Embedded Nurse Case Managers in Primary Care: My Experience and Strategies for Success

Jul 26, 2021 | Blog

By Kelva Edmunds-Waller, MSN, RN, CCM

The primary goals for embedded nurse case managers include chronic disease management and avoidance of hospital readmissions. I currently manage about 55 patients in the resident clinic. On a typical day, I begin by reviewing discharge reports, including patients discharged following an ED or inpatient admission. Transition of care (TOC) assessments account for 50% of my workday. On average, I complete TOC assessments on five patients per day. Assessments are comprehensive and focus on

reviewing discharge instructions, medication review and management, scheduling follow-up with the primary care and specialty providers, and coordinating recommended diagnostic tests and procedures. Screening for social determinants of health is also a component of each assessment. Social determinants that frequently impact the patient's ability to follow the care plan include access to care, income insecurity, limited reading and health literacy.

Kelva Edmunds-Waller

Medication management involves resolving medication discrepancies, assisting patients in obtaining medications, teaching patients about each medication's purpose, and how to self-administer medications. Due to income insecurity or payer requirements, a call to the provider may be necessary to communicate that a medication is not covered or unaffordable for the patient. If an alternative medication is not available, I initiate prescription assistance program applications and follow-up to help patients obtain prescribed medications. If a patient cannot self-administer medications independently, I engage appropriate family members for assistance. Some patients come into the clinic for assistance with reading prescription labels to fill pill boxes correctly.

It may also be necessary to coordinate post-acute care services (i.e.home health, remote patient monitoring) following a hospital discharge. Involvement of post-acute care services requires ongoing follow-up and collaboration to evaluate the care plan's effectiveness and make revisions as needed. To reduce or prevent hospital readmissions, I follow up with patients or caregivers weekly during the 30-day transition periods to assess the patient's health status and proactively manage any problems that may negatively impact the care plan. Regular communication with the primary care provider and other team members occurs to ensure that the team has updated information on the patient's health status. Referrals to psychology, social work, and community outreach to address social determinants, advance care planning, and mental

and behavioral health issues enable me to manage my time efficiently to focus on nursing-related interventions.

I use data to stratify and identify patients with high-risk chronic diseases. When I identify these patients, I contact them to discuss the availability of case management services to improve life quality, prevent hospital admissions, and reduce out-of-pocket health care costs. If patients consent to services, they are placed in a chronic disease management program. Case management services are available to transitional care patients who cannot independently self-manage or need ongoing supervision and support.

My encounters with patients are primarily telephonic. Good communication skills help to establish trust and rapport. In practice, I find that it is more effective to listen to patients first, then clarify what I heard before responding. This practice creates an opportunity for the patient to partner in shared decision-making versus only agreeing to the health care professional. When I am in the clinic, I typically schedule visits with patients for chronic disease management. Following a comprehensive assessment, case management interventions include education, goal setting, and monitoring. I use motivational interviewing to assess a patient's readiness for change and to help the patient establish at least one goal in a session to improve disease self-management. Common patient barriers to disease self-management include a lack of knowledge about the disease, its progression, trajectory, and complications. The embedded case manager has an essential role in removing barriers to facilitate patient self-management. Using "plain talk," analogies, and metaphors help patients understand complex pathophysiology, gain insight into their illness, and increases self-efficacy.

Strategies for Success

A comprehensive implementation plan is critical to ensure the success of embedded case management programs in primary care. Nurse case managers have the experience and skills to improve the patient experience, health outcomes, and healthcare utilization. An implementation strategy benefits the case manager, providers, the clinic team, and the organization. Implementation strategies to consider include:

1. Understanding the clinic's patient profile, including demographics, culture, and social determinants, to match the right case manager to the population
2. Evaluating clinical leadership knowledge of the role of case managers and providing education as appropriate
3. Outlining in writing the role of the nurse case manager for every team member to prevent role confusion and to utilize the case manager effectively
4. Setting aside time for the leadership team, clinical team, and nurse case manager to meet informally to facilitate the integration of a new service into the team
5. Integrating population health modules or technologies into the existing EMR to improve the efficiency of documentation and communication to benefit the case manager and the clinical team
6. Utilizing data analytics to extract and process useable data to identify at-risk populations at the point-of-care to allow proactive versus reactive case management
7. Identifying outcome measures to demonstrate and present the added value of case managers to clinic leadership, the clinic team, and the case manager
8. Implementing electronic referrals for case management to increase efficiency and to track referral sources
9. Orienting the case manager within the clinic setting and including the case manager in email distribution lists

10. Equipping the case manager with the training and decision-support tools to meet or exceed performance expectations, including identified outcome measures and quality indicators

Case managers have a unique and versatile set of skills that can benefit many care settings. As the U.S. health care system transforms, the role of case managers will continue to evolve. Primary care is a great place. The availability of post-acute care services has already changed the health care landscape. As accountable care organizations increase and reimbursement models continue to reward performance and quality outcomes, case managers are equipped and prepared to provide high-quality, value-added professional case management service in any setting.