IMPLEMENTATION GUIDE SUPPLEMENT

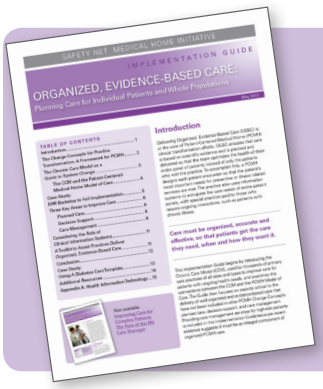
ORGANIZED, EVIDENCE-BASED CARE:

Improving Care for Complex Patients: The Role of the RN Care Manager

February 2012

Introduction

This resource sheet defines care management (sometimes called case management) and provides practical recommendations about how to provide care management services to high-risk patients. We originally included care management (CM) under the Care Coordination change concept. More recently, we made it part of Organized Evidence-based Care to give more emphasis to the clinical aspects of care management. CM refers to the more intensive services provided by a nurse or other health worker to a patient with complex medical and psychosocial needs. It encompasses both efforts to coordinate care and to deliver clinical services such as monitoring, self-management support and medication review and adjustment. CM is viewed by many policy gurus as a key cost reduction strategy even though a recent AHRQ-sponsored comprehensive review of CM for adults with medical illness and complex needs concluded that it has "minimal effects on overall costs of care."[1] However, the literature does include many successful interventions[2] that suggest that such services delivered by well-supported care managers to thoughtfully selected patients can improve key outcomes.



Also available
Organized, Evidence-Based Care: Planning Care for Individual Patients and Whole Populations

Care Management: Program Features

Who should be a care manager?

The skills and training of care managers should match the needs of the patients. All patients with multiple health and social issues need information, effective clinical therapy, patient activation and self-management support, emotional support, and

help with care navigation and coordination. The last three needs can be addressed by a wide range of health workers if trained in relevant counseling approaches (e.g., motivational interviewing, teach-back). The needs of the patient population for clinical information and treatment influence the optimal background of the care manager. For patients with complex medical needs, most care managers are nurses because of the breadth of their clinical information and experience. However, a social worker or behavioral health specialist may well be more appropriate for patients whose primary needs are psychosocial and/or substance abuse.

What patients should be care managed and how should they be selected?

The answer to this question depends in part on the primary goal of the CM program. The evidence suggests that CM is most successful for patients at high risk of the program's primary outcome. For example, CM programs trying to prevent re-hospitalizations would identify patients in hospital or recently discharged with risk factors for readmission. CM programs with broader goals (e.g., reduce total costs) have had greater difficulty demonstrating success because of challenges in identifying the patients most likely to benefit from CM. The recent emphasis on cost savings has focused attention on identifying more complex, sicker patients with multiple conditions. Many organizations use homegrown or proprietary predictive models to identify patients at highest risk of expensive care. Prediction models have generally performed poorly especially when based on retrospective administrative data. Greater reliance on socio-behavioral risk indicators such as medication nonadherence, lack of a regular physician, or social isolation may be more helpful. The HARMS 8 instrument developed by CareOregon is a nice example of a tool that identifies the population that is at the tipping point, where intervention makes a difference, not the ones who are already high utilizers. In other words, patients who are likely to benefit the most by a CM program addressing socio-behavioral risks.

What characteristics of care management programs are associated with success?

A. Training

Additional training of care managers improves program success. The content of the training is of course dependent on the focus and goals of the program. But all care managers should be skilled at empowering and helping patient reach self-management goals, and using protocols to guide clinical management.

B. The Role of Treatment Goals

Most patients selected for CM interventions have multiple chronic conditions and other factors adding to the complexity of their care. Without clear treatment goals, a well meaning care manager can devote considerable time and energy to complex patients without much evidence of impact. CM interventions with specific goals AND strategies or protocols for reaching those goals appear to be more successful. Treating to explicit targets whether they are measures of disease control (e.g. BP or PhQ-9 levels) or the prevention of specific adverse outcomes such as readmissions may be critical to success.

C. Care Management Program Intensity and Duration

The AHRQ review indicates that the success of CM programs tends to increase with the amount of face-to-face contact between care manager and patient. Telephone-only interventions have generally been unsuccessful. There is also some suggestion that longer duration programs are more effective—e.g., six months or longer.

D. Care Manager Situation and Support

CM is most successful when fully integrated with the patient's medical care and providers. The link with primary care is especially critical. Care managers should ideally function as members of the primary care team, although that is not always possible. Chaos could result if the care manager and primary care clinician are not collaborating on a single care plan, so close communication is essential. Evidence also suggests that care managers benefit from access to a physician or team specializing in the target clinical condition. For elderly patients with multiple health and/or social needs, regular review of patients with a consulting general internist or geriatrician has been helpful.

How will we know if a CM program is making progress?

Since CM programs tend to target the sickest patients with the highest utilization, it is easy to be fooled into thinking the program is successful by comparing pre- and post-program utilization because, on average, the highest utilizers this year will have lower utilization next year. Since most organizations have limited CM resources, it may be wise initially to identify more high risk patients than can be care managed, divide them into two groups (ideally at random), assign CMs to one group, and compare key outcomes. While this sounds like research, it may be wise practice management given the high cost of a CM program and the limited evidence of their success. The comparison group will help you evaluate whether any improvement seen in the CM group is the result of the CM or would have happened anyway without extra intervention.

CM program progress should be evaluated by the extent to which patients are achieving major program goals—e.g., reduced hospitalizations, better disease control, better patient quality of life, reduced emergency room use. Since improved care coordination is often an important goal, a list of various care coordination measures is included in the Care Coordination implementation guide.

Case Study: TEAMcare

The TEAMcare study recently published in the New England Journal of Medicine[3] has attracted considerable attention because of its very positive outcomes among patients with poorly controlled medical conditions (BP, LDL, and/or HbA1c) AND depression. Nurse care managers co-managed patients with their primary care doctors. What characteristics of TEAMcare were associated with its success?

1. Patients worked with nurses and primary care providers (PCPs) to collaboratively establish clinical and self-management goals that guided management.

2. Nurses provided structured visits to the patients in their primary care clinic every two to three weeks until goals were reached, then telephone follow-up every four weeks.

3. Nurses monitored progress and made medication adjustment recommendations to the PCP by protocol, and provided self-management support in an effort to reach treatment targets.

4. Nurses met weekly with a psychiatrist, general internist, and psychologist to review new cases and patient progress.

Although TEAMcare patients had two or more chronic conditions, they weren't as elderly or as sick as the complex, older patients that many CM programs target. Nonetheless, the close ties with PCPs, the emphasis on developing treatment goals and adjusting management to reach them, seeing patients in person, and having regular access to expert clinicians appear to be features of successful CM programs.

Resources & Tools

Rich E, Lipson D, Libersky J, Parchman M. Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I/ HHSA29032005T). AHRQ Publication No. 12-0010-EF. Rockville, MD: Agency for Healthcare Research and Quality. January 2012. Accessed here.

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1 *Comparative Effectiveness of Case Management for Adults With Medical Illness and Complex Care Needs*. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); June 3 2011.

2 Bodenheimer TS and Berry-Millett R. Care Management of Patients with Complex Health Care Needs: The Synthesis Project, Issue 19 Publisher: Robert Wood Johnson Foundation, 2009.

3 Katon WJ, Lin EH, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med*. 2010;363(27):2611-2620.

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Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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