THE CMSA STANDARDS OF PROFESSIONAL CASE MANAGEMENT PRACTICE

OUTCOMES
Course Module Narrative

Purpose

This module discusses on the Case Management Society of America (CMSA) Standard of Practice: Outcomes.

Effective

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Behavioral Objectives

The behavioral objectives of this module are:

1. Define outcomes and how they pertain to case management performance improvement (PI), and quality
2. Understand how the utilization of adherence guidelines, standardized tools, and or proven processes can be used in case management PI
3. Demonstrate how the utilization of evidence-based guidelines in client populations may be leveraged as part of case management PI

Standard

Changes to the standard appear underlined.

- The professional case manager, through a thorough individualized client-centered assessment, should maximize the client's health, wellness, safety, physical functioning, adaptation, health knowledge, coping with chronic illness, engagement, and self-management abilities (CMSA, 2016, p.24).

How demonstrated

Adherence to this Standard is demonstrated as:

- Created a CM plan of care based on the thorough individualized client-centered assessment
- Achieved through quality and cost-efficient CM services, client's satisfaction with the experience of care, shared and informed decision-making, and engagement in own health and health care
- Evaluated the extent to which the goals and target outcomes documented in the CM plan of care have been achieved
- Demonstrated efficacy, efficiency, quality, safety, and cost-effectiveness of the professional case manager's interventions in achieving the goals documented in the CM plan of care
- Measured and reported impact of the CM plan of care
- Applied evidence-based adherence guidelines, standardized tools and proven care processes
- Applied evidence-based guidelines relevant to the care of specific client populations
- Evaluated client and/or client's family or family caregiver experience with CM services
- Used national performance measures for transitional care and care coordination such as those endorsed by the regulatory, accreditation, and certification agencies, and health-related professional associations to ultimately enhance quality, efficiency and optimal client experience (CMSA, 2016, p.24)

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Introduction

Case management is at the forefront of the United States' health care reform efforts appearing throughout the Patient Protection and Affordable Act of 2010 you find topics such as CM, care coordination, transition of care, and the prevention of avoidable readmissions. Professional case managers demonstrate value through attention to process improvement methodologies, producing measurable outcomes, and achievement of process effectiveness through use of outcome indicators. Organizations leverage outcomes to demonstrate support of their mission, vision, and strategic objectives. This module addresses process improvement and outcomes at both the individual and organizational levels.

Definition of key terms

Terms used in this module and defined herein ensure common understanding.

Benchmarking	According to AHRQ, "A measurement of the quality of an organization's policies, Benchmarking is the process of comparing a practice's performance with an external standard. Benchmarking is an important tool that facilitators can use to motivate a practice to engage in improvement work and to help members of a practice understand where their performance falls in comparison to others. Benchmarking can stimulate healthy competition, as well as help members of a practice reflect more effectively on their own performance." (AHRQ, 2013)
Desired outcome	As pertains to CM practice, a desired outcome is the intended result of an intervention, or set of interventions, undertaken by an individual or organization. The CMSA Standards of Practice broadly defines significant functions that are part of the CM process, which aims to achieve desired outcomes.
Evidence-based care	An early definition, offered by Sackett et al, was "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (1996). The definition, adapted by the National Academy of Medicine (formerly the Institute of Medicine) is "care delivered that is supported by evidence, and care supported by evidence that is delivered." (Medicine, 2017)
Goal	This term is often used interchangeably with desired outcome and should include an objective measurement for assessing its achievement as well as a timeframe within which it is anticipated to be accomplished.
Indicator	Indicators are used to evaluate quality in healthcare. They must be standardized and evidence-based to track clinical performance and outcomes. Example of quality indicators include, but are not limited to, measures related to prevention, inpatient admissions, patient safety and pediatrics (AHRQ QI, 2017)
Outcome	The measurable results of CM interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle (CMSA, 2016). Outcomes describe the results and consequences from the care received; outcomes also result from care that was not received (Tahan and Treiger, 2017).

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Outcomes, Continued

Definition of key terms, continued

Performance	Performance in healthcare is evaluated through established measures to demonstrate accurate, useful information on healthcare quality that assist in decisions made by consumers, employers, physicians, other clinicians, and policymakers (Core Measures, 2017).
Performance Improvement	Process Improvement (PI) uses measures and standards it achieve desired results. PI modules should include (Science of Improvement: How to Improve, 2017): • Setting an aim: what are you trying to accomplish? • Establish measures: how will change be interpreted as improvement? Selecting changes: what change will result in improvement
Quality	In 2001, The Institutes of Medicine defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." (IOM, 2001). This definition remains current and is used by other established healthcare resources like ARHQ and HRSA.

