LA DOJ-CCM Review Tool

Question Number	Question
ENGAGEMENT	
001	Evidence that the CCMA accepted the referral within 3 business days. Effective 2/1/23 as per DOJ Compliance guide.
002	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.
003	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.
004	Evidence at a minimum, the community case manager had at least two (2) of the required (4) face-to-face contacts occurring in the last 30 days prior to the member's transition from the nursing facility.
NEEDS ASSESSMENT	
005	An assessment is in the record.
006	The community case manager shall conduct an initial community case management assessment within 14 days of the transition date for transitioned members. For transitioned members who are not connected with a CCM prior to transition from a NF, the assessment shall be conducted within 14 days of the referral date. Effective 6/1/22 as per DOJ Compliance guide.
007	The community case manager shall conduct an initial community case management assessment within 14 days of the referral date for diverted members. Effective 4/1/22 as per DOJ Compliance guide.
008	A formal reassessment shall be conducted for a member who has received CCM for at least 10 months to determine the member's continued need for community case management services beyond the 365 day mark.
009	For members who receive community case management beyond 365 days, a formal reassessment is due every 6 months thereafter.
010	The assessment identifies the member's medical and healthcare needs, based on the preferences of the member.
011	The assessment identifies the member's behavioral health support needs based on the preferences of the member.
012	The assessment identifies the member's personal support needs across all activities of daily living.
013	The assessment identifies the member's social/recreational needs, based on the preferences of the member.
014	The assessment identifies the member's vocational/educational needs, based on the preferences of the member.
015	The assessment identifies the member's housing needs, based on the preferences of the member.
016	The initial needs assessments of member's needs identify the need for transportation services and supports to meet the daily needs and preferences of members.
017	The assessment identifies the diet and nutrition needs of the member, based on member preferences.

Question Number	Question
018	The assessment is conducted using a team-based approach and include the CCM, LMHP, member, and member's family/natural supports as available and desired by the member.
019	The needs assessments include inputs from medical providers who are identified by the member prior to assessment.
020	The needs assessments include inputs from the behavioral health providers (including peers) who are identified by the member prior to assessment.
021	Primary language spoken by the member is documented.
022	Any translation needs of the member are documented, if applicable.
023	Religious/Spiritual needs of the member were assessed.
024	The assessment identified the member's nationality or ethnic origin, and the degree to which the member's cultural background is important to the member.
PERSON-CENTERED PLAN OF CARE	
025	The Person-Centered Plan of Care is in the record.
026	The person-centered plan of care reflects the member's vision.
027	The person-centered plan of care reflects the member's strengths as identified in the assessment process.
028	The person-centered plan of care reflects the member's preferences as identified in the assessment process.
029	The person-centered plan of care reflects the member's goals as identified in the assessment process.
030	The person-centered plan of care shall include Services and supports to meet the member's goals and assessed needs (formal andinformal)
031	The person-centered plan of care shall identify all service providers.
032	The person-centered plan shall identify the type of service to be provided.
033	The person-centered plan shall identify the amount of each service to be provided.
034	The person-centered plan of care shall include frequency of services.
035	The plan of care shall include strategies to address identified barriers(strategies to address Unmet needs).
036	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.
037	The community case manager shall develop the plan of care within 14 days following the community case management assessment
038	The plan of care shall be updated when there are changes in the member's needs or circumstances, goals, services or providers.
039	The community case manager shall exchange information with providers/organizations delivering care, including cross sharing of plans during team meetings, to ensure the plan remains current and to determine if the members' needs are being met and if there is progress towards goals
040	There is evidence that a crisis plan was developed.
041	There is evidence that the crisis plan includes potential causes and strategies for recognizing and addressing a crisis.
042	There is evidence that the crisis plan includes contact information for crisis resources in members' community
REFERRAL AND LINKAGE	
043	For diverted members, the community case manager shall connect members with service providers to respond to urgent needs within 7 days following the referral.
MONITORING AND FOLLOW-UP	

Question Number	Question
044	Ongoing contact is made with the member at least monthly or more frequently as indicated to monitor the member's needs, member's status, or member's risk factors.
045	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.
046	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.
047	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.
048	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.
049	Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure Member does not feel isolated.
050	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.
051	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).
052	Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure member health and welfare in the community, including reporting of critical incidents to appropriate agencies.
053	Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure member health and welfare in the community, including follow-up activities to ensure the member is protected from harm and prevent similar incidents from reoccurring.
054	Ongoing contact is made with the member at least monthly or more frequently as indicated to monitor whether member is making progress towards his/her desired goals.
055	The CCM facilitated team meetings to include the member, member's natural supports, TC if applicable, support coordinator if applicable, and member's main providers for the purpose of reviewing the member's plan, revising interventions if needed, identifying service gaps, developing strategies to address gaps, and determining any additional actions steps needed and the responsible party.
056	If member has an unplanned hospitalizations, psychiatric admissions, or NF admissions, the CCM facilitated a team meeting within 5 days of the hospitalization/NF admission. Effective 10/1/23.