

Diabetes Disease Management Programs - 2008

The diabetes disease management programs are designed to create and maintain key desired behaviors of a diabetes population and the providers who care for them to improve member health status, thereby reducing health care costs. Our programs incorporate all interventions necessary to optimize patient care. They are based on the most up-to-date, evidence-based clinical practice guidelines developed and reviewed by physicians, and are based on American Diabetes Association guidelines.

Objectives:

The primary objectives of the diabetes programs are to:

- Slow disease progression
- Reduce risk of member acute exacerbations and death
- Educate and empower members toward self-management of diabetes and co-morbidities
- Improve members' quality of life through lifestyle management support and goal setting
- Educate and support physicians through evidence-based medicine

Program information and decision support activities are directed at improving/maintaining member health status and include condition monitoring, adherence to treatment plans, comorbid management, lifestyle issues (such as goal setting, techniques, problem solving), and community resource support.

Diabetes Disease Management Programs	Eligible Members
HealthQuest Program administered by Healthways Services, Inc. (HWAYS)	Commercial HMO/POS Fully Insured PPO Medicare Advantage
HealthPlus internally administered program	Medicaid, TPA, Supplemental Medicare

Eligibility: Members with diabetes are identified for both programs through medical and pharmacy claims analysis and referrals, using any one of the following claims criteria or referral sources without continuous enrollment requirements:

1. On insulin or oral hypoglycemics defined in the HEDIS® NDC list; **or**
2. At least 1 Emergency Room visit with a diagnosis of diabetes (ICD-9's 250, 357.2, 362.0, 366.41, 648.0) in the last 12 months; **or**
3. At least 1 inpatient discharge with a diagnosis of diabetes (ICD-9 250, 357.2, 362.0, 366.41, 648.0) in the last 12 months; **or**
4. At least 2 outpatient visits with a diagnosis of diabetes (ICD-9 250, 357.2, 362.0, 366.41, 648.0) with different dates of service in the last 12 months; **or**
5. An A1c claim with a value = or > than 7%; **or**
6. Physician, UM, or Case Management referral based on symptoms and treatment plan; **or**
7. Health Risk Appraisal; **or**
8. Member referral.

Enrollment and participation in either program is automatic once HealthPlus identifies the member's eligibility. HWAYS and HealthPlus update diabetes registries monthly. Newly identified members receive an introductory packet explaining how members become eligible to participate, how to use the program, and how to opt out. All inpatient admissions are evaluated for case management interventions. Members who meet eligibility criteria remain in the registry and are eligible for the program unless they choose to opt out of the program. Members may opt out of the program by calling 1-800-345-9956, ext. 1943, option 5, or by e-mailing dismgmt@healthplus.org.

Physicians may enroll a member in the programs and/or receive additional information about the diabetes programs by contacting HealthPlus at 800-345-9956, ext. 8194, to speak with a Disease Management Coordinator, or by e-mailing dismgmt@healthplus.org.

Interventions based on stratification:

HWAYS risk stratification methods include utilization of clinical and financial data, predictive modeling capabilities and self-reported information using proprietary tools. Members are stratified into one of four levels with Level 1 stratification comprising the lowest acuity level and Level 4 stratification representing the highest level.

In the HealthPlus internal program, members are stratified into one of three risk levels (Low, Moderate or High) as defined below.

High

Member is either diagnosed with diabetes or placed on insulin and/or oral hypoglycemic agents and meets one or more of the following criteria through medical record review, internal data sources, self-reported data, case management identification or physician feedback:

- 2 or more ER visits for diabetes in one quarter
- 1 or more inpatient admissions for diabetes in prior 12 months

Moderate

Member is either diagnosed with diabetes or placed on insulin and/or oral hypoglycemic agent, not previously identified as high risk, and has met one or more of the criteria listed below:

- 1 or more missed services in the prior 12 months (A1c, LDL-C, retinal exam or kidney function)
- Not on an ACE Inhibitor or ARB
- 1 ER visit in prior quarter

Low

Member is either diagnosed with diabetes or placed on insulin and/or oral hypoglycemic agents and does not meet criteria for moderate or high risk.

