WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Care Plan Development and Implementation
PAGE: 1 of 11	**REPLACES DOCUMENT:**
APPROVED DATE: Oct 2010	**RETIRED:**
EFFECTIVE DATE: April 2011	**REVIEWED/REVISED:** 9/13; 6/14; 6/15; 6/16; 5/17, 1/18, 12/18, 2/19, 7/19, 10/19, 1/20**, ~~10/20~~ 11/20**
PRODUCT TYPE: MEDICAID	**REFERENCE NUMBER:** LA.CM.01.02

SCOPE:
Louisiana Healthcare Connections (LHCC) Medical Management department

PURPOSE:
The purpose of this work process is to outline the process for development, implementation, and review of an individualized plan of care for ~~each~~ all members in case management [KF1][ALM2] [KF3][ALM4]which includes participation from the member, member's authorized representative/guardian and treating providers.

WORK PROCESS:
A. Care Plan Development

1. During the assessment phase, the Care Manager (CM) assesses the member's needs, identifies problems and may reassign the priority level by obtaining information through:
    - Review of the initial screenings and additional assessments
    - The referral source
    - The Primary Care Physician (PCP)
    - Other providers/specialists
    - The member or member's authorized representative/guardian
    - Medication Reconciliation
    - Review of the authorization, claim system, and/or pharmacy system data

2. The CM identifies physical, ~~mental~~[KF5][ALM6]behavioral health, social determinants of health and educational needs, along with other support services and community resources that may assist with improving the member's access to health care and his/her quality of life.

3. The individualized care plan (ICP) is developed **~~within 45 calendar days following the assessment and~~**[AD7][CG8][KF9][ALM10][AD11][ALM12] in conjunction with the member, the member's authorized representative/guardian, the managing physician, and other members of the health care team. The ICP is based on member preferences, medical necessity, available support systems to assist the member in the home setting, community resource/service availability, and the potential for member adherence to the prescribed care plan.

- A care plan with at least one problem, a short and long term goal, with at least one of the interventions being a taskable intervention, is required at all times for the case to be classified as "actively" managed.
- If a taskable intervention is more than 30 days overdue, the case will be considered overdue[KF13][ALM14]. If taskable intervention is overdue, the Care Manager will complete the intervention or update care plan to reflect new intervention date if Care Manager is unable to complete the intervention at that time.

4. Prioritized goals are established, and barriers to meeting goals or complying with the ~~plan of care~~ICP are identified, in consultation with the member and/or the member's authorized representative/guardian, as well as possible solutions to the barriers.

5. The ICP includes, at a minimum:
    - Prioritized goals – Both short term and long term goals are identified with the member and/or member's authorized representative/guardian, and are specific, realistic and measurable. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible
    - Identification of ~~at least one barrier~~ [KF15][ALM16]barriers to meeting the goals specified in the care plan, and recommended solutions for each barrier, including language, literacy (general and health), visual or hearing impairment, motivation, cognitive limitations, cultural and/or spiritual preferences, transportation, mobility, lack of family or care giver support
    - Interventions based on the member's problems and goals, including the development of member self-management plans to assist the member in managing his/her health

6. Once the plan of care has been created, it is shared with the member's PCP and other identified healthcare providers. Care plans consisting of problems/goals/interventions related to substance use should only go to the provider treating the substance use disorder.

B. Care Plan Implementation

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1. The CM may assign tasks or send referrals to other staff in the Integrated Care Team (ICT) as follows:
    - Program Specialist to manage or assist with psychosocial issues or locate resources.
    - Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments and finding healthcare providers.
    - Community Health Services Representative (CHSR) to assist with community referrals, in home or office visits, coordination of care, and outreach activities
    - Behavioral Health Care Manager to assist with behavioral health needs (if currently with Physical Health (PH) CM)
    - PH Care Manager to assist with physical health needs (if currently with BH CM)

2. The CM monitors the member's progress towards care plan goals by contacting the member at defined intervals according to the case acuity, or individual need or preference, as agreed upon by the member. Minimum contacts are noted in Table 1. Additional contact may be necessary and the Care Managers must use their clinical skills and judgment to determine appropriate follow up frequency. The CM must make three (3) attempts at different times of the day on non-consecutive days, within their designated timeframe indicated below, or what was agreed upon with the member. If all three attempts are unsuccessful, an attempt to contact letter is sent to the member. For high risk members with a CM engagement score of >40, a request for a home visit may be made to reach the member.

