



DISEASE MANAGEMENT PROGRAM



DISEASE MANAGEMENT PROGRAM

INTRODUCTION

The goal of Blue Cross of Idaho's disease management program is to improve the quality of life for our members with chronic illnesses such as congestive heart failure, diabetes, asthma and/or low back pain. Disease management uses the latest proven medical knowledge (evidence-based medicine) to help members stay healthy, live longer and spend less on health care. While these chronic illnesses cannot be cured, a team approach to disease management can improve both the physical and emotional well being of our members.

Under the guidance of their personal doctors, members who take part in our program play an active role in managing their illness. Members are educated on what they can do to improve their health and quality of life. The results are measured and feedback shared with the member's doctor so the doctor can better assist the member in managing their health. Members who are involved in managing their chronic illness may see improvements in other health issues and even lower their out-of-pocket costs for medical services.

HISTORY

Blue Cross of Idaho's disease management program was launched in 2001 with a focus on congestive heart failure (CHF) because it is one of the most expensive chronic illnesses to treat. Our main goals in the program were to reduce hospital admissions for members with CHF and make sure they were taking their medications properly. Members were engaged through educational materials, one-to-one coaching and doctor outreach. Through these efforts, we were able to increase compliance with appropriate medication usage and decrease hospital readmission rates by five percent.

During 2003 and 2004 we significantly enhanced our disease management program by hiring trained health care professionals to act as health coaches. We also launched a biometric monitoring component to the program, providing equipment to our high-risk CHF members that allows them to report their condition from home.

Additionally, we expanded the program to include diabetes and asthma. Members with diabetes receive consultation from a clinical diabetes educator, education, nutritional consultation from a registered dietician and high-risk members receive at-home monitoring. We outreach to members with asthma to educate them on proper use of medication, which helps to keep them out of the emergency room and/or avoid hospital admission.

DISEASE MANAGEMENT UTILIZES EVIDENCE-BASED MEDICINE AND A TEAM APPROACH TO:

- Educate members
- Support behavior modification
- Improve quality of life
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Increase doctor involvement
- Lower out-of-pocket costs

In 2005, we launched a new program for low back pain that will help members find the best treatment for their particular needs. We have improved all of our disease management programs through the use of sophisticated software, enabling us to reach more members and increase efficiency.

DISEASE MANAGEMENT PROGRAM PROCESS OVERVIEW

Our disease management program:

- Identifies members who meet the criteria for a specific disease management program.
- Stratifies members in low/moderate or high-risk categories.
- Promotes self-management through personalized member intervention.
- Educates and outreaches to doctors.
- Reports feedback to members on how they're doing so that they are motivated to improve their health even more.
- Reports feedback to doctors, and in certain circumstances employers, to keep them informed regarding clinical and/or financial outcomes.

IDENTIFICATION & STRATIFICATION

We use sophisticated software to analyze claims data and identify members who will benefit the most from participating in a disease management program. The members that we identify are typically those who are at the highest risk for disease progression, which could result in future hospitalization or treatment that is costly.

Not all members with chronic illnesses will benefit from a disease management program. Those with complex diseases or complications may have extensive medical needs and individual case management would be more appropriate for them. With case management, Registered Nurses work closely with members whose illnesses require constant attention because they can be life threatening, leave the member with serious disabilities or both. Case management also strives to promote quality, cost-effective outcomes for our members.

Once we have identified a member for enrollment in a specific disease management program, we place them into either a low/moderate or high-risk category. This is done by analyzing claims.

INTERVENTIONS, EDUCATION & OUTREACH

Once potential members have been identified, we send them an introductory letter to tell them they meet the criteria for a disease management program. When the member receives the letter, they can choose to “opt-out” of the program and we will not contact them further unless they express an interest in the program at a later date. We use an “opt-out” program (rather than “opt-in”) because industry experience shows a significantly higher member participation rate, 80-95 percent versus 30-40 percent with opt-in programs.

The level of intervention that a member receives is based on whether their risk level is low/moderate or high.

- Low/moderate-risk members receive educational materials in the mail and have access to disease management health coaches. Doctors may also receive educational materials on the latest evidence-based guidelines for treating the specific disease.

- High-risk members receive the greatest amount of intervention. They receive educational materials, work with a disease management health coach one-on-one through reminder phone calls, work with a registered dietician and some members qualify to use at-home biometric monitoring equipment.

For both risk levels, the member and their doctor(s) receive an annual profile of the member's health indicators, which help the member stay up-to-date on their care and help their doctor provide the best possible care.

