The Role of Case Management in Transitions of Care

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What is Case Management?

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.

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**Tsunami Warning:**

Peter McMenamin, PhD, Senior Policy Fellow—Health Economist, American Nurses Association


http://www.ananursespace.org/blogs/peter-mcmenamin/2014/03/14/rn-retirements-tsunami-warning

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

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Table 1: Conventional vs. Collaborative Care

<table>
<thead>
<tr>
<th>Conventional</th>
<th>Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authoritarian</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Authoritarian patient centered</td>
<td>Patient centered, with team members</td>
</tr>
<tr>
<td>Patient-centered, with team members</td>
<td>Patient centered, with team members</td>
</tr>
<tr>
<td>Sharing responsibility for care outcomes</td>
<td>Sharing responsibility for care outcomes</td>
</tr>
<tr>
<td>Continuous, coordinated</td>
<td>Continuous, coordinated</td>
</tr>
<tr>
<td>Primary care delivered in one-size-fits-all</td>
<td>Primary care delivered via individualized visits, phone calls, and online communication</td>
</tr>
<tr>
<td>15-minute visits</td>
<td>15-minute visits</td>
</tr>
<tr>
<td>Payment based on quantity</td>
<td>Payment based on value (considers both quality and cost)</td>
</tr>
<tr>
<td>Fees for service</td>
<td>Fees for service</td>
</tr>
<tr>
<td>Preventive, focused on health</td>
<td>Preventive, focused on health</td>
</tr>
<tr>
<td>Communications is inconsistent</td>
<td>Communications is imperative</td>
</tr>
</tbody>
</table>

Source: American Nurses Association, 2014 - Implementing the Institute of Medicine's Recommendations, Interdisciplinary Collaborative Care Model.
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.

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

The Medically Complex Patient
**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

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**Calling for Integrated Health Services**

“We need a comprehensive, integrated approach to service delivery. We need to fight fragmentation.”

WHO Director-General, 2007 (1)

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**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

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

<table>
<thead>
<tr>
<th>Health Complexity</th>
<th>N of Patients</th>
<th>N of Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated Acute Presentations</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Uncomplicated Chronic Conditions</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Chronic Multiple Diagnoses</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Medical &amp; Behavioral Comorbidities</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>High Health Service Use</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Impairment and Disability</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Personal, Social, Financial upheaval</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Trouble accessing coordinated health services</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

- Adapted from: Hripcsak G, J Am Med Inform Assoc. 2004

CMSA Integrated Case Management Training Manual
Seventy-five Percent of Mental Health Patients Are Seen in the Medical Setting

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.
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

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 crises intervention
  - Chronic, catastrophic, or terminal illness
  - Social issues such as a history of abuse, neglect, or losses in 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 SELECTION PROCESS FOR CASE MANAGEMENT (cont)

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 data assessments using standardized tools, when appropriate. Example criteria may include, but are not limited to:
  - Physical/functional
  - Medical history
  - Psychosocial/behavioral
  - Mental health
  - Cognitive
  - Client strengths and abilities
  - Environmenal and residential
  - Family or support systems dynamics
  - Social
  - Religious
  - Financial
  - Health insurance status
  - History of substance use
  - History of abuse, violence, or trauma
  - Vocational/educational
  - Caregiver(s) capability and availability
  - 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; progress goals (short and long term); provider options; and available health care benefits.

- 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

Evidence of use of relevant, comprehensive information and data required for client assessment from many sources including, but not limited to:
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.
- Documentation of opportunities for intervention, such as:
  - Lack of education or understanding of:
    - The disease process
    - The current condition(s)
    - The medications
    - The disease process and consequences
    - The treatment plan
  - Lack of established, evidenced-based plan of care with specific goals
  - Over- 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 medications
  - The disease process and consequences
  - The treatment plan
- 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 rates of 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, participation in decision-making, and outcome goals.
- 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 of care, documentation of assessment of outcomes, documentation of adherence with plan of care, documentation of problem-solving and conflict resolution, and awareness of availability of 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
- 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.

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:
- 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
Program Intensity Grid

The program intensity grid – DRAFT version, provides a framework for all the various interventions that are synonymously and interchangeably used with case management. The idea of the matrix is to establish a threshold for the practice of case management functions, but still provide a meaningful place in healthcare delivery for other "non-case management" functions.

Intensity Grid – page 1

Intensity Grid Levels

Leadership and Managerial Roles
CM Specialty Roles
Complex Case Management
CM Medical/Behavioral/Social Supporting Roles
Intensity Grid Columns

<table>
<thead>
<tr>
<th>Primary Role</th>
<th>CM Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Setting</td>
<td>CM Activities</td>
</tr>
<tr>
<td>Population Served</td>
<td>Outcome Aides</td>
</tr>
<tr>
<td>CM Education and Experience</td>
<td>Typical Caseload</td>
</tr>
<tr>
<td>CM Training</td>
<td>Management Duration &amp; Intensity of Contact</td>
</tr>
</tbody>
</table>

Traditional versus Integrated Case Management (ICM)

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

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.
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 Concepts (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


**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.

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, pharmacists
- 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

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

CAPS – Consumers Advancing Patient Safety – Toools www.capsforall.org

NTCC - National Transitions of Care Coalition – Provider & Consumer Tools www.ntcc.org

OMSA - Case Management Society of America – OM Medication Adherence Guidelines & Disease Specific Adherence Guidelines, OMSA-Standards of Practice www.omsa.org

ICM – Integrated Case Management –


AMDA (Dedicated to Long Term Care Medicine) ‘Transitions of Care in the Long Term Care Continuum practice guideline’ - http://www.amda.org/docs/clinical/TOCCPGIndex.html

ACC and IHI – Hospital to Home – Reducing Readmissions, Improving Transitions –

http://www.h2hquality.org/


NASW = National Association for Social Workers - http://www.socialworkers.org/Resources

VNAA Blue Print for Excellence – www.vnaablueprint.org

Resources for Development Measures

The Joint Commission (TJC)

http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf

Agency for Healthcare Research and Quality (AHRQ):


National Committee for Quality Assurance (NCQA)


American Medical Association (AMA)


American Nurses Association (ANA)

http://www.nursingworld.org/Framework-Measuring-Nurses-Contributions-to-Care-Coordination
Waves of Change

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

Questions

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