POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 1 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

SCOPE: Louisiana Healthcare Connections'(LHCC) Population Health and Clinical Operations Department (PHCO)~~Disease Management Department~~

~~This policy and procedure applies to all staff involved in operations and management of Behavioral Health care management and disease management services.~~

PURPOSE:

~~Louisiana Healthcare Connection's~~LHCC's Disease Management (DM) Program has ~~/ Health Coaching Programs have as~~ an overarching goal of helping ~~member~~enrollees with chronic physical and behavioral health conditions ~~(or symptoms indicating possible risk of a chronic behavioral health condition)~~ achieve the highest possible levels of wellness, functioning, and quality of life. The Disease Management Program is a sector of the Care Management Program within Population Health and Clinical Operations.

The diagnoses targeted by the Physical Health DM programs are as follows:

- Asthma
- Heart Failure
- Diabetes
- Hypertension
- Obesity (Adults and Pediatrics)
- HIV/AIDs
- Hepatitis C
- Sickle Cell Disease

The diagnoses and/or symptoms targeted by the Behavioral Health DM ~~Health Coaching~~ programs are as follows:

- Depression
- Anxiety
- Perinatal Depression
- Attention Deficit Hyperactivity Disorder (ADHD)

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 2 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

The DM programs related to Asthma, Heart Failure, Diabetes, Hypertension, and Weight Management are delegated to Envolve People Care (see Program Descriptions for each program in the attachments). All other programs are managed directly by LHCC Care Management staff.

~~DM Health Coaches~~Care Managers support and collaborate closely with primary care physicians, specialists and other providers to ensure ~~member~~enrollees and providers have access to the most effective and efficient resources for managing a ~~member~~enrollee's chronic physical and behavioral health condition(s). Disease-specific measurable goals are established so that the ~~DM Health Coach~~Care Manager and the ~~member~~enrollee/family/provider can measure the effectiveness of the Disease Management program. DM program participation is ~~voluntary, and~~voluntary and requires ~~member~~enrollee (or ~~member~~enrollee guardian) consent.

POLICY:

Each of the above listed DM programs are based on clinical practice guidelines and include evidence-based assessments. This policy will outline the DM program's procedure for the following:

- DM goals
- identification of program participants
- assessments
- stratification of acuity, minimum outreach, and re-assessment expectations
- outreach/~~member~~enrollee education guidelines
- provider involvement
- program discharge guidelines
- measures of efficiency
- program oversight

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 3 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

~~For more information on processes and flows related to each individual program and LA.DM.257 provides a detailed work process related to all DM programs.~~

~~Louisiana Healthcare Connections is not a medical provider of services and does not provide direct care and/or treatment to any of our program participants. The care management and disease management staff provides education in a health advisory role only.~~

PROCEDURE:

DM Goals

The overarching goal of the DM program(s) is to help ~~member~~enrollees achieve the highest possible levels of wellness, functioning, and quality of life. This is accomplished through a collaborative approach between DM staff and ~~member~~enrollee/family/provider to establish disease-specific measurable goals that allows the DM staff and the ~~member~~enrollee to track the effectiveness of interventions and make adjustments to interventions depending on symptom stability or lack thereof.

Specific goals of the DM ~~Depression, Anxiety, Perinatal Depression, and ADHD~~ Programs are as follows:

1. Increase ~~member~~enrollee/families understanding of the disease, its effects, and possible treatment options
2. Increase appropriate self-management behaviors to support ~~member~~enrollee coping/management of the ~~member~~enrollee's condition specific symptoms
3. Support, educate, and improve appropriate use of medications to treat the ~~member~~enrollee's condition specific symptoms

4. Increase integrated treatment planning

5. Prevent symptom escalation/exacerbation via preventative coaching. If symptoms escalate, DM will transition ~~refer~~ the ~~member~~enrollee to the appropriate level of Care Management (CM) for further assistance. ~~or Complex Care Management (CCM) levels of intervention~~

Identification

~~Member~~Enrollees are identified for the disease management programs through claims information indicating the below diagnosis or through ~~member~~enrollee screenings/assessments completed by the Care Management team. In addition, the ~~member~~enrollee is overall stable with no additional co-morbidities. If the ~~member~~enrollee is unstable or has additional co-morbidities, they will be referred to Care Management (CM) and then can transition to Disease Management once stable, if needed.

