

## **HOW DISEASE MANAGEMENT WORKS WITH YOUR PATIENTS**

As part of Community Health Plan's ongoing mission, the disease management staff outreaches those members with Asthma, Diabetes or Hypertension by telephone to perform health risk assessments (HRAs), assisting with chronic disease management and with prevention of potential medical complications. This practice enables the Disease Managers to identify those individuals at highest risk for complications such as acute exacerbation of their asthma or a hospital admission for diabetes that is out of control.

The Disease Management Program includes an initial telephone outreach call to the members who have been identified as high risk, or referred to the Disease Management Program by their practitioner or other source. The program is explained to them, as well as the role of the nurse, and the voluntary nature of the program. If the member consents to participation in the program, then the interview continues and the nurse completes the Health Risk Assessment, or "HRA," which is a valuable tool in determining future risk related to the patient's health.

During the interview process, the Disease Manager determines the level of understanding the patient has of his/her disease process and whether or not any additional education is required. The patient may need formal education, such as that provided by a Certified Diabetes Educator, or another form of formal education. Or the patient may simply need a longer appointment time with the doctor or other provider to enable them to better understand how to manage their diabetes, asthma or hypertension. In some cases, the patient may simply need some written resources, such as pamphlets, or access to internet resources or websites.

Other resources that may be provided to the members/patients may include identification of alternative pharmacy resources to remedy formulary or co-pay resources; this may occur when a patient may not be adhering to a prescribed plan of care due to financial constraints limiting the ability to pick up a prescription, so they are not taking the medication as prescribed, causing them to have symptoms reoccur. This is one of many ways that the Disease Manager acts as an advocate for your patients.

Another way the Disease Manager can assist your patients is to identify barriers to care. For instance, if the patient has trouble finding transportation to an appointment, the Disease Manager may be able to find an alternative resource/means of transportation to allow the patient to get to the appointment and remain adherent to your ongoing plan of care for him/her.

In summary, the objectives for the Disease Management Program include the following:

- Improve the ability of members to self-manage their disease through the provision of relevant information, tools, and training.
- Increase members' knowledge of their condition and treatment options and delay further progression and related complications.
- Improve health outcomes and compliance with disease specific evidence based guidelines.
- Enhance quality of life by encouraging and empowering members with self-management.
- Optimize healthcare utilization.

These are only some of the ways that the Disease Management Team assists your patients with managing their asthma and diabetes. Please contact the Disease Management Department at (866) 440-2479 if you have any questions regarding these programs. We will be happy to answer any questions you may have about them.