Washington State
Health Care Authority

Disease Management Strategies in Washington State
Final Status Report

As Required by Substitute Senate Bill 5841
Chapter 462, Laws of 2005

January 2009

Washington State
Health Care Authority
PO Box 42700
Olympia, WA 98504-2700

Copies of this report will be available at: http://www.hca.wa.gov/leg_reports.html

Washington State
Health Care Authority

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January 20, 2009

The Honorable Chris Gregoire
Washington State Governor
Legislative Building
P.O. Box 40002
Olympia, WA 98504-0002

Mr. Thomas Hoemann
Secretary of the Senate
Washington State Senate
P.O. Box 40482
Olympia, WA 98504-0482

Ms. Barbara Baker
Chief Clerk of the House
House of Representatives
P.O. Box 40600
Olympia, WA 98504-0600

Dear Governor Gregoire, Mr. Hoemann, and Ms. Baker:

The Washington State Health Care Authority is pleased to submit our final status report to the Legislature on our findings related to disease management programs as directed by Substitute Senate Bill 5841 and RCW 41.05.13 as enacted in chapter 462, Laws of 2005. It is clear that much progress has been made by the health care community in improving disease management for our citizens.

If you have any questions or desire additional information, please contact Regina Gallwas at either 360-923-2823 or regina.gallwas@hca.wa.gov.

Sincerely,

Steve Hill
Administrator

cc: Senator Karen Keiser, Chair, Senate Health & Long-Term Care Committee
Senator Cheryl Pflug, Ranking Minority Member, Senate Health & Long-Term Care Committee
Representative Eileen Cody, Chair, House Health Care & Wellness Committee
Representative Bill Hinkle, Ranking Minority Member, House Health Care & Wellness Committee
Christina Hulet, Governor's Policy Office
Jonathan Seib, Governor's Policy Office
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Rhoda Donkin, Coordinator/Analyst, Senate Health & Long-Term Care Committee
Dave Knutson, Research Analyst, House Health Care & Wellness Committee

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Introduction

This report is submitted in compliance with Substitute Senate Bill (SSB) 5841 which was passed by the Legislature in 2005. The bill was signed by the Governor and enacted as chapter 462, Laws of 2005. Section 3(1)(d) of the legislation amended RCW 41.05.13 and directed the Health Care Authority (HCA) to issue two status reports regarding management strategies for asthma, diabetes, heart disease, and other chronic diseases. The statutory provision reads as follows:

> *(1) The authority shall coordinate state agency efforts to develop and implement uniform policies across state purchased health care programs that will ensure prudent, cost-effective health services purchasing, maximize efficiencies in administration of state purchased health care programs, improve the quality of care provided through state purchased health care programs, and reduce administrative burdens on health care providers participating in state purchased health care programs. The policies adopted should be based, to the extent possible, upon the best available scientific and medical evidence and shall endeavor to address:*
>
> **********
>
> *(d) Exploration of common strategies for disease management and demand management programs, including asthma, diabetes, heart disease, and similar common chronic diseases. Strategies to be explored include individual asthma management plans. On January 1, 2007, and January 1, 2009, the authority shall issue a status report to the legislature summarizing any results it attains in exploring and coordinating strategies for asthma, diabetes, heart disease, and other chronic diseases. This report provides a summary of disease management activity in the state by health care plans, health clinics, and state health care purchasing agencies. The January 1, 2009, report will describe any results attained in exploring, developing, and coordinating strategies for chronic diseases such as asthma, diabetes and heart disease.*

This report is the final status report and provides an update of disease management activity in the state by health care plans / insurers, health care clinics, and state health care purchasing agencies since the January 2007 report.

Background

In 2005, the Governor's Office noted that five percent of Washington residents covered by government health care programs were responsible for approximately fifty percent of total program costs. Nationally, a July 2008 Health Affairs article by the Kaiser Family Foundation notes that:

> *Over the last 10 years, the number of working age adults with major chronic conditions increased by 25 percent. Forty percent of the population has one or more chronic disease and make up three-fourths of health care spending.*

The 2006 Legislature established the Blue Ribbon Commission on Health Care Costs and Access (BRC). One of the sixteen recommendations issued by the Commission in January 2007, stated: "Become a leader in the prevention and management of chronic illness."

The 2008 Legislature passed Engrossed Second Substitute Senate Bill (E2SSB) 5930 (enacted as chapter 259, Laws of 2007) which implemented many of the Commission's recommendations. This legislation directed the Department of Social and Health Services (DSHS), in collaboration with the Department of Health (DOH), to design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. In addition, the DSHS was directed to evaluate the effectiveness of current chronic care management efforts in the Health and Recovery Services Administration (HRSA) and the Aging and Disability Services Administration (ADSA).

The legislation also directed the Health Care Authority (HCA), in collaboration with DOH, to design and implement a chronic care management program for state employees enrolled in the state's self-insured Uniform Medical Plan.

In addition, the Legislature passed Engrossed Second Substitute House Bill (E2SHB) 2549 (enacted as chapter 295, Laws of 2008). The legislation directed the DOH to establish a medical home collaborative pilot project, based on the collaborative model, to implement medical homes for addressing chronic care management programs.

The agencies will report on their activities and results in a separate report to the 2009 Legislature.

Disease Management Survey Response Summary

2007 Status Report

The initial status report, completed in January 2007, described how health care plans / insurers, clinics, and state agencies were implementing disease management programs (http://www.hca.wa.gov/leg_reports.html). The results of the 2006 comprehensive survey indicated multiple disease management approaches were being implemented in the state.

The 2006 survey tool was divided into seven sections: Program Description, Integration, Population, Data, Staffing, Costs, and Reporting. Results for each of these sections were summarized by Health Plans, Health Care Clinics, and State Agencies.

Disease Management information was requested for the following chronic diseases: asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), cardiovascular disease (CVD), depression, diabetes, drug abuse, muscular skeletal, high risk obstetrical and neonatal intensive care (HROB/NIC), human immunodeficiency virus (HIV), obesity, oncology, and other. (See 2007 Disease Management report: http://www.hca.wa.gov/leg_reports.html.)

Observations in the 2007 Disease Management Status Report included:

- Disease management programs were being implemented statewide through multiple venues and using multiple models. A lack of an integrated approach limited the ultimate impact on the population's outcomes. Traditional disease management programs focused on a specific chronic disease and may or may not address the multiple medical issues and other complications of that disease. This narrow scope of focus could limit the ultimate impact on the individual patient's outcomes.
- Many organizations, health plans, health care clinics, and state agencies were transitioning to the chronic care model, which addresses the co-morbidities of chronic diseases through an organizational approach to caring for people with chronic disease in a primary care setting.
- Many health plans / insurers, state agencies, and most health care clinics participated in DOH's Collaborative to improve health outcomes in individuals with asthma, diabetes, and heart disease.
- In 2007, Disease Management program participation for health plans and health care clinics totaled approximately 200,000 persons.

2009 Status Report

The HCA developed a Request for Information (RFI) which was submitted to the health plans / insurers, health care clinics, and state agencies to describe changes in their Disease Management programs since 2007. Organizations were requested to use the 2006 RFI form if responding for the first time or if new programs were initiated since completing the 2006 RFI form. Thirty health insurance carriers, health care clinics, and state agencies were sent the RFI.

The 2008 survey tool was divided into three sections: Summary of changes to Disease Management Program, Data, and Other/Additional Comments. (See detailed responses in Appendix E.)

The survey identified that disease management programs and strategies in Washington have improved and expanded since the completion of the 2007 Disease Management Report. By 2008 most health plans / insurers, health care clinics, and state agencies have moved from individual disease management programs to the "chronic care" or "planned care" model, both of which integrate multiple chronic conditions.

The availability of electronic medical records (EMR) and health risk assessments (HRA) improved identification of potential disease management candidates. Health plan / insurer enrollment in disease management increased to approximately 440,000 persons in 2008, compared to 180,000 in 2006, which represents a 250 percent increase. Health care clinic disease management participation increased from 14,443 persons in 2006 to 75,094 in 2008, representing a 500 percent increase.

Conclusion

Based on information contained in this report (Appendices D and E), it is clear that the treatment of chronic diseases, especially asthma and diabetes, has greatly improved in our state in the past two years. The health plans / insurers, clinics, and state agencies responsible for implementing improved methods for treating chronic diseases have changed their focus from treating a specific disease to addressing the associated co-morbid conditions.

Health plans / insurers, health care clinics, and state agencies are expanding chronic disease programs. State agencies are collaborating on various legislatively mandated projects. Examples include medical homes for the aging and disabled with chronic diseases, and children with special health care needs. Many plans have implemented HRAs which enable them to identify enrollees at risk for a chronic disease.

A number of health care clinics and health plans have instituted electronic health records. The availability of this data on an immediate basis is used to identify potential chronic disease patients, allow medical staff and patients to track test results to better manage their care, and measure the return on investment for the health care clinics and health plans. Chronic disease management requires comprehensive, sophisticated Health Information Technology (Health IT). The quality of these programs will be dependent

upon the capability of the Health IT systems implemented by the health plans / insurers and health care clinics.

The Puget Sound Health Alliance Community Checkup Report measures the consistency with which medical practices provide services known to be effective to promote better health, especially for people with chronic conditions such as diabetes, heart disease, and depression.

The Washington State Medical Association's Washington State Medical Education and Research Foundation published clinic practice guidelines to assist physicians treating specific chronic diseases.

In summary, much has been achieved in advancing the Governor's goal of "Better management of those with chronic illnesses."

APPENDIX A

Glossary of Terms and Acronyms

BH - Basic Health. The HCA state-subsidized low-income health program.

Case Management - A method of managing the provision of health care to members with high-cost medical conditions. "Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communications and available resources to promote quality, cost-effective outcomes and occurs across a continuum of care, addressing ongoing individual needs" rather than be restricted to a single practice setting. When focused solely on high-cost inpatient cases, it may be referred to as large case management or catastrophic case management.

CDEMS - Chronic Disease Electronic Management System was developed by the Washington State Diabetes Control Program in 2002. CDEMS is a database application designed to assist care providers and management to track the quality of care provided to patients. CDEMS is provided at no cost to the clinics.

CDEMS is the upgrade to Disease Electronic Management System (DEMS) that allows clinics to track additional health conditions.

CHF - Congestive Heart Failure.

Chronic Disease - A disease having a slow onset and lasting for a long period of time.

Chronic Care Model (CCM) - An organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidence-based interactions between an informed, activated patient and a prepared, proactive practice team. This model emphasizes evidence-based, planned, integrated collaborative care.

Clinical Guidelines - Systematically developed statements to assist practitioners' and patients' decisions about health care to be provided for specific clinical circumstances.

Co-morbid - Existing simultaneously with and usually independently of another medical condition.

COPD - Chronic Obstructive Pulmonary Disease.

CVD - Cardiovascular Disease.

Disease Management Program (**disease management**) - A program of health care specific to a designated population (i.e., diabetic patients), offering an organized, systematic pathway to guide clinicians and patients through predetermined steps to measurable outcomes. The program encompasses five elements: clinical guidelines, a coordinated delivery system, health care provider support, patient support and education, and outcomes management.

The process of intensively managing a particular disease. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. Similar to case management, but more focused on a defined set of diseases.

Electronic Health Record (EHR) – Electronically stored information about an individual's health history, treatments, and other related information held by a health care provider. An EHR may include information in a variety of forms such as X-rays or computerized scan results, and EHRs of varying sophistication are possible. Some capabilities offered by EHRs include viewing patient medical histories, ordering prescriptions and lab work, and treatment advisory functions. These records are sometimes also referred to as electronic medical records or EMRs.

The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

Electronic Medical Record (EMR) - A medical record in digital format. In health informatics, an EMR is considered by some to be one of several types of EHRs. The term has sometimes included other Health Information Technology systems which keep track of medical information, such as a practice management system which supports the electronic medical record.

ESRD - End Stage Renal Disease.

Health information technology (Health IT) - Comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of Health IT will: improve health care quality; prevent medical errors; reduce health care costs; increase administrative efficiencies; decrease paperwork; and expand access to affordable care.

HO - Healthy Options. The DSHS/HRSA managed health care program.

Medical Home - A phrase for patient-centered care, making sure enrollees/clients have a single accessible source of primary care, medical oversight, and timely information.

National Committee for Quality Assurance (NCQA) - An independent, 501(c)(3) non-profit organization whose mission is to improve the quality of health care. The organization develops and manages health care measures that assess the quality of care provided to patients by commercial and Medicaid managed health plans.

NCQA-Disease Management - NCQA offers accreditation for organizations that offer comprehensive Disease Management programs with services to patients, practitioners, or both.

NICU - Neonatal Intensive Care Unit.

PEBB - Public Employees Benefits Board. The HCA program that contracts for employee benefits, including health care.

Planned Care Model - An organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidence-based interactions between an informed, activated patient and a

prepared, proactive practice team. The Planned Care Model emphasizes evidence-based, planned, integrated collaborative care. (Same as the Chronic Care Model.) For more information, go to the DOH web site:
http://www.doh.wa.gov/cfh/WSC/model_info/default.htm

PSHA - Puget Sound Health Alliance. The Puget Sound Health Alliance is a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost increases across King, Kitsap, Pierce, Snohomish, and Thurston Counties.
http://www.pugetsoundhealthalliance.org

PEHP - Public Employees Health Plans, includes Uniform Medical Plan and Aetna Public Employees Plan of Washington.

SKCPHD - Seattle King County Public Health Department.

Washington State Collaborative (Collaborative) - A systematic approach that engages primary care organizations and their patients with chronic diseases in changing the care system from an acute care model to a model designed to manage chronic disease.

WSMA - Washington State Medical Association.

WSM-ERF - Washington State Medical Education and Research Foundation.
http://www.wsma.org

APPENDIX B

2009 Disease Management Matrix

Health Plans / Insurers	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular Skeletal	HIV	NICU	Obesity	Oncology	Other
Aetna, Inc.	x	x	x	x	x	x	x	x	x	x		x	x	x
CIGNA Health Care	x		x	x	x	x			x			x		x
Columbia United Providers	x		x		x									
Community Health Plan of Washington	x					x								
Group Health	x	x	x			x	x			x				
Kaiser Permanente Northwest	x	x	x			x	x							x
Molina Healthcare of WA	x		x	x		x								
PacifiCare/United Healthcare of WA		x	x			x								
Premera Blue Cross	x		x	x	x	x	x		x				x	x
Regence BlueShield	x	x	x	x	x	x								
PEHP - Uniform Medical Plan & Aetna Public Employees Plan of Washington*		x	x			x								x
Uniform Medical Plan	x			x										

Health Care Clinics	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular Skeletal	HIV	NICU	Obesity	Oncology	Other
Everett Clinic	x	x	x			x								**
Franciscan Medical Group						x								**
MultiCare Medical Group						x								**
Overlake Medical Group														**
The Polyclinic														**
Rockwood Clinic						x								**
SeaMar Community	x					x								

Health Care Clinics	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular Skeletal	HIV	NICU	Obesity	Oncology	Other
Health Clinics														
Swedish Physicians	x					x								**
University Medical Neighborhood Clinics						x			x					**
Wenatchee Valley Clinic														**
Yakima Valley Farm Workers Clinic	x													

State Agencies	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular / Skeletal	HIV	NICU	Obesity	Oncology	Other
Department of Corrections														***
Department of Veterans Affairs														***
Labor and industries														***
DSHS - Health and Recovery Services Administration/Fee For Service														**

* - Under development
** - Participate in DOH WA State Collaborative
*** - Case manage chronic diseases
CHF - Congestive Heart Failure
CVD - Cardiovascular Disease
COPD - Chronic Obstructive Pulmonary Disease
ESRD - End Stage Renal Disease
HIV - Human Immunodeficiency Virus
NICU - Neonatal Intensive Care Unit

APPENDIX C

2007 Disease Management Matrix

Health Plans / Insurers	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular Skeletal	HIV	NICU	Obesity	Oncology	Other
Aetna, Inc.	x	x	x	x		x	x		x	x			x	x
CIGNA Health Care	x		x	x	x	x			x			x		x
Columbia United Providers	x		x											
Community Health Plan of Washington	x					x								
Group Health	x	x	x			x	x			x				
Kaiser Permanente Northwest	x	x	x	x	x	x	x	x	x		x			
Molina Healthcare of WA	x		x	x		x								
PacifiCare of WA	x	x	x	x	x	x	x				x		x	
Premera Blue Cross	x	x	x						x				x	x
Regence BlueShield	x		x	x		x			x					x
Uniform Medical Plan*	x											x		x

Health Care Clinics	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular Skeletal	HIV	NICU	Obesity	Oncology	Other
Franciscan Medical Group			x			x								**
MultiCare Medical Group						x								**
Overlake Medical Clinics						x								**
The Polyclinic			x			x								**
Swedish Physicians						x								**
University Medical Neighborhood Clinics						x								**
Wenatchee Valley Clinic						x								**

State Agencies	Asthma	CHF	CVD	COPD	Depression	Diabetes	ESRD	Drug Abuse	Muscular Skeletal	HIV	NICU	Obesity	Oncology	Other
Department of Corrections														***
Department of Veterans Affairs														***
Labor and Industries														***
DSHS - Health and Recovery Services Administration/Fee For Service	x	x		x			x							****

* - Under development
** - Participate in WA State Collaborative
*** - Case manage chronic diseases
**** - 1/2007 Chronic Care Management Program begins
CHF -Congestive Heart Failure
CVD - Cardiovascular Disease
COPD - Chronic Obstructive Pulmonary Disease
ESRD - End Stage Renal Disease
HIV - Human Immunodeficiency Virus
NICU - Neonatal Intensive Care Unit

APPENDIX D

Summary of Survey Responses by Category

1. Health Plans/Insurers

Twelve health plans/insurers were sent the RFI Update survey and 100% responded. Eight of the managed care health plans/insurers surveyed currently contract (*) or have contracted (**) with the HRSA Healthy Options, the Public Employees Benefits Board (PEBB), or the HCA Basic Health (BH) programs. Other health plans surveyed have a share of the commercial health care market in Washington.

The following health plans/insurers were sent the survey:

Aetna Health Care (AHC) **
CIGNA Health Care (CHC)
Columbia United Providers (CUP)*
Community Health Plan of Washington (CHPW)*
Group Health Cooperative (GHC)*
Kaiser Permanente NW (KP)*
Molina Healthcare of WA (MHW)*
PacifiCare/United Health Group*
Premera/BC of WA/AK (PBC)**
Regence BlueShield (RBS)*
Public Employee Health Plans – PEBB self-insured plans
- Uniform Medical Plan (UMP)
- Aetna Public Employees Plan of Washington (APEPW)

2008 RFI Health Plan/Insurer Response Summary

- Disease management participation increased from approximately 180,000 persons in 2006 to approximately 440,000 in 2008, a 250% increase.
- The plans reported that most of the elements of their Disease Management programs remain the same.
- Most of the plans moved to the chronic care model, which integrates co-morbidities.
- The large plans (Aetna, CIGNA, Group Health, Kaiser, Regence) have expanded their Disease Management programs to include other chronic illnesses, i.e., depression, obesity, oncology.
- In 2007, Aetna launched The ActiveHealth Program, a NCQA accredited DM program.
- In August 2008, PEHP awarded a contract for all UMP and APEPW enrollees.
- UMP initiated an Asthma/COPD Disease Management program April 2007 (UMP enrollees only).

- Group Health initiated use of a vendor, Aviva, for planned care outreach to its patients seen by a network of contracted providers. Group Health's Disease Management/Chronic Care model was already in place.
- Many plans use a Health Risk Assessment to identify potential disease management candidates and to collect data.
- Aetna, CIGNA, and United Healthcare used collected data for Return on Investment (ROI) metrics.
- Two health plans, Group Health and Kaiser, use EMR to identify potential candidates and collect data.
- Five of the eight state-contracted plans have National Committee for Quality Assurance (NCQA) accreditation for Medicaid (Molina), Commercial (Group Health, Kaiser Permanente, PacifiCare of WA/United Heath Group), and Medicare (Group Health, Kaiser, PacifiCare of WA). Aetna and CIGNA are not NCQA accredited in Washington, but have NCQA accreditation in other states.
    - In 2007, NCQA expanded its Quality Improvement disease management standards for managed care organizations (MCO) accreditation. NCQA also added Complex Case Management.
    - United Healthcare Services, ActiveHealth Program, and Kaiser Permanente Care Management Institute have obtained disease management accreditation through NCQA.

2. Health Care Clinics

A representative sample of health care clinics, based on size, location, and population, were sent the survey. Ten of the twelve clinics contacted, 83%, responded. Seven health care clinics responded in 2006.

	2007 Report	2009 Report
Everett Clinic (EC)	No	**Yes**
Franciscan Medical Group (FMG)*	**Yes**	**Yes**
MultiCare Medical Group (MCMG)*	**Yes**	**Yes**
Overlake Medical Clinics (OMC)*	**Yes**	**Yes**
The Polyclinic (PC)*	**Yes**	No
Rockwood Clinics-Spokane (RC)*	No	**Yes**
SeaMar Medical Clinics (SMMC)*	No	**Yes**
Swedish Physicians (SP)*	**Yes**	**Yes**
University Medical Neighborhood Clinics (UMNC)*	**Yes**	**Yes**
Vancouver Clinic (VC)	No	**Yes**
Wenatchee Valley Clinics (WVC)*	**Yes**	No
Yakima Valley Farm Workers Clinics (YVFWC)*	No	**Yes**

*Participate in DOH Collaborative

2008 Health Care Clinics Disease Management Survey Response Summary

- Responding health care clinics reported participation in clinic disease management programs increased from 14,443 persons in 2006 to 75,094 in 2008, a 500% increase.
- The health care clinics reported that most of the elements of their disease management programs remain the same.
  - Primary focus is on Asthma and/or Diabetes programs.
  - Everett Clinic includes Congestive Heart Failure and Cardiovascular Disease programs.
- Most large health care clinics have disease management programs and participate in health plan disease management programs.
- Multiple health care clinics adopted the Chronic Care Model (see Glossary).
- Most large health care clinics continue to participate in the DOH Collaborative on chronic disease.
- Many clinics have implemented, or have scheduled implementation of, electronic health records.
- Franciscan Medical Group expanded its disease management program to its entire primary care population.
- MultiCare expanded disease management of diabetic patients to all clinics in the MultiCare Management Group in 2008.
  - MultiCare intends to expand to CHF, Asthma, Depression, and other chronic illness as time and resources allow.
- Sea Mar Community Health Centers has a care coordinator project. Care coordinators work with patients with chronic and behavioral health conditions to help patients access resources and case management support.
- UWMC physicians who meet or exceed the clinical outcomes for patients under their care receive recognition through the NCQA Diabetes Physician Recognition Program (DPRP).
  - 28 physicians have achieved NCQA DPRP recognition.

3. State Agencies

The state agencies addressed in this survey included:

Department of Corrections (DOC)
Department of Health (DOH)
Department of Social and Health Services/Health Recovery Services Administration (DSHS/HRSA)
Department of Veteran Affairs (DVA)
Health Care Authority (HCA)
Labor and Industries (LNI)

Overview

Depending upon their mandate, population, and demographics, state health care purchasing agencies treat chronic diseases by using clinical guidelines, case management, and/or disease management programs.

Department of Corrections

The DOC facilities are in the process of seeking national accreditation from the American Correctional Association (ACA). Some of the health care standards address the management of chronic and communicable diseases. To meet these standards DOC has: made national guidelines and other resource material available to staff as reference; and developed policies and procedures, forms, and processes to schedule follow-up visits and specialty referrals when clinically indicated.

Department of Health

The DOH does not purchase health care services. However, it works with primary care organizations and plans to improve outcomes of chronic disease through the Washington State Collaborative (Collaborative).

The Collaborative, as indicated in the 2007 Disease Management Report, was exploring expansion of its scope. After consultation with health plans, state agencies, professional associations, primary care providers, and quality improvement organizations, DOH changed the structure of the Collaborative to focus efforts on reaching practices with 5 or fewer providers. In addition, the Collaborative is now co-led with DSHS in partnership with the University of Washington, adding pediatrics to the previous adult focus.

The Collaborative's sixth cycle, The Washington State Collaborative to Improve Health, focuses on adults and children. Providers are enrolled in 1 of 5 clinical focus areas: Diabetes; Hypertension; Asthma (children or adults); Obesity treatment and prevention for children; and Medical Homes for children with special health care needs. There are 2,665 patients in the pilot populations in 32 practices enrolled.

The Chronic Disease Electronic Management System (CDEMS) registry is given to providers to assist them to deliver better population-based care and practice evidence-based preventive medicine. Currently there are 119 primary care offices in Washington

and 1,284 providers that use CDEMS to track the outcomes of one or more diseases. There are 67,632 patients in these registries. Fifty-one of the clinics reported tracking 6,435 Medicaid patients in its registry.

