Optimizing Outcomes

Innovations in Case Management

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9:15 a.m.–10:00 a.m.  Optimizing Outcomes: Innovations in Case Management

HL (Heather) Shepherd Baker, Administrative Director, The Brookdale Center for Healthy Aging & Rehabilitation, Naples, FL

As the acuity of the rehab population increases, the challenge we face is aligning resources to optimize outcomes. This session will explore innovations within case management services relative to realigning care delivery models, the advent of a risk assessment tool, and opportunities for collaboration with community-based entities in expanding supportive programming.
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- Welcome! & Introductions
  - Canvas attendees for their roles within the field of rehabilitation, and interest in today’s presentation
  - Speakers’ Profile:
    Heather Baker, Administrative Director

heather.baker@nchmd.org
www.nchmd.org/brookdale

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• Learning Objectives:
  • Explain the scope of case management services
    - Discuss the shift in acuity, blend of medical management & adjustment/transitional care needs, references to industry practice, & translation to outcomes
  • Discuss the value of predicting risk
    - Look at an example of a discharge risk assessment tool—development of, applications for, & outcomes achieved
  • Describe supportive programming opportunities
    - Partnering with community-based entities: research, programming, & home disposition support
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- As a rehabilitation hospital, our case managers take the lead in coordinating care for patients & families with the primary goal of optimizing outcomes for all stakeholders.

- In starting this project, we looked at two primary outcome measures related to case management services—FY11 data:
  - “Discharge to home” was at 76% compared to the case mix adjusted benchmark of 79%
  - Patient satisfaction with discharge planning—raw score of 85.5

- Journey of Service Development: 2011-2013
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- Then, we looked at industry references related to standards of practice and predicting outcomes.
  - Commission on Accreditation for Rehabilitation Facilities (CARF) related to accreditation for Medical Rehabilitation Case Management
  - The Advisory Board Company: Data-Driven Leadership—Unlocking the Value of Department Assessment, Defining Desired Outcomes
  - Journal Articles & References:
    - Prochaska’s Stages of Change
    - Case Management Adherence Guidelines, Case Management Society of America (CMSA)
    - “We Are All in This ‘Readmission’ Mission Together,” Professional Case Management Journal, July/August, 2010
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**Innovational Strategies:**

- **Strategy 1:** Realign professional resources within case management
- **Strategy 2:** Develop a “risk measurement tool” as a means of predicting outcomes
- **Strategy 3:** Implementation of a e-notification to medical case managers on tests & procedures
- **Strategy 4:** Advent of Community Linkages
- **Strategy 5:** Development of a Patient/Family Guide: Transition & Discharge Checklist
- **Strategy 6:** Development of patient/family support services
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**Strategy 1: Re-aligning Resources—**

- Our case management team had evolved to having two RN Case Managers and one case manager with expertise in social services.
- Each case manager had her own caseload & had responsibilities to physician practice groups overall.
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**Strategy 1: Re-aligning Resources**

- The proposed model aligned each physician service with a dedicated medical case manager.
- The social service case manager serves in consultation to all of the teams to address complex social/discharge planning needs.

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- **Rehab Associates of Naples Service**
  - Medical Case Manager
  - Rehab Case Manager (Consultative Involvement)

- **NCH Physician Group Service**
  - Medical Case Manager
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**Features:**
- Double team approach on select-complex patients/family dynamics
- Increased intensity of concurrent utilization review on tests/procedures & transitional training
- Resulting in improved patient satisfaction scores & discharge disposition to home—(no new costs & potential expense reduction)
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Strategy 2: Predicting Outcomes—

