Society for Social Work Leadership in Health Care Conference

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Integrating Care Coordination: Strengthening the Continuum

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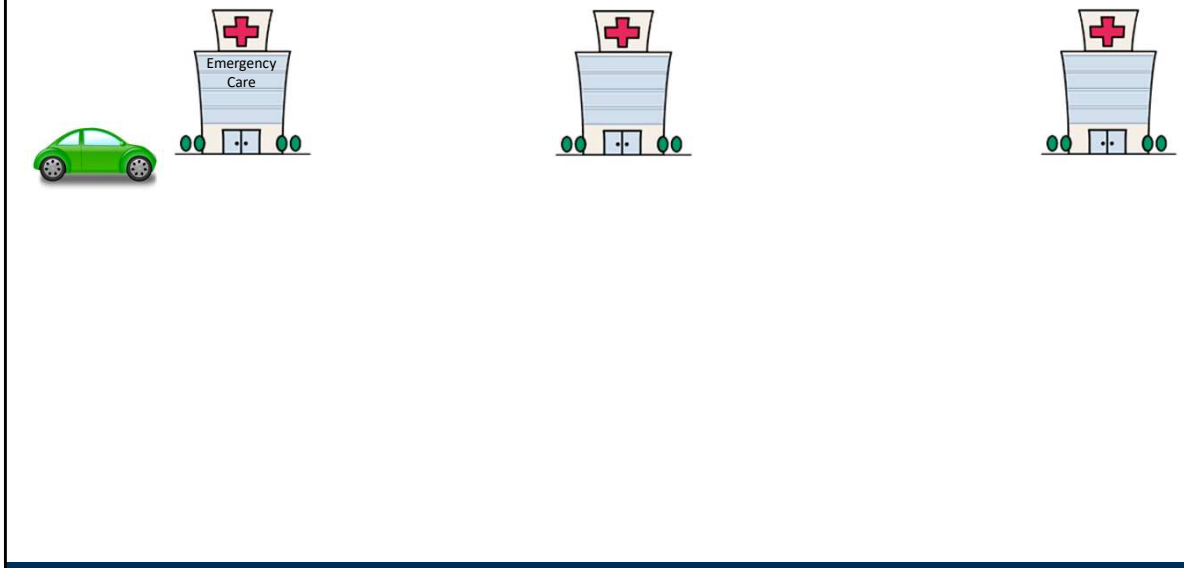
Learning Objectives

1. Identify one difference between the traditional case management approach and the integrated approach to case management.

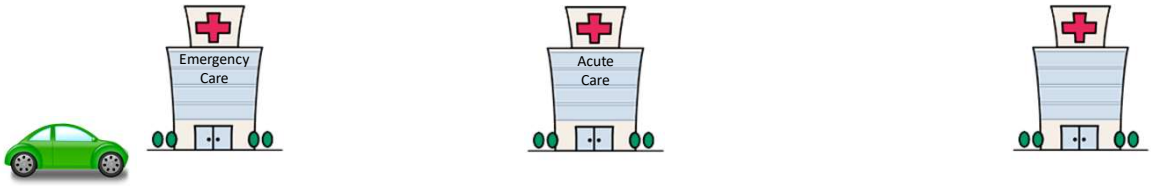
2. Describe two differences between care coordination, care management and case management.

3. Identify two benefits resulting from the CC&ICM framework's implementation.



Story—

People are vulnerable when they move between different parts of the health care system.(Click)



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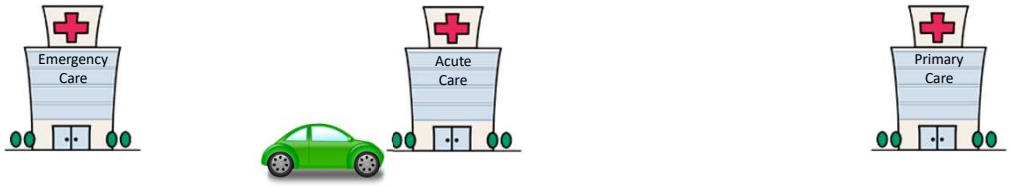
Care transitions threaten patient safety as they can increase the possibility of losing critical clinical information and require an increased degree of coordination. (Click)



