Clinical Services FAQs

2021

Q1: Does a patient have to trigger for a Highmark Clinical Services program, or can a member be referred to Clinical Services by a provider?

A1: Any provider (PCP, Specialist, Facility, etc.) can refer any Highmark member from their practice if they feel an individual may need additional support for chronic conditions and complex medical needs including social determinants of health, behavioral health, and wellness needs.

Q2: Does Highmark still accept the fax referral form or is it all electronic now? (NaviNet)

A2: The NaviNet referral process is the preferred method for submitting a provider referral however Highmark still does accept the fax referral form.

Q3: What is the process once the referral is made? How many calls does the member receive? What if the member cannot be reached?

A3: Once the referral is made, it is sent over to the non-clinical team for review. After review, they will create a referral task and it is sent over to Case Management, this service is only available within our footprint (PA, DE, and WV).

- Highmark Complex Case Managers have 20 business days to complete 3 calls and 30 days to complete the member assessment. An Unable To Reach letter is sent after the 2nd outreach.
- After a referral is made, please allow 5 business days for Highmark case management to outreach
- Highmark complex case managers use all available means to reach members with incomplete contact information. This is usually the result of inactive or disconnected telephone numbers. The nonclinical support staff search all available internal systems as well as external sources such as phone directories to attempt to find an accurate phone number for the member. We also work with physicians for high-cost claimants to identify and find correct numbers.
- In addition, every effort is made to honor a member's request for a specific call back. If a member cannot be contacted telephonically, an "Unable to Reach" letter is sent. Included with the letter are materials that encourage the member to contact the 24/7 nurse line as needs change or if the member simply wishes to speak directly to a clinician. An additional call attempt is made as a follow up to the letter. Highmark complex case managers vary the times of phone attempts to increase the likelihood of reaching members and time zones, and other factors are also considered to increase the opportunity to engage members.
- If a member declines to enroll in a program, Highmark nurses will use motivational interviewing to help the member recognize discrepancies between current and desired state of health. If a member is adamant in the decision not to participate in the program, the complex case manager offers to send condition-related educational/informational material and encourages the member to call if any future need arises.

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- Members’ risk levels may change monthly based on a variety of factors, including diagnosis, utilization and claims. A nurse will contact a member each time they trigger for an outreach unless the member specifically requests to be included on a “do not contact” list.

- Not all members may feel comfortable discussing their personal health concerns telephonically, so Highmark has integrated the power of technology to provide these members with an opportunity to engage through a channel that is favorable to them. Specifically, the digital consumer care engagement platform, powered by Sharecare, provides members the ability to meaningfully engage and manage all their health in one place—at their fingertips, through their smartphones. Capitalizing on artificial intelligence and proprietary data algorithms, members are presented with personalized content and engagement opportunities that are tailored to their unique needs. Members who have been identified as unable to reach telephonically will receive targeted messaging that encourages them to contact a case manager or presents them with applicable digital health and lifestyle coaching opportunities.

Q4: If a provider makes a referral, is it guaranteed that a member will be outreached?
A4: Yes, if the member has the CM benefit.

Q5: Will there be an update as to the status of the referral or a place in NaviNet the provider can check the status?
A5: A provider can check the status of a referral and member’s engagement in program by accessing the “Inquiry of Member Involvement in Clinical Care & Wellness” tool in NaviNet. This tool can be accessed clicking the **Case Management Referral and Inquiry Link** under **Workflows for this Plan** to go to the **Clinical Care & Wellness** page then selecting the **Inquiry of Member Involvement in Clinical Care & Wellness.**

Q6: What is the feedback loop once the member is in a program back to the PCP? Will the provider receive periodic updates once the member is enrolled and engaged in a program?
A6: Outreach and feedback to providers for members enrolled in a program is on a case-by-case basis (complex case, high cost, additional information is needed, etc.). A nurse may reach out to the provider who referred the member to further discuss the referral or obtain additional information regarding the referral. If a provider would like to receive outreach from a Highmark case manager regarding their referral to further discuss the case, the provider can note that in the comments section of the referral.

Q7: Is there a dedicated phone number or individual that a provider can speak to regarding a CM/DM referral to Highmark?
A7: The provider can call into Member Services/Provider Services to speak with an individual to create a referral.

