The CENTER *for* CASE MANAGEMENT

Building a Remote Case Management Workforce

Throughout the COVID-19 Pandemic, the critical need for case managers and social workers have been "front and center" however, they have not necessarily been positioned at the front lines as they were in the past. In todays new landscape, we are finding that, except for inpatient departments, Case Managers and Social Workers are extremely effective interacting with patients and families in the virtual world. Case Management team spends time in 1:1 assessment and interaction, is more available, and more effective in follow ups.

Comprehensive assessments and interventions are consistent with the evidence-based practices currently in place in ambulatory settings. Case Managers and Social Workers will continue to use their skills to develop care plans, monitor goals and outcomes, and prepare the patient and family for self-sufficiency in managing their health and psychosocial needs.

The Remote Care Manager should be considered "**The Case Manager of Authority**",  (also relevant in ambulatory case management) meaning that they have a comprehensive view of the patient and, outside of delegation at other sites, will be the main Case Management contact with the patient and family. Delegation occurs when the patient is admitted to an inpatient site where other Case Management professionals are responsible for aspects of their care (such as discharge planning). The Case Manager of Authority will be responsible for connecting with these colleagues to ensure they, too, have a comprehensive view of their needs while under their care and visa versa upon discharges or transitions. Developing a model for Remote Case Management must take into consideration various elements, from technology, to HIPPA, to ensuring effective interventions.

The ability to meet "face to face" (ZOOM, SKYPE, FACTIME) for an initial assessment will be critical. Every effort should be made to use technology available to both the patient and the case manager for a successful interview. While virtual face to face is considered the most effective, not everyone will have this capacity. Preparing for an assessment should take into consideration both a virtual solution and a telephone call.

Mission and Goals for Remote Case Management

The mission of case management is to provide best practice coordination for patients that will ensure they are engaged and able to manage their care in the community and/or in the appropriate setting.

Case Management will be available to support complex patients who need assistance in crisis and/or maintaining independence and successful management of chronic conditions.

Goals:

- Ensure appropriate care at the appropriate level of care
- Avoid unnecessary hospitalization
- Ensure patient engagement and activation

7 Primary Characteristics of Remote Case Management

1. **Client/Patient identification and selection**: Focuses on identifying clients who would benefit from case management services through appropriate screening mechanisms. This step may include obtaining consent for case management services, if appropriate.
2. **Assessment and problem/opportunity identification**: A comprehensive evaluation of patients current and future needs that identifies current needs and provides key information to build a comprehensive care plan
3. **Creation and documentation of a case management plan**: Establishes goals of the intervention and prioritizes the client's needs, as well as determines the type of services and resources that are available in order to address the patient's milestones, goals, and long term outcomes.
4. **Interventions:** Puts the case management plan into action. Paces the case across both the episode and continuum of care
5. **Evaluation of the case management plan and follow-up**: Involves the evaluation of the client's status and goals and the associated outcomes. Evaluates goals based on patient centered goals and deliberate milestone
6. **Discharging Patients from Active Case Management:** Brings closure to the care and/or episode of illness. The process focuses on discontinuing case management when the client transitions to the highest level of function, the best possible outcome has been attained. This could also include reducing interventions.
7. **Tracking for Follow Up:** When the patient is discharged from active services, they should be tracked for about a year to ensure patients continue to manage and maintain goals.

Patient Populations requiring remote case management support:

- Patient Discharges screened in (by the hospital case managers/social workers) for rising risk or high risk
- Patients who have been working with a remote case manager who has delegated care to the hospital case management team

Today, the 2 most popular ambulatory or remote case management opportunities occur when the patient is transitioning from an inpatient hospital or post-acute stay, or when they have been diagnosed with a chronic illness requiring changes in lifestyle. Patients with chronic illness can be considered high risk or rising risk depending on the extent of their illness and number of co morbidities.

Transitions in Care:

Patients who have been screened at high or rising risk following discharge from the hospital. Often these patient's have characteristics such as a number of co morbidities, high cost or multiple medications, or psychosocial issues impacting their ability to manage their recovery without assistance.

Chronic Care Management

These are patients with chronic medical conditions and need support to maintain health in the community. These are often patients who also have complex psychosocial and economic issues.

Embedded Practices in Remote Case Management

Case Management, today, has evidence-based standards that are relevant in any setting. RN's and Social Workers professionals work in the service of the patient and family, but also within the context of the reality of reimbursement and the needs for efficiency. Nurses, social workers, physicians, and others working in case management provide the engine that drives coordinated care as each patient and family receive a customized journey into and throughout their health care journey.

There are both individual as well as interdisciplinary components of this service. This includes:

Individual Professional Contribution	Team Based Care Planning
▪ Comprehensive patient evaluation ▪ Managing and Monitoring Goals and Milestones ▪ Clinical Interventions in Health Literacy ▪ Patient Activation and Relationship Building ▪ Access and Advocacy	▪ Weekly Huddles with Care team ▪ Co Management with Social Work ▪ Co Management with the Physician

Building a remote case management program is essential in these times of Post COVID19. **The Center for Case Management** provides tools, processes, workflows, job descriptions, staffing plans, and dashboards to ensure a comprehensive and effective team.

The Center for Case Management: www.cfcm.com or bgeld@cfcm.com