

## Disease Management Programs, Case Management Program, Clinical Practice Guidelines & Bridges to Excellence

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## Disease Management Programs

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### Disease Management Programs Overview

The BCBSTX Disease Management Program provides chronically ill BlueChoice subscribers with the resources to remain healthy and maintain their quality of life. The program is available to subscribers diagnosed with asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, metabolic syndrome, obesity, and/or those who need assistance with tobacco cessation. 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 as needed. When appropriate, BCBSTX will notify Physicians of changes in their patients' health status and encourage patients to maintain open communication with their Physician.

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### 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 adherence to 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.
  - Enhance subscriber closure of condition specific gaps in care
- 

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## Disease Management Programs, continued

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### **Disease Management 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.

The Blue Care Connection® Program staff coordinate all chronic condition participant services and collaborates with specialty staff to ensure continuity and coordination of care for those subscribers with a moderate or severe condition. The focus of the condition management program includes the management of five core chronic conditions; Diabetes, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Asthma. A hierarchy is used to determine which of multiple conditions a subscriber is experiencing has the highest priority to include the management and support of comorbid conditions.

In addition, the Blue Care Connection® Program staff has experience in and processes in place to manage chronic conditions, such as hypertension, low back pain, metabolic syndrome, cancer and oncology related diagnosis, migraine headaches, gastroesophageal reflux disease, and osteoarthritis.

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## Disease Management Programs, continued

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### Physician Integration/ Collaboration

The Blue Care Connection<sup>®</sup> program plan of care is designed to support the physician's treatment plan. The physician may be contacted by the clinician and/or Plan medical director for clinician to clinician consultation as follows:

- Clarification of the subscriber's treatment plan including open gaps in care;
- Clarification of medications;
- Subscriber is non-compliant with treatment;
- There are concerns related to subscriber safety and/or quality issues;
- Behavior or lifestyle is detrimental to the condition being managed;
- Clinician cannot reach the subscriber and has information that could be vital to share with the provider.

Blue Care Connection<sup>®</sup> resources can help a subscriber plan and manage their health, but does not replace the care of a physician. The intent of the physician collaboration is to alert the physician to gaps in health care and outreach to the physician to involve them in facilitating condition specific gap closure. The physician collaboration is designed to respect the physician's knowledge and strengthen the relationship between the physician and their patient.

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### Gap Closure

Gap closure focuses on showing improvement in the subscriber's care through engaging them and their physician in better management of health outcomes. The Blue Care Connection<sup>®</sup> clinical staff can identify opportunities from claims that a physician may not be able to identify during a normal office visit. To identify gap closure and health improvement opportunities, the clinician researches a subscriber's claims history through review of claims history available in the medical management system platform. Gap closures and health improvement opportunities may include the following:

- Diabetes
    - No physician office visit in 6 months
    - No eye exam in the past 12 months
    - No HbA1C in the past 12 months
    - No low density lipoprotein in the past 12 months
- 

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## Disease Management Programs, continued

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**Gap Closure,**  
continued

- Asthma
    - No physician office visit in the past 6 months
    - Not on controller medications
  - Chronic Obstructive Pulmonary Disease (COPD)
    - No physician office visit in the past 6 months
    - Bronchodilator adherence
  - Coronary Artery Disease (CAD)
    - No physician office visit in the past 6 months
    - No low density lipoprotein in the past 12 months
    - Beta Blocker usage
  - Congestive Heart Failure (CHF)
    - No physician office visit in the past 6 months
    - Angiotensin II Receptor Blocker (ARB)/Angiotensin Converting Enzyme (ACE) usage
-

## Case Management Program

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### Case Management Program Overview and Compliance

**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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## Case Management Program, continued

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**Case  
Management  
Program  
Overview  
and  
Compliance,**  
continued

Hard copy materials are not distributed to HIV/HCV. 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
- 

**Outcome  
Measures**

The Case Management Program is URAC accredited and meets state regulatory requirements for case management. Standard reports are produced periodically and summarize:

- Resource utilization
  - Subscriber's self-reported adherence to Physician's plan of treatment
  - Overall subscriber satisfaction
  - Quality of life and functional status
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## Case Management Program, continued

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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 subscribers. This program monitors BlueChoice 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 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 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 program staff. 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** — All participants receive a comprehensive educational book covering a multitude of pregnancy and infant care related topics.

