DISEASE MANAGEMENT PROGRAMS

Procedural Manual

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Annotated to meet 2014 NCQA Health Plan Standards, Guidelines and Procedures
DISEASE MANAGEMENT PROGRAMS

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OVERVIEW

A. Program Description: Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Children’s Mercy Pediatric Care Network (CMPCN) identifies two chronic conditions that are relevant to its membership: asthma and diabetes. This document explains the disease management programs.

B. Program Goals: Disease management programs can improve outcomes, reduce hospital length of stay, improve quality of life, and lower overall costs. Chronic disease and medically complex conditions have a significant impact on quality of life, health care outcomes and costs.

C. Program Objectives. CMPCN elected to implement a comprehensive asthma and Diabetes prevention and management program for the following reasons:

1. Consistent clinical practice guidelines are available with core recommendations.
2. High readmission rate of hospitalizations can be controlled
3. Complications are preventable.
4. Variation in care was evidenced in HEDIS scores. (Diabetes)
5. Prevention of Impaired Glucose Tolerance, childhood obesity with PCP education programs, increased diagnosis of chronic diseases

D. Clinical Practice Guidelines (CPG): the disease management programs operate under the direction of clinical experts and approval by the Clinical Quality and Management committee.

2. Diabetes – CPG’s adapted from these sources: The National Diabetes Education Program Guidelines, the Centers for Disease Control (CDC), and The American Diabetes Association, Standards of Medical Care, January 2010, Diabetes Care
3. Childhood Obesity Action Network (COAN implementation guide), 2007
4. CPG Approval and Posting: CPGs are approved by the Clinical Quality Management Committee (CQMC) as explained below:
   a) Committee reviews CPGs annually
   b) CPGs are posted to the contracted health plan website under the provider resources portal as well as the CMPCN website- www.cmpcn.org

E. Patient centered Medical Home – An approach to provide comprehensive health care. The PCMH facilitates teamwork between patients, their PCP’s, their health care team, and the
patient’s family. The programs will assist contracted PCP’s in achieving minimum requirement of Level 1 PCMH. Standards include:

1. Enhance Access and continuity
2. Identify and Manage patient population (DM Programs)
3. Plan and Manage Care (DM Programs)
4. Provide Self-Care Support and Community Resources
5. Track and Coordinate Care
6. Measure and Improve performance

I. PROGRAM CONTENT

A. Condition Monitoring: the program addresses the following:
   1. Initial/ongoing assessment to evaluate member ability to self-manage their chronic disease
   2. Quality of life and functional status
   3. Adherence to treatment plan
   4. Level of control
   5. Factors that impact health status:
      a. Environmental conditions
      b. Medication adherence
      c. Smoke exposure
   6. Co-morbidities and lifestyle issues
   7. Depression Screening- assessed with member utilizing DM staff, if not previously completed by CM.

B. Patient Adherence to Prescribed Treatment Plan: The program provides support and education concerning adherence to provider treatment plan and current clinical practice guidelines. An individualized treatment plan includes problems/barriers, interventions and short and long term goals.
   1. Outreach calls to members to on behalf of the PCP to assess:
      a. Level of control
      b. Medications
      c. High-risk behaviors
      d. Acute/chronic complications
      e. Goal setting and problem solving
      f. Psychosocial adjustments
      g. Nutrition

Comment [CR3]: QI 8 A-Program Content
Comment [CR4]: QI 8 A 1- Depression Screening A-6 assessed in CM procedural guide and CARE / Depression Tab/CARE
h. Self-Care behaviors
   i. Frequency of provider visits and screening exams

2. Self-management skills
3. Educational mailings
4. Collaborative communication between member and provider

C. Consideration of Other Health Conditions
   1. Smoking cessation
   2. Medication adherence
   3. High risk behaviors
   4. Behavior health issues
   5. Obesity
   6. Other co-morbid conditions

D. Lifestyle Issues as Indicated by Clinical Practice Guidelines
   1. Establish goals including identified issues related to lifestyle.
   2. Document goals and results in CARE (Case Assessment and Referral Evaluation - the documentation system for CMPCN. Incorporate identified issues into the following sources:
      a. Member education materials
   3. Empower members toward:
      a. Proactive self-management of their chronic disease
      b. Understanding appropriate use of resources
      c. Utilizing education materials to identify and address early signs and symptoms
      d. Adherence to their treatment plan as monitored by:
         i. Claims data/Gaps in Care Data- (Gaps in Care information is HEDIS related information related to adherence to those measures specific to age, disease state, etc.)
         ii. Specific goals established via CM assessment.

