Reimagining care management: Achieving better results for people with diabetes and other chronic conditions

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Executive Summary

Comprehensive, proactive care management is crucial for people with chronic conditions, many of whom struggle to navigate the healthcare system while managing their health at home. However, with the healthcare industry still straddling the line between fee-for-service and value-based care, key care management stakeholders remain misaligned and unable to work together effectively.

Common pain points, including failing to enroll the right people and missing the mark on holistic, socioeconomically sensitive services, leave patients feeling lost in their chronic care management journey.

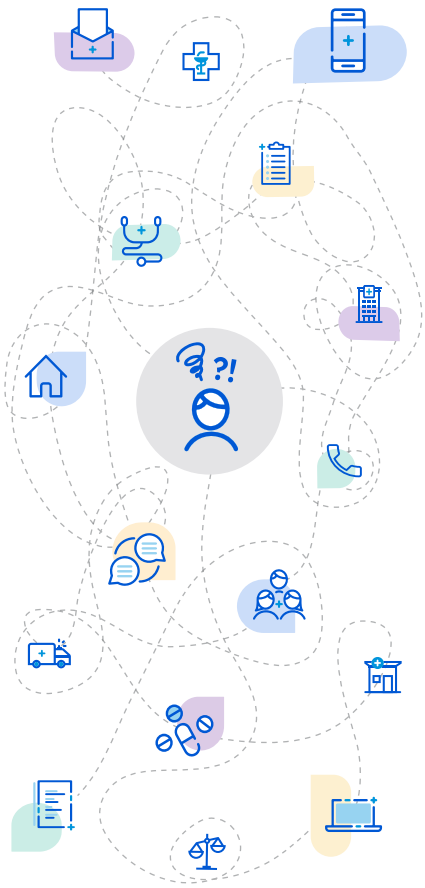
Bridging the gaps in our financial, technical, and clinical strategies will require all partners to identify and acknowledge our shortfalls. We have to take action, including:

1. **Embracing the idea of care management as a team effort**
2. **Exploring new data analytics techniques to get more proactive about care**
3. **Taking advantage of partners able to expand and augment available resources**
4. **Leveraging existing relationships to improve engagement, retention, and coordination**
5. **Advocating for policy and payment changes that incentivize appropriate reimbursement for care management**

By developing new strategies to collaborate across organizational lines, we can more equitably share the responsibility for supporting the health and wellness of people with chronic conditions and create a care management environment that is truly effective for people in need.

Introduction

37.3 million people in the United States live with diabetes and related complications[1], leading to disability, death, and high spending. Between the daily requirements of blood sugar testing, the need to complete regular preventive screenings, visits to multiple specialists, complicated medication routines, and juggling multiple chronic conditions, it can feel like a full-time job. Couple that with the untold millions negatively affected by social needs, and it becomes more challenging.



Care management exists across health plans, physician practices, hospital systems, community groups, and other members of the care continuum. Each area often has disparate goals and incentives structures: different lenses through which they view their populations and responsibilities. And while care management is a crucial part of helping people with chronic diseases live their best lives, the misalignment can lead to care management that is fragmented and duplicative. In turn, this can leave the person being cared for feeling frustrated, confused, and demotivated to engage with the health system.

In a recent Accenture poll[2]:

1. Two-thirds of people reported a negative experience with their healthcare providers; one-third said their interactions have left them less likely to seek out care in the future.
2. More than half of respondents believe that clarity from their providers around treatments and health conditions, as well as empathy and emotional support, are integral to keeping them on track with their health.
3. And 35% prioritize well-coordinated interactions and good communication between medical staff when gauging the quality of their experiences.

To create a better future for people with diabetes and other costly chronic diseases, it is time to reexamine the current state of care management. Healthcare stakeholders must develop the tools and relationships to leverage data assets, effectively build engagement with patients, and take advantage of innovative partnerships with aligned incentives. Working in harmony, these attributes can enable seamless collaboration and the ability to make a positive impact on every person's life.

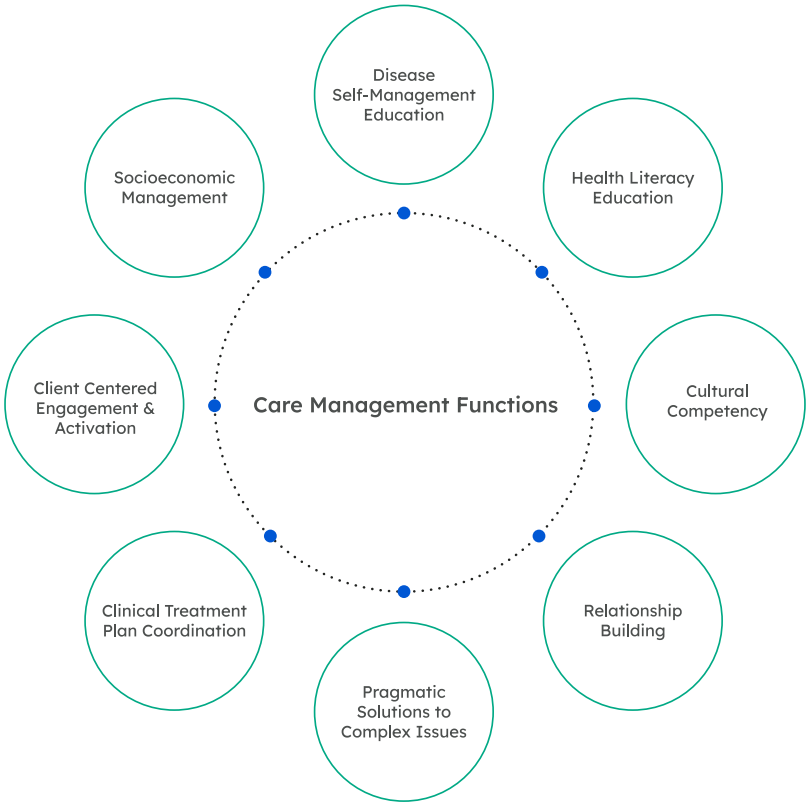
What is care management?

Unlike the similarly named *case management* that focuses on optimizing the utilization of specific services to control costs, care management coordinates care in a team-based approach. This approach is designed to holistically address factors that affect an individual's ability to live a healthy, productive, well-balanced life with a secondary benefit of reducing healthcare costs across the system.

Care management is the process of addressing modifiable health risks, such as engagement with care services, care plan adherence, and lifestyle factors.

Health plans typically have the most incentive to provide care management because of the financial risks of higher spending due to poor health status and member attrition when consumers face challenges such as medical literacy, consistent engagement, and more.

Despite this fact, health plans and their partners aren't necessarily seeing notable return on investment. Identifying and overcoming the pain points of the care management process is essential for maximizing outcomes and achieving the shared goals of the healthcare system.



Source: Access to Healthcare Network, May 18, 2023

Common pain points in the care management continuum

Care management is a complex undertaking with many common challenges, including crossed wires over ownership of the task, insufficient data to make optimal decisions, and engagement tactics that miss the mark with patients. Identifying these issues is the first step toward addressing them via innovative strategies and partnerships to keep the patient top of mind in all care management activities.

1. Difficulty with enrolling the right populations in care management

Plans don't always have the right data or resources to conduct analysis and risk assessments for an entire population that may be in need of care management.

One blinded case study from McKinsey[3] noted that 80% of members with likely unplanned readmissions were left out of care management due to resource constraints and limitations of the plan's predictive modeling.

Readmission reduction program, McKinsey blinded client example

20% identified

Due to resource constraints and predictive model limitations, about 80% of members with likely unplanned admissions were not chosen for targeting

15% reached

Approximately 1/4 of identified members were never reached; they either didn't have a valid phone number or never responded

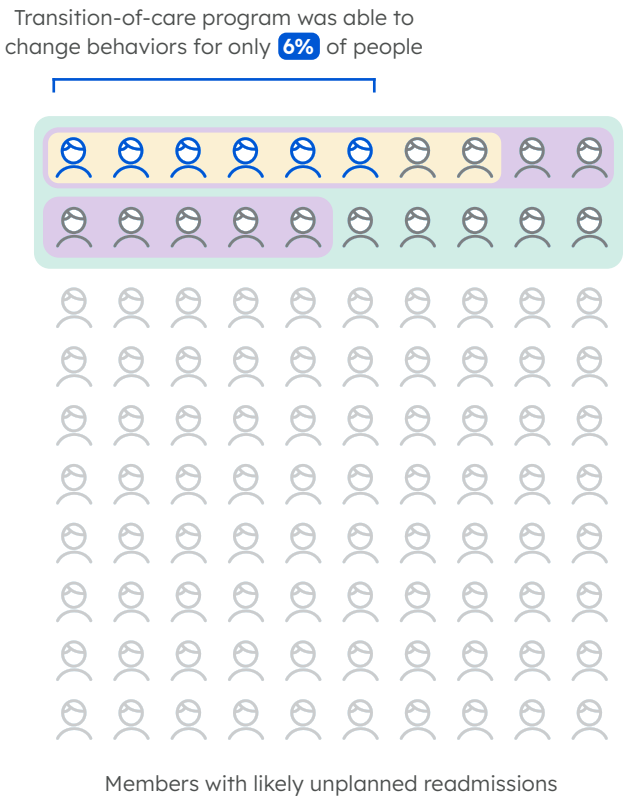
8% engaged

Half of members who picked up the phone refused to engage or dropped off before completion of the program

6% behaviors changed

20% of engaged members, though engaged with the care management nurse, never followed through on follow-up actions

Source: McKinsey & Company, May 18, 2023



2. Too much, too little, and too late when engaging with patients

Care management most often breaks down when programs are not built around the person receiving the services. In a hybrid value-based world, health plans and primary care providers may both have strong incentives to take an active role in care management, but their activities often overlap in an unhelpful way.

People with diabetes, and especially those with multiple chronic conditions, may receive care management services from different entities. Sometimes, the advice or direction can be contradictory or confusing, such as when a health plan offers suggestions on A1C control that conflicts with what a dietician says about meal planning.

When patient education and directions are not coordinated and aligned, it can cause frustration for the patient. Oftentimes, this leads a person to pull back from engagement with care management partners.

> Care management is supposed to create a circle of supportive, coordinated care around the person being treated. But in reality, it often just places the patient in the center of a swirling storm. We need to do a better job of aligning workflows and incentives to calm the chaos that so often leads to patient frustration and disengagement from their own care process.
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On the other end of the spectrum, people who are not engaged with care management are at risk of overutilization, avoidable crisis events, and poor outcomes. This is often a result of resource constraints and of relying too exclusively on retrospective data, such as claims. Care management teams are then not able to quickly identify emerging signals in a person's health journey, which can lead to increased risk in that individual's health and well-being — as well as higher total costs of care.

3. Struggling to develop whole-person care with a socioeconomic focus

Experts agree that 80% to 90% of health is attributable to non-clinical factors, including lifestyle choices and structural and social determinants of health.[4]

Many stakeholders are only in the beginning stages of collecting standardized social determinants of health (SDOH) data to guide personalized care activities. Integration of novel data sets with clinical claims information to inform decisions on an individual or population health basis remains a nebulous future state.

Without these insights, care management sponsors are unable to fully understand the non-clinical challenges that contribute to a person's high-risk clinical status — and they certainly will lack the tools, know-how, and resources to engage patients appropriately and address any issues with the help of community-based partners and other members of the care team.

Reinventing the existing care management ecosystem

To craft a new future for care management, we must reinvent a new status quo to add value for all participants in the care process. We can do this by maximizing existing resources while exploring innovative strategies and novel partnerships to truly meet the needs of individuals throughout the continuum of care.

With more collaborative planning, more sophisticated use of data, a fresh look at partnership opportunities, and a more consistent, person-friendly approach to engagement, the health system can solve its pain points and achieve its shared goals.

1. Embrace the idea of care management as a team effort

To streamline activities, care management sponsors must be fully aware of what their partners are doing — and ideally have some degree of input into each other's efforts. By working collaboratively, sponsors can leverage each other's strengths - including the sharing of safe and secure data assets - and problem-solve together to create an integrated care management team united for the good of the patient. This may require tackling frictions or lingering misconceptions about business relationships — but will ultimately produce shared benefits for everyone involved.

2. Explore new data analytics techniques to get more proactive about care

> Care management isn't easy. No one is stepping on each other's toes on purpose: It's just a difficult, complex task that the legacy healthcare system isn't designed to accomplish. Fortunately, we're moving into a new era where we can leverage changing incentives and technologies to create a more structured, open approach to coordinating care for people with chronic conditions.
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Analytics tools are advancing quickly, opening up new opportunities for data aggregation and actionable insights. Care management leaders will need to prioritize the collection of rich and timely data sets, including publicly available and patient-reported SDOH data; admission, discharge, and transfer (ADT) feeds; patient monitoring devices; pharmacy and supply orders; and other types of information that could help generate new signals about a person's health status.

For example, diabetes supply ordering patterns can signal problems with a person's adherence and self-care routines. Someone who stops ordering supplies on a regular basis may be struggling with costs, may not have a stable home at which to receive deliveries, or has fallen away from their recommended care plan for other reasons. The predictive power of this type of data, which is traditionally only used as a business metric for healthcare supply chain companies, could have significant value for informing care management activities.

3. Take advantage of partners able to expand and augment available resources

Even the largest health plans are operating with few resources available for advanced care management. Fortunately, a number of new players with focused expertise are entering the field with the goal of expanding existing capabilities and providing more dedicated, tailored care management to individuals.

These prospective partners range from nonprofits and community-based organizations with a focus on SDOH to durable medical equipment (DME) companies able to leverage their unique position in the healthcare ecosystem to further support people with chronic conditions like diabetes. Health plans can benefit from building out partnerships with these organizations and extending their reach more deeply into the places where people live, work, and play.

4. Leverage existing relationships to improve engagement, retention, and coordination

By expanding their scope with next-generation partnerships, health plans and other care management sponsors can start to address the most challenging aspects of care management: engaging individuals and affecting behavior change.

