# CareOregon's CareSupport Program

The CareSupport Program provides multidisciplinary, person-centered case management services to our at-risk members. Our staff works in teams comprised of Registered nurses, master's prepared Behavioral Health Specialists, Clinical Pharmacists and Medical Assistants (health navigators). Each team is aligned with specific clinics to provide better linkage in support of the primary provider's care plan.

## *The CareSupport model*

The CareSupport Program supports members who: (1) are at risk for or experiencing a functional health decline because of lack of appropriate supports or self management, (2) are using the health care system ineffectively or inappropriately, or (3) are experiencing a significant health-related transition in their life, such as hospital discharge to home with advanced disease. Overlaying these criteria is the expectation that we enroll members who have "modifiable" risk factors.

Using the Wagner Chronic Care Model as a framework, CareSupport staff attempt to optimize the productive interaction between the patient and provider, working closely with both the patient in becoming informed and activated and the medical team in being prepared and proactive in the medical home.

In many cases this involves working with members to improve their self management or with medical providers to find or coordinate medical services, social services or both as needed.

## *Proactive identification of at-risk members*

Providers are an important referral source to our program (see below). Providers often recognize patients who are moving toward poor outcomes that can be avoided with early intervention, who may be lacking critical supports, or who have self management/ behavioral barriers to managing their health. State and county case workers, as well as mental health and social services agencies provide additional referrals.

CareOregon also used other strategies to proactively identify at-risk members. A claims based predictive model, called the Adjusted Clinical Groups Predictive Model (ACG-PM) identifies the presence of constellations of health conditions (as reported on claims by ICD-9 codes) that indicate high medical risk. Setting the ACG software system to

identify members who receive a risk score indicating a 50 percent or greater chance of being in a high-cost group in the next year identifies 2 to 3 percent of the membership quarterly.

We also complete a Health Risk Assessment (HRA) on new members enrolling with our plan. These HRAs are conducted by telephone or are mailed to our members if telephone contact is not successful. The HRA results in a score that indicates health status and predicts complexity, or risk. Members with elevated HRA scores are automatically referred to the CareSupport program for further assessment.

Internal CareOregon Utilization Management, Pharmacy and Quality processes are another source of referral:

- Nurses within our Utilization Management Unit doing in hospital concurrent review rounds recognize the risks that members may face upon discharge from the hospital and can refer to CareSupport when a member faces barriers to a safe and effective discharge. The prior authorization process allows a nurse to alert a CareSupport case manager when a member is planning a high-risk procedure so that proactive discharge planning can occur.

- In our Pharmacy Department, members who meet the eligibility criteria for our Medication Therapy Management Program (MTMP) are also assessed for risk factors that should be addressed by CareSupport staff and are referred to CareSupport when indicated.

- Quality Improvement staff will identify indicators for CareSupport involvement when monitoring and resolving member complaints and while following up on adverse events.

Finally, we use several reports to more proactively identify members who may require assistance and support. One report identifies members who were in the Emergency Department within the past 48 hours and provides the admitting diagnosis or diagnoses. Another report identifies members who were discharged from a hospital or Skilled Nursing Facility within the past 48 hours and provides the admitting diagnosis or diagnoses. A third report identifies members who are currently hospital inpatients.

## *CareSupport Interventions*

Each CareSupport intervention is patient-specific. Our CareSupport program is not disease-specific as most enrolled members have multiple chronic conditions as well as multiple psychosocial challenges. We assess members globally and provide interventions that are most likely to improve their health status. .

A benefit of our highly integrated program is the opportunity for CareSupport staff to refer members enrolled in the CareSupport Program for additional support available from the Health Education program or the Pharmacy Unit. Many health education/health promotion opportunities are available to members on a case-by-case basis, for example, tobacco cessation counseling. Our Clinical Pharmacists provide ongoing pharmacotherapy counseling to our members, particularly those who have been newly diagnosed with a chronic condition and prescribed unfamiliar medications, or those who require a very complicated regimen of medications.

Each member is enrolled when modifiable risk factors are identified and is provided client-centered interventions for time period that is determined by the member's progress toward health status goals. The member's goals, as the goals of the case manager's goals and those of the provider are considered when designing interventions and assessing progress.

Evaluation of the CareSupport program has shown significant improvements both in health outcomes and cost, based on claims data, as well as functional status, as measured by a pre and post survey of enrollees using a validated functional status tool (Health Utilities Index – HUI).