**Note: To ensure BCBSTX subscribers have the opportunity to participate in the Special Beginnings Program, physicians must contact the UM Department 800-441-9188 or access iEXCHANGE Web or the iEXCHANGE IVR 800-413-0869, immediately, with notification of any pregnancy for their BCBSTX subscribers. Subscribers may also call 888-421-7781 directly to enroll.**

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## Clinical Practice Guidelines, continued

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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.

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### Wellness Guidelines

Promotion of preventive health is a major objective of the BCBSTX Quality Improvement Program. The Adult, Infant, Child and Adolescent, and Prenatal Wellness Guidelines have been adopted by BCBSTX and are provided to BlueChoice subscribers. The Wellness Guidelines are available on the BCBSTX Provider website at [bcbstx.com/provider](http://bcbstx.com/provider), under Clinical Resources.

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### Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are also available for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, geriatrics, hypertension (HTN), chronic pain, metabolic syndrome, hyperlipidemia weight management, tobacco cessation, and advanced care planning. To assist in patient education, these guidelines are available to Physicians by calling the Disease Management Department at **800-462-3275**, or you may access the guideline references on the BCBSTX Provider website at [bcbstx.com/provider](http://bcbstx.com/provider), under Clinical Resources.

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### Clinical Practice Guidelines for Asthma

- [Expert Panel Report 3 \(EPR 3\): Guidelines for the Diagnosis and Management of Asthma \(2007\)](#)
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### Clinical Practice Guidelines for Chronic Obstructive Pulmonary Disease (COPD)

- [Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease \(2009\)](#)
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## Clinical Practice Guidelines, continued

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### **Clinical Practice Guidelines for Congestive Heart Failure (CHF)**

- [2009 Focused Update: ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults \(2009\)](#)
  - [The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure \(JNC 7\) Full Report \(2004\)](#)
  - [Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure \(JNC 7\) \(2003\)](#)
- 

### **Clinical Practice Guidelines for Coronary Artery Disease (CAD)**

- [2007 Chronic Angina Focused Update of the ACC/AHA 2002 Guidelines for the Management of Patients With Chronic Stable Angina.](#)
  - [ACC/AHA 2007 Guidelines for the Management of Patients With Unstable Angina/Non-ST-Elevation Myocardial Infarction: Full Text](#)
  - [AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2006 Update: Endorsed by the National Heart, Lung, and Blood Institute](#)
  - [Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women: 2007 Update](#)
  - [Aspirin for the Prevention of Cardiovascular Disease: U.S. Preventive Services Task Force Recommendation Statement. Annals of Internal Medicine \(2009\)](#)
- 

### **Clinical Practice Guidelines for Diabetes**

- [Primary Prevention of Cardiovascular Diseases in People With Diabetes Mellitus: A Scientific Statement From the American Heart Association and the American Diabetes Association \(2006\)](#)
  - [Standards of Medical Care in Diabetes - 2010](#)
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## Clinical Practice Guidelines, continued

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### Clinical Practice Guidelines for Geriatrics

- [Guidelines for Improving the Care of the Older Person with Diabetes Mellitus \(2003\)](#)
  - [Exercise Prescription for Older Adults With Osteoarthritis Pain: Consensus Practice Recommendations \(2001\)](#)
  - [The Beers List: Criteria for Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions \(2003\)](#)
  - [AGS Clinical Practice Guideline: Prevention of Falls in Older Persons](#)
  - [AGS Clinical Practice Guideline: Pharmacological Management of Persistent Pain in Older Persons](#)
- 

### Clinical Practice Guidelines for Hyperlipidemia

- [Adult Treatment Program \(ATP\) III Full Report 2004 Update](#)
  - [Managing Abnormal Blood Lipids: A Collaborative Approach \(2005\)](#)
- 

### Clinical Practice Guidelines for Hypertension (HTN)

- [The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure \(JNC 7\) Full Report \(2004\)](#)
  - [Reference Card from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure \(JNC 7\) \(2003\)](#)
  - [Dietary Approaches to Prevent and Treat Hypertension \(2006\)](#)
- 

### Clinical Practice Guidelines for Chronic Pain

- [Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society \(2007\)](#)
  - [Adult Cancer Pain - NCCN Guideline](#)
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## Clinical Practice Guidelines, continued

