CASE MANAGEMENT
FROM ACUTE CARE TO THE COMMUNITY ACROSS THE CONTINUUM OF CARE
“Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensible health needs, through communication and available resources, to promote quality cost effective outcomes. Case Management is a vital strategy for successful healthcare management at all levels of the continuum of care.”

CMSA Standards of Practice 2010
"Case Management in Hospital/Health Care Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self determination."

ACMA 11/2002
ROLES OF CASE MANAGERS

- Hospitals and integrated Care delivery systems including acute care, subacute care, long term acute care (LTAC) facilities, skilled nursing facilities and rehabilitation hospitals.
- Ambulatory care clinics and community based organizations
- Corporations
- Public health insurance programs workers compensation, occupational health, disability, liability, casualty, automotive accident and health long term care insurance
ROLES OF CASE MANAGERS

- Private health insurance Medicare, Medicaid and state funded programs
- Independent and private case management companies
- Geriatric services residential and assisted living
- Long term care services for home and community based
- Hospice palliative and respite care programs
- Physician and medical group practices
- Life care planning programs
- Disease management companies
CASE MANAGEMENT PROCESS

• Identifying high risk and high cost cases to be managed
• Assessing the patient’s needs and the treatment goals
• Reviewing benefits preliminary care plans and goals
• Developing a treatment plan specific to the patients needs
• Cost effectively coordinate access to needed services
• Evaluate the patient’s response to treatment and collaboration
• Evaluate the providers services to promote quality of care
• Evaluate the effectiveness of case management involvement
• documentation
• Maintain appropriate documentation
CASE MANAGEMENT ROLES

- Patient Advocacy
- Patient Education
- Patient triage
- Quality Management
- Resource Management
- Provider Liaison
CARE MANAGEMENT PROGRAM

- Access Coordinator
- Utilization Review Coordinator
- Case Manager/Care Coordination
- Discharge planner
- Clinical Social Worker
- Physician advisor
STANDARDIZATION AND CERTIFICATION

- **CCM** Case Management Standards of Practice 1995 updated 2002 and then 2010. [www.cmsa.org](http://www.cmsa.org)
- Case Management Certification **CCM** as part of Case Management Commission for Certification 1993.
- Case Management Administrator CMAC since 1998
- American Case Management Association hospital based certification since 1999
- American Accreditation Healthcare Commission/URAC since 1999
- Colleges and Universities offer tracks in Case Management at the undergraduate and graduate levels.
TRANSITIONS OF CARE

- Medication Management
- Transition Planning
- Patient and Family Engagement
- Information Transfer EHR
- Follow-up Care
- Healthcare Provider Engagement
- Shared Accountability across Provider and Organizations
ACUTE CARE MODELS

- ACO
- Navigator Case Management/UR
- Medical Model Homes
- Advanced Primary Care Practice Model
- Chronic Care Model
- Guided care model
- Disease Management Model
SECTION 3025 PATIENT PROTECTION AND AFFORDABLE CARE ACT

Hospital readmissions provision requires hospitals to

• Initiate care transition for high risk populations
• Arrange timely post discharge follow-up and health education for high risk patients
• Provide high risk patients and caregivers with assistance to seek timely interventions from providers
• Assess and engage high risk patients and caregivers in self management support.
• Two Midnight Rule, Observation and Inpatient LOC.
CASE MANAGEMENT & PUBLIC POLICY

- Case Management Model Act
- National Case Management Week Resolution Oct 13-15
- National Nursing Bill
- Telemedicine Bill
- Multi-state Licensure Compact.
- Legislation to support changes in the Observation Level of care
NEW MODELS ACA

- Navigator
- Assistor
- Care Coordination
- Advanced Practice Nurses/Physician Assistance
- Medical Model Homes
- ACO Provider based Pioneer Models
- ACO Physician models
CAPE COD NEW MODELS

- Harbor Community Health Medical Model Home
- Duffy Health Center Hyannis
- Outer Cape Health Services: Wellfleet, Provincetown, Harwich
  [http://outercape.org/](http://outercape.org/)

ACO Provider/ Patient shared Accountability or Hospital based to the Community.

Cape Cod health network ACO, Emerald Physician ACO
Physicians of Cape Cod ACO

Cape Cod Healthcare integrated delivery System Acute Care Hospitals, Physician ACO models, VNA Care delivery Skilled Rehabilitation, Outpatient rehabilitation, Outpatient Health centers.
WEBSITES

- CMSA Case Management Society of America: http://www.cmsa.org/
- Center for Case Management Certification: http://ccmcertification.org/
- American Case Management Association: http://www.acmaweb.org/
- Center for Medicare and Medicaid: http://www.cms.gov/
- National Transitions of Care: http://www.ntoc.org/
- Intergenerations: http://www.intergens.com/