Innovation in Complex Case Management: The 4 C's Approach, Then & Now

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Agenda

- Session Goals
- Case Management Overview
- Healthcare Landscape
- Complex Care
- 4Cs
- 4Cs Strategies
- Case Studies

Goals for the Session

- Create a framework for case managers and health care professionals on how to drive innovation in managing complex patient cases. To do so by enhancing patient outcomes by fostering seamless **collaboration** among multidisciplinary teams, ensuring effective **coordination** of resources and services, maintaining clear and consistent **communication** with all stakeholders and delivering **comprehensive care** tailored to the individual needs of complex cases.

- Key highlights for all: focus on elements that contributes to a modernized strategy and innovation in the following areas of the healthcare landscape: **capacity management, complex care**, **care giver support** and **critical conversations** that lead to actionable strategies. These elements are essential and interdependent on achieving optimized resource allocation, improved patient outcomes and successful case management outcomes across the continuum of care.

Case Management Overview

Case Management History, Then

In the early 1900s, case management strategies were implemented by public health nurses at Yale University School of Nursing. A collaborative effort was established between a clergyman and the superintendent of the school. The clergyman described the nurse's role and the requirements he sought in the following ways:

1. Knowledge and expertise;
2. **Communication** skills;
3. Cost containment;
4. **Collaboration** with physicians;
5. Appropriate allocation of resources;
6. Responsibility for overall care of the patient and family;
7. Provision of each patients emotional and psychosocial support and the assurance of a dignified and peaceful death; **(Client Centered)**
8. **Coordination** and management of care;
9. Facilitation of the delivery of patient care activities;
10. Obtaining funds for special programs.

What's Old Is New Again: The History of Case… | Relias Media, *By* ***Toni Cesta***, *PhD, RN, FAAN*

Case Management History, Then

In the late 1980s, community-based case management programs were emerging in many parts of the country as a mechanism for managing patients and resources in capitated environments. One important example is the Carondelet Saint Mary's Model in Tucson, AZ. These emerging and contemporary models returned case management to its original roots: the community. Case management had completed a circle that took more than 100 years to circumnavigate.

The 1990s: As a result of the re-emergence of community-based case management, the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), funded five demonstration projects that used registered professional nurses in the role of community case managers to coordinate care for Medicare beneficiaries.

While case management principles could be found in a variety of community-based settings before the 1980s, case management was not widely used or well understood. It was not until the 1980s that case management truly came into its own. Before 1983, healthcare costs were not of major concern to the healthcare provider. Because most healthcare reimbursement was based on a fee-for-service structure, there were no financial incentives to reduce costs. In fact, because the use of resources was financially rewarded by the healthcare system, overuse abounded.

Early Hospital-based Case Management

Two hospitals attempted to respond to the changing times by addressing the changes in healthcare reimbursement, shortened lengths of stay, and dwindling hospital resources. Carondelet St. Mary's Hospital in Tucson, AZ, and New England Medical Center in Boston, were the first to recognize the need to redesign their nursing departments.

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Case Management Process Overview

"A collaborative process that assesses, plans, implements, coordinates monitors and evaluates the options and services required by the client's health and human services needs".

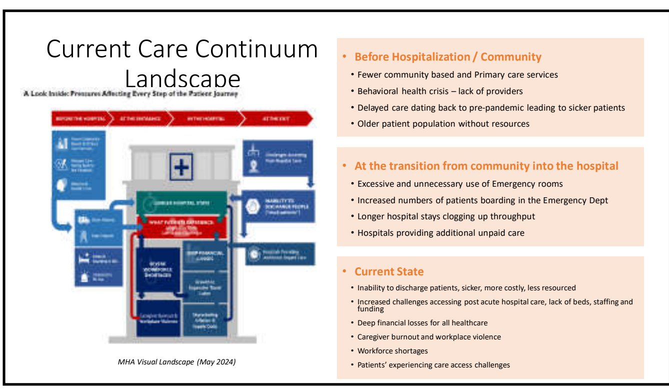
Screening → Assesses → Stratifying Risk → Planning → Care Coordination

