



IssueBrief

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Renewed emphasis on team-based, coordinated care places the professional case manager center stage

The quality, efficiency and cost-effectiveness of U.S. health care delivery now stand in the spotlight. It's an old story, but one that has received renewed attention over the last decade. The actors, while familiar, are taking on new and expanded roles. In particular, the professional case manager, as care coordinator, team facilitator and client advocate, is taking center stage.

Professional case managers have been and continue to be clinical partners in the delivery of health care. They are uniquely suited to support care coordination, whether the setting is a hospital, a rehabilitation center, an accountable care organization, a patient-centered medical home or any other health care organization or facility.

Coordinated, team-based care remains at the heart of quality care, in models old and new. It offers one remedy to our ailing health care system, and the board-certified case manager brings the education, skills and talent to deliver it.

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In the primary care context, the Agency for Healthcare Research and Quality (AHRQ) has identified six functions of care coordination, explained David Meyers, MD, director of the AHRQ Center for Primary Care, Prevention, and Clinical Partnerships.

1. Determine and update care coordination needs
2. Create and update a proactive plan of care
3. Communicate: Between health care professionals & patients/family
 - Within teams of health care professionals
 - Across health care teams or settings
4. Facilitate transitions
5. Connect with community resources
6. Align resources with population needs¹

Case managers, functioning as care coordinators, can perform these functions, he said. The case manager forges connections between the patient and the health care system. He or she can improve coordination among its various settings, including ambulatory care, subspecialty care, hospitals, hospice, acute care, pharmacy, etc.—as well as in the workplace and schools.

¹Meyers, D., et al. "The Roles of Patient-Centered Medical Homes And Accountable Care Organizations in Coordinating Patient Care," Agency for Healthcare Research and Quality; www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483.

Everything old is new again

Case managers have been part of the care-delivery ensemble for years, but—as with care coordination generally—recently the spotlight has turned on both, said Annette C. Watson, RN-BC, CCM, MBA, founder and principal, Watson International Consulting; senior vice president, Community Transformation Department, Taconic IPA in Fishkill, N.Y.; and immediate past-chair of the Commission for Case Manager Certification.

Those who perform case management often hold various titles; among them, navigator, care coordinator and discharge planner. They may come from such diverse backgrounds as rehabilitation counseling, occupational therapy, workers' compensation and nursing.

But the essential functions of case management—assessment,

planning, coordinating, monitoring and evaluation—should always be the same if what they do is really case management, said Watson.

Meyers remarked on this juxtaposition of the new (case managers in the medical home and accountable care models) with the old. "People have been performing case management functions for the last 30 years." The expertise and knowledge they have acquired is invaluable. "They can take the learning and experience to the field," he said. With the medical home and ACO gaining traction, there's "a lot of opportunity" for case managers to make a difference in these new models of care.

The new era brings new expectations for quality improvement and efficiency. So while much of the cast remains the same, the role of the case manager is expanding. The script is now wholly revised, cast and crew are better prepared, and the professional case manager is the rising new star.

Connecting the team

Care coordination is essential to ensuring patients receive the care and treatment they need in this increasingly complex and fragmented health care system. An equally important consideration is to whom the other members of the health care team turn to provide it. Case managers are uniquely positioned to coordinate care, particularly with regard to assessment; facilitation of communication among all stakeholders, including providers, payers, the person receiving services and his or her support system; monitoring and

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evaluation; and developing and updating the care plan.

The medical home provides an example: It may include nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioralists, social workers, case managers and others. The board-certified case manager can take the lead in working with the client to define care needs and to develop and update a care plan. This approach achieves both optimum value and more desirable outcomes for all—clients, their support systems, the providers and the payers.

As the complexity of care increases and the demand for accountability grows, we're seeing increased interest in care coordination, said Janice L. Genevro, Ph.D., lead, primary care implementation team, AHRQ's Center for Primary Care, Prevention, and Clinical Partnerships.

In both the PCMH and the ACO, care coordination is a core element. "Anyone who has received care from more than one provider, even just going to a pharmacy to get a prescription filled, knows that although we expect providers to talk to each other, they often don't. Information is not shared and that can create problems," Genevro said.

In our fragmented system, patients often don't know what they don't know, she added. They don't know what information to convey to their various providers. They may not understand drug interactions, and they may not realize the need for



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follow up. For a range of reasons, patients often don't get the information they need.

