

Disease Management Programs & Clinical Practice Guidelines

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Disease Management Programs & Clinical Practice Guidelines, continued

Disease Management Programs Overview

The BCBSTX Disease Management Program provides chronically ill BlueChoice/BlueChoice Solutions subscribers with the resources to remain healthy and maintain their quality of life. The program is available to subscribers diagnosed with asthma, cancer, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, hypertension, low back pain, metabolic syndrome, HIV/Hepatitis C (HCV) and end stage renal disease. Subscribers who are oncology patients receiving inpatient chemotherapy at per diem facilities or subscribers who are admitted to the NICU for 10 days or longer are also targeted for program intervention. Subscriber enrollment is voluntary; candidates are identified through continuous recruitment.

BCBSTX takes a comprehensive approach to Condition Management by involving the patient, the Plan and the attending Physician in the education and counseling process. BCBSTX will notify Physicians in writing of their patients' enrollment in the program and provide periodic updates on patient progress. BCBSTX also will notify Physicians of changes in their patients' health status and encourage patients to maintain open communication with their Physician.

Program Goals

BCBSTX has established the following goals for the Disease Management Program:

- Enhance subscriber self-management skills
 - Reduce intensity and frequency of disease-related symptoms
 - Enhance subscriber quality of life, satisfaction, and functional status
 - Improve subscriber compliance with the Physician's treatment plan
 - Improve communication among subscriber, Physician, and health plan
 - Facilitate appropriate health care resource utilization
 - Reduce hospitalizations, emergency room visits, and associated costs related to the disease; and reduce work absenteeism and medical claim costs.
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Disease Management Programs & Clinical Practice Guidelines, continued

Program Overview and Compliance

Periodic assessments are conducted to identify diseases that have a significant impact on subscribers. To identify subscribers appropriate for disease management, risk stratification is performed using pharmacy, lab and medical claims as well as the predictive modeling tool. Based on stratification results, targeted interventions are offered to address subscribers' levels of disease severity.

Subscribers with mild severity may receive educational materials and other self-management tools to support their Physician's treatment plan. Each subscriber with the condition receives a seasonal mailer and an outbound call. Subscribers with a moderate or severe condition are eligible for extended program components.

Asthma, Cancer, Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure (CHF), Coronary Artery Disease, Hypertension, Low Back Pain and Metabolic Syndrome. A contracted population care management company administers the program components for those subscribers with a severe condition, and focuses on enhancing and supporting Physicians' treatment plans. Subscribers electing to enroll in the vendor managed programs have 24-hour, toll-free access to a care management nurse and receive:

- A customized self-management plan
- Personalized education and self-management tools
- Guidance counseling
- Audio library topics
- A proprietary tracking system to monitor progress
- Behavior modification interventions
- Social service support for assistance in addressing barriers to self-management
- Biometric monitoring devices, if appropriate

Any subscriber who is referred for the program and does not meet the disease severity enrollment criteria or who requires supplementary support is referred to the Disease Management Department for appropriate intervention. These interventions address barriers to optimal health status, including financial barriers, limited specialist involvement, durable medical equipment needs, and self-care limitations. Additionally, subscribers may receive home health interventions and intensified telephone follow-up.

Note: Federal Employee Program (FEP) only offers the following programs – asthma, congestive heart failure (CHF), diabetes & hypertension.

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Disease Management Programs & Clinical Practice Guidelines, continued

Program Overview and Compliance, continued

Oncology and NICU. The oncology and NICU programs are administered internally by specialty R.N.s along with an assigned oncologist or neonatologist. The assigned specialist is not an employee of BCBSTX, but is a credentialed, practicing HMO Blue Texas network specialist. The focus of the programs is on enhancing and supporting the Physician's treatment plan and on assisting the subscriber with navigation through the medical care system while maximizing their benefit dollars. Program components include the following:

- Weekly telephonic case review with the Plan medical director, an assigned oncologist or neonatologist, and the oncology or NICU R.N.
- Ongoing telephonic contact between the Plan medical director and the attending oncologist or neonatologist to discuss the appropriate level of care and treatment
- Coordination of home health and DME
- Social service support for assistance in addressing barriers to discharge

HIV/Hepatitis (HCV). The HIV/HCV program is administered internally due to the very sensitive nature of the conditions. The focus of the program is to enhance and support the Physician's treatment plan and assist the subscriber with navigation through the medical care system while maximizing their benefit dollars. Program components include:

- Monthly telephone follow-up and intervention by an R.N.
- Internet-based resources regarding community-based support
- Coordination of durable medical equipment, if appropriate
- Social Service for assistance in addressing barriers to self-management

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Program Overview and Compliance, continued

Hard copy materials are not distributed to oncology, HIV/HCV, or NICU subscribers; however, HIV/HCV subscribers are coached regarding appropriate Internet resources available to them.

