Diabetes Disease Management Program Description

2015
**Introduction**

Diabetes is a disease characterized by high levels of blood glucose, either the result of defects in the production of insulin and/or the body’s inability to use the insulin it produces. These high levels of blood glucose can lead to increased risk for hypertension, hyperlipidemia, retinopathy, neuropathy, and nephropathy. According to the Centers for Disease Control and Prevention (CDC), approximately 29.1 million people in the United States (9.3% of the population) are affected by diabetes (2012), both diagnosed and undiagnosed. From 1980 through 2012 the number of diagnosed individuals with Diabetes within the United States rose from 5.1 million to 21 million (HCCI, May 2015).

Diabetes and its related conditions can lead to heart disease, blindness, and loss of limbs among other complications. Diabetes is the leading cause of kidney failure. It is the seventh leading cause of death in the United States. In 2012 the estimated direct costs of diabetes in the United States was $176 billion, according to the Health Care Cost Institute report, May 2015.

Diabetes is a chronic disease that can be controlled with client education, medication management, and identification and elimination of triggers in the environment. Valence Health’s Diabetes Management Program (program) is designed to identify and improve clinical outcomes for our members with diabetes, through the development and promotion of strategies that lead to better quality health care, cost effective outcomes, and higher member satisfaction. The program incorporates a structured process which defines goals, interventions, and outcome measures and provides guidance and focus for improvement. The overall program design and structure are parallel to other Valence Health disease management programs, while goals, interventions, and outcome measures are specific to diabetes.

Stratification, assessment, and interventions are based on best practices designed to address the obstacles and unique complexities that this vulnerable population faces and are consistent with the American Diabetes Association, Diabetes Care, *Standards of Medical Care in Diabetes, 2014*. This guideline is annually reviewed and adopted by Valence Health.

Outcome measures are quantifiable, reliable, and link directly to the program goals. The measures are routinely tracked to document progress and provide feedback regarding the program success and/or the need to revise interventions to achieve the desired outcomes.

Valence Health works with the client health plans to customize this program to fit the specific needs of the client’s member population and regulatory requirements. Changes and modifications are presented in attachments to this program description.

**Goals, Strategies, and Outcomes Measures**

The overall program goal is to control diabetes by reducing impairment and risk, resulting in improved clinical outcomes and decreased health care costs. The objective of the program is to teach timely interventions to help stabilize the member’s diabetes, and promote effective diabetes self-management through a collaborative effort of all members of the healthcare team, the patient/caregiver and the Disease Manager.

Strategies to accomplish this goal include:

- Identification and stratification of members with diabetes on a monthly basis
- Providing general and focused interventions, based on stratification and assessment
Conducting outreach, engagement, assessment, and education to high risk members with diabetes, and their families/caregivers, to improve their health care outcomes and to develop diabetes self-management strategies

Facilitating communication, teamwork, coordination and management of necessary health care services

Assisting members requiring community resources such as transportation and food stamps

Outcomes measures used to assess the effectiveness of the program include:

- Reduction in diabetes-related emergency room utilization
- Reduction in diabetes-related inpatient hospital admissions
- Improvement in appropriate screenings such as LDL, HgA1c and microalbuminurea (dependent on available client data)
- Member program satisfaction and self-reported improvement in diabetes management

Program Overview

Member Identification
Members are systematically identified, based on HEDIS methodology, and stratified on a monthly basis. See Appendix A for information about identification and stratification, including sources.

Member Stratification
Subsequent to identifying a member with diabetes, data from the above sources is compared to the descriptions in the Stratification Levels (Appendix A) and the member is assigned one of three levels of risk (I, II, or III). The process results in the identification of and consistent application of appropriate resources and interventions for the member. The stratification level is reviewed at least monthly while managing the member’s care and members may move from one level to another based on changes in their condition.

