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Care Management Workbook

Revised February 2025

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1. Care Management

DMAHS Definition

Care Management means a set of Enrollee-centered, goal-oriented, culturally relevant and logical steps to assure that an Enrollee receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links Enrollees to, services as necessary across providers and settings. At a minimum, Care Management functions must include, but are not limited to:

1. Early identification of Enrollees who have or may have special needs;
2. Assessment of an Enrollee's risk factors;
3. Development of a plan of care;
4. Referrals and assistance to ensure timely access to providers;
5. Coordination of care actively linking the Enrollee to providers, medical services, residential, social, behavioral, and other support services where needed;
6. Monitoring;
7. Continuity of care; and
8. Follow-up and documentation.

Care Management is driven by quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, Enrollee satisfaction, adherence to the Care Plan, improved Enrollee safety, cost savings, and Enrollee autonomy.

2. Case Management

DMAHS Definition

Case Management, a component of Care Management, is a set of activities tailored to meet a Enrollee's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and non-clinical, by connecting the Enrollee to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

As in Care Management, *Case Management* activities also emphasize prevention, continuity of care, and coordination of care. Case Management activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased Enrollee satisfaction; adherence to the Care Plan; improved Enrollee safety; and to the extent possible, increased Enrollee self-direction.

3. Enrollee–Centered Care Management Conceptual Framework

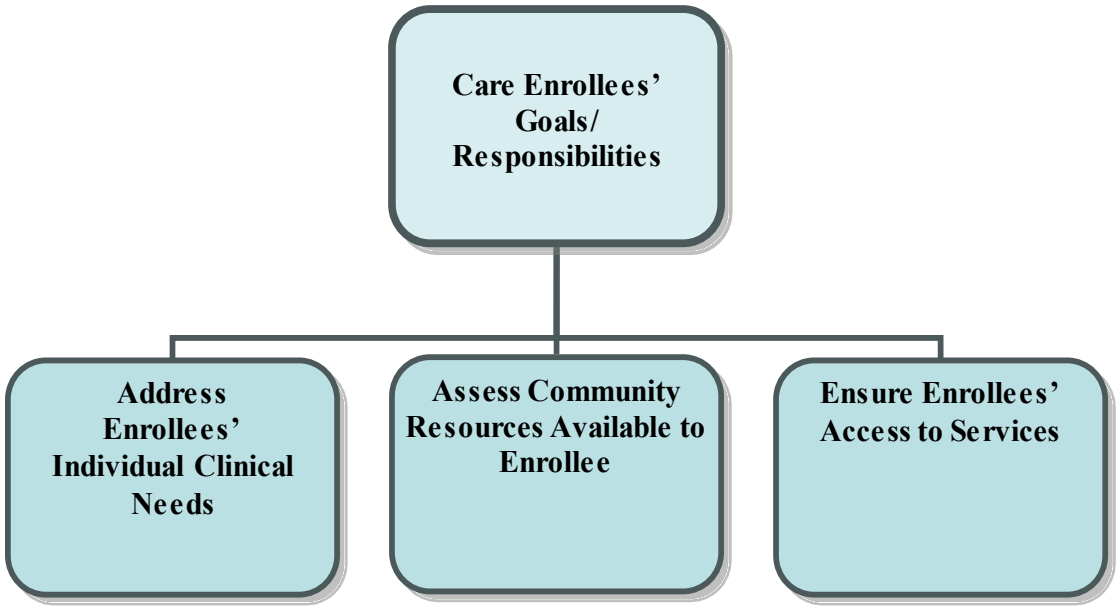
Overview
The Division of Medical Assistance and Health Services' (DMAHS) core quality mission is to develop and implement program, policies, and activities that promote positive health outcomes and are consistent with current medical standards. As such, DMAHS seeks to improve the current Care Management program to better meet the needs of the target population. Care should be less fragmented and more holistic; Care Managers should strive to better communicate across settings and providers; and Enrollees should have greater involvement in their Care Management.

Goals
DMAHS' goals for the Care Management program include:

- Provide access to timely, appropriate, accessible, and Enrollee-centered health care;
- Improve the quality of care and health outcomes for Enrollees;
- Tailor care to the Enrollees' needs by using evidence-based treatment, best practices, and practice-based evidence to manage services by duration, scope, and severity;
- Ensure health plans involve Enrollees and their family in the care process;
- Reduced Emergency Room visits and avoidable hospitalizations;
- Promote effective and ongoing health education and disease prevention activities;
- Provide cost-effective care; and
- Promote information sharing and transparency.

Equally as important to an effective Care Management program is the development of a set of expectations for what is required from Care Managers (Illustration 1). Key Care Management responsibilities relate to understanding the needs of individuals and ensuring access to needed Care Management services.

Illustration 1. Care Management's Goals



Overall Philosophy

Through Care Management, Contracted health plans will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, MCOs will:

- Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.
- Design and implement Care Management services that are dynamic and change as Enrollees' needs and/or circumstances change.
- Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.

