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Care Managers and Knowledge Shift in Primary Care Patient-Centered Medical Home Transformation

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Primary care practices across the United States are implementing a new model of care, the patient-centered medical home (PCMH), in an effort to improve care to patients and, consequently, control health care costs. The addition of care managers is a key aspect of PCMH implementation with important implications for the production and reproduction of authoritative knowledge in primary care. Redistribution of patient interaction from the primary care provider to a range of other health care providers in this model of care is a significant means by which primary care approaches to the prevention and management of chronic diseases such as diabetes are being transformed. Based on a study of a health insurance company-sponsored primary care transformation project in Michigan, we explore the perceptions of care management from the perspective of providers and practice staff to examine these shifts in knowledge and their broader implications for primary care. This research demonstrates how the diffusion of clinical power and knowledge production redefine primary care relationships to patients, as traditional hierarchies shift to team-based care. The addition of care managers reshapes power and agency within clinical practice and understandings of the social dimensions of chronic illness. Care management emphasizes the affective qualities of provider care-giving, euphemized in terms of teamwork, partnerships, and relationships; however, these are also measured through the perceptions of patient transformation into self-managed owners of their illness.

Key words: authoritative knowledge shift, care management, primary care transformation, clinical culture change, chronic illness management

Introduction

One of the most significant transformations occurring in health care in the United States is the implementation of the patient-centered medical home (PCMH) model in primary care. Becoming a PCMH practice involves change on a number of levels from business performance

reorganization to individual patient empowerment. The overall goals are improving care quality, cost effectiveness, and population health outcomes (Arend et al. 2012; Peikes et al. 2012). A central objective of the PCMH model is to address the rising costs stemming from the escalation of chronic diseases. Primary care thus shoulders the double burden of preventing and managing rising chronic disease while also being responsible for lowering health care costs. Successful PCMH implementation projects demonstrate that they “offset the new investments in primary care in a cost-neutral manner and...produce a reduction in total costs per patient” (Grumbach et al. 2009:1). Cost reductions for employers and health insurers, measured through lower hospitalizations and emergency department visits, are significant drivers behind their investment in PCMH transformation projects (NCQA 2015; PCPCC 2008).

Yet, the prevention and management of chronic diseases such as diabetes are increasingly multifaceted. They involve many intersecting physical and social complexities and an exponential multiplication of technologies available to address them (May et al. 2005; Peikes et al. 2012; Sidorov et al. 2002). In this context of increasing complexity, PCMH redistributes patient interaction from physicians to a range of other health care providers, and practice transformation involves the “empowerment” of patients as well as of

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non-physician clinical and other staff (Hesse et al. 2012; Sweeney et al. 2012; Wise et al. 2011). A team approach to patient care seeks to release physicians from the overload of chronic illness management and administrative functions by devolving the time-consuming aspects of patient care, such as education and support (e.g., dietary and self-monitoring tasks of diabetes management), to other clinical staff (Hall et al. 2014; Hall, Webb, and Tamayo-Friedel 2014; Karagiannis et al. 2014; Solimeo et al. 2014). This is meant to encourage comprehensive patient care and pay off in business efficiencies and quality improvements (Daaleman et al. 2014). The PCMH moment highlights the underlying social forces which impact health outcomes as health care providers are called upon to delve extensively into the personal lives of patients and engage with community resources to promote health education, lifestyle, and environmental changes. (Anderson 1990; CDC 2001; Niessen et al. 2000).

Care managers have become an important dimension of this transformation (Hiss et al. 2007; McMurray et al. 2002; Wagner et al. 1996). They fill many roles depending upon implementation approaches and processes, capacities of various sized practices, location of practice, and service populations (Ackroyd and Wexler 2014; Hall et al. 2014; Hall, Webb, and Tamayo-Friedel 2014). They are at the center of the ways in which PCMH innovations are redefining primary care relationships to patients (Phillips et al. 2014) and indexing the diffusion of clinical power and knowledge production that occurs as traditional hierarchies shift to team-based care (McKinlay and Marceau 2008; Scholle et al. 2011; Solimeo et al. 2014). This raises important questions about how the addition of care managers is affecting patient health and health care. In this article, we examine the redistribution of patient contact to care managers, its impacts on knowledge and power in clinical practice, and the potential implications of this transformation for patients and policy. We focus on the perceptions of care management from the perspective of providers and practice staff, utilizing qualitative data collected in a mixed-methods study of health insurance company-sponsored primary care PCMH practice transformation in Michigan.

