POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Perinatal Substance Use Disorder Care Management Program
PAGE: 1 of 7	**REPLACES DOCUMENT:**
APPROVED DATE: 2/2018	**RETIRED:**
EFFECTIVE DATE: 3/1/2018	**REVIEWED/REVISED:** 01/20, 3/2120
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CM.31

SCOPE:
Louisiana Healthcare Connections (LHCC) Medical Management Department

PURPOSE:
To establish the components of the perinatal substance abuse care management program.

POLICY:
The Perinatal Substance Use Care Management Program is an Integrated Care Management program. The program is in place to educate members in the perinatal period (prenatal and postpartum) about the risks of comorbid substance use, and to educate and assist the member in accessing services for treatment of substance use disorders.

PROCEDURE:

A. The perinatal substance use care management program is available to all pregnant members **with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS), fetal alcohol syndrome, or neonatal opioid withdrawal syndrome (NOWs) for babies born with opioids (Emergency Contract 6.19.1.3**[QW1][ALM2]**).**

B. LHCC will use a variety of methods to identify members who may benefit from care management **which include but are not limited to:**~~.~~

- Appropriate health risk screening/assessment
- Notice of Pregnancy (NOP) – the notices of pregnancy are reviewed to identify pregnant mothers with potential issues related to substance use disorders.
- Referrals – Members are also identified through referrals from families, caregivers, providers, community organizations and health plan.

C. Stratification

All members enrolled in the perinatal SUD management program are stratified based on acuity to determine the appropriate level of intervention. Stratification is based on information obtained from the Health Risk Screening/Assessment (HRA) and the Pregnancy Substance Use Journal Members are stratified into three levels:

- Low Risk – condition is present, but is well controlled; symptom remission; less need for education; and/or have low readiness to change coupled with a low reported risk of Neonatal Abstinence Syndrome (NAS). For example: member may present with a history of SUD disorder (placing member at risk for relapse) but denies current reported use; and/or members Drug of Choice does not indicate high risk of NAS.
- Moderate Risk – uncontrolled disease, member requires education and assistance related to their condition(s); and/or has moderate readiness to change evident by current engagement in treatment and/or low history of relapse
- High Risk – uncontrolled disease evident by member history of frequent and recent relapses and history of resistance to treatment. Member requires education/resources related to the member's condition, has co-morbid conditions, and/or has high readiness to change.

D. Condition Specific Assessments

All identified members are contacted within 30 days of identification to initiate comprehensive health assessments (see LA.CM.01.01 for general Care Management Assessment Work Process).

In addition to the general Care Management assessment and screening process. The PN SUD program uses the following additional condition specific assessment:

Pregnancy Substance Use Journal Louisiana – The PN SUD Journal tracks member symptoms pre and post-delivery (including NAS[QW3][ALM4] or NOWs diagnosis and/or NICU admission or lack of), and members self-reported drug of choice (DOC). The Pre delivery portion of the assessment is initiated within 30 days of identification. The Journal is then updated periodically thereafter in order to monitor and update information related to members PN SUD signs/symptoms, and treatment response. Participants that screen positive for possible PN SUD are advised to discuss these

responses with their doctor. Mental health education, provider contact information, and assistance with scheduling an appointment is also provided.

- ~~**Low Risk** ***(not applicable for members with increased suicide risk)***~~
  - ~~**Participants are assigned to this group when they are determined to have entered into the maintenance phase of treatment or determined to be at a minimal or mild risk level based on current SUD use history (PN SUD Journal symptom screening).**~~
  - ~~**Perinatal SUD symptoms will be reassessed at regular intervals to monitor changes to member reported symptoms. Individuals who are in this category are provided focused education material designed to educate them on their disease process, medications, and relapse prevention planning.**~~

- ~~**Moderate Risk**~~
  - ~~**Moderate risk participants are provided ongoing mail and telephonic outreach to provide education regarding available treatment options, collaborate with community providers, all in an effort to increase the member's ability to self-manage their condition. Additionally, participants are provided referrals to community resources where needed, such as transportation and community support groups relevant to diagnosis.**~~
  - ~~**Perinatal SUD symptoms will be reassessed at regular intervals to monitor changes to member reported symptoms. Post-delivery updates regarding ongoing participating member outcomes will be updated within 30 days of delivery. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.**~~

- ~~**High Risk**~~

~~**High risk participants receive all of the interventions provided in the moderate risk program. Additionally, care management staff will participate in ICT Rounds to identify care gaps, review treatment response and offer feedback to providers as necessary. Perinatal SUD symptoms will be reassessed at regular intervals to monitor changes to member reported symptoms.**~~

E. Outreach and Education

Outreach Frequency is based on acuity and follows the guidelines for Care Management outlined in LA.CM.01.02. Multiple communication strategies are used in care management programs to include written materials, telephonic outreach, and web-based information, in person outreach through Community Health Representatives program and care managers as needed, and participation in community events.

