Hospital Case Management Staffing Trends

Lu Calkins

Vice President Product Operations, Midas+ Solutions

Objectives

- Understand various case management models

- Review challenges of regulatory, payer, and hospital needs to case managers

- Discuss how Midas+ Care Management can be used by the Case Management Team to support these challenges and requirements

Models/Programs

- Ambulatory Care Management
- Health Connections Initiative
- Comprehensive Primary Care Initiative
- Community Based Care Transition Program
- Triad+ Work Model
- Patient Centered Medical Home (PCMH)
- Transition Nurse Model
- Intensive Case Management

Positions – To Name a Few

- Population Health Coaches
- Population Health Care Coordinators
- Transition Coaches
- Transition Nurse Specialist
- Transition Nurse
- Transition Coordinator
- Transition Case Manager
- Care Coordinators

Growth

The demand for skilled, qualified case managers continues to rise in order to meet the requirements of healthcare reform and the needs of a growing population of elderly, complex patients.

Transitions of Care Services

1. Phone call for follow-up post discharge
   - Completed at approximately 76% of hospitals
   - No significant variation between size of hospital

Transitions of Care Services
(continued)

2. Facilitation of scheduling primary care physician appointment

   – Completed at approximately 70% of hospitals

   – Frequency increased as staffed beds increased

Other Transition Services Offered

- Follow-up with post-discharge caregivers for patient status

- Transportation to and from appointments/treatments

- In-home assessments

- Monitoring of in-home electronic health monitoring

Current Hospital Trends

Inpatient case management departments are providing majority of transitions of care in hospitals less than 200 beds.

Separate transitions management team within the hospital are providing majority of transitions of care in hospitals over 500 beds.

Transition Nurse Model

Hospital-based Transition Case Manager

- Assigned while patient is in-house by meeting criteria

- Works with patient and family during inpatient stay

- Stays with them for 30 days post-discharge

- Funded by hospital

Intensive Case Management Model

- Hospital-based

- Very specific/focused type of patient

- High utilization / High-risk patients

- Follows patient into the community

- Very involved with the patient and their care

- Involvement in more than "healthcare" concerns to keep patient out of hospital

Triad+ Work Model

- RN NCM – Nurse Case Managers

- MSW – Medical Social Workers

- UM – Utilization Management RNs

- CMA – Case Managers Assistants

  CMA/CM ration = 1:4 or 1:5

  Need well defined roles

  Need documented processes

Case Manager Assistants - CMA

Possible responsibilities:

- 2nd IM and Observation letters
- Verify guardianship with court
- Obtain PCP
- Schedule transportation
- Transmit documentation
- Call/fax provider offices
- Make phone calls, fax, scan, etc.

Population Health

Improving the health status of a defined population by focusing on health status (quality), cost of care, and the experience of care (triple aim).

Not all members of a defined population are active. Patient populations are broader than those currently seeking care.

Areas of Focus

Acute Care
- Utilization Management; Acute Case Management; Compliance

Transitions/Readmissions
- LACE/ProjectRED/etc.; Continuing Care Network; RN Transition Coaches

Areas of Focus *(continued)*

High-risk Individuals

- Advanced Population Health Analytics; Coaches and Population Health Care Coordinators; Patient-centered Medical Home

Prevention

- Basic Analytics (such as registries); RN Population Health Coaches; Patient-centered Medical Home

Inter-related Components

Connected providers organized to meet the clinical needs of a population

- Access – geographic, timing, clinical types

- Incentives to address cost, quality, experience

- Sharing of information across the Clinical Integrated Network (CIN)

Inter-related Components *(continued)*

Care Management

- Support capabilities to improve total cost of care and improve quality of care

- Key differences from traditional roles:

  1. Follow the patient, not the provider
  2. Motivational interviewing

Ambulatory Care Management

- RN Population Health Coaches - 1:5,000 members

- Population Health Care Coordinators (SW) – 1:3000 members

- RN Transition Coaches – Following inpatient admission

- Administrative Staff – To allow nurses and social workers to work at the top of their license

Population Health Programs

Medicare Shared Savings Program (MSSP)

- Established by the Affordable Care Act

- To facilitate coordination and cooperation among providers for Medicare Fee-for-Service (FSS) and reduce cost.

