

Development of Disease Management and Chronic Care Management (moving away from emphasis on traditional Prior Authorization Review)

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Our process is driven by the movement to increasing enrollment of seniors and chronically ill and disabled members in Medi-Cal managed care plans and is not unique or original. We have undertaken the task in the fashion described in the following because of the need to be sparing of resources. It is difficult to conceive because of the numbers of really complex cases of a program as intense in person power as some of the very comprehensive commercial products. But this approach is necessary because of opportunities for acquiring an SPD (seniors and persons with disabilities) population and the limitation in resources with which we are confronted.

At the outset what we are doing to implement a new approach to medical management is made possible by the availability of a dedicated medical business analyst working within the department with direct contact and incorporation as a team member with medical, nursing and review staff during all steps of extraction of data, drill down and preparation for preparation. As noted, with limit on resources and diversity and segmentation into discrete sub-groups, we must choose to do a simpler number of small preliminary drill downs of our population to reasonably focus our interventions on those most where efforts will be effective. This first step is very important to assure understanding of data quirks and development of a focused assessment of needs and useful intervention possibilities.

An approach we have found useful has been fairly quickly done by using simple processes of “look back/look ahead” searches to quickly assess if some changes observed or made in the past (or proposed to test) can be detectable in some preliminary way. This becomes motivation to develop a process on some sub-populations using more small short searches to define the environment and needs before developing a full intervention.

Working with Asthma Disease Management:

We have extracted ED (emergency department) visits and hospital admissions from the group referred to the McKesson Disease Management program before and after referral. The decrease in utilization was about 30% in both ED and Hospital. Preliminary evaluation suggests that this benefit was mostly a result of the effect of guiding relatively new members who were unaware of their benefits or the identity of their primary care physician. Directing them to a proper point of access seemed to have a very desirable effect. This seems to confirm the need to “keep it simple. Our results were similar to the delegated Valley Health Plan, which also contracts with McKesson.

Additional information analyzed was the fact that our Asthma Measure HEDIS rates are not improving and in fact seem to be slipping in an insignificant way (statistically not very significant). As a first take we were struck that only 10 % of our official HEDIS sample were enrolled in the McKesson program. Our composite rates were slightly over 40%. However the HEDIS score in this sub group was over 70%. Clearly if this rate were transferred to our whole cohort the rates would improve.

These disparities may partially be explained by our population spread between county clinics, Kaiser and delegated groups and therefore outside the eligibility for McKesson. We are looking into this question with detail studies.

SPD response:

Based on experience that a major cause of ED visits and “custodial level” admissions occur in the disabled and seniors because of economic, logistical, social isolation and depression we will explore ways to identify important factors in this group. This may require and apply some techniques using general and psychiatric social worker screening techniques and evaluations cases with frequent ED visits. The intervention process can be as simple as causing mental health referrals and medical evaluations.

Intense work with Local CCS (California Children’s Services) and processes:

Another project is working to carefully but laboriously track potential CCS cases, pharmacy treatments and continuous care when transition out of CCS responsibility occurs. We are automating reporting and tracking

preparing to work with the regional centers and long term care groups to develop enrollment and case information that will be used for care coordination.

We are working to slowly mold our formulary into an appropriate vehicle for the SPD members. We have performed look back/look a head studies to demonstrate the immediate effects of formulary changes. This demonstrates a significant savings with an effective change and shows that other changes do not show much benefit. This helps to fine tune our with formulary changes to show the effects.

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