

The Health Plan Disease Management and Health Promotion Programs

The Health Plan's Disease Management and Health Promotion Programs are multi-disciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes, chronic heart failure, and chronic obstructive pulmonary disease. The Health Plan's pregnant members are also monitored with the intent to identify those at high risk for premature delivery.

Disease management programs support the practitioner-patient relationship and plan of care, emphasize the prevention of exacerbations and complications using evidence based practice guidelines and patient empowerment strategies. The Health Plan programs continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health status. The essential elements of disease management include understanding the course, clinical implications, and trajectory of specific diseases; identifying and targeting patients likely to benefit from intervention; focusing on prevention; and working toward resolution of resource-intensive problems.

Program Content

Each management program includes condition monitoring that is ongoing and proactive. This allows the member, the practitioner, and the disease manager to assess how well the condition is being managed. Monitoring is done through the use of regular clinical assessments with surveillance of pharmacological management, lifestyle management, and assessment of the member's understanding of the condition itself as well as the related comorbid conditions likely to affect overall health status.

Member adherence to the program's treatment plan is an integral part of disease management. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. High risk members are called at periodic intervals. Detailed questions are asked about the member's condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life. A specific plan of care is developed based on the findings from a clinical assessment and functional inventory. Ongoing monitoring by the disease manager ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the case manager is determined by the severity of symptoms. This may result in daily contact in times of high risk or concern. When home care is needed in high risk-cases, the disease manager works with the practitioner and a home care agency to coordinate necessary care and services.

In all instances, disease management and health promotion programs must give consideration to other health conditions that directly effect the member's overall health status. A multi-disciplinary approach to disease management enables the disease manager to develop a treatment plan that includes condition monitoring of comorbid conditions frequently associated with chronic medical conditions.

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Because lifestyle issues are strongly linked with chronic disease and high risk pregnancy, strategies to address current lifestyle and the need to modify behavior is addressed in every program. Whether members need interventions addressing issues such as smoking cessation or weight loss management, the disease manager is able to address readiness to change and to provide additional resources to affect needed change.

The Health Plan's Disease Management and Health Promotion Program elements include:

- Identification of evidence-based standards of care, best practices, evidence-based
- intervention strategies, and targeted outcomes
- Identification of the member and assessment of health status
- Proactive intervention to include the application of appropriate therapies and systematic surveillance of appropriateness of medication, education and counseling about daily self-management, and symptom management
- Tracking of the member's clinical and functional status over time
- Assessment of effectiveness of treatment and sharing of knowledge gained to achieve optimal member outcomes.

Attention to all program elements and improvements in all of these areas will likely lead to improved outcomes for the many who are at risk or who suffer chronic diseases.

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Diabetes Program

The Diabetes Program is designed to modify risk factors associated with diabetes as well as slow the progression of microvascular and macrovascular complications. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Members with diabetes require long-term, continual health care to maintain appropriate glycemic control and to decrease the risk of long term complications such as neuropathy, nephropathy and blindness. Program goals include:

- glycemic control,
- reduction of risk factors,
- optimization of functional capacity,
- prevention of microvascular and macrovascular complications, and
- facilitation and enhancement of the patient/doctor relationship.

Program Content

Member identification is conducted by ICD-9 analysis of ambulatory and inpatient claims and inpatient DRG 294 and 295. Diagnosis codes include: 250.XX, 357.2, 362.0, 366.41, and 648.0. Other methods of identification include health risk screening and direct referral by the primary care physician or specialist. Member stratification is based on severity of illness and comorbid conditions.

The diabetes program relies on the population based HEDIS®¹ *Comprehensive Diabetes Care* measures for outcomes analysis. The same measures are also used at the individual member level for those members stratified as high risk and who participate in The Health Plan's telephonic diabetes management program. Primary attention is given to assisting the member in reaching and then maintaining glycemic control. Daily self blood glucose monitoring and quarterly A1c testing are the indicators used to monitor glycemic control. Additional indicators include lipid monitoring and control, dilated eye exam performance, and monitoring of kidney function.