Definition of Care Management

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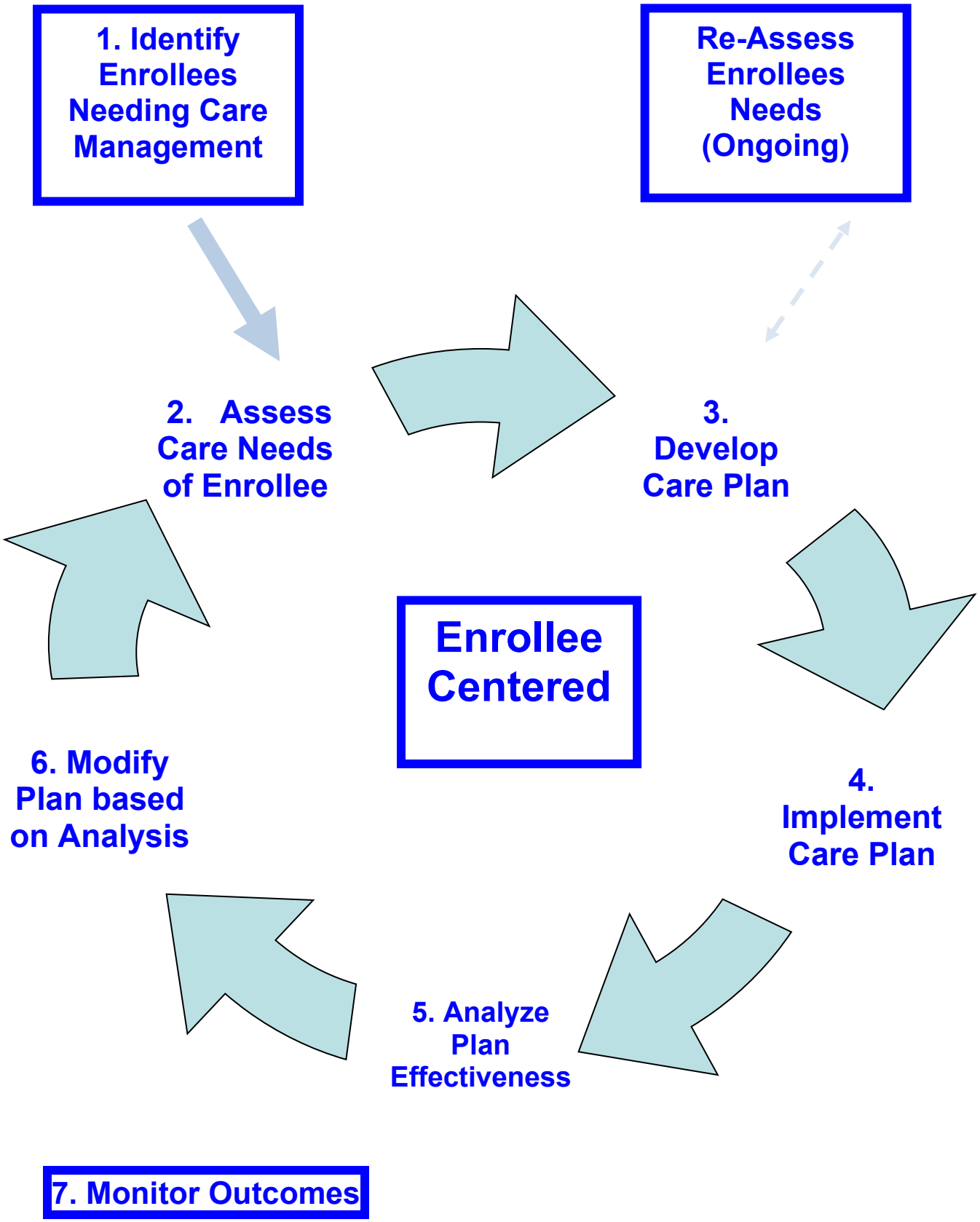
Components of Care Management (Illustration 2)

Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:

1. Identification of Enrollees who need Care Management;
2. Comprehensive needs assessment;
3. Care Plan development;
4. Implementation of Care Plan;
5. Analysis of the effectiveness and appropriateness of Care Plan; and
6. Modification of Care Plan based on the analysis.
7. Monitor Outcome

Illustration 2. Components of Care Management/Overall Process.



Components:

1. Identification of Enrollees Who Need Care Management:

The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees (except for DCP&P and ID/DD Enrollees) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed comprehensive needs assessment (if deemed necessary by a healthcare professional), with ongoing Care Coordination and Management as appropriate. All elements of the State approved IHS tool that appear in this Workbook must be included in the MCOs' screening tool.

2. Comprehensive Needs Assessment (CNA):

The MCOs will conduct an approved CNA on new Enrollees following the evaluation (by a healthcare professional) of their Initial Health Screen results. Specifically, MCOs must conduct a CNA on any Enrollee identified as having potential Care Management needs, as well as all DCP&P and ID/DD Enrollees. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appear in this Workbook must be included in the MCOs' assessment tool.

3. Plan of Care to Address Needs Identified:

Based on the comprehensive needs assessment, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. *(See Process Flow: Illustration 3)* With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. All Care Plans must be updated at least annually. Outreach to assess needs and update care plans must be done telephonically or face-to-face, depending on the Enrollee needs.

