CCMC's CMLearning Network® Customized Education Workshop

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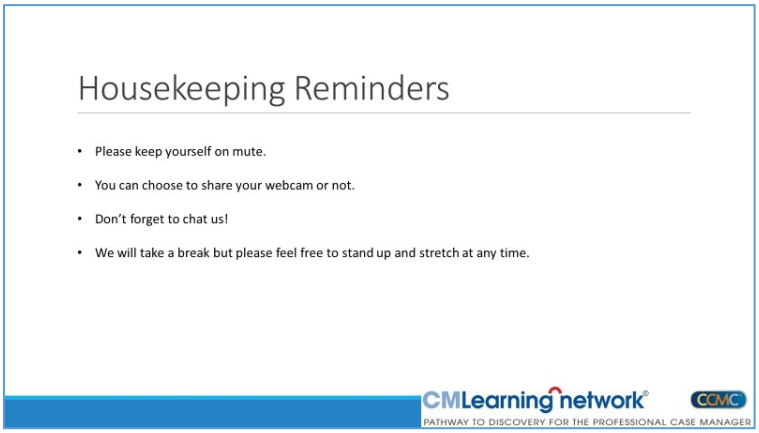
Welcome to CCMC's Customized Education in partnership with Commonwealth Care Alliance!

February 25th, March 2nd, and March 4th, 2021

9:00AM- 1:00PM EST



Additional Information

- The recording for the sessions will not be available.
- The course workbook has been emailed and we will provide the link in the chat box.
- Please continue to monitor your emails for follow up information prior to each virtual session.
- 12 CEs for Nurses, social workers, and CCMs are awarded for FULL attendance at all sessions.

CMLearning network® CCMC
PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

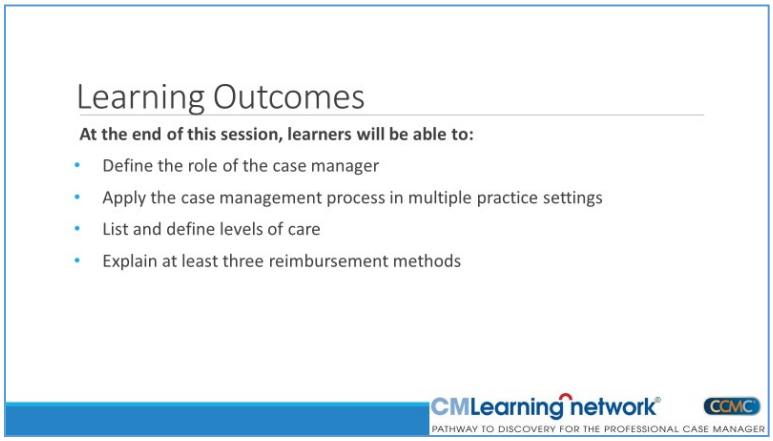
Introduction

- Reminders
- The Commission for Case Manager Certification
- Exam
- Accreditation
- Criteria
- Workbook

CMLearning network® CCMC
PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

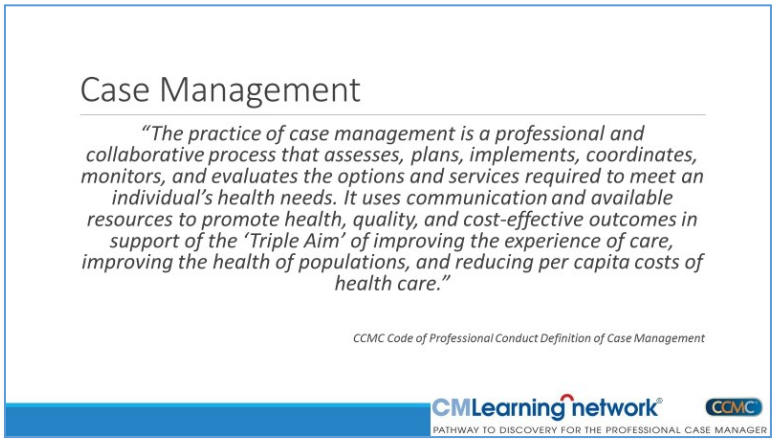
Domain 1

Care Delivery and Reimbursement Methods



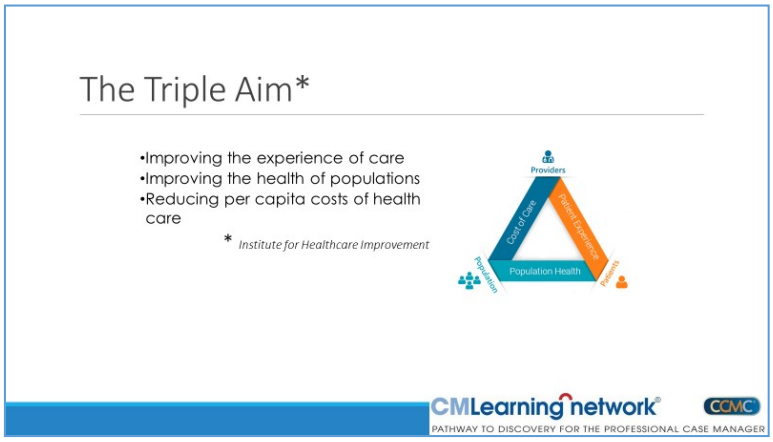
Learning Outcomes

- At the end of this session, learners will be able to:
  - **Define** the role of the case manager
  - **Apply** the case management process in multiple practice settings
  - **List and define** levels of care
  - **Explain** at least three reimbursement methods



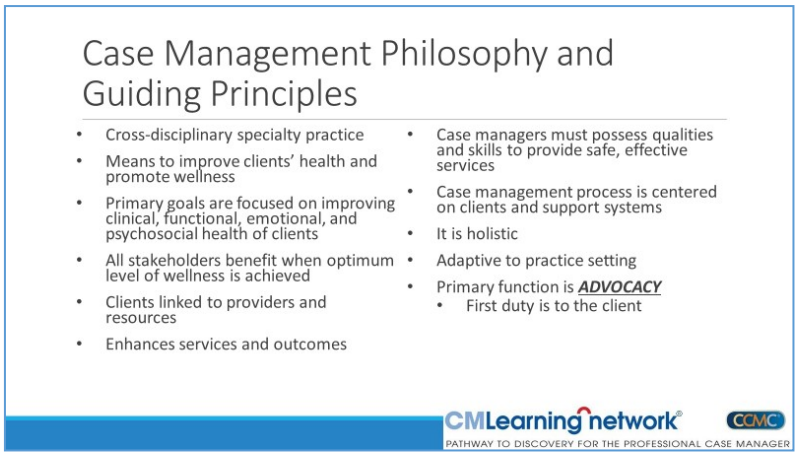
Case Management definition

- "The practice of case management is a professional and **collaborative process** that **assesses, plans, implements, coordinates, monitors**, and **evaluates the options and services required to meet an individual's health needs**. It **uses communication and available resources** to **promote health, quality, and cost-effective outcomes in support of the 'Triple Aim'** of improving the experience of care, improving the health of **populations,** and **reducing the** per capita **costs** of health care."



The Triple Aim

- The Triple Aim came out of the Institute for Healthcare Improvement in 2008
- The intent was to improve the health care system through the simultaneous pursuit of:
    - **improving the experience of care**
    - **improving the health of populations**
    - **reducing the per capita costs of care**

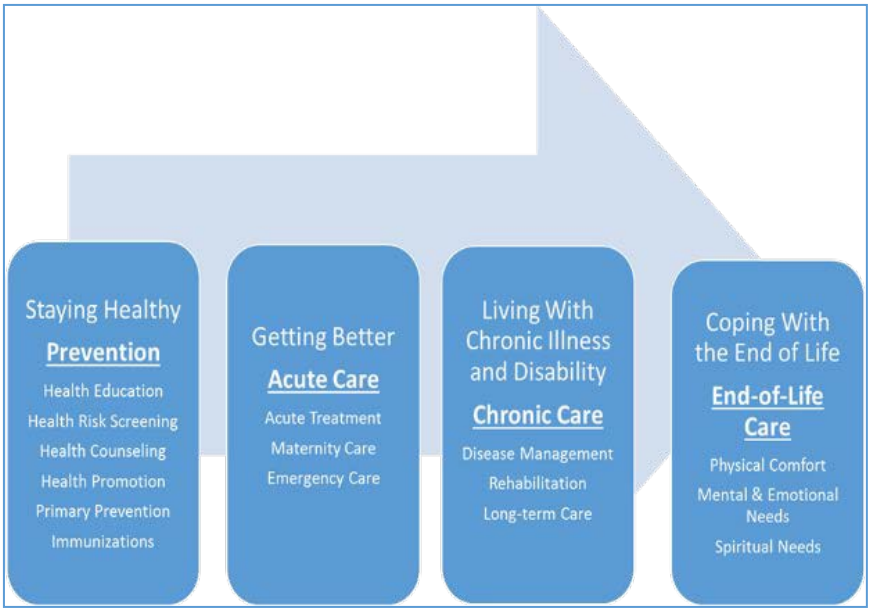


Case Management Philosophy and Guiding Principles

- Case management is a **multidisciplinary specialty** within the health and human services professions
    - **Adaptive to the multiple practice settings** in which case managers function, and the settings in which clients receive their care and services
- **Primary goals** are focused on **improving** clinical, functional, emotional, and psychosocial **health of clients as an integrated whole, impacting clients with complex health needs served at a single point or through primary, on-going case management** (Fraser, Perez, & Latour,2018)
    - Case management can **improve outcomes** when care is appropriately managed, efficiently provided, and effectively executed
- It is guided by the **ethical principles** of autonomy, beneficence, nonmaleficence, veracity, and justice
    - Primary function in case management is ***ADVOCACY***
    - **First duty of a case manager is to the client**

- Enhances services and outcomes, maintains privacy and confidentiality, and **adheres to ethical, legal, and regulatory standards**

- Case management process is **centered on clients and support systems**
  - It is holistic
- **Clients linked to providers and resources**, based on their **cultural beliefs, values and identified needs (clinical, behavioral, and social determinants) across the continuum**
- Stakeholders **benefit when optimum level of wellness is achieved**.



Continuum of Care

- **Health care continuum**—Care settings that vary across a continuum based on levels of care that are also characterized by complexity and intensity of resources and services. Sometimes, it is referred to as the continuum of health and human services; in this case, the focus is more on the type of **services available across the care settings**, which include those that address socioeconomic, psychosocial, and social determinants issues rather than just medical care.[1]

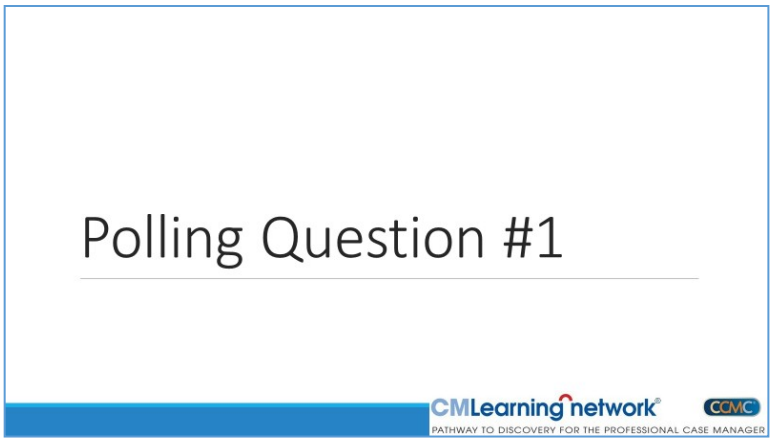
[1] **Tahan, Hussein M.. CMSA Core Curriculum for Case Management (Kindle Locations 2547-2550). Wolters Kluwer Health. Kindle Edition.**

Integrated Care

Definition:

- **"The availability of coordinated health services from all complexity domains (biological, psychological, social and health system) without…impediment." (Fraser, Perez, & Latour,2018)**
- **Integrated** system of care that **guides and tracks clients over time** through a comprehensive array of health and social services spanning all levels of care; matches the needs of the client with their needs and their resources.[2]
- **Matches** ongoing needs of **clients to resources (medical, behavioral, social, and other related to social determinants)**
    - Facilitating primary care needs
    - Ongoing to support management of chronic disease, palliative or end of life care
- **Includes multiple levels** that vary in complexity and intensity
    - Proactively identify complex clients, through early assessment and regular reassessment
    - Recognize factors across biological, psychological, social, and health systems
- **Coordinates care** across disciplines, and service agencies)
    - Work with interprofessional team members to ensure clients' needs are met across service lines (Behavioral, Chronic disease, etc.)
- **Integrates care** in a range of settings

[2] **Tahan, Hussein M.. CMSA Core Curriculum for Case Management (Kindle Locations 1980-1982). Wolters Kluwer Health. Kindle Edition.**



The intent of the Triple Aim was to improve the health care system through the simultaneous pursuit of all the following, except:

a. Improving the experience of care

b. Reducing the overall length of stay

c. Improving the health of populations

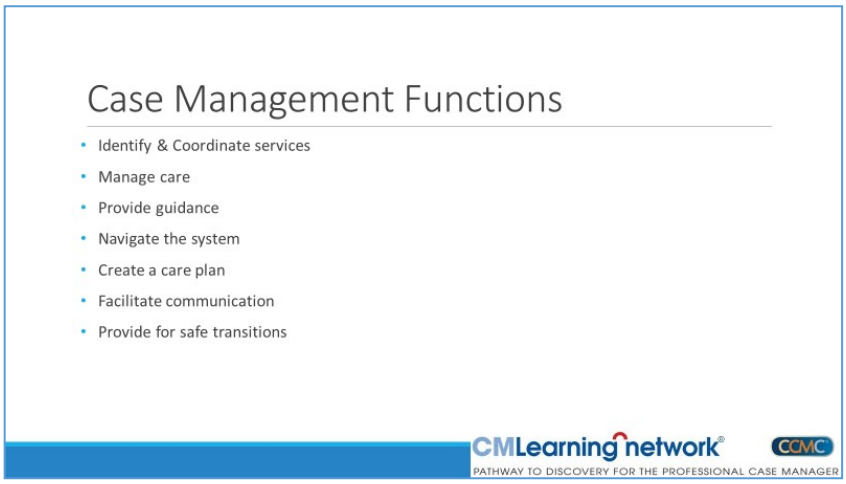
d. Reducing the per capita costs of care

Roles and Functions of Case Managers with Other Providers

Case Management Roles

- **Coordinator** - organizes events or activities and negotiates with others to ensure they work together effectively
- **Communicator** - able to convey or exchange information, news, or ideas,
- **Collaborator** - working jointly with another person or group on an activity towards a common goal
- **Clinician** – a health care professional that works as a primary care giver and having direct contact with and responsibility for clients, uses their knowledge to identify client problems and develop an effective plan of care
- **Educator** - a person who provides instruction or education to meet the assessed needs of clients.

- **Transition Planner** -Considering all the client needs, (clinical, including medical and behavioral), cultural and social, coordinates continuity of care from one healthcare setting to another setting, or between health care practitioners as their condition and care needs change.
- **Leader –** The case management leader is a role model, innovator, integrator, communicator, collaborator and coach. They are skilled and knowledgeable in case management and is adept at managing interpersonal relationships at all levels. These include relationships between case management and:
    - Clients/support systems
    - Case management community
    - Other departments/disciplines
    - Key stakeholders from other agencies (payor, provider, public and private, employer)
    - Representatives from accrediting bodies, regulatory and government agencies
- **Utilization Manager** – ensures cost-effective care delivery and use of services, focuses on efficient transition of clients from one level of care to another.
- **Quality Manager** - ensures products and/or services meet quality, safety, and efficiency standards
- **Negotiator** – negotiates with managed care companies and providers to ensure the provision of appropriate care and services across the continuum.
- **Advocate** - A person who assists, defends, or pleads for clients, ensures that the needs of clients and families are met, placing clients /families interests above all others.
- **Researcher** – evaluates services and outcomes through empirical research and/or utilizes findings to effect changes in standards, policies, and practices
- **Risk manager** – identifies areas of risk in the care environment and processes and recommends and/or executes an action plan to mitigate these risks.



Case Management Functions

8 Essential Activities

Using the case management process:

- **Assessment –** collection of in-depth information about situation and functioning – must include medical, behavioral health, psychosocial, social determinants of health
- **Planning –** determining specific objectives, goals, actions to meet the assessed needs
- **Implementation –** executing the plan, linking assessed needs with services or resources to achieve goals
- **Coordination –** organizing, procuring, integrating services and resources necessary to accomplish the case management plan
- **Monitoring –** reviewing information from all relevant sources to ensure effectiveness
- **Evaluation –-** determining and documenting plan effectiveness
    - **Outcomes** – measurable results used to assess effectiveness of case management interventions

In order to :

- **Advocate** – assist client/support system to obtain care needed in the right place and at the right time, advocate for complete assessment of both medical and behavioral health issues
    - **General**…Legal, Ethical, Legislative

- **Identify & Coordinate services** – based upon a needs assessment, determines resources and/or services necessary and then coordinates those resources or services to ensure quality, cost effective, optimal outcomes
- **Manage care** – utilizing the essential activities of case management to do so
- **Provide guidance** – help clients to understand options and services, and enable them to make informed choices
- **Navigate the system** – educate and empower clients to be able to navigate the healthcare system
- **Create a care plan** – developed collaboratively with client/family
- **Facilitate communication and coordination** among members of the health care team, involving client in decision-making
- **Educating** the client/family about treatment options, resources, benefits, concerns
- **Provide for safe transitions**

Role of the Case Manager in Different Settings

- Our consumers and clients need to understand that case managers work with them to get the health/ behavioral care and other community services they need; in other words, case management provides all the necessary resources and services at the **right time, with the right provider, in the right care setting and in the right amount.**

Acute Care

- Hospital, emergency department, rehabilitation facilities,
    - based on organizational needs/structure
    - **Rapid changes** in the healthcare landscape are impacting the evolution of hospital case management
    - **Newer models of acute case management** are leaving behind the UR and discharge planning functions (in some cases) and working toward future reimbursement systems (bundled payment, capitation, shared savings), and integrated case management models to achieve outcomes that:
        - Manage the whole client – medical clients may have behavioral health issues, and behavioral health clients may have medical issues. Important to ensure that the team managing the client views the client holistically and addresses ALL issues
        - identify and overcome social determinants of health that impede progression of care
        - prevent or minimize circumstances that result in increased care needs or financial risk
        - better coordinate transitions to meet the needs and preferences of the client by exploring opportunities to move case management **beyond the walls** of the hospital and into the community, covering the full care continuum for selected at-risk clients
        - Promote **shared decision making**
    - Market shift is toward **value-based care (VBC)** – reimbursement models reward quality, safety, client experience, and value, not quantity
    - **Advocacy** is the acute care case manager's primary ethical obligation – it must be viewed as an unwritten contact between the case manager and the client

Post-acute care

- **Subacute, home care, long-term care, palliative, hospice, residential, custodial**
- **Proactively prevent return of clients to acute care setting**
- Monitor the client's condition to prevent deterioration or disease progression as possible

- Reduce risk and need for emergency services
- Optimize holistic, multidisciplinary delivery of care across the continuum
- Improve quality and continuity of care and services – ensure that ALL needs are addressed.
- Maintain safety

Provider systems

Patient Centered Medical Home (PCMH)

- Coordinate care and services in a timely manner
- Ensure assessment of both medical and behavioral health issues
- Engage client/family in shared decision making
- Health education, self-care management
- Remote monitoring of client condition and regimen
- Follow up tests, procedures, consults
- Coordinate transition of care activities

Community

- **Assisted living, physical and mental health day health programs, physician practices, medical homes, home care, dual eligibility member programs**
- **Support and empower clients/families** to achieve optimal level of wellness or function
- **Focus on preventative and basic interventive (primary) care, access to care**, scheduling appointments, health promotion, education, management of chronic illness, screen for signs of depression or behavioral health issues
- **Reduce or prevent demand for acute, complex, or expensive care**
- Use of regularly scheduled telephonic outreach
- **Role has evolved** to meet the needs of the disabled and seniors in the community
- **More popular now due to ACA 2010** (Value-based purchasing, Readmission Reduction Program, reduced reimbursement for hospital care)
- Ensuring visits after discharge from acute/sub-acute facilities to reduce readmission risk

- Outreach, screening, and risk reduction programs improve lives of **at-risk clients** Care planning, maintaining continuity of care and services, measuring outcomes of care, and ensuring consistent follow-up care are important functions
- Developing a client centered plan of care including long term support services.

Insurance/Managed Care

- **Commercial carriers, third-party administrators**
- **Focus is health and wellness** of the enrollee and as liaison between providers of care and the insurance company
- **Coordinate care**, solve problems, advocate, and educate
- **Build programs** to identify enrollees at risk for illness or avoidable disease progression
- **Provide care** for dual eligible members with significant medical, behavioral and social complexities.
- Ensure enrollee receives the **most effective care**
- Ensure **timely, cost-effective** treatments
- Ensure **adherence** to medical regimen, self-management, and reduce stress or frustration
- May provide telephonic or face-to-face case management
- Engage in **utilization management** activities

Workers Comp

- **Evaluating and assessing** needs of worker, extent of injury or illness
- **Assess for signs of depression or other behavioral health issues**
- **Coordinate** multiple healthcare providers
- **May be provided telephonically, on-site, or a combination of both**
- Ensure continued employment and facilitate return to work
- **Lost time indemnity and catastrophic cases** are the most common referrals to case management

Occupational Health – disability management

- Perform **case analysis and benefits assessments**
- Review **interventions**

- **Promote collaboration** among stakeholders
- **Develop return to work (RTW) and retention plans** specific to the individual
- **Coordinate benefits**, services, and community resources
- **Be sensitive to behavioral health issues and/or depression**
- **Develop transitional work program**
- **Develop worksite modification**, job **accommodation**, or task **reassignment** processes
- **Recommend** ergonomic, safety, risk mitigation strategies
- **Promote** health and wellness interventions

Military/VA

- Manage care across **multiple providers/settings**
- **Coordinate the coordinators**
- **Assess for behavioral health issues, depression**

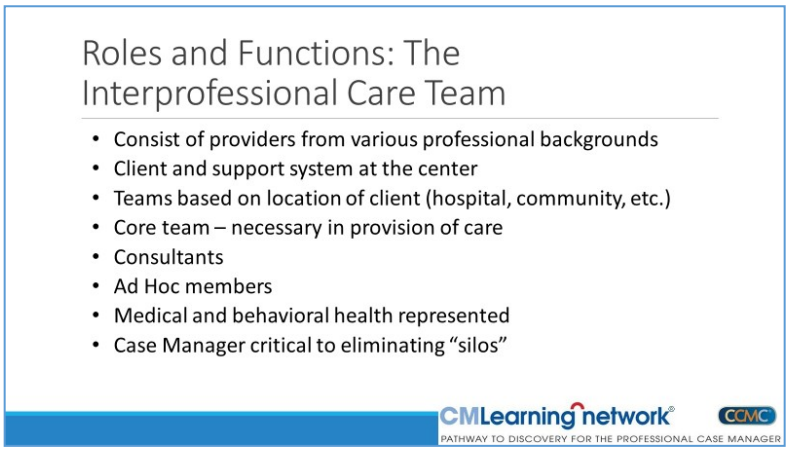
Telephonic/Virtual Case Management

- Work in a **variety** of settings
    - Worker's compensation
    - Third-party administration
    - Group health providers
    - Acute care
    - Other providers of CM services
- **Requires**
    - Objectivity
    - Clear communication
    - Commitment to diversity
    - Ethical standards

Medicare/Medicaid

- Case management roles with special **focus on needs of seniors and individuals with significant medical, behavioral and social complexities.**

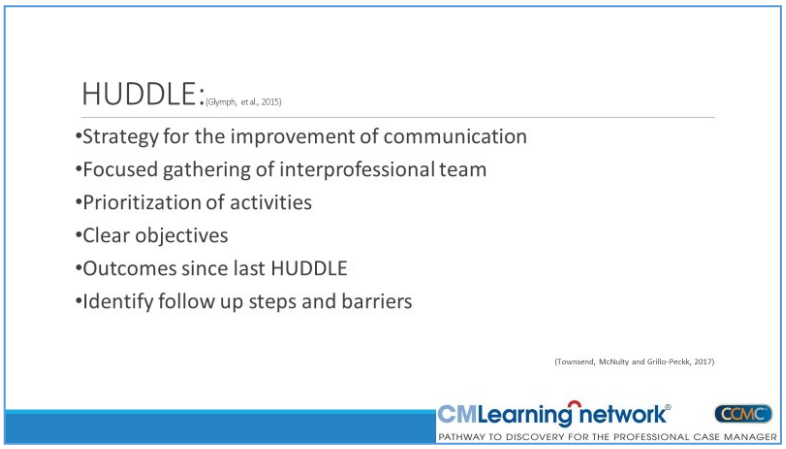
https://www.nursingcenter.com/pdfjournal?AID=804799&an=01269241-200807000-00002&Journal_ID=54025&Issue_ID=804796



The Interprofessional Care Team

- Intrinsic to health care reform models and integrated care models
- Case Manager critical to eliminating "silos"
- Team includes:
    - Client and support system at the center
    - Providers from multiple disciplines
        - Core team: Physicians, Nurses, Case manager/Social Worker, dietary, pharmacy and others involved with the direct care of the client
        - Core team based on setting of care (hospital, community, etc.)
        - Consultants: Rehab medicine, PT, OT, SPT, etc., Other medical or Behavioral Health professionals as indicated
        - Ad Hoc members: could include finance, departmental / organizational leadership or others, usually on a one-time or situational basis
    - Either at point of care, or across the continuum, it is critical for the CM to view the care of the client's health as a "complex, integrated system" and not compartmentalized issues. (Fraser, Perez, & Latour,2018)

Therefore, The Case Manager must assess and plan for all the client's care needs, including clinical, behavioral, social and environmental.



One mechanism that is used to facilitate the work of an interprofessional team is the HUDDLE.

- HUDDLES are a strategy for the improvement of communication to facilitate better outcomes.
- HUDDLE is an acronym for:

  Health Care, Utilizing, Deliberate, Discussion, Link, Events (Glymph, et al., 2015)
- Focused gathering of interprofessional team. All participants
- Prioritization of activities
- Clear objectives
- Outcomes since last HUDDLE
- Identify follow up steps and barriers

Glymph, D.C, Olenick, M., Barbera, S., Brown, E.L., Prestianni, L., & Miller, C. (2015). Healthcare utilizing deliberate discussion linking events (HUDDLE): A systematic review. *AANA Journal, 83*(3), 183-188.
Townsend, C.S., McNulty, M. & Grillo-Peck, A. (2017). Implementing huddles improves care coordination in an academic health center. *Professional Case Management,22*(1), 29-35.

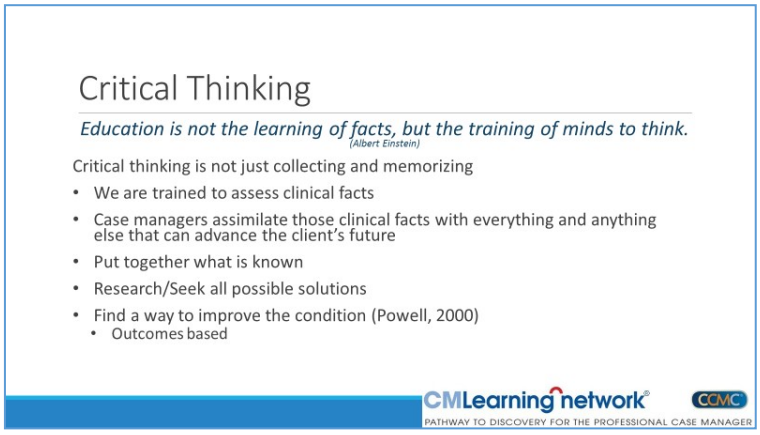
Goals of Case Management Services

- The overarching goal of case management is to assess the client in a holistic manner, and address the medical/behavioral health, as well as the cultural and social determinants of health needs of the client.
- Client-centered care – ensure clients receive the right care at the right time, in the right place, at the right cost, with the right outcomes. This includes:
    - Interprofessional coordination – be an active participant of the healthcare team
- Client/support system engagement to ensure adherence and achievement of goals
    - Transitional care – ensure safe and effective care transitions from one level of care to another.

Qualities of a Case Manager

- **Good clinical knowledge** – ability to apply clinical knowledge/experience to case management e; understanding the course of an illness or injury to determine client needs and how to best address those needs. Case managers with broad experience, including medical and behavioral health knowledge/skills are better prepared to provide case management services to clients with complex issues across settings.
- **Verbal and written communication skills** –

- able to converse with all members of the interprofessional team to ensure optimal, efficient holistic care;
- able to communicate with the client/support systems in a way that is understood and can impact care and outcomes;
- able to ensure that the interprofessional team considers all aspects of care
- **Knowledge of community resources and funding sources** helps to develop a timely, appropriate, cost-effective plan of care
- Good **interpersonal skills** – able to build positive relationships
- **Creativity** – looks for ways to solve problems and provide services when there may not be an obvious mechanism to do so
- **Desire to learn** – interested in lifelong learning opportunities
- **Critical thinking skills** – ability to put together what is known about the problem, research all possible solutions, and find a way to improve the condition; focused on outcomes

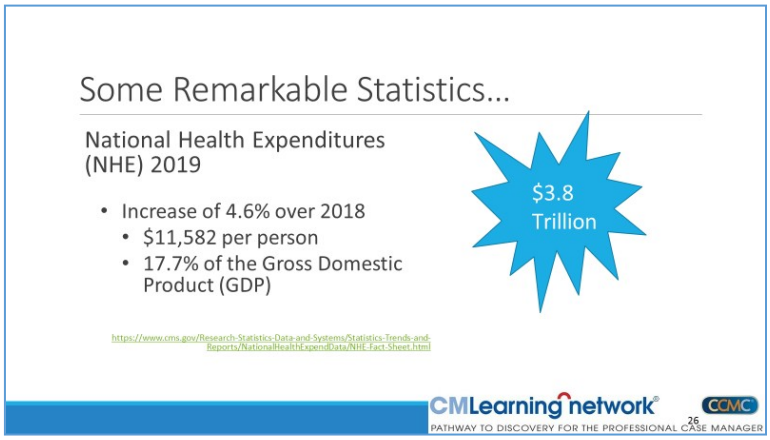


Critical Thinking

- ***Education is not the learning of facts, but the training of minds to think. (Albert Einstein)***
  - Critical thinking is not just collecting and memorizing

- We are trained to assess clinical facts and be sensitive to signs and signals that indicate need for further assessment
- Case managers assimilate those clinical facts with everything and anything else that can advance the client's future
- Put together what is known
- Research/Seek all possible solutions
- Find a way to improve the condition (Powell, 2000)
- Outcomes based
  - Determine the desired outcome(s)
- Focus on what to do (Powell, S.K. and Tahan, H.M., 2017)

https://youtu.be/dItUGF8GdTw?t=2



Health care spending is rising at alarming rate. According to the Census Bureau, the

population of the US in 2019 was approximately 328, 000,000. At $11,585 per person, that means national health care expenditures represented 3.8 TRILLION dollars.

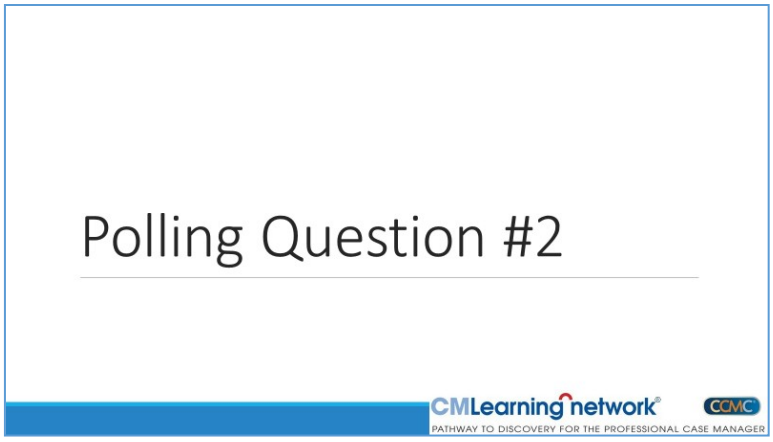
https://www.census.gov/library/visualizations/interactive/population-increase-2018.html

https://www.healthleadersmedia.com/finance/us-healthcare-spending-grew-46-2019-hit-38t

Increased need for case managers

- Demands imposed on the healthcare delivery system by the Patient Protection and Affordable Care Act of 2010 to improve primary care have resulted in an increase in case management opportunities in Patient Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs) and other settings.
- Rising cost of care
- Increased complexity of treatment
- Transitions of care issues
- At-risk population groups
- Convoluted, fragmented care systems
- Improve client engagement
- Literacy, education, cultural barriers

- Increased need for homecare case management due to:
  - Federal homecare Prospective Payment System (PPS)
  - Increase in managed care plans and capitation
  - Growth of integrated delivery systems, value-based purchasing and ACA of 2010 (including the CMS Hospital Readmissions Reduction Program



The primary ethical obligation of the case manager, which is considered an unwritten contract between the case manager and the client, is:

a. Planning

b. Evaluation

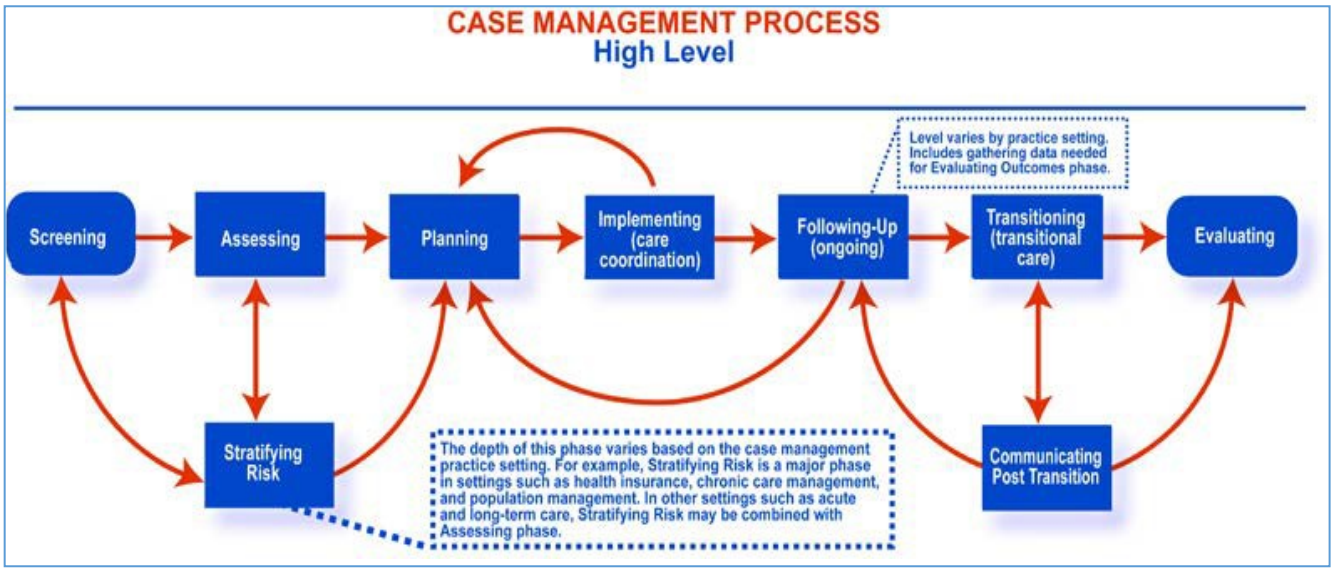
c. Advocacy

d. Intervention

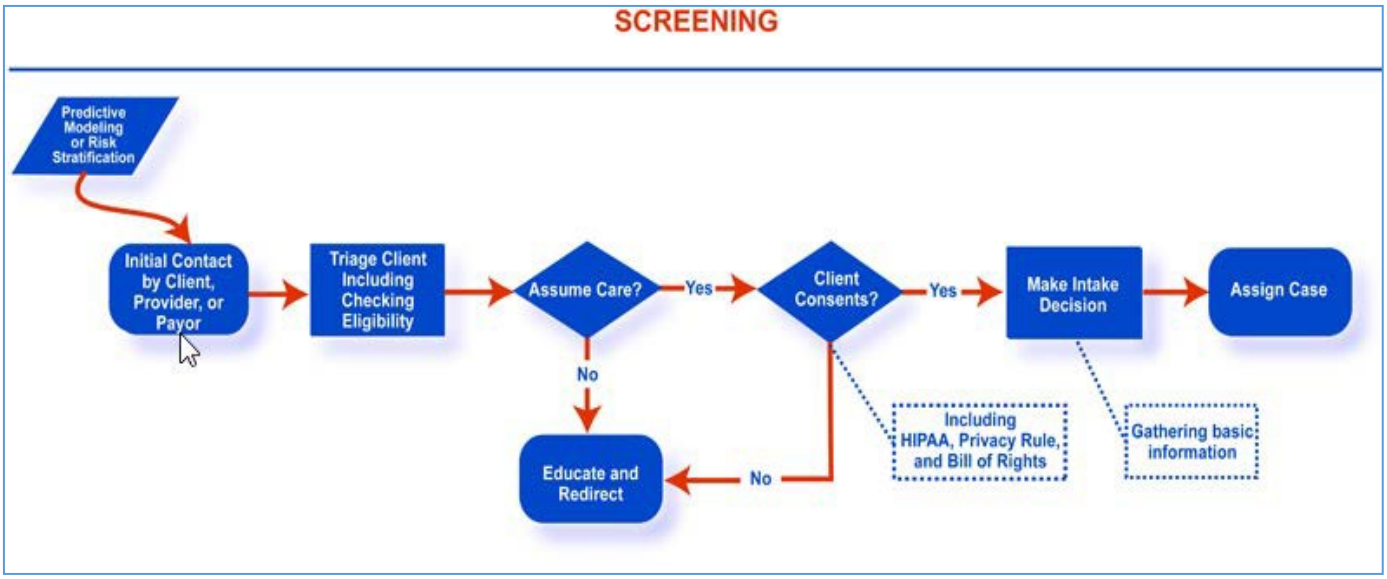
Case Management Process and Tools

The Case Management Process Applied

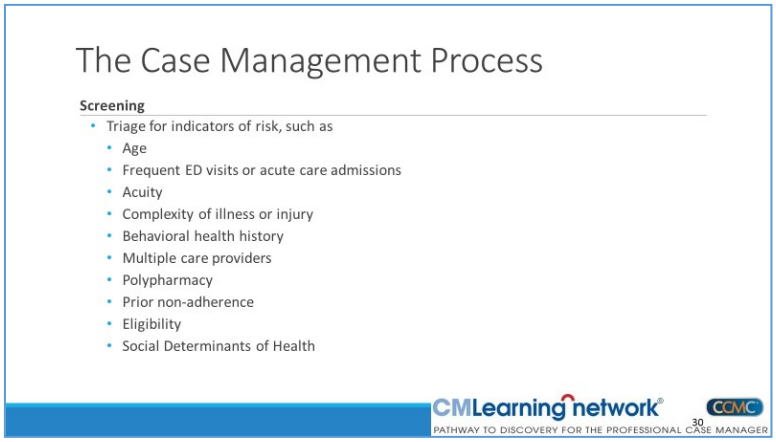
- Case management is a collaborative process within the health and human services
- Can be applied across all settings in which case management is practiced, though the roles may be different
- A telephonic care management model also applies the case management process, with limited or no face to face interaction.
- The process remains a series of phases working together to help clients and their support systems deal with health and related matters
- The earlier case management is introduced into the case, the better the outcome



- High level overview of process
- Process is not linear – can move forward or backward as needs evolve or change



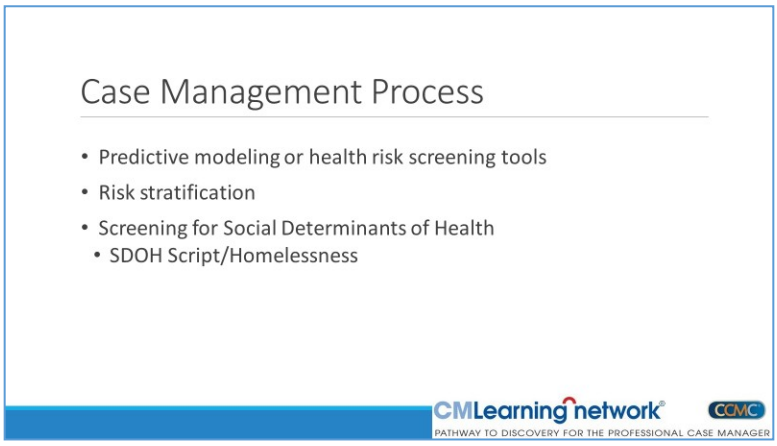
Screening



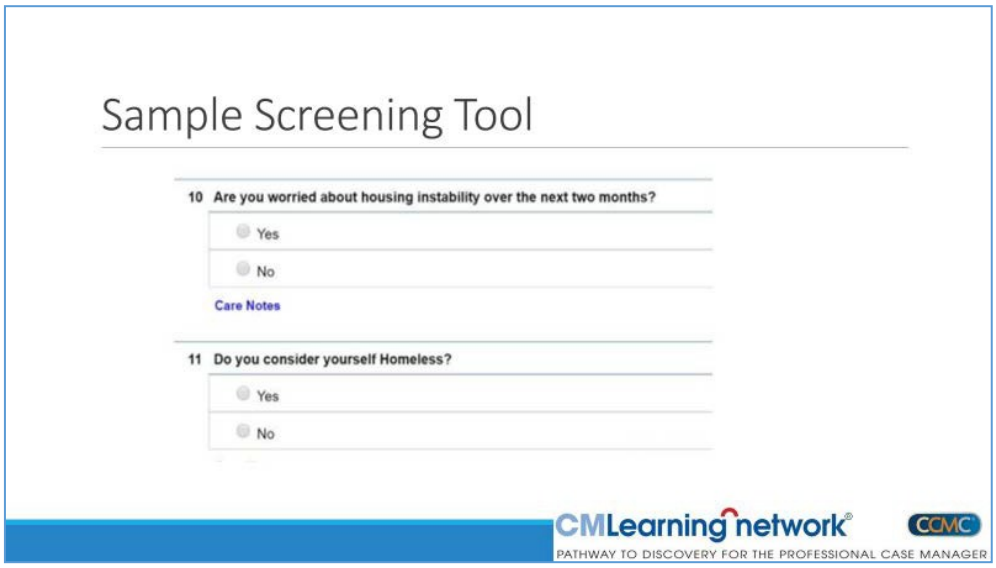
Screening is done to ensure appropriateness for case management services to prevent misuse of case management time and services

- In a program driven model, screening enables the appropriate match of a client to a care manager.

- Triage for indicators of risk, such as
  - Age
  - Frequent ED visits or acute care admissions
  - Acuity
  - Complexity of illness or injury
  - Behavioral health history
  - Multiple care providers
  - Polypharmacy
  - Prior non-adherence
  - Eligibility
  - Social Determinants of Health



- Predictive modeling or health risk screening tools
- Risk stratification
- Screening for SDOH/Homelessness



Screening Tools such as your own provide an objective scoring system to identify potential risks based on SDofH.

Social Determinants of Health…Facts:

- "In analysis of public announcements of new social determinants of health programs operated by US health systems from Jan. 1, 2017, to Nov. 30, 2019, researchers from New York University uncovered at least a $2.5 billion in investments from 57 health systems that collectively included 917 hospitals. The health system funds were allocated to 78 unique programs launched during that time." (LaPointe, J. , 2020)
- "Socioeconomic factors are responsible for approximately 40 percent of a patient's health, while just 20 percent was tied to care access and quality of care, the American Hospital Association (AHA) recently reported." (LaPointe, J. 2018)

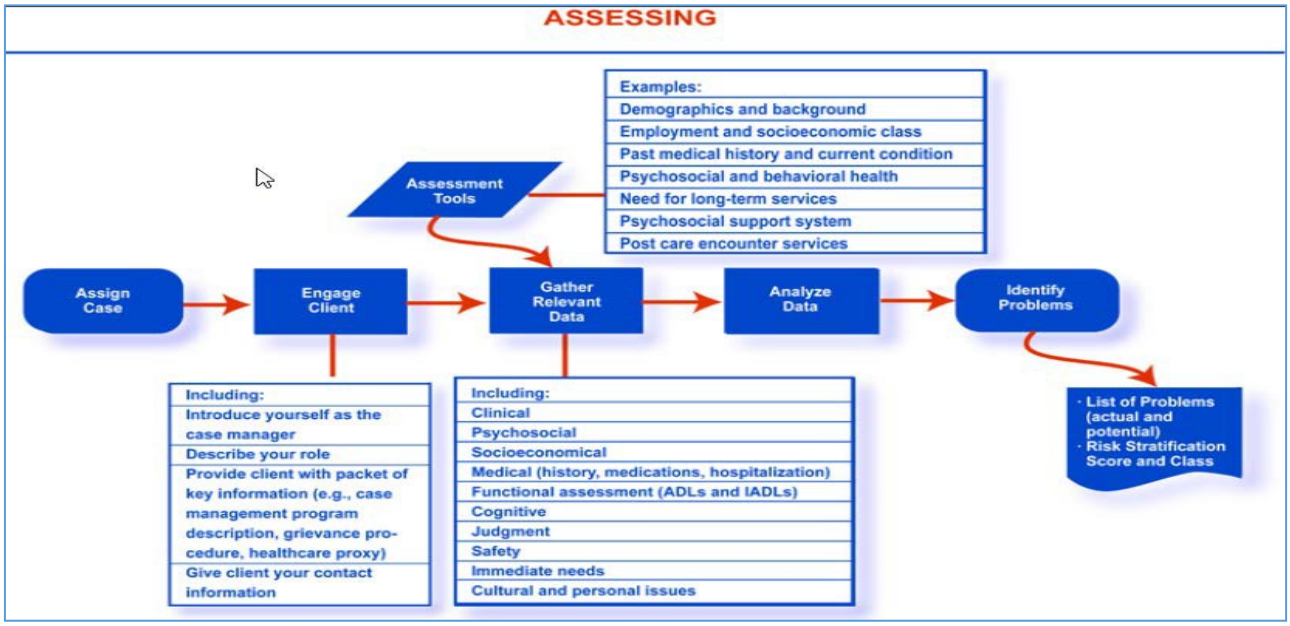
- "Commonly-cited statistics show that social determinants of health can impact between 80 to 90 percent of patient outcomes. In efforts to improve outcomes while lowering costs, the healthcare industry including federal agencies has made a conscious effort to develop programs that address one or more social determinants of health." (LaPointe, J. 2020)

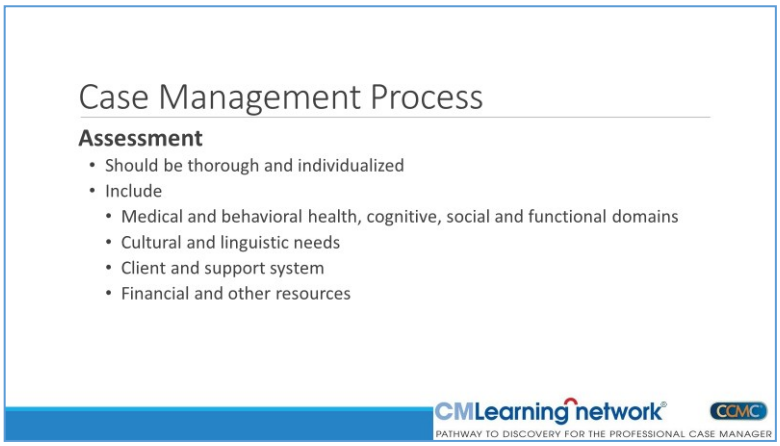
LaPointe, J. (2018) How Addressing Social Determinants of Health Cuts Healthcare Costs from https://revcycleintelligence.com/news/how-addressing-social-determinants-of-health-cuts-healthcare-costs
LaPointe, J. (2020) How Much are Health Systems Spending on Social Determinants? From https://revcycleintelligence.com/news/how-much-are-health-systems- spending-on-social-determinants

Social Determinants of Health:

- **Are responsible for 40% of a person's health**
- **Impact 80-90% of outcomes**

Assessment





- Tools created for in depth assessment, consider in Integrated case management models
- Should be thorough and individualized
    - Review medical records
    - Meet/speak with client
    - Discussion with treatment team
- Engage the client without pestering
    - Failure to respond to phone calls/letters can be indicative of lack of interest
- Include
    - Medical, cognitive, behavioral health, social and functional domains
    - Cultural and linguistic needs
    - Client and support system
    - Financial and other resources

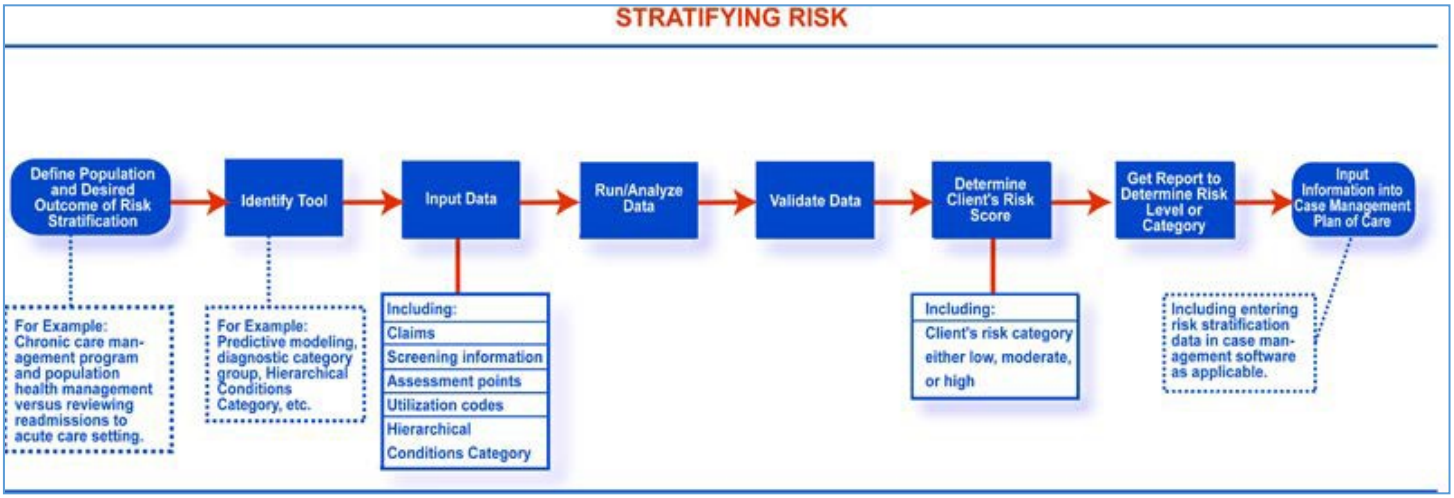
Assessment areas

- Client demographics
    - Resources
- Personal information
    - Family support

    - Finances
    - Knowledge
- Use of healthcare resources
- Insurance information
- Physical functioning and limitations
    - What is their understanding of the disease?
    - Let them tell you what they think their diagnosis/disease is in their own words.
    - What is the effect on their body?
    - What is their understanding of the results of non-adherence?
    - Are they able to adhere to the plan of care?
- Physical assessment
- Psychosocial and behavioral health assessment
- Communication
    - Are they understanding the questions and the statements?
    - Do they know the definition of adherence?
    - Refrain from using medical terminology.
    - Written material should be written at or below a fifth-grade level.
    - Don't assume they understand what you are telling them – have them repeat it back in their own words, and them explain it, including giving examples.
- Psychosocial network
    - Are they open to change?
    - Are they ready to make a change?
- Cultural, religious, spiritual
- Needs and interests

- Clients' abilities and attitudes regarding adherence to the healthcare regimen, and to medications
- Situational
    - Social determinants of health
        - Environment, including housing situation, temperature control, household pests
        - Transportation availability
        - Family support
        - Financial insecurity, including medical insurance
        - Food insecurity
        - Other

Risk



- Goes to the likelihood of experiencing poor health outcomes
- Identify clients with highest health risk
- Classification of clients into one of three risk categories
    - High
    - Moderate
    - Low
- Determines appropriate level of intervention based on client's situation and needs
- Facilitates delivery of targeted risk category-based case management interventions and services to enhance outcomes
- Assessing the client's understanding of their condition(s) will help to determine the level of case management intervention that will be needed. To fully assess, you need to ensure that they truly understand what the disease or illness is and what it means to their recovery and their future level of health. Have them tell you what they think their disease/diagnosis is about in their own words.
- What is the effect on the body, and what are the consequences if they are unable or unwilling to follow the treatment plan? Are they willing and/or able to make lifestyle or other changes if necessary? How does this episode/acute illness relate to comorbid conditions they are experiencing, including behavioral health?

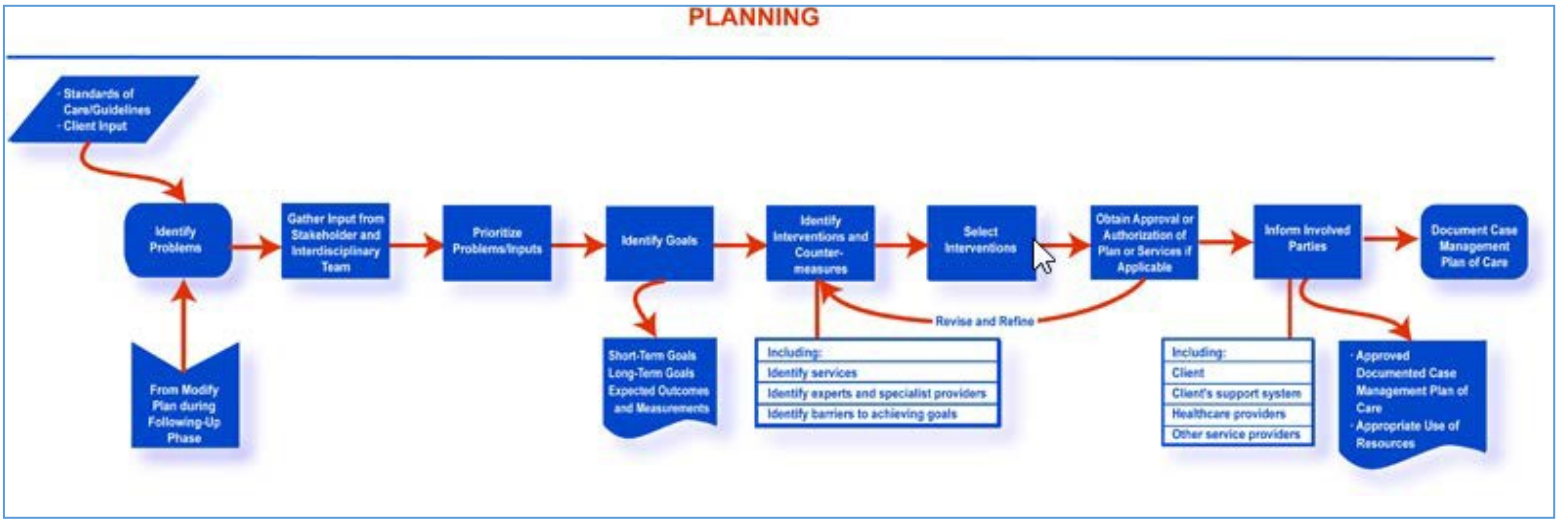
- It is important throughout the case management process to ensure that you are communicating in a way that can be understood. Explanations should be given in plain language; written material should be clear and written at a 5th grade or below level. And always ask for the client to repeat back what you have said to them in their own words, to explain what that means, and to give examples to illustrate what they have said.

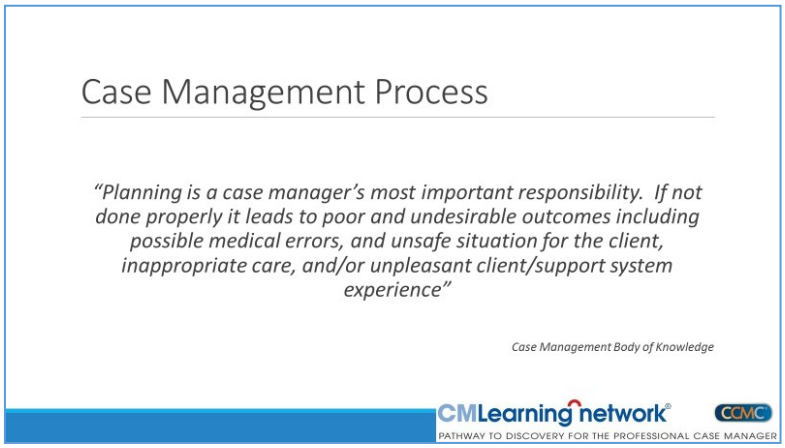
Acuity

- Goes to the need for level and frequency of comprehensive and integrated case management intervention
- Represents the level of complexity of the case management intervention, the severity of the client's needs, and the response of the healthcare delivery system
- Determined through a process of stratification that encompasses many factors and can be a complex process using not only current clinical information, but also historical claims information
    - Support system
    - Behavioral health
    - Cognition/education
    - Resources
- Factors impacting acuity:

- Current illness or injury, client understanding of the illness or injury, and the complexity of the condition
- Are there comorbid conditions present that will impact on the acuity of the current condition?
- How complex are the medical/behavioral needs
- What care is needed immediately and what care might be needed moving forward
- What is the anticipated next level of care, and what are the considerations necessary for the transition?
- Medication concerns – number, type, and potential for adverse reactions
- What is the extent and engagement of their support system?
    - A client can live with multiple family members, but if they are all unavailable, due to other responsibilities, then they are not an adequate support system.
- Can we expect that care needs will be met if the individual is incapable of managing self-care?
- What is the cognitive status and educational level of both the clients and the support system?
- What is their health literacy and understanding of the condition and the care that is and will be required?
- What is the intensity and complexity of needs, and what is the intensity of the resources and services that will be necessary?

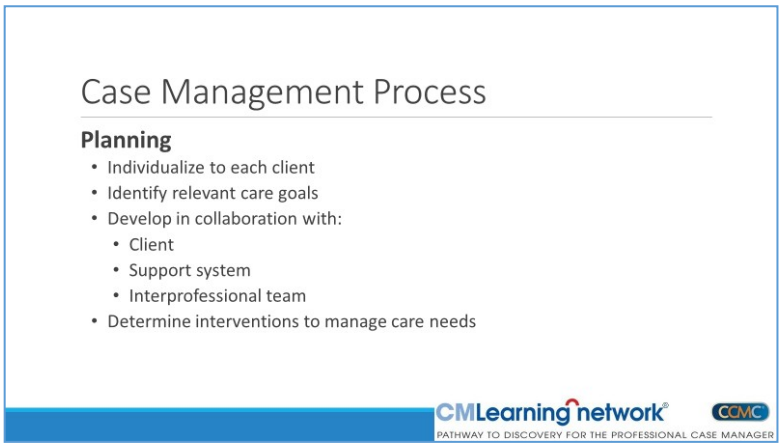
Planning





"Planning is a case manager's most important responsibility. If not done properly it leads to poor and undesirable outcomes including possible medical errors, and unsafe situation for the client, inappropriate care, and/or unpleasant client/support system experience"

Case Management Body of Knowledge



Planning

- The plan should be individualized to each client
- Inclusive of appropriate long-term support services
- Optimizes available resources
- Identify relevant care goals
- Develop the plan in collaboration with the:
  - Client
  - Support system
  - Interprofessional team
- Determine interventions to manage care needs

Establishing goals

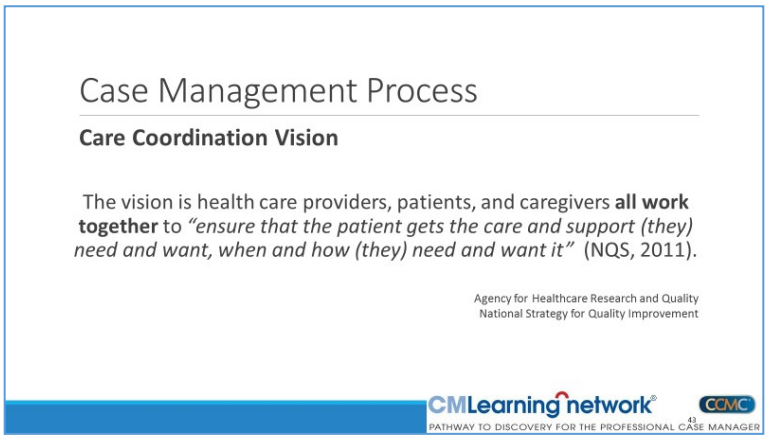
- Should be short- and long-term goals

- Specific
- Measurable
- Attainable
- Relevant
- Time Based

- They are determined by the client/support system
  - Do not impose your beliefs/judgements
  - You are NOT meant to solve the problem – but give direction for the client to solve the problem

Planning considerations

- Specific to the client/support system
  - Needs/wants/preferences
  - Participation in development of plan
  - What does success look like?
- Ongoing follow up
- Interprofessional team collaboration
- Needed resources and services



Care Coordination vision

The vision is health care providers, patients, and caregivers **all work together** to *"ensure that the patient gets the care and support (they) need and want, when and how (they) need and want it"* (NQS, 2011).

-Agency for Healthcare Research and Quality, National Strategy for Quality Improvement

- Care coordination
  - Involves numerous participants
  - Is necessary when participants are dependent upon each other to carry out disparate activities for the client's care
  - Each participant needs knowledge of the role and resources of others involved in the process
  - Communication is required to exchange information
  - Goal of care coordination is to facilitate the appropriate delivery of health care services

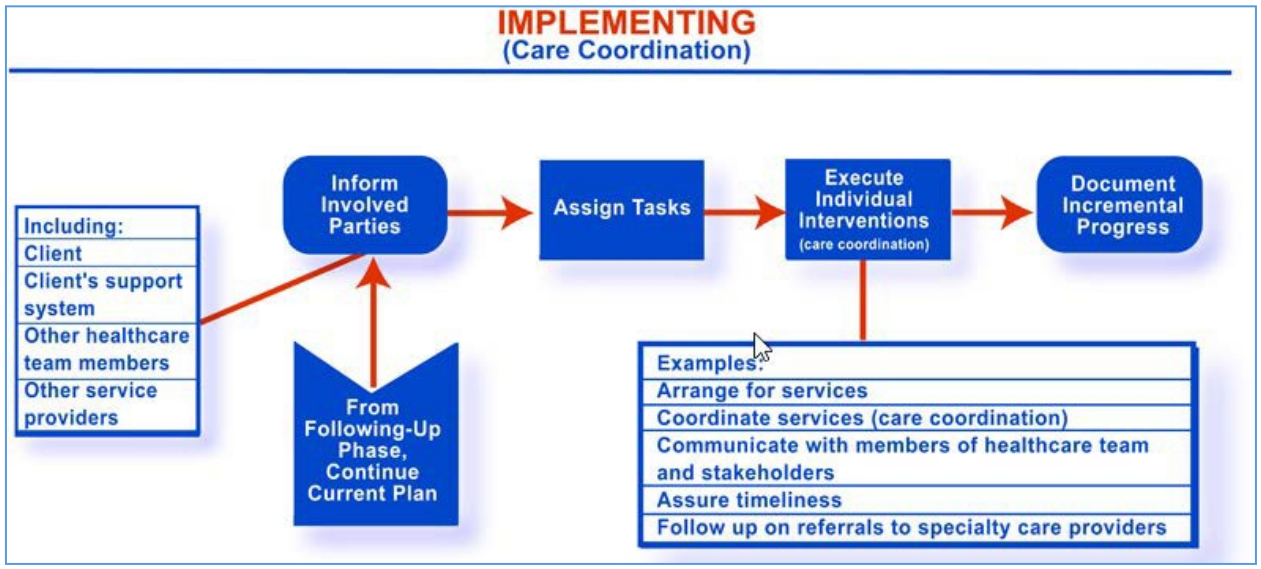
Video: https://www.youtube.com/watch?v=Vy13GO3hUMM

Benefits of Care Coordination

Conscious, ***patient-centered coordination of care improves the person's experience*** *and* ***leads to better long-term health outcomes****, as demonstrated by fewer unnecessary hospitalizations, repeated tests, and conflicting prescriptions, as well as clearer discourse between providers and patients about the best course of treatment (NQS, 2013).*

Agency for Healthcare Research and Quality
National Strategy for Quality Improvement

Implementing

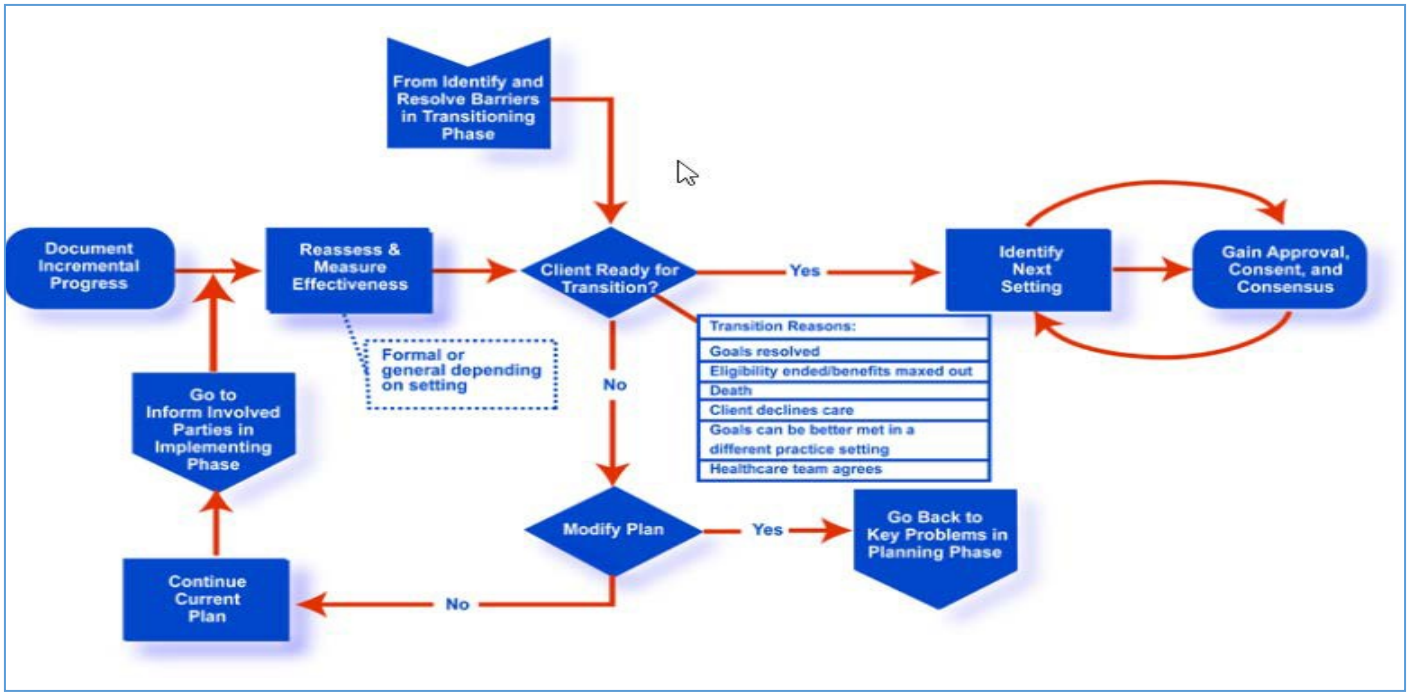


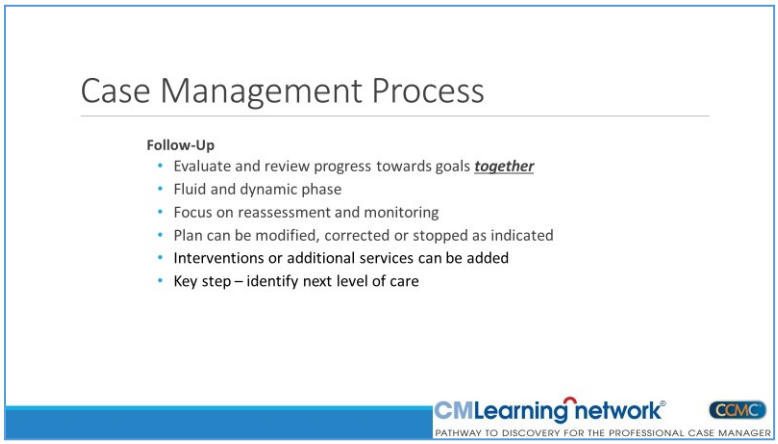
- Communication is critical every step of the way – stakeholders must be kept informed to demonstrate the value of the case management process
- Ensure optimum care, services, and outcomes
- Delivery of cost-effective services and resources within the framework of the benefit system
- Facilitate the highest level of client autonomy and engagement
- Advocate for the client/support system
- Resolve the client's health problems to the extent possible

- Assure a favorable care experience for all parties involved

Case Management Body of Knowledge

Follow-Up

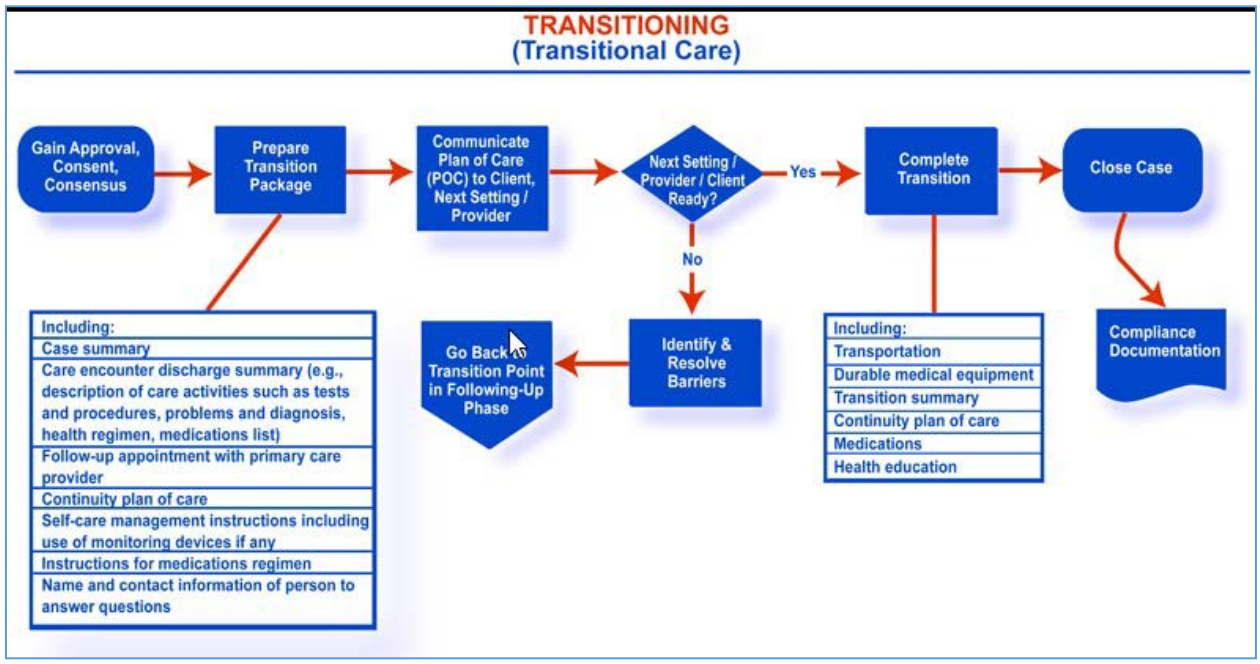


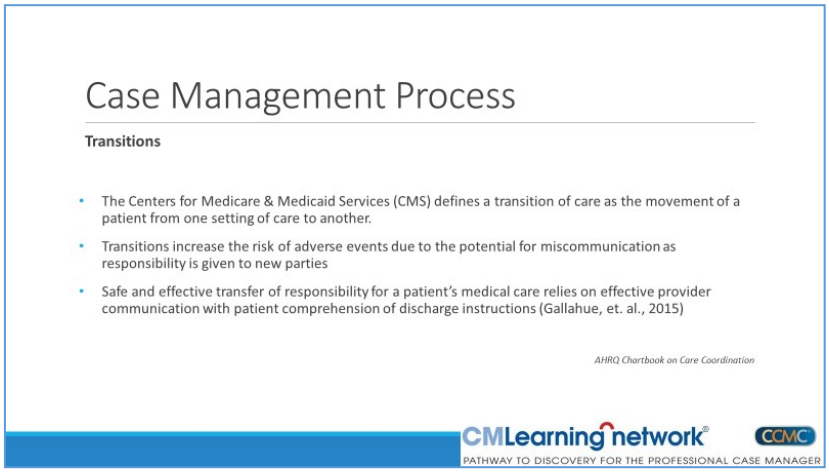


- Client and case manager evaluate and review progress towards goals ***together***
  - As often as indicated or on a prescribed timetable
- This is a fluid and dynamic phase

- Case manager's primary role – ***advocate***
- Focus is on reassessment and monitoring of client condition
- Plan can be modified, corrected or stopped as indicated
- Interventions or additional services can be added
- A key step in this phase is identifying the next level of care
- Transitions must be justified by the client's condition, needs, and care goals
- Review potential care settings
- Determine which best meets the goals, needs and preferences of the client and support system
- Changes are implemented with approval of the client/support system, members of the interprofessional team, and the payer representative
- Work within the framework of the payor system
- Follow-up phase may be impacted by:
    - Lack of knowledge about care or condition
    - Lack of effective support system
- Identified barriers may threaten the success of the plan of care

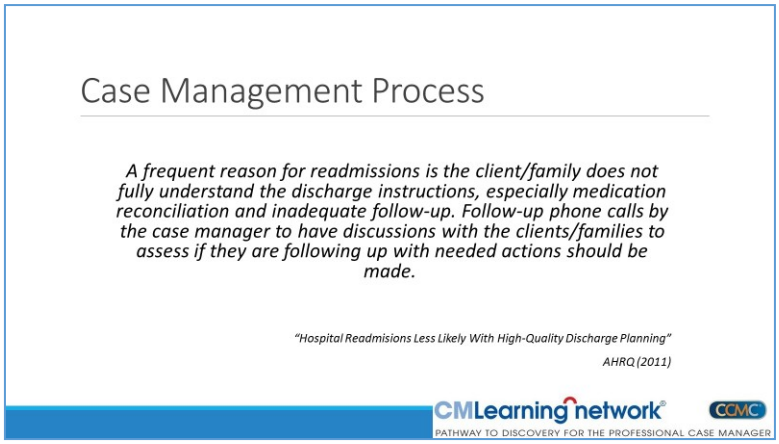
Transitions





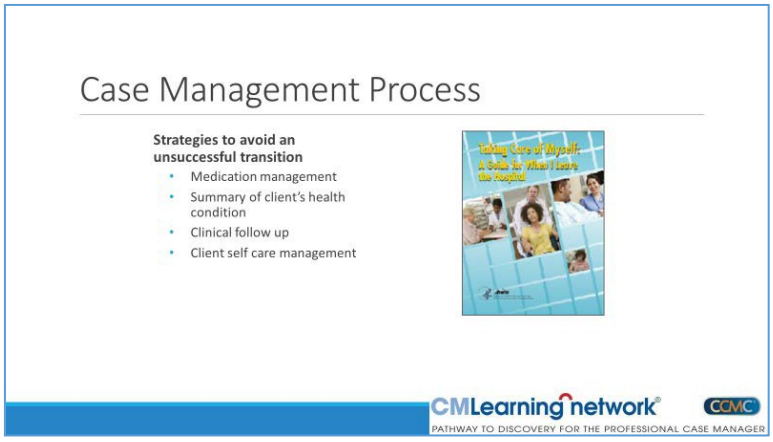
- The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another.
- Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties
- Hospital discharge is a complex process representing a time of significant vulnerability for patients.

- Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with patient comprehension of discharge instructions (Gallahue, et. al., 2015)



Preventing readmissions and empowering clients to be active participants in their care to the extent they are able, can be achieved.

- Through regularly scheduled telephone calls to support the management of the client,
- Ensure that post-discharge visits are performed for members within 48 hours



- https://www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf
  AHRQ Chartbook on Care Coordination
- Transitional planning is the movement of the client from the most complex level of care to the least complex level of care, and ensures that appropriate services are provided in the appropriate level of care for the client at that moment in time

- Interacting with other members of the interprofessional team,
- Engaging in “warm hand-offs” when a client transitions from one level of care to another, including when your clients move to another level of care,

- Transitional care is the facilitation of the care and services to ensure the coordination and continuity necessary as the client moves from one level of care to another
  - Medication management has become more important than ever before
  - Critical to smooth transition is to ensure that the next provider/level of care receives a summary of the client’s current health condition and prior care and treatment, with clinical results of tests and procedures
  - Arrangements for appropriate and timely clinical follow up should be part of the transition plan
  - Assessment of the client’s ability to manage self-care, with implementation of services that may be necessary should the client not be able to care for themselves

Common causes for nonadherence

(excluding medications)

- For nonadherence to self-care regimens, the most common causes are related to self-care activities, the client, the provider, and the system.
- Self-care activity related
  - How involved, complex, or frequent the activity is

    - Need for special devices or equipment that are perceived as too complex or difficult
    - Requires the assistance of another person or persons
    - A prior unpleasant experience related to activity
    - Time needed for activity
- Client-related
    - Does not understand importance of performing the activity
    - Lacking knowledge or skill necessary for the activity
    - Afraid of complications
    - Not enough financial resources for necessary items
    - Too busy
    - Poor or no support system
    - Poor health literacy
    - Mental/behavioral health issues impacting ability to be adherent
    - Housing issues
    - Substance abuse issues
    - Negativity or denial
    - Inconsistency in performing activity
- Provider-related
    - Poor provider relationship, not enough time
    - Poor communication; use of medical terminology
    - Unable to understand instructions
    - Poor health education or follow up; limited access to provider to answer questions or provide further explanation

- System-related
  - Uninsured/underinsured
  - High out of pocket expense
  - Limited or no access to provider, facility, pharmacy
  - Shortage or delayed availability of supplies

Adherence

- Adherence to all health and medical recommendations (including behavioral health) or regimen is an important predictor of positive outcomes
- Case manager responsibility is to assess the ability and attitude of the client to adhere to regimen considering any behavioral health indications that the client may not be adherent
- Nonadherence behaviors may be exhibited in the areas of medication intake, care activities, exercise or dietary restrictions, and follow-up care.

Medication Therapy Management

Case manager's role:

- Primarily to ensure safe and effective use of medications based on the plan of care
- Assessment of medication regimen
  - Review medication with the team to ensure appropriateness of the medications, including medications for ALL conditions, both medical and behavioral health

- Identification of problem medications
- Review medications with clients regarding what the medication is for
- Education and counseling regarding medications, usage, and what specific condition they are for should be provided, with teach-back to ensure understanding by the clients and support system and reduce potential for adverse medication events
- Education should include potential hazards, particularly with polypharmacy; persistence; schedule
- Assessment of the ability of the client to adhere to the medication regimen regarding maintenance of continuity and schedule
- Includes accessibility of medications, and ability to get the medications.
- Shared accountability with healthcare team (physician, pharmacist, etc.) and the client/support system

Teach-Back

- **http://www.teachbacktraining.org/**
- Helps to ensure understanding of what has been taught
- Involves asking client to state in their own words what they need to know or do about their health
- Confirms that you have explained in a manner that they can understand the information you have shared with them
- If they repeat back what you have said in your words, consider that they have not understood what you told them and try again

Medication Management

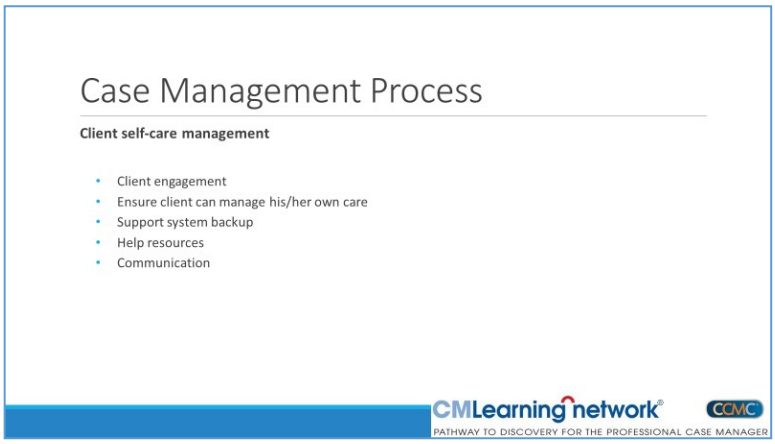
- Provide client/support system with medication checklist
- Include **all** medications
  - Prescriptions
  - Over the counter

- Vitamins/herbal supplements
    - Important to assess based on cultural practices.
    - How are medications supplied?
        - Local pharmacy
        - Mail order meds

Medication Reconciliation

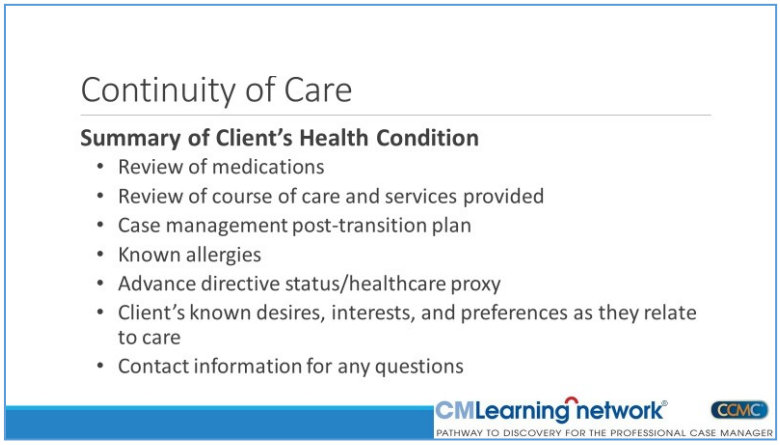
Process to reconcile ALL medications taken

- The case manager can be responsible to complete a list of all medications being taken by the client but is not necessarily the person responsible for completing a full medication reconciliation
- They should be monitored for compatibility, necessity, and safety to reduce adverse events; to identify any duplications in medication or therapeutic category; ongoing need for the medication; and to ensure reduction in potential adverse events and medication incompatibilities that can result in increased care and cost
- Include over-the-counter, herbal supplements and vitamins
- Compare to pharmacy records, prescription containers, physician orders
- Medication reconciliation is particularly critical after an acute care discharge as the medications may be the same as they were taking at home, but because the hospital formulary may use a different form or brand name the clients would not necessarily recognize that it is the same medication
- One of the ways the case manager can help with medication reconciliation is to collect and communicate the information to the healthcare team, but it may be the responsibility of the pharmacist to do the reconciliation



Client self-care management

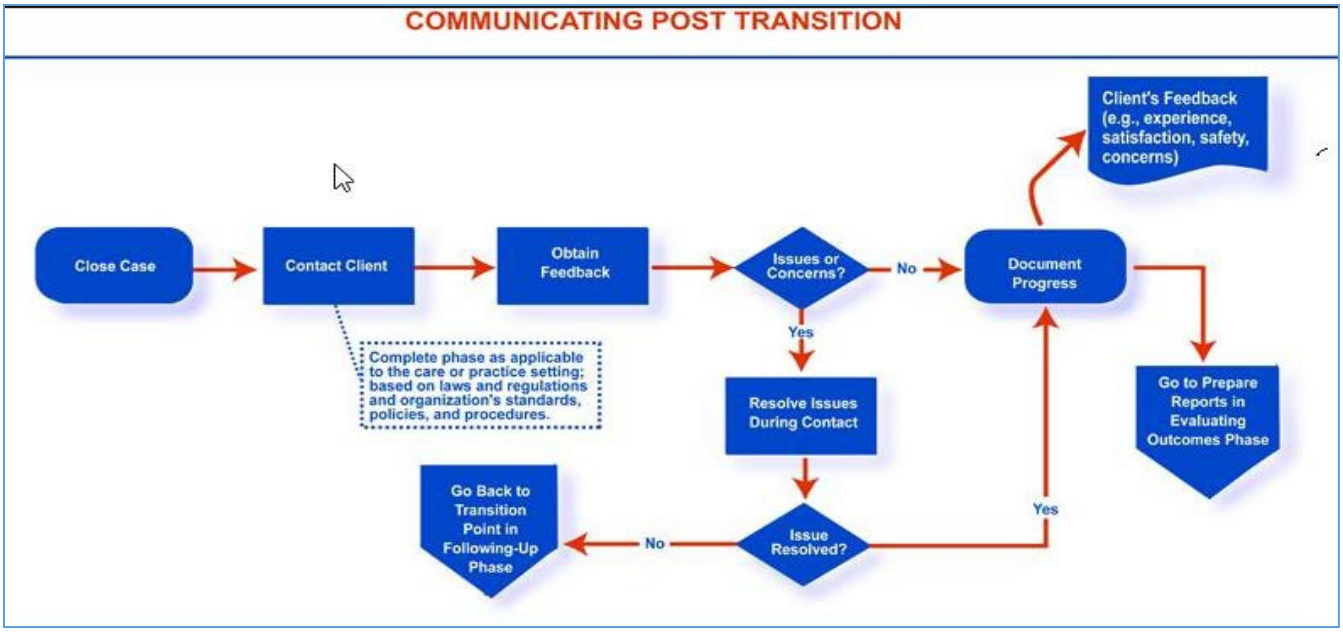
- **Client engagement**
  - Client centered, goal oriented (Fraser, Perez and Latour, 2018)
- Ensure client can manage their own care
  - "Engagement to activation" (Fraser, Perez and Latour, 2018)
- Support system backup
  - Collaborative partnership between and among the client, family, other caregivers, providers (Fraser, Perez and Latour, 2018)
- Help resources
- Communication

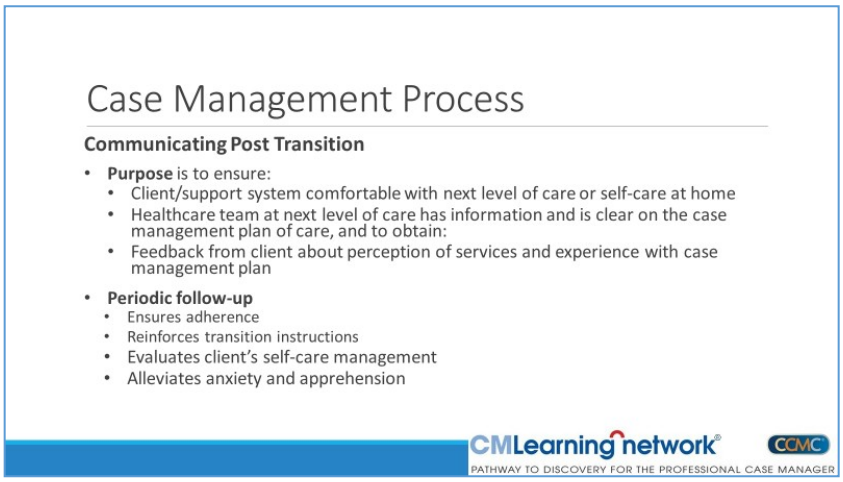


Summary of Client's Health Condition

- Review of medications
- Known allergies
- Review of course of care and services provided
- Case management post-transition plan
- Advance directive status/healthcare proxy
- Client's known desires, interests, and preferences as they relate to care
- Contact information for any questions

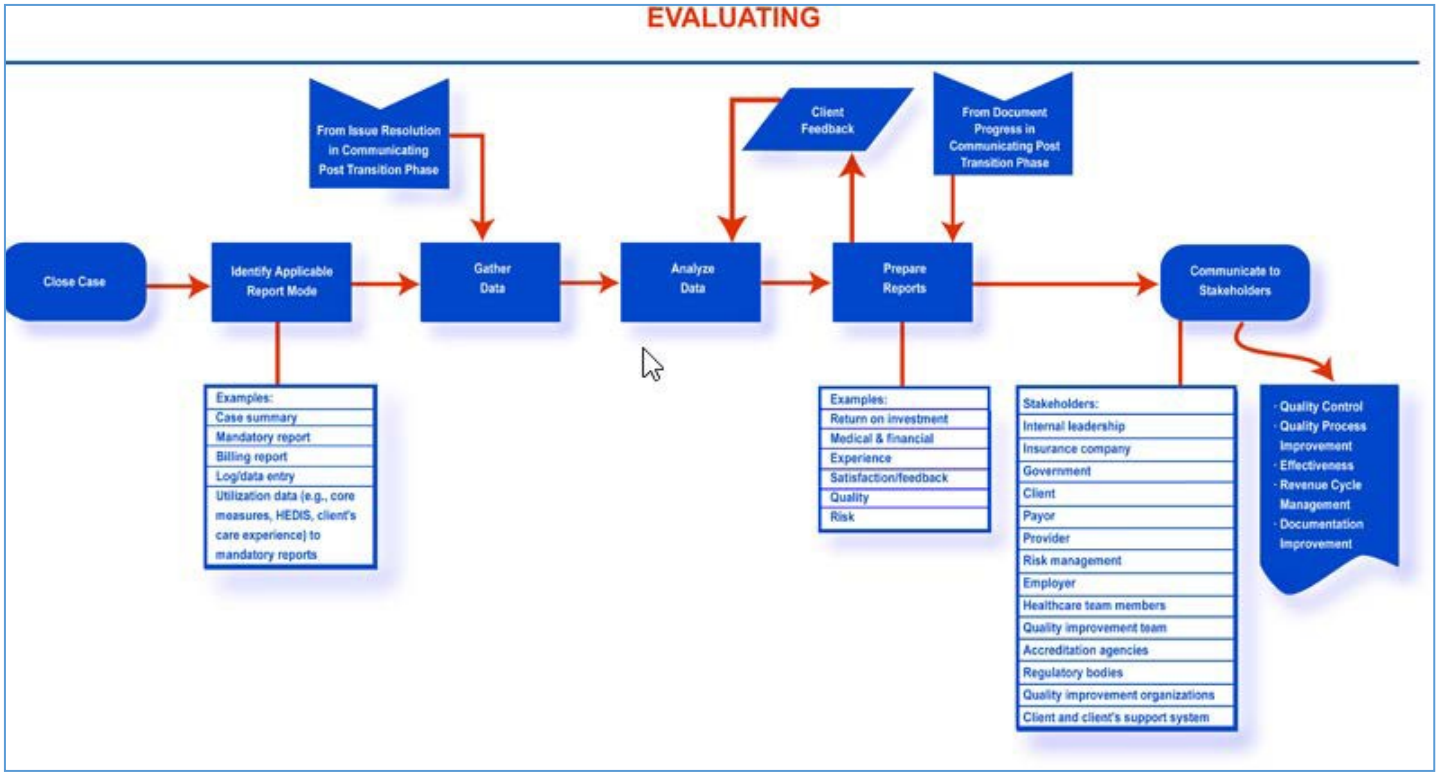
Communicating Post Transition

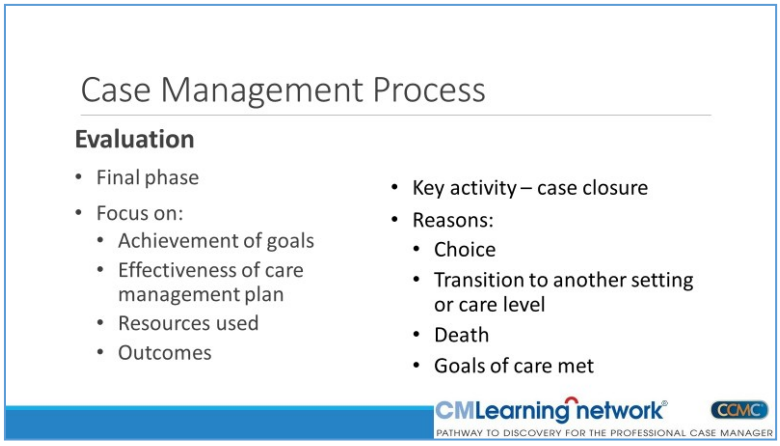




- **Purpose is to ensure the:**
  - Client/support system is comfortable with next level of care or self-care at home
  - Healthcare team at next level of care has information and is clear on the case management plan of care, and to obtain:
  - Feedback from client about perception of services and experience with case management plan
- **Goals of post transition communication**
  - Provide periodic follow-up
  - Ensure adherence
  - Implement transition instructions
  - Evaluate ability of self-care management

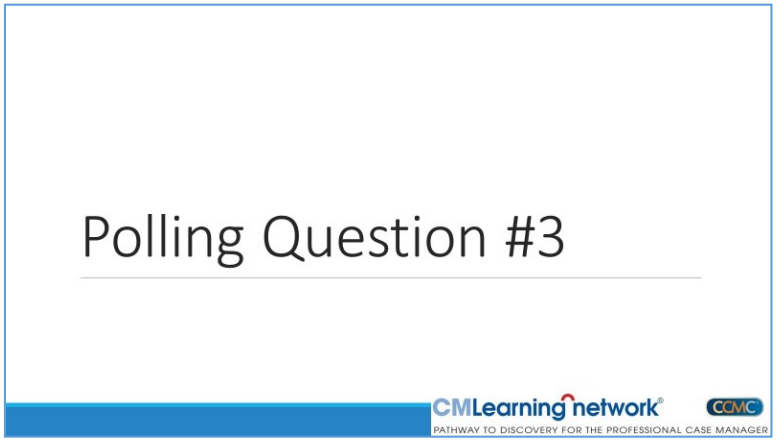
Evaluation





- Final phase
- Focus on:
  - Achievement of goals
  - Effectiveness of care management plan
  - Resources used

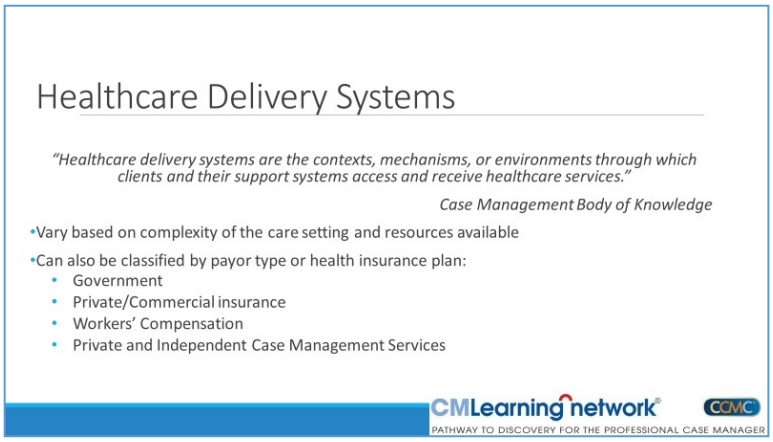
    - Outcomes
- Key activity – case closure
- Reasons:
    - Choice
    - Transition to another setting or care level
    - Death
    - Goals of care met



Client-centered care coordination leads to better long tern outcomes by all the following, except:

a. **Fewer hospitalizations**
b. **Less repetition in testing**
c. **Improved communication**
d. **Increased placement in SNF**

Levels of Care/Care Settings



Healthcare Delivery Systems

- *"Healthcare delivery systems are the contexts, mechanisms, or environments through which clients and their support systems access and receive healthcare services."*

  Case Management Body of Knowledge

- Vary based on complexity of the care setting and resources available
- Classified into 3 main types:
  - Pre-Acute
  - Acute
  - Post-Acute
  - Can also be classified by payor type or health insurance plan:
  - Government
  - Private/Commercial insurance

- Workers' Compensation
- Private and Independent Case Management Services

- **Health Maintenance Organizations (HMO)**
  - An organization that provides for or arranges for coverage of designated health services for a fixed prepaid premium
  - Providers receive predetermined payment (per member/per month)
  - Primary care provider is the gatekeeper
  - Access to specialists through primary care provider and limited to that which is necessary for the client's condition
  - Out of Network coverage is very limited

- **Preferred Provider Organization (PPO)**
  - Insurance product in which contracts are established with providers of care (preferred providers)
  - Contract provides better benefits when preferred providers are used as an encouragement for members to use them
  - Can use out of network providers with higher out of pocket costs

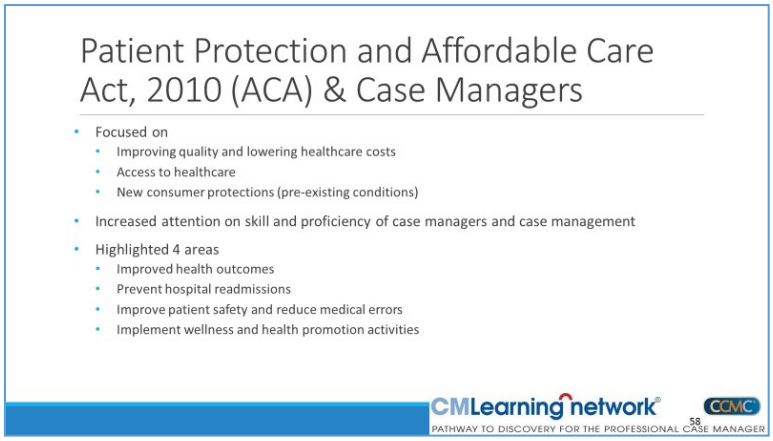
- **Point of Service Plans (POS)**
  - Allows members to choose between participating and non-participating providers
  - Allows for blend of HMO and PPO

- **Integrated Delivery System (IDS)**
  - Partnerships between physicians, physician groups, hospitals and other providers to manage care
  - Usually involves contact with payer
  - Provides services across the continuum
  - May become Accountable Care Organization (ACO)

- Increasingly popular today – most common with academic medical centers partnering with other health care organizations across the continuum to create vertical integration (health delivery system that provides a complete spectrum of care – at a minimum, hospitals, a medical group, and a health plan within a single organization)

Models of Care

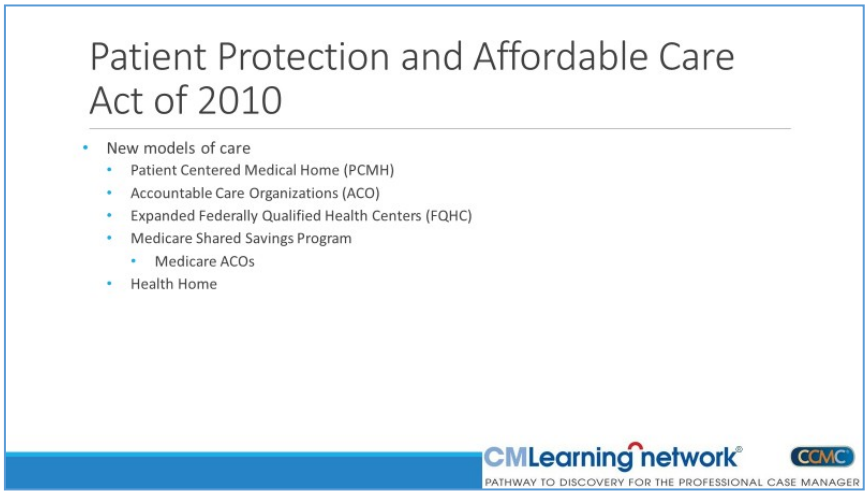
- Apply to all practice settings
- Services vary from one setting to another
- Variation reasons:
  - Professional discipline
  - Staffing mix
  - Interprofessional team
  - Context of care setting
  - Unique needs of client/support system



Patient Protection and Affordable Care Act, 2010 (ACA)

- Focused on increased access to healthcare services, reduced costs through payment reductions, and attention to wellness and prevention
- Improved access to care and insurance; no limitations for pre-existing conditions; coverage to age 26 for dependent children

- Rewards value-based care and quality, safe care delivery
- Increased attention was placed on care coordination, the skill and proficiency of case managers, and case management beyond the acute care setting
- Highlighted 4 areas
    - Improvement in health outcomes by implementing activities of quality reporting, effective care management, and care coordination to encourage and increase compliance including using health homes
    - Comprehensive programs of patient centered education, discharge planning and post discharge follow up to improve hospital discharge to reduce hospital readmissions
    - Use of best practices, evidence base medicine, and information technology to improve patient safety and reduce errors
    - Implementation of wellness and health promotion activities
- Focus on improved care transitions, particularly those from hospital to the next level of care, and reducing hospital readmissions
- Required changes to the health care delivery system by expanding public programs, creating health insurance exchanges (HIEs), and cost containment
- Required new reimbursement models, and provided for financial incentives



Models of care emerging from ACA

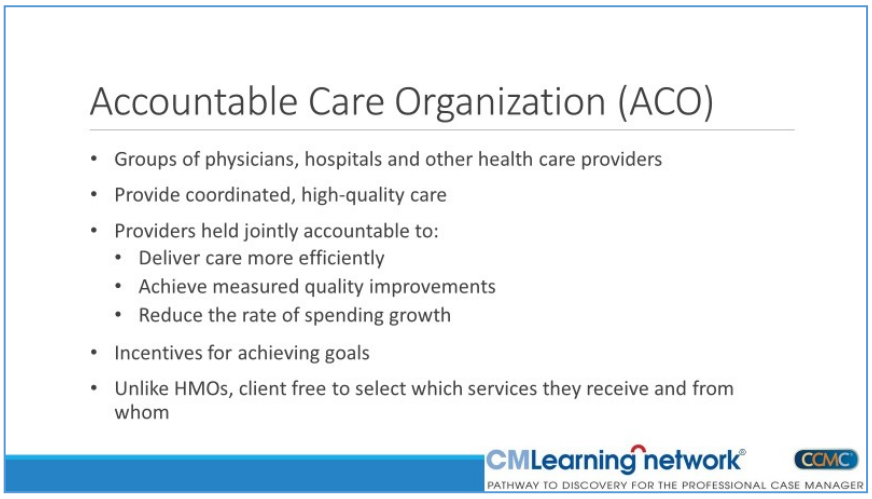
Patient-Centered Medical Home (PCMH)

- American College of Physicians defines the Patient-Centered Medical Home as a care delivery model in which treatment is coordinated through the primary care physician to ensure the patient receives the necessary care when and where they need it, in a manner they can understand (includes behavioral health and medical care)
- They are primary care organizations that have an emphasis on care coordination and communication
- The goal is for higher quality and lowered costs, with an improved patient and provider experience of care
- They serve all populations and accept reimbursement from both governmental and commercial payers
- Current movement is towards a focus on population health – identification of chronic conditions and utilization of evidence-based concepts and quality metrics to manage care
- Principles of the PCMH:
    - Each patient has an ongoing relationship with a primary care provider who coordinates all care for the patient
    - The practice is physician-directed with all members of the team collectively responsible for ongoing care of the patient

- There is a **whole person orientation** with the **primary care physician responsible for either meeting all needs of the patient across all life stages, or arranging for appropriate care from other qualified professionals**
- Care coordination occurs across all elements of the healthcare system and into the community, utilizing information technology and exchanges to ensure that required care and services are delivered when and where needed in a culturally and linguistically appropriate manner
- Access to care is enhanced with open scheduling and the use of new technological methods of communication
- Decision making is guided using evidence-based medicine and clinical decision-support tools
- Shared decision making, between the patient and provider, ensures that patient expectations are met
- Physicians voluntarily accept accountability for improved quality through continuous performance measurement and improvement
- Information technology supports enhanced communication, performance measurement, education, and optimal patient care

- Role responsibilities for case managers in PCMH[3]
  - Coordination of care and services
  - Facilitate timely access to care
  - Patient engagement in shared decision making
  - Health education/self-care management
  - Remote monitoring of care and adherence
  - Follow up re: tests, procedures, consults, appointments
  - Facilitation of long-term planning
  - Coordinating care transitions

[3] Adapted from Tahan, Hussein M.. CMSA Core Curriculum for Case Management (Kindle Locations 2952-2953). Wolters Kluwer Health. Kindle Edition.

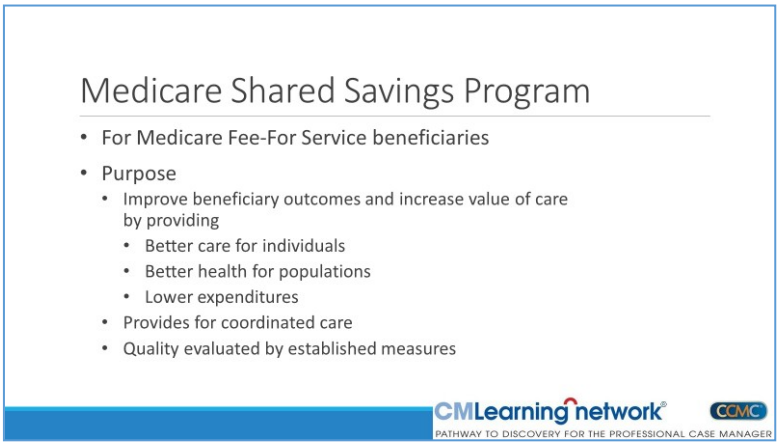


Accountable Care Organization (ACO)

- Came from the ACA under the CMS Center for Innovation
- Main purpose is to improve beneficiary outcomes and increase value of care by providing better care for individuals, better health for populations, and reducing growth in expenditures (Triple Aim)
- These are groups of physicians, hospitals and other health care providers that are expected to provide coordinated, high-quality care
- Participation is voluntary
- The goal is to deliver high quality, coordinated care to Medicare beneficiaries, particularly those with chronic illnesses, so they can access the right care at the right time, avoiding unnecessary duplication of services and preventing medical errors
- The providers are held jointly accountable to deliver care more efficiently, achieve measured quality improvements, and reduce the rate of spending growth
- The ACOs are incentivized to achieve these quality measures
- Unlike HMOs, clients are free to select which services they receive and from whom

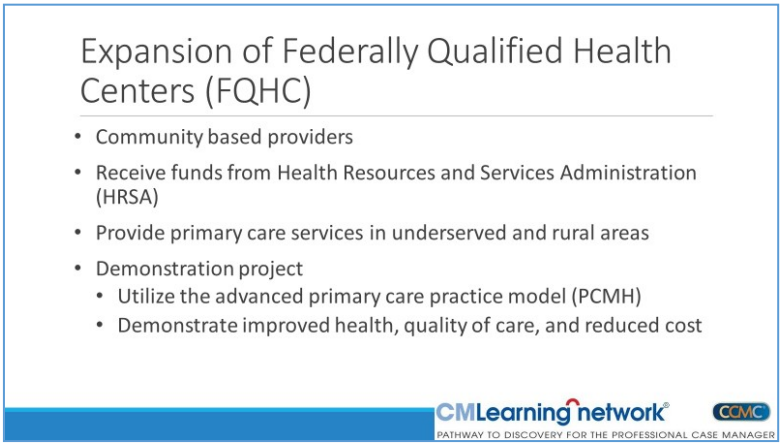
Core components of an ACO:

- They are provider led
- Have a strong base in primary care
- All providers are accountable for quality and cost
- Payments are linked to improvements that reduce cost
- Performance is measured through quality measures.
- There are 33 measures in 4 domains:
  - Client/caregiver experience
  - Care coordination/client safety
  - Preventive health
  - At-risk populations



- A Medicare type of ACO that facilitates coordination and cooperation among providers

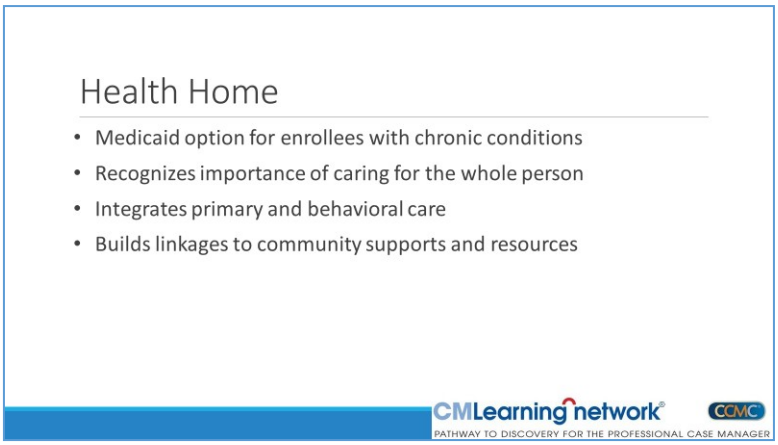
- For **Medicare Fee-For Service beneficiaries** to eliminate fragmented care and obtain coordinated, high quality care
- Purpose is to:
  - Improve beneficiary outcomes and increase the value of care by providing
    - Better care for individuals
    - Better health for populations
    - Lower expenditures
  - Provide for coordinated care
- Like ACOs in structure, as a client-centered organization
- client and provider share in care decisions
- Quality evaluated by established measures
- Organization is incentivized by sharing in savings it achieves for the Medicare program



Expansion of Federally Qualified Health Centers (FQHC)

- Community based providers that receive funds from the Health Resources and Services Administration (HRSA)
- Qualify for special Medicare and Medicaid reimbursement systems
- Originally grant funded as safety net services
- Their main purpose is to provide primary care services in underserved and rural areas
- ACA added a demonstration project designed to evaluate the impact of the advanced primary care practice model (PCMH) on improving health and quality of care and reducing cost of care for Medicare beneficiaries.

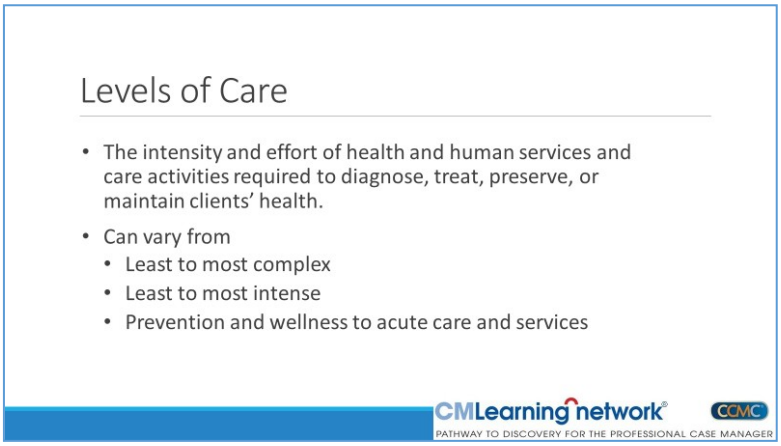
- Participating FQHCs agreed to adopt care coordination standards of NCQA, which directly involves case managers.
- ACA also increased federal funding to the FQHCs to meet the demands of the increased numbers of people who gained healthcare coverage



Health Home

- Medicaid option for service delivery for enrollees with chronic conditions (Medicaid is the only payer)
- Integrates primary and behavioral care by bringing primary care, prevention services, and wellness activities into the behavioral health setting
- Builds linkages to community supports and resources
- Established through ACA to provide care coordination for adults and children with at least two chronic conditions (medical and behavioral); **or** having one chronic condition and being at risk for another; **or** having one serious and persistent mental health condition.
- **Offers coordinated care for individuals with multiple chronic health conditions, including mental health and substance use disorders, recognizing the importance of caring for the whole person**
- Team-based clinical approach that includes the consumer, their providers, and family members when appropriate
- Providers may include primary care practices, community mental health centers, federally qualified health centers (FHQCs), etc.

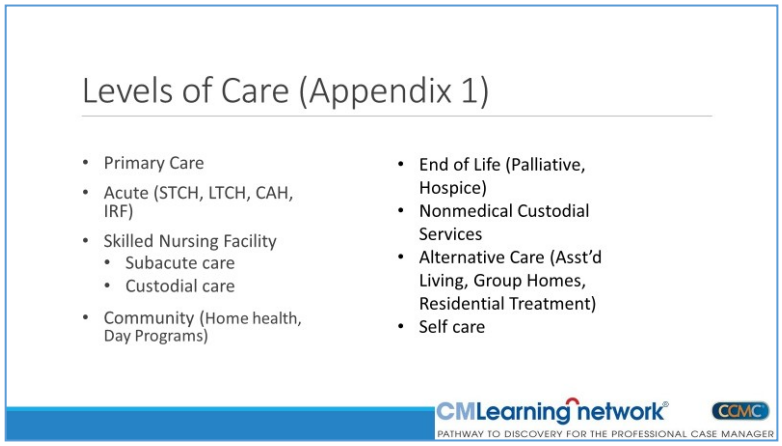
- The aim is to improve quality and reduce costs
- Services provided through the Health Home include:
    - comprehensive care management
    - care coordination and health promotion
    - comprehensive transitional care from inpatient to other settings
    - individual family support
    - referral to community and social support services
    - use of health information technology to link services
- Required services include:
    - each client must have a comprehensive care plan
    - services must be quality-driven, cost effective, culturally appropriate, person- and family-centered, and evidence-based.



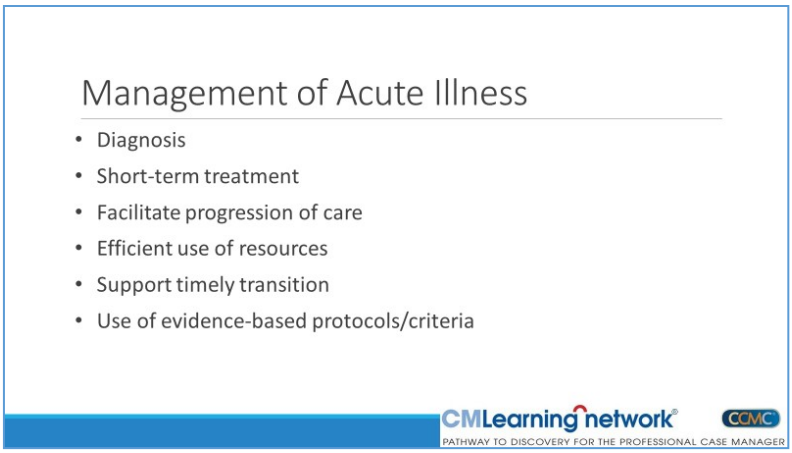
Levels of Care

- The level of care is the intensity of resources and services necessary to diagnose, treat, preserve, or maintain an individual's physical and/or emotional health and functioning.
- The complexity and intensity of case management services are impacted by the context (level) of care setting, client's health condition and needs, reimbursement method (managed care, capitation, bundled, etc.), type of care provider, and intensity of resources and services required to meet the needs.

- Levels will vary across the continuum, moving from the least to the most complex (from prevention and wellness, to nonacute, rehabilitation, subacute, and to acute and up to critical) depending on the resources and services necessary at any moment in time
- The levels include prevention and wellness, nonacute, rehabilitation, subacute, acute and critical



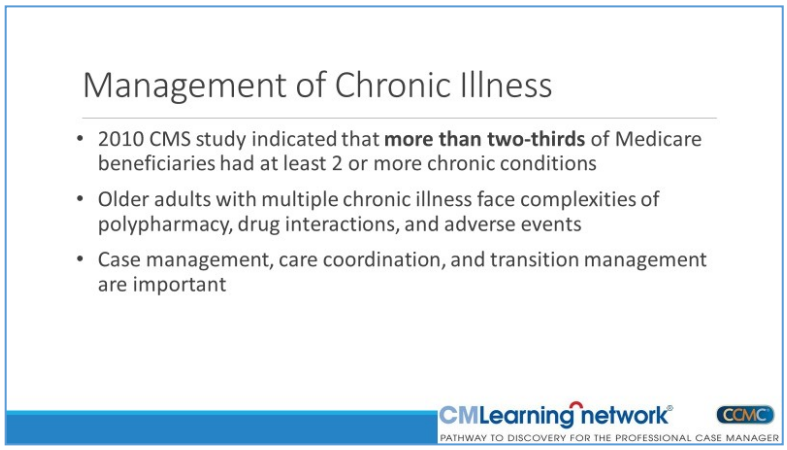
The descriptions for each of these levels of care can be found in Appendix 1 at the end of this domain.



Management of Acute Illness

- Acute illnesses are characterized by rapid onset and short duration
- Diagnosis is a critical piece, without which it is difficult to treat the actual illness

- Short-term treatment should be based on relieving symptoms and the underlying illness when possible
- The case manager is integral in facilitating progression of care, ensuring that the course progress in a logical fashion without unnecessary or unavoidable delays
- Monitoring the efficient use of resources – timely facilitation of tests and procedures, ensuring that the plan includes services related to the illness and eliminating studies that have no bearing on the illness or the plan
- Ensure that your assessment includes not only the current state, but supports timely transition, and considers need for alternative arrangements if the client has alterations to his prior state of functioning
- Use of evidence-based protocols/criteria are a good baseline to support dialogue with the interprofessional team to ensure that the team is working together towards a safe, optimal outcome for the client.



Management of Chronic Illness

- 2010 CMS study indicated that more than two-thirds of Medicare beneficiaries had at least 2 or more chronic conditions – assess for depression and other behavioral health issues
- Older adults with multiple chronic illness face complexities of polypharmacy, drug interactions, and adverse events

- Clients with chronic illness often will receive care from multiple providers in multiple settings increasing the possibility that behavioral health issues may not be recognized or addressed
- Clients with chronic illness can benefit from case management intervention to ensure understanding of the illness, treatment modalities, and importance of adherence to the plan - and this can be especially important for seniors who, as noted above, may have multiple chronic conditions
- Coordination of multiple physician visits and plans can assist clients with chronic conditions to be better able to self-manage
- Assistance as clients with chronic conditions transition out of an acute care episode can mean the difference between a smooth transition and a readmission to the hospital

Management of Disability

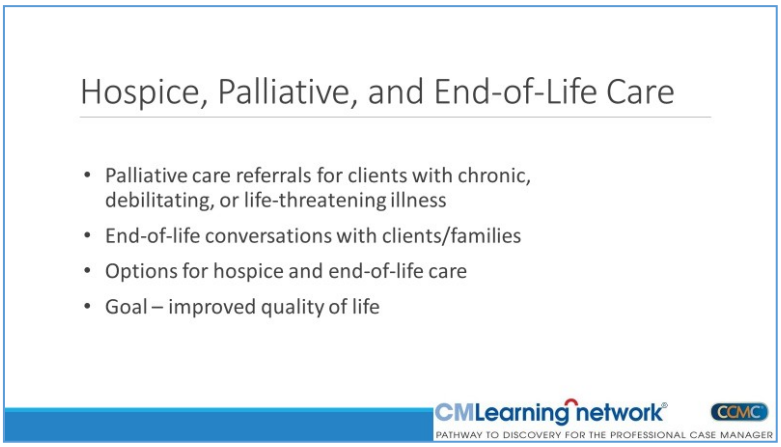
- Disability can be defined as a lack of or inability to function in a certain aspect of daily living
- Primary mission of disability management programs is to reduce financial costs associated with disability in a non-combative environment
- Programs include access to employer provided benefit plans and services – they include:
    - Workers' Compensation
    - Health care services (including 24-hour medical coverage)
    - Sick leave
    - State disability, both short- and long-term
    - Salary continuation, pension, retirement plans

- Union plans
- Medical leaves of absence
- Family leave
- Paid time off (PTO)
- Social security disability

Focus of disability management

- **Employer Based Wellness and Illness Programs**
  - Frequently under the purview of Disability Management or Occupational Health
    - Educational efforts to prevent workplace injury
    - Monitoring of employee health trends
    - Efforts to promote wellness
      - Smoking cessation
      - Weight loss
      - Exercise programs
      - Stress reduction
    - Employee assistance programs
    - Occupational health and safety programs
  - Support for disability that is not job-related
    - Help manage the psychological issues that can accompany a disability
      - Critical to assess for behavioral health issues
  - Support for recovery
    - Sick or extended leave for job-related injury or illness
    - Short- and long-term disability benefits
    - Workers' Compensation
    - Case management, return-to-work, disability management programs
  - Reasonable accommodation
    - Duty to accommodate individuals with disabilities
    - Use of assistive technologies or devices
    - Job modifications and modified or transitional work programs
    - Adherence to laws and regulations

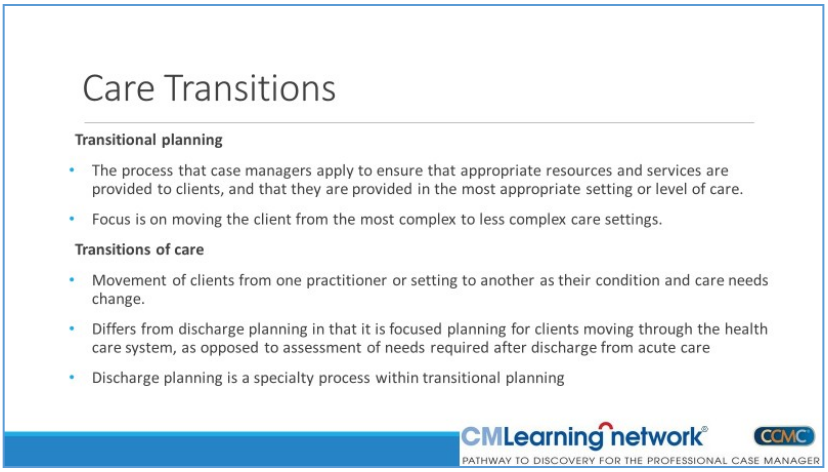
- Facilitation of services
- Reduce costs associated with disability



Hospice, Palliative, and End-of-Life Care

- Attention has increased since enactment of ACA
- Studies consistently demonstrate that individuals desire to die peacefully, with dignity and free from physical symptoms, and they do not want to die alone
- There is an increased understanding of symptom control (pain management, comfort care), advanced care planning, preferences, quality of life
- A barrier to obtaining these services is the lack of understanding about the benefits for hospice and palliative care, and the misperception that these services are only for individuals with limited days or weeks to live
- Timely palliative care referrals for clients with chronic, debilitating, or life-threatening illness, as well as timely referral to hospice result in beneficial effects on symptoms, cost, greater likelihood of dying at home, and a higher level of client and family satisfaction
- A good death is one that is free from avoidable distress and suffering and in accordance with the individual's and support system's wishes and is culturally appropriate
- End-of-life conversations with clients/families should be facilitated by the case manager to ensure that the individual's wishes are known and can be honored when the time is right (The Conversation Project toolkit can be downloaded here: https://www.caremanagementtools.com/conversation-project)

- Options for palliative, hospice and end-of-life care – can be provided in the following settings:
    - Client's home
    - Freestanding hospice center
    - Hospital
    - Skilled care facilities and nursing homes
    - Long-term care facilities
    - Ambulatory care clinics
    - Residential facilities
- Goal – improved quality of life – unfortunately, individuals who could benefit from either palliative or hospice care often do not receive it, or receive it too late to have a positive impact on outcome, including the client experience (late referrals)
- Palliative care can be delivered while the individual is still receiving life-prolonging measures
- Palliative care aims to relive suffering and improve quality of life for individuals with advanced illness and is offered simultaneously with other appropriate medical treatment
- Hospice care provide comprehensive and compassionate care for persons with a terminal illness and limited life expectancy (generally 6 months or less) – must include assessment and services to address psychological and behavioral health issues
- Hospice benefits are designed to cover the individual's needs, including physician services, medications, durable medical equipment, nursing services, home health aides, social services, and spiritual care
- Case managers can be instrumental in communication and earlier referral to palliative care and hospice programs



Care Transitions

- Care transitions involve the movement of individuals from one health care setting or practitioner to another
- Occurs as the individual's condition and care needs change
- Occurs at multiple care settings (emergency room to inpatient admission, critical care to regular unit, acute care discharge to home or next level of care, primary care provider to specialist, etc.)
- Includes all services necessary to facilitate coordination and continuity of care as individual moves between settings or providers

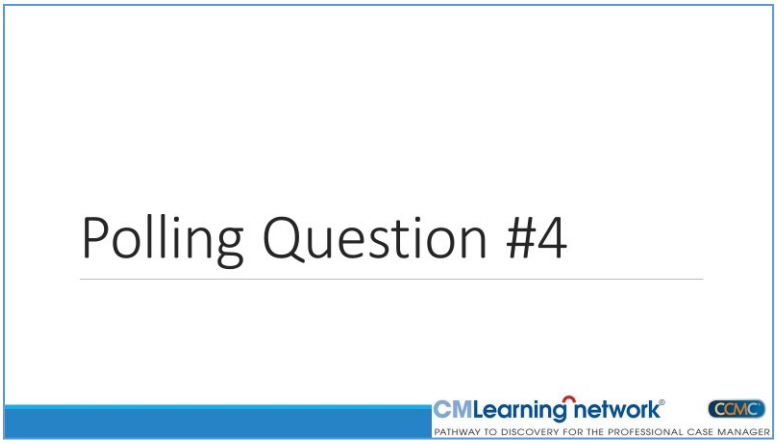
Transitional planning

- The process that case managers apply to ensure that appropriate resources and services are provided to clients, and that they are provided in the most appropriate setting or level of care.
- Focus is on moving the client from the most complex to less complex care settings.
- Important to include considerations beyond just the next level of care as relates to holistic planning for all client needs.

Transitions of care

- Differs from discharge planning in that it is focused planning for clients moving through the health care system, as opposed to assessment of needs required after discharge from acute care

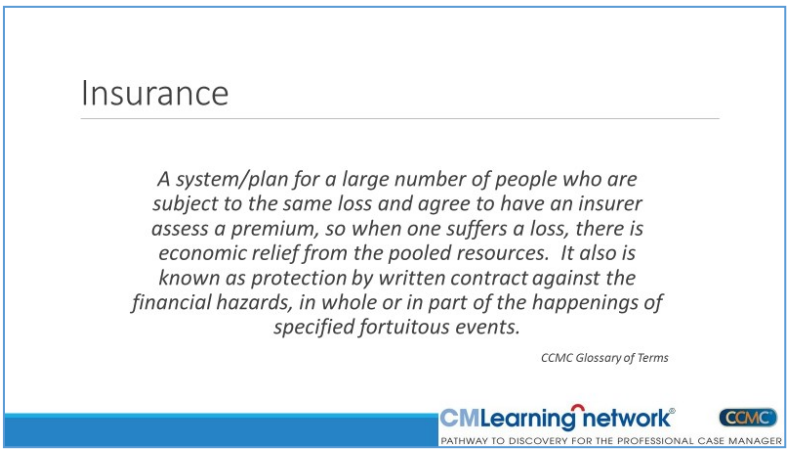
- Discharge planning is a specialty process within transitional planning and should be comprehensive – not just basic discharge instructions.



Groups of physicians, hospitals and other health care providers that are expected to provide coordinated, high-quality care are known as:

a. **Patient Centered Medical Home**
b. **Accountable Care Organization**
c. **Federally Qualified Health Center**
d. **Health Home**

Reimbursement & Payment Methodologies



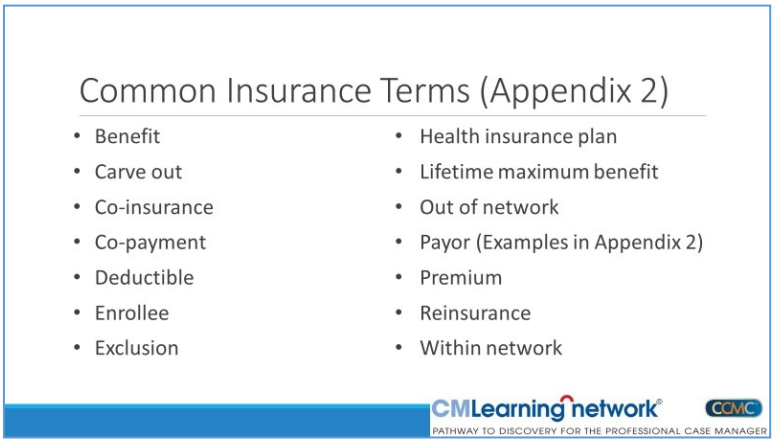
Insurance

A system/plan for a large number of people who are subject to the same loss and agree to have an insurer assess a premium, so when one suffers a loss, there is economic relief from the pooled resources. It also is known as protection by written contract against the financial hazards, in whole or in part of the happenings of specified fortuitous events.

CCMC Glossary of Terms

Types of Insurance

- Health
- Automobile
- Life
- Disability
- Homeowners/Renters
- Long-term care



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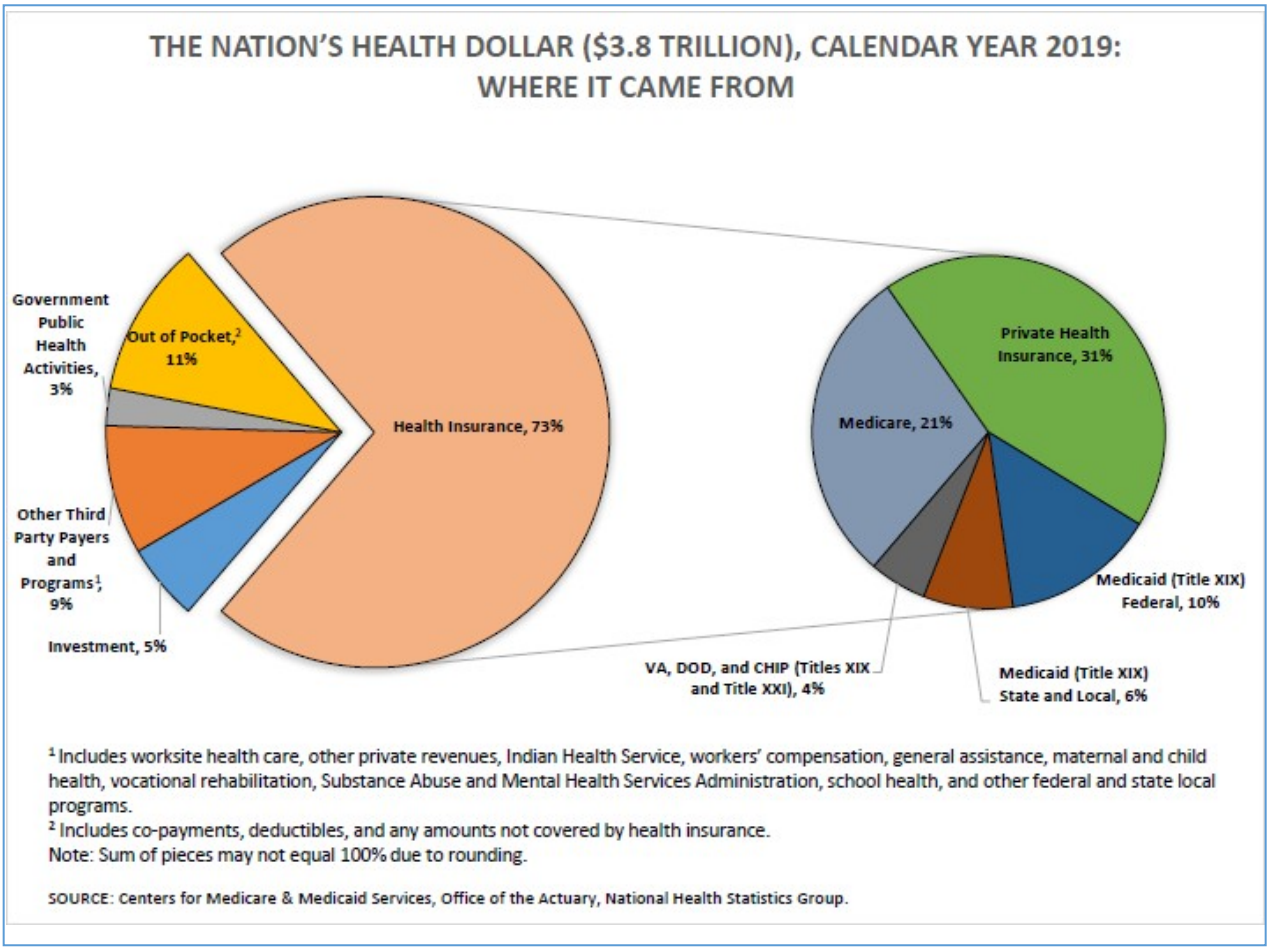
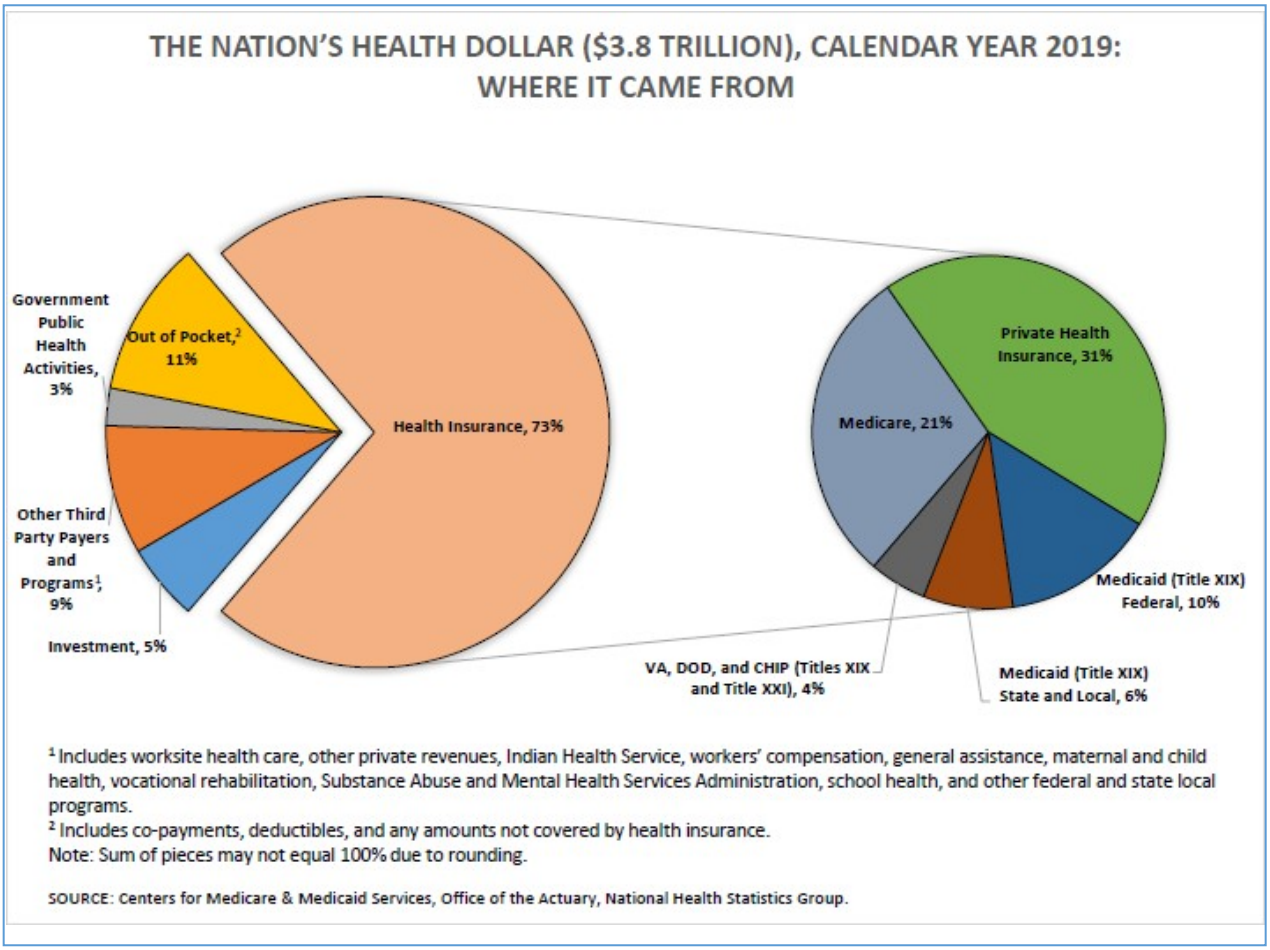
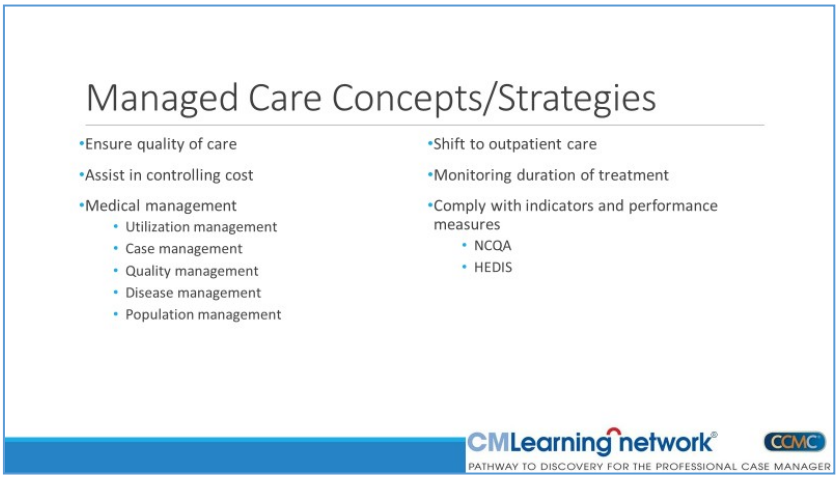


In 2019, 3.8 trillion dollars was spent on healthcare. It is not surprising that 73% of our healthcare dollar was spent on health insurance, the largest component being for private insurance.



It should also come as no surprise that the largest healthcare expenditure was for acute care. More than half of every dollar was spent between hospital and physician care.



Managed Care Concepts/Strategies

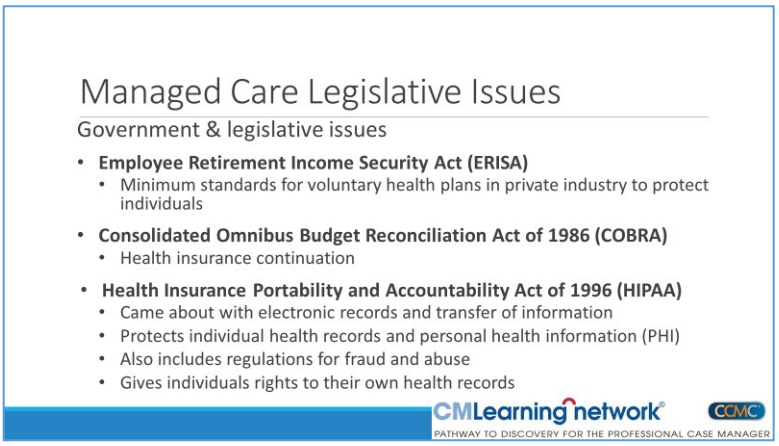
- Strategies used to ensure quality of care or assist in controlling cost
  - Medical management

- Utilization management
    - Compliance with procedures and practices written into the contractual agreements between health plans and providers (precertification, authorization, level of care, denial and appeal processes)
    - Medical necessity determinations for admission and treatment
    - Reimbursement methods (per diem, case rate)
- Case management
    - System of healthcare delivery that aims to provide a generalized structure and focus when managing the use, access, cost, quality, and effectiveness of healthcare services
- Quality management
    - Quality metrics impacting reimbursement
    - Section 1886(o) of the Social Security Act established Value-Based Purchasing (VBP). Organizations and providers can either receive incentives or penalties for meeting or not meeting quality metrics
    - Example – Quality domains are safety, clinical care, efficiency and cost reduction, and client and caregiver-centered experience of care/care coordination
    - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf
    - Example - ACA (2010) established the Hospital Readmission Reduction Program (HRRP) – hospitals can lose up to 3% of total Medicare reimbursement for the year if their readmissions for specific conditions exceed what is considered acceptable. Quality is a major component of this.

  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4439931/pdf/nihms682650.pdf
- Disease management
    - Health promotion and illness prevention strategies (client education, risk reduction programs, etc.)

