Insurance
INSTITUTE OF EAST AFRICA

MEDICAL MANAGEMENT FOR HEALTHCARE PROFESSIONALS

Online Course

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Introduction

Over the last several years, landmark reports have brought attention to the gaps between evidence-based best practices and the care some patients actually receive. However, when health care organizations adopt medical management tools, the gap closes. As care improves, costs go down. The **Medical Management for Healthcare Professionals** online course provides the information tools you need to ensure that more consumers and patients receive safe, effective, affordable care.

Suitability

This course is suitable for:

- Care Managers
- Case managers
- Government benefit programs administrators
- Health insurance provider staff
- Medical directors
- Medical management staff
- Pharmacy benefit manager staff

Learning Objectives

On completion of this course, you'll be able to:

- Understand the role of medical management in health insurance provider organizations
- Identify how and why a delegation is used in medical management
- Examine the role of medical management in providing pharmacy services
- Recognize the importance of preventive care and self-care programs
- Explore strategies for managing complex individual cases
- Understand disease management—its purpose, processes, and programs
- Learn how medical management is used in different types of care
- Quality management methods—measurement and improvements

Module One: Course Overview and Introduction

Learning Objectives

- **Introduction**

Module Two: Medical Management in Health Plans

Learning Objectives

After completing this module, you should be able to:

- Name and briefly describe the main medical management programs.
- Explain how the characteristics of a health plan and its members affect medical management in the plan.
- Discuss how medical management interacts with other health plan functions.
- Define delegation and subdelegation and discuss the issues related to them.

What is covered

- Medical Management Programs
  - Quality Management
  - Utilization Management
  - Clinical Practice Management
  - Case Management
  - Disease Management
  - Preventive Care and Self-Care
- Medical Management Factors
  - The Type of Health Plan
  - The Member Population
  - Other Considerations
- Medical Management Organization and Staff
  - Medical Management Personnel
  - Medical Management Committees
  - The Integration of Medical Management Programs
- Medical Management and Other Health Plan Functions
  - Network Management
  - Provider Compensation
  - Risk Management
  - Legal Affairs
  - Claims Administration
  - Member Services
  - Finance
  - Sales and Marketing

    - Information Management
- Delegation
    - To Delegate or Not to Delegate?
    - Delegated Activities
    - Delegation to Provider Organizations
    - Oversight of Delegation
    - Subdelegation

Module Three: Healthcare Quality and Quality Management

Learning Objectives

After completing this module, you should be able to:

- Explain why healthcare quality and quality management are important;
- Describe the three dimensions of healthcare quality (structure, process, and outcomes);
- Identify the six key factors in healthcare quality (according to the Institute of Medicine);
- Discuss how legislation and regulation, healthcare purchasers, accrediting bodies shape quality management.

What is covered

- Why Are Quality and Quality Management Important?
- The Development of Quality Management
- The Three Dimensions of Quality
    - Quality of Structure
    - Quality of Process
    - Quality of Outcomes
- Other Concepts of Quality
    - Six Key Factors in Healthcare Quality
    - Organizational Quality: The Model of the Baldrige Award
- Evolving Expectations
    - Legislation and Regulation
    - Purchasers
    - Accreditation Bodies

Module Four: Quality Assessment and Measurement

Learning Objectives

After completing this module, you should be able to:

- Explain what it means to say that a measure of healthcare quality is meaningful, relevant, feasible, reliable, and valid;
- Describe the three main sources of data for measuring healthcare quality—clinical records, administrative data, and surveys—and give the advantages and limitations of each;
- Identify and describe the four main components of performance measurement;
- Describe how healthcare processes are categorized and prioritized; and
- Discuss the different types of quality standards and quality indicators.

