

Care Management

An Implementation Guide for Primary Care Practices

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Introduction

Care management is, broadly speaking, processes and functions that a primary care team can apply to help patients more effectively prevent and manage their medical conditions. Care managers are professionals in the health care team that help with completing care management with the patients as part of the clinical team.

Research has shown that care management can be an effective means of helping patients to improve clinical values, reduce unnecessary care, and reduce health care costs. However, if not implemented effectively, care management can also be expensive and have no impact on outcomes. Hence, the importance of this guide.

There are a variety of reasons why primary care practices are beginning to consider care management. This guide will help health systems and especially practice teams consider the issues that may emerge in the process of implementing care management, so that decisions can be made that best fit the individual context of each practice.

Who should use this guide?

This guide is designed to be used by care managers new to the role of care management as well as by clinicians and staff in a practice to guide effective implementation of care management. It is based upon research conducted by the authors and others regarding successful strategies used in other practices with documented outcomes.

How to use this guide

This guide was intended to give practice teams a “heads up” about important implementation issues, and therefore, we advise at least skimming through all of the sections before setting up the program. Feel free to read it from the beginning to end or skip around to specific sections as needed.

At the end of each section is an assessment. Answering the self-assessment questions may also help your practice to determine where your needs are the greatest.

Throughout the guide we have provided quotations from a series of interviews we conducted in primary care practices that use care managers. These quotations provide insight from patients, practice members, and care managers who are actively engaged in care management right now.

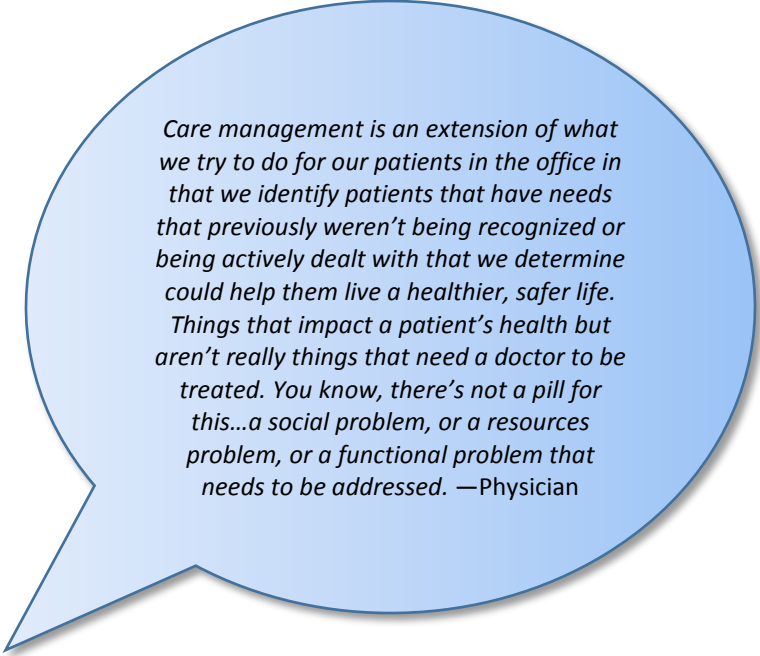
What is Care Management and Why Would My Practice Want It?

Care management versus a care manager

Care management can be both a set of processes and associated goals for those outcomes shared by many members on a health care team, as well as a role for one person called a care manager. First, what is care management?

Beginning broadly with care management as a process, one formal definition of care management is that it is a “team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively.” It also encompasses those care coordination activities needed to help manage chronic illness.¹

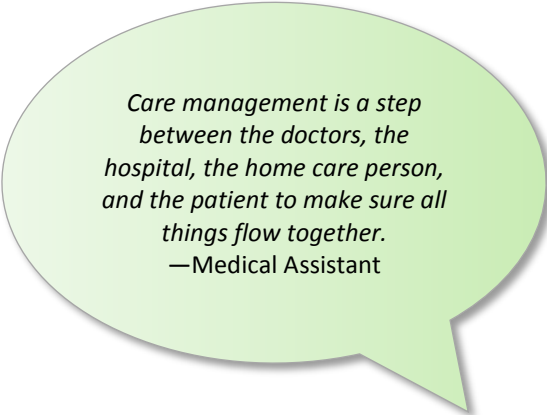
Another formal definition of care management is that it is “a set of activities designed to assist patients and their support systems in managing medical conditions more effectively. The goals of care management are to improve patients’ functional health status, enhance coordination of care, eliminate duplication of services, reduce the need for expensive medical services, and increase patient engagement in self-care.”²



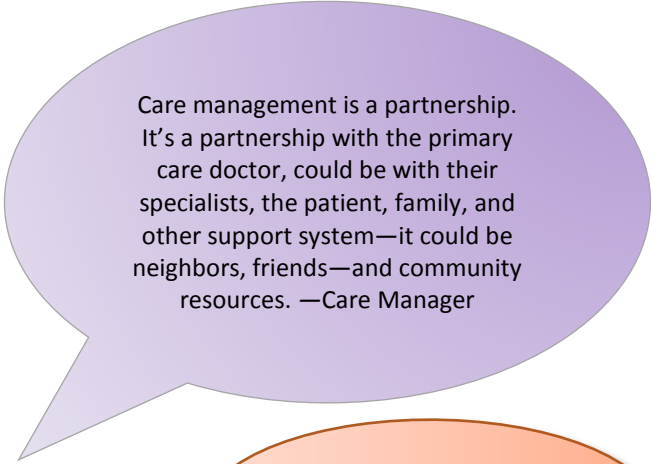
Care management is an extension of what we try to do for our patients in the office in that we identify patients that have needs that previously weren't being recognized or being actively dealt with that we determine could help them live a healthier, safer life. Things that impact a patient's health but aren't really things that need a doctor to be treated. You know, there's not a pill for this...a social problem, or a resources problem, or a functional problem that needs to be addressed. —Physician

Last, care management has also been described as “Programs [that] apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.”³


Here is how some of our practices participating with us on implementing care management have described it:



Care management is a step between the doctors, the hospital, the home care person, and the patient to make sure all things flow together.
—Medical Assistant



Care management is a partnership. It's a partnership with the primary care doctor, could be with their specialists, the patient, family, and other support system—it could be neighbors, friends—and community resources. —Care Manager



It's just good patient care.
—Clinic Coordinator

So then, what specifically is a care manager?

A care manager is a member of the practice team who works directly with patients to provide care management. A care manager is usually an experienced nurse, social worker, or other health care professional who coordinates care and handles patient needs.

It may be easier to understand the care manager role by describing common or everyday activities care managers can perform.

A care manager can:

- Develop a plan of care that complements the provider's plan of care and that addresses physical, educational, and psychosocial needs for the patient/family. Note that plan of care can be an area of misunderstanding. There may be three plans: 1) The medical plan created by the provider, 2) the self-management action plan developed with the patient, and 3) the care management implementation plan which the care manager uses to address barriers, address risk/safety, or marry the medical plan and self-management action plan.
- Identify patients needing additional support such as those with chronic conditions needing management or social issues impeding health improvement

The care manager can help friends and family understand different illnesses the patient is dealing with, different chronic diseases that the patients are needing care managing for, so ... not only do they help the patient, but they also help the people caring for the patient.

—Referral Specialist

- Provide self-management support with a focus on health behavior changes to manage chronic conditions. This usually includes using a motivational interviewing or an empowerment approach with patients.

A patient advocate. The care manager is somebody who acts as a liaison between the primary care provider and the patient. Quite often she'll come and sit in on the visits, and kind of hear what the provider and the patient discuss and recommendations, and then she serves as a resource for the patient when they leave here.

—Physician Assistant

- Provide patient/family education with teach back (teach back is a method used by healthcare providers to confirm whether a patient understands what is being explained)
- Provide resource support, education and care coordination during transitions between health care settings or to home or a facility
- Provide assistance with medication management and reconciliation
- Refer patients to community and social service resources for additional help and support
- Assist with advance directives

Diversity of the care manager role

What we have observed is that there is a lot of diversity regarding what care management is in the primary care practice setting. Care management can take on a very narrow focus or a very broad focus to cover a lot of ground depending on the size of the practice, the patient population, and the goals for the practice. Care management in one practice may focus on a certain patient population such as patients with diabetes; whereas, in another practice, it can be very broad and include patients with a number different conditions and issues. For

example, in one practice, tasks may include educating patients, teaching insulin injection, and providing follow-up for blood sugar monitoring. In another practice, the care manager may assist patients with care transitions, medication reconciliation/management, and chronic disease management and education, and provide health behavior change coaching and self-management goal setting. Care management often includes taking the lead role in care coordination between multiple providers of care and services, both medical care and community-based care. In addition, the care manager may be part of or even lead the practice's quality improvement team. In the section called Structuring Care Management (page 35) we discuss how care managers can play quite different roles in different settings and seek to attain different outcomes for different types of patients. There we outline the decision-making process for the practice considering the addition of a care manager.

Along with this diversity in roles and responsibilities comes diversity in the care manager role name. Names for this type of role include:

- Care manager – this may have several prefixes to it such as *complex*, *moderate*, *hybrid*, or *nurse* (e.g., nurse care manager or complex care manager)
- Case manager
- Care coordinator or clinical care coordinator
- Health navigator, nurse navigator, or patient navigator
- Nurse educator, diabetes educator, patient educator, or health educator
- Health coach



So how do you decide what to call your care manager? It depends on the circumstances including who you plan to hire for this role and what your patients and practice members might suggest as most fitting. There are no hard and fast rules. Here is what we have learned, however. *Care manager* and *care coordinator* are often very similar to one another. They often both deal with patients with chronic conditions. The difference is that the care coordinator usually focuses a bit more on care transitions and coordination of care activities; whereas, the care manager tends to focus more on chronic disease management. *Case manager* often refers to mental health and substance abuse

or social service activities. Patients often take issue with the title of *case manager*. One patient we interviewed was aghast: “I’m not a *case*!” she said.

The *educator* titles may focus a bit more on the education role, such as a diabetes educator who spends much of his or her time teaching patients how to eat properly and manage their insulin. *Health educators* are a specific profession that is quite different (see www.nches.org), so that title is not usually used or recommended. *Patient educator* is more appropriate. *Navigators* focus their activity more on helping the patient navigate or transition between health care settings. This has been very popular for cancer care for example. Last, care managers are not often called *health coaches*, as *health coaches* usually focus most of their attention on helping patients with making motivational health behavior changes such as quitting smoking or losing weight.

More important than what title you select for the role is that those interacting with the role know what it is and what it does and does not do.


All this about care management sounds good, but does it work? What are the outcomes?

The evidence about care management benefit

So, the question is – does care management “work?” Meaning, does care management deliver important outcomes such as improvement in patient clinical measures, satisfaction with care, or reduced cost to the health care system? The answer is a qualified “yes,” depending on which outcome, for what condition, and on how the care management was implemented.

Care management was originally implemented in the form of telephone-based disease management programs. These were off-site programs usually run by insurance or disease management companies to identify high cost patients. Usually a nurse would reach out to them by phone to engage them in disease management. These programs often suffered from low engagement rates and separation from the patient’s care provider. Therefore, their effectiveness was quite variable.⁴⁻⁸

With the influence of the chronic care model and the patient centered medical home, much more care management moved directly into the primary care practice setting, which we call “embedded”



Every time I talk about care management, I always start off with “this is the best thing we’ve done in primary care for the last decade.” —Practice Manager

care management in this guide. Again, the results are variable and depend on the condition under study, but the results are generally much more favorable.⁹⁻¹⁴ There is a growing evidence base demonstrating the overall greater effectiveness of care managers embedded in the primary care practice, with the care manager as a team member, and other team members contributing to the care management work effort.¹⁵⁻¹⁸

Programs that focus on care transitions in an attempt to reduce hospital readmission have generally fared well. They reduce

It [care management] is as important as what I do because it doesn't matter what I do if they don't follow through. So the [care manager] stands in the gap and helps to get everything done and coordinates it all... I see that in the future they're indispensable. I'm telling you indispensable.
—Physician

readmissions, improve coordination with primary care after hospital discharge, and reduce emergency department usage.¹⁹⁻²¹

The authors of this guide have studied implementation of care management in primary care in three studies and have identified favorable outcomes and cost results from an embedded care manager approach.²²⁻²⁷

I find it [care management] really helpful especially in the hospital discharge patients that somebody is reaching out to those people clarifying medication questions...so it helps focus my time, and I think we've had several times where there's been errors or patient misconceptions that have been caught in that period of time where they're at high-risk for readmission, and so that's definitely a big piece of the care management job. —Physician

I think the most effective thing is having a point person for the patient and for the business, but more for the patient. It adds to the continuity of care. Like I said the time constraints on a physician are so tight now to see more and more patients that it's hard to spend 45 minutes with a patient and then talk to them on the phone for another half hour with them or another provider trying to get this, this, and this done when a [care manager] can do it easily, and the patient now has a face, a name, someone to call to they're more likely to call I think... As far as quality of care, I think it's much improved. —Physician

What are the benefits of having a care manager in the practice? What do practices get out of it?

In a nutshell, practices—once they get a good care manager and have successfully implemented care management processes/workflows—cannot stop raving about the benefit of care management in their practice in terms of improving the quality of care they provide for their patients and how it has reduced stress and taken some of the burden off of the clinicians and other staff.

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Assessment - **Is our practice ready to embark on care management? Is our practice ready to hire a care manager?**

1. What is our vision for care management?
2. Do we have a clinical/physician champion for the work? Who?
3. What are our overall goals for care management? What is our practice hoping care management will achieve?
4. What are the activities that will lead to achieving the overall goals?
5. Are there external pressures to implement care management? What motivates our staff doing the care management work?
6. Does our practice have the financial means or a plan for the financial means to pay for the care manager or the time of other staff to do care management tasks?
7. How will we define the role of the care manager? What are the specific tasks?
8. Does our practice or community have individuals who are qualified to fill the role of care manager?
9. Do we have the space to locate a care manager in our office or work with another organization to house the care manager?
10. What is the mental model (picture of care management) of the clinicians and staff about what a care manager is and can do? Are they on the "same page?" How can differences of thinking about care management be resolved?
11. What specific patients are appropriate for the care manager? Do we want to focus on patients with chronic disease or hospital discharge, social issues, or based on insurance coverage?
12. How will we incorporate our patients' perspectives?

Selecting the Right Care Manager and Clarifying the Care Manager Role

What features should I look for in a care manager?

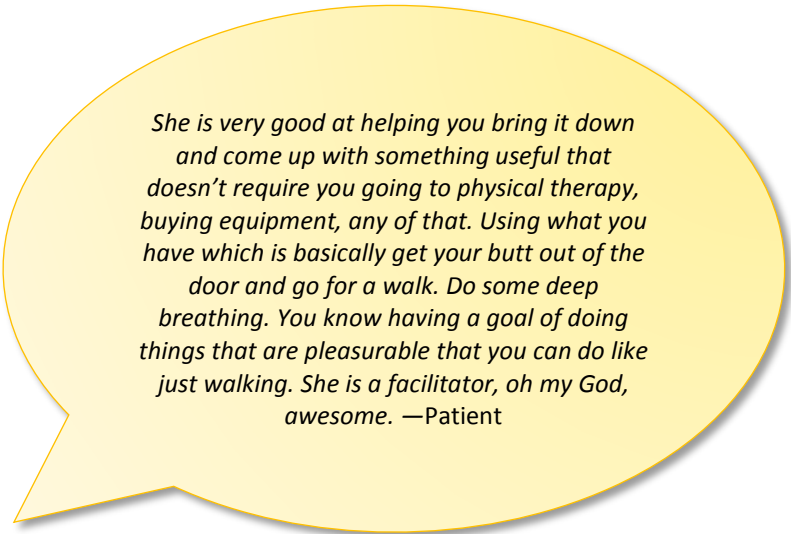
This is often a very common question that organizations have as they begin the process of considering care management. They realize that they need the role of “care manager,” but are not sure what kind of person with what kind of background to hire.

A first step in determining the “right” care manager is to consider specifically the extent and type of duties of the care manager. Second, determine what the key features of an individual should be, regardless of their specific duties.

Matching the person’s background to the needs of the practice patients

The needed skills and responsibilities of the care manager depend on many factors, including the funding mechanism (such as if only certain insurance plans are reimbursing for care management), the predominant issues in the patient population (such as lots of patients with diabetes, lots of ER visits, or younger population with child mental health issues), and the availability of qualified staffing.

The two most common backgrounds for care managers are nurses and social workers; however, many other professionals make excellent care managers including pharmacists, behavioral health providers, registered dietitians, and health educators. The general rule is that the “right fit” person (see below) trumps the specific type of educational background unless it is critical for the specific role. For example, if the care manager role is primarily to help elderly seniors with gaining resources for Medicaid and skilled nursing, then a social worker might be the best fit background; whereas, if the role has a heavy emphasis on medication adjustments post-hospitalization, a nurse or pharmacist might be the best fit.




She is very good at helping you bring it down and come up with something useful that doesn't require you going to physical therapy, buying equipment, any of that. Using what you have which is basically get your butt out of the door and go for a walk. Do some deep breathing. You know having a goal of doing things that are pleasurable that you can do like just walking. She is a facilitator, oh my God, awesome. —Patient

We recommend that a practice do a short assessment to determine their care management needs by way of something we call a “Card Study.” Basically it is a way to systematically assess your needs for different types of care management. Please refer to the appendix, page 104, for instructions and an example survey or “card.”

Finding that “right fit” person

Let’s face it – a key role of the care manager is to engage and assist patients. This may be directed toward helping to educate patients, finding assistance for them, or helping to motivate them to change behaviors or to consider new ways of living or managing their health. Regardless of the specific duties or areas of content covered by the care manager, there are certain personal attributes that are critical to being an effective care manager.



She [care manager] is a very good listener. I mean she is personable, she is funny, and she listens well, and that’s what I needed right then.
—Patient

First, think if you were the patient. What would you want if you –

- needed assistance with finding a temporary skilled nursing facility?
- were completing advance directives?
- were just diagnosed with diabetes and had to learn how to inject insulin?
- wanted to quit smoking or lose weight?
- just came home from the hospital with a long list of medications to take and instructions to follow?

What would you want from someone in these situations? This is what we have heard people say makes a good care manager:

- Is a good listener (really listens, conveys true understanding). Many wonderful nurses struggle in the role of care manager because they want to tell the patient what to do. The problem is that a lot of care management is working from where the patients are and drawing them out. Many patients don't like to be told what to do.
- Friendly and personable, but also knows when to push
- Has a natural curiosity/desire to seek out resources, often referred to as "detective work"
- Knowledgeable in the sense of being competent without being arrogant, and okay with asking because you can't know everything
- Understands the concept of self-determination; provides guidance, but respects the individual's ability to make his/her own decisions
- Follows through, including being able to coordinate with other members of the team and get back with decisions
- Knows when to involve others and to what extent
- Provides the right amount of communication with the team
- Can use the electronic medical record (EMR) efficiently and

I think she [Care manager] has got an especially good way of connecting with patients.... When I hear her talk on the phone or meet with people in person, she really puts them at ease. They feel comfortable with her. She takes her time them. It's very comforting. —Physician

I love [care manager name]. She's very good with the patients. I think she's very good at education. They listen to her, so she definitely comes across to the patients. They receive her very well. I even have a lot of them that call and specifically ask for her now, so that's nice. —Medical Assistant

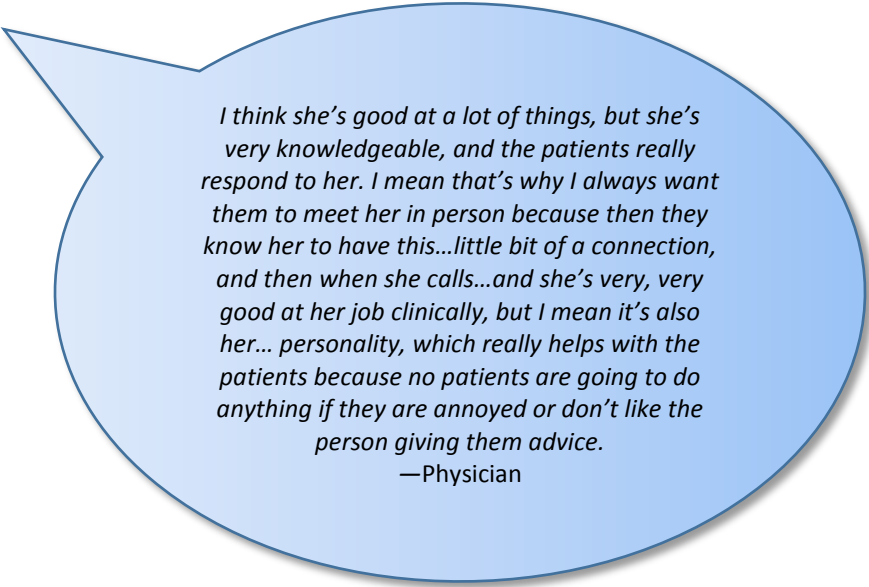
A lot of it is choosing the right person for the [care manager] role, conscientious person, skilled person, and someone that can be pleasant in a number of settings. Somebody that you have a great relationship with that you trust to help co-manage with you, and someone who's good at multi-tasking to help you improve care to all your patients. —Physician

handle data and quality improvement issues (this one is increasingly important)

One characteristic that has been debated is the personal physical attributes of the care manager. There are different schools of thought on this – some think that the care manager should project some degree of health and robustness, where others believe the person who has had some health struggles understands patients better. This is your decision; however, a person who has a lot of very obvious health problems may struggle with the demands of the job and have difficulty spending their time motivating and educating others if they do not “walk the walk” themselves.

