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INSIDE

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What Case Managers Can Expect From Medicare's 2019 OPPS

More focus on social determinants of health

Case managers can expect some changes in their roles under the Medicare 2019 Hospital Outpatient Prospective Payment System (OPPS) final rule, effective Jan. 1, 2019.

Focusing on patient-driven healthcare, the rule acknowledges the importance of case managers addressing social determinants of health. It also addresses reimbursement disparities between inpatient and outpatient services.

For instance, the rule's Meaningful Measures place the focus on preventive care, better communication and coordination of care, strengthening family engagement, and working with communities to promote health. *(http://bit.ly/2S4A4CO)*

"The OPPS rules will impact case managers," says **Ellen Fink-Samnick**, MSW, ACSW, LCSW, CCM, CRP, principal of EFS Supervision Strategies in Burke, VA.

Under the proposed new OPPS rule, there is a greater focus on patient choice. This makes it necessary for more effective patient dialogues, Fink-Samnick says.

"There is a greater focus on mastery of technology and interoperability for consumers — and, thus, their case managers," she says. "And there's a strong focus on outpatient care facilitation."

> "THERE IS A GREATER FOCUS ON MASTERY OF TECHNOLOGY AND INTEROPERABILITY FOR CONSUMERS — AND, THUS, THEIR CASE MANAGERS."

The proposed rule will require case managers to be diligent about making sure patients have what they need in their communities, says

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Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM, a senior director of care management at Cleveland Clinic in Ohio. McLaughlin-Davis also is the immediate past president of the Case Management Society of America (CMSA).

"Case managers will need to be cognizant of what is and isn't available," McLaughlin-Davis says.

Their focus should be on improving quality of care, as well as lowering costs of care, she adds. "Look at what is available for patients and help them manage transitions."

The focus on social determinants of health is positive, Fink-Samnick says.

"Let's not forget that $1.7 trillion is spent on 5% of the population, and their problems mostly are related to social determinants of health," she says.

"The new OPPS rules will ramp up case managers and their organizations to more closely align with nonclinical community resources that can address the social determinants of health," Fink-Samnick adds. "Connecting patients with those resources reduces readmissions and saves overall costs."

This reality is why four out of five payers have these kinds of programs in place and healthcare organizations increasingly are engaged in vertical mergers, such as CVS and Aetna. Such mergers enhance care and service access, minimize food and pharmacy insufficiency, and assure greater population health and wellness, she says.

The CMS Meaningful Measures Initiative, launched in 2017, approaches quality measures through fostering operational efficiencies and reducing costs, collecting, and reporting burden, according to the final rule. The objectives include:

- address high-impact measure areas that safeguard public health;
- patient-centered and meaningful to patients;
- outcome-based where possible;
- fulfill each program's statutory requirements;
- minimize the level of burden for healthcare providers;
- significant opportunity for improvement;
- address measure needs for population-based payment through alternative payment models;
- align across programs and/or with other payers.

The rule's quality reporting section notes that organizations will see the following benefits from Meaningful Measures:

- eliminating disparities;
- tracking measurable outcomes and impact;

EXECUTIVE SUMMARY

The new Medicare 2019 Hospital Outpatient Prospective Payment System final rule focuses on patient-driven healthcare, acknowledging the importance of addressing social determinants of health.

- Changes that will affect case managers include the rule's focus on preventive care, better communication and coordination, working with communities, and strengthening family engagement.
- The rule has a strong focus on outpatient care facilitation.
- Case managers should focus on improving quality of care, as well as lowering costs of care.

• safeguarding public health;
• achieving cost savings;
• improving access for rural communities;
• reducing burden.[1]

The final rule is promoting a wellness model for the Medicare population, McLaughlin-Davis says.

"We don't have all the pieces in place yet, so that's why organizations really are focusing on social determinants and behavioral health of patients, along with medical health and integrating both," she explains. ■

REFERENCE

1. The Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. *Fed Reg.* Nov. 21, 2018;CMS-1695-FC:1-1182. Available at: https://bit.ly/2E6oKmK.

Care Connectors Help Close Gaps With Medicaid Population

Keep patients on track medically

When gaps in care reports began popping up, leaders at Alcona Citizens for Health knew something had to be done.

"We got these reports and started noticing deficiencies in certain areas," says **Karen Koenig**, RN, care management department manager at Alcona Citizens for Health in Alpena, MI. Alcona is a federally qualified nonprofit health center that serves populations covered by Medicaid, Medicare, and private pay.

