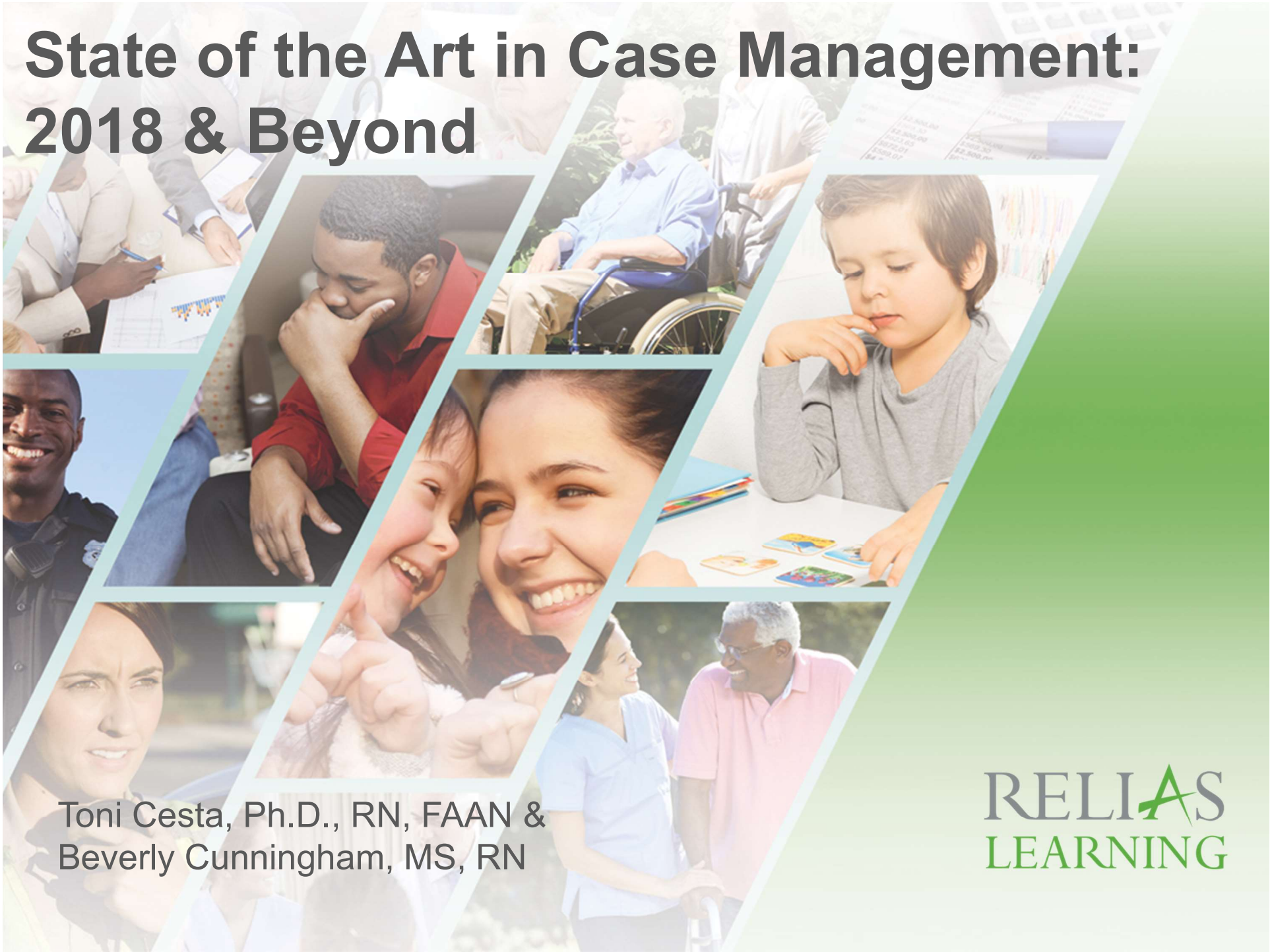
State of the Art in Case Management: 2018 & Beyond



Toni Cesta, Ph.D., RN, FAAN &
Beverly Cunningham, MS, RN

RELIAS LEARNING

Speakers

- **Toni Cesta**, PhD, RN, FAAN

Founding partner of Case Management Concepts, LLC. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of Case Management. Dr. Cesta also writes a monthly column called *Case Management Insider* in AHC Media's *Hospital Case Management* newsletter. She has been active in the research and development of Case Management for over 20 years.

- **Beverly Cunningham**, MS, RN, ACM

Founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board. Bev is also the former Vice President of Resource Management at Medical City Dallas Hospital.

OBJECTIVES

- Understand the history of case management.
- Review how case management fits into today's healthcare system.
- Discuss ways in which case management is a strategy for managing cost and quality under the latest CMS reimbursement models.

THE HEALTH CARE INDUSTRY TODAY

- 32% of healthcare dollars are spent on hospital care
- Per capita spending on healthcare = $9,990 (this is 2/3% higher than the second highest spending country – United Kingdom)
- 18% of the gross national product is spent on healthcare
- Uncompensated (bad debt and charity) care in hospitals = 6% of revenue
- The United States ranks 31st in life expectancy and 30th in infant mortality (World Health Organization 2015)
- A recent study demonstrated that close to 1/3 of the $1.6 trillion we now spend on healthcare goes to care that is *duplicative, fails to improve patient health and may actually make it worse*

THE ENVIRONMENT IN WHICH WE WORK

- Rising bed demand
- Over crowded emergency departments
- Hospital gridlock
- Internal process delays/lack of resources
- Older, more complex patients

THE MANDATE FOR CHANGE

- Unjustifiable practice variation
- Disconnects between quality outcomes and intensity of care
- Poor health outcomes and patient safety record
- Highest cost health care in the world
- No real system of care
- Patient dissatisfaction
- Payer dissatisfaction
- Quality and safety “gaps”
- Care inequity
- Misguided incentives of care

CHALLENGES OR……

OPPORTUNITIES????

HEALTH CARE PROCESSES EVOLUTION

- Processes have evolved over time and haphazardly
- Departments and disciplines remain siloed
- Staff do not have time to focus on process improvements and typically “work around” broken systems

HEALTHCARE COSTS: WHAT THEY WERE

What do you remember?

PROSPECTIVE PAYMENT

- 1965 Medicare program initiated
- Billing based on costs incurred
- 1983 PPS initiated
  - DRGs condensed diagnosis and procedure codes into classification system for in-patient acute care reimbursement
- 1997 MS-DRGs initiated: Medicare Severity – Diagnosis Related Groups

RELATIVE WEIGHT

An assigned weight that is intended to reflect the relative resource consumption associated with each DRG. The higher the relative weight, the greater the payment to the hospital.

MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS: MS-DRG EXAMPLES

MS-DRG	MAJOR DIAGNOSTIC CATEGORY	M/S	DESCRIPTION	RELATIVE WEIGHT	GEOMETRIC LOS	ARITHMETIC LOS
030	1- Diseases & Disorders of the Nervous System	Surgical	Spinal Procedures W/O CC/MCC	1.7835	2.6	3.4
054	1	Medical	Nervous System Neoplasms W MCC	1.3048	3.9	5.3
055	1	Medical	Nervous System Neoplasms W/O MCC	1.0191	3.0	4.1
195	4 – Diseases and Disorders of the Respiratory System	Medical	Simple Pneumonia and Pleurisy, Age Greater than 17 W/O CC/MCC	0.7044	2.9	3.4
330	6 – Diseases and Disorders of the Digestive System	Surgical	Major Small & Large Bowel Procedures W CC	2.5491	7.1	8.4
652	11 - Diseases and Disorders of the Kidney and Urinary Tract	Surgical	Kidney Transplant	3.1502	5.7	6.6

CASE MIX INDEX

The sum of all DRG weights, divided by the number of cases represents the average of all relative weights for the designated time period

