Our mission is to improve the health and quality of life of our members
Diabetes Care Program Evaluation

Program Title: Diabetes Care Program


Introduction: The Diabetes Care Program is designed to improve the health status and decrease complications of members with diabetes through improved adherence of both members and clinicians with the American Diabetes Association (ADA) Standards of Care. The Diabetes Care Program is the process of coordinating health care interventions and communications for members with diabetes in which patient self-care efforts are significant; supporting clinician and member relationships and the member’s plan of care; emphasizing prevention of exacerbations and complications utilizing the ADA Standards of Care and patient empowerment strategies; and evaluating clinical, humanistic and economic outcomes on an ongoing basis with the objective of improving overall health.1

2015 Program Goals:

- To decrease complications of members with diabetes by increasing clinician adherence to ADA Standards of Care regarding Hemoglobin A1c (HbA1c) testing, cholesterol (LDL-C) screening, medical attention for nephropathy, Dilated Retinal Eye (DRE) Exams, and blood pressure (BP) control.

- To increase member adherence with ADA Standards of Care regarding HbA1c testing, LDL-C testing, medical attention for nephropathy, DRE Exams, and BP treatment.

- To decrease the frequency of diabetes related inpatient admissions, readmissions within 30 days, and emergency room (ER) visits.

- To promote healthy lifestyle, measurement of blood sugars as prescribed by the clinician, adherence to medication regimen, weight management, physical activity, smoking cessation, and adherence to recommended screenings/tests.

2015 Program Objectives:

- During the measurement year, increase the percentage of members receiving:
  - At least one HbA1c test
  - A DRE Exam
  - An LDL-C screening
  - Medical attention for nephropathy

- Increase the percentage of members with:
  - HbA1c good control of < 7%
  - HbA1c good control of < 8%
  - LDL-C level < 100 mg/dL

- BP level of < 130/80 mm Hg
- BP level of < 140/90 mm Hg

- Decrease the percentage of members with:
  - HbA1c poor control of > 9%
  - Inpatient admissions
  - Readmissions within 30 days
  - ER visits

- Promote healthy lifestyle, diet and nutrition, measurement of blood sugars as prescribed by the clinician, adherence to medication regimen, weight management, physical activity, smoking cessation, and adherence to recommended screenings/tests through targeted telephonic and educational mailings.

**Measurements:** Overall effectiveness of the program is measured through annual participation rates and audited HEDIS® results.

### Annual Participation Rate

Eligible members are identified and passively enrolled in the Diabetes Care Program. Members may “opt out” of the Program at any time, and elect not to receive disease management (DM) services, by notifying the Diabetes Disease Manager or the Care Connector Program, either telephonically or in writing. Participation Rates are tracked and reported annually.

<table>
<thead>
<tr>
<th>Year</th>
<th>Diabetes Membership (avg)</th>
<th>Opt Out</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>9,059</td>
<td>16</td>
<td>99.99%</td>
</tr>
<tr>
<td>2014</td>
<td>7,984</td>
<td>23</td>
<td>99.99%</td>
</tr>
<tr>
<td>2013</td>
<td>5,875</td>
<td>29</td>
<td>99.51%</td>
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<tr>
<td>2012</td>
<td>4,664</td>
<td>29</td>
<td>99.38%</td>
</tr>
<tr>
<td>2011</td>
<td>4,265</td>
<td>4</td>
<td>99.99%</td>
</tr>
</tbody>
</table>

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2 HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)
3 Program membership numbers are annualized
Diabetes Management

2015 HEDIS® Results

The 2015 HEDIS® Results are based on measurement year 2014 data.

