Blue Choice PPO\textsuperscript{SM} Provider Manual - Condition Management/Disease Management Program, Case Management Program, Clinical Practice Guidelines and Bridges to Excellence

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Blue Choice PPO Provider Manual  
- Condition Management/ 
Disease Management Program

**Condition Management/Disease Management Program Overview**

The **Blue Choice PPO** Condition Management/Disease Management (DM) Program provides **Blue Choice PPO** subscribers with the resources to remain healthy and maintain their quality of life. The program is available to subscribers diagnosed with chronic conditions and specific diagnoses such as: asthma, Cardiovascular Condition Clusters (coronary artery disease, peripheral artery diseases, angina and atherosclerosis, congestive heart failure, hypertension, Musculoskeletal Leading Indicators, Chronic Obstructive Pulmonary Disease, and Diabetes and/or those who need assistance with Tobacco Cessation, Weight Management and Metabolic Syndrome (Leading Indicators of MetS, diabetes and coronary artery disease. Subscriber enrollment is voluntary; candidates are identified through continuous recruitment.

**Blue Choice PPO** takes a comprehensive approach to Condition Management by involving the patient, the Plan and the provider in the education and counseling process. **Blue Choice PPO** will notify providers in writing of their patients’ enrollment in the program and provide periodic updates on patient progress as needed. When appropriate, **Blue Choice PPO** will notify providers of changes in their patients’ health status and encourage patients to maintain open communication with their Provider.

**Program Goals – Condition Management Program**

**Blue Choice PPO** has established the following goals for the Condition 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 provider’s treatment plan
- Improve communication among subscriber, provider, and health plan
- Facilitate appropriate health care resource utilization
- Reduce avoidable 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
Periodic assessments are conducted to identify conditions that have a significant impact on subscribers. To identify subscribers appropriate for condition 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 provider’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 Condition Management 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 chronic conditions such as: Diabetes, Coronary Artery Disease (CAD) and Cardiovascular Condition Clusters, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Low Back Pain, 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.
Physician Collaboration

The Condition Management program plan of care is designed to support the provider’s treatment plan. The provider 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
- Alert the provider of the patient’s condition specific gaps to care;
- Obtain information necessary to close a gap in care and/or Determine that the gap has already been closed;
- 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 resources can help a subscriber plan and manage their health, but does not replace the care of a provider. The intent of the physician collaboration is to alert the provider to gaps in health care and outreach to the provider to involve them in facilitating condition specific gap closure. The physician collaboration is designed to respect the provider’s knowledge and strengthen the relationship between the provider and their patient.
Gap Closure

Gap closure focuses on showing improvement in the subscriber’s care through engaging them and their provider in better management of health outcomes. Condition Management clinical staff can identify opportunities from claims that a provider 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 HbA1C in the past 12 months
  - No low density lipoprotein in the past 12 months
  - No test for microalbuminuria in the past 12 months and with Hypertension and not on ACE inhibitors or ARB in the past 6 months

- **Asthma**
  - Not on controller medications

- **Chronic Obstructive Pulmonary Disease (COPD)**
  - Bronchodilator adherence

- **Congestive Heart Failure (CHF)**
  - No physician office visit in the past 6 months

- **Coronary Artery Disease (CAD) and Cardiovascular Condition Clusters**
  - No low density lipoprotein in the past 12 months
Complex Case Management Programs focus on the one to two percent (1% - 2%) of the population with late stage chronic or catastrophic conditions such as: transplants, major trauma, rare diseases, and end of life issues. The Utilization Management and Blue Care Connection staff members are trained on medical events that may trigger a referral to complex Case Management.

Care Coordination and Early Intervention Program is a transition of care model that fosters clinical improvement. The program provides pre-admission, inpatient, and post-discharge outreach designed to provide educational and safety support to subscribers having an admission for a targeted diagnosis or procedure code that has been identified as having a high potential for readmission and/or post discharge complications. The program focus is to reduce readmissions, emergency room visits, and improve subscriber health outcomes.

NICU. The NICU program is administered internally by specialty R.N.s along with an assigned neonatologist. The assigned specialist is not an employee of BCBSTX, but is a credentialed, practicing 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 neonatologist, and the NICU R.N.
- Ongoing telephonic contact between the Plan medical director and the attending 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

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
- Goals met
- Overall subscriber satisfaction
- Quality of life and functional status
Special Beginnings® Program

Childbirth-related expenses have become one of the largest components 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 Blue Choice PPO subscribers. This program monitors Blue Choice PPO 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 Blue Choice PPO.

Program Overview — The Special Beginnings program includes a pregnancy risk assessment, educational materials, and targeted outreach during the pregnancy and for six weeks after delivery. 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. The Special Beginnings website accessed through Blue Access for Members also provides a wealth of pregnancy related information.

Note: To ensure Blue Choice PPO subscribers have the opportunity to participate in the Special Beginnings Program, physicians must contact the Medical Care Management Department at 800-441-9188 or access the iEXCHANGE Web application, immediately, with notification of any pregnancy for their Blue Choice PPO subscribers. Subscribers may also call 888-421-7781 directly to enroll.
Clinical Practice Guidelines will be reviewed and revised, as appropriate, at least every two years. Guidelines may be reevaluated and updated more frequently, depending on the availability of additional data and information relating to the guideline topic.

Clinical practice guidelines are reviewed and adopted 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.

Promotion of preventive health is a major objective of the BCBSTX Quality Improvement Program. The infant, child, adolescent, adult, and preventive care guidelines have been adopted by BCBSTX and are provided to Blue Choice PPO subscribers. The Preventive Care Guidelines are available on the BCBSTX Provider website under Clinical Resources: http://www.bcbstx.com/provider/clinical/tx_preventivecare.html

Clinical Practice Guidelines (CPGs) are available for asthma, attention deficit/hyperactivity disorder, cardiovascular disease, depression, diabetes, hypertension (HTN), metabolic syndrome, tobacco cessation and weight management. 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 that are currently available on the BCBSTX Provider website under Clinical Resources: http://www.bcbstx.com/provider/clinical/cpg.html
Blue Cross and Blue Shield of Texas (BCBSTX) is now licensed as a sponsor of the **Bridges to Excellence** (BTE) **Recognition Programs**, offered by the Health Care Incentives Improvement Institute (HCI3) – access the following link for more information - [hci3.org](http://hci3.org). There are two programs offered: the Diabetes Care Recognition Program and the Cardiac Care Recognition Program. The aim of these programs is to improve the care given to patients with diabetes and cardiac disease and reward physicians who give exceptional care. These programs also demonstrate our company’s commitment to improving the quality of health and wellness of BCBSTX subscribers.

Physicians who treat subscribers with diabetes and cardiac disease are invited to become **BTE recognized** 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.

To find a detailed description of BCBSTX’s BTE Diabetes Care and Cardiac Disease Recognition Programs, refer to the **BTE Program Guide** located on the BCBSTX provider website at the following link: [bcbstx.com/provider/training/bridges_excellence.html](http://bcbstx.com/provider/training/bridges_excellence.html)

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