

COMPREHENSIVE CHRONIC DISEASE MANAGEMENT AND CARE COORDINATION PROGRAM DESCRIPTION

2010

CHRONIC CONDITION	Diabetes, CHF, Coronary Artery Disease
Population Relevance	<p><u>Diabetes</u> – Diabetes now affects nearly 24 million people in the United States, an increase of more than 3 million in approximately two years, according to the National Institute of Health, Report on Diabetes Statistics, 2007. Prevalence of Diagnosed and Undiagnosed Diabetes in the United States, All Ages, 2007:</p> <p>Total: 23.6 million people—7.8 percent of the population—have diabetes.</p> <p>Diagnosed: 17.9 million people</p> <p>Undiagnosed: 5.7 million people</p> <p>In New York State, the New York Diabetes Coalition reports that 1.1 million people- 7.7% of New York’s population- are estimated to have diagnosed diabetes. Another 450,000 New Yorkers with Type 2 diabetes remain undiagnosed.</p> <p>Diabetes can lead to serious complications, such as blindness, kidney damage, cardiovascular disease, and lower-limb amputations, but people with diabetes can lower the occurrence of these and other diabetes complications by controlling blood glucose, blood pressure, and blood lipids</p> <p><u>Diabetes Prevalence in the CIPA population:</u></p> <p>In 2008, the prevalence of CIPA patients with diabetes is 9.8%.</p> <p><u>Congestive Heart Failure Prevalence -</u> Heart failure is a cumulative consequence of all insults to the heart over someone’s life.¹ It is estimated that nearly 5 million Americans have heart failure.² Currently, about 5 million Americans are living with Heart failure and about 550,000 new cases are diagnosed each year. The prevalence of Heart Failure nearly doubles with each decade of life.²</p>

	<p><u>Congestive Heart Failure Prevalence in the CIPA population:</u> Patients with heart failure are 1.3% of the total CIPA patient population and have been identified by the payers as high risk for repeated hospitalizations that could benefit from disease management interventions.</p> <p><u>Coronary Vascular Disease Prevalence</u> – Stable coronary artery disease is the leading cause of death in the US, attributing to approximately 1 out of 5 deaths. The total cost annual cost of coronary artery disease is approximately \$130 billion with approximately 13 million Americans living with CAD ¹ Forty-three percent (43%) of all deaths in NYS were caused by cardiovascular disease which is twice as many deaths as the next leading cause of death – cancer ³. New York State ranks number 1 in the nation for death due to ischemic heart disease.³</p> <p><u>Coronary Vascular Disease in the CIPA population:</u> Coronary artery disease accounts for 2.6% of the total CIPA patient population.</p> <ol style="list-style-type: none"> 1. American Heart Association. <i>Heart Disease and Stroke Statistics – 2003 update</i>. Dallas, Tex: American Heart Association, 2002. 2. www.heartfailure.org, accessed January 6, 2009 3. http://www.health.state.ny.us/nysdoh/heart/healthy/healthy.pdf accessed January 13, 2009
<p>Program Description and Purpose</p>	<p>The Care Coordination program of the Catholic Independent Physicians Association (CIPA) was developed as a means to strengthen the clinical office’s chronic disease care coordination capabilities. The care coordination program encompasses disease management strategies that are implemented and sustained by the physician’s office, focusing on the utilization of evidenced based clinical practice guidelines. The CIPA disease management program utilizes care coordinators, who are R.Ns and LPNs, and are the staff in the physician office. Care Coordinators, function at the office in collaboration with and under the direction with the MD, as part of the team. Care Coordinators are trained by the CIPA office initially and on an ongoing basis. CIPA provides R.N. disease management specialists at the CIPA office for outreach and consultation to the physician office based program.</p>

