Disease Management Program
INTRODUCTION

The goal of Blue Cross of Idaho’s disease management program is to empower members and/or caregivers (following HIPAA regulations as a health plan), in concert with their physicians and other care providers, to effectively manage disease and prevent complications through adherence to medication regimens, regular monitoring of applicable labs/vital signs, a healthy diet, exercise and other lifestyle choices. We also screen members for depression and other psychosocial issues that tend to be a comorbid condition related to the toll a chronic condition can have on a member.

Our disease management programs also support the physician or provider/patient relationship and plan of care, emphasizing the prevention of exacerbations and complications through evidence-based practice guidelines, and evaluating clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health. To further enhance our member’s ability to make informed medical decisions, we educate those with chronic conditions of asthma, chronic obstructive pulmonary disease (COPD), depression, diabetes and/or heart failure (HF) on the importance of adhering to evidence-based care guidelines for their condition(s) so they remain up to date and aware of services and tests that physicians recommend, and why.

Members involved with managing their chronic condition(s) may see improvements in other health issues and even lower their out-of-pocket medical costs.

HISTORY

Blue Cross of Idaho launched the disease management program in 2001 with a focus on HF because it was one of the most expensive chronic conditions to treat. Our main goals in the program were to reduce hospital admissions for members with congestive HF and make sure they were taking their medications properly. We engaged members through educational materials, one-to-one phone calls and physician outreach. Through these efforts, we were able to increase compliance with appropriate medication usage and decrease hospital readmission rates by five percent.
We significantly enhanced our disease management program in 2003 and 2004 by hiring trained healthcare professionals as health coaches. We also launched a biometric monitoring component to the program and provided equipment to our high-risk HF members that allowed them to report their condition from home. Additionally, we expanded the program to include asthma and diabetes. Those members receive consultation from a clinical health coach that educates them on the proper use of medication and emphasizes their physician’s treatment plan.

Since that time we have also added management programs for COPD and depression that utilize the overall processes of the other programs.

**Disease Management Program Process Overview**

Blue Cross of Idaho’s disease management program:

- Identifies members meeting the enrollment criteria for a specific disease management program
- Stratifies members in low or high-risk categories
- Promotes self-management through personalized member intervention
- Collaborates with physicians to reinforce treatment plans
- Reports feedback to members/provider on specific chronic management issues and/or successes
- Completes care coordination referrals with other department areas of Medical Quality Management, such as to case management, when the acuity and/or medical stability of the member is heightened
- Reinforces evidence-based practice guidelines for member informed-decision making needs
- Completes an annual member satisfaction survey with analysis for process improvement

**Identification & Stratification**

Using a HIPAA compliant process, we identify a target population of members with a disease diagnosis monthly via claims analysis. We then apply exclusion criteria for members with other conditions/illnesses that would prevent them from engaging in a specific management program (like HIV, end stage renal disease).

We then stratify the identified members for recent inpatient or emergency room visits related to complications of their condition that indicate the member may be at high risk for disease progression and would benefit from an immediate health coach outreach call. In addition, we identify members for all our program diagnosis and can enroll one member in all our programs at once, if they qualify, and conduct all interactions through one main clinician health coach only.

Blue Cross of Idaho and the Blue Cross Blue Shield Association, follow the recommendations established and published by The Care Continuum Alliance (carecontinuum.org), a leader
in population health management research that sets the industry standard for identification methodology, terminology and other disease-management components.

Our member’s health dictates where Blue Cross of Idaho’s Medical Quality Management department can best manage his or her healthcare needs. If a member has an acute health or behavioral health issue and a greater need for care coordination, or a complex set of health issues and self-management education is not in the best interest of the member at that time, case management always trumps disease management, whether those needs are for acute, complex or behavioral health service needs.

