



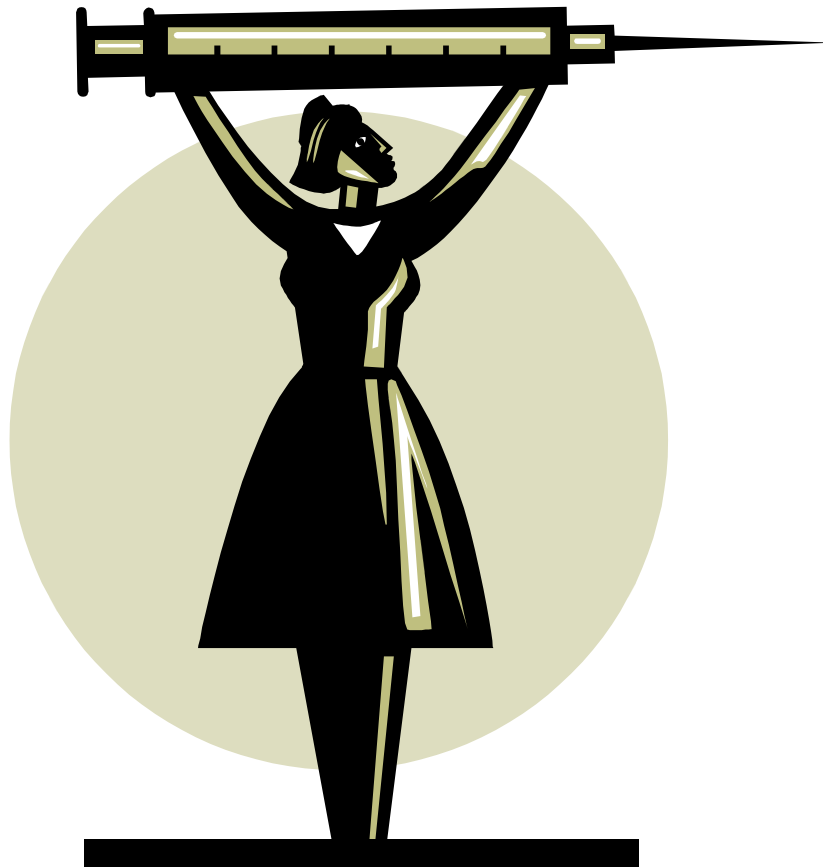
HealthCare Partners™

Nevada

*HealthCare Partners of Nevada*

*Diabetes*

*Disease Management Program*



*2010*

## ***DIABETES DISEASE MANAGEMENT PROGRAM***

The HealthCare Partners of Nevada (HCPNV) offers a Disease Management program for members with Diabetes. Improved self-management can improve the daily quality of life for members with a specific disease or condition, so HCPNV offers communication with a Registered Nurse or other health professional(s) to assist members with Diabetes and to manage their symptoms more effectively. This is a free service offered to our members.

The Disease Management Program focuses on monitoring and improving adherence to treatment plans by emphasizing patient education, and actively monitoring those members most at risk for signs and symptoms of decompensation.

### ***Member Enrollment***

Members are identified as potentially having Diabetes through claims, or through referral by a PCP or specialist, are contacted by phone for confirmation and screening. Members may also self-refer by contacting provider, or designee, directly. Participation in the Program by members is voluntary and there is no additional cost to the member. All members receive educational materials about their disease.

## ***INTRODUCTION***

Diabetes is a common, costly, disabling and deadly condition. Diabetes is associated with significantly reduced physical and mental health, resulting in a markedly decreased quality of life.

Serious long-term complications include cardiovascular disease, chronic renal failure, retinal damage, which can lead to blindness, several types of nerve damage, and microvascular damage, which may cause erectile dysfunction and poor wound healing. Poor healing of wounds, particularly of the feet, can lead to gangrene, and possibly to amputation.

Adequate treatment of diabetes, as well as increased emphasis on blood pressure control and lifestyle factors such as not smoking and maintaining a healthy body weight, may improve the risk profile of most of the chronic complications.

## ***SCOPE***

23.6 million Americans have Diabetes — 7.8 percent of the U.S. population. Of these, 5.7 million do not know they have the disease.

- Each year, about 1.6 million people ages 20 or older are diagnosed with Diabetes.
- The number of people diagnosed with diabetes has risen from 1.5 million in 1958 to 17.9 million in 2007, an increase of epidemic proportions.
- It is estimated that 57 million adults aged 20 and older have pre-Diabetes.