Qualifications and care management: Can the care manager be a medical assistant?

The short answer is generally no, but it depends. A first issue with a medical assistant (MA) is workflow. MAs who have responsibility for rooming patients and do not have “open ended” time to work with patients as their needs permit are not a good role fit, regardless of personal skill. A second issue is medical knowledge. Generally, care managers must be able to make independent decisions and, within scope, operate as a provider. A care manager who provides incorrect information due to lack of medical or other needed knowledge, or has to ask the doctor or others in the office for assurance or answers is not a good fit for the care manager role. That being said, many MAs provide excellent support for some care management activities, such as identifying patients in the registry who need follow-up care, calling to set up physician or care manager visits, or keeping medication lists and other health care encounters up to date. Some MAs with exceptional interpersonal skills can act as a sort of health coach or motivator for patients to attend community programs or to set and track goals around preventive health issues. They are also one of the first to identify a



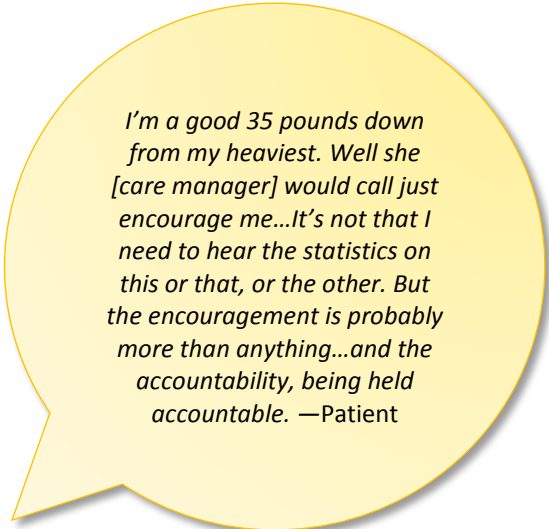
I think she's good at a lot of things, but she's very knowledgeable, and the patients really respond to her. I mean that's why I always want them to meet her in person because then they know her to have this...little bit of a connection, and then when she calls...and she's very, very good at her job clinically, but I mean it's also her... personality, which really helps with the patients because no patients are going to do anything if they are annoyed or don't like the person giving them advice.

—Physician

patient needing care management because patients may let the MA know more about themselves than the provider.

The importance of role clarity

A common problem that happens when new care managers are hired is that their roles and responsibilities are very ill-defined. Although flexibility and open-mindedness are generally good characteristics to have, lacking clarity often spells trouble for implementing a new role. A key problem is that other office staff members lack an understanding of this new role and therefore may try to fit the new person into a traditional role rather than understanding the new role. For example, office LPNs may feel threatened by an RN in the practice with the role of care manager if his/her role is to work separately with patients in independent visits to assist patients with chronic disease management. The LPNs may feel the RN is not “helping” by not rooming patients or answering triage calls, or they may feel threatened that she/he will take over essential tasks that are already theirs. Therefore, it is good to start with a basic understanding of the key goals to be accomplished by the overall work of care management and then divide out the responsibilities of different people on the team, including the care manager. Then have those roles and responsibilities spelled out in a written document that can be modified as needed over time and that is clear to everyone so they all know how their roles are alike or different and what the care manager role is contributing to the overall work in the practice. See the appendix, page 96, for examples of care manager job descriptions to define the role for your care manager and other care management staff.



I'm a good 35 pounds down from my heaviest. Well she [care manager] would call just encourage me...It's not that I need to hear the statistics on this or that, or the other. But the encouragement is probably more than anything...and the accountability, being held accountable. —Patient

Regardless of the specific job description, here are some key roles played by care managers:

- Educator – impart knowledge about a health condition, how to manage a health condition, or how to use specific equipment or medications
- Motivator – help patients identify and connect health improvement goals with actual plans

- Accountability partner – provide follow-up and connection that is the extra nudge to keep progress moving, including monitoring progress and helping with setbacks
 - Liaison – work between the provider and other entities to identify and monitor needs and communicate to the needed groups
 - Cost container/resource re-deployer– Care managers often work with registries to identify patients who are at risk for expensive health conditions and try to prevent or reduce utilization; for example, patients who over-utilize the ER when calling the doctor would be more appropriate.
 - Social worker – identify family or social needs and connect with resources for assistance
 - Data manager – identify practice-level population health goals and track how the practice is doing in relation to those goals
- She [care manager] offered up advice to know sometimes there were things that I would mention that I hadn't even thought of. She was very easy to talk to on the phone. It was a comfortable conversation, so it was a really nice way instead of having to call somebody myself or having to initiate a follow-up. It was really nice to have somebody jump in and check in. —Patient*

She [care manager] offered up advice too. You know sometimes there were things that she would mention that I hadn't even thought of. She was very easy to talk to on the phone. It was a comfortable conversation, so it was a really nice way instead of having to call somebody myself or having to initiate a follow up it was really nice to have somebody just call and check in. —Patient

The successful care manager will actively manage her or his role with activities such as planning and relationship building with the



practice clinicians and staff, educating others on his/her role, meeting regularly to discuss progress and process, give and receive feedback. This work is very

important to facilitating a team relationship that will conduct care management successfully.

Once the care manager role is generally well-defined it might help to have a short “elevator speech” to share with others as they have questions. This both helps get the team “all on the same page” with regard to what the care manager is and what s/he does, but also is critical to patient engagement. One consideration is for each team member to have a script for how each would use the care manager role.

Here are a few examples:

“Mrs. Smith, this is Jane. Jane is our care manager. She has a nursing background, but her job as a care manager is to work with you as you recover from surgery. She will be calling you to make sure your care is coordinated across different doctors, and that you are recovering well.”

“Hi, my name is Jane. I am a member of the team of people providing care for you at practice X. My role is the care manager. This means that I work with you and your doctor to help you with how you can be as healthy as possible.”

“Jane is our care manager. This means she is an expert in helping our patients with learning about different diseases and how they can prevent and manage them, and with other resources that can help.”

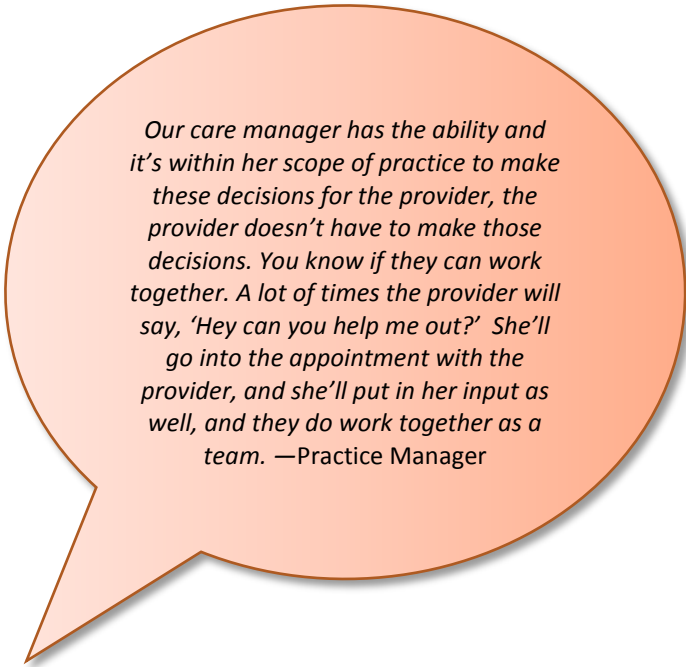
“Jane is our care manager. When patients in this practice have the diagnosis of X like you, and when their X value is at a number where we are concerned for your health, we refer patients to care management services. Jane will work with you and me, the three of us as a team. She will work with you in identifying barriers and problem-solve through them, setting personal goals and stay in communication with you in between visits to see what’s working and what isn’t.”

How to identify the right care manager

By this point, you should have a sense of the kind of duties the care manager will perform and the background needed to do them, but how do you assure you’re getting the right kind of person? Some of the traditional techniques used in hiring can be useful including providing role clarity and asking good interview questions, but these additional suggestions are investments that will likely pay dividends:

- Ask for and scour references. Look for people who have no hesitation in singing the praises of this person. The care manager needs to be likable.

- Involve many people in the hiring decision. Get a 360° evaluation of the potential care manager from many diverse angles.
- Use their résumé as a means of identifying interview questions. Having the candidates describe their role in whatever is being portrayed on the résumé provides significant insight.
- Use behavioral-based interviewing. This technique uses actual past behavior to predict future behavior. Questions such as how the candidates have handled conflict with providers or peers in the past and how they have worked in a team, including their role, are especially telling.
- Look for people who have gone beyond their usual job responsibilities and sought out other opportunities, such as serving on a unit council, assisting in developing new programs, or serving on committees.
- Have the candidate “shadow” another role in the practice for a half-day and then ask for a follow-up assessment from the person shadowed.
- Look for evidence of good follow-through – fast, rapid thank yous, requests for information, etc.
- Look for flexibility and resourcefulness. Due to the lack of definition and unknowns of the position, these are key traits of the care manager.
- Most important is evaluating why the candidate wants this particular position. If it isn't clear, s/he probably isn't the right candidate.



Our care manager has the ability and it's within her scope of practice to make these decisions for the provider, the provider doesn't have to make those decisions. You know if they can work together. A lot of times the provider will say, 'Hey can you help me out?' She'll go into the appointment with the provider, and she'll put in her input as well, and they do work together as a team. —Practice Manager

Some learnings from Role Change Theory

Role Change Theory is a way of looking at what it takes to successfully make a new role work in practice.^{1,2} This applies quite well to care management, as care managers are often a new role in practice. Their inclusion also means that other roles in the practice, or at least some tasks or duties, change as well. Commonly, the care manager has no peer in the practice. Consider the table below in how you and your practice members are viewing the role of care manager.

Making sure you address all the five elements of Role Change Theory, along with role clarity, can make the difference between successful and not successful care management. This is also covered in “What are cues that care management is not working well and what can be done about it?”, page 60.

Not only do you need well-trained care managers who have good skills, but you have to have a way to introduce them to your patients or to connect them with your patients so that they feel comfortable that you're working together, and that it's okay to talk with them. That's huge. —Physician

Does your care management effort successfully address all these areas?			
Domain	Definition	Questions for your practice	Tips on Success
Structural Autonomy	The freedom to make choices about how, when, and where role responsibilities are fulfilled.	What degree of autonomy do care managers have, in what areas, and how?	Successful care managers do have a lot of autonomy within the framework of their role. Constantly having to ask for approval makes care management cumbersome.
Institutional Support	Demonstrated by strong commitment to a new role in the form of leadership, financial support, and material resources to facilitate and support change and the new role.	Is care management adequately resourced in terms of personnel, space, funding to deliver it to patients, and other material needs? Is there buy-in/support for it at the health system organization and practice level?	As with many things, under-resourced means underperformance. People completing care management tasks need the support of others and the tools (place to sit, phone line, etc.) to complete the activities of their role without undue burden.

Domain	Definition	Questions for your practice	Tips on Success
Client demand and trust	The extent to which clients desire and demand what the person in the new role is doing and trust the person in the role to deliver this service.	Do the patients feel the care manager is sufficiently qualified to help them? Do they trust him or her as a member of the health care team?	Care managers and those performing care management tasks need to be adequately qualified to do what they are doing. Patients must have a sense of trust in care managers that their knowledge is accurate and that they are acting in the patients' best interests with their behaviors and words.
Cultural credibility for new role	Trustworthiness and acceptance of the role within the culture of the organization.	Do the providers and staff trust the care manager to do the specified tasks in that role? To work with patients independently? To extend the work of the provider?	Lack of trust on the part of providers and other staff is a key reason for failure of care management. Providers need to develop a new "mental model" of providing care in a team setting to make this work.
Resources and mobilization of new role occupants	Time and appropriate expertise needed by role occupants to carry out the demands of a new task.	What training, background, and expertise are needed from the care manager? Is the care manager role adequately resourced in terms of time to achieve goals?	Care managers and those performing care management tasks need the appropriate training and expertise to do this work. Care managers need adequate time to address patient concerns.

The importance of planning and set up

Although this section has a lot of good ideas about what to look for in a care manager and what a care manager might need, it is important to emphasize the role of planning. Once you have a care manager in the role, it is important to be attentive to the processes that will make care management work effectively. See Implementation and Sustainability Issues (page 48) for considerations regarding planning and managing care management in your practice. In our experience, the care manager, care management leadership and physician leadership will play a key role in setting up this new role. Good planning means good results with many things as well as with care management.

The leadership needs to provide [care managers] with the structure.
—Practice Manager

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1. Isaacson N, Holtrop JS, Cohen D, et al. Examining role change in primary care practice. *J Prim Care and Community Health*. 2012 Jul 1;3(3):195-200. Epub 2012 Feb 11. doi: 10.1177/2150131911428338. Cited in: PubMed; PMID: 23803781.
2. Turner R. Role change. *Ann Rev Sociol*. 1990 Aug;16(1):87-110. doi: 10.1146/annurev.so.16.080190.000511.

Assessment - **What should we look for in a care manager?**

1. How will we assess the care managers' skills and knowledge level, including how the gaps are addressed (i.e., know when they don't know, say "I don't know," ask questions)?
2. Does the candidate have strong organizational skills (i.e., ability to organize most important tasks, juggle priorities, work efficiently)?
3. Does the candidate have strong interpersonal skills (i.e., friendly, personable, good listener)?
4. Does the candidate demonstrate attributes of teamness (i.e., communication follow-through, other orientation, willingness to help, close the loop communication)?
5. Does the candidate have the ability to learn and utilize health care data and the electronic medical record?
6. Is this person flexible and does she/he have the capacity to work during the hours needed and the ability to travel to different locations if needed?

Training the Care Manager and Practice Team ____

Good training = good care management success

We have learned from talking with newly hired care managers that they often felt “thrown” into the role with very little formal training. They repeatedly described a strong desire for additional training or having a mentor—an experienced care manager to learn from as well as to receive feedback from. They also need a peer group that will assist in providing best practices and support.

What type of training does your care manager need to be adequately prepared for this new role in your practice? Some things to consider are the care manager’s background/experiences, goals for your program, the patient population targeted for

Training has been a huge issue because we all come from different backgrounds, and so you might have a care manager who worked a lot of hard stuff and is comfortable with CHF. I was a diabetic educator, so I am very comfortable in the diabetic world.... I’ve done a lot of self-education. —Care Manager

I just wish we had more training, and I wish there was more of a set program to this...I’ve done a lot of reading on transitional care and care management, and I know there are programs out there that teach care management, and I just kind of wish that there was a focus for our job because it’s just really hard to do because there is no focus. —Care Manager

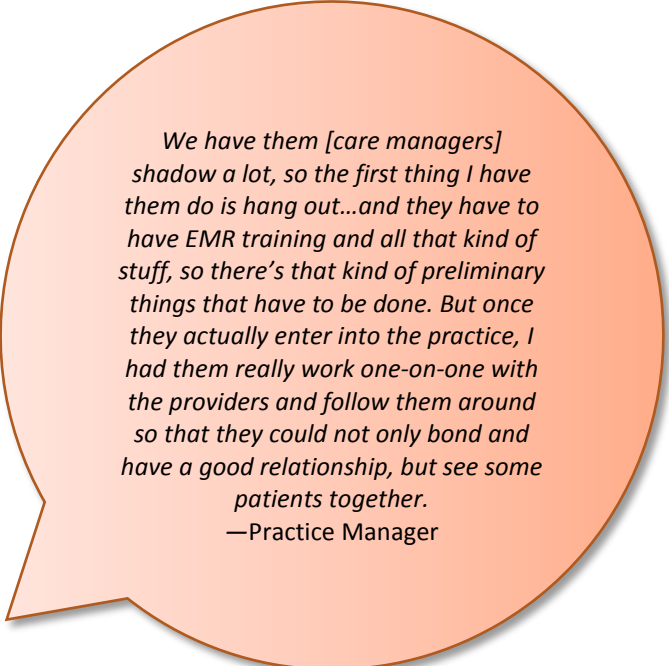
care management, as well as the tasks your care manager will be performing. We have learned that care managers perform a wide variety of tasks in this role and therefore we recommend a comprehensive training that covers a variety of topics, is evidence-based, utilizes standardized tools, and includes both

self-management support and motivational interviewing components (see training topics below). If the care manager has spent most of his or her career in the inpatient setting, it is important to provide education on the ambulatory side of patient care. They come with little to no knowledge of ambulatory evidence-based care for chronic conditions and preventive care.

Care management training topics

In the section below, we make recommendations about possible places for training, however, no training is likely to be completely comprehensive for your individual practice needs. Therefore, we have compiled a list of basic care manager training needs. You can then assess the extent to which different training opportunities match up with this list. Note that content (i.e., disease specific) knowledge is in addition to this list. Many nurses have content-area knowledge as it relates to disease processes and medications; however, most care managers will need content-area specific training to fill in gaps left lacking in their educational background including evidence-based ambulatory care if they have not worked in an ambulatory setting such as home care. Recommended topics include:

- Introduction to care management: Defining the care manager role, tasks and key responsibilities
- Chronic Care Model
- Patient-Centered Medical Home concepts
- Facilitating practice change and quality improvement, including use of PDSAs
- Teamwork, communication and collaboration – building relationships with team members
- Health behavior change: factors relating to why patients change or do not change
- Health assessments: how to conduct them and which ones are important
- Motivational interviewing
- Health coaching and counseling (patients and families)
- Self-management/goal setting (SMART goals)



We have them [care managers] shadow a lot, so the first thing I have them do is hang out...and they have to have EMR training and all that kind of stuff, so there's that kind of preliminary things that have to be done. But once they actually enter into the practice, I had them really work one-on-one with the providers and follow them around so that they could not only bond and have a good relationship, but see some patients together.
—Practice Manager

- Health literacy
- Care transitions/coordination
- Identifying community-based patient resources, including eligibility requirements and preferred methods of communication
- Navigating the insurance/Medicare/Medicaid systems
- Population health management: using registries and risk management scores to identify patients for care management
- Navigating the EMR: how to access patient information and document in the EMR
- Appropriate documentation to support billing for care management services

Just establishing that relationship with the office in the very beginning was beneficial. Building that relationship as a team, knowing what my role is, what your role is...but getting the word out to the rest of the staff not just the providers. My meetings with providers were weekly for about a month, and then I just had them monthly for a little over a year.

—Care Manager

For successful implementation within 6-8 weeks, your care manager will need to:

- Learn about the role and begin to understand the specific functions/tasks of the care manager.
- Begin building relationships with the providers and clinic staff – this can be accomplished by having the care manager shadow

Even the pharmacist, we have local pharmacies down the street here call me about a patient that had come in several times confused about medications back and forth, and we were talking about maybe getting them bubble-packed for the patients so that they didn't have to worry about taking them right.

