The Future Vision of Case Management

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Objectives

• Identify opportunities to incorporate population health within the case management competencies

• Change mental models that include population health and transitions of care in case studies, examples and scenarios

• Explore how case management practice is evolving to meet the social determinants of health needs of the patients, clients and families we serve.
Standards of Professional Case Management Practice

- Client Selection process for professional case management services
- Client assessment
- Care needs and opportunities identification
- Planning
- Monitoring
- Outcomes
- Closure of professional case management services
- Facilitation, coordination, and collaboration
- Qualifications for professional case managers
- Legal
- Ethics
- Advocacy
- Cultural competency
- Resource management and stewardship
- Professional responsibilities and scholarship
Standards of Professional Case Management Practice

- Client Selection process for professional case management services
- Client assessment
- Care needs and opportunities identification
- Planning
- Monitoring
- Outcomes
- Closure of professional case management services
- Facilitation, coordination, and collaboration
- Qualifications for professional case managers
- Legal
- Ethics
- Advocacy
- Cultural competency (Cultural Sensitivity)
- Resource management and stewardship
- Professional responsibilities and scholarship

How do we change our case management practice model from an organizational (vertical) perspective to a population health (horizontal) perspective?
Population Health (2008)

- Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.
- Health systems care for multiple populations without even knowing the distinct differences and needs of the populations.
- Over a decade of discussions and evidence-based practice in regard to population health!

(Kindig, Asada & Booske, 2008)
Our New Paradigm:

The focus of healthcare has shifted from individual inputs to population outcomes.
Population Health Management – Future State

Today:
Reactive and Volume-based

The Future:
Proactive and Value-based

Drivers

- Health Reform
- Affordability Gap
- Triple Aim
- Weight of the Nation
- Reimbursement

Health System
Population health management provides comprehensive Evidence-based strategies for improving the systems and policies that affect health care quality, access, and outcomes, ultimately improving the health of an entire population.

Encourage me!
Educate me!
Treat me holistically!
I will pay you!

Individuals are accountable for their health with the health system as their health advocate.

Miksch, T. & Blackburn, C., 2015
Case Study - Academic Medical Center

• Trauma Level One and Burn Center (April 2018)

• High Population – Homeless & Medi-Cal (Medicaid)

• Mental Model – That Case Management is at Fault

• Hospital Metrics
  • Length Stay Increasing
  • CMI Decreasing
  • Readmissions Increasing (Especially from High Referral Sources)
  • Staff Engagement Low
  • Burnout High
  • Revenue Capture Backlog $38 Million
Case Study - Academic Medical Center

• Care Management Redesign

  • Organization Non-Negotiables
    • No Additional FTE
    • No Disruption to Patient Throughput
    • Limit Union Inquiries

  • Director Non-Negotiables
    • Needed Dedicated Project Manager
    • One Year Timeline to Complete Project (Based on Organizational Non-Negotiables)
    • Executive Sponsorship from CFO, CMO & CNO
Current State “Triad” Model Focuses Primarily On Discharge Planning And Has Unbalanced Span Of Control

**Current State Operating Model**

- **CM Director**
- **Care Management**
  - Care Management (CM) Supervisor – RN
  - Care Manager – RN 37 (26 FTE)
  - Transition of Care Manager (TCM) – RN 2 (2 FTE)
- **Social Work**
  - CMA Program Supervisor – RN
  - Care Management Associate (CMA) 9 (9 FTE)
  - Social Workers 29 (23 FTE)
- **Post Acute Program**
  - Social Work (SW) Supervisor
  - PAC Manager

**Key**

<table>
<thead>
<tr>
<th>Primary Focus</th>
<th>DC Planning</th>
<th>Care Progression</th>
<th>Revenue Capture</th>
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</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>39 (28 FTE)</td>
<td>9 (9 FTE)</td>
<td>29 (23 FTE)</td>
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Future State “Quad” Model Redistributes DC Planning, Care Progression, And Revenue Capture Responsibilities Transition To “Quad” Model Will Maintain A Net Neutral Budget