	<p>Key components of the CIPA physician office based disease management program/care coordination program are:</p> <ul style="list-style-type: none"> • Coordinated and integrated care by the primary care physician office; • Comprehensive care in a team approach across the care continuum and specialties; • Evidenced based guidelines; • Population definition and patient engagement; • Quality care improvement; • Practitioner and patient intervention tools; • Education of care coordinators enabling the care coordinator relationship with chronic ill patients in the office setting. • Collaboration between care coordinators and CIPA disease management staff regarding patient interventions on a case by case basis
<p>Guideline Source</p>	<p><u>Diabetes:</u> The diabetes evidenced based guidelines are adopted from the 2008 American Diabetes Association Clinical Practice Recommendations. The format of the guideline is adapted from the New York Diabetes Coalition.</p> <p><u>Congestive Heart Failure</u> – The congestive heart failure guideline is adopted from the Eleventh Edition December 2009 Institute for Clinical Systems Improvement (ICSI).</p> <p><u>Cardiovascular Disease Management</u> – The cardiovascular disease management guidelines are adopted from the Thirteenth Edition April 2009 Institute for Clinical Systems Improvement (ICSI).</p>
<p>Program Oversight</p>	<p>Design, monitoring and improvement of the program are under the direction of the CIPA Clinical Integration Committee that meets, minimally, quarterly. The CIPA Clinical Integration Committee is composed of board certified practitioners from appropriate specialties whose input provides clinical guidance as to the efficacy and accuracy in the adoption of the evidenced based guidelines. As new information on</p>

	<p>the guidelines is obtained, for example, from government research sources and/or clinical and technical literature, the CIPA Clinical Integration Committee provides the oversight as to whether this information is adopted. The Vice President of Medical Affairs at CIPA oversees the implementation of the disease management programs and assists in the development of the program content.</p> <p>The CIPA Disease Management Department is responsible for but not limited to :</p> <ol style="list-style-type: none"> 1. Disease management program content, insuring that it is consistent with the current clinical practice guidelines. 2. Evidenced based guidelines adoption and systematic review and revisions based on new information 3. Data integration 4. Appropriate and timely patient identification 5. Providing patient interventions 6. Evaluating patient materials 7. Patient self management process 8. Communication of the program to patients and caregivers 9. Enforcement of patient rights and responsibilities 10. Coordination of care 11. Quality improvement activities 12. Operations inclusive of staffing, credentialing, confidentiality
<p>Program Objectives</p>	<ol style="list-style-type: none"> 1. Improve the care of patients with chronic disease through a proactive approach in the clinical office setting. 2. Assist the physician office to establish a plan of care according to patient needs and evidenced based guidelines. 3. Provide a system that stratifies the population for application of various interventions by the practitioner practice. Provide information that can be used by the offices to empower the patient to manage their condition. 4. Enhance the patient and practitioner relationship as a partnership. 5. Provide current disease management information to the practice.

Program Design

A. Identification of Patients for the Disease Management Program:

Patients in the office based disease management program are identified for inclusion by:

- Reports based on encounter data and pharmacy data as applicable
- Physician and practice team;
- Referrals from the managed care organizations, hospitals, home care, skilled nursing, specialists, pharmacists;
- Patient self referral.

B. Decision Support Information: The care coordinator at the office is pivotal for providing collaborative care, incorporating ‘real time’ decision support to the primary or specialty care practitioners. The CIPA Disease Management Program is physician office based and utilizes a formal registry and reporting system. Care coordinators employed by participating physicians and trained in disease management are embedded in primary care offices. The care coordinator monitors patient care and makes interventions for patients not meeting targeted goals. according to the evidence based guidelines that have been adopted by CIPA. . Physician offices have unique patient information at his/her office that is comprised of encounter data, lab results, patient reported , specialist/referrals, and health plan information that is shared with the practitioner The CIPA Clinical Integration team provides input in developing the content of the information sent to the practitioner to aid in the patient decision making process. Program content including evidence based guidelines adopted from a recognized source, reference articles, model letters and updates are communicated by either email, fax or, mail or the CIPA website. Printed copies of the information on the CIPA website are available upon request by contacting the CIPA office at **1-877-304-2472**.

