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Value-Based Integrated Case Management at Payor Level

Implementation and Impact

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ABSTRACT

Purpose of Study: Case management is an ideal service for patients with health complexity. However, most case management models do not integrate medical and behavioral health training and interventions, and there are little data evaluating these models in privately insured populations. The purpose of this study was to evaluate impact of an integrated case management (ICM) service at the payor level.

Primary Practice Setting: Health care insurance company.

Methodology and Sample: A multimethod observational study was conducted at a health care insurance company in the Pacific Northwest of the United States. We conducted focus groups of case managers, leaders, and administrators and statistical analyses of outcomes data. Measures included care quality data (discharge follow-up appointment, cost per case, depression and anxiety measures, customer experience and satisfaction, and audit scores) of members receiving ICM services and employee focus group data (acceptability, adoption, feasibility, appropriateness, fidelity, and sustainability) related to the practice of ICM.

Results: Care quality data suggest ICM reduces mental health symptoms and increases discharge follow-up appointments for members. Implementation challenges include new employee orientation to ICM model, traditional views of case management, performance evaluation, documentation, and information technology. Facilitators of implementation include training, autonomy, and leadership support.

Implications for Case Management Practice: Organizations should be aware both of the benefits and challenges related to implementing ICM. Open communication between case managers and leadership and an improvement-focused culture appear to be important elements of implementation success. Future research should examine the perspective of members receiving ICM services and the implementation of ICM into health care delivery systems.

Key words: *behavioral health integration, case management, implementation research, multimethod evaluation, payor*

Chronic disease management accounts for about three-quarters of total health expenditures in the United States (Buttorff et al., 2017). Sixty percent of adults have at least one chronic medical condition; about 42% have two or more (Thomas et al., 2005). Nearly 60% of patients with multiple chronic diseases also have comorbid behavioral health problems (Thomas et al., 2005). Behavioral health problems (i.e., mental health, substance use, and adverse health behaviors) multiply costs for patients with comorbid medical issues and stress the health care system (Smith et al., 2016).

Case management, the collaborative process of coordinating, facilitating, and monitoring health care services provided to a patient, is one approach for helping patients with complex health problems (Case Management Society of America, 2016; Commission for Case Manager Certification, 2015; Fraser &

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M.M. designed and conducted this study. B.D. and R.K. assisted with study design. M.M. and Y.S. wrote the first manuscript draft. All authors critically revised this work for important intellectual content and accuracy. R.A. and Y.S. assisted with data collection and analysis.

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Campagna, 2018); however, research outcomes are mixed. A Cochrane review suggests that management of people with multimorbidity has little to no effect on morbidity and health service utilization and moderate effect on mental health outcomes, medication adherence, and health behavior change (Stokes et al., 2015). A meta-analysis found case management was not an effective model for reduction of secondary case use or total costs (Kathol et al., 2016). Subgroup analyses, however, suggest that case management can improve outcomes within a model of behavioral health-integrated team-based care (Kathol et al., 2016). Research on models of integrated case management (ICM) and their evaluation are lacking in the scientific literature.

One example of an integrated model is ICM. ICM is a high-intensity, cross-disciplinary, longitudinal "assistance and support" model for those with comorbid medical and behavioral health conditions and increased service use (Kathol et al., 2016, 2018). A licensed nurse, behavioral health provider (e.g., social worker, psychologist, and professional counselor), or registered dietitian provides ICM by addressing clinical and nonclinical barriers to health improvement, with the goal of eventually returning patients (called "members" by health plans) to standard outpatient care. Although the ICM model is promising, there are little empirical data available to determine its value (Kathol et al., 2020). The purpose of this study was to identify challenges and facilitators related to the implementation of ICM in a health care insurance company.

