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 self-insured 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 telehealth 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.

Social Determinants of Health — Community Health Services Program

Community Health Worker (CHW) consults may be prompted by events that could adversely impact the health and well-being of a member. Harvard Pilgrim CHWs are frontline public health workers who apply their unique understanding of the experience, language, and culture of the populations they serve to act as liaisons between health and social services and the community, helping to facilitate members' access to care and guiding them in navigating the health care system. CHWs may:

- Participate in the interdisciplinary care team in a variety of ways including: assessing health risk, providing input to the member's care plan, collaborating with care teams on key care management decisions, and assisting members in meeting goals related to social determinants of health (SDoH) and health related social needs. Provide support on complex cases with behavioral health and registered nurse case managers.
- Identify health-related social needs gaps that create barriers to the member's care and advocate with members to overcome these barriers.
- Conduct in-person home and community visits to identify and address member needs.
- Assist member in accessing care, including navigating state and federal benefits, accessing community-based resources with referrals and warm handoffs, and coordinating and supporting members in transitions for long-term care.
- Provide culturally appropriate health education, information and outreach in a variety of local settings (such as schools, clinics, shelters, community centers, etc.), with the goal of increasing health knowledge and self-sufficiency.
- Use recovery strategies such as motivational interviewing, empathic listening, harm reduction, positive behavioral support techniques, limit setting, and strength-based approaches to support members in attaining goals.

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 multidisciplinary care management teams 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.

Behavioral Health Clinical Care Management

Care Management programs
Harvard Pilgrim Health Care behavioral health care managers work with members and their providers to support their behavioral health (mental health & substance use) needs. They help members overcome barriers, connect them with resources and services, locate participating providers, create an aftercare plan, explain benefits and conditions and work with members to find solutions to any difficulties within the treatment plan. Behavioral health care management is available to any member who needs a little extra help or information managing their condition. We offer the following behavioral health care management programs:

Supportive Care
The Supportive Care program provides members and/or caregivers with education, support and guidance to lead healthy lifestyles. It also offers integrated behavioral health care management services for members with co-existing medical and behavioral health conditions. The program has a holistic approach to address any behavioral health issues that may be impacting physical health.

Complex Care
The Complex Care program helps members with complex behavioral health conditions regain optimal health and improved functioning in their preferred natural setting. A comprehensive assessment identifies immediate needs and guides the development and implementation of a care plan with goals prioritized by the member or their guardian to help the member meet their goals and self-manage their conditions.

Peer Support
Our Peer Support program provides support to members who are taking the first steps in recovery from a behavioral health condition or substance use. A Peer Recovery Specialist works with members who have recently entered or completed acute treatment or have needed medical care for a behavioral health and/or substance use-related illness to create a personalized recovery plan and provide information on treatment programs and community supports.

Transitions of Care
The Transitions of Care program is offered as a resource to members who have been recently admitted to / discharged from an acute level of care. Behavioral health care managers work to ensure follow-up needs are met and identify any risks for re-admission to help provide a smooth transition back to the community.

Emergency Department (ED) Re-Admission Diversion
The ED Re-Admission Diversion program assigns a behavioral health care manager to work with members who have made recent or repeated visits to the ED with behavioral health symptoms. The behavioral health care manager will provide support, offer appropriate services and assist with crisis planning to help the member better address situations that do not require a visit to the ED.

Referral to BH Care Management Programs

If a Harvard Pilgrim provider or BH clinician identifies a member with barriers to care or has determined that a member may benefit from a BH care management program, they may refer the member to our BH care management program for additional follow up and assistance. by calling the Provider Service Center at 800-708-4414.

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 care managers 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

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 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
07/01/19	rolled up Disease Specific programs into complex care; made minor edits throughout social worker program for clarification; removed the Inpatient Facility Management program
11/01/19	removed RN 24/7 program; added Chronic Care program
08/03/20	removed care coordination program; updated health coach language; updated rare diseases; added post facility discharge program
10/01/21	added Pharmacy Program; updated social work language; updated PFC language; updated health coach language
11/09/22	Removed Health Coach, updated social work language, updated PFC language
01/01/23	reviewed; administrative edits
09/01/23	updated for behavioral health insourcing effective on 11/01/23
09/12/23	additional updates for behavioral health insourcing effective on 11/01/23
11/17/23	removed reference to health coaches
03/01/24	updates to Behavioral Health Clinical Care Management