POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME**: Care Management Program Description
PAGE: 1 of 42	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
INITIAL EFFECTIVE DATE: 1/2012	**REVIEWED/REVISED:** 09/12, 9/14; 11/14, 9/15, 1/16, 10/16, 3/17, 3/18, 8/18, 2/19, 6/19, 10/19, 01/20, 11/20, 03/21
REVISED EFFECTIVE DATE: 2/1/15	
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER: LA.CM.01**

SCOPE:
Louisiana Healthcare Connections Medical Management (LHCC) and Quality Improvement Departments

PURPOSE:
To describe the LHCC's Care Management Program

POLICY:
The Medical Management and Quality Improvement departments will maintain a Care Management Program Description which contains the goals and objectives of the program, identifies the target Care Management population, outlines the infrastructure of the program and describes an overview of the methods and processes of identifying and assessing members, managing member's care, and measuring the impact of interventions.

LHCC will submit Care Management Program policies and procedures to Louisiana Department of Health (LDH) for approval within thirty (30) days from the date the Contract is signed, annually, and prior to any revisions. In addition, LHCC will submit Care Management reports monthly or as indicated by LDH.

DEFINITIONS:
Care Management: the overall system of medical management, care coordination, continuity of care, care transition, chronic and complex case management, and independent review. LHCC will ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.

Case Management: Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population, including those with acute and chronic conditions, to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment

and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes. Case Management consists of four levels of care which include Complex Case Management, Case Management, Care Coordination, and Disease Management/Health Coaching.

Care Coordination: Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member's care

Complex condition: Members who are classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; individuals that are in need of more intensive programs or services; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life.

Chronic condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine. Chronic conditions are persistent or frequently recurring conditions of significant duration that may limit an individual's activities and require ongoing medical care to optimize the individual's quality of life.

Basic behavioral health services: Mental health and substance abuse services which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities. Basic Behavioral Health Services include, but are not limited to, screening, brief intervention and assessment, prevention, early intervention,

medication management, treatment and Referral Services provided in the primary care setting and as defined in the Medicaid State Plan. Basic Behavioral Health Services may further be defined as those provided in the enrollee's PCP or medical office by the enrollee's (non-Specialist) physician (e.g., DO, MD, APRN, PA) as part of routine physician evaluation and management activities. These services shall be covered by the MCO for enrollees with both physical health and behavioral health coverage.

Specialized Behavioral Health Services (BHS) –Mental health services and substance abuse services that include, but are not limited to, services specifically defined in LHCC's Health Plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider.

Special Health Care Needs Population - An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements.

REFERENCES: Current NCQA Health Plan Standards and Guidelines; Current Healthy Louisiana Managed Care Organization (MCO) contract language

ATTACHMENTS:
EPC Pediatric Obesity Program Description
EPC Asthma Program Description
EPC Back Pain Program Description
EPC Traditional Diabetes Program Description
EPC Heart Failure Program Description
EPC Hypertension Program Description
EPC Weight Management Program Description
EPC COPD Program Description
EPC Hyperlipidemia Program Description
EPC Heart Disease Program Description

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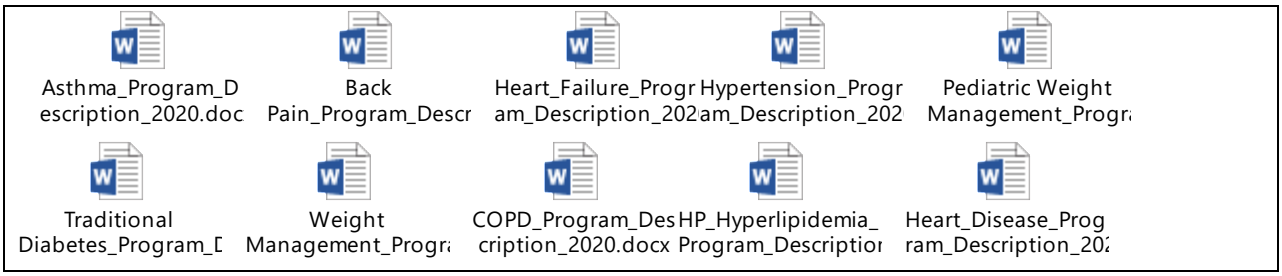

REVISION LOG	DATE
Attachment A: Complex Case Management is the former LA.CM.01 and was replaced by this policy (Case Management Program Description) on 4/10/13.	4/2013
Added "Children with special healthcare needs co-occurring medical and behavioral health conditions" to Case Management Criteria	11/2013
Reviewed and revised with additions to reflect process for Plan and BH integrated rounds in place.	1/2014
Removed attachment: Complex Case Management. It is now its own policy. Changed Director of Medical Management to Director of CM. Changed number of cases to 65	9/2014
LA Procurement 2015 Policy Update	11/2014
Added Case Management work flow	2/15
Changed Case to Care; Changed "The Plan" to "LHCC;" Changed "Complex Care" to "Chronic Care," Revised Scope, Goals, Functions & Outcomes.	9/15
Reviewed and revised to include CCMP program additions	1/16
Reviewed and revised to include BH contract language and BH related personnel additions (I.e. Behavioral Health Practitioner, etc.)	1/16
Changed "Chronic Care Management" to "Complex Care Management"	1/16
Changed DHH to LDH	10/16
Updated dates, added Envolve People Care	3/17
Updated dates, functions, program segments, data sources Changed Care to Case Manager; CMD to SVPMA, MC to CHS	3/18

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Added DM, CHS, BHCM Added BH goal and Health Coaching criteria Removed LTSS Added Special Health Care Needs Added NAS to outcomes Updated goal of ED Removed Paramedicine Program Updated Sickle Cell, Anxiety, Depression and PSUD Changed Care Management to Case Management Changed Case Managers to Care Managers Changed "The Plan" to LHCC	
Added Care managers will also collaborate with PMUR (Pharmacy Medication Utilization Review) staff in ICT Staffing Model Added Asthma and Depression assessments to condition-specific assessments Removed attachment: EPC (Nurtur) Program Description Added attachments: Nurtur Pediatric Obesity Program Description, Nurtur Asthma Program Description, Nurtur Back Pain Program Description, Nurtur Diabetes Program Description, Nurtur Heart Failure Program Description, Nurtur Hypertension Program Description, Nurtur Weight Management Program Description	8/18
Changed "Case Management Program" to "Care Management Program" Updated dates and metrics to reflect 2019 Removed LTSS services as a Care Coordination function Capitalized Registered Nurse Changed VPMM reports to COO to reporting to SVPCO Removed laboratory data as data source Added LaEDIE (ED Registry) as a data source Grammatical and format changes Removed Nurse Advice Line under "Other referral sources" due to duplication Removed risk stratification for outreach timeframe based on acuity levels (high, medium, low)	2/19

