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Healthcare Solutions

Case Management

The Strategic Approach to Healthcare Management

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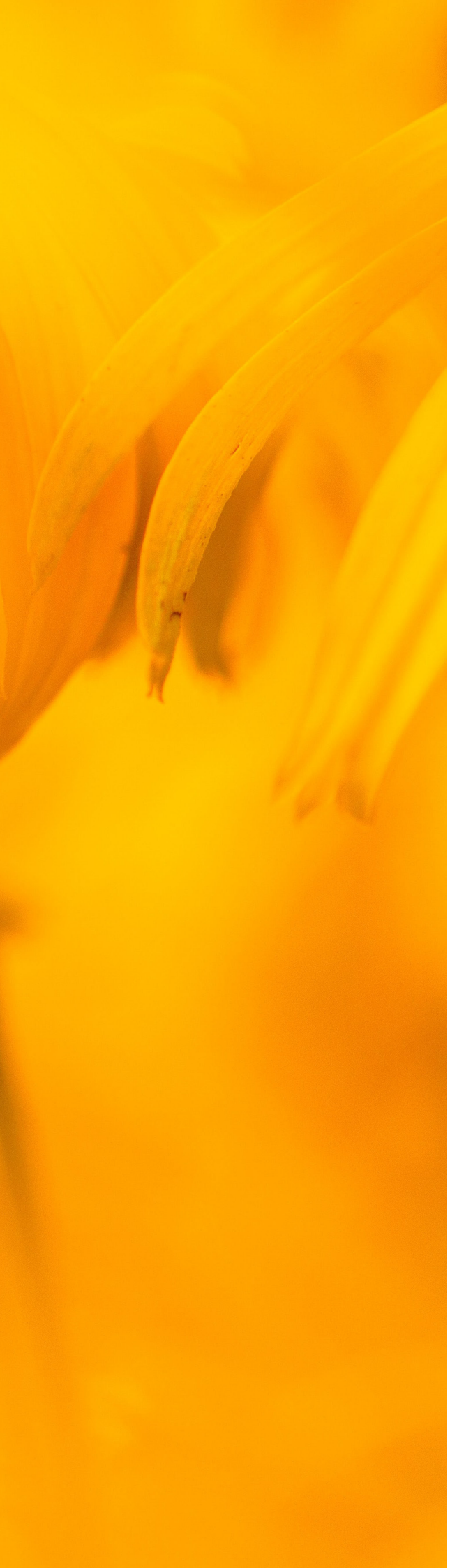


CONTENTS

What Is Case Management?

There is a fundamental shift in today's healthcare system from the perspective of care delivery and payment models. This shift is driven by the following crucial aspects that influence the care delivery process.

Reduction in the cost of care

Improve quality of care delivery

Focus on value based care

Data driven care decisions

Healthcare providers today have realized that the overall scope of health depends on the complexities of a patient's physical, mental and behavioral requirements. As a result of this, care providers are looking to incorporate social service entities into the care continuum.

Case management has emerged as a vital component of value based care. Yet as the healthcare system evolves, some gaps open up as a result of it. Case management is an iterative approach that can bridge these gaps. It is made up of the following processes:

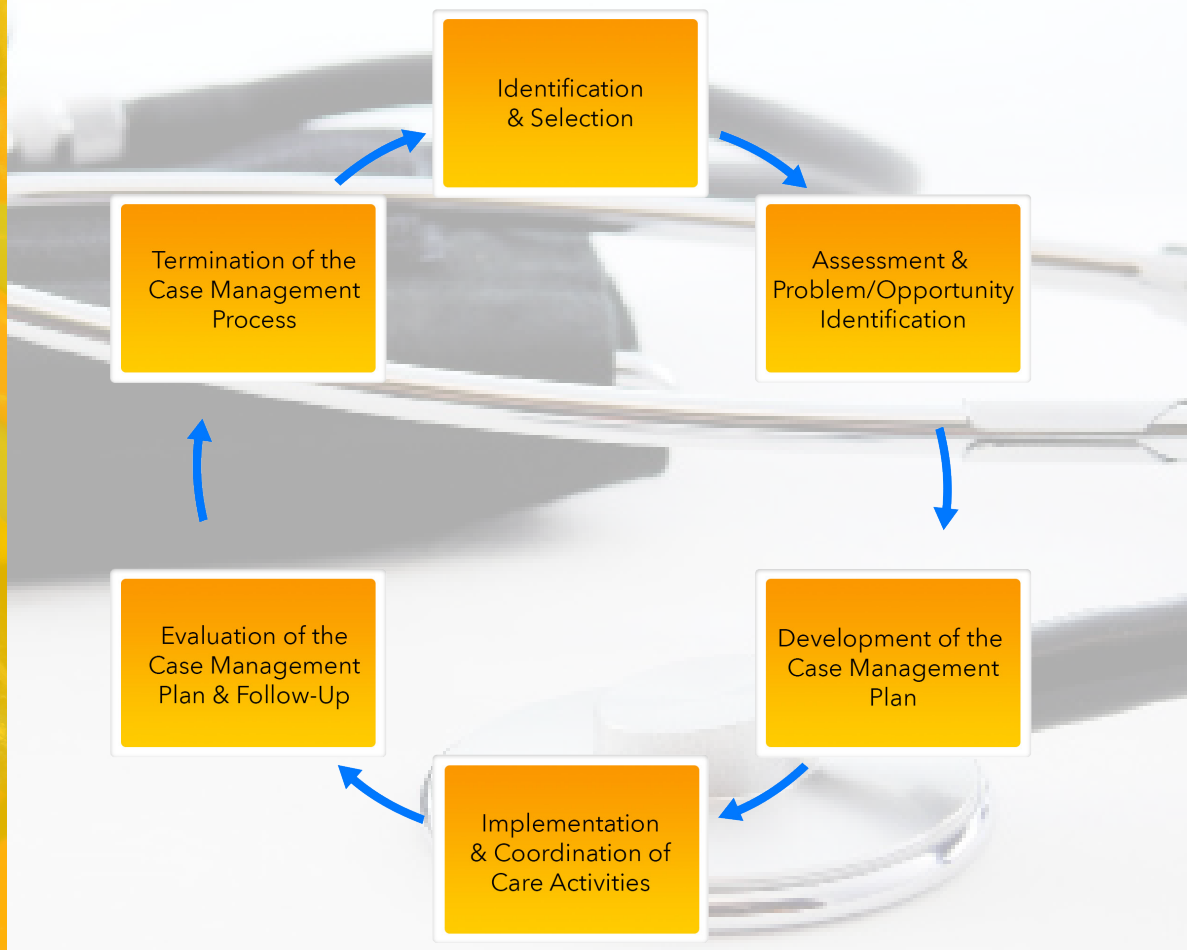
Assessment

Planning

Facilitation

Care Coordination

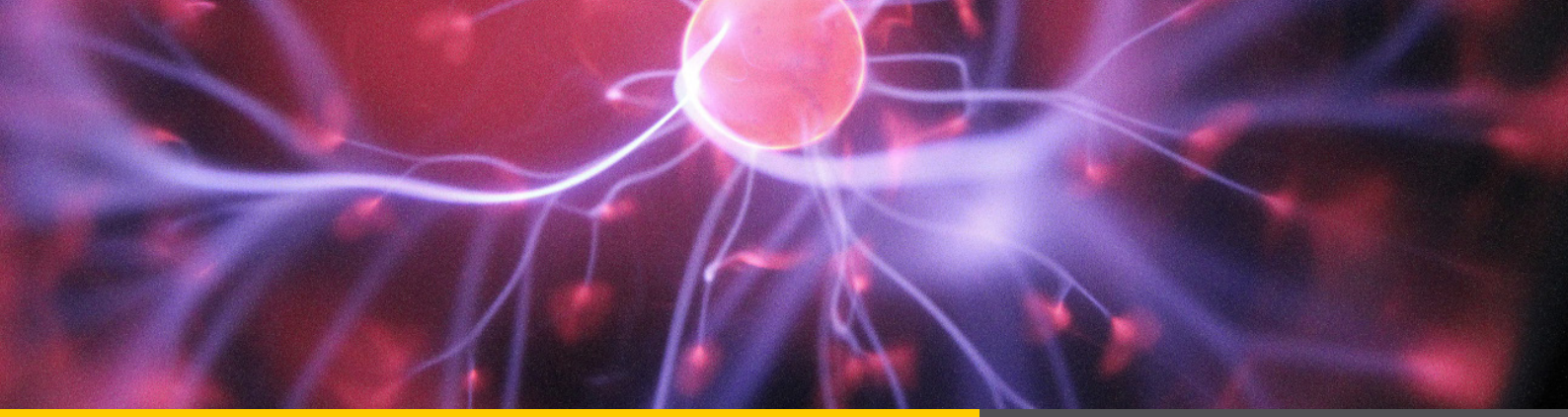
Evaluation



Integrated Case Management

Integrated Case Management (ICM) leverages the expertise of a wider number of professionals. Besides just doctors, this approach 'integrates' the skillet of therapists, nurses, social workers and physicians to create customized care plans across the care continuum. Such a focused approach that is also flexible in the way it allows for patients to be monitored is particularly helpful in supporting multi-morbidity cases.

When care givers begin to assess both the medical and mental condition of a patient in a single evaluation, appropriate health interventions and treatment planning is more effective. By adopting a team based approach, ICM assures participants that there is always a trained professional on standby to support, assist and guide a patient and maintain stabilization outside a hospital environment.