Program Specific Identification Requirements	
BH DM Program	Requirements specific to this program
Depression	~~Member~~Enrollees age 18 +
Anxiety	~~Member~~Enrollees ages 12+ (if ~~member~~enrollee is a minor participation requires guardian consent)
Perinatal Depression	~~Member~~Enrollees ages 12+ and currently pregnant or recently delivered (postpartum)
ADHD	~~Member~~Enrollees ~~ages from birth +~~ ~~Member~~Enrollees any age (if ~~member~~enrollee is a minor participation requires guardian consent)
PH DM Program	Requirements specific to this program
Diabetes	Pediatric and Adult Population

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 5 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

Asthma	Pediatric and Adult Population
Heart Failure	Adult Population
Hypertension	Adult Population
Obesity	Pediatric and Adult Population
HIV/AIDs	Adult Population
Hepatitis C	Adult Population
Sickle Cell Disease	Pediatric and Adult Population

As mentioned above, ~~Louisiana Healthcare Connections~~ LHCC ~~will~~ uses a variety of methods to identify ~~member~~enrollees who may benefit from DM.

- Health Needs Assessment(s) – Newly enrolled ~~member~~enrollees receive an initial health screen. This screening will be used to identify ~~member~~enrollees with risk factors that may indicate the need for DM. Screenings or assessments will be initiated within 30 days of identification with ~~member~~enrollee/guardian consent. Assessment and re-assessment can also be requested at any time by the ~~member~~enrollee(s), ~~member~~enrollee guardian(s), and/or provider(s).
- Predictive Modeling – Utilizing predictive modeling with specified filters, eligible ~~member~~enrollees will be proactively identified as being newly diagnosed and/or receiving prescription treatment for one of the DM diagnoses. ~~Depression, Anxiety, Perinatal Depression, or ADHD~~. Our predictive modeling tool is a ~~claims based~~claims-based system that identifies those at risk by examining recent service utilization.
- Referrals – ~~Member~~Enrollees are also identified through referrals from families, caregivers, providers, community organizations and internal health plan staff.

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 6 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

Assessments

All identified ~~member~~enrollees are contacted within 30 days of identification to complete the Health Needs Assessment and a DM Program evidenced-based Condition Specific Assessment(s), if applicable. ~~Assessments will be initiated within 30 days of identification, subject to member~~enrollee ~~voluntary participation.~~

Health Needs Assessments will be re-assessed at a minimum of yearly (or upon ~~member~~enrollee / guardian request or upon indication of a significant change in condition).

Condition Specific DM Assessments will be re-assessed at regular intervals (with ~~member~~enrollee consent) throughout the DM program to monitor ~~member~~enrollee symptom response to Health Coaching interventions.

Additional screenings are completed with the ~~member~~enrollee to assess for further needs such as social determinants in health needs and care gaps.

Based on the Care Managers assessment with the ~~member~~enrollee, the Care Manager ~~For detailed work processes related to the use of each program's condition specific assessment(s) please see work process LA.DM.257.~~

~~Participants that screen positive for a DM program related diagnosis in the absence of claims history related to that diagnosis are advised to discuss screening responses with a physician.~~

~~Stratification~~

~~Disease Management (DM)/Health Coaching Program objectives include the provision~~provides ~~of telephonic~~ coaching, education, ~~motivational interviewing interventions,~~ and ~~member~~enrollee/caregiver connection to support resources to promote ~~member~~enrollee adherence to treatment guidelines and facilitate

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 7 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

~~member~~enrollee self-management of his/her disease processes. The Care Manager follows up with the ~~member~~enrollee within the agreed upon frequency of contact via telephonic outreach.in ~~DM programs attempt to identify and engage member~~enrollees ~~proactively prior to symptom escalation.~~

Potential Exclusionary Criteria

The following criteria are high risk predictors that indicate a ~~member~~enrollee may not be appropriate for a DM ~~coaching~~ program, and instead may require case management~~CM/CCM~~ levels of intervention:

- Recent episodes of serious illness, injury, or surgery (in the past 60 days)
- Recent Inpatient Admission for Behavioral Health (in the past 6 months)
- Recent Inpatient Admission for Physical Health (in the past 30 days)
- Comorbid conditions related to Physical or Behavioral Health ~~:~~
  - ~~Bipolar disorder~~
  - ~~Schizophrenia/Schizoaffective disorders~~
  - ~~Autism or Autism with Psychosis~~
  - ~~Substance Use Disorders~~

~~**Acuity Levels, Outreach Frequency, and Re-administration of Condition Specific Assessments**~~

