# Managed Care in the Age of Accountability



*by Wendy Tercero, RN, BSN, PHN*

---

*We know that managed care offers opportunities to HIM professionals, but what role does information itself play? This article surveys the kinds of health information that managed care organizations need to make decisions. The author looks at processes related to care delivery and gives examples of the type of information each area requires.*

---

Today value and accountability (cost and quality) are key concepts driving the restructuring of our healthcare system. Accountability is the data-driven response of providers to the demands of payers and consumers regarding the value of the healthcare they purchase. These demands require an organization to provide information that merges clinical, financial, and patient-centered data.

Additionally, as managed care grows, quality and cost will reach equilibrium, and today's economically driven model will have stabilized, turning into one that truly balances cost and quality. Healthcare organizations of the future will need to implement information systems that support decision making. This includes documenting utilization and quality of care and facilitating analyses and reporting information back to individual practitioners and their peers so they can judge their own effectiveness, particularly when addressing the needs of high-risk populations. Such data-driven provider feedback has the potential to favorably impact admission and emergency visits and adherence to clinical pathways, guidelines, and protocols.

## Information for Managing Across the Continuum

In a managed care environment, the healthcare organization -- whether a traditional HMO or a provider group operating under a fully capitated contract -- may be delivering all of the healthcare services required by a population of people. This environment demands more sophisticated management of patient care processes. Rather than waiting until people develop health problems and then reactively treating those problems, it is necessary to manage patient wellness to minimize costly hospitalizations and improve all aspects of patient care quality.

This article provides an overview of the care delivery processes used today in many managed care organizations, coupled with examples of the types of information an organization would require in order to support the ongoing monitoring and management of these processes.

## Managed Care Organization Healthcare Delivery Management Processes

### Case Management

In the past, case management was widely recognized as a central tool to screen, assess, plan, and evaluate the care of patients with specific disease conditions or functional impairments. Today, the definition of case management has changed somewhat with the institution of governing practice standards and a credentialing process. Case management no longer focuses primarily on disease conditions and is now more broadly defined as a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. Another distinction is that case management occurs across all care settings along the continuum of care, representing both the payer and provider. The case manager may become involved with individual families, assist in planning the redesign of a home for a newly disabled patient, or even be called upon to intervene with a patient's employer. Different types of case management include telephonic, mostly for wellness and preventive care, on-site, for involved and catastrophic illness, and utilization case management.

The case management process is a comprehensive process with an essential role in each of the following processes:

**Disease Management**

One of the greatest challenges of any healthcare organization is caring for the particular needs of a few while efficiently managing the more common needs of many. What has been discovered, as more disease management programs are implemented, is that providing effective coordinated care to those with specific disease states not only optimizes the outcomes of the few, but actually improves the health of the many and the overall efficiency of the healthcare organization.

Disease management involves the integration of care for persons with special healthcare needs. By creating a distinct discipline for disease management, the managed care organization has replaced what has been the domain of the primary care physician, with the coordination of care to provide a complement of services aligned by common protocols and collaborative practices to enhance the efficiency, effectiveness, comfort, convenience, and outcomes associated with specific disease states. Disease management may be facilitated via the primary care physician or may be managed by a separate functional unit in the managed care organization.

*Information Needed for Disease Management*

1. Reports that contain summarized data collected from new member assessments that include the member's description of his/her healthcare needs, preferences, and health status. (This information is used as a baseline for individual coordination of care and helps to guide organizational priorities for risk reduction in populations at large)

2. Reports that provide information about the incidence of targeted disease states at the summary and individual member level of detail

3. Information that allows the organization to track the disease management process. This type of information includes data that is used to measure the effectiveness of disease management interventions by comparing managed care organization performance against appropriate internal or external benchmarks, e.g., annual inpatient admissions per thousand for asthmatics and tracking variances to established disease protocols and pathways

4. Reports of key performance measures that the organization has defined as key measures. These may include measures such as frequency of preventive services, adequacy of and access to the continuum of care, and the effectiveness of the screening and follow-up programs for the disease population

5. Utilization information from pharmacies and laboratories for the disease management member population. The case manager uses this information to track medication and lab test compliance to protocols defined for the disease management program

6. Health outcomes information for the disease management population, both for the individual member and for the particular group of members participating in the program

7. Cost and quality outcome information for comparative analyses for the organization, to evaluate implementation costs and overall savings realized from the program

**Wellness Management**

Recent studies have attributed nearly 1 million deaths annually and 70 percent of treatment costs to preventable diseases. Prevention and wellness comprise two main areas. One is related to lifestyle and emphasizes good nutrition, exercise, stress management, and smoking cessation, and the other addresses medical conditions that may be modified or avoided by means of immunization or screening and monitoring programs.

Healthcare reform and increasing costs have served as a catalyst for delivery systems to learn that costs can be controlled more effectively by keeping the population healthy and preventing disease than by treating disease. Accordingly, managed care organizations are paying closer attention to the composition of the covered population as well as measuring and monitoring the overall general health status of the population. They are doing so by proactively identifying high-risk populations within the membership and providing a greater emphasis on health promotion and wellness.