Program Goals

- Increase the ability to manage mental health needs within the community, and avoid utilizing emergency or inpatient services.
- Enhance the individual's ability to reintegrate into the community with extended support.
- Identify possible service gaps and break down barriers that impede the individual's ability to maintain stabilization outside the hospital environment
- Enhance or maintain the individual's quality of life.

Specialized Services

- Case Management and assessments
- Extensive Outreach
- Family Support Services
- Medication Counseling

Complex Case Management

Complex Case Management, as the name suggests, is more in-depth and exhaustive. This approach is designed to support the participating members in a wide range of care settings. Designated case managers who are trained to evaluate members at health risks, direct them to the most appropriate care programs. This focused approach improves the quality of care they receive.

Coordinated care systems enable case managers to identify patient needs and zero in on the guidance they require to achieve total fitness. Case managers enrich the patient with education and an efficient care plan, that helps eliminates hurdles in care delivery.

Goals of the CCM programs:

- Reduce the member's hospital admissions and readmissions for preventable treatment and disease complications
- Validate that a discharge plan is in place for the member and encourage adherence to it
- Assist in the coordination of the physician's treatment plan, consistent with the member's benefits. Help improve the member's overall satisfaction with his/her health care
- Refer members to the appropriate Case Management (CM)/ Disease Management (DM) program(s).

Some of the Criteria for Inclusion in Complex Case Management

- Complex case management program criteria are split into a two-pronged approach comprising – risk factor/s and complex social needs.
- Members should have medical complexity that is compounded by related psychosocial, health behavioral needs.

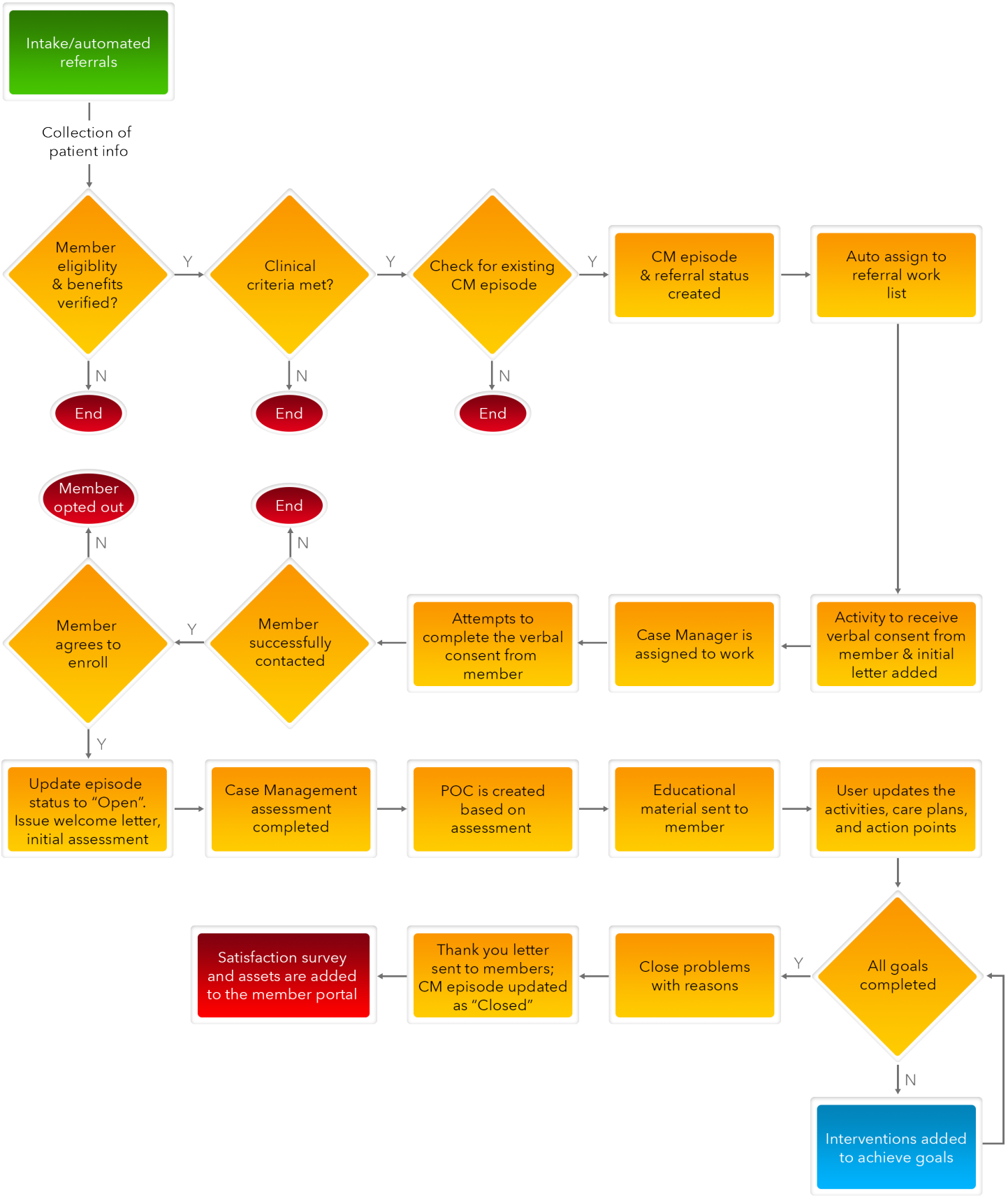
Members with one or more of the following risks:

- Acute health care needs, diagnoses, or hospitalizations
- Complex medical issues and/or co-morbidities
- Frequent admissions (3 within 3 months)
- Multiple Emergency Department (ED) visits (> 4 ED visits/rolling 3 months)
- Predictive modeling identified risk level

and one or more of the following needs:

- Adherence to treatment (meds, visits, behavior change, diet etc.)
- Care Coordination to facilitate communication between providers, appointment making, transportation, specialty visits.
- Patient Education and Activation
- Community Resources to recognize, refer to and access care
- No PCP visit in 6 months

The Workflow:



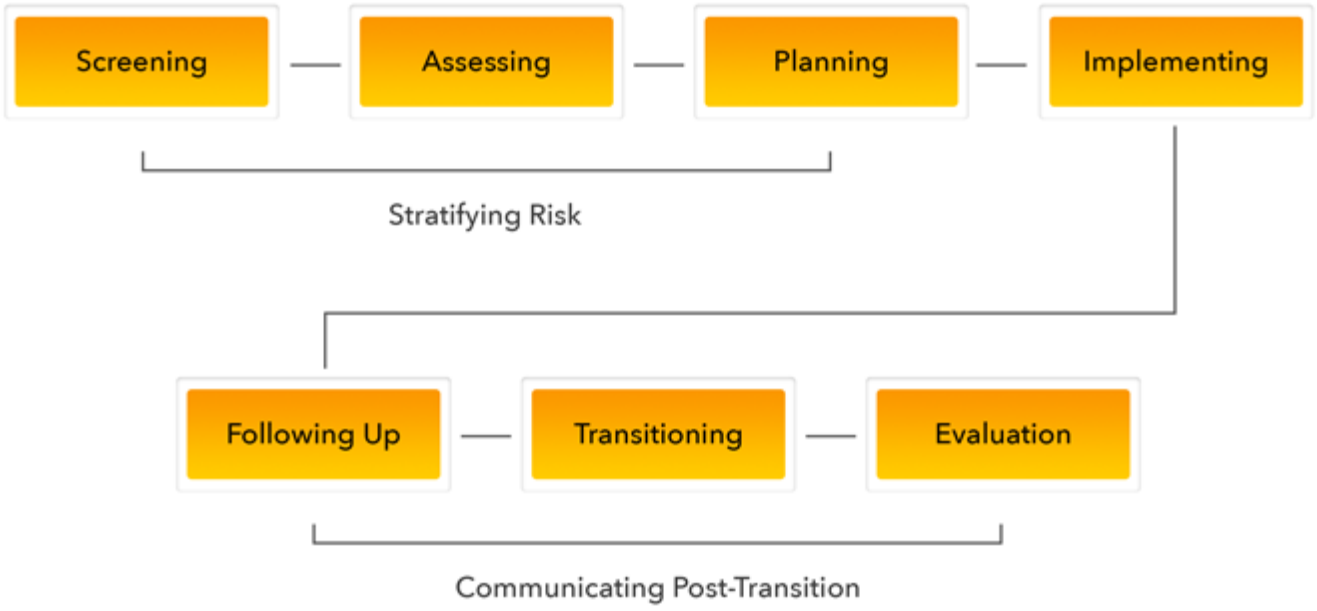
Member Sources for Case Management Program

The client source – that is, how case managers come in contact with clients / members and/or their support systems – varies based on their practice setting. For example:

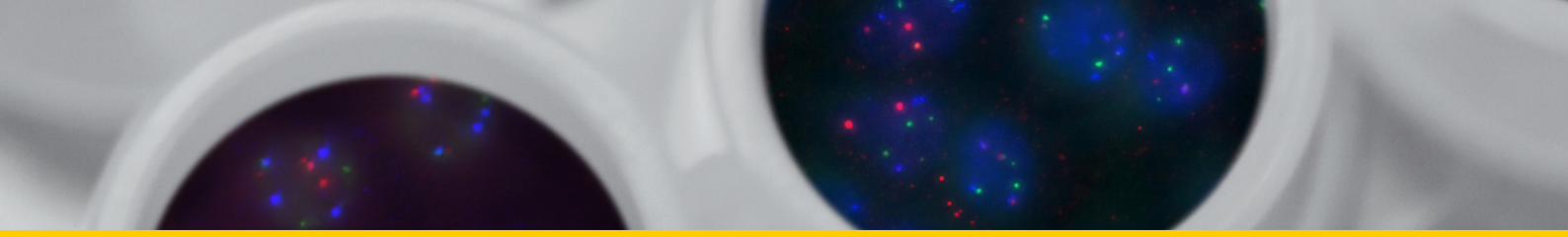
- Case managers may implement the process for a client upon direct contact via the telephone by the client/support system or upon referral from other professionals operational for the payer organization
- An acute care setting-based case manager may implement the process for a client after referral from any of the healthcare team members, including the physician, primary nurse, social worker, consultant, specialist, therapist, dietitian, or manager.
- In many organizations, the job of case managers is to visit every new admission and carry out a high-level review of the client's situation for the purpose of identifying whether the client are getting benefited from case management services.

The Case Management Process

The Case Management Process consists of nine phases through which case managers provide care to their clients



This process is iterative in nature and cyclical, the phases are being revisited until the desired outcome is accomplished.



Screening

The main responsibility of case managers in screening is to establish if a client would benefit from such services or not. Key information gathered during screening will include, to the extent possible

- Risk stratification category or class
- Claims data
- Health services utilization
- Past and current health condition
- Socio economic and financial status
- Health insurance coverage
- Home environment
- Prior services
- Physical/emotional/cognitive functioning
- Psychosocial network and support system
- Self-care ability

