CHANGE HEALTHCARE

Insight. Innovation. Transformation.

InterQual® Coordinated Care

Manage the Care of High-Risk Members and Patients

As chronic illness now accounts for more than 90% of the nation's $3.3 trillion in healthcare costs,[1] managing chronic disease has become a critical business challenge for health systems and health plans.

In 2015, Medicare began paying a monthly fee to providers who deliver chronic case management for beneficiaries with multiple chronic conditions. However, implementing effective chronic case and disease management solutions for members or patients with potentially high-cost conditions remains a complex process. First, developing and maintaining up-to-date, evidence-based care management content takes considerable time and requires staff with advanced skills. Second, assessments are often duplicative for those with multiple conditions, which can be frustrating for both the care manager and member/patient.

InterQual® Coordinated Care is an integrated, software as a service (SaaS) solution designed to help health systems and health plans manage high-risk conditions and complex cases. Explicitly developed to address cases in which members/patients have more than one condition, InterQual Coordinated Care relies on the same rigorous, evidence-based process that has made InterQual the gold standard of decision support.

By merging assessment components for all relevant conditions, InterQual Coordinated Care enables the creation of a single, blended care plan. This inclusive approach is more efficient than multiple redundant plans, which can absorb staff time and increase patient frustration.

A Holistic Approach

The solution's comprehensive member/patient assessment takes a holistic approach to co-assess applicable medical, behavioral, and social determinants of health. As care managers are better informed about the patient's full circumstances, they are able to more easily improve outcomes and prevent readmissions. InterQual Coordinated Care is accessed from within the case management workflow systems, increasing care manager efficiency.

Comprehensive Assessments

InterQual Coordinated Care provides assessments in a simple Q&A format. The Primary Assessment addresses common care barriers, including social determinants of health. The case manager has the flexibility of adding one or more of 40 patient conditions to create a patient-specific assessment in real time. The assessment also includes complex case management, special needs, ADL screening, IADL screening, cognitive screening, and caregiver needs, among many others.

In addition to the Primary Assessment, the solution includes a Palliative Care Assessment, High Risk Neonate and Caregiver Discharge Assessment, Screening Tool Assessment, Long-Term Services and Support Assessment, and a Readmission Reduction Assessment to help mitigate avoidable readmissions within 30 days of hospital discharge.

Integrated, Cloud-Based Solution

InterQual Coordinated Care is a flexible SaaS solution that can be easily integrated into either homegrown or commercially available care management systems. With InterQual Coordinated Care, you receive comprehensive evidence-based content, combined with a modern, user-friendly interface for conducting assessments.

The SaaS platform consists of a cloud-based backend and an easily integrated frontend. This architecture helps you reduce your IT burden by providing real-time access to content and software upgrades without the need to wait for installation and validation, while still affording you control of when to upgrade to newer content. The architecture also offers the freedom to make InterQual Coordinated Care available throughout a networked system, such as a multi-hospital and outpatient network or multi-location health plan, without increasing your IT burden.

InterQual Coordinated Care works with any modern browser, and utilizes an application programming interface (API) that is available in tech-friendly HTML and JSON formats.

InterQual Coordinated Care Helps:

Increase efficiency—General, case management, and disease-specific questions are blended into a single assessment instead of multiple, siloed assessments. Questions, answer choices, and interventions that are common to multiple diagnoses are not duplicated, saving time for clinicians and members/patients.

Manage care holistically—In addition to co-assessing medical, behavioral, and social needs, assessment questions take into consideration co-morbidities and cross-condition issues for a clearer overall picture of a person's health.

Reduce costs—Evidence-based, tailored care management programs allow you to better control the medical costs of high-risk members/patients.

Enable consistent decisions based on evidence-based content—With industry-leading content from InterQual Criteria, you save time and resources developing and updating clinical content.

Meet regulatory requirements—URAC has awarded InterQual Coordinated Care accreditation for both care management and disease management, affirming our commitment to quality and accountability. InterQual Coordinated Care has been used to help health plans meet NCQA PHM5, MBHO QI8, and SNP program requirements, which require plans to have various processes and systems in place to support members.

[1] Centers for Disease Control and Prevention, "Health and Economic Costs of Chronic Diseases," January 12, 2021. https://www.cdc.gov/chronicdisease/about/costs/index.htm

InterQual Coordinated Care Offers:

Flexible SaaS integration—InterQual Coordinated Care is a cloud-based solution that can be easily integrated into homegrown or third-party care management delivery systems.

Goal and barrier hierarchy—Health issues are rated by priority status on a scale of 1 to 6, giving care managers the ability to quickly prioritize care.

Care management—Nurse/patient action questions promote interaction with provider for care management issues.

Standardized screenings—The solution includes multiple industry-validated, copyrighted, standard screening tools to assess member/patient status. Screening results are weighed, or "scored," and can drive care plan barriers or trigger additional questions or surveys.

Education materials for case managers—Includes materials to guide case managers in consistently providing information about specific conditions and condition management for members/patients.

Educational materials for members/patients—Companion member/patient-facing fulfillment materials are included to reinforce the education delivered by the care manager.

urac CERTIFIED Disease Management Expires 01/01/2024

urac CERTIFIED Case Management Expires 01/01/2024

Management and Condition-Focused Modules:

- Alcohol Use Disorder
- Alzheimer's Disease/Dementia/Major Neurocognitive Disorder
- Asthma
- Atrial Fibrillation
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Bone Marrow Transplant/Stem Cell Transplant
- Cancer
- Cerebral Vascular Disease/Stroke/TIA
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease Chronic Pain
- Chronic Traumatic Brain Injury
- Chronic Wound
- Cocaine Use Disorder
- Complex Case Management
- Coronary Artery Disease
- Depression
- Diabetes
- Dyslipidemia
- End Stage Renal Disease
- Generalized Anxiety Disorder
- Heart Failure
- Hepatitis B&C/Cirrhosis
- High-Risk Pregnancy
- HIV Disease/AIDS
- Hypertension
- Low Back Pain
- Lupus
- Migraine Headache
- Multiple Sclerosis
- Obesity
- Opioid Use Disorder
- Panic Disorder
- Rheumatoid Arthritis
- Schizophrenia
- Sleep Apnea
- Social Anxiety Disorder
- Solid Organ Transplant
- Specific Phobia/Agoraphobia
- Ulcerative Colitis

Standalone Assessments:

- High-Risk Neonate and Caregiver Discharge Assessment
- Long-Term Services and Support (LTSS)
- Palliative Care Assessment
- Readmission Reduction Assessment
- Screening Tool Assessment

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