Methods

Study Design

A multimethod observational study was conducted to assess care quality data and focus group data related to the practice of ICM in a health care insurance company. All participants were employees of a health care insurance company in the Pacific Northwest United States that trained case managers in late 2011 and then implemented ICM in early 2012. Employees were invited to attend focus groups if they provided ICM services to plan members, supervised case managers, or provided support services to case managers. Participants attended one of five groups based on their position: onsite case managers; offsite case managers; supervisors; and engagement specialists. One of the authors facilitated all five focus groups using a semistructured format with prewritten questions.

Program Description

Integrated case managers are an important component of the payor's mission to support members with medical and behavioral health needs. The ICM model takes a whole-person, relationship-based approach to identify and address the member's clinical and nonclinical barriers to health improvement. Case managers are interdisciplinary trained and utilize narrative assessments to identify and address the members' barriers in the biological, behavioral health, social, and health system domains using the INTERMED Complexity Assessment Grid (Kathol et al., 2020). Member-centric goals are set and measured pre- and post-case management services. Members are targeted for outreach, using algorithms that identify members with health complexity—polychronic, co-occurring behavioral health condition, functional impairment, care gaps, avoidable care, high cost, and high utilizers.

The ICM model takes a whole person, relationship-based approach to identify and address the member's clinical and nonclinical barriers to health improvement.

Case managers are trained and participate in quarterly motivational interviewing skill-building activities and individual coaching sessions with a motivational interviewing network of trainers (MINT). The purpose of the ongoing training is to ensure case managers are practicing at the highest skill level to support engaging the member in services and addressing their barriers to following their providers treatment plan, accessing care, and receiving coordinated care across providers (e.g., primary care, behavioral health, and specialty). Case managers generally are registered nurses, registered dietitians, and licensed mental health clinicians (e.g., mental health counselors, psychologists, and social workers). Most have at least 5 years of clinical experience and motivational interviewing skills, as well as demonstrated professional skills, including excellent verbal and written communication, engagement, critical thinking, problem-solving, and flexibility. Case managers help members by ensuring access to evidence-based, coordinated care among all the member's providers, addressing the member's clinical and nonclinical barriers, assisting the member in learning the self-management skills necessary to effectively manage their conditions, and providing support throughout their health journey. The goal is for the member to learn the skills they need and have a treatment team that can support the member after ICM services have ended. There were 12 case managers for every supervisor. The average case manager had a case load of 250–300 members per year. Daily caseload was about

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40 members at this insurer. Members who qualified for ICM services received services for 60–120 days, on average.

Data Collection and Measures

All care quality data were obtained from standard internal reporting processes based on claims data and analyzed to determine impact of ICM on key performance indicators (discharge follow-up appointment, cost per case, depression and anxiety measures, customer experience and satisfaction, and National Committee for Quality Assurance [NCQA] audit scores). All focus group meetings were audio recorded and then transcribed by a professional transcriptionist. One author was present at all focus groups to record and take notes. Semistructure interview questions were designed to measure implementation variables, specifically acceptability, adoption, feasibility, appropriateness, fidelity, and sustainability (Proctor et al., 2011). All focus group sessions lasted around 1 hr and took place at the site of employment.

Analysis

Care quality data were organized and analyzed using descriptive statistics for normal data. Focus group data were analyzed using thematic analysis to identify, analyze, and report patterns (Braun & Clarke, 2006). Furthermore, an inductive, data-driven approach was used to identify and organize a coding frame that fit the presenting data. The analysis followed six steps:

1. read all interviews independently to create familiarity with the data, noting initial ideas;
2. code transcripts, generating initial codes of interesting features of the data;
3. collate and combine codes into potential themes, gathering all data relevant to each potential theme;
4. review themes to check whether themes work in relation to coded extracts and entire data set;
5. analyses to refine themes, remove redundancies, and generate coding maps; and
6. select vivid, compelling extract examples and create narrative review of themes.

Authors met during Steps 2–6 to discuss codes, refine themes, and develop a consensus. There were no disagreements that required arbitration. Authors used NVivo software (https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home) to code interview data and calculate interrater reliability (Cohen's kappa coefficient).

The average case manager had a case load of 250 - 300 members per year. Daily caseload was about 40 members at this insurer.

