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

Program Title: Diabetes Program

Evaluation Period: January 1, 2017 – December 31, 2017

Introduction: The Diabetes Program is a system of coordinated healthcare interventions and communications for a population with a condition in which patient self-care efforts are significant. Evidence-based medicine and a team approach is used to:

- Empower members
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the clinician/patient relationship
- Emphasize and reinforce use of clinical practice guidelines

2017 Program Goals: The goal of the Diabetes Program is to effectively identify members with potentially avoidable healthcare needs and intervene to positively impact the health outcomes and quality of life for members with Diabetes. By using a multi-faceted approach to achieve the best possible outcomes the Diabetes Program can lower costs through preventing avoidable episodes of care and better coordination of care. Program goals include:

- Partner with members, their caregiver and their primary and specialty care clinicians to develop a plan of care or action plan by a health educator.
- Improve medication adherence.
- Facilitate appropriate communication across the entire care team.
- Optimize diabetes management and close relevant gaps in evidence based care.
- Educate members on diabetes diagnosis and self-management.

2017 Program Objectives: During the measurement year, increase clinician adherence to American Diabetes Association (ADA) Standards of Care and the percentage of members receiving:

- At least one Hemoglobin A1c (HbA1c) test
- A Dilated Retinal Eye (DRE) Exam
- Medical attention for nephropathy
- Statin therapy and adherence
• Increase the percentage of members with:
  o HbA1c good control of < 7%
  o HbA1c good control of < 8%
  o Blood pressure (BP) level of < 140/90 mm Hg

• Decrease the percentage of members with:
  o HbA1c poor control of > 9%
  o Inpatient admissions
  o Readmissions within 30 days
  o Emergency room (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\textsuperscript{1} results.

### Annual Participation Rate

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

<table>
<thead>
<tr>
<th></th>
<th>Diabetes Membership (avg)\textsuperscript{2}</th>
<th>Opt Out</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>10,594</td>
<td>153</td>
<td>99.98%</td>
</tr>
<tr>
<td>2016</td>
<td>10,135</td>
<td>114</td>
<td>99.98%</td>
</tr>
<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>
</tr>
</tbody>
</table>

\textsuperscript{1} HEDIS\textsuperscript{®} is a registered trademark of the National Committee for Quality Assurance (NCQA)

\textsuperscript{2} Program membership numbers are annualized
Diabetes Management

2017 HEDIS® Results

The 2017 HEDIS® Results are based on measurement year 2016 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%)³
- HbA1c Good Control (<7.0%)
- HbA1c Good Control (<8.0%)
- DRE Exam Performed
- Medical Attention for Nephropathy
- BP Control < 140/90 mm Hg

**Findings:** In measurement year 2016, a total of 8,158 members were identified with diabetes. A systemic sample of 603 members showed 523 (86.73%) received HbA1c testing, 224 (37.15%) received HbA1c Poor Control (> 9.0%), 307 (50.91%) received HbA1c Good Control (< 8.0%), 257 (42.62%) received a DRE Exam Performed, 543 (90.05%) received Medical Attention for Nephropathy, 392 (65.01%) received BP Control < 140/90 mm Hg. Through additional required exclusion criteria, 6,693 members were identified for HbA1c Good Control (< 7.0%). A systemic sample of 478 members showed 185 (38.70%) received this indicator.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
<td>86.59%</td>
<td>90.78%</td>
<td>83.19%</td>
<td>86.73%</td>
</tr>
<tr>
<td>HbA1c Poor Control (&gt; 9.0%)</td>
<td>36.28%</td>
<td>38.43%</td>
<td>45.42%</td>
<td>37.15%</td>
</tr>
<tr>
<td>HbA1c Good Control (&lt; 8.0%)</td>
<td>54.12%</td>
<td>50.61%</td>
<td>45.42%</td>
<td>50.91%</td>
</tr>
<tr>
<td>HbA1c Good Control (&lt; 7.0%)</td>
<td>40.68%</td>
<td>34.72%</td>
<td>31.94%</td>
<td>38.70%</td>
</tr>
<tr>
<td>DRE Exam Performed</td>
<td>57.93%</td>
<td>40.70%</td>
<td>44.93%</td>
<td>42.62%</td>
</tr>
<tr>
<td>LDL-C Screening</td>
<td>77.13%</td>
<td>RETIRED</td>
<td>RETIRED</td>
<td>RETIRED</td>
</tr>
<tr>
<td>LDL-C Controlled (LDL &lt; 100 mg/dL)</td>
<td>39.18%</td>
<td>RETIRED</td>
<td>RETIRED</td>
<td>RETIRED</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
<td>80.64%</td>
<td>81.74%</td>
<td>90.68%</td>
<td>90.05%</td>
</tr>
<tr>
<td>BP Controlled &lt; 140/80 mm Hg</td>
<td>37.96%</td>
<td>RETIRED</td>
<td>RETIRED</td>
<td>RETIRED</td>
</tr>
<tr>
<td>BP Controlled &lt; 140/90 mm Hg</td>
<td>63.41%</td>
<td>66.43%</td>
<td>58.07%</td>
<td>65.01%</td>
</tr>
</tbody>
</table>

³ This is an inverted rate with a lower rate indicating better performance.
The goal to meet or exceed the 2017 Quality Compass® 90th Percentile for all CDC measures (HbA1c Testing 92.82%; HbA1c Poor Control (> 9.0%) 29.07%; HbA1c Good Control (< 8.0%) 59.12%; HbA1c Good Control (< 7.0%) 41.65%; DRE Exam Performed 68.33%; Medical Attention for Nephropathy 93.27%; and BP Controlled < 140/90 mm Hg 75.91%) were not met.

Two CDC measures (HbA1c Poor Control (> 9.0%) and Good Control (< 7.0%)) met the 2017 Quality Compass® 66.67th Percentile, two measures (HbA1c Good Control (< 8.0%) and BP Controlled < 140/90 mm Hg) met the 2017 Quality Compass® 50th Percentile, two measures (HbA1c Testing, and Medical Attention for Nephropathy) met the 2016 Quality Compass® 33.33rd Percentile and one measure (DRE Exam Performed) met the 2017 Quality Compass® 10th 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 2016, a total of 3,472 members were identified as needing a statin medication. Of those members, 2,075 (59.76%) received a statin therapy and 964 (46.46%) of the 2,075 members had 80% adherence.

<table>
<thead>
<tr>
<th>Measure</th>
<th>MY 2015</th>
<th>MY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received Statin Therapy</td>
<td>62.38%</td>
<td>59.76%</td>
</tr>
<tr>
<td>Statin Adherence 80%</td>
<td>59.29%</td>
<td>46.46%</td>
</tr>
</tbody>
</table>

SPD Received Statin Therapy met the 2017 Quality Compass® 33.33rd Percentile and SPD Statin Adherence 80% met the 2017 Quality Compass® 5th Percentile.

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4 The source for data contained in this publication is Quality Compass® 2017 (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

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits</td>
<td>11,416</td>
<td>10,757</td>
</tr>
<tr>
<td>Inpatient admissions</td>
<td>3,308</td>
<td>3,303</td>
</tr>
<tr>
<td>Readmission within 30 days</td>
<td>585</td>
<td>402</td>
</tr>
<tr>
<td>Member Count</td>
<td>7,505</td>
<td>7,730</td>
</tr>
</tbody>
</table>

Hospital Cost with a Primary Diagnosis of Diabetes

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Cost</td>
<td>$11,416</td>
<td>$10,757</td>
</tr>
<tr>
<td>Inpatient Cost</td>
<td>$3,308</td>
<td>$3,303</td>
</tr>
<tr>
<td>Readmit Cost</td>
<td>$7,505</td>
<td>$7,730</td>
</tr>
</tbody>
</table>
Members with Diabetes by Category of Aid

