# 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

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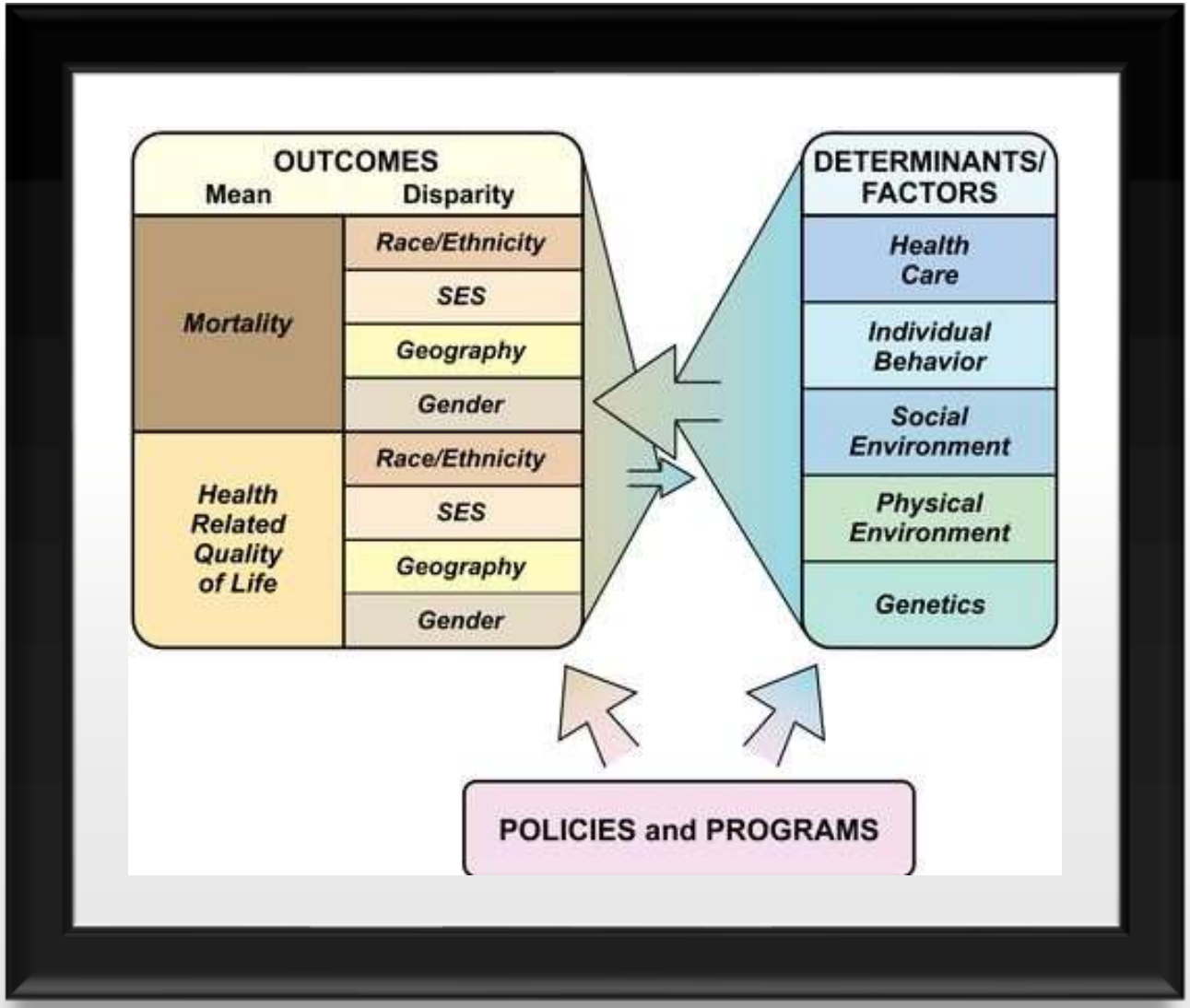
- Legal
- Ethics
- Advocacy
- ~~Cultural competency~~ **(Cultural Sensitivity)**
- Resource management and stewardship
- Professional responsibilities and scholarship

