Population Health Management Program
Blue Cross of Idaho is dedicated to improving our members’ health and quality of life. Our Population Health Management Programs aim to improve care and health outcomes while reducing costs for members who have or are at risk of developing chronic conditions. By encouraging member self-management and facilitating optimal care with doctors and their patients, these programs can help members and employers achieve cost-effective healthcare that promotes a greater quality of life.

We offer Population Health Management Programs supporting members with the following conditions:

- Diabetes
- Asthma
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Cardiometabolic Syndrome (for Healthy Measures product only)

These Population Health Management Programs will help participants maintain or improve their physical and psychosocial well-being through cost-effective and personalized health solutions. The programs will complement a member’s relationship with his or her healthcare providers by encouraging healthy behaviors and effective, efficient treatment.

We also seek to:

- Help individuals maintain or improve their level of health and educate them on ways to decrease their risks.
- Increase awareness of factors that can affect health and longevity
- Enable individuals to become accountable for their health behaviors

We identify members who may benefit from the programs based on their individual health status and needs. We hope that these programs help members and their providers make more informed decisions. Members involved with managing their chronic condition(s) may see overall improvements in their health and even lower their out-of-pocket medical costs.

**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 guidelines for treating asthma are readily available, people with the condition do not always receive appropriate treatment or follow their providers’ medical advice. Some people with asthma frequently visit the emergency room for treatment of flare-ups and many visits lead to hospitalizations.
We review the medication routine for participants in our Asthma Management Program and encourage them to develop a sick day action plan, and know how to recognize and avoid triggers that lead to problems with their asthma.

**Our asthma program has two main goals:**
1. Increase the percentage of members with asthma who use medication appropriately
2. Decrease emergency room visits/inpatient admissions to treat asthma

**Chronic Obstructive Pulmonary Disease (COPD) Management Program**

COPD is a term used to describe chronic bronchitis and emphysema which limit 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. There is no cure for COPD, and it tends to get worse over time with flare-ups ranging from mild to life-threatening and becoming more common and severe the longer you have the condition.

People with COPD may detect flare-ups early and deal with them through pre-prescribed rapid action plans, which can stop the flare-up from progressing to an emergency situation.

We encourage members with COPD to lead healthy lifestyles, adhere to their medication, get preventive vaccinations, create self-management strategies and sick day action plans with the help of their physician.

**Our COPD program has two main goals:**
1. Increase the percentage of members with COPD who use their medication appropriately
2. Decrease emergency room visits/inpatient admissions for complications/exacerbations of COPD

**Depression Management Program**

Depression is one of the most prevalent mental health conditions in the United States, affecting approximately 19 million American adults each year. Depression affects 5 to 8 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.

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 the development of depression which may cause people to withdraw from their relationships, work and society. Researchers believe that more than one-half of people who commit suicide suffer from depression.

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, recover and return to their daily activities.

The primary focus of the Depression Management Program (DMP) at Blue Cross of Idaho is to improve the quality of life for our members with depression by helping them receive proper screening, diagnosis, treatment and management of the condition.

**Our Depression Management Program has two main goals:**
1. Improve the number of members who receive appropriate office follow-up after beginning an antidepressant medication
2. Help improve medication adherence
**Diabetes Management Program**

Diabetes is a chronic condition that requires education and continuous medical care. 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, people with diabetes respond well to our population health management program.

The diabetes population is stratified into different risk categories:

- **High Risk:**
  - Patients either use the ER or Inpatient services because of health complications from their condition
  - Patients are on two or more oral diabetes medications or insulin, indicating they are having difficulty managing their blood sugar,
  - Patients have an A1c value greater than eight, indicating they are having difficulty managing their diabetes condition

  *We encourage high-risk members to take health assessments, assign them a clinical health coach and provide a “My Health Record” book to use year round for tracking health and lab reminders for the member and their provider.*

- **Low Risk:**
  - Patients are not using ER or inpatient services to treat their conditions
  - Patients are on one or fewer oral diabetes medications
  - Patients have an A1c value of less than eight

  *Our wellness coaches work with low-risk members on lifestyle behavior goals.*

Our diabetes program goals for members include:

- Participants receive tests for HbA1c (measures the average level of a member's blood sugar over 90 days) at recommended intervals
- Participants maintain HbA1c under control at equal or less than 7 percent or as recommended by their physician
- Participants receive an annual dilated retinal eye exam
- Participants receive an annual test for lipids
- Participants with abnormal lipids are treated with optimal lipid-lowering agents
- Participants manage lipids within national guidelines: equal to or less than 100mg/dL (equal or less than 70mg/dL for recent cardiovascular disease events)
- Participants maintain blood pressure equal to or less than 130/80
- Participants take their medication as it is prescribed
- Participants test urine annually for protein/kidney damage unless on appropriate medication
- Participants take optimal medications for kidney protection

**Heart Failure 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.

Prescription drugs and effective therapy use can help people with heart failure live longer and improve their quality of life. Additionally, people who watch their weight, exercise, quit smoking, use less salt and take their medication properly can slow the progression of HF 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 about their progress.

We provide participants of our HF Management Program with biometric monitoring equipment to help them track their condition. 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 population health management health coach’s computer and identifies members whose conditions may be getting worse. The health coach uses the information to educate the member and encourage appropriate action such as communicating to the doctor. The health coach may also contact the member’s doctor about his or her concerns.

