



Diabetes Disease Management Program

A. Program Content

GHC-SCW is committed to helping members, and their practitioners, manage chronic illness by providing tools and resources to empower members to act to improve their health and chronic conditions. Diabetes is a major concern for GHC-SCW due to the increase in number of members being diagnosed and the health risks and costs associated with poor control. Proactive practitioner intervention and support, in collaboration with health education and clinical outreach, helps members manage their chronic conditions.

GHC-SCW has designed the Diabetes program to educate members about diabetes, teach members how to self-manage their disease, emphasize the importance of regular care, and provide support tools and screenings to reduce diabetic-related complications, morbidities and death. The content of the diabetes program includes condition monitoring, patient adherence to treatment plans, consideration of other health conditions, lifestyle issues and ongoing screening for behavioral health concerns. The organizations adopted clinical practice guidelines for diabetes care and management listed in Appendix A are the clinical basis for the program. Current guidelines are posted on ghcscw.com.

Along with performing disease-specific clinical activities, GHC-SCW's Diabetes Educators and Clinical Pharmacists also have a significant impact on the development, implementation and improvement of the program. Examples of how they impact disease management at GHC include:

- Provide education to patients about the disease
- Regularly monitor both self-tested and laboratory tested blood glucose levels
- Educate patients on how to use home blood glucose monitoring equipment
- Monitor patient compliance with prescribed therapies and scheduled clinic and laboratory appointments
- Screen for drug/drug, drug/food, drug/disease interactions and adverse reactions
- Provide medication management and review.
- Perform periodic blood pressure/cholesterol level checks
- Target high-risk and high-utilizing patients for education and/or intervention,
- Conduct outcomes research to form the basis for treatment guidelines
- Involve the pharmacy and therapeutics committee in disease management processes
- Influence prescribing patterns
- Educate other pharmacists and physicians about treatment guidelines
- Provide expert information on medications and pharmacotherapy
- Use health system databases to track drug expenditure patterns and health care professionals' adherence to regimens

Condition monitoring

GHC monitors condition for all diabetic members in the program and uses either outreach calls, MyChart messages or postal letters as reminders if monitored indicators are past due. Items monitored include:

- Date and result of most recent hemoglobin A1C
- Date and result of most recent fasting lipid panel (LDL, HDL, total cholesterol, and triglycerides)

- Date of most recent medical attention for diabetic nephropathy (urine micro albumin, etc.)
- Date of most recent diabetic retinal eye exam (DRE)
- Prescriptions for diabetic medications (date prescribed, date filled)
- Prescriptions for lipid lowering agents (date prescribed, date filled)
- Prescriptions for hypertension (date prescribed, date filled)
- Co-morbidities (asthma, hypertension, cardiovascular disease, hyperlipidemia)
- Date and result of most recent blood pressure measurement-

Adherence to Treatment Plans

Members work with Diabetes Educators, Clinical Pharmacists, Registered Dietitians, nursing staff and their primary care practitioner who monitor patient adherence in the following areas:

- Modification of risk factors
- Weight control
- Blood Pressure control
- Medication compliance
- Nutritional Guidelines
- Scheduling regular practitioner appointments
- Physical Activity Level
- Tobacco Cessation
- Self-Monitoring of Blood Glucose
- Self-Administration of Insulin
- Quarterly testing of HbA1C
- Clinical Practice Guidelines (see Appendix A)

Members may check future appointments, outstanding orders, medication lists, lab and diagnostic test results through GHCMYChartSM-a secure interactive online patient health portal. Blood glucose monitoring devices are provided at no cost to the member and results are downloaded during appointments with health educators. All encounters and treatment plans are documented in the EMR.

Medical and behavioral health comorbidities and other health conditions

GHC-SCW is committed to a collaborative approach to disease management, especially for those members with multiple co-morbidities such as asthma, hypertension, cardiovascular disease, hyperlipidemia and/or depression. The diabetes registry includes current lab, prescription and risk factor data. Prior to creating the treatment plan, consideration is given to the members learning style preferences, cognitive abilities, socio-economic factors, and/or physical limitations. A team approach ensures members requiring more intensive care get the right care at the right time.

- Clinic staff (CMA's, LPN's, RN's, Practitioners, lab, radiology) have access to the electronic medical record and can see the problem list for each member.
- Practitioners refer patients to Clinical Specialists, Health Educators or Behavioral Health to support the needs of the patient.
- Registered Dietitians document their encounters with members contributing to the plan of care.
- Case Managers may also ensure appropriate care for those with more complex needs that meet criteria

Health Behaviors

Behavior modification is an essential component of diabetes management. GHC-SCW Health Educators (Diabetes Nurses, Tobacco Cessation Counselors, Registered Dietitians) work with members to provide personalized support and to promote healthy lifestyle options. Members may receive individual counseling as needed or are provided information regarding alternative resources.

