Caseload and Documentation

Sunshine Health

Child Welfare Specialty Plan

Community Based Care
Integrated Health

sunshine health

Introduction

- Sunshine Health contracts with CBCIH to provide care coordination services to CWSP members through the network of CBC Lead Agencies across the state.
  - Nurse Care Coordinators (NCCs)
  - Behavioral Health Care Coordinators (BHCCs)

- Healthcare Management Functions (HMF)
  - Contract—Exhibit A, Scope of Services
  - Care Coordination Activities

- Standards for the provision and documentation of Care Coordination services were developed jointly by CBCIH and Sunshine Health

Healthcare Management Functions

- The Healthcare Management Functions (HMF) define all potential activities that may be provided to, or on behalf of, a member.
- They include activities related to:
  - Enrollment
  - Communication/Training
  - Care Coordination
  - Utilization Management
  - Pharmacy
  - Quality Improvement
  - Network Management

Focus: Care Coordination Activities
Which members (i.e., population) require certain activities, documented when (i.e., frequency) and for how long (i.e., duration)

HMF Documentation Standards - Care Coordination

Standards	Applicable Caseload Variable
• CBCIH shall coordinate, collect, and submit initial Sunshine Health's Health Risk Assessments.	HRA Due 30 Days (PH)
• CBCs educate caregivers and Dependency Case Managers. • CBCs identify/timely refer members needing referrals and provide referral or appointment assistance.	New Member Outreach (PH); Well-Care Visit Appointment Outreach (PH)
• CBCs assess members' and caregivers' needs/skills. • CBCs assist DCM/caregiver with member access to benefits.	ECC/Medically Fragile (PH); ER Admit Last 30 Days (PH); HEDIS 30 Days (PH); HP Case Mgmt (BH); HP Case Mgmt (PH); IDD (BH); IL Transition Planning (BH); IP Last 60 Days (BH); IP Last 60 Days (PH); Medical Foster Care (PH); MDT/CSS Last 90 Days (BH); New Member Outreach (PH); Pregnant (PH); Psych Meds Last 30 (BH); Sentinel Event Last 30 Days Follow-Up (BH); Well-Care Visit Appointment Outreach (PH)
• CBCs participate in discharge planning for members. • CBCs follow up post-discharge with members/caregivers.	ER Admit Last 30 Days (PH); IP Last 60 Days (BH); IP Last 60 Days (PH); MDT/CSS Last 90 Days (BH)
• CBCs follow up post ED visit for access to services/benefits.	ER Admit Last 30 Days (PH)
• CBCs collaborate as required with ECC/MFC members.	ECC/Medically Fragile (PH); Medical Foster Care (PH)
• CBCs send transition plans and collaborate with Sunshine Health.	IL Transition Planning (BH)
• CBCs notify SH of pregnancies and facilitate pregnancy care.	Pregnant (PH)
• CBCs participate on ICTs/HLOC MDTs/CTTTMs and follow up.	Medical Foster Care (PH); MDT/CSS Last 90 Days (BH)

Caseload Variables

- Determined by CBCIH and identify members who may require care coordination services. Some examples of caseload variables include members who have been hospitalized, those who receive or need specialized placement, and those who are pregnant.
- Developed using data and information provided by the Health Plan to identify members in need of care coordination
  - Nurse Care Coordinators and Behavioral Health Care Coordinators provide services and document the activities within Integrate®
  - Reports are generated to ensure documentation and provision of Care Coordination activities and included as Key Performance Indicators (KPI)
- Caseloads are generated and locked at the beginning of each month.
- The caseload does not preclude the provision of necessary Care Coordination services to any member in need, including those who are not specifically identified on the caseload.
- Documentation of Care Coordination activities is monitored by CBCIH during quarterly monitoring activities and monthly KPI reports.

Caseload Variables – Integrate® CASES App

Behavioral Health

- HP Case Mgmt (BH)
- IDD (BH)
- IL Transition Planning (BH)
- IP Last 60 Days (BH)*
- MDT/CSS Last 90 Days (BH)
- Psych Meds Last 30 (BH)
- Sentinel Event Last 30 Days Follow-Up (BH)

Physical Health

- ECC/Medically Fragile (PH)
- ER Admit Last 30 Days (PH)*
- HEDIS 30 Days (PH)
- HP Case Mgmt (PH)
- HRA Due 30 Days (PH)
- IP Last 60 Days (PH)*
- Medical Foster Care (PH)
- New Member Outreach (PH)
- Pregnant (PH)
- Well-Care Visit Appointment Outreach (PH)

*Other associated activities completed upon notification of an admission are prompted by Alerts. See Alert Variables for examples and corresponding Workflows on Integrate®.