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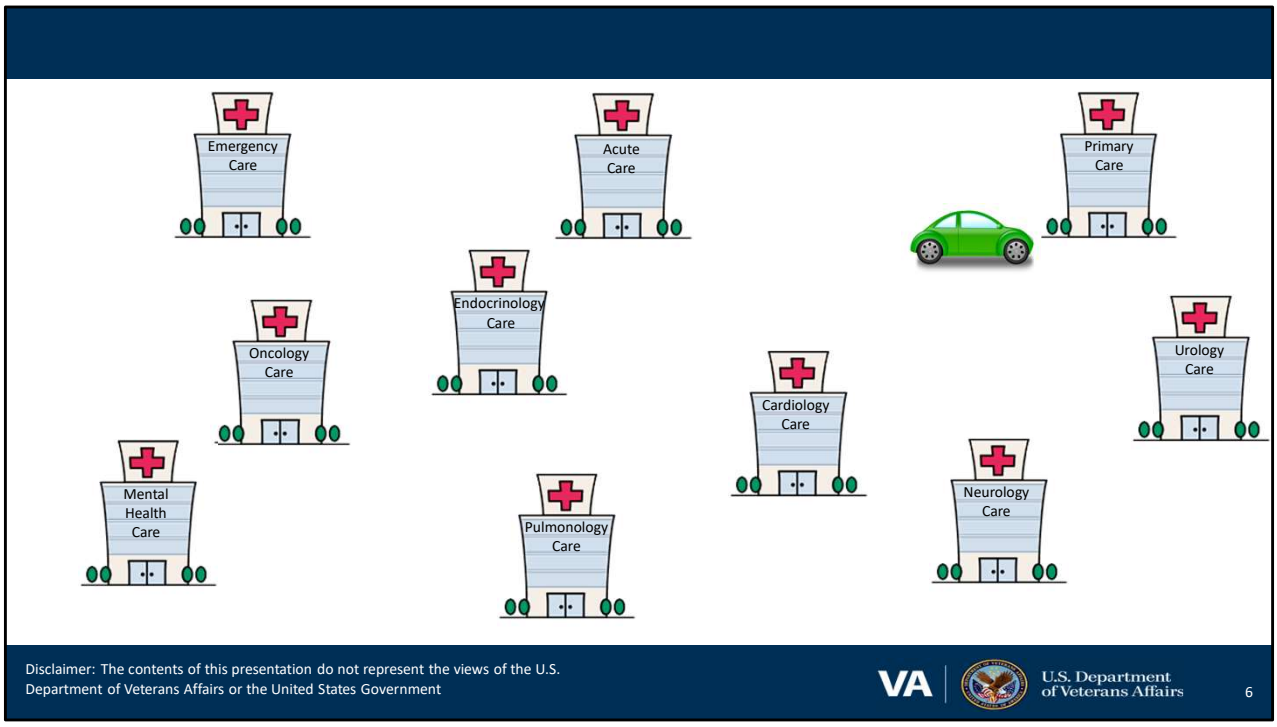
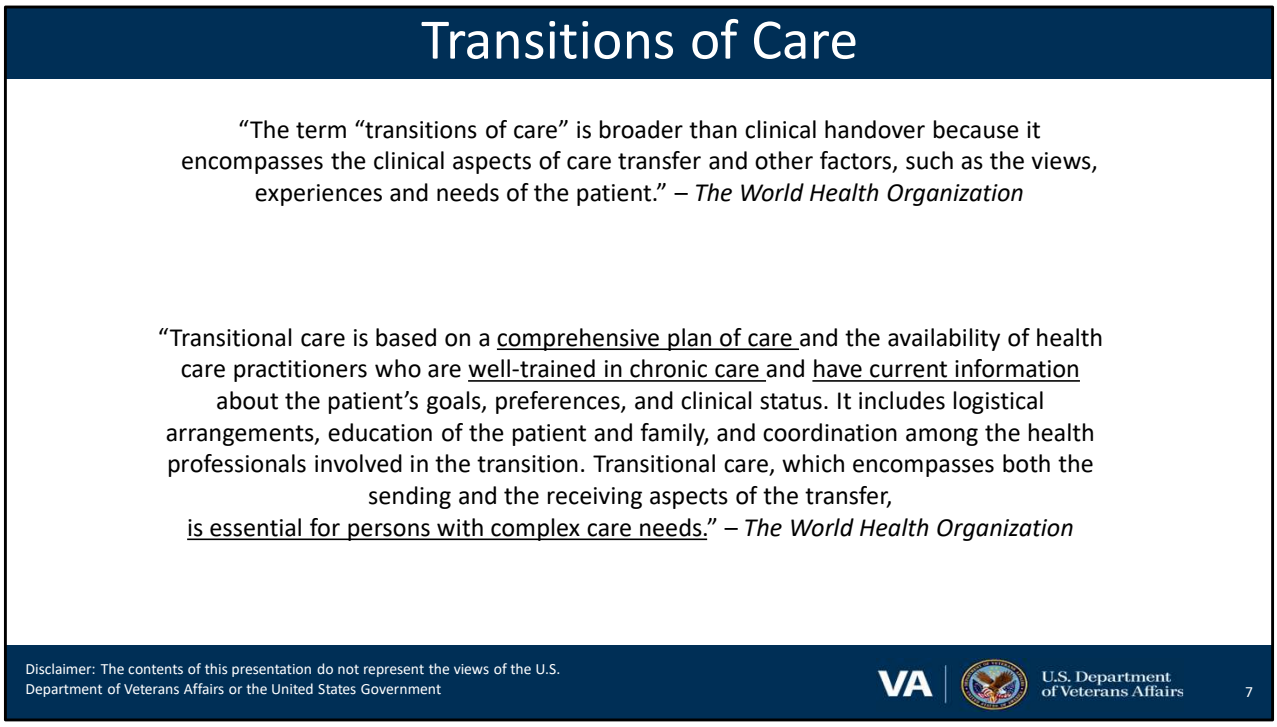


Those persons with complex health issues are most likely to undergo multiple transitions of care not only from primary care to the ED or acute care but also to specialists like oncology, cardiology, urology, endocrinology, mental health, neurology, pulmonology not to mention the in home care providers, physical therapists , etc. And with each one of these transitions there are potentials for potholes without good care coordination. They can easily get confused with who to call for what health issue or need or to communicate symptoms.

