RN care managers

Role at a glance: RN care manager

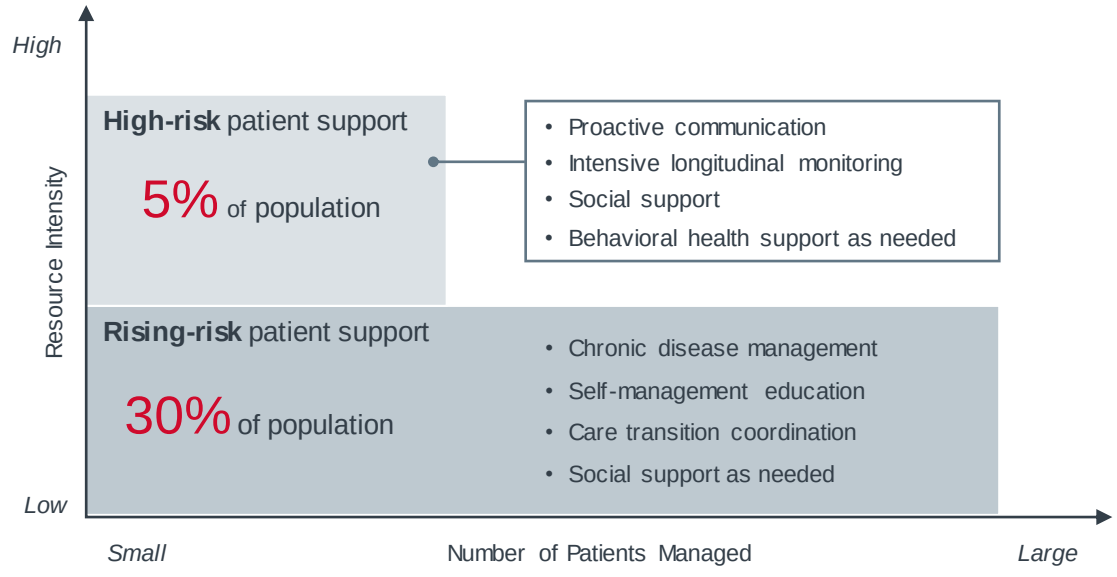
The RN care manager supports high- and rising-risk patients with multiple chronic conditions and/or social needs to help them navigate clinical services, connect with non-clinical services, and improve self-management.

Credentials:	Registered nurse
Target population:	High- or rising-risk patients
High-risk panel size:	150-250 total panel size, 30-50 active patients
Rising-risk panel size:	400-500 total panel size, 50-100 active patients
Median salary:	$66,300 ($61,599-$71,168)[1]
Evidence-based ROI:	Strong majority of studies show positive impact on quality, utilization, and cost
State scope of practice considerations:	Scope of practice is determined by state legislatures, which means states may reimburse differently for services

Key roles and responsibilities

The RN care manager's primary role is to help high- and rising-risk patients navigate their care and improve chronic disease self-management. Responsibilities will vary according to the care manager's target patient population: rising-risk care managers should focus on patient education and adherence to care plans; high-risk care managers should provide those same services, augmented with wraparound support to meet the particular needs of their more complex patients.

Responsibilities of high- and rising-risk care managers



Source: Bureau of Labor Statistics Occupational Outlook Handbook, "Registered Nurse," 2017; "Average Nurse Care Manager Salary," PayScale.com; "RN Care Manager Salaries," Glassdoor.com; Population Health Advisor research and analysis.

1) Includes medians from various sources that denote RNs, Nurse Care Managers, and RN Care Managers.

Deployment models

Organizations deploy care managers according to their target patient populations and the level of patient demand across clinics. High-risk care managers should mostly be embedded in clinics, while rising-risk care managers may provide virtual support from an administrative center or a single clinic location.

	Embedded	*Virtual*	*Mobile and/or Community-Based*
Benefits	• Increases physician referrals • Improves care coordination (e.g. team huddles, warm handoffs)	• Reduces travel time for staff • Scales easily	• Provides care manager with a well-rounded picture of patient condition (e.g. home environment) • Increases patient convenience
Drawbacks	• Requires clinic space • Office staff may "co-opt" care managers to perform administrative or clinical tasks unrelated to their care management role • A rotating model may pose a travel burden on staff	• Lowers physician referral • Lessens care team integration • Makes face-to-face patient contact more difficult to arrange	• Requires increased oversight to ensure care standardization • Lowers physician referral • Lessens care team integration • Lack of dedicated office/work space may pose challenges to workflow
Considerations	If a given clinic doesn't meet required volumes to sustain a care manager, the care manager may also provide clinic-based virtual services (e.g. transitions of care phone calls) to achieve scale	Patient contact is typically telephonic with patients assigned to care management teams according to primary care provider	Care managers divide time between patient homes and other community settings, but may also come into the clinic to facilitate warm handoffs

Funding and financing

Care managers are often the first addition to the care team for organizations entering into population health management and risk-based contracts. While organizations may use grant funding (including Center for Medicare & Medicaid Innovation funding) to start care management programs, many ultimately absorb these programs into internal budgets.

