OBJECTIVES

Identify the core domains of the Wholistic Case Management© (WCM) Framework
Explain the impact of Wholistic Case Management on value-based care.
Describe three key responsibilities of case managers in ensuring an optimal personal care experience.
Discuss the ethical impact of using a WCM approach to care.

VALUE-BASED CARE

Not just about improvement in healthcare:
• Quality
• Safety
• Cost efficiency
• Revenue
• Incentives
Rather:
• Improving a person’s health, well-being, and quality of life
• Enhancing functioning and productive life
• Promoting independence
• Requiring a “wholistic” approach to health and health care services
FOR OUR DISCUSSION

On a scale of 1-10, how attentive is your organization to Value-Based Care? With 1 not so attentive to Value-Based Care, and 10 very attentive:

• 4 or under,
• 5,
• 6 or more,
• 10?

WE MUST CARE FOR THE PERSON WITH AN ILLNESS …

NOT THE ILLNESS OF THE PERSON …

STAGGERING

$1.7 Trillion
Dollars spent on 5% of the population

1% of the population accounts for 20% of health care costs
5% of the population accounts for nearly 50% of health care spending

People with the worst health care… Those who need it the most and get the least, feel it the most.

(Weissmann, 2012; Sullivan, 2018)
THERE IS A DRAMATIC AND UNPRECEDENTED TRANSFORMATION OCCURRING IN OUR HEALTHCARE INDUSTRY ... AND IT REQUIRES THE SKILLS AND VALUE OF PROFESSIONAL CASE MANAGERS ...

AVOIDABLE EXPENSES

In the US, $32 Trillion dollars, and estimated to grow at 5.5% through 2025

Chronic diseases comprising the majority of $$

(Beaton, 2017)

TOP 10 MOST EXPENSIVE CHRONIC DISEASES (BEATON, 2017)

10. Stroke: $33B
9. Asthma: $56B
8. Arthritis: $128B
7. Obesity: $147B
6. Cancer: $171B
5. Alzheimer's Disease: $236B
4. Diabetes: $249B
3. Alcohol-related health issues: $249B
2. Smoking-related health issues: $300B
1. Cardiovascular diseases: $317B
**REWARDING VALUE NOT VOLUME**

- Payment is shifting to reward value and quality
- 50% of traditional fee-for-services Medicare payments are tied to quality and/or value through alternative payment methods by end of 2018


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**VALUE-BASED PROGRAMS**

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<tr>
<td>ADVHC</td>
<td>GME IPA</td>
<td>ACA</td>
<td>HBP</td>
<td>FAMA</td>
<td>HCC-FFP</td>
<td>ESRD-CC</td>
<td>HAC</td>
<td>VM</td>
<td>OPP-EP</td>
<td>HNC</td>
<td>HPS</td>
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(Engagement Models:
- ACOs
- Medicare Access & CHIP Reauthorization Act
- ACA (Affordable Care Act)
- HBP (Medicare Payment Improvement Act)
- FAMA (Primary Care Case Management Act)
- HAC (Hospital Acquired Conditions Reduction Program)
- VM (value-based purchasing)
- OPP-EP (Office/Outpatient Performance Program)
- HNC (Hospital National Consistency Program)
- HPS (Hospital Professional Services Program)
- HCC-FFP (Hospital Readmission Reduction Program)
- ESRD-CC (End Stage Renal Disease Quality Incentive Program)
- NCCN (National Comprehensive Cancer Network)
- SNF (Skilled Nursing Facility Performance Program)
- SNV (Skilled Nursing Facility Value-Based Purchasing Program))

Centers for Medicare & Medicaid Services, 2017
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

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**ENGAGEMENT AND DIGITAL TECHNOLOGY**

- New technologies are changing how people engage in their health and interaction with the healthcare system
- Over 75% of patients expected to use digital health services in the future

(Biesdorf and Neiderman, 2014)
IT IS UNLIKELY TO ACHIEVE OPTIMAL VALUE-BASED CARE WITHOUT **WHOLISTIC CASE MANAGEMENT® SERVICES**

**COSTLIEST PATIENTS WE CARE FOR**

- Those with chronic illness(s) and a functional (ADLs) limitation:
  - Have 4X higher medical costs
  - >$21,000 annually
  - Spend 2X as much out of pocket despite having much lower incomes
  - Are 3X as likely to be hospitalized