—Care Manager

practice team members including providers to learn the workflow and role tasks and identify ways for the care manager to communicate with staff. This may also include participating in huddles at specific times during the

day, team meetings (i.e., monthly provider meetings) and quality improvement activities. The goal is to have the care manager become an integral member of the care team with a clearly defined role as quickly as possible.

- Identify community resources and begin building relationships and partnerships in the medical neighborhood (hospital, skilled nursing facilities, home health, pharmacies, community agencies).
- Understand the EMR/IT tools necessary to perform the job (care management software, disease registries, care management billing codes, etc.).

I don't feel like the training was sufficient, and not because the topics that they're training us on wasn't stuff that we were going to use, but I needed more of...somebody to almost hand-hold me for the first couple of visits. Documentation that's required, and we didn't get that documentation training until probably about 5 or 6 months into the project...I think those first couple of visits were terrifying.
—Care Manager

They kind of gave us an overview on that, but no there's been no formal this is how you do it. It's been pretty much go forth and figure it out [laughter].
—Care Manager

Specific care manager training programs and resources

This list is not comprehensive nor necessarily a recommendation. There are a variety of *basic* training programs available for newly hired care managers as well as *advanced* training programs for more experienced care managers. Social work and nursing continuing education credits may be available.

Care Management

Plus: <http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/dmice/research/care-management-plus/education-outreach/training.cfm>

National Academy of Certified Care Managers: www.naccm.net

Care Transitions Program Training: <http://caretransitions.org/about-our-training/>

Commission for Case Manager Certification: <https://ccmcertification.org>

Care Management Training (a product of Geisinger Health System): <https://xghealth.com/xglearn-care-management-training/>

Commission for Case Management Association

<http://www.cmsa.org>

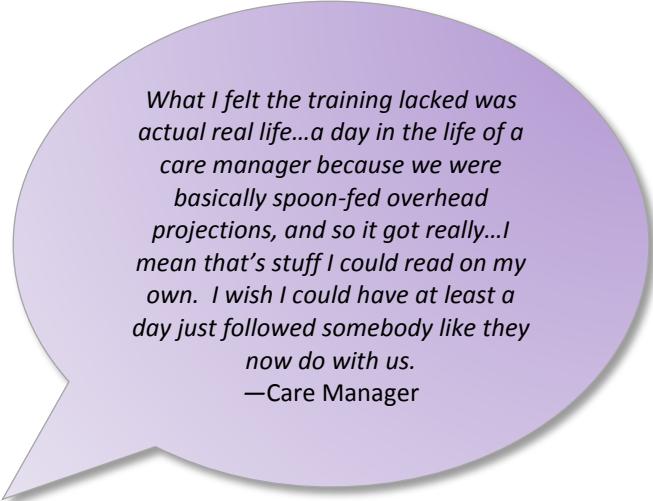
Motivational Interviewing Network of

Trainers: <http://www.motivationalinterviewing.org>

Training the providers and staff about care management


Although a big emphasis is on and should be on the training of the care manager, the introduction of a care manager means the introduction of new roles and workflows for everyone in the practice. We recommend that you run an internal training program for your providers and staff that covers the following topics below. It is also important to think of this more as a development process together, rather than a “this is how you do this” type of training. Ideally, key roles in the practice should be represented in the discussion as the care manager role is defined, the workflows are worked out, and the overall goals and aims of the work are defined. Having a clinician or care manager who has already successfully implemented care management in their practice and who can talk about its value is also helpful. These topics are listed as key to consider in the roll out to everyone in the practice.

- Goals for the care management service: what you hope to achieve and why; importance to the practice
- Role and tasks of the care manager: what this role does and does not do, how the care manager can support providers, staff and patients



What I felt the training lacked was actual real life...a day in the life of a care manager because we were basically spoon-fed overhead projections, and so it got really...I mean that's stuff I could read on my own. I wish I could have at least a day just followed somebody like they now do with us.
—Care Manager

- Workflows: decision making/problem solving; how care management services affects workflows; how care management will be delivered and how different roles are impacted by the availability of care management services.
- Process for learning as care management is implemented: how will you



I am doing training on motivational interviewing and self-management support, and I'm training new care managers... The amount of folks needing to have education really increased, and so what we are doing is we are providing two sessions of motivational interviewing and self-management. The first session is for beginners; second session is for folks who have been there before, so it's really building upon that first one, and really honing of skills for MI and self-management. —Complex Care Manager

know it's working? How to provide input, how to tweak processes.

- What data will the organization collect to determine effectiveness; who will ensure the data is up-to-date, based on evidence-based guidelines and that it is accurate; and how the team will use this data to drive care management services.
- Resources for care management. Although the care manager will rely mostly on this information, it would be good for all staff to have a general idea as well, to help with communicating with patients.
- Billing and coding so that associated billing can take place for care management.

Additional training opportunities

Here are some additional ideas when training a new care manager that we have found to be helpful.

- Job shadowing where a new care manager observes an experienced care manager working with patients for a day or two in the practice.

- Web-based trainings provide a valuable opportunity for care managers to learn more about the pathophysiology, evidence-based guidelines and health behaviors essential for optimal management of one or more of the following: diabetes, heart failure (CHF), COPD, depression, asthma, and chronic pain.
- Learning collaborative/forum: peer care managers meet on a regular basis and discuss issues, problem solve, learn about new topics relevant to care management, and share best practices as well as resources.

Assessment - **How should we train the care manager and the team?**

1. Is our practice willing and able to support off-site paid training?
2. Who in our practice can orient the care manager to his or her new role and how the practice works?
3. Is there a way for our care manager to shadow an experienced care manager working in another practice?
4. How will our practice clinicians and staff learn about the care manager role and how the care management process will work?
5. How will our practice clinicians and staff determine how their role interacts with care management?
6. What are the skills and knowledge base of the care manager and other care management roles to be identified? How will gaps in these areas be addressed?
7. What additional trainings will our care manager need in order to address gaps in knowledge or lack of skills?
8. Is there a peer group of care managers that meets in our community that our care manager can join?
9. Who will provide oversight of the care management services and how will this be reimbursed?


Structuring Care Management

Structure refers to the way a role or process is set up—how it is organized. Structure can include aspects of a role such as location, types of activities, opportunities for interaction, basic needs, and planning and decision-making. How you structure your care management program will have a large effect on your practice, your patients, and the outcomes of the program.

Structure as location for the care manager

We begin with the location – where the care manager works physically – because we have found this to have such important implications for other decisions about structuring the care manager role. There are three ways in which care management programs are structured for physical location:

- 1) Off-site care management
- 2) Co-located care management
- 3) Embedded care management



At one point I had seven different practices, and I'm going to tell you it was pure chaos [laughter]. I felt like I was never in the right place at the right time to be seeing patients or catching those transitions of care, and so if I were you know as far as embedment goes I think it's really important that a care manager is as much as possible dedicated to just one practice or a practices that are really in close proximity because...it really had an effect on the amount of patients you could see and you know engage as well just the productivity on behalf of the care manager. —Care Manager

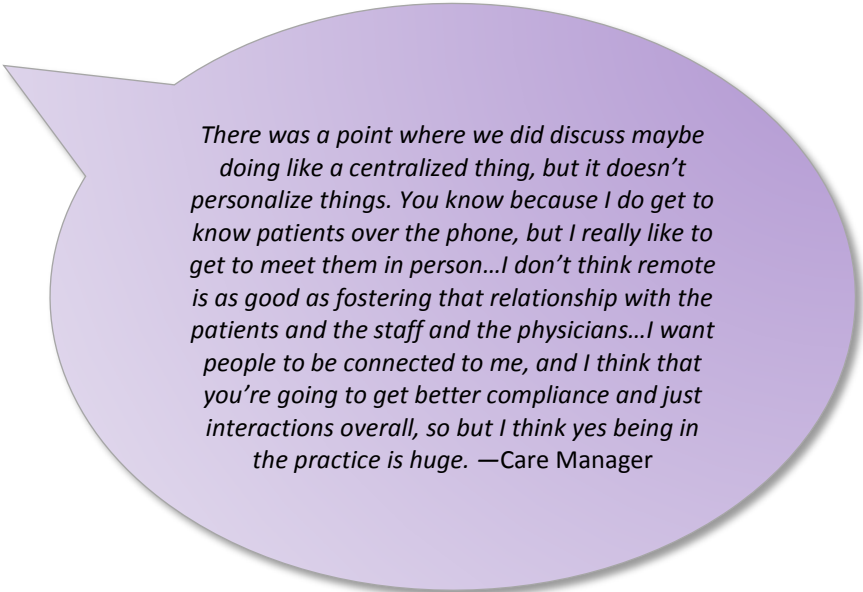
Off-site care management

In the off-site structure, the care manager works outside of the practice in a centralized location.

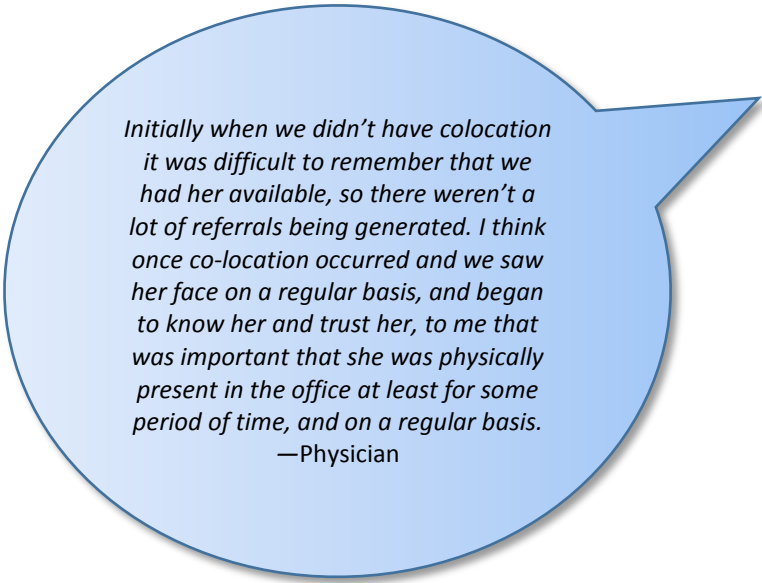
Usually the care manager in this situation works as a support to multiple practices. The care manager may coordinate with an on-site practice team member, and patient visits are conducted via telephone.

Off-site care managers may make visits to see patients at the practice or in their homes or other

location, but their primary work location is not the practice. Off-site care managers often work for another entity and not the practice.



There was a point where we did discuss maybe doing like a centralized thing, but it doesn't personalize things. You know because I do get to know patients over the phone, but I really like to get to meet them in person...I don't think remote is as good as fostering that relationship with the patients and the staff and the physicians...I want people to be connected to me, and I think that you're going to get better compliance and just interactions overall, so but I think yes being in the practice is huge. —Care Manager

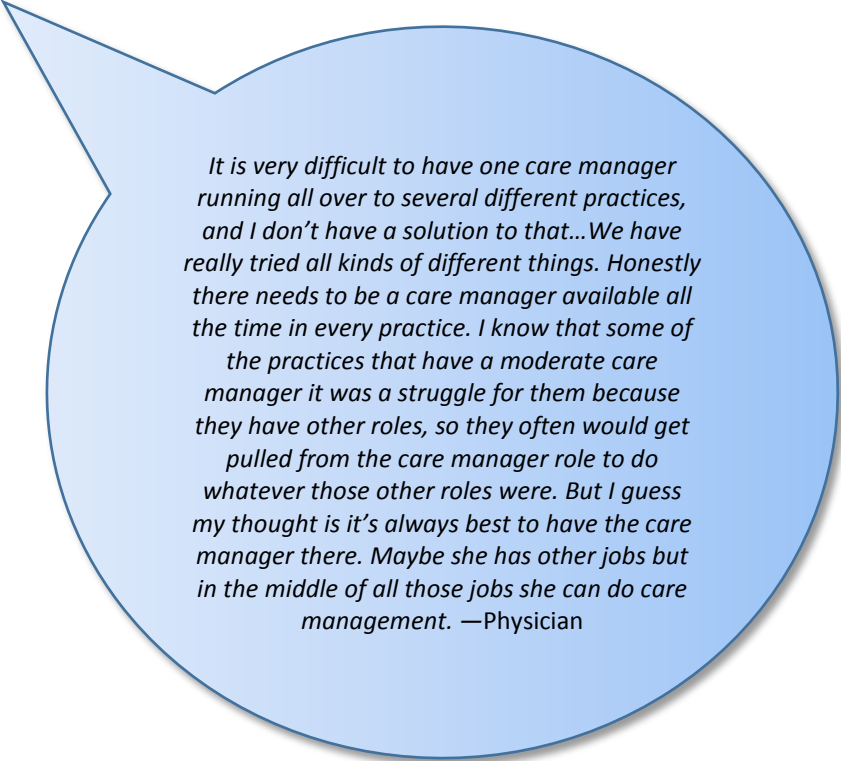


Initially when we didn't have colocation it was difficult to remember that we had her available, so there weren't a lot of referrals being generated. I think once co-location occurred and we saw her face on a regular basis, and began to know her and trust her, to me that was important that she was physically present in the office at least for some period of time, and on a regular basis.

—Physician

Co-located care management

Co-located care managers work at several practices, but generally do not work for the practice. Generally, the care manager works for an associated practice association or organization. S/he spends a half-day up to multiple days per week at the practice. The care manager is able to meet with patients by phone or face-to-face while in the practice. In some cases, s/he also travels to meet with patients at their home. There is some integration with the care team, but it is often limited by the care managers not being at the practice on all days.



It is very difficult to have one care manager running all over to several different practices, and I don't have a solution to that...We have really tried all kinds of different things. Honestly there needs to be a care manager available all the time in every practice. I know that some of the practices that have a moderate care manager it was a struggle for them because they have other roles, so they often would get pulled from the care manager role to do whatever those other roles were. But I guess my thought is it's always best to have the care manager there. Maybe she has other jobs but in the middle of all those jobs she can do care management. —Physician

Embedded care management

Embedded care managers work on-site in the practice and are integrated within the primary care team. The care manager conducts patient visits via telephone and in person. In some cases, but not usually, s/he can visit patients at the hospital and in the home. The care manager works for the practice.

A summary of the pros and cons for each of the three structures for care management appears in the table.

Care Manager Work Location		
	Pros	Cons
Off-site	<ul style="list-style-type: none"> • If the care manager is provided by another organization, the practice may not have to hire and pay for its own care manager. • Office space in the practice is not needed for a care manager because all patient visits are conducted via telephone or home visit. • May have a larger patient caseload (panel); phone call visits tend to be shorter compared with face-to-face visits • If multiple care managers are working in the same office/organization, they have more peer-to-peer interactions, communication and support across care managers 	<ul style="list-style-type: none"> • Difficult to reach patients via telephone (e.g., patient phone disconnected or calls not returned) • Patients less likely to engage (e.g., patient may not trust a nurse calling and be confused with her/his health plan) • Care manager not integrated into the practice team and workflow • Lack of provider buy-in to use the care manager due to their employee or temporary status in the practice • Care manager may feel isolated/disconnected from practice team • Care manager may not have access to the EMR and communication avenues within EMR such as instant messaging; care manager may thus lack clinical understanding regarding the patient

	Pros	Cons
Co-located	<ul style="list-style-type: none">• Care manager able to serve more than one practice particularly if the practices are very small (e.g., solo physician practices)• Care manager able to provide face-to-face visits in the practice as well as outside of the practice (e.g., home visit)• Promotes warm hand-off when provider introduces care manager to the patient and lets the patient know how the care manager can assist him• Allows for more open communication between care manager, providers and staff (i.e., more impromptu huddles and face-to-face conversations when the care manager is visibly present in the practice)	<ul style="list-style-type: none">▪ Care manager not onsite daily and therefore has less face-to-face contact with patients, providers, and staff▪ Care manager may or may not be integrated into the practice team and workflow▪ Care manager may need to learn several EMRs and log into several EMRs if working with several practices▪ Lack of provider buy-in to use the care manager due to their employee or temporary status in the practice▪ Care manager may spend a lot of time traveling to and from practice(s) and therefore be less efficient; it also takes away from time spent with patients▪ If care manager is calling from off-site, the patient may not recognize the phone number, then s/he may be concerned the call is coming from insurance provider vs. doctor's office

	Pros	Cons
Embedded	<ul style="list-style-type: none"> • More integration and information sharing with the primary care provider(s), health team and in the EMR • Care manager is more visible and therefore, utilized more often by providers/staff • Allows for more open and ongoing communication between care manager, providers and staff (e.g., more impromptu huddles and face-to-face conversations throughout the day) • Care manager is more readily available to attend onsite team meetings and participate in quality improvement initiatives • Patients are often difficult to reach via telephone and therefore, having an opportunity to meet with patients face-to-face is very beneficial • Practice team builds a strong relationship with care manager – sees what s/he can do for patients – increases trust • Care management services are incorporated into the structures and workflows of the practice • Promotes warm hand-off when provider introduces care manager to the patient and lets the patient know how the care manager can assist him/her • Relationships are built with patients and continue over time 	<ul style="list-style-type: none"> • Care managers may experience more interruptions during the day • Care managers may get pulled into doing tasks that are not considered “care management” (i.e., if the care manager is a nurse then s/he may get pulled into doing triage if short-staffed) • A small practice may not have a sufficient number of high risk patients to warrant the services of a care manager • If only certain patients are eligible for care management, it can be difficult to sort through them and only offer to those patients <ul style="list-style-type: none"> ▪ Lack of peers in the practice

Lessons learned from our experience and the literature about location

- To the extent possible, primary care practices should carefully select and properly train and resource care managers to work *within their own practices*.
- There is a growing literature demonstrating that the closer the care manager is to the practice team, the more visible and engaged s/he is with the providers, staff, and patient care. Several papers have strongly suggested the need for an embedded care manager.¹⁻⁴
- When care managers are available to meet with patients during or after provider visits, fully utilize the EMR for patient visit notes and tracking, and maintain ongoing communication with providers and staff, they are viewed as very resourceful and effective.

Structure as role type: types of care management services

Part of the structure of the care manager role is clarity on the care manager's main types of activity. Some of that clarity comes as the practice moves toward the mindset of each individual working to the top of his/her license or certification. The care manager should spend time on the things s/he is uniquely qualified to do. Here, we list the five main categories of care management services.

1. Transitions of care

The care manager helps patients manage their care transitions between and among health care providers and settings (e.g., transitioning from hospital to home), including referrals to other providers. Care managers also provide follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

A large task in this category is medication reconciliation, where the care manager reviews all medications, adherence, financial resources to pay for medication, and identifies potential drug interactions. A comprehensive assessment of the patient's medical, functional, and psychosocial needs is conducted by the care manager.

2. Care coordination

The care manager works with patients, families, and caregivers to identify potential gaps in meeting the patient's functional, psychosocial, behavioral, and financial needs. Care managers assist patients with getting the appropriate delivery of health care services to achieve optimal health or end-of-life outcomes. This includes calling health care agencies or specialists on behalf of patients. This is different from, but overlaps with, transitions of

care services. Care coordination occurs with or without the patient actually going to another care facility.

3. Education and follow-up

The care manager helps patients manage their chronic conditions by providing education and continuous follow-up. For example, the care manager may educate newly diagnosed diabetic patients, teach insulin injection, and have patients keep a blood sugar log and food record. The care manager follows up with patients usually bi-weekly or monthly via telephone, patient portal, or face-to-face when the patient is at the practice seeing his or her PCP. The care manager tracks how the patient is doing over time.

4. Health behavior change counseling and self-management goal setting

The care manager works with the patient and the patient decides what health behavior change(s) the patient would like to make. The care manager uses counseling/coaching techniques such as motivational interviewing to empower patients to facilitate behavior change (versus telling the patient what to do). The patient identifies one or two goals to work on and these are recorded in the medical record. The patient decides on how often follow-up visits will occur with the care manager to receive ongoing support with goals and to track progress.

5. Connecting patients with community resources

The care manager identifies individual patient needs including gaps in care, and connects patients with necessary resources that are often life changing (e.g., durable medical equipment, home health care, mental health services, and diabetic classes). For more information about resources, please go to our “Resources” section on page 66.

