Humana Healthy Horizons in Louisiana Provider DOJ CCM Quality Monitoring Tool Elements

Humana
Healthy Horizons®
in Louisiana

LAHLYXYEN0523

Humana Healthy Horizons in Louisiana is a Medicaid product of Humana Benefit plan of Louisiana, Inc.

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General requirements

Meet requirements **Not meet requirements**

The record is accurate and clearly legible to someone other than the writer.	
ENTIRE record is accurate and clearly legible.	ENTIRE record is accurate and clearly legible.

Each page of record identifies the member.	
ALL pages within the record identifies the member.	Not all of the pages within the record identifies the member.

All entries in the record include the name of the person making the entry.	
ALL entries include name of person making entry.	Not ALL entries include name of person making entry.

All entries in the record include the name of the person making the entry's professional degree and their relevant identification number, if applicable.	
All entries in the record include the name of the person making the entry's professional degree* and their relevant identification number, if applicable. *Professional degree can include graduate and undergraduate professional degrees such as B.A., B.S., M.S., M.A., Ph.D., APRN, etc.	NOT All entries in the record include the name of the person making the entry's professional degree and their relevant identification number, if applicable.
N/A: If the person making the entry has no professional degree or relevant ID number.	

All entries in the record include date where appropriate.	
ALL record entries include date.	Not all record entries include date.

All entries in the record include signature (including electronic signature for EMR systems) where appropriate.	
ALL record entries include signature including electronic signatures.	Not all record entries include signature.

Each record includes member's address.	
 Record contains member's FULL mailing address or documentation of why not **E.g.,** Jane Doe 123 Alphabet St, Lafayette, LA 70508. Member Homeless.	 Record does NOT contain member's FULL mailing address and NO documentation of why not.

Each record includes emergency contact information.	
 Record includes emergency contact information OR documentation why not. **E.g.,** Jane Doe reports having no living relatives and no support system. Jane Doe refuses to provide emergency contacts.	 Record does NOT include emergency contact information. No documentation why not.

Each record includes date of birth.	
 Record includes full date of birth of member.	 Record does not include full date of birth.

Each record includes gender.	
 Record includes either biological gender or self-identified gender OR there is documentation as to why not. **E.g.,** Member refused to identify as specific gender. Member refused to disclose identified gender.	 Record does NOT include gender whether biological or self-identified without documentation.

Each record includes relationship and/or legal status.	
 Record includes relationship and/or legal status of member OR there is documentation as to why not. Relationship status = married, single, divorce, etc. Legal status=under custodial care of, power of attorney, curator, judicial commitment, etc.	 Record does NOT include relationship and/or legal status. No documentation as to why not.

Each member has a separate record.	
 Evidence of one member per record.	 Evidence of multiples members' information being kept in one record.

For telemedicine/telehealth services, there is evidence in the record of verification of recipient's identity.	
Evidence in the record of verification of recipient's identity.	NO evidence in the record of verification of recipient identity.
N/A: No telemedicine/telehealth services provided	

For telemedicine/telehealth services, when possible (i.e., at the next in person treatment planning meeting), providers must have the recipients sign all documents that had verbal agreements previously documented.	
Evidence of all documents with verbal agreements previously documented are signed within record.	NO evidence of documents with verbal agreements previously documented signed in the record.
N/A: No telemedicine/telehealth services provided	

Member rights

- There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.
- Evidence the CCM Agency has inquired about and/or received any documentation related to a member's advanced directive.
- If utilizing telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services.
- If utilizing telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks, if applicable.
- If utilizing telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth, including privacy related risks, if applicable.

Needs assessment

- A needs assessment is in the record.
- Evidence that the referral from OBH and/or the MCO is in the record.
- For diverted members, a needs assessment is completed within four (4) business days of referral.
- A needs reassessment is completed every ninety (90) days or whenever the condition, needs or risk level of the member change using an LDH-approved assessment tool(s), if applicable.
- For members transitioning from a nursing facility, the needs assessment is conducted by the LDH transition coordinator.
- The initial needs assessment of member's needs identifies the need for **medical services** and supports to meet the daily needs and preferences of members.
- The periodic needs reassessments of member's needs identify the need for **medical services** and supports to meet the daily needs and preferences of members.
- The initial needs assessment of member's needs identifies the need for **behavioral health** services and supports to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **behavioral health** services and supports to meet the daily needs and preferences of members.
- The initial needs assessment of member's needs identifies the need for **health care services and adaptive equipment services** and supports to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **health care services and adaptive equipment services** and supports to meet the daily needs and preferences of members.
- The initial needs assessment of member's needs identifies the need for **social/recreational services** and supports to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **social/recreational services** and supports to meet the daily needs and preferences of members.
- The initial needs assessment of member's needs identifies the need for **educational/vocational services** and supports to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **educational/vocational services** and supports to meet the daily needs and preferences of members.
- The initial needs assessment of member's needs identifies the need for **housing and housing supports services** and supports to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **housing and housing supports services** and supports to meet the daily needs and preferences of members.