Population based disease management strategies include the annual eye exam coupon program as well as appropriate educational mailings throughout the year. The provision of diabetic supplies and glucometers for self-monitoring of blood glucose and other diabetes benefits are important components of the program.

High risk members receive telephonic disease management intervention from a diabetes nurse specialist who provides individualized interventions that include the evaluation of appropriate

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medication use, education and counseling about self-management, surveillance of symptoms, and consideration of other health conditions based on nationally recognized ADA guidelines.

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the patient's condition and information is gathered about patient status, treatment plan adherence, functional status, and quality of life. A specific plan of care is developed based on the American Diabetes Association's *Standards of Medical Care for Patients with Diabetes Mellitus*. Ongoing monitoring by the diabetes manager ensures timely intervention in the event of a change in risk status. The frequency of outbound calls to the member is determined by the severity of symptoms. This may result in daily contact in times of high risk as well as consultations with the physician. When home care is needed, the nurse works with the home care agency to coordinate the necessary care and services.

A major component of the Diabetes Program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms of hyperglycemia and hypoglycemia are included. Each member contact includes a review of medications and medication compliance. Lifestyle issues are addressed through education and include the importance of exercise, diet, proper self management skills and, when indicated, smoking cessation interventions. Members are also referred to certified diabetes educators and the Ohio Valley Pharmacy Care Network, (certified pharmacists in diabetes education) to increase member understanding of the disease process and enhance self-management skills.

A successful diabetes program is dependent on the coordination of health care services. The role of the physician is vital and this program is intended to complement the medical care each member receives from his/her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the care manager to coordinate the necessary care for the member. Evidence based guidelines are available and recommended for use by the physician to medically manage their patients with diabetes. The Health Plan Diabetes Flowchart based on The Health Plan Guidelines and ADA Standards of Medical Care is mailed annually to physicians for use to document diabetes care.

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Chronic Heart Failure

The chronic heart failure program is designed to modify cardiovascular risk factors and slow disease progression. This is accomplished by promoting treatment plan compliance through education, counseling and support.

Program goals include:

- reversal of, or stabilization of symptoms of chronic heart failure,
- optimization of functional capacity,
- improvement in quality of life,
- reduction in frequency of hospitalization, and
- facilitation and enhancement of the patient/doctor relationship.

Program Content

Member identification is conducted by ICD-9 analysis of ambulatory and inpatient claims and inpatient DRG 127. Diagnosis codes include: 398.1, 402.91, 425.1, 425.4, 428.0, 428.1, and 428.9. Other methods of member identification include health risk screening and direct referral by the primary care physician or cardiologist. Member stratification is based on severity of illness using New York Heart Association classification.

The chronic heart failure program relies on population based measures of assessment of left ventricular function, ace inhibitor use, and hospitalization utilization. The same measures are used at the individual member level for those members stratified as high risk and who participate in The Health Plan's telephonic chronic heart failure program. Primary attention is payed to the application of appropriate pharmacological therapies including the use of ace inhibitors and beta-blockers, enhancement of self-management skills, and systematic surveillance of those with symptomatic heart failure to prevent hospitalization.

Population based disease management strategies include targeted educational mailings throughout the year. High risk members receive telephonic disease management intervention from a chronic heart failure nurse specialist who provides individualized interventions that include the evaluation of appropriate medication use, education and counseling about daily self-management, and member recognition of early signs and symptoms of heart failure requiring intervention. Enrolled members receive home scales, referrals for nutritional education to address dietary compliance, referrals for home oxygen/respiratory therapy when indicated, and immunizations. Consideration of other health conditions, such as diabetes and chronic obstructive pulmonary disease are included in the management program.

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the patient's condition and information is gathered about patient status, treatment plan adherence, functional status, and quality of life. A specific plan of care is developed based practice guidelines from the *ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult*. Ongoing monitoring by

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the chronic heart failure manager ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to members by the nurse is determined by the member's severity of symptoms. This may result in daily contact in times of high risk or concern as well as consultations with the physician. When home care is needed, the nurse works with the physician and home care agency to coordinate the necessary care and services.

