New Opportunities for Case Management
Leadership in our Changing Environment

2012 ACMA Kentucky/Tennessee Chapter Case Management Conference
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Partners in Care Foundation
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Agenda

- The ACMA - a Strong Base
- Partners in Care Foundation
  – Who we are
- A Practice Framework
- Impact of Case Management
- Rapidly Changing Health Care Environment
- How Case Management Perspective Can Lead and Staff the Needed Changes
Leadership Strengths of SSWLHC

ACMA...A Strong Base

- Value of Peers
- Platform for building and sharing best practices
- Case Management – key to patient centered practice
- We have indirect power, and can mobilize leadership and resources from others
- Move leadership from cases to systems
- OCCUPY HEALTHCARE!
Partners in Care

Who We Are...

- A transforming presence, an innovator and an advocate to shape the future of health care
- We address social, environmental, and self-care determinants of health to broaden and sustain the impact of medicine
- With a two-fold approach – evidence-based models for practice change and for enhanced self-management
- Changing the shape of health care through new community partnerships and innovations
Partners in Care

Who We Are...

- We focus on leveraging opportunities for change by targeting:
  - Large populations
  - Reducing suffering -- bad outcomes
  - Costly conditions
  - Opportunities for change -- a meaningful idea and promising partner(s)
The Time for Interdisciplinary Leadership is NOW – Dramatic Scale of Change

- Moving away from hospital-centric care
- Home and community as the locus of care
- Proactive population health management
  —The power of measurement and HIT
- Rapidly changing safety net
- Growing demand for alternative approaches and innovations in care
- Mandated changes (CMS / ACA/Duals demos)

TESTING, TESTING by Atul Gawande
http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande
Moving to Integrated Care – Beyond Silos

- The current system is **fragmented and episodic** while the big issues are **chronic** conditions.

- This creates chasms that patients fall through.

- Some silos are within organizations, especially large ones – and some between sites of care.

- We need to build bridges together and align incentives – Use patient stories and track outcomes to guide the redesign.
What Can I Do?

- Case management is not always in the C suite
- But we have skills in building relationships, in helping people re-frame their views - bringing new information, new questions, promising changes
  - We have patient stories & can gather data
- We have a supportive external changing environment – federal leadership is racing along – in our direction..
Case Management Travels Across the System With the Patient

- But even we need better integration
- Get feedback from the next setting – how did my linkages for the patient work?
- Continuing QI for continuity and outcomes
- We have a story they may not want to hear – it is not more medicine that will drive better population health – IT IS ADDRESSING THE WHOLE PERSON IN ENVIRONMENT – outcomes are patient driven
The Expanded Chronic Care Model:
Integrating Population Health Promotion
Ecological Social Work Practice Framework: A Perfect Fit for Health Reform

Enduring Social Work Framework

State & National Policy
Community Resources & Partnerships
Institutional Practices
Other Caregivers
Patient/Family
Social Determinants of Health at different ecological levels

**Psychosocial determinants**
- Participation in civic activities and social engagement
- Strong social networks
- Feelings of trust
- Feelings of power and control over life decisions
- Supportive family structure
- Positive self-esteem

**Other individual-level determinants**
- Decreased drug & tobacco use
- Regular physical activity
- Safe sexual activity

**Community Determinants (Protective)**
- Safe and healthy physical environments
- Supportive economic and social conditions
- Open and stimulating learning environments
- Supply of nutritious food and water
- Availability of affordable housing
- Availability of meaningful, paid employment; flexible & supportive work environments

**Biophysical determinants**
- Genetic risks
- Physical disabilities
- Neurological disabilities

**Early learning & child care determinants**
- Encouragement of exploration
- Mentoring in basic skills
- Celebration of developmental advances
- Guided rehearsal and extension of new skills
- Protection from inappropriate disapproval, teasing or punishment
- A rich and responsive language environment

*encompasses a wide variety of knowledge, skills, and behaviours such as those surrounding pre/post natal care, nutrition, life skills, parenting techniques, etc.