Example: The Apgar Score related to risk of infant mortality

<table>
<thead>
<tr>
<th>Appearance (Skin Color)</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue all over</td>
<td>Blue at extremities</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>“0” beats per minute</td>
<td>&lt;100 beats per minute</td>
<td>&gt;100 beats per minute</td>
</tr>
<tr>
<td>Grimace (Reflex Irritability)</td>
<td>None</td>
<td>Grimace / feeble</td>
<td>Sneeze / cough / pull away</td>
</tr>
<tr>
<td>Activity (Muscle Tone)</td>
<td>No flexation</td>
<td>Some flexation</td>
<td>Active</td>
</tr>
<tr>
<td>Respiration</td>
<td>None</td>
<td>Slow, irregular</td>
<td>Good, crying</td>
</tr>
</tbody>
</table>
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Strategy 2: Predicting Outcomes

- Five areas were identified thought to have high correlation to success of patients discharging home:
  - Admission Functional Level
  - Readmission Risk
  - Environmental Factors
  - Health Literacy
  - Self Efficacy
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**Strategy 2: Predicting Outcomes**

- Development of SHARE Discharge Outcome Risk Assessment—administered by Medical Case Manager as triage tool

- Risk cases are those that score between 4-7 points—cases that are “on the fence” of going home vs. needing a skilled facility
## SHARE Discharge Outcome Risk Assessment

**Patient:** ________________  **Assessment Date:** ________________

### Self-efficacy—belief in ability to complete tasks/reach goals

- **High Level:** willingness & demonstrated practice (2)
- **Intermediate Level:** situational awareness—needs planning assistance (1)
- **Low Level:** limited insight—cognitive and/or situational (0)

### Health Literacy

- Visually Impaired
- Hearing Impaired
- Cognitive Impaired
- Polypharmacy, ≥4
- No Primary Care Physician
- Language/Cultural Barriers

### RIM Admission Notes

### Readmission Risk

- Age ≥65
- Active Co-morbidities ≥2
- Substance Dependency
- Readmission in 30 days
- Hospital Acquired Infection
- History of Frequent Falls, >1/year

### Environmental Accessibility

- Home environment appropriate (0)
- Home with accessibility issues (1)
- Homeless (2)
- Family/Social Network
- Able and available caregiver (0)
- Caregiver constraints (1)
- No capable caregiver (2)

### Environmental Accessibility Notes

### Additional Information

- No Social Service/Case Manager Consult—Continue to monitor for progress/issues
-小朋友Consult: SHARE consultation/referral to:
- Monitoring frequency recommendation: __2/week__ __5/week__ __other__

**RN Assessment Signature**

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Beta Implementation—3 Month Pilot
(Feb-April, 2012)

- 240 Discharges—15% of population was identified “at risk” using the SHARE Assessment
- Breakdown of identified risk factors
- Intensity of direct patient/family interactions increased up from 2.75 to 3.8 contacts per discharge
- Discharge to home: 61%
- Patient satisfaction—% of “very good” went from 36.7% (pre-beta) to 64%

[Pie chart showing distribution of various factors such as Environment, Self Efficacy, Admission, FIM® Rating, Health Literacy, and Readmit Risk]
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208 Discharges—16% of population was identified “at risk” using the SHARE Assessment

Breakdown of identified risk factors—(flex up admission FIM® rating; flex down Environ Factors)

Intensity of direct patient/family interactions increased to 6.94 contacts per discharge (up from a high of 3.8)

Discharge to home: 70.5% (up from 61%)

Patient satisfaction—up to 68% “very good”
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<table>
<thead>
<tr>
<th>Consultative Focus</th>
<th>Interventional Strategies</th>
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</table>
| **Self Efficacy**           |  Promoting early patient care conferences  
                              |  Neuropsychology consultation/counseling                                                  |
|                            |  Support groups  
                              |  Caregiver support                                                                        |
| **Health Literacy**         |  Primary Care Provider  
                              |  REALM                                                                                     |
|                            | Portability Profile                                                                     |
| **Admission FIM® Rating**   |  Emphasis on early family training sessions  
                              | Assistive devices; technology                                                              |
| **Readmit Risk**            |  Primary care/specialists follow-up appts  
                              | Provider collaboration on high-risk conditions: CHF, etc.                                   |
| **Environmental Factors**   |  Home evaluation; modifications  
                              | Financial resources                                                                        |
|                            |  Rehab engineering                                                                       |
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Strategy 3: Collaboration with Information Technology—Test & Procedure Review:

- Implementation of a e-notification to medical case managers
- Retro & concurrent reviews
- Recently expanded to “stat” orders
- Reporting tool
- Applications to Healthcare System
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Strategy 4: Advent of Community Linkages

- Post-acute provider service profiles
- Quarterly forums
  - Collier DME Initiative
  - Need for Community Provider Forum on Medication Therapy Management

As a CARF-accredited inpatient medical rehabilitation organization, we have a responsibility to ensure access to services for the people we serve. It is essential that, in mapping out post-discharge services, planning is done in collaboration with all stakeholders. Additionally, as resources are identified—we must ensure that the care plan will foster ongoing recovery toward the achievement of predicted outcomes.

Some of these relationships are defined through the broader NCH Healthcare System, and others are more specific to the niche of rehabilitative medicine. We are vested in ensuring that our relationships with providers are evergreen.

We define our relationships with providers in the community through two primary means:
1. Maintaining a master roster of providers, including information on the scope of service, contact information, and areas of specialization.
2. Working in collaboration with providers on program development to identify unmet needs and explore the opportunities for expanding services and/or staff development initiatives.

To that end, we invite providers to update their profiles with us. Please utilize the Community Linkages—Provider Profile to share with us any updated information on the organization.

Additionally, we invite providers to participate in quarterly forums. These will be held at the rehabilitation hospital affording an opportunity for providers to interact with hospital & medical staff members. Providers may showcase their services by setting up a vendor table. Additionally, a formal panel discussion will be scheduled for each session to discuss the needs of the rehab population and ways in which we as a provider community can better meet these needs.

For more information, please email Brittany.thoman@nch-md.org
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- Former patient’s spouse provided input & guided development
- Providing to patients/families in Phase IV of the stay

As your healing progresses, the team will focus on transitional skill building & services. This is a time when education is provided related to ongoing health management, as well as fine tuning skills for a successful transition into the community.

The discharge date is determined on the basis of individualized progress toward goals. Your input is important in setting the discharge date. Your case manager will be overseeing your care plan through these phases. Please feel free to talk with your case manager about any adjustments that may need to be explored.

This guide was developed with the input of families we’ve worked with in the past. It’s a checklist of sorts so that we can work together & ensure we have everything well in hand for your discharge.

Our goal is to ensure we provide you with exceptional care management services toward shared success in outcomes. If at any time you have questions, please let us know. We are here to serve you.

Sincerely,
Heather

HL Shepherd Baker, Administrative Director
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Strategy 6: Development of Patient/Family Support Services

- C:ARES—Caregiver Support Group
  - Needs survey of current patients/families & community
  - Collaboration with Jewish Family & Community Services

- Brain Injury Peer Visitor Program
  - Patterned off of Mended Hearts Program
  - Partnering with Brain Injury Peer Visitor Association—Georgia
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Outcome Tracking & Trending: Patient Satisfaction With Discharge

- Most recent 12-week run @ 85.2
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Outcome Tracking & Trending: Discharge to Home

- Most recent 12-week run at 81.7% (77.3%) (nation case mix adjusted)
- 12-week CMI:
  - Brookdale: 1.25
  - Nation: 1.29
- FY11 CMI:
  - Brookdale: 1.17
  - Nation: 1.26
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• Q&A...Discussion?

• References
  – The Role of the Social Worker on the Case Management Team, Toni Cesta, PhD, RN, FAAN; Hospital Case Management, Jun 2012
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References, continued

- Health Literacy for Seniors, Mary Gynn; The Florida Nurse, 2013
- Understanding Cultural and Linguistic Barriers to Health Literacy, Kate Singleton; Kentucky Nurse, 2010

Assessment Tools

Blaylock Risk Assessment Screening Score (BRASS; Blaylock & Caslon, 1992)