The deficiencies were due to inadequate staffing, inconsistent workflow, and knowledge deficits in using the electronic medical record (EMR).

It was clear that the gaps were not something that one person could close. It would take a team of people, including providers, medical support staff, RN care managers, and care connectors, she says.

Care managers provide patient education, self-management goals, and follow up with patients after hospital stays. Their job is to make sure patients are not readmitted and have received appropriate education and goal-setting. There also are community health workers to address patients' social determinants of health, including housing status, transportation, and behavioral health issues.

"We have six care managers, seven care coordinators, and six community health workers," Koenig says.

Care connectors primarily are LPNs. Their job is to review insurance reports to see which check-ups, vaccines, and preventive care patients have missed and need scheduled before the year's end. These gaps might include the following:

• body mass index (BMI) reports;
• checking diabetic patients' A1c level;
• checking blood pressure for hypertension patients;
• performing diabetic eye exams and foot tests;
• screening diabetics for kidney problems;
• flu shots;
• ensuring children are up to date on immunizations;
• lead testing in children by their second birthday;
• testing children with sore throats for strep infection;
• breast cancer screening;
• cervical cancer screening;
• chlamydia screening;
• medication management;
• smoking cessation education;
• making sure asthma patients are using inhalers as prescribed.

Patients must receive all of the screenings and preventive care needed, per insurance incentives for closing care gaps. Care connectors work to make sure patients come to the center on time and receive the screenings, immunizations, and other care they need.

"In a given month, there might be 700 gaps," Koenig says. "They won't get to all of them, but by working on it monthly, we have been able to address the most that is possible."

One strategy is to follow a calendar year schedule. "At the beginning of the year, we schedule complete physical exams [CPEs] and child wellness exams," she says. "We get those patients in for more comprehensive visits, and that's a big focus at the beginning of the year."

The following are some other seasonal priorities:

• **First quarter:** "It's a continuous process, and even at the end of the year, we will schedule people due for a well child check-up," Koenig says.

But the health center's workflow is smoother if care connectors can get some patients in for wellness exams and physicals at the beginning of the

year. Also, patients might have some other care gaps identified after their physicals, so it works best to have enough time remaining in the year to schedule those after the physical and lab work is complete, she adds.

• **Second quarter:** In Alpena, patients start returning to the northern Michigan region from warmer climates and they often need CPEs and primary care provider visits, Koenig says.

"April is when they may be returning from Florida or Arizona, and so we see an increase in patients then," she says. "Their gap is highest at the beginning of the year because everyone is due for everything, and then it closes."

• **Third quarter:** Summertime is when the health center schedules many well child visits because these are combined with sport physicals. "They want the sports physical completed before the next school year," Koenig says. "We don't separate well child visits and sports physicals."

• **Fourth quarter:** Flu shots are scheduled in the fall, and this is when care connectors try to get patients to come in for any other preventive visits that are needed.

"We catch up on anything we haven't focused on," she says.

Care connectors also help reconcile insurance records for patients with what the health center has in its records.

For example, sometimes a patient will call the health center to say he or she has a new provider. But when the patient's payer sends over a list of care gaps, that patient still is listed. Care connectors have to call the payer and make sure the patient is taken off the center's list and put on the new provider's list, Koenig explains.

In another case, there might be a person who signs up for the state health plan and does not indicate who the provider will be.

"If they don't respond, they're auto-assigned to a provider, and they might be auto-assigned to us even if they end up going to a doctor at another facility," she says.

"Because the insurance says we're the primary care provider, any gaps that are not closed are impacting our scores because we're responsible for that patient," Koenig adds. "So we have to clean up that list, and the care connectors tell the patient to call the number on their card and let them know that Dr. Jones is their doctor."

It takes some effort to get people off the list, but the care connectors make it happen, she says.

"They see those lists constantly and know who our patients are and which people are not in our system, and so they reach out to them to see if they need a primary care provider," Koenig says.

When patients first sign up for Healthy Michigan plans, they need a health risk assessment to identify chronic illnesses and risk behaviors. Then they might need education, smoking cessation classes, or nutritional and exercise information. Some payers also require annual depression screening and smoking status reports, she says.

"We have a clinical event manager in the electronic medical record that will put out alerts about patients' gaps, but mostly care connectors work on the gap list from insurers," Koenig says.

