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In the transition to value, case management builds the bridge to whole-person health

Research backed by real-life experience demonstrates that spending to improve management of social health factors for at-risk populations results in lower resource utilization and reduced overall costs.[1] When health care organizations help vulnerable clients address the social determinants of health—factors such as economic stability, physical environment, education, food and housing security—they can positively affect health outcomes.

Those who pay for care are paying attention. Accountable health organizations and others with value-based, capitated payment arrangements are financially at risk when social factors become a barrier to member health. That's why care coordination and case management programs that connect clients to needed community resources are at the heart of demonstrations projects like the Centers for Medicare & Medicaid Services' Comprehensive Primary Care initiative and a host of advanced payment models.[2]

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1 Nichols, L., & Taylor, L. (2018, August). Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities. Retrieved December 5, 2018, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0039

2 Innovation Models. (n.d.). Retrieved December 6, 2018, from https://innovation.cms.gov/initiatives/index.html#views=models

There are cultural and resource limitation hurdles to overcome," says Vivian Campagna, MSN, RN-BC, CCM, the Commission's Chief Industry Relations Officer. "But identifying and connecting clients with important community services can be accomplished effectively, particularly with a case manager."

It can indeed, says Bonnie Ewald, program manager of strategic development and policy for social work and community health at Rush University Medical Center. Ewald speaks from experience; she manages several program development and policy advocacy initiatives aimed at integrating health care and social services at Rush and across the country, including leading the Center for Health and Social Care Integration, which serves as a national convening and technical assistance hub to advance practices that break down barriers to health.

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> — BONNIE EWALD, MA, ASSOCIATE DIRECTOR, CENTER FOR HEALTH & SOCIAL CARE INTEGRATION, PROGRAM MANAGER OF STRATEGIC DEVELOPMENT AND POLICY, SOCIAL WORK AND COMMUNITY HEALTH, RUSH UNIVERSITY MEDICAL CENTER

Aligning financial incentives to reward integrated practice—a model that considers how mental, physical and social well-being relate to health of populations—is not easy under current payment policies. Changing the mindset of health care providers from volume-based, fee-for-service care to a value-based, whole-person mindset continues to be a challenge because so many providers are in the midst of making the volume-to-value transition. Hospitals and physician practices alike may find themselves working with one foot in each payment world.

"How do you move towards value in a system where volume is still rewarded? How do you move from a focus on acute inpatient care to more preventive primary care?" Ewald asks. The answer is to draw from a mix of reimbursement sources to enable innovative clinical and community partnerships, and then build on more value-based sources as they mature.

A business case to support scaling up

With research supporting care coordination and integration with community organizations as key factors for mitigating social health barriers, professional case managers are positioned to anchor and lead integrated care coordination programs as they scale to reach more clients and communities. But the stakes are high as organizations extend care coordination activities into the community. Early funding from grant organizations and the Center for Medicare & Medicaid Innovation was only designed to move innovation forward, not to sustain programs long term. Efforts should take sustainability into account from the start.

What's needed is a business case to define the value of community-oriented case management in terms that both payers and providers can understand.

"We need to get specific and develop the evidence base for workforce deployment, resource management and patient selection," Ewald says. "We need to demonstrate the value of the skill set we bring to the table in the context of what's needed to effectively address social needs within health care settings, and define the activities, tasks and services that result in these improved patient outcomes. And we need to define client risk factors or characteristics that help us to best target our work, so that we are as efficient and effective as possible."

Defining success elements and measuring outcomes provides quantifiable data to advance programs and elevate the role of case managers.

"The metrics that health care often looks at don't capture all the value-added activities that case managers provide," Ewald says. "There's an art and science to social work and

case management. You all are trained in an evidence-based approach in engaging in and addressing people's issues—that's the science. But there is also an art to developing relationships with people and helping them navigate systems that are really complicated. Those pieces don't always cleanly come out in the metrics or in the cost evaluation. We are really good at collecting qualitative feedback—our clients love us, our health care partners love us. But in the business world, qualitative feedback is not enough."

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Cost savings support scale

Effective programs leverage the skills of social workers, nurses and other professionals who deliver care coordination and case management services in concert with clinical and community providers. Ewald outlines several characteristics of effective case management practices that research suggests are essential for success:[3,4,5]

1. Using empathic language and gestures to communicate effectively;
2. Anticipating the patient's needs to support self-care;
3. Providing actionable information clients can use to manage care;
4. Minimal handoffs so there aren't as many opportunities for gaps in communication. This allows case managers to build rapport and develop a relationship based on frequent touch points.
5. Person-specific, tailored interventions designed around client-identified needs.
6. Ability to effectively link individuals to services and following whether services were engaged; and
7. Trusting care team relationships, with case managers working in partnership with primary care and establishing buy-in with providers for the value of program services.

