

Engage, empower, enhance, enable: Tools for measuring quality in case management



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Agenda

- Welcome and Introductions
- Learning Objectives
- **Patrice Sminkey**, CEO, the Commission
- **Cheri Lattimer**, Executive Director, CMSA
- Question and Answer Session

Audience Notes

- There is no call-in number for today's event. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the tab to the left of your screen. Please refresh your screen if slides don't appear to advance.
- Please use the "chat" feature below the slides to ask questions throughout the presentations. We will pose questions after the presentation and will address as many as time permits.
- A recording of today's session will be posted within one week to the Commission's website, www.ccmcertification.org
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

Learning Objectives Overview

After the webinar, participants will be able to:

- Discuss the gaps in performance and outcomes measures being applied today in case management;
- Describe the impact of appropriate measures for quality improvement and care enhancement of professional case management;
- Summarize the standard and collaborative measures that show promise for evaluating the effectiveness of case management services; and
- Discuss how the increased demand for measurement is changing the structure of the case management team.

Introduction



Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

- Webinars
- Certification Workshops
- Issue Briefs
- Speaker's Bureau



AHRQ Measures Database is LIVE

primarycaremeasures.ahrq.gov/care-coordination/

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Care Coordination Measures Database

Choose Categories
(Click on a category below to reveal its search filters.)

- Perspectives
- Coordination Activities
- Broad Approaches
- Patient Age Group
- Patient Condition Group
- Setting

Search Now >>

Search Settings

- Show measures that relate to any of my selections
- Only show measures that relate to all of my selections

Care Coordination Measures Database

Get Started

What is the Care Coordination Measures Database and what does it do?

It can be difficult to measure the extent to which care coordination has been implemented in health care settings. This Database, based on AHRQ's [Care Coordination Measures Atlas](#), is intended to assist evaluators and researchers interested in care coordination measurement. Users of the database can compare more than 60 validated care coordination measurements tools found in the Database, many of which are intended for ambulatory care settings to identify those that are most appropriate for their needs.

For more information about how the Care Coordination Measures Database was developed, please refer to the [Background page](#). To learn more about implementing care coordination, please consult the related resources below.

Related Resources and Content

- [Care coordination resources](#)

An evolving case management team

- Increasing prominence of quality measurement and evaluation functions
- Significant increase in emphasis on quality measurement as a core competency
- A more sophisticated case management team includes a quality evaluation professional



Ellen Schultz 2014 CMLearning Network Webinar, "Care Coordination Measurement: Tools for today, tools for tomorrow"

Engage, empower, enhance, enable: Tools for measuring quality in case management



Engage, empower, enhance, enable:
Tools for measuring quality in
case management

E4 – CMSA & Why

Engage

Empower

Enhance

Enable

The Industry Continue to Ask?

- 1. What is case management?**
- 2. What do case managers do?**
- 3. Where do they work?**
- 4. Who can be a case manager?**

www.cmsa.org/e4

e4: Engage, Empower, Enhance, Enable

- √ Engage – Helping you become more efficient, effective and competitive
- √ Empower – Optimizing mobilization of your skills and resources
- √ Enhance – Strengthening your skills and competencies
- √ Enable – Maximizing your potential

Understanding Work Force, Education & Practice of Case Management



e4

Engage Empower Enhance Enable™

Provide resources and information on the practice of case management.

