FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

PAVING THE PATH TO VALUE:
Care Management and Coordination

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AAFP

The goal of care management and coordination is to individualize health care to meet each patient's specific needs. Health care systems that are patient centric, outcome driven, and include payment structures that support services which patients need will be better aligned to meet this goal. In the current fee-for-service (FFS) health landscape, this alignment is often difficult to accomplish, as outcomes are based on how care is incentivized. But the landscape is changing.

Care Management and Coordination in VBP

Cost and patient outcomes are closely tied to effective care management and coordination in VBP arrangements with all payers.[1-4] Depending on your practice's specific payment arrangements and the needs of your patient population, the following core concepts can lead to better health outcomes for your patients and improve performance in your VBP contracts.[4,5]

Patient education – Providing patients with education to help manage their chronic conditions is an essential care management activity.[4] It may include providing patients with health tracking instruments and reviewing results with them; holding classes to help them manage chronic conditions; and offering education and referring patients to community resources. For example, your practice might host monthly diabetes group visits to improve A1C. The frequent touches and support from these group visits can lead to better health outcomes for patients with type 2 diabetes and help the practice meet quality measure requirements.

Care planning – Care plans are an opportunity to better align health care goals with patient and caregiver preferences.[4] They are essential to care management—particularly for patients with multiple complex chronic conditions. Thorough care planning involves patients, caregivers, and the care team developing goals and action steps together; sharing the care plan with patients and all caregivers; and regularly reviewing and updating the care plan to determine if changes or additional resources are needed. This planning process ensures patients and caregivers are equipped to manage care in a way that meets the patients' needs, while aligning with the practice goals of improved patient care and performance on quality and utilization in VBP arrangements.

Managing medications – Medication management is a necessary and ongoing process[4] throughout a patient-physician relationship. It entails:[5,6]

- reconciling medications after any transition of care;
- reconsidering and/or changing medications based on patient feedback;
- checking available medications periodically for better options; and
- ensuring medications prescribed are clinically necessary, have acceptable side effects, and do not pose a significant cost burden to the patient.

As prescription costs continue to rise, more patients are concerned with health care costs. Managing their medications can result in cost savings, avoid emergency department visits and hospital utilization, and lead to better patient outcomes.[7]

With the shift away from FFS, primary care serves as the foundation of value-based payment (VBP). Likewise, care management and coordination are integral to aligning and meeting the goals of VBP.

Risk stratifying populations and managing data – Risk stratification guides physicians and care teams to group their patients into levels of risk based on factors such as diagnosis, condition severity, social determinants of health, and care utilization.[8] It is intended to support longitudinal care management and allocate practice resources and services proportional to patients' needs and based on their level(s) of risk. Typically, risk stratification is done by an algorithm in the electronic health record (EHR), registry, or population health system. These systems may identify patients who need outreach, have care gaps, or have upcoming preventive screenings due. Once identified, the care team can reach out to patients with reminders and follow up via telephone, automated calls, the patient portal, or mailings to patients.

Coordinating care across the health system – Care management and coordination require communication through multiple modalities.[4] Physicians and care teams discuss patient care with specialists and hospitals; incorporate specialist and hospital provider input into patients' care plans; and engage with patients about ongoing care management through the patient portal and by telephone.

Care coordination spans the health care system with care teams reviewing hospital admissions, discharges, and emergency department visits; tracking tests and referrals to make sure results are returned; and providing appropriate community resources and patient education. Monitoring emergency department visits and hospital utilization are beneficial in VBP arrangements for many reasons, including ensuring appropriate use of services, and, when appropriate, scheduling follow-up care to reduce avoidable readmissions.[9]