4. Implementation of Care Plan:

The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the plan. This includes making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regime.

5. Analysis of Care Plan Effectiveness and Appropriateness:

Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. Analysis must occur at least annually. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.

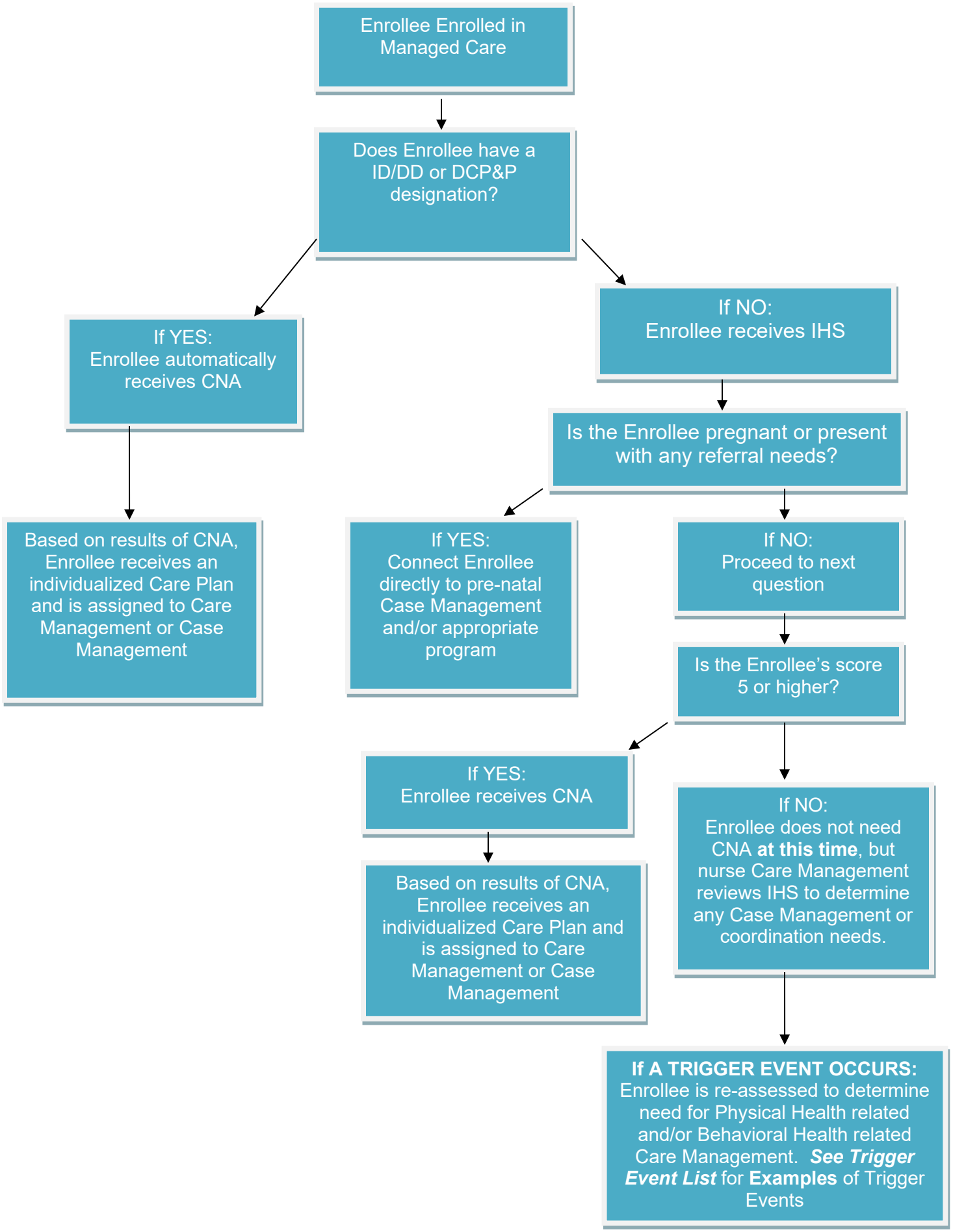
6. Modify Care Plan Based on Analysis:

Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.

7. Monitoring Outcomes:

The MCO must develop policies and procedures that describe protocols detailing how it collects and monitors population based outcomes. The MCO will conduct Satisfaction surveys using the DMAHS approved Care Management Member Experience Survey tool. Results will be made available to DMAHS upon request.

Illustration 3.Process Flow for IHS and CNA



Trigger Events

Examples of Events include, <u>but are not limited to</u>:

- **Unplanned hospitalization**
- **2 or more ER visits in 6 months**
- **Exacerbation of chronic condition and/or disability requiring increased medical visits or hospitalization (i.e. Diabetes, COPD, CHF, Asthma, CKD, Obesity, ADHD, OCD, Anxiety, etc.)**
- **Mental Health hospitalization**
- **Provider referral as a result of: medical screenings and diagnoses, pregnancy/postpartum status, MH/SUD screening results, housing insecurity, at risk of or homeless, transitioning out of intensive BH service, disengagement from medical or mental health services (3+ missed appointments), other**
- **Self-referral as a result of: health concerns, death of a loved one, suicide attempt without hospitalization, homeless/housing insecurity, pregnancy/postpartum status, caregiver stress, other**
- **Risk indicators identified from MCO internal systems data sources (i.e. new terminal illness or BH diagnosis, 3+ address changes within past year, etc.)**

4. Outreach Overview

Two Levels of Outreach: Initial and Aggressive.

