Community Health Network of Connecticut, Inc.™

'COMMUNITY CARES' Quality Improvement Programs

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Community Resource Nurse

The One with the Sun!

Building healthier communities together.

Healthy Connections Outreach

- Links members by referral to appropriate health services and programs; Care Coordination staff fluently bilingual in English and Spanish; language line service
- HEALTHY CONNECTIONS CALLS – welcome calls to each new member and new mother; part of a comprehensive education outreach on CHNCT benefits, services, community resources and PCP selection

Healthy Connections Outreach

- EPSDT/WELL CHILD CARE PROGRAMS – member and provider notification; Healthy Connections Reminder Cards
- CIRTS – outreach support for the 'CT Immunization Registry Tracking System'
- NEWBORN TRACKING PROGRAM (HUSKY A & B) – assistance with PCP appointment scheduling as needed

CHNCT Healthy Beginnings

HEALTHY BEGINNINGS

- PROGRAM GOAL: to encourage early entry into prenatal care and to keep postpartum appointments; prevent preterm labor and reduce low birth weight babies through education - affecting habits - outcome

- A complete health risk assessment is conducted by the Healthy Beginnings nurse to assess whether a member is high, moderate or low risk.

HEALTHY BEGINNINGS

- Members are followed throughout their pregnancy and post partum visit
- Every member receives three educational mailings; added mailings – learning needs
- Members at high risk for premature delivery or low birth weight babies are managed by intensive disease management RNs
- Transportation assistance

HEALTHY BEGINNINGS

- HIGH RISK MEMBERS RECEIVE:

- Contact with an intensive RN disease manager at least monthly through the pregnancy and postpartum
- A comprehensive assessment that addresses physical, social and behavioral health issues
- Individualized care plans
- Education about pregnancy and community resources that can help
- Nurses address behavioral health needs and make referrals to the 'CT Behavioral Health Partnership' where appropriate

HEALTHY BEGINNINGS

- LOW RISK MEMBERS RECEIVE:

- Calls from an LPN at least once a trimester and postpartum
- Assessment of risk status on each call; transfer to an intensive disease manager if needed
- Education about community resources that may be helpful

HEALTHY BEGINNINGS

- PRENATAL MEMBER INCENTIVE

- Members who have a doctor visit in the first trimester or within 42 days of enrollment are eligible
- Eligible members receive a $25 Target gift card once the claim comes in
- Attempts are made to contact the member and resend if the gift card is returned in the mail

HEALTHY BEGINNINGS

- POSTPARTUM PHOTO PACKAGE INCENTIVE

- Members who keep a postpartum visit between 21 and 56 days after delivery are eligible
- Eligible members receive a photo package coupon from JCPenney with a value of $49.95
- Attempts are made to contact members if the incentive is returned in the mail

Healthy Airways

HEALTHY AIRWAYS

- A DISEASE MANAGEMENT PROGRAM: offer support and intensive RN disease management for members with asthma
- GOAL: Increase members' understanding and use of asthma medications; keep regular medical appointments; have an action/treatment plan so that ED visits and hospitalizations can be avoided; referral to a specialist as needed/indicated
- MEMBERS with utilization that indicates asthma is out of control are targeted (2 annual ED visits or 1 hospitalization with primary dx of asthma; informed of the program – desired to be followed

HEALTHY AIRWAYS

- MEMBERS receive telephonic intervention from intensive RN disease managers, addressing clinical and social challenges and coordinating care
- MEMBERS receive an asthma action/treatment plan to complete with their provider
- EDUCATIONAL mailings-Krames on demand (for appropriate comprehension level)

HEALTHY AIRWAYS

- NURSES address behavioral health needs and make referrals to the ‘Connecticut Behavioral Health Partnership’ where appropriate

Healthy Cells

A Sickle Cell Initiative

HEALTHY CELLS

- A DISEASE MANAGEMENT PROGRAM to educate members about sickle cell disease and encourage receiving regular medical care – primary care and specialty hematology care
- GOAL: to decrease ED utilization by encouraging preventive self care – improving pain control and diminishing 'flare ups'
- ALL MEMBERS with sickle cell disease are eligible to receive telephonic intervention from intensive RN disease managers, addressing clinical and social challenges and coordinating care.

HEALTHY CELLS

- MEMBERS receive individualized educational mailings-Krames on demand
- NURSES address behavioral health needs and make referrals to the ‘ Connecticut Behavioral Health Partnership’ where appropriate

HEALTHY KIDS

HEALTHY KIDS

- A program to encourage the keeping of scheduled appointments for regular medical visits and immunizations – compliance with the EPSDT/Well Child Care periodicity schedule-birth through adolescence
- Healthy Connections Reminder Cards – well care visit cards mailed monthly; overdue appointments - reminder calls
- Transportation-1st yr. of life if needed

HEALTHY CONNECTIONS

- MAMMOGRAM & PAP SMEAR OUTREACH
- Annual reminder postcard for mammogram screening – members age 40 years and over
- Annual reminder postcard for pap smear screening – members age 18 years and over
- Adult Well and Preventive Care Visits; adult reminder cards

HEALTHY CONNECTIONS

- LEAD SCREEN TEST OUTREACH
- A program to remind members to receive periodic lead screen tests
- CHNCT identifies members that are due or overdue for lead screening
- Screening notification cards are mailed to the ‘Head of Household’
- Notification cards contain educational information on lead poisoning, screening and prevention safeguards

Healthy Living with Diabetes

HEALTHY LIVING WITH DIABETES

- Intensive RN disease management program for members identified as having diabetes; telephonic assessment of disease status/needs – self care goals defined
- Telephonic education/counseling to support the member's appropriate self care for their disease
- Individualized member care plans
- Individualized educational mailings

HEALTHY LIVING WITH DIABETES

- Encourage participation to define/progress with self care goals: dilated eye examinations, proactive foot examinations
- Encourage adherence with medical treatment plan and visit schedule
- Evaluate progress in self care goals: lipid/cholesterol levels; glycated hemoglobin levels; microalbumins
- Provide support in pregnancy diabetes DM; augment with ‘Healthy Beginnings’ program

HEALTHY LIVING WITH DIABETES

- Nurses address behavioral health needs and make referral to the ‘Connecticut Behavioral Health Partnership’ where appropriate

CARE MANAGEMENT

- Intensive RN disease management services specific to a member's special health needs across the continuum of the healthcare delivery system
- Necessary medical, social and mental health care for our members – Husky A, Husky B and Charter Oak

COMMUNITY CARES