Q8: What is available with each referral?
A8: Highmark’s multidisciplinary clinical team telephonically outreaches to members who have been referred by a provider or identified with the greatest opportunity for impact. Highmark’s identification model and internal referral processes from UM help to identify the right member and the right intervention. The right member has risk factors, conditions, complications or other health factors that could lead to exacerbation of their health if left unmanaged. The right intervention assists the member in managing their health, resulting in tangible benefits, including prevention of hospital admission or readmission, an ER visit, a shift of a procedure or service to a lower-cost and higher-quality site of care, reduction in the member’s spend on pharmacy and referral to hospice.

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Complex Case Management: Highmark's complex case management program provides clinician outreach and engagement for complex and impactable members identified and prioritized using our proprietary, data-driven member identification model.

Outreach components include transition of care complex case management, population-based algorithmic criteria to capture emerging risk, high-cost claims, emergency room management and utilization management (UM) referrals.

Disease Management: Highmark's clinically focused, member-centric disease management program is fully integrated with case and utilization management and lifestyle programs. A multidisciplinary team helps members engage in the behavior change process to better manage their specific condition(s) and overall health. Disease management is delivered for the most prevalent and emerging health conditions, including asthma, coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, musculoskeletal pain, metabolic syndrome and behavioral health.

Specialty Case Management: Cases are identified for specialty intervention based on diagnosis and other variables embedded in the Member Listening System. These variables trigger the case to the appropriate clinical team for timely specialty intervention. Care services and health conditions appropriate to specialized interventions typically include transplant, oncology, pediatrics/neonates (high risk), high-risk maternity/maternity, behavioral health, hemophilia and wellness/lifestyle management.

General Information: Highmark's health management programs are exclusively opt-in, requiring members to actively engage and participate in the program versus passively enrolling in the program. Only with an opt-in approach can members commit to working with a clinician who is specially trained in motivational interviewing and works toward the development of mutually defined short- and long-term goals. This approach supports effective engagement in the behavior change strategies necessary to result in improved health outcomes and lasting change.

The Member Listening System: This is a precision-targeted identification and stratification technology, identifies members with high utilization, high spend and other traits that indicate an opportunity for clinical intervention. This innovative technology combines cutting-edge machine learning and clinical expertise that allows Highmark nurses to proactively identify members with rising risk before high-cost events occur and match members to the right intervention, at the right time, delivered the right way for them along the health care continuum. Members are always encouraged to contact the 24/7 nurseline for any immediate or ongoing clinical concerns and may enroll in a health management program at any time.

Once enrolled in a care management program, Highmark nurses also leverage a social determinants of health (SDOH) questionnaire. Leaders across Highmark Health collaborated to develop a Universal SDOH Assessment to identify member needs in seven different SDOH Domains that include: food security, housing stability, transportation, financial strain, health literacy, social connections and safety. The domains are assessed via 13 questions from validated tools that are designed to identify an individual's social needs. This allows Highmark nurses to understand and address the specific SDOH factor(s) that are barriers to the members' health. The results of this assessment guide the clinician's discussion with the member and may include the resource and referral tool, Highmark Community Support, to connect them with social services in their community. SDOH are assessed with every member interaction. Highmark nurses can also assist the member with obtaining a PCP if the member does not currently have one by sending a list of the providers that are in network.

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The term graduation is not used, as it implies that members have completed, once and for all, their health management. Members are encouraged to maintain whatever level of contact with the complex case manager they may wish to sustain the gains they have made. Virtually all chronic conditions exacerbate and remit in their symptoms, impacting the member's overall health status and ability to function successfully at work and at home. Members may complete their short- and long-term goals but may need to re-engage with the clinician should their symptoms recur, or they simply want additional support. The average duration of program participation for complex case management is 60-90 days.

Q9: Which program would we utilize (post ED follow-up calls) to prevent index stays for chronic conditions?

A9: Transition of Care/ Post-Discharge Outreach. Highmark's discharge planning process ensures that continuous, appropriate quality care is delivered to each member with input from the member's physician, facility staff and all relevant service providers.

The process ideally begins prior to a scheduled admission and continues throughout the concurrent management of services and involves:

- Primary caregiver(s) and support system
- Living arrangements
- Anticipation of discharge needs, including special equipment, availability of resources, obstacles to care and/or discharge
- The need for referral to case management

Q10: What are the triggers, scope and content of engagement for Transition of Care Calls?

