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A Resource Center for Today's Case Manager

Bringing care closer to the community, practice and home

Bonnie Ewald, MS
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Agenda

- Welcome and Introductions
- Learning Outcomes
- Presentation:
  - **Vivian Campagna, MSN, RN-BC, CCM**
    Chief Industry Officer, Commission for Case Manager Certification
  - **Bonnie Ewald, MS**
    Manager, Strategic Development and Policy Dept. of Social Work and Community Health Rush University Medical Center, Chicago
- Question and Answer Session

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Audience Notes

- There is no call-in number for today's event. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the tab to the left of your screen. Please refresh your screen if slides don't appear to advance.

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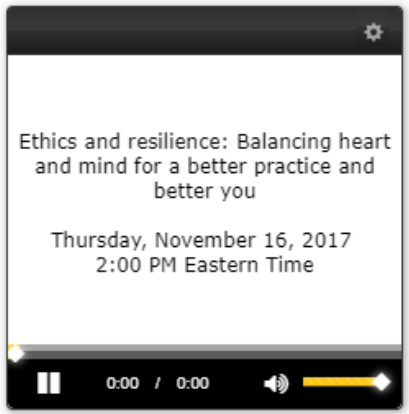
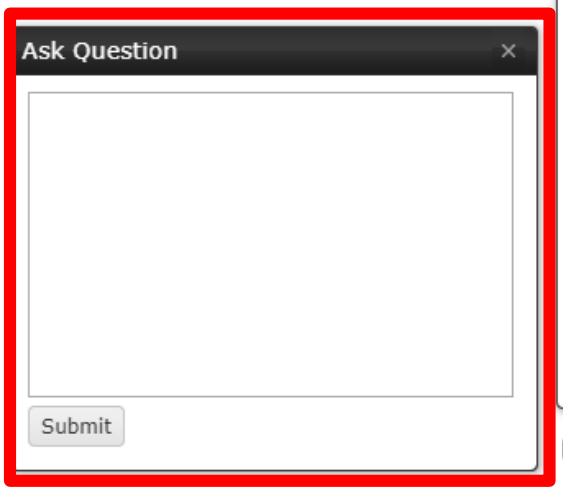
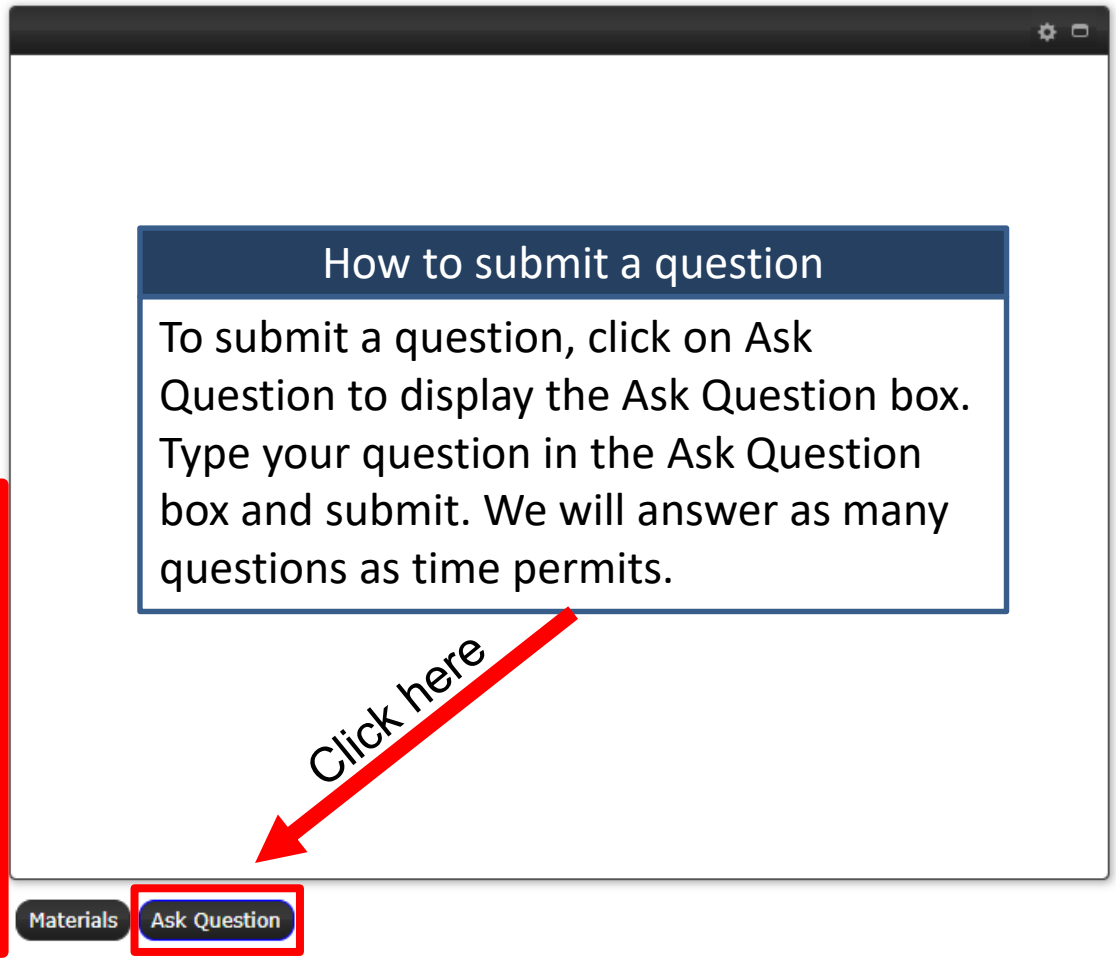

Ethics and resilience: Balancing heart and mind for a better practice and better you
Thursday, November 16, 2017
2:00 PM Eastern Time
0:00 / 0:00


Ask Question
Submit


How to submit a question
To submit a question, click on Ask Question to display the Ask Question box. Type your question in the Ask Question box and submit. We will answer as many questions as time permits.
Click here
Materials
Ask Question

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Audience Notes

- A recording of today's session will be posted within one week to the Commission's website, www.ccmcertification.org
- One CCM continuing education credit for board-certified case managers (CCM) and one ANCC nursing contact hour continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

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Learning Outcomes Overview

After the webinar, participants will be able to:

1. Identify systematic barriers faced by case managers and community-based service providers.
2. Describe efforts to build evidence-based case management practices in order to influence reimbursement streams.
3. Employ new reimbursement and contracting opportunities that open doors for case management services.

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Chief Industry Officer

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CareManagement

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Payers have a vested interest

"Drawing on lesser-known economic models and available data, we show how a properly governed, collaborative approach to financing could enable self-interested health stakeholders to earn a financial return on and sustain their social determinants investments."

