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.

• Explore regulatory & legislative trends for homeless populations.

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 management
• Legal
• Ethics
• Advocacy
• Cultural competency
• Resource management and stewardship
• Professional responsibilities and scholarship
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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 always knowing the distinct, sometimes different needs of the populations.
- Over a decade of discussions and evidence-based practice in regard to population health!

(Portig, 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

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.

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.

Miksch, T. & Blackburn, C., 2015

Case Study - Academic Medical Center

• Trauma Level One and Burn Center
  • High Population – Homeless & Medi-Cal (Medicaid)
  • Mental Model – That Case Management is at Fault

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

Case Study - Academic Medical Center

• Care Management Redesign
  • Organization Non-Negotiables
    • No Additional FTE’s
    • 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
Proposed Future State

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 of Stay: Increasing, Decreased
  - CMI: Decreasing, Increased (highest in years)
  - Readmissions: Increasing, Decreased
  - Staff Engagement: High, Low
  - 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: Suffolk County

Population Health: Achieving Success

Case Management Application

- 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

Regulatory/Legislative Trends for Homeless Population

- CASE EXAMPLE - CALIFORNIA
- SB1152 – Hospital Patient Discharge Process for Homeless Patients

Homelessness is a GROWING issue!

2018

California – 129,072 (10,836 Veterans)
Massachusetts – 20,068
185 - Veterans

1,031 – Unaccompanied Students
Washington, D.C. – 6,904 (306 Veterans)
Missouri – 5,883 (507 Veterans)
Root Causes of “Modern Homelessness”  
1970 - Current

- Social Determinants of Health
- Mental Health & Opioid Crisis – 1990 Crack Epidemic (LA)
- Deinstitutionalization (Mental Health System Housing / Justice System Housing)
- Decline of Single-Room Housing – Affordable Housing Crisis
- Average Individual Savings Rate Declining (5% in 2015 v. 17% in 1975) – No “Nest Egg” for Emergencies
- Better Tracking Data – Homelessness has become more visible

Changing Attitudes, Mental Models & Legal Recourse – “Homelessness is Not a Crime”

- 1979 - Callahan v. Carey (Class Action Lawsuit – Homeless vs. New York City) – “Right to Shelter”
- 1981 - Callahan v. Carey Consent Decree – Legal Right to Shelter for Homeless Individuals in New York City
- 2006 – “Jones Agreement” City of LA Settlement giving the right for homeless to sleep in public places – growth in “encampments”
- 2009 – Child in Need of Supervision, Services & Protection – “Unaccompanied Youth” – “Rights of the Runaway” – 44 States have enacted protection statutes
- 2013/2014/2019 – Massachusetts – Homeless Bill of Rights – PENDING

- H.3595 - Passed Joint Committee on Housing (5/13/13)
- H.1354 – Reported favorably by committee on Housing, referred to committee on Health
- H.695/S.46 – Filed in 2017 – Continuing Debate
CA SB1152

- California State Bill 1152 requires hospitals to have the following requirements in place by January 1, 2019.
- Hospitals must maintain a written homeless discharge planning policy and process.
- Hospitals are required to inquire about each patient’s housing status and to ensure homeless patients are prepared to return to the community by connecting him/her with available community resources, treatment, shelter and other supportive services.
- Hospitals must document the interventions as evidence of compliance.
- Case Managers, Clinical Social Workers, Nurses and Physicians will be responsible for ensuring UC Health meet the requirements of the new law.
- Epic Enhancements to support the law:
  - Admission and Discharge navigators for Nurses, Clinical Social Workers and Case Managers will be updated before January 1st.
  - A new patient list of homeless patients will be available.
  - Two new patient list columns:
    - Homeless – icon will indicate patient is homeless
    - Homeless Assess – if discharge documentation requirements are completed, a check will display.

Nursing Admission Navigator – Interprofessional Section

Nursing Discharge Navigator – Homeless Disposition Section