WSHIP Care Management Programs

July 2008

Care management services to WSHIP enrollees on January 1, 2007, were enhanced and expanded to a significantly larger number of enrollees than were served in 2006.

Care management services include:

- Utilization management (medical necessity reviews for inpatient & other services)
- Case management
- Disease management
- Specialty review for experimental and investigational determinations

Special features of the enhanced program are:

- Unique program developed especially for WSHIP as opposed to an off-the-shelf, one size fits all approach
- Earlier identification and referral of enrollees who may benefit from care management, based upon diagnoses identified in the pre-enrollment Standard Health Questionnaire as well as analysis of monthly medical and pharmacy claim data
- Local case managers who work only on WSHIP cases
- Increased support for the chronic care model and medical home concept
- Case and disease management services integrated and delivered to the enrollee through a single nurse or social work care manager, regardless of the number of disease co-morbidities
- Holistic disease management programs specially designed to meet the needs of WSHIP's high-risk population using evidence based guidelines and individually appropriate coaching
- Connectivity and coordination with caretakers and community care management resources
- Non-duplication of services
- Seattle based, not-for-profit partner

Integrated Case and Disease Management

Care management professionals collaborate with enrollees and their healthcare providers to improve the enrollee’s timely access to, and appropriate use of, healthcare services, equipment, supplies, and community resources. Care managers work exclusively with WSHIP enrollees to assure knowledge of the program’s unique features. They are located
throughout the state to ensure familiarity with the enrollee’s local medical environment and available services.

Case management helps empower enrollees to receive the right care at the right time in the right setting. Key components include individual assessment, care planning and resource identification, linking patients to needed services, service implementation and coordination, monitoring service delivery, advocacy, and evaluation.

Disease management educates and facilitates enrollees’ self-management of their disease. These programs emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies. WSHIP previously had a disease management program for depression. In 2007, with the advent of our current partner, the depression program was revamped and a disease management program for HIV/AIDS was added.

2008 Disease Management Program Expansion & Enhancements

WSHIP’s disease management program is expanding July 1, 2008, to include diabetes, asthma, coronary artery disease (CAD) and congestive heart failure (CHF). Future expansions such as weight management to address the obesity epidemic and smoking cessation will also be explored.

Additionally, WSHIP is exploring opportunities to enhance its program by integrating prescription drug management services, data and expertise available through its Pharmacy Benefits Manager, Medco Health. Integration of prescription drug management will improve our ability to identify enrollees earlier who may benefit from disease management, increase patient engagement opportunities and participation by utilizing “teachable moments” such as prescription fills/refills; better identify potential drug-therapy related health risks; and facilitate access to and support from Medco’s specialty pharmacists and Therapeutic Resources Centers. (In 2007, prescription drugs accounted for over 42% of WSHIP’s total claim costs.)

Key Characteristics of the WSHIP Disease Management Program

In January of 2007, WSHIP contracted with Qualis Health, a Washington-based, non-profit care management company, to provide an integrated care management program. The program includes disease management, case management, utilization review, and specialty review. The disease management program is unique and was specifically designed for WSHIP’s population; most of whom already have serious or chronic illnesses and/or are at high risk. Participants in the disease management program have a single care manager to facilitate, support, and coordinate their care management needs. This is a key component of our program intended to contribute to the development of trust, to assure consistency of information and to avoid communication problems that can arise when an enrollee is required to interface with multiple care managers. Care managers are located throughout the state based on WSHIP’s demographics to ensure knowledge and understanding of standards of care, health and social services, and community resources.
An integrated, web-based software system provides seamless information sharing between all program staff and facilitates communication, coordination, and reporting.

The disease management program uses the principles of the Chronic Care Model\(^1\) to achieve an effective, patient-centered chronic care delivery system that is clinically coordinated, evidence-based, and proactive. Care managers support—and do not compete with, replace, or work independently of—direct care providers. They strive to empower the patient to self-manage his or her condition(s) while reinforcing the need to access healthcare services through a medical home or primary care physician. The care manager’s local presence and familiarity with the enrollee’s community, providers and resources facilitate these efforts.

Care managers use a holistic approach that focuses on the patient as a whole. The most prevalent primary diagnoses within the WSHIP population are end stage renal disease, HIV/AIDS, diabetes, congestive heart failure, coronary artery disease and neurological disorders. Multiple co-morbidities are present with most enrollees with these conditions. Care plans are individualized for each enrollee based on evidence-based clinical guidelines for primary diagnoses and co-morbidities. The disease management program is also fully integrated with other care management activities such as case management, hospital reviews/discharge planning, etc. This integration allows the participant and his or her providers to have a single source of support and coordination throughout the continuum of their care needs without experiencing the traditional “silos” often present in non-integrated programs. It also facilitates earlier identification of enrollees who may benefit from participating in the disease management program.