Health Affairs

TOPICS JOURNAL

POLICY INSIGHT COMMUNITY HEALTH

HEALTH AFFAIRS > VOL. 37, NO. 8: MEDICAID, MARKETS & MORE

POLICY INSIGHT

Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities

Len M. Nichols[1] and Lauren A. Taylor[2]

AFFILIATIONS

PUBLISHED: AUGUST 2018 Free Access https://doi.org/10.1377/hlthaff.2018.003

SECTIONS VIEW ARTICLE PERMISSIONS SHARE TOOLS

ABSTRACT

Good research evidence exists to suggest that social determinants of health, including access to housing, nutrition, and transportation, can influence health outcomes and health care use fo vulnerable populations. Yet adequate, sustainable financing for interventions that improve social determinants of health has eluded most if not all US communities. This article argues that underinvestment in social determinants of health stems from the fact that such investments are in effect public goods, and thus benefits cannot be efficiently limited to those who pay for them—which makes it more difficult to capture return on investment. Drawing on lesser-known economic models and available data, we show how a properly governed, collaborative approach to financing could enable self-interested health stakeholders to earn a financial return on and sustain their social determinants investments.

Source: Health Affairs, August 2018 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039

HEALTH PAYER INTELLIGENCE

xtelligent HEALTHCARE MEDIA

Home News Features

80% of Payers Aim to Address Social Determinants of Health

Payers are focusing on addressing the social determinants of health, expanding value-based reimbursement, and improving consumer engagement in the near future.

AJMC Managed Markets Network

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In Focus Blog – Published on: November 16, 2018

Azar: CMMI Will Get More Involved in Addressing Social Needs Driving Health Issues

Laura Joszt

HHS Secretary Alex Azar plans to ensure his agency handles both the health and the human services, as stated in its name, of Americans. In a recent speech, he hinted that the Center for Medicare and Medicaid Innovation will be doing more work in areas adjacent to healthcare, such as food insecurity, and housing, utility, and transportation needs.

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Hospital CFO Report

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Physicians Leadership Executive Moves Transaction & Valuation Human Capital & Risk Patient Flow Facilities Mana

Patient Engagement Pharmacy ACOs Population Health Legal & Regulatory Compensation Payers Opioids Rank

Financial Management

Medicaid for rent, food? 'Stay tuned,' HHS chief says

Written by Kelly Gooch | November 15, 2018 | Print | Email

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Introduction

Bonnie Ewald, MS
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RUSH UNIVERSITY MEDICAL CENTER

CHaSCI

Center for Health and Social Care Integration

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Bringing care closer to the community, practice, and home

CCMC webinar, November 29, 2018

What brings us here today?

Before we get started…

Are you currently providing case management as part of any fee-for-service and/or value-based healthcare reimbursement opportunities?

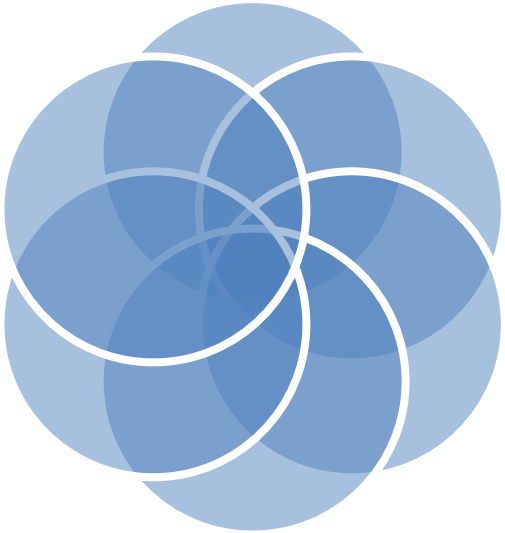
- We'll get to more details later
- For now, please let us know via question box

Context and defining a solution

What shapes our health?