- **12 million Americans**
  - 3/4 are Whites
  - 2/3 are women
  - 1/2 are over 65 years of age
  - >25% did not finish high school

Khullar, September 28, 2017, NYT

**VARIOUS RELATED TERMINOLOGIES**

- Integrated care
- Integrated behavioral health/Behavioral health integration
- Collaborative care
- Shared care/Shared services
- Integrated case management
- Wholistic case management

**Commonality:** integration of health care services & resources to address client's needs, whether, behavioral health, physical, social, etc.
THE CASE MANAGEMENT EVOLUTION

Community Based Social Work & Public Health Nursing

Catastrophic Case Management

Acute Care Case Management

Integrated Behavioral Health

Wholistic Case Management ©

WHOLISTIC CASE MANAGEMENT® (WCM)

• A framework or care model for case management that goes beyond the provision of clinical care based on the client's needs including physical health and disease process.

• This approach to care targets the full client:
  • addressing psychological, behavioral, emotional, and socioeconomic issues that affect the client's health condition and,
  • ability to be fully engaged in self-managing his or her own health.

(Tahan & Fink-Sonnick, 2017)

WHY WHOLISTIC CASE MANAGEMENT®

• Complex and multiple chronic illnesses
• Incidence of co-occurring mental health and chronic medical conditions
  • Depression not always diagnosed and treated
  • Suboptimal care
  • Poor outcomes
• Vulnerable client populations
• Evidence indicates social determinants of health play a significant role in client's health, well-being, and outcomes
• Client's struggle with self-care management and engagement in own health
SOME CONCERNS
• 29% of adults with medical conditions also suffer mental health disorders
• 68% of adults with mental health disorders also suffer medical conditions
• Monthly total healthcare expenditure for an individual with depression and chronic medical condition(s):
  • $1,420 compared to $860 for an individual without depression — a difference of $560
• Individuals with serious mental health disorders die 25 years earlier than the general population
  (Druss and Walker, 2011)

SOME CONCERNS
• Almost 1/3 of patients with schizophrenia did not receive appropriate medical treatment for their diabetes
• 62% and 88% respectively did not receive appropriate treatment for high blood pressure and high cholesterol
  (Nasrallah, et al., 2006, in Druss and Walker, 2011)
• Those who do not pursue mental health services:
  • 45.7% cannot afford it
  • 15.3% do not know where to go
  • 11.7% because of limited coverage by health insurance plans
  • 9.3% fear confidentiality issues
  • 7.9% fear experiencing negative effect on their jobs
  (Druss and Walker, 2011)

OUR LIFESTYLE BEHAVIORS CONTRIBUTE 50% TO WHAT MAKES US HEALTHY.
WE SPEND ONLY 4% ON HEALTHY BEHAVIORS COMPARED TO 88% ON MEDICAL SERVICES.

BIPARTISAN POLICY CENTER REPORT — "F" AS IN FAT: AMERICA'S FUTURE, 2013
KEY CHARACTERISTICS OF WCM

- Caring for the whole person
- Enhancing a person’s health and not just managing health care services
- Integration of mental health professionals in primary care medical settings
- Close collaboration between mental health and medical care providers – seamless approach to care
- Shared responsibility in planning, delivery, and evaluation of health and human services
- Focus on treating the whole person and whole family in a person-centered approach to care
- Case managers play a significant role in coordinating care and services

TYPES OF SERVICES OF WCM

- Health promotion
- Disease prevention
- Health maintenance
- Health counseling
- Client education and engagement
- Diagnosis and treatment of acute and chronic illnesses
- Caring for diverse client needs:
  - Medical
  - Physical
  - Functional
  - Psychosocial
  - Mental
  - Behavioral
  - Emotional
  - Socioeconomic
  - Spiritual

BENEFITS OF WCM

- Improvement in:
  - Client’s access to services
  - Client’s health, well-being, quality of life
  - Quality and safety
  - Efficiency and effectiveness of services
  - Satisfaction with the care experience
  - Reduction in cost
  - Improved adherence to care regimen
  - Increased involvement in self-management
  - Delayed progression of illness
  - Prevention of fragmentation and duplication of services
  - Elimination of barriers to care
TENET 1: IOM SIX AIMS OF QUALITY HEALTHCARE

