CCM
THE CENTER FOR CASE MANAGEMENT

New Definition

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Readmission/ED Revisit[1] Checklist: Prevention Strategies[2]

Pre-admission

- ❑ Patient education and discussion about upcoming surgery, tests, treatments, meds

Emergency Department Visit

- ❑ Comprehensive assessment by ED case manager or SW on every patient during prime time
- ❑ Patient self-assessment in OBS[3]
- ❑ Medication Reconciliation
- ❑ Palliative Care consults in ED
- ❑ Develop program for High ED Utilizers (“frequent friends”)
- ❑ Call patients with lab and test results from the ED

Inpatient Admission

- ❑ Imbed Risk for Readmission Tools in Case Management and SW Initial Assessments
- ❑ Comprehensive admission assessment, with embedded risk for readmission tool[4]
- ❑ Improve discharge instruction sheet—make more individualized rather than solely a legal document
- ❑ Don’t discharge the patient until they are truly clinically stable for 24 hours-CCM
- ❑ Medication Reconciliation
- ❑ Referral to Financial Planning Counselors
- ❑ Discuss Care Transitions Checklist[5] at least 24 hours before discharge (CCM)
- ❑ Designate specific RNs to teach patients—not everyone enjoys it or is good at it
- ❑ Require all CM and clinical staff read Hard Choices for Loving People[6]
- ❑ Use SBAR format for verbal and written handoffs- CCM
- ❑ Provide staff nurse to staff nurse handoffs to SNFs, Home Care/hospice, LTACHs, Rehab
- ❑ Work with Medical Exec to require MD Discharge Summaries to be completed on discharge or within 24 hours
- ❑ Develop SNF Capability List/Grid and distribute to EDs, IP units, all CM and SW staff[7]
- ❑ Develop Care Paths/CareMaps™/CareCalendar™ with outcomes and patient/family responsibilities for a 90-day recovery period—CCM
- ❑ Deliver discharge medications to bedside on day of discharge
- ❑ Analyze data collection tools in use and determine how much predictive value they truly have[8]

Post-discharge Health Coaching

- ❑ Visits by Nurse Practitioners[9]
- ❑ Visits by home-visiting MDs
- ❑ Visits by NP and Pharmacists[10]
- ❑ Schedule post-discharge appointment with PCP
- ❑ Medication Reconciliation
- ❑ Use of IT: RoundingWell, Wellbe, etc. for chronic conditions and behavioral change

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Medical Home/PCP Office

- ❑ Structure immediate post-discharge visit with PCP[11]
- ❑ Medication Reconciliation
- ❑ Embedded Case Managers and SW (for behavioral health evaluations)
- ❑ Evaluate for depression and substance abuse
- ❑ Refer for behavioral health needs/symptoms

Post-acute Continuum

(Home Care/Hospice, IRFs, LTACHs, SNFs, LTC, Medical Home RN or CM)

- ❑ Standardize form for PT/OT recommendations[12]
- ❑ Develop narrow networks of highest quality Home Care agencies and SNFs, including their use of Interact™ and their history of readmissions/ED revisits
- ❑ Care management and/or coaching by outsourced companies[13]
- ❑ Medication Reconciliation
- ❑ My Circle of Support[14]: Professional Helpers, Family, Neighbors, Friends, Church/Support Groups, Volunteer Groups/Clubs
- ❑ Call patients with lab and test results from last day of stay
- ❑ Better supervision of Home Health aides by RNs– CCM
- ❑ Use and/or develop condition or disease/population-specific programs in HC and SNFs
- ❑ Develop a charter with all post-acute agencies[15]
- ❑ Order sets per diagnosis sent to post-acute agencies

Community

- ❑ Use Area Agency on Aging for information
- ❑ Parish Nursing
- ❑ Meals on Wheels
- ❑ Referrals to Specific Community Agencies that have specialized services
- ❑ Include certified Lifecare Planners for legal, health, and financial advice
- ❑ Patient Portals to Hospital, Medical Homes, etc.

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Endnotes

1 Benchmark is 1% for 72 hour Bouncebacks *with* an IP admit. Silverman, M, "Keeping an Eye on 72-Hour Bouncebacks; Emergency Physicians Monthly; October 8, 2014. Based on HCUP 6 state data, revisit rate within 3 days of index ED visit is 8.2%, 32% occurring at a different hospital.

2 "Patients with low physical function, poor self-rated health, and moderate-to-severe depression were at the highest risk of 30-day readmissions." In Odonkor, C., Understanding the Readmissions Nexus: A Focus on the Triad of Patient, Provider, and Community Factors; *Readmissions News*; May 2015, p2.

3 Walsh, K. in ED Case Management: The Compendium of Best Practices: Danvers: HCPro, 2nd Ed 2014.

4 Charleson, LACE, SHM's 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)

5 Coleman, E.; www.CareTransitions.org/tools for providers

6 Dunn, H. Hard Choices for Loving People, 5th Edition; A&A Publishers, Inc, info@hardchoices.com

7 Best practice from Lee Memorial Health System, Ft. Meyers, FL.

8 Recommendation for Seth Blumberg, MD, MPH, Consulting Associate, CCM.

9 www.bostonglobe.com/business/2015/05/10/new-model-aims-to-curb-health-costs-with-personal-care. Featuring Beth Israel, Boston

10 Vincencio, D, Silberstein, S, Capenas, A. "Preventing Readmissions with Help from Pharmacists"; June 18, 2015. Featuring Discharge Clinic of Mercy Hospital and Medical Center, Chicago; and Comprehensive Pharmacy Services.

11 Coleman, E. Structuring the Post-MD visit (source unable to be identified)

12 Idea from Lee Memorial Health System, Ft. Meyers, FL.

13 Navihealth, certified Geriatric Case Managers, etc.

14 From Overlake Hospital Medical Center. 1995

15 Baystate Health, Springfield, MA.