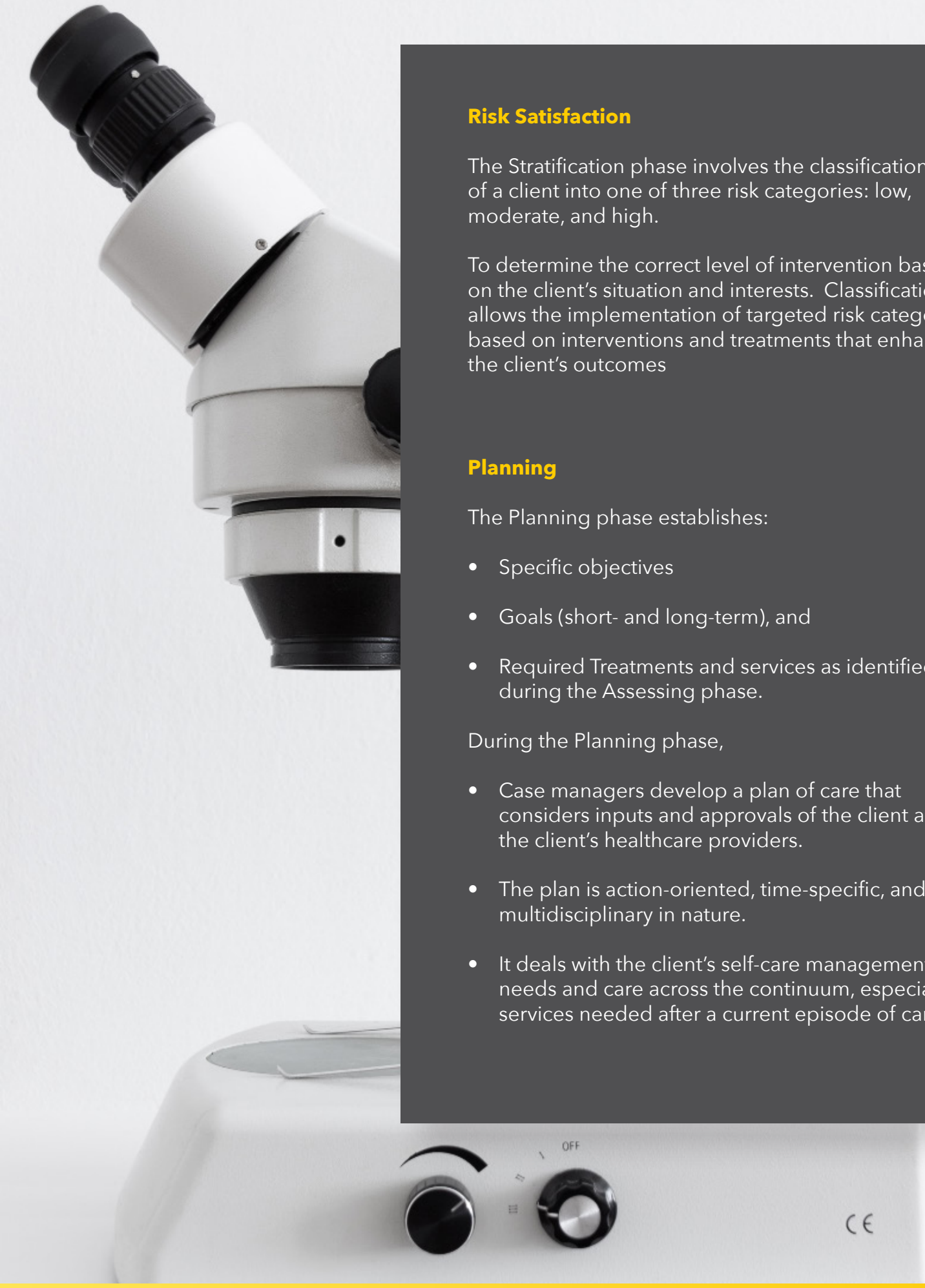
Assessment

Assessing phase engages the collection of information about a client's situation. Information should include

- Past and current health conditions
- Service utilization
- Socioeconomic and financial status
- Insurance coverage
- Home condition and safety
- Availability of prior services
- Physical/emotional/cognitive functioning
- Psychosocial network system
- Self-care knowledge and ability
- Readiness for change.

The primary role of case managers has two objectives to achieve while assessing:

- Identifying the Member's key problems to be addressed, as well as individual needs and interests.
- Building a complete case management plan of care that addresses these problems and needs.



Risk Satisfaction

The Stratification phase involves the classification of a client into one of three risk categories: low, moderate, and high.

To determine the correct level of intervention based on the client's situation and interests. Classification allows the implementation of targeted risk category-based on interventions and treatments that enhance the client's outcomes

Planning

The Planning phase establishes:

- Specific objectives
- Goals (short- and long-term), and
- Required Treatments and services as identified during the Assessing phase.

During the Planning phase,

- Case managers develop a plan of care that considers inputs and approvals of the client and the client's healthcare providers.
- The plan is action-oriented, time-specific, and multidisciplinary in nature.
- It deals with the client's self-care management needs and care across the continuum, especially services needed after a current episode of care.

Implementing: Care Coordination

The Implementing phase highlights on the implementation of the specific case management activities and interventions that are essential for achieving the goals set in a client' plan of care. This responsibility is commonly known as care coordination.

During this phase,

- The case manager organizes, secures, integrates, and modifies (as needed) the health and human services and resources necessary to meet the client have needs and interests.
- Case manager should keep sharing information on an ongoing basis with the client's and support systems, the healthcare providers, the insurance company, and community-based agencies.

Following-up

This phase focuses on the following

- Review
- Evaluation
- Monitoring
- Reassessment of a client's health condition

Case managers primary objective will be to evaluate the correctness and usefulness of the case management plan and its result on the client's health condition and outcomes.
During this phase:

- The case manager further gathers sufficient information from all relevant sources.
- Shares data with the client, healthcare providers, and others.
- Documents in the client's health record the findings.
- Modifies the case management plan, and recommendations for care.

These activities are repeated at frequent intervals and as needed.

Case Management Goals, Objectives, Strategies, Challenges, & Advantages

Why Case Management?

Goals of Case Management:

While the goals of case management are well understood, it is important for caregivers to organize their thoughts. The following are the goals of case management:

Safety: This must be the main focus and goal of the entire healthcare system. It is more than the classic "do no harm" approach. It means no one should ever be harmed by the care process during the course of treatment.

Effectiveness: Medical sciences should be used to assure the best available treatment techniques and to prevent the overuse/underuse of these techniques.

Patient-Centered: The patient's culture, social background, and needs must be respected. Patients must be encouraged to actively participate in making healthcare decisions.

Timely: Care should be prompt. Delays that do not provide information or time to heal should not be tolerated.

Efficient: Continuous effort should be focused on reducing all types of waste (equipment, supplies, space, utilization, and time) in order to ultimately reduce costs.

Equitable: High-quality care should be available to everyone regardless of race, ethnicity, gender, or income.

- To improve the health of populations, a wide-spread approach that requires the engagement of partners across the community.
- To reduce per capita (per person) health care costs and allowing organizations to use the resources in other ways. It should not focus entirely on cost reduction, but rather the value received from the money invested.

Objectives of Case Management:

Objectives of case management are developed to provide actionable, measurable steps that will be taken to meet the goal. They are measured using timelines, budgets, performance measures, and quantifiable resources.

- The patient experience goal should include specific objectives to identify and measure all aspects of care, education, decision-making, treatment modalities, quality, satisfaction, and outcomes for the entire experience.
- The goal of improving the health of populations may go beyond the health system itself and encompass the entire healthcare community
- The goal of reducing the per capita cost of healthcare needs to include objectives that define cost reductions, but they should not focus just on cost-savings. They should identify and measure cost reductions, as they relate to the value received from the money invested.

