Eleven Insights on the Future of Care Management
Care management is the best way to reduce avoidable costs quickly.

In the aftermath of the 2012 presidential election, there’s no longer any room for debate. Hospitals and health systems need to focus on reducing avoidable health care spending—not just because Americans are getting older and therefore sicker, less procedural, and less profitable when they’re in the hospital, but because providers can expect to assume financial risk for health care utilization eventually, if not imminently.

Health care institutions can reduce avoidable costs in a few different ways. They can deploy health plan management processes and incentives. They can collaborative with other providers on quality and cost initiatives. And, they can actively manage patients across multiple episodes and care settings.

Key Levers for Inflicting Avoidable Costs

You will almost certainly need to pursue all these approaches in the coming years. For most members, though, we recommend focusing on care management first and foremost. Executed well, care management can yield a quicker return than plan management or partner engagement initiatives, and can be comparatively easier to implement. Unfortunately, today, few institutions have the people, processes, or technologies they need to effectively manage population health.
The **ideal** care management organization looks very different from today’s health system.

If American hospitals and health systems were redesigned from scratch to be care management enterprises, they would be organized far differently. Today’s institutions typically have an inpatient-focused case management infrastructure, a fragmented delivery system, non-aligned incentives, and cultural barriers that impede improvement efforts.

In contrast, the ideal care management system would create and implement personalized care plans for every patient. Primary care would be accessible to everyone. The system’s incentives and organizational structures would promote cross-continuum communication and collaboration. And the entire enterprise would be supported by ubiquitous, actionable data.

**Characteristics of an Optimal Care Management System**

**PERSONALIZED MANAGEMENT**
- Care management appropriately matched to individual patient, population need
- Oriented toward patient-centered goals that will drive clinical metric improvement

**ACCESSIBLE PRIMARY CARE**
- Team available to patient for access, education, decision support
- Accessible when, where patient needs care

**ALIGNED ACROSS THE CONTINUUM**
- Multidisciplinary team works together to maintain unified care plan across patient needs
- Data transparency, sharing to ensure streamlined patient care

**OUTCOMES-DRIVEN SYSTEM**
- Dashboard aligned to key cost, quality goals for improving population health
- Information available across the continuum to track utilization
You can expand your care management capabilities incrementally.

Don’t worry that your institution looks nothing like the care management ideal. Hospitals and health systems can develop the capabilities they need gradually. Begin by building strategic alignment. Then identify and implement care management initiatives in specific areas within targeted population groups. Over time, broaden care management scope and capabilities to encompass your entire system and serve the whole population.

An Incremental Approach to Care Management Transformation

- **Positioning the Organization for Success**
  - Setting Vision, Leadership
  - Outlining Staffing
  - Aligning the Continuum

- **Addressing Short-Term Opportunities**
  - Prioritizing Initiatives
  - Coordinating the Team
  - Spurring Ongoing Management

- **Accelerating System Transformation**
  - Addressing Care Transitions
  - Improving Patient Access
  - Engaging Patients

- **Expanding the Enterprise to Maximize Performance**
  - ELEVATING THE CARE MANAGEMENT ENTERPRISE
    - Setting Vision, Leadership
    - Outlining Staffing
    - Aligning the Continuum

- **Managing High-Risk Patients Effectively**
  - Prioritizing Initiatives
  - Coordinating the Team
  - Spurring Ongoing Management

**Impact**

**Time**
INSIGHT FOUR

Commit to a **vision**, and articulate how you plan to get there.

**Before anything else, you need to define** and communicate your commitment to care management. In practice, that means creating and disseminating a long-term vision for your organization that explicitly incorporates care management goals. At the same time, you need to marry that strategic vision with a short-term action plan for how you’re going to advance your care management goals in the next year.