        - Disease management is a system of coordinated health care interventions and communications for populations with conditions in which client self-care efforts are significant (DMAA, 2006)
    - Population health management
        - Defined by NCQA as "…a model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions. The goal is to maintain or improve physical and psychosocial well-being and address health disparities through cost-effective, tailored health solutions (definition adapted from the Population Health Alliance)"
        - https://www.ncqa.org/programs/health-plans/disease-management-dm/
- Shift to outpatient care
    - Decrease hospital bed days by shifting from inpatient to observation
    - Decisions regarding best care setting based on clinical condition and treatment options
- Monitoring duration of treatment
    - Length of stay
    - Lifetime maximum
    - Episode-of-care maximum payment
- Comply with indicators and performance measures (Domain 3)
    - NCQA
        - Focus on quality of systems, processes and service a managed care or health plan delivers to its enrolled
- HEDIS (Healthcare Effectiveness Data and Information set)

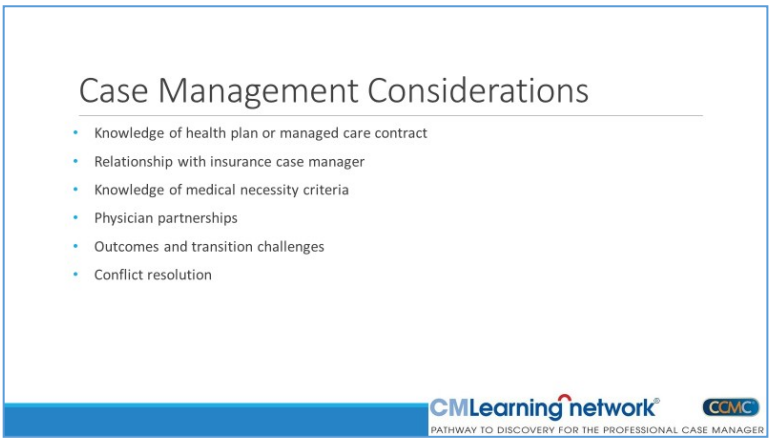
https://www.ncqa.org/hedis/



Managed Care Issues

Government & legislative issues

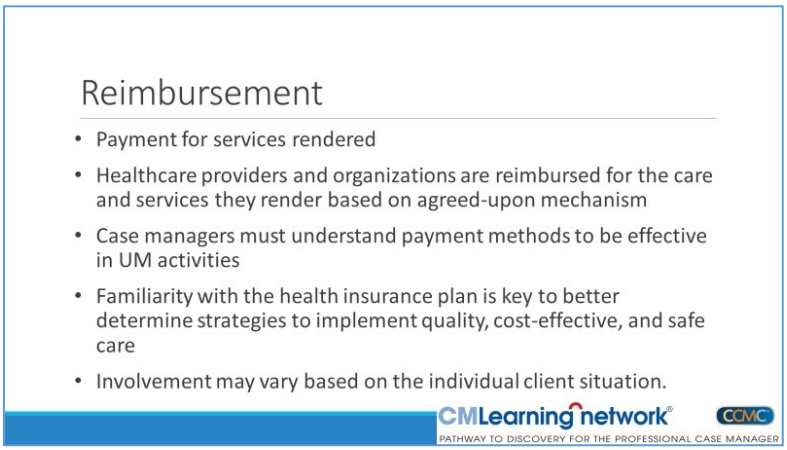
- **Employee Retirement Income Security Act (ERISA)**
  - ERISA sets uniform minimum standards to ensure that employee benefit plans are established or maintained in a fair and financially sound manner. In addition, employers have an obligation to provide promised benefits and satisfy ERISA's requirements for managing and administering private retirement and welfare plans.
  - Applies to voluntary health plans (benefit plans) in private industry, specifically for self-insured employer groups
- **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**
  - Requires certain employers to allow qualified employees, spouses, and dependents to continue health insurance coverage when it would otherwise stop (upon leaving employment, death of employee)
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
  - Came about with electronic records and transfer of information
  - Protects individual health records and personal health information (PHI)
  - Limits release of information to minimum reasonable needed for the disclosure
  - Also includes regulations for fraud and abuse
  - Gives individuals rights to their own health records



Case Management Considerations

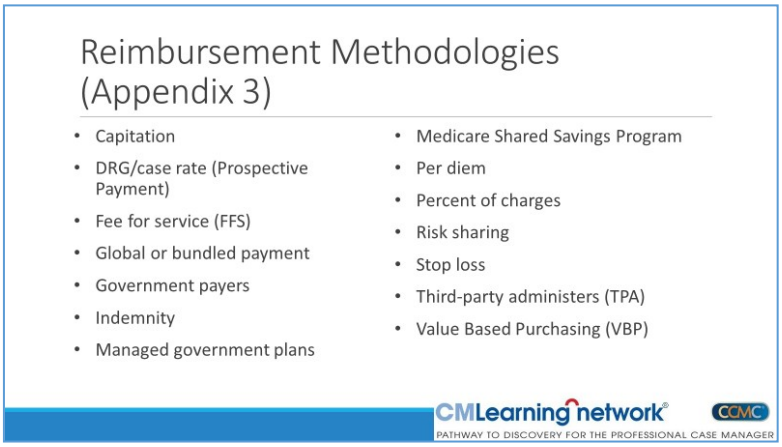
- Case managers must have knowledge of health plan or managed care contract, including:
  - the payer contact information
  - reimbursement methods (per diem, case rate, etc.)
  - utilization review and management requirements (including medical necessity criteria used by the plan)
  - approved post-acute providers
  - denial and appeal processes and procedures
- Relationship with insurance case manager
  - Be aware of the role complexity of the insurance case manager, particularly when looking for nontraditional use of funds
  - Advocate when client needs may not be part of the benefit structure
  - Understand that they are regulated by others in the approval process
  - Know contractual and legislative timeframes for decision making
  - Communication is key!!! Make them an ally, not a foe
- Knowledge of medical necessity criteria
  - Be aware of the utilization review/management criteria used
  - Understand benefits of specific plan
  - Develop effective plan of care and broker for appropriate services as needed and across the continuum
  - Ensure optimal use of benefits
  - Coordinate care and services to include client, families, and care providers

- Physician partnerships
  - Function effectively as a leader or facilitator
  - Work closely with physicians to establish appropriate, timely plans of care
  - Collaborate to address denials
  - Educate physicians about the plan and their utilization management procedures
- Outcomes and transition challenges
  - Understand impact of underinsurance, or un-insurance, on care delivery, access to services, and outcomes
  - Identify psychosocial and financial barrier that will impact care and outcomes
  - Understand reasons for non-adherence behaviors and address them to prevent undesired outcomes
  - Be sensitive to cultural or religious factors that may impact behavior and care positively or negatively
- Conflict resolution
  - Coordinate care activities when client choice is at odds with clinical recommendations
  - Use case conferences to resolve conflicts between clients/families and treatment team regarding treatment options
  - Assume role of advocate when needed
  - Seek counsel of third party (client representative, etc.) if unable to resolve conflict
  - Use ethics consult when necessary
  - Participate actively in multidisciplinary rounds

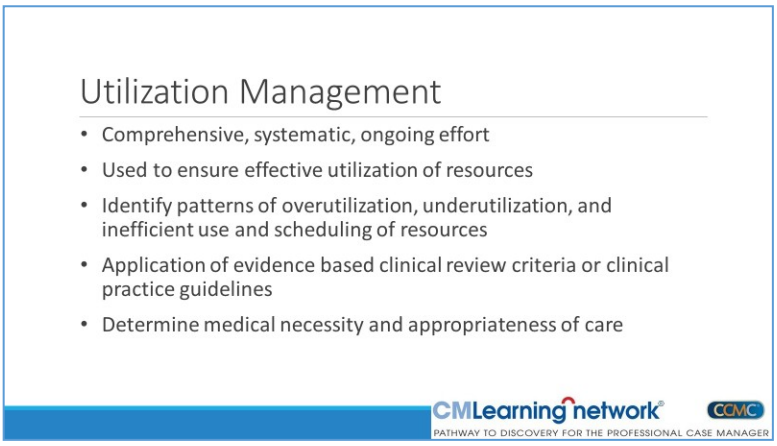


Reimbursement

- Payment for services rendered to a client/support system
- Healthcare providers and organizations are reimbursed for the care and services they render based on an agreed-upon mechanism such as:
    - A prospective payment method for Medicare and Medicaid benefit programs
    - Negotiated rates for nongovernmental payors (commercial insurers)
- Case managers must understand payment methods to be effective in UM activities
- To maximize reimbursement and reduce denials and appeals, you must be familiar with the health insurance plan of the client to better determine strategies to implement quality, cost-effective, and safe care
- The extent of your involvement with healthcare reimbursement activities may vary based on the individual client situation.



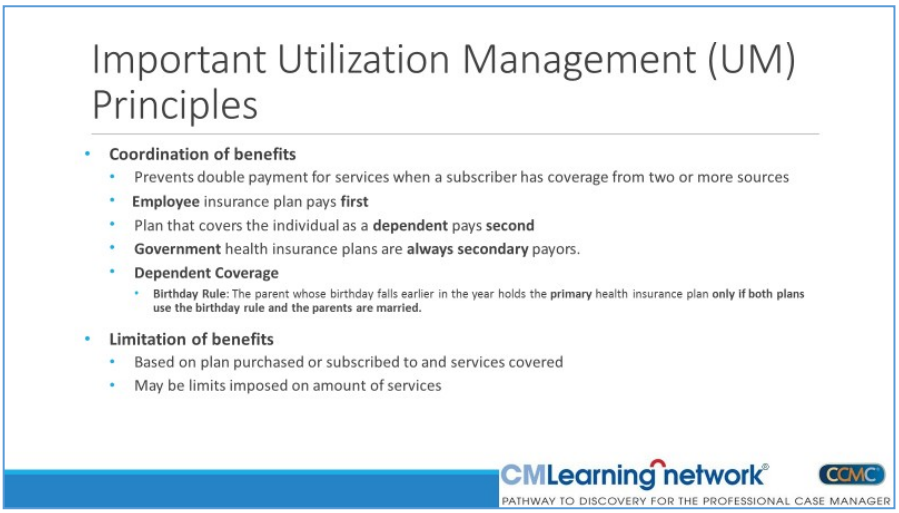
The descriptions for each of these levels of care can be found in Appendix 3 at the end of this domain.



Utilization Management

- **Comprehensive**, systematic, ongoing effort
- Used to **ensure effective utilization of resources** – maintain individual at most appropriate level of care and ensure proper reimbursement
- Reviews care and services to **ensure medical necessity**, are provided in the most appropriate setting, and meet or exceed quality standards
- Identify patterns of **overutilization, underutilization**, and **inefficient use** and scheduling of resources
    - Overutilization – resources or services are used unnecessarily or when medically unnecessary
    - Underutilization – resources that were medically indicated but not utilized
    - Appropriate utilization – resources or services used efficiently based on medical necessity
- Application of clinical review criteria or clinical practice guidelines (MCG, InterQual, etc.)
    - Guidelines provide access to evidence-based best practices and care-planning tools across the continuum of care, supporting clinical decision-making and documentation as well as enabling efficient transitions between care settings. https://www.mcg.com/care-guidelines/care-guidelines/
    - helps support better client outcomes through integrated, streamlined care (McKesson, 2013. InterQual Actionable Evidence-Based Criteria Portfolio Enabling shared, clinical decision support. Accessed September 1, 2020 from: https://www.mckesson.com/documents/health-plans/interqual-criteria/

- Data analysis can provide insight into critical benchmarks such as length of stay, re-admissions, and skilled nursing facility/inpatient rehabilitation admission rates. https://www.mcg.com/care-guidelines/care-guidelines/
    - Cost of providing care and services
    - Improvement made in care and services based on identified gaps in the delivery system
- UM **focus areas**
    - Clinical care – review for medical necessity; client at appropriate level of care; monitor over- and/or underutilization; prevent fragmentation or duplication; avoid potential for medical errors
    - Reimbursement – communicate with third-party payers to obtain authorizations or follow federal statues for medical necessity and discharge planning
    - Denials – process to recognize denials to appeal for reversal
    - Transitions of care – movement to most appropriate level of care; ensure safe transitions; obtain authorization for proposed level of care/services
    - Evaluation – monitor medical necessity, level of care, denials, appeals; report on metrics (denial rate, overturn rate, inappropriate admissions, unscheduled readmissions)
- **Reviews**
    - Prospective – Those conducted prior to the delivery of the services requested. Prospective reviews may be for inpatient or outpatient services.
    - Concurrent - Those performed while patient is still hospitalized, and services are being provided. Concurrent review also occurs with additional physical medicine.
    - **Retrospective** - Those performed after the requested service or procedure has already occurred and the worker has been discharged. Retrospective reviews may be inpatient or outpatient



Important Utilization Management (UM) Principles

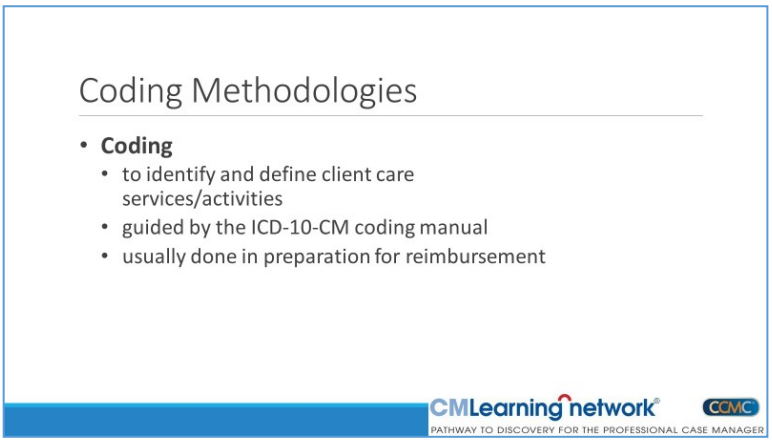
- **Coordination of benefits**
  - Coordination of benefits (COB) is used when a client has more than one health insurance plan and you must coordinate coverage for services among the plans.
  - Prevents double payment for services when a subscriber has coverage from two or more sources
  - First, you determine which plan is primary and then begin to coordinate the benefits with the secondary plan.
  - Employee insurance plan pays first
  - Plan that covers the individual as a dependent pays second
  - Government health insurance plans (i.e. Medicare, Medicaid) are always secondary payors.
  - Dependent **Coverage**
    - **Birthday Rule**: The parent whose birthday falls earlier in the year holds the **primary** health insurance plan **only if both plans use the birthday rule and the parents are married.**
- **Limitation of benefits**
  - A health insurance plan that an individual purchases or subscribes to contains a list of benefits the payor provides for the subscriber. Some of these benefits may limit what is covered in the plan. Fewer limitations typically mean higher

premiums and vice versa. The insured is only able to choose from the benefits the payor offers.

- Limitation of benefits may specify the number of days allowed, such as behavioral healthcare as an inpatient (level of care). Skilled nursing, home care services, and palliative/hospice care services may also have a limited number of days or type of service (i.e., type of provider involved, such as home health aide, registered nurse, occupational therapist) permitted under the plan. Based on plan purchased or subscribed to and services covered
- Limits may be imposed on the number of sessions/care episodes or a client's response to a service (i.e., outcomes of care).
- Limitation **of Benefits Examples:**
    - Number of episodes
        - A maximum of 10 psychosocial counseling sessions per year using a licensed counselor
        - 6 home care visits (visiting nurse service) allowed after an acute hospital stay
        - 30 days of inpatient hospitalization per year for a behavioral health condition
    - Response of client/support system
        - Payment for physical therapy sessions stops when the client fails to improve
    - Medication-based
        - Payment covered only for generic medications in a specific medication class

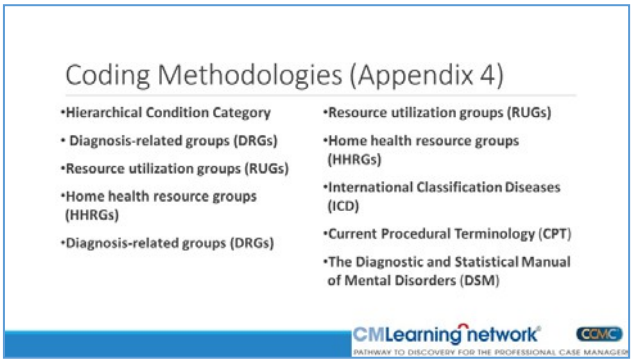
Cost Containment Principles

- Necessary to curtail spiraling costs of healthcare
- Applied across all practice settings
- Reduce over- or underutilization of services
- Ensuring hospital days are appropriate
    - Assigning appropriate level of care
    - Evidence-based practice protocols
    - Prevent care delays
- Compliance with contractual agreement
- Use of case management, health promotion and illness prevention strategies
- Preventing care delays
    - Services or interventions not provided in a timely and efficient manner
    - Responsibility can be assigned based on impact on length of stay, outcomes, cost, appropriateness of service, use of resources
- Use of formularies
    - Limiting the drugs that can be prescribed
    - helps to reduce cost by using generics or possibly allowing high-cost brand name drugs with review and approval



Coding Methodologies

- **Coding**
  - mechanism to identify and define client care services/activities as primary and secondary diagnoses and procedures
  - guided by the ICD-10-CM coding manual, which lists the various codes and their respective descriptions.
  - usually done in preparation for reimbursement for services provided.

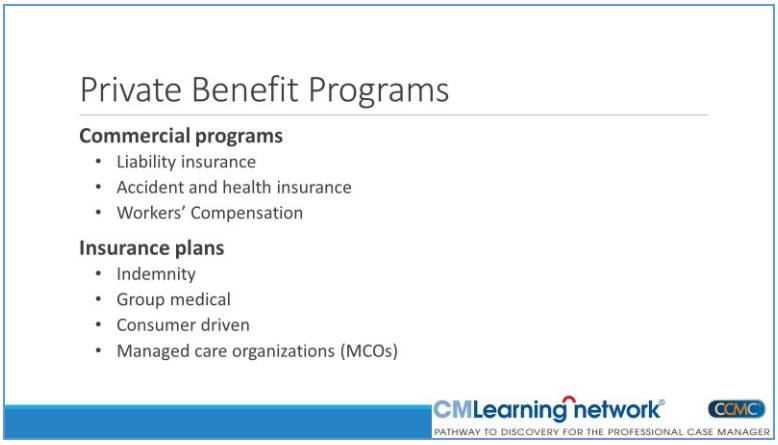


The descriptions for each of these levels of care can be found in Appendix 4 at the end of this domain.

Financial Resources

- Health insurance plans vary in
  - Benefits offered
  - Premiums charged
  - Procedures for accessing care
  - Amount of reimbursement
  - Sources – can be governmental and nongovernmental and support health insurance
  - Payor – typically health insurance plan. Plan reimburses healthcare providers and agencies for services rendered during an episode of care or an encounter with at healthcare professional. **(See Table 1 at end of Domain 1)**
    - Government benefit programs
      - Medicare
      - Medicaid
      - Military
      - VA
    - Nongovernment benefit programs
      - Auto insurance
      - Workers' compensation
      - Liability insurance
    - Commercial insurance programs
      - Group medical insurance
      - Consumer-driven programs

        - Managed care plans (HMOs, PPOs, EPOs)
    - Self-pay
        - Individual assumes responsibility for expenses incurred
- Funding sources or funding systems
    - Charity care
        - Not-for-profit organizations with a charitable mission that assume responsibility for expenses
    - Private organizations
        - For-profit organizations or private employers that pay for care, not through health insurance plans



Private Benefit Programs

Commercial programs

- **Liability insurance** – benefits paid for bodily injury, property damage, or both
- **Workers' compensation** – plan that provides medical benefits and lost wages for persons who have an illness or injury caused by or occurring because of work. Focus on return to work. Heavy use of case management.
- **Accident and health insurance** – includes payment for health-related costs. May have maximum limitations and may include long- or short-term disability for salary replacement.

Insurance plans

- **Indemnity** – security against possible loss or damages. Covered loss reimbursement paid in predetermined amount. In health insurance, these plans are also known as "fee for service" plans. Gives greatest amount of flexibility and freedom. Can be more costly.
- **Group medical** – health care coverage for select group of people. One of major benefits offered by employers. May be choices of coverage plans, optional coverages that can be purchased (short- or long-term, vision, dental).
- **Consumer driven** – allow members to use health savings accounts (HSAs), or health reimbursement accounts (HRAs) to pay routine expenses directly. Usually in conjunction with a high-deductible health plan (HDPD) that protects from catastrophic expenses. HSAs and HRAs can be self-funded, pretax, or tax benefit.
- **Diagnosis-specific benefits** – additional funding by regulatory agencies (state, federal, local), cover specific diagnoses (end-stage renal disease, cystic fibrosis, crippled children, Easter Seals, etc.).
- **Managed care organizations (MCOs)** – generic term for plans that are not HMOs but manage the care received by the members. Maintain quality and cost-effectiveness with focus on delivery and payment of services. Goal is to deliver value with access to quality, cost-effective care.

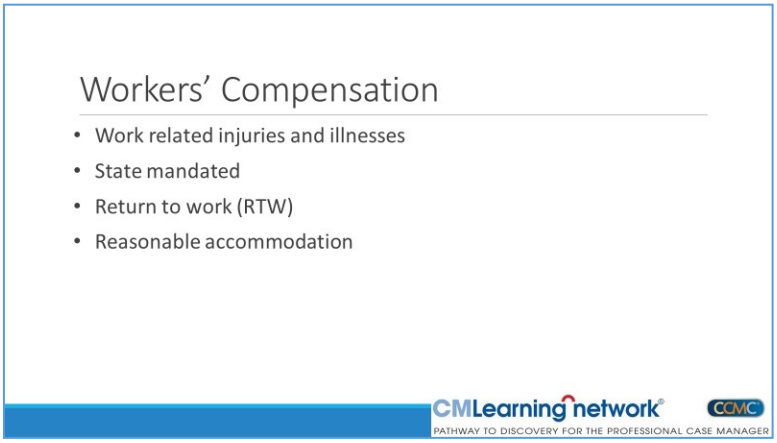
Public Benefit Programs

Government programs

- **Medicare**
    - Created in 1966, Title 18 of the Social Security Act as Health Insurance for the Aged and Disabled
    - Intended to finance medical care for persons age 65 and older or the disabled who are entitled to social security benefits
    - Overseen by CMS
    - Mandates hospital services through the conditions of participation (COPs) for hospitals
    - Traditional Medicare
    - Part A covers hospital, skilled nursing care, nursing home (with skilled need), hospice, home health care
    - Part B covers physician, outpatient, ambulance, clinical research, and mental health services
    - Part D covers prescription drugs
- **Medicare Advantage**
    - Created by the Balanced Budget Act of 1997
    - Option for Medicare enrollees
    - Provided by private insurance plans
    - Provides many services normally received under traditional Medicare with additional benefits
    - Managed care plans, networks are based on plan contracts and may be narrow
- **Secondary Medicare Insurance**
    - For Medicare beneficiaries who do not participate in Medicare Advantage Plan
    - Covers co-pays and other financial responsibilities not covered by traditional Medicare
- **Medicaid**
    - Created in 1996, Title 19 of the Social Security Act
    - Finances health care of indigent and other special designated groups

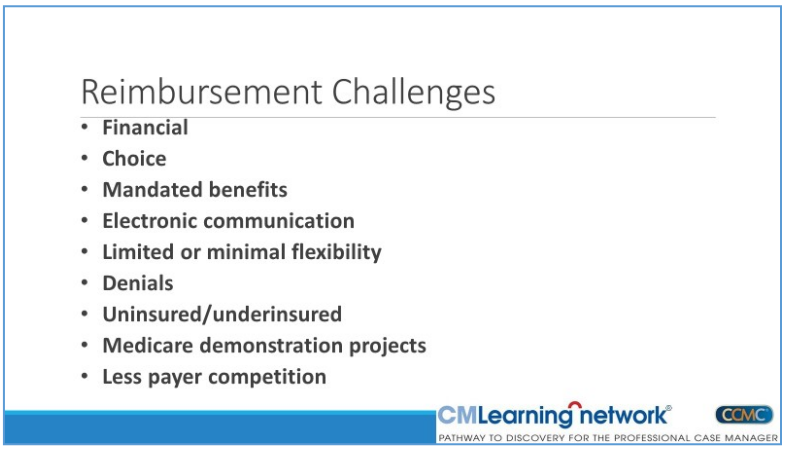
- Financed jointly by federal and state governments
- Eligibility criteria vary from state to state
- Based on income, assets, and dependents

- **Managed Medicaid**
  - Like Managed Medicare for Medicaid recipients
  - Focus on cost containment, improved access, and quality of care
  - Provides many healthcare services a Medicaid recipient would normally receive on a prepaid capitated basis
  - May have narrow networks
- **Tricare**
  - Military benefit of US Department of Defense Military Health System
  - Provides healthcare benefits and coverage to:
    - Active duty personnel
    - National Guard and Reserve members
    - Military retirees, their families, survivors, and certain former spouses of military personnel
  - Affords civilian health benefits military personnel and their dependents
  - Plan offers medical, dental, and special coverage by uniting the healthcare resources of the military with civilian networks of healthcare providers, hospitals and other facilities, pharmacies, and medical suppliers
  - Provides access to high quality healthcare



Workers' Compensation

- Work related injuries and illnesses
- State mandated and administered social insurance program
- Financed by mandatory employer contributions through private or state-sponsored insurance, or by self-insuring
- Designed to pay expenses of employees who are harmed, killed or become sick with a work-related illness while performing job-related duties
- Covers lost wages, medical expenses, disability payments, and costs associated with medical care, rehabilitation, and retraining
- There are persons excluded from workers' compensation (business owners, casual workers, domestic employees in private homes, independent contractors, etc.)
- Return to work (RTW)
- Reasonable accommodation



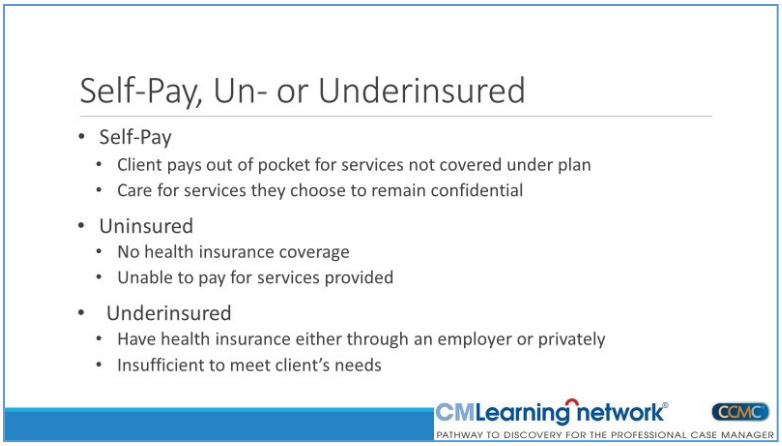
Reimbursement challenges

- **Financial** – financial incentives may compromise quality
- **Choice** – limitations unless paying out-of-pocket or PPO
- **Mandated benefits** – by state regulations
- **Electronic communication** – mandated by ACA; cost to small providers may not be cost effective

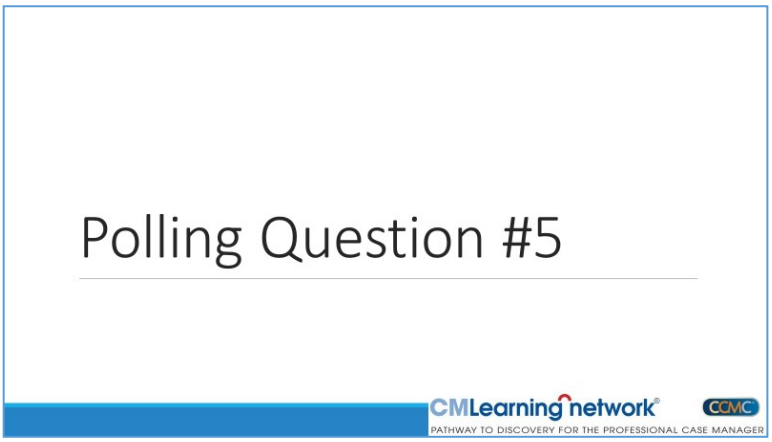
- **Limited or minimal flexibility** – particularly for nontraditional treatments, uncovered benefits, post-acute levels of care
- **Denials** – focus on administrative/technical rather than payment for services provided
- Uninsured**/underinsured** – limited or no payer source
- **Medicare** demonstration **projects** – VBP or global funding creating new reimbursement methods
- **Less** payer **competition** – reduction of the number of payers in the marketplace limiting consumer choice

- **Clients in these three groups are often your greatest challenge. Finding community, local, state, and federal resources to provide care and services to those with the greatest needs is a hallmark of case management.**
  - **Uncompensated care** occurs when a client/support system receives care, does not pay for the services, and the provider does not receive reimbursement. Uncompensated care falls into two categories: charity care and bad debt.
    - **Charity care** is free full or partial care provided to clients who cannot afford to pay for needed healthcare services.
    - **Bad debt** results from clients unwilling to pay for services, which can include co-payments, deductibles, or all charges. It also includes clients who cannot pay for

healthcare services and do not apply for financial assistance or are ineligible for it.



- **Self-pay**
  - Client pays out of pocket for services not covered under plan
  - Client does not have dental insurance, pays in full at the time of service
  - Care for services they choose to remain confidential
- **Uninsured**
  - No health insurance coverage
  - Unable to pay for services provided
- **Underinsured**
  - Typically employed individuals but employer provides only minimal coverage
  - Have health insurance either through an employer or privately
  - Coverage insufficient to meet client's needs



Utilization management includes the review of care and services to ensure medical necessity and to identify patterns of

a. **Abuse, malingering and non-compliance**
b. **Adherence, readmission and LOS**
c. **Overutilization, underutilization and inefficient use of resources**
d. **Scheduling ED visits and billing**

APPENDICES DOMAIN 1

Appendix 1

- **Primary Care**
  - Primary care is the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it. It is how the two main goals of a health services system, optimization and equity of health status, are approached. (from https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html)

Acute

- **Short Term Care Hospital (STCH)**
  - defined by the Social Security Act as an organization that is primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care of the injured, disable or sick persons, or rehabilitation services for the same population
  - This includes the general community hospital, academic medical center, children's hospitals, cancer hospitals, behavioral/psychiatric hospitals
  - Average length of stay 4-5 days

- **Long Term Care Hospital (LTCH)**
  - Certified by Medicare as an acute hospital
  - Treat medically complex patients that require long-stay hospital level care
  - Focus on patients who, on average, stay more than 25 days
  - Specialize in the care of patients with more than one serious condition and who may improve over a longer period with intensive care and services, ultimately returning home

- **Critical Access Hospital (CAH)**
  - Designed to reduce financial vulnerability of rural hospitals and improve access to care by keeping essential services in rural communities
  - They are at least 35 miles from any other hospital
  - Have no more than 25 beds
  - Average length of stay is 96 hours for acute care
  - Provide 24 hour, 7-day emergency care
  - Focus on providing care for common conditions and outpatient care, accessing large hospitals for more complex treatment

- **Inpatient (Acute) Rehabilitation**
  - Acute level of care – designated as an acute hospital by Medicare
  - Can be provided in a stand-alone facility or as a distinct part within an acute care hospital
  - Provides coordinated, intensive rehabilitation services
  - Admitted person must be able to tolerate 3 hours of combined rehabilitation services a day
  - 60% of admitted patients required to fall into one of 13 categories
    - Stroke
    - Spinal cord injury
    - Congenital deformity
    - Amputation
    - Major multiple trauma
    - Fracture of the femur (hip)
    - Brain injury
    - Neurological disorders (Multiple Sclerosis, Muscular Dystrophy, Parkinson's)
    - Burns

- Certain arthritis conditions that significantly impair ambulatory function and ADLs without improvement from aggressive and sustained outpatient treatment, but have the potential to improve with intensive rehabilitation

Sub-Acute

- **Skilled Nursing Facility**
  - licensed healthcare residences for individuals who require a higher level of medical care than can be provided in an assisted living facility
  - provide 24-hour, 7 day a week skilled nursing care
  - services that can only be provided under the supervision of skilled and licensed healthcare personnel who are required to manage, observe, and evaluate the skilled care activities
  - commonly used for short-term rehabilitative stays
  - Expectation is that the individual will be able to return to the community

- **Subacute care**
  - Subacute care is a level of care needed by a client who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to most clients in a skilled nursing facility – criteria is 4.5 to 8.0 direct nursing care hours daily
  - Can be for short-term physical rehabilitation, complex medical services (including wound care or intravenous therapy), or long-term chronic care (medically stable but with a relatively high need for nursing or other ancillary services)
  - Less intensive than acute rehabilitation
  - Generally, clients in a subacute facility only receive between one and two hours of therapy per day.
  - The average length of stay at a subacute facility is also generally longer than at an acute hospital

Long term care

- **Long Term Care (Custodial care)**
  - A range of services and support, given safely by unskilled, unlicensed personnel who help meet both the medical and non-medical needs, including ADLs, of people who cannot care for themselves for an extended period
  - Not generally covered by insurance, except for long-term care insurance
  - Residential facilities
    - Provide support and/or custodial care for those unable to live independently
      - May have a mental or physical condition

- **Nursing homes (Non-medical custodial services)**
  - Provide services for those who do not require hospitalization but are unable (for reasons of physical or mental problems) to remain in their home to receive care
  - Provides room, meals, and assistance with ADLs
- **Respite care**
  - temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program to provide rest or time off for the caregiver

Alternative Care Settings

- **Assisted Living Facilities (ALF)**
  - Provide housing for seniors who require minimal assistance with their ADLs
  - Personal care services (meals, housekeeping, transportation, ADL assistance) are provided as needed
  - Person lives on their own in a residential facility paying a monthly rent and fees for services received
  - May be part of a retirement community, nursing home, senior housing complex, or stand-alone
  - Do not provide complex medical services

- Usually like a personal home or apartment
- Paid for with private funds, though some long-term care policies provide for the fees

- **Group Homes**
  - Small, residential facilities that function to care for clients with chronic disabilities
  - Generally, have six or fewer residents
  - Staffed 24 hours with trained personnel
  - Typically, a single-family residence
  - Usually adapted to meet the special needs of the clients, who may have chronic mental or physical disabilities and require assistance or supervision with ADLs
- **Residential treatment facilities**
  - May also be referred to as rehab facilities
  - Serve as live-in situation providing therapies for substance abuse, behavioral issues, or mental illness
  - May be locked (very restrictive) or unlocked (allowing more freedom within the facility)
  - Most have a clinical focus and often utilize behavior modification techniques

Community

- **Adult/Pediatric day services**
  - Provide social engagement as well as caregiver respite services
  - Coordinate and provide non-medical services to assist in maintaining the individual in the least restrictive setting
- **Outpatient care**
  - medical, surgical, or behavioral health care provided in a community or ambulatory setting, not requiring an overnight stay
  - May be operated by a hospital, SNF, or as a free-standing facility
- **Self-care**
  - Capable of providing all ADLs, and other care independently

- **Home health care**
  - Provision of intermittent skilled care, under a plan of care established and reviewed by a physician, to clients in their home
  - May include skilled nursing, PT, OT, speech, and medical social work services
  - To qualify, person must be homebound – unable to leave home or require great effort to leave and be under the care of a physician

End of Life Care

- **Palliative care**
  - Focus is on relieving symptoms related to chronic illness
  - Can be implemented at any stage of a severe or chronic illness
  - Can have ongoing treatment for curative care concurrently
  - Not dependent on prognosis
  - Goal is to maintain quality of life by managing symptoms such as pain, dyspnea, fatigue, nausea, anorexia, depression
  - Team approach to work together to anticipate, prevent and treat suffering
  - May include the use of medication dosages or routes not standard, and
  - medications used off label
- **Hospice Care**
  - End-of-life care for those with a prognosis of six months or less
  - Certification can be renewed indefinitely
  - Focus is to provide palliation of symptoms with a goal of promoting comfort
  - Offers support for both client/support system
  - For managed Medicare members, hospice is provided as a carve-out with Medicare covering the cost of the hospice benefit, and services for unrelated needs paid by the managed care organization
  - Can be provided in the home, an inpatient hospice facility, hospital or SNF that has a contractual arrangement with a hospice provider or program

Appendix 2

Common Insurance Terms

Benefit **-** Amount payable by a health insurance company (payor) to a healthcare provider for a client's care (services rendered). This amount is based on the covered services in the health plan.

Carve out - Services excluded from a healthcare provider's contract. Usually these services are rendered under a different arrangement with other providers. For example, mental health or chemical dependency services are carved out from the agreement of a family practitioner.

Co-insurance – a type of cost sharing in which the insured person pays or shares part of the medical bill. Enrollee pays a percentage, not a fixed amount, of the costs of covered healthcare services and the insurance company pays the rest. The enrollee pays co-insurance only until the agreed upon maximum amount in the plan has been reached. This arrangement assumes shared risk between the enrollee and the insurer. Example: You have already paid the $1,000 out of pocket (from above definition) that is your deductible. If the health insurance plan allows $100 for an office visit, and your co-insurance is 20%, then you pay $20 and insurance pays the balance ($80).

Co-payment – a supplemental cost-sharing arrangement between the member and the insurer in which the member pays a specific charge for a specified service. Copayments may be flat or variable amounts per unit of service and may be for such things as primary care visits, specialist visits, ambulance transportation, emergency department (ED) visits, and prescriptions. The payment is incurred and paid at the time of service. Drug co-payments may further be scaled for formulary, brand name, and generic medications. Example: You have met your $1,000 deductible and the service you have accessed has a copayment (physician office visit) of $15 – you pay the $15 and insurance pays the balance.

Deductible - Fixed amount or percentage an enrollee pays for services before the insurer begins to pay.

Enrollee – an individual who subscribes for a health benefit plan provided by a public or private healthcare insurance organization.

Exclusion – a service or services not covered by the plan.

Health insurance plan – a plan that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance (accident, disability income, medical expense, accidental death and dismemberment).

Lifetime maximum benefit **-** Maximum amount a health insurance plan will pay to an enrollee over their lifetime.

Out of network **-** Healthcare providers (e.g., primary care providers, specialty care providers) who do not have a contract with the plan.

Payor **– (**Also known as *insurer*.) An insurance company responsible for the health insurance benefit plan for an enrollee.

Premium **-** Fixed dollar amount an enrollee pays to the payor, typically monthly.

Reinsurance (Stop loss) **-** Insurance obtained to cover losses incurred while covering claims that exceed a specified dollar threshold.

Within network **-** Healthcare providers (e.g., primary care providers, specialty care providers) who have a contract with the plan.

Appendix 3

Reimbursement Methodologies

Capitation – a fixed amount of money per-member-per-month (PMPM) paid to a provider for covered services rather than for services provided. Typical to HMOs. Payment is the same regardless of how many times the member uses the services.

DRG/case rate (Prospective Payment) – patient classification scheme that provides a means of relating the type of patient a hospital treats to the costs incurred by the hospital. It is based groups of patients using similar resource consumption and length of stay. It classifies inpatient stays into groups for payment purposes and is used by CMS to pay hospitals for Medicare and Medicaid recipients, but can be use by private health plans for contracting purposes

Fee for service (FFS) – providers are paid for each service performed, as opposed to capitation. Fee schedules are an example of fee-for-service.

Global or bundled payment – a predetermined all-inclusive fee for a specific set of related services, treated as a single unit for billing or reimbursement purposes. Combines reimbursement for both facility and professional services into one lump sum payment.

Government payers – Medicare and Medicaid.

Indemnity – security against possible loss or damages. Member pays provider, and then gets reimbursed, based on a predetermined amount, by the company

Managed government plans – payment by a plan that agrees to pay health care benefits for specific populations, such as Medicare or Medicaid. Payer must follow government regulations; at a minimum must provide same services offered under government plans.

Medicare Shared Savings Program – key component of Medicare delivery system reform initiatives included in the ACA. Participation is voluntary in this risk sharing contract with upside and downside risks. The goal is coordinated care. Participating organizations are required to collect and report on quality measures.

Per diem – daily reimbursement rate for all inpatient hospital services provided in one day to one client regardless of actual costs to the healthcare provider.

Percent of charges – Negotiated percentage rate of charges billed that will be reimbursed by the payer.

Risk sharing – process whereby an HMO and contracted provider each accept a partial responsibility for the financial risk and rewards involved in cost-effectively caring for the members enrolled in the plan and assigned to a specific provider.

Stop loss – used to share risk in complex clients. Payment may increase after a specific dollar threshold is met. (Hospital payment converts from DRG to percent of charges once threshold is reached.)

Third-party administers (TPA) – organization outside of the insuring organization that handles only administrative functions (utilization review, claims processing). Used by organizations that fund the health benefits.

Value Based Purchasing (VBP) – payment based on outcomes of specific diseases. Outcomes may include: mortality and morbidity rates; core measures; clinical outcomes; length of stay; cost; readmission and complication rates; satisfaction with care.

Appendix 4

Coding Methodologies

Hierarchical Condition Category (HCC)

- Risk adjusted model originally designed to estimate future health care costs for clients
- Relies on and mapped to clinical coding information (e.g., International Classification of Diseases-Tenth Revision, Clinical Modifications [ICD-10 CM]) and diagnostic groups
- Originally used to identify Medicare high-cost chronic conditions (e.g., diabetes, kidney failure)
- Assigns a risk adjustment factor (RAF) score
- Can use the RAF to predict costs and utilization
- Helps communicate patient complexity and paint a picture of the whole person
- By accounting for difference in patient complexity, quality and cost performance can be more appropriately measured.
- https://www.aafp.org/practice-management/payment/coding/hcc.html

Diagnosis-related groups (DRGs)

- System used to pay for acute inpatient care that is based primarily on a patient's principal diagnosis
- Standardizes prospective payment to hospitals
- Encourages cost containment
- Covers all charges (with some exceptions) for inpatient stay

Resource utilization groups (RUGs)

- System used to pay for care provided in a nursing facility that is based on amount, intensity, and type of resources used, including nursing care and therapies

Home health resource groups (HHRGs)

System used to pay home health agencies for services based on the resources used and the duration of the services

International Classification of Diseases (ICD)

- (**ICD**-10-CM) is a system **used** by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.
- Medical classification list by the World Health Organization (WHO)
- To standardize diagnoses
- Contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases
- Used for coding medical records in preparation for reimbursement

Current Procedural Terminology (CPT)

- A medical code set copyrighted and maintained by the American Medical Association (AMA).
- Like ICD-10, except it identifies services rendered rather than diagnoses
- Used primarily in the outpatient setting for coding and billing
- The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

The Diagnostic and Statistical Manual of Mental Disorders (DSM)

- handbook used by health care professionals
- United States and much of the world as the authoritative guide to the diagnosis of mental disorders. **DSM** contains descriptions, symptoms, and other criteria for diagnosing mental disorders.
- The **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition** (**DSM-5**) is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric

Association (APA). In the United States, the DSM serves as a universal authority for psychiatric diagnoses. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the appearance of a new version has significant practical importance

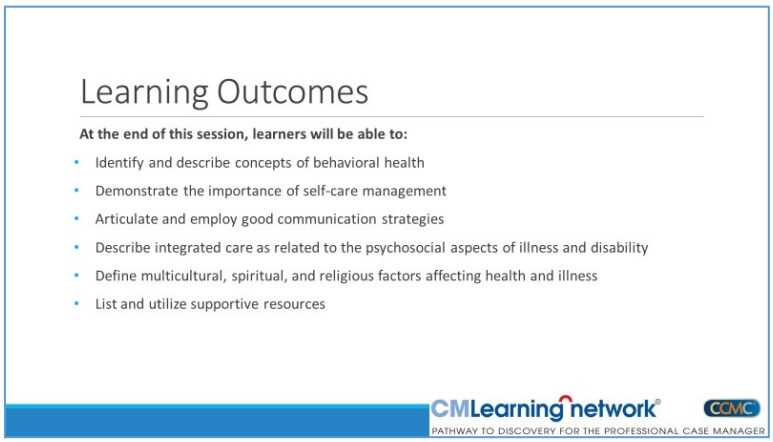
- Descriptive terms and identifying codes to report medical services and procedures performed by providers
- Usually used for billing purposes

Table 1

Examples of Payors

Payor Sources	Government benefit programs	•Medicare •Medicaid •Military coverage •Veterans insurance
	Nongovernment benefit programs/ Commercial insurance programs	•Auto insurance •Workers' compensation •Liability insurance •Group medical insurance •Consumer-driven programs •Managed care plans such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs)
	Self-pay	Client/support system, which assumes responsibility for expenses incurred in the receipt of healthcare services from a provider or agency
Funding Systems	Charity care	Not-for-profit organization with a charitable mission, which assumes responsibility on behalf of a client/support system for expenses incurred for the receipt of healthcare services
	Private Organizations	For-profit organizations or private employers who pay for care especially as fee for service in mechanisms other than a health insurance plan arrangement

Domain 2 - Psychosocial Concepts and Support Systems

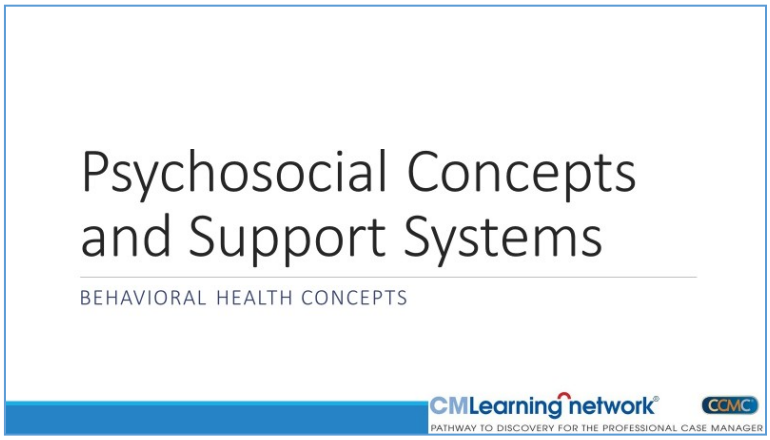


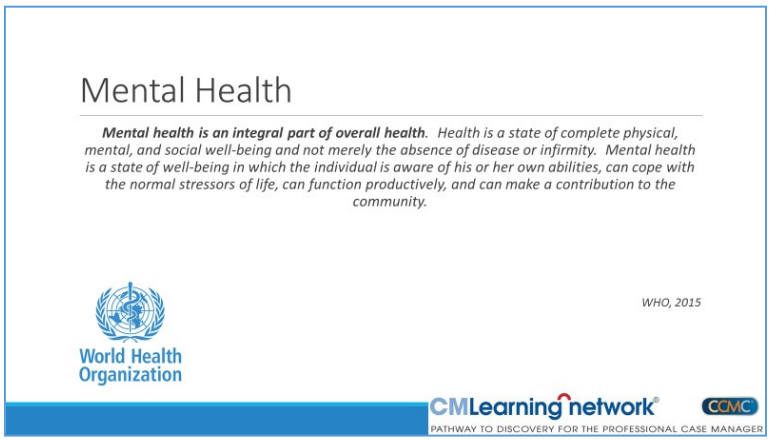
Learning Outcomes

At the end of this session, learners will be able to:

- Identify and describe concepts of behavioral health
- Demonstrate the importance of self-care management
- Articulate and employ good communication strategies
- Describe integrated care as related to the psychosocial aspects of illness and disability
- Define multicultural, spiritual, and religious factors affecting health and illness
- List and utilize supportive resources

Behavioral Health Concepts

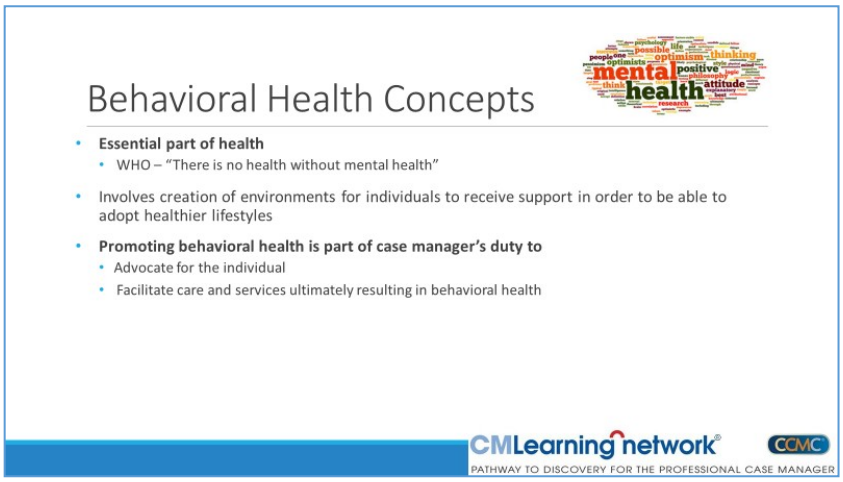




Mental Health

World Health Organization

> ***Mental health is an integral part of overall health***. *Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Mental health is a state of well-being in which the individual is aware of their own abilities, can cope with the normal stressors of life, can function productively, and can make a contribution to the community. (WHO, 2015)*



Behavioral Health Concepts

Essential part of health

- WHO – "There is no health without mental health"
    - Promotion of behavioral health involves the creation of environments for individuals to receive support to be able to adopt healthier lifestyles
- Core functions of case management include assessment, treatment planning, intervention, monitoring, and evaluating. These are essential when working with clients who have severe behavioral health issues.
    - The case manager plays an integral role in the coordination of care, which includes locating and facilitating access to the needed care and services, both for mental/behavioral health issues as well as for medical or social issues.
- **Promoting mental health is part of case manager's duty to:**
    - Advocate for the individual
        - In an integrated case management environment, it is especially important to advocate for the client to be treated holistically for behavioral health issues in whatever setting the client presents.
    - Facilitate care and services that can ultimately result in improved behavioral health for the client

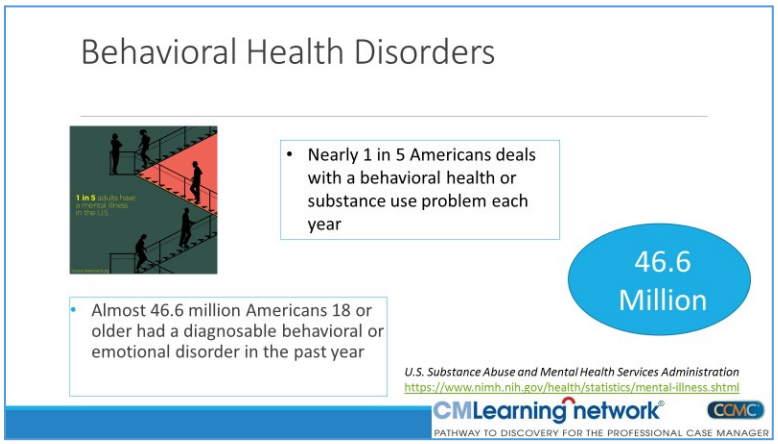
- Coordination of ALL services and supports is also integral to the individual living successfully in the community
    - Provision of enhanced and longitudinal care to a defined population
- We know that may individuals with behavioral health diagnoses often find it difficult and frustrating to find the right agency or provider to obtain necessary treatment -it is part of the role of the case manager to advocate and ensure that the client can find the right agency or provider.
    - The Care Manager facilitates care and ensures adherence
- The WHO developed an action plan that, when implemented, will help persons with behavioral health diagnoses to find it easier to access services
- Aspects of the plan are that the care is delivered by appropriately skilled health workers in **general care settings**, that the treatment will be more responsive to the individual needs, and that the individual will have improved access to government disability benefits, housing, and employment programs
- There are effective strategies for prevention as well as effective treatments and ways to help relieve suffering
- Depression is one of the behavioral health diagnoses that can be prevented - the key is to find mental health care and social services capable of providing necessary treatment and support
- **Serious** behavioral health diagnoses **are further complicated when chronic medical conditions, social issues, and problems with access to care are present**

- Percent of emergency department visits with depression indicated on the medical record: 10.1%
- These complex individuals account for 10% of the population, but can often use more than 70% of health care resources

- **Treatment more often occurs in the general medical sector, with primary care physicians providing 70% of treatment for behavioral health conditions**

- 85% of behavioral health clients are seen by medical doctors, so an integrated approach to their care, addressing both medical and behavioral health-related issues Is important and effective.

Source: National Hospital Ambulatory Medical Care Survey:
2016 Emergency Department Summary Tables, table 13 pdf icon[PDF – 738 KB]



Behavioral Health Disorders

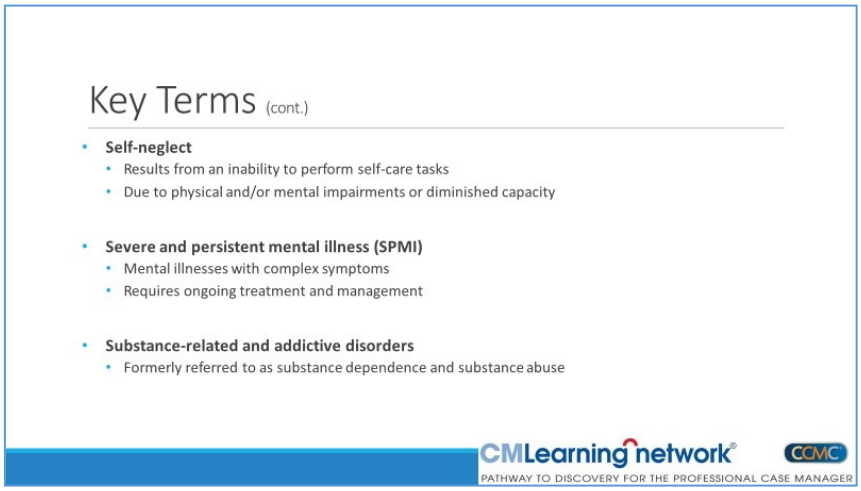
- **Data released in July 2017 by SAMHSA (US Substance Abuse and Mental Health Services Administration) indicated that nearly one in five Americans has a behavioral health diagnoses or substance use disorder**
- National surveys on substance use disorder and health indicated that almost 46.6 million Americans 18 or older had a diagnosable mental, behavioral, or emotional disorder within the past year
- Additional information on mental health can be found on the U.S. National Institute of Mental Health website (https://www.nimh.nih.gov/index.shtml)

- The National Alliance on Mental Illness reported that in 2017 approximately 1in 5 adults in the United States, totaling 46.6 million people, experienced behavioral health diagnoses resulting in $193.2 billion in lost earnings
- These statistics don't include substance related disorders
- The National Institute on Drug Abuse reports that in 2013, illicit drug use resulted in $11 billion in health care costs in the United States $11 billion in health costs due to illicit drug use in 2013
- In the same year, substance use, specifically alcohol, cost $25 billion in health care

Key Terms

- **Behavioral Health –** the broad category that addresses behavioral problems that have a bearing on health and is the job of **all care settings** and done by clinicians and health coaches of various disciplines or training. **Provision of behavioral health care is not limited to mental health professionals.**
  - Includes:
    - Client activation and health behaviors
    - Mental health conditions
    - Medical/Surgical health conditions
    - Substance use
- **Behavioral health case management**
  - Method of providing cost-effective, quality care by **managing the holistic health concerns** of individuals, families, and groups in need of extensive services
  - Requires integration, coordination, and advocacy for **complex mental and physical health care services** from a variety of health care providers and settings

- It is delivered within the framework of planned behavioral health outcomes



- **Self-neglect -** Self-neglect results from an adult's inability to perform essential self-care tasks due to physical and/or mental impairments or diminished capacity
  - Tasks may include:
    - providing essential food, clothing, shelter, health care
    - obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety
    - managing financial affairs
    - adhering to prescribed medications

- **Severe and persistent mental illness (SPMI) -** Severe and persistent mental illness describes those individuals with mental illness that have complex symptoms
  - They require ongoing treatment and management, and most often require varying types and dosages of medication and therapy
  - Persons with severe and persistent mental illness frequently have alcohol- or drug-related problems as well as physical health problems that also require treatment, and may complicate the diagnosis and treatment of the primary medical condition

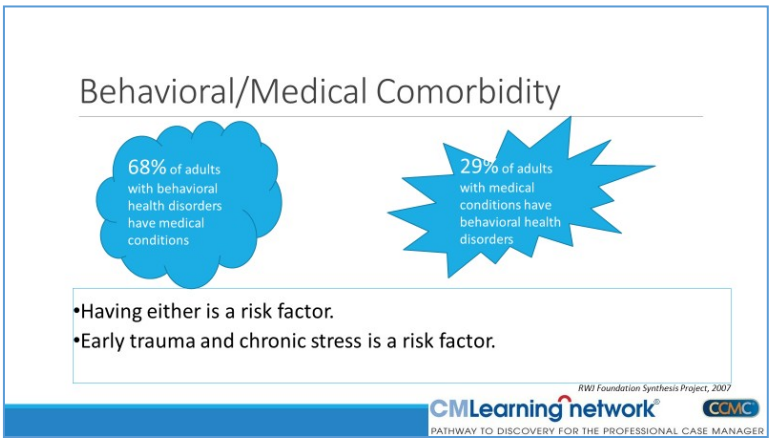
- **Substance-related and addictive disorders -** formerly referred to as substance dependence or abuse, involve the use of mind-altering substances yielding three basic

types of disorders: substance intoxication, substance withdrawal, and what is now called "substance use disorders"

Behavioral Disorders

- There are many different behavioral disorders that present differently
- These include:
  - depression
  - bipolar affective disorder schizophrenia
  - psychoses
  - dementia
  - intellectual disabilities
  - developmental disorders including autism spectrum disorders (ASD)
- The key to treating behavioral disorders is to find health care and social services capable of providing treatment and necessary support
- Approximately 10% of the population is considered complex, which is when serious behavioral disorders are further complicated by chronic medical conditions, social issues, and problems accessing care
- This small segment of the population can often use more than 70% of health care resources
- Behavioral conditions are more likely to be treated in the primary care sector
- Primary care physicians give 70% of behavioral health treatments, with 85% of behavioral health clients being seen in the physical health sector

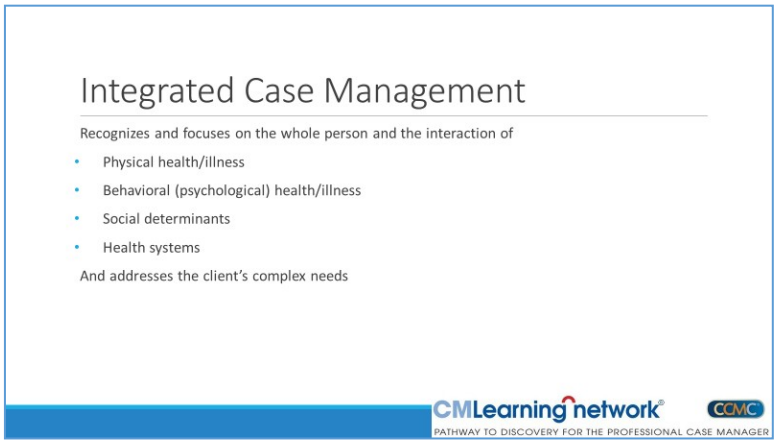
- An integrated approach (discussed later) is an effective means of addressing both the health and non-health-related issues



Behavioral/Medical Comorbidity

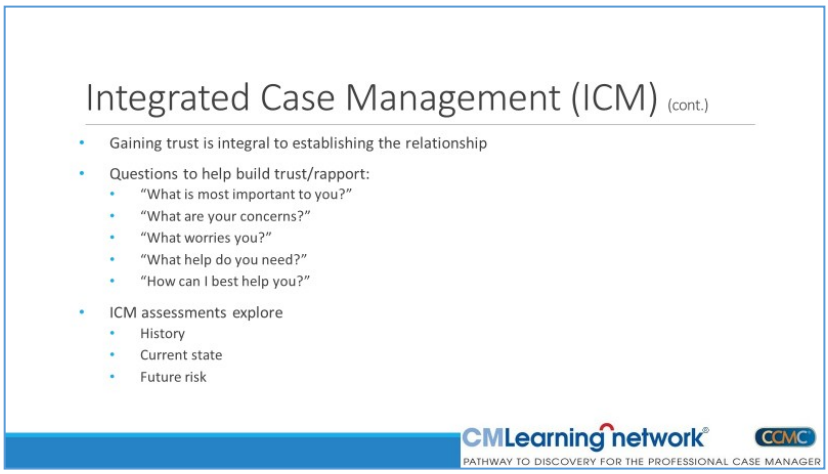
- 2011 report from the Robert Wood Johnson Foundation Synthesis Project entitled "Mental Disorders and Medical Comorbidity" found that 68% of adults with behavioral disorders also have medical conditions and 29% of adults with medical conditions have behavioral disorders
- The research showed evidence that having each type of disorder is a risk factor for developing the other
- Also, the Adverse Childhood Experiences Study (ACES), which will be addressed later, determined that early exposure to trauma and chronic stress may be risk factors for both behavioral and medical disorders
- The Synthesis Project report also stated that increased costs resulted when medical and behavioral conditions co-occur.

Integrated Case Management



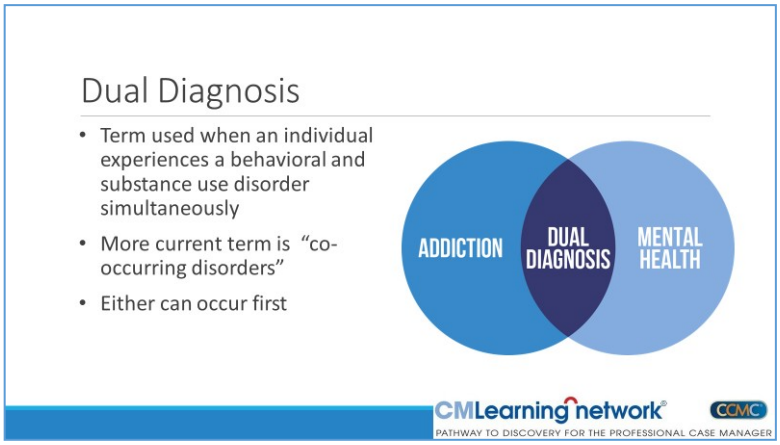
- Recognizes and focuses on the whole person and the interaction of
  - Physical health/illness
  - Behavioral health/illness
  - Social determinants
    - Inadequacy of social networks (Kathol, et.al, 2011)
  - Health systems
    - Limited, poorly controlled access to needed services (Kathol, et.al, 2011)
- Aids with clients with complex needs
  - Interacting chronic and/or multi-morbid conditions,
  - Includes behavioral and substance use disorders (Kathol, et.al, 2011)
- **Integrated case management –can be provided in a variety of settings (acute care, clinics, health plans, community, telephonically) by nurses, social workers, and licensed behavioral health professionals**

Kathol, R.G., Lattimer, C., Gold, W., Perez, R., and D. Gutteridge (2011). Creating clinical and economic "wins" through integrated case management. The Journal of Ambulatory Care Management, 34(2), pp. 140-151.



- In an integrated case management process, it is critical to establish rapport and a relationship built on advocacy to work with clients
  - The client must feel that they can trust the CM,
  - The CM must genuinely demonstrate empathy and concern for the client's well-being
- Integrated case management assessment explores history, current state, and future risk
  - History can be a predictor of future risk
  - Generally, the past six months should suffice

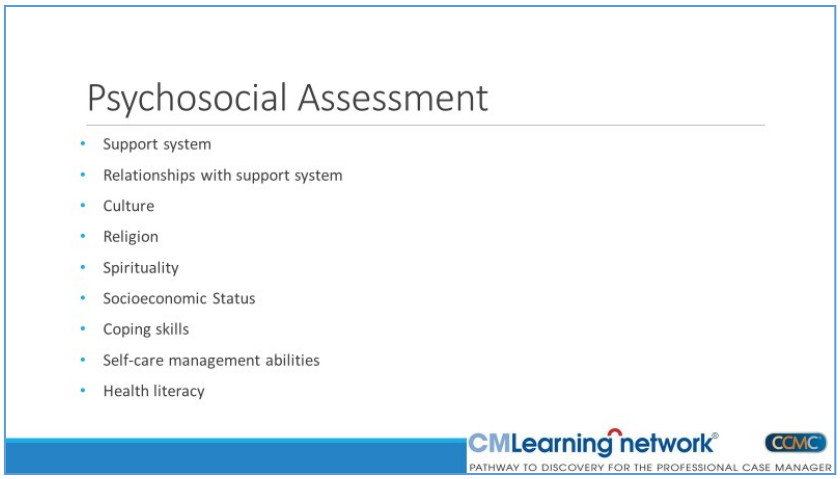
Perez, R. and Fraser, K. (2018). Mechanics of integrated case management, health complexity, and integration between behavioral health and physical health. In K. Fraser, R. Perez and C. Latour (Eds.) CMSA's Integrated Case Management. New York: Springer Publishing Co., LLC. PP. 21-35



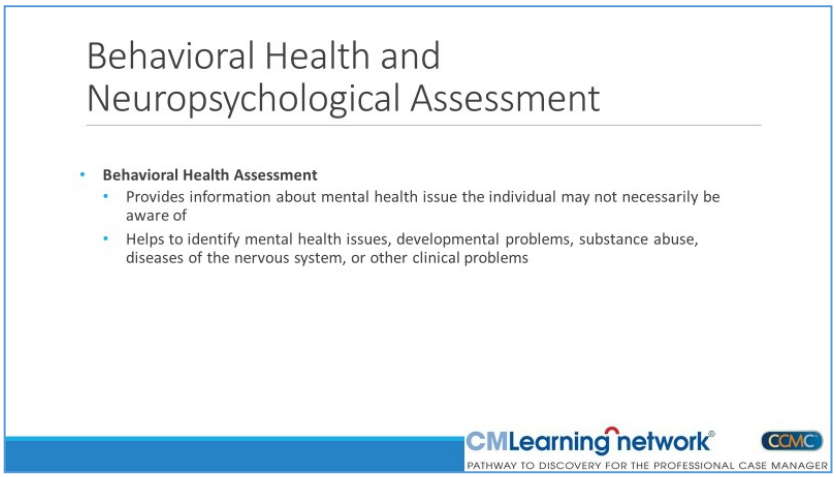
Dual Diagnosis

- Dual diagnosis was first identified in the 1980s among individuals with coexisting severe behavioral health and substance use disorders
    - The Substance Abuse and Mental Health Services Administration (SAMSHA) uses the term *co-occurring disorders* (COD) to refer to the concurrent disorders
- Many clients with co-occurring disorder do not receive treatment for either
- Individuals diagnosed with co-occurring disorders often need more intense treatment due to the complexity of their case emphasizing the importance for clinicians to provide effective and efficient treatment to these clients
- These individuals also face greater consequences from substance use disorder compared to those clients diagnosed with only a behavioral health disorder such as schizophrenia or bipolar disorder
- Examples of such consequences include:
    - greater exacerbation of psychiatric symptoms
    - medication nonadherence
    - increase in aggressive and violent behaviors
    - poor personal hygiene
    - emergency room visits
    - inpatient psychiatric placements.

Psychosocial Assessment



- Psychosocial factors including the client's support system and culture play a significant role in the provision of care to clients and maintaining health, wellness, and optimal functioning
- To ensure the delivery of appropriate and safe care, it is critical for the case manager to integrate key psychosocial information about the client/client's support system into the case management plan of care
- This must be done at an early stage of the client's care, beginning with screening and assessment of needs and throughout the Case Management Process, since psychosocial factors play a significant role in a client's progress toward health, independence, stability, and/or recovery
- It is essential for the case manager to be continually cognizant of the psychosocial aspects of a client's case and to share with all members of the multidisciplinary healthcare team relevant information gathered during the various phases of the Case Management Process or while interacting with the client/support system
- Assessment should include information about:
    - Support system
    - Relationships with support system
    - Culture
    - Religion
    - Spirituality
    - Socioeconomic status
    - Coping skills
    - Self-care management abilities
    - Health literacy

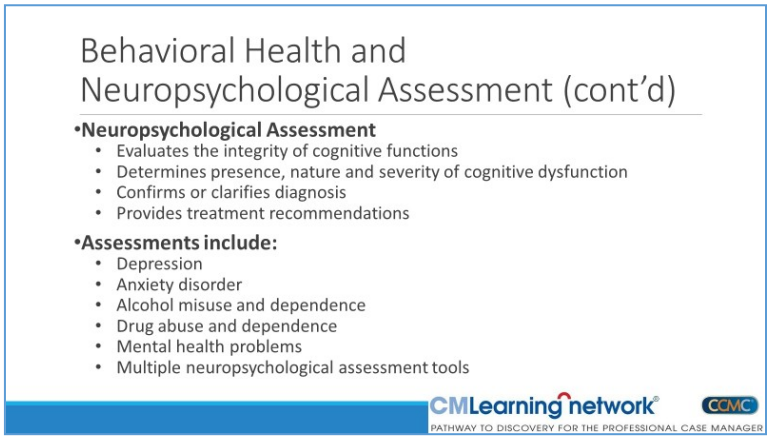


Behavioral Health and Neuropsychological Assessment

Behavioral Health Assessment

- Behavioral health assessments are critical to being able to assist clients with behavioral health issues
- Many of these clients are more likely to be seen in the general medical sector, so it is imperative that there is appropriate recognition and documentation of the behavioral health issues
- The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association in 2013, is the current standard - uses 3 major components to make a diagnosis:
  - diagnostic classification
  - diagnostic criteria sets
  - descriptive texts
- Many behavioral health disorders present with a combination of symptoms and behavior – as a result, comorbid medical, mental health, and substance use problems present significant challenges.
- Services for treatment, rehabilitation, and support in many cases are easily accessible in the community, and it is the case manager who is integral in finding and helping the client to access these
- Case management coordination is important to maintain the effectiveness of these services

- Assessments should include information about:
  - Depression
  - Anxiety disorder
  - Alcohol use and dependence
  - Drug use and dependence
  - Behavioral health problems
  - Multiple neuropsychological assessment tools
- Provides information about behavioral health issue the individual may not necessarily be aware of
- A behavioral health assessment can identify:
  - behavioral health problems (anxiety disorders, depression, bipolar disorders, eating disorders, among others
  - Developmental problems (learning disabilities, autism)
  - Substance use disorders (alcohol and drug abuse and dependence)
  - Diseases of the nervous system (Alzheimer's, Huntington's, Parkinson's, Epilepsy)



Neuropsychological Assessment

- The major purposes of a neuropsychologic assessment are to identify:
  - The integrity of cognitive functions -
    - determine the presence, nature, and severity of cognitive dysfunction
  - Differential diagnosis –

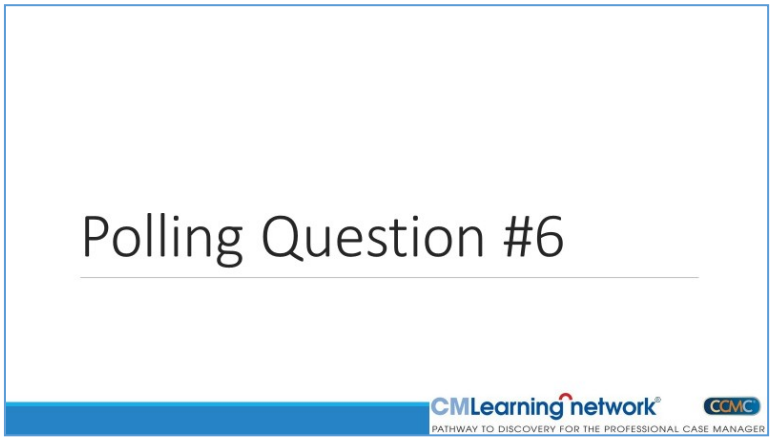
    - confirm or clarify a diagnosis.
  - Treatment planning –
    - provide treatment recommendations for cognitive disorders and psychological adjustment.
- The evaluation can also serve to assess readiness to return to work or other important life activities, such as financial management and driving, after a brain injury or neurologic illness. Such evaluations address whether a person is able, from a mental ability perspective, to make a successful return to major life roles.
- Multiple neuropsychological assessment tools might be part of the comprehensive assessment

Risk Factors

- Risk factors are those things that make someone vulnerable to developing behavioral health diagnoses
- Similar in nature to the etiology of behavioral health diagnoses, it's difficult to differentiate between risk factors and causation.
- People don't inherit behavioral health diagnoses; rather, they inherit genes that make them susceptible to them
- Extreme adversity in one's environment can be a cause or contributing factor of behavioral health disorders
- Still, the picture is complex. Take post-traumatic stress disorder (PTSD), for example. To develop PTSD, someone must experience a trauma, and the person must be

biologically/genetically predisposed to developing PTSD. Otherwise, everyone exposed to trauma would develop PTSD, and this isn't the case.

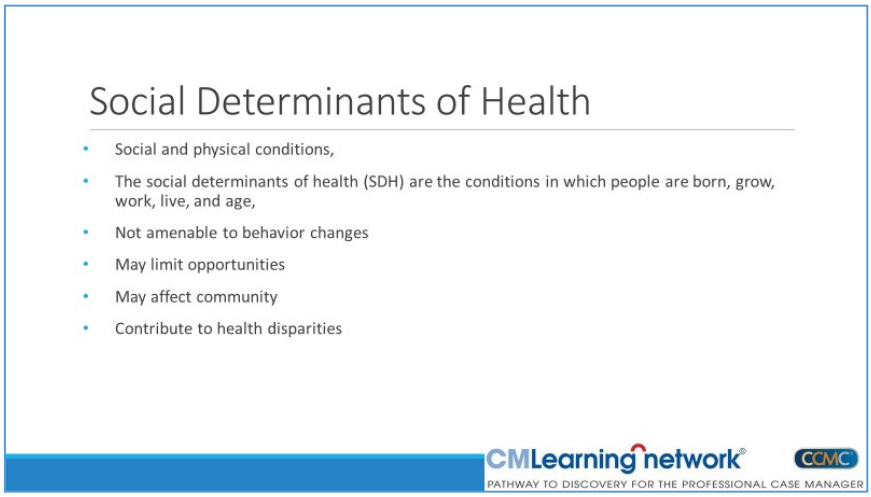
- In doing a risk assessment, include such factors as:
  - Familial history
  - Environment
    - Chronic stressors
    - Low quality of life
    - Trauma
    - Exposure to toxins
    - Family/relationship problems
    - Child abuse



Dual Diagnosis (also known as co-occurring diagnoses) is a term used when an individual experiences a:

a. **Behavioral Health and medical diagnoses**
b. **Two medical diagnoses**
c. **Medical diagnosis with a related sequela**
d. **Behavioral Health and Substance Use Disorder**

WHAT ARE SOCIAL DETERMINANTS OF HEALTH?