There is really no right or wrong approach regarding the distribution of time the care manager spends in each of these activities, and they in fact often overlap. The key is clarity on the goals of the care management program and which activities support those goals. For aid in decision-making regarding the focus of care management, see the appendix, page 104, to complete a card study in your practice.

Structure as communication vehicles

Another way to view structure is to consider the means in which different roles in a practice communicate. What are the structures for communication? This of course does not apply only to care management, but all roles in a practice that need to communicate to get work done. It is especially important in care management, however, because the care manager is usually not working

independently, but in coordination with others to make sure patient care needs are met. There is really no right or wrong here either in terms of how communication can occur; however, consider the need for documentation, how to reduce burden, and how to make sure important parts of communication do not “fall between the cracks” and get lost. We have found that flexible and multiple types of communication are useful. Here are some things to consider having in place:

- Meetings – Once a week or once a month meetings are useful for considering the big picture, studying data/results, getting broad input, and making decisions together. If there are regular Patient-Centered Medical Home or Quality Improvement meetings, the care manager should be included. Meetings are a great way for key members of the team to consider bigger or process issues with care management.
- Huddles – Huddles are shorter, mini-meetings to address issues coming up that day. Often they are at the beginning of the day with the mini-team (provider, care manager, medical assistant) to discuss what is happening that day and to make everyone aware and on the “same page.” This is also a good time to identify potential patients coming in that day who may benefit from care management.
- Patient team conferences – “Sit down” meetings in which the provider, care manager, and other key care team members discuss quality metrics associated with the population, utilization metrics, patients’ treat-to-target status, and where the patients are in the care management process.
- Hallway talks – Brief exchanges usually between two team members about a specific patient care issue. Often they are to follow-up and make quick decisions or refer back and forth.
- EMR messaging – Sending communication through the EMR. Key advantage: documentation. You can also attach a patient chart so it provides the context of the patient in question.
- Structured communication that is efficient and effective. Consider using a tool such as SBAR (situation, background, assessment, recommendation). This aids in knowing the direction the care management is going.
- Good ol’ post-it notes – Much like hallway talks, but when you can’t reach each other.

Structure as care manager role needs

Care managers need some stuff in order to do their job. Here is a list of what we think most care managers need, however, needs will vary.

Care manager office space



When care managers are provided their own office space in the practice, they are able to meet with patients, families and caregivers without utilizing exam rooms. Face-to-face visits with patients can take up to an hour and therefore, having an office or access to a small conference room will not disrupt the provider's workflow or tie up an exam room.

Phone line



When care managers are provided their own direct phone line, patients are able to contact the care manager without having to call the main practice number, be placed on hold and/or get lost in the shuffle. If the care manager is not available, then the patient is able to leave a voicemail message for the care manager. Care managers often encourage patients to call them when questions/concerns arise. Some even distribute their business cards indicating that the door's always open if the patient needs anything.

Headset



There are days when a care manager may spend a majority of the time on the telephone conducting care transition/follow-up or care coordination calls for example. Wearing a headset allows for the care manager to easily navigate the patient's EMR and type notes while speaking with the patient or care providers.

EMR access/user privileges



When care managers have access to the practice's EMR, they are able to view the patient's health history, test results, medications and other important information as well as document the care manager-patient visit. We have learned that certain communication tools within EMRs are often used by care managers, providers and staff to efficiently and effectively communicate with one another (e.g., instant messaging, notes).

EMR tools/templates



Care managers may need to have tools/templates developed within the EMR to support care management work. These tools may include templates for documenting patient care plans and self-management goals and a mechanism for scheduling follow-up appointments and tracking patient progress.

I think that's been helpful for both of us because it's also saved me time, and I know it's saved them time with now they don't have to fax me anything. I just can look up everything [in the EMR]. —Care Manager

Internet



Care managers with access to the internet are able to research community-based, regional, statewide, or national resources. They may also research diagnoses and medications to allow them to better care for the patients.

Structure as care manager network

Since many care managers are the only one with that role in the practice, it is important that they have the opportunity to network with other care managers. This can be accomplished by creating a forum that allows for best practice sharing and peer support.

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Assessment - How should we organize our care management activities?

1. What are our most important patient groups to be served by the care management efforts (patients for whom we can obtain payment, patients taking eight or more medications, patients transitioning from hospital to home, patients with more than two chronic conditions, patients currently requiring the most support from clinicians)?
2. How will our patients be referred to our care manager? Is there a formal yet simple process for staff/providers to refer patients to the care manager? Do we clearly articulate to the patient receiving that the service is a choice? How will the care manager/practice document the patient agreement to the care management service, and where will this be located in the chart? Or is care manager as a team member just "how we do care" at our practice?
3. How will team members know a patient is receiving care management services and when the service has been discontinued and monitoring is returned to the practice?
4. Where will our care manager sit/be located?
5. In which team meetings, huddles, or other team communication will our care manager participate?
6. What data systems will our care manager utilize to track progress?
7. Will our care manager be an employee of the practice, health system or other entity?
8. How will our care manager-patient visits be structured, like home visits versus in practice only, phone calls versus in person, joint visits with providers?
9. Will our care manager provide education only, assist patients with self-management goals, work with the patients' families/caregivers, call resources on behalf of patients, work on our disease registries, etc.?

Implementation and Sustainability Issues: Getting Care Management Started and Making it Continue to Work Well

The importance of teams in successful care management

No matter what new service or tool is introduced in primary care, it is likely to affect the primary care team. If the team is not working well both individually and collectively, it is going to affect the success of the new intervention. Bodenheimer, et al (2014) in their sentinel article *The Ten Building Blocks of High Performing Primary Care Teams* describe team-based care as one of the four foundational elements.¹ We call this out specifically because of its importance to the success of care management, because care management will affect the roles and responsibilities of everyone on the primary care team. Building effective team-based patient care has been shown to improve patient outcomes, improve office efficiency, and decrease health care costs.²

In most practices, the primary care team includes everyone who works physically in the practice at least part-time—not only the clinical providers such as physicians, advanced practice providers and their clinical staff, but also everyone who touches patient care, such as front desk staff, the billing personnel, and others.

Some practices are large and include several teams within the overall practice. Therefore, consider the teams within the practice, such as the “Red pod” or “Team A.” The team would consist of the clinicians and nursing staff that work together regularly. Unless each care manager is assigned to a different team within the practice, the care manager is likely to work across teams within the practice.

Some practices have close administrative ties with health system personnel. Perhaps the billing or call scheduling is completed by central administrative staff. If these roles affect the care management implementation, they should also be considered part of the care management “team” in terms of successful implementation.

Elements of teamwork and being a team member

There is much written about the elements of successful teams and certainly much about what it takes to create successful teams. We will not be able to

completely cover this territory! However, we share our experience of successful teams as it relates to care management implementation as well as resources for learning more about team development in the resources section.

So what are the common elements?

- Effective teams have a shared vision, and each person on the team can connect with that vision. With regard to care management, it is important that all members of the team have a similar mental model. A mental model is how you envision what something is and how it works. All members of the team should be on the “same page” about their thinking about care management.
- Effective teams support one another, communicate freely and openly, and develop trust in one another. Communication and follow-through are extremely important. In care management, it is important to know that tasks assigned by care team members get done and what happens gets reported back, that information communicated to patients is accurate, and that feedback is received respectfully. These actions build trust.

I think it's going to take a village to take care of someone who has any type of chronic condition, and that village is going to be not only their physician and their medical assistant, but also the person who makes their appointment for them, it's going to be their care manager, their dietitian, their social worker, and the village is just going to keep growing. At the same time we have a primary care physician shortage happening across the nation, so you're going to have less and less doctors, so the doctor that is there is going to have to basically direct the team to take care of these patients, and so I think that's how we're going to survive the next couple of decades, with the village. —Practice Manager

[That's] a major paradigm shift for a doctor to realize that, you know, I have a team. I'm part of a team, and I'm not even the most important person on the team anymore. I'm just part of it, but I don't have a problem with that. I don't have an ego, so I don't care. I just want the things to get done, and now I realize we can get things done now...they [care managers] can do what I can't do. —Physician

The importance of communication across the care team

Many primary care practices are establishing consistent care teams. Having the same medical assistant, nurse, provider, and other key staff members work

together can help to improve efficiency and continuity of care for your patients. Although this is changing, most likely your practice will only have one care manager, so how do practices with multiple care teams integrate a single care manager? Following are some techniques for improving communication.

The goal is to kind of centralize everybody and make them [clerical and clinical staff] one big team, and I think because once you do that, and the patients see that you're one team then you're not separate, and then that experience with the patient can be better because you're not throwing each other under the bus.
—Practice Manager

- **Care team huddles:** Include your care manager into your daily care team huddles. If your practice has multiple care teams, consider staggering your huddles so your care manager can attend

each huddle, or can rotate to different huddles.

- **Integrated team space:** Does your practice have the ability to literally “break down walls”? If so, having a common space where all members of the care team can sit together has shown to increase communication and collaboration among team members.

She was very calm, organized, understanding, gets the info that she needs that will be beneficial to pass on to Dr. B so he doesn't have to fish and fight to find the information. He's got it. He knows if there's a medication that's coming up that needs to be refilled or if it needs to be refilled she can take care of it. All that kind of stuff. She facilitated patient care by going through the junk, filtering out those important things that were needed like tests, test results. —Patient

- **Practice staff meetings:** Include your care manager in practice meetings. If your care manager's work location is not on site at the practice, encourage him or her to come to your practice and attend these meetings in person.

- **Quality improvement teams:** Does your practice have a quality improvement team? Many practices have found it beneficial to include their care manager as part of their quality improvement team as s/he is often working with patients on improving patient outcomes that relate to quality improvement and measures within the practice.
- **Electronic communication:** Does your care manager have access to your practice's EMR? If so, is there an agreed upon place where s/he documents patient information? Coordinating patient and practice communication is one key to true team integration.

The importance of leadership

In a sense, everyone in a practice is a leader and has the opportunity to demonstrate leadership characteristics. Good leaders are people who communicate well, consider others, give good feedback, are self-aware, demonstrate competence, lead by example, and care about other people and their development. Some leaders excel by being visionary and helping the group to identify and get behind common goals; other leaders are very effective at "keeping the trains running on time."

Some individuals in a practice are placed into the role of leadership by their position and responsibility. Usually in a primary care practice this is the practice manager and medical director, but also the lead MA or the lead staff person. These people, since others are responsible to them and they are in a decision-making capacity, have the special role of formal leader. There is much to be said about leadership, but a lot of it boils down to these factors. A good leader:

- helps set a common goal and helps team members see their role in accomplishing that goal
- cares about the development of others and facilitates providing support and growth of team members
- establishes with team members reasonable expectations and then holds people accountable; handles conflict and disgruntlements with compassion, but firmness
- is adaptable to the context and situation and shares the knowledge and power – empowers team members

If practice leaders lack leadership skills, the practice will most certainly suffer losses in terms of efficiency, effectiveness, and team member and patient satisfaction. There are many quality leadership training programs available, and investing in these trainings is usually wise. Consider a program that has aspects of both transactional (how to do specific skills; for example, how to make

agreements), but also transformational (how to become a different and more skilled leader in a holistic sense). There are also leadership coaches that work one-on-one with leaders to develop their leadership skills.

The importance of process in successful care management

Even in effective teams, sometimes stumbles can happen. New circumstances arise and it is difficult to navigate forward. This continually happens in health care. Therefore, it is helpful to consider the processes your primary care team is using to assess, diagnose, and solve implementation issues in practice.

In our work with care management, we have focused on looking at what makes care management successful. This includes how to get it started, decisions to make, and then being able to deal with issues as they come up. Something we have used to help guide us is a framework called Macro cognition.³⁻⁵ This is just a fancy way of saying “how groups think about and work together to address real world problems.” We present the framework below and encourage you to think through how you are doing each of these processes as you get your care management program going. If you are doing all of these things, then it is likely you will be successful with care management in your practice.

Functions and Processes and How they Apply to Care Management		
Process	Definition	Application to Care Management Has your practice....
Planning	Any activity involving the process of intending to (re-)shape a current state into another desired state.	<ul style="list-style-type: none">▪ Determined the purpose and goals of care management?▪ Mapped out what and how specific activities will fulfill those goals?
Coordinating	Any activity that synchronizes two or more people involved in an activity. These are activities that help the care manager and other roles interact, make decisions, and understand who is doing what.	<ul style="list-style-type: none">▪ Considered how the care manager will manage activities together and separately with other practice members? With community resources? With patients?

Process	Definition	Application to Care Management Has your practice....
Decision Making	Any decision <i>in</i> the clinical process, including what decision, by whom, made how, when, where, and why about an individual patient's care management as well as decisions made at the implementation level in the practice. These are activities that help the care manager independently or with others move forward with action.	<ul style="list-style-type: none"> ▪ Determined who can make what decisions about what types of actions regarding care management tasks? ▪ Determined when the care manager acts independently or seeks advice? ▪ Determined how care management activities will be undertaken and what to do when changes are needed?
Sense-making and Learning	A deliberate and systematic attempt to find coherent, conceptual <i>situational</i> understanding. Along the way, "things" will happen that are unexpected or that are expected, but it's not clear how to handle. Sense-making and learning is the process to understand the situation, learn from it, and decide how to move forward.	<ul style="list-style-type: none"> ▪ Devoted time and resources to identify data regarding progress with care management, to review and reflect on that data, and to have a means of trying new options?
Monitoring and Detection	Tracking implementation progress or discovering a situation that is novel, or a potential opportunity or problem. It is important to have a way to identify if an activity is not leading to its goal or if there are other problems. This is part of the learning process to identify what is and is not working.	<ul style="list-style-type: none"> ▪ Put in place a way or system to identify if something is not working or achieving outcomes? ▪ Identified who will use this system and how?

Process	Definition	Application to Care Management Has your practice....
Managing the Unknown	How uncertainty, risk, and ambiguity are dealt with, including identification of ambiguities and risks, monitoring strategy, and incorporation into decision-making. Any time a new role or goal is implemented, there are going to be unknowns. How to move forward is not always clear. Work as a team to determine how to act and learn from new experiences.	<ul style="list-style-type: none"> ▪ Determined how to seek and receive answers to questions? ▪ Determined a plan for trying options and then learning from results? ▪ Developed a community attitude or culture of mild risk-taking?
PLUS - Mental Model	An explanation of someone's thought process about how something works in actual clinical practice. Shared mental models can be at the heart of effective collaboration. Mental models can also really get in the way of effective care management implementation. Role clarity and acceptance are very important for everyone to buy in to the care manager role and support it.	<ul style="list-style-type: none"> ▪ Had discussion and consensus building around what care management is and does and how it works? ▪ Identified barriers in thinking that will impede efforts to implement care management?

A key area where many practices get tripped up in implementation is in managing the unknown. *How will it work out if we try X? Will we be sorry that we tried it?* This can stifle creativity and exploration of ways of doing new things and get teams stuck with no progress. This is the realm of quality improvement, which we will touch on briefly.

Using quality improvement strategies in the implementation of care management

An ongoing series of steps in successful care management is to apply the principles of quality improvement to the process of care management. This process begins with identifying the goals and activities of care management, identifying the patients to be in care management and how these patients will be engaged in care management, and then mapping out how care management will occur, with whom, and when. However, the ongoing process of tracking progress with goals and learning is in the territory of quality improvement.

Quality improvement (QI) in health care has been around for centuries, likely beginning with introducing hand washing to medical care in the 19th century. Now quality improvement includes developing and implementing strategies to improve both the process of patient care and patient safety. Implementation of QI in primary care has been shown to enhance the change process and create a culture of continuous change. Involving your care manager on practice QI teams, whether s/he is co-located or working remotely, can be an effective strategy for better integration and bi-directional communication.

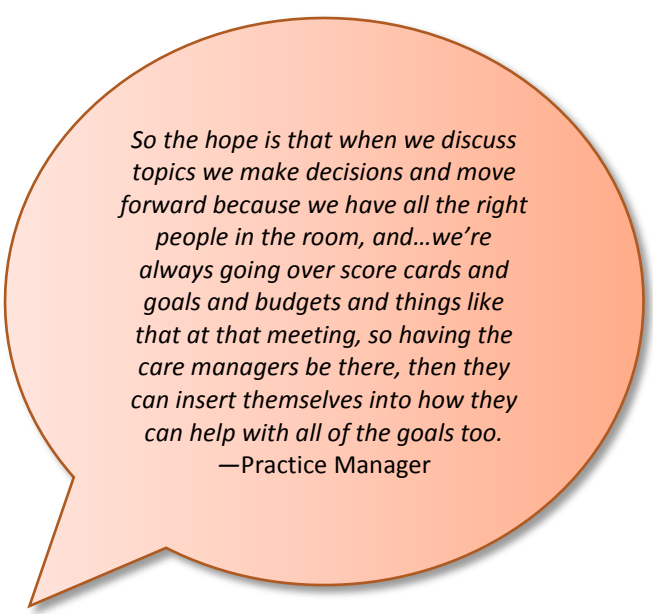
Quality Improvement (QI) teams

What Is a QI Team?

- The purpose of a QI team is to intentionally examine how care can be delivered in a better manner – with more efficiency and/or more success. The overall goal is to improve the quality and efficiency of care delivered in the practice.
- They often include a representative from various areas of the practice including clinical and administrative areas.
- They often meet regularly (weekly/bi-weekly).
- QI teams are tasked with implementing change efforts.
- Care managers are often included as QI team members.

Why Use QI Teams for Change?

- QI teams help the practice understand the overall practice system: what is actually happening.
- They increase the diversity of perspectives.
- QI teams increase the number of staff empowered to identify and seek solutions to problems—"shared leadership."
- These teams help create conditions for success, buy-in, and momentum. In our experience, a typical practice has people who tend to fall into one of these categories at these ratios: 20% want change, 50% on the fence, 30% against change.



So the hope is that when we discuss topics we make decisions and move forward because we have all the right people in the room, and...we're always going over score cards and goals and budgets and things like that at that meeting, so having the care managers be there, then they can insert themselves into how they can help with all of the goals too.

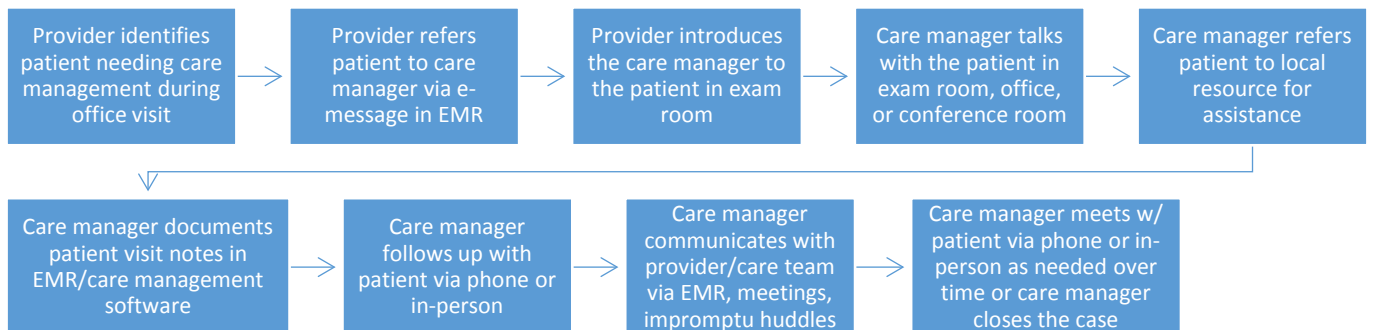
—Practice Manager

- QI teams use data to make sure changes are resulting in improvements.

