Section 18.0 - Case Management and Disease Management

18.1.1 Introduction
Mercy Maricopa Integrated Care (Mercy Maricopa) has a comprehensive case management program. The Medical Case Management team considers the medical, social and cultural needs of members by targeting, assessing, monitoring and implementing services for members identified as "at risk." Case Management services are available for all eligible members, excluding Mercy Maricopa (acute and DD) members who are identified as "at risk," such as transplant and hemophilia, or those who are high-service utilizers, and are assigned a case manager.

The Disease Management team administers disease management programs intended to enhance the health outcomes of members. Disease management identifies, educates and monitors members with the following conditions:
- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Diabetes

18.2.1 Scope
Case management is available for all eligible members who are identified as “at risk”. Disease management participation and education is available to members with the above conditions.

18.3.1 Objectives
This section discusses the case management and disease management referral process and
requirements.

18.4.1 Procedures
Case Management
A wide spectrum of services are available for members, providers and families who need assistance in finding and using appropriate health care and community resources. The Mercy Maricopa Case Management staff:

- Considers the medical, social and cultural needs of members in targeting, assessing, monitoring and implementing services for members.
- Provides assistance to members and families in navigating through the complex medical and behavioral health systems.

Please refer to the Clinical Guidelines available on Mercy Maricopa’s website for treatment protocol related to:

- Diabetes
- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)
- HIV

18.4.1-A. Referrals
The Mercy Maricopa central intake coordinator accepts referrals from any source. Please call the central intake coordinator at 800-564-5465 to make a referral. For the most part, the central intake coordinator can respond to questions and resolve the issue during the initial call. However, a case management referral is initiated for members that require more than a single intervention. Case managers will contact the member either by telephone or by letter. The Case Management staff communicates with members, family and the PCP on an ongoing basis while the member's case is open.

18.4.1-B. Case Management Mercy Maricopa Acute and DD
Mercy Maricopa provides case management services to medically complex members. The members are assigned to an RN, LPN or social work case manager who works closely with the PCP and member to coordinate care and services. The case manager also collaborates with community resources, home health services and PCPs to coordinate medical care and assure appropriate access to medical and social services.

Members who meet any of the following criteria and do not fall under other identified categories of case management also will be considered for case management services:

- High utilizers of services
- Frequent inpatient readmissions
• Substance abusers
• Poor compliance with prescribed medical treatment
• Experiencing social problems that are impacting medical care
• Overuse of emergency department
• Complex care needs

A health assessment will be conducted of each member accepted into case management. A care plan will be developed and the member’s compliance with the plan will be monitored. The case manager interacts routinely with the PCP, the member and the member’s care giver/family.

18.4.1-C. HIV/AIDS
Early identification and intervention of members with HIV allows the case manager to assist in developing basic services and information to support the member during the disease process. The case manager links the member to community resources that offer various services, including housing, food, counseling, dental services and support groups. The member’s cultural needs are continually considered throughout the care coordination process.

The Mercy Maricopa case manager works closely with the PCP, the Mercy Maricopa corporate director of pharmacy, and a Mercy Maricopa medical director to assist in the coordination of the multiple services necessary to manage the member’s care. PCPs wishing to provide care to members with HIV/AIDS must provide documentation of training and experience and be approved by the Mercy Maricopa credentialing process. These PCPs must agree to comply with specific treatment protocols and AHCCCS requirements. PCPs may elect to refer the member to an AHCCCS approved HIV specialist for the member’s HIV treatment.

18.4.1-D. High Risk OB
Members that have been identified as high-risk obstetrical patients, either for medical or social reasons, are assigned to an OB case manager to try to ensure a good newborn/mother outcome. Please refer to Section 13.0 – Maternity of this Provider Manual for additional information. The case manager may refer the expectant mother to a variety of community resources, including WIC, food banks, childbirth classes, smoking cessation, teen pregnancy case management, shelters and counseling to address substance abuse issues. A case manager monitors the pregnant woman throughout the pregnancy, and provides support and assistance to help reduce risks to the mother and baby.