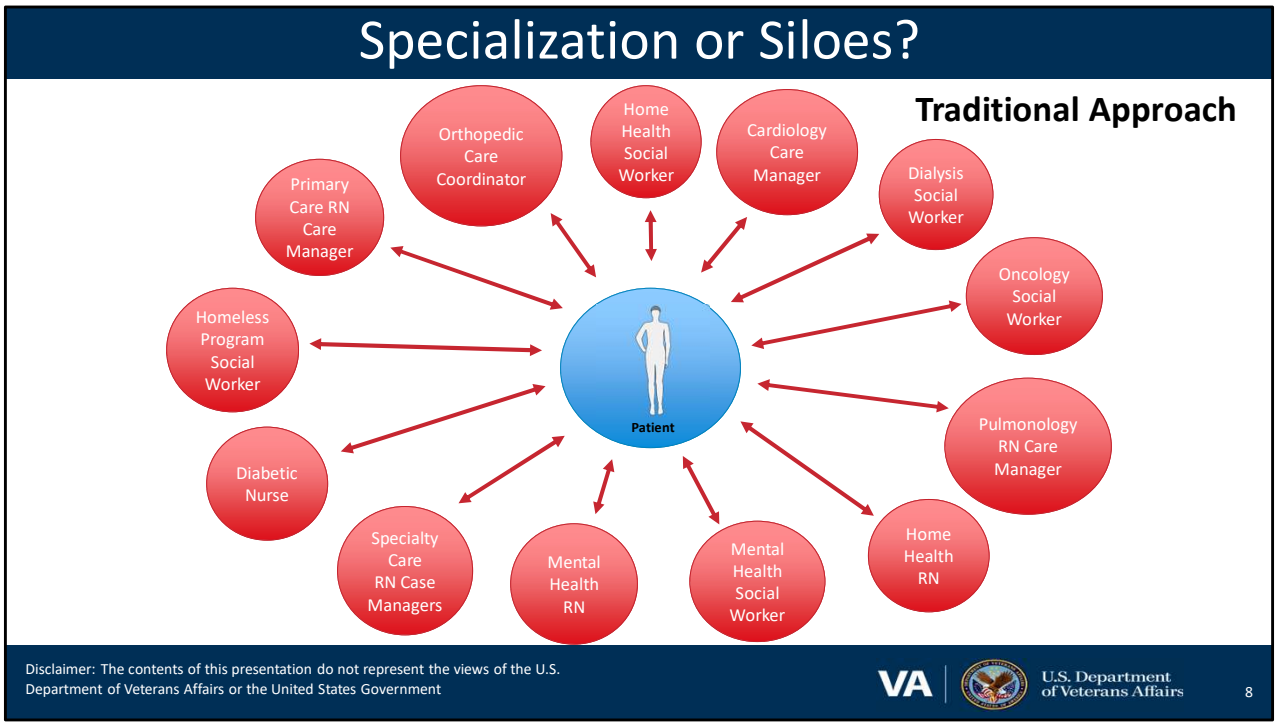
Despite the VHA being an integrated health care system nationally, the VHA experiences its fair share of care coordination challenges. Between 2014 and 2019, annual appointments for VA increased by over 3.4 million with over 58 million appointments in VA facilities in FY 2018 (MISSION ACT 101: How the law will improve VA's ability to deliver health care to Veterans - VA News) . With the MISSION Act of 2018, VHA was able to consolidate its community care programs into a new program that made it easier for Veterans and their families to navigate and allowed for greater access to community health care resources. So like other private sector health care systems, we too are faced with not only facilitating transitions between our own care

programs, but coordinating services with a larger network of community providers and resources on a much broader scale.



In a technical series on Safer Primary Care, The World Health Organization stated, The term "transitions of care" is broader than clinical handover because it encompasses the clinical aspects of care transfer and other factors, such as the views, experiences and needs of the patient."

They go on to state, "Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs"



Our health care systems and we as professionals have become highly specialized in our care of patients. We select tracts of learning in our education. We train in those specific areas to develop expertise at treating that specific component. We work within interprofessional teams that have individually trained in their specialty areas.

But, remember our Gestalt theory, the whole is greater than the sum of its parts? Well, our patient is NOT just a sum of his or her parts. They are a whole person with individualized motivations, purpose and aspirations that are receiving these specialty services. The traditional approach to case management is …..having a case manager, nurse navigator,, care coordinator, care manager, whatever the facility wants to call it in each specialty area from which the patient receives care coordination services. That includes phone calls from each different specialty, treatment plans for each specialty, medications or therapies from each specialty area, and so on. This leaves the patient with the need to coordinate care on their own. And for our patients with complex care needs, we wonder why they disengage or feel overwhelmed. That's a lot of work!

