

# Case Management – Putting the Pieces Together



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# Objectives

- Outline the key aspects of a transdisciplinary team and explain the value of the relationships that enhance communication and collaboration across each transition of patient care.
- Identify transitional care gaps that may compromise an ability to consistently provide integrated patient-centered care as the patient moves through the healthcare continuum.
- Utilize available tools and resources that support a safe, timely, effective, efficient, equitable and patient-centered patient journey across each transition of patient care.



# Case Management Definitions

## The Foundation for Each Practice

- Case Management in hospital and health care systems is a **collaborative** practice model including patients, nurses, workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses **communication** and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination. ACMA Standards of Practice & Scope of Services
- 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 patient safety, quality of care, and cost effective outcomes. CMSA Standards of Practice for Case Management
- Case Management is a **collaborative** process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It is characterized by advocacy, **communication**, and resource management and promotes quality and cost-effective interventions and outcomes. Commission for Case Manager Certification

# Philosophy of Case Management

Case management facilitates the achievement of client wellness and autonomy through advocacy, assessment, planning, **communication**, education, resource management, and service facilitation. Based on the needs and values of the client, and in **collaboration** with all service providers, the case manager links clients with appropriate providers and resources throughout the continuum of health and human services and care settings, while ensuring that the care provided is safe, effective, client-centered, timely, efficient, and equitable. This approach achieves optimum value and desirable outcomes for all - the clients, their support systems, the providers, and the payers.

# Philosophy of Case Management

Case management services are optimized best if offered in a climate that allows **direct communication** among the case manager, the client, the payer, the primary care provider, and other service delivery professionals. The case manager is able to enhance these services by maintaining the client's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. Certification determines that the case manager possesses the education, skills, knowledge, and experience required to render appropriate services delivered according to sound principles of practice.