- [What is Case Management?](#)
- [How Do I Become a Case Manager?](#)
- [I'm a New Case Manager. Now What?](#)
- [How Do I Get Certified?](#)
- [What is the Average Case Management Case Load?](#)
- [What is the ROI of Case Management?](#)

Three Broad Aims of the National Quality Strategy:

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

Six Strategies to Advance these Aims Include:

- 1 Prevention and treatment of leading causes of mortality
- 2 Supporting better health in communities
- 3 Making care more affordable
- 4 Making care safer by reducing harm caused in the delivery of care
- 5 Ensuring that each person and family members are engaged as partners in their care
- 6 Promoting effective communication and coordination of care

Moving Towards A Collaborative Care Model

Table 1

Conventional vs. Collaborative Care

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

Source: Robert Wood Johnson Foundation (November 2011). Implementing the IOM Future of Nursing Report—Part II: The Potential of Interprofessional Collaborative Care to Improve Safety and Quality. Accessed at www.rwjf.org/humancapital

New Models Across the Healthcare Landscape

New Models of Healthcare Delivery and Reimbursement

Patient-Centered Medical Home (PCMH) Primary Care Practices

Accountable Care Organizations (ACOs)

Integrated Health Delivery Systems

Population Health Management

Outcomes-Based Reimbursement With Shared Risk

Value Based Purchasing of Health Care Services

The Golden Age of Case Management



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

~ *MBNewman*

Case Manager Skills Are Required For Success in These New Models!



Knowledge and experience with care coordination

Focus on patient-centered processes

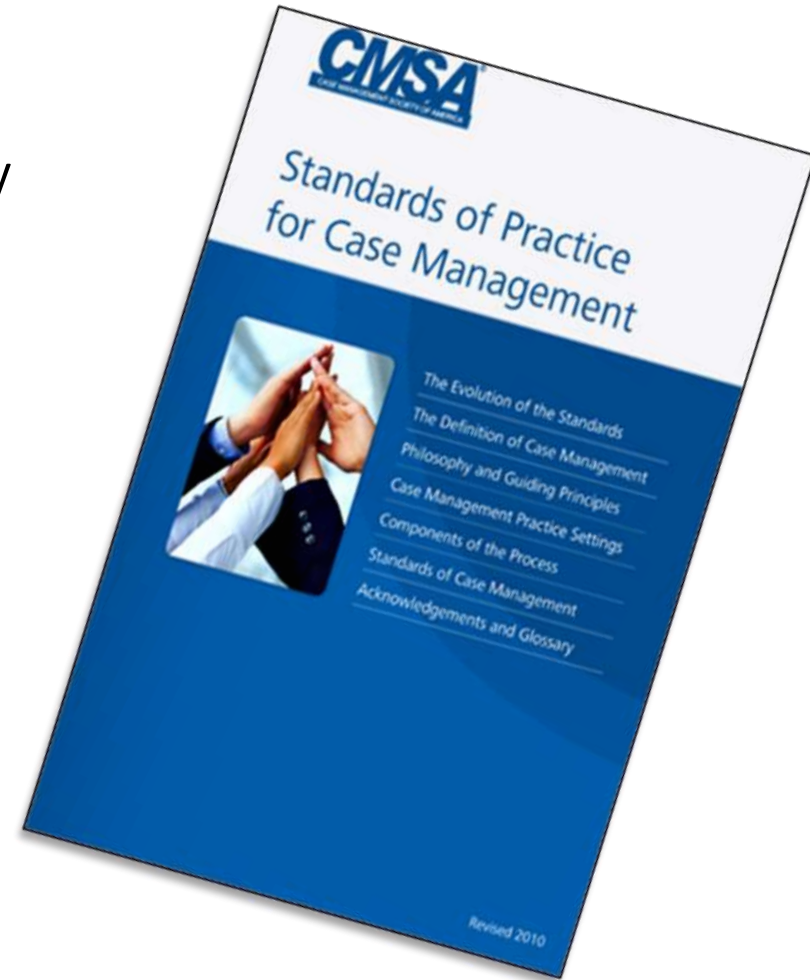
Assessment, planning, facilitation across care continuum

Knowledge of population-based care management strategies

Meaningful communication with patient, family, care team

The Framework: CMSA's Standards of Practice

The Standards are intended to identify and address important foundational knowledge and skills of the case manager. The Standards seek to present broad professional guidelines for implementation and application within a spectrum of case management practice settings and specialties. Revised in 2010.