Impact of Fragmentation

SYSTEMS

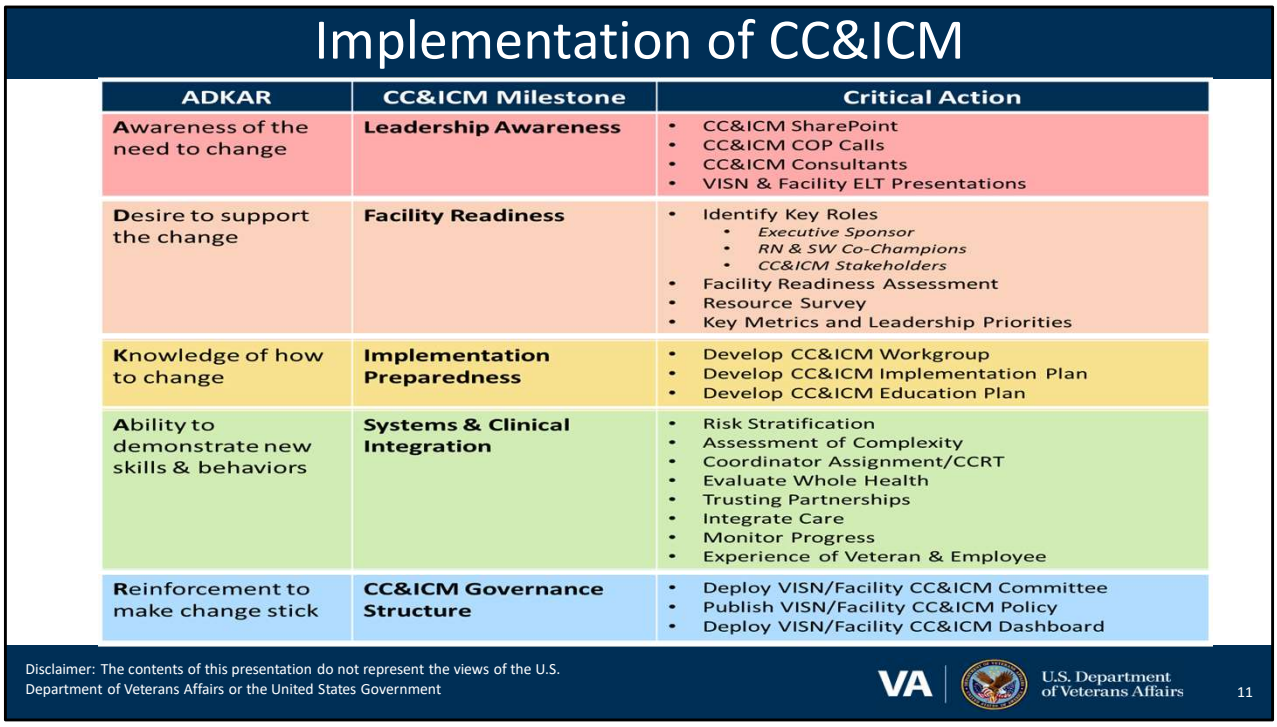
- Increase Veteran safety risk
- Sicker Veteran populations
- Silo approach to care
- Unwanted variation
- Broken communication
- Missed opportunities
- Veteran and employee frustration
- Systems waste
- Duplication of services
- Inefficient human capital
- Increased avoidable utilization of costly care
- Increased cost of care

CLINICAL

- Veteran and employee frustration
- Broken clinical processes and delays in care
- Fragmented and siloed plans of care
- Duplication of services, often sending competing information
- Veteran lacks consistent message received
- Increased Veteran confusion
- Veteran non-adherence
- Increased emergent/urgent care utilization
- Negative impact on health outcomes
- Increased costs of care for both Veteran and organization
- Increased Veteran stress and strain on quality of life

Return on Investment

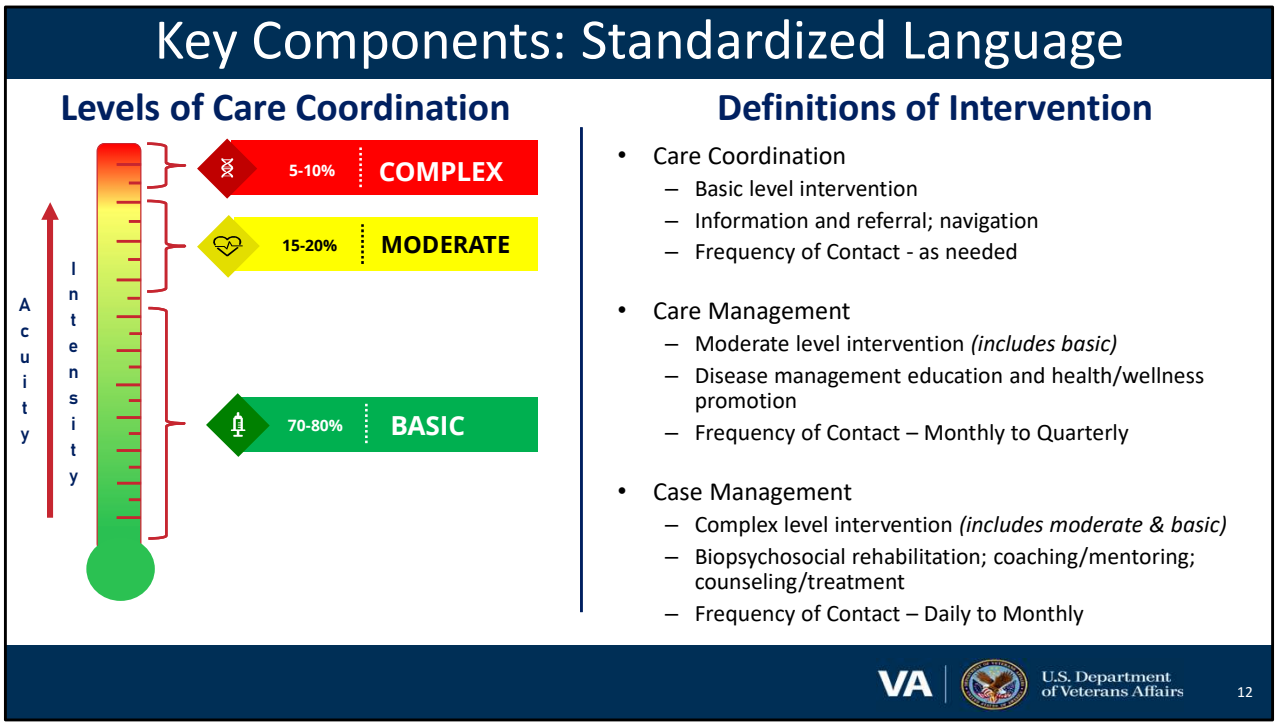
- **Emergency Room Utilization Rates**
- **Hospital Wide Readmission Rates**
- **Ambulatory Care Sensitive Conditions (ACSC) Readmissions**
- **Veteran Experience**
- **Employee Experience**
- **Cost of Care**



