THE CENTER FOR CASE MANAGEMENT

New Definition

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Community Case Management:

A Caring Blend of Heart, Art, and Science

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Introduction

Every day, Overlake Hospital Senior Care's experienced team of community case managers — masters prepared social workers and RNs — extend beyond the hospital walls to form unique far reaching partnerships with seniors. These seniors have been referred for community case management because of a complex array of social, psychological and chronic health issues that have resulted in frequent hospitalizations and emergency department visits.

Context of our Community Case Management Program

Overlake is an independent, not for profit regional medical center of 337 beds. Medicare comprises 41% of our gross patient revenue, with almost 100% DRG-based revenue. The average inpatient length of stay for Medicare patients at Overlake is 4.1 days.

The Community Case Management program is an integral part of Overlake's Senior Care program. Senior Care is a multifaceted program designed to mobilize the vast array of health resources available through Overlake Hospital Medical Center and Eastside physicians, and in the community, to promote an integrated system of care for the older adult. The staff members of Senior Care work in partnership with older adults and their physicians to promote increased health, independence and informed participation in health care decisions. In addition to Community Case Management, Senior Care provides the following services:

- Information and Assistance and Resource Coordination
- Senior membership program — serving 12,000 members, including a newsletter
- Services for family caregiver and newsletter for caregivers
- ARNP rounding in skilled nursing facilities and assisted living facilities
- Two multi-disciplinary primary care clinics specializing in care of seniors
- Extensive community education with special events
- Walking Program/Contracted fitness programs
- Geriatric Clinical Nurse Specialist implementing the NICHE program (Nurses Improving Care to Hospitalized Elders)
- Volunteer Services offering insurance counseling, estate planning and benefits check-up
- Enhance Wellness — coaching by RN to patients who want to make positive life style changes

Goals and Referral Criteria for Community Case Management

The goals of the Community Case Management program are to reduce unnecessary use of the Emergency Department, support efficient length of stays in the hospital, and reduce re-hospitalizations.

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The referral criteria for Community Case Management are:

- Impaired ability to manage disease (Cancer, Diabetes, Cardiac, CVA)
- Difficulty coping with disease (Denial, Anxiety, Depression, and Cognitive Deficit)
- Poor Functional Status
- Multiple ER/Inpatient admit (2 or more within 6 months)
- ETOH/substance/prescription drug dependence
- Inadequate support system

1. It is important to note that a given diagnosis is not the trigger for a referral. The distinguishing client behavior for referrals is the impaired ability to manage the disease and difficulty coping with the disease. Most of our clients have multiple chronic diseases.
2. We have learned that depression, anxiety, cognitive deficit, poor functional status and poor support systems are the major contributing factors to repeat Emergency Department visits and prolonged hospital stays.
3. Another characteristic is that Community Case Management clients do not often have a physician that they see on a regular basis which is both a symptom and cause of their frequent hospitalizations.

The Activities of Case Managing

Community Case Managers visit clients in their homes and to a great extent their effectiveness is based on the quality of the relationship they establish with their client. The case managers follow through and work on issues until the clients can show that they can practice the issues discussed. Cases are closed only if the client is no longer an active participant, they die or move away. There is no specific time limitation for how long a case may be open. A case may be on monitoring status for several years. Often times it may take multiple hospitalizations (which can be viewed as learning opportunities) for a client to be motivated to make some of the changes a case manager is urging them towards. The most common reason cases are closed is a client dies or the client needs are met. *So as not to confuse clients, while Medicare home health is active with a client, Community Case Management case managers are less active.* Once Medicare home health is over, the Community Case Management case manager assumes the primary role.

