Using Lessons from Disease Management and Care Management in Building Integrated Care Programs

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Nearly 31 million Medicaid beneficiaries have one or more chronic illnesses and require a variety of health and social services.[1] States interested in identifying more effective models of care for these beneficiaries are looking to various integrated care models, including the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative for Medicare-Medicaid enrollees ("dual eligibles"), to enhance access to services, improve health outcomes, and curb growing health care costs.[2]

This brief discusses the key components of existing disease management and care management programs that could be incorporated into integrated care programs for Medicare-Medicaid enrollees and other high-cost, high-need Medicaid beneficiaries. It describes best practices in disease management/care management models and provides examples of care management practices used in the financial alignment demonstrations for California, Illinois, Massachusetts, South Carolina, and Virginia.[3]

The Evolution of Disease Management to Care Management

Nearly 30 years ago, an interest in improving clinical outcomes spurred the creation of the first disease management programs. These programs focused on improving care for a *single* chronic illness such as congestive heart failure or diabetes through the use of clinical practice guidelines, patient education programs, and other tools.

Over time, there was increasing recognition that improving the quality of health care and reducing health care costs requires a broader approach that targets *multiple* co-morbid diseases simultaneously rather than a single diagnosis.[4] Individuals with multiple chronic illnesses are more likely to receive fragmented, low-quality, and high-cost care because they use so many health services, including behavioral health care and long-term services and supports, from many health professionals across a variety of settings.[5] Thus, there has been a movement away from condition-specific disease

IN BRIEF: This brief highlights best practices in disease management/care management programs and considers ways in which states can incorporate them into integrated care models like the Centers for Medicare & Medicaid Services financial alignment initiative for Medicare-Medicaid enrollees and other state initiatives for high-cost, high-need Medicaid beneficiaries.

management toward programs that manage multiple aspects of an individual's care.

Today, these principles have been incorporated into care management programs that aim to manage the many needs of the whole person across a range of health and social service settings, from the home to ambulatory care to the hospital and to post-acute care.[6] Evidence indicates that care management can, under certain circumstances,[7] improve outcomes for certain people with chronic conditions by: [8-10]

- Improving provider-enrollee communication;

- Increasing beneficiaries' adherence to recommended medication and self-care regimens;

- Facilitating greater communication between physicians and other care providers; and

- Encouraging greater use of evidence-based care.

Given the patterns of co-morbidity within their Medicare-Medicaid populations, most state Medicaid programs are no longer relying on traditional disease management programs focusing on one condition.[11,12] Instead, states have been expanding condition-specific disease management programs to make them more like care management programs, although they may continue to use the term "disease management." Likewise, industry definitions of "disease management" have evolved to reflect the need for a whole-person approach.[13] This brief uses the term "disease management/care management" or "DM/CM" to refer to programs that go beyond a simple condition-specific approach. This brief also refers to the individuals providing DM/CM as "care managers."[14]

Basic Components of Disease Management/Care Management Programs

Some states have focused on DM/CM with the goal of improving health outcomes and reducing costs. While some studies of DM/CM programs suggest a positive impact on cost savings and quality, the evidence is not strong enough to support conclusive statements about the most effective program settings, components, or strategies.[15] However, studies do identify some basic components of DM/CM, highlighted below, that can also apply to broader integration efforts, so long as states plan for the special challenges facing high-need, high-cost populations.[16-20]

1. **Targeting efforts to those most likely to benefit.** Evidence shows that interventions that are designed to target beneficiaries at significant risk of hospitalization in the coming year can demonstrate impact. Even among targeted groups, however, the impacts are mainly observed in the high-risk subset of the overall study population.[21]

   Many states pursuing financial alignment demonstrations target high-intensity care management to enrollees with the greatest risk of long-term institutionalization or avoidable hospitalization. South Carolina, for example, identifies these individuals using information on demographics, medical conditions, functional status, care patterns, resource utilization data, and relevant risk scores (e.g., Hierarchical Condition Category, Clinical Risk Groups, etc.). In addition, enrollees in a home and community-based services (HCBS) waiver are automatically stratified as high risk.