E2SSB 5930 directed the HCA, in collaboration with the DOH, to design and implement a chronic care management program for state employees enrolled in the state's self-insured Uniform Medical Plan. In 2008, the DOH participated with UMP to read and score the applications submitted for the chronic disease management program contract for UMP enrollees. The 2008 Public Employees Health Plan contract was awarded to Aetna's ActiveHealth Program.

Department of Social and Health Services/Health and Recovery Services Administration

Engrossed Second Substitute Senate Bill (E2SSB 5930) directed the Department of Social and Health Services, the Health and Recovery Services Administration/Fee For Service, and Adult and Disability Services Administration to design and implement medical homes for their aged, blind, and disabled clients in conjunction with chronic care management programs, and evaluate chronic care management efforts for the medical and long-term care programs.

Beginning January 1, 2007, HRSA/FFS implemented a Chronic Care Model (CCM) program, with the aim of identifying high-risk clients with expensive chronic conditions as they emerge. The aim is to ensure that those patients will get faster, more appropriate care. The new program is administered by two vendors under state supervision. United Health Group's AmeriChoice received the contract for the statewide application of Chronic Care Management and provides case management to all of the identified clients outside King County. AmeriChoice will use "predictive modeling" to identify the highest risk population. The King County Local Care Management Service, which operates within Seattle Human Services Department's Aging and Disability Services, was awarded the local care management contract. It took the King County clients identified as high risk by AmeriChoice and provide case management and "medical home" infrastructure services. The program was designed as a randomized control trial and the evaluation is due in December 2008.

In addition, HRSA/FFS and the DOH are working together on designing and implementing medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness.

HRSA also contracts with managed health care plans through its Healthy Options (HO) program. The HO contract requirements are based on the federal Balanced Budget Act of 1997 requirements. Contracted managed care organizations are required to have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special needs, which includes chronic diseases.

Department of Veterans Affairs

The Department of Veterans Affairs (DVA) disease management is managed by a Medical Director at each DVA facility with the assistance of a resident care team consisting of nurses, dietitians, occupational therapists, pharmacists, and other adjunct health care staff. Treatment decisions are made individually using national guidelines and other accepted care modalities related to long-term care. Registered Nurses and other professional staff are utilized as part as the comprehensive care plan. Hepatitis C, AIDS, and other infectious diseases are handled through infection control protocols managed by infection control nurses. The Departments of Nursing at the three Veterans Homes are responsible for monitoring the residents' disease process.

Health Care Authority

The PEBB and the Basic Health programs managed health care contracts have disease management requirements. Through 2007, the PEBB and BH contracts were audited using criteria based on the National Committee for Quality Assurance (NCQA) quality standard requirements, which included disease management. The 2007 and 2008 BH contracts retain the use of those standards in the monitoring process. The 2007 and 2008 PEBB contracts have specific disease management program and reporting requirements. The contractors are required to provide reports of the top five diseases or chronic conditions of PEBB members. These top five disease or chronic conditions are identified by total cost of care for all PEBB members with the disease or condition.

The PEHP includes the UMP and the APEPW. The UMP is HCA's self-insured medical program. The UMP and APEPW disease management activities are addressed in the Health Plan/Insurer Survey Response section.

The Community Health Services (CHS) program contracts with 36 not-for-profit health organizations (community health clinics with over 140 delivery sites) located throughout the state to provide medical, dental, and migrant health care services. CHS contractors include independent community clinics, hospital districts, health departments, community-based university clinics, and tribal clinics. The CHS program provides state funded grants to support basic quality, preventative, chronic, and urgent/emergent family-oriented medical and dental services. CHS does not have any disease management requirements at this time. However, for the 2007 grant cycle, CHS asked all the contracted clinics to report their top three diagnoses and what programs or initiatives they have in place to address those diagnoses and the identified needs.

Department of Labor and Industries

The Department of Labor and Industries does not perform or purchase disease management. However, it has the Occupational Health Services Project (OHS), which is a communitywide quality-improvement intervention implemented through Centers of Occupational Health and Education (COHEs). The pilot study is a community-based effort to improve occupational health services for injured workers. It will specifically test the ability to use education and incentives to decrease disability. The pilot uses occupational health leaders to increase the occupational health skills and knowledge of providers who treat injured workers.

4. Other

The Puget Sound Health Alliance (PSHA)

PSHA issued two clinical papers on diabetes and cardiovascular disease in 2006. PSHA has since released reports on major depressive disorder, asthma, low back pain, prevention, and generic prescription drugs. In February 2008, PSHA released its first Community Checkup Report. The report measures the consistency with which medical practices provide services known to be effective to promote better health, especially for people with chronic conditions such as diabetes, heart disease, and depression. The second Community Checkup is scheduled for late 2008 and will include a new measure on asthma. The Community Checkup was developed by the Puget Sound Health Alliance to measure certain aspects of care provided by medical groups located in King, Kitsap, Pierce, Snohomish, and Thurston Counties in Western Washington. PSHA has no plans to initiate a disease management program.

Washington State Medical Education and Research Foundation (WSM-ERF)

WSM-ERF completed guidelines for asthma, community acquired pneumonia, and pharnygitis. WSM-ERF had a two-year grant to fund a quality improvement program providing for the creation of physician performance reports and patient registries related to chronic and preventive care. It completed the grant and tested it with three clinics, but was unable to secure funding for full implementation.

APPENDIX E

Request for Information
Survey Responses by Respondent

Substitute Senate Bill 5841
2008 Disease Management Request For Information
(Health Plan, Agency, Clinic Name)

Current Program Name:
Date Started:

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☐Yes ☐ No

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1. *Summary of changes to Disease Management Program*
2. *Data*
   a. *What data do you collect?*
      (e.g. claims, customer service, etc.)
   b. *What are the specific measures of program success?*
   c. *What outcomes were achieved as a result of the program*
3. *Other/Additional Comments*

Substitute Senate Bill 5841
2007 Disease Management Survey Questionnaire
(Health Plan, Agency, Clinic Name)

Current Program Name:
Date Started:
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

1. ***Integration –***
   a. *Describe how the program is integrated with treating provider(s)?*
      (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. *Do you stratify risk for the intervention group?*
   c. *Are there incentives?*
   d. *Please indicate if the program is based on a client focused intervention or a provider focused intervention*
   e. *Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?*
   f. *Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)*
   g. *Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.*
2. *Population –*
   a. *What is the total population targeted?*
   b. *How are enrollees identified for the program?*
   c. *At the present time, how many are in your program?*

d. *How many may have been in your program?*

e. *What is the eligible population?*

3. *Data*

d. *What data do you collect?*

- *(e.g. claims, customer service, etc.)*

e. *What are the specific measures of program success?*

f. *What outcomes were achieved as a result of the program*

4. *Staffing*

a. *How many administrative staff are required?*

b. *How many clinical Staff?*

c. *What is the expected staff to patient ration?*

5. *What is the total cost? (contract or staffing/overhead)*

6. *Reporting*

What are the metrics used for reporting current statistics?

Request for Information Responses – Health Plans

Current Program Name: Aetna, Inc.
Date Started: *January 2007*

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒Yes ☐ No

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1. *Summary of changes to Disease Management Program*

We have had several additions and improvements to our DM program:

- *New chronic conditions, including pediatric conditions. We now offer 39 diseases in our program.*
- *Three different engagement levels for support*
  - *supportive monitoring*
  - *active monitoring*
  - *active monitoring with nurse engagement*
- *Separate programs to address other issues:*
  - *Medical Psychiatric Case Management*
  - *Depression Disease Management Program*
  - *Alcohol Disease Management Program*
  - *Anxiety Disease Management Program*
- *Incentives for those who enroll in the program*
- *Updated our staffing counts*
- *Updated customer reporting available for outcomes of DM programs*
- *Updated population counts within the program*

2. *Data*
   a. *What data do you collect? (e.g. claims, customer service, etc.)*
   b. *What are the specific measures of program success?*
   c. *What outcomes were achieved as a result of the program*

a. Updated data we collect to include Health Risk Assessment information
b. No changes.
c. Updated clinical outcome and ROI data

3. *Other/Additional Comments*

Current Program Name: Aetna, Inc**. Aetna Health Connections Disease Management (AHC-DM) Program**
Date Started: 9/1/2006

Program Description – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services*

The Aetna Health Connections Disease Management (AHC-DM) program revolutionized Aetna's approach to DM by maximizing the use of state of the art technology, promoting integration among all of Aetna's care management and wellness programs and creating a comprehensive member centric approach to the management of chronic conditions. The program delivers superior, individualized interventions that motivate and empower members to engage in risk-reducing behaviors by employing change management and motivational interviewing techniques combined with clinical tools, which are based on national clinical practice guidelines.

Piloted in 2006 and launched in January 2007, AHC-DM serves over 9 million eligible members and currently has more than 1 million members participating in the program. Unlike traditional disease management programs which often focus on delivering targeted education for a single condition, AHC-DM simultaneously provides support for more than 30 conditions and manages co-morbidities based on member need.

Industry-leading CareEngine technology, provided by our wholly owned subsidiary Active Health Management, enables Aetna to *uniquely* identify and risk stratify members for disease management program inclusion. The CareEngine also uses thousands of evidence-based clinical rules applied to each member's claims, pharmacy, lab, and self-reported data to detect potential errors and opportunities to improve care. In near real-time, providers and then members are notified of these opportunities, called Care Considerations.

Aetna relies on a Research and Development team of physicians who constantly scrutinize medical literature to apply science and evidence-based practice guidelines to establish our Care Considerations, identify new conditions and recommend clinical content for DM. Aetna recognizes that member centric strategies are required for successful engagement and has trained staff in motivational interviewing, change theory and successful communication techniques. Focus has been placed on improving the health of racial and ethnic minorities through the use of Spanish speaking staff, Spanish fulfillment materials and program specific modification.

Aetna's disease management program demonstrates the power of information and innovation. AHC-DM uses cutting edge technology, comprehensive member data and state of the art outreach strategies to inspire members to take action in partnership with their physicians and their health plan. It is fully coordinated with Aetna administered programs. For example, as part of our single-nurse model, we established a hierarchy within our programs to identify who the member's primary contact will be when the member qualifies for more than one of our programs. All Aetna clinicians access Aetna's Electronic Total Utilization Management System or "eTUMS" and therefore all clinicians have a comprehensive view of the member. When a member qualifies for both case management and disease management, the case manager will be the primary contact initially. The case manager will coordinate more acute health needs, such as care needed after a hospitalization, through our case management program. The Aetna disease management nurse will shadow the case until the member is ready for disease management. At that time, the case manager will close the case management file and the disease management nurse will become the primary contact.

Future enhancements under consideration include development of a "Participation Index" which will identify members most likely to participate as well as piloting customized messaging based on personal preferences.

Overall member satisfaction for the AHC-DM program in 2007 was 95%. Member satisfaction surveys are conducted on an annual basis.

AHC-DM can be delivered onsite at customer locations. It is the first health plan to offer a disease management program internationally.

Disease States

Our Aetna Health Connections Disease Management program supports more than 30 medical conditions and co-morbidities, including:

- A vascular cluster consisting of diabetes (adult and pediatric), congestive heart failure, coronary artery disease, cerebrovascular disease/stroke, hypertension (adult and pediatric), hyperlipidemia (high cholesterol), and peripheral artery disease
- A pulmonary cluster consisting of asthma (adult and pediatric) and COPD
- A cancer cluster including cancers such as breast, lung, prostate, colorectal, lymphoma/leukemia, and other general cancers
- A gastrointestinal cluster consisting of gastro esophageal reflux disease (GERD), peptic ulcer disease, chronic hepatitis, and inflammatory bowel disease (Crohn's disease and ulcerative colitis)
- An orthopedic/rheumatologic cluster consisting of osteoporosis, osteoarthritis, and rheumatoid arthritis
- A neurological/geriatric cluster consisting of geriatrics, migraines, seizure disorders, and Parkinsonism
- A renal cluster consisting of chronic kidney disease and end stage renal disease
- A comprehensive set of other conditions consisting of cystic fibrosis, HIV, hypercoagulable state (blood clots), chronic low back pain, weight management (adult and pediatric), and sickle cell anemia (adult and pediatric) that vary in prevalence and severity across populations

In addition to the disease states identified above in our AHC-DM program , we also provide the following disease management programs through Aetna Behavioral Health:

- Medical Psychiatric Case Management Program
- Depression Disease Management Program
- Alcohol Disease Management Program
- Anxiety Disease Management Program

1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. The program is integrated with treating physicians in the following manner: • physicians receive personalized member specific Care Considerations so that they may address gaps in care with the member • physicians receive letters when members enroll • members are encouraged to share the plan of care and interventions that the DM nurses have given them with their physicians As described above, AHC-DM is fully integrated with Aetna administered programs. Any Aetna clinician may make a referral to the AHC-DM program on behalf of a member. Likewise, AHC-DM may make a referral to any Aetna administered program. All members are screened for depression, and if applicable, are referred to behavioral health services available in their respective benefit plan.
	b. Do you stratify risk for the intervention group?	b. Risk stratification is based on clinical algorithms embedded within our Clinical Stratification and Identification (CSID) tool and through the use of Aetna's predictive modeling tool, PULSE (Predicted Utilization by Statistical Evaluation). Our system enablement allow members to be prioritized first by medical risk and clinical actionability and then by potential for high cost and high utilization.

	c. Are there incentives?	Members identified for disease management are engaged in varying and progressive levels of intensity, depending upon the severity of their condition(s) and the overall opportunity to impact their health status as measured by a set of clinical stratification and identification algorithms embedded in our CareEngine. Engagement levels include: ▪ Supportive Monitoring: Members receive a toll-free number to access an Aetna disease management nurse 24/7, use of Aetna Navigator, our secure member website, for self-directed learning and bi-annual newsletters. They can also request biometric devices such as, glucose meters, peak flow meters and spacers as needed. ▪ Active Monitoring: Members receive all of the above, plus an introductory and welcome letter, an invitation to call our toll-free number and speak with an Aetna disease management nurse for personalized education and action plans and educational materials as needed. ▪ Active Monitoring with Nurse Engagement: Members receive all of the above plus regular outreach by an Aetna disease management nurse for individualized coaching and education at least on a quarterly basis. The CareEngine's clinical-rules set is continually run against medical claims, pharmacy and laboratory data and member self reported date, allowing for new care improvement opportunities and potential medical errors to be identified and addressed by the program in near real time. Care Considerations are member-specific suggestions for treatment, evaluation or monitoring of a clinical issue, formulated from evidence-based medical literature or established clinical guidelines. Care Considerations result in a physician and member outreach. They can be delivered to members by telephone or letter. Physicians receive them by telephone, fax, letter, or through Aetna's secure provider website via NaviNet, the multi-sponsor health care communication platform from NaviMedix. The method of member and physician delivery depends on the potential severity of the identified consideration. c. Yes. We recognize that our customers are looking for innovative and effective methods to encourage behaviors that will help employees maintain their health and better manage their illnesses and diseases while offering potential cost savings to the employer. To respond to this need, we have created the Aetna Healthy Actions Program, which includes a disease management incentive component to attract employees who normally do not engage or participate in disease management programs, and help motivate participants to change specific health behaviors. When a member is enrolled and actively participating at the active monitoring with nurse engagement program level of our Aetna Health Connections disease management program, the incentive program has the ability to apply incentive dollars directly toward the member responsibility of a medical claim

		during adjudication (deductible/coinsurance) thus reducing the member's out-of-pocket expense. If the member does not use all the dollars and the customer chooses to continue to offer this reward, the member will rollover the balance to the following year. We also offer the following incentive options to our customers: ▪ We can provide a list to the customer who wishes to self-administer an incentive, although the customer must complete the appropriate legal sign-offs related to HIPAA. ▪ We can provide complete incentive administration for the customer at an additional cost, through our Customized Communication Group. This includes managing incentive amounts and distributing incentive rewards such as gift checks, gift certificates, prizes, and tokens (gym bags, pedometers, water bottles, pens, etc.). Participants are able to track their incentives through Aetna Navigator, our secure member website. The site includes an Aetna Healthy Actions program page displaying all eligible, earned, and applied incentives for programs administered by Aetna. With any funding incentive option, customers are responsible for financing the incentive programs they offer.
	d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have co-morbid conditions, (E.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	d. The program is based on member-focused intervention. e. Yes, our AHC-DM program addresses all aspects of the member's health status, managing comorbidities in conjunction with the primary disease conditions. The member is assigned a single nurse who assesses the member for all conditions, identifies deficits, gaps in care and interventions and provides educational activities and materials to close gaps in care and increase the member's knowledge and ability to manage the member's disease(s). f. Nurses encourage members to utilize relevant community-based and state agencies. g. The AHC-DM program was developed by Aetna and in conjunction with our wholly-owned subsidiary ActiveHealth Management. Aetna nurses deliver the AHC-DM program.

2.	Population – a. What is the total population targeted?	a. In a population of 1 million members, approximately 17.5% of the members will be identified with one or more of the conditions managed in AHC-DM. ▪ This estimate is based on data analysis of a million member population and members actually identified. ▪ 82.5% will not be identified but will be reviewed by the Care Engine on an ongoing basis for changes in their condition. ▪ These statistics generally apply for any significantly sized population. In a population of 1 million members, 11.8% will likely be selected for some level of service.
	b. How are enrollees identified for the program?	b. Members are identified through the Care Engine and are stratified by the CSID and PULSE tools. In addition to these tools, identification sources include referrals from other Aetna-administered programs such as our case management and maternity programs, behavioral health, wellness and lifestyle management programs, physicians and family members, or member self-referral.
	c. At the present time, how many are in your program?	c. We had 1,076,167 members participating in the program at the end of 2Q08.
	d. How many may have been in your program?	d. Our reporting captures participation on a cumulative rolling quarter basis. Therefore, we are not able to specifically state how many members have participated in our program. At the end of our first year (2007), we had more than 930,000 unique members participating in our program. As of 2Q08, we have more than one million unique members participating.
	e. What is the eligible population?	e. Approximately 9 million members are eligible for our AHC-DM program.
3.	Data a. What data do you collect? (e.g. claims, customer service, etc.)	a. We collect and use all claims, pharmacy, and lab data, as well as member self-reported data from health risk assessments and data the member reports during member assessments.
	b. What are the specific measures of program success?	b. Each program has clinical outcomes associated with it that are measured. In addition, the program measures an overall return on investment.
	c. What outcomes were achieved as a result of the program?	c. We expect our comprehensive statistical and clinical study for the Aetna Health Connections Disease Management program to be completed year-end 2008. Our initial study performed in March 2008 showed a return of 2.5:1 for customers.

		Other recorded AHC-DM results from our initial study: Reductions in emergency room visits: ▪ 3% - Coronary Artery Disease ▪ 7% - Asthma Reductions in inpatient admits: ▪ 11% – Asthma ▪ 13% – Coronary Artery Disease ▪ 18% – Stroke/CVA We have also seen a 5% decrease in inpatient admissions.
4.	Staffing a. How many administrative staff are required? d. How many clinical Staff? e. What is the expected staff to patient ratio?	a. We currently have 222 administrative staff for our DM program. This includes case management associates, trainers and one training manager. b. We currently have 465 clinical staff for our DM program which includes one medical director, nurses, nurse supervisors/managers, pharmacists, registered dieticians, and one certified diabetic educator. c. We calculate our staff ratios against eligible members, not participating members. Our ratios are: ▪ 1 Registered nurse: 20,024 eligible members ▪ 1 Care management associate: 52,540 eligible members ▪ 1 Registered dietician: 1,000,000 eligible members ▪ 1 Medical director: 250,000 eligible members ▪ 1 Pharmacist: 500,000 eligible members ▪ 1 Supervisor: 188,235 eligible members ▪ 1 Manager: 640,000 eligible members
5.	What is the total cost? (contract or staffing/overhead)	This information is proprietary.
6.	Reporting What are the metrics used for reporting current statistics?	We provide an Aetna Health Connections Disease Management Annual Clinical Outcomes Report that is designed to track the prevalence of conditions, nurse engagement/outreach, and success in meeting key clinical indicators which are markers of quality of care. Data is presented in easy-to-read graphics by condition. The methodology and metrics measure achievement of clinical quality indicators against the enrolled population and the diagnosed population. The enrolled population is those who have a status of enrolled at any point in the reporting period (usually six months). We compare indicators for enrollees between baseline and program completion. The diagnosed population is those who have an opportunity score of at least low (using our Clinical Stratification and Identification System) for a given condition during the reporting period. Measures are taken from self-reported member data, completed health assessments and claims data (with appropriate lags). All indicators are measured in a baseline year and in the measurement period. Examples of some indicators we measure include:

		▪ Vascular cluster clinical indicators: - Appropriate use of lipid-lowering agents - LDL cholesterol monitoring - Met LDL cholesterol target for vascular condition - Met blood pressure target for vascular condition - Use of beta-blockers after heart attack - Non smokers - Diabetes-specific indicators: - Eye exam - HbA1c monitoring - Nephropathy screening - Foot exam - Congestive heart failure-specific indicators: - Appropriate use of ACEI or ARB - Appropriate use of beta blockers ▪ Asthma indicators: - Appropriate use of anti-inflammatory controller medication - Asthma action plan - Non smokers (adult program) ▪ Chronic obstructive pulmonary disease (COPD) indicators: - Appropriate use of long-acting bronchodilator - Non smokers - Participate in exercise or pulmonary rehab program ▪ Peptic ulcer disease (PUD) indicators: - Do not use NSAIDs or aspirin - Tested for H. Pylori ▪ Rheumatoid arthritis indicators: - Appropriate use of DMARDs

Current Program Name: Well Aware—CIGNA (32 conditions)
Date Started: *1999*

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒Yes ☐ No
If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1. *Summary of changes to Disease Management Program*
2. *Data*
   a. *What data do you collect? (e.g. claims, customer service, etc.)*
   b. *What are the specific measures of program success?*
   c. *What outcomes were achieved as a result of the program*

   a. *We now include trend management data from the results of the University of Michigan health risk assessment in our predictive modeling program.*
   b. *We look at quality outcomes in terms of compliance with national guidelines for chronic conditions, health care utilization patterns—particularly decreased utilization of ER and hospital with increased office visits, medication and testing compliance, and customer satisfaction with the program*
   c. *We are calculating a 2-4:1 ROI on program costs based on the methodologies of the national disease management professional organization. We have received an award from this organization for outcomes and satisfaction*

3. *Other/Additional Comments*

We have integrated other member services such as case management and health coaching so that our members have one designated person to deal with in terms of health issues but still allowing them access to the benefits of the different types of interventions.

