

Charting the Future of Primary Care: Care Coordination/Case Management

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Overview of the Presentation

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 - History
 - Models
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- Scope of Chronic Conditions
- Medicare Beneficiaries and Chronic Conditions
- MCCPRN
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History of Care Management

Early 1900s

- Public health nurses and social workers coordinated care through the Department of Public Health

Mid 1900s

- US government hired practitioners to assist World War II soldiers with complex injuries
- Insurance companies employed nurses, social workers and vocational rehabilitation counselors to manage medical and worker compensation costs



History of Care Management

- *Late 1900s*
- Medicaid and Medicare demonstrations and community programs developed case management services for defined populations in the community (e.g., mentally ill, developmentally disabled, low income, frail elderly)
- Older Americans Act authorized case management for elders through Area Agencies on Aging across the U.S.
- Health insurers developed case management programs for the catastrophically ill or injured
- Acute care hospitals, home care agencies, rehabilitation facilities and skilled nursing facilities developed case management services

Models of Care Management



Types

- Primary Care Case Management
- Medical/Social Case Management
- Private Case Management
- Nursing Case Management

Models

- Hospital-Based/Acute Care Models
- Community-Based Models
- System Models
- Managed Care Models

Several Definitions of Care Management

- The Case Management Society of America (CMSA) states:

“Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes”

Source: Case Management Society of America, 2002, p. 5.



CCMC Definition of Care Management

- The Commission on Case Management Certification (CCMC) defines case management as follows:

“Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.”

Source: CCMC, n.d. para 1

ANCC Defines Care Management

The American Nurses Credentialing Center (ANCC) is the credentialing arm of the American Nurses Association. They state:

“Nurse case managers actively participate with their clients to identify and facilitate options and services, providing and coordinating comprehensive care to meet patient/client health needs, with the goal of decreasing fragmentation and duplication of care, and enhancing quality, cost-effective clinical outcomes. Nursing case management is a dynamic and systematic collaborative approach to provide and coordinate health care services to a defined population. Nurse case managers continually evaluate each individual's health plan and specific challenges and then seek to overcome obstacles that affect outcomes.”

Source: ANCC (2008), para. 1.

ANCC Definition, continued

“A nurse case manager uses a framework that includes interaction, assessment, planning, implementation, and evaluation. Outcomes are evaluated to determine if additional actions such as reassessment or revision to a plan of care are required to meet client’s health needs.”

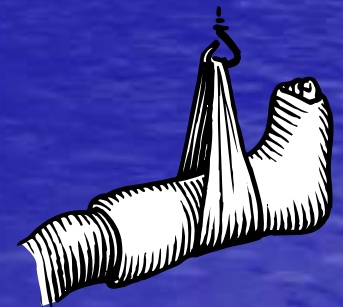
To facilitate patient outcomes, the nurse case manager may fulfill the roles of advocate, collaborator, facilitator, risk manager, educator, mentor, liaison, negotiator, consultant, coordinator, evaluator, and/or researcher.”