Biological factors

Environmental factors



Health services

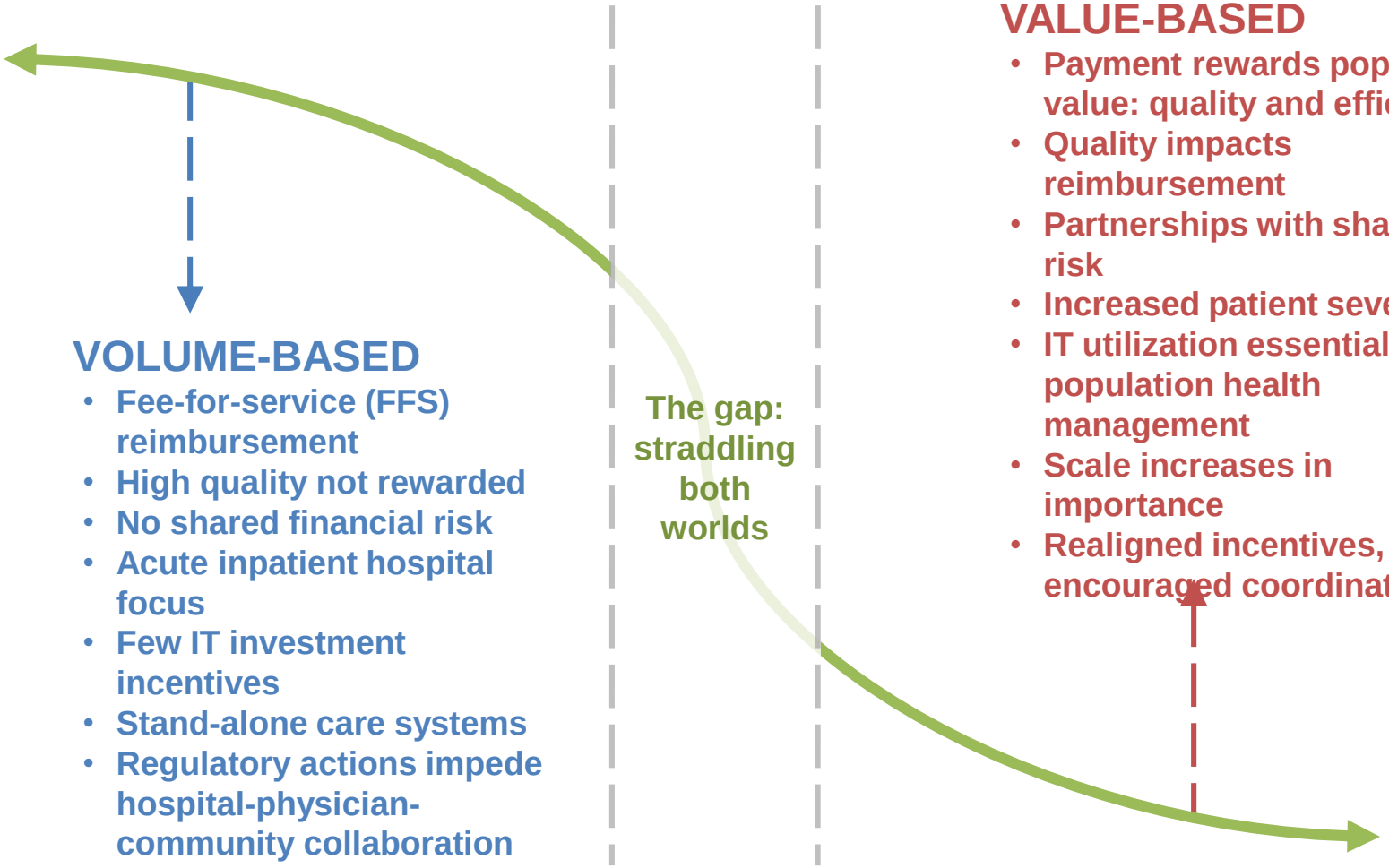
Socioeconomic & structural factors

Mental health status / supports

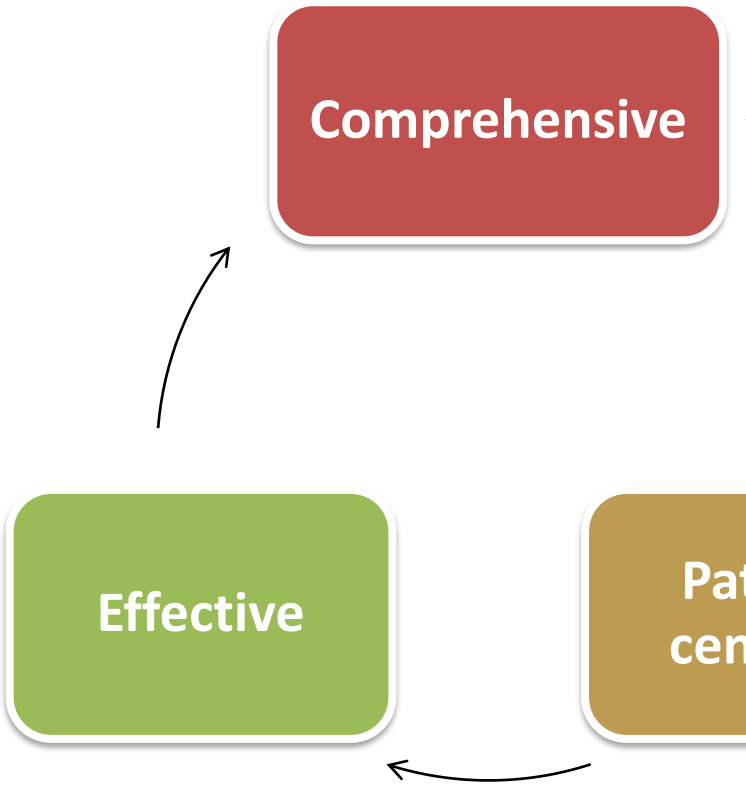
Individual health behaviors

Source: Flourish Index, 2018, University of Louisville
http://www.optimalaginginstitute.org/about-the-institute.

Volume vs. value



Making care comprehensive, patient-centered, and effective



Does care identify & address barriers to health & wellbeing - whether medical or not?

Is care responsive to individual patients' needs & wishes?

Does care help people manage chronic conditions & live safely in the community?

Defining the problem: why *isn't* it like that?

- Workforce
  - Availability / shortages
  - Skillset not always matched with interventions or given enough time to shine
- Structural factors
  - Lack of resources available
  - Discrimination and biases
  - Environmental / access issues
- Fragmented care and incentives
  - Need for care coordination
  - Reimbursement not always aligned with the care we want and need
- Given these challenges... what can evidence-based case / care management address?

Yet, social work and community-oriented case management lack business case

- Social work and other case managers have rich history of using evidence- and theory-based interventions
- Yet, their role within health care often undefined
  - → undefined value and challenges with sustainability
- Challenges to defining value include:
  - Lack of metrics and data that span sectors and meaningfully capture quality of life
  - Defining art of relationship-based care, systems navigation
  - Qualitative feedback not enough
  - Accessing reliable sources of data (health outcomes, utilization claims)
  - Studying impact of intervention amidst continuous quality improvement and moving targets

Our imperative

"Future work must develop an evidence base about:

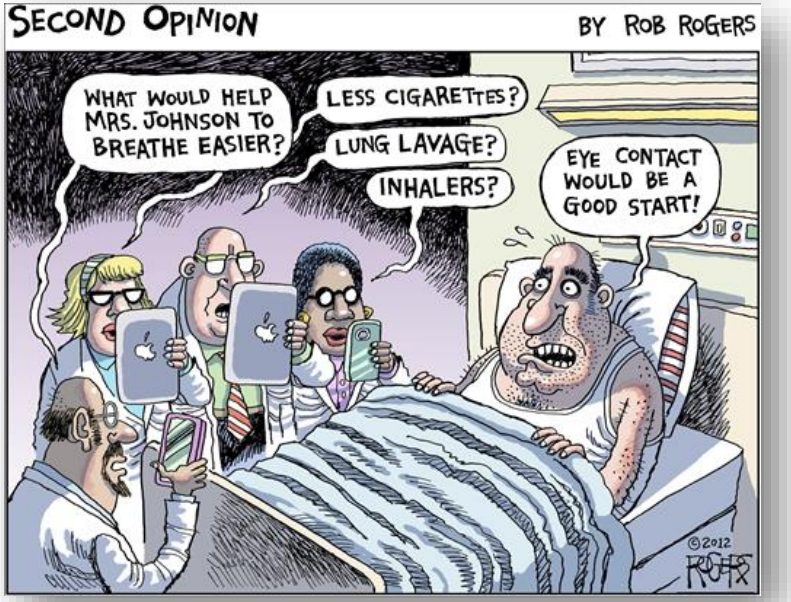
- **the professional skills and knowledge** that are required to address social needs successfully within health care settings;
- the **activities, tasks, and services** addressing social needs that directly result in improved outcomes;
- and the **patient risk factors** that are most susceptible to social support.

This level of specificity is required to support the development and refinement of models that are **credible, replicable, and sustainable**."

Source: Health Affairs 2013, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0170

Characteristics of effective case / care management

- Using empathic language and gestures
- Anticipating the patient's needs to support self-care
- Providing actionable information1
- Minimal handoffs
- Frequent touch points
- Person-specific, tailored interventions
- Ability to effectively link individuals to services
- Trusting care team relationships



Sources: 1. Mitchell, Suzanne E., et al. "Care transitions from patient and caregiver perspectives." *The Annals of Family Medicine* 16.3 (2018): 225-231.
2. Boutwell, Amy E., Marian B. Johnson, and Ralph Watkins. "Analysis of a social work–based model of transitional care to reduce hospital readmissions: Preliminary data." *Journal of the American Geriatrics Society* 64.5 (2016): 1104-1107
3. Kirst, Maritt et al. "What works in implementation of integrated care programs for older adults with complex needs? A realist review" *International journal for quality in health care : journal of the International Society for Quality in Health Care* vol. 29,5 (2017): 612-624.

Change occurs when...