Results

Care Quality Data

Members assigned to case managers had a higher percentage of medical appointments following a hospital discharge and fewer days between the appointment and the discharge, compared with members not engaged (see Table 1). Average cost per case decreased from $641 in 2012 (implementation of ICM) to $265 in 2018, a change of 59%. In 2018, members participating in ICM reported average decreases in depression (Patient Health Questionnaire-9) and anxiety (Generalized Anxiety Disorder -7) scores, of 35% and 30% respectively. The 2018 Net Promote Score (measure of customer experience; range of −100 to +100) was 84 for all commercial lines of business and 90 for high priority accounts; 96% of participants reported satisfaction with the program. NCQA Complex Case Management Standards Audit scores were 100% in 2013, 2016, and 2019.

Focus Groups

Twelve case managers, one engagement specialist, and six supervisors attended at least one of five focus groups. These sections represent the project aim to characterize the model and identify challenges and

TABLE 1
Discharge Follow-Up Appointments

	Percentage Receiving a Discharge Follow-Up Appointment			Days to Discharge Follow-Up Appointment		
2018	Participants Engaged in ICM	Nonparticipants	Percentage Change	Participants Engaged in ICM	Nonparticipants	Percentage Change
Q1	88%	71%		6.31	8.02	
Q2	88%	71%		6.86	7.98	
Q3	91%	71%		6.19	8.14	
Q4	89%	72%		6.61	7.95	
Average for year	89%	71%	20.22%	6.44	8.02	24.53%

Note. ICM = integrated case management.

facilitators of implementing ICM into a payer organization. The results below are organized into three main sections: Challenges; Facilitators; and Model and Operations. The sections represent the major themes and subthemes. Each main section includes transcript extracts and is further organized by one of three main themes: case manager, member, and system. Figures 1–3 visually display major themes and subthemes that guided the creation of the main sections below.

Challenges

Case Manager

Participants reported challenges with adopting to the ICM model of whole-person as new employees, or those not familiar with it. Integrated case management is a new framework for some. One nurse reflected that she was "trained in a very traditional way of medical and behavioral health are two different things. Nurses do the medical. Behavioral-health people do the behavioral health." The integrated model can lead to frustration as one interviewee said: "I've heard some behavioral health clinicians say, "I just can't do this." Some nurses say, "It's very anxiety producing to work with people who need to be assessed for suicidality." Nurses seem to struggle more than others with adapting to the ICM model. "For the behavioral health side of the program, I think that [addressing suicidality] felt very intuitive. I think for the nurses; it was really difficult. They're trained to find out what's wrong and fix it."

System

Interviewees report pushing back against traditional views of case management held by others in the organization. "Still a little bit of an uphill climb in terms of the old model of medical case management keeps trotting itself out, if you will, where we get a referral