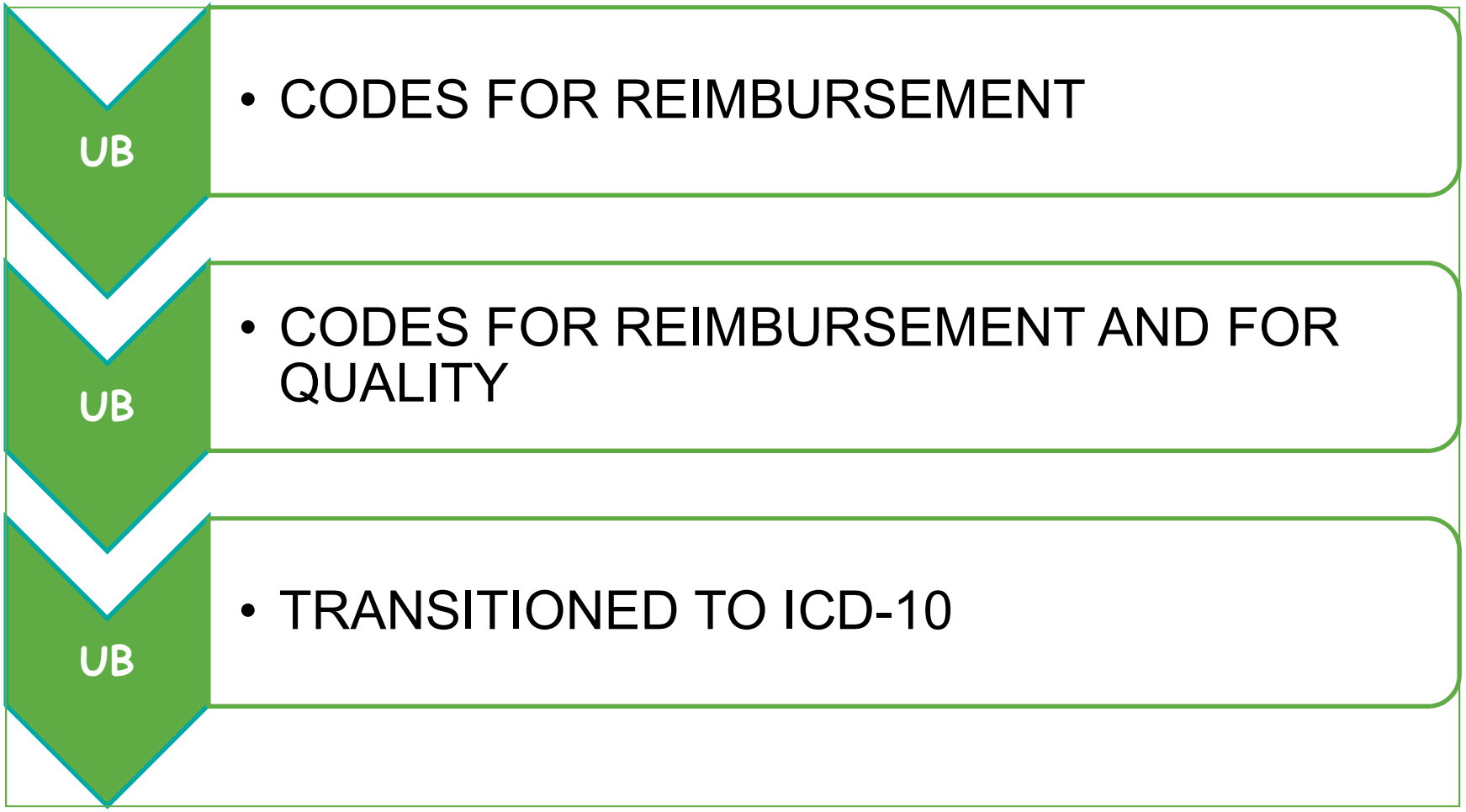
INTERNATIONAL CLASSIFICATION OF DISEASES – ICD HISTORY

- Dates back to 17th century England when codes used for mortality information: Bills of Mortality
- By 1937 known as International List of Causes of Death
- 1948 World Health Organization published list, International Classification of Diseases (ICD), showing mortality and morbidity

ICD HISTORY

- By 1977, US modified it for medical record indexing and classification—used for statistical groupings
- In 1988 Congress mandated these codes to be on claims
- Today we are at the 10th revision (ICD-10)

CHANGE IN USE OF ICD CODES



WHO CARES ABOUT DOCUMENTATION?

- Purchasers of healthcare
- Purchasers of data
- Your hospital
- OIG
- QIO
- Physicians

ICD-10 CODES

- Increased specificity
  - Identify specific disease processes
  - Identify interaction between symptoms and definitive diagnoses

	ICD-9	ICD-10
Characters	3-5	3-7
Diagnosis codes	14,315	69,101
Adding new codes	Limited space	Flexible space
Digits	3-4	7
Procedure codes	3,838	71,957

WHAT IS THE EXPECTED LOS?

- Average Medicare LOS 4.5 (National Hospital Discharge Survey 2014)
- Expected LOS is impacted by complications and comorbidities from ICD-10 codes
- Expected LOS may vary by group providing the statistics
- Measures of length of Stay
  - The geometric **mean** (GMLOS) reduces the effect of very high or low values, which might bias the **mean** if a straight average (**arithmetic mean**) is used
  - The **arithmetic mean length** of **stay** (ALOS) is the average **length** of **stay** experienced by a patient within a chosen DRG.
- Determine which metric your hospital uses

WHY DO WE CARE ABOUT LENGTH OF STAY?

- Most payers pay by the DRG or case rate
- If a patient stays in the hospital long enough, they will get sick
- LOS is publicly reported
- Gauges hospital efficiency
- Attracts managed care contracts
- Maintains competitive edge
- Aligns with regional and national benchmarks
- Now used for value-based purchasing

WHAT IMPACTS LENGTH OF STAY?

- Patient flow
- Case management's focus on the process of coordination of care
- Captain of the ship physician
- Consulting specialist timeliness
- Delays in care
- Availability of ancillary services
- Timeliness of tests and reporting
- Ability to schedule procedures and tests timely

WHAT IMPACTS LENGTH OF STAY?

- Avoidable days
- Ineffective (or effective) discharge planning
- Unfunded/underfunded patients with minimal resources post discharge
- Availability of post acute care resources, often geographical
- Effective communication
- Focused treatment for the reason the patient was admitted (not focusing on “rabbit trail” treatment)

WHAT IMPACTS THE EXPECTED LOS?

- Coding
- Complications
- Documentation
- Clinical documentation improvement (CDI) effectiveness

HOW COSTS USED TO BE…….
TO HOW THEY ARE NOW

WHAT IS MANAGED CARE?

A system that integrates the financing and delivery of appropriate health care using a comprehensive set of services.

MANAGED CARE INCLUDES MANY TYPES OF ORGANIZATIONS AND INSURANCE OPTIONS

- **Health Maintenance Organization (HMO):** provides a wide range of services for a fixed, periodic payment

- **Preferred Provider Organization (PPO):** consists of groups of hospitals, physicians and other providers who contract with an insurer, employer, third-party administrator or other group to provide health care services to covered persons

MANAGED CARE INCLUDES MANY TYPES OF ORGANIZATIONS AND INSURANCE OPTIONS

- **Point-of-Service Plans (POS):** combine HMO and PPO features. Members can choose which option they want to use at the time of service

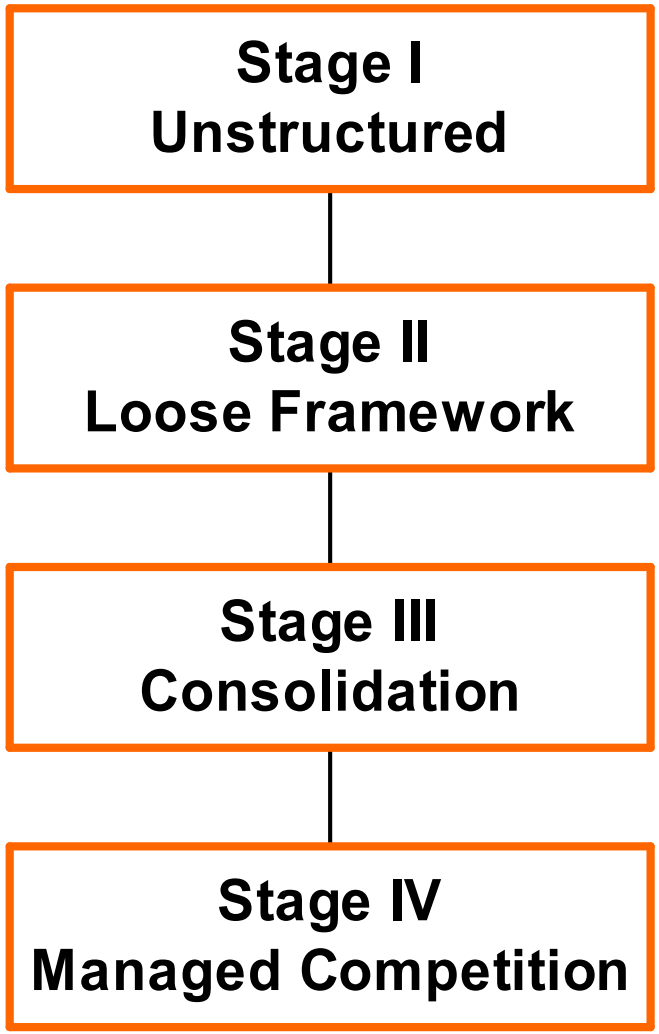
- **Indemnity or fee-for-service**: plans that incorporate features of managed care and provide benefits in a predetermined amount for covered services

- **Self-Insurance plans**: employers and businesses assume fiscal liability and the responsibilities of an insurer for their own employees

FEATURES COMMON TO MANAGED CARE

- Pre-authorization
- Rigorous utilization review
- Emphasis on use of primary physicians and other health care providers
- Financial incentives for enrollees to use providers and procedures associated with the plan
- Quality improvement programs and payment systems that make physicians, hospitals and other providers financially accountable for cost and quality of medical services

FOUR STAGES OF MANAGED CARE MARKET EVOLUTION



STAGE 1 UNSTRUCTURED: 5% of POPULATION

- Fee-for-service market penetration is dominant, while HMO enrollment is less than 5%.
- Physicians are most likely to be solo practitioners, with some group practices and the majority of physicians are family practitioners.
- The predominant type of health insurance offered in the community is indemnity insurance. The carriers who offer the most indemnity products are Blue Cross/Blue Shield (BCBS), Aetna, Cigna, Travelers and Prudential.
- Usually, patients do not need to worry about hospital bills and surgical fees charged by physicians because these health plans cover most of the expenses.

STAGE 2 LOOSE FRAMEWORK: 10-25% OF POPULATION

- As managed care penetration reaches 10-25% of the general population, there are many managed care organizations available to provide patient care.
- The four types of managed care organizations entering the market typically include Staff Model health maintenance organizations (HMOs), Group Model HMOs, preferred provider organizations (PPOs) and independent physician's associations (IPAs).
- There is also the formation of provider networks, such as a physician hospital organization (PHO) that are starting to contract with managed care organizations.