**Staffing for Disease Management Programs:**

- Utilize non clinical staff for incoming phone calls, tracking lab results, outreach phone calls for lab reminders based on when they’re due again as well as mailing out both member and physician lab reminders

- Utilize registered nurses, licensed social workers, and licensed practical nurses within their scope of practice for all clinical evaluation or interpretation of individual clinical data and health coaching calls. All clinicians are certified as Chronic Care Professionals (healthsciences.org), which includes health coaching certification, within their second year of employment

**Interventions, Education & Outreach**

Once we identify potential members, we make an outreach phone call to the member and introduce the concepts of the specific management program(s) and to engage the member into taking an active part in the self-management of his or her condition(s) with the support of the clinical health coach. If we can’t connect with a member after two attempts, we send them a letter stating their status will be considered not engaged and they need to contact us to engage in the program. Members who do engage but do not wish to collaborate with a clinical health coach and/or is self-managing their condition(s) well will be considered “passively engaged” in disease management and will receive pertinent educational information and, if applicable, lab/vital sign reminders. If the member provides us with their physician’s information, we send a letter notifying them of the member’s passive engagement into the program and, if applicable, we send the physician lab/vital sign reminders for the member as well.

Members who do engage with the clinical health coach are considered “actively engaged” and move on to complete an assessment to assess their current health state, existing co-morbidities, gaps in care, healthy behaviors, preventive care and any psychosocial issues. Based on the problems identified the member is encouraged to set their own specific goals based on issues identified via the assessment tool. The clinical health coach formulates a disease management “plan of care” for coaching the member towards those goals and then the identified physician is sent the applicable plan of care and members are encouraged to discuss this with their physician for the final loop in the collaborative team process. Both physicians and members receive applicable lab/vital sign reminders as well. Once member either disengages from the health coach, whether due to meeting goals, partially meeting goals or at max for the member, the member and the physician continue to receive lab/vital sign reminders and the member then receives quarterly educational mailings.
Using outreach and educational materials, Blue Cross of Idaho’s disease management program encourages members to:

• Be accountable for their chronic condition(s)

• Adhere to their physician’s recommendations for preventative care and treatment

• Embrace educational opportunities for informed-decision making when accessing the healthcare system

Blue Cross of Idaho encourages physicians to:

• Design patient treatment according to evidence-based clinical guidelines

• Continually plan, study and act to improve patient-based outcomes and to ensure efficient quality care

• Collaborate with the Blue Cross of Idaho Quality Management department for all provider quality-based interventions

Adoption of Clinical Practice Guidelines:

Blue Cross of Idaho’s Disease Management department utilizes the clinical practice guidelines for its current disease management programs through the annual endorsement process by the Physician’s Advisory Panel, a quality committee comprised of a quorum of contracting physicians as well as Blue Cross of Idaho employee representatives. After the annual endorsement process, we update links to the guidelines on both our company’s member and provider access areas of our website.

REPORTING

We measure three types of outcomes:

Clinical Outcomes – For reporting purposes we utilize the National Committee for Quality Assurance’s Healthcare Effectiveness Data Information Set (HEDIS) diabetes care rates as well as medication adherence as measured through the medication possession ratio (MPR). Outcome indicators also measure hospital readmission, complications or mortality.

Satisfaction Surveys – On an annual basis we send a survey to a random selection of members who participated in a program for the previous twelve months. Actively engaged members receive a certain set of questions different than those passively engaged. We present analyzed results to our quality committees for observations, discussions and process improvement opportunities.

Financial Outcomes – We measure these results based on claims cost and take emergency room visits, hospital admissions, and healthcare cost outcomes into consideration. Our goal is to illustrate those members participating in a disease management program have a slower trend in healthcare costs compared to a cohort that do not. This helps us determine the impact that participating in a disease management program has on the cost of caring for members with chronic illnesses.
Asthma Management Program

Asthma is a chronic respiratory condition characterized by:

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

Put simply, asthma is a disease that causes the airways of the lungs to tighten, making it hard to breathe.

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 frequently visiting the emergency room for treatment of flare-ups and many visits lead to hospitalizations.

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

We analyze our asthma management program member’s outcome measurements annually to see how well they are controlling their condition. Our asthma program has two main goals:

1. Increase the percentage of members with asthma using medication appropriately
2. Decrease emergency room visits/inpatient admits to treat asthma exacerbations

Chronic Obstructive Pulmonary Disease (COPD) Management Program

COPD is a mixture of two conditions, chronic bronchitis and emphysema, that limits bronchial airflow over time.