Two programs developed by Rush University Medical Center in partnership with community-based organizations—the Bridge and Ambulatory Integration of the Medical and Social (AIMS) models—use these effective practices to address the challenges of fragmented care and the need for coordination. They both leverage social work care/case managers[6] to screen high-risk populations and to address identified needs in partnership with community-based organizations.

The first, the **Bridge** model, supports older adults and those with complex medical and social health needs as they transition from a hospital stay to their home or to a skilled rehabilitation setting. It uses social workers to coordinate care and leverage

3 Mitchell, S. E., Laurens, V., Weigel, G. M., et al. (2018). Care Transitions From Patient and Caregiver Perspectives. *Annals of Family Medicine*, 16`(3), 225-231. Retrieved December 6, 2018, from https://www.ncbi.nlm.nih.gov/pubmed/29382327.

4 Boutwell, A. E., Johnson, M. B., & Watkins, R. (2016). Analysis of a social work–based model of transitional care to reduce hospital readmissions: Preliminary data. *Journal of the American Geriatrics Society*, 64(5), 1104-1107. Retrieved December 6, 2018, from https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.14086.

5 Im, J., Kirst, M., Burns, T., Goldhar, J., Ocampo, P., Wojtak, A., & Wodchis, W. (2017). What Works in Integrated Care Programs for Older Adults with Complex Needs? A Realist Review. International Journal of Integrated Care, 17(5), 107. doi:10.5334/ijic.3412

6 Ewald uses the terms "care manager" and "case manager" interchangeably.

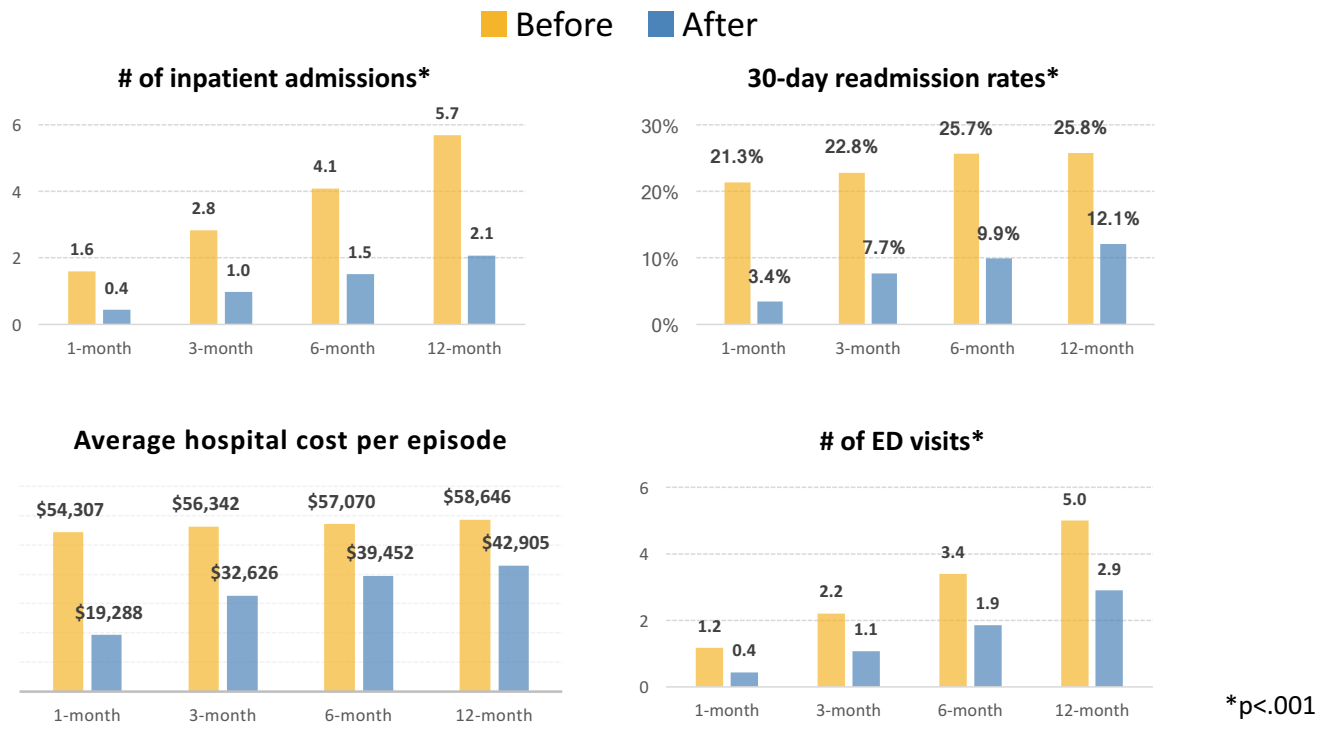
communication and therapeutic skills to activate client engagement and follow-through. That, in turn, supports healing and stability for the client.