GHC-SCW requests members complete a General Medical History Form every time they schedule a physical. Practitioners can counsel on at risk behaviors noted in the history information such as alcohol consumption, drug use, tobacco use/smoking or other hazards. Members with documented tobacco use receive outreach about access to a cessation counselor and are provided information about community resources such as the Wisconsin Quit Line. GHC-SCW covers tobacco cessation medications on its formulary for many plan members if they have a pharmacy benefit. Substance use and addiction services are primarily provided by our partner, UW Behavioral Health and Recovery. A referral is not required to initiate this service.

Psychosocial issues

GHC-SCW's Primary Care providers collaborate with Clinical Health Educators, Nursing, Case Management and Behavioral Health staff to identify possible psychosocial issues that may be significant to the conditions being managed and strive to identify interventions or resources to overcome the issues. Psychosocial issues which have potential to affect adherence to a treatment plan may include but not be limited to:

- Beliefs and concerns about the condition and treatment
- Perceived barriers to meeting treatment requirements
- Access, transportation or financial barriers to obtaining treatment
- Cultural, religious and ethnic considerations

Assessment tools play a key role in evaluating some members general level of anxiety upon learning about their diabetes diagnosis or any perceived barriers to managing their disease. GHC-SCW has incorporated the GAD-7 anxiety screening tool into its electronic health record. This patient self-assessment tool has been developed and validated in a primary care setting. It can be completed independently and reviewed at a follow-up appointment or in conjunction with the practitioner or another member of the care team. The evaluation is documented in the members EMR under "Screening Tools".

Depression screening

GHC-SCW has incorporated the PHQ-9 for monitoring symptoms of depression into its electronic health record. Primary Care and/or Behavioral Health practitioners are encouraged to obtain screenings on diabetics in the program and make recommendations for treatment if screening is positive. The Patient Health Questionnaire-9 is standardized and has been extensively studied in primary care settings. This patient self-assessment tool can be completed in the office jointly with the practitioner or independently and reviewed at a follow-up appointment. The assessment is documented within the members EMR under "Screening Tools".

Information about the patient's condition provided to caregivers who have the patient's consent

Family members and/or caregivers who want or need access to the patient's medical record are required to file a patient signed "Release of Information" consent form, indicating they may have access to their records. Patients may choose to share electronic access to their medical record by sharing password information to their GHCMYChartSM account with family members and/or caregivers. The treatment plan created by the Practitioner or Diabetes Educator can be shared with family, and is available to other health care professionals

for continuity of care. Members with diabetes can also receive the brochure Living with Diabetes “Families Can Help” which is available in English and Spanish.

Encouraging patients to communicate with their practitioners about their health conditions and treatment

GHC-SCW’s diabetes outreach letter delivered to all members in the registry encourages contact with their practitioner and stresses the importance of communication. Members have the option to utilize GHCMYChartSM a secure patient portal within the electronic medical record. All members are encouraged to sign up for an account so they can send messages directly to their care team (practitioners or nursing) or staff of the insurance plan (member services, pharmacy). Members registered, automatically get care and/or appointment reminders via their account. The MyChart App is available for both Apple and Android smart devices making it convenient for members to access.

Additional resources external to the organization

GHC-SCW recommends members living with chronic conditions participate in community resources such as the self-management support program “Healthy Living with Diabetes”. This is a high-level, evidence based program administered and supported by the *Wisconsin Institute for Healthy Aging* (<https://wihealthyaging.org/wiha-programs>), researched and proven to help people live healthier, more active lives.

WIHA also has the evidence based workshop *Living Well* for people with one or more chronic condition. Developed at Stanford University, the *Living Well* workshop meets for 2-1/2 hours a week for six weeks. Classes are highly participative, where mutual support and success build participants’ confidence in their ability to manage their health condition to maintain active and fulfilling lives. It is facilitated by two trained leaders in a classroom style, but most of the learning comes from sharing and helping others with similar challenges. Members can use the WIHA website to find a workshop by the program title and county they live in across most of Wisconsin.

In addition, members also have access to *Healthwise*, a health topics database & shared decision making resource within GHCMYChartSM and are encouraged to complete a Health Risk Assessment (HRA) available free of charge via the WebMD® Portal, also within MyChart. *Healthwise* topic information may be printed during clinic visits for members.

B: Identifying Members for Disease Management

GHC-SCW uses the following data sources to identify members for the program:

- Claims or encounter data
- Prescription data
- Problem list in the electronic medical record
- Laboratory results- Care Team staff may contact practitioners regarding patients with an elevated Blood Glucose or A1C who do not have Diabetes on their problem list
- Health risk assessments
- Data collected through the utilization management or care management process
- Member referral
- Practitioner referral

GHC-SCW does not use continuous enrollment criteria for identifying members.

C: Frequency of Member Identification

GHC-SCW's BI diabetes registry updates weekly to identify new members with diabetes based on established criteria and the above data sources.