A survey published in the *Archives of Internal Medicine* highlights the communication gap between doctors and patients. In interviews with patients on the day of their discharge, researchers found only 18 percent knew the name of the physician in charge of their hospital care. Perhaps more telling, 77 percent of physicians believed patients knew their diagnosis, but only 57 percent of patients actually knew at discharge.²

Part of the challenge for patients is that they don't realize information is not shared among their providers,

² "Communication Discrepancies Between Physicians and Hospitalized Patients." Douglas P. Olson, MD; Donna M. Windish, MD, MPH. *Arch Intern Med.* 2010;170(15):1302-1307 (<http://archinte.ama-assn.org/cgi/content/abstract/170/15/1302>).

and they don't know who is ultimately accountable. Having one person in the role of care coordinator makes sense for the patient and the team, Genevro explained. "Everyone knows who's responsible for sharing the information. There's value in having information shared at the right time, knowing who is accountable."

As a care coordinator, the case manager plays a primary role in the team approach. "This is my personal perspective: There is nothing more important than care coordination in team-based care," Genevro said.

Professional case managers are trained to facilitate communication among care settings and providers, ensure medication reconciliation from one setting to the next and educate patients and their support systems on improving self-care and adherence to the care plan.

“Professional case management is more important than ever today because of the complexities encountered in trying to navigate fragmented systems,” noted Watson.

Advocate, interpreter

Most professional case managers say that client (patient) advocacy is one of the most important things they do. It dovetails into the care coordination role; after all, the team approach is all about providing coordinated, patient-centered care to improve outcomes.

Such advocacy demands multiple conversations with all the team members—not merely the patient, Watson explained. The professional case manager engages the entire

team: He or she will collaborate with physicians about each patient’s needs, connect the recommendations with the physicians’ orders, interact with specialists and, most important, make sure it’s all communicated to the patient in an environment of trust and transparency.

Case managers facilitate communication among all the team members, and they do so in all directions. Physicians, nutritionists, pharmacists, patients, etc. may speak different languages—both literally and figuratively. The professional case manager functions as an interpreter and a diplomat, speaking the diverse “languages,” and understanding those different “cultures.”

Treatment professionals tend to speak in terms of compliance and adherence, and patients are commonly described as “non-compliant or non-adherent,” Watson explained. But perhaps something else is creating a disconnect. Another function of the case manager is to identify the barriers patients face, help them understand the need to follow the care plan, and develop strategies to effect change. Maybe it’s a misunderstanding of terms or urgency. Maybe there are side effects the patient hasn’t mentioned. Maybe finances are tight. Maybe they have other issues. The case manager becomes the investigator and helps the team find solutions.

These are skills born of experience and education, and require the deft touch of the professional case manager, who must inspire trust and confidence. “Developing trusting relationships is essential to successful care coordination,” Genevro explained.

Physicians are increasingly embracing a team-based approach, she said. They realize that the full range of services patients need often exceed what physicians can provide by themselves, and they recognize the team approach as a way to ensure patients receive comprehensive care. Helping maximize the contributions other people on the team can make to the care of patients reduces the burden on the lead clinician, especially in the medical home, she added.

Likewise, policymakers and payers recognize the value of team-based care. But, Genevro

The case for case managers as care coordinators

Care coordination efforts led by case managers make a difference in patient outcomes.

Geisinger’s ProvenHealth Navigator (PHN) offers just one of many examples. The multidimensional medical home model resulted in significantly fewer hospital admissions (18 percent) and readmissions (36 percent) when measured across the entire population. Total care costs for the entire PHN population decreased 7 percent, but this decrease did not achieve statistical significance. “Our findings, coupled with qualitative observations, however, highlight the importance of placing nurse case managers directly into the practices and arming them with data and analytical capabilities.”⁴ For additional examples, see *Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States* at www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf.

⁴ Richard J. Gilfillan, Janet Tomcavage, et al. “Value and the Medical Home: Effects of Transformed Primary Care.” *Am J Manag Care*. 2010;16(8): 607-614 (www.ajmc.com/media/pdf/AJMC_10augGilfillan607to614.pdf).

cautioned, metrics to measure it in concrete terms aren't in place yet. "We don't have well-established measures of team-based care to demonstrate effectiveness. Of real interest is developing measures that teams can use themselves to understand how well they are working together." The goal, she said, is to develop those measures to use in research and evaluation, and demonstrate that high-quality team functioning relates to processes and clinical outcomes.

