WHITE PAPER

Care Planning Software Tools: The Key to Health Plan Efficacy

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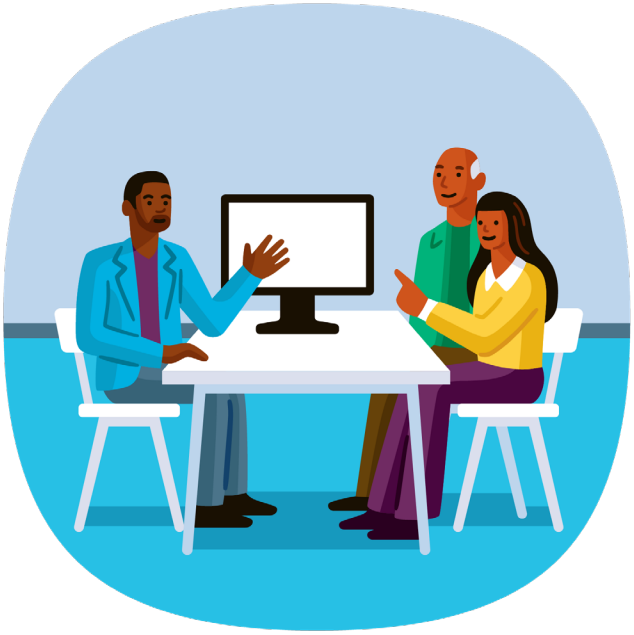

Introduction

When a Health Plan is readying itself to cover a high-acuity population, it will undoubtedly examine the health characteristics of the population and align its provider network accordingly. Nephrologists, vascular specialists, and endocrinologists need to be on hand for patients managing diabetes. Individuals with sickle cell anemia will need access to expert hematologists. The Health Plan will also examine and refine its specialty pharmacy benefit, ensuring that individuals have access to effective treatments with reasonable cost-sharing options.

What a Health Plan may not be thinking about is its care planning software tools.

Care managers, case managers, complex case managers, and social workers alike work magic when it comes to getting appointments, arranging transportation, finding a safe place for individuals to stay after being discharged from a hospital . . . the list goes on and on. Often, we find rich narratives about barriers individuals face and the myriad services arranged to assist them, all carefully documented in a note. Notes are essential—all healthcare professionals know that "if it isn't documented, it didn't happen." But notes are NOT great for handling discrete, reportable data.

Why does a health plan need discrete, reportable data about care planning?

1 Good care planning data can demonstrate the effectiveness of a care management program.

For individuals with a given diagnosis, the percentage of those who received care management—and of those, the percent that received services or care related to that diagnosis—is crucial information.

2 Good care planning data can identify the prevalence of social needs.

For individuals engaged with care management, what types of social needs are identified? What services are available to address those needs? How many individuals with needs actually receive a service?

3 Data about care and services received will allow Health Plans to evaluate the effectiveness of those services over time.

This information is key to building a provider network. It is also key in guiding toward community partnerships to develop services that are not currently available, but – as the data may reveal – needed by many members of the plan.

It's important to note a few points before moving forward.

The first is the use of the term "social needs" and not "social determinants."

Social determinants are the broader set of forces that influence the conditions of daily life from which an individual's health status arises, while social needs are immediate, pressing barriers that an individual may be experiencing.[1] Social needs are what can be addressed by a care manager as part of a comprehensive plan. Social determinants are what a Health Plan can, and should, think about when it looks at its population health status as a whole.

The second point to note is that the service evaluation and community partnership roles that a Health Plan plays cannot be understated.

In 2002, the Camden Coalition began working with Dr. Jeffrey Brenner to design a model of care where traditionally expensive patients could become better managed and therefore less expensive by addressing social factors through intensive care management. While certainly laudable, researchers ultimately concluded that hospital readmission rates among those with case management were the same as the control group, resulting in no meaningful savings. The main point, though, is that many of the interventions may have been successful if services had existed to provide the support individuals needed. "The bottom line is, we built a brilliant intervention to navigate people to nowhere," said Brenner.[2]

1 "When Talking About Social Determinants, Precision Matters, " Katie Green and Meghan Zook. Health Affairs Blog, October 29, 2019. DOI: 10.1377/hblog20191025.776011

2 "Reduce Health Costs by Nurturing the Sickest? A Much-Touted Idea Disappoints," Dan Gorenstein and Leslie Walker. Kaiser Health News, January 8, 2020. https://khn.org/news/lower-health-care-costs-by-helping-the-sickest-a-much-touted-idea-disappoints/

It is important that Health Plans do not assume that services exist for every need, medical or social, that exists within their population. A rigorous process must be in place which identifies needs, tracks which individuals are linked to services to address those needs, and tracks which services individuals end up receiving. This information is vital to driving and supporting community partnerships. Health Plans, with such a wealth of data on needs, services, and utilization, can assist these partnerships by identifying the gaps to be filled and potentially benefiting the entire population.

How does a Health Plan obtain good care planning data?

Look for care management software tools that treat this data like the valuable asset it is.

Kerry Delaney, CEO of Partners Health Plan (PHP) in New York City, a Fully Integrated Duals Advantage (FIDA), shared:

> *"One of the interesting things that we've been able to do is marry our Life Plan [care plan] information with our claims data with our outcome and quality data. So we've been able to really look and say, okay: what cohort of people are interested in moving to, for example, an Independent Living Apartment. And of those people, what are the characteristics of people who have generally been successful in that transition? What services and supports have been brought in? And by looking at that, that can help us focus on people who may be ready to go with minimal supports and bring those additional supports in place so that people have a much better chance of success."*

As mentioned earlier, care managers often write incredibly rich notes. There are some care management software platforms that offer in-note text-based reporting features that work well for tracking essential care planning metrics as long as they are configured correctly. As managers and directors of care management teams, do not shy away from rigorously testing

[3] "Level Up: Using Data to Improve Social Determinants of Health Before, During, and After COVID-19." Kerry Delaney and Doug Golub. National Association of State Directors of Developmental Disabilities Services (NASDDDS) 2020 Virtual Director's Forum. June 4, 2020. https://www.youtube.com/watch?v=MK3lgDZ6O7s.

note templates before and after they are deployed. Monitor reports from any note template sources frequently—a minimum of monthly at first—to ensure that each data element is landing in the right place and that the report is telling the story it needs to tell. Waiting a year "to have enough data to look at" is a recipe for disappointment.

Other software platforms have care plan builders that allow care managers to select problems, diagnoses, goals, services, etc. Care managers return to the care plan tool to document updates, resolve problems, or mark a goal as complete, sometimes generating shareable versions of the care plan to provide to individuals and caretakers. These have some advantages when it comes to building reports because the data is already set up to be captured discretely. Many times, the care plan builder is visually displayed in a way that translates well when constructing a report format.

Testing rigor and report analysis is still strongly advised with these tools, in addition to one more warning: beware of "chronic condition packs" your vendor may have available for download. These will likely cover the bases for evidence-based, standard pathways of care for prevalent conditions. If you decide to use these, make sure the material can be adapted to individual needs, including incorporating social needs. For example, it is essential that an individual newly diagnosed with diabetes understand the different tests, providers visits, and medications essential to managing their condition. However, if the care manager cannot add a transportation need within the care plan builder, this enabling service can get missed, and the software becomes a barrier instead of a tool.

There are undoubtedly additional types of tools beyond the two mentioned. Regardless, the primary considerations for care planning software tools are:

1. It must be flexible enough to handle clinical and social needs.
2. It must capture discrete data.
3. Routine monitoring reports that a tell clear story about identified needs, available services, and services received must be possible.

Only then can Health Plans evaluate if health outcomes of their population change over time. Outcomes evaluation is indeed a much longer-term view—a view that can only be supported through good foundational data, which in turn is supported by good care planning tools.

About the Author

Heather Barr is the MediSked Connect Product Manager. She has been with MediSked for over two years. Before joining MediSked, she spent 20 years in the healthcare industry divided evenly between payer and provider organizations. She has a Master of Health Administration from the University of Pittsburgh Graduate School of Public Health.

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