OUR PURPOSE
To do everything in our power to stand with our members in sickness and in health
Recognizing the Impact of Diabetes
11% of Texans are diabetic, 8% are pre-diabetic

106.9% growth in diabetes with chronic complications in the last year

>$8.5B in diabetes claims, $4B in kidney disease

Latinos are most likely to present with CKD and most likely to die from diabetic complications

Source: Texas BRFSS Maps, https://www.dshs.state.tx.us/chs/datalist.shtm
### Prevalence

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases without Complication</td>
<td>5.9%</td>
</tr>
<tr>
<td>Depression and Bipolar Disorders</td>
<td>2.2%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease, Including Bronchiectasis</td>
<td>1.5%</td>
</tr>
<tr>
<td>Chronic Heart Arrhythmias</td>
<td>1.5%</td>
</tr>
<tr>
<td>Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors</td>
<td>1.3%</td>
</tr>
<tr>
<td>Digestive Heart Failure</td>
<td>1.2%</td>
</tr>
<tr>
<td>Completed Pregnancy with No or Minor Complications</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Source: Texas BRFSS Maps, [https://www.dshs.state.tx.us/chs/datalist.shtm](https://www.dshs.state.tx.us/chs/datalist.shtm)
Clinical and Business Case

### Expenditure

<table>
<thead>
<tr>
<th>Condition</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes without Complication</td>
<td>$5,380,775,332</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$3,602,675,863</td>
</tr>
<tr>
<td>Cardio-Respiratory Failure and Shock, Including Respiratory D.</td>
<td>$3,466,756,423</td>
</tr>
<tr>
<td>Specified Heart Arrhythmias</td>
<td>$3,014,792,161</td>
</tr>
<tr>
<td>Diabetes with Chronic Complications</td>
<td>$2,695,120,905</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease, Including Bronchiectasis</td>
<td>$2,637,435,069</td>
</tr>
<tr>
<td>Adrenal, Pituitary, and Other Significant Endocrine Disorders</td>
<td>$2,482,621,464</td>
</tr>
<tr>
<td>Asthma</td>
<td>$2,385,824,526</td>
</tr>
<tr>
<td>Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/S.</td>
<td>$2,285,014,143</td>
</tr>
<tr>
<td>Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain</td>
<td>$2,245,636,817</td>
</tr>
</tbody>
</table>

**Prevalence**

- 0.00%  
- 5.86%
Condition Management

BlueCross BlueShield of Texas
Proactive Identification of Members

1. Collect Claim History with Predictive Modeling
   Historical claims data is included in a scheduled predictive modeling run

2. Identify Current Member Activity using real time referrals initiated by:
   - Emergency room visits
   - Preauthorization/notification
   - Self referral
   - Provider referrals
   - Human Resources staff
   - Pharmacy Data
   - 24/7 Nurseline

3. Member Stratification
   - Complex Catastrophic Care
   - High-Risk Multiple Diseases
   - Moderate-Risk
   - Low-Risk
   - Well Members

<< < < Supported by Clinical Intelligence Rules >> >>
Identifying, engaging and motivating members to be their healthiest with nurse outreach that supports real behavior change.

**Complex**
- High-risk pregnancy, admission for diabetes w/ medication non-adherence, trauma, stroke, profound behavioral health issues.
- >Call every 1-2 weeks or as needed<

**High Acuity**
- CHD w/ recent heart attack, persistent w/ medication gap, recent ER visits for diabetes or CHD.
- >Calls every 3-4 months<

**Moderate Acuity**
- Chronic condition w/ med non-adherence or w/ missing tests, asthma w/ no follow-up visit., multiple gaps in care.
- >Multi-channel support<

**Low Acuity**
- Multiple chronic conditions, significant med non-adherence, multiple gaps in care.
- >Calls every 1-2 months<

**Risk Reduction**
- No diagnosed chronic condition but with preventive service gaps.

**Preventive Opportunities**
- No specific diagnosis, but risk factors for developing chronic conditions.
Blue Care Connection®
Medical Management Process

Follows case through entire IP stay, potential for CM/DM referral

If necessary
Special Beginnings® Maternity Program

Neonatal intensive care Management

Care coordination and early invention
Pre Admit and/or post discharge outreach according to readmission risk

