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Care Management in the Real World: A Small, Private Practice's Journey

Through the addition of a care management function, practices can help high-risk patients navigate complex conditions and vulnerable care transitions.

Ambulatory care management has been around for decades in various forms with various names, but in recent years, it has evolved into an essential strategy for success in primary care practices, particularly those participating in value-based care arrangements. The reason for the growing interest in care management is its potential to improve the health of a practice's most at-risk patients while reducing costs.

But there are some uncertainties for practices exploring the model. Chief among them are the costs to get started, whether the

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effort will really increase quality of care and reduce costs, and how long it will take to see results.

This article shares a small, private family medicine practice's experience creating a care management program.

WHAT IS CARE MANAGEMENT?

Care management does not have one standardized definition, but it does have common elements across medicine.[1-4] These include coordinating and managing transitions of care (e.g., acute to post-acute care settings or acute to home), assessing and closing care gaps, addressing patient needs, coordinating care among the patient's health care team, and navigating the patient through the complexities inherent in the health care system.

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Transitions between settings and providers are times when patients are vulnerable to declining health, and a care management safety net is imperative to identify and mitigate the risk of readmission. Care gaps may be social (e.g., food or housing insecurity or lack of access to health care) or preventive (e.g., missing immunizations or cancer screenings). Patients often need education to increase the knowledge, skills, and abilities that enable them to self-manage their chronic conditions or the symptoms and functional changes associated with them. Coordinating care keeps the health care team on the same page and working in concert with the patient's identified goals. The team's assistance in navigating the complex health care system helps patients avoid getting lost and reduces or eliminates frustration.[1-4]

Based on patient-identified gaps or needs, care managers perform activities in disease management, case management, care coordination, care navigation, and social work. Care managers may be certified, licensed, or unlicensed depending on the care gaps or patient needs they will be expected to identify and fill. For example, navigating the health care system does not require a professional license, but teaching patients how to take a medication, when to take it, what side effects to watch for and manage, and what to expect from taking it are functions of licensed nurses.

Acknowledging that there is variation in how care management is defined, the definition used in this article is from the American Academy of Family Physicians (AAFP). It defines care management as "activities performed by health care professionals with a goal of facilitating coordinated patient care across the health care system. Care management programs increase patient satisfaction and improve outcomes, while reducing costs to the health care system through avoidance of unnecessary hospital and emergency department utilization."[4] The Academy's examples of care management activities and services include the following:

- Patient education,
- Medication management and adherence support,
- Risk stratification,
- Population management,
- Coordination of care transitions,
- Care planning.

These activities and services may be done by a physician or advanced practitioner (e.g., nurse practitioner, physician assistant, clinical nurse specialist, or certified nurse midwife), or they may be delegated to the most appropriate team member.

PRACTICE EXEMPLAR

Prior to joining an accountable care

KEY POINTS

- There is growing interest in care management because of its potential to improve the health of a practice's most at-risk patients while reducing costs.
- The care management program described here has generated sufficient revenue to cover salaries for two care managers who manage a population of about 200 high-risk patients.
- Care management can improve care transitions, reduce readmissions, improve patient adherence, ensure timely preventive care, and empower patients to better manage chronic conditions.

ESSENTIAL QUESTIONS WHEN STARTING A CARE MANAGEMENT PROGRAM

1. What care management services will you provide? Consider the needs of your patient population as well as the tasks that are burdening you and your staff. Consider also what services are reimbursable (more on that below).

2. Who could perform these functions? Many care management tasks require a staff member with a professional license, such as a licensed nurse or licensed clinical social worker. But others may not. Consider whether current staff members have capacity to take on some tasks or whether you need to hire someone. Our two care managers manage a population of about 200 patients total. Determining a manageable workload for care managers in your setting will depend on their experience level and patient complexity.

3. How will you identify high-risk patients who could benefit from the program? You likely have several patients who immediately come to mind as good candidates for care management because their care is complex or they are high risk. Risk stratification can help you categorize patients by risk levels. For help with this process, see "Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients," *FPM*, May/June 2019, https://www.aafp.org/fpm/2019/0500/p21.html.