**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**


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

Miksch, T. & Blackburn, C., 2015

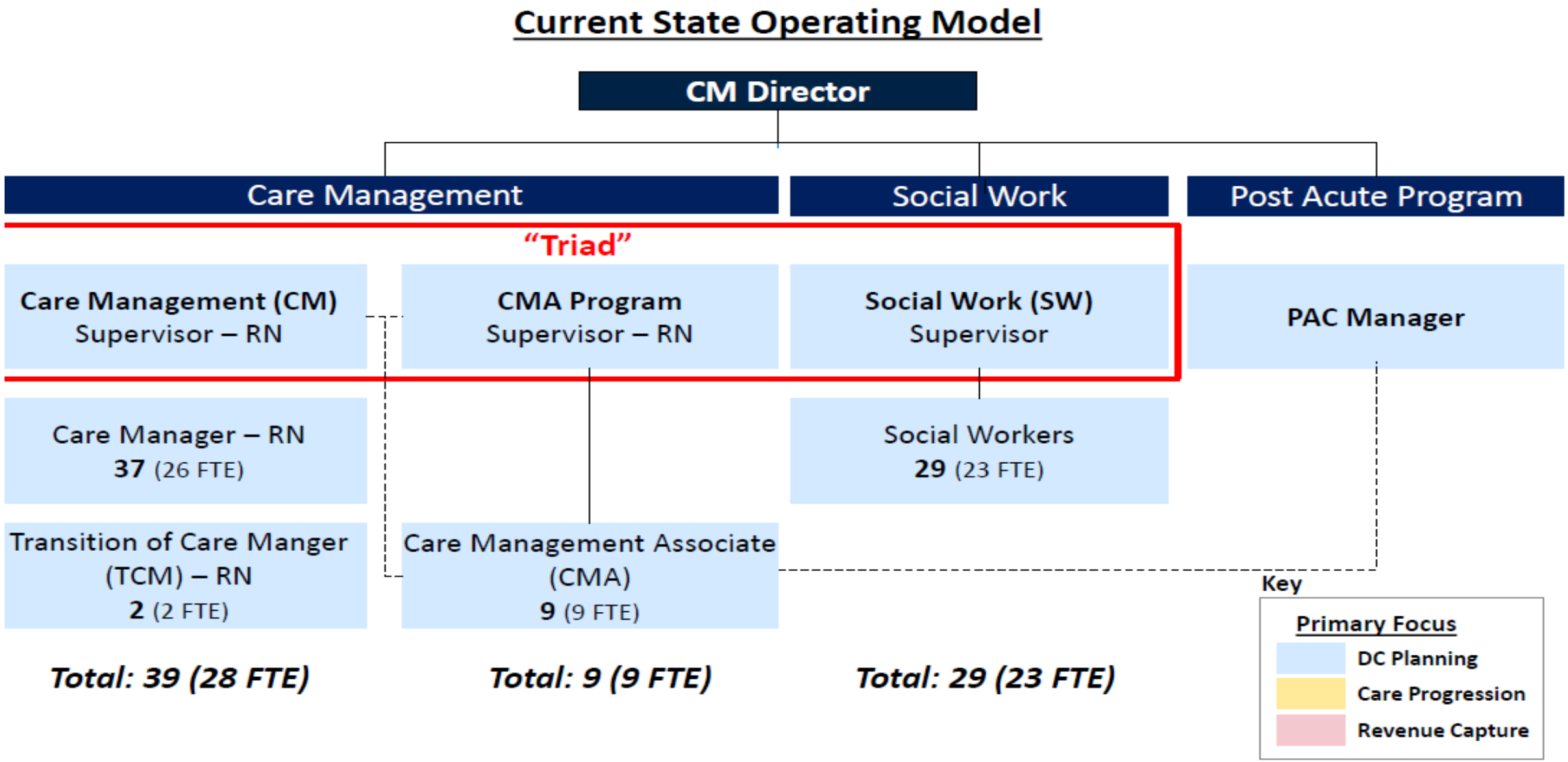
# Case Study - Academic Medical Center

- 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

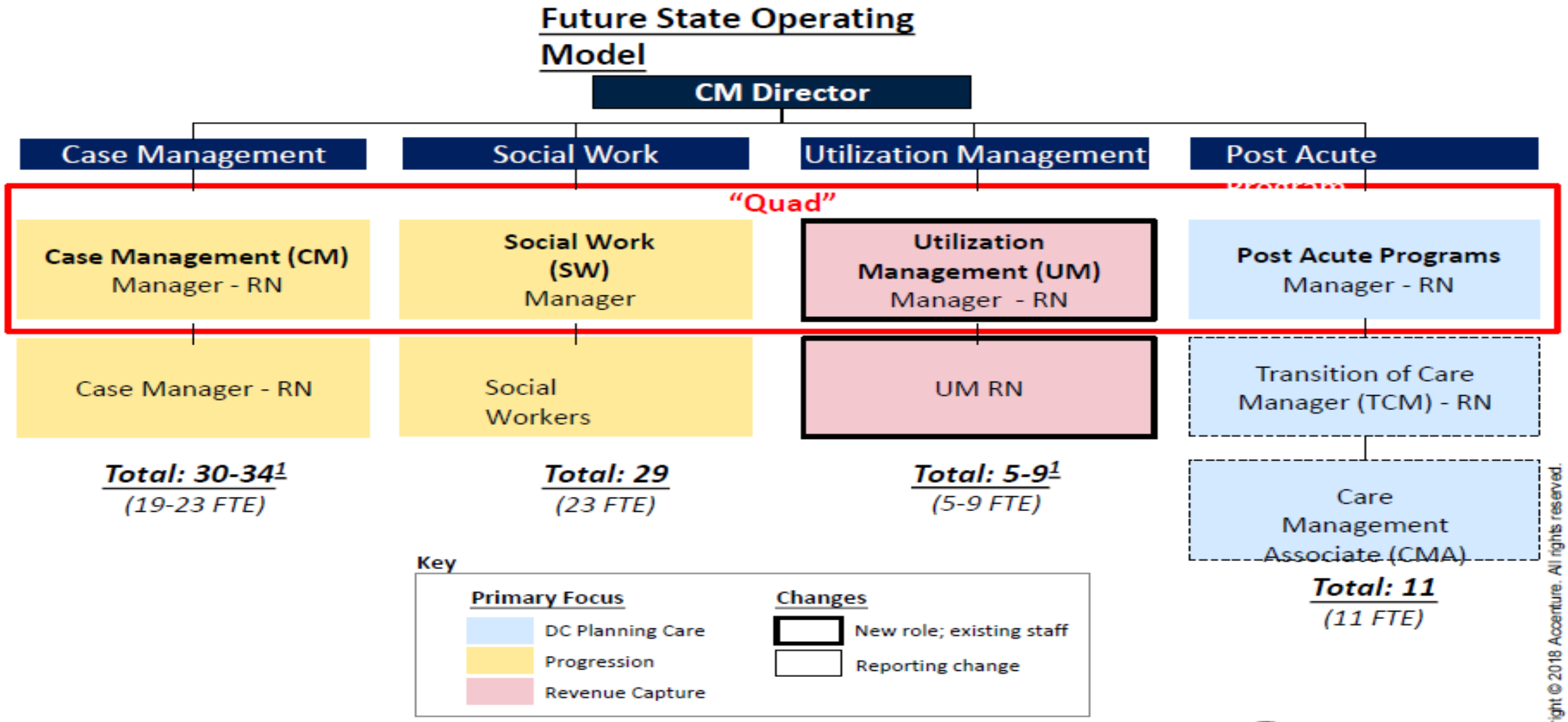
- Care Management Redesign
  - Organization Non-Negotiables
    - No Additional FTE
    - No Disruption to Patient Throughput
    - Limit Union Inquiries
  - Director Non-Negotiables
    - Needed Dedicated Project Manager
    - One Year Timeline to Complete Project (Based on Organizational Non-Negotiables)
    - Executive Sponsorship from CFO, CMO & CNO