Current Healthcare Landscape Impacts

Gillingham, D. C., & Llewellyn, A. (2016b). CCM Certification Made Easy. Blue Bayou Press

Healthcare Landscape

Current Care Continuum Landscape

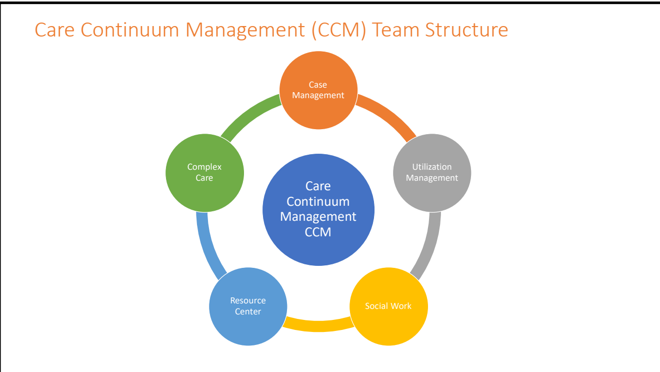


MHA Visual Landscape (May 2024)

- **Before Hospitalization / Community**
  - Fewer community based and Primary care services
  - Behavioral health crisis – lack of providers
  - Delayed care dating back to pre-pandemic leading to sicker patients
  - Older patient population without resources
- **At the transition from community into the hospital**
  - Excessive and unnecessary use of Emergency rooms
  - Increased numbers of patients boarding in the Emergency Dept
  - Longer hospital stays clogging up throughput
  - Hospitals providing additional unpaid care
- **Current State**
  - Inability to discharge patients, sicker, more costly, less resourced
  - Increased challenges accessing post acute hospital care, lack of beds, staffing and funding
  - Deep financial losses for all healthcare
  - Caregiver burnout and workplace violence
  - Workforce shortages
  - Patients' experiencing care access challenges

