New Horizons in Healthcare Case Management

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Benchmarks, Metrics & Models

presented by the

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Benchmarks, Metrics & ModelsI

This special report examines the latest trends in healthcare case management, with drawn from the most recent healthcare surveys administered by the Healthcare Intelligence Network.

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Chapter 1:
2011 Benchmarks in Healthcare Case Management
Responsibilities, Results & ROI

201 healthcare organizations describe the placement, responsibilities and impact of case managers on utilization, cost and compliance.

"[The single most important responsibility of a case manager] is to follow patients through the continuum of hospital care through discharge."
> Hospital

"[The most important factor of a successful case management program] is to have a team-oriented collaborative focus on the care and management of the patient, with a coordinated effort in involving family to assist and monitor care."
> Health plan

"[The most important contribution of the case manager] is the facilitation of the appropriate transition of care that can provide the best outcome based on patient values and goals."
> Hospital

"Being a patient advocate is one main responsibility of a case manager."
> Self-insured ERISA trust

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About the Healthcare Intelligence Network

The Healthcare Intelligence Network (HIN) is an electronic publishing company providing high-quality information on the business of healthcare. In one place, healthcare executives can receive exclusive, customized up-to-the-minute information in five key areas: the healthcare and managed care industry, hospital and health system management, health law and regulation, behavioral healthcare and long-term care.

Executive Summary

Targeted case management interventions across the health continuum are resulting in more efficient and appropriate care coordination and utilization of healthcare resources.

In its second annual **Healthcare Case Management** e-survey, conducted in January 2011, the Healthcare Intelligence Network captured the details of contemporary case management and the evolving responsibilities of today's case manager. Responses provided by 201 healthcare organizations to 24 multiple choice and open-ended questions indicate that not only are more organizations utilizing case managers, but the practice of embedding case managers at the point of care has become *de rigueur*. For example, the number of case managers working in hospital admissions offices nearly doubled from 2010 to 2011.

The average case manager case load is 50-99, say 35 percent of respondents.

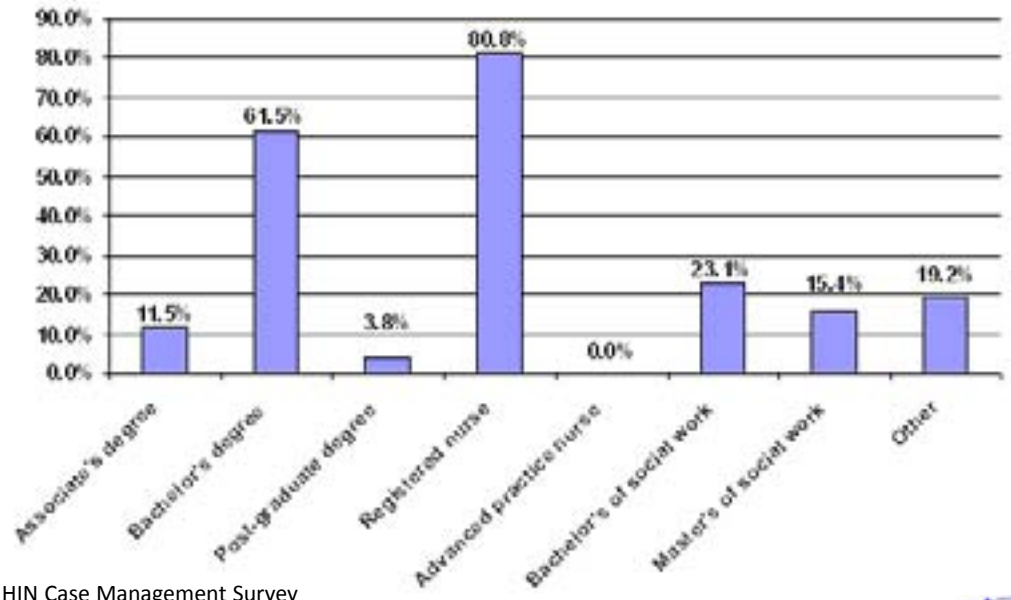
Additionally, the contemporary case manager's job description is much more likely to include home visits, crisis management and quality improvement responsibilities in 2011 than it did in 2010. New this year: metrics on case managers co-located at long-term care facilities (page 1-19) and case managers' health coaching duties (page 1-20).

