



## IssueBrief

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### Care Coordination:

# Case managers “connect the dots” in new delivery models

WELL BEFORE HEALTH REFORM WAS SIGNED INTO LAW, new models for health care delivery moved from the drawing board to the field for testing and evaluation. The impetus behind this transformation was the recognition that patients—particularly those with complex medical needs—routinely experience poor outcomes because care is not coordinated across multiple sites and providers.

The issue gained national attention in 2001 with the Institute of Medicine’s groundbreaking report, “Crossing the Quality Chasm: A New Health System for the 21st Century.” It pointed to the systemic problems in health care that lead to poor outcomes: uncoordinated organization within the delivery system; fragmentation in care delivery that slows care and removes a sense of personal accountability; poor communication and use of information technology; and failure for all health professions to work together to ensure that care is appropriate, timely, and safe.<sup>1</sup>

“Crossing the Quality Chasm” spoke broadly of how the health care system can be reinvented to foster innovation and improve the delivery of care. Over the past decade, two models of care delivery—the patient centered medical home (PCMH) and accountable care organizations (ACOs)—have emerged as promising mechanisms to eliminate

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SOURCE: Key Finding from 2009 CCMC Role & Functions Survey.

# Definitions of Care Coordination

Definitions of care coordination vary broadly. After an intensive literature search, the Agency for Healthcare Research and Quality defined care coordination in 2007 as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.”<sup>2</sup>

For the purposes of quality measurement, the National Quality Forum defined care coordination in 2006 as “a function that helps ensure the patient’s needs and preferences for health services and information sharing across people, functions, and sites over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved health care outcomes.”<sup>3</sup>

fragmentation and “connect the dots” through a common structural element: care coordination. Central to both models is a drive to break down the “silos of care” that for generations have defined the fragmentation in health care and increased the potential for errors.

Care coordination often falls within the domain of the case manager; in fact, it is among the essential activity and knowledge domains identified by the Commission for Case Manager Certification (CCMC). In the fall of 2009, CCMC surveyed nearly 30,000 case managers and analyzed the results from 6,909 completed surveys to create a detailed profile of the role of case managers today and the functions they perform across care settings. Although the survey is primarily designed to inform CCMC’s certification examination process, it also offers a look into current trends in case management, the skill set used in the field and the knowledge necessary to operate in today’s rapidly changing environment.

One key finding of the survey is that, as complexity of care increases, and the demand for accountability grows within new models of care, the role of the case manager is increasing in importance. The case manager has a key role to play in coordinating a spectrum of care through patient transitions and across multiple practitioners and care settings. Technology is rapidly evolving, and accurate communication between providers through technology is becoming more important. The case manager

offers a link and oversight on the complexity across settings and providers, the technology, and the increased need for accurate communication. These trends suggest that more case managers will be in demand as these models mature and extend their reach.

Confirmation that these models are entering the mainstream is found in the recently passed Patient Protection and Affordable Care Act. The Act directs the Secretary of Health and Human Services to establish a grant program for community-based interdisciplinary, inter-professional teams to support primary care practices, and to support patient centered medical homes. The Act also creates a shared savings program that would reward ACOs for taking responsibility for the costs and quality of care for patients. The bill requires ACOs to define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other enabling technologies.

Even before passage of health care reform, the PCMH gained traction in key announcements on the national level. In September 2009, U.S. Health and Human Services Secretary Kathleen Sebelius announced funding for state-based, multi-payer primary care PCMH demonstration programs. In the same month, the Department of Defense issued a policy “requiring implementation of the PCMH as a comprehensive primary care model to improve patient satisfaction and outcomes”

for all members of the military's health care system.<sup>4</sup> And in December 2009, the federal government committed funding for patient-centered medical home practice redesign in community health centers.<sup>5</sup>

## Two different approaches for transformed care delivery

Although both the PCMH and ACOs share care coordination as a key structural pillar for success, the models are differently targeted. In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, together representing about one-third of U.S. physicians, agreed on a set of Joint Principles of the Patient-Centered Medical Home.<sup>6</sup> The document defines the PCMH as "an approach to providing comprehensive primary care for children, youth and adults...a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." The PCMH is *oriented towards individual physician practices* that seek to change payment mechanisms for providing primary care to include vital services such as care coordination, the use of health information technology, enhanced access to care using email, texting, online chat and telephone messaging, and a team approach to care.

An ACO is a local health care organization and a related set of providers (such as primary care physicians, specialists, and



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—KEY FINDING FROM CCMC'S 2009 ROLE & FUNCTIONS SURVEY

hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.<sup>7</sup> The ACO can be a single, wholly owned organization or may be independent providers integrated by contract and the shared goal to deliver coordinated and efficient care. The ACO holds itself to measurable quality standards and, in return, its providers are reimbursed for discrete services they provide; they also share in any

savings resulting from improved coordination of care and better patient outcomes.<sup>8</sup> The ACO is an *integrated provider approach* to more efficient, effective care delivery.

