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PASSPORT HEALTH ★ PLAN

Mommy Steps

Complex Case Management

Diabetes Management

Healthy Heart Program

2016 Diabetes

Program Evaluation

Obesity Management

Chronic Respiratory Management

Congestive Heart Failure Management

Our mission is to improve the health and quality of life of our members

EPSDT Program

Rapid Response Outreach Team

Approved April 18, 2017

Diabetes Care Program Evaluation

Program Title: Diabetes Care Program

Evaluation Period: January 1, 2016 – December 31, 2016

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]

2016 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.

2016 Program Objectives:

- During the measurement year, increase the percentage of members receiving:
  - At least one HbA1c test
  - A DRE Exam
  - Medical attention for nephropathy
  - Statin therapy and adherence
- Increase the percentage of members with:
  - HbA1c good control of < 7%
  - HbA1c good control of < 8%
  - BP level of < 140/90 mm Hg

[1] http://www.carecontinuum.org/news_releases/2003/2003Briefing/MedicareDirectContDM.pdf

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- 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®[2] 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.

	Diabetes Membership (avg)[3]	Opt Out	Participation Rate
2016	10,135	114	99.98%
2015	9,059	16	99.99%
2014	7,984	23	99.99%
2013	5,875	29	99.51%
2012	4,664	29	99.38%

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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

2016 HEDIS® Results

The 2016 HEDIS® Results are based on measurement year 2015 data.

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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 2015, a total of 6,854 members were identified with diabetes. A systemic sample of 548 members showed 500 (83.19%) received HbA1c testing, 273 (45.42%) received HbA1c Poor Control (> 9.0%), 273 (45.42%) received HbA1c Good Control (< 8.0%), 270 (44.93%) received a DRE Exam Performed, 545 (90.68%) received Medical Attention for Nephropathy, 349 (58.07%) received BP Control < 140/90 mm Hg. Through additional required exclusion criteria, 5,597 members were identified for HbA1c Good Control (< 7.0%). A systemic sample of 548 members showed 161 (31.94%) received this indicator.

Measure	MY 2012	MY 2013	MY 2014	MY 2015
HbA1c Testing	84.08%	86.59%	90.78%	83.19%
HbA1c Poor Control (> 9.0%)	35.57%	36.28%	38.43%	45.42%
HbA1c Good Control (< 8.0%)	55.97%	54.12%	50.61%	45.42%
HbA1c Good Control (< 7.0%)	41.85%	40.68%	34.72%	31.94%
DRE Exam Performed	52.74%	57.93%	40.70%	44.93%
LDL-C Screening	76.99%	77.13%	RETIRED	RETIRED
LDL-C Controlled (LDL < 100 mg/dL)	42.54%	39.18%	RETIRED	RETIRED
Medical Attention for Nephropathy	79.48%	80.64%	81.74%	90.68%
BP Controlled < 140/80 mm Hg	42.04%	37.96%	RETIRED	RETIRED
BP Controlled < 140/90 mm Hg	64.68%	63.41%	66.43%	58.07%

[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 2016.

[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.

The goal to meet or exceed the 2016 Quality Compass®[7] 90th Percentile for all CDC measures (HbA1c Testing 92.88%; HbA1c Poor Control (> 9.0%) 29.23%; HbA1c Good Control (< 8.0%) 58.39%; HbA1c Good Control (< 7.0%) 40.43%; DRE Exam Performed 68.11%; Medical Attention for Nephropathy 93.56%; and BP Controlled < 140/90 mm Hg 75.73%) were not met.

One CDC measure (Medical Attention for Nephropathy) met the 2016 Quality Compass® 50th Percentile , four CDC measures (HbA1c Poor Control (> 9.0%), HbA1c Good Control (< 8.0%), HbA1c Good Control (< 7.0%), and BP Controlled < 140/90 mm Hg) met the 2016 Quality Compass® 33.33rd Percentile, and two CDC measures (HbA1c Testing, and DRE Exam Performed) met the 2016 Quality Compass® 25th Percentile.

2. Statin Therapy for Patients with Diabetes (SPD)

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

- *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
- *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Findings: In measurement year 2015, a total of 2,839 members were identified as needing a statin medication. Of those members, 1,771 (62.38%) received a statin therapy and 1,050 (59.29%) of the 1,771 members had 80% adherence.