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Changed used of word "complex" regarding moderate/medium acuity to "chronic" Changed specialty assessments to only include Sickle-Cell and Depression Changed "mental health" to "behavioral health" Changed "psychosocial issues" to "social determinants of health" along with examples Changed definition of when initial assessment is required – no longer based on when member agrees to CM. Assessment completion time based on date of identification for CM Added caregiver as an option to needing to be willing and able to participate in CM program Removed flu vaccine rate and NICU follow-up appointment from CM effectiveness measure section Added PASRR program to Population Management section Changed number of ED visits for Chronic Pain Management from 5 visits to 4 Added Perinatal Depression Program to Condition specific CM/DM program	
Added verbiage regarding CM reporting to LDH Removed specific CM goals and aligned goal verbiage to include goals to be determined by NCQA, LDH, etc. annually. Added Laboratory data back into the data source list Moved paragraph "After completing the assessment of the member as a whole, stratification as low, moderate/medium, or high priority is determined in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management." to the end of the assessment and screening section. Removed timeframe for initial outreach for high risk members Removed two CM Effectiveness measures – Postpartum outreach for members in CM and members with Sickle Cell and receiving hydroxurea	6/2019

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Re-word reassessment verbiage to align with RFP reference 6.19.4.3	10/2019
Revised definitions section to reflect RFP definitions Added 2020 EPC Disease Management Program Descriptions Updated dates to reflect 2020 CM Program Description Grammatical changes including Care Management vs Case Management and Care Manager vs Case Manager Removed CCMP is a referral source because referrals are for the CCMP program Added COPD, Heart Disease, and Hyperlipidemia to DM programs	01/2020
Added verbiage from Corporate CM Program Description regarding Program Segments and the Care Management Member Prioritization Report Added Behavioral Health specifications to Complex Case Management criteria Added Community Liaison role and description to Integrated Care Team section Added EPSDT Waiver Program information Added new criteria for Special Health Care Need based on Amendment 2 from the Emergency Contract Updated requirements of the care plan to be completed within 45 days of the completion of the assessment to reflect Amendment 3	11/2020
Added information regarding new Special Healthcare Need population, Act 412 Children's Medicaid Option (CMO) per Amendment 3	01/2021
Formatting and grammatical changes Added the following to meet Emergency Contract references: Within the care plan section: • Offering member freedom of choice in finding new providers and/or obtaining services • For members with behavioral health related disorders and may experience crisis, a plan for addressing crisis, including resources and contact information, to prevent unnecessary hospitalizations or institutionalization	03/2021

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Justice-Involved Pre-Release Program within Population Management section Annual review – updated outcomes section to remove effectiveness measures no longer included in CM Program Evaluation	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.

Care Management Program Description 2021~~0~~

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Purpose

The purpose of the Care Management Program Description is to define Case Management functions, determine methods and processes for member identification and assessment, manage member care, and measure outcomes.

Scope

Definition of Member

For the purposes of this policy the term member is an inclusive term referring to the covered individual and the family, guardian, designee, authorized representative, caregiver, supporter or other significant person involved in a fiduciary or supportive role.

Definition of Case Management

Louisiana Healthcare Connections (LHCC) adheres to the Case Management Society of America's (CMSA) definition of Case Management: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes". LHCC also abides by the principles of Case Management practice, as described in CMSA's Standards of Practice for Case Management.

The Care Management program and the tools utilized to manage care were built on evidence-based clinical practice guidelines and preventive health guidelines adopted by Louisiana Healthcare Connections Health Plan. The assessments utilize the Case Managements Society of America's (CMSA) Standards of Practice for Case Management and other evidence based tools including the PHQ2/9. Disease specific assessments include research of latest scientific sources, articles and publications from national organizations. The program also includes adherence to HEDIS effectiveness of care measures and the associated technical specifications to ensure member compliance.

LHCC trains and utilizes motivational interviewing techniques to guide member goal identification and actions.

Levels of Case Management Include

- **Care Coordination** – appropriate for members with primarily social issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing healthcare services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor medical,), or behavioral health concerns arise. Services at this level of coordination include outreach to member, assistance scheduling appointments, and assistance securing authorizations and follow up to ensure compliance.

- **Case Management** – appropriate for members needing a higher level of service, with clinical needs. Members in case management may have a chronic condition or multiple co-morbidities that are generally well managed. Members in case management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a Care Manager. Services at this level include care coordination, along with identification of member agreed upon goals and progress towards meeting those goals.
- **Complex Case Management -** a high level of Case Management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; individuals that are in need of more intensive programs or services; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex Case Management is performed by LHCC for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of Case Management include all of the above mentioned levels of care coordination and Case Management services, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care Managers will monitor member's key indicators of disease progress, i.e., HgbA1c levels and medication adherence. Pregnant members are excluded from Complex Case Management unless co-morbidities occurred before or will continue after pregnancy.
- **Disease Management** - health coaching provided by certified health coaches/disease managers for chronic medical conditions (diabetes, hypertension, COPD, congestive heart failure, and asthma,). Health coaching for behavioral health chronic conditions are provided by licensed mental health practitioners for ADHD, anxiety, depression, and perinatal depression. The program objectives include the provision of telephonic outreach, education, and support services to promote member adherence to treatment guidelines and facilitate member self-management.
- **Community Health Services –** certified community health services representatives who coordinate visits with members during provider appointments to perform on-site Case Management. This program also includes visits to members while hospitalized to engage in Case Management in an effort to reduce inappropriate re-admissions.

Mission of Care Management Program

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.

- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

Goals of the Care Management Program

- Achieve member experience with Case Management of >90% satisfaction annually
- Collaborating within multidisciplinary teams to utilize resources to promote the health and well-being of Louisianans
- Meeting HEDIS goals as designated by LDH and NCQA annually
- Supporting LHCC Population Health Strategic Plan Goals annually

Case Management Functions

Case Management functions include:

- Early identification of members who have special needs and/or other physical, behavioral, or social needs.
- Assessment of member's risk factors, current health status, current service utilization, gaps in care, and medication review.
- Obtain voluntary consent for participation in Case Management
- Utilize an Integrated Care Management model to address physical and behavioral health needs of the member.
- Development of an individualized plan of care in concert with the member and/or member's family, primary care provider (PCP), and managing providers.
- Development of a comprehensive plan of care in concert with the member and/or member's family, primary care provider (PCP), and managing providers, that includes identification of member goals, barriers to meeting those goals, and appropriate Case Management interventions.
- Referrals and assistance to ensure timely access to providers, including person-centered medical homes, if applicable.
- Active coordination of care to link members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition.
- Assistance with facilitation of continuity and coordination of care among the member's various providers.
- Ongoing monitoring, follow up and documentation of all care coordination/Case Management activities.
- Addressing the member's right to decline participation in Case Management or dis-enroll at any time.
- Accommodating the specific cultural and linguistic needs of all members

- Conducting all Case Management procedures in compliance with HIPAA and state law.

Program Segments

A defined set of care management population criteria is in place to create a consistent Care Management Program Description and a consistent measurement process of the care management program effectiveness.

The criteria below is not all inclusive; clinical judgment should be used to determine a member's appropriateness for each level of care management, considering such factors as: stability of the condition(s), available support system, current place of residence, etc. (Louisiana Healthcare Connections may make expansions on these core criteria as needed to meet regulatory requirements and changes in populations as discovered through annual assessment).

