

## The Role of Case Management in Transitions of Care

CHERI LATTIMER, RN, BSN – EXECUTIVE DIRECTOR CASE MANAGEMENT SOCIETY OF AMERICA (CMSA) & NATIONAL TRANSITIONS OF CARE COALITION (NTOCC)

---

---

---

---

---

---

---

---

## What is Case Management?



---

---

---

---

---

---

---

---

## CMSA's Strategic Mission & Vision

### CMSA's Strategic Vision

"Case managers are recognized experts and vital participants in the care coordination team who empower people to understand and access quality, efficient health care."

### CMSA's Strategic Mission

The Case Management Society of America is the leading membership association providing professional collaboration across the health care continuum to advocate for patients' wellbeing and improved health outcomes through:

- Fostering Case Management growth and development
- Impacting health care policy and
- Providing evidence-based tools and resources

---

---

---

---

---

---

---

---

## There are fewer of us . . .

Generational shifts mean fewer workers entering the US (and global) workforce

Healthcare is facing professional shortages in its critical core capabilities now and projects larger shortages in the near future

Healthcare employers will have fewer healthcare workers from which to recruit

These workers will interact with technology differently, learn differently and collaborate differently

---

---

---

---

---

---

---

---

---

---

## Tsunami Warning:

Peter McMenamin, PhD, Senior Policy Fellow—Health Economist, American Nurses Association  
Bureau of Labor Statistics [Occupational Employment Projections from 2012-2022](#).

2012 National Employment Matrix title and code	Replacement Needs by Detailed Occupation (Numbers in thousands)		Employment Projections by Detailed Occupation						Job openings due to growth and replacements
	2012-22 Replacement needs	2012	Employment		Change, 2012-22		%		
			Number	% of U.S. total employment	Number	%			
Registered nurses 29-1141	525.7	2,711.5	3,238.4	1.9	2.0	526.8	19.4	<b>1,052.6</b>	
Nurse anesthetists 29-1151	6.8	35.2	41.9	0.0	0.0	8.8	24.9	15.6	
Nurse midwives 29-1161	1.2	6.0	7.7	0.0	0.0	1.7	28.6	2.9	
Nurse practitioners 29-1171	21.4	110.2	147.3	0.1	0.1	37.1	33.7	58.5	
<b>RNs and APRNs</b>	<b>555.1</b>	<b>2,862.9</b>	<b>3,437.3</b>	<b>2.0</b>	<b>2.1</b>	<b>574.4</b>	<b>20.1</b>	<b>1,129.6</b>	
Nursing instructors and headteachers, postsecondary 25-1072	10.2	67.8	91.8	0.0	0.1	24.0	35.4	34.2	
Licensed practical and licensed vocational nurses 29-2061	180.3	738.4	921.3	0.5	0.6	182.9	24.8	363.1	
Nursing assistants 31-1054	281.4	1,479.8	1,792.0	1.0	1.1	312.2	21.1	593.6	

<http://www.bls.gov/news.release/archives/ocp120912.pdf>

---

---

---

---

---

---

---

---

---

---

## The Future of Nursing Report: Moving Towards A Collaborative Care Model

Table 1

### Conventional vs. Collaborative Care

Conventional	Collaborative
Authoritarian	Collaborative
<i>Autonomous practice culture</i>	<i>Team culture</i>
Physician driven, with physicians accountable for care outcomes	Patient centered, with team members sharing responsibility for care outcomes
Episodic, fragmented	Continuous, coordinated
Primary care delivered in one-size-fits-all, 15-minute visits	Primary care delivered via individualized visits, phone calls, and online communication
Payment based on quantity (fee for service)	Payment based on value (considers both quality and cost)
Reactive, focused on illness	Preventive, focused on health
Communication is inconsistent	Communication is imperative

Source: Robert Wood Johnson Foundation, December 2011, *Empowering the Future of Nursing Report—Part II: The Promise of Interprofessional Collaborative Care to Improve Safety and Quality*. Accessed at [www.rwjf.org/files/reports/empowering\\_the\\_future\\_of\\_nursing\\_report\\_part\\_ii.pdf](http://www.rwjf.org/files/reports/empowering_the_future_of_nursing_report_part_ii.pdf)

---

---

---

---

---

---

---

---

---

---

### What Causes Poor Transitions & Care Coordination - Often Hospital Readmissions?



---

---

---

---

---

---

---

---



Our healthcare system operates in  
**“silos” and information queues**  
– incapable of reciprocal operation with other related  
management systems & different departments of organizations



© Eric A. Coleman, MD, MPH

---

---

---

---

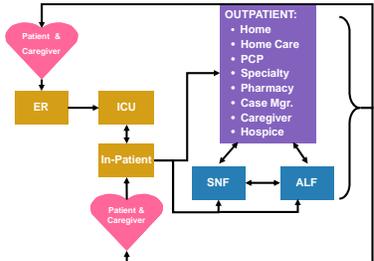
---

---

---

---

### Transition Issues Dramatically Impact Patient & Family Caregiver



---

---

---

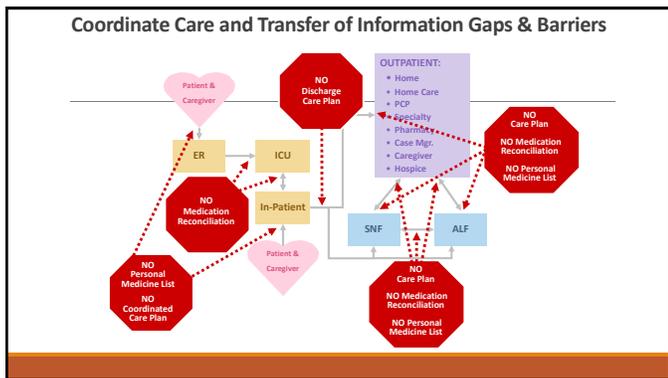
---

---

---

---

---




---

---

---

---

---

---

---

---

- ### To Date We Have Not Had Consistent and Accepted Transition Tools
- Medication Reconciliation Elements
  - Comprehensive Care Plan
  - Health or Clinical Status
  - Transition Summary
  - Patient & Caregiver Tools & Resources
  - Consistent Performance Measures That Apply to All Health Care Settings
  - Accountability for Sending & Receiving Information

---

---

---

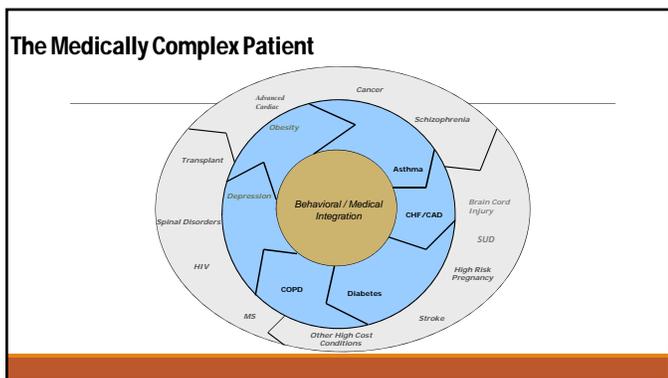
---

---

---

---

---




---

---

---

---

---

---

---

---

### Co-morbidity of Depression with Other Conditions

- 25% - cancer patients
- 27% - diabetic patients
- 20% - cardiovascular patients
- 40% - 65% - heart attack patients
- 10% - 27% - stroke patients
- 10% - 15% - new mothers
- 33% co-occurrence of substance abuse

National Institute of Mental Health, July 1999

---

---

---

---

---

---

---

---

### Calling for Integrated Health Services

**“We need a comprehensive, integrated approach to service delivery. We need to fight fragmentation.”**  
**WHO Director-General, 2007 (1)**

[http://www.who.int/healthsystems/service\\_delivery\\_toolkit/en1.pdf](http://www.who.int/healthsystems/service_delivery_toolkit/en1.pdf)

---

---

---

---

---

---

---

---

### Setting the Stage – Gaps & Barriers

- Clinical practice areas have been separated
- Reluctance of BH practitioners to work in the medical setting
- Delusion of special need for BH privacy and budget protection
- Most clinicians are hesitant and often resistant change
- Limited training or tools for support of Integrated Health Management
- Nurses, social workers, case managers have many years of training related to field of practice
  - ◊ Medical
  - ◊ Behavioral
  - ◊ Average years of practice 20 years
  - ◊ Skills focused to disease states, populations and specialty

---

---

---

---

---

---

---

---

## What Is Integrated Health Management?

Integrated Health Management incorporates the concepts of health complexity, mental health/substance use disorders as they relate to physical health problems and the impact that the interaction of the two have on patients outcomes.

- Assessment of whole patient

Integrated Health Management emphasizes the importance of uncovering and assisting with both medical and psychiatric contributors to patient problems

Provides the coordination of physical and mental health/substance use disorder services for patient so affected in an attempt to maximize clinical , functional and economic outcomes

CMBA Integrated Case Management Training Manual

---

---

---

---

---

---

---

---

## Health Complexity

Health Complexity is the interference in standard care by behavioral, social, physical, and health system factors, which require a shift from standard care to individualized care in order for patient outcomes to improve<sup>1</sup>

De Jongh P, Haysa FI, Steinfel FC. Case and Care complexity in the Medicare II. Med Clin North Am. Jul 2005

---

---

---

---

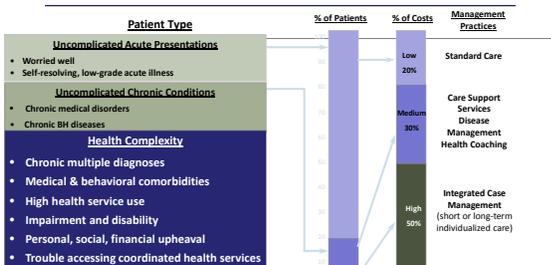
---

---

---

---

## Health Complexity



—adapted from Meier DE, J Pall Med, 7:119-134, 2004

---

---

---

---

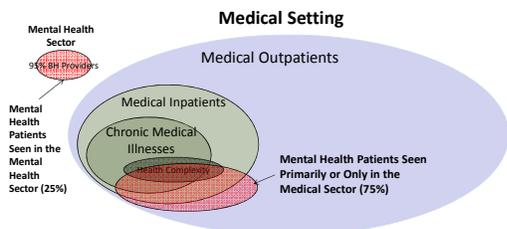
---

---

---

---

### Seventy-five Percent of Mental Health Patients Are Seen in the Medical Setting



CASE MANAGEMENT SOCIETY OF AMERICA & CARTESIAN SOLUTIONS, INC.™ ©

---

---

---

---

---

---

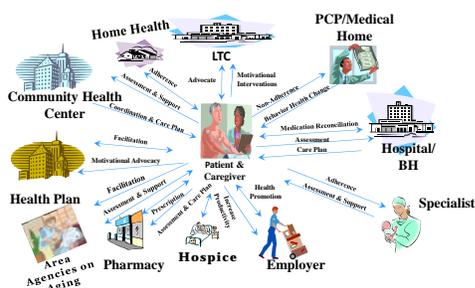
---

---

---

---

### Integrated Health Care is a Collaborative process supported by Multidisciplinary Teams in Multiple Healthcare Settings




---

---

---

---

---

---

---

---

---

---

### Creating the Collaborative Clinical Team



**Collaboration among physicians, pharmacist, nurses, case managers, social workers, allied health and supporting staff is critical to achieving the goals of the team, the organization and changing the way we deliver healthcare today**

<http://www.crystalgraphics.com/>

---

---

---

---

---

---

---

---

---

---

### Case/Care Manager Skills Are Required For Success in These New Models!



Knowledge and experience with care coordination

Focus on patient-centered processes

Assessment, planning, facilitation across care continuum

Knowledge of population-based care management strategies

Meaningful communication with patient, family, care team

© 2010 CMSA Standards of Practice 2010

---

---

---

---

---

---

---

---

### Case Management Role in Integrated Care

1. Assessment, Care Planning and Patient-Centered Care
2. Medication Adherence & transfer of information
3. Patient engagement & activation to self-management skills
4. Care coordination with community services and transitions of care
5. Motivational Interviewing and improving adherence
6. Qualification & skills required for nursing professionals integrating medical and psychiatric services

---

---

---

---

---

---

---

---

### What is Case Management?

Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

(CMSA, 2010)

---

---

---

---

---

---

---

---

### CLIENT SELECTION PROCESS FOR CASE MANAGEMENT

The case manager should identify and select clients who can most benefit from case management services available in a particular practice setting.

