

# Care Management Framework:

## *The Critical Path to Implementing a Care Management Strategy*

An emids+encore Point of View

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### AN emids+encore POINT OF VIEW

As the healthcare industry shifts to a fee-for-value model, organizations face increasing pressure to implement care management toolsets. These toolsets are intended to support improving the overall health status of patients included in the populations defined by at-risk contracts (both government and commercial). However, implementing a successful care management strategy is much more than selecting and implementing a care management application.

To roll out a new care management strategy successfully, a healthcare organization must identify, outline, and align models of care—including supporting categories, campaigns and roles—with the care management application implementation. Implementing care management successfully also requires supporting the application and the strategy with the right data, change management and governance. This point of view provides a guiding framework for the care management implementation team to follow.

*Identifying and implementing models of care is an incremental process.*

## CARE MODEL DEFINITION

A “model of care” is the evidence-based practices that the organization follows in caring for patients, regardless of how patient care is reimbursed. Identifying the models of care defines the baseline against which actual care activities will be evaluated to determine the level of care management an individual patient requires. Models of care align with the three major groupings of patients managed under at-risk contracts:

- **High Risk / High Utilization** – patients with one or more chronic conditions who require close attention to ensure they remain stable and enjoy a good quality of life. Success for these patients includes avoiding ED visits and readmissions, scheduling and keeping follow-up appointments, complying with medication and other prescribed regimens, and remediating socio-economic compounding factors, such as limited access to healthy food or an insecure support system.
- **Gaps in Care** – patients that are missing various screenings, immunizations and follow-up wellness visits. These patients do not have identified chronic conditions but are not reliably availing themselves of early detection mechanisms that can identify potential concerns before they become major issues. Identifying and addressing gaps in care ensures these patients require less invasive interventions over time, thereby improving their overall health status and reducing the resources required to care for them.
- **Wellness** – patients who do not have a chronic condition and are up-to-date on screenings, immunizations, etc. These patients may experience an acute episode (e.g., strep throat, accident requiring medical intervention) but by-and-large do not require frequent attention.

Identifying and implementing models of care is an incremental process, so a health organization should determine the initial care management priorities when starting a care management journey.

## CATEGORIES, CAMPAIGNS AND METRICS

For example, the care management model for reducing high risk/high utilization could include supporting categories such as the identification of patients with frequent emergency department (ED) visits and need for inpatient discharge follow-up. If frequent ED utilization and inpatient discharge are categories being actively monitored, then specific care management campaigns can be created to support these categories.

*Campaigns are coordinated outreach activities that address the health organization's priorities within the models of care and support maintaining and improving the health status of patients.*

Care management campaigns are an important part of the activities needed to support meeting model of care thresholds. These campaigns are coordinated outreach activities that address the health organization's priorities within their models of care. An example could be a patient being discharged who shows a noted high blood pressure trend during their hospital stay. This patient should be scheduled for a follow-up appointment with a provider to reassess their blood pressure and discuss potential treatment options if needed. Other care management campaigns might focus on encouraging people to get their annual flu shot or to schedule a particular cancer screening.

Once the campaigns have been defined, the health organization can establish care management metrics to measure the campaign performance over a specific period of time. Examples of metrics for inpatient discharge follow-up could be:

- Verifying the creation of a plan prior to discharge to assist the patient in avoiding a return to the ED or inpatient readmission.
- A follow-up call from a nurse within 24 hours from the time of discharge.

## ROLES AND WORKFLOWS

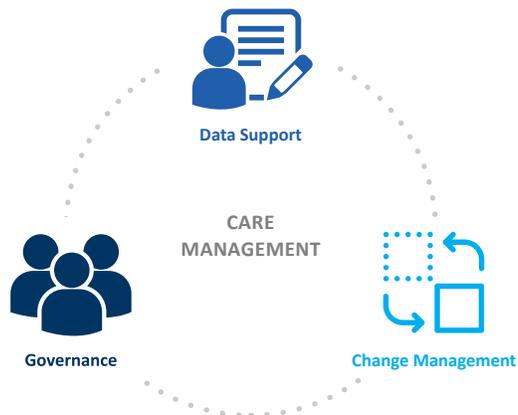
emids+encore believes that the care management roles, functions and activities must be delineated to avoid confusion between the care delivery and care management teams within the health organization. These functions and roles should be aligned as part of the care management application implementation project. Roles and activities should be defined for the patient, care management teams, and the care delivery teams.