Care Coordination Criteria
• Primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing Healthcare services • Members overusing and/or abusing services • Members that are children with a serious emotional disturbance who are eligible for the Coordinated Systems of Care program shall receive care coordination via the CSoC contractor. ~~Members that are children with a serious emotional disturbance shall receive care coordination via the Coordinated Systems of Care program (CSoC)~~[KF1][ALM2] • Permanent Supportive Housing needs
Case Management Criteria
• Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to: o HIV/AIDS o Cancer o Asthma, with associated inpatient admission o Sickle cell o Diabetes o Congestive Heart Failure o Hemophilia o ADHD o Depression o Anxiety o Perinatal Substance Use Disorder (SUD) o Adults with a Serious and Persistent Mental Illness (SPMI) o High Risk Pregnancy

- Children with special healthcare needs co-occurring medical and behavioral health conditions
- Other State-mandated criteria

Complex Case Management Criteria

- Impact Pro risk score of ≥7 for TANF members; >4.65 for all other members
- Three or more inpatient admissions within the last 6 months for same/similar diagnosis
- Three or more ER visits in the last 3 months
- Rare, High Cost Conditions
- Requiring Acute Behavioral Health intervention(s):
    - Inpatient Acute Psychiatric in the past 30 days
    - Inpatient Residential Treatment in the past 30 days
    - Member has active acute symptoms evident by active psychosis, active Substance Abuse/Dependence, symptomology indicating member is in immediate need of acute inpatient levels of care and symptomology cannot be de-escalated via a crisis prevention plan
    - Member ORCA score is 95-100 / HIGH
- Members living with a developmental or intellectual disability eighteen (18) years of age or older
- Members under eighteen (18) years of age and are receiving services under the 1915(c) HCBS waivers and any amendments
- Complex cases/ multiple co-morbidities, including but not limited to:
    - Chronic or non-healing wounds / Stage 3 burns that require extensive wound care or skin grafts
    - Requires life sustaining device – ventilator, tracheostomy, oxygen, CPAP / BIPAP, tracheostomy care or suctioning
    - TPN or continuous tube feedings
    - Recent functional decline within 90 days
    - Private Duty Nursing
    - Skilled Nursing Visits > 3 visits / week
    - Institutional/SNF/ICF/IDD
    - Multiple co-morbidities that require 4 or more specialists
    - Diabetes with Lower Extremity (LEX) episode or HgbA1c > 7
    - Post-transplant within 6 months
    - Post-discharge from NICU with a chronic/complex diagnoses
    - Catastrophic illness or injury, e.g. transplants, HIV/AIDS, cancer, serious motor vehicle accidents, etc.
    - End Stage Renal Disease (ESRD)
    - Dual diagnosis – members with serious, chronic behavioral health and physical health diagnoses
    - Congenital heart anomalies (i.e. tetralogy of fallot, hypoplastic left heart syndrome, coarctation of aorta, etc.)

Health Coaching Criteria

- Physical Health Coaching for members who have one of the chronic big 5 conditions (Diabetes, CHF, Asthma, COPD, and Hypertension)
- Behavioral Health Coaching for members who have one the chronic 4 behavioral health conditions (ADHD, Anxiety, Depression, Perinatal Depression)
- Members who meet criteria for the Community Health Service Representative program for outreach in the community or during inpatient hospitalization

Infrastructure & Tools

Organizational Structure

Chief Medical Officer (CMO)

The Chief Medical Officer (CMO) has operational responsibility for and provides support to LHCC's Care Management Program. The CMO, Senior Vice President of Population Health (SVP), and/or any designee as assigned by the LHCC President and Chief Executive Officer (CEO) are the senior executives responsible for implementing the Care Management Program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to Case Management. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the CMO, LHCC may have one or more Medical Director and/or Associate Medical Directors.

The CMO's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Assists in the development and revision of Case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Care Management Program
- Provides clinical support to the Case management staff in the performance of Case Management responsibilities
- Provides a point of contact for practitioners with questions about the Case Management process
- Communicates with practitioners as necessary to discuss Case Management issues
- Assures there is appropriate integration of physical and behavioral health services for all members in Case Management as needed
- Educates practitioners regarding Case Management issues, activities, reports, requirements, etc.
- Reports Case Management activities to the Quality Assessment and Performance Improvement Committee (QAPIC) and other relevant committees

Behavioral Health Practitioner

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of LHCC's Care Management Program. A behavioral health practitioner may participate in Case Management rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. The behavioral health practitioner may be a clinical director, a LHCC network practitioner, or behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e. doctoral-level clinical psychologist or certified addiction medicine specialist) or pharmacist, as appropriate, may be consulted on cases involving behavioral health issues.

~~Senior Vice President of Population Health (SVP)~~ Vice President of Medical Management (VPMM)

The **~~SVP~~ VPMM** is a Registered Nurse with experience in Utilization Management and Case Management activities. The **VPMM~~SVP~~** is responsible for overseeing the day-to-day operational activities of LHCC's Care Management Program. The **VPMM~~SVP~~** reports to the Chief Operating Officer (COO). The **~~SVP~~VPMM**, in collaboration with the CMO, assists with the development of the Care Management Program strategic vision in alignment with the corporate and LHCC objectives, policies, and procedures.

Case Management Senior Director/ Manager and/or Case Management Supervisor

The Director/Manager of Case Management is a Registered Nurse or other appropriately licensed healthcare professional with Case Management experience. The Case Management Director/Manager directs and coordinates the activities of the department including supervision of Care Managers, Program Specialists, Program Coordinators, and Community Health Services Representatives. The Case Management Director/Manager reports to the Senior Vice President of Population Health. The Case Management Supervisor works in conjunction with the Director/Manager of Case Management and the Directors of Medical Management and Utilization Management to execute the strategic vision in conjunction with Centene Corporate and LHCC objectives and attendant policies and procedures and state contractual responsibilities.

Integrated Care Team (ICT) Staffing Model

Care Coordination/Case Management (CC/CM) teams are generally comprised of multidisciplinary clinical and non-clinical staff, who perform functions based on degree of education and expertise. This integrated approach allows non-clinical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers work closely with the UM Clinical Reviewers to coordinate care when members are hospitalized and assist with discharge planning. Care Managers also collaborate with PMUR (Pharmacy Medication Utilization Review) staff to ensure coordinated transitional care planning and appropriate prescription management processes are utilized. The teams utilize a common clinical documentation system to maintain centralized health information for each

member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. ICT roles include, but not limited to:

Medical Director

- Physician who holds an unrestricted license to practice medicine in the State of Louisiana and is Board Certified with experience in direct patient care
- Serves as a clinical resource for Care Managers and members' treating providers
- Facilitates multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases
- Provides a point of contact for providers with questions about the Case Management process
- Communicates with practitioners as necessary to discuss Case Management issues

Care Manager (CM)

- Licensed RN Nurse, Social Worker, or LMHP (CCM credential preferred)
- Responsible for oversight of non-clinical members of the integrated CC/CM team
- Responsible for working with the member and member's treating providers to identify needs and create a care plan to help the member to achieve goals
- Participates in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers
- Communicates and coordinates with the member and caregivers, treating providers, behavioral health providers, Disease Management staff, and other members of the ICT to ensure that member needs are addressed
- Responsible for identifying resources and providers of services to ensure the greatest degree of integration into the community and the best possible health outcomes and member satisfaction
- Includes Registered Nurse remote staff who coordinate face-to-face visits with members during provider appointments to perform on-site case management at the provider office. They also visit members while hospitalized

Behavioral Health Care Manager (BH CM)

- Licensed Mental Health Provider (LHMP)
- Works with members, providers, and an integrated team
- Primary care manager for members with predominantly Behavioral Health related needs, or as secondary team member for complex case management cases
- Participates in integrated care team rounds to assist with coordination with the member's other care team members

Disease Manager
Licensed clinician (RN, RT, RD, LMHP, etc.) who provides health coaching for identified members related to specific disease management programs (diabetes, CHF, hypertension, asthma, chronic back pain, weight management, ADHD, anxiety, depression, perinatal depression, etc.)

