1023 DISEASE/CHRONIC CARE MANAGEMENT

REVISION DATE: MM/DD/YY
REVIEW DATE: 10/3/2023
EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §36-551; AMPM 1021; AMPM 1023; Division Medical Manual Policy 1023; National Committee for Quality Assurance; Case Management Long Term Services and Supports; Standard 6.

PURPOSE

This policy outlines the Administrative Services Subcontractors (AdSS) responsibilities for supporting the identification, early intervention, and management of chronic diseases and conditions, and improving wellness and quality of life for Division of Developmental Disabilities (Division) Members enrolled in or eligible for the Division Disease/Chronic Care Management Program (DCCMP). The DCCMP focuses on members at high risk ~~and/~~or with chronic conditions that have the potential to benefit from a concerted intervention plan.

DEFINITIONS

1. "Care Management" means a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk,

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cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

2. “Disease/Chronic Care Condition” means any disease or chronic condition that results in the Member being at risk for, or is already experiencing a decline in health.

3. “Disease/Chronic Condition Intervention Plan” means a protocol targeted at managing a Disease/Chronic Care Condition ~~a disease or chronic condition~~ and improving health outcomes.

~~4. “Person Centered Service Plan” means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the Member’s strengths and preferences that meet the Member’s social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to Member~~

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~~rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.~~

4. "Fatal Five" means conditions considered preventable causes of death in people with intellectual/developmental disabilities.

5. "Long COVID" means a condition where symptoms that surface after recovering from COVID-19 linger for weeks, months, or even years. The symptoms include chronic pain, brain fog, shortness of breath, chest pain, and intense fatigue.

6. "Provider" means any individual or entity contracted with the AdSS that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

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8. “Serious Mental Illness” or “SMI” means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

POLICY

~~The Division Disease/Chronic Care Management Program (DCCMP) focuses on Members with high need, high risk and/or chronic conditions to improve health outcomes. Member participation is voluntary. The AdSS shall work with support coordination and Health Care Services (HCS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment for Members.~~

~~The AdSS shall identify opportunities for improvement and applications/enhancements to support network development, sustainability, and improved outcomes.~~

A. MEMBER IDENTIFICATION/REFERRAL

1. The AdSS shall provide Care Management services for Members determined to be at risk for, or already experiencing poor health outcomes due to their disease or chronic conditions.

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2. The AdSS shall provide Care Management services for the following high risk Member populations:
   a. High Needs High Cost (HNHC) Members and
   b. Members with a Serious Mental Illness (SMI) designation.

3. The AdSS shall provide information to Members regarding their Division Disease/Chronic Care Management Program (DCCMP) that addresses Member health care needs across the continuum of care.

4. The AdSS shall ~~identify~~ consider Members ~~who may be~~ eligible for the DCCMP when they meet any of the following criteria:
   a. Have been diagnosed with a chronic medical condition and complex care needs; ~~requiring care from a multidisciplinary team;~~
   b. Are identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics, or other relevant medical testing;
   c. Have one or more of the Fatal Five ~~(aspiration; bowel~~

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98 obstruction, gastroesophageal reflux disease [GERD],
99 dehydration, or seizures) conditions: considered
100 preventable causes of death in people with
101 intellectual/developmental disabilities:
102 i. Aspiration,
103 ii. Bowel obstruction,
104 iii. Gastroesophageal Reflux Disease [GERD],
105 iv. Dehydration, or
106 v. Seizures.
107 d. Have been diagnosed with Long COVID post- Covid-19
108 condition(s); or
109 e. Have exhibited high or low utilization of services for high
110 need conditions.
111 5. The AdSS shall use the following screenings and assessments to
112 identify eligible Members eligible for the Disease/Chronic Care
113 Management Program: These screenings and assessment may
114 include, but not limited to, the following:
115 a. Early and Periodic Screening, Diagnostic, and Treatment

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(EPSDT) for qualified Members, including education and health promotion for dental/oral health services;

b. Substance use;

c. Depression; or

d. Tobacco use.

6. The AdSS shall refer Members who may be eligible and may benefit from the DCCMP program to Support Coordination, and the HCS for enrollment.