We demonstrate that as medical culture is reconstituted through the dispersal of health knowledge production across multi-sited domains—among the inter-professional team, between the primary care practice and the medical neighborhood, and most significantly, here, in perceptions of the relationship between the patient and what has become a plural primary care provider represented by the care manager—it also simultaneously masks and reinforces neoliberal ideologies about patient choice and responsibility. This research raises awareness of the impacts of new care manager roles on patient experiences of care and implications of these roles for patient-self management and health outcomes. It sheds important light on the lived experiences of care teams experiencing changes in hierarchical arrangements with the addition of care managers. Primary care practices might use the results of this research to explore internal and external motivations for improving patient care as well as patient health, generating

self-reflection on both the personal and professional meaning of the new care model. The results could also help inform training programs for both physicians and allied health professionals to ensure that these include consideration of the potential implications of emerging care models.

PCMH, Care Managers, and the Transformation of Knowledge Production

The PCMH model of care originated in the 1960s in pediatric care to provide a medical “home” in primary care for the medical records of children with special health care needs (Arend et al. 2012; Cooley 2004; Scholle et al. 2011; Sia et al. 2004). Coordinating the care for this diverse population of pediatric patients has been well studied for the past two decades (Antonelli, et al. 2008; Hamilton et al. 2012; Porterfield and DeRigne 2011; Raphael et al. 2009; Romaire et al. 2012; Sia et al. 2004; Strickland et al. 2011). More recently, the larger primary care community has adopted and adapted this model for all patients through formalized policy, including in the Patient Protection and Affordable Care Act (AAFP 2007; Robert Graham Center 2007). Today, primary care practices become the medical homes for patients at the center of neighborhoods of “other clinicians providing health care services to patients within it, along with community and social service organizations and State and local public health agencies” (Taylor et al. 2011:5).

Studies of the impact of PCMH transformation on primary care practice have tended to focus on changes in clinical markers and insurance claims data, which generally overlook the contextual factors and heterogeneity of medical home transformation (Bitton et al. 2012; Goldman and Borkan 2013). Our research addresses this gap by focusing on the dialectics between the agency of primary care clinicians and staff, and the forces within which their work is embedded, to reveal PCMH implications for the social and ideological production of health knowledge. We situate our study within the tradition of critical biomedical health services transformation research (Hahn and Gaines 1985; Lock and Gordon 1988; Mol 2008; Mol and Law 2004; Solimeo et al. 2014) and build on Jordan’s conceptualization of the processes by which authoritative knowledge—the knowledge that counts—acquires its authority and is reproduced in ways which sustain dominant sociopolitical ideologies of health care. As Jordan (1997:60) explains, “Multiple kinds of knowledge are present by virtue of the experience and background of the various participants” in social situations as diverse as childbirth, where “differing kinds of knowledge come into conflict,” to air traffic controllers, where they can “become a resource for constructing a joint way of seeing the world.” Authoritative knowledge in primary care practice is shaped and impacted by numerous factors. These include continuously broadening scientific information, evidence-based and traditional clinical practice, diversifying professional standards and training, including multiple categories of care providers, quality accountability and efficiencies, and deep relational knowledge of individual patients.



We examine how the experiences and relationships of care managers, as non-physician providers within care teams and their communities, illuminate broader conceptualizations of care, trust, and health care reform processes (Henry 2015). We also seek to address the limited attention in health services research to reflexive interpretations of health care transformation projects made by those directly engaged in implementing change (Sobo et al. 2008). By examining health care transformation through the stories those involved tell about themselves (Babcock 1980; Geertz 1973), we seek to understand primary care culture not simply as a set of ideas or practices but as complex processes in which people are engaged inter-subjectively in the production and renegotiation of health care knowledge.