~~All member~~enrollee~~s enrolled in a DM program are stratified based on acuity to determine the appropriate level of intervention. Stratification is based on information obtained from our internal specific Health Needs Assessments and a DM Condition Specific Assessment.~~
~~Stratification and frequency of outreach for DM programs are separate from the Tiered Care Management Programs Stratification system noted in the Care Management Program Description (LA.CM.01). If a member~~enrollee ~~requires intensive intervention requiring Care Management (CM) or Complex Care Management (CCM) levels of intervention DM will refer transfer the member~~enrollee ~~to a CM/CCM program(s).~~

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 8 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

~~Member~~Enrollees ~~are stratified into three levels of acuity within DM.~~

~~Acuity is established based on DM Condition Specific Assessment scoring and the Health Needs Assessment(s).~~

~~**The three levels of Acuity are as follows:**~~

~~*Low*~~	~~*Minimum Outreach due - every 8 weeks - All three attempts should be completed within the designated follow up time frame.*~~ ~~*Care Plan updates should be sent to all active providers at least quarterly or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.)*~~ ~~*(Not applicable for member*~~*enrollee*~~*s with increased suicide risk)*~~ ~~Member~~Enrollees ~~at this Level - Condition is present, but is well controlled; symptom remission; less need for education,~~

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 9 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

	~~member~~enrollee ~~is in maintenance phase of stages of change. Participants are assigned to this group when they are determined to have entered into the maintenance phase of treatment or determined to be at a minimal or mild risk level based on the depression symptom screening.~~ ~~Individuals who are in this category are provided focused education material designed to educate them on their disease process, medications, and relapse prevention planning.~~ ~~*Condition Specific Assessments will be offered at minimum every 90 days to monitor intervention response. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.*~~
~~*Medium*~~	~~*Minimum Outreach due - every 4 weeks - All three attempts should be completed within the designated follow-up time frame.*~~ ~~*Care Plan updates should be sent to all active providers at least quarterly or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.)*~~ ~~*(Not applicable for member*~~enrollee~~*s with increased suicide risk)*~~ ~~Member~~Enrollee ~~symptoms present at medium severity but member~~enrollee ~~has not escalated to CM/CCM levels as evidenced by past history of symptom maintenance. Symptoms require education/coaching related to member~~enrollee~~'s condition to prevent escalation. Moderate risk participants are provided ongoing mail and telephonic outreach to provide education regarding available treatment options, collaborate with community providers, all in an effort to increase the member~~enrollee~~'s ability to self~~

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 10 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

	~~manage their condition. Additionally, participants are provided referrals to community resources where needed, such as transportation and community support groups relevant to diagnosis.~~ ~~*Condition Specific Assessments will be offered at minimum every 90 days to monitor intervention response. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.*~~
~~*High*~~	~~*Minimum Outreach due – every 2 weeks – All three attempts should be completed within the designated follow-up time frame.*~~ ~~*Care Plan updates should be sent to all active providers at least every four weeks from last contact or sooner if a significant change has occurred (change in acuity, new problem, new goal, etc.)*~~ ~~*(Member*~~*Enrollee ~~is at increased suicide risk and/or risk of escalating into CM/CCM acuity)~~* ~~Member~~Enrollee ~~exhibits high risk of escalating to CM/CCM levels evidenced by recent symptom escalation or increased risk for suicide. DM will monitor symptoms closely while providing coaching/motivational interviewing interventions in an attempt to stabilize and de-escalate symptom progression. Symptoms require education/coaching related to member~~enrollee~~'s condition to prevent escalation. If the member~~enrollee~~'s behaviors or symptoms escalate further, case may be transitioned to CM/CCM programs.~~ ~~High risk participants receive all of the interventions provided in the moderate risk program. Additionally, DM staff may staff cases in~~

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 11 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

	~~ICT Rounds to identify care gaps or strategies to prevent symptom escalation. DM Interventions and coaching emphasize preventing symptom escalation proactively, and then coordinate services to support ongoing stabilization.~~ ~~Condition Specific Assessments will be offered at minimum every 60 days to monitor intervention response. Diagnosis specific goals and action steps are established and serve as a focal point for future communication.~~

Outreach and Education

Multiple communication strategies are used in DM programs to include written materials, telephonic outreach, and web-based information. Staff receive training yearly regarding motivational interviewing techniques designed to engage, destigmatize, educate and empower ~~member~~enrollees to improve overall health and manage symptoms.

