Capability Briefs

# Care Navigation

Collective Health

Capabilities

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Care Navigation is an interdisciplinary care management program offered by Collective Health. The team utilizes a holistic approach to identify and engage members with complex needs and ensure that they receive the appropriate care to manage their health conditions.

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# Care Navigation Overview

## Our Philosophy

We believe that effectively supporting members with complex needs is essential to enabling better outcomes for your people and enabling financial control for your organization. However, we also believe that traditional approaches to care management have not lived up to their potential.

Historically, the industry has observed the following challenges to traditional approaches:

1) Members are identified too late, or not at all
2) Cold outreach leads to engagement rates that are unacceptably low
3) Even when members do engage, the traditional RN skillset struggles to provide the holistic support that members need most

At Collective Health, we think about supporting members with complex needs differently. Here are some of the unique elements of our clinical programs:

- We are able to better identify members through more holistic data analytics (claims, engagement data, etc.) and proprietary risk modeling
- We leverage the trust members have in Collective Health in order to drive higher engagement
- We deploy an interdisciplinary care team who are better equipped to support members with the issues that are top-of-mind (e.g., pharmacy, care coordination, and psychosocial support)

We're excited by the results we're seeing from our model:

## Our Results

**We're successfully outreaching to 99% of complex members.**

The most common identification triggers are:

- Our high risk condition triggers,
- Submitted prior authorization requests, or
- Member-initiated conversations with our team Rising risk categories

**1/3 of complex members are engaged and working toward defined care goals with a member of our team.**

The most common identification triggers are:

- Cancer
- Metabolic Disorders, and
- Behavioral Health needs

**Care Navigation drove 2:1 ROI**

A cost analysis found pharmacist interventions drove health cost savings of $10.38 PEPM across the entire program. This resulted in ~$5 in total PEPM savings against the Care Navigation program fee.

## Our Approach

Our Care Navigation program is a "complex" care management program. We aim to identify high risk and rising risk members of the population (disease agnostic) early in their care journey and aid them in navigating their complex medical and psychosocial needs. In addition, any member that personal feels a need for care management is eligible to enroll.

The traditional care management models has struggled to engage members and produce measurable value for employers. Even when these programs do succeed in connecting with members, they often find cases long after the event or focus on completing lengthy assessments, not addressing the actual issues and barriers at hand. These shortcomings often support the "goals" of the program, but fail to deliver real support for members.

We leverage our role as an employer's plan administrator and our access to real-time claims and engagement data to quickly identify members in need of support. For some members, that means offering the assistance of a social worker to support their psychosocial needs and complex care navigation. For other members, that means engaging with our clinical team (pharmacists, nurses, physicians) to understand their condition, medication regimen, upcoming health needs, and/or how to find the highest value location for care. Regardless of the resource, we engage members with empathy—focusing on listening to their needs above all. This approach leads to higher engagement rates compared to traditional carrier-led care management programs, and an exceptional member experience. Below we've highlighted a few unique facets of our approach to complex care management.

### An integrated team

Disjointed care can result in increased costs and a frustrating member experience. Providing the best holistic care management begins with the team. Our Care Navigation team is comprised of Collective Health pharmacists, social workers, nurses, dieticians and Care Coordinators. We continue to evolve the team based on the needs of members. Each team member is trained to deliver member interactions that are consistent with Collective Health's industry-leading member experience.

### Timely identification and outreach

We actively outreach to members who may need more intensive coordination of care (e.g., cancer, complex maternity, behavioral health admissions, transplants, transgender surgery). Members may also access the program in other ways such as: (1) inbound warm transfer from our Member Advocates, (2) proactive outreach from the Care Navigation team, or (3) inbound call or email to the Care Navigation team.

Member Advocates are trained to identify members who may benefit from additional support through the Care Navigation program. Additionally, our proprietary Member Advocate support tool flags members for Care Navigation based on our identification logic. We find that Member Advocate referrals are a high-yield pathway for engaging members with the Care Navigation team, often earlier in their course of care as members often call in before a claim has been incurred. While it is less common, members can call our Care Navigation team directly, and we provide member-facing materials during Open Enrollment to educate members about this resource.