Community Health Service Representative
- Non-clinical personnel who are certified in health coaching
- Provides face-to-face case management in the community and with hospitalized members
- Participates in community outreach events

Program Specialists (PS)
- Program Specialists (PS) are college graduates with background in social services or other applicable health related field
- Has an assigned Care Coordination caseload and responsible for following all standards of Case Management practice
- Performs member outreach and care coordination
- Communicates and coordinates with the member and their caregivers, physicians, behavioral health providers, Disease Management staff, and other members of the ICT to ensure that member's needs are addressed
- Responsible for identifying resources and providers of services to ensure the greatest degree of integration into the community and the best possible health outcomes and member satisfaction

Program Coordinator (PC) / Care Coordinator (CC)
- A highly trained non-clinical staff person working under the direction and oversight of a CM
- Provides administrative support to CC/CM team
- Collects data for Health Risk Screening/Assessment
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager
- Works both in the office and in the community, sometimes with face to face member interaction
- Performs member outreach, education, and home safety assessments
- Assists with community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, Reading Events, etc.
- Assists with Connections Plus cell phone program, pod cast programs, etc.

Pharmacy Personnel
- Licensed Clinical Pharmacists and/or Pharmacy Technicians

- Assists with member identification based on pharmacy utilization reports
- Collaborates with the integrated care team regarding medication appropriateness, medication utilization trends, and member adherence to medication regimen

PCP, Specialist, and Behavioral Health Provider

- Collaborates with care plan development
- Assists with identification of additional needed services
- Communication of member treatments plans, as needed

Community Liaison

- Maintains collaborative relationships with Health & Family Services, government agencies, community resource and advocacy groups, to build additional community support for current and potential member
- Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed which may include attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing

Information System

Assessments, care plans, and all Case Management activities are documented in a central clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system utilizes evidence-based clinical guidelines or algorithms to conduct assessment and ongoing management and has automated prompts for follow up based on the care plan. Additionally this system allows the Case Management team to generate reminder/task prompts for follow-up according to the timelines established in the Case Management care plan. Reminders/tasks can be sent to any team member, e.g. allowing Care Managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g. inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the Case Management team to easily access all clinical information associated to a member's case in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of Case Management interventions.

Member Identification and Access to Case Management [KF3][ALM4]

A key objective of LHCC's Care Management Program is early identification of members who have the greatest need for care coordination and Case Management services. This includes, but is not limited to, members who have specialty behavioral health needs; opt-in members receiving PCS, TCM or waiver services; members with over and under-utilization factors of ED usage, polypharmacy, inpatient admissions and/or other services; those classified as children or adults with special healthcare needs; members who have ongoing healthcare services; those with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are frail, elderly, disabled, or at the end of life.

Care Management Member Prioritization Report

To provide alignment on who is receiving case management and to streamline identification and reporting, LHCC utilizes a Care Management Member Prioritization Report to assist in the identification of eligible members for screening and engagement into case management, including complex case management. Data integrated into the report includes claims/encounter data, hospital discharge data, pharmacy data, etc. The report is refreshed on a daily basis and identifies members deemed as having physical or behavioral health high needs, i.e. utilization patterns and behaviors that are impactable, based on algorithm. From here, members are triaged into health coaching, physical health case management, or behavioral health case management, which will guide the member to the appropriate care team and primary care manager. The Care Management Member Prioritization Report identifies members who report their health as poor on a health risk screener so is an avenue for identifying those members who trigger as being complex and potentially appropriate for enrollment into complex case management.

Additional case management and clinical program reports (e.g. state/CMS enrollment process, Notification of Pregnancy forms, etc.) identifying members for case management may also be used to identify members for outreach and further appraisal for case management.

Data Sources

Members are identified as potential candidates for Case Management through several data sources, including, but not limited to:

- LDH claim or enrollment data
- LHCC claim or encounter data
- Health risk assessments and/or screenings

- Specialty screening tools (i.e.; PHQ2/9, CAGE AID, etc.)
- Enrollment data from another Managed Care Organization (MCO)
- Data analysis
- Predictive modeling software (Impact Pro™)
- Hospital discharge data
- Pharmacy data from LHCC, LDH or another MCO
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- ED Utilization reports
- Laboratory data
- Readmission reports
- Concurrent Rounds
- Data sources to identify members who have co-occurring medical and behavioral health conditions
- Medical Director's referral
- Referrals from PCPs
- State/Centers for Medicare and Medicaid Services (CMS) Enrollment Process and other State/CMS supplied data
- State defined groups such as Children with Special Healthcare Needs and Aged, Blind, and Disabled (ABD/SSI)Information provided by members or caregivers
- Notification of Pregnancy (NOP) indicating high risk pregnancy
- Provider requests for authorizations and referrals and notification of members
- Outreach to specialty Providers
- Information from onsite concurrent review nurses
- State ED Registry - Audacious Inquiry (AI)

Reports identifying members for Case Management are run on at least a monthly basis (although some identification reports are generated daily and/or weekly) and forwarded to the Case Management team for outreach and further appraisal for Case Management.

Referral Sources

Members are also identified as potential candidates for case management through multiple referral avenues that help minimize the time between the need for and initiation of case management services. Direct referrals are considered high priority, and are forwarded to the case management team as expediently as possible for further evaluation of needs.

Additionally, referrals for Case Management may come from resources such as:

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Care Management Program and referral process through the Provider Handbook, LHCC's website, Provider Newsletters, and by Provider Services staff.

- Envolve People Care (EPC) Nurse Advice Line staff –the nurse advice/medical triage phone service for Louisiana Healthcare Connections Health Plan has policies and procedures in place for referring members to LHCC's Health Plan for Case Management screening. This may be accomplished via a "triage summary report" that is sent to LHCC electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at LHCC.
- Disease Management (DM) Program staff –the DM staff works closely with the LHCC Medical Management department and Case Management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as Case Management rounds, are held between the Case Management team and DM staff.
- Hospital staff, e.g. hospital discharge planning and Emergency Department staff - facility staff is notified of LHCC's Care Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform LHCC UM staff if they feel a member may benefit from Case Management services; UM staff then facilitate the referral.
- LHCC Staff –
    - UM staff work closely with Case Management staff on a daily basis and can initiate a referral for Case Management by creating a referral within the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - LHCC Community Health Services Program - Community Health Services Representatives (CHSRs) are oriented to all staff departments within the LHCC Health Plan and have a basic understanding of all staff functions. CHSRs work closely with the Case Management team, referring members who may benefit from Case Management services.
    - LHCC Member Services - Member Services staff is also oriented in all departments within the LHCC and have a basic understanding of all staff functions, including the role and function of the Case Management team.
    - Other referral sources, such as:
        - Provider Specialists / Provider Consultants
        - Member Services staff
        - LHCC Advocates
        - QI Department
        - Affiliated vendors
- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - members are educated about Case Management services in the Member Handbook received upon enrollment

and available on the LHCC's website, and through contact with Member Services and/or other LHCC staff.

