POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Perinatal Substance Use Disorder Care Management Program
PAGE: 1 of 6	**REPLACES DOCUMENT:**
APPROVED DATE: 2/2018	**RETIRED:**
EFFECTIVE DATE: 3/1/2018	**REVIEWED/REVISED:** 01/2020
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CM.31

SCOPE:
Louisiana Healthcare Connections (LHCC) Medical Management Department

PURPOSE:
To establish the components of the perinatal substance ~~abuse~~ **use disorder (SUD)** care management program.

POLICY:
The Perinatal Substance Use Care Management Program is a**n** ~~coordinated project between the Physical Health Care Management and Behavioral Health Care Management departments~~**Integrated Care Management program**. The program is in place to educate members in the perinatal period (prenatal and postpartum) about the risks of ~~comorbid~~ substance use, and to educate **and assist** the member ~~about~~ **in** accessing services for treatment of substance use disorders.

PROCEDURE:

A. The perinatal ~~substance use~~**SUD** care management program is available to all pregnant members.

B. LHCC will use a variety of methods to identify members who may benefit from care management.
- Appropriate health risk screening/assessment
- Notice of Pregnancy (NOP) – the notices of pregnancy are reviewed to identify pregnant mothers with potential issues related to substance use disorders.
- Referrals – Members are also identified through referrals from families, caregivers, providers, community organizations and health plan.

C. Stratification

All members enrolled in the perinatal SUD **care** management program are stratified based on acuity to determine the appropriate level of intervention. Stratification is based on information obtained from the Health Risk Screening/Assessment (HRA)**,** ~~and~~ the Pregnancy Substance Use Journal**, and claims data/history. Assessments utilize evidence-**

based clinical guidelines and incorporates pregnancy specific questions. Members are stratified into three levels:

- Low Risk – condition is present, but is well controlled; symptom remission; less need for education; and/or have ~~low~~ **high** readiness to change **coupled with a low reported risk of Neonatal Abstinence Syndrome (NAS)** ~~NAS~~. **For example: member may present** ~~evident by~~**with a** history of SUD disorder (placing member at risk for relapse) but ~~no~~ **denies** current reported use; and/or members Drug of Choice does not indicate high risk of NAS.
- Moderate Risk – uncontrolled disease, **member** require**s** education **and assistance** related to their condition**(s)**; and/or ~~have~~ **has** moderate readiness to change ~~evident~~ **as evidenced** by current engagement in treatment and/or low history of relapse
- High Risk – uncontrolled disease ~~evident~~ **as evidenced** by member history of frequent and recent relapses and history of resistance to treatment.~~;~~ **Member** require**s** education**/resources** related to ~~their~~ **the member's** condition~~;~~, ~~have~~ **has** co-morbid conditions,~~;~~ and/or ~~have~~ **has low** ~~high~~ readiness to change.

D. Condition Specific Assessments

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

In addition to the general Care Management (CM) assessment and screening process which already includes screening for SUD. The PN SUD program uses the following additional~~detailed~~ condition specific assessment:~~s.~~

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

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

Low Risk *(not applicable for members with increased suicide risk)*
Participants are assigned to this group when they are determined to have entered into the maintenance phase of treatment or determined to be at a minimal or mild risk level based on ~~the SUD~~ current **SUD** use history (PN SUD Journal symptom screening).

Perinatal SUD symptoms status evaluated at each scheduled interaction to monitor changes to member reported symptoms. Frequency of Outreach to follow Complex Care Management Standards outlined in LA.CM.01.01. Individuals who are in this category are provided focused education material designed to educate them on ~~their disease~~**the disease** process, **all (physical and behavioral)** medications **relevant to member's individual care needs**, and relapse prevention planning.

Moderate Risk
Moderate risk participants are provided ongoing mail and telephonic outreach to provide education regarding available treatment options, **and** collaborate with community providers, ~~all~~ in an effort to increase the member's ability to self-manage their condition. Additionally, participants are provided referrals to community resources where needed, such as transportation and community support groups relevant to diagnosis.

Perinatal SUD symptoms status evaluated at each scheduled interaction to monitor changes to member reported symptoms. Frequency of Outreach to follow Complex Care Management Standards outlined in LA.CM.01.01. ~~Perinatal SUD symptoms will be reassessed monthly to monitor changes to member reported symptoms.~~
Post-delivery updates regarding ongoing participating member outcomes will be updated within 30 days of delivery. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.

High Risk
High risk participants receive all of the interventions provided in the moderate risk program. Additionally, care management staff will

participate in **Integrated Care Team (ICT)** ~~CT~~ Rounds to identify care gaps, review treatment response and offer feedback to providers as necessary. **Perinatal SUD symptoms status evaluated at each scheduled interaction to monitor changes to member reported symptoms. Frequency of Outreach to follow Complex Care Management Standards outlined in LA.CM.01.01.**

E. Outreach and Education

Outreach Frequency is based on acuity - (acuity procedures will follow LHCC and NCQA standards for Outreach and Care Management as outlined in LA.CM.01.01, see references below).
Multiple communication strategies are used in care management programs to include written materials, telephonic outreach, and web-based information, in person outreach through Community Health Representatives program and care managers as needed, and participation in community events.

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

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

F. Discharge from Care Management

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

- The member reaches the highest possible levels of wellness, functioning and quality of life.
- The member achieves established goals regarding improvement or health care stability and is referred to community resources. This may include preventing further decline in condition when health status improvement is not possible.
- Member/family is non-responsive to care management interventions despite ~~three (3)~~ repeated outreaches **(both telephonic and in writing)**, ~~calling~~ on different days of the week, which may include weekends, at different times of the day to maximize the likelihood of successful contact. **Outreach protocols for members will follow ~~-~~acuity procedures in line with LHCC and NCQA standards for Outreach and Care Management as outlined in LA.CM.01.01.**
- Member refuses to participate in care management, following efforts to explain the benefits of the program to the member.
- The member dis-enrolls from the health plan.
- The member expires.

G. Measures of Efficacy and Reporting Mechanisms

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

- SUD symptom screening results to trend~~s~~ and support ~~intervention / ~~program development ~~to encourage member recovery~~
- Successful completion of the program based on ~~CM~~ **Care Management** closure reason (i.e.; condition stable, no other needs)

H. Program Oversight

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

REFERENCES

LA.CM.01 – Care Management Program Description
LA.CM.01.01 – Care/Case Management Assessment Process
LA.CM.01.02 – Care Plan Development and Implementation

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LA.SSFB.01- Smart Start for Your Baby: Perinatal/Neonatal Management Program Overview

ATTACHMENTS:

~~Attachment A – Perinatal SUD Workflow~~

Perinatal SUD CM Workflow_Mar 2018

DEFINITIONS:
N/A

REVISION LOG:	**DATE**
Revised verbage to mirror NCQA wording and requirements related to assessments. Updated references to include updated Care management policies.	**1-~~9-~~2020**

POLICY AND PROCEDURE APPROVAL

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

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