- The person becomes **interested in / concerned about** the need to change
- They become convinced that the change is **in their best interest** and that the benefits outweigh the costs
- They develop a **plan of action** that they adhere to
- They follow through with that plan of action and can **sustain the change**

Core skills and frameworks to leverage in case / care management

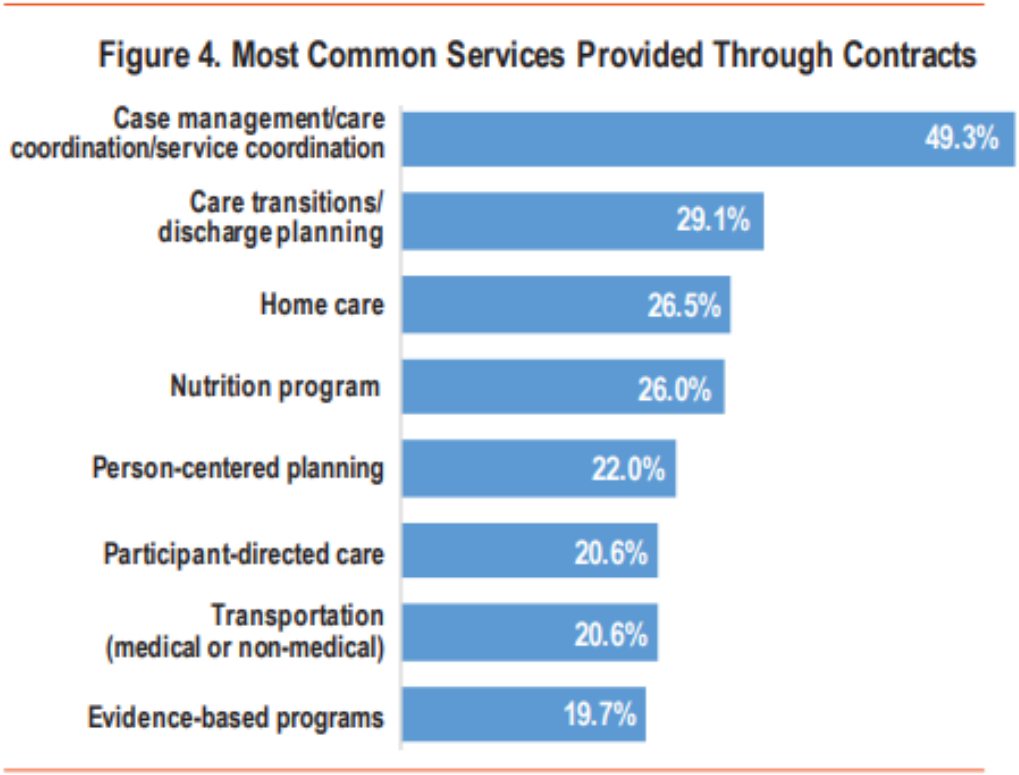
- Person in environment
  - Systems theory
- Stages of change
- Cultural humility and intersectionality
- Trauma-informed and strengths-based approach
- Psychotherapeutic techniques
  - Motivational Interviewing and OARS
  - Relational psychodynamics
  - Acceptance and Commitment Therapy
  - Cognitive Behavioral Therapy

Relationship-centered care

"I've learned that people will forget what you *said*, people will forget what you *did*, but people will never forget *how you made them feel*."

-Maya Angelou

Community-based organizations provide key supports in the community



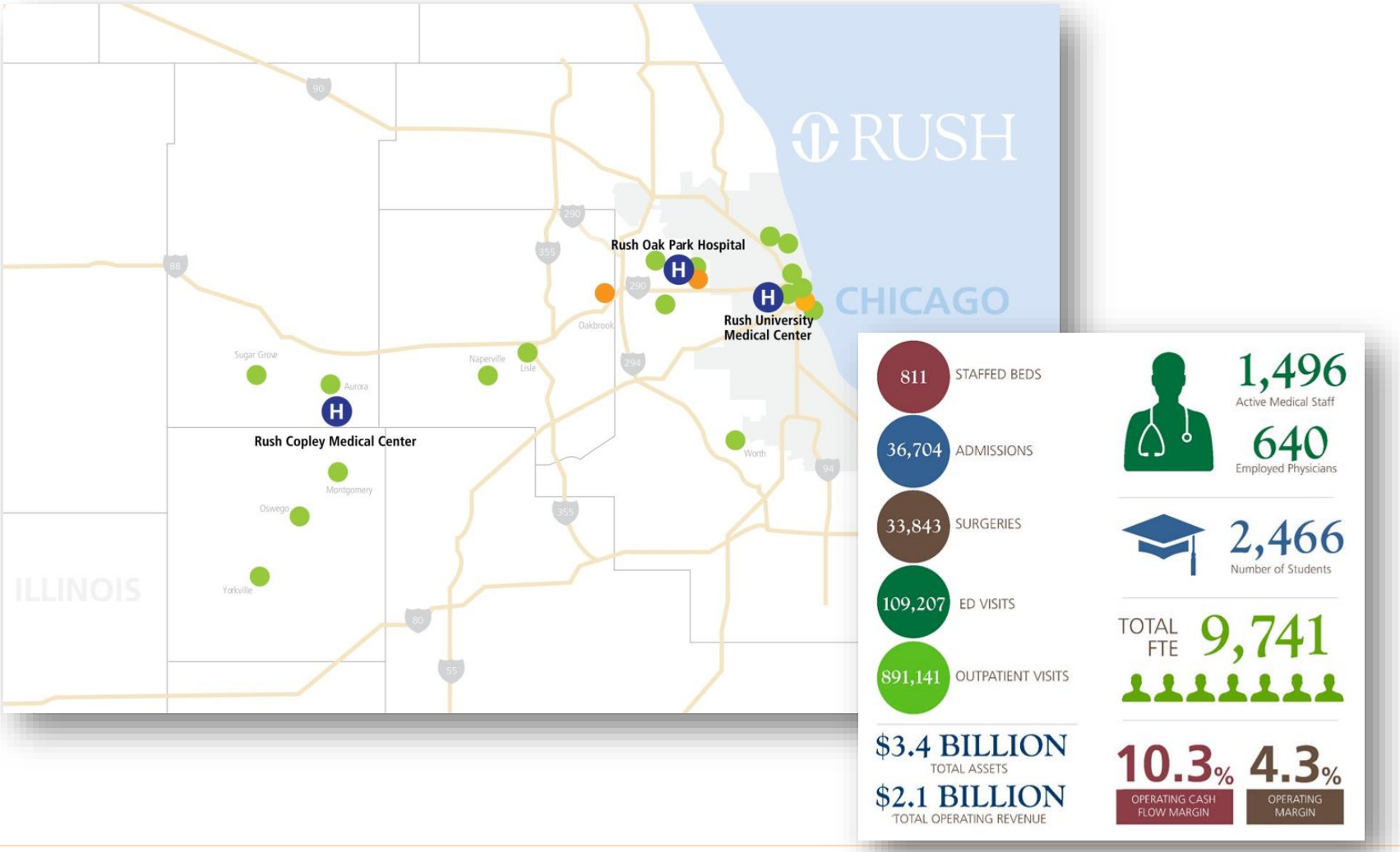
Source: Kunkel SR, Straker JK, Kelly EM, Lackmeyer AE. Community-based organizations and health care contracting: research brief. Oxford (OH): Scripps Gerontology Center; 2017. A survey of 593 area agencies on aging and centers for independent living.

