CASE MANAGEMENT: A VIEW BEYOND THE AFFORDABLE CARE ACT
13TH ANNUAL CASE MANAGEMENT CONFERENCE 2013
TAKING THE LEAD IN CARE/transitions

Presented By: Cheri A. Lattimer, RN, BSN - Executive Director, Case Management Society of America
TODAY’S HEALTHCARE ENVIRONMENT

“It's about better care: care that is safe, timely, effective, efficient, equitable and patient-centered.”

Critical Business Issues?

Providing health care services to all Americans including health prevention, care coordination, and appropriate resource coordination. To promote quality of care to improve quality of life for our citizens. A commitment to processes that focus on education, consumer advocacy, clinical optimization of resources, patient safety, and technology to achieve superior clinical and financial outcomes with positive consumer and provider satisfaction.

Problem Identification, Education and Logistical Support

Current Approaches Are Not Working

- Fragmentation of Care
- Growing Cost of Chronic Care
- Access to Care Options (24x7)
- Inconsistent Approach
- Collaborative Practice
- Whole Person Care Approach
- Transitions of Care Facilitation
- Rising Costs of Drugs
- Regulatory/Gov’ t Imperatives
- Premium Increases, MLRs and Work Force Shortages

Optimum Health

Needs Business

Critical Business Issues?
# The Future Under Health Care Reform

## How We Pay for Care
- Payment Reductions
- Bundled payments
- Shared Savings
- Value-based payment
- Independent Payment Advisory Board

## How Care Is Organized
- Accountable care organizations
- Medical Homes
- Episodes of care
- Health information exchange

## How Care is Delivered
- Center for Medicare and Medicaid Innovation
- Comparative effectiveness (evidence-based best practices)
- Multidisciplinary care teams across sites of service
- Electronic Health Records
- Care Transitions
- Improved coordination of care for dual eligible patients

Larsen Allen LLP
Three Broad Aims & 6 Priorities of the National Quality Strategy:

Better Care, Healthy People/Healthy Communities, and Affordable Care.

Six Strategies to Advance these Aims include:

1. Prevention and Treatment of Leading Causes of Mortality
2. Supporting Better Health in Communities
3. Making Care More Affordable
4. Making care safer by reducing harm caused in the delivery of care
5. Ensuring that each person and family members are engaged as partners in their care
6. Promoting effective communication and coordination of care
Emerging Models Across the Healthcare Landscape

New Models of Healthcare Delivery and Reimbursement

- Patient-Centered Medical Home (PCMH) Primary Care Practices
- Accountable Care Organizations (ACOs)
- Integrated Health Delivery Systems
- Population Health Management
- Outcomes-Based Reimbursement With Shared Risk
- Value Based Purchasing of Health Care Services
Our healthcare system operates in “silos” and information queues – incapable of reciprocal operation with other related management systems & different departments of organizations
Transition Issues Dramatically Impact Patients & Their Caregivers

Patient & Caregiver

ER

ICU

In-Patient

Patient & Caregiver

OUTPATIENT:
- Home
- Home Care
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Caregiver
- Hospice

SNF

ALF
Transition Issues Dramatically Impact Patients & Their Caregivers & Providers

Outpatient:
- Home
- Home Care
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Caregiver
- Hospice

Patient & Caregiver

NO Discharge Care Plan

ER

IN-Patient

ICU

NO Medication Reconciliation

Patient & Caregiver

SNF

ALF

NO Care Plan

NO Medication Reconciliation

NO Personal Medicine List

NO Personal Medicine List

NO Coordinated Care Plan

NO Care Plan

NO Medication Reconciliation

NO Personal Medicine List
To Date We Have Not Had Consistent and Accepted Transition Tools

• Medication Reconciliation Elements
• Comprehensive Care Plan
• Health or Clinical Status
• Transition Summary
• Patient & Caregiver Tools & Resources
• Consistent Performance Measures That Apply to All Health Care Settings
• Accountability for Sending & Receiving Information
Rehospitalization – Medicare Fee-For-Service

- Analysis of Medicare Claims data from 2003-2004
- 11,855,702 Medicare beneficiaries DC from the hospital
  - 19.6% nearly 1/5 were rehospitalized within 30 days
  - 34% were rehospitalized within 90 days
  - 50.2% of those rehospitalized within 30 days after a medical discharge there was no bill for a visit to a physician office

Rehospitalization among Patients in the Medicare Fee-For-Service Program, Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.
Figure 1. Rates of Rehospitalization within 30 Days after Hospital Discharge.
The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.