STAGE 2 LOOSE FRAMEWORK: 10-25% OF POPULATION

- Hospital admissions start to decrease as provider networks begin implementing utilization review and length-of-stay requirements. The insurance health plan activates pre-certification rules that further limit the hospitals' ability to keep a high bed-occupancy rate.
- The pricing of medical services by providers is now dominated by discounted fees
- Stage two is the most difficult stage in managed care and can last for several years. The local employer groups are marketed by health plans showing a decrease in premium rates. These low premium rates will attract employer groups to make exclusive contractual arrangements to use an HMO or a PPO.

STAGE 3 CONSOLIDATION: 25-50% OF POPULATION

- In stage three, a shake-out will occur between managed care organizations. Mergers will take place and the weak will fail.
- By now 25-50% of the population is enrolled in managed care plans.
- Large hospitals form affiliations with smaller “feeder” community hospitals as another growth strategy of managed care obtains more covered lives. Small rural hospitals improve their image to attract patients and acquire/purchase primary care practices in an attempt to control referrals.
- Preventative care (wellness) and primary care medicine are essential in stage three.
- The pricing of health care in the community is now based on pre-payment, capitation, per diems and global fees. Expenses for the managed care organizations are calculated in terms of per member, per month.

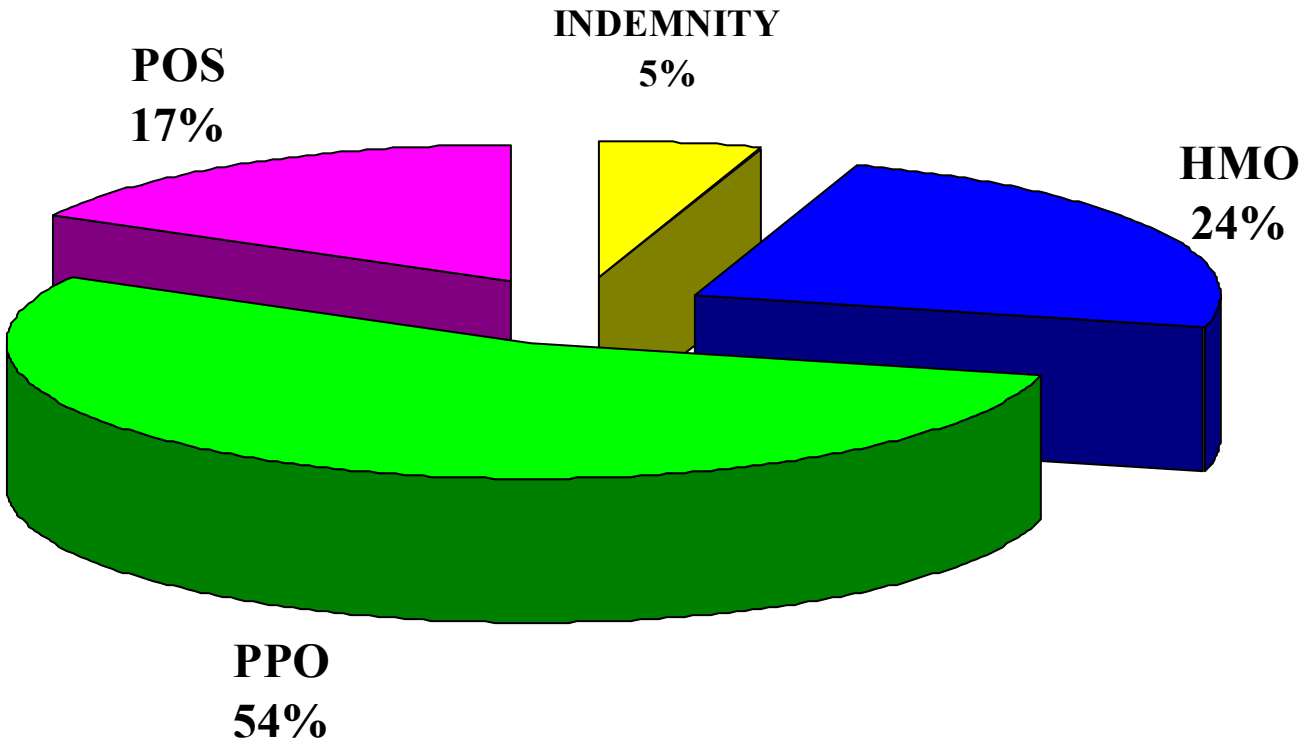
STAGE 4 MANAGED COMPETITION: 60-70% OF POPULATION

- Stage Four is a very mature managed care market. Managed care penetration reaches 60-70% of the total population, with fully integrated health care delivery systems. Most parts of the United States have not reached this stage, although some areas in California and Arizona have.
- Most providers in this stage are salaried or fully capitated by the health plan, PHO or integrated delivery network. There is a strong incentive for providers to change how health care is delivered.

STAGE 4 MANAGED COMPETITION: 60-70% OF POPULATION

- Case management for those patients/members who have chronic or catastrophic disease becomes essential for the financial survival of the managed care organization, especially those involved in Medicare or Medicaid HMOs.
- Case management emphasizes cost containment, intervention and steerage to contracted network providers.
- During this stage, pricing is only measured by cost per covered life.

MANAGED CARE TODAY



YOUR HOSPITAL'S REIMBURSEMENT FOR INPATIENT CARE

- Diagnosis Related Groups (DRG): Case rate
- Per diem: Payment for each day in hospital
- Percent of charges
- Carve-out services: Based on contract; usually for high cost services, such as implants
- Pay for performance: Reimbursement or reimbursement penalty based on clinical outcomes

YOUR HOSPITAL'S REIMBURSEMENT FOR INPATIENT CARE

- Global payment/bundled payment: Reimbursement for facility, post acute levels of care (both IP and OP) and physician
- Stop loss: Increase in payment after charge threshold met
- Outlier: Increase in payment after specific combination thresholds met, such as both LOS and charges

BUNDLED PAYMENT REIMBURSEMENT

THE NEW WAY OF DOING BUSINESS

- Many healthcare services still paid for under fee-for-service contracts
- Transitioning to value-based reimbursement—options ranging from a single procedure to full capitation for a population of patients
- Nearly every payer is experimenting with and has some sort of alternative payment method
- Forward-thinking hospitals are planning for this way of doing business

WHAT DOES BUNDLED PAYMENT MEAN?

- A hospital's financial performance may be highly dependent on downstream care – hospitals will care more where their patients go
- Expect hospitals to establish performance metrics / scorecards
- Length of Stay
- Readmission Rates
- Patient Satisfaction
- Post acute care availability
- Linking with post acute care providers who supply quality care with cost effective care
- Patient Outcome Measures

BUNDLED PAYMENTS AS A CMS STRATEGY TO CONTROL COSTS AND ENSURE QUALITY

- Placing the risk on the hospital
- Bundled payment advantages
  - Incentivize providers to choose most efficient mix of services and settings of care
  - Reduce fragmentation
  - Encourage collaboration across settings
  - Improve accountability and quality
- Extending bundled payment beyond the hospital stay to include the post-acute care world
- 40% of Medicare patients use some kind of post-acute care after hospital discharge
- Challenging situation as post-acute care payment system is complex with many utilization and outcome concerns

THE FIRST CMS MANDATORY BUNDLED PAYMENT GROUP OF PATIENTS

COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CCJR): BUNDLED PAYMENT PROGRAM

- Projected to save $343 million over 5 year period
- There are 430,000 TJRs in DRG 469 and 470 per year costing Medicare $7 billion per year
- Implementation began April 1, 2016
- With few exceptions, participation is mandatory.
- Applies to all acute care hospitals furnishing the services in 67 selected mandatory serviced areas (MSAs) (approximately 800 hospitals in 33 states)

COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CCJR): BUNDLED PAYMENT PROGRAM