**How Demonstrated:**

Documentation of consistent use of the selection process within the individual organization's policies and procedures.

Use of high-risk screening criteria to assess for inclusion in case management programs. Examples of high-risk screening criteria include, but are not limited to:

- Age
- Poor pain control
- Low functional status or cognitive deficits
- Previous home health and durable medical equipment usage
- History of mental illness or substance abuse, suicide risk, or crisis intervention
- Chronic, catastrophic, or terminal illness
- Social issues such as a history of abuse, neglect, no known social support, or lives alone
- Repeated emergency department visits
- Repeated admissions
- Need for admission or transition to a post-acute facility
- Poor nutritional status
- Financial issues

---

---

---

---

---

---

---

---

---

---

### Client Assessment

The case manager should complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each client.

**How Demonstrated:**

Documentation of client assessments using standardized tools, when appropriate. Example criteria may include, but are not limited to the following components (as pertinent to the case manager's practice setting):

- Physical/functional
- Medical history
- Psychosocial behavioral
- Mental health
- Cognitive
- Client strengths and abilities
- Environmental and residential
- Family or support system dynamics
- Spiritual
- Cultural
- Financial
- Health insurance status
- History of substance use
- History of abuse, violence, or trauma
- Vocational and/or educational
- Recreational/leisure pursuits
- Caregiver(s) capability and availability
- Learning and technology capabilities
- Self-care capability
- Health literacy
- Health status expectations and goals
- Transitional or discharge plan
- Advance care planning
- Legal
- Transportation capability and constraints
- Health literacy and illiteracy
- Readiness to change

---

---

---

---

---

---

---

---

---

---

### Client Assessment (cont)

Documentation of resource utilization and cost management; current diagnosis(es); past and present course and services; prognosis; goals (short and long term); provider options; and available health care benefits.

Evidence of use of relevant, comprehensive information and data required for client assessment from many sources including, but not limited to:

- Client interviews
- Initial assessment and ongoing assessment
- Family or caregivers, physicians, providers, other members of the interdisciplinary health care team
- Medical records
- Data: claims and or administrative

---

---

---

---

---

---

---

---

---

---

### PROBLEM/OPPORTUNITY IDENTIFICATION

The case manager should identify problems or opportunities that would benefit from case management intervention.

**How Demonstrated:**

Documentation of agreement among the client, family or caregiver, and other providers and organizations regarding the problems/opportunities identified.

Documented identification of opportunities for intervention, such as:

- Lack of established, evidenced-based plan of care with specific goals
- Over-utilization or underutilization of services
- Use of multiple providers/agencies
- Use of inappropriate services or level of care
- Non-adherence to plan of care (e.g. medication adherence)

**Lack of education or understanding of:**

- The disease process
- The current condition(s)
- The medication list

**Medical, psychosocial, mental health and/or functional limitations**

- Lack of a support system or presence of a support system under stress.
- Financial barriers to adherence of the plan of care
- Determination of patterns of care or behavior that may be associated with increased severity of condition
- Compromised client safety
- Inappropriate discharge or delay from other levels of care
- High cost injuries or illnesses
- Complications related to medical, psychosocial or functional issues
- Frequent transitions between settings

---

---

---

---

---

---

---

---

---

---

### Planning

The case manager should identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs.

**How Demonstrated:**

Documentation of relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care.

Recognition of the client's diagnosis, prognosis, care needs, preferences, preferred role in decision-making, and outcome goals of the plan of care.

Validation that the plan of care is consistent with evidence-based practice, when such guidelines are available and applicable.

Establishment of measurable goals and indicators within specified time frames. Example measures could include access to care, cost-effectiveness of care, and quality of care.

Documentation of client's or client's support system participation in the written case management plan of care; documentation of agreement with plan, including agreement with any changes or additions.

Facilitation of problem-solving and conflict resolution.

Evidence of supplying the client with information and resources necessary to make informed decisions.

Awareness of maximization of client outcomes by all available resources and services.

Compliance with payer expectations with respect to how often to contact and reevaluate the client or redefine long or short term goals.