**Parenting-focused individual determinants***
- Parenting knowledge
- Parenting skills
- Parenting behaviours

**Community Determinants (Risk)**
- Poverty & low social status
- Dangerous work
- Polluted environment
- Natural resource depletion
- Discrimination (age, sex, race, disability)
- Steep power hierarchies

**System level**
- Comprehensive social programs
- Universally available/accessible
- Integration of cross-sectoral programs & policies
- Community driven
- Quality
- Accountability
The Need for Case Management Leadership – Unique Strengths

- Dramatic changes in the shift from hospital to primary care and home and community-based care
- Requires understanding community culture
- Requires understanding regulatory requirements
- Requires multicultural approaches
- Requires understanding the different approaches to learning and doing
- Requires an understanding of different practice settings and linking them into collaboration
We are in a position to encourage leadership in major systems

- We can see the opportunities for change
- We can gather key people to collaborate
- We can encourage others to lead needed change
- It takes time….persistence…..identifying and addressing barriers to change

And it takes a business case
Shift to Population Health Management

Healthy Aging – the new longevity

*Some Core areas of work and leadership:*

- Health reform through population health management – prevalence rates/disparities
- Prevention, evidence-based leadership for community health --healthier living & self-management
- Coordination of care/Proactive care
- Patient safety – medications management
- Decision support – support for informed choice
Rapidly Changing Health Care Environment

- Growing demand for alternative approaches and innovations in care
  - ACOs
  - Community based organizations - home
  - Prevention/link with community resources
  - Home focus: Comprehensive Assessment: Transition Coaching/HomeMeds
    - Complex Care Coordination
    - Home Palliative Care/late life care
Disease Prevention / Health Promotion (DPHP)

There are resources longing for you to partner
Draw in Area Agencies on Aging & others in the Community

Evidence-based growth of enhanced self care
Evidence-based standards and sources

Reaching those who will benefit:

the Wellness CLUB
A program of Partners in Care Foundation™
Mobilizing self-care

- Lifestyle change is crucial
- Evidence-based brief models are spreading
- Our job is to find and connect those in need
Evidence-Based Programs

Self Management Programs
– Chronic Disease Self Management Program (CDSMP)
– Tomando Control de su Salud

Physical Activity / Fall Prevention Programs
– A Matter of Balance
– Active Start
– Arthritis Foundation Exercise Program
– Arthritis Foundation Walk with Ease Program

Caregiving / Memory Programs
– UCLA Memory Training
– Powerful Tools for Caregivers
– Savvy Caregiver
Rapidly Changing Health Care Environment

*Public Funding Changes – less and new*

Partners is meeting the demand with rapid deployment of care coordinators and software systems to address:

- Transitioning to managed care
- Providing health risk assessment and care coordination
- Redesign to link medicine and community systems
California Examples of Payment Redesign

- Seniors and Persons with Disabilities
- Duals Demonstration
  - Shifting costs of SNF and Medicare
  - Modifiable risk factors to stabilize
  - Alternatives to ER, Hospital and SNF
- Building an Integrated Community Care System
# Health Risk Assessment

## Demographics

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## Cognitive Function

1. **Cognitive Function**: 
   - **Yes**
   - **No**
   - **Don't know**

## Vision Function

1. **Vision Function**: 
   - **Yes**
   - **No**
   - **Don't know**

## Hearing Function

1. **Hearing Function**: 
   - **Yes**
   - **No**
   - **Don't know**

## Health Conditions

1. **Current Medications**: 
   - **Yes**
   - **No**
   - **Don't know**

## Health Habits

1. **Healthy Eating**: 
   - **Yes**
   - **No**
   - **Don't know**

## Caregiver Assessment

1. **Caregiver Present?**: 
   - **Yes**
   - **No**
   - **Don't know**

2. **Caregiver Information**: 
   - **Name**
   - **Relationship**
   - **Phone Number**

3. **Number of Caregivers?**: 
   - **Yes**
   - **No**
   - **Don't know**

4. **Support System**: 
   - **Yes**
   - **No**
   - **Don't know**

## Advance Directives

1. **Advance Directives Completed?**: 
   - **Yes**
   - **No**
   - **Don't know**

2. **Living Will**: 
   - **Yes**
   - **No**
   - **Don't know**

3. **Durable Power of Attorney**: 
   - **Yes**
   - **No**
   - **Don't know**

## Partners in Care Foundation

Changing the shape of healthcare.
Powerful, proven innovations draw on social work and nursing expertise

