



IssueBrief

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Center stage in the revolution:

A health care reform action guide for the professional case manager

As today's health care system focuses increasingly on quality outcomes and efficiency, the need for the board-certified case manager has never been more evident. The Affordable Care Act (ACA) has placed case management functions—such as planning, assessing, care transitions and specifically care coordination—center stage and turned on the spotlight.

The ACA—the health care reform legislation—identifies ways to heal the often-fragmented system. In particular, the patient-centered medical home and the accountable care organization rely on care coordination as a central pillar of their success. That care coordination is at the heart of these new and emerging models of care should come as no surprise to anyone with even a passing familiarity with the current health system.

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To meet the challenge, the professional case manager must be willing not only to embrace these new models of care, but also shape them. It is a role for which they are supremely qualified.

Board-certified case managers are on the forefront of creating value, with an eye toward operationalizing the Institute for Healthcare Improvement's Triple Aim: improve individual health, improve population health and control costs. By earning CCM® certification, they have proved that they are knowledgeable about navigating health care and are ready to meet the challenges posed and take advantage of opportunities presented by the Affordable Care Act.

Seize the moment

The Commission for Case Manager Certification™ (the Commission) and its certifiants must be part of designing these new models, not merely react to changes after they

happen. Part of this, explained Patrice Sminkey, the Commission's chief staff executive, involves a renewed focus on government relations, working with legislators and policymakers to enhance awareness and create an impact on the people who, ultimately, will create those policies. That means getting invited to the table to have a say in how case management roles, functions, responsibilities, reimbursement and the rest are defined, regardless of what words are used to describe case management in the fine print.

"This is a key opportunity to build visibility and awareness, to be part of transforming health care delivery," Sminkey explained. The message is clear: "Care coordination equals case management equals the Commission." The challenge is ensuring the message is delivered and received.

Board-certified case managers must seize the moment. They must know and understand how changes mandated by the ACA and other regulations can affect their profession, she said. And the Commission is a leading voice to advance case managers and assist in those efforts. What follows is an overview; in the coming months, the Commission will offer opportunities to learn more about this complex, but ultimately promising, new world.

The ACA

The Affordable Care Act includes various reforms designed to address fragmentation in the health care delivery system. The way many providers are

paid fails to align incentives to coordinate care in the outpatient, inpatient, home and post-acute settings and, in fact, may serve as a deterrent to effective care coordination. Such failings, and the ACA's attempts to remedy them, present tremendous opportunities for the profession of case management.

"We believe the case can be made that the care coordination reforms (articulated in the ACA) would provide incentives for provider groups to utilize the services of case managers in order to meet savings benchmarks and quality performance standards in each program," explained Sara Franko, principal, Capitol Counsel LLC.

In particular, she said, case managers can play pivotal roles in ACA care coordination initiatives that

- are designed to use integrated care to improve quality and reduce health care costs;
- establish quality and performance standards for participating providers; and
- will increase demand for professionals with experience coordinating health services for patients to meet goals associated with new models of health care delivery.

The Department of Health and Human Services (HHS) will test new models of payment and care delivery to evaluate whether providers are able to better coordinate care while improving health outcomes and reducing health care costs. Those that reduce costs and maintain or improve quality may be expanded, Franko said.

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CAPITOL COUNSEL LLC.

Several aspects of the ACA are especially important for the professional case manager, Franko noted. They include accountable care organizations (ACOs), the patient-centered medical home, community-based care transitions, Independence-At-Home and Medicare payment bundling.

Accountable care organizations

On March 31, 2011, HHS issued proposed regulations on ACOs. The proposed rule is the first step in a long process; a 60-day public comment period began April 7, 2011. CMS may make changes based on the comments received, and then the rule will be finalized. The proposed rule includes 65 quality measures across five domains—patient safety, prevention, patient and caregiver experience, at-risk populations—and, significantly, care coordination.

The proposed rule links the amount of shared savings an ACO may receive to its performance on the 65 quality standards. Given the importance of care coordination, Franko said, it follows ACOs will seek to include qualified professionals experienced in addressing key objectives associated with the model: coordinating care, using individualized care plans, and meeting patient-centeredness criteria. “The proposed regulations indicate that ACOs could utilize the services of ‘care coordinators’ or ‘case managers’ to achieve certain goals,” she said.



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Of particular interest to professional case managers:

- The quality requirements include assessments of patient and caregiver experience of care, including an assessment of how well doctors communicate with one another.
- Multiple care coordination requirements, including measures related to medication reconciliation and preparation

for care transitions, are among the 65 quality measures an ACO would be required to meet to be eligible for shared savings payments.

- ACOs would be required to submit an application that includes information describing the scope of a clinical integration system, and documentation describing plans to coordinate care (which, the proposed regulations state,



Any one of these initiatives could mean significant changes for the professional case manager. But taken as a totality, the potential changes are revolutionary in terms of expanding the breadth and reach of case management and what it can accomplish for clients. The Commission is moving forward to make sure the profession has a seat at the table, but it is essential that individual board-certified case managers take action.

could include the “utilization of case managers in primary care offices.”)

CMS also provides guidance regarding how an ACO would meet “patient-centeredness” standards. An ACO should ensure transitions in care among providers are supported, including through the use of electronic exchange of information. CMS lists eight specific “processes and actions” an ACO must include in order to meet the patient-centeredness requirement. Two, Franko said, are of particular significance to professional case managers:

- 1) processes to develop individualized care plans, including integration of community resources; and
- 2) a mechanism for the coordination of care (for example, via use of enabling technologies or care coordinators).

Patient-centered medical homes

Medical homes have been on the health care landscape for years, but they are gaining

momentum thanks, in part, to the ACA. HHS will provide grants or contracts to establish community-based health teams to provide primary care services to individuals; teams must “coordinate and provide access to high-quality health care services” in order to qualify.

Franko pointed to a provision of particular significance to professional case managers: Teams must offer coordinated and integrated care, including access to individuals that implement the care plans of patients and coordinate care, such as “integrative health care practitioners.”

Other federal initiatives hold promise

Franko described some of the other initiatives:

Medicare community-based care transitions program: Entities eligible for funding are inpatient, acute care hospitals with high readmission rates and community-based organizations that provide care transition services through arrangements with hospitals. Services to be provided include assistance with inter-

actions between patients and post-acute and outpatient providers.

Medicare Independence-at-Home program:

An Independence-at-Home practice is a legal entity consisting of an individual physician or nurse practitioner, or a group of physicians and nurse practitioners that provides care as part of a team. The team could include physicians, nurses, physician assistants, pharmacists and other health and social services staff with experience providing home-based primary care. Teams will include health and social services staff, as appropriate, who have experience providing home-based primary care services.

Medicare payment bundling:

Eligible providers include hospitals, physician groups, skilled nursing facilities and home health agencies participating in the Medicare program. CMS will develop payment methods including payment for care coordination, transitional care services and other patient-centered activities. Case managers with experience providing these services could be in demand as part of this program.

Table 1 offers a streamlined look at each of these elements.

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No time for passivity

Board-certified case managers should be familiar with their Congressional representatives. Franko offered a step-by-step guide.

- Go to www.house.gov and enter your zip code in the "Find Your Representative" section of

the site. Click on the congressman's name to get to his or her website.

- Find out where the local district office is.
- Call the office and find out the name of the health staffer and when the member will be holding public meetings, especially any that might be focused on health care.
- If possible, attend a meeting.

In the future, the Commission will ask case managers to deliver messages to their representatives on specific legislative priorities. But waiting is not an option. It is incumbent upon both the Commission *and* individual board-certified case managers to pay attention and, as needed, speak out, Sminkey said.

Sminkey is acutely aware of just how much the professional case

manager has on her or his plate. So why ask case managers to monitor emerging legislative and regulatory developments? "Because it really addresses long-term sustainability of case management," she explained. "Without attempting to understand or teach yourself about what's going on legislatively, important changes in policy—reimbursement, new models of care, etc.—could happen without input from case managers."

Lawmakers need to hear an unambiguous message about case management and the role of the board-certified case manager in these new models of care.

But they are *not* the only ones who need to hear it. Employers and colleagues do, too.

Each board-certified case manager should raise awareness

Table 1. Care Coordination Initiatives—Summary

MODEL	FOCUS
■ Medicare ACOs	Coordinate care for Medicare fee-for-service beneficiaries
■ Patient-Centered Medical Homes	Coordinate primary care for individuals with chronic conditions
■ Community-Based Care Transitions	Improve post-hospital care for high-risk Medicare beneficiaries
■ Independence-at-Home	Improve outcomes for chronically ill Medicare beneficiaries
■ Medicare Payment Bundling	Coordinate care around a hospitalization for Medicare beneficiaries

SOURCE: "Health Reform 101: What You Need to Know About the Patient Protection Act," Commission for Case Manager Certification CMLearning Network webinar; courtesy of Sara Franko, principal, Capitol Counsel LLC

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— PATRICE SMINKEY,
CHIEF STAFF EXECUTIVE,
THE COMMISSION FOR CASE
MANAGER CERTIFICATION™

of the value of the profession and CCM certification in her or his own network, Sminkey counseled. "Talk to your fellow professionals, colleagues. Do a grassroots pulse check. Do they know? Do they care?"

Having the distinction of board certification means the board-certified case manager meets all of the standards for providing case management. "It does—or should—immediately resonate in the industry: *That person can do what needs to be done.*" Sminkey said.

But that message is not always heard. "A couple of times a month, I hear from a board-certified case manager who gets a performance appraisal in which the employer didn't recognize certification." That's a lost opportunity at any time, but all the more serious now that health system redesign has such a strong need for credentialed case managers.