Complex Care

Care Continuum Management (CCM) Team Structure

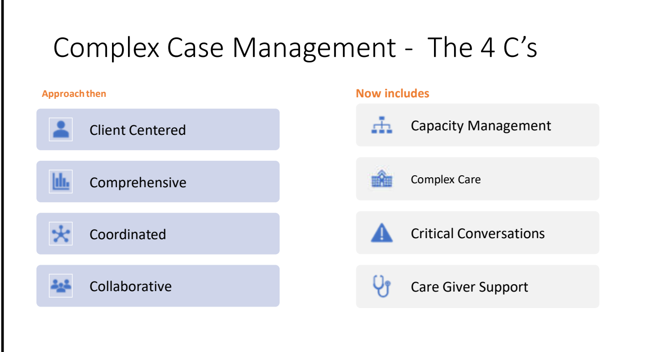


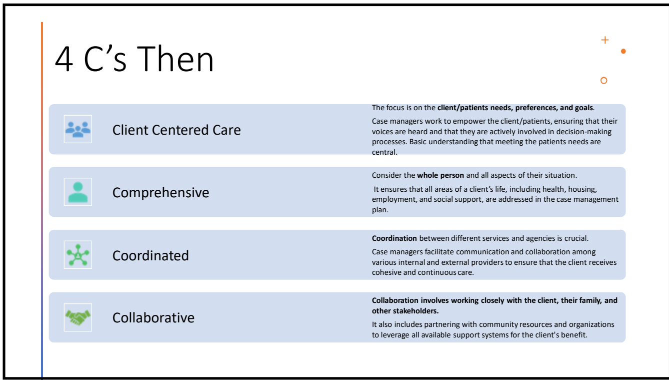
Complex Care

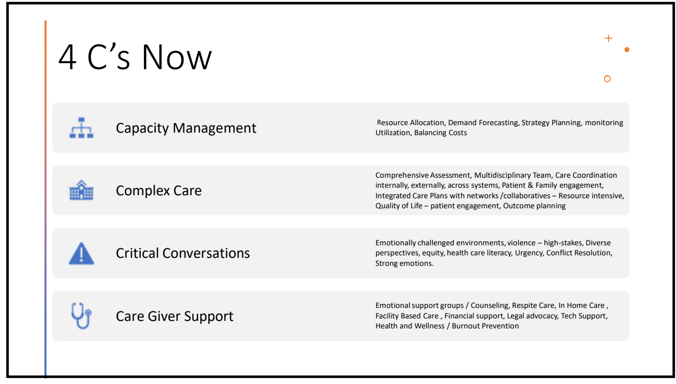
- Comprehensive approach to caring for patients with **complex needs** that have **significant barriers to discharge**.
- Collaboration to address **insurmountable** barriers that are preventing discharge providing for highly personalized, equitable and coordinated care, leading to better health outcomes and improved access to services supporting safe and timely transitions of care.
- Identifies and addresses barriers that impact an optimal & safe discharge through **proactive** and **reactive** management.

Complex Medical Needs | Psycho-Social Needs
Social Determinants of Health | Legal
Placement | Financial

The 4Cs







Capacity Management

- Capacity management refers to the process of ensuring that an organization or system has the **appropriate resources** and capabilities to meet current and future demands efficiently. It is a crucial aspect of operational management, particularly in industries like healthcare and service delivery. Here are the key components of capacity management:

Resource Allocation
Demand Forecasting
Capacity Planning
Monitoring and Adjusting
Balancing Cost & Service

In practice, effective capacity management helps organizations avoid bottlenecks, reduce waste, improve service delivery, and respond flexibly to changes in demand.

Complex Care

- Complex care refers to a **coordinated approach** to managing the health and social needs of individuals with multiple, interconnected, and often severe health conditions. These patients, sometimes referred to as "high-need, high-cost" as well as under-resourced individuals, typically require a range of services across different sectors, including healthcare, social services, and community support. **The goal of complex care is to provide holistic, person-centered care that addresses equitable access to care, for both the medical and non-medical factors affecting a person's health.**

- Complex care is crucial for **improving health outcomes** and reducing costs for individuals with high levels of need. By addressing the full spectrum of a person's needs, **complex care can lead to better health outcomes, enhanced quality of life, and more efficient use of healthcare resources.**

Comprehensive Assessment
Multidisciplinary Team
Care Coordination
Patient & Family Engagement
Integrated Care Plans
Focus on Quality of Life
Outcome Monitoring

Critical Conversations

Critical conversations refer to discussions that involve **high-stakes, emotionally charged, or sensitive topics** where the outcome is significant for the people involved. These conversations can occur in various settings, including the workplace, healthcare, personal relationships, and education. The ability to navigate critical conversations effectively is essential for maintaining trust, resolving conflicts, and ensuring positive outcomes.

- **Prepare**
- **Create a Safe Environment**
- **Stay Focused and Calm**
- **Use Clear and Respectful Language**
- **Seek Common Ground**
- **Manage Emotional Responses**
- **Follow Up**

Maintain Trust

Resolves Conflicts

Positive Outcomes

Care Giver Support

Caregiver support refers to the various services, resources, and assistance provided to individuals who care for family members, friends, or others with chronic illnesses, disabilities, or age-related needs. Caregivers often face significant emotional, physical, and financial challenges, and support systems are essential to help them maintain their well-being while effectively caring for others. **Enhances Care Quality, Prevents Caregiver Burnout, Improves Health & Wellbeing and Reduces Healthcare Costs.**

Emotional Support

Financial Support

Health and Wellness Programs

Respite Care

Legal and Advocacy Support

Technological Support

Educational Resources

Accessing Caregiver Support:
Caregiver support can be accessed through various channels, including local community centers, healthcare providers, non-profit organizations, and government programs. Many organizations offer online resources, hotlines, and in-person services to assist caregivers in managing their responsibilities while maintaining their own health and well-being.