# Current State "Triad" Model Focuses Primarily On Discharge Planning And Has Unbalanced Span Of Control



# Future State "Quad" Model Redistributes DC Planning, Care Progression, And Revenue Capture Responsibilities Transition To "Quad"

Model Will Maintain A Net Neutral Budget

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# 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)

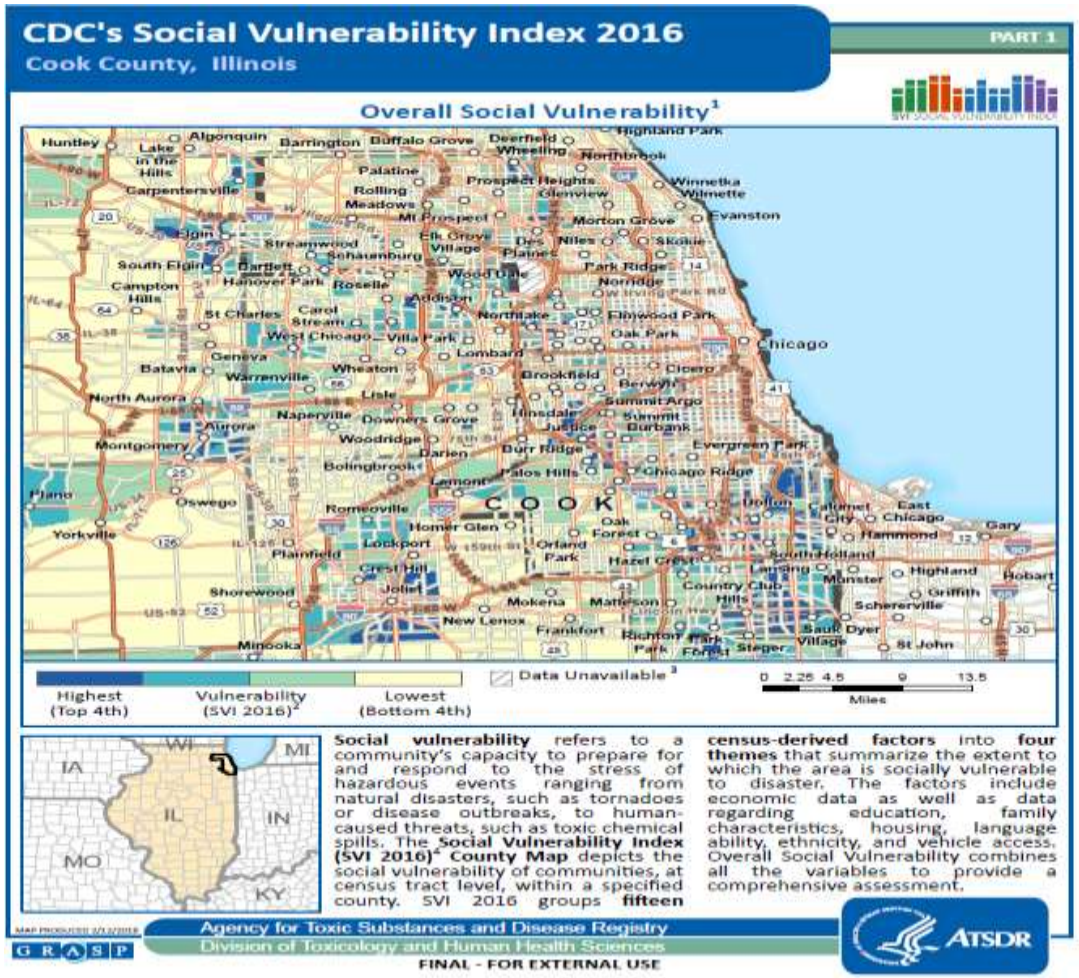
# Healthy People 2030 Framework Foundational Principles