Recognizing the need to address high emergency department utilization and readmissions; recognizing the number of Veterans with complex care needs was increasing; recognizing the breakdown in communication due to siloes of care, the Veterans Health Administration decided to develop and implement a framework called Care Coordination and Integrated Case Management or as we lovingly call it CCICM. It was built upon the ADKAR Change Management Model by ProSci incorporating the 5 elements of change, Awareness, Desire, Knowledge, Ability and Reinforcement. There are 5 milestones with critical action items for completion in each one. A national implementation leadership team with regional consultants of RNs and SWs was established to support facilities as they implement the framework and make the cultural change. I am one of 13 Regional Consultants nationally. I support the MidWest Consortium region along with 2 RN consultants. We have 34 facilities in 12 states within the upper Midwest that we support. We meet at least monthly and often more frequently with identified site representatives to walk through the 24 critical action items, help answer questions, provide tools and resources, educate, and assist in anyway possible for success. As needs are identified over the different sites, we work to create resources on a regional basis and share the wealth across all facilities.

As regional consultants, we work in a nurse and social worker dyad and expect our facilities to **assign** an RN and a SW Co-Champion to serve as a dyad of SMEs to facilitate implementation. This dyad is to assure we are working together as a team of case management professionals and working to break down the siloes that may have been established in the health care centers. Additionally, an Executive Sponsor, a C-Suite or high level manager, is assigned to support the co-champions in breaking down barriers, being visible to show support of the leadership in change, build sponsorship within managers for implementation, and to communicate with employees the need to change. Co-champions work to complete a baseline assessment of care coordination for the entire health care system by including managers and program coordinators in the many areas of the health care system in discussion about specific components of their processes. This provides a starting point by which to measure improvement. Additionally, a scan is done identifying areas where staff are completing care coordination services and the number/time of FTEE doing so. This is specifically done to identify staff outside of primary care services with specialized knowledge providing care coordination. You have to know what your current process are and who is providing the service in order to integrate the system.

While I won't touch on each of the 24 critical action items in this presentation, I will touch on several of the key components of the framework in the following slides.



The first key component was creating a standardized language across HCS for care coordination. Speaking the same language is critical in care transitions.

Research has for years identified that approximately 5% of the population spends approximately 50% of the nation's health expenditures. These are those individuals we consider to have complex care needs with multiple chronic conditions and may have psychosocial barriers who use additional health care resources, primarily associated with inpatient admissions (STATISTICAL BRIEF #540: Concentration of Healthcare Expenditures and Selected Characteristics of Persons with High Expenses, U.S. Civilian Noninstitutionalized Population, 2019 (ahrq.gov)). Those patients who require more extensive interventions and more frequent care. With the research information, 3 standardized levels of care coordination were established- Basic where approximately 80% of the population falls; moderate where approximately 15% of the population falls; and complex where that 5% are included. The idea here being that as a patient's acuity rises, their need for more intensive care coordination rises as well.

Standardized definitions for the different levels of intervention were established. We need to all be speaking the same language. As I began implementation at my VA

medical center back in 2019, this was a huge issue as many used the terms care coordination, care management and case management interchangeable. We need to make sure staff knew exactly what each entailed and how they related to each other. First, care coordination is the intervention associated with work with those patients who fall into the basic level of care coordination. This includes services such as information and referrals to other services. It could include assistance with navigating the system of care. For example, assisting a patient with scheduling two appointments on the same day so they need not travel to the facility twice in one week. The frequency of contact in this level of care is deemed as needed.