4Cs Strategies

4Cs Strategies

Capacity Management	• Awareness of patients that are medically ready • Focus on patients that are delayed in the hospital for *optimal* discharge planning • Cultivate relationships with post-acute facilities, state level escalation and community agencies • Engage services and departments to improve LOS and avoid progression delays • Awareness of hospital needs
Complex Care	• Focus on supporting patients with barriers to discharge • Collaborate with teams on cases that are escalated • Patient-Centered approach • Handoff to ambulatory providers for longitudinal support • Develop pathways based on trends
Critical Conversations	• Support critical conversations trainings / overviews • Critical conversations may be necessary for optimal discharges
Caregiver Support	• Engage caregivers (as appropriate) • Provide caregivers community service details for support

Case Studies

Case Study #1 - Mr. S

Situation:

- 84yo M retired physicist from the Ukraine admitted to the hospital with PMHx of Parkinson's disease on Sinemet, HTN, and BPH who is brought in by daughter after experiencing frequent falls, confusion, failure to thrive in the setting of non-adherence to carbidopa-levodopa. Daughter moved parents from **Out of State to Boston** to live with her after being found **unable to care for themselves**. Mr. S has exhibited rapid **cognitive decline** with **agitation** and paranoia over the last 2 months.

Background:

- Husband and wife live in Section 8 housing. Wife is primary care giver at baseline. Son out of state cut off ties with parents. Daughter, who was previously estranged from the parents since the age of 14, lives in the Boston area. Within the last year, the daughter reconnected and visited her parents every three months. Last visit revealed a change from previous visits. She witnessed an inability to care for themselves, **lack of finances and bill management, they were found with no food, no medications, unsanitary conditions and a lack of personal self-care.** Daughter brought them to live with her. Patient with a long history of paranoia, which worsened in the 2 months prior to admit. He was afraid to talk on phone (the line being tapped), afraid of being videoed (governmental conspiracies). Wife, primary caretaker, also became ill (medication **non-compliance** and inability to care for not only herself), but also unable to care the patient.

Case Study #1 - Mr. S Continued

Assessment:

The case management assessment was completed day after admission to the hospital. It was a comprehensive review of key barriers outlining the inability to transition to discharge. Not only were risks surrounding readmission identified, but it also identified many social determinants of health components that required follow up from the multi-disciplinary team. The barriers noted were:

- No HCP in a patient without decision making capability
- On a 1:1 with agitation, potential need for Guardianship
- Out of state insurance, an Out of State SCO product (Medicare & Medicaid combo)
- Out of state address, which was low-income housing
- Nationality – Russian speaking as primary spoken and written language
- No services in place (VNA, Elder Services)
- No MA PCP
- Lack of support as daughter works full time
- Primary care-giver, wife, also decompensating in her role of caring for herself and as care giver

Case management then implemented a care plan to include many internal resources within the primary and secondary teams, ensuring all aspects of the patient care is considered. The case manager requested consults for Complex Care, Social work, Geriatrics, Patient Financial Services, and the Care Transitions Specialist. Proactive alignment of assistance to address the complexities and support in the ongoing evaluation, implementation, care planning and transitions of care that ensued. Each area of focus considered important in the process to ensure that the patient receives personalized, continuous, equitable, effective care throughout their healthcare experience and hospital admission.

