CHCS Center for Health Care Strategies, Inc.

MEMORANDUM

Date: November 14, 2008

To: Dr. Michael Farber and Pat Sardo
Medi-Cal Managed Care Division
California Department of Health Care Services

From: Karen LLanos, Lindsay Palmer, and Melanie Bella
Center for Health Care Strategies

cc: Chris Perrone, California HealthCare Foundation
Vanessa Baird, California Department of Health Care Services

Re: Assessment of Case Management/Care Coordination and Disease Management Activities

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Purpose: As part of the ongoing technical assistance under the *Managed Care for People with Disabilities Purchasing Institute*, the Center for Health Care Strategies (CHCS) is pleased to provide the Medi-Cal Managed Care Division (MMCD) with findings from a survey of Medi-Cal health plans. The goal of this survey was to better understand the types of case management/care coordination and disease management activities currently underway in Medi-Cal health plans. Our understanding is that MMCD will use the survey results to form a statewide health plan work group that focuses on case management and care coordination activities. The ultimate goal of the work group will be to develop contract specifications and policy directives in these areas.

Background: CHCS, in conjunction with MMCD, developed the case management/care coordination and disease management survey. The survey was designed to cover a broad set of topics in order to provide the state with a large baseline of information regarding health plan activities in the areas of case management/care coordination and disease management (see Appendix A for the survey template). The plans were given two and a half weeks to complete the 77-question online survey. CHCS received completed surveys from 21 out of the 24 health plans (see Appendix B for survey responses). Since MMCD stressed the importance of providing confidentiality for the plans, the identities of the respondents are not disclosed.

The attached summary highlights key survey findings in three major sections: (1) case management/care coordination; (2) disease management; and (3) potential areas for further exploration by MMCD.
We hope the attached summary of survey findings provides MMCD with a better understanding of the types of case management/care coordination and disease management activities currently underway in Medi-Cal health plans as well as how these activities may set the stage for a care management work group.

SURVEY FINDINGS: Medi-Cal Health Plans Assessment of Case Management/Care Coordination and Disease Management Activities

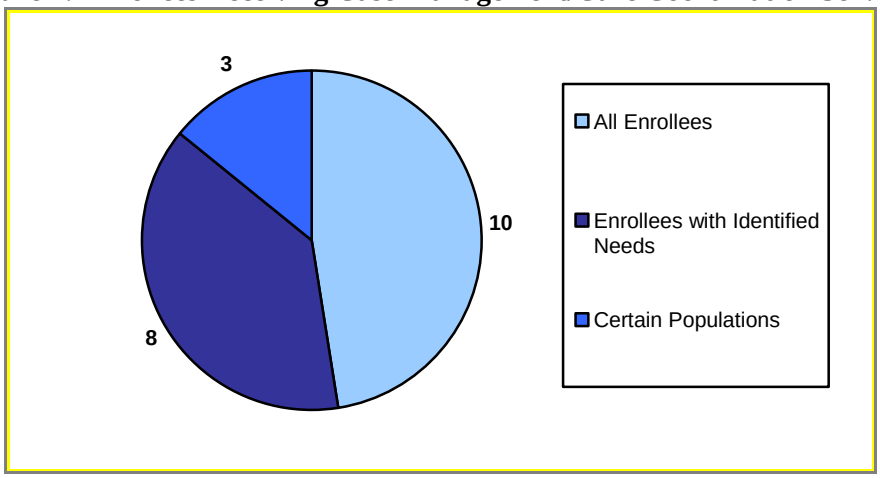
I. Case Management/Care Coordination Activities

For this survey, case management/care coordination was defined as activities which include the identification and assessment of member needs; advocacy; and the facilitation and coordination of a care plan and carved-out services (e.g., clinical, social, educational and other services needed by the member.)[1] These services are essential for populations with complex conditions, especially for seniors and people with disabilities (SPD) who often need assistance in coordinating and managing care provided by the health plan. As the current Medi-Cal contract contains few specific requirements in the area of case management/care coordination, it will be helpful for MMCD to have a better understanding of how the plans approach case management/care coordination activities.

Overview

All 21 plans provide some type of case management/care coordination services; however, they differ somewhat as to which members are eligible to receive them. Nearly half of the plans (10) provide case management/care coordination services to all enrollees. Eight plans indicated that these services are provided to members who have been identified as having case management/care coordination needs, key diagnoses, and/or chronic conditions. The remaining three plans only provide case management/care coordination services to certain groups of enrollees such as dual eligibles, those with a nursing home level of care, and those who are considered to be high-risk.

Figure 1: Enrollees Receiving Case Management/Care Coordination Services



Terminology Used

Since MMCD does not currently use a standard term for describing these types of activities, plans were asked about the terminology used to describe them. More than half of the plans (14) use the term "case management," while three plans use "care coordination." Two plans use both terms. The remaining two plans use the term "care management." When asked if they differentiate between case management and care coordination, the majority of plans (13) do not. For those that do differentiate between the two terms, many view care coordination as a component of broader care management activities. These plans view care coordination as an activity that is often specific to an event (e.g., admission to or discharge from

