

## **MDwise Hoosier Alliance Chronic Obstructive Pulmonary Disease Management Program**

### **Purpose Statement**

Chronic Obstructive Pulmonary Disease (COPD) is a major cause of chronic morbidity and a public health problem of increasing concern in the United States. It is listed as the fourth leading cause of death in the U.S., following lung cancer, heart disease, and stroke. Smoking is the biggest risk factor and most common factor for developing COPD. It is projected to be the third leading cause of death for both males and females by the year 2020.

In the United States, more than 120,000 people die a year from COPD. It costs the United States approximately \$26.0 billion per year and is the third leading reason for at-home care (after congestive heart failure and stroke).

In 2000, there were more female deaths from COPD than male deaths. In 2002, more than 61,000 females died of COPD compared to 59,000 males. Both men and women who smoke are 13 times more likely to die of COPD than those who have never smoked. The rate of COPD is on the increase and will continue to climb as our population ages.

MDwise Hoosier Alliance (MDHA) has adopted the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines (which can be located at <http://www.goldcopd.com>).

A major part of the GOLD guidelines is devoted to the clinical management of COPD and is supported by a management plan with these four components:

- (1) Assess and Monitor Disease
- (2) Reduce Risk Factors
- (3) Manage Stable COPD
- (4) Manage Exacerbations

The guidelines advise focusing treatment on:

- a) improvement of functional state
- b) prevention of disease progression
- c) and minimization of symptoms.

MDHA assesses the characteristics and needs of its member population and relevant subpopulations relying on eligibility categories, Hoosier Healthwise and Healthy Indiana Plan member demographics, self-referral services, specialty services, specific utilization patterns such as members enrolled in the Right Choices Program.

The COPD Disease Management Program is offered to all eligible members who meet MDwise Hoosier Alliance established criteria for enrollment in the program.



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## Key Elements

### 1. Program Objectives

- **Member:** to improve the health and quality of life for our members with COPD by providing specific information and interventions in the management of COPD. This includes assisting members with development and implementation of self-management plans. This includes all aspects of NCQA QI 7 and 8 requirements.
- **Provider:** to enhance practitioner understanding of and compliance with MDwise Hoosier Alliance Clinical Practice Guidelines, adopted the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines. Providers will be an active participant in the care of the member through collaboration with the care and/or case manager and through direct member contact.

### 2. Program Goals

#### MDHA COPD program goals are to:

- Identify, provide and coordinate services for members with COPD and other complex co-morbid conditions
- Facilitate processes to actively assist members and providers with the management of COPD and other complex conditions
- Facilitate access to needed resources
- Systematically assess the characteristics of our member population and sub-populations
- Maintain, review and update as needed case management processes and resource to address members needs
- Identify processes which specifically outline sources of information to identify members for case management
- Identify appropriate referral avenues for members to be referred to case management and other resources
- Maintain a case management system which supports the case management program by providing necessary evidenced-based clinical guidelines, algorithms, assessments, documentation, automatic prompts for case management follow-up and automatic documentation of staff demographics, to include, staff members name, title date and time of input or activity
- Ensure case management activities which address the assessment of individualized development of case management plans which identify the members' health status, history, medications, condition-specific issues, activities of daily living, cognitive and mental health status, life-planning activities, cultural and physical preferences and limitations, identification of barriers and how to overcome, progress assessment, prioritization of goals, follow-up, communication and self-management plan as well as involvement of caregivers and referrals to resources.



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Additionally, a case management plan will include goals for not only the member, but, caregiver goals as well as caregiver preferences and the level of involvement the caregiver has in the member's case management plan.

