

Disease Management Program Description

I. Purpose

Chronic disease conditions are among the most common, costly, and preventable of all health problems. As of 2012 about half of all adults had one or more chronic health conditions. One of four adults had two or more chronic health conditions (CDC August 2016). About 208,000 Americans under the age of 20 are estimated to have diagnosed diabetes, approximately 0.25% of that population (American Diabetes Association) and 8.4% of Americans under the age of 18 have asthma (CDC 2015). These conditions place individuals at a higher risk for complications with resulting morbidity and overutilization of services, including emergency room visits and inpatient admissions. The Tufts Health Public Plans Disease Management Program uses the latest clinical guidelines, member educational materials, motivational interviewing and self-management support strategies to educate, counsel and empower members and their caregivers.

Focus

The THPP DM program focuses on members identified as having one of four specific chronic illnesses: asthma, diabetes, chronic obstructive lung disease and heart failure. The program interventions are established using the guidelines for the National Heart Lung and Blood Institute, American Diabetes Association, American Lung Association, Global Initiative for Obstructive Lung Disease, and American College of Cardiology Foundation/American Heart Association. On an annual basis, THPP evaluates updates to these guidelines and will revise the program as needed. Medical and pharmacy claims data and utilization data are analyzed on a monthly basis to identify members using specifications closely mirrored after HEDIS inclusion criteria. Referrals to the DM program also come from Tufts Health Plan staff, practitioners, vendors, or member self-referrals. The program focuses on preventing medical complications and minimizing acute episodes through targeted interventions such as lifestyle and medication education.

II. Approach

The THPP DM program uses a population-based approach aimed at improving clinical outcomes and management of four chronic diseases: asthma, chronic obstructive pulmonary disease, diabetes, and heart failure. Members who are identified for the DM program are stratified by risk (high, medium, and low) using a proprietary algorithm. All members who are identified for DM will receive a welcome letter which explains the DM program, provides links to on-line educational resources and community supports, texting programs, and digital coaching programs for the member to access. All members are

offered the opportunity to participate in one-on-one coaching support with a Disease Manager. The welcome letter also provides a telephone number to call if the member chooses to opt out of the program. High risk enrollees are also automatically assigned to a Tufts Health Disease Manager who actively outreaches the member for enrollment in the one-on-one coaching program. Members who are contacted for one-on-one coaching are informed that the program is optional and that participation or lack of participation will in no way adversely impact their health insurance coverage.

The following list identifies methods and information for members that is made available for in order for them to learn more about their disease and have the necessary tools to self-manage their disease. This information is mailed to all members once identified for a disease and it is also sent to their corresponding Primary Care Provider. This will help ensure that PCP's are aware that their patients are enrolled into our Disease Management program and that they are informed of the educational opportunities for their patients. When appropriate, the Disease Manager will outreach directly to the PCP or treating specialists to collaborate on appropriate member goals and challenges.

Member program components include but are not limited to:

- Online and mailed educational materials
- Telephonic educational outreach
- Texting program for weekly tips and educational information specific to each condition
- Gaps in care identification and outreach letters for all members identified for Asthma, Diabetes, and COPD programs based on HEDIS measures. This includes all stratification levels and members who are or are not engaged in a coaching program.
- Referrals to visiting nurses
- In home hemodynamic monitoring devices
- Working with a Registered Dietitians and Certified Diabetes Educators
- Access to on-line and application based digital coaching programs

Providers also receive:

- Trigger letters as a result of gaps in member care are generated monthly
- New member letters are sent to providers to inform them of newly identified members with chronic disease. This letter includes the member's name, the disease program identified for, a program overview, and the telephone number to reach the Disease Management program with questions.

- A call from the Disease Manager for engaged members to encourage collaboration and inform them of the plan of care.
- Information regarding community resources available to the member
- THPP will periodically publish information in the provider newsletter regarding the Disease Management Program offerings.

Members who enroll in one-on-one coaching with a Disease Manager are evaluated telephonically for their condition and their ability (or the ability of their caregiver) to self-manage their chronic illness. Utilizing an online assessment tool, the Disease Manager will also evaluate the member's current level of knowledge and stage of change utilizing condition specific, social, and medication evaluations to identify needs. With the members consent, the Disease Manager will outreach to collaborate with the member's Primary Care Provider and treatment team to ensure a multi-disciplinary treatment plan approach to education and management of the chronic condition. The Disease Manager and Member will then work together to identify barriers, and set personalized, achievable, and prioritized self-management goals as follows:

- Individualized action plans are co-developed to assist members in making life-style and necessary behavioral changes to manage their conditions
- Members are coached to follow an action plan when they have symptoms (i.e. adjust medications, initiate a call to their Primary Care Provider (PCP, make physician office appointments, and follow their medication regimen.)
- Members are coached to make appropriate life-style changes such as modifying diet, stopping smoking, participating in exercise, or losing weight.

To achieve these objectives, the Disease Manager will utilize community resources, skilled home care interventions, digital coaching programs, and other interventions. Some members may also benefit from a referral to palliative care for assistance with goals of care discussion and symptom management. During telephonic care management, motivational techniques and health coaching is used to:

- Help members follow their treatment plans set in place by their PCP and specialties
- Help members relate these plans to their personal goals
- Help members overcome barriers to effective treatment

To ensure the Disease Managers have the most up to date information they will, prior to every outreach to a member, review the online member record which houses recent hospitalizations, authorizations for care, case management documentation, and any other wellness program

information. This information will drive review of the plan of care and call frequency which will be adjusted as clinically appropriate and as determined collaboratively with the member.

The Disease Management Program is an “Opt –Out” program and all Enrollees are considered part of the program unless he/she verbalizes the wish to decline participation or dis-enroll from the program. The method to Opt-Out of the program is stated in the Welcome Letter and is also made known to the member during the initial outreach by the Disease Manager. The member’s decision to decline Disease Management will have no impact on benefits or coverage of services.

Adherence to the program’s treatment plan and identified goals is monitored through specific measures identified and discussed during each phone call to the member. The program is a time limited program with the initial phase comprised of 12 weeks of intensive coaching followed by an additional 12 weeks of monitoring and support. Each of the four diseases have identified in a separate document standards of care. Members are evaluated for discharge from the program using established discharge criteria.

III. Goals

The Disease Management Program aims to improve the disease state outcomes of members diagnosed with asthma, chronic obstructive pulmonary disease (COPD), and diabetes. The ultimate goal of the disease management program is to help the member to self-manage their disease, understand the most up to date treatment and care options, and the importance of collaboration with their provider and treatment team to ensure applicable clinical tests are performed at appropriate intervals. Members are also educated as to the potential negative ramifications of not adhering to a treatment plan.

The program goals for engaged members include:

- a. Increase quality of care
- b. Collaborate with member/caregiver and provider on member centered goals and care plan based on evidence base condition- specific clinical assessment
- c. Assess education gaps and increase treatment plan adherence such as medication regimens and doctor visits.
- d. Reduce unnecessary hospital admissions and emergency room visits
- e. Decrease HEDIS gaps in care annually
- f. Improved Diabetes HbA1C values

IV. Staff

Non-clinical staff are assigned to manage a ‘do not outreach’ database, create and assign

cases from referrals, and at the direction of the Program Manager assign new cases as identified to the Disease Managers.

Disease Managers are licensed as a Registered Nurses, Registered Respiratory Therapists, or Registered Dietitians with Certification in Diabetes Education. The care manager's role includes:

