Ep #174: Reducing Cost and Improving Care with Case Management – with Deb Ault

Full Episode Transcript

With Your Host

David Saltzman

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David: How can understanding the four modes of medical management help you to deliver exceptionally better value for your clients? We'll find out, on this episode of ShiftShapers.

Change either paralyzes, or energizes. The choice is yours. You're listening to the ShiftShapers Podcast. You're about to learn firsthand from businesses and entrepreneurs who have successfully shaped the shifts in their industries. Get ready to become the change that you want to see. Here's your host and chief transformation strategist, David Saltzman.

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We often think about medical management as something that's kind of a behind the scenes activity, but it's starting to move to front stage and for some very, very good reasons. One of the people who's making that happen is our guest on this episode of ShiftShapers - Deb Ault, otherwise known to those near and far as Nurse Deb. Deb is president at Ault International Medical Management and so with that, welcome Deb.

Deb: Thank you for having me.

David: It's our pleasure. You've had an interesting path to get to where you are today and I think that informs a lot of our conversation. So if you wouldn't mind, would you spend a minute or two talking about how you got to where you are?

Deb: Well sure, I'm happy to do that. I am first and foremost a registered nurse. That's how I started my career at the bedside. Worked in the ER, ICU, critical care kind of areas, moved

around as a lot of nurses do exploring other areas, home health and doctors office. Landed at a telephonic nurse on call program, which was kind of good because it gave me an opportunity to further my education. It also was my first experience of working with patients over the telephone and I was always intrigued with the kind of impact that you could have not being face-to-face with patients. So that's how I wound up on the telephone side of working with patients.

I got laid off from there unfortunately when some cost-cutting initiatives came into play. You guys probably remember that time of the market when all of the big hospitals were having all these great big consulting companies come in and show them how to cut their costs. At that point in time, I was very convinced that managed care was the reason that cost-cutting was necessary on the provider side. I was very vocal about it and was involved in the nurses' union. I had been interviewed for television, spoke with many politicians about the cost-cutting that hospitals were doing, and became more and more dissatisfied at the bedside because of that, and feeling more and more pressure like a lot of nurses do to compromise patient care. So I was very anti-managed care, but then when I got laid off, having been so vocal about the cost-cutting that the providers were doing, I found myself having difficulty getting a job at any of the other large hospitals in the city.

So my husband pushed me to apply for managed care position. I kept telling him, "No, they're the evil ones. They're the reason were having to cut all these costs." To make him be quiet, I applied. Fortunately, I wound up at a company that was nurse-led and they were following the teachings of Catherine Mullahy and were doing good case management. The problem that they were having was that they were having difficulty explaining to the bean counters, especially in the self-funded major medical health plan world which is where I am, how that was having a positive financial impact for the plan.

I'd continued my education, and I'd gotten my bachelors in business with a minor in math and statistics. So they hired me essentially to learn case management because of that math

background and being able to come in and define savings and explain how getting the right patient to the right care at the right time in the right place would naturally result in the right price for the health plan. So that's how I started my career in managed care and have the typical spinoff sell merger acquisition moving around in different roles in the managed care industry.

Then about 15 years ago, we had gone through one of those buyouts by venture capital and said to my husband, “This is crazy. These guys are not the kind of people that I want to work for. I’m going to have to look for another job.” He said, “No I think it's time that we do this for ourselves.” So he convinced me to open AIMM about 15 years ago. We've been working in the self-funded major medical health plan arena ever since.

David: To level set a little bit, you break managed care down into four different types. I’d like to take a moment and explore each one of those. The first one is reactive. What does that mean?

Deb: Reactive is what we kind of traditionally think of when we think case management. So something happens. A patient becomes ill, has a catastrophic condition. They're diagnosed with something or they've had a huge amount of claims spend happen. Then a case manager steps in to react to that. I affectionately call this also a “paid historian” model, because once that diagnosis has already hit, once those claims have already arrived, it's very difficult to do anything that's going to be impactful on the clinical quality of care or on the financial control side. So reactive is kind of responding to things that have already happened, often very far back in the timetable.

David: The next piece you talk about is real-time. What is that and how does that differ from reactive?

Deb: Real-time hit the market about 20 years ago. It was predominantly nurses who were doing case management who were frustrated with reactive and who were saying, “Listen, I need to get out in front of this. I need to be able to respond right away.” So as soon as somebody gets diagnosed with cancer or MS or any kind of life altering condition, I want to get involved

real time at that point in time. That was more effective than reactive, but not still not everything that it possibly could be.

