



BlueCross BlueShield  
of Illinois

## 2009 HMO Diabetes Condition Management Program Summary

The purpose of the Diabetes Condition Management Program is to improve the quality of diabetes care by increasing the percentage of members for whom diabetes care is monitored using a flowsheet (one-page summary or an electronic medical record). The documentation system must be organized to trend information regarding HbA1c testing, LDL cholesterol screening, blood pressure screening, retinal eye exam and medical attention for nephropathy. The information must be organized to trend results over time and remind the practitioner when a service is due.

A portion of the HMO QI Fund is available to IPAs based on the percentage of members who received diabetes services in 2009 and the information was tracked on a flowsheet. Additional payments are available based upon the percentage of diabetics who have been screened for depression and the number of members who meet criteria for overall diabetes care. IPAs may also earn a Diabetes Outreach QI Fund payment for providing PCPs with a list of identified members with diabetes and for performing outreach to those members who have not already had an HbA1c, LDL-C, blood pressure, eye exam, depression screening and medical attention for nephropathy in 2009. A Diabetes Blue Star is awarded to IPAs demonstrating high levels of performance in providing routine diabetic care.

For 2009, BCBSIL identified the population of members age 18-75 years with diabetes based on at least one of the following criteria:

- two face-to-face encounters in 2007 or 2008 on different dates of service in an outpatient setting or non-acute inpatient setting with a diagnosis of diabetes,
- one face-to-face encounter in 2007 or 2008 in an acute inpatient or emergency room setting with a diagnosis of diabetes
- members who were dispensed insulin or oral hypoglycemics and/or antihyperglycemics on an ambulatory basis 2007 or 2008

BCBSIL provides IPAs with their list of members, instructions and data collection criteria. Because this program is prospective, the IPA has several months to do member outreach and provide recommended services within the calendar year. IPAs develop interventions for their physicians and/or members and submit data along with supporting documentation.

The Diabetes QI Project includes a number of initiatives for members and IPAs. Members identified as having diabetes are sent the following:

- quarterly mailings on diabetes, each addressing one topic from the American Diabetes Association Clinical Practice Guidelines. These mailings include a statement on how members were selected for the program and how to opt out of the program.
- a diabetes care card to keep track of their diabetes care
- a flu shot reminder
- an offer for a glucose meter at no charge (offer limited to one new meter every twelve months)
- information about the services offered through the BCBSIL diabetes program

An annual focused outreach mailing is sent to members with diabetes who have not received recommended services or achieved control targets. In 2008, diabetic members who did not have documentation that an LDL-C was <100 mg/dL received a mailing about cholesterol control.

In addition, the Diabetes Care Survey is sent annually to a random sample of diabetic members to assess member perception of diabetes care.

## 2009 HMO Diabetes Condition Management Program Summary

Additional resources provided to members include:

- information on managing diabetes available through the Personal Health Manager and "Ask a Nurse" on Blue Access® for Members, the secure website at [www.bcbsil.com](http://www.bcbsil.com)
- "blueprints for health," the HMO member newsletter, which includes articles on diabetes care

Additional resources provided to IPAs include:

- annual educational programs on the QI Fund Project
- quarterly QI Forums that include best practices
- a list of current members identified as being at risk for complications of influenza (including members with diabetes, asthma and/or cardiovascular disease and those age 65 and older)
- information about the free glucose meter program
- a list of members from the 2008 Diabetes QI Fund Project who did not have diabetic services, or who had services but values were not controlled

The following table summarizes the number of members who received diabetes interventions in 2008.

Interventions					
Year	Total number of unique diabetics identified during the year	Number of identified diabetic members who received quarterly educational mailings	Number of diabetic members who received influenza vaccination reminders <sup>1</sup>	Number of glucose meters distributed	Focused outreach to high risk members
2008	47,718	46,184	28,107	1,617	13,040

The following table provides the 2008 Diabetes QI Fund Project results.

2008 Diabetes QI Fund Project Results								
Year	Final Population included in the Diabetes QI Fund Project	Number and Percent of members with HbA1c <9.0%	Number and Percent of members with Retinal Eye Exam	Number and Percent of members with Blood Pressure <140/90	Number and Percent of members with LDL-C <100 mg/dL	Number and Percent of members with Medical Attention for Nephropathy	Number and Percent of members Screened for Depression <sup>2</sup>	Number and Percent of members meeting Overall Diabetes Care criteria <sup>3</sup>
2008	30,056	22,293 (74%)	16,502 (55%)	22,165 (74%)	15,633 (52%)	24,251 (81%)	18,368 / 28,535 (64%)	8,278 (28%)

Physicians may refer their HMO patients with diabetes for the Condition Management Program by completing the enclosed "Physician Condition Management Enrollment Form." Please fax the completed form to: HMO Quality Improvement at 312-228-9058. The form is also available at <http://www.bcbsil.com/provider/umqi/qualityimprovement.htm>

<sup>1</sup> Influenza vaccination reminder mailings are sent to all members age 65+ and to members identified with asthma, diabetes and/or cardiovascular disease. Members who are in more than one of these risk groups are only included in reporting for one. Members with diabetes who are also age 65+ or have asthma are not included in the number or percentage of diabetic members who received influenza vaccination reminders.

<sup>2</sup> Excludes members with a diagnosis of depression after 1/1/2006.

<sup>3</sup> HbA1c<9% AND LDL<100 mg/dl AND eye exam AND member received medical attention for nephropathy