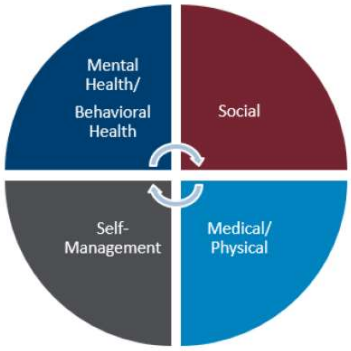
For those patients whose needs fall into the moderate level of care coordination, the assigned level of intervention is care management which is considered a population health approach focused on primary or secondary prevention of chronic disease and acute condition management. This may include care coordination services in addition to more specific services such as disease management education and health and wellness promotion. It may include helping a newly diagnosed diabetic who was recently prescribed insulin utilize resources to understand and implement their treatment regimen and overcome perceived barriers such as their work schedule as a truck driver or identifying assistance with obtaining their costly medications or specialty food. It may include answering questions of the anxious patient who was just diagnosed with congestive heart failure and is working to establish a new exercise routine and helping him/her adjust to time constraints and worry on how to get it all done in a day. It includes being proactive and establishing a frequency of contact that helps support that patient where they are at in their health care journey with disease management and social determinants of health. That frequency usually falls between monthly and quarterly contacts.

Then for those patients with more complex care needs, the case management level of intervention comes into play. This includes any provision of care management and care coordination that is needed. This level of intervention focuses on chronic disease and acute condition management like addressing biopsychosocial crises such as homelessness or at risk of homelessness, loss of income, inadequate home conditions or environment, etc. that affect a patient's ability to meet their health care or basic needs . Case management includes responsibility for the oversight and management of a comprehensive care plan often encompassing many different services/programs. Case management services may be needed to build engagement of a patient in his or her care that includes coaching and mentoring as well as techniques such as motivational interviewing. Frequency of contact usually is most intensive with contact daily, every other day, twice a week or biweekly to monthly.

Key Components: Proactive Veteran Identification

- **Risk Stratification of Veteran Population to identify At-Risk**
  - Predictive Risk Analytics Databases
  - Population Health Needs Reports
  - High Utilization Reports
  - High-Cost Reports

- **Assessment of Complexity to Determine Level of Care Coordination Need**
  - 20-question tool
  - 4 domains
  - Clinician completed



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Teach co-champions and other site staff on use of predictive analytics and reports available to them to find Veterans

Complexity Assessment Tool- Medical/Physical; Self Management; Psychosocial; Mental Health/Behavioral Health

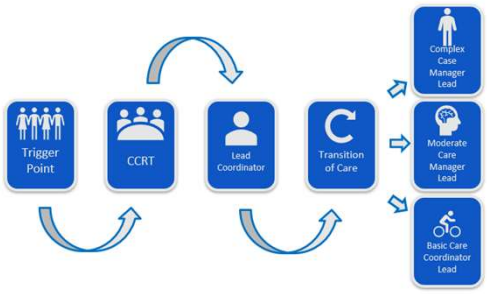
-use for case presentation-----

-eventually integrate into processes across the system

Key Components: Lead Coordinator Assignment

- **Care Coordination Review Team**
  - Interprofessional – composed based on Veteran reviewed
  - Not treatment focused – purpose only to assign a Lead Coordinator
  - 5-10 minute presentation by clinician most familiar
  - Complexity Assessment Tool domains reviewed

- **Lead Coordinator Assignment**
  - From services Veteran involved with
  - May refer to additional programs/services
  - Changes based on Veterans prominent needs
  - Episodic- not long term
  - 3 C's - *Communicates, Collaborates and Coordinates*



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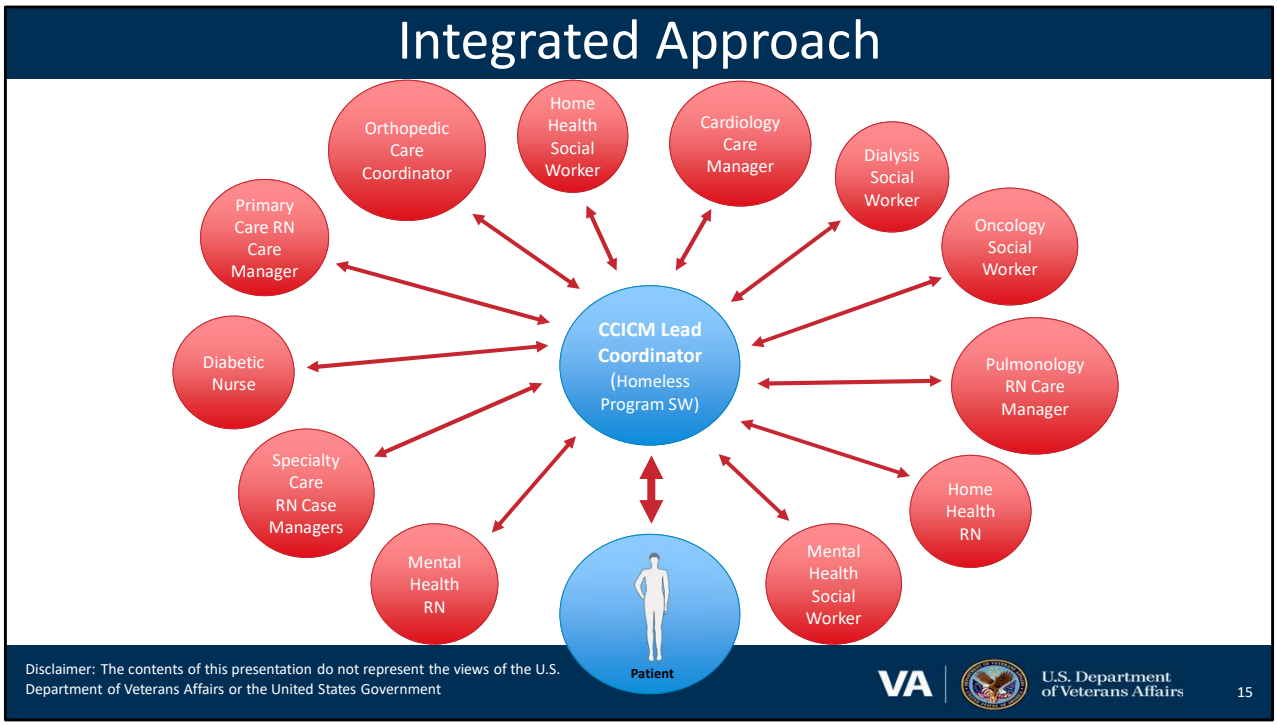
The purpose of the CCRT is to **integrate communication, collaboration, and coordination** when assigning a Lead Coordinator to Veterans identified as needing care coordination services.

