

# Case Management

**ADVISOR**™

*Covering Case Management Across The Entire Care Continuum*



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## Personal contact helps identify hard-to-find members for health plan

*Program coordinates care for the chronically ill*

**D**ania Anderson, LCSW, is something like a detective. As an outreach coordinator for Health Integrated, a targeted population health management company, Anderson visits doctors' offices, hospitals, clinics, group homes, soup kitchens, and other community agencies in her quest to locate health plan Medicaid members receiving Supplemental Security Income (SSI) benefits who could benefit from Health Integrated's care coordination programs.

The members also can benefit from Health Integrated's Synergy Targeted Population Health Management program, a health improvement program for the chronically ill that addresses medical and psychosocial challenges, Anderson says.

"These members are a challenging group to reach. They are a population frequently on the move. Some are homeless. Many of them do not have a regular place to live but do have a cell phone, and if we find them, our Synergy care coaches can keep in touch with them that way," says Anderson, who serves a managed care plan client in New York City.

Health Integrated's Synergy program provides health coaching, education, and support for chronically ill individuals through contracts with health plans.

Outreach coordinators, such as Anderson, work locally to identify community-based programs, develop relationships with physician practices, and help engage members in the Synergy program. They collaborate with Synergy care coaches.

The outreach coordinators work to develop a relationship with the key care providers and work together to see that members get the care they need, Anderson says.

For instance, the outreach coordinators notify homeless shelters when they are trying to reach a certain member.

"Sometimes that person will suddenly show up, and with the help of

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the shelter staff, we'll be able to make contact," she says.

Connectivity between all of the people and organizations involved in a member's care is the key to the success of the Synergy program, says **Mike Miniati**, vice president of marketing for Health Integrated.

"We act as a hub to connect people to all the different places that offer them help," he says.

This may be the physician, the member's health plan, community-based organizations, or the members themselves.

"Members may be receiving services from a lot of different places or may not be aware of the

resources available to them. We connect the dots," he says.

This part of the Synergy program, called Synergy Connect, has two main components that work together: care coordination and outreach coordination.

The care coordination component ensures that appropriate care is coordinated and delivered by members of the care community and establishes referral pathways to the various programs and resources available. Outreach coordination works primarily with health plans and in the local community on strategies to connect with members who are difficult to find. The goal is to collaborate with the care managers and physician practices to help overcome the members' barriers to care and encourage adherence to their treatment plan.

The outreach coordinators are a key to the success of the Synergy Connect program, Miniati says. **(For information on how the care coaches work with members, see related article on page 40.)**

"In supporting clinically complex individuals, especially among the Medicaid population, one of the biggest challenges is making contact to offer assistance. By working locally, the outreach coordinators can not only reach these individuals but also ensure that they get local assistance for social or personal issues while they receive telephonic support from a Synergy care coach," he says.

A case in point is Anderson's success in facilitating care coordination for seven members traced to a group home who were dealing with physical and mental disabilities.

Often, phone contact alone won't get the member engaged in the program, Anderson points out. For example, group homes may have only a common pay phone for the entire facility.

"In such cases, we will go to the location to work one on one with the people in need of help," she says.

Working with the health plan, Anderson took an in-depth look at the members in the group home and determined that they were high-risk, complicated cases.

"As a result, the health plan placed a nurse practitioner in the group home to ensure that the members get the care they need, and she refers any cases to me to be connected to a care coach," Anderson says.

The nurse practitioner has added medical information that helps the care coaches stay aware of the members' needs and conditions.

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### Editorial Questions

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"In addition, part of the outreach coordination process has been to create a system where the staff at the group home remind members when the care coach is scheduled to call so they can be near the telephone. This can make a big difference in continuity and success for the member," she says.

The health coaching supports the group home staff by motivating the members to remember to take their medication, wear the appropriate clothing, and engage in activities of daily living.

"Staff under too much stress might misjudge a situation, sending someone to the emergency room, for example, when that is not the best response in the circumstance. Our goal is to avoid unnecessary hospital stays with the high-risk cases," she says.

The outreach coordinators live in the area in which they work and are familiar with the services that are available.

"They have extensive knowledge of the community and can help identify and solve the social problems that members may face," Miniati says.

Working with the health plan, Anderson maintains a list of members and their primary care physicians. She meets with the physicians who provide care for the highest number of high-risk members and explains how the program benefits the member and the provider.

"We are hoping to make things a little easier for the providers. The care coach can help members prepare for their appointments and encourage them to follow their treatment plan. This kind of support reduces follow-up phone calls," she says.

Primary care physicians rarely have the time to deal with patients' psycho-social issues and welcome the assistance from the outreach coordinator and the Synergy program in general, Miniati says.

"Having the outreach coordinator meet face to face with the staff in the physician offices is part of what has proved to be a very successful rapport-building approach. We provide education to illustrate that we are there to support their plan of treatment and to assist their patients toward better care management," he says.

Once the outreach coordinators create a relationship with the physician office staff, they ask for help in updating the phone numbers and addresses they have for members and enlist their aid in contacting the members, Anderson adds.

Anderson gives providers stickers for the patients' charts to remind staff that she is trying

to reach a particular member. In addition, Health Integrated has created a prescription pad that the physicians can use to refer patients to the Synergy program. The pad has information about the program and a number that the members can call.

Anderson looks at the patient files to determine when the member she is trying to reach has his or her next appointment.

"One of the main issues with the Medicaid population is that they don't keep appointments. They have a tendency to walk in," she says.

Depending on her schedule, Anderson either goes to the clinic to meet patients herself or calls the office on the day of the visit and asks staff to give them material about the program. She leaves materials such as brochures and motivational cards for the staff to give to members and asks that it be placed in their charts.

Anderson calls members an hour or so after she estimates patients have gotten home from an appointment and tells them about the program.

When Anderson gets in touch with the members, she explains the Synergy program and how it works with their health benefits.

"We want them to know who we are and that we're calling from a program that is free through their health plan. I tell them how health coaching works. I explain that a care coach is someone who is there to listen to them and help them manage their health," she says.

When Anderson mentions that a care coach can help them deal with the stressors they encounter when they are trying to navigate the health care system, it often piques members' interest.

"They start telling me the ways they have been stressed out by the plan or their physician or their medication or the problems they have getting authorization for treatment. We let them know that we understand that stress is increased when you feel you aren't being heard and that's what a coach is for," she says.

The next step, she hopes, is to connect the member to his or her personal care coach through warm transfer or, if necessary, by scheduling an appointment.

"Sometimes I might be meeting them in the provider's office and don't have cell phone access. If that happens or if the member can't speak to a coach at the time we talk, I set them up with the next available appointment," she says.

Some members want to receive information only in the mail. In those cases, Anderson sends the information and calls them back to make sure

they received the material and find out if they are ready to work with a health coach.

“We stay in touch with the members and try to engage them whenever they are ready,” she says.

The relationship between the outreach coordinator and the physician offices is especially valuable when the Synergy care coach has been working with a member telephonically and has identified a particular need or challenge, Miniati says.

“The outreach coordinator is right there and can work face to face with the doctor’s office to solve the problem,” he says.

“Most of the time, it’s the little issues, such as that providers don’t understand the health plan’s protocol,” Anderson adds.

For instance, one member was feeling stressed because he hadn’t gotten authorization for physical therapy treatment because the specialist office didn’t realize that the primary care physician had to request the authorization.

Anderson stepped in and got the authorization number to clear the way for treatment.

The care coaches work closely with the Synergy outreach coordinators to meet the members’ needs, even when they aren’t directly involved with health care.

In one instance, a health coach was working with a Brooklyn woman who speaks French Creole and who needed to connect with people who speak her language.

She had financial constraints that prevented her from traveling around the city.

Anderson was able to connect her with a program that was within walking distance of her home and that had staff who spoke her French dialect.

“Any kind of stress can exacerbate a member’s chronic condition and make it difficult for him to adhere to the treatment plan. We try to relieve the stresses in their lives so they can concentrate on improving their health. Our goal is also to provide knowledge and information to empower the member to make changes,” she says.

Anderson can call on the company’s multi-lingual health coaches when she needs help communicating with a member who speaks little English.

“When a member speaks only Spanish, we send them information in Spanish and use Spanish-speaking coaches for the engagement process,” Anderson says. ■

## Collaborative effort helps chronically ill

*Program targets members with psycho-social issues*

An approach that incorporates its telephonic integrated health coaching services with health plan case management and other health management programs, community-based resources, and physician practices has paid off for Health Integrated.