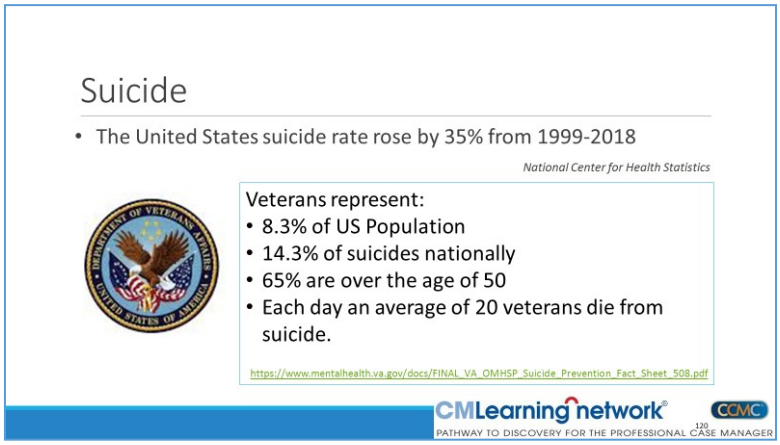
- Social factors and physical conditions in the environment
- The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (Healthy People 2000, WHO, 2020).
- SDH:
  - Are not amenable to individual-related behavior changes
  - May limit opportunities for good health choices
  - May affect a community as a whole
  - Contribute to inequities in health and health disparities

https://www.HealthyPeople.gov Social determinants of health topic area Secretary's Advisory Committee Social Determinants of Health Report Accessed 1/30/20
https://www.who.int/social_determinants/en/ Social Determinants of Health. Accessed 1/30/20.

- **Social Determinants of Health**
  - Economic stability
  - Neighborhood and Physical Environment
  - Education
  - Food
  - Community and Social Context
  - Health Care System

https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Suicide



- The National Center for Health Statistics reports that the overall suicide rate in the United States rose by 35% from 1999-2018

- Veterans, with or without catastrophic injuries, may also be suffering with post-traumatic stress disorder
- In a VA suicide prevention fact sheet, statistics indicate an average of 20 veterans commit suicide daily, a statistic more than double the general population
- (https://www.va.gov/opa/publications/factsheets/Suicide_Prevention_FactSheet_
- New_VA_Stats_070616_1400.pdf)
- Behavioral and non-behavioral health case managers must be aware of suicidal risk factors
- These risk factors should be part of the case managers assessment
- Risk factors to be aware of include:
- clients that indicate verbally or non-verbally that they do not want to live
    - do not fear death
    - have active thoughts of harming themselves
    - express a thought of how to commit suicide though they do not have a plan
    - express that they have a plan for harming themselves
- These indicators should trigger an intervention implemented by the case manager to ensure that the safety of the client and/or others is of primary concern.
- Other risk factors that should trigger a response from the case manager include:
    - Depression
    - Substance use or behavioral disorders or family history of same
    - history of a prior suicide attempt or a family history of suicide
    - violence in the family that includes physical or sexual abuse
    - the presence of firearms in the home
    - being or having been in prison or jail
    - the exposure to suicidal behavior of family, peers, or public figures that have an impact on the person.

Suicide Statistics

- Suicide is the tenth leading cause of death in the US, accounting for more than 1% of all deaths

- It is the second leading cause of death among people ages 10-34
- It is the fourth leading cause of death among people ages 35-54.
- More years of life are lost to suicide than to any other single cause except heart disease and cancer
- 44,000 Americans die by suicide each year
- There are 14.2 deaths by suicide per 100,000 persons each year
- There is one death by suicide for every 25 attempts
- 40% of persons who complete suicide have made a previous attempt
- Nine of out ten people who attempt suicide and survive, do not go on to complete suicide at a later date
- Previous suicide attempts serve as a risk factor for completed suicide
- Suicide risk is 37% higher in the first year after deliberate self-harm than in the general population
- Older white adults have triple the suicide risk than younger, non-white adults
- Suicide rates are highest among adults between 45 and 64 at 19.6 percent
- The second highest rate is 19.4 among those 85 years or older
- Compared with middle-aged older adults, younger populations have consistently lower suicide rates
- While males are four times more likely to do die by suicide, females are three times more likely to attempt suicide
- Those with substance abuse disorders are six times more likely to complete suicide than those without
- The rate of completed suicide among men with alcohol/drug abuse problems is 2-3 times higher than among those without a problem
- Women who abuse substances are at 6-9 times higher risk of suicide compared to women who do not have a problem (Above statistics downloaded from http://www.mentalhealthamerica.net/suicide)
- Behavioral health conditions are extremely common, affecting nearly one of five Americans and leading to health care costs of $57 billion a year, on par with cancer

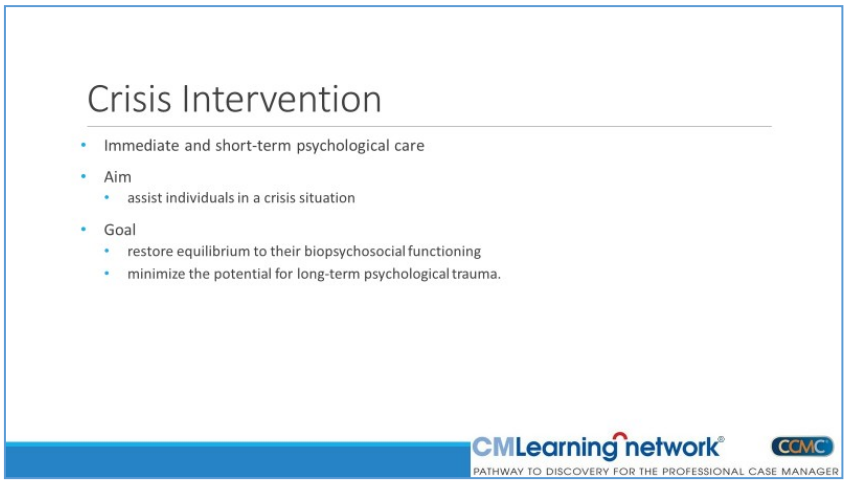
- Conditions such as depression can be very disruptive, occurring among younger as well as older Americans and leading to significant disability and lost income
- Despite this, behavioral health care is mostly separated from the primary care system—a practice that the Institute of Medicine concluded nearly 20 years ago was leading to inferior care
- In the intervening years, evidence has continued to mount that having two, mostly independent systems of care leads to worse health outcomes and higher total spending, particularly for clients with comorbid physical and behavioral health conditions ranging from depression and anxiety, which often accompany physical health conditions, to substance abuse and more serious and persistent mental illnesses

http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus Downloaded 5.3.18

- Data from 2009 indicated that **1 in 5** Americans had a behavioral health condition leading to health care costs of **$57 billion** a year

https://www.cdc.gov/nchs/products/databriefs/db362.htm

Crisis Intervention

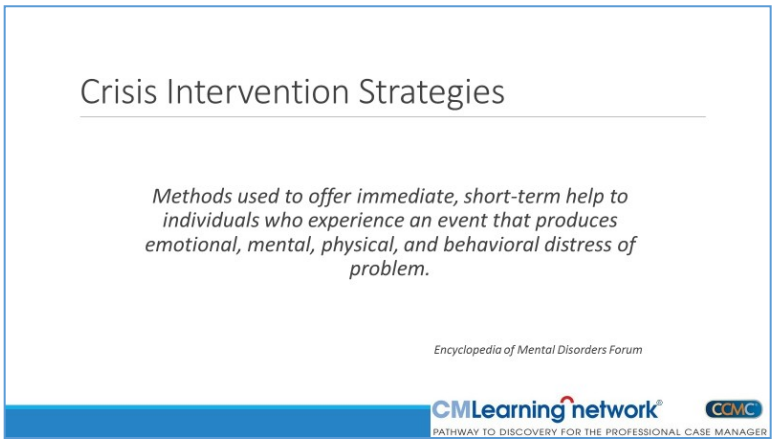


- The experience of trauma, particularly an overwhelming trauma, can leave us in a state of not knowing if our reactions are normal
- Crisis intervention – the immediate and short-term care aimed at assisting to restore equilibrium – can walk us through our “new normal”
- Crisis intervention is immediate and short-term psychological care

- Aim is to assist individuals in a crisis
- Goal is to restore equilibrium to their biopsychosocial functioning and minimize the potential for long-term psychological trauma

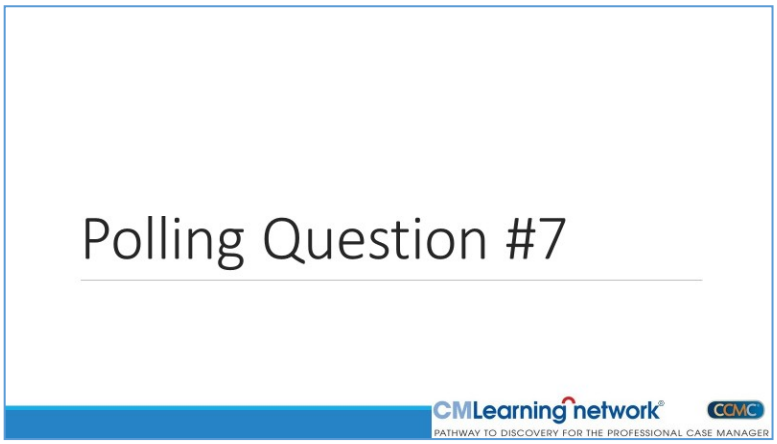
Case Management Implications

- Crisis intervention skills are necessary for case managers because of the complexity of the client conditions they deal with every day
- Crisis intervention skills allow the case manager to effectively understand and assess the situation, allowing clients to deal with the crisis, particularly when there are longer term residual effects.
- Approaches should be client centered
- May differ from client to client
- Complexity of client conditions make it necessary
- Case manager needs to effectively understand and assess situation



Crisis Intervention Strategies

- Methods used to offer immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress of problem. (Encyclopedia of Mental Disorders Forum)
- Begin by understanding the type of trauma being experienced.
- It's important to assess whether the person is presently in a state of emergency, if the situation is immediately threatening, or whether the crisis is chronic and ongoing
- Should the person be in current and direct danger, your first step will always be guiding them to safety
- Not all crises involve dangerous situations and so determining a person's level of danger won't always be necessary
- However, understanding the victim's type of trauma is crucial no matter what
- Put yourself in the victim's shoes, so to speak, and understand the crisis from their point of view and allow them to express their full emotions without the fear of being judged
- Listening is also a vital first step in assessing someone's state of need
- When a person in crisis tells their story, they can begin to draw on their cognitive skills, instead of emotional skills, which can help return them to a calmer, less reactive mental space



Integrated Case Management recognizes and focuses on the whole person and the interaction of physical health/illness, behavioral health/illness, health systems and:

a. **Is only performed by mental health practitioners**
b. **social determinants of health**
c. **is available to those with ability to pay**
d. **all the above**

Motivational Interviewing

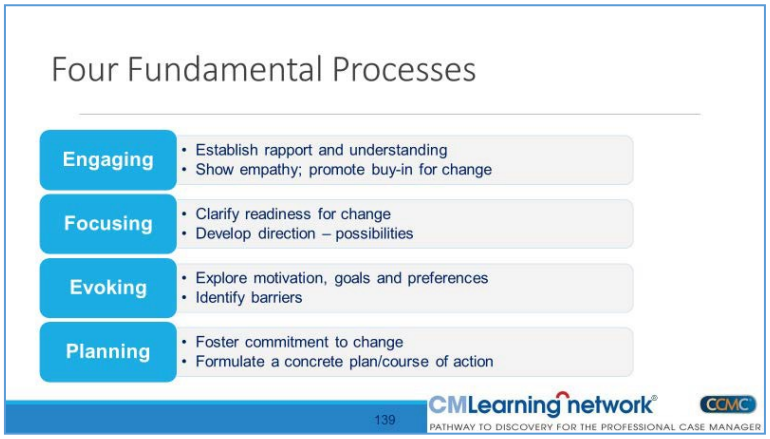
- MI is a directive, client-centric, collaborative process counseling style that assists clients to explore and resolve ambivalent feelings and insecurities, and elicits the internal motivation they need to change their behavior by helping them explore and resolve ambivalence, within an atmosphere of acceptance and compassion

- This intervention is designed to strengthen personal motivation for, and commitment to a specific goal, helping individuals become motivated to change the behaviors that are preventing them from making healthier choices
- https://sharepoint.washington.edu/uwpsychiatry/SPIRIT/resources/Documents/Care%20Manager%20Resources/What%20is%20Motivational%20Interviewing-Handout.pdf

- Benefits of MI
  - Builds trusting relationships
  - Develops rapport
  - Uncovers health and lifestyle needs
  - Provides motivation to move toward successful and desirable behaviors
  - Provides support to overcome ambivalence about the change needed and to become engaged in more healthy behaviors
  - "Hands-off" approach allows for client to be more invested in the decision as they are making it based on their reasoning and in their time
- The principle task of MI is to guide the conversation, in a supportive manner, toward eliciting the client's need and reason for wanting to change
- The role of the case manager is mainly to evoke a conversation about change and commitment
- The goal of MI is to increase the client's motivation, resulting in increasing their readiness to make a commitment to change

- By hearing themselves express a commitment out loud has been shown to help improve a client's ability to make those changes.

- For MI to be successful, the client must be engaged and motivated to change
- Communication is key in MI – gaps result in suboptimal engagement with the client / support system and outcomes will be negatively impacted
- MI is a means to bridge the communication gap with the client/ support system
- MI creates a path for the client/support system to actively participate in their care

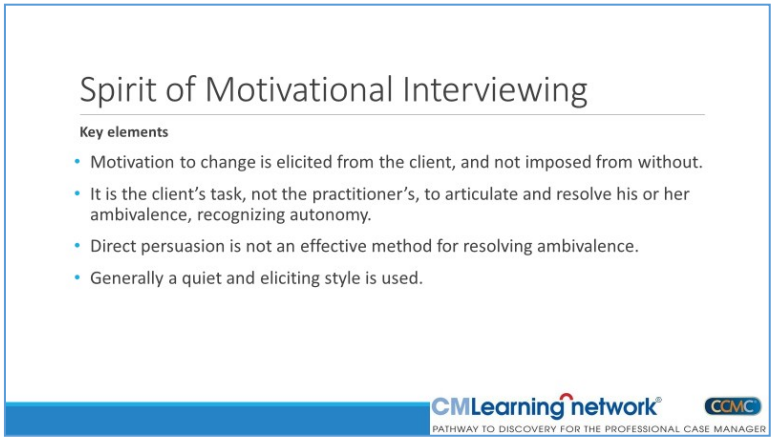


MI has four fundamental processes

- Engaging
  - To establish rapport with the client and express understanding
  - To show empathy
  - Promote buy-in for the client to change

- Focusing
  - Clarify the readiness for change
  - Help them to develop direction
  - Show them possibilities
- Evoking
  - Help them to explore their motivation
  - What are their goals and preferences
  - Assist in having them identify the barriers
- Planning
  - Foster their commitment to change
  - Let them formulate a concrete plan, develop a course of action

- How often have you had a challenge trying to talk to a client about a behavior change?
- What about the conversation made is so challenging?



Spirit of Motivational Interviewing

Key elements

- **Collaboration**: MI is done "with and for" someone, not "on or to" them – the case manager and client "work together." It is a therapeutic relationship.
- **Evoking** or drawing out the client's ideas about change
  - The case manager asks, does not tell, drawing out the client's own motivation and skills for change
- The collaboration empowers the client; at the same time, it gives them responsibility for their actions
- It is ultimately up to the client to follow through with making the change happen.
- The case manager encourages the client without judgement, and exhibits compassion as genuine care and concern, expressing understanding and validating the struggle of the client.
- It is the client's task, not the practitioner's, to articulate and resolve their ambivalence, recognizing **autonomy**.
  - Direct persuasion is not an effective method for resolving ambivalence.
  - Generally, a quiet and eliciting style is used
- Practicing **compassion** in the process

https://ytp.uoregon.edu/content/spirit-motivational-interviewing

http://www.motivationalinterviewing.org/sites/default/files/Four%20Fundamental%20Processes%20in%20MI-REV%20w%20definition.pdf

Principles of Motivational Interviewing

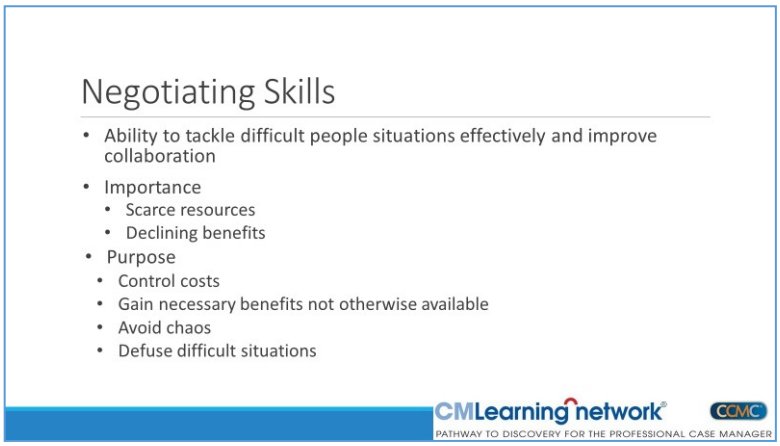
- A natural and instinctive response of trained care providers is to fix the problem, make things right, and to use knowledge acquired from training and experience to help the individual seeking care to overcome their problems
- Resist this response using the four principles of MI
- They are:
  - Express Empathy – convey an understanding of the client's perspective and acceptance of the situation; approach in a nonjudgmental and noncritical way, particularly is the client expresses reluctance to change
  - Support Self-Efficacy – affirm their success and achievements and identify their strengths to encourage their belief that they can change
  - Develop Discrepancy – work with the client to identify the difference between the current and future states, and have them specify the goals they want to achieve; help them recognize desirable behaviors; seek permission before attempting to move forward
  - Roll with Resistance – allow client to verbalize their resistance to change and share their experience about concerns or challenges; recognize what is important to them and their support system; accept their behavior, even if it is not positive or looks like they are making progress toward the desired goals
  - A fifth principle, avoid argument, is noted in some of the literature for MI. Arguments are counterproductive in the use of MI.

- **Engagement Tool** – O.A.R.S. Good skills for MI is the use of O.A.R.S.

- **O**. - **Open-ended questions**
  - allows for client to do most of the talking
  - establishes a safe environment and helps build trust and respect
  - Examples:
    - "What is most important to you?"
    - "What are your concerns?"
    - "What worries you?"
    - "What help do you need?"
    - "How can I best help you?"
- **A. – Affirmations**
  - Builds rapport, demonstrates empathy
  - Affirms client's past decisions, abilities, and healthy behaviors
  - Acknowledges positive aspect in the client's life
- **R. – Reflective listening**
  - Demonstrates that you are listening carefully
  - Observe body language, behavior
  - Reflect in your own words
- **S. – Summarizing**
  - May also include paraphrasing
  - Review what has been discussed so far
  - Can link discussion to possible trial solutions
  - Can make a transition
- The encounter can begin with asking:
- Gaining trust is critical to them sharing intimate details of their life and health

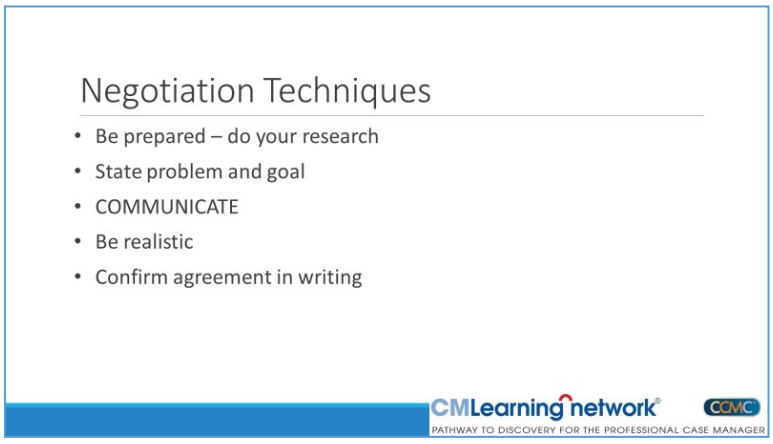
https://www.oregon.gov/oha/PH/HealthyPeopleFamilies/ReproductiveSexualHealth/Documents/edmat/OARSEssentialCommunicationTechniques.pdf

http://www.myacpa.org/sites/default/files/Intervention%20Handout.pdf



Negotiating Skills

- Ability to tackle difficult people situations effectively and improve collaboration
- Importance
    - Due to scarce resources and declining health insurance benefits
    - Purposes
        - Can control costs
        - Capacity to gain necessary benefits not otherwise available
        - Helps to avoid chaos
        - Can defuse difficult situations

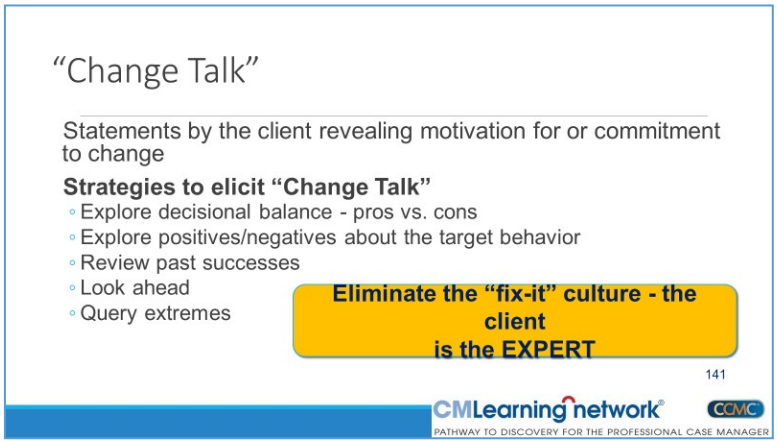


Negotiation Techniques

- **Be prepared** – do your research, understand the other side

- **State problem, goal**, and what is needed to solve the problem – state the request positively and thoroughly
- **COMMUNICATE, COMMUNICATE, COMMUNICATE**! Poor communication can create a defensive attitude. Problematic behaviors: poor listening skills; poor use of questions; improper disclosure of ideas; mismanagement of issues; being aggressive rather than assertive.
- **Be realistic** – attempting for a result that will never happen is a waste of time and energy
- **Confirm** agreement in writing and get it signed by all parties

Critical trait to possess for negotiation is **emotional intelligence** - the ability, capacity, or skill to perceive, assess, and manage the emotions of one's self, others, and groups



How Do You Get People to Change?

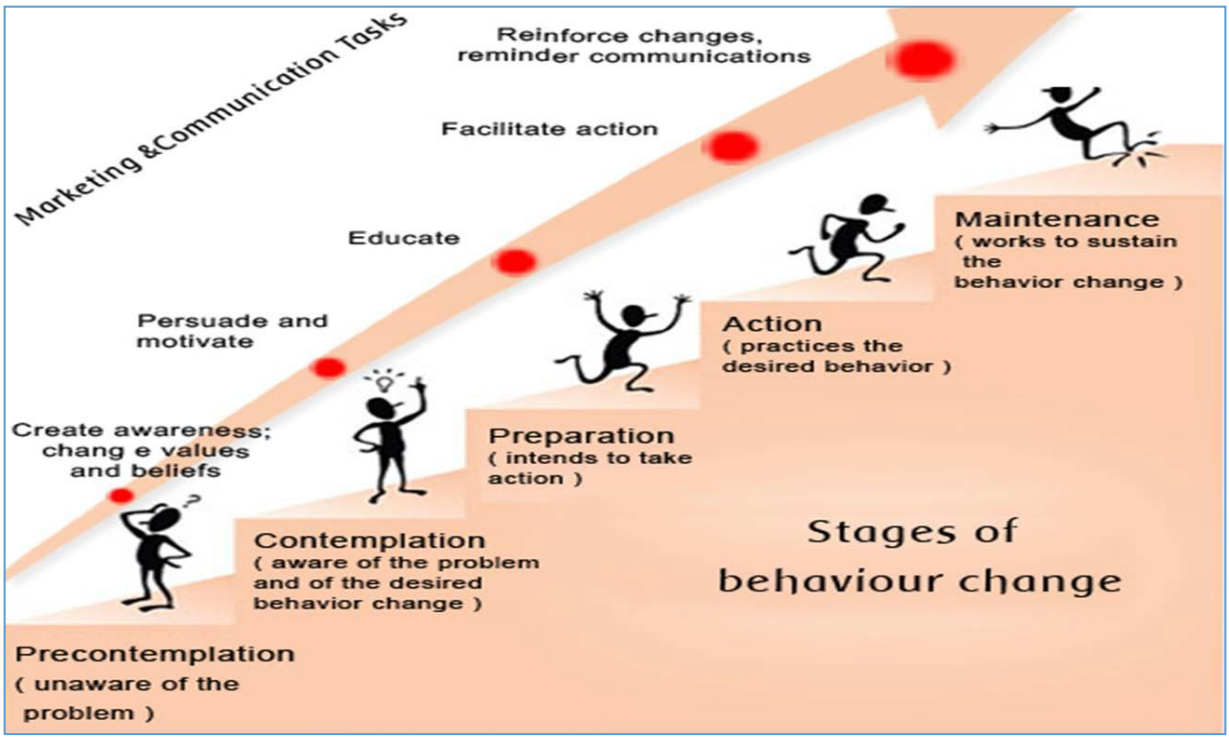
"Change Talk"

- Statements that suggest a window of opportunity for change
- Usually subtle, not a declaration, but shows contemplation to change
- Using the O.A.R.S. technique can help to elicit change talk
- Also, can look at:
  - pros and cons of the change
  - positives and negatives
  - past successes
  - look to the future

- **Don’t try to fix it – only the client can do that!!**

https://www.betheacps.com/upload/Examples%20of%20Change%20Talk.pdf

The Prochaska Model

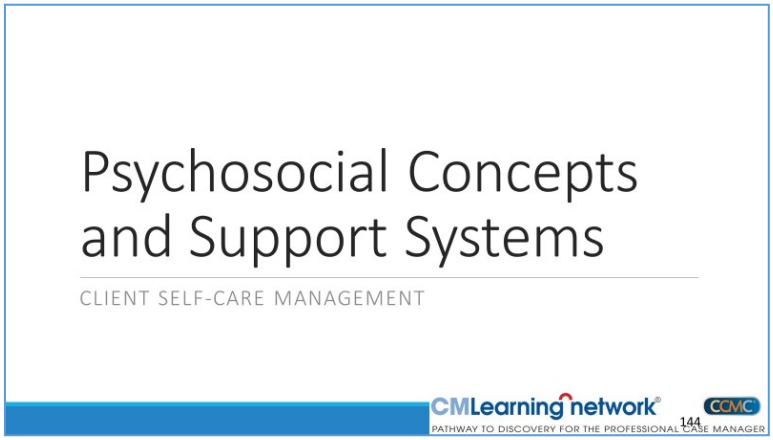


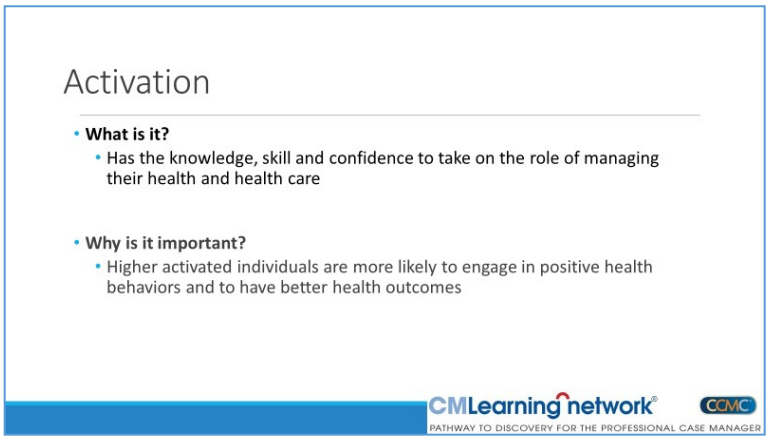
Change Theory – Stages of Change

- In the Prochaska model (also called the Transtheoretical Model) for change, assessing clients’ readiness to change involves various stages
- Clients can be at different stages of changing their behaviors during treatment
- There are 6 stages (https://psychcentral.com/lib/stages-of-change/)
    - Precontemplation – not ready to change, may not see a problem; reasons:
        - reluctance - lack of knowledge or inertia to consider change; impact of the problem has not reached their consciousness
        - rebellion – have a heavy investment in the problem; resist being told what to do
        - resigned – have given up hope of change, are overwhelmed by the problem; may have made multiple previous attempts to change

    - rationalization – have all the answers, many reasons why the problem is not a problem, at least for them
- Contemplation – willing to consider they may have a problem; this offers hope for change though they may be highly ambivalent; with help they may make a risk-reward analysis considering the pros and cons of making a change; and think about previous attempts to change and the reasons for failure in the past
- Preparation (Commitment to Action) – still may be ambivalent but the scale in tipping in favor of change; may make a serious attempt to change in this stage, and appear to be ready to commit; now they will make a realistic plan that takes into consideration the level of difficulty to change, as well as to anticipate problems and pitfalls to develop concrete solutions to them
- Action (Implementing the Plan) – putting the plan into action; typically will make public commitment to get external confirmation of the plan; knowing that others are watching is helpful; success, no matter how small, gives hope and self-confidence
- Maintenance – normally takes about 3 to 6 months to complete; new patterns of behavior have been established, though the possibility of relapse remains; threat to return to old habits becomes less intense and less frequent
- Termination – no longer feels the problem presents a threat; has complete confidence in coping skills and mechanisms

Client Self-Care Management

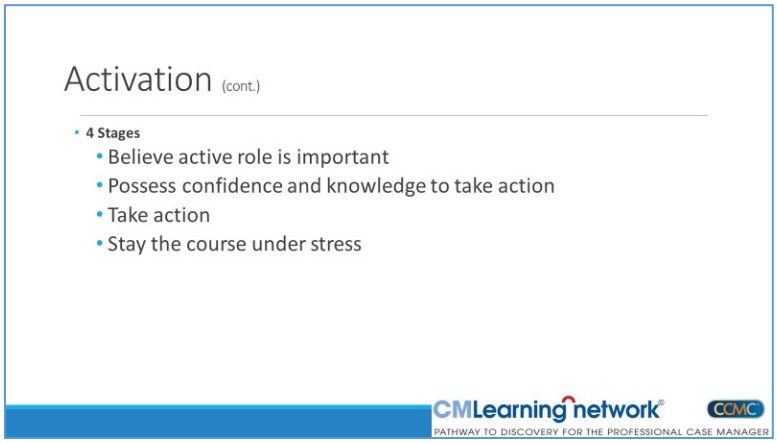




Activation

- **What is it?**
  - Has the knowledge, skill and confidence to take on the role of managing their health and health care

- **Why is it important?**
  - Higher activated individuals are more likely to engage in positive health behaviors and to have better health outcomes
- Activation underlies most health behaviors. When behaviors are more difficult or complex, or require the client to be proactive, it is generally only the individuals with high activation who do them.



- **4 Stages**
  - Believe active role is important in self-care management

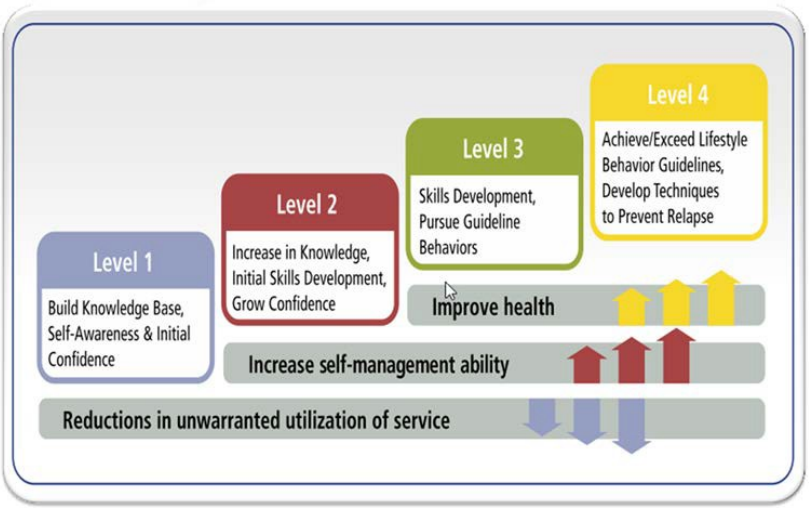
- Possess confidence and knowledge to take action
- Take action
- Stay the course under stress, staying the course even when it becomes more complex and not so easy to continue

Patient Activation Measure Items
1. When all is said and done, I am the person who is responsible for managing my health condition
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition
4. I know what each of my prescribed medications does
5. I am confident I can tell when I need to go get medical care and when I can handle a health problem myself
6. I am confident I can tell my health provider the concerns I have even when they do not ask
7. I am confident I can follow through on the medical treatment I need to do at home
8. I understand the nature and causes of my health condition
9. I know the different medical treatment options available for my health condition
10. I have been able to maintain the lifestyle changes I have made for my health
11. I know how to prevent further problems with my health condition
12. I am confident I can find a solution when new situations or problems arise with my health condition
13. I am confident I can maintain lifestyle changes, like diet and exercise, even during times of stress

Patient Activation Measure

- The questions have 4 possible choices: disagree strongly; disagree; agree; agree strongly; as well as an N/A (no answer)
- has been found useful for assessing client knowledge, skills and confidence in management of chronic conditions
- Scoring of the original is done based on a complex computation using the number of questions answered in conjunction with the response choice
- The responses to these items, when used, can give you an idea about how activated the client is even without a score
- Some of the reasons that we measure activation is that:

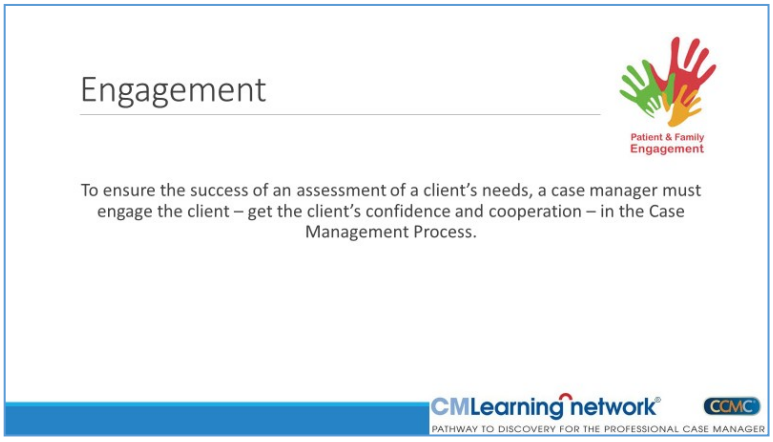
- chronically ill clients play a large role in their management
- We can individualize care plans to clients' stage of readiness
- It provides a method to evaluate interventions used to facilitate self-management



Activation Level

Some consideration for case managers:

- 4 levels
- Less Activated Patient (Level 1 and 2)
  - Just cover basics– don't overwhelm client with too much information or changes
  - Build confidence through small step successes
  - Focus on what is important to the client, jointly set realistic behavioral goals
- Patients who are Moderately Activated (Level 3)
  - Assume the clients at this level are ready to use more information than clients at the lowest level
  - Jointly set realistic goals
  - Celebrate successes
- Higher Activated Patient (level 4)
  - Go beyond the basics, provide more in-depth information
  - Plan for challenging situations
  - Plan proactively to anticipate barriers and how to overcome them

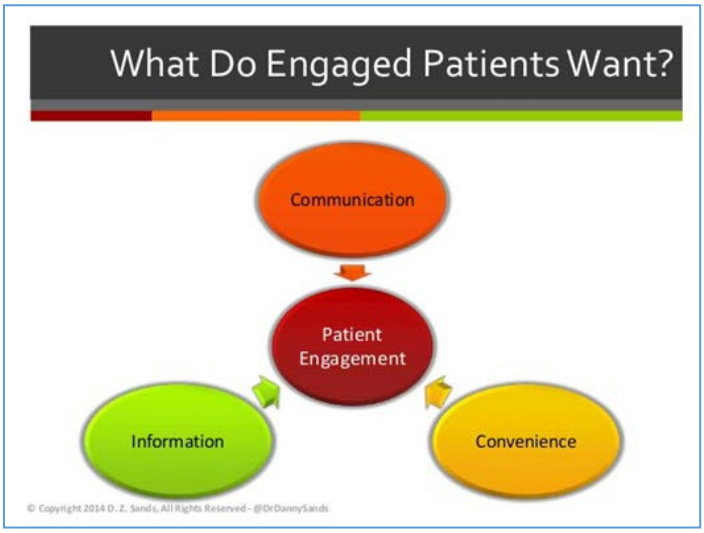


- To ensure the success of an assessment of a client's needs, a case manager must engage the client – get the client's confidence and cooperation – in the Case Management Process.
- Engagement integrates health care information and professional advice with a client's personal needs, skills, motivation, preferences and abilities
- It focuses on the behaviors of an individual that are critical to health outcomes, rather than the actions of professionals
- When the client is engaged, the case manager is working with him or her, not merely talking to them

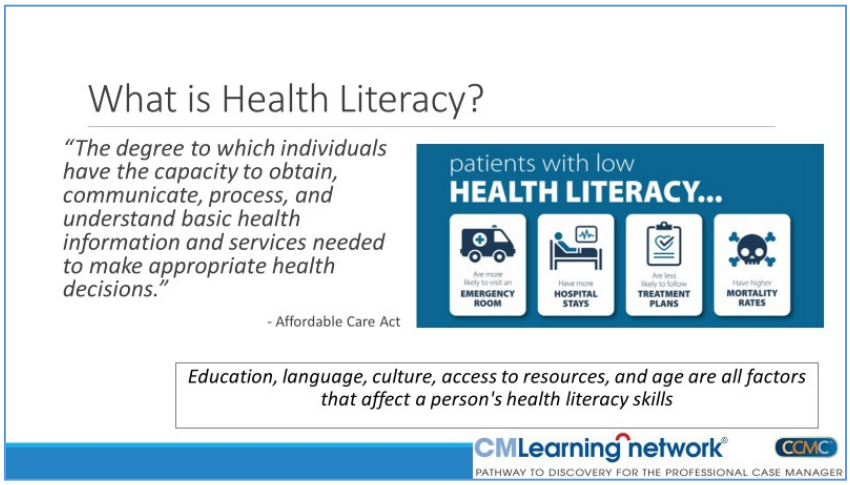
Engagement

- Begins with first encounter
- Crucial to build an effective, trusting and respectful relationship

- Client engagement can be characterized by how much information flows between client and provider, how active a role the client has in care decisions, and how involved the client or client organization becomes in health organization decisions and in policy making
- Client engagement has such an impact on health outcomes that the ACA has identified it as an integral component of quality in ACOs and PCMHs
- Factors that can impact engagement include:
  - Motivation
  - Attitudes
  - Beliefs
  - Knowledge
  - Cognitive ability
  - Education
  - Health literacy
  - Past experiences with the healthcare system
  - Degree of self-efficacy
  - Trust between client and provider



Health Literacy

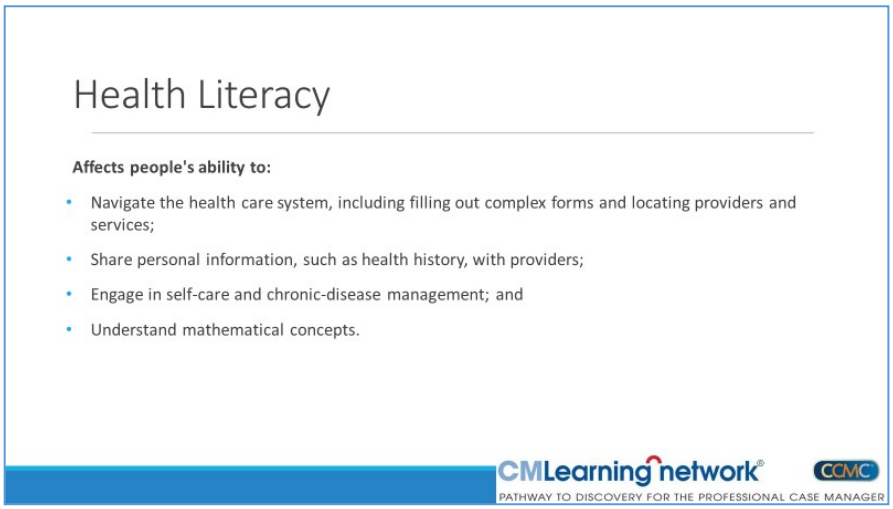


What is Health Literacy?

- *"The degree to which individuals have the capacity to obtain, communicate, process, and understand basic health information and services needed to make appropriate health decisions." (Affordable Care Act*)

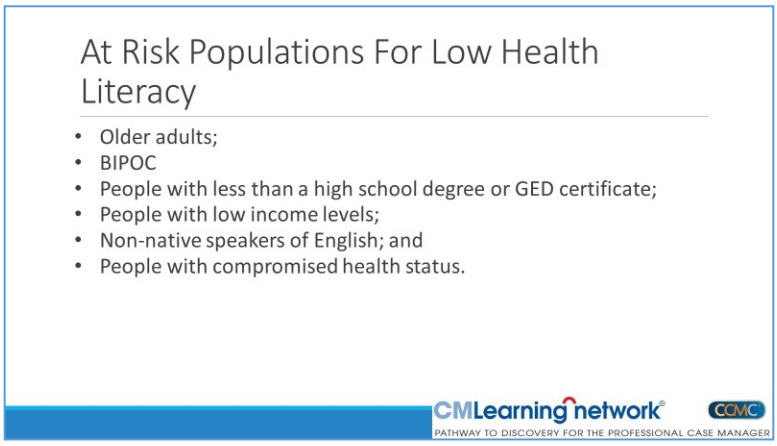
Health Literacy

- It has been defined by The Affordable Care Act as "the degree to which individuals have the capacity to obtain, communicate, process, and understand basic health information and services needed to make appropriate health decisions".
- People need to understand and use health information to choose a healthy lifestyle, seek medical care, and take advantage of preventive measures.
- Health literacy is dependent on multiple factors, including communication skills, knowledge, and culture. Education, language, culture, access to resources, and age are all factors that affect a person's health literacy skills.



Health literacy affects people's ability to:

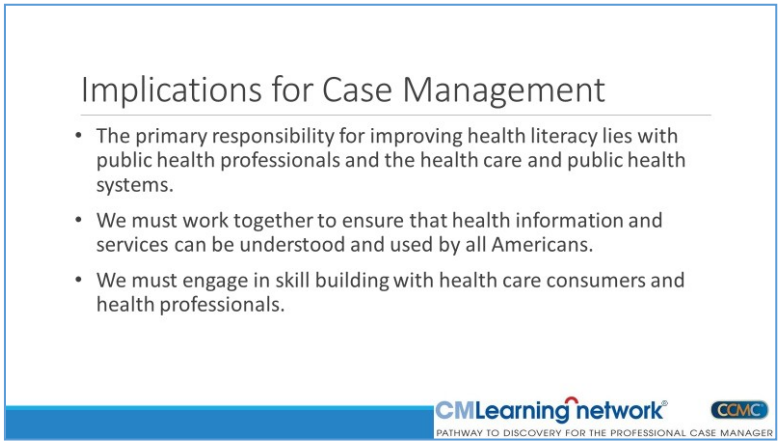
- Navigate the health care system, including filling out complex forms and locating providers and services;
- Share personal information, such as health history, with providers;
- Engage in self-care and chronic-disease management; and
- Understand mathematical concepts.
- As healthcare professionals, we can navigate the healthcare system to a reasonable extent. For those with limited or low health literacy, navigating the system is more difficult, and it may not be obvious to them that certain information may be important to share.
- Health literacy also involves mathematical and numeric concepts that include:
- The ability to measure medications (the prescription bottle says “take 5 ml” – what does that mean to a lay person?)
- Understanding nutrition labels (how much sodium is in a serving, and what constitutes a serving?)
- And how to compare health and prescription plans (in calculating premiums, copays, and deductibles)



At Risk Populations for Low Health Literacy

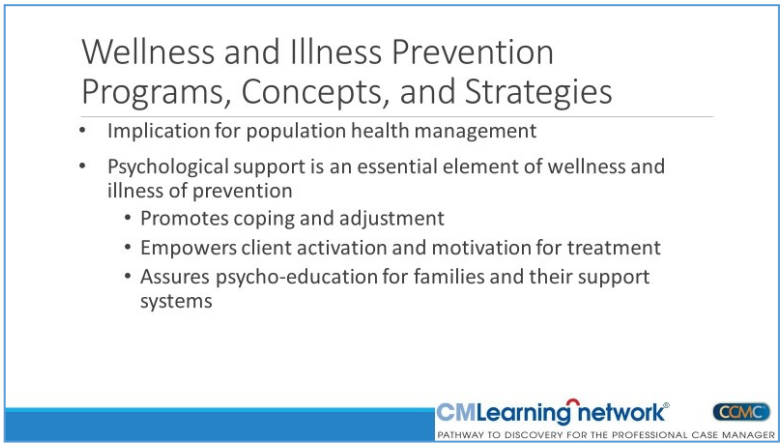
- These populations are likely to be at higher risk for low health literacy.
  - Older adults;
  - BIPOC (Black, Indigenous, People of Color)
  - People with less than a high school degree or GED certificate;
  - People with low income levels;
  - Non-native speakers of English; and
  - People with compromised health status.
- Education affects health literacy, as those with limited education have limited ability to find information and services
- They may be less able to communicate their needs and preferences, and respond to information and services
- Processing the meaning and usefulness of the information and services may also be compromised
- They may not be able to understand choices and the consequences of those choices; and they may not be able to decide which information and services match their needs and preferences, preventing them from acting in an appropriate and timely manner
- For example, clients with low health literacy levels are 4.5-times more likely to experience a post-surgical infection than individuals with adequate health literacy levels.

https://patientengagementhit.com/news/patients-with-low-health-literacy-at-risk-for-post-op-infection?eid=CXTEL000000556791&elqCampaignId=15731&utm_source=nl&utm_medium=email&utm_campaign=newsletter&elqTrackId=56ae4ababb2b4dc1b80a91835fb32d12&elq=69c9e7275ca545038c9da67d3877feb9&elqaid=16489&elqat=1&elqCampaignId=15731



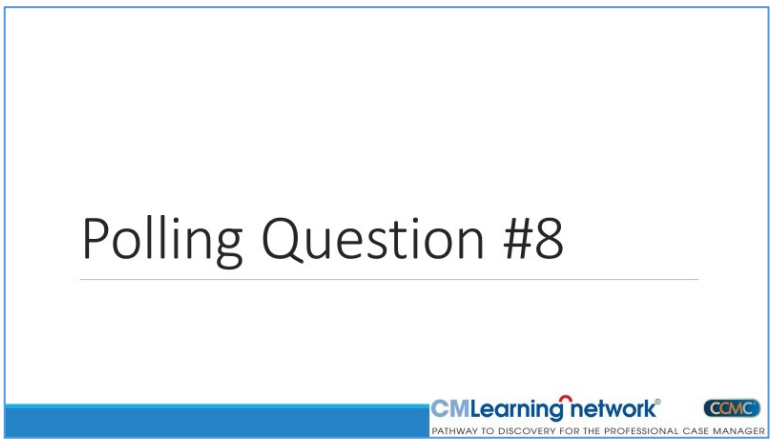
Implications for Case Management

- As healthcare professionals, and case managers, it is part of our responsibility to ensure that our clients receive the information we must share with them about their health in a manner that they can understand and process, to make informed and appropriate decisions
- The primary responsibility for improving health literacy lies with public health professionals and the health care and public health systems
- We must work together to ensure that health information and services can be understood and used by all Americans
- We must engage in skill building with health care consumers and health professionals



Wellness and Illness Prevention Programs, Concepts, and Strategies

- Health promotion and disease prevention programs focus on keeping people healthy
- Health promotion engages and empowers individuals and communities to engage in healthy behaviors, and make changes that reduce the risk of developing chronic diseases and other morbidities
- Disease prevention focuses on prevention strategies to reduce the risk of developing chronic diseases and other morbidities
- Health promotion and disease prevention programs often address social determinants of health, which influence modifiable risk behaviors
- Social determinants of health are the economic, social, cultural, and political conditions in which people are born, grow, and live that affect health status
- Modifiable risk behaviors include, for example, tobacco use, poor eating habits, and lack of physical activity, which contribute to the development of chronic disease
- Implication for population health management
    - Psychological support is an essential element of wellness and illness of prevention
    - Promotes coping and adjustment
    - Empowers client activation and motivation for treatment
    - Assures psycho-education for families and their support systems

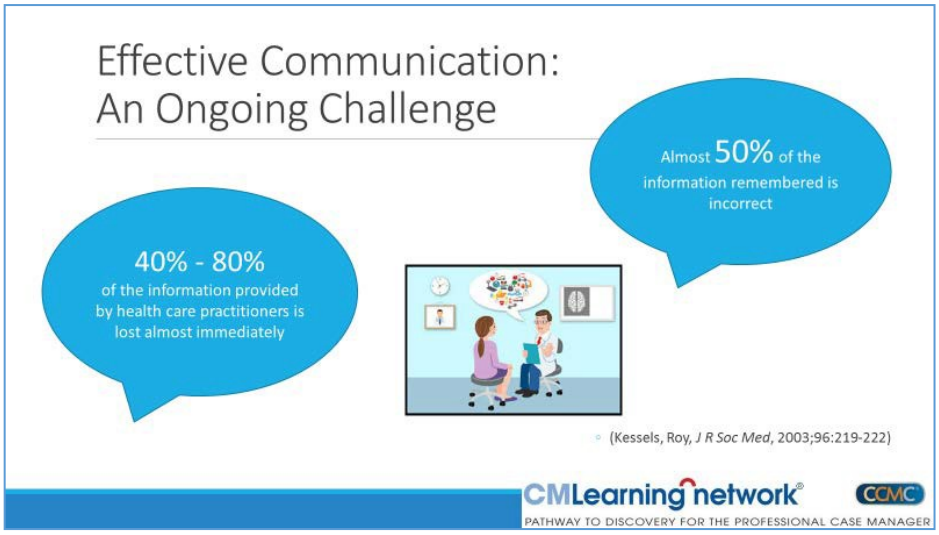


True or False:

Clients with low health literacy are less likely to visit an emergency room.

TRUE
FALSE

Communication Strategies



Effective Communication: An Ongoing Challenge

Expert in communication, Rebecca Shafir (2007) states that people only remember 25% of what was said, only a few minutes after the conversation.

- An article by Roy Kessels (2003) regarding clients' memory for medical information indicated that 40-80% of medical information that was provided to clients by their healthcare providers was immediately forgotten
- And the more information we give them the less they remember; indeed, almost half of the information that is remembered is incorrect
- Expert in communication, Rebecca Shafir (2007) states that people only remember 25% of what was said, only a few minutes after the conversation.
- The Kessels (2003) further indicated that the forgetting of information was due to three basic factors:
  - the clinician, with the use of difficult medical terminology
  - the mode of information, that being spoken vs. written;
  - the client, for reasons of limited education; language, etc.

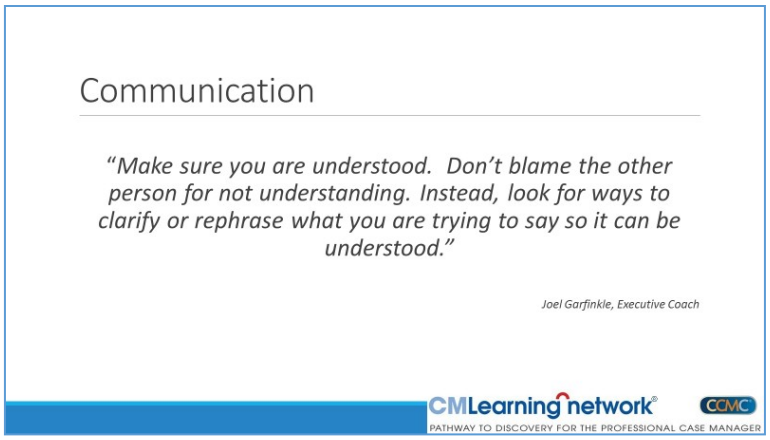
(Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals)*

Kessels, R. (2003). JR Soc Med, 219-222

Shafir, R. (2007). The Zen of Listening: Mindful Communication in the Age of Distraction. NY: Quest Books. ISBN-13 : 978-0835608268

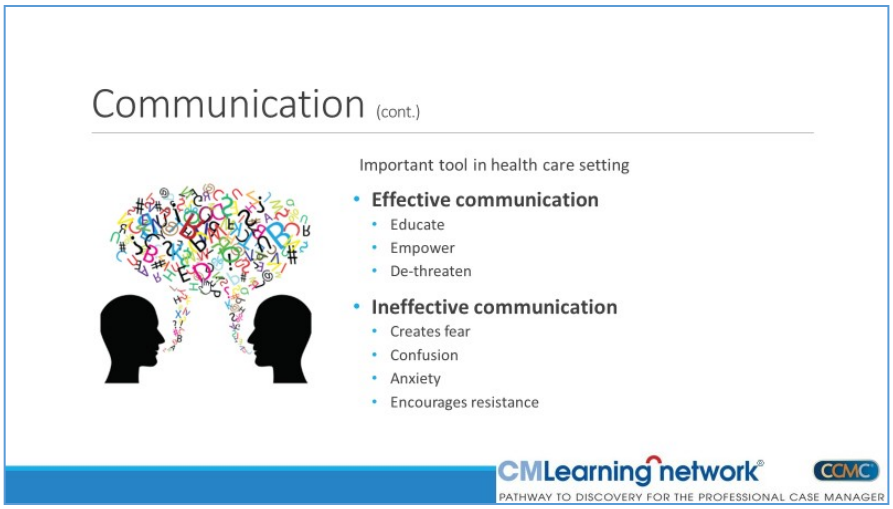
Effective communication is an ongoing challenge:

- Per the Joint Commission1, 8.7% of Americans do not speak English very well, and should be considered of limited English proficiency for healthcare purposes.
- More than 70% of sentinel events are caused by breakdowns in communication among caregivers and between caregivers and their clients
- It's important to remember that how well we communicate is determined not by how well we say things, but how well we are understood. It is our responsibility to ensure this understanding.



- *"Make sure you are understood. Don't blame the other person for not understanding. Instead, look for ways to clarify or rephrase what you are trying to say so it can be understood." (Joel Garfinkle, Executive Coach)*

[1] Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals*



- Communication is an important tool in healthcare. When effectively used, it can educate, empower, and eliminate the threat of the message that is being imparted.
- Ineffectively used, communication can cause fear, anxiety and confusion. And this can lead to the client resisting the lifestyle changes and healthy behaviors that will improve their condition.
- To communicate effectively, the case manager needs to understand how their communication skills affect the assessment and engagement of their clients, modifying their communication to address and consider factors such as age, capacity, learning, and physical ability.

- Communication is a two-way, interactive process. It is used to share information, connecting what is said or written in a message, and what is interpreted from that message.
- The goal of communication is to have the communicator and the receiver get the same message.
- Communication involves sharing ideas and meaning using a common system of symbols, signs and behaviors, using verbal, non-verbal, written, and electronic means that are modified to meet the client's needs and preferences.

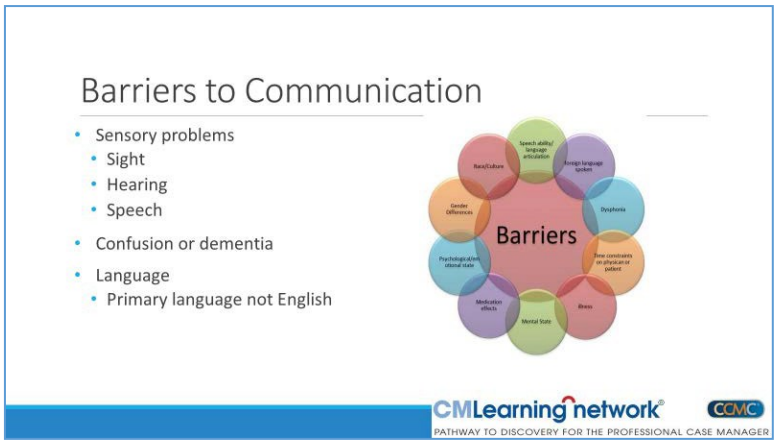
Effective Communication

- There are multiple ways that healthcare providers, and case managers, communicate with clients.
- Many people do not consider listening as communication, but you need to pay attention to what the person is saying and try to identify words that would indicate that the client is frightened, lonely, in pain or discomfort, or worried.
- Case managers should be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information.
- Non-verbal communication can be the single most powerful form of communication. The way you listen, look, move and react all send powerful messages to the client.
- When your non-verbal signals match the words you are using, they will help to increase trust and clarity in the relationship.

- Non-verbal cues can also help by repeating the verbal message; contradicting what you are saying; substituting for a verbal message (for example, what you are saying with your eyes); accenting the verbal message with gestures; or adding to the verbal message, such as by touch.

Key Tips

- **Demonstrate** effective and appropriate verbal and non-verbal skills
- **Modify** communication skills when necessary
- **Be aware** of characteristics and consequences
- **Provide** necessary information to make informed decisions
- **Use** an interpreter when appropriate
- **Employ** interpersonal skills



Barriers to Communication

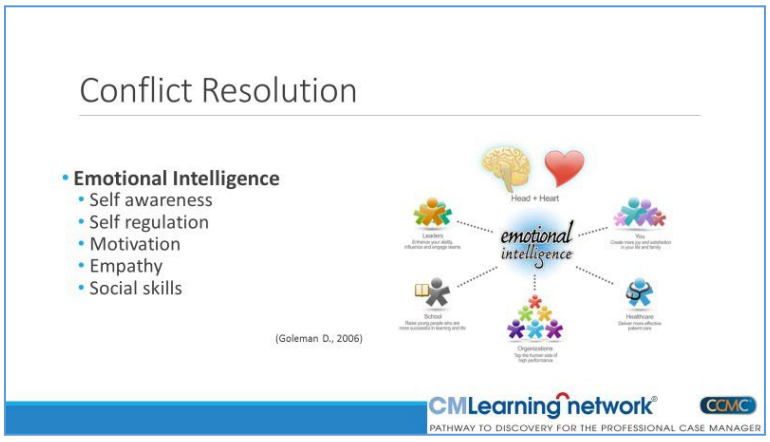
- In addition to other barriers to communication, **sensory problems**, **confusion** or **dementia**, and **language** can all prevent us from being able to communicate effectively with our clients.
- Other barriers to effective communication also include:
  - **The use of jargon.**
  - **Lack of attention, interest, distractions, or irrelevance to the receiver.**
  - **Differences in perception and viewpoint.**

- **Cultural differences**. The norms of social interaction vary greatly in different cultures, as do the way in which emotions are expressed. For example, the concept of personal space varies between cultures and between different social settings.
- **Primary language or native language not English**

Conflict Resolution

- Case managers need to be skilled at conflict resolution
- The 5-step model can help to ease the way for conflict resolution

- Focus should be on the goal, rather than the person you are in conflict with
- Open communication is key; avoid bringing emotion or reactivity into the process
- Strategies to use
  - Accommodating – meets the needs of the other party at your own expense
  - Avoiding – avoids conflict as a default action
  - Collaborating – meets the needs of all parties involved
  - Compromising – finding a solution that gives everyone a partial win, and everyone gives up something
  - Competing – taking a firm stand, useful in emergency situations when fast decisions are needed, or when someone is trying to take advantage of a situation
- Using the tools of emotional intelligence can help the case manager to deal with conflict resolution.



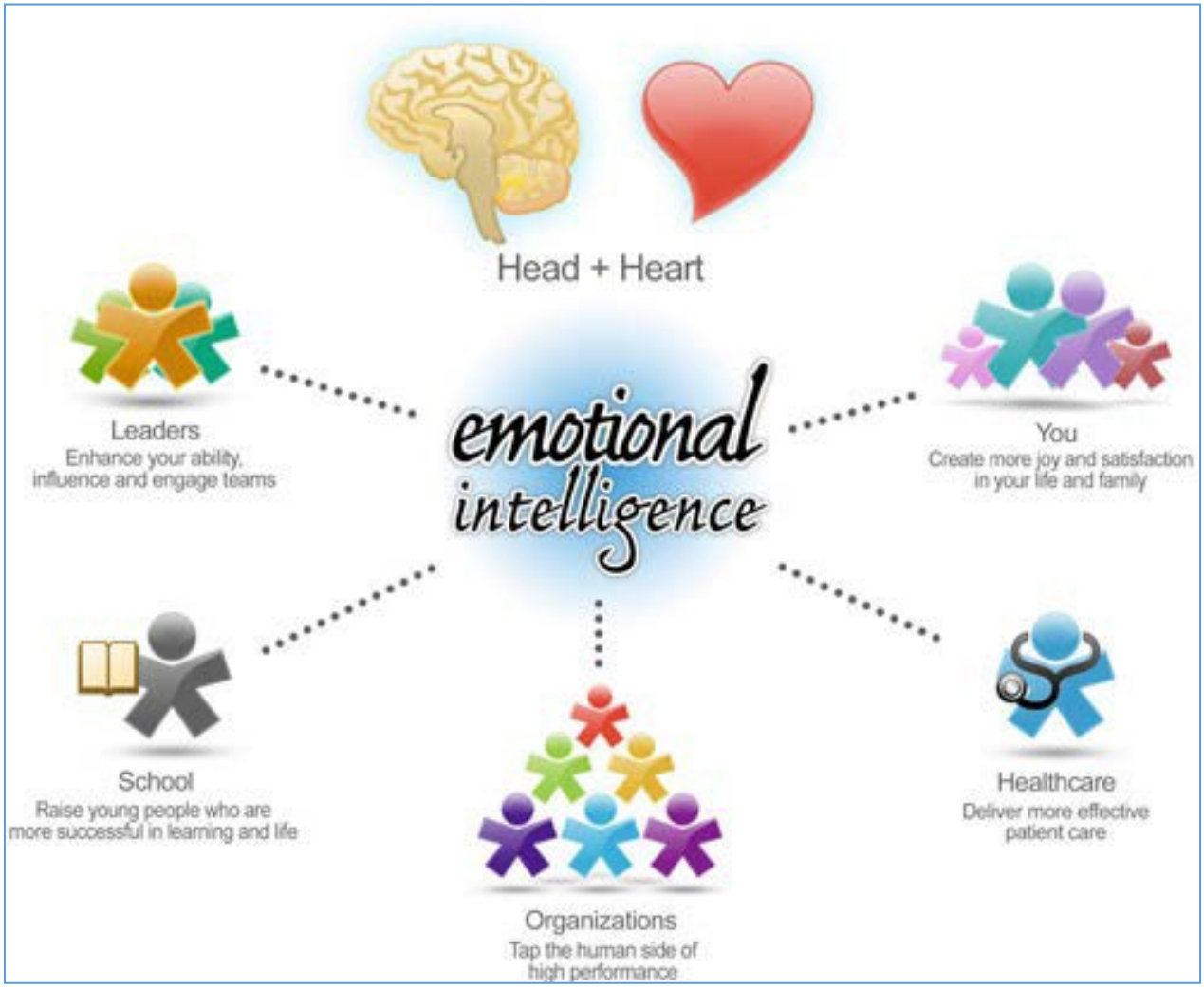
Conflict Resolution

Emotional Intelligence

- Self-awareness – know yourself; know how you feel, how your emotions and actions can affect the people around you; have a clear picture of your strengths and weaknesses, behave with humility
- Self-regulation – staying in control; rarely verbally attack others, make rushed or emotional decisions, stereotype people, compromise your values
  - Know your values – what values are most important to you, what will you not compromise
  - Hold yourself accountable – commit to admit mistakes and face the consequences

- Practice being calm – be aware of your responses in challenging situations; practice deep-breathing

- Motivation – work consistently towards goals; have high standards for the quality of your work
- Empathy – ability to put yourself into someone else's situation; pay attention to your body language; respond to feelings
- Social skills – good communicator, good at managing change, resolve conflicts diplomatically, set an example with your own behavior

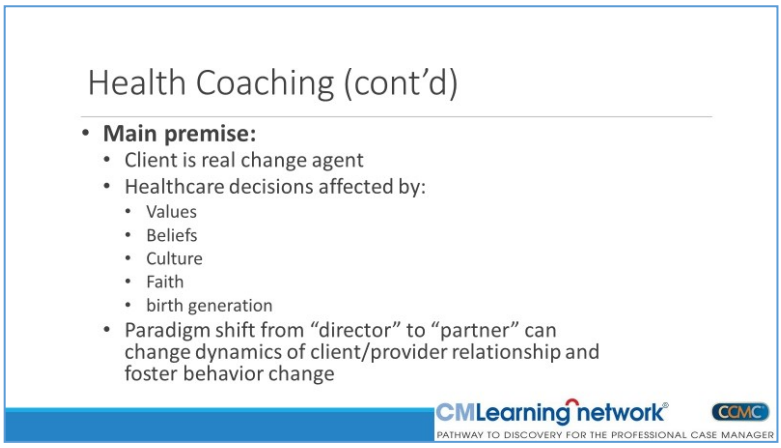


Health Coaching

How Evidence Based Health Coaching is Different

- With a Partnering/Engaging approach
  - You actively listen
  - You empower
  - It is non-judgmental
  - They are the client's concerns

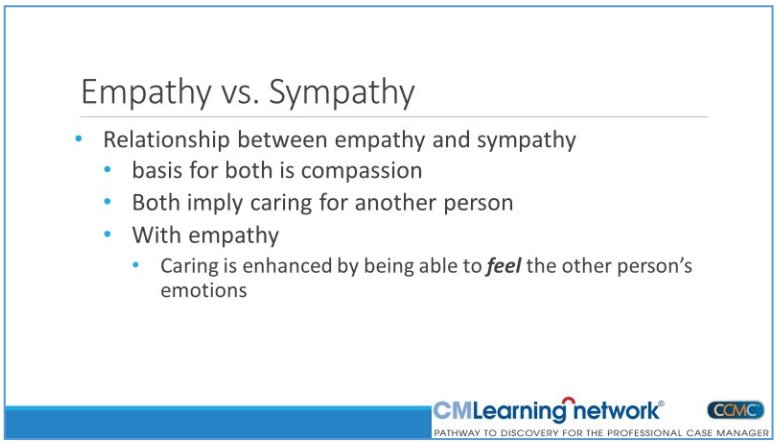
- When you are Directing/Managing
  - You give advice
  - It is diagnosis-driven
  - "We do the talking"
  - It is the provider's agenda
- Evidence-based
- Skillful conversation
- Clinical interventions and strategies
- Actively and safely engage clients in health behavior change.



Health Coaching

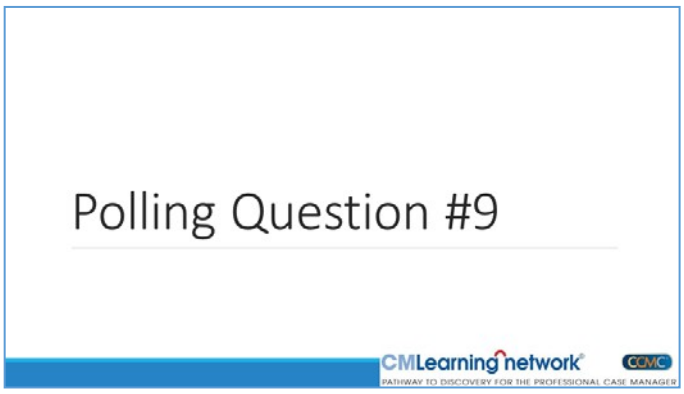
- **Main premise:**
  - client is real change agent
  - Healthcare decisions affected by:
    - Values
    - Beliefs
    - Culture
    - Faith
    - birth generation
- Paradigm shift from "director" to "partner" can change dynamics of client/provider relationship and foster behavior change

Video: https://youtu.be/1Evwgu369Jw



Empathy vs. Sympathy

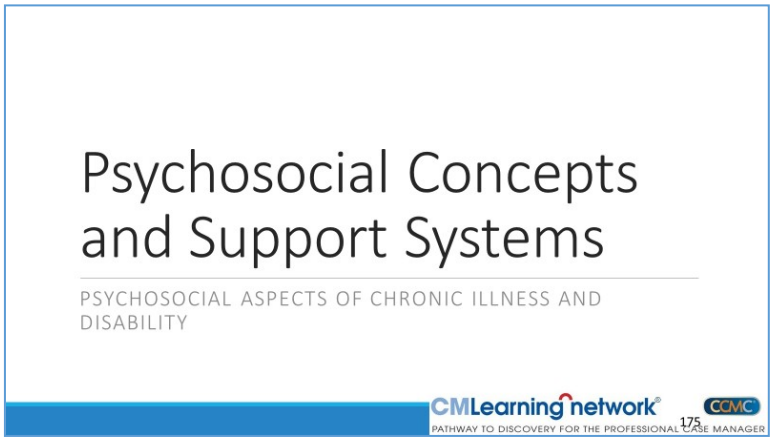
- Relationship Between Empathy and Sympathy
  - The basis for both sympathy and empathy is compassion.
  - Both sympathy and empathy imply caring for another person
  - With empathy, the caring is enhanced or expanded by being able to feel the other person's emotions.
- Empathy – **experiencing** someone else's feelings
- Sympathy – **understanding** someone else's suffering
- **Empathy fuels connection, and sympathy drives disconnection** (Brené Brown)

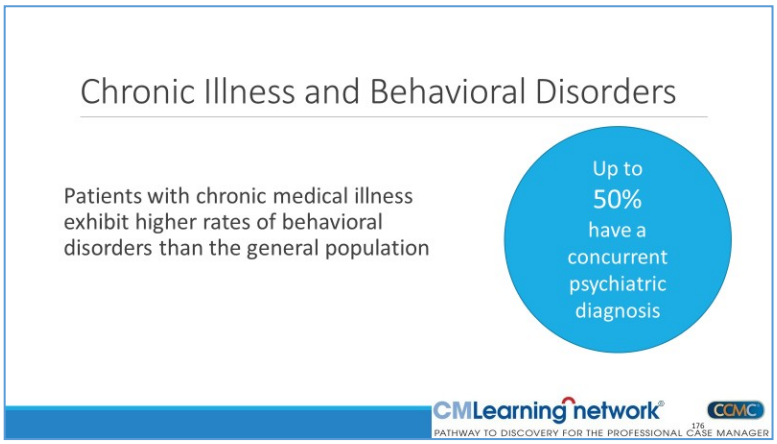


Which of the following strategies/steps for conflict resolution finds a solution that gives everyone a partial win, and everyone gives up something.

a. **Accommodating**
b. **Compromising**
c. **Collaborating**
d. **Avoiding**

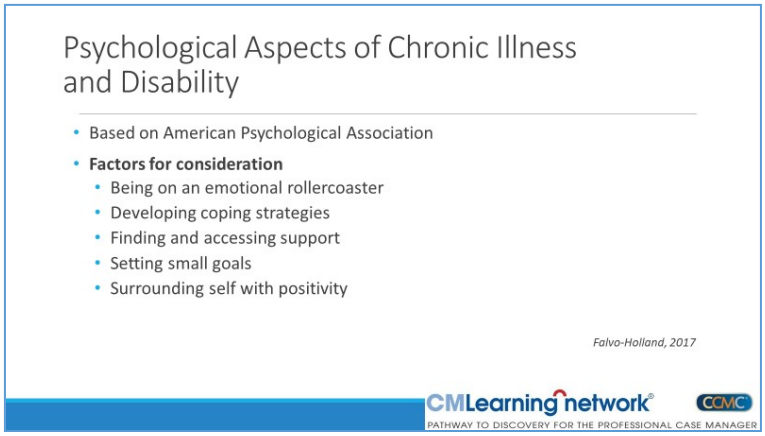
Psychosocial Aspects of Chronic Illness and Disability





Chronic Illness and Behavioral Disorders

- The Center for Disease Control and Prevention, the CDC, has found that clients with chronic medical illness exhibit a higher rate of behavioral disorders than the general population, with up to 50% having a concurrent psychiatric diagnosis.
- The incidence of an individual developing a behavioral health diagnosis also increases if a client has experienced trauma at an early age.

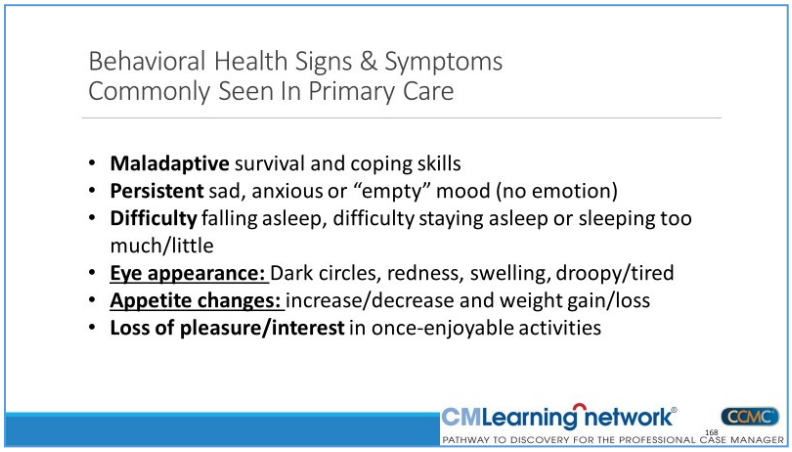


Psychological Aspects of Chronic Illness and Disability

- There are clear physiological, emotional, behavioral, and cognitive aspects of psychological adjustment to chronic illness and disability. To promote psychological adjustment, case managers encourage clients to use the following strategies to increase clients' chances of successfully adjusting to the challenges posed by chronic illnesses:
  - Remain as active as is reasonably possible
  - Acknowledge and express their own emotions in a way that allows clients to take control of their lives

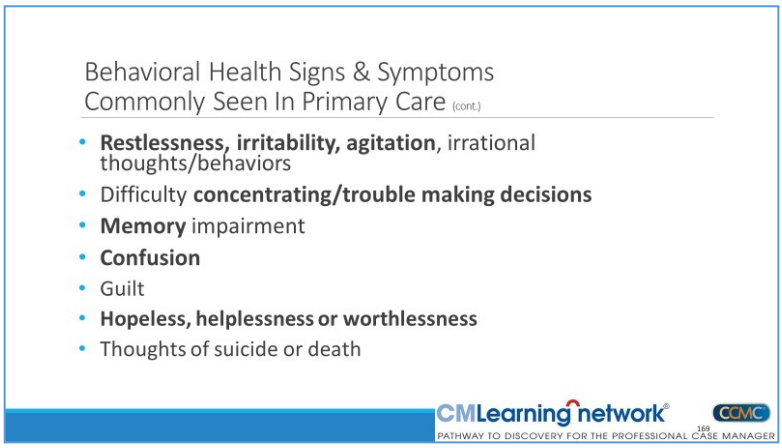
- Engage in self-care management activities
- Focus on potential positive outcomes of illness and care

- Clients often describe feeling like they are on an emotional roller coaster
- When working with them, the case manager should consider:
  - Assisting to develop coping strategies
  - Helping them find and access support services/providers
  - Setting small goals
  - Surrounding self with positivity



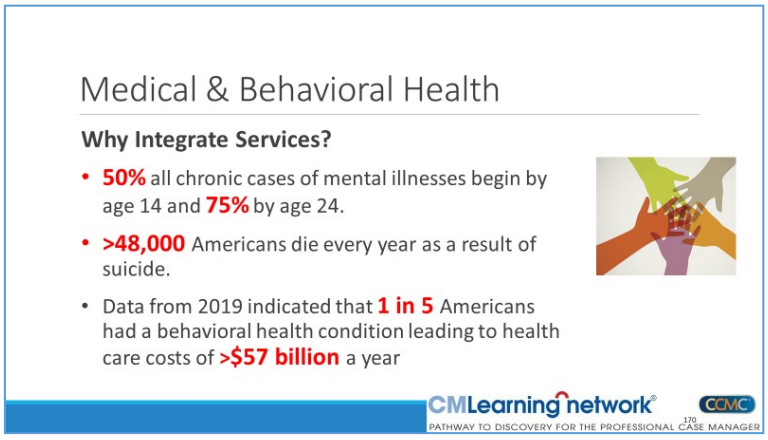
Behavioral Health Signs & Symptoms Commonly Seen in Primary Care

- Behavioral conditions **more likely** to be treated in general medical sector
- Certain mental health signs and symptoms commonly seen in primary care are listed here:
  - **Maladaptive** survival and coping skills
  - **Persistent** sad, anxious or "empty" mood (no emotion)
  - **Difficulty** falling asleep, difficulty staying asleep or sleeping too much/little
    - **Fatigue or loss of energy**
  - **Eye appearance**: Dark circles, redness, swelling, droopy/tired
  - **Appetite changes** - increase/decrease and weight gain/loss
  - **Loss of interest** in once enjoyable activities



- **Restlessness, irritability, agitation**, irrational thoughts/behaviors
- Difficulty **concentrating**/Trouble making **decisions**
- **Memory** impairment
- **Confusion** which is sometimes mistaken for dementia
- Guilt
- **Feelings of hopelessness, helplessness or worthlessness**
- Thoughts of **suicide or death**

- Always look for these signs, especially if your client appears non-adherent, has polypharmacy, or pain management issues.
- These need to be explored and treated in the primary care setting.



Medical & Behavioral Health

Mental Illness Statistics[2]

- There were an estimated 51.5 million adults aged 18 or older in the United States with Acute Mental Illness (AMI)
- This number represented 20.6% of all U.S. adults.
- The prevalence of Acute Mental Illness was higher among women (24.5%) than men (16.3%).
- Young adults aged 18-25 years had the highest prevalence of AMI (29.4%) compared to adults aged 26-49 years (25%) and aged 50 and older (14.1%).
- The prevalence of AMI was highest among the adults reporting two or more races (31.7%), followed by the White adults (22.2%). The prevalence of AMI was lowest among the Asian group (14.4%).

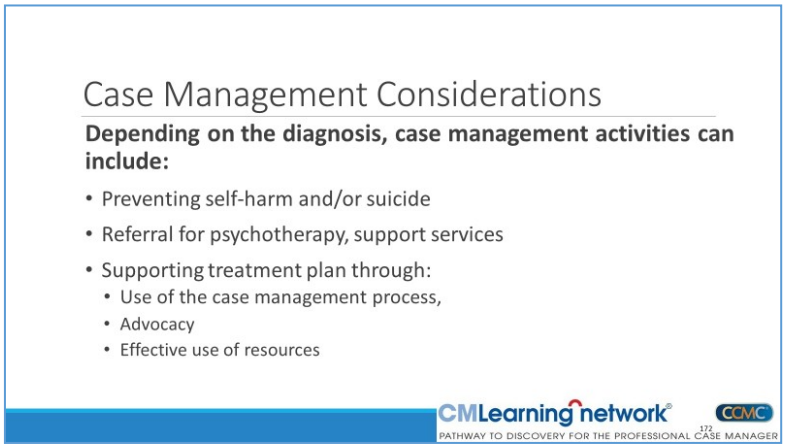
Why Integrate Services?

- The importance of integration of behavioral and primary health care will only increase in the future
- By 2020, behavioral health issues will have surpassed all physical diseases as a major cause of disability and have a negative impact on both health and healthcare costs.
- Half of all chronic mental illness begins by age 14; three-quarters by age 24. Despite effective treatment, there are long delays—sometimes decades—between the first appearance of symptoms and when people get help.

[2] 2019 statistics downloaded from www.nimh.nih.gov/health/statistics/mental-illness.shtml

Behavioral & Primary Care

- The benefits of this integration are:
  - **Seamless** for the client—improves satisfaction
  - **Reduces Stigma**
  - **Improves Access** for mental health expertise
  - **Extends Behavioral Change Expertise** into the Primary Care Center for improved management of chronic conditions (such as diabetes, cardiovascular disease)
  - **Improves** medical productivity, access and flow
  - **Contributes to the improvement** of medical clinical outcomes and functional outcomes



Case Management Considerations

- Within the behavioral health realm, barriers to effective care can include:
  - lack of adequate assessment
  - lack of resources
  - lack of trained healthcare providers
  - social stigma that is still attached to mental disorders.
- So, what should be the case management considerations for behavioral health clients? Much depends on the diagnosis, but even before that may be known, the case manager should focus on prevention of self-harm and/or suicide.

- A referral for psychotherapy or support services would be appropriate, and the case manager would be instrumental in supporting the treatment plan through usual case management process, with a focus on advocacy and effective resource utilization, as there may be limited benefits.

- Identify and address treatment issues using the **strengths model**.
- Key concepts:
  - Every individual, group, family, and community has strengths
  - The upper limits of a person's capacity to grow & change is not known
  - Even the most seemingly impoverished environments have resources and strengths
  - Behavior and achievement is often a function of the resources available or perceived to be available to the person
  - Both the strengths of the person and the environment can be used to help attain goals that they set
  - Generating options and alternative pathways to a goal is fundamental to strength-based practice
  - Strengths include:
    - Personal qualities
    - Traits
    - Talents
    - Virtues
    - Interests
    - Knowledge of the world around oneself

- As case managers our best course is to collaborate with the person and the environment
- Communication is key. Ensure that all members of the care team know the plan and how it is progressing, evaluating the outcomes, and preventing delays in care.
- As appropriate, incorporating the significant other, family, caregiver, extended support system into the care should be considered as part of the case management interventions

Challenges in Behavioral Health Case Management

- Depending on the diagnosis, case management activities can include:
  - Preventing self-harm and/or suicide or violence
  - The case manager must apply appropriate procedures in handing individuals with suicide concerns and must listen to the individual/support system carefully to determine level of suicide intent.
  - The case manager must be aware when dealing with individuals with increased risk of violence that, in addition to ensuring the protection of the individual, that investigation of domestic abuse or child abuse is conducted as well.
  - The case manager must be knowledgeable of their responsibilities as a mandated reporter
  - Referral for psychotherapy, support services
  - Supporting treatment plan through:
    - Assessment
    - Monitoring
    - Planning

    - Advocacy
    - Effective use of resources
  - Evaluate outcomes of care
  - Facilitate care progression as indicated
  - Prevent delays in care
- Advocate for activities and programs that promote healthy lifestyles
- For clients that exhibit signs of self-neglect, the inability to provide self-care tasks, the case manager must work with the care team to create a plan that will reduce these behaviors
- In the case of clients with a dual diagnosis, both disorders must be treated concurrently. The case manager should be alert to the potential for suicide.
- Treatment plans should be individually tailored to improve the general health and social functioning of behavioral health clients. Increasing stimulating, challenging, and interesting daily activities can address improvement in both general health and social functioning.
- And it is critical to establish a trusting relationship with the individual. Frequent staff turnover in an organization can contribute to poor-quality care, recidivism, and interruptions in continuity of care.

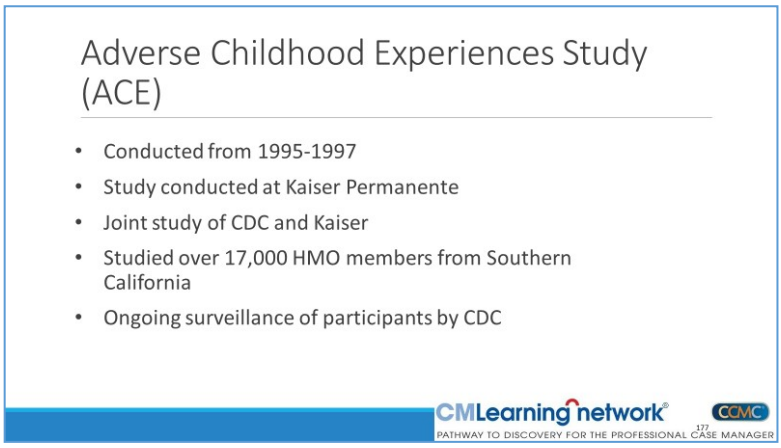
Goals for Behavioral Health Case Management

- Improving the general health of individuals

- Improving the social functioning of individuals
- Enhancing the client-case manager relationship and care continuity

Abuse and Neglect

- Often, victims of abuse or neglect will deny that it has occurred.
- Assessment must include further investigation if there is a possibility for abuse, and it is critical that the case manager intervene to reduce or eliminate risk.
- Most states have specific reporting requirements for abuse. It is also important that the case manager be familiar with their state reporting requirements and comply with them.
- Assessment needs to consider potential abuse and neglect
  - Caregiver abuse
  - Caregiver neglect
  - Child abuse
  - Child neglect
  - Domestic violence
  - Elder abuse



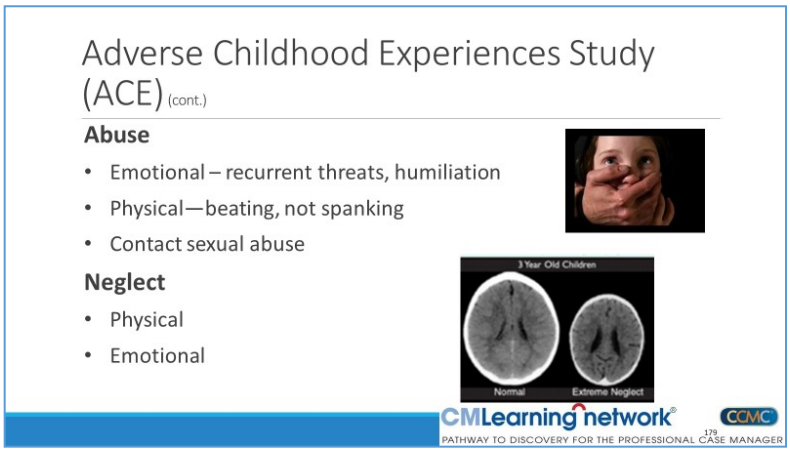
Adverse Childhood Experiences Study (ACE)

- The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and later-life health and well-being.
- The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection.
- Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.
- The CDC continues ongoing surveillance of ACEs by assessing the medical status of the study participants via periodic updates of morbidity and mortality data.
- A much-shortened version of the ACE Study questionnaire that 17,337 adults filled out at Kaiser Permanente in San Diego is available in the documents in the back of the workbook. The original questionnaire, which is on the CDC ACE Study site, has more than 200 questions.
- The ACE Study shows a direct link between child trauma and diabetes, heart disease, lung cancer, and a host of other chronic illnesses that people get when they're adults. The higher a person's ACE score, the higher risk of chronic disease when they're an adult.
- The ACE study examined Adverse Childhood Experiences which showed that being chronically exposed to 4 or more ACEs between the ages of birth and 18 years of age increases the chance of having major psychosocial, environmental, and medical problems in adulthood and it ultimately increases the chance of a premature death.
- There are 10 types of trauma measured in the ACE Study.

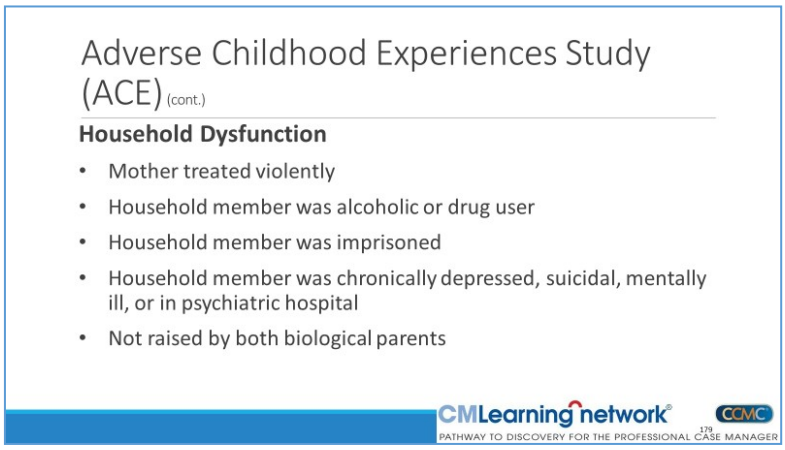
- Five are personal
    - physical abuse
    - verbal abuse
    - sexual abuse
    - physical neglect
    - emotional neglect
- Five are related to the family:
    - a parent who's an alcoholic
    - a mother who's a victim of domestic violence
    - a family member in jail
    - a family member diagnosed with a mental illness
    - the disappearance of a parent through divorce, death or abandonment
- Each type of trauma counts as one
- A person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

- All these statistics illustrate the importance of attention to behavioral health issues for case managers and should be part of your assessment as well as your integrated case management provision.

- **Video:** https://www.youtube.com/watch?v=UX7HxYeswkI



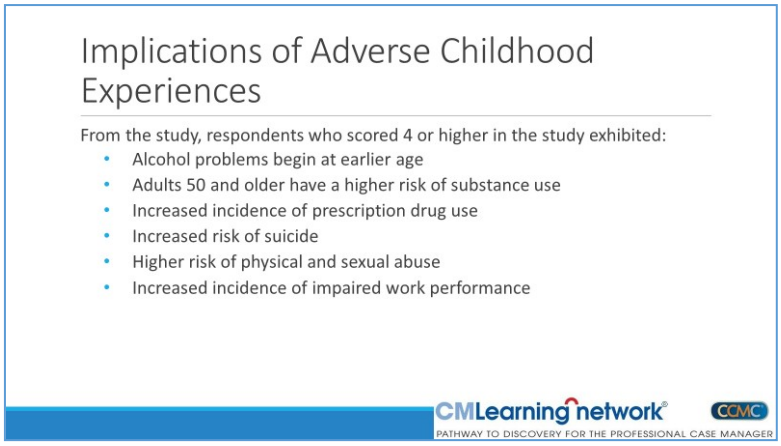
- **Abuse**
  - Emotional – recurrent threats, humiliation
  - Physical—beating, not spanking
  - Contact sexual abuse
- **Neglect**
  - Physical
  - Emotional



Household Dysfunction

- Mother treated violently
- Household member was alcoholic or drug user
- Household member was imprisoned

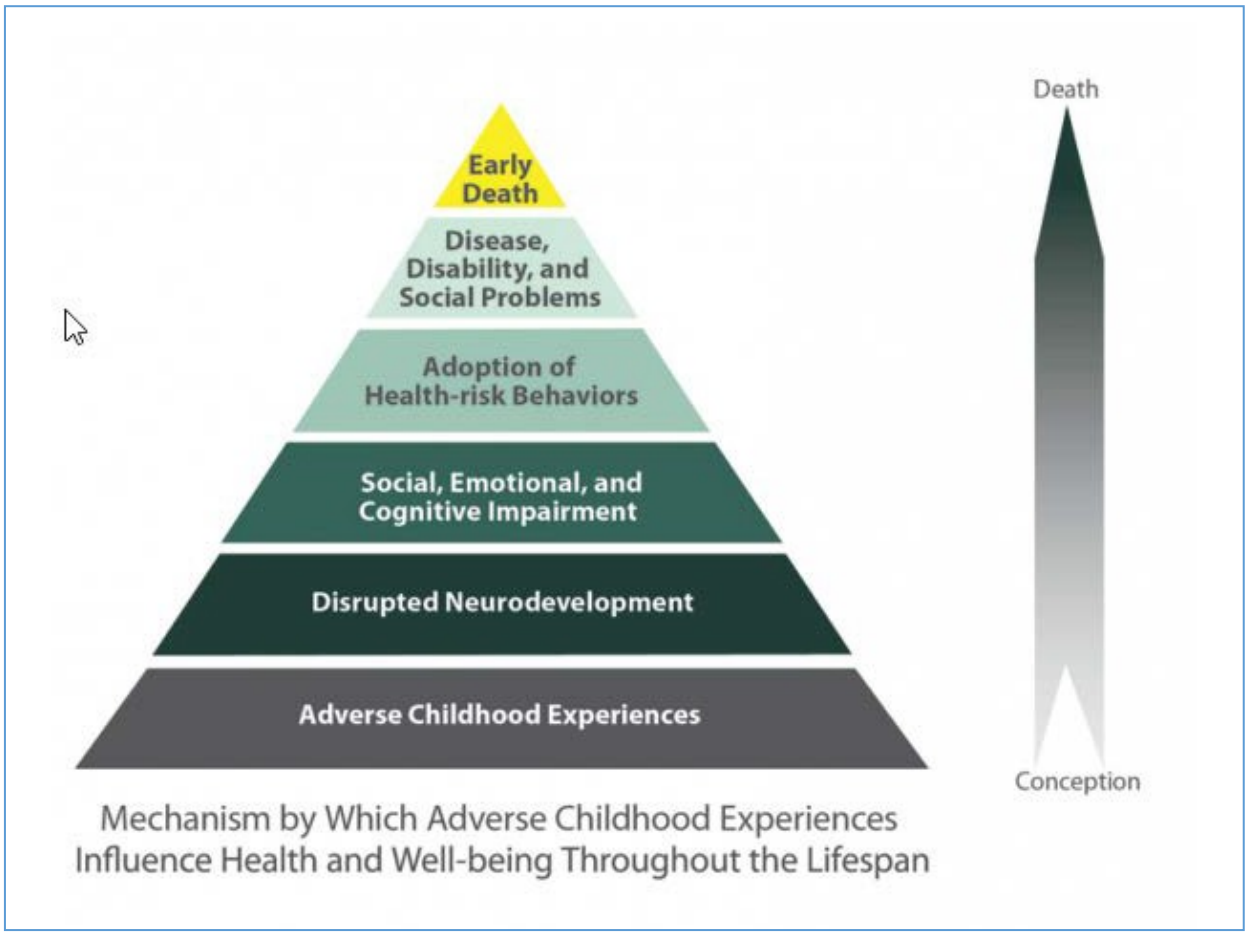
- Household member was chronically depressed, suicidal, mentally ill, or in psychiatric hospital
- Not raised by both biological parents

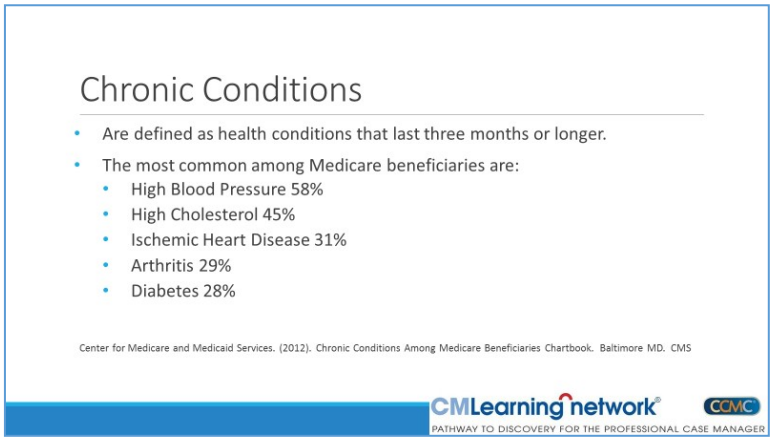


Implications of Adverse Childhood Experiences

- From the study, respondents who scored 4 or higher in the study exhibited:
  - Alcohol problems begin at earlier age
  - Adults 50 and older have a higher risk of substance use
  - Increased incidence of prescription drug use
  - Increased risk of suicide
  - Higher risk of physical and sexual abuse
  - Increased incidence of impaired work performance

Influence of ACE Through the Lifespan

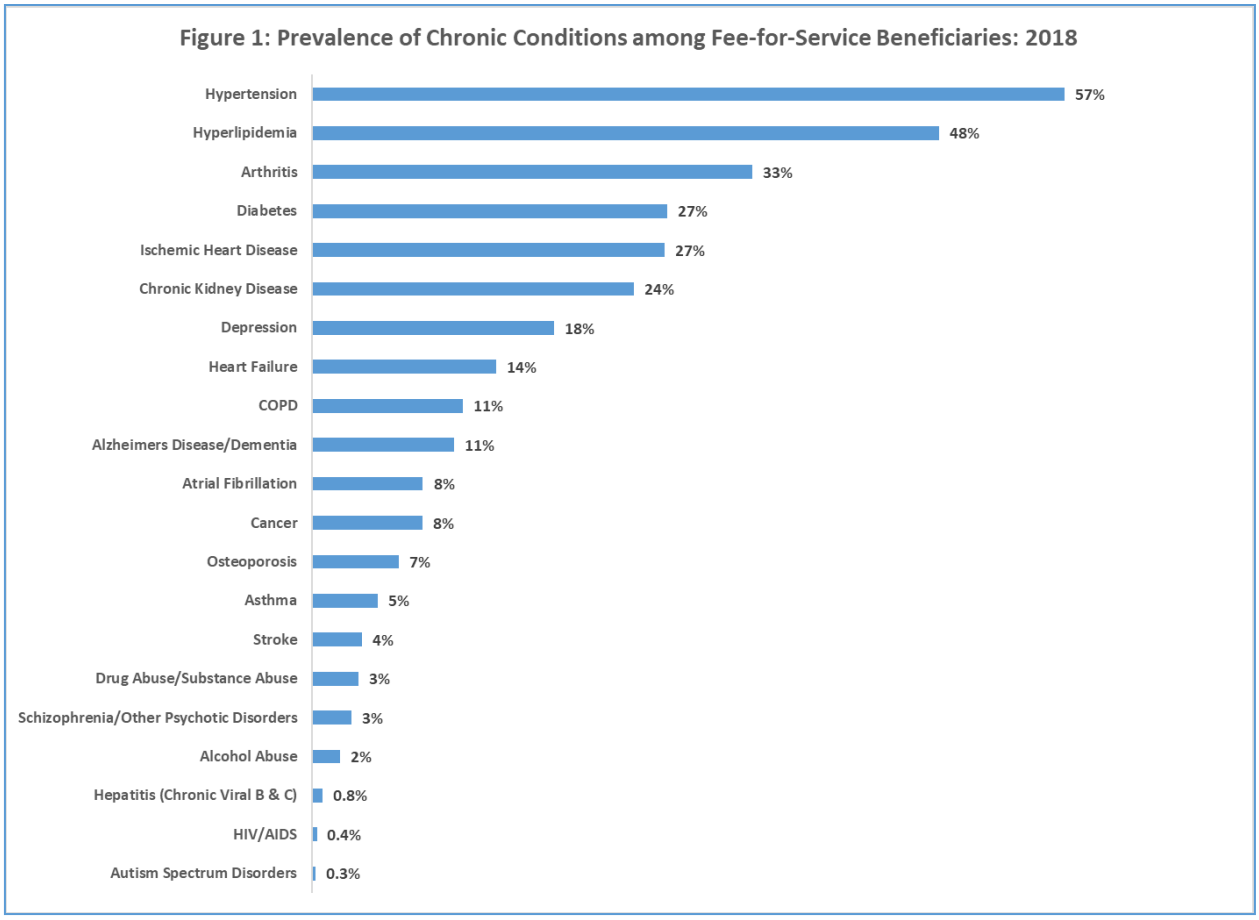


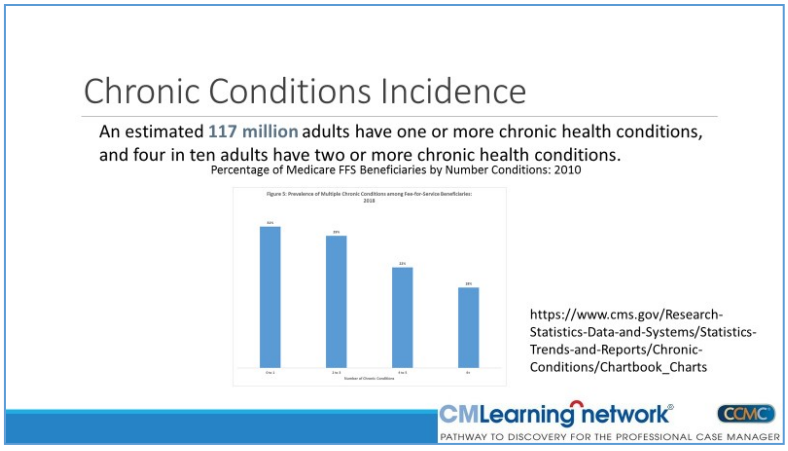


Chronic Conditions

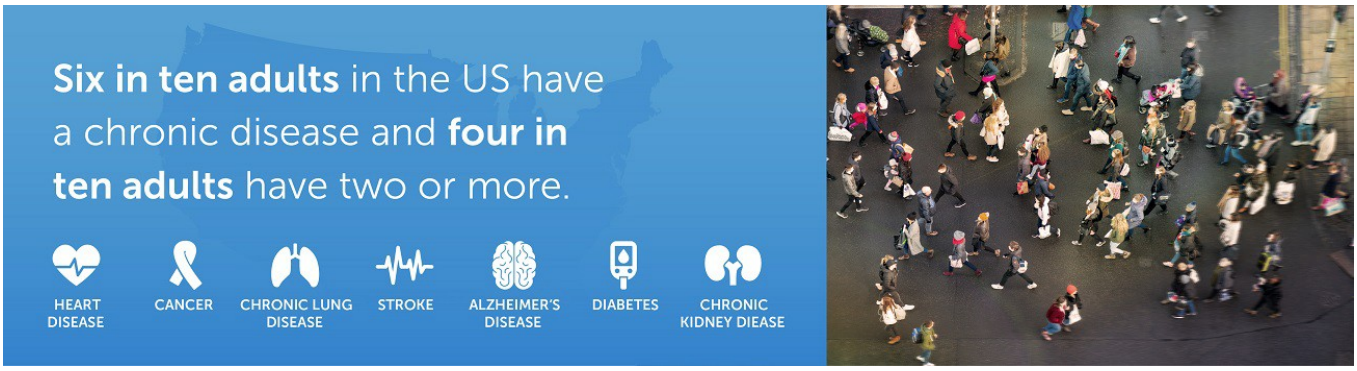
Chronic conditions are defined as those health conditions that last three months or longer.

Percentage of Medicare Beneficiaries with 21 common conditions:

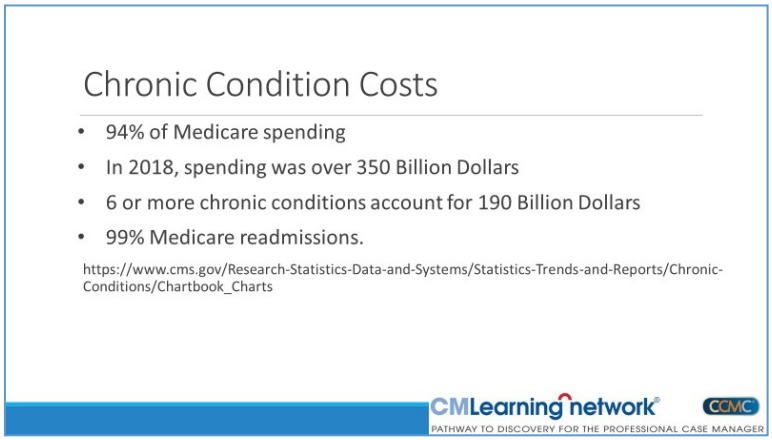




Chronic Conditions Incidence



https://www.cdc.gov/chronicdisease/about/index.htm



Chronic Condition Costs

- Treatment of Chronic Conditions accounts for 94% of Medicare spending
- In 2018, Medicare spending was over 350 billion dollars. Per capita Medicare spending for beneficiaries with 6 or more chronic conditions was three times higher than for the average beneficiary. One-third of Medicare beneficiaries without multiple chronic conditions (0 or 1 chronic condition) had Medicare costs totaling 21 billion, whereas, those with 6 or more chronic conditions (roughly 18% of FFS beneficiaries) had Medicare costs of over 190 billion dollars.
- Beneficiaries with multiple chronic conditions accounted for almost all (99%) Medicare hospital readmissions

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts

Chronic Care Model (CCM)

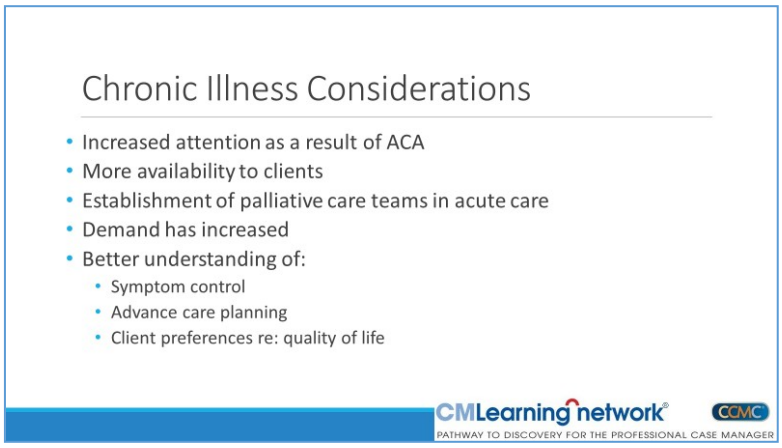
- Systems model for high-quality chronic illness care and improved outcomes
- Adopted by the World Health Organization (WHO)
- Fosters productive interactions between clients and providers to keep the client well informed and able to achieve optimal self-management
- Identified six (6) essential elements

1. Self-management support – empowers clients to manage their healthcare; healthcare teams work with clients to:
    - establish health goals
    - provide emotional support
    - develop plans of care, including transitional plans
    - optimize use of internal and external resources to manage chronic illness and its consequences
2. Community resources – linkages and partnerships with organizations in the community assist clients with chronic illness to access resources that can provide improved and more efficient programs
3. Health systems - organizational leadership committed to quality improvement; care coordination and transition management supported by the organization
4. Delivery system design – shift from reactive to proactive care; prevention and wellness should be the focus; complex needs of the chronically ill should be addressed by the healthcare team, with intense case management for high-risk clients to ensure coordination and communication across the continuum
5. Clinical information systems – electronic health records that provide information across all settings to prompt clinicians regarding timely care, care coordination,

education, and quality monitoring to ensure efficient and successful chronic care management

6. Decision support – consistent use and updating of evidence-based guidelines, with explanation to the client, to ensure participation in the decision-making process for optimal engagement in their own care

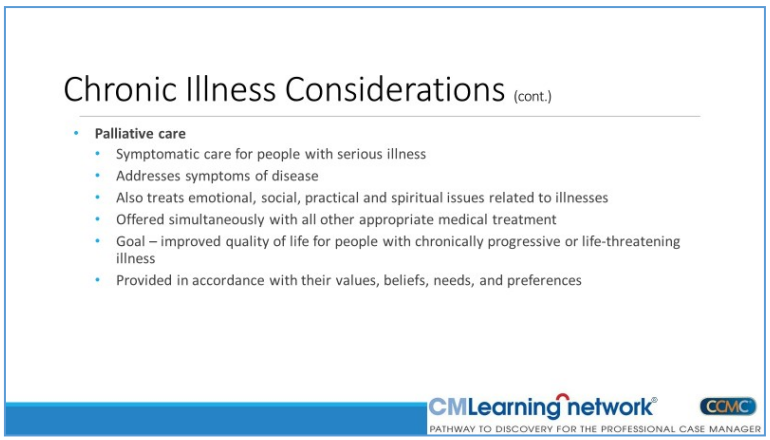
- Changes to practice systems that improve care
- Better use of non-physician team members
- Planned encounters – scheduled health visits
- Self-management support
- Care management for high-risk clients
- Links to effective community resources
- Integrating guidelines into care
- Information system/registries enhanced



Chronic Illness Considerations

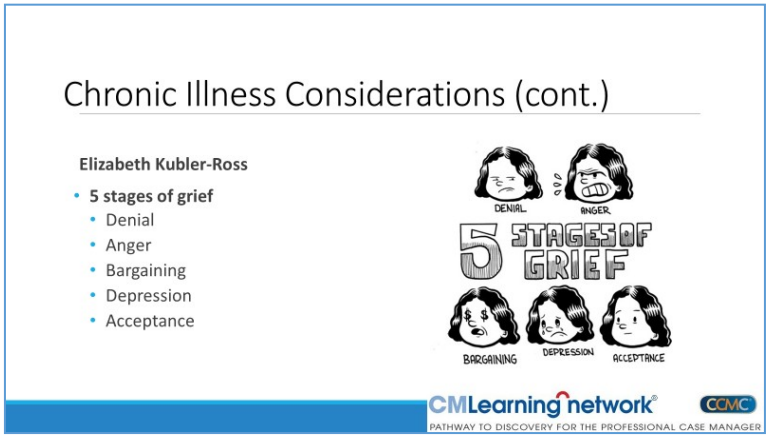
- Increased attention because of ACA
    - Readmission reduction initiatives
- More availability to clients
- Establishment of palliative care teams in acute care
- Demand has increased
- Better understanding of:
    - Symptom control

- Advance care planning
- client's preferences re: quality of life



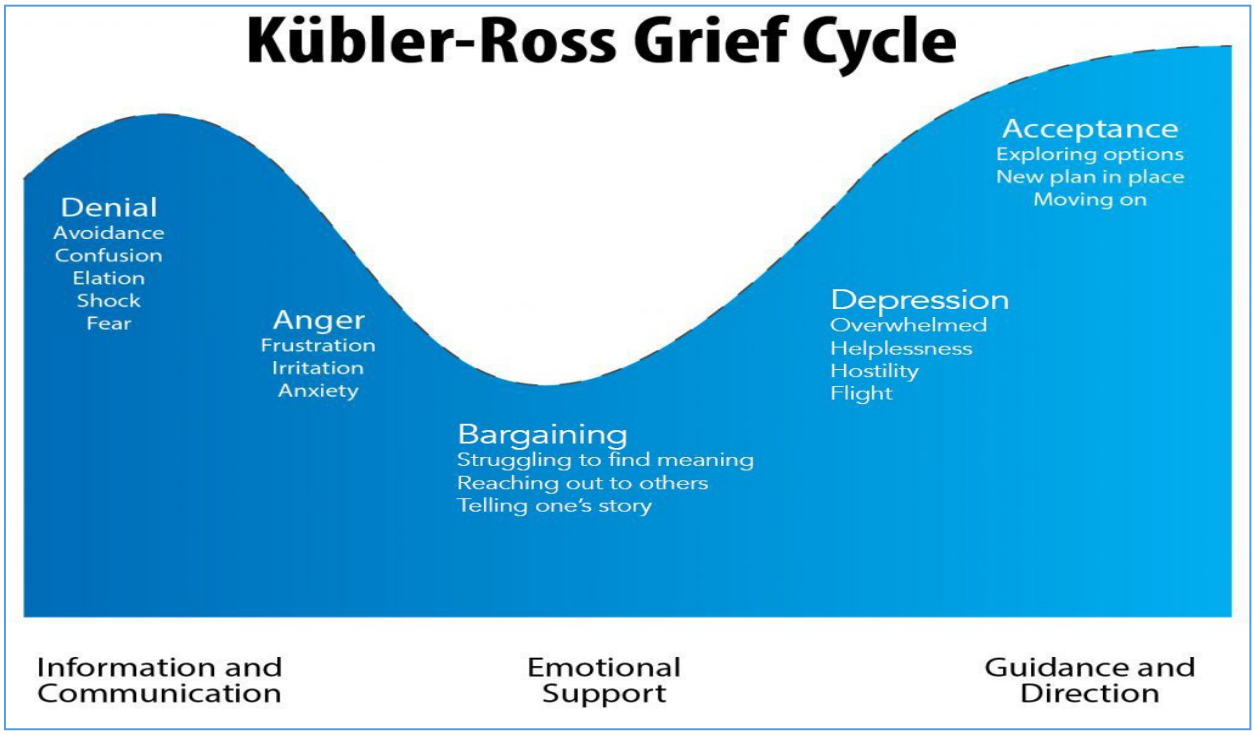
Palliative Care

- Palliative Care seeks to provide the best quality of life for people with chronic, progressive illnesses
- The goal of palliative care is to help people with serious illnesses feel better
- It prevents or treats symptoms and side effects of disease and treatment
- Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up
- When the person feels better in these areas, they have an improved quality of life.
- Offered simultaneously with all other appropriate medical treatment
- Provided in accordance with their values, beliefs, needs, and preferences



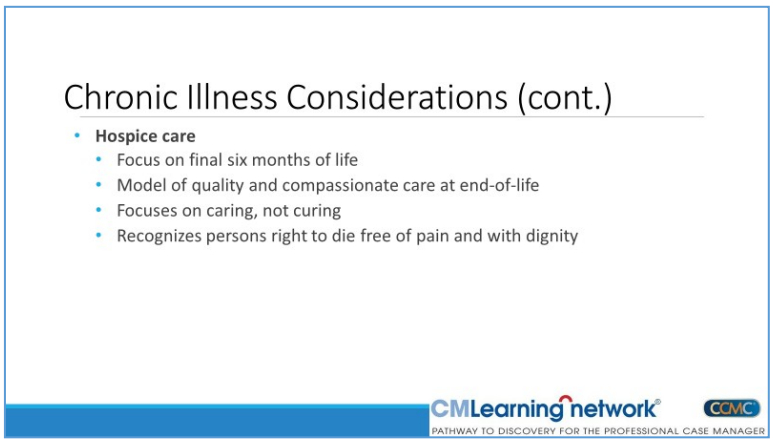
Elizabeth Kubler-Ross

5 stages of grief



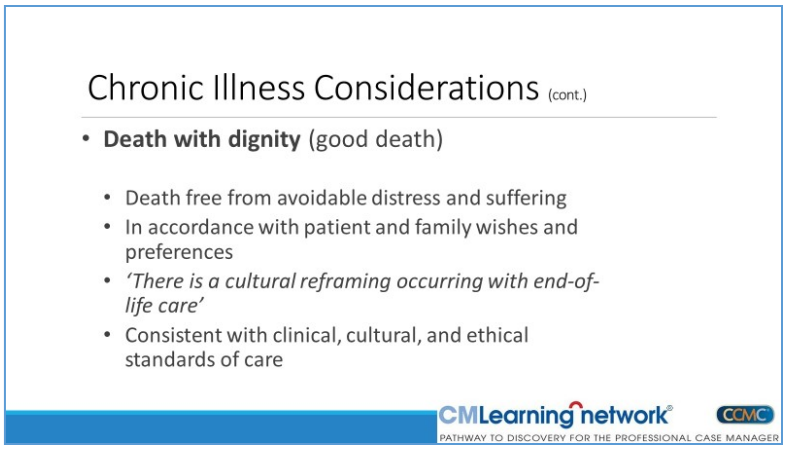
- People often think of the stages as lasting weeks or months
- The stages are responses to feelings that can last for minutes or hours as we flip in and out of one and then another
- We do not enter and leave each individual stage in a linear fashion
- We may feel one, then another and back again to the first one.
- Denial helps us to survive the loss
- Anger provides strength and can be an anchor
- Bargaining is a way to negotiate the unreality of the loss
- Once we recognize that bargaining is not going to reverse the emptiness, we move into depression, and grief enters a deeper level. While this depression may be perceived as it will last forever, it is an appropriate response to a great loss and not a sign of mental illness

- Finally, we enter the acceptance phase, where we begin to learn to live with our new reality, knowing it will never be the same.



Hospice

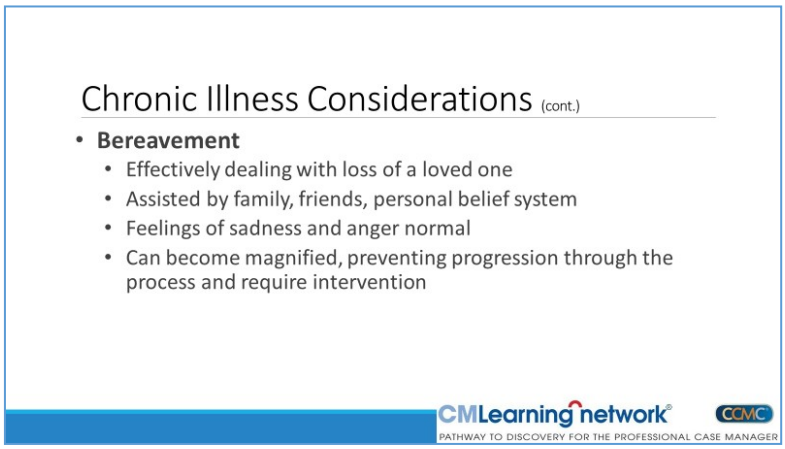
- Hospice care focuses on a person's last six months of life of less
- When curative treatment is no longer an option, hospice professionals work to make the life of clients as comfortable as possible
- This means that hospice care includes palliative care, because the goal is to make the client as comfortable as possible for the time that's left.
- Model of quality and compassionate care at end-of-life that focuses on caring, not curing
- Recognizes persons right to die free of pain and with dignity



Death with Dignity

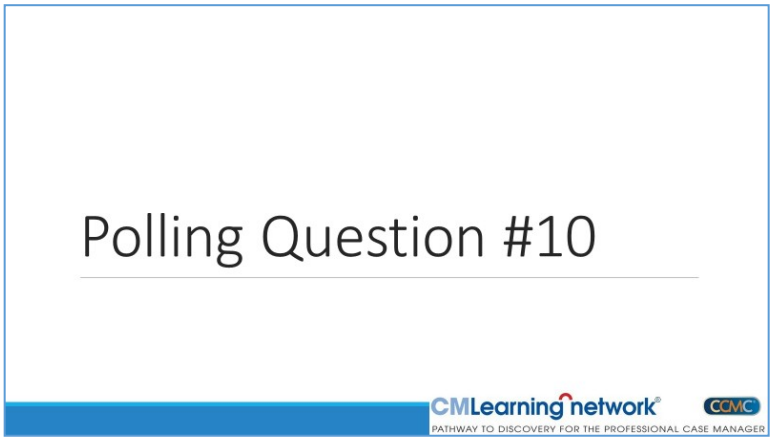
- Death with dignity (good death)

- Death with dignity – death free from avoidable distress and suffering for clients and their families and in accordance with the client's and support system's wishes
- There is a cultural reframing occurring with end-of-life care
- Care is considered reasonable and consistent with clinical, cultural, and ethical standards of care.



Bereavement

- Bereavement is effectively dealing with the loss of a loved one with the help of family, friends, and their personal belief systems—this may include feeling and expressing sadness and anger, but that's normal and they get through it
- Some people have a more difficult time processing this degree of loss and find it impossible to continue life as they knew it, showing symptoms of guilt about the death, consistent thoughts about their own death, preoccupation with feelings of worthlessness, and everyday functioning becomes impaired
- When these symptoms persist for at least 2 months after the loss, they may be attributed to complicated bereavement



True or False:

Palliative care requires certification by a physician that a client has 6 months or less to live.

TRUE
FALSE

Multicultural, Spiritual and Religious Factors

Religion vs. Spirituality

Spirituality as it Relates to Health Behavior

- Conventionally, we tend to use words like, “faith”, “spirituality”, “belief” and “religion” interchangeably.
- Faith, from a naturalistic, psychological perspective, is merely the innate drive to search for meaning, purpose and significance.
- Spirituality represents the paths a person’s faith (as defined above) travels as it seeks meaning, purpose, and significance – true power comes from within
- In these terms, faith is an internal feeling, a sense that there is “something more.” By contrast, spirituality represents the effort to find out what that “something more” might be. Spirituality results when one’s faith that has been activated.
- Belief represents the truths/claims I make because of my spiritual journey.
- Religion–Religion refers to the community of people who share similar beliefs and who work together to provide both support for going deeper into those beliefs and accountability for living up to those beliefs.
- Religions codify beliefs into sacred texts and–by means of rituals and moral practices–seek to facilitate the deepest possible connection with the beliefs the particular community holds.
- Impact on health
- Profound impacts on adherence to plan
- Integral part of healthcare and daily life
- Culture Impacts Spirituality

Health Literacy and the Role of Culture

- Personal convictions, racial, ethnic, religious, and social beliefs all shape the individual's perception of his or her health.
- The values that make up their culture can impact how they define what they feel is a health problem.
- These values also impact how they express concerns about the problem, report symptoms, decide what type of service should be obtained, when, and from whom, and respond to treatment guidance.
- If the cultural norms do not match up with the dominant values of the health care system, the individual can have trouble accessing health services.
- They will also have difficulty communicating with providers and being able to self-manage effectively.

Key Terms

We're all familiar with the terms culture, ethnicity, and cultural values, but let's look at the definition of these terms so there's no misunderstanding of what we're talking about.

Ethnic/ethnicity

- Belonging to or distinctive of a racial, national, cultural, or language division

Culture

- Common values, beliefs, traditions and/or language shared by a people in a group
- Different sets of individuals can be considered a culture. For example, the Lesbian, Gay, Bisexual, and Transgender Community, or different religious affiliations can be considered a culture.

Values

- Values are things we feel are important such as needs, motivations, goals, attitudes, and interests. Generally, cultures or sub-cultures demonstrate values typical to a group.

Cultural Competency

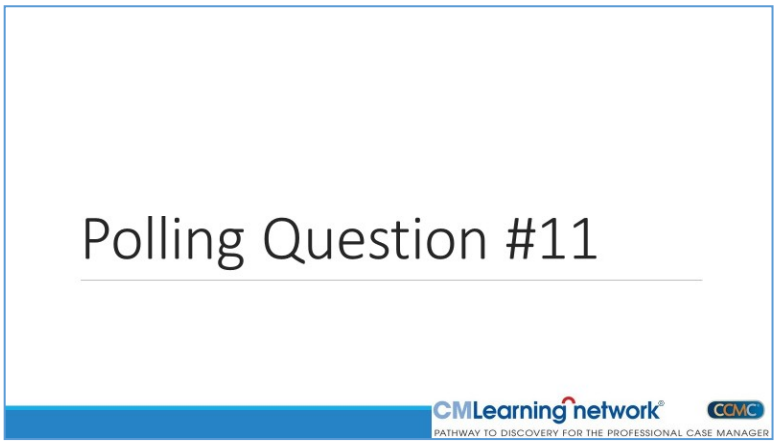
- Cultural background, language proficiency, and socioeconomic status are just a few cultural barriers that point to a need for case managers to assist a client to navigate the health care system. And these barriers don't only apply to people from other countries.
- Cultural competency, or cultural awareness and sensitivity, is defined as a competency based on the premise of respect for individuals and cultural differences, and an implementation of a trust-promoting method of inquiry.

- We must respect their values and beliefs and plan our case management strategies to be congruent with them – view person as an individual, not as a representative of the group
- Practice self-awareness
  - Know other cultures – "other awareness"
  - Identify and value differences
  - Identify and avoid stereotypes
  - Empathize with people from other cultures
  - Adapt rather than adopt – make adjustments and compromise
- Refers to the practices and behaviors that ensure that all clients receive high-quality, effective care, irrespective of cultural background, language proficiency or socioeconomic status.
- Cultural proficiency – Knowing how to learn about individual and organizational culture
  - interacting effectively in a variety of cultural environments.
- Cultural humility – lifelong commitment to self-evaluation and self-critique
  - Goal is not simply to learn and appreciate the culture of others but must include examining one's own biases and cultural limitations.
  - Engage in lifelong self-awareness and self-critique of the limitations of our own cultural perspectives and openness to new ideas and cultures
- *Cultural sensitivity* – skills that enable us to learn about and understand people who are different from ourselves, thereby becoming better able to serve them within their own communities.
  - 10 steps to cultural sensitivity
    - Take initiative to make contact
    - Show respect for other cultures, languages, and traditions
    - Learn how to pronounce names correctly
    - Be sensitive to others' feelings regarding their homeland
    - Speak slowly and clearly
    - Be yourself
    - Take time to listen
    - Don't make promises you won't or can't fulfill

- Be genuine with your friendships
- Don't allow cultural differences to become the basis for criticism and judgments

Culture and Health Care

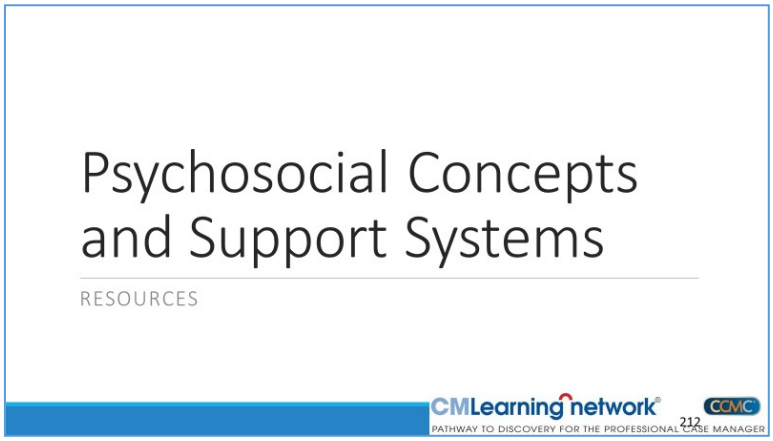
- So why is understanding culture and cultural competence important for case managers?
- Culture can present barriers to effective healthcare.
- This is significant because a lack of understanding causes **disparity** in care.
- It can result in **discrimination**, it **limits access** to care, it **prevents** a provider from giving **quality care**, and it can **create opportunities for medical errors**.
- Additionally, removing the barriers perceived by a lack of cultural understanding on the part of the professionals, the client is more likely and able to engage with the providers and improve their adherence and outcomes.
- It is part of the Standards of Practice and the Code of Professional Ethics



11. Which of the following is defined as belonging to, or distinctive of, a racial, national, cultural or language group?

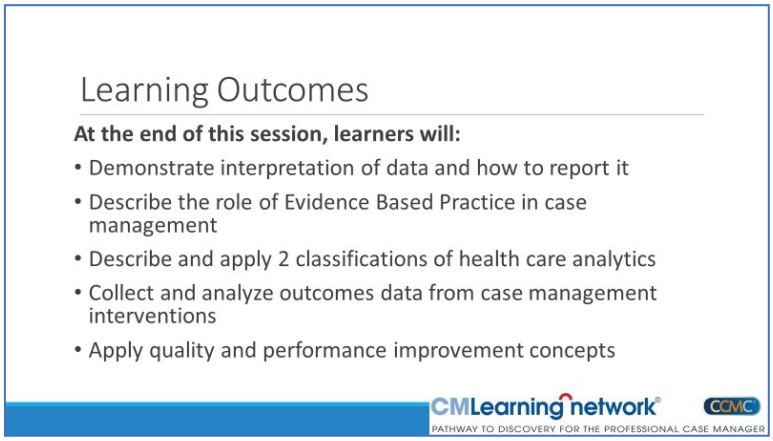
a. **Spirituality**
b. **Ethnicity**
c. **Culture**
d. **Values**

Resources



Support Programs

- Continued assessment is necessary to identify support needs of clients and families.
- If needs are identified, the case manager can refer the client to local or national disease-based programs that offer education, financial assistance, and peer support.
- Support groups are also available for clients and caregivers. Many communities have local support groups, and national organizations (Alzheimer's) offer support services and strategies for caregivers
- Pastoral counseling may be integral for clients with deeply held spiritual beliefs.
- And bereavement counseling can aid with losses of close family or friends or other losses resulting from illness or tragedy.
- Counseling and supportive interventions provided to clients and/or their support systems
- **Types**
    - Support groups
    - pastoral counseling
    - disease-based organizations
    - bereavement counseling



Learning Outcomes

At the end of this session, learners will:

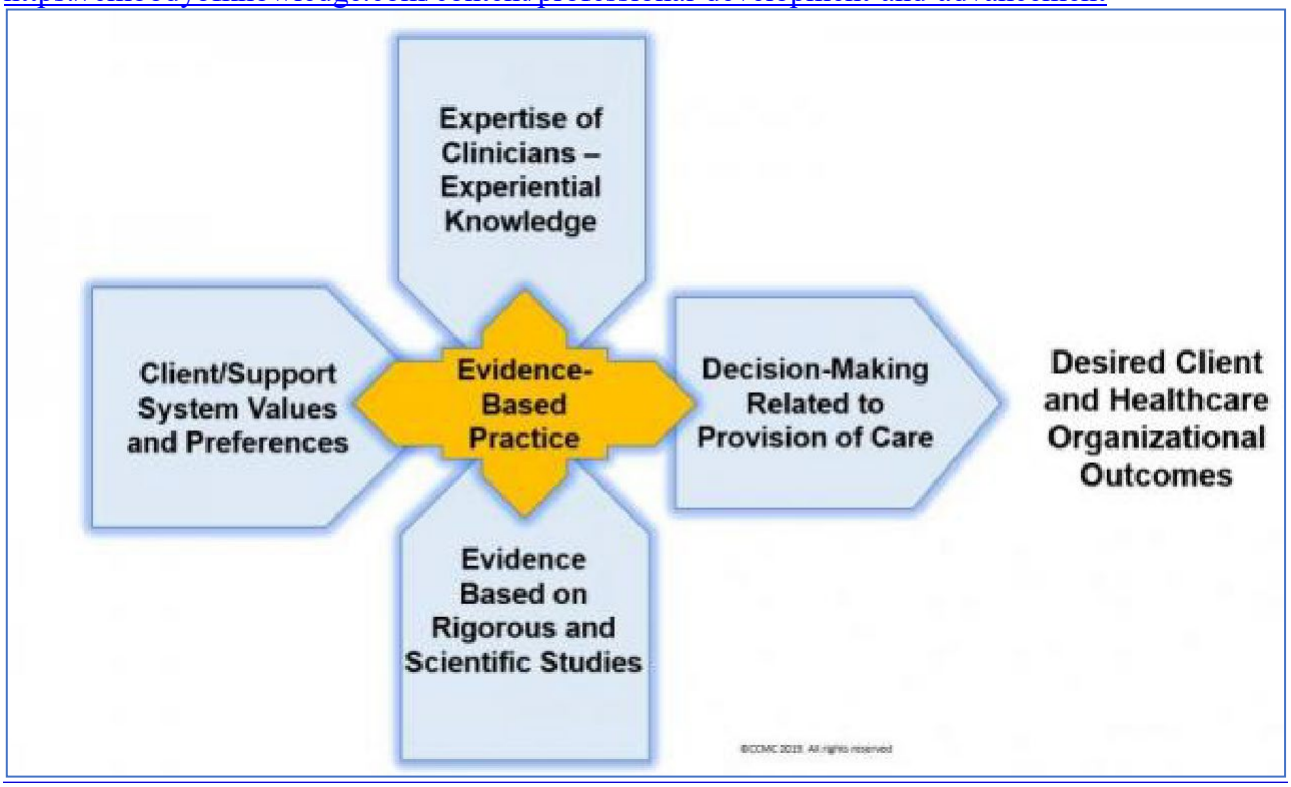
- Demonstrate interpretation of data and how to report it
- Describe the role of evidence-based practice in case management
- Describe and apply 2 classifications of health care analytics
- Collect and analyze outcomes data from case management interventions
- Apply quality and performance improvement concepts

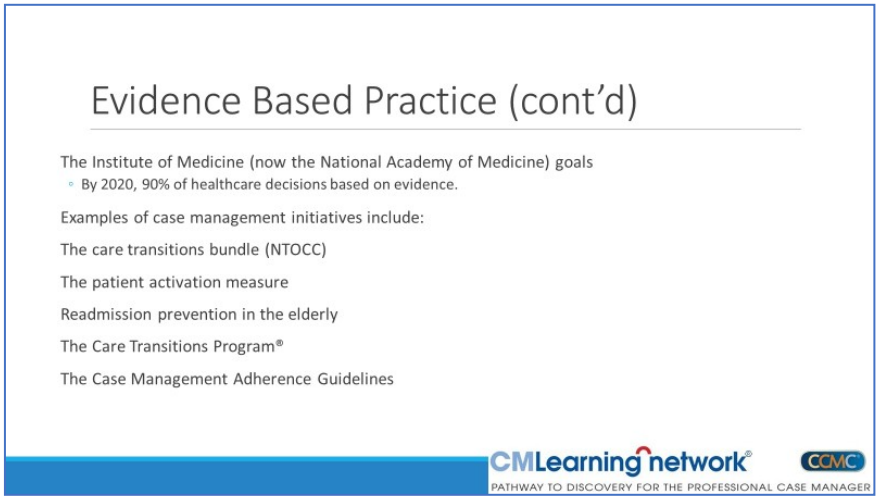
Evidence Based Practice

Evidence based practice is not new in the healthcare industry.

- It is a problem-solving approach to practice that integrates:
  - Best evidence available from well-designed research studies
  - Client values and preferences for care
  - Expertise of clinicians in making decisions about the provision of care for clients/support systems

https://cmbodyofknowledge.com/content/professional-development-and-advancement

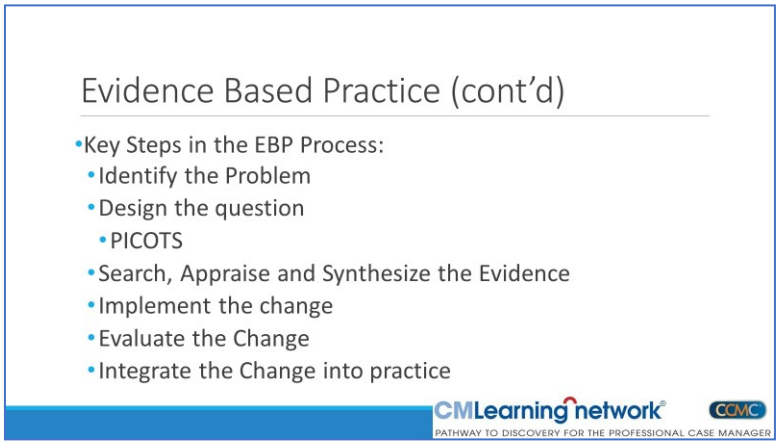




The Institute of Medicine (IOM), known today as the National Academy of Medicine, has set a goal that by 2020, 90% of all healthcare decisions in the United States will be based on evidence (IOM, 2007, p. ix).

- Examples include:

- The care transitions bundle advocated for by the National Transitions of Care Coalition (NTOCC)
- The patient activation measure work of Judith Hubbard and her colleagues
- Care of the elderly for the prevention of readmissions to the hospital work of Mary Naylor
- The Care Transitions Program®/transitional care and interventions work of Eric Coleman
- The Case Management Adherence Guidelines promulgated for by the Case Management Society of America (CMSA)

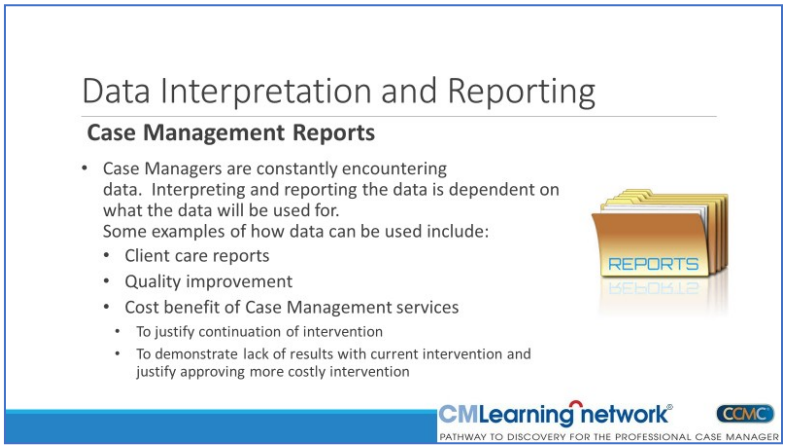


- Key Steps in the EBP Process:
  - Identify the Problem
    - Example: Need to reduce readmissions to acute setting
  - Design the question
    - Specific to the problem/narrow enough to manage
    - Use the PICOTS method:
      - P=Population
      - I-Intervention or Activity
      - C=Comparison intervention/population
      - O=Outcome on which to evaluate the practice change and its impact

        - T=Time over which the intervention will be measured
        - S=Setting where the intervention will be trialed
        - Example: In clients >65 yrs. of age, with COPD, how do post discharge telephone calls impact readmission rates?
- Search, Appraise and Synthesize the Evidence
    - Look at the available literature for the last 3-5 years
        - Example: literature and research on the use telephonic cm assessment tools
- Implement the change
    - Develop the plan
    - Evaluate current data to establish the baseline for comparison
    - Identify outcome measures
    - Involve key stakeholder
    - Demo project
        - Example: Telephone calls to all discharged persons from Unit 4A in the target group on day 2, 7, 14 , 21, 28 and 31 after discharge (more often of clinically indicated) utilizing a standard assessment tool for 3 months.
- Evaluate the Change
    - Evaluation may include the use of a rigorous QI methodology, and/or a dashboard to measure change over time.
        - Examples: As compared to the readmission rates of the same period last year, readmissions were decreased by X%.
        - Clients verbalized desire to be called less often, the frequency was viewed as intrusive.
- Integrate the Change into practice
    - Secure the approvals necessary to roll out the initiative organization-wide. Engage the stakeholders. Ensure adequate training is in place for the staff involved in performing the activity,

- Example: Utilizing ongoing meetings of stakeholders to evaluate the impact of the intervention, the need to modify the intervention, or other changes.
- Go live with all medical units on an incremental basis so all units are using the tool within 6 months.

Data Interpretation and Reporting

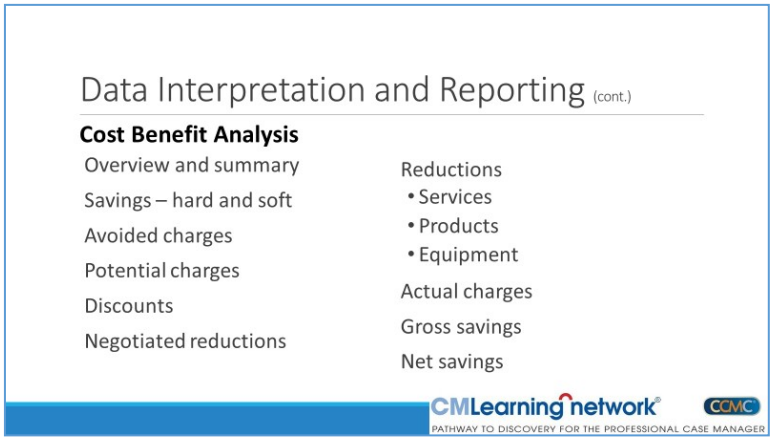


Case Management and Data

- Case Managers are surrounded by data. Data is:
  - collected and interpreted in all phases of the case management process
  - must be valid –and
  - measure what it is intended to measure
  - must be reliable -

    - accurate and avoiding bias
- interpretation of the data:
    - assigns meaning
    - conclusions, significance, and implications of the data.
    - Some examples of how data can be used include:
        - Client care reports
        - Quality improvement
        - Cost benefit of Case Management services
        - To justify continuation of intervention
        - To justify more costly intervention when plan necessitates change
        - to share appropriate data with stakeholders
- Types of data and reports are varied and include:
    - the plan of care
    - Goal(s) of intervention
    - progress or lack of progress towards goals
    - the quality, and methods to improve the quality
    - cost of the interventions
    - potential benefit based on the intervention
    - Justification for continuation of services or need for more costly intervention if indicated
    - Prior and current information for comparison

- The frequency of client reports may vary based on organizational needs/policies but should always be done at case closure. They should include:
    - Assessed need for case management involvement (the diagnosis)
    - Plan of care
    - Desired outcomes
    - Progress toward the outcomes
    - Cost of care with case management intervention
    - Cost of care without case management intervention
    - Cost savings due to case management intervention



Cost Benefit Analysis Reports

A cost-benefit report is done to formally document savings related to Case Management involvement.

- Two types of savings: Hard savings
    - directly related to the case manager's actions
    - Examples
        - Transfer to a lower level of care
        - Decrease in length of stay
        - Negotiation to a lower rate for a service
        - Change to an in-network provider
    - Soft savings

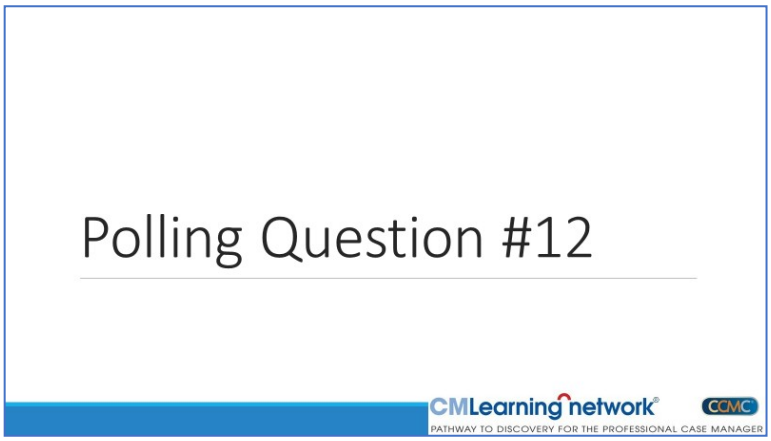
- potential savings
- harder to measure
- costs avoided because of case management intervention
- examples
    - Avoided hospital readmission
    - Prevention of medical complications
    - Avoided ER visits

To calculate the cost savings:

Cost savings = Potential costs – (Actual cost + cost of Case Management)

Report Components

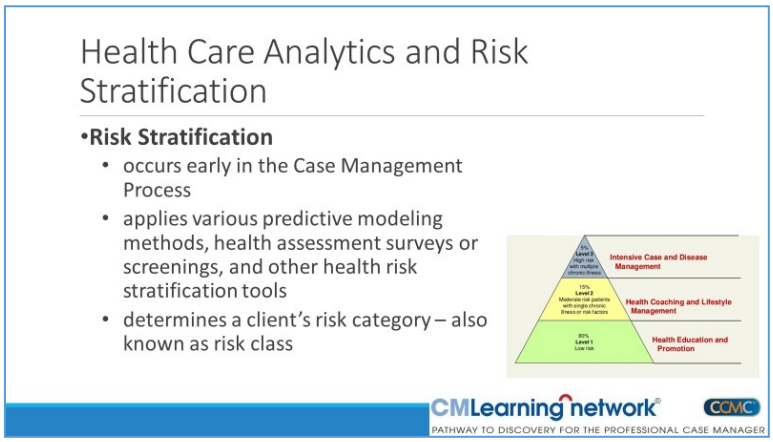
- Overview and summary -of the case
- Savings –
    - Hard - actual savings based on real numbers (discounts, negotiated reductions, etc.)
    - Soft - possible or potential savings based on avoidance of services, use experience with like clients, and past experience of the client
- Avoided charges – actual charges avoided with use of case management
- Discounts and Negotiated Reductions for
    - Services
    - Products
    - Equipment
- Actual charges -what it cost
- Gross savings total cost minus hard and soft savings
- Net savings gross savings minus the cost of the case management services



EXAMPLES OF HARD SAVINGS INCLUDE:

A. **AVOIDED ER VISIT**
B. **DECREASE IN LENGTH OF STAY,**
C. **PREVENTION OF COMPLICATIONS**
D. **AVOIDED READMISSIONS**

- Using preselected and nationally recognized criteria, case managers stratify risk to:
  - define a specific population,
  - provide the most attention necessary to clients with the greatest needs
  - consider the desired outcomes for and with those clients
  - determine interventions to achieve these outcomes.