2011 Survey Highlights

- Most responding organizations (91 percent) use case managers, up from 84 percent in 2010.
- Care coordination and patient education continue to be the top case manager duties in 2011, closely followed by discharge planning. Health coaching by case managers — a new area explored by this year's survey — was reported by 48 percent of respondents.

What is the preferred educational background of a case manager?

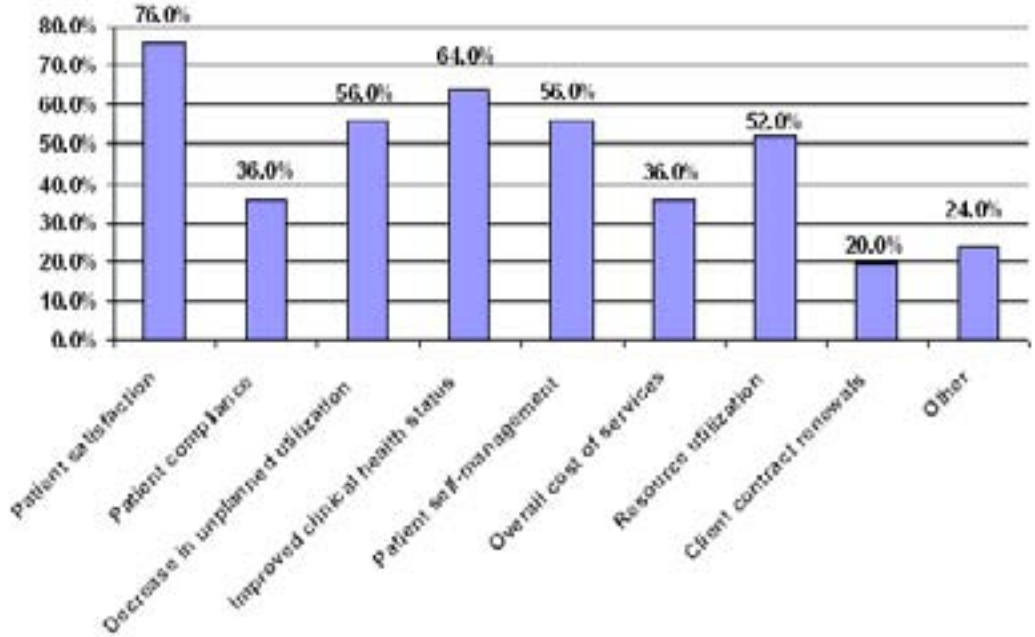
1:22: Health Plans - Case Manager Educational Background



Source: HIN Case Management Survey
January, 2011

Which of the following is considered when evaluating a case manager's performance?

1:23: Health Plans - Evaluating Case Manager Performance



Source: HIN Case Management Survey
January, 2011

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that we have major impact in improving when we use the behavior modification piece.

Survey Snapshot:

Topic: Obesity and Weight Management

Date: April 2010

Respondents: 131

Key Metric:

- ✔ 20.6% say case management is part of obesity and weight management programs directed toward children/ adolescents.

Metric 3: Obesity and Weight Management

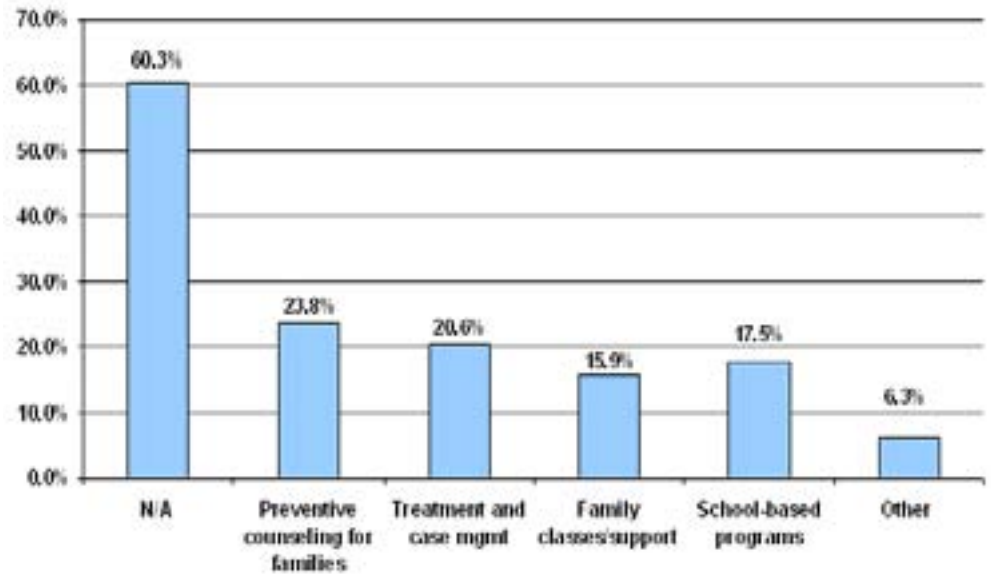
Despite early indicators of success on the obesity management front, this condition is still tied to an estimated $117 billion in healthcare costs. Not included in this estimate are indirect costs of obesity — income lost from decreased productivity, restricted activity, absenteeism and bed days. Obese individuals in the U.S. are at greater risk for chronic disease — type 2 diabetes, cardiovascular disease, hypertension, stroke and even some forms of cancer.