---

---

---

---

---

---

---

---

---

---

### Medication Adherence Assessment

**Five external domains:**

Patient

Condition – Medical & Behavioral

Treatment

Psychosocial

Health System

**Patient-related domain:**

Knowledge and beliefs

Motivation to manage

Confidence in management

Expected outcome

Understanding of the consequences




---

---

---

---

---

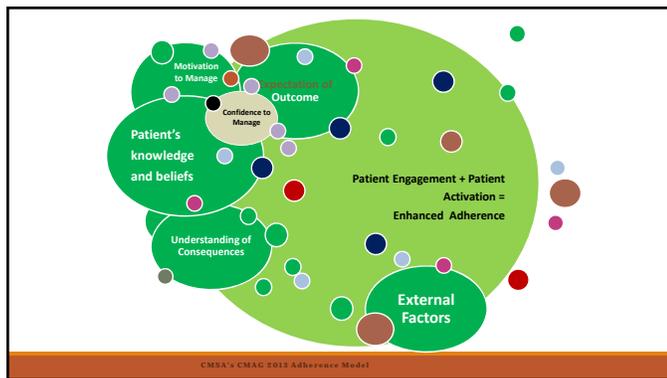
---

---

---

---

---




---

---

---

---

---

---

---

---

### Defining Patient Engagement

**“Actions individuals must take to obtain the greatest benefit from the health care services available to them”**

This definition focuses on behaviors of individuals relative to their health care that are critical and proximal to health outcomes, rather than the actions of professionals or policies of institutions.

Engagement is not synonymous with compliance.

[http://www.chh.org/pdf/CFPH\\_Engagement\\_Behavior\\_Framework\\_current.pdf](http://www.chh.org/pdf/CFPH_Engagement_Behavior_Framework_current.pdf)

---

---

---

---

---

---

---

---

### Advocacy & Patient-Centered Care

- Promotion of the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy
- Education of other health care and service providers in recognizing and respecting the needs, strengths, and goals of the client
- Facilitating client access to necessary and appropriate services while educating the client and family or caregiver about resource availability within practice settings
- Recognition, prevention, and elimination of disparities in accessing high quality care and client health care outcomes as related to race, ethnicity, national origin, and migration background; sex, sexual orientation, and marital status; age, religion, and political belief; physical, mental, or cognitive disability; gender, gender identity, or gender expression; or other cultural factors

---

---

---

---

---

---

---

---

### Facilitation, Coordination & Collaboration

The case manager should facilitate coordination, communication, and collaboration with the client and other stakeholders in order to achieve goals and maximize positive client outcomes.

**How Demonstrated:**

Recognition of the case manager's professional role and practice setting in relation to that of other providers and organizations caring for the client.

Development and maintenance of proactive, client-centered relationships and communication with the client, and other necessary stakeholders to maximize outcomes.

Evidence of transitions of care, including:

- A transfer to the most appropriate health care provider/setting
- The transfer is appropriate, timely, and complete
- Documentation of collaboration and communication with other health care professionals, especially during each transition to another level of care within or outside of the client's current setting

---

---

---

---

---

---

---

---

### Facilitation, Coordination & Collaboration

**Continued**

Adherence to client privacy and confidentiality mandates during collaboration.

Use of mediation and negotiation to improve communication and relationships.

Use of problem-solving skills and techniques to reconcile potentially differing points of view.

Evidence of collaborative efforts to optimize client outcomes: this may include working with community, local and state resources, primary care physician or other primary provider, other members of the health care team, the payer, and other relevant health care stakeholders.

Evidence of collaborative efforts to maximize regulatory adherence within the case manager's practice setting.

---

---

---

---

---

---

---

---

### What are Competencies?

- Competencies are the skills, knowledge, abilities and personal attributes that are essential to perform certain functions and which are critical to succeed in specific roles.
- A competency framework defines the knowledge, skills and attributes needed by the people working in an organization or particular profession.