*Outbound Risk-Based Identification*

We outreach to members via phone and/or email because we've found that members value flexibility.

To identify members who would benefit from Care Navigation, we utilize an open-source, replicated, academically peer-reviewed risk model that we developed jointly with Stanford University. The model is based on healthcare claims data from 2.5 million privately-insured US adults, and outperforms the leading 'black box' models in the industry, achieving an R-squared (% of variation explained) of 38.8% versus the third party leader of 24.8%. Our improved risk modeling is achieved by enriching claims data with zip code-level social determinants of health indicators (e.g., area-level education rates), and using a form of machine learning called Extreme Gradient Boosting that led us to win *The New England Journal of Medicine's SPRINT Data Challenge*. Rather than focusing only on high-cost claimants, our risk model allows us to identify 'rising risk' members who are accelerating towards high-cost claimant status and where there is an opportunity to potentially avert costly claims before they are incurred.

## A holistic approach

Our team acts as a single point of contact for the member. We believe listening to and educating members about their healthcare and benefits results in better compliance and utilization of care.

Our Pharmacists are trained to:

- Provide disease state education
- Conduct "Welcome Home" calls after inpatient admissions
- Outreach emerging high dollar cases
- Engage members with specialty drug considerations - for example, first specialty fill or overall high cost pharmacy spend
- Conduct in-depth medication reconciliation
- Assess generic substitution opportunities
- Aid members in identifying the most efficient site-of-care for services such as specialty medications, advanced imaging or outpatient surgery
- Partner with member's care team to drive efficient care plans

Our Social Workers are trained to assist with:

- Complex care navigation and provider coordination
- Identifying community resources and obtaining durable medical equipment (DME)
- Resolving complex claims and authorization issues
- Providing emotional and psychosocial support
- Behavioral health assistance/navigation (ABA coordination and conduct post psychiatric inpatient “Welcome Home” calls)

Our Dieticians are trained to:

- Conduct “Welcome Home” calls after inpatient admissions for bariatric surgeries, diabetic complications, and other diet related visits
- Outreach emerging high dollar cases
- Conduct in-depth dietary assessments
- Aid members in connecting to dietary resources in the community and to dietary providers

Our Registered Nurses are trained to:

- Conduct “Welcome Home” calls after an inpatient or emergency department visit
- Conduct in-depth assessment of member needs
- Provide disease education
- Outreach emerging high dollar cases
- Aid member in identifying the most efficient site-of-care for services
- Partner with a member’s care team to drive efficient care plans
- Support complex care navigation and provider coordination
- Resolve complex claims and authorization issues

The team also refers members to relevant clinical point solutions available to them from their employer (e.g., second opinion services, fertility services, etc.).

### Exceptional experience and engagement

Members work with one primary contact to set specific goals, address questions and concerns, and get the additional support they need. We don’t have strict time limits on our calls or use scripting or automated call dialers. The result is member-reported customer satisfaction scores of nearly 100%.

# Care Navigation Reporting

The Care Navigation program includes quarterly, year-to-date performance reporting. Reporting includes:

### Engagement insights

- Number of members identified
- Number of members outreached and engaged
- Number of high-cost claimants identified, outreached, and engaged

### Care management insights

- Top diagnoses/conditions of engaged population
- Key interventions provided to engaged members
- Program partner referrals
- Case examples
- ROI of 2:1 on pharmacy interventions

### Satisfaction insights

- Member satisfaction rating
- Member quotes

In 2021, we will introduce new Clinical Navigation reporting encompassing Care Navigation, Program Partner utilization and engagement, Personalized Recommendations and select population health metrics. These reports will be available as a supplement to existing reporting.

# Join the movement

Collective Health simplifies employee healthcare with an integrated technology solution that makes healthcare work for everyone. With more than a quarter of a million members and over 50 clients—including Driscoll's, Pinterest, Red Bull, Restoration Hardware (RH), and more—Collective Health is reinventing the healthcare experience for forward-thinking organizations and their people across the U.S. The company has developed a range of population health management solutions, and partnered with innovative companies across care delivery and diagnostics to meet the most pressing healthcare challenges for employers today.

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