Centralized Case Management (CCMx):

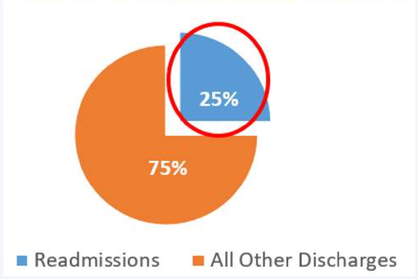
A Focused Approach to Improve Care Transitions Within Skilled Nursing Facilities

Karine Shnorhokian, MSN, RN & Carol Kulkens, MHA, MSW, LCSW, ACM-SW

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) continues to engage healthcare settings to elevate standards to improve the overall quality of care and patient spend. Within the post-acute space, it is estimated that 22%-25% of all skilled nursing facility (SNF) patients are readmitted to the hospital within 30 days.[3] Most of these readmissions are preventable, with primary reasons being due to poor discharge planning and communication.[1] Understanding that value-based care initiatives drive tighter control on the discharge planning process; the need to develop a centralized and efficient case management process within our SNF organization was identified and executed.

NATIONAL AVERAGE: SNF READMISSIONS



OBJECTIVES

1. Establish a remote Centralized Case Management (CCMx) Interdisciplinary Team that supports frontline SNF staff to optimize the discharge planning process.
2. Create an environment that proactively identifies at-risk patients and helps build a consistent processes to improve patient outcomes.
3. Provide evidence-based practice and root cause analysis to identify trends in readmissions and discuss workflow changes.
4. Encourage interdisciplinary communication and standardization while maintaining a patient-centered and quality focused initiative.

PROJECT IDENTIFICATION & DEVELOPMENT

SNFs require ongoing education to better understand patient-centered care transitions and communication techniques to address care concerns timely and efficiently.

Larger SNF organizations with many facilities find inconsistencies with discharge planning, patient optimization, and outcomes.

Discharge planning challenges for patients with complex needs would benefit from an experienced centralized case management task force.

Partnerships to both upstream and downstream providers are necessary to ensure optimal handoffs through appropriate communication channels.

Establishing an interdisciplinary Centralized Case Management (CCMx) Team results in a cohesive process of discussion; ongoing review; and support for the front line staff.

IMPLEMENTATION

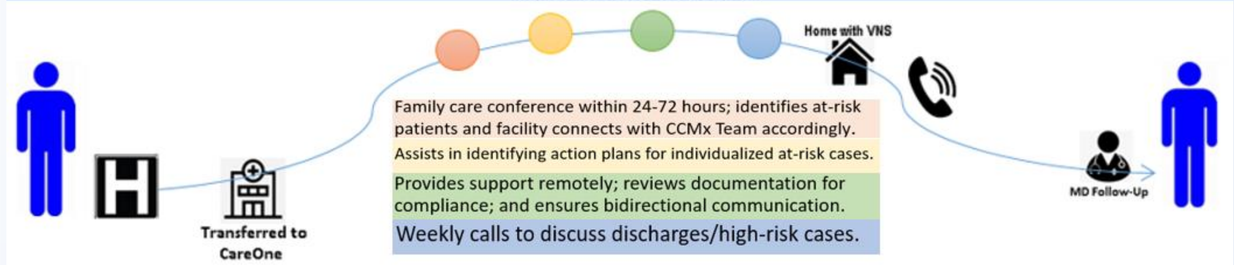
During Q2 of 2019, our organization established the CCMx Team consisting of nursing, social work, and therapy leadership.

Developed an internal system to assist in identifying patients with complex discharge planning needs and additional oversite for guidance and feedback.

Reviewed new admissions identified by the facilities that warranted further discussion and assistance.

Established "20 for 20"-- Bi-weekly calls for 20 facilities allotting them 20 minutes to discuss discharges planned for that week.

CENTRALIZED CASE MANAGEMENT (CCMx) STRUCTURED WORKFLOW



CCMx METHODOLOGY

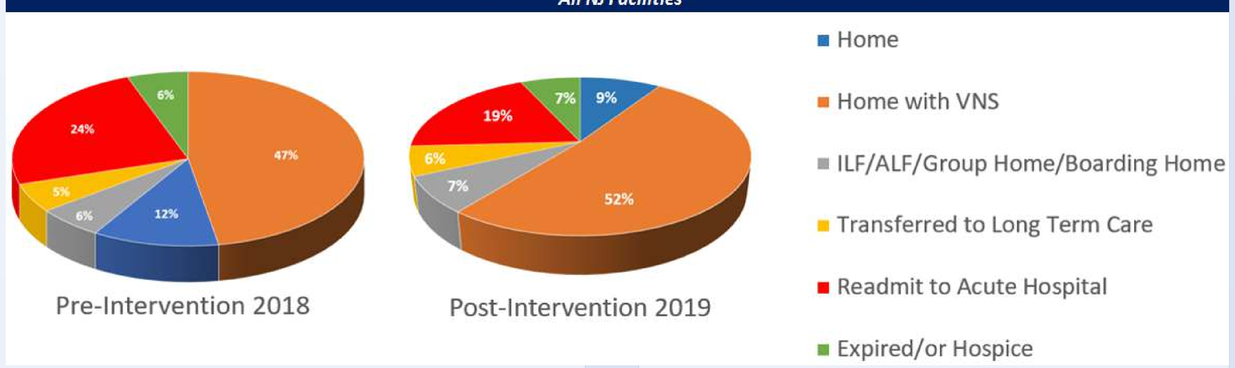
PRIOR TO ADMISSION:	UPON ADMISSION/ WITHIN 72HRS:	ONGOING UNTIL/POST DISCHARGE:
SNF team works with hospital case management to review patient(s).	All new admissions are reviewed timely and flagged for follow-up.	CCMx conducts bi-weekly calls to discuss all planned discharges.
Complete chart review and outline care needs.	Identified concerns are addressed to the CCMx Team for review and follow-up.	Ensure appropriate level of care, DMEs, and downstream provider connections are in place.
Identify psychosocial limitations, cognition barriers, and code status.	CCMx Team remotely connects to ensure care goals and documentation optimized.	Collective discussion on high-risk patients and optimizing discharge calls.
Look at risk for re-hospitalization and opportunities appropriate next level of care.	CCMx serves as a resource to give best practices and educational opportunities.	Discuss strategy for follow-up phone calls for patients and post-discharge appointments.