Nearly 21 percent of respondents to the April 2010 survey on Obesity and Weight Management said that case management is an important aspect of obesity and weight management programs for children/adolescents. (See Figure 5.) (See "For More Information.") The survey captured the steps organizations are taking to prevent and reduce obesity and related conditions and costs. Through responses provided by 131 healthcare organizations to 21 multiple choice and open-ended questions, the survey results reveal that nutrition counseling, weight management and exercise classes are the three most frequent components of organizational programs aimed at preventing or reducing obesity.

The Future of Disease Management

By Edward M. Phillips, MD, is assistant professor of physical medicine and rehabilitation at Harvard Medical School. He is director of outpatient medical services of the Spaulding Rehabilitation Hospital Network in Boston.

Figure 5: Case Management in Disease Management



HIN ©2012

Source: HIN Obesity and Weight Management Survey, April 2010

When I speak about lifestyle medicine, we like to focus on the behavior — whether someone is inactive, overeating, smoking — not the result of diseases. We also talk about using coaching from the physicians and health coaches sitting side-by-side with us, in the same

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The Medical Home Case Manager:

Profiting from Patient-Centered Care

In a new survey of healthcare organizations on the patient-centered medical home model, 60 percent of respondents include case managers on the medical home care team, with more than half of these respondents embedding these case managers within the primary care practice. An early adopter of this trend is Geisinger Health Plan. This special report provides an inside look at the selection, training, skill set, processes and benefits of Geisinger Health Plan's embedded case managers who are working on site in the payor's medical home practices.

Payoffs of Placing Geisinger Case Managers at Primary Care Sites

Diane Littlewood, RN, BSN, CDE, is a regional manager of case management for health services for Geisinger Health Plan, and Joann Sciandra, RN, BSN, CCM, is director, case management strategic planning for health services forGeisinger Health Plan..

Geisinger Healthcare System is an integrated health service organization. We are linked with providers, facilities, physician practice groups and managed care companies, which comprise the Geisinger Health Plan (GHP). We are in central Pennsylvania, and our main hospital is in Danville.

Figure 1 on page 3-2 illustrates our integrated service organization. We have over 40 community service practice sites with 700 physicians and our practice group also entertains 200 interns and a residency program as well.

The success of our patient-centered medical home (PCMH) model is from the relationship that we have with our physician practice group and the GHP. Our physician practice group brings to this model the physicians, the practice sites and the patient population. As a managed care company, we employ 70 case managers who are integral to the PCMH model. We also have a robust clinical reporting department and an actuarial department that bring success to the model. We're fortunate to be in partnership with our physician practice group.

As a health plan, population profiling and segmentation are part of our service. We use predictive modeling in profiling and segmentation, and we have case management on site. We have a disease management (DM) department with traveling nurses and a remote monitoring system for heart failure (HF) and transitions of care.

Our focus is on embedded case managers — how we choose them and train them and some of the skill sets necessary and valuable in providing case

Q&A: Ask the Experts

In this roundtable discussion, HIN's expert panelists respond to queries based on topics presented in this report.

What is a Complex Case?

Question: What constitutes a complex case?

Response: (Diane Littlewood) We use different tools, such as the driving force of the case, the presence of HF, the complexity and acuity of the case and the hospitalizations involved. The chronicity that's involved helps to identify that complex case.

Integrating the Medical Home with the Health Plan

Question: How do providers' medical homes integrate with medical plan benefits and shared success between practice and plan? Some examples would include: scope of roles and responsibilities, integration of health plan data, integration with health plan care management programs and measurements that define success.

Response: (Joann Sciandra) The key to our success has been exactly what that question raises — the integration of GHP within the primary care sites. If that integration didn't occur in the working relationship within our community practice sites, we would not be where we are today.

