Comprehensive Assessment and *Care Management Plan* review tool data dictionary for providers

California | Medi-Cal Managed Care

The *Comprehensive Assessment* is designed to gather data reflecting the **whole person**, and the *Care Management Plan* is developed based upon the needs identified by the comprehensive assessment of the member. The following data dictionary is provided to help the lead care manager (LCM) identify the necessary data that is expected to be found in the *Comprehensive Assessment* and *Care Management Plan* during the assessment and care planning process with the member.

Providers are expected to submit the completed *Comprehensive Assessments* and *Care Management Plans* to Anthem Blue Cross (Anthem) within 90 days of the member's enrollment in ECM. These *Comprehensive Assessments* and *Care Management Plans* are selectively reviewed by Anthem's Clinical team nurse liaisons implementing a standardized review tool (the review tool measures as set of criteria from which is scored as *Met, Partially met, Not met,* or *Not applicable [N/A])*. The following definitions outline the documentation needed in the *Comprehensive Assessments* and *Care Management Plans* in order to fulfill scoring requirements as *Met*. This data dictionary includes the criteria being scored during a review along with definitions.

Program measure	Documentation requirement
Eligibility/program requirements	
Opt-in to ECM date	Criteria is met if the date the member opted-in to ECM is captured on the assessment or upon the care plan.
Population of Focus	Criteria is met if there is documentation of the Population of Focus under which the member meets ECM criteria.
Demographics/member specific information	
DOB	Criteria is met if there is documentation of the member's date of birth.
Gender identification	Criteria is met if there is documentation of member-identified gender identification.
Preferred name and/or pronouns	Criteria is met if there is documentation of member-identified preferred name and/or pronouns
Nationality/tribe/ethnicity	Criteria is met if there is documentation of member-identified nationality, tribe, or ethnicity.
Preferred language (spoken/written)	Criteria is met if there is documentation of the preferred spoken and written language.
Preferred method of contact	Criteria is met if there is documentation of the member-identified methods of communication. Member-centered care allows the member to choose their preferred method(s) of communication with the care management team. For example, reported preference to receive mail, email address, the primary and secondary phone numbers the member approved for contact.

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Program measure	Documentation requirement
Emergency contact, relationship and phone	Criteria is met if there is documentation of the emergency contact, relationship, and phone.
Primary care clinic/provider and telephone number	Criteria is met if there is documentation of the PCP, including the clinic name with telephone number and address (if available).
Culture	Criteria is met if there is documentation (as appropriate) of the member's culture impacting their health and wellness including: • Cultural beliefs, religious and/or spiritual beliefs.
Health literacy	Criteria is met if there is documentation (as appropriate) of the member's or caregiver's ability to: • Understand medical problems. • Fill out medical forms. • Follow instructions for taking medications.
Physical aspects of health	Criteria is met if there is documentation (as appropriate) of the physical health of the member in the following areas: • Allergies/reactions • Current (acute/chronic) medical conditions/treatments • Past (inactive) medical conditions/treatments Current medical providers and specialists, and contact numbers • Ongoing medications, including dosage, route, and frequency • Vaccinations • Tuberculosis history • Last dental visit
Vision and hearing	Criteria is met if there is documentation (as appropriate) of the member's status with: • Vision. • Hearing.
Medications	Criteria is met if there is documentation of an initial medication review. (Created a list of current medications including): • Drug name. • Drug dose. • Drug route. • Drug time of administration. • Drug purpose or reason prescribed. • Drug prescriber (name and contact info).
Pain management	Criteria is met if there is documentation of the pain experience and interventions: • Pain experience • Pain interference in activities of daily living (0 to 10) • Pain management specialist care, provider, and last visit • Impacted condition or body part and treatment response

Program measure	Documentation requirement
Activities of daily living	Criteria is met if there is documentation (as appropriate) of the member's ability to independently: • Walk • Feed themselves • Dress and groom • Toilet • Bathing • Transfer • Use assistive or adaptive devices • Concern by family or friends about ability to care for self
Instrumental activities of daily living	Criteria is met if there is documentation (as appropriate) of the member's ability to independently: • Manage finances • Manage transportation • Shop and prepare meals • Houseclean and complete home maintenance • Manage communication • Manage medications
Behavioral health	Criteria is met if there is documentation (as appropriate) of the health status of the member in the following areas, such as: • Depression (PHQ- 2 plus question 9) • Anxiety • Trauma and stress • Cognitive functioning • Developmental factors • Any other mental health history
Substance use disorder aspects of health	Criteria is met if there is documentation (as appropriate) of the member's experience with recreational substance use or misuse of prescribed medications, such as: • Dosage and frequency of substance(s) used • Information about last use • Referrals needed for counseling
Housing	Criteria is met if there is documentation (as appropriate) of the member's access to shelter and the stability of that access, including: • Location of housing. • Concern about losing housing. • Assistance with housing. • Safety of housing environment.
Safety	Criteria is met if there is documentation (as appropriate) of the member's expressing concerns related to the following: • Physical and emotional safety. • Using residence without permission. • Someone using their money without permission.

