Chronic Disease Navigation Programs

The Health Plan’s chronic disease navigation and health promotion programs are multidisciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes, coronary artery disease, chronic heart failure (CHF), and chronic obstructive pulmonary disease (COPD). The Health Plan’s pregnant members are also monitored with the intent to identify those at high-risk for premature delivery.

Chronic disease navigation programs support the practitioner-patient relationship and plan of care; emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies. The Health Plan programs continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health status. The essential elements of chronic disease navigation include understanding the course, clinical implications, and trajectory of specific diseases; identifying and targeting patients likely to benefit from intervention; focusing on prevention; and working toward resolution of resource-intense problems.

Program Content
Each navigation program includes condition monitoring that is ongoing and proactive. This allows the member, the practitioner, and the chronic disease navigator to assess how well the condition is being managed. Monitoring is done with regular clinical assessments with surveillance of pharmacological management, lifestyle management, and assessment of the member’s understanding of the condition itself as well as the related co-morbid conditions likely to affect overall health status.

Member adherence to the program’s treatment plan is an integral part of chronic disease navigation. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. High-risk members are called at periodic intervals. Detailed questions are asked about the member’s condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life. Education is targeted at areas of concern based on the findings from a clinical assessment and functional inventory. Ongoing monitoring by the chronic disease navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the chronic disease navigator is determined by the severity of symptoms. This may result in daily contact in times of high-risk or concern. When home care is needed in high-risk cases, the chronic disease navigator works with the practitioner and a home care agency to coordinate necessary care and services.

In all instances, chronic disease navigation and health promotion programs must consider other health conditions that directly affect the member’s overall health status. A multidisciplinary approach to chronic disease navigation enables the chronic disease navigator to develop a treatment plan that
includes condition monitoring of co-morbid conditions frequently associated with chronic medical conditions.

Because lifestyles issues are strongly linked with chronic disease and high-risk pregnancy, strategies to address current lifestyle and the need to modify behavior is addressed in every program. Whether members need interventions addressing issues such as smoking cessation or weight loss management, the chronic disease navigator is able to address readiness to change and to provide additional resources to affect needed change.

The Health Plan’s chronic disease navigation and health promotion program elements include:

- Identification of best practice, evidence-based standards of care
- Intervention strategies and targeted outcomes
- Identification of the member and assessment of health status
- Proactive intervention to include the application of appropriate therapies and systematic surveillance of appropriateness of medication, education and counseling about daily self-management, and symptom management
- Tracking of the member’s clinical and functional status over time
- Assessment of effectiveness of treatment and sharing of knowledge gained to achieve optimal member outcomes

Attention to all program elements and improvement in all of these areas will likely lead to improved outcomes for the many who are at risk or who suffer chronic diseases.

Please contact The Health Plan Chronic Disease Navigation Department at 1.800.624.6961, ext. 2302 or 6980, or enroll members online at healthplan.org.