1. **Comprehensive Diabetes Care (CDC)**
   The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:
   - HbA1c Testing
   - HbA1c Poorly Controlled (>9.0%)\(^4\) \(^5\)
   - HbA1c Good Control (<7.0%)\(^6\)
   - HbA1c Good Control (<8.0%)\(^4\)
   - DRE Exam Performed\(^4\)
   - Medical Attention for Nephropathy\(^4\)
   - BP Control < 140/90 mm Hg\(^4\)

**Findings:** In measurement year 2014, a total of 5,638 members were identified with diabetes. A systemic sample of 575 members showed 522 (90.78%) received HbA1c testing, 221 (38.43%) received HbA1c Poor Control (> 9.0%), 291 (50.61%) received HbA1c Good Control (< 8.0%), 234 (40.70%) received a DRE Exam Performed, 470 (81.74%) received Medical Attention for Nephropathy, 382 (66.43%) received BP Control < 140/90 mm Hg. Through additional required exclusion criteria, 1,819 members were identified for HbA1c Good Control (< 7.0%). A systemic sample of 413 members showed 168 (40.68%) received this indicator.

<table>
<thead>
<tr>
<th>Measure</th>
<th>MY 2010</th>
<th>MY 2011</th>
<th>MY 2012</th>
<th>MY 2013</th>
<th>MY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
<td>86.49%</td>
<td>81.95%</td>
<td>84.08%</td>
<td>86.59%</td>
<td>90.78%</td>
</tr>
<tr>
<td>HbA1c Poor Control (&gt; 9.0%)</td>
<td>35.33%</td>
<td>34.76%</td>
<td>35.57%</td>
<td>36.28%</td>
<td>38.43%</td>
</tr>
<tr>
<td>HbA1c Good Control (&lt; 8.0%)</td>
<td>55.79%</td>
<td>55.48%</td>
<td>55.97%</td>
<td>54.12%</td>
<td>50.61%</td>
</tr>
<tr>
<td>HbA1c Good Control (&lt; 7.0%)</td>
<td>50.00%</td>
<td>42.18%</td>
<td>41.85%</td>
<td>40.68%</td>
<td>34.72%</td>
</tr>
<tr>
<td>DRE Exam Performed</td>
<td>43.82%</td>
<td>54.28%</td>
<td>52.74%</td>
<td>57.93%</td>
<td>40.70%</td>
</tr>
<tr>
<td>LDL-C Screening</td>
<td>76.06%</td>
<td>76.34%</td>
<td>76.99%</td>
<td>77.13%</td>
<td>-</td>
</tr>
<tr>
<td>LDL-C Controlled (LDL &lt; 100 mg/dL)</td>
<td>40.73%</td>
<td>41.04%</td>
<td>42.54%</td>
<td>39.18%</td>
<td>-</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
<td>77.41%</td>
<td>81.15%</td>
<td>79.48%</td>
<td>80.64%</td>
<td>81.74%</td>
</tr>
<tr>
<td>BP Controlled &lt; 140/80 mm Hg</td>
<td>41.51%</td>
<td>41.58%</td>
<td>42.04%</td>
<td>37.96%</td>
<td>-</td>
</tr>
<tr>
<td>BP Controlled &lt; 140/90 mm Hg</td>
<td>62.16%</td>
<td>63.64%</td>
<td>64.68%</td>
<td>63.41%</td>
<td>66.43%</td>
</tr>
</tbody>
</table>

The goal to meet or exceed the 2015 Quality Compass\(^7\) 90th Percentile for all CDC measures (HbA1c Testing 91.94%; HbA1c Poor Control (> 9.0%) 29.68%; HbA1c Good Control (< 8.0%) 58.58%; HbA1c Good Control (< 7.0%) 41.74%; DRE Exam Performed 67.86%; 45.59%; Medical Attention for Nephropathy 87.70%; and BP Controlled < 140/90 mm Hg (76.64%) was not met.

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\(^4\) CDC measures for HbA1c Poor Control (> 9.0%), HbA1c Good Control (< 8.0%), DRE Exam Performed, Medical Attention for Nephropathy, and BP Controlled < 140/90 mm Hg will be looked at for NCQA Accreditation for 2015.

\(^5\) This is an inverted rate with a lower rate indicating better performance.