B. ROLES AND RESPONSIBILITIES

1. The AdSS shall work collaboratively with the Division DCCMP, the ~~Member or~~ Responsible Person and Support Coordination to provide access, support, ~~and/~~or technical assistance to develop and implement an individualized Disease/Chronic Condition Intervention Plan.

2. The AdSS staff and providers shall participate in the development of the Division specific evidence-based guidelines.

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133 3. The AdSS shall require the Disease/Chronic Condition
134 Intervention Plan to include:~~Activities may include but are not~~
135 ~~limited to:~~
136 a. An ~~E~~exchange of clinical, medical, and administrative
137 information to facilitate well-coordinated, interdisciplinary
138 care and avoid unnecessary duplication;
139 b. ~~Conducting a~~ A comprehensive health assessment
140 conducted to identify high risk behaviors or health
141 concerns/issues;
142 c. Identification and access to:
143 i. Evidence-based practices and individualized
144 interventions/strategies;
145 i. Health education, resources and support tailored to
146 the Member's needs including maternity care
147 programs and services for pregnant Members and
148 family planning;
149 ii. Healthy living and wellness programs addressing

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health risk-reduction and healthy lifestyle choices;

iii. Industry-leading tools, technology, and strategies that improve clinical and administrative outcomes and reduce unnecessary costs; and

iv. Self-help resources/programs including digital, web based, ~~and/~~or community resources designed to improve health and wellness for specific disease/chronic conditions.

d. Regular engagement, ongoing support and technical assistance with the DCCM ~~program/~~care team to support sustainability and continuity of care;

e. Collaboration, training, technical assistance, and oversight with appropriate Providers who are part of the DCCM care team to implement the Member’s program and desired outcomes;

f. Support~~ing~~ continuity of care as part of plan implementation and discharge coordination/integration

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with the Support Coordination process and the person-centered service plan;

g. Ongoing monitoring to promote early identification of needed additional support ~~and/~~or intervention to preserve and sustain outcomes;

h. Identification and implementation of the following Provider network enhancements that support better health outcomes: ~~including, but not limited to, the following:~~

   i. Implementation of optimal clinical care pathways and interventions;

   ii. Identification of increased opportunities to expand virtual care; and

   iii. Inclusion of self-help resources/programs including digital, web based, ~~and/~~or community resources designed to improve health and wellness for specific disease/chronic conditions; and

   iv. Education for Providers regarding specific evidenced-

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based guidelines practices and desired outcomes of the DCCMP ~~successful interventions attributable to specific diseases and/or chronic conditions.~~

i. Self-care and self-management tools for health conditions that include wellness coaching and health promotion areas including the following:
   a) Healthy eating and weight maintenance,
   b) Encouraging physical activity,
   c) Managing stress,
   d) Avoiding at-risk drinking, and
   e) Identifying depressive symptoms.

3. The AdSS shall use the following components for coordination with the Division and Providers to assist the DCCMP:
   a. Data sharing,
   b. Involvement in the implementation of the program,
   c. Methodology for monitoring Provider compliance with the guidelines, and
   d. Implementation of actions designed to bring the providers

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202 into compliance with the practice guidelines.

203 4. The AdSS shall meet with the Division's HCS DCCMP Manager or
204 Administrator at least quarterly to review performance metrics,
205 successful interventions, and opportunities for improvement.

206 5. The AdSS shall monitor its Provider network's compliance with
207 the Member DCCMP interventions and shall take appropriate
208 corrective action for any noncompliance.

209

210 ~~C. OVERSIGHT AND MONITORING~~

211 ~~1. The AdSS shall meet with the HCS DCCMP Manager or~~
212 ~~Administrator at least quarterly to review performance metrics,~~
213 ~~successful interventions and opportunities for improvement.~~

214 ~~The AdSS shall monitor its provider network's compliance with the~~
215 ~~Member DCCMP interventions and shall take appropriate~~
216 ~~corrective action for any noncompliance.~~

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219 **SUPPLEMENTAL INFORMATION**

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1. The Division DCCMP focuses on Members with high need, high risk, ~~and/~~or chronic conditions to improve health outcomes. Member participation is voluntary. The AdSS shall work with support coordination and Health Care Services (HCS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment for Members.

2. The AdSS shall identify opportunities for improvement and applications or enhancements to support network development, sustainability, and improved outcomes.

Signature of Chief Medical Officer:

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