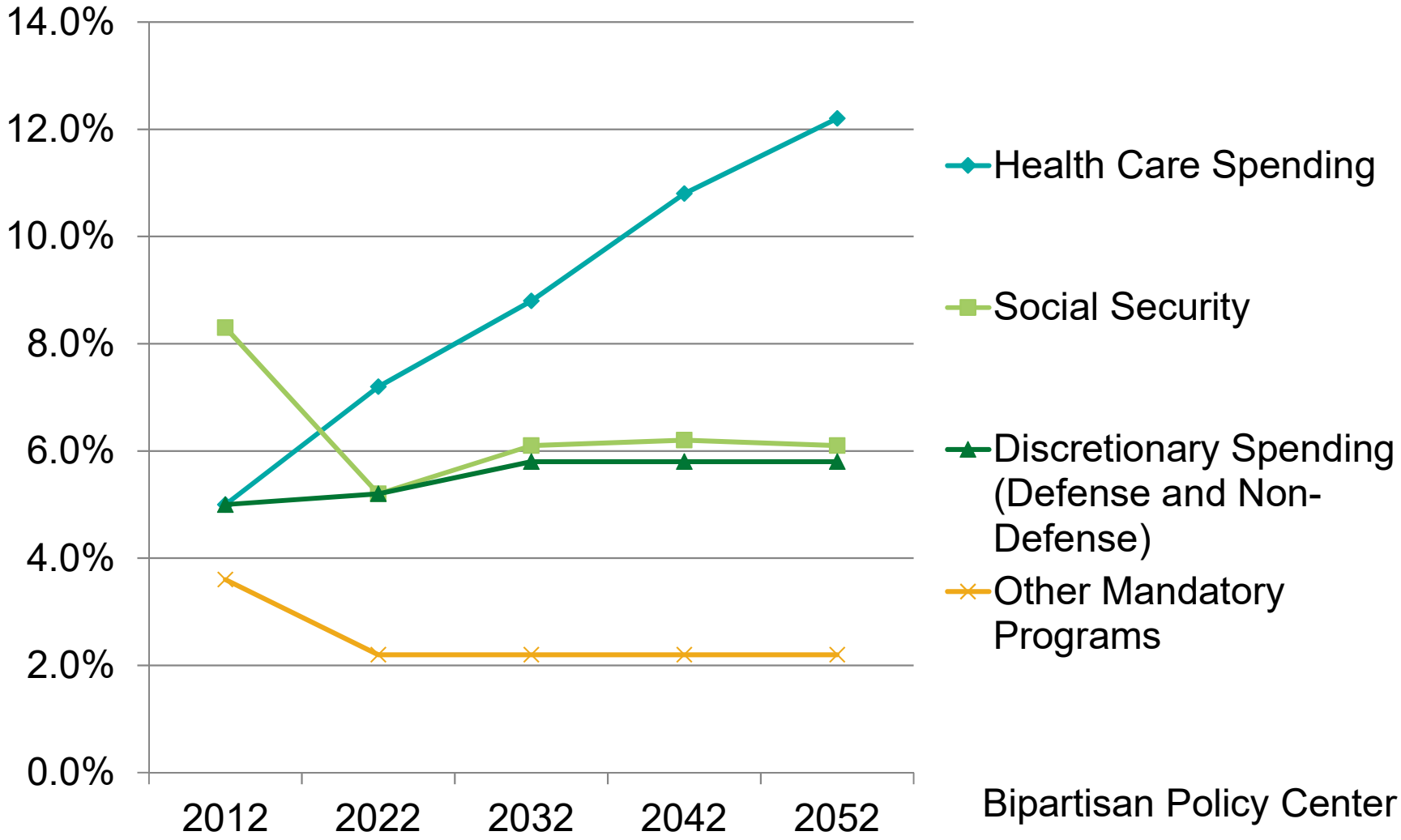
GOALS

- Aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries – hip and knee replacements
- Tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post acute care providers to work together to improve quality and coordination of care from the initial hospitalization through recovery

RESULTS OF THE CCJR INITIATIVE

- Decreased used of inpatient rehab and SNFs
- Increased use of low cost options, such as home care
- Cut referrals to one star and two star SNFs
  - Expect to see 25% of SNFs close
    - One and two star facilities
    - No IT integration with hospitals
    - Suboptimal physical therapy programs
    - No clinical protocols
    - Poor physician collaboration and alignment
    - No effective medical director (rounding on patients daily)
  - SNFs with strong medical direction and processes will flourish
- De-emphasize the poorly performing SNFs when choice is provided

HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE U.S. DEBT



THE 2012 IPPS RULE BROUGHT US TO THE LINK BETWEEN COMPLIANCE AND QUALITY: DO NO HARM OR YOU WILL NOT BE PAID!

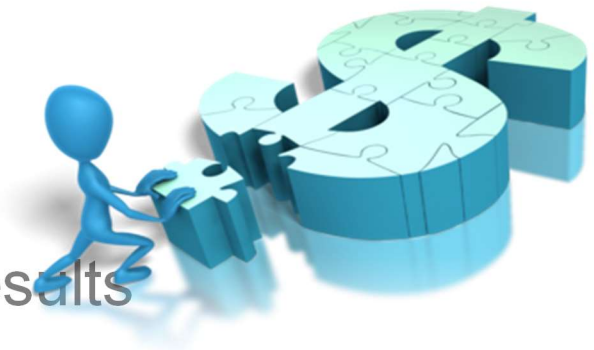
CMS DEFINES HARM

- Not following core measure evidence-based practice
- Not having satisfied patients
- Unnecessary readmissions
- Hospital acquired conditions
- Never events
- Unnecessary mortalities
- Care at a reasonable cost
- Other aspects of harm will be identified in each annual IPPS final rule update

CMS TRANSFORMED

MEDICARE'S TOOLS TO PROMOTE INCREASED QUALITY AND EFFICIENCY OF CARE

- Measured performance
- Payment incentives
- Payment deductions
- Public reporting of performance results
- National and local coverage policy decisions
- Enforcing Conditions of Participation
- Providing direct support for providers through Quality Improvement Organization (QIO) activities
- Electronic transmission of clinical and demographic data
- Annual update of the IPPS rules



PATIENT PROTECTION AND AFFORDABLE CARE ACT

Signed March 23, 2010, But Implemented Over Several Years 2010

- Expanded tax credits for small businesses' health plans
- Rebates to seniors for prescriptions drugs
- Children could not be denied coverage due to pre-existing conditions
- Some state and federal plans for adults with pre-existing conditions
- Young adults <26 allowed to stay on parents plans
- Education to attract more primary care nurses and physicians to underserved areas

PATIENT PROTECTION AND AFFORDABLE CARE ACT

- **2011**
  - Insurance companies required to spend at least 80-85% of premium dollars on healthcare or quality improvement, rather than administrative costs or profits (or they were to send rebates to customers)
  - Gradual reduction to insurance companies in Medicare Advantage program
  - Increased services to elderly and disabled
  - 50% discount on Part-D covered name-brand prescription drugs
  - Money granted to public health programs
  - Services to help Americans purchase sensible private insurance

PATIENT PROTECTION AND AFFORDABLE CARE ACT

- **2012**
  - Increase in Accountable Care Organizations
  - VBP and readmission payment program in Q4
- **2013**
  - Medicaid reimburses primary physicians at Medicare rates
  - Funding to states that craft Medicaid programs with better benefits for preventive care
  - Pilot programs for bundled payments

PATIENT PROTECTION AND AFFORDABLE CARE ACT

- **2014**
  - Nearly all adults and children must obtain health insurance or pay a fine
  - States to have online health insurance marketplace, called an exchange to offer plans for individuals and small businesses
  - Medicare disproportionate share hospital payments to decrease 75%

AFFORDABLE CARE ACT

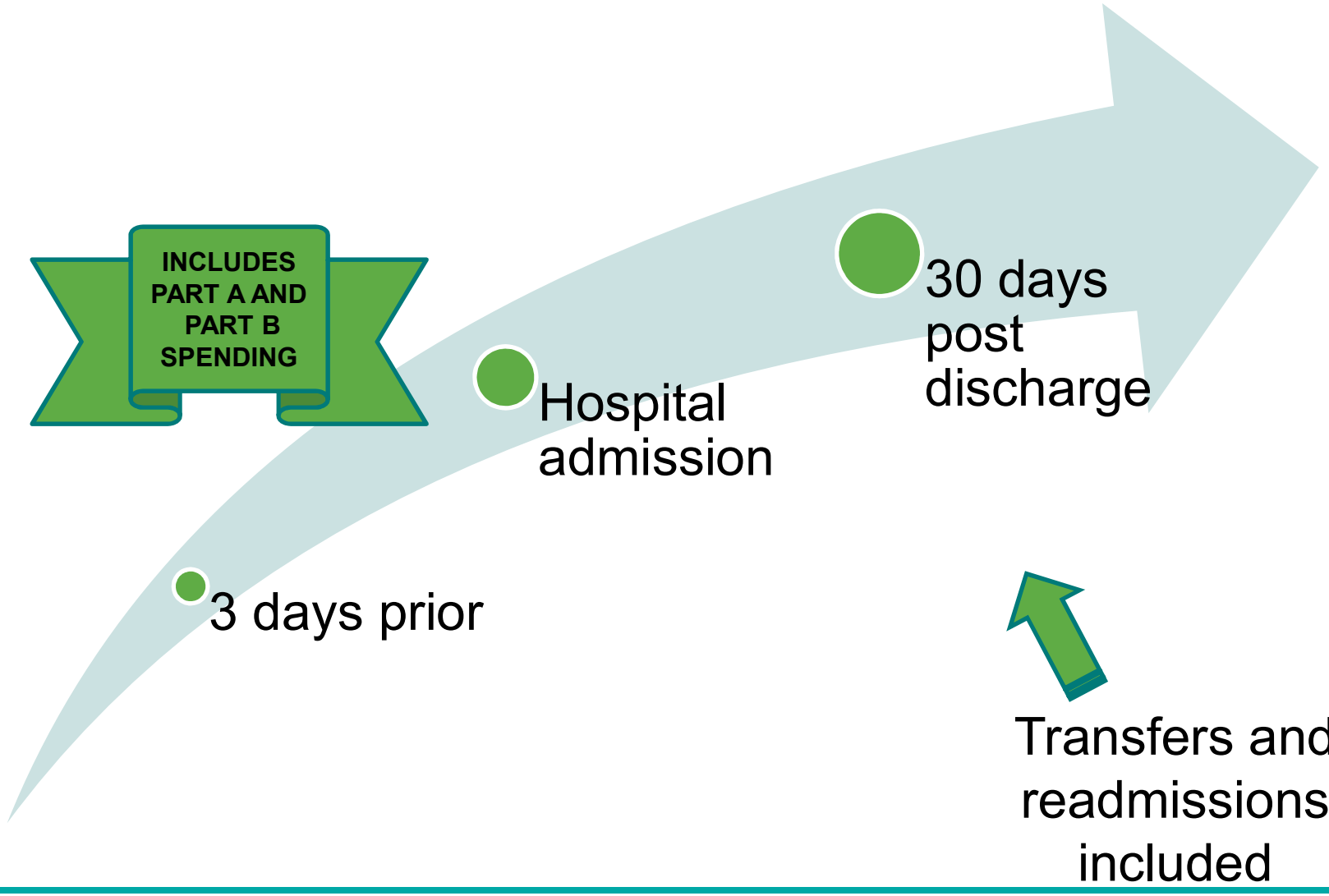
- Requires HHS Secretary to establish VBP program with incentive payments
  - DRG payment reductions
    - FY 2013 1% reduction
    - FY 2014 1.25% reduction
    - FY 2015 1.5% reduction
    - FY 2016 1.75% reduction
    - FY 2017+ 2% reduction
- CMS says this should balance the opportunity for increased reimbursement with quality measures