- Dual Eligible
- Medicaid Expansion Adult
- SSI - Adult
- SSI - Child
- TANF - Adult
- TANF - Child
- TANF - Former Foster Care
- TANF - Foster Care
- Unknown

<table>
<thead>
<tr>
<th>Category</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Eligible</td>
<td>1,462</td>
<td>1,510</td>
</tr>
<tr>
<td>Medicaid</td>
<td>3,653</td>
<td>3,802</td>
</tr>
<tr>
<td>SSI - Adult</td>
<td>1,644</td>
<td>1,687</td>
</tr>
<tr>
<td>SSI - Child</td>
<td>539</td>
<td>530</td>
</tr>
<tr>
<td>TANF - Adult</td>
<td>181</td>
<td>176</td>
</tr>
<tr>
<td>TANF - Child</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>TANF - Former</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TANF - Foster Care</td>
<td>11</td>
<td>8</td>
</tr>
</tbody>
</table>

Utilization for Members with Diabetes (per 1,000)

- ER Visits
- Inpatient Admissions
- PCP Visits
- Specialists Visits

<table>
<thead>
<tr>
<th>Category</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits</td>
<td>1,521</td>
<td>1,392</td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>441</td>
<td>427</td>
</tr>
<tr>
<td>PCP Visits</td>
<td>5,632</td>
<td>4,725</td>
</tr>
<tr>
<td>Specialists Visits</td>
<td>14,092</td>
<td>6,347</td>
</tr>
</tbody>
</table>
Analysis

HEDIS®: Passport aspires to be in the Quality Compass® 90th Percentile for each measure. In CY 2016 none of the measures achieved the 90th Percentile.

Two (2) measures achieved the Quality Compass® 66.67th Percentile:
- HbA1c Poor Control (> 9.0%)
- HbA1c Good Control (< 7.0%)

Two (2) measures achieved the Quality Compass® 50th Percentile:
- HbA1c Good Control (< 8.0%)
- BP Controlled < 140/90 mm Hg

Three (3) measures achieved the Quality Compass® 33.33rd Percentile:
- HbA1c Testing
- Medical Attention for Nephropathy
- Received Statin Therapy

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

One (1) measure achieved the Quality Compass® 5th Percentile:
- Statin Adherence 80%

Specific results include:
- Four (4) of the seven (7) CDC measures noted an increase from the previous measurement year:
  o HbA1c Testing had an increase of 3.54 percentage points
  o HbA1c Good Control (< 8.0%) had an increase of 5.49 percentage points
  o HbA1c Good Control (< 7.0%) had an increase of 6.76 percentage points
  o BP Controlled < 140/90 mm Hg had an increase of 6.94 percentage points

- Three (3) of the seven (7) CDC measures noted a decrease from the previous measurement year:
  o HbA1c Poor Control (> 9.0%)\(^5\) had a decrease of 8.27 percentage points
  o DRE Exam Performed had a decrease of 2.31 percentage points
  o Medical Attention for Nephropathy remains relatively the same with a slight decrease of 0.63 percentage points

- Both of SPD measures noted a decrease from the baseline measurement year:
  o Received Statin Therapy a decrease of 2.62 percentage points
  o Statin Adherence 80% had a decrease of 12.83 percentage points

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\(^5\) This is an inverted rate with a lower rate indicating better performance.
Member Engagement: Multiple member interventions were conducted to educate the member on the importance of screenings/tests needed based on the ADA Standards of Care. Providers were notified of members in need of screenings/tests and resources to track diabetic members and their screenings via the Care Gaps report.

Member Incentive Program: Passport utilized our Member Incentive Program targeted toward increasing provider 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 received seven (7) of the recommended screenings/tests and returned their incentive form received a total of $50 in gift card. In 2017, 586 members received gift cards for completing their screenings/tests, a 212% increase from 2016.