*Information Needed for Wellness Management*

1. Information obtained from new member assessments, functional/ health status, and patient perception of illness/wellness (this information can be used as baselines for individual coordination of care and guide organizational priorities for risk reduction for the overall member population)

2. Utilization reports of member participation in self-care programs and related self-care literature

3. Cost and quality data for comparing populations who have participated in self-care wellness programs with those who have not done so to evaluate the impact of the programs on the utilization for visits to the primary care practitioner (PCP), ER, and in the acute setting

**Demand Management (Health Management)**

The future of managed care will demand a member-focused, high-quality care delivery system combined with appropriate costs. Only then will healthcare have realized its full potential for providing value to the community.

A member-based focus will require more ownership on behalf of the enrollee/consumer of care for his or her well-being. It will require a greater sense of accountability on behalf of the provider and overall delivery system. In essence, it will forge a partnership between the member and the provider.

Demand management focuses on reducing need and demand for medical services. Reducing need involves wellness and prevention programs; reducing demand involves education and consumer empowerment to change care-seeking behavior. Managed care organizations and employers are recognizing that to improve health outcomes and lower healthcare costs, organizations need to actively involve the consumer in daily healthcare treatment decisions. Demand management focuses on meeting this goal through the use of self-care materials, nurse advice lines, and access to in-depth health information.

Anther key component of demand management is shared decision making; this encompasses consumer empowerment to allow participants to participate as informed partners with providers. Utilizing the demand management concept, the culture of healthcare for the 21st century can be described as the patient participating as a decision maker with a provider, the provider being a partner, and patients and providers sharing information. The demand management concept of patient empowerment essentially refers to self-care. Currently, the majority of care is office based and PCP driven. As managed care continues to evolve, a paradigm shift will occur, and self-care will be in the majority of the care delivery model.

The numbers may look like this:

| | Today | Future |
|---|---|---|
| Office-based care | 85% | <15% |
| Self-care | 15% | >85% |

*Information Needed for Demand Management*

1. Reports used to track member utilization of access to nurse advice line activity and the particular protocols used as a result of the nurse advice line activity

2. Quality outcome reports of protocols and key performance measures related to the protocols to support the continuous improvement process

3. Cost information coupled with the utilization information that provides a snapshot of whether the program is having an effect on the member population and its utilization of services

4. Pure utilization information to evaluate organization utilization across the continuum and to allow for comparisons to previous time periods (decreased ER visits, PCP visits, and specialty referrals, decreased visits for specific populations, symptoms, and complaints)

5. Outcome information collected on an established set of indicators that measure "before and after" quality and satisfaction with the implementation of a self-care intervention

**Quality Management**

Healthcare providers and managed care are increasingly being held accountable for the quality of the services they provide. Quality is a broad concept, but in healthcare it is typically seen as having four distinct aspects:

- structure quality
- care and service quality outcomes
- process quality
- member satisfaction

*Information Needed for Quality Management*

*Structure quality* -- information on how well the organization is structured to meet the needs of the member population it serves. This includes data about provider credentials, adequate locations of providers and facilities, and compliance with state and federal regulations

*Process quality* -- an organization requires information about its overall process quality. Data is compiled and reported back to the organization about providers and compliance to clinical pathways and guidelines established as standard process for the organization, as well as information on the variance from the pathways/guidelines

*Care or service quality information* -- this type of information includes:

- quality data collected to provide information on key performance measures across each encounter for the membership. This provides a metric for the health status achieved or maintained by a person at least in part as a result of the healthcare services provided by the organization
- summary and detail-level reports on quality data across the encounter and the episode of care for the membership, as well as for each provider group and individual provider
- utilization reports related to alternate site care settings (subacute, rehab, SNF, home) and the impact on the quality outcome
- quality reports related to care delivery at alternate-site care settings

*Member satisfaction (patient-centered data)* -- this type of information is by far the most challenging for the managed care organization to collect and turn into usable information:

- data collected from survey forms and compiled to provide information to the organization about the perceived level of quality through the eyes of the individual member served by the organization
- reports to the organization providing the percentage of individuals who felt wait times were not too long, that physician attitude was appropriate, and that the food was satisfactory

Collectively, this summarized quality information is stored to support trending of targeted performance measures (cost and quality) for comparative analysis and benchmarking across the organization and between organizations. These trended analyses are reported to executive management and accrediting bodies.

Two case examples of care delivery utilizing the managed care processes and information described in the previous section follow.

## Case Examples

### Case 1

A member is admitted to the ER for heart failure and subsequently transferred to the subacute care area for monitoring. A case manager for the subacute area contacts the case manager who represents the patient's health plan or payer.