- Community/social service agencies – community agency staff are informed of the Care Management Program during interactions with the LHCC Case Management team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential Case Management needs to LHCC staff.
- Delegated entity staff (e.g. behavioral health, vision, dental, DME/home health, etc.) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for Case Management. LHCC also regularly communicates with delegates through oversight meetings, Case Management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- State agency/state enrollment center.

The specific means, by which a member was identified as a potential candidate for Case Management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to Case Management. Multiple referral avenues help to minimize the time between need for and initiation of Case Management services. Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

The Care Management program has mechanisms in place to identify individuals with special health care needs, including:

- Individuals with co-occurring mental health and substance use disorders;
- Individuals with intravenous drug use;
- Pregnant women 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) or fetal alcohol syndrome;
- Individuals with substance use disorders who have dependent children;
- Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;
- Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR level II determination;
- Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed and have declined to enter or are transitioning out of the CSoC program;
- Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;
- ~~**Individuals with co-occurring behavioral health and developmental disabilities;**~~

- Individuals diagnosed with co-occurring behavioral health and developmental disabilities;
- Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;
- Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and
- Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, treatment, or prevention services.
- Individuals with serious mental illness who have complex chronic conditions, co-morbidities, and co-existing functional impairments and who are at high risk of inpatient admission or Emergency Department visits, including enrollees transitioning across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting[ALM5]
- **Children enrolled under the Act 421 Children's Medicaid Option (CMO), effective July 1, 2021**

Initial Screening and Assessment

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification as potential candidates for Case Management.

Case Management staff obtain consent to complete the Case Management screening and/or initial assessment once member contact is made. Case Management staff also explains the Care manager role and function and benefits of the Care Management Program to the member and/or authorized representative or guardian.

The Care Manager screens members under age 21 years of age for appropriate referral for Coordinated Systems of Care (CSoC) services. Members who screen appropriately and, with proper consent, are referred to the Statewide Management Organization (SMO).

General standardized assessments have been developed internally to address the specific issues of LHCC's unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for Case Management. All assessments are documented in the central clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity.

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Care Management Program, and are informed they are entitled to decline participation in, or dis-enroll from Case Management at any time, if allowed per state regulations. Case Management staff explains the Care Manager role and function and benefits of the Care

Management Program to the member and/or their authorized representative or guardian. The member/guardian is notified of the potential need for the Case Management team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always obtained prior to any contact. Documentation of verbal member consent to participate in the Care Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented.

Members unable to be contacted via telephone are mailed a letter requesting that the member call the Case Management team. CHSRs may also be utilized when necessary, to assist in outreach for members who are difficult to contact. CHSRs go the member's physical address and attempt to initiate contact. Outreach may also be made to local community agencies and provider offices in an effort to locate a member. If a CHSR is successful in locating the member, they may perform a general screening in person, including observation of the member in their home surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc.

Generally, candidates identified as stable regarding any medical condition, and with primarily psychosocial needs are assigned to Care Coordination. Members with chronic or complex medical conditions or meet the criteria for Case Management or Complex Case Management based on the referral, are assigned to a Case Management team member who confirm the findings of the screening assessment and will complete a more thorough assessment with the member. If the acuity of the member cannot be determined based on the referral, a non-clinical Case Management team member conducts outreach to assess the member's medical, behavioral, and social needs. Once a referral is received, a Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history.

The Care Manager then attempts outreach to the member and/or authorized representative or guardian telephonically to perform an in-depth assessment to more closely identify and prioritize the member's individual needs. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about a member's condition(s). These condition-specific assessments, such as Sickle Cell and Depression, are derived from evidence-based clinical guidelines. During the in-depth Case Management assessment, the Care Manager evaluates the full scope of the member's situation, including:

- The member's health status, including condition–specific issues and likely co-morbidities

- Documentation of the member's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring
- Assessment of activities and instrumental activities of daily living
- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.
- Assessment of behavioral health status (e.g. presence of depression and/or anxiety) and cognitive functioning
- Assessment of social determinants of health such as food, housing, safety, transportation, and other significant life stressors.
- Assessment of life planning activities such as living wills, advance directives, etc.
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of visual and hearing needs, preferences or limitations
- Evaluation of caregiver resources and potential involvement in care plan implementation
- Assessment of personal resources and limitations
- Evaluation of available benefits, community resources and other financial resources
- Assessment of educational and vocational factors

Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital Care Managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. The role and function of the Care Manager is also explained to the member's family, providers, or other involved parties. Member consent is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The Case Management team reviews the gathered information and begins to build a Case Management plan of care. The Case Management team initiates the initial assessment within 30 days of identifying the member for case management and completes the initial assessment no later than 60 days from the date of identification. The care plan is developed within 45 days following the assessment. Case Management teams may include Care Managers, Program Coordinators, Social Workers, Behavioral Health Care Managers, and CHSRs. Each contributes different skills and functions to the management of the member's case. Other key participants in the development of the care plan may include:

- Member
- Member authorized representative or guardian
- PCP and specialty providers
- LHCC Medical Directors
- Hospital discharge planners
- Ancillary providers (e.g.. home health, physical therapy, occupational therapy)

- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g. United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation; companionship, etc.)
- Other non-health care entities (e.g. Meals on Wheels, home construction companies, etc.)

After completing the assessment of the member as a whole, stratification as low, moderate/medium, or high priority is determined in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management.

Emergency Preparedness

LHCC staff will provide hurricane preparedness and evacuation planning information to all members. Staff will also discuss the importance of completing the "Get a Game Plan" EDP (Emergency Disaster Plan). During phone interactions with members the staff will encourage members to complete an Emergency Preparedness Survey (EPS). This information will be filed in the member's records for future use.

Continuity and Coordination of Care between Medical and Behavioral Healthcare

When the Case Management staff identifies a member with coexisting medical and behavioral health disorders, behavioral and physical health (or medical) Care Managers will work in collaboration to develop an integrated care plan for the member. If the member's primary identified need is a behavioral health condition, the case is referred to a Behavioral Health Care Manager who serves as the case lead, working in tandem with the medical Case Management team.

The lead Care Manager reviews the member's clinical information to assure the patient is receiving appropriate behavioral health care. If the patient does not appear to be receiving this care, the Care Manager:

- Contacts the medical provider to ask about a behavioral health consult
- Assists the member, or coordinates with the behavioral health Care Manager, to make arrangements for the behavioral health consult
- Follows up to make sure a behavioral health consult was conducted

When appropriate (including but not limited to when the lead Care Manager is revising the plan of care or evaluating a member for discharge from Case Management), the medical and behavioral Care Managers confer with each other to ensure that the necessary expertise is available to monitor and guide members' care. The primary Care Manager is responsible for ensuring the appropriate behavioral health or physical health Case Management follow up is implemented.

Outreach may also occur to treating providers and individual practitioners when appropriate. The Care Manager assures proper member consent, specific to information pertaining to behavioral health treatment, is obtained prior to any communication regarding the member.

Ongoing Management

Care Plan Development

The initial assessment serves as the foundation for the Member's Case Management care plan. The care management team collaborates with members, caregivers, treating providers, etc. to develop an individualized person centered care plan that address members' specific needs, preferences, and goals. Behavioral Healthcare coordination is incorporated in the care plan as needed. Prioritized goals are established and barriers to meeting short and long term goals or complying with the plan of care are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of the discharge plan for seamless transition as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care plan.