Multiple settings, multiple professions

It's not a role just anyone can take on, Watson warned. "Knowledge areas fundamental to professional case management are not always simple for others to understand."

And yet, she added, the label of "case manager" may be attached to an individual who lacks the necessary skills and training. The professional case manager is clinically based, independent, makes assessments and holds a professional license. Not every case manager is a professional case manager. However, all board-certified case managers are professional case managers.

"Today, case managers work in a variety of settings and may have one of several licensures. But whether it's a social worker in a human services setting or a registered nurse working in a health care organization, client advocacy resonates as the cross-cutting, essential element of case management," Watson noted. Professional case managers share

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many common skills and talents. "There are certain functional capabilities all coordinators must have" regardless of their discipline, Genevra said. Among them:

- Relate well to a variety of people
- Communicate well
- Be flexible
- Be knowledgeable
- Be respectful of cultural differences
- Respect the contributions of others

"Those functional capabilities are often associated with nurses and social workers in their professional capabilities. They are a very natural extension of their professional orientation," she said.

The expertise nurses and social workers bring equips them well. Being a case manager in the team environment is not a role one can step into unprepared. "Clinical preparation and advanced training are very important to preparing a professional to work in a

team-based care environment," she added. "To have had mentored clinical preparation is a huge advantage in being able to respond effectively and appropriately."

Why it matters

With this greater emphasis on and need for care coordination, health care organizations should look to case managers—and, in particular, board-certified case managers—to fulfill this function. Case managers can provide oversight and coordination across settings and providers, which is essential to managing transitions of care.

As reform continues to unfold, health care systems and facilities must ask themselves: *Who is performing those functions?* To have the best possible outcomes, those systems and facilities need highly qualified individuals performing those activities that constitute effective care coordination.

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professional experience to provide the right services to patients across the continuum of care,” Watson explained. “The American Board of Medical Specialties has identified many studies³ that demonstrate board-certified physicians deliver higher quality care and better outcomes than physicians who are not board-certified. Although there has been little research about this in other professional disciplines, we view board certification of case managers similarly to that of physicians and are committed to advancing the profession of case management through evidence-based practice and workforce development.”

Dynamic concepts firmly rooted in evidence

Although we know the fundamentals of the plot, the ending is yet unwritten. New models will emerge and be tested, and the case manager may find herself playing new roles.

Innovation must continue, Meyers said. During the transformation

³ Recent Research Highlights, American Board of Medical Specialties (www.certificationmatters.org/research-supports-benefits-of-board-certification/recent-research-highlights.aspx).

process, nothing should be carved in stone. “We need more innovations and more evaluations of those innovations.”

Watson offered a similar perspective: Transformation must be guided by evidence. Although the fundamentals of case management have remained consistent through the years, the settings, needs and evidence have evolved. With passage of the Affordable Care Act, it’s a brand-new scene.

Through its recurring Role & Function Survey and its newly released (and constantly updated) Case Management Body of Knowledge™ (CMBOK™), the Commission is able to embrace innovations in health care delivery and clinical knowledge—and reject those aspects that are not transformative.

The profession of case management must be nimble if it is to remain at the forefront of delivery system transformation. And that, Watson said, is why the Commission’s role in advancing the profession is so essential.

The need for such leadership will only grow: “Given the aging population, the cultural and linguistic

barriers to clear understanding of health care, social services, workers’ compensation and other insurance matters, it is likely many of us will need case managers in the future, for ourselves or a family member,” she said.

“I want to know that person is qualified for this role and the responsibilities case management entails. I want a board-certified case manager as part of the team that cares for me—or the one I love.”