The opportunity for additional education

There is a variety of approaches used for process improvement. The generalist case manager may not be aware of the distinctions between the models and where application of each approach is best suited. This module includes a brief overview of the popular models. However, process improvement (and outcomes orientation) is essential aspects of professional CM; additional education is strongly advised. The models highlighted herein are:

- FOCUS-PDCA
- Lean
- PDCA
- PDSA
- Six Sigma

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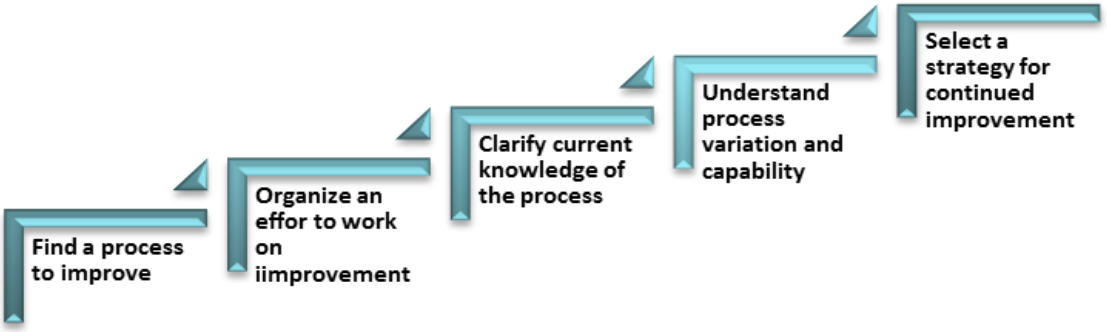
Process Improvement Method: FOCUS PDCA

W. Edwards Deming developed the FOCUS-PDCA model. It provides a model for improving processes. The model's name is an acronym that describes the basic components of the improvement process. The steps include:



PDCA is an acronym for **P**lan, **D**o, **C**heck and **A**ct. The PDCA cycle is a way of continuously checking progress in each step of the FOCUS process (Six Sigma Online, n.d.).

Process Improvement Methodology: Lean

Lean is a well-defined set of tools that increase customer value by eliminating waste and creating flow throughout the value stream. Figure 1 depicts Lean steps. Intended improvements resulting from this approach include:

- Inexpensive to implement
- Focus on improving the process, not the people
- Address the batch and queue mentality of silos by following process flow
- Promote simple, error proof systems

(Six Sigma Online, n.d.)

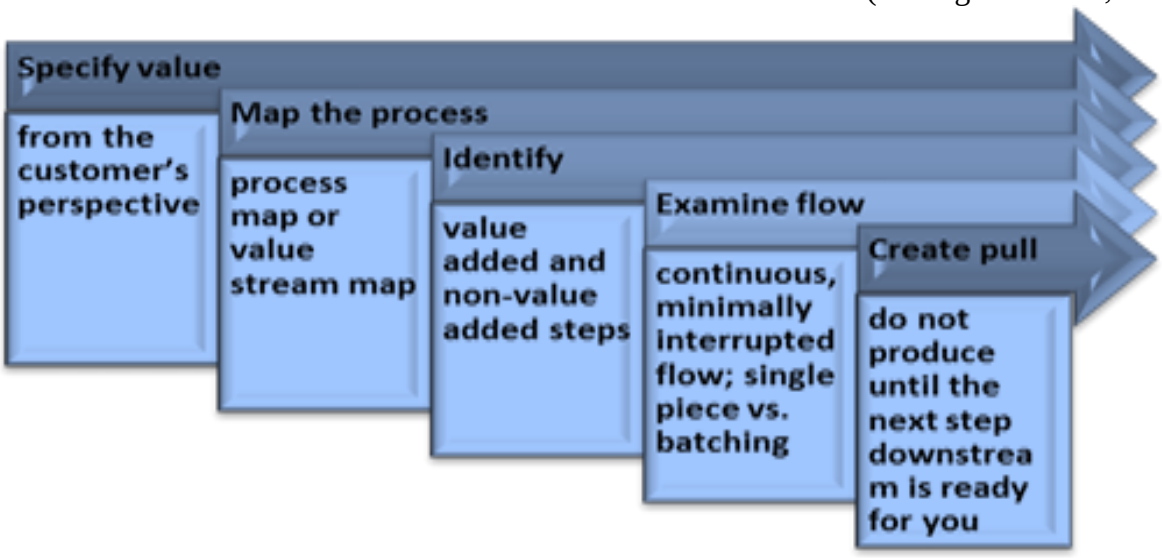


Figure 1. Lean Six Sigma

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Process Improvement Methodology: PDCA

The Deming Cycle, or PDCA Cycle (Figure 2), is a continuous quality improvement model consisting out of a logical sequence of four repetitive steps for continuous improvement and learning. (Six Sigma Online, n.d.)