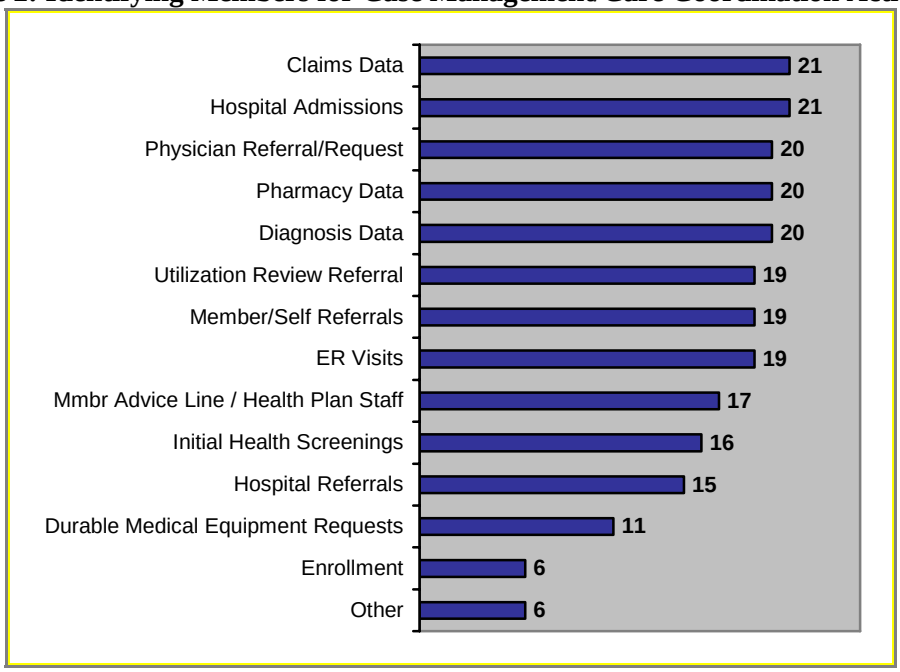
[1] Definition taken from the *Performance Standards for Medi-Cal Health Plans Serving People with Disabilities and Chronic Conditions* report (CHCF, 2005).

hospital or nursing home) and is performed by licensed physician's assistants and/or nurses. Case management, on the other hand, is viewed by these plans as an ongoing service performed by the health plan. Another plan views case management as a service pertaining to medium to high acuity patients, while care coordination pertains to patients with lower acuity needs.

Identifying Members for Case Management/Care Coordination Activities

The plans use a variety of methods to identify members for case management/care coordination activities (Figure 2). All 21 plans use claims and hospital admissions data to make referrals for case management/care coordination. Only six plans identify members for case management activities through the initial enrollment process.

Figure 2: Identifying Members for Case Management/Care Coordination Activities*

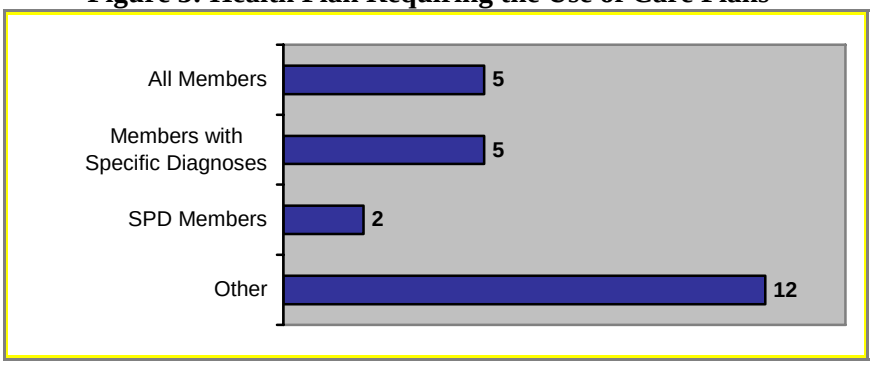


*Plans were able to submit more than one response.

Care Plans

There is significant variation among health plans when it comes to requirements regarding the development of care plans. The majority of respondents require care plans to be developed only for certain subsets of their membership (Figure 3). Only five of the plans require the development of care plans for all members.

Figure 3: Health Plan Requiring the Use of Care Plans*

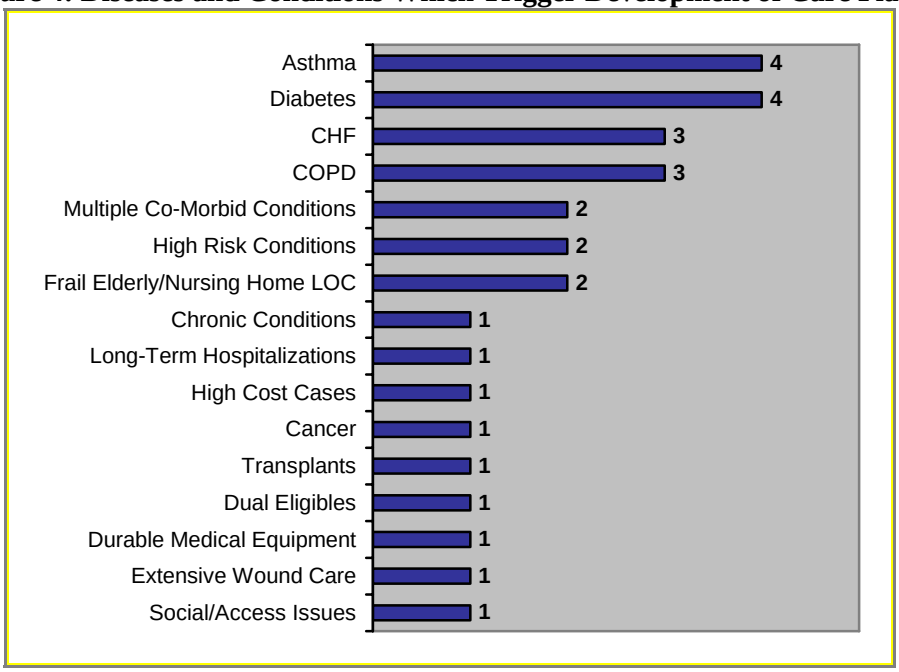


*Plans were able to submit more than one response.