## Stressing the Value of Relationships

# Key Case Management Concepts

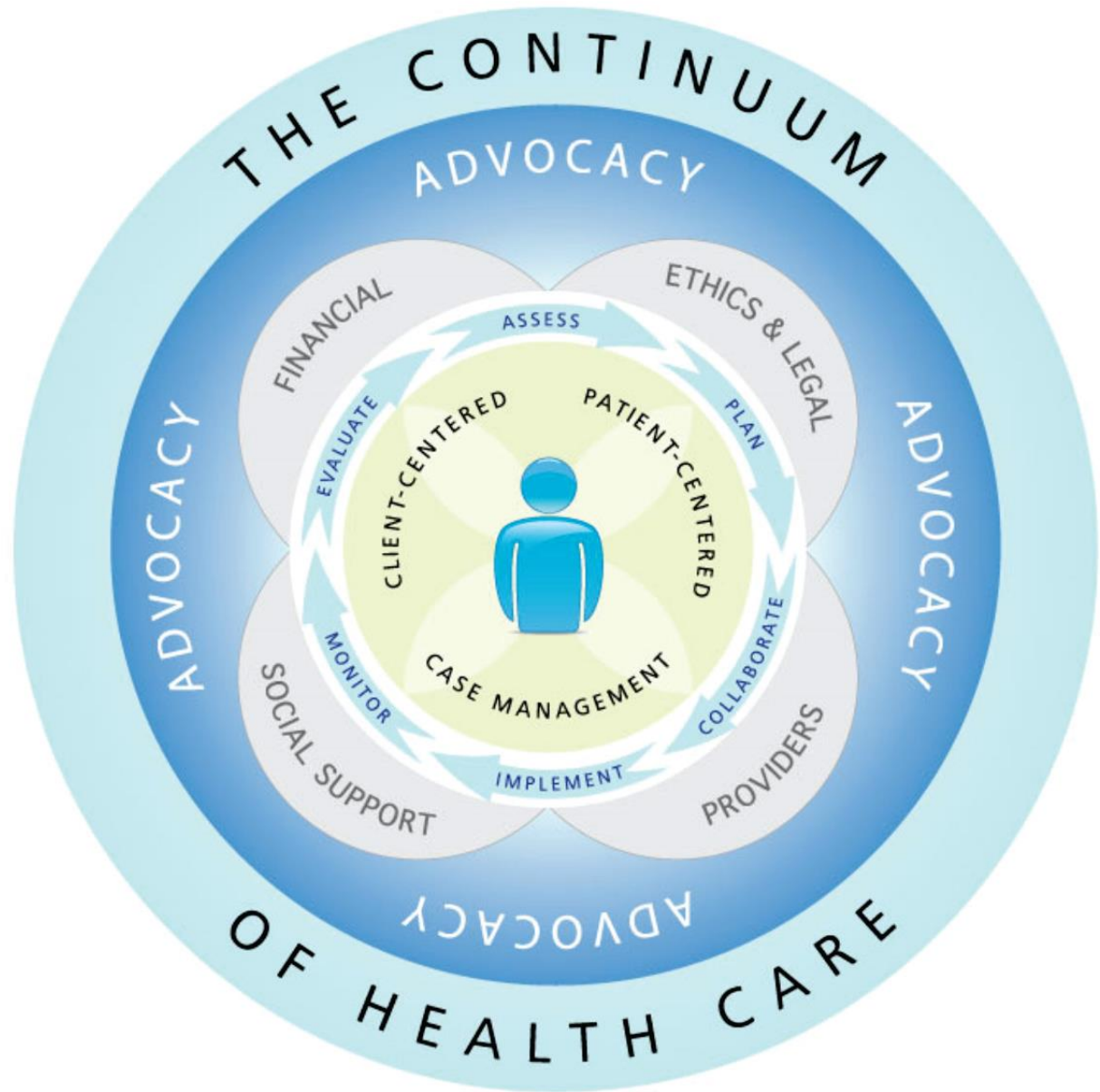
- Case managers foster the careful shepherding of healthcare dollars while maintaining a primary and consistent focus on quality of care, **safe transitions of care**, timely access to available services, advancing patient self-determination and the provision of patient-centered and culturally relevant care.

CMSA Standards of Practice for Case Management

- **The role of the case manager is most closely associated with adhering to established Standards of Practice and advancing patient self-advocacy.**
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# CMSA Standards of Practice for Case Management