- Ensure documented case management processes are followed for assessments, ongoing monitoring and evaluation of case management activities
- Provide a process to obtain feedback from members regarding satisfaction, complaints and inquiries
- Analyze and evaluate the program at least annually
- Identify and have systems in place to set performance goals, measure outcomes or effectiveness and to analyze results
- Provide interventions to support opportunities for improvement and re-measurement

### 3. Program Content

#### **The MDHA COPD Program content is comprised of the following:**

- Condition monitoring to include, but not limited to, the use of annual spirometry testing to confirm the diagnosis and to appropriately stage COPD
- Condition monitoring to include, but not limited to, members' self-management skills, inclusive of self-monitoring and medical testing, and documented self-reported information
- Development of and monitoring adherence to treatment plans, including but not limited to, medications, self-monitoring activities, and making needed appointments with PMP and specialist(s) and care gaps
- Identification of medical and behavioral health co-morbidities on an individual basis to allow implementation of the most effective treatment/care plan and self-monitoring plan. This includes referrals to specialists
- Identify possible health behaviors that may impede a member's ability to manage their condition. Promote healthy lifestyle practices such as exercise, nutrition, and smoking cessation efforts through education and resources.
- Identification of psychosocial issues that may play a part in member's adherence to treatment plan such as, but not limited to, beliefs, perceived barriers such as access to care issues, transportation and financial barriers, cultural, religious and ethnic beliefs
- Completed depression screening during the first 30 calendar days of enrollment into care management
- Identification of member's caregiver, if appropriate, and with consent of the member provide the caregiver information related to the condition and treatment plan for the member
- Encourage and assist with communication between the member and provider related to their health concerns and treatment. By doing so, establishing a Medical Home for the member.
- Increase the administration of influenza and pneumonia vaccinations
- Provide members with a list of external resources specific to the need(s) of the member



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### **Interventions to Achieve Program Content**

- Educate members about adherence to medication regimen, spirometry testing and other items that might be included within an individualized self-management plan through telephonic outreach
- Assist members to execute a healthy lifestyle by educating on smoking cessation, the importance of staying active, weight management, nutrition and the dangers of substance abuse, as appropriate for each member
- Assist members to communicate with their provider about their health conditions, treatments and self-management plans
- Upon consent of member, coordinate with member's caregiver the condition and treatment plan for the member, in addition to resources to support the caregiver's role such as About Special Kids, Indiana Family Helpline, Agency on Aging, among others
- Assist members to take action to modify smoking or start a smoking cessation program by providing information by phone and/or mail related to the Indiana Tobacco Quitline program
- Educate members on their disease state(s), future implications, and co-morbidities, including mental health, through phone contact, interactive phone response and disease specific mailings per MDwise Policy MM-10
- Coordinate annual spirometry testing and care gaps with the member and provider through ongoing telephonic contacts and/ or phone reminders
- Assist members to receive flu and pneumococcal vaccinations, as appropriate
- Coordinate with external resources as needed, such as but not limited to, 211, Indiana Family Helpline, Indiana Tobacco Quitline program and other appropriate COPD resources
- Assist member with the identification of psychosocial issues that are creating barriers to the member achieving their goals, treatment and self-management plan

### **4. Population Identification and Integration of Member Information**

All members identified as having COPD are eligible for the program. The following methods, such as but not limited to will be utilized to identify members for the COPD Disease Management Program:

- NURSEon-call encounters
- ER visit
- Health Risk Screenings
- Provider referrals (*HA416-Case Management Referral Form HHW-HIP P0017*)
- Initial Complex Assessment Tool
- Claims (medical and pharmacy)
- MDwise Corporate referrals
- DXCG Scores
- UM/PA Department
- Medical Director



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- Hospital Census and Discharge Planning
- ManagedCare.com
- Disease Management Program Referral
- Self-referrals

MDHA integrates member information from the following systems to facilitate continuity of care:

- Disease and Case/Care Management System (Pre-certification, Concurrent, Hospital, Discharge and Claims, Data)
- Utilization Management System (Pre-certification, Concurrent Review and Discharge Data)
- ManagedCare.com
- Claims (Hospital Admission and Discharge Data) DXCG risk scoring

## **5. Population Stratification**

Once identified, members are stratified into three risk groups (high – care management, moderate – case management and low – population based). Members are stratified initially based on DxCG risk scoring application and health risk screeners. DxCG ranges are identified as:

- Population-based (low): <299
- Case management (moderate): 300-499
- Care management (high): >500

Upon intake into the case management program an additional stratification occurs when the initial complex assessment has been completed within the first thirty (30) calendar days of identification. Members may risk higher or lower than the initial stratification received via the PMT. Members who have urgent case management needs are assigned to a case manager within one (1) business day of receipt of referral. Within ten (10) business days, the member will receive an initial outreach attempt by a case manager to obtain an assessment.