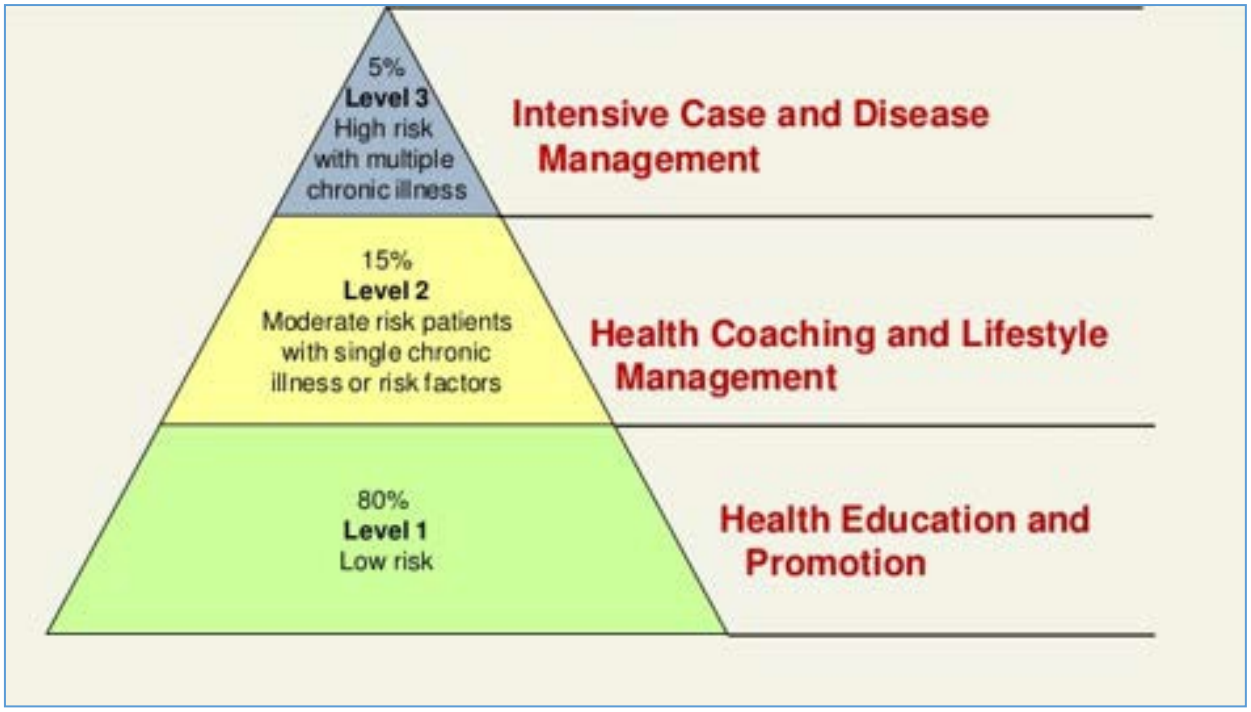


Health Care Analytics and Risk Stratification

Risk Stratification

- occurs early in the Case Management Process (Domain 1)
- applies various tools to assess for risk
- determines a client's risk category – also known as risk class:

    - Low, Medium or High
- Informs the care plan to determine:
    - Appropriate level of intervention
    - Targeted interventions to enhance outcomes



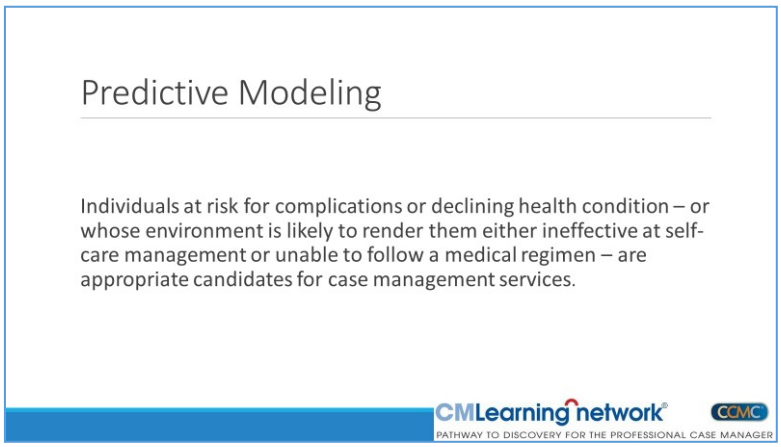
https://www.cmbodyofknowledge.com/content/stratifying-risk-0

Risk Stratification Tools

- set of predetermined questions, variables to be measured, and specific criteria
- allow for meaningful calculation of a risk score

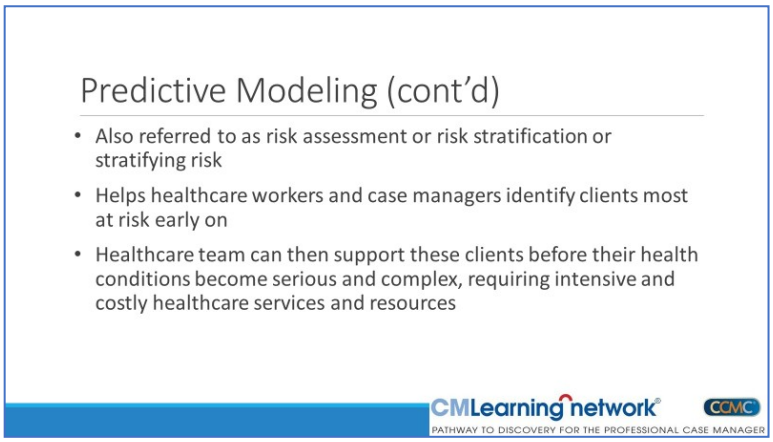
- Tools are applied depending on case management practice setting
- Some of the risk stratification options available for you as case manager include but are not limited to:
    - Predictive modeling
    - Health Risk Assessment (HRA)
    - Administrative Data
    - Telephonic Surveys
    - Community Assessment Risk Screen (CARS)
    - Hierarchical Condition Category (HCC)
    - LACE Tool
    - Integrated Case Management Complexity Grid (ICM-CAG)
    - Johns Hopkins Adjusted Clinical Group Scoring System (ACG)

https://www.cmbodyofknowledge.com/content/identify-risk-stratification-tool-use



Predictive modeling

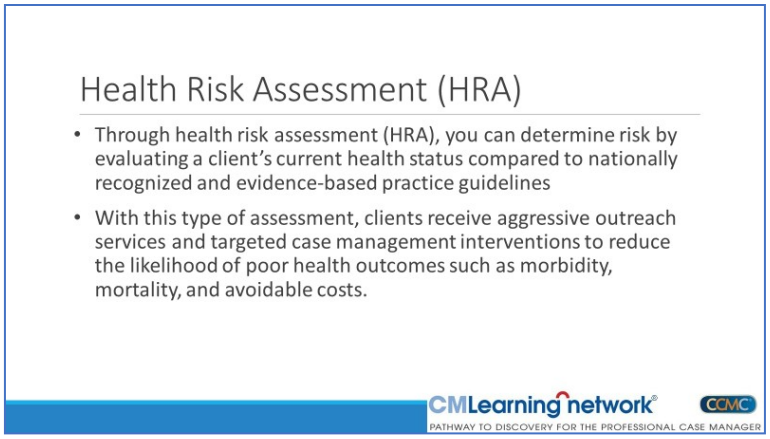
- Individuals at risk for complications or declining health condition – or whose environment is likely to render them either ineffective at self-care management or unable to follow a medical regimen – are appropriate candidates for case management services.



Predictive modeling

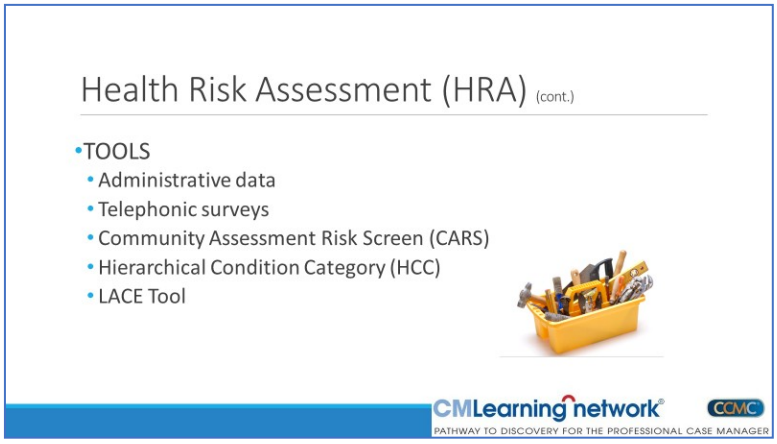
- used by managed care organizations, ACOs, and population health models
- identify which members will have the highest future medical costs
- will need increased healthcare services.

  https://www.cmbodyofknowledge.com/content/predictive-modeling-0
- Uses software to forecast probabilities
- Contains predictors likely to influence future behavior or utilization of healthcare resources such as gender, age, number of chronic illnesses, access to healthcare services
- identifies the most actionable population based on risk
- Actions taken to reduce or eliminate risk before condition becomes serious and complex
- Helps team support these clients before their complex health conditions become more serious intensive and costly healthcare services and resources.



Health risk assessment (HRA)

- questionnaire about health and lifestyle
- Used to develop personalized care plans
- Can be delivered telephonically, or written via mail in person
- Focus on clinical conditions, health risk factors, and disease state
- Assesses real-time physical, behavioral, mental, emotional and psychosocial status
- Through health risk assessment (HRA), you can determine risk by evaluating a client's current health status compared to nationally recognized and evidence-based practice guidelines
- With this type of assessment, clients receive aggressive outreach services and targeted case management interventions to reduce the likelihood of:
    - poor health outcomes such as morbidity, mortality, and avoidable costs.
- HRAs can predict clients' future healthcare service utilization and costs and the likelihood of progression toward illness or worsening of an existing condition (Gurley, 2007).
  https://www.cmbodyofknowledge.com/content/identify-risk-stratification-tool-use



Administrative data

- comes from claims systems information

Telephonic surveys

- Contact by case manager via telephone to assess how well or not a client is doing
    - Enables intervention by engaging other providers
    - Facilitates decreased readmission risk

Community Assessment Risk Screen (CARS)

- used to determine the risk for rehospitalization or ED use for seniors
- focuses on current health status and lifestyle behaviors
- similar to the health risk assessment (HRA) tool

Hierarchical Condition Category (HCC)

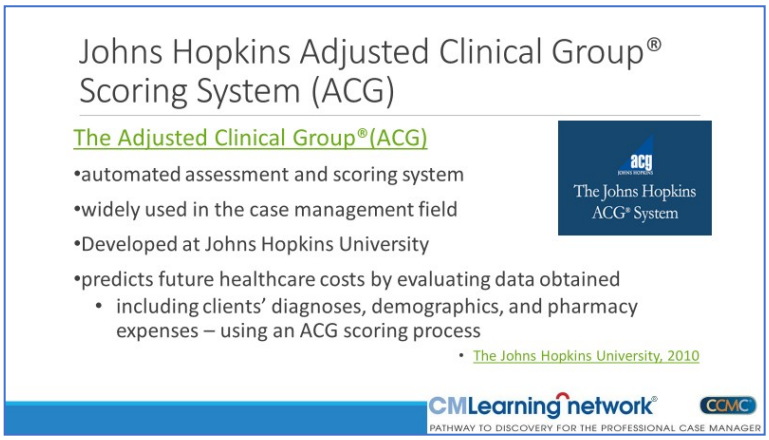
Medicare uses the CMS-HCC model to calculate risk scores that quantify and project the financial risk of each Medicare beneficiary. CMS uses risk scores created by the CMS-HCC model to adjust Medicare capitation payments to **Medicare Advantage (MA)** plans. With risk-adjusted payments, Medicare pays MA plans more money for patients with greater risk and less money for patients with less risk. Key points:

- payment methodology for Medicare Advantage members based on “risk”
- payment rate for members in same community based on the amount of risk it takes to maintain health

https://ablehealth.com/2020/07/29/complete-guide-to-cms-hcc-risk-scores-aka-raf-scores-and-medicare-risk-adjustment/

LACE Tool

- L=Length of Stay
- A=Acuity of Admission
- C=Comorbidities
- E=ED Visits
- The higher the score, the higher the risk of hospital readmission.

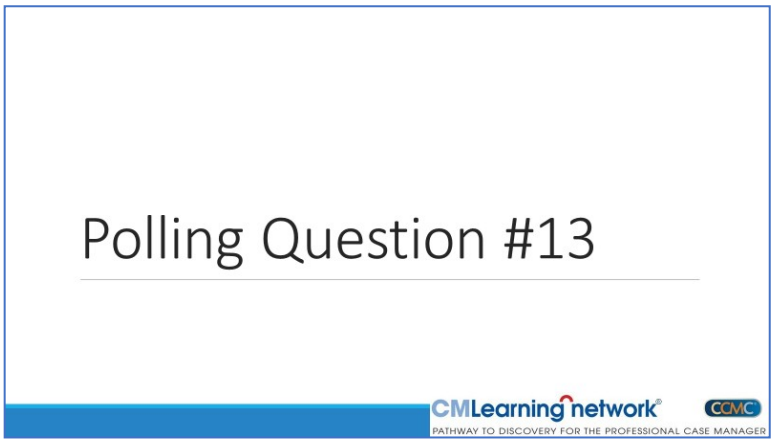


Johns Hopkins Adjusted Clinical Group® Scoring System (ACG)

https://www.cmbodyofknowledge.com/content/identify-risk-stratification-tool-use

- developed at the Bloomberg School of Public Health at Johns Hopkins University
- clusters clients into one of 102 discrete and homogenous groups
- based on a unique approach to measuring morbidity
- allows for more accurate and fairer:
  - Evaluation of a healthcare provider's performance
  - Identification of clients at high risk
  - Forecasting of healthcare utilization by clients
  - Payment structures and rates for the providers of care
  - Allocation of appropriate resources
- automated assessment and scoring system
- widely used in the case management field
- Developed at Johns Hopkins University
- predicts future healthcare costs by evaluating data obtained
  - including clients' diagnoses, demographics, and pharmacy expenses – using an ACG scoring process

The Johns Hopkins University, 2010



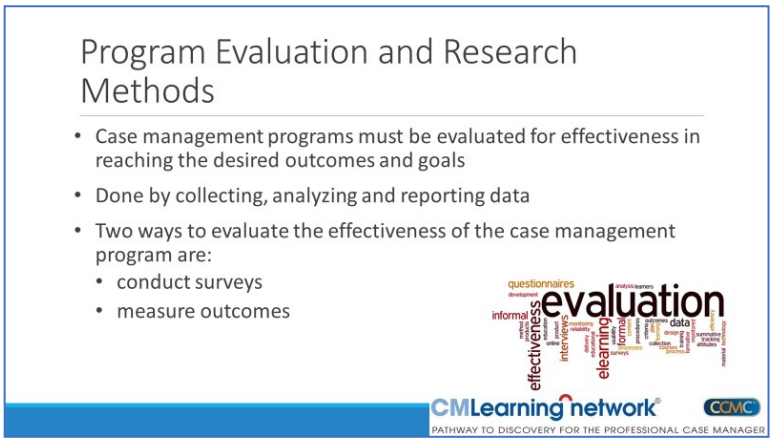
TRUE OR FALSE:

PREDICTIVE MODELING PROVIDES DATA FOR THE CM TO IDENTIFY CLIENTS AT HIGH RISK AND PREDICT THEIR HEALTHCARE UTIZATION.

TRUE

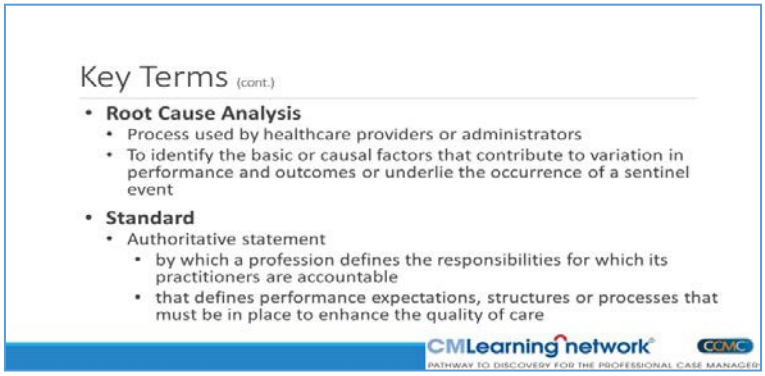
FALSE

Program Evaluation and Research Methods



Outcomes measurement

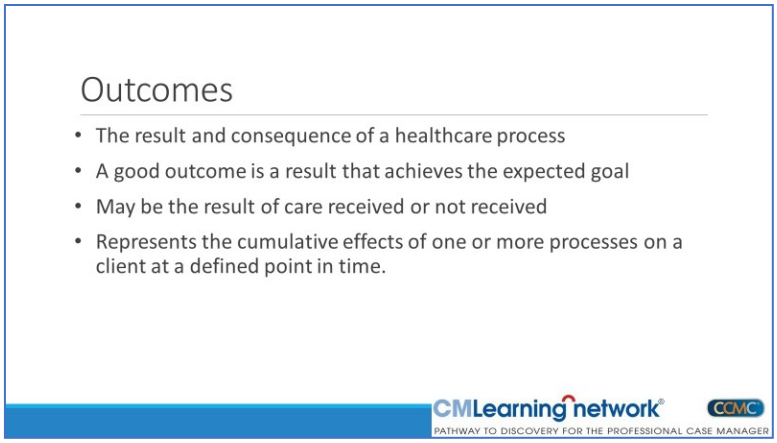
- Case management programs must be evaluated for effectiveness in reaching the desired outcomes and goals
- Done by collecting, analyzing and reporting data
- Two ways to evaluate the effectiveness of the case management program are:
  - conduct surveys to evaluate the client's perspective and perceived value of case management interventions
    - at case closure
    - must be objective
  - measure outcomes
- Clinical outcomes can be measured on individuals or groups of clients
- Setting dependent



- **Root Cause Analysis**

- Process used by healthcare providers or administrators to identify the basic or causal factors that contribute to variation in performance and outcomes or underlie the occurrence of a sentinel event

- **Standard**
  - Authoritative statement
    - by which a profession defines the responsibilities for which its practitioners are accountable
    - that defines performance expectations, structures or processes that must be in place to enhance the quality of care

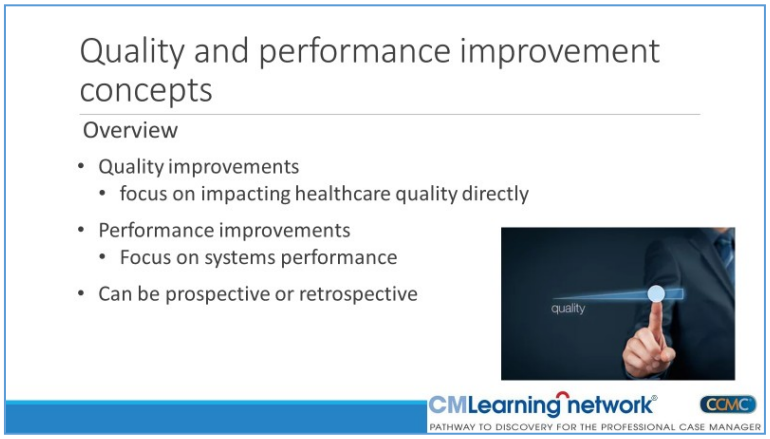


Outcome:

- result and consequence of a healthcare process
- good outcome is a result that achieves the expected goal
- may be the result of care received or not received
- represents the cumulative effects of one or more processes on a client at a defined point in time.
- Geared to stakeholder needs **(WHO ARE YOUR STAKEHOLDERS?)**
- Outcomes data provides the content
- Generally, fall into several broad categories
  - Quality
  - Financial

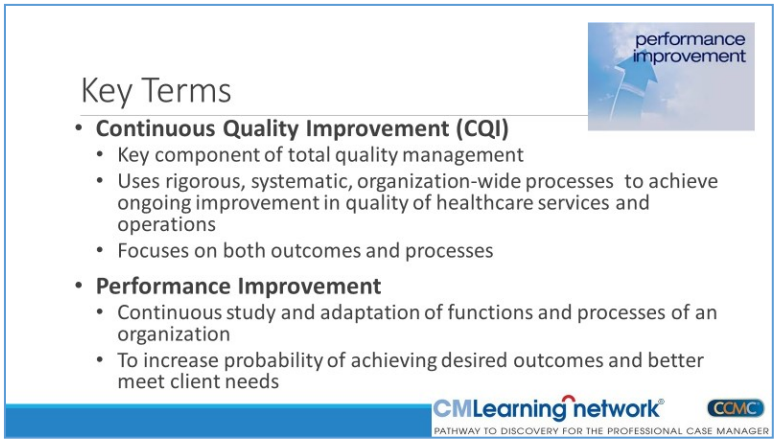
- Satisfaction
- Value

- **Examples of outcomes measured include**
  - Percentage of clients readmitted to hospital within 30 days
  - Percentage of clients adherent to treatment plan
  - Average length of hospital stay
  - Percentage of clients who returned to work
  - Percentage of clients who maintained hemoglobin A1c <9



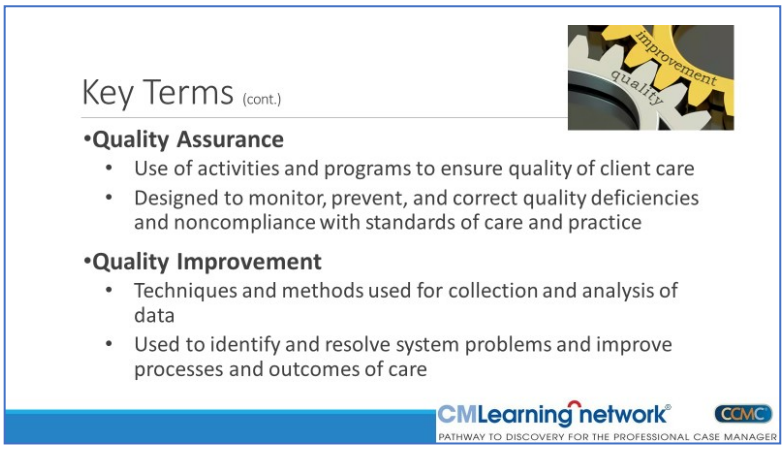
Quality and performance improvement concepts

- Quality improvements focus on impacting the quality of healthcare directly
- Performance improvements focus on the administrative systems performance.
- Both can be prospective or retrospective and aim at improving how things are done.
- An example of quality improvement may be to decrease the number of hospital acquired infections, whereas a performance improvement may be to reduce lost charges.



Key Terms

- **Continuous Quality Improvement (CQI)**
  - Key component of total quality management
  - Uses rigorous, systematic, organization-wide processes to achieve ongoing improvement in quality of healthcare services and operations
  - Focuses on both outcomes and processes
- **Performance Improvement**
  - Continuous study and adaptation of the functions and processes of a healthcare organization
  - To increase probability of achieving desired outcomes and better meet client needs



- **Quality Assurance**
  - Use of activities and programs to ensure the quality of client care
  - These activities and programs are designed to monitor, prevent, and correct quality deficiencies and noncompliance with the standards of care and practice
- **Quality Improvement**
  - An array of techniques and methods used for collection and analysis of data gathered in the course of current healthcare practices in a defined care setting
  - Used to identify and resolve system problems and improve processes and outcomes of care

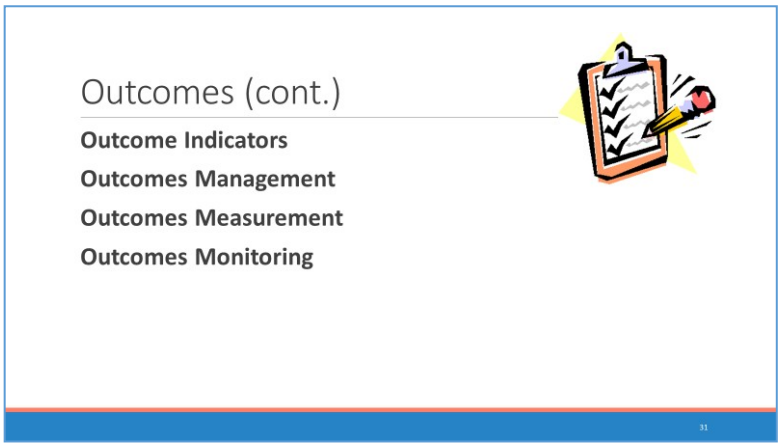
- **Quality Management**
  - The monitoring, analysis, and improvement of organizational performance
  - It is a formal and planned, systematic approach organization or network wide

- standards, the quality of client care and services provided, and the likelihood of achieving desired client outcomes

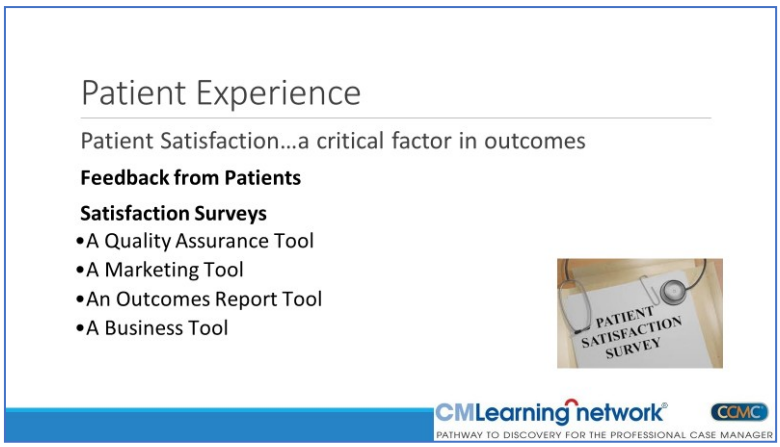
Quality Improvement Reports

Quality improvement reports

- Look at indicator being measured within the framework of the case management intervention.
- Are used to inform performance improvement measures.
  - Indicator being measured
  - Case management intervention
  - Measurement used to evaluate response to intervention
  - Improvement in quality directly related to CM intervention
- Examples of a quality indicator –
  - % clients adherent to care plan
  - % of clients with diabetes control indicated by Hgb A1C within accepted levels.



- **Outcome Indicators**
  - Measures of quality and cost of care
  - Metric used to examine and evaluate results of the care delivered
- **Outcomes Management**
  - Uses information and knowledge gained from outcomes monitoring
  - Purpose – to achieve optimal outcomes through improved clinical decision making and service delivery
- **Outcomes Measurement**:
  - systematic, quantitative observation, at a point in time, of outcome indicators
- **Outcomes Monitoring**:
  - repeated measurement over time of outcome indicators
  - Allows for making inferences about characteristics, processes, and resources produced the observed outcomes.
- **Examples of Outcomes:**
  - Percentage of clients readmitted to hospital within 30 days
  - Percentage of clients adherent to treatment plan
  - Average length of hospital stay
  - Percentage of clients who returned to work



Patient Experience

Patient Experience…a critical factor in outcomes

- In hospitals, home care, SNFs, and Health Care Plans, and other settings patient experience is an important part of outcomes measured
- have become highlighted because of the ACA.
- nursing home, homecare, community, and other settings measure client satisfaction/experience
- Uses of the data:
  - To ensure and/or improve quality
  - For marketing purposes
  - To report on outcomes
  - As a business tool

Feedback from Patients

Patient Experience…in Hospitals and Beyond

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
    - nationally standardized survey of patient perspectives of their hospital experience
    - It was developed by CMS in partnership with the Agency for Healthcare Research and Quality (AHRQ) and endorsed by the National Quality Forum (NQF)
    - scores are publicly reported at https://www.medicare.gov/hospitalcompare .
    - is administered to a random sample of adult patients across medical conditions between 48 hours and 6 weeks after discharge
    - Is not restricted to Medicare beneficiaries.
    - Hospitals collect minimally 300 responses annually to qualify
    - Hospitals can opt out of the program
    - Can lose 2% percent of overall Medicare reimbursement
    - ACA uses HCAHPS to in value-based incentive payments
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Nursing Home Surveys
    - include three standardized instruments designed to gather information on the experiences of adult nursing home residents and their family members. Each instrument is designed to meet a different need:
        - **Long-Stay Resident Survey.** An in-person structured interview for long-term residents.
        - **Discharged Resident Survey.** A questionnaire for recently discharged short-stay residents.

        - **Family Member Survey.** A questionnaire that asks family members about their experiences with the nursing home.
    - These surveys can be used in monitoring programs designed to improve residents' experiences in nursing homes.
    - The development of these instruments was jointly supported by the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality.

- **Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)**

    - **first national standardized and publicly reported survey of home health care patients' perspectives of their skilled home care.**

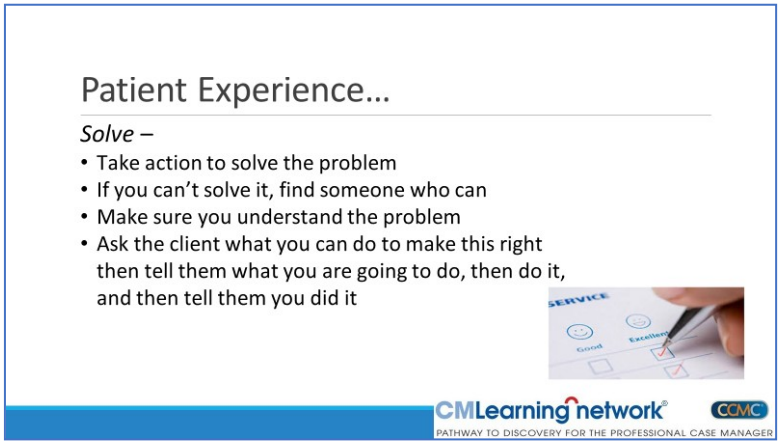
    - **The survey was nationally implemented on a voluntary basis in October 2009 and required in October 2010. The National Quality Forum endorsed the HHCAHPS in March 2009.**

    - HHCAHPS is a 34-item questionnaire and data collection methodology to measure patients' perceptions of their skilled home care.

    - The survey can be completed by the patient, a proxy

- The survey results have been publicly reported since 2012.

https://www.ahrq.gov/cahps/surveys-guidance/nh/index.html
www.hospitalcompare.hhs.gov
www.healthgrades.com
www.cms.gov



Patient Experience…

- Everyone has a responsibility to ensure patient satisfaction with their experience

- Service recovery can, and should, be practiced by everyone
- These are strategies used in service recovery

Solve –

- Take action to solve the problem
- If you can't solve it, find someone who can
- Make sure you understand the problem
- Ask the client what you can do to make it right
- Tell them what you are going to do, then do it,
- Tell them you did it.

The final strategy in service recovery is "Thank you"

Thank –

- Thank the client for bringing the problem to your attention
- for their patience and understanding
- If appropriate, give the client a gift certificate.

Other activities to improve patient experience

Post discharge phone calls

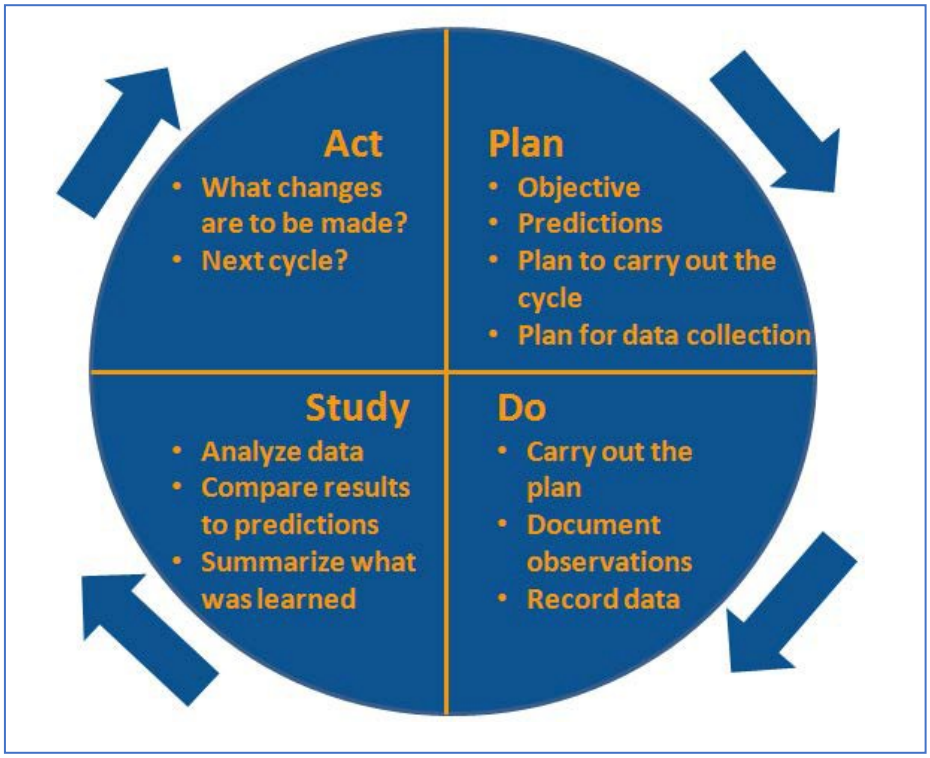
- Have also been shown to improve patient experience
- Also help reduce unnecessary readmissions and ED visits
  - Can be used to:
  - Express empathy
  - Obtain information about current condition, understanding of instructions, adherence to plan
  - Answer questions
  - Get feedback on the stay
  - Solicit suggestions for improvement
  - phone call 24-48 hrs. after discharge
  - expresses empathy
  - Confirm adherence to discharge instructions
  - Was stay satisfactory
  - suggestions for improvement

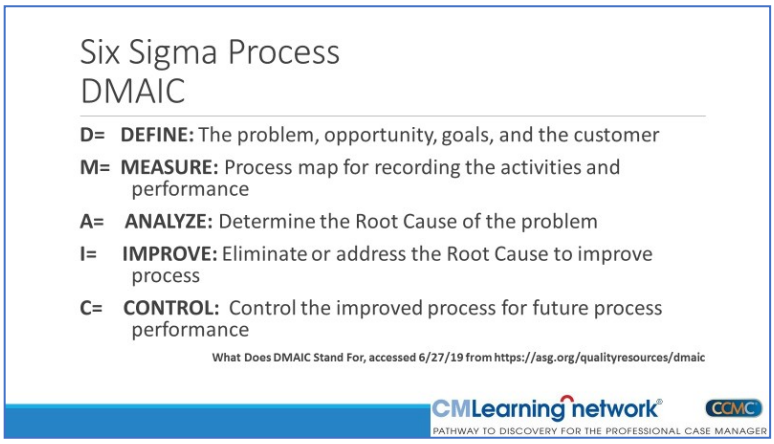
Methods of Quality Improvement

- There are several methods used to measure quality improvement. Although they vary, they all have the same basic design; to find where the problem is, to figure out an option to fix it, and to analyze the effectiveness of the changes.
- The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, a simple yet powerful tool for accelerating quality improvement.
- Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting.
- The PDSA cycle is shorthand for testing a change—

- by planning the test or observation (Plan), including a plan for collecting data
- trying it (Do) out on a small scale
- observing the results (Study), setting aside time to analyze the data and study the results
- acting (Act) on what is learned, and to refine the change based on what was learned from the test
- This is the scientific method, used for action-oriented learning.

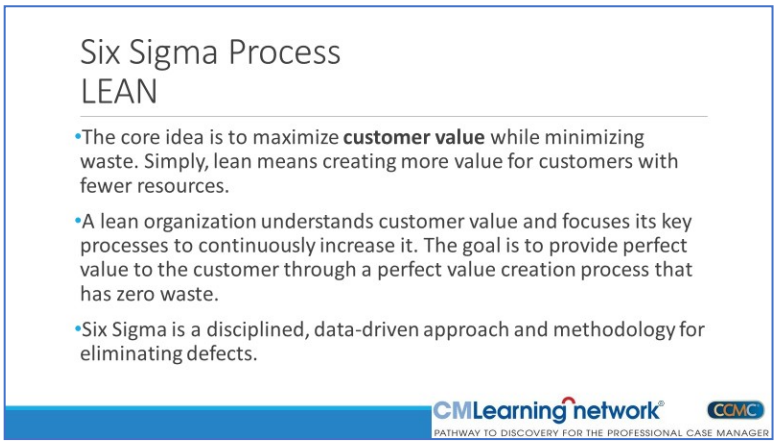
- The cycle can be repeated as needed





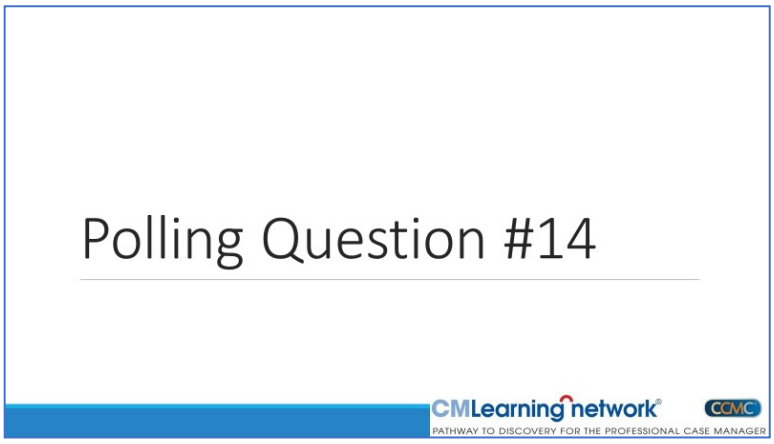
Six Sigma

- "Six Sigma is a quality program that, when all is said and done, improves your customer's experience, lowers your costs, and builds better leaders." (Jack Welch)
- Process improvement method that addresses elimination of defects in care
- Six Sigma at many organizations simply means a measure of quality that strives for near perfection.
- **Six Sigma Process - DMAIC**
  - **D=DEFINE:** The problem, opportunity, goals, and the customer
  - **M= MEASURE:** Process map for recording the activities and performance
  - **A= ANALYZE:** Determine the Root Cause of the problem
  - **I= IMPROVE:** Eliminate or address the Root Cause to improve process
  - **C=CONTROL:** Control the improved process for future process performance
  - **What Does DMAIC Stand For, accessed 6/27/19 from https://asg.org/qualityresources/dmaic**



LEAN

- The core idea is to maximize customer value while minimizing waste. Simply, lean means creating more value for customers with fewer resources.
- A lean organization understands customer value and focuses its key processes to continuously increase it. The goal is to provide perfect value to the customer through a perfect value creation process that has zero waste.
- Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects.
- The fundamental objective of the Six Sigma methodology is the implementation of a measurement-based strategy that focuses on process improvement and variation reduction through the application of **Six Sigma improvement projects**.



The quality improvement method that is part of the institute for Healthcare Improvement's (IHI) Model for Improvement is:

A. **Plan, Assess, Do, Act**
B. **Participate, Delegate Evaluate, Act**
C. **Plan, Do, Check, Act**
D. **Plan, Do, Study, Act**

Accreditation Standards and Requirements

Quality indicators

- In this era of healthcare reform, the system is increasingly looking to case managers to measure and evaluate quality and outcomes.
- Monitoring health care quality is impossible without the use of clinical indicators.
- They create the basis for quality improvement and prioritization in the health care system.
- To ensure that reliable and valid clinical indicators are used, they must be designed, defined, and implemented with scientific rigor.
- These sources of quality indicators will be discussed as we move forward in this section

Sources

- Private organizations
- Governmental organizations

Types

- **Structure** – provider capacity, systems, and processes to provide high-quality care
  - Examples – electronic medical records, medication order entry systems, number or proportion of board-certified physicians, ratio of providers to clients

- **Process** – what the provider does to maintain or improve health; typically reflect generally accepted clinical practice

- Examples – percentage of people receiving preventive services, such as mammograms; percentage of diabetics who had their blood sugar tested and controlled
- Inform consumers about type of care they can expect to receive
- Process measures are most of the quality measures reported publicly

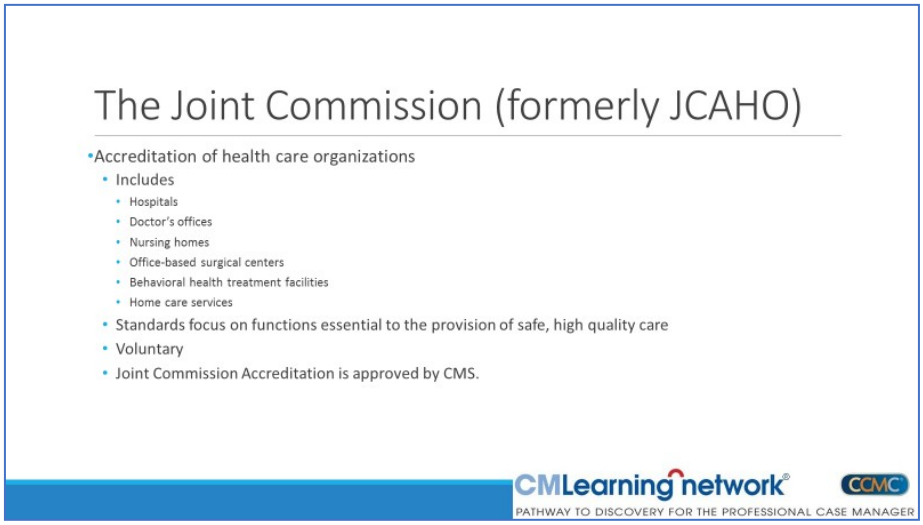
- **Outcomes** – reflect the impact of the healthcare service or intervention on the health status of clients.
  - Examples – surgical mortality rate (percentage of patients who died because of surgery; rate of surgical complications; rate of hospital acquired infections)
  - Outcomes are the result of numerous factors, many beyond the providers' control

Accreditation Standards and Requirements

- Purpose:
  - A standardized program for evaluating healthcare organizations
  - ensures a specified level of quality
  - Quality defined by a set of national industry standards

Individual vs. organizational certifications

- Individual certification - Pursued to demonstrate personal excellence in chosen field or specialty
- Organizational - voluntary survey process that assesses the extent of a healthcare organization's compliance with the standards for improving the systems and processes of care (performance) and, in so doing, improving client outcomes.



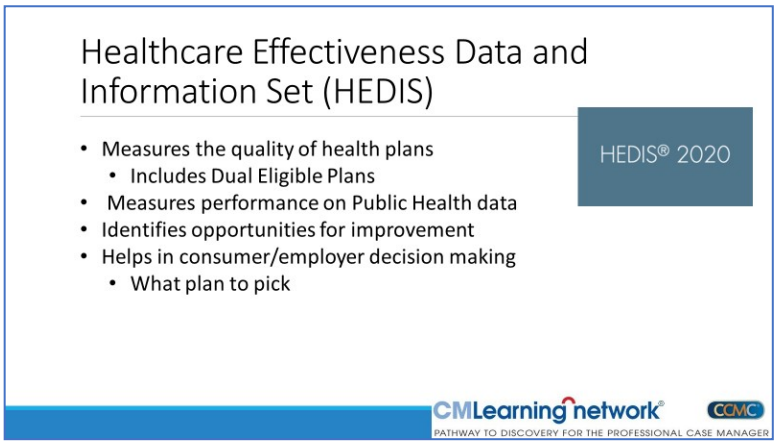
- Joint Commission accreditation can be earned by many types of health care organizations, including hospitals, doctor's offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services.

- Joint Commission standards are the basis of an objective evaluation process that can help health care organizations measure, assess and improve performance. The standards focus on important client, individual or resident care, and organization functions that are essential to providing safe, high quality care.
- Hospitals must meet eligibility standards established by the federal government to receive reimbursement from the federally funded programs, Medicare and/or Medicaid. CMS has been designated as the organization responsible for certification of hospitals, deeming them certified and meeting established standards.
    - The Joint Commission sets its standards and establishes elements of performance based on the CMS standards. CMS has approved The Joint Commission as having standards and a survey process that meets or exceeds the established federal requirements. The Joint Commission is one of several organizations approved by CMS to certify hospitals. If a hospital is certified by The Joint Commission, they are deemed eligible to receive Medicare and/or Medicaid reimbursement. Hospitals must be a member and pay a fee to The Joint Commission to be included in their survey process.

https://www.r1rcm.com/news/the-joint-commission-vs.-cms-requirements-whats-the-difference

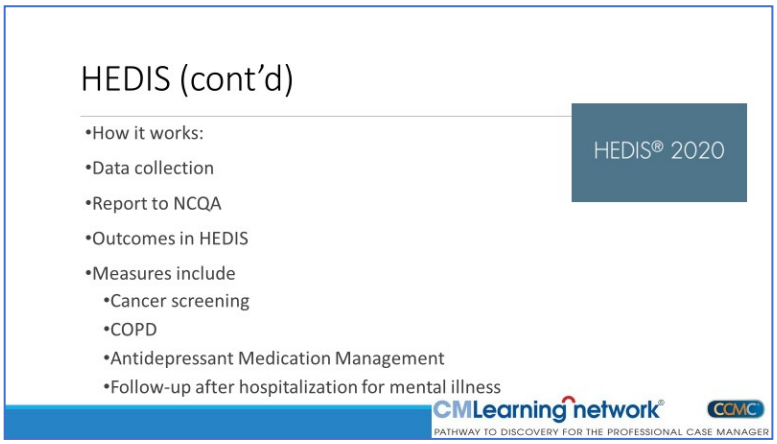
National Committee for Quality Assurance (NCQA)

- NCQA's Case Management Accreditation is a comprehensive, evidence-based accreditation program dedicated to quality improvement that can be used for case management programs in provider, payer or community-based organizations.
  NCQA's Case Management Accreditation:
  - Directly addresses how case management services are delivered, not just the organization's internal administrative processes.
  - Gets right to the core of care coordination and quality of care.
  - Is designed for a wide variety of organizations. It is appropriate for health plans, providers, population health management organizations, and community-based case management organizations.
  - Focuses on ensuring the organization has a process to ensure safe transitions.
- The standards address how case management programs:
  - Identify people who need case management services;
  - Target the right services to people and monitor their care and needs over time.
  - Develop personalized, client-centered care plans;
  - Monitor people to ensure care plan goals are reached and to adjust as needed;
  - Manage communication among providers and share information effectively as people move between care settings, especially when there are transitions from institutional settings;
  - Build in consumer protections to ensure people have access to knowledgeable, well-qualified case management staff;
  - Keep personal health information safe and secure.
- NCQA standards also call for case management program staff to stay up to date on the latest evidence and care management techniques and work towards continuous improvement in client outcomes and satisfaction.
- Remember! **NCQA** accredits organizations ranging from health plans including HMOs and PPOs to physician networks and medical groups.



Healthcare Effectiveness Data and Information Set (HEDIS) (pronounced he´-dus)

- Employers and individuals use HEDIS to measure the quality of health plans
- HEDIS measures how well health plans give service and care to their members.(WebMD)
- HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance.
- HEDIS Measures relate to many significant public health issues, such as
  - cancer,
  - heart disease,
  - smoking,
  - asthma, and
  - diabetes.
- SNPs can use HEDIS performance data to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement, and provide a set of measurement standards that allow comparison with other plans. Data allow identification of performance gaps and establishment of realistic targets for improvement. (CMSNCQA)



Here's how it works:

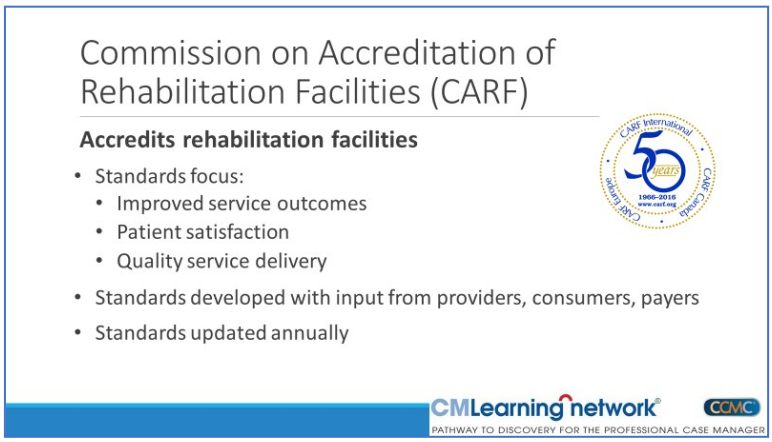
- Health plans collect data about their performance on certain services and types of care. For example, the number of children who get immunizations. They report the data to the National Committee for Quality Assurance (NCQA), which rates health plans based on 81 measures across five areas of care. Some measures are:
  - Colorectal Cancer Screening
  - Care for Older Adults
  - Plan All-Cause Readmissions
- Health plans use HEDIS to see where they are performing well, and where they need to improve. Employers and consumers can also you HEDIS measures when deciding what health plan to choose.
- Plans that meet a certain HEDIS score may become "accredited."(WebMD)

URAC (formerly Utilization Review Accreditation Commission)

- URAC believes that effective case management puts the consumer at the center of all health care decisions and is an essential driver to ensuring that consumers get the right care, in the right setting, at the right time. URAC's Case Management accreditation allows for the application of case management standards across all health care settings such as medical and social case management, behavioral health providers, hospital case management, disability and workers' compensation case management, and emerging practices.
- URAC's case management standards cover:
  - Scope of services standard; types of clients served, delivery model for case management services, qualifications for case management staff.
  - Case management staff standard; guidelines for caseload, availability of physician for consultation, a process for training and education of case managers.

- Case management process standard; criteria for identifying clients for case management services, disclosure to clients the nature or the case management relationship, documentation of consent, policies to document client assessments, policy for resolving disagreements, criteria for discharge.

- Organizational ethics and confidentiality standard; policy and procedure to protect confidentiality, promotion of autonomy of decision making, client's input into the case management plan, respecting rights of client to refuse treatment or services.
- Complaints standard; policies and procedures for clients and providers to submit a complaint.
- Remember! URAC accredits health plan programs including dental plans, healthcare management programs, pharmacy quality management programs, and provider integration and coordination programs.

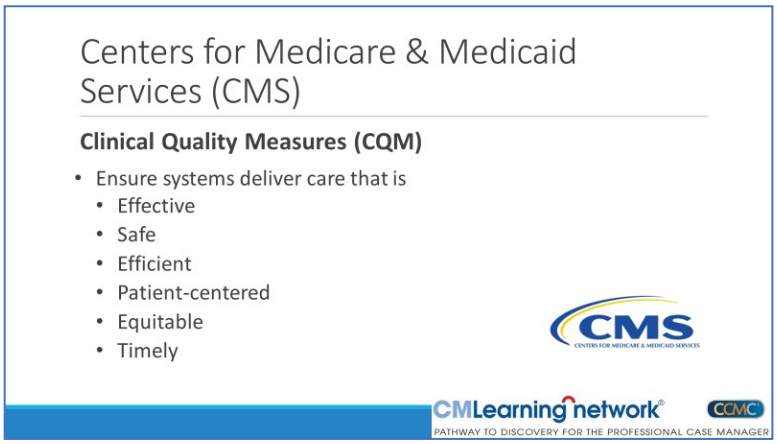


Commission on Accreditation of Rehabilitation Facilities (CARF)

- CARF is the Commission on Accreditation of Rehabilitation Facilities and accredits rehabilitation providers.
- CARF's standards focus on:
  - improved service outcomes
  - satisfaction of the persons served
  - quality service delivery.
- Each set of standards is developed with the input of providers, consumers, payers, and other experts from around the world. Each year, CARF updates its standards to ensure that they are relevant and guide service excellence.

Agency for Healthcare Research and Quality (AHRQ)

- AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used.
- AHRQ's priority areas of focus are:
  - Improve health care quality by accelerating implementation of client-centered outcomes research
  - Increase accessibility to health care
  - Improve health care affordability, efficiency, and cost transparency
  - Make health care safer:
  - Prevent healthcare associated infections
  - Accelerate client safety improvement in hospitals
  - Reduce harm associated with obstetrical care
  - Improve safety and reduce medical liability
  - Accelerate client safety improvements in nursing homes



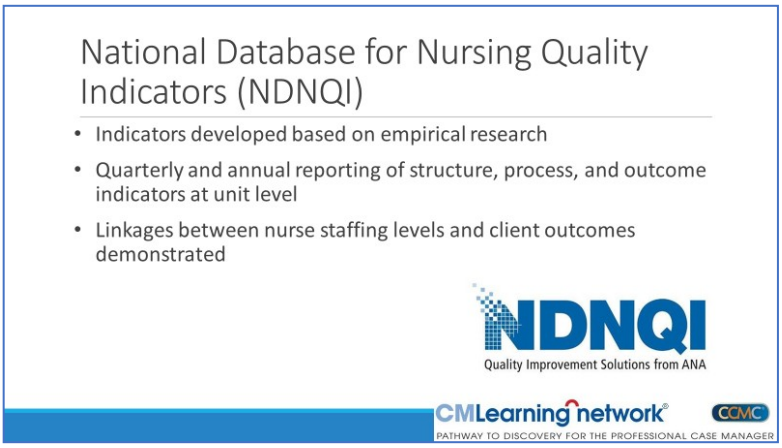
Centers for Medicare & Medicaid Services (CMS)

- The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services.
- CMS uses Clinical Quality Measures, or CQMs to ensure that health care systems deliver effective, safe, efficient, client centered, equitable, and timely care.
- CQMs are tools that help measure and track the quality of health care services provided.
- These measures use data associated with providers' ability to deliver high-quality care or relate to long term goals for quality health care.
- CQMs measure many aspects of client care including:
    - health outcomes
    - clinical processes
    - client safety
    - efficient use of health care resources
    - care coordination
    - client engagement
    - population and public health
    - adherence to clinical guidelines

National Quality Forum (NQF)

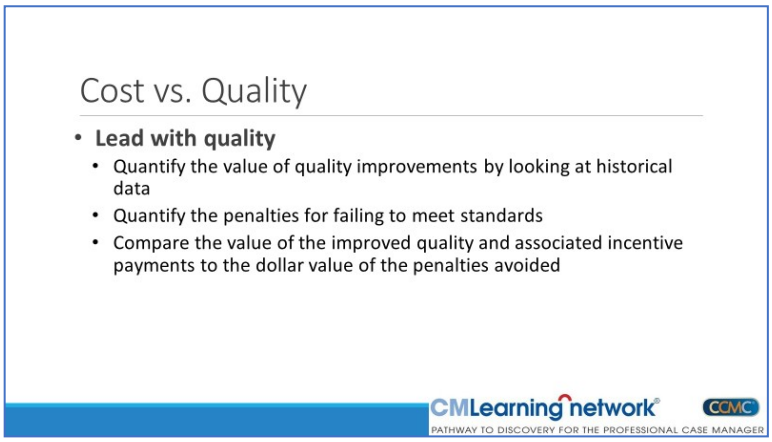
- The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that's mission is to improve the quality of healthcare. NQF promotes consensus among a wide variety of stakeholders around specific standards that can be used to measure and publicly report healthcare quality.
- NQF has endorsed performance measures that can be used to measure and quantify healthcare processes, outcomes, client perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality care. Once a measure is endorsed by NQF, it can be used by hospitals, healthcare systems, and government agencies like the Centers for Medicare & Medicaid Services for public reporting and quality improvement.
- NQF Performance Measures:
    - Convenes working groups to foster quality improvement in both public- and private-sectors;
    - Endorses consensus standards for performance measurement;
    - Ensures that consistent, high-quality performance information is publicly available; and
    - Seeks real time feedback to ensure measures are meaningful and accurate.
- NQF-endorsed measures are evidence-based and valid, and in tandem with the delivery of care and payment reform, they help:
    - Make client care safer;

- Improve maternity care;
- Achieve better health outcomes;
- Strengthen chronic care management;
- Hold down healthcare costs. New directions are further strengthening how we engage with the healthcare community to drive quality improvements.



National Database for Nursing Quality Indicators (NDNQI)

- The National Database of Nursing Quality Indicators™ (NDNQI®) is the only national nursing database that develops indicators based on empirical research and provides quarterly and annual reporting of structure, process, and outcome indicators to evaluate nursing care at the unit level.
- Linkages between nurse staffing levels and client outcomes have already been demonstrated using this database.
- Currently over 1100 facilities in the United States contribute to this growing database which can now be used to show the economic implications of various levels of nurse staffing.

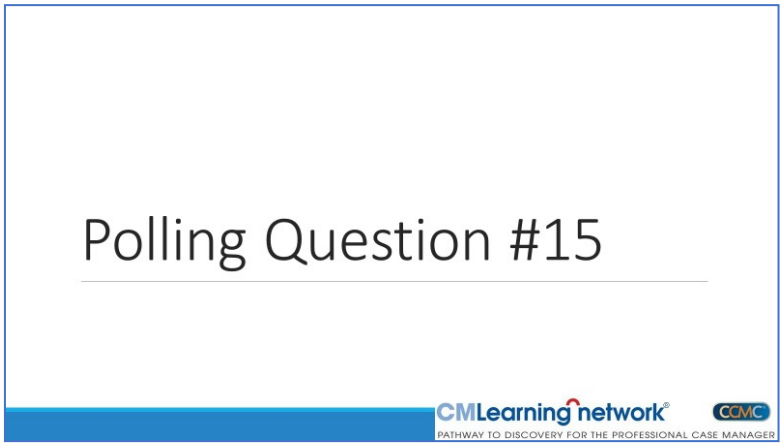


Cost vs. Quality

- Cost should not drive practice; however, in a world that is cost-containment-oriented, you as case managers should be aware that your services must provide a benefit, and you must be able to demonstrate value.
- Ensure that you lead with quality in all interventions.
- Looking at the value of the quality improvements that are contained in historical data, and being able to quantify the penalties (financial, as well as reputational) for not meeting the standards will give you, as a case manager, the ability to provide data driven return on investment for the quality improvements being recommended or implemented.
- Be aware that the cost vs. quality issue can cause an ethical dilemma. As a case manager, it can be easy to get caught between the advocacy expected of you for your client, and your responsibilities to your employer. By collecting the data we talked about on the previous slide, you may be able to document the return on investment for making the improvements to your organization.

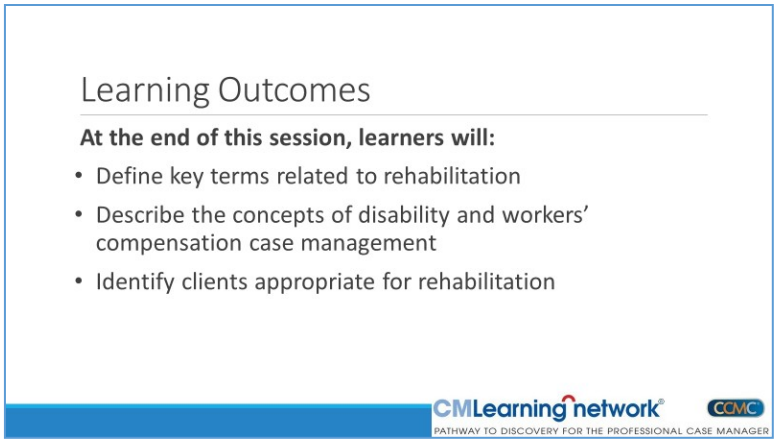
Role as advocate

- Can be caught between advocating for quality care and responsibilities to employer
- Be able to show a return on investment when spending more now will result in savings or incentives later



DATA PROVIDED TO HEDIS ON SPECIFIC SERVICES AND TYPES OF CARE ARE REPORTED TO:

A. CARF
B. CCMC
C. NCQA
D. NHL

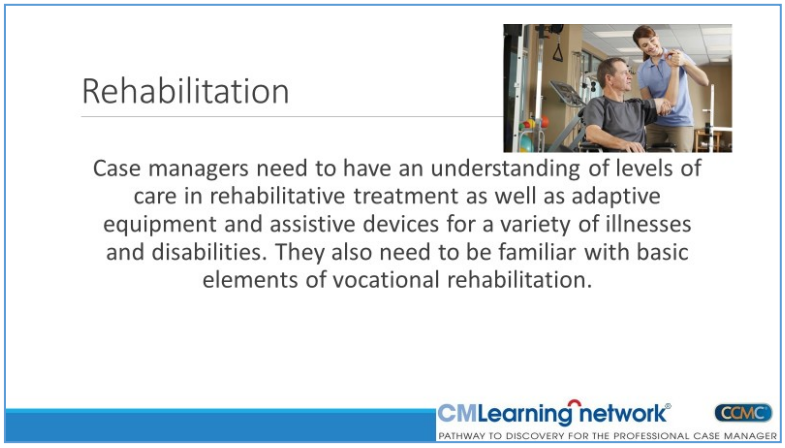


Learning Outcomes

At the end of this session, learners will:

- Define key terms related to rehabilitation
- Describe the concepts of disability and workers' compensation case management
- Identify clients appropriate for rehabilitation

Rehabilitation Concepts



Rehabilitation

- Rehabilitation is a component of both illness and disability. Vocational aspects of both chronic illness and disability can put a significant strain on the client and family. Reduction or loss of income make these cases a challenge to manage.
- As case managers, we need to understand the levels of care in rehabilitation to secure the best services to return the client to as close to his pre-illness or injury baseline as possible. This may involve the use of adaptive equipment, assistive devices, or vocational rehabilitation services to accomplish goals
- They also need to be familiar with basic elements of vocational rehabilitation.

Rehabilitation

- The Rehabilitation domain consists of knowledge associated with clients' physical, behavioral and occupational health and functioning
- Rehabilitation case management consists of specialized services offered to the clients requiring rehabilitation, usually after a debilitating injury, an acute illness, substance use disorders, or for persons with a mental or physical developmental disability.
- The case manager:
  - ensures clients' independent functioning, or
  - effective return to work.
- If complete independence or return to the same work position may not always be feasible, the case manager:
  - Ensures that clients achieve the highest possible degree of independence and return to employment with or without modified requirements and expectations.
- Rehabilitation services are usually offered to clients in a coordinated manner and through a program or approach specifically designed to achieve key objectives of improved health, welfare, and the realization of their maximum physical, social, psychological, and vocational potential for useful and productive activity.
- Disabilities in this context refer to the limitations clients experience because of injury, illness, or a congenital, behavioral, mental, or developmental health condition, including substance use disorders.

https://www.cmbodyofknowledge.com/content/rehabilitation-0 Rehabilitation

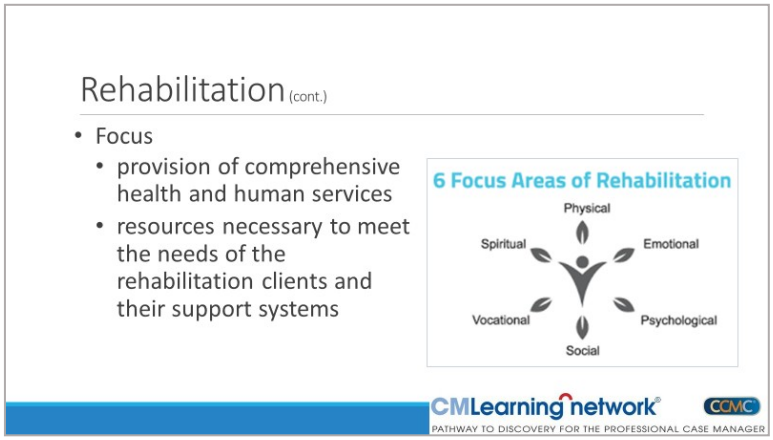
The case manager:

- Utilizes the Case Management process (Domain 1) to advocate for and to meet the needs of the rehabilitation client
  - as part of an interprofessional team including, but not limited to:
    - the client/support system, healthcare professionals as indicated by client need and practice setting.
  - to ensure the right care, at the right time, at the right cost, in the right setting for the right outcome

Rehabilitation helps the client become as “able” as possible.

https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=85&ContentID=P01149

- Within the Rehabilitation domain, the term rehabilitation is used generically to refer to the needs of clients in many populations.
- Client populations
  - Serious, complex, chronic conditions
  - Traumatic injuries resulting in physical limitations
  - Acute exacerbation of existing disease, including substance use disorders
  - Mental, behavioral or cognitive functioning issues
  - developmental disabilities

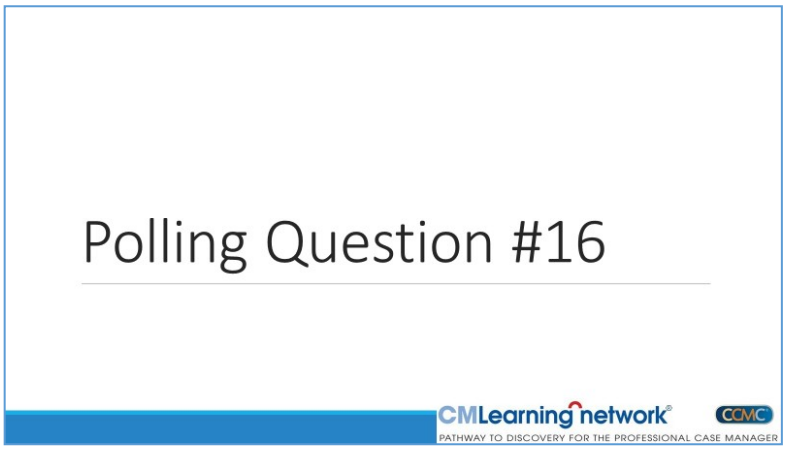


Focus

- Provision of comprehensive health and human services
- Resources necessary to meet the needs of the rehabilitation clients and their support systems.

Goals of Rehabilitation

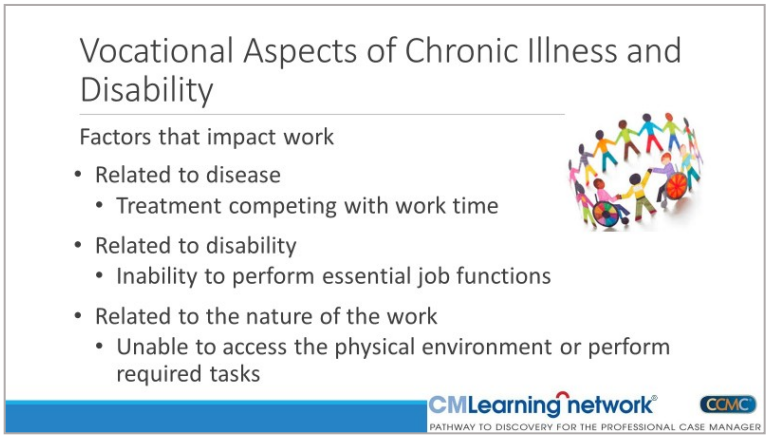
- The goals of rehabilitation are Restore clients' initial function and abilities or
  - Maximize functional level.
  - Prevent deterioration or complications in client's health
    - by teaching the client alternative techniques to effectively adapt to their health, behavioral, and/or physical condition and to adhere to health regimen.
  - Promote client's quality of life by providing, services or devices that allow the client to overcome impairment or to augment functioning.
  - Facilitate client's independence
    - modifying client's environment
    - reduce or eliminate barriers to independent functioning and
    - enhance safety.
    - Enhance access to timely, safe, quality, and cost-effective services



REHABILITATION IS APPROPRIATE FOR ALL OF THE FOLLOWING EXCEPT:

A. **ACUTE EXACERBATION OF EXISTING DISEASE**
B. **MENTAL/BEHAVIORAL ISSUES**
C. **TERMINAL ILLNESS**
D. **INJURY-RELATED DISABILITY**

Vocational Aspects of Chronic Illness and Disability



- There are many factors by which work is affected by chronic illness and disability.
- Some of these are related to the disease or disability, such as a house painter who fall off a ladder and becomes paralyzed from the waist down; or a worker with cancer who needs time off for chemotherapy, radiation and surgery.
- Other factors are related to the nature of the work, such as the physical environment and required tasks, resulting in an inability to perform the essential functions of the job.
- Often, the individual with a chronic illness or disability will continue to perform the same work they did before the illness or injury. If this is not possible, work schedules, work tasks or the work environment, may be modified to accommodate the limitations imposed by the illness or injury for the worker who is unable to access the physical environment or perform required tasks.

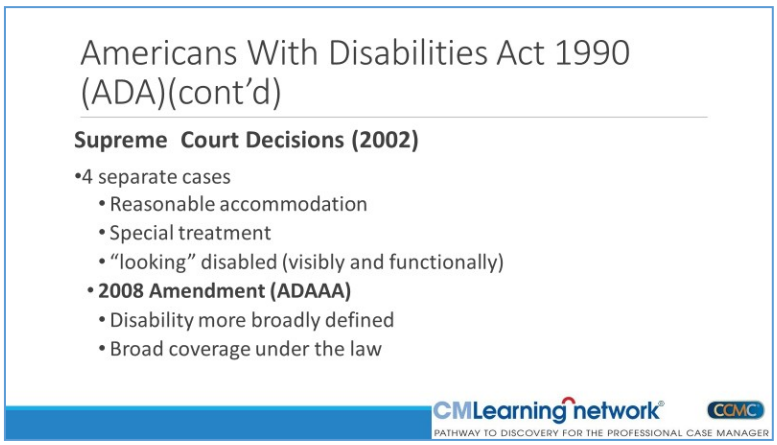
https://casemanagementstudyguide.com/ccm-knowledge-domains/rehabilitation/vocational-aspects-of-chronic-illness-and-disability/

Americans with Disabilities Act (ADA)

- Originally enacted in 1990; Amendments Act of 2008 became effective January 1, 2009 and broadened the scope of coverage under ADA and the Rehabilitation Act
- Title I (effective July 26, 1992) prohibits private employers, state and local governments, employment agencies, and labor unions from discriminating against qualified individuals with disabilities in job application, hiring, firing, advancement, compensation, job training, and other terms, conditions, or privileges of employment
- Enacted to provide clear mandate for elimination of discrimination against disabled persons
- Goal – to extend maximum opportunities for full community integration in both public and private sectors of society
    - Equal opportunity
    - Full participation
    - Independent living
    - Economic self-sufficiency
- Protection is extended to the ***individual***, not specific disabilities
- Qualifications
    - Individual must possess required skill, education, experience, and training to perform essential job function
    - Impairment must substantially limit a major life activity
    - Must be able to perform all essential job functions, with or without reasonable accommodation

- May not pose a direct threat to the health and safety of the individual or others, and the threat cannot be eliminated with modification of policies, practices, procedures, or with the use of auxiliary aids or service

- Reasonable accommodation is evaluated based on both effectiveness and feasibility for the typical employer, and the employer has the final discretion to choose a reasonable accommodation (must prove that it would cause an undue hardship)
- **Prohibits discrimination** of qualified individuals in employment settings

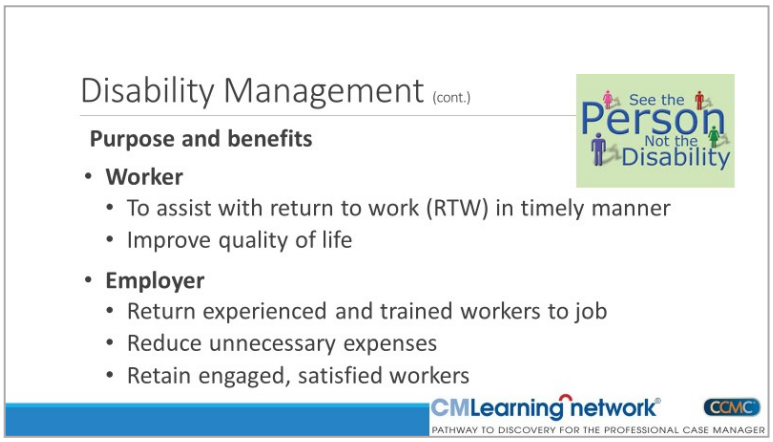


2002 Revised standards for reasonable accommodation

- On September 25, 2008, the President signed the Americans with Disabilities Act Amendments Act of 2008 ("ADA Amendments Act" or "Act"). The Act emphasizes that the definition of disability should be construed in favor of broad coverage of individuals to the maximum extent permitted by the terms of the ADA and generally shall not require extensive analysis.
- The Act makes important changes to the definition of the term "disability" by rejecting the holdings in several Supreme Court decisions and portions of EEOC's ADA regulations. The effect of these changes is to make it easier for an individual seeking protection under the ADA to establish that he or she has a disability within the meaning of the ADA.

https://www.eeoc.gov/statutes/americans-disabilities-act-amendments-act-2008

- Disability management is a workplace prevention and remediation strategy that aims to prevent disability from occurring or to intervene early following the onset of an injury or illness known to potentially result in a disability.
- The field of disability management was started about 50 years ago, from employer efforts to control disability costs. It has undergone unprecedented change and growth at least in part because of the passage of the Americans with Disabilities Act (ADA) in 1990.
- Disability management programs may consist of several specific components including:
    - prevention of work-related injury or illness,
    - support for the worker's recovery (e.g., medical and vocational rehabilitation, catastrophic case management, and life care planning), and
    - reasonable accommodations for the worker's limitations.
        - Employers also use disability management programs to assist their workers who are unable to return to work because of a job-related injury or occupational illness. Often federal and state laws mandate these programs



Disability Management

Focus

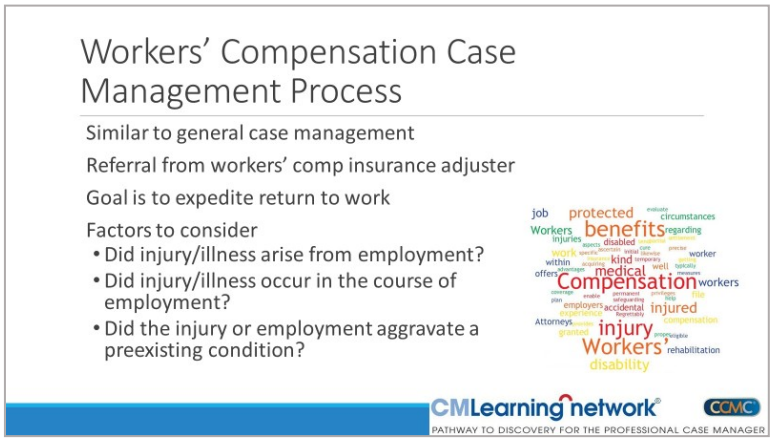
- **Prevention of job-related illness or injury**
  - Wellness/disease prevention programs
- **Support for recovery from job-related illness or injury**
  - Sick leave
  - Short- and long-term disability benefits
- **Reasonable accommodation**
  - Regulatory requirements
  - Job modifications
    - The purpose of disability management programs is to assist the worker to return to work as soon as appropriate, and therefore improve the individual's quality of life by resuming function and productive employment.
    - On the employer side, the purpose is for experienced and trained workers to quickly return to work. This also reduces unnecessary expenses and maintains engaged and satisfied workers.