Measure	**MY 2015**
Received Statin Therapy	62.38%
Statin Adherence 80%	59.29%

SPD measures (Received Statin Therapy and Statin Adherence 80%) are first year measures. The 2016 Quality Compass® rates have not yet been established.

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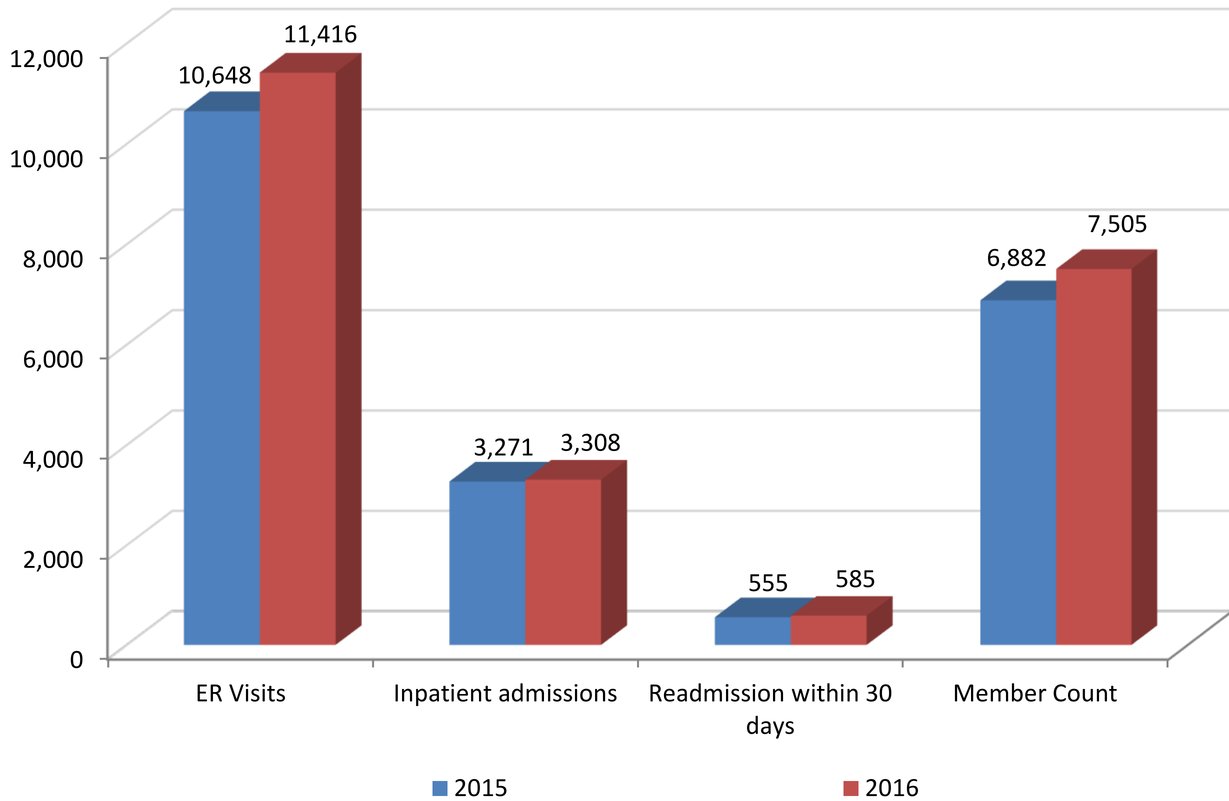
