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LESSONS LEARNED IN COORDINATION OF CARE

THE GROWING DEMAND FOR SOPHISTICATED CARE MANAGEMENT

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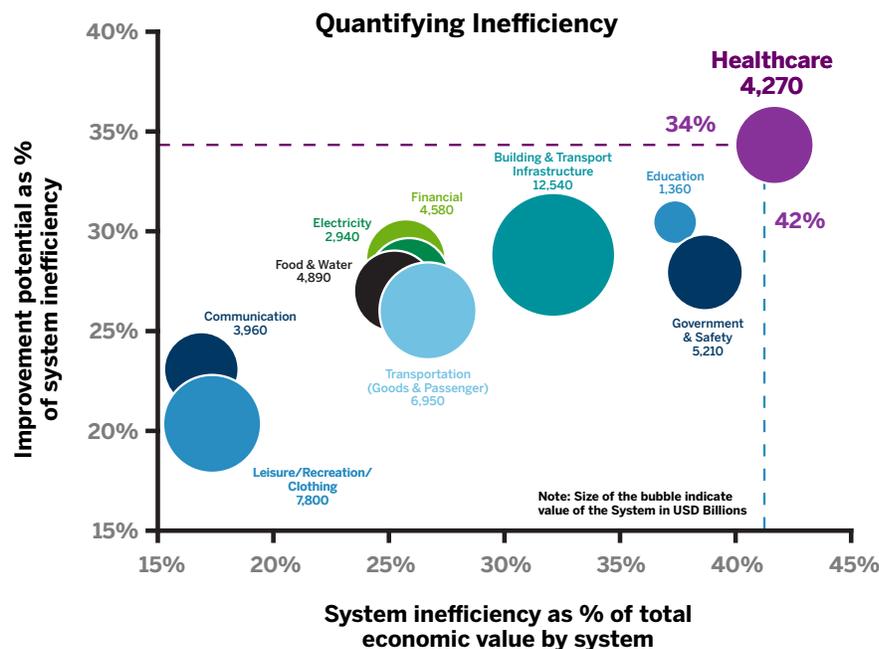
Overview

The care management movement began with the management of episodes of care and is now migrating toward managing the health of an entire population.

Healthcare often stands out as the least efficient industry in the world (as illustrated in Figure 1 below from a recent IBM thought leadership study), with more than \$2.5 trillion wasted annually. Approximately 30% of overall healthcare spending in the U.S. is deemed unnecessary. As different initiatives have been implemented over the years to combat this extent of unnecessary utilization, care management programs have evolved considerably.

A nationwide survey of physician organizations undertaken by researchers at the University of Chicago¹ and University of California-Berkeley noted that “millions of patients with chronic diseases do not receive quality care because, in large part, effective care management processes are not being practiced.” The researchers found that physician groups on average use only 32 percent of 16 recommended care management processes. One physician group in six uses none. These processes include using nurse case managers to maintain contact with patients; teaching patients how to understand and care for their illness at home; keeping a list of patients with each disease; developing timely reminder systems for patients and caregivers; and providing feedback to physicians on the quality of their care.

Figure 1: Leading the Pack in Inefficiency²



Over the past 2 to 3 decades, with the availability of advanced technology, comprehensive treatment plans, and targeted pharmaceutical drugs, more resources have been added to the arsenal of healthcare providers. This super-specialization in both personnel and treatments has further exacerbated gaps in care coordination - including poor communication and collaboration amongst providers, redundancies of diagnostic tests/services, and lack of high risk care management.

In recent years, health systems have become acutely aware of the reimbursement changes and penalties for failures in care coordination. As one example, the readmissions penalty for Medicare patients has increased

in FY14 to a 2% reduction in payments. These “value-based” payment changes have further instigated clients to rapidly develop care management programs that extend beyond the acute care environment to include community-based resources.

Finally, the push to alternative payment methodologies, such as global payments, shared savings, and bundled payments, is driving payers and providers to reduce patient care expenses and utilization through the use of more sophisticated population management tools, data analytics, and technology-enabled solutions.

1. Easton, J. 2003. “Physicians groups not implementing care management processes proven to increase quality of patient care.” *University of Chicago Chronicle*.

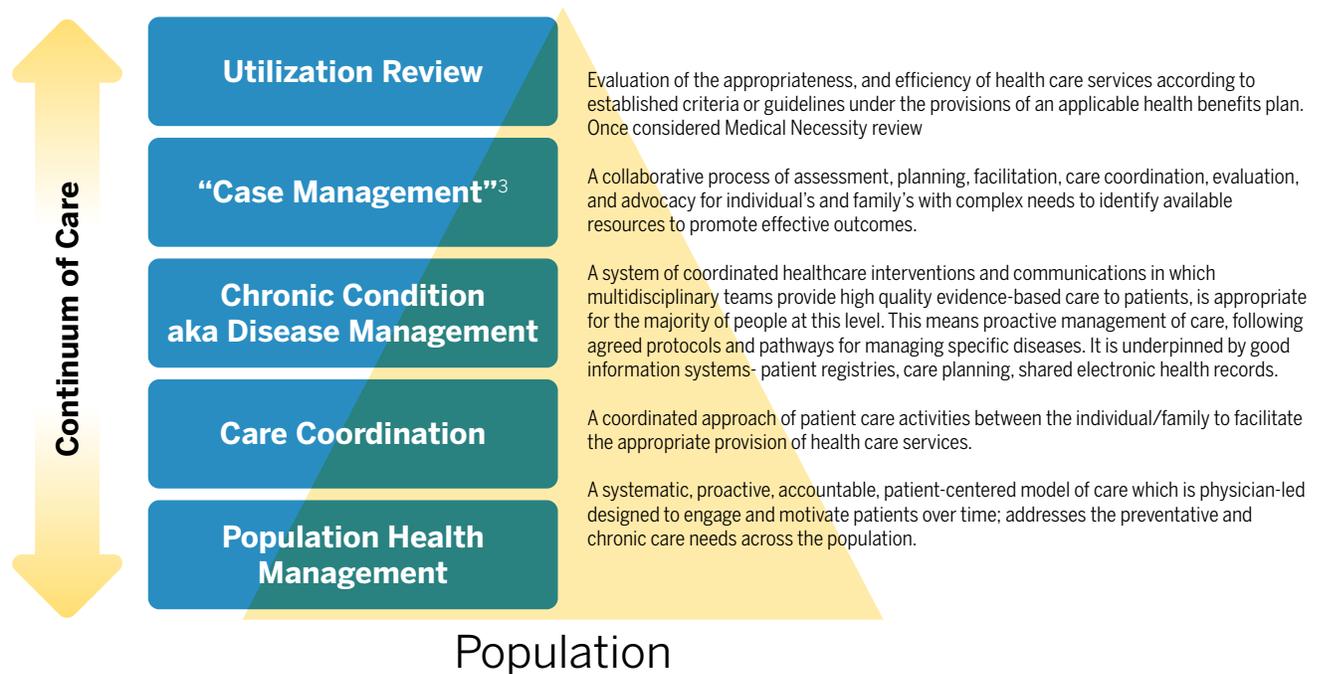
2. IBM Healthcare and Life Sciences. 2010. “Redefining Value and Success in Healthcare: Charting the Path to the Future.”

Illustrative Drivers for Sophisticated Care Management

A health system client asked FTI Consulting to assist with enhancing their care management program offerings to include population health management. The client was approached by a large, self-insured employer to reduce the employer’s health care expenditures at the consequence of losing this employer’s business. The employer stated that their health costs were severely impacting their bottom-line and their employees lacked sufficient knowledge on how best to manage their health care needs and where to obtain the right care, at the right price with the best outcomes.

In another situation, a health provider client requested assistance in ramping up their care management team to manage their dual eligible population. This resulted after they received a deficiency report from Centers of Medicare and Medicaid Services (CMS) outlining numerous concerns within their care management program.

Figure 2: Progression of Care Management Programs



Key Care Management Methodologies and Lessons Learned

The above illustration (Figure 2) provides an overview of the evolution of different methodologies involved in Continuum of Care Transformation, which are discussed in more detail below.

1. Utilization Review

Utilization Review was initiated in the 1980s with an initial focus on precertification of specific health care services, medical necessity review and referral services. When initially installed, it reduced, to a limited extent, healthcare expenditures; however, it led to the following:

- Increased provider dissatisfaction. Providers viewed this process as intrusive. They saw utilization review requirements as being a barrier to providing quality care to their patients.
- Increased patient dissatisfaction. Patients were frustrated over their inability to secure referrals for certain services. This requirement was perceived by them as hindering care.
- Conflicts in Medical Necessity, Services and/or procedures were deemed medically necessary however not necessarily covered by employer benefit design.

3. As defined by Case Management Society of America (CMSA).

Lesson Learned: Precertification and medical necessity reviews are costly and do not necessarily enhance quality of care or add value.

Lesson Learned: Analysis of denied cases reversed upon appeal has resulted in the development of tools to identify appropriate cases to alleviate costly resource use.

Lesson Learned: Better aligned benefit designs have significantly diminished appeal reversals.

2. Case Management

Utilization Review alone did not meet the needs of patients with more comprehensive or complex care needs. These patients were often discharged from acute care settings without any assessment or evaluation of post-acute needs.

Lesson Learned: Case Management of all patients from day one of their acute stay minimizes unnecessary days, helps to improve the planning for post discharge needs, and effectively reduces length of stay.

