



# Diabetes

*Care Coordination*

## *Diabetes Introduction*

Care Coordination for participants with chronic diseases has the ability to improve clinical outcomes and participant satisfaction with the health care system and facilitate reduction of health care costs.

eQHealth Solutions utilizes the National Coalition on Care Coordination (N3C) definition of Care Coordination: “Care Coordination is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a Care Coordinator manages and monitors an individual’s needs, goals, and preferences based on a comprehensive plan.”

For people with multiple chronic conditions, and/or those who have limited support systems, finances, and resources to access the healthcare system, Care Coordination is particularly important. This population requires both medical and social supports to address these issues. To be successful, Care Coordination must focus on:

- Establishing an interdisciplinary team
- Developing and implementing individualized care plans
- Coaching and behavior modification to promote participant self-care
- Coordinating care across all health care settings
- Providing for the social support needs of this population
- Providing condition specific physician and clinical practice guidelines
- Providing education and assistance (both participant and provider) in meeting the recommended standards of care.

These components support the Care Coordination philosophy of integration of clinical treatment guidelines, disease prevention strategies, participant self-care education, and social support services while demonstrating a quantifiable cost savings to the payer.

## *Clinical Practice Recommendations*

Clinical Practice Guidelines are evidence based statements and recommendations written by clinicians and multidisciplinary panels to assist physicians with participant assessments and condition management.

The Diabetes Care Coordination Program is constructed around the **American Diabetes Associations’ “Standards of Medical Care in Diabetes”** and the Milliman Diabetes Care Guidelines. The combination of these guidelines considers not only the physician practice standards of care but also the appropriate clinical components of Care Coordination team interventions to ensure the participant has been properly educated, has appropriate medical and social resources, and is able to self-manage their disease process.

## *Objectives*

The objectives of this program are consistent with those set forth by the American Diabetes Associations’ “Standards of Medical Care in Diabetes.” It focuses on both the participant and family/caregiver’s medical and social needs.

Objectives:

- Participant achievement of optimal health through the administration of a general and disease specific assessments, self care education, coaching and behavior modification,

wellness screenings, in person and telephonic comprehensive engagement and interventions to help resolve barriers to care

- Promote adherence to recommended drug therapy
- Promote physician understanding of and adherence to the American Diabetes Association's standards of care
- Promote standardization of physician treatment practices consistent with national standards and provider peers
- Provide education and instruction on self care measures related to glycemic control including: medication adherence, weight reduction, diet adherence, and warning signs of disease complications and what to do in those situations
- Early identification of participants for intervention by Care Coordination staff
- Promote a multidisciplinary approach to care
- Promote a strong participant-physician-Care Coordinator relationship
- Demonstrate cost savings related to the integrated Care Coordination program
- Improve participant quality of life

### ***Program Inclusion and Exclusion Criteria***

#### **Inclusion Criteria**

- 1 or more inpatient discharges with a primary diagnosis codes:
  - 250.0\*-259.0\*
  - 357.2 (Diabetic Neuropathy)
  - 362.0\* (Diabetic Retinopathy)
  - 366.41 (Diabetic Cataract)

#### ***OR***

- 2 or more E and M encounters with diagnosis codes:
  - 250.0\*
  - 357.2 (Diabetic Neuropathy)
  - 362.0\* (Diabetic Retinopathy)
  - 366.41 (Diabetic Cataract)

- **Outpatient CPT:**

- 92002 - Ophthalmological Services; New Participant, intermediate
- 92004 - Ophthalmological Services; New Participant, comprehensive
- 92012 - Ophthalmological Services; Established Participant, intermediate
- 92014 - Ophthalmological Services; Established Participant, comprehensive
- 99387 – Initial Comprehensive Preventive Medicine Services; New Participant, 65 years and over
- 99397 - Initial Comprehensive Preventive Medicine Services; Established Participant, 65 years and over

#### ***OR***

- **2 or more Outpatient facility charges including Emergency Room Visits with CPT4 codes:**



- Sulfonylureas

<b>Generic Name</b>	<b>Brand Name</b>
glimepiride	Amaryl
glipizide	Glucotrol
glipizide and metformin	Metaglip
glyburide	DiaBeta, Glynase, Micronase
glyburide and metformin hydrochloride	Glucovance

- Thiazolidinediones

<b>Generic Name</b>	<b>Brand Name</b>
pioglitazone	Actos
rosiglitazone	Avandia
rosiglitazone and metformin	Avandamet

- Biguinides

<b>Generic Name</b>	<b>Brand Name</b>
glipizide and metformin	Metaglip
metformin	Glucophage, Glucophage XR
metformin and glyburide	Glucovance
repaglinide and metformin	Prandimet
rosiglitazone and metformin	Avandamet

- Incretin Memetics

<b>Generic Name</b>	<b>Brand Name</b>
exenatide	Byetta

- DPP4 Inhibitors

<b>Generic Name</b>	<b>Brand Name</b>
sitagliptin	Januvia
sitagliptin and metformin	Janumet

## Exclusion Criteria

- End Stage Renal Disease (585.6)
- Transplants (996\*, V42\*, 33.6, 37.51-37.54, 37.60, 37.62, 37.63, 37.65, 37.66, 37.68)
- HIV/AIDS (042, 079.53)
- Hemophilia (286\*)
- Hospice
- Non-skin cancers with evidence of active treatment (claims for chemotherapy, radiation therapy, etc.) **exclude all except 173\*, 184\*, 187\*, 198\*, 232\*, 233\*, 216\*, 221.2, 238.2, 239.2, 239.5, 236.3, 236.6**
- Gestational Diabetes (648.0\*)
- Diabetes Insipidus (253.5, 588.1)

- Polycystic Ovary Syndrome

### **Severity Stratification**

Eligible Diabetes participants will be initially stratified into three severity levels based on claims data. Stratification is re-evaluated each time new clinical information is received after a Care Coordinator-participant encounter, and/or at least every six months for the entire population.

The severity assigned to a participant determines the type and intensity of interventions that the member will receive as part of Care Coordination.

Severity levels include:

#### **Low Level**

- Diagnosis of Diabetes based on identification criteria **AND at least one** of the following:
  - OR**
  - Diagnosis of Diabetes and 1 controlled co-morbid condition (**except** hypertension, heart disease, and/or hyperlipidemia).
    - OR**
    - HgbA1c $\leq$ 6.5% (as identified through the HRA or lab data if available)
      - OR**
      - 1 or more oral medications related to the diagnosis of Diabetes

#### **Medium Level**

- Diagnosis of Diabetes **AND at least one** of the following:
  - One inpatient hospitalization within the last 6 months related to Diabetes as primary diagnosis
  - One ER admission within the last 6 months related to Diabetes as primary diagnosis
  - Diagnosis of Diabetes and hypertension
  - Diagnosis of Diabetes and heart disease
  - Diagnosis of Diabetes and hyperlipidemia
  - Diagnosis of Diabetes and 2 or more controlled co-morbid conditions
  - HgbA1c 6.6-8% (as identified through the HRA or lab data if available)

#### **High Level**

- Diagnosis of Diabetes **AND at least one** of the following:
  - More than one inpatient hospitalization within the last 6 months related to Diabetes as primary diagnosis

- More than one ER visit within the last 6 months related to Diabetes as primary diagnosis
- One or more complicated co-morbid conditions
- Insulin therapy
- Co-morbid condition of Depression
- HgbA1c  $\geq 8.1\%$  (as identified through the HRA or lab data if available)
- Documentation of insulin pump therapy

Care Coordination staff will validate the participants' diagnosis of Diabetes and their agreement to participate in the program. Any participant who does not want to participate in the program can opt out at any time.

Medium and high-risk members who are unable to be contacted will receive low level interventions and will be reevaluated every six months for updated demographic information.

All enrolled participants are reassessed for severity every six months based on claims data. If the stratification level has changed, the Care Coordinator will be notified of the change, via a system notification alert, and the participant will be reassessed. If there is no change in the stratification, the Care Coordinator proceeds with the current plan of care.

## ***Participant Interventions***

### **Participant Introductory Call/Visit**

At program introduction, each participant will receive an informational welcome kit. The program welcome kit will provide the participant with information about the program, the opt-out process, and general Diabetes education. The Care Coordinators will attempt to reach the participant within **60 days** of identification to perform an initial assessment and functional survey.

If the Care Coordinator is unable to reach the participant after four attempts (including at least one after normal business hours call), a written notification will be sent to the participant. If the participant does not respond to any attempts at outreach within 30 days, the participant will be transitioned to the low level of the program and receive mailed material.

### **Participant Follow Up Visits or Calls**

All participants enrolled in a program will receive at least one additional visit or phone call after the initial visit/call. Based on the initial visit/call assessment, the member may receive further Care Coordinator interactions at scheduled intervals.

### **Emergency Situations**

In the event a participant is having an emergency while being assessed by the Care Coordinator the Care Coordinator will instruct a family member to call 911. If a family member is not present, the Care Coordinator will contact Emergency Medical Services while keeping the participant on the phone until emergency responders arrive. The Care Coordinator will also contact the participant's physician to notify him/her of the situation. If the situation is not life threatening, the Care Coordinator, if a Registered Nurse, may decide, based on their clinical knowledge, if the physician should be notified prior to emergency services. This will be up to the Registered Nurse to use his/her clinical judgment and direct care appropriately.

## **Care Transition**

When a Care Coordination participant is admitted to the hospital the Care Coordinator will be notified of the hospitalization. The Care Coordinator will then contact the participant while they are still in the acute setting. If the participant has been hospitalized related to their current, chronic condition, the participants will be re-assigned to a High Severity level of management for at least 1-2months for intensive education, coaching and behavior modification related to self-care measures, medication use and adherence, and follow up.

## **Participant Education**

Educational information will be sent to participants when deemed appropriate by the Care Coordinator. In addition, educational wellness and preventive care reminders will be sent to all program participants quarterly.

Topics of participant education may include:

- Diabetes self-monitoring (including self-monitoring of blood glucose levels)
- Appropriate dietary needs
- Value of meal planning by a registered dietician or certified Diabetes educator
- Encourage the purchase of a medic-alert bracelet
- Signs and Symptoms of hypo/hyperglycemia
- Treatment of hypo/hyperglycemia
- Clinical benefits of achieving glyceemic control
- Blood pressure control self-management
- Lipid level self-management
- Use of ACE Inhibitors/ARBS for the prevention of kidney disease
- Use of aspirin therapy as a preventive treatment related to cardiac disease
- Physical Activity
- Weight Reduction
- Smoking Cessation
- When to notify physicians
- Medications
- Management of co-morbid conditions
- Self-management tracking tools

## **Multidisciplinary Team**

A multidisciplinary team of healthcare professionals will collaborate to ensure the participants' clinical, functional, financial, psychosocial, environmental, and support system needs are met. Team members include, but are not limited to, internal physician advisors, community physician advisors, treating physicians, registered nurses, pharmacists, registered dieticians, and behavior health specialists. Any or all of these team members may participate in case conferences to coordinate care for individuals who require intense management.

## Individualized Plan of Care

Every participant enrolled in the program will work collaboratively with the Care Coordinator to develop an individualized plan of care consistent with national guidelines and the physician treatment plan.

James Prochaska noted that in order for behavior change to be successful a person must want to make the change and must be involved in how the change will occur. The Care Coordination system will identify a list of participant problems based on their answers to the assessment tools. The Care Coordinator will review these problems with the participant to prioritize identified problems and discuss possible problem resolutions.

The Care Coordinator will supply the participant with any/all tools they may need to make informed decisions related to their problems and plan of care such as:

- Physician treatment plan
- Disease specific information
- Self-care education
- Community Resource referrals
- Medical equipment

## Low, Medium and High Level Interventions

- Care Coordinator access
- Welcome kit
- Nurse visits/calls providing health education, behavior modification and/or health coaching.
  - **High level – At least 10 scheduled calls/visits (*more calls may be completed per the Care Coordinator’s assessment*)**
    - Call/Visit Schedule – Initial, then months 1, 2, 3, 4, 5, 6, 8, 10, and 12
  - **Medium level – At least 6 scheduled calls/visits (*more calls may be completed per the Care Coordinator’s assessment*)**
    - Call/Visit Schedule – Initial, then months 2, 4, 7, 10, and 12
  - **Low level- At least 2 scheduled calls/visits (*more calls may be completed per the Care Coordinator’s assessment*)**
    - Call/Visit schedule- initial and then month 2
- Assessment of the participants social environment and psychosocial support system (either telephonically or through Care Coordinator home visit when indicated)
- Access to community resources to assist with social, family, financial needs.
- Access to behavioral health resources to screen for depression and instruction on coping with chronic conditions
- Identification and resolution of gaps in care (wellness visits, physician follow up schedule, recommended follow up testing, medication adherence, etc.)
- Education materials tailored to the participant’s primary language and reading level
- Ongoing collaboration with the primary care physician
- Assessment of co-morbidities and development of plan to address any uncontrolled conditions
- Evaluation of medications and medication adherence
- Coordinate the introduction of anti-platelet or anticoagulant therapy into the participant’s treatment plan (unless contraindicated)