Using flow maps and PDSA cycles to improve processes

The first step in improving an office system such as care management is to map your current process. Drawing a picture or a flow map of exactly how the process currently occurs can be a powerful tool. To create a flow map, simply list the current steps in order of completion. It is usually best to begin at the point where the patient engages the process (i.e., check-in). In order to draw an accurate flow map, it is also important to have all of the key staff involved. For example, you can't map the check-in procedure if a front office staff is not part of the process. The following diagram is an example of one practice's flow map for care management:

It's just been awesome how much [the QI team] has improved things because it made us realize that people are listening, and we can bring forth the problems that we see every day. And we have fixed things like you would not believe. It's just really so much better and it feels like everybody...like people higher up are listening to us. —Medical Assistant on LEAN team



After the QI team has mapped out the steps, they will need to think about how well each step is working. Going beyond just whether the step is working, challenge each step of a process and consider if it is valuable, adequate, and flexible. Ask whether the step creates value for the patient, or is it a waste of time and energy?⁶

In addition, it can be helpful to measure. If you encounter a process that is continually problematic, you may need to be more graphic in your evaluation by using a cause and effect diagram, also known as a fishbone diagram, to understand the root causes of problems. There are many resources on fishbone diagrams on the internet.

Next, consider the use of Plan Do Study Act (PDSA) cycles. PDSAs are small tests of change to see how they work. You may consider using worksheets to try and document these small cycles of change. A good PDSA Cycle Template can be found on the website: <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pdsacyclededebits.pdf>.

Complete the PDSA cycle by planning out the new step, trying it out (do), see how it works (study), and then try something else (act). For example, say you want to see how it works to have reception staff identify patients who might be eligible for care management. They get a list of criteria for eligible patients and steps for referral to care management. You have one reception staff member try to identify eligible patients for one half day, discuss how it worked, and try it again for a longer time period, or try something else if it didn't work well.

Getting started with care management – important things to be done on the way to care management success

Identifying patients for care management

Care management can be an intensive and costly process and is not necessary for all patients. Identifying patients who can benefit the most from care management is key for the success of your program. For some practices, payers will be determining which patients to target for care management, or the hospital system or organization may determine patients to receive care management services. There are also some predictive models a practice can use to determine which patients to target for care management. However, care managers often work with patients by finding them in two ways:

1. Patients fit into a bucket of services that care managers look for and reach out to so they can engage the patient in care.
2. Providers or other staff in the practice identify a patient with a need in which care manager services may benefit and refer the patient to the care manager.

For approach 1, care managers are often looking for patients to reach out to. A very common bucket of patients who may be reached out to are those who are transitioning from care settings. The care manager (or other staff member) may look through the list of hospital discharges or ER visits to identify patients in the

practice. S/he may then look for patients with certain types of conditions in which follow-up after discharge is needed. Care managers also often look for patients who are potentially over-utilizing services, such as visiting the ED instead of the practice for care that could be provided in the practice.

Another key way that care managers reach out to patients for care is when they are out of range for certain desired clinical values. For example, care managers may comb through the EMR and use the registry function to identify diabetic patients who have not had a visit in the past six months and whose clinical values (A1c, blood pressure, lipids, etc.) are out of recommended range. The care manager may reach out to the patient to have the patient visit the doctor and then the care manager. Care managers and other staff may contact patients to recommend that they complete preventive care as well, such as assisting them in scheduling a mammogram or colon cancer testing.

In addition to care managers proactively finding patients who may need additional care, the care manager provides an important role in helping facilitate additional care of patients who are being seen for a visit at the practice or in which the patient or caregiver has initiated care. This usually falls into the category of the patient being out of range on clinical values, but usually is the result of social needs that make it difficult for the patient to meet his or her health goals. This includes issues of difficulty paying for medications, transportation problems, getting enrolled in services and plans such as Medicaid, and other health and safety issues. Good sources of information and referral for patients being seen by the provider that day include the huddle, the Medical Assistant rooming the patient, and the receptionist. Some care managers make home visits to assess the home environment and educate patients. Many times, however, care managers work with patients during visits to the practice or through phone calls.

Determining workflows for care management

An important part of the planning and learning your practice will do about care management is to determine the workflow of care management. As we mentioned above, there may be different ways that patients are identified and are referred to the care manager, so you will likely need multiple workflows for the different scenarios. This section lists some important questions in determining the workflows for the different type of work. We also provide examples in the appendix (page 106) of possible care manager workflows.

Here is a list of questions to ask in determining the care management workflow:

- How are patients identified for care management? Who identifies the patient?


- Once the patient is identified, how is the referral made to the care manager? Who is involved in this process? Where will care management services be provided?
- What happens during the care management visit? What is the usual length of the visit? How is this communicated to the rest of the care team members?
- What happens with patient follow-up? How is this communicated?

If workflow concerns arise, consider using the quality improvement steps described earlier in this section.

How long does it take for care management to begin working successfully?

In our experience, we have found that a well-implemented care management effort takes about six months to get running relatively well. Some considerations that may make it take a longer or shorter amount of time include:

- How much work needs to be done on role clarity? If practice members are all on the “same page” with respect to what a care manager is and does and how they interact with the role, this will go much faster. If they are all trying to “figure it out” as they go along, defining the role and processes on the fly, this will take much longer.



They [care managers] have been a big help because you know in the beginning we weren't really sure. It wasn't communicated to us what their role was actually going to be, but...I don't know what we would do without them now. They've really helped a lot, and they've made my life a lot easier because now I have more time to just keep my doctor going if a more complicated patient comes along or needs help with their medications or something, you know, the care managers come in and help out with that so I can keep going. —Medical Assistant

I think the biggest thing is educating everybody, and continuing to educate them to get them to buy in, and if you get the physicians to buy in that helps with you know the rest of the staff buying in.

—Care Manager

- How experienced is the care manager? If s/he has already been a care manager, been involved in the community, has a lot of training in patient engagement and communication, knows primary care, and knows the community resources, this will go faster.
- Is the care manager already known by the practice members? If s/he has already established a good rapport with practice members and established their trust in another role, this can go much faster. (Watch for difficulty with role clarity and role transitions though!)

- Does the care manager readily have what s/he needs to do the job? If he or s/he is spending time fighting to get a phone line, a place to sit, access to the EMR, etc., this will take away from effective implementation happening faster.

What are cues that care management is not working well and what can be done about it?

Here are some examples of care management, after a reasonable introduction period, not working well looks like:

- Providers and staff do not refer to the care manager.
- Providers and staff really don't know the care manager or what s/he does.
- Providers and staff don't trust the care manager.
- The care manager is often pulled into routine clinical care – rooming patients, giving injections, etc.

We were struggling with that for a long time, kind of just unsure of her [care manager's] schedule and where she was. She has a lot of meetings and things, and sometimes that's why she's not in the building, but as the clinical staff we never know where she is or why, so that's a struggle. —Medical Assistant

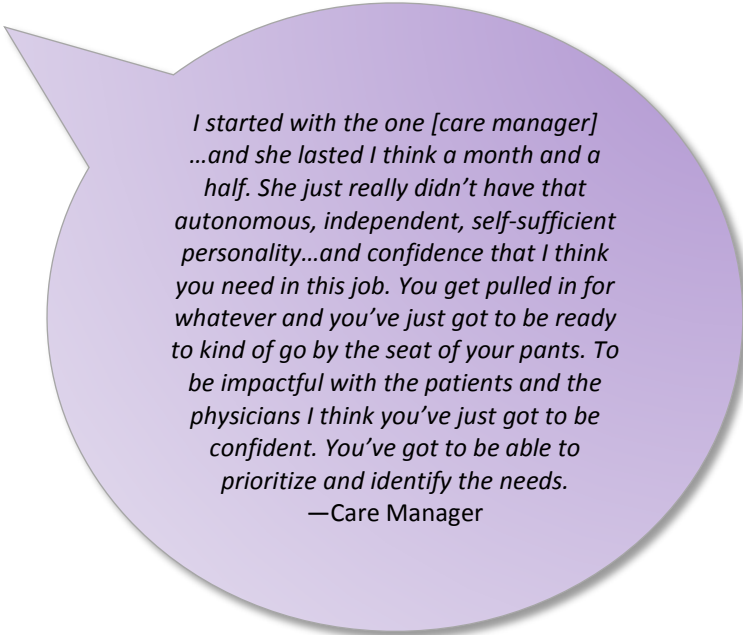
- Providers and staff don't believe that a care manager is needed, feel threatened, or feel that they should provide care for the patient (i.e., lack of interest in team care).
- There are no data on the effectiveness of the program, or the data show that no impact is being made.
- The care manager works as an independent operation – separate from the practice without communication with providers and staff.

Again, we refer you to the quality improvement section of this guide (page 54) to determine what the issues are for difficulty for care management implementation. Thoughtful explanation can often reveal the source of the problem. In general, the difficulties clump into these categories (and can include multiple categories):

External factors make implementation difficult. For example, only some health insurances pay for care management. Is there a new way to approach implementation given this factor? Can all patients at least get some care management help?	The care manager is not a good fit in some way. Lack of trust emerges when the care manager is not adequately trained which results in lack of trust in referral. Sometimes this can be remediated by training, sometimes not. Personality factors often play a role as well. Care managers need to have supportive, empathetic personalities and show good follow-through.
Structural problems prevent the care manager from frequent interactions with care team members. This prevents clinicians and staff members from getting to know the care manager and what s/he can offer.	Not being on the “same page” or mental model across the team results in confusion about what care management is and who is doing what and why.

Paying attention to those aspects of how groups think about and work together to address real world problems will help you implement and sustain your care management program. Considering these processes, here is a tongue-in-cheek list for making care management (or any intervention) NOT work. In other words, here are ways to derail successful implementation:

1. Have a mental model about the way things are or should be and don't change it to accommodate new information or ways of doing things. (Mental models)
2. Don't think the new initiative is important and don't try to consider alternative view points on its benefits.
3. Don't take the time or the steps to plan out who might need to be involved or the resources needed. (Planning)
4. When an unknown pops up and you're not sure what the answer might turn out to be, just stop and be stuck. (Managing unknown)
5. Don't work with other people to make sure your efforts are working in concert with one another. (Coordination)
6. Just keep doing what you're doing and do not make decisions about what to do next. Whine and complain about how difficult it is and blame the EMR/health system/insurance companies/etc. (Decision making)
7. Don't look for new information, but when you do get new information, don't consider it or incorporate it into your plans or decisions. (Monitoring and detecting; Sense-making and learning)



I started with the one [care manager] ...and she lasted I think a month and a half. She just really didn't have that autonomous, independent, self-sufficient personality...and confidence that I think you need in this job. You get pulled in for whatever and you've just got to be ready to kind of go by the seat of your pants. To be impactful with the patients and the physicians I think you've just got to be confident. You've got to be able to prioritize and identify the needs.
—Care Manager

Resources for improving primary care teams

We recommend the following websites, videos, and toolkits related to teams in primary care.

TeamSteps for Office Based Care – a set of tools and strategies related to optimizing team performance in an office-based care setting. This resource is intended for practice facilitators—individuals who play a key role in leading and

assisting practices with their quality improvement and practice transformation efforts.

<https://www.ahrq.gov/teamstepps/officebasedcare/index.html>

Primary Care Team Guide – practical advice, case studies, and tools from practices that have markedly improved care, efficiency, and job satisfaction by transforming to a team-based approach.

<http://www.improvingprimarycare.org>

Team Training Essentials: A Research-Based Guide, by Eduardo Salas (Routledge Press, 2015) – this succinct (180 page) book outlines best practices for team training, as based in organizational psychology research.

Resources for quality improvement

We recommend the following articles and videos related to implementing quality improvement.

Dr. Mike Evans Video: An Illustrated Look at Quality Improvement in Health Care – this video is from Dr. Mike Evans, Associate Professor of Family Medicine and Public Health at the University of Toronto. The video discusses the tools and techniques for quality improvement in healthcare.

<http://www.ihl.org/resources/Pages/AudioandVideo/MikeEvansVideoQIHealthCare.aspx>

Making Every Minute Count: Tools to Improve Office Efficiency – an article that describes some techniques practices can use to employ QI in primary care.

<http://www.aafp.org/fpm/2005/0400/p61.html>

Resources for creating effective workflow in clinical practice

The following training and websites provide information on how to create effective workflows.

Practice Facilitation Handbook - Module 5 Trainer's Guide: Mapping and Redesigning Workflow – this is a chapter from a training guide that covers how to map workflows in a practice and then make changes.

<https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod5trainers.html>

Improve Workflow and Remove Waste – this site from the Institute for Healthcare Improvement lists steps a practice can take to eliminate waste and streamline workflows.

<http://www.ihl.org/resources/Pages/Changes/ImproveWorkflowandRemoveWaste.aspx>

Workflow Standardization Worksheet – this worksheet from the Safety Net Medical Home Initiative, national Patient-Centered Medical Home (PCMH) demonstration project, helps practices assess patient visit activities that can be standardized as part of team workflows.

<http://www.safetynetmedicalhome.org/sites/default/files/Workflow-Standardization-Worksheet.pdf>

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Assessment - Does our practice have what it takes to include a care manager in our team?

1. What is the level of trust and teamness among our current practice members?
2. Do we have a lot of employee turnover? If so, how this be handled with the care manager?
3. How do our employees feel about adding a new role?
4. What is their understanding of the role of a care manager?
5. How has our practice responded to quality improvement efforts so far?
6. Does our practice have experience with creating a positive, change-oriented team culture?
7. Does our practice have an overall sense of the mission that is shared by the practice members?
8. Do our practice members understand their individual roles and how they contribute to the overall goals of the practice?
9. Does our vision for the practice include population-based health and proactive care for patients before they have an acute injury or illness?
10. Does our practice know how to use quality improvement processes to improve upon decision-making, monitoring for problems, trying new options, reflecting on them in order to improve the way we do things?
11. Does our practice have access to resources for help with these areas if our internal work is not effective (such as coaches, training)?
12. What are the elements that will make care management considered successful and do we have the means to employ those elements?

Resources

The importance of knowing resources

Connecting patients with the necessary resources to successfully manage their chronic conditions and improve their health and quality of life is an important task of the care manager. This often includes working with the patient's family or caregiver or calling a resource on behalf of a patient so that his or her needs are met and to ensure adequate follow up. For example, a patient, for various reasons, may not follow

Maybe it's a social problem. Maybe it's a transport problem. It's just a myriad of stuff. Getting [medications] for people, and I don't know how she [care manager] does it, but she manages to have a meaningful impact and helps to find whatever resources are out there.—Physician

"I see a higher level of quality care for our patients, the ones that are the sickest. You know the ones that are going into the hospital several times.

There's a better quality of care because before when it was a medical assistant with the provider providing this care I didn't feel like they always had the time or they weren't aware of all the resources that are available in the community to give the care that was necessary for the patient.

—Practice Manager

up with his or her provider after being in the hospital. Or a newly diagnosed patient with diabetes may feel overwhelmed, and the care manager steps in and works closely with a durable medical equipment agency to get this patient his or her needed supplies (glucose meter, lancets, test strips, etc.). In some cases, the care manager will go above and beyond and complete the paperwork needed to ensure the patient gets his or her mail-order supplies.

The importance of taking the time before-hand to get to know resources

We recommend that care managers spend time up-front, meaning prior to meeting with patients, to develop

knowledge about resources that are available at your local, state, and national level. It is also very helpful if the care manager begins to develop relationships

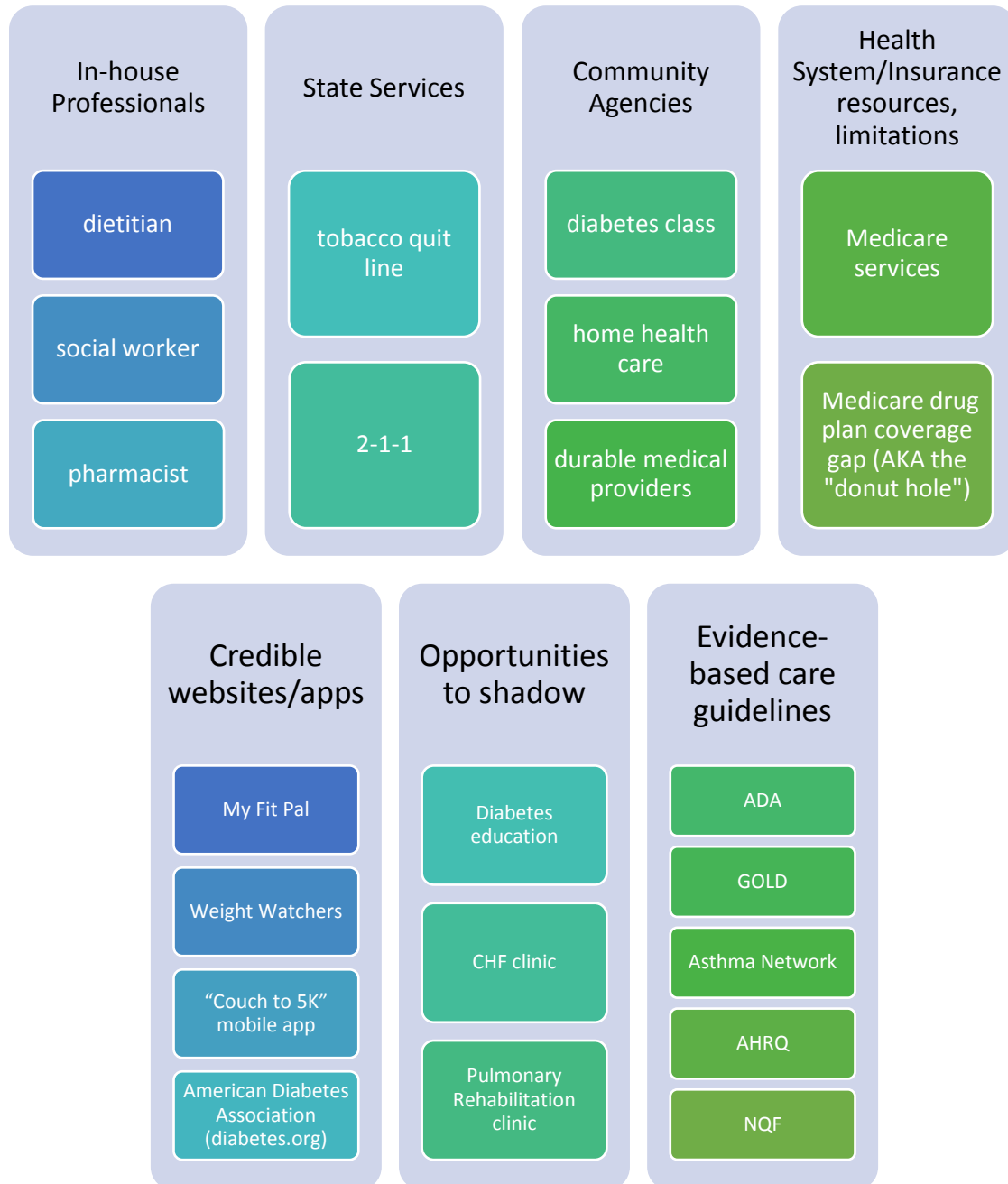
with contact persons at the agencies/resources within his/her community. For example, the care manager visits a skilled nursing care facility, meets with the director, and learns about the services provided. The care manager is then able to get a sense of the living environment and makes the decision on whether or not to refer patients to that facility in the future. In addition, getting to know the director and being able to refer patients *directly* without having to jump through hoops is key to a smooth and successful referral process.

I began to reach out to community resources I didn't even know existed, but I began to essentially make calls and talk about my role and what I was doing in the practice, and so that's probably initially what was most helpful. —Care Manager

She's [care manager's] been a great resource for a lot of different things, and she has resources for it seems like everything. If you just go to her and you don't know where to go, and say, "Hey, this is what I have. I have a patient that has this." And she'll say, "Well that's our social worker, or that doesn't go here. That should go here." So she's a great person, and it's great having her here in the office. —Medical Assistant

So what resources exactly do care managers refer to?

Examples of common resources that care managers refer to include the following.



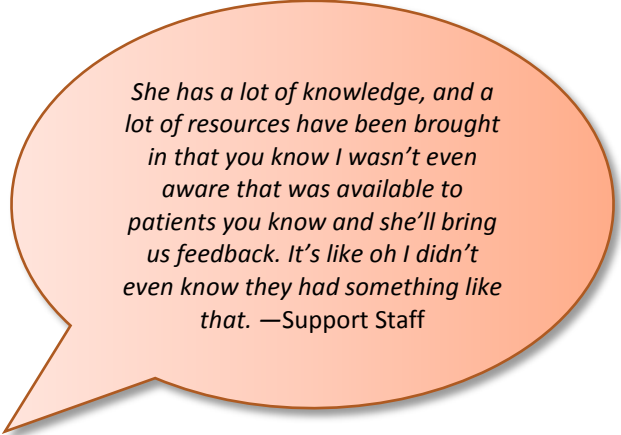
Care managers may also stock a variety of resources (supplies) onsite at the practice such as inhalers, glucose meters, blood pressure logs, blood sugar logs, educational handouts, pamphlets such as a diabetes booklet or binder to give to patients.

