**Purpose**
The Disease Management Program has a clearly defined program description that includes information about identifying eligible patients and targeting interventions to patients based on their needs or risk level. The program describes how it identifies patients who can benefit from Disease Management, how it determines the best action for each patient, based on health needs and how it takes those actions.

**Objectives**

I. To promote consistency in long-term management approaches and optimize treatment for patients with targeted conditions.
II. To achieve optimal levels of wellness in these targeted patients.
III. Improve the patient’s basic understanding of his/her disease process.
IV. Increase provider awareness and participation with recommended treatment modalities.
V. Monitor patient’s condition, including consideration of other health conditions and addressing lifestyle issues.
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VII. Early collaborative care management or physician intervention when specific patient indicators exceed the established threshold.
VIII. Attain increased compliance with treatment regimen.
IX. Reduce emergency room utilization and frequency of inpatient admissions.
X. Reduce and delay late stage disease manifestations.

**Program Description**
Care Coordination Institute offers Disease Management programs for all eligible health plan members who are identified with diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, hypertension and hyperlipidemia. The goal of the program is to support the practitioner/patient relationship and plan of care. The program emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines. The program works collaboratively with the participant’s treating providers to identify opportunities for prevention or intervention in an effort to provide well-coordinated care.

All members with a confirmed diagnosis for the targeted condition who meet the eligibility criteria are automatically eligible for enrollment in the program. Welcome packets are mailed to the member describing how they became eligible for participation, what services are available and how to access the services offered.
Criteria for Identifying Patients Who Are Eligible for the Program

To be eligible for Disease Management services, a patient must meet the following 4 criteria:

I. Be a covered member (patient) under contracted payor populations selecting/assigned Disease Management Services.

II. A predictive risk model, Milliman Advanced Risk Adjusters (MARA) prospective model, uses the most recent 12 months of claims data to predict risk for the upcoming 12 months of utilization and cost. A patient is eligible for Disease Management if he or she has a MARA total prospective risk score between 9.99 and 2.

III. Must have one of the six conditions: diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, hypertension, or hyperlipidemia.

IV. Patients who are not already receiving care coordination services (data source: Caradigm).

Evaluating Patient Risk Level and Interventions

A. The Disease Management Program stratifies patients with one of the six conditions into low, moderate or high risk categories based on the number of conditions, stages of specific conditions, clinical data, barriers, depression, psychosocial and health behaviors. The risk stratification tool accounts for comorbidities and severity of risk factors and assigns a point value that determines a patient’s risk level and determine whether an intervention is necessary.

B. The number, frequency and type of interventions are based on the patient’s identified condition, their response to the comprehensive health assessment and risk stratification scoring table. Interventions are automatically assigned based on patient responses to general needs, community support services, life planning, cognition mental health, cardiovascular, respiratory, sleep, nutrition, endocrine, functional status, lifestyle, health maintenance and barriers.

C. The stratification scoring tool is utilized to ensure risk stratification levels are applied uniformly to patients with similar profiles and needs. Annually, patient’s stratification tools are randomly selected and audited for uniformity.

Medical and Behavioral Health Comorbidities and Other Health Conditions

A. Medical comorbidities are assessed utilizing patient responses to the cardiovascular, respiratory, and endocrine topics embedded in the health assessment. Based on patient responses appropriate interventions are assigned to the plan of care.

B. Behavioral comorbidities are assessed utilizing patient responses to the Patient Activation Measure (PAM). This tool provides a baseline measure of patient’s readiness to make behavior change. Care plans can be individualized to clients’ stage of readiness.

C. The PHQ9 depression screening tool is used to assess patient depression. If the patient scores ≥ 10 the Health Coach verifies whether or not the patient sees a mental health practitioner, takes medications if prescribed, participates in support activities, attends counseling or other behavioral management interventions.
D. Health behaviors are addressed within the nutrition and lifestyle topics in the assessment. Motivational interviewing is utilized to address goals and interventions in the plan of care to reduce unhealthy behaviors. If the patient may benefit from weight management programs, smoking cessation programs, the employee assistance program, diabetes support groups, community-based resources, wellness programs and higher level of care, the health coach would initiate the referral process.

E. Psychosocial issues such as religion/spirituality, cultural/religious needs and language barriers identified during the assessment are taken into consideration in the delivery of the care plan. A patient’s beliefs, concerns, and perceived barriers, i.e. access to treatment, transportation and financial barriers are taken into consideration for the condition and treatment requirements.

Consumer Input
In order to maximize program effectiveness program surveys are mailed to each program participant that graduates, dis-enrolls or is discharged from the program. The survey gauges program effectiveness and satisfaction with members of the care team. The survey helps to provide ongoing development of program content for patients. In addition consumer groups are able to request program specific changes for their population.

Patient Support
Caregiver support is assessed in the comprehensive health assessment using the community support services topic. If caregiver support is needed then results of the assessment are communicated to the physician to help coordinate care.