SOMOS Your Health, LLC ("MSO")
Department Care Management
Internal Policy Number 101.7

Title

Care Management Systems

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of the Care Management Platform. The Director of Care Management will review and ensure compliance with all applicable state and federal laws and regulations. The policy will be reviewed and approved by the Quality Management (QM) Committee.

REVIEW AND APPROVAL HISTORY					
VERSION	**REVIEWED BY**	**REVIEW DATE**	**APPROVED BY**	**APPROVAL DATE**	**DESCRIPTION OF CHANGE**
1	**Quality Committee**	**Jan. 2024**	**Quality Committee**	**Jan. 2024**	

Contacts/Scope

This policy describes the SOMOS Care Management System which supports case management activities and monitors individualized care plans pursuant to NCQA Case Management Standard 4, Care Monitoring, Element A.

Glossary/Definitions

- **Chief Medical Officer:** The governance of the CMO is critical to the Care Management program's effectiveness. The CMO serves as a resource to determine the medical needs of the Member and clinical appropriateness of treatment based on established evidence-based clinical guidelines and standards.
- **Director of Care Management:** Provides oversight of the Case Management programs and services. Works with the CMO and Medical Directors to meet organization and department goals and develop and tracks measurable outcomes of department services.
- **Program Specific Assessment:** Screening tool to help identify and evaluate health risks and provide individual health promotion interventions.
- **Individualized Care Plan (ICP)/Individualized case management plan:** Plan of care developed by a member and/or a member's interdisciplinary care team or health plan that includes prioritized goals that considers the patient's and caregiver's goals, preferences to be utilized, including the appropriate level of care, planning for continuity of care including transition of care and transfer between settings and collaborative approaches to be used, including family participation.[1]

[1] NCQA CM 3, Element A

Procedures

To ensure that case management is provided according to best practice standards, SOMOS develops and implements written policies and procedures, consistent with best practices and complying with state and federal law as well as SOMOS's contractual obligations. The following procedure outlines the overall functionality of the Care Management System in support of case management activities and monitoring of individual care plans.

I. Evidence-based guidelines or algorithms to conduct assessment and management.

The SOMOS Diabetes Care Management program utilizes evidence-based guidelines for conducting patient assessments.

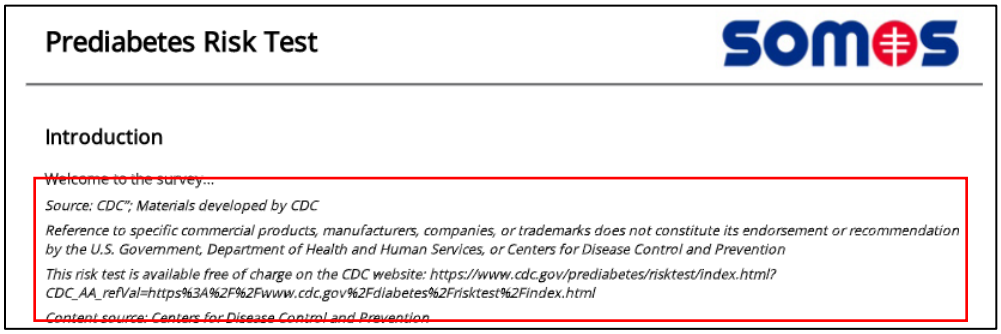
- *Diabetes Self-Care: Patient Report Assessment*


Diabetes Self Care: Patient Reported Assessment

Diabetes Self Care

Created by Health Catalyst Clinical Team with guidance from HTTPS://www.cdc.gov/diabetes/index.html

- *Prediabetes Risk Test*


Prediabetes Risk Test

Introduction

Welcome to the survey...

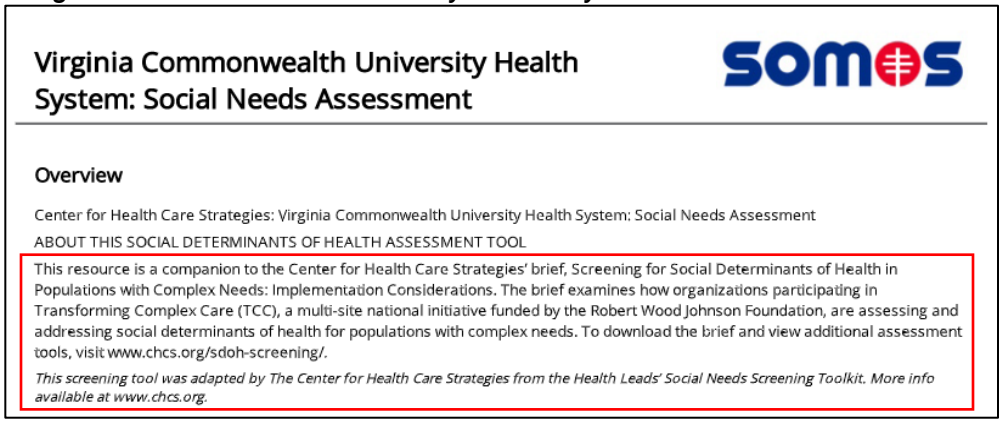
Source: CDC"; Materials developed by CDC