A major component of the chronic heart failure program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and the recognition of symptoms are included in the teaching process. These warning signs are reviewed with each assessment call along with a review of medications and medication compliance. Lifestyle issues are addressed through education and include the appropriateness of exercise, diet, self management skills and, when indicated, smoking cessation interventions. Patients are encouraged to keep a record of their daily weight and to notify the physician if they experience a weight gain of two pounds in one day or three pounds in one week.

A successful chronic heart failure program is dependent on the coordination of health care services. The role of the physician is vital and this program is intended to compliment the medical care the member is receiving from his/her physician. The goal of the management program is to foster a collegial relationship between the physician and the care manager in order to coordinate the necessary and appropriate care for the member. Evidence based guidelines are available, distributed regularly, and recommended for use by the physician to medically manage their patients with chronic heart failure.

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Chronic Obstructive Pulmonary Disease Program

The chronic obstructive pulmonary disease program is designed to modify risk factors associated with COPD as well as slow the progression of the disease. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Members with COPD require long-term, continual health care to maintain functional status and to help eliminate disease exacerbations. Program goals include:

- slowing the progression, or stabilization of symptoms of COPD,
- optimization of functional capacity,
- improvement in quality of life,
- reduction in frequency of hospitalization, and
- facilitation and enhancement of the patient/doctor relationship.

Member identification is conducted by ICD-9 analysis of ambulatory and inpatient claims and inpatient DRG 88. Diagnosis codes include: 491, 491.0, 491.1, 491.2, 491.20, 491.21, 491.8, 491.9, 492, 492.0, 492.8, 493.2, and 496. Other methods of member identification include health risk screening and direct referral by the primary care physician or pulmonologist. Member stratification is based on severity of illness and frequency of hospitalization with exacerbations.

The chronic obstructive pulmonary disease program relies on population based measures of hospitalization utilization and emergency services utilization. The same measures are also used at the individual member level for those stratified as high risk and who participate in The Health Plan's telephonic COPD management program. Primary attention is given to the evaluation of appropriate medication use, education and counseling about daily self-management, and recognition of early COPD exacerbations.

Population based disease management strategies include targeted educational mailings throughout the year. High risk members receive telephonic disease management intervention from a COPD nurse specialist who provides individualized interventions that include the evaluation of appropriate medication use, education and counseling about daily self-management, and recognition of early signs and symptoms of COPD exacerbation requiring intervention. Enrolled members receive home scales if needed, smoking cessation interventions if indicated, referrals for nutritional education, referrals for home oxygen/respiratory therapy when indicated, pulmonary rehabilitation, and immunizations. Consideration of other health conditions, such as diabetes and chronic heart failure are included in the management program.

Initial management of acute exacerbations include identification of precipitating factors (e.g., infection, volume overload, pulmonary thromboembolism, environmental changes, or overuse of sedating medication) and tailoring drug therapy according to:

- the degree of reversible bronchospasm
- prior therapy at a stable baseline
- recent pharmacotherapy and prior medication toxicity
- presence of contraindications to specific medications

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- specific therapies indicated by the precipitating cause of the exacerbation

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the member's condition and information is gathered about health status, treatment plan and adherence, functional status, and quality of life. Ongoing monitoring by the COPD manager ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the nurse is determined by the member's severity of symptoms. This may result in daily contact in times of high risk or concern as well as consultations with the physician. When home care is needed, the nurse will work with the physician and home care agency to coordinate the necessary care and services.

A major component of the COPD Program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms are included in the teaching process. These warning signs are reviewed each assessment call along with a review of medications and medication compliance. Education also includes the appropriateness of exercise, diet, self management skills, the proper use of metered dose inhalers and, when indicated, smoking cessation interventions.

A successful COPD program is dependent on the coordination of health care services. The role of the physician is vital and this program is intended to compliment the medical care the member is receiving from his/her physician . The goal of the management program is to foster a collegial relationship between the physician and the case manager in order to coordinate the necessary and appropriate care for the member. Evidence based guidelines are available and recommended for use by the physician to medically manage their patients with COPD.