---

---

---

---

---

---

---

---

### CMSA's Competency Map – Defining Role & Function

Six levels:

- Case Management Assistant
- Entry Level
- Mid-Level
- Senior
- Advanced
- Executive

---

---

---

---

---

---

---

---

### CMSA's Competency Map

Each level has 13 competencies, divided amongst 5 domains:

- Case Management Concepts – consisting of The Case Management Process, Competency Validation, Analytical and Critical Thinking.
- Knowledge and Understanding – consisting of Legal/Ethics, Regulatory, professional Education, and Business Management .
- Communication – consisting of Effective Engagement and Empowerment and relationship management.
- Outcomes Improvement – consisting of Research and Quality and Implementing Value-add solutions.
- Leadership – consisting of Change management and Workforce Development.

---

---

---

---

---

---

---

---

### Member Engagement Strategy

Wonder what this intensity grid is about?

Category	Item	Value	Item	Value	Item	Value	Item	Value	Item	Value	Item	Value	Item	Value	Item	Value	Item	Value	Item	Value
Financial	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100
Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	Profit	80	Cost	20	Revenue	100	

---

---

---

---

---

---

---

---



### Intensity Grid Columns

Primary Role	CM Method
Health Care Setting	CM Activities
Population Served	Outcome Aides
CM Education and Experience	Typical Caseload
CM Training	Management Duration & Intensity of Contact

---

---

---

---

---

---

---

---

### Traditional versus Integrated Case Management (ICM)

<u>Traditional</u>	<u>Integrated Case Management</u>
illness-focused	Complexity-focused
Problem-based (check list)	Relationship-based (dialogue)
Occasionally longitudinal	Always longitudinal
Biomedical clinical assessment training	Multi-domain assessment and management training
Regular handoffs	Few handoffs
Illness targeted care plans	Biopsychosocial and health system-based care plan
Graduation based on process measurement and completion	Escalation of care or graduation based on clinical, functional, cost outcome measurement

---

---

---

---

---

---

---

---

### Integrated Case Management Working with the Complex Patient and Their Caregiver Improving Transitions of Care

---

---

---

---

---

---

---

---

**Overcoming Challenges or Barriers with the Complex Patient**

Introduce team-based care:

- Collaborate with pharmacists
- Educate patients on how to take their medications.

Improve access and communication:

- Offer patients the opportunity to contact the provider's office with any questions.
- Use telemedicine, particularly in rural areas.
- Assess patient/caregiver's understanding of diagnosis, treatment options, and prognosis.

---

---

---

---

---

---

---

---

**Strengths-based Assessment**

- Use respect and empathy in your patient/caregiver interactions.
- Recognize patient/caregiver strengths and use of those abilities to effect change.
- Help them use effective coping skills and insights to manage current crisis.
- Recognize and help resolve difficulties.
- Distinguish cultural norms and behaviors from challenging behaviors.

---

---

---

---

---

---

---

---

**Assessment with your Complex Patient is an Ongoing Process**

- Keep assessments flexible, varying with presenting problem or opportunity.
- Regularly reassess patient/caregiver's needs and progress in meeting objectives.
- Facilitate goal-setting discussion based upon their needs during all phases of their care.
- Assess effectiveness of interventions in achieving patient's goals.
- Communicate changes to the health care team.

---

---

---

---

---

---

---

---

### Interdisciplinary Team Concepts

1. Remember your care team members come from diverse training and backgrounds within the same specialty.
2. Teams should focus on a defined goal with parameters, such as a specific unaddressed care need , improvement on a quality measure or a particular setting or patient population.
3. Together team members will determine the team's mission and common goals.

---

---

---

---

---

---

---

---

### Interdisciplinary Team (Cont)

4. Teams must develop respect, competence, accountability and trust for each other to define and treat not only patient problems but those affecting process and workflow.
5. It is key to develop a communication process that defines how the team will solve differences and build collaboration.
6. The outcomes of the team's work must be deemed superior to individually based outcomes.

---

---

---

---

---

---

---

---

“Life is ten percent what happens to you and ninety percent how you respond to it.”

Lou Holtz

---

---

---

---

---

---

---

---

### Critical Thinking

---

Making the arguable, in-arguable.  
Using a holistic approach when transitioning your patient .  
Know your research, current well rounded findings  
applicable to your medically complex patient expertise.

---

---

---

---

---

---

---

---

### Barriers To Learning for the Medically Complex Patient

---

- Hospital setting—a difficult, stressful learning environment.
- Emotional and cognitive overload—patients are scared and feel like they are bombarded with information.
- Reluctance to change—many patients are in denial of their condition or overwhelmed by the number of lifestyle changes they must make.
- Low health literacy.