Case Study #1 - Mr. S Continued

Response:

The Complex Care Team consult order was placed 2 days after Mr. S's admission into the hospital. Conversations began with daughter and team, assessing barriers regarding social determinants of health, financial, psych-social, legal and placement. A comprehensive, proactive review of interventions necessary was created to ensure a safe and supportive discharge plan, including critical conversations regarding the patient's status and future barriers as follows:

- ❖ Patient with complex needs including Parkinsons, **dementia with behaviors** and medication non-adherence, total care, lift OOB: Patient experienced paranoia and thought his medications were being poisoned, his wife stopped picking them up. Psych eval completed.
- ❖ Geriatrics and social work both created care plans supporting Mr. S.
- ❖ OGC involved to review HCP was validity.
- ❖ Patient needing i**nsurance change from Out of State to Mass**, a disenrollment from United **SCO** from Out of State was implemented: Complex Care and PFS worked with insurance entities to disenroll, daily discussions about process took place for out of state and MA. Mr. S had been dis-enrolled from the primary SCO on paper, however still showing as prime in CMS. Involved our external resources, EOHHS Ombudsperson, MHA, who advocated with out of state Medicaid system which then **did** terminate, and Mass Health was applied for.
- ❖ Mr. S needed **address changes** with social security: Complex Care, Social Work, PFS all assisted daughter with process which took many rounds of attempts for the system to upload. Required EOHHS assistance again.
- ❖ **HCP or Guardianship needed:** Complex Care helped support Geriatrics eval, psych eval and social work to obtain a window where patient was eventually able to sign a HCP, OGC cleared.
- ❖ The wife / primary **care giver failing:** Complex Care learned from daughter that her mother was being hospitalized. Aligned the care teams for Mr. & Mrs. S which promoted a transition to Geri- psych for Mrs. S. Both parents ill, in two separate hospitals, daughter given ongoing care giver support. Options offered to help the daughter cope with difficult situation.
- ❖ **No PCP**: Complex Care Care Transitions Specialist worked with Transitions Clinic to support PCP options once the insurance changed. Additional support given to find a Russian speaking provider that Mr. S.
- ❖ **Dementia bed search with pending insurances**: CCT met with SNF's weekly to advocate, had Ombudsperson assist for 1:1 add on, worked with PFS for insurance details for transparency to SNF's
- ❖ Community plan also set up as a back-up, Section 8 voucher obtained, community services researched, day programs, VNA's
- ❖ Rehab Care progression list for optimal PT sessions, allowed him to go from hoyer lift to walker with a RW by Discharge.
- ❖ After being admitted, patient discharged to a SNF with insurance auth from the out of state SCO.

Case Study #1 - Mr. S Continued

Response Continued:

Unfortunately, the story does not end there.

- Even after providing an ideal preparation to Mr. S for the transition, hand off to the facility, extensive communication between the case manager, team, Complex Care, the daughter, unfortunately Mr. S bounced back to the hospital within 24hours of transfer due to an aggressive episode during transition.
- The case manager's evaluation of the plan was deemed that all the necessary pieces were in place and was adapted to the changing needs of not only the patient and his stability, but the facility and their bed availability. They worked with Complex Care, the other consults, the multidisciplinary team and collaboratively worked the plan to fit the situation. Even with the most coordinated approach to a customized complex care plan, you can never identify what non-existent barriers may pop up that you have no control over.
- Upon the case managers post transition follow up, we were updated that the wife had unexpectedly been hospitalized in a geri-psych program, (Mr. S was told), and she was not able to be at the facility upon the transition of the patient. His anxiety, concern and inability to cope with the transition, in the setting of his Parkinson's dementia and his wife not being there, caused his outburst and his return.
- We picked up where we left off. Our process began again with the case manager ensuring the stabilization of Mr. S, assessment of next steps, risk eval, collaboration, planning new SNF referrals, implementing and coordinating once again with Complex Care, social work and geriatrics. Complex Care was able to leverage external resources to press upon taking the patient and having them trust us that the fiscal process was completed, it was taking time to show.
- We aligned with the continued care planning of the wife as well, and both Mr. S and Mrs. S were discharged the same rehab facility. Mr. S was discharged on and **out of state insurance** still was prime. (even with documentation from them that the there was a termination on file and MH was active)! **198 days in the hospital.**

This case embodied Complex Care mitigating insurmountable barriers preventing discharge. We were able to provide coordinated, equitable care, leading to better health outcomes and improved access to services for this patient for have a safe transition of care. All parties were interdependent on achieving the most optimal outcome.