Reference to specific commercial products, manufacturers, companies, or trademarks does not constitute its endorsement or recommendation by the U.S. Government, Department of Health and Human Services, or Centers for Disease Control and Prevention

This risk test is available free of charge on the CDC website: https://www.cdc.gov/prediabetes/risktest/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Frisktest%2Findex.html

Content source: Centers for Disease Control and Prevention

- *Virginia Commonwealth University Health System: Social Needs Assessment*


Virginia Commonwealth University Health System: Social Needs Assessment

Overview

Center for Health Care Strategies: Virginia Commonwealth University Health System: Social Needs Assessment

ABOUT THIS SOCIAL DETERMINANTS OF HEALTH ASSESSMENT TOOL

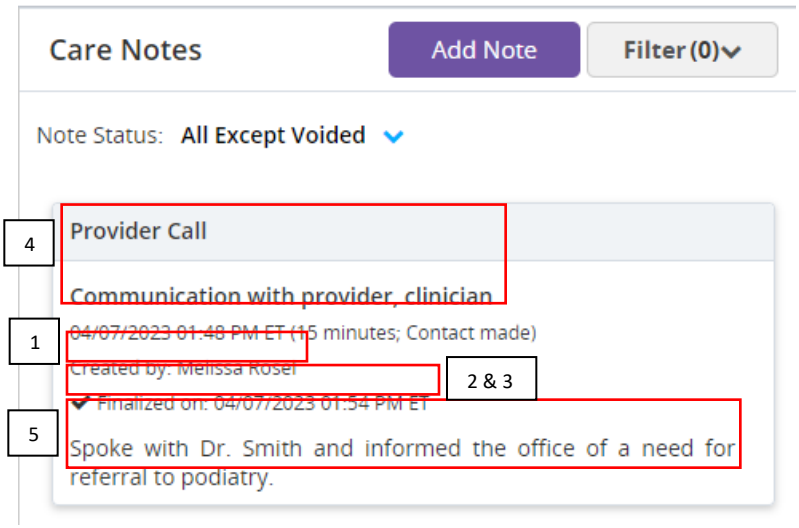
This resource is a companion to the Center for Health Care Strategies' brief, Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. The brief examines how organizations participating in Transforming Complex Care (TCC), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing social determinants of health for populations with complex needs. To download the brief and view additional assessment tools, visit www.chcs.org/sdoh-screening/.

This screening tool was adapted by The Center for Health Care Strategies from the Health Leads' Social Needs Screening Toolkit. More info available at www.chcs.org.

II. Automated documentation of entries within The Care Management System

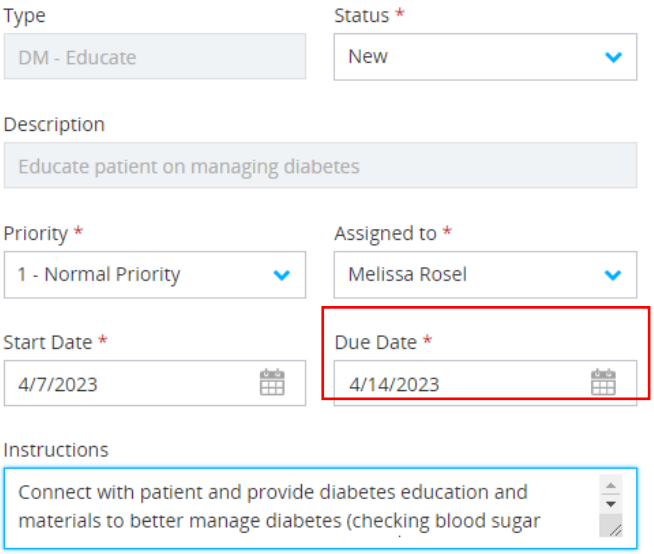
The Care Plan is generated by program specific assessment information, notes, and other points of data withing the record. Data captured in the entry include:

1. Name
2. Date (System auto populated)
3. Time (System auto populated)
4. Action type
5. Notes

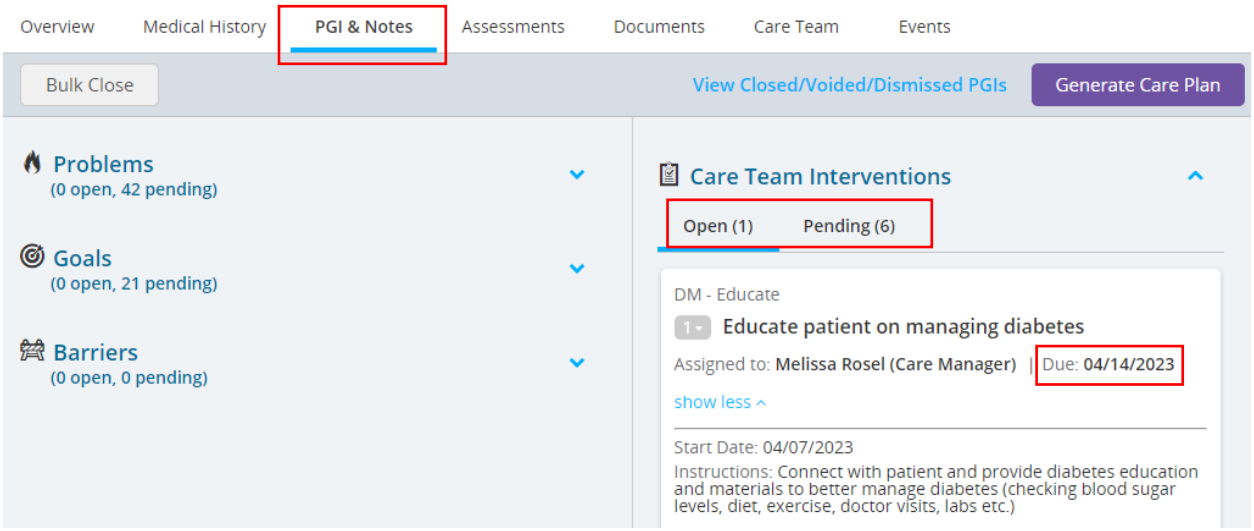


III. Automated prompts

The Care Management Platform allows users to set target due dates for problems, goals, interventions and patient activities.

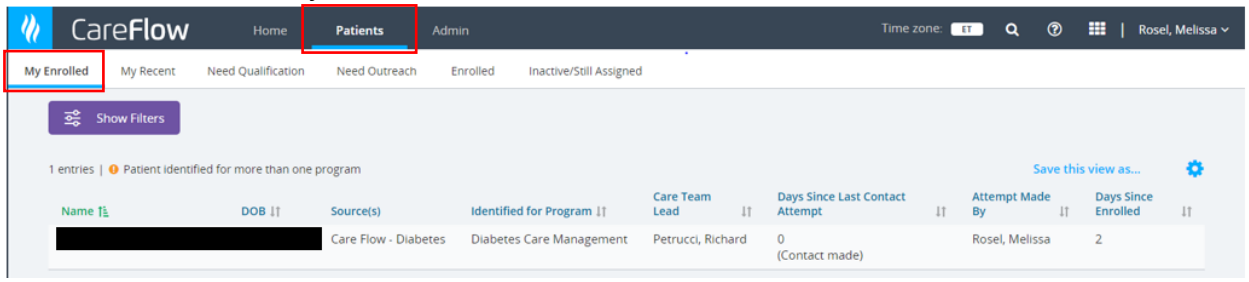


The user can access the available items and their due dates within the PGI & Notes dashboard. Users can also see what items are “open” or “pending” for each category within the PGI & Note dashboard.

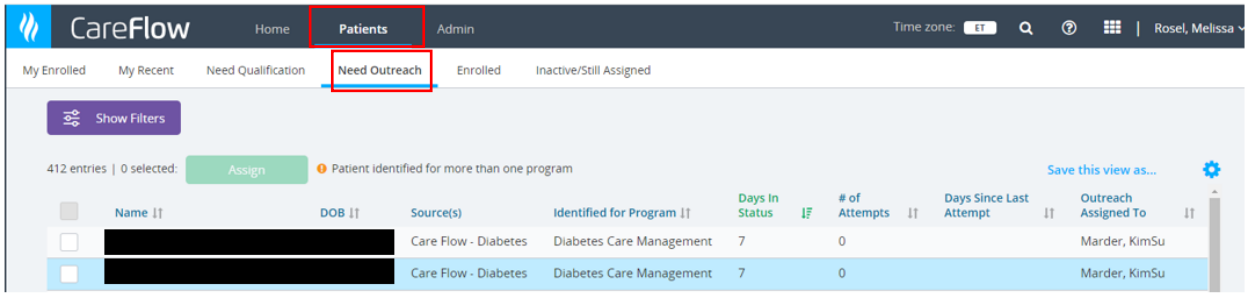


Additionally, users are able to manage their assigned caseload from the “Patients – My Enrolled” dashboard. This dashboard gives users a high level overview of the assigned cases. To further view certain aspects of the case, users can utilize the “Patients –Need Outreach or Enrolled” dashboards. These dashboards provide an overview of the specific aspects of the case that need to be addressed.