\(^6\) Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.

\(^7\) The source for data contained in this publication is Quality Compass\(^®\) 2015 (Medicaid) and is used with the permission of the NCQA. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.
Hospital Utilization with a Primary Diagnosis of Diabetes

Utilization for Members with Diabetes (per 1,000)
Analysis

HEDIS®: Passport aspires to be in the Quality Compass® 90th Percentile for each measure.

One (1) measures achieved the Quality Compass® 75th Percentile:
- HbA1c Testing

One (1) measures achieved the Quality Compass® 66.67th Percentile:
- BP Controlled < 140/90 mm Hg

One (1) measures achieved the Quality Compass® 50th Percentile:
- HbA1c Good Control (< 8.0%)

Two (2) measures achieved the Quality Compass® 33.33rd Percentile:
- HbA1c Good Control (< 7.0%)
- Medical Attention for Nephropathy

One (1) measure achieved the Quality Compass® 25th Percentile:
- HbA1c Poor Control (> 9.0%)

One (1) measure achieved the Quality Compass® 10th Percentile:
- DRE Exam Performed

Specific results include:
- Five (5) of the seven (7) CDC measures noted an increase from the previous measurement year:
  o HbA1c Testing an increase of 4.19 percentage points
  o HbA1c Poor Control (> 9.0%) had an increase of 2.15 percentage points
  o DRE Exam Performed an increase of 5.19 percentage points
  o Medical Attention for Nephropathy an increase of 1.10 percentage points
  o BP Controlled < 140/90 mm Hg had an increase of 3.02 percentage points

- Three (3) of the seven (7) CDC measures noted a decrease from the previous measurement year:
  o HbA1c Good Control (< 8.0%) had a decrease of 3.51 percentage points
  o HbA1c Good Control (< 7.0%) had a decrease of 5.96 percentage points
  o BP Controlled < 140/80 mm Hg had a significant decrease of 17.23 percentage points

Member Engagement: Multiple member interventions are conducted to educate the member on the importance of screenings/tests needed based on the ADA Standards of Care. Clinicians are notified of members in need of screenings/tests and resources to track diabetic members and their screenings via the Care Gaps report. The Care Coordination Department has Case Managers in high volume/clinician office in order to educate and encourage the members face-to-face to complete screenings.
Member Incentive Program: Passport utilized our Member Incentive Program targeted toward increasing clinician and member awareness of ADA Standards of Care recommended screenings/tests, including:

- HbA1c testing
- LDL-C screening
- Microalbumin
- DRE
- BP
- Influenza vaccination
- Foot inspection
- Weight with BMI
- Nutritional/exercise education

Members who receive seven (7) of the recommended screenings/tests and return their incentive form received a total of $50 in gift card. In 2015, 1,402 members received gift cards for completing their screenings/tests, a 24% increase from 2014.

Community and Provider Engagement: Clinicians received status updates on members enrolled in the Diabetes Care Program and provided reference information on the ADA Standards of Care on Passport’s website. Community activity involvement included collaboration with the Kentucky Diabetes Symposium and Kentucky Diabetes Network (KDN) to gain knowledge and information about the latest treatment options and procedures and new medications available.

ER/Readmissions: The Diabetes Care Program received daily facility-specific ER and readmission reports. Staff used this report to identify members diagnosed with diabetes. Members identified received targeted mailings and telephonic outreach. Members who are newly identified with diabetes received a new member packet, along with individualized and quarterly mailings. High risk members also received telephonic outreach. The Diabetes Care Program began a collaborative effort with Passport’s ER Navigators for targeted face-to-face, mailing and telephonic outreach to members with asthma who have an ER visit.

Risk Stratification: During 2015, an average of 9,059 members was enrolled in the Diabetes Care Program, an 88% increase from 2014. Of those members enrolled, an average of 1,007 was identified as high risk. There were 750 members who were active with one-on-one telephonic outreach by the Diabetes Disease Managers, a 78% increase from 2014. A total of 2,237 members received a new member packet via mail. Three separate attempts are made to contact the member. All members receive quarterly mailings, and high risk members receive individualized mailings based on assessment by the Diabetes Disease Managers.