The PCMH is targeted at primary care practices, while the ACO includes health care services across the continuum, including primary care, specialty care, long term care and acute care.

Because the PCMH uses many of the same approaches as the ACO to achieve patient-centered care, some ACOs employ the PCMH model in their primary care practices, and as part of the overarching system that also includes specialists, hospitals, and other ambulatory care settings.

## Geisinger: A model medical home within an ACO

One ACO using the PCMH in primary care and to great success is the Geisinger Health Plan. The Pennsylvania-based plan includes nearly 90 hospitals (two wholly owned by Geisinger) and some 17,000 providers serving about 245,000 members. Geisinger directly employs 750 physicians practicing in more than 37 sites.

Although Geisinger employed both disease management and case management since the mid-1990s in defined chronic disease management programs, it began a new medical home program in late 2006 designed specifically to serve targeted patients in its Medicare Advantage program. The project initially focused on two large clinics, with a goal to reduce the health risks of complex patients identified through predictive modeling tools and hospitalizations.

"The problem of fragmentation of care and the activity in the marketplace around transitions in care turned out to be a whole new opportunity for us," said Janet Tomcavage, RN, MSN, vice president of health services for Geisinger Health Plan. "After only six months we were able to see a reduction in overall hospital admissions around heart failure, pneumonia, COPD and the frail elderly, and the program demonstrated a 20 percent reduction in hospital readmissions."

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Geisinger has enlarged the program, called the ProvenHealth Navigator<sup>SM</sup>, and now uses 61 "embedded case managers" at 37 practice sites to coordinate care for some 40,000 Medicare lives and 25,000 commercial members. The

nurse case managers work as part of the primary care health team, embedded in the clinic setting. Although they are employed by the health plan, they work in partnership with the community-based practices, managing a total Medicare Advantage population of approximately 800 by focusing on a maximum of 150 patients with complex health care needs.

"In the past we had case managers who took up space, often at the back of the clinic, and they may or may not have managed patients in that particular clinic," Tomcavage said. "In the medical home model, the case manager is geographically mixed with the clinicians, right there in the flow of the practice and patient flow. They really work as an extension of the physician practice, but they have the knowledge of the health plan. It's a model that is strong clinically, with a robust population management focus. And I think they are one of the keys to success for the medical home."

The Geisinger medical home program has been widely lauded as a model for similarly positioned health plans to drive quality, enhance member experience and save costs. Since so much of the program's success is based on the work of high-quality



professionals in case management, Tomcavage said the screening process for bringing in case managers to function in this new model of care focuses on the right mix of skills and abilities.

“There’s a science and art to case management,” she said. “You need a good clinical skill set, but also good decision making and strong critical thinking skills. The art of case management is forging that relationship with the provider team. If the clinician can’t connect with the provider and the patient as part of the team, they will fail. I have seen smart, clinically savvy nurses who can’t function in a case management role because they don’t have the art of engagement and activation.”

Geisinger Health System has an endowment fund that reimburses nurses for the cost of continuing education and testing for case management certification. The health plan also provides its own continuing education programs that support case management certification. Most of Geisinger’s embedded case managers hold a bachelor’s degree and, if they are not already certified case managers, they agree upon hiring that they will work towards getting the credential. Tomcavage said that, as the medical home program has grown, she has seen an increase in interest among the younger Geisinger nurses to seek case management certification.

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said. “We are continuing to see at least a 15 to 20 percent reduction in hospital readmission in every phase for the full practice—not just for the patients in case management. We want to be able to say that, by managing a small percentage of the Medicare population in a practice, case management can drive medical expenses down for the whole population at that practice. We have to be able to take the current dollars in the system and get more for it.”

### **Care coordination positioned as a function, not a role**

Across the continent, Qualis Health is also testing new health care delivery models. Qualis Health is the nonprofit organization that serves as the Quality Improvement Organization (QIO) designated by the Centers for Medicare & Medicaid Services to serve Idaho and Washington. It also works with health care organizations to improve the health of individuals and populations as a consultant in utilization management, care coordination, clinical quality improvement and health information technology and operations improvement. For a number of years, Qualis Health has based its quality improvement efforts on

key elements of the Chronic Care Model, which was developed by Ed Wagner, MD, MPH, director of the MacColl Institute for Health-care Innovation, with support from The Robert Wood Johnson Foundation. The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care as the community, the health system, self-management support, delivery system design, decision support and clinical information systems.

In partnership with the Commonwealth Fund and the MacColl Institute, Qualis Health launched an initiative in April 2009 to assist primary care safety net clinics become NCQA-recognized patient centered medical homes. The Safety Net Medical Home Initiative is assisting more than a dozen clinics across five regions, providing technical support and assistance to become medical homes.

The initiative includes care coordination as an essential element, but each location will interpret the NCQA standards in its own way. Much depends on the payment model adopted in each region, and whether case management will be reimbursed as its own



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function under the local model. Without reimbursement specifically tied to care coordination, it is difficult for clinical practices to invest in a dedicated case manager position.