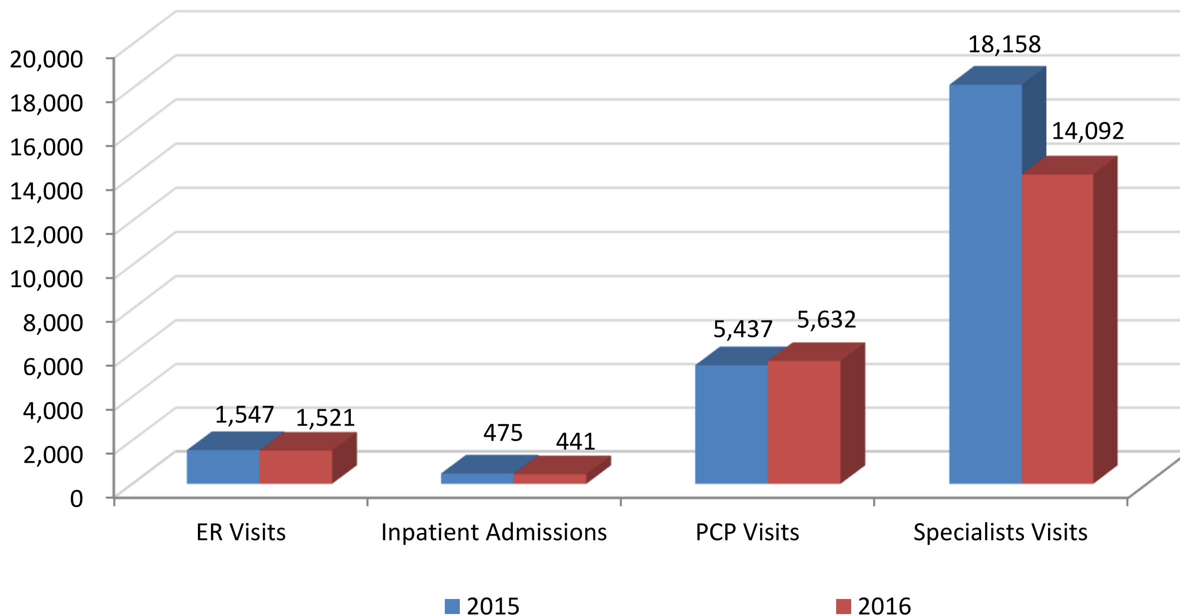
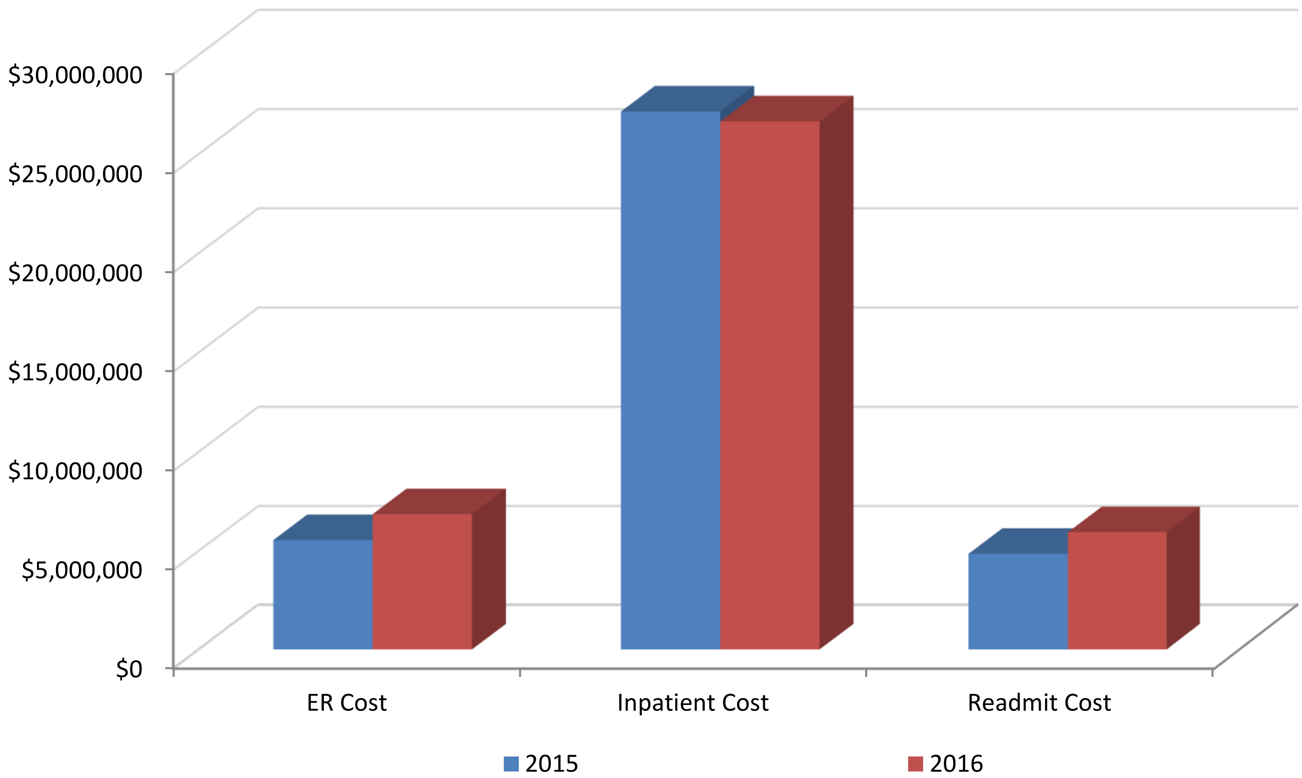
[7] The source for data contained in this publication is Quality Compass® 2016 (Medicaid) and is used with the permission of the NCQA. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.