---

---

---

---

---

---

---

---

### Modify Patient Beliefs and Behavior

---

- Provide educational information to support patient/caregivers participation in the plan of care.
- Simplify when possible.
- Empower patients to self-manage their condition.
- Ensure that patients understand their risks if they don't adhere to medication regimens.
- Ask patients about the consequences of not taking their medications or treatment guidelines.
- Have patients restate positive benefits of taking their medications and following treatment orders.
- Address fears and concerns.

---

---

---

---

---

---

---

---

### Provide Communication and Trust

- Improve interviewing skills
- Practice active listening
- Provide emotional support
- Use plain language
- Elicit patient's input in treatment decisions

Source: [http://www.acpm.org/?MedAdherTT\\_ClinRef](http://www.acpm.org/?MedAdherTT_ClinRef)

---

---

---

---

---

---

---

---

---

---

### Patient Communications

Having a clear understanding of how the use of technology impacts patients is critical for care managers and other providers if they want to effectively engage their patients and improve clinical outcomes.

By utilizing technology that patients are already familiar and comfortable with, providers can eliminate potential barriers associated with the use of novel technology, and focus their efforts directly on patient care.

---

---

---

---

---

---

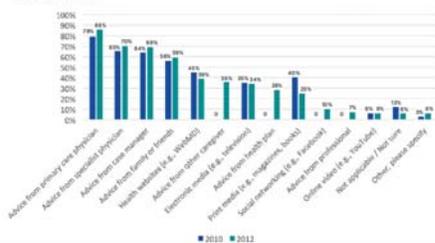
---

---

---

---

Figure 3: What sources of health information do most of your clients/patients typically rely on?



Source: 2012 Health IT Survey Series, Trend Report #5: Patient Engagement Strategies

---

---

---

---

---

---

---

---

---

---

### Cultural Factors

Affirm patient/caregiver dignity and respect cultural, religious, socioeconomic, and sexual diversity.

Assess cultural values and beliefs, including perceptions of illness, disability, and death.

Use the patient/caregiver's values and beliefs to strengthen the support system.

Understand traditions and values as they relate to healthcare and decision-making.

---

---

---

---

---

---

---

---

### Communicating with Non-English Speaking Patients

Use a professional medical translator if at all possible to decrease "false fluency" with medical phrases.

Inform translator you want translation as literal as possible and tell you if there is not literal translation.

Ensure in advance the translator and the patient understands the conversation will be confidential.

Watch the patient while the translator speaks and when the patient replies paying attention to the body language.

Speak directly to the patient as if the translator was not present.

---

---

---

---

---

---

---

---

### Case Manager's Role In Education

- The focus here is patient safety and self-management.
- Verifying with the patient that she/he is KNOWLEDGEABLE about and is ADHERING to the treatment regimen as prescribed.
- Notify the treating physician &/or specialist, of any discrepancies, inconsistencies, or misunderstandings by the patient.

---

---

---

---

---

---

---

---

## End of Life Care Planning

End of Life consistent with their needs, values and preferences.

Revisit and implement patients' advance care plans.

Care plans should detail the care patients want to receive if they are unable to speak for themselves.

Emphasize palliative care, psychosocial support and timely referral to hospice care.

---

---

---

---

---

---

---

---

“Trust yourself. You know more than you think you do.”

Benjamin Spock

---

---

---

---

---

---

---

---

- Draw on your own experience
- Evidence-based sources
- Patient's family, support system
- Community resources, advocacy groups
- Team members
- Peers
- Medical Directors
- Case conferences

---

---

---

---

---

---

---

---

### Case Manager's Must "Advertise" Their Role

- Describe requisite clinical expertise
- Define provision of whole patient support and advocacy
- Support towards behavior change & adherence
- Validate outcomes of case management
- Represent the clinical value
- Believe in the value of what you do