Development of Care Coordination Measures



- **AHRQ** – Care Coordination Measurers Atlas
- **NQF** – Performance Measures for Care Coordination
- **CMS** – SOW for QIOs focus on Care Transitions & Care Coordination
- **TJC** – Core Performance Measures & Patient Safety Standard #8 Medication Reconciliation
- **URAC** – Incorporated Transition of Care in revised CM Standards – Case Management Measures
- **NCQA** – Complex Case Management Standards
- **AMA** – PCPI Transitions of Care
- **ANA** – Framework for Measuring Nurse’s Contribution to Care Coordination

AHRQ – Defining Care Coordination

Care Coordination is a multi-dimensional concept that encompasses many facets of healthcare organization and delivery. Because poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs, coordination of care is increasingly recognized as critical for improvement of patient outcomes and the success of healthcare systems. In Phase 3 of this project, measures submitted focused on key areas of emergency department transfers, medication reconciliation and timely transitions.

The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

- http://www.qualityforum.org/Publications/2014/12/NQF-endorsed_Measures_for_Care_Coordination_Phase_3.aspx

Achieving Coordinated Care

There are two ways of achieving coordinated care: using broad approaches that are commonly used to improve health care delivery and using specific care coordination activities.

- Examples of broad care coordination approaches include:
 - Teamwork.
 - Care management.
 - Medication management.
 - Health information technology.
 - Patient-centered medical home.
- Examples of specific care coordination activities include:
 - Establishing accountability and agreeing on responsibility.
 - Communicating/sharing knowledge.
 - Helping with transitions of care.
 - Assessing patient needs and goals.
 - Creating a proactive care plan.
 - Monitoring and followup, including responding to changes in patients' needs.
 - Supporting patients' self-management goals.
 - Linking to community resources.
 - Working to align resources with patient and population needs.

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/>

URAC Case Management Measures

The case management measures cover the following domains:

- Medical readmissions
- Percentage of participants that were medically released to return to work
 - Disability and workers' compensation only
- Complaint response timeliness
- Overall consumer satisfaction
 - Excludes disability and workers' compensation
- Percentage of individuals that refused case management services
- Three-Item Care Transition measure
- Patient activation measure

VHA HANDBOOK 1110.04

- **PERFORMANCE MEASURES:** The facility Case Management Program must monitor quality and performance for all CMs using aspects designed for:
 - a. Utilization. This includes items such as impact on acute care admissions, unanticipated readmissions, bed days of care, emergency department or urgent care, long term care admissions, and end of life care.
 - b. Flow of Care. This includes items such as access and transitions that include seamless handoffs across the entire health care spectrum.
 - (1) Clinical Outcomes. This includes items such as: those related to the Veteran's achievement of the plan of care goals, adherence to medication or other aspects of the plan of care, functional status, and safety.
 - (2) Cost. Cost-effective analysis tools are available through the VA Health Economic Resource Center at:
 - (3) Satisfaction. This includes the Veteran, family, caregiver, and health care team.

http://www1.va.gov/optometry/docs/VHA_Handbook_1110-04_Case_Management_Standards_of_Practice.pdf

NCQA HEDIS & Performance Measurement

- **Measuring Performance**

- The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

<http://www.ncqa.org/HEDISQualityMeasurement.aspx>

Moving Beyond General to Case Management-Specific

- Case management-specific assessments and care planning – four domains: biological, psychological, social & health system
- Case management interventions specific to patient preference/directed & assessment outcomes
- Medication lists and adherence
- Coordination of resources, communication and transitions
- Patient engagement/activation reduction of barriers, i.e., health literacy, non-adherence
- Case manager contribution and attribution of documentation