Lastly, the program strongly encourages, utilizes, and coordinates with existing community resources. Connecting participants to appropriate educational, health, social and advocacy resources facilitates self-management and reduces duplication of services and program costs.

**Disease Management Program Methodology and Processes**

The disease management program is designed to support the physician or practitioner/patient relationship and plan of care, emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluate clinical, quality-of-life, and economic outcomes on an on-going basis with the goal of improving overall health.

**Eligibility, Identification and Enrollment**

All WSHIP non-Medicare enrollees are eligible for participation in the disease management program. Early and effective identification of candidates who could benefit from such services is critical. WSHIP uses a variety of sources to optimize this selection including data mining techniques to survey claims and pharmacy data for prospective enrollees, the enrollee’s Standard Health Questionnaire completed within 90 days prior to enrollment, and self-referrals from enrollees as well as from providers. All pre-service, concurrent, or retroactive requests for service that are entered into the integrated care management

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software system are automatically routed to a care management referral coordinator for screening.

Upon receipt of the referral, the care manager contacts the eligible enrollee. The initial conversation presents the merits of the disease management program to the enrollee. The enrollee may opt out at this time or at any point later in the process. When the enrollee expresses interest or agrees to enroll in the program, the care manager sends the enrollee an introduction packet that includes a more complete explanation of the program, a copy of the “Patient Bill of Rights” and a “Release of Information” form for enrollee signature should he or she desire to enroll.

**Assessment, Stratification and Care Plans**

Upon enrollment, the care manager uses a disease-specific MEDecision OptiCarePath™ questionnaire to assess the enrollee’s disease state. This tool, which is based on nationally recognized and evidence-based clinical information, allows the care manager to stratify the enrollee’s disease state and identify specific problems, interventions, barriers, and goals. The data gathered during this comprehensive assessment allows the care manager to accurately stratify the enrollee as either high acuity or low acuity. High acuity enrollees are medically unstable, have no medical home, lack community resources, have only minimal medical service involvement, are geographically isolated, lack insight into their disease, are frequently hospitalized and/or make frequent use of the emergency room. An enrollee is considered low acuity if he or she is stable, has a medical home, community support, and well established resources, but has an identified need for adherence support.

The assessment and stratification of an enrollee allows the case manager to craft an individualized care plan that consists of specific interventions unique to the needs of the enrollee and on a timeline suited to his or her acuity level. For example, a low acuity enrollee may only need a monthly phone call from the care manager, while the high acuity enrollee may need frequent phone calls combined with provider coordination and authorization of ancillary services. Whatever the acuity, the care manager's targeted interventions are designed to enable the enrollee to establish a stable, supportive medical home that has the following expectations:

- it is prevention and primary care focused;
- it is patient centered to promote patient responsibility;
- it involves a primary, personal physician collaborating with other health professionals as necessary;
- it coordinates with and supports the activities of any disease specific, community based care managers already involved in the enrollee’s care;
- it is formally tied to specialists and inpatient care as needed;
- it is accessible when needed regardless of day or time;
- it is continuous; and
- it is culturally effective.

Those expectations are met through the active involvement of the care manager. The care manager’s care planning and coordination on behalf of the enrollee will:
• involve assessment and monitoring of enrollee needs;
• facilitate timely access to services and resources;
• use active, participatory listening;
• facilitate communication among the enrollee, primary and specialty providers;
• connect enrollees with community support organizations including health, education and social services;
• develop, monitor, update and follow-up with individualized care planning and care plans;
• support access to referrals and education;
• assist the enrollee to maximize effective, efficient, and innovative use of existing resources; and
• monitor outcomes for the enrollee.

Outcome Measures and Graduation

Patient informed self-management is the ultimate goal of the disease management program. That is accomplished through the active education, support, and empowerment of the enrollee to make informed decisions regarding his or her health and well-being. The care manager will continue supporting the enrollee as long as there is a role to play on behalf of that individual. The enrollee should reach a point where graduation from the program is warranted. However, graduation will occur only with the consent of the enrollee. Once this occurs, the care manager will send the enrollee a closing letter and a reminder that he or she may re-refer to the program should there be a change in medical status.

Standard outcome measures are used to determine the result of disease management actions and interventions. Among the metrics in use are the Patient Health Questionnaire (PHQ-9) scores for measuring degrees of depression; and treatment adherence, medication adherence and social support system for HIV/AIDS. These performance indicators are measured periodically, usually beginning with the initial assessment, then at six-month intervals and then at graduation.

Also, upon graduation, the graduate is given the opportunity to complete a client satisfaction survey. The Client Satisfaction Questionnaire (CSQ-8), originally developed by Clifford Atkinson at the University of California at San Francisco, has gained widespread acceptance in health care. The CSQ-8 consists of eight questions that measure the patient’s satisfaction with quality of service, outcome of service, and general satisfaction. Different sets of 4-point response choices, with each set of responses weighted from one to four, are used for each item.