Insurance and health system benefits

If the patients you serve are insured by specific insurers, these insurers will often offer services to help their insured patients. This of course includes what is covered under the patient's insurance benefit, but also other educational services that might be helpful in the patient's progress with health improvement.

Some example of these services include:

1. Case management of complex patients needing specific benefits and/or providers, i.e. transplants, high-risk newborns, complex cancer, multiple trauma
2. Online educational programs
3. Discounts on health-related services, such as Weight Watchers or a fitness facility

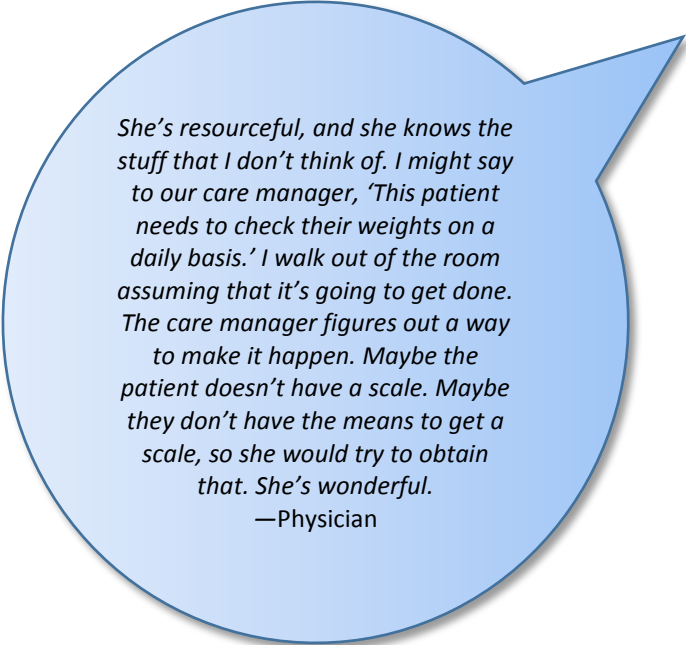


She has a lot of knowledge, and a lot of resources have been brought in that you know I wasn't even aware that was available to patients you know and she'll bring us feedback. It's like oh I didn't even know they had something like that. —Support Staff

Care managers need an understanding of health insurance and its impact on care. Who qualifies for Medicare, Medicaid, and what are the basic coverage guidelines for these? They should know what commercial payers are prevalent for the population services and what product lines and network they offer.

Organizing resources

As the care manager begins to identify and gather resources, s/he will need to organize them in such a way that they are readily available when working with patients and easy to update as things change and new resources are added. Keeping resources updated is an important and ongoing task of the care manager. There are different ways in which resources can be organized: three-ring binders, file folders/cabinet, "Resource" folder located on the computer. We have observed care managers posting frequently used resources in their offices on bulletin boards.



She's resourceful, and she knows the stuff that I don't think of. I might say to our care manager, 'This patient needs to check their weights on a daily basis.' I walk out of the room assuming that it's going to get done. The care manager figures out a way to make it happen. Maybe the patient doesn't have a scale. Maybe they don't have the means to get a scale, so she would try to obtain that. She's wonderful.

—Physician

Tips for putting it all together

1. Identify existing resource guides – why reinvent the wheel? Check with your local hospitals, health departments, senior programs, recreation departments, chamber of commerce, etc.
2. Work with others to identify resources. Talk with other care managers, practice team members, family, friends and even your patients! Tap into existing resources and your own experiences.
3. Identify resource options that are low- or no-cost. Patients may not be able to afford the cost of a diabetes class, for example, or insurances may not cover certain costs.
4. Search the Internet (e.g., Medicare.gov, American Heart Association, CDC.gov, etc.) for reputable resources.
5. Personally visit community agencies. Set up a meeting, introduce yourself, describe your program, participate in a class (e.g., diabetes education), identify how best to refer patients to the agency. Are there financial or other requirements that must be met? Is there a contact person with a direct phone line for you as the care manager or the patient to call?

6. Resource topics may include but are not limited to:
 - ☒ Diabetes
 - ☒ CHF
 - ☒ COPD
 - ☒ Asthma
 - ☒ Weight management
 - ☒ Depression
 - ☒ Mental health/Counseling services
 - ☒ Nutrition
 - ☒ Physical activity
 - ☒ Tobacco cessation
 - ☒ Financial assistance programs (for medications, equipment, etc.)
 - ☒ Transportation
 - ☒ Home health services (e.g., Meals on Wheels)
 - ☒ Rehab/skilled nursing facilities
7. Evaluate and update your resources regularly – it's amazing how quickly resources change!
 - ☒ Add new resources and share them with your team members
 - ☒ Join a list-serve or request to be on a mailing list for updates, newsletters, etc.

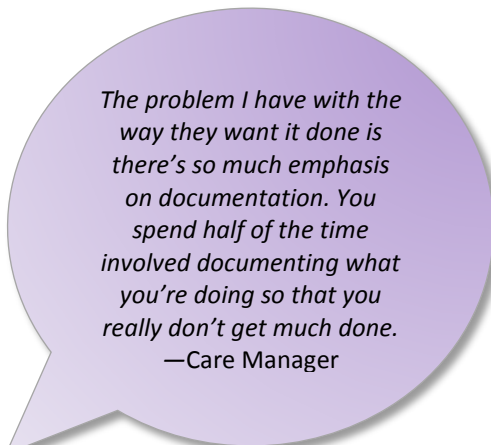
Assessment - **What resources are available in our community as well as at the state, national and health plan level to support care management?**

1. Does our practice already have a community resource directory, or list of important resources that will facilitate helping patients with care management needs? Based on the population serviced in the practice, do we have relationships with frequently utilized agencies?
2. Does our practice have the time and personnel to investigate new resources, how they work, the cost, who is eligible, including the time to visit resources in the community and build relationships?
3. Is there a community group or organization that provides a resource directory?
4. Is there a process in place to provide our patients with a warm hand-off to resources?
5. Who in our practice makes referrals and to what resources?
6. Are there educational materials, handouts, supplies needed in house for care manager-patient visits?
7. How will resource referral tracking be done? What is tracked and what is not?

Data Collection, Management and Analytics _____

How do we capture care manager activity?

An important first question is – do you want to capture care manager activity and for what purpose? Some practices need to know for purposes of reporting and reimbursement, but an important factor is the amount of time it takes to document versus the need for the documentation. Documentation can be very time-consuming and therefore frustrating for care managers, just as it is for other types of providers. Of course, documentation is often necessary for billing purposes, but otherwise, it is wise to consider the time and effort involved versus if that time could be otherwise used to serve more patients or serve at higher quality those patients already served. An important consideration in the process of learning to implement a new service (such as care management) is to collect data that will help you to be reflective about what is working and producing the outcomes you are hoping to achieve.

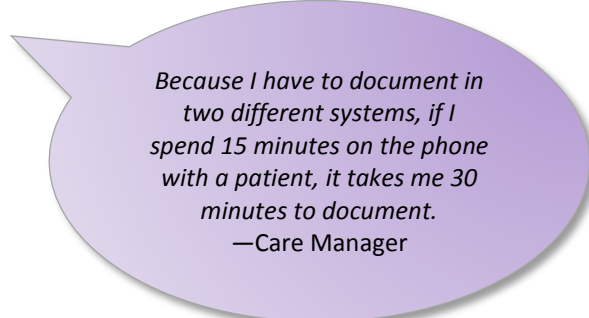


The problem I have with the way they want it done is there's so much emphasis on documentation. You spend half of the time involved documenting what you're doing so that you really don't get much done.
—Care Manager

Some considerations in documentation

Some aspects of documentation to consider (but are not always needed in all cases) are the following:

- Specific patient visits
- Type of patient visit (phone or in-person)
- Length of visit
- Type of service provided (education, self-management support, care coordination, medication reconciliation, social work, mental health, etc.)
- Patient's chief complaint, key conditions, and/or issue being worked on
- Goal and goal accomplishment
- Other individuals consulted about the patient, the time it takes, and what is discussed
- Resources accessed



Because I have to document in two different systems, if I spend 15 minutes on the phone with a patient, it takes me 30 minutes to document.
—Care Manager

- Incomplete calls or visits scheduled
- Refusals and no shows
- Patient concerns or complaints (and compliments)

From these data, the following can be calculated (partial list):

- Number of visits on average per patient and per type of patients
- Average number of patients seen per care manager and types of contacts (face-to-face, phone)
- Frequency of types of visits for types of patients
- Average number of months patients receive care management services
- Number of patients with improvement based on condition(s) receiving care management services, and the number of patients reaching treat-to-target
- Value to patients
- Key resources important to the care management process

What are ways to improve efficiency for documentation?

One of the key issues with inefficiency is the need for the care manager to double document. This is when the care manager has to document care in the EMR and also a separate care manager system. Since synchronous documentation (documenting in one EMR places the data in the other) is usually missing, this requires the care manager to double enter in multiple systems. This is a key complaint of many care managers. Often the data needed for reimbursement are more detailed than what is captured in the EMR, so a separate system is needed (see below). It is also often the case that EMRs are not easily (or not possible or too expensive) to be reconfigured to capture care management data.

What data should we be tracking?

To determine what data to track, consider first if you need to track data and second what data will 1) show if you are meeting your practice's quality improvement goals, and 2) maximize your reimbursement. Therefore, there is no one set answer. It really depends on your patients, quality improvement efforts, and opportunity for reimbursement. An important balance is to consider what payers need and what each practice wants to examine as two separate issues.

Should we have a separate care manager database or data system?

Again, this is another context-dependent question. If the EMR does not have the capability to capture the type of data needed for reporting, then the answer might be yes. That is, yes if there is a need to capture data for quality improvement or payment considerations. The following are possible systems to consider. Remember that there will be upfront and ongoing costs for the system as well as for the personnel time to enter the data.

How might the EMR system support care management?

Some EMR systems have the capability to support a variety of care management areas including preventive and acute care, chronic disease management as well as palliative and end-of-life care. Here are some features within the EMR often used by care managers:

- Electronic scheduling
- E-communication with providers/staff (e.g., instant messaging)
- Disease management tools
- Assessment tools
- Population management/reports (e.g., diabetic registry)
- Out of scope/target patients (to identify individuals for care management, e.g., patients with HbA_{1c} >7)
- Personalized patient care plans
- Online goal setting tools or templates built within EMR
- Monitoring/flagging/reminders (e.g., follow-up appointments with patients)
- Referral management

Care management templates within EMR

The following page shows an example of a template that could be implemented in an EMR.

Documentation Example for Patients with Diabetes:

Encounter Date: {date} **Encounter Type:** {phone/office visit} **Encounter Duration:** {time}

Encounter Contact: {contact code} **Care Manager:** {name}

CARE MANAGER ENCOUNTER

Current Concern:

Identified Barriers:

Interventions:

- {CARE MANAGEMENT: code}
- {COORDINATION OF CARE: code}
- {MEDICATION RECONCILIATION: code}

Goals: {SMART goals: Specific/Measurable/Achievable/Relevant/Timely}

- {GOAL 1***}
- {GOAL 2***}

*Assess importance/confidence of each goal on a scale of 1 – 10***

Diabetes Action Plan

Last A1C***

Last eye exam***

Last foot exam***

Frequency of glucose testing***

Blood sugar goals***

A1C goal***

Demonstrates/verbalizes understanding of glucometer***

Confidence level 1 – 10***

Diabetic education class***

Any diabetes center affiliation***

Type of glucometer***

DME***

Blood glucose testing range***

Reviewed signs/symptoms of hypoglycemia (IE: nervous, shaky, fatigued and confusion)

Reviewed signs/symptoms of hyperglycemia (IE: thirsty, hungry, fatigued, polyuria, blurred vision)

Carb counting: (3-4 carb servings per meal/15 grams carb per serving)

SOCIAL SUPPORT: Community resource referral to: {name(s)}

SPECIALISTS:

OVERDUE:

Follow up: {date/time/code}

Assessment - **What data to do we need and what do we do with it?**

1. What types of data are needed to justify our care management program and keep it funded?
2. How will we go about determining if care management is working?
3. How will we access data from the EMR in a way that is meaningful?
4. How will we interpret the data?
5. Do we have resources that can help in the data extraction and interpretation process?
6. How will data/reports be generated to determine if our care management program is meeting its intended goals?
7. What is the balance of our time and effort put forth in collecting and reviewing data versus the meaningfulness of what we learn from it?
8. Does our practice have the resources to build in care management tracking or add on a program to do that?

Paying for Care Management

Am I supposed to fully pay for the cost of the care manager?

Until recently, most health plans have not provided for care manager direct reimbursement, and most practices do not fully cover the cost of the care manager with direct reimbursement alone. This may change as the Centers for Medicare and Medicaid Services put in place key parts of MACRA, the Medicare Access and CHIP Reauthorization Act of 2015. MACRA will replace the Sustainable Growth Rate formula by paying clinicians for the value and quality of care they provide. However, until MACRA is fully implemented, reimbursement for care management will vary widely by region. Some of the factors involved in this variation include:

- Health insurance plans coverage
- Types of patients in your practice
- The background of the care manager (social workers versus registered dietitian versus nurse, etc.)
- State and federal policies
- What the patient needs (care coordination versus diabetic education, etc.)

What are options for funding a care manager?


Currently there are two main avenues for covering the cost of the care manager in your practice: direct reimbursement and quality incentives. Please note that payment models are changing rapidly and there may be other options available to pay for care management services in your practice.

Direct reimbursement

Direct reimbursement is an avenue or funding source when the care manager's time is covered by billing for the care management services s/he provides as a care manager. This also may include coverage under billing codes that care managers may provide together with other health care team members including the physician or other staff members (i.e., Transitional Care Management or TCM code under Medicare). An obvious advantage of this reimbursement is that it is directly tied to the care manager services provided and comes when s/he provides the service regardless of the outcome. If the practice does the care coordination or spends the time, then the practice gets the payment. A disadvantage and something to watch out for is that many health plans have codes available, but do not pay on them.

Quality incentives

Quality incentives are funds that come to the practice for the practice meeting quality benchmarks under pay for performance. For example, if the practice has X% of diabetic patients having a complete bundle of preventive services completed, the practice receives a bonus payment of \$XX. Although this is not direct reimbursement for care management services, it is likely the result of work the care manager (and others) did to assure that the patients were meeting this benchmark. Often, however, care managers do not see the connection between their work and the results of these incentives. It is critical to make that connection for them. These funds of course can be attributed to other quality improvement priorities (such as EMR upgrades for example), but can also be considered funds available for covering the staff that makes such outcomes possible.



I feel like our role pretty much is based around the financial aspects of the practice, and that is keeping patients out of the hospital because it costs money. You know keeping patients out of the ER because it costs money. Getting those patients in for their gaps in care because it brings money into the office. —Care Manager

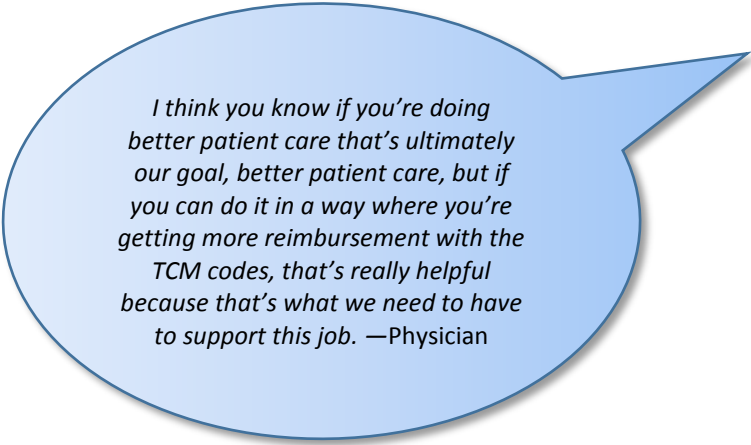
Quality incentives can be substantial, but are uncertain. Patients have minds of their own and might not follow recommendations and therefore not meet benchmarks. Thus, these incentives cannot be guaranteed. Another issue with quality incentives is the need to collect and be able to report on data, so information systems and personnel with the time and skill to do this are required (see previous chapter, Data Collection, Management and Analytics).

Shifting work

One way that some practices have been able to afford a care manager is through shifting of work. This is related to what the providers do and their productivity. For example, a practice may shift some of the work of the physician to the care manager such that the physician has the time to see (and bill for) more patients. This option has existed for some time and has not taken hold, suggesting that it is not a reasonable solution; however, it may be particularly useful for primary prevention issues, such as weight loss and smoking cessation. It only works when the provider is already providing the service (so the shift can happen) and s/he is willing to give it up to another professional (the care manager) and thus additional patients can be scheduled (and billed).

Key considerations in payment and billing

Make sure the health plan actually pays for the code they list. Some list codes as placeholders, but do not pay on them.



I think you know if you're doing better patient care that's ultimately our goal, better patient care, but if you can do it in a way where you're getting more reimbursement with the TCM codes, that's really helpful because that's what we need to have to support this job. —Physician

Consider the cost to get the payment versus the payment in the light of quality patient care. If it costs more to provide the service than the reimbursement (or quality incentives) available to cover it, then consider whether that is the best use of your care manager's time.

Which insurances cover what services and at how much? If your practice has a lot of different insurance providers, it can be confusing and downright maddening to try to figure out what to do with each individual patient. Most practices consider the insurers that cover most of their patients and then develop processes to address all patients regardless of insurance. Although hand picking patients and offering what is covered only for those patients with a particular insurance may sound attractive (not providing uncovered services to patients who don't have that benefit), it is a nightmare in terms of developing standard protocols and efficiencies. Workflows and communication in a practice can suffer greatly.

A key concern that arises with payment and billing is the issue of the patient being surprised with a large bill from the practice. If the patient has been informed ahead of time of the possibility of a bill, the expected cost, and makes the agreement to pay for it, then a patient receiving a bill may not be an issue. However, we have found that patients do not expect to pay for care management services. They feel it is a service of the practice and practice team, and unless they choose to take advantage of additional services, they believe they should not pay for time with a nurse or social worker (in the role of care manager). Although most patients do pay a co-pay for a physician visit, the general sense of paying for care manager services is not the same. Most practices that choose to provide care management decide that it is not a cost to the patient, but a care team service to be provided at no cost to the patient if the patient needs the services. Instead, these practices figure out if reimbursement can be gained "on the back end," meaning that the services are

provided and then sent to the billing department who then figures out if the insurer can pay and should be billed and then assure that patients do not receive a bill. This also removes the great uncertainty about who gets what based on what is paid for. These types of unknowns make the delivery of care management miserable when there are so many different plans with so many different payment options. These unknowns can keep care management from working in a practice.

In the future practices may consider the option of a co-pay for specific services that the patient chooses proactively. This requires that the practice inform patients of the optional additional professional services available in a practice and have a different way of providing care through patient self-selection and choice.

What are some possible payment codes?

It is beyond the scope of this guide to highlight all possible options and to provide instructions on how to meet payment codes. However, the table below is designed to help spur initial thinking about services your practice may be able to offer that may fall under the umbrella of care management.

Direct Reimbursement Revenue Opportunities		
Opportunity	Description	Issues
Care manager evaluation and management (E & M) as an independent provider	"Incident to" care of a provider; Allows certain care manager types to bill E & M codes for care manager work in conjunction with the care of a primary care physician.	Only certain professional types are allowed to utilize this option; for example RD and MSW since they are considered independent providers.
Nurse or other provider visit (99211)	Office visit for the evaluation and management of an established patient that may not require the presence of a physician.	Does not pay that well for a visit that often lasts much time.
T-codes	Allows specified allied health professionals phone or in-person visits for disease management for patients with specified chronic conditions.	Only some insurers have and pay on t-codes; often involves patient co-pay; allows for phone or in-person visit.

