Chapter 13:

Care Management

Review/Revised: 01/18, 01/19, 01/20, 06/20, 01/21, 01/22, 01/23, 03/23, 01/24, 01/25

CARE COORDINATION

13.0 HEALTH APPRAISAL (HA)

See the BCBSAZ Health Choice Pathway Model of Care for Additional Detail.

Care coordination starts with a comprehensive health assessment of the beneficiary's medical, psychosocial, cognitive, functional, behavioral health, and social determinant needs. This assessment, called the Health Appraisal (HA), documents the beneficiary's perception of their healthcare needs. Initial HAs are conducted within 90 days of enrollment with Health Choice Pathway, and reassessments are completed annually. The HA results, along with claims information and predictive modeling, are used for risk identification. (Health Choice Pathway Model of Care)

13.1 INDIVIDUALIZED CARE PLAN (ICP)

The HA directly impacts the development of the beneficiary's Individualized Care Plan (ICP), which is a focused and member-centric living document. The ICP incorporates health concerns and gaps in care to meet each member's needs. It is ideally developed with the beneficiary and their support network. For those who did not complete the HA, an ICP is developed by reviewing claims information and gaps in care. The ICP includes elements such as initial health assessment scores, medical history, activities of daily living, life planning activities, healthcare preferences, goals for maximizing wellness, additional resources, visual and hearing needs, and cultural/linguistic preferences. The beneficiary may receive a copy of their ICP by mail, and primary care providers and other interdisciplinary care team members may receive it through secured email, fax, or standard mail.

13.2 INTERDISCIPLINARY CARE TEAM (ICT)

The ICT may include a Health Choice Pathway HA nurse, care manager, behavioral health care manager, pharmacy representative, medical director, the beneficiary, and their caregiver/support person. The beneficiary's PCP and other relevant providers are encouraged to attend. Beneficiaries are encouraged to participate in the development and reassessment of their care plan to promote health literacy and self-management of chronic conditions. ICT members are notified of meetings via telephonic outreach, standard mail, email, and/or face-to-face interactions. Feedback and discussion on identified goals and interventions take place during the ICT meetings, and the care plan is reviewed and updated based on recommendations.

13.3 CARE MANAGEMENT PROGRAMS

Health Choice Pathway uses a risk stratification process to review and analyze each beneficiary's healthcare needs. The process uses a modified Charlson Comorbidity Index to identify beneficiaries as high, moderate, or low risk. High-risk and targeted moderate-risk beneficiaries are referred to a Care Management (CM) program, where a Care Manager provides intensive, personalized care management services and goal setting for members with complex needs. The CM program supports members with multiple chronic conditions and/or specialty medications. Health Choice Pathway offers care management programs for chronic conditions such as Diabetes, Congestive Heart Failure, COPD, high-risk OB, and others, as well as special programs for unique cases like transplants, medication therapy management, and behavioral health conditions.

13.4 PROVIDER REFERRALS

Provider referrals are encouraged. Completed Care Management Referral Forms and pertinent medical documentation should be faxed to the Care Management Department at (480) 317-3358.