- The initial needs assessment of member's needs identifies the need for **transportation services and supports** to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **transportation services and supports** to meet the daily needs and preferences of members.
- The initial needs assessment of member's needs identifies the need for **nutrition services and supports** to meet the daily needs and preferences of members.
- The periodic reassessments of member's needs identify the need for **nutrition services and supports** to meet the daily needs and preferences of members.
- The need assessment includes input from the **member/legal representative**.
- The need assessment includes inputs from **family/natural supports** who are identified by the member prior to assessment.
- The need assessment includes inputs from **medical providers** who are identified by the member prior to assessment.
- The need assessment includes input from the **behavioral health providers** (including peers) who are identified by the member prior to assessment.
- The need assessment includes input from **others important to the member** who are identified by the member prior to assessment, if applicable.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **functional status** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **co-morbidities** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **recovery environment** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to f**amily and/or natural support system** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **purpose and productivity** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **housing preferences** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **community inclusion and engagement** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.

- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **risk of harm** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **treatment and recovery history** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.
- Evidence that the need assessment has information from the member to identify gaps in care pertaining to **crisis and relapse triggers** to proactively address such gaps in care to reduce risk of readmission or other negative outcomes.

Person-centered plan of care development

- The person-centered plan of care is in the record.
- Person-Centered Plan of care is signed by the member and/or member's guardian/legal representative.
- Person-centered plan of care is dated.
- The person-centered plan of care reflects the member's needs as identified in the assessment process.
- The person-centered plan of care reflects the member's strengths as identified in the assessment process.
- The person-centered plan of care reflects the member's preferences as identified in the assessment process.
- The person-centered plan of care reflects the member's choices as identified in the assessment process.
- The person-centered plan of care reflects the member's goals as identified in the assessment process.
- The development of a plan of care shall include family, if applicable.
- The development of a plan of care shall include natural supports, if applicable.
- The development of a plan of care shall include providers, if applicable.
- Evidence the community case manager provided timely notice (at least 7 days prior to the proposed meeting date) of planning meetings to all individuals the member identifies and requests to be a part of the planning process
  Note: Community case managers may engage providers via telehealth modalities for the development of the plan of care/planning meetings.

- At a minimum, the person-centered plan of care shall include member's goals.
- At a minimum, the person-centered plan of care shall include member's desired outcomes (as stated in the member's own words).
- At a minimum, the person-centered plan of care shall include services and supports to achieve these goals and meet member's needs (formal and informal). This should include medical, behavioral health, housing, social, educational/vocational and other services requested by the member or identified as part of the assessment or planning process.
- At a minimum, the person-centered plan of care shall include name of service provided.
- At a minimum, the person-centered plan of care shall include unit of service provided.
- At a minimum, the person-centered plan of care shall include duration of service provided.
- At a minimum, the person-centered plan of care shall include frequency of service provided.
- At a minimum, the person-centered plan of care shall include service providers.
- At a minimum, the person-centered plan of care shall include strategies to address identified barriers (strategies to address Unmet needs).
- At a minimum, the person-centered plan of care shall include crisis resources to prevent unnecessary hospitalization or institutionalization in accordance with member needs and preferences.
- At a minimum, the person-centered plan of care shall include an emergency contact.
- At a minimum, the person-centered plan of care shall include an identified shelter in place.
- At a minimum, the person-centered plan of care shall include an evacuation plan.
- At a minimum, the person-centered plan of care shall include documentation the member participated in the planning process and was offered freedom of choice of services and providers.
- For members transitioning from a nursing facility, the plan of care shall be developed within 14 days following the member's discharge from the nursing facility.
- For diverted members, the community case manager shall connect members with service providers to respond to urgent needs within 7 days following the referral.
- For diverted members, the plan of care was developed within 30 days following the referral.
- Plans of care shall be reviewed at least every 90 days to determine if changes are needed or when there is a significant change in the member's needs or change of circumstances, if applicable.
- At a minimum, plans of care shall be revised at least every 6 months, if applicable.
- Documentation within the record that the community case manager shall provide a copy of the plan of care to the member and his/her caregiver, if applicable.

Referral and linkage

- Evidence the community case manager ensured services and supports are coordinated between all agencies that provide services to the member, including the MCO.
- Evidence the community case manager exchanged relevant information with agencies or professionals to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care.
- For those members residing in a nursing facility, community case management activities begin at least 60 days prior to the member's discharge from the nursing facility, with an option to engage earlier if recommended by the LDH transition coordinator, in order to plan for an effective and successful transition to a community living setting.
- Evidence that the community case manager collaborated with the member/legal representative to develop a transition plan.
- Evidence that the community case manager collaborated with the LDH transition coordinator to develop a transition plan.
- Evidence that the community case manager collaborated with the MCO to develop a transition plan.
- The transition plan shows evidence that providers, resources, and supports in the community were secured to begin immediately upon the member's transition to the community.
- Evidence that the community case manager attended transition planning meetings with the transition coordinator.
- Evidence the community case manager attended transition planning meetings with the member/legal representative.
- Evidence at a minimum, the community case manager had at least four (4) face-to-face contacts in the 60-day period prior to the member's transition from the nursing facility.
- Evidence at a minimum, the community case manager had at least two (2) of the required four (4) face-to-face contacts occurring in the last 30 days prior to the member's transition from the nursing facility.
- For diverted members, community case management activities begin within 1 business day of referral from the MCO. Community Case management, at a minimum a phone contact, shall begin within 1 business day of referral from the MCO.

