



Hoosier Alliance Is An AmeriHealth Mercy Company

MDwise Hoosier Alliance
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MDwise Hoosier Alliance Diabetes Disease Management Program Description

Purpose

According to the American Diabetes Association, *Standards of Medical Care in Diabetes-2010* (located at <http://www.mdwise.org/docs/providerbehavioralhealth/gl-Diabetes.pdf>), Diabetes is a chronic illness that requires continuing medical care and ongoing patient self-management education and support to prevent acute complications and to reduce the risk of long-term complications.¹

Data from the 2011 National Diabetes Fact Sheet indicates in the United States, there are about 18.8 million people diagnosed with Diabetes, 7.0 million people with undiagnosed Diabetes, and 79 million people with pre-Diabetes. For the pediatric population, about one in every 400 children and adolescents has type 1 Diabetes.²

Some complications of Diabetes include:

- Heart disease and stroke (cardiovascular disease)
- Blindness (retinopathy)
- Nerve damage (neuropathy)
- Kidney damage (nephropathy)
- Amputations
- Periodontal disease
- Birth defects and spontaneous abortions
- Depression

Due to the statistics available regarding Diabetes and its potential impact for our members, MDwise Hoosier Alliance has developed a Diabetes Disease Management Program and has adopted the American Diabetes Association (ADA) Standards of Medical Care in Diabetes 2010. The Diabetes program strives to improve the quality of care and self-management skills of our members and minimize the long-term complications due to Diabetes.

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

¹American Diabetes Association (ADA) Standards of Medical Care in Diabetes 2010

²http://www.cdc.gov/Diabetes/pubs/pdf/ndfs_2011.pdf



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Key Elements

1. Program Objectives

- **Member:** to improve the health and quality of life for our members with Diabetes by providing specific information and interventions in the management of Diabetes. 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, from the American Diabetes Association, Standards of Medical Care in Diabetes-2010. 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 Diabetes program goals are to:

- Identify, provide and coordinate services for members with Diabetes and other complex co-morbid conditions
- Facilitate processes to actively assist members and providers with the management of Diabetes 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 Diabetes Program content is comprised of the following:

- Condition monitoring to include, but not limited to, annual Dilated Retinal Exam, HbA1c and LDL-c testing
- 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, dilated retinal exams, HbgA1c, LDL-c, and neuropathy exam 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, Diabetes camps, Diabetes education, 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 dilated retinal exams and care gaps with the member and provider through ongoing telephonic contacts and/ or phone reminders
- Assist members to receive influenza 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, Diabetes camps, Diabetes Educators and other appropriate Diabetes resources
- Assist member with the identification of psychosocial issues that are creating barriers to the member achieving their goals, treatment and self-management plans

4. Population Identification and Integration of Member Information

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



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- UM/PA Department
- Medical Director
- 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

Identification Logic:

Finds members, age 18 - 75 years with at least one of the following:

- Any acute IP or ED service or 2 or more OP or nonacute IP on different dates of service with diabetes diagnosis in last 2 years
- Any dispense of insulin or oral hypoglycemics/ antihyper-glycemics in ambulatory setting in last 2 years (follow HEDIS spec)

ICD-9: (as defined by HEDIS 2011 CDC specs (table CDC-B)) 250, 357.2, 362.0, 366.41, 648.0

Stratification Logic:

Low: Member identified as having diabetes AND

- No ER or IP claims for asthma in previous 12 months

Moderate: Members manually identified via HRS feed or added to PMT

High: Diabetes member with total of:

- 1 or more diabetes ER claim, diabetes inpatient claim or diabetes observation claim in a rolling 12 month period
- 1 or more related complications such as peripheral vascular disease, diabetic ketoacidosis, diabetic retinopathy, hyperosmolar coma, kidney complications, or coronary artery disease
- Manually via HRS or assessments in PMT



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Additionally, members can be identified internally through claims and stratified through DxCG risk scores as follows:

- 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.

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 Diabetes 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.



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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*)
- 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 Diabetes 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



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- Evaluation of available benefits within the organization and from community resources
- 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 Diabetes
- 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 an endocrinologist and/or diabetes educator
- 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. Diabetes 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:

- Medication adherence to diabetes and cardiovascular medications
- Progress and/or success with smoking cessation by member self-report
- Reduction in ER visits/costs related to Diabetes as identified by claims and utilization information
- Reduction in inpatient hospitalizations/costs related to Diabetes as identified by claims and utilization information



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- Routine office visits at least 2 times a year as identified by member and provider communication, care gaps and claims information
- Documented annual influenza vaccination 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 Diabetes to assure education continuity. The staff will be trained by MDHA Medical Director or designee annually on the American Diabetes Association, Standards of Medical Care in Diabetes-2010.



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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
- The MDwise Health Plan Provider Web site, 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 Diabetes 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 Diabetes 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 Diabetes 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 Diabetes per 1,000 total members	Claims with ICD9 code of 250*, 357.2, 362.0, 366.41, 648.0 and any of the CPT codes 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	3% reduction for members in Diabetes Care Management
Rate of ER visits for Diabetes per 1,000 total members	Claims with ICD9 code of 250*, 357.2, 362.0, 366.41, 648.0 and any of the CPT codes 99281-99285	3% reduction for members in Diabetes Care Management
PMP Office visits every 6 months with Diabetes ICD9 code	Claims with any of the ICD9 codes of 250*, 357.2, 362.0, 366.41, 648.0	90% of members in Diabetes Care Management will have at least two (2) PMP office visits during a 12 month period.
Number of members participating in the Diabetes Disease Management Program	Informatics report-Dashboard	NA
Documentation of annual Influenza Vaccination	Claims with ICD9 code of 250*, 357.2, 362.0, 366.41, 648.0 and a HCPCS of G0008	100% of all members in Diabetes Care Management will have received an annual Influenza Vaccination
Rate of members receiving LDL-c lab testing in the Diabetes Disease Management Program	Claims with ICD9 code of 250*, 357.2, 362.0, 366.41, 648.0 and any of the CPT codes 80061, 83700, 83701, 83704, 83721	90% of all members in Diabetes Care Management will have received a LDL-c test
Rate of members receiving Dilated Retinal Exam in the Diabetes Disease Management Program	Claims with ICD9 code of 250*, 357.2, 362.0, 366.41, 648.0 and any of the CPT codes 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92108, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	90% of all members in Diabetes Care Management will have received a Dilated Retinal Exam



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Rate of members receiving HbgA1c lab testing in the Diabetes Disease Management Program	Claims with ICD9 code of 250*, 357.2, 362.0, 366.41, 648.0 and any of the CPT codes of 83036 and 83037	90% of all members in Diabetes Care Management will have received a HbgA1c test
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13. Annual Evaluation

The Diabetes 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 Diabetes Disease Management Program has demonstrated improvement in the services and quality of care provided to members
- Evaluate the overall effectiveness of the Diabetes Program
- Allow for exploration of barriers and limitations of the Diabetes Program
- Revise areas as needed to improve effectiveness of the Diabetes 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.