VALUE-BASED PURCHASING 2018

2% of all Medicare Payments at Risk

THE FIRST FRIGHTENING AND CONFUSING MEASURE: EFFICIENCY

A QUICK LOOK AT THE FIRST EFFICIENCY MEASURE



MEDICARE SPENDING PER BENEFICIARY SCORING

- 1.0 is the expected score
- Lower is better: 0.85 = 15% less than expected
- Higher is worse: 1.10 = 10% higher than expected
- Check your scores on hospital compare

WHAT DOES MEDICARE SPENDING PER BENEFICIARY MEAN TO US?

- Manage resources during stay
- Focus on successful and efficient care transitions
- Hardwire multidisciplinary teams
- Manage discharge plan
- Manage keeping the patients out, once discharged
- Align with next level of care providers

Your results are published on www.hospitalcompare.hhs.gov

HCAHPS: HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS HOSPITAL SURVEY

- What do our patients think of us?
- Can we use this data to benchmark best practices and conduct research?
- Can we identify performance strengths and weaknesses?

WHERE WE DID BEST

- Overall hospital ratings (56%) rated either “9” or “10” with 10 being the best
- 94% of respondents would either definitely (71%) or probably (23%) recommend their hospital to family/friends
- Highest scores for communication with doctors/nurses
  - 87% of doctors treated patients with respect and courtesy
  - 81% of nurses

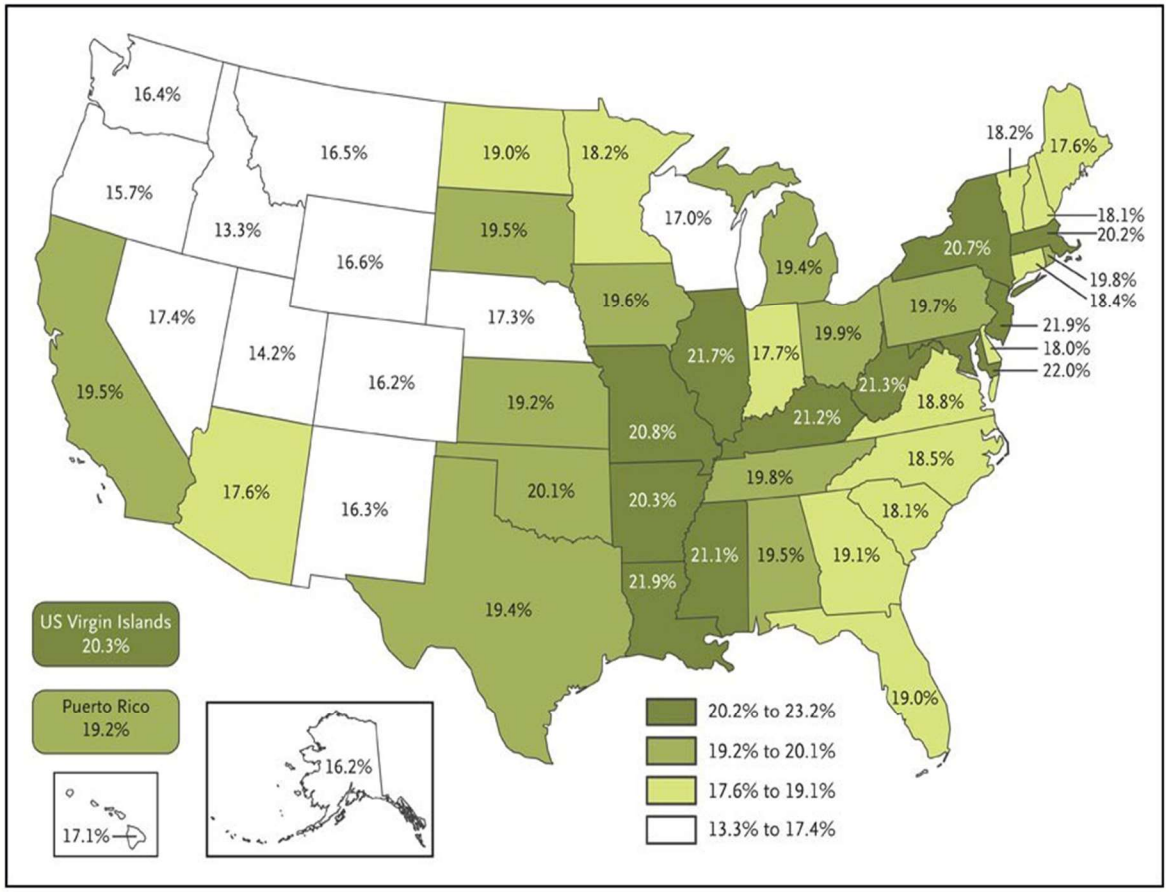
WHERE WE DID WORST

- Lowest scores for communication about medications and discharge information
  - 26% reported that hospital staff never described possible side effects of new medications in a way they could understand
  - 24% reported that hospital staff never talked with them about whether they would have the help they needed when they left the hospital
  - 18% reported they never received written information about symptoms or health problems to look for when leaving the hospital

HOSPITAL READMISSIONS REDUCTION PROGRAM

- IPPS 2013 final rule discussed additional readmission diagnoses conditions identified by Medicare Payment Advisory Commission
- Required under Affordable Care Act
- Much disagreement with CMS's response to public comments about recommendations to excluded unrelated and planned readmissions
  - All readmissions are included without regard to the principal diagnosis of readmission
- Readmissions exclusions
  - In-hospital deaths
  - Patients not enrolled in Medicare FFS for at least 30 days post-discharge
  - Patients discharged AMA
  - Patients under the age of 65

Impetus for Readmission Penalties: High, Costly Readmission Rates



Readmission rates w/in 30 days of discharge…The NEJM study found 50% of readmitted non-surgical patients didn't see a community doctor for follow-up

Source: *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, Jencks et al., New England Journal of Medicine, April 2, 2009.

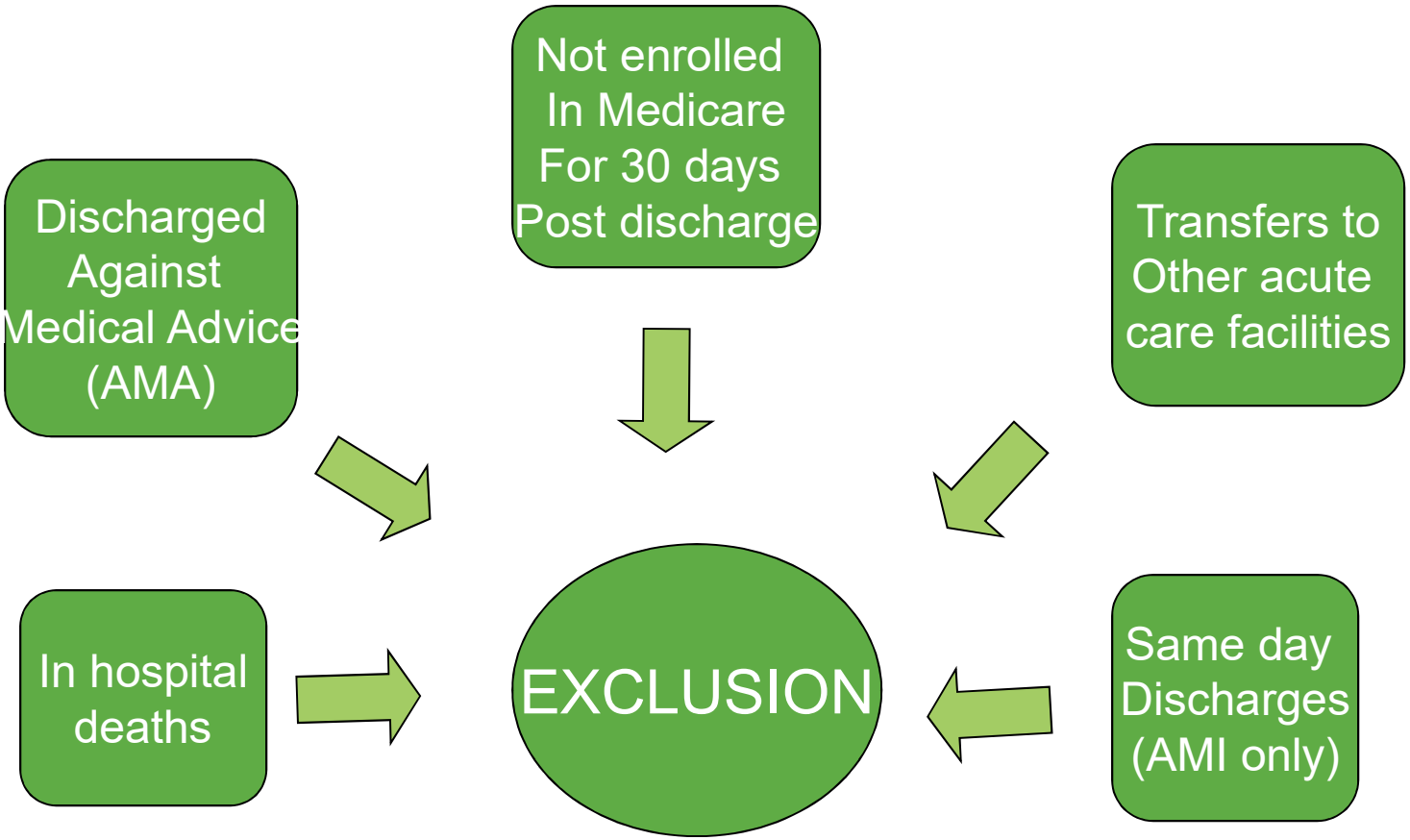
WHAT DO READMISSIONS LOOK LIKE?