### ***Prevalence of Diabetes by type***

- Type 1 (previously called insulin-dependent or juvenile-onset) Diabetes accounts for 5 to 10 percent of all diagnosed cases of Diabetes.
- Type 2 (previously called non-insulin-dependent or adult-onset) Diabetes accounts for 90 to 95 percent of all diagnosed cases of Diabetes.

### ***Deaths linked to Diabetes***

- Diabetes is the seventh leading cause of death listed on U.S. death certificates.
- Cardiovascular disease is the leading cause of death among people with Diabetes and about 68 percent die of heart disease or stroke.
- The overall risk for death among people with Diabetes is about double that of people without Diabetes.

### ***Diabetes cost***

- Total health care and related costs for the treatment of Diabetes run about \$174 billion annually.
- Of this total, direct medical costs (e.g., hospitalizations, medical care, treatment supplies) account for about \$116 billion.
- The other \$58 billion covers indirect costs such as disability payments, time lost from work, and premature death.

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\*The National Institute of Diabetes and Digestive and Kidney Diseases. National Diabetes Statistics, 2007. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2008.

<http://www.diabetes.niddk.nih.gov/dm/pubs/statistics/>

*Updated*

## ***NEVADA STATISTICS***

- 7.5% of Nevada adults had been told by a doctor that they have Diabetes.
- The prevalence of Diabetes has increased slightly from 6.5% in 1992 to 7.5% in 2006.
- 31.3% of Nevada residents ages 55 or older have Diabetes.
- 10.2% of Nevada residents who were overweight or obese have Diabetes compared to normal weight residents only 3.0% have Diabetes.
- 24.8% of Nevada residents who diagnosed with heart diseases have Diabetes.
- 11.5% of all asthma patients have Diabetes.
- 13.1% of Nevada residents that was depressed have Diabetes.

## ***PROGRAM STRUCTURE***

The components of HCPNV's Diabetes program are described below. The Program and the interventions are depicted in flow chart format in *Attachment 1*.

## ***MEDICAL LEADERSHIP***

The oversight of the Healthcare Partners of Nevada's Diabetes program falls under the leadership of Dr. Amir Bacchus, Chief Medical Officer. Dr. Bacchus will ensure that all Federal, State rules and regulations, and Accreditation standards met by the group.

## ***COMMUNICATION WITH GROUP-BASED PHYSICIANS AND/OR SPECIALTY PHYSICIANS***

Dr. Amir Bacchus, and or his designee, will educate all group-based physicians on the requirements of the Diabetes program. This may be accomplished during the new hire orientation period. An annual meeting is held for existing physicians within the practice to discuss the program and allow feedback. For those groups without multiple physician resources, external PCP colleagues or Endocrinologists will be invited to the annual meeting.

Annually the group will review the current program, relevant policy and procedures, member program educational material, clinical practice guidelines, reports and trending, inclusive of patient satisfaction surveys, and will make recommendations for program enhancements

The written program description and policies will be distributed and readily available for physician review.

## ***STAFF ROLE DESCRIPTIONS AND EXPECTATIONS***

The staff members involved with the Diabetes program and their role descriptions are outlined below:

### ***Medical Director and/or Group Physician designee:***

- Clinical Qualifications –
  - Appropriate Education and Post-Doctoral training
  - Professional experience and staff appointments
  - Board Certification in internal medicine and/or endocrinology
  - Current licensure
  - Other sub-specialties as indicated
- Coordination/Chair of annual meeting
- Ongoing review of program
- Initial and ongoing education to physicians and staff
- Compliance monitoring of centers
- Patient care plan documentation

- Physician(s) education on documentation in the patient chart including coordination of care with social services, specialty care physicians and home health
- Physician(s) education on documentation in the patient chart including patient evaluation based on care plan, clinical guidelines and practice recommendations for Diabetes

***Nurse and/or Care Coordinator:***

- Clinical qualifications –
  - RN licensed in the state of Nevada.
  - Five years in a professional setting such as hospital or clinic setting.
  - Minimum of two years actual work experience related to case management, utilization management, quality assurance, discharge planning or other cost management programs and/or other equivalent work experience.
- Documentation in chart of patient enrollment date
- Outreach calls to patients
- Anticipatory guidance
- Patient education on disease process and documentation
- Patient self-management training and documentation
- Review of patient files/checklists

***Office Manager or Admin Staff:***

- Quarterly reporting to Health Plan including outcomes and logs
- Responsible for maintaining program binders and updates

There is a formal orientation and training program for all new staff involved in the program. All existing staff will be assessed by the Medical Director, and/or his designee to ensure proper and consistent execution of the program. Please see HealthCare Partners of Nevada’s policy for orientation and annual evaluation of staff. Documentation is maintained for all staff orientation, training and assessment activities.

***ENGAGEMENT OF PROGRAM PARTICIPANTS, PHYSICIANS,  
OTHER TEAM PATIENTS***

Timelines will be followed as per the HealthCare Partners of Nevada’s Access Plan with regards to patient appointment availability. Emergent cases will be seen immediately. Urgent cases will be seen within 24 hours. Symptomatic routine cases will be seen in 7 calendar days and nonsymptomatic routine cases will be seen within 30 calendar days. After hours access will be available to Diabetes patients via:

- HCPNV Customer support
- Answering service
- Physician or case manager phone contact number
- Directions to closest ER

## ***PROGRAM MANAGEMENT***

The clinical guidelines adopted by the HealthCare Partners of Nevada are based on the following nationally recognized guidelines:

[http://care.diabetesjournals.org/content/31/Supplement\\_1](http://care.diabetesjournals.org/content/31/Supplement_1)

Updates in these guidelines will initiate a change or modification to the program documentation. If no changes are made to the guidelines, annual review and approval will be documented within the meeting minutes.

Individualized patient intervention strategies and goals are developed in collaboration with all treating physicians and consistent with nationally accepted clinical guidelines. Our care plan outlines the activities/interventions in the program, both member-directed and interventions that the program delivers to the member.

Co-morbid conditions are considered and built into the individual patient's care plan. Collaboration with the health plan may occur to address participant needs beyond participation in the Diabetes management program.

The following is the basic action plan for all Diabetes program members:

- Physical assessment
- Medication profile
- Diagnostic testing results
- Disease entity education and self management techniques
- Lifestyle issues and education are addressed including smoking, lack of exercise, obesity, poor nutrition, and abuse of drugs or alcohol.
- Mental health and/or social needs of participants are considered and referral management is conducted where needed.
- Influenza and pneumococcus vaccination is administered, as available, to patients between the months of October and February.
- Patient and/or family discussions regarding treatment preferences, living wills, advance directives will occur as indicated. Hospice consultations may be addressed if the patient meets criteria for Hospice services.
- Condition monitoring is also included in the treatment plan. This includes:
  - Patient reminders given to alert patient's to testing that should be performed
  - Patient surveys to allow data collection on health status and functional ability
  - Outbound calls made to patients for purposes of health counseling sessions

Documentation in the patient chart will include adherence to the individual's action plan. This will include adherence with self-management, medications and attending needed office visits.

## ***IDENTIFICATION OF MEMBERS***

Identification of members with Diabetes occurs monthly based on medical claims data and utilization management authorizations. Additional identification includes member health risk assessment, by self, family, or practitioner referral.

HCPNV uses the following mechanism to identify members who might benefit from Diabetes Disease Management program:

- Claims data – Hospitalization / ER visits in the last 12 months, including twenty-three hour observation for HF.
- Health risk assessment results
- Referrals from utilization (UM) and care management (CM)
- Referrals from members and practitioners
- Other disease management programs, as applicable

Claims-based data sources are analyzed on a monthly basis to identify individuals newly diagnosed with Diabetes. Referrals from UM processes/data, care managers, practitioners, and self-referral from members occur on an ongoing basis. All members diagnosed with Diabetes and all those who may benefit from the Diabetes disease management program are eligible.

HCPNV will provide evidence to the health plan that referral source methods are reviewed annually to assess effectiveness and recommendations are made for improvement if needed.

HCPNV provides interventions to members based on stratification. The Program and the interventions are depicted in flow chart format in *Attachment 1*. All members will receive an intervention based upon the member's stratification or classification of Diabetes.

### ***STRATIFICATION OF MEMBERS***

Members are stratified into low, medium, and high risk. An “event” is defined as an emergency room visit, twenty-three hours observation, or inpatient admission – hospital or skilled nursing facility. Refer to *Attachment 2*.

All members enrolled in the program will be reassessed annually or more often as clinically indicated.

### ***PROGRAM STEPS***

Distribution of HCPNV Diabetes disease management program information starts when we sent the member a general awareness welcome letter that introduces some of the components of the program and the concept of disease management. The mailing also notifies members of their access to a nurse care coordinator. In addition, all members may receive a home visit with environmental assessment after an emergency department or inpatient event for Diabetes.

This is followed by a disease-specific mailing within 30 days which includes:

- Information about care coordination and condition monitoring including self-management of chronic disease.
- Description of services included, and how to opt out. A member presumed to be in the program unless they choose to “opt out”.
- Explanation of how a member is identified as eligible for our program
- Information discussion Diabetes triggers identification, encouraging, goal setting and appropriate lifestyle modification around exercise, and smoking.

- Encouragement to work with their practitioner to develop and adhere to a Diabetes care plan
- Encouragement to call a care coordinator with a focus on behavioral modification, overall assessment of other health conditions as they relate to Diabetes and overall health, goal setting, and problem solving.

Condition monitoring occurs on an ongoing basis. The care coordinator will analyze the member's medical record and obtain data from member self report. If clinical gaps are identified for a medication and/or treatment, a telephonic intervention will be conducted by the Care Coordinator. The member is educated about the importance of filling their prescription or completion of a treatment, and is encouraged to seek additional care. The Care Coordinator will notify the member's PCP.

### ***Care Coordinator Services***

Care Coordinators provide support to individuals to facilitate improved behavior, motivation, confidence, decision-making skills, and knowledge and awareness of their disease and self-management.

Six dimensions of assistance to facilitate moving the member through the disease self-management continuum are provided to high-risk members:

1. Chronic condition support: Care Coordinators provide the Diabetes with awareness and understanding of the condition, address gaps in care, address lifestyle changes and help the member overcome barriers related to treatment adherence.
2. Decision support: Care Coordinators assist the member to use decision-making skills through discussion of their current medical information, as related to tests and treatment.
3. Decision support for symptom support: Care Coordinators and members freely discuss the member's current medical information and make informed decisions regarding their symptoms.
4. Information support: Care Coordinators provide medical information, not directly associated with a decision, to a member.
5. Prevention support: Care Coordinators provide support to a member to help prevent complications, exacerbations or development of health problems not associated with a chronic condition.
6. Provider communication support: Care Coordinators educate and support a member having general communication difficulties with his/her practitioner.

On an annual basis, group-based physicians will receive, in writing, any formal changes made to the program as a result of the annual meeting. Changes will be made within the program description and distributed to the involved staff.



## **PERFORMANCE MEASUREMENT METHODOLOGY AND REPORTING PLAN**

Participation rates are measured annually. Outreach success is monitored quarterly with a focus on successful outreach for high-risk members.

Program effectiveness is measured by:

- HEDIS criteria for Diabetes is obtained from the respective Health Plan
- Trending of Emergency room and inpatient utilization
- Complaints and inquiries about the program is obtained from the respective Health Plan
- Member satisfaction with the program

Outcomes measurement for the Diabetes program will be tracked, trended and reported to the health plan on a quarterly basis. Outcomes reporting as well as member logs will be presented to the health plan no later than 30 days following the close of each quarter.

- 1<sup>st</sup> quarter data will be reported by April 30\*
- 2<sup>nd</sup> quarter data will be reported by July 31\*
- 3<sup>rd</sup> quarter data will be reported by October 31\*
- 4<sup>th</sup> quarter data will be reported by January 31\*

\*In the event that there are no members identified for the program, HCPNV, will report to the health plan in writing that there were no outcomes for the identified quarter.

### ***The following indicators will be reported:***

- # Members enrolled in program by stratification, data report to be generated by Complex Case Management Information System (CCMIS)
- # Members declined enrollment by stratification, data report to be generated by Complex Case Management Information System (CCMIS)
- Days/1000, data report to be generated by Health Care Economics (HCE)
- Admits/1000, data report to be generated by Health Care Economics (HCE)
- Average length of stay, data report to be generated by Health Care Economics (HCE)
- 30 day readmit rate, data report to be generated by Health Care Economics (HCE)
- % of members with follow-up within 30 days with PCP or specialist (if clinically indicated), data report to be generated by encounter data.
- % HgBA1c testing, % HgBA1c good control (less than 7.0%) A% HgBA1c poor control, levels > 9.0% drawn within 90 days from start of program, data report to be obtained from CCMIS. – data collected from HEDIS Report
- % LDL screening and % LDL-C control (less than 100 mg/dl) – data collected from HEDIS Report
- % Eye examination performed – data collected from HEDIS report