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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 \(USPSTF\) \(2003\)](#)
  - [Department of Health and Human Services \(HHS\) and the Department of Agriculture \(USDA\) Dietary Guidelines for Americans 2005](#)
- 

### Clinical Practice Guidelines for Tobacco Cessation

- [Helping Smokers Quit: A Guide for Clinicians \(2008\)](#)
  - [Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women](#)
  - [Treating Tobacco Use and Dependence: 2008 Update](#)
- 

### Clinical Practice Guidelines for Metabolic Syndrome

- [Diagnosis and Management of the Metabolic Syndrome \(2005\)](#)
  - [ACC/AHA Diet and Lifestyle Recommendations: Revision \(2006\)](#)
  - [ACC/AHA Obesity and Cardiovascular Disease: Pathophysiology, Evaluation, and Effect of Weight Loss \(2005\)](#)
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## Clinical Practice Guidelines, continued

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### **Clinical Practice Guidelines for Advanced Care Planning**

- [Evidence for Improving Palliative Care at the End of Life: A Systematic Review. Annals of Internal Medicine. 15 January 2008, Volume 148 Issue 2, Pages 147-159.](#)
- [Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians. Annals of Internal Medicine. 15 January 2008, Volume 148 Issue 2, Pages 141-146.](#)
- [Goldstein N, Fischberg D. Update in Palliative Medicine. Annals of Internal Medicine. 2008;148:135-140.](#)
- [Advanced Cancer and Palliative Care Treatment Guidelines for Patients - Version I, December 2003. National Comprehensive Cancer Network](#)
- [National Consensus Project for Quality Palliative Care \(2004\). Clinical practice guidelines for quality palliative care.](#)
- [Education in Palliative and End-of-life Care, The EPEC Project](#)

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## Clinical Practice Guidelines, continued

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### **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.

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### **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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## Clinical Practice Guidelines, continued

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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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## Clinical Practice Guidelines, continued

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### 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

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### 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
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## Bridges to Excellence

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### Bridges to Excellence



Blue Cross and Blue Shield of Texas (BCBSTX) is now licensed as a sponsor of the **Bridges to Excellence (BTE) Diabetic Care Link program (DCL)** – access the following link for more information – [bridgestoexcellence.org/](http://bridgestoexcellence.org/). The aim of the DCL program is to improve the care given to patients with diabetes and reward physicians who give exceptional care. This program also demonstrates our company's commitment to improving the quality of health and wellness of BCBSTX members.

Diabetes is the seventh leading cause of death in the United States, affecting 24 million Americans. Diabetes has multiple complications; the U.S. health care system pays more than \$100 billion annually in medical costs.

Physicians who treat diabetic patients are invited to become **BTE recognized** – access the following link for more information - [bridgestoexcellence.org/Physicians](http://bridgestoexcellence.org/Physicians), and have the opportunity to earn annual incentives by providing superior care based on BTE guidelines. BCBSTX will incentivize a BTE recognized physician \$100 per BCBSTX selected patient, per program year for up to 150 patients with a maximum payout of \$15,000 per year.

Learn more about **Bridges to Excellence** by accessing the following link - [bridgestoexcellence.org/](http://bridgestoexcellence.org/).

Find a detailed description of BCBSTX's program for recognized BTE DCL physicians in the **BCBSTX Program Guide** located on the BCBSTX website at the following link [bcbstx.com/provider/bridges\\_excellence.html](http://bcbstx.com/provider/bridges_excellence.html).

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## **Bridges to Excellence**, continued

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### **Diabetes Care Link (DCL) Frequently Asked Questions**

#### **What is the Bridges to Excellence Diabetes Care Link Program?**

Founded in 2002, Bridges to Excellence (BTE) is a not-for-profit company whose mission is to create significant progress in the quality of care in a variety of areas. This is achieved by recognizing and financially rewarding physicians who demonstrate that they provide quality care that meets established guidelines.

BCBSTX has collaborated with BTE to implement the Diabetes Care Link (DCL) program. Additional details are available on BTE's website at [bridgestoexcellence.org](http://bridgestoexcellence.org).

#### **Is BTE a national program?**

BTE is a national program offered in more than 20 states and recognizes thousands of physicians across the United States. Please refer to BTE's website for additional details on all programs offered at [bridgestoexcellence.org](http://bridgestoexcellence.org).