The team approach to Blue Cross of Idaho's disease management program encourages members to:

- Learn how to take care of themselves with behaviors that have a positive effect on their illness.
- Stick to their doctor's recommendations for preventative care and treatment.
- Use information from their doctor and/or health coach to take care of themselves on a daily basis.
- Make good choices when it comes to using the health care system.

Blue Cross of Idaho works with doctors to encourage them to:

- Design patient treatment according to evidence-based clinical guidelines.
- Use what they learn from their patients' outcomes in their daily practice.

REPORTING

The purpose of the disease management program is to improve the quality of life for our members with chronic illnesses. To accomplish our goal, we must be able to measure both subjective and objective improvement in the member's health status.

We measure two types of outcomes:

1. Clinical Outcomes – are measures of process indicators or outcome indicators. Process indicators measure the appropriate use of laboratory tests, procedures and prescription drugs, all of which can have an impact on member disease, mortality and health care utilization. Outcome indicators measure hospital readmission, complications or mortality.
2. Financial Outcomes – are measures based on claims cost. We look at emergency room visits and hospital admissions as well as health care cost outcomes. This allows us to determine the impact that participating in a disease management program has on the cost of caring for members with chronic illnesses.

Before launching a specific disease management program, we analyze 12 months of data to establish baseline measurements. After the implementation of a disease management program, we calculate post treatment measures at 12 months. Reports of clinical outcomes are provided to members and their doctors. Providers and employers may also request aggregate reports that are compliant with Health Insurance Portability and Accountability Act for both types of outcomes.

ASTHMA DISEASE MANAGEMENT PROGRAM

Asthma is a chronic respiratory condition characterized by:

- increased airway responsiveness to a variety of stimuli,
- inflammation of the airways, and
- potentially severe, but usually reversible, airway constriction.

More simply, it is a disease that causes the airways of the lungs to tighten, which makes it hard to breathe.

Between 1985 and 2000, the overall prevalence of asthma in the United States increased 75%. From 1970 to 1997 the age-adjusted death rate increased by 56%. Each year, billions of dollars are lost in school days and work productivity due to asthma and its complications.

Even though clinical guidelines for treating asthma are readily available to members and their doctors, members do not always receive the best possible treatment. Members with asthma are frequent visitors to the emergency room for treatment of flare-ups and many of these visits lead to hospitalizations.

The key intervention for asthma members is to review their medication routine. Members with asthma are typically treated with “controller” and “reliever” inhalers. Controller inhalers are used daily to help prevent asthma symptoms and keep asthma attacks to a minimum. Medical research has shown that using controller inhalers or medications should be the member’s main therapy. Reliever inhalers are used to reduce asthma symptoms after they have started and work immediately to open the patient’s airways. They can be used in conjunction with controller inhalers or saved for flare-ups. A good way to help prevent asthma from becoming worse is to closely monitor the ratio of controllers to relievers.

Members who enter our asthma disease management program are carefully tracked for outcome measurements to see how well they are controlling their illness. Our asthma program has two main goals:

1. Increase the percentage of members with asthma who use their medication appropriately.
2. Decrease emergency room visits to treat acute asthma for our members who take asthma medication on a regular basis.

CONGESTIVE HEART FAILURE DISEASE MANAGEMENT PROGRAM

Congestive heart failure (CHF) is one of the most expensive and potentially debilitating diseases. It is often the result of coronary artery disease, hypertension (high blood pressure) and/or cardiac rhythm disturbances.

The introduction of new prescription drugs and the effective use of existing therapies can help members live longer and improve their quality of life. Additionally, members who watch their weight, exercise, quit smoking, use less salt and take their medication properly can slow the progression of CHF in its early stages. Studies have shown that the best way to help members receive optimal treatment is to educate them on how to best take care of themselves and to provide feedback to their doctors regarding their progress.

To aid in tracking our members condition, we provide biometric monitoring equipment in the form of a scale. The Cardiocom TELESCALE® and software allow us to monitor high-risk CHF members from home by tracking their weight and clinical symptoms. The information is transmitted via phone line to the disease management health coach's computer and identifies members whose clinical condition is outside parameters set by their doctors. The health coach uses the information to educate the member and communicate the member's condition to his or her doctor.

Members who enter our CHF disease management program are carefully tracked for outcome measurements to see how well they are controlling their illness. Our CHF program has three main goals:

1. Increase the number of members who are on optimal treatment.
2. Increase the number of members who are controlling their blood pressure to equal or less than 120/80 and complying with blood pressure medication use and diet and lifestyle guidelines.
3. Reduce hospital admission and readmission rates.