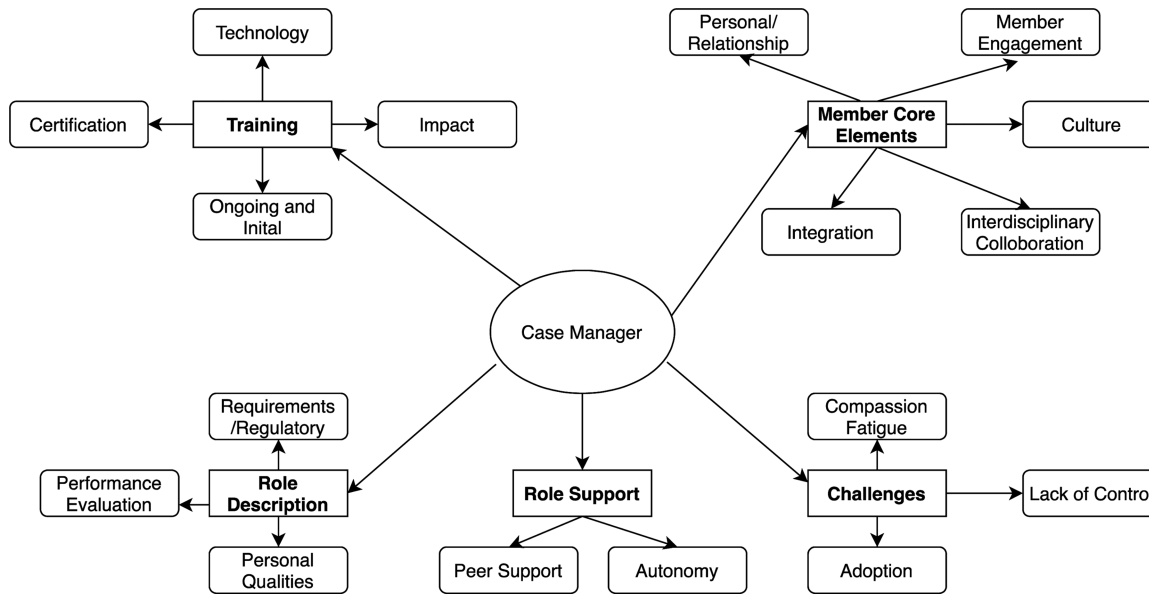

FIGURE 1
Case manager thematic map.

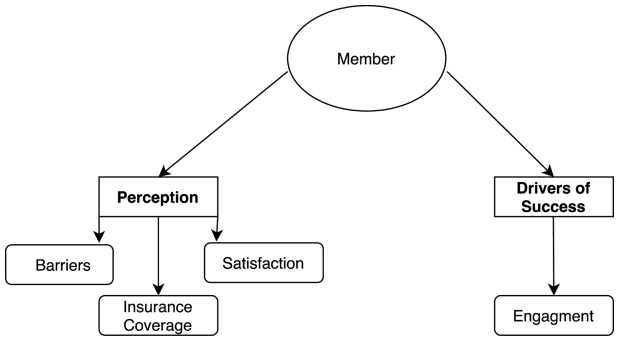

FIGURE 2
Member thematic map.

saying, 'We need a nurse to work with this member.' No, not necessarily going to be a nurse who works with this member." "It's the old way. People are still understanding that it's different with integrated case management and that we have really worked hard to talk about clinicians, not nurses, or social workers, or behavioral health but clinicians."

Performance evaluation is a common challenge. For example, case managers often use motivational interviewing (MI) during phone calls with members, which does not always fit standard quality metrics. "How do you fit MI—which is kind of touchy-feely, relational—into these [quality] categories?" The challenge of measuring the impact of ICM is not lost on the leaders. "That's always the challenge of our leadership, is to figure out measures so that when actuaries or people that are auditing are looking at our work, they need to be able to see that we're making an identifiable, quantifiable difference."

Documentation is an ongoing requirement and challenge for case managers, due to the type and amount of information collected. "One of the biggest barriers to our efficiency and the number of people that we could talk to and work with is all the time that we spend gathering data, verifying things, finding things, confirming things." Another challenge of documentation is the variation in technology, which adds to the case manager's workload. "There's about eight different software programs you have to learn, right? I think it's about eight."

Finally, case managers feel the strain that comes from changing market demands, new contracts and business lines, new quality assurance requirements, and changing performance measure priorities. "They renegotiate what their expectations are for the year. There's a different focus for that year over last year and so sometimes I think that's also a driver, too, because what ends up getting put in those queues, what gets prioritized from our leadership isn't consistent from year to year." Although some case managers initially resist program change, they often become champions for the change, once they "buy" into it.