What is covered

- What to Measure
  - Is the Measure Meaningful?
  - Is the Measure Relevant?
  - Is the Measure Feasible?
  - Is the Measure Reliable and Valid?
- Where Is the Data?
  - Clinical Records
  - Administrative Data
  - Surveys
  - Other Focused Data Collection Activities
- Components of Performance Measurement
  - Performance Component 1: Key Customers
  - Performance Component 2: Services
  - Performance Component 3: Identifying, Categorizing, and Prioritizing Processes
  - Performance Component 4: Developing Quality Standards and Quality Indicators

Module Five: The Performance Measurement System

Learning Objectives

After completing this module, you should be able to:

- Discuss the main questions in designing a health plan's performance measurement system: What is the purpose of measurement? Will the plan or providers be measured? Who will use the measurement? What will be measured?
- Distinguish between structure, process, and outcome measures, and give the advantages and disadvantages of each;
- Describe the characteristics that make a performance measure scientifically sound: reliability, validity, precision, and adaptability; and
- Explain how data from different sources (administrative data, clinical records, and surveys) is gathered, analyzed, and used differently.

What is covered

- Designing a Performance Measurement System
  - The Purpose
  - The Plan or Providers?
  - The Users of the Information
  - What to Measure
- Structure, Process, and Outcome Measures
  - Process Measures
  - Outcome Measures
- Performance Measures: Technical Criteria
  - Risk Adjustment
  - Interpretability of Results
- Sources and Types of Performance Data
  - Administrative Data
  - Clinical Records
  - Member/Patient Surveys
  - Tracking Complaints

Module Six: Reporting and Challenges in Measurement

Learning Objectives

After completing this module, you should be able to:

- Distinguish between internal and external reporting,
- Describe reports cards for health plans and provider groups, and
- Discuss some of the issues and challenges in performance measurement.

What is covered

- Internal and External Reporting
  - The Value of Reports
- Report Cards
  - Health Plan Report Cards
  - Provider Report Cards
- Challenges in Quality Measurement
  - Comparability
  - Subjectivity
  - Biased or Misleading Reporting
  - Electronic Health Records
  - Resources
  - Overcoming Obstacles

Module Seven: Utilization Review: How UR Works

Learning Objectives

After completing this module, you should be able to:

- Explain why and how utilization review is conducted.
- Distinguish between medical and administrative review.
- Explain what utilization guidelines are, what they are based on, and how they are used.
- Distinguish between utilization guidelines and clinical practice guidelines.
- Describe a typical authorization system.
- Describe the use of prospective, concurrent, and retrospective UR.
- Identify the sort of services that are typically subject to UR.

What is covered

- An Overview of Utilization Review
- Utilization Guidelines
  - Clinical Practice Guidelines
  - The Value of Utilization Guidelines

- The Authorization System
  - Streamlined Authorization Processes
  - Physician Authorization
  - Self-Referral
- Prospective, Concurrent, and Retrospective Review
  - Prospective Review
  - Concurrent Review
  - Retrospective Review
- Use of Resources
- The Focus of Utilization Review

Module Eight: Utilization Review: Appeals, Regulation and Accreditation, and Other Issues

Learning Objectives

After completing this module, you should be able to:

- Discuss some of the issues that can arise from the non-authorization of benefits based on UR.
- Describe the steps of appealing a non-authorization, including independent external review.
- Summarize the main regulatory requirements for utilization review.
- Summarize the standards of agencies that accredit UR programs.
- Discuss some of the issues related to UR, such as relations with plan members and providers, the use of information technology, staffing and training, the relations of UR programs and claims departments, the use of community standards of care, and the evaluation of UR.

What is covered

- Non-authorizations
  - Legal Liability
- The Appeal Process
  - The Appeals Process
  - Formal Appeal Level One
  - Formal Appeal Level Two
  - Independent External Review
  - Using Appeals Data
- Regulation
  - The Practice of Medicine
- Accreditation
- UR Issues
  - Information Management
  - Staffing and Training
  - UR and Claims
  - The Use of Community Standards of Care
  - Evaluating UR Results

Module Nine: Case Management: What It Is and How It Works

Learning Objectives

After completing this module, you should be able to:

- Describe the role, responsibilities, and qualifications of a case manager
- State the main purposes and goals of case management
- Discuss the different needs of health plan members that case management can meet
- Describe the steps of the case management process

What is covered

- The Case Manager
- Case Management and Health Plans
  - Case Management Activities
- Meeting Needs
  - Medical
  - Financial
  - Psychosocial
  - Vocational
- The Case Management Process
  - Case Identification
  - Assessment
  - Planning
  - Implementation and Monitoring
  - Evaluation
  - Case Management Reports