## The Continuum of Health Care and Professional Case Management

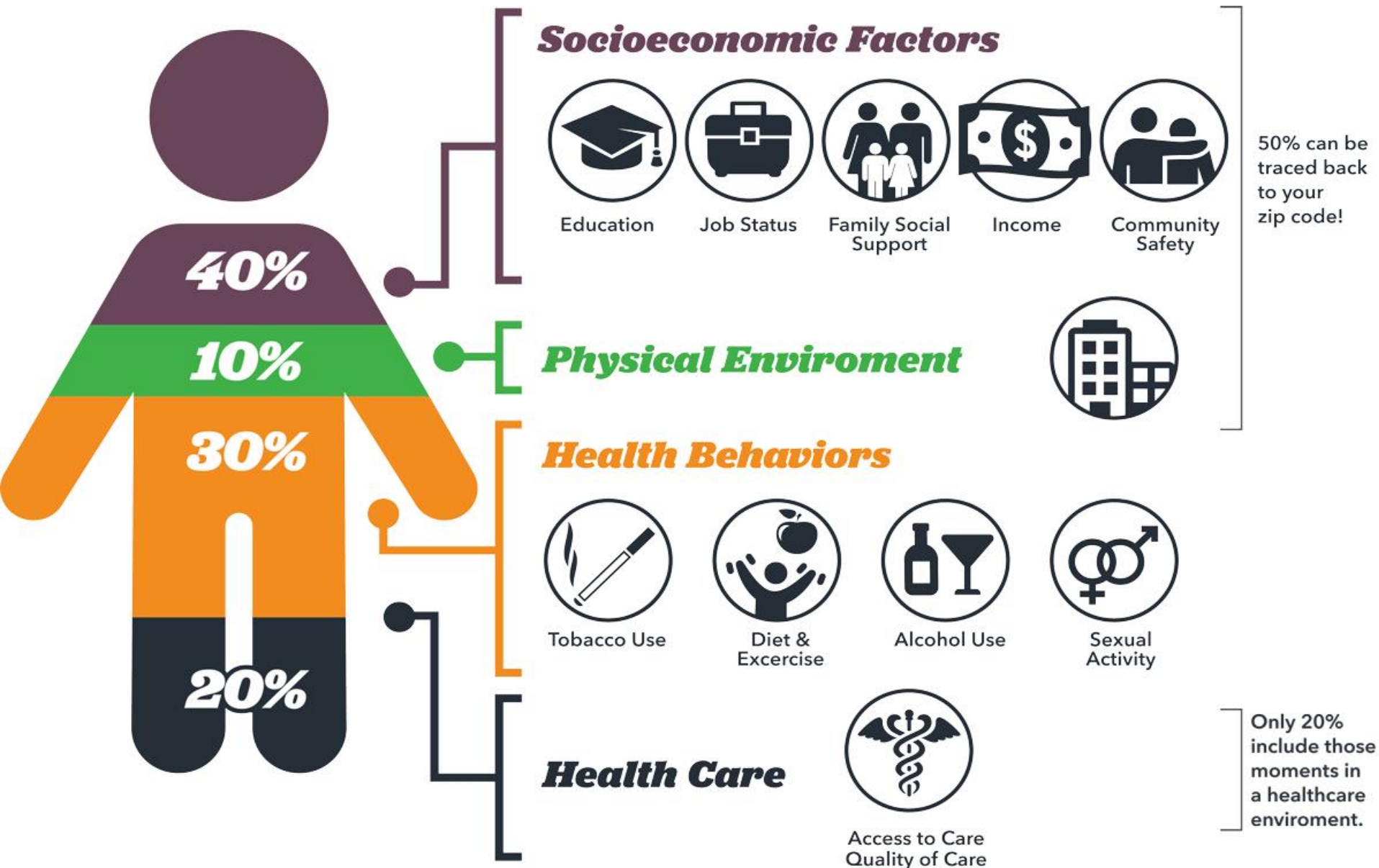


# Transitions of Care Standards

## Identify Patients at Risk for Poor Transitions

- Includes the use of a validated health risk assessment tool and communication of health risk assessment findings to known episodic care managers across the care continuum
- Screening for medical, behavioral and social factors associated with high-risk for poor transitions, including social determinants of health

# Social Determinants of Health



# Transitions of Care Standards

## Complete a Comprehensive Transition Assessment

- Evaluate and document patient/family/caregiver engagement and understanding of current health status.
- Assess self-management abilities, which may include activities of daily living (ADL), instrumental activities of daily living (IADL), patient's decision-making ability and/or willingness to participate in care planning discussions.

# Transitions of Care Standards

## **Perform and Communicate a Medication Reconciliation**

- Compilation of a full medication history, including both prescribed and non-prescribed medications, from all available sources.
- Identification of patients who may be at high-risk for medication related adverse events or non-adherence due to polypharmacy, opioids, high-cost / specialty drugs.
- Review of medication history against active medications in the current setting.
- Verification of medication list accuracy with patient or caregiver.
- Verification of medication adherence with patient or caregiver, and assessment and documentation of any adherence and access barriers, including coverage, affordability, or transportation.