As CMS shows growing support for non-traditional services intended to lower total cost of care, revenue-generating opportunities for RN care managers continue to grow.[1] Reimbursement codes RNs can provide care for include:

- Fee-for-value codes such as
  - AWV[2] (G0438, G0439),
  - TCM[3] (99495, 99496)
  - CCM[4] (99487, 99489, 99490), and
  - ACP[5] (99497, 99498)
- Evaluation and Management code 99211
- Behavioral health codes, when the RN provides care coordination support, such as
  - General BHI[6] code 99484
  - Psychiatric Collaborative Care Model (CoCM) codes (99492, 99493, 99494)[7]
  - Assessment and Planning for patients with cognitive impairment (99483)

1) in order for the services to be reimbursable, they must be provided incident-to a physician. Incident-to services refer to services provided in an outpatient setting by a licensed non-physician practitioner (e.g. clinical pharmacist) under the supervision of a physician and billed for by that supervising physician. Each code has different requirements regarding the level of supervision required.
2) Annual Wellness Visit.
3) Transitional Care Management.
4) Chronic Care Management.
5) Advance Care Planning.
6) Behavioral health integration.
7) These codes were formerly G0502, G0503, G0504, and G0507 until January 1, 2018.

Source: "Medicare Payment for Registered Nurse Services and Care Coordination," American Nurse Association, 2017; Population Health Advisor interviews and analysis.

Key performance indicators

Cost and utilization outcomes are important to demonstrate a quantitative ROI for the RN care manager in primary care. However, true behavior change happens longitudinally, so providers should use process measures to capture a full picture of care management operations and impact.

Care and access metrics

- Care management outreach to patients (e.g., phone calls)
- No show appointments as percentage of total scheduled appointments
- Time from PCP referral to specialist appointment
- Percent of target population receiving screening exams and immunizations
- Disease management education, smoking cessation counseling completed
- Patient adherence to care plan

Patient engagement metrics

- Time between identifying and reaching out to target patients
- Percentage of eligible patients that enroll in care management
- Percentage of patients with documented self-management goals
- Use of shared decision-making tools
- Response time to electronic patient queries
- Patient graduation rates from disease management programs

Outcomes metrics

- Change in patient activation measure (PAM) scores
- Patient satisfaction
- Hospital admissions per 1,000 patients for at-risk populations
- ED visits per 1,000 patients for at-risk populations
- Per-member-per-month spend

For a full list of metrics, see the Cross-continuum Care Management Metric Pick List on advisory.com

Return on investment

RN care managers maintain ongoing communication with their patients to ensure early identification and proactive management of non-clinical and self-management needs. Proactive engagement can improve quality outcomes, reduce downstream utilization, and ultimately, lower the cost of care.

Improve quality

10/10

Studies demonstrate improved quality outcomes[1]

Improve utilization

11.5/12

Studies demonstrate decrease in hospital admission and/or readmission[2]

9/11

Studies demonstrate decreases in emergency department utilization[3]

Reduce cost

12/12

Studies demonstrate decreased costs[3]

33% Of annual escalation from rising- to high-risk can be prevented through care management

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1) Two studies show both positive and neutral impacts.
2) Admissions and readmissions. One study shows decreased admissions but no impact on 90-day readmissions.
3) Two studies show both positive and neutral or negative impacts. Some studies showed lower utilization or cost as compared to a control group.

Source: Hong C, et al., "Caring for High-Need, High-Cost Patients," *Commonwealth Fund*, 2014, 19; Population Health Advisor, *Playbook for Population Health*, Advisory Board; Population Health Advisor interviews and analysis.

Questions to consider when deciding whether to hire an RN care manager

1. *Complexity of patient population*. Organizations tend to reserve RN care manager time for high-risk patients, or to oversee rising-risk management provided by a lower-cost team member. If your program is targeting multiple risk levels, RNs may need to be supplemented by additional care team members. What is your target population, and what staff types are you currently deploying to meet their needs?

2. *Primary drivers for patient complexity.* Social workers may be better-equipped to manage patients whose complexity is driven primarily by unmet behavioral health needs, since they're trained to provide short-term therapy. What proportion of your high- or rising-risk patients have behavioral health diagnoses?

Alternative hires to meet care management demand

Organizations looking to provide care management to rising- or low-risk patients may consider hiring medical assistants (MAs) to promote top-of-license care. For high- or rising-risk patients with behavioral health needs, many organizations hire social workers to fill the care manager role.

	Nurse care manager *Registered nurse*	**Social worker care manager** *LCSW (MSW plus two years of supervised experience[1])*	**Medical Assistant** *Certified medical assistant*
Target population	At-risk patients with multiple chronic conditions	At-risk patients with behavioral and psychosocial needs	Low- or moderate-risk patients
Main tasks	• Promotes medical self-management • Provides care coordination, community resource referrals	• Provides behavioral health support • Provides care coordination, community resource referrals	• Provides care coordination scheduling support • Supports panel management (e.g. reminder calls for gap closure)
Benefits	Trained in clinical chronic disease management, self-management support	• Trained to identify and address comorbid non-clinical, behavioral health needs • May be more familiar with community resources	• Least expensive • Common team member in primary care that can be upskilled
Drawbacks	Lack of behavioral health training	Lack of medical training	Limited scope of practice (i.e. lack of medical, behavioral health training)

1) Licensure requirements vary by state.

Source: Population Health Advisor interviews and analysis.