Bringing care closer to the community, practice and home

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Vivian Campagna, MSN, RN-BC, CCM
Chief Industry Officer
Commission for Case Manager Certification
Agenda

• Welcome and Introductions
• Learning Outcomes
• Presentation:
  • Vivian Campagna, MSN, RN-BC, CCM
    Chief Industry Officer, Commission for Case Manager Certification
  • Bonnie Ewald, MS
    Manager, Strategic Development and Policy Dept. of Social Work and Community Health Rush University Medical Center, Chicago
• 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.
To submit a question, click on Ask Question to display the Ask Question box. Type your question in the Ask Question box and submit. We will answer as many questions as time permits.
Audience Notes

• A recording of today’s session will be posted within one week to the Commission’s website, www.ccmcertification.org

• One CCM continuing education credit for board-certified case managers (CCM) and one ANCC nursing contact hour continuing education credit is available for today’s webinar only to those who registered in advance and are participating today.
After the webinar, participants will be able to:

1. Identify systematic barriers faced by case managers and community-based service providers.

2. Describe efforts to build evidence-based case management practices in order to influence reimbursement streams.

3. Employ new reimbursement and contracting opportunities that open doors for case management services.
Bringing care closer to the community, practice and home

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Payers have a vested interest

“Drawing on lesser-known economic models and available data, we show how a properly governed, collaborative approach to financing could enable self-interested health stakeholders to earn a financial return on and sustain their social determinants investments.”

Source: Health Affairs, August 2018
Azar: CMMI Will Get More Involved in Addressing Social Needs Driving Health Issues

Laura Joszt

HHS Secretary Alex Azar plans to ensure his agency handles both the health and the human services, as stated in its name, of Americans. In a recent speech, he hinted that the Center for Medicare and Medicaid Innovation will be doing more work in areas adjacent to healthcare, such as food insecurity, and housing, utility, and transportation needs.

Hospital CFO Report

Financial Management

Medicaid for rent, food? 'Stay tuned,' HHS chief says

Written by Kelly Gooch | November 15, 2018 | Print | Email
Introduction

Bonnie Ewald, MS
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Bringing care closer to the community, practice, and home
CCMC webinar, November 29, 2018

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What brings us here today?

Before we get started...

Are you currently providing case management as part of any fee-for-service and/or value-based healthcare reimbursement opportunities?

- We’ll get to more details later
- For now, please let us know via question box
Context and defining a solution
What shapes our health?

- Biological factors
- Environmental factors
- Socioeconomic & structural factors
- Health services
- Mental health status / supports
- Individual health behaviors

Source: Flourish Index, 2018, University of Louisville
Volume vs. value

VOLUME-BASED
- Fee-for-service (FFS) reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- Few IT investment incentives
- Stand-alone care systems
- Regulatory actions impede hospital-physician-community collaboration

The gap: straddling both worlds

VALUE-BASED
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

The gap: straddling both worlds
Making care comprehensive, patient-centered, and effective

Comprehensive

Does care identify & address barriers to health & wellbeing – whether medical or not?

Effective

Does care help people manage chronic conditions & live safely in the community?

Patient-centered

Is care responsive to individual patients’ needs & wishes?
Defining the problem: why isn’t it like that?

- **Workforce**
  - Availability / shortages
  - Skillset not always matched with interventions or given enough time to shine

- **Structural factors**
  - Lack of resources available
  - Discrimination and biases
  - Environmental / access issues

- **Fragmented care and incentives**
  - Need for care coordination
  - Reimbursement not always aligned with the care we want and need

- Given these challenges… what can evidence-based case / care management address?
Yet, social work and community-oriented case management lack business case

- Social work and other case managers have rich history of using evidence- and theory-based interventions
- Yet, their role within health care often undefined
  → undefined value and challenges with sustainability
- Challenges to defining value include:
  - Lack of metrics and data that span sectors and meaningfully capture quality of life
  - Defining art of relationship-based care, systems navigation
  - Qualitative feedback not enough
  - Accessing reliable sources of data (health outcomes, utilization claims)
  - Studying impact of intervention amidst continuous quality improvement and moving targets
Our imperative

“Future work must develop an evidence base about:

- the professional skills and knowledge that are required to address social needs successfully within health care settings;
- the activities, tasks, and services addressing social needs that directly result in improved outcomes;
- and the patient risk factors that are most susceptible to social support.