To learn more about the role and functions of the professional or board-certified case manager in new models of care, read the issue brief, “Care Coordination: Case managers ‘connect the dots’ in new delivery models,” at www.ccmcertification.org/pdfs/Care_Coordination-Case_Managers_Connect_the_Dots_in_New_Delivery_Models.pdf

For more on team-based care, visit www.ccmcertification.org/pdfs/issuebrief_2_3_case_management.pdf

To learn more about the CM Body of Knowledge go to www.cmbodyofknowledge.com

Knowledge Framework, Body of Knowledge, advance the profession of case management

The Commission for Case Manager Certification's recently launched Case Management Body of Knowledge™ (CMBOK™, available at www.cmbodyofknowledge.com) is the first comprehensive, Web-based, peer-reviewed, online case management knowledge resource. This online educational tool offers the foundational knowledge a professional case manager must possess to work independently and effectively. The CMBOK was written by leading experts in the field and addresses both the science and art of case management. The CMBOK is built on the Case Management Knowledge Framework, which represents years of research, coupled with hands-on knowledge gathered through the Commission's experience with the CCM® examination.

It reflects what professional case managers know *and* what they do, covering both practice and policy.

CMBOK's launch comes in the wake of several federal initiatives endorsing the

critical role care coordination plays in new models of care. Case management plays a crucial role in realizing the goals of each of these initiatives; it is a tool to both improve patient care and lower costs.

The Framework comprises seven essential domains of case management knowledge and practice, which are illustrated below. Under those seven there are 38 subdomains, more than 350 specific topics and nine major phases in an overall Case Management Process. Those phases through which case managers provide care to their clients are as follows:

- Screening
- Assessing
- Stratifying risk
- Planning
- Implementing (care coordination)
- Following up
- Transitioning (transitional care)
- Communicating post transition
- Evaluating

The overall process is iterative and cyclical; the phases are revisited as necessary until the desired outcomes are achieved and the client's interests are met.

The Case Management Knowledge Framework is an important contribution to the health care policy community, offering a detailed and structured description of the process, interwoven with the foundational knowledge domains of case management.

It represents, the Commission believes, the first step in addressing the widespread lack of understanding among lawmakers, policymakers and regulators about case management. They *want* to learn more; what they lack is resources. The Case Management Knowledge Framework begins to address this, giving the Commission a seat at the table where it can help shape the future of health care delivery.

(For details on the Framework and the CMBOK see "Current, evolving and always available: The Case Management Body of Knowledge," available at www.ccmcertification.org/pdfs/issuebrief_2_1__current_evolution.pdf.)



About the Experts



David Meyers, MD, is director of AHRQ's Center for Primary Care, Prevention and Clinical Partnerships. He has served in that role since February 2008. Prior to this appointment, he helped to direct the center's Practice-Based Research Network initiatives, served as a medical officer for the U.S. Preventive Services Task Force and as a project officer for the Health Information Technology Portfolio, and in 2007 served as the center's acting director. Before joining AHRQ in 2004, he practiced family medicine, including maternity care, in a community health center in southeast Washington, D.C., and directed the Georgetown University Department of Family Medicine's practice-based research network, CAPRICORN. He is a graduate of the University of Pennsylvania School of Medicine and completed a family practice residency at Providence Hospital/Georgetown University. After residency, he completed fellowship training in primary care health policy and research in the Department of Family Medicine at Georgetown University.



Janice L. Genevro, Ph.D., M.S.W., is senior dissemination and implementation scientist and is a member of the Prevention/Care Management Portfolio at AHRQ's Center for Primary Care, Prevention, and Clinical Partnerships. She provides dissemination and implementation support to the U.S. Preventive Services Task Force and works to improve health and health care through the transformation of primary care services. A psychologist who

specializes in the translation of health services research into effective practice, she earned a doctoral degree in health psychology from the University of California, San Francisco. As a post-doctoral fellow at the National Institute of Child Health and Human Development, she conducted research at the intersection of child development and health. She has served as a faculty member and staff researcher at the Johns Hopkins Bloomberg School of Public Health, working with other faculty and staff to evaluate programs designed to improve primary care pediatrics through the integration of child development services into routine care. She currently serves as a member of the Institutional Review Board of the National Human Genome Research Institute, National Institutes of Health.



Annette C. Watson, RN-BC, CCM, MBA, is the Commission's immediate past-chair and serves as senior vice president, Community Transformation for Taconic IPA, a 4,000-member strong physician association optimizing the quality and value of medical services in New York's Hudson Valley region. She is also founder and principal of Watson International Consulting. Previously, she served as managing director of global emerging business for CARF International, and before that as senior vice president at URAC. Watson has served as a Commissioner since 2007. She is a long-term member of the Case Management Society of America and was a founding member of the New England chapter.

Join our community of professional case managers!



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