Module Ten: Case Management: Issues in Case Management

Learning Objectives

After completing this module, you should be able to:

- Discuss certain strategic choices health plans must make in setting up a case management program (in-house or outsourced? How much onsite and how much telephonic?).
- Describe how health plans meet the challenges of integrating case management with other functions, staffing and training, and using technology.
- Report the measures a health plan can take to minimize the risk that can arise from case management activities.
- Describe how health plans evaluate their case management programs.
- Discuss the regulation, certification, and accreditation of case management.

What is covered

- Choices and Challenges in Case Management
  - In-House Versus Outsourcing
  - Onsite Versus Telephonic Case Management
  - Integration with Other Health Plan Functions
  - Staffing and Training
  - Information Management Systems
- Risk Management
  - Documentation
  - Confidentiality and Disclosure
  - Early Intervention
  - Oversight of Delegated Case Management
- Evaluating Programs
- Regulation, Certification, and Accreditation
  - Regulation
  - Certification
  - Accreditation

Module Eleven: Disease Management

Learning Objectives

After completing this module, you should be able to:

- Explain how disease management programs work.
- State the benefits of DM programs.
- Discuss the delegation of disease management by health plans to other entities.
- Describe the main activities in developing and implementing a DM program, including choosing the disease to be targeted, identifying and recruiting those who could benefit, educating participants, developing or adopting clinical practice guidelines, gaining provider support, and evaluating the program.

What is covered

- How Does Disease Management Work?
- Why DM Programs?
  - Return on Investment?
  - Regulation and Accreditation
- Who Provides Disease Management?
  - To Delegate or Not?
- Developing and Implementing a Program
  - Identifying the Population
  - Recruiting and Educating Patients
  - Developing Clinical Practice Guidelines

  - Gaining Provider Support
  - Other Development and Implementation Activities
- Other Considerations
  - Evaluation
  - Legal Issues
  - Information Management

Module Twelve: Acute Care: Inpatient and Emergency Care

Learning Objectives

After completing this module, you should be able to:

- Describe the role of the attending physician in managing a person's inpatient acute care.
- Discuss the potential benefits and drawbacks of using primary care providers and hospitalists as attending physicians.
- Discuss the reasons for the high cost of emergency services.
- Identify and discuss several strategies to reduce the cost of emergency services while maintaining or enhancing quality.

What is covered

- Inpatient Acute Care
  - The Role of the Attending Physician
  - The Hospitalist
  - PCPs as Attending Physicians
  - Strategies for Using Hospitalists
- Emergency Services
  - Emergency Services Quality
  - Emergency Services Costs
  - Educating Members
  - Telephone Triage
  - Withholding Benefits
  - Improving Access to Primary Care
  - Urgent Care
  - Observation Care
  - Focusing on Frequent ED Users

Module Thirteen: Acute Care: Clinical Pathways and Centers of Excellence

Learning Objectives

After completing this module, you should be able to:

- Define a clinical pathway and state its purpose.
- Discuss the uses and advantages of clinical pathways.
- Describe how clinical pathways are developed, including the involvement of health plans.
- Define and describe centers of excellence.

What is covered

- Clinical Pathways
  - The Use of Clinical Pathways
  - The Advantages of Critical Pathways
  - The Development of Clinical Pathways
  - Implementation and Revision
  - Health Plan Involvement
  - Risk Management
- Centers of Excellence

Module Fourteen: Post-Acute Care

Learning Objectives

After completing this module, you should be able to:

- Describe subacute care and discuss the role of medical management in it.
- Compare and contrast subacute care and skilled care.
- Discuss the role of medical management in the care provided in skilled nursing facilities (SNFs) and by home healthcare agencies (HHAs).
- Discuss the advantages of palliative care and hospice and report how health plans can encourage their use and ensure their quality.