II. IDENTIFYING MEMBERS FOR DISEASE MANAGEMENT PROGRAMS: CMPCN employs multifaceted strategies to identify members and automatically enrolled them in the disease management programs that meet criteria.

A. Disease Management Registry (Asthma, Diabetes and Pre-Diabetes)
   1. Monthly claims and pharmacy data reports

B. Internal/External Referrals
I. DAILY INPATIENT CENSUS REPORT
2. CASE MANAGERS/UTILIZATION REVIEW TEAM
3. NURSE HELPLINE
4. CLAIMS/ENCOUNTER DATA (INCLUDES PHARMACY)/GAPS IN CARE REPORT
5. PROVIDER OFFICE
6. MEMBER/Self-Referral

III. PROVIDING MEMBERS WITH INFORMATION: CMPCN provides members with written information about the disease management program. PCP will also be notified of members with increased utilization via PCP directive (outreach phone calls, post card, member letter, etc.)

A. HOW TO USE SERVICES
1. Health Plan-
   a. Information about disease management programs
   b. Clinical services resource team and how to access
2. Introduction letter and packet sent to new members within CMPCN
3. CMPCN Clinical Services (888) 670-7262
4. Provider Education- CMPCN website: www.cmpcn.org

B. HOW MEMBERS BECOME ELIGIBLE TO PARTICIPATE
1. All members with a diagnosis of asthma/diabetes are eligible to participate and are automatically enrolled in the disease management programs.
2. Members may self-refer to these programs by calling CMPCN clinical services. (1-888-670-7262)
3. Providers may refer members to the program.

C. HOW TO OPT OUT
1. Members are automatically enrolled in the program until they opt out. Members receive information about the disease management program in the New Member Packet.
   a. Members can opt out of the disease management programs by notifying CMPCN Clinical services or Health Plan Customer Service.
   b. Customer Service sends email to CMPCN Clinical Services of members’ decision to opt out.
   c. Opt-out information documented in CARE

IV. INTERVENTIONS BASED ON ASSESSMENT

A. RISK STRATIFICATION: The disease management programs classify eligible members into stratification levels according to condition severity or other clinical or member-provided...
information. The program tailors content; education and support for each risk level; members may move into different risk levels during the program.

1. **Monthly Disease Management Registry Report:** Members who are diagnosed with asthma/diabetes are included in the disease management programs using historical claims data. This includes those who meet at least one of the following criteria during the past year:

   a. **Asthma DM Registry**
      i. \( \geq 8 \) pharmacy claims for short acting beta agonists in the past 12 months.
      ii. \( \geq 1 \) asthma-related (primary diagnosis-top 3) emergency visit in the past 12 months.
      iii. \( \geq 1 \) asthma-related (primary diagnosis-top 3) hospital visit in the past 12 months.

   b. **Diabetes DM Registry**
      i. \( \geq 2 \) diabetes-related (primary diagnosis-top 3) emergency department visits within the past 12 months.
      ii. \( \geq 1 \) diabetes-related (primary diagnosis-top 3) hospital visits within the past 12 months.
      iii. Members who were dispensed insulin or oral hypoglycemic/antihyperglycemics in the past 12 months on an ambulatory basis.

   c. Members who had two face to face encounters with different points of service in an outpatient setting or non-acute inpatient setting or one face to face encounter with an acute inpatient or emergency department (ED) setting in the past 12 months with a diagnosis of diabetes.

   d. **Pre-Diabetes/Impaired Glucose Tolerance DM Registry**
      i. Members having more than two billed diagnosis codes in the past 12 months. (Codes include: 277.7; 790.2; 256.4; 790.6)

B. **Risk Stratification Interventions:**

1. Table 1(a, b) lists the primary risk stratification criteria for low, medium and high risk categories.
2. Table 2(a, b) lists interventions for members based on assigned risk category.
Table 1a: Asthma Risk Stratification