COPD risk stratification criteria:

- Low Risk (Population Based): DxCG range: <299
  - At least one claim for COPD, emphysema or chronic bronchitis, age 18 years and older
  - keeping regular appointments with their PMP
  - compliant with their self-management goals
- Moderate Risk (Case Management): DxCG range: 300-499
  - Criteria for Level 1 + 1 claim for a short acting bronchodilator or newly diagnosed with COPD
  - Not keeping regular appointments with their PMP
  - Not compliant with some of their self-management goals
  - Stable co-morbidities



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- High Risk (Care Management): DxCG range: >500
  - COPD members with total of 1 or more inpatient claims, ER claims or observation claims with diagnosis of COPD or COPD related complications, such as respiratory failure or right heart failure and any combination in a 12-month rolling period
  - Not keeping regular appointments with PMP or Specialist
  - Imminent risk for dialysis
  - Not compliant with some or all of their self-management goals
  - Unstable co-morbidities

## 6. Levels of Activity for Member Outreach

The stratification risk group drives the level of interventions

- **Low-Population Based**

*Criteria:* Members who meet Low-risk level as outlined in the Stratification Section.

Members with COPD having a low-risk score are flagged for population-based intervention but members can move from one classification to another based on changes in their severity or exacerbation of symptoms.

*Primary Responsibility:* MDwise

***Interventions focus on:***

Members will be engaged through disease specific and preventative care population-based interventions including educational materials, appointment and preventative care reminders. Pregnant members shall receive standard pregnancy care educational materials. Members will receive tobacco cessation materials about the Indiana Tobacco Quitline and access information for MDwise 24-Hour Nurse Call Line. All members in population-based management will receive the above mentioned interventions bi-annually per MDwise Policy MM-10.

- **Moderate-Case Management**

*Criteria:* Members who meet Moderate-risk level as outlined in the Stratification Section are outreached to by AVR, USPS and/or telephonically at least quarterly. Automated prompts are created in the documentation system to alert case managers when outreaches are scheduled.

*Primary Responsibility:* MDwise Hoosier Alliance Case Management Technicians and Nurse Case Manager Level 1.

***Interventions include, but not limited to:***

- Welcome letter providing the member with information about case management and how to contact the Case Management Department in order to speak with a nurse.  
(HA333-New Member Welcome Letter HHW-HIP M0001)



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- Resource Letter providing the member with MDwise Member Services information, including transportation services and 24 Hour Nurse Call Line, transportation benefit information, community resource information including Indiana Tobacco Quitline, 211, and Indiana Family Helpline. (*HA426 Case Management Resource Letter HHW-HIP M0008*)
  - Disease specific outreach related to COPD and medication adherence through Soundbites. (*HA413 Condition-Specific Soundbites Blasts M0549*)
  - Preventative care reminders
  - Assistance with transportation issues
  - Assistance with setting up appointments with PMP and/or specialists
  - Assistance with pharmacy issues
  - Appointment reminders, as need
- **High-Care Management**  
*Criteria:* Members who meet High risk level as outlined in the Stratification Section are outreached to telephonically and/or USPS at least quarterly. Automated prompts are created in the documentation system to alert the case manager when outreaches are scheduled.

*Primary Responsibility:* MDwise Hoosier Alliance Case Manager

*Interventions focus on, but are not limited to:*

- All interventions under Low-Population Based and Moderate-Case Management
- Member participation letter sent to PMP (*HA058-Praticiatption in Case Management P0268*)
- Goals letter sent to the member and PMP (*HA061-Case Management Intro Letter M0367*)
- An initial complex health risk assessment will be completed within 30 calendar days of identification including, but not limited to:
  - Initial assessment of members' health status, including condition-specific issues
  - Documentation of clinical history, including medications
  - Initial assessment of the activities of daily living
  - Initial assessment of mental health status, including cognitive functions
  - Initial assessment of life-planning activities, including the presence of health care power of attorney or DNR orders, if applicable
  - Evaluation of cultural and linguistic needs, preferences or limitations
  - Evaluation of visual and hearing needs, preferences or limitations
  - Evaluation of caregiver resources and involvement
  - Evaluation of available benefits within the organization and from community resources