A10: Not every inpatient admission will result in outreach from a case manager. Transition of care cases are analyzed through Highmark's proprietary rules and logic methodology to determine risk and level of opportunity to impact. Highmark continues to refine the models to identify members sooner and prioritize those with greatest need. Members may have had an admission with high cost, but many individuals receive health-related services on an outpatient basis and may not incur high costs.

The Transition of Care Program is designed to help the member successfully transition from one level of care to another, usually from a more intensive level of care to a less intensive level of care. The program is patterned after Dr. Eric Coleman's research from the University of Colorado, often described as the "Four Pillars." The goal is to improve care transitions by providing members with tools and support that promote knowledge and self-management of their condition as they move from hospital to home.

The program assesses members for gaps and/or barriers to care in the following areas: care coordination including follow-up visits with primary care physicians or specialists, support systems, medication knowledge and adherence, health and wellness and understanding of the condition(s).

The intent of the program is to support members' ability to navigate through the health care system and provide them with tools to assist in health care decision-making. An important goal during the transition phase is to help members access and engage with any other programs that will help them to better manage their condition and overall health.

Highmark's transition of care program has realized a savings of $875 PMPM over a 6-month time period and transition of care services are provided as necessary at no additional fee.

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Q11: Once a program is completed by the member, is there any additional follow-up? What about the timing of the follow-up when the member has chronic conditions and has a high-risk score?

A11: Members are encouraged to maintain whatever level of contact with the complex case manager they may wish to sustain the gains they have made. Virtually all chronic conditions exacerbate and remit in their symptoms, impacting the member's overall health status and ability to function successfully at work and at home. Members may complete their short- and long-term goals but may need to re-engage with the clinician should their symptoms recur, or they simply want additional support. The average duration of program participation is 60-90 days.

Q12: For providers that do not have pharmacists in their office, how can Highmark help the provider with pharmacy outreaches (addressing cost, quality and medication management opportunities) for their patients?

A12: If they have opted into HM Pharmacy, the clinical pharmacists may provide targeted outreach to members and physicians for issues regarding:

- Specialty drugs (e.g., chemotherapy and pulmonary hypertension)
- High number of prescription drugs
- Potential drug interactions
- Possible alternatives or formulary issues

Providers can also call benefit services if there are questions.

Q13: What is the COVID-19 referral used for?

A13: During these unprecedented times, Highmark understands that the providers may not have the ability to outreach to every member at risk for COVID-19. Highmark is committed to assisting providers in providing members, with chronic conditions and complex medical needs, additional support through Highmark's Clinical Care & Wellness programs (Case and Disease Management). The Provider Referral Process on NaviNet allows providers to quickly and easily recommend Highmark members to the Clinical Care and Wellness programs. Providers can consider referring members from their practice if they feel that an individual may be at risk of contracting COVID-19 and may benefit from a Highmark nurse proactively calling to provide guidance.

Q14: How can Highmark help us with high ED usage in our members?

A14: ER usage is utilized in our monthly identification and stratification process in the following ways:

- **Frequent ER queries** search for members who have had 2 or more ER visits within a 12-week period.
- Within our condition-specific case management programs, we address a number of gaps in care that **may include ER visits** related to chronic conditions or visits for certain diagnoses, such as chest pain, where an office visit was not noted within a specific number of days.
- Complex case managers use the Nurse Dashboard as a guide to identify potential gaps in care, **including frequent ER use**, etc., when working with a member, regardless of the type of program that may have triggered the initial contact.
- During outreach with a member, Complex Case Managers utilize a specific **assessment that focuses on ER visits**.
    - The clinician explores the reason for ER visits and assesses if the services could be managed in a more appropriate setting, such as an urgent care facility or a physician's office.

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Q15: How can providers better collaborate with Highmark's Case Management / Disease Management team (CM/DM) to enhance member outreach and services?

A15: Providers can better collaborate with CM/DM by being open to education about Highmark's CM / DM Programs and Services that are offered to members. Physician education materials will be sent to providers. Another way to openly communicate and collaborate with Highmark's CM Team is by being receptive and responsive to phone calls from the team.

Q16: Does Highmark provide case management services to members who have Highmark as their secondary payer (i.e., Medicare Prime)?

A16: No, Highmark does not provide case management services to members who have Highmark as a secondary payer.

Q17: If a referral is submitted for a member and they have a plan in which Case Management or other services are carved out, does Highmark notify the member if they do not have CM services under their Highmark plan?

A17: No, Highmark would not outreach to the member.

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