Initial Outreach **is to be utilized for all new "General Population" Enrollees in order to complete an IHS.**

Purpose: To identify Enrollees that may have Care Management needs (not easily identified otherwise - as with PSC).

- **Minimal Standards:**
  - **At least 2 different methods required, i.e. telephonic, electronic (confirmed email), written correspondence, etc.**
  - **Completed within 45 days from enrollment.**
- **Policies must be developed describing purpose, standards, definitions, timeframes and process.**
- **Policies must include a process developed to address the Enrollees not found (i.e. returned cards, no response) after the initial outreach efforts are completed. The process must include:**
  - **A detailed plan of the MCO's use of internal 'systems' to identify and contact these Enrollees (i.e. utilization data, P.A. reports, pharmacy data, etc.)**

Aggressive Outreach **is to be utilized to complete a CNA.**

Purpose: To complete a comprehensive needs assessment of Enrollees who have been identified as having potential CM needs.

- **Minimal Standards:**
  - **To include at least 3 attempts using a combination of various types of methods, i.e. telephonic, electronic (confirmed email), face to face (home or virtual visits) and resources such as providers, external agency contacts, etc.**
  - **Completed within 45 days from enrollment for ID/DD & DCP&P.**
  - **Completed within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources (i.e. referrals, data alerts, utilization reports, pharmacy data, risk scores, clinical judgment etc.).**
- **Policies must be developed describing purpose, standards, definitions, timeframes and procedures.**
- **Policies must include a process developed to address the Enrollees not found even after reasonably aggressive outreach efforts are complete. The process must include:**
  - **The utilization of community based care management to outreach and assess the needs of members identified with special needs and ID/DD members who may be hard to reach.**
  - **A detailed plan of the MCO's ongoing use of internal 'systems' to identify and contact these Enrollees including systems 'alerts' that will indicate to staff that outreach is ongoing and aggressive.**

  ***All Outreach policies must also include the MCOs' plans for how they will monitor the success of their process, including benchmarks and self-correction methods to improve success rates over time.**

5. CM Component Timeframes and Standards

Process Steps	Timeframe
1. ID of Enrollees w/potential CM needs	**a. ID/DD & DCP&P: At Enrollment per PSC** **b. General Population: By completion of IHS** **c. Other (Any population): Data Mining, Risk Scores, Referrals, Concurrent Review, etc.** * MCO's will have identification process policies and procedures describing all the components used for identification, including systems used to support proper identification, how system(s) will be used, interconnectability and information flow chart, internal flags and responsible unit/person (tools must include at minimum, risk scores, data mining, sentinel events, and time tables to be used for identification, etc.)
2. IHS Completion	**a. ID/DD & DCP&P: N/A** **b. General Population: 45 days from enrollment** (ABD children must have priority for completion) **c. May be completed and scored using information from data sources.** *MCO's will have policies in place describing how they will stratify.
3. CNA Completion	**a. ID/DD & DCP&P: 45 days from enrollment** **b. General Population: 30 days from identification of Care Management needs.** • **IHS score of 5 or greater** • **Identification through other sources (i.e. referrals, data alerts, utilization reports, pharmacy data, risk scores, clinical judgment, etc.)**
4. Care Plan Development	**a. 30 days from CNA completion (all populations)**
5. Outreach (Timeframes and Standards listed in document titled "Outreach Overview")	**a. Initial Outreach** (To new *general* population Enrollees in order to complete an IHS) **--- *Minimal* Standards:** **1. At least 2 different methods required.** **2. Completed w/in 45 days from enrollment.** **Individual MCO's will develop policies describing their outreach procedures, standards and definitions. **b. Aggressive Outreach: --- *Minimal* Standards:** **1. To include <u>at least 3</u> attempts using a combination of various types of methods, i.e. telephonic, electronic (confirmed email), face to face (home or virtual visits) and resources such as providers, external agency contacts,** **2. Completed within 30 days of IHS completion (for Enrollees with IHS score of 5 or more) or 45 days from enrollment for ID/DD and DCP&P.** **MCO's must develop policies describing purpose, standards, definitions, timeframes and procedures. Policies must include a process developed to address the Enrollees not found even after reasonable aggressive outreach efforts are complete.