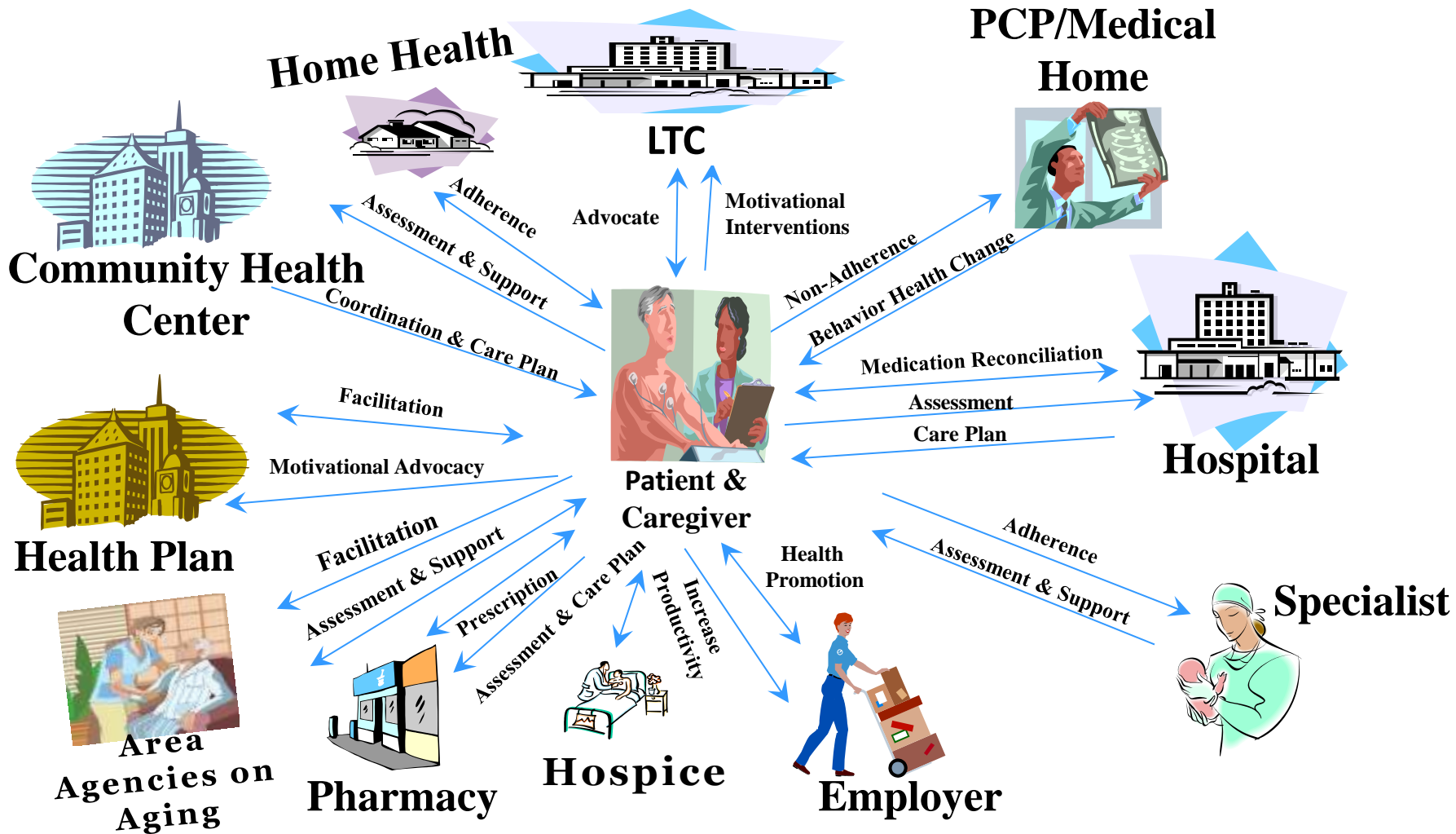
Record of Patient Outcome Measurement (ROM)