Facilitators

Case Manager

Facilitators included training, support, and autonomy stemming from the leadership level. Workplace training is an essential component of ICM performance, and some disciplines are more prepared than others. "MI training is going to be huge and especially marrying that piece with social workers, behavioral health specialists, they really have a good base with that. They really come out prepared." One case manager recommended new employees "need to be encouraged just to plunge forward" and that "early on, in early education, you need to weed through who's cut out for this." After completing the training, the case managers reported training as the most

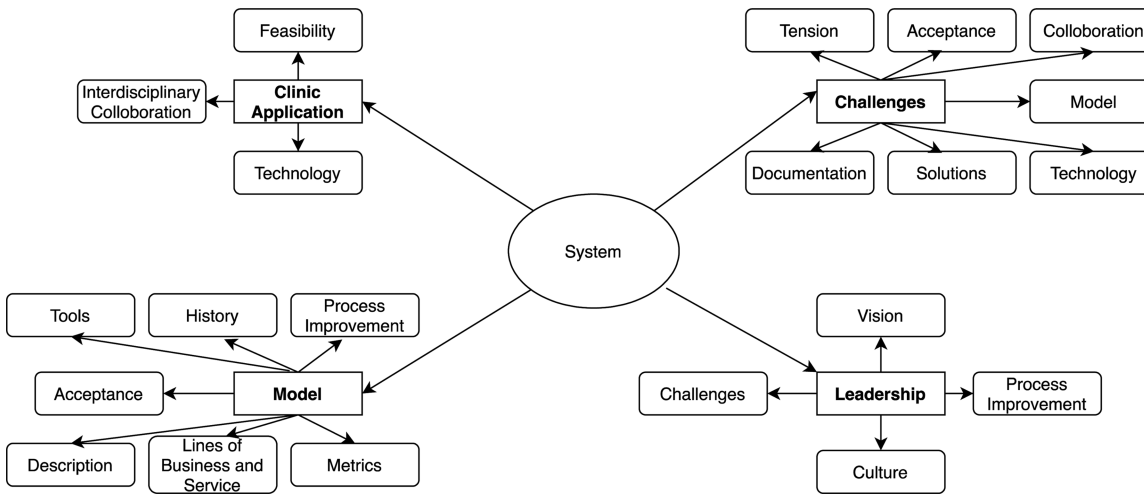

FIGURE 3
Organization system thematic map.

beneficial onboarding process, and constantly use those learned skills as they serve members.

In addition to training, support (e.g., peer-to-peer tutoring) is a key factor in ICM success and contributes to growth and skill improvement. "That's huge. I think that's a really big deal, is to be able to have that support, have different outlets." The case managers also identified leadership-supported autonomy to seek out and develop their own resources. "We really didn't ask for permission. We recognized this need and said, "We need to create [peer meetings] for ourselves."

System

ICM leaders reported lines of business and service as critical indicators of corporate direction and guidelines for operations and strategies. "The other thing that affects all of us is each team has different lines of business they deal with." Regulations and metrics also provided a framework for ICM leaders to follow and was integral in their day-to-day operations. "Keeping quality, creating value while you have all the other administrative mandates, it's a lot. We've got so many metrics looking at how many cases you open, how many did you engage. It's in a helpful way, but it's always balancing that." Although regulations guided business operations, ICMs were mindful of the tension between business needs and member needs.

Model and Operations

Case Manager

ICMs perceive their service as part of a continuum of care and view themselves as partners with community providers. "The perspective is that we're just an extension of their team. We're part of their team. I present it as that wraparound support on this end of things and in addition to the providers they have face-to-face … but really as a part of the team." ICMs recommend telehealth for members in areas with a provider shortage. "Leveraging technology for things like Teladoc or online counseling. Just ways to reach folks that are remote and don't necessarily have access to that care …"

ICMs report a personal approach in assessment and data gathering as a key element of the model. "It's a partnership. You're working symbiotically." In order to build a relationship of trust, ICMs changed their assessment approach to utilize a more conversational style and collect health information. "… The relationship, and then the conversation can just—it may not be linear from an assessment perspective. But you can see where you're touching maybe nonlinearly on all these topics, but just how we can flow conversations with people and extract a lot of information out of a phone call."

Finally, case managers discussed how the required metrics and regulations direct the points that are needed in the ICM model. "Our current accreditation is NCQA. As we are training and developing, we always have to make sure we have a pulse on and make sure that's integrated into this model as well." These requirements have led to the development of a guidebook and procedure to direct ICM and member engagement.