What is covered

- Subacute Care
  - Medical Management
- Skilled Nursing Facilities
  - Medical Management
- Home Healthcare
  - Utilization and Case Management
  - Quality Management

- End-of-Life Care
  - Choosing Palliative Care
  - The Role of the Health Plan

Module Fifteen: Preventive Care and Wellness Programs

Learning Objectives

After completing this module, you should be able to:

- Describe health plan preventive care programs.
- Discuss the considerations and issues related to health risk assessments.
- Describe employer wellness programs.
- Discuss the legal issues related to wellness programs.

What is covered

- The Benefits of Prevention and Wellness
- Preventive Care
  - Types of Preventive Care
  - Preventive Care and Medical Management
  - Preventive Care Programs
  - Immunization Programs
  - The ACA: Coverage of Preventive Services Without Cost-Sharing
- Health Risk Assessment
  - Obtaining Information
  - HRA Content
  - Administering HRAs
  - Participation
  - Using HRA Data
  - Other Considerations
- Wellness Programs
  - Health Assessment
  - Planning
  - Implementation
  - Evaluation

Module Sixteen: Pharmacy Benefit Management: Formularies and Pricing

Learning Objectives

After completing this module, you should be able to:

- Compare and contrast the different types of drug formularies.
- Describe requirements for prior authorization, step therapy, generic and therapeutic substitution, and dispensing.
- Describe how formularies are developed and managed.
- Describe how health plans and PBMs lower their costs by maintaining pharmacy networks and negotiating discounts and rebates from manufacturers.
- Report some of the ways technology can be used both control costs and ensure quality and safety.

What is covered

- Drug Spending
- Cost-Sharing
- What Drugs Are Covered?
- Rules for Prescribing and Dispensing
  - Prior Authorization
  - Step Therapy
  - Drug Substitution
  - Dispensing Guidelines
- Developing and Managing the Formulary System
  - The P&T Committee
  - Drug Selection
  - Member and Provider Satisfaction
- Managing Drug Prices
  - The Network
  - Discounts and Rebates
  - Trends in Drug Prices
- Technology
  - POS Systems

Module Seventeen: Pharmacy Benefit Management: Medical Management Approaches

Learning Objectives

After completing this module, you should be able to:

- Describe drug utilization review (DUR)—prospective, concurrent, and retrospective.
- Report how case management, disease management, and medication therapy management can be used in drug therapy.
- Identify the main ways health plans and PBMs can prevent drug errors.
- Report how health plans and PBMs improve physician utilization of drug therapy through education, profiling, incentives, and risk-sharing.
- Report how plans and PBMs encourage member compliance with drug therapy through education and technology.
- Identify some of the main laws and regulations that affect pharmacy benefit management.

What is covered

- Drug Utilization Review and Management
  - Prospective DUR
  - Concurrent DUR
  - Retrospective DUR
- Case, Disease, and Medication Therapy Management
  - Case Management
  - Disease Management
  - Medication Therapy Management
- Preventing Drug Errors
- Provider Utilization Strategies
  - Education
  - Provider Profiling
  - Incentives and Shared Risk
- Member Compliance with Drug Therapy
  - Education
  - Technology
- Pharmacoeconomic Research

Module Eighteen: Specialty Services

Learning Objectives

After completing this module, you should be able to:

- Discuss the advantages and disadvantages for a health plan of delegating coverage of specialty services to another organization.
- Describe medical management approaches in behavioral healthcare.
- Describe medical management approaches in dental care
- Describe medical management approaches in vision care.
- Describe medical management approaches in complementary and alternative medicine (CAM).

What is covered

- Carve-Outs
- Behavioral Healthcare
- Managing Behavioral Healthcare
  - Providers
  - Clinical Practice Guidelines
  - Utilization Management
  - Case Management
  - Disease Management
  - Integration of Behavioral Healthcare and Medical Care
  - Quality Management
- Dental Benefits
  - Utilization Management
  - Quality Management
- Vision Care Benefits
  - Utilization Management
  - Quality Management
  - Coordination with Medical Care
- Complementary and Alternative Medicine Coverage
  - Coverage of CAM
  - Liability
  - Providers
  - Utilization Management
  - Quality Management
  - Integrating CAM with Medical Services
  - Evaluating CAM Outcomes

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