- 77.6 % are medical
- 22.4% are surgical
- 1/5 or 19.6% of the 11,855,702 Medicare beneficiaries discharged from hospitals are readmitted within 30 days
- 34% are rehospitalized within 90 days

PHYSICIAN VISITS

- 50.2% of the patients who were rehospitalized within 30 days after a medical discharge to the community, did not see their doctor within those 30 days
- The average length of stay of a rehospitalized patient is 0.6 days longer that patients of the same diagnosis

EXCLUDED FROM READMISSIONS



READMISSION RISK ADJUSTMENT

Adjusts for case-mix difference based on the clinical status of the patient

- Demographic variables
- Comorbid diseases
- Indicators of patient frailty

Does not adjust for

- Complications of care
- Admission source
- Socioeconomic status
- Hospital size, specialty or location

INCLUSION IN THE READMISSION PENALTY PROGRAM

MEASURE	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Acute MI	X	X	X	X	X	X
Heart Failure	X	X	X	X	X	X
Pneumonia	X	X	X	X	X	X
COPD			X	X	X	X
Total Hip and Total Knee Arthroplasty			X	X	X	X
Coronary Artery Bypass Graft Surgery					X	X
Hospital-Wide All-Cause Readmissions					x	x

PENALTY ADJUSTMENT

- Applied annually
- Applied if any of the conditions or procedures have a performance that is worse than the national average
- Applies to all Medicare discharges for that year
- Applies to a portion of the hospital's payment

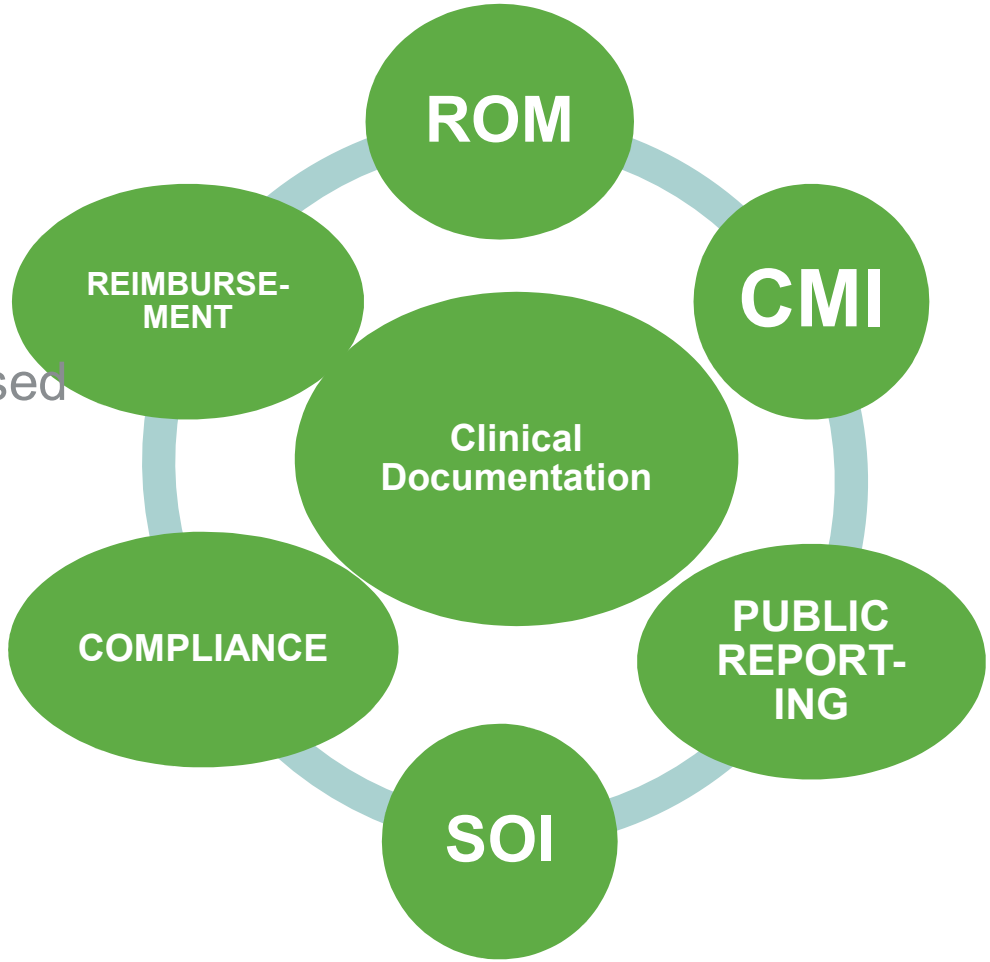
2012	1%
2013	2%
2014	3%
2015	3%
2016	3%
2017	3%
2018	3%

ACCOUNTABLE CARE ORGANIZATION (ACO)

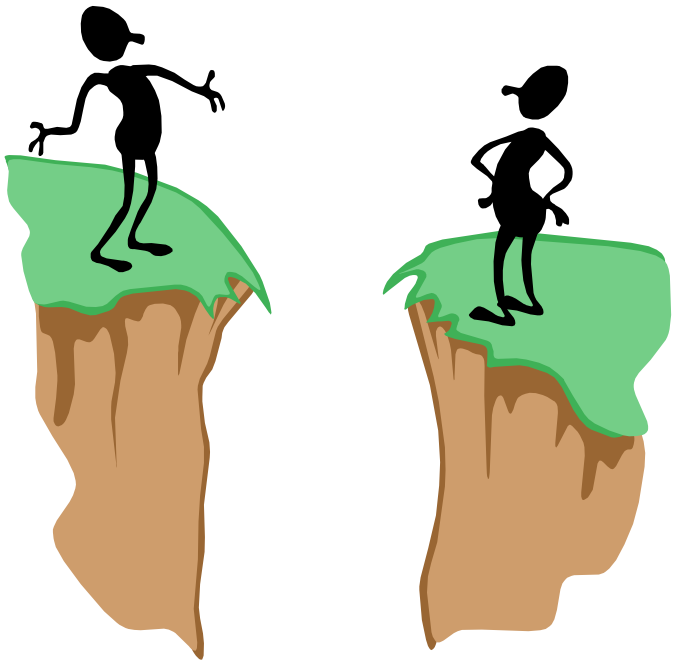
- Responsibility of patients throughout the healthcare continuum
- 33 quality metrics (scaled back from 70)
- Pioneer ACOs (those from 2011) received payment just for reporting data—such as # of patients receiving mammograms and readmissions 30 days after hospitalization
- Eventually there will be financial consequences for poor performance

DOCUMENTATION: WHY WE CARE ABOUT IT

- Clinical information is our most valuable asset
- Drives reimbursement
  - Case mix index
  - Hospital-acquired conditions
  - Next generation of value based purchasing
- Indicates severity
  - Risk of mortality
  - Severity of illness
  - Complication rates
- Used by public reporting to drive excellence