6. IHS Scoring Strategy and Condition List

IHS Questions	CM Stratification Triggers	Scoring
#1	Admitted to the hospital in past 6 months or in-patient BH hospital / psychiatric hospital admission in past 12 months??	1 admit = 1 pt. 2 admits = 2 pts. 3+ admits = 3 pts.
#2	Emergency room visit in past 6 months?	0 - 1 visit = 0 pts. 2 - 4 visits = 1 pt. 5+ visits = 2 pts.
#3	Planned future hospital admissions or surgeries?	1 pt.
#4	Self-rating of health: Excellent, Very Good, Good, Fair or Poor.	Fair = 1 pt. Poor = 2 pts.
#5	Medical and mental health conditions: List of Conditions attached	0 conditions = 0 pts. 1 - 2 conditions = 1 pt. 3+ conditions = 2 pts.
#6	Uses **four** or more prescribed medications or 1+ prescribed psychiatric medication?	1 pt.
#7	Use any medical equipment Currently? DME Exceptions: Cane, Walker, Crutches, Nebulizer, Diabetic Supplies	2 pts.
#8	Need help with Activities of Daily Living? (e.g., bathing, medication, feeding).	2 pts.
#9	What is your living situation today? (When delivered telephonically, allow enrollee to answer open-ended questions and refer to scoring guidance; when delivered via mail, allow member to circle multiple choice answer)	I have a safe and steady place to live = 0 pts. I am worried about physical safety of my home or losing housing in the near future = 3 pts. I do not have a steady place to live (e.g., temporarily staying with others, in a hotel, in a shelter, on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) = 5 pts.
Total Score	**Next Recommended Step**	
0-4	Enrollee does not need to undergo clinical needs assessment at this time, but may need other services.	
5+	Conduct clinical needs assessment.	

6. IHS Scoring Strategy and Condition List

1	Asthma
2	COPD (Chronic Obstructive Pulmonary Disease)
3	Tuberculosis
4	Seizures
5	Memory Problems
6	Depressive Disorders (If Enrollee answers “yes”, the following are for reference only: Major Depressive Disorder, Persistent Depressive Disorder/Dysthymia, other specified Depressive Disorder & Unspecified Depressive Disorder)
7	Schizophrenia & other Psychotic Disorders (if Enrollee answers “yes”, the following are for reference only: Schizophrenia, Delusional Disorder, Schizoaffective Disorder, Other specified Schizophrenia Spectrum & other Psychotic Disorder)
8	Congestive Heart Failure
9	Heart Disease
10	Hepatitis
11	Diabetes
12	Kidney Failure
13	On Organ Transplant List
14	Paralysis
15	Multiple Sclerosis
16	HIV/AIDS
17	Stroke
18	Lead Poisoning
19	Sickle Cell disease
20	Cancer w/treatment
21	Hemophilia
22	Pregnancy
23	Bipolar & Related Disorders (If Enrollee answers “yes,” the below are examples for reference only: Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, Other Specified Bipolar and Related Disorder, Unspecified Bipolar and Related Disorder)
24	Trauma and Stressor-Related Disorders
25	Currently receiving Medication Assisted Treatment (MAT) for a Substance Use Disorder (SUD)
25	Currently in treatment for alcohol or other substance use
26	Substance related disorders (If Enrollee answers “yes,” the following are examples for reference only: Alcohol use / dependency, Opioid use / dependency, Cannabis use / dependency, Hallucinogen use / dependency, Inhalant use / dependency, Stimulant use / dependency)

8. COMPREHENSIVE NEEDS ASSESSMENT

(General Population, Peds, ABD, and ID/DD Caregiver)	
ELEMENTS	**QUESTIONS**
DEMOGRAPHICS	
1	What is your name (Enrollee)?
2	What is your primary telephone number?
3	What is a secondary telephone number we could use?
4	In case of an emergency, what is the name and telephone number of a person we can contact?
5	What is the primary language spoken in the home?
6	What is your current address?
7	Who is providing the information to complete the assessment (include name and relationship to Enrollee)?
8	Is there a guardian involved?
HISTORY	
1	Who is your current primary care provider or family doctor? (Provide name and telephone number)
	What was the date of last appointment?
2	Do you see any specialists? (Provide names and telephone numbers)
	What was the date of last appointment?
3	Do you see a dentist? (Provide name and telephone number)
	What was the date of last appointment? Routine or emergency care?
4	Which of the following medical conditions do you/have you had? (Select: Asthma, Chronic Obstructive Pulmonary Disease, Tuberculosis, Seizures, Memory Problems, Heart Failure, Heart Disease, Hepatitis, Diabetes, Kidney Failure, On Organ Transplant List, Paralysis, Multiple Sclerosis, HIV/AIDS, Stroke, Lead Poisoning, Sickle Cell disease, Cancer w/treatment, Hemophilia, Pregnancy/Postpartum Status, any of the SMI Diagnoses [refer to all listed in the HIS], Other)
5	On a scale of 1 to 5, with 1 being "poor health"; 2 being "fair health"; 3 being "good health"; 4 being "very good health"; and 5 being "excellent health", how would you rate your overall health during the past three months, including medical, dental and mental health?
6	Which medications are you taking, including over-the-counter medications and supplements?
	Do you need any help taking your medications?
	Which pharmacy do you use? (Provide name)
7	Do you have vision problems not corrected with lenses?
	If yes, explain.
8	Do you have hearing problems not corrected with assistive aids?
	If yes, explain.
9	What is your current height?
10	What is your current weight?
	Have you lost weight in the past 6 months without trying?
	How much have you lost?
	Have you gained weight in the last 6 months without trying?
	How much have you gained?
11	Are your immunizations up-to-date?
12	Are your preventive screenings up-to-date, both medical and dental?
FUNCTIONALITY	
1	Do you have a problem with any of these? (Select: independent as age appropriate; dependent as age appropriate; requires assistance; completely dependent)
	Ambulation/Walking
	Bathing with sponge, bath, shower
	Oral health (brushing, flossing, chewing)
	Dressing
	Toilet Use
	Transferring (in and out of bed or chair)
	Eating

