

Successful Care Management: The New Healthcare Imperative

Combining the human element with technology – for lower costs and better-quality care



viewpoint: care management

- As healthcare costs and complexity continue to rise, care management must become more efficient. And collaboration across the entire healthcare spectrum is the key. As payers, providers and members/patients come together – enabled by automated technologies – care management will at last deliver on its promise.



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Introduction

The complexity of managing healthcare is increasing as providers and payers struggle to contain costs and improve quality of care for patients. What they've learned along the way is that successful and effective care management requires more than a care manager and a patient, and more than a healthcare provider and a payer. Rather, it calls for collaboration among all these constituents; through that effort, they share information and improve outcomes for patients/members, which in turn helps reduce costs.

Facilitating across-the-board collaboration requires the use of automated systems and tools to connect all constituents and provide the right information at the right time to the right resource. Uniting the human element with technology greatly increases the success of care management programs.

This white paper provides an overview of the reasons collaboration is needed, the perspectives of key stakeholders, and the tools available to successfully implement a collaborative IT strategy for care management.

Why collaborate?

Just as costs have skyrocketed for the quality healthcare Americans expect and demand, so have the volumes of information on and for patients.

Although collaboration has increased, much critical information - on prescribed medicines, checkup results, lab results, ongoing care, payments and more - still remains unshared across a variety of industry constituents. Ties between the various holders of the information often remain fragmented. More than just an inconvenience, however, this lack of communication is financially costly and, worse, disrupts the goal of providing patients with the best care possible.

Beyond the dollar costs, there are many other reasons why those involved in the healthcare spectrum are striving for a better care management methodology:

- An aging population and growing patient/member volumes, coupled with the growing rate of chronic disease
- Clinical staff shortages
- Care inefficiencies
- A need to demonstrate return on systems investments

The answer is collaborative care management. As healthcare constituencies work together more and more to strengthen the linkage between preventive management, disease management and information integration, costs will be better contained and patient outcomes improved.

We're beginning to see a greater push for care management between health plans and providers. In fact, these parties are increasingly updating and improving their care management and automation technologies. And while private industry is currently the primary driver for adoption of care management programs and improvements, the heightened focus by Medicare will also help speed the change.

The payer perspective

Successful care management offers payers many opportunities for strengthening collaboration with other healthcare constituents - as well as for reducing costs and improving patient outcomes. For example, care management tools help payers manage patient data more easily and integrate it better with clinical and financial data on behalf of providers.

Payers use a vast amount of information from a plethora of sources: data on member utilization patterns, member financial data, clinical claims data, outcomes data and more. Underwriters create massive amounts of data as they identify and quantify that risk on prospective enrollees. Since payers have all that information, it's not surprising that they're leading the care management charge, with at least 99 percent of them providing some form of care management program.

Another key reason why care management is on the increase - and why payers see care management programs as critical offerings - is the aging U.S. population.

Older members typically require more services and more care, and can benefit most from care management programs.

Care management is also critical to payers because their customer base is in a constant state of flux. On average, membership longevity in any health plan is just two-and-one-half years; for Medicaid plans, membership longevity is only five to six months. Why? Job changes, lifestyle changes and other marketplace demands pull members from one health plan to another.

With such frequent changes in plan membership, payers say most members will "re-present" in plans they've left previously - often multiple times over the years. Therefore, it's important that strong programs are in place to provide a continuum of care for all members. If a member has a chronic condition such as diabetes and leaves one health plan for another - but does not receive a continuum of care in the new plan - when that member "re-presents" into a previous plan, his or her condition may have worsened considerably, increasing the care needed and costs. With greater collaboration, the patient is more likely to receive a continuum of care and improved outcomes.

Additionally, since payers are often accountable to shareholders or investors, controlling costs is especially important. That's not easy in healthcare today. Analyst firm Frost & Sullivan estimates costs associated with care management will climb from about \$1.3 billion in 2004 to almost \$1.8 billion by 2005.

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Truly successful care management will help stem the rising costs associated with care, in ways both mundane and profound. For example, while technology can be used to improve routine office matters, it also can be used to strengthen and improve the payer-doctor-patient relationship.

The provider perspective

Increased availability of information and changes in technology have revolutionized how patients interact with their providers – upping the ante for providers in terms of care management and patient education.

First, consumerism is having a profound influence on patients. For example, a patient may see an advertisement on television for a certain prescription drug and then ask his provider whether that medication would work. Providers often struggle with what care management programs require in terms of patient demands and program outcomes.

The Internet has also revolutionized patient/provider interaction. Physicians and other providers need to be able to respond differently than they did 10 to 15 years ago, because patients have much more information available at their fingertips through sources such as Web portals and discussion groups. It's estimated that the number of health plan members who actively take advantage of "personalized" health portals has increased by the millions this year alone.