Member Complaints: During 2015, there were no complaints received regarding the Diabetes Care Program or the Diabetes Disease Managers.
Program Materials

Member materials:
- Diabetes Assessment Form
- Basic Diabetes Care Book
- Don’t Let Diabetes Get You Down
- Hemoglobin A1c
- My A1c Chart
- Over-the-Counter Products
- Important Things to Know About Diabetes & Kidney Disease
- Testing Your Blood Sugar
- Make Your Sick Day Plan
- Take Care of Your Teeth and Gums
- Take Control of Your Diabetes
- 6 Ways to Control Diabetes and Live Well
- My Diabetes Disaster Plan
- What is Cholesterol
- My Blood Sugar and Diet Log
- Type 2 Diabetes
- Let’s Eat Healthy

Clinician Materials:
- Care Coordination: Your Connection to Disease and Case Management Programs Brochure
- Admitted 1on1 Letter
- Unable to Contact (UTC) Letter
- DM Discharge Letter
- Thank You Referral Letter
- Program Discharge Letter
- Member Opted-Out Letter

- Be a Smart Grocery Shopper
- My Diabetes Emergency Plan
- Take Good Care of Your Feet
- Diabetes and the Flu
- Diabetes and Exercise
- Protect Your Vision with a Dilated Eye Exam
- Using a Preferred Glucometer (Blood Sugar Meter)
- Hypoglycemia – “Low Blood Sugar”
- Diabetes Reminder Postcard
- Your Diabetes Medicine – Metformin
- Your Diabetes Medicine – Sulfonylureas
- Your Diabetes Medicine – Insulin
- Learn the Truth about Your Child’s Diabetes
- Ketones and How to Test for Them
- Have Diabetes? You Can Lower Your Chances of Heart Disease and Stroke
Barriers and Opportunities

**Barrier:** Clinician identification of needed testing, as recommended by the ADA Standards of Care.

**Opportunity:**
- Collaborate with Provider Relations to educate clinicians during all site visits to improve compliance with ADA Standards of Care recommendations.

**Barrier:** Member lack of knowledge about diabetes.

**Opportunity:**
- Increase members and caregivers knowledge regarding the appropriate treatment, and appropriate self-management skills, for persons with diabetes.
- Increase community awareness regarding the diagnosis, appropriate treatment, and appropriate self-management skills for persons with diabetes by distributing educational materials at health fairs and events.
- Increase member awareness regarding the appropriate treatment and appropriate self-management skills for persons with diabetes by:
  - Face-to-face outreach
  - Telephonic outreach
  - Member newsletters
  - On-hold SoundCare messages
  - Passport’s website
  - Member educational materials
- Collaborate with ER Navigators for identification of members for targeted mailing and telephonic educational outreach.

**Barrier:** Member lack of knowledge of ADA Standards of Care recommendations for testing and results.

**Opportunity:**
- Educate members on the specific ADA Standards of Care recommendations for screenings/tests.
- Perform targeted telephonic outreach to diabetic members delinquent in ADA Standards of Care recommendations for screenings/tests.
- Utilize the Care Connector Program to assist members with urgent issues related to diabetes.
Interventions completed in 2015:

**Provider Education:**
- Increased clinician awareness of the ADA Standards of Care recommended diabetic screening including, HbA1c testing, LDL-C screening, microalbumin, DRE, BP, influenza vaccination, foot inspection, weight with BMI, and nutritional/exercise education through Embedded Case Managers, the Diabetes Disease Managers, and through Provider Relations site visits.
- Updated “Care Coordination: Your Connection to DM and Case Management Programs” pamphlet for clinician education on support programs Passport offers to members with diabetes.

