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## Care coordination programs adapt to real-world challenges

Health plan initiatives expand to address transportation, food, and other barriers to care

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Digital Vision

ONCE LIMITED TO major disease states such as asthma, diabetes and congestive heart failure, disease management has become a far more comprehensive tool for health plans. Not only has it expanded to encompass less-prevalent conditions such as Hepatitis C and Lyme disease, it addresses non-clinical barriers to care, such as scheduling and patient transportation.

It does no good to manage the chronically ill in doctors' offices and medical facilities if the member has no means to get to the appointment. After the industry has struggled for years to increase member participation in DM programs, companies such as Philadelphia-based AmeriHealth Mercy have gone one step further to address the socioeconomic barriers that many members face—particularly those in the Medicare and Medicaid segments, and members in rural settings.

It's important to realize that care coordination (also known as intensive care management, or ICM) isn't simply a dressed-up disease management program, according to Tom Lyman, senior

vice president of market expansion at AmeriHealth Mercy. “PerforMED, our care coordination program is a population-based health management program that uses many of the same tools as traditional DM programs, such as predictive modeling,” he says. “What makes it different is that it doesn’t address individuals with disease states, per se...it addresses the 10% of a plan’s membership that spends the most money, regardless of chronic illness. PerforMED is a best-practice case management program that provides one-stop, blended programs to our members.”

To provide such a high level of individual service, care coordinators need to have access to a lot of data from a lot of different sources. Integrated, flexible technology is the key to making that possible.

“Without folding in new technologies and borrowing longer-term engagement strategies from pure DM programs, today’s care coordination programs look no different than case management from yesteryear,” according to Joel Hoffman, a principal in the Denver office of Reden & Anders Ltd. “Predictive modeling, enhanced engagement stratification engines, and staying in touch with the patient after the culmination of a high-cost event afford better outcomes—and thus better returns over traditional case management. It’s like case management on steroids.”

Tracking individuals through a fragmented and compartmentalized health-care delivery system is a daunting task, says JoAnn Balara, RN, BSN, manager of care management products for Phoenix-based QCSI, an IT solutions provider for healthcare payers. “In order

to truly improve the outcomes of these special needs populations, health plans need systems that provide visibility into a member’s care across the entire health-care continuum.”

Compared with traditional DM programs, it’s easier for health plan executives to understand the value of care coordination initiatives, Hoffman points out. “There’s an intuitive understanding of the value that these programs have,” he says. “Despite a very long and prosperous run for disease management, it could be said that the industry still struggles at times to demonstrate a true cause-and-effect relationship of disease management programs with outcomes.

But care coordination is more hands-on with the people that cost the most, and therefore its impact may be more easily understood by customers. To this end, many traditional DM companies have added care coordination or Intensive Case Management capabilities.”

Lyman concurs, adding that “the key to successful care coordination is getting the information necessary to manage the care of members into the hands of those who are charged with managing that care.”

Treating this population with a non-coordinated approach doesn’t address the driving factors that underlie the problem, and sooner or later, you’ll run out of options.

#### A ‘REAL-WORLD’ MODEL

When AmeriHealth Mercy realized that its previous efforts at disease management weren’t lowering costs and improving outcomes, the plan decided to

conduct a population profile of its members. The comprehensive study showed that the majority of its highest spenders (more than 80%) were in the Supplemental Security Income (SSI), aged, blind or disabled category.

Even more telling, these weren’t necessarily individuals who had a chronic disease—they were individuals who had multiple diseases. Many of the people identified had three disease states, and some had as many as five. To further complicate matters, some of those chronic illnesses were not addressed by DM programs, such as multiple sclerosis and cerebral palsy. Those people do not fit neatly into traditional programs because of their multiple comorbidities and psychosocial issues.

Even though AmeriHealth Mercy had been managing members with diabetes, asthma and other major disease states, there was no demonstrable change in its costs to treat those populations. Costs were managed and services coordinated through prior authorization and utilization management; episodic case management; referral management; special needs identification; and network management contracts.

“Historically, our approach to managing care was the same for all members, regardless of their illness burden. But our costs continued to go up, and eventually we decided that we just didn’t know enough about those people to make a positive change,” Lyman explains. “We had put programs in place based on utilization statistics, but those didn’t address the driving needs of our populations.”

In its population management approach, AmeriHealth Mercy stratifies its members into one of four risk groups:

Level I: Uncomplicated members with little or no known risk and low utilization. These members require preventive health education and primary care and occasionally need case management.

