Care Management Log INSTRUCTIONS

1. PLEASE NOTE that for the purposes of this log, "Care Management" refers to ALL services described in the Care Management section of the Managed Care contract with MO HealthNet. For many plans, this includes services such as Case Management, Care Coordination or other case assistance activities that the Plan may not necessarily describe as "Care Management". Nevertheless, if it fits the MO HealthNet definition of "Care Management" as described in the contract, it should be included in this log.

2. For reporting purposes, use field names EXACTLY as shown in the specifications. Do NOT change spelling or add spaces to field names.

3. For fields with an Acceptable Values list, include ONLY items from that list. Be sure they are spelled EXACTLY as given in the specifications. Even minor deviations in spelling may result in your submission being rejected.

4. Any field with a data type of "Text" is limited to a maximum of 255 characters. Any characters beyond that will be truncated. (It is very unlikely that you will ever need that many characters for the fields requested for this report. Most Text fields are limited to an Acceptable Values list anyway.)

5. Submit report in a pipe-delimited file format.

6. The first row of the pipe-delimited file MUST contain the field names.

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
Year	Number		NEW FIELD. Report the 4-digit calendar year for the time period the log covers. REQUIRED FIELD.
Quarter	TEXT	Jan-Mar Apr-Jun Jul-Sep Oct-Dec	NEW FIELD. Report the quarter for the time period the log covers using only the Acceptable Values. REQUIRED FIELD.
HealthPlanName	TEXT	AetnaBetterHealth HomeState MissouriCare	Report the Health Plan Name using only the Acceptable Values. NOTE that there are NO SPACES in the plan names in the Acceptable Values list. REQUIRED FIELD.
HealthPlanRegion	TEXT	Eastern Central Western Southwestern	Use Drop Down list. Do not add other rows. Do not change wording of items. REQUIRED FIELD.
PatientDCN	TEXT		8-character patient ID assigned by MO HealthNet. Must be formatted as TEXT in order to preserve leading zeros. REQUIRED FIELD.
PatientLastName	TEXT		Member's last name. REQUIRED FIELD.
PatientFirstName	TEXT		Member's first name. REQUIRED FIELD.
PatientPhone	TEXT		The phone number listed as the best option for the member, formatted as: xxx-xx-xxxx.
DOB	DATE		Member's date of birth, formatted as mm/dd/yyyy. REQUIRED FIELD.
Gender	TEXT	M F M->F F->M	Report gender using only the Acceptable Values. REQUIRED FIELD.
DateIdentified	DATE		The date that the member was identified as potentially needing case mangement services. Format as mm/dd/yyyy. REQUIRED FIELD.
HowIdentified	TEXT	PCP Behavioral Health Provider/Referral Other Provider MHD Self/Member/Family/Guardian Health Plan identified Other	The method used to identify the member as potentially needing care management services. Report using only the Acceptable Values. REQUIRED FIELD.
ReasonIdentified	TEXT	Behavioral Health Concerns Physical Health Concerns Lead Levels Pregnancy Requested by MHD Requested by PCP Other	NEW FIELD. The reason that the member was referred for screening and thought to potentially need care management services. Report using only the Acceptable Values. REQUIRED FIELD.
InitialScreeningCompletionDate	DATE		The date that the initial screening for CM services was completed, formatted as mm/dd/yyyy.

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
ReasonInitialScreeningNotDone	TEXT	Unable to contact member Member no longer enrolled in plan Member contacted, but refused screening Recently Screened; No new needs identified	If an initial screening was not completed for a member who was identified as potentially needing CM, list the reason why not. Report using only the Acceptable Values.
CMReferralDate	DATE		The date that the member was referred for CM services, formatted as mm/dd/yyyy. This would be after the screening was completed and they had been determined to have met CM criteria.
FirstAttemptedContactDate	DATE		The date that Health Plan staff first attempted to reach the member after they were referred for CM, formatted as mm/dd/yyyy.
ReasonServicesNotOffered	TEXT	Unable to contact member Member no longer enrolled in plan Screening Completed; Member does not meet criteria Referred to Disease Management	If CM services were not offered to a member who was identified as potentially needing such services, indicate why not. Report using only the Acceptable Values.
CMServicesRefused	TEXT	Yes No	Indicate whether the member refused CM services when offered. Report using only the Acceptable Values.
InitialAssessmentCompletionDate	DATE		The date that the CM Initial Assessment was completed, formatted as mm/dd/yyyy.
CMEnrollmentDate	DATE		The date that the member was officially enrolled in CM, formatted as mm/dd/yyyy.
ReasonForCM1	TEXT	3+ Emergency Department visits in a quarter Admission to Psychiatric Hospital or Residential Substance Abuse Program Asthma Autism Spectrum Disorders Bipolar disorder Cancer Chronic Pain Congestive Heart Failure COPD Diabetes Eligible for SSI Foster Care/Adoption Subsidy Foster Care/Out-of-Home Placement Hepatitis C HIV/AIDS Inpatient Stay of 2+ weeks Lead Organ failure requiring supportive treatment and potentially requiring transplant Pregnancy PTSD Readmission Recurrent Major Depression Schizophrenia Sickle Cell Anemia Substance Dependence Disorder Title V Services Identified by Health Plan	The Reasons that the member was identified as potentially needing CM services. You may report up to 4 different reasons for CM, using the 4 fields listed here. Report using only the Acceptable Values. REQUIRED FIELD if 'CMEnrollmentDate' is present.
ReasonForCM2			
ReasonForCM3			
ReasonForCM4			

FIELD NAMES	DATA TYPE	ACCEPTABLE VALUES	NOTES
LevelOfCM	TEXT		This is the level of care management services provided to the patient. Use the labels commonly in use by your plan, but BE CONSISTENT! Don't put "Medium" for some records and "Med" for others, etc. You should be choosing from a list of 4-6 options. REQUIRED FIELD if 'CMEnrollmentDate' is present.
TypeOfCM	TEXT	Physical Behavioral Both	The reason that the member was enrolled in CM services. If the member was NOT enrolled, give the reason that they were identified as potentially needing CM services. Use Drop Down list. Do not add other rows. Do not change wording of items. REQUIRED FIELD if 'CMEnrollmentDate' is present.
MostRecentAttemptedContactDate	DATE		The most recent date that the Health Plan attempted to contact the member for CM services, formatted as mm/dd/yyyy.
MostRecentActualContactDate	DATE		The most recent date that the Health Plan actually reached and spoke to the member for CM services, formatted as mm/dd/yyyy.
CMDischargeClosureDate	DATE		The date that the member was discharged from CM or their case was otherwise closed, formatted as mm/dd/yyyy.
ReasonForDischargeClosure	TEXT	Achievement of Goals/Stabilized Condition/Improved Health Pregnancy Ended Deceased Member request to withdraw from CM Member request to withdraw from health plan Unable to contact member	The reason that the member was discharged from CM or their case was closed. Report using only the Acceptable Values.
QuarterlyHospitalizationCount	INTEGER		The number of times that the member was in the hospital during the quarter. Count the number of DISCHARGES from the hospital. (If a member was admitted during the current quarter but has not been discharged yet, do not count them. They will be counted in a subsequent quarter when they are discharged.) REQUIRED FIELD if 'CMEnrollmentDate' is present.
Comments	TEXT		NEW FIELD. Any comments that you wish to add. This field is limited to 255 characters. Anything beyond that will be truncated.