When we bring up a new site, we go out to the site and do an orientation. We educate everyone on medical homes and our goals. We have 10 quality metrics that the site agrees to; these metrics are reviewed throughout the year and will be measured at the end of the year. We make the whole site part of the medical home. Every individual in that site has an important role, and that's been a key to our success. The person who answers the phone is as important as the provider. We have seen a chain of success by doing it that way. At our meetings, we share metrics, readmission rates, ER per member per month, generic versus brand and ambulatory care services. We consider whether we are doing enough at a site. Sometimes we'll see some primary care sites that are low, and ask, "What do we need to do to get patients in more?" We'll look at our colonoscopy rates. "Why are they low?" "Do we need to reach out?" Having the claims makes this relationship valid and facilitates change.

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Case Managers in the Primary Care Practice: Tools, Assessments and Workflows for Embedded Care Coordination

This special report examines two parallel East Coast efforts in embedded case management: Nurse Navigators in Bon Secours Health System's Advanced Medical Home program, and Nurse Case Managers at the heart of CDPHP's Enhanced Primary Care effort.

Following in the footsteps of Geisinger Health System's embedded case manager model, both initiatives are driven by the same core desire to move from a provider-centered to a patient-centered model. Both organizations say the model is helping to reduce hospital readmissions and ER visits and tighten transitions of care for high-risk patients.

Bon Secours Embedded Nurse Navigators Transform Primary Care

Robert Fortini is vice president and chief clinical officer at Bon Secours Health System.

We are going to talk about the Clinical Transformation project underway in the Bon Secours of Virginia Medical Group. We have about 350 employed physicians at 80 locations across Virginia from Virginia Beach into the Richmond area. My team has been charged with transforming the way care is delivered.

BSMG Medical Home Clinical Transformation Project

- ✔ The goal of a PCMH is to improve quality, efficiency and satisfaction for both patients and physicians. This is done by providing prompt, cost-effective, and coordinated access to a comprehensive range of services — to provide a "**System of Care**."
- ✔ To maintain organizational "**Alignment**" with new revenue lines: "Meaningful Use," PQRI, HEDIS, ACO.
- ✔ To improve "**Capacity and Compliance**."

http://www.emmisolutions.com/medicalhome/pcpcc

Source: Robert Fortini, Bon Secours Health System

Figure 1

Figure 1 shows something everyone should be familiar with these days — the concept of a medical home. It references the principles of a medical home as crafted by the American Academy of Family Practice (AAFP). It is the basis for a number of different recognition programs, first and foremost the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition program. (See "For More Information.")

Locating Care Managers

Question: Has it been difficult to find the RN care managers?

Response: (Charlene Schlude) It hasn't. We had a fairly large case management program to begin with. We chose to deploy seasoned case managers who are already working here at the health plan on our telephonic program first. Now we will be hiring additional case managers. Then we hope to continue to backfill and train for the telephonic program, always trying to take our more established nurses. It can be sometimes difficult because it's not as if you can recruit someone with previous medical practice experience in a PCMH because it is fairly new, and there aren't many people with that experience. I have a few nurses that previously worked in a practice and worked clinically in the health plan. That was helpful because they understood the culture of a practice. You don't want to disrupt that workflow.

Case Manager Communication Methods

Question: Do the case managers use e-mail or text messaging to keep in touch with their members?

Response: (Charlene Schlude) We currently cannot e-mail our members. We are getting a new care management system in December. We will be able to e-mail. We have not been e-mailing from our current system due to confidentiality concerns, but the new system will have that capability. It will have a member portal and security built in it for that. As a health plan, we have an initiative to try and gain e-mails on our members so that we have more access to that. Text messaging is something that we are very interested in because we know that many people like to use text. The only texting we are doing is a program called Text4baby, which is for maternity cases. It is a program that we offer to people, and they just have to opt in to receive text-pushed messaging. That is the only texting technology we are using right now.

Identifying PMPM Cost

Question: Are you using any resources that help you identify where the biggest impact can be made on PMPM cost?

Response: (Charlene Schlude) That is the ROI methodology that we are looking to develop, and we are going to be working with a consultant to help us do that. In case management, if you talk nationally to people about ROI for case management, it is difficult to track or identify it because the interventions around case management are so broad and so varied from social to financial to education. It becomes challenging. We are looking for support and consulting to help us with that. It will probably be associated with a comparison of inpatient