



Care Management Value: Outcomes, Transparency Focus

Do care management programs provide value? I would argue that they do, but not in the way that vendors have measured value in the past. For years, care management vendors have used ROI as the primary measure of program success. And since that first ROI report was delivered to the first care management program purchaser, ROI has been hotly contested, and cast as inaccurate and inflated.¹

While there are a number of issues related to ROI calculations today – not the least of which is the research methodology – rather than strictly offering financial savings, we see value as next logical step in how care management programs should measure success.

A new take on ROI

A new look at ROI is only the first of three value factors that payers should consider when evaluating a care management program. Care management programs should focus on three key areas:

- impact the most important clinical measures;
- offer transparency into the program’s inner workings; and the
- creation of a partnership between the vendor and payer.

Consulting firm Deloitte recently examined care management in a report targeted at health plans. They, too, challenge the methodologies used, the fall-out from regression to the mean and other issues that impact accurate measurement of ROI. Deloitte, however, suggests utilizing “alternative metrics includ(ing) a mix of operational, interventional and outcome-based results. (T)hese metrics are rapidly becoming proxies for the often-challenged calculation of clinical and financial outcomes related to DM activities.”²

We, too, are re-examining what’s measured and how we measure it to better understand program success. In addition to a new look at program measures, we support opening the “black box” of care management programs by enabling clients to delve into data all the way down to the member level. By implementing programs that improve clinical measures and program transparency, the care management industry creates a foundation that ensures better participant chronic disease management and quality of life.

In addition to a renewed exploration of savings measures, we believe that care management program transparency and vendor/client partnership are ripe for improvement.

Clinical measures

If we take the focus off ROI, what should care management vendors explore to judge a program’s success? While Deloitte suggests

that health plans “evolv(e) their DM programs, adopting a more holistic approach with robust value propositions, clear metrics and outcomes, and focused on the integration of member information and experiences across the health care spectrum” to remain relevant and competitive, we believe that care management vendors should have the same goals.

We’re very interested in pursuing clinical outcomes metrics that have a demonstrated savings and impact on health, and applying these metrics only to participants under active management. The goal is improve specific, important measures rather than attempt to fix every health issue. If we concentrate on just those health issues that have been shown to generate savings, we can make an impact and eliminate gaps in care. We can likely lower costs through gaps-in-care improvement.

The American Journal of Managed Care explored this idea in 2008 when researchers made a number of recommendations concerning the clinical and financial impact of a number of clinical measures.

These are the highlights of what they found:³

- “Output measures are best defined as those that most closely relate to the outcome of a patient’s care, or that have the highest correlation with that outcome.”
- Manage the “measures that are most closely related to the avoidance” of negative health events.
- “Although practices such as taking the patient’s medical history and performing a physical are time-honored parts of the medical evaluation and may be prerequisites to interventions of proven clinical or economic benefit, they do not reduce morbidity or mortality directly—which is the measure of output that is important to payers and purchaser—and as a result have little or no actuarial value.”

We’ve arrived at important measures for a number of chronic illnesses including congestive heart failure, coronary artery disease, diabetes, asthma, chronic obstructive pulmonary disease and depression. The data typically is derived from claims, self-reported by the member or extracted from online health portal usage.

Depending on the disease, we want to know about beta-blocker use, blood pressure, anti-platelet medication, LDL, A1c, flu and pneumococcal vaccinations, controller medications and provider contacts.

Program transparency

Get rid of the “black box.” Most care management programs allow only a limited view of program data with the rest hidden in

arcane data warehouses. Vendors make it difficult to learn how many times participants are contacted or what's discussed during a call. We believe that eliminating the black box and providing a full and open view into program metrics is an essential component of any care management program.

This transparency is key to building vendor trust among payers. The view into program metrics should allow payers to see data down to the member level. Payers should quickly be able to deduce:

- The number of interventions each member receives;
- The communications method used to contact the member and specific messaging; and
- Understand the type of education each member gets.

Care management programs should be ever-evolving. Analysis of care management programs should take place with cooperation between the vendor and the payer. While it seems common sense, vendors should be able to answer any question about the program. Vendors and payers must agree on the program that's offered and why, and, importantly, change the program as necessary depending on outcomes.

When this kind of transparency is available 24/7 to payers, it creates a long-term relationship and lets them see for themselves how well the program is performing.

Partnership

Long-term vendor/payer partnerships are the natural progression of supporting the right clinical measures and providing program transparency. As vendors learn to think more like their clients while bringing expertise and optimized programs to the table, we can expect the relationships to continue to grow and flourish. Better vendor/client relationships benefit all those involved with care management programs.

Conclusion

Bringing together new ways to improve care management—the best clinical outcomes measures, program transparency and the vendor/payer partnership—gives the industry an opportunity to reshape the programs that are offered and bring a better product to payers and participants, alike.

About the author:

Naoise Colgan is Vice President of Care Management Services at McKesson Health Solutions, a provider of care management services to commercial and government payers.

For more information, call 800.782.1334
or email MHS@McKesson.com.

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Sources:

¹"Take Your Meds, Exercise—and Spend Billions." Bloomberg BusinessWeek. February 4, 2010. Accessed December 15, 2010. http://www.businessweek.com/magazine/content/10_07/b4166046292556.htm

²Van Den Eynde M, Rohman A, Haddock B, Arends A. "Disease Management: A changing landscape calls for innovation in commercial health plans." Deloitte. 2010.

³de Brantes F, Wickland PS, Williams JP. "The Value of Ambulatory Care Measures: A Review of Clinical and Financial Impact from an Employer/Payer Perspective." The American Journal of Managed Care. June 2008.