Case Management Metrics:

Charting Care Coordination Across the Continuum

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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

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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

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.

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.

Metric 1: Patient Education and Outreach

Survey Snapshot:

Topic: Patient Education

Date: July 2009

Respondents: 134

Key Metric:

- ✔ 38% say case or care managers are the primary patient educators in their organizations.

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.

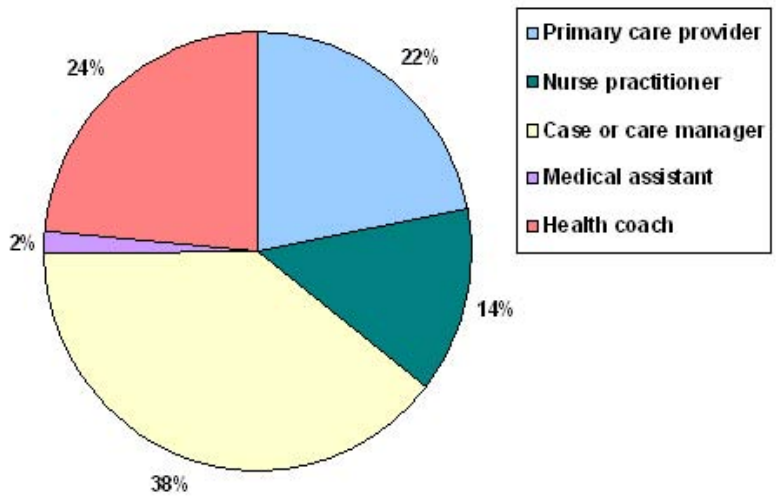
Thirty-eight percent of respondents to the July 2009 survey on Patient Education and Outreach said case managers are the primary patient educators. (See Figure 3.) The survey identified emerging trends and metrics in the areas of patient education and outreach and determined their effect on health outcomes, 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.

Figure 3: Primary Patient Educator



Source: HIN Patient Education Survey, August 2009

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