Addressing the Needs of At-risk Populations using CMSA's Integrated Case Management: *THE* Patient-centered Care Approach

INTRODUCTION

A review of nursing literature overwhelming supports the use of a holistic approach to case management and care coordination lead by a primary case manager. CMSA's Integrated Case Management Program (ICM) provides support and training to guide the case manager in the development of trusted relationships with those they serve, cross-disciplinary training to become a better informed primary case manager, and reinforces a holistic approach needed in patient-centered care. CMSA's ICM methodology trains case managers to conduct a comprehensive assessment that systematically addresses the four domains of health, while also assessing social determinants. The information and data obtained from this assessment process allows the case manager to determine risk, and to prioritize that risk for a more effective and patient-centered care plan. CMSA's ICM program encourages a return to critical thinking and clinical judgment rather than the 'check box' approach seen in recent years. CMSA's ICM program has always been holistic and patient-centered, and stakeholders are now seeing the value in investing in this training as it also supports quality measures and regulatory requirements. Following is an article demonstrating evidence for an integrated case management approach.

The coordination of care has always been a component of healthcare but over the last decade professionals and consumers have been significantly impacted by medical errors resulting in reduced life expectancy (Lamb, 2014, p. Chapter 1). As a result of these alarming facts, the Institutes of Medicine developed a blueprint that was intended to achieve six aims: "safe,

effective, patient-centered, timely, efficient and equitable healthcare" (Lamb, 2014, pp. Chapter 1, p.2). Because of this call to action, practice professionals and the academic research community joined to create innovations and improvements. Examples include value-based purchasing plans, clearing houses for the development of quality and safety programs, and pay-for-performance which rewards providers for avoidance of adverse outcomes like readmissions and falls (Lamb, 2014, p. Chapter 1).

The intention of patient-centered care coordination is that all patients, regardless of condition, disease severity or social situation will receive the care that is needed, is delivered according to their preferences, and all providers involved in the patient's care are updated with what has been implemented (Lamb, 2014, p. Chapter 1). For individuals with more complex conditions, case management is involved to coordinate an array of care and services. This level of care goes beyond transitional care coordination. A trusted relationship is required to engage and retain the individual to realize reduced health improvements. At its core, care coordination is about collaboration and communication among providers, patients, families, and any other member of the health care team to improve the health and safety of the patient. Health care should be coordinated and integrated to include transfer of patient information. This includes safe and efficient transfers between healthcare settings. Interventions that have demonstrated effective care coordination include follow-up, case management, and integrated clinics.

To effectively coordinate care across the continuum, possessing clinical knowledge is necessary to be able to perform the role. While care coordination can be a team effort, someone must lead the team, and that someone must have the expert clinical knowledge to ensure the appropriate activities take place. CMSA's ICM program can help case managers become competent in taking on the role of the primary point of contact.

Gaps in care occur with poor communication, from delays in service delivery, over-use of resources, as well as under use of resources (Cesta, 2018). The more fragmented the care, the more likely care will not be effectively coordinated. Individuals with complex health needs are significantly at risk for poor care coordination. Most highly complex patients have comorbid medical and behavioral conditions further complicated by social barriers and find it difficult to self-manage.

Avoidance of poor care coordination, especially for patients with complex health conditions, requires a consistent point of contact (Seddon, Krayer, Robinson, Woods, & Tommis, 2013). Issues faced by patients with complex needs often transcend medical care, and definitions and role of the case manager must be established (Seddon, Krayer, Robinson, Woods, & Tommis, 2013). That single point of contact should be at the helm of a care team and perform as the captain of a ship to ensure timely delivery of care and prevention of service duplication and delay. This requires that care teams be trained in their specific role and function, and mechanisms for communication with the primary point of contact are in place (Seddon, Krayer, Robinson, Woods, & Tommis, 2013).

Care coordination and case management models vary by community, target population, and relevance to social determinants, health or diagnosis (Conway, 2016). The individual being assessed for case management intervention will have unique needs even if they are included in a targeted population. Comprehensive assessments with targeted interventions can improve health outcomes. For those with complex health conditions, care coordination, monitoring for changes, and implementation of a care plan result in benefit to the patient. When a comprehensive assessment, care planning and care coordination are provided, the overall quality of care improves, is effective at keeping the patient in their preferred environment and decreases hospital

admission (King, Boyd, & Dagley, 2017). These activities should be performed using a holistic approach with targeted interventions agreed upon with the patient. An example would be to facilitate care in the home that meets a patient's clinical needs while supporting their preference to remain in the home. According to King, the most successful case management systems include collaboration between primary and secondary care, coordination of health services and needed social services (King, Boyd, & Dagley, 2017).