**Member Education:**
- Educated members/caregivers regarding diabetic screenings through face-to-face outreach, telephonic outreach, member newsletters, on-hold SoundCare messages, Passport’s website, and member educational material.
- Distributed new member packet and assessment form to 2,237 newly diagnosed diabetic members to assess the member’s understanding and current treatment of their diabetes and provide follow-up with recommendations based on the member’s needs.
- Utilized the auto-dialer technology to engage 1,223 members in diabetic care gap reminders. Of those members, 259 (21%) completed their screenings/tests.
- Passport’s Vision Program mailed 2,052 DRE Forms and made 2,948 outreach calls to members concerning the importance of receiving a DRE Exam. The Diabetes Care Program mailed 3,736 diabetes testing reminder postcards to members to remind them of the importance of recommended annual diabetic testing.
- Leveraged the Care Connector Program to engage members in need of assistance making appointment during auto dialer campaigns to reduce diabetic care gaps.
- Maintained a member engagement reward strategy to encourage member compliance with screening.
- Updated “Special Health Programs, Just for You!” brochure for member education on support programs available for them.
- Developed the following new educational materials:
  - Your Diabetes Medicine – Sulfonylureas
  - Your Diabetes Medicine – Insulin
  - Learn the Truth about Your Child’s Diabetes
  - Ketones and How to Test for Them
  - Have Diabetes? You Can Lower Your Chances of Heart Disease and Stroke
  - Teen Basics Book
Screening Activities:
- Administered the Patient Health Questionnaire (PHQ) 2 and the Pediatric Symptom Checklist-17 (PSC-17) a depression screening used with member’s ages 4 to 17. There was 180 adult members screened and 49% of those members had a positive result and the PHQ-9 was administered. Of those members, 88 were referred for Behavioral Health (BH) services. There was 14 pediatric members screened using the PSC-17 screening tool and 28% of those members had a positive result. Of those members, four were referred for Behavioral Health (BH) services.

Identification Activities:
- Identified and outreached to members with inpatient admissions or ER visits.
- Evaluated all member materials to ensure each piece is clear and concise. Materials continued to be utilized for member mailings; in addition to face-to-face education with the members at the clinician’s office.
- Continued to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.
- Distributed the Diabetes Member Satisfaction Survey to members enrolled in the Diabetes Care Program, reviewed surveys as received and conducted outreach to those members who indicate “fair” or “poor” responses on their survey (if the member completes contact information section of the survey tool) and monitored surveys for trends, none identified. Provided feedback to individual staff when appropriate and addressed any identified areas that needed improvement, none identified.

Community Activities:
- Increased community initiatives related to the diagnosis and treatment of diabetes through:
  - Collaborated with Provider Relations and Embedded Case Managers to educate clinicians regarding available monthly Care Gap Reports that identified members who need an LDL-C screening, HbA1c test and microalbumin.
  - Collaborated Passport’s Vision Program to increase outreach to members delinquent in obtaining their DRE Exam.
  - Collaborated with community resources to assist members in getting corrective lenses, if needed.
  - Collaborated with pharmacies to distribute member education when dispensing the preferred testing meter.
  - Collaborated with community partners to continue to raise awareness of diabetes within the community such as KDN state-wide diabetes initiative, ADA, improve diabetes care, and control complications associated with diabetes, and local Departments of Health.
  - Collaborated with community agencies and statewide initiatives to increase awareness of diabetes and diabetes management.
Interventions completed in 2015 (Continued):

- Collaborated with Text for Health™ messaging to provide healthy, helpful information to members through Passport sponsored cell phones.

- Participated in community forums to determine additional community resources and best practices related to a healthy lifestyle for our members including:
  - Kentucky Diabetes Symposium
  - Greater Louisville Association of Diabetes Educators (Glade)
  - SOAR (Shaping our Appalachian Region)
  - Howard L. BOST Forum “Doing Care Differently”
  - Tri State Association of Diabetes Educators (TRADE)
  - American Association of Diabetes Educators Annual Meeting

Planned Interventions for 2016:

New Enhancements:

- Enroll appropriate members with diabetes in the Stay Healthy at Home Program to assist members with recognizing glucose readings and symptoms of hyper or hypoglycemia.