Defining a solution: considerations

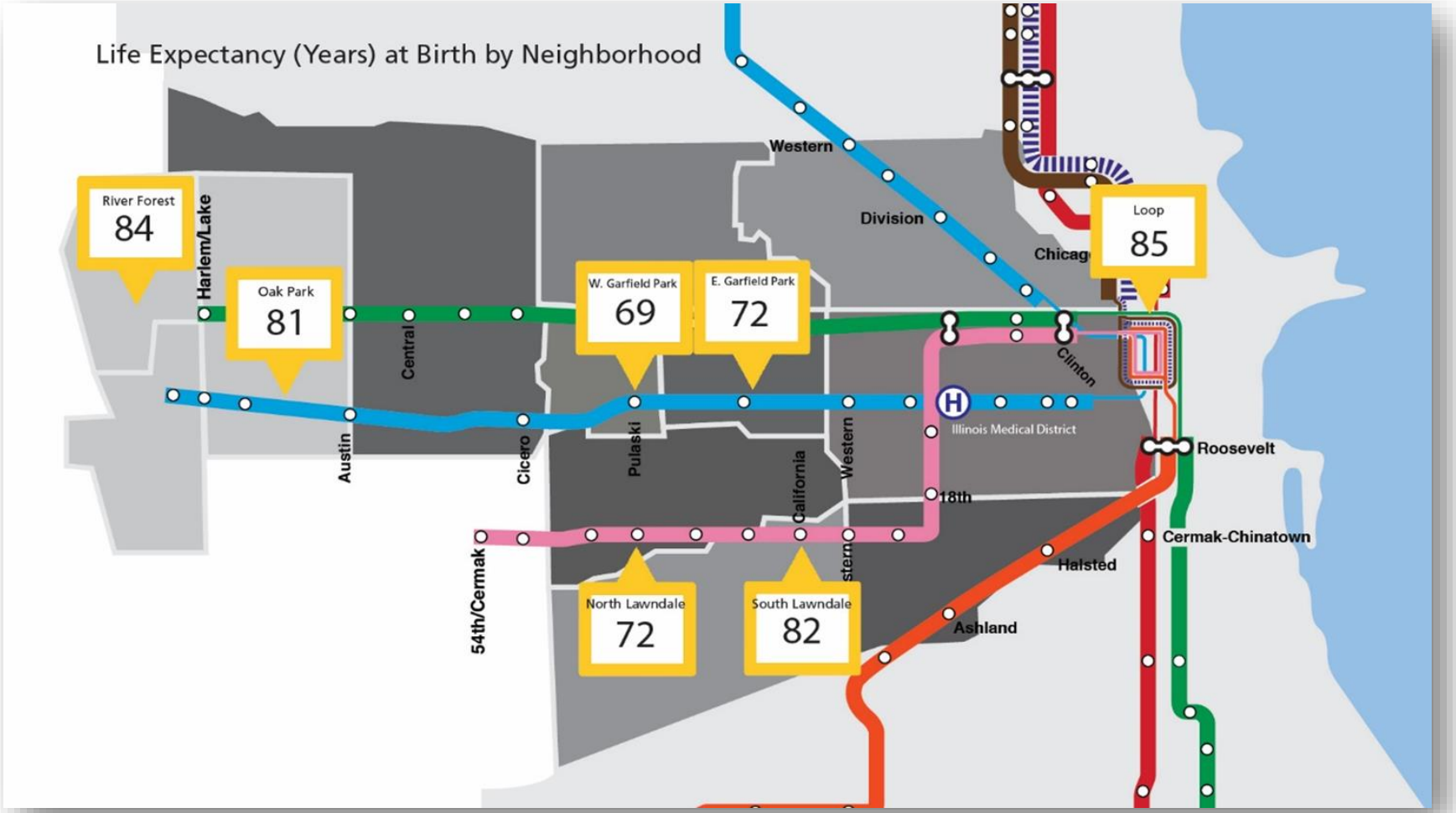
- Target population
  - Risk stratification v. predictive modeling
- Episodic v. longitudinal
- Home base
  - Centralized hub v. practice v. inpatient v. outsourced
- Discipline
  - Navigators, nurses, social workers, community health workers
  - Who is the go-to? For which patients?
- Interdisciplinary practice
  - Hand-offs, information transfer, loop closure
  - Care planning - what to include?
- Telemedicine
- Post-acute care
  - SNFs, rehab, home health, LTACs, pharmacy, DME
- Community resources
  - Transportation, nutrition, mental health, aging network
- Caregivers

Our work at Rush

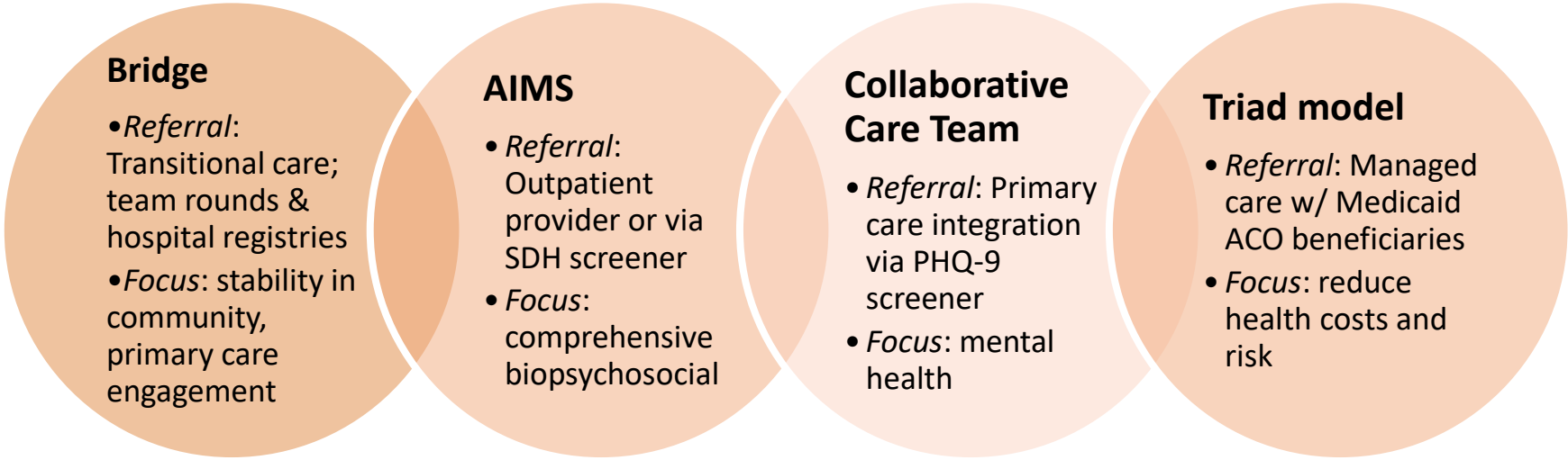
Academic medical center serving the south and west sides of Chicago



