The Chronically Ill and Managed Care

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Managed care institutions differ in their structures and strategies, but their organizational missions consistently include the improvement of community health. Despite this avowed mission, it is increasingly evident that this vital goal remains unmet for certain segments of the communities served. "Vulnerable" populations with "special needs" by definition require special attention. Patients and their families, regulators, insurers, and researchers are recognizing the importance of better serving these special groups. Those responsible for quality improvement, risk adjustment, and outcomes assessment are realizing that service to such groups is a critical component of the managed care model.

Chronically ill individuals have long fought the battles and faced the disappointments inherent in the traditional healthcare system. These challenges are well known to include barriers to entering the system, caused by inadequate insurance coverage; extensive travel times to a specialist; lengthy wait times for an appointment; or disinterest by providers. Once these barriers are overcome and the patient is in the system, inadequate treatment often results from delays, discontinuity, inaccessibility of specialists of choice, cultural incompetence, or the lack of psychosocial support required to cope with symptoms, treatment, and complications.

A focus on special populations benefits not only the afflicted, but also the managed care organization and the community at large. Careful efforts to serve special needs patients can motivate an organization to reexamine basic strategies and operations. The critical importance of data collection, patient education, provider cooperation, and community links are highlighted by an analysis of the processes and outcomes of care provided the chronically ill. This analysis presents an opportunity for the organization to evaluate carefully its incentives, communication channels, and delivery system design. Improved healthcare, educational and social system links, potential early warnings of disease trends, and increased empowerment all help accomplish the broad mission of improving community health.

Because the delivery and financing of managed care often parallels the acute care, visit-based, procedural orientation of the fee-for-service sector, challenges remain. However, the organization, governance, and financial incentives of managed care organizations present the potential for innovative approaches and improved quality. The core processes and external interfaces involved in managed care provide natural opportunities throughout the institution's operations to accommodate the unique needs of disadvantaged groups. The characteristics of a group, including

age, gender, types and multiplicity of conditions, and prior utilization, must be considered, from the beginning in the early stages of community health assessment and must continue to be a consideration through contract negotiation, service delivery, pricing, and outcomes evaluation. Success of the care management model depends upon the managed care organization's view of itself as a pivotal point within both the healthcare system and the entire community.

Many factors can blur managed care's focus on the health of populations. The boundaries of a chronic illness management program can be constrained by conflicting goals and markets, sources of financing, and research limitations. In reality, the purchaser of care often drives the model, and the perspectives of employers, business coalitions, and other organizations whose members are primarily working enrollees do not necessarily include all the interests of the broader community.

Research on disease management and treatment protocols is developing. Additional research is being conducted on the epidemiology of chronic illness and the measurement of outcomes in the care of the chronically ill. Studies based on individuals in treatment, as well as on community-based populations, are required for results useful to a managed care organization. For those who present for care, it is crucial to have disease management protocols in place. For an organization whose mission is to improve the health of the population, it is equally important to understand the likelihood that enrollees will become patients and the mechanisms that have the potential to slow or prevent that transition. Although a firm's market position and the community's health can both be improved by translating research findings into illness surveillance, prevention, and education efforts, the task can prove uncomfortable and time-consuming for an organization struggling to survive in competitive markets.

Care for the chronically ill requires interactions among many different service organizations with potentially disparate goals, funding sources, and political orientations. Effective mobilization and management of services involve more than adding services to a treatment plan. They require mediating the components of care such as medical treatment, education, psychosocial support, physical rehabilitation, and job training. To the extent that target markets for these service organizations differ, the risks of fragmenting the care for the individual and of segmenting the population served by the managed care organization are increased.

Both transitional and long-term designs must acknowledge market realities and the responsibility of managed care organizations for the health of their communities. Care management programs for vulnerable populations require knowing the market and understanding potential partnerships. Public health agencies, skills training centers, and traditional safety-net providers can offer valuable links to specialty care for the chronically ill. The experience of managed care organizations in establishing alliances with provider groups or hospitals could be invaluable in designing innovative relationships with nontraditional health institutions, such as elementary and secondary schools. Although seldom viewed as a new type of chronic care delivery partner, schools can provide the mechanism for managed care

organizations to screen and detect chronic disease, to implement disease prevention programs, and to monitor medication regimens.

Relatively little research exists on the ideal mix, organization, or orientation of providers to satisfy effectively the needs of the chronically ill patient. We do know that the traditional model of periodic visits by a chronically ill patient to a primary care physician is ineffective without a team possessing the expertise, time, and resources to manage care. As important as medical and social service providers is an engaged patient who is active in the planning, delivery, feedback, and evaluation of care. To affect outcomes that are functionally and clinically relevant, the interactions must be effective within the facilities; across the service providers; and among the team members, which are defined as the patient, family, provider, and community.

The effectiveness of chronic care management models relies on data provided by and for the clinicians, agencies, and patients. Both management information and clinical decision support systems are essential. Ideally, these systems are composed of a registry of diseases and practice protocols or guidelines to which new cases can be added and from which symptom-based or diagnosis-oriented information can be extracted and analyzed to provide alternative pathways for care management. Data must also support management of the organization. Both the complexity of care management and the fixed-price basis of many managed care arrangements require mechanisms for data collection, monitoring, and feedback. Decisions about whether to provide services internally or to contract for services from external agencies are made initially and throughout the care management process. These make-buy decisions and the transactions associated with them rely on accurate financial and clinical data, much of which are collected as part of the standard medical encounter record and accounting systems.

As already noted, chronic illness management is more than a periodic review of the diagnoses, procedures, and progress notes from the medical provider's chart. Patients, providers, and managers must be able to integrate, access, respond to, and modify health and healthcare data. This capability is necessary to assess health status, to identify the appropriate provider, to select therapies, to monitor costs, and to measure results. These data are crucial to an effective infrastructure and responsive management of chronic illness.

Managed care concerns the alignment of financing, service delivery, patient care, and population health. New structures and strategies addressing the needs of the chronically ill can comfortably reside within traditional managed care models, as well as within newer organizations based on provider networks, community alliances, or hospital-centered delivery systems. The importance of serving special populations demands that the administrative and research challenges be met. The espoused missions of managed care organizations and the legitimate expectations of the public require accountability for the health and healthcare of the entire community.