Members who are identified through referral – self, provider, medical/case management, member services, health information line, or the wellness programs – are screened to determine the appropriate level of program. The Case Manager reviews the authorization and claims/pharmacy history in the Care Manager system (as available), as well as data within Vision (as available), and places the member in the appropriate level. Members hospitalized or treated within the ER within the past year where diabetes was the principle diagnosis are placed in Level III, members who have a history of diabetic complications are placed in Level II, and all others and for those where utilization data is unavailable are placed in Level I. Members identified through data sources are automatically stratified into the appropriate level, based on the established algorithm, and a case is automatically opened in Care Manager.

The stratification level rating is documented in the Care Manager system. Members who move to a higher Level will automatically be moved in the Care Manager system and an Alert sent to a nurse case manager. For members who move from Level II or III to Level I, their case manager will be notified and will have the option of allowing the move or retaining the member in the higher Level, based on the needs of the member.
**Member Intervention**

The following outlines interventions and frequency of member contact based on the identified stratification level. The diabetes disease management program is an opt-out program.

**Level I – Well Controlled**

Level I is a mail-only program. The focus is on population-based interventions for members, including both disease-specific and general preventive care.

A letter is mailed to members annually, which describes:

- How the member became eligible to participate in the program
- How to use the services
- How to opt out of the program
- How to speak with a nurse case manager if requested

Diabetes and preventive health educational materials are mailed twice a year. Diabetes-specific materials include self-management condition monitoring tools (i.e. charts to assess blood sugars, food diaries), information about diabetic co-morbidities (including appropriate labs and timeframes), and information about chronic disease and depression. General preventive care educational pieces address health behaviors (i.e. smoking cessation, nutrition, exercise) and information about community resources. Educational pieces are assessed for cultural and linguistic applicability and address psychosocial issues, based on the client population.

**Level II – Not Well Controlled (identified co-morbidities)**

Level II combines all of the mailed interventions identified above for members stratified as Level I as well as telephonic outreach assessment.

A nurse case manager or health educator conducts telephone outreach to members to:

- Explain health plan benefits and how to access needed services
- Assess the member’s health status (medical, behavioral, psychosocial), understanding of diabetes self-management concepts, and adherence to prescribed treatment plan (including medical testing and medication adherence)
- Develop a disease-specific plan of care to address problems, barriers, and goals towards achieving self-management and better outcomes
- Encourage, support and reinforce members’ efforts to effectively manage their diabetes through participation with their primary care physician (PCP) in the development and maintenance of a diabetes treatment plan
- Level II interventions focus on managing identified co-morbidities appropriately

The case manager communicates and coordinates with the PCP and member to develop or revise diabetes treatment plans, as necessary. Supplemental educational materials may be provided to the member, based on identified need and the prioritized plan of care, and may include subjects such as medications, eye exams, foot care, and local community resources.

Member contact is highly individualized, with the frequency of member contact determined by the member’s disease status. Member and provider contact is anticipated one time per month until the member’s diabetes disease process is well-controlled and the member meets goals for self-management.
and self-monitoring skills. The case manager will work with the PCP to ensure follow-up within one week if/when the member’s needs escalate (i.e. diabetes-related ER or hospital admission)

Level III – Very Poorly Controlled
Level III combines all of the mailed interventions identified above for members stratified as Level I as well as telephonic outreach assessment.

A nurse case manager conducts telephone outreach to members to:

• Explain health plan benefits and how to access needed services
• Assess the member’s health status (medical, behavioral, psychosocial), understanding of diabetes self-management concepts, and adherence to prescribed treatment plan (including medical testing and medication adherence)
• Conduct a comprehensive case management assessment, including assessment beyond diabetes and co-morbidities
• Develop a comprehensive plan of care to address problems, barriers, and goals towards achieving self-management and better outcomes
• Encourage, support and reinforce members’ efforts to effectively manage their diabetes through participation with their primary care physician (PCP) in the development and maintenance of a diabetes treatment plan
• Provide extensive management and coordination of services
• Depending on identified need, may coordinate a face to face visit with a Diabetes Educator for intensive, client-specific education.
• Assist member and PCP in identifying network providers for necessary specialty services such as endocrinology and ophthalmology
• Monitor member’s status on a regular basis, through contact with member and provider

Member contact is highly individualized, with the frequency of member contact determined by the member’s disease status. Member and provider contact is may be as frequent as every one to two weeks, until the member’s diabetes disease process is well-controlled and the member meets goals for self-management and self-monitoring skills. More frequent contact may be required if the member’s condition remains unstable.

