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
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

www.pace.org
www.ccmcertification.org
AHRQ Measures Database is LIVE

http://primarycaremeasures.ahrq.gov/care-coordination/
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

Engage, empower, enhance, enable:
Tools for measuring quality in case management
E4 – CMSA & Why

Engage

1. What is case management?
2. What do case managers do?

Empower

3. Where do they work?
4. Who can be a case manager?

Enhance

Enable

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

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
• 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.

• 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.

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
<table>
<thead>
<tr>
<th>OUTCOME MEASURES</th>
<th>BASELINE</th>
<th>FOLLOW-UP ASSESSMENTS</th>
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<tbody>
<tr>
<td></td>
<td>Time period recorded</td>
<td>Week 4</td>
</tr>
<tr>
<td>Clinical measure related to personal goal:</td>
<td>Regular use;</td>
<td>Decreasing use;</td>
</tr>
<tr>
<td></td>
<td>Multiple prescribers</td>
<td>1 prescriber</td>
</tr>
<tr>
<td>Functional measure related to personal goal:</td>
<td>Bedridden;</td>
<td>Regular physical</td>
</tr>
<tr>
<td></td>
<td>traction</td>
<td>therapy</td>
</tr>
<tr>
<td>Health-related quality of life</td>
<td>3 days</td>
<td>12 days</td>
</tr>
<tr>
<td># healthy days /month</td>
<td>2/10</td>
<td>6/10</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>(Scale 0-10)</td>
<td></td>
</tr>
<tr>
<td>CAG Score</td>
<td>28</td>
<td>24</td>
</tr>
<tr>
<td>Health care clinical measure (1)</td>
<td>9/10</td>
<td>7.5/10</td>
</tr>
<tr>
<td>Average score on pain scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care clinical measure (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Health care functional measure (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back flexion</td>
<td>60 degrees</td>
<td>80 degrees</td>
</tr>
<tr>
<td>Health care functional measure (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work hours for days/week</td>
<td>4 hrs for 3 days/wk;</td>
<td>8 hrs for 5 days/wk;</td>
</tr>
<tr>
<td></td>
<td>restricted activities</td>
<td>restricted activities</td>
</tr>
<tr>
<td>Health care service use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>4 per month</td>
<td>1 visit</td>
</tr>
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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.
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.
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
“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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Executive Director
Case Management Society of America and the National Transitions of Care Coalition

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

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.
Resources for Development Measures

- The Joint Commission (TJC)-
  [http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf](http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf)

- Agency for Healthcare Research and Quality (AHRQ)-

- National Quality Forum (NQF) -
  [http://www.qualityforum.org/measures_reports_tools.aspx](http://www.qualityforum.org/measures_reports_tools.aspx)


- National Committee for Quality Assurance (NCQA)


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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