<table>
<thead>
<tr>
<th>Activities Previous 12 Mo.</th>
<th>Points Per Activity</th>
<th>Initial Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visit in Past 12 Months</td>
<td>1 point/asthma visit</td>
<td>Low: 0-3 total points</td>
</tr>
<tr>
<td>Hospitalization in Past 12 Months</td>
<td>2 points/asthma visit</td>
<td>Medium: 4-6 total points</td>
</tr>
<tr>
<td>Any Oral Corticosteroids in Past 12 Months</td>
<td>1 point</td>
<td>High: ≥ 7 total points</td>
</tr>
<tr>
<td>≥ 8 Short acting Beta 2 Agonist Canisters in Past 12 Months</td>
<td>1 point</td>
<td></td>
</tr>
</tbody>
</table>

Table 1b: Diabetes Risk Stratification

<table>
<thead>
<tr>
<th>Activities Previous 12 Mo.</th>
<th>Points per Activity</th>
<th>Initial Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>One ED visit within the previous 12 months</td>
<td>1 point/diabetes visit</td>
<td>Low: 1 total points</td>
</tr>
<tr>
<td>Member on insulin/hyperglycemic</td>
<td>1 point</td>
<td>Medium: 2-3 total points</td>
</tr>
<tr>
<td>Hospitalizations in the previous 12 months</td>
<td>2 points/diabetes visit</td>
<td>High: ≥ 4 total points</td>
</tr>
</tbody>
</table>
### Table 2a: Asthma Risk Stratification Interventions

<table>
<thead>
<tr>
<th>RISK STRATIFICATION INTERVENTIONS</th>
<th>Low Risk = 0-3 Pts.</th>
<th>Medium Risk = 4-6 Pts.</th>
<th>High Risk = ≥ 7 Pts.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Targets those with Intermittent Asthma and Well Controlled Asthma</strong></td>
<td>Maintain members in DM registry.</td>
<td>Spring/Fall Outreach Mailing to facilitate scheduling of provider appointments and medication adherence</td>
<td>Same components as for Medium Risk</td>
</tr>
<tr>
<td></td>
<td>Monitor for any level changes.</td>
<td>Directed mailings from PCP including; What is Asthma? Asthma Action Plan</td>
<td>Screening for referral to case management by Disease Management Specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Individualized treatment plan developed for members opened in case management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Encourage PCP communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CM referral to behavioral health if indicated</td>
</tr>
</tbody>
</table>

Comment [CR13]: Q8 A 1-2
# Table 2b: Diabetes Risk Stratification Interventions

<table>
<thead>
<tr>
<th>RISK STRATIFICATION INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low=1 pts.</strong></td>
</tr>
</tbody>
</table>

### Targets those with a diabetes diagnosis
- Maintain members in DM registry.
- Monitor for changes in status.

### Targets those with not well controlled diabetes
- Disease and age-specific educational materials:
  - **Type 1**
    - What is Type 1 diabetes?
    - DKA Prevention
    - Carb Counting Handout
  - **Type 2**
    - 7 Healthy Tips
    - Physical Activity
    - Type 2 Hand Out
- CM Referral to behavioral health if indicated

### Targets those with poorly controlled diabetes
- Disease and age-specific educational materials:
  - **Type 1**
    - What is Type 1 diabetes?
    - DKA Prevention
    - Carb Counting Handout
  - **Type 2**
    - New Diagnosis/Starting Insulin
    - 7 Healthy Tips
    - Physical Activity
    - Type 2 Hand Out
- Screening for referral to case management (CM) by Disease Management Specialist
- Individualized treatment plan developed for members opened in case management
- Targeted mailing of additional resources
- Referral to community-diabetes education program
- Encourage PCP communication
- CM Referral to behavioral health

*Comment [CR14]: QF 8 A 1-3*
V. ELIGIBLE MEMBER PARTICIPATION
CMPCN measures member participation rates quarterly.