Reactive - when I think of the reactive model and the impact that it's going to have on clinically a patient, it's minimal. The horse is already halfway across the stream; telling them to change paths is difficult at that point. It's disruptive in a negative way. They've already established relationship with care providers. Financially, what you see happen in groups that have reactive case management is they follow trend. If the trend increases 8%, they're going to financially perform at 8%, 9%. If they're really lucky, maybe 7%.

When you get into real-time and you start getting engaged with members at the time of diagnosis, then you can begin to have an impact clinically because you're educating them. At least getting them to understand what questions they need to be asking their care providers. You're also able to have more of a steerage in that which specialists are going to be chosen. Yes, maybe the doctor who diagnosed them with cancer told them a doctor he was going to refer them to but they haven't seen that doctor yet. So if there's another option that they need to be thinking about, they're more open and receptive to it.

It also has a better impact financially. So those groups typically are going to beat trend not by a huge amount, but they will come in a couple of points under trend in comparison to everybody else in the market. So it does have an impact. It's better than reactive, but it's still event-driven.

David: Then there's proactive, which I guess means what it sounds like, but how does that happen in practice?

Deb: So proactive is, if you remember a couple of years ago, we went back to expanding the list of things that require precertification. So there's been this big back and forth and back and forth in the market for things like imaging studies. So maybe you get a pre-cert request for somebody who's going to have an MRI and that MRI is highly suspicious of a catastrophic diagnosis. At that point, you get the member engaged. Start

having conversations with them and say, “Hey I have gotten your precertification completed. When will you get the results back?” You’re building rapport much earlier in the course of illness.

Now, of course, sometimes those will come back no big deal. It was negative. Everything is benign. It's fine. They're not going to need any treatment. So, yeah, there is a little bit of “waste” there, but the benefit of doing it that way is in those instances where it does truly come back important, catastrophic, serious, you've already got rapport built with the patient. They already know that you're there to help them. Making sure that they're getting the right care, making sure that the timing is flowing smoothly, making sure that they're getting care in the right place.

So because you're able to do that, you're able to have a more active role in helping them get the care that's right for them. Doesn't always mean that they’re going to do what I would do or what you would do David, but they're going to make an informed decision. They’re going to have all of the tools and resources and support and guidance at their fingertips to help them through that. So you've become proactive because you've gotten in front of that date of diagnosis. Something is suspicious, there's a high likelihood. There's a potential coming down the pike, now we’re being proactive about getting that person engaged.

David: Now a word from our sponsor.

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So then we go from being in front of the date of diagnosis to actually in front of the diagnosis altogether with the fourth piece which you call predictive.

Deb: Absolutely. I love predictive and I think that it is where everybody should be and probably everybody will be before too much longer. There are great tools out there and have been for quite a while. The problem has been that not a lot of people have wanted to adopt them. Some people are averse to the cost even though it's a minimal cost to do any kind of claims data mining or predictive risk modeling. There's been questions about, "Is this clinically valid? Is this mathematically valid?" I think we've overcome all of those hurdles with a couple of products in the industry. So you can now begin to actually do predictive risk modeling. Guess what? You can initiate case management based on prediction.

Again, is every person that you predict is going to spend $25,000 in claims next year, definitely going to spend $25,000 in claims next year? No. Nobody has got a crystal ball that's 100% accurate, but it's worth the time and energy to invest in doing predictive risk modeling and the medical management that goes along with it. That's really where you can begin to have a maximum impact on people's lives, on what happens to them clinically and what happens to the plan financially.

So with the proactive model of medical management, we talked about where a group is going to perform in comparison to trend. You can really begin to have a good impact on spend. If you do predictive, then you can not only have the impact of proactive

which will continue, but you can also flatten that trend out long term. So if you think of reactive as being right about trend, real-time slightly below trend, proactive cutting trend off, cutting that in half or stopping the flow of dollars, and then predictive as leveling that out long term.

David: You say there's products that are out in the market that do a pretty good job with predictive modeling. I remember years ago when I was with Humana. It was one of the things we chased and the number we always looked at was R squared - more colloquially I guess, how often you predict correctly. Where are those numbers at today? I know there's a lot more data that's flooded into those models that should have increased that.

Deb: So it depends on whether you're looking at clinical prediction or financial prediction. Most of the ones that are really worth using are going to be at least 80% accurate both clinically and financially. There's always going to be that 20% the guy who drives his Lamborghini around the curve too fast and ends up in the side of the mountain that you can't predict. At least 80% accuracy should be the threshold that you're looking for as you're shopping for those.

David: So one of the things we talk about a lot on the podcast - and you may have heard us talk about it - is compliance, and how you get folks to actually engage. I know that you feel that Americans are kind of unique in that they don't really respond to carrots. So that being the case, what do you use? Sticks, or orange sticks, or some combination of the two or…?

