Condition (Disease) Management

Helping people manage chronic health issues.

What resources and tools are available to members?

- Access to a designated care manager
- 24/7 Nurseline is an optional program tool for questions and guidance concerning immediate medical issues, helping to deter unnecessary ER visits
- Another optional tool for members is the Due Date Plus mobile app, which supports women throughout their pregnancy to achieve healthy birth outcomes

What is Condition Management? Our Condition Management program supports members with chronic conditions and diseases, empowering them to better manage their health. It also helps members make lasting self-care improvements that enhance quality of life and reduce medical costs.

Which chronic conditions and diseases does the program cover?

Conduent offers URAC accredited Condition Management programs for the following conditions and diseases:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Heart Disease (CHD)
- Diabetes
- Degenerative Joint Disorder (DJD)
- Gastroesophageal Reflux Disease (GERD)
- Hyperlipidemia
- Hypertension
- Pregnancy

Other programs may be developed for customers based on disease prevalence of your population, i.e., depression.

How are members identified for Condition Management?

Using our integrated care management system, we identify members for condition management through:

- Predictive modeling that identifies high-risk, non-adherent and/or high utilizing members with specific conditions who would benefit from the program
- A utilization review process that identifies appropriate members
- Health Risk Assessments
- Self or family referral in response to engagement materials and media
- Provider referrals

How is personal and health information protected?

All Condition Management activities comply with HIPAA policies and procedures to protect the confidentiality of sensitive member and client data.

What happens once a member has been referred to Condition Management?

Once a member has been identified, we send an invitation describing the program's features and benefits, and how to enroll.

We contact the member to explain the program benefits and answer any questions. The care manager then assesses the member's strengths and concerns to determine needs, establish health and lifestyle goals, and develop a person-centered care plan.

What are the care manager's responsibilities?

The care manager uses evidence-based care guidelines throughout the Condition Management process. The care manager's responsibilities include:

- Assessing health status, health literacy and barriers to improvement
- Developing SMART (Specific, Measurable, Attainable, Realistic, Timed) goals with the member to maintain or improve health status and prevent future complications
- Establishing an engagement strategy with the member that may include text messages, telephone or email contacts and in-person coaching groups
- Educating and coaching the member to adopt healthy behaviors, and providing feedback that promotes quality outcomes
- Empowering the member to engage in a productive relationship with their providers
- Monitoring the member's condition and progress in reaching their health goals, and appropriately adjusting the care plan
- Notifying and coordinating care with the member's providers
- Providing preventive screening reminders, and monitoring medication and treatment plan engagement using evidence-based care guidelines
- Assisting members in efficient utilization of plan benefits and access to all appropriate health and supportive resources
- Helping members prepare for appointments, tests or surgeries
- Making appropriate referrals to community programs, providers and other needed support services

What are the qualifications of care managers?

Our care management team consists of licensed clinicians and engagement specialists, and may also include pharmacy technicians and provider specialists. Many of our licensed clinicians hold advanced certifications in specialty areas. Additionally, all staff is trained to use motivational interviewing techniques.

What resources and tools does the care manager use to assist the member?

Our Integrated Care Management System provides access to medical and claims data and adherence information. It also links to member benefits and plan requirements.

We also provide a Web-based library of more than 3,000 health- and condition-related topics that are illustrated, easy to understand and available in multiple languages.

We use only nationally recognized, evidence-based guidelines including, but not limited to:

- Care guidelines from MCG Health, LLC
- Institute for Clinical Systems Improvement
- American Diabetes Association
- American Heart Association
- National Cancer Institute
- National Institutes of Health Guidelines

When is a member discharged from the program?

A member is discharged from the program when:

- He or she can self-manage their condition effectively
- Personal health goals are met
- The member decides to leave the program
- The member no longer meets health plan eligibility criteria

Learn more about us at www.conduent.com/caremanagement.

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