#### **Why should I become a BTE DCL-recognized physician?**

BCBSTX's DCL program offers you the opportunity to evaluate and demonstrate the level of quality of care you deliver. Participating in the program gives you tools to continuously improve your practice, receive national recognition and positive incentives. In addition, your patients will know that they are receiving care from a physician that has demonstrated he or she delivers a superior level of care. Being BTE DCL recognized automatically ensures your participation in the BCBSTX diabetes program.

#### **Does obtaining BTE recognition improve the quality of health care?**

The program is designed with an understanding that patients may seek the care of various types of primary care physicians (PCPs) and endocrinologists (Endos) for treatment and management of their diabetes.

BTE's DCL requirements assess process measures and outcomes representing high standards of care for patients with diabetes. BTE believes that the DCL program has the potential to significantly improve the quality of care experienced by many patients with diabetes and to reduce the financial and human burden of unnecessary hospitalizations and complications.

As seen in historical results, BTE believes that if physicians participate in programs where they follow proven, evidence based guidelines and submits data to validate performance, the quality of care of patients with chronic disease states will improve.

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## Bridges to Excellence, continued

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**Diabetes  
Care Link  
(DCL)  
Frequently  
Asked  
Questions,**  
continued

### **What is the eligibility criterion to become BTE recognized?**

1. Physicians must execute a data use agreement with the data aggregator partner through which they plan to submit data for BTE's automated performance assessment process (see additional information on submitting data on page 19).
2. The BTE physician eligibility requirements are:
  - Must be licensed as medical doctor (MD) or doctor of osteopathy (DO)
  - Must provide continuing care for people with the condition of measurement and be able to meet the minimum patient sample sizes
  - Must submit the required data documenting their delivery of care for all eligible patients in their full patient panel, when available otherwise for a specified sample of eligible patients with the condition of measurement
  - Applicants must use PAO-supplied or approved methods for submitting data electronically
3. Learn the specifications and BTE measures
4. Determine whether to apply as an individual physician or physician group

### **What are the differences between applying as an individual physician or physician group?**

An individual physician applicant represents one licensed physician practicing in any setting who provides continuing care for patients with diabetes (or the condition of measurement). A physician group applicant represents any group with three or more licensed for a common panel of patients and practice at the same site, defined as a physical location.

### **Are there any payout incentives differences if you are BTE recognized as an individual or physician group?**

Physicians are eligible to receive \$100 per patient, per physician OR group, per program year, up to 150 patients or \$15,000. BCBSTX strongly encourages physicians to become BTE recognized as individual physicians in order to receive the individual maximum benefits and to allow the claims to be identified in our processes.

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## Bridges to Excellence, continued

### Diabetes Care Link (DCL) Frequently Asked Questions, continued

#### How do I become BTE DCL recognized?

To attain recognition in the BTE DCL program, eligible physicians voluntarily submit medical record data demonstrating that they provide high levels of diabetes care. There are three different paths available to physicians for DCL recognition:

1. NCQA: Physicians or practices that qualify for NCQA's Diabetes Provider Recognition Program (DPRP) assessment program will be recognized by BTE for the Diabetes Care Link (DCL) program at the corresponding level (i.e. DPRP Level I= DCL Level I). To achieve DPRP Recognition, physicians submit data on outcome and process measures for a sample of their patients with diabetes.
2. Automated Performance Assessment System: Physicians or practices connected to a BTE-participating data aggregator (i.e., EMR vendor, Health Information Exchange, Care Management Software) may have their data submitted on their behalf to an independent Performance Assessment Organization (PAO) for an automated evaluation of their diabetes care. Physicians or practices who demonstrate that they provide high levels of diabetes care are recognized in the BTE Diabetes Care Link (DCL) program at Levels I-III.
3. American Board of Internal Medicine: Physicians can elect to supplement sample for Performance Improvement Module (PIM) data for submission through IPRO portal.

