1023 DISEASE/CHRONIC CARE MANAGEMENT

REVISION DATE: XX/XX/XXXX
REVIEW DATE: 10/3/2023
EFFECTIVE DATE: July 20, 2022
REFERENCES: 42 CFR Part 457; 42 CFR Part 438; A.R.S. §36-551; AMPM 1021; AMPM 1023; National Committee for Quality Assurance; Case Management Long Term Services and Supports; Standard 6.

PURPOSE

This policy outlines the requirements for the Division of Developmental Disabilities (Division) Disease/Chronic Care Management Program (DCCMP). The ~~program~~ DCCMP focuses on Members with chronic conditions, ~~and/~~or at high risk, and ~~may~~ has the potential to benefit from a ~~targeted~~ 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, cost, and help achieve better health outcomes. Distinct from ~~Case Management~~ Support Coordination, 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.~~

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 ~~disease or chronic condition~~ and improving health outcomes.

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. "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.~~

6. "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.

7. "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.

8. "Service Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.

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

1. The Division 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.

2. The Division shall provide Care Management services for the following high risk Member populations:

   a. High Needs High Cost (HNHC) Members,

   b. Members with a Serious Mental Illness (SMI) designation, and

   c. Tribal Health Program (THP) Members.

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

4. ~~A~~The Division shall consider a Member ~~is~~ eligible for the ~~Disease/Chronic Care Management Program (~~DCCMP~~)~~ ~~program who meets~~ when they meet any of the following criteria:

a. ~~Has been d~~diagnosed with a chronic medical condition and complex care needs; ~~requiring care from a multidisciplinary team;~~

b. ~~Is i~~Identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics, or other relevant medical testing;

c. 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:~~

i. Aspiration,

ii. Bowel obstruction,

iii. Gastroesophageal Reflux Disease [GERD],

iv. Dehydration, or

v. Seizures.

d. ~~Has been d~~Diagnosed with Long COVID ~~Covid-19~~

condition(s); or

e. ~~Has e~~Exhibited high or low utilization of services for high need conditions.

B. PROGRAM COMPONENTS

1. The Division shall require ~~T~~the Medical Management (MM) Committee ~~DCCMP Disease/Chronic Care Management Program~~ provide~~s~~ a focused assessment of opportunities and development of a Disease/Chronic Condition Intervention Plan ~~intervention plan~~ to better manage disease or conditions for ~~targeted~~ Members, improve health outcomes and quality of life.

2. The Division shall require the Disease/Chronic Condition Intervention Plan to include: ~~following DCCMP activities: Program activities include:~~

   a. Screenings and assessments to identify high risk behaviors or emerging health issues.

   b. Coordination of treatment as appropriate, with the AdSS

for the following conditions: ~~including but not limited to:~~

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

ii. Substance use;

iii. Depression; or

iv. Tobacco use.

3. The Division shall require the DCCM nurse ~~development of an individualized Disease/Chronic Condition Intervention Plan that involves~~ work~~sing~~ closely with the ~~Member and/or~~ Responsible Person in developing and obtaining ~~their~~ agreement with the Disease/Chronic Condition Intervention Plan. ~~plan.~~

4. The Division shall require the following components in the Disease/Chronic Condition Intervention 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 providers, specialty care providers and medical/behavioral treatment teams;

d. Regular contact by Health Care Services (HCS) 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;

f. Individualized targeted interventions designed to improve and sustain Member engagement in treatment;

g. Actions to be taken by the ~~Member and/or~~ Responsible Person; and

h. 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 Disease Chronic Care Management (DCCM) 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 that includes: ~~may include but is~~

~~not limited to~~

a) Health screening;

b) Annual health exams;

c) Cancer screening;

d) Dental/oral health services;

e) OB/Gyn care; and

f) Maternity care programs and services for pregnant women.

i. Engagement, ongoing support, and technical assistance with Support Coordination and the AdSS to integrate the Disease/Chronic Condition Intervention Plan into the Plan of Care ~~Person Centered Service Plan~~ to support sustainability and continuity of care.

j. Self-care and self-management tools for health conditions that include wellness coaching and health promotion areas including the following:

i. Healthy eating and weight maintenance,

ii. Encouraging physical activity,

iii. Managing stress,

iv. Avoiding at-risk drinking, and

v. Identifying depressive symptoms.

~~4. Once the Division's HCS Health Care Services team determines the Member to be ready for discharge, the Member shall may be discharged from the Disease/Chronic Care program.~~

~~5.~~ The Division's DCCM nurse shall discharge the Member from the Disease/Chronic Care program upon determining the Member is ready to be discharged or when the Member states they no longer wish to continue with the DCCM program.

~~6.~~ The DCCM team shall be ~~is~~ available for technical assistance and consultation to Support Coordination ~~and/~~or the AdSS to support the discharge from DCCMP. ~~transition.~~

~~7.~~ The Division shall allow the Member to re-enroll in the DCCMP ~~may be re-enrolled based on the recommendation of~~ when recommended by Support Coordination or the AdSS, ~~and/~~or

identified through HCS utilization reviews or reports.

C. DIVISION OVERSIGHT AND MONITORING

1. The Division shall collaborate~~s~~ with the AdSS to evaluate the effectiveness of the program by assessing the Members' ability to self-manage their condition or disease and measuring other outcomes at least annually. ~~at predetermined points after enrollment~~.

2. The Division shall consider these outcomes when evaluating the effectiveness of the DCCMP: ~~Other outcomes may include~~
   a. Cost or utilization of services,
   b. Clinical quality, and
   c. Process measures.

3. The Division shall work~~s~~ in partnership with the AdSS to educate Service ~~p~~Providers regarding the specific evidence-based guidelines and desired outcomes of the program.

4. ~~The AdSS staff and providers may participate in the development of the Division specific evidence-based guidelines.~~

4. The Division shall monitor~~s~~ the AdSS to ensure Service ~~p~~Provider compliance with the Member Disease/Chronic Condition Intervention Plan and that appropriate corrective action is taken for any noncompliance.

5. ~~Health Care Services~~ The Division's HCS shall track and trend performance metrics and outcomes identifying successful interventions and provide reports to the Division Medical Management Committee.

6. At least quarterly the Division shall meet~~s~~ with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results.

7. ~~On an annual basis, t~~The Division shall perform~~s~~ an Operational Review of the AdSS on an annual basis that includes review of the DCCMP compliance.

8. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

   a. Annual Operational Review of each AdSS;

b. Review and analyze deliverable reports submitted by the AdSS; and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

1. The Division DCCMP focuses on Members with high need, high risk or chronic conditions to improve health outcomes. Member participation is voluntary. The DCCMP 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.

2. For specific services provided by THP refer to the applicable Intergovernmental Agreements (IGAs).

Signature of Chief Medical Officer: