CARE MANAGEMENT
AND THE VALUE-BASED TRANSITION

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Calls, faxes, and notices from case managers, care managers, care navigators, health navigators, care coordinators, community health workers, and many other patient-centered care team members are lighting up the phones and EHR portals. Care managers are arriving from various settings: inpatient, ambulatory, insurer-based, centralized, home health, skilled and long-term care.

Confusion with who’s calling, why they’re calling, and what they want can cloud the view and frustrate providers and patients. “All of the above” appear to be crowding the landscape of individual practices and not recognized as much needed support for providers in managing their overflowing panel of high-risk patients. “All of the above” is designed to provide a level of support to the physician, the patient, and their caregivers that will assist in coordinating care in our fragmented health care systems, improving clinical outcomes and the quality of life for patients.

As health care delivery shifts from fee-for-service to value-based care, and physicians reconcile competing and sometimes contradictory incentives, there is value to adding an expanded health care team to the equation. Although independent physicians may not necessarily be convinced they need or want an extended team added on to their already hectic day, there is evidence that care management can offload work, and provide relief to providers and sustainability in this new and ever-changing health care environment.

Several definitions of care management (CM) are recognized throughout the health care industry. Titles are interchangeable with varied responsibilities attached to the risk of the identified population with activities and interventions designated to manage the cohort of patients. CM applies the strategies and interventions designated to manage medical and behavioral health conditions, and the social determinants, more effectively.

The goal of CM is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, non-duplicative services. Health care systems, payers, individual practices, and newly formed clinically integrated networks (CINs) are embracing and financing CM as an integral resource that embraces value-based care and the Quadruple Aim: achieving better health through improved outcomes, improving the patient experience, lowering the cost of care, and improving the work life of providers.

WHO ARE CASE MANAGERS?

Most case managers are registered nurses (RNs) or master’s of social work (MSWs), credentialed through the Commission for Case Manager Certification or the American Nurses Credentialing Center, the certifying body for the American Nurses Association. Both certifications are regarded as the gold standard for case management excellence.

The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote safety, quality of care, and cost-effective outcomes.”

EXPANDING THE TEAM

In addition to RNs and MSWs, the interdisciplinary team may also include pharmacists, pharmacy assistants, nutritionists, behavioral health experts, community resources, CM assistants, etc. Depending on the specific model of CM and the financier of this resource, CMs may be embedded within the ambulatory care setting or provide centralized, telephonic services.

CM staffing models are designed to enable an efficient workflow and allow professionals to work at the top of their license with other members of the health care team working with identified populations to coordinate care in alignment with the Quadruple Aim. Considering all definitions, the Quadruple Aim guides the strategies and interventions regardless of the title. What makes the difference is the needs of the specific population, the individual practice, and the value the provider sees as quality to patients and practice.

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AFFECTING QUALITY AND COST

As you integrate population health strategies, value-based care, and CM into your practice, you may see practice expenses rise as you invest in the future of health care. With long-range expectations, however, look for the cost of care to be reduced as quality rises and utilization of high-cost services decrease; duplication of services, emergency department visits, hospital admissions, and readmissions.

With CM outreach and engaging and activating patients in their care, providers will also see the benefits of CM with a reduction in acute and long-term complications and disease-specific exacerbations. Independent practices with a smaller population of high-risk patients will likely struggle to justify an investment into CM services and explore the opportunity to share CM resources or redesign practice infrastructure and utilize internal staff resources.

Larger practices, Accountable Care Organizations (ACOs), Alternative Payment Models (APMs), or CINs will depend on CM models and interventions to support their goals for achieving value-based care. Contracting with payers or partners are all options available to financially support the necessary resources for success in the value-based world of health care.

WHAT IS THE CASE MANAGEMENT APPROACH TO PATIENT CARE?

Case management practices are multifaceted, managing care across the continuum. With a focus on quality care and the quality of life that includes clinical and psycho-social management, continued communication with providers and patients is essential. Accepting responsibility for an individual population, the case manager will act as the integrator of the patient and health care team focusing on the goals of care and outcomes for quality, utilization, and cost.