Continuum of Care & Spectrum of Services

How will you coordinate care beyond your service?

Enrollment

Health & Wellness

Specialist

Home Health
Skilled & LTC

Palliative Care

Sub-acute Rehab

Acute Hospitalization

Health

Doctor's Office

Case/Disease Management

Hospice

Respite Care

OP Therapies

Skilled Nursing Care

Skilled & LTC

Diagnostic & Treatment Center

Health

Long Term Acute Hospital
The Care Transitions Intervention

• Does encouraging older patients and their caregivers to assert a more active role in their care transition reduce rates of rehospitalization?

Transition Models

- Dr. Eric Coleman – Transition Coaching - http://www.caretransitions.org

- Dr. Mary Naylor – Advanced Nurse Practitioners- http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.asp

- Dr. Chad Boult – Guided Care Nurse – http://www.guidedcare.org

- Boston University Medical Center - Project RED – Re-engineering Discharges – http://www.bu.edu/fammed/projectred/

- Society of Hospital Medicine – Project BOOST- http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm
Emerging Models

• **Transition of Care Clinic** - Tallahassee Memorial Hospital – Dr. Dean Watson, Chief Medical Officer
  
  [Transition Center Image]

  [http://www.tmh.org/TMHTransitionCenter](http://www.tmh.org/TMHTransitionCenter)

• **Rush Enhanced Discharge Planning Program** – Rush University Medical Center - Robyn Golden, MA, Director of Older Adult Programs. [robyn_golden@rush.edu](mailto:robyn_golden@rush.edu)
Seven Essential Intervention Categories

1. Medications Management
2. Transition Planning
3. Patient and Family Engagement / Education
4. Information Transfer
5. Follow-Up Care
6. Healthcare Providers Engagement
7. Shared Accountability across Providers and Organizations

Source: http://www.NTOCC.org/compendium (2011)

http://www.ntocc.org/Toolbox/browse/
Waves of Change

• New models of health care delivery and reimbursement are quickly evolving

• Their success is contingent on effective care coordination

• This in turn requires interprofessional and transdisciplinary collaboration
Current Focus in The New Health Care Landscape

Better Health

Lower Cost

Better Care
And What Will Get Us There!

Patient & Caregiver

Better Health

Providers

Lower Cost

Community

Better Care
Goals Of These New Models

- Minimize fragmentation & improve transitions of care
- Focus on patient safety and quality of care
- Improve the patient’s experience with care
- Expand access to care
- Reduce the cost of effective care
- Payment that recognizes value of patient-centered care
What These New Models Require

Processes to promote evidence-based medicine, patient engagement, and care coordination, including:

- Patient-centered philosophy and operations
- Coordinated and integrated care
- Use of evidence-informed medicine
- Use of health information technology for data sharing/reporting capabilities
- Continuous quality improvement processes
NTOCC Provides Tools & Resource Development for Patient and Family Caregivers

Tool Highlights

- **Guidelines for a Hospital Stay with Helpful Definitions**
  For Patient, Family, & Caregiver

- **Taking Care of MY Health Care**
  Français & Español

- **My Medicine List**
  Français & Español

- **Patient TOC Bill of Rights**
Additional NTOCC Tools & Resources for Providers
TOC Compendium Functionality

• **TOC Compendium** holds > 308 journal articles, resources and industry links

• The **Compendium** allows users to browse by care strategy (medication management) or care setting (hospital, home care, etc.)

• Users may also search through the **Compendium**: by entering the name **Coleman** all of the Dr. Eric Coleman’s articles will be brought up

• **Individuals may recommend a new resource to be added to the Compendium**

• The **Compendium** is updated annually – released April 2013

• CMS linked to the **Compendium** in March 2011 supporting the application process for the Community Based Transition Program
Transition of Care Evaluation Software Tool

Improving Transitions of Care

Click 'Create New Project' to begin.
There are no open projects existing to resume at this time. Clicking this button will allow you to create a new project to measure transitions of care.