Acuity	**Needs**	**Minimum Frequency of Contact**
Critical/High	Episode of serious illness or injury; discharge planning, and outpatient coordination of service needs; complex or chronic condition, symptomatic and at risk for admission or readmission.	Minimum of weekly contact [KF17][ALM18]based on the last weekly outreach contact until stable. Once stable, every 1-2 weeks until complications are stabilized, barriers removed,

		and/or needed services are in place. Contact at least every four weeks once stable unless condition deteriorates. All three attempts should be completed within the designated follow-up time frame. 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.) Face to Face visits provided as needed through Community Health Representatives~~[AD19]~~[ALM20] Team
Moderate	Complex condition with many health care needs; condition is mostly stable with adequate care giver support. If member assigned as high acuity previously and now demonstrates compliance with care plan , and making progress toward meeting care plan goals (acuity can be changed from high to moderate).	The first follow-up contact should be within one week, within two weeks, or within four weeks of the last contact. All three attempts should be completed within the designated follow-up time frame. 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.) Face to Face visits provided as needed through Community Health Representatives~~[AD21]~~ Team[ALM22]

Low	Primarily psychosocial needs; no current unmet need for health care services but may have a history of condition that places the member at risk for potential problems or complications. If member assigned to a higher acuity level previously, member is now adherent with the care plan, has met some goals, and making significant progress toward meeting remaining care plan goals (acuity can be changed from high/moderate to low).	One or two contacts and evaluation for care coordination discharge as appropriate Care Plan updates should be sent to all active providers at least yearly/annually or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.) Face to Face visits provided as needed through Community Health Representatives~~[AD23]~~ Team[ALM24]

TABLE 1

3. CM documents agreed upon frequency of contact and method of contact within the Case Summary and/or Notes Summary.

4. The CM monitors progress toward desired outcomes. As applicable, the CM may contact the member's PCP, other providers, and other individuals such as, a school nurse or personnel, Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), community case manager[KF25][ALM26], Transition Coordinators, and representatives of community organizations or resources to which the member has been referred for updates on meeting defined goals. [KF27][ALM28]Exclusions include those who are receiving treatment for substance use disorders. Only the treating provider for substance use disorders should be contacted.

C. Care Plan Evaluation

1. The CM regularly evaluates the member's progress considering the following factors:[KF29][ALM30][AD31][ALM32]
   - Change in the member's medical or social determinants of health

- Change in the member's behavioral health status
- Change in the member's family situation or social stability
- Change in the member's functional capability and mobility
- Change in the member's cognitive status
- Follow-up on status of referrals submitted or provided to member
- The member's progress in reaching the defined goals
- The member's compliance with the established plan of care
- Change in member or authorized representative/guardian's satisfaction with the CM program
- Change in the member's quality of life
- Benefit limitations
- Recent discharge from a physical health or behavioral health inpatient facility and/or ED over utilization

2. The CM makes necessary changes to the ICP and modifies the goals based on the findings of an ongoing evaluation. The CM contacts the PCP, or other members of the ICT, as needed to discuss modifications and obtain an updated, mutually agreed upon ~~medical~~ [KF33][ALM34]treatment plan. Any contacts made by the CM and any changes in status, goals, or outcomes are documented in the clinical documentation system. The CM team also monitors the case on an ongoing basis for quality indicators, and if present, makes the appropriate referral to the Quality Improvement Department.

3. It is the responsibility of the CM to facilitate communications [KF35][ALM36]among applicable team members. Teams utilize a common clinical documentation system to maintain centralized health information for each member, which 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, based on severity and complexity of the member needs during weekly integrated rounds.

4. 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 discharge from an inpatient facility), or at the request of the member. The ICP is also updated at

these times and shared with the PCP or primary behavioral health provider with each successful Member encounter.

D. Discharge from Case Management

1. The CM may receive input from the PCP, member/member's authorized representative/guardian, and other health care providers involved in the member's plan of care to determine the appropriateness of discharging from the case management program.

2. The following criteria will be used to determine when discharge from case management should occur:
   - The member's eligibility terminates with the Plan
   - The member requests to dis-enroll from the CM program
   - The member refuses to participate in care management
   - CM 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 the maximum medical improvement or established goals regarding improvement or medical stability (which may include preventing further decline in condition when improvement is not medically possible).
   - ~~Insurance benefits are exhausted~~ [KF37][ALM38]~~and community resources are in place~~
   - The member expires during case management.
   - ~~Confirmation of utilized resources~~ [CG39][ALM40]~~previously provided to the Member.~~

3. Once the member is identified as eligible for discharge from case management services the CM:
   a. Discusses the impending discharge from case management with the member and/or member's authorized representative/guardian
   b. Provides the member and/or member's authorized representative/guardian with contact information for future reference

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c. Presents community resources and assists in making arrangements, if applicable.
d. Coordinates with another insurance plan if the member is transitioning to another plan
e. Informs the member's PCP and other providers, when appropriate, regarding the impending discharge

4. A letter noting the member is discharged from case management services must be generated and sent to the PCP, additional healthcare providers, and member, with documentation for the reason of discharge and a reminder to contact the CM if future medical concerns arise.