Assessing the Landscape

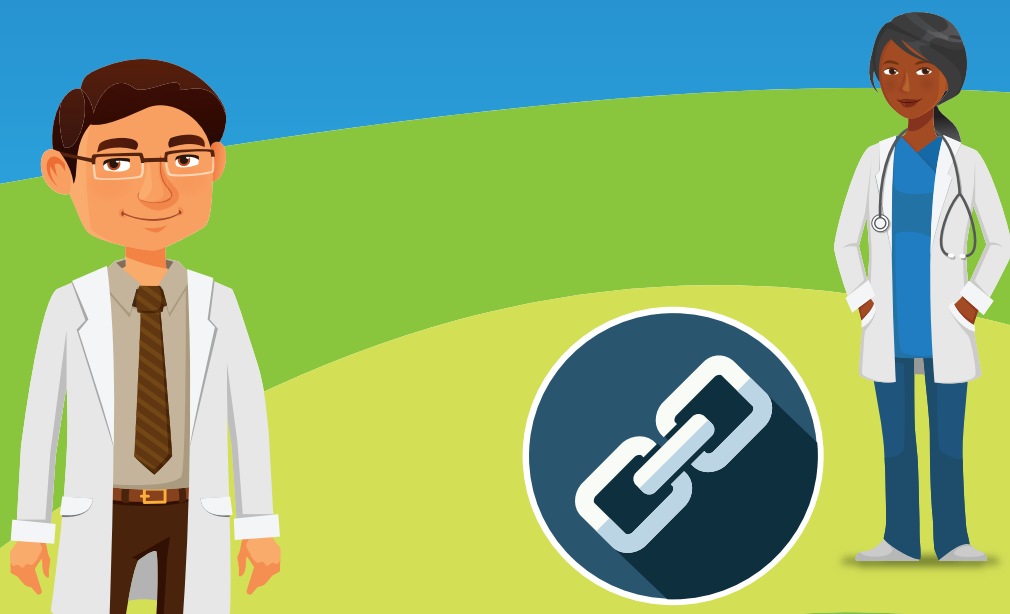
The goals set forth by the Health Care Payment Learning & Action Network (HCP-LAN) to accelerate the percentage of health care payments to alternative payment models (APMs) by 2025 are lofty (50% for Medicaid and commercial payers; 100% for Medicare and Medicare Advantage),[10] but only you can decide what is right for your patients, practice, and care team. For example, Category 4 APMs are not right for every practice and may adversely impact patients and physicians if practices are not ready to take on a high level of risk. The care delivery transformation required to take on incremental risk takes time, resources, and dedication.

Moving out of the broken FFS system will ultimately improve patient outcomes and allow physicians the flexibility to provide care the way they want to provide it, supported by a payment system that compensates them appropriately. Implementing care management and coordination is an effective means to move toward that goal.

A Path Forward

Elements of care management and coordination require open communication and trust between patients and their care team to be truly effective.[3] Patient-centered care management and coordination, and with thorough care plans, are necessary for success in VBP. Practices that utilize the flexibility VBP provides, along with innovative care delivery, will thrive in meeting the quadruple aim of health care—better patient outcomes, lower costs, improved patient experience, and improved clinician experience.

The HCP-LAN's APM framework outlines the payment reform landscape[11] and provides a path to greater flexibility supported by alternative payment and partnership between patients and their care teams. This infographic describes the activities that can be supported by various payment categories.



Category 2

FFS with link to quality and value

Additional—albeit often minimal—payment tied to quality may allow practices to transform care in VBP models. In addition to the volume-based FFS care management and coordination codes, quality incentive payments may allow practices to nominally expand their care management services through focused efforts. For example, risk stratifying patients to identify those most at risk for poor health outcomes can focus your practice's care management resources.

Category 1

FFS with no link to quality and value

Practices tied to FFS may use the Annual Wellness Visit to identify care gaps, connect with patients who have not had a visit in a while, and engage more frequently with patients with higher care costs. Use chronic care management (CCM) and transitional care management (TCM) services to coordinate and manage patient care on a volume basis. However, CCM and TCM have specific billing requirements, limiting the flexibility to implement innovative care management practices.

Category 4

Population-based payments

Partial- to full-capitation arrangements provide the highest level of flexibility for care delivery innovation. Management services often expand to address health disparities and social determinants and provide care to patients at the time, place, and level of intervention most appropriate to their needs.

Category 3

APMs built on FFS

Models, such as the Comprehensive Primary Care Plus Track 1, the Medicare Shared Savings Program, and accountable care organizations provide flexibility through additional payments for taking on accountability for utilization and/or cost. However, the extra payments may not fully replace FFS. Additional payments allow for increased flexibility in care delivery, including hiring additional staff to support care management (e.g., care managers and coordinators, integrated behavioral health specialists, social workers, integrated pharmacists).

AAFP Resources

Chronic Care Management Toolkit – www.aafp.org/ccm-toolkit
Transitional Care Management Toolkit – www.aafp.org/tcm-toolkit
Risk-Stratified Care Management Rubric – www.aafp.org/rscm-rubric
Risk-Stratified Care Management Scoring Algorithm - www.aafp.org/rscm-algorithm
Care Management Return On Investment Calculator and Building the Business Case - www.aafp.org/care-management

References

Go to www.aafp.org/care-management-coordination to see a full listing of references.