Care Management in Managed Care

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OVERSIGHT COMMITTEE

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Care Management in Managed Care

- According to the National Committee for Quality Assurance+ (NCQA) is a collaborative process of
  - assessment planning
  - facilitation
  - care coordination
  - evaluation
  - advocacy
  - for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family,
  - while promoting quality, cost-effective outcomes (2014).

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- Goals:
  - Health plans incorporate core medical home and health home principles in approach to the managed care population not enrolled in and care managed by a health home
  - Help the patient achieve the best health and quality of life possible by
    - preventing chronic disease
    - stabilizing current chronic conditions
    - preventing acceleration to a higher risk category with higher costs. (American Academy of Family Physicians, http://www.aafp.org/practice-management/pcmh/initiatives/cpci/rscm.html)
  - Improved clinical outcomes
  - Improved population/situational awareness
  - Improved system efficiencies and effectiveness

Care Management in Managed Care

- Application of risk stratified care management
  - American Academy of Family Physicians (http://www.aafp.org/practice-management/pcmh/initiatives/cpci/rscm.html):
    - Risk-stratified care management
      - Method to systematically identify and monitor the patient population
      - Begins with a periodic and systematic assessment of each patient's health risk status
        - using criteria from multiple sources
        - develop a personalized care plan
      - A patient's health status may be reflected by a score or placement in a specific category
        - based on the most current information available

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      - This assessment will assist the physician and care team in
        - predicting health care needs
        - recommending appropriate preventive and chronic care services
      - Based on the outcome of the risk assessment, a personalized care plan can then be developed
        - in collaboration with the patient and/or family
      - The care plan or category of health risk may fluctuate due to
        - expenditures
        - significant changes in the patient's health

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    - Risk-stratified care management
      - The identification of a patient's health risk category is the first step towards
        - planning, developing, and implementing a personalized patient care plan by the care team
        - in collaboration with the patient
      - Population needs will vary. For some, the plan may address a need for
        - more robust care coordination with other providers or
        - intensive care management or
        - collaboration with community resources

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    - Risk-stratified care management
      - For example
        - In a practice panel of 1,000 patients, there will likely be close to 200 patients (20%) who could benefit from an increased level of support.
        - This top 20% of the population accounts for 80% of the total health care spending in the United States, with the very highest medical costs concentrated in the top 1% (via the Commonwealth Fund Issue Brief, May 2011).

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    - Risk-stratified care management
      - Patient groupings
        - **Primary Prevention (Level 1 and 2):**
          - Level 1, low risk: Patients who are healthy and have no known chronic diseases
          - Level 2: Patients who are healthy but showing warning signs of potential health risks
          - Patients in the primary prevention category tend to be lower in their health care resource expenditures.

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        - **Secondary Prevention (Level 3 and 4):**
          - Level 3, intermediate risk: A patient who has a chronic disease, is managing it well, and meeting their desired goals
          - Level 4: Those who are not in control of his/her disease but have not developed complications
          - Patients in the Secondary Prevention category tend to be moderate users of health care resources.

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      - Patient groupings
        - **Tertiary Prevention (Level 5):**
          - Level 5: If a patient's chronic disease has progressed, become unstable, or new conditions and/or significant complications have developed
          - Patients in the tertiary prevention category usually rank high in health care resource expenditures.

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        - **Catastrophic (Level 6):**
          - An additional, non-public health Level 6 category is reserved for extreme situations, such as a pre-term baby who needs intensive long-term care, a patient who has a severe head injury, or anyone requiring highly complex treatment.
          - Patients in the catastrophic category have extremely high health care resource expenditures and may be under the care of several sub-specialists.

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- Next steps
  - Continue discussion with the plans on case management, goals, and expectations
  - Continue development of evaluation process
  - Incorporate new guidance into next contract