About This Guidebook

This book presents guidance for implementing care management programs in healthcare organizations. It includes practical guidance on structuring a care management program, establishing effective processes and teams, and continually measuring and improving its value to the organization.

Our goal is to help your organization meet its population health management goals—improving outcomes, reducing costs, and increasing the quality of life for the patients you serve.

Meant to be adapted

We intend this guidebook to be practical and actionable—but also flexible enough to conform to your organization’s unique population health management goals, resources for care management, and vision for the role that care management can play in supporting population health. The recommendations in this guidebook are based on best practice, but aren't prescriptive "one size fits all." You’ll need to adapt them based on how far along you are in implementing care management, what’s working well for your organization, and where there are gaps.

Developed with Partners Healthcare

Health Catalyst produced this guidebook in collaboration with care management experts at Partners Healthcare, a nonprofit healthcare organization in Massachusetts. Founded in 1994 by Brigham and Women’s Hospital and Massachusetts General Hospital, the Partners organization includes community clinics, community hospitals, and academic medical centers. It participates extensively in at-risk contracting with both CMS and commercial payers. In select chapters of this guidebook, you’ll see case studies based on the Partners integrated Care Management Program (iCMP).

Aligned with the three systems for improvement

Health Catalyst uses the Three Systems framework to describe the components of meaningful improvement work in healthcare. We’ve seen that without all three components in place, organizations struggle to create and sustain clinical, operational, or financial value. These components are also vital to creating and sustaining effective care management programs. In each chapter of the guidebook, you’ll see a sidebar panel like this, identifying how the topic of the chapter aligns with one or more of the three systems.

- **Best Practice:** Standard “knowledge” work (guidelines and standard workflows) needed to guide and improve best practice.
- **Adoption:** Standard organizational work (teams, processes, mindset changes) needed to implement programs.
- **Analytics:** Standard data sources, analysis, and workflow tools needed to identify populations, support the care management workflow, and measure the outcomes.

Supported by services

Health Catalyst’s Population Health Management Team includes experts who can partner with you to plan, build, and optimize your care management program. Ask your Engagement Lead about accessing this support:

- **Strategic services:** Assess organizational readiness, identify opportunities, refine care management populations, and outline a strategic plan for care management in your organization.
- **Operational services:** Support program planning, hiring, training, and operational management to meet patient needs.

Powered by technology

Health Catalyst can supply data, analytics, and decision support technology to advance your care management and population health strategy. For information about our product portfolio, visit [healthcatalyst.com](http://healthcatalyst.com) or connect with your Engagement Lead.
Contents

Structure: Includes recommendations on the role of care management to support population health and how an organization can prepare to implement care management.

1. Introduction to Care Management .......................................................... 4
2. Readiness Assessment ................................................................. 9
3. Governance and Organizational Structure ........................................... 11

Process: Includes guidance on creating care management programs that support your organization's strategic goals, plus best practice recommendations for five common steps in the care management process.

4. Care Management Process Overview .................................................... 14
5. Patient Stratification ..................................................................... 17
6. Refining Patient Lists and Assignments ............................................ 20
7. Patient Assessment and Care Planning .............................................. 24
8. Care Coordination: Day-to-Day Workflow ......................................... 28
9. Engaging Patients .......................................................................... 30

People: Includes recommendations for forming care teams with effective roles—and for finding, training, and supporting people to fill those roles.

10. Care Team Roles ........................................................................... 33
11. Hiring, Training, and Support ....................................................... 36

Improvement: Includes recommendations for measuring outcomes from care management to drive improvements in your care management programs.

12. Measuring Outcomes ..................................................................... 39
1 Introduction to Care Management

This chapter provides a summary of the role of care management in population health, trends in care management, and Health Catalyst’s vision for meeting the needs of organizations as they implement care management. It also lists key research and resources.

Why focus on care management?

- **Responsibility for population health is rapidly shifting from payers to providers.** Before the launch of the Affordable Care Act and the Triple Aim Initiative, population health was the purview of health insurance companies. Now, value-based care models (e.g., accountable care, shared risk/shared savings) require that providers improve the quality and efficiency of healthcare delivery across the entire patient population they serve. Providers who do not initiate and improve population health management risk losing significant financial incentives attached to care delivery, as well as competitive advantages (market share, revenue).