While consumer marketing is an impetus for a patient to demand a new course of treatment, easy access to critical information and a complete personal medical history – as well as information on clinical trials and drug interactions – can help a doctor better explain why a particular course of treatment may or may not be in the patient's best interest.

Providers should also understand two other important drivers for patients today: costs and referrals. It's crucial for providers to find a balance between the two factors so that everyone can maximize the value to be gained from care management.

What's more, the healthcare system today is not structured for providers to be educators. Time constraints, heavy patient loads and skyrocketing expenses have

served to decrease the amount of face time most providers spend with patients. Providers have made it clear that if they're to participate in care management programs, they want to be financially incented.

The patient perspective

Care plan members view their access to healthcare as both a necessity and a right. Patients are holding providers more accountable for improving outcomes, and they want to participate more in their own care. With increased access to care come more opportunities for everyone in the healthcare continuum to be more involved at all levels.

Members can work collaboratively with care managers through the Web to access materials, communicate on an ongoing basis, complete health risk assessments and conduct other activities. By regularly accessing health and wellness information, patients will remain healthier through self-monitoring, will require less time being educated in person by caregivers, and will increase quality of life by decreasing the need for acute services.

Providers can facilitate this process by using secure portals on the Web to review and sign off on care management plans, receive alerts from care managers, and offer up specialized programs and information for their patients, such as weight control guidelines.

Good Internet-based member tools will help assist consumers in navigating the health system so they become more informed about their choices:

- *Decision support tools* can provide members with health plan selection information and cost calculators, benefits configurations and comparisons, and pharmacy and drug comparisons.
- *Health and wellness content* can include disease and condition information, treatment options, information on medical tests, first aid and self care information, medical terminology, medical answers and chat rooms.
- *Health and wellness tools* can include personal health records, drug interaction information, targeted messaging, health decision guides and healthy lifestyle planners.

- *Clinical interaction tools* can include provider access to the patient's health record, online disease management reporting, care coordination through nurse or care manager, predictive modeling for risk segmentation, and nurse intervention.

Making it all work

Providing a holistic approach to care is going to be critical. A holistic approach looks at a patient's overall health versus focusing solely on "incidents"; it examines what's happened before and helps predict what might happen after. That means integrating across the healthcare spectrum to understand the whole picture. A holistic approach also offers better cost management for employers, providers and care plan enrollees.

Achieving truly integrated and holistic care management requires collaboration at all levels, including:

- Patient risk screening
- Disease management
- Alternate encounters (such as RN clinics, team visits, group visits, home visits)
- Team-based care
- Cross-continuum coordination
- Outreach
- Population screening and analysis
- Patient enrollment
- Guidelines/protocols (including wellness and prevention)
- Point of care
- Patient empowerment

In sum, a successful focus on care management involves providing the right care at the right place at the right time at the right cost. Members should be managed across the continuum of care, with interaction taking place between the care manager, member and physicians. Care management programs should encourage strong payer to member, member to provider, payer to physician, and physician to member relationships. See figure 1.