3. Chronic Condition/Care Management

Managing individuals with chronic conditions evolved into the main stay of care management in the 1990s. Prevalence and progression of chronic conditions account for approximately 80% of healthcare spending. The question became do we identify chronically ill individuals earlier in their disease course to positively impact outcomes, as well as assist them in partnering with providers in the management of their own health conditions? The realization dawned that getting individuals involved in any care management program was highly challenging.

Lesson Learned: Collaboration with patients is essential to closing "gaps in care", in supporting care management activities, and in getting patients engaged in improving care of their chronic illnesses.

4. Care Coordination

Beginning in the late 1990s, the idea of Care Coordination was developed to address patient needs throughout the continuum of care. Interdisciplinary Care Coordination Departments were developed with nurses, social workers, utilization review nurses and discharge planners. However, the primary focus remained on managing the patient's care throughout his/her hospitalization ensuring tests were completed at the appropriate level of care, at the appropriate time, and decreasing avoidable days and denials.

Lesson Learned: Most departments were challenged with the concept of care coordination and they reverted back to utilization review and discharge planning.

Lesson Learned: Coordination of care requires a collaborative process with physicians, nursing and care management in order to achieve the appropriate patient care outcomes throughout the continuum.

5. Population Health Management

Currently, employers are increasingly distressed over employee healthcare expenses. This has resulted in payers and providers experimenting vigorously with global payment and clinical integration strategies. In turn, this had led to the evolution of care management towards patient-centered population health management. Offering this type of approach comes with many costs and challenges - acquisition and utilization of technology, predictive analytics, provider leadership, new governance structures and change management initiatives.

Lesson Learned: Adding Population Health Management to one's care management programs requires strategic planning. Organizations that do not invest time in such planning will reap operational "chaos". It requires involving the information technology team, evaluating the current roles within care management to align with those for population health management, i.e., health coaches, behavioral coaches. The staff will require re-education on the tools needed to manage populations ranging from well, to chronically ill, to complex.

Care Process Management — A Strategic Approach to Lessons Learned

Care process management (CPM)⁴ is the application of business process management (BPM) methodology to clinical processes. As defined by the CPM framework, care can be improved using BPM through automation and collaboration.

CPM proponents have noted that application of business process management within the healthcare environment has been challenging because many practitioners do not see healthcare as a "business" rather as a "calling." Healthcare practitioners are not "servicing customers" but "caring for patients." For these critics, it is important to note that CPM does not change what a provider does to care for a patient. It focuses on process improvements - on coordination and collaboration between care providers.

We find this framework to be of great value in organizing the key Lessons Learned within the respective stages of evolution of care management programs (see Figure 3). The CPM approach is useful in this context as it reminds us that there are specific process improvements that can be undertaken within the context of an over-arching framework that can lead to significant improvements in outcomes. At the same time, the CPM approach also reminds us that the focus is on improving the process of care coordination not on changing medical decision-making.

Figure 3: Key Lessons Learned in Coordination of Care (Using a CPM Framework)



Challenges

Extensive integration and collaboration are required to manage the care of an entire population and frequently limited resources are available to do so. Existing programs are not prepared to support the continuum of care transformation.

Healthcare providers are working to form relationships to link acute care, sub-acute care, and ambulatory care. These relationships take years to form and develop. Unfortunately, time is not on the side of providers as changes are needed urgently.

Efforts need to include an evolution in the patient's management of his/her own healthcare and chronic conditions.

Next Steps in Evolving Your Care Management Program

First, an assessment must be undertaken of current care management program offerings coupled with their results.

- It has been our experience that handoffs from inpatient to sub-acute and ambulatory settings are not monitored or tracked which often results in readmissions or other poor outcomes. Take a candid look at what is offered within the sub-acute and ambulatory settings, identifying opportunities to enhance coordination, developing and building partnerships, and closing care gaps.
- Preparing patients for managing their own health is imperative in reducing avoidable readmissions.

Second, look at technology and tools available to support transition from inpatient to sub-acute and ambulatory settings.

- Having reliable processes in place to keep providers informed about details from the inpatient setting and continuing care into sub-acute and ambulatory settings will add to improving results.
- Tools should include active participation of the patient/their family.

Third, engage a strong reporting methodology and structure which allows you to quickly act on challenging issues.

4. Dickman, A. et al. 2012. "Care process management: Using BPM tools and methodology in the healthcare environment." IBM developerWorks.

Closing Thoughts

Continuum of care transformation requires the development of a comprehensive strategy involving all vested stakeholders, from inpatient, sub-acute, and ambulatory care settings, including active ownership and participation by the patient. A detailed implementation plan has to be developed and executed collaboratively. By applying technology, using data skillfully, and developing effective processes and structures, providers can deliver higher quality of care at lower costs.

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