The Centers for Medicare and Medicaid Services and the state of Georgia are contracted with WellCare Health Plans, Inc. to provide comprehensive, cost-effective managed care health services to enrolled members.

WellCare offers comprehensive Case and Disease management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. WellCare trusts you will help coordinate the placement and cost-effective treatment of patients who are eligible for our Case and Disease Management Programs. In turn, our Case and Disease Managers alleviate your workload by focusing on time-consuming tasks such as:

- **Evaluation**—A Case Manager, a registered professional nurse will conduct a comprehensive assessment of the member to determine where he/she is in the health continuum. This assessment gauges the members’ support systems and resources and seeks to align them with appropriate clinical needs.

- **Planning**—The Case Manager collaborates with the member or caregiver and provider to identify the best way to fill any identified gaps or barriers to improve access and adherence to the provider’s plan of care.

- **Facilitation**—The Case Manager works with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member or caregiver or as complex as arranging services, transportation and follow-up.

- **Advocacy**—The Case Manager is the members’ advocate within the complex labyrinth of the health care system. Case managers assist them with seeking the services to optimize their health. Case management emphasizes continuity of care for members through the coordination of care among physicians and other providers. Case management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.
WellCare’s Case Management team is comprised of specially trained registered nurses who assess the member’s risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.

Case Managers work collaboratively with and assist the Primary Care Physicians (PCPs) to coordinate care for the member and expedite access to care and needed services. The Case Management team also serves in a support capacity to the PCP and assists in actively linking member to providers, medical services, residential, social and other support services, as needed. The physician may request case management services for any of the Plan members.

The Case Management process illustrates the formation of one seamless Case Management Program and begins with Member identification, and follows the Member until discharge from Case Management. WellCare’s philosophy is that these programs are an integral management tool in providing a continuum of care for our Members. The Case Management process is as follows:

- Identification
- Clinical Assessment and Evaluation
- Care Planning
- Service Facilitation and Coordination
- Member Advocacy

Members are discharged from the Case Management program when one or more of the following reasons occur:

- 80% of goals are met;
- Non-adherence to CM Treatment plan or Medical plan;
- Termination from the plan;
- Member request to be discharged from program;
- Death; or
- Unable to contact

Members commonly identified for WellCare’s Case Management Program include:

- Catastrophic – head injury, near drowning, burns, etc.
• Complex – multiple co-morbidities or multiple intricate barriers to quality health care, i.e. HIV/AIDS.
• Lead- Blood Lead Levels equal to or greater than 10 mcg/dL.
• High Risk Obstetrics Program – teen pregnancy, past history of low birth weight, history of pre-term birth, etc.
• Transplantation – solid organ or tissue transplants from evaluation to 1 year post-transplant
• Special Needs Population – developmentally delayed, autism, failure to thrive, etc.
• Long Term Care – medically frail elderly.

Disease Management Program

WellCare’s Disease Management Program focuses on providing education for members with chronic conditions and empowering the member to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease. WellCare’s Disease Management Program pro-actively identifies members with chronic conditions using an algorithm that addresses utilization, cost, and severity of illness. WellCare’s Disease Management Program targets the following conditions:

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

WellCare’s Disease Management Program educates members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management.

The program also focuses on educating the provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of members, improve health outcomes and decrease medical costs.

In addition, WellCare makes available to providers and
members general information regarding health conditions on WellCare’s web site at: www.georgia.wellcare.com

Member and Provider Access to Case and Disease Management

If you would like to refer your WellCare patients to either or both of these programs, you may

1) Call the Care Management Referral Line at 1-866-635-7045 Monday through Friday,

or

2) Complete the Care Management Referral Form and fax to WellCare (web site link to referral form)

Members may self-refer or receive referral by a provider to the program(s) utilizing:

Care Management toll free line, 1-866-635-7045, TTY/TTD available in unit.

If a WellCare Member would like to speak with a nurse after-hours or on weekends, they may contact WellCare’s Nurse Advice Line at: 1-800-919-8807.

TTY/TTD Nursing Advice Line: 1-800-955-8770