4. How will you pay for it? Some services will generate revenue more quickly because they are immediately billable, such as diabetes education, self-monitored blood pressure management, transitional care management, or chronic care management. Make sure your staff knows how to document and code for all billable care management services. It's possible that adding care management to your practice will create some additional capacity for physicians, increasing their productivity and revenue. Additionally, if you participate in value-based care arrangements, consider whether an investment in care management will ultimately pay for itself in shared savings.

organization in 2015, I (Dr. Brull) had never heard of care management. I own a practice in rural Kansas that belongs to a loose association of five small practices. When we were was first introduced to the concept of care management, we were somewhat skeptical about what return on investment (ROI) it might provide. The promise that a good care manager would lead to "downstream savings" was interesting, but we needed to pay for the position in the here-and-now. We began the discussion in our practice by outlining the duties of the care manager, determining which services would generate revenue immediately, and calculating whether we could afford to fund the position. (See "Essential questions when starting a care management program.")

We initially planned to solve two needs with one person. In addition to building a care management program, we were also beginning to perform annual wellness visits (AWVs) on our Medicare population. As a mature practice, we did not have much free time in our schedules to incorporate this new service, so we proposed that our new hire would perform AWVs 50-75% of the time and create the care management program the rest of the time. In our first year of doing both, this worked well, but as the success of the care management program grew, we quickly realized that we needed to hire a second care manager.

Our first care manager was a licensed clinical social worker, and we quickly realized how valuable it was not only to have this position but also to have hired a social worker to fill it. In addition to providing AWVs and traditional care management services (e.g., patient/family education, medication adherence support, and coordination of care), she quickly leapt into assessing and solving for social determinants of health, learning how to enroll patients in both Medicaid and Medicare, connecting patients to resources to obtain lower cost medications, and finding creative ways to use community programs to support our patients. A year later, we hired our second care manager and chose a registered nurse whose skills in chronic disease management and patient care complemented those of our social worker.

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Over time, as the AWV process became streamlined and our practice added another partner who had capacity to also do these

visits, both care managers devoted more time directly to care management. They currently manage a population of about 200 patients, working hand-in-hand with our nursing teams to identify patients who require more intensive check-ins throughout each month. Home visits are a regular part of the work they do. It's where they provide vitals checks, medication set up, safety evaluations, patient education, resource identification and connection, and more. To support this work, we built systems in our electronic health record (EHR) to log, track, and communicate the needs of patients, as well as bill for the time spent working with each patient.

Care management bridges the gap between physician visits, providing the safety net patients desperately need.

The activities our care managers perform before, after, and between physician visits support patient adherence to the plan of care and medications, ensure that patients receive timely preventive care, empower patients to be active members of their health care team and self-manage their chronic conditions, and ensure access to health care and community services. Care management bridges the gap between physician visits, providing the safety net patients desperately need. These activities contribute to our success in value-based care arrangements, which generate shared savings for our practice. They also improve our patient outcomes. For example, by focusing on patients with frequent visits to the emergency department (ED) and enrolling them in care management services, our ACO reduced the overall rate of ED visits from 731 per 1,000 patients per year in 2016 to 469 by the third quarter of 2020.

It can be challenging for a practice to document the full ROI of care management, because its effects on a patient population and any associated savings often take time and occur downstream. Practices rarely have access to the financial data related to patient care that takes place outside their four walls. However, we can assess our internal ROI. Financially, our care management program has generated sufficient revenue — through a combination of care management and using our care management team to support performance of AWVs — to cover both care managers' salaries. It took one year to build the program enough to support our initial care manager and another year to support the second care manager.

More importantly, the value of having two individuals in our practice dedicated to supporting the needs of our most vulnerable patients has been impossible to measure. In the past, I frequently felt frustrated about my lack of ability to help my patients outside of my practice walls. My patients would share barriers that kept them from optimal health, and I had no power to fix them. With this team, I am now able to offer assistance and bring hope.

MOVING FORWARD

Physicians may be hesitant to embrace care management because it feels undefined. It does not have a standardized definition, there are many different models, and execution varies. But the flip side is that practices can design care management programs that suit their needs and the needs of their patients. Our hope is that sharing how one small practice created a financially sustainable care management program will be helpful to others considering the model, whether they are looking for ways to succeed in value-based care arrangements or, more importantly, to improve care for their most vulnerable and at-risk patients. FPM

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