Wellmark Blue Cross Blue Shield of South Dakota

DECEMBER 2009

Chronic Illness Support and Education Services Overview

Wellmark Blue Cross and Blue Shield engages and educates our members about their chronic conditions and provides tools to help them manage those conditions for optimum health. The services target the chronic conditions with the highest impact on health today:

- **high-risk asthma**
- **chronic obstructive pulmonary disease (COPD)**
- **congestive heart failure**
- **coronary artery disease**
- **diabetes**

Goal

Increase patient adherence with the clinician's treatment plan while supporting and reinforcing the relationship between the patient and his or her clinician.

Services

The member receives:

- Information – Comprehensive Web-based tools, printed self-care education and ongoing telephonic assistance to help members manage chronic conditions and comply with their clinician's care plan.
- One-on-one coaching – Personalized calls provided to those patients with high-risk conditions identified as needing additional help or assistance in managing his or her disease.

Program Components and Objectives

Core Conditions Program Objectives

Asthma, High-Risk	Chronic Obstructive Pulmonary Disease (COPD)	Congestive Heart Failure	Coronary Artery Disease	Diabetes
Reduce number of ER visits and hospital admissions	Lessen severity of COPD episodes and enhance functional status	Avoid hospitalizations and reduce impact of related conditions	Reduce acute cardiac episodes and events	Reduce number of ER visits and hospital admissions
• Improve prevention and self-management techniques • Modify environmental exposures and behaviors • Reduce adverse affects from medications	• Prevent upper airway infections with flu/ pneumonia vaccinations • Increase adherence to medication regimen and treatment plan	• Increase early recognition and intervention • Promote risk factor modification • Increase adherence to medication regimens	• Increased compliance with medical therapies • Educate on cardiovascular risk factors and early recognition of symptoms	• Improve prevention or reduce complications through better self-management techniques • Gain better control and improve management of glucose levels

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Impact Conditions

In addition, Chronic Illness Support and Education Services provide support for the following impact conditions:

- Acid Related Stomach Disorders
- Atrial Fibrilation
- Fibromyalgia
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Low Back Pain
- Osteoarthritis

Impact Conditions Objectives:

- Reduce hospital admissions and ER visits
- Reduce complications through self-management techniques
- Increase adherence to medication regimens
- Increase levels of success in pain management
- Educate participants on what to expect from their condition

Program Eligibility

Wellmark works proactively to identify members with chronic conditions in which patient self-care efforts are significant. Chronic Illness Support and Education Services (also known as the Disease Management Program) are available to all fully-insured Wellmark Blue Cross and Blue Shield of South Dakota members, and members of some self-funded plans.[1] Eligible participants are identified for the program based on Wellmark's medical and pharmacy claims. Clinicians, nurses, and Wellmark members are encouraged to make referrals to the program.

Identification of Risk Level

The severity of a participant's condition is determined through the use of state-of-the-art predictive modeling tools supplemented with personal health assessment data, if available. Members are stratified as low-, medium-, or high-level risk, and members with the highest stratification receive the greatest intensity of intervention.

Level One	Participants who are stable and at lowest risk for utilization or aggravation of their condition.
Level Two	Participants who are at some risk for utilization or aggravation of their condition.
Level Three	Participants who represent moderate risk for utilization or aggravation of their condition, however still preventable.
Level Four	Participants at highest risk for utilization or aggravation of their condition and timely action is required to mitigate risks.

Data is refreshed weekly to identify new participants. Members identified with a condition are part of the program, but they may choose to opt out of the program at any time. No age restrictions apply to the diabetes and asthma programs; members must be 18 years of age or older to participate in the COPD, CAD, and CHF programs.

[1]BlueCard® Host members (members covered by a Blue Plan other than Wellmark) are not eligible for the Chronic Illness Support and Education Services. Members may be eligible for similar programs offered by their Blue Cross Blue Shield Home plan.

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Communication Touch Points for Members and Clinicians

Standard Patient/Member Interventions

Activity	Frequency for Core Conditions	Frequency for Impact Conditions
Welcome Call and Follow-Up Letter/Packet – Verify diagnosis, introduce program, educate about disease condition.	Initially	Initially
Newsletters (Disease-specific) – Provide condition-specific information, self-care reminders, topical articles, and lifestyle suggestions.	Quarterly	—
Good Health Guidelines Reminders – Mail reminders to make appointment to receive recommended care based on individual's condition(s) and program guidelines.	3x per year and flu*	2x per year and flu
Depression Screening – Assess member for depression. If symptoms present, with member's permission, notify the primary care provider.	Annually**	Annually
Action Plans – Establish tools for members to encourage use of self-management skills and maximize his/her time with his/her provider.	—	Initially
Home Heart Failure Monitoring – for select heart failure participants.	As needed	—
Home Pulmonary Education Program – for select COPD participants	As needed	—
Care Calls – Provide telephonic interaction with registered nurse to assess readiness to change, provide education, increase self-management skills, and help member identify a behavioral change goal.	Varies per disease condition and stratification level (2-39 times per year**)	Varies per disease condition and stratification level (1–26 times per year)
Self-Care Goals & Education Materials – Send to member after Care Calls to reinforce behavioral changes and support member's goal.	As needed**	As needed
Program Satisfaction Survey (Sampling Methodology) – Survey randomly selected members for satisfaction levels with program content, interventions, and professional staff.	Annually**	Annually
Dedicated Toll-free Number – Provide access to specially trained staff to answer members' general or condition-specific questions.	24 hrs/day, 7 days/week	24 hrs/day, 7 days/week

*All asthma members will receive the good health reminder mailing only for the flu vaccine.

**Asthma population will be put into program via predictive model. Top 25 percent of identified participants will be active.

Standard Clinician Touch Points

When a member enrolls in the program, information is provided to the patient's primary care clinician (as identified by the member) as follows:

Activity	Frequency for Core Conditions	Frequency for Impact Conditions
Introductory Letter	Once (when clinician's first patient enrolls in program)	Once (when clinician's first patient enrolls in program)
Member Newsletters	Quarterly Online***	—
Standards of Care Flow Sheets	Online*** and On Request	—
Evidence-Based Treatment Guidelines	Online*** and On Request	—
Program Satisfaction Survey: Conducted annually to assess the effectiveness of the program from the clinician's perspective.	Annually	—
Face-To-Face Discussions with RN (Clinical Integration Managers)	Ongoing	—
PHQ-9 Depression Screening Packet: Member is identified in the packet. Includes cover letter and PHQ-9 assessment.	On Positively Screened Members	—
Telephone Support: 24/7 access to dedicated toll-free number: 866-816-5264.	Ongoing	Ongoing

***www.wellmark.com (Provider > Health Management > Chronic Illness Support and Education)

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One-on-One Nurse Support for Members

Members identified as high-risk have the added support of one-on-one telephonic nurse support from an experienced health professional. The goal of the coach is to support the member and encourage progress to achieve member-defined lifestyle modification, wellness goals, and medical treatment plan supported goals.

Inquiries and Referrals

To refer a member for Chronic Illness Support and Education Services:[2]

- Call the Chronic Illness Support Team: 866-816-5264.
- Contact One Call Connect by calling 1-888-780-1862, or by using the One Call Connect Referral form at www.wellmark.com (Provider > Health Management > One Call Connect).

For additional information:

- Call the Chronic Illness Support Team: **866-816-5264**.
- Visit us online at www.wellmark.com (Provider > Health Management > Chronic Illness Support and Education Services).
- Contact your Wellmark network relations manager.

[2]Chronic Illness Support and Education Services are provided by Healthways, Inc. Member participation is voluntary and at no additional cost.

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