- % Screening and appropriate follow-up for nephropathy – data collected from HEDIS Report
- % received education on disease specific information, data report to be generated by Complex Case Management Information System (CCMIS)
- Flu and/or pneumococcus vaccine rate, data report to be obtained from CAHPS report from HEDIS, per respective Health plan

***On an annual basis, HCPNV records and reports the following:***

- Member participation rates. The rate is calculated by dividing all members who have received any intervention, by the number of all members who are identified as eligible for the program, regardless of stratification or intervention level of enrollment. The data report to be obtained by Complex Case Management Information System (CCMIS)
- Annual Diabetes Report, to be obtained by Complex Case Management Information System (CCMIS) and member profile. Includes:
  - the number of diabetics participating the CHF management program
  - percent of diabetics reporting annual eye exam
  - percent of diabetics reporting semiannual A1C measurements

### ***PROFESSIONAL APPROACH TO PARTICIPANTS***

Education for staff interacting with Diabetes program participants includes the following:

- Diabetes Disease Process and Management
- Member rights
- Member confidentiality
- Member's right to use complaint/grievance process
- Courteous, respectful participant interactions
- Member involvement in program improvements
- Expressed support for participant/physician relationship

The staff member's immediate supervisor will monitor staff interactions to ensure compliance with the above. On an annual basis, staff will receive formal feedback regarding their compliance with the program as per internal policies and procedures.

### ***COMPLAINT MANAGEMENT***

HCPNV will make every effort to address member and provider concerns regarding the Diabetes program. HCPNV will advise the health plan of any complaint regarding services provided to members. HCPNV will cooperate with the health plan in the 09.2009SK

complaint resolution of member and/or provider complaints. If HPCNV is unable to resolve complaints internally, HPCNV will refer the member to the Health Plans Customer Service and provide them with the toll-free telephone number.

Member and provider complaints and outcomes will be tracked and reported to the health plan on a quarterly basis.

Member adverse events will be reported to the Health Plan's Risk Manager within 24 hours of identification.

### *MEMBER EDUCATION*

HPCNV Diabetes program will introduce disease management services to members by:

- Introductory letters
- Phone Calls

Introductory information will include information and contact numbers for Diabetes program as well as verbal and written consent for program participation. The member will be assigned a care coordinator with training in Diabetes. A complete clinical assessment will be completed to include Diabetes status, co-morbid conditions, medication regime and current treatment plan. A plan will be developed with the member regarding call and appointment schedules to encourage member participation in Diabetes program.

Educational material will be:

- Integrated into clinical management system
- Consistent with best practice recommendations
- Designed to meet State and/or Federal cultural competency requirements
- Available in different learning modalities: written pamphlets, telephonic discussion,
- Reviewed on an annual basis for appropriateness and accuracy
- Designed to encourage member self management and monitoring

### *CONTINUOUS QUALITY IMPROVEMENT*

HPCNV will submit a written description of CQI Plan on an annual basis to the Health plans. CQI outcomes will be incorporated into clinical and business processes.

### *OBSERVATION/REVIEW*

HPCNV will provide the Health plans access, if requested, to perform side by side review of participant calls and/or interviews with staff delivering interventions. Review of participant mailings and educational material will also be completed.

The Health plan will also perform an annual file review. This will consist of a review of five files for compliance with audit elements:

- Physician Care Plan
- Evidence that performance is documented and evaluated based on care plan, clinical guidelines and practice recommendations for Diabetes.
- Evidence of outbound/outreach calls, follow up on physician care plan, outcome measurement
- Appropriate coordination of care if applicable
- Evidence of member education on Diabetes program, disease process, and self management

Operations review will consist of the following:

- Evidence of member contact appropriate based on member acuity
- Consistently submitting complete outcomes reports and participant logs
- Consistently meeting reporting timelines

### *INFORMATION EXCHANGE*

HPCNV will maintain protected health information per the Business Associate agreement with the Health plans. Methods for exchanging information meet HIPAA requirements. Member information will remain confidential and HPCNV will not disclose to any 3<sup>rd</sup> party except as permitted by law.

### *ANNUAL REVIEW*

The HPCNV Diabetes program will be updated annually and presented to the MSO Diabetes program review committee for review and approval. The update process will include:

- Evaluation of prior year's activities, both subjective and objective
- Clinical outcomes trended
- Member program satisfaction evaluated and tracked
- Description of the new year's planned activities, including problems to be solved, and measurements of success.

***ACKNOWLEDGEMENT AND APPROVAL:***

Submitted by:

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