Source: ANCC 2008, para. 1

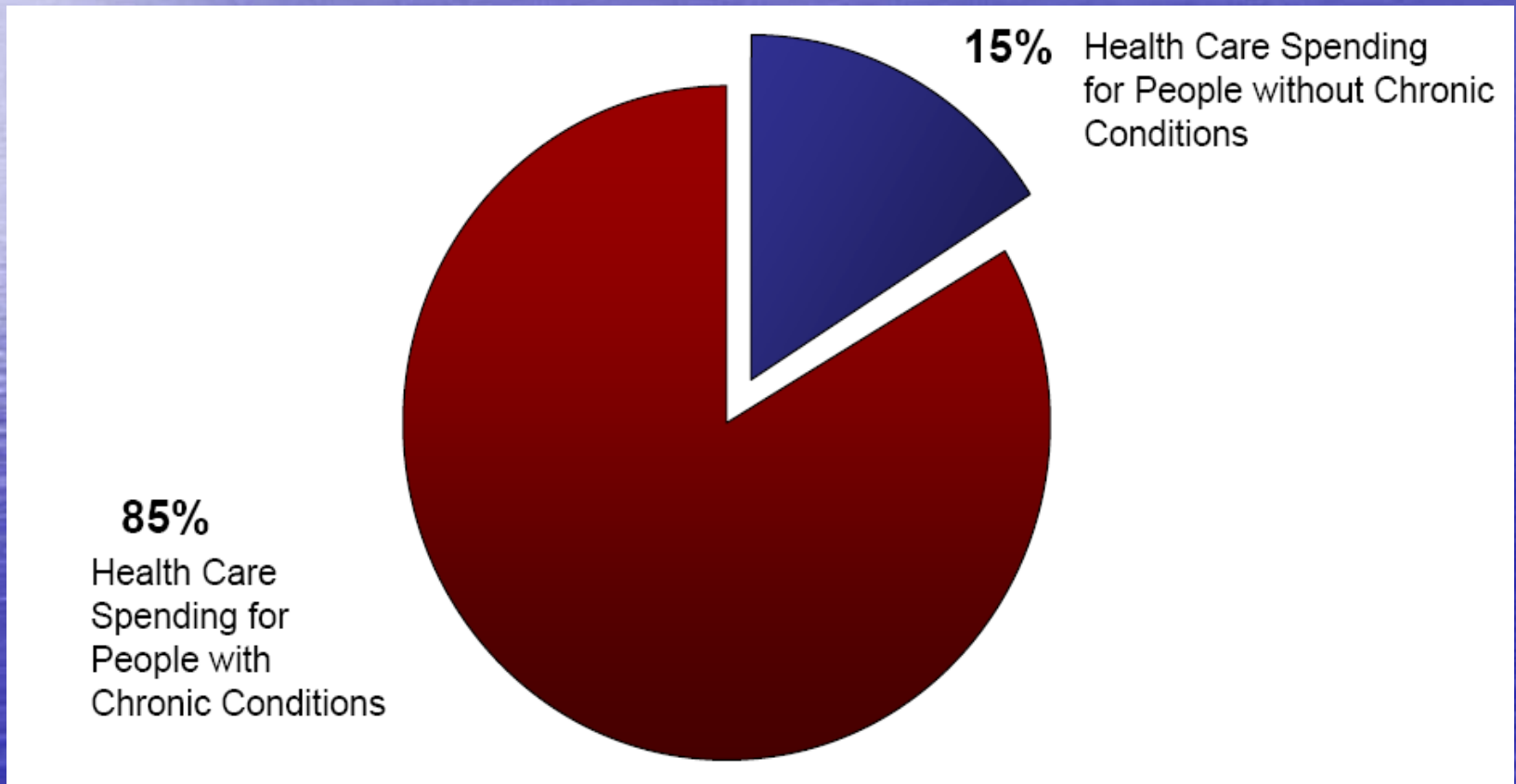


Number Of People With Chronic Conditions

- In 2000, 125 million Americans had one or more chronic conditions
- This number is projected to increase by more than one percent each year through 2030
- Between 2000 and 2030, the number of Americans with chronic conditions will increase by 46 million people

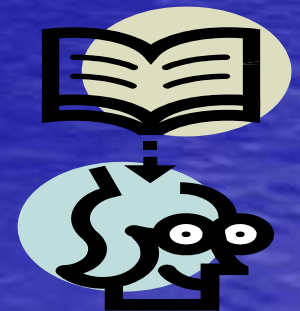


Chronic Conditions And Health Care Spending In 2004



The Impact Of Chronic Conditions On Individuals, Their Caregivers, And Physicians

- People with chronic conditions report not receiving adequate information
- More than half of people with serious chronic conditions have three or more different physicians
- People with serious chronic conditions believe they do not receive needed treatment
- People with serious chronic conditions have trouble accessing specific services



The Impact Of Chronic Conditions On Individuals, Their Caregivers, And Physicians

- In treating patients with chronic conditions, physicians believe their training did not adequately prepare them to:
 - Coordinate in-home and community services
 - Educate patients with chronic conditions
 - Manage the psychological and social aspects of chronic care
 - Provide effective nutritional guidance
 - Manage chronic pain