The purpose of CCRT is to assign a Lead Coordinator to meet the prominent needs of the Veteran. The Lead Coordinator is a single, readily accessible and clearly identifiable point of contact for the Veteran, their family, the caregiver and the care team members. The LC's primary responsibility for ensuring the care is coordinated across settings, services and episodes of care and the care plan is delivered as clinically indicated.

Lead Coordinator assignments are usually outside of Primary Care, utilizing those staff identified in the Resource Survey I mentioned earlier who are working in specialty program areas and are trained in complex care coordination and case management. This allows the nursing and SW staff in primary care to focus on patients at that more moderate level of care management in a more proactive manner. Additionally, the LC is already involved with the patient's care and is familiar with the patient and their needs.

And while other care team members continue to work directly with the Veteran, the LC oversees care coordination and facilitates interprofessional team communication, reduces task and intervention duplication and improves the quality of care plan delivery.



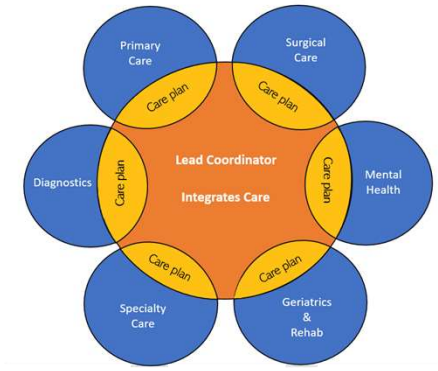
So how does that look compared against the traditional approach? As you can see in the slide here the Veteran has one central point of contact, the Lead Coordinator. This doesn't mean that the LC completes case management across the entire system. What it means is that the LC communicates with the different areas and providers involved in the patient's care to assure they are all working in the same direction and that treatment goals are in line with the patient's goals.

Let's say the patient is missing appointments with the Mental Health SW. That provider reaches out to the LC to discuss their concerns. The LC is aware the patient has been in inpatient for issues associated with her diabetes and has been unable to attend. Or, instead of being hospitalized, let's say maybe she has disengaged due to a poor experience. The LC, not knowing this, would contact the patient to assess the situation and provide intervention to reengage the patient. Because the LC is the single point of contact, there is a trusting relationship that is built to help facilitate this type of interaction. We'll talk more about that in a bit.

The providers involved in the care of the patient continue to provide the same services but now have an additional resource to assist them in their coordination of care. Another example of the integrated approach, let's say while working with the

patient the LC identifies a duplication of services, the LC would work with the respective clinical areas to coordinate the care to reduce the duplication (Example).

Key Components: Lead Coordinator Assignment



Integrated Approach

- **Whole Health**
- **Building Trusting Partnerships**
  - "…demonstrating positive health outcomes for patients who trust their health care providers. Amid health care systems becoming more and more complex, a focus on the relational aspects of health care provision may be warranted and truly value based. – The Joint Commission, 2017
- **Strengthening Care Across the Continuum**
  - Communicates, collaborates and coordinates
    - Single Point of Contact for Patient
    - Removes duplication in services
  - Integrates care plans
  - Community Care

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The Lead Coordinator receives ongoing training in the utilization of Whole Health techniques for working with patients. The VA fully supports the Whole Health approach and made it a part of the 2018-2024 VA-level Strategic Plan (Office of Patient Centered Care & Cultural Transformation (OPCC&CT) - Patient Care Services (va.gov)).

"Whole Health is an approach to health care that empowers and equips people to take charge of their health and well-being and to live their life to the fullest." https://www.patientcare.va.gov/Patient_Centered_Care.asp

Whole Health techniques are incorporated into Lead Coordinator annual competencies and we have a Personal Health Inventory that assists the patient in walking through different areas of their life, identifying priorities and then examining how these fit into their health care goals. The Lead Coordinator incorporates the Veteran's mission, aspirations and purpose into their interventions and assists other team members in knowing and using these as well to assist the patient in meeting goals.