THE GAP BETWEEN PUBLIC REPORING AND HOSPITAL OUTCOMES



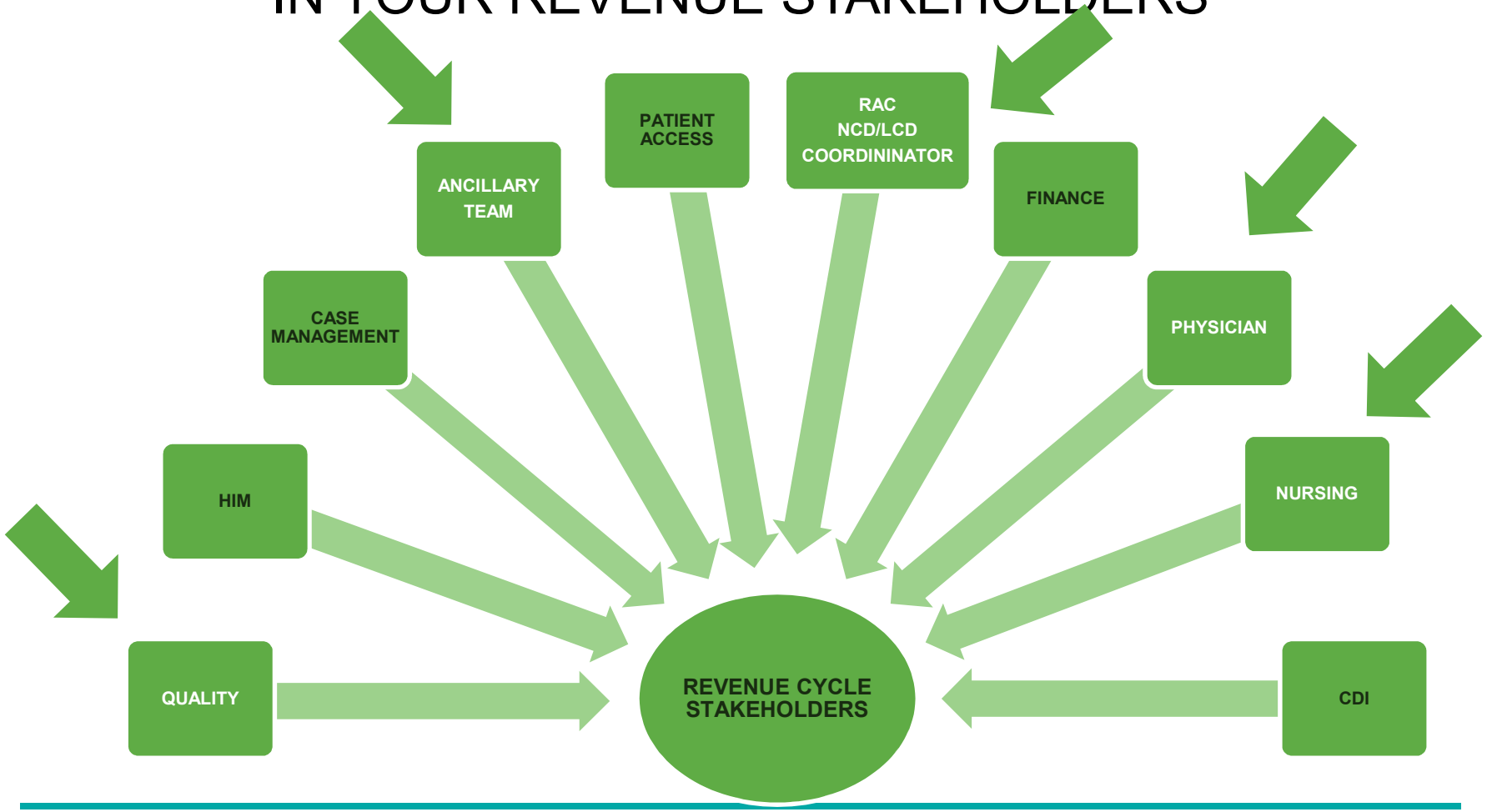
What's in the Record

WHAT IT TAKES TO DECREASE THE GAP

- Alignment with new stakeholders
- Education for all stakeholders
- Engaged physician relationships
- Strong case management leadership role
- Hardwired processes
- Effective clinical documentation improvement
- Evidence-based case management strategies
- Healthcare reform dashboard

WHAT IT TAKES TO DECREASE THE GAP: ALIGNMENT

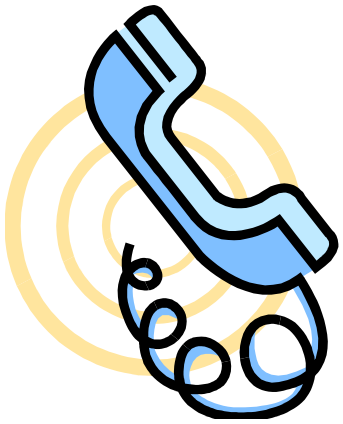
HEALTHCARE REFORM DEMANDS A CHANGE IN YOUR REVENUE STAKEHOLDERS



WHAT IT TAKES TO DECREASE THE GAP: ALIGNMENT

- Internal stakeholders
  - Staff
  - Physicians
  - Leadership

- External stakeholders
  - Next level of care providers
  - Physicians



HEALTHCARE REFORM STAKEHOLDER RESPONSIBILITY

	READMISSIONS	HCAHPS	CORE MEASURES	HOSPITAL ACQUIRED CONDITIONS	MEANINGFUL USE MEASURES	CDI	LOS REDUCTION STRATEGIES
CASE MANAGER							
SOCIAL WORKER							
NURSING							
QUALITY MGMT							
PHYSICIAN							
APN or PA							
EDUCATOR							
PATIENT NAVIGATOR							
CLINICAL NURSE LEADER							
NCD/LCD COORD							
ANCILLARY STAFF							

WHAT IT TAKES TO DECREASE THE GAP: EFFECTIVE CLINICAL DOCUMENTATION IMPROVEMENT

WHAT IT TAKES TO DECREASE THE GAP: EVIDENCE-BASED CASE MANAGEMENT STRATEGIES

- Readmissions
- Spending per Medicare Beneficiary
- Care Coordination
  - Through the hospital
  - For specific patient types/diagnosis
- Linking the Continuum
- Community Case Management
- Physician Relationships

EVOLUTION OF CASE MANAGEMENT

1. 1920 –- Psychiatry and social work; out-patient settings
1. 1930 –- Public health nursing
2. 1950 –- Behavioral health across the continuum
3. 1985 –- Acute care
4. 1990s –All healthcare settings

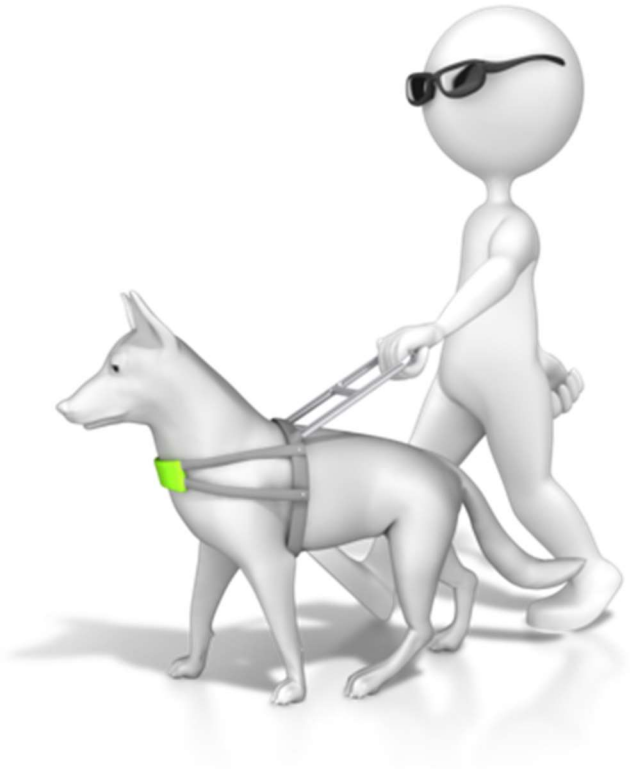
WHY IS CASE MANAGEMENT USED IN HOSPITALS?

- To promote quality, safe and cost-effective care
- To promote utilization of available resources to achieve clinical and financial outcomes
- To ensure appropriate access to care
- To work collaboratively with patient / family, physician, providers, payers and others to develop and implement a plan that meets the individual's needs and goals
- To interject objectivity, healthcare choices and promotion of self-care where it is lacking

CASE MANAGEMENT'S OVER-RIDING GOALS

- Enhance **quality** of care
- Promote **cost-effective** health care environment

TAKING A LOOK AT CASE MANAGEMENT DEFINITIONS



CASE MANAGEMENT SOCIETY OF AMERICA'S CASE MANAGEMENT DEFINITION

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes

NATIONAL ASSOCIATION OF SOCIAL WORKERS CASE MANAGEMENT DEFINITION

- Social work case management is a method of providing services whereby a professional social worker assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors., evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.
- A professional social worker is the primary provider of social work case management. Distinct from other forms of case management, social work case management addresses both the individual client's biopsychosocial status as well as the state of the social system in which case management operates.
- Social work case management is both micro and macro in nature: intervention occurs at both the client and system levels. It requires the social worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide him or her with needed services, resources, and opportunities.
- Services provided under the rubric of social work case management practice may be located in a single agency or may be spread across numerous agencies or organizations.

AMERICAN CASE MANAGEMENT ASSOCIATION'S DEFINITION OF CASE MANAGEMENT

Case Management in Hospital/Health Care System is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self determination.

COMMUNITY CASE MANAGEMENT

- Target high-risk, high-cost subgroups in a population-focused framework
- Manage and coordinate care across the continuum
- Track quality, clinical & cost outcomes

WHY CASE MANAGEMENT IN THE COMMUNITY?

Provides a system of care used to oversee the patient's healthcare processes and link steps

1. Keep patients connected.
2. Ensure that energy and resources are matched to patient needs.
3. Monitor outcomes and compare to evidence-based guidelines.
4. Makes sure its simple and fits into daily practice.

THE PROBLEM

- Missed treatments, prescriptions unfilled or not taken, missed physician appointments
- Frequent admissions or visits to ED
- Poor health care behaviors
- Busy health care staff
- Lack of systematic way to assess and pro-actively deal with issues that affect adherence, quality of life, outcomes

NURSE CASE MANAGERS AND SOCIAL WORKERS IN COMMUNITY SETTINGS

- Nurse and social work case managers work collaboratively on moderate and high risk patients.
- Staff RNs work with low risk patients.
- Nurse case managers direct their work on high risk or moderate risk, clinically complex patients.
- Social Workers focus on high or moderate risk patients with psychosocial and financial issues.
- Both provide patient education.
- Both coordinate referrals as needed.