Of those that responded "Other," five plans require the development of care plans only for members who receive case management services. Three plans require care plans for those who are high-risk, while another three plans require care plans for members "as deemed appropriate" or following an assessment. One plan indicated that it does not require the use of care plans.

For the five plans that only develop care plans for members with specific diseases and/or chronic conditions, the most common conditions were asthma, diabetes, chronic obstructive pulmonary disease, and congestive heart failure. A few plans also mentioned one or more of the following as the basis for developing a care plan: comorbid conditions, durable medical equipment, social/access issues, and members requiring extensive wound care (Figure 4).

Figure 4: Diseases and Conditions Which Trigger Development of Care Plans*



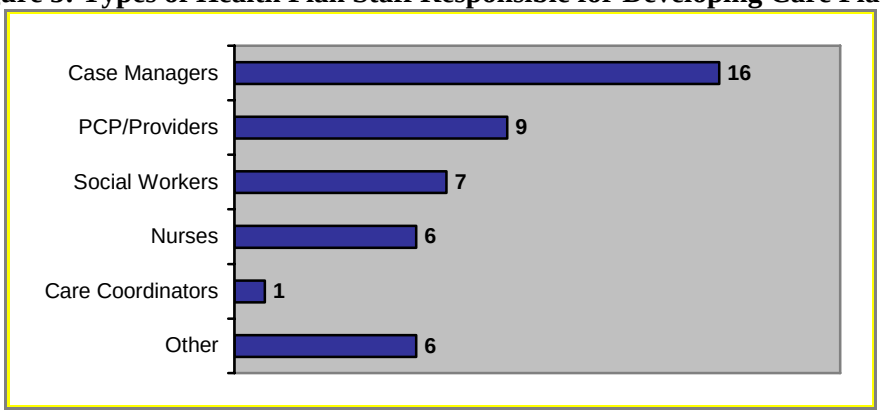
*Plans were able to submit more than one response.

Plans were asked whether the care plans were required to follow a standardized template (e.g., corporate form or per national treatment guidelines). Twelve health plans require the use of a standardized template when developing care plans and four of the health plans do not. Three plans use vendor developed guidelines or software programs. Another plan uses a standardized care plan that can be tailored to individual members. Member involvement in the development of the care plan is discussed below.

The majority of responding plans update care plans as a result of changes in a member's health status. For two additional plans, updates take place at the time of an office visit or during routine follow-up calls. Another plan updates the care plan as frequently as the member requests it. None of the plans have a threshold requirement to update care plans on an annual basis.

The majority of plans use case managers to develop care plans for their members. As described in the chart below, providers and social workers are also heavily utilized in this process. Two of the plans that responded "Other" use members in the development of their care plans as well.

Figure 5: Types of Health Plan Staff Responsible for Developing Care Plans*



*Plans were able to submit more than one response.

Provision of Case Management/Care Coordination Services

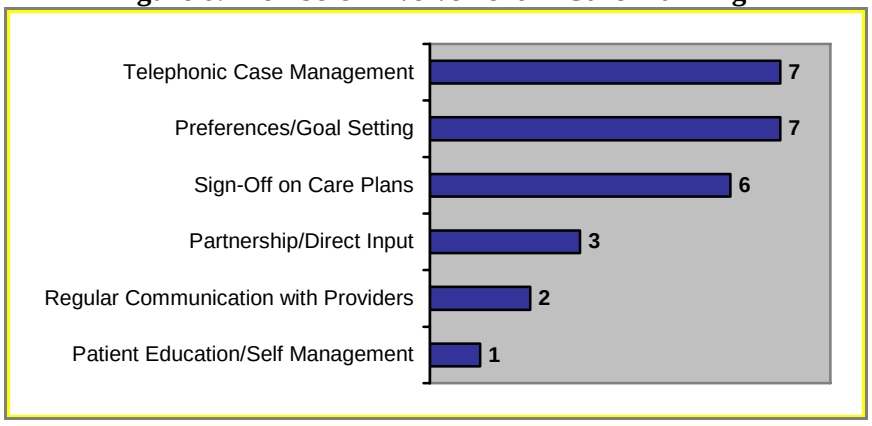
There are a variety of ways in which case management/care coordination activities are provided by the plans. All of the plans indicated that case management/care coordination activities are performed at least in part over the telephone, with over half using mailings as well. Only four plans use home visits as a means of performing these activities, while six plans do so during office visits with providers.

Plans were also asked to identify which health care professionals were responsible for performing overall case management/care coordination activities. All 21 plans use registered nurses and almost half also use social workers. Physicians, support staff, and licensed vocational or practical nurses are each used by close to one-third of the plans. Two plans use health educators, while one uses gerontologists.

Member Engagement

The plans vary greatly in the degree to which members are involved in the development of their care plans (Figure 6).

