1023 DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §36-551, AMPM 1023, Division Medical Manual Policy 1023

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 or eligible for the Division Disease/Chronic Care Management Program.

DEFINITIONS

1. "Disease/Chronic Condition Intervention Plan" means a protocol targeted at managing a disease/chronic condition and improving health outcomes.

2. "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.

3. "Person Centered Service Plan" is 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 rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

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

The AdSS shall identify members who may be eligible for the program including members who:

1. Have been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team;
2. Are identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing;
3. Have one or more of the Fatal Five (aspiration; bowel obstruction, gastroesophageal reflux disease [GERD],

dehydration, or seizures) conditions considered preventable causes of death in people with intellectual/developmental disabilities;

4. Have been diagnosed with post- Covid-19 condition(s); or

5. Have exhibited high or low utilization of services for high need conditions.

6. The AdSS shall use screenings and assessments to identify eligible members. These screenings and assessment may include, but not limited to, the following:

    a. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for qualified members, including education and health promotion for dental/oral health services

    b. Substance use

    c. Depression

    d. Tobacco use

7. The AdSS shall refer members who may be eligible and may

benefit from the program to Support Coordination, and the HCS for enrollment.

B. ROLES AND RESPONSIBILITIES

The AdSS shall work collaboratively with the Division DCCMP, the member/ responsible person and Support Coordination to provide access, support and/or technical assistance to develop and implement an individualized Disease/Chronic Condition Intervention Plan. Activities may include but are not limited to:

1. Exchange of clinical, medical and administrative information to facilitate well-coordinated, interdisciplinary care and avoid unnecessary duplication.
2. Conducting a comprehensive health assessment to identify high risk behaviors or health concerns/issues.
3. Identification and access to:
    a. Evidence-based practices and individualized interventions/strategies.

b. Health education, resources and support tailored to the member's needs including maternity care programs, services for pregnant members and family planning.

c. Healthy living and wellness programs addressing health risk-reduction and healthy lifestyle choices.

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

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

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

5. Collaboration, training, technical assistance and oversight with appropriate providers who are part of the care team to implement the member’s program and desired outcomes.

6. Supporting continuity of care as part of plan implementation and discharge coordination/integration with the Support Coordination process and the person-centered service plan.

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

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

   a. Implementation of optimal clinical care pathways and interventions.

   b. Identification of increased opportunities to expand virtual care.

   c. 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.

d. Education for providers regarding specific evidenced-based practices and successful interventions attributable to specific diseases and/or chronic conditions.

C. OVERSIGHT AND MONITORING

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

2. The AdSS shall monitor its provider network's compliance with the member DCCMP interventions and shall take appropriate corrective action for any noncompliance.

Signature of Chief Medical Officer:

Anthony Dekker, D.O.