**Future State Operating Model**

- **CM Director**
  - **Case Management**
    - Case Management (CM) Manager - RN
    - Case Manager - RN
    - Total: 30-34\(^1\) (19-23 FTE)
  - **Social Work**
    - Social Work (SW) Manager
    - Social Workers
    - Total: 29 (23 FTE)
  - **Utilization Management**
    - Utilization Management (UM) Manager - RN
    - UM RN
    - Total: 5-9\(^1\) (5-9 FTE)
  - **Post Acute**
    - Post Acute Programs Manager - RN
    - Transition of Care Manager (TCM) - RN
    - Care Management Associate (CMA)
    - Total: 11 (11 FTE)

**Key**

- **Primary Focus**
  - DC Planning Care
  - Progression
  - Revenue Capture

- **Changes**
  - New role; existing staff
  - Reporting change
Case Study - Academic Medical Center

• Trauma Level One and Burn Center (January 2019)

• High Population – Homeless & Medi-Cal (Medicaid)

• Mental Model – Case Management is at Fault Organizational Efficiency Needed

• Hospital Metrics
  • Length Stay
    • Increasing
    • Decreased
  • CMI
    • Decreasing
    • Increased (highest in years)
  • Readmissions
    • Increasing
    • Decreased
  • Staff Engagement
    • Low
    • High
  • Burnout
    • High
    • Low
  • Revenue Capture
    • Backlog $38M
    • Backlog: $1.8 Million
Healthy People 2030 Framework
Foundational Principles

• Health and well-being of all people and communities are essential to a thriving, equitable society.

• Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental and social health dimensions.

• Investing to achieve the full potential for health and well-being for all provides valuable benefits to society.

• Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.

(continued)
Healthy People 2030 Framework
Foundational Principles

• Healthy physical, social and economic environments strengthen the potential to achieve health and well-being.
• Promoting and achieving the Nation’s health and well-being is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, and not-for-profit sectors.
• Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors.
Use of Big Data

• IT promises to revolutionize the way care is delivered and coordinated.
• Data access will allow connectivity between a patient’s primary care provider and required specialists.
• Case managers are essential conduits for effectively gathering and managing this information in creating a truly differentiated patient experience of the highest quality.
Leveraging Big Data: Cook County
Population Health: Achieving Success

Successful Population Health Management Must Be Highly-Tailored to Particular Segments of the Population

Case Management Application Connecting Theory to Practice

• Provide a Higher Level Systems Perspective.

• Move from Micro-Thinking to Macro-Thinking. What is the Greater Impact?

• Reinforce the Importance of Interdisciplinary Approaches to Care Delivery.

• Possibility thinking.

Clack, J., 2017
Questions

• How could we collaborate with community partners to improve care delivery and care transitions in our most vulnerable neighborhoods?
• Would these efforts improve population health ...
  • access to care?
  • equity in care?
  • quality of care?
  • effectiveness of care?
  • efficiency of care?
• What is the business case? (Cost-Benefit Analysis)
Case Study

• Heart Failure
  • Traditionally the focus has been acute care only
  • Need to incorporate beyond the acute care setting

• What is the role of case management across the continuum?
CHF Application Across the Continuum

• Horizontal Observation of Disease State
  • Acute-Care Hospital
  • Long-Term Acute Care Hospitals
  • Skilled Nursing Facilities
  • Assisted Living Facilities
  • Home Health
  • Primary Care Clinics
  • Specialty Clinics
  • Workers Compensation
  • Employee Health & Wellness
  • Public Health

In Order to be Successful ...
We No Longer Can Have a Siloed Vertical Perspective
Professional Case Managers as Intrapreneurs

Traits & Skills of Intrapreneurs

- Persuasive
- Driven
- Knowledgeable
- Willing to Learn
- Leader
- Team Builder
- Risk Taker
- Confident
- Forward Thinker
- Organized
- Financial Savvy
- Ability to Delegate
- Multitasker
- Persistent
- Passionate
Questions