POLICY AND PROCEDURE

DEPARTMENT: Case Management	**DOCUMENT NAME:** Behavioral Health Disease Management Programs Policy
PAGE: 1 of 11	**REFERNCE NUMBER:** TBD
APPROVAL DATE:	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE:	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:**

SCOPE: Disease Management Department

This policy and procedure applies to all staff involved in operations and management of Behavioral Health care management and disease management services.

PURPOSE:

Louisiana Healthcare Connection's Disease Management (DM) / Health Coaching Programs have as an overarching goal of helping members with chronic behavioral health conditions (or symptoms indicating possible risk of a chronic behavioral health condition) achieve the highest possible levels of wellness, functioning, and quality of life.

The diagnoses and/or symptoms targeted by the Behavioral Health DM Health Coaching programs are as follows:

- **Depression**
- **Anxiety**
- **Perinatal Depression**
- **Attention Deficit Hyperactivity Disorder (ADHD)**

DM Health Coaches support and collaborate closely with primary care physicians, behavioral health specialists, and other providers to ensure members and providers have access to the most effective and efficient resources for managing a member's chronic behavioral health condition(s). Disease-specific measurable goals are established so that the DM Health Coach and the member/family/provider can measure the effectiveness of the Disease Management program. DM program participation is voluntary, and requires member (or member guardian) consent.

POLICY:

Each of the above listed DM programs are based on clinical practice guidelines and include evidence-based assessments. This policy will outline the DM program's procedure for the following:

- **DM goals**
- **identification of program participants**

POLICY AND PROCEDURE

DEPARTMENT: Case Management	**DOCUMENT NAME:** Behavioral Health Disease Management Programs Policy
PAGE: 2 of 11	**REFERNCE NUMBER:** TBD
APPROVAL DATE:	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE:	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:**

- **assessments**
- **stratification of acuity, minimum outreach, and re-assessment expectations**
- **outreach/member education guidelines**
- **provider involvement**
- **program discharge guidelines**
- **measures of efficiency**
- **program oversight**

For more information on processes and flows related to each individual program and – LA.DM.257 provides a detailed work process related to all DM programs.

Louisiana Healthcare Connections is not a medical provider of services and does not provide direct care and/or treatment to any of our program participants. The care management and disease management staff provides education in a health-advisory role only.

PROCEDURE:

DM Goals

The overarching goal of the DM program(s) is to help members achieve the highest possible levels of wellness, functioning, and quality of life. This is accomplished through a collaborative approach between DM staff and member/family/provider to establish disease-specific measurable goals that allows the DM staff and the member to track the effectiveness of interventions and make adjustments to interventions depending on symptom stability or lack thereof.

Specific goals of the Depression, Anxiety, Perinatal Depression, and ADHD Programs are as follows:

1. **Increase member/families understanding of the disease, its effects, and possible treatment options**
2. **Increase appropriate self-management behaviors to support member coping/management of the member's condition specific symptoms**

3. **Support, educate, and improve appropriate use of medications to treat the member's condition specific symptoms**

4. **Increase integrated treatment planning via referral and collaboration with Evidence Based Providers (EBPs). Examples of provider collaboration within DM programs includes but is not limited to:**
    - **EBP Behavioral Specialist referrals: MST, FFT, Bibliotherapy, Psychiatry, ABA etc.**
    - **Collaboration/referral to medical providers: PCPs, etc.**
    - **Education on the importance of accurate diagnosis and treatment and recommendations for Behavioral Health Specialist reassessment of members who received initial screenings via PCPs.**

5. **Prevent symptom escalation via preventative coaching. If symptoms escalate, DM will refer the member to Care Management (CM) or Complex Care Management (CCM) levels of intervention**

Identification

Program Specific Identification Requirements	
Program	**Requirements specific to this program**
Depression	**Members age 18 +**
Anxiety	**Members ages 12+ (if member is a minor participation requires guardian consent)**
Perinatal Depression	**Members ages 12+**
ADHD	**Members ages from birth + (if member is a minor participation requires guardian consent)**

Louisiana Healthcare Connections will use a variety of methods to identify members who may benefit from DM.

- **Health Needs Assessment(s) – Newly enrolled members receive an initial health screen. This screening will be used to identify members with risk factors that may indicate the need for DM. Screenings or assessments will**

be initiated within 30days of Identification with member/guardian consent. Assessment and re-assessment can also be requested at any time by the member(s), member guardian(s), and/or provider(s).