Other specific program objectives may include:

- Identifying and improving value-based care initiatives
- Improving Transitional Care programs
- Providing more care to more people in real-time
- Reducing unnecessary utilization of services, e.g. admission/ readmission to acute care facilities, length of stay in acute and sub-acute facilities, unneeded treatments and procedures; urgent/emergent care visits; duplication of services
- Assuring follow-up office visits are obtained within 30 days of hospital discharge
- Assuring at least 2 office visits/yr. are scheduled and kept for certain chronic conditions
- Eliminating gaps and fragmentation in care

Strategies of Case Management:

To achieve objectives, clearly-defined strategies (policies or specific action plans) need to be developed. Strategies are determined by analyzing a program's strengths, weaknesses, opportunities, and threats and then using that information to build appropriate strategies that outline the steps that need to be taken to achieve each objective.

- Using cost-savings in other ways to enhance the overall experience
- Avoiding complications that lead to admissions/ readmissions
- Controlling disease progression through education and patient engagement
- Monitoring and managing variances
- Streamlining processes to improve productivity and workflow efficiency
- Improving access and use of appropriate services
- Increasing home visits to assess patient and environment

Explore The Benefits of Case Management

Roles and Responsibilities in Case Management

Case managers are appointed to handle specific duties. Their roles and responsibility can change given the number of stake holders involved in the healthcare system. The following are the roles and responsibilities of case managers from different perspectives.

Health Insurer Setting

- Check benefits
- Negotiate rates with providers
- Recommend coverage exceptions where appropriate
- Coordinate referrals to specialists
- Arrange for special services
- Coordinate claims with other benefit plans

Health Care Provider Setting

1. Validate coverage & benefits with the health insurers to make sure that the provider is correctly paid
2. Organize the services associated with discharge or return home
3. Provide patient education
4. Provide post-care follow-up
5. Coordinate services with other health care providers

Employer Setting

1. Verify medical reasons for employee absences
2. Follow up with patients when they are absent from work due to ill health
3. Provide health education
4. Assist employees with chronic illnesses
5. Provide on-site wellness programs
6. Help employees to seek specialized treatment when need arises

Medical Social Workers

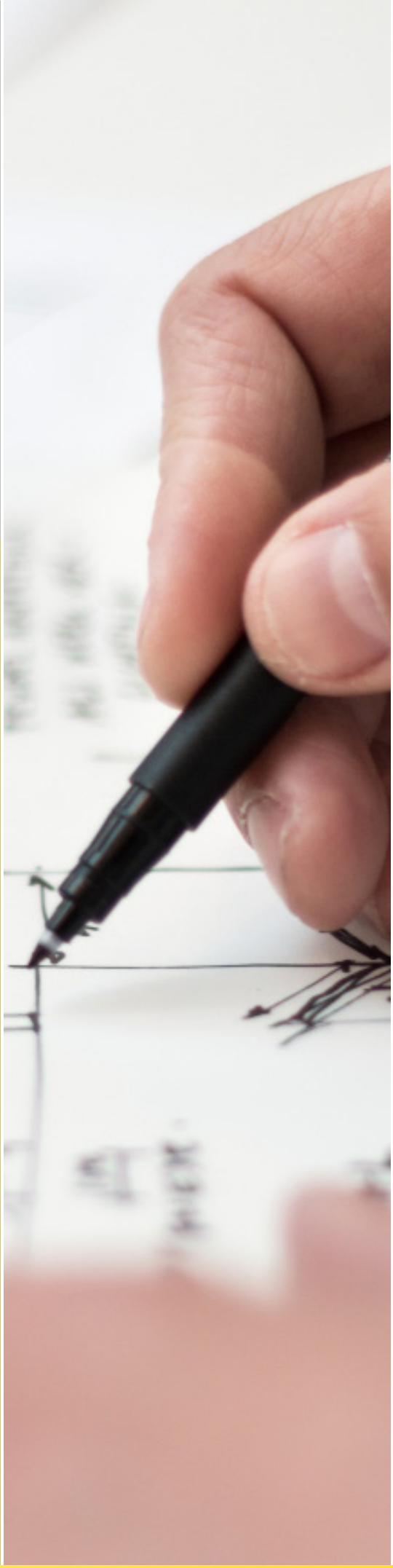
1. Provide comprehensive safety net services including short term case management for individuals who are unable to access community-based services
2. Enroll clients in the Programs and recertify them annually
3. Enroll clients in Early Intervention Services
4. Serve as a backup for general intake and referral to case management for the entire county services system
5. Coordinate entry into nurse case management, including assistance with discharge coordination and transfer from community based medical case management
6. Troubleshoot navigation of the medical care system
7. May screen emergency assistance requests