CCMx CHECKLIST

INTRODUCTORY CARE COORDINATION:	ENSURING SAFE DISCHARGES:	MAINTAINING OUTCOMES:
Initial conversations with the patient and family regarding plan of care.	Review barriers for safe discharge with interdisciplinary team.	Confirm and arrange specific services needed on discharge.
Review safe discharge projection, early education, training, and family needs.	Confirm home assessments and services for those with limited family support.	Educate patient on disease risk and how to escalate concerns post-discharge.
Address financial and psychosocial services available; and make appropriate referrals.	Review functional or clinical requirements that need to be carried over in the home.	Assist with access to care, social determinant risks, and community support.
Use internal tools to identify at-risk patients to help further align care needs.	Verify and complete medication reconciliation.	Discuss with downstream providers on follow-up needs or barriers.

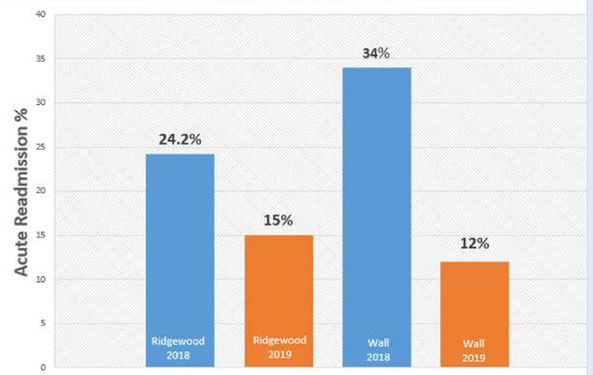
CareOne Dispositions April to November Pre & Post CCMx Interventions

**All NJ Facilities*



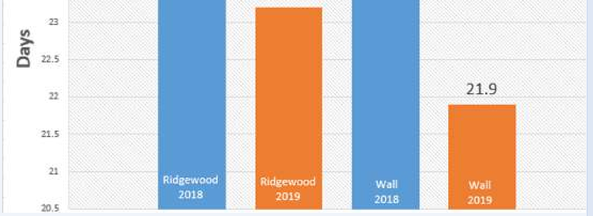
ACUTE READMISSIONS 2018 Q2 & 2019 Q2

**Data Pull Reflects Two Facilities*



AVERAGE LENGTH OF STAY 2018 Q2 & 2019 Q2

**Data Pull Reflects Two Facilities*



LESSONS LEARNED & NEXT STEPS

Preliminary Q2 2019 claims data shows a decrease in overall readmissions, and a slight decrease in length of stay compared to Q2 2018 claims data.

Post-intervention disposition data pulled from April 2019 to November 2019 shows a decrease in readmissions compared to 2018 for all NJ facilities.

Next steps involve the development of an internal risk-stratified measurement tool that is built on key patient characteristics including: clinical, functional, social determinants, compliancy, goals of care, level of assistance, etc.

Based on a patient's risk-stratified score, it will further develop a patient-centered care plan to tailor needs specific to that individual.

Overall goals are to ensure next level of care is managed appropriately and necessary follow-up is maintained.

REFERENCES

1. Britton, C. M., Ouellet, M. G., Minges, E. K., Gawel, M., Hodshon, B., Chaudhry I. S., (2018, Nov). Care transitions between hospitals and skilled nursing facilities: Perspectives of sending and receiving providers. *The Joint Commission Journal of Quality and Patient Safety , 43(11)* , 565-572. http://doi: 10.1016/j.jcjq.2017.06.004

2. Jacobsen, J. ML., Schnelle, F. J., Saraf, A. A., Long, A. E., Vasilevskis, E. E., Kripalani, S., Simmons, F. S. (2016, July). Preventability of hospital readmissions from skilled nursing facilities: A consumer perspective. *The Gerontological Society of America , 57(6)* , 1123-1132. http:// doi:10.1093/geront/gnw132

3. Mendu, L. M., Michaelidis, I. C., Chu, C.M, Sahota, J., Hauser, L., Fay, E., Smith, A., Huether, MA., Dobija, J., Yurkofsky, M., Pu, T. C., Britton, K. (2018, July). Implementation of a skilled nursing facility readmission review process. *BMJ Open Quality , 7(3)* , e000245. http:// 10.1136/bmjoq-2017-000245

Contact: Karine Shnorhokian
Email: Kshnorhokian@care-one.com