Hospital Utilization with a Primary Diagnosis of Diabetes
12,000
10,000
8,000
6,000
4,000
2,000
0
10,648
11,416
3,271
3,308
555
585
6,882
7,505
ER Visits
Inpatient admissions
Readmission within 30 days
Member Count
2015
2016


Utilization for Members with Diabetes (per 1,000)
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
1,547
1,521
475
441
5,437
5,632
18,158
14,092
ER Visits
Inpatient Admissions
PCP Visits
Specialists Visits
2015
2016



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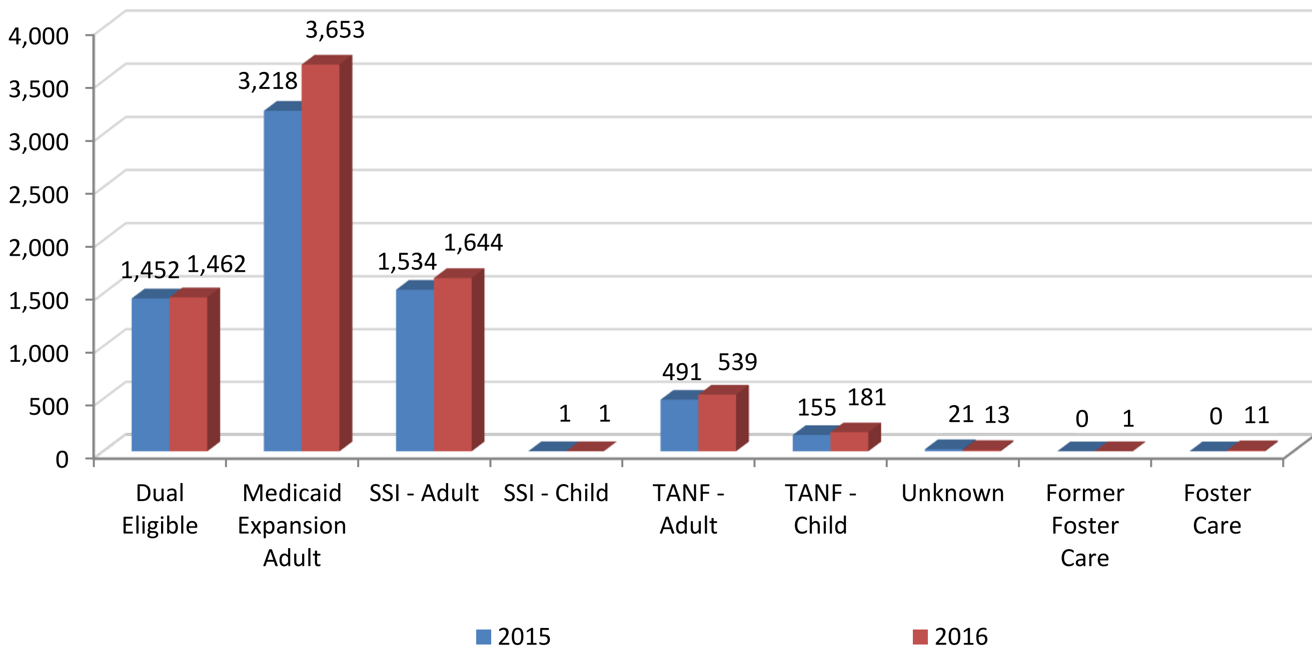

Analysis

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

One (1) measures achieved the Quality Compass® 50th Percentile:
- Medical Attention for Nephropathy

Four (4) measures achieved the Quality Compass® 33.33rd Percentile:
- HbA1c Poor Control (> 9.0%)
- HbA1c Good Control (< 8.0%)
- HbA1c Good Control (< 7.0%)
- BP Controlled < 140/90 mm Hg

Two (2) measure achieved the Quality Compass® 25th Percentile:
- DRE Exam Performed
- HbA1c Testing

Specific results include:
- Three (3) of the seven (7) CDC measures noted an increase from the previous measurement year:
  - Medical Attention for Nephropathy an increase of 8.94 percentage points
  - HbA1c Poor Control (> 9.0%)[8] had an increase of 6.99 percentage points
  - DRE Exam Performed an increase of 4.23 percentage points

- Five (4) of the seven (7) CDC measures noted a decrease from the previous measurement year:
  - HbA1c Testing a decrease of 7.59 percentage points
  - HbA1c Good Control (< 8.0%) had a decrease of 5.19 percentage points
  - HbA1c Good Control (< 7.0%) had a decrease of 2.78 percentage points
  - BP Controlled < 140/90 mm Hg had an decrease of 8.36 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.