- A customized self-management plan
- Personalized education and self-management tools
- Guidance counseling
- Behavior modification interventions

Any subscriber who is referred for the asthma or diabetes program component and does not meet the condition severity enrollment criteria or requires supplementary support is referred to the Texas Case Management Department for appropriate intervention. These interventions address barriers to optimal health status including financial barriers, limited specialist involvement, durable medical equipment needs, and self-care limitations. Additionally, these subscribers may receive home health interventions and intensive telephone follow-up.

Congestive Heart Failure. The program is managed by the Texas Case Management Department, and supports the Physician's treatment plan. Program components include the following:

- Home health visits
- Education and self-management tools
- Coordination of durable medical equipment (DME) for self-management
- Telephone follow-up and intervention by an R.N.
- Social service support for assistance in addressing barriers to self-management

Outcome Measures

The Disease Management Program is in alignment with NCQA standards and state regulatory requirements for disease management systems. Standard reports are produced periodically and summarize:

- Resource utilization
- Subscriber's self-reported compliance with Physician's plan of treatment
- Overall subscriber satisfaction
- Quality of life and functional status

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Special Beginnings[®] Program

Childbirth-related expenses have become the largest component of health care costs today. To maintain costs and to assist female subscribers in achieving healthy pregnancy outcomes, BCBSTX offers the Special Beginnings program, our obstetrical wellness program, to most of our BlueChoice/BlueChoice Solutions subscribers. This program monitors BlueChoice/BlueChoice Solutions subscribers from program referral through the first six weeks of the infant's life with a goal of achieving healthier families through proactive pre- and post- natal health education. In addition, BCBSTX provides high-risk pregnancy case management services to all BlueChoice/BlueChoice Solutions subscribers.

Program Overview — The Special Beginnings program includes a pregnancy risk assessment, educational materials, and targeted communications during the pregnancy and for six weeks after delivery. BlueChoice/BlueChoice Solutions program participants also have access to an obstetrical registered nurse case manager throughout the program.

Risk Assessment — When the plan is notified of a subscriber's pregnancy, the subscriber is contacted to determine her interest in participating in the voluntary Special Beginnings program. If she chooses to participate, an individualized risk assessment is conducted and follow-up monitoring of her pregnancy is coordinated through a scheduled series of follow-up calls with an obstetrical nurse case manager. The call schedule varies according to the risk level of the pregnancy; however, women with normal pregnancies receive a minimum of two calls before and one call after delivery. During the call made within 4-6 weeks after delivery, a depression screening is completed to ensure any issues related to post-partum depression are addressed. If the screening is positive, additional outreach is made until the issue is resolved or stabilized with treatment.

Educational Materials — The Special Beginnings nurse works with the participant to provide effective communication and educational materials throughout the pregnancy and for at least six weeks after delivery.

Note: To ensure BCBSTX subscribers have the opportunity to participate in the Special Beginnings Program, physicians must contact the UM Department (1-800-441-9188) or access iEXCHANGE Web or the iEXCHANGE IVR (1-800-413-0869), immediately, with notification of any pregnancy for their BCBSTX subscribers.

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Clinical Practice Guidelines Overview

BCBSTX annually reviews and adopts clinical practice guidelines as the foundation for its Disease Management Programs, quality initiative and provider tools. The guidelines are based upon nationally recognized clinical expert panels, and are available to assist Physicians in clinical practice.

Wellness Guidelines

Promotion of preventive health is a major objective of the BCBSTX Quality Improvement Program. The Prenatal Care, Childhood/Adolescent and Adult Wellness Guidelines have been adopted by BCBSTX and are provided to BlueChoice/BlueChoice Solutions subscribers. The Wellness Guidelines are available on the BCBSTX Provider Web site at www.bcbstx.com/provider (under *UM/QI/Medical Management*, click on *Wellness Guidelines*).