“There’s a lot of synergy between the PCMH and the Chronic Care Model,” said Michael B. Garrett, MS, CCM, vice president of business development for Qualis Health and past CCMC commissioner. “The philosophy within that model is that care coordination is not necessarily a person; rather, it’s a function.

Garrett, a certified case manager who started his career in workers compensation case management, said there is “enormous opportunity to increase knowledge and awareness to create competency in case management.”

“For this new decade, the emphasis for case management will likely be in the ambulatory care setting—in physician practices, integrated delivery systems and ambulatory care centers,” he said. “The PCMH and Chronic Care Model are targeted at primary care practices and require the incorporation of care coordination in order to be successful. In many instances, case management is just being called by other terms, such as Guided Care,<sup>9</sup> nurse navigators, or health coaches.”

“Calling it something other than case management is both an opportunity and threat,” he noted. Garrett identified a “blurring of terms” within the new models of care that may expand the role of case managers significantly, or

may open the door for unlicensed lay people—or even technology—to fulfill loosely defined care coordination functions within the new models.

In his role in business development for Qualis Health, a number of project proposals pass across Garrett’s desk each year. “There are more opportunities for care coordination out there, but it’s not clear they want licensed and certified case managers providing these services,” he said. “In the last few years, when people talk about care coordination, sometimes they mean a functionality of an electronic medical records system to transmit essential information to the right person at the right time.”

Garrett recommends that case managers keep abreast of the rapidly changing landscape and take a leadership role in the development of new care models. To do that, case managers should:

- Become knowledgeable about the new delivery models;
- Become familiar with new forms of reimbursement for these new models of delivery (e.g., pay-for-performance and value-based purchasing);
- Become familiar with their organizations’ clinical and financial goals as they relate to these delivery models. For example, is the organization trying to increase immunization or mammography rates, or decrease hospital readmission rates? How can the case manager help operationalize those goals (e.g., incorporation of those clinical guidelines into

the case management care plan)?

- Consider how they can participate in and contribute to the operations of their organizations. How can they become a part of these models and help achieve these goals?
- Find ways to demonstrate how they bring value to the organization or program.

“The challenge for health care organizations in implementation of these new care delivery models is who they will select to provide care coordination (e.g., unlicensed personnel, registered nurses, social workers) and how they will educate, train and develop those care coordinators to fulfill all of the corresponding roles and functions,” Garrett said.

## CCMC certification follows roles and functions

As the terms around care coordination blur within these new models of care, the work of CCMC to promote the professional practice of case management through certification has never been more important. Care coordination, an essential activity of the case manager, must follow professional practice standards in order to advocate for the patient, ensure patient safety and generate value for the organization. The CCMC Role & Functions Survey plays a significant part in following case manager activity across practice settings, informing the CCMC® credentialing process and aligning case management practice to the highest ethical standards and behavior in the field.

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## ENDNOTES

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## About the Experts



**Janet Tomcavage, RN, MSN**, is vice president of Health Services for Geisinger Health Plan in Danville, Pennsylvania. She has worked for more than 20 years in disease management and other health management areas. Most recently her work

has focused on the development and implementation of enhanced medical management strategies including medical home, disease management and case management interventions that optimize quality and efficiency outcomes.

Tomcavage earned her bachelor of science in nursing from Bloomsburg State University and her master of science in nursing from College Misericordia. She has held certifications as a certified diabetes educator and advanced practice for diabetes management. She has co-authored several articles on diabetes management and disease management and has lectured nationally on diabetes management, disease and case management, medical home, and other medical management strategies.



**Michael B. Garrett, MS, CCM**, is vice president of business development for Qualis Health, an independent, private, nonprofit health care quality improvement organization headquartered in Seattle, Washington. He has worked for Qualis Health

for 20 years in a variety of development, operational and strategic positions. Garrett has published numerous journal articles on various aspects of care management, and has spoken at national and regional conferences. He has written and edited four books in the field of case and care management. He recently authored two chapters of the book published by the Case Management Society of America, *CMSA's Core Curriculum for Case Management, 2nd Edition*.

Garrett holds a bachelor's degree in psychology from Gonzaga University and a master's degree in clinical psychology from the University of Idaho. He is a certified case manager, registered mental health counselor, certified vocational evaluator and a nationally certified psychologist. He is a member of the Clinical Accreditation Committee of URAC, a commissioner with the Commission for Case Manager Certification, a member of the Case Management Society of America's Task Force for the Revision of the Scope of Practice for Case Management and a member of the Editorial Board of Lippincott's Journal *Professional Case Management, the Official Journal of the Case Management Society of America* and is a member of a number of professional associations, including the National Association for Healthcare Quality.



The Pathway to Certification is CCMC

Commission for Case Manager Certification  
15000 Commerce Parkway, Suite C ■ Mount Laurel, NJ 08054  
(856) 380-6836

[www.ccmcertification.org](http://www.ccmcertification.org)