Measurable Indicators of Program Efficacy

Measurable indicators of program efficacy are reported and measured in three areas: clinical outcomes, economic outcomes, and patient satisfaction.

These measures are described in the chart on the next page for each of WSHIP’s disease management programs.
# Measurable Indicators of Disease Management Program Efficacy

<table>
<thead>
<tr>
<th>Disease Management Program</th>
<th>Clinical Outcomes</th>
<th>Economic Outcomes</th>
<th>Patient Satisfaction</th>
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<tbody>
<tr>
<td><strong>Depression</strong></td>
<td>Patient Health Questionnaire (PHQ-9)^1 administered at opening and closing of case; Medication adherence.</td>
<td>Averted savings (inpatient, ER, outpatient, home health) using Milliman national benchmark data; also includes redirecting enrollee to PPO providers and any negotiated savings.</td>
<td>Client Satisfaction Questionnaire (CSQ-8)^10 mailed to enrollee at time of case closure.</td>
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<td><strong>HIV/ AIDS</strong></td>
<td>Medical Home^2 measured by Medication Adherence^3, Treatment Adherence^4 and Support System^5; Data obtained via case manager assessment and questionnaire administered at opening and closing of case.</td>
<td>Same as above</td>
<td>Same as above</td>
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<td><strong>Diabetes</strong></td>
<td>A1C Level^6, Diastolic Blood Pressure^7, Cholesterol Level^8; Measures obtained from enrollee or physician initially and at case closure; Medication adherence.</td>
<td>Same as above</td>
<td>Same as above</td>
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<tr>
<td><strong>Asthma</strong></td>
<td>Hospital Admission for asthma, Inhaler Use, Flu Shot, Smoking Quit Rate; Medication adherence.</td>
<td>Same as above</td>
<td>Same as above</td>
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<td><strong>Coronary Artery Disease (CAD)</strong></td>
<td>Diastolic Blood Pressure^7, Cholesterol Level^8. Measures obtained from enrollee or physician initially and at case closure; Medication adherence.</td>
<td>Same as above</td>
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<td>Congestive Heart Failure (CHF)</td>
<td>Blood Pressure at target&lt;sup&gt;4&lt;/sup&gt;, Cholesterol Level&lt;sup&gt;8&lt;/sup&gt;. Measures obtained from enrollee or physician initially and at case closure; Medication adherence.</td>
<td>Same as above</td>
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<sup>1</sup>The Patient Health Questionnaire (PHQ-9) consists of a brief, 9-item enrollee depression assessment specifically developed for use in primary care. The PHQ-9 has demonstrated usefulness as an assessment tool for the diagnosis of depression in primary care with acceptable reliability, validity, sensitivity, and specificity. The nine items of the PHQ-9 come directly from the nine DSM-IV signs and symptoms of major depression. A score of 0-9 correlates to a provisional diagnosis of mild depression. A score of 10-20 suggests moderate depression, and a score of 20-27 is an indicator of severe depression.

<sup>2</sup>The medical home is centered on the needs of the patient and family and is guided by a personal primary care provider who partners with the patient to coordinate and facilitate care in order to help patients navigate the complexities of the health care system. The case manager in the medical home model is not a “gatekeeper” who restricts patient access to services but rather facilitates and coordinates care. To be effective, medical homes must be accessible, comprehensive, continuous, coordinated, compassionate, and culturally effective. The medical home provides health promotion, disease prevention, health maintenance, behavioral health services, patient education, diagnosis and treatment of acute and chronic illnesses.

<sup>3</sup>Medication Adherence: Patient knowledge of medications and their willingness to adhere to dosing guidelines. This includes an understanding of what medications are being taken, when they are to be taken, how they are to be taken and potential side effects.

<sup>4</sup>Treatment Adherence: Focus on maintenance of provider relationships, securing and keeping appointments, understanding disease processes, understanding treatment plans, acknowledging need for continuing a treatment plan, and making informed treatment decisions.

<sup>5</sup>Support System: Promoting enrollee self-actualization as a means of obtaining the basic economic and social network necessary to maintain optimal health.

<sup>6</sup>A1C Level: Optimal level of ≤ 7%.

<sup>7</sup>Diastolic Blood Pressure: Optimal level ≤ 80 mm Hg.

<sup>8</sup>Cholesterol: Target level ≤ 200.

<sup>9</sup>Blood Pressure at Target: ≤ 130/85

<sup>10</sup>Client Satisfaction Questionnaire (CSQ-8): Originally developed by Clifford Atkinson at the University of California at San Francisco, it has gained widespread acceptance in health care. The CSQ-8 consists of eight questions that measure the patient’s satisfaction with quality of service, outcome of service and general satisfaction. Different sets of 4-point response choices, with each set of responses weighted from one to four, are used for each item.