Case Management
Discharge planning and post discharge outreach by CM nurse

Condition Management

Low Acuity
• Mailers

High/Med. Acuity
• Telephonic

Focus on:
Diabetes
Asthma
Cardiac Clusters
CHF
COPD

Wellness Coordinator
Smoking cessation, weight mgmt. and metabolic syndrome based on members’ Readiness to Change

Pre Authorization
Claims Data/ Predictive Model
FSU
Self Referrals/Condition Support program
24/7 Nurseline

Utilization Management

FSU 24/7 Nurseline
Special Beginnings® Maternity Program

Follows case through entire IP stay, potential for CM/DM referral

If necessary
Special Beginnings® Maternity Program

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Focus on:
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Asthma
Cardiac Clusters
CHF
COPD

Wellness Coordinator
Smoking cessation, weight mgmt. and metabolic syndrome based on members’ Readiness to Change
Our Member Engagement Model

- Consent Secured;
- Assessment Conducted
- Problems Identified

Member Identified

Interventions implemented

GOALS MET

Care plan reassessed

Care Management criteria triggered

Personalized Care Plan Developed
Member Outreach

Identify Members

Verify Program Eligibility

Outreach to Member

Transfer Interested Members to Clinician

Non-clinical staff can educate members about our Medical Management programs.

Clinical staff are focused on members interested in one of our Medical Management programs.
Gap Closure/Physician Collaboration Model of Care

- Emphasizes opportunities for improvement in gaps in care for the core chronic conditions

- Engaged members receive condition specific education; access to resources and a customized plan of care.

- Outreach to network physicians for members who we are unable to reach by telephone or email

**Targeted core conditions:**

- Diabetes
- Asthma
- Congestive Heart Failure (CHF)
- Cardiovascular Condition Clusters
- Chronic Pulmonary Obstructive Disease (COPD)
We focus on the most significant chronic conditions.

Our value proposition is based on the chronic conditions that represent 30% of claims spend*.

Identifying and closing the gaps in care that matter delivers the most effective clinical outcomes.

Members with a chronic condition and no open targeted gaps are 55% less likely to have a hospital admission/ER visit.

**Diabetes**
- HbA1C in the past 12 months
- Physician office visit in 6 months
- LDL level in the past 12 months
- Microalbuminuria in past 12 months
- ACE/ARB medication in past 6 months for diabetics with hypertension

**Cardiovascular Condition Clusters**
- LDL level in the past 12 months

**Congestive Heart Failure (CHF)**
- Physician office visit in 6 months

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

**Asthma**
- On Controller Medication

* * Source: Health Care Service Corporation (HCSC) 2014 claims incurred.
ALL GAPS MATTER — Just some of the hundreds of gaps

**Preventive Gaps**
- Lack of immunizations, mammograms, cervical screenings, colonoscopies

**Lifestyle Gaps**
- Physical inactivity / poor nutrition / BMI>=25
- Tobacco use
- Abnormal cholesterol

**Condition-Specific Gaps**
- No emergency action plan in place for asthma, or condition-specific screenings done
- Member not following physician's treatment plan

**Psychosocial Gaps**
- Positive depression screen
- Inadequate financial, family or other resources
- Cultural or religious barriers

**Knowledge Gaps**
- Member does not understand need to track blood pressure readings or how to read
- Member does not know how to use peak flow meter

**Medication Compliance**
- No beta blocker use with Coronary Artery Disease diagnosis
- Asthmatic not on controller meds
- Diabetic not taking diabetic meds
Client Example – Annual Wellness Exam Incentive

To increase annual wellness exam compliance, this client increased participation by offering an incentive in the form of a premium reduction.

≈30,000 Eligible Members

21,900 (73%) Members took their annual wellness exam

15,330 (70%) of these Members did not have an annual exam 1 year prior

• 13.6% of Members were diagnosed with a new condition following the exam.
Please Review with Your Doctor
This plan may help you and your doctor have a conversation about steps you can take to be healthier and provide you with warning signs of when to seek help.

I will discuss when to call my doctor with these problems:

1. I have changes in my feet (redness or sores).
2. I feel burning when I go to the bathroom (urine).
3. I feel thirsty or need to go to the bathroom often.
4. I need to take a new over the counter medication.
5. If my blood sugar is above ______ or below ______ my target range.

