THE CENTER FOR CASE MANAGEMENT

New Definition

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15 Best Practices in Acute Care Case Management

After 30 years of not only pioneering provider-side case management, but paying attention to Case Management practice, it is time to list at least 15 best practices. These are listed below and described as much as possible.

1. Case managers and social workers are respectful partners, each discipline working to the top of their license. Ideally, social workers and RN case managers should be paid equally based on years of experience to eliminate animosity between the two groups of professionals
2. In-person assessment of every patient and their family (if available); not just screening. Assessments are not just a way to gain information, but they are instrumental in beginning what is usually a quick relationship with a patient and family.
3. Assessments should have some tool that evaluates the patient's risk for readmission embedded in them. The classic tools currently are the 8 P's from the Society of Hospital Medicine,[1] the LACE tool,[2] and the Charleson Comorbidity Scale (with additions as shown in *italics* in Figure A). US healthcare is still in a learning curve as to which tools are the most predictive.
4. Care coordination rounds (not "Discharge Planning" rounds) at least Monday through Friday on every unit, ideally led by case managers or social workers, but sometimes led by the nurse manager or charge nurse. They need by held as well on Intensive Care Units. Next steps should *always* be discussed.
5. Weekly or bi-weekly complex care/clinical progression rounds, preferably led by the physician advisor in a teaching/problem-solving capacity and the director of CM. Identification of barriers for progression to realistic clinical or psychological outcomes is extremely important. In attendance at these complex care rounds should be patient financial planning, a representative from finance, and other key administrators. If these rounds don't help after a few sessions, then there should be an individual conference with that patient's hospitalist or specialist and professionals from the community. In academic medical centers, these rounds might be held weekly in different specialties, such as oncology, surgery, cardiology, medicine.
6. 1 FTE educator for large departments, who should be in charge of orientation, assigning and supervising preceptors, and organizing monthly speakers based on the learning needs of the staff. Important topics are: How to help people with chronic illnesses and conditions, how to prevent readmissions, role plays of how to conduct an assessment, how to talk with doctors proactively, how to conduct a family meeting, etc.
7. CM and SW in the ED during prime times. In large EDs prime time may be 24 hours/day! Case Managers and Social workers should not be pulled to other units. ED Case Management is a specialty and there are a lot of responsibilities involved.
8. Staff meetings weekly during times of intense change in the model or responsibilities. CM staff members as a group go through growth stages just like children.[3] They need a chance to get through the polite stage to the "Why are we here?" stage. In this stage, the manager or director needs to explain the rational for the department over and over again. For example, "we are here to achieve the triple aim of the right patient at the right level of care within the right timeframe." Once the staff members feel like they understand why they are there, they

enter a "Bid for Power" stage. There are some staffs that never get past the "Bid for Power" stage, unfortunately. But if the manager/director understands this is occurring, there are ways through it to get to the constructive stage. In my experience, very few staffs as a whole get to the Esprit stage, and if they get there, the phase doesn't last for long! The staff members always need feedback on their successes and problems as related to their data, which should be part of the weekly agenda.

9. A dashboard for CM that describes accountabilities such as shown below:
   - LOS/flow and capacity: DRGs started it all! (1983)
   - No payer denials (including from Medicare)
   - Cost/loss per case
   - Low readmission rates
   - Satisfaction: Patients/families, MDs, staff (HCAHPS)
   - Regulatory compliance with CMS' CoP, PEPPER report
   - Avoidable/delay days
   - Observation level of care rate
10. Administrative/clerical support for director and for case managers and social workers. Sometimes these are called Case Aides or Case Management Assistants.
11. A data analyst specifically for the CM department, or at least shared with another department. Data is crucial for a case management department to review on a regular basis.
12. An onsite Physician Advisor with specific dedicated time for the CM department. Dedicated time should be reserved by the PA for talking with MDs about their concerns, being a member of the UR Committee (best practice is for the committee to meeting monthly, not quarterly).
13. Monthly meetings with the post-acute agencies to discuss their specialties and needs, review readmission statistics from each agency, and make announcements about new programs. Any LTACHs, IRFs, Home Care/Hospice, and SNFs within the surrounding community should be invited. Food should be served and the meeting should held at a convenient time for the agencies. Data should be prepared ahead of time for these meetings.
14. Inpatient and Outpatient/Transition CM under the same VP and director. See Figure B.
15. Family meetings frequently before problems arise. Family meetings are crucial to patient progression. Sometimes they need to be held with the attending physician, and sometimes they can be conducted with an MD present. Social workers usually have the best feel to make this call. Bonnie Geld, MSW and Vice-president of CCM suggests that during the family meetings, case management professionals identify the "Influencer", which isn't necessarily the Power of Attorney, the lawyer in the family, or the best friend, but a person that has influence over the decision-making of the patient and family. It may actually be the clergy person, or the daughter who seems to swoop in last minute.

Figure A

In this example, there is no permanent calculation, just a relative weighting toward high risk.

Mild-Moderate Risk	✓	Moderate Risk	✓	High Risk
History, Myocardial Infarction		Diabetes with Complications		Moderate to Severe Liver Disease
Congestive Heart Failure		Hemiplegia (1 side paralysis)		Metastatic Cancer
Peripheral Vascular Disease		Kidney Disease		HIV AIDS
Stroke		Cancer NO metastases (include leukemia/lymphoma)		Neuromuscular Degenerative Disease
Diabetes with NO Complications		Unhealed wound		*History severe mental illness*
Chronic Lung Disease (COPD, Asthma, Emphysema)		Active drug/alcohol abuse		*Developmental delay/retardation/brain injury*
Connective Tissue or Rheumatic Disease		Incontinent bowel and/or bladder		*Dementia*
Peptic Ulcers				
Mild Liver Disease				

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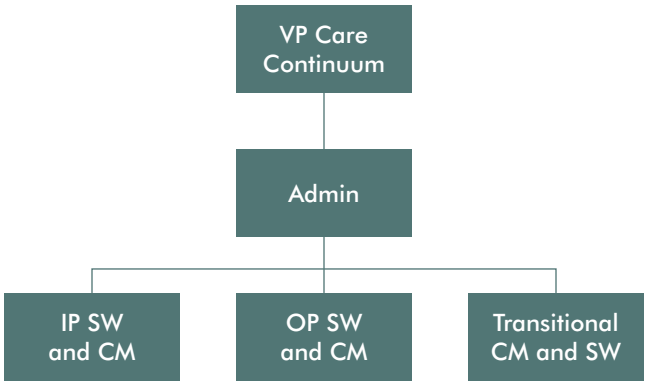
Figure B Suggested Organization Chart for Connecting IP and OP



Endnotes

1 Society of Hospital Medicine; If score over 4, indicates high chance for readmission; 8 P's = (Principal Dx—cancer, PNA, MI, CHF, COPD, DM; Prior hospitalization, Poor health literacy, psychological, Patient support, polypharmacy—over 8 meds—Problematic meds, Palliative care)

2 LACE tool from Health Research and Educational Trust: Length of Stay, Acuity of Admission, Co-morbities; history of recent Emergency Dept. visits

3 Cog's ladder of group development is based on the work, "Cog's Ladder: A Model of Group Growth," by George O. Charrier, an employee of Procter and Gamble, published in a company newsletter in 1972. The original document was written to help group managers at Procter and Gamble better understand the dynamics of group work, thus improving efficiency. It is now also used by the United States Naval Academy, the United States Air Force Academy, and other businesses — to help in understanding group development. *Source: Wikipedia.com*