Case Study #2 – Ms. H

Situation:

This is a 56yo African American female who has a **complex past medical history** of AKI (acute kidney injury), Allergic rhinitis, Asthma, Cataract, CHF (congestive heart failure), Chronic pain, Cystoid macular edema, left eye, Diabetes, Edema of lower extremity, Genital herpes, GERD (gastroesophageal reflux disease), Gout, History of diabetes mellitus, type II, Hyperlipidemia, Hypertension, Hypokalemia, Keratoconus, Left eye injury, Major depressive disorder, Non-insulin treated type 2 diabetes mellitus, **obesity (peak weight 750 lbs, currently ~418 lbs** after gastric sleeve), Obstructive sleep apnea (adult) (pediatric), Pigmentary retinopathy, and Snoring. and who has a past surgical history that includes Cholecystectomy; Sleeve Gastroplasty; and Dilation and curettage of uterus. She has a history of CHF and CAD and presents now with leg swelling and worsening shortness of breath despite having been recently started on torsemide. Patient is a known **high ED utilizer** with Ambulatory Care management involvement.

Background:

Ms. H lives with her boyfriend in an apartment, endorses **complex family dynamics** within her larger family, patient is **disabled,** does not work, receives SSI and SNAP benefits. She is ensured by managed Medicaid plan. She is **dependent on a motorized wheelchair** for getting around. She has **bariatric equipment** including hospital bed, commode and cane. She a PCA in place. For supports she identifies she has her SO, mother, father and two grandchildren. Additionally, Ms. H notes her ambulatory care manager as a source of support in her life.

Case Study #2 – Ms. H Continued

Assessment:

The case management assessment was completed day after admission to the hospital. It revealed multiple layers outlining social determinants of health, High Risk Ambulatory Care management involvement, high utilizer of the ED, mental health concerns, an acute care plan, on disability, managed Medicaid in an under 65yo, bariatric equipment needs with some noted in disrepair, h/o trauma, high risk for readmission, discrepancies of services in place, and mistrust in the health care system.

Barriers noted within the initial assessment:

- Bariatric equipment needs as well as a 3 person assist for transfers
- Psycho-social difficulties with h/o trauma, anxiety, panic attacks and life stressors
- Acute Care plan
- High Risk Ambulatory Care management with high ED utilization
- Mistrust in the healthcare system
- VNA not wanting to take patient back

The case manager began to implement care planning necessary to transition to discharge. Cardiology, emergency medicine began medical work up for increased LE swelling and SOB. The proactive approach for barrier management included the case manager suggesting consults / weigh in from Complex Care, PM&R, Psychiatry, Social Work, Chronic pain, neurology, rehab and Care Transitions Specialist. Case management set forth a plan for Integrated interventions in a patient with chronic health conditions, high-risk criteria and resource intensive. Appropriate proactive planning begins at the time of admission, and utilization of resources is key when coordinating care in a patient that is known to necessitate immense resources for care.

Case Study #2 – Ms. H Continued

Response:
The Complex Care Team consult order was placed 9 days after Mrs. H's admission into the hospital.