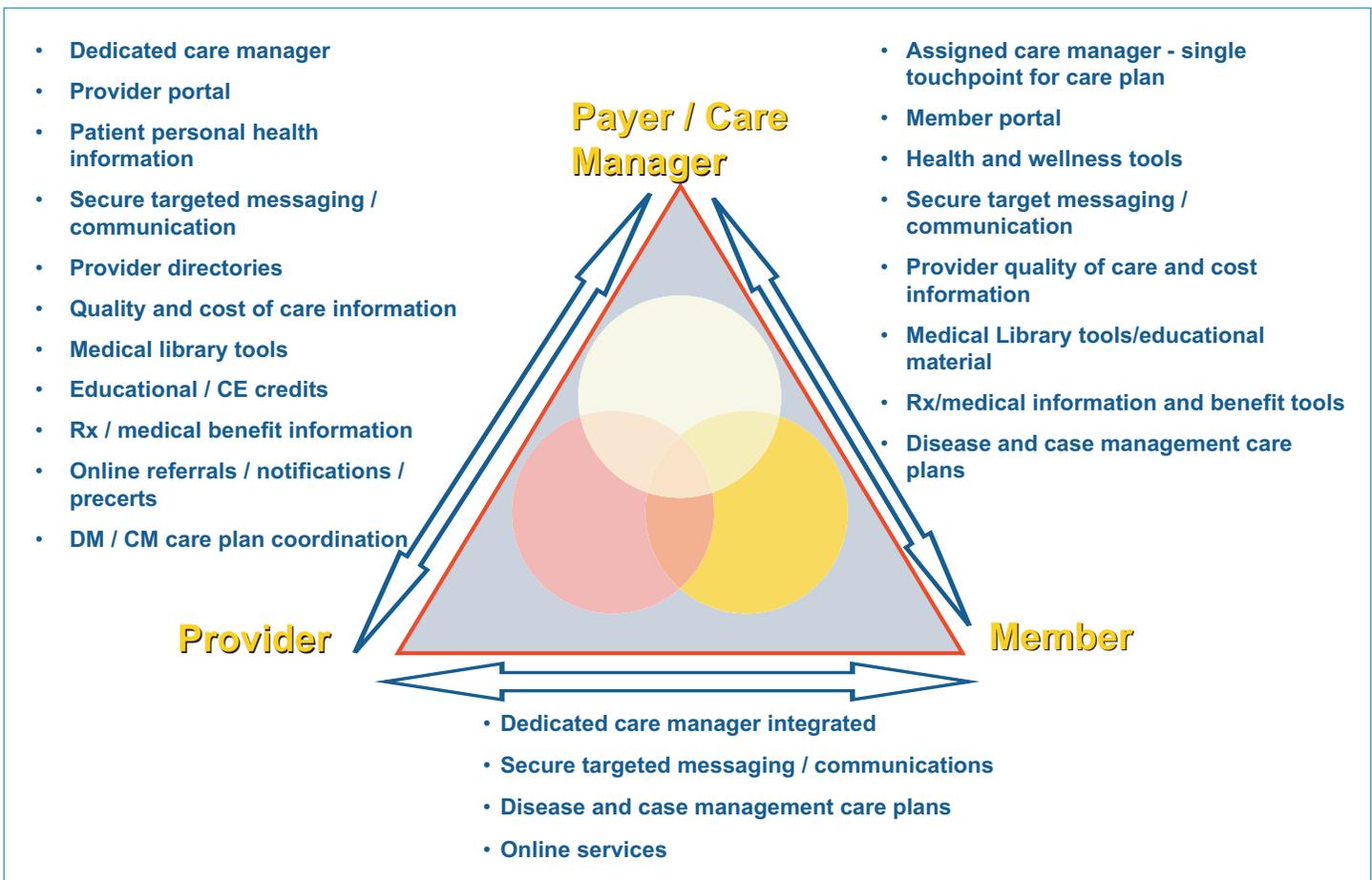


Figure 1. Payer/Provider/Member integration for better outcomes

Technology's place

The greatest opportunity to improve care management comes through the collaborative efforts of the various healthcare constituencies linked through technology.

To enhance care management programs for payers, members and providers, an integrated system is needed. Typical elements of an integrated care management system include automatic alerts and features to notify the manager if the member needs immediate intervention. The optimal model will empower the member through online education, enhanced communication with the care manager and other benefits.

A Web-based component within such an integrated system allows for more direct communication about sensitive issues. For instance, it can be difficult for a physician to set aside an appointment time to talk to a patient about weight management matters. But with relevant information readily available on the Web – and the physician directing the patient to take advantage of it – the patient can learn about the issues associated with weight management and what might happen if he doesn't manage his weight. It can be an easier and more direct way to address sensitive issues such as weight loss.

The key to creating information a care manager can use is to interface pertinent data from other systems. For instance, the core system can provide information on eligibility, provider, authorizations, claims, pharmacy and immunizations, while other sources might provide information on member services, underwriting, health risk assessments and decision support.

Rather than being bogged down with information that's repeated in multiple sites, the optimal method for data sharing is to link the care manager to data sources in external systems. Elements such as lab reports, medical records, notes from a home health agency and scanned documents can

all be accessed via secure links on the Web. Built-in security features can eliminate the possibility of data falling into the wrong hands. (Security can be limited based on the enrollee, user type and ID, for instance.)

Technology now exists for care management systems to monitor patients and then trigger alerts to care managers if a patient isn't complying with the prescribed course of treatment, or if there are other factors that might trigger a deterioration in health. (Triggers might include drug interactions or rising blood sugar levels.) Home monitoring devices can be set up to send information back to the care manager via telephone or Web portal.

By seeing what triggers reaction from the care manager, the patient can better understand what issues may impact his health and better comply with prescribed treatment, ultimately improving health and saving costs.