- The **goals** of disability management are to:
  - Connect all the individual worker's care, benefit, and case management components so that they complement each other
  - Integrate the occupational and non-occupational disability benefits, absence, and paid leave programs, focusing on an early return to work
  - Coordinate the medical, employee assistance, behavioral health, health promotion, disease management, and case management services.

- Components of disability management programs include:
  - Processing of applications for health benefits, and coordination of benefits to ensure timely access
  - Clarification of job limitations and modifications, linking all stakeholders for return to work, coordinating care with treating providers and ensuring

appropriate timely treatment, identifying essential job functions in order to seek reasonable accommodation

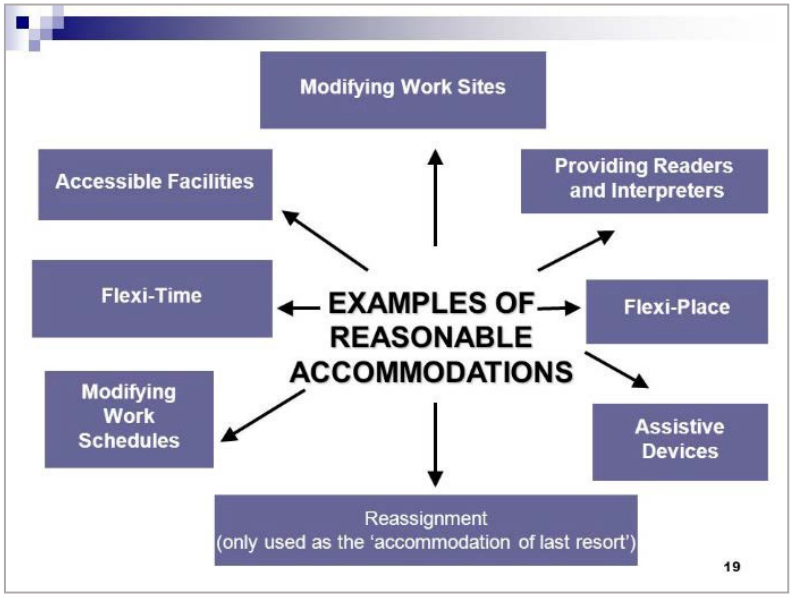
- Working within ADA regulations to develop modified job and return to work options, with reasonable accommodation and determination of essential job functions as appropriate
- Assisting the worker to return to work with understanding and acceptance from supervisors, gain agreement with job accommodation options
- Safety and illness prevention programs, aiding with reasonable accommodation, identification of job aids, assistive devices, ergonomics
- Education of supervisors, treating physicians, and others about the return-to-work process

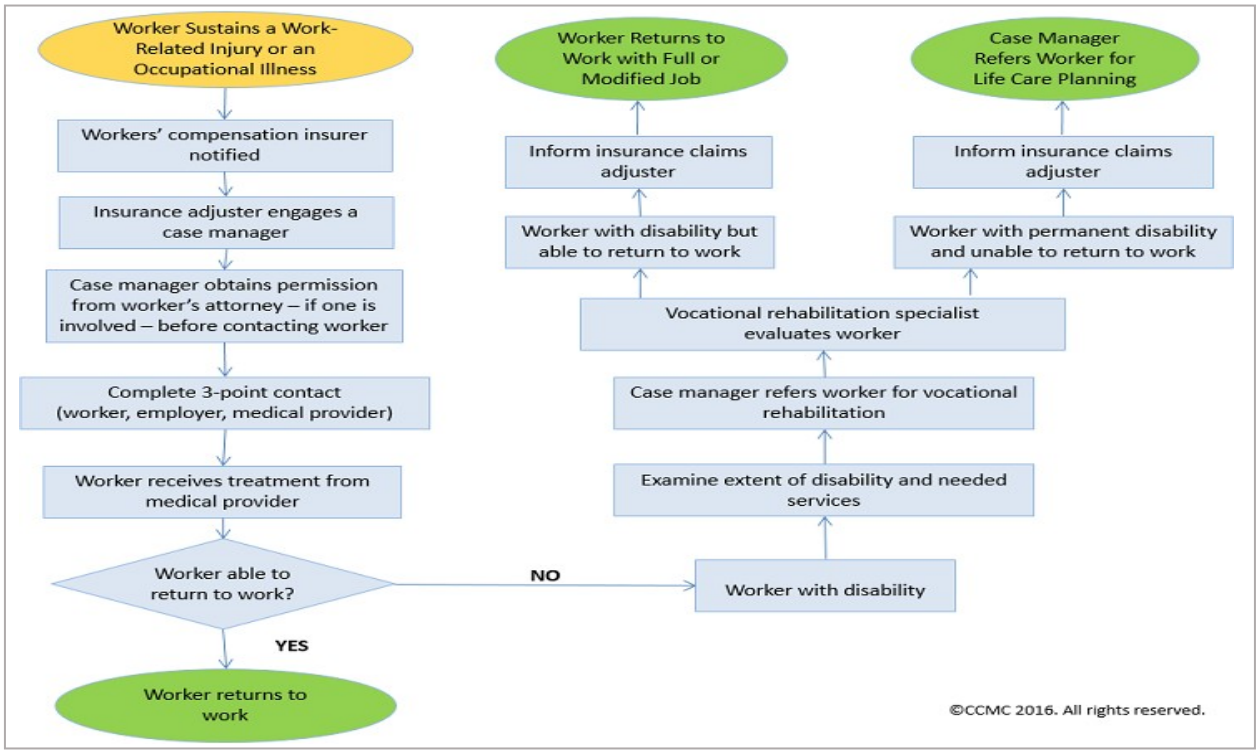


Workers' Compensation Case Management Process

- Case management in this specialty practice focuses primarily on the care of the client suffering from a work-related injury or an occupational illness.
- The functions are like general case management practice.
- Workers' compensation is a benefits program created by state law to provide medical, rehabilitation, income, death, and other benefits to workers and their dependents due to injury, occupational illness, or death resulting from a compensable work-related claim covered by the law.

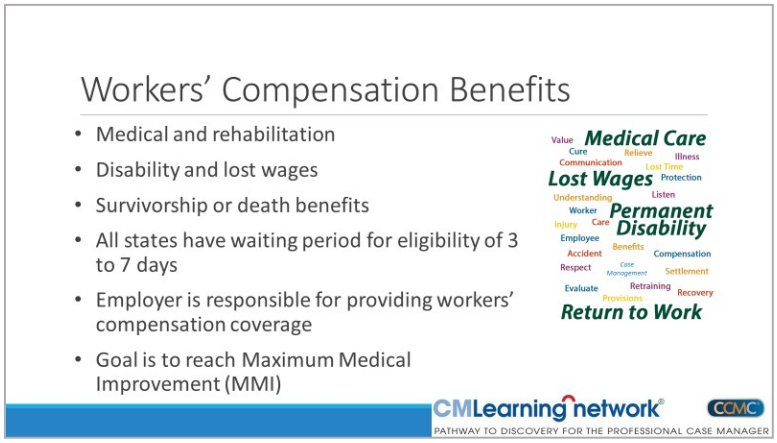
- Often the clients of workers' compensation case management require complex services
- Clients of workers' compensation may also be referred to as "workers" or even "injured workers," but it is important to realize that these terms also include those who have suffered an occupational disease, not just injury.





Workers' Compensation Case Management Process

- This is the process followed in worker's compensation case management.
- Referral is from the workers' compensation insurance adjuster
- The goal is to expedite return to work (RTW)
- Other considerations:
  - The workers' compensation insurance representative or adjuster then performs a necessary comprehensive investigation to determine whether the injury is covered and compensable. A similar process is used when a worker suffers an occupational disease.
  - Every worker has the right to claim benefits under workers' compensation for a job-related illness or injury. The claim is first filed with the insurance company (or self-insuring employer) before benefits kick in and the workers' compensation case management process commences.
  - The workers' compensation insurance adjuster must consider many factors during the investigation. However, the primary criteria used by the adjuster to determine that indeed a work-related injury has occurred, are the following:
    - Did the injury arise out of employment?
    - Did the injury occur during employment?
    - Did the accidental injury or nature of the employment aggravate or accelerate a preexisting condition?



Workers' Compensation Benefits

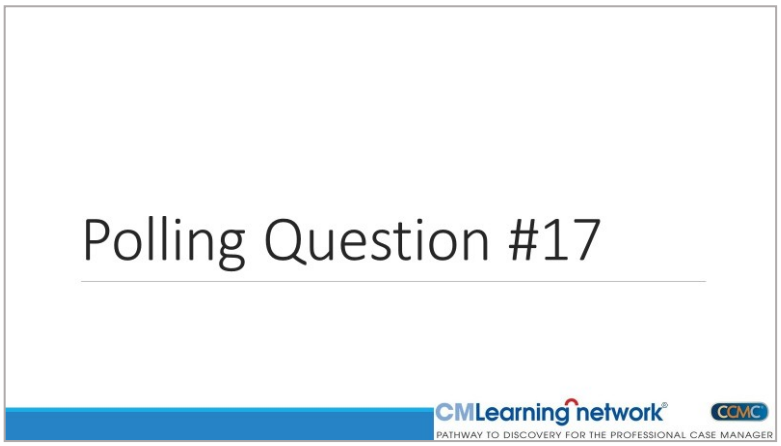
- Workers' compensation insurance benefits usually start after a mandatory waiting period.
- Benefits provided:
    - Medical and rehabilitation
    - Disability and lost wages
    - Survivorship or death benefits
        - All states have waiting period for eligibility of 3 to 7 days
        - Employer is responsible for providing workers' compensation coverage
        - Employers or businesses are responsible for providing workers' compensation insurance benefits to their employees. They cannot charge an employee for benefits provided under workers' compensation or for any portion of the business's workers' compensation insurance premium.
        - The medical and rehabilitation benefit pays 100% of the cost for all injury-related medical (and surgical) services to cure or alleviate the effects of the injury. The injured worker does not incur any co-payment or deductible for services needed and provided.
        - Most states pay the injured employee a percentage of the weekly wages. This may start at 60% and increases to about 80% of the earnings the worker may have received if able to work.
        - Survivorship benefits are also sometimes referred to as death benefits. If the worker dies from a compensable injury, the surviving spouse and/or minor children – and lacking such, other dependents as defined by law – are entitled to regular cash benefits, often weekly. The amount is equal to two-thirds of the deceased worker's average weekly wage for the year before the accident that resulted in the worker's death.

Maximum Medical Improvement

- Term to indicate that the injured worker has recovered from injuries to a level at which a physician states that further treatment will not substantively change the medical outcome.

Federal Workers Compensation Programs

- The Office of Workers Compensation Programs (OWCP) of the Department of Labor handles administers four major disability compensation programs.
- These include:
    - Energy Employees Occupational Illness Compensation program
    - The Federal Employees' Compensation Program (FECA)
    - Longshore and Harbor Workers' Compensation Program
    - Coal Mine Workers' Compensation Program
- Provide wage replacement benefits, medical treatment, vocational rehabilitation and other benefits to certain workers or their dependents who experience work-related injury or occupational disease.

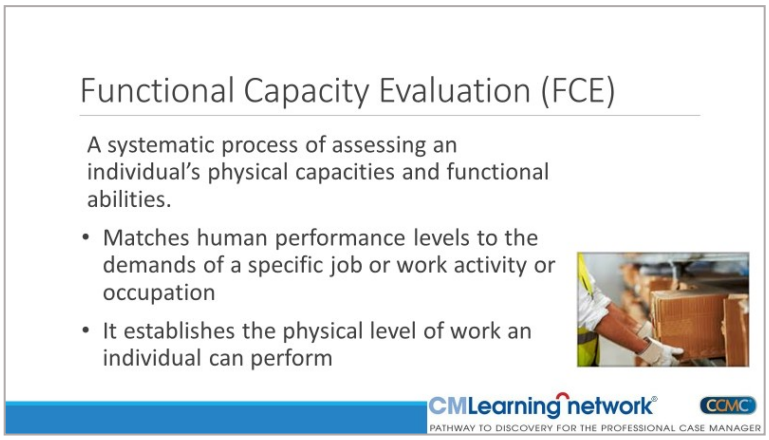


THE AMERICANS WITH DISABILITIES ACT (ADA) WAS AMENDED TO MORE BROADLY DEFINE DISABILITY AND ITS COVERAGE UNDER THE LAW IN

- **A. 1997**
- **B. 1990**
- **C. 2000**
- **D. 2008**

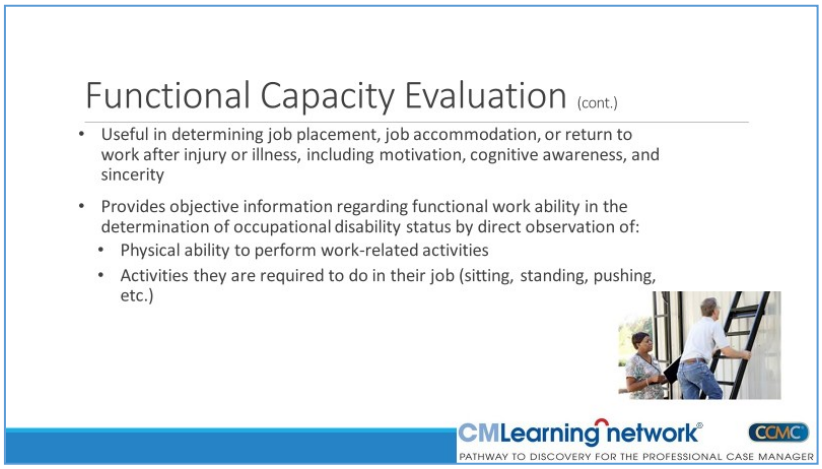
Vocational and Rehabilitation Service Delivery Systems

Main goal of rehabilitation is the reduction or reversal of impairment, disability, or handicap caused by illness or injury to enable the individual to reach the maximum level of physical, mental, and social functioning



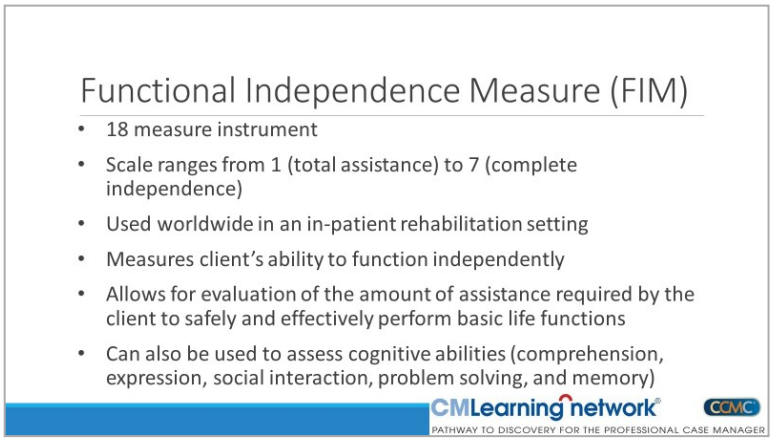
Functional Capacity Evaluation (FCE)

- A systematic process of assessing an individual's physical capacities and functional abilities.
- The Evaluation is done in a structured setting, not the place of work, and performed by a physical therapist or physician.
- The worker is examined as they complete activities, directly measuring the physical level of work they can perform.



- It is a comprehensive exam that can be used to determine job placement, job accommodation or return to work
- Can provide objective information in determination of an occupational disability.

- Matches human performance levels to the demands of a specific job or work activity or occupation
- It establishes the physical level of work an individual can perform
- Useful in determining job placement, job accommodation, or return to work after injury or illness
- Can provide objective information regarding functional work ability in the determination of occupational disability status.
- The FCE is used in occupational health case management to directly measure the client's ability to perform work related activities. It can be part of the initial assessment, used to determine the work conditioning plan or to reassess progress and ability to return to work.
- During the FCE the client is evaluated as they perform activities they are required to do in their job. This may include, but is not limited to:
    - Squatting
    - sitting
    - pushing
    - pulling
    - turning
    - standing
    - kneeling
    - balancing
    - navigating stairs
    - hand grip
- The amount of time the client can perform each of these tasks is important.
- The FCE is dependent on the participation of the individual being evaluated, and only reflects what they are able or willing to do at the time of the evaluation.
- Dependent on motivation, cognitive awareness, and sincerity
- Factors that may influence this include, sincerity of effort, motivation, and mental alertness.



Functional Independence Measure (FIM)

- 18 measure instrument
- Scale ranges from 1 (total assistance) to 7 (complete independence)
- Used worldwide in an inpatient rehabilitation setting
- Measures client's ability to function independently
- Allows for evaluation of the amount of assistance required by the client to safely and effectively perform basic life functions
- Can also be used to assess cognitive abilities (comprehension, expression, social interaction, problem solving, and memory)

Key Terms:

Assistive Device:

- Any tool that is designed, made, or adapted to assist a person to perform a task.

Assistive Technology:

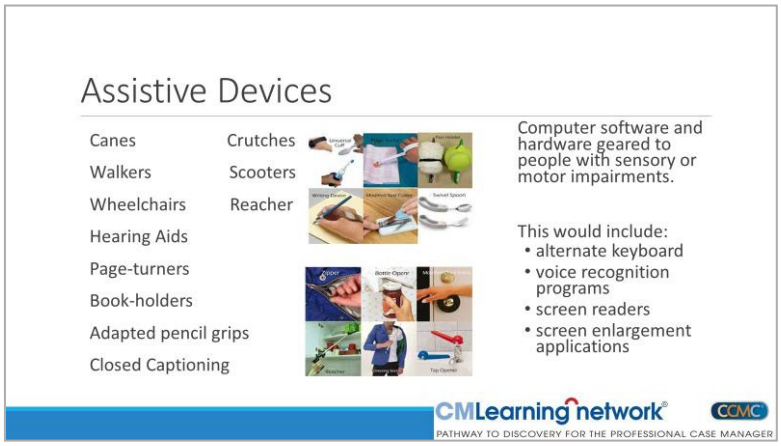
- Any item, piece of equipment, or product system, whether acquired commercially or off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Examples are listening devices, speech production equipment and low vision devices.

Assistive Technology Services:

- Any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. Ergonomics (or human factors): The scientific discipline concerned with the understanding of interactions among humans and other elements of a system. It is the profession that applies theory, principles, data and methods to environmental design (including work environments) to optimize human well-being and overall system performance.

Types of Assistive Devices and Technologies

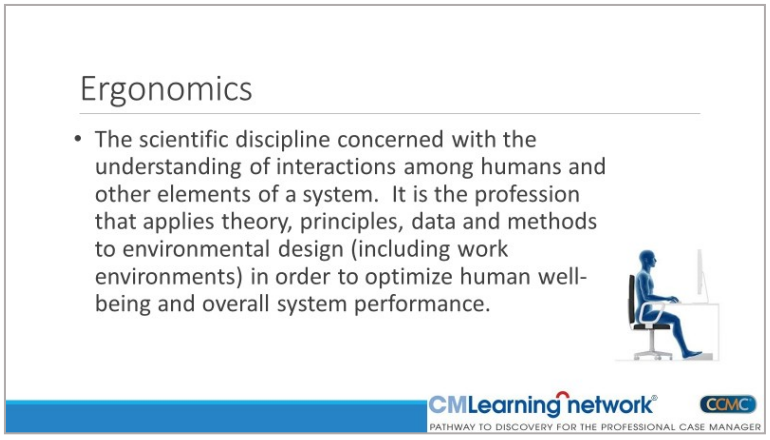
- Assistive devices are tangible items that assist a person with a disability to carry out a task
- Use of the device allows the individual with impaired abilities or functional limitations to gain greater independence in performing activities
- They can also be used for job accommodations
- Tangible items or pieces of equipment that aide a person with a disability in carrying out a task
- Can be high-tech such as computers and hearing aids
- Can also be as simple as a cane or reacher
- Purpose of the device is to improve function and independence
- Frequently used as job accommodations.



Assistive Devices

- These items are all considered assistive devices. Assistive devices can aid mobility (wheelchairs, canes, etc.), sensory or motor impairment (computer software and hardware, allowing use of the computer), assist with orientation to person, place, or time (clocks, calendars, smartphones), telecommunication devices for the deaf (teletypewriter TTY, or text telephone device TTD)
    - canes

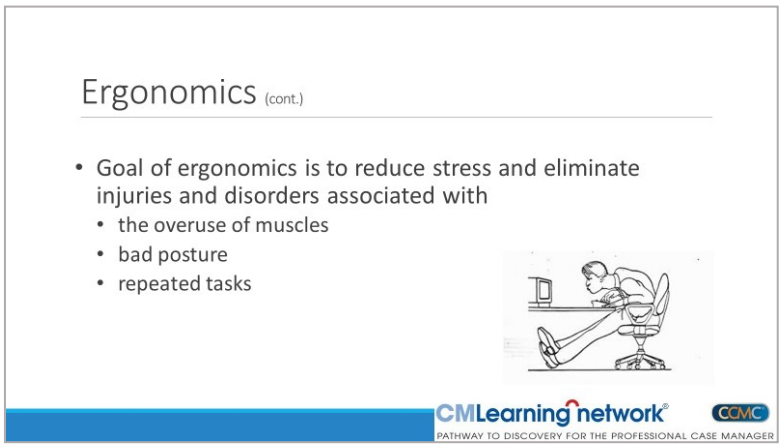
- crutches
- walkers
- scooters
- wheelchairs
- Hearing Aids
- Page-turners
- Book-holders
- Adapted pencil grips
- Closed Captioning
- Reacher
- Computer software and hardware geared to people with sensory or motor impairments.
- This would include:
  - alternate keyboard
  - voice recognition programs
  - screen readers
  - screen enlargement applications



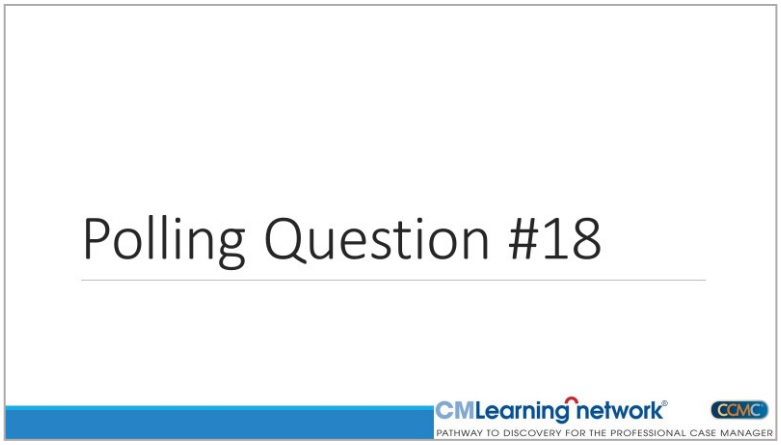
Ergonomics

- Ergonomics originates from the Greek words “ergon”, meaning work, and “nomoi”, meaning natural laws. The International Ergonomics Association defines ergonomics as the understanding of interactions among humans and other elements of a system.

- An ergonomic adjustment can be as simple as adjusting the position of lighting to avoid eye strain. It can also be complex involving engineering to redesign a factory to allow for better ergonomics for workers.
- The scientific discipline concerned with the understanding of interactions among humans and other elements of a system. It is the profession that applies theory, principles, data and methods to environmental design (including work environments) to optimize human well-being and overall system performance.



- Goal of ergonomics is to reduce stress and eliminate injuries and disorders associated with
  - the overuse of muscles
  - bad posture
  - repeated tasks

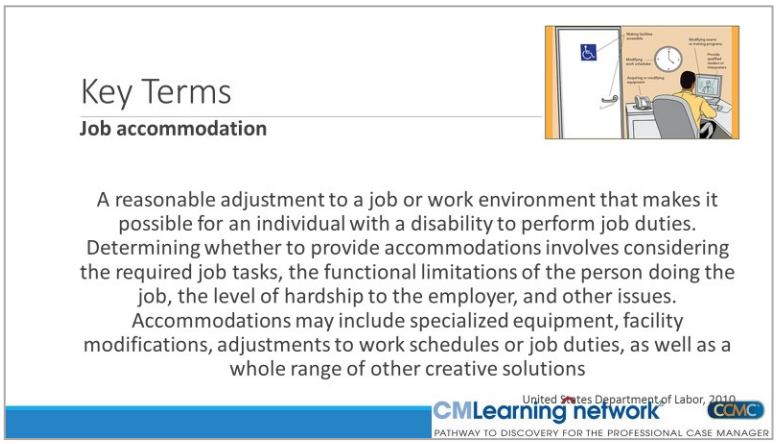


TRUE OR FALSE:

ASSISTIVE DEVICES CAN INCLUDE COMPUTER HARDWARE AND/OR SOFTWARE

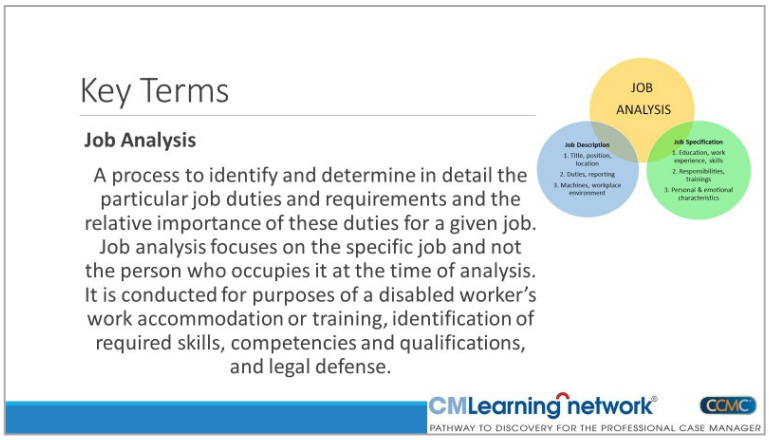
TRUE
FALSE

Key Terms

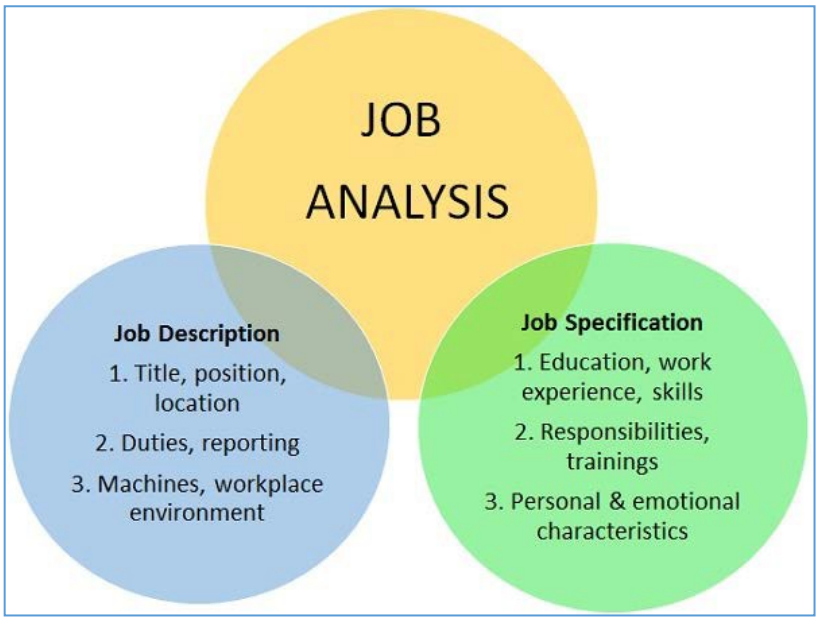


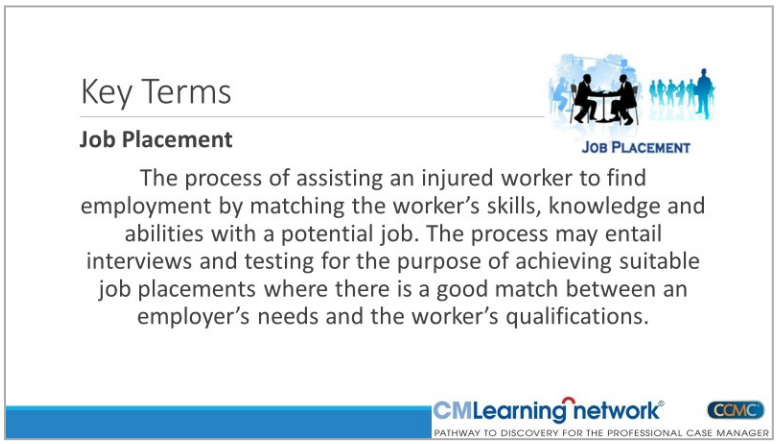
- **Job accommodation**
  - A job accommodation is a reasonable adjustment to a job or work environment that makes it possible for a disabled person to perform job duties.
  - The job accommodation is individualized and focused on access. It can be the use of voice recognition software or an adjustable height desk to accommodate a wheelchair.
  - The term job modification is sometimes used interchangeably with job accommodation. The job modification, though, is an across-the-board change to a job description that targets the skills a person can do.
  - The person with the disability is responsible to request a job accommodation. To make the accommodation, there are several factors to consider:
  - Identify the functional limitations – which tasks cannot be performed without accommodation
  - Identify the accommodations – what is needed should be discussed with the employee
  - Determine reasonable solutions – ADA requires reasonable accommodation, but if it causes financial difficulty, is disruptive to the workplace, or fundamentally changes the operation of the business, the accommodation would not be considered reasonable.

- Make the accommodation – employer determines accommodation based on cost, feasibility, and effectiveness
- Monitor effectiveness – to achieve desired outcome, otherwise the process should be repeated.
- A reasonable adjustment to a job or work environment that makes it possible for an individual with a disability to perform job duties. Determining whether to provide accommodations involves considering the required job tasks, the functional limitations of the person doing the job, the level of hardship to the employer, and other issues. Accommodations may include specialized equipment, facility modifications, adjustments to work schedules or job duties, as well as a whole range of other creative solutions. (United States Department of Labor, 2010)
- Job Accommodation Network https://askjan.org/



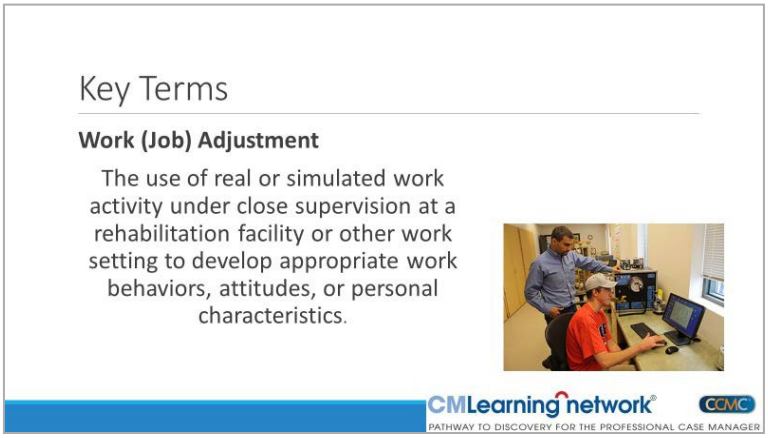
- **Job Analysis**
  - Another way of describing a job analysis is that it is a process to identify and determine in detail the job duties and requirements and their relative importance for a given job.
  - Key information is gathered through interviews, questionnaires or direct observation to develop a description or specifications of the job. It is not a description of the person.
  - The purpose is to establish and document the job relatedness of employment procedures such as training, selection, compensation and performance appraisal.
  - It is conducted for purposes of a disabled worker's work accommodation or training, identification of required skills, competencies and qualifications, and legal defense.



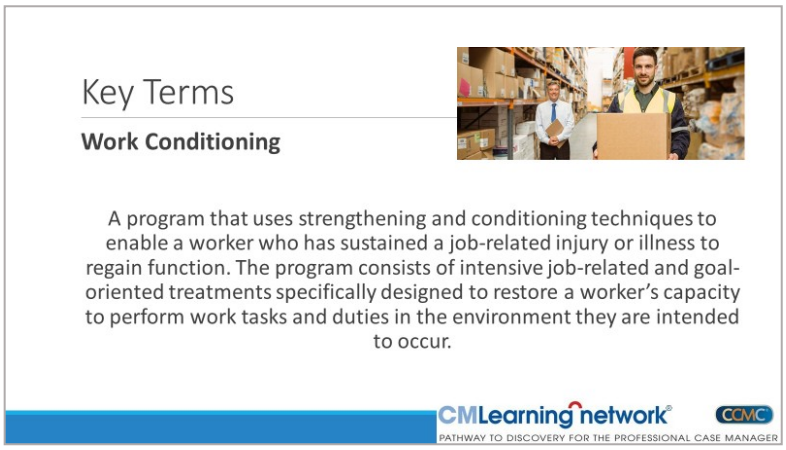


- **Job Placement**
  - Job placement is what it sounds like.
  - It is assisting an injured worker to find employment by matching the skills, knowledge and abilities of the worker with a potential job.
  - Interviews and testing, for achieving suitable job placements, may be conducted to determine if there is a good match between an employer's needs and the

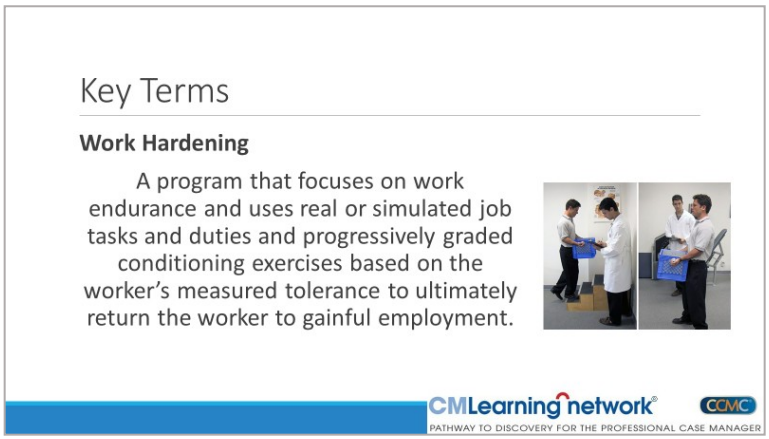
worker's qualifications.



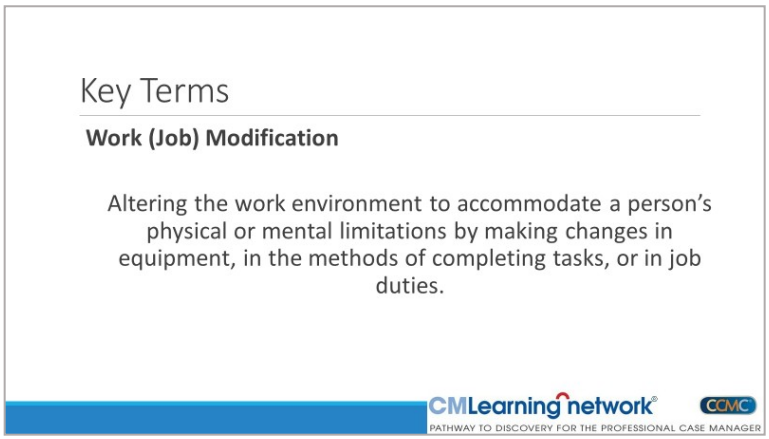
- **Work Adjustment**
  - Work adjustment is using simulated work activity in a controlled environment, such as a rehab facility.
  - Work adjustment training is a program for persons whose disabilities limit them from obtaining competitive employment. It typically includes a system of goal directed services focusing on improving problem areas such as attendance, work stamina, punctuality, dress and hygiene and interpersonal relationships with co-workers and supervisors.
  - Purpose is to develop appropriate work behaviors, attitudes, or personal characteristics
  - Services can continue until objectives are met or until there has been noted progress. It may include practical work experience or extended employment.



- **Work Conditioning**
  - Work conditioning is an intensive, work-related, goal-oriented conditioning program designed specifically to restore systemic neuromusculoskeletal functions (e.g., joint integrity and mobility, muscle performance (including strength, power, and endurance), motor function (motor control and motor learning), range of motion (including muscle length), and cardiovascular/pulmonary functions (e.g., aerobic capacity/endurance, circulation, and ventilation and respiration/gas exchange).
  - Uses strengthening and conditioning techniques to enable a worker who has sustained a job-related injury or illness to regain function.
  - The program consists of intensive job-related and goal-oriented treatments specifically designed to restore a worker's capacity to perform work tasks and duties in the environment they are intended to occur.
  - The objective of the work conditioning program is to restore physical capacity and function to enable the client to return to work.

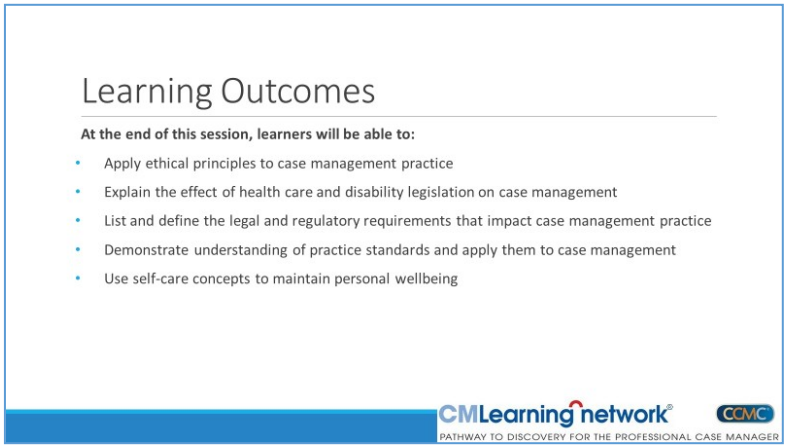


- **Work Hardening**
  - In contrast to work adjustment, which focuses on more personal issues, work hardening is a program that is a highly structured, goal-oriented, and individualized intervention program, providing clients with a transition between the acute injury stage and a safe, productive return to work, and focuses on endurance
  - Uses real or simulated job tasks and duties and progressively graded conditioning exercises based on the worker's measured tolerance to ultimately return the worker to gainful employment.
  - Treatment is designed to maximize the worker's ability to return to work safely with less likelihood of repeat injury. Work hardening programs are multidisciplinary in nature and use real or simulated work activities designed to restore physical, behavioral, and vocational functions. They address the issues of productivity, safety, physical tolerances, and worker behaviors.



- **Work Modification**
  - Altering the work environment to accommodate a person's physical or mental limitations by making changes in equipment, in the methods of completing tasks, or in job duties.
    - If modifications cannot be made the worker will have to change jobs or apply for disability status.

Domain 5 - Ethical, Legal, and Practice Standards



Learning Outcomes

At the end of this session, learners will be able to:

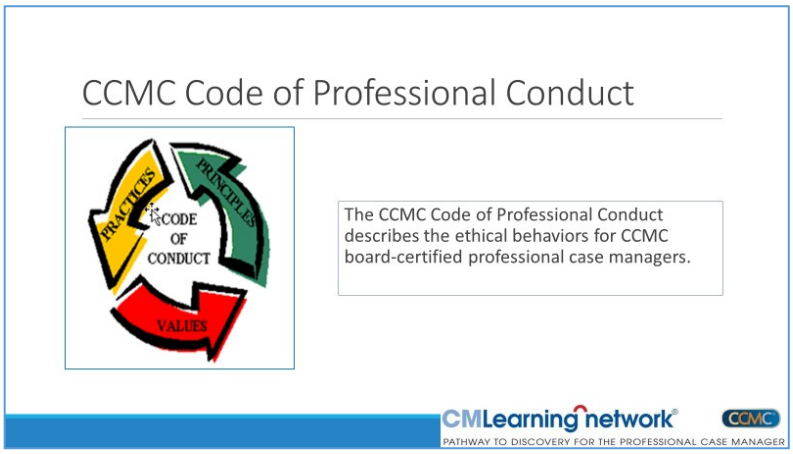
- Apply ethical principles to case management practice
- Explain the effect of health care and disability legislation on case management
- List and define the legal and regulatory requirements that impact case management practice
- Demonstrate understanding of practice standards and apply them to case management
- Use self-care concepts to maintain personal wellbeing

Ethics

Ethics

- A universally accepted set of rules of behavior based on ideas of what is considered right and wrong that are adopted by a group of people[1]

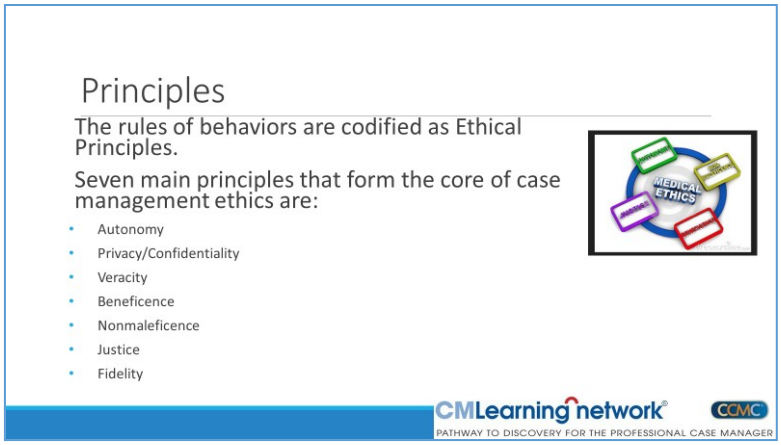
[1] *Merriam-Webster Dictionary*



Code of Professional Conduct for Case Managers

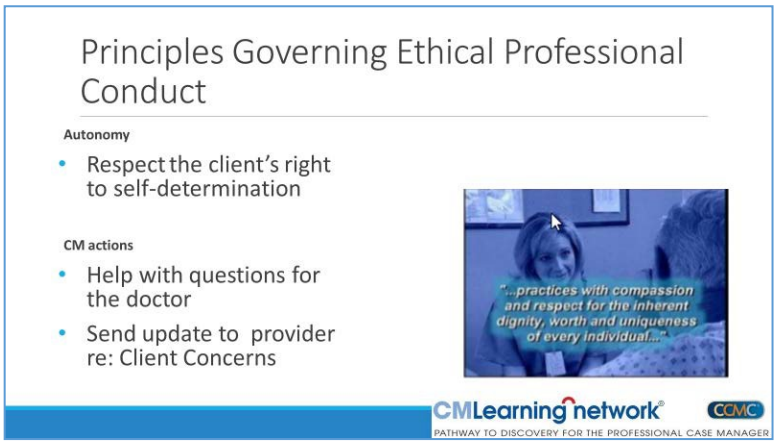
- The CCMC Code of Professional Conduct contains information of the ethical standards for professional case managers and is included in the workbook.
- The code establishes the high standards expected of CCMC certified case managers and describes the level of professionalism required of them.
- The code is binding to all CCMC certificants, regardless of their title, position, type of employment or method of compensation, and they govern all those who have the right to use the CCM credential mark, whether or not those marks are actually used.
- Originally adopted in 1996, the **CCMC Code of Professional Conduct for Case Managers was created to protect the public interest and ensure quality care.** The Code is reviewed every year and has been updated about every 5 years to ensure its relevance to the case management profession. (Most recent revision 2015)
- Compliance with the CCMC Code sets board-certified case managers apart and requires them to react with wisdom and responsibility every day. This assures employers that, no matter how quickly changes come, board-certified case managers remain responsible to put the client first and follow ethical principles to protect the client's safety, privacy and autonomy.
- The code describes the ethical behaviors for CCMC board-certified professional case managers and you need to become very familiar with it.
- You also must abide by codes of conduct adopted by your licensing body as well as professional organizations you may belong to.

- State practice acts
- Codes of Ethics for professional bodies
    - NASW
    - ANA
    - Others (profession specific)

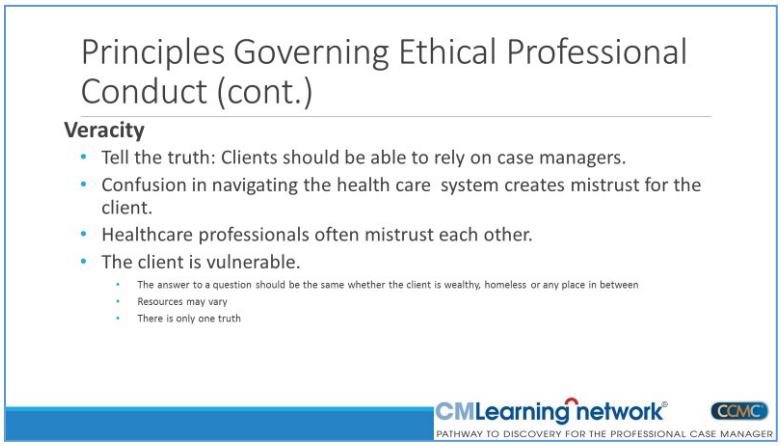


Principles

- The rules of behaviors are codified as Ethical Principles. As case managers, you need to know the seven main rules that form the core of case management ethics. They are: Autonomy, Privacy/Confidentiality, Veracity, Beneficence, Non-Maleficence, Justice and Fidelity.
- The rules of behaviors are codified as Ethical Principles.



- **Seven main principles** that form the core of case management ethics are:
  - **Autonomy**
    - Autonomy, the right to self-determination, is the foremost ethical principle. Case managers can facilitate this by helping with questions for the doctor and sending updates to provider with the client's concerns.
    - Respect the client's right to self-determination
  - **Privacy/Confidentiality**
    - Personal Health Information must be kept confidential



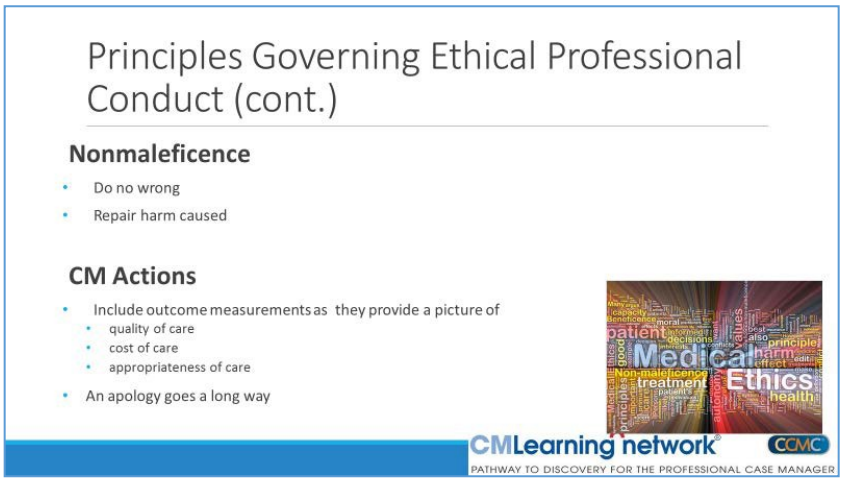
Veracity

- Veracity forces case managers to tell the truth at all times. The clients may be confused by a treatment plan or family members may not want their loved one to know the "truth" about their health status, but it is our duty to keep them truthfully informed. This will allay any mistrust a client may have for the health care system.

- Tell the truth: Clients should be able to rely on case managers.
- Confusion in navigating the health care system creates mistrust for the client.
- Healthcare professionals often mistrust each other.
- The client is vulnerable.
    - The answer to a question should be the same whether the client is wealthy, homeless or any place in between
    - Resources may vary
    - There is only one truth

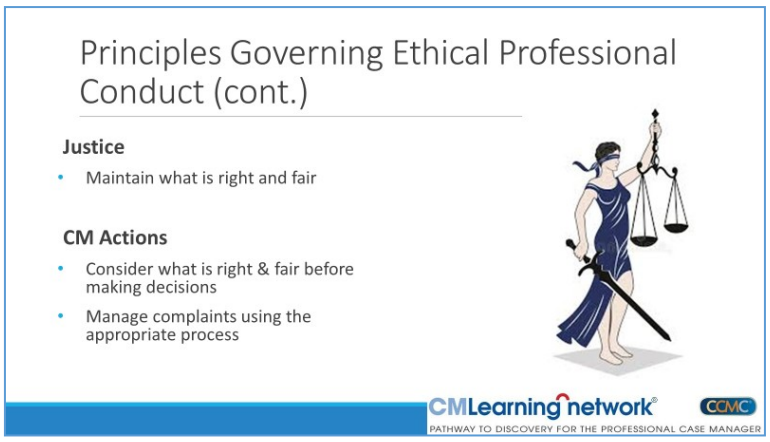
Beneficence

- Beneficence means the duty to do good.
- Promote good
- Further Client's Legitimate interests
- Prevent or Remove from Harm
- Act for the Client's Good



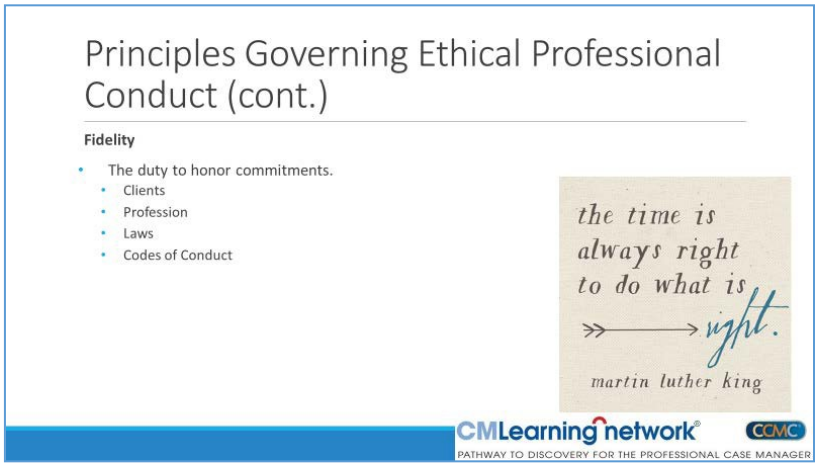
Nonmaleficence

- Non-maleficence means the duty to avoid harm. Prevent harm to clients or, rectify any harm to a client. Do no wrong
- Repair harm caused
- CM Actions:
    - Include outcome measurements as they provide a picture of
    - quality of care
    - cost of care
    - appropriateness of care
    - An apology goes a long way



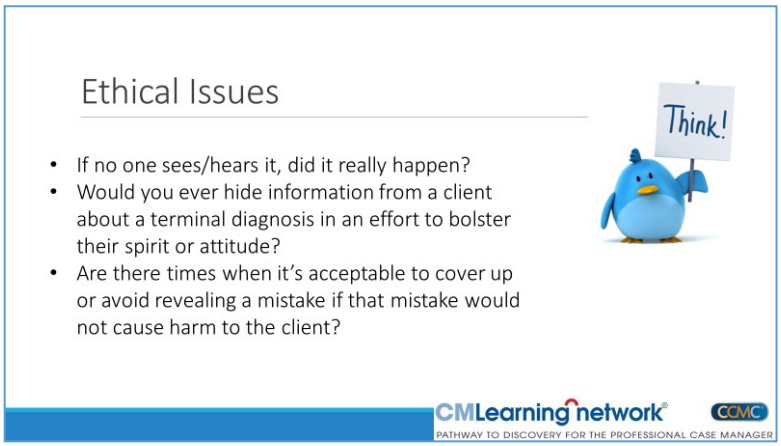
Justice

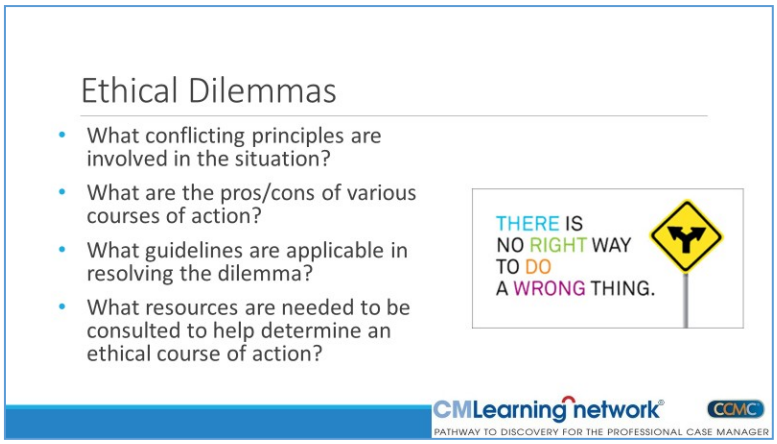
- Justice, the duty to treat everyone equally. Consider what is right and fair before making any decisions. Put your own beliefs in check, don't judge other's beliefs. Maintain what is right and fair
- CM Actions:
  - Consider what is right & fair before making decisions
  - Manage complaints using the appropriate process



Fidelity

- Fidelity is the duty to honor commitments. Case managers have a duty to their clients and their profession to fulfill their professional responsibilities according to all applicable laws and codes of conduct.





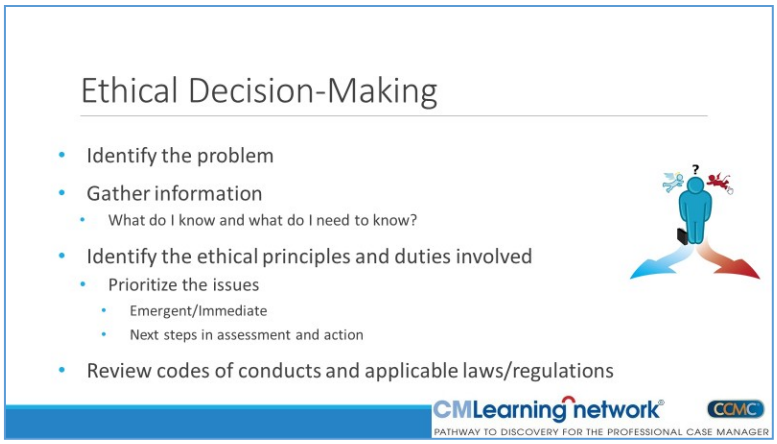
Ethical Dilemmas

- Sometimes case managers must use ethical principles and codes of conduct to deal with ethical dilemmas they may face. Ethical dilemmas occur when an individual must choose between two or more conflicting ethical principles. When a case manager is attempting to determine if an ethical dilemma exists and then manage it, certain questions may help the process:
  - What conflicting principles are involved in the situation? Identify them and see if they are conflicting.
  - What are the pros/cons of various courses of action? Ask yourself – WHAT IF...
  - What guidelines are applicable in resolving the dilemma?
  - What resources are needed to be consulted to help determine an ethical course of action?

- If you are unable to determine this on your own, ask for assistance. Some people have difficulties asking for assistance. As a case manager you are not expected to know everything, but you should know where to turn if you need assistance.

Ethical Issues in Healthcare Facilities

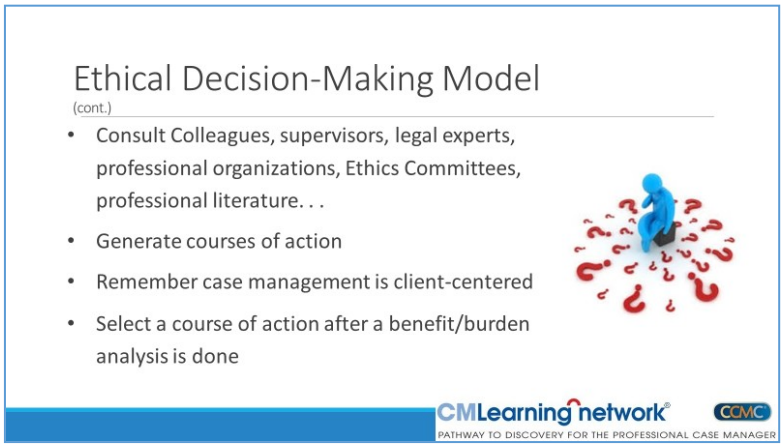
Clinicians worry about providing high quality care with limited resources and balancing duty to clients with the obligation to be stewards of resources.[2]



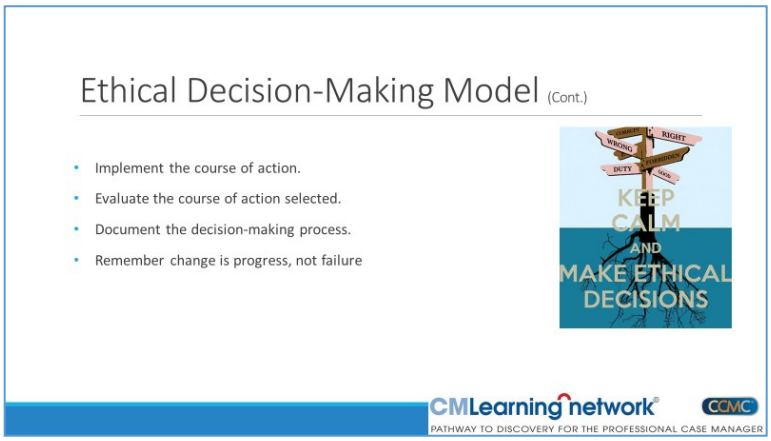
[2] *April 2009 Issue of American Journal of Bioethics*

An Ethical Decision-Making Model

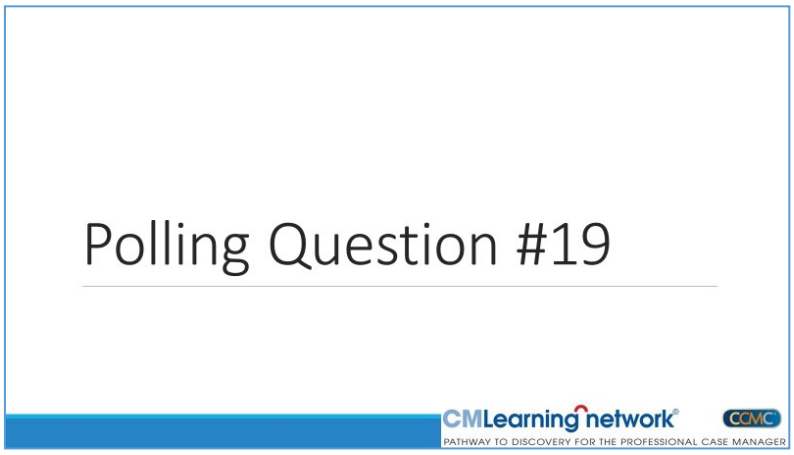
- To help resolve ethical dilemmas, an Ethical Decision-Making Model can be used. The model should be used to make sure you are informed of all the sides to the issue and you do not allow any personal feelings or biases to become involved. Here is the model at a glance:
    - Identify the problem.
    - Gather information. What do I know? What do I need to know?
    - Identify the ethical principles and duties involved.
        - Prioritize the issues
            - Emergent/Immediate
            - Next steps in assessment and action
    - Review codes of conducts and applicable laws/regulations.



- Consult Colleagues, supervisors, legal experts, professional organizations, Ethics Committees, professional literature.
- Generate courses of action.
    - Remember, case management is client-centered
- Select a course of action after a benefit/burden analysis is done.
    - Creating an action plan need not be a fancy document. Your notes may be sufficient, the important part is avoiding chaos and moving forward in a manner that best serves your client and incorporated ethical principles



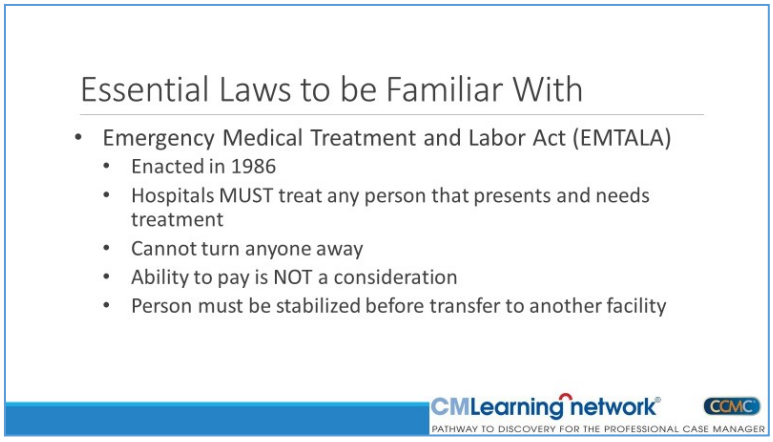
- Implement the course of action.
- Evaluate the course of action selected.
- Document the decision-making process.
- Remember change is progress, not failure
- You should also know your employer's policy for ethical decision making.



The ethical principle that requires one to do no harm is:

a. **Beneficence**
b. **Veracity**
c. **Justice**
d. **Non-maleficence**

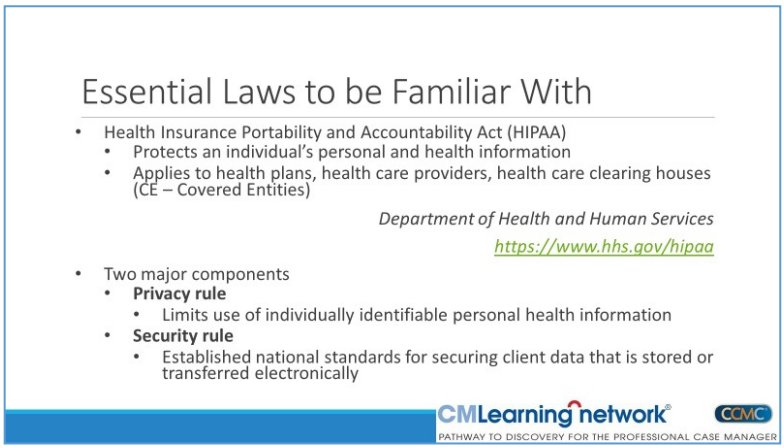
Health Care and Disability Related Legislation



Essential Laws to be Familiar With

Emergency Medical Treatment and Labor Act (EMTALA) (1986)

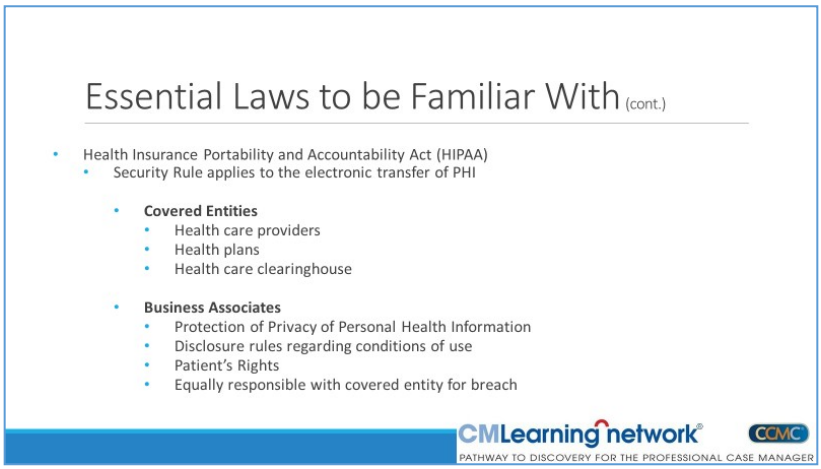
- States that any person who presents themselves at an emergency department in need of treatment MUST be treated regardless of their ability to pay
- Hospitals cannot turn anyone away if they need treatment
- They must stabilize any person before they can be transferred to another facility



Health Insurance Portability and Accountability Act (HIPAA)

https://www.hhs.gov/hipaa

- HIPAA is a broad act that covers many different aspects related to care. It may have been discussed earlier, and will be mentioned again in Ethics, but this is the broader view of HIPAA
- HIPAA covers how medical information is used and disclosed. This information is called protected health information (PHI)
- Applies to Health plans, Health Care Providers, Health Care Clearing Houses (CE - Covered Entities)
- Protects an individual's personal and health information
- It also covers the rights an individual has for obtaining access to their medical (or their children's) information and for making corrections to that information.
- **Privacy rule** -
    - Limits use of individually identifiable personal health information
- **Security rule -**
    - Established national standards for securing client data that is stored or transferred electronically



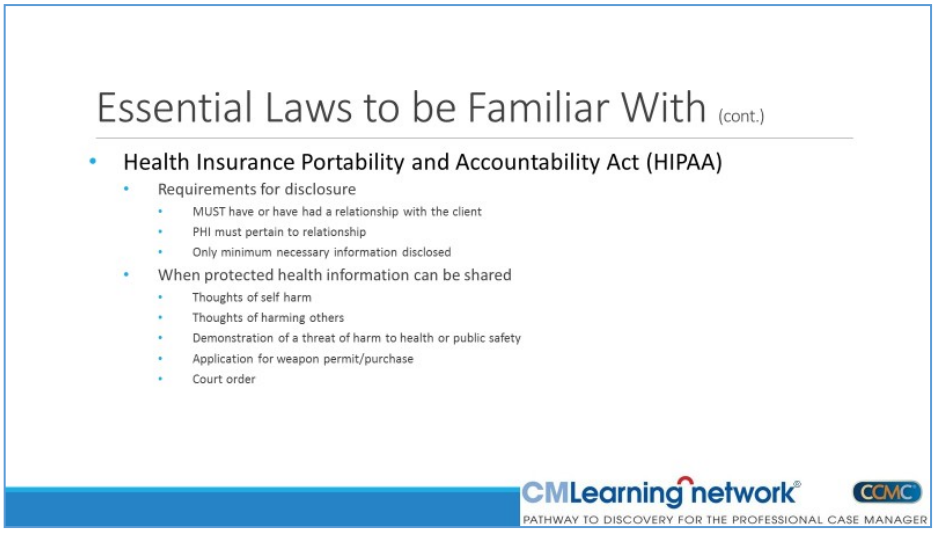
Covered entities

- Those organizations or providers that
  - Provide the healthcare for the client (physicians, hospitals, clinics, etc.)
  - Pay for the healthcare that is provided (health plans, health insurance companies)
  - Health care clearinghouses (process electronic transfer of information)

Business Associates

- A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.
- Covered entities must obtain satisfactory assurances from its business associates that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity
- The satisfactory assurances must be in writing, whether in the form of a contract or other agreement between the covered entity and the business associate (Business Associate Agreement – BAA)
- They are equally responsible with covered entity for breach
- Examples of Business Associates
  - A third-party administrator that assists a health plan with claims processing
  - A CPA firm whose accounting services to a health care provider involve access to protected health information.

- An attorney whose legal services to a health plan involve access to protected health information



- For there to be disclosure of protected health information (PHI), 3 primary things are required
- Relationship Requirement – the covered entity or business associate MUST have or have had a relationship with the client
- The PHI requested must pertain to that relationship.
    - Minimum Needed Information – the disclosure must only disclose the minimum information necessary for the health care operation at hand
    - As for the minimum necessary standard - Insurance companies (not healthcare payors) may request, with a valid authorization and subpoena “All Medical Records.” The insurance company may not be entitled to “All” under the minimum necessary standard.

Confidentiality Under HIPAA

- In recognition of the integral role that family and friends play in a client’s health care, the HIPAA Privacy Rule allows these routine – and often critical – communications between health care providers and these persons. Where a client is present and has the capacity to make health care decisions, health care providers may communicate with a client’s family members, friends, or other

persons the client has involved in his or her health care or payment for care, so long as the client does not object.

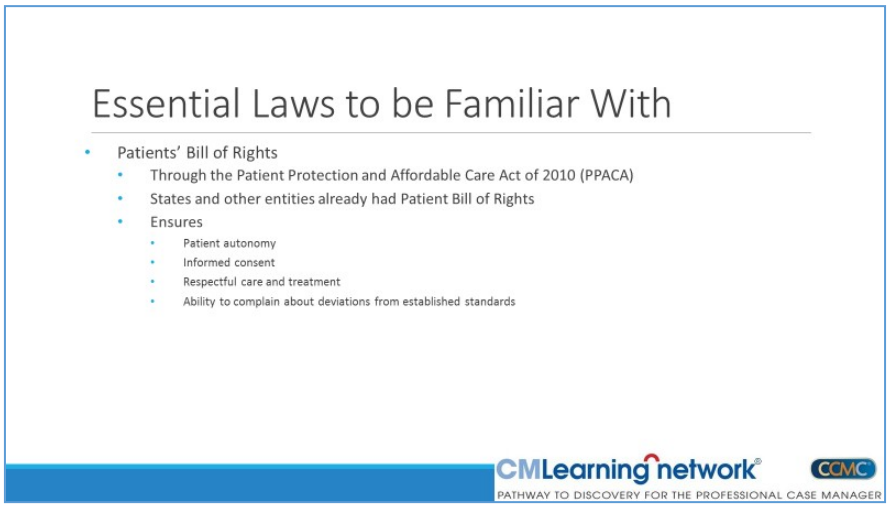
- Where a client is not present or is incapacitated, a health care provider may share the client's information with family, friends, or others involved in the client's care or payment for care, if the health care provider determines, based on professional judgment, that doing so is in the best interests of the client.
- Psychotherapy notes by nature, with few exceptions, require a covered entity to obtain a client's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes.
- Another scenario - you are arranging for a walker to be delivered to a client's house. While talking to the vendor, you tell them that the client was tested for a sexually transmitted disease while in the hospital and was found to be positive. Does this violate the minimum needed information requirement?

