THE CENTER FOR CASE MANAGEMENT

New Definition

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Highly-Reliable Hospital Case Management: Defining Patient/Family-Centered Standards

What Highly-Reliable Means

According to Webster, the adjective "reliable" means "consistently good in quality or performance; able to be trusted". Going one degree further, "Highly-reliable" is the new phrase for describing hospitals that provide consistent delivery of safety and quality. Dr. Mark Chassin, MD, FACP,MPP, MPH, President and CEO of The Joint Commission believes that the concept of high reliability will be a game changer if safe and effective processes are executed and sustained over long periods of time. He acknowledges that the industry has seen "pockets of excellence", but that there is high variability in performance.[1] Demonstration projects that are not sustainable, or only focus on certain populations, come to mind.

The same concept and goal of high reliability can and should be applied to case management services in hospitals and across the continuum. There are several compilations of important standards available to guide case management departments in a variety of settings. The overarching standards can be found in CMSA's "Standards of Practice for Case Management", first promulgated in 1995 and recently revised in 2010.[2] These standards have helped put case management on the political, economic, and practice setting map. "While the Standards are offered to standardize the process of case management, they are also intended to be realistically attainable by individuals who use appropriate and professional judgment regarding the delivery of case management services to targeted client populations. Additionally, the Standards may serve to present a portrait of the scope of case management practice to our colleagues and to the health care consumers that work in partnership with the case management professional." CMSA promotes client/patient-centered practice (defined as assess, plan, collaborate, implement, monitor, evaluate) across the continuum of health care.[3]

Acute Care Case Management Standards

Specifically for hospitals, the evaluation criteria for achieving the ACMA/The Joint Commission Franklin Award of Distinction states[4]:

- The case management service demonstrates that practice is interdependent and not the function of one person or discipline
- The service demonstrates respect for distinct professional identities and skills
- The practice of case management is the catalysts for stronger relationships that achieve the best care for patients and families
- The practice of case management provides leadership, competence, and expertise in the solution or resolution of defined problems
- The service has evolved through evaluation and innovation
- The patient care provided achieves clinical, operational, and/or quality outcomes

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- Practice is validated by measurable and reportable outcomes
- Improved clinical outcomes are documented to the extent that improvement can be replicated in other hospitals or health systems

In terms of outcomes, one measure of case management can be located in the US Department of Health and Humans Services' national HCAHPS Survey results. It is a 20 question survey sent to patients after hospitalization to measure their perspectives of the quality of care they received. Unfortunately, there is only one HCAPHs question — #19 — that specifically measures the patient's evaluation of case management services: "During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?"[5] Question #20 is related as far as information in writing about symptoms or problems to look out for after discharge, but is generally considered a deliverable of staff nurses as they educate patients, rather than the sole responsibility of case managers.

Another important contribution to case management standards is the definition/description of Care Coordination from the Agency for Healthcare Research and Quality (AHRQ). This is especially needed as hospitals are moving towards becoming Accountable Care Organizations (ACOs). AHRQ[6] has provided standards of care coordination throughout healthcare from three vantage points: The patient and family, the professionals, and the system.

"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."

Three different perspectives:

1. *Patient/family*: "Patients, their families, and other informal caregivers experience failures in coordination particularly at points of transition. Transitions may occur between health care entities and over time and are characterized by shifts in responsibility and information flow. Patients perceive failures in terms of unreasonable levels of effort required on the part of themselves or their informal caregivers in order to meet care needs during transitions."
2. *Health Care Professionals*: "Patient and family-centered team-based activity designed to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the health care system. Clinical coordination involves determining where to send the patient next (sequencing among specialists), what information about the patient is necessary to transfer among health care entities, and how accountability and responsibility is managed among all health care professionals. Care coordination addresses potential gaps in meeting patient's interrelated medical, social, developmental, behavioral, education, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to patient preferences."
3. *System Representative*: "The goal is to facilitate the appropriate and efficient delivery of health care services both within and across systems."

AHRQ's definition of Care Coordination is consistent with that of Clinical Integration from The Center for Case Management (CCM):

> *"Clinical integration in any small part of the continuum, let alone the whole continuum over time and place, is relentless attention to the details regarding each patient/family's current status and the creation of a realistic plan to maintain or acquire an improved health status to which all participants can commit. Clinical integration requires the acquisition, interpretation, and precise acting upon information, enhanced by consistent care-givers and collaboration."*[7]

A New Angle for Assessing Your Service: How Does Case Management Look from the Bed?

For the last 25 years, CCM has noted that the challenge and the solution for healthcare involves CONTINUITY OF A PLAN OF CARE AND CONTINUITY OF A TEAM. Perhaps that goal is finally on the horizon; Dr. Chassin suggests that the place to start with building high reliability is a self-assessment. A unique test is to assess case management services as if you were actually an inpatient in one of *your* hospital beds. The dozen criteria in Figure 1 are offered to assist your department with a self-assessment.

Endnotes

1 Bosognano, M, and Chassin, M. (March 8, 2012) Highly Reliable Hospitals-The Work Ahead; Institute for Healthcare Improvement webinar.

2 CMSA (2010) Standards of Practice for Case Management; *www.cmsa.org/standards*; retrieved July 5, 2012, pg 1-30.

3 Ibid, p. 5

4 *www.acma.org/Franklinaward*; retrieved July 5, 2012

5 *www.hcahpsonline.org/surveyinstrument* (March, 2012); retrieved July 5, 2012

6 AHRQ (2010) Care Coordination Measures Atlas, AHRQ pub #11-0023-EF, December, 2010, p 4-5.

7 Zander, K. (1998 training materials), S. Natick, MA: The Center for Case Management.

Figure 1. What Every Inpatient and Family Should Receive from Case Management and Social Work Services

1. Support of nationally-published Patient Rights and dignity
2. Accurate factual information regarding this admission communicated in a timely and accurate way to all members of the current treatment team in acute care and the next level of care
3. Empathy for the patient and family story surrounding this admission, regardless of payer, socioeconomic status, specific circumstances that precipitated the need for care
4. Advocacy for and teamwork that directly addresses unique, individual needs
5. Coordination of timely, strategic interventions that result in outcomes that are important to the patient and, if possible and legal, the family
6. Assessment within 24 hours of admission of Demographics, Risk Stratification, and causal Attribution if this is a Readmission
7. Procurement of funding and detailed arrangements for a safe, smooth, and sustained transition to the next level of care that will promote recovery, restoration, the highest level of wellness possible, or a comfortable death ; i.e. provision of options to meet ADLs and IADLs
8. Immediate access to Social Work services as needed or requested for skilled support during the crisis of the hospitalization including family meetings, and decisions regarding healthcare for the near future
9. Liaison between the immediate, "hands-on" healthcare team and the payer and payer regulations
10. Access to financial planning if needed or requested
11. Information about who to contact if needed post-discharge until under the care of the designated accountable professional or care-giver of the next level of care
12. Data collected from the patient and family clinical and experience with clinical management of their care will be evaluated in detail and in trended data to improve the clinical outcomes and inpatient experience of others.