Figure 6: Members' Involvement in Care Planning*



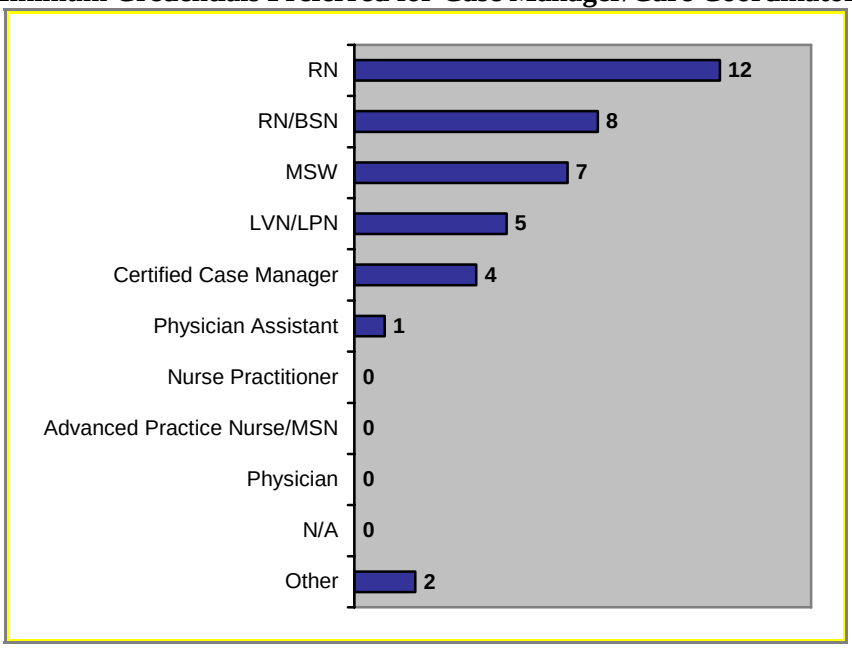
*Plans were able to submit more than one response.

Plans were asked whether or not they use incentives for either members or providers for treatment compliance. Two of the plans offer incentives to members participating in certain programs or who receive certain types of services (e.g., prenatal). The majority of respondents, however, offer no member incentives. One plan indicated that it plans to develop these types of incentives in the future. Similarly, only seven of the responding plans offer incentives to providers.

Staffing

Three quarters of the plans require case managers/care coordinators to receive some type of specialized training. However, only two plans require that case managers/care coordinators be certified in case management. To drill down on this point further, plans were also asked about the minimum credentials preferred for case manager/care coordinator positions. Figure 7 outlines the variation in requirements of the responding plans.

Figure 7: Minimum Credentials Preferred for Case Manager/Care Coordinator Positions*

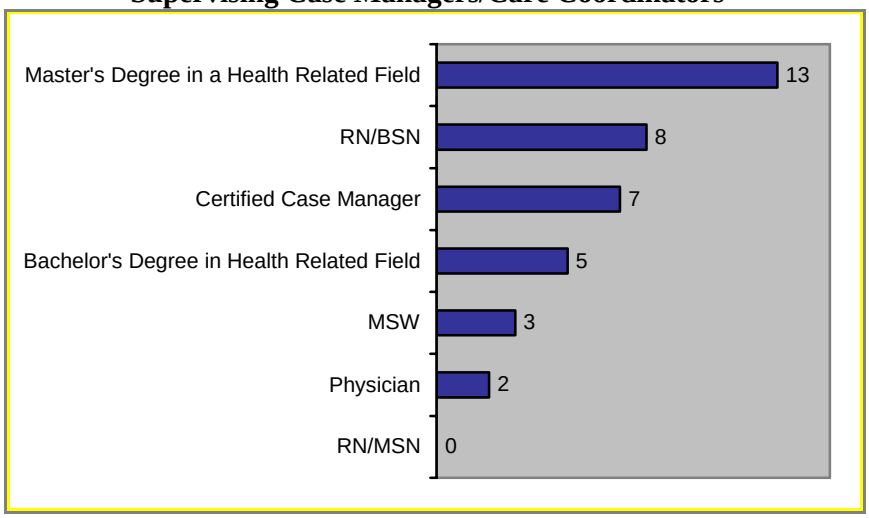


*Plans were able to submit more than one response.

For those that responded "Other," one plan reported a bachelor's degree in a related field as the preferred minimum credential while another indicated its preference is a licensed certified social worker. Almost all plans (18) also indicated they use health plan support staff to assist in the case management/care coordination process.

Plans were also asked about minimum credentials for health plan management staff who directly supervise case managers/care coordinators. Almost all of the respondents (19) indicated they have a set of minimum credentials; however, as with the case managers/care coordinator credentials, the required experience varies. Most plans look for supervisors to be registered nurses (RN) or to have a bachelor's degree in nursing (BSN) (Figure 8).

Figure 8: Minimum Credentials for Health Plan Management Staff Supervising Case Managers/Care Coordinators*

