CHAPTER 13:

Care Management

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CARE COORDINATION

22.0 HEALTH APPRAISAL (HA)

Care coordination begins with a comprehensive health assessment of the beneficiary's medical, psychosocial, cognitive, functional, and behavioral health needs. This comprehensive assessment, called the Health Appraisal (HA), captures the member's perception of his/her health care needs. All newly enrolled members are mailed a copy of the HA. Using a population-based care approach, PCPs are required to screen all members for behavioral health conditions or disorders using standardized screening tools, such as the Health Appraisal. Contracted behavioral health providers assist members to complete a HA at intake and around the time of the comprehensive annual assessment. The HA results, as well as claims information, act as a mechanism for risk identification and enrollment into our Care Management Programs. (NCQA HPA 2023, PHM 4A, SNP 2A)

22.1 CARE MANAGEMENT PROGRAMS

Our comprehensive care management programs are designed to improve the quality of life for members with chronic or complex conditions, high risk and/or high-cost factors. We utilize a risk stratification process to review and analyze each member's health care needs. Member risk stratification for health complications and/or hospitalizations ensures accurate placement of our members into high, moderate, or low risk categories.

High risk beneficiaries are referred to one of our care management programs, depending on their specific needs. Care management programs include the following.

- Complex Care Management (CCM): The CCM program provides intensive, personalized care management services and goal setting for members who have complex health needs and require a wide variety of resources to manage health and improve quality of life. The CCM program serves members with multiple chronic conditions, Health Related Social Needs (HRSN), specialty medications, and dual AHCCCS/Medicare enrollemnt.
- Care Management: We offer care management programs for members with chronic conditions such as Diabetes, COPD, heart failure, renal disease, HIV, and Hepatitis C. There are special programs for more unique cases such as transplants, medication therapy management, and high utilizers of emergency department services. We also provide care

management for individuals with substance use disorders, justice involvement or members prescribed multiple medications with potential for abuse.

- Maternal Health Care Management: We offer a care management program for pregnant women with high-risk conditions. Maternity care managers are nurses who provide condition specific education and assist pregnant women obtain the medical, behavioral, social, and community resources they need during the pregnant and post-partum period.
- Behavioral Health Care Management: Behavioral Health Care Management is available for adult and child members with coordination needs related to a behavioral health condition.
- Children's Care Management Programs: We offer care management for pediatric members with special needs, including but not limited to those with a Children's Rehabilitative Services (CRS) condition, Arizona Early Intervention Program (AzEIP) enrollment, autism, or other special health care needs.
- Justice Reach-In Program: The Justice Reach In program provides support and coordination for members transitioning out of the justice system back into the community.

Members in Care Management programs are supported by a care management staff member. Care Managers complete an individualized care plan, which is based on a Health Appraisal, sets member approved goals, and educates to advance health literacy. Care management plans are shared with members of the care team to facilitate coordination of care.

22.2 PROVIDER REFERRALS

Providers may refer beneficiaries to any of our Care Management programs by completing the Care Management Referral Form located on our website. Completed referral forms and any pertinent medical documentation should be sent to the Care Management Department by fax to (480) 317-3358. Providers and members may also request referral to Care Management Programs by calling the Customer Service Line: (800) 322-8670.

22.3 SELF-MANAGEMENT TOOLS

We developed a set of evidence-based self-management tools which are interactive and help members determine health risk factors, provide guidance on health issues, and recommend ways to improve health or reduce risk. The tools provide information to assist members in improving their health literacy. They are also mailed to care-managed members when the tools support the member's self-management or care management plan goals. These tools are located on the BCBSAZ Health Choice Arizona and BCBSAZ Health Choice Pathway websites, at the following locations:

BCBSAZ Health Choice Arizona: https://www.healthchoiceaz.com/health-wellness/health-tips/

BCBSAZ Health Choice Pathway: https://www.healthchoicepathway.com/members/health-wellness/ (NCQA HPA 2023, PHM 4B)