Motivational interviewing techniques are incorporated into disease/age specific talking points designed to engage, destigmatize, educate and empower members to improve overall health and manage symptoms.

Written materials will be written at or below a fifth grade reading level. Within seven to ten days of enrollment in the program, members will receive a welcome letter including details about the program, information about how to contact care management staff, including LHCC's toll-free number, condition specific education materials and any other relevant health-related materials. Frequency of mailings will vary based on the level of acuity and member's individualized care plan.

The following table provides information on the program interventions provided to the members based on their acuity levels:

Acuity Level	Program Interventions

Low Risk	**Participants are assigned to this group when they are determined to have entered into the maintenance phase of treatment or determined to be at a minimal or mild risk level based on current SUD use history (PN SUD Journal symptom screening). Individuals who are in this category are provided focused education material designed to educate them on their disease process, medications, and relapse prevention planning.**
Medium Risk	**Provided ongoing mail and telephonic outreach to provide education regarding available treatment options, collaborate with community providers, all in an effort to increase the member's ability to self-manage their condition. Additionally, participants are provided referrals to community resources where needed, such as transportation and community support groups relevant to diagnosis.**
High Risk	**Provided ongoing mail and telephonic outreach to provide education regarding available treatment options, collaborate with community providers, all in an effort to increase the member's ability to self-manage their condition. Provided referrals to community resources where needed, such as transportation and community support groups relevant to diagnosis. Additionally, care management staff will participate in ICT Rounds to identify care gaps, review treatment response and offer feedback to providers as necessary.**

Perinatal SUD symptoms will be reassessed at regular intervals to monitor changes to member reported symptoms. Post-delivery

updates regarding ongoing participating member outcomes will be updated within 30 days of delivery. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.

F. Discharge from Care Management

The following criteria will be used to determine when discharge from care management is appropriate:

- The member reaches the highest possible levels of wellness, functioning and quality of life.
- The member achieves established goals regarding improvement or health care stability and is referred to community resources. This may include preventing further decline in condition when health status improvement is not possible.
- Member/family is non-responsive to care management interventions despite ~~three (3) repeated outreaches, calling on~~[QW5][ALM6] ~~different days of the week, which may include weekends, at different times of the day to maximize the likelihood of successful contact~~ reasonable outreach attempts and utilizing a variety of modalities including field visits, telephonic, or virtual outreaches.
- Member refuses to participate in care management, following efforts to explain the benefits of the program to the member.
- The member dis-enrolls from the health plan.
- The member expires.

G. Measures of Efficacy and Reporting Mechanisms

LHCC will monitor engagements and enrollment numbers for the Perinatal SUD Case Management program in addition to the following:

- SUD symptom screening results to trend and support program development
- Successful completion of the program based on CM closure reason (i.e.; condition stable, no other needs)

H. Program Oversight

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The Medical Director is responsible for the clinical oversight and evaluation of all potential quality of care concerns/issues related to the Perinatal SUD care management program

REFERENCES
LA.CM.01 – Care Management Program Description
LA.CM.01.01 – Care/Case Management Assessment Process
LA.CM.01.02 – Care Plan Development and Implementation
LA.SSFB.01- Smart Start for Your Baby: Perinatal/Neonatal Management Program Overview

ATTACHMENTS:

DEFINITIONS:
N/A

REVISION LOG:	**DATE**
Revised verbiage to mirror NCQA wording and requirements related to assessments. Updated references to include updated Care management policies.	1-2020
Annual review – moved acuity level and program interventions bullet points to "Outreach and Education" and changed to format from bullet points to table **Added contract reference 6.19.1.3**	**03/2021**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, t~~he Company's P&P management software,~~ is considered equivalent to a signature.

~~**The electronic approval retained in RSA Archer GRC, Centene's P&P management software, is considered equivalent to a physical signature.**~~

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