Examples of the day to day work of a case manager include:

- Teach about medications
- Arrange for bill paying
- Arrange for DME
- Find volunteers to fix roofs
- Assess home care needs
- Suggest a new doctor
- Teach stress management
- Arrange transportation to doctors appointments
- Work on referring to alcohol treatment
- Suggest pain management approaches

Community Case Management Outcome Tracking/Documentation

The ten areas that are tracked as to outcome status and behavior changes are:

1. Building a trusting relationship with the case manager
2. Building a trusting relationship with the primary care physician
3. Pro-active management of chronic disease(s)
4. Improved medication management
5. Implementation of advanced directives
6. Functional status maintenance/improvement
7. Activated support system
8. Increased personal and home safety
9. Educated/supportive caregiver
10. Client self-efficacy

The outcome grid in the client chart asks the case manager to mark the client progress for each of the above goals (using the well-known Prochaska and DiClemente stages of change model)[1] along the following parameters.

- Not interested in the change
- Considering the change
- Working on the change
  - Making progress
  - Staying the same
  - Losing ground
- Practices the change

Guidelines have been developed to define what each level of change means for each outcome. The charting grid allows the case manager to rapidly identify and document barriers (variances) to the client's progress and determine a plan to help them overcome the barriers which include:

- Physiological condition
- Cognitive status
- Caregiver unavailable
- Socioeconomic barriers
- Low client/caregiver priority
- Cultural factors
- Transportation unavailable
- Community resources unavailable
- Equipment/supplies unavailable
- Physician coordination

Qualifications of Case Managers

The average caseload per FTE is 35. Case managers assume primary or secondary responsibility for a case depending on the urgency of the presenting issues. An MSW/RN team is ideal.

1 Prochaska, J. and DiClemente Stages of Change Model, *cellinteractive.com/ucla/physician_ed/ stages_change* AND all related references on *uri.edu/research/cprc/publications/authors/JProchaska*.

We are often asked if social workers or nurses make better case managers. Our response is that it is best to have a team of RN and MSW even if both are part time (perhaps making up the equivalent of an FTE), than 1 full time person filling a whole FTE. The work is challenging and demanding and needs both sets of skills. See Figure 1 for a comparison of core skills. Basically, case managers need to be resourceful and creative, and most of all see the humanity of the person beyond the challenging circumstances they may find themselves in. Specific qualities that are sought after in each of our community case managers are:

- Experience in community settings (rehab, home care, wellness programs)
- Experience in working with older adults
- Creative and resourceful self-starters
- Autonomous
- Willing to do whatever "hands-on" work is necessary, such as getting a mattress, filling out forms
- Creative use of self vs. authoritarian power

FIGURE 1

Social workers bring strengths in the following areas:

- Financial issues
- Qualifying for benefits
- Psychosocial issues
- Grief/loss/depression
- Personality disorders
- In-depth expertise on Community Resources

Nurses bring strengths in the following areas:

- In-depth knowledge of common chronic illnesses
- Medication Management skills
- Emphasis on education around chronic disease
- In-home assessment/recommendations to MD regarding acute & chronic illness

All staff need to have:

- Excellent relationship building skills
- Broad knowledge of community resources
- Broad knowledge of common chronic illnesses
- Enjoy older clients/families

Our Results

CLINICAL RESULTS

A. Studies and tabulations of our outcome tracking have shown only 50% of clients have achieved the Practicing level at 3 months, but by 9 months progress is evident in all outcomes and at 15 months major success is noted in:

Medication management

Chronic disease management

Functional status

Support system

B. Community Case Management clients make the most progress in improved Instrumental Activities of Daily Living vs. Activities of Daily Living.

FINANCIAL

A. Enrollment in Overlake Senior Care's Community Case Management program is:

Associated with a large decrease in Inpatient admissions

Associated with an equally large increase in Outpatient admissions

Overall hospital charges are dramatically reduced

B. For inpatient admissions that do occur after enrollment, hospital charges per day are reduced as well.

CLIENT SATISFACTION

Clients comment that case managers have "helped physically and mentally", "provided clear instructions", "taught them about medications", "helped them feel better", and "provided them with assistance with care for greater independence".

Conclusion

Community Case Management is a blend of heart, art and science. As Disraeli said "the greatest good you can do for another is not just to share your riches but to reveal to him his own." Community Case Management is a common sense, relatively low cost approach to improved management of the Medicare patient that benefits both patient families, physicians and the health care system.