	Continence (controls bowel and bladder by self)
	Shopping
	Cooking
	Using the telephone
	Housework
	Doing laundry
	Driving
	Managing finances
2	Do you have a family Enrollee or other caregiver assisting you?
	How often is assistance provided? (Select: daily, weekly, weekends, all of the time)
	Do you feel you need additional help?
3	Do you currently use home health services?
	List home health services used, agency name, hours, and frequency.
4	Do you currently use any medical equipment and/or supplies?
	List medical equipment and supplies used and DME company.
5	Do you need transportation to and from medical appointments?
6	Do you have an emergency plan? (Drop down menu to include: Do you know what to do in case the electricity goes off? Who would you call if you need medical help? What would you do if there was a fire in your apartment, etc?)
NUTRITION	
1	Do you follow any special diet? If yes, please describe.
2	How is your appetite?
3	Do you have any feeding or eating issues? [Drop down menu to include: difficulty chewing or swallowing, dry mouth, GI disturbances (constipation, distension, diarrhea), food allergy, lactose intolerance, GT feeds, excessive fussiness, spitting up, projectile vomiting, colic, difficulty sucking, receives special formula]
4	Do you have any difficulty obtaining food or formula?
5	Do you make use of WIC, food bank, food stamps, or other resources to obtain food?
DEVELOPMENTAL CONCERNS (Note: ID/DD Enrollees must be asked these questions)	
1	Do you attend school/day program?
	If yes, what is the name of the school/day program?
2	In what grade/type of day program are you currently enrolled?
3	Do you receive special services/ therapies at school/day program? (IEP, occupational therapy, physical therapy, speech therapy, other)
4	Have you informed the school/day program about your medical condition(s) or medications?
5	*Question for parent/caregiver:* Is there any activity that your child can't do that other children his/her age can do?
6	*Question for parent/caregiver:* Do you have any concerns about your child's behavior?
SUPPORT/ COMMUNITY RESOURCES	
1	Do you participate in community support programs?
	What community support services do you currently have or need?
2	Do you currently have a Case/Care Management through another agency or program (i.e., DCF/CSOC, DDD, DCP&P, SCHS, waiver)?
	What is the Case/Care Management's name and contact information?
3	What type of living arrangement do you have? (Select: house, apartment, assisted living, boarding home, nursing home, temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned bldg, bus or train station, in a park, other)
4	Are you worried about physical safety/stability of your housing?
5	If in permanent housing, who do you live with? (Select: alone, friend, other family Enrollee, paid help, spouse or significant other, other)
	Is current residence suitable for home care? (Only to be asked if applicable)
6	Do you have any friends or family that are willing to provide emotional support?
7	Do you have any barriers to care (i.e. difficulty getting appointments, transportation, don't like doctor)?
PSYCHOSOCIAL HISTORY *(Note: These questions are only to be asked of Enrollees who are 10 years old and older)*	
1	Do you drink alcohol?
	On a typical day, how many drinks do you have? (open-ended)
	On average, how many days per week do you drink alcohol? (open-ended)
2	Do you smoke or use tobacco?