D: Providing Members with Information

How members become eligible and how to use services:

All members on the BI Diabetes registry are automatically included in the program to receive outreach materials to help them learn to live well with diabetes unless they choose to Opt out. New and existing members with diabetes receive a program letter about the services available on a quarterly basis. Communications explain the importance of managing diabetes and highlight both internal and external resources and important contact information at GHC-SCW. Mailings may also include an educational newsletter with tips, stories, recipes and more resources.

How to opt in or out:

The program letter explains how members can opt out of future program outreach materials associated with being on the BI diabetes registry by contacting GHC-SCW Quality Management staff.

E: Interventions based on Assessment

GHC-SCW provides interventions for diabetic members based on stratification. Different interventions for members are based on the severity of illness, completion of diagnostics and the results of those tests and examinations.

Tier 1: All new and existing registry members

Tier 1 Interventions:

- Program letter mailed to all new and existing registry members quarterly (unless they opted out)
- Access to diabetes nurse educators and/or primary care practitioner
- Diabetes-related classes reimbursable as wellness activities by the insurance plan
- Practitioners notified of outreach activities

Tier 2: Subset of members who are overdue for follow up meeting one or more criteria

- HgbA1C >9% OR have not had a HgbA1c in 13 months
- LDL >100mg/dL OR no LDL done in the last 13 months
- Blood pressure not recorded for 6 months and/or $\geq 140/90$ mmHg
- Urine micro albumin due
- Dilated Retinal Exam due

Tier 2 Interventions: same as Tier 1 plus

- Contact related to needed diagnostics via secure messaging, phone calls or mailings
- Orders placed for needed testing or scheduled appointment with diabetes educators and/or primary care

Tier 3: Subset of members referred to Case Managers

Tier 3 Interventions: same as Tier 2 plus CM involvement

F: Eligible Member Active Participation

GHC-SCW annually reports the active participation rate to the Clinical and Service Quality Committee. The data represents the number of members with at least one interactive contact in the year analyzed. An interactive contact is defined as a two –way interaction in which the member receives self-management support and includes anyone who utilized a health educator or specialist, a health coach or had a phone or MyChart consultation related to diabetes. Disease management survey participation is also considered an interactive contact.

G: Informing and Educating Practitioners

Instructions on how to use DM services

GHC-SCW provides practitioners with information about program services via the following:

- Provider resources page on **ghcscw.com** maintains a current version of all DM program descriptions
- New practitioner on-boarding letter and/or at orientation
- Updates in organizational newsletters
- Health Maintenance Modifiers for labs and screening
- Best Practice Alerts

How the organization works with practitioner’s patients

Practitioners have EMR access to an encounter in Chart Review for all contacts the member has with nursing, health educators, clinical pharmacists, behavioral health or case managers. Communications include secure electronic messaging, telephone and/or in person contact.

H: Integrating Member Information

GHC-SCW utilizes a common electronic medical record system (Epic[®]) which allows for integration of member information for continuity of care. This information can be extracted into a variety of reporting tools utilized by the organization that focus on the diabetes population to ensure relevant interventions and allow for comprehensive coverage by the health information line, case management program, utilization management program, quality management outreach program and health/wellness education.

Epic Link and Care Everywhere functionality within the system allow staff to see the patients’ medical record if they have been seen by a partnering facility utilizing the Epic system and ensures access to patient information while they are out of the service area.

I: Experience with Disease Management

GHC-SCW surveys a sample of registry members who participated in the program (did not opt out) annually for feedback on their experiences with services and the usefulness of disseminated materials/ information. GHC-SCW clinics also utilize Press Ganey to administer CG-CAHPS to patients who had a practitioner or health education encounter to gather experience information related to these visits. Complaints are managed through Member Services per protocol.

J: Measuring Effectiveness

HEDIS results are analyzed monthly to look for trends or changes in compliance. GHC-SCW's Quality team, along with other stakeholders in the organization, pursue opportunities to impact measure performance. These typically target areas where a measure is below the 50th percentile as well as ensuring measures stay near or above the 75th percentile. Measures include the entire relevant population of diabetic members.

Each measure:

- 1) Address a relevant process or outcome
- 2) Produces a quantitative result
- 3) Is population based
- 4) Uses valid data and methodology
- 5) Is compared to a benchmark or goal

GHC-SCW selects and tracks one performance measure for each DM program. An annual quantitative and qualitative analysis is conducted to identify cause and areas of opportunity if goals are not achieved on the measure selected.

Appendix A Diabetes Disease Management Program Clinical Practice Guidelines

GHC-SCW has a representative of the organization participate in a city-wide guideline working group to improve the consistency of care across the Madison area. Guidelines undergo periodic review within the UW Health Center for Clinical Knowledge Management and GHC-SCW formally adopts the guidelines recommended by this working group. UW Health has endorsed the *American Diabetes Association Standards of Medical Care in Diabetes* with additional recommendations for screening constructed internally.

- 1) Standards of Medical Care in Diabetes: Adult / Pediatric – Inpatient / Ambulatory last revised 04/2017
Next review date January 2018