Coordination of Care
NHCAR Ins. 2701.09(g)(8)

The health carrier's system for ensuring the coordination of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services, behavioral health services and other community resources, and for ensuring appropriate discharge planning.

This information is provided as part of Harvard Pilgrim's 2017 Health Care Access Report as required by the State of New Hampshire's network adequacy requirements. For current Harvard Pilgrim policies, please refer to the most current Provider Manual, available on www.harvardpilgrim.org.

Harvard Pilgrim Health Care

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. Harvard Pilgrim nurse care managers utilize Motivational Interviewing, a directive member-centered interviewing style, for eliciting behavior change by helping members explore and resolve ambivalence.

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

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. The algorithms use medical and pharmacy claims data such as diagnoses, patterns of care, places of service, and apparent absences of expected services in order to identify those at risk.

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.

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. Certified renal 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.

The Inpatient Facility Care Management Program

On-site nurse care managers follow members admitted to high volume rehabilitation facilities and skilled nursing facilities to facilitate appropriate utilization and discharge planning activities. Nurse care managers are assigned to all rehabilitation and skilled nursing facilities. A team of nurse care managers is assigned to manage telephonic concurrent review and discharge planning for all acute facilities.

They manage the utilization of benefits and coordination of services for Commercial members. Telephonically, they conduct concurrent and facilitate discharge planning and post discharge coordination of care at all of these facilities. This model is also applied to all out-of-area/out-of-network admissions.

Nurse care managers work collaboratively with members and their caregivers to ensure compliance with the plan of

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care, and address the psychosocial needs of patients and families. The main goal is early identification and proactive intervention/care management of members with existing or new targeted diagnoses so that nurse care managers can determine risk and/or potential need for intervention through telephonic outreach.

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 calls is to identify and coordinate treatment plan issues related to discharge medication compliance, to return the member to pre-hospitalization activity levels whenever possible and to prevent re-hospitalization. Members may also be referred to one of the other programs.

Clinical Transitions Program

Harvard Pilgrim's Transition Team provides decision support for prospective members and an opportunity to discuss their individual concerns with Harvard Pilgrim nurse and member services staff. The team is available on-site at the work-place or by phone during open enrollment and throughout the year.

Prepared for Care℠ Program for Employer Groups

The Prepared for Care 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 review of high-cost claims, a care manager contacts the member to assess and identify the member's health care needs, coordinate services and develop a customized plan. Members may also self-refer to the program.

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 material is mailed to the member, as appropriate.

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 or result in more costly use of health care resources. Harvard Pilgrim medical social workers provide psychosocial assessment and information about available resources, and participate in proactive and comprehensive care planning, as appropriate, 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 and they are also able to accept referrals to extend emotional support services to members identified in need of such services in the care and disease 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

Cardiac Program

The cardiac care management program addresses the total health care needs of members diagnosed with coronary artery disease and heart failure through a system of interventions that improves members' health in the short term, and prevents, delays, or reduces the severity of long-term complications. Members are identified through claims data analysis and by referrals from nurse care managers, physicians, and member self-referral.

Quality of life through self-management skills increases adherence to standards of care, improves member satisfaction, improves provider satisfaction and, as a result, reduces total health care costs. This program enables Harvard Pilgrim to identify those at highest risk, allowing for early intervention.

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

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.

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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.

RN–24/7

RN–24/7 is a 24-hour, seven-day-a-week, toll-free nurse line. Registered nurses with an average of 15 years of experience help members with questions about medications, recently diagnosed conditions, upcoming doctor's visits, or other health-related topics. Harvard Pilgrim's partner for RN–24/7 is Optum, a leader in personal health management solutions.

- RN–24/7 includes access to the audio Health Information Library of 1,700 recorded topics (with nearly 600 available in Spanish) that allows a member to listen to recorded health and well-being messages.
- Bilingual nurses are available to address the needs of Spanish-speaking callers.
- A language line translation service supports callers in more than 140 languages.
- Access to *http://www.harvardpilgrim.org.*
- Access to *Live Nurse Chat*, an interactive website that connects you with a nurse for a personal online conversation.

This program is available for purchase by employer groups.

Health Coach Program (Lifestyle Management Program)

A dedicated team of certified health coaches provide personal guidance and support to members empowering them to make informed decisions about lifestyle management opportunities. Areas of focus include: healthy eating, activity and exercise, stress reduction and life balance, blood pressure control, weight and cholesterol management, and smoking cessation. The health coach collaborates with members to identify barriers to wellness and/or healthy lifestyle, provides online resources and educational materials to promote self-reliance, guides the development of an individualized healthy lifestyle roadmap, and provides one to one telephonic support. The program assists employers with controlling their health care costs by actively engaging their employees and families in promoting their personal wellbeing.

This program is available to all members 18 years of age and older who are enrolled in fully insured products or ASO accounts.

Members are identified through Health Risk Assessment, on-site employer health fairs, *HPHConnect*, and referrals from nurse care managers, providers, and self-referrals.

High Risk Chronic Obstructive Pulmonary Disease Program

Members are identified as program candidates through analysis of claims data, Health Risk Questionnaires, and referrals from nurse care managers, physicians, and member self referral. Harvard Pilgrim's High Risk Chronic Obstructive Pulmonary (COPD) Program is designed to support and educate members about ways to slow disease progression and minimize the effects on their quality of life. The nurse care manager engages and develops a personalized plan with members to attain their maximum potential by proactively managing their symptoms. The nurse care manager utilizes telephonic outreach and collaborates with physicians to educate members about self-management skills, energy conservation behaviors, early recognition of complications, and lifestyle modifications.

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

High Risk Asthma Program

Harvard Pilgrim's High Risk Asthma Program identifies members through monthly analysis of claims data, Health Risk Questionnaire, member self-referral and referrals from nurse care managers and physicians. The Asthma nurse care manager works collaboratively with members, caregivers, and physicians to ensure an individualized and appropriate plan of care. Through educational and on-line resources focusing on asthma triggers, medication usage, self-care management skills, and lifestyle modifications, the members are empowered to manage their condition and to prevent secondary complications.

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

High Risk Diabetes Program

The High Risk Diabetes Program is designed to help improve the member's quality of life through member engagement and education and to increase their ability to manage their condition and to prevent or delay secondary complications. Diabetes nurse care managers work one-to-one with members telephonically to assess and develop an educational plan of care. Education focuses on diabetes, medication usage, diet, and early identification of complications and lifestyle modifications.

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Members are identified through claims data analysis, Health Risk Questionnaire, member self referral and referrals from nurse care managers and physicians.

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

PUBLICATION HISTORY

01/15/12	updated program availability information in the Health Advance℠ Predictive Modeling and Harvard Pilgrim HeartBeats℠ sections
08/15/12	reviewed; minor edits for clarity
12/15/12	changed name of cardiac care management program; updated and changed name of the rare disease program
09/01/13	added concurrent review information to The Inpatient Facility Care Management Program section
03/15/15	added info about motivational interviewing to overview; changed program names of Hearbeats 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