CLINICAL INFORMATION SYSTEMS

Electronic Health Record

- Registries
  1. Clinical registries
  2. Disease Management registries (payer, providers)
  3. Special Disease-specific templates

Patient Subgroups

- Providers and/or staff receive triggers for Disease Management program
  - A1c – Diabetes Self-Management Referral
  - Psychiatric triggers such as medication adherence, substance abuse triggers

Care Planning

- Triggers & lists generated for those high risk (blood glucose triggers to inpatient diabetes nurse educator)
- Share information with patients and providers to coordinate care

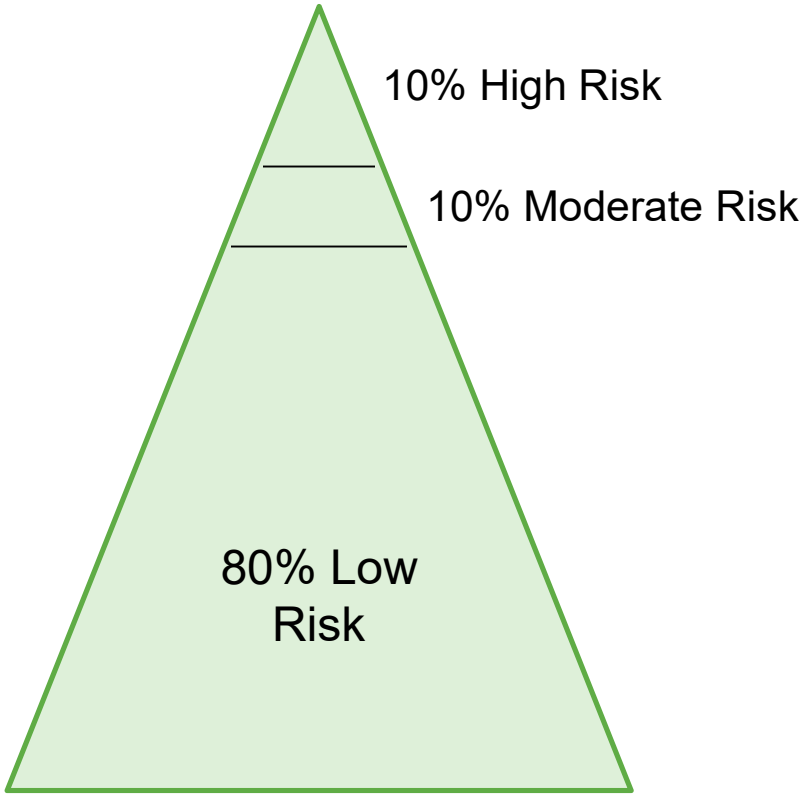
SELF-MANAGEMENT SUPPORT

- Emphasize Patient Role
  - Multiple providers send this message to patient
  - Case Manager assesses patient self-management readiness
- Care Planning & Problem Solving
  - Checklists & Question Templates
  - Use of motivational interviewing techniques

RISK ASSESSMENT AND STRATIFICATION

- Review Medical History
- Current Meds
  - How are they obtaining them now?
  - Are they taking them regularly? (BP meds one month/diabetes meds the other month)
- Current problems:
  - Health Issues
  - Social: Family support system
  - Cultural: Beliefs, Values, Travel patterns
- Financial income, assets:
  - Do they qualify for Federal or special state/local programs
- Socio Demographics
- Risk Assessments for probability of hospitalization and complexity of disease
  - How do you perceive your health?

RISK STRATIFICATION CATEGORIES



GOALS

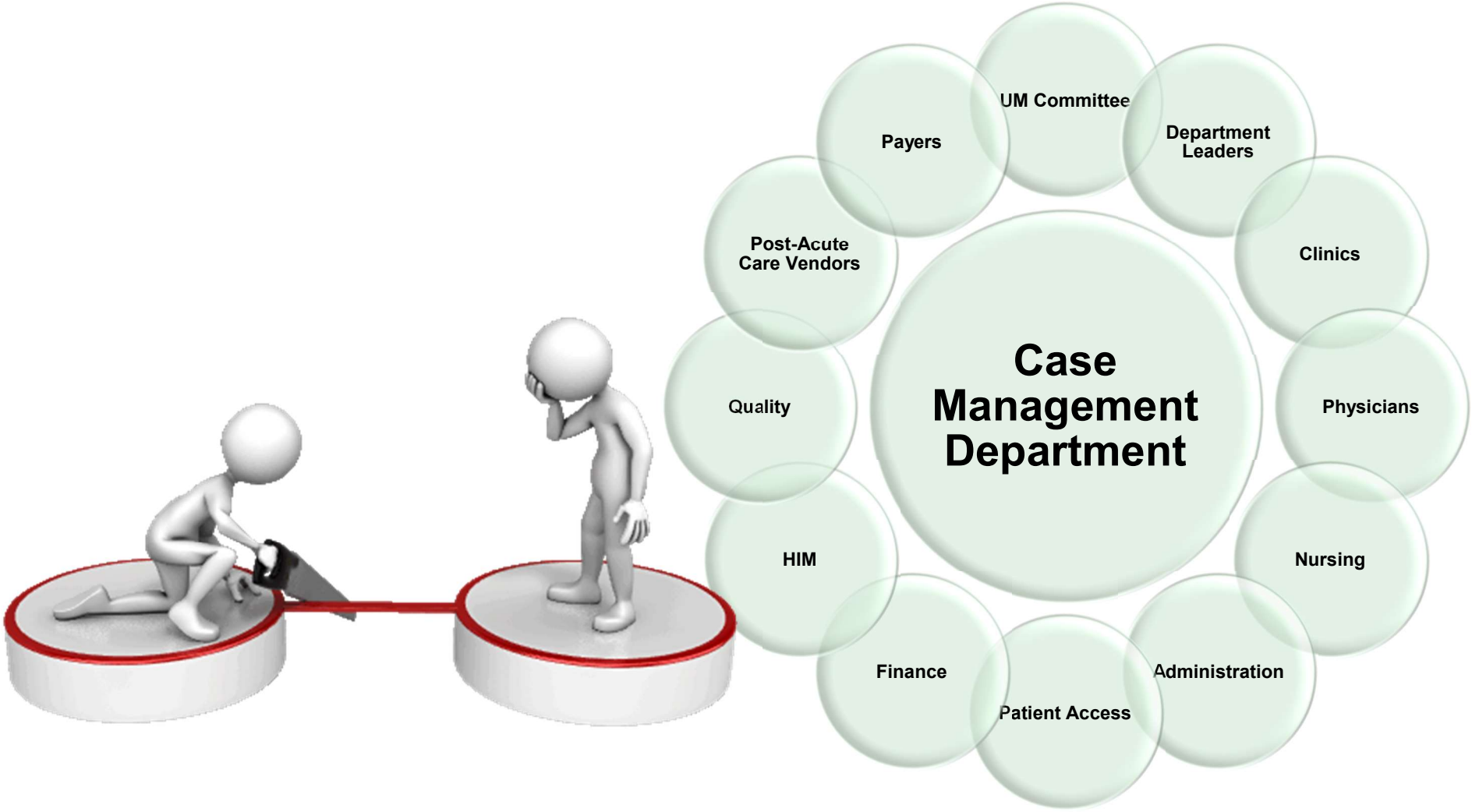
- Reduce Emergency Department visits, readmissions and in-patient LOS
- Improve the coordination of services following discharge from hospital

  Integrate acute episodes with community continuum

  Improve quality and satisfaction with care
- Improve coordination of care across all levels

WHAT DOES HEALTHCARE REFORM MEAN TO CASE MANAGEMENT?

HEALTHCARE REFORM STRATEGY: STRENGTHEN KEY RELATIONSHIPS



HEALTHCARE REFORM STRATEGY: REQUIRES STRONG CASE MANAGEMENT OVERSIGHT

- Right model
- Right roles, with the right functions
- Align relationships
- Education of current staff
- Effective orientation of new staff
- Accurate competencies
- Hardwired departmental processes
- Knowledge of who does what
- Integrate staff into hospital processes
- Physician relationships

CASE MANAGEMENT STRATEGIES TO OFFSET REDUCTIONS IN MEDICARE REIMBURSEMENT

- Focus on readmissions for like diagnoses
- Have the right case manager in the right position
- Understand the critical role of the RN case manager and Social Worker case manager
- Identify physician champions for care coordination

HEALTHCARE REFORM STRATEGY: HARD WIRED PROCESSES

- Daily rounds
- Engaged physicians
- Processes consistent among key staff and physicians

NEXT STEPS

- Find your results for VBP, readmissions and Spending per Medicare Beneficiary Measure
- Determine how you benchmark against others
- Assure an effective audit program to identify documentation and coding errors
- Watch out for those other payers—they often mimic CMS

RESOURCES

- Hospital Compare website www.hospitalcompare.hhs.gov
- Hospital VPB program details http://www.cms.gov/Hospital-Value-Based-Purchasing
- Fact sheet on proposed payment changes www.cms.gov/apps/media/fact_sheets.asp
- Proposed rule: https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-09985.pdf
- New HCAHPS transition survey questions http://www.caretransitions.org/documents/CTM3Specs0807.pdf
- Current data collection periods for all data collected www.medicare.gov/hospitalcompare/data/aboutdata/data-updated.aspx

IT'S TIME FOR QUESTIONS

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THANK YOU

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