# Transitions of Care Standards

## **Establish a dynamic care management plan that addresses all settings throughout the continuum of care.**

- Review of all available data, including information gathered from patient self-report or from individuals within the patient's support network.
- Review of goals for care and potential transitions for settings and levels of care with patient/family/caregiver.
- **Tracking methodology for high-risk patients with an ongoing care management plan.**
- Identification and documentation of advance care planning documents.
- Documentation of referrals and linkages to community resources and services.
- Documentation of patient and support network agreement to referrals and linkages.
- Supporting documentation that services and referrals meet the expectations and requirements of payers.
- Identification and documentation of **episodic** or **longitudinal care managers coordinating transitions across the care continuum.**
- Communication and sharing of the care plan to known episodic or longitudinal care managers across the care continuum.

# Transitions of Care Standards

## Communicate Essential Care Transition Information to Key Stakeholders Across the Continuum of Care

- Appropriate TOC stakeholders are identified. These stakeholders may include: patient and caregivers, regular ambulatory care provider, pharmacists in all relevant settings, **care manager at the next care setting, payer, and community service agencies.**
- A standardized, securely maintained framework for communication transfer is used
- Communications are deployed electronically whenever possible.
- Information transfer includes an acknowledgement of receipt.
- Essential transition information is communicated including both clinical and social determinants of health. Clinical determinants should include, as appropriate:
  - Diagnosis, co-morbidities, chronic condition
  - Medications, known history of adherence
  - Potential for polypharmacy, opioid or substance abuse
  - Labs and other tests
  - Appointments
  - Cognitive or functional impairments
  - Behavioral health issues



**Silos Restrict the Flow of Information and  
Compromise the Team's Ability to Advance a Safe,  
Timely, Efficient, Effective, Equitable and Patient-  
Centered Practice of Case Management**

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**Collaboration**  
**Communication**  
**Relationships**  
**Transitions**  
**Care coordination**  
**Cooperation**



# The Heart of a Practice of Case Management

# Transdisciplinary Teams

- Identify members of the team and common knowledge gaps.
- Members are not “poofed” into their role.
- All team members share a deep understanding of what each member of the team does to advance an efficient and effective transition of care.
- Move from “what I do” to “what do I need to do to help my patient be more successful in achieving desired goals”
- Look beyond siloed roles and functions to facilitate a sharing of information among all members of the transitional team.

# Communication

- Requires a sender and receiver
- Ineffective communication pathways are a significant barrier to advancing successful transitions of care.
- Care coordination can not occur in an environment that does not support **smooth handovers** of patient-focused information.
- **Effective communication is the cornerstone of a “street smart” case management practice.**
- Supports the belief in and empowerment of a shared patient-specific mission.

A LOT OF  
PROBLEMS  
IN THE WORLD  
WOULD  
DISAPPEAR  
IF WE TALKED  
TO EACH OTHER  
INSTEAD OF  
TALK ABOUT  
EACH OTHER.