*Intervention:* The patient receives care coordinated by the case management team, which includes the following:

- education related to routine cardiac care and warning signs of potential problems. All family members and potential caregivers are included in this education process
- a coordinated care plan with scheduled monthly visits to the specialty heart care clinic
- a referral to the telephonic case management program, in which the patient will be monitored by a case manager who checks (via telephone) that the patient is taking the prescribed medication and following the proper diet and plan of care as defined on discharge
- visits by the cardiac home health specialist in between visits to the specialty clinic (this intervention often avoids a needless hospital admission)

*Result:* Patient is discharged two days earlier than expected, medications are prescribed to speed recovery, and visits to alternative care delivery sites keep costs to a minimum. Patient satisfaction is reported to the hospital and the payer as 100 percent satisfied with the process. The case management team is successful in meeting utilization and cost goals.

Health information assists this organization to continue to fund and support proactive intervention programs like these (case management, wellness management, and telephonic case management). Information on the effectiveness of the case manager, the impact of the specialty care efforts, and alternative care delivery sites on utilization and costs provide the justification.

For example, reports will indicate the following to the organization decision-makers:

- reduction in acute admission costs
- reduction in length of stay costs
- comparative utilization and cost reports on pre- and post-implementation of telephonic case management program indicate a reduction in visits to PCP and the ER as well as a reduction in admissions
- comparative utilization and cost reports on pre- and post-implementation of alternate site care settings indicate a reduction in visits to PCP and the ER as well as a reduction in admissions
- utilization and quality outcome reports show a positive impact on the overall health of the membership
- patient satisfaction with care given is reported at 100 percent

### Case 2

A group of primary care practitioners would like to receive approval to see certain patients who, under the current protocol, are an automatic specialty referral. To get this approval, the group decides to implement several protocols with very specific process and outcome measures for the following specialty areas: tennis elbow, EKG testing and evaluation, and minor dermatological conditions (acne). Additionally, all patients who meet the criteria for the protocol and are treated according to the protocol are asked to complete a patient satisfaction survey.

The group collects this information in a database for six months and generates the following information in a report:

- total number of eligible participants and total number of actual patients who followed the new protocol. Included in this report are the treating practitioners and total number of specialty referrals. This allows the group to identify practitioner compliance with new protocol as well as the utilization of specialty care by practitioners who did not comply with the protocol

- comparative cost and utilization information on pre- and post-implementation of new protocols. This report indicates substantial savings on specialty care costs

- quality outcome information that indicates no change in quality outcome to patient when treated by the primary care practitioner or by the specialty care practitioner

- patient satisfaction with new protocol is 100 percent, and most comment that they prefer a "one-stop shop" instead of being shuffled from one practitioner to another

This information is shared with health plan executives. The results are so impressive that the health plan implements similar protocols across all network providers and continues to use the information to evaluate needs for primary and specialty care on a regular basis.

What is more impressive in this example is that the reduction in specialty referrals equal an overall reduction in costs without significant impact on the outcome to the patient, and the patients report that they prefer the new process and are 100 percent satisfied. Quality of care has not been affected by providing cost-effective care.

## Conclusion

In total, comprehensive information is needed to support the prospective planning of patient care capabilities and methods available in a healthcare organization and to support the ongoing evaluation of clinical practice to assess all forms of patient care and the quality of services rendered.

Inherent in the types of information described above are the types of information that regulatory bodies require, especially if an organization is able to generate some information related to quality and performance, patient satisfaction, wellness, and utilization. This topic alone would merit an article of its own, based on some of the demands and challenges of getting the data and reporting on the types of information regulatory bodies require.

Planning and evaluation are both components of continuous enhancement of the value delivered to the community, health outcomes achieved, service quality, appropriateness of care, cost, and efficiency -- and focus on the relationships between these variables. Further, planning and evaluation activities can span all care delivery settings to provide an integrated view of the delivery system from an episode of care or population perspective and span the continuum of preventive care, acute care, and chronic and rehabilitative care. Health information management professionals will need to provide information to the decision makers for sophisticated planning and evaluation of a number of different processes or aspects of care delivery management.

## References

Aspen Publishers. *The Healthcare Software Sourcebook.* 1997. Gaithersburg, MD: Aspen Publishers, Inc., 1997.

Aspen Publishers. *The Managed Healthcare Handbook.* Gaithersburg, MD: Aspen Publishers, Inc., 1996.

Born, Patricia, and Cheri Geckler. "HMO Quality and Financial Performance: Is There a Connection?" *Journal of Health Care Finance* 24, no. 2 (1998): 65-77.

*Capture & Use Data to Measure, Monitor & Manage the Total Delivery of Care.* Philadelphia, PA: Global Business Research LTD, 1997.

*Clinical Population-based Key Indicators.* Seattle, WA: Clinical Planning & Improvement, Group Health Cooperative, 1996.

Donabedian, A. "Evaluating the Quality of Medical Care." *Milbank Memorial Fund Quarterly* 44, no. 3, supp. (1966): 166-206.

*Healthcare Outcomes and Accountability.* Washington, DC: Zitter Group, 1997.

---

***Wendy Tercero*** *is a project management associate in QuadraMed's health information solutions division, Hermosa Beach, CA. She can be reached at wtercero@aol.com.*

---

**Article citation**:
Tercero, Wendy. "Managed Care in the Age of Accountability." *Journal of AHIMA* 70, no.4 (1999): 20-24.

---