- **Predictive Modeling – Utilizing predictive modeling with specified filters, eligible members will be proactively identified as being newly diagnosed and/or receiving prescription treatment for Depression, Anxiety, Perinatal Depression, or ADHD. Our predictive modeling tool is a claims based system that identifies those at risk by examining recent service utilization.**
- **Referrals – Members are also identified through referrals from families, caregivers, providers, community organizations and internal health plan staff.**

Assessments

All identified members are contacted within 30 days of identification to complete the Health Needs Assessment and a DM Program evidenced-based Condition Specific Assessment(s). Assessments will be initiated within 30days of identification, subject to member voluntary participation.

Health Needs Assessments will be re-assessed a minimum of yearly (or upon member / guardian request or upon indication of a significant change in condition).

Condition Specific DM Assessments (for example: PHQ 9, OASIS, Edinburgh and ADHD Rating Scale) are monitored by the DM Health Coaches and ~~will be~~ re-assessed at regular intervals (with member consent) throughout the DM program. This allows our Health Coaches to monitor member symptom response to Health Coaching interventions.

For detailed work processes related to the use of each program's condition specific assessment(s) please see work process LA.DM.257.

Participants that screen positive for a DM program related diagnosis in the absence of claims history related to that diagnosis are advised to discuss screening responses with a physician.

POLICY AND PROCEDURE

DEPARTMENT: Case Management	**DOCUMENT NAME:** Behavioral Health Disease Management Programs Policy
PAGE: 5 of 11	**REFERNCE NUMBER:** TBD
APPROVAL DATE:	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE:	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:**

Stratification

Disease Management (DM)/Health Coaching Program objectives include the provision of telephonic coaching, education, motivational interviewing interventions, and member/caregiver connection to support resources to promote member adherence to treatment guidelines and facilitate member self-management of his/her disease processes. DM programs attempt to identify and engage members proactively prior to symptom escalation.

Potential Exclusionary Criteria –

The following criteria are high risk predictors that indicate a member may not be appropriate for a DM coaching program, and instead may require CM/CCM levels of intervention:

- **Recent episodes of serious illness, injury, or surgery (in the past 60 days)**
- **Recent Inpatient Admission for Behavioral Health (in the past 6 months)**
- **Recent Inpatient Admission for Physical Health (in the past 30days)**
- **Comorbid conditions:**
    - **Bipolar disorder**
    - **Schizophrenia/Schizoaffective disorders**
    - **Autism or Autism with Psychosis**
    - **Substance Use Disorders**

Acuity Levels, Outreach Frequency, and Re-administration of Condition Specific Assessments –

All members enrolled in a DM program are stratified based on acuity to determine the appropriate level of intervention. Stratification is based on information obtained from our internal specific Health Needs Assessments and a DM Condition Specific Assessment.

Stratification and frequency of outreach for DM programs are separate from the Tiered Care Management Programs Stratification system noted in the Care Management Program Description (LA.CM.01). If a member requires intensive intervention requiring Care Management (CM) or Complex Care Management

(CCM) levels of intervention DM will refer transfer the member to a CM/CCM program(s).

Members are stratified into three levels of acuity within DM.

Acuity is established based on DM Condition Specific Assessment scoring and the Health Needs Assessment(s).

The three levels of Acuity are as follows: **Note all attempts mentioned below relates to the time frame in which attempts are due. Attempts may be restarted based on acuity based on frequency. For Example attempts started in High Acuity (every 2 weeks) could potentially have 6+ outreaches within a one month time frame that could be continued based on clinical need and restarted each month).**

Low	***Minimum Outreach due - every 8 weeks - ~~All three a~~Attempts should be completed within the designated follow-up time frame and should take place on different days/times and via both telephonic and mailers.~~.~~*** ***Care Plan updates should be sent to all active providers at least quarterly or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.)***

POLICY AND PROCEDURE

DEPARTMENT: Case Management	**DOCUMENT NAME:** Behavioral Health Disease Management Programs Policy
PAGE: 7 of 11	**REFERNCE NUMBER:** TBD
APPROVAL DATE:	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE:	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:**

	(Not applicable for members with increased suicide risk) **Members at this Level - Condition is present, but is well controlled; symptom remission; less need for education, member is in maintenance phase of stages of change. Participants are assigned to this group when they are determined to have entered into the maintenance phase of treatment or determined to be at a minimal or mild risk level based on the depression symptom screening.** **Individuals who are in this category are provided focused education material designed to educate them on their disease process, medications, and relapse prevention planning.** ***Condition Specific Assessments will be offered at minimum every 90 days to monitor intervention response. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.***
Medium	***Minimum Outreach due - every 4 weeks - ~~All three attempts~~Attempts should be completed within the designated follow-up time frame and should take place on different days/times and via both telephonic and mailers.~~.~~*** ***Care Plan updates should be sent to all active providers at least quarterly or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.)*** ***(Not applicable for members with increased suicide risk)*** **Member symptoms present at medium severity but member has not escalated to CM/CCM levels as evidenced by past history of symptom maintenance. Symptoms require education/coaching related to member's condition to prevent escalation. Moderate risk participants are provided ongoing mail and telephonic outreach to provide education regarding available treatment options, collaborate with**