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- Development of an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the case management plan
- Identification of barriers to meeting goals or complying with the plan
- Facilitate member referrals to resources and follow-up to determine whether members act on referrals
- Development of a schedule for follow-up and communication with members
- Process to assess progress toward care management planned interventions
- Review of the member's claim history
- Contact with the member's family and healthcare providers
- Development and communication of member self-management plans
- A process to assess progress or course changes against the member's care management plan
- Identifying member needs related to their diagnosis of COPD
- Evaluate the member's care gaps and coordinate services to achieve all preventative care with PMP
- Education around medication and self-management adherence, exercise, proper nutrition, and smoking cessation.
- Evaluate the appropriateness of a specialty referral to a pulmonologist
- Coordination with the PMP regarding member education, self-management and use of appropriate medications, modifications to care plan and change in member classification from high-moderate risk to low risk
- Depression Screening completed within 30 calendar days of enrollment
- Disease specific assessments, as appropriate
- Condition monitoring to include co-morbidities

## **7. COPD Program Outcome Measurements for Re-stratification**

After six (6) months, the member's progress towards their self-management/treatment plan is evaluated using outcome measurements. Based on the outcome measures listed below, the member will be reassessed and re-stratified according to, but not limited to, Section 5 Population Stratification:

- Adherence to bronchodilators and corticosteroids as determined by pharmacy adherence report, member self-report and member's clinical history report.
- Progress and/or success with smoking cessation by member self-report
- Reduction in ER visits/costs related to COPD as identified by claims and utilization information
- Reduction in inpatient hospitalizations/costs related to COPD as identified by claims and utilization information
- Routine office visits at least 2 times a year as identified by member and provider communication, care gaps and claims information



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- Documented annual influenza vaccination as identified by claims and/ or care gap information
- Annual spirometry testing as identified by claims and or care gap information
- Care Gap issues addressed within 30 days of gaps being identified
- Care Plan goals are met with documentation supporting achievement of goals

Evaluation of member's outcomes will continue every 6 months while engaged in case/care management activities. Based on this evaluation the member can be moved to population-based, case management, or remain in care management.

## **8. Member Participation and Opting Out of the Program**

Eligible members are considered enrolled in the Program and receive outreach and interventions without a specific request for participation. Participation is voluntary and the member has the right to "opt out" of the program. Following an explanation of case management and reason for the contact, if member declines to continue with case management the member is given the case manager's phone number in case they reconsider. The member may re-enter the Program at any time by contacting the case manager at the number provided.

## **9. Indiana Tobacco Quitline Information**

The Indiana Tobacco Quitline is a free phone-based counseling service that helps Indiana smokers quit. All members in Case or Care Management will receive information by phone and/or USPS. Services include:

- One on one coaching for Tobacco Users who have decided to quit
- Resources for Healthcare Providers who want to improve patient outcomes
- Best Practices for Employers who want to implement smoke-free policies
- Support for Family and Friends who want to help loved ones stop smoking
- Tools for Tobacco Control partners to complement their current programs

Services are available 7 days-a-week in more than 170 languages. 1-800-QUIT-NOW (800-784-8669) or <http://www.in.gov/quitline>.

## **10. Staff Training, Credentials, Certification and Documentation System**

- Staff Training  
It is imperative that our staff have training in the treatment of COPD to assure education continuity. The staff will be trained by MDHA Medical Director or designee annually on the GOLD (Global Initiative for Chronic Obstructive Lung Disease) guidelines.



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- **Credentials and Certification**  
The case manager will be a currently licensed RN with at least 3 years of clinical experience. After initial training, the case manager will review the Clinical Practice Guidelines training annually. The case manager will receive ongoing training through seminars, publications and other education avenues as they become available. Education and training provided will focus on preparing the case manager to become a certified case manager (CCM).
- **Documentation System**  
All interaction with the member and provider will be automatically documented with the staff member's ID and date and time of the action in the member's case file. Automated prompts for follow up contacts with the member will be addressed in the member's plan of care. Clinical Care Guidelines are used to develop assessments with algorithms in the case management documentation system. Staffing ratios for case/care management is 1:200.