REFERENCES:
LA.CM.01 Care Management Program Description
LA.CM.01.01 CM Assessment Process
Current NCQA Health Plan Standards and Guidelines

ATTACHMENTS:

DEFINITIONS:.
CM includes PH & BH in this work process

REVISION LOG

REVISION	DATE
Ensure Member Involvement *Underlined verbiage was added (1.e)* e. If a CM or designee has made at least three (3) unsuccessful telephonic outreach attempts at different times of the day, and there is no response to attempt to contact letter, a low or medium risk case may be closed based on the inability to contact the Member. If it is a high risk case, Member Connections referral must be made. If home visit is unsuccessful, then a high risk case may be closed based on the inability to contact the Member. *Changed (e.ii)* ii. The *Note Reason* field select '1st Attempt', '2nd Attempt', 'Max Attempt' **changed to** "In the Outreach drop down box, select appropriate number of attempt (1st, 2nd, 3rd, Max); in the note text area, document type of attempt (telephonic, letter or member connections home visit attempt) with result."	8/2013

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Deleted: (e.iii) iii. When letters are used instead of phone calls, the *Note Reason* should be changed to reflect the attempts. Generate the letter and instead of accepting the letter, save the letter. Then go to the Notes module and click *Edit Note* and enter the appropriate *Note Reason* as above.	
Made the following changes: A. 2. "Lead" to "primary CM" A. 5. & 11 & 12 "level of CM"; "level" and "Priority" to "case acuity" A. 7. "ICT" to "department" B. 11. "bi-weekly" to "twice a month" C. 2. changed "closing a case" to "discharging from the case management program" C. 3. "Ineligible/Disenrolled" to "Termination of Coverage" C. 3. In the Case Summary module, select 'Start case closure' and select the *Close Reason* as 'Member refuses services'. C. 3. A. Changed "care plan" to "plan of care" C. 3. E. Added "Care Coordination Outreach' or 'SSFB OB Outreach V2'." C. 3. F. Added "In the Case Summary module, select 'Start case closure' and select 'Deceased'." In place of "The case status must be changed…." C. 3. F. Changed "QI Event" to "email"; "Case Conference" to "General Note"; removed "complete a reminder…." C. 5. Added "Case Closure" NCQA Date to 2013	6/2014
Removed language that is in other policies. Changed treatment plan to plan of care. Added Specialist and Medication Reconciliation to care plan development. Added physical, psychosocial to the types of needs CM identifies. Added Behavioral health case management to the list that CM can assign tasks to. Changed behavioral to psychosocial in factors for evaluation. Added "Re-submission of the plan of care to the new PCP should occur as soon as the new PCP has been identified" to the transition to PCP. Updated NCQA reference.	6/2015
Removed language that did not pertain to Care Plan Development Added language to reflect policy LA.CM.01.	7/2016
In section A6, added other identified Health Care Providers. Edited table to follow ICM .	5/2017
Update verbiage in statement on Interventions. Changed Member Connections Representative to Community Health Services	1/2018

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Representative (CHSR). Updated statement on home visit by CHSR to include if engagement score is >40. Added statement on letter of discharged members to include additional healthcare providers.	
General grammatical corrections made throughout the work process. The addition of "and resources" was added to the Program Specialist's description. The removal of "obtaining lab results" and the addition of " healthcare providers" was added to the Program Coordinator description. The addition of "with each successful Member encounter" replaced the verbiage "as applicable" The bullet point " Confirmation of utilized resources previously provided to Member" was added under Discharge from Case Management.	12/2018
Added BH Care Manager and referenced CM/BH CM instead of just Care Manager Changed psychosocial to social determinants of health Added "member preference" to ICT description Changed one goal to short and long term goal Removed "Once member agrees" to Once plan of care has been created Added "BH Care Manager to assist with BH needs if currently in PH CM and vice versa	02/2019
Defined CM as including PH & BH in this work process Added: The CM must make three (3) attempts at different times of the day on non-consecutive days, within their designated timeframe indicated below, or what was agreed upon with the member. If all three attempts are unsuccessful, an attempt to contact letter is sent to the member. For high risk members with a CM engagement score of >40, a request for a home visit may be made to reach the member. Reworded this bullet from criteria to discharge from CM: CM 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	7/19
Changed verbiage within contact frequency chart from "monthly" to every 4 weeks and "bi-weekly" to every two weeks Added requirement of documenting method of contact within documentation of frequency of contact	10/19

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Re-worded statement regarding when a reassessment is needed to align with RFP verbiage, "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."	
Added "All three attempts should be completed within the designated follow-up time frame." to frequency of contact table for high and medium acuities	01/2020
Updated policy to reflect Amendment 3 requirements of the care plan being completed within 45 days of the completion of the assessment	**~~10~~1/2020**
Updated policy to reflect LDH verbiage recommendations	**04/2021**

WORK PROCESS APPROVAL

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

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