- **Care management is the foundation of an organization’s population health infrastructure.** Care management is now considered a best practice in population health management. Essential components of a care management program include the following:
  - Identification of patient populations with modifiable risks
  - Alignment of care management services to the local population
  - Staff recruitment/education and physician engagement
  - Patient/family/caregiver engagement and self-management support
  - Performance measurement

- **Care costs are extremely high for patients with one or more chronic conditions.** A very small percentage of patients with chronic conditions account for a very large percentage of U.S. healthcare costs. Estimates vary, ranging from 1% of patients accounting for 20% of national expenditures to 8–15% of patients contributing to 50% of costs. According to the Partnership to Fight Chronic Disease, 191 million Americans had at least one chronic disease in 2015, 75 million had two or more, and 31 million had three or more. Annually, medical costs associated with care of these patients exceed $2.5 trillion. Care management programs identify these high-risk and high-cost patients, enabling providers to focus efforts on improving outcomes and reducing costs in this patient subpopulation.

- **Risk stratification is an essential care management process, but can be challenging.** Identifying patients who will benefit most from care management—for example, those at high risk of disease exacerbations, hospitalization, or mismanaged medications—is critical to program success. This requires a sophisticated approach that combines clinical risk-stratification tools, near real-time patient data analysis, and clinician review.

Key principles

Organizations implement care management in a variety of ways to meet a variety of goals. This guidebook is informed by basic principles that can apply in a range of circumstances.

In each chapter, key principles related to the topic appear in a sidebar.

Growing toward PHM

Population health management (PHM) requires organizations to evolve—and this takes time and an integrated strategy. How can you know if you’re moving forward?

As described in our Population Health Management handbook, Health Catalyst’s framework outlines areas of transformation that together help organizations grow:

- **Data transformation:** Lay the groundwork for a high-functioning data and analytic platform
- **Analytic transformation:** Build a structure to identify and evaluate opportunities
- **Financial transformation:** Balance risks and set a sustainable course forward
- **Care transformation:** Identify and implement appropriate changes in care delivery

Optimizing care management is key to many organizations’ care transformation efforts.
Introduction to Care Management

Trends in care management

- **Integration of payer and provider care management program delivery.** Care management programs for high-risk patients have traditionally been managed by payers; however, providers are increasingly establishing their own programs. Integrating these two models can leverage the strengths of both.\(^6,9,11\)
- **Use of risk stratification tools to identify high-risk and rising-risk patients.** Stratification tools—especially those that can combine multiple data sources, filter patients based on risk models or other factors, and create algorithms based on filters—make patient identification more effective.\(^5,13,16\)
- **Practice-based high-risk care management.** The literature has shown that care management is most effective when patients receive services that are “anchored” in the primary care practice where they receive the majority of their care.\(^6,9\) (To manage resources efficiently, some organizations assign each care manager to several practices located near each other.)

Basic requirements of care management

To reduce costs and increase the quality of care for patients in care management programs, organizations need five specific capabilities:

1. **Data integration:** The ability to combine data from the electronic health record, claims, and other disparate data sources in a format that makes the data actionable.
2. **Patient identification:** The ability to identify cohorts of patients for care management, using stratification tools/algorithms and clinical oversight.
3. **Care planning and team coordination:** Patient-centric tools that integrate with the care team’s workflow, support workflow tasks, and foster communication with the patient and family.
4. **Patient engagement:** Tools that help patients and family communicate with the care team and manage goals.
5. **Performance measurement and reporting:** The ability to meet payer reporting requirements on quality and outcomes measures, and to analyze data in order to plan program improvements.

Health Catalyst believes that supporting care management is vital for helping organizations meet population health goals. This support involves technology (data warehousing, analytics, and workflow tools); assistance in adoption of care management programs (such as readiness assessments, workflow mapping, and data source planning); and best-practice guidance for care management implementation.

In this guidebook, you’ll find links to best-practice resources to assist in program design and implementation.