Offices are encouraged to coordinate a plan of care such that the physician, patient(and /or caregiver) and care coordinator are in agreement. All office based medical records have a unique patient care plan comprising testing data, treatment data, adherence data and assessment of psychosocial issues. Patients are included in the plan of care through the care coordinator with assistance from CIPA disease management as requested. Interventions may occur in pre visit preparation of the patient, collaborating with the patient on the management of their condition during an office visit, and follow up to the care plan after the office visit has

occurred and /or new information is received

C. Disease Management by Risk Stratification and Interventions: (see attachments A, B, and C for disease specific stratification). Office based disease management is provided with a model for risk stratification that is customized to meet the population served in the practitioner office. The physician office submits their stratification plan to CIPA for review. The physician and/ or care coordinator classifies the patient into the risk category and can move the patient into a more intensive category depending on the patient condition, individualized needs and medical judgment. Interventions are individualized to meet the patient learning style and self management goals. Patient input regarding program content is collected by the individual offices providing disease management functions as well as through a layperson advisory board at CIPA. Caregiver support is assessed and considered as needed when disease management interventions are utilized.

Patient materials are evaluated a minimum of every 3 years by CIPA or when new information is made available.

D. Availability and Access of Disease Management Program:

Patients are enrolled in the program through their engagement in the physician office. . Patients who do not wish to receive any education about their condition or follow up calls can make their request known to the Care Coordinator at the physician office or indicate preference for communication. Though a patient is not engaged, efforts will continue in providing educational materials to the patient about their condition. . The physician is also involved in these circumstances where the patient is not engaged When CIPA is notified of patients that should be in disease management by outside resources and contacts, the physician office is, in turn, notified within 30 days of receipt of the information. **The physician includes any new patients with the relevant chronic condition into the disease management program within 30 days of knowing about the patient.**

E. **Continuity of Care**

Activities of treating practitioners, specialists, and healthcare facilities, encompassing the care continuum, are incorporated into the care of the patient in the disease management program through the efforts of the care coordinator at the physician office.

<p>Program Information</p>	<p>The physician office based disease management program is a voluntary program that is available to all CIPA physician participants in family practice, internal medicine, pediatrics, allergy, pulmonary, cardiology, and endocrinology.</p> <p>CIPA provides evidenced based guidelines, program content consistent with the guidelines, evidence or background of the program content, , educational sessions for the care coordinators, reference articles on the website, stratification methodology with supporting interventions, feedback to practitioner regarding their patient outcomes as compared to the community standard, assistance to the practitioner offices by CIPA disease management staff , and unique interventions such as Emmi, Health Buddy, Care and Health Connections, and the Patient Activation Measure System. The CIPA Western New York IPA, Inc., Clinical Integration Plan booklet outlines and summarizes the information necessary for practitioners to become a participant as well as recruited by CIPA Physician Services CIPA Practitioners have access to the CIPA disease management program staff for discussion on disease management-related issues.</p> <p><i>Additional information is available by either accessing CIPA's Web site at www.cipawny.org or contacting CIPA disease management staff at 716-862-2160 Monday thru Friday, 8am to 5pm. For disease management calls, practitioners and patients can contact the CIPA office</i></p> <p><i>The CIPA disease management program functions through delegation to the practitioner offices. Information regarding the disease management program is available to the patients through the physician offices. Additional information regarding disease management is available to patients as well on the CIPA Web Site at www.cipawny.org. or contacting CIPA disease management staff at 716-862-2160 Monday thru Friday, 8am to 5pm A toll free number is available to patients and practitioners for any questions regarding CIPA office based disease management at 1-877-304-2472 where they will reach a voice message that provides instructions on how to proceed Primarily, patients are advised to contact the physician office for any questions regarding the disease management /care coordination program. For disease management urgent calls, the patient is advised to contact their primary care physician office and follow the triage instructions that are available to patients 24 /7.</i></p> <p><u>Physician Rights:</u></p> <p>Practitioners participating in the CIPA disease management program have</p>
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	<p>the right to:</p> <ol style="list-style-type: none"> 1. Obtain information about CIPA’s organization, its staff and its staff’s qualifications and any contractual relationships. 2. Be informed of how CIPA expects the coordination of interventions with treatment plans for individual patients 3. Know how to contact the person responsible for managing and communicating with the practitioner’s patients. 4. Be supported by CIPA to make decisions interactively with patients regarding their care. 5. Receive courteous and respective treatment by the CIPA staff. 6. Communicate complaints to CIPA.
<p>Patient Rights and Responsibilities and Expectations</p>	<p>The Patient has the right to :</p> <ol style="list-style-type: none"> 1. have information about the physician office and CIPA, its staff and its staffs qualifications and any contractual relationships (including programs and services provided on behalf of CIPA); 2. decline participation or disenroll from the programs and services offered by CIPA ; 3. know which staff members are responsible for managing their disease management services and from whom to request a change; 4. make health care decisions interactively with their practitioners and care coordinators; 5. be informed of all disease management options included or mentioned in the clinical guidelines, even if a treatment is not covered, and to discuss options with treating practitioners; 6. have personal identifiable data and medical information kept confidential; know what entities have access to their information; know procedures used by the doctor office and CIPA to ensure security, privacy and confidentiality; 7. be treated courteously and respectfully by CIPA and the physician office; 8. communicate complaints to the physician office and receive instructions on how to use the complaint process, including the standards of timeliness for responding to and resolving issues of quality and complaints; 9. receive understandable information <p>The Patient is expected to:</p>

