Case Management Metrics: Charting Care Coordination Across the Continuum

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Case Management Metrics:
Charting Care Coordination
Across the Healthcare Continuum

This special report is based on data from Healthcare Intelligence Network (HIN) benchmark surveys from 2009 to present. This report is aimed at CEOs, medical directors, case managers, disease management directors, managers and coordinators, health plan executives, care management nurses, business development executives and strategic planning directors.

Speakers
Toni Cesta, PhD, RN, FAAN, senior vice president of operational efficiency and capacity management at Lutheran Medical Center in Brooklyn, New York
Connie T. Commander, RN-BC, BS, CCM, ABDA, CPUR, is the president of Commander's Premier Consulting Corporation
Michael Demagall, LNHA, LPN, administrator for Bath Manor & Windsong Care Center
Robert Fortini, PNP, vice president and chief clinical officer at Bon Secours Health System
Stuart Levine, MD, corporate medical director of HealthCare Partners Medical Group
Rebecca Ramsay, BSN, MPH, senior manager of care support and clinical programs at CareOregon
Craig Samitt, MD, MBA, president and CEO of Dean Health System
Jessica Simo, program manager with Durham Community Health Network for the Duke Division of Community Health
Dr. Edward Phillips, MD, director of outpatient medical services at Spaulding Rehabilitation Hospital Network and assistant professor of the Department of Physical Medicine and Rehabilitation at Harvard Medical School
Marcia Wade, MD, FCCP, MMM, senior medical director at Aetna Medicare
Barbara Wall, JD, founder and principal of CareSync Consulting (formerly Hagen Wall Consulting)

Moderator
Melanie Matthews, HIN executive VP and chief operating officer

Editors
Patricia Donovan
Jessica Papay

Cover Design
Jane Salmon
# Table of Contents

Overview: Case Management in 2011 ................................................................. 5  
2011 Survey Highlights.......................................................................................... 6  
Conclusion.............................................................................................................. 7  
**Metric 1: Patient Education and Outreach**.................................................... 8  
15 Steps to Improve Patient Education and Outreach ........................................ 8  
**Metric 2: Medication Adherence**.................................................................... 16  
Case Management Approach to Medication Adherence ................................... 16  
**Metric 3: Obesity and Weight Management**.................................................. 18  
The Future of Disease Management .................................................................... 18  
**Metric 4: Managing Care Transitions Across Sites**....................................... 20  
6 Approaches to Care Transition Barriers ........................................................... 20  
**Metric 5: Home Visits**.................................................................................... 23  
Home Visit Pilot Reduces Unplanned Readmissions .......................................... 23  
**Metric 6: HRAs in Case Management**............................................................ 26  
Using HRAs to Identify Risk in the Elderly ........................................................ 27  
5 Domains of Patient Assessment for Case Selection ......................................... 28  
**Metric 7: Reducing Avoidable Emergency Room Visits**................................. 30  
Case Management Strategies for High-Utilization ED Patients ......................... 30  
**Metric 8: Reducing Hospital Readmissions**................................................... 33  
A Multidisciplinary Approach to Reducing Rehospitalization Rates .................. 34  
**Metric 9: Patient-Centered Medical Homes**................................................ 37  
Embedding Case Managers in the Primary Care Practice .................................. 37  
**Metric 10: Improving Patient Experience & Satisfaction**.............................. 40  
Patient Satisfaction and ED Case Management ............................................... 40  
Patient Satisfaction a Reality of Healthcare ...................................................... 41  
**Glossary**.......................................................................................................... 43  
**For More Information**.................................................................................... 44  
**About the Speakers**......................................................................................... 50
## List of Figures

