Care Management

Overview

Care management is a collaborative process which plans, implements, coordinates, monitors and evaluates options and services to promote the highest quality and most cost-effective outcomes for Harvard Pilgrim members utilizing multichannel digital capabilities and engagement techniques. Harvard Pilgrim nurse care managers apply Motivational Interviewing, a directive member-centered interviewing style engagement technique, for eliciting behavior change by helping members explore and resolve ambivalence. Additionally, members are offered a Care Management app, free of charge.

Contact Information

For information about care management programs, contact your Harvard Pilgrim care manager at 888-888-4742.

Program Candidates

Members are identified as potential candidates for care management programs through predictive modeling, disease-specific algorithms, hospital discharge review processes, high-cost claims analysis, as well as direct physician or member self-referral. When a member is identified as someone who might benefit from care management intervention, a care manager contacts the member and family to assess the situation and to collaborate with the member and the member's primary care physician as appropriate.

Special Programs and Services

Complex Care Program

The Complex Care Program uses computerized algorithms to identify members at risk for hospitalization within the upcoming 12 months. These algorithms use medical and pharmacy claims data such as diagnoses, patterns of care, places of service, in order to identify those at risk. Members can also be identified as program candidates through referrals from nurse care managers, physicians, and member self-referral.

At the program's core is nurse outreach and support. A nurse care manager works with the identified member to help address specific health needs through care planning, communication, and coordination. Together, the care manager and member develop a personal plan that will promote self-reliance and improved quality of life with an expectation of reducing the need for acute hospitalization. Close interaction with a member's primary care physician and relevant specialists is also an important component of the care manager's role.

This program is available to all members enrolled in fully insured products and ASO accounts.

Chronic Care Program

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's annual health care costs.

Although common and costly, many chronic diseases are also preventable. Many are linked to lifestyle choices that are within a member's own hands to change. Proper nutrition, becoming more physically active and avoiding tobacco for example can help keep members from developing many of these diseases. Even if a member already has diabetes, heart disease, COPD, Asthma or another chronic condition, care management can help members better manage their illness, avoid complications and prolong life. Harvard Pilgrim's Chronic Care Program implements health strategies to reduce the incidence and burden of chronic diseases and related conditions.

Oncology Care Management Program

Proactive outreach is conducted to eligible members who have been identified by careful analysis of claims data. Members may also self-refer or be referred by their physicians. The nurse care manager collaborates with other providers and caregivers, helping members understand and navigate complex treatment plans. Through education and enhanced self-management tools, these specially trained nurses work with members to reduce inpatient and emergency room utilization, to reduce the incidence of avoidable treatment side effects, carefully monitor pain management, and when indicated, help members and families cope with end-of-life needs.

This program is available to all members enrolled in fully insured products. ASO accounts may purchase these services.

Chronic Kidney Disease Program

Members are identified as program candidates through claims data analysis and referrals from nurse care managers, dialysis vendors, and physicians. Nurse care managers collaborate with members and their caregivers to ensure compliance with the plan of care, using telephonic outreach, hospital follow-up, and referrals to social workers. Education is at the core of this program, focusing on dietary and fluid restrictions, medication adherence, energy conservation measures, self-care strategies, and lifestyle modifications. The nurse care managers also provide feedback to primary care physicians and nephrologists.

This program is available to all members enrolled in fully insured products. ASO accounts may purchase these services.

Care Coordination Program

Unique to this telephonic program are the proactive outreach follow-up phone calls to members within three days of discharge from acute care facilities. The goal of the call is to assess the member and any gaps in care. The NCM identifies and coordinates treatment plan issues related to discharge instructions, medication changes, follow up care, the return of the member to pre-hospitalization activity levels whenever possible and to prevent re-hospitalization. The NCM assures the member has a safe and appropriate discharge plan in place. Members are assessed and gaps in care are identified and addressed. This call may include member education, coordination of care with families and providers, and referral to an HPHC Care Management program.

Clinical Transitions Program

Harvard Pilgrim's Clinical Transitions program enables prospective and active members to receive decision support and discuss specific issues or concerns regarding their specialized medical care with a NCM and / or member service staff prior to enrollment. The NCM assists with the planning needed to ensure continuity of the prospective member's care. In addition, the NCM 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 transitioning care when they are impacted by changes in plan design. (i.e. tiered and focused networks)

Medical Social Work Services

Medical social work referrals may be triggered by events that could adversely impact the health and well-being of a member. Harvard Pilgrim medical social workers provide psychosocial assessments including addressing members psychosocial determinants of health. They provide information about available resources and participate in proactive and comprehensive care planning, including:

- Application to public benefit programs (e.g., Medicaid, food stamps, fuel assistance)
- Referral to available community services (e.g., adult day health care, social day care)
- Location of appropriate support or educational group
- Application and/or advocacy for vocational and/or educational services
- Access to transportation for medical care
- Planning for long-term home and residential care needs (e.g., assisted living, skilled nursing placement)
- Access to legal services
- Coordination of complex community services
- Collaborative discharge planning with the nurse care manager for members with complex needs

The Harvard Pilgrim Medical Social Workers are independent licensed practitioners who provide emotional support services to members identified in need of such services in the care management programs. The goals of the program are as follows:

- Meet the ongoing emotional needs of our populations
- Assist members toward positive health outcomes
- Better manage chronic and catastrophic diseases and life changes

Rare Disease Program

The Rare Disease Program is an integral component of the care management department and includes proactive member identification, coordination of care and member education. The care manager works collaboratively with members, their caregivers and their health care providers to ensure clinical quality and the most appropriate plan of care, reduce unnecessary utilization, and promote adherence to the plan of care through member/family education and support. The Rare Disease Program demonstrates an effective implementation that empowers members to manage their illness and improve the quality of their life, while reducing overall costs. The clinical conditions included in this program are Crohn's disease, lupus, Multiple Sclerosis, Parkinson's Disease, Rheumatoid Arthritis, Ulcerative Colitis, Amyotrophic Lateral Sclerosis, Chronic Inflammatory Demyelinating, Polyneuropathy, Cystic Fibrosis, Dermatomyositis, Gaucher disease, Hemophilia, Myasthenia Gravis, Polymyositis, Scleroderma and Sickle Cell Disease. This program is available to all members enrolled in fully insured products. ASO accounts may purchase these services.

Sending Member Referrals or Clinical Information to HPHC

FAX

Fax documents to **617-509-1159**

PHONE

Call Care and Disease Management at **866-750-2068**

EMAIL

Send emails to: **requests_for_care_management@harvardpilgrim.org** (underscore between each word)

If you are sending PHI this email should be encrypted per the standards of your organization. This email box is checked three times a day and a response will be received within one business day.