- Conducting comprehensive clinical and social focused assessment that identifies:
 - Health and social service needs that are not being met
 - Barriers to treatment, such as financial needs, lack of transportation, untreated symptoms of depression, and inadequate social support that could impede quality of life
 - Member's and/or caregiver's confidence level in managing his or her chronic condition
- Developing a fully coordinated, comprehensive care plan in collaboration with member and/or caregiver to ensure optimum disease/condition management that promotes self-management practices and improves continuity of care:
 - Partnering with member and PCP to develop member-centric plan of care
 - Ensuring that the member action plan is available to member, family and other care providers
 - Facilitating referrals to other team members and community-based providers /resources to meet the specific needs of the member, including coordinate with Tufts Health Public Plan Complex Nurse Case Managers and Behavioral Health Case Managers as well as Clinical Community Outreach staff to ensure that all of the members disease management, case management, and access to community resources are met. Examples of services provided by Clinical Community Outreach staff are help with applications for housing, government nutrition assistance programs, transportation, financial, and fuel assistance programs.
- Providing support, coaching and self-management skills to assist the member/caregiver in understanding and following his/her physician plan of care and the importance of making lifestyle changes needed to support their health:
 - Using disease-specific, evidence-based teaching models to support member education
 - Incorporating motivational interviewing in health coaching techniques to strengthen the member's motivation for and commitment to change.

The Disease Manager's competencies include:

- Communicating effectively with team members to identify members at risk for readmission who are appropriate for the Disease Management Program
- Demonstrating the ability to work with PCPs and members to create a member-specific care plan to promote member self-management of chronic diseases and conditions

- Demonstrating the ability to work with all stakeholders to improve member quality of life and end-of-life planning
- Having knowledge of disease-specific community resources and their capability for providing care
- Demonstrating the ability to evaluate a member's capacity to meet his/her self-care needs and demonstrating that the member's goals and preferences are incorporated into the care plan
- Demonstrating an understanding of evidenced-based treatment strategies for chronic diseases
- Demonstrating an understanding of health coaching principles, including:
 - Strategies to evaluate member's and caregiver's confidence level in managing chronic conditions
 - An understanding of motivational interviewing techniques and the ability to incorporate these into practice
 - An understanding of Teach-Back principles and ability to incorporate into practice
- Demonstrate an understanding of appropriate use of resources such as internal team members, educational materials, digital coaching programs, and other technologies and devices.

Member Identification

On a monthly basis, THPP QTA staff identifies members meeting criteria for Disease Management programs through a claims Analyzer, utilizing medical, behavioral health, and pharmacy claims. Members are then stratified using a proprietary algorithm to separate them into one of three risk levels. Additional identification sources include, but are not limited to, referrals from the following sources:

- Utilization Management (both medical and/or behavioral health)
- Complex Medical Care Management
- Behavioral Health Care Management
- Clinical Community Outreach
- Population Health and Wellness
- Tufts Health Plan Customer Service
- Physicians and other practitioners
- Member or member's caregiver

The type of and level outreach and desired engagement are driven by the complexity and care level of the member's disease as identified utilizing a proprietary stratification algorithm. The algorithm stratification coupled with the clinical telephonic health

assessment enables the Disease Management clinician to further stratify the member in order to identify appropriate goals and accompanying interventions.

As members may present with complex needs beyond those of the skillset of Disease Management, the Disease Manager will refer members to Complex Medical and Behavioral Health care managers for consult and collaboration. On an every other week basis a rounds event will occur which enables the Disease Managers to present identify individual member's barriers and challenges and obtain feedback from Medical and Behavioral Health Case Managers, Clinical Community Outreach specialists, and Medical and Psychiatric Doctors for consultation and feedback. Rounds provide the opportunity for staff collaboration and ongoing learning.

V. Program Evaluation

Program effectiveness and participation rates are measured by:

- Percent of members outreached
- Percent of members outreached and engaged
- Number of cases managed
- Percentage of care plan goals met
- Number of cases closed, by closure type
- Number of members who 'opt-out' or refuse
- Member responses from bi-annual satisfaction survey
- Gaps in Care rates of engaged members

Resources:

- Heart Failure: 2013 American College of Cardiology Foundation/American Heart Association (ACCF/AHA) Guideline for the Management of Heart Failure
- Diabetes: Scope of Practice, Standards of Practice and Standards of Professional Performance for Diabetes Educators (AADE 2005).
- American Diabetes Association 2017 Standards of Care
- Asthma: National Asthma Control Initiative (NACI)
- COPD: American Thoracic Society



705 Mount Auburn Street
Watertown, MA 02472-1508
tuftshealthplan.com