OUTCOME MEASURES	FOLLOW-UP ASSESSMENTS				
	Time period recorded	Baseline	Week 4	Week 8	Week 12
Clinical measure related to personal goal: <i>Off narcotics</i>		<i>Regular use; Multiple prescribers</i>	<i>Decreasing use; 1 prescriber</i>	<i>Off narcotics</i>	<i>Off narcotics</i>
Functional measure related to personal goal: <i>Walk with wife in evening</i>		<i>Bedridden; traction</i>	<i>Regular physical therapy</i>	<i>Walking with wife 3 times a week</i>	
Health-related quality of life <i># healthy days /month</i>		<i>3 days</i>	<i>12 days</i>	<i>21 days</i>	<i>23 days</i>
Patient satisfaction <i>(Scale 0-10)</i>		<i>2/10</i>	<i>6/10</i>	<i>9/10</i>	<i>9/10</i>
CAG Score <i>(Total score for period recorded)</i>		<i>28</i>	<i>24</i>	<i>20</i>	<i>18</i>
Health care clinical measure (1) <i>Average score on pain scale</i>		<i>9/10</i>	<i>7.5/10</i>	<i>5/10</i>	<i>3/10</i>
Health care clinical measure (2) <i>PHQ-9</i>		<i>8</i>	<i>-</i>	<i>-</i>	<i>-</i>
Health care functional measure (1) <i>Back flexion</i>		<i>60 degrees</i>	<i>80 degrees</i>	<i>100 degrees</i>	<i>100 degrees</i>
Health care functional measure (2) <i>Work hours for days/week</i>		<i>0</i>	<i>4 hrs for 3 days/wk; restricted activities</i>	<i>8 hrs for 5 days/wk; restricted activities</i>	<i>8 hrs for 5 days/wk; new job description</i>
Health care service use <i>Emergency room visits</i>		<i>4 per month</i>	<i>1 visit</i>	<i>0</i>	<i>0</i>

cmsa.org/icm



But we need to go further in recognizing that care coordination is a collaborative process supported by multidisciplinary teams that must coordinate, communicate and transfer information with each other, their patients, family caregivers and the community.



The leading membership association providing professional collaboration across the health care continuum.

Continued Support for Care Coordination



Transitional Care Codes Implemented January 2013

National Average \$142.96

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

National Average \$231.11

- 99496: Transitional Care Management Services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge.

FY2015 Medicare Physician Fee Schedule (PFS) – Effective January 2015 – CPT Code 99490

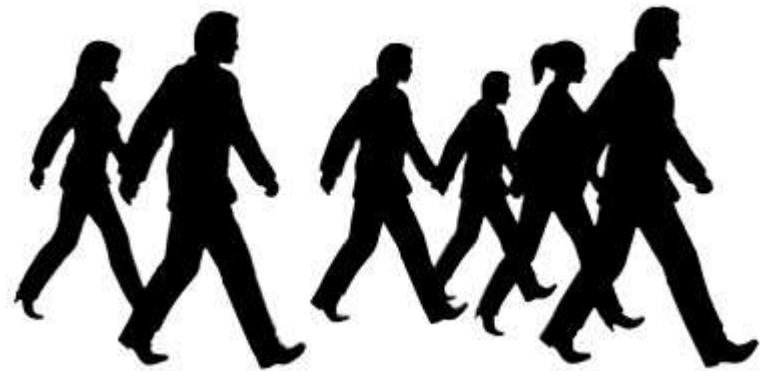
Chronic Care Management Codes (CCM)

- Focus on paying for team based care
- Patients with two or more chronic conditions
- Separate fee for managing multiple conditions
- 20 minutes of clinical labor time & may be provided outside of normal business hours
- Billed no more frequently than once a month
- Care management services may be provided by social workers, nurses, case managers, pharmacist
- Services must be available 24X7 to patients and their family caregivers
- Providers using the CCM code must have an electronic health record or other health IT

Health Policy Initiatives 2015

- 21st Century Cures Act
- Better Care Act
- Medicare Transitional Care Act 2015
- IMPACT Act of 2014
- Meaningful Use Phase 3
- Advanced ACO Model
- Primary Care Transformation

Are We Moving Too Slowly, Marking Time, or Too Fast?