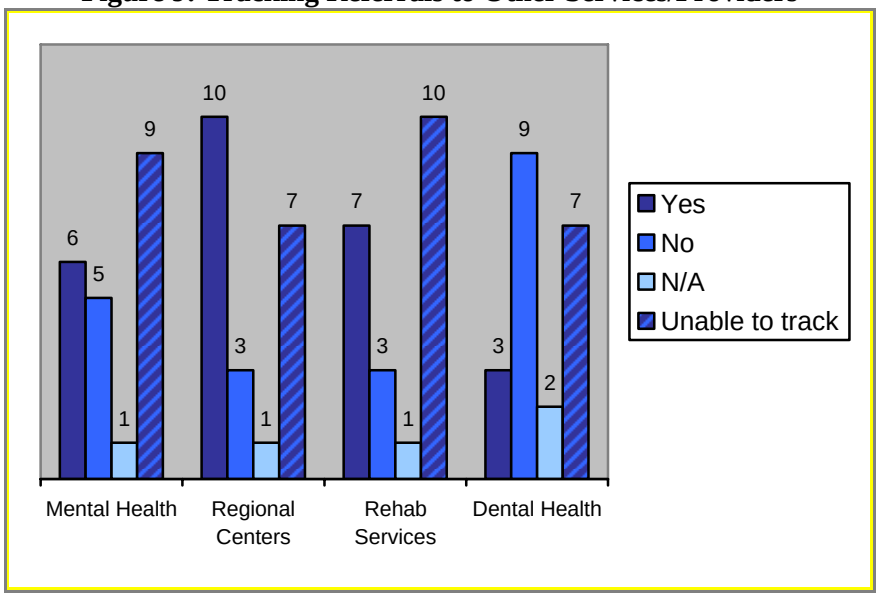


*Plans were able to submit more than one response.

Monitoring and Reporting

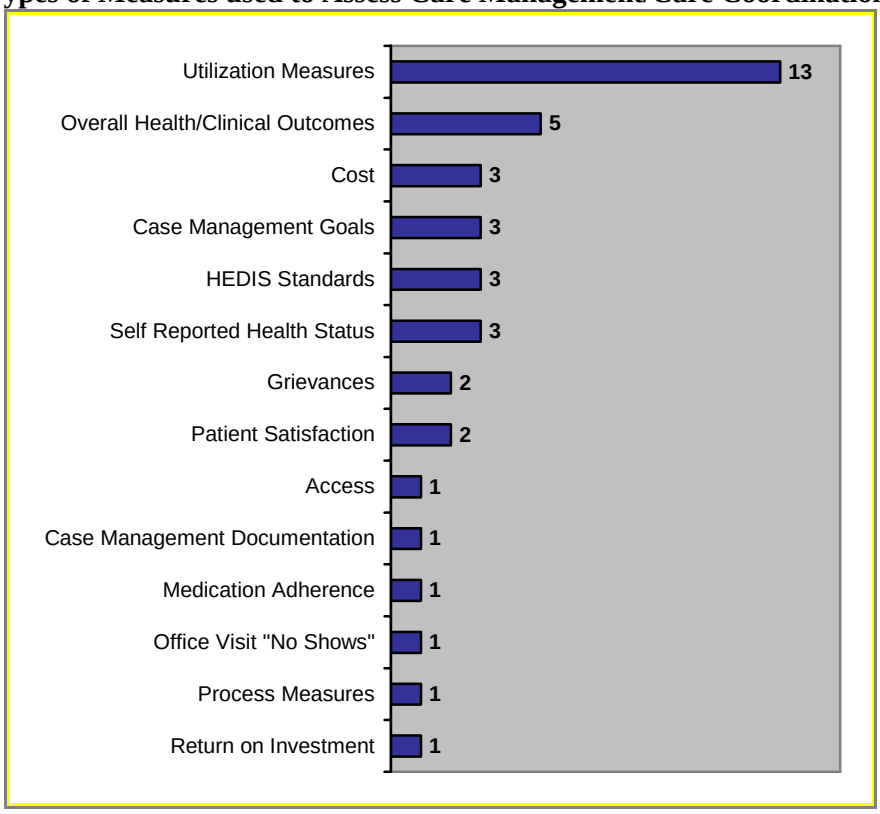
In order for case management/care coordination staff to provide comprehensive services, they need access to information related to all health and psychosocial services members receive. One source of this information is referrals to out-of-plan services. Plans were asked whether they track referrals that are made to other services/providers including mental health providers, regional centers, alcohol/drug rehabilitation services, and dental services. Between one-third and one-half of health plans are unable to track this information (Figure 9).

Figure 9: Tracking Referrals to Other Services/Providers



Plans were also asked about the types of measures used to determine member improvement as a result of case management/care coordination activities. Utilization measures, including those that track admission and readmission rates, are used by most of the plans. Clinical outcomes are also widely used by plans. Figure 10 outlines the measures used by the plans.

Figure 10: Types of Measures used to Assess Care Management/Care Coordination Programs*



*Plans were able to submit more than one response.

Return on Investment (ROI)

Seven of the plans reported using a "return on investment" analysis on their case management/care coordination activities. Of these plans, most measure it based on utilization data and costs. One plan measures ROI informally through member satisfaction surveys and by monitoring disenrollment rates and utilization costs.

Best Practices in Case Management/Care Coordination

Plans were asked to share best practices regarding case management/care coordination activities. Practices/approaches of the eleven plans that responded included:

- Implementing an integrated, multi-disciplinary team approach;
- Using a pyramid model with "high touch" complex case management at the top and population based mailings at the bottom;
- Adopting evidence-based interventions in areas such as care transitions, dementia case management, and motivational interviewing;
- Using case management staff in expanded roles;
- Using technology such as online visits, cell phone text message reminders, and telephonic outreach for screenings with triage for selective home visits;
- Adopting the case management practice guidelines developed through the Case Management Society of America;
- Incorporating standardized procedures, documentation, and reporting; and
- Incorporating culturally and linguistically competent care.

II. Disease Management Activities

The Disease Management Association of America has defined disease management as "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."[2] Complex need populations, including the SPD population, are often more likely to have these types of conditions. Under current Medi-Cal requirements, plans must initiate and maintain disease management programs. However, it is up to the plans to determine which diseases to target and to identify and encourage members to participate.

Overview

All 21 plans provide some type of disease management services for their members; however, there is broad variation in what these activities entail and for whom they are provided. For example, one plan's disease management activities focuses solely on health education materials and programs while another reported that only a cohort of its case management population is referred to disease management services.

Terminology Used

The majority of responding plans use the term "disease management." Of the four plans that use another term, three refer to activities as "health management" and the fourth as the Chronic Care Improvement Program.

Conditions Targeted by Disease Management

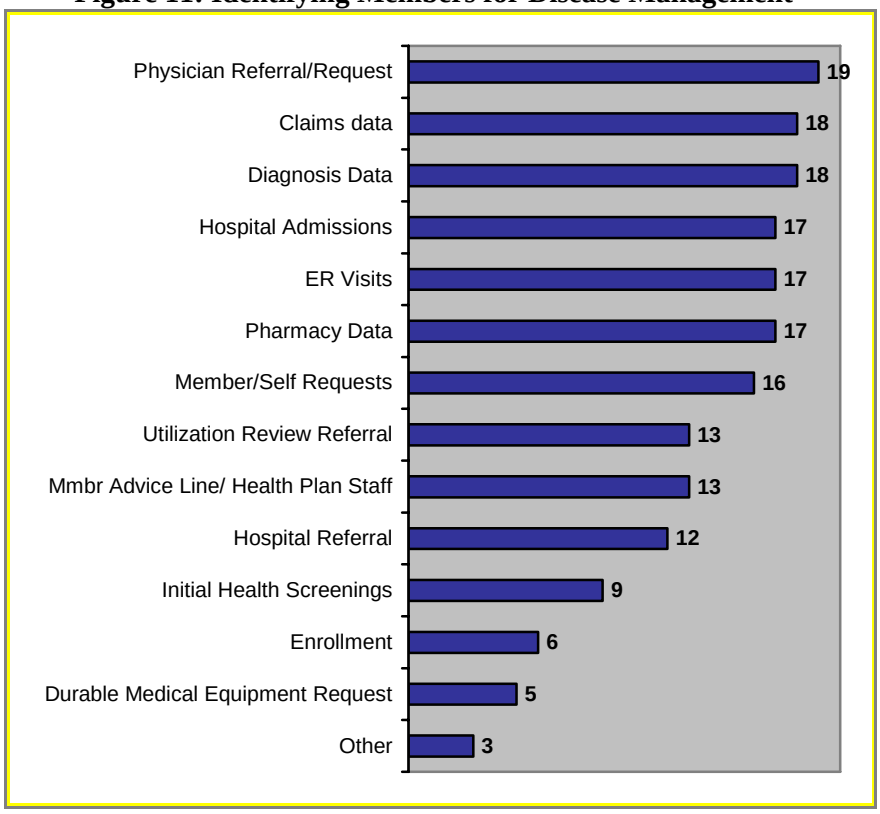
Plans were asked to identify which conditions and/or disease are covered by their disease management programs. Asthma, diabetes, congestive heart failure, and chronic care management/multiple diseases were identified by more than 50 percent of the plans. Coronary Artery Disease, obesity, and prenatal/postpartum were identified by a third of the plans. Pain, catastrophic illness/injury, cancer, and HIV/AIDS are targeted less often.

Identifying Members for Disease Management

As with case management/care coordination activities, plans use a variety of methods to identify members for disease management. Physician referral/requests, claims, and diagnosis data were most often cited as ways to identify members for disease management (Figure 11).

[2] Disease Management Association of America: http://www.dmaa.org/dm_definition.asp

Figure 11: Identifying Members for Disease Management*

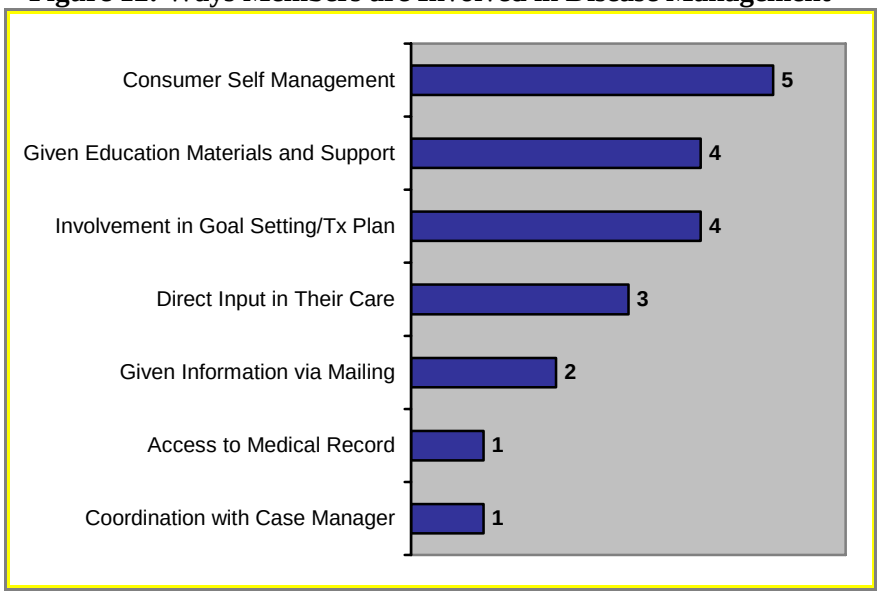


*Plans were able to submit more than one response.

Member Engagement

As with case management/care coordination services, the plans vary greatly in the role that members play in their disease management as shown in Figure 12.