Monitoring and follow-up

- Ongoing contact is made with the member at least monthly or more frequently as indicated to monitor the member's needs.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to monitor the member's status.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to monitor the member's risk factors.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Member is receiving needed services, in accordance with the member's plan of care and assessed needs.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Individual preferences continue to be sufficiently reflected in current plan of care.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure the plan of care meets the member's changing needs.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Member is satisfied with services and providers (including health, behavioral health and other supports) rendering such services.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Member has good access to health care and pharmacies for prescription drugs.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Member does not feel isolated.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure current living setting is safe, stable and healthy.
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure whether the member is satisfied with the current living arrangement or is interested in changing such arrangements
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Immediate issues are resolved before they impair the members' ability to function or maintain in the community (e.g., housing eviction).
- Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Member health and welfare in the community.

CCM monitoring form

- Evidence the contact's name was documented. If not member, reason documented why member was not available.
- If contact not member, reason documented why member was not available.
- Evidence the contact date was documented.
- Evidence the contact method was identified.
- For telemedicine/telehealth services, there is evidence in the record the member was informed of all persons who are present.
- For telemedicine/telehealth services, there is evidence in the record the member was informed of the role of each person.
- For telemedicine/telehealth services, documentation if recipient refused services delivered through telehealth.
- Evidence the type of contact was identified: successful vs unsuccessful.
- Evidence eligibility verification was documented.
- Evidence the review of benefits was documented.
- Evidence any changes in living situation were documented and why changes occurred, if applicable
- Evidence any problems with the current living situation were documented, if applicable.
- Evidence any changes in non-paid caregivers (e.g., family and friends) were documented and why, if applicable.
- Evidence any crisis services were documented and why, if applicable.
- Evidence any ER visits were documented and why, if applicable.
- Evidence any hospitalizations were documented and why, if applicable.
- Evidence the last appointment date with psychiatrist/BH prescriber was documented.
- Evidence the next appointment date with psychiatrist/BH prescriber was documented.
- Evidence the last appointment date with PCP was documented.
- Evidence the next appointment date with PCP was documented.
- Evidence medication was reviewed with member, if applicable.
- Evidence a medication reconciliation was completed, if applicable.
- Evidence any problems with filling or taking medications was documented and why, if applicable.
- Evidence the member was asked if they have experienced any changes in their physical or mental health.

- Evidence the member was asked if they have changed any providers and if yes, documented reasons for change.
- Evidence the member was asked if they needed any new or additional services and if yes what services are needed is documented.
- Evidence the member was asked if they have any issues with acquiring food/meals were documented.
- Evidence the member was asked if they have any issues with personal care or acquiring personal care products were documented
- Evidence the member was asked if they have any issues with SSI/SSDI were documented.
- Evidence the member was asked if they are able to make decisions about what they do with their time each day and when.
- Evidence the member was asked if they are able to do activities they want outside of their home.
- Evidence progress and/or lack of progress towards goals was documented.
- Evidence current care alerts were documented.
- Evidence identified barriers were documented.
- Evidence CCM action items to address problems/barriers were documented.
- Evidence any modifications to case acuity/frequency/case name/case type were documented.
- Evidence a crisis plan was reviewed/updated with the member.

Cultural competency

- Primary language spoken by the member is documented.
- Any translation needs of the member are documented, if applicable.
- Language needs of the member were assessed (e.g., preferred method of communication), if applicable.
- Identified language needs of the member were incorporated into services, if applicable.
- Religious/spiritual needs of the member were assessed.
- Identified religious/spiritual needs of the member were incorporated into services, if applicable.
- Ethnic needs of the member were assessed.
- Identified ethnic needs of the member were incorporated into services, if applicable.

Adverse incidents

- Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency **immediately upon discovery**.
- Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.
- Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery. **https://ldh.la.gov/index.cfm/page/2454**

Telehealth notes

The following is a list of the HIPAA-Compliant forms of video communication technology:

1. Apple Face Time
2. Facebook Messenger Video Chat
3. Google Hangouts Video
4. Zoom
5. Skype
6. Simple Practice

The following is a list of Business Associate Agreements (BAAs):

1. Skype for business/Microsoft Teams
2. Updox
3. VSee
4. Zoom for Healthcare
5. Doxy.me [doxy.me]
6. Google G Suite Hangouts Meet
7. Cisco Webex Meetings/Webex Teams
8. Amazon Chime
9. Go To Meeting
10. Spruce Health Care Messenger

This information is found in Informational Bulletin 20-5 (Revised November 24, 2020)