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**Scripps Health’s OneScripps Initiative**

Recognizing the importance of beginning with the end in mind, the San Diego-based Scripps Health system developed a ten-year strategic vision that focused on the most important components of a care management platform: greater coordination across sites of care, greater value for the community, and greater physician alignment. Scripps complemented its long-term vision with an immediate and actionable to-do list, which included streamlining access points and exploring a system-wide diabetes management strategy.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Identify and reduce variation in quality and cost</td>
<td>Break even on Medicare by 2016</td>
<td>Greater alignment between inpatient, outpatient care</td>
<td>Greater health care value for community</td>
<td>Greater physician alignment</td>
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**10-Year Vision**

**Immediate Care Management Action Plan**

- Streamline patient access points to reduce patient wait times
- Explore system-wide diabetes strategy to improve chronic care management
- Evaluate post-acute care partnerships to improve handoffs

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**CASE STUDY**

Identify and reduce variation in quality and cost

Break even on Medicare by 2016

Greater alignment between inpatient, outpatient care

Greater health care value for community

Greater physician alignment

Greater health care value for community

Greater physician alignment
Cultivate care management leaders at all levels.

**As much as institutions need to integrate** care management objectives into overall future plans, they also need to give leaders explicit responsibility for care management. For many organizations, the newly created “Chief Transformation Officer” position is at the helm of these efforts.

CTOs spend most of their time managing operational details, but they are also responsible for strategic guidance and relationship-building. Unsurprisingly, we’ve found that most successful CTOs have experience directly relevant to population management—in physician management, health plan administration, and/or in strategic planning—as well as strong relationship-building skills.

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### Breakdown of CTO Time Spent on Job Responsibilities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEADING EXTERNAL ACTIVITY</strong></td>
<td>70%</td>
</tr>
<tr>
<td>Engaging with health plans, employers</td>
<td></td>
</tr>
<tr>
<td><strong>MANAGING THE TRANSITION</strong></td>
<td>20%</td>
</tr>
<tr>
<td>Filling system gaps, transforming operations</td>
<td></td>
</tr>
<tr>
<td><strong>ADVISING ON THE FUTURE STATE</strong></td>
<td>10%</td>
</tr>
<tr>
<td>Tracking market trends, analyzing federal, state legislation</td>
<td></td>
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### Percentage of Population Health Leaders Ranking Responsibilities as High Priority Across Next 18 Months

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Ensuring data access, sharing</td>
<td>93%</td>
</tr>
<tr>
<td>Targeting specific high-risk populations for intervention</td>
<td>83%</td>
</tr>
<tr>
<td>Defining the organization’s management, staffing structure for population health management</td>
<td>80%</td>
</tr>
<tr>
<td>Creating a business case for population health management initiatives</td>
<td>80%</td>
</tr>
<tr>
<td>Establishing a patient-centered medical home</td>
<td>77%</td>
</tr>
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1 Advisory Board Company Population Health Leaders survey, n=30, Fall 2012.
2 Percentage of survey respondents “strongly agreeing” or “agreeing” that responsibility is high priority.
Care management efforts, and the CTOs who lead them, require strong support from senior executives. To be truly effective, though, CTOs also need buy-in from other levels of staff and clinicians, including many people the CTO is unlikely to encounter directly. That’s why some institutions are creating working groups specifically charged with supporting care management efforts.

**Rosalind HealthCare’s Accountable Care Task Force**

Recognizing the need for organization-wide engagement in care management, Rosalind HealthCare*, built their own “A” team—an accountable care task force made up of key VPs from across the organization, whose charter is to prepare the system for value-based care delivery.

This task force is effective because of three distinctive aspects of its charter. The task force is accountable to an executive cabinet, which reviews all of the group’s recommendations. The group ensures that it represents a cross-continuum perspective by incorporating key individuals in the ambulatory side of the business as well as hospital leaders. Finally, the task force ensures that its recommendations turn into specific action plans for frontline staff.