- There are **exceptions**, however. No authorization is required for
  - Public health
  - Abuse, Neglect, domestic violence
  - Court order signed by a judge
  - Response to a HIPAA Investigation Subpoena (different from a state lawsuit subpoena)

- A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the client (State laws vary as to whether such a warning is mandatory or permissible).
- When protected health information can be shared
  - Consent of client (WRITTEN)
  - Continued Treatment

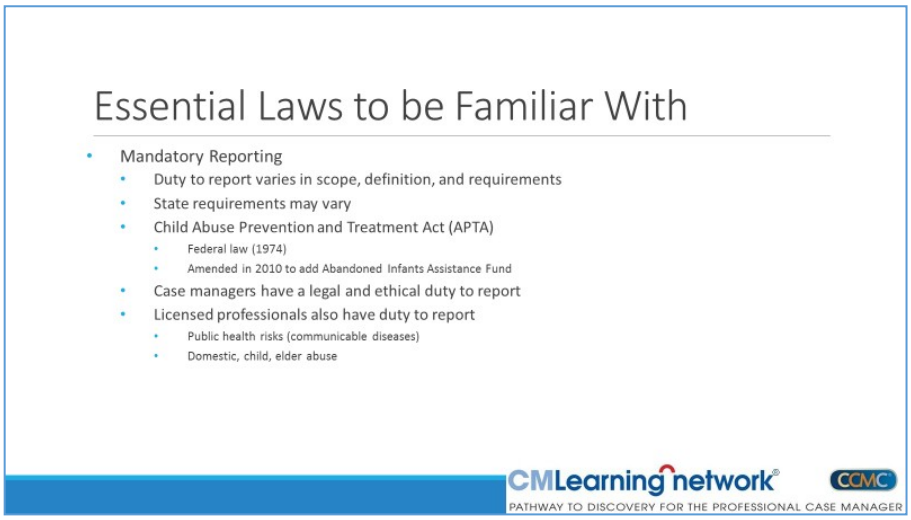
- To comply with the law - some states require mandated reporting of abuse, danger to public health
- To communicate a threat
    - Thoughts of self-harm
    - Thoughts of harming others
    - Demonstration of a threat of harm to health or public safety
    - Application for weapon permit/purchase
    - Court order

https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf



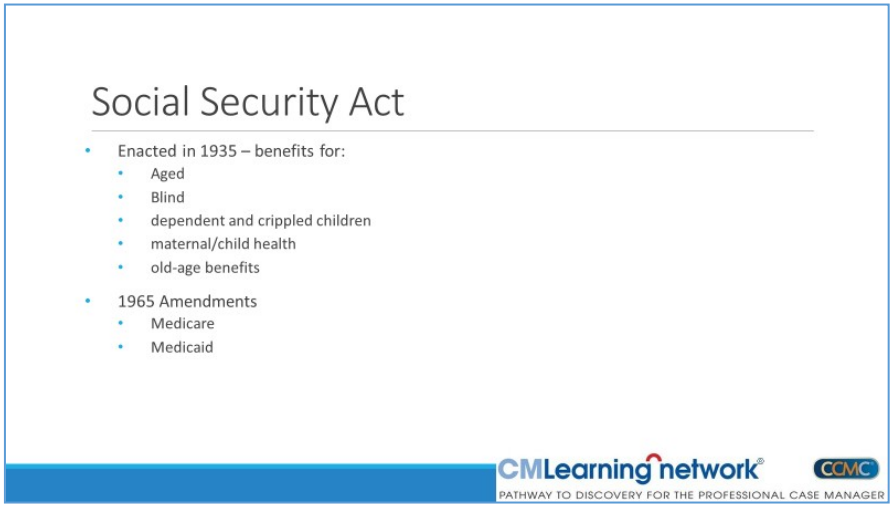
Patients' Bill of Rights

- Relates to access to healthcare services through the Patient Protection and Affordable Care Act of 2010 (PPACA) (also referred to as ACA)
- May already be part of your state requirements
- Ensures that clients have autonomy, and can make their healthcare decisions without interference; are provided with the ability to give informed consent; receive respectful care and treatment; and are able to complain about deviations from established care standards without fear of reprisal
- Case managers should be familiar with the Patient Bill of Rights in their state or organization



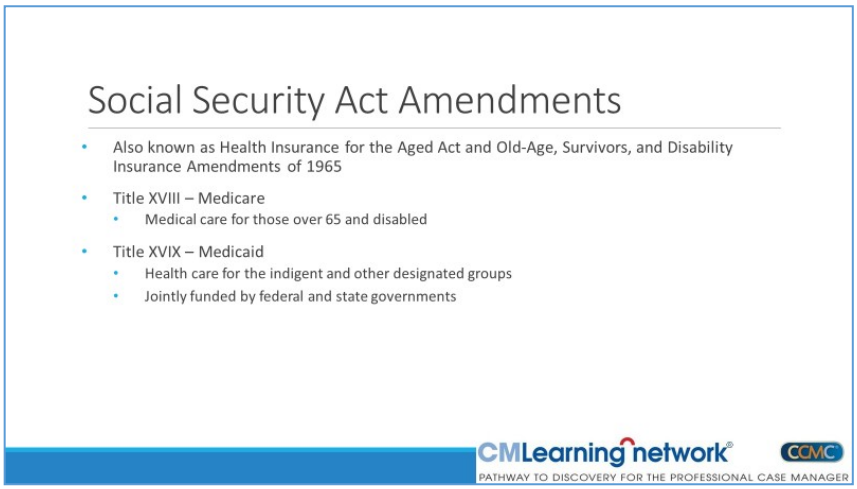
Mandatory Reporting

- State and federal laws regarding mandatory reporting
- Be aware of reporting requirements by state, license, or profession

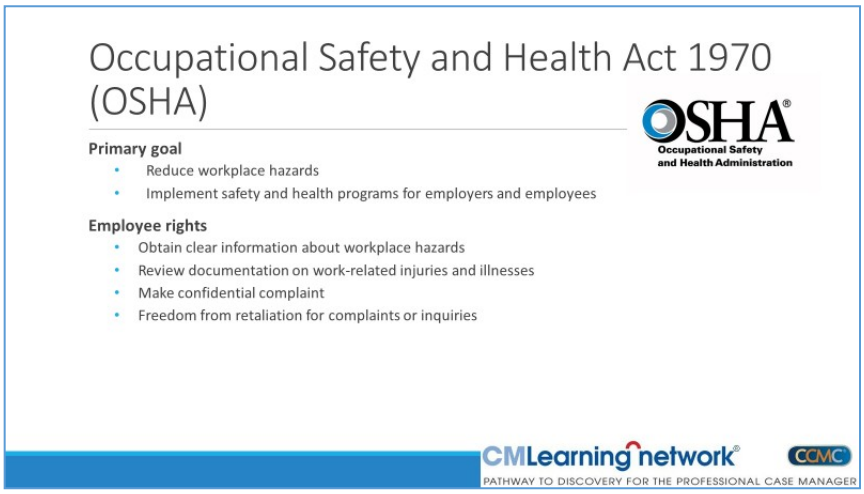


Social Security Act

- Enacted in 1935 – provided benefits for the aged, blind, dependent and crippled children, maternal/child health, and old-age benefits.
- Amendments to the act in 1965 gave us legislation in which the most important provisions resulted in creation of Medicare and Medicaid



- Also known as Health Insurance for the Aged Act and Old-Age, Survivors, and Disability Insurance Amendments of 1965
- Provided medical care for the elderly and poor families
- Title XVIII – Medicare
  - Medical care for those over 65 and disabled persons entitled to Social Security benefits
- Title XVIX – Medicaid
  - Provided for health care for the indigent and other designated groups
  - Jointly funded by federal and state governments
  - Criteria vary from state to state
- Medicaid and Medicare demonstration projects employed social workers and human service workers to arrange for and coordinate medical and social services to defined client populations in the community, particularly the elderly.



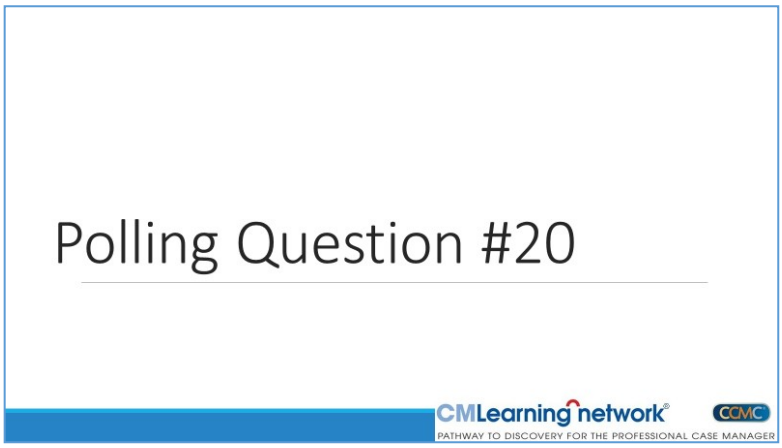
Occupational Safety and Health Act 1970 (OSHA)

Primary goal

- Reduce workplace hazards
- Implement safety and health programs for employers and employees

Employee rights

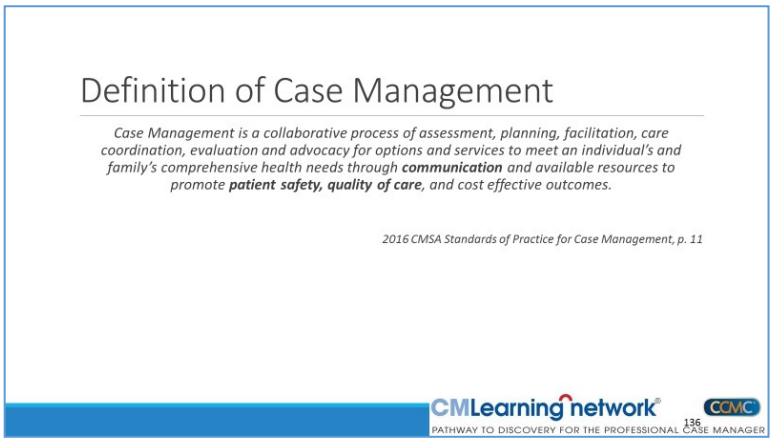
- Obtain clear information about workplace hazards
- Review documentation on work-related injuries and illnesses
- Make confidential complaint
- Freedom from retaliation for complaints or inquiries



Exceptions to HIPAA privacy protections include all but:

A. **Public health issues**
B. **Family request**
C. **Abuse, neglect, or domestic violence**
D. **Court order**

Confidentiality

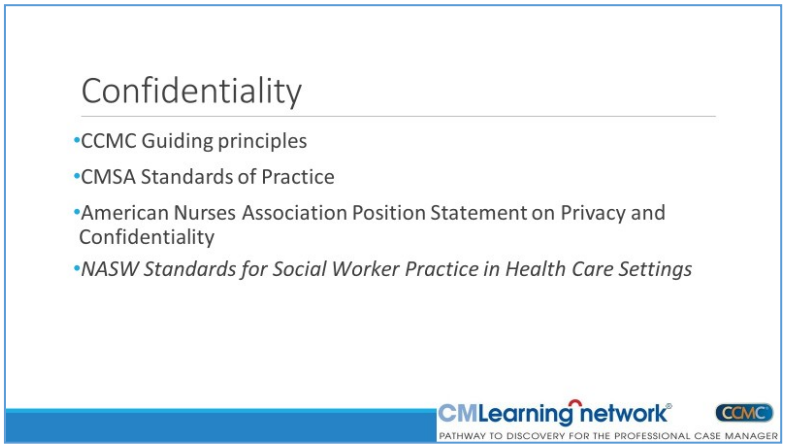


Definition of Case Management

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* ***patient safety, quality of care****, and cost-effective outcomes. (2016 CMSA Standards of Practice for Case Management, p. 11)*

http://solutions.cmsa.org/acton/media/10442/standards-of-practice-for-case-management

- When it comes to our standard of care and liability - communication, client safety and quality of care are very important because they can lead to liability when we fail to meet the standard. These three areas encompass all that we do as case managers.



Case managers enhance the case management services and their associated outcomes by maintaining clients' privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards and guidelines, as appropriate to the practice setting.

(CCMC Guiding Principles – CCMC Code of Professional Conduct)

The professional case manager shall adhere to all applicable federal, state, and local laws and regulations, which have the full force and effect of law, governing all aspects of case management practice including, but not limited to, client privacy and confidentiality rights.

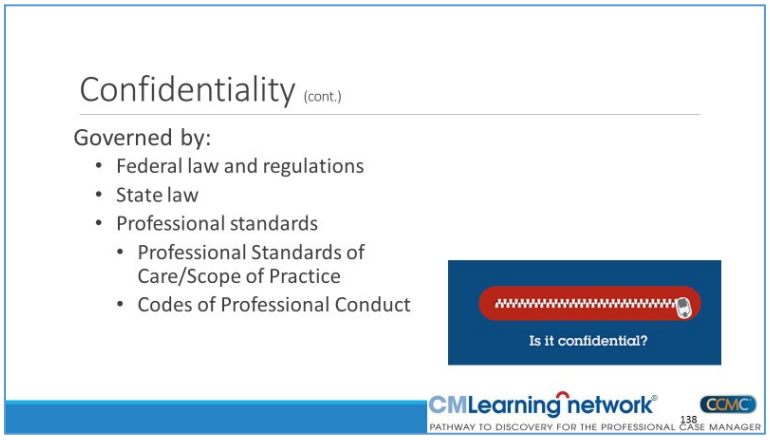
(CMSA Standards of Practice for Case Management, Revised 2016)

Confidentiality protections should extend not only to health records, but also to other individually identifiable health information, including clinical research records, oral reporting, images and mental health therapy notes. This protection should be maintained in the treatment setting and in all other venues.

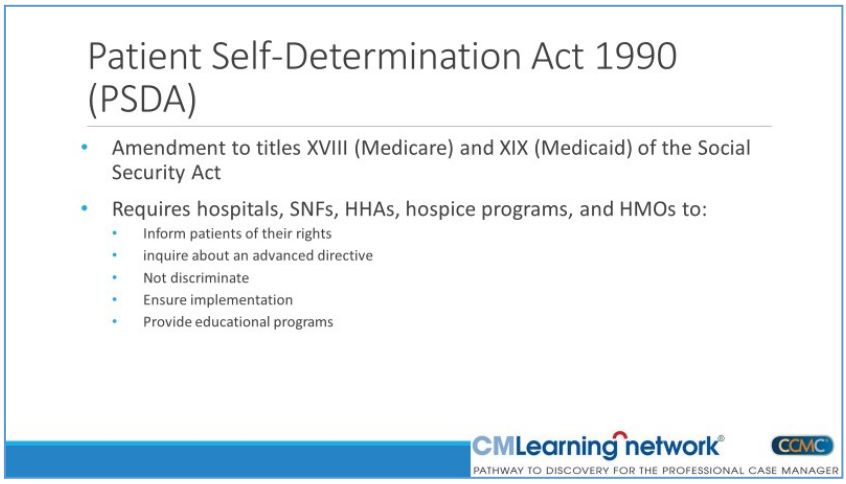
(American Nurses Association Position Statement on Privacy and Confidentiality, June 2015)

Acceptance of these responsibilities— which include upholding a client's right to ***privacy and confidentiality*** *and promoting client self-determination.*

(NASW Standards for Social Worker Practice in Health Care Settings – 2016)



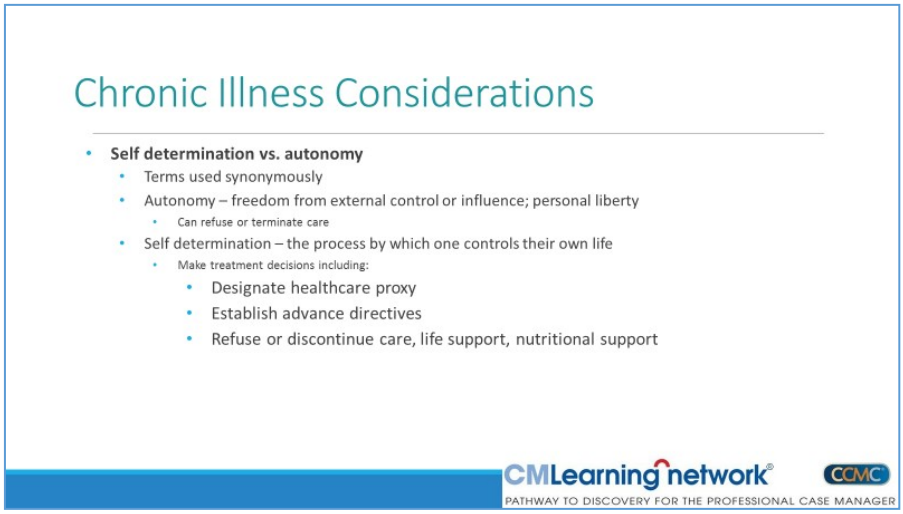
Advance Directives



Patient Self-Determination Act 1990 (PSDA)

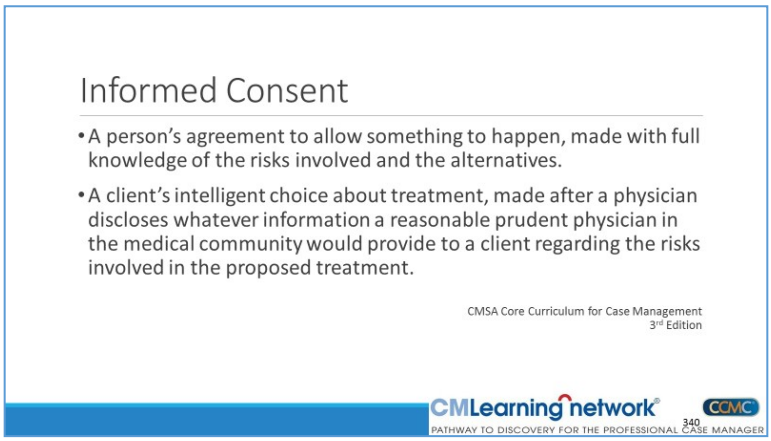
- Amendment to titles XVIII and XIX of the Social Security Act
- Requires hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations (HMOs) to
  - Inform clients of their rights under State law to make decisions concerning their medical care
  - Periodically inquire as to whether a client executed an advanced directive and document the client's wishes regarding their medical care
  - Not discriminate against persons who have executed an advance directive

- Ensure that legally valid advance directives and documented medical care wishes are implemented to the extent permitted by State law
- Provide educational programs for staff, clients, and the community on ethical issues concerning client self-determination and advance directives



Self-Determination vs. Autonomy

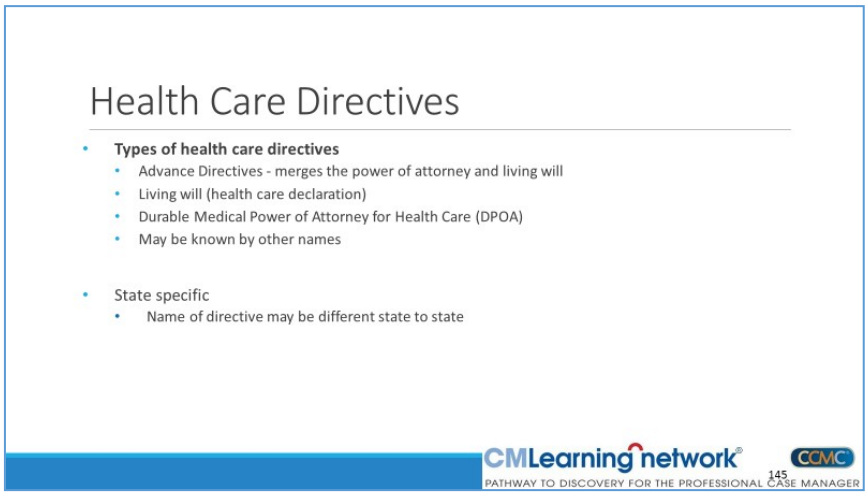
- Terms used synonymously
- Autonomy – freedom from external control or influence; personal liberty
  - Can refuse or terminate care
- Self-determination – the process by which one controls their own life
  - Make treatment decisions including:
    - Designate healthcare proxy
    - Establish advance directives
    - Refuse or discontinue care, life support, nutritional support
- Self-determination is making treatment decisions, such as designating a healthcare proxy, establishing advance directives, deciding to refuse or discontinue care, and choosing not to be resuscitated or withdraw nutritional support.
- Autonomy a form of personal liberty in which the client holds the right and freedom to make decisions regarding his or her own treatment and course of action and take control for his or her health, fostering independence and self-determination.



Informed Consent

1. A person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives.
2. A client's intelligent choice about treatment, made after a physician discloses whatever information a reasonable prudent physician in the medical community would provide to a client regarding the risks involved in the proposed treatment.[3]

- Consent is a requirement for medical disclosures. It is also a requirement for treatment.

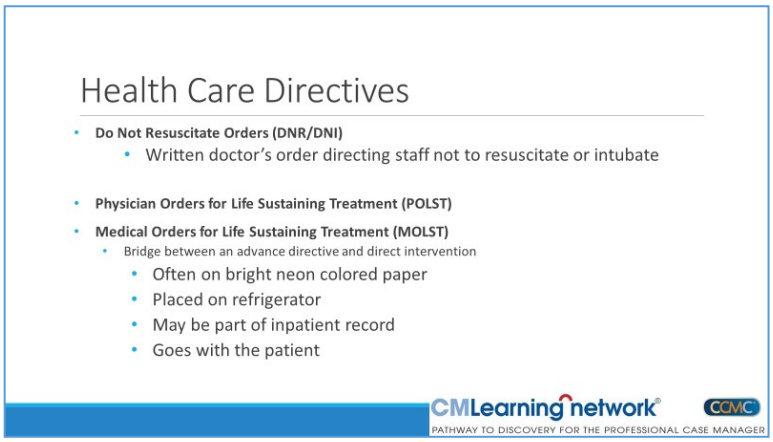


Health Care Directives

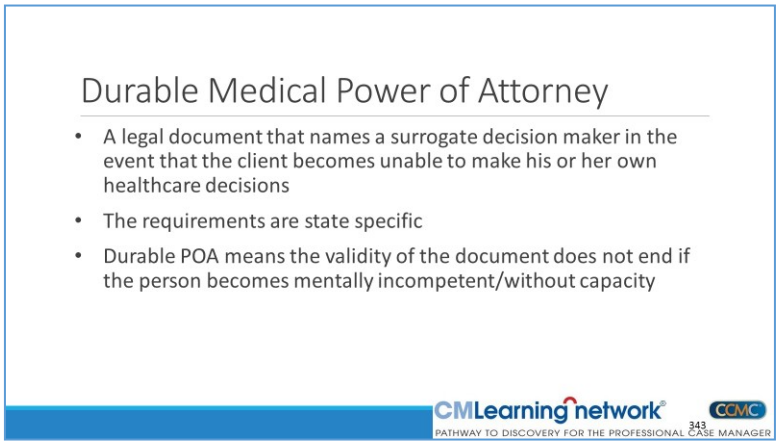
- When it comes to making health care decisions, an individual may choose to appoint someone to carry out their wishes should they be unable to do so themselves.

[4]CMSA Core Curriculum for Case Management, 3rd Edition

- Advance Directives may either name the person they wish to make those decisions, and/or spell out what they wish to have happen
- **There are many types of health care directives**
    - Advance Directives are a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor
    - Advance Directives are state specific – know what your state law and requirements are
    - There are many different names for advance directives, and they may have different names for similar documents from state to state
    - Advance Directives – some will merge the power of attorney (POA) and the living will
    - Living will - health care declaration of what the individual wants, or does not want done, medically if they become too ill or injured to direct care
    - Durable Medical Power of Attorney for Health Care (DPOA) – appointment of another person to make medical decisions when they are unable to make them themselves
- The case manager's duty is to assure that the individual's wishes are followed. This includes working with the family and the decision maker to fulfill the wishes of the individual when they had the capacity to make the decision, understanding the consequences of those decisions. When there are issues related to these advance directives at the time they are needed, consult with the ethics committee, administration, clergy, or social work may be beneficial to resolve them.



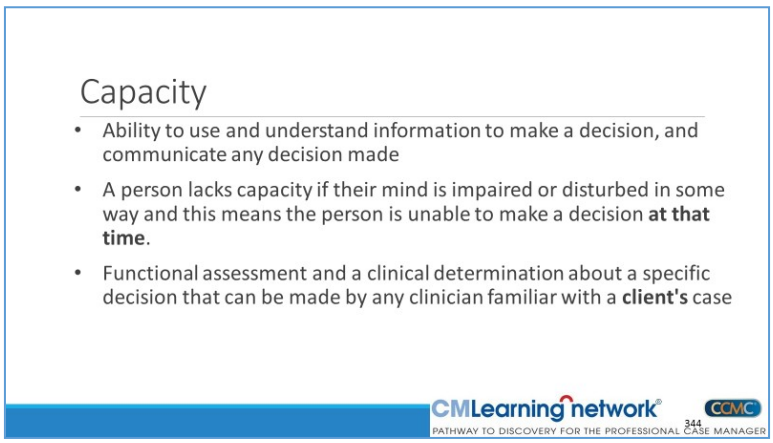
- **DO NOT RESUSCITATE/DO NOT INTUBATE (DNR/DNI) –** A written physicians order, based on the wishes of the individual or decision maker, not to resuscitate and/or intubate should the individual stop breathing
- **PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) –**
  - It is a bridge between an advance directive and direct intervention
  - Most states print them on bright neon paper
  - Usually recommended to be kept on the refrigerator
  - May become part of the hospital record when admitted



DURABLE MEDICAL POWER OF ATTORNEY (POA)

- Legal document that names a surrogate decision maker if the individual becomes unable to make their own decisions
- Requirements are state specific

- Durable POA means that the document is valid if the individual is deemed incompetent or lacking capacity to make decisions
- POA documents may be limited based on the type (general, special, healthcare)
- A durable POA can only be revoked if the client has capacity, or by a court appointed conservator if the individual is lacking capacity
- May also be known as a **Health Care Proxy**



Capacity

- Clinical capacity to make health care decisions is the ability to understand the benefits and risks of the proposed health care, to understand possible alternatives, and to make and communicate a health care decision. Assessment of this capacity requires evaluation of the following:
  - Medical factors (e.g., the client's medical condition, sensory deficits, drug side effects, emotional and psychiatric issues)
  - Functional abilities (physical, cognitive, and psychologic)
  - Environmental factors (e.g., risks, supports, impediments to capacity)
- Appropriate health care practitioners determine this type of capacity when needed and document the determination process.
- Clinical capacity **is specific to a particular health care decision** and thus is limited to that decision. The level of clinical capacity needed to make a health care decision depends on the complexity of that decision.

- To ensure that the individual has the capacity to make the decision presented to them, such as consent for treatment, a capacity determination may be requested.
- In many cases, a psychiatrist will be consulted, but it does not have to be done by a psychiatrist
- Capacity is issue specific, meaning that a person may be able to understand the results of an action or decision for one or more concerns (such as appointing a health care proxy), and is limited to that decision.
- Involve family members in the case management plan and recommend they seek legal help to establish power of attorney, durable power of attorney, or legal guardianship if capacity is a concern. **Legal guardianship can only be ordered by a court.**

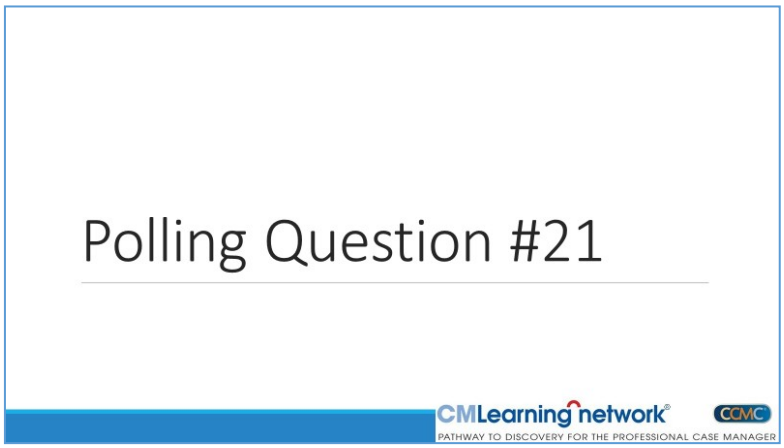
Competency (Legal Incapacity)

1 : the quality or state of being mentally competent[4]

- The mental ability and capacity to make decisions, accomplish actions, and perform tasks that any human being would be reasonably expected to perform adequately.
- **<u>Competency is a legal judgment rendered by a Court</u>** after hearing evidence.

[4] *Source: Merriam-Webster's Dictionary of Law ©1996. Merriam-Webster, Incorporated. Published under license with Merriam-Webster, Incorporated. retrieved on 2/6/2018 from* http://dictionary.findlaw.com/definition/competency.html

- If capacity is an issue, the family may need to have competency decided legally through a court competency hearing. **Only the court can declare a person to be legally incompetent.**
- The role of the CM is to advocate on behalf of the client if there is a reason to question competency.
- Only a court can order and appoint a guardian or conservator. A valid document must have a docket number and judge's signature on it.
- When relying on legal documents, the CM must see the documents. We can never take one's word for their "authority."
- "I'm the POA," "I'm the guardian," "I'm the healthcare proxy/representative" must be verified by seeing the document



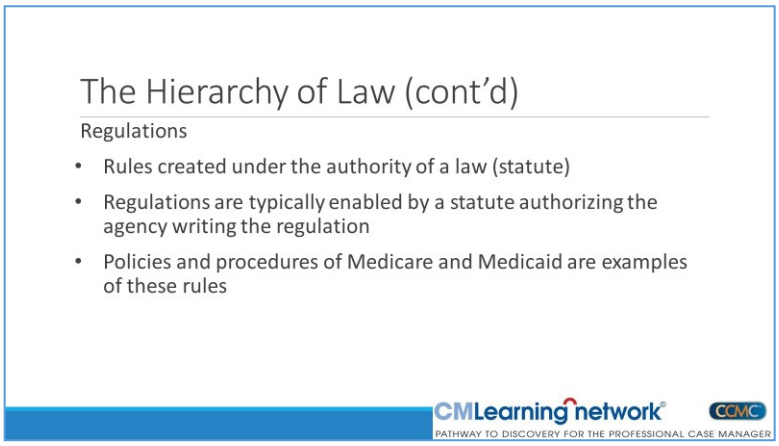
Capacity is determined by a

A. Family member or surrogate
B. Judge
C. Hospital
D. Health care professional

Legal Considerations

The Hierarchy of Law

Federal laws and regulations preempt or supersede state law (Doctrine of Supremacy). State law supersedes local law. But in the absence of federal law, or when a state law would provide more protections for consumers, employees, and other residents than what is available under existing federal law, state law holds. An example of the Doctrine of Supremacy are the current laws legalizing marijuana in some states that can be reversed, should the Federal government decide to enforce existing federal drug laws. Case managers must adhere to all Federal and State laws.

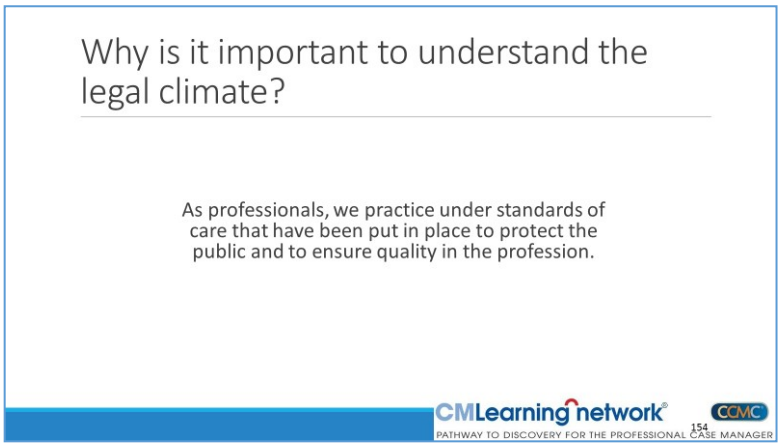


A regulation is a rule created under the authority of a law or statute.
For example, the regulations under Medicare and Medicaid are created under the law that created Medicare and Medicaid. In this case, Title 18 and 19 of the 1965 Amendments to the Social Security Act of 1935.

Professional licensing laws are state specific. As a Case Manager, you must be familiar with the licensing laws, and/or practice acts that govern the profession in the state(s) in which you are licensed.

Application of Law in Case Management

- There are many laws, rules, and regulations that impact case managers
- In the case of federal laws, they provide a minimum mandatory standard for all 50 states
- But remember that licensing laws are state laws, and as such vary from state to state
- You must always be aware of, and abide by, laws that govern your profession and license in the state(s) in which you are licensed.



Application of Law

Why is it important to understand the legal climate?

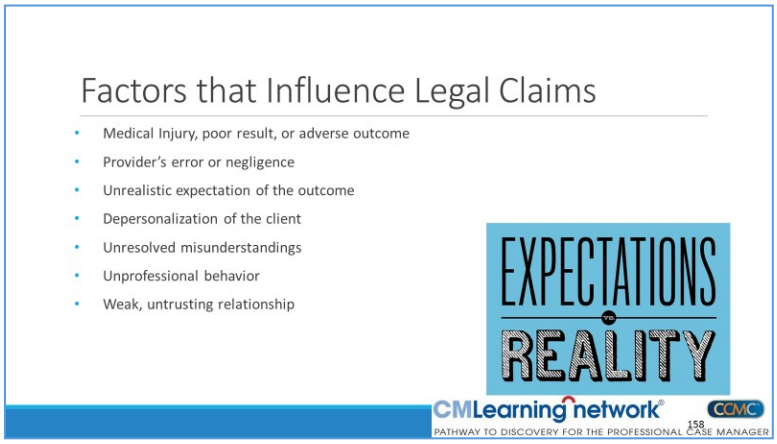
- As professionals we have an obligation and an ethical duty to uphold the laws, rules, and regulations that impact on our interactions with our clients
- As health professionals we are placed in a position of authority and confidence. We are entrusted with assisting clients and their family members to make life altering decisions.
- Because of the role we play in the health care system, it is important for us to understand our legal responsibilities to those we serve.
- As professionals, we practice under standards of care that have been put in place to protect the public and to ensure quality in the profession.

Historic Reasons for Lawsuits

- Here are some reasons people sue their health care providers.
  - Omission or commission of an act that harmed the client
    - Failing to do something we should have done
    - Doing something that we should not have done
  - False imprisonment -clients belted to wheelchairs, hands tied to bed rails, etc.
  - Assault - the intentional touching of another person without the consent of the other
  - Endangering the life of another

- Note that false imprisonment is not just for hospitals or nursing homes. Case managers may make home visits. If a client becomes agitated and is held down or their movements are restrained it may be viewed as an assault or battery.

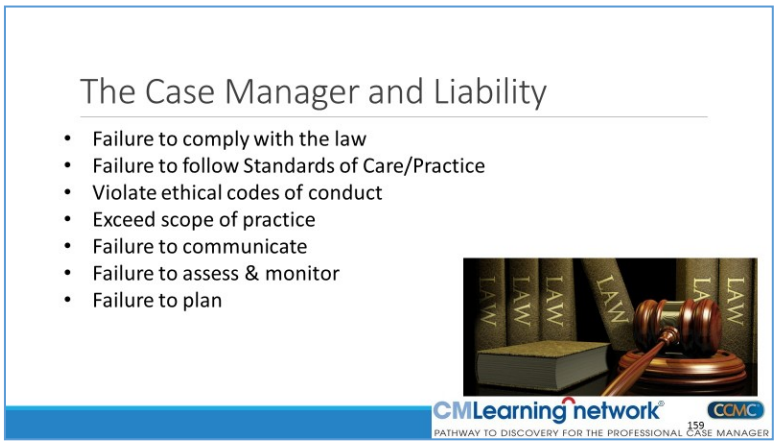
- The legal definition of assault is threatening the person/ making them apprehensive and may include an actual touching.
- As health care professionals, we can be sued for many reasons.
    - Improper treatment or education
    - Failure to warn a client of known risks
    - Improper disclosure of identifiable health information (HIPAA violation)
    - posting client pictures on social media
    - Unsafe discharge
- As health care professionals, we can be sued for many reasons.



Factors that Influence Legal Claims

- When it comes to lawsuits in the healthcare area, many factors influence legal claims.
    - Medical Injury, poor result, or adverse outcome
    - Provider's error or negligence
    - Unrealistic expectation of the outcome
    - Depersonalization of the client
    - Unresolved misunderstandings
    - Unprofessional behavior
    - Weak, untrusting relationship
- Sometimes, bad things happen, and no one is at fault.

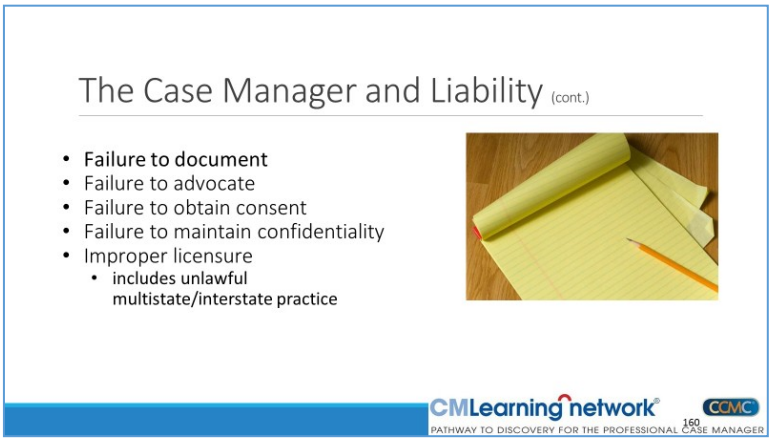
- The client and their family's expectations versus the reality is very important. It sets the stage for the development of the relationship.
- Does the client or family members have unanswered questions? Do they feel that their wishes are ignored?



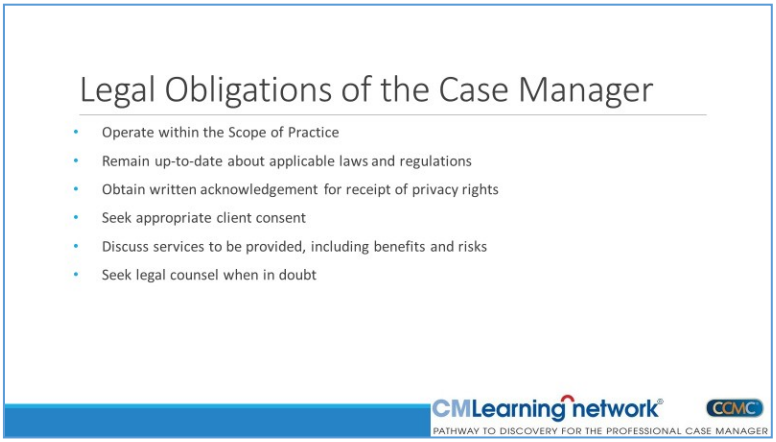
The Case Manager and Liability

Here are some of the potential liability claims.

- Failure to comply with the law
- Failure to follow Standards of Care and Standards of Practice
  - Practicing outside the scope of your practice or role
- Failure to communicate with the client/support system
- Failure to assess and monitor – just putting a plan in place does not absolve you from monitoring it to ensure that it is helpful
- Failure to plan and not have the ability to implement a plan

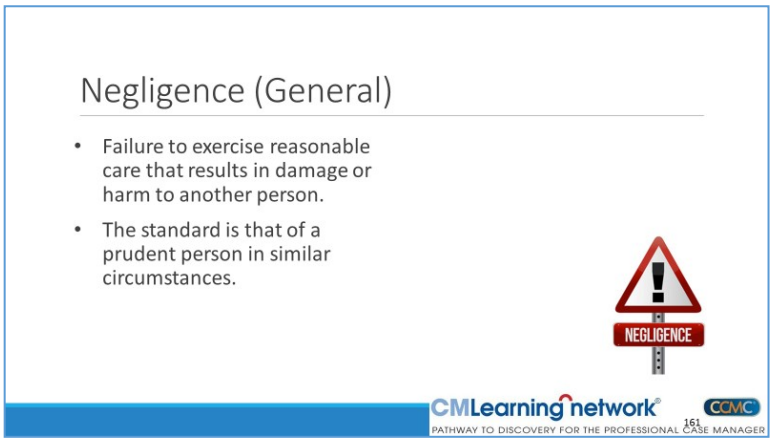


- Documentation is the one sure way that we can make sure it is known what we did
- Failure to advocate – advocacy is our primary function when dealing with clients
- Failure to obtain consent – both for treatment and for case management services
- Failure to maintain confidentiality – HIPAA violation
- Improper licensure (includes unlawful multistate/interstate practice) – telephonic case management when not licensed in the state in which the client seeks treatment
- Assessment and recommendations need consistency. Case managers need to ensure that thought is given to practice, not just completing a form or questionnaire.



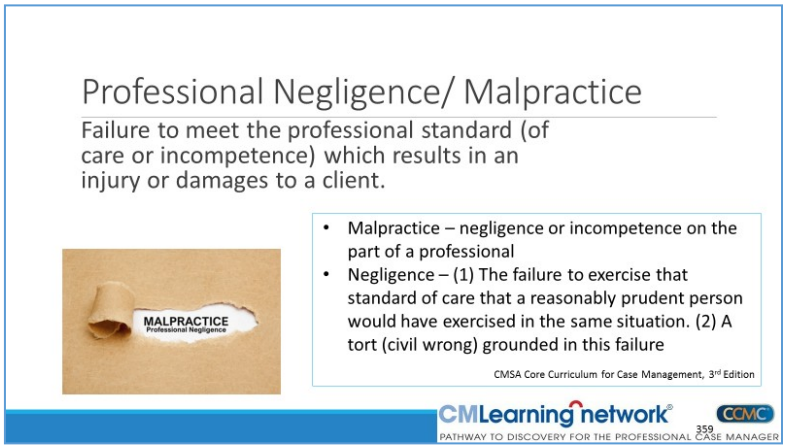
Legal Obligations of the Case Manager

- Operate within the Case Management Standards and Scope of Practice
- Remain up-to-date about applicable laws and regulations
- Obtain written acknowledgement for receipt of privacy rights
- Seek appropriate client consent
- Discuss services to be provided, including benefits and risks
- Seek legal counsel when in doubt

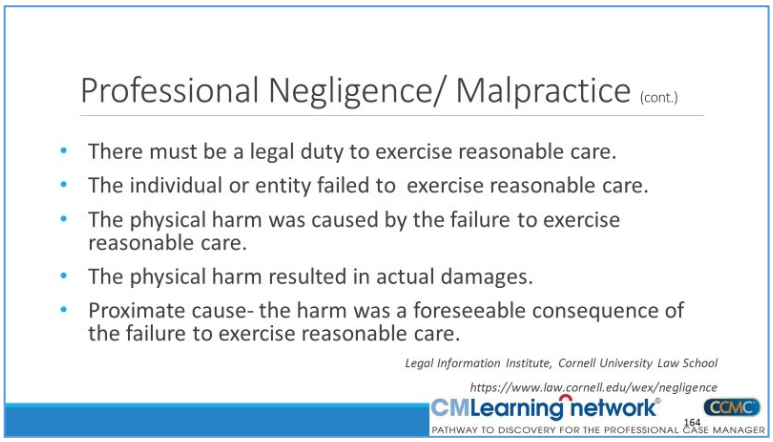


Negligence (General)

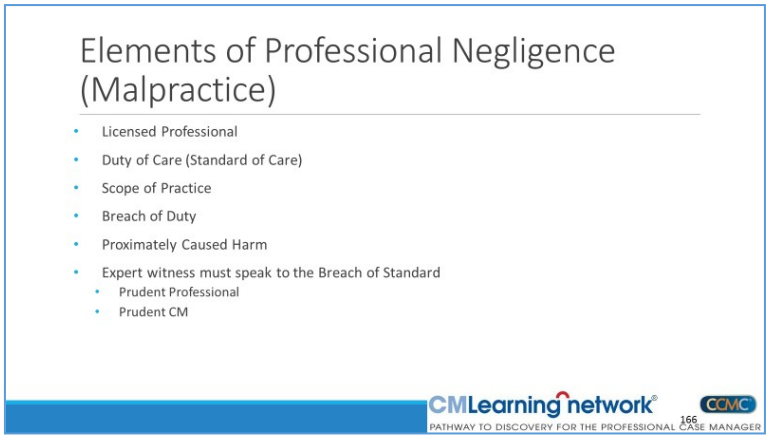
- Negligence is failure to exercise reasonable care that results in damage or harm to another person.
- The standard is that of what a prudent person in similar circumstances would do.
- Usually consists of an action or actions, but can consist of an omission where there was a duty to act
- This negligence standard applies to the public
- As health professionals, we have a standard of care and if we have failed to live up to that standard, which resulted in harm to another person, we may be sued for negligence.



Failure to meet the professional standard (of care or incompetence) which results in an injury or damages to a client is considered malpractice.



- For a lawsuit to be successful, there are four required elements;
  - A well-established duty,
  - An obvious breach of such a duty,
  - Damages or injuries the client suffered,
  - A proximate cause or connection between the breach and the client (evident in the resulting harm) (Tahan & Trieger, 2016).



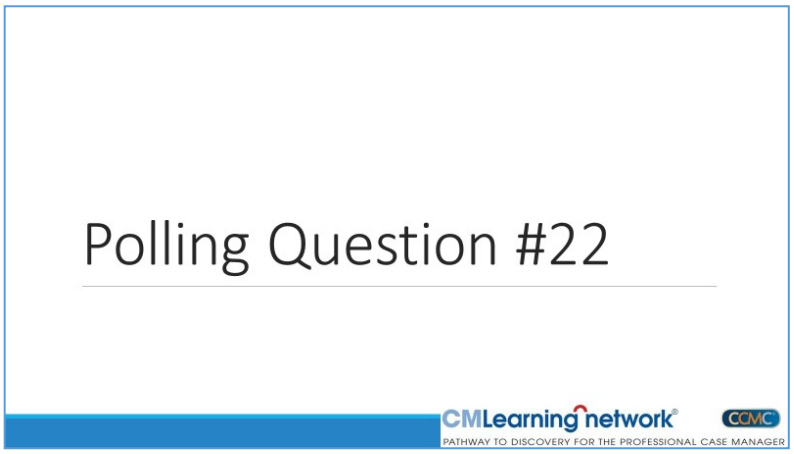
Elements of Professional Negligence (Malpractice)

- Must be a Licensed Professional
- There must be a Duty of Care (Standard of Care)
- Scope of Practice defines the role
- Breach of Duty has occurred
- The breach has proximately caused harm

- An Expert witness must speak to the Breach of Standard
  - Prudent Professional
  - Prudent CM
  - Case managers are held to a higher standard than the average individual

Professional Standard (Negligence)

- Is designed to protect the professional
- More difficult burden of proof
- Requires an expert witness
- Many states have additional protection



Legal obligations of the CM require that they

A. **Operate within the case management standards and scope of practice,**
B. **Remain up to date on laws and regulations**
C. **Seek legal counsel when necessary**
D. **All of the above**

Practice Standards

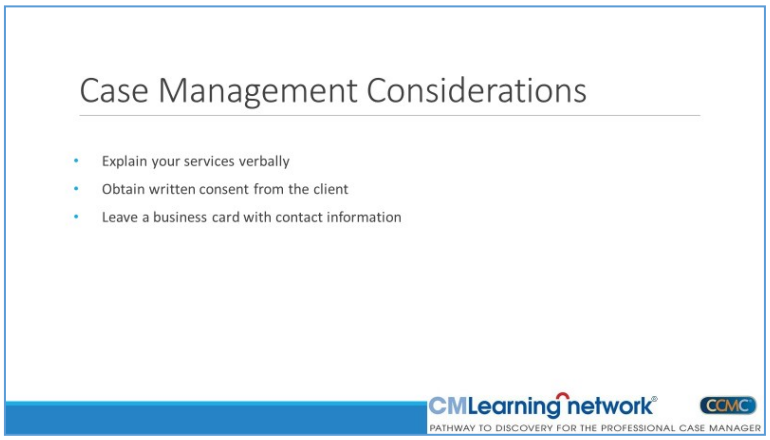
Case Management Competence

Basic ways to meet your required level of competence is to be sure you have the appropriate training to be a case manager, that you have the experience and expertise to manage your client's case, and that you have the appropriate licensure to practice.

- Competence is demonstrated through license, training, and experience, as well as other evaluations
- Working within the scope of practice of the Standards that govern your profession
- Seek information when something is out of the scope of your experience or expertise
- Certification is another way to demonstrate competence

- Competence requires lifelong learning
- Stay abreast of current changes in health care.
- Attend seminars.

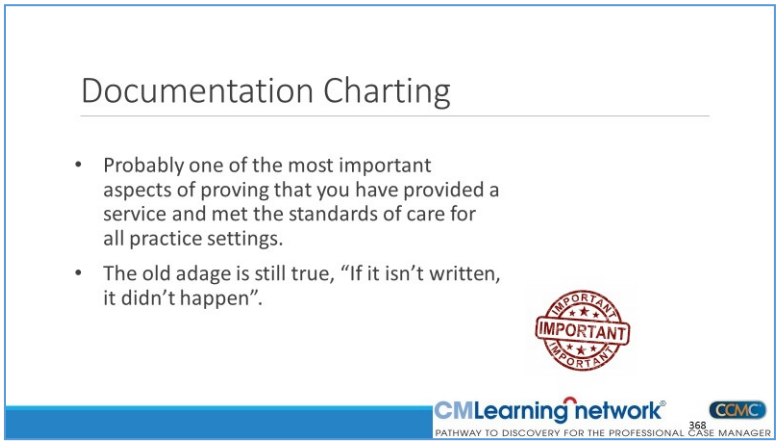
- Network with other professionals.
- Maintain your certification.
- Read professional journals.



Case Management Considerations

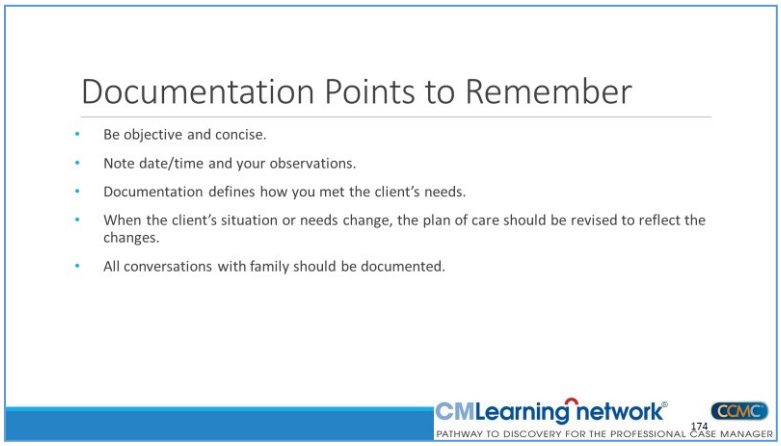
- Establishing your professional relationship with the client and family members is one of the first steps to being successful in providing case management services and decreasing the potential for liabilities. This is done by clearly explaining your role, who you report to and will share pt. information with, getting consent, establishing realistic expectations and maintaining open communication.
- Make sure you obtain your consent in writing for case management services.
- If you perform telephonic case management, the need to obtain consent does not change; it is just a change in method, not message.
- Provide consent (perhaps attached to email)
- Review the consent with the client
- Allow for questions and answer to the best of your ability
- Be honest; who will you share info with?
- You can read the consent form to the client, ask for their consent (after answering questions)
    - State, “I am acknowledging your agreement for CM services and record time/date”

- Make sure the client and their family members have your contact information. Oftentimes questions come after your visit with them.
- Explain your services verbally
- Obtain written consent from the client
- Leave a business card with contact information



Documentation Charting

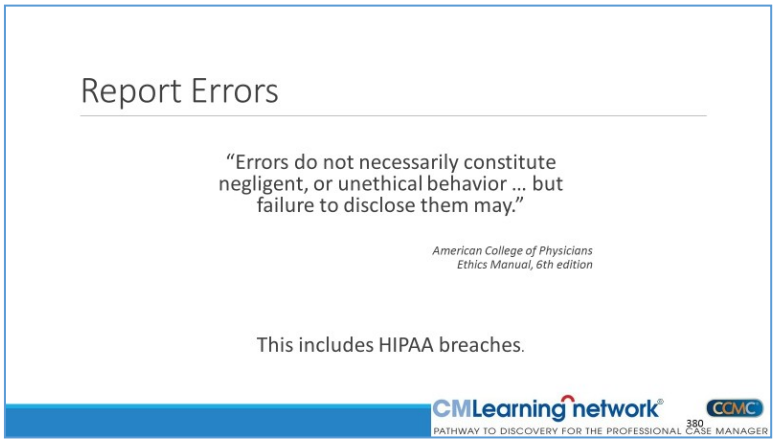
- Probably one of the most important aspects of proving that you have provided a service and met the standards of care for all practice settings.
- The old adage is still true, "If it isn't written, it didn't happen."



Documentation Points to Remember

- Be objective and concise.
- Note date/time and your observations.

- Documentation defines how you met the client's needs.
- When the client's situation or needs change, the plan of care should be revised to reflect the changes.
- All conversations with family should be documented.
- Do not add subjective feelings to the notes. Just document the facts. Describe the situation. Document with the understanding that the notes may be read by the family, client or an attorney. Be objective!



"Errors do not necessarily constitute negligent, or unethical behavior … but failure to disclose them may."[5]

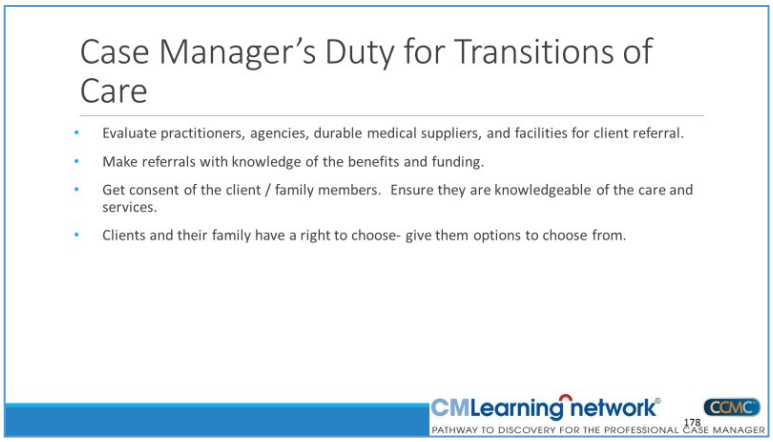
- To Err is human.
- To not report it or correct it, is trouble.
- Remember to report errors.
- An apology, when appropriate can go a long way to reducing liability exposure.
- This includes HIPAA breaches.

[5] *American College of Physicians Ethics Manual, 6th editio*

Social Media Pitfalls

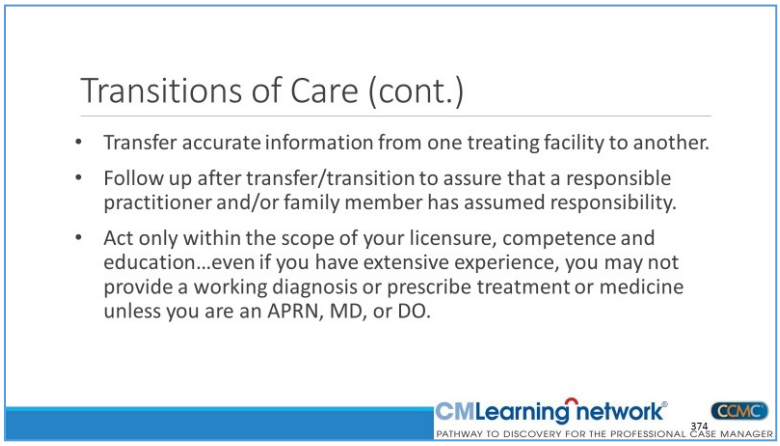
- With the increase in the use of social media, health care professionals are presented with a challenge of separating their professional life from their social life.
- When it comes to the cell phone, it can be a helpful means of communication-such as direct calls to clients. However, it can become a legal pitfall if used to share client information. This sharing can be done in very innocent ways.
- Confidentiality extends to social media.
- You may be one click away from disaster

https://www.youtube.com/watch?v=i9FBEiZRnmo

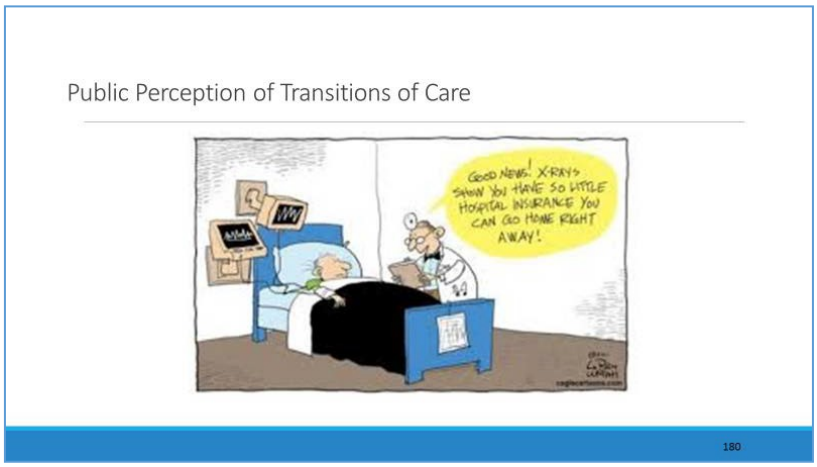


Case Manager's Duty for Transitions of Care

- Regardless of the practice area you work, transitions of care is very important. Transitioning from hospital to home- or from hospital to a SNF- or from hospital to rehab facility- transitioning from home back to work.
- Make sure that you:
  - Evaluate practitioners, agencies, durable medical suppliers, and facilities for client referral.
  - Make referrals with knowledge of the benefits and funding.
  - Get consent of the client / family members. Ensure they are knowledgeable of the care and services.
- **<u>Clients and their family have a right to choose.</u>**

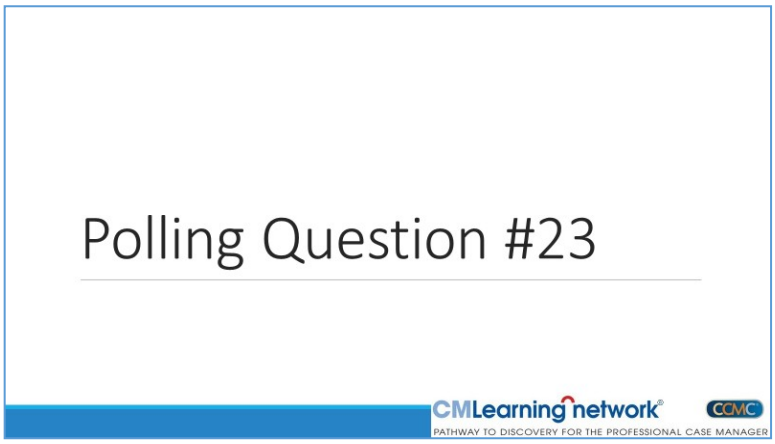


- Transfer accurate information from one treating facility to another.
- Follow up after transfer/transition to assure that a responsible practitioner and/or family member has assumed responsibility.
- Act only within the scope of your licensure, competence and education…even if you have extensive experience, you may not provide a working diagnosis or prescribe treatment or medicine unless you are an APRN, MD, or DO.
- If your employer is demanding you refer within "network" when you know that would result in more expensive, lesser (even dangerous) quality, you have not only a legal, but ethical dilemma.
- ***Remember, your duty is to the client.***



Public Perception of Transitions of Care

- The public's perception may be that we discharge or eliminate services because of the insurance or hospital. It is important for us to work with families and their resources.
- As case managers we are in the position to access for gaps in care and then take action to fill those gaps. Failure to properly access for gaps can lead to trouble.

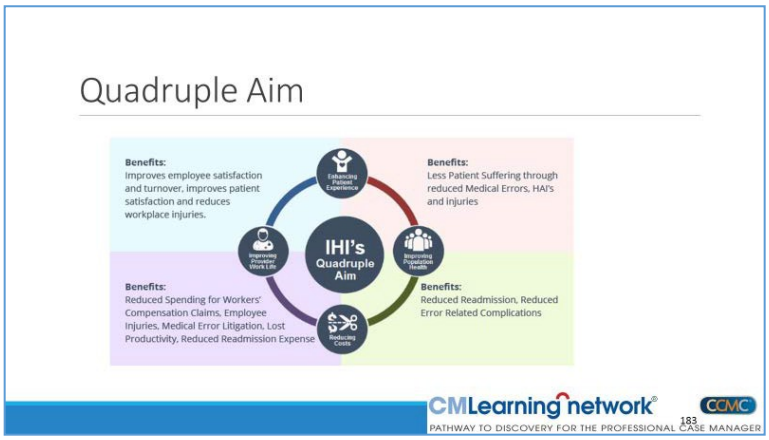


Use of a personal cell phone is an acceptable means of sharing client information.

True

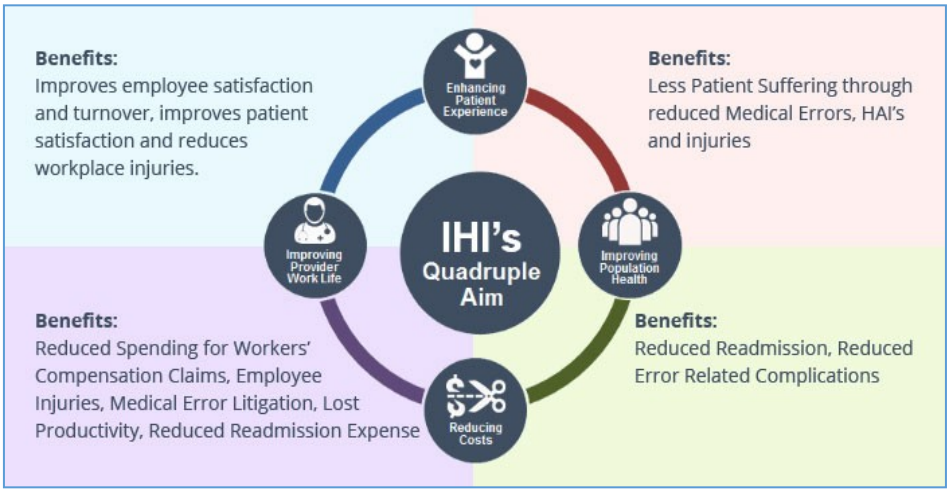
False

Self-Care



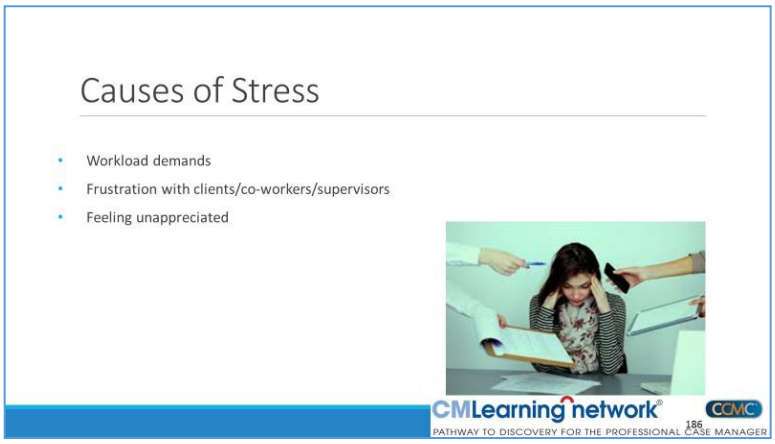
Quadruple Aim

- We discussed the Triple Aim previously - enhancing the client experience, improving population health, and reducing costs which is widely accepted to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction.
- Burnout is associated with lower client satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim.
- Hence, the Triple Aim has been expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff, without which achieving the Triple Aim may be difficult



Take Care of Yourself in the Process

- We've spent a lot of time discussing our clients' needs. That's certainly important, but it's also important for you to attend to your own needs to prevent burnout or unethical behaviors caused by stress.
- Stress is the body's reaction to feeling under pressure. Stress can be positive, such as the excitement following a promotion, but it can also be negative, such as feeling overwhelmed by new technology.
- The negative stress is what you have to acknowledge and take steps to diminish by self-care.



Causes of Stress

- There are many causes of stress in the workplace.
- Workload demands are a prime example. Feeling like you don't have enough time to deal with all of your clients' needs.
- Frustration with your clients, especially those that are non-adherent.
- Dealing with co-workers and supervisors can sometimes be extremely frustrating, especially if you already feel over-burdened by your workload demands.
- Finally, with your hard work and dedication to your job, you may feel unappreciated, leading you to wanting to scream.
- Workload demands, including the multiple demands of working at home

Workplace Safety

- Another cause of workplace stress may be concerns for your safety.
- Working from home adds concerns of domestic violence or abuse to the mix

- To allay this fear, you should be aware of workplace safety protocols, whether you're in an office or in the field.
- Make sure you're aware of your employer's emergency preparedness guidelines.
- Increasing terrorism and workplace violence should be acknowledged and strategies developed so you know what to do if they occur.
- If protocols are not in place, encourage your employer to develop them.
- All of these stressors can have detrimental effects both on you and your clients. That is why self-care is so important.

Stress causes increases in…[6]

- One of the most important aspects of self-care is to have a work-life balance.
- The "2007 Deloitte & Touche USA Ethics & Workplace" study found that 91% of the respondents were more likely to behave ethically at work when they had a work-life balance.
- Cutting corners in care and documentation occur when a case manager feels pressured to complete tasks but cannot meet deadlines.
- The American Institute of Stress reports that increased levels of job stress, as assessed by the perception of having little control but lots of demands, have been demonstrated

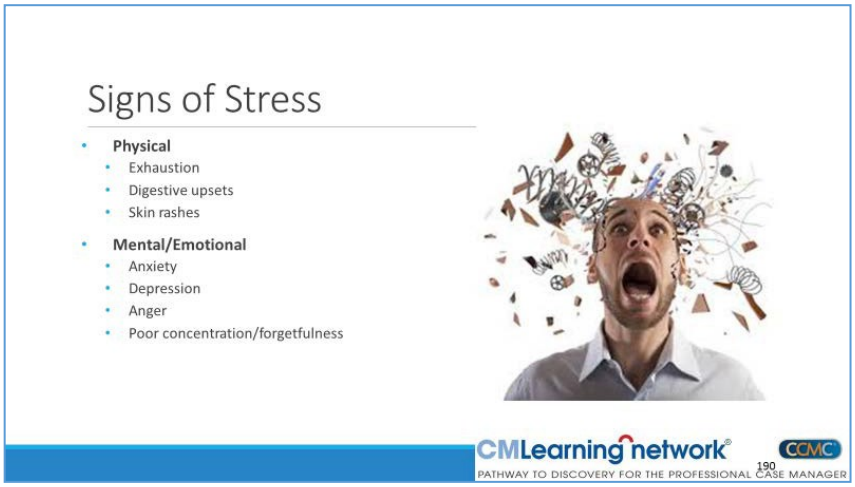
6 *American Institute of Stress 2007 Deloitte & Touche USA Ethics & Workplace Study*

to be associated with increased rates of medical disorders like hypertension and heart attacks.

- They also report stress causes increased job turnover and work-related accidents.

Stress Causes Decreases in...[7]

- The institute also reports that stress causes diminished productivity and customer service.

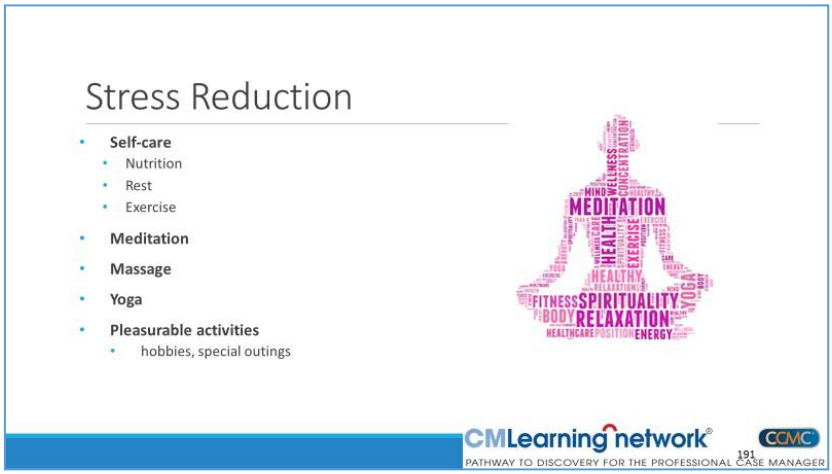


Signs of Stress

- Stress may show up as physical problems. Exhaustion, headaches, digestive upsets and skin rashes are just a few examples.

[7] *American Institute of Stress 2007 Deloitte & Touche USA Ethics & Workplace Study*

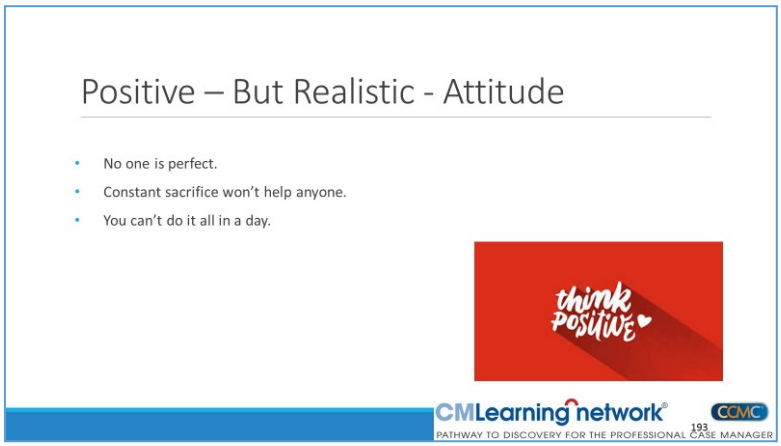
- Mental or emotional problems may be exhibited by anxiety or depression, anger, poor concentration or forgetfulness or low self-esteem to name a few examples.



Stress Reduction

- You need to take time out for yourself to reduce the stress inherent in your job.
- Here are just a few stress reduction activities:
  - **Self-care**
    - Nutrition
    - Rest
    - Exercise
  - **Meditation**
  - **Yoga**
  - **Pleasurable activities**
    - hobbies, special outings

- Other stress reduction activities include:
  - Decrease intake of alcohol, drugs, caffeinated beverages
  - Listen to music
  - Creative visualization
  - Deep breathing
  - Progressive relaxation
  - LAUGH A LOT WITH FAMILY & FRIENDS!



Positive – But Realistic – Attitude

- Adopting a positive and realistic attitude can be an effective "stress buster".
- Remember that perfection is an ideal that can rarely be achieved. Instead, take pride in giving your best effort.
- Sometimes, the best way to help your clients is to help yourself.

- Constant sacrifice won't help anyone. When you're sick, take time to recover. Use your vacation time for a well-deserved break.
- Finally, remember that you can't do everything in one day. Instead, at the end of your workday, focus on what you've completed, rather than on uncompleted tasks.
- Remember, tomorrow is another day.

Manage Stress

- You can manage stress by understanding why providing case management may be so stressful.
- You should be aware of the signs of stress and take steps to relax, manage your time and stay healthy.
- Finally, seek help if you're having trouble coping. Your good health matters to your co-workers, clients and to you.