Introduction
Health care professionals and government leaders increasingly understand that improving care coordination among the various care settings can improve patient safety, quality of care, and health outcomes while avoiding significant costs.

This web evaluation tool is an open resource, available free of charge for any institution or facility undertaking a Transition of Care evaluation and quality improvement project. The tool is designed to allow users to track data and report findings of projects developed using the NTOCC Evaluation Plan process.
CMS Selects the Second Round of Sites for the Community Based Care Transitions Program

Posted on 3/14/2012 by NTOCC

Today, the Centers for Medicare and Medicaid Services (CMS) announced the second set of sites selected for the Community-Based Care Transition Program (CCTP). Authorized by the Affordable Care Act, the CCTP provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients' transitions effectively.

read more...

Coalition Dedicated to Improving Patient Transitions and Care Attains New Organizational Status

Posted on 2/29/2012 by NTOCC

National Transitions of Care Coalition (NTOCC) becomes 501(c)(4) Organization

Little Rock, AR - February 15, 2012 - The National Transitions of Care Coalition (NTOCC), an organization dedicated to improving patient transitions through the healthcare system, has announced its formal incorporation as 501(c)(4) organization. The Coalition was founded in 2006 as a partnership between the Care Management Society of America (CMSA) and Sanofi U.S. Last year, the two founders, along with the 32 members of NTOCC’s Advisory Task Force, elected to establish NTOCC as an independent, membership-based organization.

read more...

National Transitions of Care Coalition (NTOCC) Launches Three New Resources to Assist Practitioners in Addressing Issues Related to Transitions

Posted on 2/28/2011 by NTOCC

Little Rock, AR (PRWeb) February 28, 2011 — The National Transitions of Care Coalition (NTOCC) is pleased to announce the release of three new resources designed to assist practitioners in addressing issues related to transitions.
Tools & Resources for Patient Engagement
Overview

Patient engagement is essential to achieving improved health outcomes, better patient care, and patient safety. Patients who understand their medical condition and participate in developing their care plans are more likely to comply with their provider’s recommended care. They are also better able to communicate information to providers, which can assist in diagnoses and creating care plans.

Use of the VNAA Blueprint resources for consistent and effective processes for patient engagement enables patients to take a more active role during care transitions. These activities hold promise for reducing hospitalization rates and contributing to improved outcomes (Hibbard & Greene, 2013) (F.)
“We’ve medicalized so many things, but transitions are not medical events. It’s about the team working together. It’s a person event.”

Jennifer Fels, RN, MS, Director, Southwestern Vermont Medical Center
Continuous Quality Improvement Process
How can you assess this patient’s level of understanding?
The Golden Age of Case Management

“New models of health care delivery and reimbursement, and a laser-sharp focus on improving the quality and experience of health care, have put case management at the crossroads of a changing landscape in healthcare.”

~ MBNewman
Definition of Case Management
CMSA Standards of Practice

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes.
# Philosophy and Guiding Principles

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<th>Principle</th>
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<td>Client-centered, comprehensive, and holistic</td>
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<td>Collaboration, coordination, communication</td>
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<tr>
<td>Facilitate self-determination through advocacy and education</td>
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<td>Promote evidence-based care, safety, wellness</td>
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<td>Integrate behavioral change principles and cultural competency</td>
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<td>Assist with navigating health care system</td>
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<td>Pursue professional competence and excellence</td>
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CM Role, Functions, Activities

Inherent in definition of case management:

- Performs CM process
- Use effective communication and collaboration
- Advocacy is key component
- Focus on meeting client’s health care needs
- Promote quality outcomes and cost-effectiveness

