Evaluation of the Care Manager Role in Primary Care

Malaika Stoll MD, MPA
Lehigh Valley Health Network

Lynn M. Deitrick RN, PhD
Lehigh Valley Health Network, Lynn.Deitrick@lvhn.org

Nancy Gratz MPA
Lehigh Valley Health Network, Nancy_C.Gratz@lvhn.org

Pam Marcks
Lehigh Valley Health Network, Pamela.Marcks@lvhn.org

Kathleen Moser
Lehigh Valley Health Network, Kathleen.Moser@lvhn.org

Follow this and additional works at: https://scholarlyworks.lvhn.org/administration-leadership

Part of the Business Administration, Management, and Operations Commons, Health and Medical Administration Commons, Management Sciences and Quantitative Methods Commons, Nursing Commons, and the Primary Care Commons

Published In/Presented At
Evaluation of the Care Manager Role in Primary Care

Malaka Stoll MD, MPA; Lynn Detrick, PhD, RN; Nancy Gratz, MPA; Pam Marcks, Kathleen Moser
LEHIGH VALLEY HEALTH NETWORK ALLENTOWN, PA

BACKGROUND
What primary care cannot address in the office or clinic, it may be the role of the care manager. This is because of the technical tools for supporting care coordination include Electronic Health Records, allowing information to flow across time and care settings. Individuals can be identified to support care coordination, with various models for primary care "Care Managers" emerging.

Lehigh Valley Health Network (LVHN) is a large hospital and health system in Pennsylvania that operates in a multi-payer, largely fee-for-service environment. Seven LVHN primary care practices were participating in the PA Chronic Care Collaborative, a State-wide chronic care program. LVHN primary care practices are participating in the PA multi-payer, largely fee-for-service environment. Seven LVHN primary care practices were participating in the PA Chronic Care Collaborative, a State-wide chronic care program.

STUDY OBJECTIVE
To describe the role of a Care Manager implemented as part of a PCMH initiative in a multi-payer, largely fee-for-service environment.

METHODS
Characteristics design that includes qualitative and quantitative components. These are:

1. Pre- and post-intervention interviews and focus groups with practice staff. Key areas include care management responsibilities, qualifications, challenges, and successes.
2. Grounded theory method with thematic coding used to develop concepts from data systematically collected and analyzed.

RESULTS

1. CHANGING PERCEPTIONS OF THE CARE MANAGER

Table 2: Care Manager Perceptions: Pre and Post Implementation

<table>
<thead>
<tr>
<th>TIME</th>
<th>DESCRIPTION OF CARE MANAGER</th>
<th>PRE-CARE MANAGER RESPONSIBILITIES</th>
<th>POST-CARE MANAGER RESPONSIBILITIES</th>
<th>EXAMPLES OF COMMENTS</th>
</tr>
</thead>
</table>
| Pre-care  | Integral part of a team with patient care | G, F | A, E | "Care management is not only desirable but also expected in this practice."
| Post-care | Economically and medically important     | A, B, C, D, F | A, B, C, D, F | "Our practice changed 'target' definition because if the patient was uninsured, the plan would be "impossible for 1 P/T CM."

2. IMPROVING THE RISK PROFILE OF PATIENTS WITH DIABETES

The first graph below shows data for all typical patients with diabetes. The second graph depicts data for light gray group, which is defined as having higher risk factors such as advanced age and poor adherence to certain medications. The third graph shows data for all patients moving from high to lower risk categories. The impact is clear. Responding to this call is the PCMH, which is developing for diabetes.

3. IMPROVING THE RISK PROFILE OF PATIENTS WITH DIABETES

The PCMH initiative resulted in all LVHN practices successfully implemented. In our study, the role of the Care Manager varies depending on the background of the individual. As a network, we search for a more standardized approach and continue to learn from the six "case studies" we are studying. Within the network, there has been an animated debate over the ideal background of the care manager. From our study, we learn that there is a wide range of duties within, "care management," and individuals with a variety of backgrounds add value to parts of the job description. One strategy for resource-restricted primary care practices may be to utilize a team approach to care management. That is, to take stock of the team’s strengths, interests and capacity of existing clinicians and staff, and divide up the key care management roles. Some parts of the job—such as patient reminders, coordinating referrals and so forth—do not require a highly clinical background. Other parts, such as reconciling complex medication lists, may require highly trained individuals such as CRNPs. Managing a registry likely requires some understanding of data and information systems. Many practices will not have this type of expertise readily available, and will need training. The PCMH initiative resulted in all LVHN practices successfully implemented. In our study, the role of the Care Manager varies depending on the background of the individual. As a network, we search for a more standardized approach and continue to learn from the six "case studies" we are studying. Within the network, there has been an animated debate over the ideal background of the care manager. From our study, we learn that there is a wide range of duties within, "care management," and individuals with a variety of backgrounds add value to parts of the job description. One strategy for resource-restricted primary care practices may be to utilize a team approach to care management. That is, to take stock of the team’s strengths, interests and capacity of existing clinicians and staff, and divide up the key care management roles. Some parts of the job—such as patient reminders, coordinating referrals and so forth—do not require a highly clinical background. Other parts, such as reconciling complex medication lists, may require highly trained individuals such as CRNPs. Managing a registry likely requires some understanding of data and information systems. Many practices will not have this type of expertise readily available, and will need training.

The PCMH initiative resulted in all LVHN practices successfully implemented. In our study, the role of the Care Manager varies depending on the background of the individual. As a network, we search for a more standardized approach and continue to learn from the six "case studies" we are studying. Within the network, there has been an animated debate over the ideal background of the care manager. From our study, we learn that there is a wide range of duties within, "care management," and individuals with a variety of backgrounds add value to parts of the job description. One strategy for resource-restricted primary care practices may be to utilize a team approach to care management. That is, to take stock of the team’s strengths, interests and capacity of existing clinicians and staff, and divide up the key care management roles. Some parts of the job—such as patient reminders, coordinating referrals and so forth—do not require a highly clinical background. Other parts, such as reconciling complex medication lists, may require highly trained individuals such as CRNPs. Managing a registry likely requires some understanding of data and information systems. Many practices will not have this type of expertise readily available, and will need training.