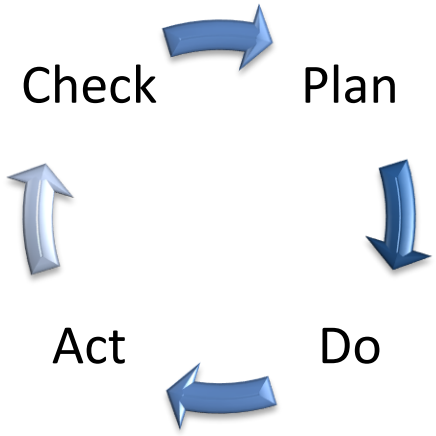

Figure 2. Deming's PDCA Cycle

Process Improvement Methodology: PDSA

The PDSA cycle (also known as PDCA). Its origin can be traced back to statistics expert Mr. Walter A. Shewart who introduced the concept of PLAN, DO and SEE. Subsequently, Deming modified the SHEWART cycle as **P**lan, **D**o, **S**tudy, and **A**ct (Six Sigma Online, n.d.).

Process Improvement Methodology: Six Sigma

Six Sigma is a rigorous and a systematic methodology that utilizes information (management by facts) and statistical analysis to measure and improve a company's operational performance, practices and systems by identifying and preventing 'defects' in manufacturing and service-related processes in order to anticipate and exceed expectations of all stakeholders to accomplish effectiveness (Six Sigma Online, n.d.).

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Client-centered outcomes

The case manager utilizes information gleaned from the assessment and develops a CM plan of care based on the individual needs of the client. It is essential understand the essence of a problem in order to develop a targeted strategy. The strategy will then take into account the client's strengths, weaknesses, and available resources in order to address it more effectively.

The examination of care needs and opportunities leads to understanding desired outcomes and allows for achievement of reasonable success measures within a specific timeframe. These outcomes are divided into short-, intermediate-, and long-term timeframes. Making this distinction supports fulfillment of accreditation requirements, such as URAC's CM Accreditation Standards and the National Committee for Quality Assurance CM Accreditation Program.

As part of a client-centered approach, the case manager discusses individualized goals of the case management plan of care (CMP) with the client/caregiver and incorporates feedback in order to attain consensus and maximize the potential for a collaborative working relationship. Once activated, the case manager continuously evaluates the effectiveness of interventions in the CMP. Documentation reflects the achievement of progress toward client goals. The case manager communicates progress to the client/caregiver. Identification of alternative approaches, which may be utilized to overcome barriers to success, is important when progress is slower than originally anticipated. This approach helps minimize client frustration.

The case manager recognizes that modifying the CMP and/or its desired outcomes, to be more reasonably achievable within the stated timeframe, based on changes in the client's health condition or circumstances.

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Writing client-centered outcomes

There are many ways in which to write goals that are measure and indicate the impact of CM intervention. The Planning module mentions the use of the SMART approach to CMP development. Figure 3 illustrates SMART goal tenets.

Figure 3. SMART goals

Use of a SMART approach contributes to the objective appraisal of goal achievement. The case manager uses a pre-selected measurement scale as a gauge of success for the effectiveness of CM interventions.

Without an objective goal, the determination of success is subject to individual interpretation, which may render the results less meaningless. This is especially true when assessing the overall effectiveness of a CM program.

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Addressing versus resolving CM-identified needs and opportunities

The wording used in setting CMP desired outcomes has a tremendous influence on whether it is reasonably achievable and objectively measurable.

Influences of achievability include, but are not limited to:

- Scope of case manager practice (e.g., licensure, certification)
- Scope of the CM program (e.g., program description, job description)
- Organizational policy and process
- Legal obligations
- Ethical considerations
- Level of anticipated care team collaboration
- Client/caregiver barriers (e.g., knowledge, skills)
- Available resources
- Means of objective measurement

Goals written in terms of resolving a need or opportunity may be unachievable if the case manager does not have complete control over the interventions associated with goal achievement. When written in terms of addressing a need or opportunity, achieving a desired outcome becomes a more reasonable expectation.