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Prenatal Care Program

The Prenatal Care Program is designed to improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with pre-term birth and other complications of pregnancy. This is accomplished by providing prenatal education, promoting safe health behaviors, and enhancing the management of maternity care for women identified at high risk for premature labor and delivery. Program goals include:

- reduction in the incidence of preterm births,
- reduction in the incidence of low birth weight babies,
- reduction in the number of neonatal intensive care unit days, and the
- provision of improved prenatal education, promotion of safe health behaviors, and enhanced management of maternity care for women identified as high risk for premature labor and delivery.

Program Content

Member identification and enrollment is initiated once a pregnant member is identified or a referral is received. Referrals may come from the physician, The Health Plan Outreach Program, self referral, and claims data. Physicians are provided a prenatal risk screening tool to forward to The Health Plan. Postcards are also provided to the physician office for use in member self-enrollment.

Outcomes monitoring is continuous and reported regularly. These reports include:

- rate of preterm deliveries
- rate of low birth weight deliveries
- rate of cesarean sections deliveries
- NICU days/1,000 births
- NICU length of stay
- rate of smoking at enrollment and at delivery
- rate of prenatal care in the first trimester
- rate of check-up after delivery

The targeted time for enrollment of all members is between 12 to 15 weeks gestation. A telephonic assessment of the clinical and psychosocial status of the member is completed by outreach staff at enrollment and again at week 24. Consideration is given to other health conditions. The assessment tool along with the prenatal risk screen completed by the physician is reviewed by the program nurse. The mother-to-be is placed in the appropriate low risk pregnancy group or the high risk pregnancy group to be case managed. A late referral education component is available for those women enrolled after 34 weeks gestation. A partial program is offered for those individuals who decline to enroll in the complete program but who want to receive educational materials.

The identification of low-risk pregnant women early in pregnancy is designed with the intent of

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improving the outcome of the pregnancy. Educating the pregnant woman on healthy lifestyle measures reduces risk factors throughout the pregnancy. The low risk pregnant woman receives an initial assessment, a second trimester assessment, a third trimester assessment, and postpartum assessment conducted by the Outreach Department. The final call ensures the well being of mother and child.

High-risk pregnancies are monitored and managed aggressively as early as possible and continuously throughout the pregnancy. This group receives general educational mailings as well as specific educational materials based on assessment findings. All participants receive proactive calls from the prenatal care nurse. The prenatal care nurse promotes positive outcomes for the pregnancy through individualized interventions. A specific plan of care is developed based on the risk status. Ongoing monitoring by the prenatal care coordinator ensures timely intervention in the event of a change in risk status. The frequency of outbound calls to participants by the prenatal care nurse is determined by the severity of pregnancy risks and complications. This may result in daily contact in times of high risk or concern. When home care is needed in high risk-cases, the prenatal care nurse works with the physician and home care agency to coordinate the necessary care and services.

A major component of the program is to educate the pregnant woman on proactive and healthy lifestyle measures that reduce risk factors throughout the pregnancy. This is achieved by providing mailings of educational materials addressing prenatal care, birth alternatives, and newborn care as well as verbal education during assessments focusing on pregnancy wellness and patient-specific risk factors. Lifestyle issues are addressed such as illegal drug use and smoking. Smoking cessation interventions are a major focus for those members who are identified as smokers or recent smokers. Standard education materials are available for all members and risk-specific written educational materials are provided for specific pregnancy issues. ACOG and March of Dimes are the resources for risk specific educational materials. All identified pregnant members receive an initial mailing in the first trimester and the third trimester. Smoking cessation is offered telephonically as a major component of the program.

A successful prenatal care program is dependent on the coordination of healthcare services. The role of the physician is vital and this program is intended to compliment the medical care the member is receiving from her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the prenatal care nurse to coordinate the necessary healthcare to promote a healthy mother and a healthy baby.