Case managers will use several methods of communication for collaboration and provider approval in care delivery with respect for the providers’ daily commitments and time constraints. Patient-centered care begins within primary care who accept ownership of the patient with incentives to provide value-based care. As part of the care team, case managers utilize past clinical experience and skills and serve as a patient advocate, working alongside the physician to assess the treatment plan and patient adherence along the trajectory of their condition. With frequent contact, the case manager provides ongoing education and support with self-management strategies, developing patient-centered goals of care and a trusting relationship with both the patient and the physician.

Adults with chronic conditions, physical disabilities, or serious illness are managed differently than a pediatric population serving children with chronic conditions, disabilities, or behavioral issues. Chronic condition management, transitions of care, and advanced care planning support utilizing evidence-based clinical guidelines, and protocols are active interventions carefully adapted to the needs and resources available to each individualized case, adult and pediatric. This approach is individualized and integrated according to specialty or diagnosis — for example, Oncology Case Management or ESRD Case Management where the clinical nurse expert coordinates care with specialists, primary care, and the health care team with problem solving and identifying options to improve quality.

Whether complex case management or chronic condition management, all models develop a plan of care in collaboration with the patient, family, and providers to ensure adherence to the treatment plan. Medication management with effectiveness of therapies and adherence has a high priority in the interventions of CM with ongoing follow-up.

The social determinants of health (SDOH) demand the attention of the care manager and deployment of other team members, addressing the entirety of care and the demands of the social and economic conditions that influence the health of individuals. As case managers assess patients’ needs and identify their social and economic influences, the care plan and goals of care are individualized accordingly.

We know that the social and economic factors have an insidious effect on the health of individuals and populations. SDOH are recognized as those conditions in which we live, work, learn, and that influence the health we can achieve. This is another element of holistic care that case managers address, deploying resources and interventions that impact outcomes. The ability of practices to shift from one model to another within the same program provides flexibility and enhances the continuity of care. Developing relationships with patients is an integral component of CM. Knowledge, clinical thinking skills, empathy, and compassion are all assets of an effective case manager. Building a trusting relationship with the patient leads to patient engagement and the ability to make a difference for the patient and their support system. Extending these attributes across the continuum of care, case managers are sensitive to all the needs of their patients following them through their journey. "Crucial conversations” and advanced care planning are included according to where the patient is in the trajectory of illness, and the case manager will ensure the patient’s goals of care are honored in collaboration with the physician and health care team.

There is evidence that care management can offload work and provide relief to providers and sustainability in this new and ever-changing health care environment.
How do you demonstrate the value of the case manager and validate their activity and value?

It takes the right care manager, regardless of the title or role, to be successful. Engaging and collaborating with physicians, health care team members, patients, and families takes a special person with professionalism, clinical skill, drive, and a commitment to make a difference. The value of case management comes from monitoring patient and provider satisfaction, the quality of care and the quality of life preserved, as well as the impact on the burden of illness and the cost of care. Administrative oversight holds case managers and models of care responsible for all of the above. They also monitor case management activity, productivity, caseloads, interventions, quality, and outcomes, holding case managers to high standards and accountability. As we calculate return on investment and look to reduce the burden of illness, we are also able to realize the value of human interaction and caring that can impact the course of illness for individuals.

At the end of the day, we are all looking for a solution to the current state of health care and ways we can improve the quality of life for those under our care. CM opens the door as part of the solution and is committed to making a difference.

How we can help you

PAMED’s Care Centered Collaborative has invested in the clinical and operational expertise to assist Pennsylvania physician practices and organizations better understand and operationalize CM programs. The Collaborative’s services range from practice review and analysis of current CM programs to the creation and implementation of custom programs.

Find out more by contacting Diane Littlewood at (570) 641-2552 or dlittlewood@patientccc.com. You can also learn more at www.patientccc.com.