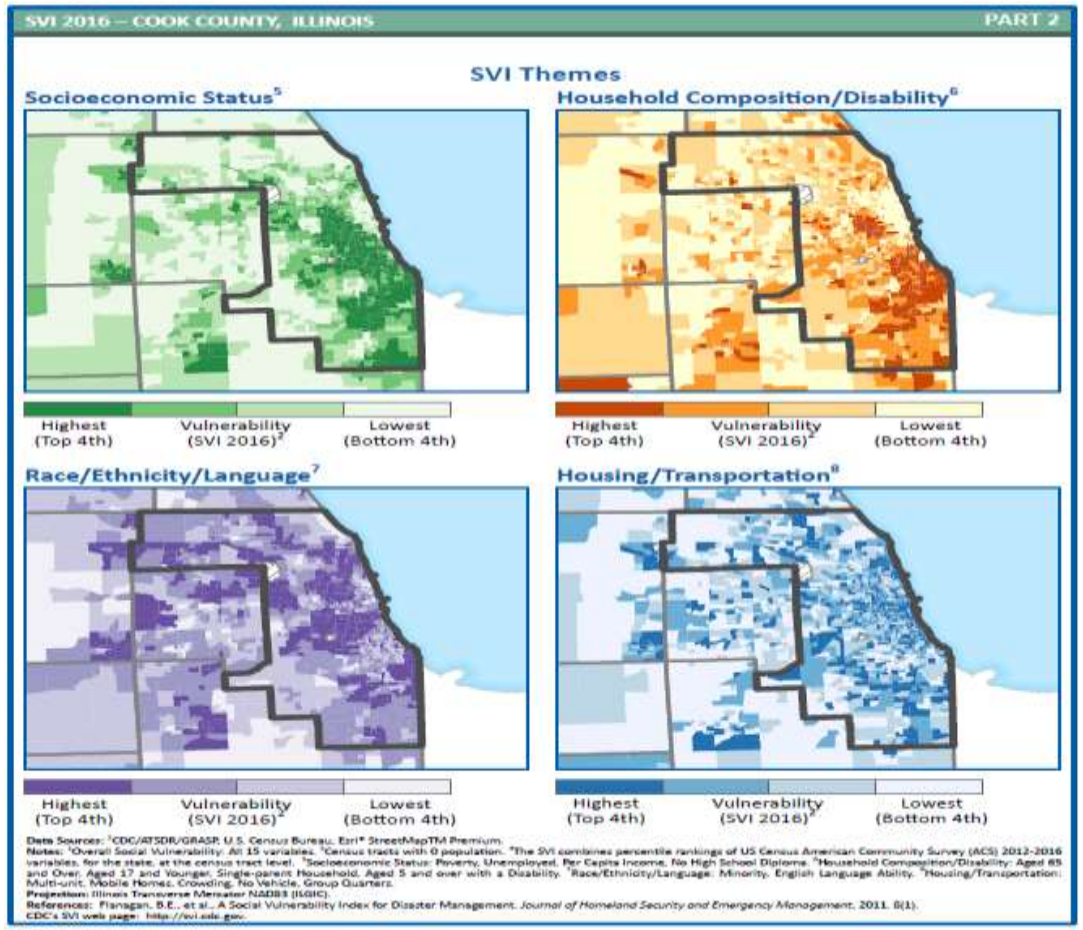
- Healthy physical, social and economic environments strengthen the potential to achieve health and well-being.
- Promoting and achieving the Nation's health and well-being is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, 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