- Continue development of educational materials geared towards children 9-17 years of age to help with understanding and knowledge of disease process and management.

Continued Interventions:

- Increase clinician awareness of the ADA Standards of Care recommended diabetic screening on Passport’s website, through Embedded Case Managers, the Diabetes Disease Managers, and through Provider Relations site visits.

- Identify and outreach to members with inpatient admissions or ER visits.

- Expand upon current processes to develop additional relationships with participating ERs to promote discharge planning and education regarding appropriate ER use.

- Educate members/caregivers regarding diabetic screenings through:
  - Face-to-face outreach
  - Telephonic outreach
  - Member newsletters
  - On-hold SoundCare messages
  - Passport’s website
  - Member educational materials

- Evaluate all new member materials to ensure each piece is clear and concise. Materials continue to be utilized for member mailings; in addition to face-to-face education with the members at the clinician’s office.
- Administer the PHQ-2, PHQ-9 (for adults) and PSC-17 (for children ages 4-17) to prescreen and screen for depression in diabetic members and referred members to the BH team as needed.

- Review surveys as received and conduct outreach to those members who indicate “fair” or “poor” responses on their survey (if the member completes contact information section of the survey tool).

- Monitor for trends, provide feedback to individual staff and address any identified areas that needed improvement.

- Continue to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.

- Continue to leverage the Care Connector Program to engage members in need of assistance making appointment during auto dialer campaigns to reduce diabetic care gaps.

- Continue to leverage the access of auto-dialing technology to engage more members in diabetic care gap reminders.

- Continue promotion of the Member Incentive Program to encourage member compliance with diabetic screenings/tests.

- Continue collaboration with Text for Health™ messaging to provide healthy, helpful information to members through Passport sponsored cell phones.

- Increase community initiatives related to the diagnosis and treatment of diabetes through:
  - Continue collaboration with Provider Relations and Embedded Case Managers to educate clinicians regarding available monthly Care Gap Reports that identified members who need an LDL-C screening, HbA1c test and microalbumin.
  - Continue collaboration with Passport’s Vision Program to increase outreach to members delinquent in obtaining their DRE Exam.
  - Continue collaboration with community resources to assist members in getting corrective lenses, if needed.
  - Continue collaboration with pharmacies to distribute member education when dispensing the preferred testing meter.
  - Continue collaboration with community partners to continue to raise awareness of diabetes within the community such as KDN state-wide diabetes initiative, ADA, improve diabetes care, and control complications associated with diabetes, and local Departments of Health.
  - Continue collaboration with community agencies and statewide initiatives to increase awareness of diabetes and diabetes management.
  - Continue collaboration with community partners to provide supportive services to members/families who need advance illness management services without the requirement of discontinuing active treatments.
- Continue distribution of educational materials at health fairs and special events.
- Continue participation in the Kentucky Diabetes Symposium, Glade, SOAR, and TRADE.

Overall the Diabetes Care Program noted improvements in 2015. Once again, Passport noted an increase to the number of members participating in the Diabetes Care Program. The program was able to develop several new pieces aimed at engaging our younger population of diabetics including the new “Teen Basics Book.” A focus group of teens’ feedback was used to help develop the book, so it would be focused and more appealing to the teen member population. The two Diabetes Disease Managers are working in tandem with our Shrinking Childhood Obesity with Real Expectations (SCORE) and Healthier Options for People Everyday (HOPE) Disease Managers to make sure the diabetic members are focusing on eating healthy, nutritious meals and working on reducing any risks associated with obesity. Based upon the 2014 evaluation, Passport developed new and innovative initiatives to strive towards the overall goal of improving the health and quality of life for our members with diabetes.