Designing the Role of the Embedded Care Manager

By Patricia Hines, Ph.D., RN and Marge Mercury, RN, MS, CMCE

The Embedded Care Manager
The use of an Embedded Care Manager (“ECM”) to coordinate services within the complex healthcare delivery system is sharply increasing. Health systems and health plans embarking on clinical integration or targeting improvements in disease specific health outcomes see care management as a critical capability. Historically, the functions and responsibilities of a care manager have been as unique as the organizations that employ them (see Figure 1). However, there have been overlaps or redundancies with the roles and responsibilities of the care manager and the patients they serve. As a result, patients experience confusion around who is the primary care manager responsible for guiding their care. The ECM serves as a central point of contact, thereby eliminating redundancy. The primary goal of an ECM is to effectively manage patients at high risk for healthcare complications and improve their quality of life. It is anticipated that ECM interventions will subsequently prevent unnecessary admissions, readmissions, and over-utilization in a healthcare system, putting into practice the Institute of Healthcare Improvement’s Triple Aim™ of better care, better health, and lower costs.

Care management is defined as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocating for options and services to meet an individual’s health needs through communication and available resources to promote quality cost effective outcomes.” Over the years, emphasis around disease management, population management, and complex care management have emerged. Fundamentally, the same tools and techniques employed by care management are utilized for these programs. Disease management focuses on specific diseases, population management focuses on large populations of patients that are stratified by risk, and care management approaches are developed for each subgroup.

Typical Care Manager Functions and Responsibilities

<table>
<thead>
<tr>
<th>Health Plan Care Manager</th>
<th>Hospital Care Manager</th>
<th>Primary Care Provider or Office Based Care Manager</th>
<th>Employer Health Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiates case rates for non-participating healthcare provider services</td>
<td>Conducts concurrent admission review using Interqual or M&amp;R criteria</td>
<td>Verifies coverage and benefits with insurers</td>
<td>Verifies the medical reasons for employee absences</td>
</tr>
<tr>
<td>Recommends and approves coverage exceptions when appropriate</td>
<td>Promotes effective and efficient utilization of clinical services</td>
<td>Coordinates home services at point of hospital discharge</td>
<td>Conducts follow up with employees with work absences due to poor health</td>
</tr>
<tr>
<td>Coordinates referrals to specialists</td>
<td>Serves as a patient advocate; performs patient education</td>
<td>Provides Patient Education</td>
<td>Provides work safety and health education</td>
</tr>
<tr>
<td>Arranges for healthcare</td>
<td>Completes an</td>
<td>Provides post-care</td>
<td>Assists employees</td>
</tr>
</tbody>
</table>
Examples of ECM Programs
Aetna health plan piloted an ECM program in 2007 at 36 primary care practices. The concept of health plan-sponsored ECMs at that time was revolutionary. Instead of health plan care managers communicating with physicians and patients by telephone, the health plan care manager was embedded in the physician offices, providing face-to-face interaction with the staff and patients. The patient management team included RNs, social workers, and/or behavioral health specialists. The model provided for more collaboration with the primary care providers: care managers developed care plans, monitored the ongoing symptoms of their patients, and coached them to self-manage their conditions. Through focused oversight, an ECM can enhance continuity of care, which ensures that patients are receiving the necessary testing and procedures. Their efforts result in improved health outcomes, reduction or avoidance of complications, and unnecessary hospitalizations.

Since Aetna introduced the concept of an embedded care manager, other organizations have followed suit, and experienced similar success. In 2008, Geisinger Health System of Danville, Pennsylvania placed their first ECM program in primary care practices. Since launching their program, “ProvenHealth Navigator,” avoidable hospital readmissions were reduced by 53 percent; hospitalizations decreased by 25 percent; and the length-of-stay for patients decreased by 23 percent.

Lutheran Medical Center in Brooklyn, New York is an example of a hospital organization that adapted the concept of an ECM as a method to boost quality of care for their patients. They place an ECM in the emergency department to focus on identifying high-risk patients due to their chronic illnesses. The care manager also evaluates the appropriateness of hospitalization and level of care. Through their efforts, they have reduced re-admissions, and provided alternatives to admission when appropriate. Placing a care manager in the emergency room offers the patient early intervention by someone who can initiate plans of care for a high-risk patient who typically has a history of high utilization.