#### See the chart below for more information:

Performance Assessment Organization (PAO)	Level of Assessment	Mode of data Submission/cycle of submission	Cost
NCQA	Level I and II	- NCQA workbook/July via NCQA portal - 1 time submission – sample of 25 patients	\$400.00 per physician
BTE Automated System - EMR	Level I, II and III	- Direct electronic submission - Submissions sent quarterly – all patients - Limited effort on behalf of physician to submit	No BTE fee
BTE Automated System –  Direct Submission Portal  ABIM ( <i>available 7/1/09</i> )	Level I, II and III	- Downloadable template from website  - Can either submit automatically or manually complete template  - Training will be available	\$95.00  Performance Assessment Organization transaction fee

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## **Bridges to Excellence**, continued

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**Diabetes Care  
Link (DCL)  
Frequently  
Asked  
Questions,**  
continued

### **What is the duration of BTE recognition?**

For DCL recognitions achieved on or before Dec. 31, 2009, recognition status remains in effect for three years from the date on which a Performance Assessment Organization (PAO) awards recognition. Beginning Jan. 1, 2010, the DCL recognition duration will be shortened to two years from the date on which a PAO awards recognition.

### **What are the plans to grow the number of physicians that are BTE DCL recognized?**

BCBSTX will identify physicians that treat our diabetic members and encourage those physicians to become BTE DCL recognized so they can receive rewards through this program.

### **How does the BCBSTX BTE program work?**

Once a physician becomes BTE DCL recognized, BCBSTX will identify our diabetic members that the physician manages. Communications will be sent to the physician to obtain biometric information about the member. When that information is received at BCBSTX, the physician will be advised that he/she can submit a claim with a specific code for reimbursement.

### **Are members assigned to multiple physicians during a program year?**

No, a member is assigned to only one physician during a program year.

### **How much is the physician incentivized for the BCBSTX diabetic program?**

Physicians are eligible to receive \$100 per patient, per physician or group, per program year, up to 150 patients or \$15,000.

### **Are Blue Card members included in BCBSTX's diabetic program?**

Blue Card members are not included in the program at this time.

### **How often will BCBSTX acknowledge new BTE DCL recognized physicians and include them in the program?**

BTE will send BCBSTX a file on a monthly basis of the newly recognized physicians. BCBSTX will identify the patients for these physicians and send communications to the physician to initiate the process for this program.

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## Bridges to Excellence, continued

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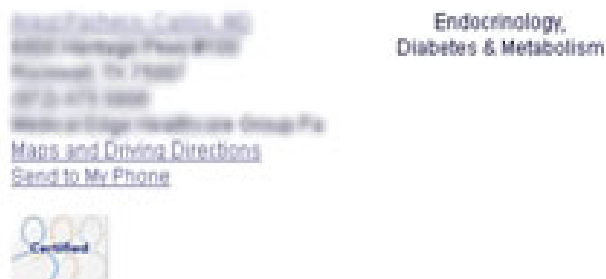
### Diabetes Care Link (DCL) Frequently Asked Questions, continued

#### Who should I contact for additional information about BCBSTX's BTE diabetic program?

Additional information can be obtained by contacting your PPN Network Representative or by contacting Jill Brooks, RN, Medical Program Specialist at 972-766-6397, [Jill\\_Brooks@bcbstx.com](mailto:Jill_Brooks@bcbstx.com), or Rebecca Ford, RHIA, Senior Manager, Texas Health Information, 972-766-8234, [Rebecca\\_Ford@bcbstx.com](mailto:Rebecca_Ford@bcbstx.com).

#### How do BCBSTX members know if a physician is BTE recognized?

When members use the Physician Finder tool on the BCBSTX website, BTE-recognized physicians are indicated with the BTE logo beneath their certifications' and recognitions' listing.



Additionally, all BTE recognized physicians are promoted on BTE's physicians list on the **HealthGrades Physician Quality Ratings** website at [healthgrades.com/](http://healthgrades.com/). Physicians who completed NCQA's Diabetes Physician Recognition Program (DPRP) are promoted as recognized practices and physicians through **NCQA's Recognized Physician Directory** at [ncqa.org/tabid/74/Default.aspx](http://ncqa.org/tabid/74/Default.aspx).

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## Bridges to Excellence, continued

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### Additional Resources

Bridges to Excellence - [bridgestoexcellence.org/](http://bridgestoexcellence.org/)

HealthGrades - [healthgrades.com/](http://healthgrades.com/)

National Committee for Quality Assurance (NCQA) Physician  
Recognition - [ncqa.org/tabid/74/Default.aspx](http://ncqa.org/tabid/74/Default.aspx)

American Board of Internal Medicine - [abim.org/default.aspx](http://abim.org/default.aspx)

BCBSTX Provider Finder -  
[bcbstx.com/onlinedirectory/index.html](http://bcbstx.com/onlinedirectory/index.html)

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