Community Case Management

Improving Transitions of Care Since 1995

UCHealth

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Description of Program

The Community Case Management (CCM) program at Poudre Valley Hospital and Medical Center of the Rockies has been operational in the community since 1995. The program was created to assess and manage care of patients needing frequent ER and hospital visits by providing home visits and care coordination. This is a program unique in the country that has evolved over decades with careful self-monitoring and evaluation. The program consists of three advanced practices nurses, two masters prepared nurses and one social worker. The program's goals are to lessen hospital readmissions and ED visits, promote increased client independence and coping, and provide transitional care through care management and care coordination, education and referral to other resources. The program provides home visits with patients by an Advanced Practice Nurse (APN), Masters Prepared Nurse, or Licensed Clinical Social Worker (LCSW).

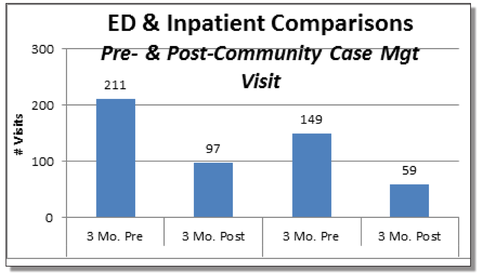
Transitional care is a form of care for the chronically ill adult that focuses on avoiding and preventing poor outcomes for the highly vulnerable and chronically ill (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). A systemic review of 21 articles was done to explore the best models for transitional care and it was recommended to have a nurse be the team lead (especially those prepared for advanced practice), have an in-person home visit, and to focus on patient self-management (Naylor et al., 2011). These recommendations follow the same framework as the Transitional Care Model and the community case management program.

What We Do

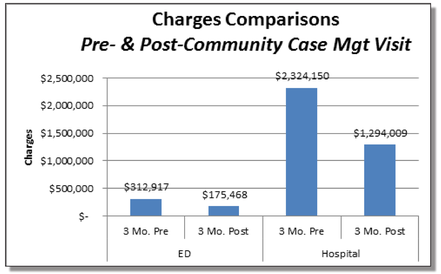
- Provide a comprehensive patient assessment in the home
- Provide periodic oversight of patients through home visits and phone coordination
- Develop and strengthen support networks for patients
- Assist the patient to utilize the health care system appropriately
- Provide this service at no charge to patients who might otherwise not be eligible for other assistance

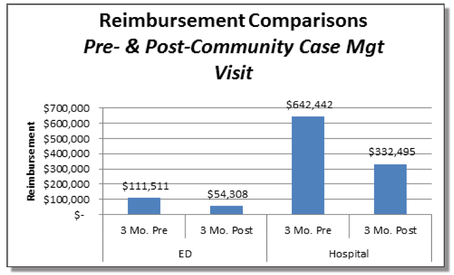
Referral Process

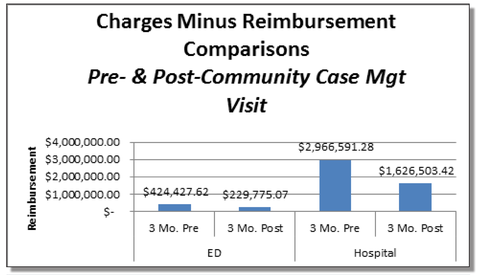
Our referrals are required to be patients within our University of Colorado Health system and can be referred by any concerned party; a doctor's order is not required. Our program is offered at no charge. It has been consistently delivered as a community benefit. This allows for unique flexibility in managing patient problems. Once a referral is made, the assigned Community Case Manager contacts the patient within three business days and makes an appointment for a home visit.



In 2015, patients who were open to CCM services decreased their visits to the emergency department by 56% from the previous 3 months, and decreased their visits to the hospital by 60% from the previous 3 months.







The charges accrued by this primarily Medicare and Medicaid population, go down after a community case manager becomes involved with the patient. Most importantly, the amount of money the hospital loses after being reimbursed goes down after a community case manager becomes involved. In other words, the hospital loses less money if the patient is seen by a community case manager.

Discharge Process

A patient is discharged from CCM services when

- The patient improves functioning
- Treatment goals are met
- CCM interventions are not needed
- The patient enters a long-term facility or other agency services.

In 2014 the average length of service was 9 months.

Meeting Patients Where They Are

On the initial visit, a complete assessment is conducted which includes, review of medical history and limited exam, medication review and reconciliation, evaluation of psychosocial status, functional status and limitations, home safety, advance directives, identification of other services being utilized and financial resources. An ongoing visit plan is established based on patient complexity and needs.

Why

The community case management program came into existence as a solution to prevent unnecessary hospital readmissions and ER visits. The program aims to improve patient care coordination, especially with transitions of care. Developing data to analyze effectiveness has always been a priority.

2015 Outcome Data

The program has historically prioritized writing an annual report. Data collection and analysis have been done annually since inception of the program. Annual reports have included analysis of newly opened clients' charges and reimbursements as well as visits to ED and to UC Health hospitals both 3 months pre and 3 months post initiation of CCM services.

References

Naylor, M., D. Aiken, L., Kurtzman, E., Olds, D., & Hirschman, K. (2011). The importance of transitional care in achieving health reform. Health Affairs, 30(4), 746-754. doi:10.1377/hlthaff.2011.0041

Naylor, M., Bowles, K., McCauley, K., Maccoy, M., Maislin, G., Pauly, M., Krakauer, R. (2011). High-value transitional care: translation of research into practice. Journal of Evaluation in Clinical Practice, 19, 727-733. doi:10.1111/j.1365-2753.2011.01659.x