

An Overview of Integrated Managed Care

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Abstract

Created as a response to the need for more efficient healthcare delivery, managed care continues to be a major influence on the critical decisions made by healthcare providers in the United States. Development of managed care strategies requires an analytical breakdown of costs (inputs) and outcomes of all aspects of patient care. Care thus rationalized is intended to result in greater patient satisfaction and more economic efficiency. Ultimately, 2 important questions about performance need to be addressed by managed care providers: "Are we doing the right thing?" and "Are we doing the right thing well?"

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Today, the focus of managed care has moved away from the management of individual components of care to more comprehensive disease management programs. The rationalized approach of analysis and integration of all components of patient care is expected to result in cost savings that are due to

more efficient use of resources and more positive patient outcomes.

Rationalizing Care: Inputs and Outcomes

The inputs or costs associated with treatment of a particular disease are relatively easy to measure. These include assessment of the activities of physicians, nurses, laboratory personnel, and other providers; services provided by hospitals, nursing homes, and other sites of care; and care-related drugs and devices. The outcomes produced by these factors and how effectively they are applied to a particular patient's needs are, perhaps, more difficult to quantify. Economic outcomes, although useful, often are applied too narrowly and fail to assess total costs adequately. For example, the overall cost of treatment must be determined as part of the drug budget, not merely the cost of medications.

Patients can be evaluated by traditional clinical outcomes; for example, was the disease cured, improved, or not treated? Other measures that are essential parts of rationalized care include: the resultant quality of patients' lives, their ability to carry out activities of daily living, and their overall satisfaction. These less tangible factors may be influenced by simple and relatively controllable factors such as timeliness, respect and caring for the patients' needs, and effective communication between patients and providers.

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A number of cost-containment strategies have been devised that are relatively easy to implement, including visit copayments and limitations on available drugs. However, strategies such as these need to be assessed as a group rather than individually because individual strategies do not function independently. Efforts to reduce costs by targeting specific components of care often result in unanticipated higher costs of other components. For example, in a study of the managed care of 5 diseases, the choice of available medications was limited by a restricted formulary. Ultimately, many patients needed remedial therapy, leading to higher rates of drug utilization and greater use of office, emergency department, and hospital services.¹

In addition, the intensity of care has not been proven a marker of the best outcomes. A recent report found that the length of stay for patients with community-acquired pneumonia (CAP) varied significantly in different hospitals; the medical outcomes of the patients with the shortest stays were similar to those of patients with the longest stays.² Findings such as these have led to the development of more integrated approaches to managed care.

**Disease Management:
Improving Care, Reducing Costs**

Disease management is an integrative approach to managed care for common illnesses, particularly those with high treatment costs. This approach may be defined as the systematic evaluation and improvement of delivery of medical care throughout the disease process, designed to reduce complications, manage demand, and improve clinical, humanistic, and economic outcomes.³ In practice, disease management requires the determination of effectiveness of care, including the accuracy of the diagnosis, the effectiveness of therapy, the recovered or improved

quality of life, and a minimal use of resources.

Because a small percentage of patients with a particular illness generally incur the majority of the costs for treatment, another aspect of the disease management strategy is identifying the population at highest risk for the most serious and costly episodes of a disease. Efforts can then

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be focused on measures to prevent occurrence of such episodes or to reduce the severity of the illness when it does occur. Economic efficiency results from improved outcomes for the patients who are the most seriously ill.⁴

Several national organizations have developed guidelines designed to facilitate disease management. For example, the American Thoracic Society (ATS) and the Infectious Diseases Society of America (IDSA) have created guidelines for CAP.^{5,6} Based on clinical evidence and recommendations from experts in adult infectious diseases, algorithms have been developed to aid clinicians in performing the following tests:

- identifying those at high risk for severe illness,
- choosing empiric treatment for inpatients and outpatients, and
- optimizing a subsequent shift to pathogen-directed therapy.

Local factors, such as the resistance patterns of respiratory path-

ogens in a specific community, must be considered when implementing these guidelines.

Disease Management Recommendations

All policies for disease management are designed to address issues important to managed care, including minimizing unnecessary variation in treatment practices, balancing multiple components of patient care, optimizing outcomes for those at risk for greater severity of disease, and decreasing the need for remedial treatment.

The following are descriptions of instruments that can be adapted and implemented locally as practice standards or disease management policies:

- Practice guidelines are broad recommendations on the process of care for particular clinical diseases and are based on well-designed studies, expert opinion, and a general consensus.
- Standards of care differ from practice guidelines by being more focused and based directly on well-designed, randomized controlled studies.
- Critical pathways or care maps translate a guideline or standard into an algorithm for care that can be used by healthcare providers to implement the guidelines or standard or to monitor compliance with them. Medical review criteria and performance measures are similar in intent.
- Physician profiles determine the rate of compliance with guidelines and standards and are available for physicians to review. However, with the current focus more on the process of care, rather than the individual practi-

tioner, a more appropriate name for this instrument may be process profiles.

- Disease management encompasses most of the instruments described, as well as diagnosis, treatment, management, and monitoring, and, when possible, prevention. Patients' health status, quality of life, and satisfaction with care are also taken into account.

In summary, managed care has begun to focus on comprehensive disease management programs that use analysis and integration of all components of patient care to result in cost savings.

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