This includes the notion of “partnership,” for example, which is a central organizing concept in becoming patient-centered (ACP 2014). It is used to frame contact between the practice and patients, the teamwork of practice staff, and relationships with others in the medical neighborhood. The reconceptualization of primary care in the de-hierarchizing terms of partnerships, teams, and relationships attenuates the extensive reorganization of the production of clinical knowledge in the context of neoliberal health policy, where clinicians act as enforcers of patient individual responsibility to be good, healthy citizens. (Ayo 2012; Brown and Baker 2012; Galvin 2002). Authoritative primary care knowledge is reformed at the nexus of interpretations of the nature of caring for chronic disease patients, with and against biometric measures of health, perceptions of patient responsibility and self-management, and the degree to which social determinants of health are seen as pliable by the individual.

Embedded in the philosophy of PCMH, care manager praxis is a critical location of health knowledge production and health redefining processes. The literature on care managers describes them as serving as direct and accessible resources for patients struggling with long-term diseases, such as diabetes, and as having a positive impact on patients. Care managers’ duties might include assisting with the empanelment of patients and working with them to access needed screening and risk management services. This might involve reminders for preventive care such as foot and eye appointments for patients with diabetes; follow-up communication to patients after scheduled procedures or emergency hospitalization; and connection with educators, nutritionists, social workers, or other health care providers (Daaleman et al. 2014; Findley et al. 2014; Haas and Swan 2014; Hall, Webb, and Tamayo-Friedel 2014; Hiss et al. 2007; Sepers et al. 2015; Taliani et al. 2013; Wang et al. 2014).

Care coordination on behalf of patients with parties external to the practice is, in theory, distinguished from care management which occurs mostly with patients within the practice. However, care managers often are responsible for both care coordination and care management. Care managers may serve as liaisons between multiple entities involved in patient health care, such as health insurance companies, community services, and hospitals. They may conduct in-depth assessments

with patients and spend time discussing and coordinating the patients’ many resource needs (Ackroyd and Wexler 2014). Hence, care management may include many different activities and may be carried out by providers with a variety of training and background (Ackroyd and Wexler 2014; Findley et al. 2014; Haas and Swan 2014; Thom et al. 2014).

Moreover, various professions are adapting to the PCMH model, especially those that work directly with the social dimensions of patient care and understand patient trust as central to effective transformation (Jortberg et al. 2012). Everett et al. (2014) draw attention to how physician assistants and nurse practitioners in primary care are being streamed into the PCMH model. Fisher and Dickinson (2014) advocate for increased valuation of the psychology profession in PCMH, particularly with regards to diabetes management. They describe the stressor factors of social determinants impacting diabetes and point out the ways in which psychologists in primary care could address them, possibly as supervisors of care managers (Fisher et al. 2010). This draws attention to shifts in the valuation and measurement of particular knowledges, capacities, and approaches in primary care and how these might shape business and reimbursement reform.

Our analysis focuses on the ways in which providers and staff give meaning to patient health improvement in their interpretations of care manager roles. In particular, we find that care manager roles are seen as diffusing power and agency by giving ascendancy to the relational and social dimensions of chronic illness care within clinical practice. Our attention to these phenomenological processes of meaning-making among clinicians and staff illuminate the reshuffling of authoritative knowledge production taking place in PCMH primary care transformation.

Methods

This research is situated within a larger study of projects to pilot the implementation of PCMH delivery system improvement strategies in Michigan and New York. These pilots were sponsored by two different regional health insurance companies. The PCMH strategies implemented in these projects focused on improvements in structures and processes within practices with the intention of reducing costs, improving health outcomes, and improving both patient and provider experiences. The initial results of the pilot evaluations were presented for member-checking to three advisory committees: one in each state composed of physicians and practice staff and a national committee made up of the medical directors of the Alliance of Community Health Plans.