Community Based Organization (CBOs) Medical Case Managers

1. Receive referrals from Central Intake Coordinator or Medical Doctor
2. Serve Level 1 & 2 clients and possibly Level 3 if client is assessed by nurse case manager and deemed appropriate for the level of care
3. Provide MCM services to those who have chronic medical needs and/or are at a higher functioning level

Nurse Case Managers

1. Clinically assess clients for home care and home delivery of meals
2. Screen and assess Level 3 & 4 clients for Nurse Case Management
3. Provide patient consultations
4. Provide specialized health education
5. Clinically assess physical, mental and safety needs of clients at home
6. Clinically assess client's medication adherence



Challenges in the Case Management Process & Programs

Workflow and Process Challenges

- **Manual Eligibility and benefits verification:**
  For nurse case managers who handle patient intakes, things can get tedious and resource intensive. The main challenge they face is during the verification of member eligibility criteria and benefits for the referred / assigned CM program

- **Worklist case assignment:**
  The case assignment process is leading to a heavy work load for the nurse case managers which results in a decrease in the quality of care, leading to poor health outcome

- **Patient and Provider communication:**
  Communication and coordination between patients and care teams experience delays due to non -integrated contacts, notes, and letters and documents, programs

- **Inefficient workflow transitions:**
  Due to lack of appropriate provider workflows, activity tracking mechanisms, integrated care plans, inefficiencies in workflow transitions arise that vastly hamper the quality of care delivery.

- **Lack of consistency in care:**
  Deviations from the prescribed care plan often leads to process deviations within care teams resulting in patient dissatisfaction.

- **Scattered patient information:**
  The lack of organized patient information, based on demographics and coverage details often reduces the effectiveness of care givers to make more informed health decisions.

How Technology is Changing Case Management

Promising Health Information Technologies

Advanced Case management solutions are helping providers:

- Integrate disparate data
- Provide resources for underserved populations
- Track and care for their patients and clients
- Better operational efficiencies
- Report complete outcomes

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Evolution towards Value-based Care

Healthcare stakeholders are shifting towards value-based care and it gives importance to quality and outcomes rather than the volume of services provided. This care model focuses mainly on prevention, recognizing the medical conditions which can be avoided or addressed.

- Lifestyle changes
- Simple medical procedures like screenings
- Complete treatment (not just biological, but also psychological and social)
- Patient-centric treatment

Value Based Care from a Case Management Perspective

Value based care is a holistic approach; its implementation requires the following:

- Data collection
- Care coordination
- Information Exchange

A Comprehensive Case management system should allow healthcare institutions to:

- Construct a longitudinal record of care, including the patient data received from other providers and organizations.
- Enabling providers with more comprehensive patient data –with these more comprehensive records–to better assess the value of ordering yet another diagnostic test.
- Improve patient safety by avoiding contraindicated prescription medications.
- Providers can evaluate quality indicators and the effectiveness of treatments for both individuals and broad populations.
- Community and social service organizations can provide valuable insight and better predict the potential outcome of a particular individual.
- Share and assess the data–in addition to collecting the data

*"The case management framework is all about the utilization of **knowledge, skills and competencies** to effectively care for clients."*

New Models for Case Management

Traditional Case Management	New Case Management Model
Managed directly by provider organization	Managed by health plans, care management organizations, and provider organizations
Behavioral and physical health-focused	Whole person care (behavioral, medical, social)
Medicaid FFS	Part of bundled/full-risk capitation arrangement
Face-to-face and telephonic interventions	Digital and tech-enabled intervention
Targeted case management	Health homes and speciality medical homes

Promising Health Information Technologies

Healthcare is shifting, and the modification brought about by legislative reform, payment restructuring and technology will be touching every aspect of the field.

Case management technology is transforming the following:

- The way that case managers do their duties but, in some cases, will completely alter the responsibilities itself.
- The arrival of EHRs, wearable technology and the apps that influence them convert into instant communication to overtake the majority of case managers' lives in the coming years.
- The technology exists to place a patient in the correct post-acute setting and these systems will only become more widespread.

In conclusion, case managers will have more access to data and connectivity with their patients once they leave the healthcare settings. Staying connected to patients is going to become a critical function of the case manager. This is not just to avoid the penalties a hospital can anticipate to face if a patient is readmitted within the 30-day window, but also to improve outcomes by helping patients receive the appropriate level of acuity at the right times. Not only will patient communication be enhanced but how they interact with providers will change for the better.

We Can Help

Case management enables care providers to look beyond the traditional'one size fits all approach'. It offers the ideal strategy for care providers to maximize the value of care by matching the needs of the patient with the right medical services.

Explore the possibilities of case management in your healthcare practice.

Speak to Our Experts Today!

About Us

Think Simple. Build Powerful.

That's not just a philosophy; it's our way of life. We are determined to meet your needs and expectations by delivering simple solutions; solutions that would help you derive meaningful insights and better outcomes for your business.

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