Recognizing the importance of goal formulation is essential to avoid consistent failure in reaching desired outcomes. In that instance, these failures lessen the impact of the CM program and reflect upon case manager performance.

Scenario: Identifying an achievable, measurable client-centered goal

Don Masters is a fifty-six (56) year old male with recent onset of Type II Diabetes Mellitus (DM). During his assessment, the case manager learns that he lacks understanding about his current health condition and how he can take better care of himself in order to minimize the development complications.

In developing a CMP, the case manager identifies the opportunity, *Knowledge deficit relating to diabetes.* It is later learned that the client must return to working a full-time schedule of days/evenings rotation in order to maintain health insurance benefits. In addition, he is dependent upon public transportation after recently allowing his automobile registration and insurance policy to lapse.

The case manager considers possible interventions to utilize in addressing this knowledge deficit. He discovers that the community hospital, located within walking distance of the client's home, offers a twelve (12) week diabetes education program. The next class begins in three (3) weeks. There are morning and evening sessions for the class. The instructor allows Mr. Masters to attend whichever session works with his shift schedule.

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Scenario: Identifying an achievable, measurable client-centered goal, cont.

Considering all known influencers, the case manager and client identify a desired outcome for this need as, *Completes a comprehensive diabetes education program within six (6) months*. An alternate option for this opportunity, *Understands diabetes as a health condition and the affect it has on overall health*. The reason this goal was not chosen was that measuring the client's level of understanding was not easily measurable in an objective manner. However, the case manager will be able to verify that the client enrolled and completed the proposed course in the stated timeframe.

Demonstrating program process improvements

From a department perspective, demonstrating efficacy, quality, and cost-effectiveness improvements are significant activities that support reaching program goals, which, in turn contribute to achievement of the organization's strategic goals. An example of leveraging PI methodology to improve department outcomes is illustrated in the following example:

Based on in-depth study of previous years' program outcomes, the HartNet Health Plan set a strategic goal to improve three (3) quality measures. The Case Management Department is charged with selecting and implementing one (1) of the three quality improvement initiatives, which is to focus on improving the percent of diabetic members who received an HbA1c measurement at least annually. The desired outcome was to achieve an 80% testing adherence rate within 24 months of program launch.

Realizing this was going to be a multi-year project, the PDCA method was selected to document the improvement cycle. A "Plan" is devised based on objective data, which demonstrated a consistent lack of outreach to both members and providers. Among the "Do" interventions are: notification of plan members diagnosed with diabetes of the special outreach program, educational materials regarding HbA1c were sent, three nutritional education classes were held, outbound follow-up calls were placed to members identified in higher risk categories, educational updates sent to providers, courtesy reminders for HbA1c testing (with follow-up notification to member and provider if no claim for testing was submitted). All activity is documented using database entry and claims data analysis.

The first "Check" was performed six (6) months after the interventions began. There was a slight improvement in adherence to HbA1c testing but it was not statistically significant at that time. Subsequent checks, performed monthly thereafter, demonstrated a steady improvement in the testing rate. At the one-year mark, the testing rate had leveled off a 75% for a two (2) month period. Additional "Actions" undertaken included outreach to individuals who had not responded on first attempt. Subsequent measurement showed improvement up to 82% adherence. This was monitored on an ongoing basis and the outreach program because part of the department's standard approach to diabetic care management.

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Reporting the impact of the care plan or PI opportunity

Communication plays a significant part in the PI process. It is important to verify organizational administrative policy to ensure smooth communication and inclusion of input and participation of all stakeholders and appropriate sources.

In addition, it is essential to document the impact of the PI initiative properly. The manner in which this is accomplished may be affected by the information system used (e.g., automated reporting capabilities) so it is also important to define documentation needs and expectations from the outset.

Considerations in documenting PI include:

- Describe the entire PI process from problem identification forward, delineate what formal changes were implemented
- Evaluate results and communicate as appropriate to relevant parties. Specify to whom and the date when reporting the results
- What are the recommendations /actions suggested for the next improvement period based on the analysis and barriers identified?
- What is the timeframe for repeat monitoring?

