CARE N CARE QIP PROGRAM- 2022

DIABETES: TYPE 2: WITH COMORBITIES OF HTN & HLD PLAN DOCUMENT

Implementation date: 1/1/2022

Description of the QIP

The Centers for Medicare and Medicaid Services (CMS) QIP goals for health plans focus on improving health outcomes and enrollee satisfaction. The QIP is conducted over a three year time period. The goals of the QIP program include alignment with the CMS Quality Strategy, targeted goals for selected chronic condition, specific interventions and measureable outcomes. CMS Quality Strategy Goals focus on the following:

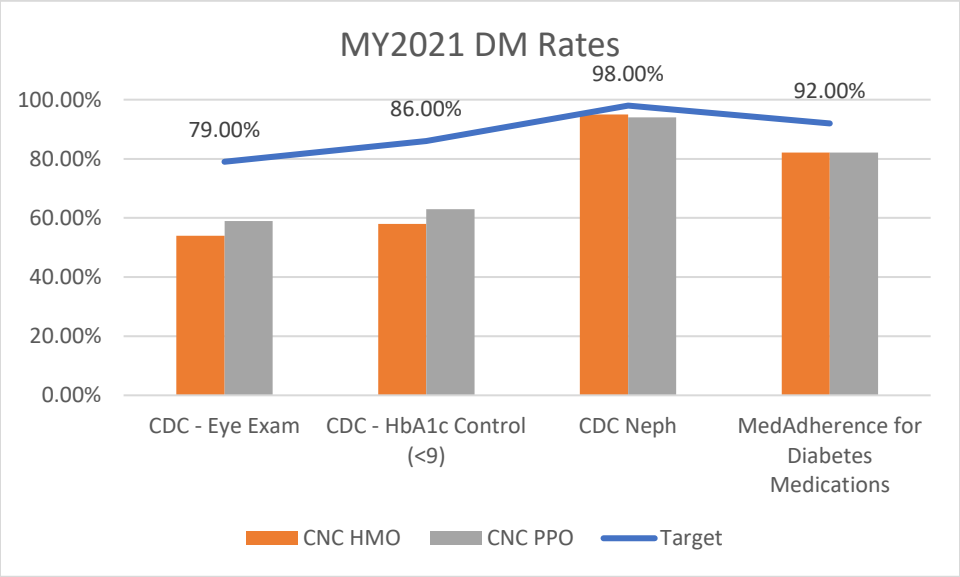
- Make care safer by reducing harm caused while cares delivered.
    - Improve support for a culture of safety.
    - Reduce inappropriate and unnecessary care.
    - Prevent or minimize harm in all settings.
- Help patients and their families be involved as partners in their care.
- Promote effective communication and coordination of care.
- Promote effective prevention and treatment of chronic disease.
- Work with communities to help people live healthily.
- Make care affordable.

Targeted Chronic Condition

The 2022 Care N Care Quality Improvement Program (QIP) is focused on diabetes mellitus. Diabetes affects nearly 37.3 million Americans and is associated with an estimated $237 billion in health care costs. DM is a complex disease that is largely self-managed by patients. Many factors influence overall DM self-management, including psychological and social/emotional factors.

The target CMS Quality Strategy Goals for the CNC Diabetes Mellitus QIP will include goals to promote effective communication and coordination of care and promote effective prevention and treatment of diabetes mellitus in the CNC population. The anticipated outcomes from this QIP include reduction in hospitalization rates as evidenced by decrease in hospital related medical expenses (cost of care) and improvement in overall diabetes care HEDIS measures including screening eye exams, kidney care and controlling blood sugar. As our baseline we will be using the HEDIS measures performance for Measurement Year 2021 as follows:

CNC PPO (H6328) MY2021				
	Measures	Eligible Population	Compliant	MY2021 Rate
HEDIS	Diabetes Care- Eye Exam	1321	784	59%
HEDIS	Diabetes Care- Kidney Disease monitoring	1321	1238	94%
HEDIS	Blood Sugar Controlled	1321	826	63%
CNC HMO (H2171) MY2021				
	Measures	Eligible Population	Compliant	MY2021 Rate
HEDIS	Diabetes Care- Eye Exam	676	362	54%
HEDIS	Diabetes Care- Kidney Disease monitoring	676	639	95%
HEDIS	Blood Sugar Controlled	676	390	58%



Total Enrollment: CNC PPO: 9,606 CNC HMO: 3,690

Target Population

The target population for this QIP are CNC members with diagnosis of diabetes mellitus. There are currently 1,997 CNC members with a diagnosis of Diabetes. The sum of these two groups (HMO and PPO) represents approximately 15% of the total CNC population. This is the rationale for selection of this chronic conditions.

Planned Interventions

The interventions for this target population will include risk stratification and outreach to members who would benefit from enrollment into the diabetes disease management program. Patients identified at

highest risk (Tier 4) for hospitalization will be considered for enrollment in complex case management program and/or transitions of care program for any post hospital or skilled nursing encounter.

A multidisciplinary team including primary care physician, specialists, pharmacist, nurse case managers, nurse practitioners and social worker case managers will address gaps in care for this target group. Interventions planned include assessment of Tier 3, Tier 4 members, identification of problems and individualized care planning to improve health outcomes. The types of interventions will focus on increasing the member's ability to self-manage the disease, increasing medication adherence and providing care coordination for identified care gaps. Psychosocial assessments will be included in the multidisciplinary approach to improving health outcomes for this group.

Intervention types will include the following:

- Provider Education: Targeted mailings and interaction
- Enrollee Education: Targeted mailings
- Medication Adherence: Pharmacist intervention
- Rewards and Incentives Program
- Home Visits: Target members that are homebound or need home evaluation
- Social Determinants of Health (SDOH) interventions
- Health Promotion and Disease Prevention Outreach and Education
- Increase Annual Wellness Visits

Measurement Methodology

The measurement methodology will include the following:

- Counts of Member's enrolled in program- % member engagement > 30
- Diabetes Care- HbA1c in control-HEDIS Measure
- Diabetic Care-Screening Eye Exam-HEDIS STARs Measure
- Diabetes Care-Kidney Disease Monitoring-HEDIS STARs Measure
- Diabetes Care- Oral Diabetes Medications – PQA STARs Measure

Baseline Measures

- Counts of Member's enrolled in program
    - % member engagement > 30
- Diabetes Care
    - HbA1c in control-HEDIS Measure > 86%
- Diabetic Care
    - Screening Eye Exam-HEDIS STARs Measure >79%
- Diabetes Care
    - Kidney Disease Monitoring-HEDIS STARs Measure > 98%
- Part D Med Adherence

- Oral Diabetes Medication > 92%

Data Sources

The following data sources will be utilized to measure the goals:

- Medical Records
- Health Effectiveness Data Information (HEDIS)
- Plan Data (customer service, appeals)
- Claims (Medical, Pharmacy, Lab)
- Surveys (enrollee, beneficiary satisfaction, other)
- TCS Acuity (Care Management System)
- Envision Part D Pharmacy Benefit Manager
- Health Risk Assessment (HRA) tools

Clinical Guidelines

The following clinical guidelines will be utilized to shape this QIP:

- American Diabetes Association. Standards of Medical Care in Diabetes
- US Preventative Services Task Force (USPSTF)-guidelines for preventative care of normal adults.
- Diabetes Standards of Care and Clinical Resources. US Department of Health and Human Services
- https://www.ihs.gov/diabetes/clinician-resources/soc/