Written materials mailed to ~~member~~enrollees will meet criteria as outlined by current contract~~RFP~~ and LDH requirements. ~~Within seven to ten days of voluntary enrollment, m~~~~M~~~~ember~~Enrollees will receive a welcome letter including details about the program, information about how to contact DM staff (including LHCC's toll-free number), condition specific education materials and any other relevant health-related materials. Frequency of mailings will vary based on the level of intervention and based on the individual ~~member~~enrollee's Self-Management Plan.

Provider Involvement

In partnership with our health plan partners, Louisiana Healthcare Connections will ~~make available developed resources~~work collaboratively with the ~~member~~enrollee's providers to help primary care physicians and specialists recognize and manage ~~member~~enrollee's physical and/or behavioral health

symptoms. LHCC also collaborates with community partners to provide resources to ~~member~~enrollees in their area.

Program Length

~~Member~~Enrollees may participate in the Program as long as they remain medically eligible, are receiving primary health care coverage with LHCC and have not requested to be disenrolled from the program.

Discharge from Disease Management

The following criteria will be used to determine when discharge from disease management is appropriate:

- The ~~member~~enrollee reaches the maximum improvement.
- The ~~member~~enrollee achieves established goals regarding his/her improvement or health care stability and is referred to community resources. This may include preventing further decline in condition when health status improvement is not possible.
- ~~Member~~Enrollee/family is non-responsive to DM interventions despite multiple attempts to contact (based on health plan standards regarding outreach).
- ~~Member~~Enrollee declines to participate in DM, following efforts to explain the benefits of the program to the ~~member~~enrollee.
- ~~Member~~Enrollee's symptoms escalate indicating a need for a higher level of intervention (such as CM or CCM).

  ~~a. Examples of possible indicators of symptom escalation include but are not limited to:~~

  ~~i. Diagnosis with a Severe Mental Illness (SMI)~~

  ~~ii. Admission to an inpatient psychiatric program~~

~~iii. Increase in condition specific acuity scoring despite interventions~~

- The ~~member~~enrollee disenrolls from the health plan.
- The ~~member~~enrollee expires.

Measures of Efficacy and Reporting Mechanisms

Louisiana Healthcare Connections will monitor program engagement, enrollment, and successful program completion metrics for the DM program(s)

In addition to program specific monitoring the health plan will monitor the following:

- HEDIS: Antidepressant Medication Monitoring Effective Treatment (AMM)
- HEDIS: Follow-Up Care for Children Prescribed ADHD Medication (ADD) Measures
- HEDIS: Comprehensive Diabetes Care (CDC)
- Completion of Sickle Cell Assessments for ~~member~~enrollees identified for Sickle Cell Program
-

~~Program Oversight~~

~~The Medical Director is responsible for the clinical oversight and evaluation of all potential quality of care concerns/issues related to the depression disease management program.~~

POLICY AND PROCEDURE

DEPARTMENT: ~~Case Management~~Population Health and Clinical Operations	**DOCUMENT NAME:** ~~Behavioral Health~~ Disease Management Programs ~~Policy~~
PAGE: 14 of 14	**REFERENCE NUMBER:** LA.DM.258
APPROVAL DATE: 7/27/20	**REPLACES DOCUMENT:** LA.DM.234, LA.DM.256, LA.DM.236, LA.DM.235
EFFECTIVE DATE: 7/27/20, 01/23	**RETIRED DATE:**
PRODUCT TYPE: Medicaid	**REVIEW/REVISED DATE:** 5/21, 6/22,10/22

ATTACHMENTS:

Asthma_Program_Description.docx
Heart_Failure_Program_Description.docx
Hypertension_Program_Description.docx
Pediatric_Weight_Management_Program_D
Traditionl_Diabetes_Program_Description.d
Weight_Management_Program_Descriptior

REFERENCES:

LA.CM.01 – Care Management Program Description
~~LA.CM.01.01 – Care/Case Management Assessment Process~~
~~LA.CM.01.02 – Care Plan Development and Implementation~~
~~LA.DM.257 – Disease Management All Programs Work Process~~

DEFINITIONS:

REVISION LOG

REVISION	DATE
New Policy	01/2020
Annual review and grammatical changes	05/2021
Changed Medical Management to PHCO	06/2022
~~Changed " Medical Management to PHCO"~~ Changed "Members" to "Enrollees" Updated to reflect overall DM program for PH and BH diagnoses	10/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.