New report: Community health plans improving care for patients with chronic illnesses

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Community health plans are partnering with physician practices to initiate a range of care management programs for people living with chronic diseases; these programs have resulted in decreased emergency room (ER) use, improved health and lower costs. The findings, released today by the Alliance of Community Health Plans (ACHP), are part of a report that is a comprehensive look at the way community health plans partner with providers to improve care.

Care management is the coordination of care and services for chronically ill patients who require complex, one-on-one and personalized care, and is emerging as a foundation of patient-centered medical care. At many ACHP plans, a plan-employed care manager works with a medical practice to coordinate services for patients living with long-term, chronic diseases, through activities such as patient education, referral to community resources and agencies, help navigating health care systems and coordination of information among multiple providers. Innovative health plans, including Geisinger Health Plan, Group Health Cooperative and Independent Health have launched care management initiatives in partnership with medical practices, resulting in improved patient experiences.

"Improving how we care for those living with chronic disease is a national priority and requires that we understand not only the role physicians and practices play, but also how health plans can help advance

and integrate care," said ACHP President and CEO Patricia Smith. "With this report, we demonstrate the critical role community based health plans play as a partner in improving the delivery system."

ACHP also found significant cost savings when reviewing results from its members' care management programs, primarily due to prevention of avoidable hospitalizations and ER visits. Between January and July of this year, for example, Group Health Cooperative reported total cost savings of more than $2.5 million for patients in its case management programs.

In this report, which notes the evolution from disease management to care management approaches that address the "whole person" including social, environmental or financial barriers to good health, ACHP focused on five key themes that could be adapted more broadly to replicate the positive results found in the care management work of community health plans:

1. Physician Partnerships. A plan-employed nurse working within a provider's practice - whether a plan-affiliated or networked practice - allows patients to view the nurse more as an extension of the physician, therefore improving the patient's experience of truly coordinated care.

2. Face-to-Face Encounters. Personal meetings with a care manager can be used to confirm a doctor's instructions, answer medication questions or learn how to use a medical device.

3. Multidisciplinary Teams. Involving social workers, geriatricians and others in a care management program can help patients and families access specialized services they need.

4. Appropriate Use of Technology. Technologies can increase communication with a patient or speed the delivery of health

information to a care manager. This enables a more seamless support system for patients seeing a range of providers or accessing multiple services.

5. Community Mindedness. Familiarity with their local communities helps health plan nurses connect patients to community based organizations that can provide, for example, necessary nutrition, housing, financial, social and home health services.

ACHP released its care management report along with a companion Care Management Handbook for health plans looking for greater detail on integrating care management programs. The care management documents are part of a new ACHP series on delivery system reforms, Health Plan Innovations in Patient-Centered Care. The series looks to fill the existing gap in the literature when it comes to identifying ways community based health plans can partner with medical practices and communities to keep patient needs front and center as well as deliver high-value care. Papers on the role of health plans in innovative primary care delivery and transitions of care will follow this first installment on care management.

"The right care and high quality benefits can yield healthier, more satisfied patients; further, enhanced care management services offer the potential of reduced costs" Smith said. "In an era of tight budgets, people think that the only way to reduce costs is to trim services, but our analysis of community based health plans providing care management finds this is not the case."

Provided by Alliance of Community Health Plans