DIABETES DISEASE MANAGEMENT PROGRAM

Diabetes is the seventh leading cause of death in the United States and is the leading cause of kidney failure, blindness and amputations in adults and is a major risk factor for heart disease and stroke. Due to the aging population and a greater prevalence of obesity and sedentary lifestyles, the number of people diagnosed with diabetes has been increasing to epidemic proportions. Approximately 6% of the US population has diabetes. Of those people, it is estimated that one-third don't even know they have the disease.

Careful management of blood glucose levels and control of other risk factors such as weight, cholesterol and blood pressure can reduce acute and long-term complications from diabetes. A positive side effect is cost savings that result within one to two years of the start of a disease management program. Diabetes is a chronic illness that requires continuous medical care and member education to make positive changes in the member's health. Because of this, diabetes members respond well to a disease management program.

Members who enter our diabetes disease management program are carefully tracked for outcome measurements to see how well they are controlling their illness. We use a biometric monitoring device to manage and closely monitor our most high-risk diabetic members.

Our diabetes program has two main goals:

1. Increase the percentage of members who comply with recommended treatments and maintain test results within parameters shown below:
 - Test for HbA1c (measures the average level of a member's blood sugar over 90 days) within the guidelines of member's glycemic control (testing once per quarter, semi-annually or annually).
 - Undergo a dilated retinal eye exam annually.
 - Maintain HbA1c under control at equal or less than 7.0%.
 - Manage lipids to national guidelines: equal or less than 100mg/dL (equal or less than 70mg/dL for recent cardiovascular disease events).
 - Maintain blood pressure at equal or less than 120/80.
 - Comply with medication usage.
 - Undergo documented foot exam annually.
2. Increase the percentage of members with cardiovascular disease and diabetes that are being treated with lipid-lowering agents.

LOW BACK PAIN DISEASE MANAGEMENT PROGRAM

Low back pain is the most common and most expensive work-related disability in the United States. Nationally the cost of care for back pain exceeds \$100 billion a year. Two-thirds of these costs are indirect, due to lost wages and reduced productivity. Low back pain is the primary cause of work-related disability for people under age 45 and is the second most common cause of absenteeism.

Eight out of 10 individuals will have low back problems at some time in their life with muscle strains being the most common cause. The majority of cases are not serious and 95% will recover with conservative treatment alone. There is good evidence that adequate conservative treatment could help avoid inappropriate surgery and the associated risks.

Individuals that are well informed about the diagnosis, treatment and a realistic time frame of recovery from low back pain have a higher success rate with conservative treatment and prevention of further low back problems.

The natural stimulus for the healing process is active movement. Ultimately developing and maintaining an active lifestyle including a gentle exercise program for low back pain will decrease recovery time and reduce recurrences of low back pain.

A key element in the treatment and prevention of further low back pain problems is to decrease or eliminate risk factors, which include obesity, smoking, sedentary life style or job and improper lifting techniques.

Life style changes such as diet, smoking cessation, exercise including a combination of stretching, strengthening and aerobic conditioning and proper lifting techniques may be necessary.

Key strategies for intervention involving low back problems include:

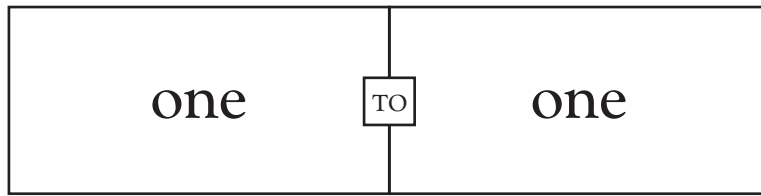
- Increasing the understanding of the disease process of low back pain.
- Raising the awareness and understanding of appropriate treatment, diagnostic testing and disease course.
- Emphasize conservative treatment within a timely manner including appropriateness of limited, short-term analgesic use.
- Promote importance of maintaining a healthy lifestyle.

Members who enter our low back pain disease management program are carefully tracked for outcome measurements to see how well they are managing their low back pain. Our low back pain program has three main goals:

1. Overall improvement in Oswestry pain and disability questionnaire and SF-12 v2 Health survey scores.
2. Decrease work absenteeism and work presenteeism while increasing productivity.
3. Reduction in inappropriate surgical procedures for low back pain.

Blue Cross of Idaho is dedicated to improving our members' health and quality of life. Our disease management program focuses on those individuals who are at highest risk for developing complications or troublesome effects of chronic illnesses. By encouraging member self-management and facilitating optimal care with doctors and their patients, Blue Cross of Idaho's disease management program can help members and employers achieve cost-effective health care that promotes a greater quality of life.

Please contact 1-800-365-2345 for more information on these programs.



It's a ratio that most-accurately represents
our dedication to unparalleled customer service and to you,
OUR NUMBER-ONE PRIORITY.



An Independent Licensee of the Blue Cross and Blue Shield Association