Disease Management Program Overview

Molina Healthcare of Wisconsin, Inc. wants providers to be aware of disease management programs offered to assist with care management. Molina Healthcare has programs that can help providers manage their patient's condition. Molina Healthcare works closely with Participating Providers in the identification, assessment and implementation of appropriate interventions for Members, including Member health education and providing educational materials. Molina Healthcare’s care managers have immediate, reliable access to evidence-based clinical guidelines to conduct assessment and manage Members who are receiving program services. These evidence-based tools include standardized assessments and Member individualized care plans that are available within the secure care management electronic platform. Disease-specific interventions include but are not limited to:

- Asthma
- Diabetes
- Hypertension
- Coronary Artery Disease
- Congestive Heart Failure
- COPD

A care manager/nurse is on hand to teach Members about their disease. He/she will manage the care with the Member’s assigned PCP and provide other resources. There are many ways a Member can enroll in these programs. One way is through medical or pharmacy Claims. Another way is through doctor Referral. Members can also ask Molina Healthcare to enroll them. It is the Member’s choice to be in these programs. A Member can choose to dis-enroll from the program at any time.

For more info about Molina Healthcare’s programs, please call:

- Member Services Department at 855-326-5059
- TTY at 414-847-1779 (English)
- Visit www.molinahealthcare.com

Program Eligibility Criteria and Referral Source

Program interventions are designed for Molina Healthcare Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the Molina Healthcare’s coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with his/her health condition(s). Additionally, all identified Members will receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Healthcare and request to be removed from the program.
Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy data for all classifications of medications;
- Encounter Data or paid Claim with a relevant diagnosis code
- Member Services welcome calls made by staff to new Member households and incoming Member calls. Eligible Members are referred to the program;
- Practitioner/provider referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication.

**Practitioner/Provider Participation**

Participating Providers may be notified whenever their patients are enrolled in a disease management program. Practitioner/provider resources and services may include:

- Annual practitioner/provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Provider newsletters promoting the disease management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

To find out more information about the disease management programs, please call Molina Healthcare’s Member Services Department at 855-326-5059.

**Breathe with Ease**

Molina Healthcare of Wisconsin, Inc. provides an Asthma Disease Management program called Breathe with Ease, designed to assist Members in understanding their asthma condition. Molina Healthcare has a special interest in asthma, as it is one of the top chronic diagnoses for its Members. This program is based on NHLBI Asthma Guidelines and meets NCQA requirements. The program educates the Member and family about asthma symptom identification and control. Molina Healthcare’s goal is to partner with the provider to strengthen asthma care in the community.

**Breathe with Ease Program Activities**

Members are managed based on individual needs which also determine the frequency of contact. Low risk Members are provided with general asthma education and an asthma newsletter. Molina Healthcare’s goal is to provide Members with a basic understanding of asthma and related concepts, such as common triggers. Molina Healthcare also encourages Members to see their PCP regularly for asthma status checks, and important preventive and well-child care.
Molina also offers Members identified as having high needs an opportunity to participate in a more intensive asthma program. These Members are contacted more frequently and assisted with understanding on how to use their medications, making provider appointments or ensuring that they receive specialty care.

**Additional Asthma Program Benefits**

- **Hospital Follow-up** – Molina Healthcare has a hospital follow-up program for patients with asthma. A Registered Nurse (RN) Care Manager calls all patients hospitalized for complications related to asthma. The RN Care Manager completes an assessment of the patient’s medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent to the PCP’s office upon request.

- **Condition-targeted education materials.**

- **Asthma Newsletters** – Molina Healthcare distributes asthma newsletters to identified Members.

**Healthy Living with Diabetes**

Molina Healthcare has a diabetes health management program called Healthy Living with Diabetes designed to assist Members in understanding diabetes and self-care. Molina Healthcare’s diabetes health management program follows the standards and guidelines established by NCQA.

The goals of diabetes management are to:

- Complete a diabetes self-management program and initiate a personal action plan.
- Maintain (near) normal A1-c or meet established A1-c goal.
- Obtain annual preventive exams and tests (A1-c, dilated retinal exam, urine microalbuminuria, foot exam, and lipid panel).
- Adhere to optimal medication regimen and avoid adverse effects from diabetes medications.
- Initiate and maintain a regular program of brisk walking or other preferred physical activity.
- Prevent acute episodes of diabetes necessitating emergency room visits or hospitalizations.
- Identify psychosocial issues (access to treatment, cultural & religious beliefs or positive depression screenings) and modify interventions to support adherence.
- Meet Members’ and families’ expectations and satisfaction with diabetes care.
- Support Participating Provider network in improving the quality of care with persons who have diabetes.

