WHITE PAPER

FEBRUARY 2016

Developing Care Management Programs to Serve High-Need, High-Cost Populations

Executive Summary

INSIGHTS FROM THE
HEALTH CARE TRANSFORMATION TASK FORCE

The care management continuum refers to a suite of services and interventions designed to improve care for high-need, high-cost patient populations. Overall, the goal of care management is to help improve and coordinate care for the most complex patients, often those who are often facing multiple chronic conditions. From the initial identification of patients in need, to coordination of care and communication across settings and providers, to evaluation of patient outcomes, care management provides whole-person and patient-oriented care to help high-need patients and their families and caregivers effectively manage their conditions.

As the health care system shifts from a fee-for-service structure to value-based payment programs, appropriate provision of services across the care management continuum can increase value and improve outcomes for patients, while effectively reducing unnecessary care and acute care episodes requiring high-cost interventions.

Unlike traditional, condition-specific disease management programs, complex care management incorporates multidisciplinary teams to provide care across a continuum, linking patients with multiple chronic conditions, advanced illnesses, and/or other medically complex issues to appropriate provider teams and a wide variety of resources. Successful care management programs include many components, or building blocks, that ensure comprehensive, effective, patient-centered services.

The care management process begins by identifying the patients with the highest need and engaging them in the care management process. Once a provider assesses a patient's needs and complete health situation, a personalized care team of various physicians, caregivers, and medical professionals, is formed. This care team must coordinate efforts across settings, enabled by infrastructure for sharing clinical health information. At the heart of these programs, though, is the patient, and patients and their families and caregivers should be involved in managing the patients' own health. Patients with specific chronic illnesses who can benefit from traditional disease management receive those services as one part of the care management continuum.

As patients move through health care system, and specifically in the event of an acute care episode, transitional care is key to preserving high quality care and preventing lapses in care management. Finally, the goal of care management is to improve the quality of care for patients. In order to assess whether this goal is being met, effective care management programs employ a common quality measurement and evaluation framework that can be used to both assess individual care management programs, and to compare outcomes between different programs.

Health Care Transformation Task Force Members operate a variety of care management programs that include most of the care management building blocks. The Appendix to this paper provides detailed examples of case studies led by patient, payer, and purchaser member organizations. Together, the case studies demonstrate that: (1) Properly addressing the patient-centric nature of care management is critical to a program's success; and (2) Effective care management reduces the need for inpatient hospital services.

Through the experiences from their care management programs, Task Force members have identified several lessons learned and opportunities for improvement:

- ***Ensuring Meaningful Patient and Caregiver Engagement*** – Engaging patients and informal caregivers, including family, at all levels of care delivery is integral to the success of care management programs. Forming meaningful partnerships with patients and family caregivers occurs not just at the point of care, but also at the system design/redesign level, and at the community level. At the point of care, treating the patient as the center of the care as well as a member of the care team, and utilizing techniques such as motivational interviewing and face-to-face communication can go a long way to engage a patient and will help the care team to better understand the needs of the patient. At the system level, patients and caregivers can offer important feedback and perspective on care procedures and tools such as patient portals, and should therefore be included in governance discussions and on leadership committees. At the community level, patients and caregivers can help bridge a potential gap between acute care and community-based care management resources.

- ***Performance Measurement: Evaluation of Care Management*** – The Task Force recommends that care management programs include processes for evaluating patient-reported outcomes (PROs) and low- or no-value care. PROs provide information that is important to providing whole person care: health status and behavior, severity of pain, physical functioning, quality of life, etc. This information is most important to patients and may not be available anywhere else. While PROs have been widely used in clinical trials and research, the measures are just beginning to gain traction in public and private value-based purchasing programs. Furthermore, current measurement tools are imperfect. Improving PRO measurement tools and incorporating them into a care management structure can build patient engagement and hold practices accountable for patient health improvements. In addition, care management programs should incorporate a system for evaluating low- or no-value care (i.e., higher intensity treatments that do not yield better outcomes). Care management programs are designed to eliminate care that is either not desired by patients or does not serve to improve clinical outcomes. To effectively evaluate success, these programs should collect information on incidences low- and no-value care in order to reduce waste, improve care, and lower costs.

- ***Context Matters: Defining the Scope of Care Management Programs*** – There is no one-size-fits-all approach for care management. Each program serves its own patient population, reflective of local demographics. In addition, practice size, setting, and program sponsorship and governance impact the resources that a program has at its disposal. Successful care management programs will leverage their resources in the best way for their patient population, while coordinating care between providers and programs.

- ***Designing for Success: Tailoring Care Management Programs to Individual Patients*** – Successful care management programs respond to the specific needs of the patient. This is made possible through the establishment of a trusting relationship at the outset of care. Considerations for the high-need, high-cost population include the patient’s health insurance provider, access to community resources, language preferences, socioeconomic status, and culture. Care management programs and plans should be continuously assessed and adapting to the ever-changing needs of the patient.

- ***Overcoming Resistance to Services*** – Both providers and patients can exhibit resistance to care management, partially because advancing the Triple Aim involves changing the status quo. Providers who are philosophically aligned with the program, have a track record in improvement, and who are financial invested in the program's success may provide the strongest leadership for an effective program. For patients, education, patience, empathy, and peer support are critical in overcoming the fear, anxiety, shame, distrust, or other factors that may influence patient resistance to services.

In conclusion, effective care management programs take various forms, yet successful programs incorporate certain foundational building blocks that highlight patient need and a patient-centered approach to care. Care management programs should be structured in a way that best suits the patient demographics and available resources of the provider organization, and care managers should work to engage patients and caregivers in creating the care plan and managing a patient's health. These care plans should be individualized and respond to changing patient needs. Finally, care management programs should be continuously evaluated using patient reported outcome measures in order to evaluate the quality of care and to ensure that care management programs are successfully improving outcomes while reducing costly care that is either not desired or not clinically beneficial to patients.