[8] This is an inverted rate with a lower rate indicating better performance.

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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:

- Influenza vaccination
- BP
- Microalbumin
- Foot inspection
- Weight with BMI
- HbA1c testing
- DRE

Members who receive seven (7) of the recommended screenings/tests and return their incentive form received a total of $50 in gift card. In 2016, 188 members received gift cards for completing their screenings/tests.

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 2016, an average of 10,135 members were enrolled in the Diabetes Care Program, an 89% increase from 2015. Of those members enrolled, an average of 1,517 were identified as high risk. There were 401 members who were active with one-on-one telephonic outreach by the Diabetes Disease Managers, a 53% decrease from 2015. A total of 1,265 members were identified as newly diagnosed with diabetes. 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 2016, there were no complaints received regarding the Diabetes Care Program or the Diabetes Disease Managers.

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Program Materials

Member materials:

- Basic Diabetes Care Book
- Don't Let Diabetes Get You Down
- Hemoglobin A1c
- My A1c Chart
- Over-the-Counter Products
- Testing Your Blood Sugar
- Important Things to Know About Diabetes & Kidney Disease
- 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
- Diabetes Reminder Postcard
- Be a Smart Grocery Shopper
- My Diabetes Emergency Plan
- Take Good Care of Your Feet
- Diabetes and the Flu
- Diabetes and Exercise
- Hypoglycemia – "Low Blood Sugar"
- Using a Preferred Glucometer (Blood Sugar Meter)
- Learn the Truth about Your Child's Diabetes
- Diabetes Care… Just for Teens
- Protect Your Vision with a Dilated Eye Exam
- Your Diabetes Medicine – Metformin
- Your Diabetes Medicine – Sulfonylureas
- Your Diabetes Medicine – Insulin
- Ketones and How to Test for Them
- Have Diabetes? You Can Lower Your Chances of Heart Disease and Stroke

Clinician Materials:

- Care Coordination: Your Connection to Disease and Case Management Programs Brochure
- Admitted 1on1 Letter
- Unable to Contact Letter
- Discharge Letter
- Thank You Referral Letter
- Discharge 1on1 Letter
- Opted-Out Letter
- Enrolled Letter

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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.

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Interventions completed in 2016:

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.

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.
- Passport's Vision Program mailed 2,767 DRE Forms to members concerning the importance of receiving a DRE Exam. The Diabetes Care Program mailed 2,509 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 new Member Satisfaction Survey Postcard directing members to the Passport website to fill out their survey. There is a specific survey number based on the program the member was enrolled in. If the member would prefer to have a hard copy mailed to them, they can call into our Care Connector line and they will mail one to them to fill out and return.

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 were 179 adult members screened and 37% of those members had a positive result and the PHQ-9 was administered. Of those members, 67 were referred for Behavioral Health (BH) services. There were three pediatric members screened using the PSC-17 screening tool and 33% of those members had a positive result. Of those members, one was referred for Behavioral Health (BH) services.

Identification Activities:

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Interventions completed in 2016 (Continued):

- 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 with 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.
  - Collaborated with community partners to provide supportive services to members/families who need advance illness management services without the requirement of discontinuing active treatments.
  - Continued distribution of educational materials at health fairs and special events.
  - Continued participation in the Kentucky Diabetes Symposium, Glade, SOAR, and TRADE.

- Participated in community forums to determine additional community resources and best practices related to a healthy lifestyle for our members including:
  - Kentucky Diabetes Symposium

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Interventions completed in 2016 (Continued):

- 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
- Region 8 Health Fair

Planned Interventions for 2017:

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.

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Planned Interventions for 2017 (continued):

- 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 Care Message vendor 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, KDN, Glade, SOAR, and TRADE.

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Overall the Diabetes Care Program noted improvements in 2016. Once again, Passport noted an increase to the number of members participating in the Diabetes Care Program. 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 2015 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.

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