Figure 12: Ways Members are Involved in Disease Management *



*Plans were able to submit more than one response.

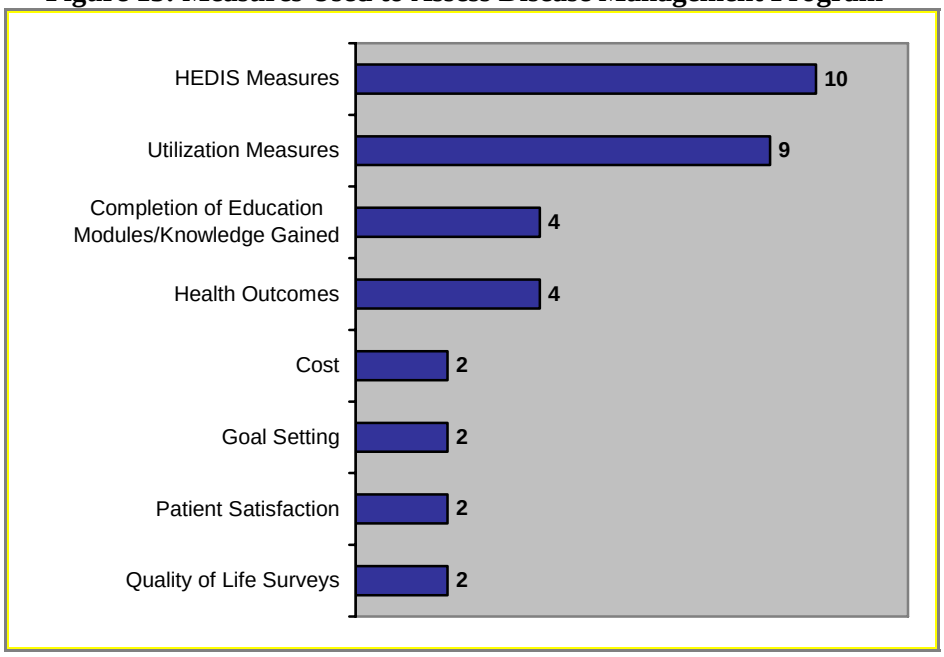
Plans were split fairly evenly in terms of whether they offer member incentives or other rewards for treatment compliance. Twelve plans offer incentives, although two of those plans do so only for certain services/programs. The remaining plans do not offer such incentives.

Seven plans offer incentives to providers. While a couple of additional plans have pay-for-performance programs based on quality indicators or decreased utilization of certain services, they are not specific to member compliance in disease management.

Provision of Disease Management Services
All but one of the plans uses registered nurses to perform disease management functions. Support staff, social workers, physicians, and health educators are each used by four to seven plans. Less reported choices included pharmacists, licensed vocational/practical nurses, and those with a bachelor's degree in a related field.

Monitoring and Reporting
Plans were also asked about the types of measures used to determine member improvement resulting from disease management activities. Utilization measures, including those that looked at both decreased utilization and readmission rates, as well HEDIS measures are used by most plans (see Figure 13).

Figure 13: Measures Used to Assess Disease Management Program*



*Plans were able to submit more than one response.

Return on Investment (ROI)
Only about a quarter of the plans look at the return on investment for their disease management activities. Of these plans, most measure it based on utilization data and costs.

Best Practices in Disease Management
Plans were asked to share any best practices or promising approaches regarding disease management activities.

Of the seven plans that responded, promising practices/approaches include:

- Adopting standardized assessment questions;
- Incorporating identification and risk stratification approaches;
- Utilizing treatment algorithms that are shared with physicians;
- Launching proactive, intensive outreach campaigns;
- Developing educational pathways and materials for members;
- Using pharmacists in disease management;
- Developing disease management databases; and
- Offering member incentives.

III. Potential Areas for Further Exploration

This section outlines five areas for consideration that may serve as a starting point for MMCD discussion of potential changes to contract standards related to case management/care coordination and disease management. These five areas are:

1. Common definition of case management/care coordination;
2. Policies procedures for case management and disease management;
3. Case management/care coordination (provision of);
4. Case management/care coordination for SPD beneficiaries; and
5. Monitoring and reporting.

1. Developing a common definition for case management/care coordination

As mentioned previously, the majority of plans (14) refer to these activities as "case management." Nine plans use their own definition for case management/care coordination. Most plans described case management as a "collaborative process," presumably between the care team and the member. MMCD could use the definitions submitted by plans as a starting point for the MMCD work group in developing a common definition for case management/care coordination (see Appendix C for the definitions submitted by the plans).

2. Using uniform polices/procedures for case management and disease management

MMCD's managed care contracts do not specify requirements related to case management and disease management guidelines.

Plans were asked if they have policies and procedures to guide staff in providing case management/care coordination services and disease management. All 21 plans have some type of policy and/or procedure for conducting case management. One plan uses policies, procedures, and Millman Care Guidelines[3] to guide its case management staff. In regards to disease management, eighteen plans use national guidelines, policies, procedures or training for staff. MMCD could conduct follow-up research to better understand the types of policies and procedures used by plans in an effort to assess the potential for standardization.

Plans were also asked to indicate whether they use clinical guidelines or clinical pathways to ensure that members receive appropriate care for his/her specific disease. Fourteen plans use national disease management guidelines or clinical pathways, three plans use "modified" pathways/guidelines, and three plans reported using "other" (i.e., a combination of national and modified guidelines; Millman Care

[3] Milliman Care Guidelines are evidence-based clinical guidelines. http://www.careguidelines.com

Guidelines). This could be another opportunity for MMCD to better understand the guidelines and clinical pathways used by plans.