System

Leadership is closely involved in driving the model, but more importantly, actively involved in the constant improvement of processes. "… The two of them together are incredible, incredible leaders. That's made a huge difference. That's the main thing that they do is ask for honest feedback…they take that information and act on it." A member-centric culture permeates the organization beginning with the CEO and including all other staff. "I think the other thing is that [the organization is] built on a foundation of customer service. Our CEO is customer oriented and I … feel like it's definitely the foundation on which we build our relationships and so it enters into case management as well." This culture encourages leadership to create high expectations for ICM recruitment and retention. "… [Leadership] is very—when they hire somebody, they really seek to hire the best and they hire great people."

Discussion

Summary

Study results suggest ICM reduces costs, helps improve member mental health, and increases discharge follow-up appointments. Successful ICM implementation appears to require significant training (initial, ongoing, and cross-discipline training), peer and leadership support, and case manager autonomy. Organizations should be aware of challenges related to performance evaluation, traditional views of case management, clerical burden, and tension between business needs and the person-centric values of the ICM model. Open communication between case managers and organizational leadership and an improvement-focused culture also appear to be important elements of implementation success.

Implications for Case Management Practice

Organizations should be aware both of the benefits and challenges related to implementing ICM. Open communication between case managers and leadership and an improvement-focused culture are important elements of implementation success. We describe three implications below.

High-Need, High-Cost Patients

Patients with complex health and social needs use a disproportionate share of medical care at significant costs (Long et al., 2018). The needs of this patient population extend beyond care for their physical ailments to social and behavioral health needs, which are often of central importance to their overall well-being. Integrated case management and care coordination are ideal services for these high-need patients. One study shows that case management, care coordination, and behavioral health integration were associated with improved indicators for common chronic conditions, reduced inpatient costs in some sites, and improved patient experience in all sites (Gilmer et al., 2018).

Integrated Case Manager Training

Integrated care training is not the norm in the current U.S. health care system (Martin et al., 2019). It seems that most case managers have foundational knowledge and experience in nursing or mental health (e.g., social work). Integrated case management requires significant additional training in motivational interviewing, medical and behavioral health literacy, interprofessional communication, high-quality verbal and written communication, chronic condition management, and health complexity case identification and risk measurement.

Health Information Technology

Findings from this study suggest that clerical burden (e.g., assessment and documentation) can be high for integrated case managers. Assessment can take place across several conversations. Once the conversation with the member is over, the case manager manually pulls information from various databases to complete the assessment document. Case managers should have access to an integrated health information system that automatically pulls from multiple databases and allows communication with multiple stakeholders. Ideally, population health decision support would conduct analyses to determine which patients could most benefit from interventions.

Strengths and Limitations

This study is one of the first to examine the implementation of the ICM model into a large health insurance organization and includes data from multiple levels (case manager, supervisor, and leader). Focus groups were conducted by an independent researcher (first author) who is not employed by the participating organization. Groups were attended by approximately 25% of the total case managers and 75% of the case management leadership (team leads and senior clinicians). There was no effort to verify qualitative findings through observation and no interviews or focus groups with members.

Statement of Ethics

This study was approved by the Institutional Review Board of Arizona State University (identifier: STUDY00007128). Verbal informed consent was secured from all participants, after the procedures had been fully explained to them. The participants did not receive any compensation.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2): 77–101. https://doi.org/10.1191/1478088706qp063oa

Buttorff, C., Ruder, T., & Bauman, M. (2017). *Multiple chronic conditions in the United States* (Vol. 10). Rand. https://www.rand.org/content/dam/rand/pubs/tools/TL200/TL221/RAND_TL221.pdf

Case Management Society of America. (2016). *Standards of practice for case management* (Rev. ed.). Author. https://ccmcertification.org/sites/default/files/docs/2017/code_of_professional_conduct.pdf