**The Healthy Living with Diabetes program includes:**

- **Hospital Follow-up** – Molina Healthcare has a hospital follow-up program for patients with diabetes. An RN Care Manager calls all patients hospitalized for complications related to diabetes. The RN Care Manager completes an assessment of the patient’s medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent to the
• Clinical Practice Guidelines – Molina Healthcare adopted the American Diabetes Association (ADA) guidelines for diabetic care.

• Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members.

• Diabetes Education – Member education and materials are provided to all participants. We encourage providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.

Heart Healthy Living – Cardiovascular Disease (CVD) Management Program

Molina Healthcare’s Heart Healthy Living disease management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with Participating Providers in the identification, assessment and implementation of appropriate interventions for Members with CVD.

While CVD can encompass many different conditions that often co-exist, Molina Healthcare has chosen to target three (3) subprograms: heart failure, coronary artery disease (CAD) and hypertension. The literature supports the selection of these three (3) conditions as being responsive to interventions aimed at the development of adequate self-management skills in optimizing clinical outcomes and improving quality of life.

The Heart Healthy Living program includes:

• Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with CVD. An RN Care Manager calls all patients hospitalized for complications related to CVD. The RN Care Manager completes an assessment of the patient’s medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent to the PCP’s office upon request.

• Clinical Practice Guidelines – Molina Healthcare adopted the National Heart, Lung and Blood Institute (NHLBI) and the American Heart Association guidelines for cardiovascular care.

• Cardiovascular Disease Newsletters – Molina Healthcare distributes newsletters to CVD Members.

• Cardiovascular Disease Education – Member education and materials are provided to all participants. Molina Healthcare encourages providers to refer patients to these services, especially for newly diagnosed heart disease or those having difficulty managing their disease.

Healthy Living with COPD

Molina Healthcare’s Healthy Living With COPD health management program is a collaborative team approach comprised of patient education, clinical case management and provider feedback. Molina Healthcare works closely with Participating Providers in the identification, assessment and implementation of appropriate interventions for Members with COPD. The goal is to provide a continuum of coordinated, comprehensive care that reduces acute episodes requiring Emergency Care, and promotes improved quality of care for Members.
The Healthy Living with COPD program includes:

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with COPD. An RN Care Manager calls all patients hospitalized for complications related to COPD. The RN Care Manager completes an assessment of the patient’s medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent the PCP’s office upon request.

- Clinical Practice Guidelines – Molina Healthcare follows the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for COPD care.

- COPD Newsletters – Molina Healthcare distributes newsletters to COPD Members.

- COPD Education – Member education and materials are provided to all participants. Molina Healthcare encourages providers to refer patients to these services, especially for newly diagnosed Members or those having difficulty managing their disease.

Pregnancy Health Management Program

Molina Healthcare cares about the health of its pregnant Members and their babies. Molina Healthcare’s pregnancy health management programs are designed to make sure the Member and her baby get the needed care during the pregnancy. Case Managers are available to assist in the management of high-risk pregnant Members during the pregnancy, in the postpartum period and between pregnancies. Molina Healthcare requests that providers complete and return the pregnancy notification form as soon as pregnancy is confirmed. In addition to providing Members access to a highly care-focused program, Molina Healthcare offers incentives for each notification of pregnancy (NOP) form that providers submit prior to the 3rd trimester.

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate-to-high-risk for a disease condition for the mother, the baby or both. “Healthy Baby and Me” is an OB Medical Home program available to Members who are identified as having a high risk pregnancy and meet the program requirements. This comprehensive prenatal program includes the services of a Care Coordinator embedded in the OB provider’s office. Contact Molina Healthcare at 855-326-5059 for more information or to make a referral to this program.

The Motherhood MattersSM pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester-specific assessment and interventions appropriate to the potential risks and needs identified. The Motherhood MattersSM program does not replace or interfere with the Member’s physician assessment and care. The program supports and assists physicians in the delivery of care to Members.

The Motherhood MattersSM pregnancy management program encompasses clinical case management, disease management and Member education, 24-hour Nurse Advice Line, Member outreach and provider communication. The prenatal case management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every Member participating in the program. The program activities include early identification of pregnant Members, early screening for potential risk factors, provision of telephonic and written trimester-appropriate education to all pregnant Members, referral of high-risk Members to prenatal case management, and provision of assessment information to physicians.
Prenatal Case Management – Members assessed to be high risk are contacted via telephone for further intervention and education. A care plan is developed and can be shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care Referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management database generates reminders for callbacks for specific assessments, prenatal visits, and postpartum visits.

Member Outreach – The Motherhood MattersSM Program is promoted to Members through various means including, the Member Handbook, Member mailings, provider newsletters, and marketing materials.