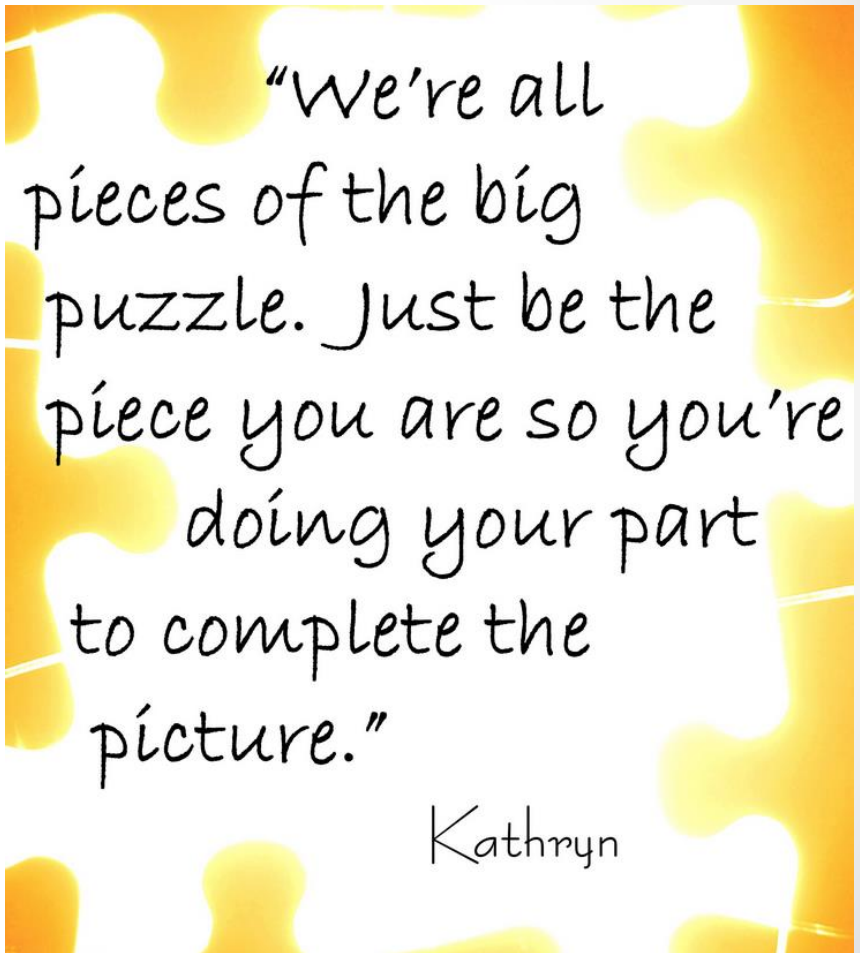
# Relationships



Members of the transdisciplinary team realize their unique roles, functions and responsibilities while sharing their individual knowledge and skills with all members of the transitional care team to support overarching patient specific and identified goals.

# Relationships

- Case managers develop **real time relationships; informal linkages and strong bonds of trust** with all team members
- Who are the multidisciplinary team members?
  - Patient & caregiver
  - Acute care team
  - Payer team
  - Post-acute care team
  - Community resource team



**What Specific Role Do You Play?**

# Transitions



- Successful transitions are a process not an event.
- Often include multiple components.
- Exchange information with all providers and referral sources in a timely manner.
- Ensure appropriate post-discharge follow up and access to community resources
- Clearly define team members' roles; ensure each fulfills responsibilities in a timely manner.