The proposed plan of care is discussed with the member and/or member authorized representative or guardian, the PCP, and the health care team. The member's role is discussed and member/caretaker and provider input is obtained and used to modify the goals according to member's/member's caregiver's ability and willingness to participate. The Care Manager assures all parties are in agreement with the care plan to ensure successful implementation.

Members assigned to Care Coordination, or members identified as moderate/medium priority assigned to Case Management have an abbreviated care plan. The care plan for members in complex Case Management includes, at a minimum:

- Prioritized goals – goals are specific, realistic and measurable. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible based on their strengths and weaknesses
- Reflect cultural, language, and disability considerations of member
- Identification of barriers to meeting the goals and recommended solutions for each barrier
- Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals
- **Offering member freedom of choice in finding new providers and/or obtaining services**
- Interventions to reach those goals, including development of member self-management plans. The Care Manager assures the member has a full understanding of their responsibilities per the self-management plan.

- Planning for continuity of care
- Collaboration with and involvement of family and significant others, health care providers, interdisciplinary team, etc.
- The schedule for on-going communication with the member and other involved parties, based on individual needs and member preference
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated
- **For members with behavioral health related disorders and may experience crisis, a plan for addressing crisis, including resources and contact information, to prevent unnecessary hospitalizations or institutionalization**

The care plan, which includes condition-specific goals and interventions, is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines such as for diabetes, Sickle Cell Management, or ADHD, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Monitoring and Evaluation

Once the member's plan of care is agreed upon, the agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of LHCC. Revisions to the care plan are made when necessary, e.g. when the member's condition progresses or regresses, when goals are reached, etc. Significant revisions to the plan of care are also shared with the PCP. A schedule for follow up and monitoring of the member's progress is developed, using as a minimum the intervals defined according to priority level and current needs. The Care Manager may consult with other members of the Integrated Care team, such as a Program Specialist or Care Coordinator to manage or assist with psychosocial issues or a Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/tasks to be created for each case, alerting the Case Management team when follow-up contacts are needed. Follow-up reminders can be set for daily, weekly, monthly, etc. contacts. Intervals for follow-up are based on the goals and time lines in the Case Management care plan.

The Care Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers' or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Member or caretaker agreement to participate in Case Management (agreement may be oral or written; if oral, the Care Manager documents the discussion with the member/caretaker)

- Notes, including a summary of team conferences and all communications with the member/family, Healthcare providers and any other parties pertaining to the member's case
- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available
- The Case Management care plan, including:
    - Prioritized goals (both long term and short term treatment objectives), barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - LHCC to follow-up with the member/caretaker to determine whether member has acted on referrals made by the care team
    - The member's self-management plan
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below

The Care Manager regularly evaluates the member's progress considering the following factors:

- Change in the member's medical status or behavioral health status
- Change in the member's social stability
- Change in the member's physical or behavioral functional capability and mobility
- Progress made in reaching the defined goals
- The member's adherence to the established Case Management care plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels follow up behavioral health appointments etc.
- Changes in the member or family's satisfaction with Case Management services and other services addressed in the care plan
- The member's quality of life
- Benefit limits and financial liability

The plan of care is reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly (new problem, goal, barrier, or acuity change), or at the request of the member. LHCC's plan of care is also updated at these times and shared with the PCP, as applicable.

The Care Manager implements necessary changes to the Case Management care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, appropriate specialists or other members of the healthcare team, as needed to discuss modifications and obtain an updated medical or behavioral treatment plan. The Case Management team also maintains the care plan along with necessary referral services when the member

changes PCP/behavioral health provider. The Case Management team considers alternatives in healthcare delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved are in agreement with changes the care plan to ensure ongoing success. The Case Management team also monitors the case on an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement department.

Discharge from Case Management

The Care Manager may receive input from the PCP, member/family/guardian/caretaker, and other health care providers involved in the member's plan of care to determine the appropriateness for closing the case. The following criteria are used on an ongoing basis to determine when discharge from Case Management should occur:

- Member terminates with LHCC
- Member/family requests to dis-enroll from Case Management
- The member/family refuses to participate in Case Management despite efforts to explain how it can benefit the member
- LHCC is unable to reach member despite at least three (3) different types of attempts (phone attempts at different times during day, visit to home, letter submission with address correction request, and/or contacting PCP/WIC/Specialists/Programs) to locate and engage the member
- The member reaches maximum medical or behavioral improvement or reaches established goals regarding improvement or medical/behavioral stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources
- Insurance benefits are exhausted and community resources are in place
- Member expires

If the above criteria indicate a case should be closed, the Care Manager, as appropriate:

- Coordinates care with the new medical or behavioral entity and community resources as required, allowing for a smooth transition for the member
- If Case Management has been refused by the member/family, the Care Manager provides the member with contact information for future reference and documents the refusal in the clinical documentation system
- Contacts the PCP and other providers, when appropriate, regarding impending discharge from Case Management
- Discusses the impending discharge from Case Management with the member/family
- Presents community resources and assists in making arrangements with those relevant at the time of discharge

A letter noting the member has discharged from Case Management is generated and sent to the PCP and the member. The letter documents the reason for discharge and includes, if the member has not terminated with LHCC, a reminder to contact the care team in the future should medical or behavioral concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented.

Program Assessment and Impact Measurement

Population Assessment

At least annually, LHCC will assess the entire member population and any relevant subpopulations (e.g. Foster Care, Chisholm, HCBS, etc.) to determine if the Care Management Program meets the needs of all members eligible for Case Management. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age (especially children/adolescents and elderly), gender, ethnicity, race, and/or primary language, and benefit category. Other data used includes diagnostic and utilization data (e.g. overall claims received, inpatient admissions and ED visits, and pharmacy data). The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and members with serious and persistent mental illness (SPMI).

Results of the population assessment are analyzed and subsequent enhancements made to the Care Management Program if opportunities for improvement or gaps in Case Management services are identified. Potential revisions to the Care Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.
- Revisions to types of Case Management activities assigned to specific members of the Case Management team (e.g. clinical versus non-clinical staff responsibilities)
- Implementation of targeted training, (e.g. related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff)
- Improvement in identification of appropriate community resources provided to members and process for assisting members in accessing resources
- Identifying regionalized geographic trends to target specific Care Management programs

The annual population assessment may be a separate document or included as part of an annual Case Management and/or Quality Improvement program evaluation and will be presented to appropriate committees, such as the Quality Assessment and Performance Improvement Committee (QAPIC), for review and feedback.

Member Experience with Case Management

Member satisfaction with Case Management is assessed no less than annually. Member satisfaction surveys, specific to Case Management services, are completed at least annually for members enrolled in Case Management. On a monthly basis, members who had been enrolled in Case Management for ≥ 45 days and successfully completed the Care Management Program in the prior month, as well as a random sample of members who are currently enrolled for ≥ 45 days, are outreached telephonically to survey their assessment of the program. The results of the surveys are aggregated and evaluated and are included in the overall evaluation of the Care Management Program, which may be part of the annual Quality Improvement and/or Care Management program evaluation as described below.

Member complaints and grievances regarding the Care Management Program are also monitored no less than quarterly. Results of the analysis of member satisfaction surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and determine which opportunities to pursue regarding changes to the Care Management Program, as needed.