The Tampa, FL-based targeted population health management company contracts with health plans to help manage the care of chronically ill members who also struggle with psychological issues and face social challenges.

“Left alone, these psychosocial challenges can undermine the best efforts of physicians, family members, and even patients in managing chronic diseases. We work with the 10% to 15% of a health plan’s chronically ill population that represents as much as 50% of the cost of care,” says **Mike Miniati**, vice president for marketing.

Health Integrated’s Synergy Targeted Population Health Management program provides health coaching, education, and support for chronically ill individuals through contracts with health plans. Care coaches, most of whom have a behavioral health background, work telephonically with members to help them manage their chronic illnesses and psychosocial barriers.

They collaborate with the company’s community-based outreach coordinators if the member needs transportation to the doctor’s office, help with housing problems, or other community resources.

Having outreach coordinators in the community helps Health Integrated’s care coaches connect with hard-to-reach members. **(For a look at how the outreach coordinator program works, see related article on page 37.)**

“We initiate outreach telephone calls and mailers to engage the members so the care coaches can work with them over the phone on preventive care. Then we work together as a team with the coaches and physician practices to find a solution to problems and to empower these members to work on improving their health,” says **Dania Anderson**, LCSW, Health Integrated outreach coordinator who works with members of a New York City-based Medicaid managed care plan.

The outreach coordinators and the health

coaches work closely with the health plan's case management and other care management programs as well, Miniati says.

"We share what we do with the health plan and they share what they do. We work together to get help for the members so they can be healthier and stay out of the hospital," he says.

The program includes Care Coordination Grand Rounds during which Health Integrated's staff and the health plan's clinical leadership review the challenging cases and brainstorm ways to ensure that appropriate care is being delivered smoothly.

"We work together on the challenging cases and figure out the best way to manage them," he says.

Health Integrated takes the health plan's claims and other data and uses its proprietary predictive modeling tools to identify the highest-risk members who are eligible for the program.

"We also work with health plans to identify groups that may not fit into a particular algorithm but still might be challenging for the health plan to manage," Miniati adds.

For instance, one client requested that Health Integrated work with its Supplemental Security Income (SSI) patients whether or not they met the predictive modeling criteria.

When members are identified for the program, they receive an automated voice message telling them they will receive a mailing about a new program offered by their health plan.

After the mailing has been delivered, they receive an outreach call from engagement specialists who are trained to engage the members and educate them about the program.

"We don't talk about specific conditions. We talk about how we can help them work with their health care providers to feel better. We invite every member to work with a Synergy clinician, but we also offer them the option of participating in other ways," he says.

For instance, some members choose to receive help in managing their care through an e-mail or an interactive voice response system, mailings, or a combination of both.

If people are not reached or don't agree to participate in the beginning, Health Integrated reaches out to them on a regular basis to remind them of the program and their option to work with a health coach to improve their quality of life.

"When people don't engage in the beginning, we don't give up on them. We regularly ensure they know that the program is open to them. The whole idea is to stay in touch with the members until the point in time when they want to actively

participate in the program and possibly engage with clinicians," he says.

When members agree to participate in the program, they are assigned a care coach who may be a licensed social worker, a psychiatric nurse, a licensed mental health counselor, a family therapist, or a registered nurse.

"We lean more toward the behavioral sciences because many members with exacerbated chronic illnesses also have psycho-social issues that have not been addressed. We identify and overcome the psycho-social barriers before we start working on the chronic issues," Miniati says.

The care coaches work with the members to establish long-term goals and start by working on short-term goals that will help them meet their long-term goals.

"We don't tie the goals directly to a condition, but look at long-range goals, like being able to go to a grandson's baseball game without getting tired out or feeling uncomfortable. A short-term goal might be something like walking a half block as a starting point," he says.

The care coaches also empower the members to better communicate with their physicians.

For instance, the member may not be following through with the treatment plan simply because he or she doesn't understand the doctor's instructions. The care coach works to increase understanding of the treatment plan and to frame questions for the member to address with the physician on the next visit.

Members typically work with the same clinicians for as long as they are in the program.

"By addressing the critical interplay between medical, psychological, and social health and by offering all targeted members with the opportunity to engage with a dedicated care coach, Health Integrated has established a program unlike any in the industry that delivers improved quality of life for members, better clinical outcomes, and lower health care costs," Miniati says. ■