WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** CM Assessment Process
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APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/12	**REVIEWED/REVISED:** 09/13, 9/14, 9/15, 9/16, 9/17, 8/18, 2/19, 6/19, 7/19, 02/20, **101/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CM.01.01

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management

PURPOSE:
To ensure a consistent and comprehensive assessment process to identify members for care management

WORK PROCESS:

1) The Plan staff will receive training on use of assessments including identification and screening of behavioral health conditions.

2) The Plan uses standard assessment templates. Assessments are documented in the clinical documentation system which can be viewed by all staff on the Integrated Care Team (ICT) allowing continuity and coordination of care.

3) Outreach to complete the assessments are completed within thirty (30) days of identifying the member for Case Management by completing three (3) telephonic attempts on non-consecutive days and at different times of the day. If all three attempts are unsuccessful, an attempt to contact letter is sent to the member. For high risk members with a CM engagement score of >40, a request for a home visit may be made to reach the member.

4) Once the member has been successfully contacted, applicable screenings such as the Health Risk Screening (HRS), are completed to assess the member's needs.

5) The HRS is based on the member's age to help further identify clinical history, behavioral health needs, social determinants of health and/or needs that may not be available through claims data and predictive modeling.

6) Based on the findings from the screening(s), the member is either warm transferred to an Enrollment Care Manager or a Care Manager already assigned to the case, if available. If Care Manager is not available to receive the warm transfer, a "Complete HRS" task is submitted to the appropriate team queue for staff assignment.

7) The member is assigned to the appropriate CM staff member (Care Manager, Program Specialist, or Behavioral Health Care Manager) based on the following acuity level identified in the HRS.

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1. **High** – Unstable (Assigned to Care Manager (Physical or Behavioral))
   - Member unstable and/or has a chronic or complex condition with ongoing physical or behavioral health needs.
   - Currently hospitalized.
   - Symptomatic and at risk for immediate ED visit, admission or readmission.
2. **Moderate** – Chronic and/or co-morbid conditions but stable (Assigned to Care Manager (Physical or Behavioral), Program Specialist (LCSW or LMSW only)
   - Member is stable but has chronic health care needs, behavioral health care needs, or social determinants of health with adequate care giver support
   - Current need for routine ongoing physical or behavioral services, which may include but are not limited to PCP visits, specialist visits, home care provider, lab work, medications, or referral and intervention by community organizations.

- **Low** – Stable with multiple or co-morbid conditions or social determinants of health (Assigned to Behavioral Care Manager or Program Specialist)
  - Member is stable but the screening indicates a possible risk for a potential problem or complication, can be primarily psychosocial needs
  - History of illness or injury but member currently requires little or no medical, behavioral, or social support services or, if they do, the family is managing the care well.

8) The CM staff initiates the initial assessment within 30 days of identifying the member for case management and completes the initial assessment **~~and care plan~~** no later than 60 days from the date of identification.

Assessments are founded on evidence-based clinical guidelines and will include evaluation of:

- the member's health status, including condition-specific issues;
- clinical history, including medications;
- activities of daily living related to at least six basic ADLs (bathing, dressing, toileting, transferring, feeding and continence);
- behavioral health and cognitive status;
- social determinants of health;
- visual and hearing needs, preferences or limitations;

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- life-planning activities (i.e. wills, living wills or advanced directives);
- cultural and linguistic needs, including health literacy;
- caregiver/support resources available to the member and involvement
- available benefits; and community resources.

9) If appropriate, the CM staff completes additional disease specific assessments, such as Sickle Cell and Depression which can identify individual risk factors and/or needs.

