Complex Case Management: Payer Perspective

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Previous - Vice President of Accountable Care - iCare
* Medicare Special Needs Plan
  * Dual Eligible for Medicare and Medicaid
* Family Care Partnership
  * Long-term Care
* SSI
* Badger Care
Social determinants of Health

• Income
• Education
• Health/Disease Status
• Genetics
• Family & Social Support
• Mental Health
• Physical & Social Environment

Health Outcomes & Wellbeing
MULTIPLE CHRONIC ILLNESSES

- Lack of Guidelines
  - Conflicting Recommendations

- Shifting Priorities
  - Multiple conditions

- Polypharmacy
  - Medication Management

- Multiple Providers
  - Inconsistent & Duplicative Care
Complicating factors

- Low Engagement
- Communication Challenges
- Navigating the System

Limited Health Literacy

Low Income
- Poor Nutrition
- Inadequate Housing
- Complex Lives

- Adherence
- Social Supports
- Complex Medical Conditions

Substance Abuse & Mental Illness
Other Member Barriers

Family Support

Transportation

Substandard Housing
WHO IS IN CHARGE?

Multiple Case Managers

Multiple Funding Streams

Primary Care & Specialty Providers
Challenge
## Payer Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
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<tbody>
<tr>
<td>Member Engagement &amp; Accountability</td>
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<tr>
<td>Multiple Payers for single member</td>
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<tr>
<td>Multiple case managers</td>
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<td>Shortage of Mental Health Providers</td>
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<td>Easy Access to services for members</td>
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<td>Understanding the population</td>
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<tr>
<td>• High Cost</td>
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<td>• Frequent ER user</td>
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Payer Barriers

- Traditional view of encounters
- Health Information Exchange
- Alignment of incentives & measures
- Meaningful Measures
- Inflexibility of payment models/benefit package
- Member opt-out option
# FOCUS AREAS

| Dedicated Care Coordination teams | - RN as a consultant  
|                                  | - Develop relationship with member  
|                                  | - Case conferences |
| Specialty Teams                  | - Disease Management  
|                                  | - Behavioral Health  
|                                  | - Readmission Prevention |
| Medication Management            | - 90 Day Optimization  
|                                  | - Refill reminder calls  
|                                  | - Mail Order |
| Engage Community-Based Providers  | - Pharmacies  
|                                  | - FQHC/Clinics  
|                                  | - Residential/Group Homes |
Improving Communication, Making Connections, Engaging Members
<table>
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<tr>
<th>STRATEGIES</th>
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<tr>
<td><strong>Member as partner</strong></td>
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<tr>
<td>- Patient Activation Measure (PAM)</td>
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<td>- Health Coaches/Wellness Clubs</td>
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<td>- Member-centered plan/Social Engagement</td>
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<td>- Free phones</td>
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<td><strong>Predictive Analytics</strong></td>
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<tr>
<td>- Intensive Case Management</td>
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<tr>
<td>- Disease Management</td>
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<tr>
<td>- Behavioral Health</td>
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<tr>
<td><strong>Medication Management</strong></td>
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<tr>
<td>- Local Pharmacy partnerships</td>
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<tr>
<td>- Reduce polypharmacy</td>
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<tr>
<td>- Pharmacy Benefit Manager relationship</td>
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<tr>
<td><strong>Engage Community-Based Providers</strong></td>
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<tr>
<td>- FQHC/Clinics</td>
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<tr>
<td>- Community Paramedic Programs</td>
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<tr>
<td>- Residential &amp; Social Service Agencies</td>
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Making Connections

Managed Care Organization

Hospital

Providers

Pharmacies

SNF/LTACH

Community Agencies
MCO AS PARTNER

“We’re here to help you”

“Call me if I can help”

Scripts Filled

Coordinate Other Visits

Providers Call MCO Care Coordinator

Reduce Tension
COMMUNICATION

A REALLY BIG DEAL!

Provider Visits

Home Visits

IDT
SHARING INFORMATION
COMMUNITY HEALTH INFO EXCHANGE

- Community-based clinics
- Residential
- Pharmacy
- Payer
- Health Care Providers
- Social Service Agencies

iCare
INDEPENDENT CARE HEALTH PLAN
IN SUMMARY

Complex Case Management

Requires Multiple Strategies:

- Member-Centered Care Coordination
- Communication Across the System
- Leverage Community Partnerships
QUESTIONS?

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