No longer unsung

Case managers are the unsung heroes in guaranteeing delivery of quality health care, and the Commission is working to change the "unsung" part. In the last few months, the Commission has redoubled its government affairs efforts, making its voice heard where decisions are being made.

The changes wrought by the ACA provide a tremendous opportunity for board-certified case managers. But they bring risk as well. The very definition of the profession hangs in the balance, Sminkey warned. "With all these new and emerging models of care and delivery systems, the term/reference/phrase 'case manager' or 'case management' leads to potential confusion in the industry about who you are hiring, who you are having deliver that care, and what you are expecting of that person." Case management has been around for more than 20 years, but during that time, she explained, those who perform the services have been called many different names: navigators, care coordinators, discharge planners and disease managers among them.

In some respects, preparing for radical health care system transformation requires a return to the fundamentals. "We aren't reinventing the wheel. We are reinforcing what we've always known," Sminkey said.

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Moving forward, the Commission is working to ensure the professional case manager's role is acknowledged as essential to the delivery of quality, cost-effective and efficient care. It is also delivering the reminder: Certification ensures the professional case manager has the core competency needed to fulfill this role.

Never has that been more important. "It's ours to lose. If we don't take care of it, nobody else will. Moving this forward, the onus falls on us individually," Sminkey warned. "Don't assume employers or policymakers understand the value of professional case management or the value of certification. Talk about it. Profess it. Don't be quiet." ■

Knowledge Framework will help advance Commission’s policy efforts

The Commission recently unveiled a Case Management Knowledge Framework, an important step in its revitalized efforts to inform and shape health care policy. The Framework represents years of research, coupled with hands-on knowledge gathered through its experience with the CCM examination.

It reflects what professional case managers *know and* what they *do*. Put another way, it addresses not just the science of case management, but also its practice and policy.

Its launch comes in the wake of several federal initiatives endorsing the critical role care coordination plays in new models of care. (See page 5.)

Case management plays a crucial role in realizing the goals of each of these initiatives; it is a tool to both improve patient care and lower costs.

The Framework comprises seven essential domains of case management knowledge and practice, which are illustrated below. The Framework also includes nine major phases in an overall Case Management Process. Those phases—through which case managers provide care to their clients—are as follows:

1. Screening
2. Assessing
3. Stratifying risk
4. Planning
5. Implementing (care coordination)
6. Following up
7. Transitioning (transitional care)
8. Communicating Post Transition
9. Evaluating

The overall process is iterative and cyclical; the phases are revisited as necessary until the desired outcomes are achieved and the client’s interests are met.

(For details on the Framework, see “Current, evolving and always available: The Case Management Body of Knowledge” at www.ccmcertification.org/pdfs/cmbok_issue_brief.pdf.)

The Case Management Knowledge Framework is an important contribution to the health care policy community, offering a detailed and structured description of the process, interwoven with the foundational knowledge domains of case management.

It represents, the Commission believes, the first step in addressing the widespread lack of understanding among lawmakers, policymakers and regulators about case management. The Case Management Knowledge Framework offers a standardized way to consider case management and its impact on coordination of care. ■

The Case Management Knowledge Framework



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About the Experts



Sara Franko, principal,
Capitol Counsel LLC.

Franko's work is focused on health care matters before the U.S. Congress. She provides clients with strategic advice and direct advocacy based upon her over 25 years of experience working in Congress and the private sector. Specializing in health care matters and congressional oversight, Franko works closely with clients in developing multifaceted strategies to advance their legislative interests and respond to congressional inquiries. Her efforts on behalf of clients have resulted in legislation to improve Medicare reimbursement for outpatient cancer therapies and legislation excluding prompt pay discounts to wholesalers from Medicaid drug reimbursement calculations.



Patrice Sminkey, chief staff
executive, *Commission for Case
Manager Certification™*

Sminkey comes to the Commission from URAC, where she most recently served as senior director of sales. Prior to that, she was senior vice president, operations and client management at Patient Info-systems in Rochester, N.Y. She brings a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. She has extensive experience in client management and coordination, including marked improvement in client retention, timely and fiscally sound program implementation and an expanding book of business.

As chief staff executive, Sminkey oversees the management of all activities related to the Commission's operations, including all programs, products and services; and the provision of quality services to and by the Commission. She is a direct liaison to the Commission's Executive Committee. She works with the Commission's volunteer leadership to evaluate and develop potential new products for implementation by the Commission, and she establishes and maintains communication and working relationships with other organizations, agencies, groups, corporations and individuals.

She holds a diploma of nursing from the Chester County School of Nursing.



The Pathway to Certification is CCMC

Commission for Case Manager Certification
15000 Commerce Parkway, Suite C ■ Mount Laurel, NJ 08054 ■ (856) 380-6836
www.ccmcertification.org