1. Safe
2. Timely
3. Efficient
4. Effective
5. Equitable
6. Patient-Centered

TENET 2: IHI’S QUADRUPLE AIM

- Improving population health
- Enhancing the patient experience
- Reducing health care costs
- Supporting provider well-being and resilience

TENET 3: NATIONAL QUALITY STRATEGY

- Make care safer by reducing harm caused in the delivery of care
- Strengthen person and family engagement as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment of chronic disease
- Work with communities to promote best practices of healthy living
- Make care affordable
TENET 4: SOCIAL DETERMINANTS OF HEALTH (SDOH)

- 1/3 of patient deaths are attributed to SDoH
- Effective management of SDoH significantly improves:
  - Disease prevention
  - Health promotion and wellness
  - Medications and treatment adherence
  - Access to healthcare services and resources
  - Reduction in costs of care

SDoH are key drivers for health outcomes and health inequities.

POPULATION HEALTH IN SUMMARY

IMPLICATIONS FOR WCM

<table>
<thead>
<tr>
<th>Population</th>
<th>40 - 60%</th>
<th>20 – 25%</th>
<th>5 – 15%</th>
<th>2 - 3%</th>
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<tbody>
<tr>
<td>Risk Stratification</td>
<td>Healthy / Low Risk</td>
<td>At Risk</td>
<td>Chronic Condition</td>
<td>Active Disease</td>
</tr>
<tr>
<td>Relative Cost</td>
<td>5 – 10%</td>
<td>15 – 20%</td>
<td>30 – 40%</td>
<td>40 – 50%</td>
</tr>
<tr>
<td>Engagement</td>
<td>None / Very Low Touch</td>
<td>Low Touch</td>
<td>Medium to High Touch</td>
<td>High Touch</td>
</tr>
<tr>
<td>Care / Outreach</td>
<td>Data Analytics and Triggers</td>
<td>Call, Text, Apps, Email (Proactive)</td>
<td>Care Mgmt., Blended</td>
<td>Active Case Mgmt</td>
</tr>
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(J. Murphy, CNO, IBM Global Health. Clinical Informatics Across the Continuum, October 25, 2017)

CCMC ETHICAL PRINCIPLES

- Principle 2:
  Board Certified CMs will respect the rights and inherent dignity of all of their clients

- Principle 3:
  Board Certified CMs will always maintain objectivity in their relationship with clients

- Principle 5:
  Board Certified CMs will maintain their competency at a level that ensures their clients will receive the highest quality of service

(Commission for Case Manager Certification, 2015)
ETHICAL STANDARDS

• Section 1: The Client Advocate:
  • Board certified case managers will serve as advocates for their clients and perform a comprehensive assessment to identify the client's needs; they will identify options and provide choices, when available and appropriate

• Section 3: Case Manager/Client Relationships:
  • §9 - Description of Services: Board-certified case managers will provide the necessary information to educate and empower clients to make informed decisions
  • §10 - Relationships with Clients: Board-certified case managers will maintain objectivity in their professional relationships, will not impose their values on their clients, and will not enter into a relationship with a client that interferes with that objectivity
    (Commission for Case Manager Certification, 2015)

STANDARDS CMSA

Standard K: Ethics
• The professional case manager should behave and practice ethically, and adhere to the tenets of the code of ethics that underlie his/her professional credentials (e.g., nursing, social work, and rehabilitation counseling).
• Awareness of the five basic ethical principles
• A primary obligation to the clients cared for, with
• A secondary obligation is engagement in and maintenance of respectful relationships with coworkers, employers, and other professionals

(Case Management Society of America, 2016)

Standard M: Cultural Competence
• The professional case manager should maintain awareness of and be responsive to cultural and linguistic diversity of the demographics of her/his work setting and to the specific client and/or caregiver needs.