An example of a system set up this way is EDS ATLANTÉS. (See Figure 2.) It has the following capabilities:

- Provides automatic, real-time alerts to notify care managers if a member needs immediate intervention
- Provides online education about member conditions
- Involves patients in their own care
- Integrates health risk assessment data into the care management system
- Auto-generates condition-specific cases, care plans and service authorization packages
- Auto-generates business-to-business transactions when predefined thresholds are reached
- Receives authorization requests electronically and auto-approves using rules logic
- Auto-generates correspondence and educational materials
- Auto-generates tasks and reminders for care managers based on rules logic

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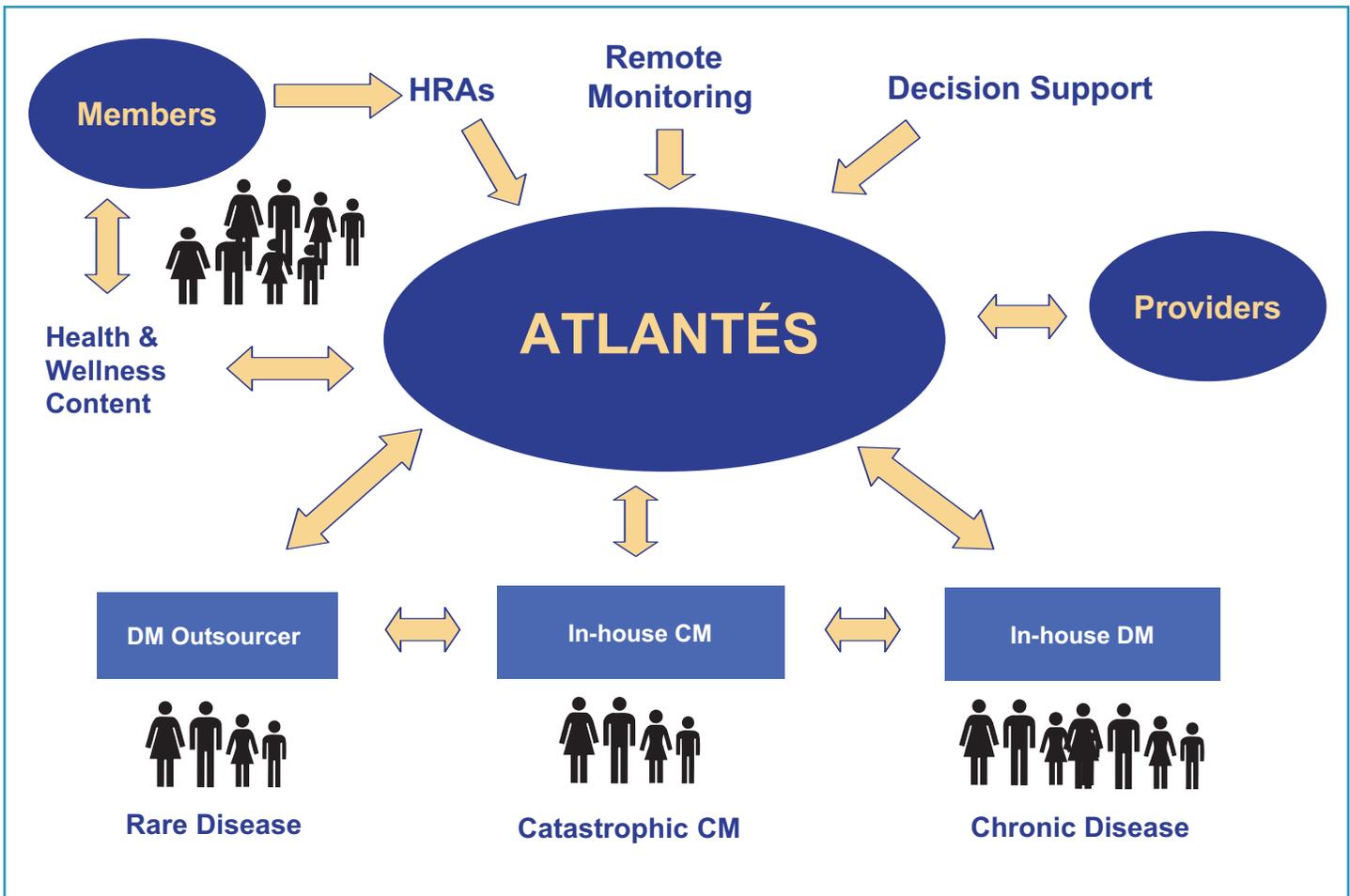


Figure 2. EDS ATLANTÉS

Conclusion

The surest way to increase patient satisfaction is to keep patients healthy. Over the next decade, improved care management – enabled by technologies designed to aid in preventive care, patient education and predictive modeling – will offer U.S. health-care more creative and intuitive methods to achieve patient satisfaction, improve collaboration between payers, providers, patients and care managers, and realize cost savings.

About EDS

EDS provides a broad portfolio of business and technology solutions to help its clients worldwide improve their business performance. EDS' core portfolio comprises information-technology, applications and business process services, as well as information-technology transformation services. EDS' A.T. Kearney subsidiary is one of the world's leading high-value management consultancies. With more than \$20 billion in annual revenue, EDS is ranked 87th on the *Fortune 500*. The company's stock is traded on the New York (NYSE: EDS) and London stock exchanges. Learn more at eds.com.

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