Creating a Sustainable Care Management Program

PROGRAM	
Define your purpose	• Purpose = what do you want to cause by implementing a Care Management Program? • Alignment = Does this purpose align with the practice mission, vision and values? • Success = How does this program contribute to the strategic plan of the practice?
Document workflows	• Comprehensive documentation is the foundation of a sustainable program, and essential for tracking improvements. • Develop procedures for care management enrollment and services. Define metrics to track outcomes. • Reevaluate your program and process periodically to identify opportunities for improvement
Develop a CM registry	• Work within your EHR (if possible) to develop a care management registry that tracks patients enrolled in CM services • Document non-face-to-face and phone interactions in patient record, track time spent (per month) in registry • Use registry to discuss patients enrolled in CM services during care team meetings
Create accessible care plans	• Work within your EHR (if possible) to develop patient focused, goal oriented care plans that can be accessed by members of the care team within the patient record • Create the care plan as a *working document*: Include health goals, barriers, confidence scales and follow up plans • Celebrate small wins when health goals are met – share these wins with the care team AND recognize the patient's success
PEOPLE	
Defined responsibilities	• Staffing is the HEART of a sustainable care management program! • The care manager is part of the practice to support chronic disease management and patient care needs • The CM assesses patients readiness to change, develops and monitors care plans, connects patients to resources • The CM follows up with patients during transitions of care to provide continuity and support
Thriving individual	• Is your care manager dedicated to continuing to develop his/her skillset? • Is your care manager working at the top of his/her licensure? • Is your care manager person focused, well organized and comprehensive?
Thriving team	• Does your care manager openly communicate and seek input or feedback from members of the care team? • Is your care manager involved in other clinic/organizational committees (i.e. quality improvement, patient engagement)? • Offers support and makes a positive impact on the team environment
Sink or swim assessment	• Care manager often expresses feeling overwhelmed with current caseload • Difficulty integrating into the care team: Provider is hesitant to share the patient relationship with CM • Care manager is consistently asked to complete other clinic duties that take away from time to perform role effectively • Assessment shows sinking: Create a SAFE and supportive workplace

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PERFORMANCE	
Learn to Love Data	*If you don't measure it, it doesn't matter* *If you measure it* ***but don't share it****, it will not matter to anyone else!*
PMPM Expenditures	• PMPM = (Per member per month) expenditure – This data is provided to practices by payers in value based contracts (VBC) • Gather Observed PMPM (practice data) vs. Expected PMPM (regional data), chart and compare this quarterly • Record any differences between practice and regional data. Performance rates below "averages" could indicate potential savings in healthcare costs for your patients and potential gains in VBC. Care Management owns a piece of this success!
Utilization	• Care management has a direct effect on utilization rates • Track your successes with reduction in ER and IHU, correlate this with reductions in PMPM expenditures. • Time stamping practice changes or new interventions with care management services is one way to show how CM is contributing to savings • Effective care coordination with specialists can increase the efficiency of specialist visits and potentially reduce high cost utilization – tracking referral workflows for high cost specialists can show how CM is making an impact
Patient Engagement	• Motivational Interviewing can engage patients to take accountability in their own health. • CM creates a support system to help patients close gaps in care that can lead to improved patient health and clinical quality measure (CQM) performance • Improving patient engagement can lead to an increase in patient satisfaction, loyalty and contribute to long term attribution
Patient Success Stories	• Collecting qualitative data is just as important as quantitative data! • Create patient surveys specific to care management services • Document goal attainment as success stories to share during care team meetings • Display patient success stories as part of your external communication plan to drive the value of CM in your practice

Notes: