# CARE COORDINATION CARE MANAGEMENT PROGRAM

## Program Description and Summary

The Care Coordination Program conducts identification and outreach to members in the home setting who may benefit from care and disease management services. The Care Coordination Nurse Care Manager (NCM) evaluates members for care and disease management programs and works collaboratively with the member, their caregivers, and health care providers to ensure the most appropriate plan of care. Incorporating motivational interviewing techniques the NCM assesses the members understanding of their current health status and potential health risks. The NCM proactively identifies and addresses gaps in care to prevent re-hospitalization. This program includes:

- Post Hospital outreach
- Coordination of care
- Member education
- Provider collaboration

## Program Goals

- Assure safe discharge plan in place post hospitalization
- Identify members in need of care and disease management services and refer eligible members to the appropriate programs
- Empower members to make informed health care decisions
- Assess and facilitate coordination of care
- Engage members in their health goals and promote member self-reliance.
- Inspire and motivate adherence to health and wellness measures
- Identify barriers to adherence with the treatment plan, including medication adherence
- Identify and educate members regarding potential complications/interactions/side effects related to multiple medication use
- Reduction / prevention of avoidable hospitalizations, readmissions and ER visits

## Program Components

**Post Hospitalization Discharge Follow-Up**

Unique to the program is our pro-active post-hospitalization outreach call. The NCM calls members within three business days—post discharge from in-patient facilities. Through this call the NCM assures the member has a safe and appropriate transition plan in place. Members are assessed and gaps in care are identified and addressed. Medication reconciliation and adherence are a major focus. This call may include member education coordination of care with families and providers, and referral to an HPHC Disease Management program.
**Clinical Transition:**
The Clinical Transition program enables prospective and active members to discuss specific issues or concerns regarding their specialized medical care with a nurse care manager prior to enrollment. The nurse care manager assists with the planning needed to ensure continuity of the prospective member’s care. In addition, the nurse care manager may assist active members with a safe and reasonable transition of care to new providers when they are impacted by physicians and/or providers disenrolling from the HPHC provider network. This Care Manager will also assist members in transiting care when they are impacted by changes in plan design (i.e. tiered and focused networks).

**Decision Assist:**
The Decision Assist program provides personalized, telephonic support services, where by the nurse care manager helps members make informed decisions about upcoming care, such as whether to proceed with a test or surgery or assists the member when changes in plan designs impact their care.

The nurse care manager uses specific clinical guidelines and online resource tools to help members:
- Understand their treatment options so they can participate more fully in decisions about their care.
- Learn about and weigh what’s important to them in making decisions.
- Identify questions to ask their physician.
- Access easy-to-understand clinical information and resources.
- Find relevant benefit and cost information.

**High Cost Claimant:**
These members identified as HCC have reached an established dollar threshold of total incurred expense for in-patient, out-patient and pharmacy claims. HCC members not being managed are identified on a weekly basis and assigned to a NCM for outreach to determine if they are at risk and in need of care management or coordination assistance. The NCM will also refer members to DM programs when appropriate.

**Prepared for Care Program:**
The PFC program offers select employer groups a dedicated Nurse Care Manager to provides the following dedicated services:
- Customized Clinical Transition support
- Decision Assist support
- Onsite care management presence at employer events
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**Revenue Management Out Reach Program:**
These members are identified as having chronic care gaps or barriers that prevent them from receiving care. Self-reported member data or claims data indicate that the member is not being treated for chronic diagnoses or that the diagnoses or treatment plans are not clear. The ANCM outreaches to members to provide care coordination, facilitate provider visits and clarify diagnoses and treatment plans. The ANCM will collaborate with providers to facilitate care and confirm diagnoses and treatment plans. The ANCM will also refer members to DM programs when appropriate.

**Member requests for CM:**
The Care Coordination NCM responds to member requests and referrals from various sources including but not limited to:

- Care Managers
- Clinical Transition Program
- Decision Assist Program
- Disease Management Programs
- Health Questionnaire
- High Cost Claimant Report
- Member Services
- Medical Social Workers
- Other HPHC departments
- Providers
- Self-Referral/Family Referral
- Vendors

Members are identified via internal customized algorithms which utilize medical, pharmacy, clinical and claims data available with the HPHC enterprise data warehouse. They are also identified through hospital discharge data. In addition data from external sources such as employers, and third party pharmacy vendors are incorporated when available.

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