As the approaches by the two insurers were radically different, with one focusing on more internally-directed change versus the other which was more externally-directed change, the theme for this sub-study emerged through observation and interaction with the internally-directed demonstration. Consequently, this research reports on the experience in practices within one state, Michigan. In Michigan, practices were selected for study because they had participated in the Patient Centered Medical Home Pilot sponsored by the

Table 1. Participant Practices

Practice	Specialty	Ownership	Population	Number of Providers	Number of Staff
A	Family Practice	System	Rural	12	36
B	Internal Medicine	Private	Suburban	3	8
C	Family Practice/Internal Medicine	Private	Suburban	19	75
D	Family Practice	System	Rural	5	16
E	Internal Medicine	Private	Suburban	5	12
F	Family Practice	System	Suburban	3	12
G	Family Practice	Private	Suburban	16	72
H	Family Practice	Private	Rural	13	28
I	Family Practice	System	Suburban	14	45
J	Family Practice	Private	Rural	23	95
K	Family Practice	System	Suburban	7	28
L	Internal Medicine	Private	Suburban	7	20
M	Family Practice	System	Suburban	10	32
N	Family Practice	Private	Suburban	5	18

Priority Health insurance company, which was based on a competitive grants process. Care managers were hired by each practice using grant money provided by the insurer to facilitate PCMH transformation. The care managers came from a range of professional backgrounds, including nursing, social work, and athletic coaching. These care managers were practice employees, embedded within the practice site, and could see all practice patients, not just those covered by the insurer providing the grants.

As in other early studies of the PCMH model, most care managers in this one focused on patients with diabetes. This is because diabetes has very specific protocols for management and guidelines for assessment and is a major focus of health plans' quality and performance measures. Tools such as the Health Care Effectiveness Data and Information Set (HEDIS) are used by 90 percent of the health insurance companies in the United States, drive many of the pay-for-performance programs for primary care providers, and have traditionally included several metrics related to diabetes management (NCQA 2015). Diabetes management is also the subject of training courses specifically available for care managers and diabetes educators.

The research was reviewed by and received expedited approval from the authors' Institutional Review Board. Research was carried out by an interdisciplinary team which included anthropologists, health services researchers, health economists, and a social worker. Data were collected in three phases between 2010 and 2012 in fourteen urban and suburban practices (eleven family practices and three internal medicine practices) (see Table 1). Practices ranged in size from three providers and eight staff to twenty-three providers and ninety-five staff. Six practices were system-owned, while eight were privately-owned.

Using an open-ended questionnaire, we conducted semi-structured interviews with thirty-three key informants between April and June 2011 at the individual practice sites.

Each interview lasted approximately thirty minutes. Key informants were typically the physician leading the transformation, practice administrator, or staff involved in the pilot project. They were asked to describe their practice's motivation to participate in the pilot projects; the nature of the specific changes they implemented; and the improvements, benefits, challenges, and frustrations arising from their participation in the pilot. Interviewees were also asked to reflect on the long-term sustainability of the changes implemented.

We also held ten one-hour focus groups within each practice site, with a total of sixty-six practice staff, specifically excluding physicians and practice administrators, between April and June 2012. Focus group questions were similar to those posed in the individual interviews, focusing on participants' overall experiences participating in the pilot projects. Focus group participants were also asked to describe their perceptions of the utility and effectiveness of the care manager for patient health and how the changes impacted their work.

Lastly, we conducted follow-up interviews with twenty-five individual practice leaders between May and June 2013 at individual practice sites. These interviewees were usually recruited from practices' quality improvement teams and were generally physicians and practice managers identified to researchers as the most knowledgeable about practice transformation efforts. We were able to interview care managers in half the practices in these follow-up interviews, as they had been hired or integrated into the specific pilot transformation by this phase of data collection. In these interviews, participants were asked to revisit questions regarding their perceptions of the transformation process, the sustainability of changes made, including how improvements continued or were possibly retracted, and how challenges were overcome or new ones emerged. As all interviews and focus groups were conducted at the practice sites, investigators spent considerable time in the clinical

environment and were able to observe the team context, dynamics, and functions in action.