3. Providing case management/care coordination

Identifying Members Needing Case Management/Care Coordination: Although plans use a variety of methods to identify members needing case management/care coordination, most appear to rely on claims and hospital admissions data. This suggests that plans may be waiting until a hospitalization occurs to identify members needing case management/care coordination. MMCD could encourage plans to use both prospective (e.g. health screens) and retrospective (e.g. claims data) mechanisms to identify these members.

Mechanisms Used to Provide Care Services: Most plans provide case management/care coordination over the telephone and through the mail. MMCD could suggest that plans consider using a case management/care coordination strategy that ranges from lower-touch (e.g., telephonic care management) to higher-touch case management (e.g., in-home visit) based on the clinical needs of members.

Care Team Approach: Many Medicaid programs use multidisciplinary care teams that are comprised of nurses, physicians, social workers, and mental health professionals to provide care. All 21 plans use registered nurses to provide case management/care coordination. As mentioned earlier, plans also use social workers, physicians, and other support staff to provide case management/care coordination. Based on these responses, it seems that many plans could be using a care team approach. MMCD may want to follow up with plans to confirm this assumption. If most plans are using a care team approach, MMCD could consider sharing examples of how plans are structuring their care teams.

Specialized Training for Care Managers: The majority (75%) of plans require case managers/care coordinators to receive specialized training in current principles, procedures, and knowledge of case management. If plans are using similar trainings for their case management, it may be an opportunity for MMCD to standardize this training across all plans.

4. Modifying requirements related to SPD beneficiaries

The goal of the 2005 Performance Standards project was to assess how Medi-Cal's contract standards could be modified to accommodate a large influx of SPD beneficiaries. Although a large-scale expansion of managed care has not occurred, there is still a significant portion of SPD beneficiaries enrolled in Medi-Cal plans. Since all the plans that responded enroll SPD beneficiaries, there are several areas of opportunity to modify contract standards to ensure that SPD beneficiaries are receiving the most appropriate care possible.

Care Plans: Only two plans require that care plans be developed specifically for SPD members. Other plans only require care plans for members with certain chronic conditions (e.g., diabetes, congestive heart failure, asthma, chronic obstructive pulmonary disease), comorbidities, long-term hospitalizations, high-cost cases, or those requiring intensive care coordination. It is interesting to note that all of the county organized health systems (COHS plans), in which SSI-eligible beneficiaries are enrolled on a mandatory basis, require care plans to be developed for all their members **(**Appendix D shows a break down of survey responses by COHS-only plans). MMCD could identify a core set of chronic conditions that could signal to health plans that a care plan be developed for members with these conditions. The state could also consider reviewing the care plan templates used by plans to see if there is a core set of questions or a standardized template it wants to share with all plans.

Another important consideration in regard to care plans is the periodicity requirements of updating a member's plan. None of the health plans indicated having a threshold requirement to update care plans on

an annual basis. MMCD could consider some type of frequency -- perhaps starting with "trigger events" that could be defined jointly between plans and MMCD.

Guidelines: More than 55% of the plans do not use case management/care coordination guidelines that are specific to SPD beneficiaries. The remaining 45% of plans said they did use these types of guidelines. The COHS-only responses for this question are consistent with the all-plan responses (i.e., three out of five COHS use guidelines that are specific to SPD beneficiaries). As a starting point, MMCD could consider requiring all COHS plans to have these types of guidelines in place. If MMCD decides not to modify its contract standards, at a minimum, the state could consider sharing the types of guidelines used with all plans.

Disease Management: Plans were asked if they used different disease management strategies for people with multiple chronic conditions. The majority of plans use the same disease management approach regardless of a member's condition. There were, however, plans that approach disease management differently. One plan uses a database to identify members with multiple chronic conditions and then tailors disease management calls accordingly. For other plans, disease management is seen as a relevant care strategy only for members with single diseases. In these plans, members with multiple chronic needs are moved out of disease management and into more comprehensive care management programs. Due to the varied responses, MMCD may want to follow up with plans to better understand how it might develop contract standards related to disease management strategies for SPD beneficiaries.

5. Enhancing Monitoring and Reporting Requirements

Plans are mostly collecting utilization measures (e.g., admission and readmission rates) and some clinical outcomes to assess the effectiveness of their case management/care coordination and disease management activities. Since the survey responses provide very high-level information about these measures, MMCD could consider taking an inventory of the specific measures plans collect. Based on this information, the state could determine if there are any opportunities for standardizing measurement requirements.

An area where most plans appear to have problems collecting data is referrals made to dental care, mental health, and drug and alcohol services. Although reasons may vary, many plans have difficulty accessing referral data for services carved-out of the health plan benefit package and provided by fee-for-service providers. MMCD could conduct follow-up conversations with plans and providers to discuss how contract provisions and procedures for referral services can be enhanced to facilitate the exchange of these types of data.

Conclusion

These recommendations are meant to be a starting point for the state in considering opportunities to standardize case management/care coordination and disease management processes. Pending MMCDs priorities, we could also discuss ways to further develop these considerations into contract specifications or policy directives via a work group process.

Appendices

- Appendix A: Survey Template
- Appendix B: Survey with 21 Plans' Responses
- Appendix C: Case Management/Care Coordination and Disease Management Definitions
- Appendix D: COHS-only Responses