Case managers also work very closely with the PCP to make sure that the member is following through with all prenatal appointments and the prescribed medical regimen. Members with complex medical needs are also assigned a medical case manager so that all of the member’s medical and perinatal care issues are addressed appropriately.
Disease Management
The Disease Management team administers disease management programs intended to enhance the health outcomes of members. Disease management targets members who have illnesses that have been slow to respond to coordinated management strategies in the areas of diabetes, respiratory (COPD, asthma), and cardiac (CHF). The primary goal of disease management is to positively affect the outcome of care for these members through education and support and to prevent exacerbation of the disease, which may lead to unnecessary hospitalization.

The objectives of disease management programs are to:
- Identify members who would benefit from the specific disease management program.
- Educate members on their disease, symptoms and effective tools for self-management.
- Monitor members to encourage/educate about self-care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care.
- Provide evidence-based, nationally recognized expert resources for both the member and the provider.
- Monitor effectiveness of interventions.

The following conditions are specifically included in Mercy Maricopa’s Disease Management programs and have associated Clinical Guidelines that are reviewed annually.

18.4.1-E. Asthma
The Asthma Disease Management program offers coordination of care for identified members with primary care physicians, specialists, community agencies, the members’ caregivers and/or family. Member education and intervention is targeted to empower and enable compliance with the physician’s treatment plan.

Providers play an important role in helping members manage this chronic disease by promoting program goals and strategies, including:
- Preventing chronic symptoms.
- Maintaining “normal” pulmonary function.
- Maintaining normal activity levels.
- Maintaining appropriate medication ratios.
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations.
- Providing optimal pharmacotherapy without adverse effects.
- Providing education to help members and their families better understand the disease and its prevention/treatment.
18.4.1-F. Chronic Obstructive Pulmonary Disease (COPD)
The COPD Disease Management program is designed to decrease the morbidity and mortality of members with COPD. The goal of the program is to collaborate with providers to improve the quality of care provided to members with COPD, decrease complication rates and utilization costs, and improve the members' health. The objectives of the COPD Disease Management program are to:

- Identify and stratify members.
- Provide outreach and disease management interventions.
- Provide education through program information and community resources.
- Provide provider education through the COPD guidelines, newsletters and provider profiling.

18.4.1-G. Congestive Heart Failure (CHF)
The CHF Disease Management program is designed to develop a partnership between Mercy Maricopa, the PCP and the member to improve self-management of the disease. The program involves identification of members with CHF and subsequent targeted education and interventions. The CHF Disease Management program educates members with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements and benefits of smoking cessation.

18.4.1-H. Diabetes
The Diabetes Disease Management program is designed to develop a partnership between Mercy Maricopa, the PCP and the member to improve self-management of the disease. The program involves identification of members with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing member compliance with diabetes care and self-management regimens. Providers play an important role in helping members manage this chronic condition. Mercy Maricopa appreciates providers' efforts in promoting the following program goals and strategies:

- Referrals for formal diabetes education through available community programs
- Referrals for annual diabetic retinal eye exams by eye care professionals as defined in Mercy Maricopa’s Diabetes Management Clinical Guidelines
- Laboratory exams that include:
  - Glycohemoglobins at least twice annually
  - Micro albumin
  - Fasting lipid profile annually
- Management of co-morbid conditions like blood pressure, CHF, and blood cholesterol.

18.4.1-I. Active Health
Mercy Maricopa has contracted with Active Health Management to administer a patient health-tracking program with providers. Members will be receiving letters concerning their “Care
Considerations” as well.

Active Health will expand Mercy Maricopa’s opportunities to identify members at risk for poor health outcomes and to communicate directly with the providers who are responsible for their care, in a time-critical mode. It also enables the member to work closely with their physician to choose treatments and tests that are right for them. Active Health utilizes data received through claim, lab and pharmacy submissions to identify potential opportunities to meet evidence based guidelines, such as through the addition of new therapies, avoidance of contraindications or prevention of drug interactions. When an opportunity is identified for our member, a formal patient-specific communication will be sent to the provider to assist in offering health care to the patient based upon the physician’s independent medical judgment. A “Care Consideration” letter will be sent to the member as well, encouraging them to discuss the “Care Consideration” with their physician.

It is important to note that this program is not a utilization review mechanism and does not constitute consultation. Mercy Maricopa’s goal is to offer timely, accurate and patient-specific information to facilitate patient care and improve outcomes.

Examples of “Care Consideration” are:
- If the member is a diabetic and there are no records that the patient has had their eyes checked or an HgA1c lab has been done.
- If the patient has a heart condition and there are no records to show that the member is on any type of drug to lower cholesterol.