Complex and structural issues affect people's health



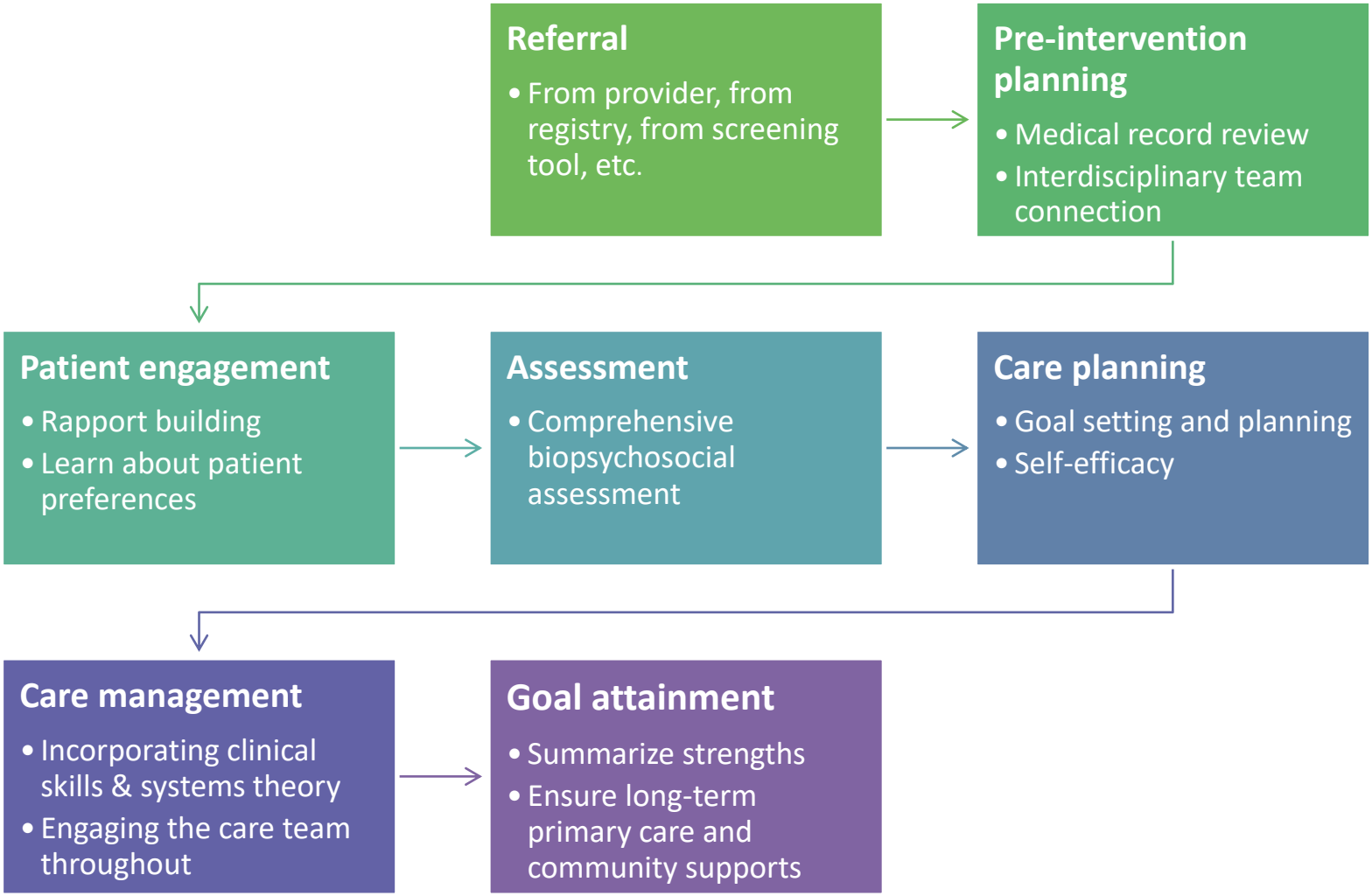
Care management at Rush



Priorities across care management initiatives:

- Patient engagement in care & self-efficacy
- Primary care engagement
- Community resources
- Care coordination

