State of Wisconsin - Department of Health Services - Division of Long Term Care
Family Care / Partnership Resource Series RS Memo 13-03
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Resource Series provides MCOs with best practices, guidance and/or reference materials. This series does not include directions on contract requirements or directives from the Department.

DHS and MCO Six-Month and Ongoing Member Reassessment Guideline

Purpose: The 2013 Family Care Contract allows for Managed Care Organizations (MCOs) to determine the most appropriate Interdisciplinary Team (IDT) staff to conduct the reassessment. This may include both the Registered Nurse (RN) and social service coordinator (SSC) or just one of these professionals. The purpose of this resource memo is to provide guidance for MCOs in using this flexibility.

DHS staff and MCO staff in the Care Management Workgroup collaboratively developed this guidance in response to MCOs' request to have flexibility to fully leverage the expertise of their IDT staff, for the six-month reassessment process. This guideline assists IDT staff in determining member characteristics, needs, or changes that would require involvement by the RN or social service coordinator (SSC).

The DHS-MCO contract requires that reassessment must occur no later than the end of the six-month period after the month in which the previous assessment was completed; however, this guideline clarifies and emphasizes that IDT members are expected to work together to continually reassess member needs as part of high-quality care management.

Part One of this guideline defines the core elements of the assessment which includes physical, social and emotional components. Part Two of this guideline addresses the collaborative and consultative process that IDT staff should follow with any reassessment, and outlines the processes to determine whether the RN, SSC, or both IDT staff members will participate in the face-to-face reassessment with the member.

I. Reassessment Core Elements

The contract allows MCOs to determine the most appropriate IDT staff to conduct the reassessment. It further allows RN participation in the reassessment to be dictated by the member's need while making sure all members have access to the RN whenever needed. For example, RNs may provide less time in reassessments of members with few health-related needs, and more time on reassessments for members with complex health-related needs.

Core elements to be reviewed at the six-month reassessment include:

Assessment Element	Assessment or Data Gathering
Medication review and discovery of changes	• Review of medication list, or report from member or caregivers about a change in medication. (When alerted to changes, the RN must provide assessment of medication regimen, per contract reference V. C.1.d.iii.)

Assessment Element	Assessment or Data Gathering
Behavioral status	• Any changes in behaviors of the individual (observed or reported) or new onset or change in a behavior that would trigger evaluation for potential medical, mental health or medication review.
Stability and independence offered in living environment	• Are there reports or observations of challenges within the member's current living situation? • Has the member's functioning stabilized? Improved? • Other considerations: the member's relationship with others with whom he/she lives, frequent falls or other risks identified in the current living environment. If these are identified, then assessment must be conducted.
Financial Issues	• Has anything changed that would impact the member's financial eligibility for the program? • Does the member need new or additional supports to maintain his or her eligibility? • Other financial concerns?
Mental health status	• Any changes in the member's coping mechanisms, such as: ability to filter distractions or information appropriately, behaviors that are challenging to manage, or unusual isolation/and withdrawal type behaviors?
Significant changes in ADLs or IADLs	• Has any functional decline been observed? In what areas? • Are the member's preferences in regards to privacy, services, and daily routine properly addressed?
New onset of or instability in physical condition, including pain	• Any reported changes in the member's health, complaints of new onset of pain, or any new physical symptoms?
Significant change in weight, nutrition status, or skin integrity	• Any observations of noticeable weight gain or loss since last visit (e.g., clothing is not fitting). • Are there reports from caregivers or member regarding: o Lack of appetite or eating poorly or eating more than usual. o New difficulty in swallowing, or coughing when swallowing. o A change in wound status, new onset of a wound or worsening wound condition.
Change in cognition	• Are there any observations or reports from caregivers on changes in the member's cognitive status? • Is there a new onset of symptoms or is the member presenting with increased confusion or forgetfulness?
Changes in natural support system	• Are there changes or anticipated changes in the member's natural support system? • Do any reports from caregivers or family include changes or anticipated changes in the member's natural support system? • The IDT staff should also continuously assess the stress level of, and ability for natural supports to continue assisting with caring for the member. • Self Directed Support options and the ability to remain in the community should also be reviewed at reassessment.