All interviews and focus groups were audio-recorded and transcribed. Transcriptions were coded and analyzed by multiple investigators assisted by NVivo 9 qualitative data management software. Individual phrases within the data as a whole were categorized using open coding and then coded according to a theme using selective coding. Both *a priori* (such as interview question topics) and emergent themes were included in the analysis. All data were first coded independently, then compared in an iterative process, and reviewed holistically for recurrent ideas, perceptions, and experiences for investigators to come to agreement on categories (Dye et al. 2000; Lecompte and Schensul 1999). We also used Nvivo's tool which calculates Cohen's Kappa coefficient to measure interrater reliability and facilitate coding agreement in our process. Areas with wide agreement in experience were probed for exceptions, and themes with diversity in experience explored with further analysis (Goetz and LeCompte 1981; Wolcott 2001).

Nvivo's matrix coding function facilitates visualization of strong intersections across broad categories. While some confluence would be expected when applying this function to data broadly coded for "the role of care managers" and for "perceived impacts of the transformation for patients," unexpected and interesting evidence was also revealed about the impact of care managers on changes in the construction and application of health knowledge. We developed our interpretive analysis around this conceptual framework, focusing on salient dimensions of the process (Michrina and Richards 1996), including participants' structural and local contextual understandings of PCMH, their reflections on knowledge and power shifts brought about by the addition of care managers to provider teams, and their expressions of the reconstitution of patient health in relation to the affective quality of the dialogical relations nurtured by care managers with patients. Names used in the direct quotes are pseudonyms.

Provider and Clinical Staff Perspectives on PCMH and Care Management Implementation

In all three phases of the research, clinicians and staff gave meaning to the challenges of learning and implementing PCMH transformation by describing it as an extension of what their individual practices were already doing. In this process of "constructing a joint way of seeing the world" (Jordan 1992:3), transformation produced and reproduced knowledge in both practical action and reflections on the diffusion of power. Practical changes included, for example, providing open access appointments; implementing systems to follow-up with patients after visits, labs, radiology, etc.; and developing guidelines for common conditions. Shifts in domains of knowledge involved patient engagement and decision support, patient-focused responsibility or "ownership" for one's own care, and team-based care. Care managers figured notably in all these points of change.

As already mentioned, care managers across all the practices in Michigan were primarily focused on diabetes management. The care manager's job was described as overseeing challenging cases with multiple physical, mental, and social complications. The main goal of care management was described as "getting the numbers down" (referring to patients' hemoglobin A1c test results for patients with diabetes and/or blood pressure readings for those with hypertension). To reach this goal, care managers were responsible for ensuring follow-up with medications, appointments, and tests; helping with all types of referrals; having face-to-face contact with patients; taking on communication with various levels of staff involved in patient care, maintaining oversight and management of patient self-care, and in some cases assisting with patients' socioeconomic or literacy barriers. As detailed below, patient health improvement was emphasized in terms of the affective character of the social relations established between the care manager and her/his patients.

Across practices, systemizing a redistribution of patient interaction to allied health care providers was valued as a means of addressing efficiency and comprehensiveness of care. In financial terms, however, many of the tasks required to meet PCMH standards were not billable to insurance and involved time commitments that take away from the practices' ability to schedule a sufficient number of appointments in a day to support a viable business. The services of care managers and others focused on the prevention of chronic diseases and their complications came to be reinterpreted as viable for reimbursement. As one physician put it:

Patients with chronic medical conditions require so much time and energy and effort on the part of the general internist that we don't get reimbursed near what [we should]—at least for complexity level—as opposed to somebody who comes in that needs a surgical procedure.... If you're talking about somebody like one lady I saw today for pre-op who has diabetes, hypertension, anxiety, and obstructive sleep apnea, did I mention high cholesterol, obesity, and she was here for a pre-op and her EKG is now abnormal.... I need to account for all those things.

This physician felt strongly that if a patient like this could spend thirty or sixty minutes of billable time with the care manager, there would be a significant impact, concluding, "If we can stop the march of chronic disease, then I think that's worthwhile for insurance. It's very worthwhile for patients."

Here, the social dimensions of the work done by a care manager draw authoritative meaning from a broader neoliberal framing of health care in which value is expressed as a cost efficiency. Chronic illness not only transforms the patient; it transmutes clinical practice hemmed in by structural expectations of provider efficacy. As illustrated in the next section, primary care relationships with patients are "recentered" by care managers in the PCMH model of care, as their affective sociality is read as an indicator of transformation success. Primary care improvement is effectively measured by making over perceived indifferent (and thus expensive)

chronic illness patients into responsible self-managers, more invested in their own care.