	How much do you smoke a day? (Select: less than one pack a day, 1-2 packs a day, 2 or more packs a day)
	Do you want to quit smoking?
3	Do you use recreational or street drugs?
	On a typical day, how much do you use?(open-ended)
	How many times a week do you use recreational or street drugs?
4	Have you had any recent behavioral health and/or substance abuse treatment? If yes, please describe.
5	Depression screen (PHQ-2): Over the last 2 weeks, how often have you been bothered by any of the following problems? (Select: not at all, several days, more than half the days, or nearly every day)
	Little interest or pleasure in doing things
	Feeling down, depressed or hopeless
6	Are you (or the person you are caring for) thinking of doing anything that may be harmful to yourself (themselves) or someone else?
7	Do you ever feel unsafe at home?
8	Is there something else you need me to know? Please provide any additional relevant information.
Supplemental Questions for ID/DD Beneficiaries (Note: Care Managements should tailor questions to either the caregiver or Enrollee, as appropriate)	
1	Is the Enrollee disruptive or aggressive towards themselves or others?
2	Is Enrollee prevented from participating in any activities due to mental health or behavioral issues?
3	Is Enrollee currently receiving mental health and/or substance abuse services?
4	As the Enrollee's caregiver, describe the Enrollee's cognitive status.
5	Has the Enrollee's behavior changed in the last 6 months? If so, what is the impact?
6	Please describe how you care for the Enrollee (i.e., what kinds of task do you do for the Enrollee? Do you care for the Enrollee full time, etc.?)
7	Do you feel that the Enrollee you care for is getting enough help?
8	Is there any help that ***you*** would like?
9	Do you want information about benefits/services available?
10	Do you have a Support Coordinator? If yes, do you know how to reach him/her?
11	When was the last time you were in contact with your Support Coordinator?
Questions for MCO Care Manager	
1	**Cognitive Function**
	In the Care Manager's opinion, what is the Enrollee's cognitive functioning level? (Select: alert/disoriented, easily distracted, requires considerable assistance, requires total assistance)
2	**Behavioral Health**
	While completing this assessment did the Enrollee sound depressed or overly anxious or did caregiver state same?
	In the Care Manager's opinion, are there behavioral health issues pertaining to the Enrollee or caregiver?
3	**Risk Factors**
	What are the Enrollee's risk factors? (Select: none, smoking, alcohol/drug dependency, obesity, nutritional, special needs, other)
	In the Care Manager's opinion, does the Enrollee have a risk of violence and/or abuse?
4	**Health literacy**
	In the Care Manager's opinion, does the Enrollee (or caregiver) understand his/her health needs?
	Is the Enrollee (or caregiver) able to communicate his/her health care needs?
5	**Long-term/Ongoing Care Service Needs**
	Does the Care Manager identify any long-term care and/or ongoing service needs for this Enrollee?
6	**ID/DD Enrollees**
	Based on the Enrollee's responses to ALL CNA questions, assess the Enrollee's functionality, social supports, and clinical needs. Select from the following to assess support needed: low, medium, or high.
7	**Overall Impression**
	Based on the Enrollee's responses to the CNA, what are the key pieces of information that must be in this particular Enrollee's Care Plan? Care Managers must use their clinical judgement when determining member need for Behavioral or 'General' Care Management.

8. DMAHS CARE PLAN

Based on the Comprehensive Needs Assessment results, the Care Manager will assign all Enrollees to a care level, develop a Care Plan for each Enrollee, and facilitate and coordinate the care of each Enrollee according to his/her needs. At the time of enrollment, the Care Manager shall place all children who are under DCP&P/DCF and all children and adults identified as ID/DD into its Care Management program at Level 2 or above until a Comprehensive Needs Assessment is performed and an individualized Care Plan is developed. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create and manage a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes individually tailored to meet the identified Care/Case Management needs. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. The Care Manager must also continually evaluate the Care Plan to update/change it in accordance with the Enrollees' needs.

The MCOs must have effective systems, policies, procedures and practices to create, refine and execute a plan of care. The MCOs are required to develop internal integrated electronic information systems with seamless interoperability in order to provide Care Managers with access to all essential data related to the Enrollee (including but not limited to: Enrollee's clinical history, diagnosis, sentinel events, urgent/on-going care need), other data sources (pharmacy, utilization) and data mining tools (predictive modeling, risk scores) to: (1) place a Enrollee into his/her appropriate care level (for that particular date in time); (2) implement his/her Care Plan; (3) monitor Care Plan for effectiveness and appropriateness; and (4) modify the Care Plan to accurately reflect any change in the Enrollee's circumstances.

Care Plan Components

The Care Manager will initiate, facilitate and monitor specific activities, interventions and protocols that lead to accomplishing the goals and objectives set forth in the Care Plan. The Care Plan will include, at a minimum:

- Clinical history and diagnosis(es)
- Functional, cognitive, and mental health status
- Level of care
- Family Enrollee/caregiver/facilitator resources and contact information
- Assigned primary care physician
- Any assigned external program manager
- Clearly identified, Enrollee-centered, and measurable short/long-term goals and objectives
- Key milestones towards meeting those short/long-term goals and objectives
- Immediate service needs
- Accommodation needs, auxiliary aids, and services
- Use of services not covered by DMAHS (e.g., psychosocial support, local community resources, etc.)
- Enrollee self-management goals
- Barriers to care
- Follow-up schedule
- Assessment of progress, including input from Enrollee and/or caregiver

Enrollee Involvement in Care Plan Development

The MCOs must have policies, procedures and practices in place to ensure that there are mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in Care Plan development. The policies will include procedures the Care Managers will follow to involve Enrollees and/or their caregivers (according to their abilities) in developing a plan to address their health care needs and promote self-direction. If an Enrollee's primary care physician declines to participate in the Care Plan development, the Care Manager must ensure that the Care Management plan is provided to the Enrollee's primary care physician.

Interventions

Care Plans will call for, and the Care Managers must use a variety of interventions and approaches to execute the Care Plan, including but not limited to: Enrollee education through telephonic outreach, face-to-face visits and in-home assessments.

Care Plan Fluidity

Care Plans will indicate an Enrollee's current level of care. They will anticipate routine needs and actively track up-to-date progress toward meeting the stated goals. With the understanding that Enrollees' care needs and circumstances change, the MCO must develop protocols that evaluate Enrollee needs on a continual basis.