Clinical Practice Guidelines

Clinical Practice Guidelines are also available for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, geriatrics, guidelines for multiple diseases, hypertension (HTN), low back pain, and weight management. To assist in patient education, these guidelines are available to Physicians by calling the Disease Management Department at **1-800-462-3275**, or you may access the guideline references on the BCBSTX Provider Web site at www.bcbstx.com/provider (under *UM/QI/Medical Management*, click on *Clinical Practice and Behavioral Health Guidelines*).

Clinical Practice Guidelines for Asthma

- Global Initiative for Asthma (GINA) Workshop Report (2003)
 - National Asthma Education and Prevention Program Expert Panel - Guidelines for the Diagnosis and Management of Asthma - Update on Selected Topics (2002)
 - National Asthma Education and Prevention Program Expert Panel - Report 2: Guidelines for the Diagnosis and Management of Asthma (1997)
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Disease Management Programs & Clinical Practice Guidelines, continued

Clinical Practice Guidelines for Chronic Obstructive Pulmonary Disease (COPD)

- Global Initiative for Chronic Obstructive Lung Disease (2003)
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Clinical Practice Guidelines for Congestive Heart Failure (CHF)

- ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult (2001)
 - Adult Treatment Program (ATP) III Full Report (2001)
 - The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) Express (2003)
 - Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (2003)
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Clinical Practice Guidelines for Coronary Artery Disease (CAD)

- ACC/AHA Guideline Update for the Management of Patients with Chronic Stable Angina (2002)
 - ACC/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction (2004)
 - Adult Treatment Program (ATP) III Full Report (2001)
 - The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) Express (2003)
 - Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (2003)
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Clinical Practice Guidelines for Diabetes

- American Diabetes Association: Clinical Practice Recommendations 2005
 - **Position Statements**
 - *Standard of Medical Care in Diabetes*
 - *Diagnosis and Classification of Diabetes Mellitus 2005*
 - *Diabetes Care in the School and Day Care Setting*
 - *Diabetes Care at Diabetes Camps*
 - *Diabetes Management in Correctional Institutions*
 - *Hypoglycemia and Employment/Licensure*
 - *Third-Party Reimbursement for Diabetes Care, Self-Management Education, and Supplies*
 - Technical Reviews
 - Committee Reports and Consensus Statement
 - Position Statements and ADA Statements
 - National Standards for Diabetes Self-Management Education
 - Adult Treatment Program (ATP) III Full Report (2001)
 - The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) Express (2003)
 - Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (2003)
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Clinical Practice Guidelines for Geriatrics

- Alcohol Use Disorders in Older Adults (2003), Pocket Guide
 - Exercise Prescription for Older Adults with Osteoarthritis Pain: Consensus Practice Recommendations (2001)
 - Guidelines Abstracted from The American Academy of Neurology Practice Parameters: Early Detection of Dementia (2002)
 - AGS/BGS/AAOS Guideline for the Prevention of Falls in Older Persons (2002)
 - Guidelines Abstracted from the Guideline for the Prevention of Falls in Older Persons (2002)
 - The AGS Guideline on the Management of Persistent Pain in Older Persons (2002)
 - Oral Anticoagulation for Older Adults (2002), Pocket Guide
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Clinical Practice Guidelines for the Guidelines for Multiple Diseases

- Recommended Childhood and Adolescent Immunization Schedule. Advisory Committee on Immunization Practices (CDC) (2005)
 - Recommended Adult Immunization Schedule. Advisory Committee on Immunization Practices (CDC) (2005)
 - Clinician's Packet: Treating Tobacco Use and Dependence. A How-To Guide For Implementing the Public Health Service Clinical Practice Guideline (2003)
 - U.S. Preventive Services Task Force - Screening for Obesity in Adults (2003)
 - A Statement for Healthcare Professionals from the Nutrition Committee of the Council on Nutrition, Physical Activity, and Metabolism of the American Heart Association. (AHA) (2001)
 - Dietary Guidelines for Americans 2005
-

Clinical Practice Guidelines for Hypertension (HTN)

- The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) Express (2003)
 - Adult Treatment Program (ATP) III Full Report (2001)
 - Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (2003)
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Clinical Practice Guidelines for Low Back Pain