Requires key skills and knowledge

Aligned with Standards of Practice
### Conventional vs. Collaborative Care

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<th>Conventional</th>
<th>Collaborative</th>
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<tr>
<td>Authoritarian</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Autonomous practice culture</td>
<td>Team culture</td>
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<tr>
<td>Physician driven, with physicians accountable for care outcomes</td>
<td>Patient centered, with team members sharing responsibility for care outcomes</td>
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<tr>
<td>Episodic, fragmented</td>
<td>Continuous, coordinated</td>
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<tr>
<td>Primary care delivered in one-size-fits-all, 15-minute visits</td>
<td>Primary care delivered via individualized visits, phone calls, and online communication</td>
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<tr>
<td>Payment based on quantity (fee for service)</td>
<td>Payment based on value (considers both quality and cost)</td>
</tr>
<tr>
<td>Reactive, focused on illness</td>
<td>Preventive, focused on health</td>
</tr>
<tr>
<td>Communication is inconsistent</td>
<td>Communication is imperative</td>
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Knowledge and experience with care coordination

Focus on patient-centered processes

Assessment, planning, facilitation across care continuum

Knowledge of population-based care management strategies

Meaningful communication with patient, family, care team
Recognizing that Care Coordination is a Collaborative process supported by Multidisciplinary Teams in Multiple Healthcare Settings Case Managers are a Key Component
To Make It All Work, We Must Learn How to Communicate with Each Other.
“The biggest problem with communication is the illusion that it has been accomplished.”

George Bernard Shaw
Effective Communication = Effective Engagement

Open and honest conversations are critical to promote interprofessional approach to patient care.

Bring active listening skills into everyday conversations.

Need to be fully in the moment for meaningful communication to occur.

Connect on a personal level to build trusting relationships.
7 Tips for Clinicians

• Use plain language
• Limit information (3-5 key points)
• Be specific and concrete, not general
• Demonstrate, draw pictures, use models
• Repeat/Summarize
• Teach-Back (Confirm Understanding)
• Be positive, hopeful, motivating
Teach-Back: Closing the Loop

New information: disease, medication, treatment, or management

Explain new concept to patient

Patient recalls and comprehends new concept

Assess patient recall and comprehension

Adherence

Assess patient recall and comprehension

Tailor and clarify information for patient based on assessment

1. The hospital staff took my preference and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.

2. When I left the hospital I had a good understanding of the things I was responsible for in managing my health.

3. When I left the hospital I clearly understood the purpose for taking each of my medications.
Improving Communication

Transitions of Care

Provider Accountability

Care Coordination Hub

Verify

Key Information

Clarify

Receive / Receiver(s)

ACT

Active Patient/Family Engagement

NTOCC Measures Work Group, 2008
Responsibilities of Health Professionals for Seniors in Transition

Sending health care team

- Stable for transfer
- Patient/caregiver understand and are prepared
- Transfer information is complete
- Contact person’s name and number

Receiving health care team

- Review transfer information promptly and clarify
- Incorporate patient’s goals/preferences in care plan
- Document contact information

(c) Eric A. Coleman, MD, MPH
Characteristics of High-Performing Collaborative Teams

- **Shared Goals**
  - Everybody is working toward the same goals. Promoting patient- and family-centered care is paramount.

- **Clear Roles**
  - Team members are clear on how to work together and how to accomplish tasks. No individual members are more important than the team.

- **Mutual Trust**
  - People have solid and deep trust in each other and in the team’s purpose. Each team member respects the team processes and other members.

- **Effective Communication**
  - Everyone understands goals and knows what is expected. Criticism is constructive and is oriented toward problem-solving and removing obstacles.

- **Measurable Processes/Outcomes**
  - Documenting processes and outcomes as well as sharing successes; for example, improved clinical outcomes or patient satisfaction.
What Causes Hospital Readmissions?
Case Study

Mrs. Johnston is an 87 year old female in good health. She has GERD, minor urinary incontinence, and severe arthritis in her right knee. She has prescribed medication to treat these ailments. She is relying more on pain medications for her knee. Her leg is beginning to turn outwards and has given way on several occasions. She is a widow, lives by herself in her own home in a suburb in the Midwest. Patient swims five days a week, eats healthy balanced meals, volunteers at her church, plays bridge, quilts and keeps up with current events and politics. She has four adult children, three who in the city and one in a neighboring state. Mrs. Johnston is scheduled for a right knee replacement.
Case Study

- November 17th visit with the Orthopedic Surgeon
- January 8th admitted for surgery
- January 11th transition to home for rehabilitation
- February 1st admitted to hospital patient confused, not eating, sleeping constantly and diagnosed with Clostridium difficile (Day 29th post discharge)
- February 7th transition to Skilled Nursing Facility
- March 14th transition to home

What Happened that Impacted this Transition?
Case Study – Making A Difference?