This level of specificity is required to support the development and refinement of models that are credible, replicable, and sustainable.”

Characteristics of effective case / care management

- Using empathic language and gestures
- Anticipating the patient’s needs to support self-care
- Providing actionable information
- Minimal handoffs
- Frequent touch points
- Person-specific, tailored interventions
- Ability to effectively link individuals to services
- Trusting care team relationships

Change occurs when...

- The person becomes **interested in / concerned about** the need to change
- They become convinced that the change is **in their best interest** and that the benefits outweigh the costs
- They develop a **plan of action** that they adhere to
- They follow through with that plan of action and can **sustain the change**
Core skills and frameworks to leverage in case / care management

- Person in environment
  - Systems theory
- Stages of change
- Cultural humility and intersectionality
- Trauma-informed and strengths-based approach
- Psychotherapeutic techniques
  - Motivational Interviewing and OARS
  - Relational psychodynamics
  - Acceptance and Commitment Therapy
  - Cognitive Behavioral Therapy
Relationship-centered care

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

-Maya Angelou
Community-based organizations provide key supports in the community

Figure 4. Most Common Services Provided Through Contracts

- Case management/care coordination/service coordination: 49.3%
- Care transitions/discharge planning: 29.1%
- Home care: 26.5%
- Nutrition program: 26.0%
- Person-centered planning: 22.0%
- Participant-directed care: 20.6%
- Transportation (medical or non-medical): 20.6%
- Evidence-based programs: 19.7%

Defining a solution: considerations

- **Target population**
  - Risk stratification v. predictive modeling
- **Episodic v. longitudinal**
- **Home base**
  - Centralized hub v. practice v. inpatient v. outsourced
- **Discipline**
  - Navigators, nurses, social workers, community health workers
  - Who is the go-to? For which patients?
- **Interdisciplinary practice**
  - Hand-offs, information transfer, loop closure
  - Care planning - what to include?
- **Telemedicine**
- **Post-acute care**
  - SNFs, rehab, home health, LTACs, pharmacy, DME
- **Community resources**
  - Transportation, nutrition, mental health, aging network
- **Caregivers**
Our work at Rush
Academic medical center serving the south and west sides of Chicago
Complex and structural issues affect people’s health.
Care management at Rush

Bridge
- **Referral:** Transitional care; team rounds & hospital registries
- **Focus:** stability in community, primary care engagement

AIMS
- **Referral:** Outpatient provider or via SDH screener
- **Focus:** comprehensive biopsychosocial

Collaborative Care Team
- **Referral:** Primary care integration via PHQ-9 screener
- **Focus:** mental health

Triad model
- **Referral:** Managed care w/ Medicaid ACO beneficiaries
- **Focus:** reduce health costs and risk

**Priorities across care management initiatives:**
- Patient engagement in care & self-efficacy
- Primary care engagement
- Community resources
- Care coordination
Bridge and AIMS process

Referral
- From provider, from registry, from screening tool, etc.

Pre-intervention planning
- Medical record review
- Interdisciplinary team connection

Patient engagement
- Rapport building
- Learn about patient preferences

Assessment
- Comprehensive biopsychosocial assessment

Care planning
- Goal setting and planning
- Self-efficacy

Care management
- Incorporating clinical skills & systems theory
- Engaging the care team throughout

Goal attainment
- Summarize strengths
- Ensure long-term primary care and community supports
Operational considerations

- Led by social worker from health entity or community partner

- Duration
  - 4-8 weeks
    - 4 is typical for transitional care cases (post-discharge)
    - 6-8 is typical for ambulatory referrals
  - Not uncommon for people to be re-referred in future

- Intensity
  - 20-30 calls and/or in-person visits

- Time spent
  - 2-6 hours per case

- Caseload
  - 30-40 active cases at any given time
  - Approximately 2 new cases per day (opened and closed, of course)
Bridge and AIMS in use across the country
Financial sustainability
How to pay for programs?