Updating Care Plan

The MCO will develop a process for reviewing and updating Care Plans with Enrollees and/or caregivers on an as-needed basis, but no less often than annually. Updates must include the assessment of progress toward goals to ensure the plan of care accommodates new information or circumstances. All Care Plans must be updated at least annually. Outreach to assess needs and update Care Plans must be done telephonically or face to face, depending on the Enrollee needs.

Coordinating Care Plan Across Services and Agencies

Services called for in the Care Plan will be coordinated by the MCO's Care Management staff, in consultation with any other case managers already assigned to an Enrollee by another entity. Care Managers will work in partnership with the Enrollee and/or caregiver, PCP and other case managers to ensure that the Enrollee's needs and preferences for health services and information sharing across people, functions, and sites are met over time. Effective coordination will facilitate

beneficial, safe and high-quality Enrollee experiences and improved healthcare outcomes

Care Plans for Individuals in DDD and DCF/CSOC

When providing Care Management services for Enrollees with intellectual and/or developmental disabilities (ID/DD), the MCO must focus on the complexity of a Enrollee's health conditions, social factors, and functional needs. Planning beyond the physical needs of the person with disabilities to improve health and quality of life is necessary in order for the Enrollees with ID/DD to reach their optimal level of wellness.

- *Assessment of Needs for Enrollees:*
  As in the case with other MCO Enrollees, Enrollees with ID/DD will be assessed to determine any possible Care or Case Management needs using DMAHS' comprehensive needs assessment tool. However, for these Enrollees, the assessment of the responses to social and functionality questions are as important as the assessment of the responses to the clinically-focused questions.

- At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF and all children and adults identified as ID/DD into its Care Management program at Level 2 or above until a Comprehensive Needs Assessment is performed and an individualized Care Plan is developed.

- *Coordination with DDD and DCF/CSOC:*
  The MCO will encourage cooperation with DDD and DCF/CSOC to ensure the provision of effective Care Management services. Ongoing communication and information sharing with DDD and DCF/CSOC is essential to develop and maintain a comprehensive Care Plan.

Care Management Member Experience Survey

1. Was your Care Manager easy to contact and followed up with you to assist with any care needs?

   (1) Never
   (2) Rarely
   (3) Sometimes
   (4) Often
   (5) Always

2. Was your Care Manager knowledgeable about your health care needs?

   (1) Not at all knowledgeable
   (2) Slightly knowledgeable
   (3) Moderately knowledgeable
   (4) Very knowledgeable
   (5) Completely knowledgeable

3. How much time did your Care Manager spend addressing (your/your child's) needs, questions or concerns?

   (1) Never
   (2) Rarely
   (3) Sometimes
   (4) Often
   (5) Always

4. How would you rate the overall helpfulness of (your/your child's) Care Manager in the following areas:

   - Providing information or advice about (your/your child's) health care or treatment plan.

     (1) Not at all helpful
     (2) Slightly helpful
     (3) Moderately helpful
     (4) Very helpful
     (5) Extremely helpful

   - Assisting and/or coordinating (your/your child's) care and treatment.

     (1) Not at all helpful
     (2) Slightly helpful
     (3) Moderately helpful
     (4) Very helpful
     (5) Extremely helpful

- Providing referrals and/or resources to help manage (your/your child's) health care condition, social or lifestyle needs.

    (1) Not at all helpful
    (2) Slightly helpful
    (3) Moderately helpful
    (4) Very helpful
    (5) Extremely helpful

5. Did the Care Manager offer to send you any written materials?

    Yes/No

    - If yes, how helpful were the written materials in helping you to understand and manage (your/your child's) health condition?

        (1) Not at all helpful
        (2) Slightly helpful
        (3) Moderately helpful
        (4) Very helpful
        (5) Extremely helpful

6. Do you feel that (your/your child's) cultural and language needs are recognized and addressed by (your/your child's) Care Manager?

    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often
    (5) Always

7. How much do you agree with the statement, "The Care Manager treated me with courtesy and respect"?

    (1) Completely disagree
    (2) Somewhat disagree
    (3) Neither agree nor disagree
    (4) Somewhat agree
    (5) Completely agree

8. How much do you agree with the statement, “The Care Management Program helped (you/your child) reach your health goals”?

    (1) Completely disagree
    (2) Somewhat disagree
    (3) Neither agree nor disagree
    (4) Somewhat agree
    (5) Completely agree

9. How would you rate your overall satisfaction with (your/your child's) assigned Care Manager?

    (1) Not at all satisfied
    (2) Slightly satisfied
    (3) Moderately satisfied
    (4) Very satisfied
    (5) Completely satisfied

10. How satisfied are you with the overall quality of the Care Management Services/Program?

    (1) Not at all satisfied
    (2) Slightly satisfied
    (3) Moderately satisfied
    (4) Very satisfied
    (5) Completely satisfied

11. How likely is it that you would recommend the program?

    (1) Not at all likely
    (2) Slightly likely
    (3) Moderately likely
    (4) Very likely
    (5) Completely likely