ABS Automated Benefit Services

# Managed Care Services

## Disease Management

The ABS Disease Management Program focuses on keeping patients with specific chronic conditions healthy by educating the individual on improving self-management techniques. Members are referred to the program by their doctor, or may be invited to join based on ABS staff review of hospital stays and claim reports.

Population disease management considers aggregate data from the population as a whole, and focuses on the most prevalent chronic conditions such as COPD, asthma and heart failure. Assessment of the population dictates disease focus and interventions.

Program Scope

The Disease Management Program includes the evaluation of multiple resources to determine patients who would benefit from disease management services. Resources from which one may be referred for disease management include but are not limited to:

- Claims Data
- Discharge Data
- Pharmacy Data
- UM Process Data
- Discharge Planner Referral
- Member Self-Referral
- PCP/ Specialist Referral
- Case Management Program Referral

Patients will be stratified into high, moderate and low risk categories. High risk patients may receive individualized disease management interventions including but not limited to phone interventions, frequent written communication, and in-person counseling. High risk patients may also be referred for case management services when necessary. Moderate risk patients may receive disease specific mailings and written communications. Low risk patients are monitored. All patients are offered the opportunity to speak with a disease management professional. Continual evaluation of risk status identifies members at early stages in the disease process and allows for early intervention.

Disease management strategies will be based in four domains:

- At-Risk Populations
- Preventive Health
- Care Coordination
- Patient Safety

Each of these domains will encompass several areas of focus or measures.

- At-Risk Populations
- Diabetes - Hgb. A1c, BP, LDL, HTN Control
- Hypertension
- Ischemic Vascular Disease
- Heart Failure
- Coronary Artery Disease
- Preventive Health
- Influenza and Pneumococcal immunization status
- Adult weight screening and follow up
- Tobacco use and cessation education
- Screening for depression, colorectal cancer
- Mammogram screening
- Adults with a blood pressure measurement
- Care Coordination
- All condition readmissions
- Ambulatory Sensitive Condition Admissions for COPD and CHF
- Medication reconciliation after discharge
- Patient Safety
- Fall risk assessment

Program Evaluation

Providers, patients, and, if indicated, family members are surveyed at the termination of care on their level of satisfaction with the Disease Management Program. Results are analyzed to identify opportunities for improvement. Actions are initiated to improve performance when needed. In addition member complaints and inquiries are reviewed for potential satisfaction concerns.
Annually the disease management staff reviews program effectiveness. The findings are used to modify the program and improve its efficiency and effectiveness.

To determine the effectiveness of the program, ABS will utilize valid methods of measure with clearly identified specifications.