	<ol style="list-style-type: none"> 1. follow care and advice offered by the office based disease management program 2. provide the physician office with information necessary to carry out its services; 3. notify the practitioner regarding preferences of contact from the disease management program or whether the patient does not want to engage in the program. 						
<p>Measurement and Quality Improvement</p>	<p>The Disease Management Program is monitored for outcomes and effectiveness through the Clinical Integration/Quality Improvement (CI/QI) Program, administered by the Clinical Integration Committee. The CI/QI program addresses measurements in place, analytical resources, interventions and re-measurements of DM activities. The Clinical Integration committee defines at least two measures for each DM program in place to monitor, evaluate and identify opportunities for improvement and operationalized utilizing a QI workplan as a guide.</p> <p>Annually, the Disease Management Program shall collect feedback from practitioner’s focusing on their experience with the following:</p> <ol style="list-style-type: none"> 1. Usefulness of services available to practitioners. 2. Helpfulness of CIPA staff. <p>The Disease Management Program is evaluated on an annual basis including the measurement of accomplishing goals and objectives, barriers and opportunities for improvement. The following years Disease Management Program will be based on, at least in part, the findings from the annual evaluation.</p>						
<p>Integration and Delegation</p>	<p>Integration of CIPA Patient Oriented Disease Management Program into the Practitioner Practice</p> <p>CIPA delegates disease management activities to physician practices that have undergone a successful predelegation assessment These delegated entities are required to meet specific NCQA standards, as outlined below, and in their supporting documents. CIPA evaluates and approves the delegated entities Disease Management program, QI functions and supporting documents annually. CIPA maintains accountability for the quality of services provided by the delegated entities.</p> <p>The following table outlines the duties to be performed by CIPA and those duties delegated to the Practitioner Practice:</p> <table border="1" data-bbox="480 1734 1442 1845"> <thead> <tr> <th>Activity</th> <th>Delegation</th> <th>Delegated function</th> </tr> </thead> <tbody> <tr> <td>Evidenced-Based Programs</td> <td>No delegation</td> <td>Offices adopts</td> </tr> </tbody> </table>	Activity	Delegation	Delegated function	Evidenced-Based Programs	No delegation	Offices adopts
Activity	Delegation	Delegated function					
Evidenced-Based Programs	No delegation	Offices adopts					

	Patient Services	Delegated	The delegated entity will : 1. identify population with CAD, CHF, and Diabetes and stratify; 2. integrate patient data , 3. enlist all patients in practice with the 3 conditions for active participation, 4. support patient self management with consumer tested information, coaching, reminders and community referrals; 5. commitment to patient rights and expectations of patients, 6. encourage patient and practitioner communication
	Care Coordination	Delegation	The practice will: 1. give patients information on progress toward treatment goals, 2. Coordinate referrals and providing relevant information to case management programs and other health resources
	Measurement and Quality Improvement	Delegation -specific	The practices will be delegated the measuring and analyzing of patient experience and will take action to improve the effectiveness of the programs in that practice
	Program Operations	No Delegation	