---

---

---

---

---

---

---

---

### FY2015 Medicare Physician Fee Schedule (PFS) – Effective January 2015 – CPT Code 99490

- Chronic Care Management Codes (CCM)**
- Focus on paying for team based care
  - Patients with two or more chronic conditions
  - Separate fee for managing multiple conditions
  - 20 minutes of clinical labor time & may be provided outside of normal business hours
  - Billed no more frequently than once a month
  - Care management services may be provided by social workers, nurses, case managers, pharmacist
  - Services must be available 24X7 to patients and their family caregivers
  - Providers using the CCM code must have an electronic health record or other health IT
- <http://www.cms.gov/newroom/media/RELEASEDATABASE/FACT-SHEETS/2014-FACT-SHEETS-ITEMS/2014-07-08-1.HTML>

---

---

---

---

---

---

---

---

### CASE MANAGEMENT Can Promote Safe, Effective Care Transitions & Coordination For the Medically Complex Patient

- Patient-centered care — patient's goals and preferences
- Patient (or caregiver) education to increase activation and self-care skills
- Accurate communication and information exchange during handovers
- Medication reconciliation and safe medication practices
- Procurement and timely delivery of services
- Ensuring "sender" maintains responsibility for patient until "receiver" confirms assumes responsibility
- Follow-up with patient/caregiver within 48 hours after a transition from a setting or service

---

---

---

---

---

---

---

---

### Don Berwick on Partnerships for Patients



“No **Single** entity can improve care for millions of hospital patients alone. Through strong partnerships at national, regional, state and local levels – including the public sector and some of the nation’s largest companies – we are supporting the hospital community to significantly reduce harm to patients”  
April, 2011

---

---

---

---

---

---

---

---

---

---

### Case Management, TOC & Care Coordination Resources

- CAN – Caregiver Action Network- Family Caregiving Resources – [www.caregiveraction.org](http://www.caregiveraction.org)
- CAPS - Consumers Advancing Patient Safety – Toolkits [www.patientsafety.org](http://www.patientsafety.org)
- NTOCC - National Transitions of Care Coalition – Provider & Consumer Tools [www.ntocc.org](http://www.ntocc.org)
- CMSA - Case Management Society of America – CM Medication Adherence Guidelines & Disease Specific Adherence Guidelines, CMSA Standards of Practice - [www.cmsa.org](http://www.cmsa.org)
- ICM – Integrated Case Management - <http://www.cmsa.org/Individual/NewsEvents/IntegratedHealthManagementTraining/tabid/380/Default.aspx>
- AMDA’s (Dedicated to Long Term Care Medicine™) Transitions of Care in the Long Term Care Continuum practice guideline - <http://www.amda.com/tools/clinical/TOCCPG/index.html>
- ACC and IHI – Hospital to Home – Reducing Readmissions, Improving Transitions - <http://www.h2iquality.org/>
- AHRQ – Agency for Healthcare Research and Quality - Questions Are The Answers – [www.ahrq.org](http://www.ahrq.org)
- NASW – National Association for Social Workers - <http://www.socialworkers.org/Resources>
- VNAA Blue Print for Excellence – [www.vnaablueprint.org](http://www.vnaablueprint.org)

---

---

---

---

---

---

---

---

---

---

### Resources for Development Measures

- The Joint Commission (TJC)- [http://www.jointcommission.org/assets/1/18/TJC\\_Annual\\_Report\\_2014\\_FINAL.pdf](http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf)
- Agency for Healthcare Research and Quality (AHRQ)- [http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/ccm\\_atlas.pdf](http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/ccm_atlas.pdf)
- National Quality Forum (NQF) - [http://www.qualityforum.org/measures\\_reports\\_tools.aspx](http://www.qualityforum.org/measures_reports_tools.aspx)
- URAC - <https://www.urac.org/wp-content/uploads/CaseMgmt-Standards-At-A-Glance-10-9-2013.pdf>
- National Committee for Quality Assurance (NCQA) <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015.aspx>
- American Medical Association (AMA) - <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>
- American Nurses Association (ANA) - <http://www.nursingworld.org/Framework-for-Measuring-Nurses-Contributions-to-Care-Coordination>

---

---

---

---

---

---

---

---

---

---

## Waves of Change

*Changing is like Breathing – And we all know what happens when we stop Breathing*



## Questions

Cheri Lattimer RN, BSN  
[clattimer@cm-innovators.com](mailto:clattimer@cm-innovators.com)

---

---

---

---

---

---

---

---