- Grants from governmental or philanthropic entities

- Health system / hospital $
  - Value-based contracts
  - Fee-for-service billing
  - Community benefits reports (non-profit hospitals)

- Medicaid home- and community-based service waivers
  - Impact of privatization

- How else is your case management work funded?
“CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible patients need to stay on track with their treatments and plan for better health.”
What are CPT Codes?

- Codes overseen by AMA, used by Medicare and commercial payers to reimburse for services
- Fee For Service (FFS) - episode-based payment
  - Submit claim when described services are provided and eligibility criteria are met
  - Medicare historically has reimbursed for face-to-face visits (e.g., Evaluation/Management visits, psychotherapy) - but not care management or other non-face-to-face work
  - New care management codes a significant development
Relevant Medicare FFS codes

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Behavioral Health Integration
- Advance Care Planning
- Health Behavior Assessment & Intervention (HBAI)
- Caregiver Health Risk Assessment and Care Planning
- Cognitive Impairment Assessment & Care Planning
- Individual and Group Psychotherapy
Things to note about CCM and BHI

- All codes must be billed by a physician and/or non-physician practitioner (PA, NP, CNS, CNM: “qualified health providers”)
  - Typically primary care, but may be of another specialty
  - Verbal consent obtained by billing provider
  - Can include time from team members (*see next slide*)

- Subject to Medicare Part B’s 20% co-insurance
  - Ideal to target duals or individuals with a Medicare supplement / Medigap or secondary insurance to help cover this 20%
  - At beginning of calendar year, patients may have to pay bills related to CCM/BHI to meet their Part B or secondary insurance deductible

- Can bill for BHI and CCM in same month
  - But... this is an operational challenge
Who counts as clinical staff?

- MDs and NPs only eligible billing providers for TCM, CCM, BHI
  - “Clinical staff”/“auxiliary personnel” can provide services under “general supervision” of billing provider

Who counts as clinical staff?

- Specific disciplines / licenses not identified by CMS
- Opens door for conservative interpretation

"Auxiliary personnel means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner)"

“Services and supplies furnished incident to transitional care management and chronic care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by clinical staff. The physician (or other practitioner) supervising the auxiliary personnel ….”

- Code of Federal Regulations, §410.26 Services and supplies incident to a physician’s professional services
Other ways of demonstrating value

- Impact on utilization
  - Reduce unnecessary ED visits and hospital readmissions
  - Total cost of care
  - Reduce no-shows
    - An operational headache for clinics

- Provider satisfaction
  - PCP burnout a significant issue

- Patient satisfaction
  - And downstream marketing impact
A look at Bridge’s impact with high-utilizers

- N=423, 2015-2016, for patients with 5+ hospitalizations in last 12 months

- Health services utilization
  - # of inpatient admissions
  - 30-day readmission rates
  - Average length of stay
  - # of ED visits

- Inpatient hospital cost
  - Average hospital cost per episode
  - Total hospital cost

- Time frame: 12-month, 6-month, 3-month and 1-month before and after the intervention

Changes in health services utilization

![Graphs showing changes in health services utilization](image)

- **# of inpatient admissions***
  - Before: 1.6, 2.8, 4.1, 5.7
  - After: 0.4, 1.0, 1.5, 2.1

- **30-day readmission rates***
  - Before: 21.3%, 22.8%, 25.7%, 25.8%
  - After: 3.4%, 7.7%, 9.9%, 12.1%

- **Average hospital cost per episode**
  - 1-month: $54,307, $19,288
  - 3-month: $56,342, $32,626
  - 6-month: $57,070, $39,452
  - 12-month: $58,646, $42,905

- **# of ED visits***
  - 1-month: 1.2, 0.4
  - 3-month: 2.2, 1.1
  - 6-month: 3.4, 1.9
  - 12-month: 5.0, 2.9

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Organizing and advocating for a better future

Archstone Foundation Announces...

Support for Integrating Social Needs into the Delivery of Health Care to Improve the Nation’s Health

Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health

Type: Consensus Study
Topics: Health Services, Coverage, and Access, Health Care Workforce, Select Populations and Health Equity
Board: Board on Health Care Services
Question and Answer Session

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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.
- A recording of today’s webinar and slides will be available in one week at
  http://ccmcertification.org

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