Opportunity	Description	Issues
G-codes	Documents comprehensive assessment of and care planning by a physician or other qualified health care professional for patients requiring chronic care management services.	G0506 may only be billed once per beneficiary, in conjunction with the start or initiation of CCM services. CPT codes 99487, 99489, and 99490 may be billed with G0506, assuming the billing requirements are met.
Capitated payment (per member per month or PMPM)	A fixed amount of money per patient per unit of time paid in advance for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Can be used to cover care that falls outside of the traditional office visit.	PMPM fee is not intended to defray start-up costs associated with implementing a care management program, nor to provide payment to practices for improved outcomes and/or savings that result from their care management efforts. Payers may be cautious about offering upfront payment alone, without at least some shared risk if savings are not realized.
Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD)	Nutrition counseling provided by an RD.	Only used by a RD; limited number of visits (3 hours total 1 st year); must have specific diagnosis (i.e. diabetes, chronic kidney disease).

Opportunity	Description	Issues
Medicare specific		
Initial Preventive Physical Examination (IPPE), also known as the “Welcome to Medicare Preventive Visit”	An introductory visit only within the first 12 months a patient has Medicare Part B; includes a review of medical and social history and counseling about preventive services. This visit can be used to initiate Chronic Care Management, which is the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions.	Medicare pays for one IPPE per beneficiary per lifetime for beneficiaries within the first 12 months of the effective date of the beneficiary’s first Medicare Part B coverage period.
Medicare Annual Wellness Visit	An annual visit to develop or update a personalized plan to help prevent disease and disability based on health and risk factors. Includes a health risk assessment.	Must be enrolled in Medicare anytime in first year. Visit requirements for assessment and prevention plan.
Smoking Cessation Counseling	Medicare Part B covers up to 8 face-to-face visits in a 12-month period provided by a qualified doctor or other Medicare-recognized practitioner.	As of October 1, 2016, the copayment/coinsurance as well as the deductible for 99406 and 99407 are now waived, so Medicare beneficiaries have no out-of-pocket costs.

Opportunity	Description	Issues
Chronic Care Management Services: CPT Codes: 99490 or Complex CCM: 99487 and 99489 (Moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or qualified health care Professional)	<p>Chronic care management services, at least 20 minutes of clinical staff time directed by a physician, certified nurse midwife, clinical nurse specialist, nurse practitioner, or physician assistant, per calendar month, with the following required elements:</p> <p>Two or more chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.</p>	Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner. A practitioner must obtain patient consent before furnishing or billing CCM. Consent may be verbal or written but must be documented in the medical record. Requires a comprehensive care plan to be established, implemented, revised, or monitored.
Care coordination Transitional Care Management (TCM): CPT Codes: 99495/99496	<p>Face-to-face visit with PCP within 14 days of discharge;</p> <p>Face-to-face visit with PCP within 7 days of discharge.</p>	Has to do with post-hospitalization, having an interactive contact with the patient within 2 days following discharge (i.e., phone call via care manager), a face-to-face visit with the PCP within 7 days (higher reimbursement) or within 14 days. If the patient is not re-admitted during the 30-day TCM period, then the practice can receive an even higher reimbursement amount.

Opportunity	Description	Issues
Intensive Behavioral Therapy for Obesity (Go447 individual; Go473 group)	Medicare pays for behavioral counseling for beneficiaries with a body mass index of 30 kg/m ² or greater. These patients are eligible for one face-to-face visit every week for the first month; one face-to-face visit every other week for months 2-6; and one face-to-face visit every month for months 7-12, if the beneficiary achieves the required weight loss.	Counseling must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Document the patient's clinical condition and qualifying BMI, how much weight the patient has lost at the six-month mark, and the counseling and dietary assessment that occurred at each visit. Be sure to sign the encounter note to ensure proper payment.

Areas for future work

Obesity care management may be one area that practices can address in the future. We have been disappointed to find few options for direct reimbursement for patients with a primary diagnosis of obesity in the absence of other chronic conditions. Yet patients are highly desirous of weight loss and may be interested in paying the primary care practice out of pocket for weight loss assistance. This is true for other primary preventive health behavior options.

Additional options may continue to open up for funding care management. As stated at the beginning of this chapter, payment under MACRA begins in 2019 with an initial performance period beginning in 2017 for the Merit-based Incentive Payment System (MIPS), one of two payment tracks created under the MACRA. The MIPS program rolls into a single performance program several existing quality and performance improvement programs: PQRS, Value-based Modifier, and Meaningful Use. The other payment track is Advanced Alternative Payment Models (APMs). Both of these tracks require submission of data on your care quality. Further discussion of MACRA is beyond our scope here. See <https://qpp.cms.gov/> for more details.

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Assessment - **How will we pay for care management?**

1. Does our practice have access to direct payment options? What are they and how much?
2. What is a reasonable amount of care manager activity/panel size to generate this activity?
3. What quality incentives are available to support care management? What is the total amount and what can be allotted to this?
4. Is our practice willing to provide care management services to all patients based on need, or only to patients with specific covered services? How will this be handled in workflows?
5. What training might be needed for providers, staff, care managers and billers to take advantage of payment for care management?

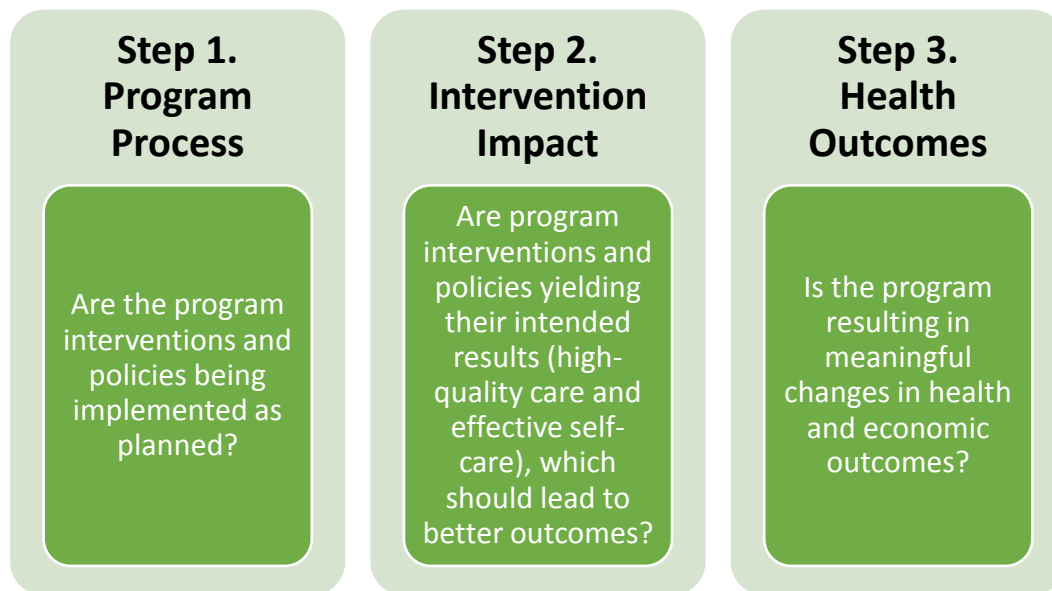
Evaluation – How is your Care Management Program Working? _____

The importance of identifying goals and measuring success

Demonstrating and evaluating the value and success of your care management program is an essential part of your implementation plan. Your evaluation plan can assess indicators such as improved health and clinical outcomes for patients, efficient use of healthcare services, provider adherence to evidence-based standards of care, and decreased healthcare costs (e.g., hospitalizations, readmissions, emergency department use). In order to develop your evaluation strategy, practices should consider:

- Determining measurements to evaluate program success
- Ways to determine areas for improvement
- Ways to build continued support for your care management program

The Agency for Healthcare Research and Quality (AHRQ), in their toolkit “Designing and Implementing Medicaid Disease and Care Management Programs”¹ recommends the following conceptual model for measurement of successful care management programs:



Using the model outlined above, practices can design a program that yields desired outcomes and allows for creation of a measurement strategy that determines whether the program results in meaningful change.

In addition, practices should choose measures based on the following considerations:

- Quality and usefulness of measures
- Balance of process and outcome measures
- Source of measures
- Feasibility of data collection
- Potential for improvement

The following table reprinted from AHRO's "Designing and Implementing Medicaid Disease and Care Management Programs"¹ gives examples of measure types, data sources, positives and negatives of each, and examples.

Evaluation Considerations				
Measure Type	Data Sources	Positives	Negatives	Examples
Structure - Infrastructure required to deliver high-quality care	Policies and procedures. Program monitoring report.	Easy to measure. Directly actionable by program administrators.	Link to health outcomes often weak. Structure may be difficult to change due to constraints.	Qualifications of the care manager. Protocols for identifying patients for care management.
Process - Implementation of services and procedures	Observation and discussion with key participants. Documentation of activities.	Helps to identify what is working and not working in terms of activity roll-out.	Can take time to collect and reflect upon. Different team members may have conflicting views.	Handoff from provider to patient time. Patient satisfaction working with the care manager.

Measure Type	Data Sources	Positives	Negatives	Examples
Process - Services that constitute recommended care	Claims data. Self-reported data. Care management reports and logs.	Directly actionable by program or providers. Impact on clinical outcomes variable.	Depends on administrative measures. Evidence base for impact of process measures varies. Might fail to match intervention.	Percentage of diabetic patients with retinal eye exam. Percentage of heart failure patients advised about salt intake.
Outcome - Measures of health and disability	Medical records. Lab results. Self-reported data.	Ultimate purpose of care management programs. Most relevant to patients and policymakers. Often included in vendor contracts.	Influenced by extraneous variables. Time lag to change might be long. Difficult to collect clinical data from EMRs sometimes.	Percentage of asthmatic patients visiting emergency room. HbA1c levels among diabetic patients. Average medical costs per patient.

For example, a practice wants to set performance measures for its asthma and diabetes care management programs. The practice may choose measures that have demonstrated quality improvement and cost impact, such as:

- Inpatient admission and/or emergency department visit rates for asthma and diabetes
- Percentage of asthma patients classified by stage of disease severity
- Percentage of asthma patients with a written asthma management plan
- Diabetic flow sheet being completed in the medical record
- Blood pressure measurement done and documented at every continuing care visit

An important consideration for practices is to determine the feasibility of data collection – what will the administrative burden be for each type of measure? From AHRQ,¹ the following table describes data sources and their positives and negatives.

Types of Data and Uses		
Data Sources	Positives	Negatives
Administrative Data Claims	Low cost and accessible. Provides process measures.	Coding errors. Provides no outcome measures.
Program Data Patient assessments, care manager reports	Available. Relevant for some outcomes.	Often self-reported and less reliable.
Clinical Data Medical records and lab results	Best source for outcome measures.	Costly. Records sometimes inaccurate.
Patient Survey and/or input from a Patient Advisory Group	Easy to measure.	Costly. Low response rate. Self-reported data sometimes unreliable.

Examples of outcomes measured in care management programs

- Diabetes metrics
 - Foot exams
 - Retinal eye exams
 - HbA1c levels
 - Micro albumin
 - 3 and 6-month PCP follow-up visits
- Blood pressure (Systolic/diastolic)
- Lipids (LDL, HDL, etc.)
- Body Mass Index
- Patient assessments completed (I.E.: PHQ-9, asthma action plan)
- Emergency room visits
- Hospital readmission rates
- Identifying medication mistakes
- Patient self-management goals identified/attained
- Successful patient-resource connections

The importance of considering process

Although the emphasis may be on delivering patient-specific clinical or cost reduction outcomes, it is important to remember that to get to these outcomes, care management has to be implemented well. This means that it needs to be an effective, efficient operation. If the clinicians are tasked with identifying and referring eligible patients for care management, and they do not do this consistently or effectively, then this impacts the success of achieving patient outcomes. In the end, for care management to be effective, care managers need to work with patients to change their behaviors, whether it is improving their diet for a lower HbA_{1c} or coming into the practice instead of the emergency department.

Therefore, it is important to keep an eye on hiccups in the process and have a plan for removing mental model barriers, improving efficiencies, and addressing communication and coordination issues. Questions to ask during a process evaluation include:

- Are the targeted patients getting to care management? If not, what is happening such that other patients are targeted?
- Are the patients participating in care management when it is offered? If not, what is happening such that they are declining participation?
- What is the time commitment for each of the roles associated with care management? Are there opportunities for reducing time spent while maintaining coordination among roles?
- Are patients having difficulty setting and achieving goals? If so, what is within the practice team's control to do to improve patient success?
- How are the practice team members feeling about how care management is working? Does it feel like a burden or hassle? Does it feel like patients are getting better care? If so/not, what might be the source of the issue?
- Do patients feel like they are getting better care? Do they feel that it is helpful to have a care manager as part of their care team?

The process for collecting this information does not need to be cumbersome. Especially in a small practice, it involves mostly asking people these questions and then listening earnestly to their answers. For the most honest answers, it might help to have someone not in the practice and not in conflict with the practice do the asking and recording of the answers. This might help uncover underlying issues such as interpersonal conflict or lack of credibility or trust in a role. Another strategy is to have staff member observe or shadow one another


to help get another pair of eyes on what is happening and how processes might be improved.

The importance of patient input

Patients are the ultimate recipients of care management services. If they don't participate with a care manager or in the care management efforts offered, then there is really no care management program.

Here are some ways you might consider the input of patients in evaluating care management:

- Utilize the patient advisory board – Many practices now have patient advisory boards to help them determine practice priorities and how to go about providing services in a way that works well for patients. Put your care management questions on the agenda and see what patients have to say about your plans and how it is going.
- Include an assessment of patients' experience with care management. Assessments can be periodic (some patients some of the time) or regular (all patients at set time intervals). After some period of time, you could include a short written survey of patients' satisfaction and progress with care management.
- Have care managers and others keep notes when patients express frustrations or joys about participating in care management. Review these notes quarterly to see if there are any patterns.
- Ask patients who refuse care management what would help them to be involved. Is there anything that could be done differently?



I appreciated having the care manager check in on me, someone I trust...someone who listened and looked after my needs. —Patient

General tips for successful evaluation

Some other tips for developing a successful care management evaluation system:

1. Begin collecting data early: ideally, data collection and measurement should begin before your care management program begins. This allows for a "baseline" to compare with, and allows for your practice to identify any problems with data or data collection methods before you start your care management program.

2. Work with stakeholders to develop measures: data can be an effective tool for gaining support from stakeholders as long as they trust the data and are in agreement with the measures. It is important to include all stakeholders in decisions, including providers, staff, and payers.
3. Communicate results to stakeholders: an important part of your measurement strategy should be how you will communicate your results. Reporting accurate and meaningful data can be powerful motivators for providers, staff, and payers!

And remember, a measurement and evaluation strategy is key for determining your care management value and ensuring its success and sustainability. According to the AHRQ's "Designing and Implementing Medicaid Disease and Care Management Programs," the most successful measurement strategies are designed in conjunction with program interventions and reflect program goals; and measurement is helpful only if the results are used to improve the program and communicate program value to stakeholders.

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Assessment - **How will we know if our care management efforts are successful?**

1. What is the overall goal of our care management efforts?
2. Does our practice have a means of assessing quality improvement efforts?
3. Can these assessment methods be applied to care management? How?
4. What will the metrics of success be? Consider financial, patient care, and patient outcomes and provider and staff outcomes.
5. Who will track success measures and when?
6. Is there a specific system we will use?
7. How will we know if we are not successful?
8. How will we assess what is working and what is not?
9. What will we do to change if we are not getting to our outcomes?

Appendix

Care manager job descriptions

JOB DESCRIPTION

TITLE: Complex Care Manager

FLSA: Exempt

DEPARTMENT:

LOCATION:

JOB SUMMARY:

Provides care management and care coordination for adult and pediatric patients with complex illness, in the primary care setting, under minimal supervision. In partnership with the primary care practice leadership team, the Complex Care Manager leads care management within the team through process improvement, workflow redesign, providing assistance with training, and delegating to other members of the team.

Serves in an expanded health care role to collaborate with specialists, members of the health care team, and patients/families to ensure the delivery of quality, efficient, and cost-effective health care services. Assesses plans, implements, coordinates, monitors and evaluates all options and services with the goal of optimizing the patient's health status. Integrates evidence-based clinical guidelines, preventive guidelines, and protocols, in the development of individualized care plans that are patient-centric, promoting quality and efficiency in the delivery of health care.

Manages a caseload of approximately 150 complex patients; of which 30 to 50 patients are actively followed by complex care manager. Provides targeted interventions to avoid hospitalization and emergency room visits. Coordinates care across settings and helps patient/families understand health care options. Infrequent, but possibility of home visits.

MAJOR DUTIES AND RESPONSIBILITIES:

1. Identifies the targeted high risk population within practice site(s) per PCP referral, risk stratification, and patient lists. Includes patients with repeated social and/or health crises.
2. Assesses over time the health care, educational, and psychosocial needs of the patient/family. Uses standardized assessment tools such as depression screening, functionality, and health risk assessment.

3. Collaborates with PCP, patient, and members of the health care team, including continuum of care settings and community. Responsible for developing a comprehensive individualized plan of care and targeted interventions. Continually monitors patient/family response to plan of care, and revises the care plan as indicated.
4. Provides patient self-management support with a focus on empowering the patient/family to build capacity for self-care.
5. Implements systems of care that facilitate close monitoring of high-risk patients to prevent and/or intervene early during acute exacerbations.
6. Implements clinical interventions and protocols based on risk stratification and evidence-based clinical guidelines.
7. Coordinates patient care through ongoing collaboration with PCP, patient/family, community, and other members of the health care team. Fosters a team approach and includes patient/family as active members of the team. Takes the lead in ensuring the continuity of care which extends beyond the practice boundaries. Serves as liaison to acute care hospitals, specialists, and post-acute care services.
8. Provides follow-up with patient/family when patient transitions from one setting to another. Completes timely post-hospital follow-up: Medication reconciliation, PCP or specialist follow-up appointment, assess symptoms, teach warning signs, review discharge instructions, coordination of care, and problem solve barriers.
9. Demonstrates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills.
10. Maintains required documentation for all care management activities.
11. Works with practice and PO/PHO leadership to continuously evaluate process, identify problems, and propose/develop process improvement strategies to enhance care management and Patient Centered Medical Home delivery of care model.
12. Reviews the current literature regarding effective engagement and communication strategies, care management strategies, and behavior change strategies and incorporates into clinical practice.

SKILLS AND ABILITIES:

1. Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community

agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.

2. Demonstrates ability to work autonomously and be directly accountable for practice.
3. Demonstrates ability to influence and negotiate individual and group decision-making.
4. Demonstrates ability to function effectively in a fluid, dynamic, and rapidly changing environment.
5. Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving, critical thinking, analysis skills and decision-making, priority setting, work delegation, and work organization.
6. Demonstrates ability to develop positive, longitudinal relationships and set appropriate boundaries with patients/families.

Required Qualifications:

- Current Registered Nurse, Nurse Practitioner, Physician Assistant or Master of Social Work License
 - Three years of experience with adult medicine and pediatric patients in primary care/ambulatory care, home health agency, skilled nursing facility, or hospital medical-surgical setting, within the past five years
 - Knowledge of chronic conditions, evidence based guidelines, prevention, wellness, health risk assessment, and patient education
 - Critical thinking skills and ability to analyze complex data sets. Ability to manage complex clinical issues utilizing assessment skills and protocols
 - Excellent assessment and triage skills. Ability to implement evidence base interventions and protocols for chronic conditions
 - Demonstrates excellent communication--both verbal and written
 - Excellent interpersonal and facilitation skills
 - Ability to affect change, work as a productive and effective team member, and adapt to changing needs/priorities
 - Time management, priority setting, work delegation and work organization
 - General computer knowledge and capability to use computer

Preferred Qualifications:

- Bachelor's degree or higher, in clinical field
- Care management experience
- Experience as participant in continuous quality improvement
- Completion of self-management support training

JOB DESCRIPTION

TITLE: Moderate Risk Care Manager

FLSA: Exempt

DEPARTMENT:

LOCATION:

JOB SUMMARY:

Provides care management and care coordination for adult and pediatric patients with mild to moderate illness, under minimal supervision. In partnership with primary care practice leadership team, the Moderate Risk Care Manager leads population management within the team through process improvement workflow redesign, providing assistance with training, and delegating to other members of the team. Collaborates with members of the health care team to empower patients to manage their chronic conditions. Assists patients, who are at risk for developing chronic conditions, to minimize these risks. Serves in an expanded health care role to collaborate with PCP and patients to ensure the delivery of quality, efficient, patient centered, and cost-effective healthcare services. Assesses, plans, implements, monitors, and evaluates delivery of individualized patient care with the goal of optimizing the patient's health status. Provides self-management support and patient education.

