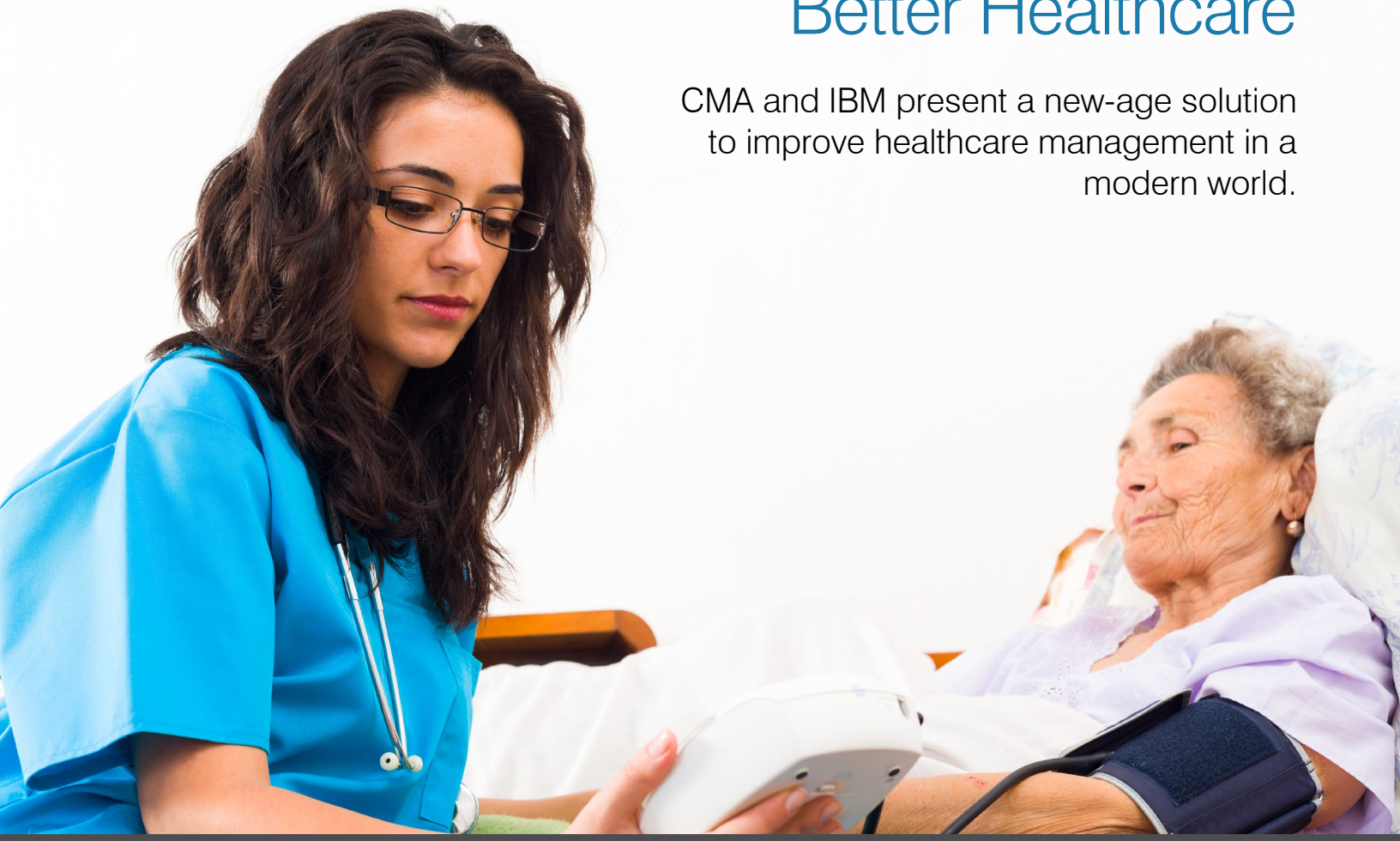
Improved High-Risk Patient Management is the Key to Better Healthcare

CMA and IBM present a new-age solution to improve healthcare management in a modern world.



The prices for healthcare have reached astronomical heights, especially in the United States. New York State, for instance, spends $50+ billion a year on Medicaid. Florida, one of the highest grossing states for healthcare use in the U.S., saw a $13 billion dollar leap in spending between 2001 and 2011, totaling over $22 billion dollars in 2011.[6] It has become essential for states, healthcare clinics, hospitals, nursing homes, and other healthcare providers to start analyzing healthcare and Medicaid costs. This includes comparing spending patterns to devise new, effective methods for improving care at reduced costs.*

The Kaiser Family Foundation broke down costs in their report on the Concentration of Health Care Spending in the U.S. Department for Health and Human Services. They found that around 50% of the U.S. population spends almost 97% of the allotted budget for healthcare.1 In the state of New York, the percentage of Medicaid dollars spent on high-risk individuals – patients with multiple chronic illnesses – is extremely high. Although these high-risk individuals only make up around 20% of the population, they consume around 80% of the state of New York's total Medicaid costs*.

CMA, IBM, and the state of New York have partnered together to create a solution. The Health Home Initiative has the power to revolutionize the way healthcare is delivered and managed. By focusing on the early detection of high-risk patients, New York hopes to cut Medicaid budgets while improving the quality of life of its citizens.

"New York is committed to meeting the health care needs of all its residents and is taking innovative steps to reform and reconfigure our Medicaid program to improve the delivery of quality care and control costs," State Health Commissioner Nirav R. Shah, M.D., M.P.H. said in a press release. "The new initiatives are critical elements in providing better care for patients at lower costs for taxpayers."[5]

OBJECTIVES OF HEALTH HOME INITIATIVE

According to a 2012 study performed by The Robert Wood Johnson Foundation, the managed care models that offer, "Even modest reductions in emergency room use, avoidable hospitalizations, and specialty care can lead to cost savings." "With effective disease and care management programs, these savings could be more significant."3 This study concluded that introducing "high-need, high-cost beneficiaries" into managed care increases the potential for cost savings. For the healthcare industry, it has become "both an economic and political imperative" to change the traditional delivery systems of health services.[3]

This is precisely what the Health Home Initiative has set out to accomplish in the state of New York. By utilizing state-of-the-art electronic systems that are integrated with efficient business process procedures, care coordinators will be able to identify high-risk individuals early and deliver the appropriate level of care to improve quality of service and health outcomes.

Not only will patients receive better care, but the state of New York will also save significant costs by preventing avoidable

inpatient hospital stays, reducing Emergency Room cases, and reducing hospital re-admission rates. The Health Home Initiative has the potential to affect nearly every facet of healthcare – from mental illness, to substance abuse, disease-related care, preventative care, follow-up care, and more.

THE CATALYST FOR CHANGE

With the release of the Affordable Care Act (ACA) health reform law on March 23, 2010, a temporary 90% federal match rate was authorized for health home services – a new Medicaid option that provides enhanced services for enrollees with chronic conditions.[4] This new model of care has been aimed to help improve the quality and clinical outcomes of patient care while simultaneously reducing costs through more effective care.

On November 16, 2010, The Center for Medicaid and Medicare Services (CMS) issued outlines of requirements, choices, and funding to help states and healthcare providers navigate these new opportunities. As a way to improve the coordination and management of care for Medicaid enrollees – especially those with the most complex and expensive needs – the Health Home Initiative offers significant federal support in the form of a 90% match of all services that are initiated. This support is continually offered for two years.[4]

Up to $500,000 of Medicaid funding is also available for hiring personnel, consumer and provider outreach, training, consultation, system development, infrastructure building, and overall planning.[4] This is offered to states and healthcare facilities as an opportunity to track re-admissions, as well as to calculate savings due to improved care coordination and disease management.

THE FEATURES OF A BETTER CARE MANAGEMENT SYSTEM

With the pressure to meet increasing patient demands while simultaneously balancing rising healthcare costs, many states and care facilities are turning to technology. The Health Home Initiative solution harnesses hi-tech breakthroughs while pairing them with new patient care procedures.

The latest trends in healthcare point to a more collaborative decision-making process, where the patient is intricately involved in their own health management. This includes healthcare providers teaching patients about disease self-management. Education paired with structured care procedures is one way to ensure ongoing monitoring to detect potential health concerns and high-risk patient cases sooner.[2]

New, integrated procedures and clinical information systems are also required to effectively track care between providers. Coordination between primary care, specialty providers, and community support teams is essential to identifying potential high risks.[2]

Collecting data is another important aspect to creating a better care management system. For instance, the state of New York uses claims, encounters, pharmacy data, and post-inpatient discharge continuation of care to ensure that patients are transitioned to another level of care. This process initiates a type of internal red-flag system that can track chronic illness management, and measure the indicators of poor disease management that lead to higher-cost treatments.[2]

Ongoing assessments of these quality measures are conducted at different levels of the Health Home Initiative. Overall, the state of New York will monitor cost savings by tracking preventable hospitalizations, emergency department use, detoxification, and so on. This level of in-depth monitoring will allow the state to recognize and categorize high-risk patients earlier by comparing current costs to past medical records.[2]

Overall, pairing new care procedures with integrated technology systems that cross the entire healthcare spectrum will help patients receive the right level of treatment before and after procedures. Taking these steps will ensure optimum recoveries and save Medicaid and other health costs by reducing the number of preventative health visits, such as trips to the emergency care. Proactive detection of high-risk patients will also speed the diagnosis process for patients, as well as offer better management for high-risk cases.

IBM AND CMA PARTNERSHIP

IBM and CMA have partnered together to build the infrastructure needed and create a plan to uncover high-risk patients sooner—all while reducing healthcare costs. This breakthrough new method of healthcare management is being launched in the state of New York. IBM and CMA are also working with care coordinators, non-profits, and other organizations to create an advanced, highly-integrated system that delivers the best care possible to patients.

THE NEW SOFTWARE TO DRIVE HEALTHCARE MANAGEMENT

IBM's Cúram Social Program Management Solution provides patients with easier access to government healthcare through full lifecycle support. Designed to fit client needs, Cúram software empowers patients and providers with an enhanced collaboration tool to gain visibility into health and social goals. IBM Cúram was created to improve the quality of care and reduce escalating healthcare costs.

By offering treatment that allows doctors to focus on treating high-risk, extremely vulnerable groups – such as the elderly, homeless, at-risk-youth, and people with mental, physical, and developmental disabilities – medical professionals can easily design personalized care plans that coordinate care delivery schedules across multiple practices and care teams. Every individual group is directly involved with the sustained, improved care of their patients.

IBM Cúram is complete with assessments that evaluate every patient's individual needs. Customized care plans can then be deigned based on those requirements. With enhanced collaboration between medical teams and patients, this commercial, off-the-shelf solution is pre-built with the business-driven configurations that can meet the most complex challenges.

GOALS OF THE STATE OF NEW YORK'S CARE MANAGEMENT MISSION

The state of New York is focused on building a culture where healthcare is centered on patients. Powered by individuals, the Health Home Initiative aims to enhance communications amongst multiple providers so care plans can be optimized to fully rehabilitate patients – through every phase of the recovery process.

To achieve these goals, the state of New York plans to implement evidence-based best practices, where outcomes, performance, and patient recoveries measure the success of care provided. Improved information systems, integrated practices, and patient-centered procedures provided by IBM and CMA are also being utilized to achieve these goals.

EXPECTED OUTCOMES

The state of New York expects to establish inter-disciplinary models of care to improve healthcare quality while reducing the cost of care for Medicaid beneficiaries with complex, high-risk medical conditions. They also intend to strengthen and retain primary care physicians, better coordinate and integrate patient care, and prevent malpractice cases and misdiagnosis.

CONCLUSION

IBM and CMA are developing a solution that has the ability to change the management and delivery of healthcare in the United States. This is the first time a solution like this has ever been released at such a large magnitude. Through enhanced, state-wide integration, multiple health practices will be able to coordinate and build customized plans for high-risk patients to ensure the right care and follow-up procedures are being executed. The state of New York is expected to significantly reduce Medicaid costs by offering care necessary to high-risk patients to avoid preventable health costs.

Discover how CMA and IBM's Health Home Initiative is transforming the healthcare industry today.

Business Partner IBM™

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