Utilizing adherence guidelines as a benchmark for PI

In 2003, the World Health Organization defined adherence as "the extent to which a person's behavior – taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider" (2003). The definition has not been updated since development. Using the term adherence fosters patient ownership and responsibility for mutually agreed upon therapeutic regimens. Patient buy-in to the treatment is an important factor that fosters appropriate medication taking.

CMSA's Case Management Adherence Guidelines (CMAG) addresses CM interventions for improving patient adherence to medication therapies. The core guidelines provide current information, tools, and common practices. These are useful within an organization seeking to improve its population adherence to treatment metrics.

Utilizing standardized tools as interventions for PI

Case managers may use standardized tools as part of their intervention strategy for performance improvement. The previously mentioned CMAG adherence improvement tools include utilizing a patient contract, providing incentives to support positive behavior change, motivational communication skills, patient reminder systems (e.g., medication wallet card, medication diary, pill organizer), and reminder strategies (e.g., follow-up phone calls, setting calendar reminders). In addition, CMAG offers knowledge and motivation level assessments such as the Readiness Ruler and Modified Morisky Scale. These tools are used to set baseline measures and assess the degree of change achieved. The case manager documents use of tools and results obtained according to organization policy and information system requirements.

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Outcomes, Continued

Utilizing proven processes as interventions for PI

Case managers may use proven processes as interventions for performance improvement. An example used in acute care settings by case managers and the interdisciplinary health care team is Project BOOST (Better Outcomes for Older Adults through Safe Transitions), a national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home. BOOST objectives (n.d.) include:

- Identify high-risk patients on admission and target risk-specific interventions
- Reduce 30-day readmission rates for general medicine patients
- Reduce length of stay
- Improve facility patient satisfaction and H-CAHPS (Hospital Consumer Assessment of Health Providers and Systems) scores

Improve information flow between inpatient and outpatient providers BOOST tools (2017) include:

- Condition specific tools
- Medication reconciliation
- Pain Management
- Post-acute Care Transitions
- Opioid Safety
- PediBoost

Use of evidence-based guidelines for 30-day readmissions

Case managers may utilize evidence-based guidelines for prevention of readmissions. One example of such guidelines is found in The Institute for Healthcare Improvement (IHI) and its SMART Discharge Protocol. IHI offers evidence based guidelines and tools for preventing avoidable readmissions on its website. A link to IHI is included in the "Additional Resources" section of this module. Additional evidence is being generated through the Centers for Medicare and Medicaid Innovation Center, the Agency for Healthcare Research and Quality, the Leapfrog group, the Institute for Healthcare Improvement, and other nationally recognized organizations and agencies.

Use of evidence-based guidelines for safe transitions of care

Case managers may utilize evidence-based guidelines to optimize transitions of care strategies. Several options are available and can be more specific to the place of practice. The Center for Healthcare Research and Transformation report that those at highest risk of readmission typically have modifiable risk. CHRT advocates use of the LACE or 8Ps tool for those making transitions from the acute care setting. (Improving Care Transiutions, n.d.). Dr. Eric Coleman developed the Care Transition Measure (CMT) which include 15- and 3-question surveys. The CMT-3 has been endorsed by the National Quality Forum (Coleman, n.d.). In order to improve communication between facilities transitions patients, The Joint Commission developed the Target Transitions Tool (Transitions of Care, 2013). This is certainly not a comprehensive list.

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Outcomes, Continued

Module questions

1. Indicators provide an objective basis to measure improvement in health care delivery and/or systems. True / False
2. The D in the process improvement method referred to as PDCA signifies which of the following:
   A. Document
   B. Deliver
   C. Do
   D. Draft
3. SMART goals support the objective measurement of client goal achievement. True / False

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Additional resources

American Board of Quality Assurance and Utilization Review Physicians
http://www.abqaurp.org

Case Management Society of America (CMSA)
Awards for Practice Improvement and Research
http://www.cmsa.org/Individual/MemberResources/AwardsRecognition/AwardforCaseManagementPracticeImprovement/tabid/556/Default.aspx

CMS Resources and Care Transitions
https://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html

Institute for Healthcare Improvement
http://www.ihi.org/Topics/Readmissions/Pages/default.aspx

The Joint Commission
https://www.jointcommission.org

The Leapfrog Group
http://www.leapfroggroup.org

National Association for Healthcare Quality
http://www.nahq.org

National Committee for Quality Assurance
http://www.ncqa.org

SixSigma
http://www.isixsigma.com

URAC
http://www.urac.org