COPD is caused by damage to the lungs over many years, usually from smoking or exposure to other lung irritants like chemical fumes or air pollution, though a rare genetic disorder can also lead to COPD. As yet, there is no cure for COPD, and it tends to get worse over time. The natural course of the disease is chronic and progressive physiological deterioration punctuated by acute-on-chronic exacerbations. An exacerbation can range from mild to life-threatening. The longer you have COPD, the more severe these flare-ups are.

Members can prevent or detect exacerbations early and deal with them through pre-prescribed rapid action plans and prevent respiratory failure and the need for hospitalization. Our interventions for our members with COPD includes the promotion of a healthy lifestyle,
medication adherence, preventive vaccinations, collaborative self-management strategies and the existence of a self-action plan that is given to the member by their physician. This gives the member a green light-go, yellow light-caution, red light-stop and call your doctor plan to help minimize any pending exacerbations.

We analyze our COPD management program member's outcome measurements annually to see how well they are controlling their condition. **Our COPD program has two main goals:**
1. Increase the percentage of members with a COPD who use their medication appropriately
2. Decrease emergency room visits/inpatient admits for complications/exacerbations of their COPD

## Depression Management Program

Like diabetes and heart disease, depression is a serious medical illness that is quite common. Depression is one of the most prevalent mental health conditions in the United States, affecting approximately 19 million American adults each year. Depression affects about five to eight percent of the United States’ adult population in any 12-month period. In fact, depression ranks as the largest cause of disability in the developed world and the fourth-largest cause of disability in the developing world.

The symptoms of depression vary widely and may greatly impact the social and economic well-being of sufferers. Psychological, biological, environmental and genetic factors contribute to its development. Depression is disruptive in many ways and may cause people to withdraw from their relationships, from their work and from the very fabric of society. To make matters worse, researchers believe that more than one-half of the people who commit suicide were suffering from depression at the time.

Of all the mental illnesses, depression is among the most responsive to treatment and highly treatable. Most people diagnosed with serious depression can receive treatment and return to their routine daily activities with relief from their feelings of depression.

The primary focus of the Depression Management Program (DMP) here at Blue Cross of Idaho is to improve the quality of life for our members with depression advocating for the proper screening, diagnosis, treatment and management in the primary care setting.

**Our Depression Management Program has two main goals:**
1. Improve the number of members that receive appropriate office follow-up after receiving an antidepressant medication treatment
2. Help improve medication adherence to the recommended length of therapy
Measurements for the Depression Management Program are by:
1. HEDIS measurements regarding the Acute Phase and Continuation/Maintenance Phase for antidepressant utilization
2. The response to the member satisfaction survey at the completion of the program
3. Improvement in PHQ-9 score

**Diabetes Disease Management Program**

Diabetes is a chronic condition that requires continuous medical care and member education to make positive changes in the member's health. 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. Because of this, diabetes members respond well to our disease management program.

We carefully track members of our diabetes disease management program for outcome measurements to see how well they are controlling their illness.

Our diabetes program goals for members include:

- 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, semiannually or annually)
- Receiving a dilated retinal eye exam annually
- Maintaining HbA1c under control at equal or less than 7.0 percent or as recommended by their physician
- Receiving and annual test for Lipids
- Treating abnormal lipids with optimal lipid-lowering agents
- Managing lipids within national guidelines: equal or less than 100mg/dL (equal or less than 70mg/dL for recent cardiovascular disease events)
- Maintaining blood pressure at equal or less than 130/80
- Practicing medication adherence
- Testing urine annually for protein/kidney damage
- Taking optimal medications for kidney protection
**Heart Failure Disease Management Program**

Heart failure (HF) 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 show 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. The Cardiocom TELESCALE® and software allow us to monitor high-risk HF members from their home by tracking their weight and clinical symptoms. The unit transmits the information via phone line to a disease management health coach’s computer and identifies members with clinical conditions outside parameters set by their doctors and those that could be exacerbating their condition and going into congestive heart failure. The health coach uses the information to educate the member and communicate the member's condition to his or her doctor.

We track our HF disease management program members for outcome measurements to see how well they are controlling their illness. Our HF program has two main goals:
1. Increase the percentage of HF members who use their medication appropriately
2. Reduce hospital admission and readmission rates

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**Blue Cross of Idaho is dedicated to improving our members’ health and quality of life.** Our disease management program focuses on those individuals 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 healthcare that promotes a greater quality of life.

*Please contact 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.