# Transitions

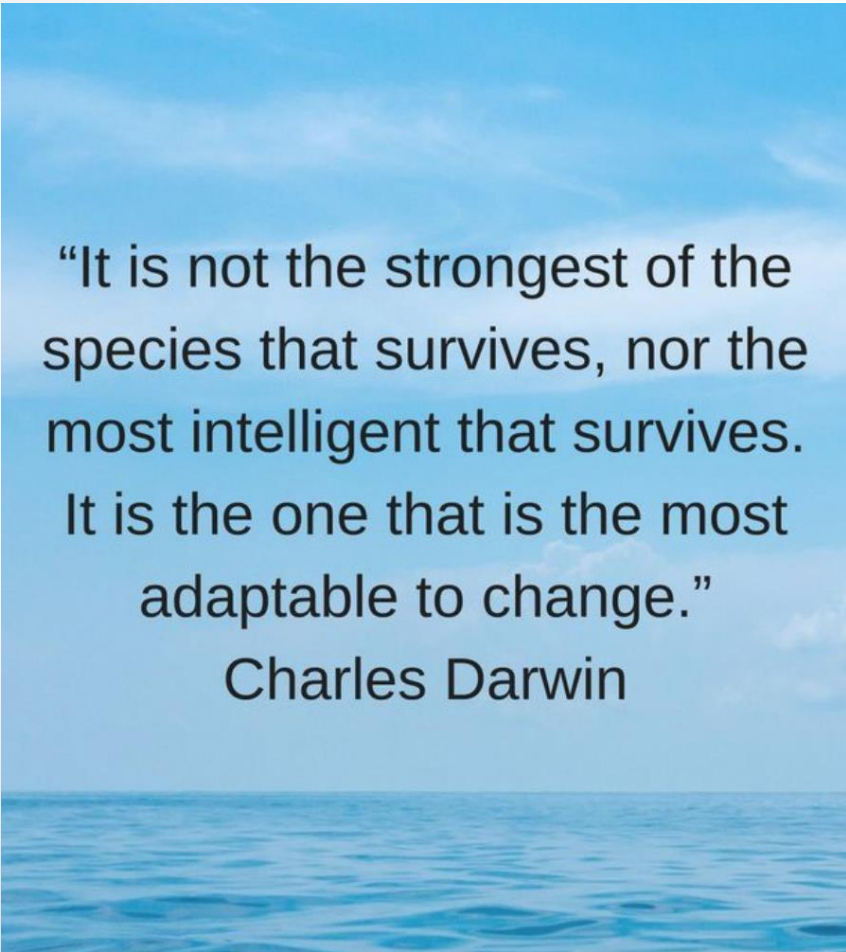
Essential aspects of care transitions

- Patient & caregiver education
- Patient & caregiver engagement
- Patient & caregiver well-being
- Manage complexity
- Care continuity
- Accountability

**YOU ARE PART  
OF A PUZZLE IN  
SOMEONE'S LIFE.  
YOU MAY NEVER  
KNOW WHERE YOU  
FIT. BUT, SOMEONE'S  
LIFE MAY NEVER  
BE COMPLETE  
WITHOUT YOU IN IT.**

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# Care Coordination



“It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.”  
Charles Darwin

- Does your care coordination partner have a different transitional goal?
- Each one of us is accountable and responsible for facilitating the patient’s successful transition to the next level of care; to the next encounter with another healthcare professional; to a level in which the patient is capable of managing their own care.

# Who Guides the Patient?

And a survey of 1,000 seniors said!

- 85% diagnosed with some health condition
- 64% have seen more than 3 providers in the past year
- 69% say they rely on themselves or family to coordinate care.
- 63% of those who were hospitalized said **NO** one coordinated care in the first 3 months following discharge

**There continues to be a focus on  
and utilization of the rawhide  
philosophy of care coordination**

# Care Coordination

Understand your coordination partner's motivation

- Social?
- Financial?
- Advocacy?
- Patient safety?
- Outcomes?
- Recognition?
- Other....



**Excellence IN CARE  
COORDINATION is measured  
in quality not quantity; in the  
performance of duties, not the  
completion of tasks and, in the  
facilitation of desired outcomes,  
not the delivery of instructions.**

# Cooperation

"You can do  
what I cannot  
do. I can do  
what you  
cannot do.  
Together we can  
do great  
things."

- *Mother Teresa*

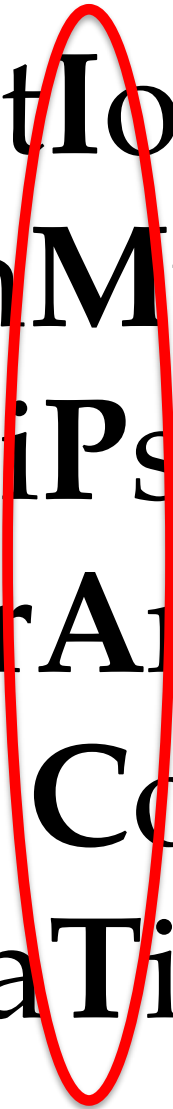
- Cooperation does not exist without the development of relationships.
- Realize the strengths of the transdisciplinary team and the challenges they face.
- Case management is NOT a contact sport.
- Walk in your transitional care partner's shoes



HUDSON RIVER PLANE LANDING  
January 15, 2009

# Cooperation Fosters Collective Accountability

Collaboration  
Communication  
Relationships  
Transitions  
Care Coordination  
Cooperation



# Chattanooga Man's Daily Struggle, Excessive 911 Calls Become Catalyst for Change



# Wouldn't It Be Nice If!

- There was a pathway for telling our story in order to foster a greater community awareness of the practice of case management.
- Common goals for case management could be established across practice settings.
- Consumers were provided education regarding transitional care processes.
- There was a greater focus on the attainment of patient goals rather than financial goals.