(Case Management Society of America, 2016)
A HUMOROUS PERSPECTIVE...

http://www.youtube.com/watch?v=zh9fibMaEk

IT HAS BEEN AN EVOLUTION ... WCM – THE NEW FRONTIER

Fragmented Care (Silos) → Coordinated Care → Case Managed Care

Co-located Care → Integrated Care → Wholistic Care (WCM)

MAJOR INFLUENCES IN WHOLISTIC CASE MANAGEMENT

Wholistic Case Management

- Physical Health (Physical Illness)
- Behavioral Health (Mood, Cognitive, & Emotional Well-Being)
- Functional Status (Physical & Behavioral Outcomes of Illness)
- Engagement in Own Health (Self-Management Ability, Social Support)

Social Determinants of Health:
(Genetics, Lifestyle Behavior, Social Circumstances, Environmental and Physical Influences, & Medical Care)
**WHOLISTIC CASE MANAGEMENT MODEL®**
(TAHAN AND FINK-SAMNICK, 2017)

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**CORE CASE MANAGEMENT ACTIVITIES**

- Comprehensive Assessment
- Coordination and facilitation of care and treatments
- Brokerage of services to keep clients in the community
- Health education of clients and their support systems
- Transitional planning to the right care setting
- Concurrent assessment, monitoring, and evaluation of client’s condition and response to treatment
- Reporting observations to appropriate healthcare providers (e.g. psychiatrist, primary care) and team
- Collaboration with payers and community agencies

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**COMPREHENSIVE CASE MANAGEMENT ASSESSMENT IS ESSENTIAL**

- Medical health status and condition, history
- Cognitive and behavioral
- Mental health, substance use, depression, strengths and limitations
- Professional, educational, vocational
- Self-Management and engagement status, readiness to change
- Social, psychosocial status
- Financial circumstances
- Beliefs, values, needs, and preferences
- Access to care and services
- Health insurance status
- Barriers to getting care and resources
- Advanced directives planning
- Pertinent legal situations
- Client priorities and self-identified care goals
- Functional status
- Transitional or discharge planning needs and services
- Durable medical equipment
- Transportation capability and constraints
- Follow-up care (e.g., primary care, specialty care, and appointments)
- Safety concerns, appropriateness of home or residential
**CORE PRINCIPLES OF INTERVENTIONS**

- **Patient-centered team care**
  - PCPs, care managers & behavioral health consultants collaborate effectively using shared care plans that incorporate client care goals & diverse needs.
  - Care team shares responsibility for a defined group of clients tracked in a registry.
  - Mental health specialists provide caseload-focused consultation as opposed to ad-hoc advice.

- **Population-based care**
  - Treatment plan articulates personal goals & clinical outcomes that are routinely measured by evidence-based tools (e.g., PHQ-9 Depression Scale).
  - Treatments are changed if client is not improving.

- **Measurement-based treatment to target**
  - Clients offered evidence-based treatments.
  - Psychotherapies and medications proven to be effective.

- **Evidence-based care**
  - Healthcare providers are accountable for quality of care and clinical outcomes, not just the volume of care and services provided.

- **Accountable care**
  - Frequency of access to services
  - Scheduled/unscheduled
  - Emergency department, acute
  - Length of stay
  - Cost of services
  - Experience of healthcare services
  - Clinical quality measures
  - Depression screening
  - Referrals to specialty services and resources
  - Health risk assessment and screening
  - Health disparities

**CORE COMPETENCIES OF WCM®**

- Interpersonal communication
- Collaboration and teamwork
- Screening and comprehensive assessment
- Motivational interviewing
- Care planning
- Intervention and care coordination
- Cultural competence and adaptation
- System’s thinking and practice
- Practice-based learning and quality improvement
- Informatics and health technology
TANGIBLE TAKEAWAYS

• Case managers play a key role in achieving value for all: clients, providers, payors, and regulators.
• Integrated health services is not enough – there is more of concern, not just the medical and mental health conditions and services.
• Wholistic Case Management® is successful only when we understand and manage the social determinants of health.
• 60% of health outcomes are dependent on the client’s behavioral, social and environmental dynamics; 10% are dependent of medical care.
• Case managers are well positioned to assume the role of Wholistic Case Management®.

CONTACT INFORMATION

Hussein M. Tahan, PhD, RN, FAAN
System Vice President of Nursing Professional Development and Workforce Planning, MedStar Health System
htahanrn@gmail.com

Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP
Principal, EFS Supervision Strategies, LLC
www.efssupervisionstrategies.com
efssupervision@me.com
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