What Made the Accountable Care Task Force Effective

<table>
<thead>
<tr>
<th>Accountable to System Executive Cabinet</th>
<th>Areas of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health system C-suite</td>
<td>CLINICAL INTEGRATION</td>
</tr>
<tr>
<td>• Cabinet confirms task force recommendations</td>
<td>PROVIDER ENGAGEMENT</td>
</tr>
<tr>
<td>Cross-Continuum Perspective</td>
<td>PCP EXPANSION</td>
</tr>
<tr>
<td>• Engages leaders, staff across acute, ambulatory network (i.e., strategy, quality)</td>
<td>CARE MANAGEMENT, COORDINATION</td>
</tr>
<tr>
<td>Decision Making Authority</td>
<td>INFORMATION ACCESS</td>
</tr>
<tr>
<td>• Directs work groups (i.e., inpatient, outpatient, clinical administration), to translate plans into frontline action</td>
<td>FINANCES, RISK MANAGEMENT</td>
</tr>
</tbody>
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* Pseudonym
Find ways to leverage existing infrastructure.

**There's no question—you're going to** have to make significant investments to support the transition to care management, especially in IT and building a care management team. But before you open your checkbook, figure out what you can achieve utilizing the resources already at your disposal: existing staff and community resources.

**LifeBridge Health’s Care Redesign Teams**
To prepare for population health management, leaders at LifeBridge Health, a health system in Baltimore, assembled care redesign teams on the inpatient side and in the emergency department to audit current staff, roles, and functions.

The care redesign teams, which included care managers, social workers and nurses, met weekly for nine months. The teams evaluated the roles and responsibilities that should be associated with key care management positions, identified gaps and redundancies among current positions, and produced prescriptive resources.

**Integrated Health Partners’ Community Resource Speed Dates**
Integrated Health Partners, a physician-hospital organization in Battle Creek, Michigan, pioneered an efficient method for evaluating potential partnerships: a community “speed dating” event. Care teams, including physicians and nurses, met with community health care organizations to learn about available resources. Each seven- to ten-minute “date” included a brief overview of the community groups, recommended referral protocols for tapping into available services, and a specific action plan for the care team when using the community resource.

**Care Management Staff Audit Tool**
Check out advisory.com/caremanagement to access the Care Management Staff Audit Tool, a compilation of current and future care management functions designed to help you benchmark your existing staff against projected needs.

**INSIGHT SIX**
Find ways to leverage existing infrastructure.

**JOB DESCRIPTIONS**
Outlined roles for inpatient positions, transitions coaches

**DAY-IN-THE-LIFE SUMMARY**
Overview of daily routine, primary duties and activities

**Topics of Discussion**
1. Description of community group, resources available, benefits to patient
2. Referral protocol to community resource group
3. PDSA (Plan-Do-Study-Act) action plan encouraging physicians to use services
You can’t manage without **connecting** the system—through organizational design as well as IT.

**For any organization with population** management aspirations, a robust IT care management infrastructure is essential. Seamless connectivity between settings of care, clinical and business knowledge management, care management analytics, and advanced decision support are all key ingredients for care management capabilities.

But technology is just part of the infrastructure you need to be an effective care manager. You also need to create the human infrastructure, by reorganizing job roles and reporting relationships to encourage cross-continuum collaboration.

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**Davenport Health’s System Director of Care Management**

At Davenport Health—a hospital system in the Northeast, high-risk patients were slipping through the cracks as they transitioned between care settings, and organizational silos between inpatient case management and outpatient care management were to blame. Davenport unified the care management function under a single director, so now one leader can establish common goals for the care and case management teams, and team members can quickly share better ways to engage patients or coordinate across sites.

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1 Pseudonym
2 Diagram represents proposed changes to organizational structure
Focusing on high-risk patients will give you the biggest care management return.

There is no better or quicker return on care management investments than targeting high-risk patients. While we encountered many permutations of high-risk care management in our research, the successful approaches all shared three elements:

1. **A System for Identifying and Prioritizing Patients**
   To target high-risk patients, providers need data from numerous sources (EMR, patient registries, claims data, and pharmacy data, for example), as well as an algorithm that identifies current and future high-cost, high-risk patients. To further narrow the target group, some organizations are also layering psychosocial assessments on top of clinical evaluations.

2. **High-Risk Care Manager Capabilities**
   Once they have identified and prioritized high-risk patients, institutions need to match these patients with the resources they need to succeed—which requires dedicated additional staff.