Current Program Name: New Arrivals Date Started: 2004		
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services The expectation is that Community Health Plan will facilitate early recognition of women with a high probability for delivering at-risk, high cost newborns so that timely intervention can be initiated and outcomes improved. Educational outreach will be offered to all Community Health Plan maternity patients. New Arrivals is a prenatal wellness program offered by Community Health Plan of Washington. The purpose of the program is to provide all eligible expectant members in the prenatal and postpartum stages of pregnancy with additional support, coordination of resources, and ongoing education. The program also offers a high-risk case management program for those members requiring additional supports during their pregnancy. The expectation is that the case manager will assist with facilitating early recognition of women with a high probability for delivering at-risk, high cost newborns so that timely intervention can be initiated and outcomes improved. This program is designed to complement the care the member is already receiving from their Provider and stress the importance of the patient/practitioner relationship to minimize the risk of adverse pregnancy outcome.		
1.	Integration – a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each) b. Do you stratify risk for the intervention group? c. Are there incentives? d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have co-morbid conditions (e.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these	A. New Arrivals Program New Arrivals is a prenatal wellness program offered by Community Health Plan of Washington. The purpose of the program is to provide all eligible expectant members in the prenatal and postpartum stages of pregnancy with additional support, coordination of resources, and ongoing education. The program also offers a high-risk case management program for those members requiring additional supports during their pregnancy. The expectation is that the case manager will assist with facilitating early recognition of women with a high probability for delivering at-risk, high cost newborns so that timely intervention can be initiated and outcomes improved. This program is designed to complement the care the member is already receiving from their Provider and stress the importance of the patient/practitioner relationship to minimize the risk of adverse pregnancy outcome. B. Yes, we stratify. See below. Low acuity, level I: • Members identified with minimal to no risk factors as determined via completion of a telephonic interview process. They are connected to their PCP and or OB/GYN who coordinates their care and are informed and active in the management of their condition. They are connected to their community resources. • Intervention: They will receive educational materials to include the book “Your Journey through Pregnancy”, free car seat, free application assistance with WIC and First Steps. Moderate acuity, level II: Members identified with a • Co-morbid conditions or DME needs. Their connection to their PCP or community resources may be fragmented. There may be cultural, language, psychosocial, or transportation barriers to care. There is some medical plan of care or medication non-adherence concern. • Interventions: Follow-up letter generated to PCP post HRA (Health Risk Assessment); a care plan with intervention recommendations initiated; patient-specific education materials sent

	services. Please include the vendor's name.	according to their needs; referral as necessary to DM team, to community resources; and, if indicated a referral to case management. High Acuity, level III: • The HRA psychosocial assessment data confirms these members have a severe and/or deteriorating chronic condition, multiple co-morbidities, complex care needs, and multiple medications. They may be poorly connected to their PCP and specialists who may not be collaborating on a care plan. There are cultural, languages, psychosocial, or transportation barriers to obtaining services. Community resources have not been accessed. ER use may be high and hospitalizations may be frequent. Care plan and medication non-adherence may be present and could be life threatening. • Intervention: Follow-up letter generated to PCP post HRA. Summary of findings and recommendations is created and sent to the PCP. Patient specific clinical education materials sent. Community resources referral and entitlement assessment. If indicated, CM team referral. • Educational outreach will be offered to all maternity members. ▪ For those members who have particular questions about their pregnancy, ▪ Access is available to an OB nurse 24 hours a day using the toll free baby line 1-800-359-Baby (2229). ▪ Members are provided a book called Your Journey through Pregnancy. ▪ We have also provided additional pregnancy information members can utilize by accessing our web-site. The web-site address is: www.chpw.org c. Yes, there are incentives. Children First™ program. CHP promotes member health through the Children First program. Children First is a health promotion incentive program that emphasizes the importance of prenatal care and children's health and safety. It rewards eligible pregnant moms and children that receive prenatal care, complete well child exams, and are current with their immunizations. The program provides important health information to enrollees and incentives for obtaining preventive health services according to the recommended schedule for prenatal care and well child exams. Incentives, in addition to our existing car seat, bike helmet and "Healthwise" handbook, include a booster seat, welcome baby kit, child cupboard locks and school backpack. d. The program is focused on client interventions with provider integration e. The program integrates with other co-morbid conditions via referrals to the Disease and Case Management programs f. The program integrates with WIC, First Steps, and other maternity or new born State programs g. The New Arrivals program is a combined vendor and Plan run program. The vendor, Matria, contacts and risk screens all pregnant members identified via the State eligibility information. Once the initial triage is completed, those cases needing more intensive interventions are sent to CHP for active assessment, support and interventions as needed
2.	Population –	

	a. What is the total population targeted? f. How are enrollees identified for the program? g. At the present time, how many are in your program? h. How many may have been in your program? i. What is the eligible population?	a. All pregnant members b. Via eligibility notification from the State c. 3,011 d. 10,711 e. 10,771
3.	Data a. What data do you collect? (e.g. claims, customer service, etc.) d. What are the specific measures of program success? e. What outcomes were achieved as a result of the program	a. Claims and encounters b. Prenatal care initiated within the first trimester, pre term birth weight, rate of low birth rate, NICU admission rate and ALOS c. 93.45% of participants initiated care in the first trimester Pre term birth with was 7.18% vs. national pre term birth rate of 12.73% Rate of low birth rate was 5.44% vs., national rate of 8.20% NICU admission rate was 5.64% versus national average of 10% ALOS is expressed as NICU days per 1000 birth were 659, which is below national averages
4.	Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ration?	a. 0.1 Admin staff b. 2 in house at CHP and vendor relationship with Matria c. 1 to 30 in Case Management
5.	What is the total cost? (contract or staffing/overhead)	Proprietary
6.	Reporting: What are the metrics used for reporting current statistics?	See #3

Current Program Name: Community Health Plan Diseases Management Program
Date Started: January 2006

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒*Yes* ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	Summary of changes to Disease Management Program	See Attached updated appendix P78 1c Yes there are incentives 2c. 2034 newly identified members P79 4a. 0.5 FTE 4b. 3.0 RN FTEs
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? What outcomes were achieved as a result of the program	See attached updated Appendix
3.	Other/Additional Comments	

Current Program Name: ***Community Health Plan Disease Management Program*** **Date Started:** January 2006

Program Description – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services* Community Health Plan's Disease Management Programs serves our members with asthma and diabetes. These free and voluntary programs are designed to support our members with a chronic condition, Primary Care Providers (PCP) who work with them, and to reinforce the established provider/patient treatment plan. The CHP Disease Management Program team consists of RNs with physician oversight. We offer our identified members with asthma or diabetes the following services:

- A welcome letter to the program and a HRA with the option of declining to participate
- An initial telephonic intake assessment administered by a RN
- Current evidence based educational materials
- Translation services
- A follow up letter to the PCP detailing current patient concerns after our initial assessment if indicated
- Plan Level Case Management for a patient, if indicated, after consultation with the PCP.

CHP is required to assign 'risk scores' for eligible identified members with chronic disease. Risk stratification is determined through the predictive model in the Plan's Data Warehouse (an aggregated prospective and retrospective risk score from pharmacy and claims data), the Health Risk Assessment (HRA – a tool that is used to catalog, assess, and estimate the probability of an adverse health effect), and direct communication with the patient's primary provider. The assigned acuity levels, based on risk scoring are as follows:

Low acuity, level I:

- These patients have, for example, mild to moderate asthma or well controlled diabetes. They are connected to their PCP who coordinates their care and are informed and active in the management of their condition. They are connected to their community resources.
- Our intervention: They will receive DM biannual newsletter.

Moderate acuity, level II:

- These are patients who may benefit from disease, medication, or safety education. They may have co morbid conditions or durable medical equipment (DME) needs. Their connection to their PCP or community resources may be fragmented. There may be cultural, language, psychosocial, or transportation barriers to care. There is some medical plan of care or medication non-adherence concern.
- Our intervention: A follow-up letter is generated to the PCP after our initial assessment). A care plan consult and intervention recommendations are initiated. Education materials are sent to the patient, parent or guardian. Patients are referred to community resources if it appears they may benefit from these.

High Acuity, level III:

- These patients are likely to have a severe and/or deteriorating chronic condition, multiple co morbidities, complex care needs, and multiple medications. They may require DME and/or custodial care. They may be poorly connected to their PCP and specialists who may not be collaborating on a care plan. There is likely a cultural, language, psychosocial, or transportation barrier to attaining services. Community resources have not been accessed. ER use may be high and hospitalizations may be frequent. Care plan and medication non-adherence is likely present and could be life threatening.
- Our Intervention: A follow-up letter is generated to the PCP after our initial assessment. A care plan consult and intervention recommendations are initiated. A plan level case management (PLCM) consultation is initiated with the PCP. Education materials are sent. There is a community resources referral and entitlement assessment. If indicated, the patient will be referred to other Plan-based services for additional support. The Plan's disease management team does not diagnose conditions, prescribe treatment, or initiate physician treatment plan changes. We will make recommendations to the PCP based on our initial assessment and subsequent information we receive when following up with our member. We will also contact the PCP and/or the PCP's your nurse immediately if a patient safety issue is identified.

1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each) b. Do you stratify risk for the intervention group? c. Are there incentives? d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	a. We offer to the health care provider: • A follow up letter to the PCP detailing current patient concerns after our initial assessment if indicated • Examples of our educational materials • Plan Level Case Management for a patient, if indicated, after consultation with the PCP. b. CHP is required to assign 'risk scores' for eligible identified members with chronic disease. Risk stratification is determined through the predictive model in the Plan's Data Warehouse (an aggregated prospective and retrospective risk score from pharmacy and claims data), the Health Risk Assessment (HRA – a tool that is used to catalog, assess, and estimate the probability of an adverse health effect), and direct communication with the patient's primary provider. c. Incentives are offered for certain behaviors d. Member focused interventions e. Yes – see above f. CHP collaborates with our CHC clinics and providers and many of them are very active in the Diabetes Collaborative. Our Clinical Quality department is very active with our clinics in providing educational materials for diabetes and asthma and collaborates with various vendors to enhance CHP's efforts to improve care for our DM members. The DM program is part of the Care Management department and interacts directly with our members and providers to provide one on one assessment and improve care and member self-management. g. CHP disease management program was developed and is operated by CHP.
2.	Population – a. What is the total population targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	a. Total population is targeted and is approximately 220,000 b. Enrollees are identified by data mining in the CHP Data Warehouse c. Total enrollment 2034 newly identified members d. Current churn rate is ~ 8,000 members per month - which indicates approximately 4% turn over each month. e. Eligible population is estimated at 15,000 – approx 8,000 members with diabetes and 7,000 members with asthma
3.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. The CHP's Data Warehouse contains pharmacy and claims data, the DM team utilizes a Health Risk Assessment (HRA – a tool that is used to catalog, assess, and estimate the probability of an adverse health effect), and direct communication with the patient's primary provider. b. Specific measures of success are improved self-management, coordinated plan of care by PCP with member and family involvement. c. Decreased hospitalization, decreased ER utilization, improved HEDIS results

4.	Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ratio?	 a. 0.5 FTE b. RN – 3.0 FTE c. Expected ratio 1:100
5.	What is the total cost? (contract or staffing/overhead)	Total Cost – proprietary.
6.	Reporting What are the metrics used for reporting current statistics?	Metrics are – for Diabetes and Asthma Monthly 1 – Number of members in each program – diabetes and asthma 2 – Members contacted per month Annual 1 – Hospital days per 1000 2 – Hospital admits per 1000 3 – ER utilization 4 - Pharmacy costs 5 – Member Satisfaction 6 – Provider Satisfaction

Substitute Senate Bill 5841
Disease Management
Group Health Cooperative

Patient-Centered Planned Care at Group Health Cooperative

Overarching philosophy:

In recent years the concept of Disease Management has become widespread in American Healthcare. The four elements of Disease Management (identification of a population with a particular disease, pro-active outreach, evidence-based interventions, follow-up and tracking) are the cornerstone of any form of planned care. Rather than having a series of independent Disease Management programs reaching out to the same patient multiple times, Group Health has and continues to improve the development and use of systems to integrate all of a person's planned care needs together to give patient a more holistic and personalized care experience.

Planned Care Model:

Group Health uses the **Planned Care Model** in its design of its population management programs. The planned care model is predicated on and places high value on evidence based medicine, shared decision making, and stewardship of finite resources. The planned care model is based upon the Chronic Care Model (Wagner et al *MacColl Institute for Healthcare Innovation*) developed at Group Health and contains two key attributes; "*planned proactive care*" and "*opportunistic care*." The planned care model identifies the recommended care for a variety of chronic conditions including but not limited to diabetes, heart disease, asthma, depression, congestive heart failure, hypertension and others. Recommended care is based on evidence based guidelines, and facilitates practitioners' ability to oversee, monitor, and evaluate care through developed systems. Planned proactive care is the establishment of a comprehensive medical plan based on the disease conditions and guided by evidence based clinical practice guidelines. Opportunistic care supports planned proactive care by assuring that care needs are managed regardless of the nature of the encounter. Each and every time a member interacts with the practitioner, the practitioner reviews recommended care to assure all needs are being met. For example, a member with diabetes or heart disease who comes in for a visit related to flu symptoms will also have their care needs for diabetes and/or heart disease assessed to assure they are receiving the recommended care related to their chronic condition. This level of integration for opportunistic population-based care while attending to the member's acute episodic care needs is the crux of the planned care model, a cornerstone of Group Health's Quality Improvement Program. Because of this proactive approach, the planned care model is able to meet the needs of newly diagnosed members, those with multiple chronic conditions, or those who have progressed to a more frail or disabled state.

Identification:

Three things determine a person's planned care needs. First, by knowing someone's age and gender Group Health can offer appropriate evidence-based interventions (such as immunizations, cancer screening). Secondly, completion of the Health Profile Questionnaire is an important step toward identifying and meeting the needs of members enrolled in a population management program such as diabetes or heart disease. Thirdly, for those members with one or more chronic conditions Group Health identifies and tracks planned care needs related to those. Multiple data sources are utilized such as medical records, pharmacy data, lab data and claims data to identify members with particular chronic illnesses (such as those with diabetes, heart disease, asthma, HIV, etc.).

Outreach:

Group Health uses both opportunistic and planned approaches to outreach. Group Health believes that one of the most powerful interventions for improving health care outcomes is member activation and self-management of their chronic conditions and health maintenance and therefore has developed a number of processes aligned with this belief.

The **Health Profile** facilitates member outreach based upon risk factors and member self-reported readiness to change. The Health Profile is a comprehensive, interactive online tool available on MyGroupHealth, the organization's member website. The questionnaire asks about health history, nutrition, exercise, safety practices, health risks, as well as management of chronic conditions including diabetes, heart disease, hypertension, asthma and depression. A multi-prong approach via member magazine, web, health fairs, mailings, are employed to raise awareness of the health profile with ongoing monitoring of completion rates.

Members who receive care at Group Health's owned and operated medical centers which utilize Epic, electronic health record system, may have data that automatically populates the health profile. Correspondingly, information collected in the health profile questionnaire is automatically entered into Epic. The seamless integration of clinically useful and

relevant patient information improves the depth of knowledge the practitioner and health care team has of the member – in advance of a first visit – so that health risks and concerns are known and proactive care planning can immediately begin.

Upon completion of the questionnaire, members receive an assessment identifying areas in need of change and a personalized care plan developed with information therapy and/or referral to programs (i.e. weight management or smoking cessation) specifically targeted to meet the member's health care needs.

In addition, lifestyle coaching is offered. **Lifestyle Coaching** allows members to directly engage and further support the effectiveness of any behavior change associated with the completion of the questionnaire. Lifestyle Coaching telephone services are provided by health care professionals skilled in motivational interviewing. Lifestyle coaching offers support to members with lifestyle risks (tobacco use, stress, weight management, nutrition and exercise needs) with targeted actions based on these risk factors. Coaches offer support, information and assistance to motivate members to make appropriate changes to their lifestyle which will result in improved health. Members who receive a disease impact score of 'good control' or 'fair control' can contact coaches directly for assistance. Members who receive a disease impact score of 'poor control' are contacted by the lifestyle coach. Additionally, a member can be referred to a coach by their practitioner or health care team.

A more intensive level of lifestyle coaching is health coaching. Members who are identified in 'poor control' are assessed to determine if they would benefit from health coaching. Health coaching begins with complex predictive modeling and data analysis using multiple data sources including claims, lab, pharmacy, and utilization, as well as health profile data to stratify the population. The health coach can support a member across the entire continuum of health status, from wellness to medical treatment decision support to chronic condition management. The focus of health coaching is improved disease self-management and risk factor mitigation. Members engaged in personal health coaching receive a welcome kit and targeted outreach written and telephone communications for chronic condition gaps, post hospital discharge, chronic condition prevention updates, flu vaccine reminders, etc.

The health care team or care management staff is also notified of members who are identified in 'poor control'. A secure message is automatically sent into a special in-basket folder alerting the MA/LPN pool staff for members who receive care by group model practitioners and Care Management staff for members who receive care by contracted model practitioners. Staff are instructed to review the member's care to determine if active and appropriate management of diabetes is present, with potential follow-up actions including contacting the patient for clarification of information, arranging for an appointment with the PCP or appropriate meds or tests, or referral to complex case management program.

In addition to health coaching services via completion of the Health Profile, planned care outreach for members who receive care from contracted model practitioners is available through **Avivia**, a contracted vendor. Avivia identifies the diabetes and heart disease and/or heart failure population, assesses care gaps based on personalized data, and conducts outreach and targeted coaching utilizing motivational interviewing with a focus on behavior change to facilitate improved health outcomes. Members are contacted by phone and mail. Health coaching provides an additional focus on disease management. Integrated care for members with chronic disease is provided by Avivia coaches who refer patients with specific clinically-focused questions to their PCP during business hours or Consulting Nurse Services after hours. Avivia coaches refer to Care Management services for any patient in need of catastrophic, complex or short-term care issues, plan of care collaboration or facilitation of DME or alternative care settings.

Birthday letter with health maintenance reminders are sent to all members. Specific health maintenance and preventive care needs including evidence based reminders specific to many chronic conditions such as diabetes, heart disease, hypertension, and asthma are outlined. The letter is designed to identify the most important elements of health maintenance care for specific chronic conditions as well as highlight other preventive health maintenance needs such as heart care, cancer screening, and vaccinations. Through this member outreach activity, Group Health aims to educate, activate, and support members in their chronic disease management as well as preventive health maintenance. Each letter is individualized to assure the member's health maintenance gaps and needs outlined are specific to them. For example, the letter includes a list of guideline recommended activities for diabetes, coronary artery disease, and cancer screening (breast, cervical and colon) as well as lists any overdue individual health maintenance areas applicable to the member. Recommendations may involve medications, lab tests (e.g. HbA1c, microalbuminuria), screening tests (e.g. eye exam, mammography, chlamydia screening), or vaccinations. Members are asked to contact their doctor to discuss and address these recommendations.

Interventions:

Many resources and programs have been developed to support members for management of specific chronic conditions. The programs range from general support to more intensive depending on the patient's care needs. Group

Health has a mature system for developing evidence-based guidelines for all major clinical conditions. We have a comprehensive set of evidence-based interventions for diabetes, heart disease, depression, asthma, cancer screening, children, teens, young adults, and the elderly. We participate in the National Committee of Quality Assurance (NCQA) with their HEDIS measures, but go beyond that to track additional measures in conjunction with our colleagues at Kaiser Permanente and elsewhere around the country. **Clinical practice guidelines** on the management of many chronic conditions, which form the basis for Group Health's population management program, are developed, updated, and distributed to practitioners. Clinical practice guidelines are disseminated on Group Health's intranet, which are accessible to group model practitioners and through the internet for contracted model practitioners.

Products and Kits such as glucose monitoring meters and foot care kits for routine foot care are provided free to Group Health members. A sick day kit, which members are encouraged to obtain before they get sick, provides information needed in the event of the flu or other illness. The kit includes a record sheet, sample packets of broth, Gatorade, and glucose tablets, as well as a thermometer.

Group Health's member website, **MyGroupHealth** at www.ghc.org, contains a rich array of patient self-management tools and resources. The central repository for clinical information about diabetes, heart disease, pregnancy care, and depression is located in the virtual Condition Centers where members can access educational materials as well as interactive health quizzes and online discussion groups facilitated by clinician moderators (CDE RN, pharmacist and registered dietician). For members who receive their care at Group Health owned and operated medical centers, personal health information from the member's visits automatically populates the electronic medical record facilitating direct personal understanding and activates the members towards positive health outcomes. This is particularly useful for members with conditions such as diabetes who can have their HbA1C, blood glucose, lipid, height and weight, and BP results time trended and displayed in a line graph, bar graph, or table format. All of the member's After Visits Summaries are also available on MyGroupHealth, which may include the health maintenance reminders, further supporting and engaging patient activation and self-management.

Group Health's "**Living Well with Chronic Conditions**" class is designed for all patients with chronic diseases, including those in the diabetes, heart care, hypertension, COPD and CHF populations. These workshops are offered throughout Group Health's service area several times throughout the year. Each class covers topics such as diet, exercise, pain, medication management, stress management, goal setting and dealing with emotional challenges. The goal of the program is to help members improve their health and their ability to cope with their chronic condition by setting incremental goals for improvement and working towards them in a supportive environment. Group Health will be testing the use of an online Living Well class beginning in 2009.

Complex Case Management is a primary care based program for members who require a higher level of care coordination and/or complex medical and/or social support. Case management services are centrally managed statewide but locally deployed to patients within the Group Model and to patients receiving care by contracted Network providers. Case management services are provided by RN case managers whose primary function is coordination of an individual's health needs throughout the episode of treatment and across care settings. It is a short-term intervention driven by entry and exit criteria. Case managers work with members with multiple chronic conditions and the member's primary care practitioner to develop a comprehensive care plan with focused interventions. Ongoing evaluation of those interventions and enhancing the member's self-care/self-management skills, and improving care coordination are key outcomes of the program.

Follow-up and tracking:

Responsibility for constantly improving the quality of care at Group Health rests with everyone in the organization, and is not simply delegated to a "Quality Department." Patients are involved at all levels of the organization to help develop better systems of care in ways that meet their needs. Every primary care provider gets regular feedback reports showing how well his or her patients are doing compared to other Group Health providers and national benchmarks with respect to evidence-based planned care interventions. This includes all of the NCQA HEDIS measures plus additional measures considered vital to the health of our enrollees (such as appropriate use of ACE-inhibitors, statins, and aspirin).These data are tracked at the individual provider, clinic, district and regional level, and are separated by different health plans and lines of business within Group Health. Leaders in our delivery system take note of the health of our members, how our providers are doing individually and as a whole.

The Primary Care **Physician Dashboard Report** provides an organization-wide comprehensive performance reporting system for physicians. This standardized report contains measures that are reported to group model and contracted model primary care physicians throughout Group Health's delivery system. As a performance information tool, this

individual dashboard for physicians supports practice improvement and performance management and aligns individual physicians' performance with the organizational goals. Measures on the quarterly Physician Dashboard report focus on the key areas of continuity, access, clinical processes, and quality in prevention, chronic disease, acute care, and use of services. Measures for diabetes population management are included on the report such as the percentage of paneled members with diabetes who had at least one hemoglobin A1c test who met the specific age and time period requirements.

Patient-specific practitioner reports identify members whose care is outside the guideline. These communication tools are distributed to practitioners to serve as point-of-visit reminders so actions can be implemented and care can be returned to within the guideline. The **Planned care exception reports** is a panel management report which lists the members in the practitioner's panel who have diabetes, heart disease, hypertension and other care gaps and the member's status according to the guidelines. The report lists the patients who are not meeting recommended target laboratory result values or who are due soon and/or overdue for recommended health maintenance. Rates for recommended ongoing care items and target laboratory result values by clinic, department, and primary care practitioner are also reported.

Current Program Name: Asthma
Date Started: *1999*

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?

☐Yes ✔ No (see below)

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1. • *Summary of changes to Disease Management Program*
2. *Data*
   a. *What data do you collect? (e.g. claims, customer service, etc.)*
   b. *What are the specific measures of program success?*
   c. *What outcomes were achieved as a result of the program*
3. *Other/Additional Comments*

- *1107 = Health Plan Division*
- *3038 = Group Practice Division*
-
- *4145 = Total Asthma Population*

Current Program Name: Secondary Prevention of Coronary Artery Disease – Disease Management Program
Date Started: 1996

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
X Yes ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	Summary of changes to Disease Management Program	1g. Group Health believes that one of the most powerful interventions for improving health care is patient activation and self management of their chronic conditions and health maintenance and therefore has developed a number of processes aligned with this belief. This includes: • Post Cardiac Event Workbook: New members are offered a copy of *An Active Partnership for the Health of Your Heart*. • Welcome Letter: Newly identified members are sent a welcome letter, which provides an overview of the program as well as available resources to support them. • Group Model Patient Outreach: Medical Assistants conduct telephone outreach to give reminders about labs, reiterate medication instructions and set up appointments. The team RN provides specific interventions in self-management and education about managing the condition. The team pharmacist provides education and counseling regarding medication management. • Planned care outreach for members who receive care from contracted model practitioners is available through **Avivia**, a contracted vendor. Avivia identifies the diabetes and heart disease population, assesses care gaps based on personalized data, and conducts outreach and targeted coaching utilizing motivational interviewing with a focus on behavior change to facilitate improved health outcomes. Members are contacted by phone and mail. Health coaching provides an additional focus on disease management. Integrated care for members with chronic disease is provided by Avivia coaches who refer patients with specific clinically-focused questions to their PCP during business hours or Consulting Nurse Services after hours. Avivia coaches refer to Care Management services any patient in need of catastrophic, complex or short-term care issues, plan of care collaboration or facilitation of DME or alternative care settings. • Information: Members receive a written visit summary of all visits with recommended treatment plans in layman's terms. • MyGroup Health: Patient self-management tools, after visit summaries and resources are offered on Group Health's website. • Classes: Group Health "Living Well with Chronic Conditions" classes are designed for all patients with chronic diseases and offered throughout the State. Group Health was an initial founder of population based registries and development of evidence based

		tools that have been shared locally, nationally and elsewhere. Group Health has long standing relationships with community organizations, participants in collaboratives, collaboration with Kaiser and other health plans, and regularly shares its learnings and welcomes best practice learnings from other organizations. Group Health provides care to its members through either group model practitioners or contracted model practitioners.
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	No change
3.	Other/Additional Comments	Group Health initiated use of a vendor, **Avivia,** for planned care outreach to its patients seen by a Network of contracted providers. See description above.

Current Program Name: CHF Case Management **Date Started:** 1998		
Program Description – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services* This program is designed for RN case managers to provide disease management for Class III, IV CHF patients. The delivery model emphasizes initial face to face visits with telephonic follow up as needed to monitor progress. RNs work in conjunction with cardiology, CIM, PC MDs and approved protocols to manage pts. Pts. are referred to the program by MD, hospitalists, hospital liaison nurses. All patients have primary care provider oversight..		
1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each) b. Do you stratify risk for the intervention group? c. Are there incentives? d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	1a. CHFCMs attempt to see pts. with referring MD for initial encounter after pt. determined eligible for admission. CHFCM is the primary case manager for the pt. during the period the pt. is enrolled in the program. All communication regarding pt. issues/progress/visits comes from CHFCM to referring MD as well as PC team via Epic. Clinic RNs provide supporting role to CHFCM. b. Yes c. No d. Program is based on joint intervention. Client is encouraged to initiate intervention for questions/issues with CHFCM via phone, or secure messaging. Provider visits occur periodically based on disease severity, or on recommendation of CHFCM/ or pt. e. The CHF case managers coordinate with other caregivers regarding the management of comorbid conditions of the CHF patients (e.g., nephrology case management, home care visiting nurses. Efforts are underway to contact every patient with a primary diagnosis of CHF within 48 hours of discharge to ensure a smooth transition and assess whether CHF case management is required/appropriate. The CHFCMs do coordinate with other caregivers regarding the comorbid conditions of the pts. i.e. they closely coordinate care with dialysis case mgrs. They are also designing the situation where the CHFCM will only consult with the complex case manager when the CHF is not the primary dx. f. g. Developed & operated by GH.
2.	Population – a. What is the total population targeted?	2a. Stage 3 & 4 CHF.

	b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	Through referring MD, hospitalists, HLNs, etc. c. Usually around 520 pts. d. We believe there are more patients that may qualify but are not in the program – identification of all patients hospitalized for CHF and a systematic review and assessment for case management eligibility is an improvement strategy initiated in 2008. e. see 2a.
3.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	3a. volumes, geographic area b. Hospital and ER utilization, palliative care admissions, customer satisfaction. c. Data has demonstrated decreased hospital admissions and length of stays, decreased urgent care utilization and more appropriate referrals to palliative care.
4.	Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ration?	4a. Currently no admin. staff b. aprox 6.5 FTE RN c. 120 cases/ FTE
5.	What is the total cost? (contract or staffing/overhead)	5. Aprox. $500K
6.	Reporting What are the metrics used for reporting current statistics?	Service line dashboard report. Improvements in 2008 include quarterly audits to assure a consistent and standardized approach to care is delivered and a patient satisfaction survey is under development for implementation q4, 2008.

Current Program Name: Diabetes – Disease Management Program
Date Started: 1992

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
X Yes ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	Summary of changes to Disease Management Program	Group Health believes that one of the most powerful interventions for improving health care is patient activation and self management of their chronic conditions and health maintenance and therefore has developed a number of processes aligned with this belief. This includes: • Planned care outreach model within the group model care teams: A strategy that involves a systematic review of a specific population's needs and then identifies the appropriate care and follow-up at the individual patient level. • Planned care outreach for members who receive care from contracted model practitioners is available through **Avivia**, a contracted vendor. Avivia identifies the diabetes and heart disease population, assesses care gaps based on personalized data, and conducts outreach and targeted coaching utilizing motivational interviewing with a focus on behavior change to facilitate improved health outcomes. Members are contacted by phone and mail. Health coaching provides an additional focus on disease management. Integrated care for members with chronic disease is provided by Avivia coaches who refer patients with specific clinically-focused questions to their PCP during business hours or Consulting Nurse Services after hours. Avivia coaches refer to Care Management services any patient in need of catastrophic, complex or short-term care issues, plan of care collaboration or facilitation of DME or alternative care settings. • Information Therapy: Members receive a written visit summary of all visits with recommended treatment plans in layman's terms. • Patient Outreach Letters: All adult members in the diabetes population are sent an annual patient-centered letter focused on their health maintenance needs. • Members with diabetes may receive all or part of the Right Track Notebook, a comprehensive patient self-care guide. • MyGroup Health: Patient self-management tools and resources are offered on Group Health's website. • Classes: Group Health "Living Well with Chronic Conditions" classes are designed for patients with chronic diseases and offered throughout the State. Group Health was an initial founder of population based registries and development of evidence based tools that have been shared locally, nationally and elsewhere. Group Health has long standing relationships with community organizations, participants in collaboratives, collaboration with Kaiser and

		other health plans, and regularly shares its learnings and welcomes best practice learnings from other organizations. Group Health provides care to its members through either group model practitioners or contracted model practitioners.
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	No change. See original diabetes program description.
3.	Other/Additional Comments	Group Health initiated use of a vendor, **Avivia,** for planned care outreach to its patients seen by a Network of contracted providers. See description above.

Current Program Name: HIV PROGRAM **Date Started: 1998**		
After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program? *XYes* ☐ *No* If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.		
1.	Summary of changes to Disease Management Program	**Third paragraph under program description should now read:** The HIV specialist coordinates a multidisciplinary team that supports the patient in managing their HIV. Team includes Clinical Pharmacist, HIV Nutritionist, and nursing support for care management services. All Team members specialize in HIV care and complete HIV-related continuing education on a regular basis. **Fourth paragraph should now read:** Program coordination is centralized, but direct care is provided through circuit-riding clinics held on a regular schedule at 7 of our 20 Puget Sound medical centers. This allows patients to receive HIV care as close to their chart-bases as possible
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. OK as is b. **Replace prior bullet "% completed SW outreach contacts" with** "% completed outreach contacts" **AND** **Delete entire "Under review for '07 baseline" addition to list of measure bullets** c. OK as is
3.	Other/Additional Comments	**No other changes to prior submission other than the following:** **"Integration 1d." , first bullet, should now read:** Client Focused Intervention: availability of care management support as well as once yearly outreach contacts to screen for acuity of need in 14 bio-psychosocial domains

Current Program Name: Nephrology **Date Started:**		
After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program? *x☐Yes ☐ No* If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.		
1.	Summary of changes to Disease Management Program	FTE reduction in staff to: 2.5 RN case managers for Nephrology; 1 FTE for pre-dialysis, 1 FTE for dialysis patients, 0.5 for transplants. No longer have a social worker for this program but instead reorganized the social component amongst the nurse case managers and clinical teams.
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	
3.	Other/Additional Comments	

Current Program Name:
Date Started:

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
X *Yes* ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

4.	Summary of changes to Disease Management Program	Overview: ▪ KPNW uses the chronic care model in disease management programs ▪ KPNW has re-organized and centralized most of the case and care management programs and added case management resources under a new department called Clinical Quality Support Services or CQSS with a goal for improved coordination and better ability to support patients with comorbid conditions. This department includes the following RN FTEs: o 16 FTE chronic case management including transitions (post hospital and ED outreach) o 8 FTE diabetes o 3 FTE specialty (trauma, rehab, transplant) o 5 FTE CHF o 8 FTE Population care (current focus is new insulin starts) o Additional FTEs are included as pharmacy resources, program managers/director, and physician mentors) ▪ Costs/resources for other disease management programs which are not centralized in CQSS, such as for the Kaiser Kidney Program, are not captured. ▪ Several of our disease management programs have been certified by NCQA for Program Design (a National certification for KP; these include diabetes, CAD, CHF, asthma). ▪ All members are eligible for DM services who meet criteria for the particular program regardless of product line or payor. ▪ Registries and clinical practice guidelines are standard resources linked to DM programs. ▪ KPNW provides incentives to practitioners based on organizational goals toward meeting selected HEDIS effectiveness of care measures. ▪ DxCG predictive modeling was done recently in the Northwest Region as a pilot to identify the top 1% of resource intensive members—this included members with the most prevalence chronic diseases such as diabetes, CHF, CAD, asthma. ▪ The Panel support tool, developed to identify care gaps by drawing information and data from the EMR, was implemented in primary care. This enables the health care team (HCT) to be more proactive in addressing all care gaps (including those for prevention and multiple conditions) by both inreach and outreach; therefore making the HCT an important and more effective component of all the disease management programs.

		The Depression Care Management program was discontinued. New agreements were made between Primary Care and Mental Health for managing patients with depression. Mental Health consultants are co-located at many medical offices in the KPNW delivery system.
5.	Data g. What data do you collect? (e.g. claims, customer service, etc.) h. What are the specific measures of program success? i. What outcomes were achieved as a result of the program	Monthly tracking for HEDIS effectiveness of care measures shows significant improvement. KPNW has included in the incentive team payment plans for health plan and medical group employees, a composite measure to improve the percentage of EOC measures above the 90th percentile and to decrease the percentage of measures below the 75th percentile. Additionally other specific measures are included in the incentive plans. The panel support tool helps practitioners and their health care teams to identify all care gaps for all patients in their panel at any point in time.
6.	Other/Additional Comments	**Obesity**: Although we do not have a formal disease management program, we di have evidence based clinical practice guidelines, and have a physician specialist who is championing efforts among adult and pediatric primary care providers, as well as working within the communities in the service areas where we provide care. (Dr. Keith Bachman). The CPGs show the following tools available for practitioners. KPNW Practice Resources • KPNW Utilization Guidelines • KPNW Patient Education Handout • NWP CME • KPNW HealthConnect tools Kaiser Permanente and the Rudd Center for Food Policy and Obesity at Yale University are trying to change the perceptions of health care providers by launching a free online toolkit. Keith is the coauthor of a toolkit called "Preventing Weight Bias: Helping Without Harming in Clinical Practice." It includes handouts, fact sheets, PowerPoint presentations, articles, and group discussion guides. (completed in 2007)

Appendix D-2.F

Substitute Senate Bill 5841
Disease Management
Kaiser Permanente Northwest

• ***Below Threshold*** •	• ***Above threshold***	• ***Above target***	• ***Above stretch***
• *DM poor glucose control* • *% measures above 90th percentile* •	• *Colorectal cancer screening* • *Controlling high blood pressure* • *Diabetes bundle* • ***>>Well child visits 0-15 months*** • *Well child visits 3-6 years* • *Prenatal visits during first trimester* • *7-day follow-up after MH hosp (Apr 08)* •	• ***>>Cervical cancer screening*** • *% measures below 75th percentile* • • *[Breast cancer screening (exec AIP only)]* •	• *A.L.L.* • *Childhood immunizations (combo 3)* • *(now over HEDIS 2007 90th %)* • •

Bold indicates change relative to threshold/target/stretch since last month, with direction indicated by <<arrows>>

- Cervical cancer screening hit target!
- DM poor glucose control and DM glucose screening continue to decline.
- Well child visits age 0-15 months moved above threshold in June. We discovered a minor error in the compilation of visit data for all the well child visit measures, which has been corrected. Well child visits age 3-6 years was incorrectly reported at target last month. All 2008 data reported via Targets and Tools has been corrected.
- Childhood immunizations moved above stretch in April, and above the HEDIS 2007 90th percentile as of June!
- The anti-depression medication "optimal contacts" measure has been removed from 2008 targets, including both composite measures. NCQA has dropped this measure from HEDIS 2009.

<u>Composite measures</u>

- The denominator is now 70 rather than 72, reflecting the removal of the optimal contacts measures. This changes the percentages slightly.
- Percent below the 75th percentile, we improved slightly to 30% (21 measures).
- Above 75th: none
- Below 75th: persistent beta blockers (Comm), controlling high blood pressure (Medicare)
- No longer included: anti-depression medication optimal contacts (Comm, Medicare)
- Percent above the 90th percentile, we moved up slightly to 38.6% (27 measures)
- Above 90th: childhood immunizations (combo 3), CVC cholesterol control (Medicare)

- Below 90th: CVC cholesterol screening (Medicare)

Current Program Name: breathe with ease
Date Started: 2002

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒*Yes* ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	Summary of changes to Disease Management Program	Most elements of this Disease Management program remain the same as the initial report. Item 1g - The most significant change in this program involves the vendor subsystem used to manage our DM database. Pfizer Pharmaceuticals no longer supports the Informacare platform. As a result, Molina Healthcare's Disease Management databases now resides in the Trizetto CareAdvance platform, effective June 2008. This software arrangement is managed through Molina Healthcare's corporate office. Item 2c – The most recent program enrollment across all product lines was 19,858 Item 2e – The age criterion has been expanded to ages 2 and over. (Previously this was ages 2-57)
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	With the exception of augmenting the DTEC measures noted in our initial submission, the data collected for this program's metrics have remained relatively static. The updated set of DTEC metrics include: ➢ Percentage of identified members had a disease specific ER visit during the evaluation period. ➢ Percentage of identified members had a anti-IgE Antibody (omalizumad) prescribed ➢ Percentage of identified members with short-acting beta-agonist (SABA) drug but no controller medication. ➢ Percentage of identified members had no asthma major medication group prescribed. ➢ Percentage of identified members admitted for asthma had no follow-up visit within 45 days of discharge. ➢ Percentage of identified members with an ED visit for asthma did not fill a prescription for a controller medication. The most prevalent demonstration of our outcomes is MHW's continuation in scoring in the 90th percentile for NCQA accreditation scoring standards on the Use of Appropriate Medication for People with Asthma HEDIS measure. This on-going result demonstrates MHW's commitment to the asthmatic population. The revised DTEC measures were selected to supplement the HEDIS measures and indicate areas of continued opportunity in this population.
3.	Other/Additional Comments	

Current Program Name: Heart Healthy Living **Date Started:** 2005		
After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program? ☒*Yes* ☐ *No* If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.		
1.	Summary of changes to Disease Management Program	Most elements of this Disease Management program remain the same as the initial report. Item 1g - The most significant change in this program involves the vendor subsystem used to manage our DM database. Pfizer Pharmaceuticals no longer supports the Informacare platform. As a result, Molina Healthcare's Disease Management databases now resides in the Trizetto CareAdvance platform, effective June 2008. This software arrangement is managed through Molina Healthcare's corporate office. Item 2c – The most recent program enrollment across all product lines was 6,696
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	The Controlling High Blood Pressure HEDIS measure is now used as one of the program's key metrics The updated set of DTEC metrics include: ➢ Percentage of identified members with hypertension had no kidney function testing during the reporting period. ➢ Percentage of identified members with hypertension had a prescription for Thiazide or loop diuretic treatment but no evidence of serum potassium within the previous 12 months. ➢ Percentage of identified members with hypertension had no follow-up visit within 45 days of hospital discharge. ➢ Percentage of identified members with heart failure had no lipid profile during reporting period. ➢ Percentage of identified members with heart failure had a prescription for Thiazide or loop diuretic treatment but no evidence of serum potassium within the previous 12 months. ➢ Percentage of identified members with heart failure had ACE Inhibitor/ARB Treatment, but their serum potassium was not checked. In regards to the HEDIS measure, we again see an increasing improvement in the Controlling High Blood Pressure measure, after specification changes resulted in a re-baselining of this rates in 2007 for the purposes of year-to-year data comparisons. The DTEC results generally followed this same pattern of improvement for the CVD population.
3.	Other/Additional Comments	

Disease Management
Molina Healthcare of Washington, Inc.

Current Program Name: Healthy Living with COPD
Date Started: 2005

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒*Yes* ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	Summary of changes to Disease Management Program	Most elements of this Disease Management program remain the same as the initial report. Item 1g - The most significant change in this program involves the vendor subsystem used to manage our DM database. Pfizer Pharmaceuticals no longer supports the Informacare platform. As a result, Molina Healthcare's Disease Management databases now resides in the Trizetto CareAdvance platform, effective June 2008. This software arrangement is managed through Molina Healthcare's corporate office. Item 2c – The most recent program enrollment across all product lines was 423.
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	The set of DTEC used to monitor this program has been updated as follows: ➢ Percentage of identified members had a disease-specific ER visit. ➢ Percentage of identified members having no follow-up within 45 days of a hospitalization. ➢ Percentage of identified members with two or more office visits for COPD but no COPD-control drug treatment. ➢ Percentage of identified members had at least one exacerbation, but no bronchodilator usage during the reporting period. Results on the DTEC measures have been variable and statistically inconclusive due to small populations within these measures.
3.	Other/Additional Comments	

Current Program Name: Healthy Living with Diabetes
Date Started: 2002

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒*Yes* ☐ *No*

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	Summary of changes to Disease Management Program	Most elements of this Disease Management program remain the same as the initial report. Item 1g - The most significant change in this program involves the vendor subsystem used to manage our DM database. Pfizer Pharmaceuticals no longer supports the Informacare platform. As a result, Molina Healthcare's Disease Management databases now resides in the Trizetto CareAdvance platform, effective June 2008. This software arrangement is managed through Molina Healthcare's corporate office. Item 2c – The most recent program enrollment across all product lines was 4,304
2.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	With the exception of augmenting the DTEC measures noted in our initial submission, the data collected for this program's metrics have remained relatively static. The updated set of DTEC metrics include: ➢ Percentage of identified members had no HbA1c during reporting period ➢ Percentage of identified members had no lipid profile during reporting ➢ Percentage of identified members had no kidney function testing during reporting period ➢ Percentage of identified members had no urine protein test during reporting ➢ Percentage of identified members had no eye exam during reporting ➢ Percentage of identified members had no follow-up visit within 45 days of hospital discharge In terms of outcomes, we continue to see a general improvement in HEDIS results in all of our measured diabetic populations. While we don't always seen the desired increase in all submeasures of the HEDIS Diabetic measure set each year, overall trends show improving compliance rates among our diabetic members. Even with the improvements, the current HEDIS results combined with some variable DTEC results indicate the presence of continued opportunities within our Diabetic populations.
3.	Other/Additional Comments	

Current Program Name: **Coronary Artery Disease (CAD)**

Date Started: UnitedHealth Group has successfully provided disease management (DM) services for 24 years for commercial, Medicare and Medicaid populations. We currently provide DM for over 589,000 beneficiaries throughout the United States.

Program Description* – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services*

The CAD program is designed to reduce unnecessary hospitalizations, health care costs and improve quality of life. Using a sophisticated stratification process, individuals are targeted for interventions based on acuity level and potential for impact. The program provides information and resources CAD patients need to:

- Reduce or eliminate risk factors, such as: high cholesterol, high blood pressure, diabetes, excess weight, obesity, tobacco usage and lack of physical activity
- Maintain a healthy lifestyle and adhere to physician treatment plans and medication regimens including proper use of beta blockers, ACE inhibitors, statins and antiplatelets
- Effectively manage their condition and co-morbidities, including depression
- Receive the most clinically-appropriate, cost-effective and timely diagnostic testing and procedures

CAD program interventions include:

- A focus on compliance with medication regimens and reducing/eliminating risk factors
- Individualized action plans to help program participants to proactively monitor symptoms
- Educational programs that promote good lifestyle choices and self care

CAD high acuity program includes:

- Care opportunities by specialty-trained registered nurses
- Proactive outbound and responsive inbound nurse calls
- Satisfaction and quality-of-life surveys

* *Please note that this program is subject to change annually or semi-annually as necessary.*

1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Disease management (DM) nurses reach out to treating providers when any gaps in care are identified and work with them to increase medications or modify as appropriate for the members condition. Many times we will coordinate conversations between DM medical directors and the treating provider when the situation requires a peer to peer conversation. <u>Roles:</u> DM Nurse/Treating Provider: Actively manage members with specific diseases including coordination of care, resources and treatment. DM Nurse/Case Manager: Coordinate with CM – DM to make sure that all acute and chronic

		conditions are addressed and appropriately managed. (DM for Diseases; CM for acute conditions).
	b. Do you stratify risk for the intervention group?	b. Yes. We use Impact Pro, our proprietary risk modeling and analysis tool to stratify risk data. Impact Pro is a predictive modeling application designed to identify health plan members and beneficiaries who are most likely to develop catastrophic medical or financial outcomes within the next 12 months. Impact Pro uses episodes of care, other disease-based markers and prior utilization as inputs to identify members at risk. Impact Pro performs several functions to support accurate high-risk assessment: ▪ Prospective health risk assessment, which predicts expected future costs and utilization ▪ Identification of members who are most likely to develop catastrophic financial outcomes ▪ Identification of members who are most likely to be hospitalized
	c. Are there incentives?	c. We have utilized incentives in the past for our CM programs (when supported by our customers and allowed by regulatory entities). The Centers for Medicare and Medicaid Services (CMS) currently has restrictions on the use of incentives for Medicare-covered populations.
	d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Yes, it is based on both. Some interventions required collaboration with the provider. Some interventions are able to be addressed with the member/nurse relationship.
	e. Many chronic diseases have co-morbid conditions, (E.g. diabetes/CAD); does the program integrate with other conditions?	e. Yes. Our medical management team will deploy appropriate resources to complement and support the evolving requirements of the direct care system and coordinate care for an integrated beneficiary experience. Our integrated, value-driven approach to care management will combine medical and behavioral care management services into a single program to support the holistic needs of the beneficiary, including those with multiple co-morbidities.
	f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. Yes. Our CAD program uses only those guidelines developed and adopted by nationally recognized sources. The CAD program is supported by the American Heart Association and the American College of Cardiology.
	g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. The CAD Disease Management program is administered internally at Optum Health.
2.	**Population –** a. What is the total population	a. The total population targeted is all Secure Horizons members enrolled in our Medicare Advantage

	targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	(Part C) and Medicare Part D plans. b. We rely on the rules and the process described below to complete data-driven case identification and risk leveling for our medical management programs. **Activity 1: Data Receipt and Validation.** We receive Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant claims, eligibility, and provider data, and load the data warehouse to perform predictive modeling and risk leveling. Our data warehouses are capable of accepting large, line-level claims extracts and have been proven effective in receiving claims outside our internal system from fiscal agents in different state and federal programs. **Activity 2: Claims Analysis.** Upon loading and verification, we run the data through Impact Pro, our state-of-the-art predictive modeling software. Impact Pro allows us to understand the future costs of the beneficiary's care, assign a level of risk associated with future health care costs and determine eligibility for programs and services. Impact Pro data feeds into our CM tool that is easily accessible through point-and-click navigation by our CM and DM staff. **Activity 3: Health Risk Assessment** Conduct health risk assessment, which predicts expected future costs and utilization. c. Total members currently in program: 2,959 d. Total members who have been in program for 2008 so far: 7,723 e. The total eligible population is all Secure Horizons members enrolled in our Medicare Advantage (Part C) and Medicare Part D plans with Coronary Artery Disease (CAD).
3.	**Data** a. What data do you collect? (E.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. We receive Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant claims, eligibility, and provider data, and load the data warehouse to perform predictive modeling and risk leveling. b. Amount of identified opportunities (gaps in care, medication, lifestyle or provider) that are addressed and closed. Ultimately the member reaching their goals Cost savings opportunities for the member, medical cost savings for the client. Member being directed and utilizing all available resources. All appropriate medications being taken at appropriate doses and intervals. All appropriate providers being involved in members overall health. Member is now following a more health lifestyle including weight and smoking cessation. c. ROI is dependent on the individual client's population. Generally, we achieve ROI:1- 2:1.
4.	**Staffing** a. How many administrative staff	a. 1 non-clinical to every 4-5 clinical staff

<table>
<tr><td></td><td>are required?
b. How many clinical Staff?
c. What is the expected staff to patient ration?</td><td>b. CAD – 19 (as of last census on 7/23)
c. Ratios are dependent upon specific client requirements</td></tr>
<tr><td>5.</td><td>What is the total cost? (contract or staffing/overhead)</td><td>We would be happy to discuss this with you pending further information on your specific requirements.</td></tr>
<tr><td>6.</td><td>Reporting
What are the metrics used for reporting current statistics?</td><td>We will report on DM processes, outcomes and savings and provide program profiles that together provide a comprehensive picture of DM program performance and cost. The comprehensive DM report will:

▪ Provide metrics on disease prevalence within the population
▪ Summarize program intervention types to provide insights into beneficiary interaction through
▪ the DM Program
▪ Demonstrate efficacy of DM program interventions on improving both beneficiary behaviors
▪ (evidence-based medicine compliance and utilization) and overall health (average payments and risk scores)

The DM Report will include the following profiles:
<table><tr><td>DM Enrollment Summary Profile</td><td>Beneficiaries eligible for program participation
Reasons for non-enrollment in DM Program, including percentage of program eligible beneficiaries who we were unable to contact and percentage who opted not to participate</td></tr><tr><td>Risk Stratification & Intervention Summary Profile</td><td>Summary of interventions for actively engaged beneficiaries
Average number of interventions for actively engaged beneficiaries by condition-specific DM program</td></tr><tr><td>DM Outcomes Profile</td><td>Utilization, including top utilization cost drivers for beneficiaries with qualified DM conditions
Compliance with evidence-based medicine standards for qualified beneficiaries</td></tr><tr><td>EBM Compliance by DM Program</td><td>Number and percentage of those with the specified condition who are compliant with evidenced-based medicine rules, by prior and current year</td></tr><tr><td>Impact of DM</td><td>Savings and ROI metrics for each DM program</td></tr></table></td></tr>
</table>

Current Program Name: **Congestive Heart Failure (CHF)**

Date Started: UnitedHealth Group has successfully provided disease management (DM) services for 24 years for commercial, Medicare and Medicaid populations. We currently provide DM for over 589,000 members throughout the United States.

Program Description* – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services*

The Heart Failure disease management program combines personal interaction, a range of educational resources and real-time monitoring to allow individuals to gain information and manage their condition. The goal is to reduce unnecessary hospitalization and health care costs and improve health for those individuals who have heart failure.