- May participate in MSSP by creating or joining an Accountable Care Organization (ACO)

- Focus on high-risk members

Population Health Programs

Bundled Payment for Care Improvement (BPCI)

1. Retrospective Acute Care Hospital Stay Only

2. Retrospective Acute Care Hospital Stay plus Post-Acute Care

3. Retrospective Post-Acute Only

4. Acute Care Hospital Stay Only

BPCI Phases of Implementation

Three of the four models have two phases

Phase 1 – CMS and participants prepare for implementation and assumption of financial risk.

Phase 2 – "Risk-bearing" period

Readmissions

FY 2015 National Program Penalties

- 2,610 hospitals were assessed penalties ranging from 0.01% to 3% of Medicare revenue

- Readmission rates are assessed on 3 years prior performance (07/2010 - 06/2013)

- Total penalties were $428,000,000

- 75% of hospitals penalized

Patient-centered Medical Home

1. Transformational care to primary care

2. Team-based approach

3. Focused heavily on relationship between patient and primary care

4. Uses Care Coordinators – Case Managers

Care Coordination is the Key

Embedded Care Coordinators

- Community-based approach
- High touch, face-to-face

Whole person management

- Manage conditions and co-morbidities
- Clinical and psycho-social issues
- Based on comprehensive plan of care

Behavior Modification

Common Interventions

- Medication management

- Transition planning

- Shared accountability between providers and organizations

- Provider engagement

- Follow-up care

- Patient and family engagement and education

- Information transfer

How Do You Keep Track?

Concurrent Review

Certification

Discharge Planning

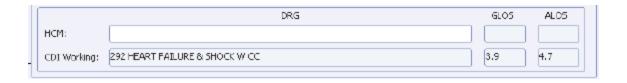Support Services

Focus Study

SmarTrack

Worklists

Community Case Management

Concurrent Review

1. Assuring level of care for inpatient admissions are being met

2. Review past reviews or past encounters for details

3. Using the GLOS and ALOS for the DRG that they are currently assigned you have a visual for planning (HCM and CDI DRG)

	DRG	GLOS	ALOS
HCM:			
CDI Working:	292 HEART FAILURE & SHOCK W CC	3.9	4.7

Certification

1. Visualization of shared payer information outlining approvals and denials

2. Ability to trigger a user if a denial is received

3. Integrate to send payer reviews via Curaspan Review Central

Discharge Planning

1. Sharing documentation of initial assessment to the EMR via an Outbound ReporTrack Document Conversion Interface

2. Customized user fields to gather additional requirements based on your model's needs

3. Monitor planned discharge date to alert giving Medicare's Important Message

Support Services

1. Communicate with post-acute providers via integration with Curaspan Discharge Central

2. Worklists alert staff of needed follow-up

3. Document in Midas+ and via an Outbound ReporTrack Document Conversion Interface information is shared as progress note in EMR

Focus Study

1. Endless opportunity to build a customized "module" to gather data for your systems needs

2. Consider using LACE scoring tool as a focus study

3. Consider doing an assessment of prior transition plan on a readmitted patient via an assigned focus study when the patient is readmitted

SmarTrack

1. Use profiles for report ease and standardization (you can't improve what you can't measure and monitor)

2. Utilizing patient tracking lists will allow you to group like patients together

3. Implementing worklists for appropriate staff will help standardize your processes and assist in not missing patients

ReporTrack

1. Ability to push reports out to managers to monitor case manager utilization, volumes, patient information, etc.

2. Schedule reports to be delivered to the desktop before arriving at work to gain efficiency

3. Use only when a "list" of multiple data is needed

Community Case Management

1. Does not need to be linked to a particular encounter (hospital or clinic), so crosses the continuum

2. Contains assessments, problem lists, etc.

3. Alerts staff when patient has had an encounter

4. Alerts when follow-up is needed to the worklist

Interfaces and Integration

1. Current integration with MCG, Interqual, Executive Health Resources, and Curaspan

2. Move your documentation to the EMR via an Outbound ReporTrack Document Conversion Interface

The Future

The best transitional care model is not about a particular model but what all of the models have in common.

Let's do this together.

Thanks for attending.
Are there any questions?

Lu Calkins, Vice President Product Operations, Midas+ Solutions
   luella.calkins@xerox.com