3. **Centralized Care Plans**
   Care plans are a critical element of effective patient management. These plans, which should be frequently updated and revisited, ought to reflect not only important clinical metrics, but also goals that are important (and motivating) to the patient.

For more information on managing high-risk patients, see the Care Transformation Center study, *High-Risk Patient Care Management: Prioritizing High-Value Opportunities for Managing Total Cost of Care* at advisory.com/caremanagement

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**Grayson Health's Predictive Prioritization**

Grayson Health System believes in the power of identification and prioritization. Using the Advisory Board’s Crimson Population Risk Management tool, Grayson integrates a variety of disparate data sources, then applies a predictive algorithm to “rank” patients in terms of their risk profile. Nurses at Grayson then actively intervened with highest-scoring patients through a condition management program, which resulted in a significant decrease in inpatient admissions and real cost savings.

<table>
<thead>
<tr>
<th><strong>Crimson Population Risk Management</strong></th>
<th><strong>Grayson’s Condition Management Program</strong></th>
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<tbody>
<tr>
<td>• Integrates paid medical and pharmacy claims, eligibility criteria, and demographic detail</td>
<td>• Experienced nurse provides in person, telephonic health coaching, medication compliance support</td>
</tr>
<tr>
<td>• Applies predictive algorithm to generate list of highest-risk patients based on predicted future utilization</td>
<td>• Nurse and patient set goals, track progress through program</td>
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**Insight Eight**

$46 Reduction in PMPM paid for participants in condition management program versus non-participants

33% Decrease in inpatient admissions among program participants

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1 PMPM paid for participants $668, non-participants $714; Jan 2012-Feb 2012.
Massachusetts General Hospital’s High-Risk Care Manager Role

As part of the six-year CMS Medicare Care Management for High-Cost Beneficiaries Demonstration project, Massachusetts General Hospital created a multi-disciplinary team focused on the most expensive and riskiest five percent of patients. One of the most important members of the team is the high-risk care manager, an RN with more than 20 years of experience, who collaborates with primary care doctors to design care plans and coordinates with other providers who are essential to managing the care of these patients.

As opposed to an inpatient case manager focused on the acute care episode, or the medical home health coach who might be charged with patients at all acuity levels, the high-risk care manager is responsible for navigating and activating high-risk patients across all parts of the continuum, augmenting existing resources but not replacing any existing staff.

High-Risk Care Manager Job Description

**Experience**
- Registered Nurse
- 20+ years experience in care management, clinical care delivery

**Characteristics**
- Driven to activate patients, strong ability to forge meaningful relationships
- Strong critical thinking skills promote the resolution of complex care problems
- Dedicated patient advocate
- Resourceful in filling patient needs
- RN-to-patient ratio of 1:200-250

In selecting staff for the high-risk care manager role, Mass General recruited for clinical experience, but especially for personality and drive, since the care manager must be able to build effective relationships with patients and doctors. Relationship-building is such a critical element that as the program is rolled out from Mass General to other hospitals within Partners HealthCare, Partners is letting care managers work with a maximum of three clinics at a time, in hopes that the nurses and primary care doctors establish a strong collaborative rapport.

**CASE STUDY**

**CMS Medicare Care Management for High-Cost Beneficiaries Demonstration Results at Massachusetts General Hospital**

- 35% Decrease in ED visits
- 20% Decrease in hospitalizations
- 4% Decrease in mortality rate
Scrutinize your care management roll-out plans for the near-term **business case**.

Just managing high-risk patients better will require considerable investment in time, expertise, and capital. Don’t rush to expand your care management efforts too broadly to moderate- and low-risk patients. And as you consider rolling out additional care management initiatives, ask yourself where the business case is strongest today.

1. Does your care management expansion plan align with existing resources and priorities (for example, reducing avoidable readmissions)?
2. Does your expansion plan align with how your institution plans to evolve its reimbursement model?
3. Are there opportunities to leverage existing (or free) resources?