10) Once a full assessment has been completed and the member's needs have been identified with conclusions drawn, the CM staff begin to build the member's individualized plan of care based on the member's preferences and goals. **The process for care plan development and implementation can be found in LA.CM.01.02.**

REFERENCES:
MCO-P RFP – Section 6 Core Benefits and Services
LA.CM.01.02 Individualized Care Plan
LA.CM.01 Care Management Program Description
Current NCQA Health Plan Standards and Guidelines

ATTACHMENTS:

DEFINITIONS:
CM includes PH and BH in this work process

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REVISION LOG	**DATE**
High – Unstable: 1. Case Manager initiates member contact within 7 days - changed from "1 business day" 2. assessment is completed as quickly as the member's health condition requires but no later than 30 days of admission to case management – changed from "no later than 15 days of referral from the initial screening" Low Stable with multiple or co-morbid conditions – Case Manager contacts the member within one month of the referral screening and completes the assessment as quickly as the member's health condition requires, but no later than 30 - changed from "45"	8/13
Case manager changed to Care Manager. In Section 5 – added Program Specialist In Section 7 – changed The Program Manager to a member of the ICT.	9/14
"The Plan" changed to "LHCC" and "Case Management or Case Manager" changed to "Care Management or Care Manager"	9/15
No revisions	9/16
Under Work Process #4-changed "The Program Coordinator(PC) or Member Connections Representative (MCR)" to "Appropriate Medical Management/Behavioral Health"; removed "to explain the care management function, inform the member that they can opt out of the program at any time and performs a telephonic general screening assessment within 14 days of receipt of the referral to determine whether the member meets criteria for care management" to a "telephonic General Health Risk Screening (GHRS) within 7 to 14 days, but not to exceed 30 days of receipt of referral/task". Under Work Process #5-changed "screening assessment" to "GHRS" added "/or" after "clinical history and" changed "The screening assessment is scored to allow the member to be prioritized for review and follow up by the RN Care Manager or Program Specialist" To "GHRS is scored to allow the member to be prioritized for review and follow-up by a Physical Health Care Manager (PHCM), Behavioral Health Care Manager (BHCM), or Program Specialist (PS". Under Work Process # 6- Removed "This includes, but is not limited to : Special needs such as developmental delay, severe orthopedic or persistent muscle tone abnormalities, seizure disorder, major chromosomal abnormalities, etc. Assistance needed with activities of daily living (e.g. bathing, toileting, dressing, ambulating) or instrumental activities of daily living (e.g. preparing meals, shopping, basic housekeeping, etc.) particularly when there is no support system. Social or economic constraint such as lack of financial; support, lack of social, family or significant other support, illiteracy, or significant communication barriers, access to care issues, transportation, or abuse or suspected abuse." Under Work Process #7 changed "a new case assignment task" to "Resource assistance task, referral or new case assignment task". Under Work Process #8 "Moderate" added to the #2 "with adequate care giver support" after "member is stable but has complex health care needs"	9/17

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Under Work Process #8 "Low" added "can be primarily psychosocial needs" after "Member is stable but the screening indicates a possible risk for a potential problem or complication" Under Work Process #9 changed from "The Care Manager conducts an individualized needs assessment tool, which includes higher level and condition specific questions (such as for asthma, diabetes, etc) to identify individual risk factors and needs" to "The Care Manager completes a Health Risk Assessment (HRA), in addition to any disease specific assessments, such as Sickle Cell, Diabetes or HIV, which can identify individual risk factors and/or needs." Under Work Process #10 Removed "The" and changed "treatment plan" to "plan of care, with input from the member"	
No Revisions	08/18
Moved contents of assessment after screening has been completed Spelled out General Health Risk Screen Removed timeline for outreach for High, Medium, and Low risk Updated contents of assessment with NCQA requirements Removed Diabetes and HIV from specialty assessment and added Depression Added NCQA standards, CM Program Description, and Care Plan Development and Implementation Work Process as references	02/2019
Changed General Health Risk Screening to Health Risk Screening	6/19
Defined CM as including PH & BH in this work process Changed the timeline for initiating the assessment to: within 30 days of identifying the member for case management and completes the initial assessment and care plan no later than 60 days from the date of identification	7/19
Added 3 telephonic attempts for initial outreach Removed that HRS is scored Updated steps to reflect current process	02/2020
Removed care plan from being completed within 60 days of identification due to Amendment 3 requirements. **Added LA.CM.01.02 as a policy to reference for care plan development**	**110/2020**

WORK PROCESS APPROVAL

The electronic approval retained in RSA Archer, ~~Centene's P&P management software,~~ is considered equivalent to an actual signature on paper.

~~Sr. VP, Population Health: Electronic Signature on File~~
~~Chief Medical Officer: Electronic Signature on File~~