- Coordinate the introduction of ACE/ARB therapy into the participant’s treatment plan related to prevention of nephropathy (unless contraindicated)
- Reinforcement of an individualized meal plan
- Referrals to dietician related to special dietary needs, meal planning, and/or weight reduction
- Coordination of all necessary screenings related to co-morbid complications including: retinopathy screening, diabetic neuropathy screening, diabetic nephropathy screening, cardiovascular disease screening (hypertension, hyperlipidemia), and screening foot exam
- Quarterly general health reminders (such as annual flu vaccines, pneumococcal vaccines, and updated tetanus vaccination )
- Smoking Cessation assistance
- Weight reduction assistance
- Ongoing reassessment and adjustment of the plan of care
- Annual participant satisfaction survey

### ***Physician Interventions***

Local physician involvement is critical to Care Coordination. In order for participants to achieve optimal success in managing their chronic illnesses, they must be able to work with a primary care physician.

The Diabetes Care Coordination program involves physicians/providers in the program by:

- Providing current American Diabetes Association guidelines through a provider web portal
- Providing current treatment algorithms
- Providing written and/or verbal notification of participant involvement in Care Coordination
- Ongoing communications between the participants’ Care Coordinator and the physician to notify the physician of urgent and emergent health issues and assist with participant adherence
- Access to an annual participant profile highlighting Care Coordination activities over the last year and how the provider ranks in adherence to the standards of care with that participant
- Practice support tools
- Provider practice profile
- Annual provider satisfaction survey

### ***Program Evaluation***

Program outcomes will be measured at least semi-annually. Participant outcome measures will be compared to pre-enrollment baseline data. In addition, participants will be measured against those eligible participants who elected to opt-out of the program.

### **Clinical Measures**

- HgbA1c reduction to within acceptable range as noted by the American Diabetes Association
- Adherence with scheduled HgbA1c monitoring
- Adherence with annual microalbumin screening
- Adherence with annual retinal eye exam screening
- Adherence with annual lipid screening
- Adherence with blood pressure screening
- Adherence with annual professional foot exam
- Adherence to use prophylaxis aspirin therapy (unless contraindicated)
- Adherence to use of ACE/ARB therapy and the prevention of kidney disease (unless contraindicated)

## **Quality of Life Measure**

- SF 12

## **Financial Measures (enrollees compared over time to eligible program participants who chose not to participate)**

- Admits/thousand (program enrolled participants)
- Days/thousand (program enrolled participants)
- ALOS (program enrolled participants)
- % of total admissions for diagnosis of Diabetes(program enrolled participants)
- Admits/thousand for the diagnosis of Diabetes (program participants)
- # Diabetes enrollees with ER visits
- # of total ER visits for Diabetes

## **Program Quality Measures**

- Annual participant satisfaction
- Annual provider satisfaction

## ***References***

Bessie Ann Young, MD, MPH; Elizabeth Lin, MD, MPH; et al. Diabetes Complications Severity Index and Risk of Mortality, Hospitalization, and Healthcare Utilization. *American Journal of Managed Care*: Vol 14 No 1; p 15-24.

American Association of Clinical Endocrinologists (AACE). American Association of Clinical Endocrinologists medical guidelines for clinical practice for the management of diabetes mellitus. Microvascular complications. *Endocr Pract* 2007 May-Jun;13(Suppl 1):50-5.

National Collaborating Center for Chronic Conditions/National Institute for Health and Clinical Excellence (NCCCC/NICE). Type 2 diabetes. The management of type 2 diabetes. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 May. 49 p. (Clinical guideline; no. 87)

American Diabetes Association. Standards of Medical Care in Diabetes-2010. *Diabetes Care*. Accessed at [http://care.diabetesjournals.org/content/33/Supplement\\_1/S11.extract](http://care.diabetesjournals.org/content/33/Supplement_1/S11.extract)

AADE. American Association of Diabetes Educators. [www.diabeteseducator.org/AADE7/index.shtml](http://www.diabeteseducator.org/AADE7/index.shtml)

Diabetes Statistics, American Diabetes Association, <http://www.diabetes.org/diabetes-statistics>