Case Management

KDHE Approved 9/30/2021

The Case Management Society of America defines Case Management as a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to facilitate an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes.

Care Management

The Sunflower case management/care coordination program is designed to help members obtain needed services by using a multidisciplinary team that includes physicians, nurses, social workers, behavioral health professionals, chronic disease specialists and pharmacists. Focusing on the whole person by partnering with our trusted providers to ensure members receive the right services, in the right place, at the right time. These services are implemented through levels of Care Management:

- Care Coordination
- Case Management
- Complex / Intensive Case Management

Some of the benefits of care management are:

- Working with members to develop a care plan
- Speaking with members at scheduled times
- Interacting with members doctors'
- Helping connect members with community programs and services
- Coordination and assistance with appointment scheduling

Care Coordination

- Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants (providers) concerned with a patient's care to achieve safer and more effective care.

- The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care.

Improved health outcomes.

Social Determinants of Health

What does the term “social determinants of health” mean?

- Conditions of the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Goal of “social determinants of health”.

- Create social and physical environments that promote good health for all.

Employment

Housing

Food Insecurity

Social Integration

Social Determinants of Health

These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

Employment

- Sunflower Transition to Employment, GED preparation, transportation etc.
- Project SEARCH statewide coordination, Employment Support Facilitator participates in Community/State action groups and supports member's needs.

Housing

- Housing Support Facilitator participates in Community/State action groups and supports member's needs.

Food Insecurity

- Farmers Market Vouchers

Social Integration

- Enhanced transportation to local community events and social activities for members receiving F/E and PD waiver benefits. Sunflower also assists members with finding events and activities. (Three round trips per year.)

Case Management

Focuses on four main Care Management Activities

- Medical Activities:
  - Keeping in contact with the member at home or in a health care facility
  - Assessing the member's needs, course of treatment, and progress
  - Arranging services and equipment
  - Coordinating activities with the health care team
  - Providing health education
- Financial Activities:
  - Counseling the member and family about benefits, out of plan coverage, and other limitations

Case Management

- Behavioral/motivational activities:
  - Supporting the member and family in dealing with the illness or injury
  - Offering reassurance and information about the members illness and treatment
  - Encouraging the member to pursue a healthy lifestyle
  - Making referrals for counseling or specialists as needed
- Vocational Activities:
  - Assessing a members past education, employment history, work experiences, job skills, and vocational interests
  - Making referrals for psycho-vocational testing, work evaluation, and on-the-job training as appropriate

Complex / Intensive Case Management

- This is a high level of care management services for members with highly complex needs and limited supports, 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; or those that are frail, elderly, disabled, or at the end of life.
- These members have highly complex conditions or multiple co-morbidities and need significant support to coordinate care or more effectively manage their conditions. Services are more intensive at this level of care management and include coordination of care, identification of member's desired outcomes, member-driven goals, identification of interventions, and tracking of progress meeting goals.

We Encourage Coordination of Care

To ensure overall best care for the member, every participating specialist, including behavioral health, must maintain contact and open communication with the member's PCP.

- Why? **Coordination of care between PCP and referred specialist providers improves the quality of care to our members**.
  - Affects members' perception of the care they are receiving.
  - Enhances continuity of care, which allows for better management of treatment and follow-up care when PCPs work in partnership with the referred specialist.
- When? **Coordination and communication should take place:**
  - At regular and periodic intervals during treatment, especially when medication has been initiated of changed or a patient's condition has altered.
- How? **Facilitate communication by**:
  - Talking with members about the importance of interaction with their treating clinicians. Encouraging members to follow through on PCP referrals to specialist providers, and documenting in their medical record if the follow up did not occur.
  - Providers can use our newly created Office Visit Checklist to help them prepare.
  - Contacting referrals for an update. Again, PCP and specialist providers must develop some form of communication in order to know the full spectrum of that member's treatment plan.

Working Together to Help Members Feel Good Every Day

- When providers work together, it helps prevent:
  - Harmful drug interactions
  - Making symptoms worse
  - Extra time at the doctor's office or hospital
  - Uncomfortable or painful tests that are not needed

- How providers can help encourage our members:
  - Talk about the doctors they are seeing
  - Sharing about treatments they are receiving
  - Signing release forms allowing providers to share information
  - Helping members keep appointments

Working Together to Help Members Feel Good Every Day

- Physical and mental health connection:
  - Conditions that affect both physical and mental health can complicate treatment. And recovery may take longer. That's why treatments work better when all of the providers work together.

- How providers can help encourage our members:
  - Assess mental and emotional status ratings.
  - Encourage members to access mental health and/or substance use disorder services.

Working Together to Help Members Feel Good Every Day

- Health activities available to our members:
  - Wellness checkups
  - Preventative care
  - Screenings
  - Immunizations

- How providers can help encourage our members:
  - Schedule health activities
  - Healthy eating
  - Physical activities
  - Tobacco cessation

Accessing Care Management

Members can self refer for care management services by calling Sunflower Health Plan's **Customer Service Center at 1-877-644-4623**.

Members who have been newly determined eligible for support through a Home and Community Based Services (HCBS) waiver will be automatically assigned to a care coordinator for outreach.

New members who already receive HCBS services will be automatically assigned to a care coordinator for outreach.

Sunflower makes coordination of care easy by listing the member's primary care physician and phone number on the main member page in the Secure Provider Portal.

sunflower health plan

Questions?