For instance, a health organization may decide that for those patients who seek healthcare only when needed, the care management team point of contact will coordinate recommended follow-ups with the providers, and the care delivery team point of contact will manage medication reconciliation. These coordinated and combined functions and activities provide a total care management approach and support the health organization's care management goals and objectives. emids+encore recommends using scenarios to define how care delivery and care management will work together in an effective care management situation. These scenarios help the clinicians better understand what each role is responsible for within the care management workflows.

Since changes in source systems can impact the data the care management application receives, care management data must be continuously monitored to make sure the right data is being integrated.

## THREE KEY FUNCTIONS FOR CARE MANAGEMENT

The model of care, categories, campaigns, and metrics are enabled by three key functions: data support, change management, and governance.



### *Data Support*

A care management application requires data to identify patients who should be included in a particular campaign. This data comes both from data collected during the care delivery process and from claims. While the interactions with patients around care management activities are documented in the application, the patient's inclusion in categories and campaigns is initiated as a result of the patient condition as described by the care delivery (i.e., EHR) data. Therefore, it is critically important that data the care management application needs be identified and monitored as it moves from the various sources to the care management application.

For example, the care management application must have the most up-to-date height, weight, vital signs and medication information for patients, as well as a comprehensive list of patient visits and providers. To support vital information needs, a data integration plan must be defined, implemented and continuously monitored – since changes can occur in the source systems that can affect the data flowing to the care management application. The data requirements and the effort needed to interface the required data to the care management application are typically a time-consuming critical path item in a successful care management application implementation.

### *Change Management*

Change management focuses on the care management workflow modifications required after an initial model of care with supporting workflows has been implemented within the care management application. Via reporting and analytics of metrics and outcomes, organizations monitor progress and opportunities for workflow modifications. Change management then enables new methods to be integrated into the existing care management procedures to improve the care management process and outcomes further.

*A care management strategy can achieve iterative impact.*

For example, a clinic could be found to have a growing number of no-shows for morning appointments, so workflows could be modified to include a pre-appointment confirmation process or clinic hours could be extended into the evening. Other examples include new methods for identifying patients for interventions, ensuring coordinated contact, and communicating and documenting interventions with patients and providers. Health organizations should expect an iterative impact to care management workflows based on outcomes and affiliated analytics.

### *Governance*

Governance is vital to decision making and buy-in throughout the care management implementation process. emids+encore recommends that a healthcare organization author a project charter to define the health organization's care management goals, objectives, roles and responsibilities of the project team members, the project phases, and timing.

Healthcare organizations also need a steering committee to ensure that the right stakeholders are involved in setting care management priorities. This steering committee provides the project with a decision-making process throughout the course of the care management implementation. The committee also uses information obtained through reporting and analytics to determine the care management priorities, roles, and campaigns.

## CONCLUSION

Many care management products exist currently, but few vendors offer the framework needed for a successful care management implementation. This lack of structure creates a high risk of a failed implementation and missed opportunities to improve care. As part of implementing a care management framework, emids+encore recommends health organizations:

- Identify their models of care.
- Introduce governance to prioritize campaigns and change management efforts.
- Include change management processes to improve outcomes iteratively.
- Delineate clearly the roles of care management and care delivery.
- Ensure that data is sourced correctly and monitored continuously for use in the care management applications, reporting, and analytics.

When all of these pieces are in place, a care management strategy can achieve iterative impact, creating the positive outcomes that all health organizations seek to achieve via a care management implementation.