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Medica Health Support℠ Condition Management Program for Individual and Family Plan Members

Provider FAQ

What is condition management?
Condition management provides a targeted, condition-specific focus that we believe will have greater impact with our members. Conditions to be managed are diabetes, hypertension, and asthma. These three conditions are among the most common and manageable chronic conditions encountered by our members.

How do we identify eligible members for the Condition Management Program?
The program identification process can utilize a variety of sources such as HRA's lab data, internal and external referrals or advanced algorithms which include medical and pharmacy claims to identify members based on their condition and level of severity. Then, we reach out and engage these members with tools and interventions that support their specific condition and situation.

Is the program mandatory for identified members?
No. The Condition Management Program is voluntary for eligible members.

How do we engage members?
A team of engagement coordinators or registered nurses reach out to eligible members by mail and phone to invite them to participate in the most appropriate type of intervention, based on their risk level and willingness to engage. The registered nurses will help educate the members about their chronic condition and will help members self-manage their condition.

Who supports the Condition Management Program?
A team of registered nurses support the program. They conduct an initial assessment and when combined with medical and pharmacy claims data serves as the foundation for a detailed action plan. Subsequent phone sessions allow the nurse to identify gaps in care, help the member identify and set goals, and create a plan together to achieve those goals. The nurse will encourage the member to keep scheduled appointments with their providers and share their progress of managing their condition. Frequency of phone sessions vary and is tailored to the member's condition(s), severity, gaps in care and the nurse's initial assessment.

How does the Condition Management Program differ from complex case management?
Our Condition Management Program targets members with a condition-specific diagnosis of diabetes, hypertension or asthma. The program identifies and engages members who are capable of self-managing their condition(s) and improving their outcomes when given the right level of education and support. Complex case management involves members who have multiple complex medical needs, diseases and co-morbidities requiring services to support them.

When does a participant complete the program?
Members typically complete the program when they reach their goals or demonstrate the ability to self-manage their condition. Program completion is often dependent on medication compliance, clinical stabilization, closed gaps in care and reduced acuity level due to the intervention.

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