VI. INFORMING AND EDUCATING PROVIDERS ABOUT DISEASE MANAGEMENT PROGRAM

A. Written Information About Program and Services
1. Letter mailed to PCPs includes a list of their CMPCN patients who are enrolled in the disease management programs (health plan specific) with explanation of how we work with the members.
   a. Providers receive a list of their enrolled patients upon member initial enrollment and at least annually thereafter.
2. CMPCN website (www.cmpcn.org) includes materials for the disease management programs.

B. Education Program for Providers and Staff: Disease Management Specialists present the Clinical Practice Guidelines via standardized didactic curriculum to providers and staff at the PCP office. This information can also be presented as part of the Patient Centered Medical Home model.
1. Goals of Didactic Education
   a. To empower providers to diagnose and treat chronic diseases according to national guidelines.
   b. To empower providers to teach their patients how to self-manage chronic diseases
2. Shadow Time at PCP Practice: Disease Management Specialists are available to the staff for hands-on application of best practices (e.g. spirometry; written asthma action plans; medication devices, monitoring, etc.). This role is for education only and no patient care is provided unless working alongside clinic staff during shadow time.
3. Program Monitoring –Provider-Specific Performance: The Disease Management Specialists promote best practices by measuring provider-specific metrics for contracted PCP offices. Data outcomes are presented to providers and staff to discuss progress and challenges, and to give educational updates as needed.
4. Utilization Reports:
   a. Annual reports are sent to providers that include the number of members with chronic disease. This information also available on the provider portal for PCMH.
   b. Results of provider metrics are provided to participating clinics.
   c. A new member listing is provided for PCPs caring for members already enrolled in the disease management program monthly.

Comment [CR15]: QI 8 F DM quarterly reports
Comment [CR16]: QI 8 G Monthly/Annual Letters to PCP’s re: Members in DM programs, CMPCN Portal Registries
Comment [CR17]: CMCPN Portal- Asthma/Diabetes Registry available
Comment [CR18]: QI 8 G- Informing and Educating providers
**VII. INTEGRATING MEMBER INFORMATION**

**A. CARE System:** CMPCN uses the CARE documentation system to integrate member health information. CARE allows access to referrals and claims and to the DM registry which includes information about claims, pharmacy and utilization. Member information is integrated from the following programs:

- Disease Management Program
- Case Management Program
- Utilization Management Program

**B. Collaborative Management with CARE:** CARE allows Utilization Management Nurses, Case Managers and Disease Management access to notes and assessments of their counterparts. Claims and Authorizations can be reviewed in this program.

1. If a member is not already in a Disease Management (DM) program or Case Management (CM) program, the CM or DM can send a referral/consult through CARE to the appropriate staff member. The DM Specialists will act as a specialty consultant with the Case Manager as the primary contact.

2. If a member is in both Case Management and Disease Management, the specialist and Case Manager collaborate on the care and education provided. This includes:
   a. Home/clinical/school visits
   b. Education materials
   c. CMPCN Clinical Services Management Rounds

**VIII. MEASURING EFFECTIVENESS:** This information will be provided to the health plan quarterly to submit to the state.

**A. Quarterly State Report**

1. Total number of members enrolled and disenrolled during the quarter

**B. Analysis Report of DM Programs**

1. Description of eligibility criteria and method used to identify and enroll members
2. Active participation rate: Percentage of identified eligible members who received an intervention divided by the total population who meet criteria for eligibility
3. Total number of active members having one or more diagnosis code (ICD-9 Codes) relating to each DM program
4. Member Satisfaction with Disease Management program experience
   a. Annual member satisfaction survey
   b. Annual analysis of member complaints or grievances related to the programs
5. Performance against at least two important clinical aspects of the CPGs:

   a. **Asthma**
      i. Use of appropriate medications for asthmatics (HEDIS)
      ii. Spirometry or Asthma Control Test (ACT) validated questionnaire

   b. **Diabetes**
      i. HEDIS data measures the percentage of members 18-21 years of age with diabetes (Type 1 and Type 2) who had all of the following medical evaluations:
         - Eye exam (retinal)
         - HbA1c testing
         - LDL-C screening
         - Medical attention for nephropathy
      ii. HEDIS like measures completed for those patients less than 18 years of age.
         - Members with an HgbA1C
         - Members with a micro albumin

C. **Annual Quality Assessment and Improvement Report**

   Reports are prepared for each health plan to include in their annual report, as requested.