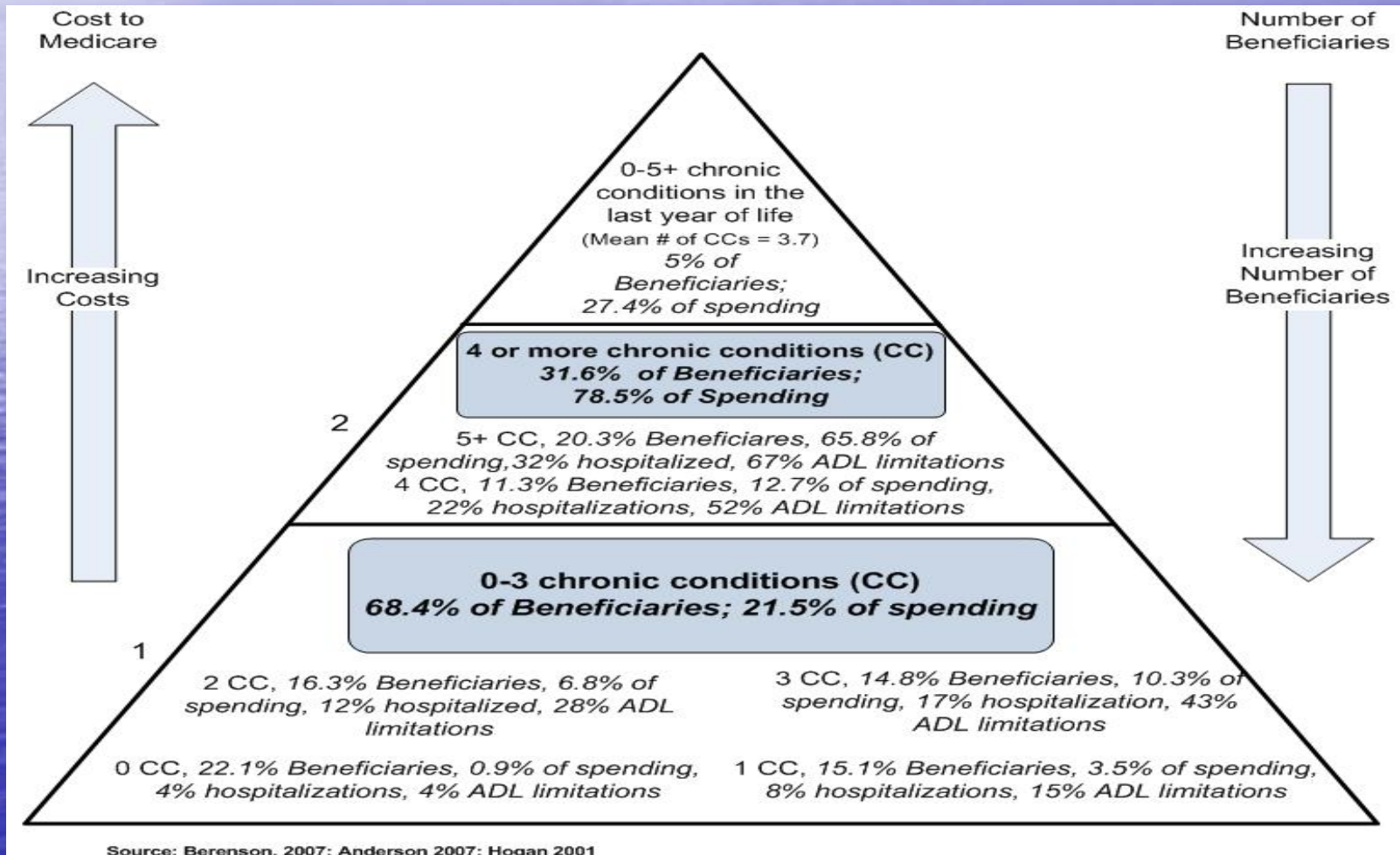


Problem

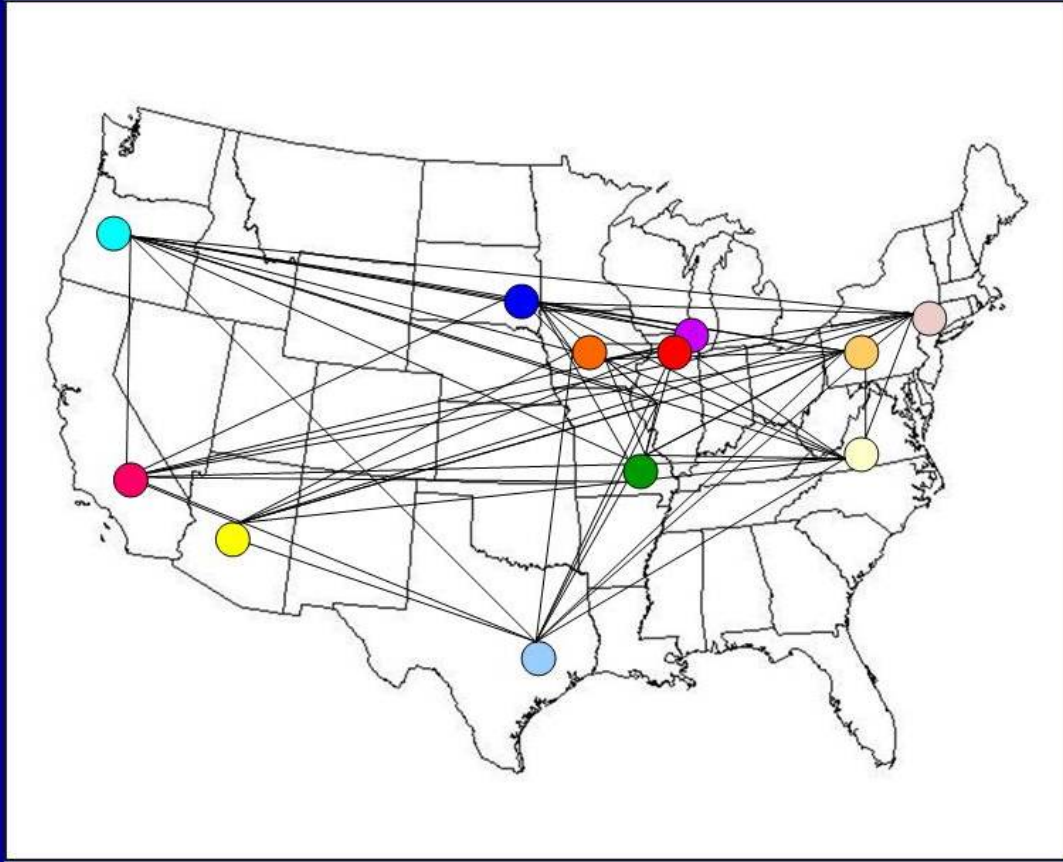
- Total Medicare spending was over \$370 billion in 2006 (CBO, 2007), and is predicted to exceed \$420 billion by 2009
- 75% of high cost Medicare beneficiaries diagnosed with a major chronic condition (CBO, 2001)
- 70% of inpatient spending was for beneficiaries with a chronic condition



Medicare Beneficiaries By Level Of Need



MCCPRN Network Members



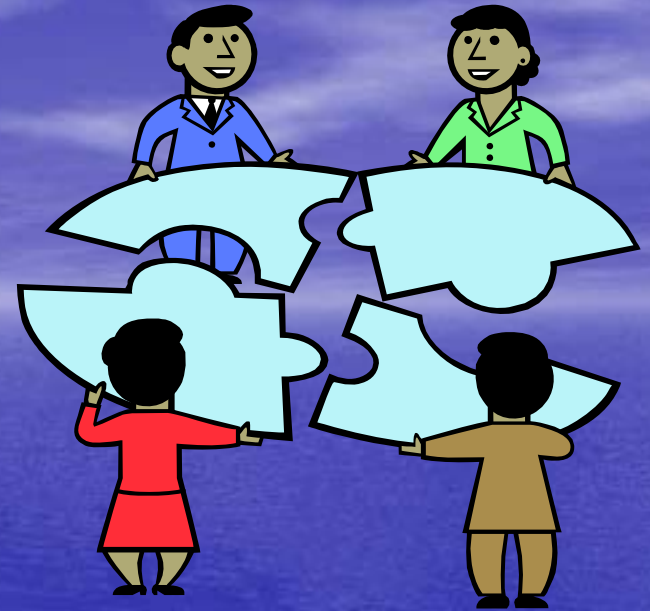
Mission and Purpose

- Develop, execute and evaluate innovative, evidence-based chronic care initiatives focused on high cost, comorbid, fee-for-service beneficiaries
- Serve as leading national resource to advance the science and operational standards of care management



Goals

1. To *identify* the most challenging and high cost (due to their complex, interacting chronic illnesses) Medicare beneficiaries;
2. To *improve* our understanding of which specific interventions and related operational process adjustments can achieve the greatest positive benefit at the lowest possible cost by efficiently researching, designing, implementing, testing and validating better ways to provide care management for these complex chronically ill Medicare beneficiaries;



Goals

3. To *provide* a reproducible, reliable and scalable framework to implement effective standardized care management services nationwide by continually updating best practice processes and guidelines for care of complex chronically ill Medicare beneficiaries; and
4. To *implement* a comprehensive and dynamic evaluation strategy by identifying new methods and metrics to quickly assess the impact of developments in care management components that have implications for current or future policy.



Issues for Ongoing Research

- What is the optimal target population
- Should there be episodic vs. continuous enrollment
- How should transitional care intervention be incorporated
- How do we provide care coordination as efficiently and effectively as possible
- What mix of medical care interventions and social service supports is most efficient
- What is the most effective staffing model
- What is the optimal caseload
- What financing mechanism should be put in place

Reference List

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