Program measure	Documentation requirement
Food security	Criteria is met if there is documentation (as appropriate) of the member's access to food resources including: • Enough food. • Frequency of hunger. • Amount of food.
Social connection/support	Criteria is met if there is documentation (as appropriate) of the members social connections or forms of support.
Family member/individual supports Caregiver resources and involvement	Criteria is met if there is documentation (as appropriate) of the member's caregiver resources, including: • Caregiver assistance. • In-home supportive services program enrollment and the number of hours. • Name of the person providing care.
Benefits and other services	Criteria is met if there is documentation of the member's status in the following areas, such as: • Government benefit programs • Employment status Health-related services
Legal involvement	Criteria is met if there is documentation of the member's reporting any active matters in the following areas, such as: • Court ordered services • APS or CPS
Life/End of life planning	Criteria is met if there is documentation (as appropriate) of the member's life planning including: • Advanced planning in place. • Ways to improve health. • Priorities and goals for the next year. • Barriers to implementation of plan.
Member priorities	Criteria is met if there is documentation (as appropriate) of the member's life planning including: • Member concerns about overall health. • Member chosen first steps to improve health. • Member chosen first steps to work on in ECM.

Program measure	Documentation requirement
Narrative summary	Criteria is met if there is documentation (as appropriate) of the pertinent information regarding the member's status in physical health, behavioral health, substance use history, and social determinants of health issues that are important to the member. These member-identified priorities and/or problems are then used to develop the goals as part of the action plan. For example: The summary also includes initial plans of follow up with the member (proposed frequency or timeframe) to address these needs (while building rapport identifying areas of resilience and increasing ability to self-manage). Being patient-centered also includes reference to the members agreement to the plan. For example: This is a 52-year-old female under PoF_____ (*identifies member eligibility for the program*). Completed initial assessment with the member and identified areas to support the member_____ (*list needs identified in the assessment*). Developed an action plan with the member prioritizing these goals of_____ care (*list 2-3 goals, *include any referrals generated – with details of who, where, when and why*). Will continue to meet with the member to build rapport and to learn more about member's SDOH and ability to self- manage (*understanding of health condition, definition of success, motivation/readiness to change, social environment, coping skills.(list out the elements from the audit that are missing- including plans for health promotion/education*). Based upon member needs (*person-centric*), will schedule calls/meetings on a bi-weekly basis to start (*tiering - Risk Stratification*), transitioning to once a month as we complete goals and member reports greater confidence and self-efficacy in managing their health. At next meeting, will meet with the member to discuss (*can list goals and specific interventions*) on/in_(*list a time period or a specific date -recommend a time period that way you have some flexibility in schedule, for example, in two weeks vs on a specific date*). Reviewed plan with the member. Member agreed to plan (*person-centered*).

Care management plan

When the CMPs are reviewed by the Anthem clinical team we look for these elements:
1. Development of the Care management plan is based upon discussions with the member to determine what the member-focused priorities are. The LCM will also take into consideration any gaps or problems identified during the assessment process.
2. Identify the root issue/problem to be addressed with the member
3. Formulate this information into a goal(s) that are SMART (specific, measurable, achievable, realistic, and time-specific) and
4. List a series of actions or interventions created to address these issues, aiming to achieve positive improvement/resolution to that that issue.*

*Note – Actions/Interventions created to meet a goal should be what you can do 'for the member', 'with the member', and should also include member-centric interventions which the 'member can do for themselves' (self- management). Interventions associated with a goal should have a positive impact on meeting that goal (be directly related to the goal). If some interventions listed in the CMP do not relate to the member goals or if there are minimal interventions listed (or missed opportunities to meet that goal not noted) overall interventions may be marked as *Partially met*.

Eligibility/program requirements	
Established member goals	Criteria is met if there is documentation (as appropriate) of the member's chosen goals based on the problems identified, including priority or urgency assigned to each goal by the member. Goals shall be written in the SMART (specific, measurable, achievable, relevant, and timely) format.
Interventions/action steps	Criteria is met if there is documentation (as appropriate) of the planned interventions or actions that are being taken to accomplish this goal. (what you do for the member; with the member; what the member does for themselves-self-management).
Dates (initiated and/or completed)	Criteria is met if there is documentation (as appropriate) of the date the goal was initiated and the date the goal was completed, if applicable.
Identified strengths	Criteria is met if there is documentation (as appropriate) of the member's self-identified strengths (key reminder to be incorporated when providing services to the member to remind and reinforce during readiness to change talks).
Barriers	Criteria is met if there is documentation (as appropriate) of potential barriers that may prevent the accomplishment of the intervention/action step.

Documentation/reporting requirements:

- Time frame: Was the comprehensive assessment completed within 90 days of consent documented?
  - Assessment must be completed within 90 days of consent to CM services.
- Were reassessments documented if needed?
  - Reassessments of the member occur following a change in health status. Triggering events may include inpatient admissions, post-care conferences with the PCP, or other changes in the member's healthcare and support needs.

* Reminder — ECM providers need to send all *Comprehensive Assessments* and *Care Management Plans* to Anthem via the provider portal as soon as completed within 90 days of enrollment and every six months thereafter, unless there is a significant change in member status which would result in the *Comprehensive Assessment* and *Care Management Plan* being updated and submitted more frequently