Outcomes

Louisiana Healthcare Connections measures effectiveness of Case Management no less than annually using at least three measures that assess the process or outcomes of care for members in Case Management. Additional details regarding these measures are identified in the QI work plan. Measures of effectiveness may include indicators such as:

- ~~**Readmission rate for members in Case Management with specific diagnoses such as CHF or asthma**~~
- Repeat ED visits for members in Case Management
- Rate of members at risk of pre-term birth receiving 17-P
- ~~**Rate of diabetic members with HbA1c screening**~~
- Incidence of NAS diagnosis for newborns of mothers enrolled in Perinatal Substance Use Disorder Program
- P**ost Discharge Outreach to prevent readmissions**

Measurement and analysis of the Care Management Program is documented as part of the annual Quality Improvement and/or Care Management Program Evaluation. The Care Management Program is evaluated at least annually and modifications to the program are made as necessary. LHCC evaluates the impact of the Care Management Program by using:

- Results of the population assessment.
- The results of member satisfaction surveys (i.e. members in Case Management.
- Member complaint, grievance, and inquiry data regarding the Care Management Program.
- Practitioner complaints and practitioner satisfaction surveys regarding the Care Management Program.

- Other relevant data as described above.

The evaluation covers all aspects of the Care Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. Based on the results of the measurement and analysis of the Care Management program effectiveness and satisfaction, at least one intervention will be implemented to improve clinical performance and one intervention to improve member satisfaction after the first annual evaluation. The evaluation and recommendations are submitted to the Medical Management Committee for review, action and follow-up. The final document is then submitted to the Board of Directors/governing body through the Quality Improvement Committee for approval.

Population Management

LHCC's Care Management Programs focused on specific member populations may include, but are not limited to:

- **Perinatal/NICU Management Program**
  LHCC's Start Smart for Baby® pregnancy management program emphasizes early identification and stratification of pregnant members, and education and Case Management interventions to improve birth outcomes for all pregnant members. The program includes:
    - Early identification of pregnancy
    - Risk screening and stratification to determine appropriate interventions
    - Member outreach and education
    - Member incentives for accessing prenatal and post-partum care
    - A Progesterone injection program that may include home visits
    - Specialized management of pregnant members with depression or substance use disorder
    - NICU management and follow up
    - Provider education and incentives for improving birth outcomes and access to appropriate prenatal and post-partum care

  It also includes high risk OB management for reproductive age women with a history of poor birth outcomes and those with high risk pregnancies. Start Smart staff assist members, in person when necessary, to gain access to prenatal care, provide education on healthcare needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and non-covered services, such as specialty BH services and dental services, and community resources. The program extends through the postpartum period to improve maternal outcomes and prevent risk in subsequent pregnancies, and extends through the first year of life for LHCC-enrolled babies.
- **Emergency Department Diversion Program**
  The goal of our ED Diversion Program is to decrease inappropriate ED utilization through the redirection of members to appropriate levels of care.

A specialized Integrated Care Team, consisting of experienced Care Managers, Social Workers and Behavioral Health Care Managers, focuses on access to care issues and resource education. Interventions include linking the member to a PCP, educating them about and helping them to access transportation, and providing education on the importance of getting the right care, at the right time, in the right setting. CHSRs provide in-person visits and education for members who need intensive assistance. We also provide education and incentives to providers, such as incentives for serving as a Patient Centered Medical Home.

- **Transplant Management**
  Designated Case Management staff coordinates care and assist with access to transplant centers of excellence for members who need transplants through LHCC's specialized Transplant Program. Program staff work closely with appropriate providers to obtain necessary clinical information and required lab work to facilitate timely evaluation of transplant candidates, assist in processing prior authorization (PA) requests for transplant services, assist Members in coordinating needed care and transportation and lodging for out-of-town evaluations or procedures, and follow Members for up to 12 months post-transplant.
- **Palliative Care Program**
  This program serves members with cancer and other advanced chronic and debilitating illnesses with indicators of persistent challenges with pain and symptom management, as identified by such factors as pharmacy and ED use. Care Managers will make referrals for and incorporate hospice services into the care plan, as indicated.
- **Pharmacy Lock-In Program**
  LHCC's Pharmacy Lock-In Program uses LDH approved policies and procedures to ensure appropriate use of Medicaid benefits, and serve as an educational and monitoring parameter. Pharmacy staff will monitor claims data to identify signs of a consistent pattern of misuse or overuse.
- **HCBS Waiver Opt-In**
  The Home and Community Based Services (HCBS) Waiver Program identifies all members receiving HCBS services on a monthly basis to perform outreach and offer assistance to all HCBS members to understand new benefits provided by Healthy Louisiana within 90 days of identification. The LHCC Case Management department will work collaboratively with the member, family and waiver service providers to ensure continuity of care.
- **Chisholm**
  The Chisholm population is a result of a class action lawsuit filed by the Advocacy Center in 1997 to make the Louisiana Department of Health (LDH) live up to its obligation to arrange for necessary services under regular Medicaid to children on the "New Opportunities Waiver" waiting list. In April 2015, Louisiana Managed Care Organizations (MCO) were designated by State authorities to ensure that members who fall in the Chisholm population receive appropriate services to accommodate their most fragile members with chronic conditions. All Chisholm class

members are under the age of 21. Identification and outreach is completed to assist member with Medicaid services to which they are entitled. The program staff also collaborates with the member's Support Coordinator, Care Manager (BH) or provider of services on the plan of care for the member. This includes, but not limited to, providing education regarding healthcare benefits and assisting to ensure the health and safety of the member.

- **EPSDT EHH and IN Waiver Members**
  The Early and Periodic Screening Diagnosis and Treatment (EPSDT) Waiver members receiving Extended Home Health (EHH) and Intermittent Nursing (IN) must be monitored to ensure they are receiving all hours of authorized services whenever possible. This is a result of a class action law suit and corresponding settlement agreement approved by the court on March 31, 2020. The Class members in AJ v. LDH are defined as follows: All current and future Medicaid recipients under the age of twenty-one (21) in Louisiana who are certified in the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive EHH or IN services. In coordination with Louisiana Medicaid's Crisis Response Team (CRT), LHCC's Transition of Care team will initiate notification for any class member who has received less than 90% of his or her prior approved EHH or IN services for at least two (2) consecutive weeks and will work to ensure services are in place at the existing or alternate level of care to ensure the member is not at serious risk of institutionalization due to lack of EHH or IN services.
- **Act 421 Children's Medicaid Option (CMO)**
  Members who qualify for the Act 421 Children's Medicaid Option are those individuals who are 18 years or younger with a disability defined as a medically determinable physical or mental impairment that results in marked and severe limitations and has lasted or is expected to last at least one year, or to result in death, even if their parents earn too much to qualify for Medicaid. Effective July 1, 2021, this population will be treated as a Special Health Care Needs population and will be offered Case Management services outlined in this policy to assist with their physical, behavioral, or psychosocial needs.
- **PreAdmission Screening and Resident Review (PASRR) and PASRR Transition**
  The PASRR program uses Licensed Clinicians to provide education, assessments and linkage to resources to LHCC members applying for nursing home placement. LHCC members who have applied for admission to a nursing facility (NF) must be "screened" for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions. The purpose of PASRR is to ensure that all NF applicants are thoroughly evaluated, that they are placed in nursing facilities *only* when appropriate. The PASRR process consists of the Level I Screening, Level II MI Evaluation, and Determination. The goal is to

provide support and resources for members who are going into a nursing home and to ensure successful transition from nursing home into the community with social supports.