The Bridge program has achieved stellar results, even with the highest risk clients, or superutilizers (those with five or more hospital admissions in a 12-month period). A subset of the Bridge program focusing on superutilizers includes more intensive care management and long-term support (up to a year, depending on a client's needs) than the standard Bridge model, which is focused on the month after hospitalization.

In a recent study[7] of 588 superutilizers engaged in the Bridge model, the total annual number of hospital admissions per patient was nearly cut in half, decreasing from 5.76 before the program's start to 2.38 admissions after the intervention. Thirty-day readmission rates went from 25.5 percent for the group to 13.4 percent, and the annual number of emergency department visits declined from 5.39 to 3.38. Hospital costs for study participants were reduced nearly $200,000 per person over a 12-month period after the intervention (average of $335,339 total costs in the 12 months before vs. $135,672 in the 12 months after). (See Figure 1.)

The second model Rush has developed also coordinates care for patients and integrates a range of both clinical and community-based resources. **AIMS** uses a centrally-based cadre of social workers who integrate into primary and specialty care practices and work collaboratively with clients referred to them—those who

7 Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (2018, November). Social work-based transitional care intervention for super utilizers of medical care: a retrospective analysis of the bridge model for super utilizers. *Social Work in Health Care*. Retrieved December 6, 2018, from https://www.tandfonline.com/eprint/8P2RNZSP6eK3a8Rjbwaf/full



Source: Xiang, X., Zuverink, A., Rosenberg, W., & Mahmoudi, E. (accepted). Social work-based transitional care intervention for super utilizers of medical care: A retrospective analysis of the Bridge Model for Super Utilizers. Social Work and Health Care, "Social Workers in Integrated Healthcare: Improving Care throughout the Life Course" Special Issue.

Figure 1. Changes in health services utilization.

need extra support for complex mental and physical health issues. These case managers assess client needs and then provide risk-focused care coordination, focusing on addressing the clinical, mental, social and functional issues that affect the client's ability to follow a doctor's plan of care. AIMS social workers are integrated into primary and specialty care teams.

Rush also offers other care management programs involving nurses, patient navigators, psychiatrists, and pharmacists. However, Bridge and AIMS—designed by and implemented by social workers—are structured to emphasize the strengths of the case manager a combination of training in systems navigation, patient activation and engagement, care coordination and behavioral health care management. Both AIMS and Bridge programs use a standardized protocol that includes a thorough patient assessment, care planning and case management. (See Figure 2.)

Scaling up and spreading it nationwide

Rush's Center for Health and Social Care Integration has measured program outcomes[8] and successfully scaled AIMS and Bridge models so they can be implemented in partnership with other organizations across the country. More than half of these replication sites are led by community-based organizations, Ewald says.

"We know that community-based organizations, such as Area Agencies on Aging and Centers for Independent Living, provide a lot of really important community supports—so it's natural to integrate them into broader care teams," Ewald says. "We want their services to be sustainable and available to people in the communities across the country who need them. Health care contracts in partnership with community-based providers can

