Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Condition Management/Disease Management Program, Case Management Program and Clinical Practice Guidelines

Important note: Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

In this Section The following topics are covered in this section:

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Condition Management/ Disease Management Program Overview

The **Plan** Condition Management/Disease Management (DM) Program provides **Plan** members with the resources to remain healthy and maintain their quality of life. The program is available to members 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), oncology, diabetes and coronary artery disease. Member enrollment is voluntary; candidates are identified through continuous recruitment.

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

Program Goals – Condition Management/ Disease Management Program

The **Plan** has established the following goals for the Condition Management Program:

- Enhance member self-management skills
- Reduce intensity and frequency of disease-related symptoms
- Enhance member quality of life, satisfaction, and functional status
- Improve member adherence to the provider's treatment plan
- Improve communication among member, 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 member closure of condition specific gaps in care

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Condition Management/ Disease Management Program Overview and Compliance

Periodic assessments are conducted to identify conditions that have a significant impact on members. To identify members 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 members' levels of disease severity.

Members with mild severity may receive educational materials and other self-management tools to support their provider's treatment plan. Each member with the condition receives a seasonal mailer and an outbound call. Members 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 members 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, Oncology and Asthma. A hierarchy is used to determine which of multiple conditions a member is experiencing has the highest priority to include the management and support of comorbid conditions.

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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 member '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;
- Member is non-compliant with treatment;
- There are concerns related to member safety and/or quality issues;
- Behavior or lifestyle is detrimental to the condition being managed;
- Clinician cannot reach the member and has information that could be vital to share with the provider.

We have resources that can help a member 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 member.

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Gap Closure

Gap closure focuses on showing improvement in the member's care through engaging them and their provider in better management of health outcomes. Condition Management clinical staff can identify opportunities from claims data 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 member'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 microalbuminura 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

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Case Management Program Overview and Compliance	**Complex Case Management Programs** focus on the highest risk 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 members 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 member 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 member 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 meets state regulatory requirements for case management. Standard reports are produced periodically and summarize: • Resource utilization • Goals met • Overall member satisfaction • Quality of life and functional status

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Women and Family Health

Childbirth-related expenses have become one of the largest components of health care costs today. To maintain costs and to assist female members in achieving healthy pregnancy outcomes, BCBSTX offers a maternity/fertility program, to **Plan** members.

Whether you are pregnant or planning to get pregnant, BCBSTX may provide the following resources:

- Ovia Health™ apps feature health trackers and provide videos, tips, coaching and more.
- Well onTarget® has self-management programs about pregnancy that members can take online, covering topics such as healthy foods, body changes and labor.

Our maternity specialists will support members by phone from early pregnancy until six weeks after delivery if your pregnancy is high-risk.

Note: *To ensure* ***Plan*** *members have the opportunity to participate in these programs, physicians must contact the Medical Care Management Department at* ***1-800-441-9188*** *or Availity® Authorizations & Referrals, immediately, with notification of any pregnancy for their* ***Plan*** *members. Members may also call* ***1-888-421-7781*** *directly to enroll.*

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Clinical Practice Guidelines Overview	Clinical Practice Guidelines will be reviewed and revised biannually, as appropriate. 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.
Preventive Care Guidelines	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 **Plan** members. The Preventive Care Guidelines are available on the BCBSTX Provider website under Clinical Resources: https://www.bcbstx.com/provider/clinical/clinical-resources/preventive-care
Clinical Practice Guidelines	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 member 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: https://www.bcbstx.com/provider/clinical/clinical-resources/cpg