The answers to these questions will be different for every institution and every initiative. However, our research suggests that once you look beyond the high-risk patient population, you’ll find several likely targets for care management efforts:

- A focus on transition management to avoid readmission penalties
- A drive toward lower-acuity utilization leveraging your ambulatory care network
- A push toward lower-cost interventions to better engage patients in their own care

For more information on care management roll-out strategy, see the Care Transformation Center study, *High-Risk Patient Care Management: Prioritizing High-Value Opportunities for Managing Total Cost of Care* at advisory.com/caremanagement
You need to **engage** patients in their own health care.

**Without your patients being engaged** in their own health care, your best efforts at care management will be ineffective. So it’s not surprising that when we profiled advanced care management programs around the country, we often found them focusing intensively on improving patient engagement. Out of the myriad patient engagement tactics we encountered, three were especially noteworthy: patient-directed discharge education, survey-based feedback loops, and peer mentoring.

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**WellMed Medical Group’s Care Companions Program**

WellMed Medical Group, a San Antonio-based multi-site physician organization, is using a peer support model to augment the care team and encourage patient engagement. WellMed staff paired well-managed diabetic patients with poorly-managed diabetic patients, as a way to provide additional support to those struggling with their condition.

WellMed has mentors and mentees take a Diabetes 101 course and then asks mentors to meet periodically with their poorly-managed counterparts to talk through challenges and offer suggestions. WellMed has all participants document and submit notes from these sessions monthly, so the WellMed care management team can analyze the information to figure out what’s working and what isn’t. Program leadership uses de-identified data to track the effectiveness of the peer mentoring program.

Mentors and mentees are both benefiting from the program.

<table>
<thead>
<tr>
<th>Percent Increase in Blood Sugar Checks</th>
<th>After Six Months of Program</th>
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<tbody>
<tr>
<td>MENTORS</td>
<td>15%</td>
</tr>
<tr>
<td>MENTEES</td>
<td>32%</td>
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</table>

"In five years, all of our chronic disease patients will be engaged with either a peer mentor or our own internal health coaches. We've just scratched the surface."  

Physician

The Care Companions Program, funded by a Peers for Progress Grant, was adapted from the Latino Health Access California program designed for 20- to 40-year-old patients with Type 2 diabetes. WellMed plans to extend the model to heart disease and other conditions in the future.

For an extensive compilation of patient engagement tactics, see the Health Care Advisory Board publication, *Competing on Patient Engagement*, available at advisory.com/patientengagement.
Becoming a population manager is a cultural transformation.

Make no mistake, turning your institution into a care management enterprise is a huge cultural transformation, one that will affect clinicians, frontline staff, and leaders alike. You’ll need to draw on the entire arsenal of change management tools to accomplish this transition, including vision-setting, management-by-objective, education, financial incentives, and personal and institutional relationship-building.

Take our quick diagnostic survey to see how well you’ve prepared your organization for the coming transformation.

**Six Questions for Executives about Care Management Transformation**

1. What is your “burning platform” for driving the organization toward population management? Acceptance of risk contracts? Competitive differentiation through population management capabilities?

2. Have you created ongoing education efforts around this platform? Have you done so through all levels of the organization?

3. Have you evolved your metrics and dashboards to include population management-centric measures?

4. Have you investigated incentive schemes that reward care management performance?

5. Have you identified respected physician and nurse leaders to champion these goals through the clinical enterprise?

6. Have you built cross-continuum partnerships with entities that are also motivated to create population management capabilities?
For more resources on care management, visit advisory.com/caremanagement.

More Support on Care Management

Population Health Advisor
Cohort-driven collaborative supporting the Chief Transformation Officer combining in-person peer summits with ongoing, in-depth research and customized guidance.
advisory.com

Crimson Care Registry
Real-time patient registry to improve outcomes and overall population health by harnessing clinical data and giving clinicians evidence-based prompts at the point of care.
advisory.com/crimson

Evolent Health
Population health and managed services company that provides technology, tools, and on-the-ground resources to support health systems in executing on their population health and care transformation objectives.
evolenthealth.com

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