8 Ibid.

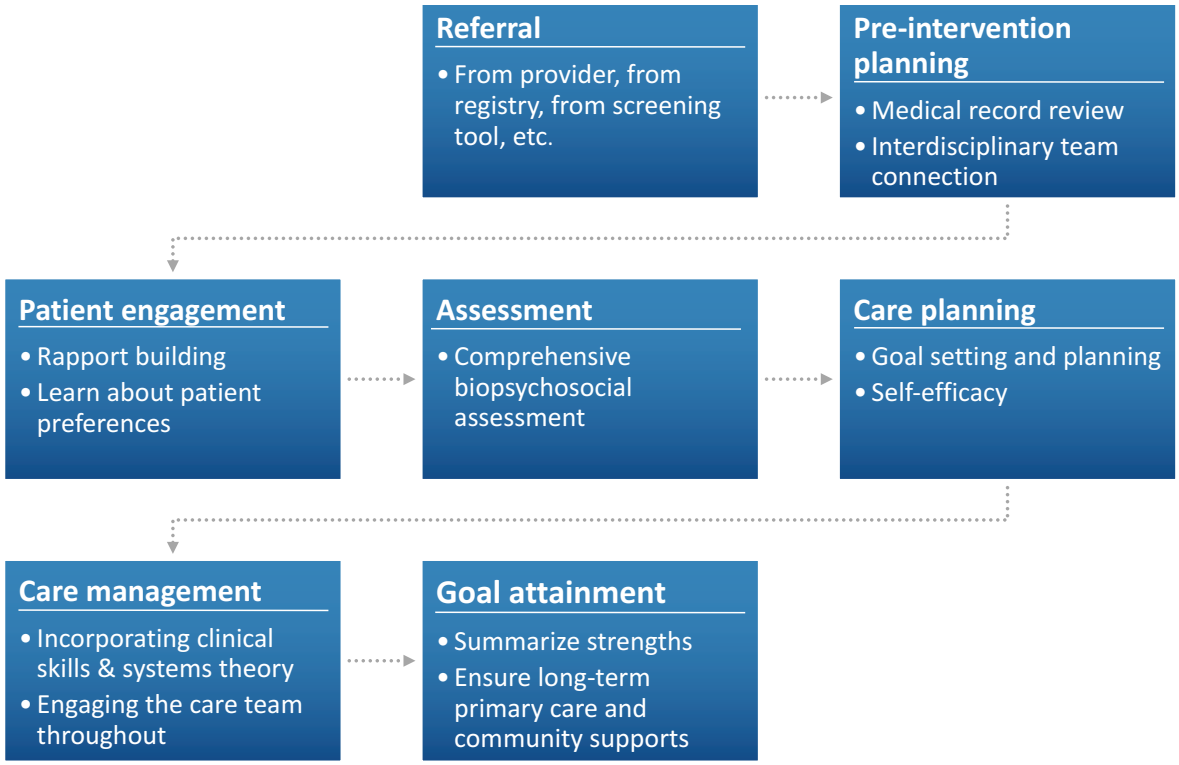


Figure 2. Bridge and AIMS process.

offer opportunities to tap into available, established resources."

Ewald emphasized that a benefit of scaling a structured model like AIMS and Bridge is efficiency. "Replication sites do not have to recreate the wheel. They build on the protocol we have to integrate social work and care management, and can also draw on our evidence to inform their own growth."

Research points to success elements

While AIMS and Bridge programs have demonstrated success and scaled in multiple locations, there are numerous other programs in use across the country—many of which are still in development and testing stages—that integrate clinical and social health elements. They vary across a range of factors; the populations they target, various approaches they leverage and payment structures they use may be different from one program to another. Not surprisingly, their effectiveness varies as well.[9]

That's why policymakers, payers and health care leaders are keeping a close eye on successful programs. The holy grail is to identify key characteristics for success that may be adopted and deployed in other communities.

Financial stability as a key goal

Seed funding from CMS helped establish the value of clinical-community case management programs across the country. Programs like the Comprehensive Primary Care initiative funded training and practice transformation in team-based care delivery, while also identifying the reporting metrics necessary to advance successful program elements.

Sustained funding for local programs, however, may come from a range of sources. Health systems such as Rush invest in the programs to fulfill value-based contracts. But providers can also seek reimbursement under billing codes that CMS has established to cover the time—outside of a patient face-to-face visit—that providers spend on care coordination for Medicare clients.

"Transitional Care Management, Chronic Care Management and Behavioral Health Integration codes are all new since 2014. They offer reimbursement for care such as non-face-to-face case management or care coordination provided by many care teams," Ewald says. "They're valuable opportunities because, in the past, recognition for the work teams do under the supervision of a primary care physician has been hard to account for financially."

The codes must be billed by a physician or a non-physician practitioner, such as a physician assistant, nurse practitioner or other defined qualified health provider. But that means you can have clinical staff providing the wrap-around care in partnership with the billing provider. Ewald cautions that organizations carefully understand the training requirements for personnel delivering the services as they must meet designation as "clinical staff" and "auxiliary personnel" under the billing codes to ensure compliance.

Ewald also said that the payment codes fall under Medicare Part B, which is accompanied by a 20 percent patient co-pay. Paying the extra fees for care management may be a hardship for some clients. "We have to make sure someone has a Medicare supplement or secondary insurance to help cover the cost," she said. "At the beginning of the calendar year especially, it might be hard for some members to meet that deductible, and we need to make sure that patients aren't feeling the cost of this service."

