Care Management

Special Programs and Services

The Complex Care Program (Predictive Modeling)
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, and places of service, to identify those at risk. Members may also be referred into programs by nurse care managers and physicians, or themselves.

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
Our oncology care management program is designed to provide members with access to our oncology care managers, who work collaboratively with the members, their caregivers and their providers to develop the most appropriate plan of care, encourage adherence to it, and reduce unnecessary utilization. Members undergoing active chemotherapy and/or radiation treatment are eligible for this program. It offers a member-centered care plan that addresses both clinical and psychosocial issues, including support for family members. The program targets adults and children with malignant cancer diagnoses.

Chronic Kidney Disease Program
Members are identified as program candidates through claims data analysis and referrals from nurse care managers, dialysis vendors, physicians or self-referral. 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 and pharmacists. 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.

Fully insured members, based on criteria, may be eligible for care management by Monogram Health, a partner provider, for in-home nephrology care management and tele health services.
Healthy Pregnancy
The Healthy Pregnancy Program is a care management program for women with high-risk pregnancies. Members are triggered for identification via a proprietary algorithm, which considers maternal age, prenatal medications, ART and previous obstetrical claims history.

Obstetrical care management nurses provide education to ensure that the member can engage in optimal healthy behaviors during pregnancy. The nurse provides specific support and clinical collaboration between the care management team, social work, and the obstetrical care provider. The member's nurse is available throughout the pregnancy, providing ongoing follow-up, and may be contacted directly by the member if she or a family member has questions or needs additional assistance as the pregnancy progresses. After delivery, there is telephonic outreach for up to six weeks.

Transgender Care Management
Harvard Pilgrim's Transgender program is designed to assist members with questions and concerns through member/caregiver engagement, to increase their ability to manage their health, and to aid in prevention or delay secondary complications. The program is open to members of all ages. Each member is assigned to a Nurse Care Manager who works collaboratively with the member/caregiver to ensure the most appropriate plan of care based on goals identified by the member. The program empowers members through education while reducing overall costs.

Post Facility Discharge Program
Unique to this telephonic program are the proactive outreach follow-up phone calls to members within two business days of notification of discharge from acute care facilities. The goal of the call is to assess the member and identify and resolve any gaps in care. The nurse care manager identifies treatment plan issues related to discharge instructions, medication changes, and follow-up care, as well as returning the member to pre-hospitalization activity levels whenever possible and coordinates the necessary care to prevent re-hospitalization. The nurse care manager ensures that the member has a safe and appropriate discharge plan in place. This call may include member education, coordination of care with families and providers, and referral to a Harvard Pilgrim Care Management Program.

Clinical Transitions Program
Harvard Pilgrim's Clinical Transitions program provides prospective and active members with decision support in which they discuss specific issues or concerns regarding their specialized medical care with a nurse care manager and/or member service staff 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 when circumstances change such as a change in their product or plan design or if one of their providers retires or is no longer available in the Harvard Pilgrim network.

Prepared for Care Program for Employer Groups
The Prepared for Care (PFC) program offers select employer accounts a designated nurse care manager to work with their employees and dependents. Upon discharge from an acute care, rehabilitation, or skilled nursing facility, and/or based on claim review, a nurse care manager contacts the member to assess and identify health care needs, coordinate services, and develop a customized plan. A dedicated nurse care manager also outreaches potentially at-risk members, based on HPHC reports and algorithms. Members may also self-refer to the program by contacting their dedicated nurse care manager.

High-risk pregnancy management is an integral component of Prepared for Care and includes proactive identification and outreach. Telephonic counseling is provided regarding the identified risks, and educational materials are mailed to the member, as appropriate.

An email address and phone line are provided to facilitate member communication with the dedicated NCM.
Medical Social Work/Community Health Work – SDOH, Health Equity Program
Medical social work consults 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 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 resources and 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 and other needs
- 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
- Addressing food, housing and job insecurity

The Harvard Pilgrim Medical Social Workers are Certified Community Health Workers 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 in this program include, but are not limited to, 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, Ehlers Danlos Syndrome and Sickle Cell Disease.

Pharmacy Program
The Clinical Pharmacy Program goal is to prevent inpatient admissions and reduce avoidable emergency room visits. The team works collaboratively with the internal CM/MSW team to assist members with medication concerns and barriers to care. This includes an evaluation of patient medication profiles, education of members and caregivers to improve awareness of their treatment plans, monitor treatment response and improve their understanding and compliance with the medication regimen.
The team contributes to:

- The development, execution and monitoring of cost saving and quality clinical initiatives such as medication adherence and Medicare Star ratings.
- The identification of populations at risk and the development of strategic initiatives to improve medication management, quality outcomes and value-based prescribing outcomes for patients, using population health analytics.
- The collaboration with and establish strong personalized relationships with patients, partners, providers, and care team.
- Serve as a resource and medication expert to the Care Management team regarding medication policies, policy changes, pharmacy formulary, formulary changes/updates, therapeutic alternatives, and remain up to date with current clinical guidelines.

Connecting members with their care team

We also facilitate high-touch, sustained, and supportive relationships between members and their care team through our free mobile care management app, which connects members with a team of Harvard Pilgrim nurses and health coaches who can help answer questions and support member health through two-way messaging. The member’s care team can help with things like managing health conditions, weight loss, managing medications, and making sure all health screenings are up to date. In addition to two-way messaging functionality, the app also delivers clinical programs to members’ smartphones or tablets in the form of a customized, interactive, daily health checklist.

PUBLICATION HISTORY

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<thead>
<tr>
<th>Date</th>
<th>Changes</th>
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<tbody>
<tr>
<td>01/15/12</td>
<td>updated program availability information in the Health AdvanceSM Predictive Modeling and Harvard Pilgrim HeartBeatsSM sections</td>
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<tr>
<td>08/15/12</td>
<td>reviewed; minor edits for clarity</td>
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<tr>
<td>12/15/12</td>
<td>changed name of cardiac care management program; updated and changed name of the rare disease program</td>
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<tr>
<td>09/01/13</td>
<td>added concurrent review information to The Inpatient Facility Care Management Program section</td>
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<tr>
<td>03/15/15</td>
<td>added info about motivational interviewing to overview; changed program names of Heartbeats to Cardiac and Health Advance to Complex Care; added medical social work support program information; made minor edits throughout the special programs and services section for clarification</td>
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<tr>
<td>07/01/19</td>
<td>rolled up Disease Specific programs into complex care; made minor edits throughout social worker program for clarification; removed the Inpatient Facility Management program</td>
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<td>11/01/19</td>
<td>removed RN 24/7 program; added Chronic Care program</td>
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<tr>
<td>08/03/20</td>
<td>removed care coordination program; updated health coach language; updated rare diseases; added post facility discharge program</td>
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<tr>
<td>10/01/21</td>
<td>added Pharmacy Program; updated social work language; updated PFC language</td>
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<td>11/09/22</td>
<td>Removed Health Coach, updated social work language, updated PFC language</td>
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