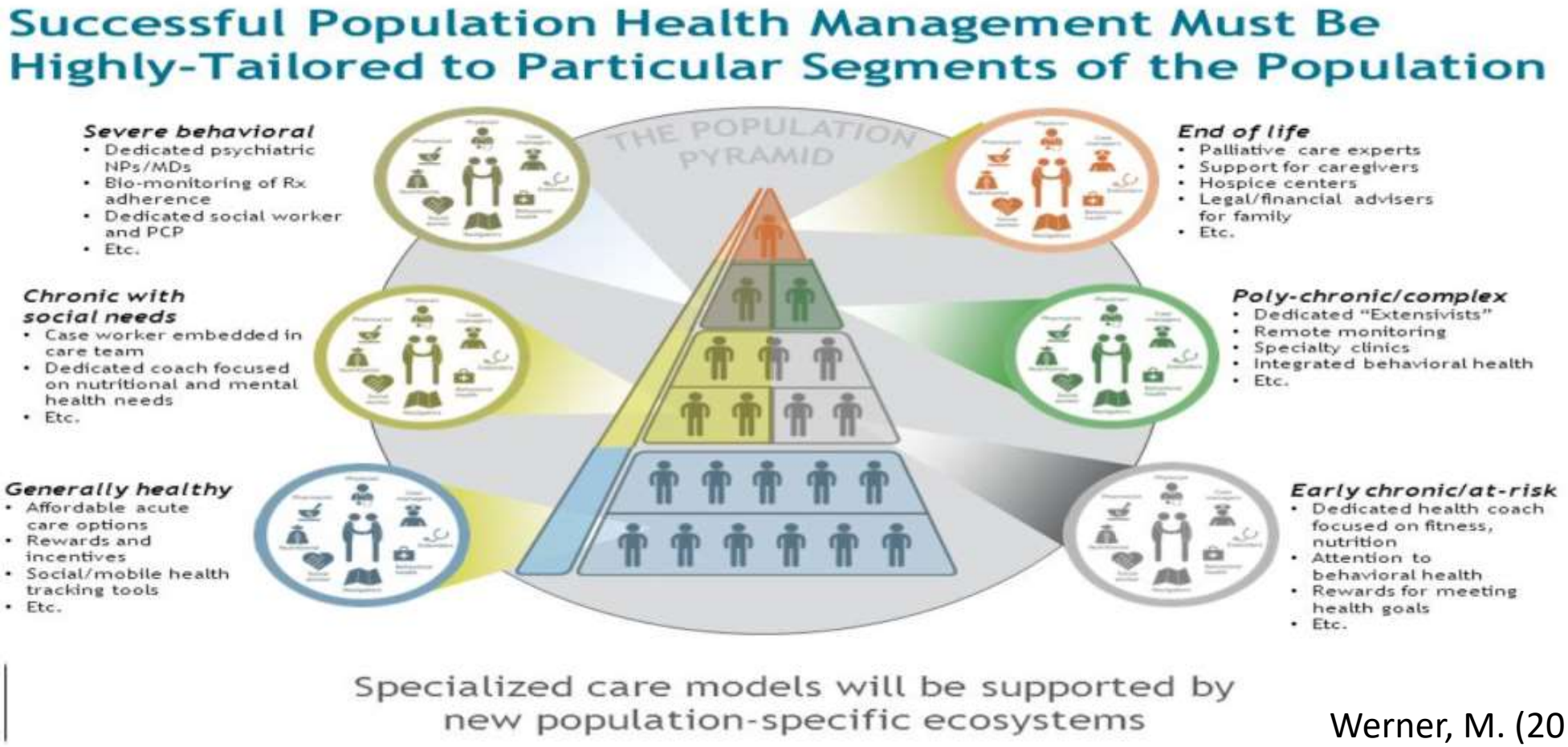
- IT promises to revolutionize the way care is delivered and coordinated.
- Data access will allow connectivity between a patient's primary care provider and required specialists.
- Case managers are essential conduits for effectively gathering and managing this information in creating a truly differentiated patient experience of the highest quality.