Member Assessment
Members stratified into Levels II and III will receive a comprehensive telephonic diabetes management assessment. Member and caregiver interviews are the primary information source used to complete the assessment, with supporting information obtained from the member’s PCP and/or other providers involved in the member’s care.

The assessment is used to:

• Identify and record:
  • Diabetes condition monitoring including self-monitoring and physician monitoring
  • Adherence to treatment plans, including medication adherence
  • Clinical and behavioral health history and status, including co-morbidities and other health conditions
• Health behaviors
• Psychosocial needs
• Depression screening
• Determine member’s desired level of participation. Identify any need for community resources, outside of the health plan.
• Develop a comprehensive disease management plan, when appropriate.

Plan Development
For members who have completed the assessment, a Case Manager collaborates with the member to develop a comprehensive plan of care which:

• Meets the member’s needs
• Addresses member preferences, including the member’s desired level of involvement in case management and self-management
• Identifies prioritized goals
• Specifies timeframes for follow up and re-evaluation
• Considers contingency options in anticipation of care gaps, changes in psychosocial needs, and/or disease complications
• Maximizes the potential for achieving outcomes
• Includes the following educational components:
  • Basic facts about diabetes, proper use of testing and medications, and adherence to a diabetes treatment plan
  • Information regarding diabetes self-management techniques and self-monitoring skills

The Case Manager discusses the plan with the member and/or caregivers and amends the plan as needed to gain consensus. The Case Manager encourages members to communicate with their practitioners about their health conditions and treatments. The Case Manager may communicate with the PCP and providers involved in the member’s care, to obtain clinical information necessary to finalize the member’s plan and to assist in the implementation of the care plan.

Program Implementation
The program focuses on educating and empowering members towards self-management of diabetes. Valence Health follows established processes to:

• Notify the PCP and appropriate specialists that the member is receiving diabetes management services, provide contact information, and answer any questions about the diabetes management plan
• Provide copies of the care plan to the PCP and specialists identified by the member, as requested
• Coordinate referral to appropriate providers and community based resources to provide required services for the member
• Coordinate transportation services to appointments, as needed
• Assess member’s progress toward overcoming barriers to care and meeting treatment goals
• Document the member’s original care plan and subsequent updates/ revisions, member and provider contacts and interventions, within the member’s record
• Address any quality of care concerns with the health plan medical director

Ongoing Assistance and Plan Modification
Valence Health contacts members according to the agreed upon schedule documented in the care plan. During the call, the Case Manager asks specific questions about the member’s current clinical and psychosocial status and offers interventions to identified issues. If the member reports a decline in their baseline clinical/behavioral health status or has specific questions that the Case Manager is unable to answer, the member is referred to their PCP or appropriate specialty provider, facilitated by the Case Manager as appropriate.

Valence Health routinely reviews the member’s status and may modify the plan to address (a) changes in the member’s clinical and/or psychosocial status (b) member compliance with the care plan, and (c) issues identified by the member and/or the treatment team regarding the overall plan and management of the case.

The Case Manager may implement changes to the care plan to identify and arrange for additional services, and/or alternate treatments.

Program Exit Criteria
Members in all levels of the Diabetes Management Program will be disenrolled from the program for any of the following reasons:
• Loss of eligibility in the health plan
• Member requests disenrollment from the diabetes management program
• Lack of participation, e.g. member cannot be reached after multiple attempts

Members in Levels II or III who meet the goals identified in their care plan will be moved to Level 1 and will remain in the program unless they meet one of the exit criteria listed above. Prior to discharging a member for lack of participation, Valence Health will make three telephonic attempts to reach the member, followed by an “unable to reach” letter. The case may be opened again if the member has re-gained eligibility or if s/he is identified again, by the appropriate criteria and stratification, after six months post-discharge.

