Feeling Good about Case Management: *What Does it Take??*

CMSA, Long Island, NY: 2012

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The Center for Case Management

Objectives: *CELEBRATE YOU!*

I. Acknowledge the intense nature of the work of case management professionals, and those lead and those that support them

II. Review old and new goals of case management departments across the country, and the processes they are using to achieve them

III. Evaluate ways to sustain energy and commitment for case management responsibilities without "numbing out"

How does “feeling good” look?

How does “feeling good” feel??

Not this!
Not most days, anyway..

I. The Nature of Our Work

- Relentless
- Non-linear
- Multiple project management
- Time-sensitive
- LEGAL
- Not a job for everyone! (J. Birmingham)

HX: Case Mgmt Goal Evolution

- LOS: 3 Phases (Handout: "Hanging Fruit" Ladder)
- Managed Care, Admits/1000
- Throughput
- Collaboration with SW, RNs, MDs, RNCM, FINANCE
- CMS Compliance: IM, HINNs, RACs, Choice, Face-to-face
- Denials: Medical Necessity
- Transitions across Levels of Care
- P4P
- Readmissions
- Care Coordination within ACO, Medical Home
- FUTURE: Cost per case

Case Management Services connect the Boardroom to the Bedside

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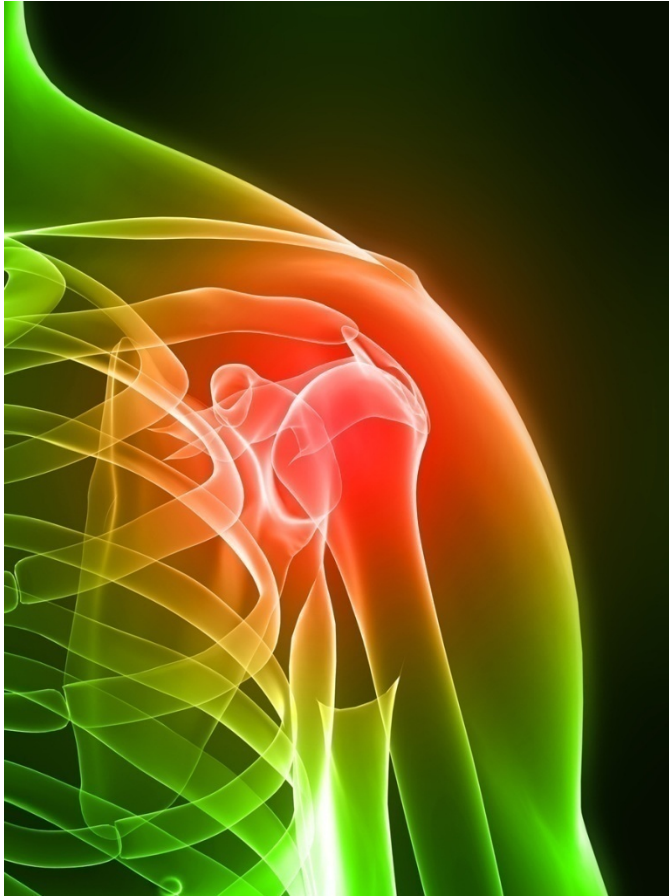
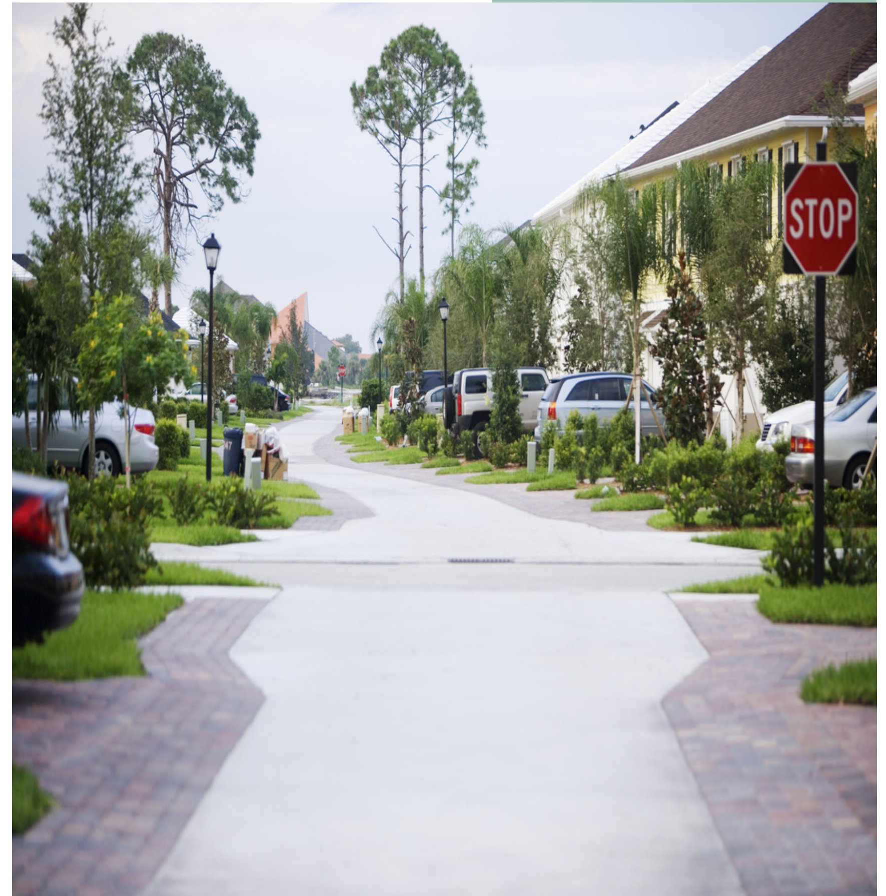
Case Management RNs and SWs Connect Biology to Community





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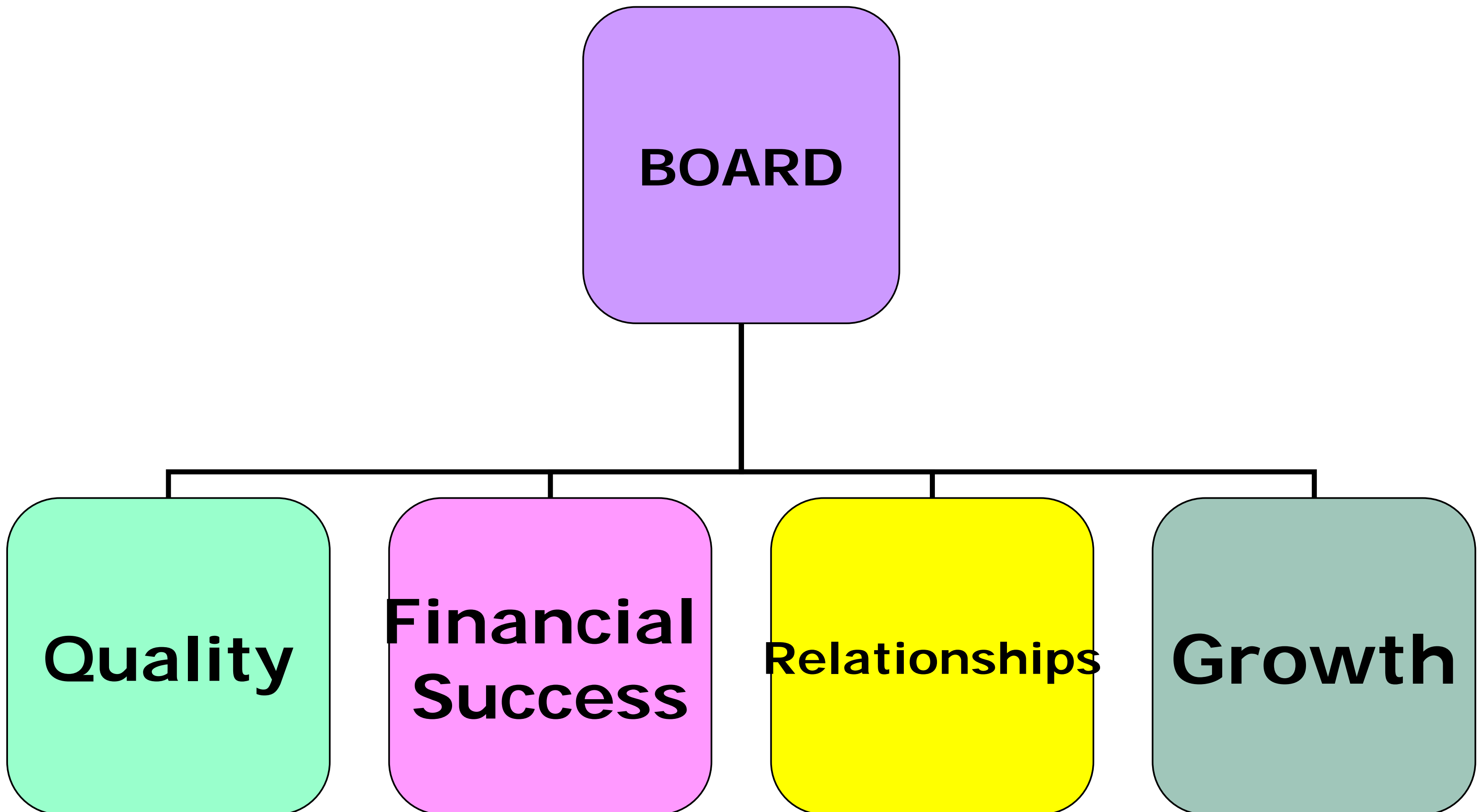
Case Management Addresses Margin and Mission



#1 QUALITY

Patient Satisfaction

Specific **questions on satisfaction survey**
Number of patient /family complaints a bout service

Readmissions

Accuracy of **discharge planning level of care**
Robust use of post-acute continuum

Awards and Public Image

Support of core measures and other quality indicators

Sentinel Events and Legal Suits Pending

Case management services as eyes and ears for pending quality issues

Physician Appointments and Credentialing

Support from Case management services for the content of care, the process of care, and utilization

Transition Projects include Care Coordination

- **Care Transitions***
- **RED** (Re Engineering Discharge)**
- **BOOST** (Better Outcomes for Older Adults through Safe Transitions***
- **INTERACT (Interventions to Reduce Acute Care Transfers)******
- **STAAR*******
- **H2H: Hospital to Home********
- **Wrap-around Case Management ™******:**

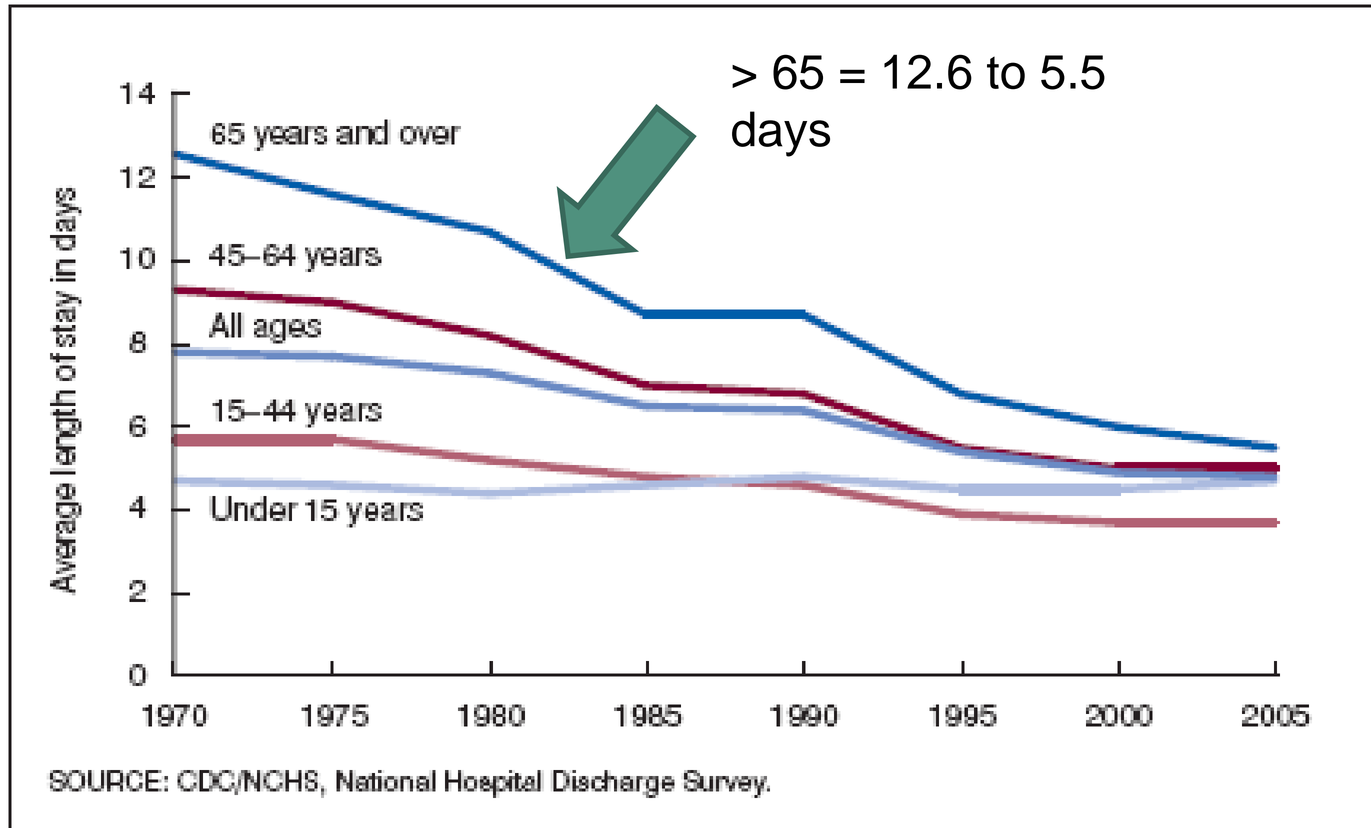
Safe, Smooth, and Sustained!

*Coleman et al, University of Colorado Health Sciences
**Greenwald, et al, Boston Medical Center
***Hospitalmedicine
****CMS
*****IHI: Mass, Washington, Ohio, MI
******ACC and IHI
******The Center for Case Management, Inc.

#2 FINANCIAL OPERATING MARGIN

- **Payer Contracts**
  - Case Management **Director at negotiation table Case managers uphold contract rights**
  - CNS CONDITIONS OF PARTICIPATION
- **LOS**
  - **Case management services manage patient and family expectations**
  - **Case manager provide team leadership and care coordination**
  - **Skilled physician advisor**
  - **Care Coordination Rounds**
- Days Cash on Hand, Days in AR
  - **Denial prevention**
  - **Astute denial appeals**
  - **Good internal IT that connects with the Revenue Cycle**
- **Cost per case**
  - **Use of evidence-based practice interventions and diagnostics**
  - **Transitioning patient from ICU to step-down or floor**

CDC : US LOS STAYS



2 UNDERLYING PHILOSOPHIES that effect systems, policies, BEHAVIORS

1. THERE IS NO SUCH THING AS A SIMPLE DISCHARGE!!

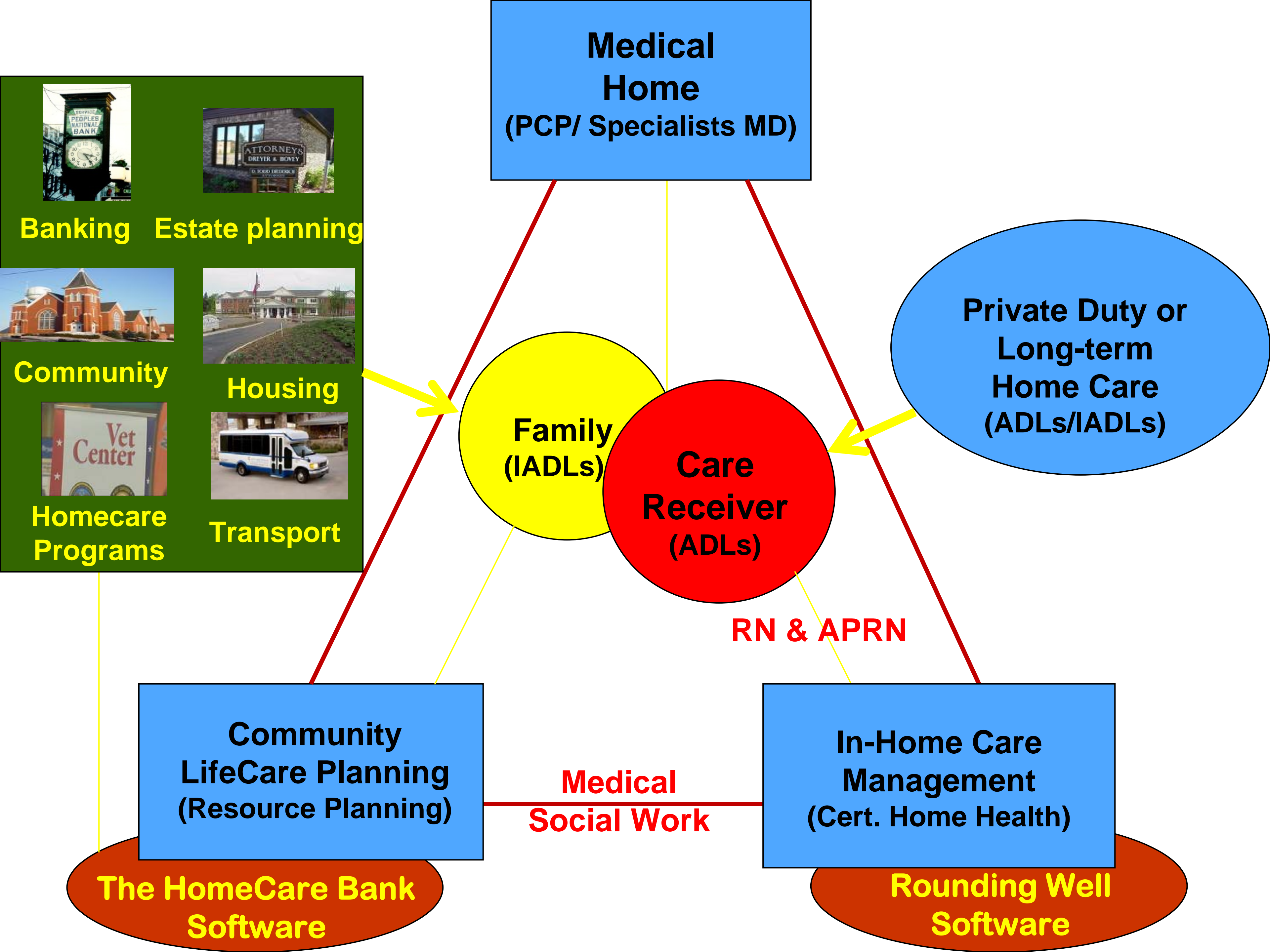
#2 The Family is the other Patient

IF YOU HAVEN'T MET THE PATIENT OR FAMILY UNTIL THE DISCHARGE DAY, YOU DON'T KNOW THEM AND YOU <u>WILL</u> MAKE MISTAKES

Example: Thanksgiving dinner and discharge planning

#3 Growth

- **Market Share/Competition**
  - Decrease LOS equates to increase census if the business is out there
    Decrease patient volume lost to diversion from the ED
- **New Product/ Service Lines and Physicians**
  - Service line (program of care) membership of case managers and social workers
- **New Facilities**
  - Monies saved by case management interventions help fund the "new tower"
- **Relationship with Community**
  - Relationships with Post-acute facilities, in and outside of health system



Medical
Home
(PCP/ Specialists MD)
Banking
Estate planning
Community
Housing
Homecare
Programs
Transport
Private Duty or
Long-term
Home Care
(ADLs/IADLs)
Family
(IADLs)
Care
Receiver
(ADLs)
RN & APRN
Community
LifeCare Planning
(Resource Planning)
Medical
Social Work
In-Home Care
Management
(Cert. Home Health)
The HomeCare Bank
Software
Rounding Well
Software

#4 Internal Relationships

Physicians:
PCPs, Intensivists, ED, Specialists, HOSPITALISTS

Case management services are a support to prescribing physicians

Recruitment and Retention

If unit-based, case management services help stabilize nursing units

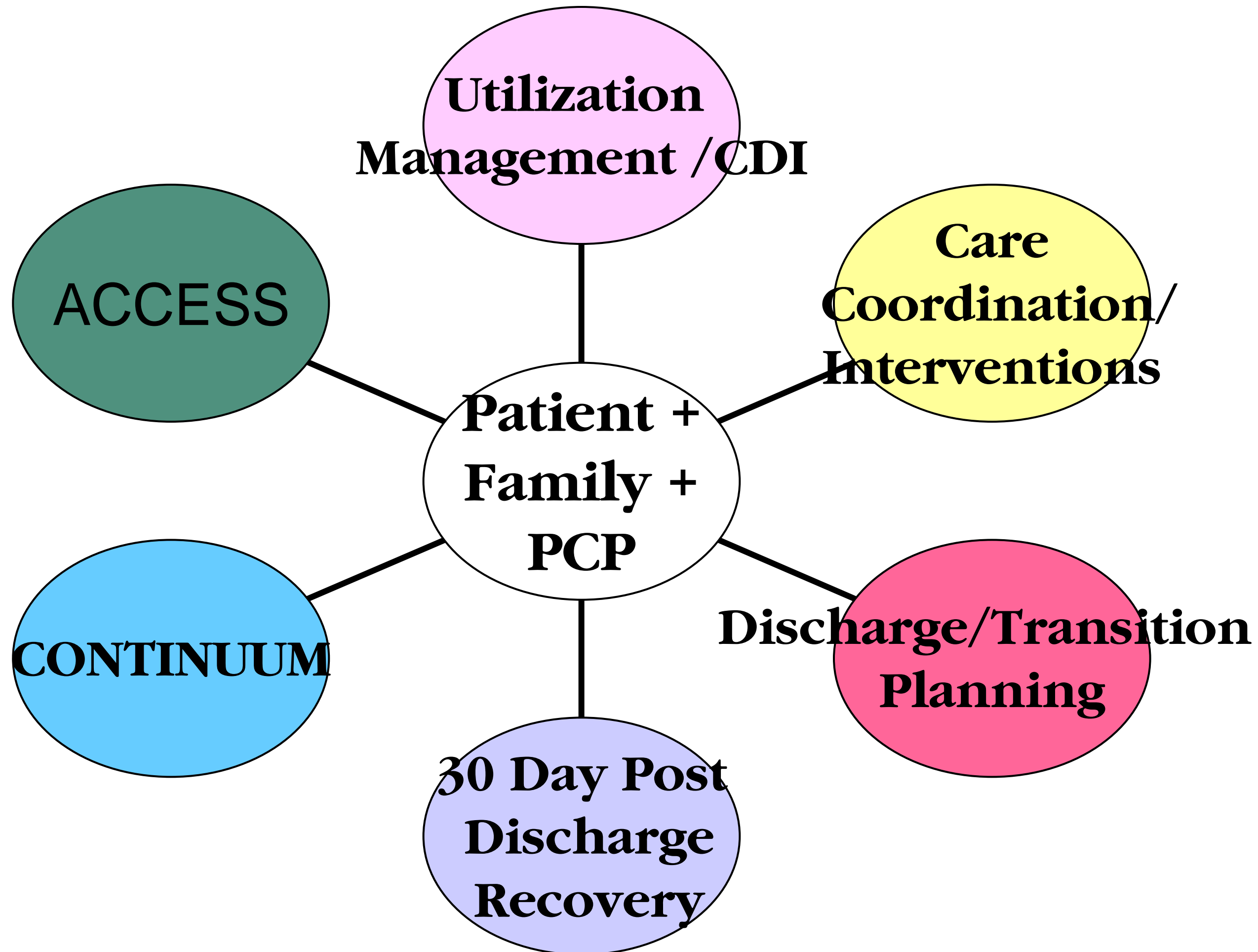
Unions

Best Practice Components: 6 Core Functions

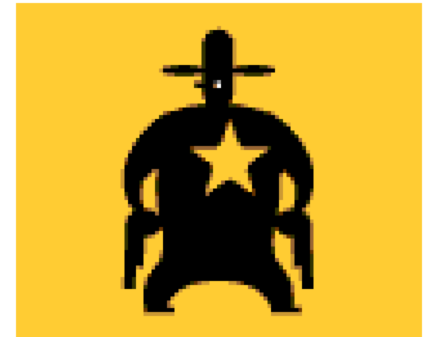
Case Manager as CASE LEADER*

*S. Johnson, Lippincott's Professional Case Management, 2010

"What does this patient and family need from our team today?"



AUTHORITY



1. **Referent—patient-centered**
2. **Legitimate—position in organization, license**
3. **Expert—clinical, resources**
4. **Information—payer, patient, family**
5. **Reward and Punishment--goals**

Source: French and Raven “The Bases of Social Power” (See handout)

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Thought…..

Case management is NOT a profession; it is a specialty, largely within nursing and social work

Being a specialty doesn't make you special, it makes you different

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What are signs and symptoms of dysfunction?

- No desk space or chair
- No computer space
- Complaints about "role confusion"
- Bosses disagree
- Blame

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All environments:
A world of ADHD and sound bites

- Keeping the focus is everything!
- Getting people to pay attention to your agenda is the challenge!

"I am a moth"

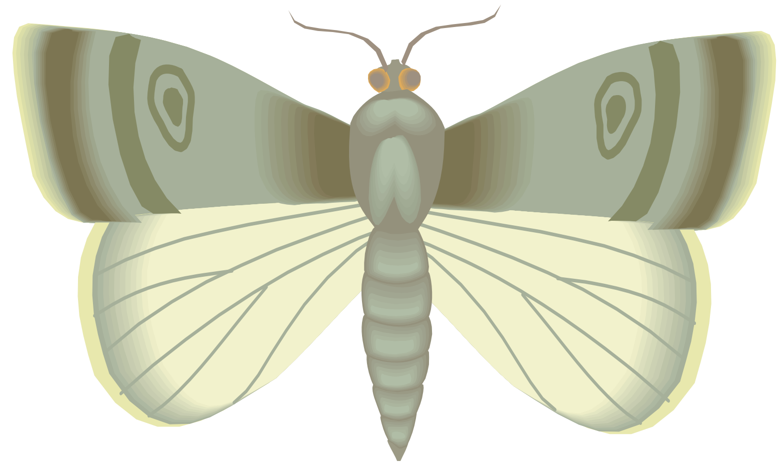
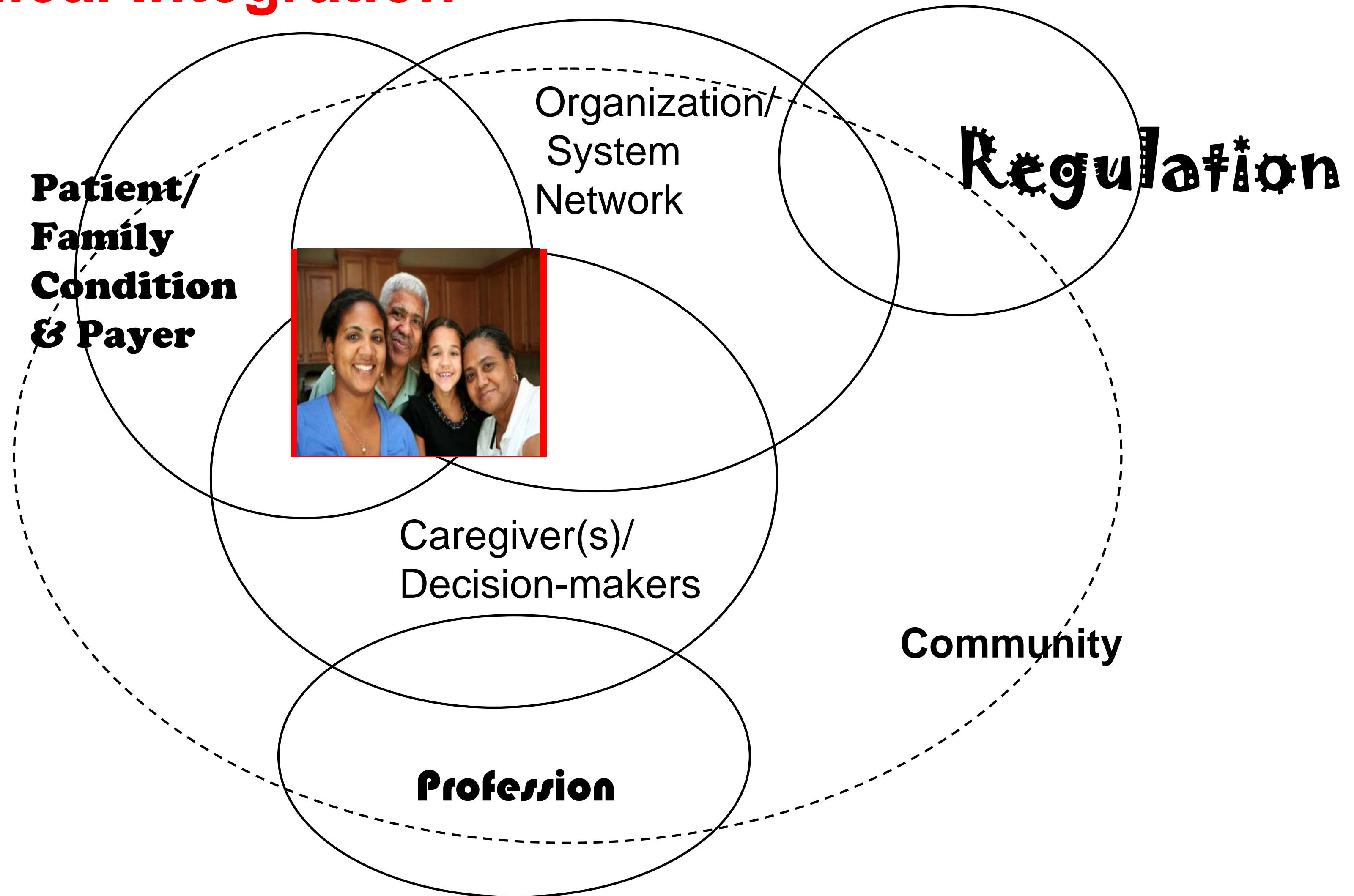


Illustration by
David Harbaugh

"You could be discharged today if we can locate the doctor, who's on rounds, to authorize a physician extender to delegate the responsibility to a social worker, who's been tied up with psychosocial patients. The administrator was available, but she just signed up for Dancing with the Stars*."*

No one else is positioned at the Nexus of Clinical Integration



Clinical Integration in any small part of the continuum, let alone the whole continuum over time and place, is relentless attention to the details regarding each patient's current status and the creation of a realistic plan to maintain or acquire an improved health status to which all participants can commit. Clinical integration requires the acquisition, interpretation, and precise acting upon information, enhanced by consistent care-givers and collaboration.

(K. Zander, CCM, 1998)

The Social Work Specialty

- Psychosocial needs
- Managing Family Expectations
- Problem-solvers
- Advocates
- Ambassadors to the community
- “Voice of the Voiceless”

Social Work: Crisis Intervention

- Crisis of hospitalization
- Crisis of diagnosis
- Crisis of discharge or transfer
- Crisis of the future

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Who Does What?

- **RNs, therapists, etc.: Plan for the day**
- **MD: Plan for the day and stay**
- **CM: Plan for the stay and pay**
- **Clinical SW and APNs: Plan for the way**
- **Access/Registration: Plan for today**
- **UR Committee: Plan for Delay**
- **And Physical Therapy is King! (**Differentiate between PT screen vs. assessment, PT aide, Nursing ambulating); MGH has PT and Nutrition automatic "sliding scales" for advancing

To the patient and family…

- We are a team with your physician(s), NPs, nurses, and therapists.
- As your case manager, I will be working with you from now until your transition to put together a plan for your [recovery]
- As your social worker, I will be available to you and your [family] as you go through this hospitalization if you need help with relationships, finances, and other decisions

Every patient needs something different from Case Management services

- Patient A: negotiate with their payer
- Patient B: convince the MD that the patient needs home care, and convince home care that they want the patient!!
- Patient C: have a family meeting that includes the doctor
- Patient D: gather information and get people involved with problem-solving the patient’s new onset of confusion
- Patient E: determine why this patient was readmitted
- Patient F: IV heroin user needs IV antibiotics
- Patient G: undocumented alien
- Patient H: find a payer
- Patient I: find the legal guardian
- Etc., etc., etc.

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Core Coordination Skill is Lateral Leadership: "Leading When You're Not in Charge"*

Case Managers provide decision support and problem-solving through the act of pulling others into an activity or goal. (Zander)

*Source: Fisher, R and Sharp, A. Getting It Done; HarperPerennial, 1998.

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Lateral Leadership (Zander)

- Involves inclusion and coordination rather than delegation
- Provide relentless, purposeful communication and information
- However, you have to know job boundaries, personalities, and the culture
- Takes a lot of energy and focus
- Empowers people
- "Think like a shark, act like an octopus"

© The Center for Case Management, 2006

Case Example: JIM

- 52 year old male, 350 pounds
- LOS: 28 days for cellulitis of leg
- Medicaid
- Hx schizophrenia
- Day 5: fell, had MI, resuscitated
- 2 weeks ICU
- Dialysis 3 times/week
- Pulled out shunt 3 times
- Brother told ICU SW that “another person” (name in chart) was responsible for plans;
- Original wound site healed, but now breakdown on buttocks
- Yesterday MD wrote: “Patient could die unpredictably at any time”
- Vital signs always stable
- 2 nursing homes refused him, another cannot provide transport to dialysis
- Medicaid CM has no suggestions

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II. News for Case Management Nation

- What are the innovations and implications?

Care Coordination is Central

- "Care Coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.
- Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for the different aspects of care."
- Three Perspectives/Measures

1. The Patient and Family
2. The Professionals
3. The System

AHRQ Pub #11-0023-EF; Care Coordination Measures Atlas; December 2010, p.4

It starts with Access CM

- Case management in admitting, outpatient
- Control of pre-auth, pre-cert, level of care determination at all entry points
- Involvement or control of bed placement

4 Main Reasons for ED CM

1. Level of Care Determination
   OBS vs IP—avoid RAC fines
   Connect with Patient Placement
2. Document Provider-preventable Conditions—especially transfers from other facilities (for Medicaid starting July, 2012)
3. Direct Discharge from ED to HH, SNF, etc.
   "Debulk" the ED to decrease wait times;
   Improve Flow and Capacity
   Increase referrals within system (if chosen)
4. Develop and Implement CM Plan for "High Utilizers"

CM in ED Now On the Map

- Psych patients put social workers in EDs
- ***RAC put nurse case managers in EDs***

Example:

At Lee Memorial Health Systems, Ft. Meyers, FL, Case Managers in the ED from 8am-8:30pm M-Sat, and 8am-5pm Sunday (with SW 2p-10:30pm M-Sun), savings of $4.5M by ensuring that patients were in the right status and transferring patients that did not meet admission criteria to a more appropriate level of care"

Source: Nesheim, C., Hospital Case Management, Vol 19, No 8, August 2011, p. 122.

INTERVENTION$

INTERVENTION SUMMARY 2010 JAN-DEC Lee Memorial HS		
	Interventions	**Saved**
Obs to IP criteria found ($5,600 each)	953	$5,336,800
IP admission avoided ($2,000 each)	503	$1,006,000
Obs admission avoided ($1,062 each)	206	$218,772
Potential admit made Obs before registered ($800 each)	99	$79,200
Ambiguous orders clarified ($71 each)	686	$48,706
IP to Obs - Code 44 ($372 each)	126	$46,872
ED visit avoided ($103 each)	129	$13,287
Avoided system funding ($50 each)	299	$14,950
Grand Total	**3001**	**$6,764,587**

ED's Role in Society = Sociomedical System of Care

"The hospital ED is perhaps the only local institution where professional help is mandated by law, with guaranteed availability for all persons, all the time, regardless of problem".

- Treatment of illness
- Identification of basic social needs
- Extension of existing community resources

(Source: James Gordon, MD, MPA, (1999)The Hospital Emergency Department as a social Welfare Institution, Annals of Emergency Medicine, Vol 33(3), March, pp 321-325)

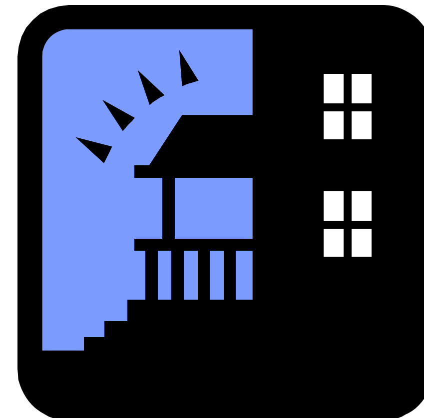
The Shift from Gate to “The Porch”!

Good Goals 2000-2010

- Provide assistance to care givers from social service for psych, abuse, addiction
- Link to social service agencies for ADLs
- RN case managers for UR: Medical necessity OBS vs. IP
- Decrease loss from RAC
- Increase flow and capacity
- “Debulk” the ED
- Decrease diversion

New Goals 2011-2020

- Decrease readmissions
- Decrease re-visits and hyper-utilization
- Help the community deal with chronic illness



ICU Escalation at UMassMemorial

- Everyone on same page with same information

New at MGH

- 5.6 Hour LOS reduced to 3.5 by having physician evaluate the patient first (within 20-30 minutes unless trauma, stroke, acute pain), along with a midlevel provider
- **CMS demonstration project: computer notification of specially designated case managers for enrolled frequent fliers or when paramedics are called to home**
- CMS project to eliminate 3 overnight rule before SNF

Source: www.healthleadersmedia.com , C.Clark, May 13, 2011

Senior EDs

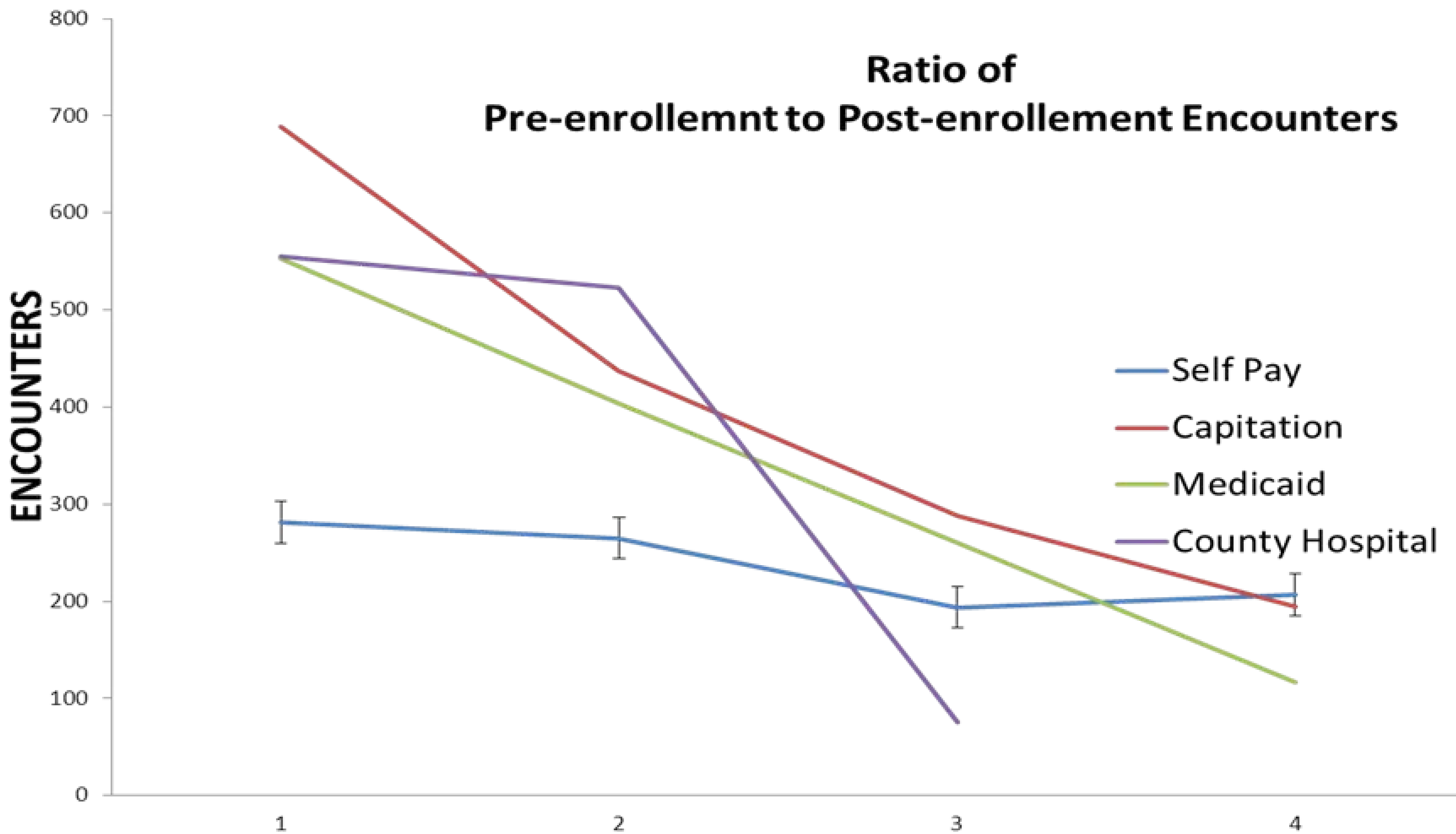
1. Designed to reduce anxiety, confusion, and falling risk (lighting, softer colors, noise abatement, handrails, non-reflective flooring)
2. Retrained ED nurses and MDs in geriatrics
3. **Provided a full-time social worker**
4. Spear-headed by Bill Thomas, MD
5. First in US: Holy Cross Hospital, Silver Spring, MD 2008 for $150,000

Integrated CM
Dealing with Health Complexity

- Texas Health Harris Methodist Hospital, Ft. Worth

Health complexity= "The interference with standard care by the interaction of biological, psychological, social, and health system factors".

Use Integrated Case Management (2010) Kathol, Perez, Cohen; NY: Springer


Ratio of
Pre-enrollemnt to Post-enrollement Encounters
ENCOUNTERS
800
700
600
500
400
300
200
100
0
1
2
3
4
Self Pay
Capitation
Medicaid
County Hospital

CMS 9th Statement of Work

- **August, 2008-July 31, 2011**
- **14 states*: to coordinate care and promote seamless transitions across setting, including from the hospital to home, skilled nursing care, or home health care. QIOs will also look to reduce unnecessary readmissions to hospitals that may increase risk or harm to patients and cost to Medicare."***
- **Includes many initiatives--Those applying to case management are**:

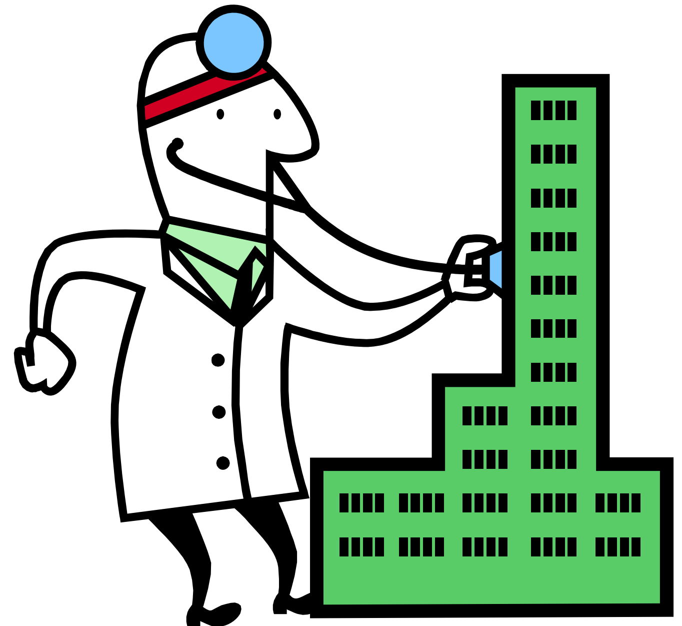
1. Readmission Rates: Unplanned within 30 days
2. HCAPS Questions 19 and 20
3. PCP appt within 30 days

- **MI, Ala, GA, FL, IN, LA, NE, NJ, NY, RI, PA, Tx, WA CO.**

- Office of Clinical Standards and Quality (2008) Fact Sheet: CMS awards contracts for quality improvement organizations' 9th Statement of Work; Baltimore, MD: Centers of Medicare and Medicaid Services; www.cms.hhs.gov ; retrieved 12/30/98; p. 3.

REDUCED MEDICARE PAYMENTS FOR Excess (preventable) 30-day HOSPITAL READMISSIONS

- MI (National = 19.8%)
- CHF (National = 24.8%)
- Pneumonia (National = 18.4%)



Structure of an Accountable Care Organization (ACO)

"An ACO is a local health care organization and a related set of providers (primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population."

"The goal is to deliver coordinated and efficient care. ACO's that achieve quality and cost targets will receive some sort of financial bonus, and under some approaches, those that fail will be subject to a financial penalty.

RWJF,10-09 Summary: Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandries? Devers, K and Berenson, R, The Urban Institute, p1.

ACO (continued)

In order to meet the requirements of this type of incentive system, an ACO needs to be able to:

- **Care for patients across the continuum of care, in different institutional settings**
- **Plan, prospectively, for its budgets and resource needs**
- **Support comprehensive, valid and reliable measurement of its performance**

RWJF,10-09 Summary: Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandries? Devers, K and Berenson, R, The Urban Institute, p1.

NCQA (2011) Patient-Centered Medical Home and Medical Neighborhood

- 3 Levels of Medical Home (Lead by primary care physician and a care team; began in pediatrics for coordinating complex clinical and social service needs)
- Payment reforms include additional per-patient monthly payment
- Criteria:

1. Patient-centeredness, now including patient surveys and advisory committees
2. <u>Coordinating care across time and settings</u>
3. Tracking information, not just having an electronic medical record
4. Strong focus on integrating behavioral healthcare with physical health

- Source: E. Fisher, MD, NEJM Sept 18, 2008 and NCQA, Jan 31, 2011

$1 BILLION Grants for CMS INNOVATION 2012

- For Medicare, Medicaid, CHIP populations, including high cost/high risk, multiple chronic diseases and/or mental health and substance abuse; poor health status due to socioeconomic or environmental factors, frail elderly

- <u>3 year projects to achieve 3-part aim:</u>

✓ Identify and test new care delivery and payment models to produce **better care, better health, reduced cost**

✓ Identify new models of workforce development

✓ Rapid deployment to new populations of patients in conjunction with other public and private sector partners

99 AWARDEES

- 42 included Case/Care Managers (navigators, health coachers, care transition specialists, NP as care coordinator, care management plans, SW as engagement advisors)
- 28 included “care coordination teams”, with RNs and/or SW but emphasized other roles
- 29 not case-manager based (i.e. radiology, ICU data bases, statistical predictors, technology, IT)

Projects and Populations

- 1-5% Complexly Ill
- Chronic pain
- Alzheimers
- Sepsis and delirium detection
- Dental
- Geriatric Emergency Depts
- ESRD
- Substance Abuse
- Hi-risk/Disabled pediatrics
- Released prisoners

?Competition?

- Patient and family activators
- Behavioral health triage therapists
- Paramedics (in-home monitoring, lab work, etc)
- Respiratory therapists for asthma
- Peer navigators
- Dental hygienists
- Pharmacy management
- Medical information coordinators
- Individualized Care management plans

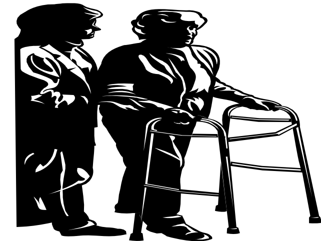
Changes to Medicare Advantage PLANS

- Reduces rebates paid to MA plans
- Bonus payments to high quality plans

CMS Announces Initiative to Reduce SNF Readmissions

Posted on: 3/21/2012

The Centers for Medicare & Medicaid Services (CMS) announced a new initiative aimed at avoiding readmissions.



Through the $128 million Initiative to Reduce Avoidable Hospitalizations among nursing facility residents, CMS will partner with independent organizations to improve care for long-stay nursing facility residents on Medicare and Medicaid, facilitating transitions to and from inpatient hospitals and nursing homes.

QUIZ

- **WHICH 4 Medications** account for 2/3 Emergency Hospitalizations!

- (65.7% due to too much dosage or right dosage but bad effect) between 2007-9 from 58 hospitals; CDC National Electronic Injury Surveillance System, Cooperative Adverse Drug Event project with ½ patients over 80;
- Source: Remington Report: March/April 2012, p 8-10.

Here they are!

1. **Warfarin**
2. **Insulins**
3. Oral anti-platelet agents
4. Oral hypoglycemic agents
5. Antibiotics
6. Digoxin

MEDICARE INDEPENDENCE AT HOME DEMO

- To provide high-need Medicare beneficiaries with primary care services in their homes.

Medicaid Payment Demonstration Projects

- Creates new demonstration projects in Medicaid for up to 8 states to pay bundled payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as ACOs to share in cost savings.

Data Collection to reduce health care disparities

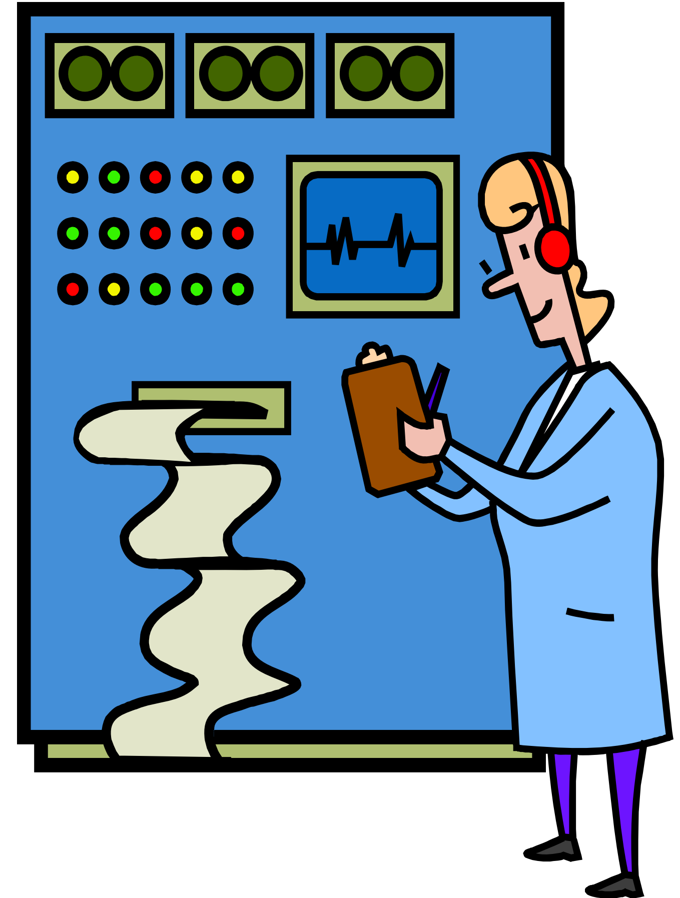
- Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations

Fraud and Abuse Prevention

- Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and CHIP; requires additional entities to register under Medicare

Medicare Value-based Purchasing

- Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance of quality measures and requires plans to be developed to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory centers.



Decrease Medicare Spending per Beneficiary Fiscal 2015

- **October 1, 2014 hospitals accountable for cost of care for acute, rehab, snf, HHA, and other post-acute providers for 30 days post-discharge. Includes Part A and B for 3 days before discharge to 30 days after (adjusted to age and severity)**
- **Implications:**

  Documentation (CDI

  Efficient transitions

  No readmissions

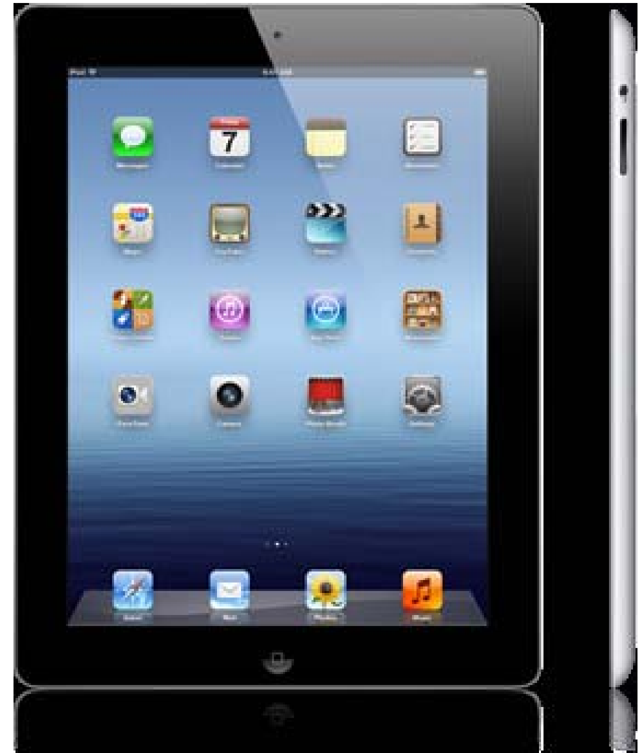
  Least expensive post-acute solutions

Prediction: The Shrinking Hospital

- Big ED Front Porch/Mall, Ultra-Specialized ICUs and Surgeries
  - (M. Hill)
- Nurse practitioners and case managers will connect patients to services and resources across time and place
- Invite: Make your ED predictions

Prediction:
Technology will change everything!

- Websites such as Davita.com for CKD
- Appointment and check-up calls
- I PADs
- Social networking
- APPs; e.g. RxMINDME, My health records
- Caringbridge.com
- **Zeo and Siri will be case managing**



III. How do we get ready?

Don’t “Numb Out”

- **Signs of numbing out:**

1. You stop listening
2. Processing, not customizing
3. You never get away from your desk
4. You don’t ask or see anymore because it is more work if you do
5. You talk about your work, not your practice

Finding your own “Mojo”

- **When did you make a difference?**
- **What do you need to feel mastery?**
- **What makes your heart sing**?

Work together on the Challenges

- Don’t start down the bad-talk route about patients and their families
- Weekly staff meetings
- Read the literature and listen to audio-conferences
- Go visit hospitals that have found answers
- Peer audits
- Set high standards
- Measure and reward accomplishments

Challenge #1
Time Management

- How do you get from Caseload to Workload?
- I worry about too much computer time, no “face time”

How many minutes do you <u>really</u> have in a day?

- Basic work minutes
- Minus lunch, breaks
- Minus standing meetings, such as rounds
- What is left?
- Remember that number!

Average 8-15 “Juicy Jobs”/Day

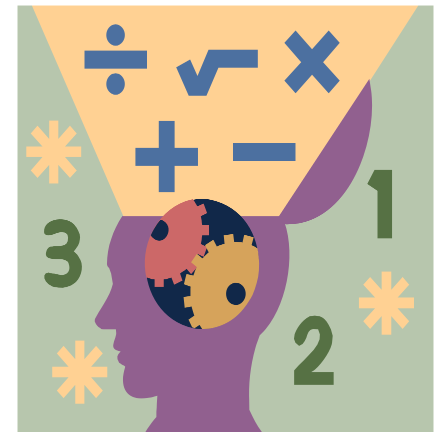
- Plans are unraveling
- Planned team or family meeting
- Emergency team of family meeting
- Patient, family, or MD complaint
- Issue needs extensive follow-up
- Readmissions
- Your boss is upset about something involving you

Do you really want an acuity system??

- Proposed by Huber, D. and Craig, K., U. of Iowa S.O.N, identifying indicators, drivers and sub-drivers of case management complexity matched/addressed by the intervention's "dosage".

CM Dosage includes:

1. **Amount: the quantity of the target activity in one episode**
2. **Frequency: The rate of occurrence or repetition**
3. **Duration: How long the activity is available over time**
4. **Breadth: The number and type of possible intervention components or activities**



Challenge #2
Protect the Cognitive Work

- From research by P. Potter at Barnes Jewish
- The thinking time that goes into the doing time
- Cognitive Load is how many activities and distinct pieces of information a person can hold at any time
- Different than multi-tasking

Challenge #3
Maintain Autonomy, Love Ambiguity

Assessment keeps you autonomous!
(Assessment is more than gathering facts)

- **Assessment <u>begins a relationship, gives information, sets expectations</u>**
- **Assessment is basis of planning, setting direction, anticipating problems and resources**
- **Assessment tools help structure questions and thoughts, although there is no perfect form**

Challenge #4
Stay Clinical!

Example

Delirium vs. Dementia vs. Depression

QUIZ

- What condition is currently on the rise in people ages 65 and older (which make up 1/8 of the US population) and 2/3 of all cases?
- Source: Oltermann, M., Lab Management, 2011 CHEST.

Learn Integrated Case Management:

Health Resources

- For patients with complex patients who have combinations of interacting chronic and/or multi-comorbid illnesses, including mental and substance use disorders, inadequate social networks, limited or poorly-coordinated access to health services by providing individualized support/care management procedures

- <u>Settings include:</u>
  - ED
  - Community
  - Payers

- Kathol, Perez, and Cohen; Integrated Case Management, NY: Springer, 2010
- Kathol, Lattimer, Gold, Perez, and Gutteridge; Creating Clinical and Economic “Win” through Integrated Case Management: Lessons for Physicians and Health System Administrators; Professional Case Management Vol, 16, NO. 6; P 290-8.

Challenge #5: Get your "groove on" as a department

- You are only as strong as your department's weakest person
- Set your standards high (see handout)
- Sub-committees for forms, IT, hiring, inservice
- Lots of staff meetings to problem-solve
- **Share literature: Your Medical Mind by J. Groopman and P. Hartzband (2011)**

Mostly: Be Kind to Each Other