Feeling Cared About: Care Managers' Affective Pathways to Responsible and Efficient Health Care

The direct engagement provided by the care manager for patients with chronic disease was described as highly beneficial largely because of the care manager's affect. Many interviewees excitedly shared their impressions that patients were thrilled with the unique type of education and aid the care manager offered. A staff member on a quality improvement team in a large suburban practice described care management as "huge" because she saw "how wonderful it was, and how it really affected our patients, and just hearing the different stories, the different successes that she had with them. It was just wonderful just to hear..." For example, patients diagnosed with diabetes may become more "accountable," as one practice manager in a mid-sized practice put it, because "I think sometimes they have a question or concern...[and] may be hesitant to call the doctor and bother the doctor, but I think they're more comfortable calling and talking to [the care manager] about it."

Some focus group participants linked the value of the care manager's role in the diffusion of care away from the physician to the relational quality she provides:

Participant 1: They all liked being able to come and talk to her in person....

Participant 2: It was nice because sometimes you know the doctor, if they're coming in for one problem that's not related to the diabetes, sometimes the doctor only has time for that specific issue that they came in for; so it was nice for them to have her.

The care manager releases physicians and other staff from these kinds of calls, which as this practice manager continued, "was just awful" to manage because they did not have time for this level of patient interaction. The option to call, talk, and question someone for a substantial amount of time is described as freeing for patients who might otherwise feel limited by the time constraints of primary care physicians.

As care managers get more time, the value of the relational aspects of the care they provide is bolstered:

It definitely is a good thing for us and for the patients because they get the proper care that they need; to get all their questions answered...not feeling rushed. When you have somebody that's willing to spend an hour or an hour and a half with you teaching you these things, making you comfortable doing it, it makes a huge difference.

In a follow-up interview, a physician agreed, "I think a lot of those patients...for them it's the face-to-face time with somebody who's listening...the physician hasn't been able to do that...[the patients] really grabbed onto that and really enjoy that and find it a good experience." Indeed, the "patient-centered"

primary aim of PCMH transformation is to give patients a good experience: to feel cared about and listened to, not rushed or intimidated by physicians. Clinicians and staff perceived care managers as achieving this by contributing to the increased efficiency of the practice by freeing clinicians from the intense level of interaction required to shift patients from a passive to an active relationship of knowledge production and practice.

Where some patient resistance to using the care manager was mentioned, it was the care manager's relational role that eased the shift in the redistribution of authoritative power from physicians to other providers. As one care manager in a suburban family practice described it:

The few [patients] that said they didn't want to work with me, we kind of like would inch me in a little bit at a time, and now [it's] like I was their best friend. So even in the beginning when they thought, "No we don't want her in here, and we don't want her pestering us, we want doctor." Now it's kind of like they go around doctor or just...call me, "What can you do for me?"

While there was diversity in the training and approaches of care managers, the intersubjective relationality of care managers with patients was perceived as key to patient health improvement. Tools such as the patient empowerment model or motivational interviewing were described in ways which illustrated reflexive interpretation of how patient health is being reconstituted through the dialogical processes engaged between patients and care managers. A staff focus group participant summed it up as follows:

And those care managers have had patients in their office crying because nobody's ever taken the time... They've got to have a one-on-one with someone that they feel cares, and...I think what has come out from some of these programs is patients have responded with, "For the first time, I feel like someone cares about me."

The reconstruction of knowledge is reinforced as relationships build. As one care manager described, her work is successful when gauged on a longitudinal, subjective measure in patient transformation and engagement (as well as standardized biometric measures):

I have one particular patient that I've been working with for quite a while. I started probably three years ago, and he had a condition called deny-abetes for a long time... and didn't really want to acknowledge that he had the condition, and in...this past year, he decided that "Oh, okay, I do have diabetes," and basically his physician has been kind of saying, "Well we'll roll with it," and he decided, "No, I think I need to do something about this." What was interesting when I first met this man, he and I didn't get along at all...Our personalities clashed, and it was not a good relationship...but he also had severe pain; he also had severe chronic depression...those kind of things, so originally when I talked to him I asked him to tell me what his priority was...the most important issue was for him to manage his depression. And so I know that the diabetes was contributing to his depressive disorder, but he didn't know that.