Communication and Confidentiality

Confidentiality
Effective communication is critical to the success of any disease management program. Various individuals who have an interest in the well-being of the member and the management of the member’s care must be kept informed, and have an opportunity to participate in decisions affecting the member. This includes caregivers who have consent from the member to be included in care planning.

In order to facilitate effective and efficient communication, guidelines have been established to address the exchange of information during the disease management process. Health information obtained
through various programs is integrated across systems to facilitate continuity and coordination of care with minimal disruption or repetition. Information is integrated from the following areas: disease management programs, case management programs and utilization management. To ensure confidentiality, no voluntary disclosure of member specific clinical or non-clinical information will be made except to persons authorized to receive such information to conduct disease management activities. All information is considered confidential.

**Continuity of Care**

In order to ensure continuity of care for members in the program, Valence integrates information from the following systems:

- Health information line
- Other disease management programs
- Case management
- Utilization management
- Wellness programs

Information is received from/sent to these programs, either through Alerts through the Care Manager system (disease/case/utilization management) or through secure email (health information line and wellness). A roster of members in the diabetes disease management program is distributed weekly to the client, for distribution to their health information line and wellness partners.

**Communication with Providers**

Practitioners are provided with information on how to use disease management services and how Valence Health works with a practitioner’s patients who are in the program in a variety of ways, including:

- Health Plan website
- Provider Manual
- Practitioner and staff electronic communications and postal mailings

**Satisfaction and Effectiveness of the Case Management Program**

In conjunction with the client health plan, Valence Health annually evaluates active member participation rates, member satisfaction with the program and specific program performance measures to identify opportunities for improvement. Data is obtained from member satisfaction surveys, complaints and inquiries, medical management case audits, claims/encounters, pharmacy information, and additional sources to identify:

- Active member participation rate: The total number of identified eligible members with at least one interactive contact, divided by the total number of identified eligible members
- Satisfaction with the diabetes management program, including frequency of contact and effectiveness of the case manager
- Improved quality of life
• Improved health status
• Opportunities for outcomes improvements
• Opportunities for process improvements

Valence Health employs and tracks at least one performance measure for the Diabetes Management Program. For each identified measure, Valence Health will:
  • Address a relevant process or outcome that is population based
  • Produce a quantitative result
  • Use data and methodology that are valid for the process or outcome being measured
  • Analyze results in comparison with a benchmark or goal

Evaluation methods include analysis of member surveys, quality management reviews and claim data analysis. Based on the results of the analysis, Valence Health and the client identify interventions and (a) implement at least one intervention to improve performance and (b) re-measure results to determine performance. Valence Health continues to re-measure to determine the intervention effectiveness using methods consistent with initial measurements.

**Staffing and Resources**

The Disease Management Program plays an integral role in improving the quality of life and promoting cost effective outcomes for members with diabetes.

The program is staffed by registered nurses, health educators and outreach coordinators, under the direction of the Director of Medical Management. Diabetes management is coordinated by the Case Manager assigned to the case. The Case Manager works closely with the member, the member’s PCP, other health care providers, and the member’s family while managing the case. The Case Manager will contact other resources, including community resources, as needed to assist in the process of meeting a member’s health care needs.

**Annual Evaluation and Approval of Diabetes Management Program**

On an annual basis, Valence Health reviews the Diabetes Management Program, including the evidence-based guideline that forms the clinical basis of the program, to ensure that the program is clinically current and meets the needs of the member population. The annual evaluation also includes identification of metrics, barriers, and opportunities for improvement for the program in the next year. The annual evaluation is presented to the Valence Health Quality Management Committee, chaired by the Chief Medical Officer, as well as any appropriate client health plan committees.
## Program Review/Updates

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<tr>
<th>Date</th>
<th>Change</th>
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<tr>
<td>June 2014</td>
<td>• Review for compliance with NCQA 2014 standards</td>
<td>Allison Hoffman, Manager Quality Management Programs</td>
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<td></td>
<td>• Updated to clearly reflect that program is opt-out</td>
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<tr>
<td>June 2015</td>
<td>• Review for compliance with NCQA 2015 standards</td>
<td>Chris Fisher, Director Disease Management</td>
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<td></td>
<td>• Updated to clearly reflect all sources used for identification and stratification</td>
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<td>• Updated to reflect preliminary review of history prior to leveling members identified via referral</td>
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<td>• Updated to reflect use of health educators as part of disease management care team</td>
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<td>• Revised Level II intervention focus on identified co-morbidities</td>
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Appendix A
Identification and Stratification