REFERENCE: 2010 NCQA DM STANDARD – PT 1, ELEMENT A

APPROVED CI COMMITTEE: FEBRUARY 25, 2010

MODEL FOR TARGETING INTERVENTIONS

ATTACHMENT A

DIABETES DISEASE MANAGEMENT RISK STRATIFICATION AND INTERVENTIONS

RISK	CRITERIA	PRACTITIONER INTERVENTIONS
<p>Entry level</p> <p>* if patient lacks insight of disease or does not believe diagnosis at any time, consider educational session</p>	<p>Entry into program in the past 6 month - includes newly diagnosed</p>	<p>Disease review with the patient by the nurse care coordinator to include but not limited to: 1. self blood glucose testing and monitoring, 2. exercise, 3. nutrition, 4. medication education, 5. when to call the practitioner, 6. yearly DRE, 7. flu shot, 8. dental exam, , 9. foot care</p> <p>Advanced directives</p> <p>Introduction letter to patient with copy of goals</p> <p>EMMI as indicated</p> <p>CHS diabetes self management education program</p> <p>Depression screening</p> <p>Begin to monitor patient condition</p> <p>Connection to plan wellness website or wellness site link on CIPA website</p> <p>Place in appropriate risk category</p> <p>Consider Care Connections for any socioeconomic issues at any risk level.</p>
<p>Low Risk</p> <p>Have disease but meeting goals</p>	<p>Diabetes under good control – labs, BP</p> <p>No missed appointments or missing labs</p> <p>Medication compliant</p> <p>Monitoring blood glucose level as directed</p> <p>smoking</p>	<p>As above and:</p> <p>Registry review 2 times a year.(monitor health)</p> <p>Wellness and disease prevention education and follow-up-</p>
<p>Moderate Risk</p>	<p>Identified with at least one</p>	<p>Above plus:</p>

<p>Have at least 1 gap in care</p>	<p>gap in care: A1c 7 or greater but <9 , LDL > 100,<150)) Missing lab values for LDL, HbA1c, BP greater than 130/80 but less than 160/100 Missing appointments Recent addition of medication (oral diabetes therapy or insulin) to control glucose</p>	<p>Quarterly office visits or outreach contact (mail and/ or telephone) as needed. (3-4 times per year) CIPA disease management staff assistance Assess 'readiness to learn' for Behavior Modification Coaching – Follow up to missed labs or appointments Nurse visits ***Care Connections for any socioeconomic issues</p>
<p>High Risk</p>	<p>: Any one of the following Comorbidities BP 160/110 or greater LDL > 150 2 or more hospitalizations r/t condition HbA1c >9 Metabolic Syndrome defined as any 3 or the following 5: 1. Elevated waist circumference -≥ 40in for men, ≥35 in for women 2. Elevated triglycerides ≥ 150 or on drug tx 3. Reduced HDL-C - <40 mg/dl men, < 50mg/dl women or on drug tx 4. Elevated BP ≥130/80 or on meds for 5. Elevated fasting glucose ≥100mg/dl or on meds for.</p>	<p>All interventions above plus: CIPA disease management staff tracking of patient care and assistance to care coordinators Minimum of monthly office visits or outreach calls as needed Home Care referral Collaboration with health plans for special programs Community resources such as EAP, meals on wheels</p>

**** office should obtain advanced directives**

ATTACHMENT B

**CONGESTIVE HEART FAILURE DISEASE MANAGEMENT RISK STRATIFICATION
AND INTERVENTIONS**

Risk	Criteria	Practitioner Interventions
Entry level	<p>All newly diagnosed patients with CHF</p> <p>All new patients to practice with CHF</p>	<p>Disease review with patient by care coordinator : on smoking cessation if applicable, diet (follow low salt diet, low fat for lipid control, increase fruits and vegetables, discourage alcohol, , Immunizations, daily weights, continue taking meds</p> <p>Introduction letter with copy of clinical practice guideline. goals, self management information</p> <p>Assign EMMI program</p> <p>Depression screening</p> <p>Registry review 2 times /year</p> <p>Preventive care teaching**Advanced directives</p> <p>Consider Care Connections for any socioeconomic issue regardless of risk level</p>
Low Risk- 1 gap in care	<p>BP greater than 130/80</p> <p>Missing labs or appointments</p> <p>Consuming excess NA in diet</p>	<p>Smoking cessation if applicable</p> <p>Diet counseling – decrease NA, increase fruits and vegetables, discourage alcohol,</p>