Care coordination activities are typically performed by a registered nurse who is supported by a team that helps locate needed resources for the patient (Cesta, 2018). The lead case manager or care coordinator should then make sure these are shared with the patient and family and validate that these resources will meet the patient's needs (Cesta, 2018). Interdisciplinary care team rounds are an important activity to monitor and communicate the progress of a patient and to validate that the plan put in place is actually accomplishing what it was meant to accomplish (Cesta, 2018). Once the group shares any gaps in care or delays, collaboration to establish recommendations to rectify the situation are made and resources are provided. These recommendations are made to the primary case manager or care coordinator to carry out the corrections for continued efforts in health improvement. Of note, it is important to distinguish the difference between interdisciplinary or multidisciplinary rounds from an end-of-shift report (Cesta, 2018). These rounds bring key team members together to function in a collaborative fashion ensuring a patient receives appropriate services and supports (Cesta, 2018).

Care team rounds also support the development of a comprehensive care plan. Depending on the practice setting care team rounds occur weekly at a health plan, for example, or at the bedside before a scheduled transition. Regardless of the setting, case management supported by a care team, led by a primary point of contact, results in improved patient safety,

efficiency, transparency to the patient and family, and the treatment team, and is the key driver of improved outcomes (Cesta, 2018).

Care planning with targeted care coordination and facilitation are integral to improving the quality of care. These activities are included as quality metrics for Medicare Access and CHIP Reauthorization, known as MACRA. MACRA was signed into law in 2015 and became effective in April of 2016 (Ma, May, Knotts, & DeVitto Dabbs, 2018). Under MACRA, Medicare Part B reimbursement shifts from fee-for-service (F4S) to pay for performance (P4P) to encourage and incentivize efforts to reduce cost and increase quality with several provisions directly tied to care planning and care coordination (Ma, May, Knotts, & DeVitto Dabbs, 2018), MACRA defines payment models that reward providers who meet criteria in Quality Advance Care Information Resource Use and clinical improvement (Ma, May, Knotts, & DeVitto Dabbs, 2018).

The Agency for Healthcare Research and Quality (AHRQ) focuses on specific care coordination activities. AHRQ's Care Coordination Measures *Atlas* guides stakeholders in achieving how and when specific care coordination measures were carried out (AHRQ, 2014). The *Atlas* defines key domains that include care coordination activities and the approach related to the activities. For example, care coordination activities may include the establishment of accountability, assessment of needs and goals, or linkage to community resources (AHRQ, 2014). The approach examined may include care management or teamwork focused on care coordination (AHRQ, 2014).

The National Commission for Quality Assurance (NCQA) provides accreditation standards for health plans, providers and provider practice performance using Healthcare Effectiveness Data and Information Sets (HEDIS). The measures examine effectiveness, access

and availability of care, utilization, risk adjusted utilization, and measures collected using electronic clinical data systems (NCQA, 2018). Health plans, providers and practices report, using HEDIS measures, on the rate of their respective population's access to identified services like childhood immunizations or breast cancer screening; access to care such as regular prenatal care or annual dental visits; utilization of care such as child well care or mental health visits; risk adjusted utilization for the number of all-cause readmissions or emergency department utilization; and measures using electronic clinical data systems like evidence of depression screening and follow-up or unhealthy use of alcohol screening (NCQA, 2018). NCQA uses the data to issue accreditation but also aggregates the data to provide quality ratings for health plans, a Quality Compass and the State of Healthcare Quality Report (NCQA, 2018).

The Centers for Medicare and Medicaid (CMS) have also directly linked reimbursement to quality patient outcomes. CMS defines meaningful use measurement for transitions of care requiring a summary of the care record to accompany a patient from one setting or provider to another (Medicaid, 2014). CMS requires demonstration of at least fifty percent of transitions have a summary of care record that follows the patient (Medicaid, 2014). The caveat with this measure is the requirement that only patients whose records are maintained using an EHR are included in the measurement. To meet the requirement, providers and organizations must be able to receive and transmit care and referral summaries electronically (Medicaid, 2014).

Care coordination and those that are responsible for these activities, whether identified as case managers or care coordinators, need to be holistically assessing the individual for what is important to the individual, what are their preferences, and what social barriers may interfere with improved health (Hughes, Chester, Sutcliffe, Xie, & D., 2015).

Care coordination and who performs can mean different things to different people; there are multiple definitions of care coordination. But successes in care coordination are dependent on the perspective of the patient and family, health care professional, or the healthcare system, and while those perspectives may differ, the most important perspective is that of the patient and family because if their needs and preferences are met, if they are well informed, the patient will experience health improvement.

CMSA's Integrated Case Management Program supports care coordination and transition activities because of the holistic and relationship-based approach. Integrated case management resulted in reduced ED visits and hospitalization for Fallon Community Health Plan in Worcester, Massachusetts according to *Case Management Advisor* (Case Management Advisor, 2012). Behavioral health specialists from the interdisciplinary team are consulted for available Fallon Community Health Plan includes a behavioral assessment with medical assessments, and then a behavioral health specialist is consulted for available treatment options. This strategy has resulted in fewer inpatient days, ED visits, and reduced use of unplanned medical care (Case Management Advisor, 2012).

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