Community and Provider Engagement: Providers received status updates on members enrolled in the Diabetes Program and provided reference information on the ADA Standards of Care on Passport’s website.

ER/Readmissions: The Diabetes 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 were newly identified with diabetes received a new member packet, along with individualized mailings. High risk members also received telephonic outreach.

Risk Stratification: During 2017, an average of 10,594 members were enrolled in the Diabetes Program, a 10% increase from 2016. Of those members enrolled, an average of 1,617 were identified as high risk. There were 135 members who received one-on-one telephonic outreach by a Diabetes Health Educator, a 297% decrease from 2016. Three separate attempts were made to contact the member. All members received an initial mailing, and high-risk members received individualized mailings based on assessment by a Diabetes Health Educator.

Member Complaints: During 2017, there were no complaints received regarding the Diabetes Program or a Diabetes Health Educator.
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
- Diabetes – Type 1 and Type 2
- Diabetes Take Control, Live Better
- 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
- Diabetes Nutrition Basics
- Are You at Risk for Type 2 Diabetes?

Clinician Materials:
- Practitioner Program Overview
- Unable to Contact Letter
- Opted-Out Letter
- Program Discharge Letter
- Discharge 1on1 Letter
- Enrolled Letter
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

**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 2017:

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 a Diabetes Health Educator, and through Provider Relations site visits.

Member Education:
- Educated members/caregivers regarding diabetic screenings through face-to-face outreach, telephonic outreach, member newsletters, Passport’s website, and member educational material.
- Passport’s Vision Program mailed 8,217 DRE Forms to members concerning the importance of receiving a DRE Exam.
- Leveraged the Care Connector Program to engage members in need of assistance making an appointment.
- Maintained a member engagement reward strategy to encourage member compliance with screening.
- Developed and implemented new telephonic Member Satisfaction Survey. Questions include how the program helped the member understand their health condition, if the Health Educator was professional and polite, if the program materials were helpful, if the Health Educator gave information that helped the member make decisions about their care, if the Health Educator helped the member deal with their health condition, and if their overall health and quality of life had improved since working with the Health Educator.

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 95 adult members screened and 81% of those members had a positive result, leading to the PHQ-9 being administered. Of those members, 77 were referred for Behavioral Health (BH) services. There were three pediatric members screened using the PSC-17 screening tool and none of those members had a positive result.
- Administered the Member Satisfaction Survey telephonically to members enrolled in the CHF 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.
Identification Activities:
- Identified and outreached to members with inpatient admissions or ER visits.
- Continued to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.

Community Activities:
- Passport increased community initiatives related to the diagnosis and treatment of diabetes through:
  - Collaborated with community resources to assist members in getting corrective lenses, if needed.
  - 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 Shaping our Appalachian Region (SOAR).

- Participated in community forums to determine additional community resources and best practices related to a healthy lifestyle for our members including:
  - SOAR
  - School-based educational programs
  - Health and Wellness Fairs
  - Prevention Workshops

Continued Interventions:
- Increase clinician awareness of the ADA Standards of Care recommended diabetic screening on Passport’s website, through a Diabetes Health Educator, and through Provider Relations site visits.
- Identify and outreach to members with inpatient admissions or ER visits.
Planned Interventions for 2018 (continued):

- 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
  - 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 refer 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.

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

- Continue collaboration with CareMessage vendor to provide, helpful information to members with Passport sponsored cell phones.

- Increase community initiatives related to the diagnosis and treatment of diabetes through:
  - Continue collaboration with Provider Relations, Population Health Managers, and Embedded Care Advisors 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 community resources to assist members in getting corrective lenses, if needed.
Planned Interventions for 2018 (continued):

- 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 SOAR.

Overall the Diabetes Program noted improvements in 2017. Once again, Passport noted an increase to the number of members participating in the Diabetes Program. Based upon the 2017 evaluation, Passport developed new initiatives to strive towards the overall goal of improving the health and quality of life for our members with diabetes.