## **11. Practitioner Notification and Involvement**

In-Network Practitioners are notified about the program in several ways:

- The MDwise Hoosier Alliance Provider Manual
- The MDwise Hoosier Alliance Web site, [www.hoosieralliance.org](http://www.hoosieralliance.org)
- The MDwise Health Plan Provider Web site, [www.MDwise.org](http://www.MDwise.org)
- IHCP Provider Bulletins
- Case management outreach encounters and updates with the PMP

Practitioners receive the following written notification regarding their patients' participation in the COPD Disease Management Program:

- Notification of high-risk member enrollment in one-on-one care management, along with a copy of the plan of care goals (*HA058-Participation in Case Management P0268 and HA061- Case Management Intro Letter M0367*)
- Notification of a change in risk level of members enrolled in case/care management (*HA059-Discharge from Case Management M0368*)
- Notification of members eligible for COPD disease case management that the case managers were unable to contact, either initially or for follow up to collaborate on patient demographics and update of any relevant clinical findings (*Letter to be developed*)
- Notification of members upon graduation from the COPD disease care management program (*HA059-Discharge from Case Management M0368*)



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## 12. Measurements

Cost/ Benefit Measurements	Measurement Capture	Performance Goal
Rate of inpatient admissions for COPD per 1,000 total members	Claims with ICD9 code of 491, 492, and/or 496 and a CPT code of 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	3% reduction for members in COPD Care Management
Rate of ER visits for COPD per 1,000 total members	Claims with ICD9 code of 491, 492, and/or 496 and a CPT code of 99281-99285	3% reduction for members in COPD Care Management
Rate of members with COPD stratified as high risk-care management on bronchodilators and corticosteroid medications	Members with COPD as an active disease in CCNX, with Program of Care Management that have claims for bronchodilators and a corticosteroid (See attached list of medications)	90% of all members in COPD Care Management will have pharmacy claim for a bronchodilator and a corticosteroid medication
PMP Office visits every 6 months with COPD ICD9 code	Claim for a PMP office visit with an ICD9 code of 491, 492, and/or 496	90% of members in COPD Care Management will have at least two (2) PMP office visits during a 12 month period.
Number of members participating in the COPD Disease Management Program	Informatics report-Dashboard	NA
Percentage of members receiving spirometry testing to confirm or reassess the diagnosis of COPD	Claims with ICD9 code of 491, 492, and/or 496 and a CPT codes of 94010, 94014-94016, 94060, 94070, 94375, and/or 94620	90% of members in COPD Care Management will receive spirometry testing
Documentation of annual Influenza Vaccination	Claims with ICD9 code of 491, 492, and/or 496 and a HCPCS of G0008	100% of all members in COPD Care Management will have received an annual Influenza Vaccination



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### **13. Annual Evaluation**

The Chronic Obstructive Pulmonary Disease Case Management Evaluation is conducted collaboratively by the Senior Director of Clinical Services, Case and Disease Management Supervisor, Supervisor of Quality Improvement and the Chief Medical Officer. The program is evaluated annually and presented in the first quarter of the following year to the Physician Advisory Committee. Quarterly statistics are reported to the Physician Advisory Committee.

Objectives, activities, processes and outcomes are evaluated at a minimum of annually in order to:

- Calculate annual participation rates
- Determine whether the Chronic Obstructive Pulmonary Disease Management Program has demonstrated improvement in the services and quality of care provided to members
- Evaluate the overall effectiveness of the COPD Program
- Allow for exploration of barriers and limitations of the COPD Program
- Revise areas as needed to improve effectiveness of the COPD Program
- Obtain feedback from members regarding satisfaction with care management and to analyze member complaints and inquiries
- Implement intervention(s) to improve performance

MDHA also reviews and updates its case management processes and resources to address member needs. Policies are reviewed annually during the Quality Service Committee.