

# What We Talk About When We Talk About Care Management

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**E**mphasis on care management has become ubiquitous in the era of value-based payment. At the vanguard of the movement, policy makers such as Medicare have emphasized care management via a variety of initiatives, ranging from payment models that encourage longitudinal care management<sup>1</sup> to billing codes that reimburse clinicians for coordinating the care of patients who have chronic conditions.<sup>2,3</sup> Hospitals and physician groups increasingly view care management as a key area for investment and as a strategy for succeeding in a value-based environment,<sup>4</sup> and there have been isolated reports of success within value-based payment models.<sup>5</sup>

However, despite widespread enthusiasm, complex care management and coordination activities are not associated with differences in quality, utilization, or cost outcomes in prominent value-based payment models such as the Medicare Shared Savings Program (MSSP).<sup>6</sup> One potential driver is the variability in how care management programs are defined and implemented. For instance, a survey of individuals leading care management programs demonstrated such a wide range of roles, program characteristics, patient selection methods, and measurement strategies that researchers faced challenges when attempting to classify programs.<sup>7</sup>

In light of this variation, it is important for policy makers and clinicians to clearly define care management in order to evaluate its impact on patient care. Doing so is vital because care management is not a monolithic concept, but rather one that encompasses several distinct types of activities: those related to clinical conditions, health care utilization, and patient experience and access. Although these types of activities need not be mutually exclusive or at odds with each other, failing to distinguish between them when implementing care management programs carries risks.

Organizations may invest in programs that emphasize one activity while expecting the benefits of another, creating misalignment among organizational goals, program investments, and eventual results. For example, care management programs that emphasize disease management may improve quality performance (eg, increasing adherence to guideline-concordant processes for a given disease) while worsening cost performance by increasing utilization<sup>8</sup> (eg, if

## TAKEAWAY POINTS

- ▶ As a broadly defined care delivery strategy, care management can improve outcomes but has yielded variable results, particularly within value-based payment models.
- ▶ One contributing factor is that care management encompasses different types of activities, functions, and goals.
- ▶ A framework categorizing care management as disease management, utilization management, and/or health care navigation interventions can help providers and payers invest in, implement, and reap benefits from care management programs.

patients who were previously nonadherent to guideline-concordant care begin receiving more of it).

Consequently, organizations that build disease management-heavy programs expecting them to drive performance in total costs of care reforms, such as accountable care organizations, may fail to see return on investment and arrive at the conclusion that “care management” does not work. This dynamic may exist in the MSSP, in which clinical condition-focused management initiatives have failed to contribute to cost savings.<sup>9</sup> For patients, the end result of confusing the functions, benefits, and risks of different care management activities is that some individuals may receive care management services they do not need, while others do not receive services that they do need.

To address this issue and support organizational efforts to engage and succeed in value-based care, we offer a care management taxonomy based on the distinct activities of managing clinical disease (hereafter, *disease management*), containing health care utilization (hereafter, *utilization management*), and improving patients' navigation through the health care system (hereafter, *health care navigation*). We contrast these 3 activities by focusing on differences in function, target populations, requisite competencies, and key risks and limitations (Table).

### Disease Management Activities

Care management programs focused on disease management predate the era of value-based care.<sup>10-12</sup> These programs target

**TABLE.** Attributes of Different Care Management Activities

Care management activity	Disease management	Utilization management	Health care navigation
Main function	Provision of evidence-based care	Reduction of unnecessary health care utilization	Removal of structural barriers to care
Target population	Patients with chronic conditions	Patients at high risk for frequent emergency department, hospital, and postacute care use	Patients facing difficulties accessing and/or coordinating care
Core competencies	<ul style="list-style-type: none"> <li>• Translate clinical knowledge into care processes</li> <li>• Ability to support patients' self-management</li> </ul>	<ul style="list-style-type: none"> <li>• Data analytics</li> <li>• Clinical triage</li> </ul>	<ul style="list-style-type: none"> <li>• Resource identification</li> <li>• Customer service</li> </ul>
Risks and limitations	<ul style="list-style-type: none"> <li>• Little focus on social determinants</li> <li>• Little emphasis on cost performance</li> <li>• May not involve patient-centered processes</li> </ul>	<ul style="list-style-type: none"> <li>• Inadvertent reductions in appropriate or necessary care</li> <li>• Under- or overemphasis on "super-utilizer" patients</li> <li>• May not involve patient-centered processes</li> </ul>	<ul style="list-style-type: none"> <li>• Excess resources expended without benefit</li> <li>• Little emphasis on cost performance</li> <li>• May emphasize patient-centeredness at the expense of quality or cost performance</li> </ul>

patients with chronic conditions, using medical evidence to create processes that improve patients' disease self-management via steps such as medication adherence and lifestyle or behavioral changes (eg, related to diet and exercise).