Heart failure program highlights include:

- Comprehensive assessments by specialty trained registered nurses to determine the appropriate level of intervention.
- Proactive outbound and responsive inbound nurse calls.
- At-home biometric monitoring of weight and related symptoms. Members diagnosed with Heart Failure in the inpatient setting within the previous 24 months qualify for the program. By placing the biometric monitor in patients' homes to track weight and heart failure symptoms, the program serves as the eyes and ears for the treating practitioner by providing real-time, actionable information whenever their patient has a status change and/or warrants clinician intervention. Supported by clinical staff, the biometric monitor is an electronic scale and monitoring device that asks questions about how the patient feels and sends the answers back via a toll-free telephone line. The patient submits their weight and answers the questions asked by the monitor first thing in the morning and just before going to bed. Information from the monitor is reviewed automatically in real-time and assigned an acuity score by the system as the patient submits their weight twice daily.
- Individuals do not graduate from this program and must remain compliant with daily weighing to take full advantage of the program.
- Immediate nurse interventions if the individual's weight or other symptoms indicate that intervention is warranted.
- Alert reports sent to physicians if significant issues are detected. If no alerts are triggered, a monthly summary report is sent to facilitate data sharing on critical findings.
- Medication therapy monitoring and adherence management for beta blockers, angiotensin converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARB).
- Educational materials and behavior change programs.
- Satisfaction and quality-of-life surveys.

** Please note that this program is subject to change annually or semi-annually as necessary.*		
1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Alert reports are sent to physicians if significant issues are detected. If no alerts are triggered, a monthly summary report is sent to facilitate data sharing on critical findings. Certain high risk cases enrolled in both CHF DM and targeted care management (CM) programs are co-managed by the DM nurse and a field based care manager.
	b. Do you stratify risk for the intervention group?	b. Yes. We use Impact Pro, our proprietary risk modeling and analysis tool to stratify risk data. Impact Pro is a predictive modeling application designed to identify health plan members and members who are most likely to develop catastrophic medical or financial outcomes within the next 12 months. Impact Pro uses episodes of care, other disease-based markers and prior utilization as inputs to identify members at risk. Impact Pro performs several functions to support accurate high-risk assessment: ▪ Prospective health risk assessment, which predicts expected future costs and utilization ▪ Identification of members who are most likely to develop catastrophic financial outcomes ▪ Identification of members who are most likely to be hospitalized
	c. Are there incentives?	c. We have utilized incentives in the past for our CM programs (when supported by our customers and allowed by regulatory entities). The Centers for Medicare and Medicaid Services (CMS) currently has restrictions on the use of incentives for Medicare-covered populations.
	d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. As stated above, the program includes both client or member-focused interventions and outreach to the member's providers as clinically indicated.
	e. Many chronic diseases have co-morbid conditions, (E.g. diabetes/CAD), does the program integrate with other conditions?	e. Yes. Our medical management team will deploy appropriate resources to complement and support the evolving requirements of the direct care system and coordinate care for an integrated member experience. Our integrated, value-driven approach to care management will combine medical and behavioral care management services into a single program to support the holistic needs of the member.
	f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. Yes. In instances where our case manager determines that a members needs are complicated by a variety of social issues and/or co-morbidities, we will also refer our members to our High Risk Case Management program for co-management with the Heart Failure program. In the HRCM program, trained case managers will work with the member to identify opportunities where additional community-based support will be appropriate to help support the members overall Heart Failure care plan. From a clinical standpoint, Optum Health's Heart Failure program uses only those guidelines developed and adopted by nationally recognized sources. The HF program is based upon the evidence based guidelines of the American College of Cardiology and the American Heart Association Inc i.e., ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic

		Heart Failure in the Adult and ACC/AHA Clinical Performance Measures for Adults with Chronic Heart Failure.
	g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. As part of it's operation of the Heart Failure program, Optum Health's has a strategic partnership with Alere Medical, Inc.
2.	**Population –** a. What is the total population targeted? b. How are enrollees identified for the program?	a. The total population targeted are all Secure Horizons members enrolled in our Medicare Advantage (Part C) and Medicare Part D plans. b. We rely on the rules and the process described below to complete data-driven case identification and risk leveling for our medical management programs. **Activity 1: Data Receipt and Validation.** We receive Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant claims, eligibility and provider data, and load the data warehouse to perform predictive modeling and risk leveling. Our data warehouses are capable of accepting large, line-level claims extracts and have been proven effective in receiving claims outside our internal system from fiscal agents in different state and federal programs. **Activity 2: Claims Analysis.** Upon loading and verification, we run the data through Impact Pro, our state-of-the-art predictive modeling software. Impact Pro allows us to understand the future costs of the member's care, assign a level of risk associated with future health care costs and determine eligibility for programs and services. Impact Pro data feeds into our CM tool that is easily accessible through point-and-click navigation by our CM and DM staff. **Activity 3: Health Risk Assessment** Conduct health risk assessment, which predicts expected future costs and utilization.
	c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	c. Within our disease management groups, we currently have approximately 13,000 members enrolled in the Heart Failure Program. d. Since the inception of the program, over 40,000 members have been enrolled at one time or another. e. The total eligible population is all Secure Horizons members enrolled in our Medicare Advantage (Part C) and Medicare Part D plans with Congestive Heart Failure (CHF). We estimate that at a prevalence rate of 3.4 percent, there are approximately 23,000 members who meet the criteria for the Heart Failure program within the Secure Horizons population.
3.	**Data**	

	a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. We receive Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant claims, eligibility, and provider data, and load the data warehouse to perform predictive modeling and risk leveling. b. We measure program success based on a number of factors, including, but not limited to identification, enrollment, admissions, re-admissions, ER visits, PMPM cost savings, member satisfaction and quality of life, ACE/ ARB uses, beta blocker usage and closure of identified care gaps in evidence-based medicine (EBM) measures. Claims-based pre/post studies to measure overall ROI and clinical outcomes can also be designed and executed. c. Value story findings are positive: ▪ 98 percent of the participants are satisfied with the program ▪ 87.8 percent of the participants would recommend the program to others ▪ 100 percent of the enrolled high risk members are screened for depression ROI is dependent upon individual client's population. Generally, a senior population could see up to a 2.2:1 ROI. This has been validated through a claims study comparing the baseline admits/1000 to the program period admits/1000 for the HF eligible population.
4.	**Staffing** a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ration?	a. See response to item c. below. b. See response to item c. below. c. Staffing ratio 450:1 supports productivity and client expectations. Note: These are subject to change upon working through specific client requirements.
5.	What is the total cost? (contract or staffing/overhead)	We would be happy to discuss this with you pending further information on your specific requirements.
6.	**Reporting** What are the metrics used for reporting current statistics?	We will report on DM processes, outcomes and savings and provide program profiles that together provide a comprehensive picture of DM program performance and cost. The comprehensive DM report will: ▪ Provide metrics on disease prevalence within the population ▪ Summarize program intervention types to provide insights into member interaction through the DM Program ▪ Demonstrate efficacy of DM program interventions on improving both member behaviors (evidence-based medicine compliance and utilization) and overall health (average payments and risk scores)

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<tr><td>DM Outcomes Profile</td><td>Utilization, including top utilization cost drivers for members with qualified DM conditions
Compliance with evidence-based medicine standards for qualified members</td></tr>
<tr><td>EBM Compliance by DM Program</td><td>Number and percentage of those with the specified condition who are compliant with evidenced-based medicine rules, by prior and current year</td></tr>
<tr><td>Impact of DM</td><td>Savings and ROI metrics for each DM program</td></tr>
</table></td></tr>
<tr><td>7.</td><td>Additional Information</td><td>This DM program encompasses best practices that fully comply with national accreditation and regulatory requirements, as demonstrated in the following list of current affiliate accreditations from the National Committee on Quality Assurance (NCQA):

▪ CHF – full patient and physician oriented DM, effective dates (4/06 to 4/09)</td></tr>
</table>

Current Program Name: **Diabetes**

Date Started: UnitedHealth Group has successfully provided disease management (DM) services for 24 years for commercial, Medicare and Medicaid populations. We currently provide DM for over 589,000 members throughout the United States.

Program Description* – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services*

Diabetes Disease Management drives better outcomes and lower costs for patients living with diabetes and the payers who help to sponsor their care. Diabetes Disease Management is a population-bases program that helps patients understand their diagnosis, its implications, and how to take informed action to optimize their health. Through a robust stratification process, individuals are targeted for intervention based on acuity and potential for intervention.

Program interventions include:

- Coaching by experiences diabetes nurses focusing on high value topics like getting patients to high quality providers, addressing gaps in care evaluated against evidence-based medicine and driving patients to make necessary behavior changes to reduce risk factors.
- Targeted, multi-modal (mail, IVR, etc.) interventions focusing on specific gaps in care (e.g., a missed eye exam).
- On-line and paper-based self-management tools that allow patients to develop and execute personalized action plans to improve their health and reduce risk factors associated with their illness.
- Focus on clinical opportunities that reduce short-term unit cost and long term utilization.
- Integration with UnitedHealth Premium Provider network and product suite including United Resource Network and Optum Health Behavioral Solutions.
- More accurate and efficient member outreach through the use of new technology and optimized staffing models.
- Identification of high risk diabetes members through claims analysis, health assessments, inpatient notifications and nurse triage.
- Specialized clinical consultants focused on specific diabetes value drivers to improve outcomes and maximizing value for health plans.
- Clinical interventions and education focus on four main value pillars: Right Provider, Right Medication, Right Care and Right Lifestyle.

The diabetes DM value drivers listed below provide examples of the types of customized activities that might be discussed in the disease manager's follow-up calls with the member.

Right Doctor	Right Care
Referrals to BH provider for depression Empowering member to communicate effectively with	Regular dilated eye exams and annual foot exams Annual HgA1c test with a goal of less than 7 percent

their provider Verifying an established relationship with provider Guidance on discussing a referral to a specialist with their PCM Referral to in-network provider	Self blood glucose monitoring Education on preparing for doctor visits (For example removing their footwear upon arriving as a reminder to get a foot exam) Educational services to determine appropriate ER use Online information and visual aids for symptom identification Immunization recommendation for influenza vaccination and pneumonia vaccine
Right Medication	**Right Lifestyle**
Missing medications – ACE inhibitors, anti-platelets, statins, increase in insulin dose, addition of a long/short-acting insulin to current regimen Proper dose titration to manage blood pressure and LDL target 100 mg/dl Medication adherence Lab tests to ensure drug efficacy Monitoring for potential prescription duplications or interactions	Eating in ways to best control blood sugar levels, such as controlling sugar and carbohydrate consumption Evaluate need for weight control program Evaluate need for exercise program Evaluate need for smoking cessation program Personalized health and wellness portal, trackers Telephonic and online wellness coaching Online and printed educational resources

** Please note that this program is subject to change annually or semi-annually as necessary.*

1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Disease management (DM) nurses reach out to treating providers when any gaps in care are identified and work with them to increase medications or modify as appropriate for the members condition. Many times we will coordinate conversations between DM medical directors and the treating provider when the situation requires a peer to peer conversation. <u>Roles:</u> DM Nurse/Treating Provider: Actively manage members with specific diseases including coordination of care, resources and treatment. DM Nurse/Case Manager: Coordinate with CM – DM to make sure that all acute and chronic conditions are addressed and appropriately managed. (DM for Diseases; CM for acute conditions)
	b. Do you stratify risk for the intervention group?	b. Yes. We use Impact Pro, our proprietary risk modeling and analysis tool to stratify risk data. Impact Pro is a predictive modeling application designed to identify health plan members and members who are most likely to develop catastrophic medical or financial outcomes within the next 12 months. Impact Pro uses episodes of care, other disease-based markers and prior utilization as inputs to identify members at risk. Impact Pro performs several functions to support accurate high-risk assessment: ▪ Prospective health risk assessment, which predicts expected future costs and utilization ▪ Identification of members who are most likely to develop catastrophic financial outcomes ▪ Identification of members who are most likely to be hospitalized

	c. Are there incentives?	c. We have utilized incentives in the past for our CM programs (when supported by our customers and allowed by regulatory entities). The Centers for Medicare and Medicaid Services (CMS) currently has restrictions on the use of incentives for Medicare-covered populations.
	d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Yes, it is based on both. Some interventions required collaboration with the provider. Some interventions are able to be addressed with the member/nurse relationship.
	e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	e. Yes. Our medical management team will deploy appropriate resources to complement and support the evolving requirements of the direct care system and coordinate care for an integrated member experience. Our integrated, value-driven approach to care management will combine medical and behavioral care management services into a single program to support the holistic needs of the member, including those with multiple co-morbidities.
	f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. Yes, our Diabetes program uses only those guidelines developed and adopted by nationally recognized sources. The diabetes program is supported by the American Diabetes Association. Our evidence-based-medicine (EBM) guidelines for diabetes management are based on national HEDIS measures, including HbA1c testing/control, cholesterol testing/control, monitoring kidney disease, and annual retinal exam.
	g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. The diabetes disease management program is administered internally at Optum Health.
2.	**Population –**	
	a. What is the total population targeted?	a. The total population targeted are all Secure Horizons members enrolled in our Medicare Advantage (Part C) and Medicare Part D plans.
	b. How are enrollees identified for the program?	b. We rely on the rules and the process described below to complete data-driven case identification and risk leveling for our medical management programs. **Activity 1: Data Receipt and Validation.** We receive Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant claims, eligibility, and provider data, and load the data warehouse to perform predictive modeling and risk leveling. Our data warehouses are capable of accepting large, line-level claims extracts and have been proven effective in receiving claims outside our internal system from fiscal agents in different state and federal programs. **Activity 2: Claims Analysis.** Upon loading and verification, we run the data through Impact

		Pro, our state-of-the-art predictive modeling software. Impact Pro allows us to understand the future costs of the member's care, assign a level of risk associated with future health care costs and determine eligibility for programs and services. Impact Pro data feeds into our CM tool that is easily accessible through point-and-click navigation by our CM and DM staff. **Activity 3: Health Risk Assessment** Conduct health risk assessment, which predicts expected future costs and utilization.
	c. At the present time, how many are in your program?	c. Total members currently in program: 3,346
	d. How many may have been in your program?	d. Total members who have been in program for 2008 (through 7/2008): 4,093
	e. What is the eligible population?	e. The total eligible population is all Secure Horizons members enrolled in our Medicare Advantage (Part C) and Medicare Part D plans with diabetes.
3.	**Data** a. What data do you collect? (e.g. claims, customer service, etc.)	a. We receive Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant claims, eligibility, and provider data, and load the data warehouse to perform predictive modeling and risk leveling.
	b. What are the specific measures of program success?	b. The Diabetes Disease Management programs primary goal is to reduce the progression and complications of diabetes. This is accomplished by focusing on individuals at multiple levels of acuity to manage costs and improve long term outcomes while delivering value by targeting the largest diabetes cost drivers including inpatient and ER utilization and pharmacy savings. The diabetes disease management program began in October 2005. • Claims validated measurement based on DMAA methodology. • 4 percent decrease in admits per 1,000 diabetes members. • 5 percent decrease in ER visits per 1,000 diabetes members. • 50 percent improvement in enrollment and engagement rate in year 2 of program.
	c. What outcomes were achieved as a result of the program	c. ROI is dependent on the individual client's population. Generally, we achieve 1.8:1 – 2.2:1.
4.	**Staffing** a. How many administrative staff are required?	a. 1 non clinical to every 4-5 clinical staff
	b. How many clinical Staff?	b. Diabetes – 26 (as of last census on 7/23)
	c. What is the expected staff to patient ratio?	c. Ratios are dependent upon specific client requirements
5.	What is the total cost? (contract or staffing/overhead)	We would be happy to discuss this with you pending further information on your specific requirements.

<table>
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<td>6.</td>
<td>Reporting
What are the metrics used for reporting current statistics?</td>
<td>We will report on DM processes, outcomes and savings and provide program profiles that together provide a comprehensive picture of DM program performance and cost. The comprehensive DM report will:

▪ Provide metrics on disease prevalence within the population
▪ Summarize program intervention types to provide insights into member interaction through the DM Program
▪ Demonstrate efficacy of DM program interventions on improving both member behaviors (evidence-based medicine compliance and utilization) and overall health (average payments and risk scores)

The DM Report will include the following profiles:
<table>
<tr><td>DM Enrollment Summary Profile</td><td>Members eligible for program participation
Reasons for non-enrollment in DM Program, including percentage of program eligible members who we were unable to contact and percentage who opted not to participate</td></tr>
<tr><td>Risk Stratification & Intervention Summary Profile</td><td>Summary of interventions for actively engaged members
Average number of interventions for actively engaged members by condition-specific DM program</td></tr>
<tr><td>DM Outcomes Profile</td><td>Utilization, including top utilization cost drivers for members with qualified DM conditions
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</table>
</td>
</tr>
<tr>
<td>7.</td>
<td>Additional Information</td>
<td>This DM program encompasses best practices that fully comply with national accreditation and regulatory requirements, as demonstrated in the following list of current affiliate accreditations from the National Committee on Quality Assurance (NCQA):

▪ Diabetes – full accreditation for patient oriented DM, effective dates (12/07 to 12/10)</td>
</tr>
</table>

Appendix D-2.I

Substitute Senate Bill 5841
Disease Management
Premera Blue Cross

Current Program Name: Premera Healthy Connections Disease Management program
Date Started: December 1, 2005

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☐Yes **x☐ No**

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	*Summary of changes to Disease Management Program*	*No significant changes to the program were made.*
2.	*Data*	
	a. What data do you collect? (e.g. claims, customer service, etc.)	*We collect medical and pharmacy claims data. These data, along with eligibility, are sent to our vendor partner in order to identify members and determine program efficacy via outcomes reporting.*
	b. What are the specific measures of program success?	*Measures of program success would include ROI, improvement in utilization measures (decrease in ER usage, decrease in admissions and decrease in LOS/bed days). Additionally, we measure improvement in distinct clinical measurements for diabetes, heart failure and coronary artery disease.*
	c. What outcomes were achieved as a result of the program	*For our first program year (2006), we did report an ROI of 3.34:1 for the core conditions of diabetes, heart failure and coronary artery disease. There was general improvement in the clinical and utilization metrics.*
3.	*Other/Additional Comments*	

Current Program Name: Internal Disease Management

Date Started: *The Regence BlueShield disease management program expanded in May of 2007 to include Diabetes, CAD, CHF, Asthma, COPD and Depression.*

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

Regence disease management programs are population-based programs designed to improve the quality of life for members with chronic conditions, increase the member's ability to self-manage their condition, and reduce the overall financial burden to both the employer and to the member.

We proactively identify, contact and seek to engage members who could benefit from the programs using our comprehensive data and systems. We use predictive modeling to stratify members into three risk levels for delivery of appropriate, targeted interventions. Claims data are queried each month to identify new participants and to update the stratification. Members are also identified through referrals from internal sources such as customer service or case management, and external sources such as healthcare providers, members and their families. Those identified for the program receive tailored educational materials and clinical support based on their specific health needs and goals.

Regence Disease Management targets members with the following conditions:

- *Diabetes*
- *Asthma*
- *Chronic obstructive pulmonary disease (COPD)*
- *Congestive heart failure (CHF)*
- *Coronary artery disease (CAD)*
- *Depression*

1. ***Integration –***
   a. *Describe how the program is integrated with treating provider(s)?*
   (E.g. nurse/MD, Nurse/case management, and what is the role for each)

   b. *Do you stratify risk for the intervention group?*

   c. *Are there incentives?*

   d. *Please indicate if the program is based on a client focused intervention or a provider focused intervention*

   e. *Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?*

   f. *Please indicate if the program collaborates with other community based interventions/alliances or state agencies*

1a. Regence BlueShield's disease management program clinicians work closely with the case management and utilization management staff to provide a coordinated medical management program. The goal of our program is to support the provider's treatment plan and members are encouraged to share any information they receive from the program with their provider. Care providers for members that are working with a program clinician are sent a notification letter letting them know that their patient is participating in our program, with the exception of those in the depression program. Disease management clinicians collaborate with the member's provider as needed.

1 b. Currently, we identify potential participants using a predictive modeling tool and through retrospective claims analysis. Members are stratified into three risk levels (low, moderate, and high risk). The intensity of interventions are based on the member's risk level.

1c. Health Risk Assessments are available online through ***myRegence.com****. Members earn Reward points just for completing the assessment, and are given immediate feedback regarding online programs or information they may benefit from. Our disease management programs feature additional risk assessments that gather more condition-specific information.*

1d. The program is based primarily on patient-focused interventions. By providing education and support tailored to the individual, we can help our members develop self-care skills, manage their condition, make the most of their health care benefits, and prevent or postpone future complications related to their condition. Program clinicians collaborate with a member's

	(E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	*provider as needed and support the provider's treatment plan for the member.*
	g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	*1e. Disease management clinicians utilize data from our predictive modeling tool, as well as their clinical assessment of the member, to identify comorbid conditions. The comorbid conditions are addressed by the program clinician. Participants in our disease management program receive quarterly care reminder mailings as appropriate, educational newsletters and may opt-in to work with a clinician for additional support.* *1f. Regence BlueShield has participated in the Washington Diabetes Quality Initiative Action and the Diabetes Coalition.* *1g. Regence BlueShield's disease management program was developed and is operated within our organization.*
2.	*Population –*	
	a. What is the total population targeted?	*2a. Currently, there are 612,290 Regence BlueShield members eligible for our disease management programs.*
	b. How are enrollees identified for the program?	*2b. We identify potential participants through, predictive modeling, retrospective claims analysis, self-referral, referral from another internal program, or from the member's provider.*
	c. At the present time, how many are in your program?	*2c. Currently, there are 34,853 members participating in the disease management programs. This number represents members of varying risk levels. Some members receive educational materials only and some members are managed telephonically by a program clinician.*
	d. How many may have been in your program?	*2d. There were 38,756 members identified for our disease management programs.*
	e. What is the eligible population?	*2e. Currently, there are 612,290 members eligible for Regence BlueShield's disease management programs.*
3.	*Data* *a. What data do you collect?* *(e.g. claims, customer service, etc.)* *b. What are the specific measures of program success?* *c. What outcomes were achieved as a result of the program*	
4.	*Staffing* *a. How many administrative staff are required?* *b. How many clinical Staff?* *c. What is the expected staff to patient ration?*	*4a. Currently, there is 1 administrative staff.* *4b. Currently, there are 5 clinical staff.* *4c. The expected staff to patient ratio is 1 FTE to approximately 250 members.*
5.	*What is the total cost? (contract or staffing/overhead)*	• *Not available*
6.	*Reporting* *What are the metrics used for reporting current statistics?*	• *6a. Metrics include number of members eligible, identified and participation by condition and risk level, number of members opting out, HEDIS measures, and member satisfaction.*

Substitute Senate Bill 5841
Disease Management
Public Employees Health Plans

Substitute Senate Bill 5841
Disease Management
Public Employees Health Plans
Aetna Public Employees Plan (Aetna PEP)—25,000 covered lives
Uniform Medical Plan (UMP) —180,000 covered lives

Current Program Name:

Date Started: *August 2008*

Program Description *– What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services*

Case Management began July 2004 (For UMP enrollees only)

Program Description: *RN and MD level support to enrollees that have complex medical needs including high costs, high risks, and needs that fall outside benefit structure. Certain benefits require case management such as inpatient rehab/psych/SNF/home health. Enrollees receive assistance with inpatient admissions, coordination with multiple providers, finding appropriate non-network providers when a network provider is not available and negotiate rates, designing discharge plans, and working with family members who are caring for enrollees with complex medical needs.*

1. ***Integration –***
   a. *Describe how the program is integrated with treating provider(s)?*

      (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. *Do you stratify risk for the intervention group?*
   c. *Are there incentives?*
   d. *Please indicate if the program is based on a client focused intervention or a provider focused intervention*
   e. *Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?*
   f. *Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)*
   g. *Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.*

   a. *The case managers work with the providers and facilities in care coordination*
   b. *Yes, open cases are either active or on monitor status.*
   c. *No.*
   d. *Client focused intervention.*
   e. *The program treats the entire individual. If the person is being discharged from case management they might be turned over to disease management for their diabetes, while the enrollee is in case management, they are treated as a whole person, not by their specific disease.*
   f. *The program collaborates with other internal programs, bariatric surgery, asthma/COPD management, ActiveHealth disease management, and tobacco cessation.*
   g. *The program was developed by the clinical staff at UMP and continues to be managed through collaboration between the UMP clinical staff and Avidyn the vendor who provides case management through the UMP TPA Fiserv*

2. *Population –*	
a. *What is the total population targeted?*	a. *Less than 0.25% of UMP enrollees.*
b. *How are enrollees identified for the program?*	b. *Enrollees are identified through self referrals, provider or facility referrals, through claims, high dollar claims, and through software which looks for enrollees who have received certain services or have certain diagnosis.*
c. *At the present time, how many are in your program?*	c. *About 200 enrollees.*
d. *How many may have been in your program?*	d. *872 enrollees were in case management CY 2007.*
e. *What is the eligible population?*	e. *Non-Medicare primary UMP enrollees who have complex medical needs or need inpatient care for psych, SNF, or rehab, or home healthcare. (Medicare primary enrollees must be in case management for certain specific inpatient care only.)*
3. *Data*	
a. *What data do you collect?* (e.g. claims, customer service, etc.)	a. *Diagnosis, services received, satisfaction, outcomes, volumes, length of time case is open, total case types, and some financial data.*
b. *What are the specific measures of program success?*	b. 1. *Patient satisfaction* 2. *Percent of high-cost patients managed in case management.* 3. *Percent of enrollees managed in case management (at least 0.1% of the overall population).* 4. *All psych / SNF/Rehab cases are in case management.*
c. *What outcomes were achieved as a result of the program*	c. 1. *Improved quality of care for enrollees with complex medical needs, for example, quality discharge plan for enrollees being discharged from inpatient psych facilities.* 2. *Excellent satisfaction scores from enrollees.* 3. *Care is medically necessary; for example, enrollee who is not improving and not receiving therapy would not continue to receive coverage of skilled nursing days.* 4. *Decrease costs, for example, case managers can negotiate rates with providers who are not in the network or get a facility to join the network, or provide home health care instead of inpatient care.* 5. *30 percent of enrollees with costs greater than 100,000 dollars in CY2007 were being case managed.*
4. *Staffing*	i) *2.0 FTE's of administrative staff, (Avidyn).*
a. *How many administrative staff are required?*	ii) *6.0 FTE's of registered nursing staff and 0.5 FTE of MD staff, (Avidyn).*
b. *How many clinical Staff?*	iii) *1 RN to 35-40 enrollees.*
c. *What is the expected staff to patient ration?*	
5. • *What is the total cost? (contract or staffing/overhead)*	*1.4 million / year*
6. • *Reporting* • *What are the metrics used for reporting current statistics?*	*Reporting, what are the metrics used for reporting current statistics?* *Monthly, quarterly and annual reports are provided*

Current Program Name: *Asthma/COPD Disease Management*
Date Started: *April 2007 (**for UMP Enrollees Only**)*
Program Description *– What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services began*

RN contacts identified members and assists them: to develop an action plan, with medications, to receive appropriate treatment and routine visits with their provider. RN also communicates with enrollees providers to ensure care is collaborative.