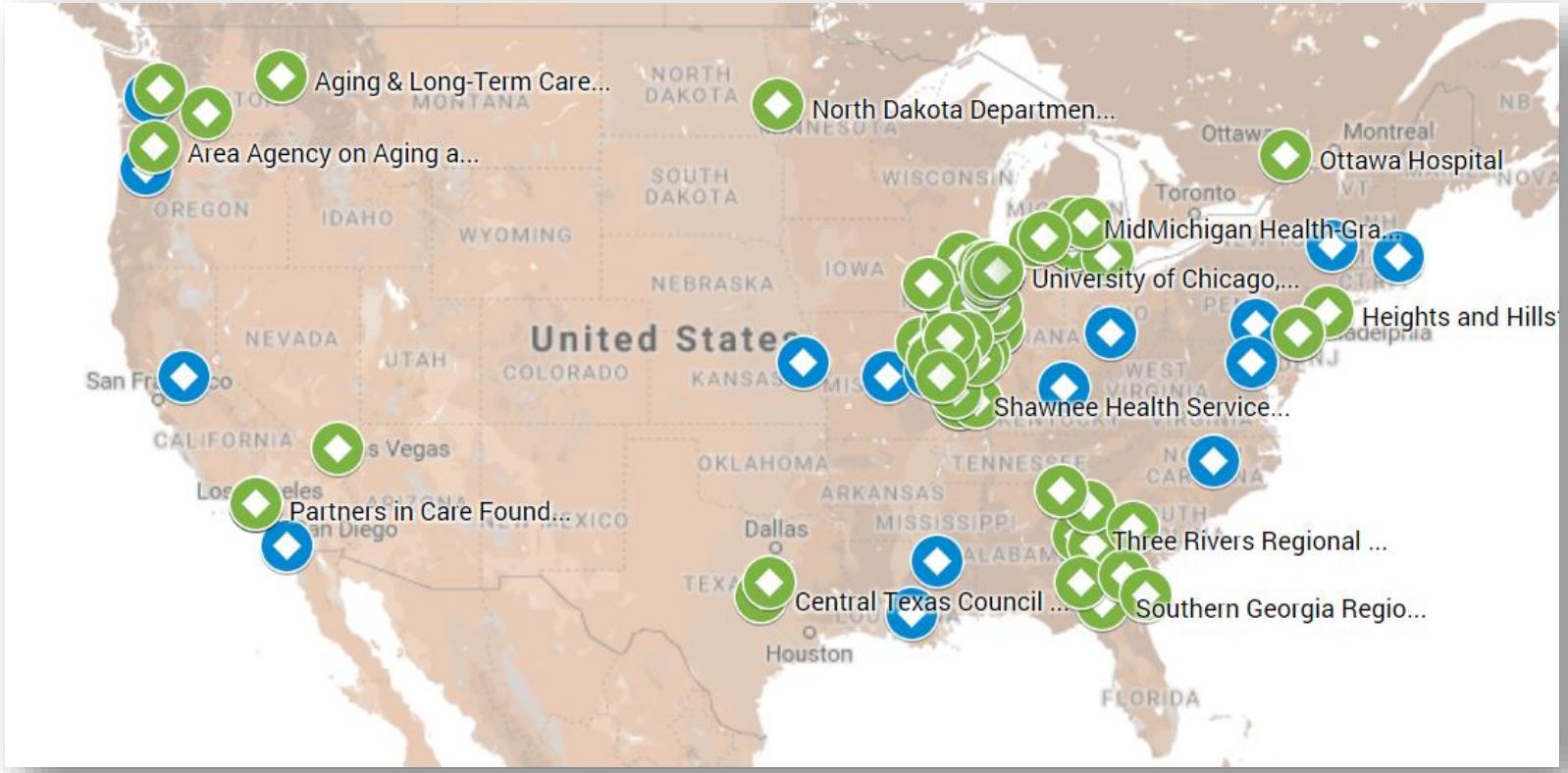
Bridge and AIMS process



Operational considerations

- Led by social worker from health entity or community partner
- Duration
  - 4-8 weeks
    - 4 is typical for transitional care cases (post-discharge)
    - 6-8 is typical for ambulatory referrals
  - Not uncommon for people to be re-referred in future
- Intensity
  - 20-30 calls and/or in-person visits
- Time spent
  - 2-6 hours per case
- Caseload
  - 30-40 active cases at any given time
  - Approximately 2 new cases per day (opened and closed, of course)

Bridge and AIMS in use across the country



Financial sustainability

How to pay for programs?

- Grants from governmental or philanthropic entities
- Health system / hospital $
  - Value-based contracts
  - Fee-for-service billing
  - Community benefits reports (non-profit hospitals)
- Medicaid home- and community-based service waivers
  - Impact of privatization
- How else is your case management work funded?

Federal policy matters

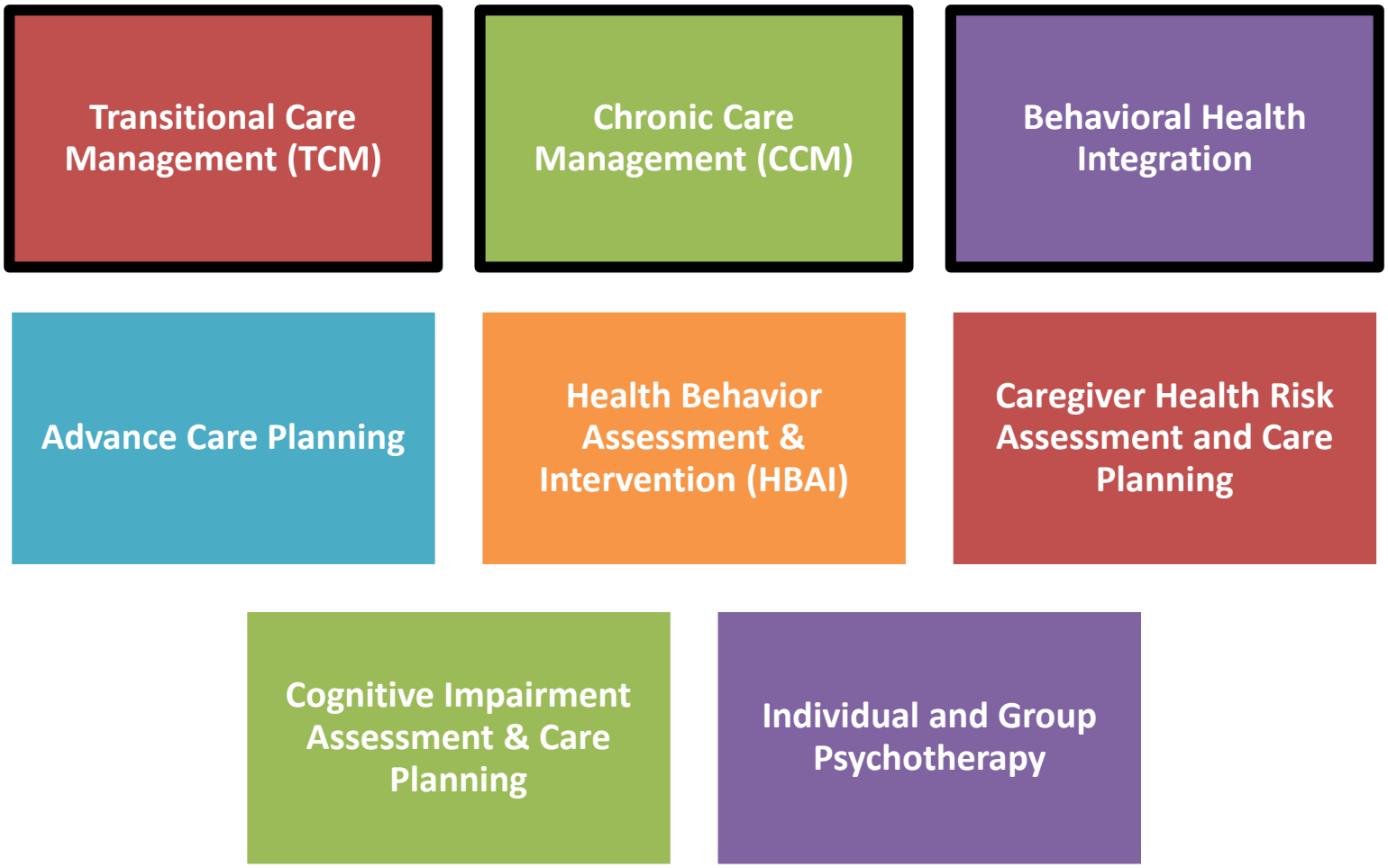
"CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible patients need to stay on track with their treatments and plan for better health."

(NEJM 2015, PYA 2017)

What are CPT Codes?

- Codes overseen by AMA, used by Medicare and commercial payers to reimburse for services
- Fee For Service (FFS) - episode-based payment
  - Submit claim when described services are provided and eligibility criteria are met
  - Medicare historically has reimbursed for face-to-face visits (e.g., Evaluation/Management visits, psychotherapy) - but not care management or other non-face-to-face work
  - New care management codes a significant development

Relevant Medicare FFS codes



Things to note about CCM and BHI

- All codes must be billed by a physician and/or non-physician practitioner (PA, NP, CNS, CNM: "qualified health providers")
  - Typically primary care, but may be of another specialty
  - Verbal consent obtained by billing provider
  - Can include time from team members *(see next slide)*

- Subject to Medicare Part B's 20% co-insurance
  - Ideal to target duals or individuals with a Medicare supplement / Medigap or secondary insurance to help cover this 20%
  - At beginning of calendar year, patients may have to pay bills related to CCM/BHI to meet their Part B or secondary insurance deductible

- Can bill for BHI and CCM in same month
  - But… this is an operational challenge

Who counts as clinical staff?