The main function of disease management initiatives is to drive greater use of evidence- or guideline-based care. In turn, the requisite competencies for this type of care management activity consist primarily of the ability to translate clinical knowledge into care processes and engage patients in their own care (eg, via motivational interviewing, self-management support). From the perspective of organizational performance goals, this type of program can align with value-based care delivery by improving disease-specific metric performance. However, there is a dearth of evidence that disease management programs lead to appreciable reductions in total costs of care.<sup>6,8,9</sup> Because disease management programs emphasize evidence- or guideline-based medicine, they are also limited by the lack of medical evidence in many areas of clinical care.

Another limitation of disease management programs is that they are not designed to address nonclinical determinants of clinical, quality, and cost outcomes. For example, hyperglycemia and hypoglycemia in insulin-dependent patients with diabetes can result from food insecurity—an issue that cannot be addressed by clinical strategies such as insulin titration. The clinical focus of these care management programs excludes social and other determinants of health.

### Utilization Management Activities

Like disease management, utilization management is not a new concept. However, interest in these programs has increased significantly as more clinicians and organizations have gained the ability to collect utilization information (eg, through advances in data capture via the electronic health record and interoperability via admission/discharge/transfer, or ADT, messaging) and the incentives to reduce utilization under value-based payment and

delivery reforms. Rather than maximizing guideline-concordant care, the core main function of this care management activity is to reduce unnecessary health care utilization, particularly high-cost utilization associated with emergency department (ED), hospital, and postacute care facility care.

Given this focus, utilization management programs target patients at risk for high utilization (sometimes called "super-utilizers") and emphasize core competencies such as data analytics and robust clinical triage capabilities, which can be used to identify and intervene in the care of super-utilizers. The specific strategy for triage can vary, with some organizations embedding care managers within their primary care infrastructure to reduce utilization related to ambulatory care-sensitive conditions,<sup>13</sup> whereas others station utilization managers in EDs to more directly curb inappropriate hospitalization.<sup>14</sup>

The major limitation of utilization management programs is the risk of inadvertently deterring appropriate care. No clinical triage processes are perfect, and it can be challenging to prospectively determine when ED or acute hospital care is medically necessary. Moreover, these programs do not inherently distinguish between clinical and social drivers of utilization. As organizations seek to discern that for themselves, underemphasis on social drivers can lead to disappointing results, while overemphasis on super-utilizer patients can create underinvestment in programs targeted to average- or low-risk individuals—interventions that have similar if not greater ability to curb unnecessary utilization.<sup>15</sup> Finally, although patient experience is a key element of value-based care, organizations that heavily emphasize utilization management may be perceived as "gatekeepers" that lack patient-centered processes.

### Health Care Navigation Activities

As a method for delivering patient-centered care, health care navigation has received increased attention in the era of value-based payment. Organizations have created new roles for "health navigators"<sup>16</sup> or "health coaches" who focus on helping to remove

structural barriers for patients who have difficulties in accessing and/or coordinating care.<sup>17</sup> As another example of health care navigation, primary care clinics have enabled direct referrals to community-based programs to address adverse social determinants of health.<sup>18</sup> By improving individuals' experience and/or ability to access care, navigation-focused care management programs can support success in value-based payment arrangements via greater patient engagement and continuity.

However, because navigation seeks to address individualized barriers to care, there are also risks to broad implementation within value-based payment initiatives. In reducing barriers to care, organizations may spur utilization that unintentionally counteracts efforts to manage costs of care. The potential benefits from patient navigation and engagement may also be undercut by features of payment model design. For instance, most heavily emphasize quality and cost outcomes over patient experience outcomes, reducing the degree to which improved navigation is reflected in payment model performance.

## Conclusions

As a broadly defined care delivery strategy, care management can improve outcomes. However, the results to date have been variable, particularly within value-based payment models. One way to improve the design, implementation, and potential benefits of care management programs is to utilize a framework that distinguishes among different types of activities, functions, and goals encompassed by the concept of care management. ■

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**Source of Funding:** None.

**Author Disclosures:** The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

**Authorship Information:** Concept and design (LMM, JML); drafting of the manuscript (LMM); critical revision of the manuscript for important intellectual

content (LMM, JML); administrative, technical, or logistic support (LMM); and supervision (JML).

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