Over time, effective value-based reimbursement programs will pay for themselves by way of lower 30-day hospital readmission rates, reduced emergency department use and total cost of care. Results like the Bridge model study are not unlike results of other "hot spotter" programs that target high-risk populations with integrated clinical and social health services.

For example, the Camden Coalition's Link2Care care management program also focused on clients with complex needs and showed a 46 percent drop in average hospital admissions in the six

9 Baker, J. M., Grant, R. W., & Gopalan, A. (2018). A systematic review of care management interventions targeting multimorbidity and high care utilization. BMC Health Services Research, 18(1), 65 (abstract). Retrieved December 5, 2018, from https://www.ncbi.nlm.nih.gov/pubmed/29382327

months after enrollment.[10] Likewise, a program administered by Mount Sinai Medical Center saw a reduction in emergency department visits following patient enrollment in a team-based, integrated care management program.[11]

These programs achieve significant cost reduction by focusing on the very highest risk clients. As CMS moves more physician practices to advanced practice reimbursement models, it's important to note that successful models share an emphasis on patient engagement, care coordination and case management elements—all functions case managers execute across the care continuum to achieve better patient outcomes and lower costs.

In Rush's accountable care organization, physician practices look at program results and apply them against specific patient populations to calculate additional staffing support for care coordination. Significant savings translate into the ability to hire more personnel, so more patients benefit.

"When you can say that this group of doctors started working with social workers to provide care management, and then their emergency department rates went down significantly—and you can name specifics, like moving from an average of five emergency department visits before the intervention, to three visits in the year after—that's significant. When your audience is looking at budgets and how to fund new positions, that's what they're going to care about."

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But it doesn't hurt to track other factors that can add to the value proposition for case management. Ewald offers provider and patient satisfaction as additional elements in the value equation.

"If you are working with patients to set follow-up appointments and arrange transportation, you're able to both get them the care they need *and* reduce no-shows for your providers—and that's a really big headache you're alleviating for clinics. It's also important to study your impact on physician burnout and provider satisfaction because of your program, and, of course, to ask how your work is changing the care experience for patients and families. Case management can not only increase patients' satisfaction and outcomes, but may also help get caregivers connected to care and services they could benefit from as well."

As integrated professional case management programs proliferate, measuring and quantifying value will remain essential to ensure ongoing leadership support and program funding. Established value supports program growth and extension to cover more clients. For instance, at Rush, success with Bridge and AIMS has led to institutional support "so that care management is available to anyone who needs it," Ewald notes.

Value-based payment models are ideally envisioned to support whole-person health. "The good news is that new payment models recognize the social and mental health needs of clients," says Campagna. "As case managers, it's incumbent upon us to make the connections and serve our clients' needs. And in the current climate, where new payment codes are being tested and tried, it's critical that we take this opportunity to demonstrate the value of care coordination, case management and patient engagement so that whole-person health programs like these become the norm for health care organizations." ■

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10 A Coalition Creates a Citywide Care Management System. (2014, June 13). Retrieved December 6, 2018, from https://www.rwjf.org/content/dam/farm/reports/program_results_reports/2014/rwjf69151

11 Lynch, C. O., Wainberg, A., Jervis, R., Basso-Lipani, M., Bernstein, C. C., & Kripalani, T. (2016). Implementation science workshop: A novel multidisciplinary primary care program to improve care and outcomes for super-utilizers. *Journal of General Internal Medicine*, 37(7), 797-80. Retrieved December 6, 2018, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4907941/.

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VIVIAN CAMPAGNA works with individuals and organizations interested in certification (CCM®/CDMS®), related products and services through the Commission's broader marketing and promotions efforts. She fosters strategic partnerships and alliances and provides insight and guidance related to industry trends and developments.

Campagna has been involved in case management for more than twenty years. She has held staff and administrative positions on both the independent and acute care side of the industry. She has published articles on case management topics and is a frequent presenter and educator. She was a founding member of the Long Island chapter of CMSA, and served on the board and the conference committee of the NYC chapter of CMSA.

Campagna was a member of the inaugural class of certified case managers and worked with CCMC as a volunteer for more than 10 years. She is a former Commissioner and past chair for the Commission. Campagna earned her nursing diploma from St. Clare's Hospital and Health Center School of Nursing, her bachelor's degree from CW Post Center of Long Island University, and her master's degree in nursing from Seton Hall University. She is certified in case management by both the Commission for Case Manager Certification and the American Nurses Credentialing Corporation.

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