Care Coordination Activities & Caseload Variables

Examples of medical and behavioral health indicators and the corresponding Care Coordination Activities are provided on the following slides. They do not reflect all of the activities that Care Coordinators may provide to, or on behalf of, CWSP members.

Care Coordination Activities

IP Admit Last 60 Days (BH)*

- Review of inpatient admission /readmission notification information
- Participation in discharge planning, including identification of appropriate referrals and scheduling and maintaining 7-Day Follow-Up Appointment
- Review of care gaps and coordination of post-discharge services and timeliness of appointments
- Participation in follow-up staffings and coordination of Higher Level of Care Multidisciplinary Team (HLOC MDT) staffing, if needed
- Timely response to Sunshine Health regarding the 7-Day Follow-Up appointment and specific plan of action to prevent a readmission
- Identification and assistance in resolving any barriers to accessing services
- Caregiver/member/DCM education on symptoms and resources/supports

*Other associated activities completed upon notification of an admission are prompted by Alerts. See Alert Variables for examples and corresponding Workflows.

Care Coordination Activities
MDT/CSS Last 90 Days (BH)

- Facilitation of HLOC MDT with all appropriate parties prior to placement in STFC Level I, Level II, TGC, SIPP, OOS Residential Treatment and Substance Abuse Inpatient Residential as needed or, at minimum, every 90 days
  - Identification of behavioral health needs and appropriate services of children with complex needs and/or those who have been identified as in need of specialized services
  - Ongoing assessment of the treatment needs
  - Coordination of therapeutic and support services, discharge planning, and resolution of any barriers identified for children with complex needs and/or those who have been identified as in need of specialized services

Care Coordination Activities

Psych Meds Last 30 (BH)

- Assistance in obtaining psychotropic medication
- Coordination of follow-up appointments and assistance with barriers
- Education of caregiver/member/DCM regarding medication, importance of medication monitoring appointments, and offer resources from Krames Health Library
- Refer members who may need behavioral health case management

IL Transition Planning (BH)

- Participate in meetings/staffings and communicate notice to Sunshine Health
- Provide assistance and resolution of barrier to accessing services for youth transitioning from the child welfare system
- Provide information related to transition plan to Sunshine Health

Care Coordination Activities

Sentinel Event Last 30 Days Follow-Up (BH)

- Assessment of health care needs
- Refer members who may need behavioral health case management
- Education of caregiver/member/DCM regarding benefits, including self-help and after-hours resources, and offer resources from Krames Health Library

IDD (BH)

- Coordination of referrals to services
- Assistance with placement stability
- Educate caregiver/member/DCM regarding resources and plan benefits

Care Coordination Activities

HP Case Management (BH) & (PH)

- Assessment of enrollee's needs
- Coordination of behavioral health services
- Collaboration with Sunshine Health Case Management team

New Member Outreach (PH)

- Review of HRA
- Educate caregiver/member/DCM regarding resources and plan benefits
- Review medical records, health histories, etc. and share with appropriate parties
- Assessment of enrollee's needs, including assistance with PCP assignment, completion of well care visit appointments

Care Coordination Activities

Medical Foster Care (PH)

- Participate in MFC calls and CMAT staffings
- Review MFC Plan of Care and distribute to appropriate parties
- Outreach to caregiver(s), DCM, Sunshine Health, and providers
- Review medical records, health histories, etc. and share with appropriate parties
- Review care gaps and provide updates on appointments/services
- Educate caregiver/member/DCM regarding resources and plan benefits

ECC/Medically Fragile (PH)

- Participate in calls and staffings
- Review medical records
- Outreach to caregiver(s), DCM, Sunshine Health, and providers
- Review care gaps and provide updates on appointments/services
- Educate caregiver/member/DCM regarding resources and plan benefits

Care Coordination Activities

Pregnant (PH)

- Participate in calls and staffings
- Coordinate completion of Notice of Pregnancy form
- Request and review records, send to CBCIH Compliance and upload into IMV
- Review care gaps and provide updates on appointments/services
- Outreach to caregiver(s), DCM, Sunshine Health, and providers
- Provide education and support to caregiver/member/DCM regarding resources and plan benefits, including birth control options
- Facilitate referrals to community resources