This care manager detailed how she built a relationship with the patient over the course of several months, communicating with him “one way or another” every week, and describing how he became increasingly engaged as he came to terms with what they recognized together as emotional attachment issues related to diet originating in his childhood. Over time, through their conversations, they also tackled together a range of other social anxiety issues. She concluded, “So now he knows what drives him: that he’s seeking comfort. It’s really very interesting. He went from an A1c that was over 12 percent in September...to the last A1c draw that we did...March 8th...was 6.9.”

Narratives of patient success, such as this, measured good health in biomedical standards, such as weight loss and a lower percentage of hemoglobin A1c in the blood which indicates diabetes control. However, the affective quality of the relationship the care manager developed with the patient—how she made him feel cared about—was described as possibly the single-most important indicator of patient health improvement. Related through moving stories which detailed the heroic care manager coaxing the most “complicated case” to “take ownership of their illness” (two different practice managers describing the role of care management in year-3 interviews) the “partnership” created by the care manager results in patient individual responsibility and symbolizes broader PCMH transformation success.

Successful care management was discussed and measured in terms of perceived sociopsychological changes in patients resulting from the meaningful and social quality of the form of care, as well as measurable improvements in health. Clinicians and staff were highly reflective on how the patient-care manager relationship marks shifts in the production of knowledge and power in the clinical setting toward effective, direct, and positive outcomes for patients affected by chronic disease. In this relationship, a new place for knowledge production is created, and the patient is transformed. As care managers build networks of relationships, the social, community, and personal knowledge held by nurses, health coaches, educators, and other staff ascends where it may have been formerly subordinated to the specialized medical knowledge of physicians.

Teams, Partnerships, and Relationships: Diffusing Power and Knowledge Production in the Management of Chronic Illness

Several examples highlight the ways meaning was vested by care management in the leveling concepts of teams, partnerships, and relationships. Most clinicians and staff discussed the importance of the team approach as fundamental to PCMH practice change. The care manager appeared to be especially crucial and effective where patient care is decentralized and spread across a well-organized collective of harmonized providers. Diversity in perspectives emerged to illustrate how processes of power and knowledge diffusion were at work. A female care manager in a medium-sized practice added a gender dimension to her thoughts:

I think...the doctors I’m working with...like that time with the patients. They’re all female. They kind of like that hands-on thing, and with one of the female doctors, she was kind of like “I don’t want you getting in my way [laughs], with what I’m doing with the patients; with my relationships.”...[B]ut then she saw the benefit....

A physician was eager to emphasize that the role of the care manager was not elevated but integral to the new team-based approach being implemented in which knowledge and some decision making is shared. This physician, in a relatively large practice, noted:

Patients said, “Oh, Dr. McGarry, he does a pretty good job; but wow, Paula [the care manager], we really enjoy working with her. And that’s perfectly fine because if they’re going to identify her as the person who is advocating for them and providing them with education that they understand and those sorts of things, then I don’t have a problem with that. But what I’m trying to convey is that there is a partnership between the clinician and the [care manager], but at the same time, there’s kind of this dynamic where it’s all functioning as part of a team.

Others found that it was sometimes the physicians who were most challenged by this redistribution of power and knowledge. As one physician described:

Primary care doctors increasing[ly] have to understand that providing primary care, it’s a team. It’s not like the good old days where the doctor is out there doing it all for herself or himself. You’ve got to do it as a team, and that’s the only way that you can do it in today’s world. The team obviously includes a lot of different components, a lot of different people, but one of the things that I’ve been impressed with is how important care management is in that.

In these examples, clinicians and staff process the impacts of the redistribution of patient care across a spectrum of providers, in which the care manager’s role takes particular ascendance. They reflect critically on the social relations redefined between care managers and other clinical staff. At the professional level, non-physician primary care clinicians are well aware of their potential power in care management (Everett et al. 2014). As the providers who work most closely with the personal and social issues of patients, they mobilize patient trust and compliance by expanding the place of their authority in PCMH restructuring. Framed in terms of teamwork, partnerships, and relationships, the language of transformation tempers or obscures both the dispersal of primary care provider authoritative knowledge within practices and broader notions about responsibility and choice in the management of chronic illness.