Assessment Element	Assessment or Data Gathering
Changes in vocational and educational status	• Is there a change in member's preference regarding vocation or education goals including an interest in supported employment or other types of employment opportunities?
Changes in risk	• Is the current risk assessment adequately addressing identified risks? • If no risk agreement was in place, is one indicated now? • Review includes mental health and AODA issues, health and safety assessment and vulnerability /risk for abuse and neglect.
Member understanding of rights	• Are there any changes in the member's understanding of his/her rights, preferences for executing advance directives, guardian, durable power of attorney or activated power of attorney for health care issues?

II. IDT Staff Collaboration

Reassessment of member needs, both on an ongoing basis and during the more formal six-month review requires effective communication within the IDT. IDT staff are expected to demonstrate ongoing collaboration between disciplines, recognizing that the RN, SSC, and in Partnership, the Nurse Practitioner (NP), each bring a unique and required perspective to the assessment/reassessment process.

MCOs must develop and implement proper care management protocols to assure ongoing communication among all IDT members in all instances, including when only one of the IDT staff is present for a face-to-face reassessment.

The DHS/MCO Care Management Workgroup identified several situations that require immediate communication when all IDT staff are not present for the face-to-face reassessment. These are reflected in the table below. The IDT staff who conducted the reassessment must document in the member record that the appropriate members of the IDT were notified in these instances.

NOTIFY SOCIAL SERVICE COORDINATOR WHEN:
Change in financial status, relative to risk issue, abuse, eviction or unpaid bills: a. Financial status issues that may affect the member's ability to maintain eligibility in the program. b. The member may need assistance to manage cost share, contributions to living expenses or assistance to establish a budget to pay expenses.
Significant change in social or natural supports: a. Caregiver stress, quality, or inability to continue in the needed capacity. b. The member is nearing end-of-life. c. A change in physical functioning of a caregiver or change in caregiver supports.
Identified risk: a. Potential abuse/neglect of a member. b. Change in a member's mental health status. c. Change in a member's cognition. d. Change in a member's behaviors or onset of new behaviors. e. The member is in an unsafe living situation.

NOTIFY SOCIAL SERVICE COORDINATOR WHEN:
Change in vocational goals: a. A member expresses a choice to work or to retire. b. The member's employment setting changed or the member wants the setting to change.
Advance Directives or legal decision-making: a. Concerns are noted about whether the legal decision-maker is representing what is in the best interest of member. b. Possible conflicts of interest are identified that require further assessment. c. The member appears to have a change in condition that might precipitate activating or deactivating the Power of Attorney for Health Care.

NOTIFY RN or NP WHEN:
Significant changes in a member's known behaviors or onset of new behaviors: a. Significant changes in behavior could be evidence of undiagnosed medical conditions or the presence of pain or distress.
Significant changes in a member's chronic health or medical condition. This may involve, but is not limited to: a. The member's need for, or awareness of, multiple medical visits, including Emergency Room or urgent care visits. b. Significant changes in a member's functional status. c. Identification and intervention of medication discrepancies or changes. d. The member has unplanned weight loss or unexpected weight gain.
Discharge or transition planning needs such as planning for: a. Changes in medication, b. Changes in activity, c. Wound-care intervention, d. Changes in natural or paid supports, and e. Any type of care that needs advance planning to promote a smooth transition for the member.
Identified risk factors related to health and safety are addressed in the risk assessment including, at a minimum: a. Pain, b. Skin integrity, c. Medication, d. Mobility, and e. Falls prevention.

If you have questions regarding this memo, please email DHSOFCE@wisconsin.gov.

Contract reference:
2013 annual DHS-MCO contract (V. Care Management)