- Helping hospital and home health track post-discharge outcomes
- Addressing reducing avoidable readmissions – over time, avoiding admissions
- Building collaboratives
- Working with CBOs – community based organizations
Reducing Hospital Readmissions

- 19.6% of Medicare, 16.5% of Medicaid patients are readmitted within 30 days, costing over $15B annually
- A large percentage of re-admissions are “potentially” avoidable
- CMS guidelines have suggested that future reimbursements will be reduced for readmissions, especially those considered potentially avoidable
- Most State Medicaid programs are following CMS lead
Transitions: A community shared transformational initiative (CTTP)

- Post-hospital changes must include multiple partners
- A defined community with standardized information flow/standards of care
- Redefine discharge plan/SNF/home health
- Addition of the new “bridge to home” for post-hospital patient coaching and support
Westside Care Transitions Collaborative

Post Acute Support System
PASS® Care Transitions

UCLA Health System
(Hospitals & Faculty Practice Group)

Partners in Care Foundation
(Community-Based Organization)

St. John’s Health Center

Santa Monica UCLA Medical Center

Skilled Nursing Facilities

In Home Medical / Hospice & Palliative Care

Home Health / Private Duty

Behavioral Health

Wise & Healthy Aging

Homeless Housing & Medical Care

Other Collaborative Members
Hospital Transitions: The Coaching Model

- Transition care initiated in the hospital and followed home by Community Coaches
- Daily interaction with hospital case management, social services and other appropriate staff
- Interaction with patient:
  - Face-to-face during inpatient admission
  - Face-to-face at Home post discharge (48 – 72 hours)
  - Telephonic, day 2, 7, 14 & 30 post discharge
Medication Safety: HomeMeds℠

- Developed through funding from the John A. Hartford Foundation and the U.S. Administration on Aging
- HomeMeds℠ is designed to enable community agencies to keep people at home and out of the hospital by addressing medication safety
- Social workers can inventory and report
- Practice change with workforces/settings that already go to the home – more cost effective use of existing effort
Medication Safety: HomeMeds℠

- **In-home collection** of a comprehensive medication list with notes on how each drug is being taken, plus vital signs, falls, symptoms, and other indicators of adverse effects

- **Use of evidence-based protocols** and processes to screen for risks and deploy consultant pharmacist services appropriately

- **Computerized medication risk assessment** and alert process with comprehensive report system

- **Consultant pharmacist** addresses problems with prescribers
Another Key Focus -- The Last Year of Life

- Encouraging and leading decision support
- Training other disciplines
- Providing platforms for self-determination
- Care at home
Home Palliative Care – A New Model of Care

- Developed with Kaiser / Dr. Richard Brumley
- In-Home Palliative Care
  - Hospice – a big decision
  - Communication in need of major training
- Key elements of our model
  - Trust in home care team
  - Call Center 24/7
  - Decision support

LETTING GO:
http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande
Better Care and Better Costs

- With Random Control Trials in 2 additional states:
  - Patient and Family Satisfaction UP
  - Provider Satisfaction UP
  - Costs DOWN – average of 30%
Advanced Illness Coordinated Care (AICC) Program, developed by Dr. Dan Tobin

Designed to:

- Targets specific diagnoses for appropriate advanced care planning
- Offer in home counseling
- Reduces the rate of patients dying in the hospital by providing patients the opportunity to spend the end-of-life in the setting of their choice;
- Empowers patients to become more proactive in the delivery of their end-of-life health care services
AICC Program Design

The program consists of a 3-month intervention of up to 6 in-home counseling visits, focusing upon:

- Relief of death anxiety (counseling component)
- Informed decision making about therapeutic options and communication with surrogates, family members, caregivers and health care providers
- Identification of opportunities for improved care coordination
Physician Orders for Life-Sustaining Treatment (POLST)
Community-Based Care

Our Methods of Change

- Inspire partnerships with community-based organization (CBO) for CMS grant to fund innovations in care transitions
- Active role in root cause analysis and community strategic planning for transformational change
- Vision/Persistence/Shared Voices
Closing Thoughts

- Rapidly changing healthcare
- Natural time for case management engagement and leadership
- We have the values and framework needed, and must build allies to voice and help lead the needed changes
For more information visit our websites:

www.picf.org
HomeMeds.org

Handouts of today’s presentation are available online:

www.picf.org>Events>Presentations