Works primarily with moderate risk patients to optimize control of chronic conditions and prevent/minimize long term complications. Manages a caseload of approximately 500 patients; of which 90-100 are actively supported at a time.

MAJOR DUTIES AND RESPONSIBILITIES:

1. Identifies the targeted population within practice site(s), per PCP referral and registry reports.
2. Assesses the healthcare, educational, and psychosocial needs of the patient/family.
3. Collaborates with PCP, patient, and members of the health care team, to assess patient, develop and implement an agreed upon plan.
4. Provides self-management support and empowers the patient to achieve optimal health and independence.
5. Implements evidence-based care, chronic disease protocols and guidelines. Utilizes registry to identify patients with chronic conditions, and a gap in clinical care. Utilizes patient list to ensure overdue tests/labs are completed, monitors individual patient progress and population management.

6. Coordinates patient care by linking patients to resources; including community resources.
7. Provides follow up with patient/family when patient transitions from one setting to another. Completes post hospital discharge calls: Medication reconciliation, PCP or specialist follow up appointment, assesses symptoms, teaches warning signs, coordinates care, reviews discharge instructions, and problem-solves barriers.
8. Demonstrates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills.
9. Participates in continuous quality improvement to enhance care management in the office setting.
10. Maintains required documentation for all care management activities.
11. Works with practice and PO/PHO leadership to continuously evaluate processes, identify problems, and propose/develop process improvement strategies to enhance the Patient Centered Medical Home.
12. Reviews the current literature regarding effective engagement and communication strategies, care management strategies, and behavior change strategies and incorporates into clinical practice.

SKILLS AND ABILITIES:

1. Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
2. Understands chronic disease management strategies and is able to implement appropriate protocols and guidelines.
3. Demonstrates ability to work autonomously and be directly accountable for practice.
4. Demonstrates ability to influence and negotiate individual and group decision-making.
5. Demonstrates ability to function effectively in a fluid, dynamic, and rapidly changing environment.
6. Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization.

Required Qualifications:

- Current Registered Nurse, Nurse Practitioner, Physician Assistant, Licensed Practical Nurse, Master of Social Work, Registered Dietitian, or Pharmacist License
 - Two years of experience with adult medicine and pediatric patients in primary care/ambulatory care, home health agency, skilled nursing facility, or hospital medical-surgical, within the past five years
 - Knowledge of chronic conditions, evidence-based guidelines, prevention, wellness, health risk assessment, and patient education
 - Excellent assessment and triage skills
 - Demonstrates excellent communication-both verbal and written
 - Excellent interpersonal and facilitation skills
 - Ability to affect change, work as a productive and effective team member, to be flexible, and adapt to needs/priorities
 - Time management, priority setting, work delegation and work organization
 - General computer knowledge and capability to use computers

Preferred Qualifications:

Bachelor's degree or higher, in clinical field

Care management experience

Experience as participant in continuous quality improvement

Completion of self-management support training

****Complex and Moderate Risk Care Manager descriptions provided by the Michigan Primary Care Transformation Project**

Job Description: Practice Clinical Care Coordinator (PCCC)

Bachelor's degree in Nursing (BS or BSN)
Certification/Certification eligible in appropriate discipline
RN licensure in the State in good standing
Previous related work experience required

XX organization serves patients and families throughout southwest and south central Michigan. We offer a full range of services from primary care to advanced critical care at more than 60 locations. Locally owned and governed, we are the region's leading healthcare system and one of the area's largest employers. Our physicians and staff are nationally recognized for many exceptional achievements in quality, safety and service.

We believe XX patients deserve the best possible care and we are always working to achieve it. So, whether you enjoy working with patients, or supporting those who do, an exciting career is waiting here for you.

Responsible for navigating patients through transitions of care in the healthcare system, inpatient services to outpatient services to home, based on individual and patient population needs. Serves as a clinical resource to patients, families, and staff in the delivery of care to all patients. Works collaboratively with the interdisciplinary team to provide a continuum of care, that is efficient, cost-effective, minimizes fragmentation, and achieves desired treatment outcomes. Ensures communication between patient/family and all healthcare providers. Bachelor's degree (BSN or BS) and two to five years of experience including clinical nursing experience in an acute care setting; or equivalent combination of education and experience. Master's degree preferred. Licensed as a registered nurse in the state.

Mental & Visual Fatigue: Work which produces high levels of mental/visual fatigue, e.g., interactive and repetitive or small detailed work requiring alertness and concentration for sustained periods of time, the operation of and full attention to a personal computer or CRT between 40 and 70 percent of the time.

Physical Effort: The job produces some physical demands. Typical of jobs that include regular walking standing, stooping, bending, sitting, and some lifting of light weight objects.

Life Support Certification Required: BLS

**PCCC description provided by Bronson Health System

Conducting a card study

The term “card study” came from when primary care researchers would use little index cards to record their observations about patients with certain conditions or characteristics as a way to determine if there was a pattern that might enlighten them. Today, the term should probably be survey study, but the concept is the same. Essentially it refers to tracking something for every eligible patient that comes in. In this case, conducting a card (or survey) study might help to understand your care management needs.

Step 1: Pick out a typical day or half day in your practice.

Step 2: Give a stack of surveys to each clinician in the practice (physician or advanced practice provider) and instruct them on how to use the surveys. See example for care management card study provided.

Step 3: Have each clinician complete a survey or “card” for each consecutive patient for that half or full day (you just need to do it enough to determine if it is representative of the patient issues evident in your practice).

Step 4: At the end of the day (or half-day) examine the responses. What are the most frequent care management needs identified? For what patients?

Reflection:

Having these data will help you and your practice members to determine the most predominant care management needs and for which patients these needs present. Of course, you can get an intuitive sense without doing the card study, but doing something like a card study helps you to determine if your intuition actually plays out with the patterns in real patients.

We found that mental health needs were predominant in our surveyed populations. Perhaps if that is the case for your practice you might want to prioritize having a care manager with a clinical social work background or someone with really good access to mental health resources knowledge. If you have an older population with a lot of care transitions issues, you might want to consider a nurse with experience in home health care or hospital care.

See a sample card on the following page.

Patient Care Needs Card Study

To be completed by provider after each consecutive adult, non-OB patient.

PLACE STICKER HERE
Provider, Patient identifier,
age, gender, insurance
information

1. Reason for visit: (check all that apply)

- ☐ Acute (brief complaint) ☐ Chronic problem
☐ Health maintenance/annual ☐ Other: _____

2. Do you, the provider, have a continuity relationship with this patient (continuity = having seen patient in 2 or more visits **prior** to today's visit)?

- ☐ Yes ☐ No

3. Please select how much you perceive this patient has/does not have **each of the following** needs. Please circle **one number for each need** on the scale from 1= not at all to 5= very much needed.

	Not at all				Very much
A. Mental health services (ex: counseling, psychiatry consultation)	1	2	3	4	5
B. Social support (ex: food, employment, housing, transportation, safety)	1	2	3	4	5
C. Self-management support/behavior change	1	2	3	4	5
D. Care coordination between settings or providers	1	2	3	4	5
E. Medication titration/adjusting/education	1	2	3	4	5
F. Health education (ex: diabetic teaching)	1	2	3	4	5
G. Nutrition counseling	1	2	3	4	5
H. Spiritual support/pastoral care	1	2	3	4	5
I. Health insurance navigation	1	2	3	4	5
J. Dental services	1	2	3	4	5
K. Other: _____	1	2	3	4	5

4. Which care need do you believe is the **TOP priority today** for this patient? Select **ONE choice only**.

TOP priority (circle one): A B C D E F G H I J K or ☐ Patient has no care needs

5. In your opinion, how likely would this patient be to act on a referral to receive services for the top priority you identified in #4?

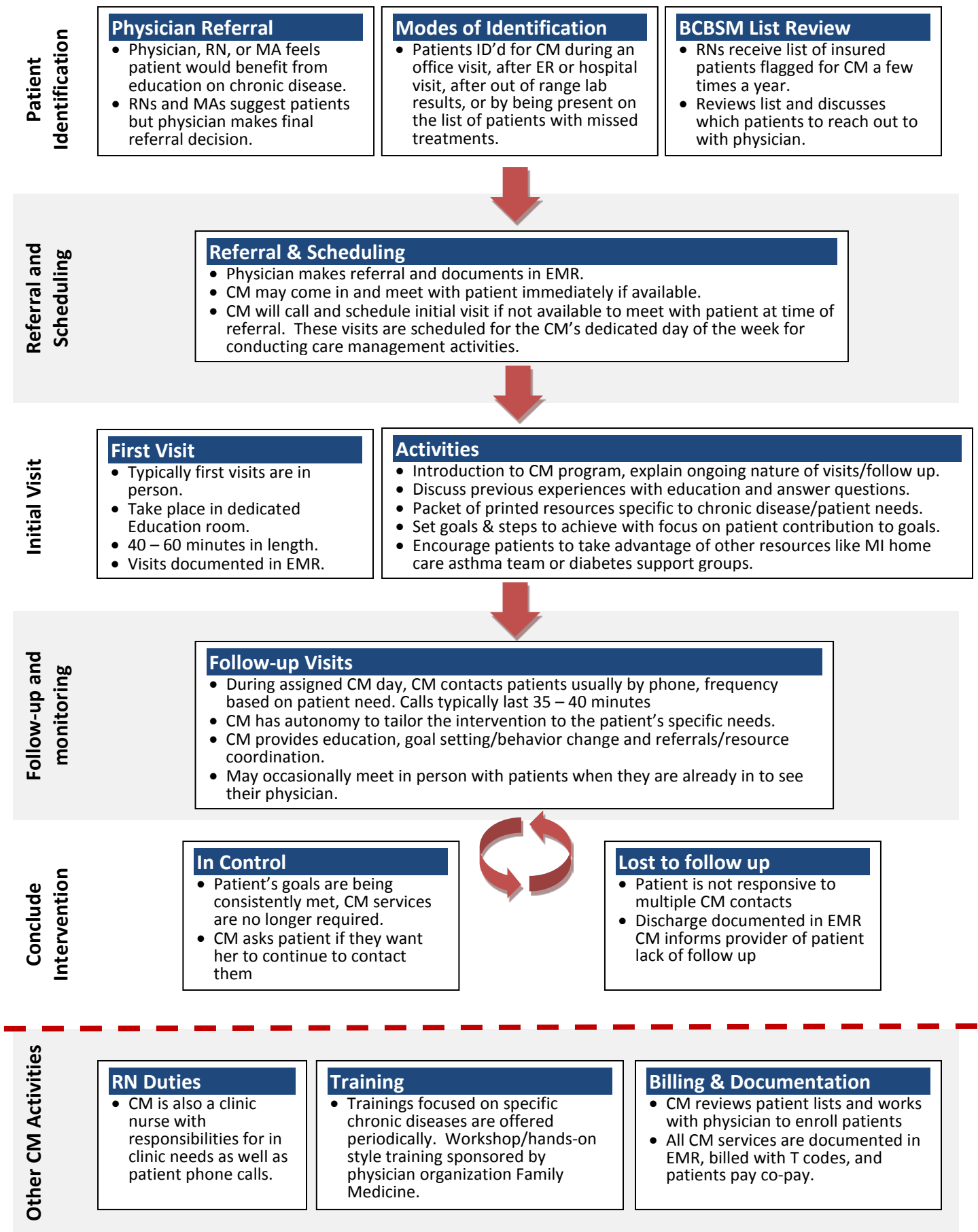
- ☐ Not at all ☐ Somewhat ☐ Very likely ☐ NA – patient has no care needs

6. Optional - Other comments or notes, please share them here.

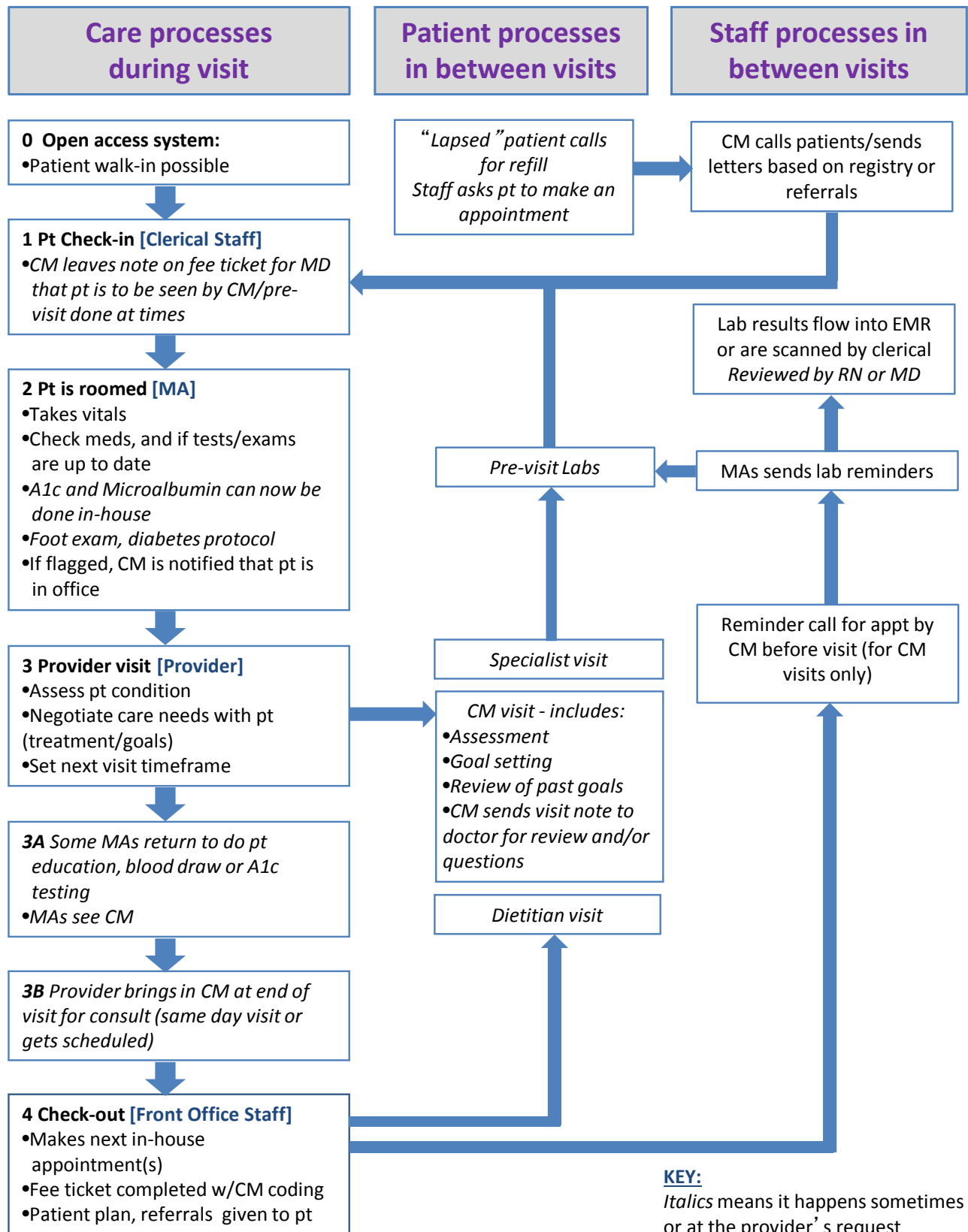
Workflows for care management

The following three pages contain sample workflows.

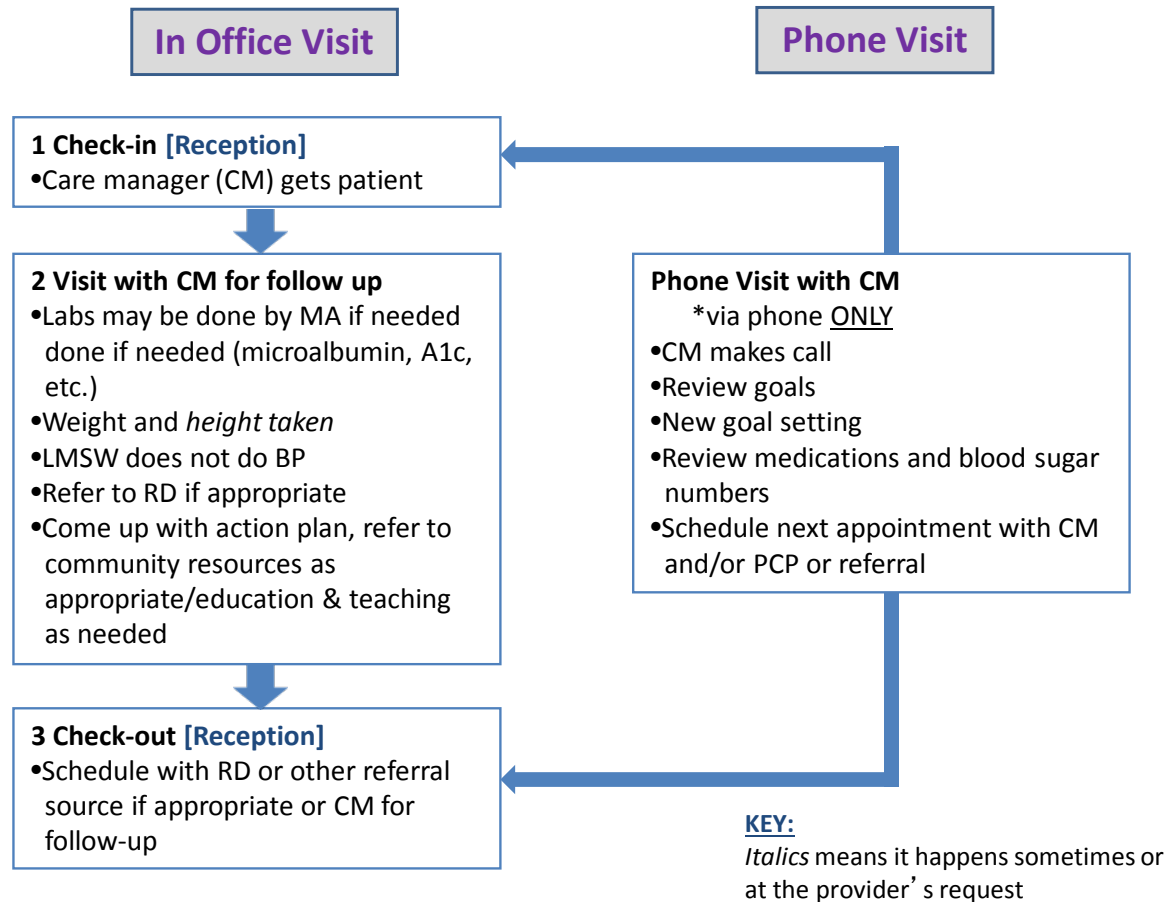
CARE MANAGEMENT (CM) PROCESS OVERVIEW



Care Management Task Diagram (Diabetes care)



Patient Pathway for PCV - EI [Practice 11]



Qualitative Changes:

- Many labs are completed in house making it easier to identify patients at risk (i.e. borderline diabetes) so the referral can be made on site.
- There have been 2 intakes completed over the phone secondary to patient challenges getting in the office (bedbound patient).
- Both CMs are working together to pre-identify potential patients (using Registry).
- CM's had a process for referral that worked, but because of the training needed for the new management team this process has been put on hold.
- Some providers feel that approach during their visits is very different. Now the CM and MA work together to help each patient get individualized care so the provider visits can be more focused.
- CM does reminder calls on Monday and Thursday for patients with upcoming CM appointments.
- Some patients get weekly calls if they are not making progress.