SCIENCE- IN-BRIEF

TURNING SCIENCE INTO ACTION

Provider Perspectives on Essential Functions for Care Management in the Collaborative Treatment of Hypertension: The P.A.R.T.N.E.R. Framework

The following is a synopsis of "Provider Perspectives on Essential Functions for Care Management in the Collaborative Treatment of Hypertension: The P.A.R.T.N.E.R. Framework," published in the April 2015 issue of *The Journal of General Internal Medicine*.

What is already known on this topic?

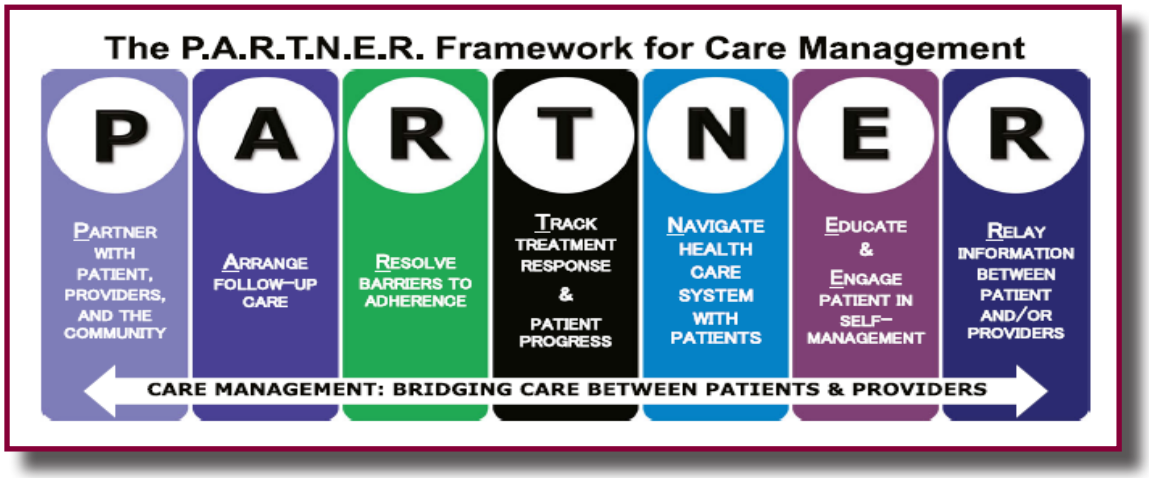
Care management is a widespread strategy used to improve treatment and control of chronic diseases in the United States. It involves non-physician care managers working with patients to coordinate clinical care and support chronic disease self-management. Care management can help improve patients' health and reduce costly healthcare utilization.
Previous studies of care management have examined provider perceptions of care managers' roles, preferences for care manager qualities, satisfaction with care management programs, and motivation for participating in care management. But to implement effective care management in clinical practice, it is important to understand the value of specific care management functions such as arranging follow-up care or tracking treatment response. Providers' views on specific care management functions should be taken into account in order to design effective care management programs and to ensure provider buy-in.

What is added by this article?

The authors enumerate the care management functions that providers believe are necessary for effective collaboration in hypertension care management. They developed the P.A.R.T.N.E.R. framework to organize the list of these care management functions and the specific tasks associated with each function. To identify the essential care management functions and their associated tasks, the authors conducted focus groups and performed qualitative analysis of the perspectives of 39 primary care providers in Baltimore County and Baltimore City. These providers represent six clinics (two that serve large African American patient populations and four in medically underserved areas) with large proportions of patients with uncontrolled hypertension. . The clinics are part of an integrated network of 17 primary care practices across Maryland that operate in a managed care model.

Providers felt that more patient education, self-management support, and individually tailored treatment were necessary to improve hypertension care—but that all of these were difficult to provide on their own. They felt that collaborating with care managers could help provide these additional supports, but stated that collaborating with care managers should not increase providers' workloads or inadvertently worsen fragmentation in the healthcare team.

Figure 1. P.A.R.T.N.E.R. framework: Essential functions of care managers



Source: Hussain et al., 2015

What are the implications of these findings?

The P.A.R.T.N.E.R. framework provides guidance for the design of effective care management programs by listing essential care management functions and their associated tasks. It includes only those functions and tasks that providers cannot effectively deliver on their own but that providers in the study felt were important. Because it is based on provider perspectives on care management, others can use this framework to develop their own programs and enhance buy-in and engagement. The P.A.R.T.N.E.R. framework can also guide measurement and evaluation of adult chronic disease care management programs.

In contrast to other care management models, the P.A.R.T.N.E.R framework describes how to integrate chronic disease care management into clinical practice. It highlights the care management functions that providers thought necessary to bridge clinical care and self-management for adults with hypertension.

Future research should focus on validating this framework in other settings and among different patient and provider populations and on evaluating the impact of specific care management functions on patient outcomes. Although the P.A.R.T.N.E.R. framework is based on input from one network of providers from one county, it is consistent with strategies that have been proposed elsewhere to improve management of hypertension and other chronic diseases.

Resources

1. The Chronic Care Model: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
2. Million Hearts® - Hypertension Control: Change Package for Clinicians: http://millionhearts.hhs.gov/Docs/HTN_Change_ Package.pdf
3. The Synthesis Project: Care Management of Patients with Complex Health Care Needs: http://www.rwjf.org/en/library/research/2009/12/care-management-of-patients-with-complex-health-care-needs.html

Citation

Hussain T, Allen A, Halbert J, Anderson, CAM, Boonyasai, RT, Cooper, LA. Provider Perspectives on Essential Functions for Care Management in the Collaborative Treatment of Hypertension: The P.A.R.T.N.E.R. Framework. J Gen Intern Med 2015; 30(4):454–61. doi: 10.1007/s11606-014-3130-4