**PROFESSIONALISM**  
**Is Being fully**  
**accountable**

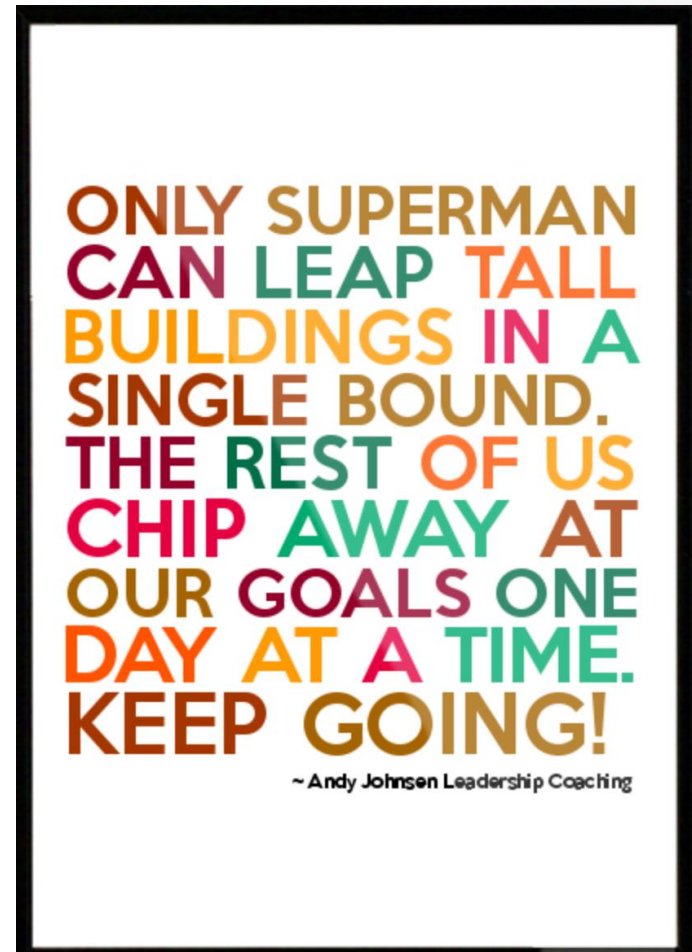




PARIS  
IN THE  
THE SPRING

# Final Thoughts

- The role of the case manager is constantly evolving.
- Success starts at the top of the food chain. Develop and maintain communication pathways with the leadership team in the language they understand.
- Create dynamic interactive processes and programs that extend beyond the walls of your practice.
- **CELEBRATE YOUR SUCCESSES**



# Better Together



# Resources

- **ACMA Standards of Practice & Scope of Services for Health Care Delivery System Case Management and Transitions of Care (TOC) Professionals**
  - [www.acmaweb.org](http://www.acmaweb.org)
- **CMSA Standards of Practice for Case Management**
  - [www.cmsa.org](http://www.cmsa.org)
- **Transitional Care Standards**
  - [www.transitionsofcare.org](http://www.transitionsofcare.org)
- **Definition and Philosophy of Case Management**
  - <https://ccmcertification.org/about-ccmc/about-case-management/definition-and-philosophy-case-management>
- **Let's Get Together – Collaboration and Case Management**
  - <https://www.cmsatoday.com/2017/12/04/lets-get-together-collaboration-and-case-management/>
- **Collaboration in Case Management**
  - <https://www.cmsatoday.com/2016/02/17/collaboration-in-case-management/>
- **Project ACHIEVE**
  - <https://achieve.med.uky.edu>

# The Rest of the Story

