive newsletters that feature articles regarding the latest treatment guidelines.