

DM DISEASE MANAGEMENT ADVISOR™

Whole-population approach aims for early identification and intervention

New, integrated model of care targets risk rather than disease

After years of relying primarily on outside vendors to provide DM services, some organizations are considering offering such programs internally—or at least devising new ways to make healthcare programming less fragmented. Fueling this trend is a demand for less-expensive programming and a growing recognition that stand-alone programs focused on single disease states do not necessarily offer the best value.

There is evidence that several of the big players, including Aetna and Humana, are taking a fresh look at how they can better integrate their DM/wellness offerings. In fact, convinced that this type of transition will accelerate in the coming years, Pittsburgh-based High-

mark Blue Cross and Blue Shield showcased the evolution of its Blues on Call Plus Program for attendees during the National Managed Health Care Congress meeting in Atlanta in March.

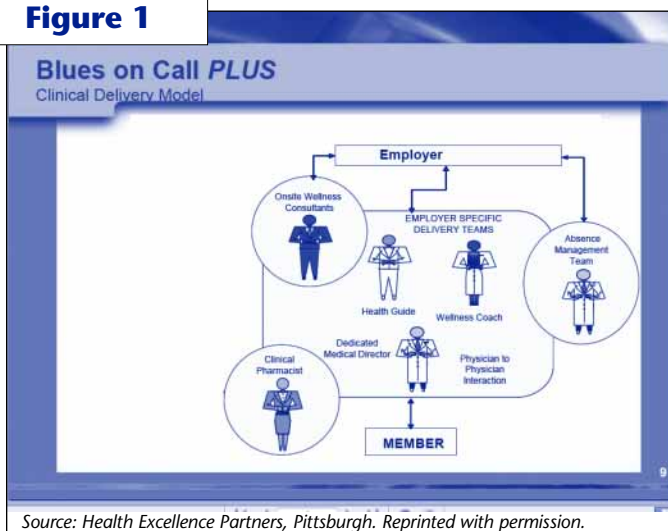
The approach is designed to take a more aggressive stab at dampening healthcare costs by intervening with a much greater proportion of the population, and doing so at an earlier stage—before individual risks begin to multiply. Further, rather than building the program entirely from within or completely outsourcing the model, the approach was assembled with both internal and external components. This was not an easy process, the presenters said, although they were optimistic that the resulting model will be in a better position to capitalize on the power of prevention and make the system more accessible to users.

Payers want integration

Highmark went to work on a more integrated model of care because customers—employers and individual members—wanted to go to one place for all of their healthcare needs, said **Michael Dubroff, DO**, vice president of Health Excellence Partners, the division of Highmark that oversees the new program. Employers/payers are desperate to contain spiraling healthcare costs, and there is little evidence that siloed programs offer any kind of economic advantage, he added.

Consequently, Highmark developed some new capabilities and took steps to consolidate core systems and processes so that case management, DM, and other services can be accessed and managed through the same system and account-specific care management team (see **Figure 1** below). Although care management services (e.g., behavioral health) have been brought in-house, the model still includes some outsourced services, Dubroff said. However, developers have taken steps to integrate

Figure 1



these services to the point at which all of the care components work off of the same data and can be accessed through the same system.

“In building this model, what we looked at was employer-specificity, and a care team that includes a wellness coach, a health guide, and a medical director,” said Dubroff. “And then [we also use] worksite wellness consultants to help drive the method and champion it.”

Absence management is coming

Among the new services that have been integrated into the model is absence management, which is triggered when an employee has been absent for 72 hours or longer. “The employer-driven information goes to a team of physicians; they will contact the member’s physician, do an assessment of the diagnosis, and establish an expected return-to-work date,” said Dubroff.

A key aim of absence management is to connect people with appropriate care right away, said Dubroff. “If you look at claims information and aggregate healthcare conditions, close to 25% of the time you will find a diagnosis that is referable to low-back pain,” he said. “If you can get someone directly into a care delivery system, have a case manager call them, and have a physician call their physician, you have a significantly better chance of getting them back to work sooner, as opposed to waiting for short-term disability and, subsequently, a workers’ compensation claim.”

Not all of Highmark’s customers are opting for absence management, a new concept to the marketplace, noted Dubroff. But he predicted that such services will be commonplace in the next few years as employers look increasingly for enhanced employee productivity from their health benefits.

Flexibility is key

The Highmark model is not driven by claims data, but by rules that take into account data from several sources, including claims, lab values, pharmacy data, health risk assessments, and even employer productivity

data, said Dubroff. Before providing services, analysts will look at all of the data that are available for a population and prepare what Dubroff referred to as an opportunity assessment, a process that essentially homes in on where interventions can potentially make an impact from a clinical/financial standpoint.




A key advantage of looking at an entire population is that it gives you the flexibility to allocate resources where they are most needed, said **Ian Duncan, FSA, MAAA**, president of Solucia, Inc., a Hartford, CT-based actuarial firm that worked with Highmark to develop the Blues on Call Plus program. “You can address case management if that is the prevailing concern of the population or where the potential savings might be, or you can move more resources toward wellness if that appears to be where the investment should be made,” said Duncan.

According to Duncan, the population assessment essentially involves the following three steps, which build on one another:

- ▶ Identification
- ▶ Segmentation
- ▶ Stratification

Through this multilayered analytical process, Highmark can determine which conditions or diagnoses are prevalent in a population, which level or intensity of intervention is needed for the various subgroups of peo-

Figure 2

Blues On Call Plus Population Segments		
	ICM	Intensive Case Management High dollar cases (> \$50,000 over 3 months) Specific diagnoses such as cancers, ALS, Lymphoma
	PCC	Primary Chronic Conditions Asthma, COPD, CHF, CAD, Diabetes (with associated comorbidities)
	THC	Targeted Health Conditions Maternity, Depression, Obesity, Back Pain, Osteoarthritis, Osteoporosis, Hypertension, Gastrointestinal Disorders, Migraines & Headaches
	NTHC	Non Targeted Health Conditions Those with claims for other than preventive care as well as those conditions defined above in ICM, PCC & THC (lower prevalence, lower cost and modifiable condition).
	AR	At Risk No claims other than preventive care (positive utilization only). HRA indicated significant risk
	AW	Apparently Well Well on basis of HRA and/or biometric screenings with no claims other than preventive (positive utilization only).
	NU	Nonusers No HRA or claims

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ple who exhibit common characteristics, and what the potential future costs and cost-savings are from the various groups, Duncan said (see **Figure 2** above).

The opportunity analysis provides a framework not just for clinical and financial metrics, but for operational or process metrics, as well, he said. “Simply having a model, and being explicit about its components sets up the analysis that then needs to be done as people are brought into the program,” he said, acknowledging that some of the outcomes anticipated in the model are based on assumptions rather than hard data. “The DM components of the model—the risk factors, the costs, the effectiveness of the interventions—are pretty well known because they have been studied.” However, outcomes from case management have not been well studied, and wellness programs are too new for anyone to have good results, he said. “We have set up a framework so that Highmark can go out and collect the data.”

Data on wellness are lacking

In designing the model, Highmark’s goal was to target risk, rather than disease, noted Dubroff. Consequently, the

challenge is to intervene with people early enough to prevent risk deterioration. “We’re trying to prevent symptoms from becoming conditions, conditions from becoming disorders, and disorders from becoming disability,” he said, noting that this approach offers the best opportunity for flattening the medical cost trend curve. “You will never decrease that because you can’t have increased technology and increased aging of the population, and also anticipate saving pure dollars. But you can get a handle on the spiraling of the medical cost trend curve.”

Whether the model will work is still an open question. Dubroff reported that 150,000 people are currently engaged in Blues on Call Plus, but the approach is still too new to report outcomes. Additionally, it is unclear what level of a financial commitment toward wellness interventions will produce a financial benefit.

“The wellness/at-risk population does not yet fit into the financial model because we have so little data at our fingertips in terms of effectiveness of wellness interventions,” said Duncan. “But potentially the highest value from the program—and what employers want—is this prevention, because it prevents transition to a higher-risk segment.” ■