	smoking	Immunizations Registry review 2 x per year
Moderate Risk -2 gaps in care	2 or more: Missing physician appointments Missing labs non Not taking medications as ordered Co morbid conditions such as depression Weight gain of 3 or more pounds in 2 days Symptomatic with mild exertion, increase coughing,, swelling	Above plus: Face to face contact by care coordinator at appointment Care transitions if applicable Review medications with patient Health Buddy Home care Bimonthly phone calls CIPA office disease management coach for assistance and intervention resource
High Risk	Inpatient visit or ER visit occurred within 12 months or NYHA functional class IV – symptomatic at rest: need to sit up in a chair to sleep, weight gain or loss of more than 5 lbs in 2 days, confusion, unrelieved chest pain, unrelieved SOB Or 3 gaps in care in moderate risk	All above plus: Contact Case Management at Health Plan for specific health plan programs Care coordinator contact patient monthly - weekly Palliative care Hospice

**** office should obtain advanced directives**

ATTACHMENT C

CORONARY ARTERY DISEASE RISK STRATIFICATION AND INTERVENTIONS

Risk	Criteria	Practitioner Interventions
Entry level	<p>All newly diagnosed CAD pts</p> <p>All new patients in practice with CAD</p>	<p>Disease review with patient by care coordinator includes smoking cessation, diet, exercise, medications</p> <p style="text-align: center;">Depression screening</p> <p style="text-align: center;">Emmi</p> <p style="text-align: center;">Introduction letter to disease management with copy of guideline goals</p>
<p style="text-align: center;">Low Risk</p> <p style="text-align: center;">Meeting goals</p> <p>*If patient lacks insight of disease or does not believe diagnosis at any time, consider educational session</p>	<p>Family history of Cardiovascular disease</p> <p>Obtains labs and labs are within normal limits</p> <p>smoking</p>	<p style="text-align: center;">Emmi</p> <p style="text-align: center;">Self management tools</p> <p>Care coordinator in office setting to provide self management tools – smoking cessation, diet, exercise</p> <p>Connection to plan wellness websites</p> <p style="text-align: center;">Depression screening</p> <p style="text-align: center;">Registry review yearly (monitor health)</p> <p style="text-align: center;">Emphasis on preventive care</p> <p style="text-align: center;">** Advanced directives</p> <p>Consider Care Connection for any socioeconomic issue</p>
<p style="text-align: center;">Moderate Risk</p> <p style="text-align: center;">2 gaps in care</p>	<p>Co morbid condition such as depression, peripheral vascular disease, diabetes</p> <p>Two or more gaps in care is identified such as:</p>	<p style="text-align: center;">Above plus:</p> <p style="text-align: center;">Office based plan of care</p> <p style="text-align: center;">Self management log for review at time of appointment</p>

	<p>Elevated LDL greater than 150</p> <p>hypertensive, greater than 130/80</p> <p>sedentary lifestyle</p> <p>BMI greater than 30</p> <p>Smoking</p> <p>Pt .not taking prescribed medications</p>	<p>Patient coaching and goal setting</p> <p>Symptoms of depression: refer to mental health specialist</p> <p>Assess medication compliance</p> <p>A minimum of a quarterly contact by care coordinator for reinforcement of self management and lifestyle changes</p>
<p>High Risk</p> <p>2 or more gaps in care plus an ER or inpatient admission within rolling year</p>	<p>Patient has 2 or more gaps in care in moderate risk and</p> <p>Patient has one or more ER/Inpatient admission for cardiovascular diagnosis within a rolling year</p>	<p>Above plus:</p> <p>Collaborate with plan case management for plan specific programs</p> <p>Home care</p> <p>Discuss case with physician</p> <p>A minimum of monthly contact by care coordinator</p> <p>Outreach to CIPA Disease Management specialists as resource</p>

**** office should obtain advanced directives**