1. ***Integration –***
   a. *Describe how the program is integrated with treating provider(s)?*
   (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. *Do you stratify risk for the intervention group?*
   c. *Are there incentives?*
   d. *Please indicate if the program is based on a client focused intervention or a provider focused intervention*
   e. *Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?*
   f. *Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)*
   g. *Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.*

   a. *A letter is sent to the provider the enrollee identifies as their primary care provider explaining that the enrollee is in the program and what the program is.*
   b. *Yes the entire eligible population is stratified into five categories.*
   c. *Free asthma/COPD supplies, like a peak flow meter.*
   d. *Enrollee focused with outreach to providers.*
   e. *No this is focused on Asthma or COPD, if the enrollee has another condition that is managed by ActiveHealth enrollee would be referred to that program, if they had complex medical needs referred to case management, and for tobacco cessation referred to* Free & Clear*.*
   f. *As stated above. In addition the program was chosen because of the States initiative and focus on Asthma.*
   g. *Program is run and managed in collaboration with Avidyn and Fiserv. PEHP staff provider oversight of contract, clinical performance, and ensure performance guarantees are met.*

2. Population – *a. What is the total population targeted?* *b. How are enrollees identified for the program?* *c. At the present time, how many are in your program?* *d. How many may have been in your program?* *e. What is the eligible population?*	*a. Enrollees with either an admission or emergency room visit in the last 12 months for Asthma or COPD, initially over 7000 enrollees identified.* *b. Through a review of claims data.* *c. 120 enrollees* *d. 195 total enrollees.*
3. Data *a. What data do you collect?* *(e.g. claims, customer service, etc.)* *b. What are the specific measures of program success?* *c. What outcomes were achieved as a result of the program*	*a. In addition to volumes, enrollment, recruitment numbers, we collect clinical performance data, percent who have had a flu shot, use a peak flow meter, use a spacer, see their providers, smoking status, etc.* *b.* *1. Fewer than one-hundred and five (105) emergency room visits and fewer than 27 hospitalizations combined for asthma and COPD, during that year for every 100,000 non-Medicare UMP enrollees.* *2. 85 percent will receive a flu shot annually.* *3. 90 percent satisfied satisfaction survey.* *c. See next page.*
4. Staffing *a. How many administrative staff are required?* *b. How many clinical Staff?* *c. What is the expected staff to patient ration?*	*a. Avidyn 1 FTE* *b. Avidyn 1 RN. Internally 1 to manage the contract and clinical performance.* *c. 120 enrollees-1 RN*
5. What is the total cost? (contract or staffing/overhead)	*$275,000 annually*
6. Reporting *What are the metrics used for reporting current statistics?*	*See 3 c*

Current Program Name: *Surgical Obesity or Bariatric Case Management*
Date Started: *January 1, 2007, for UMP enrollees only; began January 1, 2008, for Aetna PEP enrollees*
Program Description *– What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services* ***.***

1. ***Integration –***
   a. *Describe how the program is integrated with treating provider(s)?*
   (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. *Do you stratify risk for the intervention group?*
   c. *Are there incentives?*
   d. *Please indicate if the program is based on a client focused intervention or a provider focused intervention*
   e. *Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?*
   f. *Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)*
   g. *Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.*

   a. *The bariatric nurse case manager works with the providers and facilities in care coordination both before and after surgery.*
   b. *No, only in the sense that enrollees must meet certain criteria to qualify for bariatric surgery.*
   c. *No*
   d. *Enrollee focused intervention.*
   e. *Yes enrollees must have co-morbid conditions to qualify for the program and not have diagnosis that would preclude them as a surgical candidate. While those co-morbid conditions are not managed in this program (they would be sent to one of the other programs if the condition required management), they are closely followed as one goal of bariatric surgery is for resolve of most co-morbid conditions.*
   f. *We have worked with HRSA, the Office of the Medical Director, and other PEBB health plans, like Group Health to design the program and compare data.*
   g. *Program developed entirely internally by the UMP clinical and communication staff. Avidyn provides the nursing and MD staffing and Fiserv provides the technical support, online questionnaire, reporting data base, etc.*

2.	• *Population –* *a. What is the total population targeted?* *b. How are enrollees identified for the program?* *c. At the present time, how many are in your program?* *d. How many may have been in your program?* *e. What is the eligible population?*	*a. Because of the risks involved this is a benefit that is very personal and no enrollee is targeted, pushed, or encouraged to identify for it.* *b. Enrollees choose to initiate and must complete an online questionnaire.* • ***UMP:*** *About 200, 79 have had surgery, 21 are approved and waiting to have surgery and the rest are in the process to get approved for surgery.* • ***Aetna:*** *About 80, 10 who have had surgery.* *c.* ***UMP:*** *All 200 are those who have been and stayed in the program. We have had well over 600 apply and leave at varies stages of the process.* • ***Aetna:*** *About 100 have applied, with only 80 being in the actual program.* *d. Very limited benefit for a very small population of enrollees who have a BMI of 40 or greater, have significant disease, and are considered by scientific evidence to be a candidate for the surgery. Only adult enrollees 21-64 years of age. (Health Technology Assessment Committee also approved laparoscopic banding for adolescents who meet the criteria ages 18-21)*
3.	• *Data* *a. What data do you collect?* • *(e.g. claims, customer service, etc.)* *b. What are the specific measures of program success?* *c. What outcomes were achieved as a result of the program*	*a. Because this program is so closely monitored there is immense clinical data and claims data related to these patients.* *b. Positive outcomes without complications.* *c.* ***UMP:*** *79 patients have had surgery, average complication rate 29 percent and two deaths. Lots of success stories, complete resolve of co-morbid conditions, ability to discontinue medications and 50 percent loss of initial body weight.* • ***Aetna:*** *About 5 have had surgery with a very low complication rate.*
4.	*Staffing* *a. How many administrative staff are required?* *b. How many clinical Staff?* *c. What is the expected staff to patient ration?*	*a. Internally, none. Fiserv 1 FTE. Avidyn 2 FTE's. Aetna: 1 FTE* *b. Internally, 1 FTE. Avidyn 3 RN's, 0.5 MD. Aetna 1 RN and 0.5 MD.* *c. About 100 active cases per RN and 50 monitor cases.*
5.	*What is the total cost? (contract or staffing/overhead)*	***UMP:*** *$170,000.* ***Aetna:*** *$85,000:* *Costs do not include the technical support from Fiserv or the internal staff costs.*
6.	*Reporting* *What are the metrics used for reporting current statistics?*	*See III a.*

Request for Information Responses – Health Care Clinics

1. ***Integration –***

   a. Describe how the program is integrated with treating provider(s)?

   (E.g. nurse/MD, Nurse/case management, and what is the role for each)

   - *Staff (Medical Assistants or nurses) are expected to review disease management and health maintenance management reminders incorporated in the EMR at each visit. Providers are responsible for management of prompts specific to control of the chronic disease and to provide additional information to patients who may be resistant to consenting to a particular level of care.*

   b. ***Do you stratify risk for the intervention group?*** *Groups are not stratified with the exception specifics of disease burden that the QI disease management team wants to push for improvement. Example: Diabetic patients in a practice with HgA1C >9.*

   c. ***Are there incentives?*** *First, The Everett Clinic's core value #1 is "doing what is right for the patient" and optimal patient management is part of that core value. Additionally, primary care providers will receive a small financial stipend based on their performance in achieving optimal disease and health maintenance management.*

   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention.

   e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions? Yes, based on prompts for specific assessments such as BP and LDL control in a patient with Diabetes, glucose control in CAD/CVD.

   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) Not specifically at this time, however, we are actively involved with Puget Sound Health Alliance which is charged with comparing performance in disease management and preventive care management for patients in the Puget Sound region.

   g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name. The Everett Clinic has developed and maintained the process/program with the support of our EMR.

2. *Population –*

   a. What is the total population targeted? Patients who have had an E and M code (office visit charge) and seen in the last 4 years and have a Primary Care Provider

   b. How are enrollees identified for the program? This is an automated process based on Chart Problem list and/or age/sex of the patient

   c. At the present time, how many are in your program? 97,500 unique patients

   d. How many may have been in your program? Not known

   e. What is the eligible population? Not known

3. *Data*

   a. What data do you collect? Data is extracted from the EMR and ancillary data bases electronically. Additionally, staff are able to input some specific data directly into the patient data base (example: patient who may have had a colonoscopy 5 years ago when living in another area)

   (e.g. claims, customer service, etc.)

   b. What are the specific measures of program success? The number of unique patients who are up to date in all disease and preventive care items.

c. *What outcomes were achieved as a result of the program?* *Providing value to the patient with cost effective care.*

4. *Staffing*
   a. *How many administrative staff are required?* *Disease Management and Preventive Care management is only a part of the responsibilities of our oversight group. It is not possible to assess FTE*
   b. *How many clinical Staff? Clinical staff have a multifaceted role and non are exclusively involved in this area.*
   c. *What is the expected staff to patient ration?*
5. *What is the total cost? (contract or staffing/overhead)* *Information not available*
6. *Reporting*
   What are the metrics used for reporting current statistics? *% of patients up to date in key metrics by provider, by specialty and by clinic location*

Current Program Name: Chronic Disease Management
Date Started: *July 2007*

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒Yes ☐ No

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	*Summary of changes to Disease Management Program*	*Initially, FMG focused on DM specific measures for a small population of physicians and clinics. We have recently expanded our monitoring of LDL and A1C value to our entire primary care population. This population is in excess of 9,000 patients. Furthermore, we are in the midst of bringing in a disease management RN to oversee the entire FMG outcomes measure program with a focus on excellence in clinical quality and achievement of NCQA recognition in the area of diabetes. Our ultimate goal is to achieve NCQA recognition for our entire primary care physician population by FY2011.*
2.	*Data* *a. What data do you collect? (e.g. claims, customer service, etc.)* *b. What are the specific measures of program success?* *c. What outcomes were achieved as a result of the program*	*a.* *We collect A1C and LDL data on all patients with a diagnosis of Type I and Type II diabetes. In addition, we participate in some components of PQRI and our focus has been on dermatology, surgical services, DM, ophthalmology, and rheumatology. Finally, we measure our usage of generic medications against our usage of brand name drugs. We collect via claims and lab data.* *b.* *The measure of success for LDL is to obtain a value less than 100. The goal for A1C is a value less than 7. The measures of success for PQRI is defined by CMS and it equates to submitting data on 3 quality measures for at least 80% of the agreed upon population. The criteria for generic use is defined by the Uniform Medical Plan and varies based on drug classifications.* *c.* *73% of our DM patients have an A1C less than 7. 87% have a value less than 8. 55% of our DM patients have an LDL less than 100. We received incentive pay for our participation in both PQRI and the UMP Generic Medication Program. We have improved both our communication and monitoring of outcomes that equate to improved health and safety for our patient population.*
3.	*Other/Additional Comments*	• *Once we have completed our initial work on diabetes our goal is to expand to all chronic illnesses, with a specific focus on preventive and wellness care.* •

Appendix D-3.B

Substitute Senate Bill 5841
Disease Management
MultiCare Medical Group

Current Program Name: Chronic Disease Mangement
Date Started: *May 2008*

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒Yes ☐ No

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1.	*Summary of changes to Disease Management Program*	*Population:* *MMG* *Total diabetics 7500 to date 1000 patients have been contacted via proactive outreach calls* *staffing* *MMG; 2 Medical Assistants to contact patients*
2.	*Data* *a. What data do you collect? (e.g. claims, customer service, etc.)* *b. What are the specific measures of program success?* *c. What outcomes were achieved as a result of the program*	*MMG program began in may of 2008 no data on outcomes has been evaluated*
3.	*Other/Additional Comments*	

- ***Current Program Name: Chronic Care Management***
- ***Date Started:*** *April 2006*
- ***Program Description*** – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
- *Application of the chronic care model to diabetic patients at Tacoma Family Medicine (TFM). TFM is the residency program and clinic at MultiCare. This model will be rolled out to 3 pilot clinics in MultiCare Medical Group (MMG) in 2007, and all of MMG clinics in 2008. We are starting with Diabetes, but intend to expand to CHF, Asthma, Depression and other chronic illness as time and resources allow.*
-
-

1. ***Integration –***
   a. *Describe how the program is integrated with treating provider(s)?*

   (E.g. nurse/MD, Nurse/case management, and what is the role for each)

   b. *Do you stratify risk for the intervention group?*

   c. *Are there incentives?*

   d. *Please indicate if the program is based on a client focused intervention or a provider focused intervention*

   e. *Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?*

   f. *Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)*

   g. *Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.*

a. All diabetic patients in TFM (about 524) receive the service. Patients are a part of a diabetic registry in the clinic. An employed Chronic Care nurse calls patients from the diabetic list based on lab values and date last seen. The patient is encouraged to attend a nurse only visit where labs are reviewed and ordered if needed, symptoms reviewed, a foot exam is completed, self management goals set and immunizations followed up. Date of last eye exam, dental exam and when last seen by diabetic educator are all reviewed and referrals sent as needed. The patient is then appointed with the provider for follow-up within 2 weeks.. Patients that are unable to make nurse only appointments are able to do telephone visits with the chronic care nurse, where all the same info is reviewed. Self management education material is sent, orders for labs and immunizations are entered and the patient is asked to come in a minimum of 2 days prior to provider appointment for completion of labs. Those patients which are unable to be contacted by phone are sent a letter asking them to call for a nurse visit as well as reminders that an appointment with their provider is needed.. Patients that are scheduled to see provider but do not wish to attend a nurse only appointment are sent a letter 2 weeks prior to appointment with ordered labs. Group visits occur monthly with different topics each month related to diabetes. This group is educational as well as supportive.

b. Stratified only by diagnosis

c. Only to provide improved care. No financial incentives at this time

d. Client focused, by need for clinic appointment or abnormal lab value

e. Not at this time

f. Diabetes Collaborative

g. Operated by our organization

2. *Population –*

   a. *What is the total population targeted?*

   b. *How are enrollees identified for the program?*

   c. *At the present time, how many are in your program?*

   d. *How many may have been in your program?*

   e. *What is the eligible population?*

a. Currently about 500 patients. Total diabetics in MMG are about 5,000. All diabetics should receive the service in 2007-2008

b. By diagnosis

c. As above

3. *Data*

   a. *What data do you collect?*
   (e.g. claims, customer service, etc.)

   b. *What are the specific measures of program success?*

   c. *What outcomes were achieved as a result of the program*

a. 1) Tests: A1C, LDL/Lipids, Renal Function (proteinuria), Eye exam (retinopathy), foot exam, BP.
2) Immunizations: Flu, Pneumovax
3) Counseling: Self-Management goals
4) Health Maintenance: ASA over 40 years
5) Follow-up appointments
b. A1C below 8, BP management 130/80, LDL less than 100
c. Current A1c values for all TFM diabetics average 7.7, LDL is 108 and BP is 123/72

4. *Staffing*

   a. *How many administrative staff are required?*

   b. *How many clinical Staff?*

   c. *What is the expected staff to patient ration?*

a. .25
1 LPN, 24 residents, 8 facultyc. N/A

5. *What is the total cost? (contract or staffing/overhead)*

$45000

6. *Reporting*
   What are the metrics used for reporting current statistics?

A1C, LDL, BP, ASA use, neuro foot exams done, smoking cessation.

Current Program Name: CDEMS
Date Started: *June 2006*

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒Yes ☐ No

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1. *Summary of changes to Disease Management Program*

   We are using this registry to participate in the Washington State Collaborative to Improve Health for diabetes. All of our patients are enrolled, and lab interfaces allow data to be downloaded directly.

2. *Data*
   a. *What data do you collect? (e.g. claims, customer service, etc.)*
      a. Visit data: blood pressure, foot exam, reports of eye exams, self management goals, smoking status and smoking cessation counseling offered. Lab data: HbA1c, LDL, microalbumin.
   b. *What are the specific measures of program success?*
      b. The program allowed us to begin tracking outcomes for our diabetic patients – success in implementation was measured by percentage patients involved in the registry. We are now at 100% of patients documented.
   c. *What outcomes were achieved as a result of the program*
      c.
3. *Other/Additional Comments*

Substitute Senate Bill 5841
Disease Management
Overlake Medical Group

Current Program Name: Washington State Collaborative to Improve Health
Date Started: April/May 2008
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

1. • **Integration –**
   a. Describe how the program is integrated with treating provider(s)?
   • (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. Do you stratify risk for the intervention group?
   c. Are there incentives?
   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention
   e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?
   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)
   g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

1a. A pilot group of 111 patients followed by a single provider.
b. No.
c. The collaborative has an incentive for the clinic that may reach $7250. Incentives are not currently used for providers or participants.
d. We use both client and provider focused interventions.
e. Our registry can do this but we are not currently using this function. As the Collaborative is tracking improvements of core measures in blood pressure reduction, however, as we proceed we will examine medication refills and other interventions targeted at improving blood pressure and therefore cardiovascular health.
f. We are participating in the Washington State Collaborative to Improve Health – Diabetes track.
g. We are using the CDEMS registry, which was developed by the Collaborative. The implementation of its precepts is all developed internally.

2. Population – a. What is the total population targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	a. Total population in our CDEMS registry is 548. The target population we are using to test our interventions is one physician's patient panel of 111 patients. b. Billing data or identified by provider - ICD-9 250.xx c. 111 patients – the panel of our test physician d. 111 patients – though the changes we have proven with this panel will be implemented to the total group as appropriate. e. The eligible population of diabetics in our clinic is 548.
3. • Data a. What data do you collect? • (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. Data is collected from visits, as providers supply on a data sheet specifically constructed for our CDEMS database, and from lab data imported from PacLab. b. For the Collaborative, tracked measures for improvement include percentage of patient population with a documented HbA1c, the percentage of that population with an HbA1c of below 7, and the average A1c value of the patient panel, the percentage of patients with a blood pressure of <130/80 mmHg, percentage of patients with an LDL of below 100 mg/dl, average LDL value, percentage of patients with a documented self-management goal, and percentage of smoking patients who have been offered smoking cessation counseling. c. So far, we have seen an increase of the percentage of our patients with a documented self management goal, from 8 percent to just under 20 percent. For additional information about our improvements, please see the enclosed spreadsheet from the Collaborative.
4. Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ration?	a. 4 administrative staff members are involved in the project, as well as 2 medical records staff. b. 2 clinical staff - 1 provider and 1 medical assistant are mainly involved with the Collaborative, but the other 5 providers and 4 MAs also participate. c. N/A
5. What is the total cost? (contract or staffing/overhead)	No additional costs have been incurred.
6. Reporting What are the metrics used for reporting current statistics?	Monthly reports using data collected in CDEMS track changes in lab data. We also deliver narrative reports detailing the changes in procedures we have attempted, with the results of those changes.

Substitute Senate Bill 5841
Disease Management
(Health Plan, Agency, Clinic Name)

Rockwood Clinic
Dr. Robert Benedetti, Medical Director

Current Program Name: Diabetes
Date Started: February 2002.

Program Description – *What is the intervention? Please be specific about the coordination, referral, provider and ancillary services*
In 2002 Rockwood began participation in the Washington State Diabetes Collaborative. Since then we have continued to apply focused quality improvement activities towards Diabetes

1.	**Integration –**	
	a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	all Family Medicine and Internal Medicine provider and their clinical staff participate in Registry based, planned care for their patients with diabetes, using a "team" concept as outlined in the Chronic Care Model of Dr. Ed Wagner
	b. Do you stratify risk for the intervention group?	NO
	c. Are there incentives?	NO
	d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	client focused.
	e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	all care at Rockwood is done in an integrated fashion
	f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	we formerly integrated care with the Diabetes Collab, but no longer actively do so.
	g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	No outside vendors are used.

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Substitute Senate Bill 5841
Disease Management
(Health Plan, Agency, Clinic Name) Rockwood Clinic
Dr. Robert Benedetti, Medical Director

Current Program Name: Asthma
Date Started: November 2007

Program Description – *What is the intervention? Please be specific about the coordination, referral, provider and ancillary services*
one physician and his clinical staff are participating in the WA St. Asthma collaborative.

1.	**Integration** –	
	a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	one physician and his staff as above
	b. Do you stratify risk for the intervention group?	no
	c. Are there incentives?	no.
	d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	client focused
	e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	all one at Rockwood is done in an integrated fashion.
	f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	yes
	g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	no vendors are used.

Substitute Senate Bill 5841
Disease Management
Sea Mar Community Health Centers

Current Program Name: Chronic Care Program

Date Started: April 2008 (1999 initial work started with state and federal Chronic Disease Collaboratives)

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

After involvement in federal and state collaboratives to make improvements in patient outcomes based on the Chronic Care Model, Sea Mar is continuing with a focus on team based care and spreading to other conditions by hiring care coordinators to facilitate this effort at each clinic site. Care coordinators work with patient with chronic and behavioral health conditions to help patients access resources, case management support, and with data tracking and quality improvement to ensure that we are providing quality care based on the Chronic Care Model. The position is clinically based and part of daily clinic flow and operations. The care coordinator helps connect patient to Sea Mar and non Sea Mar resources but does not see patients on an appointment basis.

1. **Integration –**
   a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. Do you stratify risk for the intervention group?
   c. Are there incentives?
   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention
   e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?
   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)
   g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

a. The position reviews daily schedules to identify high risk chronic disease patients. The care coordinator is part of the daily huddle with physicians and medical assistants to identify patients to see and then sees the patients before the provider visit and if necessary after the visit. The care coordinator follows up with a call to the patient and ongoing tracking to make sure they are connected and follow-up with necessary services.
b. No
c. No
d. Client focused intervention but also in the process of changing provider behavior.
e. The program is starting with the conditions we have worked on closely with the Collaborative work: diabetes and asthma. Eventually we hope to expand and provide case management support to patients with all chronic conditions. Currently if a patient has other co-morbid conditions the care coordinator can direct patients to resources and services for those conditions as long as it relates to the overall care of the primary condition.
f. Yes, depends on where the clinic is located. Examples include: Washington State Department of Health Diabetes Prevention and Control Program, local health departments (for example King County Asthma Program and REACH Coalition), Community Health Plan of Washington Disease Management Program, American Lung Association, STEPS programs, local community based organizations, CHOICE Regional Health Network, etc.
g. Developed and operated by Sea Mar Community Health Centers.

