Moving from Case Management to Care Management: Lessons Learned

March 27, 2019
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Objectives

• Identify the main elements that differentiate case management from care management.
• List two key organizational strategies for moving this change into practice.
• Describe three core competencies for care managers.
Where have we come from?

- Community based models emerged as early as the 1860s
- Hospital-based models particularly emerged during the DRG phase of payment as a way to contain costs
- Nursing case management: hospital and community
- Targeted case management: Medicaid covered and defined…
- Managed care: case/care management
- The field is constantly evolving and changing
In behavioral health organizations:

• Existing (health homes, blended case management programs etc.) and emerging models (CCBHC, value based payments) require continued change for staff

• Case manager role remains defined by statute but competencies emerge and change based on increasing knowledge

• Challenge becomes how do we move case managers (while still maintaining their primary functions) into a team based model with a focus on whole health, wellness, recovery and resilience
Emerging competencies: as much the how as the what

- Team based care participation: nursing, primary care, psychiatry, peer support, clinicians
- Increased health literacy to support across multiple systems: i.e. why is primary care important, how does physical health impact behavioral health, what is my role?
- Role in data driven care: participating in review of data, doing screenings when appropriate and understanding their role in and relevance to recovery
Planning for change:

- **Aligning Concepts**: Changing how we think—training, printed material, conversation
- **Aligning Practice**: changing how we use language and practices at all levels; implementing values based change-supervision, rapid cycle change processes, data dashboards
- **Aligning Context**: changing regulatory environment, policies and procedures, community support—leadership connecting to the why, continued evaluation of what staff need to make the change
The process of change in two organizations:
Change for AuSable Valley CMHA

• Historically a capitated system: PMPM reimbursement model
• 2014 Governor Snyder introduced Michigan’s State Health Care Innovation Plan, the Blueprint for Health Innovation (Grant from CMS for Innovation Model Design Initiative)
• Shift thinking from Volume-based to Value-based
• Integrated Health Learning Collaboratives, two tiers
• Data-driven decision making: Not with current systems!
• Internal culture shift; whole person care
• Must expand community partnerships for collective impact
• Time to be creative
Change for AuSable Valley CMHA: How to prepare staff to meet this change

• Train, Train and Re-train. Utilize every opportunity to talk health integration, both formally and informally. Utilize National, State, and local speakers.

• Change the paradigm of the role of physical health care professionals in mental health. Give them as many tools as possible and allow them to figure out which ones work for the people they serve.

• Have each team determine a goal that will move them closer to the vision of care management and then keep following up on those goals and asking for updates.
Who We Are

- CHCS is one of 38 Local Mental Health Authorities in Texas providing treatment for:
  - Serious mental illness
  - Intellectual and Developmental Disabilities (IDD)
  - Substance use disorders
- Emphasis is on safety net services for the uninsured and underinsured
- In FY 2018, CHCS served nearly 37,000 clients with over 825,000 individual services
CHCS Structure

- **Three Operational Divisions**
  - Adult Behavioral Health
  - Children’s Behavioral Health/ Long Term Care
  - Restoration and Transformational Services (substance use and homeless services)

- **Support Divisions**
  - Office of People and Culture (formerly Human Resources)
  - Information Technology
  - Financial Services
  - External Relations
  - Legal
  - Medical Services
  - CHCS Foundation
  - Compliance
Major Local Collaborators
Our Most Valuable Asset: Our People

• Our dynamic workforce consists of 1,100 dedicated physicians, case workers, therapists, social workers, nurses and administrators

• We provide hope and healing with 79 different programs located at 31 clinics and facilities throughout Bexar County
Change for The Center for Health Care Services

• New leadership
• Transitioning to become CCBHC
• 1115 Waiver
• Industry drive to focus more on outcomes rather than services (fee for service to value based)
• Non-expansion state, high uninsured population so need for tight management of care for highest outcomes
• Strong integration with primary care on site, strong community connections
Philosophy of Preparing Staff for Change

• Leadership starts at the top – model the change behavior you are seeking
• Make bold and creative decisions about service delivery
• Be accountable for decisions and resilient in the face of change
• Learn to pivot quickly
• Recruit for performance behaviors
• Demonstrate leadership when the system noise begins
Implementation

• Create Performance Standards for all staff
• Create Accountability Councils
  – Treatment and Care Council
  – Administrative and Policy Council
  – Data Integrity Team
• Implement annual business planning
  – Cross-cutting Metrics
  – Process Improvements
  – Quarterly reviews
  – Annual Accountability
• Organizational Change
  – Decisions are made at the Executive Leadership level
Strategies for change:

• Case to Care Training for direct care staff and leadership

• TicToc Trauma Informed Training for entire staff

• Introduction of Behavioral Principles: One Center Mindset, Accountability and Attention to Detail, Challenge and Question, etc.

• Communication with staff via bi-monthly newsletter about CCBHC activities and other Center-wide activities to insure transparency and consistency in messaging
Case Management to Care Management Training

• One day *in person* training for direct care (and management) staff: concepts and practice ideas

• Content:
  – Changes in health care and where do I fit
  – Key elements of care management: care transitions, care coordination, data driven care, team based care, health literacy and supporting health behavior change.
  – Action planning for change
Panel discussion
References

• Avery, Marc, The Role of the Care Coordinator in Safety Net Populations, March 2014: [link]