- North American Spine Society (NASS) Unremitting low back pain. LaGrange (IL): North American Spine Society (2000)
 - North American Spine Society (NASS) Herniated disc. LaGrange (IL): North American Spine Society (2000)
 - North American Spine Society (NASS) Spondylolysis, lytic spondylolisthesis and degenerative spondylolisthesis (SLD). LaGrange (IL): North American Spine Society (2000)
 - North American Spine Society (NASS) Phase III clinical guidelines for multidisciplinary spine care specialists. Spinal stenosis version 1.0. LaGrange (IL): North American Spine Society (2002)
 - American College of Occupational and Environmental Medicine, Guidelines for Care of Acute and Subacute Occupational Low Back Pain Complaints (1997, 2003, 2004)
 - Institute for Clinical Systems Improvement, Adult low back pain (2003)
 - American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Major Depression (2000)
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Clinical Practice Guidelines for Weight Management

- U.S. Preventive Services Task Force - Screening for Obesity in Adults (2003)
 - Recommendations and Rationale – Screening for Obesity in Adults, U.S. Preventive Services Task Force (USPSTF) (2003)
 - Summary of the Evidence - Screening and Interventions for Obesity in Adults (2003)
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Disease Management Programs & Clinical Practice Guidelines, continued

Clinical Practice Guidelines for Use of Antiretroviral Treatment for Adults with a Confirmed Diagnosis of HIV/AIDS

These practice guidelines are based on *Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents, Panel on Clinical Practices for Treatment of HIV Infection*, Department of Health and Human Services, and Henry J. Kaiser Foundation, February 5, 2001, and are not intended to replace your clinical medical judgment. Each medical decision should be based on current medical knowledge and practices considered in the clinical circumstances of the individual patient.

Goals

To provide guidelines for:

- the use of antiretroviral therapy to decrease HIV RNA levels (Viral Load)
 - the use of antiretroviral therapy to decrease CD4 T lymphocyte count (CD4) counts
 - decreasing the risk of opportunistic infection
 - optimal pharmacotherapy with minimal insult to body systems and side effects
-

Assessment

- Complete history and physical at least yearly
 - Lab evaluation of Viral Load, CD4, CBC, liver profile, lipid profile, chemistry profile, VDRL or RPR, HCV level, and HBV level
 - PPD skin test
 - Inquire about symptoms of night sweats; unexplained fever, fatigue, rash, lymphadenopathy, thrush, weight loss, or changing body composition
 - Yearly eye exam
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Therapy

- Asymptomatic with CD4 count > 200 but < 350 and any value for Viral Load
 - Generally would offer treatment, but must also consider the current clinical status and patient's willingness to accept and comply with therapy*
- Asymptomatic with CD4 count > 350 and Viral Load > 55,000 by RNA
 - Initiate therapy
- Asymptomatic with CD4 count > 350 and Viral Load < 55,000 by RNA
 - Generally can defer therapy and observe lab values and clinical presentation
- Symptomatic or AIDS diagnosis regardless of lab values
 - Initiate therapy
- Hepatitis A and B immunization recommended for all patients
 - Pneumovax vaccine recommended for all patients
- Viral Load and CD4 count testing frequency:
 - Every 3 – 4 months for routine monitoring or
 - 2 – 8 weeks after initiation of therapy and monthly until Viral Load levels are undetectable or
 - 2 – 8 weeks following a change of therapy and monthly until Viral Load levels are undetectable or
 - At the time of a significant clinical event

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Disease Management Programs & Clinical Practice Guidelines, continued

Patient Education

General Counseling

- Explanation of HIV/AIDS disease process
- Explanation of disease transmission
- Symptoms to report immediately to the physician
- Explanation of treatment plan
- Patient's responsibilities
- Affect of tobacco, alcohol, or drug usage
- Availability of community-based support services
- Recommended vaccinations
- Role of nutrition
- Role of exercise
- Need for advanced directives or other legal documents

Medications

- Dosing schedule to include relation to meals
- Expected side effects and management measures available
- Importance of adherence to the schedule and consequence of non-adherence
- Strategies for travel

Specialist Involvement

Specialist involvement may be necessary in the following situations:

- Yearly eye exam
 - Complicated regimen
 - Disease progression despite treatment
 - Secondary malignancy
 - Co-morbid conditions complicating treatment
-