How the HealthQuest Program (an NCQA® Accredited Disease Management Program administered by HWAYS) works with physicians and their Commercial and Medicare Advantage patients:

1. Members receive an introductory welcome packet containing:
 - A welcome letter
 - The toll-free telephone number to the HWAYS Care Enhancement Center RNs
 - Diabetes-specific personal health workbook
2. The member's primary care and/or treating physician receives a companion welcome packet when a member is enrolled containing:
 - A welcome letter
 - The toll-free telephone number to the HWAYS Care Enhancement Center RNs
 - Diabetes-specific standards of care
 - A list of the diabetes-specific material the member receives in the member welcome packet
3. HWAYS RNs (Provider Services Managers or PSMs) provide follow-up contact to the primary care and/or treating physician. The HWAYS RNs provide and review reports which describe the PCP's members enrolled in one or more of the HWAYS programs, the risk stratification level of enrolled members (as determined by HWAYS), and whether the member is accepting calls from the program. The PSMs routinely audit medical record data and provide information to the PCP on ways to improve the plan of care.
4. Members with diabetes are assessed for other chronic conditions through general health assessments conducted by the Care Enhancement RNs during member calls.
5. Surveys are mailed annually to members. The surveys address satisfaction with the program, productivity, absenteeism, and perceived health status.
6. Surveys are mailed annually to physicians to measure satisfaction with the program.
7. Members in the diabetes program receive a disease-specific newsletter quarterly.

How the HealthPlus administered Program works with Medicaid Members:

Note: TPA and Supplemental Medicare members receive informational mailings, and their PCPs receive profile reports; but they do not receive phone calls or case management related services.

Member Interventions

Risk Level → Intervention ↓	Low	Moderate	High
Introductory letter and program packet informing how member was identified, how to use the services and how to opt out	Once initially	Once initially	Once initially
Disease-specific newsletter	Twice a year	Twice a year	Twice a year
Standard of Care Service reminders in newsletter	Annually	Annually	Annually
Automated telephonic standards of care reminder	Annually	Annually	Annually
Diabetes Control Network and Healthy At Heart educational mailings (Pfizer opt-in program)	Monthly x 1 Yr	Monthly x 1 Yr	Monthly x 1 Yr

Risk Level → Intervention ↓	Low	Moderate	High
Diabetes education class	Once a year	Once a year*	Once a year*
Satisfaction Survey	Annually	Annually	Annually
Diabetes special equipment	As needed	As needed	As needed
Eye care service mailed survey	Once a year	Twice a year	Twice a year
Nutrition seminar	Annually	Annually	
Web-based personalized support and education	Ongoing	Ongoing	Ongoing
Face-to-face education (hospital-sponsored programs)	Ongoing	Ongoing	Ongoing
Missed services reminder letter (A1c, LDL-C, retinal exam, kidney function tests)		At least annually	At least annually
Automated standards of care reminder message	Once a year	Once a year	Once a year
Automated telephonic missed service message – annual retinal exam		Once a year	Once a year
Automated telephonic missed service message – A1c, LDL, Kidney, DRE		Once a year	Once a year
Telephonic assessment for standards of care compliance if 2 or more ER visits in 90 days			Monthly
Case management discharge telephonic assessment for standards of care compliance after inpatient admission for diabetes in one quarter			Each discharge
Enrollment for case management (post hospitalization)			As needed
Referral to case management		As needed	As needed

* Or more often with change in medical condition

Physician Support

Intervention	Frequency
Program update mailing (including clinical guidelines) to PCPs and appropriate specialists	Annually
Provider Manual introduction to programs	Once initially
Patient Care Profile identifying potential missed services and co-morbid conditions	At least annually
Notification of Disease Management Program information in <i>Provider Plus</i> newsletter	Annually
Compliance reports (with comparative analysis) to PCPs	Annually
Educational presentation on pharmacy utilization to high volume providers	As needed
HEDIS® compliance reports with academic detailing	At least annually
Educational tools for offices (e.g., personal diabetes care record, diabetes care flow sheet, diabetes care stickers, diabetes foot exam stamp, diabetic retinal exam report sheets)	As needed
Diabetes Control Network and Healthy At Heart physician support mailings (Pfizer opt-in program)	Quarterly
Web-based support, including access to many patient education tools, clinical guidelines and forms	Ongoing

Explanation of Member and Physician Interventions:

- Standard of care service reminders:** Diabetes-related standard of care service reminders are provided to adult members and parents/guardians of pediatric members at least annually in a newsletter and by automated telephone message. These reminders urge them to talk with their doctor about when to obtain an A1c test, a cholesterol test, a test for kidney function, and a retinal exam.
- Telephonic assessment for standards of care service compliance:** Members hospitalized or who seek ER services for diabetes are called and assessed for education and self-care needs, using a scripted approach.
- Automated telephonic reminders** are sent to members whose claims history suggests are missing services (A1c test, LDL Cholesterol test, kidney function test, and retinal exam).
- Diabetes special equipment:** HealthPlus benefits allow members to obtain a glucometer through participating DME providers or pharmacies.
- Eye care service mailed survey:** Members receive a reminder postcard in the spring asking if they have obtained a retinal exam yet in the year and, if so, through what provider.
- Nutrition seminar:** A nutrition seminar that includes preparation of foods that are heart healthy, diabetes friendly, and address a specific theme (such as holiday foods or breakfast) are held in Flint and Saginaw locations once a year.
- Coordination with tobacco cessation, weight management, and depression screening services:** Coordination is available to Medicaid members receiving diabetes disease management services.
- Case management:** Members with diabetes and complex care needs qualify for evaluation to enroll in HealthPlus case management. Members in the HealthPlus diabetes program who are discharged from the hospital with a primary diagnosis of diabetes are evaluated for case management.
- Comorbidity evaluation:** The case management assessment process includes a thorough evaluation of the patient's medical conditions and psychosocial issues. The case management program involves ongoing management of the patient's conditions. Diabetes Care Profiles sent to PCPs include identification of the comorbidities end stage renal disease, coronary artery disease, heart failure, cerebrovascular accident, hypertension and retinopathy.

10. **Diabetes Control Network and Healthy At Heart Program** (offered by Pfizer Pharmaceuticals) is a sequenced 12-month series of mailings to members who opt in. This program is approved by the Michigan Department of Community Health for participation by Medicaid-eligible members. Member mailings include newsletters addressing heart health, food, exercise, travel, total health, and doctor/patient communication topics. They also address topics specific to diabetes management. PCPs of members who opt in are invited to opt in to receive recent and relevant information on managing dyslipidemia, hypertension or diabetes, epidemiologic updates, reports on clinical trends, and useful practice tips.

The following diabetes services are available to all eligible members – Commercial, Medicare Advantage, Medicaid, TPA, Medicare Supplemental groups:

- Diabetes Care Profiles:** Member-specific reports to PCPs of recent diabetes-related services and medication fills, and comorbid conditions as well as ER visits, inpatient admissions, and medication management. This report is produced at least annually. The Diabetes Care Profile provided to primary care physicians includes claims-based documentation of comorbid conditions (End Stage Renal Disease, Coronary Artery Disease, Heart Failure, CVA, Hypertension, and Retinopathy).
- Diabetes missed services reminder letters:** With primary care physician (PCP) permission, reminder letters are mailed under their name to their members who have been identified as not meeting diabetes standards of care for A1c, LDL-C, nephropathy testing, and diabetic retinal examinations. The letters encourage members to contact their PCP for services.
- HealthPlus website:** The website provides information about diabetes, including materials and links targeting adults, teens, and children. (See www.healthplus.org which includes information and links for members [adults, teens, and children] and physicians [*Diabetes Educational Materials, some available in Spanish*].)
- Healthy At Heart Program:** Members with a pharmacy benefit who are receiving hypertension or cholesterol medications are offered opt-in participation in the Pfizer Healthy At Heart Program, 12 monthly sequenced educational mailings. It includes a diabetes component if the member indicates a diabetes diagnosis at the time of enrollment.

Participation Rates:

HealthPlus measures the participation rates for both the HWAYS and HealthPlus-administered diabetes programs annually. 2006 and 2007 rates are reported below.

	HealthQuest Diabetes Program Commercial & Medicare Advantage		Medicaid	
	2006	2007	2006	2007
Participants (numerator)	5,689	6,070	1,523	1,763
Diabetes population (denominator)	5,808	6,108	1,581	1,854
Participation rate	98.0%	99.4%	96.3%	95.1%

2007 participation rate specific to Medicare Advantage line of business = 99.3%

Measures of Effectiveness:

HealthPlus employs and tracks performance measures for each disease management program. Each measurement:

- Addresses a relevant process or outcome
- Produces a quantitative result
- Is population based
- Uses data and methodology that are valid for the process or outcome measured
- Has been analyzed in comparison to a benchmark or goal

Current measures include the following HEDIS® measures:

1. Hemoglobin A1c (HbA1c) testing
2. HbA1c poorly controlled (>9.0%)
3. Eye exam (retinal) performed
4. LDL-C screening performed
5. LDL-C controlled (<130 mg/dL)
6. LDL-C controlled (<100 mg/dL)
7. Kidney disease (nephropathy) monitored
8. Blood pressure controlled (<130/80 Hg mm)
9. Blood pressure controlled (<140/90 Hg mm)
10. HbA1c <7

Member Satisfaction:

HealthPlus annually evaluates satisfaction by evaluating member survey results and member complaints.