Commission for Case Manager Certification. (2015, February). *Foundational principles: Newly revised professional code of conduct provides a framework for ethical, high-quality care (issue brief)*. https://ccmcertification.org/sites/default/files/issue_brief_pdfs/23_-_updated_code_of_conduct.pdf

Fraser, K., & Campagna, V. (2018). Under the case management practice "umbrella": CMSA's standards and CCMC's code of conduct. *Professional Case Management*, *23*(6), 342–344. https://doi.org/10.1097/NCM.0000000000000326

Gilmer, T. P., Avery, M., Siantz, E., Henwood, B. F., Center, K., Pomerance, E., & Sayles, J. (2018). Evaluation of the behavioral health integration and complex care initiative in Medi-Cal. *Health Affairs (Millwood)*, *37*(9): 1442–1449. https://doi.org/10.1377/hlthaff.2018.0372

Kathol, R. G., Andrew, R., Squire, M., & Dehnel, P. (2018). *The integrated case management manual*. Springer.

Kathol, R. G., Knutson, K. H., & Dehnel, P. J. (2016). *Indirect and direct physician support for integrated case management in adults*. Springer.

Kathol, R. G., Padrino, S. L., Melek, S. P., Hopper, K. C., Rado, J. T., Franz, M. A., Rivelli, S. K., & Nasra, G. S. (2020). Delivery model for outcome-producing care management in patients with health complexity. *Care Management*, *26*(5), 16–22. https://issuu.com/academyccm/docs/cm_oct_nov_2020?fr=sODViYjIyNTM4NDE

Long, P., Abrams, M., Milstein, A., Anderson, G., Apton, K. L., & Dahlberg, M. L. (2018). *Effective care for high-need patients: Opportunities for improving outcomes, value, and health*. National Academy of Medicine. https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf

Martin, M., Bauman, D., Allison, L., & Myerholtz, L. (2019). Integration as both standard of care and

standard of training. *Family Medicine*, *51*(8):701–702. https://doi.org/10.22454/FamMed.2019.733470

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R, & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(2), 65–76. https://doi.org/10.1007/s10488-010-0319-7

Smith, S. M., Wallace, E., O'Dowd, T., & Fortin, M. (2016). Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. *Cochrane Database of Systematic Reviews*, *3*(3), CD006560. https://doi.org/10.1002/14651858.CD006560.pub3

Stokes, J., Panagioti, M., Alam, R., Checkland, K., Cheraghi-Sohi, S., & Bower, P. (2015). Effectiveness of case management for "at risk" patients in primary care: A systematic review and meta-analysis. *PLoS One*, *10*(7), e0132340. https://doi.org/10.1371/journal.pone.0132340

Thomas, M. R., Waxmonsky, J. A., Gabow, P. A., Flanders-McGinnis, G., Socherman, R., & Rost, K. (2005). Prevalence of psychiatric disorders and costs of care among adult enrollees in a Medicaid HMO. *Psychiatric Services*, *56*(11), 1394–1401. https://doi.org/10.1176/appi.ps.56.11.1394

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Rachel Andrew, MS, LMFT, CCM, is the owner of Rachel Andrew Consulting LLC, providing consultation and training on integrated case management. She is a director at a health plan with more than 2.7 million members where she leads a multidisciplinary team including case management, care transition management, condition management, wellness coaching, and other population health projects. Her prior experience includes more than 25 years of university teaching in behavioral health and education programs and speaks nationally on the topic of Value-Based Integrated Case Management. She has more than 10 years of experience in community mental health, including as a director for five clinics and leading grassroots community projects focused on improving the well-being of the community. She has practiced as a mental health therapist in psychiatric hospitals, schools, and community mental health clinics. Rachel's work in other settings includes insurance case management and utilization management clinical roles. Rachel holds certificates in minority mental health, integrated case management, LEAN, and Synectics creative problem-solving and is a certified case manager and child mental health specialist.

Roger Kathol, MD, is a Professor in Internal Medicine and Psychiatry at the University of Minnesota. He has been practicing, teaching, and researching at the interface of internal medicine and psychiatry for nearly 40 years.

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