disease management provides education for optimal health

Our disease management programs are designed to help members manage their chronic conditions, improve their quality of life, and minimize the cost of health care. Our approach goes far beyond knowledge-based education, using best-practice treatment guidelines that allow members to proactively take an active role in managing their conditions. Enrolled members receive interactive online support, as well as educational mailings and are invited to call as needed. Those at higher risk may also receive telephone outreach from a nurse, and certain members may be provided with home biometric monitoring.

Members with these conditions will benefit

Asthma
Members with moderate to severe persistent asthma are provided age-appropriate education about medications and modifications of environmental exposures that trigger asthma. This program is designed to help members (or the parents of pediatric members) learn to effectively manage their symptoms.

Diabetes
Members with diabetes are provided education about blood glucose control, medication compliance, routine screenings, and lifestyle modifications to prevent or slow disease progression and avoid complications. Certain high-risk members may also be eligible for in-home monitoring of blood glucose levels and symptoms.

Chronic obstructive pulmonary disease (COPD)
Members with chronic bronchitis, emphysema, or a combination of those conditions are provided with education designed to prevent or lessen the severity of disease progression. Education includes proper medication use, energy conservation, breathing and oxygen use, and exercise techniques. Certain high-risk members may also be eligible for in-home symptom monitoring.

Heart failure
Members with heart failure are provided education about signs and symptoms and how to monitor and manage them. Medication usage is discussed, along with the importance of diet, follow-up appointments, and lifestyle modifications. Certain high-risk members may also be eligible for home monitoring of weight and symptoms.

Coronary artery disease (CAD)
Members who have had a heart attack, bypass surgery, or angioplasty are provided with education to ensure proper medication use, control high blood pressure, stop smoking, lower cholesterol, improve nutrition, increase exercise, deal with stress, and maintain other preventive health measures. Certain high-risk members may also be eligible for additional home monitoring of blood pressure and symptoms.

Through personalized coaching and support, our disease management programs help members understand and better manage their chronic condition.

How these programs work

Members are identified for these programs through admission authorizations, medical claims, lab tests, and pharmacy data, as well as direct referrals from physicians. Members are automatically enrolled unless they choose to opt out. Self-referrals are accepted online and by telephone from eligible members.

The level of services is dependent on the degree of each member's condition and risk. At a minimum, members will receive a welcome packet, quarterly condition-specific newsletters, and online support. Members at a higher level of acuity may receive periodic calls from their dedicated nurse care manager, and certain members may also be eligible for home monitoring services.

Online Care Center

All members enrolled in disease management programs have access to the Online Care Center, a self-management portal that provides engaging, condition-specific educational content, as well as the ability to securely communicate with a nurse care manager. Electronic alerts and reminders are sent to reinforce the program.

Coordination with physicians

These programs are not a substitute for patient/physician communication. These programs enhance that relationship through sharing of certain information with physicians regarding member participation. Notifications may be made regarding enrollment and members who choose to opt out. For members on home monitoring, adverse changes in symptoms or biometric values trigger an immediate notification to the patient's nurse care manager, who may, if necessary, alert their physician.

Home biometric monitoring can provide additional security and facilitate timely intervention for selected members.

Program integration

These programs are delivered as part of our "whole person" approach that integrates NurseHelp 24/7,℠ case management programs, CareTips clinical messaging, and our Wellness Assessment. This integrated suite of programs shares a single technology platform, allowing increased visibility and cross-program coordination among clinicians, as well as a seamless experience for members.

Reporting

Employers may receive reports that include aggregate program activity, member engagement data, unique members reached, and outcomes metrics, including HEDIS scores and member satisfaction. See your Blue Shield account manager for more information on reporting eligibility and frequency, and to review a sample report.

For more information about our disease management programs, please contact your Blue Shield account manager or account representative. These programs are offered by Blue Shield of California and Blue Shield of California Life & Health Insurance Company.

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