Patient Centered Medical Homes (“PCMH”) are also utilizing the support of an ECM to work alongside healthcare professionals. A PCMH is not simply a place of care, but a model of primary care. The Taconic Independent Practice Association (“TIPA”) is a 4,000 physician member organization located in Fishkill, New York that has also adopted the use of an ECM. The goal of their pilot was to demonstrate that patient-centered, care-coordinated services as part of an advanced primary care model can deliver safe, effective, and efficient care to achieve the Triple Aim™. However, the challenges that TIPA (and other providers) faced was the implementation of a care manager in a fee-for-service marketplace. Health plans typically do not reimburse for care manager services within the primary care practice. As a result, TIPA sought...

<table>
<thead>
<tr>
<th>services, such as disease management, home care, condition specific testing</th>
<th>expanded assessment of patient and family needs</th>
<th>follow-up with chronic illnesses</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Coordinates delivery of covered services with community services</th>
<th>Facilitates interdisciplinary patient care rounds and/or conferences to identify treatment goals</th>
<th>Obtains pre-authorization and/or referrals to other healthcare services or providers</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Coordinates claims with other benefit plans</th>
<th>Directs and participates in the development of patient care protocols and policies</th>
<th>Conducts data reporting to identify gaps in care or services and conducts patient outreach to facilitate follow up care or services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Conducts telephonic outreach to a member before, during, and after specific healthcare interventions</th>
<th>Mobilizes resources to achieve expected clinical outcomes within the desired timeframe</th>
<th>Provides patient education sessions for various health conditions; e.g., diabetes, CHF, COPD, etc.</th>
</tr>
</thead>
</table>

| | Assures employee access to Employee Assistance Programs (“EAP”) | Collaborates with workers’ comp insurer on care plan and return to work efforts |
funding from their payer community for an advanced primary care pilot. They reported that the health plan response was very positive, as they were willing to be part of an innovative approach with care management.

Designing and Implementing an ECM model
A well-trained ECM who can assist patients in managing their health conditions, prioritize their healthcare needs, prevent complications through standardized care protocols, and navigate an increasingly complex healthcare system is invaluable to any healthcare organization. The successful implementation of the ECM model should include:

**Design:** The first step toward integrating care management into an office is to develop and communicate the ECM’s job description within the practice setting. A job description for the ECM can be derived from the Care Management Society of America’s definition of care management. However, the ECM’s job description may need to be modified to reflect the role and responsibilities within a specific practice location. Once developed, communicate this to the office team so everyone understands their roles and the likely patient workflow redesign that the office has adopted to welcome the ECM as a new team member. For smaller practices, a centralized resource that can be utilized by multiple offices may be more cost effective.

**Professional Development:** Provide specialized training to the ECM in educating, motivating, and coaching patients to include disease-specific protocols. Since an ECM supports the same clinical guidelines as clinicians, have them attend the same interdisciplinary workshops. Training should also include how to identify and access resources in the community. These would include respite care, community meals-on-wheels programs, alternate housing options, home and health assessments, and long-term financial planning. This knowledge is invaluable to the ECM’s role. Patients will benefit through improvements in self-management and health outcomes, resulting in declines in emergency department and inpatient utilization.

**Information Technology (“IT”):** Develop an IT framework that supports collaboration with, and for, the care management of populations or multiple diseases. A data warehouse that can produce disease registries, balanced scorecards, and integrate with advancing EMR, telemedicine, and call centers will be key. This should provide access to key patient information that encourages best practices and facilitates communication between providers.

**Scope of Responsibilities:** The ECM role works best when there are at least six physicians to support the expense of a care manager. This can depend on the criteria used to identify the patient population for whom the care manager will be responsible and is typically identified by either risk stratification or disease-specific criteria. As noted earlier, physician practices may utilize a shared care manager model across two or more clinics.

Physicians need to be trained and encouraged to refer patients with chronic conditions to the care manager embedded in their practices. The office practice should establish a means for the clinical staff to refer patients to ECMs. In this step, it will be important to evaluate current workflow, recognizing the possible need to redesign and reorganize practice staff to create a team-based approach toward patient care.