Deb: It's different from group to group to group. I think that's one of the key characteristics. If you want to be successful in continuing to provide health benefits, but being able to do that in a financially feasible way, you have to understand your population and what works for them. Don't get me wrong. I've got a group or two that their members will respond to a drawing for a $5 movie coupon. But those are pretty few and far between. Generally speaking, as Americans, we're pretty affluent. Even offering somebody a big-screen TV may not be enticing to them. For the most part, you're not really able to buy

behavior. You may be able to buy participation, but participation isn't going to generate the outcomes that you want if people don't change their behavior. So it's a real challenge.

I think the only thing that has truly worked in my experience… what I've seen work is an intensive education campaign and a culture shift within the organization, the employer organizations, since the employer is the one that's providing the health plan. When you begin to get that happening, then your engagement rates go up. Engagement results in behavior change. Behavior change results in cost reduction. So it's really appealing to the nobler motive as Carnegie would say. That seems to work best with the most of our groups or most Americans.

In other countries, things are different. As we travel the globe, we find that different cultures have different motivations. Most of the people that I work with…again, I work in a self-funded major medical health plan arena. So these are all people who are gainfully employed and they can pretty much afford the things that you would offer. Although I will tell you that I have seen groups be very successful, especially with the younger generation….so if the population of the plan is very young, offering incentives for things like extra days off, because we find that a lot of people in that millennial generation are seeking better work life balance, but again that's not always as effective at getting the behavior change which is the real outcome that you're striving for.

So it really boils down to education and changing the culture of the organization. It really has to start at the top of the organizations. So the C suite has to be on board and they have to be focused on this. They have to be focused on a combination of a couple of different things. They have to be focused on how do we improve the health of our members and simultaneously control the cost of our health plan. So that's a balance that they have to be focused on. If they focus just on cost, we're back in the old HMO world and that's not going to get us where we want to be.

If they focus just on health - especially if the tenure of the population isn't a long one - they may be investing in making that person healthy for their competitor when they leave and go to work for somebody else. So there's a real balance there. The C suite has to be involved in setting up what that balance is going to be for their organization.

David: There's a lot of conversation going on around a topic that you may have bumped into called noncompliance. Where do you stand on noncompliant and working with noncompliant individuals as a tool to help move trend and to move claim spend?

Deb: So that's an interesting topic because as nurses we work with patients. The whole noncompliance issue is continual. You have to really step back and start thinking about things like Prochaska method and where somebody is on the stages of change scale and those kinds of things. There's noncompliance for a lot of different reasons. We have to determine whether that noncompliance is what I call the result of free will. "I'm fully educated about the ramifications of my choice but I'm going to make this choice anyway," versus noncompliance that comes from a position of lack of knowledge.

When it's coming from a position of lack of knowledge, there's a lot that can be done, by case management and in particular, medical management, to make sure that that person is equipped with all of the information, resources, support, guidance that they need so that they can make the best choice possible. I talked a little earlier about the HMO world. Most self-funded health plans at least don't want to dictate treatment. They don't want to be in the business of practicing medicine for their employees. They're in the business of making widgets or whatever their core business is. They do want their people to have the information to make the right choices for them.

So distinguishing noncompliance into two different categories, the categories I call it a free will versus lack of information and education and then applying Prochaska method and

motivational interviewing techniques and things to make sure that that patient has everything that they need.

David: So we've got about a minute or two left. We always like to wrap up by asking our guests where they see the future. You certainly are out on the edge and doing some things that other folks maybe haven't embraced yet. Where do you see your field going? Where do you see the future?

Deb: I really feel like we're at a great crossroads right now. I'm not sure that everybody in the industry recognizes it. I think especially with everything that's happening politically, one of two things will happen. Either we, meaning those of us in the industry, will step up and revolutionize healthcare or we'll end up with a single-payer nationalized healthcare kind of system. I think were at that point that in the very short term we're going to have to make a decision as a country and go one way or the other.

I think that we as an industry have the capability. We have the tech. We have the mind power. We have the resources to truly revolutionize healthcare. I think that the tools are there. The question will become whether those who are providing health plans, the employers that are sponsoring health plans will get on board with it and will grasp it, and whether the big carriers will embrace it or not. Whether the big hospital providers will embrace it or not. I think that's yet to be seen. I think we'll go one of two ways. We'll either revolutionize it and it will be a beautiful thing or we'll end up in a nationalized system.

David: Well that certainly is a stark choice and we'd love to have you back as that unfolds and talk to you more about where the direction is. Deb Ault, president at Ault International Medical Management. Nurse Deb, thanks for sharing your expertise with the ShiftShapers audience.

Deb: Thanks for having me. I look forward to talking again sometime soon.

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