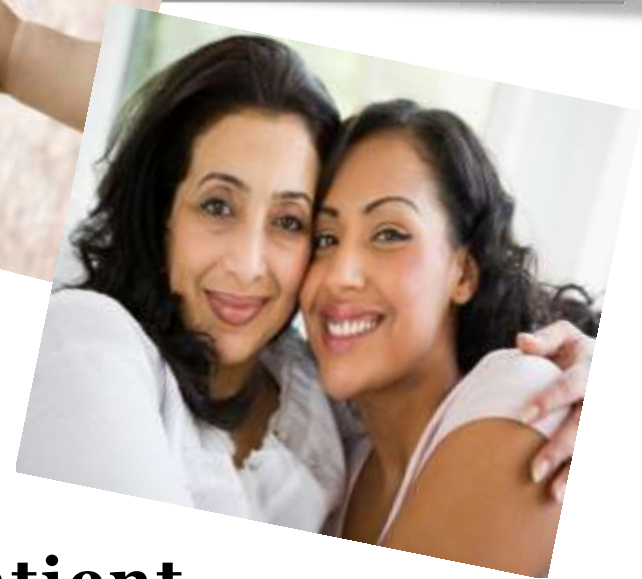


What Can We Do?

- Focus on patient-centered care
- Continuous improvement
- Effective team practice with financial and performance measure alignment
- Team leadership
- Cultural sensitivity and community focus
- Integrate behavioral health care with primary care

Opportunities to Improving Transitions & Performance Measures for Case Management

- Increased resources for team-based training
- Interprofessional education & competencies
- Outdated financial models
- Incomplete patient integration
- Technology gaps & barriers
- Meaningful performance measures
- Innovation for culture change
- Case management attribution for documentation and payment



Don't Forget The Patient

Don Berwick on Partnerships for Patients



“No **single** entity can improve care for millions of hospital patients alone. Through strong partnerships at national, regional, state and local levels – including the public sector and some of the nation’s largest companies – we are supporting the hospital community to significantly reduce harm to patients” April 2011

Question and Answer Session



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May 15, 2015 *American Journal of Managed Care*

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AJMC Authors Create Way to Measure Lack of Care Coordination, and Relationship to Cost

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The theory that a lack of coordination leads to poor health outcomes and higher costs drives US healthcare policy. But for the first time, a new study in *The American Journal of Managed Care* measures this phenomenon—and confirms it...

Related News

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(Source: National Kidney Foundation Inc) Washington, D.C.- The National Kidney Foundation (NKF) is pleased with the Senate Finance Committee's announcement, under the...

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One of the nation's premier academic medical centers has joined the Excelera national specialty pharmacy network. Minneapolis, Minn. (PRWEB) May 15, 2015 ExceleraRx Corp....

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Resources for Development Measures

- The Joint Commission (TJC)-
http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf
- Agency for Healthcare Research and Quality (AHRQ)-
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/ccm_atlas.pdf
- National Quality Forum (NQF) -
http://www.qualityforum.org/measures_reports_tools.aspx
- URAC - <https://www.urac.org/wp-content/uploads/CaseMgmt-Standards-At-A-Glance-10-9-2013.pdf>
- National Committee for Quality Assurance (NCQA)
<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015.aspx>
- American Medical Association (AMA) - <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>
- American Nurses Association (ANA)- <http://www.nursingworld.org/Framework-for-Measuring-Nurses-Contributions-to-Care-Coordination>

Thank you!

- Please fill out the survey after today's session
- Those who signed up for Continuing Education will receive an evaluation from the Commission.
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