- ❖ We began a **client centered approach** to reviewing the clinical complexities of Ms. H's case and understanding the multitude of barriers that this patient was facing. The Complex Care team was able to unravel a long history of care **trauma** that this patient experienced. At this time in reviewing her chart, we identified that she had experienced 23 hospital visits and / or admissions prior to this encounter.
- ❖ We reviewed the Physical Therapy consult 5 days after admit. These notes indicated that this patient was a **lift OOB, required bariatric sling, 3 person assist** for standing, 2-3 person assist for return to supine/side-lying. This level of assist was going to be a barrier to a SNF discharge. Placed on the **PT care escalation team** list to optimize PT treatments. Cooperative and wanting to work with therapy. Found that **pain** is a limiting factor.
- ❖ We reviewed PM&R (Physiatry) notes who consulted on hospital day 16. They indicate that the patient is limited in walking due to pain in her LE's. At baseline she is independent with mobility and able to perform transfers from bed to power wheelchair using stand step transfers. Identified a plan for pain and up-titration of medications including nociceptive, neuropathic and psychogenic. Advocated for a higher level of rehab care in the setting of significant weight loss and positive gains able to be made.
- ❖ Psych concerns noted and endorses **depressed mood, anxiety, panic attacks with history of multiple traumas.** Had seen a psychotherapist for 30 years until their retirement the year prior. Assisting patient to find additional supports in community for psychotherapy
- ❖ Reviewed her 42 SNF denials , most of the concerns were related to the patient (now 388lbs) being over their weight limit and "unable to accommodate".
- ❖ Worked with our external collaborators to advocate for the patient to access an aggressive rehab plan to support not only her size which is a specialized approach to care, but also that she has never been given an opportunity to access a higher level of rehab, based on insurance denials and declined access clinically in the past. Patient as also voiced reservations of inpatient rehab settings related to a history of previous trauma she experienced. We worked with our resources / acute rehab partners to see how we could get them to a yes.
- ❖ Reviewed her community support history with service providers as she has had multiple VNA's. The providers reported that the patient was difficult to care for in the community as there was limited assistance and broken equipment. Care Transitions Specialist helped obtain a new hoyer and bariatric sling.
- ❖ Updated her DME profile of what the patient had that was working and was not in working order.
- ❖ Reviewed and updated her weight management profile and identified that she is now 388lbs which is improved from her last documented weight of 418lbs.
- ❖ We explored her PCA hours in the community as well to understand more of what the patient was able to receive. Gave her education about the resources that may be available to her like the PACE program.

Case Study #2 – Ms. H Continued

Response Continued:

- After multiple meetings with external collaborators, we were able to convince patient to accept a bed at an acute rehab. With rehab, PM&R and our contacts within the community, we were also able to ensure she was authorized for this level of care.
- The Care Transitions Specialist worked on obtaining a new hoyer and bariatric sling for her transition home when needed
- Concerns for discharge were brought up from the acute rehab. We did support them by identifying that this patient could be supported if help was needed on transition, however Ms. H was successfully discharged home from acute rehab with the services through a VNA we helped coordinate.

The approach to this case involved the Then and Now aspects of case management. From beginning to end it was client centered, collaborative, comprehensive and well-coordinated with internal teams and external resources. Additionally, we factored in some of the work with our current social determinants of health where complex care became involved. Critical care conversations were necessary, not only to support this patient and her pathway, but also support and advocate to the care givers, VNA's, in this case. This case embodied actionable strategies to support right site of care at the right time.

Resources

- What's Old Is New Again: The History of Case… | Relias Media, *By **Toni Cesta**, PhD, RN, FAAN*
- The Four C's of Patient Care | 2020-11-24 | Relias Media, *By **Jeanie Davis***
- Introduction to the Case Management Body of Knowledge | CCMC's Case Management Body of Knowledge (CMBOK) (cmbodyofknowledge.com)
- Smith, Laura E. MD; Escobar, Trancy CMAC, MBA; McCabe, Andrea MHA, et al. "Optimization of Patient Progression in a New Era: A Comprehensive Framework." *Professional Case Management* 29(3):p 91-101, May/June 2024. | DOI: 10.1097/NCM.0000000000000700
- Gillingham, D. C., & Llewellyn, A. (2016b). CCM Certification Made Easy. Blue Bayou Press

Questions?