<table>
<thead>
<tr>
<th>Figure 1: Case Manager Utilization</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 2: Case Manager Work Locations</td>
<td>6</td>
</tr>
<tr>
<td>Figure 3: Primary Patient Educator</td>
<td>8</td>
</tr>
<tr>
<td>Figure 4: Primary Contacts for Medication Adherence</td>
<td>16</td>
</tr>
<tr>
<td>Figure 5: Case Management in Disease Management</td>
<td>18</td>
</tr>
<tr>
<td>Figure 6: Primary Coordinators of Care Transitions</td>
<td>20</td>
</tr>
<tr>
<td>Figure 7: Transitional Care Statistics</td>
<td>21</td>
</tr>
<tr>
<td>Figure 8: Primary Conductors of Home Visits</td>
<td>23</td>
</tr>
<tr>
<td>Figure 9: 4 Reasons to Conduct Home Visits</td>
<td>24</td>
</tr>
<tr>
<td>Figure 10: Reviewers of HRA Results</td>
<td>26</td>
</tr>
<tr>
<td>Figure 11: HRA Outputs</td>
<td>27</td>
</tr>
<tr>
<td>Figure 12: Uses for HRA Data</td>
<td>27</td>
</tr>
<tr>
<td>Figure 13: HRAs Linked to Care Management Program</td>
<td>28</td>
</tr>
<tr>
<td>Figure 14: Staffing Models to Reduce Avoidable ER Use</td>
<td>30</td>
</tr>
<tr>
<td>Figure 15: 5 Reasons to Embed a Case Manager in the ED</td>
<td>31</td>
</tr>
<tr>
<td>Figure 16: Strategies to Reduce Readmissions</td>
<td>33</td>
</tr>
<tr>
<td>Figure 17: Primary Responsibility for Reducing Readmissions</td>
<td>34</td>
</tr>
<tr>
<td>Figure 18: Stratifying Patients into Care Management</td>
<td>35</td>
</tr>
<tr>
<td>Figure 19: Professionals on the PCMH Team</td>
<td>37</td>
</tr>
<tr>
<td>Figure 20: Embedded Case Managers</td>
<td>38</td>
</tr>
<tr>
<td>Figure 21: Details of Embedded Case Management</td>
<td>38</td>
</tr>
<tr>
<td>Figure 22: Primary Responsibility for Improving Patient Satisfaction</td>
<td>40</td>
</tr>
<tr>
<td>Figure 23: Impact of Case Management on Patient Satisfaction</td>
<td>41</td>
</tr>
<tr>
<td>Figure 24: Scorecard Example for Unblinded Patient Satisfaction</td>
<td>42</td>
</tr>
</tbody>
</table>
Case Management Metrics: Charting Care Coordination Across the Healthcare Continuum

Case management has been identified as a key driver in value-based healthcare delivery as well as a cornerstone of accountable care. 2011 market research by the Healthcare Intelligence Network found that more than 90 percent of survey respondents are using case managers to help identify and manage high-risk patients and reduce avoidable utilization of services.

But exactly where along the healthcare continuum are case managers positioned, and where is their impact felt most acutely? This special report dives deep into several years of market research to identify case managers’ influence and contributions in 10 key areas and provide supporting best practices or case studies from industry thought leaders.

Overview: Case Management in 2011

Targeted case management interventions across the health continuum are resulting in more efficient and appropriate care coordination and utilization of healthcare resources. To set the stage for an examination of the varied contributions of case managers, it is essential to examine a few key metrics from the second annual Healthcare Intelligence Network Case Management survey conducted in January 2011.

The 2011 Case Management survey captured the details of contemporary case management and the evolving responsibilities of today’s case manager. (See “For More Information.”) Responses provided by 201 healthcare organizations to 24 multiple choice and open-ended questions indicate that not only are more organizations utilizing case managers, but that the practice of embedding case managers at the point of care has become de rigueur. For example, the number of case managers working in hospital admissions offices nearly doubled from 2010 to 2011.

Additionally, the contemporary case manager’s job description is much more likely to include home visits, crisis management and quality improvement responsibilities in 2011 than it did in 2010.

Survey Snapshot:

Topic: Case Management
Date: January 2011
Respondents: 201
Metrics:

✔ 91% use case managers.
✔ Top CM duties are care coordination, patient education and discharge planning.
Metric 1: Patient Education and Outreach

To paraphrase a commercial that was popular for years in the East, an educated consumer is the healthcare industry’s best customer. A patient or health plan member that grasps their healthcare options, the plan of care for a chronic condition and the impact of their behaviors on health status is less likely to wind up in the hospital or the emergency room (ER) for treatment of an avoidable condition. Healthcare organizations are learning that an investment in patient and member education is money well spent.

Thirty-eight percent of respondents to the July 2009 survey on Patient Education and Outreach said case managers are the primary patient educators. (See Figure 3.) The survey identified emerging trends and metrics in the areas of patient education and outreach and determined their effect on health outcomes, medication adherence and healthcare cost and utilization. Through responses provided by 134 healthcare organizations to 26 multiple choice and open-ended questions, the survey results offer lessons in the value of educating patients and members about disease management and self-care.

15 Steps to Improve Patient Education and Outreach

By Barbara Wall, founder and principal of CareSync Consulting (formerly Hagen Wall Consulting). Ms. Wall has consulted on several medical home pilots in the Northwest.

Based on my experiences with the patient-centered medical home (PCMH) model, I have developed a list of 15 pre-process and process changes that practices can implement before and during full-scale adoption of the medical home model.

1: Reclassify Your Patient Panel

Keep in mind that the goal is for purchasers to pay for the services that are part of this new model. Proof of its value is demonstrated in part by improvements in clinical outcome measures. A pre-process change that physician practices should consider is to look at their patient panel and classify it in ways that make sense to health plans and other payors of care. One of the initial tasks is to validate whether their members still consider