- PCP sent medical information to the Surgeon for 1st visit
- Patient had a Medicine List and FAQ for 1st visit
- Surgeon provided written instructions or office health coaching
- Admission medication reconciliation & transition medication reconciliation were completed with patient and family caregiver with health coaching
- Health coaching interventions for urinary incontinence issues and care plan options
- Timely transition summary, care plan and transition medication reconciliation were available to the PCP, home health agency and physical therapist on transition from hospital
- Follow transition call with patient & family scheduled 24-48 hours after transition with possible home visit at day 4 or 5
- Scheduled post transition visit with PCP prior to transition home
Beginning January 1 2013 payment for Transitional Care Management post-discharge from acute care facilities:

– *Transitional Care Management Services* (TCM)
– *Complex Chronic Care Coordination* (CCCC)

*These codes are important because we are acknowledging the importance of care coordination and transitions of care at the point of the patient leaving one provider/facility and moving to another.*
Transitional Care Codes - 2012

**National Average $142.96**
- 99495: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 calendar days of discharge.

**National Average $231.11**
- 99496: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least high complexity during the service period
  - Face-to-face visit, within 7 calendar days of discharge.
Clinical Staff
(under supervision of a physician or other qualified clinician)

- Communicate with the patient or caregiver (by phone, e-mail, or in person),
- communicate with a home health agency or other community service that the patient needs,
- educate the patient and/or caregiver to support self-management and activities of daily living,
- provide assessment and support for treatment adherence and medication management,
- identify available community and health resources, and
- facilitate access to services needed by the patient and/or caregivers.
Moving Forward in 2013

• Medicare Transitional Care Act – reintroduce Fall 2013
  NTOCC Recommended changes incorporated into bill:
  – “Findings” which include multiple care transition models and references NTOCC’s work on care transitions issues
  – An expanded definition of “eligible entities and providers” (physician, physician assistant, nurse, case managers, pharmacists, social workers etc. are eligible to provide services)
  – Broadens the definition of “Transitional Care Services” to support evidence-based care transition models which align with NTOCC’s seven essential elements.
  – Includes language to require the documentation of a family caregiver during the plan-of-care process.
  – Requires the development of measures to address and hold accountable both the sending and receiving side of the transition.

• Encouraging the expansion of payment codes supporting multidisciplinary care coordination and transitions of care

• Bringing greater awareness to legislators and regulatory bodies on the value of case/care management (pharmacist, nurses, social workers) and the important role they play in care coordination

• Continued focus on aligning the payment incentives with performance outcomes
Development of Care Coordination Measures

- **AHRQ** – Comparative Effectiveness Research for Case Management
- **NQF** – Performance Measures for Care Coordination
- **CMS** – 10th SOW for QIOs supports Care Transitions
- **TJC** – Patient Safety Standard #8 Medication Reconciliation
- **URAC** – Incorporated Transition of Care in revised CM Standards
- **NCQA** – Complex Case Management Standards
- **AMA** – PCPI Transitions of Care
- **ANA** – Care Coordination Quality Measures
We Have Come A Long Way
YOU – CASE/CARE MANAGER
Can Promote Safe, Effective Care Transitions

- Patient-centered care — patient’s goals and preferences
- Patient (or caregiver) education to increase activation and self-care skills
- Accurate communication and information exchange during handovers
- Medication reconciliation and safe medication practices
- Procurement and timely delivery of services
- Ensuring “sender” maintains responsibility for patient until “receiver” confirms assumes responsibility
- Follow-up with patient/caregiver within 48 hours after a transition from a setting or service
Waves of Change

• *Changing is like Breathing – And we all know what happens when we stop Breathing*

Questions

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