**Our HF program has two main goals:**

1. Increase the percentage of participants who use their medication appropriately
2. Reduce ER, hospital admission and readmission rates

**Cardiometabolic Syndrome Program for Healthy Measures**

Members with our Health Measures product can receive health management for cardiometabolic syndrome (CMS). People with CMS have a combination of distorted body measurements and abnormal biometric tests. We identify eligible members through the results of tests shown on their Health Qualification Form. While each measurement or abnormal test may signify a health risk, the presence of at least three of the following five factors indicates CMS:

- Abnormal waist size measurement
- High blood pressure
- High blood sugar (prediabetes or diabetes)
- High triglyceride level
- Low HDL level

CMS is a reversible condition that if uncorrected, may lead to diabetes, heart disease or death.

**Goals for the program are to encourage a lifestyle transition from unhealthy behaviors to wellness.**

- lose weight
- be physically active
- eat healthy foods
- avoid tobacco and second hand smoke
- Correct medication use

*We measure outcomes each year to ensure participants continue to improve their health.*

**Process Overview**

Blue Cross of Idaho’s Population Health Management Program process includes:

- Identifying members who may benefit from specific programs
- Identifying members in low- or high-risk categories
- Contacting potential participants
- Working with physicians to reinforce treatment plans
- Reporting specific chronic management issues and/or successes to members and providers
• Referring potential participants to other Medical Quality Management areas, such as Case Management, when appropriate based on the members’ condition
• Reinforcing evidence-based practice guidelines to help members make well-informed decisions
• Using feedback from members for process improvement

**Health Management Expertise**

Blue Cross of Idaho and the Blue Cross Blue Shield Association, follow the recommendations established by The Care Continuum Alliance ([carecontinuum.org](http://carecontinuum.org)), a leader in population health management research that sets the industry standard for population health management programs.

An individual member’s health dictates how 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 his or her best interest, we will offer appropriate case management before population health management.

We have registered nurses, licensed social workers, and licensed practical nurses on staff to perform all clinical evaluations and interpretations of individual clinical data and health coaching calls. All clinicians are certified as Chronic Care Professionals ([healthsciences.org](http://healthsciences.org)), which includes health coaching certification, within their second year of employment.

**Identifying Participants**

We identify members who may benefit from our health management programs by reviewing claims to see who has been diagnosed or received treatment for a disease or condition that might qualify them for health management. We exclude members with other conditions or illnesses that would prevent them from engaging in a specific management program (like HIV, end stage renal disease).

We also identify recent hospital or emergency room visits related to complications from these conditions that indicate a member may be high risk and would benefit from immediate health coach consultation. If we identify a member as a candidate for more than one program, we enroll him or her in each applicable program and assign one health coach for all.

**Interventions, Education & Outreach**

Once identified, we call potential participants to introduce the concepts of our management program(s) and encourage the member to take an active part in the self-management of his or her condition(s) with the support of the clinical health coach. If we do not reach the member after two attempts, we send a letter asking him or her to contact us to engage in the program.

If a member contacts us but does not wish to collaborate with a clinical health coach and/or is self-managing his or her condition(s), we consider him or her “passively engaged” in the program and send pertinent educational information and, if applicable, lab/vital sign reminders. If the member provides us with his or her physician’s information, we send a letter notifying the physician of the member’s passive engagement with the program and, if applicable, send the physician lab/vital sign reminders for the member.

We consider members who engage with a clinical health coach actively engaged and move on to complete an assessment to measure their current health state, identify other conditions, gaps in care, healthy behaviors, preventive care and psychosocial issues. Based on the assessment, the health coach encourages the member to set his or her specific goals. The clinical health coach formulates a population health management “plan of care” to reach those goals. We encourage members to discuss this plan with
their physician for the final loop in the collaborative team process. Once a member has met goals or finishes health coaching, we continue to send the member and physician periodic lab/vital sign reminders.

WORKING TOGETHER
An important aspect of our health management programs is working with participants and their providers to ensure we all have the same goals.

PARTICIPATING MEMBERS
Using outreach and educational materials, Blue Cross of Idaho’s population health management program encourages members to:
• Be accountable for their chronic condition(s)
• Adhere to their physician’s recommendations for preventive care and treatment
• Embrace educational opportunities for informed-decision making when accessing the healthcare system

PHYSICIANS AND HEALTHCARE PROVIDERS
Blue Cross of Idaho encourages physicians to:
• Treat patients 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 Medical Quality Management Department

BLUE CROSS OF IDAHO
Blue Cross of Idaho’s Population Health Management department uses clinical practice guidelines endorsed by our Physician’s Advisory Panel for its programs. This panel is compromised of contracting physicians and Blue Cross of Idaho employee representatives. We provide links to these guidelines on the member and provider access areas of our website.

REPORTING
We measure the results of our program in the following ways:
• Clinical outcomes – Based on industry standards surrounding best practices.
• Member satisfaction – Based on the results of an annual survey of members who participated in a program.
• Financial outcomes – Based on claims cost and emergency room visits, hospital admissions, and healthcare cost outcomes with a goal that members who participate in a population health management program have lower healthcare costs compared to people with similar conditions who do not participate.

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.**