HEDIS 30 days (PH)

- Review care gaps and information in Sunshine Provider Portal, IMV, and FL SHOTS
- Provide outreach regarding appointments/services
- Educate caregiver/member/DCM regarding health and wellness guidelines, immunization schedules, and plan benefits

Care Coordination Activities

ER Admit Last 30 Days (PH)* & IP Admit Last 60 Days (PH) *

- Confirm follow-up with PCP
- Assess status of specialty referrals, when indicated
- Review medication/treatment compliance, when indicated
- Refer to Sunshine Health case management if chronic condition management is needed
- Review claims since admission

*Other associated activities completed upon notification of an admission are prompted by Alerts. See Alert Variables for examples and corresponding Workflows on Integrate®.

Well-Care Visit Appointment Outreach (PH)

- Provide outreach to assist with scheduling annual well-visit appointments
- Educate caregiver/member/DCM regarding health and wellness guidelines, immunization schedules, and plan benefits

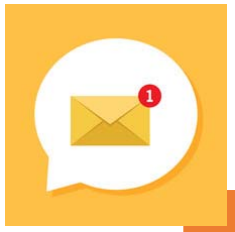
Alert Variables

- CBCIH generates alerts to notify Care Coordinators of potentially important information that should be reviewed and assessed for necessary Care Coordination actions.

- Alerts that are received by Care Coordinators are typically related to a particular event or circumstance and should be acknowledged by entering a Note in the IMV Application within Integrate®.

- Documentation of alerts may also include reference to and/or the uploading of additional related information, such as emails from CBCIH and Sunshine Health.

NCC/BHCC Alerts



Alert Name	NCC	BHCC
New Case Management	x	x
New Emergency Room Admission or Discharge	x	
New Inpatient Admission	x	x
HRA Alerts	x	x

NCC/BHCC Alert Activities
ER Admission/IP Admission

- Outreach to caregiver/member/DCM to complete assessment of needs
- Provide education regarding follow-up with PCP or community provider
- Review discharge plans/orders, including specialty referrals
- Coordinate services, including appointments, medication, DME, referral to community resources, or other indicated needs
- Assess potential barriers and provide resources, including Krames Knowledge Library, expanded benefits, appropriate use of emergency room and emergency resources (911, 24-hour Nurse Advice Line, 988, 24-hour Behavioral Health Crisis Line, urgent care), and Sunshine Health Community Resource Database
- Make referral to Sunshine Health Case Management if chronic condition management is indicated

Evaluation and Monitoring

Quantitative measurement indicates completion of IMV notes entered for each member meeting criteria for a Caseload Variable and placed the Caseload.

Qualitative measurement includes a sample review of IMV notes to assess that Care Coordination activities are aligned with HMF, and expected activities related to Caseload and Alert Variables.

CBC Lead Agency performance will be reflected in quarterly monitoring reports and monthly Key Performance Indicator reports.

Frequently Asked Questions

What type of documentation is required if there are no current needs that are identified for a member who meets a Caseload Variable?

- Monthly documentation of Care Coordination activities for members who meet a Caseload Variable may include an assessment of needs, a review of records and information, education and/or other discussion with related parties, etc.

Are other CBC Lead Agency and/or subcontractor staff involved in providing Care Coordination activities able to enter documentation into Integrate?

- Yes, anyone associated with the case who has access to Integrate may document activities provided to, or on behalf of, a member. However, NCCs and BHCCs should be aware of the activities and the members' needs to provide oversight related to Care Coordination. NCC and BHCC activities must also be documented.

Frequently Asked Questions

Are all members eligible to be placed on a Caseload due to the associated variables?

- Yes, all CWSP members are eligible to be placed on a Caseload based upon the variables.
- CWSP Member Definition: a child who is Medicaid eligible and is enrolled in the Sunshine Health, Child Welfare Specialty Plan

Will Care Coordinators be able to generate a report for their agency's Caseload and will it reflect how many notes they have entered for that month?

- Yes. The Cases application allows Care Coordinators to generate a report for their CBC Lead Agency, including the NCC Caseload, the BHCC Caseload, or a combination of both, and it will identify any notes that have been entered. Other CBC Lead Agency staff and subcontractors will not have specific reports but can assist with activities related to an NCC or BHCC Caseload.

How are members removed from the Caseload?

- Members will no longer be reflected on a Caseload once they no longer meet the variable criteria.

Contact Information

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