

1023 DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: July 20, 2022

REFERENCES: A.R.S. §36-551; AMPM 1023

PURPOSE

This policy outlines the requirements for the Division of Developmental Disabilities (Division) Disease/Chronic Care Management Program. The program focuses on members with chronic conditions, and/or at high risk, and may benefit from a targeted 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, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.
2. “Case Management” means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes. Case Management

for DES/DDD is referred to as support coordination.

3. "Disease/Chronic Intervention Plan" means a protocol targeted at managing a disease/chronic condition and improving health outcomes.
4. "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.
5. "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 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 focuses on members with high need/high risk and/or chronic conditions to improve health outcomes. Member participation is voluntary. The Disease/Chronic Care Management Program shall develop individualized intervention plans that include early identification of potential members, coordination of treatment, and chronic disease management strategies including education and self-management of conditions. The program shall work with Support Coordination, and the Administrative Services Subcontractors (AdSS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment.

A. CRITERIA FOR ENROLLMENT

A member is eligible for the program who:

1. Has been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team;
2. Is identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing;

3. Has 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. Has been diagnosed with post- Covid-19 condition(s); or
5. Has exhibited high or low utilization of services for high need conditions.

B. PROGRAM COMPONENTS

The Disease/Chronic Care Management Program provides a focused assessment of opportunities and development of an intervention plan to better manage disease or conditions for targeted members, improve health outcomes and quality of life.

Program activities include:

1. Screenings and assessments to identify high risk behaviors or emerging health issues, coordination of treatment, as appropriate, with the AdSS including but not limited to:
 - 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
2. Development of an individualized Disease/Chronic Condition Intervention Plan that involves working closely with the member and/or responsible person and obtaining their agreement with the plan. The plan includes the following components:
- a. Goals.
 - b. Opportunities, interventions and resources to improve long term health outcomes.
 - c. Coordination with primary care provider/specialty care provider(s) and medical/behavioral treatment teams.
 - d. Regular contact by Health Care Services with the member and/or responsible person.
 - e. Evidence-based guidelines to enhance the health, wellness and quality of life of the member while reducing

the need for hospitalization and other costly treatments.

Individualized targeted interventions designed to improve and sustain member engagement in treatment.

- f. Actions to be taken by the member and/or responsible person.
- g. Health education, resources and support tailored to the member's needs, including but not limited to:
 - i. Understanding chronic disease/conditions and improving health, wellness and quality of life
 - ii. Working with the care team, treatment/ services providers and allied supports
 - iii. Establishing and maintaining treatment relationships that foster consistent and timely interventions
 - iv. Understanding the member role in health and wellness
 - v. Healthy living and wellness programs
 - vi. Self-help resources/programs including digital, web based and/or community resources designed to improve health and wellness for specific disease/ chronic conditions

vii. Health risk-reduction and healthy lifestyle choices,
including tobacco cessation.

viii. Preventative care may include but is not limited to:

- 1) Health screening
 - 2) Annual health exams
 - 3) Cancer screening
 - 4) Dental/oral health services.
 - 5) OB/Gyn care
 - 6) Maternity care programs and services for pregnant women.
3. Engagement, ongoing support and technical assistance with Support Coordination and the AdSS to integrate the Disease/Chronic Condition Intervention Plan into the person-centered service plan to support sustainability and continuity of care.
4. Once the health care services team determines the member to be ready for discharge, the member may be discharged from the disease/chronic care program. The Team is available for technical assistance and consultation to Support Coordination

and/or the AdSS to support the transition.

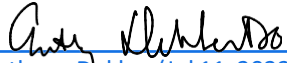
5. The member may be re enrolled based on the recommendation of Support Coordination, the AdSS and/or identified through HCS utilization reviews/reports.

C. OVERSIGHT

1. The Division collaborates with the AdSS to evaluate the effectiveness of the program by assessing the members' ability to self-manage their condition/disease and measuring other outcomes at predetermined points after enrollment. Other outcomes may include cost/utilization of services, clinical quality, and process measures.
2. The Division works in partnership with the AdSS to educate providers regarding the specific evidenced-based guidelines and desired outcomes of the program. The AdSS staff and providers may participate in the development of the Division specific evidence-based guidelines.
3. The Division monitors the AdSS to ensure provider compliance with the member Disease/Chronic Condition Intervention Plan and that appropriate corrective action is taken for any noncompliance.

4. Health Care Services shall track and trend performance metrics and outcomes identifying successful interventions and provide reports to the Division Medical Management Committee.

5. At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of the Disease/Chronic Care Management Program compliance.

Signature of Chief Medical Officer: 
[Anthony Dekker \(Jul 11, 2022 14:17 PDT\)](#)
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