**Care load:** A typical care manager has approximately four encounters per patient per year. This includes face-to-face visits, telephone calls, and joint meetings with a medical team member. As needed, the ECM should schedule home appointments with the patients, converse with physicians and specialists, contact outside agencies and companies for their patients, and/or arrange other services that will enhance the patient’s care and well-being. Roughly half of ECM encounters should involve providing patients or caregivers with connections to community programs. In many cases, ECMs are helping patients and caregivers to deal with social and organizational needs, such as caregiver fatigue, medication assistance, healthcare coaching, and financial needs.
Population Health Outcomes: Tracking an individual’s progress toward achieving their health goals, while managing their chronic conditions, should be an integral part of any ECM program. Patients and their significant others should be seen as true “partners in care” by identifying their personal goals, engaging in education, participating in strategies to facilitate compliance, and reporting health outcomes to their provider team. To achieve this, care management requires an EMR system that meets the specific documentation standards of a care manager model, which is rarely available in a physician’s office. Evaluate how this can be solved; the care manager needs to develop care plans, set healthcare reminders and tracking, as well as allow communicate across and between the entire healthcare team.

Practice Leader: Identify and appoint a strong practice leader to support the ECM model. The resource of a care manager embedded in a practice requires significant time and training to implement, and there must be a strong commitment on the part of a practice leader to see it through to completion and ongoing improvement.

Lessons Learned
What has been learned from the early adapters of an embedded care manager model is the need for a well-executed implementation plan. Assure that the ECM’s role and responsibilities have been clearly communicated to the team, and allow the staff to participate in the redesign of their workflow and responsibilities. Most importantly, communicate to patients the added resource of a patient advocate in the addition of the care manager. Let patients know when and where to call so they can enlist the assistance and support of the ECM in managing their healthcare needs.

Sustaining the ECM Model
Once implemented, the ECM program must quickly ensure that patients living with complex conditions, and/or disabilities in active courses of treatment, avoid disruptions in their care. When designed and implemented correctly, the ECM model minimizes the potential for duplication of services, eliminates gaps and fragmentation in services provided, and ensures that care is provided to individuals as seamlessly as possible. The outcomes will result in enhanced quality of care and patient satisfaction as the ECM role helps the patient remain in their usual residence. Factors that foster success with the ECM model include:

Care coordination: This is an expertise that takes time, effort, and financial resources that are currently not adequately recognized by payers. The ECM model supports a physician practice’s move towards a PCMH. Solicit payer reimbursement as the model matures; payers may be willing to financially support the program, particularly if they see proof that it reduces costs (e.g., by avoiding readmissions) and/or improves outcomes.

Training and Process Redesign: Provide opportunities to train existing caregivers to new roles with an emphasis on communication, coordination, collaboration, and accountability. Ensure adequate visit time for patients with the ECM. Allow ECMs to get to know their patients. They need to learn about the unique personality of each patient, their learning style and preferences, as well as those of their caregivers. Time and communication ensures that patients understand the situation at hand and their role, which results in better outcomes. Plan and/or redesign the workspace and patient visit schedule in such a way that it supports ECM visits, care planning, and patient education. Patients need more than just interaction with a medical assessment and/or messaging device. They need to see the ECM and physician evaluate and respond to the information they provide.

Protocols: Revise the office practice patient protocols at least once a year to make sure they conform to the latest clinical and patient management recommendations. Build care management strategies today, while understanding that the protocols and processes will continually evolve. Organizational change of this magnitude requires a cultural transformation and a clear mandate about the patient.

Improve Care: Continuous improvement should be an ongoing initiative. Some patients who improve as a result of the program may not need to remain in the program, particularly those who learn to manage their conditions effectively. Others may
Designing the Role of the Embedded Care Manager (Cont’d)

need the discipline of daily reporting to remain on track.

As seen in healthcare over the years, care management has played a pivotal role in facilitating quality, cost effective care. As the demand for greater value for the consumer grows, so will the demand for care managers that can assist organizations to meet those objectives. The successful evolution from a volume-based to a value-based reimbursement system will require organizations and individuals to embrace the changes required in this era of healthcare transformation.

For more information on embedded care managers, please contact Dr. Hines at 310.320.3990 or phines@thecamdengroup.com or Ms. Mercury at 585.512.3906 or mmercury@thecamdengroup.com.

[i] Care Management Society of America definition of care management
[ii] Hostetter, Martha; “Quality Matters Care Study: Aetna’s Embedded Care Managers Seek to Strengthen Primary Care” The Commonwealth Fund 2010
[iii] Bonvissuto, Kimberly; Managed Healthcare Executive; “Embedded care managers prove their worth for payers, patients”
[iv] “6 Reasons to Embed a Care Manager in the Emergency Department”, Best Practices in Contemporary Care Management, April 2011
[v] Taconic IPA, Website: Advanced Primary Care & Care Coordination Services