	community providers, all in an effort to increase the member's ability to self-manage their condition. Additionally, participants are provided referrals to community resources where needed, such as transportation and community support groups relevant to diagnosis. ***Condition Specific Assessments will be offered at minimum every 90 days to monitor intervention response. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.***
High	***Minimum Outreach due - every 2 weeks - ~~All three attempts~~Attempts should be completed within the designated follow-up time frame and should take place on different days/times and via both telephonic and mailers.~~.*** ***Care Plan updates should be sent to all active providers at least every four weeks from last contact or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.)*** ***(Member is at increased suicide risk and/or risk of escalating into CM/CCM acuity)*** **Member exhibits high risk of escalating to CM/CCM levels evidenced by recent symptom escalation or increased risk for suicide. DM will monitor symptoms closely while providing coaching/motivational interviewing interventions in an attempt to stabilize and de-escalate symptom progression. Symptoms require education/coaching related to member's condition to prevent escalation. If the member's behaviors or symptoms escalate further, case may be transitioned to CM/CCM programs.** **High risk participants receive all of the interventions provided in the moderate risk program. Additionally, DM staff may staff cases in ICT Rounds to identify care gaps or strategies to prevent symptom escalation. DM Interventions and coaching emphasize preventing**

	symptom escalation proactively, and then coordinate services to support ongoing stabilization. **Condition Specific Assessments will be offered at minimum every 60 days to monitor intervention response. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.**

Outreach and Education

Multiple communication strategies are used in DM programs to include written materials, telephonic outreach, and web-based information.
Staff receive training yearly regarding motivational interviewing techniques designed to engage, destigmatize, educate and empower members to improve overall health and manage symptoms.

Written materials mailed to members will meet criteria as outlined by current RFP and LDH requirements. Within seven to ten days of voluntary enrollment, members will receive a welcome letter including details about the program, information about how to contact DM staff (including LHCC's toll-free number), condition specific education materials and any other relevant health-related materials. Frequency of mailings will vary based on the level of intervention and based on the individual member's Self-Management Plan.

Provider Involvement
In partnership with our health plan partners, Louisiana Healthcare Connections will make available developed resources to help primary care physicians, and behavioral health specialists to support the ~~recognize and~~diagnosis and treatment ~~manage member's~~of member's behavioral health symptoms.

Discharge from Disease Management
The following criteria will be used to determine when discharge from disease management is appropriate:

- **The member reaches the maximum improvement.**
- **The member achieves established goals regarding his/her improvement or health care stability and is referred to providers and community resources.**

This may include preventing further decline in condition when health status improvement is not possible.

- **Member/family is non-responsive to DM interventions despite multiple attempts to contact (based on health plan standards regarding outreach).**
- **Member declines to participate in DM, following efforts to explain the benefits of the program to the member.**
- **Member's symptoms escalate indicating a need for a higher level of intervention (such as CM or CCM).**
    a. **Examples of possible indicators of symptom escalation include but are not limited to:**
        i. **Diagnosis with a Severe Mental Illness (SMI)**
        ii. **Admission to an inpatient psychiatric program**
        iii. **Increase in condition specific acuity scoring despite interventions**
- **The member disenrolls from the health plan.**
- **The member expires.**

Measures of Efficacy and Reporting Mechanisms

Louisiana Healthcare Connections will monitor program engagement, enrollment, and successful program completion metrics for the DM program(s)

In addition to program specific monitoring the health plan will monitor the following:

- **HEDIS: Antidepressant Medication Monitoring Effective Treatment (AMM)**
- **HEDIS: Follow-Up Care for Children Prescribed ADHD Medication (ADD) Measures**

Program Oversight
The Medical Director is responsible for the clinical oversight and evaluation of all potential quality of care concerns/issues related to the depression disease management program.

POLICY AND PROCEDURE

DEPARTMENT: Case Management	**DOCUMENT NAME:** Behavioral Health Disease Management Programs Policy
PAGE: 11 of 11	**REFERNCE NUMBER:** TBD
APPROVAL DATE:	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE:	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:**

ATTACHMENTS:

REFERENCES:

LA.CM.01 – Care Management Program Description
LA.CM.01.01 – Care/Case Management Assessment Process
LA.CM.01.02 – Care Plan Development and Implementation
LA.DM.257 – Disease Management All Programs Work Process

DEFINITIONS:

REVISION LOG

REVISION	DATE
New Policy	01/2020

POLICY AND PROCEDURE APPROVAL

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

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