# Leveraging Big Data: Cook County



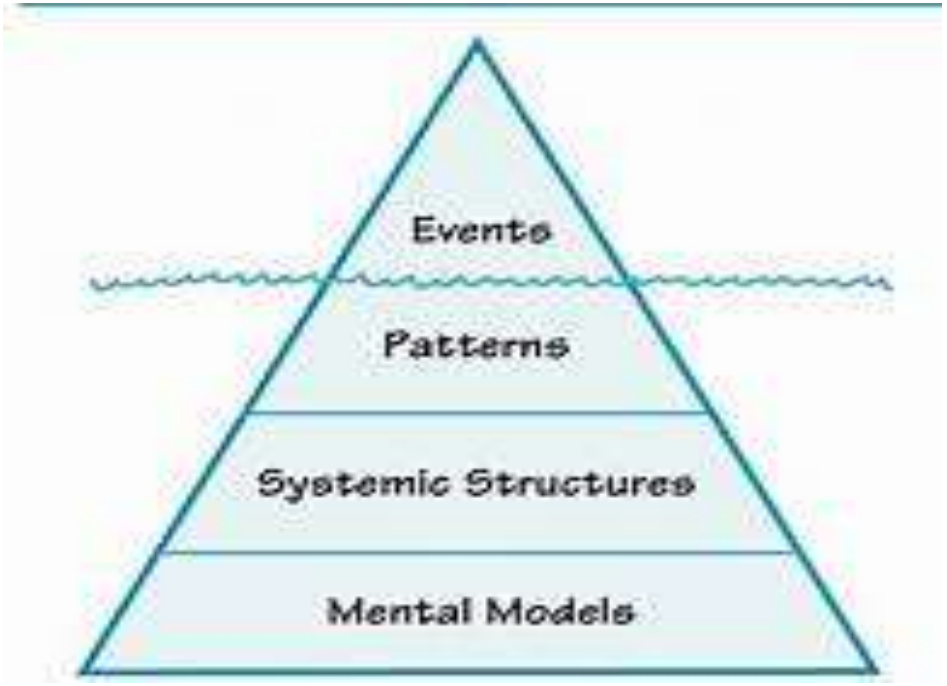
# Population Health: Achieving Success




Werner, M. (2015)