2. **Conducting comprehensive assessments to identify needed services and develop a care plan.** By requiring care managers to conduct assessments, states may determine the presence and severity of chronic conditions among beneficiaries and identify potential co-morbid conditions. The information that DM/CM programs collect in the assessment forms the basis for an individualized care plan, which establishes a course of action that takes into account an enrollee's goals and preferences. Many states recognize that comprehensive assessments should take place shortly after enrollment to identify needs, and assessments should be repeated regularly so that care plans reflect the changing needs of enrollees. Those with complex care needs will likely require more frequent and more comprehensive assessments to determine how they function in their daily lives and the extent of their family and other social supports.[19]

In Massachusetts' financial alignment demonstration, Medicare-Medicaid Plans are required to assess a number of domains, including: immediate needs and current services, functional status, personal goals, accessibility requirements, housing/home environment, employment status and interest, food security and nutrition, and social supports. Plans must conduct a comprehensive assessment within 90 days of enrollment and at least annually thereafter.

3. **Ensuring in-person contact between beneficiaries and care managers.** Telephonic, population-based approaches may not be well suited for high-need, high-cost beneficiaries who may be more difficult to contact and have more complex health care needs.[20] Programs for these populations should consider including some form of in-person contact with a care manager.

   For high-risk enrollees, Illinois requires a member of the care team to engage in face-to-face contact with the enrollee at least once every 90 days or more frequently, if specified in the HCBS waiver. Washington also requires face-to-face interactions in its demonstration in order "to build essential trusting relationships that will foster beneficiaries to effectively communicate their needs, expectations, and strategies to meet their self-defined health goals."[24]

4. **Using appropriately trained care managers.** Many programs rely on care managers who are either licensed nurses or certified nurse case managers to deliver most of their interventions.[21] Though clinical expertise is useful for

such positions, care managers should also demonstrate the ability to help determine beneficiaries' goals and preferences as well as their health care needs.

Illinois, for example, requires Medicare-Medicaid plans to establish policies for appropriate requirements for care managers, which could include assigning enrollees with higher-level needs to care managers with clinical backgrounds such as registered nurses, licensed clinical social workers, and rehabilitation specialists. These care managers may also have community-based experience working with the elderly, persons with disabilities, including developmental disabilities, and person-centered planning approaches. Low risk enrollees may be assigned care managers with non-clinical backgrounds, such as counselors or peer support counselors.

5. **Requiring care management team composition that meets enrollee needs.** DM/CM programs should draw on a wide variety of professionals, including physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, educators, and social workers.[26] Some programs have found social workers especially valuable in assessing eligibility for and arranging services.[27] For high-need, high-cost beneficiaries, the care team might also include community mental health workers, peer specialists, personal care assistants, physical and occupational therapists, and family caregivers.[28] The mix of professionals will vary across beneficiaries and over time, as their needs change.

California specifies a wide variety of professionals that may participate in its demonstration's care teams, including: designated primary care providers, nurses, case managers, social workers, patient navigators, county social workers and service providers, senior service coordinators, pharmacists, behavioral health service providers, and other professional staff within the provider network. The team can change according to enrollee preferences, and

the enrollee can choose to limit or disallow altogether the role of county waiver service providers, family members, and other caregivers on the team.

6. **Facilitating timely communication of changes in health status and service use.** Rather than rely solely on claims data to inform DM/CM, states may obtain more timely health information, including that submitted directly from providers and care managers and/or electronic health records.[29] This is especially useful to track hospital and emergency room admissions.

In South Carolina, Medicare-Medicaid Plans have access to a unified system called Phoenix, which integrates waiver intake, service planning, assessment, and authorization information, and alerts users to changes in status. For example, Phoenix will notify the health plan when an assessment is being conducted and again when the assessment and level of care determination are complete. Care managers can then access the results of the assessment and incorporate its contents into care planning.

