GETTING ‘BACK TO BASICS’ IS THE KEY TO UNLOCKING THE PROMISE OF NEW TECHNOLOGY IN CARE MANAGEMENT

By: Bryan Komornik

While once a mere aspiration, better health outcomes at a lower cost of care has become the principal mandate of effective healthcare management. Health plans face an increasingly steep challenge in this realm: drug prices and service rates continue to climb while chronically ill, vulnerable, and complex member populations swell.

Health plans have made significant strides in recent years, with an increasing focus on the implementation of care management solutions and extending their reach into communities to improve plan utilization and maximize engagement. Yet, engagement and outcomes continue to lag.

Health plans have historically relied upon siloed systems and point-of-service solutions to engage and coordinate the care of their members, success has been limited. Such solutions have sometimes worked at an individual level, but they are rarely scalable or flexible enough to manage all of the disparate populations that health plans serve. What is more, they are often implemented across already-siloed organizations and don’t capitalize on enterprise-level data-analytics and member-engagement tools.

Leveraging new, nimble technology to unlock the potential of care management organizations is undoubtedly a critical piece of this puzzle. Yet, new technology layered on top of inefficient processes only breeds complexity for care management organizations and members alike. Technology can only support what business process enables. To address the principal mandate, health plans and care management organizations must first address their underlying business processes before implementing the next best tech solution.

New technology alone can’t break through the siloes that create fragmented experiences

As health plans connect fragmented operations to a fragmented member experience, they tend to become highly dependent on manual processes and workarounds required to address infrastructure limitations and gaps in vendor and system architectures. Attempts at better integration of systems and processes have been either nonexistent or too limited in scope to be impactful. In some cases, we have seen those attempts lead to even more manual processes. Case workers and managers are tenacious and passionate about addressing needs and often exacerbate the situation despite their best intention to serve the member.

Meanwhile, reporting on member data is limited and, more often, isolated. Anchored by claims data, gaining real insight into member behavior is also limited. Reporting is hindered due to the claims lag and the ad hoc production of operational reports by disparate teams. Attempts to assess population needs and identify the meaningful drivers of member behavior in these fragmented environments are often futile. Few health plans have mastered the omnichannel architecture that reflects the way most of us communicate in today’s world. For example, member preferences and behaviors may be collected and used by one part of a health plan’s

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organization but are not visible to the enterprise due to resolutely siloed business units.

There is a clear case for leveraging new technology to solve for entrenched operational problems in care management. Yet, most care management organizations still fail to see real gains as the result of implementing new technology alone. Investments are made and solutions are tweaked, but health plans—and care management organizations in particular—are still waiting to see a real uptick in member engagement.

Platform-based solutions are the latest class of technology with promise to digitize and modernize the care management experience for end-users and members themselves. Yet, technology is only an enabler. To truly reap the benefits of flexible technology, health plans must take a radical departure from their historical operations and address their underlying business strategy first. In other words, new technology should enable business processes and not the other way around.

BEFORE LEVERAGING NEW TECHNOLOGY, DESIGN A CONNECTED CARE EXPERIENCE

Historically, health plans have leveraged new technology and folded it into their existing business plans and operating structure. By failing to identify process inefficiencies and understand their connection to the member’s clinical journeys up front, health plans and care management organizations have simply layered new technology on top of old business problems. This has a crippling effect on a care management organization’s ability to meet member needs efficiently and expeditiously.

Digital technology brings immense promise in delivering better care across complex populations, but leveraging new technology to its full extent requires that organizations first apply fresh thinking to their core mission and operations. Only then can underlying business processes be effectively evaluated and new technology considered.

1| Re-engage with your mission

For care management organizations, missions are largely centered on improving patient outcomes (including social and behavioral) and empowering members in the management of their own health. Care management organizations must return to their roots and realign around the basics: This means defining and documenting the processes that deliver the right care at the right time for members. It also means seeking to define how the organization proactively collaborates with providers to ensure member care plans are working.

Embracing these imperatives, care management organizations are uniquely positioned within health plans to meet two of the industry’s primary mandates: lower the cost of care (administrative and medical) and improve health outcomes. The following criteria are necessary to achieve this:

- Clearly defined mission which is clearly tied to the strategy and business processes that support that vision.
- Demonstrated impact of those current and future-state process to the bottom line, both in terms of administrative costs and outcomes.
- Realignment around the “basics” to better control reserves, manage networks, and boost appropriate care use and quality of care.

2| Re-align around the member experience

Understanding the member’s clinical journey is vital to delivering a quality, personalized care experience. Yet, organizations often take too narrow a view, either focusing on limitations in the experience today and not the ideal, future-state experience of tomorrow, or by not leveraging the view from the outside-in. These are some of the steps an organization should take to clearly define the ideal member experience:

- Avoid creating an experience that only solves for gaps and limitations of today. Think three to five years out and document the desired journey, unfettered of today’s process and operational limitations. Start with a clean slate, and work backward.
- Clearly document how business processes will align with a clear care management vision and how users need to interact with systems and members alike.
- Understand the journey by looking from the “outside in.” What are the processes like for a member? For a provider? Engage other inbound
partners who also serve the member care journey (community-based partners, providers, etc). Define how referral patterns are process-enabled and where they should be.

- Document the feedback loop. Checking in on members cannot merely be an exercise in checking the box of a discrete care plan, it should be about truly understanding member needs and engaging in all components of their health (social, behavioral, and medical).

3| Assess your data and technology

When we recommend assessing data and technology, we emphasize again that this is not a technology problem, but a business problem. Yes, nimble technology and data-driven insights do yield capabilities to scale, expand, and mature, but how are the benefits of new technology to be reaped?

- Elevate the need for a data-driven strategy. The key for health plans is unlocking data that today lives across a number of disparate systems and using it to move beyond basic touchpoints. Care management teams will remain limited in their ability to impact member behavior if they cannot meet members in “moments that matter”

- Select technology based on the business processes that will support a connected care experience, understanding that no two member experiences will be exactly the same. Select technology that supports the desired member journey and the member experiences it will support.

- Pursue “Best of Breed” approach while acknowledging that there isn’t a single silver bullet. When considering new technology, an understanding of the organization’s limitations will point to the right mix of solutions that effectively align with the mission, strategy, and business processes.

CONCLUSION

The goal of delivering better, more efficient, personalized care can be realized through the strategic re-engagement with the organization’s mission, a re-alignment around member experience, and a business process-oriented assessment of data and technology. The single most important measure of an effective CCM organization is whether it offers better care and a better experience for members. The organization that looks at its business processes first will be far more equipped to utilize technology to produce a simple, consistent, and reliable experience that will enhance member trust and improve engagement.