Conclusion

The introduction of care managers in the context of PCMH transformation was challenging for many practices. Care managers were seen to fill vital roles in the management of chronic disease, yet their value, which emerged from the sociality of



their relationships with patients, is not readily measurable or billable. Many worried considerably about what to do when the grant money for the pilot program ran out. Indeed, a few practices have lost their care manager since the end of the pilot. Others were able to retain and support their care managers through Michigan's participation in the Center for Medicaid and Medicare Services (CMS) Multi-payer Advanced Primary Care Practice Demonstration (MiPACT 2011). Recognizing the important clinical role of and cost-savings resulting from the care managers, CMS developed a billing code in 2015 to reimburse chronic care management to either physicians or other health care professionals, such as care managers (Medical Learning Network 2015). Due to the defined diagnoses, management, metrics, and potential financial incentive from insurance companies for improvement in patient outcomes metrics, diabetes is often selected as the first condition to address through care management services (Ciervo et al. 2015; Liss et al. 2014; Sepers et al. 2015; Taliani et al. 2013; Wang et al. 2014). Although all practices independently decided to initially serve patients with diabetes using the care managers, all care managers participating in this study have expanded their services to patients with a variety of chronic conditions, including depression and other behavioral health concerns.

The presentation of "patient experience" here is limited to staff and clinicians' perspectives, as no interviews were conducted with patients. That said, health provider interpretations of patient experience are important to consider for their influence on practice and policy. While cost savings are the ultimate driving force for change in a market-driven health care system, we have shed light on some of the underlying processes through which improvements in patient health are perceived in relation to transformations in the distribution of clinical knowledge and power. As articulated by physicians, practice staff, and care managers, the new role of the care manager has largely improved physician, staff, and patient experience of care in the pilot practices. The interaction of the care manager and patient is largely driven by the personality of the care manager, the time allotted to the relationship, and the unique skill set of individuals in this role. While a few physicians preferred to personally discuss shared decision-making and self-management with patients, most appreciate the benefits of the expanded team.

The integration of care managers engages a process of redistribution of clinical power from one vested in the authoritative biomedical knowledge of physician-centered care to one more diffused in the social phenomenological interface of care manager and patient. The primary care provider is no longer an individual but a collective whose knowledge governing practice has shifted significantly. For some primary care physicians, this shift highlights the limits of their capacity to tend to chronic illness in the context of socioeconomic inequalities and predicts the imminent end of primary care (Chen et al. 2014a, 2014b; Friedman et al. 2014; McKinlay and Marceau 2008). For others, it reinforces the need to hold steadfast to primary care physician-centered practice (Phillips, Bazemore, and Peterson 2014; Phillips et al. 2014).

In commenting on an earlier version of our analysis, Susan Shaw (2013) noted that this research raises questions about which "model predominates in health care generally, with what kinds of consequences for knowledge, practice, and expertise." Social and ideological tropes of responsibility and choice in chronic illness management are produced and reproduced within the narrow instances of human interaction perceived to take place between care managers and patients. As such, they reproduce ideologies that support the continuity of the social systems which renew and affirm neoliberal political-economic structuring of health care. These signal processes by which authoritative knowledge is constructed and reveal deeper understanding of the ways in which the implementation of PCMH and care management reflect transformation not just of medical culture but of the politics of chronic disease. This shift in the locale of authoritative knowledge within practices brought about by care managers may be displacing hierarchies in medical culture. However, it also highlights how the shift to individualized "lifestyle" experience dilutes the social-cultural contexts and globalizing forces that pattern health and well-being. This may obscure the possibilities to interrogate the causal links and associations between society, economy, and polity and the distribution of outcomes of disease (Manderson and Smith-Morris 2010). The reflexive interpretation of health care transformation presented here uncovers the ways in which broad sociocultural and political processes are dialogically embedded in health practices and knowledges.

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