# 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.



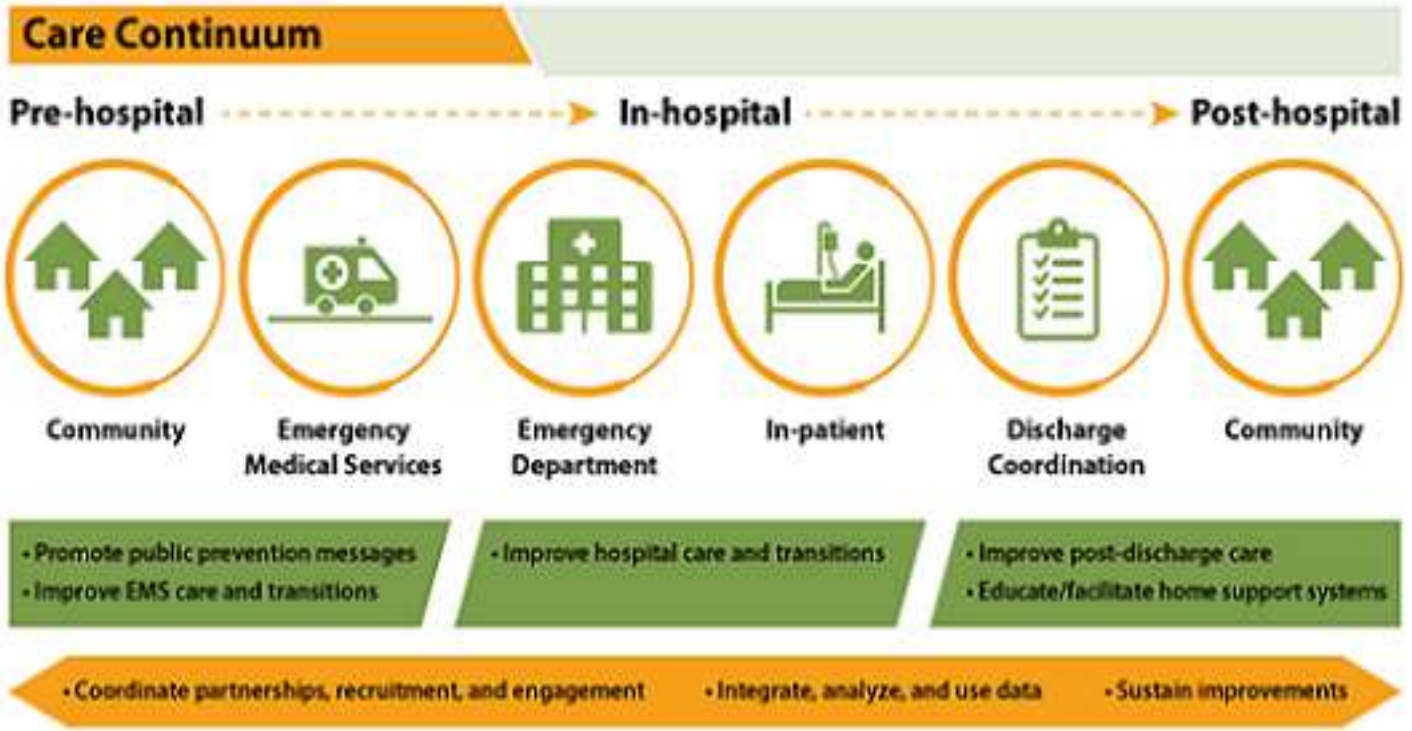

Clack, J., 2017

# Questions

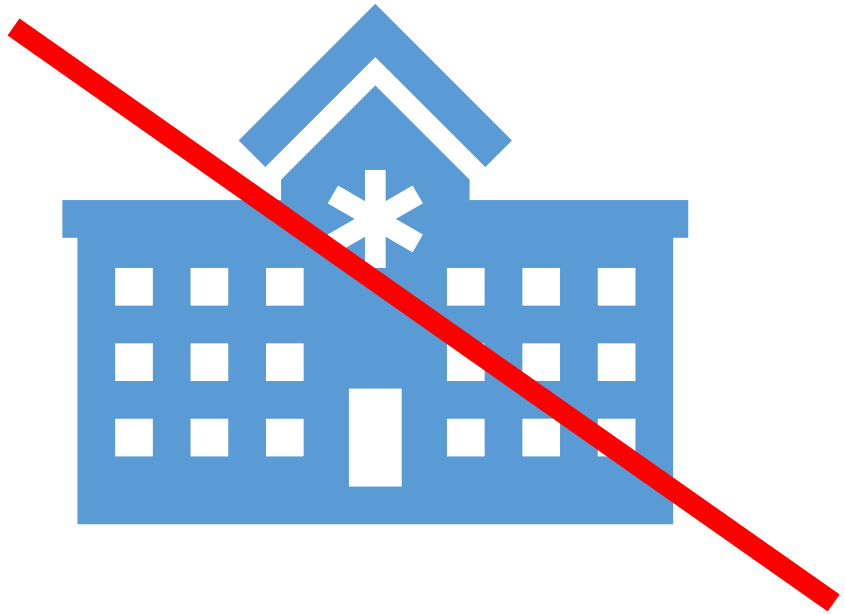
- How could we collaborate with community partners to improve care delivery and care transitions in our most vulnerable neighborhoods?
- Would these efforts improve population health …
  - access to care?
  - equity in care?
  - quality of care?
  - effectiveness of care?
  - efficiency of care?
- What 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



**In Order to be Successful …**
**We No Longer Can Have a**
**Siloed Vertical Perspective**

- 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

# Professional Case Managers as Intrapreneurs

# Questions