The EMR list could tag a gap that actually was a coding error, so they need to be checked manually.

"It's more important for care connectors to address what the insurance is saying the patient needs versus what the EMR is saying," she says. "Insurers send gap reports every month, saying which patients need this or that."

The care connector's job is to reconcile the insurer's gap report with what the EMR says the patient has had done. When there are coding errors, this is how the care connector identifies and rectifies them. "The care connector is the middle person to make sure that what we say we do is the same thing the insurance said they received from us," Koenig explains.

As the care connector program began, there were full department meetings with care connectors each month. That is no longer necessary, so the meetings are held quarterly or as needed, she notes.

"We're spread out across seven counties in Northern Michigan, so we can do a Skype meeting with a representative from an insurance company when we take on a new payer plan," she says. "We have a conversation with them about how they want their gaps reported, and we explain that this needs to be faxed, rather than entered online." ■

EXECUTIVE SUMMARY

A nonprofit health center developed best practices in identifying and addressing gaps in care.

- Closing a gap in care requires a team effort.
- Gaps can include diabetes check-ups, flu shots, preventive health screenings, etc.
- Care connectors can help organizations reach out to patients to complete check-ups, screenings, vaccinations, and other care gaps.

Training Program Helps Create Stable Case Management Workforce and Workflow

Promotes work-life balance

Training new case managers sometimes takes a team approach and can involve education, training, mentoring, and follow-up for six months to a year.

That has been the experience of one Indiana company with more than 300 case managers providing services to a population that spans the entire state.

Case management training lasts a minimum of 90 days but often extends for months longer, says **Suzanne Ludwig**, BMMT, professional development manager in Cedar Grove, IN. Ludwig trains case managers for Indiana Professional Management Group (IPMG), which provides case management services through a contract with the state of Indiana Bureau of Developmental Disabilities Services.

"Robust training leads to longer retention of individuals," Ludwig says.

"We work with individuals on Medicaid waivers," says **Stephanie Felix**, an IPMG professional development manager in Avon, IN.

IPMG has been named one of the best companies to work for in Indiana for the past four years, Felix says.

"There's a survey given to all case managers to fill out," she says. "That speaks volumes to the company and our culture and that so many of our employees love what we do."

Once trained, case managers tend to stay with IPMG, but the company is continually hiring and training new managers to handle growth demands, notes **Emily Fike**, IPMG professional development manager in Orland, IN.

One key to success is empowering case managers and giving them responsibility, Fike says.

"We do have a lot of training because we process many intakes for new individuals coming into services," Fike says. "That creates a need for additional case managers."

> "WE HAVE TO STRIKE A BALANCE BETWEEN MICRO-MANAGEMENT OF NEW CASE MANAGERS AND PULLING BACK TO GIVE THEM THE FREEDOM THEY NEED TO DO IT ON THEIR OWN."

The key to successfully training new case managers is to meet them where they are in their professional knowledge and development, Felix says.

"Trainers need to be able to adjust our training style to what works best for each particular case manager, as they are learning," Felix says. "If someone learns more with hands-on training, then trainers can help with that."

A successful training program should be adaptable, Ludwig says.

"We have a nice curriculum that we follow, but things happen differently for different case managers at different times," she says. "Also, we have to strike a balance between micromanagement of new case managers and pulling back to give them the freedom they need to do it on their own."

Ludwig, Felix, and Fike offer these suggestions for providing a successful case manager training and orientation program:

• **Start with virtual orientation.** Case manager training is a minimum of 90 days, per Indiana law. Also, case managers must take a certification exam prior to their 90th day, Ludwig says.

For IPMG case managers, the first day of orientation includes a half day of virtual instruction. This includes a discussion of human resources policies and an overview of their jobs and responsibilities, Ludwig says.

This is followed by in-person orientation and technology setup. "We provide new employees with a tablet and provide them with access and security," Ludwig says.

• **Provide weekly training curriculum.** "Each week, they have different training that they take on their own and individually," Fike says. "They learn the material, following the curriculum, and then take an assessment."

Virtual training makes it possible to train people over a wide geographic area, Ludwig notes.

"One benefit to virtual training is that people can work from their homes and have that level of independence and self-management and flexibility," she says. "There's a benefit for them, but the drawback is isolation, and some people learn

better when they have someone next to them, so we're supporting new employees with multiple training methods."

• Divide training into blocks/ structures. "We have a nine-week structure. Around week two, we have new employees shadowing case managers — usually in the middle of the week," Ludwig says.

Each week, the new case manager's responsibilities and caseload increase, building slowly, she says. "It takes a couple of months to get to a full caseload."

The goal is for case managers to complete day-to-day tasks independently. By 120 days, case managers should be done with the first tier of training, Ludwig adds.

"We give case managers written resources, written guides, quality standards, and all the things they need to complete their tasks," Ludwig says. "And we give them continual feedback about how they're doing and when learning is going to take place."

New case managers still need support after 120 days. They move on to their geographically based team, and within the team, they have a mentor, Ludwig explains.

"They work with the mentor and still have support for the next three months."

• Touch on work-life balance. One key to retaining successful case managers is to ensure they can handle the work-life balance.

"That's very important," Fike says. "Our case managers have to serve all ages of individuals, from as young as 18 months to an elderly population, individuals living in family homes or living with housemates."

Case managers visit patients at their homes or meet them in the community. They provide services with a person-centered philosophy, helping patients build supports that will enable them to achieve their visions and dreams, Fike explains.

If case managers fail to maintain a good work-life balance, they could get lost in their jobs.

"One of the biggest tools we use is to help case managers monitor their caseload, having them send us a weekly report," Ludwig says. "Time management and self-management are real struggles for some people, so we teach them how to monitor things on their own."

• Introduce case managers to the team. "At the beginning, we introduce case managers to the team they are going to be on, so they can start integrating with that team out of the gate," Fike says. "When they complete training, they're already comfortable with other case managers and peers and at team meetings."

Integrating new case managers into the teams helps them build necessary relationships and reinforces their education, Ludwig notes.

"They're out doing their jobs, but it helps to talk with case managers who have been through the training," she says.

• Evaluate and conduct progress report. "While case managers are in the training program, we meet with them every 30 days, 60 days, and 90 days," Felix says. "We do an official progress report and evaluation, meeting with them to talk about any concerns we may have and to help them navigate whatever task they may not be getting, so we might offer additional support."

In addition, direct managers meet one on one with each trainee once a week for the first 60 days, Ludwig says.

"Around 60 days we might bump them to every other week, depending on the case manager and where we are," she says. "We don't want to pull support from someone too soon or give them more support than they need."

• Review and adapt as needed. "We continually review and adapt our methods," Ludwig says. "As a department, we meet weekly and are constantly reviewing things because we want consistency and to have everything as up to date as possible."

The virtual education introduces case managers to the skills and information they need to learn, but the real learning is hands-on, she notes.

"It doesn't click with case managers until they're doing the task," Ludwig says. "Our job is to present the material [virtually] because they'll need it and we have to do it systematically, and it's the best way we can get information to all of these people in multiple locations."

But case managers truly connect the dots when working one on one with mentoring case managers, she adds.

When professional development managers review new case managers' work and assist them, they first provide a 100% review of their work. As time goes on, they will not look at every single item, Fike says.

As case managers progress in their knowledge and skills, the reviews might involve spot checks, Felix says.

"We just want to make sure they really understand everything and that there are not any concerns," she says.

"Once they get it, we lessen up the review and point them to the resources they need," Fike adds. "We cater to each case manager and where they are and how they handle it, gradually building their confidence and moving them toward independence."

Case managers give positive feedback about their training, and their retention also suggests it works well.

"It takes a special person to be a case manager and work with the population we have, so the case managers who come here really want to be here and work with these individuals," Felix says. ■

Hospitals Take Social Determinants of Health Beyond Theory, Put Data to Use

The healthcare community is gradually accepting that social determinants of health (SDOH) can improve quality of care. Finding a way to apply the data can be difficult, but several hospitals and health systems are showing how it can be done.

SDOH involves socioeconomic and societal issues, such as lack of transportation to follow-up visits and poor nutrition, that can play a role in the delivery of healthcare, affecting outcomes and quality of care. The relevance of SDOH has been getting attention for several years, and some organizations are seeing success with applying the data in ways that directly affect patients.

However, not everyone is on board, says **Adaeze Enekwechi**, PhD, former associate director for health programs in the White House Office of Management and Budget under the Obama administration. She also previously served as a policy authority with the Congressional Budget Office and the Medicare Payment Advisory Commission. Enekwechi is now a vice president at McDermott+ Consulting in Washington, DC.

"I wouldn't say it's a foregone conclusion that everyone has accepted the importance of social factors and how they can adversely affect health. More people are aware of it, but there are many nonbelievers despite the research and data," she says. "Among those who understand the importance of social determinants, the systems that have been collecting data on things like race, ethnicity, and language access are finding ways to use that data in a meaningful way. But not every hospital has that."

Knowing Your Patients

Enekwechi says SDOH often boils down to simply knowing where your patients come from. She uses the example of a hospital in Chicago, where some patients might come from the affluent Hyde Park neighborhood, and others might come from the inner city, where resources are quite different.

"That kind of data on patients, broken down by ZIP codes or other factors, can help you address an issue like no-shows. You might find that many of these patients are reliant on public transportation and that for them to come from less than 10 miles away, they have to make a two-hour commitment to public transportation," she explains. "That causes them to miss work. If you're expecting them to leave their hourly job, lose that income because their lunch hour won't accommodate the visit and the travel time, you're expecting far more of that patient, and it is not realistic."

Matching no-shows to SDOH as simple as ZIP codes can identify patients who need intervention beyond the standard processes that might apply to all no-show patients, she says.

"Calling them and leaving messages or sending postcards is not going to solve the problem," she says. "They have to work, they have to deal with transportation issues that you and I might not have, and no matter how much they want to do the right thing for their health, those circumstances can't come together in a way that gets them to their 11:00 a.m. appointment."

Some Simple Steps

There are ways to apply SDOH without an expensive purchase of data and analysis, Enekwechi says. Even a simple focus group can reveal information about the limitations some patients face, she says. Partial solutions might include a Saturday clinic for those who have a hard time making weekday appointments, she notes.

"That's the kind of peeling-back-the-onion approach to using social determinants to understand your patients better. It's not always a large program with lots of data analysis, but it can be. If you haven't done this before, you need a place to start."

Hospitals often have a wealth of data available to them, but merging that information in a way that improves quality can be challenging, she says. Layering another volume of demographic data on top of that only complicates matters, she says.

"I'm starting to see that health systems want to understand their patient populations in a holistic manner, and they're starting to see social determinants of health as a key tool in achieving that. But so far,

we're seeing more in pockets, and I'm hoping to see growth in the near future," she says.

Even the smallest hospital can use SDOH to address patient issues and improve quality, Enekwechi says. Payers can drive the use of SDOH because they have a vested interest in making sure patients experience the best outcomes and because they may have existing resources and data analysis capacity to help hospitals apply the information in a meaningful way. Hospitals interested in making more use of SDOH might first approach payers for assistance, she suggests.

Data Reduces Readmissions

In recent years, the use of SDOH to improve care has focused mostly on reducing hospital readmissions, notes **Bita Kash**, PhD, MBA, FACHE, director of the Center for Outcomes Research at Houston Methodist hospital. Methodist has worked recently to collaborate with community not-for-profit partners to improve post-discharge self-care support for patients at highest risk of readmissions, she notes.

Some of the issues have involved food security, for instance, so Methodist worked with the local Meals on Wheels program, which has specially trained staff and volunteers who go into the home to deliver food but also make note of the recipient's health and any existing needs. Another community partnership uses the medical home concept to ensure discharged patients are seen by a physician after leaving the hospital.

"The research team at the Center for Outcomes Research realized that, not just at Methodist but nationally, this is the way to address some of the most challenging aspects of care. Research is showing that hospitals with the highest proportion of Medicaid patients are engaging in many, many partnerships," Kash says. "Methodist is investing a lot of money into supporting community providers and energy into developing partnerships and key relationships in the community."

The center has researched the most useful ways to apply SDOH in reducing readmissions and found that the high impact strategies involve community collaborations, she says.

Deprivation Index Helps

A good resource for hospitals seeking to use SDOH is the Area Deprivation Index Datasets, Kash says. Based on a measure created by the Health Resources and Services Administration, the datasets use census data at the ZIP code level to denote access to key health-related resources based on 17 indicators. The indicators involve issues such as poverty, education, housing, and employment. *(More information about the datasets can be found online at: https://bit.ly/2IlHU7m.)*

"One of things we have realized is that those measurements need to be taken down to the census block measure because ZIP code still leaves a lot of variability in levels of poverty and health issues," Kash says. "We're also comparing that measure to older measures that most health service researchers have been collecting in the past, such as race, ethnicity, and insurance status, and looking for the best formula to use. Not one risk prediction model works for all hospitals and regions, so even within a hospital system, it's still very hospital-specific."

Commonly used measures such as Medicaid status, age over 45 years, and disease complexity are still strong predictors of an avoidable readmission, Kash notes. They can be used in conjunction with other SDOH rather than abandoning any proven use of those measures, she says.

"I would encourage those working in hospital quality and safety to consider developing hospital-specific prediction models incorporating Area Deprivation Index data at the block level," Kash says. "Sometimes as researchers, you get stuck with your hypotheses, so you have to be careful not to get caught up in that one index that you thought was the coolest thing on earth but really isn't as effective as the old indicators of population at risk. It's still very important to pay attention to Medicaid, age, and the other measures that have been proven."

Homelessness Addressed

SDOH play an important role in improving quality and outcomes for the members of LA Care Health Plan in Los Angeles, many of whom are some of the poorest in the community, says **Richard L. Seidman**, MD, MPH, chief medical officer. Seidman is responsible for developing and implementing strategies and initiatives to ensure quality for the health plan's more than 2 million members.

"Assessing and determining social determinants of health is a core strategy because of the very significant potential impact on outcomes, quality, and costs," Seidman says. "We've established a social determinants of health committee and recently hired a program manager for health equity who will help us

target our efforts and help those in the community with traditionally lower outcomes."

The SDOH committee has identified the determinants that are most relevant to the health plan's members. Those include homelessness and preventing homelessness, food insecurity, income insecurity, transportation, and early childhood education.

For homelessness, LA Care committed $20 million in grant funding to an organization that subsidizes permanent housing for homeless members, Seidman says. The program is close to reaching its goal of placing 300 members in permanent housing over a five-year period. The health plan also partners with organizations that help prevent homelessness by identifying those at high risk.

When patients have severe asthma, LA Care sends healthcare staff to their home to look for triggers.

"In some cases, we have to partner with legal advocates to help negotiate and manage relationships with landlords. Mold abatement is a common concern with these patients," he says. "The landlord may refuse to repaint or recarpet, even though the mold is the primary trigger that is preventing the patient from achieving good asthma control."

Aid Where Homeless Live

The health plan has provided additional grants to subsidize move-in costs and costs associated with the timely discharging of patients from an acute care facility to other housing such as a recuperative care facility.

LA Care also has healthcare providers for the homeless that are funded through the federal government. They are designated as homeless clinic providers and included in the LA Care network.

"They are providers who are very skilled with the homeless population and excellent at identifying social determinants on top of meeting their healthcare needs," Seidman says. "For income security, we work with a vendor that matches our members with available benefits and the earned income tax credit."

> "ASSESSING AND DETERMINING SOCIAL DETERMINANTS OF HEALTH IS A CORE STRATEGY BECAUSE OF THE VERY SIGNIFICANT POTENTIAL IMPACT ON OUTCOMES, QUALITY, AND COSTS."

One of the challenges in utilizing SDOH is identifying the organization's business drivers and incentives, Seidman says.

"A business has to clearly understand their priorities and incentives to determine whether or not an investment in addressing social determinants may lead to returns that the organization can keep as a return on their investment, either to reinvest in the program or provide to the shareholders," Seidman says. "Those business drivers are unique to each business. In our setting as a Medi-Cal managed health plan, there are some disincentives related to how we are funded. We have to be cautious in our investments to ensure an appropriate return, so we can reinvest those funds and sustain good outcomes, which is our goal."

Identifying Food Insecurity

LA Care's SDOH application is still too new to generate data showing improvements in outcomes, length of stay, readmissions, or other metrics, Seidman says. He expects the results to be positive and in line with research showing the benefits of SDOH.

"It is a challenge for healthcare providers, systems, and payers to step into a space that has not been traditionally considered a space for healthcare. We hear people talking about it as the medicalization of social issues," Seidman says. "We intend to expand on our commitment in the space. We currently have a request for proposals for a community resource platform we can make available throughout the health plan but also for providers in our network."

LA Care also tracks government funding programs, so it can direct the health plan's grants to areas not adequately served by other funding. One priority identified by the health plan involves food insecurity, with LA Care providing $2 million over the past three years to 24 programs addressing members' lack of access to healthy food.

With one program, LA Care is providing funding for an initiative that provides medically tailored meals to patients recently diagnosed with congestive heart failure.

Northwell Health, a not-for-profit healthcare network based in Great Neck, NY, that includes 20

hospitals, is creating what it calls the Social Vulnerability Index (SVI). At intake, every patient is given a "social physical" similar to the clinical physical, says **Ram Raju**, MD, senior vice president and community health investment officer.

"Based on that, we give them a risk index, and every time that patient comes for an encounter, the physician will be able to see that this patient not only has clinical issues but also has social risk factors," he explains. "When they click on the notice of a high-risk factor, the record will show why the patient has been designated that way and the specific risk factors that led to that high index."

The network already uses a resource that identifies transportation resources by ZIP code and generates an email notifying the transportation service that this patient will need assistance. The SVI will be tied into that system, as well other resources.

"The idea is that we want to give social risks as much importance as the clinical risks. If the person has diabetes and lives in an area where fresh food is never available, he will not be able to follow the diet you give him, and the diabetes will never get better despite all the medications you give," Raju says. "If we figure out that food security is a major issue in a certain ZIP code, we should be able to use our community funding dollars to focus on areas we know need help. We will be able to measure the food insecurity risks in that area before and after a few years of funding intervention and see if the effort was successful."

One challenge has been how to weight SDOH against each other, Raju says. Every interest group — behavioral health, substance abuse, homelessness — will campaign to have its related SDOH weighted heavily in the SVI. Raju says the decisions must be based on metrics and data, but there still will be disagreements, and decisions will have to be made.

Raju recounts the tale of a woman with breast cancer who had lived in the same apartment for years. The woman, an undocumented immigrant, said that the landlord wanted her to move out so that he could raise the rent. She said that the landlord threatened to report her to immigration authorities and that she resisted.

The woman underwent surgery and returned home. But she said that the landlord told her that the moment she stepped outside, for any reason, he would change the locks. She could not call the police for help because she was in the country illegally, he told her.

"She had to make a decision whether to go to her follow-up chemotherapy treatment and be homeless or stay in her house and let the cancer take care of itself. She chose to remain at home," he says. "We could have had the best world class surgeons operating on her and giving her the best medicine ever invented, but it wasn't going to work if she faced that decision at home."

Northwell Health responded to this SDOH by working with the New York Law Association to provide pro bono legal assistance to patients in such situations.

"We need people to understand it's not just about the medication or how good a doctor you are. The real measure should be what happened to your patient in the end," Raju says. "In medicine, we have a habit of measuring how well we did, when we should be measuring how well the patient got. There's a very big difference." ■

Conflicts on Discharge Decision: Home or Skilled Nursing Facility?

Discharge to a skilled nursing facility is sometimes recommended in order to ensure continued independent community living for frail patients. Conflicting views as to what is best for the patient sometimes raise ethical concerns.

To learn more about the disposition decision-making process, researchers looked at the factors associated with the surrogate's decision to discharge to a skilled nursing facility instead of home.[1] Of the 182 community-dwelling patients in the study, 133 were discharged to a skilled nursing facility and 49 went home.

"The most interesting ethics issue from our study centers around the outcomes when family members and hospital staff expressed different opinions," says **Jennifer L. Carnahan**, MD, MPH, MA, the study's lead author and a scientist at Indiana University's Center for Aging Research, focusing on care transitions, especially from the skilled nursing facility setting to home.

Even when physical therapy recommended a skilled nursing facility placement, the family sometimes disagreed. "The way this typically comes up is when there is disagreement between the medical team and the

caregivers about the optimal discharge destination for patients with impaired decision-making," says Carnahan.

If the family member objected to a skilled nursing facility placement, the patient often would be discharged home. "This suggests that there is disagreement about whether a skilled nursing facility or going home with family is in the best interests of the patient," says Carnahan.

For the clinical team, the question frequently becomes what is "safe enough," says **Laura K. Guidry-Grimes**, PhD, a clinical ethicist at the University of Arkansas for Medical Sciences in Little Rock. Patients' decision-making abilities, their levels of social and financial support, and the severity of their medical conditions all should be considered. The following are some common scenarios:

• patients without decision-making capacity are unable to identify worsening symptoms, understand the need for treatment or monitoring, or know when to reach out for medical help;

• the patient's home presents safety concerns, such as a gas stove that the patient tends to leave on, unhygienic spaces, or a heater that does not work;

• family members want to take an incapacitated patient home, but there is no one available to monitor the patient.

"We see cases where families dismiss healthcare aides, which makes the patient especially dependent on the diligence and competence of family," says Guidry-Grimes. Many patients need extensive rehabilitation or skilled nursing help but lack insurance or financial resources to cover the cost. Facilities also can deny patients if they are too full or if the patient presents psychiatric complexities.

"Some facilities are much better run than others," adds Guidry-Grimes. "For clinicians who have these insights, even discharge to a facility can seem far from ideal."

If the patient is his or her own decision-maker, these questions are important from an ethics standpoint, says Guidry-Grimes:

• Does the patient adequately understand that the discharge is considered unsafe and what other options are available?

• What additional barriers might be affecting the patient's decision?

• Are there any ways to further enable the patient's autonomy interests?

"The patient might feel coerced by family not to accept placement into a facility," says Guidry-Grimes. Institutional pressures to discharge patients when they are medically ready are another complicating factor. "It can be ethically reasonable to allow the patient a little more time to think through the options, perhaps with support from pastoral care or a loved one," says Guidry-Grimes.

For patients who lack decision-making capacity, "the ethical issues become mountainous," says Guidry-Grimes. "We see many cases where these patients are incapable of caring for themselves in the most basic sense."

A congestive heart failure patient could start out with a manageable disease that becomes increasingly dire because of failure to take medications. Unhygienic environments and exposure to the elements can further exacerbate medical problems.

"What can be particularly tricky, ethically speaking, is when these patients still express clear preferences for unsafe discharge," says Guidry-Grimes. Patients' preferences carry ethical weight even if they are not authorized as their own decision-makers.

"Some negotiation on discharge might be possible based on what the patient expressly prefers," says Guidry-Grimes. When incapacitated patients do not have a surrogate decision-maker, there are additional obstacles to getting them into any facility. For one thing, no one is available to sign consents.

"These situations are ethically challenging," says Guidry-Grimes. Staff often feel uncomfortable restraining the patient or coercing them to stay in the hospital until adult protective services or a public guardian takes responsibility. The alternative also is ethically problematic. "Giving in to the patient means that healthcare staff are knowingly allowing a vulnerable patient to go to an unsafe situation," she says.

For incapacitated patients who have surrogate decision-makers, request for an unsafe discharge raises questions about the ethical appropriateness of the surrogate.

"A surrogate should have a demonstrated interest in the patient's welfare and make decisions that are reasonably consistent with the patient's known values and interests," says Guidry-Grimes. She recommends that ethicists facilitate safe discharges by:

• helping staff think through these issues proactively before a distressing case occurs;

• working with healthcare teams to address common questions that arise when a patient or surrogate requests something that appears unsafe;

• providing training on capacity evaluations, criteria for surrogate decision-makers, institutional policy, and local law.

"The more we can help healthcare teams think through these issues as a team, the better," says Guidry-Grimes. ■

REFERENCE

1. Carnahan JL, Inger L, Young RS, et al. Factors associated with posthospital nursing facility discharge for patients with impaired decision-making. *J Am Med Dir Assoc* 2018: 19(10):916-917.

CASE MANAGEMENT ADVISOR™

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CE QUESTIONS

1. **Which of the following is *not* one of Medicare's Meaningful Measures Initiative objectives?**
   a. Address high-impact measure areas that safeguard public health
   b. Patient-centered and meaningful to patients
   c. Place case managers in every primary care provider clinic and outpatient facility
   d. Outcome-based where possible

2. **With a focus on patient-driven healthcare, how might case managers contribute to the goals under the Medicare 2019 Hospital Outpatient Prospective Payment System final rule?**
   a. They can make certain clinicians provide care according to the model of right time, right place, right level of care
   b. They can focus on social determinants of health
   c. They can reduce documentation burdens and regulatory reporting obstacles
   d. All of the above

3. **Which of the following is a common care gap patients might experience?**
   a. Checking diabetic patients' A1c level
   b. Checking blood pressure for hypertension patients
   c. Making sure children are up to date on immunizations
   d. All of the above

4. **According to Stephanie Felix, which of the following is a key to successfully training new case managers?**
   a. Meet them where they are in their professional knowledge and development.
   b. Provide financial incentives for each major training step taken and successfully completed.
   c. Rely solely on electronic educational materials.
   d. None of the above

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.