Discuss with my doctor when to call 911, go to the Emergency Department or Urgent Care:

Notes from my Doctor:

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Smart phone Users: iPhones and Androids

- Diabetes Logbook
- Glucose buddy
- Calm
- Diabetes Pal
- My Fitness pal
- Centered (iPhone only)
- My Net Diary Diabetes
- ICE Standard with Smart 911

Diabetes Online Videos:

- Diabetes Basics
- Eating out
- Type 2 Diabetes: Medications
- Diabetes Type 2 EMMI Video
- How to check your sugars EMMI
- How to pick Non-starchy Fruits and Vegetables
- How to give Insulin shot
**Member Action Plan**

**HYPOGLYCEMIA (LOW BLOOD SUGAR)** - If I recognize signs/symptoms of hypoglycemia:

- Hungry
- Light-headed or confused
- Sweaty
- Nervous and shaky
- Sleepy
- Heart palpitations

I will: Check my blood sugar.

- Eat a snack containing fast-acting carbohydrates (approximately 15 g of carb). E.g. ½ cup or 4 ounces of fruit juice, ½ cup or 4 ounces of regular (not diet) soft drink, 8 ounces or 1 cup of milk, 3 to 4 glucose tablets, 5 or 6 pieces of hard candy, 1 tablespoon of sugar or honey.
- Glucagon kit or pen may be recommended by your doctor.
- Re-check my blood sugar in 15 minutes; if less than , eat an additional serving.
- Repeat these steps until My blood glucose is at least ___ mg/dl.

And I will consider the cause:

- Not eating anything in several hours
- Medications
- Excessive alcohol consumption
- Some critical illness
- Taking too much insulin

Carry candy or glucose tablet at all times.

**HYPERGLYCEMIA (HIGH BLOOD SUGAR)** - If I recognize signs/symptoms of hyperglycemia:

- Fatigue
- Blurred vision
- Headache
- Increased thirst
- Frequent urination

I will: Check my blood sugar.

- Drink plenty of non-caloric fluids (water, sugar free drinks)
- Adjust my meal plan and activity level
- I will call my primary care provider if my blood sugar is more than ___ (above 200 or 240 mg/dl) ___ times in a row within ___ hours

And I will consider the cause:

- Medication: Forgetting to take medication, Not using enough insulin or oral diabetes medication, or on steroids.
- Diet: Not following a diabetic eating plan.
- Exercise: Being inactive.
- Situational: Having an illness or infection, surgery, or injury.
- Stress: Such as family conflict or workplace challenges.
What is the most clinically and financially effective way to manage an illness?

To prevent it!
Success Stories
My Story
Community Health Strategy
Traditional Community Investments
In order to create a meaningful public health impact in Texas that aligns with available dollars and financial outcomes, BCBSTX recognized the need to address issues of diabetic chronic kidney disease and tobacco-related illness through targeted community investments, media campaigns and thought leadership.
Evidence Based Framework

1. Identify an actionable community health problem
2. Identify the business need
3. Build focused approach to improve health outcomes within targeted communities
4. Create actuarially sound metrics

LASTING AND MEASURABLE IMPACT IN PUBLIC HEALTH THAT ALIGNS WITH OUR BUSINESS INTERESTS
Population Prevalence

Map 20. Age-Adjusted Prevalence of **Diabetes** in Texas by Public Health Region, 2012


Source: Texas BRFSS Maps, https://www.dshs.state.tx.us/chs/datalist.shtm
Clinical and Business Case

**Diabetic Nephropathy**

- **11%** of Texans are diabetic, **8%** are pre-diabetic.
- **106.9%** growth in diabetes with chronic complications in the last year.
- **>8.5B** in diabetes claims, **$4B** in kidney disease.
- Latinos are most likely to present with CKD and most likely to die from diabetic complications.

**COPD**

- **>5B** in 2015 claims for COPD and Asthma.
- **5.5%** of Texans have COPD.
- % of COPD patients has doubled in the last year.
- More common among >65yrs with incomes less than $25K.
- **11%** of COPD patients in Texas are smokers.

Source: Texas BRFSS Maps, https://www.dshs.state.tx.us/chs/datalist.shtm
Your most valuable possession?

Your Health