The shift from volume- to value-based healthcare is forcing many organizations to rethink traditional care management models. Find out how payors and providers are evolving their service models to align with shifting reimbursement.
WHO OWNS CARE MANAGEMENT TODAY?

The ongoing shift from fee-for-service to value-based healthcare reimbursement has catalyzed significant changes in care management and care coordination, which are emerging as top priorities for health plans as well as providers in various value-based reimbursement contexts.

Health plans have historically led the vast majority of care management initiatives, as they have had the infrastructure to support large-scale programs in order to manage medical costs and improve clinical outcomes in fee-for-service environments. In the light of today’s growing number of risk-share and gain-share relationships, however, ownership of care management can sometimes be less clear-cut. Providers (who increasingly share the financial benefits of successful care management) are beginning to invest in their own programs. And while health plans still drive the majority of care management, many plans aim to share, or even delegate at least some of their programs to providers such as ACOs and PCMHs.

THE QUESTION OF SHARED OWNERSHIP

For better or worse, it’s not always clear where programs like chronic and transitional care management, case management, and behavioral health management are best suited to reside. And although plans may express a desire to delegate care management to providers, providers often aren’t equipped to take on this responsibility. Plans and providers will ideally approach care management collaboratively as to prevent high-risk patients from falling through the cracks and to improve patient compliance.
Common Challenges

Wellframe has been working with a broad range of organizations that provide care management services. Having observed these organizations navigate common challenges, opportunities, and strategies as they work to adapt to new clinical and financial realities, we’ve highlighted 5 profiles of care management programs in evolution:

1. LARGE STATE HEALTH PLAN WITH A GROWING MEDICARE ADVANTAGE (MA) POPULATION

This MA plan has provided care management to its highest risk members for a long time. Now, it must reach a larger proportion of members with its existing care team in order to sustain and improve revenue through Five Star ratings. Its primary challenge is achieving broader goals, including clinical and financial risk management, as well as quality improvement, without additional resources.

2. SMALL STATE HEALTH PLAN WITH PREDOMINANTLY COMMERCIAL BUSINESS: DIFFERENTIATES ON CUSTOMER SERVICE AND AFFORDABILITY

Well over half of this state health plan’s business is full risk, while a growing percentage entails risk-sharing with providers. This plan aims to delegate care management to providers, but cannot do so in the short term as many of its partnering providers don’t yet have the infrastructure needed to take on care management responsibilities. As a result, it must improve the efficiency and effectiveness of its own program with modest FTE and infrastructure investment.
3. LARGE MULTI-PRACTICE PHYSICIAN ORGANIZATION

This organization is taking on risk from health plans in blocks of tens of thousands of patients: first through gain-share, then risk-share, then full capitation. The practice has a care management program in place, but it’s limited in scope. To mitigate growing risk, this physician organization needs services that accomplish more than coordinating healthcare resources and scheduling follow-up appointments. However, its desire to sustain longitudinal relationships with patients can’t be realized without significant investment in IT infrastructure, analytics, training, and workflow development.

4. MEDICAID MANAGED CARE PLAN WITH SIGNIFICANT MEMBER GROWTH

For the first time, this plan is integrating care management for chronic disease and behavioral health in order to efficiently and effectively support a new wave of vulnerable, transient, and hard-to-reach members. The plan is looking to use digital tools—an increasingly preferred channel for support and engagement among lower income members with chronic care and behavioral health needs— to extend the scope and effectiveness of its program.

5. LARGE STATE PLAN LEADING A PATIENT-CENTERED MEDICAL HOME

This plan is sponsoring infrastructure and resources to in-network providers who are incentivized to develop practices around enhanced primary care, population health, and care management. The health plan provides ongoing financial support to partner practices, which do not have the means to invest in technological infrastructure and service resources on their own. But despite significant investment in information exchange, analytics, and performance evaluation, this health plan remains challenged to scale care management services effectively across its large geography and patient population. Point of care patient contact alone does not guarantee successful patient engagement at scale.
COMMON CHALLENGES AND OPPORTUNITIES FACING CARE MANAGEMENT TODAY

LIMITED CAPACITY

First, plans and providers have limited capacity to reach high-risk patients, despite investment in nurse care managers. It’s not uncommon for plans to reach less than 2% of their members, with nurses touching one patient per hour for an average of just two dozen patients per week. Patient contact is often scheduled once every few months, resulting in disjointed, high-friction relationships.

LIMITED REACH

Second, sub-optimal engagement channels consistently inhibit successful care management and expansion of care management resources to include variety of healthcare professionals. Plans and providers find landline telephone communication—standard practice in most programs—particularly burdensome as fewer and fewer patients own a landline telephone, let alone answer it. Also, patients and care managers agree that connecting over landline phones can be time-consuming and frustrating. In-person visits, while they can be quite valuable for clinicians and patients alike, are neither scalable nor comprehensive, and little insight remains into the patient’s health between visits.

NEW OPPORTUNITIES EMERGING WITH MOBILE

At the same time, mobile device usage is on the rise across all demographics. American adults are using smart phones to access information and communicate in nearly every aspect of life and work. On the back of widespread adoption, mobile is well positioned to transform care management as we know it. As the most intimate and scalable channel for patient engagement that we’ve ever had, mobile presents a clear opportunity to advance the care management industry.
Evolving Care Management with Wellframe

That’s where Wellframe comes in. Our mobile platform for care management helps all of the care management profiles described to overcome challenges to patient engagement and improve patient outcomes without additional investment in infrastructure or headcount.

How Wellframe Works

The Wellframe application delivers a personalized care plan to patients via a simple daily health checklist. As patients interact with their care plans, the application captures information about patient’s day-to-day progress and summarizes it in real-time on the clinician’s dashboard, where the platform dynamically prioritizes which patients need attention on any given day. Using these insights, care managers can communicate directly with patients via the app’s secure mobile messaging feature.

With Wellframe, you can improve patient engagement, increase care management effectiveness, reduce costs of care and improve quality metrics.

The Wellframe Impact

Wellframe does not replace human care, but rather amplifies it. By drastically reducing administrative burden, it empowers care managers to operate closer to the top of their license, connecting with patients in a more continuous and better informed manner. By facilitating a more continuous connection, Wellframe helps patients feel supported and cared for. Lastly, it is designed to enhance the effectiveness of care management by mitigating healthcare utilization, increasing revenue through value-based payment, and improving patient retention.

For more information, please visit www.wellframe.com