- MDs and NPs only eligible billing providers for TCM, CCM, BHI
  - "Clinical staff"/"auxiliary personnel" can provide services under "general supervision" of billing provider
- Who counts as clinical staff?
  - Specific disciplines / licenses not identified by CMS
  - Opens door for conservative interpretation

"**Auxiliary personnel** means any individual who is acting under the supervision of a physician (or other practitioner), regard**less of whether the individual is an employee, leased employee, or independent contractor** of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner)"

"Services and supplies furnished **incident to transitional care management and chronic care managemen**t services can be furnished under **general supervision** of the physician (or other practitioner) when these services or supplies are **provided by clinical staff**. The physician (or other practitioner) supervising the **auxiliary personnel** …."

- Code of Federal Regulations, **§410.26 Services and supplies incident to a physician's professional services**

Other ways of demonstrating value

- Impact on utilization
  - Reduce unnecessary ED visits and hospital readmissions
  - Total cost of care
  - Reduce no-shows
    - An operational headache for clinics
- Provider satisfaction
  - PCP burnout a significant issue
- Patient satisfaction
  - And downstream marketing impact

A look at Bridge's impact with high-utilizers

- N=423, 2015-2016, for patients with 5+ hospitalizations in last 12 months

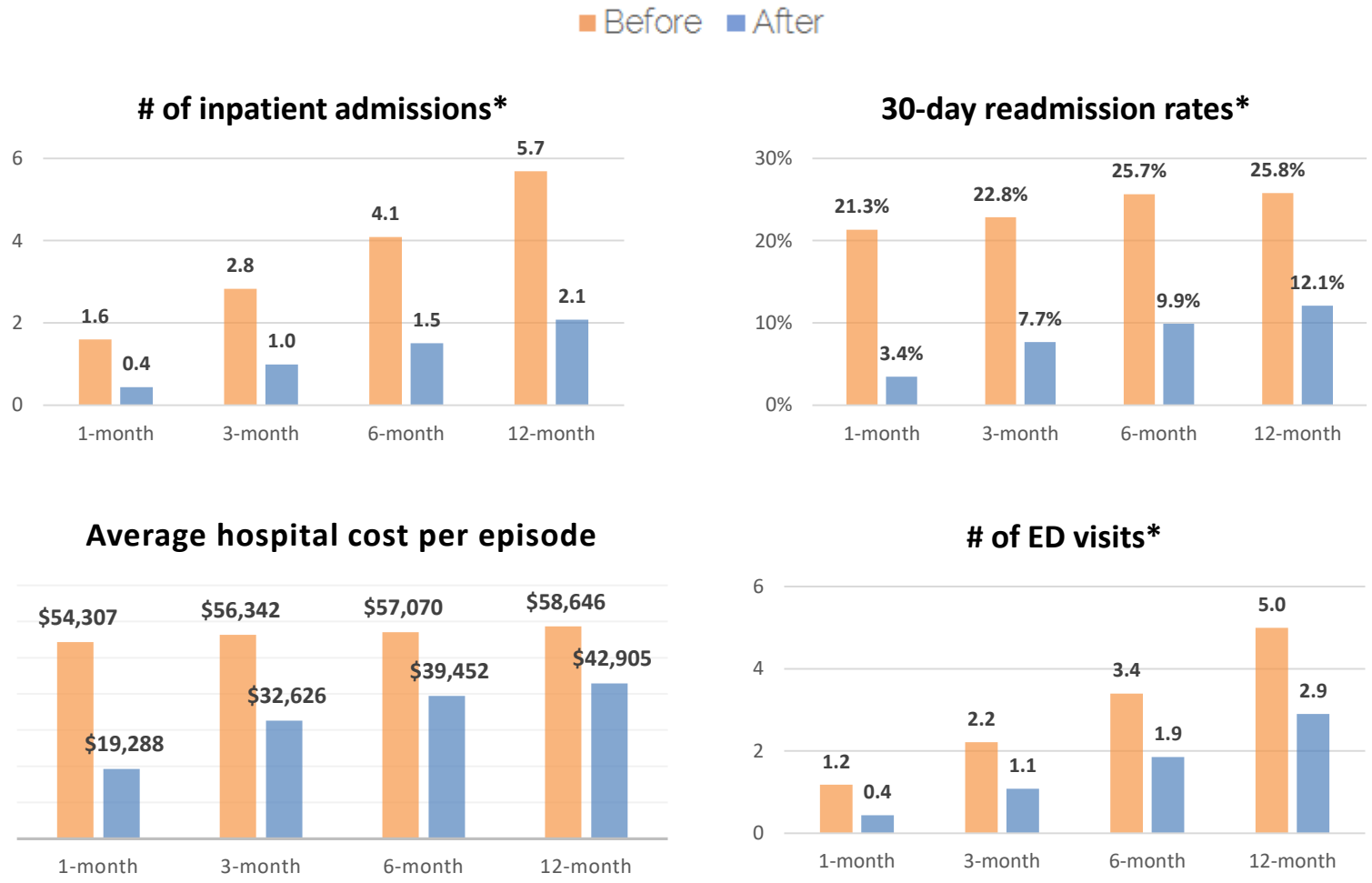
- Health services utilization
  - # of inpatient admissions
  - 30-day readmission rates
  - Average length of stay
  - # of ED visits

- Inpatient hospital cost
  - Average hospital cost per episode
  - Total hospital cost

- Time frame: 12-month, 6-month, 3-month and 1-month before and after the intervention

Source: Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (accepted). Social work-based transitional care intervention for super utilizers of medical care: A retrospective analysis of the Bridge Model for Super Utilizers. Social Work and Health Care, "Social Workers in Integrated Healthcare: Improving Care throughout the Life Course" Special Issue.

Changes in health services utilization



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Source: Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (accepted). Social work-based transitional care intervention for super utilizers of medical care: A retrospective analysis of the Bridge Model for Super Utilizers. Social Work and Health Care, "Social Workers in Integrated Healthcare: Improving Care throughout the Life Course" Special Issue.

Organizing and advocating for a better future

Archstone Foundation Announces...

Support for Integrating Social Needs into the Delivery of Health Care to Improve the Nation's Health

$250,000 to the
to examine the
of health care.

ocial needs care, and
gists, to support
ll be made on how to:
tial needs care among
and 3) optimize the

raining and oversight,
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final report.

The National Academies of | SCIENCES ENGINEERING MEDICINE

Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health

Type: Consensus Study

Topics: Health Services, Coverage, and Access, Health Care Workforce, Select Populations and Health Equity

Board: Board on Health Care Services

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Question and Answer Session

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Thank you!

- Please fill out the survey after today's session
- Those who signed up for continuing education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at http://ccmcertification.org

Commission for Case Manager Certification

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