2.	Population – a. What is the total population targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	a. Unknown at this time, but currently population of patients with diabetes and asthma is approximately 7,000. b. By diagnosis, last visit date, and clinic location. c. Program has just started, but currently approximately 600 patients in the program and 7,000 patients in the chronic disease registry. d. Unknown. e. Patients with a diagnosis of asthma or diabetes and at a clinic with a care coordinator (will be hiring this position for all clinics, but currently at 3 clinics).
3.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. Chronic disease process and clinical outcomes, productivity #s for providers and care coordinators, cycle times, no show rates, and eventually provider and patient survey data. b. Increase in chronic disease process measures and improved clinical outcomes (see below for metrics). Also increase in patient and provider satisfaction with care given to patients with chronic conditions. Overall increase in provider productivity and reduced cycle times. c. No immediate data yet, but have seen definite increases in process measures. In a pilot care coordinator project over a 5 month period we saw the following: increase in DM patients with a retinal exam from 22% to 41%, increase in those with diabetes health education from 24% to 43%, average # days of exercise increase from 2.5 to 4 times a week, and average HbA1c was reduced from 8.7 to 8.0.
4.	Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ratio?	a. 1 position, Chronic Care Program Director (ideally 1.5 positions). b. Eventually will have at least one care coordinator at all clinic sites (approximately 10-11 positions). Medical director (MD) is part of the senior care team and in charge of the department. Clinic directors (MD) at each clinic help with training and are part of the clinic care team. c. Pilot stage of program and still trying to figure this out.
5.	What is the total cost? (contract or staffing/overhead)	a. Unknown at this time, but approximately $500,000.
6.	Reporting What are the metrics used for reporting current statistics?	Diabetes: HbA1c <7%, HbA1c >9%, BP<130/80, LDL <100, LDL completed in the last year, self-management goal set in the last year, retinal exam in the last year, nephropathy monitoring in the last year, and foot exam in the last year. Asthma: symptom days/nights in the last two weeks, action plan in the last year, persistent asthma on controller medication, persistent asthma with spirometry completed in the last year, self-management goal in the last year, environmental tobacco smoke assessed in the last year and result.

Substitute Senate Bill 5841
Disease Management
Swedish Physicians' Clinic

Current Program Name: Swedish Physician Diabetes Program
Date Started:

After reviewing the 2006 RFI submission for the 2007 report, are there changes or revisions to your Disease Management program?
☒ Yes ☐ No

If yes, please describe and summarize those changes in the section below and update the data section. It is not necessary to complete a summary for each disease management program submitted in 2006. If new disease management programs have been added, please complete the RFI Questionnaire for each program.

1. Summary of changes to Disease Management Program

Swedish Physicians continues to improve its diabetes care. While all of our providers have been versed in the chronic care model and utilizing the CDEMS registry for the past few years, we have more providers engaged in various aspects of the Model such as implementing the "planned visit," providing outreach to get patients in for visits who have not been seen according to the guideline, and becoming more comfortable with establishing mutually agreed upon goals for self-management. The Medical Assistants are better trained to provide monofilament exams, and to utilize our reports for patient recall.

We now have 29 providers who have received NCQA Recognition since last year, with another 8 in process.

During the past 12 months, our organization has been implementing EPIC electronic medical record across our hospital system, primary care and specialty care clinics. This should be completed in the next six months, along with an upgrade to the system scheduled for spring of 2009. It has been a huge undertaking. We are learning how to most efficiently and effectively utilize the EMR. We still do not know the reporting capabilities of the EMR so continue to use our CDEMS for our disease management work.

We have two teams, representing two clinics that are participating in the Washington State Collaborative session that began this year and runs through May 2009: one team in the Diabetes Track and one team in the new Asthma Track. We hope to establish some workflows and measurement around asthma that can be shared with other providers who across our organization.

We have added some functionality to the CDEMS Database that allows us to add track multiple disease states while entering the patient information only one time. We are using this for our new work in Asthma. We also moved the database to a new SQL server which is more robust. This is the culmination of several months of work.

The number of diabetes patients has remained relatively constant. As of Sept 1, 2008, we had 3,034 diabetes patients in our registry. We also now have 25 asthma patients.

2. Data
   a. What data do you collect? (e.g. claims, customer service, etc.)
   b. What are the specific measures of program success?
   c. What outcomes were

For diabetes, we have added some tracking measures to those on the 2006 report. We also look at % patients with HbA1c>9%, % patients with LDL>130, and % patients with BP>140/90; % of patients meeting all three goals for HgA1c<7, LDL<100 and BP<130/80.

Our new asthma measures from the Washington State Collaborative include:

1. Percentage of patients who have visited an ED for asthma in past 3 months
2. Percentage of patients with persistent asthma whose asthma is well controlled
3. Percentage of patients with a documented level of severity
4. Percentage of patients with a documented level of control

	achieved as a result of the program	5. Percentage of patients with persistent, not well controlled or poorly controlled asthma prescribed an ICS at lave visit 6. Percentage of patients with persistent asthma ever evaluated for environmental triggers by history of exposure or allergy testing 7. Percentage of patients with persistent asthma who have a current written asthma management plan. We do not have any reliable data yet but should by next year.
3.	Other/Additional Comments	

Current Program Name: Diabetes Quality Improvement **Date Started:** June 2007		
Program Description – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services* Provide evidence-based, planned system of care for patients with diabetes to improve standard outcomes measures.		
1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each) b. Do you stratify risk for the intervention group? c. Are there incentives? d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have co-morbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	a. Primary Care is provided by Internal Medicine, Family Practice, ARNP's, and PA-C providers in conjunction with skilled nursing staff. Services are coordinated via a fully integrated EMR, standardized tools and feedback reports. b. No—all patients with diabetes are included. c. No financial incentives. Improvement in quality of care was our goal. d. Program is based both on provider and patient focused intervention, as this is the most effective. e. Yes -- with Cardiovascular. f. Yes, this project utilized work done as part of the Washington State Diabetes Collaborative. g. Programs developed and operated internally, utilizing National Commission on Quality Assurance standards.

2.	Population – a. What is the total population targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	a. Adults 18 years to 75 years old with a diagnosis of diabetes. b. Any patient with diagnosis of Diabetes. c. 3,238 diabetic patients at the study time December 2007. d. 3,238 diabetic patients at the study time December 2007. e. All patients ages 18-75 with diagnosis of Diabetes.
3.	Data d. What data do you collect? (e.g. claims, customer service, etc.) e. What are the specific measures of program success? f. What outcomes were achieved as a result of the program	a. Clinical data extracted from our electronic medical record, including outcomes measurements of: HbA1C, LDL cholesterol, blood pressure control, smoking status, microalbumen (kidney testing), monofilament testing (foot care), and eye care. b. Outcomes measurements as listed above based on standards from NCQA. Physicians who meet or exceed the clinical outcomes for patients under their care receive recognition through the NCQA Diabetes Physician Recognition Program (DPRP). c. 28 physicians have achieved NCQA DPRP recognition. http://recognition.ncqa.org/PSearchResults.aspx?first=&last=&city=&zip=&org=UW+Medicine&state=WA&rp=3
4.	Staffing d. How many administrative staff are required? e. How many clinical Staff? f. What is the expected staff to patient ration?	a. This project was completed with .3 FTE administrative staff. b. 4 clinical staff involved in varying stages of the project, and .2 FTE of physician time consistently. In addition, IT support was utilized throughout the duration of the project.
5.	What is the total cost? (contract or staffing/overhead)	Application Fees: $2,780 Direct staffing cost: approximately $27,000 IT cost part of network overhead – not tracked separately.
6.	Reporting What are the metrics used for reporting current statistics?	HEDIS measures of HbA1C control, Blood pressure control, LDL control, Foot Care, Retinal examinations, Nephropathy assessment, Smoking status and cessations advice and treatment. *DPRP Clinical Outcomes Criteria Set Forth by NCQA* *HbA1c<7.0%……40% of patients* *HbA1c>9.0%……≤15% of patients* *Blood pressure≥140/90mmHg……≤35% of patients* Blood pressure<130/80mmHg……25% of patients *Complete lipid profile……85% of patients* *LDL>130mg/dL……≤37% of patients* LDL<100mg/dL……36% of patients *Eye Exam……60% of patients*

		Foot Exam……..80% of patients *Nephropathy assessment.....80% of patients* *Smoking status and cessation advice or treatment.....80% of patients*

Current Program Name: Low Back Pain **Date Started:** May 31, 2006		
Program Description – *What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services* To implement rapid access of physician and physical therapy services to patients with low back pain, with appropriate follow-up, imaging, and specialty consultation**.**		
1.	**Integration –** a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each) b. Do you stratify risk for the intervention group? c. Are there incentives? d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have co-morbid conditions, (E.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	a. Same day or next day scheduling for patients with low back pain to see their primary care provider to ensure a musculoskeletal reason for low back pain. Same day or next day scheduling for patients with musculoskeletal low back pain to see the physical therapist for evaluation and treatment. b. No. c. Improved patient care and access was our incentive. d. The program is client-based, focusing on rapid access, with attention to pain and function. It is also provider-focused, reducing barriers to rapid treatment in a team-based approach. e. Low back pain may exist with mood disorders as a co-morbid condition. As much mechanical low back pain resolves rapidly, screening for depression is deferred until the two-week follow-up visit unless there are clinical reasons to initiate at the first visit. f. Not specifically. It is based on the National Commission on Quality Assurance (NCQA) Back Pain Recognition Program, which was in draft form at the start of the project. g. This was an internal project, in conjunction with Puget Sound Sports and Spine located at Harborview Medical Center and UW Medicine Eastside Specialty Center Physical Therapy.

2.	Population – a. What is the total population targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	a) All adult patients presenting to the UW Medicine Factoria Clinic with acute mechanical low back pain. b) All adult patients presenting to the UW Medicine Factoria Clinic with acute mechanical low back pain. c) In the six months of the project, 56 patients were referred to UW Medicine Eastside Specialty Center Physical Therapy. We have not continued to formally track the number of referrals due to resource constraints, although they remain stable based on provider demand. d) During the six months of the project, ten patients were not scheduled with UW Medicine Eastside Specialty Center Physical Therapy: two were due to language barrier, one due to cost (self-pay), and seven who preferred to be seen by another physical therapy office. e) 66 patients in six months, seen by seven primary care providers.
3.	Data a. What data do you collect? (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a) The data collected were referrals to physical therapy, and patients who saw the physical therapist based upon our electronic medical record. We had considered tracking imaging and specialty referrals, but resource constraints led us to place that next phase of the project on hold. b) The initial plan was for outcome measures to be number of patients seen for low back pain, number of patients referred to physical therapy, number of patients discharged from physical therapy, and number of patients referred for specialty care. As stated, we did not specifically track the latter due to resource constraints. c) Improved patient satisfaction due to the streamlining of access.
4.	Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ration?	a) The managers of the UW Medicine Factoria Clinic and Eastside Specialty Center were involved throughout the project. b) One physician, one physical therapist, and one nurse were involved throughout the project. A second physical therapist joined towards the end of the six-month project. One physician assistant student was involved as part of her MEDEX culminating project.
5.	What is the total cost? (contract or staffing/overhead)	The staff time involved in this project was not tracked.
6.	Reporting What are the metrics used for reporting current statistics?	Currently, this project is on hold. Should our resource constraints lift, we would anticipate following the National Commission on Quality Assurance Back Pain Recognition Program standards and criteria, available at http://www.ncqa.org/tabid/169/Default.aspx

Substitute Senate Bill 5841
Disease Management
Yakima Valley Farm Workers Clinic

Current Program Name: YVFWC Asthma Home Visiting

Date Started: Initially in 2000 just in Toppenish, have spread since to other communities in the Yakima Valley based on grant availability

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

Asthma home visitors, paraprofessionals trained according to the ALAW master home environmentalist standards. The provide home environmental assessment and education, about trigger, for families of children with asthma and other allergies. The home visitors also provide basic teaching on what asthma is, and social service referrals.

1. **Integration –**
   a. Describe how the program is integrated with treating provider(s)?
   (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. Do you stratify risk for the intervention group?
   c. Are there incentives?
   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention
   e. Many chronic diseases have co-morbid conditions, (E.g. diabetes/CAD), does the program integrate with other conditions?
   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)
   g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

a. Home visiting services are provided to patients referred by primary care providers. Staff chart in the shared YVFWC electronic medical record, so that medical staff have access to information gained and services provided on home visit. Home visiting staff coordinate with physician and nursing staff as appropriate for the care of the patient.

b. Our internal program evaluation indicates that the intervention is most effective for children with more severe asthma, in terms of meeting outcomes for reduced ER visits and hospitalizations, so we attempt to concentrate limited services on those more severe patients. However, since this is a grant-funded program we need to be responsive to the priorities of the funders. Some funders would prefer to see services to all with the disease rather than risk stratification.

c. We are sometimes able to provide low-cost, asthma friendly cleaning kits to families, as a part of the home environmental education to teach what cleaning products will be less irritating to the child's asthma. We also are sometimes (depending on funding) able to provide medicine boxes (assists in organizing medications/equipment), pillow and mattress covers. Peak flow meters (provided by the American Lung Association of the Northwest) are provided when available.

d. Client focused intervention.

e. The most common co-morbidity we identify with childhood asthma is obesity, and yes our staff do coordinate with dietitians in the clinics as availability allows. Inquiries and information are made regarding gastro esophageal reflux disease (G.E.R.D.), eczema and upper respiratory allergies.

f. Yes, this is a collaborative approach. American Lung Association of the Northwest, Educational Service District 105, school nurses, and others are a part of the Yakima County Asthma Coalition. Our Coordinator also serves on the Washington Asthma Initiative Steering Committee providing liaison with statewide programs.

g. We provide the services directly. We find we are best able to recruit and train appropriate bilingual staff necessary.

2. *Population –*

a. *What is the total population targeted?*	a. *Children and adults with asthma who are patients of YVFWC in Yakima Valley.*
f. *How are enrollees identified for the program?*	b. *Enrollees are identified through provider referrals, school nurse referral and patient lists.*
g. *At the present time, how many are in your program?*	c. *Approximately 40.*
h. *How many may have been in your program?*	d. *>400-500 since its inception*
i. *What is the eligible population?*	e. *Children and adults with asthma who are patients of YVFWC as well as high risk children referred by school nurses in the Yakima Valley.*

3. *Data*

a. *What data do you collect? (e.g. claims, customer service, etc.)*	a. *We collect risk data, home environmental risks, and outcome data.*
b. *What are the specific measures of program success?*	b. *Impact evaluation measures are hospitalizations and ER visits, but we look at intermediate measures such as reduced home triggers and days of missed school.*
c. *What outcomes were achieved as a result of the program*	c. *A 2003 evaluation determined that for those children/families who received a high-dose of the intervention (8-12 visits over one year) they had significant reduction in hospitalization and ER utilization.* *We are currently working with a PhD fellow at UW to do more detailed analysis of our complete dataset.*

4. *Staffing*

a. *How many administrative staff are required?*	a. *PT data entry for evaluation + portion of an evaluator staff*
g. *How many clinical Staff?*	b. *3 home visitors and 1 working supervisor/coordinator*
h. *What is the expected staff to patient ration?*	c. *35-50 per home visitor*

5. *What is the total cost? (contract or staffing/overhead)*

In past years, this program has been funded by a variety of grant funds, as well as underwritten by the organization. Grant sources in past have included federal EPA, federal Office of Rural Health, and the Washington Health Foundation. We currently have a grant from the Healthcare Authority under the Community Health Care Collaborative (CCHC) grant program. That grant is $125,000 over two years (07-09), but does not cover the entire costs of operating the program.

6. *Reporting*
What are the metrics used for reporting current statistics?

Currently we report the number of unduplicated students in a target school district served by the program and the demographic characteristics of those students each quarter. The number of students in the target school district with asthma, and the percent of those who have an Asthma Care Plan or Emergency Care Plan on file with the school. The percent of students with asthma who have authorization to self administer their medication. A comparison of absenteeism for 2007-2008 for students with asthma who participated in the program vs. those who did not participate. And the number of county child care providers who received Little Lungs Breathing training.

Request for Information Responses – State Agencies

Substitute Senate Bill 5841
Disease Management
Department of Corrections

Current Program Name: DOC
Date Started: unknown
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
DOC does not currently have DM programs. With the exception of Hepatitis C, most chronic diseases are handled within the primary care encounter with a primary care practitioner: ARNP, PA, or MD. Treatment decisions are made on a case by case basis using national guidelines wherever possible. Nurses and other professional adjuct staff are utilized as necessary, for example nurses and dieticians for diabetic education. Hepatitis C is handled through protocol which is driven by infection control nurses. Mid-level practitioners and physicians are involved at key decision-making nodes in the protocol. The nurse is responsible for monitoring the patient independently as long as the patient remains within the parameters of the protocol. The Hepatitic C protocol has been in place since approximately 2003.

1. **Integration –**
   a. Describe how the program is integrated with treating provider(s)?
   (E.g. nurse/MD, Nurse/case management, and what is the role for each)
   b. Do you stratify risk for the intervention group?
   c. Are there incentives?
   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention
   e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?
   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)
   g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

2. Population –
   a. What is the total population targeted?
   b. How are enrollees identified for the program?
   c. At the present time, how many are in your program?
   d. How many may have been in your program?
   e. What is the eligible population?
3. Data
   a. What data do you collect?
   (e.g. claims, customer service, etc.)
   b. What are the specific measures of program success?
   c. What outcomes were achieved as a result of the program
4. Staffing
   a. How many administrative staff are required?
   b. How many clinical Staff?
   c. What is the expected staff to patient ration?
5. What is the total cost? (contract or staffing/overhead)
6. Reporting
   What are the metrics used for reporting current statistics?

Substitute Senate Bill 5841
Disease Management
Department of Health
Washington State Collaborative

Current Program Name: Washington State Collaborative
Date Started: February 1999

Program Description – A systematic approach that engages primary care organizations and their patients with chronic disease in changing the care system from an acute care model to a model designed to manage chronic disease. Primary care providers and their staff use the evidence-based Chronic Care Model to focus their system changes on proven components that encourage high quality disease management. The Washington State Collaborative uses a team approach and requires 3 or more staff including a senior level manager participates in the 13-month initiative. Participants develop their own patient registries and learn how to respond to population-based reports which reflect how the primary care organization is addressing the clinical management needs of all of their patients with chronic disease. At the same time, the clinic team starts to engage their patients in self management goal setting and offers planned visits for chronic disease. Participating organizations focus on one chronic disease to learn these important system changes to improve quality and then spread to other conditions. Washington State Collaborative offers a choice of focus on diabetes or cardiovascular disease prevention. Over 114 primary care teams have participated in 5 Collaboratives with improved outcomes at the end of each 13-month Collaborative cycle. The Washington State Collaborative is sponsored by Department of Health including the Diabetes Prevention and Control Program, Heart Disease and Stroke Program, Tobacco Cessation Program; and Qualis Health; and Improving Chronic Illness Care (RWJ-Group Health).

1. **Integration –**
   a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)

   a) The implementation of the Chronic Care Model encourages engagement of a team (not just the provider) and includes physicians, nurses, health educators, MAs', laboratory, front desk and the patients.

   b. Do you stratify risk for the intervention group?

   b) The stratification is based on the team's desired outcomes for their target population. Providers may stratify by single outcome measures or by patients who have not received recommended tests or check-ups in the recommended timeframe.

   c. Are there incentives?

   c) The participating primary care organizations are offered scholarships to offset travel to learning sessions; staff replacement costs; and funds for chart abstraction to start the electronic registry. A free registry is offered by the Department of Health along with free technical support for start-up and training on the registry.

   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention

   d) The program is focused on provider interventions to help them to change their delivery system design. These changes include preparing teams to fulfill patient needs and at the same time helping the patients to participate in their own health care (self-management support).

   e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?

   e) Yes. By changing the way that primary care organizations approach chronic disease care, there is an integration of co-morbidities.

   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)

   f) The Washington State Collaborative and its co-sponsors have had or currently have support from the American Heart Association, the American Diabetes Association, several pharmaceutical companies, HRSA Medicaid, Pacificare, Premera Blue Cross, CHPW, Regence, Aetna, Uniform Health Plan, and Washington Academy of Family Physicians. Department of Health Programs that have participated in the past or are current participants include STEPS to a Healthier Washington, Heart Disease and Stroke Prevention, Tobacco Prevention and Control, Immunization, and Cancer Prevention and Control. The Diabetes Prevention and Control Program has historically been the lead program.

   g. Please identify whether the disease management program are developed

and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

g) The Washington State Collaborative is developed and implemented by the co-sponsoring organizations; primarily by the Department of Health's Diabetes Prevention and Control Program and Heart Disease and Stroke Prevention Program, and Qualis Health, with input from the organizations mentioned above.

2. Population –

   a. What is the total population targeted?

   b. How are enrollees identified for the program?

   c. At the present time, how many are in your program?

   d. How many may have been in your program?

   e. What is the eligible population?

a) The target population is all primary care providers; all patients with diabetes or cardiovascular disease.

b) The primary care organizations volunteer to participate. They in turn determine which enrollees will be followed in the collaborative. The Collaborative defines the patient population eligible depending on what disease they choose to focus on.

c & d) At least 114 primary care practice teams have been through the Collaborative. Some provider teams come from the same clinical system (such as Swedish Medical Centers) and spread the concepts to their entire provider network, so it is difficult to estimate the number of patients involved. We do know that over 72,000 patients of 928 primary care providers are entered in the DOH CDEMS registry in 165 clinics across Washington State.

e) In general, the eligible patient population must be adults 18 and older and for the diabetes focus, must be diagnosed with Type 1 or Type 2 diabetes, and not be pregnant.

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3. Data

   a. What data do you collect? (e.g. claims, customer service, etc.)

   b. What are the specific measures of program success?

   c. What outcomes were achieved as a result of the program

a) We collect clinical outcome data and process data from all participating clinics during the 13-month cycle. Clinical outcome data includes laboratory results from the participating patients. Process data includes services, such as foot exams and eye exams, performed on patients.

b) Specific measures of program success are outcome and process measures. Teams are required to report monthly during the 13-month cycle on required outcome and process measures. The report is on the total patient population, not individual patients. Measures for diabetes include: %of patient's with A1C<7%; percent of patients with blood pressure <130/80 mmHg, % patients with LDL Cholesterol <100 mg/dL, Documentation of Self Management Goal and Tobacco Cessation Counseling. The teams may also track optional measures, such as use of ACE Inhibitors, Aspirin use, Kidney function testing, dilated eye exam and comprehensive foot exams. Measures for heart disease were similar: percent of patients with LDL < 130; percent of patients with blood pressure < 140/90, etc.

c) As for outcomes achieved, in each 13-month cycle of the Washington State Collaborative, most primary care teams improve outcomes above a determined baseline. The participant teams, as part of their enrollment process, provide initial data from a patient's medical records abstraction, this is taken as the baseline for the collaborative work.

4. Staffing a. How many administrative staff are required? b. How many clinical Staff?	For required staffing, the Collaborative requires at least 2 fulltime staff including the director and the improvement advisor and coordinator. Part-time faculty include a medical director; and up to 6 faculty to run the 2-day learning sessions.
c. What is the expected staff to patient ration?	For clinical staff, participating teams must have at least one provider and two other team members, which have been described above. Each clinical system determines staff to patient ratio based on their available resources.
5. What is the total cost? (contract or staffing/overhead)	Approximately $700,000 for one 13-month cycle for 30 primary care practice teams and their patients
6. Reporting What are the metrics used for reporting current statistics?	Data from each team is aggregated to produce the median percentages for the required measures of all participating teams in the 13-month Collaborative cycle.

Substitute Senate Bill 5841
Disease Management
Washington Department of Veterans Affairs

Current Program Name:
Date Started:
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

1. **Integration –**
   a. Describe how the program is integrated with treating provider(s)?
   (E.g. nurse/MD, Nurse/case management, and what is the role for each)

   b. Do you stratify risk for the intervention group?

   c. Are there incentives?

   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention

   e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?

   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)

   g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

Disease management is managed by a Medical Director at each DVA facility with the assistance of a resident care team consisting of nurses, dietitians, occupational therapists, pharmacists and other adjunct health care staff. Treatment decisions are made individually using national guidelines and other accepted care modalities related to long term care. Registered Nurses and other professional staff are utilized as part as the comprehensive care plan. Hepatitis C, AIDS and other infectious diseases are handled through infection control protocols managed by infection control nurses. The Departments of Nursing at the three Veterans Home are responsible for monitoring the residents' disease process. Physicians and Mid-level practitioners drive the total resident care plan. Residents are referred to the federal VA for specialty care and/or consultation when their conditions or diseases surpass the facilities' capability.

2. Population –

   a. What is the total population targeted?

   b. How are enrollees identified for the program?

   c. At the present time, how many are in your program?

   d. How many may have been in your program?

   e. What is the eligible population?

3. Data

   d. What data do you collect?

   - (e.g. claims, customer service, etc.)

   e. What are the specific measures of program success?

   f. What outcomes were achieved as a result of the program

4. Staffing

   a. How many administrative staff are required?

   b. How many clinical Staff?

   c. What is the expected staff to patient ration?

5. What is the total cost? (contract or staffing/overhead)

6. Reporting

   What are the metrics used for reporting current statistics?

Substitute Senate Bill 5841
Disease Management
Health Care Authority/Community Health Services

Current Program Name: COMMUNITY HEALTH SERVICES (CHS)
Date Started:
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
CHS allocates grant to 37 Community Health Clinics with 163 delivery site, to provide primary care services to the uninsured and underserved population of Washington that are at or below the 200% of the Federal Income Guidelines. In their primary care practice they incorporate chronic disease management models addressing multiple health issues. In the grant application, do clinics have to indicate they have a Disease Management program? If so, what. No, they identify their top diseases and what are they doing to decrease risks or increase outcomes; programs, classes or disease management programs. It just happens that most of the diagnosis are chronic diseases and I would say that a great number of the clinics have disease management programs.