Often patients can become disengaged from their health care goals and providers due

to bad experiences or a lack of trust as I spoke of earlier. A Joint Commission article from January of 2022 notes "findings that echo other research demonstrating positive health outcomes for patients who trust their health care providers. Amid health care systems becoming more and more complex, a focus on the relational aspects of health care provision may be warranted and truly value based." They go on to state, "Fostering trust and plain language communication with patients is essential to improved transitional care when it's done in concert with hospital-based approaches to coordination and facilitated collaborations across care settings. Within the implementation of CC&ICM, there is a focus on building relationship-based care resources to strengthen soft skills of the Lead Coordinator so they can build a trusting relationship with the patient. The Lead Coordinator works collaboratively with members of the Interdisciplinary team fostering trust in these relationships as well. Ultimately, through this relationship-based care, the level of trust between a patient and Lead Coordinator and health care team increases and ultimately that will impact the patient's engagement in the care plan.

The Lead Coordinator serving as the primary point of contact for interdisciplinary team members promotes seamless care along the continuum through that collaboration, coordination and communication. Through this, duplication occurring within the system of care is reduced and The LC is familiar with care plans from the various services the patient works with and with regular communication with active health care team members across the continuum, helps to integrate the care plans assuring the Veteran's MAP are central. This is done in that collaboration and communication. Assuring that professionals know what is important to the Veteran and the treatment goals center around this.

We have a Integrated process team nationally working to improve the care coordination processes between community providers working with Veterans and our VA system. The amount of services received in the community by any given Veteran varies depending on geographical region and availability of specialty services within their local VA health care facility. In each health care center, members of the community care departments are involved on the Care Coordination Review Team to provide their insight into the Veteran's needs and they work to identify Veterans for referral for LC assignment.

Implementation Process

- **Phased Rollout**
- **Estimated timeframe –**
  - Critical action items - 24-48 months
  - Culture change – much, much longer
- **Barriers**
  - Buy-In
  - Competing Priorities at multiple levels
  - Resources
  - Siloes- My staff, my resources
  - Clinically complex vs. behavioral issues

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Phased Rollout

3 Phases- started October 2021; phase 2 April 2022; Phase 3- March 2023

Phase site selection was based on many variables including the complexity level of the health care center and its geographical location. The idea was to have facilities in each of the 3 Phases in each the 4 VHA regions.

Estimated Timeframe- Project management vs change management; This implementation was and still is focused on change management. Shared Governance was built into the process through inclusion of key stakeholders in an implementation workgroup and sub-workgroups. As education was provided on the CCICM framework, we found utilizing the excitement of those eager for change and their knowledge of the care coordination processes and systems key in its improvement. Excitement builds excitement. While I will say there wasn't anyone who disagreed with the idea that improvement in these processes wasn't needed, not everyone was on board with the change.

We did encounter several barriers from the C-Suite level all the way to front line staff.

Buy-in- We've all heard it, "Why do I have to change?" "We've always done it that way" Its going to be more work"

Return on Investment

	VHA Facility 1 Western State		VHA Facility 2 Southern State	
	Utilization Rate	**Cost Savings**	**Utilization Rate**	**Cost Savings**
VA ER	↓35%	$190,000	↓32%	$80,000
Community ER	↓32%	$60,000	↓47%	$45,000
VA Hospitalization	↓52%	$3.6M	↓43%	5.3M
Community Hospitalization	↓68%	$690,000	↓19%	$800,000

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Over 1 year period

The Quadruple Aim in Healthcare

Last Thoughts

- Of the population 50 years and older, the number with at least one chronic disease is estimated to increase by 99.5% from ≈71.522 million in 2020 to ≈142.66 million (134.74 153.39) by 2050
- Those with multimorbidity are projected to increase ≈91.16% from 7.8304 million in 2020 to ≈14.968 million in 2050.

"…health care systems and policymakers should prioritize cost-effective interventions that have the potential to reduce the cost of chronic disease management to the health care system. – Ansah & Chiu, 2023

In closing, a research study published in January this year in Frontiers in Public Health looked at the over 50 years of age population within the United States and projected that the population of 50 years and over with at least 1 chronic disease will increase by 99.5%. Additionally, it projects that the number of those over 50 with multimorbidity will increase by approximately 91%. But let's not forget the rest of the population as well who might have chronic diseases or multimorbidity. And that is before we add in any of the social and environmental issues that we all know help create the complex in complex care needs. Social workers were taking care of social determinants of health before they had even coined the phrase, right?

And I'm not sure I could say it any better, " health care systems and policymakers should prioritize cost-effective interventions that have the potential to reduce the cost of chronic disease management to the health care system. So as we look to meet the complex care needs of patients, whether physical, mental or social, we need to strengthen our continuum through communication, collaboration and coordination that integrates a patient's goals, preferences, and clinical status as well as social and environmental issues among the health professionals involved in the transition. What does that scream to you? To me it says SOCIAL WORK! Thank you.

Resources

Ansah, J. P., & Chiu, C. T. (2023). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in public health*, *10*, 1082183. https://doi.org/10.3389/fpubh.2022.1082183

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QUESTIONS