7. **Fostering interaction among care managers and providers.** Communication across the care team is the key to coordinated care. Research shows that two main factors affect the strength of the relationship among care providers: (1) having the same care manager work with all the beneficiaries for a given primary care provider; and (2) occasional opportunities for care managers and providers to interact in-person.[30]

South Carolina facilitates interactions between care managers and providers from the beginning by requiring that waiver care plans are discussed in a three-way conference between the waiver case manager, state staff reviewer, and Medicare-Medicaid plan. This conference allows all parties to discuss the service recommendations, ask questions, or request a review from an independent ombudsman if there is a disagreement.

When one care manager works with all of a primary care provider's patients, it improves communication and makes the care team's relationships stronger.

8. **Promoting self-management.** Studies have shown that teaching beneficiaries about self-care, including recognizing symptoms, adhering to diet and exercise recommendations, and taking medications properly is a distinguishing factor of successful DM/CM programs.[31]

   Massachusetts recognizes that the focus and content of health promotion and wellness informational activities must be relevant to the specific health needs and high-risk behaviors in the population. It requires that Medicare-Medicaid Plans provide a range of activities for enrollees, their family members, and other significant informal caregivers. Topics could include chronic condition self-management, smoking cessation, nutrition, and prevention and treatment of alcohol and substance abuse.

9. **Using evidence-based tools and protocols.** States frequently distribute evidence-based care guidelines and protocols to providers to standardize and improve care.[32] A basis in reliable evidence increases the likelihood that an intervention will be effective and is particularly important when trying to convince state leaders, providers, and stakeholders to support and engage in the planned intervention. During the development stages, states should also solicit input from care managers and other staff who will be asked to use the various tools. The greater the

involvement of stakeholders, the more likely it is that a program will generate buy-in from frontline staff.

Virginia requires that Medicare-Medicaid Plans work with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the nursing facility benefit.

While these components are important elements in a DM/CM program, the emphasis given to them may vary based on the population of interest and the organizational and financial contexts of the program. For example, extensive clinical training of care managers may be good practice for beneficiaries with complex medical needs but less crucial for beneficiaries who primarily require connections to social support services.

Conclusion

Integrated care models, like the Financial Alignment Initiative, present states with an opportunity to increase and enhance DM/CM services for Medicaid-only and Medicare-Medicaid enrollees. To maximize the opportunity, states should incorporate the basic components of DM/CC as outlined in this brief into their integrated care programs to further improve the management of beneficiaries' care.

Endnotes

[1] R. Kronick, M. Bella, T. Gilmer, S. Somers. "The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions." Center for Health Care Strategies, October 2007.

[2] Additional description of integrated care models can be found in the Centers for Medicare & Medicaid's Dear State Medicaid Director letter, dated July 10, 2012 and available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf.

[3] The Memoranda of Understanding and Three-Way Contracts can be found on the CMS Medicare-Medicaid Coordination office site: http://www.cms.gov/Medicare-Medicai-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Financial AlignmentInitiative/FinancialModelstoSupportStateEffortsinCareCoordination.html.

[4] M. Charlson, R. Charlson, W. Briggs, J. Hollenberg. "Can Disease Management Target Patients Most Likely to Generate High Costs? The Impact of Comorbidity."*General Internal Medicine*, 22, no. 4 (2007): 464-469.

[5] E. Rich, D. Lipson, J. Libersky, M. Parchman. "Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions." U.S. Agency for Healthcare Research and Quality, January 2012. Available at http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_11787_956295_0_0_18/Coordinating%20Care%20for%20Adults%20with%20Complex%20Care%20Needs.pdf.

[6] R. Brown. "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses." March 2009. Available at http://socialwork.nyam.org/nsw/care/Brown_Executive_Summary.pdf.

[7] Three types of interventions have been demonstrated to be effective in reducing hospitalizations for Medicare beneficiaries with multiple chronic conditions who are not cognitively impaired: (1) transitional care that engages patients while in the hospital and follows them for 4-6 weeks after discharge; (2) self-management education that uses 4-7 week long community-based programs to "activate" patients in managing their conditions; and (3) coordinated care that identifies high-risk patients and provides them with an initial assessment, ongoing monitoring, and better information exchange between providers. (Brown 2009).