Overview

• Stratification is based on a 12 month claims look-back period.
• Members are identified on a monthly basis.
• Stratification strategy is assessed annually, by client, to determine the best methodology for the specific client population.
• All members are reassessed annually to determine if they are in the appropriate Level.
• Members can be referred into the program at any time through self-referral, practitioner-referral, and the UM/CM process. Upon referral, they will be assessed for the appropriate Level.
• Valence uses client-specific data for assessment into the program. Available data may also be used for identification and stratification from the following sources (as applicable): health management, wellness or health coaching programs, health appraisal results, laboratory results, and information from EHRs.

Sources

Sources used to identify members with a diagnosis of diabetes include:

• Data Reports:
  • Monthly Diabetes Report, generated from claim, encounter, and pharmacy data. This report automatically populates in Care Manager and generates real-time Alerts for staff to begin interventions for higher Level stratifications.
  • Monthly ED Utilization Report, generated from claim data. This report is pulled from vQuest and sorted to determine ED use with a diagnosis of diabetes.
• Data obtained through the utilization management processes, case/care management process, and system reporting (includes real-time hospitalization information). This information is received by the DM case managers through Care Manager system alerts.
• Member self-identification through submission of an enrollment questionnaire, Health Appraisal results, or telephonic self-referral
• Referral by providers through direct contact with UM/disease/case management staff
• Referral by Member Services, Health Information Line, and Wellness/Health Coaching Programs (as applicable to the client)

Identification of Diabetic Population (HEDIS specifications for diabetes)

Members with diabetes are identified using the following data sources, which are based on the HEDIS specifications for identifying a diabetic population. Continuous enrollment criteria are not applied. Members may also be identified as having diabetes through referral sources. These members are reviewed and stratified by the disease management team.

• UM and Claims Data (vQuest): At least one ED visit with diabetes as the principal diagnosis OR
• UM and Claims Data (vQuest): At least one acute inpatient claim/encounter with diabetes as the principal diagnosis OR
• Claims/Encounter Data (vQuest): At least two outpatient visits on different dates of services, with diabetes as one of the listed diagnoses OR
• Pharmacy (vQuest): At least one pharmacy claim for insulin or oral hypoglycemic/anti-hyperglycemics. OR

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<th>Pharmaceutical Categories include</th>
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<td>Alpha-glucosidase inhibitors</td>
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<td>Amylin analogs</td>
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<td>Antidiabetic combinations</td>
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<td>Miscellaneous antidiabetic agents</td>
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<td>Sulfonylureas</td>
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<td>Thiazolidinediones</td>
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• Lab Data (vQuest): At least one HbA1c AND one microalbumin test AND one outpatient visit with diabetes as one of the listed diagnoses OR
• EHR Data: Registry information from Vision, identified as diabetic through EHR OR
• UM/CM Case Alerts: Daily report from system, referred by nurse based on diagnosis of diabetes for any requested prior authorization or concurrent review OR
• Health Appraisal: Use Care Manager reporting out of “referral source” dropdown field for “Health Appraisal” OR
• Wellness Program: Use Care Manager reporting out of “referral source” dropdown field for “Wellness/Health Coaching Referral” OR
• Member/Practitioner Referrals: Use Care Manager reporting out of “referral source” dropdown field for “Member Referral” or “Practitioner Referral”

### Stratification

**Level III – Very Poorly Controlled**
- One or more acute inpatient claim/encounter with diabetes as the principal diagnosis OR
- One or more ED visit with diabetes as the principal diagnosis

**Level II – Not Well Controlled**
- Diagnosis of diabetic co-morbidities (neuropathy, nephropathy, retinopathy, limb ulcer/amputation with diabetes diagnosis)

**Level I – Well Controlled**
- Remaining population