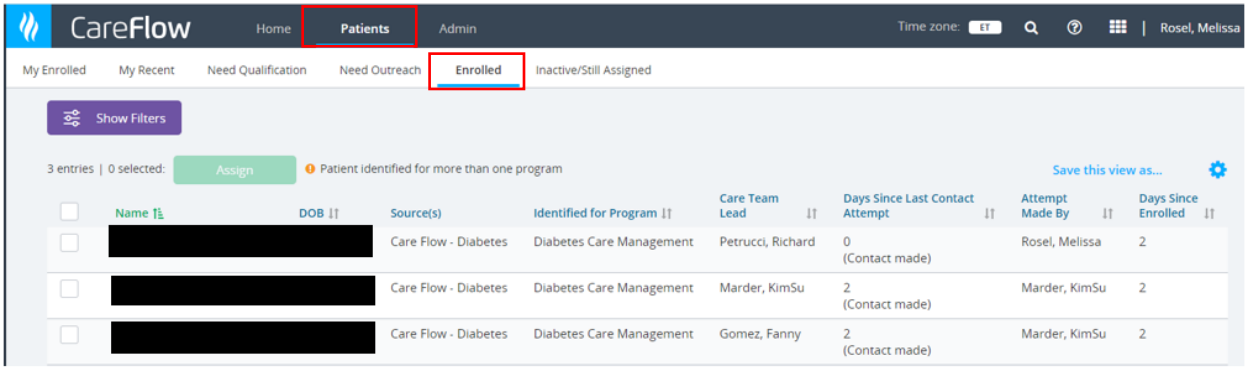
- *Patients – My Enrolled*



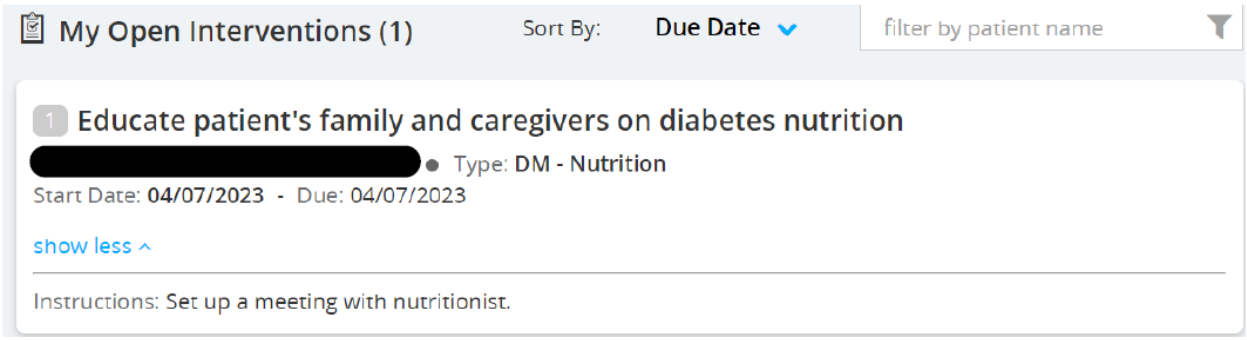
- *Patients – Need Outreach*



➢ *Patients – Enrolled*



When interventions are created for a care plan, the care manager sets a due date to follow up on the interventions.



Monitoring and Oversight

The overall Care Management program is monitored and evaluated on a continuous basis and progress towards goals are measured and evaluated. Progress and results of the assessments and individual care plans are reviewed and discussed amongst Care Management Leadership, Chief Medical Officer and CM staff and escalated to the QM Committee on a quarterly basis as needed. Program quality is monitored through monthly case audits on randomly selected cases to ensure compliance with program guidelines. In the event non-compliance is discovered,

immediate investigation of the root cause commences and is reported to the Director of Care Management and Chief Medical Officer and shared with the QM Committee. Audit findings are used to share with the individual and is used as training and guidance for the CM staff.

Governance

NCQA 2020 CM Standards: CM 4, Element A

Related Policies

SOMOS CM 101.2 Case Management Care Plans and Assessment
SOMOS CM 101.3 Continuity of Care & Transition of Care
SOMOS CM 101.4 Care Management Program Monitoring
SOMOS CM 101.6 Diabetes Prevention and Care Management Program
SOMOS CM 101.8 Complex Case Management
SOMOS CM 101.9 Behavioral Health Case Management & Health Home Services

Whom Do I Contact with Further Questions?

Chief Executive Officer
Chief Compliance Officer
General Counsel