- **Department of Justice (DOJ) Population**[ALM6]
  The DOJ Target Population consists of Medicaid-eligible individuals over the age of 18 with serious mental illness (SMI) who are currently residing in a nursing facility and have been identified for transition from the nursing facility back into the community, or they have already transitioned back into the community. Members within the DOJ program are also identified as "DOJ At Risk Population", which consists of members meeting the following criteria:
    - Persons not currently admitted to a nursing facility, between 50-79 years old, with a P-linkage to an MCO,
    - and at least one of the following 3 behavioral health diagnoses in the last 2 years,
      - Anxiety Disorder (primary diagnosis ICD-10CM codes F40-F48)
      - Major Depressive & Affective Disorders (primary diagnosis ICD-10CM codes F30-F39)
      - Schizophrenia (primary diagnosis ICD-10CM codes F20-F29)
    - and at least one of the following 4 physical health diagnoses based on CMS Chronic Condition Warehouse (CCW) Condition Algorithms:
      - Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease and Bronchiectasis, Diabetes and/or Heart Disease or Stroke (Note: Heart Disease or Stroke is defined as any one of these 5 CCW conditions: Acute Myocardial Infarction, Atrial Fibrillation, Heart Failure, Ischemic Heart Disease, and/or Stroke/Transient Ischemic Attack)
    - and a combined total of at least six ED or IP visits (without regard to diagnosis) in the last 2 years.

  Once member are identified, the Care Management team offers case management services through high-touch and face-to-face engagement for members identified for this program. For individuals residing in the nursing facility, the Care Manager will work with the nursing facility to create a transition plan for the member to transition back into the community. Once the member is transitioned back into the community, the Care Manager will ensure the member stays connected with their providers, has safe and stable living arrangements, and is provided resources within the community to help manage their health care needs. Case management services are provided to the member for a minimum of 12 months or longer based on the member's needs, unless the member declines or dis-enrolls from case management. [KF7]
- **Justice-Involved Pre-Release Program**
  The Justice-Involved Pre-Release Program is a collaborative effort among the Department of Corrections (DOC), Louisiana Department of Health, and Managed Care Organizations to identify high need

incarcerated members prior to release to engage in Care Management. The program involves face-to-face care management via videoconferencing with the member prior to release to improve continuation of healthcare after incarceration. These members are provided CM services like all other members, but additional requirements and procedures for this population are provided within the Justice-Involved Pre-Release Enrollment Program Manual.

Condition Specific CM and DM Programs

Members in condition specific care/disease management programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The Case Management policies provide the instructions for identification, referrals, screening and assessment, enrollment, care plan development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from Case Management when not specifically addressed in the program.

LHCC has developed several focused Chronic Care Management Programs (CCMPs) as per state contract requirements which are designed to manage members in areas of high utilization and/or who are in greater need for Healthcare support and coordination of services. All CCMPs align with the 2020 Care Management Program Description relating to Case Management activities and initiatives unless otherwise specified within the below noted program summaries.

- **Hemophilia**
  The Hemophilia Program provides Case Management services, either in partnership with our specialty pharmacy affiliate, or by using in-house Case Management and Pharmacy staff. Case Management staff assist members in navigating the complexities of treatment plans, including condition specific education, assistance with reimbursement issues, home care needs and care coordination.
- **Sickle Cell**
  The program uses Care Managers to provide sickle cell disease education related to inheritance patterns, disease complications, symptoms and treatment, comorbid conditions, and special issues that arise with children and adolescents. Care Managers also promote use of hydroxyurea.
- **Chronic Pain Management**
  LHCC's Pain Management Program addresses multiple types of chronic pain, including but not limited to members with sickle cell disease and those with four or more ED visits in a 12-month period for a chief complaint of pain. In addition to Exercise Physiologists that currently focus on low back pain, the expanded Pain Management Program will use Health Coaches as well as Care Managers to work with the member, PCP,

treating providers, and, as applicable, ED staff, to develop, implement, and monitor a pain management plan.

- **HIV/AIDS**
  Collaboration with the member, providers, caregivers/family, and community services if applicable, to address all co-morbid conditions; provide specialized medication therapy monitoring, assist with anti-retroviral drug adherence and other co-morbid condition medication regimens; while supporting independence, self-sufficiency, effective family functioning, caregiver assistance, and use of appropriate health services
- **Hepatitis C**
  Outreach, engagement, education, assessment, support, and referrals as needed to help increase member's understanding of risk factors; promoting medication compliance and nutrition; managing fatigue and nausea; and avoiding infection risks and spread of disease.
- **Attention Deficit Hyperactive Disorder (ADHD)**
  ADHD disease management is available to members at any age with a diagnosis of ADHD, and their families. Utilizing integrated treatment planning, the goals are to increase member/families understanding of the disease, its effects, and possible treatment options; to achieve appropriate member self-management and appropriate use of medications to treat ADHD.
- **Anxiety**
  The program is available to members age 12 and above and is based on clinical practice guidelines and includes research evidence-based practices. The program goals are to increase member/family's understanding of the disease (including possible treatment options), increase appropriate self-management, improve appropriate use of medications to treat anxiety, and increase integrated treatment planning.
- **Depression**
  The goal of depression disease management is to help members achieve the highest possible levels of wellness, functioning, and quality of life. This is accomplished through increased member/families understanding of the disease, its effects, and possible treatment options; increased appropriate member self-management; appropriate use of medications to treat depression; and integrated treatment planning. The program is available to members age 12 and above.
- **Perinatal Depression**
  The goal of depression disease management is to help pregnant members, at risk or with a history of postpartum depression, achieve the highest possible levels of wellness, functioning, and quality of life. This is accomplished through increased member/families understanding of the disease, its effects, and possible treatment options; increased appropriate member self-management; appropriate use of medications to treat depression; and integrated treatment planning.
- **Perinatal Substance Use Disorder (PSUD)**
  The Perinatal SUD program aims to provide education, resource linkage, and connect pregnant members to appropriate providers when utilizing

substances which may negatively affect birth outcomes. The goal is to engage pregnant members by providing support, resources, education and ultimately increase positive outcomes for newborns, as well as allowing the mother an opportunity to achieve and maintain the best possible quality of life.

The Perinatal SUD Team utilizes medical and behavioral health care managers and/or disease managers to provide person centered care to the members. The Perinatal SUD Program goal is to provide an integrated treatment approach within the member and their identified treatment team to increase positive outcomes for newborns. The staff has specialized training in addiction and utilizes evidence based techniques to engage the member in treatment and facilitate change. The multi-disciplinary team is comprised of staff with the following expertise: Start Smart for your Baby Care Manager, Behavioral Health CM and/or Behavioral Health Disease Manager, Medical Director and Clinical/Medical Management Leadership.

Disease Management Program Delegation

Louisiana Healthcare Connections delegates the following CCMP to EPC:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure_Diabetes
- Heart Disease
- Hypertension
- Hyperlipidemia
- Obesity
- Pain Management-Low Back Pain

Program descriptions for each program can be found in the attachments section of this policy.