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Level II: Members with early chronic illness and low-risk pregnancies. These members benefit from targeted health education and lifestyle changes.

Level II+: Members with high-risk pregnancies, chronic illnesses and other complications. These members benefit from DM and case management services.

Level III: High-risk, high-cost members. People in this category include the 20% to 30% who consume 70% to 80% of healthcare resource dollars. They have predictive scores that are 4.5 times higher than average; utilize all services at three or four times the rate of average members; have complex psychosocial needs; have a behavioral health diagnosis and three or more chronic illnesses; and are on five or more prescription medications (not including any over-the-counter drugs they might also be taking).

#### EFFECTIVENESS FOR ALL

By providing comprehensive case management services, AmeriHealth Mercy is able to remove the barriers that prevent the members from accessing care—even when those barriers have nothing to do with what is traditionally considered “healthcare.” That includes ensuring members have access to physicians’ offices rather than being forced into emergency rooms, assisting members with transportation, and even addressing financial needs.

AmeriHealth Mercy’s members often come to the plan for help when they do not have enough money for medications, or when they feel they must choose between paying for medications and food. PerforMED case managers find that it is difficult to expect members to manage complex healthcare needs well when their basic needs for food and shelter are not being met.

The value of care coordination programs is not limited to people with chronic illnesses, Hoffman says, as has

traditionally been the focus of traditional DM programs. “Care coordination also addresses the populations that traditional disease management programs can miss: those who consume a large amount of medical resources very quickly, but don’t have any particular chronic disease.

“In some ways, this population—the members that can generate a great deal of costs in a very short time frame—is most visible to health plans. The savings they produce are more intuitive, as executives literally can see those people chewing up their organization’s resources. Care coordination cuts across disease states to address the high-cost members, whether they have a chronic condition or not,” Hoffman adds.

That having been said, the Medicare and Medicaid populations probably are the proverbial “low-hanging fruit” and might provide the fastest and most visible returns, Hoffman says. “Care coordination has value with all populations, but might have the most value for those in Medicaid and Medicare. Those populations have a tendency to use significant amounts of medical resources, and using a telephone just won’t get you as much savings in certain situations. The members in public programs possess certain characteristics that lend themselves to a heavier-touch solution: low socioeconomic status, lack of presence of another caregiver, limited capacities and less familiarity with today’s healthcare delivery system.”

#### TYING IT ALL TOGETHER

Although health plans are flush with a wealth of extremely detailed, member-specific information, it is stored in so

many different places that gleaning the truly useful data can be extremely challenging. To make matters worse, even when all of the information can be specifically located, it is often housed in a dozen or more disparate IT systems that can’t communicate with each other.

As a result, care coordination might result in better care and significant savings, but it also has extensive technology requirements, Balara says. One of those needs is the ability to connect providers in different settings.

“Changes in the healthcare system have resulted in shorter hospital stays, and that has moved the provision of many healthcare services into the community,”

Balara says. “The proper IT solution will make clinical data more accessible to expedite the exchange of information that links primary care providers with hospital-based providers.”

AmeriHealth Mercy chose to develop its own integrated information system called Care Connect; it utilizes a data warehouse that receives members’ data and reads them into an individualized electronic medical record. Case managers and other authorized users thus have access to a member’s pharmacy data, hospitalization and emergency room history, lab results and call-tracking data. Each team member can view and make changes in the individualized record, add new tasks and interventions, complete various comprehensive assessments, and track the member’s progress with DM-focused education and clinical outcomes.

AmeriHealth Mercy is now working on ways to receive emergency room data and physician office visit information in an electronic format, so case managers can

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ensure that members understand and are complying with changes in medication, treatments, and the recommended follow-up care.

The technology infrastructure needed to support such a broad initiative should resemble an octopus, with multiple tentacles that can reach into different places, gather the necessary data, and put it into an integrated, easily accessed central repository.

“The ideal system utilizes a single database that contains both medical and dental claims, comorbidities and case management information related to patient condition, cognitive and functional status, and a member’s unmet social needs,” Balara says. “Data from all of those disparate areas needs to be consolidated into a single system to properly support multidisciplinary coordination of care.”

Fortunately, Hoffman says, the technology currently available appears to be particularly suited to this exact role.

“In some ways, predictive modeling can be seen as more effective at identifying more broadly those members who are likely to produce high costs than it is at identifying those likely to develop a specific chronic condition,” he says. “It doesn’t ignore those with chronic conditions...It goes beyond.” MHE

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