1. **Integration –**

a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	Disease management is a component of primary care. Most patients of Community Health Centers/Clinic have complex health needs requiring assigned primary care providers to integrated disease management during their care. Clinics are staffed with a wide variety of health professionals such as MD, ARNP, PA, Dietitians, Mental Health Providers and other professionals.
b. Do you stratify risk for the intervention group?	Each Center/Clinic manages patients differently according to the disease management model, facility and resources available.
c. Are there incentives?	We are not aware of any at this moment.
d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	All programs are established with patient focus and patient needs as a priority.
e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	They do since most of the patients do have more than one chronic disease as example of Diabetes and Hypertension. They are complex in nature and treatment needs to address all needs.
f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	Most Centers/Clinics do network WA State Diabetes Collaborative, Phase II Diabetes Collaborative, Diabetes Registry, Asthma Coalition, Depression Collaborative, and other programs and agencies as appropriate.
g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	Disease management is provided at the Center/Clinic levels. CHS does not manage or develop disease management programs.

2.	• Population –	The uninsured and underserved population at or under 200% of FIG seen at the Community Health Centers/Clinics. In 2007, the approximate number of unduplicated patients seen 263,724.
	a. What is the total population targeted?	
	b. How are enrollees identified for the program?	Unknown
	c. At the present time, how many are in your program?	263,724 CHS grant program
	d. How many may have been in your program?	
	e. What is the eligible population?	All uninsured and underserved population
3.	• Data	
	a. What data do you collect?	Unknown
	• (e.g. claims, customer service, etc.)	
	b. What are the specific measures of program success?	Increase access to health care.
	c. What outcomes were achieved as a result of the program	Increase access to health care and reduced ED visit.
• 4.	• Staffing	
	i. How many administrative staff are required?	Unknown
	j. How many clinical Staff?	Staffing for the Center/Clinics is hard to determine because it varies depending on the size, resources, and population served and delivery sites of the organization.
	k. What is the expected staff to patient ratio?	Unknown
• 5.	• What is the total cost? (contract or staffing/overhead)	Unknown
• 6.	• Reporting	
	• What are the metrics used for reporting current statistics?	Not applicable

Substitute Senate Bill 5841
Disease Management
HRSA Disease Management Program

Current Program Name: There is no current DM program for FFS; this report is for the DM program that concluded July 1, 2006.
Date Started: April, 2002

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
Asthma Disease Management was contracted out to McKesson Health Solutions. The vendors identified clients for management and offered a combination of telephonic and in person care management. They referred clients to other DSHS services, e.g. long term care and mental health treatment. McKesson used a combination of communication methods to interact with providers about clients, e.g. in person meetings, fax and telephonic contact.

1. **Integration –**

a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Nurse care managers would contact the identified primary provider with gaps in treatment (e.g. labs or medications not ordered), information from assessment, and their plan of care. Physicians were requested to fax back changes to the care plan or education plan for the client.
b. Do you stratify risk for the intervention group?	b. The vendors did stratify based on the initial and follow-up risk assessments.
c. Are there incentives?	c. Incentives were offered to clients for engaging in the program. These were very small, e.g. $5 phone card or a medication box.
d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Client focused.
e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	e. Co-morbid conditions were assessed and care plans for multiple conditions were offered, but not well integrated.
f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. The vendor approached ALA for coordination on home environmental assessment, providing mattress covers, and peak flow metersetc.
g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. As above, McKesson was the contractors.

2. Population – a. What is the total population targeted? b. How are enrollees identified for the program? c. At the present time, how many are in your program? d. How many may have been in your program? e. What is the eligible population?	a. 16,000 clients in targeted eligibility group. b. Claims and eligibility data sent to vendor for processing and identifying by dx and CPT codes. c. Currently inactive, but had approximately 1,600 active participants. d. Over course of program 16,900 clients were contacted for enrollment, but had a successful engagement rate of about 39%. e. Aged Blind and Disabled Medicaid clients, not also eligible for Medicare.
3. Data a. What data do you collect? • (e.g. claims, customer service, etc.) b. What are the specific measures of program success? c. What outcomes were achieved as a result of the program	a. Claims, patient reported process and outcome measures, medical record extracted data, patient satisfaction data. b. For each condition, tracked 1) pre and post utilization and cost measures (inpatient, outpatient, physician, pharmacy, other); 2) outcomes and process measures specific to complaint and satisfaction results. c. Significant improvements according to patient self-reported measures lower rates of smoking, , increased numbers of clients with action plans for asthma. Program was cost-neutral to cost-savings in most conditions by the third year of program. Reports available on request.
4. Staffing a. How many administrative staff are required? b. How many clinical Staff? c. What is the expected staff to patient ration?	Staffing is mostly contracted out. At DSHS level, approximately 2.0 FTE's.
5. What is the total cost? (contract or staffing/overhead)	Total cost for asthma about $3.6 million per year.
6. Reporting What are the metrics used for reporting current statistics?	Patient enrollment and engagement, monitoring of outcomes and processes as described above in #3.

Current Program Name: There is no current DM program for FFS; this report is for the DM program that concluded July 1, 2006.
Date Started: April, 2002

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
CHF Disease Management was contracted out to McKesson Health Solutions. The vendors identified clients for management and offered a combination of telephonic and in person care management. They referred clients to other DSHS services, e.g. long term care and mental health treatment. McKesson used a combination of communication methods to interact with providers about clients, e.g. in person meetings, fax and telephonic contact.

1. **Integration –**

a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Nurse care managers would contact the identified primary provider with gaps in treatment (e.g. labs or medications not ordered), information from assessment, and their plan of care. Physicians were requested to fax back changes to the care plan or education plan for the client.
b. Do you stratify risk for the intervention group?	b. The vendors did stratify based on the initial and follow-up risk assessments.
c. Are there incentives?	c. Incentives were offered to clients for engaging in the program. These were very small, e.g. $5 phone card or a medication box.
d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Client focused.
e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	e. Co-morbid conditions were assessed and care plans for multiple conditions were offered, but not well integrated.
f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. The vendor approached HRSA for coordination obtaining weight scales.
g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. As above, McKesson was the contractor.
h.	

2. Population –

   a. What is the total population targeted?

   a. 6,200 clients in targeted eligibility group.

   b. How are enrollees identified for the program?

   b. Claims and eligibility data sent to vendor for processing and identifying by dx and CPT codes.

   c. At the present time, how many are in your program?

   c. Currently inactive, but had approximately 1,600 active participants.

   d. How many may have been in your program?

   d. Over course of program 4,800 clients were contacted for enrollment, but had a successful engagement rate of about 40%.

   e. What is the eligible population?

   e. Aged Blind and Disabled Medicaid clients, not also eligible for Medicare.

3. Data

   a. What data do you collect? (e.g. claims, customer service, etc.)

   a. Claims, patient reported process and outcome measures, medical record extracted data, patient satisfaction data.

   b. What are the specific measures of program success?

   b. For each condition, tracked 1) pre and post utilization and cost measures (inpatient, outpatient, physician, pharmacy, other); 2) outcomes and process measures specific to complaint and satisfaction results.

   c. What outcomes were achieved as a result of the program

   c. Significant improvements according to patient self-reported measures lower rates of smoking, , increased use of ace inhibitors. Program was cost-neutral to cost-savings in most conditions by the third year of program. Reports available on request.

4. Staffing

   a. How many administrative staff are required?

   Staffing is mostly contracted out. At DSHS level, approximately 2.0 FTE's.

   b. How many clinical Staff?

   c. What is the expected staff to patient ration?

5. What is the total cost? (contract or staffing/overhead)

   Total cost for CHF about $2.4 million per year.

6. • Reporting
   • What are the metrics used for reporting current statistics?

   Patient enrollment and engagement, monitoring of outcomes and processes as described above in #3.

Current Program Name: There is no current DM program for FFS; this report is for the DM program that concluded July 1, 2006.
Date Started: April, 2002
Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
Chronic Kidney Disease Management was contracted out to Renaissance Health Care Inc. The vendor identified clients for management and offered a combination of telephonic and in person care management. They referred clients to other DSHS services, e.g. long term care and mental health treatment. Renaissance used a combination of communication methods to interact with providers about clients, e.g. in person meetings, fax and telephonic contact.

1.	• **Integration –** a. Describe how the program is integrated with treating provider(s)? • (E.g. nurse/MD, Nurse/case management, and what is the role for each) b. Do you stratify risk for the intervention group? c. Are there incentives? d. Please indicate if the program is based on a client focused intervention or a provider focused intervention e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions? f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.) g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	• a. Nurse care managers would contact the identified primary provider with gaps in treatment (e.g. labs or medications not ordered), information from assessment, and their plan of care. Physicians were requested to fax back changes to the care plan or education plan for the client. b. The vendors did stratify based on the initial and follow-up risk assessments. c. Incentives were offered to clients for engaging in the program. These were very small, e.g. $5 phone card or a medication box. d. Client focused. e. Co-morbid conditions were assessed and care plans for multiple conditions were offered, but not well integrated. f. The vendor approached HRSA for coordination on increasing AVF rates to decrease infections at access sites. g. As above, Renaissance was the contractors.

2. Population –

a. What is the total population targeted?	a. 87 clients in targeted eligibility group.
b. How are enrollees identified for the program?	b. Claims and eligibility data sent to vendor for processing and identifying by dx and CPT codes.
c. At the present time, how many are in your program?	c. Currently inactive, but had approximately 46 active participants.
d. How many may have been in your program?	d. Over course of program 132 clients were contacted for enrollment, but had a successful engagement rate of about 34 %.
e. What is the eligible population?	e. Aged Blind and Disabled Medicaid clients, not also eligible for Medicare.

3. Data

a. What data do you collect? (e.g. claims, customer service, etc.)	a. Claims, patient reported process and outcome measures, medical record extracted data, patient satisfaction data.
b. What are the specific measures of program success?	b. For each condition, tracked 1) pre and post utilization and cost measures (inpatient, outpatient, physician, pharmacy, other); 2) outcomes and process measures specific to complaint and satisfaction results.
c. What outcomes were achieved as a result of the program	c. Significant improvements according to patient self-reported measures lower rates of smoking, , increased referral to a nephrologist. Program was cost-neutral to cost-savings in most conditions by the third year of program. Reports available on request.

4.

• Staffing a. How many administrative staff are required?	Staffing is mostly contracted out. At DSHS level, approximately 2.0 FTE's.
b. How many clinical Staff?	
c. What is the expected staff to patient ration?	

5.

• What is the total cost? (contract or staffing/overhead)	Total CKD cost about $20,000 per year.

6.

• Reporting • What are the metrics used for reporting current statistics?	Patient enrollment and engagement, monitoring of outcomes and processes as described above in #3.

Substitute Senate Bill 5841
Disease Management
HRSA Disease Management Program

Current Program Name: There is no current DM program for FFS; this report is for the DM program that concluded July 1, 2006.
Date Started: April, 2002

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

COPD Disease Management was contracted out to McKesson Health Solutions. The vendors identified clients for management and offered a combination of telephonic and in person care management. They referred clients to other DSHS services, e.g. long term care and mental health treatment. McKesson used a combination of communication methods to interact with providers about clients, e.g. in person meetings, fax and telephonic contact.

1. **Integration –**

a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Nurse care managers would contact the identified primary provider with gaps in treatment (e.g. labs or medications not ordered), information from assessment, and their plan of care. Physicians were requested to fax back changes to the care plan or education plan for the client.
b. Do you stratify risk for the intervention group?	b. The vendors did stratify based on the initial and follow-up risk assessments.
c. Are there incentives?	c. Incentives were offered to clients for engaging in the program. These were very small, e.g. $5 phone card or a medication box.
d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Client focused.
e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	e. Co-morbid conditions were assessed and care plans for multiple conditions were offered, but not well integrated.
f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. The vendor approached ALA for coordination on home environmental assessment.
g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. As above, McKesson was the contractors.

2. Population –

a. What is the total population targeted?	a. 7,400 clients in targeted eligibility group.
b. How are enrollees identified for the program?	b. Claims and eligibility data sent to vendor for processing and identifying by dx and CPT codes.
c. At the present time, how many are in your program?	c. Currently inactive, but had approximately 3,000 active participants.
d. How many may have been in your program?	d. Over course of program 8,800 clients were contacted for enrollment, but had a successful engagement rate of about 32%.
e. What is the eligible population?	e. Aged Blind and Disabled Medicaid clients, not also eligible for Medicare.

3. • Data

a. What data do you collect? • (e.g. claims, customer service, etc.)	a. Claims, patient reported process and outcome measures, medical record extracted data, patient satisfaction data.
b. What are the specific measures of program success?	b. For each condition, tracked 1) pre and post utilization and cost measures (inpatient, outpatient, physician, pharmacy, other); 2) outcomes and process measures specific to complaint and satisfaction results.
c. What outcomes were achieved as a result of the program	c. Significant improvements according to patient self-reported measures lower rates of smoking, , increased numbers of clients with prescribed inhaler. Program was cost-neutral to cost-savings in most conditions by the third year of program. Reports available on request.

4. • Staffing

a. How many administrative staff are required?	Staffing is mostly contracted out. At DSHS level, approximately 2.0 FTE's.
b. How many clinical Staff?	
c. What is the expected staff to patient ration?	

5. • What is the total cost? (contract or staffing/overhead) — Total cost for COPD about $1.4 million per year.

6. • Reporting
   • What are the metrics used for reporting current statistics? — Patient enrollment and engagement, monitoring of outcomes and processes as described above in #3.

Current Program Name: There is no current DM program for FFS; this report is for the DM program that concluded July 1, 2006.
Date Started: April, 2002

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services
Diabetes Disease Management was contracted out to McKesson Health Solutions. The vendors identified clients for management and offered a combination of telephonic and in person care management. They referred clients to other DSHS services, e.g. long term care and mental health treatment. McKesson used a combination of communication methods to interact with providers about clients, e.g. in person meetings, fax and telephonic contact.

1. • **Integration –**

a. Describe how the program is integrated with treating provider(s)? • (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Nurse care managers would contact the identified primary provider with gaps in treatment (e.g. labs or medications not ordered), information from assessment, and their plan of care. Physicians were requested to fax back changes to the care plan or education plan for the client.
b. Do you stratify risk for the intervention group?	b. The vendors did stratify based on the initial and follow-up risk assessments.
c. Are there incentives?	c. Incentives were offered to clients for engaging in the program. These were very small, e.g. $5 phone card or a medication box.
d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Client focused.
e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	e. Comorbid conditions were assessed and care plans for multiple conditions were offered, but not well integrated.
f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. The vendor approached ADA to provide scholarships to their annual conference, and McKesson medical director participated in the diabetes collaborative
g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. As above, McKesson was the contractors.

2. Population –

   a. What is the total population targeted?

   a. 20,000 clients in targeted eligibility group.

   b. How are enrollees identified for the program?

   b. Claims and eligibility data sent to vendor for processing and identifying by dx and CPT codes.

   c. At the present time, how many are in your program?

   c. Currently inactive, but had approximately 6600 active participants.

   d. How many may have been in your program?

   d. Over course of program15,400 clients were contacted for enrollment, but had a successful engagement rate of about 39%.

   e. What is the eligible population?

   e. Aged Blind and Disabled Medicaid clients, not also eligible for Medicare.

3. Data

   a. What data do you collect? (e.g. claims, customer service, etc.)

   a. Claims, patient reported process and outcome measures, medical record extracted data, patient satisfaction data.

   b. What are the specific measures of program success?

   b. For each condition, tracked 1) pre and post utilization and cost measures (inpatient, outpatient, physician, pharmacy, other); 2) outcomes and process measures specific to complaint and satisfaction results.

   c. What outcomes were achieved as a result of the program

   c. Significant improvements according to patient self-reported measures lower rates of smoking, , improved rates of lab tests for diabetes, Program was cost-neutral to cost-savings in most conditions by the third year of program. Reports available on request.

4. Staffing

   a. How many administrative staff are required?

   Staffing is mostly contracted out. At DSHS level, approximately 2.0 FTE's.

   b. How many clinical Staff?

   c. What is the expected staff to patient ration?

5. What is the total cost? (contract or staffing/overhead)

   Total cost for diabeste about $5.8 million per year.

6. Reporting

   What are the metrics used for reporting current statistics?

   Patient enrollment and engagement, monitoring of outcomes and processes as described above in #3.

Substitute Senate Bill 5841
Disease Management
HRSA Disease Management Program

Current Program Name: There is no current DM program for FFS; this report is for the DM program that concluded July 1, 2006.
Date Started: April, 2002

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

End-Stage Renal Disease Management was contracted out to Renaissance Health Care Inc. The vendor identified clients for management and offered a combination of telephonic and in person care management. They referred clients to other DSHS services, e.g. long term care and mental health treatment. Renaissance used a combination of communication methods to interact with providers about clients, e.g. in person meetings, fax and telephonic contact.

1. **Integration –**

a. Describe how the program is integrated with treating provider(s)? (E.g. nurse/MD, Nurse/case management, and what is the role for each)	a. Nurse care managers would contact the identified primary provider with gaps in treatment (e.g. labs or medications not ordered), information from assessment, and their plan of care. Physicians were requested to fax back changes to the care plan or education plan for the client.
b. Do you stratify risk for the intervention group?	b. The vendors did stratify based on the initial and follow-up risk assessments.
c. Are there incentives?	c. Incentives were offered to clients for engaging in the program. These were very small, e.g. $5 phone card or a medication box.
d. Please indicate if the program is based on a client focused intervention or a provider focused intervention	d. Client focused.
e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?	e. Co-morbid conditions were assessed and care plans for multiple conditions were offered, but not well integrated.
f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)	f. The vendor approached HRSA for coordination on increasing AVF rates to decrease infections at access sites.
g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.	g. As above, Renaissance was the contractor.

2. Population –

   a. What is the total population targeted?

   A. 130 clients in targeted eligibility group.

   b. How are enrollees identified for the program?

   b. Claims and eligibility data sent to vendor for processing and identifying by dx and CPT codes.

   c. At the present time, how many are in your program?

   c. Currently inactive, but had approximately 126 active participants.

   d. How many may have been in your program?

   d. Over course of program 1,500 clients were contacted for enrollment, but had a successful engagement rate of about 98%.

   e. What is the eligible population?

   e. Aged Blind and Disabled Medicaid clients, not also eligible for Medicare.

3. Data

   a. What data do you collect? (e.g. claims, customer service, etc.)

   a. Claims, patient reported process and outcome measures, medical record extracted data, patient satisfaction data.

   b. What are the specific measures of program success?

   b. For each condition, tracked 1) pre and post utilization and cost measures (inpatient, outpatient, physician, pharmacy, other); 2) outcomes and process measures specific to complaint and satisfaction results.

   c. What outcomes were achieved as a result of the program

   c. Significant improvements according to patient self-reported measures lower rates of smoking, , increased use of AVF access rate. Program was cost-neutral to cost-savings in most conditions by the third year of program. Reports available on request.

4. Staffing

   a. How many administrative staff are required?

   Staffing is mostly contracted out. At DSHS level, approximately 2.0 FTE's.

   b. How many clinical Staff?

   c. What is the expected staff to patient ration?

5. What is the total cost? (contract or staffing/overhead)

   Total ESRD cost about $500,000 per year.

6. Reporting

   What are the metrics used for reporting current statistics?

   Patient enrollment and engagement, monitoring of outcomes and processes as described above in #3.

Current Program Name: **Centers of Occupational Health and Education (COHE)**

Date Started: July 2002

Program Description – What is the Intervention? Please be specific about the coordination, referral, provider and ancillary services

The Occupational Health Services Project is a partnership among the Department of Labor and Industries, Valley Medical Center in Renton, and St. Luke's Rehabilitation Institute in Spokane to expand occupational healthcare expertise and improve injured worker outcomes. This pilot study is a community-based effort to improve occupational health services for injured workers. It will specifically test the ability to use education and incentives to decrease disability. The pilot uses occupational health leaders to increase the occupational health skills and knowledge of providers who treat injured workers.

The OHS project is a community-wide quality-improvement intervention implemented through Centers of Occupational Health and Education (COHEs). The COHEs recruit community physicians, establish mechanisms to identify high-risk cases for long term disability, develop procedures for coordinating care, implement quality indicators, foster communication between providers and employers, offer training to participating physicians, and feed back information to participating physicians on their performance.

1. **Integration –**
   a. Describe how the program is integrated with treating provider(s)?
   - (E.g. nurse/MD, Nurse/case management, and what is the role for each)

   b. Do you stratify risk for the intervention group?

   c. Are there incentives?

   d. Please indicate if the program is based on a client focused intervention or a provider focused intervention

   e. Many chronic diseases have comorbid conditions,(E.g. diabetes/CAD), does the program integrate with other conditions?

   f. Please indicate if the program collaborates with other community based interventions/alliances or state agencies (E.g. Diabetes Collaborative, Asthma, Heart Association, etc.)

a. Each of the two pilot sites developed a Center of Occupational Health and Education (COHE) to recruit physicians (attending doctors) for the pilot, oversee care and conduct quality improvement activities. As part of the pilot project, the COHE offers Health Services Coordination, whose function is to coordinate and facilitate communication among the injured worker, physician, employer, occupational nurse consultant, and unions – when appropriate. The main goal of Health Services Coordination is to ensure that no injured worker "falls through the cracks" due to lack of integrated services.

b. No

c. yes

d. provider

e. No

f. No

g. The COHEs are not a disease management program.

g. Please identify whether the disease management program are developed and operated by your organization or whether you utilize vendors to deliver these services. Please include the vendor's name.

2. • Population –

a. What is the total population targeted?

b. How are enrollees identified for the program?

c. At the present time, how many are in your program?

d. How many may have been in your program?

e. What is the eligible population?

3. Data

a. What data do you collect?

• (e.g. claims, customer service, etc.)

b. What are the specific measures of program success?

c. What outcomes were achieved as a result of the program

•

• a. Approximately 30,000 injured workers (state-fund) per year. We have no specific target for the number of injured workers treated since they have free choice of providers.

•

• b. Injured workers have free choice of providers and if they select a COHE provider, they will receive the services referenced in the program description

•

• c. Approximately 30,000 injured workers (state-fund) per year.

•

• d. Approximately 60,000 injured workers

•

• e. State-fund injured workers in the catchment area who select a COHE provider

•

a. The primary measures for the evaluation, all derived from L&I administrative data, include:
• % of total cases that went on disability (time loss)
• % of cases on disability at different time points post claim receipt, e.g., 90 days, 180 days, or 360 days
• Duration of disability measured in days from claim receipt
• Disability costs
• Medical costs
• Total costs (sum of medical and disability costs)
• Injured worker satisfaction
• Provider satisfaction

b. Our outcome evaluation was guided by three principal aims:
• To assess the effect of the COHE on the incidence and duration of disability,
• To assess the effect of the COHE on patient satisfaction and employment outcomes, and
• To evaluate the effect of the COHE on medical and disability (time loss) costs.

In addition to these three principal aims, the evaluation also addressed a secondary aim of examining COHE-specific activities, such as health services coordination, and other related activities consistent with quality indicators, such as the submission of the report of accident within two business days.

c.

Reduced disability and lower medical and disability costs

High satisfaction among injured workers

Providers more willing to treat injured workers

COHE Cost Effects:

- Eastern Washington per COHE claim savings: $359
- Renton Washington Per COHE claim savings: $441

4. Staffing
   a. How many administrative staff are required?
   b. How many clinical Staff?
   c. What is the expected staff to patient ration?

a. Staffing varies by COHE. Both have a part-time Project Director and Medical Director and ~2 FTEs doing health services coordination

b. As of the 2nd quarter of 2006, 621 providers have joined the project.

c. N/A

5. What is the total cost? (contract or staffing/overhead)

For 2005-2007 the contract total is $1,375,000 for both COHEs (Ea. WA is $970,000 and Renton is $405,000).

COHE Medical Costs: $1,095,000 (Eastern Wa COHE medical costs: $460,000 and Renton $635,000) were billed for activities such as telephone contact with employers, providing health services coordination, and submitting the report of accident form within 2 business days.

Staffing of the COHEs is covered in the contract costs listed above.

Including these medical and administrative cost **COHE Cost-Savings were:**

Eastern Washington per COHE claim savings: $359

Renton Washington Per COHE claim savings: $441

6. Reporting
   What are the metrics used for reporting current statistics?

The primary measures for the evaluation, all derived from L&I administrative data, include:

• % of total cases that went on disability (time loss)

• % of cases on disability at different time points post claim receipt, e.g., 90 days, 180 days, or 360 days

• Duration of disability measured in days from claim receipt

• Disability costs

• Medical costs

• Total costs (sum of medical and disability costs)