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[9] C. Boult, A. Green, L. Boult, J. Pacala, C. Snyder, B. Leff. "Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's 'Retooling for an Aging America' Report. 2009." *Journal of the American Geriatrics Society,* 57, no. 12 (2009): 2328-2337. Available at http://www.ncbi.nlm.nih.gov/pubmed/20121991.

[10] R. Brown, D. Peikes, G. Peterson, J. Schore and C. Razafindrakoto. "Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients." *Health Affairs*, 31, no.6 (2012): 1156-1166.

[11] R. Kronick, M. Bella, T. Gilmer. "The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions." Center for Health Care Strategies, October 2009.

[12] C. Boyd, C. Weiss, B. Leff, J. Wolff, R. Clark, T. Richards. "Multimorbidity Patterns Analysis and Clinical Opportunities Summaries." Center for Health Care Strategies, December 2010.

[13] The Care Continuum Alliance (formerly known as the Disease Management Association of America) has expanded its definition of disease management to recognize that "the industry has moved more toward a whole person model in which all the diseases a patient has are managed by a single disease management program." The definition of disease management is available at http://www.carecontinuumalliance.org/dm_definition.asp.

[14] Our use of "care managers" encompasses care coordinators, a term often used in the demonstrations.

[15] K. McDonald, V. Sundaram, D. Bravata, R. Lewis, N. Lin, S. Kraft, et al. "Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies." AHRQ Publication June 2007, No. 04(07).

[16] Brown, 2012. op. cit.

[17] McDonald et al., op. cit.

[18] M. Au, S. Simon, A. Chen, D. Lipson, G. Gimm, E. Rich. "Comparative Effectiveness of Care Coordination for Adults with Disabilities." Mathematica Policy Research. July 2011.

[19] D. Esposito, E. Taylor, K. Andrews, M. Gold. "Evaluation of the Medicaid Value Program: Health Supports for Consumers with Chronic Conditions." Mathematica Policy Research. August 2007. Available at http://www.chcs.org/usr_doc/McKesson-CaseStudy.pdf.

[20] For additional discussion of these components see: Integrated Care Resource Center."Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model."February 2012. Available at http://www.integratedcareresourcecenter.com/pdfs/ICRCManagedFFSModels031912.pdf.

[21] R. Brown, A. Chen. "Disease Management Options: Issues for State Medicaid Programs to Consider." Mathematica Policy Research, April 2004. Available at http://www.mathematica-mpr.com/publications/pdfs/diseaseman.pdf.

[22] The targeted conditions were end-stage renal disease, chronic kidney disease, congestive heart failure, asthma, diabetes, and chronic obstructive pulmonary disease.

[23] Center for Health Care Strategies. "Washington State Medicaid: An Evolution in Care Delivery." 2008. Available at http://www.chcs.org/usr_doc/Washington_State_Case_Study.pdf.

[24] Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and The State of Washington Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. P. 84. Available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WACAPMOU.pdf.

[25] J. Verdier, V. Byrd, C. Stone. "Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States." Prepared for the Center for Health Care Strategies and Oklahoma Health Care Authority, September 2009.

[26] E. Taylor, T. Lake, J. Nysenbaum, G. Peterson, D. Meyers. "Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms." AHRQ Publication No.11-0064.U.S. Agency for Healthcare Policy and Research. June 2011.

[27] Brown, 2012. op cit.

[28] Rich et al., op cit.

[29]For example, North Carolina has developed a robust informatics center that, in addition to Medicaid claims, maintains laboratory results, real-time hospital admission/discharge/transfer data, and Medicare claims and pharmacy data for Medicare-Medicaid beneficiaries. Care coordinators, program administrators, and providers are involved in the development of the database to ensure that it meets the needs of end-users. For more information on Community Care of North Carolina's Informatics Center, see http://www.communitycarenc.org/informatics-center.

[30] Brown, 2012. op cit.

[31] Brown, 2012 op cit.

[32] R. Arora, J. Boehm, L. Chimento, L. Moldawer, C. Tsien. Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide. AHRQ Publication No. 07(08)-0063, March 2008.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees and other high-need, high-cost Medicaid beneficiaries. The state technical assistance activities provided within the *Integrated Care Resource Center* are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.