Fundamentally, care management is a trust exercise that requires openness, honesty, and frequent communication from both sides. Care management executives can jump-start these important relationships by training care managers in culturally sensitive motivational interviewing techniques, conducting outreach in conjunction with community leaders such as churches and schools, and turning to entities that already have an established cadence of contact with individuals, such as DMEs that already interact with patients at least once a month.

Becoming a familiar, trusted, and constant presence in a person's life is the best way to ensure that they keep picking up the phone and having important conversations about their status throughout their enrollment in care management.

In addition, coordinating care with referring physicians can help to avoid creating new silos or new communication barriers. Working closely with referring providers ensures that physicians can deliver aligned and complementary education and services at the right moment in the person's health journey. These relationships must be built upon a foundation of transparent, timely data exchange that keeps everyone in the trust loop.

5. Advocate for policy and payment changes that incentivize appropriate reimbursement for care management

As the value-based care environment continues to evolve, members of the healthcare ecosystem will find more incentives to work together closely on care management.

Key stakeholders will need to continue advocating for policy and reimbursement changes that adequately compensate team members for the care management work they are doing — especially in the SDOH arena adjacent to traditional clinical care.

By redesigning the financial landscape with an eye toward value and more proactive, holistic, person-centered services, we can continue to expand the scope and utility of care management and ensure that every individual who needs assistance with their chronic condition management can engage at the right level with their unique needs.

Conclusion

We must take action now to develop a care management ecosystem in which all stakeholders are able to work together effectively to identify needs, connect with patients, and achieve sustained engagement with people with significant health risks.

Doing so will require a combination of improved relationships, more sophisticated data analytics, trusted partners, and empowered individuals who feel equipped to navigate both the clinical and non-clinical challenges in their lives.

By taking a more proactive, holistic, and collaborative approach to care management, key stakeholders will be able to achieve better health and financial outcomes.

Envisioning the future of connected care management with CCS

CCS is redefining patient care at home through LivingConnected®, a unique care management solution that meets the patient where they are to achieve value for the individual and the entire healthcare ecosystem. CCS combines reliable supply delivery with comprehensive education, monitoring, and coaching from licensed diabetes educators to support people living with Type 1, Type 2, and gestational diabetes.

Our unique position at the intersection of payors, providers, and patients allows us to gather, integrate, and distribute actionable insights from historically disjointed areas of the care continuum. With its foundation in the distribution environment, CCS is in frequent contact with patients — monthly, in many cases — allowing for the development of trusted, familiar, positive relationships with individuals. In combination with our established administrative and technical connections to payors and providers, our channel-agnostic, human-first approach to care management is creating a thriving ecosystem of comprehensive, collaborative care around each individual.

With LivingConnected®, individuals living with diabetes benefit from guided onboarding to their new device and receive ongoing coaching sessions with a licensed clinician throughout their journey. Certified diabetes educators at CCS not only educate patients on their condition, but also teach them new habits and behaviors to drive improved health outcomes. Patients can engage with real people through whichever channel they prefer: app, email, or phone. As a result of guided onboarding, patients have experienced an average reduction in A1C of 1.1 percentage points.[5] In particular, one large employer group yielded a cost reduction of 45% for those enrolled vs. those not enrolled in the LivingConnected offering.[6]

Footnotes

1. The Facts, Stats, and Impacts of Diabetes. (2023, April 4). Retrieved May 18, 2023, from https://www.cdc.gov/diabetes/library/spotlights/diabetes-facts-stats.html

2. Digital adoption: Reaction or revolution? (2021, August 6). Retrieved May 18, 2023, from https://www.accenture.com/us-en/insights/health/digital-adoption-healthcare-reaction-or-revolution

3. The untapped potential of payer care management (2021, January 25). Retrieved May 18, 2023, from https://www.mckinsey.com/industries/healthcare/our-insights/the-untapped-potential-of-payer-care-management

4. Social Determinants of Health 101 for Health Care: Five Plus Five (2017, October 9). Retrieved May 18, 2023, from https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

5. 19-month patient data from 12/2020 - 7/2022; n =501 for a large national health plan as part of CCS's LivingLinked™ offering, which is a clinical education program

6. Large employer group participant program results, 2020

About CCS

CCS is a leading provider of clinical solutions and home-delivered medical supplies for those living with chronic conditions, particularly diabetes. CCS supports 150,000+ people living with chronic conditions in the United States and delivers more than 1.2 million shipments of medical supplies directly to their homes each year. The company works specifically with health plans, employers, and providers to offer both technology and hands-on educational services to holistically support members living with diabetes. After serving individuals for more than 25 years, CCS has the experience, data, and relationships in place to create a new era of home-based, proactive chronic care management. Entities managed by Riva Ridge Capital LP are the primary shareholder of CCS. To learn more about CCS, please visit CCSMed.com; LinkedIn; and Twitter.